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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH
NEW HAMPSHIRE HOSPITAL
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Jeffrey A. Meyers
Commissioner

Lori A. Shibinette
Chief Executive Officer

December 7, 2018

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 to amend an existing agreement with Mary Hitchcock Memorial Hospital (a component of Dartmouth-Hitchcock), (Vendor #177160) of One Medical Center Drive, Lebanon, New Hampshire, 03756 for the provision of Physician Clinical and Administrative Services to meet the specialized health and related clinical and administrative needs of the residents of the State of New Hampshire by modifying the scope of services to support the continued delivery of these services, with no change to the contract price limitation of $36,554,042 and no change to the contract completion date of June 30, 2019, effective upon approval by the Governor and Executive Council. 28% Federal Funds, 32% General Funds, 40% Other Funds from Medicare, Medicaid and third party insurance.

The original agreement was approved by the Governor and Executive Council on August 24, 2016 (Item # 6A).

EXPLANATION

The purpose of this request is to modify existing physician, clinical and administrative services provided by the Contractor at New Hampshire Hospital (NHH).

The Contractor provides clinical and administrative services to the Department and specifically to New Hampshire Hospital through staffing all inpatient care units with medical staff, Advanced Practice Registered Nurses, research and general hospital clinical support. New Hampshire Hospital achieved Joint Commission Accreditation in September 2018 as an Acute Psychiatric Hospital. The hospital is executing strategic initiatives that focus on safety culture, efficiency and effectiveness of work flow and becoming a data driven organization.

This request, if approved, will modify the scope of services provided by the Contract by eliminating the requirement to retain a Neuropsychologist and a Public Psychiatry Fellow while adding the following positions:

- Director of Quality Systems and APRN Services
- Director of Health System Data and Information Services.

These new positions reallocate resources to New Hampshire Hospital's most critical areas of need. The Director of Quality Systems and APRN Services will establish and implement a comprehensive Quality Assurance program that ensures New Hampshire Hospital is meeting regulatory performance metrics that focus on excellence of patient care and prioritizes a culture of safety. Additionally, this position provides oversight and supervision to the Advanced Practice Registered Nurses, ensuring standardized practice in line with established practice guidelines in psychiatric medicine.

The Director of Health Systems Data and Information Services serves as the conduit for data collection within New Hampshire Hospital. This position will oversee Health Information Services, Information Technology, the Electronic Health Record and the strategic movement of New Hampshire Hospital becoming a data driven organization.

Should the Governor and Executive Council determine to not authorize this request, the Department may not be able to provide essential services at NHH to ensure compliance with regulatory and safety requirements required to maintain accreditation with The Joint Commission, and may increase risk for many of the State's most vulnerable residents.

Area Served: New Hampshire Hospital, Concord NH

Source of Funds: 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; 32% General Funds, and; 40% Other Funds (Medicare, Medicaid & third party insurance).

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

Respectfully submitted,

Lori A. Shibinette
Chief Executive Officer

Approved by:

Jeffrey A. Meyers
Commissioner

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

State of New Hampshire
Department of Health and Human Services

Amendment #1 to the Physician Clinical and Administrative Services Contract

This 1st Amendment to the Physician Clinical and Administrative Services contract (hereinafter referred to as "Amendment #1") dated this 20th day of November 2018, 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 corporation with a place of business at One Medical Center Drive, Lebanon, New Hampshire 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 24, 2016, (Item #6A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified; and

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

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to modify the scope of services to support continued delivery of these services; and

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

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

   Nathan D. White, Director.

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

   603-271-9631.

3. Delete Exhibit A, Scope of Services in its entirety and replace with Exhibit A Amendment #1.
4. Add Exhibit K, DHHS Information Security Requirements.

This amendment shall be effective upon the date of Governor and Executive Council approval.
IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/12/18
Date

Lori Shibinette
Name:
Title:

Mary Hitchcock Memorial Hospital

11/21/18
Date

Name: Daniel P. Jantzen
Title: Chief Financial Officer

Acknowledgement of Contractor's signature:

State of New Hampshire, County of Grafton on November 21 2018, 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
- MY -
COMMISSION
EXPIRES
APRIL 19,
2022
NEW HAMPSHIRE
NOTARY PUBLIC

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

12/10/18
Date

Name:
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 will 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 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. Covered Populations and Services

The Contractor shall provide physician clinical and administrative services to various populations served by DHHS, in all seven (7) Service Areas identified below and as described herein:

2.1.1. Service Area #1 – New Hampshire Hospital (NHH)

2.1.2. Service Area #2 – Glencliff Home

2.1.3. Service Area #3 – Medicaid

2.1.4. Service Area #4 – Children, Youth and Families

2.1.5. Service Area #5 – Behavioral Health

2.1.6. Service Area #6 – Elderly and Adult Services

2.1.7. Service Area #7 – Developmental Services

2.2. General Requirements Applicable to All Service Areas

2.2.1. The Contractor shall provide psychiatric and other professional services to all service areas through the employment of appropriate Contractor staff described in the following sections, and requiring such staff to perform required services.

2.2.2. The Contractor shall work with DHHS to continue to develop and refine an integrated mental health care system applying principles of managed care for clinical treatment, educational and training programs, and related research.

2.2.3. The Contractor shall work with DHHS to jointly maintain and develop an applied research and evaluation capacity, the general purpose of which shall be to identify and address medical research issues relative to the DHHS mission under RSA 135-C. The activities shall be directed at enhancing applied research resources, capacities and activities within the State mental health services system and implementing a program of applied research relative to that system.

2.2.4. All personnel provided by the Contractor under this contract shall be employees or consultants of the Contractor. No personnel provided by

the Contractor under this contract shall be considered an employee of the State of New Hampshire.

2.3. Specific Service Requirements for Service Area #1 – New Hampshire Hospital

2.3.1. Chief Medical Officer's Administrative/Clinical Responsibilities

2.3.1.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO (NHH CEO) with respect to administrative/clinical matters, the Chief Medical Officer shall be responsible for the following:

a. To coordinate with the NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. To participate in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;
c. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
d. To perform annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Chief Medical Officer shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;
e. To perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Chief Medical Officer shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or NHH Medical Staff Organization bylaws;
f. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;
g. To provide consultation to DHHS relative to the development of the State mental health service system;
h. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the

established Customer Service Guidelines for Physicians;

i. To report to the NHH CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;
j. To participate as a member of the NHH's Administrative Executive Committee;
k. To participate as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH who represents the NHH CEO;
l. To participate with the NHH CEO in the development of the clinical budget of NHH;
m. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;
n. To establish, subject to the NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH;
o. To assist the NHH Chief Executive Office with the clinical supervision and education of all other clinical staff at NHH; and
p. To provide clinical coverage of Contractor staff as necessary.

2.3.2. Associate Medical Director Responsibilities

2.3.2.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO with respect to administrative/clinical matters, the Associate Medical Director shall be responsible for the following:

a. To coordinate with the NHH Chief Medical Officer and NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. Serves in the capacity of the chief medical officer during his/her absence;
c. To participate with the Chief Medical Officer in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;
d. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
e. To participate with the Chief Medical Officer in performing annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Associate Medical Director shall assist the Chief Medical Officer who shall consult with and seek

input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;

f. To work with the CMO to perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Associate Medical Director shall assist the Chief Medical Officer who shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or Medical Staff Organization bylaws;

g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;

h. To provide consultation to DHHS relative to the development of the State mental health service system;

i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;

j. To report to the NHH Chief Medical Officer and to the CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;

k. To participate as a member of the NHH's Administrative Executive Committee;

l. In the absence of the Chief Medical Officer, participates as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH representing the NHH CEO;

m. To participate with the NHH Chief Medical Officer and the NHH CEO in the development of the clinical budget of NHH;

n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;

o. To assist in establishing, subject to the NHH Chief Medical Officer and NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH; and

p. To assist the NHH Chief Medical Officer and the NHH CEO with the clinical supervision and education of all other clinical staff at NHH; and

q. To provide clinical coverage as necessary and to the extent possible when there are vacancies with the staff psychiatrists or advanced psychiatric nurse practitioners.

2.3.3. General Psychiatrist Responsibilities

2.3.3.1. The following responsibilities are applicable to all psychiatrists the Contractor provides to NHH under this contract. Staff psychiatrists shall be responsible for the following:

a. The formulation and implementation of individual treatment plans and clinical services, in cooperation with treatment teams, for the diagnosis, assessment, treatment, care and management of patients of NHH;
b. Maintaining and directing a clinically appropriate treatment plan for assigned cases in concert with the multidisciplinary staff consistent with NHH norms;
c. Determination, consistent with RSA 135-C, of the appropriateness of admissions, transfers and discharges;
d. Participation with other staff physicians, the NHH Chief Medical Officer, and the Associate Medical Director to provide on-call after hours coverage and serve as on-site, after hours coverage, on a 24-hour a day, 7-day a week, year round basis when necessary as determined by the NHH CEO, the NHH Chief Medical Officer, and/or the Associate Medical Director;
e. Participation in research and education activities consistent with the mission of NHH and subject to the approval of the NHH CEO;
f. Participation in the Medical Staff Organization and other administrative committees of NHH, assigned committees and task forces;
g. Performance of medical/psychiatric consultation on patients from facilities other than NHH, consistent with current NHH policy;
h. Timely completion of all necessary documentation as required by TJC and CMS standards;
i. Responsibility for completing NHH's Incident Reports in compliance with NHH policy;
j. Completion of all medical record documentation in the timeframes required by the NHH's Policy and Procedure "Medical Record Documentation" and other relevant policies and procedures, including ongoing and timely documentation of clinical care regarding medical necessity, including daily progress notes to document and support medical necessity;
k. Adherence to all NHH policies, including, but not limited to policies on Medical Records Documentation and Progress Notes;
l. Ensuring that documentation is consistent with normative data collected by the NHH compliance officer and NHH utilization review manager;
m. Provision of other services as required, which are consistent with the mission of NHH and the intent of this contract;
n. Appearing and testifying in all court and administrative hearings as required by the Department;
o. Developing and maintaining positive relationships with NHH staff, patients, families, advocates, community providers and other interest groups vital to the functioning of NHH and the DHHS system of care, including for the purpose of transition planning. In accomplishing this requirement, psychiatrists shall adhere to the standards set forth in NHH's Customer Service Guidelines for Physicians;
p. Meaningfully participating in utilization review processes, including appeals and other processes, as required by the NHH Chief

Medical Officer, the Associate Medical Director, and the NHH CEO; and

q. Demonstrating value added achievements with academic and scholarly activities including, but not limited to: teaching (clinical and didactic); attendance and participation in case conferences; engagement with the profession with presentation and/or publication; hospital in-services; and service to the hospital and community through committee work, task force work, community service with advocacy groups; and involvement with the work of DHHS, as well as other public and private agencies that serve the mentally ill, e.g. law enforcement, corrections, the court, the legislature, colleges and universities and other related entities.

2.3.3.2. All psychiatrists shall provide services on a full-time basis, and limit their practice to treating NHH patients only.

2.3.3.3. Notwithstanding the above, psychiatrists serving under this contract may perform occasional outside practice duties, with the advance written approval of the Chief Medical Officer and the NHH CEO, but only if said duties do not, in the sole judgment of the NHH CEO, interfere with the psychiatrists' duties at the NHH.

2.3.3.4. For subsection 2.3.3.2., the term "full-time" shall mean that each psychiatrist shall be required to account, through appropriate record-keeping as specified by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

a. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.
b. Psychiatrists may be permitted, subject to prior notice and the approval of both the Chief Medical Officer and the NHH CEO; to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. Psychiatrists approved for such activities shall provide documentation to the Chief Medical Officer and the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

2.3.3.5. Notwithstanding the foregoing allowance for educational or research activities specified in subsection 2.3.3.4.a., psychiatrists shall be physically present onsite at NHH not less than 36 hours per week, unless otherwise accommodated for through the Contractor's normal and customary employee leave policies.

2.3.4. Residents/Post Graduate Fellows Responsibilities

2.3.4.1. The responsibilities of all residents and post graduate fellows (PGY) shall be outlined, monitored, and reviewed by the Chief Medical Officer or the Associate Medical Director, and the appropriate attending psychiatrist.

2.3.4.2. Responsibilities for Residents/Post Graduate Fellows shall involve the advancement of the clinical initiatives underway at NHH under the

supervision of the Chief Medical Officer.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall ensure that Residents are an integral part of the Contractor's ACGME approved psychiatric residency program. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the field of public psychiatry.
b. Child/Adolescent Fellows – The Contractor shall ensure that Fellows are an integral part of the Contractor's ACGME approved child/adolescent training program. The Contractor shall incorporate a full spectrum of child/adolescent coursework and clinical experience to facilitate the NHH rotation, emphasizing areas of child welfare, family intervention, wraparound services and the juvenile justice system. Fellows shall provide coverage for the entire calendar year.
c. Geropsychiatry Fellow – The Contractor shall ensure that the Fellow is an integral part of an ACGME approved fellowship program in geriatric psychiatry. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of the elderly.

2.3.5. Psychiatric Advanced Practice Registered Nurses (APRN) Responsibilities

2.3.5.1. Psychiatric Advanced Practice Registered Nurses shall provide clinical services in extended care and admissions areas with patients with severe mental illness and medical co-morbidity morbidity in accordance with the scope of practice described in RSA 326-B:11.

2.3.5.2. The responsibilities for Psychiatric APRNs shall include but not be limited to: performing advanced assessments; diagnosing; prescribing; administering and developing treatment regimens; and providing consultation as appropriate.

2.3.5.3. APRNs shall independently prescribe, dispense, and distribute psychopharmacologic drugs within the formulary and act as treatment team leaders in accordance with State law and medical staff by-laws.

2.3.5.4. APRNs shall provide the same level of documentation as required of psychiatrists as outlined in subsection 2.3.3.1.

2.3.6. NHH Research Manager Responsibilities

2.3.6.1. The Research Manager shall be responsible for assisting in the development and management of all research at NHH. The Research Manager shall play a pivotal role in initiating and cultivating research that is efficient and responsive to the needs of the NHH CEO, psychiatrists, nursing staff, clinical investigators, administration, and patient community, and works with the Chief Medical Officer to market the research opportunities at NHH while tracking and reporting the growth and development of research activities.

2.3.6.2. The Research Manager shall develop policies and procedures to ensure that research endeavors function effectively and manages and

trains support staff in studies as the research program continues to grow and develop.

2.3.6.3. The Research Manager shall serve as the primary contact for all incoming and proposed studies, assesses feasibility and potential use of resources and guides potential projects through the process from initial proposal to planning for staffing, finding resources, reviewing budgets, and providing guidance with hospital, state and federal regulations through to completion of the project.

2.3.7. After Hours Coverage

2.3.7.1. The Contractor shall provide on-call after-hours coverage, 24 hours per day, 7 days per week, year round. Coverage shall be provided by one or more full-time psychiatrists who are certified or eligible for certification by the American Board of Psychiatry and Neurology. The coverage will be assigned in one-week increments in rotation among the full-time New Hampshire Hospital psychiatric staff. The after-hours coverage will include back-up to the psychiatry residents who provide in-house after-hours coverage and will cover in-house in the event that the assigned in-house physician is not able to provide the service.

2.3.7.2. The Contractor shall provide on-site after hours coverage, 16 hours per day, Monday through Friday, and 24 hours per day on weekends and holidays, year round.

a. The on-site after-hours coverage on weekdays, weekends and holidays shall be provided by a physician who is certified or eligible for certification by the American Board of Psychiatry and Neurology, or, is in training in an accredited psychiatry residency program with at least three years of training experience.
b. The Contractor shall maintain a pool of psychiatric physicians or resident physicians who are credentialed with New Hampshire Hospital for the after-hours work, and the after-hours physicians will be assigned to in-house after-hours coverage by the Chief Medical Officer or Associate Medical Officer with a six (6) month rolling calendar. The pool shall be of sufficient size and appropriate qualifications to ensure the Contractor's ability to meet 100% staffing level requirements and performance standards specified herein at section 4. Performance Standards and Outcomes.

2.3.8. Applied Clinical Research

2.3.8.1. The Contractor, working jointly with DHHS, shall identify and perform applied clinical research for the purpose of advancing the goals of the public mental health services system. All clinical research projects shall be approved by DHHS in advance. This shall include assessing the system's capacity, developing and/or refining clinical strategies, and training clinical staff in emerging treatment technology. The Contractor shall work jointly with DHHS to seek and obtain appropriate financial support (federal, State and foundation) to continue to build on the existing research projects. The Contractor

shall, subject to DHHS approval, ensure that publication of the findings of this research shall receive the widest possible dissemination in the services delivery system in New Hampshire and through conferences and special reports nationally and internationally.

2.3.9. Additional Requirements

2.3.9.1. The Contractor shall provide clinical personnel to perform the services required for clinical, educational, research, and training programs at NHH. The Contractor shall provide psychiatrists and other clinical personnel with sufficient professional skills and qualifications to provide the educational and research services needed by NHH.

2.3.9.2. At the direction of the NHH CEO, Contractor staff may be assigned to conduct telepsychiatry or offsite consultation not arising from the clinical operation and administration of New Hampshire Hospital or any other public health or clinical service offered by the Department. Contractor staff assigned to telepsychiatry shall have professional malpractice insurance in effect in an amount satisfactory to the Department. The Contractor shall be responsible for ensuring that staff members have malpractice insurance in effect and in amounts satisfactory to DHHS.

2.4. Specific Service Requirements for Service Area #2 – Glencliff Home

2.4.1. General Requirements

2.4.1.1. The Contractor shall provide routine or emergency telephone consultation by the Medical Director (described below) or an equally qualified physician at no additional cost, twenty-four (24) hours per day, seven (7) days per week, fifty-two (52) weeks per year, to clinical and administrative staff at the Glencliff Home.

2.4.2. Medical Director Responsibilities

2.4.2.1. The Contractor shall provide a geropsychiatrist to serve as the Medical Director. The Medical Director shall be responsible for the following:

a. Coordination of all medical care and direct psychiatric services, treatment and associated follow up to all residents of Glencliff Home;
b. Provide administrative functions, including but not limited to policy review and establishment that reflect current standards of practice; oversight of physicians; attendance at mandatory committee meetings, including but not limited to continuous quality improvement, infection control, and admissions; regularly review the use of psychotropic medications for compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations; and the provision of other assistance in meeting standards for annual State inspections and Federal regulations;
c. Deliver expert testimony in probate court as needed (e.g. guardianship cases, electroconvulsive therapy, do not resuscitate orders). Preparation may include consultation with legal counsel,

records review, and travel;

d. Provide written patient evaluations on each patient as frequently as required by the Department but in no case less than once per calendar year;
e. Serve as liaison with other organizations, such as NHH or Dartmouth-Hitchcock Medical Center, when a Glencliff Home resident is receiving services at another healthcare institution; and
f. Provide the applicable services as described herein at subsection 2.3.3.1. and its subparagraphs.

2.5. Specific Service Requirements – Service Area #3 – Medicaid

2.5.1. Department of Health and Human Services Chief Medical Officer Responsibilities

2.5.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated physician, to serve as the Department's Chief Medical Officer.

2.5.1.2. For the Chief Medical Officer, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by DHHS, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.5.1.3. The Chief Medical Officer shall maintain regular office hours consistent with DHHS' regular business hours for senior executive team members. The Contractor shall ensure that the Chief Medical Officer is provided a flexible work schedule that is consistent with the expectations of a senior executive manager at DHHS, subject to the approval of the DHHS Designee.

2.5.1.4. The Chief Medical Officer shall maintain his or her professional calendar electronically, in a format subject to DHHS approval, and make same available to the DHHS Designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes approved leave time, conferences, trainings, etc.

2.5.1.5. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Chief Medical Officer shall be subject to the prior approval of the DHHS Designee.

2.5.1.6. The Chief Medical Officer's primary workspace shall be located in Concord, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Chief Medical Officer utilizes DHHS-provided information and technology resources consistent with applicable State policies.

2.5.1.7. The Chief Medical Officer shall plan and direct all aspects of DHHS'

medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the DHHS Designee.

2.5.1.8. The responsibilities of the Chief Medical Officer shall include but not be limited to the following:

a. Developing strategic clinical relationships with physicians and in growing public/private partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms, such as but not limited to the Patient Protection Affordable Care Act (ACA), and any amendments thereto;
b. Overseeing the development of the clinical content in marketing and educational materials and ensures all clinical programs are in compliance with state and federal regulations;
c. Participating in the writing of research publications to support clinical service offerings;
d. Providing medical oversight of the state's publicly funded health insurance programs, making key policy decisions, and shaping administrative planning strategies to enhance the operating efficiency of Medicaid and CHIP and related healthcare initiatives across the state;
e. In collaboration with the DHHS Designee, directs the day-to-day operations of the DHHS program area responsible for clinical programs, benefit management, and quality improvement activities. Also serves as chief clinical liaison to other state program units, insurance providers, and professional organizations;
f. Serving as the clinical authority in reviewing and determining requests for covered and uncovered medical services and pharmacy services;
g. Participating in the development of procedural reimbursement policy;
h. Promoting and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the NH Medicaid program;
i. Identifying new developments and emerging trends in clinical practices and research that would have an impact on medical policy and/or costs, and recommends options and courses of action;
j. Within the context of implementation of federal health care reforms, such as but not limited to the Affordable Care Act and any amendments thereto, provides leadership in the planning, Medicaid program response, development of health care delivery systems, clinical quality initiatives, and related policy issues;
k. Representing the DHHS Designee at meetings and other events and serving as DHHS designee for any committees, boards, and commissions as requested;

l. Analyzing proposed and new federal legislation related to benefits management and recommends options and courses of action;
m. Maintaining and enforces policies, procedures, administrative rules, and State plan provisions that govern Medicaid medical benefits; and
n. Overseeing the implementation of contracted services, maintaining working relationships with contractors, managing contractor deliverables and services, and measuring contractor performance; and
o. Regularly attending Medicaid Management Team meetings.

2.5.1.9. Additionally, the Chief Medical Officer shall assist the DHHS Designee with managing the operations of the clinical and benefits management functions within the Medicaid program. This may include providing to the DHHS Designee input and making recommendations on staffing needs, performance standards, and other matters applicable to DHHS staff.

2.5.1.10. The Chief Medical Officer shall also provide executive team office coverage as needed and requested by the DHHS Designee.

2.6. Specific Service Requirements – Service Area #4 – Children, Youth and Families

2.6.1. DCYF Staff Psychiatrist Responsibilities

2.6.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. For purposes of this paragraph, the term "full-time" shall mean that the Staff Psychiatrist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.6.1.2. The Staff Psychiatrist is expected to work additional hours, including attending non-business hour meetings as required in order to meet the business needs of DHHS without additional cost to DHHS.

2.6.1.3. The Staff Psychiatrist shall maintain regular office hours consistent with those of DHHS senior executive team members.

2.6.1.4. The Staff Psychiatrist shall maintain his or her professional calendar electronically, in a form subject to DHHS approval, and make it available to the DHHS designee as necessary, and will keep it up to date to include leave time, conferences and trainings.

2.6.1.5. The Contractor shall ensure that the Staff Psychiatrist provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition

to any required approvals by the Contractor for its employees, the Staff Psychiatrist shall provide timely, prior notification to the designated DHHS representative of any leave time taken. Absences due to vacation and continuing education shall be planned in advanced, in consideration of the business needs of the DHHS designated program areas.

2.6.1.6. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Staff Psychiatrist shall be subject to the prior approval of the DHHS designee.

2.6.1.7. The Contractor shall ensure that any vacation or continuing education leave time by the Staff Psychiatrist shall be planned in advance and consider the business needs of DHHS, including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight.

2.6.1.8. The Staff Psychiatrist's primary workspace shall be located in Manchester, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Staff Psychiatrist utilizes DHHS-provided information and technology resources consistent with applicable State policies

2.6.1.9. The Contractor shall work directly with the DHHS designee for the Sununu Youth Services Center (SYSC), and shall ensure the following services are provided by the Staff Psychiatrist under the contract:

a. Provide medical and psychiatric services at SYSC;
b. Provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and Juvenile Probation and Parole Officers. Documents the number of comprehensive psychiatric evaluations and units of psychiatric services provided annually in direct care to youths in SYSC and the Juvenile Justice System. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;
c. Provides program development at SYSC, using a resiliency-building framework, and implementation of evidence-based practices to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;
d. Provides clinical supervision and teaching of child psychiatry residents and fellows at SYSC. Documents the number of teaching and supervision contacts annually with interns, residents, and fellows at SYSC;
e. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for JJS;

f. Documents on an aggregate level, through web-based outcome measures, the efficacy of services targeting Post Traumatic Stress Disorder, depression, substance abuse, and behavioral disorders among New Hampshire youth; and
g. Fosters improved interagency collaboration between JJS services, the area mental health agencies, and NHH to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court involved youths. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

2.7. Specific Service Requirements – Service Area #5 – Behavioral Health

2.7.1. Medical Director Responsibilities

2.7.1.1. The Contractor shall provide a part-time Medical Director and the necessary personnel to fulfill four major service components, in addition to a time study requirement in the area of behavioral health services. The four components are:

a. Medical Director for the Behavioral Health program;
b. Evidence-Based Practices Training and Consultation;
c. Behavioral Health Policy Institute (BHPI); and
d. Committee for the Protection of Human Subjects (CPHS).

2.7.1.2. The Medical Director shall be available on-site, at a DHHS designated location, for twenty (20) hours per week to provide services to the Behavioral Health service area. The Medical Director shall be available via telephone, email, and in person by appointment during that time.

2.7.1.3. The Medical Director shall, in collaboration with the DHHS designee be responsible for the following:

a. Meet weekly with the DHHS designee;
b. Address Behavioral Health clinical issues;
c. Address Behavioral Health policy issues;
d. Enhance housing support capacity planning;
e. Address Medicaid and state rule issues;
f. Address designated receiving facility maintenance and development;
g. Assist in developing Telemedicine capacity;
h. Utilizes electronic medical records;
i. Coordinate between NHH and CMHC care;
j. Evidence Based Practices (EBP) implementation;
k. Develop funding and reimbursement strategies;
l. Assist in sustainability of the "In Shape" program
m. Assess the needs of patients in NHH and Transitional Housing Services who might be served in the community; and
n. Attend meetings between the Behavioral Health program and various community stakeholder groups, such as the Community Behavioral Health Association and the Disabilities Rights Center,

to communicate about and also garner support for and input regarding Behavioral Health initiatives.

2.7.1.4. The Medical Director shall fulfill the additional following responsibilities:

a. Participate on key departmental and legislative committees, as required by DHHS, including the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the DHHS Institutional Review Board;
b. Serve as secretary for the Mental Health Council, to ensure that the work of the council supports the goals of DHHS;
c. Serve as a member of the Drug Utilization and Review Board to ensure that the Medicaid Preferred Drug List and work of the Board addresses the needs of consumers with mental illness disabilities;
d. Attend regular case conferences and sentinel event reviews. Analyze challenging clinical cases or events and recommend improvements in policy or services to address problem areas;
e. Attend monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of DHHS research participants;
f. Participate on several Behavioral Health System Transformation Workgroups, including the EBP Steering Committee, Programmatic Workgroup, and Quality Assurance Group;
g. Coordinate and meet with DHHS leadership as required by DHHS;
h. Conduct bi-monthly or more frequent Behavioral Health Medical Director's meeting to coordinate efforts, between Behavioral Health and CMHCs, regarding medical/treatment issues related to both hospital and outpatient care of people with serious mental illness and to consult on other relevant issues or concerns, including: preferred drug list issues, coordination with NHH admissions and treatment, Medicaid interruption during institutionalization, enhancement of community housing supports, use of information technology, medical director administrative issues, use of best practices, implementation of EBP's, documentation burden, integration of mental and physical health care, smoking cessation, coordinating local, state and national agendas regarding public mental health care, electronic health records, health information exchange, education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
i. Monitor the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in NH including engaging in ongoing discussions with CMHC leaders regarding the Preferred Drug List and direct education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
j. Communicate regularly with, and provide clinical consultation (including potential site visits, conference calls, and written

reports) to all Behavioral Health management staff regarding current, challenging clinical issues, including conditional discharges, Medicaid consumer cases, and suicide monitoring;

k. Collaborate with the other DHHS Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including drug choice for the Preferred Drug List, performance and impact of the Preferred Drug List on clinical care, Medicaid interruption during hospitalization and incarceration, integration of medical, mental health, and substance abuse services, and enhancement of addiction treatment capacity; and

l. Provide oversight and continuing implementation of Evidence Based Practices, including practices as part of the Medicaid Program for Community Mental Health Services as well as those practices specifically required in the Community Mental Health Agreement.

2.7.2. Evidence-Based Practices Training and Consultation

2.7.2.1. The Contractor shall provide Evidence-Based Practices Training and Consultation services as described in Appendix I, of RFP-2017-OCOM-01-PHYSI, for the purpose of sustaining and continuously improving the quality of three (3) Evidence-Based Practices (EBP) that are implemented across the New Hampshire Community Mental Health Centers (CMHC) system. The EBPs are: Illness Management and Recovery (IMR), Evidence-Based Supported Employment (EBSE), and Assertive Community Treatment Teams (ACT). Additional EBPs may take the place of these based on the availability of federal funding to support the implementation of additional EBPs in New Hampshire.

2.7.2.2. The Contractor shall provide education, training, technical assistance and consultation to the DHHS Behavioral Health service area and the CMHCs. The deliverables described below shall be provided directly to DHHS-designated Behavioral Health program staff and CMHCs designated by DHHS.

2.7.2.3. DHHS shall designate a specific DHHS Behavioral Health staff member to oversee the deliverables specified herein. The Contractor shall designate a specific representative of the Contractor to work directly with the DHHS designee in the fulfillment of these deliverables.

2.7.2.4. **Training the CMHC Workforce:** To sustain and improve the quality of IMR and EBSE services, the Contractor shall provide education and training to DHHS designated CMHCs staff.

a. The Contractor shall ensure that the training and education is provided in central locations and in a manner that best facilitates the learning of key skills and strategies that are necessary to provide IMR and EBSE in ways that support the most effective outcomes for consumers at each of the CMHCs. The training shall be designed to fulfill the specifications described in He-M

426 for CMHC providers of EBPs in NH.

b. Each training event shall include, at a minimum:
   i. Invitations provided to CMHC staff before the training event;
   ii. A description of who should attend the training;
   iii. Outcomes for participants attending the training;
   iv. Sufficient time to provide instruction and practice for skills;
   v. Content designed to improve the fidelity of the practice at CMHC's;
   vi. Documentation of all participants attending the training; and
   vii. Certificates of attendance for all participants completing the training.

c. Each training event shall be staffed by Contractor staff or other qualified professionals; such individuals shall be subject to approval of the DHHS designee.

2.7.2.5. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing IMR services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the IMR trainings in the following formats:
   i. A minimum of one two-day training for new IMR practitioners to fulfill the specifications described in He-M 426 to provide IMR services. The capacity for each of these training events shall be twenty participants and up to thirty participants depending on the availability of the training space;
   ii. A minimum of four half-day trainings for experienced IMR practitioners, of which the combination of attending any two of these events shall fulfill the specifications described in He-M 426 for ongoing providers of IMR services. The capacity for each of these training events shall be at least twenty participants and up to thirty participants depending on the availability of the training space.
   iii. A minimum of one full-day training for IMR supervisors that shall fulfill the specifications in He-M 426 for ongoing providers of IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR services through practice-specific supervision. The capacity for this training event shall be twenty participants.

2.7.2.6. **Evidence Based Supported Employment (EBSE):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing EBSE services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the EBSE trainings in the following formats:
   i. A minimum of two two-day trainings for new EBSE practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these

training events shall be twenty participants.

ii. A minimum of two half-day trainings for experienced EBSE practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The capacity for each of these training events shall be twenty participants.

iii. A minimum of two half-day trainings for experienced EBSE practitioners and EBSE supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The content shall include information on developing and improving collaboration with the New Hampshire Department of Vocational Rehabilitation and other important community partners in providing effective EBSE services. The capacity for each of these training events will be twenty participants.

2.7.2.7. **Assertive Community Treatment Teams (ACT):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing ACT services. The topic areas shall be subject to the DHHS designee's approval.

b. The Contractor shall provide the ACT trainings in the following formats:

i. A minimum of two two-day trainings for new ACT practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.

ii. A minimum of two half-day trainings for experienced ACT practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events shall be twenty participants.

iii. A minimum of two half-day trainings for experienced ACT practitioners and ACT supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events will be twenty participants.

2.7.2.8. **Assessing Fidelity to Evidence Based Practices (EBPs):** The Contractor shall assess the fidelity (organizational faithfulness to the principles of the practice) of IMR, ACT and EBSE for all CMHCs, as designated by the DHHS designee, with the exception of those CMHCs where the DHHS designee has approved a limited scope of review through the submission of an approved Quality Improvement Plan (QIP). In those organizations utilizing a QIP, the Contractor shall review those fidelity items described in the QIP.

a. In either case, fidelity assessments shall be conducted for the purpose of monitoring the implementation of IMR, ACT and EBSE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the

designated CMHCs.

b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMHC IMR, ACT and EBSE fidelity or QIP review. The schedule shall be subject to the advanced approval of the DHHS designee.
c. The Contractor shall ensure that each fidelity or QIP assessment includes, at a minimum:
   i. Written instructions to the CMHC regarding necessary observations, interviews, data access and other activities for the assessment;
   ii. A description of CMHC staff, other community providers, consumers and family members who will need to be interviewed for the assessment;
   iii. A specific written assessment schedule jointly developed by the Contractor and the CMHC;
   iv. Sufficient time to assess and evaluate the CMHC's delivery of IMR, ACT or EBSE;
   v. A debriefing at the end of the assessment to review themes from the review with CMHC leadership; and
   vi. Documentation of the assessment process, findings and scoring of fidelity items for CMHC leadership and the Department no later than four weeks following the assessment.

2.7.2.9. **Consultation to CMHC Leadership and Workforce Development**: The Contractor shall provide agency-based consultations to all CMHCs as designated by the DHHS designee to assist agencies in sustaining and providing continuous quality improvement for IMR, ACT and EBSE services. The Contractor shall ensure that CMHC leadership has access to consultations at their agencies after they have received the written documentation of the findings of each fidelity assessment described herein at subsection 2.7.2.8. Consultations shall include the development of ideas, strategies and interventions that each individual CMHC may utilize to most effectively sustain and improve IMR, ACT and EBSE services.

a. In cases where CMHCs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall ensure that such further interventions are provided only when collaboratively agreed upon by the DHHS designee, the Contractor and CMHC leadership. These interventions shall be time-limited (customarily one half-day, single events) and specifically tailored to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

2.7.2.10. **NH Behavioral Health Service Area Consultations and Collaboration:** In order to most effectively fulfill the deliverables described in this document for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services in the NH Community Mental Health system, the Contractor shall work in a highly integrated fashion with the DHHS designee and additional

DHHS Behavioral Health resources identified by the DHHS designee. This integrated alliance shall also be extended to other state and community agencies as collaboratively agreed upon by the DHHS designee and the Contractor.

a. In addition to attending designated meeting or events, the Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the DHHS designee and the Contractor. Specific activities for consultation and collaboration shall include:

i. The Contractor's attendance at the State EBP advisory committee bi-monthly meetings by the Contractor and/or designees;
ii. The Contractor's attendance at weekly meetings with the DHHS designee;
iii. Attendance of Contractor staff at monthly meetings with the DHHS designee and any additional DHHS Behavioral Health resources identified by the DHHS designee;
iv. The Contractor's attendance at quarterly meetings with the DHHS designee, and any additional DHHS Behavioral Health resources identified by the DHHS designee, to review progress of these deliverables and make any necessary resource allocations within the scope based, as collaboratively agreed upon by the DHHS designee and the Contractor;
v. The Contractor's attendance at DHHS designated meetings with NH Bureau of Vocational Rehabilitation (NHBVR) personnel to improve collaboration between EBSE services and NHBVR at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
vi. The Contractor's attendance at DHHS designated meetings with Granite State Employment Project (Medicaid Infrastructure Grant) personnel to improve collaboration between EBSE services and the Granite State Employment Project at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
vii. The Contractor's attendance at DHHS designated meetings with DHHS Behavioral Health personnel regarding Behavioral Health strategies and interventions, including proposed rule or policy and procedure changes, to better facilitate the sustaining and improvement of IMR, ACT and EBSE services in the NH Community Mental Health system;
viii. The Contractor's attendance at designated meetings with key CMHC personnel, including monthly meetings of CMHC Community Support Program directors, regarding the Contractor's activities and to better facilitate the sustaining and improvement of IMR, ACT and EBSE services; and
ix. The Contractor's attendance at other events, as collaboratively agreed upon by the DHHS designee and the Contractor, for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services.

2.7.3. Behavioral Health Policy Institute (BHPI)

2.7.3.1. Under the direction of the DHHS designee and the Behavioral Health Medical Director providing services to the Behavioral Health program, the Contractor shall conduct periodic analyses, the frequency of which shall be determined by DHHS, of Medicaid claims to address policy issues and questions under consideration from the Behavioral Health program. The Contractor shall participate in regular meetings with the DHHS designee and the Behavioral Health Medical Director to review these analyses, and associated policy implications.

2.7.4. Committee for the Protection of Human Services (CPHS)

2.7.4.1. The Contractor shall achieve the following CPHS related deliverables for the purpose of sustaining and supporting a committee to oversee research funded by federal agencies and other non-state sources, and conducted in New Hampshire DHHS-funded programs that serve people with mental illness, developmental disabilities, and substance abuse or dependence disorders, in fulfillment of NH RSA 171-A:19-a. Because of federal regulations governing the composition and operation of such committees, a certain number of scientific experts must be present on the committee. The Contractor shall provide research, scientific and human subject's expertise to the CPHS under the contract.

2.7.4.2. The Contractor shall provide staff to support the CPHS who shall:

a. Attend and fully participate in CPHS full committee meetings (once per month);
b. Conduct expedited reviews as requested by the CPHS Administrator (averaging about three per month);
c. Provide consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject's protections (e.g., pre-reviewing materials, reviewing requirements for exempt and expedited determinations, reviewing significant adverse event reports);
d. Serve on the Consent Form Template and Forms sub-committees, or others as requested by the CPHS Chairperson; and
e. Serve as the Co-Vice Chair to the CPHS.

2.7.4.3. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the DHHS designee. The availability of additional federal funds to support the implementation of additional Evidence Based Practices may also necessitate a renegotiation of priorities outlined in this deliverables plan, and a reallocation of the Contractor's time in order to assist with the construction of federal grant applications. Changes agreed upon may be subject to Governor and Executive Council approval.

2.7.5. Time Studies

2.7.5.1. The Contractor shall be responsible for performing regular time studies in accordance with CMS and DHHS Medicaid Cost Allocation

procedures in order to document activities, relating directly to the administration of the Medicaid program, to draw down federal matching revenues, which will be utilized to support costs associated with the Behavioral Health Medical Director's salary, benefits, and indirect expenses. These studies shall be provided in and documented in a format approved by DHHS.

2.8. Specific Service Requirements – Service Area #6 – Elderly and Adult Services

2.8.1. Medical Director Responsibilities

2.8.1.1. The Contractor shall provide a part-time Medical Director to the Elderly and Adult Services service area who shall provide services for the purposes of sustaining and improving the quality of services for the elderly and adults with disabilities in NH.

2.8.1.2. The Medical Director shall, in collaboration with the DHHS designee:

a. Assist in the planning and direction of the organization's medical policies and programs;
b. Strategically develop public/private partnerships with community providers, academic institutions and state/federal agencies with a focus on quality improvement;
c. Serve as a resource for chronic disease self-management or other wellness/prevention initiatives to improve the lives of individuals served by the Elderly and Adult Services service area;
d. Perform a variety of complex tasks that include the provision of medical consultation, clinical oversight, educational instruction, benefits management and quality assurance within the Elderly and Adult Services service area;
e. Provide medical oversight for all aspects of the Medicaid Program managed by the Elderly and Adult Services service area, including the waiver program for seniors and adults with disabilities, assisting in key policy decisions, identifying partnering opportunities with other program areas, and shaping administrative planning strategies to enhance the program's operating efficiency and cost effectiveness;
f. Serve as the clinical authority in reviewing requests for coverage of services not routinely offered, and providing clinical guidance to the Elderly and Adult Services service area on all such responses, as well as collaborating on developing new service coverage to respond to needs or practices identified;
g. Promote and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the Elderly and Adult Service area;
h. Identify new developments and emerging trends in clinical practice and research that would have an impact on clinical policy and/or costs and recommend options and courses of action;
i. Identify program development opportunities within federal health care reforms, such as but not limited to the implementation of the Patient Protection Affordable Care Act (ACA) and any

amendments thereto;

j. Leads planning and development of program and policy changes within the Elderly and Adult Services service area throughout the implementation of federal health care reforms, such as but not limited to the ACA and any amendments thereto;
k. Participate in the Technical Assistance Committee (TAC) that reviews clinical issues and initiatives within New Hampshire Nursing Facilities;
l. Participate in the quality assurance initiative, Sentinel Event Reviews;
m. Assist in the implementation of ACA by providing leadership in the planning and development of health care delivery systems, clinical quality initiatives and related policy issues;
n. Provide educational training to DHHS Elderly and Adult Services service area personnel, and external stakeholders;
o. Provide clinical expertise and medical consultation in Elderly and Adult Services service area grant writing and program evaluation;
p. Attend a minimum of two (2) Technical Advisor Committee meetings per annum;
q. Attend Sentinel Event Review Meetings; and
r. Meet, two times per month with the DHHS designee to review initiatives and provide consultation services.

2.9. Specific Service Requirements – Service Area #7 – Developmental Services

2.9.1. Medical Director Responsibilities

2.9.1.1. The Contractor shall provide a part-time Medical Director to the Developmental Services service area. The Medical Director shall provide services that includes two days of psychiatric consultation services per week, and is allocated at 0.4 Full-Time Equivalent.

2.9.1.2. The Medical Director shall:

a. Weekly dedicate one day to referrals from the ten Area Agencies and another day to referrals from Special Medical Services (SMS) and its child development clinics. These referrals may include the Medical Director performing evaluations, consultations and medication reviews;
b. Based on He-M 1201, chair Developmental Services' Medication Committee meetings and provide expert opinion and leadership to facilitate effective functioning of the Committee;
c. Assist the DHHS Developmental Services service area staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews;
d. Provide educational training to DHHS Developmental Services service area staff, Area Agencies, and subcontract agencies and other stakeholders, as identified by Developmental Services;
e. Provide expertise and assistance in efforts to improve New Hampshire's developmental services system; and
f. Respond to all referrals for evaluations and consultations made through the Area Agencies, SMS, and child development clinics.

2.9.2. Adult Developmental Services Interdisciplinary Clinic Team

2.9.2.1. The Contractor shall provide an Interdisciplinary Clinic Team for Adults. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Adults.

a. **Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination; including reviewing the client's entire past psychiatric treatment and medical history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each client;
b. **Neuropsychologist** – the neuropsychologist shall review all past psychiatric, medical records, neuropsychological testing and behavioral incidents. The neuropsychologist shall document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee the documentation of historical information regarding the client;
c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical, past psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support will schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.2.2. The Interdisciplinary Clinic Team for Adults shall provide the following services:

a. The Contractor shall ensure the Team accepts adults being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high quality interdisciplinary evaluations to adults with developmental disabilities and acquired brain injuries.

The Contractor shall provide a comprehensive understanding of the client with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the clients strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, Area Agencies and medical providers to provide the best quality of care for each person. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;

c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 clients per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records of each client prior to each face-to-face appointment. The Contractor's Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the visit and recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and
d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

2.9.3. Child Developmental Services Interdisciplinary Clinic Team

2.9.3.1. The Contractor shall provide an Interdisciplinary Clinic Team for Children. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Children.

a. **Child Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination, including reviewing the client's entire past psychiatric treatment history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each patient;
b. **Neuropsychologist** – the neuropsychologist shall review all past medical records, neuropsychological testing, and behavioral incidents; document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee writing the historical information regarding the child;

c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support shall schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.3.2. The Interdisciplinary Clinic Team for Children shall provide the following services:

a. The Contractor shall ensure the Team accepts children being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high quality interdisciplinary evaluations to children and adolescents with developmental disabilities. The Contractor shall provide a comprehensive understanding of the child with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the child's strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, area agencies and medical providers to provide the best quality of care for each child. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;
c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 client appointments per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records prior to each client's appointment. The Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of

caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the client's appointment and resulting team recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and

d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

3. Staffing

3.1. General Requirements Applicable to All Service Areas:

3.1.1. The following requirements apply to all personnel provided under the contract:

3.1.1.1. The Contractor shall recruit and retain qualified individuals for the staffing needs specified herein at subsections 3.3 through 3.9, and as otherwise necessary to fulfill the requirements described herein at: Section 2, Scope of Services; Section 4, Performance Standards and Outcomes; and Section 5, Reporting.

3.1.1.2. All such individuals shall be subject to DHHS approval prior to the Contractor notifying candidates of assignment/hire to fulfill a specified staffing role. DHHS shall inform the Contractor of its applicable designee for this purpose per position or service area. The designee, at his or her discretion, shall be entitled to interview any such candidate; the Contractor shall facilitate coordinating such interviews upon the DHHS designee's request.

3.1.1.3. DHHS, at its sole discretion, may rescind, either permanently or temporarily, its approval of any Contractor personnel providing any services under this contract for any of the following reasons:

a. Suspension, revocation or other loss of a required license, certification or other contractual requirement to perform such services under the contract;
b. Providing unsatisfactory service based on malfeasance, misfeasance, insubordination or failure to satisfactorily provide required services;
c. Arrest or conviction of any felony, misdemeanor, or drug or alcohol related offense;
d. Abolition of the role due to a change in organizational structure, lack of sufficient funds or like reasons; or
e. Any other reason which includes, but is not limited to: misconduct, violation of DHHS policy, or violation of state or federal laws and regulations pertaining to the applicable DHHS service area, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

In the event of such rescission, the Contractor's applicable staff member shall be prohibited from providing services under the contract for the period of time that DHHS exercises this right. In the event DHHS chooses to exercise this right, DHHS shall provide reasonable advance notice to the Contractor.

3.1.1.4. DHHS shall provide the Contractor with prior notice of exercising its right under subsection 3.1.1.3. and the reason for which DHHS has exercised its right. If DHHS removes Contractor personnel for any reason, no additional payments shall be paid by the State for any staff removed from duty by the Department

3.1.1.5. In the event that DHHS exercises its right under subsection 3.1.1.3.

a. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under the contract, including but not limited to being subject to the DHHS approval specified in 3.1.1.2.;
b. The Contractor shall be responsible for providing transition services to the applicable DHHS service area to avoid the interruption of services and administrative responsibilities at no additional cost to DHHS;
c. DHHS shall inform the Contractor of the anticipated duration for which approval will remain rescinded. If the position is assigned to NHH, and if the duration of a temporarily rescinded approval is greater than seven (7) calendar days, the Contractor shall furnish within ten (10) business days replacement Contractor staff who shall meet all of the requirements for the applicable position under the contract. The Contractor shall be responsible for providing, at no additional cost to the Department, transition services to NHH to avoid service interruption;
d. It shall be at the Contractor's sole discretion whether to initiate any internal personnel actions against its own employees. However, nothing herein shall prohibit the Contractor from seeking information from DHHS regarding DHHS' decision, unless such information is otherwise restricted from disclosure by DHHS based on internal DHHS policies or rules, State of New Hampshire personnel policies, rules, collective bargaining agreements, or other state or federal laws.

3.1.1.6. The Contractor shall ensure that, prior to providing the applicable services for the applicable DHHS service area or facility, all required licenses, certifications, privileges, or other specified minimum qualifications are met for all staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable DHHS designee with a copy of all such documents. The Contractor acknowledges and agrees that DHHS shall not be held financially liable for any fees or costs for any licenses, certifications or renewal of same, nor for any fees or costs incurred for providing copies of said licenses or certifications.

3.1.1.7. The Contractor shall ensure that all staff provided under this contract

are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. However, whereas the Contractor and DHHS agree that the continuity of operations and continuous provision of the staffing described in this contract at the level of 100%, is of paramount importance to the State, in addition to any required approvals by the Contractor for its employees, Contractor staff providing services shall provide timely, prior notification to the applicable DHHS designee for any anticipated leave time, unless otherwise stated herein for a specific position or service area.

3.1.1.8. All personnel provided by the Contractor shall be subject to the identified criminal background, registry, screening and medical examinations, as specified in the table below, for the applicable Service Area to which the individual is assigned contractual service responsibilities. The Contractor shall ensure the successful completion of these requirements for each individual assigned by the Contractor to perform contractual services prior to commencing work and shall ensure that such requirements are kept up to date as required; the Department shall receive copies of all documentation prior to the commencement of services and shall not be responsible for any costs incurred in obtaining the documentation described below:

Service Area		Required Background, Registry, Screening, and Medical Examinations
1	New Hampshire Hospital	Criminal Background, BEAS State Registry, DCYF Central Registry, Health Assessment (including TB testing and physical capacity examination).
2	Glencliff Home	Criminal Background (including RSO and OIG), BEAS State Registry, DCYF Central Registry, TB Testing
3	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
5	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
6	Elderly and Adult Services	Criminal Background, BEAS State Registry
7	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

3.2. General Staffing Requirements Applicable to Service Area #1 – New Hampshire Hospital

3.2.1. The following additional requirements shall apply specifically to personnel provided to fulfill the contractual requirements applicable to Service Area #1 – NHH, for the duration of the contract:

3.2.1.1. The Contractor shall ensure that the Chief Medical Officer actively participates in the recruitment of all other staffing needs required

under the contract for the provision of services at NHH.

3.2.1.2. The Contractor shall ensure that, prior to commencing practice at NHH, all psychiatrists are licensed to practice medicine in the State of New Hampshire, as well as boarded in their particular specialty or are board eligible, and shall commence the privileging process of the Medical Staff Organization of NHH as authorized by its by-laws. Such licenses and clinical privileges must be maintained throughout the term of the contract.

3.2.1.3. The Contractor shall ensure that all clinical personnel maintain appropriate licensure/certification relevant to the practice of their clinical disciplines.

3.2.1.4. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Chief Medical Officer role.

3.2.1.5. In addition to the provisions stated herein at subsection 3.1.1.7., staff providing services to NHH shall provide timely, prior notification to the Chief Medical Officer and the NHH CEO for any anticipated leave time. The Contractor shall be solely responsible for providing, at no additional cost to DHHS, qualified, sufficient staff coverage to fill any gap in coverage during any anticipated leave time, including sick leave, lasting more than three (3) consecutive days unless otherwise agreed upon by the NHH CEO on a case-by-case basis, and for providing appropriate transition between staff members covering for those on leave. Qualified sufficient staff coverage shall mean personnel who meet or exceed the qualifications of the vacating staff member.

3.2.1.6. The Contractor acknowledges and understands that DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

3.2.2. DHHS reserves the right, through its NHH CEO, or other designee in the absence of the NHH CEO or a vacancy in that position, at its sole discretion to rescind, either temporarily or permanently, its approval of any Contractor staff member providing services at NHH for any of the following reasons:

3.2.2.1. Loss of medical staff privileges at NHH pursuant to medical staff by-laws;

3.2.2.2. Revocation or suspension of the Chief Medical Officer's New Hampshire medical license;

3.2.2.3. Arrest or conviction of a felony, misdemeanor or drug or alcohol related offense; or

3.2.2.4. Any other reason, which includes, but is not limited to: misconduct, violation of NHH or DHHS policy or state or federal laws or regulations, malfeasance, unsatisfactory work performance, or a

determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

3.2.3. Should DHHS exercise this right, the applicable staff member shall be prohibited from providing services under the contract for any period of time DHHS chooses.

3.2.4. If the NHH CEO removes Contractor staff assigned to this service area, including the Chief Medical Officer, for any reason, the Contractor shall not be entitled to payment for the staff member during the period of removal.

3.2.5. If approval of the Chief Medical Officer is temporarily rescinded, pursuant to subsection 3.1.1.3., the Contractor shall furnish within ten (10) business days a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.2.6. DHHS shall provide Contractor staff at NHH with adequate facilities and DHHS-employed administrative support staff. Facilities shall include, but not be limited to, office space, equipment, and furnishings. Sufficient space to accomplish educational, training, and research missions shall also be made available. Administrative support staff shall include, but not be limited to, secretarial assistance, including one full-time executive secretary to support the Chief Medical Officer.

3.2.7. The Contractor, the Chief Medical Officer and all other clinical staff provided by the Contractor shall execute their responsibilities pursuant to this contract consistent with RSA Chapter 135-C, any applicable administrative rules, the by-laws of the NHH's Medical Staff Organization, The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), and in accordance with generally accepted medical standards and practices.

3.3. Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital

3.3.1. Chief Medical Officer

3.3.1.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Chief Medical Officer for NHH. The Chief Medical Officer shall possess the following qualifications and meet the following requirements:

a. The Chief Medical Officer shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Chief Medical Officer shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Chief Medical Officer shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Chief Medical Officer shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.1.2. The Chief Medical Officer may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Chief Medical Officer shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.1.3. Notwithstanding the foregoing allowance for educational or research activities, the Chief Medical Officer shall be physically present onsite at NHH not less than 36 hours per week. The Chief Medical Officer shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.1.4. In the event the Chief Medical Officer resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish within ten (10) business days, not including holidays, a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.1.5. The Chief Medical Officer shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;

b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and
e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.1.6. On an annual basis, the Chief Medical Officer and the NHH CEO shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.2. Associate Medical Director

3.3.2.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Associate Medical Director for NHH. The Associate Medical Director shall possess the following qualifications and meet the following requirements:

a. The Associate Medical Director shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Associate Medical Director shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.
b. The Associate Medical Director shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Associate Medical Director shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, addiction, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.
c. For purposes of this paragraph, the term "full-time" shall mean that the Associate Medical Director shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.2.2. The Associate Medical Director may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those

activities further the mission and goals of NHH. The Associate Medical Director shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.2.3. Notwithstanding the foregoing allowance for educational or research activities, the Associate Medical Director shall be physically present onsite at NHH not less than 36 hours per week. The Associate Medical Director shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.2.4. In the event the Associate Medical Director resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish, within 10 business days, not including holidays, a psychiatrist to serve full-time as interim NHH Associate Medical Director, until such time as the existing Associate Medical Director either resumes duty full-time or is replaced by a new Associate Medical Director. The interim Associate Medical Director shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.2.5. The Associate Medical Director shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;
b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and
e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.2.6. On an annual basis, the Associate Medical Director, together with the Chief Medical Officer and the NHH CEO, shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.3. Psychiatrists

3.3.3.1. The Contractor shall provide eleven (11) General Psychiatrists for the adult units at NHH:

a. All psychiatrists shall have appropriate experience in the specialty they are boarded or board eligible in;

b. All psychiatrists shall have completed an ACGME approved residency program in psychiatry;
c. At least one psychiatrist shall be dedicated full-time to provide services to the Inpatient Stabilization Unit (ISU); and
d. At least one psychiatrist shall be certified in addiction treatment this psychiatrist shall be a physician who is certified in general psychiatry and has significant clinical experience in addiction medicine. A fellowship training and/or board certification in Addiction Medicine or Addiction Psychiatry is highly desirable.

3.3.4. Child/Adolescent Psychiatrists

3.3.4.1. The Contractor shall provide four (4) Child/Adolescent Psychiatrists who have successfully completed their fellowship.

a. All psychiatrists shall have completed both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry.

3.3.5. Geropsychiatrist

3.3.5.1. The Contractor shall provide one (1) geropsychiatrist who has:

a. Completed an ACGME approved residency program in psychiatry, and be board certified by the American Board of Psychiatry and Neurology in Psychiatry; and
b. Completed a 1-year geropsychiatry fellowship and is specialty certified by the American Board of Psychiatry and Neurology in geriatric psychiatry. Two years of additional clinical experience in geriatric psychiatry may be substituted for fellowship training.

3.3.6. Director of Neuropsychology Laboratory

3.3.6.1. The Contractor shall provide a senior neuropsychologist who has:

a. Past experience shall include leadership responsibilities in MRI operations and the ability to integrate cognitive test results with data from structural and functional brain imaging;
b. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and shall have completed a neuropsychology postdoctoral fellowship (Houston guidelines); and
c. Evidence of scientific productivity in relation to the SPMI population and the ability to generate proposals for federal and foundation support is preferred.

3.3.7. Neuropsychologist Trainees

3.3.7.1. The Contractor shall provide three neuropsychologist trainees who:

a. Shall be clinical psychology graduate students who are obtaining specialty training in neuropsychology; and
b. Shall have three to four years of graduate instruction and training, including training experience in general psychology.

3.3.8. General Medical Director

3.3.8.1. The Contractor shall provide one full-time physician to fulfill the role of General Medical Director who shall be a primary care or internal

medicine physician who has completed residency with at least three years of experience in supervising primary care clinicians. A board certification in a primary care field is preferred.

3.3.9. General Medical Physician

3.3.9.1. The Contractor shall provide one full-time physician who is a primary care or internal medicine physician who has completed residency with at least three years of experience. A board certification in a primary care field is preferred.

3.3.10. Forensic Psychologist

3.3.10.1. Beginning in SFY 2018, the Contractor shall provide a full-time forensic psychologist. The forensic psychologist shall be a clinical psychologist (PhD or Psy.D.) with significant clinical experience in forensic psychology. A certification in forensic psychology is preferred.

3.3.11. Residents/Post Graduate Fellows

3.3.11.1. For all residents/post graduate fellows the Contractor provides to NHH under this contract, the responsibilities shall be outlined, monitored and reviewed by the Chief Medical Officer and the appropriate, attending psychiatrist.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall rotate PGY II residents and a PGY IV (chief resident) through NHH.
b. Child/Adolescent Fellows – The Contractor shall rotate three (3) child/adolescent fellows (combined 1 FTE) apportioned through the PGY IV and PGY V years or PGY V and VI years (1st and 2nd year fellows) through NHH.
c. Geropsychiatry Fellow – The Contractor shall rotate a geropsychiatry fellow (PGY V) through the NHH.

3.3.12. Psychiatric Advanced Practice Registered Nurses (APRN)

3.3.12.1. The Contractor shall provide six full-time Psychiatric Advanced Practice Registered Nurses.

a. Psychiatric APRNs shall possess an APRN degree and have board certification as Psychiatric–Mental Health Nurse Practitioner-Board.
b. At least one Psychiatric APRN with specialty in addiction or the requisite number of hours of experience in addiction treatment shall be provided.
c. At least one Psychiatric APRN shall be dedicated full-time to provide services to the ISU.

3.3.13. NHH Research Manager

3.3.13.1. The Contractor shall provide a full-time NHH Research Manager, as described below:

a. The Research Manager requires a thorough knowledge and understanding of clinical research, research protocols, and clinical operations, knowledge of GCPs and federal regulations related to

human subject research, knowledge of patient privacy and confidentiality, ability to manage teams of professionals, maintain meticulous study records, laboratory data and other information related to research protocols, and manage complex schedules and competing priorities.

b. The Research Manager shall meet the following minimum experience and education requirements:
   i. Master's degree in management or health or research related area;
   ii. Five or more years of relevant experience in clinical trials research support;
   iii. Experience with industry sponsored, federally sponsored and investigator initiated clinical research;
   iv. Experience with clinical trial budgets and billing;
   v. Through knowledge of clinical research, research protocols and clinical operations; and
   vi. Knowledge of Good Clinical Practices (GCP's) and federal regulations related to research.

3.3.14. Director of Quality Systems and APRN Services

3.3.14.1. The Contractor shall provide a full time Director of Quality and APRN Services, as described below:

a. Licensed as an Advance Practice Registered Nurse
b. Two of more years of relevant experience in a psychiatric setting.
c. Experience with quality systems, development and enhancement of organizational systems and processes.
d. Serves as Chair of the Quality Council.
e. Provides clinical standards and provides leadership for all Psychiatric APRNs.
f. Builds community relationships with professional organizations to enhance both the quality programs and APRN programs.
g. Five or more years of experience in leadership of teams.
h. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

3.3.15. Director of Health Systems Data and Information Services

3.3.15.1. The Contractor shall provide a full time Director of Health Systems Data and Information Services, as described below:

a. Five or more years of experience with collecting, analyzing, documenting and reporting hospital and/or health systems data.
b. Five or more years of experience with Electronic Health Records and development of Health Services Data Program.
c. Five or more years of experience in leadership of teams.
d. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

3.3.16. Schedule and Allocation of Positions – Service Area #1 – NHH

3.3.16.1. The following schedule shall reflect the full (100%) staffing complement for which the Contractor shall provide the required staff,

consistent with the requirements described in the Contract for the full term of the contract.

Position Title	Full-Time Equivalent
a. Chief Medical Officer	1.0
b. Associate Medical Director	1.0
c. General Psychiatrists	11.0
d. Psychiatric APRNs	6.0
e. Child/Adolescent Psychiatrists	4.0
f. Geropsychiatrist	1.0
g. Director of Neuropsychology Laboratory	0.5
h. Director of Quality Systems and APRN Services.	1.0
i. Neuropsychologist Trainees	3.0
j. General Medical Director	1.0
k. General Medical Physician	1.0
l. Forensic Psychologist	1.0
m.. PGY IV Residents	1.0
n. PGY II Residents	1.5
o. Child/Adolescent Fellow	1.0
p. Geropsychiatry Fellow	0.5
q. Director of Health System Data and Information Services	1.0
r. Research Manager	1.0

3.4. Specific Staffing Requirements – Service Area #2 – Glencliff Home

3.4.1. Medical Director

3.4.1.1. The Contractor shall, for the term of the contract, provide the part-time services of one (1) geropsychiatrist to serve at the Glencliff Home as the Medical Director. This position shall be a 0.4 Full-Time Equivalent.

3.5. Specific Staffing Requirements – Service Area #3 – Medicaid Program

3.5.1. Department of Health and Human Services Chief Medical Officer –

3.5.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated physician, identified by the Department to serve as the Chief Medical Officer. This position shall be a 1.0 Full-Time Equivalent.

3.5.1.2. The Contractor shall ensure that the Chief Medical Officer provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Chief Medical Officer shall provide timely, prior notification to the DHHS Designee of any leave time taken. Absences due to vacation and continuing education shall be planned in advance, in consideration of the business needs of the Medicaid program – including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Chief Medical Officer is on leave.

3.5.1.3. The Chief Medical Officer shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;
c. A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;
d. Have a minimum of five years of experience in a position of clinical leadership for a major public sector program, government authority or other organization involved in the delivery of public Medicaid services;
e. Have work experience in managed care settings focused on improved health outcomes;
f. Have fellowship and/or work experience in research in health services, outcomes and/or policy, as well as the ability to work collaboratively with team members and the provider community;
g. Have extensive experience and judgment to plan and accomplish goals working in a team environment;
h. Demonstrate strong verbal and written communication skills;
i. Work collaboratively with Medicaid staff to achieve program goals in an efficient and timely manner;
j. Have Board certification in either Family Medicine, Preventive Medicine/Community Health, Internal Medicine, Pediatrics, or Obstetrics and Gynecology, and with a strong working knowledge of primary care medicine;
k. Must be well versed in the regulations governing the federal Title XIX Medicaid and Title XXI Medicaid and CHIP programs and how those programs are administered in New Hampshire;
l. Possess a high degree of creativity and initiative;
m. Have expertise in clinical, policy, or outcomes research; and

n. Have work experience in project management, grant writing, contract management, and program evaluation.

3.6. Specific Staffing Requirements – Service Area #4 – Children, Youth and Families

3.6.1. Staff Psychiatrist

3.6.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. This position shall be a 1.0 Full-Time Equivalent.

3.6.1.2. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Staff Psychiatrist.

3.6.1.3. The Staff Psychiatrist shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Specialty in both child psychiatry and criminal justice;
c. Completion of both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry;
d. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
e. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
f. Possess at least five (5) years post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

3.7. Specific Staffing Requirements – Service Area #5 – Behavioral Health

3.7.1. Medical Director

3.7.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Behavioral Health service area, as identified by the Department. This position shall be available on-site at a DHHS designated location for twenty (20) hours per week (0.5 FTE).

3.7.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
c. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
d. Have at least five (5) years of experience in public mental health and services for people with mental illness.

3.7.2. Support Staff CPHS

3.7.2.1. The Contractor shall, for the term of the contract, provide a part-time Support Staff to support the Committee for the Protection of Human

Services. This position shall be allocated at 0.15 FTE.

3.7.2.2. The Contractor shall, for the term of the contract, provide a part-time Research Assistant. This position shall be allocated at 0.5 FTE.

3.7.3. Evidence-Based Practice Trainer/Consultant

3.7.3.1. The Contractor shall, for the term of the contract, provide part-time Evidence-Based Practice Trainers/Consultants. These positions shall be allocated, in total, at 1.5 FTE.

3.7.4. Behavioral Health Policy Institute

3.7.4.1. The Contractor shall, for the term of the contract, provide a part-time Behavioral Health Policy Institute Consultant. This position shall be allocated at 0.1 FTE.

3.8. Specific Staffing Requirements – Service Area #6 – Elderly and Adult Services

3.8.1. Medical Director

3.8.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Elderly and Adult Services service area. This position shall be allocated at a 0.03 Full-Time Equivalent.

3.8.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Gerontology or Preventive Medicine/Community Health;
c. Possess expertise in clinical, policy or outcomes research; and
d. Be well versed in the regulations governing the federal Title XIX Medicaid program, including requirements for the operation of waiver and State Plan services, and Title XX, the Social Service Block Program and services provided under the Older Americans Act.

3.9. Specific Staffing Requirements – Service Area #7 – Developmental Services

3.9.1. Medical Director

3.9.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Developmental Services service area. This position shall be allocated at 0.4 Full-Time Equivalent.

3.9.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Child and Adult Psychiatry; and
c. Possess expertise and experience in developmental disability, including Autism Spectrum Disorders.

3.9.2. Adult Developmental Services Interdisciplinary Clinic Team

3.9.2.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Adult Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as

specified below in Full-Time Equivalent (FTE):

a. Psychiatrist	0.1 FTE
b. Neuropsychologist	0.05 FTE
c. Neuropsychology Fellow	0.05 FTE
d. Neurologist	0.025 FTE
e. Primary Care Physician	0.025 FTE
f. Occupational Therapist	0.025 FTE
g. Administrative Support	0.025 FTE

3.9.3. Child Developmental Services Interdisciplinary Clinic Team

3.9.3.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Child Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

a. Child Psychiatrist	0.10 FTE
b. Neuropsychologist	0.05 FTE
c. Neuropsychology Fellow	0.05 FTE
d. Neurologist	0.025 FTE
e. Primary Care Physician	0.025 FTE
f. Occupational Therapist	0.025 FTE
g. Administrative Support	0.025 FTE

4. Performance Standards and Outcomes

4.1. Service Area #1 – Chief Medical Officer – NHH

4.1.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the NHH CEO, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the NHH CEO prior to being effective. The performance metrics shall be reviewed by the NHH CEO on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the NHH CEO.

4.1.2. The Contractor shall ensure the services provided by the Chief Medical Officer at NHH are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool to solicit input from the NHH CEO regarding the Chief Medical Officer's provision of services under the contract.

4.1.3. The Contractor shall develop a corrective action plan to address any concerns raised by the NHH CEO in the evaluation tool, and provide a copy of such plan to the NHH CEO for review. If the NHH CEO disagrees with the Contractor's proposed resolutions within the corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution with the Contractor.

4.2. Service Area #1 – Clinical Staff – NHH

4.2.1. Staffing levels shall be maintained at 100% at all times throughout the

contract, with the exception of the leave provisions and approval processes described in the subsections applicable to each staffing need.

4.2.1.1. DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

4.2.2. The Contractor shall ensure the following performance standards are met by all clinical staff provided by the Contractor to provide services at NHH:

4.2.2.1. Clinical staff shall support the optimum functioning of the Medical Staff Organization as evidenced by attendance of Medical Staff Organization meetings and participation in assigned committees and task forces at a rate of no less than 80% participation, excluding approved absences;

4.2.2.2. Clinical staff shall support the completion of all required documentation regarding patients as evidenced by satisfactorily completing documentation regarding patient admission, discharge and during the inpatient stay – in compliance with hospital policy – within twelve (12) months of beginning the provision of services at NHH under the contract; and by satisfactorily completing all required documentation consistent with normative data collected by the compliance officer and utilization review manager.

4.2.2.3. Clinical staff shall provide clear treatment plans with specific interventions and regular updates as required by NHH policy;

4.2.2.4. Clinical staff shall provide daily progress notes with sufficient detail to meet medical necessity and level of care criteria;

4.2.2.5. Clinical staff shall provide regular progress notes focused on specific reasons for admission and plan towards discharge; and

4.2.2.6. Clinical staff shall provide written explanation of medication decisions and reasons for change when not effective.

4.3. Service Area #3 – Chief Medical Officer – Medicaid

4.3.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the DHHS Designee, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the DHHS Designee prior to being effective. The performance metrics shall be reviewed by the DHHS Designee on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the DHHS Designee.

4.3.2. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS Designee regarding the Chief Medical Officer's provision of services

under the contract.

4.3.3. Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer, in collaboration with the DHHS Designee. In the case of a newly hired Chief Medical Officer, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.4. Service Area #4 – Staff Psychiatrist – Children, Youth and Families

4.4.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and at each contract anniversary thereafter, the Contractor and the DHHS designee, in consultation with the Staff Psychiatrist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychiatrist. The performance metrics shall be approved by the DHHS designee prior to being effective. The performance metrics shall be reviewed by the DHHS designee on at least a quarterly basis with the Staff Psychiatrist. These meetings shall be documented with written progress notes by the DHHS designee.

4.4.2. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if needed, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS designee regarding the Staff Psychiatrist's provision of services under the contract.

Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist, in collaboration with the DHHS designee. In the case of a newly hired Staff Psychiatrist, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.5. Quality Assurance Plan and Monitoring

The following Quality Assurance Plan and Monitoring shall be provided by the Contractor, subject to modification and/or augmentation as required by DHHS:

4.5.1. Service Area #1 – New Hampshire Hospital – Chief Medical Officer

4.5.1.1. The Contractor shall provide oversight of the performance of the Chief Medical Officer toward these Performance Standards and Quality Assurance Monitoring goals.

4.5.1.2. Pending development of final program metrics as required herein at subsection 4.1.1., in partnership with the NHH CEO, the Chief Medical Officer shall be responsible for the following program outcomes:

a. Ensuring the program is staffed adequately to operate NHH beds at full utilization;
b. Ensuring that Contractor staff receive necessary supervision and training to perform the tasks they are assigned;
c. Assuring that patients receive care consistent with evidence-

based care;
d. Creation and implementation of highest standard practices to protect the safety of patients, staff, and visitors; and
e. Other responsibilities detailed herein at subsection 2.3.1.

4.5.1.3. The Chief Medical Officer shall be responsible for monitoring progress toward these goals and providing regular reports, at minimum on a quarterly basis or more frequently if needed, to the NHH CEO and to the Chair of the Department of Psychiatry or his designee. The Chief Medical Officer will meet at minimum on a quarterly basis or more frequently if needed, with the Chair of the Department of Psychiatry (or his or her designee) and the NHH CEO to review progress toward these metrics. The metrics above shall be considered preliminary metrics, subject to refinement, as described herein at subsection 4.1.1., and shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.1.4. The content of the performance metrics to be measured shall be such that they assure that the Chief Medical Officer is fulfilling his or her administrative/clinical responsibilities as detailed herein at subsection 2.3.1. The following metrics shall be relevant to the Chief Medical Officer's fulfillment of his or her responsibilities:

a. The results of all Joint Commission, CMS, and other surveys pertaining to NHH;
b. Reports on clinical documentation by clinical staff;
c. Lists demonstrating completion of annual reviews of all Contractor-provided NHH clinicians to demonstrate active management, oversight, and discipline (when needed) of clinicians. The annual reviews shall include evidence of input from the NHH CEO (or their designee) on performance;
d. Records of attendance at meetings with:
   i. The NHH CEO indicating participation in formulation, implementation and supervision of all clinical programs, participation in budgeting, recruiting, plan for employment schedule, and supervision and educational plan for all Contractor-provided NHH clinical staff;
   ii. Other DHHS representatives - showing consultation in the development of the State mental health system;
   iii. NHH Executive Committee – showing executive participation; and
   iv. Executive Committee of the NHH Medical Staff Organization – showing participation in oversight of physician work; and
e. Report on availability of beds in NHH that are open for care – indicating adequate provider staffing to operate at full capacity.

4.5.1.5. The NHH CEO shall review these metrics at least quarterly with the NHH Chief Medical Officer.

4.5.2. Monitoring – Service Area #1 – New Hampshire Hospital – Chief Medical Officer:

4.5.2.1. The NHH Director of Quality Management and his or her staff shall

conduct medical record and quality compliance monitoring. Monitoring shall take place through:

a. The routine reviews of The Joint Commission, CMS, and other overseeing groups;
b. The routine NHH documentation monitoring reports produced at NHH;
c. Department of Psychiatry tracking of Annual Review completion that is a routine process of the Department;
d. Use of attendance sheets that can be developed for this purpose; and
e. Routine monitoring of bed availability.

4.5.2.2. NHH support staff shall gather information regarding meeting attendance. The NHH Director of Quality Management and his or her staff shall gather the balance of collected metrics into a report. The collected data shall be provided to the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) on a quarterly basis.

4.5.2.3. The findings from this monitoring shall be discussed in scheduled meetings between the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) at meetings that shall take place on a quarterly basis or more frequently if needed. Both parties shall maintain their notes from each quarterly meeting to support the annual performance review process.

4.5.2.4. The monitoring data, including the notes described herein at subsection 4.5.2.3., and feedback solicited from the NHH CEO shall be part of the Chief Medical Officer's annual performance review. The Contractor shall document the annual performance review on the Department's standard annual evaluation tool.

a. If there are performance difficulties that require a corrective action plan, the Contractor shall develop a proposed corrective action plan and shall share and discuss the plan with the NHH CEO prior to issuance to the Chief Medical Officer. If the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry and the NHH CEO disagree on the proposed corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution.

4.5.2.5. This plan shall be updated and revised at least annually, by the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, working with the NHH CEO and in consultation with the NHH Chief Medical Officer. New goals may be set at any time but shall be set at least annually. New goals may trigger new metrics.

4.5.3. Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.3.1. Within 45 days of the contract effective date, the Chief Medical Officer, or his or her designee, shall work with the NHH CEO and the NHH Director of Quality Management to develop a list of performance metrics based on the expected deliverables, functions and

responsibilities for each staff member as described herein at the applicable subsection in Section 2. The metrics shall monitor, at a minimum, the performance standards describe herein at subsection 4.2. The NHH CEO shall review these metrics at least quarterly with the Chief Medical Officer. This selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.3.2. The content of the performance metrics to be measured shall be such that they assure the Clinical Staff are fulfilling their administrative/clinical responsibilities as described herein at Section 2 for the applicable position. The following metrics are relevant to the Clinical Staff's fulfillment of their responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance lists of Medical Staff Organization (and assigned committees and task forces) that show who is expected to attend and who did attend;
b. Measurements of compliance with documentation policies;
c. Measurement of adherence with treatment plan policies;
d. Measurement of progress note adherence to policies including showing medical necessity and need for level of care and demonstration of reason for admission and progress towards discharge, and explanation of medical decisions and reasons for change when the plan is not effective.

4.5.4. Monitoring – Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.4.1. Monitoring of the metrics for the NHH Clinical Staff shall take place as part of the routine data collection of the NHH Quality Management Staff. The collected data shall be provided to the Chief Medical Officer and the NHH CEO on a quarterly basis.

a. The performance metrics that are developed shall involve measurements and documentation that must be collected, including meeting attendance records. Other NHH staff may be involved in data collection efforts, including staff within the information technology, health information and utilization management sections depending on the content of the developed performance metrics.

4.5.4.2. The NHH CEO, the NHH Director of Quality Management, and the Chief Medical Officer shall speak at least quarterly about the performance of the NHH Clinical Staff. Each individual shall maintain notes of every quarterly meeting; these notes shall be used to support the annual performance review process for NHH Clinical Staff. If there are performance difficulties that require a corrective action plan, the identified issues shall be discussed with the Chief Medical Officer in order to initiate an appropriate course of action to address the identified difficulty or difficulties.

4.5.4.3. Annual reviews of Clinical Staff shall be documented by the Chief Medical Officer, or his or her designee, on the Contractor's Department of Psychiatry Annual Review form. Annual reviews shall

include findings for quality assurance monitoring and feedback on performance from DHHS leaders.

4.5.5. Service Area #3 – Medicaid – Chief Medical Officer

4.5.5.1. Within 45 days of the contract effective date, the Contractor shall work with the DHHS designee overseeing the Medicaid service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.5. Together, these metrics shall form an evaluation tool. The Chief Medical Officer shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Medicaid service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.5.2. The DHHS designee shall review the findings from monitoring of these metrics at least quarterly with the Chief Medical Officer.

4.5.5.3. The Chief Medical Officer role requires initiative, relationship building, and high level leadership. The following metrics are relevant to the Chief Medical Officer's fulfillment of his or her responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance records of Medicaid Management Team meetings; and
b. A checklist of core duties and expectations, as described herein at subsection 2.5, with feedback solicited on a quarterly or semi-annual basis from the members of the Medicaid Management Team and/or other key informants, designed to monitor performance. The checklist shall rate performance and allow for comments that will help guide improvement.

4.5.6. Monitoring – Service Area #3 – Medicaid – Chief Medical Officer

4.5.6.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Checklist feedback from the Medicaid Management Team. Source: Medicaid Management Team members; and
b. Collection and collating of attendance records from the Medicaid Management Team meetings. Source: DHHS administrative support staff.

4.5.6.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Chief Medical Officer;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Chief Medical Officer's

performance on the metrics.

c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual performance evaluation tool.

4.5.6.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Chief Medical Officer's annual performance review. This review shall be conducted at six months for a new Chief Medical Officer then annually thereafter.

4.5.6.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Chief Medical Officer shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.6.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.7. Service Area #4 – Children, Youth and Families – Staff Psychiatrist

4.5.7.1. Within 45 days of the contract effective date, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall work with the DHHS designee overseeing the Children, Youth and Families service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.6. Together, these metrics shall form an evaluation tool. The Staff Psychiatrist shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Children, Youth and Families service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.7.2. The content of performance metrics developed shall be such that they assure the Staff Psychiatrist is fulfilling his or her administrative and clinical responsibilities as described herein at subsection 2.6. The following metrics are relevant to the Staff Psychiatrist and shall be part of the plan for monitoring contract fulfillment:

a. Monitoring of work hours;

i. Regular checks of the Staff Psychiatrist's electronic calendar to be sure it includes proposed leave time, conferences, and trainings;

ii. Clinical documentation monitoring to be sure it meets

standards of timeliness and completeness established by Children, Youth, and Families;

iii. Counts of activities such as the number of treatment team meetings and clinical consultations provided, types and numbers of evidence-based practices provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and

iv. Checklist feedback on effectiveness in establishing interagency collaboration between Juvenile Justice Services, area mental health services, and NHH.

4.5.8. Monitoring – Services Area #4 – Children, Youth & Families – Staff Psychiatrist

4.5.8.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Counts of Activities. Source: Staff Psychiatrist; and
b. Clinical documentation monitoring. Source: DHHS staff.

4.5.8.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Staff Psychiatrist;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Staff Psychiatrist's performance on the metrics.
c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.8.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Staff Psychiatrist's annual performance review. This review shall be conducted at six months for a new Staff Psychiatrist then annually thereafter.

4.5.8.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Staff Psychiatrist shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.8.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the

DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.9. Service Areas #2, 3, 5, 6 and 7

4.5.9.1. Upon DHHS request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes, similar to those described herein at subsection 4.5. For Service Areas 2, 3, 5, 6 and 7.

4.5.10. All Other Positions

4.5.10.1. All staff provided by the Contractor, not otherwise addressed herein at subsection 4.5, shall have annual performance reviews. The Contractor shall conduct such reviews and first obtain feedback from the applicable DHHS designee for the service area in which the staff is assigned to provide services. This feedback shall be a core element of the annual performance review process. The Contractor shall ensure that goal development is responsive to the evolving needs of DHHS over the course of the contract period.

5. Reporting

5.1. Service Area #1 – New Hampshire Hospital

5.1.1. In addition to other reports as agreed to by the parties, on an annual basis, the Contractor shall make a report in writing to DHHS that is descriptive of the Chief Medical Officers' and the clinicians' services provided by the Contractor and the Contractor's performance under this contract during the preceding contract year, the research activities provided during the preceding contract year, and planned research activities for the current contract year.

5.1.2. On an annual basis, DHHS shall submit to the Contractor a report in writing containing DHHS' evaluation of the Contractor's performance pursuant to this contract during the preceding year.

5.1.3. On a quarterly basis, or as otherwise more frequently required by the United States Department of Health and Human Services regulations, DHHS and in a form specified by DHHS, the Contractor shall provide a written report to DHHS documenting the services provided by the Contractor's staff in sufficient form and with sufficient detail to satisfy the reporting requirements of Medicare, Medicaid, and other third-party providers.

5.2. All Service Areas

5.2.1. The Contractor shall maintain and provide the DHHS designee(s) identified by the Department with up-to-date detailed personnel listings for all Contractor staff performing services under this contract. The listings shall include information, including, but not limited to; the names, titles, position costs (including salary and fringe benefit costs, direct and indirect rates), for each position for each service area for each state fiscal year.

or more frequently as required by DHHS, to ensure the accuracy of information contained therein and to ensure proper cost allocation. The listings shall be in a format as determined and approved by DHHS.

6. Compliance

6.1. Continuity of Services

6.1.1. The Contractor and the Department agree that:

6.1.1.1. It will be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit A, Sections 2 through 5;

6.1.1.2. Any breach by the Contractor will delay and disrupt the Department's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services; The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in this Exhibit A, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in Exhibit B; and

6.1.1.3. The liquidated damages as specified in Exhibit B are reasonable and fair and not intended as a penalty.

7. Definitions

CMS – Centers for Medicare and Medicaid Services
CPHS – Committee for the Protection of Human Subjects.
Department – New Hampshire Department of Health and Human Services
DHHS – New Hampshire Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act
TJC – The Joint Commission

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information," "Confidential Data," or "Data" (as defined in Exhibit K), means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or

storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic documents or mail.

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

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

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

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

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

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information

except as required or permitted under this Contract or required by law. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.
3. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If Contractor is transmitting DHHS Data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. Contractor may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS Data.
3. Encrypted Email. Contractor may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If Contractor is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. Contractor may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. Contractor may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If Contractor is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. Contractor may not transmit Confidential Data via an open wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If Contractor is employing remote communication to access or transmit Confidential Data, a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, must be used.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If Contractor is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If Contractor is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain DHHS Data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have thirty (30) days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems accessed or utilized for purposes of carrying out this contract.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting DHHS Confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have

currently-supported and hardened operating systems, current, updated, and maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

If the Contractor maintains any Confidential Information on its systems (or its sub-contractor systems) and it has not done so previously, the Contractor will implement policies and procedures to ensure that any storage media on which such data maybe recorded will be rendered unreadable and that the data will be un-recoverable when the storage media is disposed of. Upon request, the Contractor will provide the Department with copies of these policies and with written documentation demonstrating compliance with the policies. The written documentation will include all details necessary to demonstrate data contained in the storage media has been rendered unreadable and un-recoverable. Where applicable, regulatory and professional standards for retention requirements may be jointly evaluated by the State and Contractor prior to destruction.

1. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

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

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

2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from

creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

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

4. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will ensure End-User will maintain an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

5. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

6. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

7. The Contractor will not store any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

8. Data Security Breach Liability. In the event of any computer security incident, incident, or breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

9. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160

and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable health information and as applicable under State law.

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

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer, and additional email addresses provided in Section VI, 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.

VI. PERSONS TO CONTACT

A. DHHS contact for Data Management or Data Exchange issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

B. DHHS contacts for Privacy issues:
DHHSPrivacyOfficer@dhhs.nh.gov

C. DHHS contact for Information Security issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

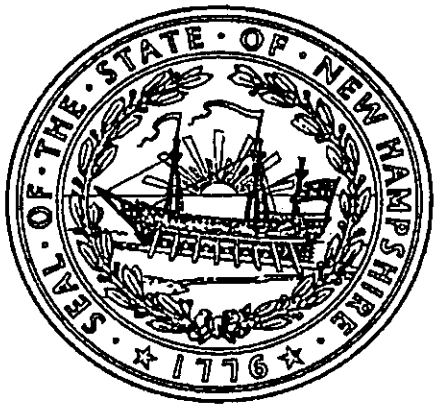
D. DHHS contact for Breach notifications:
DHHSInformationSecurityOffice@dhhs.nh.gov
DHHSPrivacyOfficer@dhhs.nh.gov

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: **0004205519**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 29th day of October A.D. 2018.

William M. Gardner
Secretary of State

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

Dartmouth-Hitchcock

CERTIFICATE OF VOTE/AUTHORITY

I, Anne-Lee Verville, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

1. I am the duly elected Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital;
2. The following is a true and accurate excerpt from the 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 Financial Officer, 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. Daniel P. Jantzen is the Chief Financial 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 Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 21 day of November.

Anne-Lee Verville, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 21st day of November, 2018, by Anne-Lee Verville.

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

Notary Public
My Commission Expires: April 19, 2022

CERTIFICATE OF INSURANCE

DATE: 10/09/2018

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

This is to certify that the Policy listed below has been issued to the Named Insured 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. This policy issued by a risk retention group may not be subject to all insurance laws and regulations in all states. State insurance insolvency funds are not available to a risk retention group policy.

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002018-A	07/01/2018	06/30/2019	EACH OCCURRENCE	$1,000,000
					PRODUCTS-COMP/OP AGGREGATE	
X	CLAIMS MADE				PERSONAL ADV INJURY	
					GENERAL AGGREGATE	$3,000,000
	OCCURRENCE				FIRE DAMAGE	
OTHER					MEDICAL EXPENSES	
PROFESSIONAL LIABILITY		0002018-A	07/01/2018	06/30/2019	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)

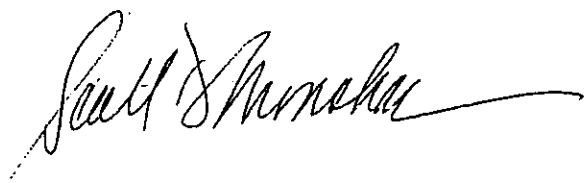
Certificate of Insurance issued as evidence of insurance for the development and operation of a substance use disorder treatment and recovery facility known as the "Dartmouth Hub."

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 DMCDONALD

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
10/19/2018

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: Dan McDonald PHONE (A/C, No, Ext): (508) 808-7293 FAX (A/C, No): (866) 235-7129 E-MAIL ADDRESS: dan.mcdonald@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			AGC4059104	07/01/2018	07/01/2019	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐ N/A						E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

Dartmouth-Hitchcock

Mission, Vision, & Values

Our Mission

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

Our Vision

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

Values

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

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2017 and 2016

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2017 and 2016

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 Subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2017 and 2016, 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 revenues for the year then ended. We did not audit the consolidated financial statements of The Cheshire Medical Center, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 8.8% of consolidated total assets at June 30, 2016, and total revenues of 9.2% of consolidated total revenues for the year then ended. Those statements were audited by other auditors whose reports thereon have been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Alice Peck Day Hospital as of and for the year ended June 30, 2017 and The Cheshire Medical Center as of and for the year ended June 30, 2016, is based solely on the reports of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the reports of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Health System as of June 30, 2017 and 2016, and the results of its operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 17, 2017

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2017 and 2016

(in thousands of dollars)	2017	2016
Assets		
Current assets		
Cash and cash equivalents	$ 68,498	$ 40,592
Patient accounts receivable, net of estimated uncollectibles of $121,340 and $118,403 at June 30, 2017 and 2016 (Note 4)	237,260	260,988
Prepaid expenses and other current assets	89,203	95,820
Total current assets	394,961	397,400
Assets limited as to use (Notes 5 and 7)	662,323	592,468
Other investments for restricted activities (Notes 5 and 7)	124,529	142,036
Property, plant, and equipment, net (Note 6)	609,975	612,564
Other assets	97,120	87,266
Total assets	$ 1,888,908	$ 1,831,734
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 18,357	$ 18,307
Line of credit (Note 13)	-	36,550
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,220	3,176
Accounts payable and accrued expenses (Note 13)	89,160	107,544
Accrued compensation and related benefits	114,911	103,554
Estimated third-party settlements (Note 4)	27,433	19,650
Total current liabilities	253,081	288,781
Long-term debt, excluding current portion (Note 10)	616,403	625,341
Insurance deposits and related liabilities (Note 12)	50,960	56,887
Interest rate swaps (Notes 7 and 10)	20,916	28,917
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	282,971	272,493
Other liabilities	90,548	69,811
Total liabilities	1,314,879	1,342,230
Commitments and contingencies (Notes 4, 6, 7, 10, and 13)		
Net assets		
Unrestricted (Note 9)	424,947	360,183
Temporarily restricted (Notes 8 and 9)	94,917	75,731
Permanently restricted (Notes 8 and 9)	54,165	53,590
Total net assets	574,029	489,504
Total liabilities and net assets	$ 1,888,908	$ 1,831,734

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, 2017 and 2016

(in thousands of dollars)	2017	2016
Unrestricted revenue and other support		
Net patient service revenue, net of contractual allowances and discounts	$ 1,859,192	$ 1,689,275
Provision for bad debts	63,645	55,121
Net patient service revenue less provision for bad debts	1,795,547	1,634,154
Contracted revenue (Note 2)	43,671	65,982
Other operating revenue (Note 2 and 5)	119,177	82,352
Net assets released from restrictions	11,122	9,219
Total unrestricted revenue and other support	1,969,517	1,791,707
Operating expenses		
Salaries	966,352	872,465
Employee benefits	244,855	234,407
Medical supplies and medications	306,080	309,814
Purchased services and other	289,805	255,141
Medicaid enhancement tax (Note 4)	65,069	58,565
Depreciation and amortization	84,562	80,994
Interest (Note 10)	19,838	19,301
Total operating expenses	1,976,561	1,830,687
Operating loss	(7,044)	(38,980)
Nonoperating gains (losses)		
Investment gains (losses) (Notes 5 and 10)	51,056	(20,103)
Other losses	(4,153)	(3,845)
Contribution revenue from acquisition (Note 3)	20,215	18,083
Total nonoperating gains (losses), net	67,118	(5,865)
Excess (deficiency) of revenue over expenses	$ 60,074	$ (44,845)

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, 2017 and 2016

(in thousands of dollars)	2017	2016
Unrestricted net assets		
Excess (deficiency) of revenue over expenses	$ 60,074	$ (44,845)
Net assets released from restrictions	1,839	3,248
Change in funded status of pension and other postretirement benefits (Note 11)	(1,587)	(66,541)
Other changes in net assets	(3,364)	-
Change in fair value of interest rate swaps (Note 10)	7,802	(5,873)
Increase (decrease) in unrestricted net assets	64,764	(114,011)
Temporarily restricted net assets		
Gifts, bequests, sponsored activities	26,592	12,227
Investment gains	1,677	518
Change in net unrealized gains on investments	3,775	(1,674)
Net assets released from restrictions	(12,961)	(12,467)
Contribution of temporarily restricted net assets from acquisition	103	670
Increase (decrease) in temporarily restricted net assets	19,186	(726)
Permanently restricted net assets		
Gifts and bequests	300	699
Investment gains (losses) in beneficial interest in trust	245	(219)
Contribution of permanently restricted net assets from acquisition	30	29
Increase in permanently restricted net assets	575	509
Change in net assets	84,525	(114,228)
Net assets		
Beginning of year	489,504	603,732
End of year	$ 574,029	$ 489,504

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, 2017 and 2016

(in thousands of dollars)	2017	2016
Cash flows from operating activities		
Change in net assets	$ 84,525	$ (114,228)
Adjustments to reconcile change in net assets to net cash (used) provided by operating and nonoperating activities		
Change in fair value of interest rate swaps	(8,001)	4,177
Provision for bad debt	63,645	55,121
Depreciation and amortization	84,711	81,138
Contribution revenue from acquisition	(20,348)	(18,782)
Change in funded status of pension and other postretirement benefits	1,587	66,541
Loss on disposal of fixed assets	1,703	2,895
Net realized (gain) losses and change in net unrealized (gain) losses on investments	(57,255)	27,573
Restricted contributions and investment earnings	(4,374)	(4,301)
Proceeds from sales of securities	809	496
Loss from debt defeasance	381	-
Changes in assets and liabilities		
Patient accounts receivable, net	(35,811)	(101,567)
Prepaid expenses and other current assets	7,386	4,767
Other assets, net	(8,934)	2,188
Accounts payable and accrued expenses	(17,820)	(23,668)
Accrued compensation and related benefits	10,349	5,343
Estimated third-party settlements	7,783	(3,652)
Insurance deposits and related liabilities	(5,927)	(14,589)
Liability for pension and other postretirement benefits	8,935	15,599
Other liabilities	11,431	2,109
Net cash provided (used) by operating and nonoperating activities	124,775	(12,840)
Cash flows from investing activities		
Purchase of property, plant, and equipment	(77,361)	(73,021)
Proceeds from sale of property, plant, and equipment	1,087	612
Purchases of investments	(259,201)	(67,117)
Proceeds from maturities and sales of investments	276,934	66,105
Cash received through acquisition	3,564	12,619
Net cash used by investing activities	(54,977)	(60,802)
Cash flows from financing activities		
Proceeds from line of credit	65,000	140,600
Payments on line of credit	(101,550)	(105,250)
Repayment of long-term debt	(48,506)	(104,343)
Proceeds from issuance of debt	39,064	140,031
Payment of debt issuance costs	(274)	(14)
Restricted contributions and investment earnings	4,374	4,301
Net cash (used) provided by financing activities	(41,892)	75,325
Increase in cash and cash equivalents	27,906	1,683
Cash and cash equivalents		
Beginning of year	40,592	38,909
End of year	$ 68,498	$ 40,592
Supplemental cash flow information		
Interest paid	$ 23,407	$ 22,298
Asset depreciation due to affiliations	-	(960)
Net assets acquired as part of acquisition, net of cash aquired	16,784	6,163
Building construction in process financed by a third party	8,426	-
Construction in progress included in accounts payable and accrued expenses	14,669	16,427
Equipment acquired through issuance of capital lease obligations	-	2,001
Donated securities	809	688

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 Mary Hitchcock Memorial Hospital (MHMH) and Dartmouth-Hitchcock Clinic (DHC) (collectively referred to as "Dartmouth-Hitchcock" (D-H)), New London Hospital Association (NLH), Mt. Ascutney Hospital and Health Center (MAHHC), The Cheshire Medical Center (Cheshire), Alice Peck Day Memorial Hospital (APD) and Visiting Nurse & Hospice for VT and NH (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.

Fiscal year 2017 includes a full year of operations of D-HH; D-H, NLH, MAHHC, Cheshire, APD and VNH. Fiscal year 2016 includes a full year of operations of D-HH, D-H, NLH, MAHHC and Cheshire, four months of operations of APD and no activity for VNH.

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, 2017 and 2016, the Health System provided financial assistance to patients in the amount of approximately $29,934,000 and $30,637,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2017 and 2016 was approximately $12,173,000 and $12,257,000, 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 2016 was approximately $124,371,000. The 2017 Community Benefits Reports are expected to be filed in February 2018.

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, 2016:

(Unaudited, in thousands of dollars)

Government-sponsored healthcare services	$ 281,014
Health professional education	32,561
Subsidized health services	25,846
Charity care	10,769
Community health services	5,701
Research	3,417
Financial contributions	1,792
Community building activities	1,789
Community benefit operations	1,107
Total community benefit value	$ 363,996

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, 2017 and 2016, the Health System reported a provision for bad debt expense of approximately $63,645,000 and $55,121,000, 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* (ASC 954), which addresses the accounting for healthcare entities. In accordance with the provisions of ASC 954, net assets, revenue, expenses, gains and losses 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 (Deficiency) of Revenue over Expenses
The consolidated statements of operations and changes in net assets include the excess (deficiency) of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on unrestricted investments, which are utilized to provide charity and other operational support. Peripheral activities, including unrestricted contribution income from acquisitions, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as nonoperating gains (losses).

Changes in unrestricted net assets which are excluded from the excess (deficiency) of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets), 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 4).

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 4).

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

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. 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 (deficiency) of revenues over expenses. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (Note 7).

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the excess (deficiency) of 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 restricted assets were invested in these pooled funds by purchasing units based on the market value of the pooled funds at the end of the month prior to receipt of any new additions to the funds. Interest, dividends, and realized and unrealized gains and losses earned on pooled funds are allocated monthly based on the weighted average units outstanding at the prior month-end.

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

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

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

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

Bond Issuance Costs

Bond issuance costs, classified on the consolidated balance sheets within long-term debt, are amortized over the term of the related bonds. Amortization is recorded within 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 $2,700,000 as intangible assets associated with its affiliations as of June 30, 2017 and 2016. There were no impairment charges recorded for the years ended June 30, 2017 and 2016.

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 (deficiency) 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 (deficiency) of revenue over expenses.

Gifts and Bequests
Unrestricted gifts and bequests are recorded net of related expenses as nonoperating 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 Financial Accounting Standards Board (FASB) issued ASU 2014-09 - *Revenue from Contracts with Customers* at the conclusion of a joint effort with the International Accounting Standards Board to create common revenue recognition guidance in accordance with accounting principles generally accepted in the United States of America and international accounting standards. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services, by allocating transaction price to identified performance obligations, and recognizing that revenue as performance obligations are satisfied. Qualitative and quantitative disclosures will be required to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The original standard was effective for fiscal years beginning after December 15, 2016; however, in July 2015, the FASB approved a one-year deferral of this standard, with a new effective date for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System. The Health System is evaluating the impact this will have on the consolidated financial statements.

In April 2015, the FASB issued ASU 2015-03 - *Imputation of Interest: Simplifying the Presentation of Debt Issuance Costs*, which requires all costs incurred to issue debt to be presented in the balance sheet as a direct deduction from the carrying value of the associated debt liability. The Health System implemented the new standard during the year ended June 30, 2017 and reclassified $3,933,000 as of June 30, 2016, to conform to the 2017 presentation.

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. Early adoption is permitted once ASU 2014-09 has been adopted. 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) may be early adopted. The Health System implemented this aspect of the new standard 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*, which makes targeted changes to the not-for-profit financial reporting model. Under the new ASU, net asset reporting will be streamlined and clarified. The existing three-category classification of net assets will be replaced with a simplified model that combines temporarily

restricted and permanently restricted into a single category called "net assets with donor restrictions." The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property, plant, and equipment have also been simplified and clarified. New disclosures will highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. Not-for-profits will continue to have flexibility to decide whether to report an operating subtotal and if so, to self-define what is included or excluded. However, transparent disclosure must be provided if the operating subtotal includes internal transfers made by the governing board. The ASU also imposes several new requirements related to reporting expenses, including providing information about expenses by their natural classification. The ASU is effective for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System and early adoption is permitted. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

Reclassifications
Certain amounts in the 2016 consolidated financial statements have been reclassified to conform to the 2017 presentation.

3. Acquisitions

Effective July 1, 2016, D-HH became the sole corporate member of VNH through an affiliation agreement. VNH is a not-for-profit corporation organized in VT providing home health, hospice and community based services to residents of NH and VT.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, The Health System recorded contribution income of approximately $20,348,000, reflecting the fair value of the contributed net assets of VNH, on the transaction date. Of this amount $20,215,000 represents unrestricted net assets and is included as a nonoperating gain in the accompanying consolidated statement of operations. Restricted contribution income of $103,000 and $30,000 was recorded within temporarily and permanently restricted net assets, respectively in the accompanying consolidated statement of changes in net assets. No consideration was exchanged for the net assets contributed and acquisition costs were expensed as incurred.

The fair value of assets, liabilities, and net assets contributed by VNH at July 1, 2016 were as follows:

(in thousands of dollars)

Assets		
Cash and cash equivalents	$	3,564
Patient accounts receivable, net		4,107
Property, plant, and equipment, net		436
Other assets		15,323
Total assets acquired	$	23,430
Liabilities		
Accounts payable and accrued expenses	$	1,194
Accrued compensation and related benefits		1,008
Other liabilities		880
Total liabilities assumed		3,082
Net Assets		
Unrestricted		20,215
Temporarily restricted		103
Permanently restricted		30
Total net assets		20,348
Total liabilities and net assets	$	23,430

A summary of the financial results of VNH included in the consolidated statement of operations and changes in net assets for the period from the date of acquisition (July 1, 2016) through June 30, 2017 is as follows:

(in thousands of dollars)

Total operating revenues	$	22,964
Total operating expenses		22,707
Operating gain		257
Nonoperating gains		2,604
Excess of revenue over expenses		2,861
Net assets transferred to affiliate		20,348
Changes in temporarily and permanently restricted net assets		(103)
Increase in net assets	$	23,106

A summary of the consolidated financial results of the Health System for the year ended June 30, 2016 as if the transaction had occurred on July 1, 2015 are as follows (unaudited):

(in thousands of dollars)

Total operating revenues	$ 1,813,935
Total operating expenses	1,852,896
Operating loss	(38,961)
Nonoperating gains	(5,953)
(Deficiency) of revenue over expenses	(44,914)
Net assets released from restriction used for capital purchases	3,248
Change in funded status of pension and other post retirement benefits	(66,541)
Other changes in net assets	-
Change in fair value on interest rate swaps	(5,873)
(Decrease) increase in unrestricted net assets	$ (114,080)

4. 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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Gross patient service revenue	$ 4,865,332	$ 4,426,305
Less: Contractual allowances	3,006,140	2,737,030
Provision for bad debt	63,645	55,121
Net patient service revenue	$ 1,795,547	$ 1,634,154

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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Receivables		
Patients	$ 90,786	$ 126,320
Third-party payors	263,240	244,716
Nonpatient	4,574	8,355
	$ 358,600	$ 379,391

The allowance for estimated uncollectibles is $121,340,000 and $118,403,000 as of June 30, 2017 and 2016.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the years ended June 30, 2017 and 2016:

	2017	2016
Medicare	43 %	42 %
Anthem/blue cross	18	19
Commercial insurance	20	22
Medicaid	13	14
Self-pay/other	6	3
	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, 2017 and 2016 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 the 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% (subject to sequestration of 2%) of reasonable costs 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. Medicare reimburses nursing home and rehabilitation services based on an acuity driven prospective payment system with no retrospective settlement.

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, 2017 and 2016, the Health System recorded State of NH Medicaid Enhancement Tax (MET) and State of VT Provider Tax of $65,069,000 and $58,565,000, 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 operating expenses 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 other operating expenses, was $645,000 and $528,000 in 2017 and 2016, 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 the 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. As part of the Medicaid Enhancement Tax Agreement effective July 1, 2014, a "Trust / Lock Box" dedicated fund mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services. During the years ended June 30, 2017 and 2016, the Health System received disproportionate share hospital (DSH) payments of approximately $59,473,000 and $56,718,000, respectively which is included in net patient service revenue in the consolidated statement of operations and changes in net assets.

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. The Health System has recognized other revenue of $1,156,000 and $2,330,000 in meaningful use incentives for both the Medicare and VT Medicaid programs during the years ended June 30, 2017 and 2016, 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.

Nonacute 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 (2011 - 2015). 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 2017 and 2016, changes in prior estimates related to the Health System's settlements with third-party payors resulted in increases (decreases) in net patient service revenue of $2,000,000 and $(859,000) respectively, in the consolidated statements of operations and changes in net assets.

5. Investments

The composition of investments at June 30, 2017 and 2016 is set forth in the following table:

(in thousands of dollars)	2017	2016
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 9,923	$ 12,915
U.S. government securities	44,835	33,578
Domestic corporate debt securities	100,953	65,610
Global debt securities	105,920	119,385
Domestic equities	129,548	100,009
International equities	95,167	61,768
Emerging markets equities	33,893	34,282
Real Estate Investment Trust	791	432
Private equity funds	39,699	33,209
Hedge funds	30,448	52,337
	591,177	513,525
Investments held by captive insurance companies (Note 12)		
U.S. government securities	18,814	22,484
Domestic corporate debt securities	21,681	29,123
Global debt securities	5,707	5,655
Domestic equities	9,048	7,830
International equities	13,888	11,901
	69,138	76,993
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	2,008	1,950
Total assets limited as to use	$ 662,323	$ 592,468

(in thousands of dollars)	2017	2016
Other investments for restricted activities		
Cash and short-term investments	$ 5,467	$ 12,219
U.S. government securities	28,096	21,351
Domestic corporate debt securities	27,762	33,203
Global debt securities	14,560	20,808
Domestic equities	18,451	19,215
International equities	15,499	13,986
Emerging markets equities	3,249	4,887
Real Estate Investment Trust	790	470
Private equity funds	3,949	4,780
Hedge funds	6,676	11,087
Other	30	30
Total other investments for restricted activities	$ 124,529	$ 142,036

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 nondistressed basis.

The following tables summarize the investments by the accounting method utilized, as of June 30, 2017 and 2016. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

(in thousands of dollars)	2017		
	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

(in thousands of dollars)	2016 Fair Value	2016 Equity	2016 Total
Cash and short-term investments	$ 27,084	$ -	$ 27,084
U.S. government securities	77,413	-	77,413
Domestic corporate debt securities	101,271	26,665	127,936
Global debt securities	40,356	105,492	145,848
Domestic equities	115,082	11,972	127,054
International equities	23,271	64,384	87,655
Emerging markets equities	331	38,838	39,169
Real estate investment trust	20	882	902
Private equity funds	-	37,989	37,989
Hedge funds	-	63,424	63,424
Other	30	-	30
	$ 384,858	$ 349,646	$ 734,504

Investment income (losses) is comprised of the following for the years ended June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Unrestricted		
Interest and dividend income, net	$ 4,418	$ 5,088
Net realized gains (losses) on sales of securities	16,868	(1,223)
Change in net unrealized gains on investments	30,809	(22,980)
	52,095	(19,115)
Temporarily restricted		
Interest and dividend income, net	1,394	536
Net realized gains (losses) on sales of securities	283	(18)
Change in net unrealized gains on investments	3,775	(1,674)
	5,452	(1,156)
Permanently restricted		
Change in net unrealized gains (losses) on beneficial interest in trust	245	(219)
	245	(219)
	$ 57,792	$ (20,490)

For the years ended June 30, 2017 and 2016 unrestricted investment income (losses) is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $1,039,000 and $988,000 and as nonoperating gains (losses) of approximately $51,056,000 and ($20,103,000), 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, 2017 and 2016, the Health System has committed to contribute approximately $119,719,000 and

$116,851,000 to such funds, of which the Health System has contributed approximately $81,982,000 and $80,019,000 and has outstanding commitments of $37,737,000 and $36,832,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Land	$ 38,058	$ 33,004
Land improvements	37,579	36,899
Buildings and improvements	818,831	801,840
Equipment	766,667	744,443
Equipment under capital leases	20,495	20,823
	1,681,630	1,637,009
Less: Accumulated depreciation and amortization	1,101,058	1,046,617
Total depreciable assets, net	580,572	590,392
Construction in progress	29,403	22,172
	$ 609,975	$ 612,564

As of June 30, 2017 construction in progress primarily consists of the construction of the Hospice & Palliative Care Center and APD's medical office building, both in Lebanon, NH. The estimated cost to complete these projects at June 30, 2017 is $7,335,000 and $9,381,000, respectively.

The construction in progress for the Borwell building reported as of June 30, 2016 was completed during the first quarter of fiscal year 2017 and the building addition for New London at the Newport Health Center was completed in the second quarter of fiscal year 2017.

Depreciation and amortization expense included in operating and nonoperating activities was approximately $84,711,000 and $81,138,000 for 2017 and 2016, respectively.

7. Fair Value Measurements

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

Cash and Short-Term Investments
Consists of money market funds and are valued at net asset value (NAV) reported by the financial institution.

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.

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, 2017 and 2016:

	2017					
(in thousands of dollars)	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		

	2016					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 27,084	$ -	$ -	$ 27,084	Daily	1
U.S. government securities	77,413	-	-	77,413	Daily	1
Domestic corporate debt securities	27,626	73,645	-	101,271	Daily–Monthly	1–15
Global debt securities	23,103	17,253	-	40,356	Daily–Monthly	1–15
Domestic equities	115,082	-	-	115,082	Daily–Monthly	1–10
International equities	23,271	-	-	23,271	Daily–Monthly	1–11
Emerging market equities	331	-	-	331	Daily–Monthly	1–7
Real estate investment trust	20	-	-	20	Daily–Monthly	1–7
Other	-	30	-	30	Not applicable	Not applicable
Total investments	293,930	90,928	-	384,858		
Deferred compensation plan assets						
Cash and short-term investments	2,478	-	-	2,478		
U.S. government securities	30	-	-	30		
Domestic corporate debt securities	6,710	-	-	6,710		
Global debt securities	794	-	-	794		
Domestic equities	23,502	-	-	23,502		
International equities	8,619	-	-	8,619		
Emerging market equities	2,113	-	-	2,113		
Real estate	2,057	-	-	2,057		
Multi strategy fund	9,188	-	-	9,188		
Guaranteed contract	-	-	80	80		
Total deferred compensation plan assets	55,491	-	80	55,571	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,087	9,087	Not applicable	Not applicable
Total assets	$ 349,421	$ 90,928	$ 9,167	$ 449,516		
Liabilities						
Interest rate swaps	$ -	$ 28,917	$ -	$ 28,917	Not applicable	Not applicable
Total liabilities	$ -	$ 28,917	$ -	$ 28,917		

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.

	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 (losses)	157	3	160
Net asset transfer from affiliate	-	-	-
Balances at end of year	$ 9,244	$ 83	$ 9,327

	2016		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,345	$ 78	$ 9,423
Purchases	-	-	-
Sales	-	-	-
Net unrealized gains (losses)	(258)	2	(256)
Net asset transfer from affiliate	-	-	-
Balances at end of year	$ 9,087	$ 80	$ 9,167

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, 2017 and 2016.

8. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Healthcare services	$ 32,583	$ 44,561
Research	25,385	16,680
Purchase of equipment	3,080	2,826
Charity care	13,814	1,543
Health education	17,489	8,518
Other	2,566	1,603
	$ 94,917	$ 75,731

Permanently restricted net assets consist of the following at June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Healthcare services	$ 22,916	$ 32,105
Research	7,795	7,767
Purchase of equipment	6,274	5,266
Charity care	6,895	2,991
Health education	10,228	5,408
Other	57	53
	$ 54,165	$ 53,590

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

9. Board Designated and Endowment Funds

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

The Board of Trustees has interpreted the NH and VT Uniform Prudent Management of Institutional Funds Acts (UPMIFA or Act) for donor-restricted endowment funds as requiring the preservation of the original value of gifts, as of the gift date, to donor-restricted endowment funds, absent explicit donor stipulations to the contrary. The Health System 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, 2017 and 2016.

Endowment net asset composition by type of fund consists of the following at June 30, 2017 and 2016:

	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

	2016			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 25,780	$ 45,402	$ 71,182
Board-designated endowment funds	26,205	-	-	26,205
Total endowed net assets	$ 26,205	$ 25,780	$ 45,402	$ 97,387

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	

Changes in endowment net assets for the year ended June 30, 2016:

	2016			
(in thousands of dollars)	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Balances at beginning of year	$ 26,405	$ 28,296	$ 44,491	$ 99,192
Net investment return	(54)	(1,477)	3	(1,528)
Contributions	-	271	699	970
Transfers	-	(216)	180	(36)
Release of appropriated funds	(146)	(1,094)	-	(1,240)
Net asset transfer from affiliates	-	-	29	29
Balances at end of year	$ 26,205	$ 25,780	45,402	$ 97,387

Balances at end of year	45,402
Beneficial interest in perpetual trust	8,188
Permanently restricted net assets	$ 53,590

10. Long-Term Debt

A summary of long-term debt at June 30, 2017 and 2016 is as follows:

(in thousands of dollars)	2017	2016
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2015A, principal maturing in varying annual amounts, through August 2031 (2)	$ 82,975	$ 86,710
Series 2013, principal maturing in varying annual amounts, through August 2043 (10)	-	19,230
Vermont Educational and Health Buildings Financing Agency (VEHFBA) Revenue Bonds		
Series 2010A, principal maturing in varying annual amounts, through August 2030 (11)	-	7,881
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2016A, principal maturing in varying annual amounts, through August 2046 (1)	24,608	-
Series 2016B, principal maturing in varying annual amounts, through August 2046 (1)	10,970	-
Series 2014A, principal maturing in varying annual amounts, through August 2022 (4)	26,960	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (4)	14,530	14,530
Series 2012A, principal maturing in varying annual amounts, through August 2031 (5)	71,700	72,720
Series 2012B, principal maturing in varying annual amounts, through August 2031 (5)	39,340	39,900
Series 2012, principal maturing in varying annual amounts, through July 2039 (9)	26,735	27,490
Series 2010, principal maturing in varying annual amounts, through August 2040 (7)	75,000	75,000
Series 2009, principal maturing in varying annual amounts, through August 2038 (8)	57,540	63,370
Total variable and fixed rate debt	430,358	433,791

A summary of long-term debt at June 30, 2017 and 2016 is as follows (continued):

(in thousands of dollars)	2017	2016
Other		
Revolving Line of Credit, principal maturing through March 2019 (3)	49,750	49,750
Series 2012, principal maturing in varying annual amounts, through July 2025 (6)	136,000	140,000
Series 2010, principal maturing in varying annual amounts, through August 2040 (12)*	15,900	16,287
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment*	811	313
Note payable to a financial institution due in monthly interest only payments from October 2011 through September 2012, and monthly installments from October 2012 through 2016, including principal and interest at 3.25%; collateralized by savings account*	-	2,952
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*	437	494
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046*	2,763	-
Obligations under capital leases	3,435	4,875
Total other debt	209,096	214,671
Total variable and fixed rate debt	430,358	433,791
Total long-term debt	639,454	648,462
Less		
Original issue discount, net	862	881
Bond issuance costs, net	3,832	3,933
Current portion	18,357	18,307
	$ 616,403	$ 625,341

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)	2017
2018	$ 18,357
2019	68,279
2020	19,401
2021	19,448
2022	19,833
Thereafter	494,136
	$ 639,454

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 of which are the Annual Debt Service Coverage Ratio (1.10x) and the Days Cash on Hand Ratio (> 75 days).

(1) Series 2016A and 2016B Revenue Bonds

Through 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. The Series 2016A Revenue Bonds mature in variable amounts through 2046. 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.

(2) Series 2015A Revenue Bonds

Through 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 variable rate as of June 30 2017 was 1.51%

(3) Revolving Line of Credit

Through the DHOG, entered into Revolving Line of Credit TD Bank, N.A. (TD Bank). Interest on the TD Bank loan accrues variably and matures at various dates through March 2019. The variable rate as of June 30 2017 was 1.63%

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

Through 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.

(5) Series 2012A and 2012B Revenue Bonds

Through 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.

(6) Series 2012 Bank Loan

Through 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.

(7) Series 2010 Revenue Bonds

Through 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.

(8) Series 2009 Revenue Bonds

Through 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.

(9) Series 2012 Revenue Bonds

Issued through the NHHEFA $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 are collateralized by an interest in its gross receipts under the terms of the bond agreement. 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.

(10) Series 2013 Revenue Bonds

Issued through the NHHEFA $15,520,000 tax exempt Revenue Bonds Series 2013A. The Series 2013A funds were used to refund Series 2007 Revenue Bonds. Additional borrowings were obtained (up to $9,480,000 Revenue Bonds, Series 2013B) for the construction of a new health center building in Newport, NH. The bonds are collateralized by the gross receipts and property. The bonds mature in variable amounts through 2043, the maturity date of the bonds, but are subject to mandatory tender in ten years. Interest is payable monthly and is equal to the sum of .72 times the Adjusted LIBOR Rate plus .72 times the credit spread rate. As part of the bond refinancing, the swap arrangement was effectively terminated for federal tax purposes with

respect to the Series 2007 Revenue Bonds but remains in effect. These bonds were paid with the proceeds of the Series 2016A Revenue Bonds.

(11) Series 2010A Revenue Bonds

Issued through the VEHBFA $9,244,000 of Revenue Bonds Series 2010A. The funds were used to refund 2004 and 2005 Series A Bonds. The bonds are collateralized by gross receipts. The bonds shall bear interest at the one-month LIBOR rate plus 3.50%, multiplied by 6% adjusting monthly. The bonds were purchased by TD Bank on March 1, 2010. Principal payments began on April 1, 2010 for a period of 20 years ranging in amounts from $228,000 in 2014 to $207,000 in 2030. These bonds were refunded in July 2016.

Outstanding joint and several indebtedness of the DHOG at June 30, 2017 and 2016 approximates $616,108,000 and $568,940,000, respectively.

Non Obligated Group Bonds

(12) Series 2010 Revenue Bonds

Issued through the Business Finance Authority (BFA) of the State of NH. 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 $2,008,000 and $1,950,000 at June 30, 2017 and 2016, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets.

For the years ended June 30, 2017 and 2016 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 $19,838,000 and $19,301,000 and is included in other nonoperating losses of $3,135,000 and $3,201,000, 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.

- 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.

- 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.

At June 30, 2017 and 2016 the fair value of the Health System's interest rate swaps was a liability of $20,915,000 and $28,917,000, respectively. The change in fair value during the years ended June 30, 2017 and 2016 was a (decrease) and an increase of ($8,002,000) and $4,177,000, respectively. For the years ended June 30, 2017 and 2016 the Health System recognized a nonoperating gain of $124,000 and $1,696,000 resulting from hedge ineffectiveness and amortization of frozen swaps.

11. 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 December 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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Service cost for benefits earned during the year	$ 5,736	$ 11,084
Interest cost on projected benefit obligation	47,316	48,036
Expected return on plan assets	(64,169)	(63,479)
Net prior service cost	109	848
Net loss amortization	20,267	26,098
Special/contractural termination benefits	119	300
One-time benefit upon plan freeze acceleration	9,519	-
	$ 18,897	$ 22,887

The following assumptions were used to determine net periodic pension expense as of June 30, 2017 and 2016:

	2017	2016
Discount rate	4.20 % – 4.90 %	4.30 % – 4.90%
Rate of increase in compensation	Age Graded - N/A	Age Graded/0.00 % - 2.50 %
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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,096,619	$ 988,143
Service cost	5,736	11,084
Interest cost	47,316	48,108
Benefits paid	(43,276)	(39,001)
Expenses paid	(183)	(180)
Actuarial (gain) loss	6,884	99,040
Settlements	-	(13,520)
Plan change	-	2,645
Special/contractual termination benefits	-	300
One-time benefit upon plan freeze acceleration	9,519	-
Benefit obligation at end of year	1,122,615	1,096,619
Change in plan assets		
Fair value of plan assets at beginning of year	872,320	845,052
Actual return on plan assets	44,763	81,210
Benefits paid	(43,276)	(42,494)
Expenses paid	(183)	(180)
Employer contributions	5,077	2,252
Settlements	-	(13,520)
Fair value of plan assets at end of year	878,701	872,320
Funded status of the plans	(243,914)	(224,299)
Less current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(243,868)	(224,253)
Liability for pension	$ (243,914)	$ (224,299)

For the years ended June 30, 2017 and 2016 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 as of June 30, 2017 and 2016 are as follows:

(in thousands of dollars)	2017	2016
Net actuarial loss	$ 429,782	$ 423,640
Prior service cost	-	228
	$ 429,782	$ 423,868

The estimated amounts to be amortized from unrestricted net assets into net periodic pension expense in 2018 for net actuarial losses is $10,966,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,123,010,000 and $1,082,818,000 at June 30, 2016 and 2017, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2017 and 2016:

	2017	2016
Discount rate	4.00 % – 4.30 %	4.20 % – 4.30 %
Rate of increase in compensation	N/A - 0.00 %	Age Graded/0.00 % - 2.50 %

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, 2017 and 2016, it is expected that the LDI strategy will hedge approximately 55% and 65%, 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	0–5	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 7. In addition, the estimation of fair value of investments in private equity and hedge funds for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The Health System's Plans own interests in 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, 2017 and 2016:

	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 7	See Note 7
Hedge funds	-	-	40,507	40,507	Quarterly–Annual	60–96
Total investments	$ 315,759	$ 522,339	$ 40,603	$ 878,701		

	2016					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 5,463	$ 10,879	$ -	$ 16,342	Daily	1
U.S. government securities	4,177	-	-	4,177	Daily–Monthly	1–15
Domestic debt securities	95,130	296,362	-	391,492	Daily–Monthly	1–15
Global debt securities	409	88,589	-	88,998	Daily–Monthly	1–15
Domestic equities	148,998	15,896	-	164,894	Daily–Monthly	1–10
International equities	12,849	77,299	-	90,148	Daily–Monthly	1–11
Emerging market equities	352	37,848	-	38,200	Daily–Monthly	1–17
REIT funds	356	1,465	-	1,821	Daily–Monthly	1–17
Private equity funds	-	-	255	255	See Note 7	See Note 7
Hedge funds	-	37,005	38,988	75,993	Quarterly–Annual	60–96
Total investments	$ 267,734	$ 565,343	$ 39,243	$ 872,320		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2017 and 2016:

	2017		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 38,988	$ 255	$ 39,243
Transfers	-	-	-
Purchases	-	-	-
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

	2016		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 42,076	$ 437	$ 42,513
Transfers	-	-	-
Purchases	-	-	-
Sales	(468)	(142)	(610)
Net realized (losses) gains	(55)	155	100
Net unrealized gains	(2,565)	(195)	(2,760)
Balances at end of year	$ 38,988	$ 255	$ 39,243

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2017 and 2016 were approximately $7,965,000 and $8,808,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2017 and 2016.

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, 2017 and 2016.

The weighted average asset allocation for the Health System's Plans at June 30, 2017 and 2016 by asset category is as follows:

	2017	2016
Cash and short-term investments	3 %	2 %
U.S. government securities	1	1
Domestic debt securities	44	45
Global debt securities	10	10
Domestic equities	20	19
International equities	12	10
Emerging market equities	5	4
Hedge funds	5	9
	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 $5,047,000 to the Plans in 2018 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)	
2018	$ 46,313
2019	48,689
2020	51,465
2021	54,375
2022	57,085
2023 – 2027	323,288

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 $33,375,000 and $29,416,000 in 2017 and 2016, 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 2017 and 2016 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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Service cost	$ 448	$ 544
Interest cost	2,041	2,295
Net prior service income	(5,974)	(5,974)
Net loss amortization	689	610
	$ (2,796)	$ (2,525)

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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Change in benefit obligation		
Benefit obligation at beginning of year	$ 51,370	$ 50,438
Service cost	448	544
Interest cost	2,041	2,295
Benefits paid	(3,211)	(3,277)
Actuarial (gain) loss	(8,337)	1,404
Employer contributions	(34)	(34)
Benefit obligation at end of year	42,277	51,370
Funded status of the plans	(42,277)	(51,370)
Current portion of liability for postretirement medical and life benefits	(3,174)	(3,130)
Long term portion of liability for postretirement medical and life benefits	(39,103)	(48,240)
Liability for postretirement medical and life benefits	$ (42,277)	$ (51,370)

For the years ended June 30, 2017 and 2016 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)	2017	2016
Net prior service income	$ (21,504)	$ (27,478)
Net actuarial loss	2,054	11,080
	$ (19,450)	$ (16,398)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement income in 2018 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, 2017 and thereafter:

(in thousands of dollars)	
2018	$ 3,174
2019	3,149
2020	3,142
2021	3,117
2022	3,113
2023-2027	14,623

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 4.20% in 2017 and an assumed healthcare cost trend rate of 6.75%, 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, 2017 and 2016 by $1,067,000 and $4,685,000 and the net periodic postretirement medical benefit cost for the years then ended by $110,000 and $284,000, 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, 2017 and 2016 by $974,000 and $3,884,000 and the net periodic postretirement medical benefit cost for the years then ended by $96,000 and $234,000, respectively.

12. 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. 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 is covered for malpractice claims under a modified claims-made policy purchased through New England Alliance for Health (NEAH). While APD remains 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, 2017 and 2016 are summarized as follows:

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

	2016		
(in thousands of dollars)	HAC *(audited)*	RRG *(unaudited)*	Total
Assets	$ 86,101	$ 2,237	$ 88,338
Shareholders' equity	13,620	806	14,426
Net income	-	50	50

13. Commitments and Contingencies

Litigation

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

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 $15,802,000 and $10,571,000 for the years ended June 30, 2017 and 2016, respectively. Minimum future lease payments under noncancelable operating leases at June 30, 2017 were as follows:

(in thousands of dollars)	
2018	$ 8,370
2019	6,226
2020	3,928
2021	3,105
2022	1,518
Thereafter	367
	$ 23,514

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 $85,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 1, 2018. There was no outstanding balance under the lines of credit at June 30, 2017. The Health System had outstanding balances under the lines of credits in the amount of $36,550,000 at June 30, 2016. Interest expense was approximately $915,000 and $551,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses of the Health System by function are as follows for the years ended June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Program services	$ 1,662,413	$ 1,553,377
Management and general	311,820	271,409
Fundraising	2,328	5,901
	$ 1,976,561	$ 1,830,687

15. Subsequent Events

The Health System has assessed the impact of subsequent events through November 17, 2017, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

Consolidating Supplemental Information - Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 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
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	3,650	1,351	(16,585)	89,177	8,034	(8,008)	89,203
Total current assets	314,877	35,313	19,986	12,672	(16,585)	366,263	36,706	(8,008)	394,961
Assets limited as to use	580,254	19,104	11,784	9,058	-	620,200	42,123	-	662,323
Other investments for restricted activities	86,398	4,764	2,833	6,079	-	100,074	24,455	-	124,529
Property, plant, and equipment, net	448,743	64,933	43,264	17,167	-	574,107	35,868	-	609,975
Other assets	89,650	2,543	5,965	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	$ 16,034	$ 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	(16,585)	83,702	13,466	(8,008)	89,160
Accrued compensation and related benefits	99,638	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	77,622	2,636	1,426	-	-	81,684	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	258,887	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	$ 8,280	$ 6,968	$ 8,129	$ 4,594	$ -	$ 68,498
Patient accounts receivable, net	-	193,733	17,723	8,539	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	(24,593)	89,203
Total current assets	5,050	315,798	35,223	20,490	12,989	21,186	8,818	(24,593)	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	$ 603	$ 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	72,806	19,718	5,365	2,946	5,048	1,874	(24,593)	89,160
Accrued compensation and related benefits	-	99,638	5,428	2,335	3,480	2,998	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	(10,970)	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	18,965	23,231	(21,285)	424,947
Temporarily restricted	444	74,304	18,198	345	1,363	265	-	(2)	94,917
Permanently restricted	-	33,433	10,679	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 Balance Sheets
June 30, 2016

(in thousands of dollars)	Dartmouth-Hitchcock	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets					
Current assets					
Cash and cash equivalents	$ 1,535	$ 1,535	$ 39,057	$ -	$ 40,592
Patient accounts receivable, net	220,173	220,173	40,815	-	260,988
Prepaid expenses and other current assets	95,158	95,158	23,595	(22,933)	95,820
Total current assets	316,866	316,866	103,467	(22,933)	397,400
Assets limited as to use	551,724	551,724	40,744	-	592,468
Other investments for restricted activities	91,879	91,879	50,157	-	142,036
Property, plant, and equipment, net	454,894	454,894	157,670	-	612,564
Other assets	65,613	65,613	36,582	(14,929)	87,266
Total assets	$ 1,480,976	$ 1,480,976	$ 388,620	$ (37,862)	$ 1,831,734
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ 15,638	$ 15,638	$ 2,669	$ -	$ 18,307
Line of Credit	35,000	35,000	1,550	-	36,550
Current portion of liability for pension and other postretirement plan benefits	3,176	3,176	-	-	3,176
Accounts payable and accrued expenses	87,373	87,373	43,104	(22,933)	107,544
Accrued compensation and related benefits	86,997	86,997	16,557	-	103,554
Estimated third-party settlements	21,434	21,434	(1,784)	-	19,650
Total current liabilities	249,618	249,618	62,096	(22,933)	288,781
Long-term debt, excluding current portion	550,090	550,090	75,251	-	625,341
Insurance deposits and related liabilities	56,887	56,887	-	-	56,887
Interest rate swaps	24,148	24,148	4,769	-	28,917
Liability for pension and other postretirement plan benefits, excluding current portion	246,816	246,816	25,677	-	272,493
Other liabilities	54,218	54,218	15,593	-	69,811
Total liabilities	1,181,777	1,181,777	183,386	(22,933)	1,342,230
Commitments and contingencies					
Net assets					
Unrestricted	217,033	217,033	158,079	(14,929)	360,183
Temporarily restricted	51,173	51,173	24,558	-	75,731
Permanently restricted	30,993	30,993	22,597	-	53,590
Total net assets	299,199	299,199	205,234	(14,929)	489,504
Total liabilities and net assets	$ 1,480,976	$ 1,480,976	$ 388,620	$ (37,862)	$ 1,831,734

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Assets								
Current assets								
Cash and cash equivalents	$ 607	$ 2,066	$ 16,640	$ 6,699	$ 5,388	$ 9,192	$ -	$ 40,592
Patient accounts receivable, net	-	220,173	17,836	7,377	5,347	10,255	-	260,988
Prepaid expenses and other current assets	7,463	95,738	5,458	3,209	2,022	4,863	(22,933)	95,820
Total current assets	8,070	317,977	39,934	17,285	12,757	24,310	(22,933)	397,400
Assets limited as to use	-	551,724	17,525	10,345	8,260	4,614	-	592,468
Other investments for restricted activities	217	114,719	18,486	2,843	5,742	29	-	142,036
Property, plant, and equipment, net	76	457,570	75,591	43,204	19,659	16,464	-	612,564
Other assets	17,950	65,782	9,496	5,028	3,929	10	(14,929)	87,266
Total assets	$ 26,313	$ 1,507,772	$ 161,032	$ 78,705	$ 50,347	$ 45,427	$ (37,862)	$ 1,831,734
Liabilities and Net Assets								
Current liabilities								
Current portion of long-term debt	$ -	$ 15,838	$ 755	$ 941	$ 466	$ 507	$ -	$ 18,307
Line of credit	-	35,000	-	-	1,550	-	-	36,550
Current portion of liability for pension and other postretirement plan benefits	-	3,176	-	-	-	-	-	3,176
Accounts payable and accrued expenses	9,857	88,557	15,866	6,791	4,589	4,817	(22,933)	107,544
Accrued compensation and related benefits	-	86,997	7,728	2,052	3,128	3,649	-	103,554
Estimated third-party settlements	-	10,534	1,569	5,206	917	1,424	-	19,650
Total current liabilities	9,857	239,902	25,918	14,990	10,650	10,397	(22,933)	288,781
Long-term debt, excluding current portion	-	550,090	26,985	20,767	11,145	16,354	-	625,341
Insurance deposits and related liabilities	-	56,887	-	-	-	-	-	56,887
Interest rate swaps	-	24,148	-	4,646	123	-	-	28,917
Liability for pension and other postretirement plan benefits, excluding current portion	-	246,816	18,662	-	7,015	-	-	272,493
Other liabilities	-	65,118	3,522	1,135	-	36	-	69,811
Total liabilities	9,857	1,182,961	75,087	41,538	28,933	26,787	(22,933)	1,342,230
Commitments and contingencies								
Net assets								
Unrestricted	16,456	234,609	58,978	32,706	14,099	18,264	(14,929)	360,183
Temporarily restricted	-	57,091	16,454	345	1,496	345	-	75,731
Permanently restricted	-	33,111	10,513	4,116	5,819	31	-	53,590
Total net assets	16,456	324,811	85,945	37,167	21,414	18,640	(14,929)	489,504
Total liabilities and net assets	$ 26,313	$ 1,507,772	$ 161,032	$ 78,705	$ 50,347	$ 45,427	$ (37,862)	$ 1,831,734

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	$ 1,447,961	$ 214,265	$ 59,928	$ 48,072	$ (19)	$ 1,770,207	$ 88,985	$ -	$ 1,859,192
Provisions for bad debts	42,963	14,125	2,010	1,705	-	60,803	2,842	-	63,645
Net patient service revenue less provisions for bad debts	1,404,998	200,140	57,918	46,367	(19)	1,709,404	86,143	-	1,795,547
Contracted revenue	88,620	-	-	1,861	(41,771)	48,710	(4,995)	(44)	43,671
Other operating revenue	104,811	3,045	3,639	1,592	(1,148)	111,939	6,418	820	119,177
Net assets released from restrictions	9,550	639	116	61	-	10,366	756	-	11,122
Total unrestricted revenue and other support	1,607,779	203,824	61,873	49,881	(42,938)	1,880,419	88,322	776	1,969,517
Operating expenses									
Salaries	787,644	102,769	30,311	23,549	(21,784)	922,489	42,327	1,536	966,352
Employee benefits	202,178	26,632	7,071	5,523	(5,322)	236,082	8,392	381	244,855
Medical supplies and medications	257,100	30,692	6,143	2,905	(273)	296,567	9,513	-	306,080
Purchased services and other	208,671	28,068	12,795	13,224	(17,325)	245,433	45,331	(959)	289,805
Medicaid enhancement tax	50,118	7,800	2,923	1,620	-	62,461	2,608	-	65,069
Depreciation and amortization	66,067	10,238	3,881	2,138	-	82,324	2,238	-	84,562
Interest	17,352	1,127	819	249	(209)	19,338	500	-	19,838
Total operating expenses	1,589,130	207,326	63,943	49,208	(44,913)	1,864,694	110,909	958	1,976,581
Operating margin (loss)	18,649	(3,502)	(2,070)	673	1,975	15,725	(22,587)	(182)	(7,044)
Nonoperating gains (losses)									
Investment gains (losses)	42,484	1,378	1,570	984	(209)	46,207	4,849	-	51,056
Other, net	(3,003)	-	(879)	570	(1,767)	(5,079)	740	186	(4,153)
Contribution revenue from acquisition	-	-	-	-	-	-	20,215	-	20,215
Total nonoperating gains, net	39,481	1,378	691	1,554	(1,976)	41,128	25,804	186	67,118
Excess (deficiency) of revenue over expenses	58,130	(2,124)	(1,379)	2,227	(1)	56,853	3,217	4	60,074
Unrestricted net assets									
Net assets released from restrictions (Note 8)	983	-	9	442	-	1,434	405	-	1,839
Change in funded status of pension and other postretirement benefits	(5,297)	4,031	-	(321)	-	(1,587)	-	-	(1,587)
Net assets transferred (from) to affiliates	(18,380)	900	143	986	-	(16,351)	16,351	-	-
Other changes in net assets	-	-	-	(2,286)	-	(2,286)	5,281	(6,359)	(3,364)
Change in fair value on interest rate swaps	6,418	-	1,337	47	-	7,802	-	-	7,802
Increase (decrease) in unrestricted net assets	$ 41,854	$ 2,807	$ 110	$ 1,095	$ (1)	$ 45,865	$ 25,254	$ (6,355)	$ 64,764

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	$ -	$ 1,447,961	$ 214,265	$ 59,928	$ 48,072	$ 65,835	$ 23,150	$ (19)	$ 1,859,192
Provisions for bad debts	-	42,963	14,125	2,010	1,705	2,275	567	-	63,645
Net patient service revenue less provisions for bad debts	-	1,404,998	200,140	57,918	46,367	63,560	22,583	(19)	1,795,547
Contracted revenue	(5,802)	89,427	-	-	1,861	-	-	(41,815)	43,671
Other operating revenue	673	106,775	3,264	3,837	3,038	1,537	381	(328)	119,177
Net assets released from restrictions	-	10,200	639	116	61	106	-	-	11,122
Total unrestricted revenue and other support	(5,129)	1,611,400	204,043	61,871	51,327	65,203	22,964	(42,162)	1,969,517
Operating expenses									
Salaries	1,009	787,644	102,769	30,311	24,273	29,397	11,197	(20,248)	966,352
Employee benefits	293	202,178	26,632	7,071	5,686	5,532	2,404	(4,941)	244,855
Medical supplies and medications	-	257,100	30,692	6,143	2,905	7,760	1,753	(273)	306,080
Purchased services and other	16,021	212,414	29,902	12,653	13,626	16,564	6,907	(18,282)	289,805
Medicaid enhancement tax	-	50,118	7,800	2,923	1,620	2,608	-	-	65,069
Depreciation and amortization	26	66,087	10,396	3,886	2,242	1,532	413	-	84,562
Interest	-	17,352	1,127	819	249	467	33	(209)	19,838
Total operating expenses	17,349	1,592,873	209,318	63,806	50,601	63,860	22,707	(43,953)	1,976,561
Operating (loss) margin	(22,478)	18,527	(5,275)	(1,935)	726	1,343	257	1,791	(7,044)
Nonoperating gains (losses)									
Investment (losses) gains	(321)	44,746	2,124	1,516	1,045	439	1,716	(209)	51,056
Other, net	-	(3,003)	-	(879)	581	(161)	888	(1,579)	(4,153)
Contribution revenue from acquisition	20,215	-	-	-	-	-	-	-	20,215
Total nonoperating gains, net	19,894	41,743	2,124	637	1,626	278	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 8)	-	1,075	-	9	442	158	155	-	1,839
Change in funded status of pension and other postretirement benefits	-	(5,297)	4,031	-	(321)	-	-	-	(1,587)
Net assets transferred (from) to affiliates	(3,864)	(18,380)	900	143	986	-	20,215	-	-
Additional paid in capital	-	-		-	-	-	-		-
Other changes in net assets	6,359	-	-	-	(2,286)	(1,078)	-	(6,359)	(3,364)
Change in fair value on interest rate swaps	-	6,418	-	1,337	47	-	-	-	7,802
(Decrease) increase in unrestricted net assets	$ (89)	$ 44,086	$ 1,780	$ 191	$ 1,220	$ 701	$ 23,231	$ (6,356)	$ 64,764

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	Dartmouth-Hitchcock	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	$ 1,387,677	$ 1,387,677	$ 302,159	$ (561)	$ 1,689,275
Provisions for bad debts	41,072	41,072	14,049	-	55,121
Net patient service revenue less provisions for bad debts	$ 1,346,605	$ 1,346,605	$ 288,110	$ (561)	$ 1,634,154
Contracted revenue	63,188	63,188	2,794	-	65,982
Other operating revenue	69,902	69,902	16,994	(4,544)	82,352
Net assets released from restrictions	7,928	7,928	1,291	-	9,219
Total unrestricted revenue and other support	1,487,623	1,487,623	309,189	(5,105)	1,791,707
Operating expenses					
Salaries	731,721	731,721	126,108	14,636	872,465
Employee benefits	197,050	197,050	34,824	2,533	234,407
Medical supplies and medications	236,918	236,918	72,896	-	309,814
Purchased services and other	208,763	208,763	68,582	(22,204)	255,141
Medicaid enhancement tax	46,078	46,078	12,487	-	58,565
Depreciation and amortization	62,348	62,348	18,646	-	80,994
Interest	16,821	16,821	2,480	-	19,301
Total operating expenses	1,499,699	1,499,699	336,023	(5,035)	1,830,687
Operating (loss) margin	(12,076)	(12,076)	(26,834)	(70)	(38,980)
Nonoperating (losses) gains					
Investment losses	(18,537)	(18,537)	(1,566)	-	(20,103)
Other, net	(3,789)	(3,789)	(56)	-	(3,845)
Contribution revenue from acquisition	-	-	18,014	69	18,083
Total nonoperating (losses) gains, net	(22,326)	(22,326)	16,392	69	(5,865)
Deficiency of revenue over expenses	(34,402)	(34,402)	(10,442)	(1)	(44,845)
Unrestricted net assets					
Net assets released from restrictions (Note 8)	1,994	1,994	1,254	-	3,248
Change in funded status of pension and other postretirement benefits	(52,262)	(52,262)	(14,279)	-	(66,541)
Net assets transferred (from) to affiliates	(22,558)	(22,558)	22,558	-	-
Additional paid in capital	-	-	12,793	(12,793)	-
Change in fair value on interest rate swaps	(4,907)	(4,907)	(966)	-	(5,873)
(Decrease) increase in unrestricted net assets	$ (112,135)	$ (112,135)	$ 10,918	$ (12,794)	$ (114,011)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Unrestricted revenue and other support								
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,387,677	$ 171,620	$ 61,740	$ 47,680	$ 21,119	$ (561)	$ 1,689,275
Provisions for bad debts	-	41,072	9,833	1,951	1,249	1,016	-	55,121
Net patient service revenue less provisions for bad debts	-	1,346,605	161,787	59,789	46,431	20,103	(561)	1,634,154
Contracted revenue	1,696	64,286	-	-	-	-	-	65,982
Other operating revenue	3,300	71,475	3,187	3,509	4,555	870	(4,544)	82,352
Net assets released from restrictions	-	8,713	322	65	119	-	-	9,219
Total unrestricted revenue and other support	4,996	1,491,079	165,296	63,363	51,105	20,973	(5,105)	1,791,707
Operating expenses								
Salaries	730	732,393	60,406	29,873	24,019	10,408	14,636	872,465
Employee benefits	219	197,165	19,276	6,824	6,260	2,130	2,533	234,407
Medical supplies and medications	-	236,918	59,121	6,597	4,246	2,932	-	309,814
Purchased services and other	22,506	211,611	14,020	12,876	11,955	4,377	(22,204)	255,141
Medicaid enhancement tax	-	46,078	7,132	2,808	1,707	840	-	58,565
Depreciation and amortization	15	62,348	11,069	4,674	2,345	543	-	80,994
Interest	-	16,821	1,046	823	467	144	-	19,301
Total operating expenses	23,470	1,503,334	172,070	64,475	50,999	21,374	(5,035)	1,830,687
Operating (loss) margin	(18,474)	(12,255)	(6,774)	(1,112)	106	(401)	(70)	(38,980)
Nonoperating gains (losses)								
Investment (losses) gains	(1,027)	(18,848)	(1,075)	627	(15)	235	-	(20,103)
Other, net	(529)	(3,647)	-	57	205	-	69	(3,845)
Contribution revenue from acquisition	18,083	-	-	-	-	-	-	18,083
Total nonoperating (losses) gains, net	16,527	(22,495)	(1,075)	684	190	235	69	(5,865)
(Deficiency) excess of revenue over expenses	(1,947)	(34,750)	(7,849)	(428)	296	(166)	(1)	(44,845)
Unrestricted net assets								
Net assets released from restrictions (Note 8)	-	2,185	107	23	586	347	-	3,248
Change in funded status of pension and other postretirement benefits	-	(52,262)	(12,982)	-	(1,297)	-	-	(66,541)
Net assets transferred to (from) affiliates	4,475	(22,558)	-	-	-	18,083	-	-
Additional paid in capital	12,793	-	-	-	-	-	(12,793)	-
Change in fair value on interest rate swaps	-	(4,907)	-	(1,115)	149	-	-	(5,873)
Increase (decrease) in unrestricted net assets	$ 15,321	$ (112,292)	$ (20,724)	$ (1,520)	$ (266)	$ 18,264	$ (12,794)	$ (114,011)

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Supplemental Consolidating Information
June 30, 2017 and 2016

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.

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

BOARDS OF TRUSTEES & BOARD OFFICERS | Effective: January 2018

Jeffrey A. Cohen, MD MHMH/DHC Trustee *Chair, Dept. of Neurology*	**Robert A. Oden, Jr., PhD** MHMH/DHC/D-HH Boards' Vice Chair *Retired President, Carleton College*
Duane A. Compton, PhD MHMH/DHC/D-HH Trustee *Ex-Officio: Dean, Geisel School of Medicine at Dartmouth*	**Steven A. Paris, MD** D-HH Trustee *Regional Medical Director, Community Group Practices (CGPs)*
William J. Conaty MHMH/DHC/D-HH Trustee *President, Conaty Consulting, LLC*	**Charles G. Plimpton, MBA** MHMH/DHC/D-HH Boards' Treasurer *Retired Investment Banker*
Joanne M. Conroy, MD MHMH/DHC/D-HH Trustee *Ex-officio: CEO, Dartmouth-Hitchcock; President, D-HH* *Effective August 7, 2017*	**Kari M. Rosenkranz, MD** MHMH/DHC (Lebanon Physician) Trustee *Associate Professor of Surgery; Medical Director, Comprehensive Breast Program; and Vice Chair for Education, Department of Surgery*
Vincent S. Conti, MHA MHMH/DHC/D-HH Trustee *Retired President & CEO, Maine Medical Center*	**Brian C. Spence, MD, MHCDS** MHMH/DHC Trustee *Associate Professor of Anesthesiology*
Denis A. Cortese, MD MHMH/DHC/D-HH Trustee *Foundation Professor at Arizona State University (ASU) and Director of ASU's Healthcare Delivery and Policy Program*	**Edward H. Stansfield, III, MA** MHMH/DHC/D-HH Trustee *Senior Resident Director and Senior Vice President for the Hanover, NH Merrill Lynch Office*
Barbara J. Couch MHMH/DHC/D-HH Boards' Secretary *President of Hypertherm's HOPE Foundation (includes leadership of all of Hypertherm's philanthropic and volunteer initiatives)*	**Pamela Austin Thompson, MS, RN, CENP, FAAN** MHMH/DHC/D-HH Trustee *Chief executive officer emeritus of the American Organization of Nurse Executives (AONE)*
Paul P. Danos, PhD MHMH/DHC/D-HH Trustee *Dean Emeritus; Laurence F. Whittemore Professor of Business Administration, Tuck School of Business at Dartmouth*	**Anne-Lee Verville** MHMH/DHC/D-HH Boards' Chair *Retired senior executive, IBM*
Senator Judd A. Gregg MHMH/DHC Trustee *Senior Advisor to SIFMA*	**Jon Wahrenberger, MD** MHMH/DHC (Lebanon Physician) Trustee Cardiologist
Laura K. Landy, MBA MHMH/DHC/D-HH Trustee *President and CEO of the Fannie E. Rippel Foundation*	**Marc B. Wolpow, JD, MBA** MHMH/DHC/D-HH Trustee *Co-Chief Executive Officer of Audax Group*

Debra A. Fournier, MHCDS, MSN, RN, APRN, ANP-BC, PMHNP-BC

Debra.A.Fournier@Hitchcock.Org

[redacted]

License and Certifications:

2004 to present	APRN: Advanced Practice Registered Nurse (Adult Primary Care & Psychiatry / Mental Health): State of New Hampshire. License No: 050234-23, expiration date: 11/07/19
2004 to 2019	Adult Nurse Practitioner (ANP) Board Certification, American Nurses Credentialing Center (ANCC). Certification No: 0383367-21
2003 to 2018	Adult Psychiatric and Mental Health Nurse Practitioner (PMHNP) Board Certification, ANCC. Certification No: 0385475-34
2002 to present	RN: Registered Nurse: State of New Hampshire. License No: 050234-21, expiration date: 11/07/19
2008 to present	Approved Ed RN BS Instructor. License No: 00127
1995 to present	Certification: CPR / AED / BLS for Healthcare Providers. AHA
2011 to 2016	Certified Brain Injury Specialist, Academy of Certified Brain Injury Specialists, Brain Injury Association of America. Cert. number: 10309
2002 to 2003	Registered Nurse: State of Connecticut.
1995 to 2005	Certification: Crisis Prevention (CPI) and restraint safety. Valley Regional Hospital, Claremont, NH

Formal Education and Degrees Earned:

2016	MHCDS (Masters in Health Care Delivery Science). Dartmouth College and Tuck School of Business. Hanover, NH
2003	MSN (Master of Science in Nursing) with specialty in Psychiatry-Mental Health and Adult Primary Care. Yale University School of Nursing, Sigma Theta Tau. Post RN clinical experience: Yale-New Haven VA, The Post Traumatic Stress Center in New Haven, CT, Resident Care Clinic at Kendal of Hanover, Dartmouth-Hitchcock Medical Center Consult & Liaison Service in Lebanon, NH.
2002	Certificate in Nursing, Yale University School of Nursing.
1999 to 2000	Organic Chemistry I, II and lab, University of Connecticut, Storrs / Hartford
1999	General Chemistry II, Notre Dame College, Manchester, NH
1998 to 1999	Physics I & II, Dartmouth College, Hanover, NH
1998	General Chemistry, New Hampshire Technical College, Claremont, NH
1992	BA in Psychology, with a minor in Women's Studies. Colby Sawyer College, New London, New Hampshire, summa cum laude.

Professional Experience:

2016 to present	Director, Psychiatric APRN Services at New Hampshire Hospital, Department of Psychiatry, Dartmouth-Hitchcock Health System, Concord, NH
2016 to present	Nurse Practitioner, Department of Psychiatry, Dartmouth-Hitchcock Medical Center, Lebanon, NH
2016 to present	Instructor, Advanced Clinical Pharmacology (MSN), School of Nursing and Health Sciences Colby-Sawyer College, New London, NH
2015 to 2016	Clinical Research Lead, ACS Level I Trauma Program. Dartmouth-Hitchcock Medical Center, Lebanon, NH.

2013 to 2016	Nurse Practitioner, Division of Trauma and Acute Surgical Care, Section of General Surgery, Department Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, NH
2006 to 2013	Nurse Practitioner, Section of Physical Medicine and Rehabilitation, Department of Orthopedic Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, NH.
2005 to 2006	Nurse Practitioner, Division of Nursing Home Practices, Section of General Internal Medicine, Department of Community and Family Medicine, Dartmouth-Hitchcock Medical Center, Lebanon, NH.
2005 to 2007	Instructor; Mental Health Nursing, Colby-Sawyer College, New London, NH.
2002 to 2004	Nurse Manager / Nurse Practitioner, Behavioral Health Department, Valley Regional Hospital, Claremont, NH.
2002	Psychiatric Nurse, Valley Regional Hospital, Claremont, NH.
1999 to 2002	Study Coordinator, "The Women and Stress / Life Stress Study", University of Connecticut Health Center, Farmington / Hartford, CT.
2001	Abstracter, "Childhood Obesity Meta-Analysis." Yale-Griffin Prevention Research Center, Derby CT.
2001	Child Care Provider, Private home.
1997 to 2000	Research Assistant, "The Treatment of PTSD in Female Survivors of Childhood Sexual Abuse," Dartmouth College and The National Center for Posttraumatic Stress Disorder, White River Jct., VT.
1995 to 1999	Behavioral Health Worker, Valley Regional Hospital, Claremont, NH.
1995 to 1997	Emergency Services Clinician, West Central Services, Inc., Claremont, NH.
1994 to 1997	Clinical Case Manager, West Central Community Support Services, Claremont, NH.
1992 to 1994	Family Educator, The Family Place Parent-Child Center, White River Jct., VT.

Academic Appointments:

2016 to present	Instructor, Colby-Sawyer College School of Nursing, New London, NH
2005 to present	Instructor, Geisel School of Medicine at Dartmouth. Hanover, NH
2015 to 2016	Academic Community Partner (mentor to senior Capstone group), Colby-Sawyer College School of Nursing, New London, NH
2005 to 2007	Instructor, Colby-Sawyer College School of Nursing, New London, NH

Publications:

Donnelly, K., Goldberg, S., Fournier, D.: A qualitative study of a group-based yoga intervention designed to facilitate community reintegration for people with traumatic brain injury and their caregivers. *Disability and Rehabilitation.* accepted

Hansen, G.S., Fournier, D.: Implementation of a pathway for management of stable thoracolumbar fractures. *Spine.* submitted

Chen, J.J., Blanchard, M.A., Finn, C.T., Plunkett, M.L., Home, K., Fournier, D.A., Suresh, G.K., Nugent, W.C.: Creation of a clinical pathway for guardianship at Dartmouth-Hitchcock Medical Center: A Quality Improvement Collaborative. *Joint Commission Journal on Quality and Patient Safety.* 40(9):389-97. 2014.

Fournier, D.: Mood Disorders (Ch 245) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care; A Collaborative Practice 4th Edition.* Mosby, 2012

Fournier, D.: Anxiety Disorders (Ch 246) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care: A Collaborative Practice 4th Edition.* Mosby, 2012.

Fournier, D.: Depressive Disorders (Ch 261) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care; A Collaborative Practice 3rd Edition.* Mosby, 2008.

Fournier, D.: Posttraumatic Stress Disorder (Ch 264) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care: A Collaborative Practice 3rd Edition.* Mosby, 2008.

Hamrin, V., Weycer, A., Pachler, M. & Fournier, D.: Evaluation of peer-led support groups for graduate nursing students. *Journal of Nursing Education* 45(1): 39-43, 2006.

McDonagh, A., Friedman, M.J., McHugo, G., Ford, J., Sengupta, A., Mueser, K., Demment, C. C., Fournier, D., Schnurr, P.P. & Descamps, M.: Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Counseling and Clinical Psychology* 73(3): 515-524, 2005.

Fournier, D., Ford, J & Talley, S.: Responses of Adults with Severe Mental Illness Participating in a Trauma-focused Assessment Study. Unpublished thesis 2003.

Posters and Scientific Conference Presentations:

Fournier, D., Goldberg, S., Figucia, C., Kennedy, P., Krauss, K., Smith, C. & Springmann, J.: An Interdisciplinary TBI Clinic; Understanding the Patient Experience. Poster at North American Brain Injury Society Annual Conference, Tampa, FL. April 2016.

Fournier, D., Martin, E. & Singer, R.: Do Patients with mild Traumatic Brain Injury Need to be Transferred to a level one Trauma Center? Poster at North American Brain Injury Society Annual Conference, Tampa, FL. April 2016.

Fournier, D., Handel, W., Hawkins, H., Lollis, SS., Pearson, A., Martin, E., Rhynhart, Fulton, Gwen, Carter, D., Batulis, N., Hanson, G.: Multidisciplinary Development of Bracing Protocol for Stable Thoracolumbar Fractures. Poster at American Congress of Rehabilitation Medicine Annual Conference, Dallas, Texas. October 2015.

Fournier, D., Rhynhart, K., Martin, E., Lollis, S.S., Pearson, A., Tobin, D., Hawkins, H., Fulton, G., Plant, C., Sweetland, D.: Management of Non-Operative Spine Fractures. Poster created for DHMC DoS Care Path project. September 2014.

Fournier, D., Pellico, L. & Hamrin, V.: Introduction of a Vicarious Traumatization Prevention Strategy for Nursing Students. Poster presented at the 20th Annual International Society for Traumatic Stress Studies Conference, New Orleans, LA. November, 2004.

Fournier, D. Hamrin, V & Weycer, A.: The Role of Peer-led Small Groups in Supporting First-year Nursing Students. Poster presented at the International Society of Psychiatric Nurses annual conference. April 2003.

Fournier, D., Thompson, L., & Ford, J.: Somatization, Health Perception and Avoidance Symptoms in Adults with Severe Mental Illness. Poster presented at the 18th Annual International Society for Traumatic Stress Studies Conference, Baltimore, MD. November, 2002

McDonagh-Coyle, A., Friedman, M.J., McHugo, G., Ford, J., Mueser, K., Descamps, M., Demment, C. & Fournier, D.: Psychometric Outcomes of a Randomized Clinical Trial of Psychotherapies for PTSD-CSA. In Symposium, PTSD-CSA Treatment: Psychological, Physiological and Hormonal Responses, Matthew J. Friedman, M.D., Ph.D. (Chair). At the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

Fournier, D., Ford, J.D. & Moffitt, K.H.: Reactions By SMI Adults to Participating in a Trauma Assessment Study. Poster presented at the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

Ford, J., McDonagh-Coyle, A., Fournier, D., Moffitt, K., & Smith, S.: PTSD and Disorders of Extreme Stress (DESNOS): Two Samples of Women in Psychotherapy. Symposium presentation at the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

Fournier, D., Ford, J.D. & Moffitt, K.H.: Patterns of Health Service Utilization – Adults with Trauma Histories. Poster presented the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

McDonagh-Coyle, A., Friedman, M. J., McHugo, G., Ford, J., Mueser, K., Schnurr, P. P., Descamps, M., Demment, C. C. & Fournier, D.: Cognitive Restructuring and Exposure Treatment for CSA Survivors with PTSD. In Symposium, Recent Advances in the Treatment of Chronic PTSD Related to Childhood Abuse and Multiple Traumatization, Marylene Cloitre, Ph.D. (Chair). At the 21st Annual Meeting of the Anxiety Disorders Association of America, Atlanta, GA. March 2001.

Ford, J.D., Fournier, D. & Moffitt, K.H., Disorders of Extreme Stress and PTSD in Women with Severe Mental Illness.: Symposium presentation at the 16th Annual International Society for Traumatic Stress Studies Conference, San Antonio, Texas. November 2000.

McDonagh-Coyle, A., Friedman, M.J., McHugo, G., Ford, J., Mueser, K., Demment, C., Descamps, M. & Fournier, D.: Cognitive Restructuring and Exposure Therapy for PTSD related to Childhood Sexual Abuse. Symposium presentation at 16th Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, Texas. November 2000.

McDonagh-Coyle, A., Friedman, M.J., McHugo, G., Ford, J., Mueser, K., Demment, C., Descamps, M. & Fournier, D.: Cognitive-Behavioral Treatment for Childhood Sexual Abuse Survivors with PTSD. Symposium presentation at 15th Annual ISTSS meeting, Miami, Florida. November 1999.

Local (Regional) Presentations:

Fournier, D.: Traumatic Brain Injury and Falls. NH State Falls Conference. Bedford, NH. October 2017.

Allen, D. & Fournier, D.: After the Storm. Building Resiliency Following Violence. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, August 2017

Goldberg, S. & Fournier, D.: LoveYourBrain Yoga; Past, Present and Future. NH Brain Injury Association Annual Conference, Concord, NH, May 2017

Handle, W. & Fournier, D.: Optimizing Neuroplasticity and Resilience in Clinical Practice. NH Brain Injury Association Annual Conference, Concord, NH, May 2017.

Donnelly Pearce, K. & Fournier, D.: Yoga and Meditation for TBI: Evidence, Innovations, and Ways Forward. VCU Brain Injury Rehabilitation Conference, Williamsburg, VA, May 2017

Fournier, D.: Optimizing Neuroplasticity and Resilience in Clinical Practice. American Associate of Neuroscience Nurses. Green and White Mountain Chapter Quarterly Meeting, Hanover, NH, January 2017.

Fournier, D., Figucia, C., Kennedy, P., Krauss, K., Smith, C. & Springmann, J.: From Classroom to Clinic: Researching the Patient Experience to Build a New Model of Care for Patients with Traumatic Brain Injury. Nursing Grand Rounds, DHMC Lebanon, NH, April, 2016.

Fournier, D., Hawkins, H., Handel, W., Sweetland, D.: Closing the Quality and Cost Gaps: Improving the Care of Patients with Non-Operative Traumatic Spine Fractures. Value Grand Rounds, DHMC, Lebanon, NH, September 2015. Nursing Grand Rounds, DHMC February 2016.

Fournier, D.: Update from the World Congress on Brain Injury; Rehab Implications. DHMC, Lebanon, NH, April 2014

Fournier, D.: Resiliency. Palliative Care In-service. Lebanon, NH. April 2014

Fournier, D.: TBI series: TBI, transitions of care, and effects on the family. DHMC, Lebanon, NH Nov 2013, Jan 2014.

Fournier, D.: Assessment and Management of Traumatic Brain Injury in Primary Care. Lecture delivered to General Internal Medicine Associate Providers at Dartmouth-Hitchcock Medical Center, Lebanon, NH. June 2013.

Fournier, D.: Polypharmacy in Geriatrics. Lecture for Geriatric RN / APRN Boot Camp at Dartmouth-Hitchcock Medical Center. Feb 2013, April 2013, June 2013, April 2014.

Fournier, D. & Morneau, G.: Traumatic Brain Injury and Return to Work. Lecture for New England Association of Case Management, Dartmouth-Hitchcock Medical Center. May 2013.

Fournier, D.: Traumatic Brain Injury in the Clinic Setting; What is Resiliency? Workshop at the DHMC Annual Rehab Medicine Conference. Lebanon, NH, Sept 2012.

Fournier, D., Kimball, J.: Recovery After Brain Injury. Lecture delivered at the NH Brain Injury Association Annual Conference, Concord, NH. May 2012.

Fournier, D.: Cervical Collars; Understanding appropriate immobilization following cervical spine injury. Lecture delivered at Residents' Trauma Conference, Dartmouth-Hitchcock Medical Center, June 2011.

Fournier, D: Physical Medicine and Rehabilitation at DHMC. Lecture delivered Dartmouth Medical School, Hanover, NH. April 2011.

Fournier, D., Gallagher, M., Gates, C., Muller, D., Smith, J.: Multidisciplinary Care: Selected Cases from Rehabilitation; Special Nursing Grand Rounds. Delivered October 2010

Silveira, R., Fournier, D.: Brain Injury; The Beauty and the Beast. Lecture series for the Sunapee Visiting Nurses Association, New London, NH. October, 2010

Fournier, D., Atkinson, D., Stinson, M., Pauw, S., Walsh, M.: Rehabilitation Efforts in Haiti. Multiple presentations delivered, including DHMC Medical Grand Rounds April 2010

Fournier, D.: Treating Patients with Traumatic Brain Injury. Lecture series for training staff nurses at DHMC, August and October 2010.

Fournier, D.: Care of Older Adults Following a Trauma: Rehabilitation Issues. Lecture delivered at Residents' Trauma Conference, DHMC, October 2009

Fournier, D.,: Physical Medicine and Rehabilitation at DHMC: Evolution and Future Goals. Lecture delivered at Residents' Trauma Conference, July 2009.

Fournier, D: The Anatomy and Physiology of Mild Traumatic Brain Injury; and why we need to know. NH Brain Injury Association Annual Conference, Manchester NH, May 2009.

Fournier, D: Clinical Evaluation of Depression and Anxiety in Cancer. Keynote Address at Oncology NP Retreat, Stowe, Vermont, October 2008.

Fournier, D.: Nursing and Vicarious Traumatization. Lecture delivered at the Yale School of Nursing. September 2003.

Fournier, D.: Strategies for Passing Standardized Exams. Lecture delivered at Connecticut Mental Health Center, April 2003.

Fournier, D.: Life After Trauma: How 9/11 and other stressors effect our lives. Community lecture delivered at the Blackstone Library, Connecticut. May 2002.

Fournier, D.: PTSD and Nursing Practice. Lecture delivered at the Yale School of Nursing. February, 2002

Fournier, D., Robinson, K., Thompson, L. & Weycer, A.: Issues Facing the Student Nurse in a Psychiatric Setting. Panel discussion at the Yale School of Nursing. January, 2002.

Fournier, D. & Pellico, L.: Vicarious Traumatization and Other Consequences of Caring. Lecture delivered at the Yale School of Nursing. September, 2001.

Fournier, D., Moffitt, K.H. & Ford, J.D., Disorders of Extreme Stress and PTSD in Women with Severe Mental Illness: An Introduction. Presentation at the University of Connecticut's Conference on Women and Gender. March 2001.

Fournier, D.: The Sequelae of Potentially Traumatic Events. Lecture delivered at the Yale School of Nursing. February, 2001

Recent Conferences Attended:

2018	Patient Experience, Empathy and Innovation Summit. Cleveland, OH
2017	NH Brain Injury Association Annual Conference. Concord, NH
2017	Williamsburg Brain Injury Rehab Conference, TBI Model System, Virginia Commonwealth University, Williamsburg, VA
2016	Advanced Practice Provider Executives Leadership Summit, Boston, MA
2016	North American Brain Injury Society (NABIS) Annual Conference on Brain Injury. Tampa, FL.

2015	American Congress of Rehab Medicine Annual Conference; Progress in Rehabilitation Research. Dallas, TX. Member of Brain Injury SIG
2015	Arkansas Trauma Rehabilitation Conference, Arkansas Trauma Rehabilitation Program, Little Rock, Arkansas.
2015	The Dartmouth Institute and the Masters in Health Care Delivery Science Symposium. Hanover, NH
2014	Summit on Health Care Delivery, United Health Care. Minnetonka, MN
2014	International Brain Injury Association, 10th World Congress on Brain Injury. San Francisco, CA
2013	11th Annual North American Brain Injury Conference, New Orleans, LA
2012	NH Brain Injury Association Annual Conference. Concord, NH
2012	Williamsburg Brain Injury Rehab Conference, TBI Model System, Virginia Commonwealth University, Williamsburg, VA
2011	Trauma Rehabilitation, Spaulding Rehab, Boston, MA
2010	American Congress of Rehab Medicine Annual Conference; Progress in Rehabilitation Research. Member of Brain Injury Special Interest Group
2010	Brain Injury Family Intervention Training, TBI Model System, Virginia Commonwealth University, Williamsburg, VA
2009	DHMC 19th Annual Conference on Trauma, Lebanon, NH
2009	New Hampshire Brain Injury Association Annual Conference, Manchester, NH
2008	American Academy of Physical Medicine and Rehabilitation, Sixty-ninth Annual Assembly, San Diego, CA
2008	Vermont's Twentieth Annual Brain Injury Conference, Burlington, VT
2008	New Hampshire's Twenty-fifth Annual Brain Injury Conference, Manchester, NH
2007	American Academy of Physical Medicine and Rehabilitation, Sixty-eighth Annual Assembly, Boston, MA

Other Professional Activities and Awards:

2017 to present	Chair of the New Hampshire Hospital Quality Council (appointed position)
2016 to 2018	Board of Governors Member representing more than 500 associate providers. Elected position (3 year term)
2017	Active Committee Participation within New Hampshire Hospital: Quality Council (Chair: Deb Fournier) Personal Safety Emergency Reviews (co-Chair: Deb Fournier) Executive Safety Committee (Chair: Allen Coen)
2014 to 2016	Committee Participation within Dartmouth-Hitchcock Medical Center: Development of Interdisciplinary TBI Assessment Clinic (Lead: Deb Fournier) Development of Multidisciplinary Poly-Trauma Clinic (Lead: Deb Fournier) Trauma and Acute Care Surgery Research Development (Lead: Deb Fournier) Nursing Research Development (Lead: Gay Landstrom / Jean Coffey) Promoting Professionalism Committee (Lead: Rick Barth) Professional Nurse Advancement Model (Lead: Johanna Beliveau) Graduate School Development (Lead: Gay Landstrom) Strategic Planning for Professional Nursing (Lead Gay Landstrom)
2014	DHMC Department of Surgery Care Path Award for *Management of Non-Operative Spine Fractures* (value $12,500)
2014	Awarded tuition scholarship to the Masters in Health Care Delivery Science program at Dartmouth. (Approximate value $100,000)
2004 to present	Member of the New Hampshire chapter of the American Nurses Association
2003 to 2007	Member of the Women's Supportive Services Board of Directors, Claremont, NH

2002 to present	Inducted member of the International Honor Society for Nurses: Sigma Theta Tau – Delta Mu chapter, currently; Colby-Sawyer/DH chapter.
2001 to 2002	Member of Special Interest Ethics group of the Center for Nursing Policy and Ethics at the Yale School of Nursing
1999 to 2000	Volunteer for local HeadStart Program (provided support to classroom teachers of 3-5 year-old children with multiple psychosocial stressors)
1998 to 2005	Member of International Society of Traumatic Stress Studies
2001	Member of Planning Committee for "Power Day" (A retreat designed to encourage collaborative relationships among all medical personnel)
1999	Committee for Enhanced Education and Screening for Survivors of Domestic Violence, Sullivan County, NH
1992 to 1993	Volunteer for Women's Informational Services, Lebanon, NH
1992	Summa Cum Laude, Colby-Sawyer College, New London, NH
1991 to 1992	Volunteer for Women's Supportive Services, Claremont, NH

Research and Selected Quality Improvement Projects:

2016 to present	Participating in the LoveYourBrain Yoga Program: The Experiences of the Traumatic Brain Injury Community. CPHS 2016 study #00029657 ($3000 grant from NH Brain Injury Association) Principle Investigator: Kyla Donnelly Pearce, MPH Co-Investigators: Deb Fournier, APRN, Shari Goldberg, PhD
2015 to 2016	Evaluation of an Interdisciplinary Traumatic Brain Injury Clinic at Dartmouth-Hitchcock; Patient Experience. CPHS 2015 study #00029167 (unfunded). Principle Investigator: Deb Fournier, APRN Co-Investigator: Shari Goldberg, PhD
2015 to 2016	Clinical management and transfer status of patients with mild traumatic brain injury. CPHS 2015 Study #00028907 (unfunded). Principle Investigator: Deb Fournier, APRN Co-Investigators: Eric Martin, MD, Kirk Dufty, MD, Bob Singer, MD
2010 to 2016	Management of non-operative traumatic thoracolumbar fractures: TLSO standardization. CHPS 2014 Study # 00028200 (unfunded). Principle Investigator: Deb Fournier, APRN. Physician representatives: Kurt Rhynhart, MD, Adam Pearson, MD, S. Scott Lollis MD
2012 to 2014	Interdisciplinary committee on the guardianship process at DHMC. Founders: Deb Fournier, APRN & Michelle Blanchard, MSW Committee lead: Michelle Blanchard, MSW, J Jasper Chen, MD
1998 to 2001	"The Women and Stress / Life Stress Study" Principal Investigator: Julian D. Ford, Ph.D. Study Coordinator: Deb Fournier
1995 to 2000 (funding period)	"The Treatment of PTSD in Female Survivors of Childhood Sexual Abuse" The Principal Investigator on this grant was Matthew J. Friedman, M.D., Ph.D. Research Assistant: Deb Fournier

CURRICULUM VITAE

Updated: June 12, 2018
Date Originally Prepared: August 1, 2013

NAME **ALEXANDER PETER de NESNERA, M.D.**

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Concord, NH 03301
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E-Mail: alexander.denesnera@dhhs.nh.gov

EDUCATION

1999-2001	**John Heinz School of Public Policy and Management** **Carnegie-Mellon University/American College of Physician Executives (ACPE)** **Certificate in Medical Management**
1983-1986	**Dartmouth's Geisel School of Medicine** **Hanover, NH** **M.D.**
1981-1983	**St. George's University School of Medicine** **Grenada, West Indies** **Diploma of Medical Sciences**
1976-1978	**New York University** **New York, NY** **BA Biology (minor Anthropology)**
1974-1975	**John Hopkins University** **Baltimore, MD**

POSTGRADUATE TRAINING

1986-1990	**Resident in Psychiatry** **Dartmouth–Hitchcock Medical Center** **Hanover, NH**

ACADEMIC APPOINTMENTS

2008-	Associate Professor of Psychiatry Dartmouth's Geisel School of Medicine Hanover, NH
1990-2008	Assistant Professor of Psychiatry Dartmouth's Geisel School of Medicine Hanover, NH

DARTMOUTH INSTITUTIONAL LEADERSHIP ROLES

LICENSURE AND CERTIFICATION

2004, 2013	Re-Certification in the Subspecialty of Geriatric Psychiatry Certificate # 1272
1998	Board Certified in Psychiatry with Certification in the Subspecialty of Forensic Psychiatry Certificate #644
1997	Board Certified in Psychiatry with Certification in the Subspecialty of Addiction Psychiatry Certificate #1345
1994	Board Certified in Psychiatry with Certification in the Subspecialty of Geriatric Psychiatry Certificate #1272
1991	Board Certified, American Board of Psychiatry and Neurology Certificate #34927
1988	State of New Hampshire Medical License #7835
1987	Diplomate, National Board of Examiners Certificate #322329

HOSPITAL APPOINTMENTS

2017-	Chief Medical Officer New Hampshire Hospital Concord, N.H.
2008-2017	Associate Medical Director New Hampshire Hospital Concord, NH

HOSPITAL APPOINTMENTS (con'd)

1990-	Staff Psychiatrist New Hampshire Hospital Concord, NH
1988-1990	Staff Psychiatrist Nashua Brookside Hospital Nashua, NH

OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH)

2006-2007	Founder and Director, Helping Heroes Bridge Program Free assessment and triage program New Hampshire Veterans and National Guard personnel
1997-2008	Consulting Psychiatrist, Secure Psychiatric Unit, Department of Corrections Concord, NH
1992-2000	Consulting Psychiatrist, Veteran Administration Hospital White River Junction, VT
1988-1989	Consulting Psychiatrist, Alzheimer's Disease and Related Disorders Clinic, Mary Hitchcock Memorial Hospital Hanover, NH
1988-1989	Medical Director, Weekend Intoxicated Driver Intervention Program Hanover, NH
1987-1988	Assistant Medical Director, Weekend Intoxicated Driver Intervention Program Hanover, NH
1980-1981	Research Assistant, Rockefeller University, New York, NY. Biochemical Research. Synthesis and testing of drugs to treat human African sleeping sickness.
1978-1986	United States Department of State, Washington, DC, Escort/ Interpreter (French). Responsibilities entailed month-long travel with and development of itinerary designed to meet professional needs of dignitaries from Europe and Africa visiting the US as guests of the US Government.

OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH) (con'd)

1977-1979	Research Assistant, New York University, New York, Biological Research. Neuroanatomical studies of lower vertebrates. Histological preparations photographed and published in an article entitled "The Organization of the Optic Tectum in Larval, Transforming, and Adult Sea Lamprey Petromyzon marinus"

UNDERGRADUATE MEDICAL EDUCATION

1990-2017	Medical Student Clerkship Director Dartmouth's Geisel School of Medicine/New Hampshire Hospital Third Year Medical Student Psychiatry Clerkship
2014	Medical Student Ethics Interest Group (DMS II) Assessing Competency for Concealed Weapons Permit: The Physician's Role

GRADUATE EDUCATION

2001-2010	University of New Hampshire Graduate Program Visiting Lecturer in Public Health Law Involuntary Commitment and Treatment of Patients Suffering from Mental Illness Manchester, N.H.
1998-2002	Clinical Adjunct Faculty Rivier College School of Nursing and Health Sciences Nashua, NH

GRADUATE MEDICAL EDUCATION

2012-	Dartmouth's Geisel School of Medicine PGY I Forensics Seminar Involuntary Hospitalization and Treatment Course Developer, Presenter
2011-	Dartmouth's Geisel School of Medicine PGY I Basic Diagnostics Course Psychotic Disorders, Mood Disorders Course Developer, Presenter
2005-2008	Dartmouth's Geisel School of Medicine PGY IV Supervision Group Course Developer, Supervisor

GRADUATE MEDICAL EDUCATION (con'd)

2001-2005	Dartmouth's Geisel School of Medicine Forensic Psychiatry Fellowship Director New Hampshire Hospital
1998-2000	American Board of Psychiatry and Neurology Board examiner, Part II Orals
1992-1998	Dartmouth's Geisel School of Medicine Dartmouth/Brown Mock Psychiatry Oral Boards Board examiner

UNDERGRADUATE COLLEGE

CONTINUING MEDICAL EDUCATION

2010-2017	Dartmouth's Geisel School of Medicine/New Hampshire Hospital Coordinator and Discussant Clinical Case Conference Dartmouth Faculty, Residents, Medical Students

COMMUNITY EDUCATION

2015	Designated Receiving Facility Site Inspector Portsmouth Regional Hospital State of New Hampshire
2013	Dartmouth's Geisel School of Medicine Dartmouth Community Medical School Lecture Series Involuntary Psychiatric Hospitalization and Treatment
2013-2014	Tewksbury State Hospital Consultant, Smoking Cessation Program Development Tewksbury, MA
2012-2017	Consultant, Riverview Hospital Augusta, ME
2004	Surveyor, Review Team for the Mental Health Unit (MHU) Department of Corrections Concord, NH

COMMUNITY EDUCATION (con'd)

2003, 2005	Surveyor, Review Team for the Secure Psychiatric Unit (SPU) Department of Corrections Concord, NH

STUDENT/FELLOW ADVISING/MENTORING

2013-2014	Mentor, Katya Hurst, M.D., Lakes Region DRF Psychiatrist
2013-2014	Mentor, New Hampshire Guardianship Statutes/Rules Project Residents: J.J. Chen, M.D. and Danielle Dahle, M.D.
2012-2013	Mentor, Leadership in Preventive Medicine Residency Governmental Public Health Experience Resident: J.J. Chen, M.D.

RESEARCH FUNDING

2009	American Psychiatric Foundation Typical or Troubled School Mental Health Education Program Grant Concord High School/ NH Psychiatric Society $6,000 Grant
2005	American Psychiatric Association Committee on Advocacy and Litigation Funding (CALF) $40,000 Public Education and Advocacy Grant
2005	Janssen Medical Affairs INC Investigator-Initiated Research Grant Family Perspectives: Treatment of Psychiatric Illnesses with Atypical, Long-Acting Injectable Antipsychotic Medication $76,000 Grant
2004	American Psychiatric Association Committee on Advocacy and Litigation Funding (CALF) $40,000 Public Education and Advocacy Grant
2004	New Hampshire Charitable Foundation Grant Family Perspectives: Treatment of Psychiatric Illnesses with Atypical Long-Acting Injectable Antipsychotic Medication $6200 Grant

RESEARCH FUNDING (con'd)

2003	American Psychiatric Association Committee on Advocacy and Litigation Funding (CALF) $30,000 Public Education and Advocacy Grant
2002	American Psychiatric Association Committee on Advocacy and Litigation Funding (CALF) $40,000 Public Education and Advocacy Grant

PROGRAM DEVELOPMENT

2010-2014	Dartmouth's Geisel School of Medicine Department of Psychiatry/Psychiatric Research Center Coordinator – Academic Detailing In Shape Outcomes Study

ENTREPRENEURIAL ACTIVITIES

MAJOR COMMITTEE ASSIGNMENTS

National/International

2014	Consultant, State of Virginia Review of Commitment and Involuntary Treatment Laws
2014	Consultant, State of Hawaii Review of Commitment and Involuntary Treatment Laws

Regional

2018	Member, Ten-Year Mental Health Plan Committee
2018	Member, Governor's Mental Health Task Force
2014-2016	Chair, Suicide Fatality Review Committee NH State Council on Suicide Prevention
2013-2014	Member, Governor's Mental Health Services Sentinel Review Team
2012-	Executive Committee, Elder and Incapacitated Adult Fatality Review Committee NH Department of Justice
2012-2016	Member, Board of Directors Adoptive Families for Children

MAJOR COMMITTEE ASSIGNMENTS

Regional (con'd)

2012-	Member, Board of Directors Office of Public Guardian
2011-2016	Executive Committee, Suicide Fatality Review Committee NH State Legislative Council on Suicide Prevention
2010-2016	Member, Suicide Fatality Review Committee NH State Legislative Council on Suicide Prevention
2009-2010	Member, NH State Legislative Commission Evaluating Mental Health Courts and Establishing Standards for the Operation of Mental Health Courts
2008-2009	Member, Advisory Committee and Editorial Board National Alliance on Mental Illness New Hampshire (NAMI-NH). Published *A New Hampshire Guidebook for Families of Adults with Serious and Persistent Mental Illness* (2014)
2008-	Member, Elder and Incapacitated Adult Fatality Review Committee. NH Department of Justice
2008-2009	Member, NH Mental Health Commission Co-Occurring Disorders Task Force
2008-2016	Member, Department of Health and Human Services Clinical Directors Council
2004	Member, NH Department of Health and Human Services Mental Health Advisory Committee Concord, NH

Institutional

2009	Member, Dartmouth's Geisel School of Medicine Faculty, Student, Staff and Alumni Advisory Subcommittee (FSSA) of the Strategic Planning Committee
1992-2017	Member, Dartmouth's Geisel School of Medicine Department of Psychiatry Medical Student Education Committee

MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES

2010-2013	American Psychiatric Association Advocacy Day – New Hampshire Representative
2004-2011	Member, Public Policy Committee National Alliance on Mental Illness – New Hampshire NAMI-NH
2003-2008	2nd Vice President, Board of Directors National Alliance on Mental Illness – New Hampshire NAMI-NH
2001-2014	Legislative Liaison New Hampshire Psychiatric Society
2001-2009	Member, Board of Directors National Alliance on Mental Illness – New Hampshire NAMI-NH
2000-2003	President Medical Staff Organization New Hampshire Hospital
2000-2002	President New Hampshire Psychiatric Society
1997-2014	Treasurer New Hampshire Psychiatric Society
1996-2014	Member, Executive Committee, New Hampshire Psychiatric Society
1990-	Member, Medical Staff Organization New Hampshire Hospital
1990-1998	Chairman, Inpatient Unit Program Committee New Hampshire Hospital
1990-1998	Chairman, Library Committee New Hampshire Hospital
1986-	American Psychiatric Association

EDITORIAL BOARDS

JOURNAL REVIEW ACTIVITY

AWARDS AND HONORS

2016	DHMC Department of Psychiatry Teacher of the Year Award
2015	New Hampshire Psychiatric Society Leadership Award
2014	American College of Psychiatrists (ACP)
2013-2014	Best Doctors in America
2012	National Exemplary Psychiatrist Award National Alliance on Mental Illness (NAMI)
2010	Erik Cogswell Memorial Award Erik Cogswell Memorial Committee (Bipolar Disorder) Seacoast Community Mental Health Center
2010	Governor's Commendation State of New Hampshire
2010	New Hampshire Senate Resolution In Recognition of Receiving the Tow Award
2010	The Gold Humanism Honor Society Thomas P. Almy Chapter Dartmouth Medical School
2010	The Leonard Tow Humanism in Medicine Award Dartmouth Medical School Arnold P. Gold Foundation
2006	Psychiatrist of the Year National Alliance on Mental Illness - New Hampshire NAMI-NH
2004	Distinguished Fellow, American Psychiatric Association
1994	Janssen Clinical Scholar
1992	American Biographical Institute Man of the Year

AWARDS AND HONORS (con'd)

1987	Psychiatry Resident Teacher of the Year Award Dartmouth Medical School
1978	Beta Lambda Sigma Biology Honor Society New York University

INVITED PRESENTATIONS

International

2017	What We Don't Know Can Hurt Us: Aggression and Violence on Psychiatric Inpatient Units: The Hospital Administrator's Role 10th European Congress on Violence in Clinical Psychiatry Dublin, Ireland

National

2016	What We Don't Know Can Hurt Us: Aggression and Violence on Psychiatric Inpatient Units: The Hospital Administrator's Role 68th Institute on Psychiatric Services (Symposium) Washington, D.C.
2016	New Hampshire's Five-Year Civil and Criminal Involuntary Commitment Laws de Nesnera, A. 68th Institute on Psychiatric Services (Poster) Washington, D.C.
2016	What We Don't Know Can Hurt Us: Aggression and Violence on Psychiatric Inpatient Units: The Hospital Administrator's Role National American Psychiatric Nurses Association Conference Hartford, CT
2015	Treatment Over Objection: Revising Rules, Reducing Guardianships de Nesnera, A.; Folks, D. 67th Institute on Psychiatric Services (Poster) New York, N.Y.

INVITED PRESENTATIONS

National (con'd)

2015 — Playing Sick: Malingering and Motivating Factors For Admission to an Acute Care Inpatient Public Sector Hospital
Davis, M.; Folks, D.; de Nesnera, A.
67th Institute on Psychiatric Services (Poster)
New York, N.Y.

2015 — Improving Antipsychotic Pharmacotherapy Via Educational Outreach to Prescribers Across a State Mental Health System
Brunette, M.; de Nesnera, A.; Dzebisashvili, N.; Xie, H.; Bartels, S.
168th A.P.A. Annual Meeting (Abstract)
Toronto, Canada

2014 — Managing Aggression, Preventing Violence: A Comprehensive Approach in an Acute Care Hospital
Folks, DG.; de Nesnera, A.; Allen, D.
66th Institute on Psychiatric Services (Poster)
San Francisco, CA

2013 — Seclusion and Restraint: Precipitants and Duration Differences Between Children and Adults (Abstract)
National American Psychiatric Nurses Association Conference
San Antonio, TX

2013 — Current Trend? Use of the Conducted Electrical Device in a Psychiatric Hospital
de Nesnera, A.; Folks, DG.; MacLeod RJ.
65th Institute on Psychiatric Services (Poster)
Philadelphia, PA

2012 — Balancing Civil Liberties with Clinical Care: Does Lengthening Initial Involuntary Admission Affect Long-Term Commitment Commitment Rate?
de Nesnera, A.; Shagoury, P.; Howell Woodbury E.; Folks, DG.
64th Institute on Psychiatric Services (Poster)
New York, NY

INVITED PRESENTATIONS

National (con'd)

2010	Choking Risk in Mental Illness de Nesnera, A.; Folks, DG. 62nd Institute on Psychiatric Services (Poster) Boston, MA
2009	Implementation of a Total Smoking Ban in a State Psychiatric Hospital de Nesnera, A.; Folks, DG. 61st Institute on Psychiatric Services (Poster) New York, NY

Regional/Local

2018	The New Hampshire Involuntary Commitment Law N.H. Psychiatric Society Annual Meeting
2017	What We Don't Know Can Hurt Us: Aggression and Violence on Psychiatric Inpatient Units: The Hospital Administrator's Role New Hampshire Hospital Association Annual Meeting Bretton Woods, N.H.
2016	A History of New Hampshire's Mental Health Commitment Laws New Hampshire Hospital Grand Rounds Concord, N.H.
2015	Treatment of Involuntarily Hospitalized Patients Portsmouth Designated Receiving Facility Portsmouth, N.H.
2015	Mental Illness Issues – How to Interact with Mentally Ill Individuals Police Standards and Training – N.H. Police Academy Concord, N.H.
2015	Involuntary Hospitalization : A Family Perspective NAMI-NH – Manchester Branch
2015	Overview of Psychiatric Diagnoses, Psychiatric Medications, and the New Hampshire Commitment Process Lebanon and Littleton Police Departments Crisis Intervention (CIT) Training

INVITED PRESENTATIONS

Regional/Local(con'd)

2015	The Involuntary Admission Process – How are Families Affected NAMI-NH Webinar Concord, N.H.
2014	Access to Mental Health Care in New Hampshire N.H. Hospital Association Annual Conference Bretton Woods, N.H.
2014	New Hampshire Hospital Overview New Hampshire Legislative Commission on Mental Health Implementation
2014	Psychiatry 101 for Judges Annual Circuit Court Training Conference for Probate Division Judges
2014	A.P.A. Career Mentor Program Resident Presentation Career Paths and Advocacy
2013	Current Trends in Mental Health Law in New Hampshire Office of Public Guardian Concord, N.H.
2013	Psychosis and Spirituality: Balancing a Patient's Spiritual and Clinical Needs Dartmouth Psychiatry Resident's Journal Club Lebanon, N.H.
2013	Overview of Mental Illness Diagnoses and Psychiatric Medications Concord Police Department Crisis Intervention Team (CIT) Training Concord, NH
2013	The Involuntary Commitment Process Concord Police Department Crisis Intervention Team (CIT) Training Concord, N.H.

INVITED PRESENTATIONS

Regional/Local (con'd)

2013	Overview of Mental Illness Diagnoses and Psychiatric Medications Lebanon Police Department Crisis Intervention Team (CIT) Training Lebanon, NH
2013	The Involuntary Commitment Process Lebanon Police Department Crisis Intervention Team (CIT) Training Lebanon, NH
2013	Institutional Stigma 9th Annual N.H. Mental Health Symposium Greater Manchester Mental Health Center Bedford, NH
2013	Mental Health Resources and the Process of Involuntary Commitment Managing Medical Emergencies Conference Geisel School of Medicine at Dartmouth Lebanon, NH
2013	Diagnosis and Treatment of Major Mental Disorders Health Information Coding Information Conference Concord, NH
2013	Introduction to Health Law – Ethical Considerations Regarding Involuntary Hospitalization, Guardianship, and Treatment National Business Institute Law Forum Manchester, NH
2013	Psychosis and Spirituality Nursing Grand Rounds New Hampshire Hospital Concord, NH
2013	Balancing a Patient's Clinical and Religious Needs Clinical Case Conference New Hampshire Hospital/Geisel School of Medicine Concord, NH

INVITED PRESENTATIONS

Regional/Local (con'd)

2012	Understanding the New Hampshire Rules regarding Involuntary Treatment Dartmouth Psychiatry Resident's Journal Club Lebanon, N.H.
2012	Why is this Patient in my Emergency Room? NH Emergency Nurses Association Conference Concord, NH
2012	Balancing Treatment with Civil Liberties UNH-Manchester Master in Public Health Program Manchester, NH
2012	Choking Risk in Mental Illness Grand Rounds, Riverview State Hospital Augusta, ME
2012	Suicide Assessment and Risk – The N.H.H. Experience NH State Suicide Prevention Council Conference Concord, NH
2012	Admitted to New Hampshire Hospital: A Look at the Involuntary Commitment Process NAMI - NH Annual State Conference Concord, NH
2011	Caring for the Patient with Korsakoff's Psychosis Clinical Case Conference Consultant Secure Psychiatric Unit – Department of Corrections Concord, NH
2011	Admitted to New Hampshire Hospital: What Families Need to Know Erik Cogswell Memorial Conference Seacoast Mental Health Center Portsmouth, NH
2011	Advocating to Providers: The Tools for Success Erik Cogswell Memorial Conference Seacoast Mental Health Center Portsmouth, NH

INVITED PRESENTATIONS

Regional/Local (con'd)

2011 Involuntary Treatment of Involuntary Patients: Issues and Concerns
Colby-Sawyer College
Mental Health Systems Course
Concord, NH

2011 Choking Risk in Mental Illness
Nursing Grand Rounds
New Hampshire Hospital
Concord, NH

2011 Overview of Mental Illness Diagnoses and Psychiatric Medications
Manchester Police Department
Crisis Intervention Team (CIT) Training
Manchester, NH

2011 The Involuntary Commitment Process
Manchester Police Department
Crisis Intervention Team (CIT) Training
Manchester, NH

2011 Helpful Strategies for Determining Psychiatric Diagnoses
Health Information Coding Education Conference
New Hampshire Hospital
Concord, NH

2010 Effective Advocacy: Our Responsibility
Dartmouth Medical School Grand Rounds
Department of Psychiatry
Lebanon, NH

2010 Typical or Troubled: Assessment of Mental Health Issues in Adolescents in a School Setting.
Concord High School Teacher Conference
Concord, NH

2010 Assessment and Treatment of Metabolic Syndrome in The Seriously Mentally Ill: A Bureau of Behavioral Health Initiative. Greater Manchester Mental Health Center
Manchester, NH

INVITED PRESENTATIONS

Regional/Local (con'd)

2009	Implementation of a Total Smoking Ban at New Hampshire Hospital. Grand Rounds Presentation, Tewksbury State Hospital Tewksbury, MA
2009	Update on the Involuntary Commitment Process in New Hampshire. Incapacitated Adult Fatality Review Committee (IAFRC). Concord, NH
2009	Legal Issues: The IEA Process-Clinical Implications Police Standards and Training Council Two-Day Police Training. Concord, NH
2009	Overview of Mental Illness Diagnoses and Psychiatric Medications. Rochester Police Department Crisis Intervention Team (CIT) Training Rochester, NH
2009	The Involuntary Commitment Process Rochester Police Department Crisis Intervention Team (CIT) Training. Rochester, NH
2008	Developing a New Hampshire Care Continuum: Acute and Community Based Services Policy Summit on Mental Health Issues and the Role for a New Hampshire Mental Health Caucus Concord, NH
2008	Advanced Care Directives and Mentally Ill Patients: Challenges in Treatment. Foundations For Healthy Communities Conference Concord, NH
2007	New Hampshire Hospital Tobacco Free Campus and Wellness New Hampshire Hospital Professional Grand Rounds Concord, NH

INVITED PRESENTATIONS

Regional/Local (con'd)

2006	Treating the Partially Compliant Schizophrenic Patient Vermont State Hospital Waterbury, VT
2006	Long Acting Injectable Antipsychotic Medication: Benefits in Treating Schizophrenia Riverbend CMHC Concord, NH
2006	Treatment Strategies in Alleviating Schizophrenia Symptoms Vermont CMHC Woodstock, VT
2005	Conference Coordinator, Elderly Mental Health Summit: Strengthening the Continuum of Care: Focus on Elderly Adults With Co-occurring Behavioral Health and Medical Disorders-Building an Integrated Health Care Model
2005	Panelist, Rivier College ARNP Program Lecture Series Topic: Providing Mental Health Care in the Public Sector
2004	Conference Coordinator, Adult Mental Health Summit: Strengthening the Continuum of Care: Focusing on Adults With Co-occurring Behavioral Health and Medical Disorders-Building an Integrated Health Care Model
2004	New Hampshire Representative, American Medical Association/ American Psychiatric Association State Legislative Strategy Conference Leadership meeting
2003	Conference Coordinator, Children's Mental Health Summit: Practical Approaches to Integrating Mental and Physical Health Services
2002	Presenter, NH Bar Association Continuing Legal Education Program. Topic: Treatment of patients deemed Not Guilty by Reason of Insanity or Incompetent to Stand Trial

INVITED PRESENTATIONS

Regional/Local (con'd)

2001	Presenter, National Alliance on Mental Illness – N.H.: Annual Conference Topic: The Challenge of Treating the Dually Diagnosed Patient in the Public Sector
2001	Committee member, National Alliance on Mental Illness-NH Spring Conference. Topic: Visions, Alliances, Change: Building Leadership for Mental Health in New Hampshire
2001	Extensive (> 100) testimony before NH Senate and House of Representatives Committees regarding mental health legislation
2001	Active leader in drafting legislation revising New Hampshire mental health statutes and rules
2000	Panelist, Residential Life Program at St. Paul's School, Concord, NH Topic: Dealing with Mental Illness-How to get help
1997	Panelist, National Alliance on Mental Illness-NH Conference Topic: Antipsychotics and Mood Stabilizers
1997	Lecturer, St. Paul's School Advanced Study Program Psychology Class. Topic: Schizophrenia: Diagnosis and Treatment
1994	Panelist, Mood Disorders Across the Life Cycle Conference; Topic: Diagnosis and Treatment of Depression in the Elderly.
1993	Panelist, Tri-State Conference on Involuntary Psychiatric Commitments, Portsmouth Pavilion. Topic: Interstate Commitment Issues between Maine, New Hampshire and Massachusetts.
1993	Panelist, Nursing Grand Rounds, N.H.H. Topic: Collaboration Of Multidisciplinary Team Approach Regarding Patient Discharge Planning

BIBLIOGRAPHY

PEER REVIEWED

Original Articles

2018 Brunette, M.; Cotes, R.; de Nesnera, A.; McHugo, G.; Dzebisashvili, N.; Xie, H.; Bartels, S.
Use of Academic Detailing with Audit and Feedback to Improve Antipsychotic Pharmacotherapy
Psychiatric Services Published Online
https://doi.org/10.1176/appi.ps.201700536 June 2018

2016 de Nesnera, A.; Allen, D.; Expanding the Role of Psychiatric Mental Health Nurse Practitioners in a State Psychiatric System: The New Hampshire Experience
Psychiatric Services 63:6, p. 482-484; May 2016
PMID: 26766758

2015 de Nesnera, A.; A History of Civil and Criminal Commitment Statutes in New Hampshire
New Hampshire Bar Journal 55:2, p. 10-13; December 2015

2015 Chen, JJ.; Dahle D.; Hinck J.; de Nesnera A.
A Cautionary Tale: The Process of Mental Health Treatment And Restoration of Sanity of Individuals who are found Not Guilty By Reason Of Insanity in New Hampshire
Annals of Psychiatry and Mental Health 3(5): 1042 (2015)

2015 Cotes, R.; de Nesnera, A.; Kelly, M.; Orsini, K.; Xie, H.; McHugo, G.; Bartels, SB.; Brunette, MF.
Antipsychotic Cardiometabolic Side Effect Monitoring In a State Community Mental Health System
Community Mental Health Journal 51(2) February 2015
PMID: 25645893

2014 Allen, D.; de Nesnera, A.; Harris, F.; Nurse-Police Coalition Improves Safety in Acute Psychiatric Hospital
Journal of Psychosocial Nursing and Mental Health Services 52:9, p. 27-31, September 2014
PMID: 25062352

2014 Davis M.; de Nesnera, A.; Folks, DG.; Confused and Nearly Naked after Going on Spending Sprees
Current Psychiatry 13:7, p. 56-62; July 2014

BIBLIOGRAPHY

Original Articles (con'd)

2014 de Nesnera, A.; Baldwin, H.; Commitment to Treatment and Care: The History of New Hampshire's Mental Health Commitment Laws, 1714-2013
New Hampshire Bar Journal 54:2, p. 24-29; Winter 2014

2014 Allen, D.; de Nesnera, A.; Moreau, M.; Barrnett, J.; Seclusion and Restraint in Children and Adults: A Comparison.
Journal of Psychosocial Nursing and Mental Health Services 52:3, p.20-25; March 2014
PMID:24200912

2013 de Nesnera, A.; Psychotic and Needing Prayer.
Current Psychiatry 12:7, p. 46-51; July 2013

2012 de Nesnera, A.; Folks, DG.; The Administrative Review Committee at New Hampshire Hospital: A One Year Follow-Up.
Psychiatric Services 63:6, p. 526-528; June 2012
PMID: 22638003

2012 de Nesnera, A.; Shagoury, P.; Howell Woodbury, E.; Balancing Civil Liberties with Clinical Care: Reviewing the Recent Change in the Involuntary Admissions Statute.
New Hampshire Bar Journal 52:4, p. 44-46; Winter 2012

2012 Allen, D.; de Nesnera, A.; Robinson, D.; Psychiatric Patients at Increased Risk for Falling and Choking.
Journal of the American Psychiatric Nurses Association 18:2, p. 91-95; March/April 2012
PMID: 22442016

2012 de Nesnera, A.; Folks, DG.; Rauter, U.; Implementing a Smoking Ban: Tips for Success.
Current Psychiatry 11:6, p. E1-E2; June 2012

2011 Brunette, MF.; de Nesnera, A.; Swain, K.; Riera, E.; Lotz, D.; Bartels, SJ.; Public-Academic Partnership: Improving the Quality of Antipsychotic Prescribing in a Community Mental Health System.
Psychiatric Services 62:9, p.1004-1006; September 2011
PMID: 21885576

BIBLIOGRAPHY

Original Articles (con'd)

2011 de Nesnera, A.; Folks, DG.; Involuntary Treatment for Involuntary Patients: The Evolution of the He-M 306 Rule in New Hampshire.
New Hampshire Bar Journal 52:1, p. 58-61; Spring 2011

2011 Allen, D.; de Nesnera, A.; Darling, F.; Cummings, K.; Transforming the Culture of Caring: Getting Hurt is Not Part of the Job.
Journal of Psychosocial Nursing and Mental Health Services 49:1, p. 45-49; January 2011
PMID: 21175121

2010 de Nesnera, A.; Folks, DG.; Gasping for Relief: Choking Risk in Schizophrenia.
Current Psychiatry 9:10, p. 86-89; October 2010

2010 de Nesnera, A; Folks, DG.; Use of an Administrative Review Committee at New Hampshire Hospital to Mitigate Risk with High Profile Patients.
Psychiatric Services 61:7, p. 660-662; July 2010
PMID: 20591999

2009 Allen, D.; de Nesnera, A.; Souther, J.; Executive Level Reviews of Seclusion and Restraint Promote Interdisciplinary Collaboration and Innovation.
Journal of the American Psychiatric Nurses Association 15:4, p. 260-264; August/September 2009
PMID: 21665812

2008 de Nesnera, A.; The Helping Heroes Bridge Program for Veterans.
Psychiatric Services 59:12, p. 1475; December 2008
PMID: 19033179

2007 de Nesnera, A.; Promoting Legislation and Public Policy Debates in State Legislatures: A Psychiatrist's Perspective.
Psychiatric Services 58:4, p. 447-448; April 2007
PMID: 17412841

2007 de Nesnera, A.; Vidaver R.; New Hampshire's Commitment Law: Treatment Implications.
New Hampshire Bar Journal 48:2, p. 68-74; Summer 2007

BIBLIOGRAPHY

Original articles (con'd)

2000 de Nesnera, A.; Grandfield, S.; Cummings, K.; Bryant, E.; Abortion: A Psychiatric Patient's Right to Choose. *Journal of Psychosocial Nursing and Mental Health Services* 38:2, p. 9-12. February 2000 PMID: 10693108

1997 Rauter,U.; de Nesnera, A.; Grandfield, S.; Up in Smoke? Linking Patient Assaults to a Psychiatric Hospital's Smoking Ban. *Journal of Psychosocial Nursing and Mental Health Services* 35:6, p. 35-40. June 1997. PMID: 9189849

1991 Pomerantz, A.; de Nesnera A., Resolution of Depressive Symptoms in Medical Inpatients after Discharge. *International Journal of Psychiatry in Medicine* 22:3, p. 281-289. March 1992 PMID: 1487392

1991 Pomerantz, A; de Nesnera, A.; Informed Consent, Competency, and the Illusion of Rationality. *General Hospital Psychiatry* 13:2, p. 138-142. March 1991 PMID: 2037244

Reviews

Book Chapters

Letters to the Editor:

2003 de Nesnera, A.; Successful Treatment with Clozapine at Higher Doses after Clozapine Induced Priapism. *Journal of Clinical Psychiatry* 64:11; p. 1394-1395. November 2003 PMID: 14658959

1996 de Nesnera, A.; Diphenhydramine Dependence: A need for Awareness. *Journal of Clinical Psychiatry* 57:3, p. 136-137, March 1996. PMID: 8617701

NON-PEER REVIEWED

Original Articles

Reviews

Book Chapters

Letters to the Editor

2012	de Nesnera, A.; The New Hampshire Experience Similar To Virginia's *American Psychiatric Association Psychiatric News* 47:20; p. 19. October, 2012
2009	de Nesnera, A.; Add New Hampshire to the List. *American Psychiatric Association Psychiatric News* 44:10; p. 38. May, 2009
2004	de Nesnera, A.; Psychology Prescribing. *American Psychiatric Association Psychiatric News* 39:14; p. 42. July, 2004

Updated By: Alexander de Nesnera, M.D.

Date: June 12, 2018

Barbara E. Dieckman RN, MS, MBA
[redacted]

Summary of Qualification

Ms. Dieckman is an analytically driven leader of change in clinical process/performance improvement and technologies that support the clinical environment. She has worked in healthcare with providers for over 20 years initially as a nurse progressing to a senior leadership role in healthcare consulting. Among her accomplishments are:

- Stabilization of eHR at a State Psychiatric Hospital
- Lead process and performance improvement projects including metric development, and data visualization for several clients in a consulting role.
- Lead the analytics team for large Houston based cancer center and delivered on time the analytics and reporting needs for the institution during their Epic implementation
- Lead several development teams in implementing a cohort discovery tool used in translational research for academic medical institutions
- Provided industry expertise to developers for large data warehouse implementations focused on providing metrics for payers on quality and cost of care

Ms. Dieckman has deep industry experience in both clinical workflows and technical systems used in healthcare. Her strengths include the ability to view and quickly derive insights from large clinical data sets, excellent communication skills, team building capabilities and she develops deep lasting client relationships.

Education

- M.S. Clinical Evaluative Sciences, Dartmouth Medical School Dartmouth
- MBA Whittemore School of Business University of New Hampshire
- BS University of Minnesota Minneapolis, Minnesota
- ADN Inver Hills College Inver Grove Heights, Minnesota

Work History and Experience

December 2018 to present Health System Strategist at New Hampshire Hospital

- Carved out a strong leadership role that began as a very ambiguous position
- Stabilized an eHR and established trust with users where the organization was close to reverting to paper
- Providing leadership for organization as it moves from self-hosted to vendor hosted solution for the eHR
- Providing leadership for the implementation of Direct Messaging Service that will allow external organizations and providers to send and receive patient data in a secure environment.

October 2011 to December 2018 Sr. Manager, Accenture

- Patient throughput process improvement lead for large not for profit health system in Georgia
- Analytics and Reporting project manager for large cancer center in Houston, Texas for Epic implementation
- Capacity Management project clinical lead for large health system in Georgia
- Clinician Change Management Project Manager at a large Healthcare system in Boston
- Clinical Lead for a Supply Chain cost savings initiative at a Children's Hospital

August 2010 to October 2011 Healthcare Quality Consultant Recombinant Data Corp

- Project Manager for several academic medical centers in New England implementing data warehouse functionality for quality and translational research
- Provided subject matter expertise in development of an analytic database for quality measures

December 2009 to July 2010 Consultant Encore Health Resources

- Provided consulting services to a large for profit healthcare system during a large scale EMR implementation

February 2006 to August 2009 Associate Perot Systems Corporation

- Clinical Transformation lead at a large academic medical center in Boston
- Change Management lead for a province wide initiative for the Public Health Department of Nova Scotia to reduce surgical wait times

July 2003 to February 2006 Industry Expert, Computer Sciences Corporation

- Subject matter advisor for a process improvement effort in Supply Chain related to OR for a major Baltimore-area health care system.
- Subject matter advisor for a team designing a clinical data warehouse, creating/validating nearly 100 provider-level measures of quality and efficiency.
- Participated in creation of a clinical data warehouse to measure health care delivery processes and outcomes.

December 1998 to February 2002 Dartmouth Hitchcock Medical Center (NH)

- Clinical Data Analyst, Clinical Quality Resources Department. Prepared data displays to answer providers' clinical quality questions
- Staff Nurse, ICU

April 1997 to October 1998 Concord Hospital (NH)

- Staff Nurse, Emergency Department.
- Chaired the Emergency Department Quality Assurance Council

September 1990 to January 1997 Abbott Northwestern Hospital (MN)

- Staff Nurse, Emergency Department
- Appointed to Interim Director, managing a staff of 75 nurses and paraprofessionals

- Managed ED and Urgent Care Center/Clinic
- Held various leadership roles within the hospital and the Allina System, including Chair of the Professional Patient Care Council
- Served on the Allina Foundation Task Force working with community resources to develop a computer link between emergency department staff, other health care agencies and social services organizations to improve outcomes for victims of domestic violence

January 1984 to September 1990 University of Minnesota Hospitals and Clinics

- Staff nurse in Medical –Surgical Intensive Care and specialized in adult and pediatric bone marrow transplant care

Program Staff List

New Hampshire Department of Health and Human Services

COMPLETE ONE PROGRAM STAFF LIST FOR EACH STATE FISCAL YEAR

Proposal Agency Name: Mary Hitchcock Memorial Hospital
Program: New Hampshire Hospital
Budget Period: July 1, 2018 - June 30, 2019

Position Title	Current Individual in Position	FTE / Year	Amnt Funded by this program for Budget Period	Total Salary for Budget Period	% of Salary Funded by this program	Site*
Example:						
Program Coordinator	Sandra Smith	40	$13,680	$43,680	31%	
Administrative Salaries						
Chief Medical Officer	Alex deNesnera	1	$ 329,600	$ 329,600	100%	NHH
Associate Medical Director	Gary Moak	1	$ 298,700	$ 298,700	100%	NHH
Director of Quality Systems & APRN Services	Deb Fournier	1	$ 135,200	$ 135,200	100%	NHH
Director of Health Systems Data & Information Systems	Barbara Dieckman	1	$ 129,376	$ 129,376	100%	NHH
General Medical Director	Thomas Koutelos	1	$ 278,100	$ 278,100	100%	NHH
Grant Manager	Marjorie Weeks	1	$ 68,744	$ 68,744	100%	NHH
Total Admin. Salaries		6	$ 1,239,720	$ 1,239,720	100%	
Direct Service Salaries						
General Psychiatrist		11	$ 2,689,382	$ 2,689,382	100%	NHH
Psychiatric APRNs		6	$ 753,239	$ 753,239	100%	NHH
Child/Adolescent Psychiatrist		4	$ 991,942	$ 991,942	100%	NHH
Geropsychiatrist		1	$ 270,530	$ 270,530	100%	NHH
Director Neuropsychology Lab		0.5	$ 76,915	$ 76,915	100%	NHH
Neuropsychology Trainees		3	$ 149,587	$ 149,587	100%	NHH
General Medical Physician		1	$ 265,225	$ 265,225	100%	NHH
Forensic Psychologist		1	$ 127,308	$ 127,308	100%	NHH
PGYIV Residents		1	$ 62,661	$ 62,661	100%	NHH
PGY II Residents		1.5	$ 87,524	$ 87,524	100%	NHH
Child/Adolescent Fellow		1	$ 68,465	$ 68,465	100%	NHH
Geropsychiatry Fellow		0.5	$ 32,786	$ 32,786	100%	NHH
Call/Night Coverage			$ 970,844	$ 970,844	100%	NHH
Total Direct Salaries		31.5	$ 6,546,408	$ 6,546,408	100%	
Total Salaries by Program		37.5	$ 7,786,128	$ 7,786,128	100%	

Please note, any forms downloaded from the DHHS website will NOT calculate. Forms will be sent electronically via e-mail to all programs submitting a Letter of Intent by the due date.
*Please list which site(s) each staff member works at, if your agency has multiple sites.

6A mac

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 FAX: 603-271-4912 TDD ACCESS RELAY NH 1-800-735-2964

JEFFREY A. MEYERS
COMMISSIONER

August 19, 2016

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

REQUESTED ACTION

Authorize the Department of Health and Human Services to enter into an agreement with Mary Hitchcock Memorial Hospital (a component of Dartmouth-Hitchcock), (Vendor #177160) of One Medical Center Drive, Lebanon, New Hampshire, 03756 to provide Physician Clinical and Administrative Services to meet the specialized health and related clinical and administrative needs of the residents of the State of New Hampshire in an amount not to exceed $36,554,042 effective November 1, 2016, or upon Governor and Executive Council approval, whichever is later, through June 30, 2019. This contract includes renewal options for up to two (2) three year periods, subject to Governor and Council approval. The funding for this contract will be from the following sources:

- 40% Other Funds (Medicare, Medicaid & third party insurance);
- 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
- 32% General Funds.

Funds to support this request are available in the following accounts for State Fiscal Years 2017, 2018, and 2019, with authority to adjust encumbrances in the State Fiscal Year through the Budget Office, if needed and justified without further approval from Governor and Executive Council:

05-95-48-481010-33170000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: ELDERLY AND ADULT SERVICES, GRANTS TO LOCALS, ADMIN ON AGING SVCS GRANT-SMPP

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	48130284	$21,000
2018	102-500731	Contracts for Program Services	48130284	$28,153
2019	102-500731	Contracts for Program Services	48130284	$29,199
			Sub-Total	**$78,352**

05-95-42-421510-79150000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: SUNUNU YOUTH SERVICE CENTER, HEALTH SERVICES

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500730	Medical Payments to Providers	42151501	$325,491
2018	102-500730	Medical Payments to Providers	42151501	$392,391
2019	102-500730	Medical Payments to Providers	42151501	$407,002
			Sub-Total	**1,124,884**

05-95-47-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS:OFC OF MEDICAID & BUS. PLCY, OFF. OF MEDICAID & BUS. POLICY, MEDICAID

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	47000021	$278,300
2018	102-500731	Contracts for Program Services	47000021	$374,358
2019	102-500731	Contracts for Program Services	47000021	$388,407
			Sub-Total	**$1,041,065**

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, ACUTE PSYCHIATRIC

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	494058000	$8,407,616
2018	102-500731	Contracts for Program Services	494058000	$11,471,661
2019	102-500731	Contracts for Program Services	494058000	$11,862,758
			Sub-Total	**$31,742,035**

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, BEHAVIORAL HEALTH

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	494058000	$351,661
2018	102-500731	Contracts for Program Services	494058000	$477,825
2019	102-500731	Contracts for Program Services	494058000	$494,500
			Sub-Total	**$1,323,986**

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, GLENCLIFF

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	494058000	$114,511
2018	102-500731	Contracts for Program Services	494058000	$152,935
2019	102-500731	Contracts for Program Services	494058000	$158,555
			Sub-Total	**$426,001**

05-95-93-930010-51910000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, SPECIAL MEDICAL SERVICES

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	561-500911	Specialty Services	93001000	$20,000
2018	561-500911	Specialty Services	93001000	$30,000
2019	561-500911	Specialty Services	93001000	$30,000
			Sub-Total	**$80,000**

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	93005947	$93,096
2018	102-500731	Contracts for Program Services	93005947	$119,981
2019	102-500731	Contracts for Program Services	93005947	$125,376
			Sub-Total	**$338,453**

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	103-502664	Contracts for Operational Svcs	93015947	$106,480
2018	103-502664	Contracts for Operational Svcs	93015947	$143,673
2019	103-502664	Contracts for Operational Svcs	93015947	$149,113
			Sub-Total	**$399,266**

EXPLANATION

The purpose of this request is to provide physician clinical and administrative services to specific populations served by the Department. The services identified will be provided across the following seven service areas:

Service Area #1 – New Hampshire Hospital
Service Area #2 – Glencliff Home
Service Area #3 – Medicaid
Service Area #4 – Children, Youth and Families
Service Area #5 – Behavioral Health
Service Area #6 – Elderly and Adult Services
Service Area #7 – Developmental Services

Presently, the Department, contracts with an academic medical center to meet the specialized health, clinical, and administrative needs identified in these service areas. Clinical focus areas include the provision of psychiatric care at New Hampshire Hospital, clinical and administrative leadership to the State's Medicaid program, and clinical leadership to behavioral health services. In addition, the Department receives physician consultation services in the area of elderly and adult services, juvenile justice services, and developmental services for children and adults.

Service Area #1 – New Hampshire Hospital

The Contractor will provide the Department, through a Chief Medical Officer, in collaboration with the Hospital's Chief Executive Officer, clinical and administrative services to best meet the evolving needs of New Hampshire residents with mental illness. This will include staffing of the newly opened Inpatient Stabilization Unit (ISU) as well as staffing for adult units, the Anna Philbrook Center for children, and the Geropsychiatry Unit. Additionally, the Contractor will work with the Department to continue to maintain and develop an applied research and evaluation capacity which shall identify and address medical research issues relative to the Department's mission. The Contractor will also provide the necessary physician and allied health care personnel, including staff certified in addiction treatment, required to deliver quality health services to patients at New Hampshire Hospital. The services provided are intended to achieve innovative and cost-effective acute psychiatric care that is oriented toward appropriate treatment, stabilization, and rapid return to the community. A recovery model will continue to be emphasized.

Service Area #2 – Glencliff Home

The Department operates the Glencliff Home to provide a continuum of services for New Hampshire's developmentally disabled, and/or mentally ill population in a home-like setting, with an emphasis on independence, dignity, and acceptance. The Contractor will provide the Department, through the expertise a Medical Director, direct psychiatric services, treatment, and associated services to all residents of the Glencliff Home. The Medical Director will serve other functions including, but not limited to, oversight of physicians, as well as other administrative duties, including review of medication use for compliance with federal law and serving as the liaison with other healthcare organizations.

Service Area #3 – Medicaid

The Department is responsible for the administration of the Medicaid medical assistance program and is dedicated to the identification of New Hampshire's health care needs through the assessment and implementation of health care and social services delivery systems. To assist the Department in the furtherance of these responsibilities, the Contractor will provide the services of a full time Chief Medical Officer. The Chief Medical Officer's responsibilities will include developing strategic clinical relationships with physicians as well as growing partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms. Additionally, the Chief Medical Officer will provide medical oversight of the state's publicly funded health insurance programs, assist in making policy decisions, and shape administrative planning strategies to enhance the operating efficiency of Medicaid and related healthcare initiatives across the state.

Service Area #4 – Children, Youth, and Families

The Department is responsible for providing supervision and rehabilitative services to youth adjudicated under state law as delinquent or as children in need of services (CHINS). The Department provides supervision, case management, and an array of rehabilitative services to youth through its staff of Juvenile Probation and Parole Officers (JPPOs) and a network of community based providers. In order to provide additional clinical expertise to the Department, the Contractor will provide the services of a full-time psychiatrist to provide psychiatric services to youth served by the Department. The psychiatrist will provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and JPPOs as well as providing psychiatric evaluations and direct care to youth served by the Department. Additionally, the psychiatrist will provide program development at the Sununu Youth Services Center (SYSC) and foster improved interagency collaboration between Juvenile Justice Services, area mental health agencies, and New Hampshire Hospital to enhance mental health services for adjudicated youth.

Service Area #5 – Behavioral Health

Through its integrated behavioral health services, the Department promotes respect, recovery, and full community inclusion for adults who experience a mental illness and children with emotional disturbances. The Department, through its behavioral health program, seeks to sustain the development and implementation of evidence based practices through the provision of technical assistance and training made possible through this contract, as well as through state and federal grant opportunities. The Contractor will provide the personnel needed to help the Department achieve positive outcomes for individuals served by the behavioral health program. Personnel include a Medical Director who will provide direction and expertise on key policy initiatives as well as evidence-based practices training consultants who will provide support in sustaining and fostering continuous quality improvement of the evidence-based practices that are implemented across the New Hampshire Community Mental Health Centers system.

Service Area #6 – Elderly and Adult Services

A critical component of the Department's statewide delivery system is its community-based provider network. The Department coordinates long-term care support services through contracts at the local level, thus reflecting the commitment of the Department to strengthen the autonomy of local communities and to direct resources to where they are needed most. In order to assist the Department in the provision of social and long-term supports to adults aged 60 and older and to adults between the ages of 18 and 60 who have a chronic illness or disability, the Contractor will provide the services of a Medical Director. The Medical Director will assist in the planning and direction of the Department's policies and programs for the purpose of sustaining and improving the quality of services for those elderly and adults served by the Department.

Service Area #7 – Developmental Services

The developmental services system offers individuals with developmental disabilities and acquired brain disorders a wide range of supports and services through partnerships with community based service networks developed through the leadership and oversight of the Department. The Contractor will provide the services of a Medical Director who will provide psychiatric consultation services as well as expert guidance and training to the Department's developmental services staff. The Contractor will also provide the services of two Developmental Services Interdisciplinary Clinic Teams with the clinical expertise needed to conduct evaluations of both adults and children with developmental disabilities and acquired brain injuries. These evaluations will be conducted based on referrals from Area Agencies.

The Contractor was selected through a competitive bidding process. The Department published a Request for Proposals for Physician Clinical and Administrative Services (RFP-2017-OCOM-01-PHYSI) on the Department of Health and Human Services website on February 25, 2016, and also notified several potentially interested vendors of the release. The Department received one proposal in response. The proposal was evaluated and scored by a team of individuals with comprehensive knowledge of the service areas addressed in the RFP. Based on this evaluation, the Department selected Mary Hitchcock Memorial Hospital to provide these services. The proposal summary score sheet is attached.

Should the Governor and Executive Council determine to not authorize this request the Department will be severely limited in its ability to provide essential services in the service areas identified above, thereby putting at risk many of the State's most vulnerable residents.

Area Served: Statewide

- Source of Funds: 40% Other Funds (Medicare, Medicaid & third party insurance);
- 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
- 32% General Funds.

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

Respectfully submitted,

Approved by:
Jeffrey A. Meyers
Commissioner

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

Physician Clinical and Administrative Services
RFP Name

RFP-2017-OCOM-01-PHYSI
RFP Number

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Mary Hitchcock Memorial Hospital	Pass	1000	857
2. 0		1000	0
3. 0		1000	0
4. 0		1000	0
5. 0		1000	0
6. 0		1000	0
7. 0		1000	0

Reviewer Names

1. Katie Dunn, Director OMBP, Deputy Commissioner
2. Michele Harlan
3. Diane Langley
4. Bob MacLeod, CEO NH Hospital
5. Dawn Touzin, DHHS, Department Controller
6.
7.
8.
9.

FORM NUMBER P-37 (version 5/8/15)

Subject: Physician Clinical and Administrative Services/RFP-2017-OCOM-01-PHYSI-01

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

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name ~~Mayr~~ Mary Hitchcock Memorial Hospital		1.4 Contractor Address One Medical Center Drive, Lebanon, New Hampshire 03756	
1.5 Contractor Phone Number 603-650-7815	1.6 Account Number	1.7 Completion Date June 30, 2019	1.8 Price Limitation $36,554,042
1.9 Contracting Officer for State Agency Eric Borrin, Director of Contracts and Procurement		1.10 State Agency Telephone Number 603-271-9558	
1.11 Contractor Signature MD		1.12 Name and Title of Contractor Signatory Robert Greene, MD EVP Chief Population Health Management Officer	

1.13 Acknowledgement: State of New Hampshire County of Grafton

On [illegible], 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

Laura K. Rogers
NOTARY PUBLIC
STATE OF NEW HAMPSHIRE
My Commission Expires May 9, 2017
Seal

1.13.2 Name and Title of Notary or Justice of the Peace

Laura K. Rogers - Notary Public

1.14 State Agency Signature Date: 8/19/16	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. Lyde Attorney	On: 8/19/16
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 8/18/2016

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 RM
Date 8/18/2016

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 _____

Date 8/10/2016

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will 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 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. Covered Populations and Services

The Contractor shall provide physician clinical and administrative services to various populations served by DHHS, in all seven (7) Service Areas identified below and as described herein:

2.1.1. Service Area #1 – New Hampshire Hospital (NHH)

2.1.2. Service Area #2 – Glencliff Home

2.1.3. Service Area #3 – Medicaid

2.1.4. Service Area #4 – Children, Youth and Families

2.1.5. Service Area #5 – Behavioral Health

2.1.6. Service Area #6 – Elderly and Adult Services

2.1.7. Service Area #7 – Developmental Services

2.2. General Requirements Applicable to All Service Areas

2.2.1. The Contractor shall provide psychiatric and other professional services to all service areas through the employment of appropriate Contractor staff described in the following sections, and requiring such staff to perform required services.

2.2.2. The Contractor shall work with DHHS to continue to develop and refine an integrated mental health care system applying principles of managed care for clinical treatment, educational and training programs, and related research.

2.2.3. The Contractor shall work with DHHS to jointly maintain and develop an applied research and evaluation capacity, the general purpose of which shall be to identify and address medical research issues relative to the DHHS mission under RSA 135-C. The activities shall be directed at enhancing applied research resources, capacities and activities within the State mental health services system and implementing a program of applied research relative to that system.

2.2.4. All personnel provided by the Contractor under this contract shall be employees or consultants of the Contractor. No personnel provided by the Contractor under this contract shall be considered an employee of the State of New Hampshire.

2.3. Specific Service Requirements for Service Area #1 – New Hampshire Hospital

2.3.1. Chief Medical Officer's Administrative/Clinical Responsibilities

2.3.1.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO (NHH CEO) with respect to administrative/clinical matters, the Chief Medical Officer shall be responsible for the following:

a. To coordinate with the NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. To participate in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;
c. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
d. To perform annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Chief Medical Officer shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;
e. To perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Chief Medical Officer shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or NHH Medical Staff Organization bylaws;
f. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;
g. To provide consultation to DHHS relative to the development of the State mental health service system;

h. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;
i. To report to the NHH CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;
j. To participate as a member of the NHH's Administrative Executive Committee;
k. To participate as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH who represents the NHH CEO;
l. To participate with the NHH CEO in the development of the clinical budget of NHH;
m. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;
n. To establish, subject to the NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH;
o. To assist the NHH Chief Executive Office with the clinical supervision and education of all other clinical staff at NHH; and
p. To provide clinical coverage of Contractor staff as necessary.

2.3.2. Associate Medical Director Responsibilities

2.3.2.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO with respect to administrative/clinical matters, the Associate Medical Director shall be responsible for the following:

a. To coordinate with the NHH Chief Medical Officer and NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. Serves in the capacity of the chief medical officer during his/her absence;
c. To participate with the Chief Medical Officer in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;
d. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
e. To participate with the Chief Medical Officer in performing annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In

preparing these evaluations, the Associate Medical Director shall assist the Chief Medical Officer who shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;

f. To work with the CMO to perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Associate Medical Director shall assist the Chief Medical Officer who shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or Medical Staff Organization bylaws;
g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;
h. To provide consultation to DHHS relative to the development of the State mental health service system;
i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;
j. To report to the NHH Chief Medical Officer and to the CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;
k. To participate as a member of the NHH's Administrative Executive Committee;
l. In the absence of the Chief Medical Officer, participates as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH representing the NHH CEO;
m. To participate with the NHH Chief Medical Officer and the NHH CEO in the development of the clinical budget of NHH;
n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;
o. To assist in establishing, subject to the NHH Chief Medical Officer and NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH; and
p. To assist the NHH Chief Medical Officer and the NHH CEO with the clinical supervision and education of all other clinical staff at NHH; and
q. To provide clinical coverage as necessary and to the extent possible when there are vacancies with the staff psychiatrists or advanced psychiatric nurse practitioners.

2.3.3. General Psychiatrist Responsibilities

2.3.3.1. The following responsibilities are applicable to all psychiatrists the Contractor provides to NHH under this contract. Staff psychiatrists shall be responsible for the following:

a. The formulation and implementation of individual treatment plans and clinical services, in cooperation with treatment teams, for the diagnosis, assessment, treatment, care and management of patients of NHH;
b. Maintaining and directing a clinically appropriate treatment plan for assigned cases in concert with the multidisciplinary staff consistent with NHH norms;
c. Determination, consistent with RSA 135-C, of the appropriateness of admissions, transfers and discharges;
d. Participation with other staff physicians, the NHH Chief Medical Officer, and the Associate Medical Director to provide on-call after hours coverage and serve as on-site, after hours coverage, on a 24-hour a day, 7-day a week, year round basis when necessary as determined by the NHH CEO, the NHH Chief Medical Officer, and/or the Associate Medical Director;
e. Participation in research and education activities consistent with the mission of NHH and subject to the approval of the NHH CEO;
f. Participation in the Medical Staff Organization and other administrative committees of NHH, assigned committees and task forces;
g. Performance of medical/psychiatric consultation on patients from facilities other than NHH, consistent with current NHH policy;
h. Timely completion of all necessary documentation as required by TJC and CMS standards;
i. Responsibility for completing NHH's Incident Reports in compliance with NHH policy;
j. Completion of all medical record documentation in the timeframes required by the NHH's Policy and Procedure "Medical Record Documentation" and other relevant policies and procedures, including ongoing and timely documentation of clinical care regarding medical necessity, including daily progress notes to document and support medical necessity;
k. Adherence to all NHH policies, including, but not limited to policies on Medical Records Documentation and Progress Notes;
l. Ensuring that documentation is consistent with normative data collected by the NHH compliance officer and NHH utilization review manager;
m. Provision of other services as required, which are consistent with the mission of NHH and the intent of this contract;
n. Appearing and testifying in all court and administrative hearings as required by the Department;
o. Developing and maintaining positive relationships with NHH staff, patients, families, advocates, community providers and other interest groups vital to the functioning of NHH and the DHHS system of care, including for the purpose of transition planning. In

accomplishing this requirement, psychiatrists shall adhere to the standards set forth in NHH's Customer Service Guidelines for Physicians;

p. Meaningfully participating in utilization review processes, including appeals and other processes, as required by the NHH Chief Medical Officer, the Associate Medical Director, and the NHH CEO; and

q. Demonstrating value added achievements with academic and scholarly activities including, but not limited to: teaching (clinical and didactic); attendance and participation in case conferences; engagement with the profession with presentation and/or publication; hospital in-services; and service to the hospital and community through committee work, task force work, community service with advocacy groups; and involvement with the work of DHHS, as well as other public and private agencies that serve the mentally ill, e.g. law enforcement, corrections, the court, the legislature, colleges and universities and other related entities.

2.3.3.2. All psychiatrists shall provide services on a full-time basis, and limit their practice to treating NHH patients only.

2.3.3.3. Notwithstanding the above, psychiatrists serving under this contract may perform occasional outside practice duties, with the advance written approval of the Chief Medical Officer and the NHH CEO, but only if said duties do not, in the sole judgment of the NHH CEO, interfere with the psychiatrists' duties at the NHH.

2.3.3.4. For subsection 2.3.3.2., the term "full-time" shall mean that each psychiatrist shall be required to account, through appropriate record-keeping as specified by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

a. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH. Psychiatrists may be permitted, subject to prior notice and the approval of both the Chief Medical Officer and the NHH CEO; to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. Psychiatrists approved for such activities shall provide documentation to the Chief Medical Officer and the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

2.3.3.5. Notwithstanding the foregoing allowance for educational or research activities specified in subsection 2.3.3.4.a., psychiatrists shall be physically present onsite at NHH not less than 36 hours per week, unless otherwise accommodated for through the Contractor's normal and customary employee leave policies.

2.3.4. Residents/Post Graduate Fellows Responsibilities

2.3.4.1. The responsibilities of all residents and post graduate fellows (PGY) shall be outlined, monitored, and reviewed by the Chief Medical Officer or the Associate Medical Director, and the appropriate attending psychiatrist.

2.3.4.2. Responsibilities for Residents/Post Graduate Fellows shall involve the advancement of the clinical initiatives underway at NHH under the supervision of the Chief Medical Officer.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall ensure that Residents are an integral part of the Contractor's ACGME approved psychiatric residency program. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the field of public psychiatry.

b. Child/Adolescent Fellows – The Contractor shall ensure that Fellows are an integral part of the Contractor's ACGME approved child/adolescent training program. The Contractor shall incorporate a full spectrum of child/adolescent coursework and clinical experience to facilitate the NHH rotation, emphasizing areas of child welfare, family intervention, wraparound services and the juvenile justice system. Fellows shall provide coverage for the entire calendar year.

c. Geropsychiatry Fellow – The Contractor shall ensure that the Fellow is an integral part of an ACGME approved fellowship program in geriatric psychiatry. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of the elderly.

d. Public Psychiatry Fellow – This program shall begin in SFY 2018. The Contractor shall ensure that the Fellow is an integral part of an approved fellowship program in public sector psychiatry. The Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of patients with severe and persistent mental illness with the Public Psychiatry Fellowship Program elements as follows:
   i. Academic Curriculum;
   ii. Presentations and consultations outlining principles in the field;
   iii. Guest speakers with topics including mental health administration;
   iv. Weekly meeting with a faculty preceptor;
   v. Lifelong mentorship; and
   vi. Contact and work with advocacy groups and other organizations dedicated to public and community psychiatry.

2.3.5. Psychiatric Advanced Practice Registered Nurses (APRN) Responsibilities

2.3.5.1. Psychiatric Advanced Practice Registered Nurses shall provide clinical services in extended care and admissions areas with patients with severe mental illness and medical co-morbidity morbidity in accordance with the scope of practice described in RSA 326-B:11.

2.3.5.2. The responsibilities for Psychiatric APRNs shall include but not be limited to: performing advanced assessments; diagnosing; prescribing; administering and developing treatment regimens; and providing consultation as appropriate.

2.3.5.3. APRNs shall independently prescribe, dispense, and distribute psychopharmacologic drugs within the formulary and act as treatment team leaders in accordance with State law and medical staff by-laws.

2.3.5.4. APRNs shall provide the same level of documentation as required of psychiatrists as outlined in subsection 2.3.3.1.

2.3.6. NHH Research Manager Responsibilities

2.3.6.1. The Research Manager shall be responsible for assisting in the development and management of all research at NHH. The Research Manager shall play a pivotal role in initiating and cultivating research that is efficient and responsive to the needs of the NHH CEO, psychiatrists, nursing staff, clinical investigators, administration, and patient community, and works with the Chief Medical Officer to market the research opportunities at NHH while tracking and reporting the growth and development of research activities.

2.3.6.2. The Research Manager shall develop policies and procedures to ensure that research endeavors function effectively and manages and trains support staff in studies as the research program continues to grow and develop.

2.3.6.3. The Research Manager shall serve as the primary contact for all incoming and proposed studies, assesses feasibility and potential use of resources and guides potential projects through the process from initial proposal to planning for staffing, finding resources, reviewing budgets, and providing guidance with hospital, state and federal regulations through to completion of the project.

2.3.7. After Hours Coverage

2.3.7.1. The Contractor shall provide on-call after-hours coverage, 24 hours per day, 7 days per week, year round. Coverage shall be provided by one or more full-time psychiatrists who are certified or eligible for certification by the American Board of Psychiatry and Neurology. The coverage will be assigned in one-week increments in rotation among the full-time New Hampshire Hospital psychiatric staff. The after-hours coverage will include back-up to the psychiatry residents who provide in-house after-hours coverage and will cover in-house in the event that the assigned in-house physician is not able to provide the service.

2.3.7.2. The Contractor shall provide on-site after hours coverage, 16 hours per day, Monday through Friday, and 24 hours per day on weekends and holidays, year round.

a. The on-site after-hours coverage on weekdays, weekends and holidays shall be provided by a physician who is certified or eligible for certification by the American Board of Psychiatry and Neurology, or, is in training in an accredited psychiatry residency program with at least three years of training experience.
b. The Contractor shall maintain a pool of psychiatric physicians or resident physicians who are credentialed with New Hampshire Hospital for the after-hours work, and the after-hours physicians will be assigned to in-house after-hours coverage by the Chief Medical Officer or Associate Medical Officer with a six (6) month rolling calendar. The pool shall be of sufficient size and appropriate qualifications to ensure the Contractor's ability to meet 100% staffing level requirements and performance standards specified herein at section 4. Performance Standards and Outcomes.

2.3.8. Applied Clinical Research

2.3.8.1. The Contractor, working jointly with DHHS, shall identify and perform applied clinical research for the purpose of advancing the goals of the public mental health services system. All clinical research projects shall be approved by DHHS in advance. This shall include assessing the system's capacity, developing and/or refining clinical strategies, and training clinical staff in emerging treatment technology. The Contractor shall work jointly with DHHS to seek and obtain appropriate financial support (federal, State and foundation) to continue to build on the existing research projects. The Contractor shall, subject to DHHS approval, ensure that publication of the findings of this research shall receive the widest possible dissemination in the services delivery system in New Hampshire and through conferences and special reports nationally and internationally.

2.3.9. Additional Requirements

2.3.9.1. The Contractor shall provide clinical personnel to perform the services required for clinical, educational, research, and training programs at NHH. The Contractor shall provide psychiatrists and other clinical personnel with sufficient professional skills and qualifications to provide the educational and research services needed by NHH.

2.3.9.2. At the direction of the NHH CEO, Contractor staff may be assigned to conduct telepsychiatry or offsite consultation not arising from the clinical operation and administration of New Hampshire Hospital or any other public health or clinical service offered by the Department. Contractor staff assigned to telepsychiatry shall have professional malpractice insurance in effect in an amount satisfactory to the Department. The Contractor shall be responsible for ensuring that staff members have malpractice insurance in effect and in amounts satisfactory to DHHS.

2.4. Specific Service Requirements for Service Area #2 – Glencliff Home

2.4.1. General Requirements

2.4.1.1. The Contractor shall provide routine or emergency telephone consultation by the Medical Director (described below) or an equally qualified physician at no additional cost, twenty-four (24) hours per day, seven (7) days per week, fifty-two (52) weeks per year, to clinical and administrative staff at the Glencliff Home.

2.4.2. Medical Director Responsibilities

2.4.2.1. The Contractor shall provide a geropsychiatrist to serve as the Medical Director. The Medical Director shall be responsible for the following:

a. Coordination of all medical care and direct psychiatric services, treatment and associated follow up to all residents of Glencliff Home;
b. Provide administrative functions, including but not limited to policy review and establishment that reflect current standards of practice; oversight of physicians; attendance at mandatory committee meetings, including but not limited to continuous quality improvement, infection control, and admissions; regularly review the use of psychotropic medications for compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations; and the provision of other assistance in meeting standards for annual State inspections and Federal regulations;
c. Deliver expert testimony in probate court as needed (e.g. guardianship cases, electroconvulsive therapy, do not resuscitate orders). Preparation may include consultation with legal counsel, records review, and travel;
d. Provide written patient evaluations on each patient as frequently as required by the Department but in no case less than once per calendar year;
e. Serve as liaison with other organizations, such as NHH or Dartmouth-Hitchcock Medical Center, when a Glencliff Home resident is receiving services at another healthcare institution; and
f. Provide the applicable services as described herein at subsection 2.3.3.1. and its subparagraphs.

2.5. Specific Service Requirements – Service Area #3 – Medicaid

2.5.1. Department of Health and Human Services Chief Medical Officer Responsibilities

2.5.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated physician, to serve as the Department's Chief Medical Officer.

2.5.1.2. For the Chief Medical Officer, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by DHHS, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.5.1.3. The Chief Medical Officer shall maintain regular office hours consistent with DHHS' regular business hours for senior executive team members. The Contractor shall ensure that the Chief Medical Officer is provided a flexible work schedule that is consistent with the expectations of a senior executive manager at DHHS, subject to the approval of the DHHS Designee.

2.5.1.4. The Chief Medical Officer shall maintain his or her professional calendar electronically, in a format subject to DHHS approval, and make same available to the DHHS Designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes approved leave time, conferences, trainings, etc.

2.5.1.5. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Chief Medical Officer shall be subject to the prior approval of the DHHS Designee.

2.5.1.6. The Chief Medical Officer's primary workspace shall be located in Concord, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Chief Medical Officer utilizes DHHS-provided information and technology resources consistent with applicable State policies.

2.5.1.7. The Chief Medical Officer shall plan and direct all aspects of DHHS' medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the DHHS Designee.

2.5.1.8. The responsibilities of the Chief Medical Officer shall include but not be limited to the following:

a. Developing strategic clinical relationships with physicians and in growing public/private partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms, such as but not limited to the Patient Protection Affordable Care Act (ACA), and any amendments thereto;
b. Overseeing the development of the clinical content in marketing and educational materials and ensures all clinical programs are in compliance with state and federal regulations;
c. Participating in the writing of research publications to support clinical service offerings;
d. Providing medical oversight of the state's publicly funded health insurance programs, making key policy decisions, and shaping

administrative planning strategies to enhance the operating efficiency of Medicaid and CHIP and related healthcare initiatives across the state;

e. In collaboration with the DHHS Designee, directs the day-to-day operations of the DHHS program area responsible for clinical programs, benefit management, and quality improvement activities. Also serves as chief clinical liaison to other state program units, insurance providers, and professional organizations;
f. Serving as the clinical authority in reviewing and determining requests for covered and uncovered medical services and pharmacy services;
g. Participating in the development of procedural reimbursement policy;
h. Promoting and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the NH Medicaid program;
i. Identifying new developments and emerging trends in clinical practices and research that would have an impact on medical policy and/or costs, and recommends options and courses of action;
j. Within the context of implementation of federal health care reforms, such as but not limited to the Affordable Care Act and any amendments thereto, provides leadership in the planning, Medicaid program response, development of health care delivery systems, clinical quality initiatives, and related policy issues;
k. Representing the DHHS Designee at meetings and other events and serving as DHHS designee for any committees, boards, and commissions as requested;
l. Analyzing proposed and new federal legislation related to benefits management and recommends options and courses of action;
m. Maintaining and enforces policies, procedures, administrative rules, and State plan provisions that govern Medicaid medical benefits; and
n. Overseeing the implementation of contracted services, maintaining working relationships with contractors, managing contractor deliverables and services, and measuring contractor performance; and
o. Regularly attending Medicaid Management Team meetings.

2.5.1.9. Additionally, the Chief Medical Officer shall assist the DHHS Designee with managing the operations of the clinical and benefits management functions within the Medicaid program. This may include providing to the DHHS Designee input and making recommendations on staffing needs, performance standards, and other matters applicable to DHHS staff.

2.5.1.10. The Chief Medical Officer shall also provide executive team office coverage as needed and requested by the DHHS Designee.

2.6. Specific Service Requirements – Service Area #4 – Children, Youth and Families

2.6.1. DCYF Staff Psychiatrist Responsibilities

2.6.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. For purposes of this paragraph, the term "full-time" shall mean that the Staff Psychiatrist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.6.1.2. The Staff Psychiatrist is expected to work additional hours, including attending non-business hour meetings as required in order to meet the business needs of DHHS without additional cost to DHHS.

2.6.1.3. The Staff Psychiatrist shall maintain regular office hours consistent with those of DHHS senior executive team members.

2.6.1.4. The Staff Psychiatrist shall maintain his or her professional calendar electronically, in a form subject to DHHS approval, and make it available to the DHHS designee as necessary, and will keep it up to date to include leave time, conferences and trainings.

2.6.1.5. The Contractor shall ensure that the Staff Psychiatrist provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Staff Psychiatrist shall provide timely, prior notification to the designated DHHS representative of any leave time taken. Absences due to vacation and continuing education shall be planned in advanced, in consideration of the business needs of the DHHS designated program areas.

2.6.1.6. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Staff Psychiatrist shall be subject to the prior approval of the DHHS designee.

2.6.1.7. The Contractor shall ensure that any vacation or continuing education leave time by the Staff Psychiatrist shall be planned in advance and consider the business needs of DHHS, including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight.

2.6.1.8. The Staff Psychiatrist's primary workspace shall be located in Manchester, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Staff Psychiatrist utilizes DHHS-provided information and technology resources consistent with applicable State policies

2.6.1.9. The Contractor shall work directly with the DHHS designee for the Sununu Youth Services Center (SYSC), and shall ensure the following services are provided by the Staff Psychiatrist under the contract:

a. Provide medical and psychiatric services at SYSC;
b. Provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and Juvenile Probation and Parole Officers. Documents the number of comprehensive psychiatric evaluations and units of psychiatric services provided annually in direct care to youths in SYSC and the Juvenile Justice System. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;
c. Provides program development at SYSC, using a resiliency-building framework, and implementation of evidence-based practices to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;
d. Provides clinical supervision and teaching of child psychiatry residents and fellows at SYSC. Documents the number of teaching and supervision contacts annually with interns, residents, and fellows at SYSC;
e. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for JJS;
f. Documents on an aggregate level, through web-based outcome measures, the efficacy of services targeting Post Traumatic Stress Disorder, depression, substance abuse, and behavioral disorders among New Hampshire youth; and
g. Fosters improved interagency collaboration between JJS services, the area mental health agencies, and NHH to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court involved youths. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

2.7. Specific Service Requirements – Service Area #5 – Behavioral Health

2.7.1. Medical Director Responsibilities

2.7.1.1. The Contractor shall provide a part-time Medical Director and the necessary personnel to fulfill four major service components, in addition to a time study requirement in the area of behavioral health services. The four components are:

a. Medical Director for the Behavioral Health program;
b. Evidence-Based Practices Training and Consultation;
c. Behavioral Health Policy Institute (BHPI); and
d. Committee for the Protection of Human Subjects (CPHS).

2.7.1.2. The Medical Director shall be available on-site, at a DHHS designated location, for twenty (20) hours per week to provide services to the Behavioral Health service area. The Medical Director shall be available via telephone, email, and in person by appointment during that time.

2.7.1.3. The Medical Director shall, in collaboration with the DHHS designee be responsible for the following:

a. Meet weekly with the DHHS designee;
b. Address Behavioral Health clinical issues;
c. Address Behavioral Health policy issues;
d. Enhance housing support capacity planning;
e. Address Medicaid and state rule issues;
f. Address designated receiving facility maintenance and development;
g. Assist in developing Telemedicine capacity;
h. Utilizes electronic medical records;
i. Coordinate between NHH and CMHC care;
j. Evidence Based Practices (EBP) implementation;
k. Develop funding and reimbursement strategies;
l. Assist in sustainability of the "In Shape" program
m. Assess the needs of patients in NHH and Transitional Housing Services who might be served in the community; and
n. Attend meetings between the Behavioral Health program and various community stakeholder groups, such as the Community Behavioral Health Association and the Disabilities Rights Center, to communicate about and also garner support for and input regarding Behavioral Health initiatives.

2.7.1.4. The Medical Director shall fulfill the additional following responsibilities:

a. Participate on key departmental and legislative committees, as required by DHHS, including the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the DHHS Institutional Review Board;
b. Serve as secretary for the Mental Health Council, to ensure that the work of the council supports the goals of DHHS;

c. Serve as a member of the Drug Utilization and Review Board to ensure that the Medicaid Preferred Drug List and work of the Board addresses the needs of consumers with mental illness disabilities;
d. Attend regular case conferences and sentinel event reviews. Analyze challenging clinical cases or events and recommend improvements in policy or services to address problem areas;
e. Attend monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of DHHS research participants;
f. Participate on several Behavioral Health System Transformation Workgroups, including the EBP Steering Committee, Programmatic Workgroup, and Quality Assurance Group;
g. Coordinate and meet with DHHS leadership as required by DHHS;
h. Conduct bi-monthly or more frequent Behavioral Health Medical Director's meeting to coordinate efforts, between Behavioral Health and CMHCs, regarding medical/treatment issues related to both hospital and outpatient care of people with serious mental illness and to consult on other relevant issues or concerns, including: preferred drug list issues, coordination with NHH admissions and treatment, Medicaid interruption during institutionalization, enhancement of community housing supports, use of information technology, medical director administrative issues, use of best practices, implementation of EBP's, documentation burden, integration of mental and physical health care, smoking cessation, coordinating local, state and national agendas regarding public mental health care, electronic health records, health information exchange, education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
i. Monitor the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in NH including engaging in ongoing discussions with CMHC leaders regarding the Preferred Drug List and direct education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
j. Communicate regularly with, and provide clinical consultation (including potential site visits, conference calls, and written reports) to all Behavioral Health management staff regarding current, challenging clinical issues, including conditional discharges, Medicaid consumer cases, and suicide monitoring;
k. Collaborate with the other DHHS Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including drug choice for the Preferred Drug List, performance and impact of the Preferred Drug List on clinical care, Medicaid interruption during hospitalization and incarceration, integration of medical, mental health, and substance abuse services, and enhancement of addiction treatment capacity; and

l. Provide oversight and continuing implementation of Evidence Based Practices, including practices as part of the Medicaid Program for Community Mental Health Services as well as those practices specifically required in the Community Mental Health Agreement.

2.7.2. Evidence-Based Practices Training and Consultation

2.7.2.1. The Contractor shall provide Evidence-Based Practices Training and Consultation services as described in Appendix I, of RFP-2017-OCOM-01-PHYSI, for the purpose of sustaining and continuously improving the quality of three (3) Evidence-Based Practices (EBP) that are implemented across the New Hampshire Community Mental Health Centers (CMHC) system. The EBPs are: Illness Management and Recovery (IMR), Evidence-Based Supported Employment (EBSE), and Assertive Community Treatment Teams (ACT). Additional EBPs may take the place of these based on the availability of federal funding to support the implementation of additional EBPs in New Hampshire.

2.7.2.2. The Contractor shall provide education, training, technical assistance and consultation to the DHHS Behavioral Health service area and the CMHCs. The deliverables described below shall be provided directly to DHHS-designated Behavioral Health program staff and CMHCs designated by DHHS.

2.7.2.3. DHHS shall designate a specific DHHS Behavioral Health staff member to oversee the deliverables specified herein. The Contractor shall designate a specific representative of the Contractor to work directly with the DHHS designee in the fulfillment of these deliverables.

2.7.2.4. **Training the CMHC Workforce:** To sustain and improve the quality of IMR and EBSE services, the Contractor shall provide education and training to DHHS designated CMHCs staff.

a. The Contractor shall ensure that the training and education is provided in central locations and in a manner that best facilitates the learning of key skills and strategies that are necessary to provide IMR and EBSE in ways that support the most effective outcomes for consumers at each of the CMHCs. The training shall be designed to fulfill the specifications described in He-M 426 for CMHC providers of EBPs in NH.

b. Each training event shall include, at a minimum:
   i. Invitations provided to CMHC staff before the training event;
   ii. A description of who should attend the training;
   iii. Outcomes for participants attending the training;
   iv. Sufficient time to provide instruction and practice for skills;
   v. Content designed to improve the fidelity of the practice at CMHC's;
   vi. Documentation of all participants attending the training; and
   vii. Certificates of attendance for all participants completing the training.

c. Each training event shall be staffed by Contractor staff or other qualified professionals; such individuals shall be subject to approval of the DHHS designee.

2.7.2.5. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing IMR services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the IMR trainings in the following formats:
   i. A minimum of one two-day training for new IMR practitioners to fulfill the specifications described in He-M 426 to provide IMR services. The capacity for each of these training events shall be twenty participants and up to thirty participants depending on the availability of the training space;
   ii. A minimum of four half-day trainings for experienced IMR practitioners, of which the combination of attending any two of these events shall fulfill the specifications described in He-M 426 for ongoing providers of IMR services. The capacity for each of these training events shall be at least twenty participants and up to thirty participants depending on the availability of the training space.
   iii. A minimum of one full-day training for IMR supervisors that shall fulfill the specifications in He-M 426 for ongoing providers of IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR services through practice-specific supervision. The capacity for this training event shall be twenty participants.

2.7.2.6. **Evidence Based Supported Employment (EBSE):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing EBSE services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the EBSE trainings in the following formats:
   i. A minimum of two two-day trainings for new EBSE practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.
   ii. A minimum of two half-day trainings for experienced EBSE practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The capacity for each of these training events shall be twenty participants.
   iii. A minimum of two half-day trainings for experienced EBSE practitioners and EBSE supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The content shall include information on developing and improving collaboration with the New Hampshire Department

of Vocational Rehabilitation and other important community partners in providing effective EBSE services. The capacity for each of these training events will be twenty participants.

2.7.2.7. **Assertive Community Treatment Teams (ACT):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing ACT services. The topic areas shall be subject to the DHHS designee's approval.

b. The Contractor shall provide the ACT trainings in the following formats:
   i. A minimum of two two-day trainings for new ACT practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.
   ii. A minimum of two half-day trainings for experienced ACT practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events shall be twenty participants.
   iii. A minimum of two half-day trainings for experienced ACT practitioners and ACT supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events will be twenty participants.

2.7.2.8. **Assessing Fidelity to Evidence Based Practices (EBPs):** The Contractor shall assess the fidelity (organizational faithfulness to the principles of the practice) of IMR, ACT and EBSE for all CMHCs, as designated by the DHHS designee, with the exception of those CMHCs where the DHHS designee has approved a limited scope of review through the submission of an approved Quality Improvement Plan (QIP). In those organizations utilizing a QIP, the Contractor shall review those fidelity items described in the QIP.

a. In either case, fidelity assessments shall be conducted for the purpose of monitoring the implementation of IMR, ACT and EBSE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the designated CMHCs.
b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMHC IMR, ACT and EBSE fidelity or QIP review. The schedule shall be subject to the advanced approval of the DHHS designee.
c. The Contractor shall ensure that each fidelity or QIP assessment includes, at a minimum:
   i. Written instructions to the CMHC regarding necessary observations, interviews, data access and other activities for the assessment;

ii. A description of CMHC staff, other community providers, consumers and family members who will need to be interviewed for the assessment;
iii. A specific written assessment schedule jointly developed by the Contractor and the CMHC;
iv. Sufficient time to assess and evaluate the CMHC's delivery of IMR, ACT or EBSE;
v. A debriefing at the end of the assessment to review themes from the review with CMHC leadership; and
vi. Documentation of the assessment process, findings and scoring of fidelity items for CMHC leadership and the Department no later than four weeks following the assessment.

2.7.2.9. **Consultation to CMHC Leadership and Workforce Development**: The Contractor shall provide agency-based consultations to all CMHCs as designated by the DHHS designee to assist agencies in sustaining and providing continuous quality improvement for IMR, ACT and EBSE services. The Contractor shall ensure that CMHC leadership has access to consultations at their agencies after they have received the written documentation of the findings of each fidelity assessment described herein at subsection 2.7.2.8. Consultations shall include the development of ideas, strategies and interventions that each individual CMHC may utilize to most effectively sustain and improve IMR, ACT and EBSE services.

a. In cases where CMHCs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall ensure that such further interventions are provided only when collaboratively agreed upon by the DHHS designee, the Contractor and CMHC leadership. These interventions shall be time-limited (customarily one half-day, single events) and specifically tailored to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

2.7.2.10. **NH Behavioral Health Service Area Consultations and Collaboration:** In order to most effectively fulfill the deliverables described in this document for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services in the NH Community Mental Health system, the Contractor shall work in a highly integrated fashion with the DHHS designee and additional DHHS Behavioral Health resources identified by the DHHS designee. This integrated alliance shall also be extended to other state and community agencies as collaboratively agreed upon by the DHHS designee and the Contractor.

a. In addition to attending designated meeting or events, the Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the DHHS designee and the Contractor. Specific activities for consultation and collaboration shall include:

i. The Contractor's attendance at the State EBP advisory committee bi-monthly meetings by the Contractor and/or designees;
ii. The Contractor's attendance at weekly meetings with the DHHS designee;
iii. Attendance of Contractor staff at monthly meetings with the DHHS designee and any additional DHHS Behavioral Health resources identified by the DHHS designee;
iv. The Contractor's attendance at quarterly meetings with the DHHS designee, and any additional DHHS Behavioral Health resources identified by the DHHS designee, to review progress of these deliverables and make any necessary resource allocations within the scope based, as collaboratively agreed upon by the DHHS designee and the Contractor;
v. The Contractor's attendance at DHHS designated meetings with NH Bureau of Vocational Rehabilitation (NHBVR) personnel to improve collaboration between EBSE services and NHBVR at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
vi. The Contractor's attendance at DHHS designated meetings with Granite State Employment Project (Medicaid Infrastructure Grant) personnel to improve collaboration between EBSE services and the Granite State Employment Project at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
vii. The Contractor's attendance at DHHS designated meetings with DHHS Behavioral Health personnel regarding Behavioral Health strategies and interventions, including proposed rule or policy and procedure changes, to better facilitate the sustaining and improvement of IMR, ACT and EBSE services in the NH Community Mental Health system;
viii. The Contractor's attendance at designated meetings with key CMHC personnel, including monthly meetings of CMHC Community Support Program directors, regarding the Contractor's activities and to better facilitate the sustaining and improvement of IMR, ACT and EBSE services; and
ix. The Contractor's attendance at other events, as collaboratively agreed upon by the DHHS designee and the Contractor, for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services.

2.7.3. Behavioral Health Policy Institute (BHPI)

2.7.3.1. Under the direction of the DHHS designee and the Behavioral Health Medical Director providing services to the Behavioral Health program, the Contractor shall conduct periodic analyses, the frequency of which shall be determined by DHHS, of Medicaid claims to address policy issues and questions under consideration from the Behavioral Health program. The Contractor shall participate in regular meetings with the DHHS designee and the Behavioral Health Medical Director to review these analyses, and associated policy implications.

2.7.4. Committee for the Protection of Human Services (CPHS)

2.7.4.1. The Contractor shall achieve the following CPHS related deliverables for the purpose of sustaining and supporting a committee to oversee research funded by federal agencies and other non-state sources, and conducted in New Hampshire DHHS-funded programs that serve people with mental illness, developmental disabilities, and substance abuse or dependence disorders, in fulfillment of NH RSA 171-A:19-a. Because of federal regulations governing the composition and operation of such committees, a certain number of scientific experts must be present on the committee. The Contractor shall provide research, scientific and human subject's expertise to the CPHS under the contract.

2.7.4.2. The Contractor shall provide staff to support the CPHS who shall:

a. Attend and fully participate in CPHS full committee meetings (once per month);
b. Conduct expedited reviews as requested by the CPHS Administrator (averaging about three per month);
c. Provide consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject's protections (e.g., pre-reviewing materials, reviewing requirements for exempt and expedited determinations, reviewing significant adverse event reports);
d. Serve on the Consent Form Template and Forms sub-committees, or others as requested by the CPHS Chairperson; and
e. Serve as the Co-Vice Chair to the CPHS.

2.7.4.3. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the DHHS designee. The availability of additional federal funds to support the implementation of additional Evidence Based Practices may also necessitate a renegotiation of priorities outlined in this deliverables plan, and a reallocation of the Contractor's time in order to assist with the construction of federal grant applications. Changes agreed upon may be subject to Governor and Executive Council approval.

2.7.5. Time Studies

2.7.5.1. The Contractor shall be responsible for performing regular time studies in accordance with CMS and DHHS Medicaid Cost Allocation procedures in order to document activities, relating directly to the administration of the Medicaid program, to draw down federal matching revenues, which will be utilized to support costs associated with the Behavioral Health Medical Director's salary, benefits, and indirect expenses. These studies shall be provided in and documented in a format approved by DHHS.

2.8. Specific Service Requirements – Service Area #6 – Elderly and Adult Services

2.8.1. Medical Director Responsibilities

2.8.1.1. The Contractor shall provide a part-time Medical Director to the Elderly and Adult Services service area who shall provide services for the purposes of sustaining and improving the quality of services for the elderly and adults with disabilities in NH.

2.8.1.2. The Medical Director shall, in collaboration with the DHHS designee:

a. Assist in the planning and direction of the organization's medical policies and programs;
b. Strategically develop public/private partnerships with community providers, academic institutions and state/federal agencies with a focus on quality improvement;
c. Serve as a resource for chronic disease self-management or other wellness/prevention initiatives to improve the lives of individuals served by the Elderly and Adult Services service area;
d. Perform a variety of complex tasks that include the provision of medical consultation, clinical oversight, educational instruction, benefits management and quality assurance within the Elderly and Adult Services service area;
e. Provide medical oversight for all aspects of the Medicaid Program managed by the Elderly and Adult Services service area, including the waiver program for seniors and adults with disabilities, assisting in key policy decisions, identifying partnering opportunities with other program areas, and shaping administrative planning strategies to enhance the program's operating efficiency and cost effectiveness;
f. Serve as the clinical authority in reviewing requests for coverage of services not routinely offered, and providing clinical guidance to the Elderly and Adult Services service area on all such responses, as well as collaborating on developing new service coverage to respond to needs or practices identified;
g. Promote and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the Elderly and Adult Service area;
h. Identify new developments and emerging trends in clinical practice and research that would have an impact on clinical policy and/or costs and recommend options and courses of action;
i. Identify program development opportunities within federal health care reforms, such as but not limited to the implementation of the Patient Protection Affordable Care Act (ACA) and any amendments thereto;
j. Leads planning and development of program and policy changes within the Elderly and Adult Services service area throughout the implementation of federal health care reforms, such as but not limited to the ACA and any amendments thereto;

k. Participate in the Technical Assistance Committee (TAC) that reviews clinical issues and initiatives within New Hampshire Nursing Facilities;
l. Participate in the quality assurance initiative, Sentinel Event Reviews;
m. Assist in the implementation of ACA by providing leadership in the planning and development of health care delivery systems, clinical quality initiatives and related policy issues;
n. Provide educational training to DHHS Elderly and Adult Services service area personnel, and external stakeholders;
o. Provide clinical expertise and medical consultation in Elderly and Adult Services service area grant writing and program evaluation;
p. Attend a minimum of two (2) Technical Advisor Committee meetings per annum;
q. Attend Sentinel Event Review Meetings; and
r. Meet, two times per month with the DHHS designee to review initiatives and provide consultation services.

2.9. Specific Service Requirements – Service Area #7 – Developmental Services

2.9.1. Medical Director Responsibilities

2.9.1.1. The Contractor shall provide a part-time Medical Director to the Developmental Services service area. The Medical Director shall provide services that includes two days of psychiatric consultation services per week, and is allocated at 0.4 Full-Time Equivalent.

2.9.1.2. The Medical Director shall:

a. Weekly dedicate one day to referrals from the ten Area Agencies and another day to referrals from Special Medical Services (SMS) and its child development clinics. These referrals may include the Medical Director performing evaluations, consultations and medication reviews;
b. Based on He-M 1201, chair Developmental Services' Medication Committee meetings and provide expert opinion and leadership to facilitate effective functioning of the Committee;
c. Assist the DHHS Developmental Services service area staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews;
d. Provide educational training to DHHS Developmental Services service area staff, Area Agencies, and subcontract agencies and other stakeholders, as identified by Developmental Services;
e. Provide expertise and assistance in efforts to improve New Hampshire's developmental services system; and
f. Respond to all referrals for evaluations and consultations made through the Area Agencies, SMS, and child development clinics.

2.9.2. **Adult Developmental Services Interdisciplinary Clinic Team**

2.9.2.1. The Contractor shall provide an Interdisciplinary Clinic Team for Adults. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Adults.

a. **Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination; including reviewing the client's entire past psychiatric treatment and medical history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each client;
b. **Neuropsychologist** – the neuropsychologist shall review all past psychiatric, medical records, neuropsychological testing and behavioral incidents. The neuropsychologist shall document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee the documentation of historical information regarding the client;
c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical, past psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support will schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.2.2. The Interdisciplinary Clinic Team for Adults shall provide the following services:

a. The Contractor shall ensure the Team accepts adults being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high quality interdisciplinary evaluations to adults with developmental disabilities and acquired brain injuries.

The Contractor shall provide a comprehensive understanding of the client with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the clients strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, Area Agencies and medical providers to provide the best quality of care for each person. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;

c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 clients per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records of each client prior to each face-to-face appointment. The Contractor's Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the visit and recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and
d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

2.9.3. Child Developmental Services Interdisciplinary Clinic Team

2.9.3.1. The Contractor shall provide an Interdisciplinary Clinic Team for Children. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Children.

a. **Child Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination, including reviewing the client's entire past psychiatric treatment history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each patient;
b. **Neuropsychologist** – the neuropsychologist shall review all past medical records, neuropsychological testing, and behavioral incidents; document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee writing the historical information regarding the child;

c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support shall schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.3.2. The Interdisciplinary Clinic Team for Children shall provide the following services:

a. The Contractor shall ensure the Team accepts children being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high quality interdisciplinary evaluations to children and adolescents with developmental disabilities. The Contractor shall provide a comprehensive understanding of the child with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the child's strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, area agencies and medical providers to provide the best quality of care for each child. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;
c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 client appointments per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records prior to each client's appointment. The Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of

caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the client's appointment and resulting team recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and

d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

3. Staffing

3.1. General Requirements Applicable to All Service Areas:

3.1.1. The following requirements apply to all personnel provided under the contract:

3.1.1.1. The Contractor shall recruit and retain qualified individuals for the staffing needs specified herein at subsections 3.3 through 3.9, and as otherwise necessary to fulfill the requirements described herein at: Section 2, Scope of Services; Section 4, Performance Standards and Outcomes; and Section 5, Reporting.

3.1.1.2. All such individuals shall be subject to DHHS approval prior to the Contractor notifying candidates of assignment/hire to fulfill a specified staffing role. DHHS shall inform the Contractor of its applicable designee for this purpose per position or service area. The designee, at his or her discretion, shall be entitled to interview any such candidate; the Contractor shall facilitate coordinating such interviews upon the DHHS designee's request.

3.1.1.3. DHHS, at its sole discretion, may rescind, either permanently or temporarily, its approval of any Contractor personnel providing any services under this contract for any of the following reasons:

a. Suspension, revocation or other loss of a required license, certification or other contractual requirement to perform such services under the contract;
b. Providing unsatisfactory service based on malfeasance, misfeasance, insubordination or failure to satisfactorily provide required services;
c. Arrest or conviction of any felony, misdemeanor, or drug or alcohol related offense;
d. Abolition of the role due to a change in organizational structure, lack of sufficient funds or like reasons; or
e. Any other reason which includes, but is not limited to: misconduct, violation of DHHS policy, or violation of state or federal laws and regulations pertaining to the applicable DHHS service area, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

In the event of such rescission, the Contractor's applicable staff member shall be prohibited from providing services under the contract for the period of time that DHHS exercises this right. In the event DHHS chooses to exercise this right, DHHS shall provide reasonable advance notice to the Contractor.

3.1.1.4. DHHS shall provide the Contractor with prior notice of exercising its right under subsection 3.1.1.3. and the reason for which DHHS has exercised its right. If DHHS removes Contractor personnel for any reason, no additional payments shall be paid by the State for any staff removed from duty by the Department

3.1.1.5. In the event that DHHS exercises its right under subsection 3.1.1.3.:

a. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under the contract, including but not limited to being subject to the DHHS approval specified in 3.1.1.2.;
b. The Contractor shall be responsible for providing transition services to the applicable DHHS service area to avoid the interruption of services and administrative responsibilities at no additional cost to DHHS;
c. DHHS shall inform the Contractor of the anticipated duration for which approval will remain rescinded. If the position is assigned to NHH, and if the duration of a temporarily rescinded approval is greater than seven (7) calendar days, the Contractor shall furnish within ten (10) business days replacement Contractor staff who shall meet all of the requirements for the applicable position under the contract. The Contractor shall be responsible for providing, at no additional cost to the Department, transition services to NHH to avoid service interruption;
d. It shall be at the Contractor's sole discretion whether to initiate any internal personnel actions against its own employees. However, nothing herein shall prohibit the Contractor from seeking information from DHHS regarding DHHS' decision, unless such information is otherwise restricted from disclosure by DHHS based on internal DHHS policies or rules, State of New Hampshire personnel policies, rules, collective bargaining agreements, or other state or federal laws.

3.1.1.6. The Contractor shall ensure that, prior to providing the applicable services for the applicable DHHS service area or facility, all required licenses, certifications, privileges, or other specified minimum qualifications are met for all staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable DHHS designee with a copy of all such documents. The Contractor acknowledges and agrees that DHHS shall not be held financially liable for any fees or costs for any licenses, certifications or renewal of same, nor for any fees or costs incurred for providing copies of said licenses or certifications.

3.1.1.7. The Contractor shall ensure that all staff provided under this contract are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. However, whereas the Contractor and DHHS agree that the continuity of operations and continuous provision of the staffing described in this contract at the level of 100%, is of paramount importance to the State, in addition to any required approvals by the Contractor for its employees, Contractor staff providing services shall provide timely, prior notification to the applicable DHHS designee for any anticipated leave time, unless otherwise stated herein for a specific position or service area.

3.1.1.8. All personnel provided by the Contractor shall be subject to the identified criminal background, registry, screening and medical examinations, as specified in the table below, for the applicable Service Area to which the individual is assigned contractual service responsibilities. The Contractor shall ensure the successful completion of these requirements for each individual assigned by the Contractor to perform contractual services prior to commencing work and shall ensure that such requirements are kept up to date as required; the Department shall receive copies of all documentation prior to the commencement of services and shall not be responsible for any costs incurred in obtaining the documentation described below:

Service Area		Required Background, Registry, Screening, and Medical Examinations
1	New Hampshire Hospital	Criminal Background, BEAS State Registry, DCYF Central Registry, Health Assessment (including TB testing and physical capacity examination).
2	Glencliff Home	Criminal Background (including RSO and OIG), BEAS State Registry, DCYF Central Registry, TB Testing
3	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
5	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
6	Elderly and Adult Services	Criminal Background, BEAS State Registry
7	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

3.2. General Staffing Requirements Applicable to Service Area #1 – New Hampshire Hospital

The following additional requirements shall apply specifically to personnel provided to fulfill the contractual requirements applicable to Service Area #1 – NHH, for the duration of the contract:

3.2.1. The Contractor shall ensure that the Chief Medical Officer actively participates in the recruitment of all other staffing needs required under the contract for the provision of services at NHH.

3.2.2. The Contractor shall ensure that, prior to commencing practice at NHH, all psychiatrists are licensed to practice medicine in the State of New Hampshire, as well as boarded in their particular specialty or are board eligible, and shall commence the privileging process of the Medical Staff Organization of NHH as authorized by its by-laws. Such licenses and clinical privileges must be maintained throughout the term of the contract.

3.2.3. The Contractor shall ensure that all clinical personnel maintain appropriate licensure/certification relevant to the practice of their clinical disciplines.

3.2.4. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Chief Medical Officer role.

3.2.5. In addition to the provisions stated herein at subsection 3.1.1.7., staff providing services to NHH shall provide timely, prior notification to the Chief Medical Officer and the NHH CEO for any anticipated leave time. The Contractor shall be solely responsible for providing, at no additional cost to DHHS, qualified, sufficient staff coverage to fill any gap in coverage during any anticipated leave time, including sick leave; lasting more than three (3) consecutive days unless otherwise agreed upon by the NHH CEO on a case-by-case basis, and for providing appropriate transition between staff members covering for those on leave. Qualified sufficient staff coverage shall mean personnel who meet or exceed the qualifications of the vacating staff member.

3.2.5.1. The Contractor acknowledges and understands that DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

3.2.6. DHHS reserves the right, through its NHH CEO, or other designee in the absence of the NHH CEO or a vacancy in that position, at its sole discretion to rescind, either temporarily or permanently, its approval of any Contractor staff member providing services at NHH for any of the following reasons:

3.2.6.1. Loss of medical staff privileges at NHH pursuant to medical staff by-laws;

3.2.6.2. Revocation or suspension of the Chief Medical Officer's New Hampshire medical license;

3.2.6.3. Arrest or conviction of a felony, misdemeanor or drug or alcohol related offense; or

3.2.6.4. Any other reason, which includes, but is not limited to: misconduct, violation of NHH or DHHS policy or state or federal laws or regulations, malfeasance, unsatisfactory work performance, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

Should DHHS exercise this right, the applicable staff member shall be prohibited from providing services under the contract for any period of time DHHS chooses.

3.2.7. If the NHH CEO removes Contractor staff assigned to this service area, including the Chief Medical Officer, for any reason, the Contractor shall not be entitled to payment for the staff member during the period of removal.

3.2.8. If approval of the Chief Medical Officer is temporarily rescinded, pursuant to subsection 3.1.1.3., the Contractor shall furnish within ten (10) business days a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.2.9. DHHS shall provide Contractor staff at NHH with adequate facilities and DHHS-employed administrative support staff. Facilities shall include, but not be limited to, office space, equipment, and furnishings. Sufficient space to accomplish educational, training, and research missions shall also be made available. Administrative support staff shall include, but not be limited to, secretarial assistance, including one full-time executive secretary to support the Chief Medical Officer.

3.2.10. The Contractor, the Chief Medical Officer and all other clinical staff provided by the Contractor shall execute their responsibilities pursuant to this contract consistent with RSA Chapter 135-C, any applicable administrative rules, the by-laws of the NHH's Medical Staff Organization, The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), and in accordance with generally accepted medical standards and practices.

3.3. Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital

3.3.1. Chief Medical Officer

3.3.1.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Chief Medical Officer for NHH. The Chief Medical Officer shall possess the following qualifications and meet the following requirements:

a. The Chief Medical Officer shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Chief Medical Officer shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Chief Medical Officer shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Chief Medical Officer shall

have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.1.2. The Chief Medical Officer may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Chief Medical Officer shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.1.3. Notwithstanding the foregoing allowance for educational or research activities, the Chief Medical Officer shall be physically present onsite at NHH not less than 36 hours per week. The Chief Medical Officer shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.1.4. In the event the Chief Medical Officer resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish within ten (10) business days, not including holidays, a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.1.5. The Chief Medical Officer shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;
b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and

e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.1.6. On an annual basis, the Chief Medical Officer and the NHH CEO shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.2. Associate Medical Director

3.3.2.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Associate Medical Director for NHH. The Associate Medical Director shall possess the following qualifications and meet the following requirements:

a. The Associate Medical Director shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Associate Medical Director shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.
b. The Associate Medical Director shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Associate Medical Director shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, addiction, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.
c. For purposes of this paragraph, the term "full-time" shall mean that the Associate Medical Director shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.2.2. The Associate Medical Director may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Associate Medical Director shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.2.3. Notwithstanding the foregoing allowance for educational or research activities, the Associate Medical Director shall be physically present onsite at NHH not less than 36 hours per week. The Associate Medical Director shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.2.4. In the event the Associate Medical Director resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish, within 10 business days, not including holidays, a psychiatrist to serve full-time as interim NHH Associate Medical Director, until such time as the existing Associate Medical Director either resumes duty full-time or is replaced by a new Associate Medical Director. The interim Associate Medical Director shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.2.5. The Associate Medical Director shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;
b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and
e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.2.6. On an annual basis, the Associate Medical Director, together with the Chief Medical Officer and the NHH CEO, shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.3. Psychiatrists

3.3.3.1. The Contractor shall provide eleven (11) General Psychiatrists for the adult units at NHH:

a. All psychiatrists shall have appropriate experience in the specialty they are boarded or board eligible in;
b. All psychiatrists shall have completed an ACGME approved residency program in psychiatry;
c. At least one psychiatrist shall be dedicated full-time to provide services to the Inpatient Stabilization Unit (ISU); and

d. At least one psychiatrist shall be certified in addiction treatment this psychiatrist shall be a physician who is certified in general psychiatry and has significant clinical experience in addiction medicine. A fellowship training and/or board certification in Addiction Medicine or Addiction Psychiatry is highly desirable.

3.3.4. Child/Adolescent Psychiatrists

3.3.4.1. The Contractor shall provide four (4) Child/Adolescent Psychiatrists who have successfully completed their fellowship.

a. All psychiatrists shall have completed both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry.

3.3.5. Geropsychiatrist

3.3.5.1. The Contractor shall provide one (1) geropsychiatrist who has:

a. Completed an ACGME approved residency program in psychiatry, and be board certified by the American Board of Psychiatry and Neurology in Psychiatry; and
b. Completed a 1-year geropsychiatry fellowship and is specialty certified by the American Board of Psychiatry and Neurology in geriatric psychiatry. Two years of additional clinical experience in geriatric psychiatry may be substituted for fellowship training.

3.3.6. Director of Neuropsychology Laboratory

3.3.6.1. The Contractor shall provide a senior neuropsychologist who has:

a. Past experience shall include leadership responsibilities in MRI operations and the ability to integrate cognitive test results with data from structural and functional brain imaging;
b. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and shall have completed a neuropsychology postdoctoral fellowship (Houston guidelines); and
c. Evidence of scientific productivity in relation to the SPMI population and the ability to generate proposals for federal and foundation support is preferred.

3.3.7. Neuropsychologist

3.3.7.1. The Contractor shall provide a neuropsychologist who has:

a. A minimum of 2 years of post-fellowship experience in neurocognitive screening and comprehensive neuropsychological assessment protocols appropriate to public sector severely mentally ill and behaviorally challenged populations;
b. Experience in the integration of cognitive test results with data from structural and functional brain imaging; and
c. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and has completed a neuropsychology postdoctoral fellowship (Houston guidelines).

3.3.8. Neuropsychologist Trainees

3.3.8.1. The Contractor shall provide three neuropsychologist trainees who:

a. Shall be clinical psychology graduate students who are obtaining specialty training in neuropsychology; and
b. Shall have three to four years of graduate instruction and training, including training experience in general psychology.

3.3.9. General Medical Director

3.3.9.1. The Contractor shall provide one full-time physician to fulfill the role of General Medical Director who shall be a primary care or internal medicine physician who has completed residency with at least three years of experience in supervising primary care clinicians. A board certification in a primary care field is preferred.

3.3.10. General Medical Physician

3.3.10.1. The Contractor shall provide one full-time physician who is a primary care or internal medicine physician who has completed residency with at least three years of experience. A board certification in a primary care field is preferred.

3.3.11. Forensic Psychologist

3.3.11.1. Beginning in SFY 2018, the Contractor shall provide a full-time forensic psychologist. The forensic psychologist shall be a clinical psychologist (PhD or Psy.D.) with significant clinical experience in forensic psychology. A certification in forensic psychology is preferred.

3.3.12. Residents/Post Graduate Fellows

3.3.12.1. For all residents/post graduate fellows the Contractor provides to NHH under this contract, the responsibilities shall be outlined, monitored and reviewed by the Chief Medical Officer and the appropriate, attending psychiatrist.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall rotate PGY II residents and a PGY IV (chief resident) through NHH.
b. Child/Adolescent Fellows – The Contractor shall rotate three (3) child/adolescent fellows (combined 1 FTE) apportioned through the PGY IV and PGY V years or PGY V and VI years (1st and 2nd year fellows) through NHH.
c. Geropsychiatry Fellow – The Contractor shall rotate a geropsychiatry fellow (PGY V) through the NHH.
d. Public Psychiatry Fellow – The Contractor shall rotate a public psychiatry fellow through the NHH.

3.3.13. Psychiatric Advanced Practice Registered Nurses (APRN)

3.3.13.1. The Contractor shall provide six full-time Psychiatric Advanced Practice Registered Nurses.

a. Psychiatric APRNs shall possess an APRN degree and have board certification as Psychiatric–Mental Health Nurse Practitioner-Board.

b. At least one Psychiatric APRN with specialty in addiction or the requisite number of hours of experience in addiction treatment shall be provided.
c. At least one Psychiatric APRN shall be dedicated full-time to provide services to the ISU.

3.3.14. NHH Research Manager

3.3.14.1. The Contractor shall provide a full-time NHH Research Manager, as described below:

a. The Research Manager requires a thorough knowledge and understanding of clinical research, research protocols, and clinical operations, knowledge of GCPs and federal regulations related to human subject research, knowledge of patient privacy and confidentiality, ability to manage teams of professionals, maintain meticulous study records, laboratory data and other information related to research protocols, and manage complex schedules and competing priorities.
b. The Research Manager shall meet the following minimum experience and education requirements:
   i. Master's degree in management or health or research related area;
   ii. Five or more years of relevant experience in clinical trials research support;
   iii. Experience with industry sponsored, federally sponsored and investigator initiated clinical research;
   iv. Experience with clinical trial budgets and billing;
   v. Through knowledge of clinical research, research protocols and clinical operations; and
   vi. Knowledge of Good Clinical Practices (GCP's) and federal regulations related to research.

3.3.15. Schedule and Allocation of Positions – Service Area #1 – NHH

3.3.15.1. The following schedule shall reflect the full (100%) staffing complement for which the Contractor shall provide the required staff, consistent with the requirements described in the Contract for the full term of the contract.

Position Title	Full-Time Equivalent
a. Chief Medical Officer	1.0
b. Associate Medical Director	1.0
c. General Psychiatrists	11.0
d. Psychiatric APRNs	6.0
e. Child/Adolescent Psychiatrists	4.0
f. Geropsychiatrist	1.0
g. Director of Neuropsychology Laboratory	0.5
h. Neuropsychologist	1.0
i. Neuropsychologist Trainees	3.0
j. General Medical Director	1.0
k. General Medical Physician	1.0

l. Forensic Psychologist	1.0
m. PGY IV Residents	1.0
n. PGY II Residents	1.5
o. Child/Adolescent Fellow	1.0
p. Geropsychiatry Fellow	0.5
q. Public Sector Psychiatry Fellow	1.0
r. Research Manager	1.0

3.4. Specific Staffing Requirements – Service Area #2 – Glencliff Home

3.4.1. Medical Director

3.4.1.1. The Contractor shall, for the term of the contract, provide the part-time services of one (1) geropsychiatrist to serve at the Glencliff Home as the Medical Director. This position shall be a 0.4 Full-Time Equivalent.

3.5. Specific Staffing Requirements – Service Area #3 – Medicaid Program

3.5.1. Department of Health and Human Services Chief Medical Officer –

3.5.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated physician, identified by the Department to serve as the Chief Medical Officer. This position shall be a 1.0 Full-Time Equivalent.

3.5.1.2. The Contractor shall ensure that the Chief Medical Officer provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Chief Medical Officer shall provide timely, prior notification to the DHHS Designee of any leave time taken. Absences due to vacation and continuing education shall be planned in advance, in consideration of the business needs of the Medicaid program – including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Chief Medical Officer is on leave.

3.5.1.3. The Chief Medical Officer shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;
c. A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;
d. Have a minimum of five years of experience in a position of clinical leadership for a major public sector program, government authority or other organization involved in the delivery of public Medicaid services;

e. Have work experience in managed care settings focused on improved health outcomes;
f. Have fellowship and/or work experience in research in health services, outcomes and/or policy, as well as the ability to work collaboratively with team members and the provider community;
g. Have extensive experience and judgment to plan and accomplish goals working in a team environment;
h. Demonstrate strong verbal and written communication skills;
i. Work collaboratively with Medicaid staff to achieve program goals in an efficient and timely manner;
j. Have Board certification in either Family Medicine, Preventive Medicine/Community Health, Internal Medicine, Pediatrics, or Obstetrics and Gynecology, and with a strong working knowledge of primary care medicine;
k. Must be well versed in the regulations governing the federal Title XIX Medicaid and Title XXI Medicaid and CHIP programs and how those programs are administered in New Hampshire;
l. Possess a high degree of creativity and initiative;
m. Have expertise in clinical, policy, or outcomes research; and
n. Have work experience in project management, grant writing, contract management, and program evaluation.

3.6. Specific Staffing Requirements – Service Area #4 – Children, Youth and Families

3.6.1. Staff Psychiatrist

3.6.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. This position shall be a 1.0 Full-Time Equivalent.

3.6.1.2. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Staff Psychiatrist.

3.6.1.3. The Staff Psychiatrist shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Specialty in both child psychiatry and criminal justice;
c. Completion of both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry;
d. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
e. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
f. Possess at least five (5) years post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

3.7. Specific Staffing Requirements – Service Area #5 – Behavioral Health

3.7.1. Medical Director

3.7.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Behavioral Health service area, as identified by the Department. This position shall be available on-site at a DHHS designated location for twenty (20) hours per week (0.5 FTE).

3.7.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
c. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
d. Have at least five (5) years of experience in public mental health and services for people with mental illness.

3.7.2. Support Staff CPHS

3.7.2.1. The Contractor shall, for the term of the contract, provide a part-time Support Staff to support the Committee for the Protection of Human Services. This position shall be allocated at 0.15 FTE.

3.7.2.2. The Contractor shall, for the term of the contract, provide a part-time Research Assistant. This position shall be allocated at 0.5 FTE.

3.7.3. Evidence-Based Practice Trainer/Consultant

3.7.3.1. The Contractor shall, for the term of the contract, provide part-time Evidence-Based Practice Trainers/Consultants. These positions shall be allocated, in total, at 1.5 FTE.

3.7.4. Behavioral Health Policy Institute

3.7.4.1. The Contractor shall, for the term of the contract, provide a part-time Behavioral Health Policy Institute Consultant. This position shall be allocated at 0.1 FTE.

3.8. Specific Staffing Requirements – Service Area #6 – Elderly and Adult Services

3.8.1. Medical Director

3.8.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Elderly and Adult Services service area. This position shall be allocated at a 0.03 Full-Time Equivalent.

3.8.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Gerontology or Preventive Medicine/Community Health;
c. Possess expertise in clinical, policy or outcomes research; and
d. Be well versed in the regulations governing the federal Title XIX Medicaid program, including requirements for the operation of

waiver and State Plan services, and Title XX, the Social Service Block Program and services provided under the Older Americans Act.

3.9. Specific Staffing Requirements – Service Area #7 – Developmental Services

3.9.1. Medical Director

3.9.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Developmental Services service area. This position shall be allocated at 0.4 Full-Time Equivalent.

3.9.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Child and Adult Psychiatry; and
c. Possess expertise and experience in developmental disability, including Autism Spectrum Disorders.

3.9.2. Adult Developmental Services Interdisciplinary Clinic Team

3.9.2.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Adult Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

a. Psychiatrist ..... 0.1 FTE
b. Neuropsychologist ..... 0.05 FTE
c. Neuropsychology Fellow ..... 0.05 FTE
d. Neurologist ..... 0.025 FTE
e. Primary Care Physician ..... 0.025 FTE
f. Occupational Therapist ..... 0.025 FTE
g. Administrative Support ..... 0.025 FTE

3.9.3. Child Developmental Services Interdisciplinary Clinic Team

3.9.3.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Child Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

a. Child Psychiatrist	0.10 FTE
b. Neuropsychologist	0.05 FTE
c. Neuropsychology Fellow	0.05 FTE
d. Neurologist	0.025 FTE
e. Primary Care Physician	0.025 FTE
f. Occupational Therapist	0.025 FTE
g. Administrative Support	0.025 FTE

4. Performance Standards and Outcomes

4.1. Service Area #1 – Chief Medical Officer – NHH

4.1.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the NHH CEO, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the NHH CEO prior to being effective. The performance metrics shall be reviewed by the NHH CEO on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the NHH CEO.

4.1.2. The Contractor shall ensure the services provided by the Chief Medical Officer at NHH are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool to solicit input from the NHH CEO regarding the Chief Medical Officer's provision of services under the contract.

4.1.3. The Contractor shall develop a corrective action plan to address any concerns raised by the NHH CEO in the evaluation tool, and provide a copy of such plan to the NHH CEO for review. If the NHH CEO disagrees with the Contractor's proposed resolutions within the corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution with the Contractor.

4.2. Service Area #1 – Clinical Staff – NHH

4.2.1. Staffing levels shall be maintained at 100% at all times throughout the contract, with the exception of the leave provisions and approval processes described in the subsections applicable to each staffing need.

4.2.1.1. DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

4.2.2. The Contractor shall ensure the following performance standards are met by all clinical staff provided by the Contractor to provide services at NHH:

4.2.2.1. Clinical staff shall support the optimum functioning of the Medical Staff Organization as evidenced by attendance of Medical Staff Organization meetings and participation in assigned committees and task forces at a rate of no less than 80% participation, excluding approved absences;

4.2.2.2. Clinical staff shall support the completion of all required documentation regarding patients as evidenced by satisfactorily completing documentation regarding patient admission, discharge and during the inpatient stay – in compliance with hospital policy – within twelve (12) months of beginning the provision of services at NHH under the contract; and by satisfactorily completing all required documentation consistent with normative data collected by the compliance officer and utilization review manager.

4.2.2.3. Clinical staff shall provide clear treatment plans with specific interventions and regular updates as required by NHH policy;

4.2.2.4. Clinical staff shall provide daily progress notes with sufficient detail to meet medical necessity and level of care criteria;

4.2.2.5. Clinical staff shall provide regular progress notes focused on specific reasons for admission and plan towards discharge; and

4.2.2.6. Clinical staff shall provide written explanation of medication decisions and reasons for change when not effective.

4.3. Service Area #3 – Chief Medical Officer – Medicaid

4.3.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the DHHS Designee, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the DHHS Designee prior to being effective. The performance metrics shall be reviewed by the DHHS Designee on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the DHHS Designee.

4.3.2. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS Designee regarding the Chief Medical Officer's provision of services under the contract.

4.3.3. Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer, in collaboration with the DHHS Designee. In the case of a newly hired Chief Medical Officer, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.4. Service Area #4 – Staff Psychiatrist – Children, Youth and Families

4.4.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and at each contract anniversary thereafter, the Contractor and the DHHS designee, in consultation with the Staff Psychiatrist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychiatrist. The performance metrics shall be approved by the DHHS designee prior to being effective. The performance metrics shall be reviewed by the DHHS designee on at least a quarterly basis with the Staff Psychiatrist. These meetings shall be documented with written progress notes by the DHHS designee.

4.4.2. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if needed, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS designee regarding the Staff Psychiatrist's provision of services under the contract.

Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist, in collaboration with the DHHS designee. In the case of a newly hired Staff Psychiatrist, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.5. Quality Assurance Plan and Monitoring

The following Quality Assurance Plan and Monitoring shall be provided by the Contractor, subject to modification and/or augmentation as required by DHHS:

4.5.1. Service Area #1 – New Hampshire Hospital – Chief Medical Officer

4.5.1.1. The Contractor shall provide oversight of the performance of the Chief Medical Officer toward these Performance Standards and Quality Assurance Monitoring goals.

4.5.1.2. Pending development of final program metrics as required herein at subsection 4.1.1., in partnership with the NHH CEO, the Chief Medical Officer shall be responsible for the following program outcomes:

a. Ensuring the program is staffed adequately to operate NHH beds at full utilization;
b. Ensuring that Contractor staff receive necessary supervision and training to perform the tasks they are assigned;
c. Assuring that patients receive care consistent with evidence-based care;
d. Creation and implementation of highest standard practices to protect the safety of patients, staff, and visitors; and
e. Other responsibilities detailed herein at subsection 2.3.1.

4.5.1.3. The Chief Medical Officer shall be responsible for monitoring progress toward these goals and providing regular reports, at minimum on a quarterly basis or more frequently if needed, to the NHH CEO and to the Chair of the Department of Psychiatry or his designee. The Chief Medical Officer will meet at minimum on a quarterly basis or more frequently if needed, with the Chair of the Department of Psychiatry (or his or her designee) and the NHH CEO to review progress toward these metrics. The metrics above shall be considered preliminary metrics, subject to refinement, as described herein at subsection 4.1.1., and shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.1.4. The content of the performance metrics to be measured shall be such that they assure that the Chief Medical Officer is fulfilling his or her administrative/clinical responsibilities as detailed herein at subsection 2.3.1. The following metrics shall be relevant to the Chief Medical Officer's fulfillment of his or her responsibilities:

a. The results of all Joint Commission, CMS, and other surveys pertaining to NHH;
b. Reports on clinical documentation by clinical staff;
c. Lists demonstrating completion of annual reviews of all Contractor-provided NHH clinicians to demonstrate active management, oversight, and discipline (when needed) of clinicians. The annual reviews shall include evidence of input from the NHH CEO (or their designee) on performance;
d. Records of attendance at meetings with:
   i. The NHH CEO indicating participation in formulation, implementation and supervision of all clinical programs, participation in budgeting, recruiting, plan for employment schedule, and supervision and educational plan for all Contractor-provided NHH clinical staff;
   ii. Other DHHS representatives - showing consultation in the development of the State mental health system;
   iii. NHH Executive Committee – showing executive participation; and
   iv. Executive Committee of the NHH Medical Staff Organization – showing participation in oversight of physician work; and
e. Report on availability of beds in NHH that are open for care – indicating adequate provider staffing to operate at full capacity.

4.5.1.5. The NHH CEO shall review these metrics at least quarterly with the NHH Chief Medical Officer.

4.5.2. Monitoring – Service Area #1 – New Hampshire Hospital – Chief Medical Officer:

4.5.2.1. The NHH Director of Quality Management and his or her staff shall conduct medical record and quality compliance monitoring. Monitoring shall take place through:

a. The routine reviews of The Joint Commission, CMS, and other overseeing groups;
b. The routine NHH documentation monitoring reports produced at NHH;
c. Department of Psychiatry tracking of Annual Review completion that is a routine process of the Department;
d. Use of attendance sheets that can be developed for this purpose; and
e. Routine monitoring of bed availability.

4.5.2.2. NHH support staff shall gather information regarding meeting attendance. The NHH Director of Quality Management and his or her staff shall gather the balance of collected metrics into a report. The collected data shall be provided to the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) on a quarterly basis.

4.5.2.3. The findings from this monitoring shall be discussed in scheduled meetings between the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) at meetings that shall take place on a quarterly basis or more frequently if needed. Both parties shall maintain their notes from each quarterly meeting to support the annual performance review process.

4.5.2.4. The monitoring data, including the notes described herein at subsection 4.5.2.3., and feedback solicited from the NHH CEO shall be part of the Chief Medical Officer's annual performance review. The Contractor shall document the annual performance review on the Department's standard annual evaluation tool.

a. If there are performance difficulties that require a corrective action plan, the Contractor shall develop a proposed corrective action plan and shall share and discuss the plan with the NHH CEO prior to issuance to the Chief Medical Officer. If the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry and the NHH CEO disagree on the proposed corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution.

4.5.2.5. This plan shall be updated and revised at least annually, by the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, working with the NHH CEO and in consultation with the NHH Chief Medical Officer. New goals may be set at any time but shall be set at least annually. New goals may trigger new metrics.

4.5.3. Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.3.1. Within 45 days of the contract effective date, the Chief Medical Officer, or his or her designee, shall work with the NHH CEO and the NHH Director of Quality Management to develop a list of performance metrics based on the expected deliverables, functions and responsibilities for each staff member as described herein at the applicable subsection in Section 2. The metrics shall monitor, at a minimum, the performance standards describe herein at subsection 4.2. The NHH CEO shall review these metrics at least quarterly with the Chief Medical Officer. This selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.3.2. The content of the performance metrics to be measured shall be such that they assure the Clinical Staff are fulfilling their administrative/clinical responsibilities as described herein at Section 2 for the applicable position. The following metrics are relevant to the Clinical Staff's fulfillment of their responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance lists of Medical Staff Organization (and assigned committees and task forces) that show who is expected to attend and who did attend;
b. Measurements of compliance with documentation policies;

c. Measurement of adherence with treatment plan policies;
d. Measurement of progress note adherence to policies including showing medical necessity and need for level of care and demonstration of reason for admission and progress towards discharge, and explanation of medical decisions and reasons for change when the plan is not effective.

4.5.4. Monitoring – Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.4.1. Monitoring of the metrics for the NHH Clinical Staff shall take place as part of the routine data collection of the NHH Quality Management Staff. The collected data shall be provided to the Chief Medical Officer and the NHH CEO on a quarterly basis.

a. The performance metrics that are developed shall involve measurements and documentation that must be collected, including meeting attendance records. Other NHH staff may be involved in data collection efforts, including staff within the information technology, health information and utilization management sections depending on the content of the developed performance metrics.

4.5.4.2. The NHH CEO, the NHH Director of Quality Management, and the Chief Medical Officer shall speak at least quarterly about the performance of the NHH Clinical Staff. Each individual shall maintain notes of every quarterly meeting; these notes shall be used to support the annual performance review process for NHH Clinical Staff. If there are performance difficulties that require a corrective action plan, the identified issues shall be discussed with the Chief Medical Officer in order to initiate an appropriate course of action to address the identified difficulty or difficulties.

4.5.4.3. Annual reviews of Clinical Staff shall be documented by the Chief Medical Officer, or his or her designee, on the Contractor's Department of Psychiatry Annual Review form. Annual reviews shall include findings for quality assurance monitoring and feedback on performance from DHHS leaders.

4.5.5. Service Area #3 – Medicaid – Chief Medical Officer

4.5.5.1. Within 45 days of the contract effective date, the Contractor shall work with the DHHS designee overseeing the Medicaid service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.5. Together, these metrics shall form an evaluation tool. The Chief Medical Officer shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Medicaid service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.5.2. The DHHS designee shall review the findings from monitoring of these metrics at least quarterly with the Chief Medical Officer.

4.5.5.3. The Chief Medical Officer role requires initiative, relationship building, and high level leadership. The following metrics are relevant to the Chief Medical Officer's fulfillment of his or her responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance records of Medicaid Management Team meetings; and
b. A checklist of core duties and expectations, as described herein at subsection 2.5, with feedback solicited on a quarterly or semi-annual basis from the members of the Medicaid Management Team and/or other key informants, designed to monitor performance. The checklist shall rate performance and allow for comments that will help guide improvement.

4.5.6. Monitoring – Service Area #3 – Medicaid – Chief Medical Officer

4.5.6.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Checklist feedback from the Medicaid Management Team. Source: Medicaid Management Team members; and
b. Collection and collating of attendance records from the Medicaid Management Team meetings. Source: DHHS administrative support staff.

4.5.6.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Chief Medical Officer;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Chief Medical Officer's performance on the metrics.
c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.6.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Chief Medical Officer's annual performance review. This review shall be conducted at six months for a new Chief Medical Officer then annually thereafter.

4.5.6.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Chief Medical Officer shall collaborate to establish goals for the upcoming year as part of the performance evaluation process.

a. New goals may be set at any time but shall be set at least annually.

4.5.6.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.7. Service Area #4 – Children, Youth and Families – Staff Psychiatrist

4.5.7.1. Within 45 days of the contract effective date, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall work with the DHHS designee overseeing the Children, Youth and Families service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.6. Together, these metrics shall form an evaluation tool. The Staff Psychiatrist shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Children, Youth and Families service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.7.2. The content of performance metrics developed shall be such that they assure the Staff Psychiatrist is fulfilling his or her administrative and clinical responsibilities as described herein at subsection 2.6. The following metrics are relevant to the Staff Psychiatrist and shall be part of the plan for monitoring contract fulfillment:

a. Monitoring of work hours;
b. Regular checks of the Staff Psychiatrist's electronic calendar to be sure it includes proposed leave time, conferences, and trainings;
c. Clinical documentation monitoring to be sure it meets standards of timeliness and completeness established by Children, Youth, and Families;
d. Counts of activities such as the number of treatment team meetings and clinical consultations provided, types and numbers of evidence-based practices provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and
e. Checklist feedback on effectiveness in establishing interagency collaboration between Juvenile Justice Services, area mental health services, and NHH.

4.5.8. Monitoring – Services Area #4 – Children, Youth & Families – Staff Psychiatrist

4.5.8.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Counts of Activities. Source: Staff Psychiatrist; and
b. Clinical documentation monitoring. Source: DHHS staff.

4.5.8.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Staff Psychiatrist;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Staff Psychiatrist's performance on the metrics.
c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.8.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Staff Psychiatrist's annual performance review. This review shall be conducted at six months for a new Staff Psychiatrist then annually thereafter.

4.5.8.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Staff Psychiatrist shall collaborate to establish goals for the upcoming year as part of the performance evaluation process.

a. New goals may be set at any time but shall be set at least annually.

4.5.8.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.9. Service Areas #2, 3, 5, 6 and 7

4.5.9.1. Upon DHHS request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes, similar to those described herein at subsection 4.5. For Service Areas 2, 3, 5, 6 and 7.

4.5.10. All Other Positions

4.5.10.1. All staff provided by the Contractor, not otherwise addressed herein at subsection 4.5, shall have annual performance reviews. The Contractor shall conduct such reviews and first obtain feedback from the applicable DHHS designee for the service area in which the staff is assigned to provide services. This feedback shall be a core element of the annual performance review process. The Contractor shall ensure that goal development is responsive to the evolving needs of DHHS over the course of the contract period.

5. Reporting

5.1. Service Area #1 – New Hampshire Hospital

5.1.1. In addition to other reports as agreed to by the parties, on an annual basis, the Contractor shall make a report in writing to DHHS that is descriptive of the Chief Medical Officers' and the clinicians' services provided by the Contractor and the Contractor's performance under this contract during the preceding contract year, the research activities provided during the preceding contract year, and planned research activities for the current contract year.

5.1.2. On an annual basis, DHHS shall submit to the Contractor a report in writing containing DHHS' evaluation of the Contractor's performance pursuant to this contract during the preceding year.

5.1.3. On a quarterly basis, or as otherwise more frequently required by the United States Department of Health and Human Services regulations, DHHS and in a form specified by DHHS, the Contractor shall provide a written report to DHHS documenting the services provided by the Contractor's staff in sufficient form and with sufficient detail to satisfy the reporting requirements of Medicare, Medicaid, and other third-party providers.

5.2. All Service Areas

5.2.1. The Contractor shall maintain and provide the DHHS designee(s) identified by the Department with up-to-date detailed personnel listings for all Contractor staff performing services under this contract. The listings shall include information, including, but not limited to; the names, titles, position costs (including salary and fringe benefit costs, direct and indirect rates), for each position for each service area for each state fiscal year, or more frequently as required by DHHS, to ensure the accuracy of information contained therein and to ensure proper cost allocation. The listings shall be in a format as determined and approved by DHHS.

6. Compliance

6.1. Continuity of Services

6.1.1. The Contractor and the Department agree that:

6.1.1.1. It will be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit A, Sections 2 through 5;

6.1.1.2. Any breach by the Contractor will delay and disrupt the Department's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services; The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in this Exhibit A, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in Exhibit B; and

6.1.1.3. The liquidated damages as specified in Exhibit B are reasonable and fair and not intended as a penalty.

7. Definitions

CMS – Centers for Medicare and Medicaid Services

CPHS – Committee for the Protection of Human Subjects.

Department – New Hampshire Department of Health and Human Services

DHHS – New Hampshire Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

TJC – The Joint Commission

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, in consideration for the Contractor's compliance with the terms and conditions of this Agreement and for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. Agreement Period: Effective November 1, 2016, or the date of Governor and Executive Council approval, whichever date is later, through June 30, 2019.
3. Funding Sources: The services described in Exhibit A, Scope of Services, are funded with:
   - 40% Other Funds (Medicare, Medicaid & third party insurance);
   - 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
   - 32% General Funds.

   3.1 DHHS reserves the right to adjust funding sources throughout the Agreement Period and will provide the Contractor reasonable notice of any such changes. Adjustments made may require a mutually agreed upon contract amendment.

   3.2 Funds must be used in accordance with the provisions of the specified CFDA numbers.
4. This is a firm, fixed price contract. The Contractor shall provide services under this Agreement based on the Budget specified below per applicable Service Area and State Fiscal Year. The Contractor shall be compensated, for providing and delivering the services described in Exhibit A, Scope of Services, on the basis of this Budget.

Budget			
Agreement Period by State Fiscal Year			
Service Area	**11/1/16-6/30/17**	**7/1/17-6/30/18**	**7/1/18-6/30/19**
1: New Hampshire Hospital	$8,407,616	$11,471,661	$11,862,758
2: Glencliff Home	$114,511	$152,934	$158,544
3: Medicaid	$278,300	$374,358	$388,407
4: Children, Youth & Families	$325,491	$392,391	$407,002
5: Behavioral Health	$351,661	$477,825	$494,500
6: Elderly and Adult Services	$21,000	$28,152	$29,199
7: Developmental Services	$219,576	$293,655	$304,490

   4.1 Any amendments to this Budget will require a written agreement by the parties in the form of a contract amendment, which may be subject to Governor and Executive Council approval and at minimum shall be subject to Attorney General approval.
5. **Invoicing**: The Contractor shall invoice DHHS monthly for services performed in accordance with the contract on invoices the format of which will be identified and approved by DHHS. The Contractor shall ensure that DHHS receives within thirty (30) days following the end of the month in which services were provided, the applicable invoice. The State shall make payment to the Contractor within thirty (30) days of receipt of an accurate invoice for Contractor services provided pursuant to this Agreement. Should a discrepancy in an invoice be identified by DHHS, it shall promptly notify the designated individual identified in

Section 7, below, prior to the due date for payment. DHHS shall not be required to pay an invoice until any discrepancy with the invoice is resolved to the satisfaction of DHHS.

5.1 Invoices must be submitted to the attention of the DHHS designee at:

ATTN: [DHHS designee]
Financial Manager
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

5.2 Each monthly invoice shall distinctly identify and differentiate the expenses as charged according to each of the seven (7) Service Areas for which services are provided. The seven (7) Service Areas are as follows:

Service Area #1 – New Hampshire Hospital (NHH)
Service Area #2 – Glencliff Home
Service Area #3 – Medicaid Program
Service Area #4 – Children, Youth and Families
Service Area #5 – Behavioral Health
Service Area #6 – Elderly and Adult Services
Service Area #7 – Developmental Services

6. **Payment:** Compensation paid by DHHS shall be accepted by the Contractor as payment in full for the services provided under the Agreement. Notwithstanding anything to the contrary contained in the Agreement 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.

7. **Financial Management:** The Contractor shall designate a contact person to resolve any questions or discrepancies regarding invoices. The Contractor shall provide DHHS with the name, title, telephone number, fax number and email address of the contact person. The Contractor shall also notify DHHS in the event of a change of the designated contact person. DHHS shall provide the Contractor with the name, title, mailing address, and telephone number of the corresponding DHHS contact person. DHHS shall notify the Contractor in the event of a change in the designated contact person.

7.1 Contingent upon additional state or federal funding and pursuant to a mutually agreed upon contract amendment, the Contractor may be asked to provide additional services appropriate for inclusion in the contract's scope, if such services are not otherwise detailed in this Agreement.

8. **Liquidated Damages**

9.1 **Continuity of Services**: As specified and described in Exhibit A, subsection 6.1, Continuity of Services, the Contractor's failure to provide required staffing, required services, or meet the performance standards and reporting requirements as described in Exhibit A, Sections 2 through 5, shall result in liquidated damages.

9.2 The Contractor and DHHS agree that:

9.2.1. It will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event that the Contractor breaches this Agreement by

failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit A, Sections 2 through 5;

9.2.2. Any breach by the Contractor will delay and disrupt DHHS's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services;

9.2.3. The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in Exhibit A, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in this Exhibit B;

9.2.4. The liquidated damages as specified in this Exhibit B are reasonable and fair and not intended as a penalty; and

9.2.5. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

9.3 **Notification:** DHHS shall make all assessments of liquidated damages. Prior to the imposition of liquidated damages, as described herein, DHHS shall issue a written notice of remedies that will include, as applicable, the following:

- A citation of the contract provision violated;
- The remedies to be applied, and the date the remedies shall be imposed (cure period);
- The basis for DHHS' determination that the remedies shall be imposed;
- A request for a Corrective Action Plan from the Contractor; and
- The timeframe and procedure for the Contractor to dispute DHHS' determination.

9.3.1 If the failure to perform by the Contractor is not resolved within the cure period identified by DHHS, liquidated damages may be imposed retroactively to the date of failure to perform and will continue until the failure is cured or any resulting dispute is resolved in the Contractor's favor.

9.3.2 The Contractor's dispute of liquidated damages or remedies shall not stay the effective date of the proposed liquidated damages or remedies.

9.4 **Corrective Action Plan:** The Contractor shall submit a written Corrective Action Plan to DHHS within five (5) business days of receiving notification as specified in subsection 9.3. Notification, for DHHS review. The Corrective Action Plan shall be subject to DHHS approval prior to its implementation.

9.5 **Liquidated Damages:**

9.5.1 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the general and specific service requirements for each Service Area as identified in Exhibit A, Section 2, Scope of Services.

9.5.2 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet and maintain the staffing levels identified in Exhibit A, Section 3, Staffing.

9.5.3 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Performance Standards identified in Exhibit A, Section 4, Performance Standards and Outcomes.

9.5.4 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Reporting Requirements identified in Exhibit A, Section 5, Reporting.

9.5.5 Liquidated damages, if assessed, shall apply until the Contractor cures the failure cited in the Notification described in Subsection 9.3, or until the resulting dispute is resolved in the Contractor's favor.

9.5.6 The amount of liquidated damages assessed by DHHS shall not exceed the price limitation in Form P-37, General Provisions, Block 1.8 – Price Limitation.

9.6 **Assessment:** DHHS shall be entitled to assess and recover liquidated damages cumulatively under each section applicable to any given incident. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

9.7 **Damages Related to Failure to Document Medical Necessity**: The Contractor shall be liable to DHHS for any losses incurred by DHHS which arise out of the failure of Contractor staff to provide the required documentation to support medical necessity as identified in Exhibit A, Section 2.3.3.1. (j) and Section 2.3.5.4.

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. The Department reserves the right to renew the Agreement for up to two (2) three-year periods, at the Department's sole discretion, considering contractor performance, and subject to the continued availability of funds and approval by the Governor and Executive Council.

4. **Disputes:** The Contractor and DHHS shall work together to accomplish the mission and goals of this Agreement. Disputes regarding the responsibilities under this Agreement between the Contractor and the Department shall be referred to the Department Commissioner or designee for resolution. Notwithstanding the foregoing, nothing herein shall affect the parties' legal or equitable rights or remedies otherwise available to them.

5. **Subcontractors:** Subparagraph 19.5 of the Special Provisions, Exhibit C, of this Agreement, Subcontractors, is deleted and replaced with the following:

19.5 If the Contractor wishes to use subcontractors to perform any services or functions required by this Agreement, the Contractor shall provide the Department with prior written notice and obtain prior written consent of the Department. Such requests shall be submitted by the Contractor to the Department Commissioner.

6. **Agreement Elements/Order of Precedence:**

6.1 RFP-2017-OCOM-01-PHYSI is hereby incorporated into this Agreement.

6.2 The Contractor's proposal submitted in response to RFP-2017-OCOM-01-PHYSI is hereby incorporated into this Agreement.

6.3 The Agreement between the parties shall consist of the following documents, and in the event of any conflict or ambiguity between the Agreement documents, the documents shall govern in the following order of precedence:

6.3.1 General Provisions (P-37);
6.3.2 Exhibit A Scope of Services;
6.3.3 Exhibit B Methods and Conditions Precedent to Payment;
6.3.4 Exhibit C Special Provisions;
6.3.5 Exhibit C-1 Revisions to Special Provisions;
6.3.6 Exhibit D Certification Regarding Drug-Free Workplace Requirements;
6.3.7 Exhibit E Certification Regarding Lobbying;
6.3.8 Exhibit F Certification Regarding Debarment, Suspension and Other Responsibility Matters;
6.3.9 Exhibit G Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections;
6.3.10 Exhibit H Certification Regarding Environmental Tobacco Smoke;
6.3.11 Exhibit I Health Insurance Portability Act Business Associate Agreement;
6.3.11 Exhibit J Certification Regarding the Federal Funding Accountability and Transparency Act (FFATA) Compliance;
6.3.12 RFP-2017-OCOM-01-PHYSI-01 and all issued addenda; and
6.3.13 Contractor's proposal submitted in response to RFP-2017-OCOM-01-PHYSI.

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:

8/18/2016
Date

RAG MD
Name: Robert A. Greene, MD
Title: EVP
Chief, Population Health Management 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:

8/18/2016
Date

RMG
Name: Robert A. Greene, MD
Title: EVP
Chief Population Health Management officer

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

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:

8/18/2016
Date

Name:
Title:

Contractor Initials RAG
Date 8/18/2016

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:

8/18/2016
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:

8/18/2016
Date

[signature] MD
Name:
Title:

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) **Definitions**.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

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

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

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

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

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

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

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

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

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

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

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

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

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

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

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

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

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

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

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

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

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

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

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Mary Hitchcock Mem Hospital
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Katja S. Fox	Robert A. Greene, MD
Name of Authorized Representative	Name of Authorized Representative
Director	EVP Chief Population Health Management officer
Title of Authorized Representative	Title of Authorized Representative
8/19/16	8/18/2016
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

8/18/2016
Date

Name: Robert A. Greene, MD
Title: EVP Chief Population Health Management officer

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: _____