

10 mac



Jeffrey A. Meyers  
Commissioner

STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF THE COMMISSIONER

129 PLEASANT STREET, CONCORD, NH 03301-3857  
603-271-9389 1-800-852-3345 Ext. 9389  
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

June 4, 2019

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

**REQUESTED ACTION**

Authorize the Department of Health and Human Services to exercise a renewal option and 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 increasing the price limitation by \$43,350,069 from \$36,554,042 to an amount not to exceed \$79,904,111, and by extending the completion date from June 30, 2019 to June 30, 2022, effective upon Governor and Executive Council approval. 28% Federal Funds, 32% General Funds, and 40% Other Funds.

This agreement was originally approved by the Governor and Executive Council on September 7, 2016, (Item #6A), and subsequently amended on January 9, 2019 (Item # 5A).

Funds are anticipated to be available in the following accounts for State Fiscal Years 2020, 2021, and 2022, with authority to adjust amounts within the price limitation, and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

**SEE ATTACHED FISCAL DETAILS**

**EXPLANATION**

The purpose of this request is to continue to provide physician clinical and administrative services to specific populations served by the Department in the seven (7) distinct service areas listed below:

- Service Area #1 – New Hampshire Hospital
- Service Area #2 – Glenclyff 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

**Service Area #1 – New Hampshire Hospital**

The Contractor provides clinical and administrative services to New Hampshire Hospital and provides staffing for all inpatient care units with medical staff including 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. The Contractor provides a Director of Quality Systems and APRN Services who oversees a comprehensive Quality

Assurance program that ensures New Hampshire Hospital is meeting regulatory performance metrics that focus on excellence of patient care and prioritize 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 Contractor also provides a Director of Health Systems Data and Information Services who serves as the conduit for data collection within New Hampshire Hospital, including overseeing Health Information Services, Information Technology, and the Electronic Health Record.

### **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 provides to the Department, through the expertise a Medical Director, direct psychiatric services, treatment, and associated services for all residents of the Glencliff Home. The Medical Director serves 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. The Director serves 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 provides the services of a full-time Chief Medical Officer. The Chief Medical Officer's responsibilities 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 provides medical oversight of the state's publicly funded health insurance programs, assists in making policy decisions, and shapes 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. The Contractor provides the services of a full-time psychiatrist to provide psychiatric services to youth served by the Department. The psychiatrist provides 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 provides program development at the Sununu Youth Services Center (SYSC) and fosters improved interagency collaboration between Juvenile Justice Services, area mental health agencies, and New Hampshire Hospital to enhance mental health services for adjudicated youth. This request, if approved, will add a full-time psychologist who will assume many of the duties that are currently performed by the full-time psychiatrist, and will reduce the psychiatrist services for DCYF to a part-time position.

### **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 for 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 provides the personnel needed to help the Department achieve positive outcomes for individuals served by the behavioral health program. Personnel include a Medical Director who provides direction and expertise on key policy initiatives as well as evidence-based practices, and training consultants, who 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 provides the services of a Medical Director. The Medical Director assists 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 provides the services of a Medical Director for psychiatric consultation services as well as expert guidance and training to the Department's developmental services staff. The Contractor also provides 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 are conducted based on referrals from Area Agencies.

More than 4,286 people have received services under this contract during the past three years. This request, if approved, will provide critical support for the delivery of services by the Department to more than 4,187 individuals statewide for the next three years.

The original agreement included language in Exhibit C-1, that allows the Department to renew the contract for up to two (2) additional three (3) year periods, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Council. This request, if approved, will exercise the first three (3) year period of this renewal option.

The Department will monitor the effectiveness of the Contractor and the delivery of services required under this contract using the following performance measures:

- Staffing levels - target 100%
- Psychiatric progress notes
- Patient length of stay trending
- Treatment plan audits
- Annual evaluations of staff performance
- Adherence to certification guidelines
- Individual metrics based on outcome targets
- Documented monitoring of work hours and attendance

His Excellency, Governor Christopher T. Sununu  
and the Honorable Council  
Page 4 of 4

Should the Governor and Executive Council not authorize this request, the Department may not be able 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: 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,

A handwritten signature in black ink, appearing to read "Jeffrey Meyers", written over a horizontal line.

Jeffrey A. Meyers

Commissioner



## FISCAL DETAILS

**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**

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	48130284	\$21,000	\$0	\$21,000
2018	102-500731	Contracts for Program Services	48130284	\$28,153	\$0	\$28,153
2019	102-500731	Contracts for Program Services	48130284	\$29,199	\$0	\$29,199
			<b>Sub-Total</b>	<b>\$78,352</b>	<b>\$0</b>	<b>\$78,352</b>

**05-95-48-481010-78720000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: ELDERLY AND ADULT SERVICES, GRANTS TO LOCALS, ADMIN ON AGING GRANTS**

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2020	540-500382	Social Service Contracts	TBD	\$0	\$39,197	\$39,197
2021	540-500382	Social Service Contracts	TBD	\$0	\$41,809	\$41,809
2022	540-500382	Social Service Contracts	TBD	\$0	\$44,110	\$44,110
			<b>Sub-Total</b>	<b>\$0</b>	<b>\$125,116</b>	<b>\$125,116</b>

**05-95-92-922010-41170000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, CMH PROGRAM SUPPORT**

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102- 500731	Contracts for Program Services	92204117	\$0	\$0	\$0

## FISCAL DETAILS

2018	102-500731	Contracts for Program Services	92204117	\$0	\$0	\$0
2019	102-500731	Contracts for Program Services	92204117	\$0	\$0	\$0
2020	102-500731	Contracts for Program Services	92204117	\$0	\$517,056	\$517,056
2021	102-500731	Contracts for Program Services	92204117	\$0	\$544,803	\$544,803
2022	102-500731	Contracts for Program Services	92204117	\$0	\$572,319	\$572,319
			<b>Sub-Total</b>	<b>\$0</b>	<b>\$1,634,178</b>	<b>\$1,634,178</b>

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

SFY	Class/Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500730	Medical Payments to Providers	42151501	\$325,491	\$0	\$325,491
2018	102-500730	Medical Payments to Providers	42151501	\$392,391	\$0	\$392,391
2019	102-500730	Medical Payments to Providers	42151501	\$407,002	\$0	\$407,002
2020	102-500730	Medical Payments to Providers	42151501	\$0	\$396,688	\$396,688
2021	102-500730	Medical Payments	42151501	\$0	\$392,444	\$392,444

## FISCAL DETAILS

		to Providers				
2022	102- 500730	Medical Payments to Providers	42151501	\$0	\$413,867	\$413,867
			<b>Sub-Total</b>	<b>\$1,124,884</b>	<b>\$1,202,999</b>	<b>\$2,327,883</b>

**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**

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	47000021	\$278,300	\$0	\$278,300
2018	102-500731	Contracts for Program Services	47000021	\$374,358	\$0	\$374,358
2019	102-500731	Contracts for Program Services	47000021	\$388,407	\$0	\$388,407
			<b>Sub-Total</b>	<b>\$1,041,065</b>	<b>\$0</b>	<b>\$1,041,065</b>

**05-95-47-470010-50000000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN  
SVCS DEPT OF HHS: COMMISSIONER'S OFFICE, OFF. OF MEDICAID & BUS. POLICY,  
MEDICAID**

SFY	Class/ Account	Class/ Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2020	102-500731	Contracts for Program Services	TBD	\$0	\$408,628	\$408,628
2021	102-500731	Contracts for Program Services	TBD	\$0	\$432,119	\$432,119

## FISCAL DETAILS

2022	102-500731	Contracts for Program Services	TBD	\$0	\$455,193	\$455,193
			<b>Sub-Total</b>	<b>\$0</b>	<b>\$1,295,940</b>	<b>\$1,295,940</b>

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

SFY	Class/ Account	Class/ Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contract s for Program Services	4940580 00	\$8,407,616	\$0	\$8,407,616
2018	102-500731	Contract s for Program Services	4940580 00	\$11,471,661	\$0	\$11,471,661
2019	102-500731	Contract s for Program Services	4940580 00	\$11,862,758	\$0	\$11,862,758
<b>2020</b>	102-500731	Contract s for Program Services	4940580 00	\$0	\$11,640,759	<b>\$11,640,759</b>
<b>2021</b>	102-500731	Contract s for Program Services	4940580 00	\$0	\$12,717,827	<b>\$12,717,827</b>
<b>2022</b>	102-500731	Contract s for Program Services	4940580 00	\$0	\$13,366,111	<b>\$13,366,111</b>
			<b>Sub-Total</b>	<b>\$31,742,035</b>	<b>\$37,724,697</b>	<b>\$69,466,732</b>

**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 DETAILS

SFY	Class/ Account	Class/ Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	92204117	\$351,661	\$0	\$351,661
2018	102-500731	Contracts for Program Services	92204117	\$477,825	\$0	\$477,825
2019	102-500731	Contracts for Program Services	92204117	\$494,500	\$0	\$494,500
			<b>Sub-Total</b>	<b>\$1,323,986</b>	<b>\$0</b>	<b>\$1,323,986</b>

**05-95-91-910010-57100000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN  
SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL,  
GLENCLIFF**

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	101-500729	Contracts for Program Services	91000000	\$114,511	\$0	\$114,511
2018	101-500729	Contracts for Program Services	91000000	\$152,935	\$0	\$152,935
2019	101-500729	Contracts for Program Services	91000000	\$158,555	\$0	\$158,555
2020	101-500729	Contracts for Program Services	91000000	\$0	\$139,309	\$139,309
2021	101-500729	Contracts for Program Services	91000000	\$0	\$148,447	\$148,447
2022	101-500729	Contracts for	91000000	\$0	\$156,475	\$156,475

## FISCAL DETAILS

		Program Services				
			<b>Sub-Total</b>	<b>\$426,001</b>	<b>\$444,231</b>	<b>\$870,232</b>

**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**

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	561-500911	Specialty Services	93001000	\$20,000	\$0	\$20,000
2018	561-500911	Specialty Services	93001000	\$30,000	\$0	\$30,000
2019	561-500911	Specialty Services	93001000	\$30,000	\$0	\$30,000
2020	561-500911	Specialty Services	93001000	\$0	\$30,000	\$30,000
2021	561-500911	Specialty Services	93001000	\$0	\$30,000	\$30,000
2022	561-500911	Specialty Services	93001000	\$0	\$30,000	\$30,000
			<b>Sub-Total</b>	<b>\$80,000</b>	<b>\$90,000</b>	<b>\$170,000</b>

**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**

SFY	Class/Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	93005947	\$93,096	\$0	\$93,096
2018	102-500731	Contracts for Program Services	93005947	\$119,981	\$0	\$119,981
2019	102-500731	Contracts for Program Services	93005947	\$125,376	\$0	\$125,376

## FISCAL DETAILS

2020	102-500731	Contracts for Program Services	93005947	\$0	\$254,893	\$254,893
2021	102-500731	Contracts for Program Services	93005947	\$0	\$280,264	\$280,264
2022	102-500731	Contracts for Program Services	93005947	\$0	\$297,751	\$297,751
			<b>Sub-Total</b>	<b>\$338,453</b>	<b>\$832,908</b>	<b>\$1,171,361</b>

**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**

SFY	Class/Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	103-502664	Contracts for Operational Svcs	93015947	\$106,480	\$0	\$106,480
2018	103-502664	Contracts for Operational Svcs	93015947	\$143,673	\$0	\$143,673
2019	103-502664	Contracts for Operational Svcs	93015947	\$149,113	\$0	\$149,113
			<b>Sub-Total</b>	<b>\$399,266</b>	<b>\$0</b>	<b>\$399,266</b>
			<b>Grand Total</b>	<b>\$36,554,042</b>	<b>\$43,350,069</b>	<b>\$79,904,111</b>



**State of New Hampshire**  
**Department of Health and Human Services**  
**Amendment #2 to the Physician Clinical and Administrative Services Contract**

This 2<sup>nd</sup> Amendment to the Physician Clinical and Administrative Services contract (hereinafter referred to as "Amendment #2"), is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 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) as amended on January 9, 2019 (Item # 5A), 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, and Exhibit C-1, Revisions to General Provisions, Paragraph 3, 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 extend the term of the agreement, increase the price limitation, and 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 1.7, Completion Date, to read:  
June 30, 2022.
2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:  
\$79,904,111.
3. Form P-37, General Provisions, Section 14.2, delete: "and issued by insurers licensed in the State of New Hampshire" at the end of said section.
4. Form P-37, General Provisions, Section 15.2, modify the first sentence only to read (italicized font added to reflect newly added language): To the extent 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 the activities which the person proposes to undertake pursuant to this Agreement *as required in N.H. RSA Chapter 281-A*.
5. Form P-37, General Provisions, Section 18, by adding the following language to the end of said section: "In the event the State wishes to change the location(s) in which the services are performed by the Contractor hereunder, in whole or in part, the State shall provide Contractor with reasonable advance written notice of the same. Thereafter, the parties shall meet in good faith in order to mutually agree upon possible adjustments to the terms and conditions, if required, which shall be documented in the form of an amendment to this Agreement in accordance with this Section 18.
6. Delete Exhibit A Amendment #1, Scope of Services in its entirety, and replace with Exhibit A Amendment #2, Scope of Services.
7. Delete Exhibit B, Methods and Conditions Precedent to Payment, in its entirety and replace with





Exhibit B Amendment #2, Method and Conditions Precedent to Payment.

8. Exhibit C, Section 10, to read (italicized font added to reflect newly added language):  
**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, *except as necessary in connection with the performance of the services and permitted by law*, 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 with respect to any records which constitute patient records, such records may be used and disclosed as permitted or required by applicable federal and state privacy laws, including but not limited to HIPAA; 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 *or not permitted or required by law* 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.

New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services



This amendment shall be effective upon the date of Governor and Executive Council approval, or July 1, 2019, whichever is later.

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

State of New Hampshire  
Department of Health and Human Services

6/4/19  
Date

Mary A. Mayas  
Name:  
Title:

6/5/2019  
Date

Mary Hitchcock Memorial Hospital  
Edward J. Merrins  
Name: Edward J. Merrins  
Title: Chief Clinical Officer

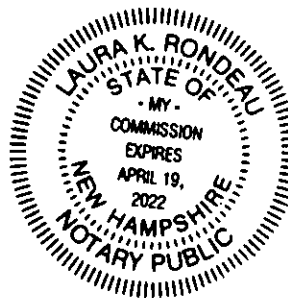
Acknowledgement of Contractor's signature:

State of New Hampshire County of Grafton on June 5, 2019, before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Laura  
Signature of Notary Public or Justice of the Peace

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

My Commission Expires: April 19, 2022



2000

1/1/10

1/1/10

New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services



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

OFFICE OF THE ATTORNEY GENERAL

6/7/2019  
Date

Lisa M. English  
Name: Lisa M. English  
Title: Special 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:



**Exhibit A Amendment #2**

**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**

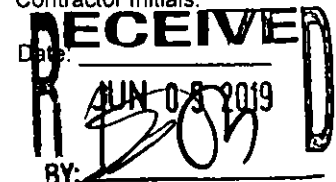
**2.1. Covered Populations and Services**

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 – Glenclyff 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 ensure adequate coverage on weekends and holidays to maintain compliance with documentation requirements to justify medical necessity of stay. This may include the need for daily progress notes on children and adults covered by Medicaid, Medicare or commercial insurance. Notwithstanding the foregoing, the parties acknowledge and agree that clinical care responsibilities may from time to time impede the providers' ability to complete daily progress notes on weekends and holidays. In such an event, the next progress note shall be written as soon thereafter as reasonably possible.
  - e. 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

---

provided by any such individual under review;

- f. 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;
- 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 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. 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;
- m. To participate with 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 establish, subject to the NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH;
- p. To assist the NHH Chief Executive Office with the clinical





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

---

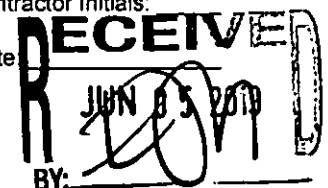
supervision and education of all other clinical staff at NHH; and

- q. 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







New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

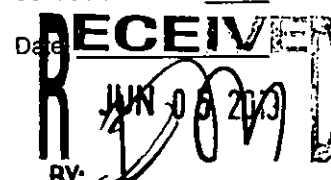
and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or Medical Staff Organization bylaws;

- 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

---

- 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 afterhours 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

---

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.
  - r. For a period of twenty-four (24) months commencing on the Amendment #2 Effective Date, one research psychiatrist will contribute 0.15 full-time equivalent (FTE) to serve as a research mentor to the NHH staff and Research Manager and will act as a liaison to trainees pursuing research opportunities at NHH. In addition, this psychiatrist will help to prepare for the work of a research investigator (Ph.D., Psy.D., M.D., or D.O.) who will begin on the thirteenth (13th) month after the Amendment #2 Effective Date. Thus, beginning on the first day of the thirteenth (13th) month after the Amendment #2 Effective Date and continuing for the remainder of the Term specified in Block 1.7 of Amendment #2, a research investigator will be added full-time, or 1.0 full-time equivalent (FTE) to serve as a research mentor to the NHH staff and Research Manager, to act as a liaison to trainees pursuing research opportunities at NHH, and to facilitate research projects at NHH
- 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

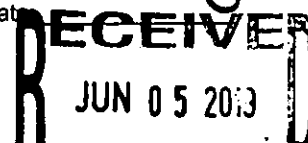
**Exhibit A Amendment #2**

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 postgraduate 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,





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 working with the research psychiatrist (in years one (1) and two (2) and with the research investigator in years two (2) and three (3) 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

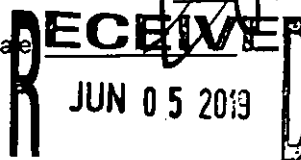
budgets, and providing guidance with hospital, state and federal regulations through to completion of the project.

**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 no less than one (1) full-time psychiatrist. Additional personnel who are provided for coverage may be either a psychiatrist or a Psychiatric Advanced Practice Registered Nurse. 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.
- The on-site after-hours coverage on weekdays, weekends and holidays shall be provided by a physician or psychiatric advanced practice registered nurse 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, or is credentialed as a psychiatric APRN through the American Nurse Credentialing Center or equivalent credentialing body.
  - The Contractor shall maintain a pool of psychiatric physicians or resident physicians or psychiatric APRNs, or a combination thereof, 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 –  
Glenclyff 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 Glenclyff 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 Glenclyff 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

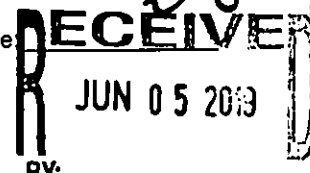
compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations; and the provision of other assistance in meeting standards for annual State inspections and Federal regulations;

- 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 Glenclyff 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





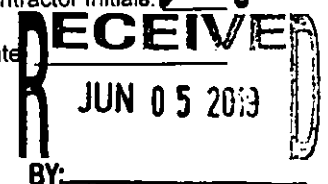


**New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services**

**Exhibit A Amendment #2**

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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 –**



## Exhibit A Amendment #2

### Children, Youth and Families

#### 2.6.1. DCYF Staff Psychologist Responsibilities

- 2.6.1.1. The Contractor shall provide, for the term of the contract, the full-time services of a designated psychologist, who is a faculty member and/or employee of the Contractor, to provide psychological 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 Psychologist 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 psychologist 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 psychologist shall maintain regular office hours consistent with those of DHHS senior executive team members.
- 2.6.1.4. The staff psychologist 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 psychologist 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 psychologist 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 psychologist 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 psychologist 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 psychologist'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



**New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services**

**Exhibit A Amendment #2**

---

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 psychologist 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 psychologist under the contract:
- a. Provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and Juvenile Probation and Parole Officers. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;
  - b. 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;
  - c. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for JJS;
  - d. 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.

**2.6.2. DCYF Staff Psychiatrist Responsibilities**

- 2.6.2.1. The Contractor shall provide the services of a designated psychiatrist, for no less than .25 FTE, 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 ".25 FTE" 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 10 hours of work per week devoted to his or her psychiatric service duties and responsibilities pursuant to this section, subject to the Contractor's



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

normal and customary employee leave policies.

- 2.6.2.2. Psychiatric services shall include, but are not limited to:
- a. Medical and psychiatric services at SYSC.
  - b. Documenting 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.
  - c. Clinical supervision and teaching of child psychiatry residents and fellows at SYSC.
  - d. Teaching and supervision contacts with interns, residents, and fellows at SYSC

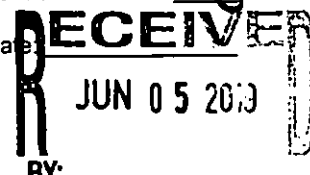
**2.6.3. Psychiatric Consultant**

- 2.6.3.1. The Contractor shall, provide the services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric consultation services to the programs within the Children, Youth and Families service area. This position shall be a .25 Full-Time Equivalent.
- 2.6.3.2. The Contractor shall ensure that the psychiatric consultant provides consultation to the Department on psychotropic medication prescriptions for youth who are in out-of-home care at a location other than SYSC. This consultation will typically include a review of the psychotropic medication prescriptions for identified youth and peer-to-peer consultation with prescribers to help ensure the appropriate utilization of psychotropic medications.
- 2.6.3.3. Notwithstanding the foregoing, the State acknowledges and agrees that the consultation services provided pursuant to this Section 2.6.3 may be limited in scope and nature due to the staffing of this position as a 0.25 Full-Time Equivalent (FTE).

**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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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).

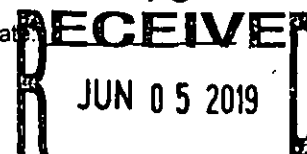
2.7.1.2. The Medical Director shall be available on-site, at a DHHS designated location, for twenty (20) hours per week to provide services to the Behavioral Health service area. The Medical Director shall be available via telephone, email, and in person by appointment during that time.

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. Review and inform Behavioral Health policy issues;
- d. Enhance housing support capacity planning;
- e. Review and inform Medicaid and state rule issues;
- f. Assist in developing Telemedicine capacity;
- g. Utilizes electronic medical records;
- h. Coordinate between NHH and CMHC care;
- i. Oversight and consultation of Evidence Based Practices (EBP) implementation;
- j. Develop funding and reimbursement strategies;
- k. Review and inform the sustainability of behavior change programs.
- l. Assess the needs of patients in NHH and Transitional Housing Services who might be served in the community; and
- m. 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.
- n. Serve as the Lead Manager for the ProHealth integration grant, working in collaboration with DHHS and identified programs to implement grant deliverables.

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

- a. Participate on key departmental and legislative committees, as





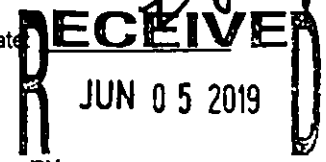
New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

---

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 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

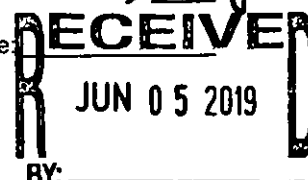
**Exhibit A Amendment #2**

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 CMH Program and Providers. The deliverables described below shall be provided directly to DHHS-designated Behavioral Health program staff and CMH staff 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 CMH Workforce:** To sustain and improve the quality of







New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

IMR, EBSE, and ACT services, the Contractor shall provide education and training to DHHS designated CMH staff. The contractor shall provide a total of 18 days of training, but schedules and requirements for each EBP as outlined below may be adjusted upon mutual agreement between the DHHS and Contractor in order to meet the needs of the CHM 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, EBSE, and ACT 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 programs of EBPs in NH.
- b. Each training event shall include, at a minimum:
  - Invitations provided to CMHC staff before the training event;
  - A description of who should attend the training;
  - Outcomes for participants attending the training;
  - Sufficient time to provide instruction and practice for skills;
  - Content designed to improve the fidelity of the practice at CMHC's;
  - Documentation of all participants attending the training; and
  - 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 CMH 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:

No less than fifteen (15) hours of training, to be presented in one (1) or two (2) training sessions, 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;

No less than fifteen (15) hours of training, to be presented



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

in two (2) to six (6) training sessions, 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.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions, 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 CMH 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:

No less than thirty (30) hours of training, to be presented in full-day training sessions, 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.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions 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.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 CMH Program staff providing ACT services. The topic areas shall be subject to the DHHS designee's approval.

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

No less than thirty (30) hours of training, to be presented in full-day training sessions 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.

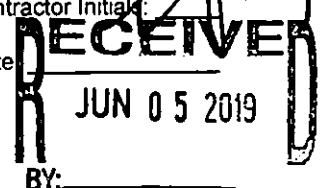
No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced ACT practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions 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 ACT and EBSE for all CMH Programs, as designated by the DHHS designee.

- a. Fidelity assessments shall be conducted for the purpose of monitoring the implementation of ACT and EBSE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the designated CMH programs.
- b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMH program, 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 assessment includes, at a minimum:

Written instructions to the CMH program regarding





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

necessary observations, interviews, data access and other activities for the assessment.

A description of CMH program staff, other community providers, consumers and family members who will need to be interviewed for the assessment.

A specific written assessment schedule jointly developed by the Contractor and the CMH program.

Sufficient time to assess and evaluate the CMH program's delivery of ACT or EBSE.

A debriefing at the end of the assessment to review themes from the review with CMH program leadership.

Documentation of the assessment process, findings and scoring of fidelity items for CMH program leadership and the Department no later than four weeks following the assessment.

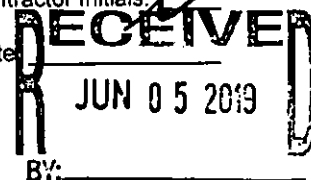
**2.7.2.9. Consultation to CMH Program Leadership and Workforce**

**Development:** The Contractor shall provide agency-based consultations to all CMH programs 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 CMH program 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 CMH program may utilize to most effectively sustain and improve IMR, ACT and EBSE services.

- a. In cases where CMH programs 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 CMH program 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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:

The Contractor's attendance at the State EBP advisory committee bi-monthly meetings by the Contractor and/or designees;

The Contractor's attendance at weekly meetings with the DHHS designee;

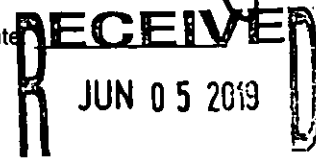
Attendance of Contractor staff at monthly meetings with the DHHS designee and any additional DHHS Behavioral Health resources identified by the DHHS designee;

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;

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;

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;

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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

system;

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

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:

- Attend and fully participate in CPHS full committee meetings (once per month);
- Conduct expedited reviews as requested by the CPHS Administrator (averaging about three per month);
- 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,



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 (.125 FTE) to the Elderly and Adult Services service area. The Medical Director, subject to the FTE allotment, shall provide services for the purposes of consultation and improving the quality of services for older adults and adults with disabilities in NH.
- 2.8.1.2. The Medical Director shall:
- a. Provide consultation and direction of the organization's clinical components to policies and procedures and administrative rules;
  - b. Serve as a technical advisor for wellness and prevention initiatives to improve the lives of individuals served by Elderly and Adult Services service area;
  - c. Perform medical consultation, clinical oversight and authority and guide education instruction, within the Elderly and Adult Services service area;
  - d. Provide guidance and consultation regarding new



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

developments and emerging trends in clinical practice, research and best practices that would have an impact on service development, service delivery and clinical policy and practice;

- e. When requested, participate in the quality initiative, Sentinel Event Reviews and other case consultation and case review convening's as requested;
- f. Meet bi-monthly with DHHS designee to review initiatives and check in on consultation services.

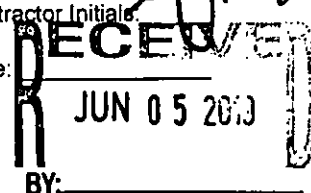
**2.9. Specific Service Requirements – Service Area #7 – Developmental Services**

**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 must dedicate two (2) days each week to the activities described below:
  - a. Referrals from the ten (10) Area Agencies, and referrals from Special Medical Services (SMS). These referrals must be prioritized over all other duties, and may include performing evaluations, consultations, and medication reviews by the Medical Director.
  - b. Based on He-M 1201, the Medical Director will facilitate Developmental Services' Medication Committee meetings as chairperson, and provide will provide expert opinion and leadership to ensure that the committee functions effectively.
  - c. Assistance for the DHHS Developmental Services staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews.
  - d. Educational training to DHHS Developmental Services staff, Area Agencies, and subcontract agencies and other stakeholders, as identified and directed by Developmental Services.
  - e. Providing expertise and assistance in efforts to improve New Hampshire's developmental services system.

**2.9.2. Developmental Services Interdisciplinary Clinic Team**

- 2.9.2.1. The Contractor shall provide an interdisciplinary clinic team for children and adults. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic.







New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

Team for Adults:

- a. **Psychiatrist (Child Psychiatrist if applicable)** – 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 shall provide the following services:

- a. The Contractor shall ensure the team accepts children and adults being referred from the Area Agencies. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

most immediate need and critical situation;

- b. The Contractor shall support the goal of the interdisciplinary clinic team by providing high quality interdisciplinary evaluations to children and 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, service providers 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 which will reduce each client's number of medical appointments and reduce each client's 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 two clients per month, for a total of twenty-four (24) 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.
- 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.
- e. The Contractor shall submit encounter documentation as directed by the Department.

**3. Staffing**

**3.1. General Requirements Applicable to All Service Areas:**

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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

**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 that 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

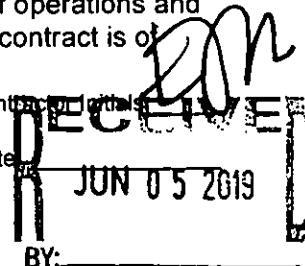


New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 is of





**New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services**

**Exhibit A Amendment #2**

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. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process for all unfilled positions.

- 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	Glenclyff 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**



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

**#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 will be at a level that ensures no impact on the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

for all unfilled positions.

- 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

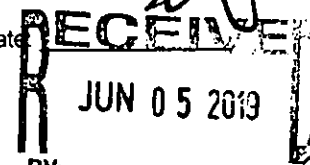
**Exhibit A Amendment #2**

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



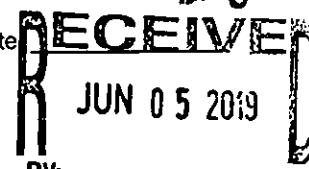


New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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:

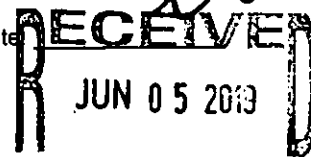
- a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;
- b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
- c. Successful collaboration with state government 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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.

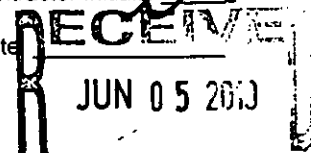
**3.3.7. Neuropsychologist Trainees**

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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 or postgraduate 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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:

Master's degree in management or health or research related area;

Five or more years of relevant experience in clinical trials research support;

Experience with industry sponsored, federally sponsored and investigator initiated clinical research;

Experience with clinical trial budgets and billing;

Through knowledge of clinical research, research protocols and clinical operations; and

Knowledge of Good Clinical Practices (GCP's) and federal regulations related to research.

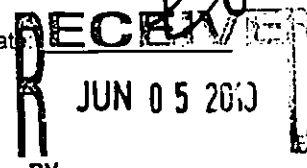
**3.3.14. Director of Quality Systems and APRN Services**

- 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

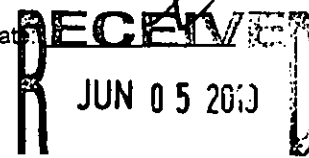
---

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 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. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

for all unfilled positions.

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
s. Research Mentor/ Investigator (Psychiatrist or Psychologist)	0.15 SFY2020, 1.15 SFY 2021, 1.0 SFY 2022

**3.4. Specific Staffing Requirements – Service Area #2 –  
Glenclyff Home**





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

**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 Glenclyff 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 Psychologist**

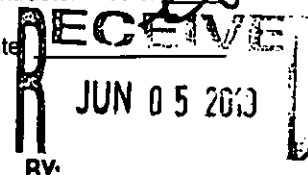
3.6.1.1. The Staff Psychologist shall possess the following qualifications:

- a. Possess a Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.) degree from a college or university accredited by the American Psychological Association.
- b. Experience and interest in both child psychology and criminal justice;
- c. Certification by NH Board of Psychologists.
- d. Maintain an unrestricted license to practice Psychology
- e. Possess at least five (5) years of experience in community mental health, criminal justice, or similar training.

**3.6.2. Staff Psychiatrist**

3.6.2.1. The Contractor shall, provide the 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 .25 Full-Time Equivalent.

3.6.2.2. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

Contractor designates for the Staff Psychiatrist.

3.6.2.3. The Staff Psychiatrist shall possess the following qualifications:

- a. Possess a medical degree (MD or DO);
- b. Specialty in child psychiatry and an interest in 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 post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

**3.6.3. Psychiatric Consultant**

- 3.6.3.1. The Contractor shall provide a part-time psychiatric consultant (.25 FTE), to work two (2) days each week for five (5) hours each day, and who meets the following criteria:
- 3.6.3.2. Has interest and clinical experience in addiction treatment and criminal justice.
- 3.6.3.3. Has completed a fellowship training and/or board certification in Child Psychiatry.

**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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 2 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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. 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):

- 3.9.2.2. a. Child Psychiatrist 0.1 FTE
- 3.9.2.3. b. Psychiatrist 0.1 FTE
- 3.9.2.4. c. Neuropsychologist 0.1 FTE
- 3.9.2.5. d. Neuropsychology Fellow 0.1 FTE
- 3.9.2.6. e. Neurologist 0.05 FTE
- 3.9.2.7. f. Primary Care Physician 0.05 FTE
- 3.9.2.8. g. Occupational Therapist 0.05 FTE
- 3.9.2.9. h. Administrative Support 0.05 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.
- 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 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 will be at the a level of 100% ensures that inthat ensures no case shall Contractor staffing affect impact to the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provider DHHS with monthly updates on the recruitment process for all unfilled positions.

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:

4.2.3. In providing services, DHMC providers shall at all times during the term comply with the Key Performance Indicators (KPI) defined below. Key Performance Indicators may be revised by mutual agreement of the parties. In the event that DHMC providers fail to satisfy any KPI's, in addition to any other rights available to NHH hereunder, DHMC shall cooperate with NHH to remedy such shortfalls and take appropriate action to alleviate the unsatisfactory performance, as determined by the Department.

**Key Performance Indicators**

4.2.3.1. 1. Psychiatric Progress Notes

- (i) Completion daily on children and adults who are certified as acute inpatient level of care.
- (ii) Completion of not less than four (4) times per week on children and adult patients that are no longer acute level of care.
- (iii) Content as it pertains to CMS local coverage determinations for NHH and NHH Policy.

2. Patient Length of Stay

- (i) Evaluation by through data collection and case review



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

of active treatment during patient stay.

3. CMS Certification Guidelines

- (i) Certifications/re-certification conducted in accordance to required CMS and NHH timeframes.
- (ii) Assigned certification status is clearly supported in psychiatric progress notes.

4. Standardized Process

- (i) Compliance with all existing and future standardized work processes with the goal of reducing variation in care.
- (ii) Individual metrics will be developed based on the target outcomes of the standardized work.

5. Treatment Plans

- (i) Completed timely and comprehensively.
- (ii) Performance measured by random monthly audits which are provided to the Chief Medical Officer and Chief Executive Officer of NHH.

6. Annual Reviews

- (i) Annual reviews are documented on all DHMC staff by the Chief Medical Officer or designee. Performance evaluation shall be in compliance with professional standards for evaluations per CMS/Joint Commission guidelines.

**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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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.

In addition to performance metrics and 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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.

4.5.1.2. 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 4.2.2., and shall be reviewed and modified by DHHS during the term to assure that they continue to be the best metrics to use to assure contract compliance.

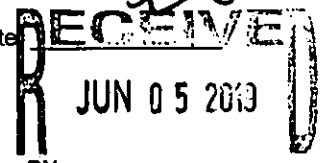
**4.5.2. Monitoring – Service Area #1 – New Hampshire Hospital – Chief Medical Officer:**

4.5.2.1. The findings from Key Performance Indicators 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.

4.5.2.2. The Key Performance Indicators 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.

4.5.2.3. 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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. In providing services, DHMC providers shall at all times during the term comply with the Key Performance Indicators (KPI) defined below. Key Performance Indicators may be revised by mutual agreement of the parties. In the event that DHMC providers fail to satisfy any KPI's, in addition to any other rights available to NHH hereunder, DHMC shall cooperate with NHH to remedy such shortfalls and the parties shall agree on any appropriate action necessary to alleviate the unsatisfactory performance.

**Key Performance Indicators**

**1. Psychiatric Progress Notes**

- (i) Completion daily on children and adults who are certified as acute inpatient level of care.
- (ii) Completion of not less than four (4) times per week on children and adult patients that are no longer acute level of care.
- (iii) Content as it pertains to CMS local coverage determinations for NHH and NHH Policy.

**2. Patient Length of Stay**

- (i) Evaluation by through data collection and case review of active treatment during patient stay.

**3. CMS Certification Guidelines**

- (i) Certifications/re-certification conducted in accordance to required CMS and NHH timeframes.
- (ii) Assigned certification status is clearly supported in psychiatric progress notes.

**4. Standardized Process**

- (i) Compliance with all existing and future standardized work processes with the goal of reducing variation in care.
- (ii) Individual metrics will be developed based on the target outcomes of the standardized work.

**5. Treatment Plans**

- (i) Completed timely and comprehensively.
- (ii) Performance measured by random monthly audits which are provided to the Chief Medical Officer and



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

Chief Executive Officer of NHH.

6. Annual Reviews

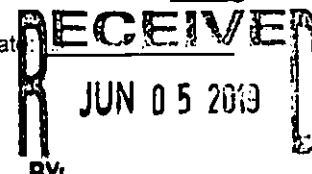
- (i) Annual reviews are documented on all DHMC staff by the Chief Medical Officer or designee. Performance evaluation shall be in compliance with professional standards for evaluations per CMS/Joint Commission guidelines.

**4.5.4. Service Area #3 – Medicaid – Chief Medical Officer**

- 4.5.4.1. 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.
- 4.5.4.2. The DHHS designee shall review the findings from monitoring of these metrics at least quarterly with the Chief Medical Officer.
- 4.5.4.3. 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.

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

- 4.5.5.1. 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





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

administrative support staff.

- 4.5.5.2. 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.
- 4.5.5.3. 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.
- 4.5.5.4. 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.
- 4.5.5.5. 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.

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

- 4.5.6.1. 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 Psychologist shall be consulted in this process and the metrics shall be subject to



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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.

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

a. Monitoring of work hours;

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

Clinical documentation monitoring to be sure it meets standards of timeliness and completeness established by Children, Youth, and Families;

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

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

**4.5.7. Monitoring – Services Area #4 – Children, Youth & Families – Staff Psychologist**

- 4.5.7.1. 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 Psychologist; and  
b. Clinical documentation monitoring. Source: DHHS staff.

- 4.5.7.2. 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 Psychologist;  
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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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.

- 4.5.7.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Staff Psychologist's annual performance review. This review shall be conducted at six months for a new Staff Psychologist, then annually thereafter.
- 4.5.7.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Staff Psychologist 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.
- 4.5.7.5. 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.

**4.5.8. Service Areas #2, 3, 5, 6 and 7**

- 4.5.8.1. 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.

**4.5.9. All Other Positions**

- 4.5.9.1. 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



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

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 this Exhibit A Amendment #2, 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 Amendment #2, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in Exhibit B



New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services

**Exhibit A Amendment #2**

---

Amendment #2; and

- 6.1.1.3. The liquidated damages as specified in Exhibit B Amendment #2 are reasonable and fair and not intended as a penalty.

**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





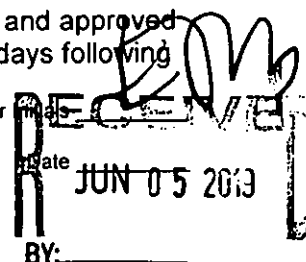
**New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services  
Exhibit B Amendment #2**

**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 Amendment #2, Scope of Services.
2. Agreement Period: Effective July 1, 2019, or the date of Governor and Executive Council approval, whichever date is later, through June 30, 2022.
3. Funding Sources: The services described in Exhibit A Amendment #2, 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 Amendment #2, Scope of Services, on the basis of this Budget.

<b>Budget</b>			
<b>Agreement Period by State Fiscal Year</b>			
<b>Service Area</b>	<b>7/1/2019- 6/30/2020</b>	<b>7/1/2020- 6/30/2021</b>	<b>7/1/2021- 6/30/2022</b>
1: New Hampshire Hospital	\$11,640,759	\$12,717,827	\$13,366,111
2: Glenclyff Home	\$139,309	\$148,447	\$156,475
3: Medicaid	\$408,628	\$432,119	\$455,192
4: Children, Youth & Families	\$396,688	\$392,445	\$413,867
5: Behavioral Health	\$517,056	\$544,803	\$572,319
6: Elderly and Adult Services	\$39,197	\$41,809	\$44,110
7: Developmental Services	\$284,893	\$310,264	\$327,751

- 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





**New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services  
Exhibit B Amendment #2**

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 – Glenclyff 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

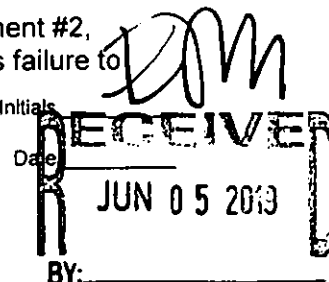
6. **Payment:** Compensation paid by DHHS shall be accepted by the Contractor as payment in full for the services provided under the Agreement. Notwithstanding anything to the contrary contained in the Agreement or in any other document, contract or understanding, it is expressly understood and agreed 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 Amendment #2, Scope of Services Subsection 6.1, Continuity of Services, the Contractor's failure to





**New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services  
Exhibit B Amendment #2**

---

provide required staffing, required services, or meet the performance standards and reporting requirements as described in Exhibit A Amendment #2, Scope of Services, Sections 2 through 5, shall result in liquidated damages.

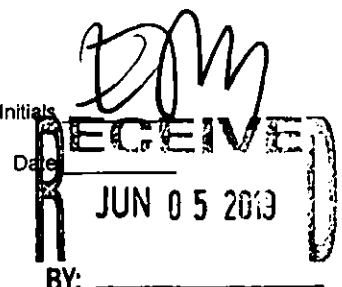
**9.2 The Contractor and DHHS agree that:**

- 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 Amendment #2, Scope of Services, 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 Amendment #2, Scope of Services, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in this Exhibit B Amendment #2;
- 9.2.4. The liquidated damages as specified in this Exhibit B Amendment #2 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.





New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services  
Exhibit B Amendment #2

---

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 Amendment #2, Scope of Services, 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 Amendment #2, Scope of Services, 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 Amendment #2, Scope of Services, Section 4, Performance Standards and Outcomes.

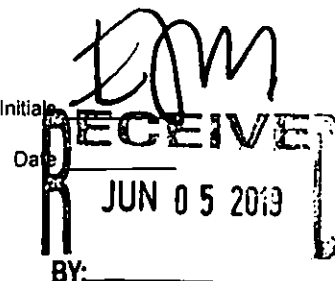
9.5.4 Liquidated damages, if assessed, shall be in the amount of \$1,000 per day for each day the Contractor fails to meet the Reporting Requirements identified in Exhibit A Amendment #2, Scope of Services, Section 5, Reporting.

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 Amendment #2, Scope of Services, Section 2.3.3.1. (j) and Section 2.3.5.4.



# State of New Hampshire

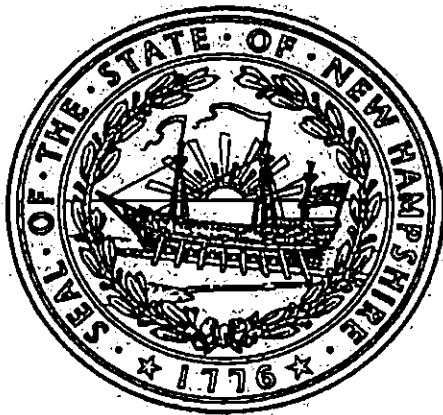
## Department of State

### CERTIFICATE

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

Business ID: 68517

Certificate Number: 0004496386



IN TESTIMONY WHEREOF,

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

A handwritten signature in black ink, appearing to read "Wm Gardner".

William M. Gardner  
Secretary of State

**CERTIFICATE OF VOTE/AUTHORITY**

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

1. I am the duly elected Secretary and Treasurer of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital;
2. The following is a true and accurate excerpt from the December 7<sup>th</sup>, 2012 Bylaws of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital:

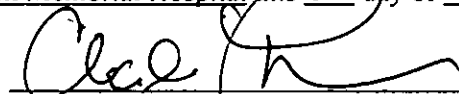
**ARTICLE I – Section A. Fiduciary Duty. Stewardship over Corporate Assets**

“In exercising this [fiduciary] duty, the Board may, consistent with the Corporation’s Articles of Agreement and these Bylaws, delegate authority to the Board of Governors, Board Committees and various officers the right to give input with respect to issues and strategies, incur indebtedness, make expenditures, enter into contracts and agreements and take such other binding actions on behalf of the Corporation as may be necessary or desirable.”

3. Article I – Section A, as referenced above, provides authority for the chief officers, including the Chief Executive Officer, the Chief Clinical Officer, and other officers, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital to sign and deliver, either individually or collectively, on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. Edward J. Merrens, MD is the Chief Clinical Officer of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital and therefore has the authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.

0

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary and Treasurer of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 5<sup>th</sup> day of June 2019.

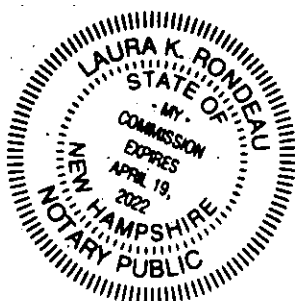


Charles G. Plimpton  
Board of Trustees, Secretary/Treasurer

STATE OF NH

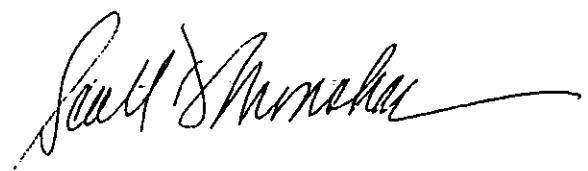
COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 5<sup>th</sup> day of June, 2019, by Charles Plimpton.



Notary Public

My Commission Expires: April 19, 2022

<b>CERTIFICATE OF INSURANCE</b>				<b>DATE: 10/09/2018</b>		
<b>COMPANY AFFORDING COVERAGE</b> Hamden Assurance Risk Retention Group, Inc. P.O. Box 1687 30 Main Street, Suite 330 Burlington, VT 05401			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.			
<b>INSURED</b> Mary Hitchcock Memorial Hospital – DH-H One Medical Center Drive Lebanon, NH 03756 (603)653-6850						
<b>COVERAGES</b> 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.						
<b>TYPE OF INSURANCE</b>		<b>POLICY NUMBER</b>	<b>POLICY EFFECTIVE DATE</b>	<b>POLICY EXPIRATION DATE</b>	<b>LIMITS</b>	
<b>GENERAL LIABILITY</b>  <div style="display: flex; align-items: center;"> <div style="width: 40px; text-align: center; border: 1px solid black;"><b>X</b></div> <div style="border: 1px solid black; padding: 2px;">CLAIMS MADE</div> </div> <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="width: 40px; text-align: center; border: 1px solid black;"></div> <div style="border: 1px solid black; padding: 2px;">OCCURRENCE</div> </div>		0002018-A	07/01/2018	06/30/2019	EACH OCCURRENCE	\$1,000,000
					PRODUCTS-COMP/OP AGGREGATE	
					PERSONAL ADV INJURY	
					GENERAL AGGREGATE	\$3,000,000
					FIRE DAMAGE	
<b>OTHER</b>					MEDICAL EXPENSES	
<b>PROFESSIONAL LIABILITY</b>  <div style="display: flex; align-items: center;"> <div style="width: 40px; text-align: center; border: 1px solid black;"><b>X</b></div> <div style="border: 1px solid black; padding: 2px;">CLAIMS MADE</div> </div> <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="width: 40px; text-align: center; border: 1px solid black;"></div> <div style="border: 1px solid black; padding: 2px;">OCCURENCE</div> </div>		0002018-A	07/01/2018	06/30/2019	EACH CLAIM	\$1,000,000
					ANNUAL AGGREGATE	\$3,000,000
					<b>OTHER</b>	
<b>DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)</b>  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."						
<b>CERTIFICATE HOLDER</b>						
NH Dept. of Health & Human Services 129 Pleasant Street Concord, NH 03301				<b>CANCELLATION</b> 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.  <b>AUTHORIZED REPRESENTATIVES</b>  		



DARTHIT-01

DMCDONALD

## 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		
INSURED  Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A: Safety National Casualty Corporation		15105
	INSURER B:		
	INSURER C:		
	INSURER D:		
	INSURER E:		

## 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 <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		AGC4059104	07/01/2018	07/01/2019	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (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

## CANCELLATION

NH DHHS 129 Pleasant Street Concord, NH 03301	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE 





## **Mission, 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, 2018 and 2017**

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

---

	<b>Page(s)</b>
<b>Report of Independent Auditors .....</b>	<b>1–2</b>
<b>Consolidated Financial Statements</b>	
<b>Balance Sheets .....</b>	<b>3</b>
<b>Statements of Operations and Changes in Net Assets .....</b>	<b>4–5</b>
<b>Statements of Cash Flows .....</b>	<b>6</b>
<b>Notes to Financial Statements .....</b>	<b>7–44</b>
<b>Consolidating Supplemental Information - Unaudited</b>	
<b>Balance Sheets .....</b>	<b>45–48</b>
<b>Statements of Operations and Changes in Unrestricted Net Assets .....</b>	<b>49–52</b>
<b>Notes to the Supplemental Consolidating Information.....</b>	<b>53</b>



## **Report of Independent Auditors**

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2018 and June 30, 2017, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

### ***Management's Responsibility for the Consolidated Financial Statements***

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

### ***Auditors' Responsibility***

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the financial statements of Alice Peck Day Hospital, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 2.8% of consolidated total assets at June 30, 2017 and total revenues of 3.3% of consolidated total revenue for the year then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Alice Peck Day Hospital, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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 report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2018 and June 30, 2017, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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

*PricewaterhouseCoopers LLP*

Boston, Massachusetts  
November 7, 2018

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

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Statements of Operations and Changes in Net Assets**  
**Years Ended June 30, 2018 and 2017**

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Statements of Operations and Changes in Net Assets**  
**Years Ended June 30, 2018 and 2017**

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

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



**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Statements of Cash Flows**  
**Years Ended June 30, 2018 and 2017**

(in thousands of dollars)

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

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

# **Dartmouth-Hitchcock Health and Subsidiaries**

## **Consolidated Notes to Financial Statements**

### **June 30, 2018 and 2017**

---

#### **1. Organization and Community Benefit Commitments**

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

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

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

#### **Community Benefits**

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

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

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

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

# Dartmouth-Hitchcock Health and Subsidiaries

## Consolidated Notes to Financial Statements

### June 30, 2018 and 2017

---

- *Subsidized health services* are services provided by the Health System, resulting in financial losses that meet the needs of the community and would not otherwise be available to participate unless the responsibility was assumed by the government.
- *Research support and other grants* represent costs in excess of awards for numerous health research and service initiatives awarded to the organizations within the Health System.
- *Community health-related initiatives* occur outside of the organization(s) through various financial contributions of cash, in-kind, and grants to local organizations.
- *Community-building activities* include cash, in-kind donations, and budgeted expenditures for the development of programs and partnerships intended to address social and economic determinants of health. Examples include physical improvements and housing, economic development, support system enhancements, environmental improvements, leadership development and training for community members, community health improvement advocacy, and workforce enhancement. Community benefit operations includes costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations.
- *Charity care (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the years ended June 30, 2018 and 2017, the Health System provided financial assistance to patients in the amount of approximately \$39,446,000 and \$29,934,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2018 and 2017 was approximately \$15,559,000 and \$12,173,000, respectively. The estimated costs of providing charity care services are determined applying a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.
- *Government-sponsored healthcare services* are provided to Medicaid and Medicare patients at reimbursement levels that are significantly below the cost of the care provided.
- *The uncompensated cost of care for Medicaid patients* reported in the unaudited Community Benefits Reports for 2017 was approximately \$126,867,000. The 2018 Community Benefits Reports are expected to be filed in February 2019.

The following table summarizes the value of the community benefit initiatives outlined in the Health System's most recently filed Community Benefit Reports for the year ended June 30, 2017:

*(Unaudited, in thousands of dollars)*

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

# **Dartmouth-Hitchcock Health and Subsidiaries**

## **Consolidated Notes to Financial Statements**

### **June 30, 2018 and 2017**

---

The Health System also provides a significant amount of uncompensated care to its patients that are reported as provision for bad debts, which is not included in the amounts reported above. During the years ended June 30, 2018 and 2017, the Health System reported a provision for bad debt expense of approximately \$47,367,000 and \$63,645,000, respectively.

## **2. Summary of Significant Accounting Policies**

### **Basis of Presentation**

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America, and have been prepared consistent with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 954, *Healthcare Entities*, which addresses the accounting for healthcare entities. The net assets, revenue, expenses, and gains and losses of healthcare entities are classified based on the existence or absence of donor-imposed restrictions. Accordingly, unrestricted net assets are amounts not subject to donor-imposed stipulations and are available for operations. Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained in perpetuity. All significant intercompany transactions have been eliminated upon consolidation.

### **Use of Estimates**

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

### **Excess of Revenue over Expenses**

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

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

### **Charity Care and Provision for Bad Debts**

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

The Health System grants credit without collateral to patients. Most are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for bad debts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage, and other collection indicators (Notes 1 and 3).

#### **Net Patient Service Revenue**

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and bad debt expense. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as estimates change or final settlements are determined (Note 3).

#### **Contracted Revenue**

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

#### **Other Revenue**

The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. This revenue includes retail pharmacy, joint operating agreements, grant revenue, cafeteria sales, meaningful use incentive payments and other support service revenue.

#### **Cash Equivalents**

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

#### **Investments and Investment Income**

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

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the excess of revenues over expenses. All investments, whether held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheet dates on a nondistressed basis.

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

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

Investment income or losses (including change in unrealized and realized gains and losses on unrestricted investments, change in value of equity method investments, interest, and dividends) are included in the excess of revenue over expenses and classified as non-operating gains and losses, unless the income or loss is restricted by donor or law (Note 8).

#### **Fair Value Measurement of Financial Instruments**

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

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

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

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

#### **Property, Plant, and Equipment**

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

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

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

#### **Bond Issuance Costs**

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

#### **Trade Names**

The Health System records trade names as intangible assets within other assets on the consolidated statements of financial position. The Health System considers trade names to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded \$2,462,000 and \$2,700,000 as intangible assets associated with its affiliations as of June 30, 2018 and 2017, respectively.

#### **Derivative Instruments and Hedging Activities**

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

On the date a derivative contract is entered into, the Health System designates the derivative as a cash-flow hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability. For all hedge relationships, the Health System formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking cash-flow hedges to specific assets and liabilities on the consolidated balance sheets, specific firm commitments or forecasted transactions.<sup>1</sup> 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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

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

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

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

#### **Gifts and Bequests**

Unrestricted gifts and bequests are recorded net of related expenses as non-operating gains. Conditional promises to give and indications of intentions to give to the Health System are reported at fair value at the date the gift is received. Gifts are reported as either temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

#### **Recently Issued Accounting Pronouncements**

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



**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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

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

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

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

**3. Patient Service Revenue and Accounts Receivable**

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

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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

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

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

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

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

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

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

**Medicare**

The Health System's inpatient acute care services provided to Medicare program beneficiaries are paid at prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is based on diagnostic, clinical and other factors. In addition, inpatient capital costs (depreciation and interest) are reimbursed by Medicare on the basis of a prospectively determined rate per discharge. Medicare outpatient services are paid on a prospective payment system. Under this system, outpatient services are reimbursed based on a pre-determined amount for each outpatient procedure, subject to various mandated modifications. The Health System is reimbursed during the year for services to Medicare beneficiaries based on varying interim

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

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

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

Certain of the Health System's affiliates qualify as Home Health and Hospice Providers. Providers of home health services to clients eligible for Medicare home health benefits are paid on a prospective basis, with no retrospective settlement. The prospective payment is based on the scoring attributed to the acuity level of the client at a rate determined by federal guidelines. Hospice services to clients eligible for Medicare hospice benefits are paid on a per diem basis, with no retrospective settlement, provided the aggregate annual Medicare reimbursement is below a predetermined aggregate capitated rate. Revenue is recognized as the services are performed based on the fixed rate amount.

#### **Medicaid**

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

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

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

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

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

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

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

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

#### **Other**

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

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

**4. Investments**

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

Investments are accounted for using either the fair value method or equity method of accounting, as appropriate on a case by case basis. The fair value method is used when debt securities or equity securities are traded on active markets and are valued at prices that are readily available in those markets. The equity method is used when investments are made in pooled/commingled investment funds that represent investments where shares or units are owned of pooled funds rather than the underlying securities in that fund. These pooled/commingled funds make underlying investments in securities from the asset classes listed above. All investments, whether the fair value or equity method of accounting is used, are reported at what the Health System believes to be the amount that the Health System would expect to receive if it liquidated its investments at the balance sheets date on a non-distressed basis.

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

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

<i>(in thousands of dollars)</i>	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
	<u>\$ 452,346</u>	<u>\$ 334,506</u>	<u>\$ 786,852</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

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

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

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

Private equity limited partnership shares are not eligible for redemption from the fund or general partner, but can be sold to third party buyers in private transactions that typically can be completed in approximately 90 days. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreement expires. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2018 and 2017, the Health System has committed to contribute approximately \$137,219,000 and \$119,719,000 to such funds, of which the Health System has contributed approximately \$91,942,000 and \$81,982,000 and has outstanding commitments of \$45,277,000 and \$37,737,000, respectively.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

**5. Property, Plant, and Equipment**

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

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

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

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

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

**6. Fair Value Measurements**

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

**Cash and Short-Term Investments**

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

**Domestic, Emerging Markets and International Equities**

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



**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

**U.S. Government Securities, Domestic Corporate and Global Debt Securities**

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

**Interest Rate Swaps**

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

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

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2018 and 2017:

	2018				Redemption or Liquidation	Days' Notice
(in thousands of dollars)	Level 1	Level 2	Level 3	Total		
<b>Assets</b>						
<b>Investments</b>						
Cash and short term investments	\$ 15,382	\$ -	\$ -	\$ 15,382	Daily	1
U.S. government securities	109,285	-	-	109,285	Daily	1
Domestic corporate debt securities	41,488	53,993	-	95,481	Daily-Monthly	1-15
Global debt securities	32,874	16,230	-	49,104	Daily-Monthly	1-15
Domestic equities	157,011	-	-	157,011	Daily-Monthly	1-10
International equities	59,924	78	-	60,002	Daily-Monthly	1-11
Emerging market equities	1,296	-	-	1,296	Daily-Monthly	1-7
Real estate investment trust	222	-	-	222	Daily-Monthly	1-7
Other	-	31	-	31	Not applicable	Not applicable
Total investments	417,482	70,332	-	487,814		
<b>Deferred compensation plan assets</b>						
Cash and short-term investments	2,637	-	-	2,637		
U.S. government securities	38	-	-	38		
Domestic corporate debt securities	3,749	-	-	3,749		
Global debt securities	1,089	-	-	1,089		
Domestic equities	18,470	-	-	18,470		
International equities	3,584	-	-	3,584		
Emerging market equities	28	-	-	28		
Real estate	9	-	-	9		
Multi strategy fund	46,580	-	-	46,580		
Guaranteed contract	-	-	86	86		
Total deferred compensation plan assets	76,284	-	86	76,370	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,374	9,374	Not applicable	Not applicable
Total assets	\$ 493,766	\$ 70,332	\$ 9,460	\$ 573,558		

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

	2017					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
<b>Assets</b>						
<b>Investments</b>						
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	86,238	55,393	-	121,831	Daily-Monthly	1-15
Global debt securities	28,142	17,518	-	45,660	Daily-Monthly	1-15
Domestic equities	144,818	-	-	144,818	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		
<b>Deferred compensation plan assets</b>						
Cash and short-term investments	2,833	-	-	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	28,809	-	-	28,809		
International equities	9,595	-	-	9,595		
Emerging market equities	2,708	-	-	2,708		
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		
<b>Liabilities</b>						
Interest rate swaps	\$ -	\$ 20,916	\$ -	\$ 20,916	Not applicable	Not applicable
Total liabilities	\$ -	\$ 20,916	\$ -	\$ 20,916		

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

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

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2018 and 2017.

**7. Temporarily and Permanently Restricted Net Assets**

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

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

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

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

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

#### **8. Board Designated and Endowment Funds**

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

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

Unrestricted net assets include funds designated by the Board of Trustees to function as endowments and the income from certain donor-restricted endowment funds, and any accumulated investment return thereon, which pursuant to donor intent may be expended based on trustee or management designation. Temporarily restricted net assets include funds appropriated for expenditure pursuant to endowment and investment spending policies, certain expendable endowment gifts from donors, and any retained income and appreciation on donor-restricted endowment funds, which are restricted by the donor to a specific purpose or by law. When the temporary restrictions on these funds have been met, the funds are reclassified to unrestricted net assets.

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

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

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2018 and 2017.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

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

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

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

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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

<i>(in thousands of dollars)</i>	2017			Total
	Unrestricted	Temporarily Restricted	Permanently Restricted	
<b>Balances at beginning of year</b>	\$ 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
<b>Balances at end of year</b>	<u>\$ 26,389</u>	<u>\$ 29,701</u>	<u>\$ 45,756</u>	<u>\$ 101,846</u>
<b>Balances at end of year</b>			45,756	
Beneficial interest in perpetual trust			8,409	
Permanently restricted net assets			<u>\$ 54,165</u>	

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

**9. Long-Term Debt**

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

<i>(in thousands of dollars)</i>	<b>2018</b>	<b>2017</b>
<b>Variable rate issues</b>		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2036 (1)	\$ 83,355	\$ -
Series 2016A, principal maturing in varying annual amounts, through August 2046 (3)	-	24,608
Series 2015A, principal maturing in varying annual amounts, through August 2031 (4)	-	82,975
<b>Fixed rate issues</b>		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	-
Series 2017A, principal maturing in varying annual amounts, through August 2039 (2)	122,435	-
Series 2017B, principal maturing in varying annual amounts, through August 2030 (2)	109,800	-
Series 2016B, principal maturing in varying annual amounts, through August 2046 (3)	10,970	10,970
Series 2014A, principal maturing in varying annual amounts, through August 2022 (6)	26,960	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (6)	14,530	14,530
Series 2012A, principal maturing in varying annual amounts, through August 2031 (7)	-	71,700
Series 2012B, principal maturing in varying annual amounts, through August 2031 (7)	-	39,340
Series 2012, principal maturing in varying annual amounts, through July 2039 (11)	25,955	26,735
Series 2010, principal maturing in varying annual amounts, through August 2040 (9)	-	75,000
Series 2009, principal maturing in varying annual amounts, through August 2038 (10)	-	57,540
Total variable and fixed rate debt	<u>\$ 697,107</u>	<u>\$ 430,358</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

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

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

\*Represents nonobligated group bonds

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

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



## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

#### **Dartmouth-Hitchcock Obligated Group (DHOG) Bonds.**

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

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

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

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

#### **(2) Series 2017A and Series 2017B Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2017A and Series 2017B in December, 2017. The Series 2017A Revenue Bonds were primarily used to refund Series 2009 and Series 2010 and the Series 2017B Revenue Bonds were used to refund Series 2012A and Series 2012B. A loss on the extinguishment of debt of approximately \$13,636,000 was recognized in non-operating gains (losses) on the statement of operations and changes in net assets, as a result of the refinancing. The interest on the Series 2017A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2040. The interest on the Series 2017B Revenue Bonds is fixed with an interest rate of 2.54% and matures in variable amounts through 2031.

#### **(3) Series 2016A and 2016B Revenue Bonds**

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

**(4) Series 2015A Revenue Bonds**

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

**(5) Revolving Line of Credit**

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

**(6) Series 2014A and Series 2014B Revenue Bonds**

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

**(7) Series 2012A and 2012B Revenue Bonds**

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

**(8) Series 2012 Bank Loan**

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

**(9) Series 2010 Revenue Bonds**

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

**(10) Series 2009 Revenue Bonds**

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

**(11) Series 2012 Revenue Bonds**

The NHHEFA issued \$29,650,000 of tax-exempt Revenue Bonds, Series 2012. The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%). Principal is payable in annual installments ranging from \$780,000 to \$1,750,000 through July 2039. The Series 2012 Revenue Bonds were refunded in February 2018.

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

**Non Obligated Group Bonds**

**(12) Series 2010 Revenue Bonds**

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

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

For the years ended June 30, 2018 and 2017 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statements of operations and changes in net assets as operating expense of approximately \$18,822,000 and \$19,838,000 and is included in other non-operating losses of \$2,793,000 and \$3,135,000, respectively.

**Swap Agreements**

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2018 and 2017**

---

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

- A Fixed Payor Swap designed as a cash flow hedge of the NHHEFA Series 2011 Revenue Bonds. The Swap had an initial notional amount of \$91,040,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 4.56% in exchange for the counterparty's payment of 67% of USD-LIBOR-BBA. The Swap's term matches that of the associated bonds. The 2011 interest rate swap was not integrated with the 2011 bonds. When the 2011 bonds were refinanced, the swap became associated with the 2015 bond. The Fixed Payor Swap was terminated in February 2018.
- An Interest Rate Swap to hedge the interest rate risk associated with the NHHEFA Series 2013 Revenue Bonds. The Swap had an initial notional amount of \$15,000,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 3.94% in exchange for the counterparty's payment at 67% of USD-LIBOR-BBA. The Swap term matches that of the associated bonds. The Interest Rate Swap was terminated in February, 2018.
- An Interest Rate Swap to hedge the interest rate risk associated with the VEHFBA Series 2010A Revenue Bonds. The Swap had an initial notional amount of \$7,244,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 2.41% in exchange for the counterparty's payment of 69% of USD-LIBOR-BBA. The swap was terminated in September 2016, while the bonds will remain outstanding until 2030.

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

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

#### **10. Employee Benefits**

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

All of the defined benefit plans within the Health System have been frozen or had been approved by the applicable Board of Trustees to be frozen by January 31, 2017.

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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

**Defined Benefit Plans**

Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2018 and 2017:

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

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

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2018 and 2017:

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

For the years ended June 30, 2018 and 2017 the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in unrestricted net assets include approximately \$418,971,000 and \$429,782,000 of net actuarial loss as of June 30, 2018 and 2017, respectively.

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

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

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

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

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2018 and 2017

---

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of June 30, 2018 and 2017, it is expected that the LDI strategy will hedge approximately 60% and 55%, respectively, of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

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

	Range of Target Allocations	Target Allocations
Cash and short-term investments	0–5%	3%
U.S. government securities	0–10	5
Domestic debt securities	20–58	38
Global debt securities	6–26	8
Domestic equities	5–35	19
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	0
Private equity funds	0–5	0
Hedge funds	5–18	11

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

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

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

The hierarchy and inputs to valuation techniques to measure fair value of the Plans' assets are the same as outlined in Note 6. In addition, the estimation of fair value of investments in private equity and hedge funds for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The Health System's Plans own interests in these funds rather than in securities underlying each fund and, therefore, are

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

generally required to consider such investments as Level 2 or 3, even though the underlying securities may not be difficult to value or may be readily marketable.

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2018 and 2017:

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

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



**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

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

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

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

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

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2018 and 2017.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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

	2018	2017
Cash and short-term investments	4 %	3 %
U.S. government securities	5	1
Domestic debt securities	41	44
Global debt securities	9	10
Domestic equities	20	20
International equities	11	12
Emerging market equities	5	5
Hedge funds	5	5
	<u>100 %</u>	<u>100 %</u>

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

The Health System is expected to contribute approximately \$20,480,000 to the Plans in 2019 however actual contributions may vary from expected amounts.

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

*(in thousands of dollars)*

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

**Defined Contribution Plans**

The Health System has an employer-sponsored 401(a) plan for certain of its affiliates, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately \$38,563,000 and \$33,375,000 in 2018 and 2017, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax- sheltered annuity plans are available to employees of the Health System. Plan specifications vary by affiliate and plan. No employer contributions were made to any of these plans in 2018 and 2017 respectively.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

**Postretirement Medical and Life Benefits**

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

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2018 and 2017:

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

The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in the Health System's consolidated financial statements at June 30, 2018 and 2017:

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

For the years ended June 30, 2018 and 2017 the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

1

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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:

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

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

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

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

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

**11. Professional and General Liability Insurance Coverage**

D-H, along with Dartmouth College, Cheshire, NLH and MAHHC are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. Effective November 1, 2017 VNH is provided professional and general liability insurance coverage through RRG. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. D-H and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.



**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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

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

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

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

**12. Commitments and Contingencies**

**Litigation**

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

**Operating Leases and Other Commitments**

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

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

*(in thousands of dollars)*

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

**Lines of Credit**

The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from \$2,000,000 up to \$30,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 29, 2019. There was no outstanding balance under the lines of credit as of June 30, 2018 and 2017. Interest expense was approximately \$232,000 and \$915,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

**13. Functional Expenses**

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

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

**14. Subsequent Events**

The Health System has assessed the impact of subsequent events through November 7, 2018, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

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



**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2018 and 2017**

---

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

**Consolidating Supplemental Information – Unaudited**

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
<b>Assets</b>										
<b>Current assets</b>										
Cash and cash equivalents	\$ 134,634	\$ 22,544	\$ 6,688	\$ 9,419	\$ 8,604	\$ -	\$ 179,889	\$ 20,280	\$ -	\$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,055	-	207,521	11,707	-	219,228
Prepaid expenses and other current assets	11,964	143,893	6,551	5,253	2,313	(72,361)	97,613	4,766	(4,877)	97,502
Total current assets	146,598	343,418	30,422	22,974	13,972	(72,361)	485,023	36,753	(4,877)	516,899
<b>Assets limited as to use</b>	8	616,929	17,438	12,821	10,829	-	658,025	48,099	-	706,124
Notes receivable, related party	554,771	-	-	-	-	(554,771)	-	-	-	-
Other investments for restricted activities	-	87,613	8,591	2,981	6,238	-	105,423	25,473	-	130,896
Property, plant, and equipment, net	36	443,154	66,759	42,438	17,356	-	569,743	37,578	-	607,321
Other assets	24,863	101,078	1,370	5,906	4,280	(10,970)	126,527	3,604	(21,346)	108,785
Total assets	\$ 726,276	\$ 1,592,192	\$ 124,580	\$ 87,120	\$ 52,675	\$ (638,102)	\$ 1,944,741	\$ 151,507	\$ (26,223)	\$ 2,070,025
<b>Liabilities and Net Assets</b>										
<b>Current liabilities</b>										
Current portion of long-term debt	\$ -	\$ 1,031	\$ 810	\$ 572	\$ 187	\$ -	\$ 2,600	\$ 864	\$ -	\$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	3,311	-	-	3,311
Accounts payable and accrued expenses	54,995	82,061	20,107	6,705	3,029	(72,361)	94,536	6,094	(4,877)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,796	-	118,498	7,078	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	-	38,693	2,448	-	41,141
Total current liabilities	57,997	217,299	26,647	19,419	8,637	(72,361)	257,638	16,484	(4,877)	269,245
Notes payable, related party	-	527,346	-	27,425	-	(554,771)	-	-	-	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,270	(10,970)	724,231	28,744	-	752,975
Insurance deposits and related liabilities	-	54,616	465	155	240	-	55,476	40	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	242,227	-	-	242,227
Other liabilities	-	85,577	1,107	1,405	-	-	88,089	38	-	88,127
Total liabilities	702,517	1,170,412	57,788	49,583	25,463	(638,102)	1,367,661	45,306	(4,877)	1,408,090
<b>Commitments and contingencies</b>										
<b>Net assets</b>										
Unrestricted	23,759	334,882	61,828	32,897	19,812	-	473,178	72,230	(21,306)	524,102
Temporarily restricted	-	54,666	4,964	493	1,540	-	61,663	20,816	(40)	82,439
Permanently restricted	-	32,232	-	4,147	5,860	-	42,239	13,155	-	55,394
Total net assets	23,759	421,780	66,792	37,537	27,212	-	577,080	106,201	(21,346)	661,935
Total liabilities and net assets	\$ 726,276	\$ 1,592,192	\$ 124,580	\$ 87,120	\$ 52,675	\$ (638,102)	\$ 1,944,741	\$ 151,507	\$ (26,223)	\$ 2,070,025

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

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Assets</b>									
<b>Current assets</b>									
Cash and cash equivalents	\$ 134,634	\$ 23,094	\$ 8,621	\$ 9,982	\$ 6,654	\$ 12,144	\$ 5,040	\$ -	\$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,109	7,996	3,657	-	219,228
Prepaid expenses and other current assets	11,964	144,755	5,520	5,276	2,294	4,443	488	(77,238)	97,502
Total current assets	146,598	344,830	31,324	23,560	14,057	24,583	9,185	(77,238)	516,899
Assets limited as to use	8	635,028	17,438	12,821	11,862	9,612	19,355	-	706,124
Notes receivable, related party	554,771	-	-	-	-	-	-	(554,771)	-
Other investments for restricted activities	-	95,772	25,873	2,981	6,238	32	-	-	130,896
Property, plant, and equipment, net	36	445,829	70,607	42,920	19,065	25,725	3,139	-	607,321
Other assets	24,863	101,235	7,526	5,333	1,886	130	128	(32,316)	108,785
Total assets	\$ 726,276	\$ 1,622,694	\$ 152,768	\$ 87,615	\$ 53,108	\$ 60,082	\$ 31,807	\$ (664,325)	\$ 2,070,025
<b>Liabilities and Net Assets</b>									
<b>Current liabilities</b>									
Current portion of long-term debt	\$ -	\$ 1,031	\$ 810	\$ 572	\$ 245	\$ 739	\$ 67	\$ -	\$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	-	-	3,311
Accounts payable and accrued expenses	54,995	82,613	20,052	6,714	3,092	3,596	1,929	(77,238)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,831	5,814	1,229	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	2,448	-	-	41,141
Total current liabilities	57,997	217,851	26,592	19,428	8,793	12,597	3,225	(77,238)	269,245
Notes payable, related party	-	527,346	-	27,425	-	-	-	(554,771)	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,593	25,792	2,629	(10,970)	752,975
Insurance deposits and related liabilities	-	54,616	465	155	241	-	39	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	-	-	242,227
Other liabilities	-	85,577	1,117	1,405	-	28	-	-	88,127
Total liabilities	702,517	1,170,964	57,743	49,592	25,943	38,417	5,893	(642,979)	1,408,090
<b>Commitments and contingencies</b>									
<b>Net assets</b>									
Unrestricted	23,759	356,518	65,069	33,383	19,764	21,031	25,884	(21,306)	524,102
Temporarily restricted	-	60,836	19,196	493	1,539	415	-	(40)	82,439
Permanently restricted	-	34,376	10,760	4,147	5,862	219	30	-	55,394
Total net assets	23,759	451,730	95,025	38,023	27,165	21,665	25,914	(21,346)	661,935
Total liabilities and net assets	\$ 726,276	\$ 1,622,694	\$ 152,768	\$ 87,615	\$ 53,108	\$ 60,082	\$ 31,807	\$ (664,325)	\$ 2,070,025

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

<i>(in thousands of dollars)</i>	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
<b>Assets</b>									
<b>Current assets</b>									
Cash and cash equivalents	\$ 27,328	\$ 10,845	\$ 7,797	\$ 6,682	\$ -	\$ 52,432	\$ 16,068	\$ -	\$ 68,498
Patient accounts receivable, net	193,733	17,723	8,539	4,659	-	224,654	12,608	-	237,260
Prepaid expenses and other current assets	93,816	8,945	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	36,708	(8,008)	394,961
<b>Assets limited as to use</b>	580,254	19,104	11,784	9,058	-	620,200	42,123	-	662,323
Other investments for restricted activities	86,398	4,784	2,833	6,079	-	100,074	24,455	-	124,529
Property, plant, and equipment, net	448,743	64,933	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
<b>Liabilities and Net Assets</b>									
<b>Current liabilities</b>									
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	8,781	-	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
<b>Commitments and contingencies</b>									
<b>Net assets</b>									
Unrestricted	258,887	58,250	32,504	15,247	-	364,888	81,344	(21,285)	424,947
Temporarily restricted	88,473	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 and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Assets</b>									
<b>Current assets</b>									
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
<b>Assets limited as to use</b>	-	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
<b>Liabilities and Net Assets</b>									
<b>Current liabilities</b>									
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	-	77,822	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
<b>Commitments and contingencies</b>									
<b>Net assets</b>									
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 Statements of Operations and Changes in Unrestricted Net Assets**  
**Year Ended June 30, 2018**

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Unrestricted revenue and other support										
Net patient service revenue, net of contractual allowances and discounts	\$ -	\$ 1,475,314	\$ 216,736	\$ 60,486	\$ 52,014	\$ -	\$ 1,804,550	\$ 94,545	\$ -	\$ 1,899,095
Provisions for bad debts	-	31,358	10,967	1,554	1,440	-	45,319	2,048	-	47,367
Net patient service revenue less provisions for bad debts	-	1,443,956	205,769	58,932	50,574	-	1,759,231	92,497	-	1,851,728
Contracted revenue	(2,305)	97,291	-	-	2,169	(42,870)	54,285	716	(32)	54,969
Other operating revenue	9,799	134,461	3,365	4,169	1,814	(10,554)	143,054	6,978	(1,086)	148,946
Net assets released from restrictions	658	11,605	620	52	44	-	12,979	482	-	13,461
Total unrestricted revenue and other support	8,152	1,687,313	209,754	63,153	54,601	(53,424)	1,969,549	100,673	(1,118)	2,069,104
Operating expenses										
Salaries	-	806,344	105,607	30,360	24,854	(21,542)	945,623	42,035	1,605	989,263
Employee benefits	-	181,833	28,343	7,252	7,000	(5,385)	219,043	10,221	419	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,055	-	329,836	10,195	-	340,031
Purchased services and other	8,509	215,073	33,065	13,587	13,860	(19,394)	264,800	29,390	(2,818)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,744	-	65,517	2,175	-	67,692
Depreciation and amortization	23	66,073	10,217	3,934	2,030	-	82,277	2,501	-	84,778
Interest	8,684	15,772	1,004	981	224	(8,882)	17,783	1,039	-	18,822
Total operating expenses	17,216	1,627,466	217,599	64,834	52,867	(55,203)	1,924,879	97,556	(794)	2,021,641
Operating (loss) margin	(9,064)	59,847	(7,845)	(1,781)	1,734	1,779	44,670	3,117	(324)	47,463
Non-operating (losses) gains										
Investment (losses) gains	(26)	33,628	1,408	1,151	858	(188)	36,821	3,566	-	40,387
Other, net	(1,364)	(2,599)	-	1,276	266	(1,581)	(4,002)	733	361	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	(14,214)	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	(14,247)	-	-	(14,247)
Total non-operating (losses) gains, net	(1,390)	2,873	1,408	2,122	1,124	(1,779)	4,358	4,299	361	9,018
(Deficiency) excess of revenue over expenses	(10,454)	62,720	(6,437)	341	2,858	-	49,028	7,416	37	56,481
Unrestricted net assets										
Net assets released from restrictions (Note 7)	-	16,038	-	4	252	-	16,294	19	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	8,254	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(26,355)	7,188	48	328	-	-	-	-	-
Additional paid in capital	-	-	-	-	-	-	-	58	(58)	-
Other changes in net assets	-	-	-	-	-	-	-	(185)	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	4,190	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	14,102	-	-	14,102
Increase in unrestricted net assets	\$ 7,337	\$ 75,995	\$ 3,578	\$ 393	\$ 4,565	\$ -	\$ 91,868	\$ 7,308	\$ (21)	\$ 99,155

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidating Statements of Operations and Changes in Unrestricted Net Assets**  
**Year Ended June 30, 2018**

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	MLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	\$ -	\$ 1,475,314	\$ 216,736	\$ 60,486	\$ 52,014	\$ 71,458	\$ 23,087	\$ -	\$ 1,899,095
Provisions for bad debts	-	31,358	10,967	1,554	1,440	1,680	368	-	47,367
Net patient service revenue less provisions for bad debts	-	1,443,956	205,769	58,932	50,574	69,778	22,719	-	1,851,728
Contracted revenue	(2,305)	98,007	-	-	2,169	-	-	(42,902)	54,969
Other operating revenue	9,799	137,242	4,061	4,166	3,188	1,697	453	(11,640)	148,946
Net assets released from restrictions	658	11,984	620	52	44	103	-	-	13,481
Total unrestricted revenue and other support	8,152	1,691,189	210,450	63,150	55,955	71,578	23,172	(54,542)	2,069,104
Operating expenses									
Salaries	-	806,344	105,607	30,360	25,592	29,215	12,082	(19,937)	989,263
Employee benefits	-	181,833	28,343	7,252	7,162	7,406	2,653	(4,966)	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,057	8,484	1,709	-	340,031
Purchased services and other	8,512	218,690	33,431	13,432	14,354	19,229	5,945	(22,212)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,743	2,178	-	-	67,692
Depreciation and amortization	23	66,073	10,357	3,939	2,145	1,831	410	-	84,778
Interest	8,684	15,772	1,004	981	223	975	65	(8,882)	18,822
Total operating expenses	17,219	1,631,083	218,105	64,784	54,276	69,307	22,864	(55,997)	2,021,841
Operating (loss) margin	(9,067)	60,106	(7,655)	(1,634)	1,679	2,271	308	1,455	47,463
Non-operating (losses) gains									
Investment (losses) gains	(26)	35,177	1,954	1,097	787	203	1,393	(198)	40,387
Other, net	(1,364)	(2,599)	(3)	1,276	273	(223)	952	(1,220)	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	-	-	(14,247)
Total non-operating (losses) gains, net	(1,390)	4,422	1,951	2,068	1,060	(20)	2,345	(1,418)	9,018
(Deficiency) excess of revenue over expenses	(10,457)	64,528	(5,704)	434	2,739	2,251	2,653	37	56,481
Unrestricted net assets									
Net assets released from restrictions (Note 7)	-	18,058	-	4	251	-	-	-	18,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-
Additional paid in capital	58	-	-	-	-	-	-	(58)	-
Other changes in net assets	-	-	-	-	-	(185)	-	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	-	-	14,102
Increase in unrestricted net assets	\$ 7,392	\$ 77,823	\$ 4,311	\$ 486	\$ 4,445	\$ 2,066	\$ 2,653	\$ (21)	\$ 99,155



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

<i>(in thousands of dollars)</i>	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	\$ 1,447,861	\$ 214,265	\$ 58,928	\$ 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	1,404,898	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	104,611	3,045	3,839	1,592	(1,148)	111,939	6,418	820	119,177
Net assets released from restrictions	9,550	639	116	61	-	10,368	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	968,352
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	7,600	2,923	1,620	-	62,461	2,608	-	65,069
Depreciation and amortization	66,067	10,238	3,841	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)	1,854,694	110,908	958	1,976,561
Operating margin (loss)	18,649	(3,502)	(2,070)	673	1,975	15,725	(22,587)	(182)	(7,044)
Non-operating gains (losses)									
Investment gains (losses)	42,484	1,378	1,570	984	(209)	48,207	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 non-operating gains (losses), net	39,481	1,378	891	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 7)	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	-	-
Additional paid in capital	-	-	-	-	-	-	8,359	(6,359)	-
Other changes in net assets	-	-	-	(2,286)	-	(2,286)	(1,078)	-	(3,364)
Change in fair value on interest rate swaps	6,418	-	1,337	47	-	7,802	-	-	7,802
Increase in unrestricted net assets	\$ 41,854	\$ 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 and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	MLH 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	839	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	66,067	10,396	3,886	2,242	1,532	413	-	84,582
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)
Non-operating 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 non-operating 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	80,074
Unrestricted net assets									
Net assets released from restrictions (Note 7)	-	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	6,359	-	-	-	-	-	-	(6,359)	-
Other changes in net assets	-	-	-	-	(2,286)	(1,078)	-	-	(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)	\$ 64,784

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

---

**1. Basis of Presentation**

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

**Dartmouth-Hitchcock Board of Trustees**

**Vincent S. Conti, Chair**

**Edward Stansfield, Vice Chair**

**Duane Compton, PhD**

**William Conaty**

**Paul Danos, PhD**

**Senator Judd Gregg**

**Roberta Hines, MD**

**Cherie Holmes, MD**

**Laura Landy, MD**

**Robert Oden, PhD**

**Charles Plimpton, MBA**

**Kurt Rhyhart, MD**

**Kari Rosenkranz, MD**

**Pamela Austin Thomson,**

**Jon Wahrenberger, MD**

**Marc Wolpow, JD**

**MARJORIE H.W. WEEKS**  
Newbury, NH 03255  
603-748-1997 • mbweeks@tds.net • linkedin.com/in/marjorieweeks

---

## **SUMMARY**

Highly capable clinical research professional with experience in investigator-initiated, federal, and industry sponsored clinical trials in hospital and academic environments. Excellent leadership, management and communication skills. Very effective at building and managing professional collaborations ensuring successful outcomes.

## **EXPERIENCE**

**Dartmouth College, Geisel School of Medicine, Department of Psychiatry, Hanover, NH**  
Effective July 1, 2016 position was transitioned to Dartmouth-Hitchcock Medical Center, Lebanon, NH

### **New Hampshire Hospital Research Manager**

**2012-Present**

- Initiated and currently building research infrastructure and culture at a 168-bed acute psychiatric care facility
- Define projects, determine resource needs, develop procedures and connect resources and support for various phases of projects to achieve successful outcomes.
- Provide one-on-one consultation including mentoring, training and educating clinical staff new to research. Consultations are highly specific and specialized resulting in the expedient facilitation of research projects.
- Promote research throughout the organization to ensure research potential is considered by all staff which yields a continuous flow of research ideas and initiatives.
- Establish, manage and maintain ongoing relationships with CEO, Administration, principal investigators, clinical staff, community, research liaisons and volunteers to increase coordination and leverage for research activities.
- Organize all research special events such as the first annual Research Retreat and Research Rounds.
- Perform all business functions including finance, compliance, supervision, IRB advisor and consultant for any ad hoc assignments pertaining to research.

### **Operations Manager, Psychopharmacology Research Group (PRG)**

**2008-2012**

- Multi-site position covering Bedford, Concord, Lebanon.
- Conducted multiple complex, multi-site, randomized clinical research drug trials involving schizophrenia and alcohol use.
- Unified and systemized process between two sites and provided training and oversight to staff to ensure smooth operations and excellent data.
- Negotiated additional funding from study sponsor for recruitment efforts.
- Transitioned busy 12 person office to new facility.
- Managed the day-to-day operations for the PRG Group and provided support to several studies.
- Activities included coordination of efforts, supervision of staff, medications monitoring, specimen collection and tracking, shipping hazardous materials, patient payments, conducting patient ratings, data queries and data entry.
- Developed policies and procedures for PRG operations.

**Project Manager, R-LAST Study (within PRG Group)****2005-2008**

- Managed a complex, multi-site, multi-state, randomized clinical research drug trial focusing on schizophrenia and alcohol use with Risperidone. Received Dartmouth Medical School, Department of Psychiatry, Psychopharmacology Research Group award for exceptional performance in the planning and execution of the study.
- Commended for most successful recruitment for a study in PRG's history.
- Created first VA approved Tissue Bank at Dartmouth Hitchcock Medical Center.
- Developed first online resource for study documents for the PRG which reduced study errors and enhanced access for all staff at all sites.
- Organized off-site 3 day start-up meeting for 40 participants from 8 sites from around the country resulting in finalized protocol, all staff trained and a rapid launch of the study.
- Coordinated use of central lab for 8 sites following FDA regulations while saving significant expense by creating our own custom lab kits and shipping materials.
- Accountabilities included staff management, coordination/implementation of the study from start up to conclusion, including recruitment, development of operating systems to track study progress, training, site monitoring, managing all IRB documentation, rater reliability, conducting weekly study meetings and study drug management.
- Provided financial management, oversight and reporting for each study site and the study sponsor.

**Project Coordinator, Dartmouth Psychiatric Research Center****2002-2005**

- Coordinated and implemented the Resident Education, Assistance and Prevention Program (REAP) research project which focused on the prevention of medication misuse and substance abuse among 3000 senior housing residents throughout the State of New Hampshire. Two additional studies then followed based on its findings of significant depression.
- Prepared study, developed contacts, created and produced all materials for the project including marketing, and conducted intervention.
- Developed and maintained databases for the accumulated interview materials of over 1300 participants.

**New Hampshire Community Loan Fund, MicroCredit-NH, Concord, NH**  
**Assistant Director – Operations**
**2000-2001**

- Oversaw daily operations for statewide non-profit program providing low interest loans and educational information for start-up businesses which significantly enhanced their business viability.
- Provided financial management/oversight and reporting, including grants and budgets, systems development, oversight and special projects on an ongoing basis.

**EDUCATION**

Masters of Public Administration  
 Bachelors of Arts in International Relations  
 Certification in Asian Studies

Michigan State University 1993  
 Michigan State University 1990  
 Michigan State University 1990

### CERTIFICATIONS & PROFESSIONAL DEVELOPMENT

- Yellow Belt Lean Sigma Six Training with The Value Institute Learning Center at Dartmouth-Hitchcock, June 2017
- Communicating with Impact – Dartmouth College September 2015
- CPR & AED Healthcare Provider Training & Certification, May 2015
- High Performance Project Management – Dartmouth College May 2015
- Dean's Leadership Intensive: "Being a Leader and the Effective Exercise of Leadership: An Ontological/Phenomenological Model," Certificate 2012
- Management Essentials at Dartmouth (MEAD) – Dartmouth College, 2008

### PAPERS

Contributed as Research Manager - Ben-Zeev, D., Wang, R., Abdullah, S., Brian, R., Scherer, E. A., Mistler, L. A., & ... Choudhury, T. (2016). Mobile behavioral sensing for outpatients and inpatients with schizophrenia. *Psychiatric Services* (Washington, D.C.), 67(5), 558-561.

Green, A., Brunette, M., Dawon, R., Buckley, P., Wallace, A., Hafez, H., Herz, M., Narasimhan, M., Noordsy, D., O'Keefe, C., Sommi, R., Steinbook, R., **Weeks, M.** (2015). Long-acting injectable vs oral risperidone for schizophrenia and co-occurring alcohol use disorder: a randomized trial. *The Journal of Clinical Psychiatry*, 76(10), 1359-1365.

Contributed as Research Coordinator - Litten, R. Z., Fertig, J. B., Falk, D. E., Ryan, M. L., Mattson, M. E., Collins, J. F., & ... Stout, R. (2012). A double-blind, placebo-controlled trial to assess the efficacy of quetiapine fumarate XR in very heavy-drinking alcohol-dependent patients. *Alcoholism: Clinical And Experimental Research*, 36(3), 406-416.

Contributed as Research Coordinator - Litten, R. Z., Ryan, M. L., Fertig, J. B., Falk, D. E., Johnson, B., Dunn, K. E., & ... Stout, R. (2013). A double-blind, placebo-controlled trial assessing the efficacy of varenicline tartrate for alcohol dependence. *Journal Of Addiction Medicine*, 7(4), 277-286.

**Barbara E. Dieckman RN, MS, MBA**  
**Warner, New Hampshire 03278**  
**Barbara.Dieckman@gmail.com**

---

## **Summary of Qualification**

Ms. Dieckman is an analytically driven leader of change in clinical process and performance improvement. 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:

- 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**

### **October 2011 to present 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

## CURRICULUM VITAE

Updated: January 2, 2019

Date Originally Prepared: August 1, 2013

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

**ADDRESS**            Office:   New Hampshire Hospital  
36 Clinton Street  
Concord, NH 03301  
Phone: (603)-271-5202  
Fax: (603)-271-5395  
E-Mail: [alexander.denesnera@dhhs.nh.gov](mailto: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**

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

**DARTMOUTH INSTITUTIONAL LEADERSHIP ROLES**

**LICENSURE AND CERTIFICATION**

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

**HOSPITAL APPOINTMENTS**

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

**HOSPITAL APPOINTMENTS (con'd)**

<b>1990-</b>	<b>Staff Psychiatrist New Hampshire Hospital Concord, NH</b>
<b>1988-1990</b>	<b>Staff Psychiatrist Nashua Brookside Hospital Nashua, NH</b>

**OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH)**

<b>2006-2007</b>	<b>Founder and Director, Helping Heroes Bridge Program Free assessment and triage program New Hampshire Veterans and National Guard personnel</b>
<b>1997-2008</b>	<b>Consulting Psychiatrist, Secure Psychiatric Unit, Department of Corrections Concord, NH</b>
<b>1992-2000</b>	<b>Consulting Psychiatrist, Veteran Administration Hospital White River Junction, VT</b>
<b>1988-1989</b>	<b>Consulting Psychiatrist, Alzheimer's Disease and Related Disorders Clinic, Mary Hitchcock Memorial Hospital Hanover, NH</b>
<b>1988-1989</b>	<b>Medical Director, Weekend Intoxicated Driver Intervention Program Hanover, NH</b>
<b>1987-1988</b>	<b>Assistant Medical Director, Weekend Intoxicated Driver Intervention Program Hanover, NH</b>
<b>1980-1981</b>	<b>Research Assistant, Rockefeller University, New York, NY. Biochemical Research. Synthesis and testing of drugs to treat human African sleeping sickness.</b>
<b>1978-1986</b>	<b>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.</b>

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

<b>1977-1979</b>	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 <u>Petromyzon marinus</u> "
------------------	--

**UNDERGRADUATE MEDICAL EDUCATION**

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

**GRADUATE EDUCATION**

<b>2001-2010</b>	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.
<b>1998-2002</b>	Clinical Adjunct Faculty Rivier College School of Nursing and Health Sciences Nashua, NH

**GRADUATE MEDICAL EDUCATION**

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

**GRADUATE MEDICAL EDUCATION (con'd)**

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

**UNDERGRADUATE COLLEGE**

**CONTINUING MEDICAL EDUCATION**

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

**COMMUNITY EDUCATION**

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

**COMMUNITY EDUCATION (con'd)**

<b>2003, 2005</b>	<b>Surveyor, Review Team for the Secure Psychiatric Unit (SPU) Department of Corrections Concord, NH</b>
-------------------	--

**STUDENT/FELLOW ADVISING/MENTORING**

<b>2013-2014</b>	<b>Mentor, Katya Hurst, M.D., Lakes Region DRF Psychiatrist</b>
------------------	---

<b>2013-2014</b>	<b>Mentor, New Hampshire Guardianship Statutes/Rules Project Residents: J.J. Chen, M.D. and Danielle Dahle, M.D.</b>
------------------	--

<b>2012-2013</b>	<b>Mentor, Leadership in Preventive Medicine Residency Governmental Public Health Experience Resident: J.J. Chen, M.D.</b>
------------------	--

**RESEARCH FUNDING**

<b>2009</b>	<b>American Psychiatric Foundation Typical or Troubled School Mental Health Education Program Grant Concord High School/ NH Psychiatric Society \$6,000 Grant</b>
-------------	---

<b>2005</b>	<b>American Psychiatric Association Committee on Advocacy and Litigation Funding (CALF) \$40,000 Public Education and Advocacy Grant</b>
-------------	--

<b>2005</b>	<b>Janssen Medical Affairs INC Investigator-Initiated Research Grant Family Perspectives: Treatment of Psychiatric Illnesses with Atypical, Long-Acting Injectable Antipsychotic Medication \$76,000 Grant</b>
-------------	--

<b>2004</b>	<b>American Psychiatric Association Committee on Advocacy and Litigation Funding (CALF) \$40,000 Public Education and Advocacy Grant</b>
-------------	--

<b>2004</b>	<b>New Hampshire Charitable Foundation Grant Family Perspectives: Treatment of Psychiatric Illnesses with Atypical Long-Acting Injectable Antipsychotic Medication \$6200 Grant</b>
-------------	---



**RESEARCH FUNDING (con'd)**

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

**PROGRAM DEVELOPMENT**

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

**ENTREPRENEURIAL ACTIVITIES**

**MAJOR COMMITTEE ASSIGNMENTS**

**National/International**

<b>2014</b>	<b>Consultant, State of Virginia Review of Commitment and Involuntary Treatment Laws</b>
<b>2014</b>	<b>Consultant, State of Hawaii Review of Commitment and Involuntary Treatment Laws</b>

**Regional**

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

**MAJOR COMMITTEE ASSIGNMENTS**

**Regional (con'd)**

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

**Institutional**

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

**MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES**

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

**EDITORIAL BOARDS**

**JOURNAL REVIEW ACTIVITY**

**AWARDS AND HONORS**

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

**AWARDS AND HONORS (con'd)**

- |             |   |
|-------------|---|
| <b>1987</b> | <b>Psychiatry Resident Teacher of the Year Award<br/>Dartmouth Medical School</b> |
| <b>1978</b> | <b>Beta Lambda Sigma Biology Honor Society<br/>New York University</b>            |

**INVITED PRESENTATIONS**

**International**

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

**National**

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

**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.  
67<sup>th</sup> 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.  
168<sup>th</sup> 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.  
66<sup>th</sup> 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.  
65<sup>th</sup> 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.  
64<sup>th</sup> Institute on Psychiatric Services (Poster)  
New York, NY

**INVITED PRESENTATIONS**

**National (con'd)**

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

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



**INVITED PRESENTATIONS**

**Regional/Local (con'd)**

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

**INVITED PRESENTATIONS**

**Regional/Local (con'd)**

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

**INVITED PRESENTATIONS**

**Regional/Local (con'd)**

- |             |   |
|-------------|---|
| <b>2011</b> | <b>Involuntary Treatment of Involuntary Patients: Issues and Concerns<br/>Colby-Sawyer College<br/>Mental Health Systems Course<br/>Concord, NH</b>                                       |
| <b>2011</b> | <b>Choking Risk in Mental Illness<br/>Nursing Grand Rounds<br/>New Hampshire Hospital<br/>Concord, NH</b>   |
| <b>2011</b> | <b>Overview of Mental Illness Diagnoses and Psychiatric Medications<br/>Manchester Police Department<br/>Crisis Intervention Team (CIT) Training<br/>Manchester, NH</b>                   |
| <b>2011</b> | <b>The Involuntary Commitment Process<br/>Manchester Police Department<br/>Crisis Intervention Team (CIT) Training<br/>Manchester, NH</b>   |
| <b>2011</b> | <b>Helpful Strategies for Determining Psychiatric Diagnoses<br/>Health Information Coding Education Conference<br/>New Hampshire Hospital<br/>Concord, NH</b>                             |
| <b>2010</b> | <b>Effective Advocacy: Our Responsibility<br/>Dartmouth Medical School Grand Rounds<br/>Department of Psychiatry<br/>Lebanon, NH</b>  |
| <b>2010</b> | <b>Typical or Troubled: Assessment of Mental Health Issues in Adolescents in a School Setting.<br/>Concord High School Teacher Conference<br/>Concord, NH</b>                             |
| <b>2010</b> | <b>Assessment and Treatment of Metabolic Syndrome in The Seriously Mentally Ill: A Bureau of Behavioral Health Initiative. Greater Manchester Mental Health Center<br/>Manchester, NH</b> |

INVITED PRESENTATIONS

Regional/Local (con'd)

- |      |   |
|------|---|
| 2009 | Implementation of a Total Smoking Ban at New Hampshire Hospital. Grand Rounds Presentation, Tewksbury State Hospital<br>Tewksbury, MA   |
| 2009 | Update on the Involuntary Commitment Process in New Hampshire. Incapacitated Adult Fatality Review Committee (IAFRC).<br>Concord, NH  |
| 2009 | Legal Issues: The IEA Process-Clinical Implications<br>Police Standards and Training Council Two-Day Police Training.<br>Concord, NH  |
| 2009 | Overview of Mental Illness Diagnoses and Psychiatric Medications.<br>Rochester Police Department<br>Crisis Intervention Team (CIT) Training<br>Rochester, NH                                |
| 2009 | The Involuntary Commitment Process<br>Rochester Police Department<br>Crisis Intervention Team (CIT) Training.<br>Rochester, NH  |
| 2008 | Developing a New Hampshire Care Continuum: Acute and Community Based Services<br>Policy Summit on Mental Health Issues and the Role for a New Hampshire Mental Health Caucus<br>Concord, NH |
| 2008 | Advanced Care Directives and Mentally Ill Patients: Challenges in Treatment.<br>Foundations For Healthy Communities Conference<br>Concord, NH   |
| 2007 | New Hampshire Hospital Tobacco Free Campus and Wellness<br>New Hampshire Hospital Professional Grand Rounds<br>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.; Barnett, 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<br><i>American Psychiatric Association Psychiatric News</i><br>47:20; p. 19. October, 2012 |
| 2009 | de Nesnera, A.; Add New Hampshire to the List.<br><i>American Psychiatric Association Psychiatric News</i><br>44:10; p. 38. May, 2009                         |
| 2004 | de Nesnera, A.; Psychology Prescribing.<br><i>American Psychiatric Association Psychiatric News</i><br>39:14; p. 42. July, 2004                               |

Updated By: Alexander de Nesnera, M.D.

Date: January 2, 2019

**CURRICULUM VITAE**  
**Gary S. Moak, M.D.**

**ADDRESS:** 14-1 Boulderwood Way, PO Box 507  
Waterville Valley, NH 03215

**OFFICE:** New Hampshire Hospital  
36 Clinton Street  
Concord, NH 03301

**I. EDUCATION**

<b><u>DATES</u></b>	<b><u>INSTITUTION</u></b>	<b><u>DEGREE</u></b>
1974-1978	University of Pennsylvania	BA
1978-1982	Robert Wood Johnson-Rutgers Medical School	MD

**II. POSTDOCTORAL TRAINING**

<b><u>DATES</u></b>	<b><u>INSTITUTION</u></b>	<b><u>SPECIALTY</u></b>
1982-1986	University of Pittsburgh	Psychiatry
1985-1986	University of Pittsburgh	Geriatric Psychiatry

**III. PROFESSIONAL DEVELOPMENT ACTIVITIES – Not applicable**

Gary S. Moak, M.D.

#### **IV. ACADEMIC APPOINTMENTS**

<b><u>DATES</u></b>	<b><u>INSTITUTION</u></b>	<b><u>TITLE</u></b>
1986-1996	University of Massachusetts Medical School (Full-time faculty, 1986-1989)	Assistant Professor of Psychiatry
1993-1994	College of the Holy Cross	Lecturer
1996-2015	University of Massachusetts Medical School	Associate Professor of Clinical Psychiatry
2015-	Geisel Medical School at Dartmouth	Assistant Professor of Psychiatry

#### **V. INSTITUTIONAL LEADERSHIP ROLES:**

<b><u>DATES</u></b>	<b><u>INSTITUTION</u></b>	<b><u>TITLE</u></b>
1986- 1989	Worcester State Hospital Worcester, Massachusetts	Clinical Director of Psychogeriatrics
1990- 1997	Clinton Hospital	Medical Director, Geriatric Medical Psychiatry Unit
1991- 1997	Clinton Hospital	Chief of Psychiatry
1997- 1999	Boston Road Clinic, Inc./ Capstan, LLC/ Fallon Community Health Plan	Director of Geriatric Services
1997- 1999	Saint Vincent Hospital, Worcester, MA Department of Psychiatry	Director, Geriatric Division
2000- 2015	Moak Center for Healthy Aging	Private practice owner and medical director
2009- 2011	University of Massachusetts Medical School.	Medical Director, Geriatric Psychiatry Consultation Project
2015 -	New Hampshire Hospital	Chief of Geriatric Psychiatry
2017-	New Hampshire Hospital	Associate Medical Director
2017-	Dartmouth-Hitchcock Medical Center	Director, Geriatric Psychiatry Fellowship Training Program

# **VI. LICENSURE AND CERTIFICATION:**

<u>DATE</u>		<u>LICENSURE/CERTIFICATION</u>
1986	Commonwealth of Massachusetts	Medical License
1987	American Board of Psychiatry and Neurology	Psychiatry
1989	State of New Hampshire	Medical License
1991- 2001 2011	American Board of Psychiatry and Neurology Recertified Recertified	Geriatric Psychiatry

# **VII. HOSPITAL APPOINTMENTS:**

<u>DATES</u>	<u>INSTITUTION</u>	<u>POSITION/TITLE</u>
1986- 1989	Worcester State Hospital	Clinical Director of Psychogeriatrics
1986- 1989	UMass Medical Center	Staff Psychiatrist
1989- 1990	Nashua Brookside Hospital	Staff Psychiatrist
1990- 1997	Clinton Hospital Clinton, Massachusetts	Medical Director, Geriatric Medical Psychiatry Unit
1994- 2015	UMassMemorial Healthcare 1994-1996  2004-2006  2009-2011	Associate Medical Staff Consultant, Geriatric Medicine Clinic Consultant, Geriatric Medical Psychiatry Unit, UMMHC~Clinton Hospital Medical Director, UMass Geriatric Psychiatry Consultation Project

Gary S. Moak, M.D.

1997- 1999	Saint Vincent Hospital	Director, Geriatric Division Department of Psychiatry
1999- 2015	Whittier Rehabilitation Hospital	Consulting Psychiatrist
2015-	New Hampshire Hospital	Chief of Geriatric Psychiatry
2015-	Dartmouth-Hitchcock Medical Center	Staff Psychiatrist

#### **VIII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH):**

<u>DATES</u>	<u>INSTITUTION</u>	<u>POSITION/TITLE</u>
--------------	--------------------	-----------------------

#### **IX. TEACHING ACTIVITIES:**

##### **A. UNDERGRADUATE (COLLEGE) EDUCATION**

**1993-1994**

**College of The Holy Cross  
Aging and Health**

I served as course faculty for this senior seminar course. Many of the students were enrolled in the Worcester Consortium Gerontology Studies Program, and were preparing to enter graduate or professional schools to pursue careers in gerontology or geriatrics. The course met for two hours per week for one semester. I led seminars based on assigned, weekly reading, and graded a final term paper.

##### **B. GRADUATE EDUCATION**

List *classes* taught for Ph.D. or Masters students - Not applicable

##### **C. UNDERGRADUATE MEDICAL EDUCATION:**

###### **i. CLASSROOM TEACHING:**

**November 14, 2017**

**Geisel Medical School**

**Course Title: Scientific Basis of Medicine**

Gary S. Moak, M.D.

I gave a lecture on dementia, by the same title, in this second-year medical school course on psychopathology. This was a one-hour lecture plus time spent preparing the content for the slides.

## **ii. CLERKSHIP OR OTHER CLINICAL UME TEACHING (e.g., ON-DOCTORING)**

**July 2018 –**

### **New Hampshire Hospital Geriatric Psychiatry Unit Teaching Rounds**

As Chief of Geriatric Psychiatry, I see all new admissions in daily teaching rounds, which are attended by the unit's psychiatrists, geriatric psychiatry fellows, and rotating psychiatry residents. This includes Geisel Medical School students if they happen to be doing their psychiatry clerkship on the Geriatric Psychiatry Unit.

This requires about 100 hours per year.

## **D. GRADUATE MEDICAL EDUCATION**

Inclusive of instruction of residents and fellows during clinical practice

**August 2015 to present**

### **Dartmouth-Hitchcock Medical Center**

#### **Healthy Aging Brain Care Clinic**

In this geriatric psychiatry outpatient clinic, I provide clinical "bedside" supervision to geriatric psychiatry fellows and PGY-3 psychiatry residents. PGY-3 internal medicine residents also precept with me in this clinic. This includes supervision of monthly rounds at Genesis of Lebanon, a nursing facility. Teaching includes one hour for group review of cases and discussion of topics or selected references from the literature.

The clinic requires about 172 hours per year of my time

**July 2018 –**

### **Dartmouth-Hitchcock Medical Center**

#### **Primary Care Geriatric Clinic, General Internal Medicine Clinic**

I supervise geriatric psychiatry fellows, who provide geriatric psychiatry consultation on challenging cases referred by the clinic geriatricians.

This requires about 150 hours per year of my time.

**July 2018 –**

### **New Hampshire Hospital Geriatric Psychiatry Unit Teaching Rounds**

As Chief of Geriatric Psychiatry, I see all new admissions in daily teaching rounds, which are attended by the unit's psychiatrists, geriatric psychiatry fellows, and rotating psychiatry residents and Geisel Medical School clerks.

This requires about 100 hours per year.

**July 2018 –**

### **Weekly didactic session with geriatric psychiatry fellows**

This weekly session focuses on discussion of one to three seminal readings from the literature of geriatric psychiatry and related fields. The goals are to expose fellows to the



Gary S. Moak, M.D.

knowledge base of geriatric psychiatry, discuss core concepts of geriatric psychiatry, and help fellows develop skills needed for their own lifelong learning in geriatric psychiatry.

**E. OTHER CLINICAL EDUCATION (e.g., PA programs)** Not applicable

**X. ADVISING/MENTORING**

**Academic years 2015-2016 and 2016-2017**

**Dartmouth-Hitchcock Medical Center**

**Transition to Practice Seminar**

This was a mentoring seminar with geriatric psychiatry fellow focused on discussion of professional roles and identity of practicing geriatric psychiatrists. It included issues related to transition from fellow to early career geriatric psychiatrist. I spent approximately 12 hours per year on this activity.

**E. FELLOWS**

<u>DATES</u>	<u>MENTEE'S NAME</u>	<u>SPECIALTY</u>
2015-2016	Frinette Checo, M.D.	Geriatric Psychiatry
2016-2017	Athari Alyazidi, M.D	Geriatric Psychiatry
2018-2019	Geraldine McWilliams, M.D.	Geriatric Psychiatry
2018-2019	Thatcher Newkirk, M.D.	Geriatric Psychiatry

**B. GRADUATE STUDENTS** Not applicable.

**C. MEDICAL STUDENTS** Not applicable.

**XI. RESEARCH TEACHING/MENTORING** Not applicable.

## **XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT:**

List activities relevant to your professional roles.

Assabet Valley Home Health Association

1991-1998

I served on the Board of Directors of this home health (VNA) organization located in Marlborough Massachusetts. It required about fifty hours per year. I also served on the Executive Search Committee for nearly one year, spanning 1994-1995, and this required 48 additional hours.

Jewish Family Services of Worcester, MA

2000-2006

I served as a member of the Guardianship Advisory Committee. Jewish Family Services Was the largest provider of public guardian services in Central Massachusetts, and this committee required thirty-six hours per year.

## **XIII. RESEARCH FUNDING:** Not applicable

## **XIV. PROGRAM DEVELOPMENT**

List any educational, clinical or research entities at Dartmouth that were created or notably advanced by your efforts

1. Geriatric Psychiatry Fellowship Program – I am in the process of updating and restructuring the program to better prepare fellows for the professional roles geriatric psychiatrists will fill in a future healthcare delivery system. This includes an emphasis on population health principles, as they apply to late-life mental disorders, and forms of collaborative care and indirect consultation to primary care teams in various settings. This will include new initiatives to imbed the fellows in the Geriatric Medicine Clinic at Dartmouth-Hitchcock Medical Center and the Community-Based Primary Care Practice at Dartmouth-Hitchcock-Concord.
2. New Hampshire Hospital Statewide Geriatric Mental Health Consultation Program – This program, which is being rolled out July 30, 2018, and is based at New Hampshire Hospital, will provide real-time telephone-based clinical consultation, on-site educational in-service training, and academic detailing to healthcare professionals all over New Hampshire to assist in the management of older adults with mental disorders. It will utilize the geriatric psychiatry expertise at New Hampshire Hospital, consisting of Geisel Medical School faculty geriatric psychiatrists, Dartmouth-Hitchcock staff geriatric psychiatry APRNs, and geriatric psychiatry fellows.

Gary S. Moak, M.D.

**XV. ENTREPRENEURIAL ACTIVITIES:** Since 2001, I have been a consultant for Moak Associates, a geriatric mental health billing company, owned by my wife, Cheryl Moak, and based in Westborough, Massachusetts. My role has been to provide Medicare compliance and practice management education and consultation to clients.

**XVI. MAJOR COMMITTEE ASSIGNMENTS:**

**National/international**

Not applicable.

**Regional**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSTITUTION</u></b>
1987	Task Force on Mental Health Services for the Elderly,	Member	Massachusetts Department of Mental Health
1988-1990	Center on Aging	Associate member	University of Massachusetts Medical Center

**Institutional**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSTITUTION</u></b>
1989-1990	Peer Review Committee	Member	Nashua Brookside Hospital
1990-1997	Credentials Committee	Member	Clinton Hospital
1990-1997	Board of Directors	Medical Staff Non-Voting Representative	Clinton Hospital
2016-present	Grand Rounds Committee	Chairman	New Hampshire Hospital
2016-present	Falls Committee	Member	New Hampshire Hospital

Gary S. Moak, M.D.

2016-present	Medical Records Committee	Member 2016-Chair -2017	New Hampshire Hospital
2017-present	Electronic Health Record Executive Steering Committee	Member	New Hampshire Hospital
2016-present	Treatment Plan Compliance Task Force	Member Workgroup chair	New Hampshire Hospital
2016-2017	Senior Management Team	Member	New Hampshire Hospital
2019-	Pain Management Committee	Chair	New Hampshire

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

##### **National/international**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSTITUTION</u></b>
1979-present		Member	American Medical Association
1983-present		Member	American Psychiatric Association
1994-2012	Medicare Carrier Advisory Network	Member	American Psychiatric Association
1994-2012	Medicare Carrier Advisory Committee Network	Representative, Massachusetts Psychiatric Society	American Psychiatric Association
1984 - 1991	Council on Aging	Fellow (1984-1986) Member (1986-1991)	American Psychiatric Association
1988 -1991	Task Force on Public Mental Health Systems and the Elderly	Member	American Psychiatric Association

Gary S. Moak, M.D.

1989-present		Member	American Geriatrics Society
1990-present		Member	Gerontologic Society of America
1996-1999	Clinical Practice Committee	Chair	American Association for Geriatric Psychiatry
1996-1999	Public Policy Committee	Member	American Association for Geriatric Psychiatry
1999- 2002	Board of Directors	Member	American Association for Geriatric Psychiatry
1999-2001	Long Term Care Initiative Scientific Steering Committee	Member	American Association for Geriatric Psychiatry
2002- 2003	Scientific Program Committee	Member	American Association for Geriatric Psychiatry
2003- 2005	Executive Committee	Secretary-Treasurer: Officer-elect 2003/04 Officer 2004-2005	American Association for Geriatric Psychiatry
2003-present		Member	International Psychogeriatric Association
2005-2009	Reimbursement Task Force	Member	American Association for Geriatric Psychiatry
2006- 2007	Council on Aging	Corresponding member	American Psychiatric
2006-2009	Executive Committee	President-elect 2006-2007 President 2007-2008 Immediate Past president 2008-2009	American Association for Geriatric Psychiatry

Gary S. Moak, M.D.

**Regional**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSTITUTION</u></b>
1991-2015	Committee on Geriatric Psychiatry	Member, 1991-1999 Chairman- 1992-1999	Massachusetts Psychiatric
1992-2015	Medicare Carrier Advisory Committee	Psychiatric Representative	Massachusetts Psychiatric Society
1993-present 2015-present		Member Member	Massachusetts Medical Society New Hampshire Psychiatric Society

**XVIII. EDITORIAL BOARDS:** Not applicable

**XIX. JOURNAL REFEREE ACTIVITY:** Not applicable

**XX. AWARDS AND HONORS:**

<b><u>DATE</u></b>	<b><u>AWARD</u></b>
1978	Phi Beta Kappa - Pennsylvania Chapter - Member
1984- 1986	American Psychiatric Association Burroughs Wellcome Fellow
2011-	American Association for Geriatric Psychiatry Clinician-of-the-Year Award
2016	Distinguished Life Fellow, American Psychiatric Association

## **XXI. INVITED PRESENTATIONS:**

### **A. International:**

International meetings should be those that are international in scope (i.e., invitees). Such meetings may be held within the U.S.

\*^Reichman, WE, Aupperle PM, Moak GS, Sultzer DL: Practical Management of Behavioral Disturbances in Dementia, A Hands-On, Case-Based Approach. Presented at the 16<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, Honolulu, March 1-4, 2003.

\*^Moak GS: Will There Be Any Geriatric Psychiatrists in the Future Healthcare Delivery System? Presidential Keynote Address, 20<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 1-4, 2007.

### **B. National:**

National meetings should be those that are national in scope (i.e., invitees). Such meetings may be held within New England.

#^Moak GS, Merowitz M: Geriatric Psychiatry in the State Hospital: Current Status and Future Directions. Workshop presented at the 39<sup>th</sup> Institute on Hospital and Community Psychiatry, Boston, 1987

\*^Introduction to Geriatric Practice: Roundtable discussion presented at the Tenth Annual Meeting of the American Association for Geriatric Psychiatry, Orlando, Florida, March 3, 1997

\*^Moak GS, Siegal A, Stein EM, et. al.: Successful Management of a Geriatric Psychiatry Practice: Workshop presented at the Tenth Annual Meeting of the American Association for Geriatric Psychiatry, Orlando, FLorida, March 6, 1997.

\*^Elderly Persons with Psychosis in the Community. Symposium discussant, presented at the 150<sup>th</sup> Annual Meeting of the American Psychiatric Association, San Diego, May 20, 1997.

#^Moak GS, Jackson J, Steinberg A: Managing a Successful Nursing Home Practice: Presented at the 11<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, San Diego, March 12, 1998.

\*^Moak GS: What You Need To Know About the OBRA Regs. In Dyck G and Moak GS. Component Workshop Number 24, Successful Practice in Long-Term Care. Presented at the 151<sup>st</sup> Annual Meeting of the American Psychiatric Association, Toronto, June 2, 1998.

Gary S. Moak, M.D.

#^Moak GS, Siegal AP: Emerging Opportunities for Geriatric Practice – Managed Care Workshop. Presented at the 12<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 15, 1999.

#^Moak GS, Stein EM: Medicare Coding Workshop. Presented at the 12<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 17, 1999.

\*\*Moak GS, Reichman W, Siegal AP, Steinberg A: Advanced Practice Management: Strategies for Building a Dementia Practice in Diverse Settings. Presented at the 12<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 18, 1999.

\*\*Moak GS, Greenspan D: How to Set Up a Geropsychiatry Unit. Presented at the 13<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, Miami, March 15, 2000.

\*\*Moak GS: Depression in the Elderly, in Steinberg AL: Review and Update of Geriatric Psychiatry. Presented at the 13<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, Miami, March 11, 2000.

#^Moak GS, Stein EM, Shellow RA: Coding/Reimbursement Controversies: How to Maintain a viable Practice in Geriatric Psychiatry. Presented at the 13<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, Miami, March 13, 2000.

\*\*Moak GS: Providers of Nursing Home Mental Health Services-Patterns of Practice. Providing Optimal Mental Health Services in Long Term Care. American Association for Geriatric Psychiatry, Washington, D.C., June 23-24, 2000.

#^Moak GS, Stein EM: Medicare Coding and Reimbursement: Presented at the 14<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, San Francisco, February 24, 2001.

\*\*Moak GS: Reimbursement Issues for Geriatric Psychiatrists. Presented at the 15<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, Orlando, February 24-27, 2002.

\*\*Stein, E, Moak G, Liptzin B: Everything You Every Wanted to Know About Coding, Documentation, and Reimbursement. Presented at the 16<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, Honolulu, March 1-4, 2003.



Gary S. Moak, M.D.

**\*^Bruce M, Vogel-Scibilia S, Hansen JC, Moak GS: Aging Well, The Successful Integration of Mental, Medical, and Social Services. Presented at the 20<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 1-4, 2007.**

**\*^Moak GS: New Developments in Medicare. In Proper Billing and Fair Reimbursement for Elder Care. AAGP's 2009 Clinical Practice Management Symposium. Presented at the 22<sup>nd</sup> Annual Meeting of the American Association for Geriatric Psychiatry. March 5, 2009, Honolulu.**

**\*^Moak GS: Geriatric Psychiatry Workforce Issues Across the Pacific. Symposium Discussant. 22<sup>nd</sup> Annual Meeting of the American Association for Geriatric Psychiatry. March 6, 2009, Honolulu.**

**\*^Kirwin P, Lyness J, Moak GS, Reynolds C, Forester B: The 2008 Institute of Medicine Report: Implications and Opportunities for Education, Public Policy/Access to Care and Research. 23<sup>rd</sup> Annual Meeting of the American Association for Geriatric Psychiatry. March 7, 2010, Savannah.**

**\*^Moak GS: Provision of Services – How Can Healthcare Organizations Incentivize Geriatric Mental Health Practitioners to Provide the Expertise They Need?. Presentation in symposium "Evolving Roles for Geriatric Mental Health Providers in the 21<sup>st</sup> Century Health Care System. Annual Meeting of the American Association for Geriatric Psychiatry, Los Angeles, March 14-17, 2012.**

**\*^Moak, G., "New Codes", in "Engaging in the Business of Geriatric Psychiatry: Making a Career and a Living in Geriatric Psychiatry", Symposium presented at the 40<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, March 15, 2018, Honolulu.**

**\*^Moak G., "The Best of Times and the Worst of Times: Opening and Closing Private Practices" in "Engaging in the Business of Geriatric Psychiatry: Making a Career and a Living in Geriatric Psychiatry", Symposium presented at the 40<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, March 15, 2018, Honolulu.**

**\*^Moak, G, "Collect Your Fees if You Want to Pay Your Office Rent: Billing, Collections and Appeals" in "Engaging in the Business of Geriatric Psychiatry: Making a Career and a Living in Geriatric Psychiatry", Symposium presented at the 40<sup>th</sup> Annual Meeting of the American Association for Geriatric Psychiatry, March 15, 2018, Honolulu.**

**C. Regional/Institutional:**

Institutional includes, Dartmouth College, Geisel, D-H, and the VAMC.

\*^Poststroke Depression: Evaluation and Treatment. Workshop presented at the Second Annual Stroke Rehabilitation Conference sponsored by The National Stroke Association, The Medical Center of Central Massachusetts, and Education Resources, Inc., Boston, October 19, 1990

\*Aging, Mental Health, and Mental Illness. Briefing presented to the Legislative Caucus on Older Citizens' Concerns, Massachusetts State House, March 27, 1997.

\*Moak GS: Geriatric Issues: Lecture presented at the Massachusetts Probate and Family Court Judicial Conference. Plymouth, October 23, 1998.

\*Freedman D, Moak GS: Defining, Diagnosing, Medicating and Treating Persons of Questionable Competency. Presented at the 5<sup>th</sup> Elder Law Institute, Suffolk University Law School and the Massachusetts Chapter of the National Academy of Elder Law Attorneys, Waltham, March 19, 1999.

\*^Moak GS: Neuropsychiatric Complications of Stroke. Stroke Management: A Paradigm for the New Millennium. Whittier Rehabilitation Hospital-Umass Memorial Healthcare Stroke Rehabilitation Conference, October 27, 1999, Westboro, MA.

\*^Moak GS: CATIE-AD: A Clinician's Perspective. Massachusetts Psychiatric Society 18<sup>th</sup> Annual Psychopharmacology Update. November 17, 2007, Waltham.

\*Moak GS: Collaborative Care and Management of Late-Life Health Problems: Presentation given in symposium Models of Care & Coverage in a Full Risk World. Coordinated Care and coverage Conference, Fallon Community Health Plan, Westborough, MA, October 11, 2012.

\*Moak GS: Challenges to Wellness. Keynote address presented at the 21<sup>st</sup> Annual Gerontological Nurses Conference, Saint Anselm College, Manchester, NH, August 21, 2015

\*^Moak GS: Depression is a Risk Factor for Cardiovascular Disease Throughout the Lifespan. Grand rounds lecture presented at New Hampshire Hospital, Concord, NH, September 17, 2015.

\*^Moak GS: Navigating the Treacherous Straits of Behavioral Health Documentation, Coding, Billing in the Era of ICD-10. Symposium presented at the Beth Israel Deaconess Hospital-Plymouth, Plymouth, MA, November 17, 2016.

\*Moak GS: Safe and Effective Geriatric Psychopharmacology. Keynote lecture presented at the 21<sup>st</sup> Annual Northeast Psychiatric Nursing conference, St. Anselm College, Bedford, NH, April 6, 2017

## **XXII. BIBLIOGRAPHY:**

### **A. Peer-reviewed publications in print or other media**

#### **Original articles:**

1. Wapnir RA, Moak GS: Beta-2-Thienyl-DL-Alanine as an Inhibitor of Phenylalanine Hydroxylase and Phenylalanine Intestinal Transport. *Biochemical Journal* 1979; 177: 347-352.
2. Moak GS, Harris H: Lack of Homology Between Dog and Human Placental Alkaline Phosphatases. *Proceedings of the National Academy of Sciences, USA* 1979; 76: 1948-1951.
3. Moak GS: Treating the Chronic Mentally Ill Elderly State Hospital Patient. *Hospital and Community Psychiatry* 1988; 39:119-120.
4. Moak GS, Zimmer B, Stein EM: Clinical Perspectives on Elderly First-Offender Shoplifters. *Hospital and Community Psychiatry* 1988; 39: 648-651.
5. Tonkonogy J, Moak GS: Alois Alzheimer on Presenile Dementia. *Journal of Geriatric Psychiatry and Neurology* 1988; 1: 199-206.
6. Moak GS: Discharge and Retention of Psychogeriatric Long-Stay Patients in a State Mental Hospital. *Hospital and Community Psychiatry* 1990; 41: 445-447.
7. Moak GS: Improving Quality in Psychogeriatric Treatment. *Psychiatric Clinics of North America* 1990; 13: 99-111.
8. Moak GS: Characteristics of Demented and Non-demented Geriatric Admissions to a State Hospital. *Hospital and Community Psychiatry* 1990; 41: 799-801.
9. Fisher WH, Moak GS: Psychogeriatric Specialization in State Mental Hospitals: Data From a Nationwide Survey. *Administration and Policy in Mental Health*; 1990: 101-110.
10. Moak GS, Fisher WH: Alzheimer's Disease and Related Disorders in State Mental Hospitals: Data From a Nationwide Survey. *The Gerontologist* 1990; 30(6): 798-799.
11. Moak GS, Fisher WH: Geriatric Patients and Services in State Mental Hospitals: Data from a National Survey. *Hospital & Community Psychiatry* 1991; 42: 273-276.

12. **Porello PT**, Madsen L, Futterman A, Moak GS: Description of a Geriatric Medical/Psychiatry Unit in a Small Community General Hospital. *The Journal of Mental Health Administration* 1995; 22: 38- 48.
13. Moak GS: Geriatric Psychiatry and Managed Care. *Psychiatric Clinics of North America*, 2000; 23: 437-451.
14. Moak GS, Borson S: Mental Health Services in Long-Term Care – Still an Unmet Need. Guest Editorial, *Am J Geriatr Psychiatry* 2000; 8:96-100.
15. Bartels SJ, Moak GS, Dums AR: Models of Mental Health Services in Nursing Homes: A Review of the Literature and Provider Surveys. *Psychiatric Services* 2002; 53: 1390-1396.
15. Moak GS: Treatment Of Late-Life Mental Disorders In Primary Care: Can We Do A Better Job? *J Aging & Social Policy* 2011; 23: 274-285.

**Book chapters:**

1. Moak GS: Disturbances of Higher Intellectual Functioning. in *Outpatient Psychiatry, Diagnosis and Treatment*, Second Edition, Lazare A, ed., Williams and Wilkins, Baltimore, 1989
2. Moak GS: Wandering Behavior in Dementing Illness. in *Disorders of Movement in Psychiatry and Neurology*, Joseph A, Young RR, eds., Blackwell Scientific Publications, Inc., Boston, 1992
3. Moak, GS: Geriatric Psychiatry Evaluation. in *Documentation Survival Handbook for Psychiatrists and other Mental Health Professionals*, Soreff S, McDuffee MA, eds., Hogrefe & Huber, Publishers, Seattle, 1993
4. Moak, GS: When the Seriously Mentally Ill Patient Grows Old. in *Handbook for the Treatment of the Seriously Mentally Ill*, Soreff S, ed, Hogrefe & Huber Publishers, Seattle, 1996.
5. Stein EM, Moak GS: The North American Model of the Organisation of Services. In *Principles and Practice of Geriatric Psychiatry*, 2<sup>nd</sup> Edition. Wiley Publications, London, 2002.
6. Moak GS: Psychiatric Consultation and Liaison. In *Psychiatry in Long-Term Care*, Reichman WE, Katz PR, eds. Oxford University Press, Oxford, 2009.

**B. Other scholarly work in print or other media**

Moak, GS, Stein EM, Rubin JEV: The Over-50 Guide to Psychiatric Medications, A Task Force Report of the Council on Aging. American Psychiatric Association, Washington, D.C., 1989. This work is a book, written for a lay readership, to educate the public about the benefits and risks of psychiatric medications in the treatment of mental disorders in older adults. It was published by the American Psychiatric Press, Inc., and subsequently translated into Japanese.

Fogel BS, Colenda C, deFigueirido JM, Larson D, Luchins D, Moak GS, Olympia J, Pfeiffer E, Waxman H: State Mental Hospitals and the Elderly: A Report of the American Psychiatric Association Task Force on Geriatric Psychiatry in the Public Mental Health Sector, American Psychiatric Association, Washington, D.C., 1993.

Siegal AP and Jackson JM: Geriatric Psychiatry Practice Management Handbook. Moak, GS Content Editor. American Association for Geriatric Psychiatry, Bethesda, 1997.

New Approaches for the Diagnosis and Management of Alzheimer's Disease. Symposium discussant. The American Journal of Managed Care 2000; 6(22), Supplement.

Moak GS: Beat Depression to Stay Healthier and Live Longer: A Guide for Older Adults and Their Families. Rowman & Littlefield, Lanham, MD, 2016.

**C. Abstracts: Include both oral, exhibit and poster presentations.**

Moak GS: Alzheimer Patients Admitted to a State Hospital: Who Are They and What Are Their Needs. Poster presented at the 39th Institute on Hospital and Community Psychiatry, Boston, October, 1987

#^Fisher WH, Moak GS: Prevalence of Alzheimer's Disease and Related Disorders in State Mental Hospitals: Correlation with Nursing Home Bed Undersupply. Poster presented at the 116th annual meeting of the American Public Health Association, Boston, November, 1988

(#) Athari Alyazidi, Andrew P. Huang, Alexander C. Bender, Aliaksandr Shakhau, and Gary S. Moak, "Frailty Among Older Adult State Hospital Patients", poster presented at the 40<sup>th</sup> Annual Scientific Meeting of the American Association for Geriatric Psychiatry, March 16, 2018, Honolulu.

**Last updated: November 2, 2018**

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

Debra.A.Fournier@Hitchcock.Org

58 Juniper Dr, SE

White River Junction, VT 05001

(603) 359-5579

**License and Certifications:**

2011 to 2016 Certified Brain Injury Specialist, Academy of Certified Brain Injury Specialists, Brain Injury Association of America. Cert. number: 10309

2004 to present APRN: Advanced Practice Registered Nurse (Adult Primary Care & Psychiatry / Mental Health): State of New Hampshire. License No: 050234-23, expiration date: 11/07/17

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: 11/07/17

2008 to present Approved Ed RN BS Instructor. License No: 00127

1995 to present Certification: CPR / AED / BLS for Healthcare Providers. AHA

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	<u>Nurse Practitioner</u> , Division of Trauma and Acute Surgical Care, Section of General Surgery, Department Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, NH
2006 to 2013	<u>Nurse Practitioner</u> , Section of Physical Medicine and Rehabilitation, Department of Orthopedic Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, NH.
2005 to 2006	<u>Nurse Practitioner</u> , 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	<u>Instructor; Mental Health Nursing</u> , Colby-Sawyer College, New London, NH.
2002 to 2004	<u>Nurse Manager / Nurse Practitioner</u> , Behavioral Health Department, Valley Regional Hospital, Claremont, NH.
2002	<u>Psychiatric Nurse</u> , Valley Regional Hospital, Claremont, NH.
1999 to 2002	<u>Study Coordinator</u> , "The Women and Stress / Life Stress Study", University of Connecticut Health Center, Farmington / Hartford, CT.
2001	<u>Abstracter</u> , "Childhood Obesity Meta-Analysis." Yale-Griffin Prevention Research Center, Derby CT.
2001	<u>Child Care Provider</u> , Private home.
1997 to 2000	<u>Research Assistant</u> , "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	<u>Behavioral Health Worker</u> , Valley Regional Hospital, Claremont, NH.
1995 to 1997	<u>Emergency Services Clinician</u> , West Central Services, Inc., Claremont, NH.
1994 to 1997	<u>Clinical Case Manager</u> , West Central Community Support Services, Claremont, NH.
1992 to 1994	<u>Family Educator</u> , 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:**

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 4<sup>th</sup> 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 4<sup>th</sup> 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 3<sup>rd</sup> 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 3<sup>rd</sup> 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 20<sup>th</sup> 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 18<sup>th</sup> 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 17<sup>th</sup> 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 17<sup>th</sup> 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 17<sup>th</sup> 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 17<sup>th</sup> 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 21<sup>st</sup> 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 16<sup>th</sup> 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 16<sup>th</sup> 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 15<sup>th</sup> 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 Association 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:**

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, 10 <sup>th</sup> World Congress on Brain Injury. San Francisco, CA
2013	11 <sup>th</sup> 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 19 <sup>th</sup> 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 present	Board of Governors Member representing more than 400 associate providers. Elected position (3 year term started January 2016)
2017	Active Committee Participation within New Hampshire Hospital: Quality Council (Chair: Deb Fournier) Utilization Management (Chair: Michael Knight) Personal Safety Emergency Reviews (Chair: Diane Allen) Executive Safety Committee (Chair: Ken McGovern)
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 <i>Management of Non-Operative Spine Fractures</i> (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 / Quality Improvement Projects:**

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

# THOMAS N. KOUTELOS M.D.

5 Mountain Lane \* Holmdel, NJ 07733 \* Phone: (347) 774 -7233

E-MAIL: [inkoutelosmd@gmail.com](mailto:inkoutelosmd@gmail.com)

## EXPERIENCE

---

2012 - present

NEW YORK, NY

### *Medical Director, Manhattan Detention Complex*

- Manage day-to-day operations of jail clinic and staff
- Facility admits approximately on thousand inmates per month
- Oversee and evaluate ten physicians, two nurse practitioners and eight physician assistants
- Facility providers encounter 20-30 sick call and 15-20 chronic care patients per day
- Attend administrative meetings with Corizon's Riker's Island Operations and Regional Medical Directors presenting monthly facility statistics and PIs
- Attend and lead monthly Facility Strategy meetings which present any deficiencies or improvements pertaining to the administration of healthcare within the facility
- Attend monthly meetings with NYC Dept. of Health reporting status of the healthcare of the patients within the facility
- Attend monthly meetings with the Dept. of Corrections in order to improve interservice communications and clinic function
- Improved existing Transfer Chart Review which subsequently was used island-wide in the other nine medical facilities
- Designed and implemented a system wide Hospital Return policy assuring proper medical follow-up and continuity of care of patients
- Assisted in the implementation of the Pre-Arrestment Screening Unit which has reduced unnecessary hospital runs
- Work closely with the Unit Mental Health Supervisor in order to assure proper monitoring and treatment of mentally-ill patients
- Disaster Plan Supervisor-recently implemented a new disaster triage for the facility
- Approve Non-Formulary Medications in order to maintain costs
- Approve or Disapprove referrals to Sub-Specialty clinics in order to medical cost
- Responsible for the rescheduling of missed pending chronic care follow-up appointments
- Cross-cover with Brooklyn House of Detention

- Team Leader on Quality Control/Utilization Management projects

**2000–2014**

**Brooklyn, NY**

*Clinical Assistant Professor, Division of Medicine in the Department of Internal Medicine/College of Medicine SUNY*

- Clinical Instructor Physician's Assistant Program Downstate Medical School

**1998–2012**

**Brooklyn, NY**

*Solo Practitioner in Internal Medicine and Infectious Diseases*

- Devoted to Primary Care and Preventive Medicine
- Manage office staff of 4 medical assistants and 1 physician's assistant

**2001-2003**

**Brooklyn, NY**

*Attending Physician, Dept. of Internal Medicine  
Long Island College Hospital*

- Medical floor Attending Physician
- Supervised and taught medical students and residents
- Oversaw clinical care of medical service inpatients

**1994-2001**

**Brooklyn, NY**

*Attending Physician, Dept. of Emergency Medicine  
Long Island College Hospital*

- Provided assessment and clinical care in emergency room setting
- Supervised and taught medical students and residents
- Presided over hospital's External Disaster Committee
- Collaborated in hospital's preparation for Y2K
- Participated as a member Clinical HIV Protocol Committee
- Assisted in P&T and EDQA committees
- Presided over Rabies Vaccine Assessment Committee
- Supervised Sexually Transmitted Tracking Committee
- Restructured hospital's medical response to biochemical terrorism

**1992-1994**

**Brooklyn, NY**

*Fellow, Division of Infectious Diseases, Dept. of Internal Medicine, Long Island College Hospital*

- Trained in the Sub-Specialty of Infectious Diseases
- Participated in Infection Control Committee

- Assigned and controlled Isolation beds in the hospital

1989-1992

Brooklyn, NY

*Resident, Dept. of Internal Medicine, Long Island College Hospital*

---

#### EDUCATION

1980-1988

Athens, Greece

*Medical Student, University of Athens Faculty of Medicine*

---

#### CERTIFICATION

American Board of Internal Medicine

Board Eligible in Infectious Diseases

Certified Correctional Health Professional

---

#### LICENSURE

Federal Licensing Examination 1990

Current New York State License

---

#### PUBLICATIONS

Serum Ferritin, Hematocrit and Mean Corpuscular Volume in

Hemodialysis. *Nephron* 1995;67:30-35.

---

#### SOCIETIES

American Medical Association

American College of Physicians

American College of Physician Executives

---

#### AWARDS

Physicians Recognition Award, American Medical Association

2011 America's Top Physicians, SLD Industries

Eagle Scout, Boy Scouts of America

## Appendix E

Program Staff List						
New Hampshire Department of Health and Human Services						
COMPLETE ONE PROGRAM STAFF LIST FOR EACH STATE FISCAL YEAR						
Proposal Agency Name: <u>Mary Hitchcock Memorial Hospital</u>						
Program: <u>New Hampshire Hospital</u>						
Budget Period: <u>July 1, 2019 - June 30, 2020</u>						
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	1.00	\$ 339,488	\$ 339,488	100%	NHH
Associate Medical Director	Gary Moak	1.00	\$ 307,661	\$ 307,661	100%	NHH
Director of Quality Systems & APRN Services	Deb Fournier	1.00	\$ 148,720	\$ 148,720	100%	NHH
Director of Health Systems Data & Information Systems	Barbara Dieckman	1.00	\$ 142,314	\$ 142,314	100%	NHH
General Medical Director	Thomas Kouteios	1.00	\$ 288,443	\$ 288,443	100%	NHH
Research Manager	Marjorie Weeks	1.00	\$ 70,806	\$ 70,806	100%	NHH
Research Mentor	Matthew Friedman	0.15	\$ 37,500	\$ 37,500	100%	
Total Admin. Salaries		6.15	\$ 1,332,932	\$ 1,332,932	100%	
Direct Service Salaries						
General Psychiatrist	Corneliu Stanciu	1.00	\$ 272,950	\$ 272,950	100%	NHH
General Psychiatrist	John Hinck	1.00	\$ 270,375	\$ 270,375	100%	NHH
General Psychiatrist	Lisa Mistler	1.00	\$ 270,375	\$ 270,375	100%	NHH
General Psychiatrist	Mark Cotterell	1.00	\$ 271,920	\$ 271,920	100%	NHH
General Psychiatrist	Mercy Isang	1.00	\$ 272,651	\$ 272,651	100%	NHH
General Psychiatrist	Michael Knight	1.00	\$ 270,375	\$ 270,375	100%	NHH
General Psychiatrist	Patrick Hattan	1.00	\$ 253,483	\$ 253,483	100%	NHH
General Psychiatrist	Samantha Gnanasegaram	1.00	\$ 265,225	\$ 265,225	100%	NHH
General Psychiatrist	Samantha Swetter	1.00	\$ 252,000	\$ 252,000	100%	NHH
General Psychiatrist	Thatcher Newkirk	1.00	\$ 250,000	\$ 250,000	100%	NHH
General Psychiatrist	OPEN	1.00	\$ 260,000	\$ 260,000	100%	NHH
Psychiatric APRNs	Margaret Abbott	1.00	\$ 131,306	\$ 131,306	100%	NHH
Psychiatric APRNs	Maryanne Fournier	1.00	\$ 128,451	\$ 128,451	100%	NHH
Psychiatric APRNs	Melissa Harlow	1.00	\$ 131,587	\$ 131,587	100%	NHH
Psychiatric APRNs	Rebecca Farver	1.00	\$ 131,328	\$ 131,328	100%	NHH
Psychiatric APRNs	Stacy Sorrell	1.00	\$ 131,306	\$ 131,306	100%	NHH
Psychiatric APRNs	OPEN	1.00	\$ 131,306	\$ 131,306	100%	NHH
Child/Adolescent Psychiatrist	David Williams	1.00	\$ 259,921	\$ 259,921	100%	NHH
Child/Adolescent Psychiatrist	Erika Ebert	1.00	\$ 270,375	\$ 270,375	100%	NHH
Child/Adolescent Psychiatrist	Robin Caron	1.00	\$ 253,874	\$ 253,874	100%	NHH
Child/Adolescent Psychiatrist	Steven Cauble	1.00	\$ 288,598	\$ 288,598	100%	NHH
Geropsychiatrist	Shakau, Aliksander	1.00	\$ 275,825	\$ 275,825	100%	NHH
Director Neuropsychology Lab	OPEN	0.50	\$ 72,500	\$ 72,500	100%	NHH
Neuropsychology Trainees	Various	3.00	\$ 147,000	\$ 147,000	100%	NHH
General Medical Physician	Elizabeth Sanders	1.00	\$ 263,718	\$ 263,718	100%	NHH
Forensic Psychologist	Andrea Muschett	1.00	\$ 116,298	\$ 116,298	100%	NHH
Neuropsychologist - Pediatric	Jonathan Lichtenstein	0.10	\$ 14,500	\$ 14,500	100%	NHH
PGY II Residents	Various	1.50	\$ 87,432	\$ 87,432	100%	NHH
Child/Adolescent Fellow	Various	1.00	\$ 69,157	\$ 69,157	100%	NHH
Geropsychiatry Fellow	Various	0.50	\$ 33,117	\$ 33,117	100%	NHH
Call/Night Coverage	Various		\$ 1,455,200	\$ 1,455,200	100%	NHH
Total Direct Salaries		30.60	\$ 7,299,933	\$ 7,299,933	100%	
Total Salaries by Program		36.75	\$ 8,632,865	\$ 8,632,865	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.



## 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: Dept of Developmental Disabilities

Budget Period: July 1, 2020 - June 30, 2021

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						
Medical Director	Jennifer McLaren	0.4	\$ 111,366	\$ 111,366	100%	Dev Disabilities
Total Admin. Salaries		0.4	\$ 111,366	\$ 111,366	100%	
Direct Service Salaries						
Psychiatrist		0.1	\$ 27,842	\$ 27,842	100%	Dev Disabilities
Neuropsychologist		0.05	\$ 9,766	\$ 9,766	100%	Dev Disabilities
Neuropsychology Fellow		0.05	\$ 2,524	\$ 2,524	100%	Dev Disabilities
Neurologist		0.025	\$ 6,819	\$ 6,819	100%	Dev Disabilities
Primary Care Physician		0.025	\$ 6,819	\$ 6,819	100%	Dev Disabilities
Occupational Therapist		0.025	\$ 2,704	\$ 2,704	100%	Dev Disabilities
Admin Support		0.025	\$ 1,159	\$ 1,159	100%	Dev Disabilities
Psychiatrist		0.1	\$ 27,842	\$ 27,842	100%	Dev Disabilities
Neuropsychologist		0.05	\$ 9,766	\$ 9,766	100%	Dev Disabilities
Neuropsychology Fellow		0.05	\$ 2,524	\$ 2,524	100%	Dev Disabilities
Neurologist		0.025	\$ 6,819	\$ 6,819	100%	Dev Disabilities
Primary Care Physician		0.025	\$ 6,819	\$ 6,819	100%	Dev Disabilities
Occupational Therapist		0.025	\$ 2,704	\$ 2,704	100%	Dev Disabilities
Admin Support		0.025	\$ 1,159	\$ 1,159	100%	Dev Disabilities
Total Direct Salaries		0.6	\$ 115,266	\$ 115,266	100%	
Total Salaries by Program		1	\$ 226,632	\$ 226,632	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.

Appendix E

Program Staff List						
New Hampshire Department of Health and Human Services						
COMPLETE ONE PROGRAM STAFF LIST FOR EACH STATE FISCAL YEAR						
<b>Proposal Agency Name:</b> Mary Hitchcock Memorial Hospital <b>Program:</b> Dept of Developmental Disabilities <b>Budget Period:</b> July 1, 2021 - June 30, 2022						
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						
Medical Director	Jennifer McLaren	0.4	\$ 114,707	\$ 114,707	100%	Dev Disabilities
Total Admin. Salaries		0.4	\$ 114,707	\$ 114,707	100%	
Direct Service Salaries						
Psychiatrist		0.1	\$ 28,677	\$ 28,677	100%	Dev Disabilities
Neuropsychologist		0.05	\$ 10,059	\$ 10,059	100%	Dev Disabilities
Neuropsychology Fellow		0.05	\$ 2,599	\$ 2,599	100%	Dev Disabilities
Neurologist		0.025	\$ 7,023	\$ 7,023	100%	Dev Disabilities
Primary Care Physician		0.025	\$ 7,023	\$ 7,023	100%	Dev Disabilities
Occupational Therapist		0.025	\$ 2,785	\$ 2,785	100%	Dev Disabilities
Admin Support		0.025	\$ 1,194	\$ 1,194	100%	Dev Disabilities
Psychiatrist		0.1	\$ 28,677	\$ 28,677	100%	Dev Disabilities
Neuropsychologist		0.05	\$ 10,059	\$ 10,059	100%	Dev Disabilities
Neuropsychology Fellow		0.05	\$ 2,599	\$ 2,599	100%	Dev Disabilities
Neurologist		0.025	\$ 7,023	\$ 7,023	100%	Dev Disabilities
Primary Care Physician		0.025	\$ 7,023	\$ 7,023	100%	Dev Disabilities
Occupational Therapist		0.025	\$ 2,785	\$ 2,785	100%	Dev Disabilities
Admin Support		0.025	\$ 1,194	\$ 1,194	100%	Dev Disabilities
Total Direct Salaries		0.6	\$ 118,720	\$ 118,720	100%	
Total Salaries by Program		1	\$ 233,427	\$ 233,427	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.



Jeffrey A. Meyers  
Commissioner

Lori A. Shibinette  
Chief Executive Officer

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

36 CLINTON STREET, CONCORD, NH 03301  
603-271-5300 1-800-852-3345 Ext. 5300  
Fax: 603-271-5395 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

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.

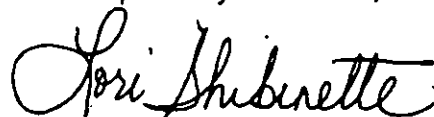
Should the Governor and Executive Council determine to not authorize this request, the Department may not be able to provide essential services at NHH to ensure compliance with regulatory and safety requirements required to maintain accreditation with The Joint Commission, and may increase risk for many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

**New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services**



**State of New Hampshire  
Department of Health and Human Services**

**Amendment #1 to the Physician Clinical and Administrative Services Contract**

This 1<sup>st</sup> Amendment to the Physician Clinical and Administrative Services contract (hereinafter referred to as "Amendment #1") dated this 20<sup>th</sup> 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.

*aj*

New Hampshire Department of Health and Human Services  
Physician Clinical and Administrative Services



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

[Signature]  
Name:  
Title:

Mary Hitchcock Memorial Hospital

11/21/18  
Date

[Signature]  
Name: Daniell P. Jantzen  
Title: Chief Financial Officer

Acknowledgement of Contractor's signature:

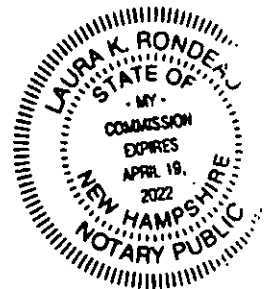
State of New Hampshire, County of Grafton on November 21, 2018, before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

[Signature]

Signature of Notary Public or Justice of the Peace

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

My Commission Expires: April 19, 2022



[Signature]

**New Hampshire Department of Health and Human Services**  
**Physician Clinical and Administrative Services**



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

[Signature]  
Name: Meghan A. L...  
Title: Attorney General

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

**OFFICE OF THE SECRETARY OF STATE**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name:  
Title:

[Handwritten mark]



## **Exhibit A Amendment #1**

### **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 – Glenduff 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





## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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



### Exhibit A Amendment #1

- 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:



### Exhibit A Amendment #1

- 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



## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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<sup>10</sup> 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



## Exhibit A Amendment #1

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 – Glenclyff 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 Glenclyff 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 Glenclyff 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,





## Exhibit A Amendment #1

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 Glenduff 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'



## Exhibit A Amendment #1

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.

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

### 2.6.1. DCYF Staff Psychiatrist Responsibilities

**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**



### Exhibit A Amendment #1

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;



## Exhibit A Amendment #1

- 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,



### Exhibit A Amendment #1

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



## Exhibit A Amendment #1

- 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



## Exhibit A Amendment #1

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





## Exhibit A Amendment #1

- 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



## Exhibit A Amendment #1

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



### Exhibit A Amendment #1

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.



## **Exhibit A Amendment #1**

### **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



## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

- 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.



## Exhibit A Amendment #1

### 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.



## Exhibit A Amendment #1

- 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;





**Exhibit A Amendment #1**

- 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 client's 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



## Exhibit A Amendment #1

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.



### Exhibit A Amendment #1

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



### Exhibit A Amendment #1

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	Glenclyff 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



### Exhibit A Amendment #1

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



### **Exhibit A Amendment #1**

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.



### Exhibit A Amendment #1

- 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;



## Exhibit A Amendment #1

- 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





## Exhibit A Amendment #1

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;



## Exhibit A Amendment #1

- 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



## Exhibit A Amendment #1

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



## **Exhibit A Amendment #1**

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:
- Master's degree in management or health or research related area;
  - Five or more years of relevant experience in clinical trials research support;
  - Experience with industry sponsored, federally sponsored and investigator initiated clinical research;
  - Experience with clinical trial budgets and billing;
  - Through knowledge of clinical research, research protocols and clinical operations; and
  - 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:

- Licensed as an Advance Practice Registered Nurse
- Two or more years of relevant experience in a psychiatric setting.
- Experience with quality systems, development and enhancement of organizational systems and processes.
- Serves as Chair of the Quality Council.
- Provides clinical standards and provides leadership for all Psychiatric APRNs.
- Builds community relationships with professional organizations to enhance both the quality programs and APRN programs.
- Five or more years of experience in leadership of teams.
- 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:

- Five or more years of experience with collecting, analyzing, documenting and reporting hospital and/or health systems data.
- Five or more years of experience with Electronic Health Records and development of Health Services Data Program.
- Five or more years of experience in leadership of teams.
- 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,



### Exhibit A Amendment #1

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 – Glenclyff 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 Glenclyff 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



### Exhibit A Amendment #1

#### 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:
- Possess a medical degree (MD or DO);
  - Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;
  - A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;
  - 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;
  - Have work experience in managed care settings focused on improved health outcomes;
  - 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;
  - Have extensive experience and judgment to plan and accomplish goals working in a team environment;
  - Demonstrate strong verbal and written communication skills;
  - Work collaboratively with Medicaid staff to achieve program goals in an efficient and timely manner;
  - 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;
  - 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;
  - Possess a high degree of creativity and initiative;
  - Have expertise in clinical, policy, or outcomes research; and



**Exhibit A Amendment #1**

- 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



## **Exhibit A Amendment #1**

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.

نمبر 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





## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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



## **Exhibit A Amendment #1**

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



**Exhibit A Amendment #1**

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



## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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. 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





## Exhibit A Amendment #1

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



## Exhibit A Amendment #1

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.



## Exhibit A Amendment #1

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

# New Hampshire Department of Health and Human Services

## DHHS Security Requirements

### Exhibit K



#### A. Definitions

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

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.
2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.
3. "Confidential Information," "Confidential Data," or "Data" (as defined in Exhibit K), means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

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

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.
5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.
6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or

**New Hampshire Department of Health and Human Services**

**DHHS Security Requirements**

**Exhibit K**



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

New Hampshire Department of Health and Human Services

DHHS Security Requirements

Exhibit K



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.

*[Signature]*  
11/2/18

**New Hampshire Department of Health and Human Services**

**DHHS Security Requirements**

**Exhibit K**



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

A handwritten signature in black ink, appearing to be "JH", is written over the "Contractor Initials" label.

11/21/18

New Hampshire Department of Health and Human Services

DHHS Security Requirements

Exhibit K



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



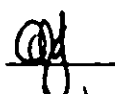
**New Hampshire Department of Health and Human Services  
DHHS Security Requirements**



**Exhibit K**

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

  
11/21/18

New Hampshire Department of Health and Human Services

DHHS Security Requirements

Exhibit K



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

**New Hampshire Department of Health and Human Services**

**DHHS Security Requirements**

**Exhibit K**



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 HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857  
603-271-8200 FAX: 603-271-4912 TDD ACCESS RELAY NH 1-800-735-2984

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, 03758 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 \$38,554,042 effective November 1, 2018, 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**

<b>Fiscal Year</b>	<b>Class/Account</b>	<b>Class/Title</b>	<b>Activity Code</b>	<b>Current Modified Budget</b>
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
			<b>Sub-Total</b>	<b>\$1,124,884</b>

**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**

<b>Fiscal Year</b>	<b>Class/Account</b>	<b>Class/Title</b>	<b>Activity Code</b>	<b>Current Modified Budget</b>
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
			<b>Sub-Total</b>	<b>\$1,041,065</b>

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

<b>Fiscal Year</b>	<b>Class/Account</b>	<b>Class/Title</b>	<b>Activity Code</b>	<b>Current Modified Budget</b>
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
			<b>Sub-Total</b>	<b>\$31,742,035</b>

**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
			<b>Sub-Total</b>	<b>\$1,323,986</b>

**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
			<b>Sub-Total</b>	<b>\$426,001</b>

**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
			<b>Sub-Total</b>	<b>\$80,000</b>

**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
			<b>Sub-Total</b>	<b>\$338,453</b>

**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
			<b>Sub-Total</b>	<b>\$399,266</b>

**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 – Glenclyff 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 – Glenclyff Home

The Department operates the Glenclyff 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 Glenclyff 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.

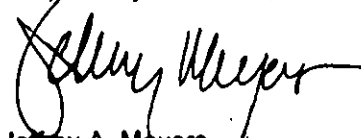
Area Served: Statewide

- 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

1. Mary Hitchcock Memorial Hospital

2. 0

3. 0

4. 0

5. 0

6. 0

7. 0

Pass/Fail	Maximum Points	Actual Points
Pass	1000	857
	1000	0
	1000	0
	1000	0
	1000	0
	1000	0
	1000	0

Reviewer Names

1. Katie Dunn, Director OMBP,  
Deputy Commissioner

2. Michele Harlan

3. Diane Langley

4. Bob MacLeod, CEO NH Hospital  
Dawn Touzin, DHHS, Department  
Controller

6.

7.

8.

9.

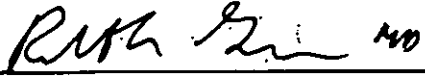
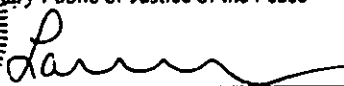

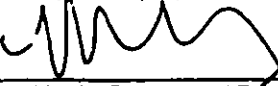
Subject: Physician Clinical and Administrative Services/RFP-2017-OCOM-01-PHYSI-01

**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 Hitchcock Memorial Hospital Dary		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 Borin, Director of Contracts and Procurement		1.10 State Agency Telephone Number 603-271-9558	
1.11 Contractor Signature 		1.12 Name and Title of Contractor Signatory Robert Greene, MD EUP Chief Population Health Management Officer	
1.13 Acknowledgement: State of New Hampshire County of Grafton On _____, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily known 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 			
1.13.2 Name and Title of Notary or Justice of the Peace Laura K. Rogers - Notary Public			
1.14 State Agency Signature 		1.15 Name and Title of State Agency Signatory K. 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:  On: Megan A. Yoder Attorney 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

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, formulas, 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 \$1,000,000 per 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.

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.



**Exhibit A**

**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 – Glenclyff 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.





## Exhibit A

- 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;



## Exhibit A

- 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



### Exhibit A

- 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.



## Exhibit A

### 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



### Exhibit A

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.



## Exhibit A

### 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.



### Exhibit A

#### 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.



## Exhibit A

- 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.





## Exhibit A

### 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.



### Exhibit A

- 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



### Exhibit A

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.



**Exhibit A**

**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.



### Exhibit A

- 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.



**Exhibit A**

**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;



### Exhibit A

- 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



## Exhibit A

- i. 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.





### Exhibit A

- 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



### Exhibit A

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:
- 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.
  - 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.
  - 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.
- 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.
  - 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.
  - The Contractor shall ensure that each fidelity or QIP assessment includes, at a minimum:
    - Written instructions to the CMHC regarding necessary observations, interviews, data access and other activities for the assessment;



### Exhibit A

- 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:



### Exhibit A

- 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.



## Exhibit A

### 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.



**Exhibit A**

**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;



## Exhibit A

- 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.



### Exhibit A

#### 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.





## Exhibit A

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;



### Exhibit A

- 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 client's 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



## Exhibit A

- 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.



## Exhibit A

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.



**Exhibit A**

- 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	Glenclyff 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:



### Exhibit A

- 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.



**Exhibit A**

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



### Exhibit A

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





## Exhibit A

- 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.



## Exhibit A

- 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



## Exhibit A

- 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:



## Exhibit A

- 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.



### Exhibit A

- 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. Thorough 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



**Exhibit A**

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 – Glencloff 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 Glencloff 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:
- Possess a medical degree (MD or DO);
  - Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;
  - A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;
  - 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;



## Exhibit A

- 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.



**Exhibit A**

**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





**Exhibit A**

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



## Exhibit A

### 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.



## Exhibit A

- 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.



## Exhibit A

- 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:



### Exhibit A

- 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.



### Exhibit A

- 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;



### Exhibit A

- 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.



## Exhibit A

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.





## Exhibit A

- 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.



## Exhibit A

### 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.



## Exhibit A

### 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.



## Exhibit A

### 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.

<b>Budget</b>			
<b>Agreement Period by State Fiscal Year</b>			
<b>Service Area</b>	<b>11/1/16-6/30/17</b>	<b>7/1/17-6/30/18</b>	<b>7/1/18-6/30/19</b>
1: New Hampshire Hospital	\$8,407,616	\$11,471,661	\$11,862,758
2: Glenciff 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 – Glenduff 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.

*RAH*

*8/18/2016*



Exhibit B

- 
- 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;

*RM*

*8/18/2016*

New Hampshire Department of Health and Human Services  
Exhibit C



- 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.

New Hampshire Department of Health and Human Services  
Exhibit C



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 employee's 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

New Hampshire Department of Health and Human Services  
Exhibit C



- 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.

RAC

8/18/2014



**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 GRANTEEES 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



New Hampshire Department of Health and Human Services  
Exhibit D



- 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 MO  
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-1.)
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

Robert A. Greene, MD  
Name: Robert A. Greene, MD  
Title: EVP  
Chief Population Health Management Officer

Exhibit E - Certification Regarding Lobbying

Contractor Initials RAG



**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

New Hampshire Department of Health and Human Services  
Exhibit F



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 8 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 (1)(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

Rita Brown  
Name:  
Title:



**CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO  
FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND  
WHISTLEBLOWER PROTECTIONS**

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;
- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;
- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);
- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;
- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;
- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;
- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;
- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;
- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

Exhibit G

Certification of Compliance with requirements pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower protections

Contractor Initials

AKG

9/27/14  
Rev. 10/21/14

Page 1 of 2

Date

8/11/2016

New Hampshire Department of Health and Human Services  
Exhibit G



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

[Signature]  
Name:  
Title:

Exhibit G

Contractor Initials

PAC

Certification of Compliance with requirements pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower protections

6/27/14  
Rev. 10/21/14

Page 2 of 2

Date 8/18/2016



**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

Ralph M. M.  
Name:  
Title:



Exhibit I

**HEALTH INSURANCE PORTABILITY 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, Title XIII, 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.

RAH

8/18/2016





Exhibit I

- i. "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



Exhibit I

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:
  - o The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
  - o The unauthorized person used the protected health information or to whom the disclosure was made;
  - o Whether the protected health information was actually acquired or viewed
  - o 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 (I). 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



Exhibit I

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



Exhibit I

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.

3/2014

Contractor Initials

RA6

Date

8/18/2016



Exhibit I

- 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  
The State

Katja S. Fox  
Signature of Authorized Representative

Katja S. Fox  
Name of Authorized Representative

Director  
Title of Authorized Representative

8/19/16  
Date

May Hinson Nam Hospital  
Name of the Contractor

Robert A. Greene, MD  
Signature of Authorized Representative

Robert A. Greene, MD  
Name of Authorized Representative

EVP  
Chief Population Health Management Officer  
Title of Authorized Representative

8/18/2016  
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

Robert A. Greene, MD  
Name: Robert A. Greene, MD  
Title: VP Chief Population Health Management Officer

New Hampshire Department of Health and Human Services  
Exhibit J



**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: _____