NH Health Care Quality
Assurance Commission

Annual Report of the
New Hampshire Health Care Quality Assurance Commission

June 1, 2019

RSA 151-G: 1 established the New Hampshire Health Care Quality Assurance Commission. Its intent is *to enable health care providers to share information about adverse outcomes and prevention strategies in learning environments which foster candor and self-critical analysis while maintaining the confidentiality of the information submitted to the Commission, the proceedings of the Commission, and the results of the Commission's deliberations.*

Members of the Commission include one representative from each acute care hospital and free standing ambulatory surgical center (ASC), a designee of the Commissioner of the Department of Health and Human Services and three "at large" public members. During the past year Tom Bunnell, Paula Carr and Sara Meade served as the public representatives.

Members of the Executive Committee include:

Chair	**Natalie Gosselin,** MS, RN, CPHQ, CSSGB Director, Center for Quality & Safety Southern New Hampshire Medical Center, Nashua
Vice-Chair	**Lori Underwood,** OTR, MBA, CPHQ VP, Quality and Patient Safety New London Hospital, New London
Past Chairs	**Lori Key**, RN, MBA Associate Chief Quality Officer - Quality Assurance & Safety Dartmouth Hitchcock Medical Center, Lebanon
	Marge Kerns, RPh VP, Clinical Services LRGHealthcare, Laconia
	Jean Corvinus, RN, BSN, MS, CPHQ, CPPS Director, Quality & Performance Improvement Frisbie Memorial Hospital, Rochester
At Large	**Jennifer Costain**, MS, CPHQ, CPPS Senior Director, Quality and Patient Safety Exeter Health Resources
	Melissa Howard, MHA, BS, RN, CPHQ Director of Quality, Infection Prevention and Service Excellence Speare Memorial Hospital, Plymouth
	Sue Majewski Chief Operating Officer Bedford Ambulatory Surgery Center, Bedford
	Christopher Tkal VP, Quality & Patient Safety Cheshire Medical Center/Dartmouth-Hitchcock, Keene

During its fourteenth year, the Commission met five times on the following dates:
2018: August 3 and October 12; 2019: January 11, March 8 and May 3

Executive Summary

The following principles were utilized as a guide by the Commission in our efforts to promote high quality and safe care to all patients seeking services in our organizations. Agenda planning incorporated these principles, including timely topics that support those principles.

Guiding Principles:

- ☑ Promote High Reliability Organizations
  Improving systems and standardizing processes to yield best outcomes, and to detect and manage unexpected events before they escalate into situations resulting in harm to patients or employees.

- ☑ Establish 'Just Cultures' within our Organizations
  Creating cultures of safety where staff and providers involved in an error are treated fairly in the investigation process and we clearly understand contributing factors that involve differentiating system and human failures from reckless behavior.

- ☑ Adopt Evidence-Based Best Practices to Improve Outcomes
  Using scientific studies to select interventions that are proven to improve outcomes and avoid harm.

- ☑ Patient Experience
  Creating a forum for patients to have open conversations about their experiences and needs and wants as invaluable information in the design and improvement of care and service delivery.

Prevention of Harm topics the Commission focused on this year included:

- ☑ Hearing from a father about the impact of the opioid crisis from a family perspective after losing their son to an opioid overdose. This led to creation of a medication disposal program, which was then launched statewide via the August Commission meeting.

- ☑ Meeting with the State of NH Licensing and Regulation Services staff to share feedback about the process of reporting Adverse Events, optimizing shared learning from events, developing regular distribution of reported events for validation purposes and creating a flowchart of reporting / feedback loops to the department.

- ☑ Proposed legislation to revise the statute for the New Hampshire Health Care Quality Assurance Commission, to add members from specialty hospitals and New Hampshire Hospital, and to make the Commission permanent and change the name to the NH Health Care Quality and Safety Commission.

- ☑ Education on the 2017 NH State Antibiogram and its implications for prescribing practices for common bacterial infections, reinforcing the principles of antimicrobial resistance and the need for a continued focus on antibiotic stewardship.

- ☑ Learning about the opioid crisis through the work of a physician who provided a history of the current crisis and a framework of substance use disorder as a chronic disease, as well as reviewed approaches to therapy and emphasized importance of reducing stigma and the role of community support.

- ☑ Reviewing best practices to detect drug diversion in the health care setting, understanding the role of the Professional Boards, learning about a new program available to nurses seeking recovery and reinforcing the role of the NH Health Care Associated Infection program in assisting with investigations through a series of case vignettes.

- ☑ Increased awareness of emerging threats in the area of health care associated infections and outbreaks including Hepatitis A, Legionnaires' disease, and influenza with discussions about best practices to address immediate threats and reduce risks.

- ☑ Shared learning, resources and best practices from the National Partnership for Patients initiative with ongoing communication about educational offerings focused on harm prevention topics.

- ☑ Continued encouragement of the adoption of a 'Just Culture' in our organizations with ongoing education using practical examples of its application through presentations by members and educational approaches used by all to reinforce the principles of a culture of safety, with particular emphasis on reporting adverse events and near misses, and how feedback is provided to staff and how reports are analyzed for severity.

- ☑ Presentation by hospital staff members who experienced assaults, including physical and verbal violent acts against them by patients, leaving incredible emotional and physical harm in the aftermath.

- ☑ Sharing and learning by all members of Patient Safety Bright Spots that occurred at their organizations in the past year to celebrate National Patient Safety Awareness Week.

- ☑ Learning from an anesthesia provider at a local hospital who has developed an innovative approach to providing an opiate-free / opiate-sparing anesthesia experience to their patient population, resulting in better outcomes and overall greater patient experience.

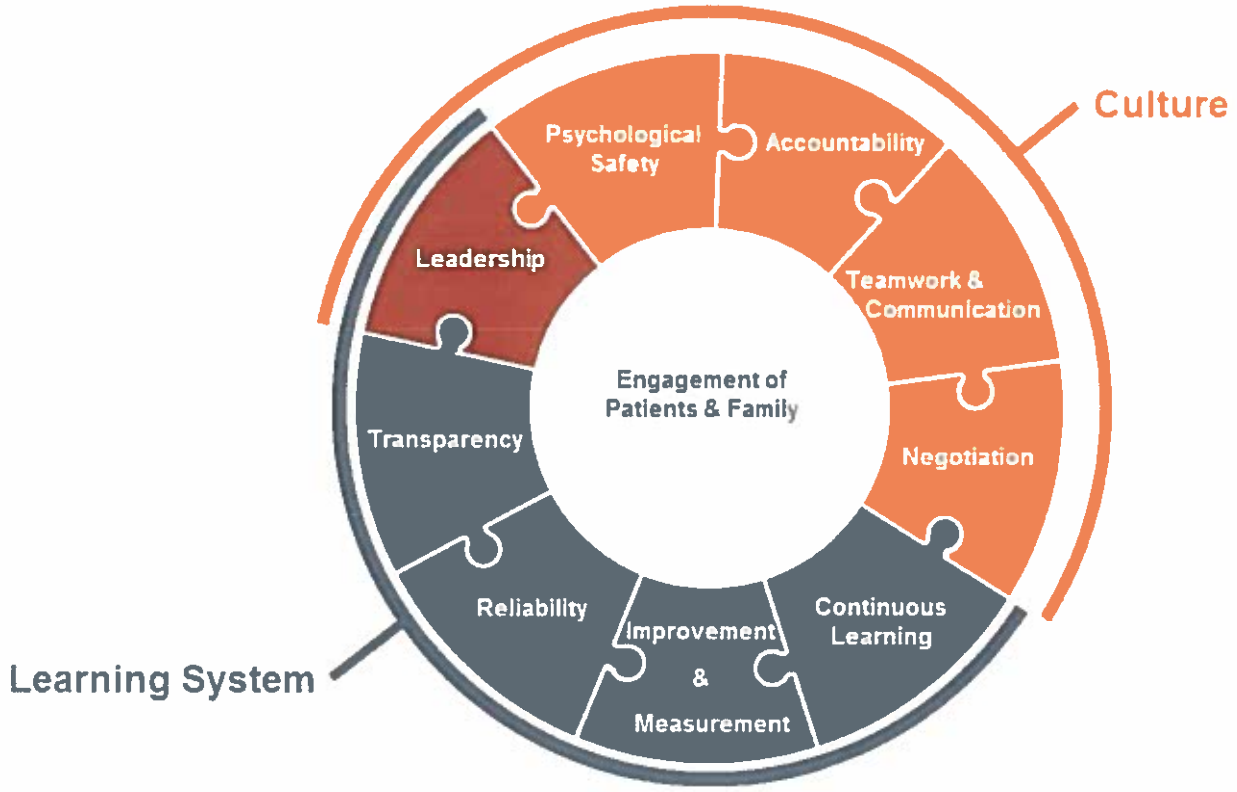
Organizational Structure and Activities

The Commission is working under the protection of RSA 151:13a and RSA 329.29A. All new members received an orientation and signed confidentiality agreements to allow for free exchange of sensitive information from members. All meetings were coordinated, and minutes recorded, by an administrative representative of the Foundation for Healthy Communities.

Through our public members, we are developing more meaningful ways to encourage patients to partner with their clinicians to ensure optimal health benefits. Their presence also improves our effectiveness in the messaging of what we are trying to accomplish, as they add tremendous insight and value by bringing the voice of the public to our discussions.

The Executive Committee met immediately after each meeting to debrief meeting content and to set agendas with suggested topics that reflected current priorities focused on eliminating harm and improving quality.

Promote High Reliability Organizations
Framework for Eliminating Preventable Medical Harm



Institute of Healthcare Improvement IHI.Org

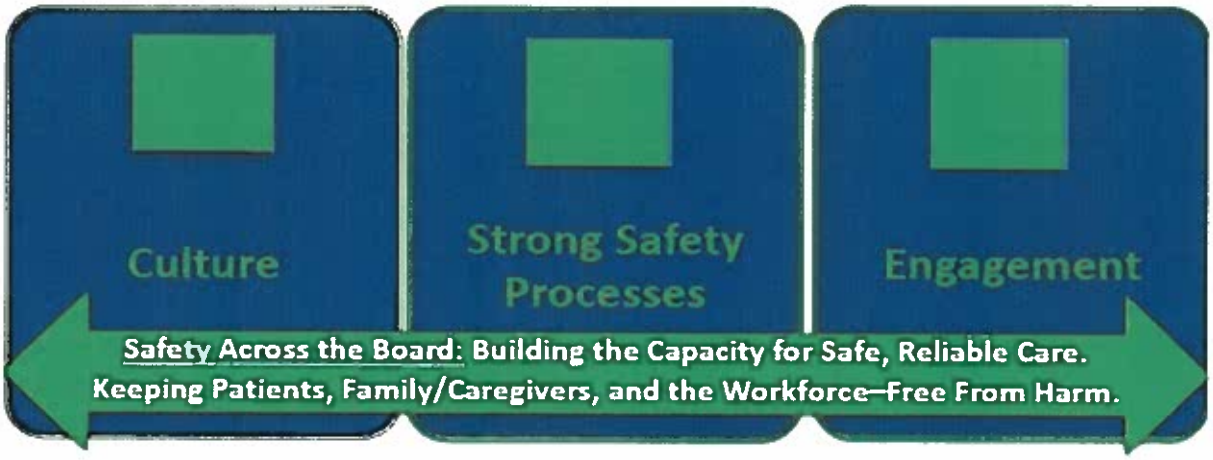
The mission of the NH Health Care Quality Assurance Commission, to eliminate preventable medical harm in NH hospitals and surgical centers, is the driving force behind the activities undertaken by the Commission membership that are highlighted in this report. The member organizations have diligently reported adverse events to the State of NH Licensing Bureau, have collectively studied the circumstances in which these events occurred, and have reacted appropriately to prevent future events. Identifying and monitoring for adverse events is an essential obligation we all take seriously, but more importantly, the Commission members have spent considerable attention on learning about and promoting the fundamental characteristics of safety and quality that reduce the likelihood of medical error that results in patient harm. This is a more proactive approach that focuses on building organizational resistance to human and process error within our complex healthcare delivery system.

High Reliability is an often-used term used to describe how highly complex, high risk, organizations that operate under hazardous conditions function while maintaining exemplary levels of safety. The Commission members continued to focus on the attributes of High Reliability Organizations (HRO) and worked together to adopt or strengthen these attributes in each member organization. The areas of focus in 2018 included:

- **Improving organizational reporting of actual and "good catch" events:** We know that other high risk industries, such as aviation and nuclear energy, have cultures that promote this type of reporting in order for the organization to react more quickly to cues that a system or process isn't working optimally. Having strong detection systems that invites employees to report, without fear or blame, is a fundamental component of HROs. HROs expect the number of reports to increase, as a marker of strong psychological safety within the workplace to find and fix problems before they cause adverse events. Commission members shared tactics used to promote reporting, including ways to make reporting easy and convenient, workflows to analyze and resolve the issues reported, and communication strategies that encouraged broad organizational learning about the reported issue.

- **Event Analysis:** One organization's experience with improving the way individual events are analyzed in order to identify predominate root causes was shared. This resulted in actionable data useful in identifying the underlying causative issue and is directing improvement resources more appropriately to reduce a variety of adverse events instead of a single event.

- **Peer support:** The outcome of a medical mistake or error can be devastating to everyone involved, including the clinicians involved. The Commission members worked collaboratively with our community representatives, and with the Foundation's Patient & Family Engagement Program Director Tanya Lord, to explore this impact and the value of a Peer Support Program. Burnout and emotional distress among healthcare professionals is an emerging national issue that requires attention and action.



Adopt Evidence-Based Practices to Improve Outcomes

Management and Prevention of Healthcare Associated Infections

NH health care organizations have continued to work on reducing and eliminating opportunities for exposure to infection. Having Dr. Ben Chan, the State of NH Epidemiologist, as a sitting member of the Commission helps foster immediate and timely awareness of emerging threats in the area of health care associated infections and outbreaks. Any updates offered at meetings are always followed by discussions about best practices to address immediate threats and reduce risks. Topics that were covered this year are listed below:

Influenza

This included discussion on flu vaccination practices, mandatory vaccination policies (with medical and religious reasons for declination, requirements that staff wear a mask during flu season) and sharing how patients may be able to know whether staff are vaccinated. After our public representative questioned why there are so many variable practices about vaccines and mask use, it was reinforced that an important role of the Commission is to be a forum to share practices in hopes of trying to promote standardization across the state.

Legionnaires' Disease

An outbreak of 19 confirmed cases in Hampton, NH occurred in the summer of 2018. Although the location was a resort and the source was one hot tub, Dr. Chan shared the findings from the CDC environmental investigation which had applications to health care settings as well. The role of chlorination and high temperatures to prohibit growth was reviewed. Hospitals shared their water risk assessments and noted areas of potential concern.

Hepatitis A

The large multistate outbreak of Hepatitis A was a topic at a few meetings this year. It has been associated with high risk populations of homelessness, substance use disorder, injection use and drug use but is spreading beyond these populations. It was initially noted in Massachusetts but due to our porous border it began to slowly increase. A spike then indicated individuals in NH were acquiring it. There is a vaccine to prevent onset so communication about promoting Hepatitis A vaccinations was key. All were encouraged to use the routine PCP structure, but the importance of using Emergency Departments and SUD treatment programs as sites to reach a given population at risk was noted, since many may not have PCPs. Hepatitis B vaccination rates are very good but Hep A is at 60% range, so there is room for improvement.

Drug Diversion in Healthcare Settings

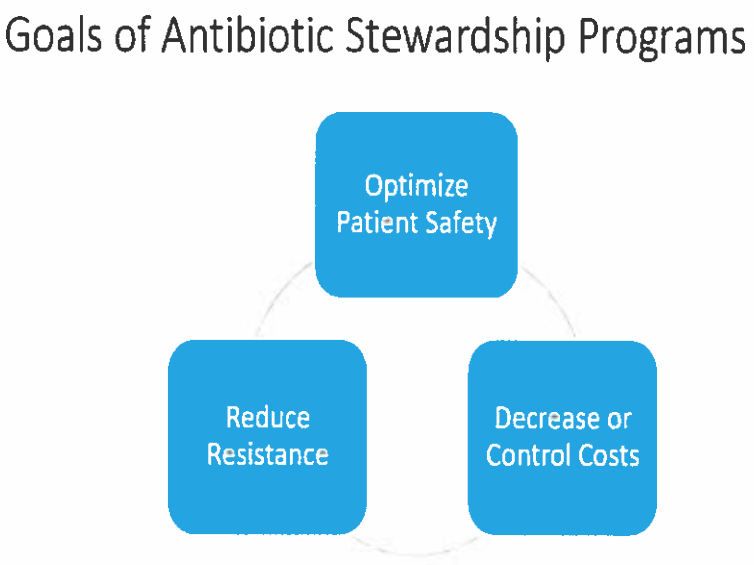
At another meeting members were provided an overview of the Healthcare-Associated Infections Program including staff, primary responsibilities including their role in the opioid epidemic and drug diversion, especially as it relates to detection in the health care setting. There is a statute requiring hospitals to report investigations of suspected diversion of

injectable drugs. Many real-life vignettes of incidents they had been involved in were provided. Learnings from these cases were shared including successes, challenges and opportunities for improvement. Resources available for drug diversion prevention were distributed. Discussions involved the balance of enforcing HR Labor laws versus employee rights. Everyone agreed that surveillance systems for detection are still not sophisticated enough and that there are wide variations so heightened awareness is critical.

Antibiotic Stewardship

Antibiotics are a powerful tool in saving lives of patients with true bacterial infections. They transformed the practice of medicine, making once lethal infections readily treatable. The prompt initiation of antibiotics to treat bacterial infections has been proven to reduce morbidity and save lives, with a recent example being the rapid administration of antibiotics in the management of sepsis. However, it is estimated that in the United States, 20-50% of all antibiotics prescribed, in acute care hospitals are either unnecessary or inappropriate.

The NH Quality and Safety Commission consider this topic a high priority focus area during the 2018-2019 year. In collaboration with the NH Department of Public Health we hosted several educational sessions with Dr. Ben Chan on efforts to improve unnecessary antibiotic prescribing and the outcomes to be tracked on the local, regional, and state level antibiograms. (An antibiogram is an overall profile of antimicrobial susceptibility testing results of a specific microorganism to a battery of antimicrobial drugs.)



A strong antibiotic stewardship program in healthcare facilities is the cornerstone for addressing the challenges of increased resistance patterns in hospitals and surrounding communities. All hospitals in NH have some form of an Antibiotic Stewardship Program. Additionally, the members of the commission offered presentations on the approach taken by their facilities to shift the culture and transition to more responsible prescribing of antibiotics. Best practices which were tested and adopted in NH Hospitals were discussed and recommended. These best practices included, but are not limited to:

- ***Changing Patient Perception***- The challenge for our health care facilities is educating people on the difference between bacterial and viral illnesses. Viral conditions are not treated with antibiotics, yet patients complain if we are not prescribing something to make, they feel better faster. Many of the commission facilities engaged in public education during office visits and giving patients information on treatment of viruses along with a get-well bag including for example: tissues, hand sanitizer, lip balm, chicken

soup, and cough drops. Additionally, many of our health care facilities are focused on patient/visitor education of hand hygiene.

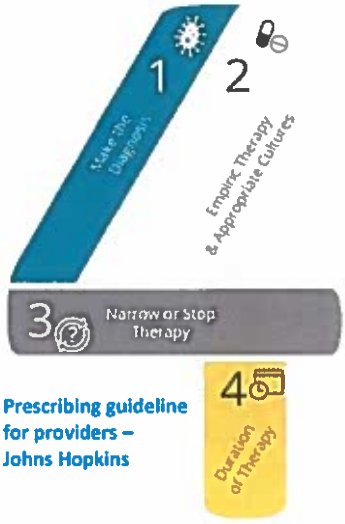


➢ ***Targeted Approach by Medical Condition***- Conditions where antibiotics tended to be overprescribed or inappropriate for susceptibility of bacterial infection include:

- Urinary Tract Infections
  - Asymptomatic – no treatment
  - Symptomatic – follow guideline for drug and duration.
- Community Acquired Pneumonia – drug sensitivity and duration of therapy.
- Skin and Soft tissue Infections- drug sensitivity and duration of therapy.

The commission has discussed the most up to date evidenced based practices for treatment of these conditions and we have worked with the infection control departments in our hospitals to spread this knowledge and encourage responsible prescribing.

➢ ***Ongoing Provider Feedback***- The formation of Antibiotic Stewardship committees within our facilities has lent itself to ongoing case review and real-time conversations with prescribers on decisions regarding appropriate use of antibiotics and dosing. These committees are impacting care while it occurs and can guide providers in better use of the evidence-based practices recommended. The use of the Johns Hopkins Model along with the antibiogram have been adopted at hospital participating in the national Antibiotic Stewardship project from Johns Hopkins and AHRQ. Reducing Days on Antibiotics in addition to resolving infections are key measures in this program.



Any medication can have serious side effects. For antibiotics, those side effects can include adverse drug reactions and development of *Clostridium difficile* infection (CDI). Patients who are unnecessarily exposed to antibiotics in treatment of viruses are placed at risk for serious adverse events with no clinical benefit. The misuse of antibiotics has also contributed to the growing problem of antibiotic resistance, which has become one of the most serious and growing threats to public health. A growing number of "superbugs" in our communities are challenging health care systems. For example, planning surgical cases for patients known to have MRSA requires additional coordination of services and infection prevention practices in order not to spread that infection to others. Over the next year or more, continuing to learn about and mitigate risk for spread of c-diff infections is a topic all NH

hospitals are participating in through the National HRET-HIIN project and exploring strategies such as the Mini-RCA for CDI process improvement and examination of practices regarding culturing stools.

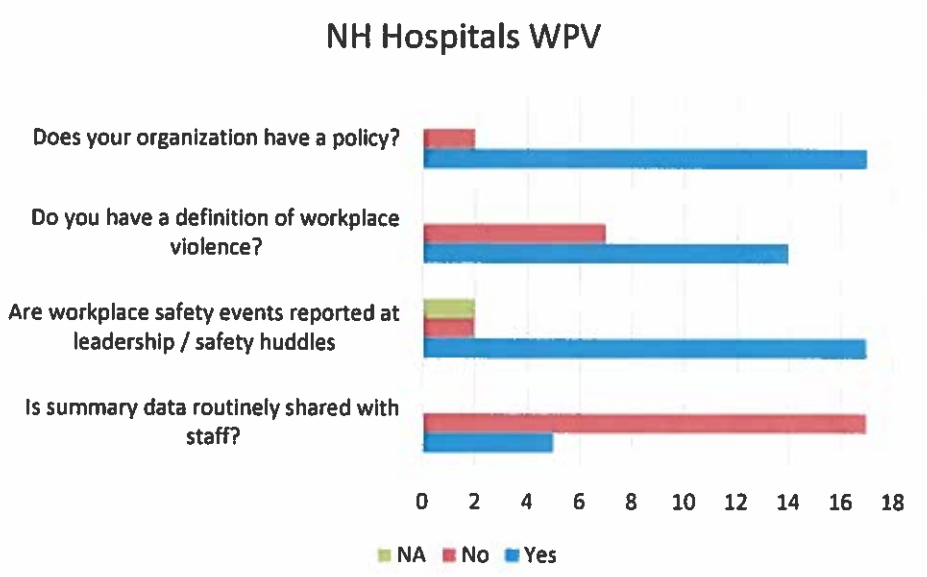
http://www.hret-hiin.org/topics/clostridium-difficile-infection.shtml

Workplace Safety

Emerging research is showing that there is a direct relationship between patient safety and worker safety. Organizations that have successfully adopted a just culture also find this encourages employees to report unsafe conditions and adverse events, including unsafe working conditions. Reducing workplace violence and injury continued to be a priority for the Commission this year and there were several activities focused on this topic.

The Commission also focused efforts on standardization across the state of the definition of Workplace Safety, so as to more accurately collect and compare data across all health care organizations. Members have been submitting individual monitoring data into the HRET HIIN Comprehensive Data System since October 2016. This has allowed members to compare themselves against others in the state. There were significant variations in the data, such as four hospitals reporting zero events.

A physician leader from the New Hampshire Hospital analyzed data collected from the hospitals on definitions, policies, which departments collect and report data etc. Results can be seen in the following chart:



An opportunity for improvement was identified as ensuring data about harm events reaches front line staff. With more sharing of information and recognition that the organization is prioritizing this harm event, more staff would likely report.

In January, 2019, two staff members from a NH hospital shared their very personal stories of being victims of workplace violence and harm. They were accompanied by the Director of Security and they each brought family members. A Security Officer shared her story of being kicked in the head by a patient, describing her prolonged, ongoing physical injuries requiring many medical appointments and care in Boston. She also described the profound impact on her life and goals especially regarding higher education; extended length of leave of absence from work and ongoing symptoms interfering with her activities of daily living. She chose to press charges, with incredible support from the organization. An ED Nurse then shared her story of being verbally assaulted and threatened by a patient over a series of ED visits. The individual made verbal threats in person, as well as extensively over social media, using the nurse's name. The incredible fear and vulnerability the nurse felt for herself and her family wreaked havoc with her daily living, being in public and arriving at work. She obtained a restraining order on the individual, again with the ongoing support from the organization. She also shared the statistic that 1 in 4 nurses have been physically assaulted at work and showed a very powerful video titled Say Something: We Won't Give Up On You.

Both staff members commented on the robust expectation and nature of reporting harm events at their organization; how seriously they are considered and the amount of support that has been provided by their employer - such as the Director of Security accompanying them to court and to the Commission meeting.

Opioid Stewardship

In response to the ongoing opioid crisis in New Hampshire, Commission members agreed to make addressing opioid prescribing practices / pain management a strategic priority for the 2018-9 Commission year. We approached this topic from several different facets which are described below.

The Opioid Crisis from a Family Perspective

Our first Commission meeting of this year opened with a father sharing his tragic story of his son's death because of an overdose. The shock that followed was profound and continued when they learned he had a hidden prescription pill addiction which began in college. This experience led to the creation of the Zero Left Behind campaign, which was then used as the foundation for a statewide Opioid Education Disposal Campaign that focused on promoting safe prescribing practices and providing patient education on the safe and proper disposal of opioid medication through the distribution and use of Deterra drug deactivation pouches through 27 hospitals throughout the state, community organizations and other avenues. Disparities in prescribing practices are an issue that still needs to be addressed but until we change the culture of prescribing, the Zero Left campaign has a role. Education is the foundation of prevention. The impact of this story led to a focus on opioid prescribing practices. Having providers be able to review data/prescribing practices can lead to changing behavior which has to happen.

The Opioid Crisis: How NH Hospitals and ASCs Can Help

A physician provided a comprehensive history of the opioid crisis sharing very alarming statistics that the rate of opioid deaths in NH in 2016 was #3 in the US and #2 in 2017. It is estimated that for every ONE opioid overdose death in 2010 there were $4.35 million in health care costs. Why does NH have such a large problem? One factor is that there are higher rates of opioid prescribing practices, which is something the Commission can address. Other reasons include:

- Shortage of treatment funding and treatment resources
- Lower rates of Suboxone prescribers/capita
- Absence of needle exchange programs
- Barriers to accessing Narcan
- Access of proximity of interstate to supply chain
- Rural setting ("Live free or die")

The take home messages for the presentation were that opioid use disorder is a chronic disease; appropriate therapy reduces mortality by 70%; the antidote to heroin is community and that words matter. We need to begin to change the culture by changing the dialogue. It doesn't cost any money and you can start today.

Drug dependence is a chronic disease which is very complicated with many contributing factors. Treatment works and there are lots of other positive benefits. Every single point in the health system should be able to provide treatment but there is a major treatment gap. Also, there are lots of privacy issues and they can be difficult to navigate. One barrier in health care is the firm belief by some that this is the wrong way to treat addiction. The best antidote to heroin is community. We must get beyond health and need to integrate with community support. There is no wrong door - we need to touch all points in community.

The Call to Action requires addressing all aspects of this disease and working at all levels of the system:

- Prevention: prescribing patterns (need to start with data) and Community education and prevention strategies
- Screening: Systematic screening of all patients in all settings
- Treatment: using evidence-based therapy in all care settings
- Recovery: including recovery services and housing community benefits (what we are doing)

Impaired Nursing Practice - Recognition & Support

The experience as a Nurse Director having had to terminate nurses for drug diversion was shared at another meeting. She provided a perspective of substance misuse in context of population health, incidence of substance use, and risk for opioid SUD in the nursing profession. She also explained medication diversion, detection and practices to minimize risk / maximize detection / awareness of diversion. Also reviewed were concepts of impaired practice and how

to approach an employee when "fit for duty" is questioned. Various reporting requirements and the role of the NH Board of Nursing were outlined.

Opiate-Free Anesthesia

The Director of Anesthesiology at a local hospital outlined his approach working towards a more opioid free / opioid sparing anesthetic experience. He reviewed the history of opioids, the development of fentanyl, early belief that addiction was rare in patients treated with narcotics, and the impact of pain being treated as the 5th vital sign. The pathophysiology of pain and how medication affects it was explained. He has been providing opiate free anesthesia by focusing on multimodal therapies. His reasons to do this include concerns with addiction, societal issues, side effects from opioid administration but also realizing that outcomes are better. His overall goal is to be more patient driven.

Patient Experience and Engagement

Incorporating the Patient Voice / Experience

The Members believe value in health care is created when patients and providers work together to achieve the patient's goals. Effective prevention of patient harm and reducing risks are achieved when both patient and their family are actively involved with their health care providers / partners. It is only through active participation from and open communication with our family members that we can provide a strong foundation necessary to address issues and ensure patients receive the safest care possible. Some highlights from our meetings this year that are examples of this include:

- Family member who lost their son to an overdose worked with providers to reduce unnecessary opioid prescriptions in the post-operative phase and discharge to home.
- Raising awareness that the stigma associated with addiction is a major barrier. A handout titled Words Matter was provided. Choosing our words carefully is one way we can all make a difference and help decrease the stigma associated with behavioral health disorders. Use of non-stigmatizing language supports understanding of addiction and other behavioral health disorders as chronic medical conditions, supports self-esteem in affected persons, and helps remove barriers to engagement in care.
- Including stories about patients in many of the presentations such as a patient who had been receiving treatment for an opioid addiction suffering a relapse due to administration of opioids for surgical procedure.
- Encouraging patients to focus on doing activities that give them pleasure, to avoid tendency to be bedridden and focused on pain. Having this conversation as part of a preoperative visit creates greater patient engagement.

Words Matter

If you want to care for something, you call it a 'flower';
if you want to kill something, you call it a 'weed'.
Don Coyhis, Founder White Bison & Wellbriety

NH Adverse Event Report for 2018

We anticipate the 2018 Adverse Event Report (aka Serious Reportable Events), will reflect a significant increase in total events. This will most notably be in the categories of Hospital Acquired Pressure Injuries and Falls with Injury. The occurrence of Adverse Events at our organizations was a regular topic at Commission meetings, and we believe there are several reasons why this increase is occurring.

- We are growing our ability to identify events through our persistent efforts to develop a reporting culture. Safety event reporting is an indicator of a strong safety culture which is foundational that promotes learning and high reliability rather than presenting as a set of events as a marker of quality. An increase in reporting by all staff has been noted, as people are not fearful that they will be blamed - all in the context of applying principles of Just Culture. Recent data from safety culture surveys reinforce this. Heightened vigilance helps foster an organizational culture.
- Surveillance has improved within the organizations, aided in part by an ability of electronic alerts and monitoring via more efficient and effective reporting systems that have been developed in conjunction with transitions to new electronic health record systems.
- When there is more transparency in sharing event data, the focus isn't on the numbers but on the depth in learning opportunities. Psychological safety, teamwork and communication, commitment to reliability, how we conduct RCA's etc., all need to be nurtured if staff are going to commit to transparency for learning and improvement.
- Ongoing discussions with the Bureau staff in clarifying and refining criteria for reporting as well as regular distribution of reported events to all Commission members continues to change the threshold for reporting. These discussions highlight and reinforce the importance of reporting which indirectly has increased the reporting by hospitals and ASCs.
- Our patient population is changing. There are changes in case mix, increased volumes, greater complexity, higher acuity and other factors – none of which are captured in the Adverse Event Report. It is also very important to note external environmental factors contributing to patients being in a setting of higher risk – such as delays in being able to transfer patients to designated receiving facilities and admission to long term care settings.
- Falls and Pressure Injuries are challenging for different reasons:
    - There are few evidence-based practices to prevent falls in any setting, so our current focus is on improving mobility and addressing delirium.
    - Pressure injuries are most suffered by critically ill patients for whom all known prevention methods have been employed and failed. Our focus now is on early detection of any compromise in skin integrity, as well as increased engagement by patients and families to assist in reducing risks.

Summary

Year 14 continued to bring NH hospitals and ASCs together to focus on the prevention of medical harm and continuous learning. Our topics have aligned with other efforts in the state including the work of many divisions within the Department of Health & Human Services, the NE Quality Innovation Network, Partnership for Patients and other professional organizations, to complement work and avoid redundancy. We are especially appreciative of our members who so willingly share their experiences, programs and methods for promoting the best patient safety practices.

The Commission will begin Year 15 in July 2019 with a continued focus on decreasing preventable harm by promoting high reliability organizations, adopting evidence-based best practices and continuing work to establish 'Just Cultures' within each institution. All public documents related to the Commission can be found at www.healthynh.org.

For questions, please call:
Natalie Gosselin, Commission Chair: 281-6835 or Anne Diefendorf, Administrator: 415-4271.

Respectfully submitted,

Anne Diefendorf

Anne Diefendorf
Administrator,
NH Health Care Quality Assurance Commission

Foundation *for*
Healthy Communities