Barriers, System Gaps, and Areas for Improvement in New Hampshire's Developmental Services System

Presented by Marissa Berg, CSNI Executive Director and Mary Anne Wisell, Executive Director of Monadnock Developmental Services

February 26th 2026

Agenda:

1. Area Agencies DAADS functions
2. Barriers to safety and reporting
3. Gaps in rules and laws
4. Opportunities to strengthen systems

A note:
Area Agencies are contractually required to perform Designated Area Agency Delivery System (DAADS) Functions and certain other services under contract with the State of NH. Most Area Agencies also choose to offer direct service provision and Service Coordination services, but are not required to do so.

The responses in this presentation are largely from a DAADS entity lens, but may also include thoughts coming from the lens of a Service Coordination or Provider Agency as well.

Area Agency Roles in Safety

How Area Agencies Protect People from Abuse & Neglect

- *Each of the ten Area Agencies is an independent nonprofit that is designated to provide services. They can choose to implement these services a bit differently, so long as it adheres to the law*
- Area Agencies perform the required administrative functions for NH to access the HCBS waiver for over 5000 people every year
- What are the DAADS functions?
  - System-level oversight and quality assurance
  - Technical Assistance for Crisis Management, upon Service Coordination request
  - Family support & self-directed service oversight
  - Provide education for individuals, families, and providers
  - DD/ABD Eligibility determinations (not Medicaid eligibility)
- Board Involvement in monitoring

DAADS Functions related to Quality Monitoring

- Monitor incident reports, crises, and notify BDS of critical incidents as supplied by providers, requesting sentinel event reports when applicable
- Analyze trends and escalate concerns
- Track corrective actions; report concerns to the Bureau of Developmental Services (BDS)
- Conduct Quality Assurance reviews, restraint data collection, monitor medication administration activities including error rates as supplied by provider agencies, facilitate Human Rights Committee (HRC), receive and submit initial mortality review and sentinel event information to BDS
- Offer system-level training
- Review rights with individuals, guardians, and families upon intake

Family Support & Participant Directed and Managed Services (PDMS) Oversight

- Training for families to manage self-directed services
- Background checks and waiver compliance for PDMS staff
- Supports through Family Support, Behavioral/Clinical information and referral, Intake/Eligibility
- Certain Human Resource Functions

Quality & Human Rights Monitoring

- Use data provided by provider agencies (incident reports, sentinel events, restraint reports, mortality reports, behavior plans, service agreements, medication error reports)to monitor quality
- Monitor timely follow-up across providers
- Review and approve behavior plans. No rights restrictions may be utilized for any person receiving services without a current plan approved by both the Area Agency HRC and the guardian (if applicable). To do so constitutes a violation of rights.
- If concerns are noted by the AA, BDS is alerted to address the issue.

Barriers to Safety & Reporting

System-wide challenges that affect abuse/neglect prevention, detection, and response.

Workforce Shortages & Instability

- Low wages + high turnover = DSP shortages
- Inconsistent training and limited supervision
- Supervisors/program managers have limited time in homes
- Limited access to clinical expertise

Limited Capacity & Natural Support Challenges

- Lack of providers offering specialized services, placements, and respite
- Individuals with communication barriers are at higher risk
- Community support can be limited due to the location of homes, employment, family dynamics, and transportation challenges.

All members of the community are mandated reporters in NH

Administrative Burden

- Heavy desk work limits Quality Assurance practices
- System shifts prioritize provider self-reporting
- Information requests to providers often require extensive back-and-forth and follow-up.

Siloed System

- Communication struggles between Area Agencies, Service Coordination agencies, providers, and oversight bodies
- Unclear roles and resistance to sharing information
- Delays in information flow reduce situational awareness

Reporting Challenges

- Fear of retaliation or service loss (families, individuals and employees)
- Bureau of Aging and Adult Services (BAAS) hotline delays and inconsistent follow-up
- Non-verbal individuals cannot self-report
- Staff misinterpret rights restrictions as “safety measures”
- Confusion on whether to call BAAS or the Office of Client and Legal Services (OCLS)

Areas to Strengthen in Investigation Systems

- Reduce delays in investigation turnaround time
- Share findings consistently across involved stakeholders
- Limited recommendations and/or systemic-factor analysis
- There is no existing methodology to share concerning information that is discovered during OCLS investigations of paid providers. BAAS has a registry, but it is not connected
- High “unfounded” rates despite concerns – consider adding inconclusive findings where further recommendations are warranted.

Limited Authority for Follow-Through

- AAs cannot require providers to implement corrective actions outside of He-M regulations
- Providers may choose not to implement recommendations
- Families/guardians may decline safeguards
- No enforcement mechanisms outside reporting to DHHS

Gaps in Rules and Laws

Where NH's system struggles—and how it could improve

Gaps in NH Laws & Rules

- Improvements needed:
  - No requirement to fund a sustainable workforce in state of New Hampshire
  - Limited enforcement authority
  - Fragmented oversight
  - No method to share/look up information related to OCLS investigations
  - Inconsistent interpretation of rules

What These Gaps Mean

- Funding & Workforce:
  - No mechanisms to ensure adequate rates or wages
  - Workforce instability undermines safety and quality
- Rule Interpretation:
  - Conflicting guidance across families, providers, and regions
- Communication:
  - Direct Billing/NH Easy reduced information flow
  - Missing/late documentation increases risk
  - Corrective actions not consistently shared

RSA 171-A Gaps

- Unclear enforcement authority
- No ability for AAs to require provider corrective action
- No statewide OCLS or method to share findings/concerns
- Overlapping oversight roles
- Focus is on reactive response, rather than rates that focus on robust preventive monitoring.

He-M Rule Gaps

- Systemic-factor analysis often incomplete in investigations
- No mandate to act on investigation recommendations
- Terminations without corrective actions leave risks unaddressed
- Inconsistent timelines and feedback across OCLS/BAAS/DCYF
- He-M 202 data reporting requirements not followed

Opportunities to Strengthen Systems

What are the changes that could be made to move us in the right direction?

Underfunding & Workforce Instability

- Gaps:
  - Individual budgets are often insufficient based on true cost of providing services
  - Budgets only increase based on a change in need, not an increase in costs to provide services
  - No minimum wage requirements for DSPs/SCs
- Improvements:
  - Increase funding, set rates, strengthen wage standards, cost of living increases.

Insufficient Clinical & Specialized Supports

- Gaps:
  - Limited behavioral/dual-diagnosis services
  - Shortage of specialized clinicians; crisis cycles
  - Declining community-based clinical resources for I/DD (loss of NH Hospital neuropsych unit, Dartmouth multi-disciplinary team, etc.)
- Improvement:
  - Rebuild clinical capacity; create statewide crisis prevention supports, strengthen AA authority surrounding clinically appropriate services, create a specialized Clinical Service Coordination role.

Limited Authority

- Gaps:
  - Responsibility without authority
  - Often overlapping, unclear roles between oversight bodies

- Improvement:
  - Strengthen authority, clarify roles, expand provider monitoring

Investigative Process Gaps

- Gaps:
  - Investigators are challenged in meeting regulatory timelines
  - Meaningful systemic analysis
- Improvements:
  - Workload appears to indicate the need for more investigators in NH
  - Timely investigations
  - Required systemic-factor reports with mandatory corrective action & follow-up
  - Create a statewide method to share information/concerns about OCLS investigations
  - Educate stakeholders about the use of OCLS investigations as a quality improvement measure. It's not intended to be punitive.

Administrative Burden

- Gaps:
  - Compliance workload promotes utilization of written data over on-site and provider agency and service coordination check-ins

- Improvement:
  - Streamline requirements and re-center on quality and person-centeredness.

Fragmented Communication & Data

- Gaps:
  - Inconsistent data sharing from OCLS
  - Reliance on multiple entities having to communicate in a timely manner.

- Improvement:
  - Integrated data systems
  - Systemic, statewide review that is directly utilized to increase quality

Helping People Understand Their Rights

- AAs, SCs, and providers teach rights and reporting at intake and annually
- Use accessible materials and repeated reinforcement
- Support self-advocacy and early reporting
- Supporting individuals through person-centered planning to increase advocacy skills

In closing:

- Improving Safety Requires:
  - Stronger oversight authority for AAs
  - Clear, coordinated, and documented roles
  - Adequate funding and workforce stability
  - Integrated data and communication systems
  - Consistent and transparent OCLS investigation practices
  - Continuing education for families, guardians, and individuals

Everyone has a shared responsibility to promote safety and quality services. No one entity can be responsible for everything. Everyone needs to be aware of their role and responsibility.