MINNESOTA
OLMSTEAD
IMPLEMENTATION OFFICE

Redacted Survey Responses: Health

These survey responses have been redacted to exclude personally identifying information.

Responses about all health goals

- affordable health care and mend that are not covered By MA metcare could be cheaper low in come
- We need to use community based, trauma informed care. ABA, while accepted by insurance, is not supported by Autistic advocates. The quality of the healthcare is important too. Hospitals should have an emergency AAC device for disabled people receiving care who were brought in a crisis like an accident so they can communicate. We need to emphasize consent. With disabled people being supported with as much agency in their care as possible.
- Yeah - lets start with NO ONE should experience abuse and neglect. How much abuse and neglect is OK? Let's reduce by 10% - so 90% of the people who are experiencing it - continue to experience it - the goal should be ZERO. I can't believe we have a goal that isn't zero.
- The health and safety goals appropriately address abuse prevention and access to services, but they do not address how funding structures affect providers' ability to meet required safety standards in community-based residential settings. Family Residential Services homes operate under the same licensing expectations as larger residential programs while often having fewer administrative resources. When funding structures do not reflect the actual support needs of individuals, providers may be forced to reduce staffing or restructure placements in ways that affect stability and oversight. Supporting funding models that align with assessed needs would strengthen health and safety outcomes and better support the integration goals of the Olmstead Plan.
- The current health and safety goals are too soft and overly dependent on training, outreach, and policy development. This approach does not produce reliable safety outcomes in practice and continues to shift responsibility onto training existing systems rather than fixing system performance. Training should not be the primary strategy. It has already been overused across agencies without producing consistent accountability or measurable safety improvements. These goals need to move away from training-centered approaches entirely and shift toward enforcement, operational standards, and performance requirements. First, enforce clear, mandatory accessibility standards in all health and public safety systems. Accessibility must be defined as functional, real-time access to services-not completion of training or availability of

policies. Second, hold agencies and providers accountable for outcomes. When accessibility fails, when abuse occurs, or when emergency response is not accessible, there must be clear corrective action requirements and consequences-not additional training cycles. Third, prioritize system design over staff education. Safety outcomes depend on whether systems are built correctly from the start, not whether staff have attended training modules. This includes communication access, emergency response design, and service delivery models that function under real conditions. Fourth, embed enforcement mechanisms into every goal. Without enforcement, these strategies become administrative activity rather than safety improvements. Fifth, shift from awareness-based models to compliance-based and outcome-based oversight. Agencies should be measured by whether individuals actually receive accessible, safe, and effective services in real time. The core issue across these goals is not lack of training-it is lack of enforcement. Without strong accountability mechanisms, these goals will continue to produce activity without guaranteeing safety or access.

- The health and safety goals recognize important protections for people with disabilities but do not address how funding structures affect providers' ability to maintain safe and stable residential environments. Family Residential Services providers are required to meet the same licensing expectations as larger residential programs while operating with fewer administrative and staffing resources. When funding does not match actual support needs, providers may be forced to restructure placements in ways that are not person-centered. Maintaining funding models aligned with assessed needs helps preserve safe community-based housing and supports the integration goals of the Olmstead Plan.
- It feels like this is a goal that is more of a CYA for the government. Having a plan just to have a plan on paper seems like more paperwork pushing.
- Just mine! When I receive all my money that was illegally seized then illegal y stolen items get paid pack in full, I wanted to build a full gym like I had in my house up north.!!
- The goals for this Olmstead Plan are simply following the natural trajectory of improvement and are not aspirational. The mission of the Olmstead Plan is supposed to provide actual growth and improvement in the lives of PWD and this plan misses the mark completely.
- Thank you for the opportunity to provide feedback. While I appreciate the inclusion of goals related to abuse, neglect, and accessibility, the current health and safety goals are too broad and lack the specificity needed to address the seriousness of the issues facing people with disabilities. The goal that “fewer people with disabilities will experience abuse and neglect” is critically important, but as written, it does not reflect the scale, urgency, or systemic nature of the problem. Recent reporting and publicly available data point to ongoing, preventable harm in care settings, including deaths associated with neglect, gaps in supervision, and limited consequences for providers when serious incidents occur. These are not isolated issues-they reflect systemic failures. In this context, high-level goals without clear, actionable strategies risk maintaining the status quo rather than driving meaningful change. The current framing does not address key drivers of harm, including: Weak or inconsistent accountability and enforcement mechanisms Gaps in oversight and follow-up when incidents occur Workforce and

supervision challenges within care settings Fragmentation across agencies responsible for licensing, oversight, and response Additionally, the goals do not clearly define how progress will be measured in a way that reflects actual improvements in safety. Without more precise metrics and transparency, there is a risk that progress could be reported without corresponding improvements in lived experience for people with disabilities. If Minnesota is serious about reducing abuse and neglect, the goals must move beyond general statements of intent and more directly confront the structural conditions that allow harm to occur. This includes setting clearer expectations for accountability, strengthening enforcement, and ensuring that safety systems respond quickly and effectively when concerns arise. As written, the goals are not sufficient to drive the level of change needed. Strengthening them to reflect the realities of the system-and the urgency of the issue-would better position the state to protect the health and safety of people with disabilities.

- There is no mention of “how” healthcare can be improved for the disabled community. -Just this year, Medica alone has cut numerous programs that once benefited me. I can no longer get the chiropractor care that is a necessity for my spine and arthritis issues. I can no longer get certain procedures covered that I did just last year. -Assistive technology, specific walkers, specific canes are still not covered by most insurance. You either must have a waiver, grant or pay out of pocket. How will the state help us with this?
- Much like curb cut outs, require fitness centers to have 10% of both aerobic and strengthening machines be universally designed. In other words, be wheelchair accessible machines. Imagine yourself needing exercise for your health, but not only can you not run or walk, you also can't use widely available fitness centers. It in the states' interest that people with mobility challenges can stay healthy by exercising, but also in our interest. Universally designed machines are widely available and don't cost any more than regular machines.
- Emergency preparedness needs to include the rights of those with disabilities. If they or guardians do not want a treatment, such as vaccines, it NEEDS to be honored.
- Woefully and deliberately limited.
- I am so sad to see the total lack of attention on health care access. Do you assume everyone with a disability is on MA and a waiver? MOST Minnesotans' with disabilities do NOT have access to MA. I work full time and have a “good” plan that costs me over $10,000 a year. I hit my out of pocket max every year. Health care costs greatly impact the budgets of every Minnesotan with a disability. Why are there NO goals to improve access to healthcare, quality health care, culturally responsible health care - not just ethnic cultures, but also disability cultures.
- I feel it is very important to train people in authority positions as well as public safety workers how to treat and respect people with disabilities. This also includes training on mental health issues as well as abuse situations with people served.
- Not enough improvements, do better MN.
- 1. Stop the “Knowledge Deficit” Fallacy: The state must stop assuming that the reason disabled people are unsafe is because staff “don't know enough.” Staff frequently know exactly what is

happening; they are simply too overworked, underfunded, or afraid of institutional retaliation to stop it. “Training” is a cheap substitute for the hard, expensive work of restaffing MDH and funding the direct care workforce. 2. Address the Chaos of the DHS Split: The Olmstead Plan is writing goals as if the state's largest agency (DHS) isn't currently shattering into three pieces (DHS, DCT, DCYF). There is no plan for how MDH or DPS will maintain safety data and investigative pipelines during this multi-year administrative chaos. The state is setting “Safety Goals” while its primary safety infrastructure is being dismantled and rebuilt. 3. Move from “Communications” to “Survival”: DPS and MDH focus heavily on “accessible communications.” While a screen-reader compatible website is a baseline requirement, it does not keep a disabled person safe. A safety service is only inclusive if the person can physically and cognitively survive the interaction or the emergency. Data goals must track survival outcomes-mortality rates, use-of-force incidents, and successful evacuations-rather than just “hours of training” or “number of brochures distributed.” 4. End the Reliance on “Prevention Plans”: Asking a provider who has already abused a disabled person to “develop a prevention plan” is an insult to the victim. Safety is achieved through consequences, not “partnerships” with predatory corporate providers. MDH and DPS must use their licensing and grant-funding powers as weapons to shut down unsafe facilities, rather than treating abuse as a “data point” to be shared at the next Subcabinet meeting.

- Health Goal 1: A good goal. Although does not address how veterans need to travel to the metro area or long distances to get care. Health Goal 2: We should make disabled people feel supported. Create networks among disabled people to help report abuse. Health Data Goal 1: A good goal. This is important in that we need to know where to go or who to call in order to be safer. Work together as disabled people to ensure that nobody is getting abused. Health Data Goal 2: This is a great goal. Some doctors refuse to help or pass us up because of the disability of some patients.
- Disability Systems Change Council (p11 under Measurable goals and strategies) -- there is NOTHING on the home and community based services that make the rest even possible. Under “tracking progress” (p14) they talk about percentages of increase or decrease. Singe digits? Then the claim: “This target reflects changes that DCYF can realistically make.” “Discipline” (p18) means suspension longer than 10 days, or expulsion...but not reducing or eliminating restraint. Later on in the document (p22), they refer to “restrictive procedures” -- but do not specifically address restraint. After reading this far, WTF is the Disability Systems Change Council for exactly? Looks like the OIO already decided on everything. Another charade like the WRAC committee, true to (redacted) past behavior. Abuse & Neglect research and goals pertain ONLY to facilities, not home environments and not group homes. NO mention of fortifying Adult Protection to become useful at all and NO mention of the catch-22 in Child Protection when families are not given sufficient funding for the HCBS supports. MDH will “Continue to train health care and other service providers about identifying and reporting abuse and neglect” -- which is absolutely stupid when NOTHING USEFUL ACTUALLY COMES OF IT. The trainers and trainees get more money, but the people get nothing. Housing Universal Design

standards (p32) says nothing about those with Chemical Sensitivities who are homeless bc of construction toxins, shared ductwork and previous tenancies destroying the air quality with their substances. Also loans for “improvements” if you already own, but no loan opportunities for NEW home owners. They want us to rent and be under the thumb of landlords. Transportation (start p 34) NO Rideshare access. More unnecessary research for “potential approaches.” That money could be spent on ACTUAL RIDES. A whole bunch of “MnDOT is working to confirm targets and baseline data.” Why is MNDOT doing it themselves and not surveying the people to see what's needed? And then cost of transportation will go up under this plan with “updated rates would also more closely match the actual cost of providing services.” Sounds like the state will not be subsidizing, which means a greater disability tax gap for us to foot. Anoka Metro Regional Treatment Center (AMRTC) p 40 -- NO mention of home and community based supports being a solution. A mention of “Increase access to peer support across all service areas”...are they going to pay people with disabilities or are they expecting us to do more volunteer work? Crisis service (p48): “DHS recommends that in the future, this goal counts voluntary residential treatment as “staying in community.” They are trying to pawn off an idea that is not, in fact, “in the community.” Community Employment (p50) - “If someone makes $600 or more per month, they are counted as having CIE. If someone makes $599 or less per month, they are counted as having non-competitive employment.” It says NOTHING about the hourly wage or how many hours. This is a stupid way to assess competitve employment. Competitive employment is GETTING A JOB AGAINST AN ABLED PERSON -- COMPETEING WITH AN ABLED PERSON FOR THE SAME JOB. They are passing off a definition that is not correct. They are also talking about allowing “subminium wages” after all the advocacy and new laws. “DHS is working on getting data that will show the number of people who have CIE” (p51) means that we're spending more money on a researcher instead of actually holding these job brokers/coordinators accountable for the already high rates they get. Councils and Advisory Boards (p61): “Minnesota is in the process of redesigning advisory councils to come into compliance with federal regulation (Access Rule). It is reforming the Medicaid Advisory Council and establishing an Interested Party Advisory Council. -- all these councils to pretend like they are engaging stakeholders. It's a ruse. Mechanical Restraints (p62) -- NOT physical restraint, NOT chemical restraint. ONLY “mechanical.” Restraint should be addressed without an adjective/qualifier. Segregated settings to integrated settings (p65) -- again no mention of home settings or group home settings as being “segregated.” If a person can't leave their home or group home in a self-directed fashion, it's segregated. Lots of consultants are being paid! (p66) to do more nothing useful. This money could be used to fund proper levels of care in HCBS settings instead of consultants. Community Engagement -- Telling us what we want to hear, but likely not to deliver bc of history of leadership. “Community engagement is accountable when there is full transparency with participants (p68) , “During engagement, facilitation must fit the needs of the community...We prioritize leading with a spirit of co-creation and honoring the community's feedback.” (p69) -- We are being fed a line of BS right now. I personally won't believe it until (redacted) no longer serves in or for a state agency and until the program designs actually support the people. “Community engagement is core to OIO's work” (p70) and yet, their procedures are exclusive, the agency representatives don't follow through meaningfully with solutions. they say “surveys will focus on quality of life for people in segregated settings...and that doesn't include everyone who is segregated. Agency Connect (p71) “OIO will track state agencies' timeliness and responsiveness” -- but not the quality of the responses. Remove (redacted). Her role on the OIO is a HUGE CONFLICT OF INTEREST to oversee this plan having been the former director of DHS Aging & Disability Services. She threw us under the bus many times during her time at DHS, namely with the Waiver Reimagine's MnChoices Assessment and Budget Methodologies. More: - No mention of Waiver Reimagine even though HSRI's own data projects people facing average $34,644 budget cuts and many will face 50-80% reductions concentrated in home and family living settings. - An independent legal analysis already in the Minnesota Senate record (O'Meara Wagner, P.A., SF 4512, April 12, 2026) written by the same attorney whose prior litigation CREATED Minnesota's Olmstead Plan identifies Waiver Reimagine as illegal under the ADA, Olmstead, and federal Medicaid law. The 2026 plan does not mention it. - Minnesota is misclassifying 5-6 person congregate settings that meet the DOJ's definition of mini-institutions as participants' “own home.” Every community integration statistic the state reports is built on miscoded data and a definition that is wrong. - No budget adequacy standard and nothing requiring that waiver budgets actually be sufficient to sustain community living. - No home care staffing or nursing goals even though nursing and DSP vacancies represent 10-15% of ALL job openings in the state. You cannot access employment, housing, or community life if there is no one to help you perform ADLs in the morning. MN leads the nation in nursing homecare shortages. Goals without access consideration are unattainable. -The public comment process itself routes feedback through a filtered anonymous Formstack survey with text boxes and checkboxes. Also, the Olmstead Plan needs to clearly define what “supports” means. We demanding tangible supports: direct and indirect, formal and informal. Supports should be meaningful to the individual and their family if they choose. Undefined terms create enforcement gaps and leave too much room for narrow interpretation and cost-shifting onto families.

- WHO came up with the new alleged simplified way to calculate budgets? Sounds like the devil himself!!
- Fund this coverage so people have actual choice option to live in community versus institutions. Fund the employees in these settings.
- almost 1/3 of the population gets sick from fragrance, so education about this is so important for health and saftey. workers, and anyone else should be encouraged to be fragrance free.
- Minnesota is misclassifying 5-6 person congregate settings that violate the DOJ's definition of mini-institutions as participants' “own home.” No budget adequacy standard and nothing requiring that waiver budgets actually be sufficient to sustain community living No home care staffing or nursing goals even though nursing and DSP vacancies represent 10-15% of ALL job openings in the state. You cannot access employment, housing, or community life if there is no one to help you perform ADLs. MN leads the nation in nursing homecare shortages. Goals

without access consideration are unattainable. Our son's disability is significant, but he is able to have a full life by living at home, supported by loved ones and his waiver funding. We are able to make sure he is supported in part time employment, access his healthcare, and live within his community by using waiver funding...

- The Health and Safety section recognizes the disproportionate harm, abuse, neglect, and trauma experienced by disabled Minnesotans, but the measurable goals and strategies remain modest, compliance-oriented, and reactive. The section focuses on reporting, training, and coordination more than systemic prevention, accountability, autonomy protections, or transformative safety reform. I recognize that the values language is strong, however the operational framework does not yet match the scale or urgency of the disparities identified in this section of the plan.
- The goals rely too heavily on awareness campaigns, training initiatives, reporting systems, and administrative processes while avoiding the underlying operational failures driving harm across Minnesota's disability system. Minnesota cannot achieve meaningful Olmstead compliance, community inclusion, abuse prevention, or health and safety outcomes while: - families cannot obtain staffing, - medically complex individuals cannot access nursing, - continuity of care is collapsing, - and caregivers are functioning as unpaid replacements for a failing workforce system. The disability system increasingly depends on family exhaustion and unpaid labor to compensate for workforce instability and inaccessible services. This is not sustainable and should not be normalized as “community integration.” The state should prioritize: - enforceable continuity-of-care protections, - measurable access standards, - workforce stabilization, - transparent reporting of unmet service hours, - protection against institutional displacement, - and outcome measurements based on actual service access rather than paper authorizations. Without addressing these structural failures directly, many of these goals risk becoming aspirational language disconnected from the lived reality of disabled Minnesotans.
- No

Health Goal 1

- Needs to be a better way to get the Vets to the Dr. and not made to feel bad for needing help
- A fundamental issue across this goal is the underlying assumption embedded in disability systems-that disability equates to reduced employability or dependency. This framing is outdated and does not reflect real-world outcomes when appropriate access supports are in place. The policy paradigm must shift from a deficit-based model (“what people cannot do”) to an access-based model (“what systems must provide to ensure full participation”). Hearing loss, for example, is highly compatible with sustained employment when communication access is properly supported. The same is true across many disability categories when barriers are removed rather than assumed as limitations. Current strategies overemphasize outreach, navigation, and identification of Veterans, while underemphasizing the structural issue: employment and independence are primarily determined by access, not diagnosis. When

communication access, workplace accommodations, and inclusive employer practices are in place, many Veterans with disabilities are fully capable of long-term competitive employment. To align with a modern disability framework, this goal should: First, explicitly decouple disability compensation from assumptions of work incapacity. Policy and outreach materials should reinforce that receiving benefits is not equivalent to inability to work. Second, prioritize access as the primary employment determinant. For Veterans with hearing loss and other disabilities, the central policy focus should be communication access, workplace accommodation enforcement, and removal of structural barriers-not expanded navigation systems. Third, reframe employment success metrics around supported participation in the workforce, not implied dependency status or benefit receipt. Fourth, ensure employment systems are built on universal design principles so that access is embedded in workplaces and service delivery, reducing the need for compensatory "navigation" systems. In summary, the required shift is from an assumption of limitation to an assumption of capability with appropriate access. Disability policy should reinforce that employment barriers are structural, not inherent-and that with proper access supports, Veterans with disabilities can and do participate successfully in the workforce.

- I understand the importance of this but not sure if it is a goal to be in the Plan.
- A narrow goal that will not improve the lives of all vets with disabilities and very few Minnesotan's with disabilities. This isn't a reach goal - it is the operational mission of the VA.
- Why have these veterans not been receiving compensation already? Services are available but more providers need to be recruited to help as well.
- I know very little about this topic. All I can add is, integrate VA/MDVA disability services with the waivered services system and make the eligibility/application more streamlined.
- This goal is categorized under "Health," but it is fundamentally an economic and legal objective. Furthermore, the proposed action steps appear to be copied and pasted directly from Employment Goal 2. Strategies like "suicide prevention," "higher education access," and "community awareness" have absolutely nothing to do with the highly technical, legally adversarial process of successfully filing and winning a federal VA disability compensation claim. "Healthcare navigators" do not write the Independent Medical Opinions (IMOs) or Disability Benefits Questionnaires (DBQs) required to win a VA claim. To actually increase disability compensation, MDVA must abandon passive "awareness" strategies and invest in aggressive legal and administrative advocacy. I suggest the following action steps: 1. Fund Independent Medical Opinions (IMOs) and Nexus Letters: The primary barrier to receiving federal VA compensation is the VA's own gatekeeping. Veterans are frequently denied because VA doctors refuse to write the necessary "nexus letters" linking their current disability to their military service. MDVA must create a state-funded grant program to cover the out-of-pocket costs for veterans to hire private, independent civilian doctors to write DBQs and nexus letters, entirely bypassing the federal VA's internal medical bottleneck. 2. Massively Expand CVSO and VSO Legal Capacity: Awareness campaigns do not win appeals. MDVA must aggressively expand the funding and capacity of County Veteran Service Officers (CVSOs) and accredited Veteran Service

Organizations (VSOs) to handle complex, multi-year federal appeals. The state must measure the reduction in CVSO caseloads and wait times, ensuring every veteran has frictionless access to a certified legal advocate to fight the federal VA's denial rates. 3. Address the Intersecting State Economic Motive: The state of Minnesota has a vested financial interest in moving disabled veterans onto federal VA compensation, as it offsets the state's own Medicaid (MA) and MnCHOICES waiver costs. If MDVA is going to use federal compensation as an Olmstead metric, the state must mandate specialized benefits counseling to ensure that winning a federal VA rating does not inadvertently push a veteran over the income cliff for state-based, non-VA community supports (like Personal Care Assistance or state-funded housing waivers).

- Qualitative interviews with Veterans on barriers they are facing and their solutions to accessing benefits and implement them in the strategies
- No

Health Goal 2A

- MN does a horrible job with making sure the disabled are cared for safely. There are checks and balances in place but not followed through on. There also should be a check and balance system in place when DHS is not following the rules to provide safety for the most vulnerable.
- A key missing element in this goal is that it focuses on reducing reported maltreatment cases without addressing upstream causes of harm, particularly communication deprivation and access failure within licensed facilities. For Deaf, DeafBlind, and hard of hearing individuals, language deprivation is a systemic risk factor that is not currently treated with the same seriousness as physical safety or staffing ratios. When individuals do not have full, consistent access to a primary language (including American Sign Language or tactile/accessible communication methods where appropriate), they are placed at significantly higher risk of isolation, misunderstanding, and vulnerability to neglect or abuse. This is a preventable system failure, not an individual issue. To strengthen this goal, strategies and action steps should include: First, establish enforceable communication access standards for all MDH-licensed facilities. This should include requirements for qualified American Sign Language fluency or interpreter availability where needed, and equivalent communication access standards for DeafBlind and blind individuals (including braille and tactile communication supports). Communication access should be treated as a safety requirement, not an optional accommodation. Second, require proactive communication access audits in licensed facilities. Facilities should be evaluated not only on incident reports, but on whether residents actually have functional, day-to-day access to communication that allows them to understand care, report concerns, and participate in decisions. Third, embed prevention requirements that address environmental and design factors that contribute to isolation. This includes accessibility features such as visual alerting systems, captioning as a default standard where applicable, and adoption of Deaf-accessible environmental design principles (including DeafSpace-informed approaches where relevant). Fourth, ensure individuals have meaningful choice in placement,

including access to disability-specific and language-accessible settings where appropriate. Safety outcomes improve when individuals are placed in environments where communication is fully accessible and culturally appropriate. Fifth, strengthen accountability for communication access failures as a form of neglect risk. If communication barriers contribute to harm or unreported incidents, that should be treated as a systemic compliance failure, not an isolated incident. In summary, reducing abuse and neglect cannot rely solely on reporting, policy updates, and post-incident prevention plans. It requires addressing the root cause: communication deprivation and lack of enforceable access standards. Without this shift, maltreatment reduction targets will not meaningfully improve safety for Deaf, DeafBlind, and other communication-dependent populations.

- This goal doesn't seem appropriate because it doesn't get at whether abuse/maltreatment is actually occurring. A maltreatment finding is not directly correlated to whether people have experienced abuse or neglect. Most abuse/neglect remains unreported. When it is reported, it can be easily screened out if the reporter doesn't know how to write it or the information to include that will increase the likelihood that it is screened in for investigation. When screened in, sometimes the investigator doesn't have enough evidence or data to substantiate.
- There is an emphasis on training folks on reporting and responding to abuse and neglect, but this isn't a full picture of what is happening. Understaffing, lack of proper training, and burnout are contributors to these challenges and shouldn't be omitted from the goal. This won't be solved with additional requirements - it requires systems change.
- Too low because the goal is not strong enough - should be multiple reductions over multiple years. There needs to be more accountability - homes and supervisors rarely report on themselves. Neglect is just as prevalent as abuse. And it causes long term trauma to the individuals - and it is rarely reported unless there is a very adverse outcome. How are investigators trained to know if workers just signed the training papers on the policies or really were trained. So many times I read ibn the investigations that “policies and procedures were adequate but not followed”. There is an automatic dismissal of people that are non-verbal. But non-speaking, does not mean that they cannot formulate answers to questions.
- Develop strategies for better onsight quality assurance and monitoring. Return to lead agency case management, separate screening from financial benefit to avoid/prevent screening for dollars. Retain lead agency screening for services and develop a more robust practice that supports professional opinion of screeners and change the appeal of screening results to prevent this. Developing more robust assessment, that supports professional practice, developing a true system of care that supports youth and adults across a spectrum of need and throughout the various geographic regions of MN so that the individuals can remain in their home communities in less restrictive setting thus avoiding institutional settings overall.
- Yet another goal, that is already required by law. Limited in focus to MDH licenses facilities. No reach goal to help the many disabled folks in unlicensed settings. AND the track record of our licensed facilities is pretty poor as it is. Most Minnesotans with disabilities do NOT live in nursing facilities or ICF-DDs.

- There needs to be more accountability and there needs to be consequences for abusers. Better training for providers and protection for those that report abuse/neglect. Care providers need support to maintain self-care as well.
- I don't understand why this is an MDH-only goal. Obviously MDH only has jurisdiction over the facilities they license, but these are not the only facilities where PWD live and face abuse. Group homes are not on this list, for instance. Neither are facilities that provide day services but are not residential. Does “hospitals” include IMDs (including those under DCT's purview)? I think this is a great goal, to be clear. I'm just not sure why it's an MDH-only goal.
- A policy does nothing if it isn't monitored or enforced. Develop ways to increase capacity to hire and retain qualified and trained staff. Implement corrective action. Hold individual perpetrators accountable criminally.
- End the Inter-Agency Disconnect Between MDH Licensing and DHS Investigation: Setting a goal for MDH to reduce abuse by 2% is fundamentally flawed because MDH is primarily a public health and data collection agency, not the primary investigative engine. Abuse reporting is routed through the Minnesota Adult Abuse Reporting Center (MAARC), and DHS or the county often acts as the Lead Investigative Agency (LIA). MDH cannot simply “develop prevention plans” for providers when the structural oversight and investigation of those providers is tangled between MDH's Office of Health Facility Complaints (OHFC) and DHS. To actually reduce abuse, the state must dismantle this bureaucratic silo. MDH and DHS must create a unified, single-point enforcement body where MDH's licensing power is directly and immediately triggered by DHS's investigative findings, ensuring that a substantiated report results in an immediate, coordinated suspension of the facility's license, rather than just an exchange of data between departments. 2. Wield Licensing Authority as a Consequence, Not a “Partnership”: Since MDH holds the licensing and regulatory power for these facilities (assisted living, home care, hospitals), their response to DHS-substantiated abuse must not be collaborative “prevention plans.” This treats corporate providers as public health partners rather than regulated entities that have just violated civil rights. MDH must use its regulatory teeth. Action steps must mandate that when a substantiated report of abuse is transmitted from the investigative agency, it automatically triggers escalating administrative consequences from MDH: heavy financial penalties, immediate conditional license status, freezes on new admissions, or license suspension. 3. Fix the Inter-Agency Data Bottleneck Between DHS and MDH: It makes no sense to give MDH a goal to reduce abuse when DHS holds almost all of the abuse data. Right now, MDH is entirely dependent on DHS to tell them when and where abuse happens. MDH cannot effectively regulate facilities or pull licenses if they are always operating in the dark, waiting for DHS to process and pass along the information. The action step must be to fix this systems disconnect. DHS and MDH must build a shared, real-time data system. MDH needs immediate access to abuse reports the second they come into DHS. If MDH only gets the data weeks or months after the fact, any “prevention plan” they write is just useless paperwork that does nothing to actually keep disabled people safe. 4. Acknowledge the Workforce Collapse as the Root Cause of Neglect: None of the proposed strategies actually prevent

maltreatment; they only respond to it. However, true prevention cannot be achieved purely through punitive regulations if the underlying system is starved of labor. Abuse and neglect are directly correlated with severe short-staffing and high employee turnover, particularly in rural Minnesota where low wages and federal graduate loan caps have decimated the nursing and clinician pipelines. MDH cannot simply demand compliance from facilities that cannot physically hire staff. Therefore, MDH must formally treat the healthcare workforce collapse as a primary public health crisis that directly causes maltreatment. Action steps must include MDH leveraging its epidemiological data to publish formal, public reports linking the workforce shortage to maltreatment rates. MDH must use this data to aggressively inform the Governor's budget proposals and legislative testimonies, demanding systemic labor interventions-such as massive rural wage subsidies, state-funded tuition/loan forgiveness for direct care workers, and emergency staffing strike teams. Preventing abuse requires structurally funding the workforce, not just writing “prevention plans” for facilities that have no staff.

- train them about importance of being fragrance free, sincee that seeems to cause a lot of providers to discriminate and be mean to disabled people.
- Qualitative interviews with people that have experienced maltreatment, how they can safely report and their solutions and implement those strategies
- I just want to point out that Intermediate Care Facilities are dual-licensed by MDH and DHS. DHS should be a partner agency in this goal.
- After working for years with group homes, the issue seems to be that they hire “bodies”. Many group homes hire part time without benefits. A rotating door for staff leaves the vulnerable clients more at risk for abuse.

Health Goal 2B

- This goal is important, but the current strategies are heavily focused on training, awareness, and data collection, rather than addressing structural risk factors that increase vulnerability to violence in the first place. Training alone does not prevent abuse if underlying conditions of isolation, communication barriers, and dependency remain unaddressed. A key missing element is communication access and language deprivation. For Deaf, DeafBlind, and hard of hearing individuals, lack of consistent, fully accessible communication (including ASL or other appropriate modalities) is a major risk factor for exploitation and underreporting of abuse. If individuals cannot fully communicate, they are less able to recognize, report, or escape abusive situations. To strengthen this goal, additional strategies should include: First, establish enforceable communication access requirements in all settings serving adults with disabilities. This includes requiring qualified communication access (such as ASL fluency or interpreters) and ensuring individuals have direct, independent access to reporting systems without relying on intermediaries. Second, require accessible reporting pathways that are fully independent of caregivers or service providers. Individuals must be able to report sexual or intimate partner violence in a private, accessible format that does not depend on others in their environment.

Third, strengthen environmental and systemic safeguards in residential and service settings. This includes reducing isolation risk factors through community integration, oversight of high-risk living arrangements, and ensuring residents have real autonomy in choosing where and with whom they live. Fourth, expand placement options in disability- and language-accessible environments where appropriate, where communication barriers are minimized and individuals are not structurally isolated. Fifth, shift from primarily training-based approaches to accountability-based prevention. Providers should be evaluated not only on whether they received training, but on whether communication access, reporting responsiveness, and safety outcomes actually improve over time. Sixth, ensure that “safe harbor” expansion includes disability-specific protections, recognizing that exploitation risk is significantly increased when communication access is limited. In summary, reducing sexual and intimate partner violence requires more than education and reporting systems. It requires structural prevention: full communication access, independent reporting pathways, reduced isolation, and enforceable accountability for environments that place adults with disabilities at elevated risk.

- The goals should be stronger and keep reducing year over year - not just annual goals
- create a supportive separate legal system for individuals with disabilities to flex timelines to allow individual with disabilities to access appropriate and effective accommodations and supports . Youth report sexual assault and are dismissed based on rigid timelines, 'reliability' of reporters, ect . Sexualization, grooming of youth and young adults with disabilities is more rampant and difficult to prevent with widespread access to social media and no accountability. Neighboring state WI passed a grooming law. ACT 88 allowing for delayed reporting by victims and ACT 89 to address training in education and other services directed towards youth.
- Why only 17%? This population already has so many things working against them. They need better protections from sexual predators, both within the population as well as outside the disabled population. Concerns need to be brought to the attention of staff, guardians, care-providers, law enforcement.
- Again, why is this an MDH-only goal? There are way more agencies that should be involved in this, not the least of which is DHS.
- Yes. I'm also not seeing anything else in strategies or action steps that explicitly focus on prevention of maltreatment itself. You hit the nail on the head. That is the smoking gun of this entire section. Every single strategy they listed-developing policies, sharing data, and creating plans after a confirmed case-is a post-incident response. They are confusing “responding to abuse” with “preventing abuse.” Waiting for a disabled person to be traumatized or neglected before stepping in to write a paperwork plan is a catastrophic systems failure. We need to add a point that calls this out explicitly and gives them actual preventative measures within their licensing wheelhouse. Here is a 4th point to round out the critique: 4. Focus on Actual Prevention, Not Just Post-Abuse Response: None of the proposed strategies actually prevent maltreatment from happening in the first place. Following up with a provider after a confirmed case is not prevention; it is post-incident response. True prevention means stopping the abuse before a disabled person is harmed. MDH must use its licensing oversight to proactively target

the conditions that breed neglect. For example, severe short-staffing and high employee turnover are direct leading indicators of maltreatment. If an assisted living facility is critically understaffed, neglect is inevitable. MDH's action steps must include unannounced, proactive inspections and freezing new admissions at facilities that fail to maintain safe staffing ratios, rather than waiting for a disabled person to be abused before intervening. This brings the whole critique together: The Inter-Agency Disconnect (DHS investigates, MDH licenses-fix the silo). The Consequence (Use the license as a weapon, not a partnership). The Data Bottleneck (MDH needs real-time data from DHS, not delayed leftovers). Actual Prevention (Stop reacting to trauma; proactively regulate the conditions-like understaffing-that cause it). Does this final piece give you the complete ammunition you need for this section?   OK, for point #4... I want to add some more context. MDH already knows there's a severe shortage of skilled nurses, clinicians, staff at assisted living facilities, hospitals, etc. There is a real workforce shortage when it comes to staffing at MDH-licensed providers, and it's even worse in the rural areas. Pay is crap in rural areas, so there's not much of a financial incentive for graduates to go move in rural Minnesota. So, while unannounced, proactive inspections and freezing new admissions at facilities that fail to maintain safe staffing ratios are great, there's systemic barriers. Not to mention, the presidential administration made changes to the cap of loans/borrowing for majors in graduate/post-grad schools, such as nursing, medical school, etc. and that's another devastating blow to the growth of that workforce. Show more This is a crucial macro-level nuance. You can't just mandate safety through penalties if the entire workforce ecosystem is collapsing. If you just aggressively pull licenses without addressing the labor vacuum, facilities close, beds disappear, and disabled people are dumped into hospitals or onto the street-which is just another form of systemic neglect. This ties right back into your overarching theme: state agencies trying to regulate their way out of resource vacuums (the “knowledge deficit fallacy” applied to staffing). Here is how we integrate that reality into Point 4, pivoting from pure punishment to demanding that MDH treat the workforce collapse itself as a public health crisis that causes abuse: 4. Acknowledge the Workforce Collapse as the Root Cause of Neglect: None of the proposed strategies actually prevent maltreatment; they only respond to it. However, true prevention cannot be achieved purely through punitive regulations if the underlying system is starved of labor. Abuse and neglect are directly correlated with severe short-staffing and high employee turnover, particularly in rural Minnesota where low wages and federal graduate loan caps have decimated the nursing and clinician pipelines. MDH cannot simply demand compliance from facilities that cannot physically hire staff. Therefore, MDH must treat the healthcare workforce collapse as a primary public health crisis that directly causes maltreatment. Action steps must include MDH leveraging its public health funding and data to aggressively lobby the legislature for systemic labor interventions-such as massive rural wage subsidies, state-funded tuition/loan forgiveness for direct care workers, and emergency staffing strike teams. Preventing abuse requires funding the workforce, not just writing “prevention plans” for facilities that have no staff. This frames the workforce shortage not as an excuse for providers, but as a systemic failure the state is ignoring. It demands that MDH stop acting like abuse is just a “policy” issue and start treating it as a raw economic/labor issue. How does this capture the rural/economic reality you outlined?   I don't know if MDH can lobby the legislature for systemic labor interventions. Would that be considered a conflict of interest for state departments to lobby state legislature? You bring up an incredibly important procedural point. There are strict rules around state agencies lobbying the legislature. According to FindLaw, under Minnesota law (Statute Â§ 3.084), sitting members of the legislature are prohibited from lobbying, and while state agency commissioners often testify and present their governor-approved budgets to legislative committees, rank-and-file state departments cannot independently register as lobbyists or directly “lobby” lawmakers outside of official budget and policy requests funneled through the Governor's office. If we tell MDH to “lobby the legislature,” they will immediately dismiss the feedback as legally impossible or outside their scope, which gives them an easy out. We need to rephrase this so it demands they use the tools they do have-administrative rule-making, data reporting, and official budget requests-without crossing into prohibited “lobbying.” Here is the revised Point 4, removing the word “lobby” and replacing it with their legal, operational levers: 4. Acknowledge the Workforce Collapse as the Root Cause of Neglect: None of the proposed strategies actually prevent maltreatment; they only respond to it. However, true prevention cannot be achieved purely through punitive regulations if the underlying system is starved of labor. Abuse and neglect are directly correlated with severe short-staffing and high employee turnover, particularly in rural Minnesota where low wages and federal graduate loan caps have decimated the nursing and clinician pipelines. MDH cannot simply demand compliance from facilities that cannot physically hire staff. Therefore, MDH must formally treat the healthcare workforce collapse as a primary public health crisis that directly causes maltreatment. Action steps must include MDH leveraging its epidemiological data to publish formal, public reports linking the workforce shortage to maltreatment rates. MDH must use this data to aggressively inform the Governor's budget proposals and legislative testimonies, demanding systemic labor interventions-such as massive rural wage subsidies, state-funded tuition/loan forgiveness for direct care workers, and emergency staffing strike teams. Preventing abuse requires structurally funding the workforce, not just writing “prevention plans” for facilities that have no staff. By changing “aggressively lobby the legislature” to “publish formal reports... and aggressively inform the Governor's budget proposals and legislative testimonies,” we are telling them to do exactly what state agencies are legally supposed to do: use their data to drive the Governor's funding requests. Does this safely bypass the lobbying restriction while maintaining the exact same systemic pressure?   Measurable Goal 2B: By January 1, 2031, the number of adults with disabilities who experience sexual and intimate partner violence will decrease to 17%. Health Goal 2B: This measurable goal is... Too low Just right Too high Not sure Strategies and action steps To reach this goal, MDH will: Continue to train health care and other service providers about identifying and reporting abuse and neglect Continue to increase sexual education for people with disabilities, care providers, and supporters Continue to gather and analyze data about sexual and intimate partner violence Continue to explore the feasibility of expanding safe harbor to all age groups Continue to coordinate the statewide response to sexual exploitation for adults ages 18-25 Do you have any ideas of other strategies and action steps to reach Health Goal 2B? Show more Here is the breakdown for this section. This is a textbook example of what you flagged earlier: using the “Knowledge Deficit Fallacy” and “Administrative Stalling” to avoid making structural changes. 1. This measurable goal is... Select: Too low. (Aiming to reduce sexual and intimate partner violence “to 17%” means the state is formally setting a goal where nearly 1 in 5 disabled adults will still be subjected to sexual violence. Setting a baseline of acceptable violence is grotesque. Furthermore, the goal is toothless because none of their strategies address the actual mechanics of why disabled people are trapped in abusive situations.) 2. Do you have any ideas of other strategies and action steps to reach Health Goal 2B? Here is the systemic teardown of their proposed strategies. They are entirely reliant on “training,” “education,” and “exploring feasibility”-which places the burden on victims and delays actual state action. 1. Abandon the “Knowledge Deficit Fallacy” for IPV Prevention: MDH's primary strategies rely on “training providers” and “increasing sexual education.” This leans on the fundamentally flawed assumption that disabled people experience intimate partner violence (IPV) because they simply don't know what abuse is, or because providers lack awareness. This is a Knowledge Deficit Fallacy. Disabled adults are not abused because of a lack of “education”; they are abused because they are structurally and economically trapped. Abusers frequently control a disabled person's housing, transportation, and basic survival care. MDH must stop treating IPV as an educational issue and start treating it as an issue of economic and physical entrapment. 2. End “Administrative Stalling” on Safe Harbor Protections: Stating that MDH will “continue to explore the feasibility of expanding safe harbor to all age groups” over a multi-year plan is classic administrative stalling. Safe Harbor laws (which prevent trafficking and exploitation victims from being criminalized and connect them to services) are a proven structural intervention. “Exploring feasibility” is a bureaucratic delay tactic that costs disabled lives. The action step must be to mandate and draft the legislative framework for expanding Safe Harbor to all disabled adults immediately, using MDH's epidemiological data on exploitation to justify the immediate need. 3. Use Public Health Funding to Force Domestic Violence Shelter Accessibility: A disabled person cannot leave an abusive partner if the state's domestic violence shelters are inaccessible. Many IPV shelters lack physically accessible beds, ASL interpreters, or have strict policies that prevent outside Personal Care Assistants (PCAs) from entering the facility. As a result, disabled victims attempting to flee abusers are frequently funneled into institutionalization or homelessness. MDH distributes massive public health and violence prevention grants. MDH must formally tie all violence prevention and public health grant funding to strict, measurable accessibility mandates for all state-funded IPV and emergency shelters. 4. Address the “State-Funded Abuser” Dynamic (PCA/Rep Payee Control): Because MDH gathers the public health data on IPV, they must structurally address who the abusers are. Often, the abuser is the victim's paid PCA or their Social Security Representative Payee. When an abused disabled person leaves, they don't just lose a partner; they lose their basic life-sustaining care and their income. MDH must use its data to highlight this specific vulnerability and collaborate with DHS to establish an “Emergency Care Bridge”-a specialized, rapid-response funding mechanism that instantly replaces a victim's PCA services and secures their income so they can safely leave an abusive caregiver without being forced into a nursing home. 5. Mandate “Caregiver Separation Protocols” in all MDH-Licensed Clinics: A primary reason disabled people cannot report IPV or sexual violence is that the abuser is often their PCA, spouse, or family member who accompanies them to every medical appointment, often acting as a physical support or even unlawfully acting as an “interpreter.” The victim literally never has a safe, private moment to disclose the abuse. MDH must use its licensing authority to mandate strict “Caregiver Separation Protocols” in all MDH-licensed hospitals and clinics. This would require providers to physically separate the patient from their caregiver/PCA for a portion of the visit to conduct private IPV screenings, utilizing independently contracted ASL interpreters or accessible communication technology, ensuring the victim has an enforced, safe window to disclose abuse without the perpetrator present. 6. Redirect Violence Prevention Grants to “By-and-For” Community Organizations: MDH distributes millions in state and federal Sexual Violence Prevention Program (SVPP) grants. Currently, the strategy is to give this money to mainstream domestic violence agencies so they can “train” their staff on disability. This trickle-down approach fails. Mainstream agencies consistently fail to provide cultural or linguistic accessibility (especially for the Deaf/DeafBlind communities). MDH must formally mandate that a protected percentage of all violence prevention and IPV grant funding goes exclusively to “by-and-for” organizations (organizations led by disabled, Deaf, and disabled-BIPOC individuals, such as ThinkSelf). Peer-led, culturally fluent community defense is statistically more effective at preventing exploitation than trying to train non-disabled mainstream providers.

- more education and figure out root cause of why it's happening.
- Qualitative interviews with people being abused and neglected and what are their solutions around prevention and safety and implement those strategies
- this has to go beyond service providers because these numbers are higher than indicated but not tracked through general population of people with disabilities.
- No

Health Goal 2C

- The current strategies are overly reliant on training, awareness campaigns, and general resource promotion. Training alone does not prevent abuse and neglect when structural risks-especially communication barriers and isolation-remain in place. A more effective approach should shift from training-based models to enforceable standards, service matching, and direct access requirements. First, prioritize enforceable communication access as a safety requirement, not an accommodation. For Deaf, DeafBlind, and hard of hearing individuals, safety depends on real-time, fully accessible communication. Wherever possible, services should be delivered in the individual's primary language (including American Sign Language when appropriate), with qualified communication professionals integrated directly into service delivery. Interpreters and auxiliary supports should be used when necessary, but the system should prioritize direct language access as the default standard wherever feasible. Second, move from generalized training to enforceable provider requirements and accountability. Providers serving disabled students must meet clear, verifiable standards for safety, reporting responsiveness, and communication access. Compliance should be measured through outcomes and audits, not participation in training. Third, strengthen direct reporting and referral pathways. Students must have immediate, accessible, and independent ways to report abuse and neglect without relying on intermediaries. Referral systems should be streamlined so that reports lead directly to appropriate investigative and protective services without unnecessary administrative steps. Fourth, focus on matching individuals to appropriate, accessible environments rather than managing risk within mismatched settings. Many abuse and neglect risks increase when individuals are placed in environments without adequate communication access or disability-specific supports. Placement appropriateness should be treated as a prevention strategy. Fifth, shift emphasis from awareness to prevention infrastructure. This includes requiring that service environments are designed to reduce isolation, ensure communication access, and provide consistent oversight, rather than relying on repeated training cycles for staff. In summary, this goal would be stronger if it reduced emphasis on training and instead prioritized enforceable communication access standards, direct service matching, and accountability for providers. Prevention depends on system design and access-not awareness campaigns.

- The goals should be stronger and go over multiple years.
- This will not be achieved, the appropriate services, approach in CW/CP do not currently exist to adequately address youth at risk of harm. Additionally, we do not have adequate supports for youth in need of care, other than hospitalization, adjudication, and crisis. We need training and support for family providers. We need training for educational staff, law enforcement, and judicial branch to address neglect and abuse of youth with disabilities to adequately provide safety and attempt to reach this goal.
- Why an MDH goal. Should our schools be expected to NOT abuse kids with disabilities. Instead they restrain students, lock them in closets, hit them and more. the goal is to reduce abuse by 42% - why not 100%????
- Community education and involvement could go a long way in helping to reduce disabled student abuse and neglect. Just getting the reports to decrease is not enough. Are they reduced because the student is afraid to say something? Then this has not been beneficial. If the number of disabled students who report experiencing abuse and neglect goes down because there is less abuse and neglect, then that is a good thing. Just the goal of reducing reports is not sufficient.
- Again, why is this an MDH-only goal? Does MDE not have a role to play? What about DHS? What about DEED (for students involved in job training programs)?

- Work with families to design, implement, and evaluate the policies and programs they are responsible for.
- Reject the 42% “Acceptable Abuse” Baseline: Setting a 2032 goal where 42% of disabled students still experience abuse and neglect is a severe failure of civil rights. The state cannot formally codify a target where nearly half of a marginalized youth population remains subjected to trauma. This goal must be rewritten not just to drastically lower the percentage, but to acknowledge that much of the abuse disabled students face is state-sanctioned within the school system itself. 2. Stop Relying on “More Training” for Mandated Reporters: MDH's strategy to “continue to train providers” assumes that disabled youth are abused because teachers, nurses, or staff just don't know how to spot the warning signs. That is simply not true. Often, staff do see the abuse-such as excessive physical restraints in a classroom or neglect in a group home-but they do not report it. They stay quiet because the person doing the abuse is their coworker, their boss, or the employer they work for, and they are afraid of losing their jobs. MDH needs to stop focusing on “identifying” abuse and start investigating and publishing public health data on mandated reporter failure to break this culture of institutional silence. 3. Address the Chaos of the DHS/DCYF Agency Split: MDH lists a strategy to “coordinate statewide response for sexual exploitation.” However, this ignores the massive structural reality that the state's human services apparatus is currently shattering. With DHS splitting into DHS, the Department of Direct Care and Treatment (DCT), and the Department of Children, Youth, and Families (DCYF), the bureaucracy surrounding youth abuse reporting is in massive flux. MDH cannot simply “continue to coordinate” when the agencies they are coordinating with are actively being restructured. Action steps must explicitly outline how MDH will maintain uninterrupted investigative pipelines with the newly formed DCYF, ensuring that abused youth do not fall through the cracks of a multi-year administrative reorganization. 4. Acknowledge Capitalism and Economic Exhaustion as Root Causes of Neglect: MDH lists a strategy to “continue to promote resources” for caregivers. This ignores the economic reality of why neglect happens in the home. Neglect is often the direct result of a capitalist system that forces parents to work two or three jobs just to scrape by. Caregivers do not have the time or energy to be emotionally present for their disabled child, let alone access deep collective and intergenerational healing work. Abuse and neglect always involve power and control dynamics, and capitalism itself is a power and control dynamic. You cannot fix poverty and exhaustion with a “resource” pamphlet. MDH must formally recognize economic deprivation as a root cause of neglect and align its public health strategies with systemic economic relief-such as pushing for guaranteed basic income for disabled families or expansive paid caregiver leave. 5. Cross-Agency Accountability for Restrictive Procedures: MDH ignores the primary site of trauma for disabled students: the public school system. While MDH shares data with the Department of Education (MDE), MDE continues to actively allow schools to use prone restraints, seclusion rooms, and physical holds. MDH must use its epidemiological authority to formally classify the use of restrictive procedures in schools as an Adverse Childhood Experience (ACE) and partner with MDE and DCYF to draft policy demanding an absolute ban on these practices. 6. Fund

Culturally Fluent Youth Intervention (Deaf/Disabled & BIPOC): Promoting “resources” is useless if those resources are clinically sterile or culturally hostile. When disabled and Deaf youth, particularly disabled youth of color, attempt to report abuse, they are frequently criminalized or pathologized by mainstream crisis systems. MDH must mandate that youth exploitation response funding is aggressively redirected away from mainstream, non-disabled agencies and exclusively awarded to “by-and-for” community organizations that possess the linguistic and cultural fluency necessary to reach disabled youth before they are pushed into the school-to-prison pipeline.

- Qualitative interviews with students that have experience abuse and neglect about their solution including prevention and safety and implement their recommendations
- Require training of all Healthcare and service providers to be trained on common disabilities and strategies to support them.
- No

Health Data Goal 1

- Needs to be a central system for where disabled persons can go to find transportation that is not fraudulent. There needs to be EVV or something to verify who they are transporting.
- This goal is directionally important, but it is currently too broad and does not specify what “accessible” means in operational terms. Without enforceable standards, accessibility risks becoming a compliance label rather than a functional guarantee during emergencies. A key missing component is real-time, direct communication access in emergency situations. Accessibility for public safety services must include the ability for Deaf, DeafBlind, and hard of hearing individuals to communicate instantly and directly with emergency responders without delay or intermediaries. This includes reliable video-based communication options and equivalent real-time access pathways that function under emergency conditions. To strengthen this goal, accessibility should be defined as operational capability, not just communication availability. That means: First, require real-time direct communication options as a core emergency service function. Individuals must be able to communicate directly with dispatch and responders in their primary language modality without relying solely on third-party interpretation layers that may introduce delay or failure points. Second, establish enforceable performance standards for accessibility during emergencies, including response time equivalency for accessible communication pathways. Third, ensure redundancy in communication systems so that accessibility is maintained even during system overloads, outages, or disasters. Fourth, move away from reliance on generalized “inclusion” language and toward functional design requirements that guarantee communication access in practice, not just policy. Fifth, incorporate community-based accessibility planning, recognizing that safety outcomes improve when individuals are part of connected, accessible networks rather than isolated environments. In summary, this goal should shift from general accessibility commitments to enforceable, real-time communication access standards in emergency

services. Accessibility in public safety is not achieved through policy statements-it is achieved through systems that function reliably in crisis conditions.

- I think this is a process goal that should be moved to a strategy
- Look at systems, how to youth, families, individual and families from marginalized communities access services? Do they provide safety? Are they purpose built to do provide safety for youth with disabilities? To support members of marginalized communities? I do not believe our system is designed for any of the above. Too many private actors have converged to access public dollars and not necessarily to support individuals.
- Why is this a goal. DPS is already mandated to use accessible communication! This isn't a reach goal - we will try to follow the law should NOT be a goal of government.
- Keep in mind that not everyone has access to all the forms of communications. Some do not have access to internet. Some do not listen to the radio. In other words, use as many platforms as possible to get the word out.
- I don't trust anything DPS does regarding people with disabilities, because I don't trust cops or cop-adjacent people to ever do anything right by PWD. But, like, if they're talking about things like “having ASL interpreters at public announcements” or “giving people ways to contact them that don't involve making phone calls,” I'm not going to oppose that.
- Partner with persons with disabilities to design, implement, and evaluate programs and policies.
- Leverage Statewide Grant Compliance for Emergency Shelters: While DPS does not oversee the 87 county emergency managers, they often administer the state and federal pass-through grants that those counties rely on. DPS should not “ask” counties for shelter data; they should mandate that any county receiving state or federal disaster preparedness funding must report on the ADA accessibility and communication readiness of their primary emergency shelters. The Data Goal should be for DPS to establish a Statewide Accessibility Audit as a requirement for grant eligibility, forcing the 87 counties to provide this data as a condition of receiving state support. 2. Modernize the State Fire Marshal's Reporting Infrastructure (NFIRS): It is true that 80% of Minnesota firefighters are volunteers without the capacity for complex case studies. However, the State Fire Marshal manages the Minnesota State Fire Incident Reporting System (MSFIRS/NFIRS). Instead of asking volunteers for “extra” work, DPS must update the mandatory statewide reporting software itself. The action step must be to add simple “Disability/Functional Needs” check-boxes to the standard incident reports that firefighters already fill out. This allows the state to pull automated, macro-level data on fire fatalities in congregate care without adding administrative burden to volunteer crews. 3. Bureau of Criminal Apprehension (BCA): Standardize Disability Data in Statewide Databases: The BCA manages the criminal justice information systems that local law enforcement uses every day. Since DPS is starting from zero data, the most effective move is to update the statewide database architecture. DPS must establish a goal to update the BCA's reporting systems so that local agencies can easily flag and track disability-related interactions. If the statewide system doesn't have a place to put the data, local agencies will never report it. DPS's job is to build the

"digital bucket" so the 87 counties have somewhere to pour the information. 4. Driver and Vehicle Services (DVS): Automated Barriers Audit: Since DVS is a direct DPS service, they don't need to ask permission from counties. DPS should implement an automated audit of DVS office wait-times and "failed application" rates specifically for individuals using the "Disability" designation. If it takes three times as long for a disabled person to get a State ID than a non-disabled person, that is a data-proven safety barrier. DPS can track this internally using the data they already own. 5. Office of Justice Programs (OJP): Force Accessibility in Victim Service Grants: Like emergency management, OJP controls the purse strings for crime victim services. DPS should not "promote" accessibility to local nonprofits; they must mandate it. The action step should be to include a "Disability Access Score" in the scoring rubric for all OJP grant applications. This forces local vendors to prove their services are inclusive to disabled victims if they want to win state contracts.
- Listen to what people want and need and barriers they are identifying through qualitative intterviews and make changes in the systems
- No

Health Data Goal 2

- You can train all you want but there needs to be real world experience such as what the police or Social Services see in real life. Watching someone on a screen is not good and only mildly helpful.
- This goal is overly dependent on training as the primary mechanism for improving emergency response. Training alone does not ensure effective performance during real emergencies, especially when systems are already under stress. It risks becoming a compliance exercise rather than a meaningful improvement in response capability. A more effective approach would shift from training-based compliance to workforce composition and operational readiness. First, prioritize hiring people with disabilities, including Deaf, DeafBlind, hard of hearing, blind, visually impaired, and other disability communities, directly into Emergency Preparedness and Response roles. Lived experience should be treated as core expertise, not an optional perspective added through training. Second, integrate disability expertise into emergency response teams as a permanent structural requirement, not a periodic training topic. This ensures that accessibility is built into decision-making processes in real time, not interpreted after the fact. Third, reduce reliance on repetitive training requirements and instead evaluate staff and systems based on demonstrated operational performance during drills and actual emergency responses. Fourth, ensure that communication access and functional needs are embedded into emergency operations planning as default infrastructure, not as a learned competency. Accessibility should be built into systems, not dependent on individual training retention. In summary, this goal would be stronger if it moved away from training-heavy compliance models and toward workforce inclusion, operational accountability, and embedding disability expertise directly into emergency response structures.

- Process goal - no measurable outcome on people - good strategy but not really an outcome goal
- Emergency preparedness needs to include the rights of those with disabilities. If they or guardians do not want a treatment, such as vaccines, it NEEDS to be honored.
- It's wretched. It takes months, urgent needs are not responded in appropriate timeframes. Lead agency, law enforcement, schools, medical staff and families are not able to access MDH for support, response or data for quality assurance.
- The COVID goal? We failed. The number of people with disabilities who died was high.
- This goal is something that will need to be tailored to each individual client. People with disabilities will have different needs during emergencies.
- Great goal. Wish there was more information on how it would be implemented but otherwise, amazing.
- Need to partner with PWD and their families.
- While training staff on Access and Functional Needs (AFN) is a basic operational requirement, it is not a "Safety Goal." This goal is a textbook example of the "Knowledge Deficit Fallacy"- assuming that the reason disabled Minnesotans face disproportionate harm during public health emergencies is that MDH staff simply don't "know" enough about disability. In reality, MDH's failure to protect disabled people during emergencies (as seen during the COVID-19 pandemic) is not due to a lack of staff training, but a lack of structural resources, funding, and enforcement power. To make this a meaningful Data Goal, MDH must move beyond "hours of training received" and track actual resource equity. I suggest the following changes: 1. Measure Outcomes, Not Attendance: "Receiving training" is a process, not an outcome. MDH must establish data goals that measure the impact of this training on disabled lives. For example: Did the training result in a measurable increase in the percentage of accessible PPE, vaccines, or medications distributed to disabled individuals in rural areas? Did it reduce the mortality rate of disabled individuals in MDH-licensed congregate care during the last public health event? Training without measurable survival outcomes is just administrative churn. 2. Address the Resource Vacuum, Not the Knowledge Deficit: MDH has lost 50% of its staffing and funding. Training the remaining staff to "understand" the needs of disabled people does nothing if there is no one available to actually execute an evacuation or deliver emergency supplies. MDH must establish a data goal that tracks the Staff-to-Need Ratio for AFN populations during an emergency. If MDH does not have the "boots on the ground" to support disabled Minnesotans, no amount of training will prevent neglect. 3. Track "Real-Time" Communication Accessibility: Emergency Preparedness and Response (EPR) staff can be trained on AFN, but if the statewide emergency communication systems remain inaccessible, that training is useless. MDH should establish a data goal tracking the Time-to-Accessible-Alert. This measures the gap between when a general public health alert is issued and when a fully accessible version (ASL, Plain Language, Braille-ready) reaches the disabled community. 4. Bridge the MDH/DHS Data Gap During Emergencies: As a data-heavy agency that relies on DHS for much of its information, MDH often lacks a real-time "map" of where disabled people are located during a disaster

(especially those on home-based waivers). Instead of more staff training, MDH should focus on a Data Goal of creating a Unified Emergency AFN Registry that integrates DHS's waiver data with MDH's EPR maps. Training a staff member on AFN is irrelevant if they don't know where the people with AFN are located during a flood, fire, or pandemic.

- Qualitative interviews with people who had emergency and what worked, did not work and their recommendations for changes
- No

Missing Health Goals

- everyone has their own stories , people with disabilities are not all the same many different needs & abilities , heath care need to in prove in all county , affordable health care and mend that are not covered By MA metcare could be cheaper low in come
- Medicaid will not be cut, public hospitals will not be closed. Care for disabled people, if a premium is missed, will have a - month grace for continue without the care being ended so long as the premium is paid within that month. Medicare for all. The VA system should not be restrictive. Veteran insurance should be accepted at all care facilities. Hospitals need access to accessible medical devices. Such as a wheelchair accessible weight taking scale.
- Access to dental care - accessibility of services to those who are in wheelchairs or have mobility challenges don't seem to be addressed - and the focus needs to be on the disabled community - not on training DPS or DHS . . . that should be a GIVEN - they are serving the needs of the people of MN.
- One important issue missing from the health and safety goals is the role that stable staffing and required licensing oversight play in maintaining safe community-based residential placements. Family Residential Services providers are required under Minnesota 245D licensing standards to maintain Designated Coordinator and Designated Manager roles and ensure staffing sufficient to meet assessed needs. Recent implementation of the flat-rate funding structure does not account for these required responsibilities and is already creating instability across smaller residential homes. As a designated coordinator working with multiple providers, I am seeing staffing reductions and restructuring of placements in order to remain financially viable. These changes increase risk to both compliance and individual safety and should be considered within health and safety planning under the Olmstead Plan.
- First, the goals still rely heavily on training, policy updates, and general accessibility language, but do not consistently define what functional access means in real-world, time-sensitive situations. In health and public safety contexts, “access” must be measured by whether individuals can directly understand, communicate, and act in real time-not just whether accommodations exist on paper. Second, there is a missing emphasis on direct language access as a first-line requirement in service delivery. For Deaf, DeafBlind, and other communication-deprived populations, safety outcomes improve when services are delivered directly in the person's primary language whenever possible (for example, American Sign Language), rather

than defaulting to layered interpretation or translation systems that can introduce delay or information loss in critical situations. Interpreters, captioning, and translation remain necessary in many contexts, but they should not be the primary design assumption for access in high-risk environments. Third, there is limited focus on workforce matching and placement of services. A stronger model would prioritize matching individuals to providers and systems that already have native-level communication capability and disability-specific expertise, rather than relying on intermediary communication supports as the default solution. Fourth, disability representation in health and safety systems is still underdeveloped. Embedding Deaf, DeafBlind, blind, and other disabled professionals directly into emergency response, public health, and safety roles would improve system design and real-time decision-making more effectively than training alone. Finally, there is a broader gap in accountability. Many of the goals emphasize training and coordination, but do not clearly define consequences or performance standards when accessibility fails in practice. In summary, the missing focus is functional access, direct communication capability, workforce inclusion, and enforceable accountability-rather than reliance on training and intermediary communication supports as the primary model of access.

- Assistive Technology assessments, supports, services and equipment are key to health and safety for those with disabilities.
- One issue missing from the health and safety goals is the importance of funding stability for small Family Residential Services homes that operate under Minnesota 245D licensing standards. I entered Family Residential Services after leaving a career of more than 30 years to support a stable one-person placement. After implementation of the flat-rate structure, I was required to accept an additional resident in order to keep the home financially viable. This type of change affects staffing expectations and placement stability. Funding structures that do not reflect assessed support needs can create risks to continuity of care in smaller residential homes.
- Where is the county involvement in the goals? How will these goals be accomplished?
- You need better trained people!! Do not skimp!! A few dollars you may save but then might cost you billions!! Like my cases!! If I wanted to and I can says my Congress members and Representatives!! They told me to just skip all this and go strait to Supreme Court and they might help with lawyer to help. They said basically they are able to take care of state and federal along with anything in-between.
- conversations around supporting self-determination, utilizing supported decision making rather than guardianship. Teaching and skill-building for people living with disabilities as well as the professionals with whom they intersect. People who lack self-determination have higher rates of abuse and maltreatment, are less likely to be believed when they report it, and never learn skills to recognize, prevent, and report abuse
- Yes. Several critical issues are not reflected in the current health and safety goals. Most notably, there is no explicit focus on accountability and enforcement when abuse, neglect, or serious harm occurs. Without clear expectations for consequences and system response, it is difficult to

ensure that harm is prevented or addressed effectively. There is also limited attention to oversight and monitoring of care settings, particularly those serving people with disabilities who rely on others for daily support. Strengthening how facilities are reviewed, investigated, and held accountable is essential to improving safety. The goals do not address timeliness and quality of response to critical incidents, including how quickly concerns are identified, investigated, and acted upon. Delays or gaps in response can have serious consequences. In addition, there is no mention of workforce capacity and supervision, which are key drivers of safety. Staffing levels, training quality, and ongoing supervision all directly impact whether people receive safe and appropriate care. There is also a gap in addressing coordination and shared accountability across agencies, particularly where responsibilities for health, safety, and licensing are split. Without stronger alignment, gaps in oversight can persist. Finally, the goals do not reflect lived experience measures of safety, such as whether people with disabilities feel safe, are treated with dignity, and have meaningful avenues to report concerns. Addressing these areas would strengthen the goals and better align them with the conditions necessary to ensure real safety for people with disabilities.

- See below
- Reforming MAEPD and allowing disabled individuals to retire without impoverishing them. Let's start with MAEPD. Currently the premium is based on not only one's earned income, but also income such as Social Security and pensions. The end result is that I'm paying nearly $7000 annually for my Medicaid and Medicare.. Before taxes, I'm paying 7.25% of my Social Security. Billionaires pay a lower rate because nobody else in America is Social Security “pretaxed”! During the pandemic I was paying more for my MAEPD premiums that I was earning. That's simply wrong. I am grateful for MAEPD but I work hard for my money and the amount I paid for my insurance is downright wrong, don't you think? Secondly and more importantly, working disabled Minnesotans can never retire or the assets MAEPD “allows” us to build up are snatched away so that we can be eligible for MA. It doesn't make sense to me, because our assets will be taken away upon our death, so why, why take them away prematurely and push us into poverty again?? In the meantime, seniors ought to be able to live with dignity, don't you think? I'm hoping that I die while I'm still working, but I may not always be able to work. I believe working disabled Minnesotans want to be grand parented at age 65 so that the MAEPD income and assets apply ongoing to determine eligibility for MA-ABD.
- Emergency preparedness needs to include the rights of those with disabilities. If they or guardians do not want a treatment, such as vaccines, it NEEDS to be honored.
- I would like to provide feedback on each of the listed goals, as they all address important but interconnected aspects of health and safety for people with disabilities. Increasing access to disability compensation is essential, but it should also ensure equity and reduce barriers in the application process. Efforts to reduce abuse and neglect are critical and should include stronger accountability systems and culturally responsive support for families. Improving accessibility in Department of Public Safety communications is a necessary step toward inclusion, especially during emergencies, and should include multiple languages and formats. Expanding training for

Minnesota Department of Health staff is also valuable, particularly if it includes real-life, community-informed perspectives. Overall, I believe these goals will lead to meaningful improvement, but additional focus is needed on mental health services, caregiver support, and ensuring that policies are consistently implemented across all communities, including underserved and immigrant populations.

- From former Olmstead Plans: Integrate primary care, behavioral health, and long-term care. Reduce gaps in access and outcomes (between Minnesotans in general and Minnesotans with disabilities)
- Supporting families, addressing staffing through retention measures, like access to health care and retirement benefits. Developing and adhering to robust and continually improving training for best practices in direct care.
- HEALTH is completely missing from every goal. Every Minnesotan should have access to health care. Sadly an increasing number of people DO NOT. Why is access to health care ignored by the Olmstead Plan.?
- Not addressing mental health or healthy relationships. Isolation must be addressed.
- HEALTH: Access to health care! MN is one of the better states for things like Medicaid reimbursement rates and it still kinda sucks. Why are the dental reimbursement rates so low that every dentist who takes MA has a six-month waiting list just for a cleaning? Why are there zero mental health services that specialize in working with people with IDD/SMI dual diagnosis? Why is maintaining eligibility for MA-EPD (which has no income or asset limits) such a headache? SAFETY: SIDEWALK ACCESS IN THE WINTER. I know there's obviously not much the state can do directly about this, but there needs to be some requirement on cities to either do sidewalk plowing or at the very least clear curbcuts themselves instead of letting whoever has the house or the business on the corner do it. I effectively have like 1/3 the mobility in winter that I do in the rest of the year because I can't safely use my rollator when there's so much snow and ice on the sidewalk. (Apologies if this goes in transportation.)
- Authentic Partnership with PWD and their families.
- 1. Unified Inter-Agency Enforcement (The MDH/DHS/DPS Gap): The most glaring omission is a plan to fix the “bureaucratic silo” between the agency that investigates abuse (DHS), the agency that licenses the facility (MDH), and the statewide safety hub (DPS). The state currently plays a shell game where no one agency is responsible for taking a license away from an abuser. A missing goal is the creation of a Unified Enforcement Task Force where a substantiated abuse report at DHS triggers an automatic, 24-hour licensing freeze at MDH and a safety alert at DPS. 2. Workforce Collapse as a Public Health Crisis: The goals ignore the fact that maltreatment and neglect are directly caused by the staffing crisis. You cannot “train” your way out of a labor shortage. The plan is missing a goal to treat the Healthcare Workforce Collapse as a primary public health emergency, with action steps to fund rural wage subsidies and emergency staffing teams to prevent the neglect that happens when one nurse is left to care for 50 people. 3. Economic Autonomy as Abuse Prevention: The plan treats abuse as a “behavioral” or “educational” issue. It misses the reality that disabled people are trapped in abusive homes and

facilities because they are economically and physically imprisoned. There are no goals to provide “Emergency Care Bridges”-funding that allows a person to instantly leave an abusive PCA or partner without being forced into a nursing home or homelessness.

- I don't think this goal area should be limited to the Dept of Public Safety and MDH. Any area that could improve accessibility to health care and health insurance without unnecessary barriers should be included. The focus on fraud is giving in to a smear campaign at the expense of the majority of people who actually need health care programs (eg. Medicaid) and making people with disabilities jump through more hoops than they already do, just to maintain their eligibility every 6 months, is nearsighted.
- We need to see more staffing to ensure that people are getting adequate care. Have an alert system to help people with disabilities. Have some way to inform responders about the disabilities that we have and know how to treat our specific disabilities.
- Needed Expertise in providing care for those with specific disabilities with mental health needs.
- Waiver reimagine changes _ HORRIBLE for disabled people!! Cutting their budget up to 80% for help such as PCA's and cutting out most paid parents will force many disabled people into institutions!! WWJD?? Not this! TRUMP - I thought he was bad until I read about this change in MN that started BEFORE the federal cuts to Medicaid!!
- Self navigation of ones own life. Autonomy. Full coverage of all needs in ones own home. NO matter the cost
- Listen to people they will tell you what needs to be changes and some of the ways to change it so it works better for them
- Waiver re-imagine issues. Serious concerns about how son will be affected by these. Waiver re-imagine needs to be permanently dissolved.
- Health, human services, public health, accessible integrated housing nutritious food, accessible transportation, waivered services, MNCHoices2 and Service agreements all need to work to stabilize families, children and individuals. This plan works in silos and is agency centric whereas to stabilize the lives of people all 7 life sustaining dimensions must work in harmony. Stabilizing people leads to vibrant communities which in turn is necessary for a sustainable economy within a constitutional society. Thes goals are not representative of the healthcare system and the role of MDH in particular. Asset limitations that have been the same dollar amount for 40 years is a problem and leads to structural poverty for people with disabilities and older adults, where is this being addressed in this plan?
- This section has a gap between the document's values and its operational commitments. The section says many of the right things about dignity, trauma, abuse prevention, safety, healing, trust, and vulnerability of disabled people, but the actual goals, metrics and strategies remain narrow and reactive. The section for health and safety seems to focus heavily on reporting and training rather than also focusing on prevention infrastructure. There's little emphasis on upstream prevention, structural safeguards, independent monitoring, accessible crisis support, caregiver accountability, and reducing dependency-related vulnerabilities. The document acknowledges enormous disparities (19% of disabled adults report sexual violence vs. 8.8% of

non-disabled adults. and 44.8% of disabled students report abuse or neglect vs. 17.4% of nondisabled peers.) Those are massive disparities, yet the plan has set goals to reduce sexual violence from 19% to 17% by 2031 and reduce abuse/neglect among disabled students from 44.8% to 42% by 2032. That seems very disconnected. The plan is basically stating it accepts that nearly 1 in 5 disabled adults may continue experiencing sexual violence and nearly half of disabled youth may continue experiencing abuse/neglect. It feels like the targets in this plan normalize unacceptable harm levels rather than developing a plan to aggressively reduce them. An area that seems to be missing is safety for people with communication disabilities, which is not heavily discussed and addressed. A major missing area is people who are nonspeaking, use AAC devices, have intellectual disabilities, have limited expressive communication, or those that rely on interpreters/support staff. These are the populations which face heightened abuse and vulnerability. But the plan as is, does not strongly discuss accessible reporting systems, communication access during investigations, informed consent protections, investigative accommodations, supported decision-making, or independent advocacy access. Another area of concern: many of us who are disability advocates are cautious about safety language because historically “safety” was often used to justify segregation, overprotection, guardianship, institutionalization, and denial of autonomy. The current document does try to balance this with inclusion language, but the plan can do more to explicitly state: “Safety cannot come at the expense of autonomy, choice, and civil rights.” This draft also minimizes the scale of institutional trauma. The document briefly references institutionalization history but does not fully address trauma caused by segregated systems, long-term institutional harm, distrust of medical systems, PTSD among disabled populations, medical ableism, and forced treatment experiences. Without acknowledging this more explicitly the plan sounds procedural rather than restorative. There is also little focus on abuse in community-based settings. This section seems to heavily focuses on licensed facilities, institutional settings and schools. However, many disabled people also experience abuse in waiver services, day programs, group homes, foster care, transportation settings, supported employment, and personal care relationships. I'd argue the plan currently focuses on environments the State directly regulates while under-addressing abuse in less visible community settings. Olmstead integration without adequate safeguards can still leave people vulnerable out in the community.

- The most significant missing issue is the statewide collapse of access to direct support services, nursing, continuity of care, and reliable staffing. None of the health and safety goals in this plan are realistically achievable if disabled Minnesotans cannot consistently access the services they are already authorized to receive. Minnesota continues to measure “access” based on approvals and authorizations existing on paper, while families and disabled individuals are left functioning as the unpaid emergency backup system when staffing, nursing, transportation, behavioral supports, or crisis supports fail in practice. This creates preventable hospitalization, institutionalization, caregiver burnout, educational instability, family breakdown, neglect, and unsafe living situations. The plan also fails to adequately address: - continuity of care, - workforce shortages, - inaccessible nursing, - medically complex home care access, - emergency backup systems, - unpaid caregiver labor, - and the disproportionate burden placed on families who are effectively subsidizing system failures. Health and safety cannot exist without actual operational access to services.

- No
- Health Goal 1: A good goal. Although does not address how veterans need to travel to the metro area or long distances to get care.
- Health Goal 2: We should make disabled people feel supported. Create networks among disabled people to help report abuse.
- Health Data Goal 1: A good goal. This is important in that we need to know where to go or who to call in order to be safer. Work together as disabled people to ensure that nobody is getting abused.
- Health Data Goal 2: This is a great goal. Some doctors refuse to help or pass us up because of the disability of some patients.
- We need to see more staffing to ensure that people are getting adequate care. Have an alert system to help people with disabilities. Have some way to inform responders about the disabilities that we have and know how to treat our specific disabilities.

End of document