



**DENDROS
GROUP**

2642 University Ave W
Saint Paul, MN 55114

Olmstead Plan Public Comment Meeting Report - Health/Safety

April 21, 2026 - 3pm-5pm

Meeting Summary

The April 21, 2026, health and safety public comment meeting was hosted by Dendros Group virtually via Zoom. The goal of the conversation was to gather public comment on the draft Olmstead Plan health and safety goals. There were three participants.

Meeting Agenda

Facilitation Team:

- Adam Harrington (Dendros Inclusion Consultant)

Schedule:

- 3:00pm -3:20pm: Welcome
- 3:20pm - 4:00pm: Presentation on Draft Olmstead Plan and Health and Safety Draft Goals
- 4:00pm - 4:50pm: Public Comment in Facilitated Breakout Rooms
- 5:50pm -5:00pm: Closing, Evaluation and Further Engagement Opportunities

Registration & Attendance

Fifteen people registered for the meeting. Five people attended the presentation and three people participated in public comment.

The participants identified as follows:

Perspectives

- Two are persons with disabilities
- Two are parents/caregivers of someone with a disability
- Two work in a disability-related field
- One is a service provider

MN County or Tribal Nation of Residence

- One in Ramsey County
- One in Stearns County
- One in Stevens County

Age Group

- Two 35-44
- One 45-54

Gender

- Three Women

Race and/or Ethnicity

- One Asian
- One Hispanic or Latino/a/x/e
- One White

Military/Armed Forces Status

- Three are not members of the military/armed forces

Experience in the Following Settings

- One in classrooms only (or primarily) for people with disabilities
- One in employment only (or primarily) for people with disabilities (for example: sub-minimum wage, sheltered workshops, 14c)
- One in housing only (or primarily) for people with disabilities (for example: group home, long-term care facility)
- One in day programs only for people with disabilities

Participant questions from registration:

The registrants were asked, “Do you have any questions about the Olmstead Plan or the process that you'd like covered in the presentation?” The following questions were asked:

- How can we create inclusive weight management, and fitness
- no. I am a person with a disability and want to listen
- Health and environmental safety in Affordable Housing Inspections, follow through, accountability for health conditions related to mold and a state department that WILL investigate and require it fixed.

Goals Overview

The following are the draft goals presented to the participants of this public comment meeting.

Health Goal 1: More Veterans with disabilities will receive disability compensation.

- Measurable goal: By June 30, 2031, 111,456 Veterans with disabilities will receive disability compensation.
- Our starting point (baseline): In 2023, 102,200 Veterans received disability compensation. That represents 35.8% of Minnesota’s Veteran population.

Health Goal 2: Fewer people with disabilities will experience abuse and neglect.

- Goal 2A is about confirmed cases of abuse and neglect in MDH-licensed facilities, including nursing homes, assisted living, hospitals, and Intermediate Care Facilities for Individuals with Developmental Disabilities.
- Goal 2B is about disabled adults who experience sexual violence.
- Goal 2C is about children with disabilities who experience abuse and neglect.

Health Data Goal 1: Department of Public Safety communications, programs, and services will be accessible for people with disabilities.

- DPS wants to make sure its communications about safety and service delivery are accessible. DPS also wants to make sure its programs and services are inclusive and accessible.

Health Data Goal 2: More Minnesota Department of Health response staff will receive training about the access and functional needs of people with disabilities in public health emergencies.

The goal will have two parts.

- Goal 2A: This goal is about MDH Emergency Preparedness and Response (EPR) staff receiving training about access and functional needs of people with disabilities and the unique needs of this population during emergencies that impact the public's health.
- Goal 2B: This goal is about the MDH Response Sections receiving training about access and functional needs of people with disabilities and the unique needs of this population during emergencies that impact the public's health.

Summary

Overview

The following discussion questions were presented to the participants of this public comment meeting.

1. What would make these goals more effective to improve the lives of Minnesotans with disabilities?
2. What would make these goals more effective to better integrate Minnesotans with disabilities in community life?
3. What's missing from these goals?

Participants raised serious concerns about understaffing, underfunding, and regulatory gaps across disability services. They criticized the lack of concrete execution plans, the absence of cultural representation in goal development, and the failure to address financial exploitation. Information was described as not digestible for many communities. Participants called for urban-rural tailored approaches, clearer document readability, and foundational awareness campaigns to reshape cultural narratives about disability. No comments were provided on emergency preparedness training.

Findings by Goal

Health Goal 1: More Veterans with disabilities will receive disability compensation.

Low rates of service connection is a barrier to Veterans Affairs (VA)-funded long-term care.

The draft goal measures the number of veterans receiving disability compensation. However, the discussion revealed that receiving compensation does not guarantee access to critical services like long-term care. A participant with 20 years of long-term care experience stated, "In my 20-year career in long-term care, I've only met one veteran who was eligible for their long-term care room and board to be paid by the VA." The same participant noted that a veteran generally must be rated 100% disabled to qualify for a VA home placement, adding, "If they have a disability when they're 30 years old, it certainly is not going away when they're 80."

Expanding eligibility could make compensation more meaningful by connecting it to actual services, potentially increasing the value of receiving compensation and encouraging more veterans to apply.

Participants linked accessibility to broader cultural and intersectional barriers.

A participant noted that a disabled Hmong-American woman veteran in their program "often talks about her frustration with the discrepancy of being a disabled Hmong woman veteran... being a minority, being a woman, being Hmong, being a veteran, and being disabled." The participant reported that the disabled Hmong-American woman veteran finds it "quite hard... to find even peer support around those key items she needs to really identify with her experiences."

Another participant observed "a huge lack of awareness of what the services are, and also some pride within some of the veterans," providing a personal example: "My own father never applied for the VA insurance because... there were others who needed it [more]."

Systemic failures exist in care coordination between VA and community providers.

Participant discussion revealed that veterans who receive compensation face barriers to coordinated care. A participant described how VA primary care and community specialist systems "do not talk," and that federal regulations make it "really hard to get VA documents." Improving interoperability does not directly increase compensation enrollment, but it addresses the issue that compensation is less valuable if the veteran cannot effectively use their benefits across systems, which implies that without system integration, receiving compensation may not translate into receiving adequate care.

A participant described fragmented care: “If you have to see a specialist, like here in St. Cloud, a lot of times you'll come to our local hospital for specialty, but they'll go to primary care at their local VA, and those systems do not talk.”

The participant also noted the complexity of a tiered eligibility system: “You are so much percent disabled, and this qualifies you for X, Y, and Z. If you're this much disabled, you get X, Y, Z, and A. It's hard to navigate.”

Health Goal 2: Fewer people with disabilities will experience abuse and neglect.

Increase staffing levels and funding in long-term care, assisted living, and group homes.

A nurse who left long-term care after COVID stated: “I question how we achieve this goal when our nursing homes, assisted living, group homes are understaffed and underpaid.” They described working 70 hours per week, on-call 24 hours a day, managing a 45-bed unit with 50 direct reports while also overseeing recreation and nutrition services, adding that this workload “is not unusual in our smaller rural areas.”

Another participant echoed, “The staff is overworked, understaffed, the capacity isn't there as well. Everything comes back to funding. How do we appropriate funding to hire more capacity, more staffing, more teams?”

Staff-to-patient ratios were cited as a specific concern. One participant reported that “most of our staff would take care of 12 patients at a time, and it's not a hospital setting. You have your nurse and your nursing assistant, and that's it.”

Replace volume-based reporting metrics with pattern-recognition approaches.

The discussion revealed a tension between mandatory reporting requirements and effective identification of actual abuse. Current systems require investigation of every reported bruise, including those from routine activities like walking while on blood thinners. A participant argued that focusing on reducing report volume (as a SMART [Specific, Measurable, Achievable, Relevant, and Time-bound] goal metric) could discourage reporting, while the real need is to shift from investigating individual incidents to identifying systemic patterns.

A participant described the reporting burden: “You have to report every single bruise you don't know where it comes from. So quite literally, for some patients who are on a blood thinner, and they bump themselves because they walk, every single bruise requires a thorough investigation.” They asked, “How do we mitigate that and spend less time investigating a 2mm by 2mm bruise, and really look at patterns?”

The same participant expressed, “A SMART goal around the amount of reporting does not feel good to me because if people know that I want you to report 2% less across the board, will that

encourage people not to report?" They recommended increased training rather than encouraging decreasing reports.

Extend regulation and staff training requirements to assisted living and group homes.

One participant distinguished between settings: "Long-term care is probably one of the most highly regulated organizations across the United States, but when it comes to assisted living and group homes, it is a lot less regulated." They added, "I don't think group home staff need any education to work there, and that worries me greatly."

The participant noted insufficient training on working with people with different abilities: "If this person has a mental health disorder, do our staff know how to work with it? How to keep themselves safe, and how to keep that patient safe?"

Add concrete, measurable targets to sexual violence prevention action steps.

A participant with expertise in violence prevention stated, "I was hopeful that there was going to be more in the plan specifically about [sexual] violence against individuals or exploitation of individuals with disabilities."

Include financial exploitation and cyber exploitation in the plan.

A participant stated: "Nowhere in here does it really talk about financial exploitation of individuals with disabilities, and that is a huge thing happening right now, more than ever, especially through cyber extortion, as well as labor trafficking."

Another participant shared a personal experience of financial exploitation by a family member who sought to become support staff for their daughter, who is nonverbal and has significant disabilities. The participant discovered the family member "saw my daughter as a financial support for them only" and added, "I did not give life to my daughter to be a piggy bank." They added, "Even your family will take advantage of the situation if there's no one advocating strongly for the person with a disability."

Ensure cultural representation in the development of abuse prevention goals.

A participant argued that without cultural framing and community input, the goals will fail because prevention strategies that work for one population may be ineffective or culturally inappropriate for another. If the goals themselves are not shaped by the communities they intend to serve, achieving measurable reductions in abuse across Minnesota's diverse population is unlikely.

A participant stated, "It needs to be a cultural framing, it needs to be coming from the culture or from the community. So I worry about the investment that we might not have here in terms of certain communities because they didn't have representation in the creation of this."

Another participant added, "The creation of these goals without that representation is going to make this plan unsuccessful."

One participant gave an example from the St. Cloud area's Somali population: "Talking about autism has been really difficult in this community because they didn't see this back in Somalia... their belief is: if you have something wrong with you, something evil is inside you. How do we not acknowledge this cultural belief?"

A participant also noted the broader implication: "If we're going to put this blanket plan out there without acknowledging the stark differences in cultural beliefs and how cultures handle certain topics, we're missing the boat."

Provide culturally and linguistically appropriate sexuality education for students with disabilities.

The participants stated that current sexuality education in schools does not reach students with disabilities, is not culturally or linguistically tailored, and fails to address the needs of LGBTQ+ and neurodivergent students. Without accessible, culturally appropriate education, students with disabilities lack the knowledge to recognize, prevent, or report sexual violence, directly undermining the goal's target.

A participant asked, "How do we stay safe and share that in a culturally linguistic way that acknowledges each culture, because some things we don't talk about? How do we do that and put it in a way that people can understand? Because it is complex depending on culture, ability to retain and gain information, and then language barrier becomes a huge thing between what we've noticed with the parents, grandparents, and the kids at school... I don't know of any schools that actually have that conversation now. "

Another participant described developing "an LGBTQ+ and autistic intimate partner violence presentation for high school age" and questioned how to get schools to "buy in on how important this work is." They added, "If we're working for our most vulnerable people in our community, it will work for everyone else."

Health Data Goal 1: Department of Public Safety (DPS) communications, programs, and services will be accessible for people with disabilities.

Participants identified that information is not digestible for many communities.

The participants' discussion encouraged DPS to expand the definition of accessibility beyond compliance to include linguistic simplicity, cultural relevance, and digestible formatting. Without addressing these barriers, DPS communications will remain inaccessible to many

people with disabilities, particularly those from BIPOC and non-English-speaking communities.

Health Data Goal 2: More Minnesota Department of Health response staff will receive training about the access and functional needs of people with disabilities in public health emergencies.

No public comments addressing this goal were given.

Additional Themes

Develop actionable execution plans that account for urban-rural differences.

Throughout the discussion, participants noted that the plan lacks concrete, actionable execution plans. A specific concern raised was that even if execution plans existed, they would not work uniformly across urban and rural settings. The discussion highlighted that staffing, transportation, and infrastructure challenges in rural Minnesota require fundamentally different approaches than those that might succeed in the Twin Cities. Without rural-specific strategies, the plan's goals are unlikely to be achieved in large geographic areas of the state.

A participant stated, “What are the actionable plans, the application or execution folks can move forward with to meet these target goal numbers?” They noted that “even if there is an applicable execution plan, it doesn't work for every demographic. Folks in urban vs. rural would need different ways to execute.”

The same participant gave a rural staffing example: “I can't send five more staff three hours up north. That's quite the complication unless they are extremely passionate.” They noted a staff member who commutes from Snake River to Bridgeview daily – a four-hour round trip – and asked, “How does that look, and how do we equip folks from smaller population towns?”

The participant suggested a career pathway approach: “How do we get younger folks to buy in and want to train themselves to be caregivers at facilities, or even a career pathway in high school for youth to encourage them to learn about the track, so we can create more of the population of professionals caring for disabled folks in rural or small towns?”

Restructure the goal documents for clearer readability and navigation.

A participant reported that after reviewing the draft goals with other professionals and individuals with disabilities, “one of the biggest concerns people had was that it was actually difficult to read.” They noted that “the way it's outlined (topics and then subtopics) is kind of

unclear where each new heading or section begins.” They acknowledged understanding the structure but concluded, “it does make it somewhat difficult for an individual or even a professional to quickly read through it and understand what's going on.”

Reshape cultural narratives about disability through awareness campaigns.

Across multiple goals, participants identified cultural beliefs as a primary barrier to achieving the plan's objectives. For Health Goal 2 (abuse and neglect), cultural beliefs about disability can prevent families from seeking services or recognizing abuse. For Health Data Goal 1 (accessible communications), information cannot be effectively delivered if communities believe disability is a curse or punishment. The discussion revealed that before any training, service delivery, or goal measurement can succeed, some communities need foundational awareness campaigns that reframe disability.

A participant working with the Hmong community described their organization's awareness campaign focused on myth versus facts, including the message: “Your child or your family isn't cursed, there's no karma, this is a natural, beautiful part of humanity.” They also stated, “I can go in and vouch for the Hmong community, but if that narrative is still there — that perspective and lens — I can only do so much.”

The participant also indicated that this challenge is not isolated to one community: “That's what I'm seeing in the Hmong culture, being in the Twin Cities myself and doing this work for close to 20 years in different capacities. Many BIPOC communities have the same lens and perspectives. So how do we navigate moving forward? We can't just hand over information or support or say, 'You need to meet these quotas, numbers, data,' when this is where my community is at.”

A participant working with Moro and Southeast Asian communities stated, “What we're hearing from the community through assessments is... they don't know how to access [resources], and they're not trained or equipped, or it's not in plain English that they truly understand, it's not digestible.”

Participant Exit Survey

Participants were invited to complete an exit survey. One out of the three participants responded to the survey.

Evaluation Metric 1: This meeting was a valuable use of my time.

- One participant strongly agrees

Evaluation Metric 2: I was able to participate fully in this meeting.

- One participant strongly agrees

Evaluation Metric 3: What would have improved your experience today?

- Nothing, had plenty of time to discuss