

Spring 2026 Public Comment Summary: Health and Safety Goals

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Introduction

This report shares findings from the spring 2026 public comment period on the draft Olmstead Plan. The public comment period sought feedback about proposed Olmstead Plan goals.

Draft Olmstead Plan background

The first Minnesota Olmstead Plan was adopted in 2015. In 2023, the Olmstead Subcabinet decided it was time for a more comprehensive update. For the plan update, OIO worked with a contractor called the Dendros Group. The Dendros Group brought on people with lived experience of disability as Inclusion Consultants. Inclusion Consultants worked with state agency staff to write goals and strategies for the draft plan.

The draft plan included both measurable goals and data collection goals. Measurable goals are specific, measurable, achievable, relevant, and time-bound (SMART). Measurable goals are the foundation of an effective Olmstead Plan. Data collection goals represent issues that agencies want to write goals about, but don't have the data to create a measurable goal yet. The draft plan grouped goals into seven topics:

- Crisis services
- Education

- Employment
- Health and safety
- Housing
- Transportation
- Transition

For more information about Olmstead, the 2026 plan drafting process, and to read the draft plan, please visit the OIO website: [MN.gov/olmstead](https://mn.gov/olmstead)

Public comment period background

The Olmstead Implementation Office (OIO) held the public comment period in partnership with the Dendros Group, Inclusion Consultants, and state staff. The public comment period took place in April and May 2026. It included:

- An online survey
- Virtual meetings and individual interviews
- Email comments and submissions from organizations

Online survey

The online survey was available in English, Spanish, Hmong, Somali, and American Sign Language (ASL).

Survey participants could choose which goal topics to share feedback about. They could also choose to give general feedback about topic areas overall, specific feedback about individual goals, or both. The survey was anonymous, and all questions were optional.

Survey questions

The survey asked the following questions about each topic area:

- Do you think reaching these goals will improve the lives of Minnesotans with disabilities? (multiple choice question)
- Are there any topics or issues you feel are missing from these goals? (comment box question)
- Do you have any general feedback about these goals? (comment box question)

The survey asked the following questions about each individual measurable goal:

- Do you think this is an important question for the lead state agency to address? (multiple choice question)
- This measurable goal is... (multiple choice question)
- Do you have any ideas of other strategies and action steps to reach this goal? (comment box question)

- Do you think reaching this goal will improve the lives of Minnesotans with disabilities? (multiple choice question)

For data collection goals, the survey asked, “Do you have any feedback about this goal?” with a comment box.

The survey also included optional demographic questions.

Virtual meetings and individual interviews

Dendros Group planned and implemented virtual meetings as part of the public comment period. Inclusion Consultants facilitated the meetings. Dendros held seven meetings, one for each topic in the plan. The meetings were intended to be an accessible alternative to the online survey. Registration was open to the public, and the meetings took place on Zoom.

Facilitators asked the following questions during virtual meetings:

- What would make these goals more effective to improve the lives of Minnesotans with disabilities?
- What would make these goals more effective to better integrate Minnesotans with disabilities in community life?
- What’s missing from these goals?

Dendros Group also offered individual interviews. The interviews were intended to be an accessible alternative to the survey and virtual meetings. Inclusion Consultants conducted the interviews.

Email comments and submissions from organizations

OIO also received public comments through email. These comments came from individuals and organizations.

Goals included in this report

- Health and Safety Goal 1: More Veterans with disabilities will receive disability compensation.
- Health Goal 2: Fewer people with disabilities will experience abuse and neglect.
- Health and Safety Data Goal 1: Department of Public Safety communications, programs, and services will be accessible for people with disabilities.
- Health and Safety 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.

Total number of community input submissions and comments

This table shows the number of submissions and comments about transportation.

Source	Number of submissions	Number of comments
Survey	46	136
Virtual meeting	15	Not available
Emails and letters	3	25

Notes:

- Submissions from organizations are counted as one respondent.
- The number of comments from virtual meetings is not available.
- Interviews are included in the survey totals.
- The number of survey submissions counts people who answered open-ended questions. Some participants may have only answered multiple-choice questions. For that reason, the number of survey submissions may not match the number of responses to multiple-choice questions.

General feedback

This section summarizes feedback about the topic overall. Feedback about specific goals is included later in this document.

Survey question: Do you think reaching these goals will improve the lives of Minnesotans with disabilities?

Response	Count	Percentage
Yes, good improvement	12	25%
Yes, some improvement	20	41.7%
No improvement	8	16.7%
Unsure	8	16.7%
Total	48	100%

Themes from all input

The plan is missing goals about important health topics.

Participants noted that the plan is missing goals about:

- Access to health care and services
- Health insurance
- Dental care

Quotes:

- “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?”
- “Why are there NO goals to improve access to healthcare, quality health care, culturally responsible health care?”
- “Department of Human Services and Minnesota Department of Health are simply playing hot potato, and health care issues are not being addressed.”
- “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 an [intellectual or developmental disability/serious mental illness] dual diagnosis? Why is maintaining eligibility for MA-EPD (which has no income or asset limits) such a headache?”
- “If you have an abscessed tooth, it can take a year to get an appointment.”
- “Require training of all health care and service providers to be trained on common disabilities and strategies to support them.”
- “The Ombudsman for Mental Health and Developmental Disabilities (OMHDD) is disappointed by the exclusion of health care access goals in previous versions of the draft ... Similarly, the omission of any references to disparities for people with disabilities is concerning. OMHDD and others have been working with MDH on disparities for people with disabilities prior to, during, and since the pandemic and we have not seen tangible outcomes from that work. It is a painfully lost opportunity not to include that work in the state’s Olmstead plan.”

The plan needs to address intersectionality and disparities within the disability community.

Participants said the Olmstead Plan must tackle disparities based on identity. These identities could include race, ethnicity, gender, sexuality, socioeconomic status, language, and more.

Quotes:

- In a virtual meeting, “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 ... [she] finds it quite hard... to find even peer support around those key items she needs to really identify with her experiences.”
- In a virtual meeting, a participant said of the abuse and neglect goals: “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.”
- In a virtual meeting, a participant said, “One important element missing from these goals is greater attention to the financial and cultural barriers immigrant families face ... Many families delay [health] care due to fear of cost, confusion, language barriers, or immigration-related concerns. More system navigation support, financial guidance, and culturally responsive case management would make these goals more effective.”
- In a virtual meeting, a participant said, “In health and safety, access to services does not always mean effective or coordinated care. Families face ongoing challenges navigating multiple systems. More coordination and culturally responsive services are needed.”

Feedback about individual goals

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

Lead agency: Minnesota Department of Veterans Affairs (MDVA)

Survey questions about Health and Safety Goal 1

The following tables show results of multiple-choice survey questions.

Do you think this is an important issue for MDVA to address?

Response	Count	Percentage
Very important	14	66.7%
Important	3	14.3%
Not very important	1	4.8%
Not at all	1	4.8%

Response	Count	Percentage
Unsure	2	9.5%
Total	21	100%

This measurable goal is...

Response	Count	Percentage
Too high	1	5%
Just right	4	20%
Too low	9	45%
Not sure	6	30%
Total	20	100%

Do you think reaching Health and Safety Goal 1 will improve the lives of Minnesotans with disabilities?

Response	Count	Percentage
Yes, good improvement	7	38.9%
Yes, some improvement	5	27.8%
No improvement	3	16.7%
Not sure	3	16.7%
Total	18	100%

Themes from all input about Health and Safety Goal 1

This goal is too narrow.

Respondents said the goal is important but should be more ambitious. Suggestions included:

- Interviewing Veterans to understand barriers to accessing benefits
- Aligning Veterans services and disability services to streamline applications and eligibility
- Increasing capacity for Veterans services

Quotes:

- “To actually increase disability compensation, MDVA must abandon passive ‘awareness’ strategies and invest in aggressive legal and administrative advocacy.”

- “Why have these Veterans not been receiving compensation already? Services are available but more providers need to be recruited to help as well.”
- “Compensation alone may help with survival, but it does not support full integration into society. The Plan needs new wraparound programs designed and led by veterans to support housing, health care, and employment.”

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

Lead agency: Minnesota Department of Health (MDH)

This goal has three parts:

- Goal 2A is about the number of reports of abuse and neglect in MDH-licensed facilities.
- Goal 2B is about disabled adults who experience sexual violence.
- Goal 2C is about children with disabilities who experience abuse and neglect.

Survey questions about Health and Safety Goal 2

The following tables show results of multiple-choice survey questions.

Do you think this is an important issue for MDH to address?

Response	Count	Percentage
Very important	22	95.6%
Important	1	4.3%
Not very important	0	0%
Not at all	0	0%
Unsure	0	0%
Total	23	100%

Do you think reaching Health and Safety Goal 2 will improve the lives of Minnesotans with disabilities?

Response	Count	Percentage
Yes, good improvement	5	26.3%
Yes, some improvement	9	47.4%

Response	Count	Percentage
No improvement	3	15.8%
Not sure	2	10.5%
Total	19	100%

Health and Safety Goal 2A: This measurable goal is...

Response	Count	Percentage
Too high	1	4.8%
Just right	2	9.5%
Too low	14	66.7%
Not sure	4	19%
Total	21	100%

Health and Safety Goal 2B: This measurable goal is...

Response	Count	Percentage
Too high	0	0%
Just right	2	9.5%
Too low	11	52.4%
Not sure	8	38%
Total	21	100%

Health and Safety Goal 2C: This measurable goal is...

Response	Count	Percentage
Too high	1	4.8%
Just right	1	4.8%
Too low	14	66.7%
Not sure	5	23.8%
Total	21	100%

Themes from all input about Health and Safety Goal 2

The data source for Health and Safety Goal 2A may not be appropriate or accurate.

Some participants raised concerns about the data source for Goal 2A. They said that the number of substantiated reports might not adequately represent cases of abuse and neglect.

Quotes:

- “The Office of the Ombudsman for Long-Term Care (OOLTC) does not agree that substantiated reports is a good measurement indicator for reduction. In far too many cases, the mere designation of ‘unsubstantiated’ does not mean that a maltreatment incident did not occur. It may simply mean that the legal burden of proof was not met to determine the event was substantiated. OOLTC strongly feels that this goal should be measured by a decrease in the number of reports received overall, not substantiated.”
- “The numbers provided do not neatly align with substantiated maltreatment reports received and reviewed by the Ombudsman for Mental Health and Developmental Disabilities (OMHDD) as well as an investigation report issued by Elder Voice Advocates. It is also critical to acknowledge that the number of confirmed cases of abuse and neglect in MDH-licensed facilities does not, in any meaningful way, necessarily correlate to fewer people with disabilities experiencing abuse and neglect in these settings as only a fraction of reports are opened for investigation.”
- “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.”

Goals about abuse and neglect need to focus on prevention.

Some community members shared they feel the abuse and neglect goals are too reactive. They suggested adding strategies to prevent abuse and neglect.

Quotes:

- This goal “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.”
- “Every single strategy they listed ... is a post-incident response. ... 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 [MDH] actual preventative measures within their licensing wheelhouse ... Stop reacting to trauma; proactively regulate the conditions – like understaffing – that cause it.”

The goals rely too much on training, rather than accountability and enforcement.

Some participants said the current abuse and neglect system needs more accountability and enforcement. They shared there are not enough consequences for people who commit abuse and neglect.

- “[MDH’s] response to Department of Human Services-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.”
- “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.”
- “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.”
- “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 direct support professional (DSP) workforce shortage must be addressed as a root cause of abuse and neglect.

Participants shared they feel the DSP shortage is a contributor to abuse and neglect. They raised concerns that abuse and neglect goals won’t be effective if the shortage persists.

Quotes:

- “After working for years with group homes, the issue seems to be that they hire ‘bodies.’ ... A rotating door for staff leaves the vulnerable clients more at risk for abuse.”

- “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.”
- “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.”
- “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.”

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

Lead agency: Department of Public Safety (DPS)

DPS should partner with people with disabilities as part of this goal.

Quotes:

- “Incorporate community-based accessibility planning, recognizing that safety outcomes improve when individuals are part of connected, accessible networks rather than isolated environments.”
- “Partner with persons with disabilities to design, implement, and evaluate programs and policies.”
- “Listen to what people want and need and barriers they are identifying through qualitative interviews and make changes in the systems.”

Health and Safety Data Collection 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.

Lead agency: MDH

This goal should expand beyond training.

Participants shared they feel this goal is overly reliant on training. They suggested a more outcome- and person-centered approach.

Quotes:

- “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.”
- “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.”
- “No measurable outcome on people – good strategy but not really an outcome goal.”
- “Training is a component ... but also policies, practices and culture have to reinforce the training – relying on training is going to likely come up short of our goal of improving the lives of those with disabilities and providing opportunities to participate in community.”
- In a virtual meeting, a participant said, “Training alone is insufficient without accountability and real-world application. Current language does not specify how effectiveness will be measured or sustained. Training must include direct input from people with disabilities and caregivers, especially those navigating complex behavioral and mental health conditions.” They proposed a revised goal: "All public health emergency training must include lived-experience input, measurable competency outcomes, and annual recertification requirements, with public reporting on training effectiveness and impact on disability outcomes.”

Strategy suggestions for Health and Safety goals

This is a list of specific strategy ideas submitted through the online written survey. Some of these comments are also quoted above. These suggestions have not been vetted by the Olmstead Implementation Office and are shared as written.

Health and Safety goals overall

- “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.”
- “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.”

- “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.”
- “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."

Goal 1

- "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."
- "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 CVS0 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)."

Goal 2 (all parts)

- "A person with a disability, disability advocate, and a professional specializing in violence prevention and human trafficking issues spoke about the need to prevent abuse and neglect. This person highlighted the disproportionate rates of violence experienced by people with disabilities, especially those with intellectual and cognitive disabilities. She recommended that this goal be strengthened through expanded data collection and research about power-based violence, including human trafficking, labor exploitation, and forced criminality. She emphasized the 'victim-offender' overlap, noting that individuals who enter the criminal justice system are themselves victims of exploitation. She advocated for improved access to services within correctional facilities, stronger reentry housing supports, and better prevention strategies. There must be systemic change to prevent victimization."

Goal 2A

- "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.”

- “Develop strategies for better oversight 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.”
- “1. 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."

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."

- "...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, etc. 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 Wisconsin 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."
- "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."

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.”

- “This will not be achieved, the appropriate services, approach in [child welfare/child protection] 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.”
- “1. 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 Department of Human Services/Department of Children, Youth, and Families 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."

- "We must do more to prevent abuse and neglect, not just respond to it after the damage has been done. In reviewing MDH Office of Health Facility maltreatment reports, required to be shared with Ombudsman for Mental Health and Developmental Disabilities upon completion, we see so many instances where the abuse or neglect was preventable. We appreciate the department taking the action to substantiate when circumstances warrant, but there are often many factors known to be indicators of potential abuse and neglect that, had they been addressed previously, could have been mitigated. Examples include a clear mismatch between the setting and the intensity of a person's support plan needs, particularly if there is a need for supervision in the community, known substance use and overdose risk not being adequately identified in the service plan, a lack of adherence to the service and staffing requirements

outlined in the plan, an overall lack of person-centeredness in the service planning and delivery, a lack of awareness on developmental disability or mental health conditions and de-escalation strategies, lack of notifying a waiver or other case manager when circumstances warrant, and more. We understand the workforce shortage challenges underlying some of these circumstances, but that is not the sole factor, nor does it absolve us as a system to do more to proactively prevent abuse and neglect in these settings.”

Data Goal 1

- “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.”
- “1. 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."

- "One family member spoke in favor of a new Purple Alert system for missing and endangered individuals who wander or elope, including individuals with autism or some other disability. Her daughter left home unnoticed, and she described the intense danger families face despite the extensive safety precautions. Children with autism have a higher risk of drowning. Amber Alerts do not cover elopement cases. We need faster responses to save lives."

Data Goal 2

- "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.”

- “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.”