MINNESOTA DIRECT CARE AND TREATMENT ADVISORY COMMITTEE MEETING MINUTES

Revision Note (November 6, 2026): These minutes were revised to clarify instances in which comments were made by DCT staff or AMRTC staff. The revisions do not change the substance of the discussion.

Meeting Information

- **Date and Time:** Wednesday, October 7, 2026, from 9:30-11:30 am CT
- **Location:** In-person location at Anoka-Metro Regional Treatment Center (AMRTC), 3301 N 7TH Ave., Anoka, Minnesota, and a virtual meeting available via Zoom for other attendees
- **Direct Care and Treatment (DCT) Advisory Committee Attendees:**
    - In-person attendees: Chair Dave Baker; Vice Chair Bianca Virnig; Commissioner Tara Jebens-Singh; Marcus Schmit
    - Virtual attendees: Sen. John Hoffman and Jim Postier
    - Excused attendees: Sen. Paul Utke and Jessica Langhorst
    - Absent attendees: James Carlson
- **DCT Advisory Committee Facilitators:** Jill Kemper and Danielle Swanson, Health Management Associates (HMA)
- **In-person Speakers and DCT Attendees:** Dan Storkamp, Executive Director, External Relations, DCT; Mitch Arvidson, Legislative Affairs Coordinator, DCT; Derrick Jones, Chief Operating Officer, Mental Health and Substance Abuse Treatment Services (MHSATS); Marshall E. Smith, Health System Chief Executive Officer, DCT; Leah Voigt Potter, Administrator, AMRTC; Dr. Frances Broghammer, Medical Director, AMRTC

Meeting Summary

- **Welcome**
    - Chair Dave Baker welcomed members to the October MN DCT Advisory Committee meeting at the Anoka facility before turning the time over to Marshall Smith to begin the presentation on MHSATS at AMRTC.
- **Presentation: Quality and Compliance**
    - DCT and MHSATS leaders provided an overview of DCT's role in Minnesota's behavioral health system, the MHSATS service lines, and AMRTC's programs, patient population, care model, staffing, funding, and planned expansion. (*Note: information found on slides is not repeated in the minutes below - see slides 3-25 below for those details*.) A summary of the discussion is provided below.

- DCT staff opened the discussion by emphasizing DCT's role within Minnesota's behavioral health continuum and described the organization's ongoing efforts to support individuals with some of the state's most complex behavioral health needs. Staff noted that, while DCT often serves individuals requiring the highest levels of care, successful treatment outcomes depend heavily on the strength of community-based services available before admission and after discharge. They reiterated that DCT views itself as one component of a larger continuum and stressed the importance of building capacity throughout the community service system.
- Committee members then inquired about DCT's funding structure, including the extent to which revenue generated through reimbursements and county payments is retained by the organization. DCT staff explained that revenue generated through services is returned to the state's General Fund rather than being directly reinvested into DCT operations. Committee members asked whether there had been discussion regarding reinvesting a portion of those revenues into expanding capacity and community supports. DCT staff noted that these conversations have occurred and acknowledged the importance of supporting counties and community providers that often serve individuals before and after DCT involvement.
- The discussion then shifted to DCT's role within the broader continuum of care. DCT staff introduced what they described as the "12-inch ruler" concept, explaining that DCT represents the highest level of intervention after community services, outpatient supports, hospitals, and other resources have been exhausted. Staff emphasized that many capacity challenges within DCT are ultimately the result of inadequate community resources and difficulties transitioning individuals back into community settings. They noted that DCT's goal is not to expand institutional care indefinitely but rather to stabilize individuals and help them return to the least restrictive environment possible. Committee members asked whether DCT has considered providing additional support to individuals waiting for placement in hospitals, correctional facilities, or other settings. In response, DCT staff described the jail consultation pilot that emerged from the Priority Admissions Task Force. Staff explained that the pilot provides support to participating counties and has generated significant interest from counties seeking assistance in managing individuals awaiting admission. Staff also described consultative services available through DCT clinicians and psychiatrists, noting that treatment teams across the state can request guidance and expertise when caring for individuals with complex needs. Committee members and DCT leadership again emphasized the importance of strengthening community-based services. Committee members noted that discussions about behavioral health capacity often focus on facilities and beds, while insufficient attention is paid to the services and supports that can prevent individuals from reaching crisis levels of need.
- The presentation then shifted to inpatient treatment services. AMRTC staff discussed current capacity, noting that available beds alone do not fully represent operational

capacity because some individuals require intensive, individualized care environments. Staff explained that a portion of existing patients could be discharged if appropriate community placements were available, and they stressed that discharge barriers continue to create system bottlenecks. Committee members asked questions about future capacity needs and whether additional facility expansion would be necessary. DCT staff responded that community placement capacity remains one of the most significant constraints affecting access to care throughout the system, rather than a need for institutional expansion

- Committee members also asked about workforce challenges and the relationship between staffing and bed availability. Members noted that shortages across the behavioral health workforce affect care delivery throughout the continuum. AMRTC staff reported that vacancies and turnover rates have improved substantially in recent years and described efforts to recruit and retain employees. DCT staff acknowledged ongoing workforce challenges, particularly for specialized clinical positions, but emphasized that employee retention and staffing levels are stronger than they have been historically. Staff further noted that employee leave usage, overtime demands, and recruitment difficulties continue to affect operations even when vacancy rates are relatively low.
- A portion of the discussion focused on services for children and adolescents. DCT staff described the complexity of the youth population served and explained that many children arrive with multiple diagnoses and extensive treatment histories. Committee members asked whether future policy changes could increase demand for specialized youth services and questioned whether additional treatment capacity may eventually be needed. The conversation expanded into a discussion of placement options for children after discharge, access to community supports, and concerns about youth being placed outside of Minnesota when appropriate in-state resources are unavailable. Committee members also inquired about family engagement and supports available to families whose children are receiving treatment. DCT staff explained that families are actively involved throughout treatment and discharge planning. Staff described efforts to provide education, support, and planning assistance to families to help ensure successful transitions back to community settings. Committee members additionally discussed opportunities for local communities to support workforce recruitment and retention efforts, particularly in regions where specialized providers are difficult to recruit.
- The discussion then turned to AMRTC's treatment model and discharge planning approach. Staff emphasized the role of interdisciplinary treatment teams and explained that discharge planning begins immediately upon admission. They described how clinical, medical, nursing, rehabilitation, pharmacy, and social work teams work together to develop individualized treatment plans and identify appropriate community placements. Staff noted that discharge planning often presents significant challenges

because many individuals require highly specialized placements that are limited in availability. Committee members asked several questions related to medication management and continuity of care. In response, AMRTC clinical staff discussed the use of evidence-based psychiatric treatments and highlighted efforts to ensure that individuals receive timely interventions. Staff described the importance of early treatment, noting that prolonged periods of untreated mental illness can worsen outcomes and make recovery more difficult. They explained how DCT clinicians work with referring facilities and correctional settings to improve treatment while individuals await admission and discussed the use of long-acting injectable medications as one tool for supporting continuity of care following discharge. Staff also identified ongoing barriers related to access to specialized psychiatric treatments within community settings and emphasized the need for broader community capacity in this area.

- AMRTC staff then provided a detailed overview of the organization's Core 4 philosophy of care. Staff explained that the model integrates person-centered thinking, motivational interviewing, trauma-informed care, and positive behavioral supports. They emphasized that the Core 4 is more than a training curriculum and instead serves as the foundation for patient engagement, treatment planning, performance improvement, and organizational culture. Staff described the model as a key factor in improving patient outcomes and reducing the use of restrictive interventions. Committee members asked about implementation of the model across DCT facilities and whether similar approaches could be shared with community providers and other healthcare organizations. Staff reported that external organizations have expressed interest in learning from AMRTC's approach and that DCT has been willing to share lessons learned and best practices.
- The Committee also discussed patient safety and quality improvement efforts. AMRTC leadership described a culture of transparency and continuous quality improvement, emphasizing that staff are encouraged to identify and report issues rather than avoid reporting concerns. AMRTC leadership reflected on significant quality improvements achieved over recent years and noted that regulatory reviews and accreditation surveys are viewed as opportunities for learning and improvement rather than solely compliance exercises. Staff highlighted progress in reducing aggressive incidents, improving patient safety outcomes, and maintaining compliance with regulatory requirements.
- Toward the end of the presentation, Committee members asked what DCT leadership most wanted the Committee to understand about the challenges facing AMRTC. AMRTC staff reiterated that the most significant issue remains the lack of community-based capacity for individuals who are ready to leave higher levels of care. Leadership stressed that patients are admitted to DCT from communities and ultimately return to communities, making investments in housing, supportive services, treatment options, and local provider capacity critical to improving system performance. Staff noted that

when individuals cannot access appropriate placements after discharge, bottlenecks develop throughout the entire behavioral health system, increasing waitlists and limiting access for those needing care.

- **DCT Advisory Committee Business**
    - **Committee Membership:** Chair Baker reported that the Committee Chairs and staff had completed outreach regarding the unfilled participation expectations for James Carlson's seat as discussed in the August DCT Advisory Committee meeting. As James Carlson had not reengaged or attended the October meeting, the Chair stated that the Committee would move forward with seeking a replacement for his position on the Committee. Chair Baker approved correspondence to the Governor's Office regarding the vacancy and no additional Committee action was requested at the meeting.
    - **St. Peter Site Visit Debrief:** The Committee debriefed its August site visit to the St. Peter facility, with much of the discussion centered on transitions from institutional care to community-based settings and the need for a stronger continuum of care. Members noted that both staff and residents expressed concerns about transitioning individuals into the community when adequate supports may not be available. There was a shared recognition that discharge decisions are often influenced by the availability and quality of community-based services, as stakeholders want to avoid placing individuals in situations where they may struggle or fail. Participants emphasized the importance of continuing to strengthen and invest in community-based supports so that individuals can successfully transition to less restrictive settings. The group also discussed the complexity of facility capacity and placement decisions. Members observed that while beds may be available, not all beds are appropriate for every individual due to differences in service levels, clinical needs, and staffing requirements. The Saint Peter visit reinforced the importance of understanding these distinctions when evaluating capacity across the system. Workforce challenges were identified as another ongoing concern, with members noting staffing shortages across nursing facilities and other care settings. These workforce pressures affect the ability of providers to meet demand and maintain appropriate levels of care throughout the continuum. Members and DCT leadership also discussed individuals who have reached a therapeutic plateau and questioned whether there are sufficient options for individuals who no longer require intensive facility-based treatment but may not be ready for a traditional community placement. Discussion suggested that there may be gaps in the current continuum and a need for additional intermediate or step-down settings that can provide the right balance of support, safety, and independence. DCT leadership described efforts to address these challenges, including expanding community-based service options, developing specialized residential programs, and creating opportunities for individuals to transition to less restrictive environments while continuing to receive needed supports. Leadership emphasized that these efforts are intended to strengthen the continuum of care and better prepare individuals for long-

term success, while acknowledging funding and operational limitations. The discussion concluded with a broader conversation about responsibility for post-discharge care and the importance of keeping the individual's needs at the center of decision-making. Members stressed the need to focus on placing people in the most appropriate setting and ensuring the necessary supports are available, while working collaboratively across state agencies, counties, providers, and policymakers to develop and sustain those services. Leadership also highlighted outpatient psychiatric and medical services as an example of a transitional support designed to maintain continuity of care, reduce service disruptions, and prevent unnecessary readmissions.

- **Upcoming Meetings:** The Committee agreed to hold a one-hour virtual meeting on November 2, 2026, from 9:00-10:00 am CT. Members suggested using the meeting to debrief the AMRTC visit, address follow-up questions from the presentation, and identify themes or recommendations to share with the DCT Executive Board. The Committee also agreed to hold its final 2026 site visit on December 10, 2026. The proposed itinerary is to begin at Southern Cities Clinic in Faribault, travel to Rochester for lunch and the Committee meeting, and conclude with a visit to the Rochester Community Behavioral Health Hospital. DCT staff will coordinate the final schedule and logistics. Committee members also suggested several topics for future Advisory Committee meetings, including:
  - Additional information on the Jail Consultation program, including participating counties, outcomes to date, and opportunities for expansion.
  - Exploring whether there are gaps in the continuum for individuals who no longer need facility-level care but cannot safely return to the community and hearing directly from counties (via Commissioner Tara Jebens-Singh) about barriers, access issues, bed capacity concerns, and areas where the Committee can help.
  - Shifting the conversation from facilities and beds toward prevention, community supports, and services that help individuals avoid entering higher levels of care (inches 2-9 on the ruler example above).
  - Ensuring separate discussions on the needs of high-acuity adult and youth populations and the differing service considerations for each.
  - Follow-up discussion on DCT revenues, funding flows, and potential reinvestment opportunities.
  - Future discussion focused on the Mentally Ill and Dangerous Task Force and Priority Admissions Task Force recommendations.
- **DCT Updates:** Dan Storkamp announced that DCT is establishing a quarterly DCT Connections meeting to bring together stakeholders that are often engaged separately, including counties, tribes, advocacy organizations, and other partners. The first meeting is planned for November 10, 2026, and will introduce DCT and create a forum for exchanging information across stakeholder groups. Committee members asked to

receive invitations and noted that the forum may help connect discussions occurring in multiple task forces and stakeholder groups. DCT also provided a brief update that their legal department is reviewing the rulemaking change related to the cost of care for individuals receiving services. Leadership noted that the proposal does not directly affect counties, though counties will have an opportunity to review the changes. Finally, Marshall Smith provided an update on recruitment for a physician leadership position at the Minnesota Sex Offender Program (MSOP). DCT received 18 applications, narrowed the pool to five candidates, and began a multi-panel interview process designed to include perspectives from across the organization. He anticipated completing the process in early November (start date at the end of 2026 or beginning of 2027) and described plans for transition support before the current leader's retirement.

- **Open Public Comment**
    - Chair Baker introduced the public comment segment of the agenda passed the floor to the public commenter, Merry Schoon. Schoon shared concerns regarding the experiences of individuals receiving services at MSOP, drawing on personal conversations with a resident who has resided at the facility for several years. They expressed concern about what they described as disrespectful treatment by some staff, including the use of derogatory language, inappropriate jokes, and a perceived lack of attention to individuals' needs and well-being. Schoon stated that, in their view, these attitudes can create barriers to successful discharge and community reintegration. They alleged that actions or circumstances arising before commitment appeal hearings may negatively affect individuals' opportunities for release and expressed concern that the system is not sufficiently focused on supporting transitions to less restrictive settings when appropriate. Finally, Schoon encouraged the Committee to be aware of these concerns and questioned perceived inconsistencies between the release of individuals from correctional settings and the continued placement of some individuals within DCT treatment facilities.
- **Wrap Up and Next Steps**
    - Chair Baker closed the meeting by noting that more information on the Advisory Committee and upcoming meetings is available on the DCT Advisory Committee webpage. The next meeting will take place on November 2, 2026, and will only be available virtually.

Minnesota Direct Care and Treatment:
Advisory Committee Meeting

OCTOBER 7, 2026

ANOKA-METRO REGIONAL TREATMENT CENTER, 3301 NORTH 7TH AVENUE, ANOKA, MN



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Today's Agenda

1. Welcome
2. Presentation: Mental Health Substance Abuse and Treatment Services
3. DCT Advisory Committee Business
4. Open Public Comment
5. Wrap Up and Next Steps

DIRECT CARE AND TREATMENT



Direct Care and Treatment Overview

Direct Care and Treatment



DCT is a highly specialized behavioral health care system

Our Mission, Vision and Values



Mission

We support meaningful lives through specialized behavioral health services others do not provide.

Vision

A Minnesota where everyone receives the behavioral health services they need.

Direct Care and Treatment

- More than 12,000 civilly committed patients and clients served annually.
- Services are delivered at about 150 sites statewide.
- Services are delivered by about 5,500 employees.



FY 2026 Operating Budget

$786.6 million

Our Core Services

- Community-Based Services
- Forensic Services
- Mental Health and Substance Abuse Treatment Services
- Minnesota Sex Offender Program
- Outpatient Services
- Support Services



Understanding DCT's Place on the Continuum of Care

Hospitals & All Other Community-Based Mental Health Services | **DCT**



Mental Health & Substance Abuse Treatment Services



Acute inpatient behavioral health care

Mental Health & Substance Abuse Treatment Services

Includes

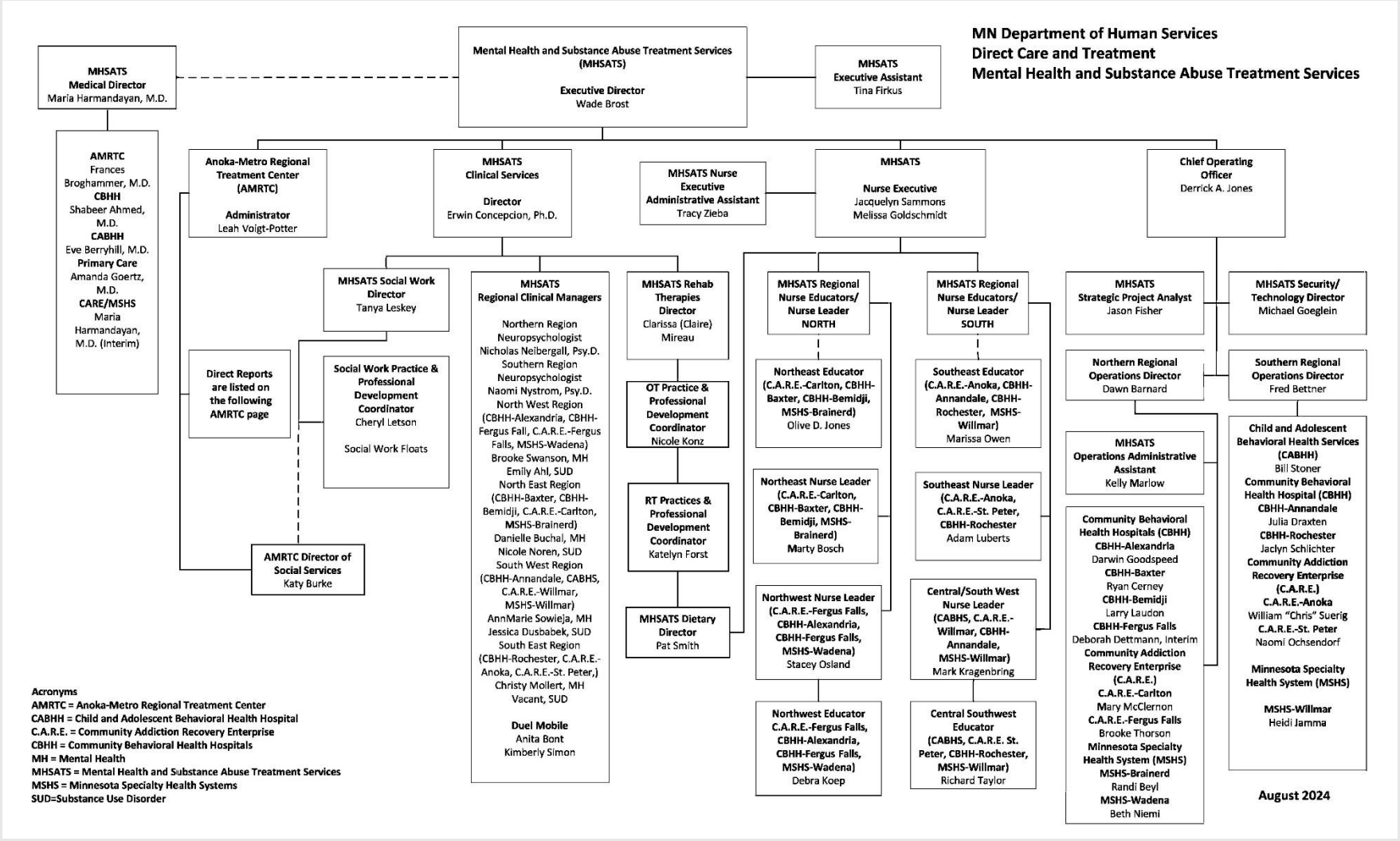
- Anoka-Metro Regional Treatment Center
- Six Community Behavioral Health Hospitals
- Child and Adolescent Behavioral Health Hospital
- Three Community Addiction Recovery Enterprise Programs
- Three Minnesota Specialty Health Systems-IRTS
- Employees: About 1,400
- Budget: $193 million
- Main Office: Vadnais Heights



Wade R. Brost

Executive Director

MHSATS Organizational Chart



Anoka-Metro Regional Treatment Center

- DCT's largest psychiatric hospital
- A 96-bed hospital on a secure campus in Anoka, MN
- Patients have been civilly committed as mentally ill or court ordered for treatment
- Patients admitted from anywhere in Minnesota



Community Behavioral Health Hospitals

- Six regional psychiatric hospitals located statewide
- Each hospital has 16 beds
- Provides short-term inpatient psychiatric care
- Patients admitted from anywhere in Minnesota
- Patients stay about 48 days



Child and Adolescent Behavioral Health Hospital

- Acute care psychiatric hospital for children ages 4 to 18
- The 16-bed hospital is located in Willmar, MN
- Serves kids and teens with complex mental illness
- Patients have multiple diagnoses ranging from brain and behavior disorders to psychiatric and traumatic stress conditions



Community Addiction Recovery Enterprise

- Provides inpatient substance use disorder treatment, relapse prevention and aftercare planning to adults
- Many patients have co-occurring mental illnesses
- Three 16-bed locations statewide



Minnesota Specialty Health System

- Three regional 16-bed intensive residential treatment (IRTS) facilities
- Provides time-limited mental health treatment in a residential setting to adults who no longer require hospitalization or other inpatient treatment but who need a period of structured care before returning home



Key Updates

- Staff vacancy rate is 8.5%
- FY26 staff turnover rate was 13.3%
- Patient volumes are greater than 92% of available beds
- Served more patients in FY26 than in FY25

- All hospitals have completed the Joint Commission recertification process
- All CARE/MSHS have been through MDH, DHS and TJC recertification surveys
- AMRTC 50 Bed Expansion
- CARE Anoka Relocation

Welcome to AMRTC



Anoka Metro Regional Treatment Center • 3301 7th Ave N, Anoka, MN 55303 • 651-431-5000

All About AMRTC

- Founded in 1900
- State of Minnesota's flagship psychiatric hospital
  - Inpatient level of care
  - Serves civilly committed patients who are court-ordered to the DCT Executive Board
- Serves patients from all 87 counties in MN
- 96 beds
- 500+ staff





Patients Served

- Gender diverse individuals ages 18+
- All patients are court ordered, many have criminal charges
- Admissions are coordinated through the Central Pre-Admissions Office

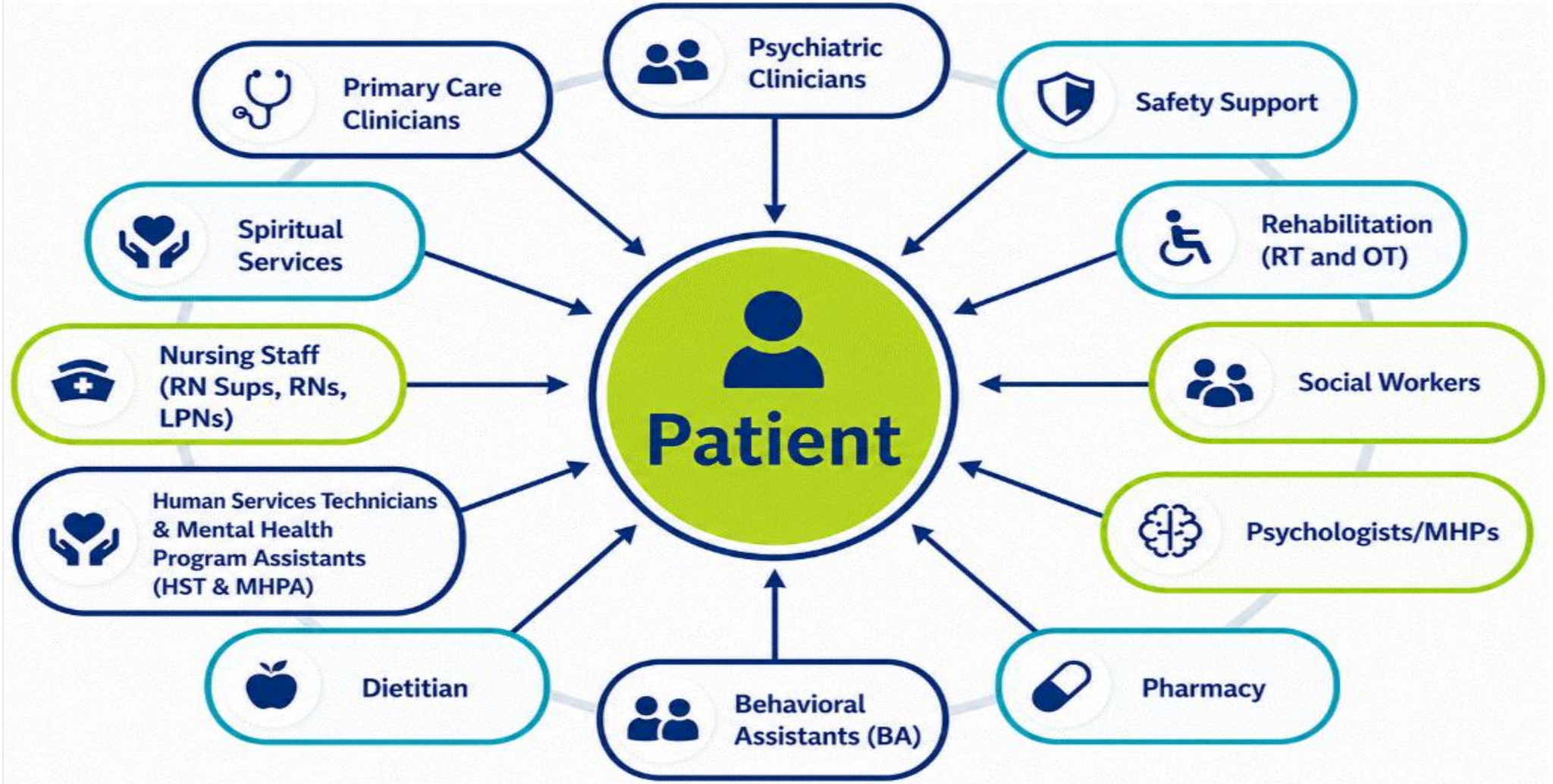
Common Primary Diagnoses

- Thought disorders (e.g., schizophrenia)
- Mood disorders (e.g. bipolar disorder)
- Personality disorders

Common Additional Diagnoses

- Chemical dependency
- Traumatic brain injury
- Diabetes, heart disease, and other chronic medical conditions

Patient-Centered Care



Effective Care Through Core 4

- DCT-developed model integrating four best practices to promote effective engagement. Core 4 is both a *culture* and *philosophy* of care.

Person Centered Thinking

Motivational Interviewing



Positive Behavior Supports

Trauma-Informed Care

Funding

- AMRTC receives appropriated funding from the state Legislature to provide patient care.
- Any revenue received through insurance or county payments for services provided, is returned to the state's General Fund.
- To receive federal funding, AMRTC must be licensed as a hospital by the Minnesota Department of Health (MDH).
- AMRTC must meet all "conditions of participation" when surveyors conduct an inspection of all patient care services, quality, patient safety, infection control, environment of care, and governance.

50-Bed Expansion Project

- $75 million investment
- Construction got underway in August and is targeted for completion in fall of 2028
- When new wing is complete and fully staffed, AMRTC will be able to treat 200 or more patients each year, depending on acuity.



DIRECT CARE AND TREATMENT



Questions?

DCT Advisory Committee Business

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MN DCT Advisory Committee Business

Advisory Committee to review and discuss the following items:

- Committee membership
- Site visit debrief
- Upcoming meeting cadence and agenda planning
- Additional Advisory Committee business

Open Comment Period

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MN DCT Advisory Committee Meeting Open Comment

The Committee is dedicated to creating a consistent, fair and transparent method for members of the public to provide comments during meetings. The last 15 minutes of each meeting will be dedicated open comment.

- Members of the public who would like to comment must submit the form on the MN DCT Advisory Committee webpage.
- Comments are limited to topics within the DCT Advisory Committee's scope.
- Each speaker is allotted about three minutes to provide their comment.
- Public comment rules and expectations include:
  - Commenters must adhere to the amount of time allotted.
  - Commenters must address the committee respectfully. Personal attacks, profanity, or disruptive behavior are not permitted.
  - Presentations or materials are not allowed.
  - Comments must not contain any personal health information (PHI) or personally identifiable information (PII) about individuals who are associated with or have received care at DCT facilities.
- The Committee Chair or meeting staff may issue a warning or end a speaker's comment if rules are violated.
- During the public comment, the Advisory Committee will listen to comments and will not engage in discussion or provide responses.

Wrap Up and Next Steps

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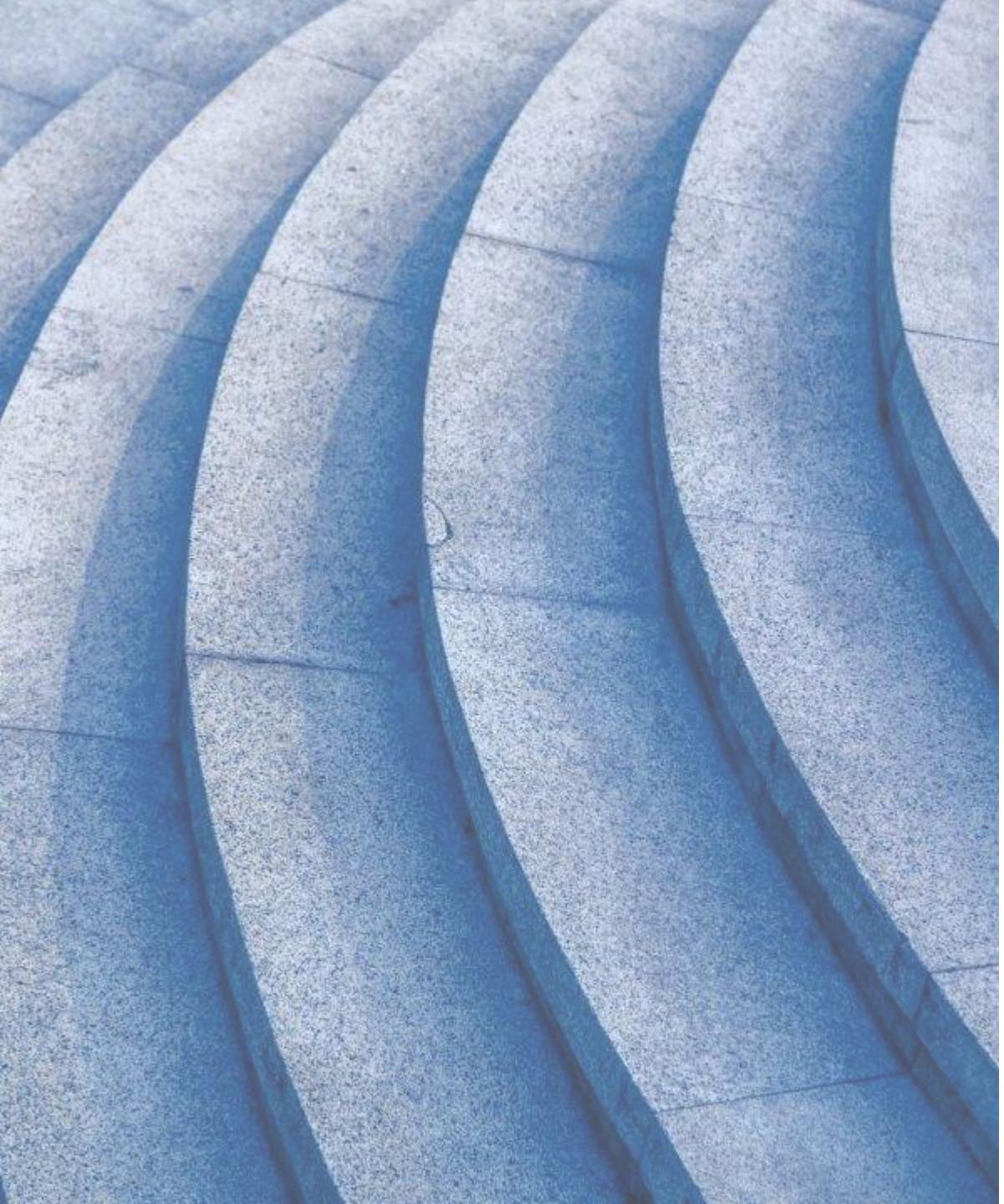

Wrap Up and Next Steps

- **Upcoming Meetings**
  - To be determined
  - Information on the Advisory Committee and upcoming meetings available on the DCT Advisory webpage
- **Questions or concerns:** Reach out to Dani or Jill (email addresses in chat)