MINNESOTA DIRECT CARE AND TREATMENT ADVISORY COMMITTEE MEETING MINUTES

Meeting Information

- **Date and Time:** Friday, February 27, 2025, from 9:00-11:00 am CT
- **Location:** In person location at Minnesota State Capitol, 75 Dr. Rev. Martin Luther King, Jr. Blvd, St. Paul, MN. 55155, Room 123 and virtual meeting available via Zoom
- **Direct Care and Treatment (DCT) Advisory Committee Attendees:** Representative Dave Baker; Jessica Langhorst; Jim Postier; Tara Jebens-Singh; Senator Paul Utke
- **DCT Advisory Committee Facilitators:** Jill Kemper and Danielle Swanson, Health Management Associates (HMA)
- **Speakers:** Marshall Smith, Chief Executive Officer (CEO), DCT; Dr. KyleeAnn Stevens, Chief Medical Officer (CMO), DCT; Carrie Briones, Legislative Director, DCT; Dan Storkamp, External Relations Executive Director, DCT

Meeting Summary

- **Welcome**
  - Chair Dave Baker began the meeting by inviting MN DCT Advisory Committee members to introduce themselves and the group they are representing on the Advisory Committee, as dictated by Minnesota legislation. Chair Baker then provided an overview of the day's agenda.
- **Committee Discussion: Committee Purpose Statement**
  - Chair Baker reviewed the Committee Purpose Statement which will be used to define Committee actions and may be included in Committee-generated materials moving forward.
  - Committee Purpose Statement: *The Direct Care and Treatment (DCT) Advisory Committee, established under state law, provides a venue for a broad range of stakeholders to advise the DCT executive board on agency operations, including practices and priorities, promoting transparent decision-making and continuous system improvement. It offers a forum for stakeholders to share guidance and insight on DCT programs and operations, helping ensure that services remain responsive, effective, and informed by the people they impact.*
  - No additional comments or edits to the Purpose Statement from Committee members.

- **Presentation: History of DCT & Comparison of Service Lines to Other Organizations**
    - Dan Storkamp, External Relations Executive Director, DCT, and Marshall Smith, CEO, DCT, began by providing an overview of the history of DCT (*see slides 5-19 below*). Discussion following the overview included:
        - Tara Jebens-Singh noted that when discussing the state's move from an institutional model, it is also important to highlight the systemic and historical harms that were disproportionately put onto people who were inappropriately housed and mistreated in these facilities, in addition to highlighting medication enhancements. Tara encouraged summaries of this work to include greater context and center on the individuals that the program is trying to uplift, treat, and heal. Chair Baker recognized and appreciated Tara's comments and noted that the Committee could include this topic as a future agenda item if the Committee desires.
    - Marshall Smith reviewed the DCT organizational structure (*see slides 20-26 below*).
    - Dr. KyleeAnn Stevens, Chief Medical Officer (CMO), DCT, then reviewed how DCT Compares to Other Health Care Systems in Minnesota (*see slides 27-30 below*). Discussion following the review included:
        - Chair Baker noted that while he was supportive of DCT's split off from DHS as a legislator, he requested to know more about DCT's relationship with the Governor's Office, as the visual implied that they are reporting to the Governor. Marshall clarified that the Governor has appointed six of the Executive Board members and the Board Chair, Carol Olson, collaborates directly with the Governor's Office when there are needs. Marshall shared that while he reports to the Chair of the Board, he also has an indirect reporting structure to the Governor's team and meets with them monthly to proactively inform them of upcoming plans. When asked about transparency between the two groups on the conversations that occur, Marshall noted that the group strives for transparency and gave the example of his recent evaluation, which he worked with Executive Board Chair Carol Olson to summarize and bring to the public meeting.
        - Tara shared appreciation for the greater sense of transparency and accountability and the complexity of DCT compared to other healthcare systems. Tara then emphasized that other healthcare systems are primarily responsible to that entity alone, including making sure that they are meeting the standards, mission, and fiscal responsibilities set by their organization. Tara noted that while DCT is also responsible for its individual entity, it is important that they (and the Advisory Committee) not forget that DCT is a public good that sits within a broader ecosystem and therefore needs to be careful that everything that's happening within DCT facilities is meeting those goals. For example, DCT could focus internally on making sure that they hit all the boxes

for the internal workings of the enterprise and still fail the broader public good of where we sit within the broader system. Therefore, DCT and the Advisory Committee must be constantly aware of not only how DCT is serving the people in their care, but also how they are part of a broader system and our communities' needs. Marshall replied by sharing that they have worked diligently over the last 10 years to improve DCT operations, outcomes, and people following several detrimental outcomes, and are proud of how far they have come. Marshall also expressed the critical need for continued funding of DCT growth and other efforts as a civil responsibility. He noted that without funding, program services and people are at risk of being cut, which would be a detriment to the community. Dr. Stevens also shared that in recent years, the DCT team has been focused on looking at gaps in the continuum of care, and it is a key area of DCT's current strategic plan to look at those gaps. They are also working with several task forces to assess aspects of the continuum of care.

        - Jessica Langhorst asked about the decision to liquidate the compensatory banks for American Federation of State, County and Municipal Employees (AFSCME) and Minnesota Association of Professional Employees (MAPE) members. She noted that other state agencies, such as DOC, which see similar levels of short staffing and overtime rates, are not deciding to liquidate the comp banks. Marshall noted that the DCT team is working with Minnesota Management and Budget to ensure that DCT is following all required policies, statutes, etc., and while he did not have the information available, he could provide an answer at a later date.

- **DCT Executive Board and Legislative Priority Updates**
    - Dan Storkamp, liaison between the Executive Board and the Advisory Committee, provided an overview of DCT Executive Board priorities. Dan shared that the Executive Board currently has three subcommittees: finance, compliance, and the Advisory Committee. The Advisory Committee subcommittee and the Executive Board agree that for the two groups to work together effectively, it is important to align on expectations. To ensure alignment, the Executive Board recommends that the Chair/Vice Chair of the Advisory Committee meet with Marshall and his staff to discuss the roles and responsibilities of the Executive Board and Advisory Committee and other priority topics involving both groups. Chair Baker agreed with this approach, and the two will coordinate the next steps for meeting in the next 60-90 days as agreed upon. Dan also continues to provide updates on the Advisory Committee to the Executive Board, including the recent addition of the open public comment portion of the Advisory Committee meeting agendas and webpage.
    - Carrie Briones, Legislative Director, DCT, gave an overview of the DCT's legislative priorities (*see slides 32-40 below*). Discussion following the overview included:

        - Chair Baker acknowledged the proposal related to the sharing of patient health information and inquired if the proposal was currently with the public safety committees for review and, if so, whether the group believed it would be a challenging proposal. Carrie shared that they are planning to package all of the policy priorities into one policy article, and Representative Frederick has volunteered to carry the language. Carrie noted they will split out the data practices items and are working to get a meeting set up with the judiciary chairs in the House and Senate, starting next week, to have a deeper dive into that language.
        - Tara inquired if federal policy changes, executive orders, or the withholding of Medicaid funds in Minnesota are impacting the DCT budget and ability to proceed as normal. Marshall shared that they are not currently seeing an impact but are continuing to monitor.
        - Chair Baker asked for clarification around what the process is for DCT in the event they may or may not agree with the governor's budget package (which they noted is still in process). Chair Baker asked if DCT must always respond to what the executive branch wants in that area or if they have more independence to enact via legislation if needed. Marshall clarified that as a member of the executive branch, their goal is to support the Governor's budget and, therefore, as questions arise, they hope to be able to work through them with the Board, the Governor's Office, legislators, and with recommendations from the Advisory Committee as appropriate.
- **Committee Business: Advisory Committee Webpage and Feedback Process**
    - Chair Baker provided an overview of the recent changes and updates to the MN DCT Advisory Committee webpage (*see slides 41-45 below*). Committee recommendations for additional updates to the webpage included:
        - Tara suggested that the group post the meeting slides before the meeting, in addition to the meeting agenda, to allow for review and preparation by both Committee members and members of the public they represent. The group agreed to proceed in this manner moving forward.
        - Tara also noted that she is comfortable providing a link to her webpage on the "Committee Members" tab of the page if members of the public want to contact them. Danielle Swanson, HMA, clarified that the "Contact Us" form on the webpage also allows individuals to select if they want a member of the Advisory Committee be included on their request/response. Jessica requested that the "Contact Us" form be listed both at the bottom of the page and in the "Committee Members" section for maximum exposure to webpage viewers. The group agreed to proceed with these edits.
- **Open Comment**

- Chair Baker gave an overview of the new open public comment process and expectations (*see slides 46-47 below*) before introducing the two public commenters signed up to speak during the meeting. A summary of the comments is provided below.
    - William (Bill) Dobbs: William began by complimenting the group on opening the meeting for public comment at only the second meeting and thanked the group for taking on the important task of advising the DCT Executive Board. William noted the purpose of his comment was to draw attention to the Minnesota Sex Offender Program (MSOP). The civil commitment program has three facilities in two cities, Moose Lake and St. Peter. William noted that individuals are held in MSOP indefinitely, with no release date, and are held not for what they did, as these are people who have already paid a price for wrongdoing by completing a prison term, but because the state believes they might commit an offense in the future. William shared that for individuals in MSOP, the surest exit from the program is death, as the number of people who have died in the program is far greater than those who have gotten permission to leave. William asked the group how we can lock up people for what they might do, which he believes does not align with the U.S. Constitution. He noted that accountability for wrongdoing is critical for both those who have committed the offense and for how the state manages the individuals. William stated that MSOP currently holds 758 individuals, three-fourths of whom have been inside for 11+ years in addition to prison time, with a slim chance of release, bringing on profound hopelessness. He noted that there is no higher education available as is provided to individuals in prison, and those inside cannot learn about local matters due to the newspaper ban. William encouraged the group to keep an open mind on the topic and learn more, as well as visit the MSOP facilities and hear from the individuals residing in the facilities. He noted that Advisory Committee members can review the report issued by the Mitchell Hamline School of Law, which identified the MSOP as "the worst of its kind," according to William. He noted that the report calls to close MSOP and to spend the money on proven and promising programs to address and prevent sexual violence. William offered his assistance to the group as needed in connecting with individuals in the MSOP. Finally, William stated that in 30 years of his existence, over $1 billion has been spent to fund MSOP with little benefit to public safety and only 34 releases.
    - Merry Schoon: Merry shared that [redacted] has been in MSOP for 9 years and wanted to share some of the recent occurrences they had experienced. Merry shared that on February 13th, personal letters were read, which she said goes against standard procedure in which they just glance at but do not review personal documents. When questioned and asked to stop by other individuals in MSOP, it resulted in a verbal confrontation between the clients and staff. She

said no laws were broken; however, 34 clients were taken to administrative restriction (including strip search). She said that according to statute, individuals are only supposed to be in administrative restriction for a maximum of 48 hours; however, [redacted] was there for 12 days with no knowledge of an investigation or ability to contact their attorney. Merry shared that recently, the MSOP staff seem to be particularly hard on the clients and are handing out restrictions for minor offenses. Merry reminded the group that the MSOP is a treatment center, not a prison, and shared that treatment sessions are only held once a week for two hours, which she said does not allow for progression for them to be released from the program. Merry also shared that they do not allow MSOP clients to write, print, or say anything negative about the program, which is almost impossible when everything around them is negative, creating a dangerous situation as they cannot express what is not going right in their environment.

    - Chair Baker thanked the commenters and transitioned to the meeting close.

- **Wrap Up and Next Steps**
    - To conclude the meeting, Chair Baker asked for Committee approval of the January meeting minutes. Jessica made a motion to approve the previous meeting's minutes, seconded by Tara. Votes to approve the January meeting minutes were as follows.

Committee Member	Voted Yea	Voted Nay	Abstained/Absent
Representative Dave Baker	X		
James Carlson			X
Senator John Hoffman			X
Jessica Langhorst	X		
Jim Postier	X		
Marcus Schmit			X
Tara Jebens-Singh	X		
Representative Bianca Virnig			X
Senator Paul Utke	X		

    - 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 two meetings will occur on March 13, 2026, from 1:00-3:00 pm CT and April 24, 2026, from 9:00-11:00 am CT.

Minnesota Direct Care and Treatment:
Advisory Committee Meeting

FEBRUARY 27, 2026

MINNESOTA STATE CAPITOL

75 DR. REV. MARTIN LUTHER KING JR, BLVD, ROOM 123 & VIA ZOOM

ST. PAUL, MN 55155

Today's Agenda

1. Welcome
2. Committee Discussion: Committee Purpose Statement
3. Presentation: History of DCT & Comparison of Service Lines to Other Orgs
4. DCT Executive Board and Legislative Priority Updates
5. Committee Business: Advisory Committee Webpage and Feedback Process
6. Open Comment
7. Wrap Up and Next Steps

Committee Discussion:
Committee Purpose Statement

Committee Purpose Statement

Purpose statement will be used to define Committee actions and may be included on Committee-generated materials.

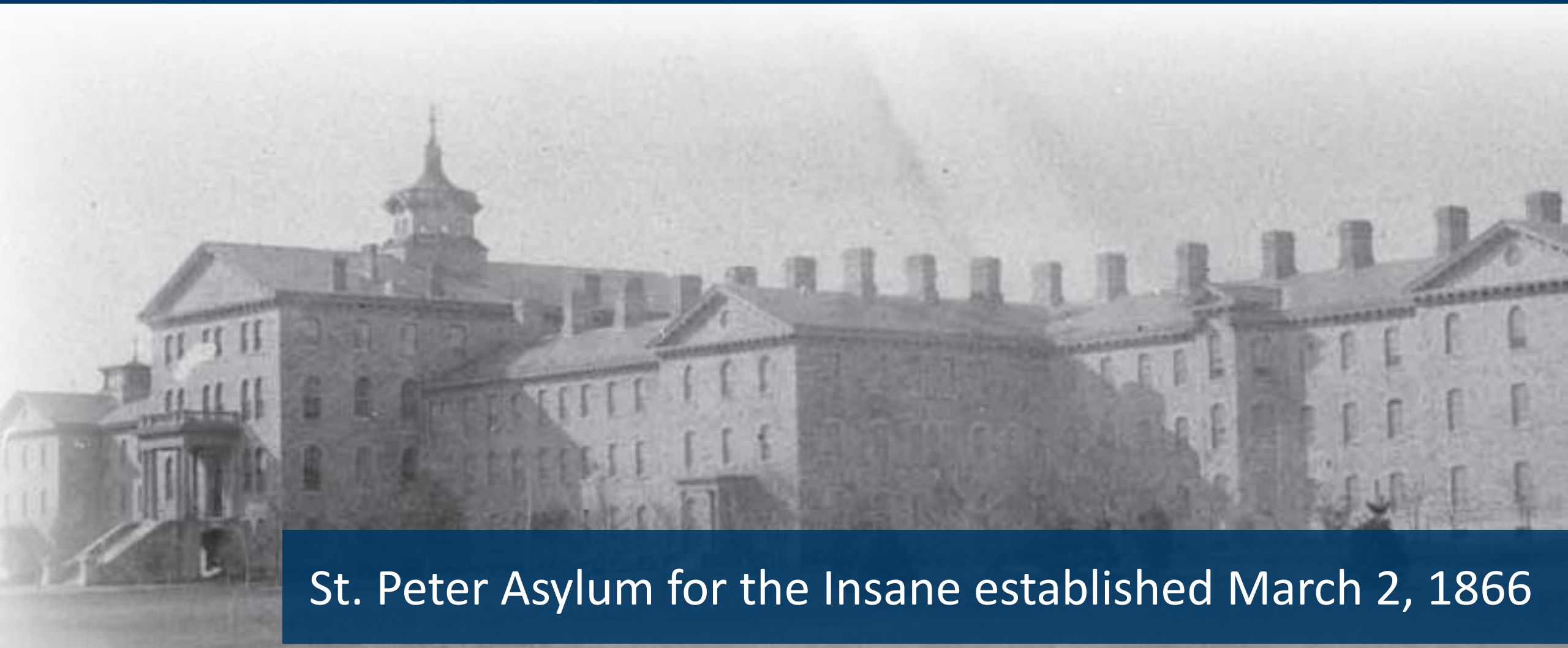
The Direct Care and Treatment (DCT) Advisory Committee, established under state law, provides a venue for a broad range of stakeholders to advise the DCT executive board on agency operations, including practices and priorities, promoting transparent decision-making and continuous system improvement. It offers a forum for stakeholders to share guidance and insight on DCT programs and operations, helping ensure that services remain responsive, effective, and informed by the people they impact.

DIRECT CARE AND TREATMENT

History of Direct Care and Treatment

From State Hospitals to State-Operated Services to Today

The State Hospitals



St. Peter Asylum for the Insane established March 2, 1866

DCT Historical Sites – 1886-1910

St. Peter	1866	DCT Forensics
Rochester	1879	Closed
Owatonna	1885	City of Owatonna
Fergus Falls	1890	DCT - CBS
Faribault	1900	MN DOC
Anoka	1900	DCT - MHSATS
Hastings	1900	Veterans Affair
Ah-Gwah-Ching	1907	Closed
Willmar	1907	CBHH
MN Security Hosp	1910	Forensics

DCT Historical Sites – 1911-2010

Gillette	1911	Gillette Hospital
Willmar	1912	Closed
Cambridge	1919	Vacant
Moose Lake	1938	MN DOC
Sandstone	1950	Federal Prison
Lake Owasso	1955	Ramsey County
Brainerd	1958	DCT CARE/TRIBE
Oak Terrace	1961	Demolished
ML MSOP	2010	DCT-MSOP

Communities Unto Themselves

- The State Hospitals were massive structures, usually built on huge campuses
- They were communities, offering shelter, food, work and recreation for patients
- Work therapy that was used on campuses included farming, laundering, sewing, and tailoring
- Some staff lived on campus as well

A Place for People that Didn’t Fit

- State hospitals served as places to put people that were deemed inappropriate to live in the community
- The hospitals had names that reflected the attitudes of the times, using words like “insane”, “imbecile”, and “inebriate”
- The prevailing theory of “treatment” was rest, work, and outdoor activities. Some people did get better and return to the community.

A National Movement

By the mid 20th Century, advances in treatment of mental illness and changes in public attitudes marked the beginning of the end for state hospitals

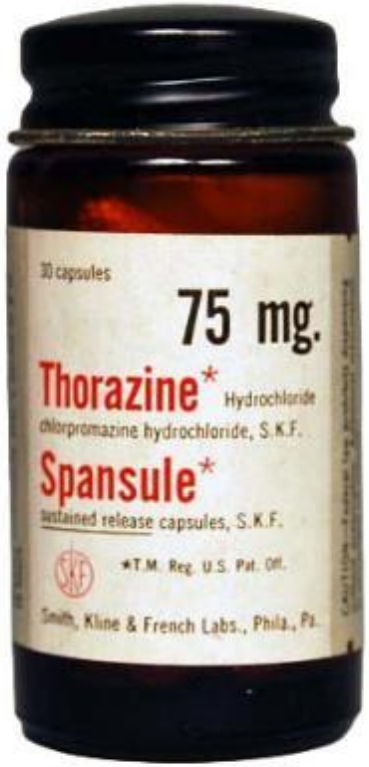
Deinstitutionalization in Minnesota and nationally was driven by two factors:

- A national movement focused on the rights of people with mentally ill (MI) and individuals with an intellectual/developmental disability (IDD) to live in the community.
- Scandals (national and local) at hospitals – overcrowding, understaffing, abuse

Deinstitutionalization in Minnesota

New medications in the 1950s allowed many people experiencing mental illness to live in the community. In Minnesota state hospitals:

- Patient stays were shortened; people who may have spent their whole life in a state hospital might be discharged after a year or two
- People experiencing mental illness in state hospitals dropped from 11,500 in the late 1950s to 2,400 in 1972



Deinstitutionalization in Minnesota

For the IDD population, fewer children were being committed as norms changed, and community supports were gradually developed. For state hospitals:

- The Welsch lawsuit, brought in 1972, led to the Welsch Decree in 1980 requiring all people with intellectual and developmental disabilities to be moved out of state hospitals
- There were 2,650 people with intellectual and developmental disabilities in state hospitals in 1980, down from 6,000 in the mid-1960s. By 2003 there were only 32.

The Shift to Community Services

- In the 1980s and 1990s, human services began to shift to community-based services for people experiencing mental illness and people with disabilities.
- State Operated Services (SOS) started on a path to follow suit: To run services in the community paid for by the same government rates as other community service providers
- In 1988, SOS's substance use disorder programs – called CARE (Community Addictions Recovery Enterprise) – began to bill for reimbursement under the same state rate system as other Substance Use Disorder (SUD) providers

Minnesota State Operated Community Services - MSOCS

- MSOCS started as a strategy to repurpose Regional Treatment Centers (RTC) staff to provide community services to people with disabilities: group homes, day programs and vocational services
  - The state needed to rapidly expand community services to comply with the Welsch decree; MSOCS helped meet this need while maintaining state jobs
  - This strategy leveraged Medicaid to pay for state-run community-based services
- The first state-run group homes were opened in 1986
  - 1997: Eastern State Operated Services established, managed by Cambridge and Faribault
  - 2002: MSOCS established, merging five regional programs

Community Behavioral Health Hospitals

- In 2003, the Legislature created a regional planning process for community-based treatment alternatives for people experiencing mental illness
- The state undertook a lengthy process of consultation with counties and other stakeholders, resulting in dramatic changes for SOS mental health
  - Regions identified needs for state-operated psychiatric hospital beds
  - Ten 16-bed Community Behavioral Health Hospitals were opened between 2006-2008
  - The 16-bed model ensured the facilities were eligible for Medicaid reimbursement
  - Three CBHHs were converted to step-down Intensive Residential Treatment Services (IRTS)

Organizational Evolution

- Up until the late 1990s, Regional Treatment Centers operated mostly independently.
- By 2010, some shared services were centralized, leadership over SOS had been elevated in Department of Human Services (DHS) and regional leadership was created
- In 2016, Marshall Smith was appointed as CEO of State Operated Services, which was renamed Direct Care and Treatment
- DCT was reorganized into a health system focused on serving people other providers cannot or will not serve
  - Created an Executive Team led by the CEO and comprised of the executive directors of each service line and systemwide leaders
  - Regional leaders were phased out
  - All critical services were more fully centralized, including quality, pharmacy and compliance

DCT Historical Challenges

- Jensen lawsuit – started in Minnesota Extended Treatment Options (METO) but became system wide concern/oversight on use of restraints, concern with Olmstead compliance
- Karsjens lawsuit re: Minnesota Sex Offender Program (MSOP) constitutionality
- Lack of funding driving staffing shortages (operating adjustments)
- Lack of/gutting of quality (not informed decision making)
- No focus on staff/census trade-offs (not informed decision-making)

More Historical Challenges

Minnesota State Hospital – Staffing, Safety, and Licensing Issues

- 2011: A patient abuse report at Minnesota State Hospital led to the resignation of the executive director, issuance of a conditional license, and changes to restraint policies.
- 2014: A patient-to-patient homicide occurred at the hospital.
- 2015: A staff member was assaulted by a patient.
- 2024: Another patient-to-patient homicide occurred, highlighting ongoing safety concerns more than a decade after earlier incidents.

Anoka Facility – Admissions, Staffing, and Federal Compliance

- 2016: At Anoka Metro Regional Treatment Center, an increasing number of admissions from county jails, combined with staffing shortages, raised concerns about patient safety and compliance. The facility faced the threat of losing certification and funding from the Centers for Medicare & Medicaid Services, resulting in a systems improvement agreement (SIA).
- In 2018: the Systems Improvement Agreement (SIA) was completed, and departments were brought into compliance with local, state, federal, and regulatory standards;
- In addition – all other regulatory issues fell into place – today DCT is in full compliance without any licensure holds.

Workplace Safety and Labor Concerns

- Staff filed complaints with the Occupational Safety and Health Administration regarding unsafe working conditions.
- Labor unions and employees publicly raised concerns about the safety of both staff and patients.
- At St. Peter, negotiations between management and labor led to additional funding from the Minnesota Legislature to address staffing needs.
- The legislature also recognized broader system-wide resource needs, signaling an important policy direction for the future.

DIRECT CARE AND TREATMENT

DCT Organizational Structure

Why Separation from DHS was Necessary

Department of Human Services

- Regulator
- Statewide policy
- Payer for health care services

Direct Care and Treatment Agency

- Treatment provider only

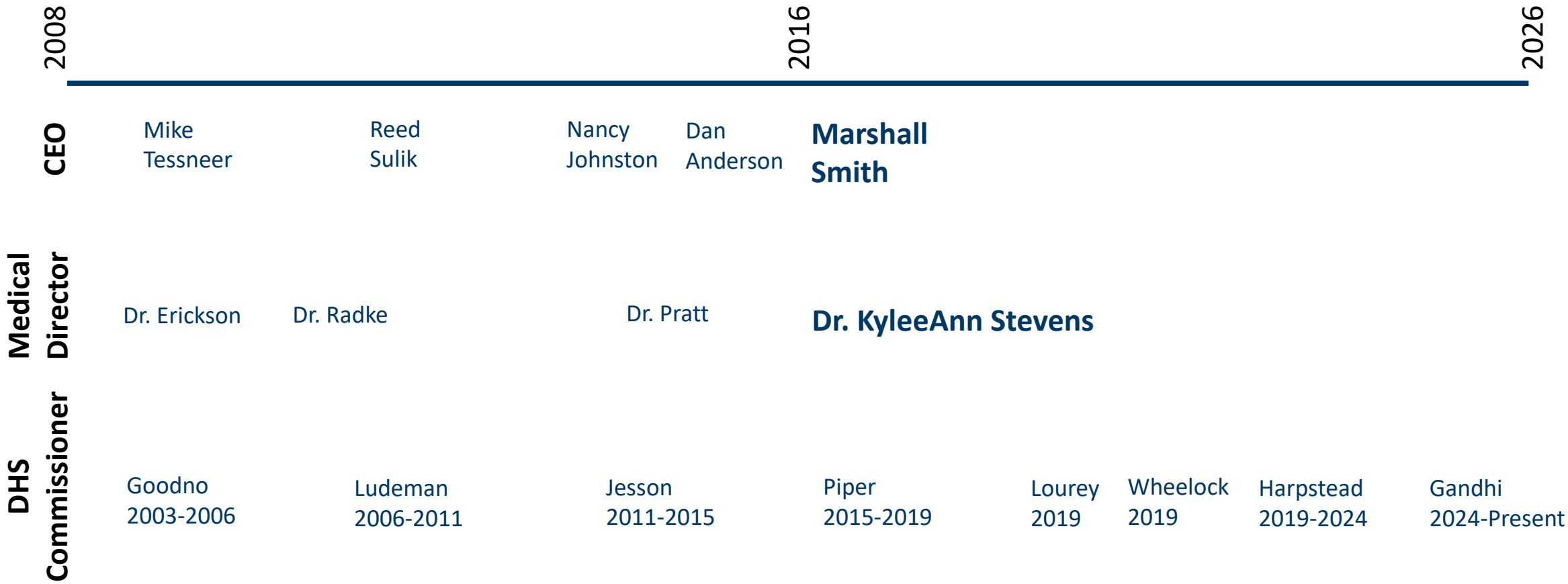
Goals of Separation

- Give DCT the structure and governance to allow it to function like other health care systems, including an Executive Board.
- Align with health care industry standards and best practices.
- Leadership that is deeply experienced in health care operations and management.
- Enhance overall patient care
- Ensure regulatory compliance
- Transition without interrupting patient and client care

Why a DCT Executive Board?

- Provides consistent health care leadership
- Preserves independent clinical judgment in patient care
- Strengthens transparency and accountability across programs and services systemwide

Consistency in DCT Leadership



DCT Executive Board Responsibilities

- Approve strategic direction and monitor performance
- Approve mission, vision, and strategic plan and direction
- Oversee the care and management of all DCT patients and clients
- Ensure clinical quality, patient safety and customer service excellence
- Ensure financial viability over operating and capital budgets

- Build strong and appropriate stakeholder relationships
- Ensure quality of medical staff
- Delegate day-to-day operations to CEO
- Ensure DCT's CEO is successful
- Focus on good government

Greater Transparency

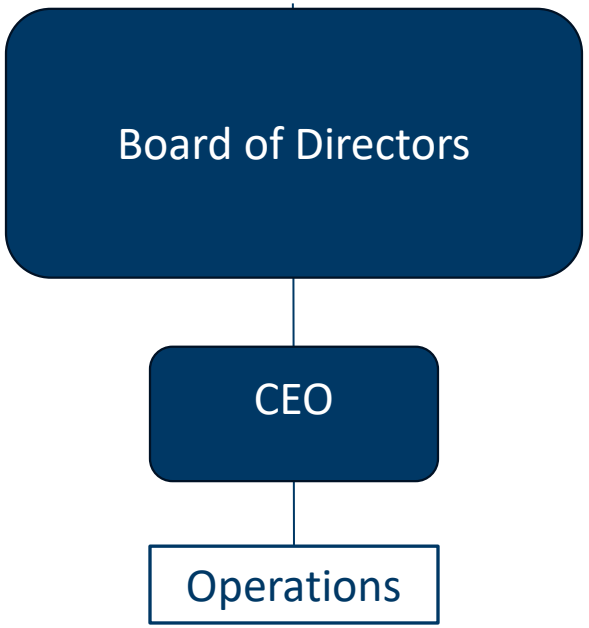
- Board offers more transparency and public accountability than exists under a more traditional commissioner-led state agency model
- Board meetings are open to the public
- Issues are openly discussed
- Ample opportunities for public to provide input and ask questions
- Records of actions taken are available for public review

DIRECT CARE AND TREATMENT

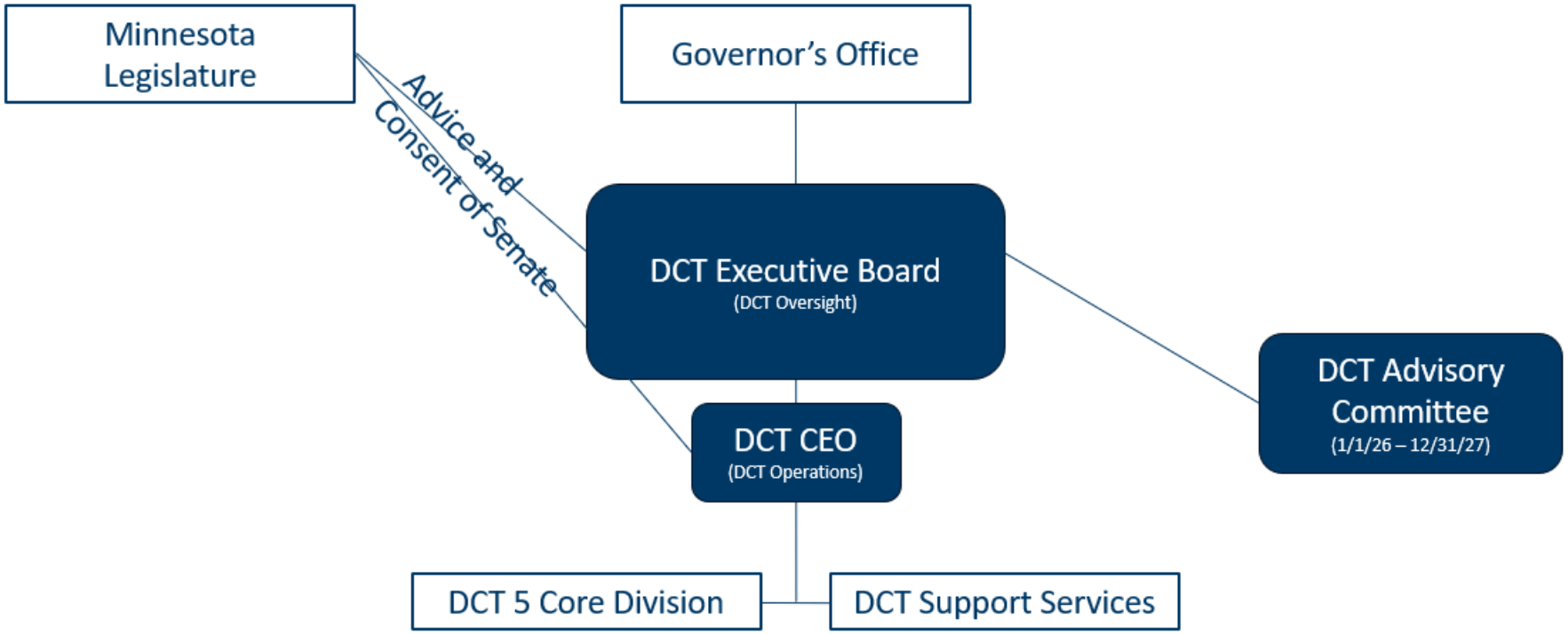
DCT Compared to Other Health Care Systems

DCT is More Complex

Other MN Health Care Systems



Direct Care and Treatment



How DCT is Similar to Other Health Care Systems

- DCT provides the same level of care as community hospitals, residential treatment programs (except FMHP and MSOP), group homes, vocational programs, and outpatient clinics.
- DCT competes for the same employees
- DCT has oversight by the same regulators
    - TJC, CMS, MDH, DHS, CARF, OSHA, and others
- We provide a continuum of services to help reintegrate individuals in the community.
- We share a common goal to support individuals' health and recovery.

How DCT is Different Than Other Health Care Systems

- DCT provides behavioral health care to those who can't receive care elsewhere. Mission driven staff. (12 Inch Ruler)
- Extra oversight by Legislature, Courts, MMB, Department of Administration, and Governor's Office. Hospital Review Board, Special Review Board for some.
- Nearly all admissions are under civil commitment.
- No ED or Urgent Care. Most admissions come from other hospitals or from corrections.
  - Central Preadmissions serves as the front door.
- We're very good at individualized treatment, deescalation, and promoting safety.
- Discharges in partnership with counties.

DIRECT CARE AND TREATMENT

DCT Executive Board Updates

DIRECT CARE AND TREATMENT

DCT Policy, Bonding and Budget Proposal Updates

2026 Legislative Calendar

Session Opened February 17

EID Break: 8 a.m. March 19 through 8a.m. March 20

Spring Break: 5 p.m. March 27 through 8 a.m. April 7

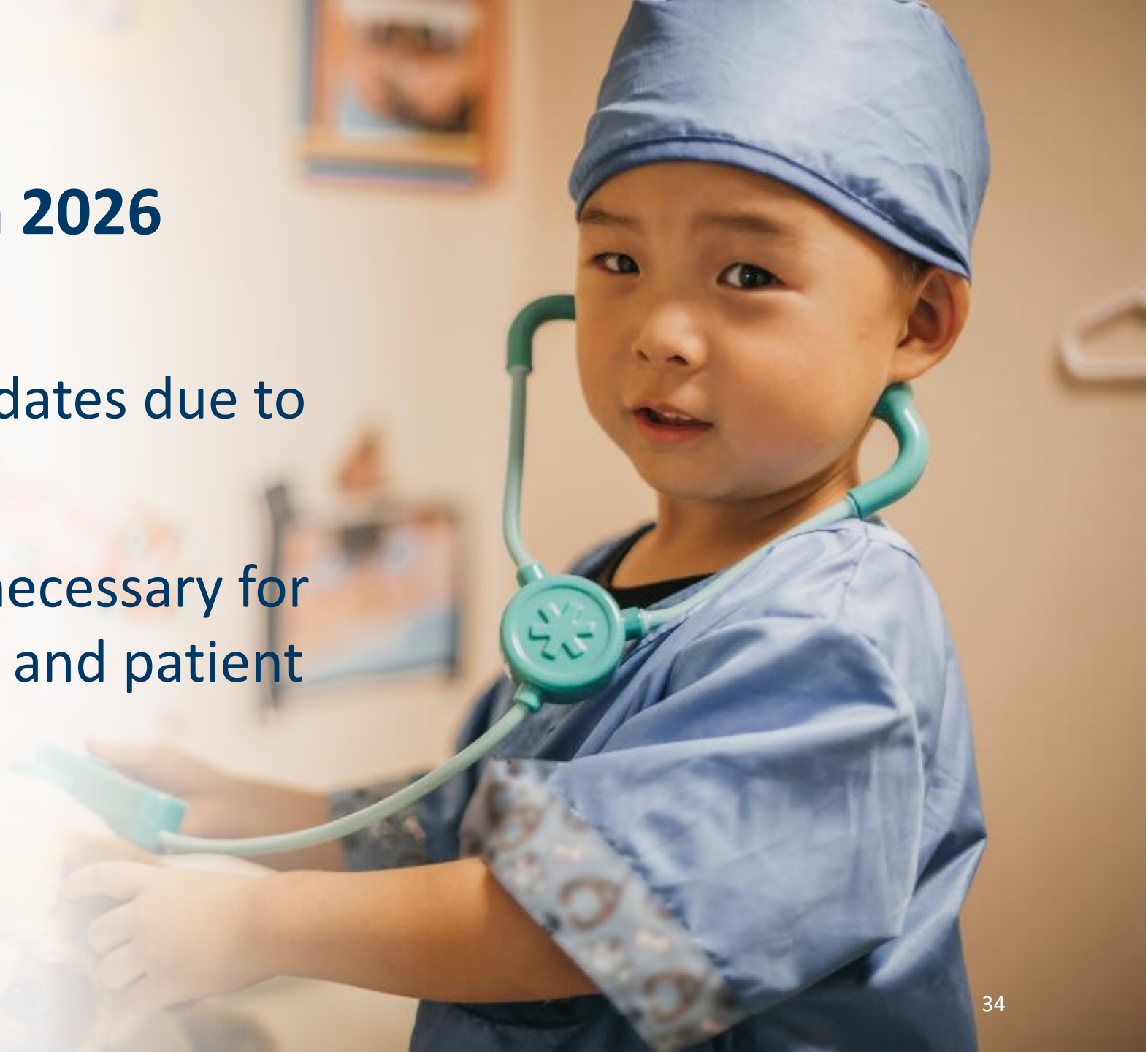
Session Adjourns May 18

Special Session(s) Unknown

Committee Deadlines:
1st Deadline: March 27
2nd Deadline: March 27
3rd Deadline: April 17

DCT's Policy Focus in 2026

- Statutes that need updates due to separation from DHS
- Sharing information necessary for healthcare operations and patient support
- Patient care



Policy Proposals

1. Update torts statute
2. DCT designee for MSOP data review
3. Limited authority to share information with courts
4. Limited authority to share patient health information
5. Providing routine patient care before emergencies arise
6. More time for Forensics patients to return for medical care

Budget Proposals - Pending

- Currently pending
- Final decisions are expected in March
- DCT proposals will be part of the Governor's budget package

Our top bonding priorities for 2026 focus on critical infrastructure

- Asset preservation: $23.7 million
- Water and sewer construction: $18.8 million
- Total request: $42.5 million

Asset preservation: $23.7 million General obligation bonds

- Addresses life and safety concerns
- Health, safety and code compliance
- Major mechanical and electrical systems
- Roof, window, and door replacement, tuck-pointing, foundation repairs

Water & sewer rehab: $18.8 million General obligation bonds

- Replaces water mains, sanitary and storm sewers throughout the lower St. Peter campus
- The systems were constructed in the 1950s and have far exceeded their useful life
- Avoids likely system breakdown and failure
- Ensures safe, sanitary conditions for about 700 patients and clients and nearly 2,000 staff

DIRECT CARE AND TREATMENT

Thank You!

Marshall Smith, CEO

Dr. KyleeAnn Stevens, CMO

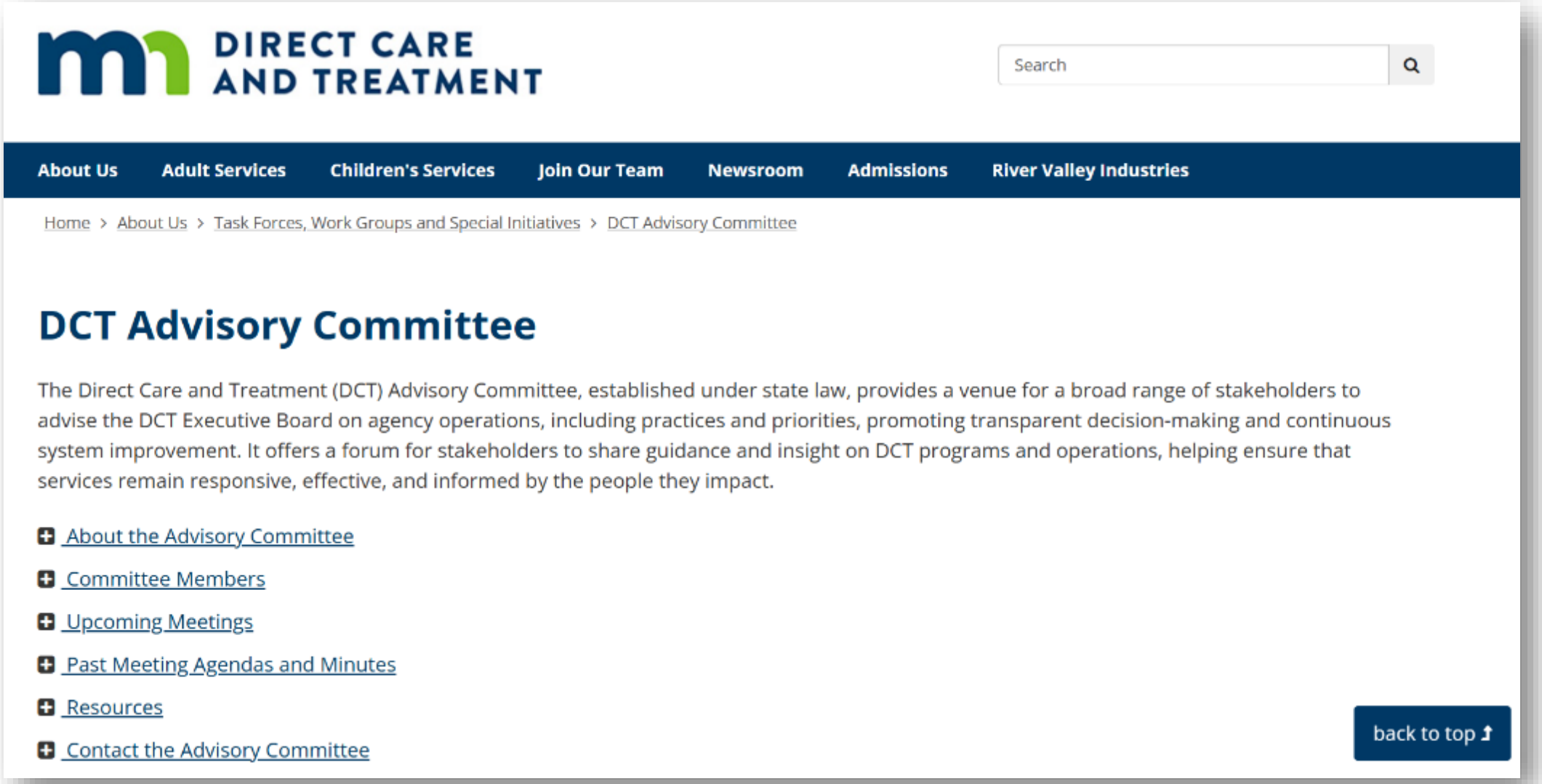
Carrie Briones, Legislative Director

Dan Storkamp, External Relations Executive Director

Committee Discussion: Advisory Committee Webpage and Feedback Process

MN DCT Advisory Committee Webpage

THE WEBPAGE HAS BEEN UPDATED TO INCLUDE THE FOLLOWING SECTIONS: ABOUT THE COMMITTEE, COMMITTEE MEMBERS, UPCOMING AND PAST MEETINGS, RESOURCES, AND CONTACT US.



MN DCT Advisory Committee Webpage (cont.)

THE UPCOMING MEETINGS SECTION INCLUDES INFORMATION ON UPCOMING MEETINGS AND THE PROCESS, RULES, AND EXPECTATIONS FOR PROVIDING PUBLIC COMMENT DURING A MEETING.

Upcoming Meetings

Date: Friday, Feb. 27, 2026
Time: 9 a.m.
Place: Minnesota State Capitol, 75 Dr. Rev. Martin Luther King, Jr. Blvd, St. Paul, MN. 55155
Room: 123
Download the agenda.

To Attend the Meeting Remotely by Zoom

One tap mobile: US: +13092053325,,96020780410#,,,,*572318# or +13126266799,,96020780410#,,,,*572318#
Meeting URL: **https://healthmanagement.zoom.us/j/96020780410?pwd=o9aVBtdKHu4Z97NYAluGaMeb11JIYo.1**
Meeting ID: 960 2078 0410
Passcode: 572318

To Provide Public Comment During an Upcoming Meeting

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

- Members of the public who would like to comment must submit this form. Please note that commenters must submit the form at least three business days prior to the next meeting.
- Comments are limited to topics within the DCT Advisory Committee's scope. Each speaker is allotted a fixed amount of time (e.g., 2-3 minutes), depending on the number of registered speakers.
- Committee staff review submissions for completeness and relevance. Staff send a confirmation email to individuals who request to comment no later than 48 hours prior to the meeting date and time with the status of their comment request. For commenters

MN DCT Advisory Committee Webpage (cont.)

VISITORS CAN ALSO VIEW PAST MEETING AGENDAS AND MINUTES AND CONTACT THE COMMITTEE OUTSIDE OF MEETINGS VIA THE FORM AT THE BOTTOM OF THE PAGE.

DCT Advisory Committee

The Direct Care and Treatment (DCT) Advisory Committee, established under state law, provides a venue for a broad range of stakeholders to advise the DCT Executive Board on agency operations, including practices and priorities, promoting transparent decision-making and continuous system improvement. It offers a forum for stakeholders to share guidance and insight on DCT programs and operations, helping ensure that services remain responsive, effective, and informed by the people they impact.

- ⊞ About the Advisory Committee
- ⊞ Committee Members
- ⊞ Upcoming Meetings
- ⊟ Past Meeting Agendas and Minutes
  - Download the Jan. 14, 2026 meeting agenda
  - Download the Jan. 14, 2026 meeting minutes
- ⊞ Resources
- ⊟ Contact the Advisory Committee

Do you have questions or concerns about Direct Care and Treatment? The DCT Advisory Committee would like to hear from you. Submit this form and we'll be in touch soon.

MN DCT Advisory Committee Webpage (cont.)

COMMITTEE MEMBERS CAN DETERMINE WHAT INFORMATION THEY WANT INCLUDED ON THEIR MEMBER SECTION (E.G., LINK TO A WEBPAGE OR LINKEDIN PAGE, CONTACT FORM, ETC.)

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⊕ About the Advisory Committee

⊖ Committee Members

These are the members of DCT's Advisory Committee and the organizations they represent:

Sen. John Hoffman, representing the Minnesota Senate

Sen. Paul Utke, representing the Minnesota Senate

Rep. Bianca Virnig, representing the Minnesota House of Representatives

Rep. Dave Baker, representing the Minnesota House of Representatives

Ramsey County Commissioner Tara Jebens-Singh, representing the Association of Minnesota Counties

Marcus Schmit, representing the National Alliance on Mental Illness, Minnesota Chapter

Jessica Langhorst, representing organized labor

James Carlson, representing people (or their families) with lived experience being served by state-operated treatment programs

Jim Postier, representing people (or their families) with lived experience being served by state-operated treatment programs

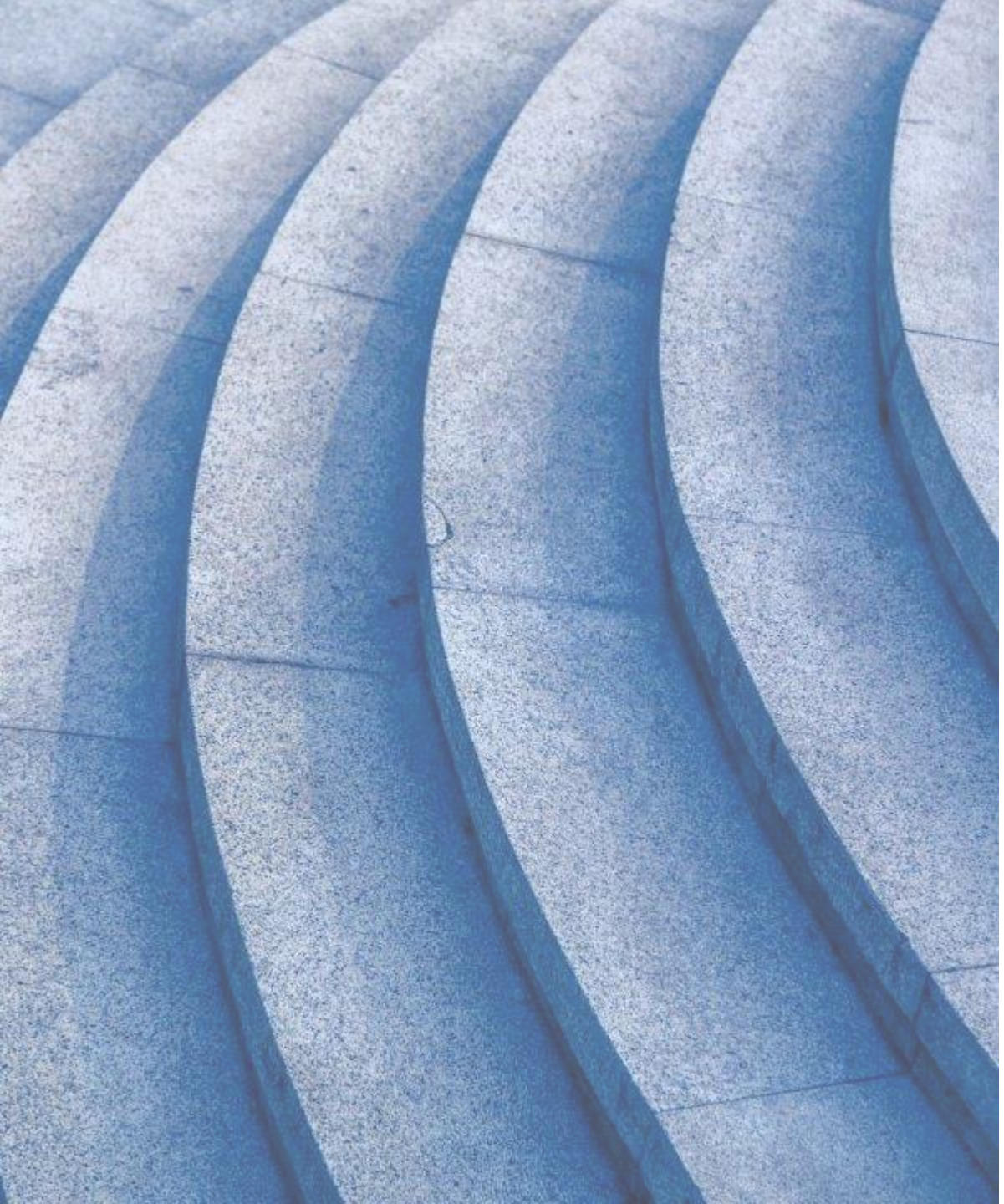
Open Comment Period

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



Wrap Up and Next Steps

- **Upcoming Meetings**
  - March 13, 2026, from 1:00-3:00 pm CT
  - April 24, 2026, from 9:00-11:00 am CT
  - 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)