MINNESOTA DIRECT CARE AND TREATMENT ADVISORY COMMITTEE MEETING MINUTES

Meeting Information

- **Date and Time:** Friday, April 24, 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 a virtual meeting available via Zoom
- **Direct Care and Treatment (DCT) Advisory Committee Attendees:** Chair Dave Baker; Vice Chair Bianca Virnig; Senator John Hoffman; Senator Paul Utke; Commissioner Tara Jebens-Singh; Jessica Langhorst; James Carlson; and Jim Postier
- **DCT Advisory Committee Facilitators:** Jill Kemper and Danielle Swanson, Health Management Associates (HMA)
- **Speakers:** Jeshua Livstrom, DCT Chief Compliance Officer; Terra Carey, DCT Chief Quality Officer; Marshall Smith, Chief Executive Officer (CEO), DCT; Dan Storkamp, External Relations Executive Director, DCT

Meeting Summary

- **Welcome**
    - Chair Dave Baker welcomed members to the April MN DCT Advisory Committee meeting before turning the time over to the speakers to present on Quality and Compliance processes at DCT.
- **Presentation: Quality and Compliance**
    - Jeshua Livstrom, DCT Chief Compliance Officer, provided an overview of DCT's contracting, procurement, and corporate compliance processes. (*Note: information found on slides is not repeated in the minutes below - see slides 3-12 below for those details*.) Livstrom emphasized the importance of clearly defining "corporate compliance" in the DCT context, explaining that for DCT it covers ethics, adherence to statewide and internal policies, non-clinical operations, and fiscal controls, with the quality program addressing clinical operations in parallel. Functionally, compliance work includes risk assessment, auditing, monitoring, ethics program development, and hotline management. He explained that DCT's compliance program is structured around a federally required framework and is not optional.

- As a billing entity, DCT is obligated to maintain an effective compliance program, and Livstrom described his team's role as ensuring the framework is fully integrated into DCT's organizational structure rather than existing as a standalone function. He stressed that governance and oversight mechanisms are still evolving as DCT continues operating as an independent agency, including the development of formal committees, workgroups, and subcommittee structures tied to compliance oversight. Livstrom highlighted that compliance training occurs at multiple levels. While statewide mandated training provides a baseline, DCT also conducts agency-specific and issue-driven training. DCT uses a mix of communication methods, including on-site postings, to ensure staff know how and where to report concerns. Livstrom also explained that DCT's primary mechanism for fraud prevention and reporting is a hotline that is available not only to employees but also to external partners and the public. All reports are reviewed by a multidisciplinary team, and fraud prevention is reinforced through policies, training, discipline, and leadership messaging. He described ethics oversight, conflict-of-interest disclosure, and open communication as key cultural components of fraud prevention. He also spent time distinguishing DCT's fraud risk profile from that of other state agencies. He explained that many high-profile fraud cases involve agencies that distribute funds as pass-through entities or administer grants. DCT, by contrast, does not administer grants and primarily functions as a direct service provider, which materially changes its risk exposure. While fraud risk is not eliminated, it more closely resembles that of other direct government service organizations rather than payer or grant-distribution agencies. He specifically noted that risks such as self-referrals or incentive-driven billing abuses are far less prevalent in DCT's structure. Livstrom then clarified procurement and contracting terminology and explained that within state government, procurement of goods and general services is distinct from contracting for professional or technical services. He described how statutory requirements shape how contracts are sourced and how heavily DCT relies on contracts negotiated by centralized state agencies rather than sourcing independently. He outlined that because many purchases flow through centrally managed contracts, DCT's internal procurement team is structured differently from its professional and technical contracting team. He also described circumstances where DCT must independently source contracts, including specialty services and payer-provider agreements related to Medicaid, Medicare, and private insurance. Livstrom explained that, as a state agency, DCT is generally required to competitively source contracts, though limited exceptions exist. He described how single-source contracts are permitted only when a sole provider is available and must be justified and approved. He also discussed the use of emergency authority contracts, noting that DCT relies on these more than many agencies due to its 24/7 operations and the risk to client safety if services lapse, particularly in rural areas where the supply of providers is limited.

- Finally, Livstrom emphasized the importance of master contract programs as a tool that allows DCT to access vetted vendors quickly without lengthy solicitations. Because full competitive processes can take months, master contracts are often the first option DCT explores to meet urgent or specialized needs. He also noted that DCT maintains internal master contract arrangements for certain medical professionals and consultants.
    - Chair Baker asked whether, given DCT's closed operating system, the primary fraud risks are related to internal purchasing or accounting issues, and whether DCT has experienced such problems. Livstrom stated that DCT has not experienced significant issues in this area. He noted that internal controls are strong and include clear segregation of duties across requisitioning, approval, purchasing, and payment. He referenced a recent audit of DCT's purchasing card program that found no deficiencies. He also identified staffing shortages or pressure to collapse roles as a potential future risk, but stated this is currently monitored and controlled.
    - Chair Baker also inquired if there are opportunities to streamline procurement and contracting requirements while maintaining safeguards, particularly to avoid discouraging local or small vendors. Livstrom agreed there are opportunities for improvement. He noted that many purchasing thresholds have not been adjusted for inflation in over a decade, making routine procurements more complex than necessary. He cited limited flexibility tools already in use but emphasized that outdated thresholds contribute to inefficiency, especially for common services like snow removal or lawn care. He stated that raising certain thresholds could allow faster access to services without compromising oversight and expressed confidence that central state agencies would be supportive of such discussions.
    - Jim Postier asked how difficult it is for vendors to become part of state master contract programs, and whether the closed nature of these lists contributes to higher costs. Livstrom explained that master contract programs are typically rebid at least every five years, providing vendors with periodic opportunities to enter or re-enter pools. He acknowledged that state prices can sometimes exceed private-sector pricing due to insurance, compliance, and contractual requirements, but suggested that large price disparities are more likely exceptions than norms.
    - Jessica Langhorst asked if DCT could rely more on state employees for services like snow removal or maintenance, and inquired if DCT could use labor agreements to ensure fair wages when contracting. Livstrom confirmed DCT's coordination with state agencies on construction and facilities requirements. He noted that wage and labor agreement requirements are often applicable, but stated he would need to confirm specifics before answering definitively.

        - Vice Chair Bianca Virnig asked if DCT has seen an increase in emergency or single-source contracts compared to past years. Livstrom stated that he has not observed a significant increase during his tenure at DCT. Instead, he noted increased reliance on master contracts as a way to access services quickly without overusing emergency or single-source authorities.
    - Terra Carey, DCT Chief Quality Officer, then provided an overview of DCT's quality processes, as well as a Malcolm Baldrige update. (*Note: information found on slides is not repeated in the minutes below - see slides 13-22 below for those details*.) Carey explained that DCT's quality system has evolved over 10–15 years and was intentionally designed to balance central oversight with service-line flexibility. She described how quality work that was once organized by specialty has shifted to align by service line, allowing quality processes to be tailored to the unique clinical, licensing, and operational realities of each program while still operating within a shared organizational framework. She highlighted that this structure supports day-to-day care delivery by ensuring appropriate processes are in place without creating unnecessary administrative burden. Some service lines have direct quality reporting relationships, while others operate through an indirect or matrixed model due to regulatory requirements. Carey emphasized that every division and work area, including non-clinical functions, participates in quality assurance activities, which supplement corporate compliance efforts and are reported annually to executive leadership. She noted a distinction between quality and compliance, describing quality as focused primarily on how care is delivered and experienced, while compliance focuses more on the business and regulatory aspects of healthcare. These functions are designed to complement one another, reinforcing both safe care delivery and organizational accountability. Carey also noted that DCT maintains a formal quality assurance plan that is regularly reviewed and updated and connected to broader organizational policies, governance structures, peer review processes, and service evaluation. She shared that the quality plan was recently renewed to reflect DCT's separation into an independent agency and the transition from a commissioner-led model to a board-governed structure. Because the quality systems were already well-established, this governance shift required refinement rather than redesign. Carey emphasized that DCT's quality approach is centered on continuous learning and described mechanisms for identifying issues, tracking trends, and ensuring corrective actions focus on improving systems rather than assigning blame. She stressed the importance of encouraging staff at all levels to report concerns and issues, noting that leadership values high levels of reporting as an indicator of a healthy quality culture. Carey also discussed how DCT's quality and planning efforts are aligned with broader organizational strategy. She described quality, safety, and improvement work as foundational to strategic planning, helping ensure that improvement efforts across programs and projects move in the same direction and remain focused on patient and

client outcomes. She noted that DCT provides multiple opportunities for internal and external stakeholders to engage in strategic planning activities, both in-person and electronically.

- Discussion following the overview included:
  - Committee members asked how DCT evaluates and manages coordination with external entities, such as counties, courts, jails, and community-based systems, given that patients and clients are defined as DCT's primary customers, but admissions and discharges occur within a broader multi-system environment. Carey responded that evaluation of coordination with external partners is explicitly part of DCT's quality framework and that quality work includes ongoing assessment of how DCT interacts with other systems involved in admissions, care transitions, and discharges. She emphasized that quality improvement is not static and requires continuously reevaluating how partnerships function and where coordination can be strengthened to better support patient and client outcomes.
  - Commissioner Tara Jebens-Singh shared feedback from stakeholders who perceive strategic planning and performance frameworks as resource-intensive management exercises and question how these efforts directly support frontline care and client outcomes. Carey acknowledged this concern and noted that strategic planning is foundational to DCT's quality improvement approach. She explained that industry-standard frameworks are intended to help organizations continuously evaluate and improve systems, not to pursue recognition or awards. She stated that these frameworks can sometimes be misunderstood as goal-oriented toward external validation rather than internal improvement and agreed that clearer communication is needed to help stakeholders understand how quality frameworks and strategic planning efforts translate into tangible improvements in care delivery and organizational performance.

- **DCT Executive Board Updates**
  - Carol Olson, Chair of the DCT Executive Board, provided a brief update on the Board's status and activities. She noted that the Board has been formally operating for less than one year (since July 1, 2025) and is continuing to learn and orient itself to the size, scope, and complexity of DCT and its programs. Drawing on her prior experience at DCT, including her role as Executive Director for Forensic Services in St. Peter before retiring four years ago, Board Chair Olson emphasized that the Board brings institutional knowledge while continuing to build its understanding of current operations and challenges. She shared that the Board has established two standing work groups, Quality & Compliance and Finance, to allow for deeper review of complex issues outside regular Board meetings. She indicated that questions raised by Advisory Committee members, particularly regarding procurement and contract efficiency,

would be taken up by the Finance Workgroup. Board Chair Olson noted that several Advisory Committee members are participating in DCT's strategic planning process, with the full Board expected to review and approve the final plan. She also highlighted the Board's commitment to ongoing education, including participation in external conferences such as those hosted by the Minnesota Association for the Treatment and Prevention of Sexual Abuse and the Minnesota Hospital Association. Finally, Board Chair Olson added that recent education topics have included health equity and workforce development, and that the Board recently formalized a more structured public comment process, anticipating increased public engagement.

- Marshall Smith, CEO, DCT, then provided an update focused on governance alignment, organizational performance, operational transitions, workforce conditions, financial stability, and technology modernization. (*Note: information found on the DCT Executive Board Meeting, April 16, 2026 summary is not repeated in the minutes below - see pages 30-41 for those details*.) Smith summarized the April meeting with the Executive Board and Advisory Committee chairs and vice chairs to align roles and expectations among the Executive Board, the Advisory Committee, and the CEO, while clarifying how each supports DCT's mission. Smith noted that discussions were intended as a starting point, not final determinations, and were meant to foster clearer collaboration while preserving the CEO's operational oversight authority. Smith then noted progress within each of DCT's five strategic pillars: Quality, Service, People, Financial, and Technology. Smith reiterated that DCT's quality systems are enabling strong regulatory performance and advancement through organizational improvement frameworks. He stressed that this work is not focused on awards, but on continuous improvement. He discussed the CARE (Chemical Addiction and Recovery Enterprise) program, including challenges with obtaining a secure leased space despite attempts with a potential lessor, necessitating a temporary suspension of services. To preserve the workforce, DCT is placing CARE staff into existing programs so they remain available for future CARE expansion.
    - Chair Baker inquired how many patients were being served at CARE Anoka, how many staff are affected, and what the transition involves. Smith shared that CARE Anoka served about 16 patients per day and employed close to 50 staff. All affected staff have been placed into other DCT roles, which leadership views as a success in workforce preservation. A long-term CARE location is in progress but not yet finalized.
- Smith reported notable improvement in workforce metrics, stating DCT currently has some of the best vacancy and turnover rates of his tenure, with vacancy rates reduced by approximately 12%, though he emphasized that legislative funding is critical to sustaining staffing levels. He shared that DCT remains financially stable, with a projected positive year-end position, supported by disciplined cost management and improved cash reserves, particularly in Community Behavioral Services (CBS). Finally, Smith noted that DCT continues implementation of its electronic health record (EHR),

with current efforts focused on system optimization and user adoption. He emphasized that technology requires ongoing investment, noting EHR funding is essential to sustained operations.

- Chair Baker asked how paid family and medical leave requirements were affecting staffing, overtime costs, and operations across DCT. Smith stated that paid leave is significantly impacting staffing, particularly in 24/7 care settings where absences must be replaced. In March alone, DCT used over 30,000 hours of FMLA, equivalent to roughly 180–200 FTEs, with January showing similar levels. These hours typically require overtime coverage due to limited funded positions. Despite staffing pressures, Smith noted that DCT has maintained 90–95% occupancy, with fluctuations driven more by patient acuity than staffing shortages. He credited workforce dedication, particularly in forensics and AMRTC, noting staff consistently step up, even when mandatory overtime is required under union contracts. Langhorst shared that during the COVID pandemic, they were able to prove that they could operate with 20% fewer staff, but emphasized that staff should be compensated appropriately for sustained workload increases. Smith agreed and added that while staff continue to meet demands, he has ongoing concerns about staff burnout.

- **DCT Advisory Committee Business**
  - Chair Baker opened the meeting for discussion on upcoming meeting dates. The Committee members confirmed plans for a June site visit to the Moose Lake facility, including structured tours in small groups to remain compliant with open meeting requirements, followed by an Advisory Committee meeting, which will be open to the public via Zoom only. Chair Baker acknowledged the complexity of MSOP and highlighted that it would likely be a focus of many Advisory Committee discussions and feedback, which is why it was chosen for the first Committee site visit. Chair Baker reminded Committee members about the option for travel/mileage reimbursement, reminding them that they would need to complete the DCT reimbursement form (available by contacting Jill, Dani, or Dan after the meeting). Additional approval forms related to the site visit will also be sent to Committee members ahead of the tour.
    - Committee members requested advance materials and context-setting to ensure the visit goes beyond an introductory overview and allows for informed observation and questioning. Committee members also inquired if they would be able to speak with residents of the Moose Lake facility. DCT leadership agreed to work with staff to provide background materials ahead of the visit and to explore opportunities for Committee members to hear directly from residents or clients, where feasible and appropriate. DCT leadership also encouraged Advisory Committee members to send any questions in advance of the meeting so they can be appropriately addressed.

- Following discussion of member availability, the committee reached consensus to cancel the July meeting due to competing priorities during the summer. The Committee noted that weekday meetings outside of legislative session may be easier to accommodate and agreed to reschedule the August meeting to August 26, 2026. Members tentatively agreed that it would take place at the St. Peter facility (DCT leadership noted that they would confirm availability).
- Finally, Committee members requested to include a walkthrough of DCT's admissions and waitlist dashboards at a future meeting to better understand system flow and capacity pressures. DCT leadership supported this request and noted they could facilitate this presentation as needed.

- **Open Public Comment**
  - Chair Baker introduced the public comment segment of the agenda and welcomed two commenters who had previously signed up to comment. The comment summaries are provided below.
    - Michael Lotti provided comment on the Minnesota Sex Offender Program (MSOP). Lotti began by commenting on the MSOP release rate and death rate, both of which he described as terrible. Lotti critiqued MSOP therapy techniques, noting that therapy processes include residents meeting individually with a clinician once every two weeks (noting it is sometimes less) and participating in a one-to-two-hour large group therapy session each week, in which individuals may not be able to speak due to group size. Lotti also noted high clinician turnover rates and stated that many clinicians are not licensed. Lotti noted that, conservatively, ~80 hours per week were unstructured time, as there are no vocational programs at MSOP and very few educational programs. Lotti stated that MSOP staff do not advocate client release per institutional policy, regardless of behavior or participation. Lotti stated that MSOP does not offer adequate therapy, instead fostering an antitherapeutic environment. He said that nearly 75 of the 750 MSOP detainees have been in residence for 11 years or more, and nearly 50% have been there more than 16 years. Lotti urged the Advisory Committee to recommend an external audit of MSOP's therapeutic structure and delivery led by leaders of other sex offender programs around the country with higher rates of success. He also encouraged the Advisory Committee to meet with MSOP residents who were not pre-chosen by DCT staff during the upcoming visit to the Moose Lake facility.
    - Cass O'Brien began by alleging violations of Minnesota statute 253D.35, which mandates that MSOP shall provide case management services to every committed person. O'Brien noted that the DCT administration claims to provide these services but refuses to assign actual case managers legally required to facilitate the court process. O'Brien stated that the judicial system is being blinded and that constitutional rights are being bypassed by administrative

neglect. O'Brien asked how DCT justifies awarding executive compensation packages exceeding $600,000.00 when the administration is currently defying the judicial regulations by making MSOP clients wait an average of 600 days for court order transfers. O'Brien highlighted that only 34 full discharges have occurred in MSOP history, stating that the MSOP mortality rate has nearly tripled its success rate. They stated that MSOP staffing is overwhelmingly dominated by security councils, rather than clinical therapists, diminishing it as a treatment facility. O'Brien stated that the current process related to 253D.35 violates state law and is failing Minnesota taxpayers, families, and victims. They asked that the Advisory Committee further assess executive salaries and DCT adherence to state law, as well as formally refer their concerns to the Office of the Legislative Auditor and the Minnesota Department of Health.

    - Chair Baker thanked the commenters and transitioned to the meeting close.
- **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 Friday, June 26, 2026 at the Moose Lake facility (see details above).

Minnesota Direct Care and Treatment:
Advisory Committee Meeting

APRIL 24, 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. Presentation: Quality and Compliance
3. DCT Executive Board Updates
4. DCT Advisory Committee Business
5. Open Public Comment
6. Wrap Up and Next Steps

DIRECT CARE AND TREATMENT

DCT Contracting, Procurement, and Corporate Compliance

Jeshua Livstrom| DCT Chief Compliance Officer

Introduction and Agenda

1. Personal intro
2. What is Corporate Compliance
3. Oversight and source framework
4. Fraud prevention and reporting mechanisms
5. Procurement and Contracting
    1. Legal, policy and oversight framework
    2. Competitive sourcing and exceptions

What is corporate compliance?

- Subject matter: ethics, statewide and organizational policy compliance, nonclinical operations, fiscal controls
- Functions: Risk assessment and management, auditing and monitoring, ethics, hotline operations

7 elements of an effective compliance program

1. Written Policies and Procedures
2. Compliance Oversight and Structure
3. Conducting Effective Training and Education
4. Developing Effective Lines of Communication
5. Enforcing Standards Through Well Publicized Disciplinary Guidelines
6. Risk Assessment, Auditing, and Monitoring
7. Responding to Detected Offenses and Developing Corrective Action Initiatives

Source Framework

- U.S. Department of Health and Human Service, Office of Inspector General, General Compliance Program Guidance, updated November 2023 / Affordable Care Act

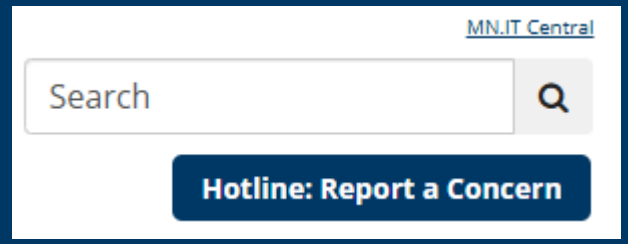
- United States Department of Justice, Sentencing Guidelines, Evaluation of Corporate Compliance Programs, updated September 2024

Key state-level oversight

- Office of Legislative Auditor
- Minnesota Management and Budget
- Department of Administration

Fraud prevention and reporting

- Hotline available to report fraud, waste, abuse, and misconduct
- Fraud prevention is integrated through the 7 elements of an effective compliance program
- Ethics and conflict of interest disclosure
- Internal messaging and culture
- Nuances about fraud risk in DCT and other state agencies



Complaints and Accommodations

- Use the **DCT Hotline** to report suspected waste, fraud, abuse or misconduct.
- Report harassment or discrimination
- Request an accommodation
- See more on the Compliance webpage

Procurement and contracting

- Procurement and Acquisitions: Equipment, supplies, commodities, and general services (e.g. custodial, window washing, snow removal)
  - Contracts are primarily driven by Department of Administration
- Professional/technical services: Discretionary services (e.g. medical, consulting, facilitation); also includes joint powers agreements, interagency agreements, income agreements
  - Contracts are primarily driven by DCT, with Department of Administration oversight
- Payer/provider agreements
  - Contracts are primarily driven by DCT

Sourcing

- Competitive sourcing: Requests for Proposals (RFPs) and Requests for Bids (RFBs)
- Master contract programs: Department of Administration, Minnesota Management and Budget, DCT
- Single source contracts
- Emergency Authority contracts
- Income agreements

DIRECT CARE AND TREATMENT

Thank You!

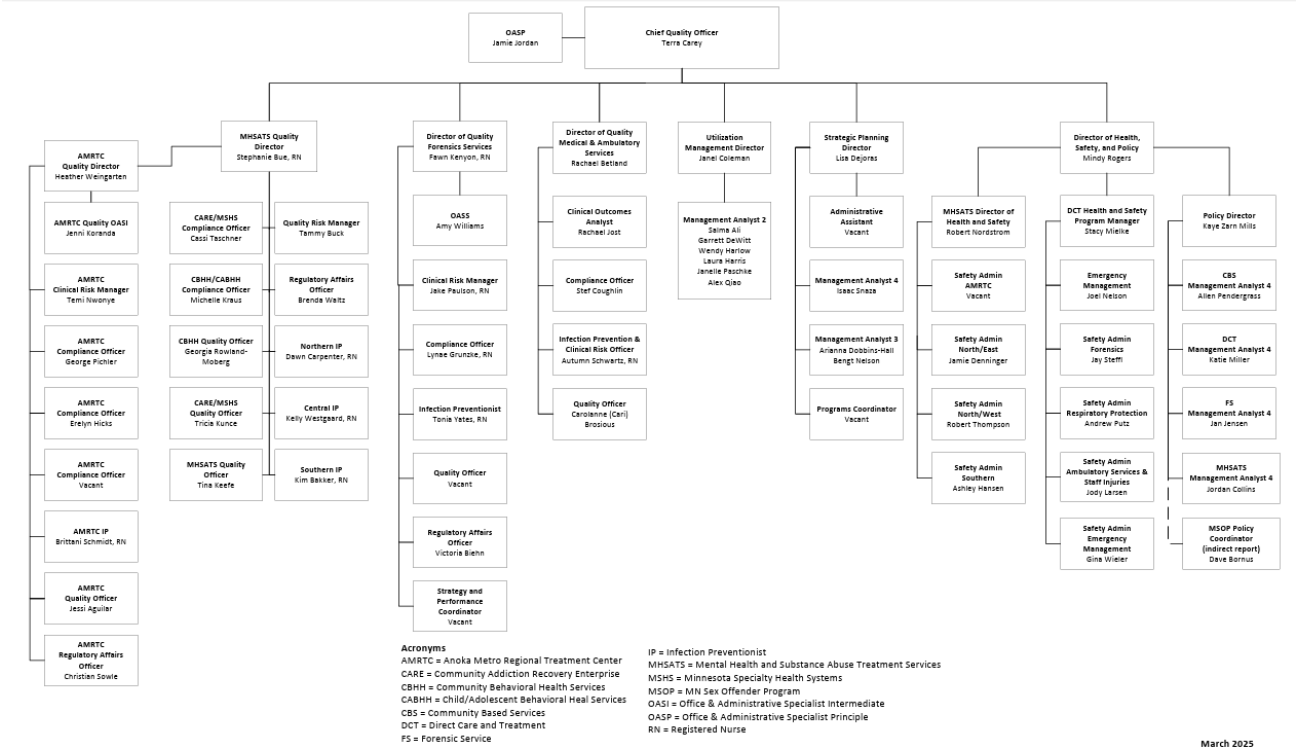
DIRECT CARE AND TREATMENT

DCT Quality and Malcolm Baldrige Update 4.24.26

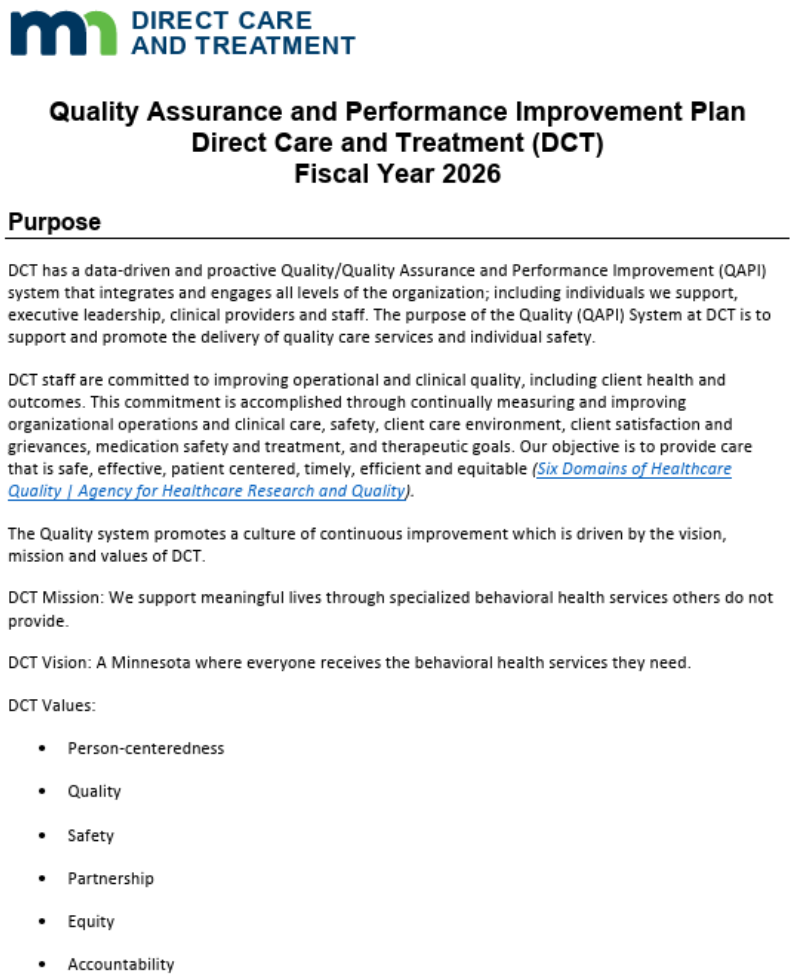
Terra Carey| DCT Chief Quality Officer

Quality Structure

- Matrixed approach with Centralized SME's and Guidance, with decentralized approach to individualized QAPI/Quality programs based on service line needs
- Direct Reporting for MHSATS, Outpatient, and FS Quality Programming
- Within each program includes either direct staffing of the dimensions outlined in the QAPI Plan, or indirect framework and integration into the overall Quality Management System.
- Every division/work area of the organization engages in quality assurance review and reporting to the DCT Executive Committee using the six domains of quality as a framework for evaluation and reporting.



Quality Plan & Assessment



DIRECT CARE AND TREATMENT

Quality Assurance and Performance Improvement Plan
Direct Care and Treatment (DCT)
Fiscal Year 2026

Purpose

DCT has a data-driven and proactive Quality/Quality Assurance and Performance Improvement (QAPI) system that integrates and engages all levels of the organization; including individuals we support, executive leadership, clinical providers and staff. The purpose of the Quality (QAPI) System at DCT is to support and promote the delivery of quality care services and individual safety.

DCT staff are committed to improving operational and clinical quality, including client health and outcomes. This commitment is accomplished through continually measuring and improving organizational operations and clinical care, safety, client care environment, client satisfaction and grievances, medication safety and treatment, and therapeutic goals. Our objective is to provide care that is safe, effective, patient centered, timely, efficient and equitable (*Six Domains of Healthcare Quality | Agency for Healthcare Research and Quality*).

The Quality system promotes a culture of continuous improvement which is driven by the vision, mission and values of DCT.

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

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

DCT Values:

- Person-centeredness
- Quality
- Safety
- Partnership
- Equity
- Accountability

- DCT has a Quality Plan connected to the Quality Systems policy which outlines the ways in which DCT engages in a robust quality program throughout the organization-being updated to reflect the updates to governance as part of separation work
- There are many components to the policy and linkage to various organizational policies including client evaluation of services, governance, and peer review processes

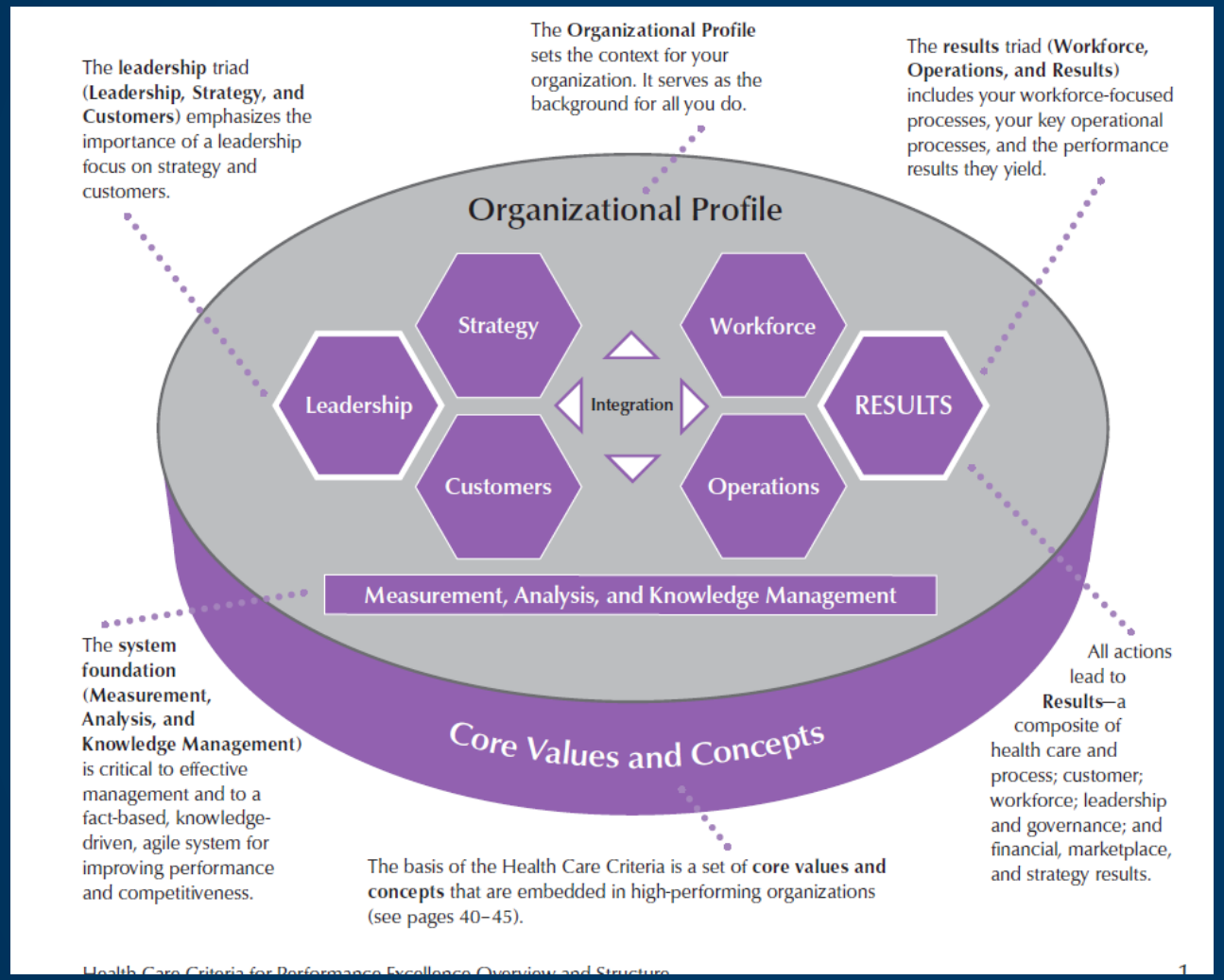
Key Components

- Focused, benchmarked plans and approaches to Quality:
  - Quality Plan
  - Annual Assessments
  - Event Reviews and Incident Reporting
  - Continuous (Performance) Improvement
  - Framework: Malcolm Baldrige
- Peer Review and Risk Management
  - Standard prompts to reviews and processes
  - Collaborative with staff and leaders to build critical evaluation and detection skills
- Quality Assurance and Corrective/Preventative Actions
- Quality Structure and Tracking

Culture

- Celebrate Success and Innovation, while “preoccupation with failure” (High Reliability model)
- Collaboration between systems to supplement traditional “performance management” with Just Culture development.
- Curious in exploring how people provide care and work within their work systems-always looking to improve
- Reporting and Amplification of issues and concerns

Health Care Criteria for Performance Excellence Overview and Structure



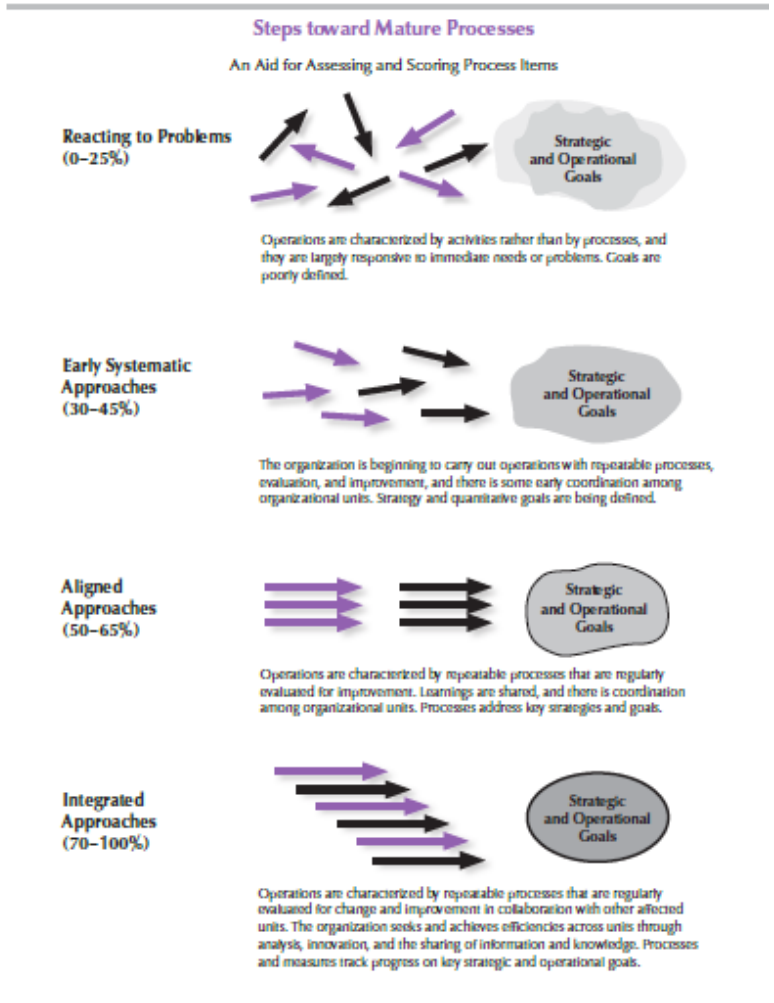
- Fully integrated around key processes
  - Admission
  - Treatment
  - Discharge
- Guided by our core values and concepts-our Mission!
- Supported by Quality Systems

Malcolm Baldrige

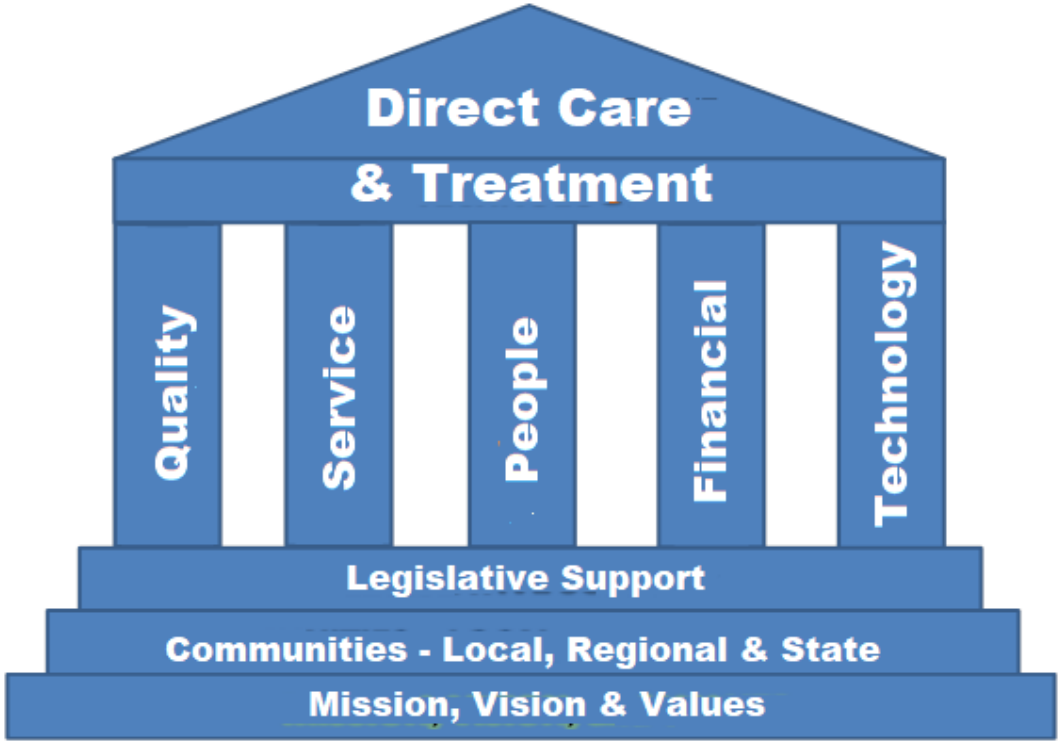
	Option 1	Option 2	Option 3
Depth of Evaluation (Baldrige Questions)	Organizational Profile (2 general topics, approximately 15 questions); click here to download the Excellence Builder and flip to the Organizational Profile questions	Organizational Profile plus Basic and Overall Level questions (19 general item topics, approximately 90 questions); click here to download the Excellence Builder and answer all questions in the Profile plus bold questions in each Category	Organizational Profile plus Basic and Overall questions plus Multiple Level questions (19 general topics, approximately 270 questions); click here to purchase/download a copy of the Business/Nonprofit, Healthcare, or Education Baldrige Criteria and answer all questions
Award Eligibility	Commitment	Engagement, Advancement, or Achievement	Advancement, Achievement, or Excellence
Application Length	7 pages	30 pages	55 pages
Focus Areas	Organizational Alignment Improvement Orientation	Level 1 plus Systematic Processes Fact-Based Evaluation & Improvement Key Results/Outcomes	Levels 1-2 plus Organizational Systems Some Innovation High Performance Results
Feedback Guidelines	Summary of findings ("Highlights and Considerations") No scoring	Strengths and OFIs at Overall Level Scoring ranges	Strengths and OFIs at Multiple Level Scoring per Baldrige Item
PEN Team, Process	• 2 Evaluators • No site visit (optional Improvement Planning session) • 90-day cycle time	• 3-5 Evaluators • 1-2 day site visit • 120-150 day cycle time	• 6-10 Evaluators • 3-4 day site visit • 150-180 day cycle time
Investment**	$1000 member ($2K nonmember)	Small/Medium: $3K ($6K nonmember) Large: $5K ($10K nonmember)	Small: $8K ($12K nonmember) Medium: $12K ($16K nonmember) Large: $16K ($20K nonmember)
Deadlines (all levels)	Cycle 1 (Spring/Summer): Letters of Intent due March 1; Applications due May 1 Cycle 2 (Summer/Fall): Letters of Intent due June 1; Applications due August 1 Cycle 3 (Fall/Winter): Letters of Intent due September 1; Applications due November 1		

Malcolm Baldrige and Strategic Planning Systems

- Structured approach to review and Strategic Plan Development
- Grown and matured, and continues to evolve and change as competencies and the program advances
- Part of overall initiatives to systematize Project Portfolios, align with Continuous Improvement work and support the organization



Our Five Pillars of Excellence



- DCT's five Pillars of Excellence are Quality, Service, People, Financial and Technology.
- The five Pillars are a framework for prioritizing our goals and plans. Each pillar supports a strategic result (or desired outcome) that is reached by developing objectives.
- The pillars support the DCT health system and ensure excellent care and programming for patients and clients statewide.
- Thank you to those who have engaged in the planning for this cycle of planning.

DIRECT CARE AND TREATMENT

Thank You!

DCT Executive Board Updates and Strategic Planning Overview

Dan Storkamp, DCT External Relations Executive Director

DCT Advisory Committee Business

MN DCT Advisory Committee Business

Advisory Committee to review and discuss the following items:

- **Upcoming meeting cadence and agenda planning**
  - Confirm June Moose Lake visit details
  - Discuss upcoming meeting cadence
- **Additional Advisory Committee business**

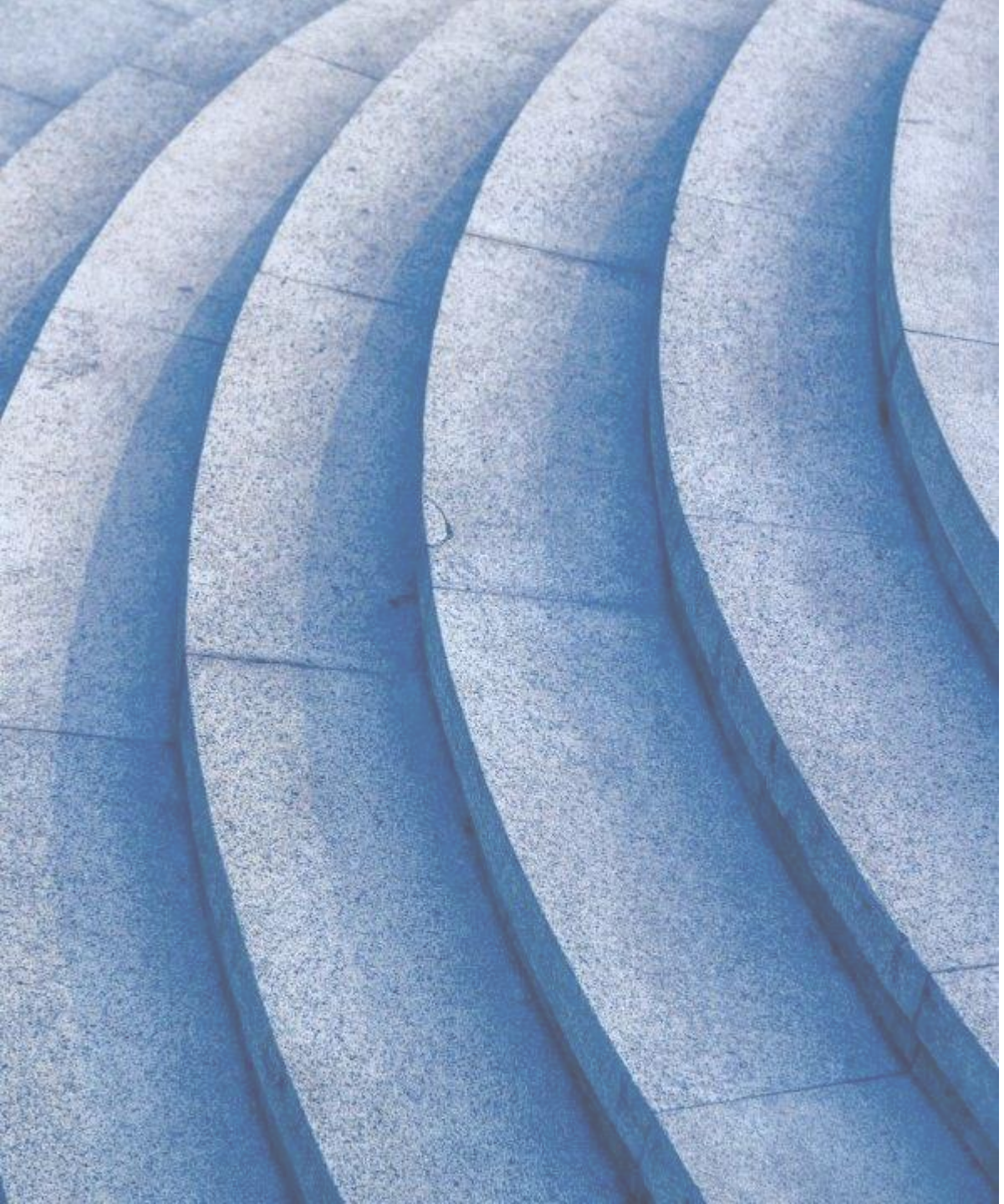
Open Comment Period

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**
  - June 26, 2026
  - 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)

DIRECT CARE AND TREATMENT

DCT Executive Board Meeting
April 16, 2026

DCT Health System CEO Update

Executive Summary

- DCT continues to demonstrate steady progress across our strategic pillars of Quality, Service, People, Financial Stewardship, and Technology.
- This month reflects strong regulatory performance, continued workforce stabilization, advancement of major capital projects, and disciplined financial management. At the same time, we remain focused on operational risks tied to workforce capacity, program transitions, and compliance-related billing interruptions.

Strategic Pillar Overview

Quality

Baldrige & Performance Excellence

- DCT remains actively engaged in the Malcolm Baldrige process, with key milestones occurring in April, including application review outcomes and evaluator engagement.
- Staff participation in national and regional conferences continues to strengthen internal capability in changing and developing leadership, system thinking, and customer experience alignment.
- Planning is underway for the Annual Excellence Conference (September 22), with strong engagement reflected in employee award nominations and Quality Fair submissions.

Regulatory

- Recent reviews across multiple programs (including CARE and MHSATS) resulted in minimal findings and strong overall performance.
- No significant regulatory concerns or inquiries reported in MSOP or CBS this month.

Key Takeaway: Quality systems remain stable and improving, with external validation reinforcing DCT's performance trajectory.

Service

CARE Anoka Transition & Long-Term Planning

- Services at CARE Anoka will be suspended in May, with all regulatory requirements completed.
- Progress continues toward the St. Paul (Energy Park) facility, with lease execution anticipated in May and completion projected for Fall 2027.
- Interim workforce and patient transition planning is underway, including reassignment to AMRTC.

AMRTC Expansion

- Project remains on schedule, with demolition expected to begin May/June and completion in 2028.
- The organization is awaiting final confirmation regarding regulatory requirements tied to licensed bed capacity.

Key Takeaway: Major service transitions and capital investments are progressing as planned, with careful attention to continuity of care and workforce impact.

People

Workforce Trends

- Vacancy rates continue to improve (429 → 403 month-over-month), with a 12% reduction across critical roles over the past year.
- Time-to-fill remains competitive, though early signs of pressure are emerging in certain labor segments.

Workforce Capacity & Leave

- MN Paid Leave activity remains high, with 681 total applications across statuses.
- March utilization totaled 30,812 FMLA hours, reflecting ongoing workforce strain.

Recruitment Strategy

- Expanded sourcing strategies (digital platforms and direct outreach) are in place to address emerging gaps.

Key Takeaway: Workforce stabilization is trending positively, though sustained pressure from leave utilization and hiring timelines requires continued focus.

Financial

- Financial outlook remains stable and consistent with prior projections.
- Projected year-end balance for core service lines is approximately $3M positive, with personnel cost pressures offset by non-personnel savings.

- MSOCS cash position improved (57 → 62 days), though temporary billing suspension for vocational services due to documentation compliance is being resolved.
- Dental Services exceeded revenue expectations, improving cash reserves to 145 days.
- Continued monitoring of MN Paid Leave impacts, particularly related to overtime.

Key Takeaway: Financial performance remains stable, with manageable risks tied to personnel costs and compliance-related billing interruptions.

Technology

- Continued progress on Electronic Health Record (EHR) implementation, including:
- Alignment with NetSmart on system optimization
- Finalization of the FY27 roadmap focused on user experience and adoption
- Planning underway for a leadership summit (June) to support future legislative strategy (FY28–29)

Key Takeaway: EHR implementation remains on track, with increasing focus on usability and long-term strategic alignment.

Governance, Taskforces & External Engagement

- Priority Admission Report: Draft nearing completion; expected submission within weeks.
- MI & D Taskforce Report: Finalized and anticipated for legislative submission by end of April.
- No new updates in committee or cabinet representation this month.

Legal & Compliance

- Board members may receive Defense & Indemnification requests; guidance provided for review and follow-up.
- A comprehensive legal and risk overview will be presented at the May meeting.
- Compliance continues to focus on contracting and procurement readiness ahead of fiscal year close.

Key Takeaway: There are no immediate legal risks requiring Board action; increased visibility and structured reporting planned.

Closing

- DCT continues to execute effectively against its strategic priorities while navigating workforce pressures and major system transitions. The organization remains well-positioned operationally and financially, with clear focus on sustaining quality outcomes, supporting staff, and advancing long-term infrastructure investments.