Mayo Clinic Health System-Fairmont Closure of Inpatient Obstetrical Care, Inpatient Pediatric Care, and Surgical Procedures Units Public Hearing Transcript

OCTOBER 28, 2024

Meeting Information

The Minnesota Department of Health (MDH) held a public hearing at 6 p.m. October 28, on Mayo Clinic Health System (MCHS)-Fairmont's closure of its inpatient obstetrical care, inpatient pediatric care, and surgical procedures units.

According to the filed submission, MCHS will be consolidating and relocating these services to its Mankato campus.

More information can be found on the Mayo Fairmont Public Hearing page (https://www.health.state.mn.us/about/org/hrd/hearing/mayofairmont.html) of the MDH website.

Meeting Transcript

>> Stacy Sjogren (moderator): Good evening, welcome to the public meeting to hear from Mayo Clinic Health Systems, Fairmont and the closure of its inpatient obstetrical care, inpatient pediatric care, and surgical procedures unit. According to the filed submission, MCHS will be consolidating and relocating these services to its Mankato campus.

My name is Stacy Sjogren. I am a facilitator with MMB Management Analysis and Development, and I am serving as the moderator for this meeting. This evening's hearing will include both in person and virtual options and is hosted by the Health Regulation Division. We are gathered here in person in the large conference room at the Mayo Clinic Health System, Fairmont located at 800 Medical Center Drive in Fairmont Minnesota to provide a forum for the community to discuss the change in service at MCHS-Fairmont.

For this hearing, online participants will be muted until the public comment portion of the meeting. In the room participants, I am asking you to all stay quiet verbally and non-verbally to demonstrate your part in this respectful listening relationship. The panelists will honor you with the same respect when you are asking your questions. At that time, in person and online participants will be selected and allowed to speak. I will give all of you, whether you're in the room or participating remotely, more directions on how that is going to work when we get closer to that time.

If you don't wish to speak, you can ask your questions, if you are participating virtually, by doing that through the chat box and a Minnesota Department of Health staff person will ask the question on your behalf. If you are in the room and don't want to ask your question, perhaps you haven't heard somebody ask that same question and you have something unique that you still want to say, but saying it by myself, like, I don't want to do that. Your other option might be to take your phone, grab the QR code that may have been handed out when you were coming in, otherwise I've got one here and you can join the meeting that way. Go into the meeting and then just post your comment in the chat as if you were participating remotely. It's not a very elegant system, but it is better than if you are just not wanting to ask that question yourself. I get it.

A little bit more about that chat feature. The chat feature is used to provide information for the session. There will be information going out if you are participating remotely. There's the camera and it will be activated during that comment period. To open up that chat box, if you are participating remotely, click on the icon that looks like a cartoon speech bubble with two lines in it. If you are using the Teams in a browser window, the icons are at the bottom of the screen. If you are using the Teams app, the chat icon is the top right corner of your screen.

There are closed captions being provided for this event. You can view captions in Teams by clicking the "more" button, probably at the top right corner of your screen. It has three little dots. Click on that more button in the Team's window and choose "turn on live captions". You can also view the captions online at the address that is probably parked below on your screen right now. Or posted in the chat.

You can find out more information about today's meeting at the MDH website, which is also being posted in the chat. So, you should be able to click live on that link.

Now, If you are having technical issues, please visit the Microsoft Support page for Teams or email the HRD Communications team and that information, yes -- you guessed it, is probably being posted in chat right now.

To all of you, whether you are in person or participating remotely, I need to share with you something called a Tennessen Warning. It sounds very serious. It is just a helpful bit of information. The Minnesota Department of Health, I'll sometimes refer to them as MDH, is hosting this meeting which, is required by state law. The intention of this public meeting is to provide an opportunity for the public to express their opinions, share their comments, and ask questions about Mayo Clinic Health System on lowering its newborn nursery level of care – that's not right. About the changes that you are making -- thank you. I just found a typo.

The Minnesota Department of Health announced this meeting through a statewide news release and notified community leaders of the meeting. Maria, Do you recall when that notification went out?

>> Maria King (MDH): We put the notice out two weeks ago, last Wednesday, the 14th.

>> Stacy Sjogren (moderator): Thank you. So here is that Tennessen Warning. The Minnesota Department of Health is hosting this public hearing to inform the public as required by law. Your comment, questions, and image may be visible during this event. You are not required to provide this data, and there are no consequences for declining to do so. The virtual presentation may be accessible to anyone who has a business or legal right to access it. By participating, you are authorizing the data collected during this presentation to be maintained by MDH. MDH will be posting a transcript of this meeting to the MDH website within ten business days of this meeting. So, with that in mind, particularly for those of you that are participating remotely, if you need to opt out, that is fine. This would be a good time to do so.

All right, our agenda for today -- is that on the screen yet, Michael? If we could get the next slide. There we go. So here is what is going to happen tonight. We are going to start with some introductions and then I am going to be introducing the woman to my right here and you will be getting a welcome from the Health Regulation Division. We'll do an overview and then the Mayo Clinic Health System team is going to do a presentation. Then we will get to the public comments and again I will give you more information about how all that is going to work in detail when we get there. And then back over to the Mayo Clinic Health Systems team for some closing remarks and then a conclusion. Pretty straightforward.

Let's find out who all else is here. I alluded to Maria earlier. Maria's over here on my right. You'll hear throughout our time together tonight; she is going to help me keep the flow going. There are a lot of moving parts, so this is Maria King. Maria King is the Health Regulation Division Director for the Minnesota Department of Health.

Then over here on the panel, we have Dr. Prathibha Varkey, Christopher Hasse. Let me back up a second. Prathibha Varkey is the president of Mayo Clinic Health System and then Christopher Hasse is the Chief Administrative Officer for the Mayo Clinic Health System. Then we have Dr. James Hebl who is the Regional Vice-President for the Mayo Clinic Health System. Travis Paul down there is the Regional Chair of Administration, yes, for the Mayo Clinic Health System, then we have Lisa McConnell. Lisa is the Regional Chief Nursing Officer from Mayo Clinic Health System. And then, Dr. Gokhan Anil, who is the Regional Chair of Clinical Practice OB-GYN Physician for the Mayo Clinic Health System.

I introduced myself. You know Maria. So, Maria, I am going to step aside.

>> Maria King (MDH): I am Maria King. Thank you everybody for joining us tonight. This is our first time having a hybrid hearing and that is a result of legislative changes from the last legislative session. We are here tonight to talk about the changes that are going to be occurring at the hospital here in Fairmont and we want to hear your voice.

There were a lot of comments that came in ahead of time and we are going to try to consolidate some of those because we may be reading them for a long time. Tonight, we are going to read from each of them and then they will, in their entirety, be published on our website. Everyone will get to have their comments read or heard. They will all be available to the public.

I want to thank Stacy for being our moderator tonight. I really appreciate it. She does a great job. And I welcome all of you and the people that have tuned in online. The last number was 100 people or so. We have a good, robust group of people interested in this information this evening. We thank you for the time you are taking to learn more about the changes here at this hospital and it is a pleasure to be here.

This public hearing is held under the law that offers the community an opportunity to learn about the hospital's plans and for the community to share their comments and questions with the hospital. In June 2021, Minnesota Legislature passed the legislation that was put into place requiring public notice and a public hearing before closure of a hospital or the hospital campus, the relocation of services or cessation of offering services. If you are interested in reading the entirety of that, it's at 144.555 in the Minnesota Statutes.

This is an opportunity for you and as staff and the public to engage with hospital leadership and hear the reasons why they have made the decisions they have regarding change in services. It also gives the community an opportunity to learn from their health care providers about how the community can continue to access health care after the changes.

MDH, the Minnesota Department of Health, received notice on September 30th of this year of the Mayo Clinic Health System Fairmont closure of its inpatient obstetrical care, inpatient pediatric care, and surgical procedure units. According to the file submission, the hospital will be consolidating and relocating those services to the Mankato campus. The Health Regulation Division is tasked with implementing the law. We're providing a forum for the hospital representatives to share information about the changes and for the public to engage with the hospital by asking questions and providing comments on those changes. The statute gives

MDH the authority to host the meeting and to ensure the public is heard. It's an opportunity to be heard about the hospital's decision and to have their feedback heard. We do not have the authority to change, delay, or prevent the proposed changes. That is the part that might seem disappointing to people, but I just want you to be aware of that. MDH does not have the ability to change, delay or prevent the proposed changes, closure, relocation. This meeting allows for an opportunity for us, as your State Health Department to offer a forum for transparency. To listen and understand the differing opinions and the perspective surrounding those important decisions such as this one and how it will affect healthcare services in your community. I welcome you to share your perspectives, your comments, and your questions tonight with the Mayo Clinic Health System leadership and I look forward to listening to tonight's discussion.

Michael, the next slide. OK.

First, we are going to hear from the Mayo Clinic Health Systems leadership team, who are going to provide information about the following. The services that they are curtailing, an explanation for the curtailment of the services and a description of the actions they will take to ensure residents in the service area continue to have access to healthcare services is being modified. I would like to welcome Dr. James Hebl, who is the Regional Vice-President for Mayo Clinic Health Systems to get us started on with that.

>> Dr. James Hebl (Mayo Clinic Health Systems): Thank you Maria and good evening, everyone. Thank you so much for coming this evening.

As mentioned, my name is Dr. James Hebl and I have the privilege of serving as the Regional Vice-President for Mayo Clinic Health Systems, Minnesota Region, which includes the Fairmont campus here. So, we will proceed with introductions for the rest of the panel in a little more detail in just a moment or two but first I would like to thank the Minnesota Department of Health for coordinating and sponsoring this evening's session. We have been working very closely with MDH over the past several weeks as we have been preparing for this session. I would like to acknowledge, as was done earlier, that this is also the first time for a public in-person component of this hearing, as was stated earlier, previously only virtual online options were available. So, I would like to thank those of you who took the time to come out tonight and be here in person as part of the session here today.

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I will go ahead and begin with introductions of the panel. I will finish off my introduction. As was mentioned, my name is James Hebl. I am an anesthesiologist by training. I have been in my role here in the Southwest Minnesota region for the past eight years. Previous to that, I worked at our Mayo Clinic in Rochester, Minnesota, for 22 years and a large portion of my clinical responsibilities in Rochester was actually to practice within labor and delivery. As an OB anesthesiologist, where I am familiar with the inner workings of a labor and delivery unit, particularly the one obviously in Rochester, MN.

So, we will now call up the rest of the folks here beginning with Dr Varkey. Dr. Varkey, would you like to introduce yourself, please?

>> Dr. Prathibha Varkey (Mayo Clinic Health Systems): Good Evening. I am Prathibha Varkey. Practicing in Telemedicine and Preventive Medicine position. I am also the president of Mayo Clinic Health System. Mr. Hasse.

>> Christopher Hasse (Mayo Clinic Health Systems): I am Christopher Hasse, Chief Administrative Officer.

>> Travis Paul (Mayo Clinic Health Systems): Good Evening, Travis Paul. I am the Regional Chair of Administration for the Southwest Minnesota region of the health system.

>> Lisa McConnell (Mayo Clinic Health Systems): Lisa McConnell, Regional Chief Nursing Officer for the Southwest Minnesota region. I have been an employee for 34 years. 20 of those years were spent here in Fairmont, including time spent as an OB nurse, practicing OB nurse. So glad to be here tonight.

>> Dr. Gokhan Anil (Mayo Clinic Health Systems): And Dr. Anil, good evening. My name is Gokhan Anil. I am a practicing OB physician. I finished 17 years with Mayo Clinic Health System. The last six years I've been in the Southwest Minnesota regions, I get the pleasure of working on all four regions of the Mayo Clinic Health System. Both our larger hubs, as well as our smaller hospitals.

>> Dr. James Hebl (Mayo Clinic Health Systems): Next slide, please Michael.

During the next 25 minutes or so, we will be accomplishing this portion of the agenda for this evening. We'll begin by giving a broad overview of our Mayo Clinic Health System followed by a summary of the upcoming clinical changes that were already shared with this group, mainly the discontinuation of the inpatient obstetrical practice, as well as the and the on-site surgical and procedure practice and lastly, the inpatient pediatric practice as well. We will then share with you what type of communication has taken place up until this point and what type of communication will continue beyond this evening. We will then describe how we continue to support our patients, our community, and our staff during the transition that we will be discussing and lastly, talk a little bit about the future of the Fairmont campus and what we as a Mayo Clinic would like to envision going forward. So, that is a little bit of the plan for this evening.

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A little bit about our Mayo Clinic Health System in Fairmont Campus. This first bullet point may or may not be familiar to some of you. The Fairmont Campus is referred to as what we call a prospective payment hospital, often times referred to as a PPS hospital. And that's just a government designation of the type of hospital and that determines how the hospital is paid for government-based patients. And so, it is a PPS hospital, which is very different from another category of hospital referred to as critical access hospital. Most of the other hospitals in our area are critical access hospitals, including our Mayo Clinic Hospital in St. James, UDH in Blue Earth, Madelia, those are all referred to as critical access hospitals, which is a different designation.

Here in Fairmont, we staff 14 inpatient beds. The average daily number of patients in this campus can range anywhere from maybe as low as eight to as high as 14 or 15. Sometimes we may get as high as 16 patients. That is the inpatient census here in the hospital.

We have a 24/7, 365 emergency department. We have a wonderful Lutz Cancer Center and Infusion Therapy Center. We have a full complement of rehabilitation services including cardiac rehab, also available are addiction treatment, behavioral health, dialysis services are provided within the community. Our Mayo Medical Store, as well as Optometry and Optical Store. As well as a full complement of laboratory services as well as radiology care are some of the examples that you see.

Listed there and then on the right-hand portion of the slide are the clinical services that are provided here on campus. Some of these are in person or others can be done in outreach or even in a virtual manner. And as you can see, they are all listed there and importantly, at the conclusion of the changes we are going to be talking about tonight, none of this you see on the screen is going to change. All these services will continue to

remain available on site here on the campus, and you will say, "Well, I see OB/GYN, and I see general surgery." And we'll comment on it in just a little bit. That outpatient OB/GYN in terms of prenatal or postnatal care will continue, on campus, as well as surgical consultation and we will talk more about that in a little bit as well. So that is just a little about our campus.

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These are the practices that are providing a challenge here to the Fairmont campus that we are going to review this evening. I am going to take the first section on obstetrics, labor, and delivery. Dr. Anil will then talk a little about the surgical practices you see listed there.

Next slide, please.

What have we seen within our inpatient obstetric practice here in Fairmont? Over the past several years we have seen a significant decline in the number of births performed and happening right here in this campus. It is not unique to Fairmont. It is not unique to Minnesota. It is a phenomenon we are seeing across the country in terms of declining birth volumes, and I will share why in just a little bit about that as well. So, when we compare 2023 to 2020, we're seeing about a 20% reduction in the number of deliveries occurring within this hospital. With 2023 numbers, we had 96 vaginal births and I believe we had 36 or 39 C-sections during 2023 as well. So, we take those numbers, that equates to about 1.8 vaginal births each week. Typically, when we are fully staffed, we had about 15 labor and delivery nurses on campus here. If you divide those numbers out and do the math, each nurse will do on average between five or six vaginal births per year. If you work out the numbers and you assume there's an average distribution for that.

Now when we talk about those deliveries, that represents just over a third of all the deliveries that are happening in Fairmont, so almost 2/3 of births from the community are already happening at a location outside of this hospital. Another 20% of births are happening at Mayo Clinic in Mankato. 5% of birth from Fairmont occur in Rochester because of high-risk pregnancies and deliveries and the other 40% of deliveries are occurring at non-Mayo locations. And so, you can see that is how these deliveries are distributed across various locations around the region.

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Why are we seeing declining volumes? This is the phenomenon we are seeing across the nation, as I mentioned. We can see here it is occurring within the state of Minnesota at significantly high levels. If we look at the birthrate in Minnesota itself, it has dropped by about 21% since 2007. It is projected to go down an additional 4% over the next ten years. So, we have a significant declining birth rate that we are seeing once again across the state of Minnesota.

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Now, that is not unique to Minnesota. As I previously mentioned, we are seeing significant reductions in birth rates and fertility rates across the entire U.S. and that is what this slide is showing you. We have two different lines there. A black line and what we'll call a gold line. The black line on top represents what we refer to as the total fertility rate. What is that? Well, that is the average number of children that a given woman would give birth to, the number of children they would give birth to in their lifetime. Right here, today, 2024, that is 1.62. So, on average, a woman today in 2024 will give birth to 1.6 children over the course of her lifetime. You can see, however, the peak of that was 3.77 back in 1957 and that rate today of 1.62 is the lowest value since

1930, which is when statistics were starting to be accumulated on this topic. So basically, women are having fewer and fewer children.

The gold line then represents what is referred to as the general fertility rate. What does that mean? The general fertility rate represents the number of live births for every 10,000 women -- 1,000 women, excuse me, who are of childbearing age and that number right now is 54.2. If you take 1,000 women between the ages of 15 and 44, they will have 54.2 children born to them. And you can compare that number to the 1970 number, and we can see that there is a 38% decline in that. So bottom line, people are having fewer and fewer children which is why we are seeing this decline once again in Fairmont, Minnesota, and more broadly across the U.S.

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To combat things with regards to a lower birthrate, we are also seeing a significantly higher number of pregnancies being defined as high risk. Why is that important? Well, high risk pregnancies are not eligible to deliver in smaller, rural communities, including on our Fairmont campus. Those higher risk deliveries are classified as higher risk, whether it is concerns with mom or concerns with baby. Right now, here today, about 35% of all pregnancies are considered high risk and that is projected to go up over the next decade by another 7%. So, in the next ten years,42%. So, approaching one out of every two babies will be delivered in a high-risk pregnancy.

We are seeing volumes go down and of the volumes that are remaining, a higher percentage of those are high risk, which once again are not eligible to be delivered in small, rural communities. That is a major contributor to the lower volumes we are seeing.

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Why is this all important? We have low volumes, we've established that. But why is that impactful? Well, there are two major reasons why low birth volumes make a difference. The first is just like anything in life, you need to be exposed to any activity or procedure on a frequent basis to maintain high levels of skill and high levels of competency and experience. And it's simply very difficult when you have a practice of any type. Whether that's a surgical practice or a labor and delivery practice, if you have low volumes and numbers, it is hard to maintain high levels of skill and competency and experience to provide the highest level of care possible. That is why it is impactful #1.

The second reason that it is impactful is, quite frankly, it is difficult to recruit physicians and at times, nurses, as well to practices that are low volumes. For example, we have physicians that are reluctant to come to practices that have low volumes where they are delivering one or two vaginal babies a week where they can go to other practices where they are doing that four, five, six times a day potentially. So, it is a challenge to recruit physicians and often nurses as well to low-volume practices. So that is the second way that low volumes can be impactful to a practice.

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I mentioned earlier that you need to maintain high volumes to provide high-quality care. This was a paper published just last June by the "Journal of The American Medical Association" that highlights one of these points. And what this study did is it looked at the risk of severe maternal morbidity. That is complications. So, look at the risk of complications in both mom as well as baby. And they looked, is there a difference in complication rates if you are delivered in a high-volume or low-volume practice. This study defined a high-

volume practice as those that deliver 460 babies a year or more. That is what they defined as high-volume, and a low volume was lower than 460 babies a year. The study then further broke those low-volume practices down into what they referred to as extremely low volume. So, those hospitals that deliver between ten and 110 babies. The next category was the very low-volume and you can see the volume there is 111 to 240 or, lastly, low-volume, which was 241 to 460. What the study found, the summary was in the blue box on the right, is that low risk patients, not even the high-risk patients we talked about earlier. Routine, low risk patients who gave birth at the rural facilities who had the extremely low volumes, which were between ten and 110 births annually, had more than a double risk of complications. A twofold higher risk of complications. If we look at the other categories, we can see the very low-volume hospital on the second line from the bottom. They had about a 37 higher risk of complications and the low-volume practices about 26% higher risk.

So, once again, this is not a phenomenon that is unique to labor and delivery. If you have specific surgical procedure as well. If you do a low number of them, we know there are higher complications. That is just the consequence of low volumes within any type of medical practice.

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So that is the issue of low volume. That was issue #1. Issue #2 is an even bigger issue and that is the national shortage of obstetricians here today. Once again, hospitals across the country, as we will see by some of the data here, are struggling with finding obstetricians and we have obviously experienced that here in Fairmont as well. So, what we are seeing here, this graph represents what percent of the demand of obstetricians is being met and we have metropolitan areas on the left and on the right, we have rural community or nonmetropolitan areas.

Let's start on the left. Within the metropolitan area or urban setting, the dark blue represents the year 2018 and the hash marks represent what they project will happen in 2030. This is from the Department of Health and Human Services so, the federal government estimates. On the left, in 2018, in metropolitan areas, there was a surplus of obstetricians. We had about 6% more obstetricians than the demand. We fulfilled that demand by 106%. But by the year 2030, there is going to be a shortage, even in metropolitan areas. We are going to fill 95% of the demand out there. So, 5% of hospitals in urban areas, or 1 in 20 is not going to have the obstetricians they need to maintain their practice.

What is discouraging is what is on the right-hand part of the screen, where things are significantly worse and more dire within nonmetropolitan areas. We can see back in 2018, only 61% of the demand was met. In other words, 40% of the OB demand, hospitals did not have the obstetricians they needed to maintain their practice and that number appears that it will be projected to continue to go down even further to the point in 2030, one out of every two rural community hospitals won't have the obstetricians they need to maintain their obstetric practice.

What is further disheartening is the pipeline of obstetricians that are in the process of going through medical school and fellowship and residency is not in a favorable place for rural communities. What do I mean by that? Well, less than 5% of medical school applicants are from rural communities. More than 95% of people going into medical school are from urban metropolitan areas. It is very difficult to recruit individuals who grew up in a metropolitan area to come out to rural USA and so the pipeline is a discouraging component for recruitment in rural areas as well.

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Right here in Fairmont we are experiencing what the nation is experiencing as well in terms of the nationwide shortage of obstetricians. Many of you, I think, are aware that we have been down to a single OB/GYN physician for the past two years here in Fairmont. We have been able to maintain the practice during that time by bringing in other obstetricians from other Mayo Clinic Health System sites outside of Fairmont. We have brought obstetricians in from Mankato and other Mayo Clinic Health System locations into Fairmont to help your one obstetrician here and to be able to continue the practice. So, you may say, “Why don't we keep doing that? It has been working.”. Well, the rest of our system outside of Fairmont is experiencing the same significant shortage of obstetricians and so we are having fewer and fewer obstetricians at all our locations. Because we have limited resources, we have a limited number of obstetricians, we are obligated to have those obstetricians go and practice in the hospitals that have the largest volumes. Unfortunately, Fairmont, out of all our Mayo Clinic Health System hospitals in Minnesota, has the lowest labor and delivery volume of any of the other hospitals. We no longer have the luxury of bringing in obstetricians from other Mayo Clinic hospitals to help fill in the gaps here in Mankato which leads us in a situation where we are down to our single OB/GYN physician.

Now we have tried to replace and recruit and hire. We have been doing that for two years since the departure of our last obstetrician. We have aggressively used a variety of recruitment techniques. We have used both our internal Mayo Clinic recruitment resources. We have also hired two separate external recruitment agencies at different times. And despite all that, we have simply not been able to generate candidates that meet our required qualifications to be considered to join our Mayo Clinic staff and that has been the recruitment of both OB/GYN's as well as nurse midwives. We simply have not been successful in that realm.

Now, because of the situation I described, we are short of staff, and we have been short of staff, which we began feeling earlier this summer. Once again, that happened when other doctors, obstetricians from outside of Fairmont no longer were able to come here and help support the practice. And because of that, we have been on diversion continuously since the end of August of this year. Once again, because of these significant staffing issues. And quite frankly, the model that we currently have with not only the low volumes and the implications of that, but the recruitment issues have created an unsustainable model that we cannot maintain if we want to ensure high quality care.

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How are we going to mitigate the situation? Well, as I mentioned, we are going to transition to what we refer to as a shared model of care. What does that mean? That was recently implemented when we began going on diversions earlier this summer. And what that means is that except for the day of delivery, all other obstetric care will continue to be provided on this campus. So, prenatal care as well as postnatal care, that can be done. You may see an obstetrician, you may see a nurse midwife, which we have recently introduced to the Fairmont campus, or Family Medicine. Any one of those providers could provide that prenatal or postnatal care. We will also continue to provide outpatient well baby pediatric care as an outpatient as well as outpatient GYN medical services. That will continue to be provided here locally.

On the day of delivery, however, the care will have to be transferred to another facility. Our preference would be that it would be transferred to our Mankato facility where we have a comprehensive OB team that I’ll talk about in just a moment, but obviously, patient choice is important, and we value and respect patient choice. We know there will be patients who choose not to deliver in Mankato. We will respect that decision and we

will assist in transitioning care to any other non-Mayo physician or practice that the patient chooses or desires. Once again, we will be very respectful of that and will support the patient in any way as needed.

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A little bit about our Mankato campus. It is one of our larger regional medical centers. It is a high-volume labor and delivery unit. They deliver between 1400-1500 babies a year. Because of that very large volume, we have a full complement obstetrical team that not only includes obstetricians and a full team of nurse midwives, but we also have an in-house anesthesia team that is present in house 24/7. We have 24/7 presence and availability of pediatricians right there in the hospital. We also have what is called a level two nursery, which is an intensive care unit for sick and premature infants also available in Mankato. We have lactation counselors as well as a great partnership with the Minnesota Milk Bank.

For children as well, many of you know the picture on the bottom right is a picture of the new family birth center that opened op in Mankato back in May of 2024. We have had several women from Fairmont already deliver in our new facility and by reporting back, had a good experience during that encounter as well.

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That is the obstetrical and inpatient OB challenge we are facing once again. Volumes and the implications of that, as well as the obstetrician shortage.

Dr. Anil is now going to talk a little bit about the next component of the transition of the programs, namely the challenges we are facing within our surgical practice, as well as the inpatient pediatric practice.

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>> Dr. Gokhan Anil (Mayo Clinic Health Systems): So, our current compliment of surgery, it consists of orthopedic surgery, ophthalmology, and general surgery. Those are the components that have impacted our practice as we have had surgeon departures from the practice. Specifically, our podiatrist who has been practicing in Fairmont, have left in May 2023, which has impacted our surgical volumes as well as care patients in Fairmont. Our last orthopedic surgeon departed this July to be close to his family in South Carolina. So we do not have any orthopedic surgeon or a podiatrist in Fairmont.

Our Ophthalmologist, since the departure of our last full-time ophthalmologist four years ago, we have been recruiting and have been able to convince one of our retired physicians from Lacrosse to come and commute to provide ophthalmology services, but he decided to fully retire again as of the summer. We have two general surgeons. Unfortunately, one of them is departing, which means we will only have one general surgeon left within Fairmont. So as Dr. Hebl talked about, we have been trying to recruit for the past four years, both internally using our recruitment as well as external recruitment firms to recruit any of these positions.

What has also happened is that our surgical volume has declined by 48% since 2019. And one of the things that we have seen is that almost 58% of the surgeries from Fairmont have been taking place in Mankato by our surgical services. Whether it is because of the departure of the services or patients' conditions require a higher level of care and a physiologist and additional services such as ICU or progressive care. So, with the current census of surgeons, we are averaging about one surgery per week, which as Dr. Hebl talked about, which is quite hard to provide high quality, safe care, as well as have the competencies of the reign of the surgical staff as well as providing surgical services in Fairmont.

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I would like to touch base on about the pediatric services as well. Pediatrics is referred to after the baby is born and discharged at the hospital, all the way to the age of 18. All those admissions have been provided in the Fairmont campus and I am going to give some numbers about what we have seen as well. The dark blue at the bottom refers to what we call inpatient admissions. Inpatient means that a medical diagnosis requires the pediatric patients to stay at least 24 hours or longer than that and the lighter blue on top is what we call observation status. The condition can be not as serious. We call them observation stays.

All these things combined in 2022, we have a total of 35 pediatric patients in our hospital, which declined down in 2024 YTD to about 17 per year. Again, we are seeing similar trends, which results in less than about one inpatient admission and some observation patients as well. We are seeing similar trends for our pediatric patients, surgical patients, which resulted in the recommendations that we were making.

Next slide.

Dr. Hebl talked about the article published in the Journal of American Medical Association, but this is also published at “US News & World Report”, which is a well-known publication that ranks hospitals for quality of safety as well. This is pertaining to all complications, and all this seems to be significantly higher, about almost 106% higher for select procedures and up to 26% higher for select medical conditions when it’s performed at a lower volume setting. Low volume relates to less experience, not only the physicians, but the entire team, nurses, anesthesiologist. So there seems to be a good reference and literature supporting that low volume tends to increase the risk factors for the patients, along with complications as well.

I will turn it over to Lisa McConnell, our Chief Nursing Officer.

>> Lisa McConnell (Mayo Clinic Health Systems): Thank you Dr. Anil.

About our communication plan, we have launched a comprehensive plan over the past several weeks, which included many conversations with our Fairmont Hospital Board. We held several town hall meetings in August with approximately 300 to 400 in attendance. We have also met with the Fairmont Community Hospital Foundation Board and have had one-on-one conversations with some of the board leaders. We have had one-on-one conversations with local and state elected officials. The Minnesota Department of Health public hearing is what we are doing today. But also had communication with the Joint Commission and stakeholders have that have already been contacted include our patients, obviously having a one-on-one personal phone call from our staff. And we have had conversations with our health system staff, our community leaders, the local media. You may have noticed the article that was in the paper recently.

We have also partnered with our county departments of health and Public Health. We’ve had conversations with them working with the community education resources and have reached out to the leaders at the area hospitals and outpatient practices and had conversations with them. And finally, conversations with our ambulance transport systems because we do know that, recognize that does, this change does mean a difference for them.

The next slide.

So, I’ll talk a little bit about our transition plans. Obviously, through the transition, we continue to have commitment to our patients, staff, and community. Our patients, we are actively work with the patients on

new birth plans, doing outreach education to expectant mothers in collaboration with public health and facilitating handoffs to the new OB/GYN providers of their choice by the patient. And with our staff, 55% of the staff who would have been in those positions have already secured new positions. Additional training is also in the works for emergency department staff on obstetric scenarios that may present within the emergency department. As far as the community, we are working with community education and public health resources.

Next slide.

Obviously, we have a commitment to the community, and I just want to say how proud I am of our hardworking nurses, and I want to express my sincere gratitude to the staff in Fairmont for their dedication, compassion, and unwavering commitment to provide high quality care to our patients. Their contributions have made a significant difference in the lives of our many patients. We understand this is a really difficult time, not only for our dedicated team, but also for our patients in the entire community. These decisions were not made lightly, and we remain committed to rural health care in Fairmont community.

I think I will turn it back over to Dr. Hebl for this next slide.

>> Dr. James Hebl (Mayo Clinic Health Systems): As Lisa alluded to, although these very difficult decisions were made based on a set of difficult circumstances, we remain committed to this community. We have every intention of maintaining a long-term presence in this community and we, as a Mayo Clinic, have no intention of closing the hospital.

What you see on the screen is evidence of our commitment to this community. Over the past ten years, so since 2014 until today, we have invested more than $25 million in this campus, which includes facility remodeling within the emergency department several years ago. Brand-new and absolutely beautiful Lutz Cancer Center and Infusion Therapy wing. We brought in the latest in terms of technology, including new MRI for equipment and facility, a pharmacy remodel.

Recently we have also launched what is referred to as primary care on demand, which is a new technology for patients to have access to a primary care physician 24/7, 365 online. Where they are able to deal with or manage about 110 medical conditions without needing to come into an emergency room, urgent care, or a clinic setting. Those are just a few examples of the investments that we have made over the past decade to the Fairmont community.

Last slide please.

So, in summary, we are here tonight to announce the discontinuation of inpatient obstetric care, day of delivery, as well as on-site surgeries and procedures and lastly inpatient pediatric care. These changes will be effective March 31st of next year, but we will likely remain on indefinite diversion of the obstetric practice unless conditions change with regards to staffing between now and March 31st. Our goal is to advance to what we call a shared model of care, which is where we share patients. Prenatal and postnatal care would continue here, either with OB or nurse midwives or family medic. With the sharing of care of the mom and baby on the day of delivery to the Mankato practice or, as I mentioned, to another no-Mayo site if the patient so chooses.

As I mentioned, the practices on the bottom will continue. In addition to those practices, I discussed in our very first slide, which includes a robust primary care practice, 24/7 emergency room, lab services, radiology

services, cancer care, fusion therapy, and all the other specialties we previously listed and discussed, once again, those will continue. If we look at the services that are provided on this campus and will continue to be provided on this campus, that will accommodate about 85% of the health care needs of this community based upon your current demographic.

I believe that is all we have for this evening. Once again, thank you so much for joining us and I will turn things back over to you, Stacy.

>> Stacy Sjogren (moderator): So, I know nothing about medicine. I know what I do, but I know nothing about medicine. So, when I am listening to these presentations, I listen to them as if I was one of you sitting out there. There was one term, I want you to do one more time because I don't think it sunk into my head and perhaps it wasn't sinking into yours, and that is defining the word diversion again. Can you have one more go at that? I don't think it's quite in my brain.

>> Dr. James Hebl (Mayo Clinic Health Systems): The diversion refers to the temporary closure of a practice or unit. Our OB practice has been on diversion, meaning we have not accepted patients because of the current staffing situation and that went into effect in late August.

>> Stacy Sjogren (moderator): So, it is a status. Thank you. And thanks, all of you, for your comments. That was very helpful.

We are going to begin our public comment portion of the meeting. This is your turn to participate by asking questions, providing comments, or sharing your perspectives. You will have up to three minutes to ask a question or share their comment. I will give a time signal and because I'm college football coach's kid it will probably (gives hand signal). And I am using my trusty clock here to give us some sense of when three minutes are up, but three minutes is usually about what you need to be able to communicate your concern or your question.

Again, though, please remember the information you are sharing is being shared virtually in a public forum. This means that any information you share is public. So, think about that before you start wanting to share any private information. That just makes sense, we want to protect your privacy.

The Mayo Clinic system folks up here will have an opportunity to respond to the questions or comments. And then for those online participants, know that you will be muted until it is your turn to ask your question or to make your comments.

So, here in more detail then is how it is going to work. For those of you who joined us in person, I think what I'm going to do, as I get a read on how many people we have remotely, I am going to start with some of the online questions that came in ahead of time. We will be hearing from Shellae and Kia who are helping us out remotely. So, we will listen to what they have been learning from those pre-submitted questions. Then I am going to check and see how many virtual hands are raised. And then for all of you in the room, can we take a moment and raise your hand, bold. I am thinking about, like, give me a sense of how many of you might want to make comments. OK, that is helpful. Thank you.

I think what I will do is I will give you a sign when we get to about the time that I am going to get ready to call on people in the room and ask that if you want to make comment, let's just all keep track over here and if you like, the first five could just cue here. That way I am not trying to remember who raised their hand first in the order around the room. It gets a little messy that way. I don't want to have everybody stand because you

might be standing for a long time and that's no fun. So, I will give you the sign and if you are ready, just come up and queue up here about five and we will go that way. Maria and I are pretty good after all the time we have worked together to read how we'll play back and forth.

Does that make sense? This is specifically for the people. Are you good? OK.

Work with me, I guess is the bottom line.

Online participants, you have two ways that you can ask a question or provide a comment. The first is to raise your virtual hand and you will be unmuted. When it is your turn to ask a question or provide a comment, that is how you do it. So, to remind you how and where to go, if you are working in the mobile app and the browser version of Teams, click on the more button, that's the "…" button. That will show you the raised hand option. That is the little thing that looks like a mitten. The icon is a little yellow hand. In the browser version, the raised hand feature is the fifth item from the top of the list.

And wait, there's more. If you are calling in on your phone, press *5 to raise your hand. Once it is your turn, press *6 to unmute yourself. So, raise your hand if you are calling in on your mobile phone. When it is your turn to speak, unmute yourself by hitting *6. Lots of directions for all sorts of different scenarios.

The second option is to type your question into the chat as I mentioned earlier and just press enter or send so that the MDH staff can see it to read it on your behalf. Click on the icon that looks like the cartoon speech bubble with two little lines in it. If you are using Teams in the browser window, the icons are at the bottom of the screen. If you are using the Teams app, the chat icon is the top right corner of the screen. And for all of you in the room, I am just realizing how weird that sounds when you are sitting here, so thank you for your patience as I get through, so everybody has a chance to be heard. We will select participants as hands are raised. For those of you that are doing it remotely and that queues it up for us there, so yay for that little bit of technology.

And to everyone, please be respectful. Everyone participating in the session tonight has an important perspective to share. Community members, you all care. You care that you will receive the services you need when you are feeling the most vulnerable. Health care staff, care about their patients and hospital administrators care that their communities are well served with the resources available. I ask you to help me create a space in which we can all be heard respectfully, get answers, not be any more stressed out than you may already be. Let's use this opportunity to learn and to hear a little bit more.

Let me see what I have missed here. Oh yeah, that is the whole team will be looking, if we are seeing abusive comments or comments that are meant to discredit or malign someone or vulgar language, we just cannot tolerate that in chat or in verbal comments. So, people who are using language that is threatening or making false accusations meant to damage reputations, etc., we will go to the next person in line.

I think I mentioned the chat moderator and the program team will help me identify commentators. I have my eye on my timer here and I think Maria, unless you can think of anything, we are good to go.

Alright Shellae, let's hear your voice first so people can recognize it and then I will ask to hear what you have been learning from the pre-submitted questions.

>> Shellae Dietrich (MDH): Can everybody hear me okay?

>> Stacy Sjogren (moderator): Yes, we got thumbs up in the room here. Go ahead.

>> Shellae Dietrich (MDH): Perfect, as Maria mentioned, we did get quite a lot of comments and questions in so we are trying to bulk them together and touch on as many as we can, but they will all be on our website after the hearing. We will start with questions we got in.

“Isn't this decision putting our citizens at risk when immediate surgery for medical emergencies is needed?” And “Is Mayo going to expand the ambulance fleet and personnel to get patients to Mankato in a timely manner?” “Can control of the hospital be sold to another hospital system willing to serve our community with OB intensive care and surgical units?” And the last question in this portion, “What is your plan for the surgical center in other areas that you will not be using? Would you be willing to lease the space out to another healthcare facility interested in providing care for our communities?”

>> Stacy Sjogren (moderator): Thank you. Dr. Hebl, you are going to be the point person for those, so I will check and see if you needed her to repeat any of those first because that was a lot at one time.

>> Dr. James Hebl (Mayo Clinic Health Systems): I jotted a few things down so I will give it a try and then you correct me please if I need correcting. So, we’ll begin with Dr. Anil with regards to the question of putting community members at risk because of the lack of available emergency surgeries. From that perspective, so you can come in on that Dr Anil.

>> Dr. Gokhan Anil (Mayo Clinic Health Systems): Well, I appreciate the concerns related to emergency services. This is utmost concern and worrying for all of us. I appreciate you waiting. The emergency department and Fairmont is equipped to handle emergencies. #1 is realizing the patient is at risk. Second, stabilizing the patient and transferring the patient to the nearest equipped facility. So that is our number one goal. To ensure that the safety of the citizens of Fairmont is always our utmost priority. Not only are they are trained to handle emergencies, but also communicate with teams, understand where the resource available to save the chance for the patient and stabilize them in the meantime. So, that’s our #1, to ensure that they assimilate, they communicate, and prepare for these emergencies just like any other Mayo Clinic system.

>> Dr. James Hebl (Mayo Clinic Health Systems): I guess I would also add that as any health care organization, it is very difficult to be all things to all patients in all locations. So, whether that emergency is an OB emergency, whether it is a gunshot wound, whether it is a heart attack, whether it is a stroke. None of those services would be able to be provided in Fairmont today but our emergency team is equipped to stabilize the patients, communicate with needed resources, whether that’s helicopter or ambulance and get them to the location where care can be provided. That would extend beyond not only obstetric emergencies but any type of emergency that may come in the doors of our facility. Here we have a fantastic E.R. crew that does truly amazing work so, thanks to them.

The next question I am going to give to Travis which is with regards to the ambulance service and some of the activity around prioritizing here.

>> Travis Paul (Mayo Clinic Health Systems): Thanks.

First off, transport is done based upon urgency or need of the patient with the sickest patients that need by helicopter ambulance and then with acute taking different routes. We are committed to transportation. We have been in discussion with our New York transport team looking at their doing that space as well as looking at creative options with other stakeholders to find solutions to transportation.

>> Dr. James Hebl (Mayo Clinic Health Systems): The next question was regards to selling the hospital based upon the affiliation agreement. Travis, do you want to comment on the affiliation agreement?

>> Travis Paul (Mayo Clinic Health Systems): Yes, happy to do that as well. So, I think if somebody mentioned before 2001, Fairmont Medical Center became part of the Mayo Health system by an affiliation agreement with the Fairmont Community Hospital Foundation. In that agreement has certain clauses and languages and first thing I want to think about, question about the changes we are discussing tonight are in alignment with that agreement that was established in 2001. So, anything about a sale would ultimately be something that the Fairmont Community Hospital Foundation would be part of. We are committed to Fairmont. We are committed to the community. We want to have a presence and that would be our—I guess I would just say, we have members of our Fairmont Community Foundation Board here with us tonight. We have had multiple conversations with their leadership. We've met with the entire board. We are fully aware of what is within the affiliation agreement with regards to any type of a future sale. We are in full compliance with that affiliation agreement, and we will continue to have ongoing discussions with the FCH board going forward as well.

>> Dr. James Hebl (Mayo Clinic Health Systems): The last comment maybe I will take with regard to the additional space. We had several town hall forums as well. We have what's truly a beautiful campus here. A beautiful facility and a lot of empty space and we have been asked what we can do with this space. Our preference as a Mayo clinic would be to work with the community to really transform the space into the medical, health and well-being hub, not only for not only the Fairmount community, but for all of Martin County. For that will take a lot of brainstorming, a lot of visioning that will engage in a lot of different stakeholders, not only our staff, community members, the foundation board as well. We would love to reimagine what we can do with this campus, really converted into once again, that the health and well-being hub going forward. A lot of possibilities are out there.

We have also had this conversation with our Fairmont Mayo Clinic Board as well. We have also had this conversation with a few local elected officials as well. And so, a lot of ideas are coming forward, but that would be work that we continue to pursue in the coming weeks and months.

How did we do on the questions? Did we hit them?

>> Stacy Sjogren (moderator): So, just a reminder everybody, that batch of questions were taken from questions or comments that were submitted before the meeting and identical questions, some of those might have been identical questions that you voted in. The next thing we are going to do --

>> Audience Member: Excuse me. Can I just ask one question? Are we able to ask a question in relation to those three? I just had one question regarding your services in the E.R. they are exceptional, no doubt about them. The E.R. is totally full all the time. Is that a concern or how are you going to address that? Because what happens is they are not seen at the clinic and the E.R. is filling up more and more and I know it is not the priority you originally dropped for that facility so that dovetails on your question before. What are you going to do with that? And then also on your transportation? I know you need to get more transportation providers because I have seen when their shift changes. People wait in the E.R. that need to go to your other facilities desperately.

>> Stacy Sjogren (moderator): So, we have a plan here, let's use that --

>> Audience Member: We've got your plan. I understood your plan for us, but I think it is not allowing people to ask some questions that they want that dovetail with what they just answered. I think that is fair to us.

>> Stacy Sjogren (moderator): And so, what I was going to say let's use that as the first question in the room and if there are any other people in the room that would like to follow-up and ask a question if you could just line up her. That will give me a sense of what we've got, and we will just do a few more in the room.

If we want to go ahead and respond to this one, I think you have two questions.

>> Dr. James Hebl (Mayo Clinic Health Systems): Dr. Anil, just the first one, which, if I heard you right, was with regards to different levels of care, a full emergency room, probably talking about primary care and management.

>> Dr. Gokhan Anil (Mayo Clinic Health Systems): Thank you for your perspective. First and foremost, is how do we improve clinic access? That is the #1 priority for all of us. We continue to recruit primary care physicians, primary care colleagues to ensure proper access. Dr. Hebl already talked about one of the other options that we started offering to our patients, including myself. My family uses this primary care on demand services that is available 24 hours a day, 365 days a year. These are Mayo Clinic positions that have access to your medical records and provide many of the conditions in a timely manner.

So, we are committed to continue to provide access by not only hiring positions that currently are actively on going, but also making sure that your sure that your needs are met 24/7. Our E.R. colleagues, E.R physicians as well. We have a fully staffed emergency room. We know that some of the patients don't need to be in the emergency room and are there because they don't have appropriate access. Our E.R. is fully equipped and staffed but our efforts are ongoing to ensure that patients have access, to all patients here. We are working towards improving our templates, improving our phone lines. I know this is sometimes an issue from our patients. We've been hearing that. We are updating that as well as ensuring that proper access to the patients is always #1 priority for us so thank you for sharing that.

>> Audience Member: My original question that I wanted to ask had nothing to do with that, but I was listening to Travis, and it brought to mind. But getting back to your, the new way to connect. The online presence, a primary care. Did you call Primary Care on Demand? What is the difference between that and the portal? Because the portal struggle with. I try to use it. I religiously try to follow it, but what happens is, I sincerely feel, it is a black hole. My information goes in, and it's very, it's very unresponsive. It would be a suggestion, as a patient, to say that is one area, if you've got people, train to use the portal. Now what you do is you've got to repair it. It is bad. It's just not responsive. It's like you, don't you feed information in, but you don't get response in a timely manner. I understand this discussion, but you've got to improve other services.

>> Leadership (Mayo Clinic Health Systems): So, Primary Care on Demand is a separate app that is currently independent of the portal. You would go to the Apple Store; you would punch in "Primary Care on Demand". You would download the app and it is a pretty seamless app I would say relative to the portal. So, it is a separate, independent functionality right now, which --

>> Audience Member: Response time is quicker?

>> Leadership (Mayo Clinic Health Systems): Yes, most people, when they need to see a physician would see a physician within three to 5 minutes.

>> Audience Member: Will the portal go away?

>> Leadership (Mayo Clinic Health Systems): No.

>> Audience Member: Thank you.

>> Dr. Scott Burtis (Fairmont, MN): First a comment. Dr. Scott Burtis. I am part of the health care community in Fairmont here for 36 years. Lots of folks get frustrated when they go to Fairmont and they hear the comment, "We don't have any beds available." By now, everyone realizes it is not beds, it is staffing so I would encourage you to be more forthright. We just don't have staffing available. We have lots of beds. We don't have any staffing.

A question on the presentation. They were showing the number of births per year, and it said 2024, it said 80. I'm curious when that was effective as of because that can be misleading.

>> Leadership (Mayo Clinic Health Systems): That was July. That was prior to the diversion status from that perspective.

>> Dr. Scott Burtis (Fairmont, MN): which date was when?

>> Leadership (Mayo Clinic Health Systems): Approximately July 21st. July 21st is when we started but fully towards the end of August.

>> Dr. Scott Burtis (Fairmont, MN): So maybe a projected expected amount would have been more precise as far as turning that trend. It looks like it is going way down from 130 some three or four years down to 80. And it sounds like it is pretty much stable, if you follow me.

>> Leadership (Mayo Clinic Health Systems): The 2024 number was a year-to-date partial number. If you were to just take that and assuming that was the first six months and double it, it would have been one number. Bute we also know how many women were in the pipeline in terms of who are currently pregnant and receiving prenatal care. If we had to project, it is hard to do so. If we were to project, the numbers would probably be about equivalent to 2023. So right around that total number of about 130 to 135. Almost identical to 2023.

>> Dr. Scott Burtis (Fairmont, MN): Yeah, It looks misleading. I looked and my first thought was, "Oh my gosh, that's going down, but it is quite far down."

And the last question I have, I was just check while we were talking. There was a journal article in 2022 that showed a direct correlation between the farther you travel for OB/GYN services, there is a significant increase in risk of NICU emergencies and complications. I would like a little more clarification on that. It sounds like you are saying we have the service in Mankato. I think it is important to realize that but the longer you, the farther you have to travel, we're in for significantly increasing the risk of complications at the NICU. How are we going to adjust for that? How are we going to accommodate for that?

>> Leadership (Mayo Clinic Health Systems): Appreciate you giving this one context. That is important information, when there is no prenatal care available. And so, what we are offering in the Fairmont community is that we'll continue providing all care which is the majority of the women in that study talked about having no care that they'll have to travel to receive any care. What we are unfortunately, even though this is again a very difficult decision given such difficult circumstances, the study referred to provides that

patients have to travel for all care, including prenatal, intrapartum care and postdelivery care. So again, this is not an easy decision to make. We prefer that we didn't have to do any of these things but given the fact we are down to one OB physician, not having enough staff, which that individual would have to be on-call 24/7, 365 days a year. It is not tenable, unfortunately.

We are projecting to have 5,000 less OB-GYNs in the country by 2030. 5,000 less than what we currently have. I was just in a meeting with the Minnesota Hospital Association. They currently have 9% less physicians and 15% of all the physician positions are in the state of Minnesota. These are unfortunate facts that we are trying to make very difficult decisions and still provide the best possible, safe care possible to our patients that minimize their risk factors. But I appreciate your comment. Thank you for sharing this.

>> Stacy Sjogren (moderator): We have got one more question in the room and then we are going to go to a question in the chat.

>> Robin (Audience Member) My name is Robin. I have just a few things I jotted down. Number one, our health care system is broken. I mean, it is broken. And I don't know if it is up to the elected officials, I don't even know if we have any here. Or the Board of Health or the Department of Health. But rural health care is, it's broken. You go into the E.R. with a broken arm and we have to go by ambulance to Mankato to get it fixed. That is not health care. That is $15,000 for a broken arm. Who can afford that? I have an $8,000 deductible. Our health care costs are going to continue to skyrocket with all these transfers, which leads me to my second thing.

We are exasperating the resources in Truman and Sherburn and Winnebago and all of our little towns because we are constantly transporting for our E.R., transporting to Mankato, transporting something from Mankato to Owatonna, Owatonna to Rochester, Rochester back to Albert Lea. And while those ambulances are constantly being diverted and moved, our little towns which are volunteer services are being exasperated. They've got to pick up somebody from Goldfinch, which is three blocks from the E.R., and bring them to the E.R. and wait there for that E.R. to discharge them to send them home.

I mean to say that nobody ever said that Fairmont was going to be doing plastic surgery or lung transplants, or anything list that. But don't say we did not take care of stroke victims or gunshot victims because I used to work on MedSurg, and I don't know who has changed it. If Mayo has, or if these larger healthcare systems have changed it. But a woman with obesity, I mean a woman does not get taller when she is pregnant, she gets fatter. She gets heavier so her BMI goes up. She is high risk, can't deliver in Fairmont. She's got high blood pressure, can't deliver in Fairmont. And then all of a sudden, all these obese are being diverted to Mankato or Rochester because they won't allow her to be delivered here. We deliver babies with mild hypertension all the time.

Regardless, I am just saying, our health care system has gone downhill here in Martin County and we, I think every single one of our elected officials in every small town should be here and they should be calling you. You are supposed to be standing up for us, the Board of Health. Everybody has a boss and the chain of command for them should be you and you should be standing up saying you know what, you cannot close that hospital. You know, you need to stay there. They need you. That is a county of 12,000 people. Now they don't even have a surgeon. Someone comes in with an appendix. They're supposed to just let it burst and drive to Mankato. I mean, it's broken, and I know down in this area it's Mayo, but up in northern Minnesota, it is

Essentia Care. It's Alina. It's Sanford. It's just a health care system of another name but the larger healthcare systems have not helped us in rural. No question, I guess, just clambering.

>> Stacy Sjogren (moderator): We heard a lot in those comments about concern about national trends and what it means regionally and what it means locally and -- I saw your heads nodding in agreement. Do you have any other comments or awareness is that might add to this understanding of what is going on?

>> Dr. James Hebl (Mayo Clinic Health Systems): Sure, maybe we will ask Dr. Varkey, our President to comment on some of the challenges or rural healthcare more broadly. How we as a system are tackling that.

>> Dr. Prathibha Varkey (Mayo Clinic Health Systems): We appreciate your sentiments and perspectives. In communities, particularly post-COVID and healthcare, suffer many more challenges than it was previously. And there are many things that Dr. Hebl shared during his presentation. Over 90% of our communities are rural, this conversation is one that we have very frequently, trying to figure out how we address some of these challenges that you faced.

Several issues that are concerning for us, when you look at rural communities, over 30% of physicians that we have in rural communities are predicted to retire in the next ten years. That is a massive number and one of great concern. There are multiple specialties that are of particular concern in rural communities across the clinic health system. But we also have issues with anesthesia and radiology. And again, this is shaped by multiple communities.

Recruitment, as you heard, is a big issue, but also people willing to stay and move to rural communities and embrace the wonderful rural lifestyle is also of concern and that is significantly changing, deteriorating post-COVID. And then, of course the question of, as communities age and have more complex issues and needs. Where is it safe to get care for those complex issues? Is it a Hospital like Fairmont or do we need to partner with a hub hospital like Vancouver. And that is the shared care model shared so many multiple issues affecting communities. Having pretty much the same discussions.

>> Stacy Sjogren (moderator): We are going to switch to our partners, Shellae and Kia who are monitoring what is being posted in the chat. I realize in the room it's hard seeing the chat feed unless you happen to be on your phone. But they are monitoring it for all of us. Are there questions in the chat that you can post for us on their behalf Shellae?

>> Shellae Dietrich (MDH): Yes, there are some questions and comments here.

One comment is, "Why not try harder to hire another OB provider. They have applied and they were trying to apply. From what we heard other nearby health facilities have hired providers, why not Mayo? We are down in deliveries because we had one provider, and he was doing an amazing job trying to keep up with the demands. Mayo choked out the OB department by not hiring more providers and sending labor patients to other facilities due to not updating the department and investing in the future."

A couple of questions. "How many births per day are there currently at Mankato Clinic Health Systems in Mankato? and can you share a list of how many providers you have actually tried to hire? Perhaps orthopedics can be shared until someone is hired here."

>> Stacy Sjogren (moderator): I think I heard three questions in there. Did you get three?

>> Shellae Dietrich (MDH): Yes.

>> Stacy Sjogren (moderator): And then, Shellae, just a note. I see a JH has their hand raised. I will get to you next. So, thanks for your patience. But let's give you all a chance to address those three questions.

>> Leadership (Mayo Clinic Health Systems): I will start with the first one, which is why don't we try harder, worked harder to hire. Obviously, I have no knowledge and I cannot comment on what the hiring practices and standards are of any other hospital other than Mayo so I don't know what the expectations of other facilities are, but what I can speak to is what our requirements here at Mayo when we hire a physician. Our expectation is when we hire physicians is that they are board-certified in their specialty. There is a national way of being certified to practice medicine. We require all of our physicians to be board-certified. That's #1.

Two, with regards to the family medicine physician, functioning as an obstetrician has become a common question we have been hearing. What we require as an organization, if we have a family medicine physician that is going to function as a full-time OB/GYN doctor delivering babies, doing C-sections. What that requires is that after their family medicine training, they need to do additional training in OB/GYN, which is possible for family medicine doctors. Once they do that, we expect two years of experience for them to come on our staff.

Those are our hiring standards or requirements that we have developed as an organization, not just a local one but as we have developed as an organization, if we want family medicine physicians to function as a full time OB/GYN doctor. We have not had any candidates that met those requirements. We did have one family medicine physician that was in the process of finishing their OB training but did not have those two years of experience. And so, to date, we have had no candidates apply that met those hiring requirements that we have set forward as an organization. That is what we require as a Mayo Clinic. Once again, the board certification and that additional training for family medicine. I cannot speak to the practices or standards or requirements of any other hospital. I am not familiar with them, but that is what we require as a Mayo Clinic.

I think that was question #1. Question number two, help me, Stacy.

>> Stacy Sjogren (moderator): Actually, Shellae, can you read questions two and maybe three, just so you can tee that up?

>> Shellae Dietrich (MDH): How many births per day are currently at Mankato?

>> Leadership (Mayo Clinic Health Systems): We do about 1500 deliveries a year so that relates to about between three to five deliveries per day average. Some days we have more and some days less, but that is the volume we have. Rochester does about 2500 a year so you can do the math on what that would be on a daily basis.

>> Stacy Sjogren (moderator): And Shellae, the third question was what?

>> Shellae Dietrich (MDH): Can you share a list of how many providers you have actually tried to hire? And it mentioned perhaps orthopedics could be shared between Fairmont, Mankato, Rochester until someone is hired.

>> Leadership (Mayo Clinic Health Systems): I think you got the first part of that question right. Yes, with regards to hiring Orthopedics, we do provide some cross coverage today with regards to orthopedics. We currently have a podiatrist that is based in Mankato that comes out and will be able to see patients here in Fairmont from a Podiatry perspective.

Also, we have a nurse practitioner that based here in Fairmont in Orthopedics that can see patients doing orthopedic assessments and T patients up to either do a virtual visit with an orthopedic surgeon as well. We do have an on-site nurse practitioner providing orthopedic care here in Fairmont as well as a podiatrist that will do outreach from Mankato as well.

Thank you.

>> Stacy Sjogren (moderator): Let's go to JH, which is Jen Harris and then over to you Katrina. Jen, if you want to come off mute and if you could share your name and maybe where you are from and your comment or question, please.

>> Jen Harris (Fairmont): Yes, my name is Jen Harris. I am from Fairmont. Used to work at Mayo. I have left Mayo twice now because of no job security, pretty much. I have a few comments and questions.

You keep saying you are committed to the community, committed to the nurses there. I can tell you there is lacking trust with your nurses and staff. You have closed ICU, closed OB surgery now. Lost Peds. There are rumors of the RNR in suit positions being taken away. Inpatient rumor to be closing. Southwest Minnesota Hospice rumored to be closing. You want to keep your employees happy but there is no trust and there are no answers when we are asking questions. We work at Mayo. We should have job security. Mayo is a huge corporation. When you get a job at May, you should be proud of it and should be able to have job security until the day you retire. Unfortunately, I have not had that, and it has made me have to find new positions two times.

Now I work out in the community, I work for home cares, work for hospice where when we have patients that are sick and we need to call and get them into our clinic in Fairmont, we are being told there are no appointments for a month, at least a month out. I'm sorry, your patient cannot be seen, go to the emergency room. We sent him to the emergency room for high blood pressure. The emergency room is bombarded with critical patients. Where are these patients supposed to go to get help? Us to being out in the homes, seeing this, what are we supposed to do when these patients need to be seen and there is nobody to see them?

That leads into, what is Mayo not doing that UHD is doing. UHD has six OB-GYN providers. Six. And you keep saying that you don't have the qualified providers that you can hire or it's all because of staffing. Well, what are you doing wrong that UHD is obviously doing right because they are getting providers. Their OB is flourishing and ours is now being closed.

I have delivered two babies in Fairmont. It was a wonderful experience. The nurses, the providers. It was wonderful. We doctored in Fairmont. Everything is good when you can get in for an appointment. So, I want to know, what is your actual plan, not a round-about political plan. I want to know what the actual plan is to recruit providers to this clinic to help keep this clinic going and to provide care that our patients in the community need.

>> Stacy Sjogren (moderator): There were a lot of comments in there and observations and some questions too. What did you capture in there that we can allow the panel to discuss and respond to and then we can just double check it in case we missed any.

>> Leadership (Mayo Clinic Health Systems): What I recorded was the bottom line was, what is the plan for recruitment? What I kind of heard loud and clear, right?

With regards to recruitment, we alluded to it, but I will emphasize it again. We have tried multiple different ways with a variety of different recruitment techniques. We have internal Mayo recruitment resources and tactics. We have an entire team of recruitment specialists that recruit for every single specialty across the medical practice. We contact local medical schools to see if there is interest in residents applying for our programs. That team goes to national meetings. If there is a national meeting for orthopedic surgeons, they go to those meetings and say we have jobs here, these various sites within Mayo Clinic Health System, including in Fairmont. They are doing a variety of tactics internally.

We have also employed two outside external recruitment agencies or headhunter agencies. They look on a national basis. They are recruiting people across the board. This is what they do. We pay them several thousands, actually approaching hundreds of thousands of dollars a year to have these agencies recruit for us as a Mayo Clinic. That is another tactic we have used.

Not only have we challenged with our internal recruitment, but the external recruitment agencies have also not been able to generate candidates either. We are not even at the point of talking about what we call signing bonuses or some of the other things we commonly hear, we haven’t even got to that point because we don't even have identified candidates from these external groups.

What is our plan? That is our plan.

I described a little bit about what we are doing internally. In addition to all the tactics that external recruitment firms do, this is what they do. This is what we pay them for and unfortunately, we just have not had success.

>> Dr. Gokhan Anil (Mayo Clinic Health Systems): I can add one thing, so I just want to make sure again that I am not going to comment on how other hospitals are doing. But OB/GYNs like myself, after medical school, we have four years of training as a residency. Physicians are wonderful and they can provide lots and lots of care, but they do have a residency specific to primary care needs of patients of men and women. So, for us to call that, you can provide no surgical service that is surgical and nonsurgical. I just don’t want to conflate these two things are not equivalent to one another.

A woman's life can be threatened because of the delivery complications. So that is one of the reasons that it is important to ensure that your physician has the proper training and experience to provide care for all patients. So again, I am not commenting on what other organizations do but this is why we have such high standards of expectations. Either have the training, along with training, some of them will have to have experience to be able to come and provide solo care because of the conditions that can require surgical intervention. These are important things to mention, it is not equivalent. A family physician cannot come and provide obstetrical care without having the proper training and experience.

>> Stacy Sjogren (moderator): Thank you for your question. I hope we got the key aspects attended to. We are going to pivot because you have been so kind waiting over here. So, we’ll be able to ask your question.

>> Audience Member: I have a couple of questions and comments. You mentioned the decreased number of applicants into the medical school and into the nursing programs and that you have been over and over and over reinforced it and repeated and repeated every program that I have ever been involved in, whether it is in the public schools, if it is in the communities, whatever. But most people that see success have a feeder

program that brings people up and puts them in those jobs or even gives them interest into what opportunities are available.

I am a member of the Fairmont School Board. We have had to cut our classes for health care operations for our students because we don't have the staff here anymore in the Fairmont Medical Center to help assist those students. And so, there goes that feeder program to our community. So, I would challenge you to invest into our community and all communities through Mayo, whether it is Southwest Minnesota, Southeast Minnesota, or any of the communities in Wisconsin, who can also benefit with that and divide up and get the feeder programs going, getting our students enthused and interested in health care. Because I think there is something missing in that. There are a lot of students and maybe it is not healthcare as being a family practice doctor or OB/GYN. Maybe it is being just starting out as a technology into the pharmacy program or it's someplace, another part in Mayo. But there is room for that to be done. And yes, we have smaller families, but there still is a need for that in our communities.

Another question I have, how many times has Mankato OB department had to go on diversion themselves because of not enough staff or no room in their brand-new facility? You mentioned that it opened in May 2024. Fairmont was closed for two weeks in June and then again on July 21st, we started the second diversion, which has continued to this day and will continue until March 31st, 2025. So, answer that, how many times has the Fairmont -- the Mankato OB department been on diversion?

>> Stacy Sjogren (moderator): We have two questions.

>> Audience Member: Two questions, I've got more.

You mentioned the on care, the Primary Care On Demand. Who is training these people? I am not trying to single out anybody in this room, but I know that my mother, who is 87 years old, does not know how to operate this. Does not. I go in, I help her with her medical chart. She does not go to Mayo. She goes to Iowa because she is closer to Estherville, but she does not know how to do that. She can't do it on her computer. She can play a solitaire game, but she can't operate this here. So, when is your and what is your program and your plan to educate people to be able to do the Primary Care On Demand? I do not see anything in any of the website. I have not seen anything on the app as to what you are doing to educate people. If you want people to use it, you have got to use the tools and help teach them the tools or help them, guide them to use the tools. I have spent days walking out of the hospital and I have seen people fumbling with their phones and I have helped them. They did not even know how to do that. How to get into their app. I would take my phone out of my pocket, yeah, I'm not supposed to carry my phone at work, but do you know how many times I have taught people myself how to use the app by using my chart as an example? We do not teach people.

>> Stacy Sjogren (moderator): Sorry, so I think I heard three questions in there. One was the really micro, local computer system right at the high school, even down to the high school level, right? And then number of diversions and then the app issue, which I am not sure is directly connected to the topic at hand, but it was brought up. But maybe suffice to say that there is a lot of emotion around the app so whether you want to address it now or not, I think they have heard the emotion around it. Is that fair to say? So go ahead.

>> Dr. James Hebl (Mayo Clinic Health Systems): I will take the pipeline question and then just to get the rest of my team ready, Dr. Anil, I'll have you take the diversion and then maybe Chris, I'll have you tale the app, portal, and those types of activities?

Regarding the pipeline, yes, we know that whatever we can do to start a pipeline as far upstream as possible is beneficial, which is why, for many years, we have been a part of what we call the Health Care Explorers program in all of the high schools. I think that is the one you were referring to. If that has discontinued in Fairmont, I am not aware of that because I know it was a pretty robust and actively used program. We have it at both Mankato high schools, Mankato East and West. We have it in New Prague. We have it in Waseca, and I know at one point we had it in Fairmont. I can't say if we have it today. That is where we have high schoolers come in and they get to rotate throughout all the hospital. They get to rotate through lab and through radiology and through nursing and shadow physicians. But they also get to work with nutrition and the dietary teams to show them all the different aspects of potential career choices in health care.

We also work with some of the larger high schools to allow students while they are in high school to train and get the certification to be a patient care assistant so that when they graduate from high school, they have that certification, they can attend a local college and immediately have a job as a PCA within our hospitals. And so those are some of the programs we have, and we are actively involved with to do what you said, which is crucially important to develop that pipeline. So that is the common pipeline. We would 100% agree so.

Do you want to comment Dr. Anil on the diversion?

>> Dr. Gokhan Anil (Mayo Clinic Health Systems): Before we do that, I also can comment on one of our nurse colleagues that actually went to medical school then came into rotations in Mankato so that we support ongoing learners. We do have role track residents that come actually spend time. We would like to make sure that they introduced them so that they can come back and work in Fairmont, Waseca, St. James as well. We have those ongoing options and also student rotations that happen to be with us. So I just want to make sure that this is so important. I, also, as a surgeon, I do have techs that learn and participate so they can continue to come and work within the health system.

In terms of diversion, I cannot tell you exactly how many times in Mankato, but we have been overwhelmed by the beds available. No health care system can provide at 100% all the time. That includes Rochester as well. Mayo Clinic Rochester goes on diversion at any given day because they get overwhelmed by the number of patients that may need care. So, I just want to make sure that we have a few instances that for a few hours we did not have enough rooms available for us to admit patients even maintain, but this is not unique. This happens in Rochester which has more than 1000 beds available for patients. I want to make sure that we try to minimize by search planning. Try to come up with contingency planning. But staffing and rooms availability are an important factor for any health care organization.

>> Leadership (Mayo Clinic Health Systems): But it is safe to say when Mankato or Rochester was to go on diversion status it would be for hours, not days and weeks like we are experiencing, for example in Fairmont. But there have been periods where for four hours here, six hours there, we will need some additional staffing. There would be periods of diversion. It doesn't happen all that frequently. I don’t have the number on the top of my head as well, but it is for hours, not days.

>> Stacy Sjogren (moderator): And then Chris, Do you want to comment on the app?

>> Christopher Hasse (Mayo Clinic Health Systems): Separate from the Mayo portal app. It is user-friendly. We rolled it out earlier in Wisconsin. We have had favorable feedback on the program and how it is used. It doesn’t just need to be on the phone. I know you mentioned the apple app download, it is also available with android. It’s been used on computers, laptops. When you initially lineup for the program there is a tutorial to

walk you through the app. The app also has live agents to help you at any point, going through answering the questions where you can help navigate through. So, there's live agent to help you get to the point where you have a visible physician.

We are also looking to revamp our Mayo Clinic Health System website to have more information about it on our homepage. And then we have several clinics that are actually working on these education sessions and people have further questions that they feel like they are not getting the answer, the chat agent online. So again, it is a newer program for us that we have been rolling out, but we are optimistic about the success and the feedback that we have been hearing from patients who have used everything. Like, just advertise that folks that have used the Primary Care on Demand app during the evenings and weekend hours.

>> Leadership (Mayo Clinic Health Systems): So essentially, those patients would have landed in the emergency department, which is why we created this access which is available 24/7. None of these apps or digital technologies will all solve the issues. So again, this is meant to be one of the additional access features.

>> Audience Member: Is there a plan to have education there at all systemwide for these? Is there a plan for education for these, for this on demand? Does it just answer that one?

>> Leadership (Mayo Clinic Health Systems): You know Amazon, right? You go in, you search for something, make a purchase. The questions that are posed in the Primary Care on Demand are very similar, user friendly, helped capture it and get you to a physician within that three-to-five-minute time frame to have a conversation.

>> Stacy Sjogren (moderator): We are going to go to you next and then, just so everybody is aware, there are about 157 people listening in online and wanting to make comments. We have staff that are looking through the comments that were submitted ahead of time and posted in chat. They are looking for questions that have already been answered and I will turn to them next. They have been waiting patiently too so I want to make sure that we get those questions answered but go ahead.

>> Audience Member: I have lots of questions.

>> Stacy Sjogren (moderator): How about three?

>> Audience Member: I started as an RN at Fairmont Community Hospital in 1986, worked med surgery, OB labor delivery, went to the O.R. Then I became a nurse practitioner, I worked at Mayo Clinic Health System, Fairmont, left for three and a half years because it was not working for me. Came back, worked another seven years.

Seeing a lot of changes over the years. I have seen episodes where we have tried to hire physicians for Fairmont, but they were also offered jobs in Mankato. So, they weren't specifically for Fairmont, and they took jobs in Mankato, or they took no jobs. Dr. Hebl, you stated in the Star Tribune and also with KEYC that you have been working with the staff, the Board of Directors of the Fairmont Community Hospital Foundation and other community stakeholders and that you will continue to work with them. Questioning, who are those stakeholders?

There is a map over in the corner that shows the service area of Mayo Clinic Health System Fairmont is not just the Fairmont community. It affects the entire Martin County, Western half -- the eastern half of Jackson County, the northern part of Iowa. All those people should have been talked with. This does not affect only the

hospital. It affects all those communities, all of our communities are trying to attract businesses to come into our communities, bring growth for our communities. What young person is going to want to come to this area? Well, they could not deliver their baby, start their family, have their child taken care of in this hospital. What company would want to come into this area when they know their young families are going to? Are they going to be limited in the services that they are provided. Also with surgical services, November, December is coming up. That is when all the colonoscopies are performed. G.I. takes care of all of those, I believe, in Mankato. They are already booked through January. So, nobody left in Martin County, Northern Iowa, in this service area is going to be able to have their colonoscopy unless it is done in this facility by our remaining surgeons. When they cannot handle all of those colonoscopies and all those procedures in Mankato, are you hiring more G.I. physicians to provide those services or are the general surgeons going to do them because what happens when you cannot provide all the services that our communities need? Are you bringing those services back to us?

>> Stacy Sjogren (moderator): Thank you. I think in there I heard, wanting to understand more completely how stakeholders are defined, is that right? And then, the colonoscopy and everybody laughed so they all know it, all coming in just November and December, but how to make those services work locally. Did I get those right?

>> Leadership (Mayo Clinic Health Systems): I will start with the stakeholders. Obviously, we can't speak to everybody, but we tried our best to speak to as many people as we possibly could, and I think I mentioned in my earlier comments that we are not finished. We will continue ongoing conversations.

Who are some of the stakeholders we spoke with? Well, it started with the community members that sit on our Board of Directors. And so, we have been having conversations with them on the challenges for literally the past 12, 15, 18 months. We have been having ongoing conversations with them so that’s one stakeholder group as our local community board members that sit with us. Another group that we had conversation with was the FCH board. As we talked about, which are obviously all community members. We had one-on-one conversations with all elected officials, both state and federal elected officials that represent Fairmont. We’ve had conversations with them. We had conversations with your local mayor, with your city administrator, your chamber CEO. We have also talked with county public health officials as well.

Those are some of the examples of the individuals that we have had conversations with along the way. Is there more work to do? Absolutely. There is absolutely more work to do, but that is what we have done up until this point. In addition to obviously our staff, where we have had three different town hall sessions with our staff members as well. So, that is with regards to that.

I’ll go to you in just a second about the colonoscopies.

Why would a family want to move to Fairmont? Let's not forget that right now, here today, two-thirds of deliveries don't happen in this hospital. They happen somewhere else already. And so, 20% happen in Mankato, 5% happen in Rochester and 40% happen in non-Mayo sites. That makes up a large percentage of patients that are already getting care, they are finding the care that they need outside this particular campus already here today.

I don't think I have to tell this group. We know that the demographics of Martin County, like many rural communities, the population decline is unfortunately happening. It is happening in every rural community in the state of Minnesota. Fewer and fewer people are moving to rural communities, we get that. And as Dr. Varkey also mentioned, the challenge with that is not only are fewer people migrating to rural communities,

but the communities are also aging. And so, as you get older, you have more complex medical conditions, and it is hard to get specialists in small communities. By nature, forcing you to go to larger urban centers and that is some of the challenge local rural communities cannot get care local because as they age, they have higher complexities, higher medical needs and we can't hire.

We have four GI positions opening in Mankato that we have been recruiting for two years. Mankato has challenges recruiting specialists as well. We have two cardiology positions that we have been recruiting too. A neurosurgery position, one ENT, two urology positions. It is not like Mankato is flush either. There are challenges with recruitment across our sites. It is by no means unique to Fairmont. I think we are four or five anesthesiologists short, radiologists, two or three. I can keep going on. It is across the board in terms of recruitment challenges.

>> Leadership (Mayo Clinic Health Systems): Colonoscopy wise, it is obvious for us that we will have to combine resources, combine GI doctors along with general surgery. At Fairmont, all the scopes have been done by our general surgeons this past year. We have done close to 880 colonoscopies in Fairmont and this year it might have been close to 1,000 if both surgeons were available. Given what you just shared, given our challenges in Mankato, we physicians will have to utilize our existing general surgery colleagues, along with GI colleagues to provide the quickest, fastest, and most appropriate care for our patients. It is dear to our heart. It can be lifesaving for patients.

Options for Cologuard is another option for patients who are otherwise skipping on their colonoscopies. It is nonprocedural option for colon cancer screening, but it's dear to our heart because we don't want a single patient to be not diagnosed. We will have to be as close to them as possible, but this is an ongoing problem that is impacting across the Midwest and across the country. 15% of all positions are open in Minnesota, as of today, and this is not just me looking.

>> Stacy Sjogren (moderator): Thank you. I apparently gave some people a heart attack when I said there were 157 questions. There are 157 people remotely, so I am sorry to you all. So, for those that are observing remotely, we've been having a robust, healthy conversation going back and forth, questions and answers and comments. There are a lot of people listening in remotely and I want to lean into that now and give them an opportunity for their comments to be heard and their questions to be asked. So Shellae, I am going to call on you to share what? Perhaps pulling out of the pre-submitted questions or the questions that haven't already been answered here so far tonight. Remember everybody, all the comments and questions, everything will be packaged and kept into the record.

Ok, but go ahead Shellae, what have you been seeing?

>> Shellae Dietrich (MDH): There are a couple more questions in the chat. First, one of them is, "Already living an hour from Fairmont and have Mayo insurance. Where am I supposed to give birth that will be covered? Hopefully try to make it to Mankato. That is one and a half hours away and not really possible."

And another question is, "What happens to the patient having an obstetrical emergency? They cannot wait to fly to Rochester."

>> Stacy Sjogren (moderator): Actually, let's just hang on a sec. Let's just do those two and come back.

>> Shellae Dietrich (MDH): OK. Let's stop there.

>> Leadership (Mayo Clinic Health Systems): Thank you. Dr. Anil can talk about the obstetrical emergency and then I will have Travis talk a little bit about the insurance issue.

>> Travis Paul (Mayo Clinic Health Systems): So, I think I understood the question. It was somebody who has Mayo insurance. The question was where to deliver. First of all, the decision on where to have your baby would be based upon a conversation with your provider and where do you want to deliver, what meets your needs. And if it's at a non-Mayo site? I am not an expert on insurance but if you have Mayo insurance, you are Tier 1, Tier 2 out-of-pocket deductible, would count against those services. You wouldn't have a new out-of-pocket deductible if you chose to have your baby at a non-Mayo site.

I hope that answers it. If not, please chat or if I missed a mark or if anybody wants a clarification. People have options.

>> Dr. Gokhan Anil (Mayo Clinic Health Systems): There is a question about emergencies. Again, as our emergency department is meant to address emergencies, #1, to timely diagnose, making sure that the patient has been stabilized. Communicate with the next facility available that is equipped to take care of those emergencies and transfer. Transport the patient to that nearest facility that is available. That is what our ER physicians and colleagues have been trained to perform. Our nursing colleagues have been trained to perform. That is not just for only for special emergencies, but all kinds of emergencies. And that is true for all of our facilities both in Fairmont along with other facilities we have ER services.

>> Stacy Sjogren (moderator): You want to give us two more questions that you spotted?

>> Shellae Dietrich (MDH): Sure, Here is one regarding recruitment. "2023 data shows the Mayo Clinic with revenues of nearly $18 billion in profits of over $1 billion. Why haven't Mayo's record-setting profits alleviated supposed barriers to recruitment? Is generating revenue more important to Mayo than providing health care in cities like Fairmont?"

>> Stacy Sjogren (moderator): And the second question?

>> Shellae Dietrich (MDH): Let me see here. This says in regard to surgery, "I was born and raised in northwest Wisconsin and many people who work for me in that region, Barron, WI, offer surgery and is a fraction of the size of Fairmont. It is not open 24/7 because of anesthesia limitations but they offer surgery on a far more regular basis than we do in Fairmont. How can an even smaller and more rural area support a surgery department that we cannot?"

>> Leadership (Mayo Clinic Health Systems): The first thing I want to clarify is the issue of recruitment is not related to finances. This is an issue of recruitment of OB/GYN physician and staff that Dr. Hebl and Dr. Anil had pointed out. The standards that we expect if they are family medicine physicians, at least two years' experience in OB/GYN.

The second thing is that it is not just there is the volumes that our staff, including teams that support the position in Fairmont and in any issues around low volumes that can predispose to quality-of-care concerns by the same.

>> Leadership (Mayo Clinic Health Systems): So, regarding the question about Barron, I don't know the specifics about Barron, however, Barron had used to have obstetrical services as well and we had to discontinue for the similar reasons. To my knowledge Barron does not have 24/7, as discussed before and may

provide elective surgery. I don't want to comment without having full knowledge but many of the things that we've discussed is beside the surgeon availability. The whole team has to have enough volume to keep us up-to-date and confident, as I talked about earlier. In our previous comments, when the volumes go down, the risk to the patient, the complications as well as the overall safety also tend to go down. So that is the factors that we tried to relate earlier, which led to the decision to discontinue surgical services. Besides just the surgeons, the whole team has to have enough volume to support the high-quality services.

>> Leadership (Mayo Clinic Health Systems): And just one more comment on Barron and Menominee. Both of those facilities previously had full time obstetrical care. In January 2023 both Barron and Menominee also discontinued their inpatient obstetrics. They still provide prenatal and postnatal care but what we are discussing here tonight exactly what happened at those Mayo Clinic Wisconsin sites in January 2023 as well.

>> Stacy Sjogren (moderator): So, here is where we are. I'm hearing from Shellae. She's the one that has been combing through the comments that were submitted ahead of time and then going through in chat and she said everything else that has been submitted looks like a comment, not question, so those will be entered into the record. Which then I can turn it over to you sooner than I thought. This I think will be the last commenter for the evening, but I am going to check in with the team before I make that blanket statement.

So please go ahead.

>> Audience Member: One of my questions is you talk about the family practice. Who wants to do OB and has done the training but needs experience. It is a lifelong problem with, well, you can't be hired, you don't have experience. Is there any type of program that they can work with Mayo and get that experience or is it just, you're not a candidate because you don' have the experience?

>> Leadership (Mayo Clinic Health Systems): We have one in Mankato currently doing that. So, family medicine physician who did the OB training working in Mankato under the guidance of an team of an OB/GYN team, a midwife team to get that two years' experience.

>> Leadership (Mayo Clinic Health Systems): Just to add, is that specific fellowship program year, not only having rotations but also the surgical experience to be accomplished within typically a year.

>> Audience Member: I understand that. I just wondered if the experience is the piece they don't have, can they get it within the Mayo walls. The winter months are coming upon us and some of these things are going to be closed in March next year. Ambulances don't go. Helicopters don't fly. We have a woman who needs a C-section. We have an appendix. How are we going to manage?

>> Leadership (Mayo Clinic Health Systems): We touched on that comment earlier. It is incredibly challenging for any rural community hospital to be all things to all patients. Whether it is a volume concern, whether it is a recruitment concern. We are not negating the fact that those things are going to happen.

>> Audience Member: And the emergency department is where those people are going to be and exactly and what are those poor people going to do?

>> Leadership (Mayo Clinic Health Systems): We all know Emergency Room physicians are trained to deliver babies. We have also put them through additional training by our obstetricians, knowing this was happening. We did that up in New Prague when we had the same exact conversation in January of this year, where we discontinued inpatient OB care in New Prague at our facility there. We are having that conversation here. Our

obstetrician team went and trained additional training for the ER docs. So, even though they get that training in their residency, we wanted to give them above and beyond that. We will have women deliver in the ER. We have that today in St. James. We have two or three deliveries a year in the St. James emergency room where we have never had obstetrical services there. So that is going to happen. That is the nature of delivery.

>> Audience Member: Vaginal delivery, but my concern is if you need a C-section, or you need a surgical procedure then. Yeah, unfortunately, putting the maternal and child health at risk.

>> Leadership (Mayo Clinic Health Systems): Your concern, is why we beef up the ability of our emergency team to be able to deal with emergencies. Like I said, it happens in emergency rooms across the state today.

>> Audience Member: I work in oncology and infusion. We have patients who need biopsies, patients that need colonoscopies. We struggle to get them to Mankato to get these services. They're older and they don't have transportation. Sometimes we have to wait a long time to be able to get those services. Losing the surgeon to be able to do some of those biopsies and some of those colonoscopies and things is going to hugely impact cancer and the oncology department and the cancer patients to not have those services.

>> Leadership (Mayo Clinic Health Systems): Travis, do you just want to comment because that's obviously an elective transportation issue, not an emergency transportation. But I think you bring up a great point of more broadly the challenges of transportation, system transportation, having a void and impacting health outcomes in rural communities.

>> Travis Paul (Mayo Clinic Health Systems): Exactly. This is a topic I can go on and on about. I hosted a group from a major insurance company in Mankato last week. We talked about rural health and the challenges and one of the things we visited with this major health insurer is could we collaborate around transportation? We have applied for some innovation funds at Mayo Clinic, looking at developing some AI solutions to better coordinate transportation as well as getting some sprinter vans or different vehicles. I think this is an area where we can partner with different communities like Fairmont. I see the buses, but could we have a regular shuttle run twice a day so you can have predictability? I could ramble here because I like the conversation where we are heading now, which is framing what can we do moving forward?

So, tying this back to Dr. Hebl's introductory comments, if you can reimagine this campus into a health and wellness hub and you can concentrate the services in the community, then patients can come to one place for services, and you can have your transportation hub based here and have shuttles to Mankato or whatever the case might be. But conversations underway, it is not a singular solution. The Mayo transport ambulances, helicopters for the sick patients, there is a tier you know. I can tell you about Sprinter vans that have the ability for stretchers and wheelchairs and then a host of others. So, I think this is the conversation we want to continue with the community and continue with their staff about what are things we can do to address common challenges. And quite honestly, I would love it if we could use this campus and this hospital to be an example for other rural markets. Sorry, I am passionate about this.

>> Stacy Sjogren (moderator): All right, I am going to check in with my team here. Are we…

>> Audience Member: There are important questions I have been following about…

>> Stacy Sjogren (moderator): No. We are not checking. What we are going to do here is…

>> Audience Member: There are serious questions in the chat about emergencies that I think people are feeling really uncomfortable about and I am just going to, for the sake of time, I am just going to go through these.

>> Stacy Sjogren (moderator): Are they questions or comments? There are questions and there are comments I think you have already addressed them, but if you have more to add to it, I think it would be appropriate to add at this time.

>> Audience Member: So, the comment is that there were some vague questions about obstetric emergencies. OK, so cord prolapse. Who is going to hold the baby's head up long enough to transport to another facility so that there can be a stat C-section? What about the mom who has a placenta abruption? And how will you handle that? It can take 10 minutes in an emergency to save both lives while a mother is bleeding out. How horrifying and frightening for the mother in the community and who is taking care of the mother who is dying, and will the providers be able to intubate newborns? How do we know that it is an emergency or how the baby is even doing when we can't put a monitor on them.

So, those are those questions. I don't know if you have comments on that, but I would like to ask you if you would make a response to that because I think that is frightening for the community.

>> Stacy Sjogren (moderator): Other comments that are in the chat here will be in full provided, made publicly available but to those comments, I would agree that it is scary for any mom who might be listening tonight wanting to be sure that there is going to be something in place for them to be taken care of.

>> Leadership (Mayo Clinic Health Systems): I will try to take that question. We would like to not to discontinue any of these services. I wish that we have enough staff. I wish we had enough OB/GYN's to provide the best care so that no woman, no child has to ever go through any of these scary things. That is why I want to do the training. My life is committed to women as well as all the nurse colleagues as well as my anesthesia colleagues. Now, I cannot say that as of the current state, ad OB/GYN cannot be in-house 24/7, 365 as of now. That is just not feasible. These are difficult decisions we are making given the fact we do not have OB/GYN physicians. We have one OB/GYN physician that is supposed to cover 365 days a year. That is not feasible. When we are taking calls, we are at home. So, when somebody calls us, we are driving from home to come emergently. And I have been in those situations. I have taken the calls in Menominee, the place that Dr. Hebl talked about in Wisconsin. I have been in those circumstances as well, so I am not going to tell any one of you saying that emergencies do not happen. They do happen.

Good news is a prolapse is one in 1,000 deliveries. It is quite rare, not a common instance. When we do not have qualified trained personnel available, the best next thing we can do is make sure we inform our patients saying we do not have the services available in this location. That is one of the reasons we are here today to talk with the community to make sure they understand their options and for high-risk women, we try to recommend for them being closer to a place that may have availability. That is #1.

Number two, for patients who are receiving care from us, we make a plan and deliver on with them so that they know exactly what they can do within reason. We live in Minnesota. Yes, I do know the roads are not always amenable to transportation so how do we prepare staff for that possibility? None of us, including physicians, do not want to be in this position as well, but unfortunately, when we do not have qualified personnel, I am going to ask you what we need to do collectively so that we minimize the risk factors to moms and babies. There is none of us would want a single citizen of this community to be harmed or be in jeopardy

because of an emergency situation. Again, heart attacks, aneurysm ruptures can happen to human beings at any given time. We do not have every qualified personnel ready and available in every single location. That is not feasible. So, I completely sympathize making these difficult decisions, but we have a very difficult set of circumstances that the Mayo Clinic cannot overcome. I have been trying to convince, been trying to find OB/GYNs in position along with my colleagues, but the country does not make enough of us and there are more needs than we can provide 24/7. I hear you, I sympathize, and I want to minimize those risk factors.

>> Stacy Sjogren (moderator): Maria is saying that we have covered the questions that were posted ahead of time. In the chat, I think we, do you have a question that has not been asked so far? Give me a second.

>> Maria King (MDH): I just want to check on this. Ok, we will take this question and then that will be the last question of the evening and then we'll go ahead. We are just trying to be respectful of people's time, but we wanted to make sure the public got – yeah, this will be the last question. Go ahead.

>> Audience Member: There is a little background. I have been at a nursing facility for 16 years. I previously worked OB labor and delivery services and I currently work in the ER. What is your plan for transportation for these emergencies because this has been an ongoing issue. We have yet to see any resolution to transportation to not only get OB patients but all emergent patients that need a transfer out of our facility in a timely manner. We are getting bombarded on days with clinic patients because there is no clinic access. Yeah, we have got strokes and traumas and heart attacks that need to get out and they are sitting, boarding in our ER because there is no way to get them out timely. And now what happens when the mom comes in bleeding, and we risk losing a mom and baby when we've got all these other borders in here trying to get out the door.

>> Travis Paul (Mayo Clinic Health Systems): This has come up a number of times tonight. For those of you who follow along, Mayo transport has implemented some new strategies in different markets. With this tiered approach, and its acuity implementing EMTs to the paramedic models as a way to scale or add more capacity. I did have a meeting with the transport folks a month ago or two months ago, when leading up to this, they are looking at the data specific to that because I hear it a lot. You know, I see that all the time. I hear the stories about length of time. So, looking at the data to see what solutions we can drive that way. I can tell you that the senior Mayo transport leaders are well aware, I won't use names, but of the situation. The tactics they have implemented again is implementing some EMTs in addition to paramedics, I think they call it tiered response, I think in September in a different market nearby, hoping to learn from that. It is not a problem having physical rigs, It's enough paramedics so I know it's a virtual paramedic training program. I think the first class are graduating soon. I met with our colleagues at Allina to see what they are doing and partnering with communities looking at solutions.

>> Audience Member: It has been an ongoing problem for quite some time. Now it is not a new problem. We ask for assistance for this and there have been no changes to it.

>> Stacy Sjogren (moderator): Alright, so I think we are at a point where we will turn it back to you for closing comments.

>> Leadership (Mayo Clinic Health Systems): I will keep this short. First, I honestly want to thank everyone for coming tonight. Hearing your perspectives is important to us. We appreciate you coming in in person for this event this evening. Your passion, your commitment for Fairmont is clearly obvious. We very much appreciate that.

Second, we are very grateful for our MDH colleagues for sponsoring and hosting tonight and we are grateful for the honest and transparent discussion we had this evening. We have heard a lot of these things from staff, but it is another great opportunity for us to hear the concerns and to do what we can where we have influence to make things better for this community. That's what I'd like to say, and once again, I appreciate everyone coming. Thank you.

>> Stacy Sjogren (moderator): A final thank you from Maria and as you are getting ready, I will slide out of your way. Just a quick note, some of these panelists -- I thought I heard someone was driving from La Crosse and they are going back, so that several of them, they are going to be scooting fast to get on the road and get back home. So. if they are leaving right away, that is why they are just needing to get on the road. Maria.

>> Maria King (MDH): Thank you, everybody, for participating tonight. It was really important to be able to hear what you had to say. All the comments that were in the chat, all of the comments that were sent in, in advance, they will all be made publicly available. And there were a lot of them so we could probably be here for another hour and a half or so to be able to read them all, but they will all be made publicly available.

>> Stacy Sjogren (moderator): Just to comment that the website said they were taking comments on that forum until the 29th of October so people can still comment.

>> Maria King (MDH): That is right. Thank you. I appreciate the help. We really take it seriously and I would echo the comments that there is a lot of passion here and can tell that there are a lot of concerns from the community, and we appreciate your providing that for the hospital.

For the next steps, under the statute, MDH, again reminding you we have the authority to hold the meeting. We have the authority to inform the public, but we cannot change, delay, or prevent the proposed changes, closures, or relocation of services. You can provide comments or feedback on the hearing website until tomorrow evening at 11:59 and then within ten days, everything will be publicly available for you to read.

Thank you to all of you from Mayo. Safe travels home for those of you who have a long distance. I really appreciate this. I wish you a good day. Thank you.

Minnesota Department of Health
Health Regulation Division
PO Box 64900
St. Paul, MN 55164-0900
651-201-4200
health.cm-web@state.mn.us
www.health.state.mn.us

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