Mercy Hospital-Unity Campus Consolidation of Addiction Recovery Services; Abbott Northwestern Hospital Discontinuation of Inpatient Kidney Transplant Surgeries Public Hearing Transcript

SEPTEMBER 25, 2025

Meeting Information

The Minnesota Department of Health (MDH) held a public hearing at 6 p.m. September 25, on Allina Health's closure of its inpatient chemical dependency unit at Mercy Hospital – Unity Campus in Fridley as well as changes to the Kidney Transplant Program at Abbott Northwestern Hospital in Minneapolis.

According to the filed submissions, Allina Health will be consolidating and relocating addiction recovery services effective Feb. 20, 2026.

The Kidney Transplant Program at Abbott Northwestern Hospital discontinued inpatient kidney transplant surgeries on June 27 but continues to provide post-kidney transplant care. Per state statute, the hospital meets an exception for the 182-day advance notice requirement due to the inability to recruit a kidney transplant coordinator, a position required for hospital transplant services

More information can be found on the Allina Mercy-Unity Campus and Abbott Northwestern Hospital Public Hearing page (https://www.health.state.mn.us/about/org/hrd/hearing/allinaunity.html) of the MDH website.

Meeting Transcript

>> Catherine Lloyd (moderator): Good evening, everyone. Welcome to the public meeting to hear Allina Health closure of the inpatient chemical dependency unit at Mercy Hospital-Unity Campus in Fridley, as well as changes to the kidney transplant program at Abbott Northwestern Hospital in Minneapolis. According to the submissions, Allina Health will be consolidating and relocating addiction recovery services effective February 20, 2026.

The kidney transplant program at Abbott Northwestern Hospital discontinued inpatient kidney transplant surgeries on June 27 but continues to provide post-kidney transplant care. Per Minnesota state statute, the hospital meets an exception for the 182-day advance notice requirement due to the inability to recruit a kidney transplant coordinator, a position required for hospital transplant services.

My name is Catherine Lloyd. I am a manager for Planning and Partnership in the Minnesota Department of Health and am serving as moderator for this meeting. This evening's hearing, which includes both an in-person and virtual option is hosted by the Health Regulation Division. We are in the auditorium at the Mercy-Unity campus, 550, Osborne Road, Fridley, Minnesota, to provide a forum for the community to discuss a change in services at Mercy Hospital-Unity Campus, and the Abbott Northwestern Hospital.

So, for this hearing, participants online will be muted until the public comment portion of the meeting. At that time, both in-person and online participants will be selected and allowed to speak -- is it my phone?

[Audio disruption]

Give us a few minutes here. Okay. We're good. Let me start this last sentence again. Are we good?

All right, for this hearing, participants online will be muted until the public comment portion of the meeting. At that time, both in-person and online participants will be selected and allowed to speak. If you wish not to speak, you can ask your question in the chat box and a Minnesota Department of Health staff person will ask the question on your behalf.

The chat feature is used to provide information for the session and to ask questions during the meeting comment period. To open the chat box, click on the icon that looks like a cartoon speech bubble with two lines in it. If you're using Teams in a browser window, the icons are at the bottom of the screen. If you're using the Teams app, the chat icon is in the top right corner of your screen.

Captions are being provided for this event. You can view captions in Teams by clicking the more button in the Teams window, then choose "Turn on live captions". You can also view the captions online at the address now being posted in the chat. So rather than reading out the URL or website, it is in the chat.

You can find more information about today's hearing on the Department of Health website also being posted in the chat. If you have any technical issues, please visit the Microsoft Support page for teams or email the HRD, which is Health Regulation Division, Communications Team at mailto:health.HRDcommunications@state.mn.us.

The Tennessen warning is next. The Minnesota Department of Health, sometimes referred to as MDH, is hosting this public 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 comments and ask questions about Allina Health’s closure on the inpatient chemical dependency unit at Mercy Hospital-Unity Campus in Fridley, as well as changes to the kidney transplant program at Abbott Northwestern Hospital in Minneapolis. The Minnesota Department of Health announced this meeting through a statewide news release and notified the community leaders of the meeting.

This is your Tennessen warning. The Minnesota Department of Health is hosting this public meeting to inform the public as required by law. Your comments, questions, and image, which may be private data, 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 10 business days of the meeting.

With this in mind, today's agenda will include introductions -- welcome from the Department of Health, Health Regulation Division Director who will provide you with an overview. And then we will hear from Allina Mercy-Unity Campus and Abbott Northwestern Hospital’s presentation. Followed by public comments and questions. And then Allina Mercy-Unity Campus and Abbott Northwestern will provide closing remarks followed by a conclusion by the HRD Division Director Maria King.

The following are today's speakers. We have Maria King. Maria is our Health Regulation Division Director for the Minnesota Department of Health. Michael Johnston, President of Mercy Hospital. Joe Clubb, Vice President, Mental Health and Addiction Services. Sarah Kaspari, Director of Advanced Heart Failure and Transplant Services. And Dan O'Laughlin, Vice President of Medical affairs and Acute Care Clinic Services. Now

I would like to welcome Maria King, Health Regulation Division Director at the Minnesota Department of Health.

>> Maria King (MDH): Hello, everybody. Thank you, Catherine. Really nice. We appreciate that all of you joined us tonight for this hearing and that you have been interested in learning more about the changes that are going to occur at Allina Health Mercy Hospital-Unity Campus as well as the changes that occurred to the kidney transplant program Abbott Northwestern Hospital. It's a pleasure to be here tonight.

The public hearing is being held so that we can satisfy the statute that offers the community an opportunity to learn about the hospital's plans and for the community to share comments and questions with the hospital. It's an opportunity for the public to engage with hospital leadership, to hear the reasons why leadership has made the decision that they have to close, change, or relocate services. And it gives you an opportunity as a community to learn about the continued access to health care after the change is made.

This hearing is being done in accordance with Minnesota statute 144.555, and if you go to that statute in Google, there were two changes passed in 2025 that haven't been yet updated, but if you click on the line, it will take you right to those changes. The Health Regulation Division is tasked with implementing this statute. We are providing a forum for the hospital representatives to share information about the changes in services and for the public to engage with the hospital by asking questions and providing comments about the changes. The statute gives the Department of Health the authority to host the meeting to ensure the public has an opportunity to be heard about the decisions that have been made and for the hospital to provide feedback back. We do not have the authority to change, delay, or prevent proposed changes, closures or relocations. This meeting provides the opportunity for us as your state health department to offer a forum for transparency, listening and understanding of the differing opinions and perspectives that there may be surrounding these important decisions.

We are going to limit tonight's discussion to only the specific topics that the hearing is being held for. We welcome you to share your perspective, comments and questions regarding these issues with the Allina Mercy-Unity leadership, and I am looking forward myself to hearing the discussion.

We're first going to hear from Allina Health leaders who are going to provide information about the services that they're modifying or curtailing, an explanation for the reasons why, and description of the actions they are taking to ensure that patients in the hospital service area and in the access area have continued services to the health services being modified. With that, I would like to welcome Michael Johnston, president of Mercy Hospital.

>> Michael Johnston (Mercy Hospital): Thank you. First of all, good afternoon, everybody. Ido appreciate you being here. Welcome to Unity Campus. My name is Michael Johnston. I'm the President of the Mercy and Unity Campus. What I would like to do is introduce my colleagues. I'll let them introduce themselves and where they work and what they do first.

>> Dan O'Laughlin (Abbott Northwestern): My name is Daniel O'Laughlin. I wasn't introduced in the beginning, but I am the Vice President of Medical Affairs at Abbott Northwestern Hospital and the Vice President for Acute Care Services for Allina.

>> Sarah Kaspari (Abbot Northwestern): Sarah Kaspari. I am the Administrative Director of the Advanced Heart Failure and Transplant Services at Abbott Northwestern Hospital.

>> Joe Clubb (Mercy Hospital): Good evening. I'm Joe Clubb and I serve as Vice President of Operations for Mental Health and Addiction.

>> Michael Johnston (Mercy Hospital): Okay. Next slide.

All right. So, our agenda today is to cover the following: we'll have the background of who and what Allina is and what we do, the gratitude we have for the services we provide, the why on the closure of the inpatient chemical dependency unit, the continued services, and our kidney transplant program update. And definitely a commitment to our teams as we move forward with this transition. Next slide please.

So, Allina Health is a nonprofit system that cares for individuals, families and communities throughout Minnesota and western Wisconsin. Next slide.

Our impact is far reaching. Allina Health is one of the largest employers in Minnesota. As of December 31, 2024, our team of employees include more than 27,000 full-time and part-time FTEs. We have over 6700 expert advanced practice providers that include physicians, nurse practitioners and physician associates.

Some of our key performance indicators from the 2024 year-end reporting are as follows. We have had 6.6 million clinic and urgent care visits. 1.4 million hospital visits, of which 1.3 million were outpatient and 105,000 were inpatient admissions. We do well over 334,000 ED visits annually. 82,000 surgical procedures a week, of which 55,000 are outpatient surgical procedures and 27,000 are inpatient surgical procedures. We do over 12,000 births annually and almost 150,000 ambulance responses in our communities.

We currently have 6700 active search studies in progress. Our Customer Experience Center handles 5.7 million calls with our patients. We distribute $435 million through our community benefit program. And through our community, about $550,000 patients are seen for health-related social needs. Next slide please.

I want to talk a little bit about Unity Hospital. As part of our overall Mercy campus, Unity has been a pillar of this market since 1969. The Unity EDC sees over 50,000 patients annually. There are about 134 med-surg beds, of which 30 of those beds are high level cardiac, which is supported by our MHVI service. We have two floors that are 44 beds that are med-surg units caring for multiple modalities. Hospitals are shared between both campuses, so we have consistency as well as our ED providers over both campuses. And I think you can see from the slide from a mental health perspective, you know we do a lot. Our emergency Department is staffed 24/7 with mental health crisis clinicians. If you want to take it, take it. Go for it. Next slide.

>> Joe Clubb (Mercy Hospital): Thank you, Michael, for that overview. I do want to speak to the mental health and addiction services. So, is that all offered on this campus? We do offer mental health and addiction services across the entire Allina Health. On this campus I want to make a couple of corrections to the number.

With the adult beds, the senior beds, and our current inpatient chemical dependency unit, that is a 24-bed unit today. That would bring us up to 85 total beds on the campus. With the closure, we would actually reduce the beds to 61.

On the campus, as Michael mentioned, we do staff the Mercy Hospital Unity campus, like all of our 12 emergency Departments with master’s prepared social workers who are crisis clinicians we call them, and they meet people in mental health and addiction crisis and provide assessments. And they also work in partnership with our sub-specialty of ED psychiatrists who evaluate the patient within the emergency department. We are currently, of the 25,000 visits across the entire Allina system for mental health and addiction, we are currently

discharging about 65% of those individuals to outpatient programs and services. This has been a change that we've seen since 2019 when we were at about 55% and we are seeing a lot of our expansion to outpatient programs and services. We have seen that increase of discharge to outpatient plans. What we're proud of is the Center for Mental Health and Addiction Services on the campus here in Fridley. It's just behind the building. If you haven't seen it, we'd love to -- we're very proud of that location and have received Allina support from our board to build that building and to raise $25 million and philanthropic dollars to support that center.

Within that center, we have our ability now, with the expansion, to serve all of our programs there. The lifespan. What that means for us is it means in the center, we serve children, adolescents, adults and our elders. And so, we have on our first floor, our outpatient addiction services. We have several tracts of outpatient addiction services for adults during the day. We also have evening tracts that we offer. In addition to this is a center that provides a virtual addiction clinic to the state of Minnesota. We provide virtual addiction care through physicians who prescribe Suboxone and other medications for addiction, as well as therapists. And that out of that clinic in that center we support and serve residents that live in 33 counties in Minnesota and western Wisconsin. We're very proud of that, and we were one of the leaders in advancing new technology and service to those that struggled to have access to addiction care.

In addition, within our partial hospital and day treatment program, our partial hospital program is a day hospital program. It's our highest level of outpatient care. And in that program, we serve children, adults, adolescents and as well a senior tract.

We've added a co-occurring partial hospital program to the services, and what that means is individuals who live with mental illness and addiction can sleep at home at night and come in for the hospital care for six hours a day. They see psychiatry, they have nursing care, and then the majority of the day is spent in individual group, individual and group therapy.

In the middle of the building is our hospital-based clinic. It is through that clinic that we have addiction psychiatry, addiction medicine, and that is an opportunity for people who need medications to support them with opioid addiction or other addictions can receive that. We also have started an injectable Suboxone clinic with that as well, so a lot of our services within the center have expanded. In addition, we provide a very valuable service to the community of chemical dependency evaluations. Every day we schedule outpatient evaluations, and we make room for walk-ins, for people to walk in because when you need addiction treatment, you need it when you need it. And so that's why we offer a walk-in service as well.

Those are the services that we provide on the campus. And I'd like to just -- I am really moving into talking a little bit about, if we go to the next slide, talk a little bit about our inpatient unit.

And I just want to lead with gratitude. For many of the staff - and I see some of you here tonight, just to express gratitude for the many years of service provided, the individuals who came through the unit, not just from this community, from across the state, and received inpatient addiction care. This unit was one of the pioneering units within the state. It was also one of the last inpatient units within the state.

For the last two years we have seen a significant change in the ability to receive authorization for payment for inpatient chemical dependency treatment. And we've seen that dwindle over the last two years, and so we went to the state, and we actually requested a waiver. And that waiver was to admit individuals who needed medication assisted or hospital assisted withdraw from their chemicals or their alcohol. We can provide that

on a medical unit, but we went to the state to ask if we could admit people who did not have a desire for treatment but knew that we have experts on the unit that could provide this care. That helped us, and that became 75% of our average daily census, which has run for the last two years of an average daily census of 10 with great fluctuation.

Those of you that work on the unit have seen that census go down and rise up. We get very excited when we get up to 15 and 16 during a period of time. But the length of stay was greatly shortened, and insurance companies were willing to pay for the time that an individual was in withdrawal, but the days of paying for inpatient hospital treatment were ending. And so, the expectation was to move individuals to residential treatment programs within the community and to intensive outpatient programs or to one of the other options that I outlined as well. And so, with the length of stay, when I was here 10 years ago, we were seeing a full unit, a waiting list and a longer length of stay, and the average length of stay has been slowly going down to sometimes three to five days really just to manage people through their withdrawal.

One of the other barriers for the unit is those of you that have been on the unit, there are some physical limitations to that unit. It was built as a unit to serve ambulatory individuals. Bathrooms are very small. It was limiting us to how many medical patients we could take on the unit, and so we did need to have those that had greater medical needs than we could manage on the unit remain on some of the medical units within the Unity campus.

But again, just really want to recognize the life saving and life changing work that has been done on that unit in the past decades. And I'm proud of those contributions but just have recognized that in the last two years with the best efforts by all of us, the demand is there to manage withdrawal. And we were admitting as many patients as possible that we were able to manage within that setting. So those are dances in new ways to provide addiction treatment. Out health plans, recognizing there were other opportunities that they would fund, really led to decreased need for the 24-bed unit. I'm really running a unit with a much smaller census. It just became so cost prohibitive when we recognize that we could care for patients who required medical withdrawal on a medical unit.

So, we will continue to advance our commitment to addiction, not just here, but we are in partnership with the Ridgeview hospitals and clinics in Waconia, and we will be bringing addiction services to our outpatient services in the 212 building in Chaska. We will be opening up a center in Shakopee and will be in partnership with St. Francis Hospital and bringing outpatient addiction treatment, as well as with the Abbott campus changes. We're going to be adding outpatient addiction treatment to that service area as well. We're very proud of our Cambridge outpatient addiction program, where they not only provide inpatient/outpatient, but provide virtual outpatient addiction care for people across the state of Minnesota. And then we will still remain outpatient services within Hastings, at our United Hospital on Hastings campus.

So, we will still admit patients who do not meet eligibility to go to one of our community detox programs like Gateway or 1800 Chicago, or Mission. And we will admit them when their medical needs require an admission to a medical bed. That concludes my comments on the closure and then our continued commitment to addiction treatment within Allina Health. I am not sure how you want to proceed.

>> Michael Johnston (Mercy Hospital): Abbott Northwestern Hospital kidney transplant program has been in existence for the past 28 years. It has performed a number of transplants and care for those patient's post-transplant as well as caring for those living donors. We are quite proud of that program and I also I want to

express my sincere gratitude to all the people who have made that program possible. It is really a testament to Sarah Kaspari and her leadership and the team that she worked with and all the patients that we have served over the years. Unfortunately, we had to make a very difficult decision June of this year when we had some staffing challenges, and given the complexities of patients, given how we pride ourselves on high quality, we made the decision to close the program on June 27th in consultation with our surgeons and nephrologists, feeling it was the best option available. Next slide? Sarah?

>> Sarah Kaspari (Abbot Northwestern): We made the decision to close the program after careful consideration of our ability to fully staff the program. The program really does require very specialized, trained transplant coordinators to be able to fully support the patients and the gift of organ donation. It is important to know that the things that aren't changing is for those patients who are on the wait list at the Abbott Northwestern Kidney Transplant program, those patients did not lose their accumulated waiting time. Their current wait times are preserved, and they can be transferred to another transplant center once they are approved by another program. And it's important to know that we are continuing to care for patients who have already had kidney transplants, so those patients can continue to come to our nephrology clinics where they'll be cared for by a transplant nephrologist. And then also want to acknowledge that we are working very closely with the patients who are on our wait list and helping them to and help you to support them and being transferred to another transplant program.

>> Michael Johnston (Mercy Hospital): At this point, do you want to open it up for questions?

>> Catherine Lloyd (moderator): Thank you, Allina. Thank you so much for your important information for the public hearing.

So now we will begin the public comment portion of our meeting. So, this is your turn to participate by asking questions, providing comments, or sharing your perspectives. Each person will have up to two minutes to ask a question or share their comment. I will give a time signal, if you can see me -- I think the mic is over on the other side. So just in case you miss my cue, I will have to verbally interrupt you so just so you know in advance. We have a lot of folks here, so we'll be sticking to that time frame.

Again, please remember that the information you are sharing is being shared virtually for a public forum. This means that any information you share is public, so please keep this in mind before sharing private medical information. Allina Health will have an opportunity to respond to questions and/or comments. Online participants will be muted until it is their turn to share their comments or ask a question. For those of you who joined us in person, please raise your hand or you can walk up to the mic across the room from me. And so, when it's your turn to ask your question or provide a comment, in both the mobile app and the browser version of teams -- let me see if I am at the right place here.

Excuse me. I was talking about online, so just make the clarification there. So, for online participants, there are two ways to 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 your question or provide a comment. In both the mobile app and the browser version of Teams, click the more button to show the "raise hand" option. in the mobile app the icon is a little yellow hand. In the browser version the "raise hand" option is the fifth item from the top of the list. You can also see this on the overhead, too, that the team is sharing. If you are calling through a phone, press *5 to raise your hand. Once it is your turn, press * 6 to unmute yourself.

The second is to type your question in the chat box, and press enter or send so that the Department of Health staff can see it to read it on your behalf. To open the chat box, click on the icon that looks like a cartoon speech bubble with two lines in it. If you're using Teams in a browser window the icons are at the bottom of the screen. If you're using the Teams app, the chat icon is at the top right corner of your screen.

We will select participants as hands are raised, read questions and comments received during the public comment period, as well as questions and comments in tonight's chat. Please remember to share your name and the city where you live before asking your questions or sharing your comment. And just so you know, I will start with the comments that we've received through the chat, and then we'll go to the mic.

Please be respectful. Everyone participating in this session tonight has an important perspective to share. Community members care that they will receive the services they need when they are most vulnerable. Health care staff care about their patients and hospital administrators care that their communities are well-served, and the resources are available. I ask that you help me make sure you can both be heard and treated with mutual respect.

With this in mind, abusive comments, comments meant to discredit or malign someone, or vulgar language will not be tolerated in chat or during verbal comments. People who use language that is threatening, make false accusations meant to damage reputations or use offensive or inappropriate language that creates an intimidating environment will be muted, and the next person in line will be given the opportunity to provide a comment.

And then at the closing, Allina Health will have an opportunity -- excuse me, during the question and comment section, Allina Health will have an opportunity to respond to your questions or comments. Our time together can be adjusted to accommodate participants who have their hands raised and have not had a chance to speak.

So, with that in mind, I am going to -- I see someone is at the mic. Okay. Sorry about that. We are going to give you two minutes to speak. There is a lot of people in here and a lot of people online, which is fabulous. And there is an error on our slide. We apologize for that.

>> Public Member: Just 3 minutes. That's a shame.

>> Catherine Lloyd (moderator): Maybe we can start with our team. Team MDH. Do you have some comments or questions that you would like to plug in right now?

>> Shellae Dietrich (MDH): Sure. We have some comments that came in prior to hearing. I can start with the first comment. I am concerned that the closing of the chemical dependency unit at Unity Hospital will eliminate needed inpatient detox beds in the Twin Cities and particularly impact the north suburban communities.

I am an RN and was both clinical development coordinator and nurse manager of Unity Chemical Dependency Unit Program in the early 2000's. I have been employed at Fairview University Intensive Outpatient Chemical Dependency Program and consulted with Park Avenue treatment programs. People who are detoxing from substances they have been abusing are experiencing emotional and physical complications that put them at risk of death. Early symptoms of withdrawal can be subtle and may not alert staff who are not experienced in managing these patients. I assume Allina is suggesting that the detox patient cans be admitted to medical beds and treated in that setting.

I believe medical nurses have expertise in managing most medical conditions requiring hospitalization. I don't believe we should expect the detox patient to fit into a standardized care setting.

Most detox units are secure units in that they are locked and access to and from them is monitored. This is because they often have patients who are either brought in on 72-hour holds, already experiencing confusion or agitation from withdrawal symptoms, or who are vulnerable to the temptation to buy drugs from people who would buy them to bring them to the hospital.

I believe Allina will allow nurses on the effective unit with higher seniority to move to positions with less seniority and other areas of the hospital. If they can be trained for that area in 30 days, thereby safeguarding the patients they would be caring for. There may not have been a discussion of adding training for nurses now working on medical units to which detox patients will now be able to routinely admitted. Finally, the nurses working on chemical dependency and detox units are there by choice. They like working with these patients. These are complex patients, each with a particular story that impacts the course of their treatment.

Chemical dependency treatment is not a broken leg or appendectomy with a predictable outcome, nor is it often viewed with the same compassion as someone who has suffered a stroke or been diagnosed with cancer. Sometimes people, nurses included, see individuals addicted to drugs or alcohol as having made bad choices at the best, and as manipulative criminals at the worst. Everyone is entitled to their opinions, but sometimes that judgment can affect the care their patients receive.

>> Catherine Lloyd (moderator): Allina team, do you have a response to the comment?

>> Allina Health Team: We have a number of patients across Allina that are cared for by our medical nurses on medical floors with great compassion, and we would expect to continue to advance that and that care in those settings.

>> Catherine Lloyd (moderator): Okay, Shellae, do you have one more, and then I'm going to hand it over to the floor. We have a few people in line.

>> Shellae Dietrich (MDH): Yes, I have one more that came in prior to hearing, another one.

Unity inpatient substance abuse is the only kind in Minnesota and shame on Allina for never utilizing and advertising for us because there are so many more that need us and that never know about us. This unit is needed, and it is necessary, and Allina did nothing to promote the difficult but necessary work we do here and instead canned us because we're not the money makers.

Allina is wrong, though, because this work isn't about money. It's about saving people who matter just as much as a heart attack or a surgical patient.

The stigma of mental health and addiction is bad enough, and now Allina is closing the only place where alcoholics and addicts can safely go if they have medical issues as well. To be cared for the whole patient, physical body, mental health, addiction, and we did so because it is our passion and alcoholics and addicts deserve to be safe and cared for like any other patient.

Closing this unit will cause deaths, plain and simple. ED and med-surg nurses are not trained in these areas, and to give physical and mental issues from their addiction. I am not hear to spar with med-surg nursing. And the public should be as sickened as we are about this unit closing. This is such an injustice to the people of Minnesota.

>> Catherine Lloyd (moderator): Allina, do you have any comments?

>> Allina Health Team: Appreciate the comments. I would say there wasn't an advertising issue. The demand for detox and withdrawal is there. Where we ran into the difficulty was even with meetings with major health plans in partnership with our contracting division, we could not move the dial on getting approval to pay for treatments. We could get approval to pay for medical withdrawal. That was what they were willing to pay, and that's where we saw the decrease in admissions to the unit. And then, again, as I stated in my opening comments, some limitations for the unit and the ability to take all medical patients because some of the comorbid medical needs had to be provided for care on the medical unit. Again, appreciate the team that provides care in those settings as well.

>> Catherine Lloyd (moderator): Thank you. And so, we have some, a couple folks here that would like to speak. If you can just provide your name and city that you are coming from.

>> Joel (Minneapolis): Yeah, my name is Joel. I am -- so yeah, city. I guess I live in Minneapolis. But I am here because I have come through this program. I want to speak out. I understand the financial obligations that you guys are in, and I could also even understand it if you guys were to switch, should go completely into a detoxification program with mental health aspects to it, due to funding. But I would like to implore you guys to not get rid of this program. Not only for myself, but close to 80 people I have talked to in the last week who have come through your program and have had long-term sobriety.

This is one of the very few programs that you guys have a very high success rate. Great. And I can speak to that, from both ends. I have gone through your program, both the mental health and the substance use aspects of the program. You guys saved my life. But more importantly, and that was four years ago, mind you. But more importantly, I work as -- I'm now an outreach director over at Twin Cities Recovery Project. I work the front lines of addiction. We're losing beds. That's the plain and simple way of putting it. We're losing beds. Minneapolis is losing beds. The surrounding suburbs are losing beds. Our recovery community is shrinking. And there's all of these TV news channels that are saying there's so many resources, but the fact of the matter is there is no detox beds open on most nights. Most treatment beds are filled every night. There are waiting lists. We're in summertime. It is usually slow. All of our shelters are full. There is nowhere for people to receive help. Outpatient program would not have been something that a person like me could have done. I'm a severe methamphetamine user. I used opiates and I am a severe alcoholic as well. I stand here before you because I came here. I'm able to hold professional titles. I work in the field now. I am myself am trying to do my best to bring people into this recovery thing, but losing beds is going to make us lose lives.

And I would love it if you guys could find some sort of way, which is why I offered the suggestion of maybe just switching all the way to withdrawal management. It seems to be what's paying the bills. A lot of different treatment centers are already switching to that. Eden Park, Park Avenue. There is a few that I can name off. There’s a lot of people moving in this direction, for what you are saying. They are not trying to pay to for us to have inpatient stays. But the problem, and this is where I want to leave you with is --

I'll leave you with this. In our community, we have a desperate need for these positions to stay, these beds to stay because unlike normal people, addicts blow their lives away. We have nothing to start from so we need to have a bed to start from because giving somebody outpatient service when they have nowhere to go afterwards does not help them.

>> Catherine Lloyd (moderator): Thank you for your comment. Allina team, do you have any comments?

>> Allina Health Team: Grateful that we were able to save your life and like many of the people we have, and we will continue to partner with those organizations that provide housing and residential treatment.

>> Catherine Lloyd (moderator): Thank you. We have another person here at the mic.

>> Tad Ackerman: Hi, guys. Tad Ackerman, former president of 2218, founder of Attitude for Gratitude podcast, PRS. I could list all the things I have done. What is most important to me is I am a recovering addict that has been coming here since I was 18. I am 41 and I have close to seven years sobriety. Some of the staff were at my wedding this summer. These people, Emily the counselor, she was like a mother to me, more than my mom at different points. I could go on and on, but with the risk of getting cut off and make all these points, put on to tell you is I've seen the front line. This place matters. And you don't find staff like this. I have been over to 100 treatment centers and a former staff named Marty would have said some of y'all will see that and be like he's a hopeless case. I'm not supposed to be here. I'm supposed to be dead. But these people, they always, always said, we're always glad you come back because you come back and keep trying. Not everywhere is like that.

As someone who suffers from bipolar and different mental health things, Unity 2 East allowed me to put myself back together, and look man, people are dying. We're losing the war. It's not getting better. I was like all the stuff you did, but that can be the cherry on top. If overdoses were going down, I'd probably feel better about this, but they're not. They're not like those of us that are trying to help with that like this. This unit is the answer.

I understand there is a financial thing behind it, but, like, find a way guys. This is one of the best treatment centers on the planet. Like you said, it was a pioneer. Be a pioneer again and figure out what the new way is. Thank you, guys, for your consideration and time.

>> Catherine Lloyd (moderator): So, Allina.

>> Allina Health Team: I appreciate them. Appreciate you lifting up Emily and other staff that work on the unit. I absolutely agree with you.

>> Catherine Lloyd (moderator): Thank you. We have another person.

>> Jerri: My name is Jerri. I have been here like nine times and each time I come, I am coming back to my family and to get me strong. I'm doing pretty good now. But the main thing is they help me, and they save me, but I am a mother and a grandmother. And by doing so, my 12 kids get better and healthier, too, because my brain and my health is healthier, and their kids get better and healthier. And all together we change to be a productive, happy family. And it's because of this place.

We talked about the outpatients. closed six of the houses that are normal. So good luck with that. You're here and I have to -- people go to inpatient treatment. No more insurance is paying. DHS won't pay for a sober bed anymore. So yeah, they have to go.

They are all closed up through GCS, six of them, and it is the saddest thing in the world. Going from the inpatient treatment family and going into a sober house, which I was scared I hadn't done that since I was 50, but that, too, gave me the time to live in the real world dealing with real stress. And then had the support of outpatient, but going back, because I tried, I said, I don't need a silver house. I have a home. Nothing worked until I went to a silver house.

You can do outpatient treatment from the same place you lived or the same area you were at before you entered treatment. It doesn't work. You have to. You can't go back. You can only go forward and without funding for the beds. New Way is shut down now. I now Leaf is shut down. I know you - I think you got your -- I think you got your gym one, but you still have to pay for your own beds. Minnesota Recovery. A lot of people can't afford that monthly rent when they're going to treatment, and they haven't been working. So yeah, the insurance was covering about $550 for a bed while the patient is going through outpatient treatment and that whole program is crumbling. And what are we going to have left? That's my question. Thank you.

>> Catherine Lloyd (moderator): Thank you for your comments.

>> Allina Health Team: We will go another person, and I will hand it over to our team right after this.

>> Jennifer: Good evening, everyone. My name is Jennifer. I'm a registered nurse here at Unity in the emergency Department. Our substance abuse inpatient unit is well known in the north metro community. People come from our community into the emergency department requesting to be admitted into our inpatient detox unit. The substance abuse unit provides vital services to provide resources and support for the people facing addiction by providing medical detox, therapy, and mental health resources and support that is needed. Without an inpatient detox unit, the Emergency Department will become the primary destination for people experiencing withdrawal. The Emergency Department is not equipped, nor the proper setting for the long-term care required for patients experiencing addiction. Closing 2 East, the inpatient detox unit, will cause additional overcrowding in the emergency departments, taking away resources and staff from the acutely ill patients that need our help. Closing this unit will delay effective treatment for people experiencing addiction and withdrawal. The community that we serve deserves and depends upon the support and services that this unit currently provides. Thank you.

>> Catherine Lloyd (moderator): Allina?

>> Allina Health Team: I just appreciate everything she said.

>> Catherine Lloyd (moderator): Okay, did we have any online comments?

>> Shellae Dietrich (MDH): No online.

>> Catherine Lloyd (moderator): So, we have another person here that would like to speak. Go ahead.

>> Scott (New Brighton): My name is Scott, and I come from New Brighton. 2009, I came through this treatment facility, and it was through the urging of my family who probably found it either through the phonebook or I can't remember how it was it was available. But I'm so grateful for the staff members. Again, they saved my life. I was jaundice at the time, and I remember the words. They said two weeks, two months, two years, we don't know how much time you've got left on your liver, and I'm glad I didn't try to test it.

Now, I know the limitations of treatment because they said I was an alcoholic and they suggested AA and I had to follow it up with AA, but it is very disappointing to hear the closing of this because through service in AA, I find to bring a group of people on the third Thursday of every month, and I just had that happen now last week or whatever, and then that time was, but I like to jokingly say this is my old alma mater. And I remember the counselors that I got close to. And some of the counselor assistants that helped me and very powerful words they had to say to stick with me to this day.

One question is because I went through the whole deal. Inpatient, outpatient and after care and that's where I brought AA back into a little bit of the outpatient and aftercare. What's going on with the lyric building? Is that even open or is that closed right now? So that would be – but I'm so very grateful for the people at 2 East. They helped me and pointed me in the right direction because treatment worked for me, but I was ready for it because I know the limitations of treatment, but I'm so very grateful for what they've done for me.

>> Allina Health Team: You are an example of the work that -- thank you for coming this evening to say that. The lyric building is where, as you know, our former outpatient addiction program was. And that building was actually purchased by Touchstone Mental Health. And they run a mental health facility out there with 16 beds, rehab building for people with mental illness. And they lease out the rest of the building to other community partners. We also have AA and Dharma Recovery and SMART recovery that come into our outpatient center in the new building. So really grateful for your service to the community because it works.

>> Catherine Lloyd (moderator): We have some more folks here. Okay, again, just your name and…

>> Lori Broderson: My name is Lori Broderson. I'm a nurse on 2 East, the substance abuse unit. The patients we care for can be your children, your parent, your grandparent or even you and tends to be the worst day of your family's life. Patients are fearful of withdrawal and question their ability to follow through when fighting this overwhelming disease of addiction. They are met with nurses who do not judge them and realize addiction is not a choice. Impulsive, impatient, angry, and despondent behaviors understood to be part of the disease and not attributed to a flaw in character or being ungrateful. When the patients decide to leave against medical advice, they're met with fellow patients who understand the struggle, pain, uncertainty and fear driving their fellow patient to leave. Just maybe these fellow patient cans dissuade you or your loved one from leaving.

Upon admission and in the few days after, patients receiving care on our unit are assessed by a nurse and treated every hour as needed. A psychiatrist or psychiatric nurse practitioner who specializes in addiction medicine, assesses the patient. These practitioners understand the complexities of withdrawal and know how to medicate these patients based on what is being abused and the frequency of use. They are aware of and understand how to treat withdrawal from drugs like kratom which is 13 to 46 times more potent than morphine but easily purchased legally at your local smoke shops. Patients receive individual care from a psychologist who provides therapy and teaches patients tools to manage social anxiety, psychiatric conditions, chronic pain, trauma from sexual, physical, verbal, and emotional abuse that drive it, the addiction. Patients are assigned an alcohol and drug counselor who counsels the patient and finds placement in outpatient and residential programs that fit the unique needs of each patient and will be covered by their insurance.

Without this unit, a patient will be admitted to a medical floor with a withdrawal. They will be seen for a few minutes by an internal medicine physician that might not even know about or understand the drug the patient is withdrawing from. The nurse, who is given little or no training on addiction in nursing school will struggle to assess and treat the patient every two to three hours with their impossibly heavy patient assignment. A social worker will meet with the patient for several minutes and provide information on outpatient treatment options. Patients will become despondent trying to get through hellish withdrawal while sitting alone in a room. A drug dealer or friend can drop off alcohol or drugs or the patient will discharge against medical advice. The most probable outcome will be a return to using drugs or alcohol that brought the patient to the

hospital in the first place. The most tragic and ultimate result of providing inadequate care for those suffering from addiction will be death. Thank you.

>> Catherine Lloyd (moderator): Allina, did you have any comments?

>> Allina Health Team: Just that we do follow a withdrawal protocol across the entire campus that we will follow. We do have addiction psychiatry and addiction medicine physicians who do see patients that are in withdrawal on our medical unit, so we will continue to provide that.

>> Catherine Lloyd (moderator): Okay.

>> Marie: I have worked on 2 East at Unity for two years and have been a nurse for 34 years. I have three family members who have died from addiction. One of which was my mother. When a person finds the courage to approach someone to help with their addiction, that's only the beginning of their journey. They often have a wall of shame, guilt, pain, trauma, and fear that can stop them from moving forward to seek help. Often they go in to seek help and struggle with finding someone that can actually help them. Sometimes they'll go into the emergency department and leave because it takes too long to be seen. If a person does not feel safe, they will not move forward with getting medical help for addiction. Once a person finally makes it through the myriads of barriers they face with getting help, we see them come on to the unit at Unity Hospital at 2 East. Many times, they have spent hours in ER, sometimes overnight. They are weary and often quite sick. We applaud their courage for coming to seek help. And this surprises them because they think that we're going to be mad at them, but we're not. We're happy that they're there. And most of the people we see will tell us they feel lonely and isolated from those around them.

It's not one kind of person that suffers from addiction. It's every kind of person. In order to provide proper care for substance abuse disorder, a whole-person approach is needed from a team of informed, well trained people. The team needs to be compassionate, understanding, trauma-informed, and have a thorough understanding of addiction. This is not possible on a medical floor.

To put a person coming into the hospital suffering with addictions on a medical floor is to provide a lesser care, and I say that with confidence. The medical floor does not have a team of experts that understand addiction. They are now surrounded by that team. The person will end up isolated from people that can help them. They also need to be around their own peers. Counselors, psychiatrists, psychologists, medical experts on addictions. Proper care for a person is detoxing and suffering from addictions can only be done on a floor that is dedicated to this type of care and that care is providing on 2 East.

>> Catherine Lloyd (moderator): Allina? No, OK. Next person. Go ahead please.

>> Charlotte Synder: Hi, my name is Charlotte Synder, and I am a registered nurse who retired from 2 East unit at Unity. 2 East is one of the only substance abuse, mental health, inpatient units in the state. And it is vital it stays open. Addiction rates and mental health needs have increased in our state affecting every person and community. We all know someone with a condition of addiction, mental health or both. I retired four years ago after 20 years of serving and caring for my patients on 2 East.

Many days we had a waiting list for the 24-hour bed unit. It takes a lot of courage for an addict to seek help and especially those with mental health. Many of our patients were returning customers. Staying sober is hard work. They knew we had a safe place, a nonjudgmental place for them to go to start over. They knew they would be, would have a safe detox, feel encouraged and given tools that they needed to be successful. We

save lives, help people and their families. Addiction affects the individual, the whole family, and ultimately the community. 2 East has counselors for group, individual, and family sessions. Psychiatrists for mental health and addiction. Doctors for medical issues, behavioral health associates to encourage -- to ensure safety by doing hourly rounds and encouraging group attendance. Chaplains for spiritual support and nurses 24/7 to address the needs of the patients in all these areas. Detoxing is a very specialized area of medicine. For example, we had patients come -- excuse me. I'll start over. We've had patients detoxing from alcohol on the medical floor come to 2 East undermedicated. 20% of the people who go into DTs, delirium tremens, die. So proper medication is very important.

2 East's staff are trained in the detox process of multiple drugs and helping patients through the process. For example, telling the difference between anxiety and withdrawal, which require different medical approaches. On the medical floors, there are no counselors, education or referrals.

Patients go back to the same circumstance without the tools they need to recover. Plus, now they've been medicated with a high likelihood of relapse, a very dangerous situation. 2 East is a very specialized area with vital expertise that cannot be bought. This unit saves lives and changes lives. Allina's decision to close this unit seems shortsighted and shows that they do not put the needs of their patients or our community first. It always seems like the bottom line is money. I don't know.

>> Catherine Lloyd (moderator): We have an online question that we're going to take. A comment. I'm going to turn the mic over here.

>> Shellae Dietrich (MDH): Yes, this comment came in the chat.

I urge you to reconsider the plan to close the inpatient chemical dependency unit at Unity Campus. In the north metro, mental health addiction needs are growing, not shrinking. Unity provides specialized, accessible care for some of our most vulnerable neighbors. Eliminating this service will create longer wait times, force patients to travel further, and increase the burden on emergency departments. While I understand the financial pressures, the broader health system and community actually save money when people receive timely mental health care, fewer ER visits, fewer hospitalizations, and better long-term outcomes. Please keep patients' lives and community well-being at the center of this decision.

>> Catherine Lloyd (moderator): Thank you. Allina? No? Okay. We have another folk here at the mic.

>> Trisha Brown (Blaine, MN): My name is Trisha Brown from Blaine, Minnesota. I have been on the chemical dependency unit for four years now. I want to begin my testimony by sharing the story of a young man I had the privilege of working with during my time on the chemical dependency unit, mental health unit. He was in his 20s and had been struggling with alcohol addiction for several years.

When he first arrived at our unit, he was angry, defensive, and skeptical about the treatment process. Like many individuals, he truly didn't recognize the depth of his addiction. There was shame, fear, and a deep mistrust that he could ever live a life without alcohol. Most of our patients that we get either from home or the emergency room are in a crisis mode, and often times when they arrive on our unit, they're high suicide and moderate suicide risk scores.

After they have met with a provider over a nurse and had a conversation and we provide that locked unit, there's an immediate sense of safety and security. These are vulnerable patients that we provide that immediate safety resource for them that is so important that they're not going to get from an outpatient

service. After receiving care from our interdisciplinary team of doctors, nurses and counselors this, young man began to change. He started opening up and participating in treatment. He connected with others on the unit who were going through the same struggle. For the first time in years, he envisioned a future that didn't involve drinking. He has now been sober for over a year and continues to write to us, thanking our staff for saving his life. Stories like his are not rare on our unit. But without this facility, they may become rare in our community.

The closure of this unit would not only eliminate a critical treatment resource, it would send a painful message to those battling addiction that they do not matter. Despite greater awareness -- excuse me, skip that.

Our unit is one of the only locked facilities in the area that provides both chemical dependency and mental health care. It offers a severe environment that reduces the chance of substances being smuggled in by visitors or family, anybody, for that matter, something that can quickly sabotage a patient's recovery. The locked nature provides a sense of structure, safety, and focus for people in early recovery, many of whom are in a fragile state when they arrive. Other units may not be able to handle. Excuse me. They may be able to handle the short-term detox, but they do not offer the ongoing integrated treatment that many of our patients need to long-term recovery. A multidisciplinary approach, medical care, psychiatric support, counseling, and group therapy address the full scope of a patient's needs. Without that, people are more likely to relapse, overdose, or cycle through emergency rooms or jails untreated and unsupported. The closure or the unit doesn't just affect individual patients. t weakens the safety net for the entire region. We already serve a population that is highly vulnerable and under resourced. Losing this facility will place pressure or emergency departments, law enforcement, and families who are struggling to help find help for their loved ones. It is not an exaggeration to say that this closure will be leading to more overdoses, more suicides, and more unnecessary deaths in our community. I urge you to consider the repercussions of the closure of the unit. Addiction is not a personal failure. It is a chronic, treatable condition, and like any other health issue, it requires access to specialized care.

We would never consider closing the only cancer treatment center in a region simply because the numbers don't look favorable on paper, yet when it comes to addiction, a condition that claims tens of thousands of lives every year, these closures are allowed to proceed with little resistance. This is the definition of stigma in action. We must do better. We must continue to fight for the resources of space, and the dignity that every person with addiction deserves. Closing this unit would be a step backward. Let's instead move forward toward a future where recovery is possible, treatment is accessible, and lives are saved. Thank you.

>> Catherine Lloyd (moderator): Allina team? Okay. Go ahead please.

>> Member of Public (Blaine, MN): I live in Blaine. I started on 2 East a long time ago. Not as long as some of our staff. Six or seven years ago, and I have done care management now for the last three or four. And so, I am not going to speak to whether the unit should be closed or not. I think that's done. I don't have a lot of hope that that will change.

What I will speak to is sort of the solutions or the trade-offs that you are giving us as far as a social worker can meet with them. They can do outpatient. They can go to the clinic and do care management. Fridays in the emergency room. Saturday, Sunday, every Saturday, Sunday in the hospital by choice Those are, that is what I want to work.

There is no LADC on the weekend. There's no addiction med doctor on the weekend. I'm it and my standard work says I walk into the room – there are three questions I ask them. Are you mentally able to meet with eviction med? Are you physically able? And are you willing? And if I fill that out, wait until Monday and get on the list to be assessed. My understanding is that's going away, and it won't even be an LADC.

So, I go in there and yep, they're my repeat patients. I know them well. I know them. I held their hands on 2 East, and I still see them coming through onto the medical floor. There's nothing I can do. I can hand them a piece of paper -- it says, “How do you know if you're drinking too much alcohol?”. They know! They've came and begged for help over and over. We have no resources for them. I'm it. I am that person you said goes and visits them. I got nothing. I have no suggestions. They'll say to me, is the staff still there? There, they want to talk about which PCT are still there. That was meaningful to them, but now I am left without even that shred of hope. I can't even say hopefully if you get assessed, we can figure out how to get your insurance to pay or at least get you into detox. That won't even be that. I will literally have a piece of paper that says, “Are you an alcoholic?”. I mean, and I do have one printed out for what services are available across, but they're not available on the weekend. I got nothing. And I've watched them die.

Pardon? I am assuming we could have some more literature or something. I mean, I guess that is a good question. What should I tell an alcoholic on Saturday morning at 8:00 a.m. when I got a referral?

>> Catherine Lloyd (moderator): Allina?

>> Allina Health Team: We have standard work that I am surprised hasn't gotten to you. And so, we should probably meet with your supervisor, who's been involved in planning for this. This and there are processes in place on the weekend, so I am surprised you don't have that information.

>> Member of Public (Blaine, MN): Will they have access to it?

>> Allina Health Team: Yep.

>> Member of Public (Blaine, MN): To a live face?

>> Allina Health Team: We will certainly meet with you and your team together and those meetings have been in process. So, I'm just --

>> Member of Public (Blaine, MN): Well, it may…

>> Allina Health Team: It may. Sorry. I won't take up more time.

>> Member of Public (Blaine, MN): It may, but I literally only work Friday, Saturday, Sunday.

>> Allina Health Team: Tomorrow we can follow up.

>> Member of Public (Blaine, MN): perfect. Thank you.

>> Catherine Lloyd (moderator): Go ahead please.

>> Gail Olson (Princeton): Good evening and thanks for being here. My name is Gail Olson. I am a registered nurse here at Unity Hospital. I’ve been here for a while. I live in Princeton. Closure of this specialized chemical dependency unit at Unity is yet another added to the list of decisions Allina has made that adversely impact our patients. Most recently Allina shut down United Hospital’s infusion department earlier this month, closed down United Hospital’s pain center, shut down Abbott Northwestern’s infusion department in 2023.

Announced plans to close United Hospital's rehab unit in 2027. Closed several clinics, including Inver Grove Heights, Maplewood and Nicollet Mall and Oakdale. Cut Mercy Hospital's pediatric beds and closed Unity surgical services last year. Now Allina plans to close Unity's inpatient chemical dependency unit and Abbott Northwestern's inpatient kidney transplant program. But this is not disturbing enough, Allina recently began a process called benchmarking. Benchmarking is a process used to compare processes and poor performance metrics from health care organizations across United States to promote operational efficiency.

However, from the viewpoints of the nurses at the bedside, caring for you and your loved ones, benchmarking too often relies on simplified data that lacks context and fails to capture the complex nature of patient care. Allina implemented benchmarking two years ago. It has resulted in nurses having increased --

>> Allina Health Team: Ma'am, excuse me. Could you please keep on topic about why we're here? Your comments about the chemical dependency unit and the --

>> Gail Olson (Princeton): It's related. They presented Allina and management presented what they do for the community, and I feel this is pertinent information for the public to be aware of that there are two sides of this. And we want our patients to be safe and we're here to make sure that that message is across.

Benchmarking has effect affected the whole entire hospital, and our patients that go to 2 East are going to go to the rest of the hospital, which is greatly impacted by benchmarking. So, I will just continue. I don't have much left.

Allina implemented benchmarking two years ago. It has resulted in nurses having increased nursing patient assignments, at times five to seven patients per nurse. We received notice yesterday from Allina that we will be going through the benchmarking process again this fall.

The nurses have been bringing forward patient safety concerns around benchmarking for two years to our leadership. We have also tried to improve safety for patients during our union negotiations without success. Allina was unwilling to negotiate safe patient assignments. Patients should be at the center of care, period.

Currently it is difficult to see the evidence that supports Allina's claims that their focus is safe, quality, patient care and the patient is a priority when their continuous -- when they are continuously closing units, shifting services, or closing services and implementing practices like benchmarking. The patients in the community will continue to pay the price for the actions of corporate health care. The closing of services, long waits in the ER, increased percentages of patients leaving without being seen, and increased patient loads on nurses will result in delays in care, and risk poor outcomes to patients. Thank you so much.

>> Catherine Lloyd (moderator): Well,, first of all, Allina, do you have any comments to that? Oh, Okay.

>> Iman: Hi. My name is Iman. I am a LADC over at 2 East. I haven't worked here for very long, like under a year. So, this news doesn't probably hurt me as much as other people. But I do have experience working in other treatment settings. So, like, the alternative options that you have mentioned, like, for example, like emergency rooms, that's not great because people, they don't get treatment. And the longer you delay treatment, your worsening treatment outcomes. And for detox, regular county detoxes can't handle some of the severe medical issues that people on 2 East face. And I know because I've worked there.

And also, it is the same for residential treatments. What if you have unmanaged diabetes? What if you have - are on dialysis? What if you have like MRSA and an infection? They can't go to treatment. And they also can't

go to detox. So, they're stuck in the emergency room where they don't get treatment. For how long? And chances are they'll just give up and that's unfortunate.

It is not your job to ensure that a level of care still exists in Minnesota. Correct me if I'm wrong, but this is the last inpatient chemical dependency unit. It's not one. You are eliminating an entire level of care. And it is not your job to ensure that there is a level of care, but if your purpose or your mission is to serve the community, like, you should at least -- I would hope that there is at least a plan to make sure that there could be another inpatient like the option is still there. So those people who are some of the most vulnerable can still get care. And I don't actually know if there's any progress towards perhaps having an inpatient chemical dependency unit elsewhere in Minnesota. So that is my question. What has Allina done about that?

>> Catherine Lloyd (moderator): Now there is a question for you.

>> Allina Health Team: I appreciate your comments. And thanks for sharing your experience. We continue to advocate for -- through those organizations, that's called March, that is actually a state lobbying group for addiction. And we continue to be active members with them as well as the mental health legislative network. And we continue to try to create bills to pass into laws that would do what we call payment reform. And then this last legislative session, they included every level of care for payment reform except for our one inpatient unit, which we advocated for and requested for that payment, but we were excluded from that.

We will continue to advocate to that organization for all the levels of care. And it is about looking at more robust payment for caring for our patients. So, the work is not done. We'll continue to partner with our own public policy on division, and we will encourage you to join our Employee Action Group, so your voice can continue to be heard, and I think you would offer a lot of value to that. But work is still in process.

>> Catherine Lloyd (moderator): So, a couple of things. One, we have one person online that has a question. And then we just wanted to recognize the first speaker because you may have had more to speak to and we kind of moved you, but then we understood the important of everyone being able to share their comments so if you had anything more you wanted to add? But before we do that, can we just take care of one question that we have online. And then we have a speaker.

>> Shellae Dietrich (MDH): That question that came in in the chat.

I'm just wondering, if someone from Allina could speak to how many people they actually interviewed for the kidney transplant coordinator profession? At Abbott Northwestern. Or did it go unfilled so that they could move forward with closing an unprofitable unit?

>> Allina Health Team: I am not going to go into how many people are interviewed. We did have open positions we continued to recruit into that, but there is a tipping point. You need to have a certain bandwidth to have that program be successful, and we were not able to achieve that. If we can't provide safe quality of care, we have to look to the partners in the community to help us out and that's what we did. Warm handoffs to other programs in the community.

>> Catherine Lloyd (moderator): Okay. We have one more and then we're going to go to our speaker. Go ahead.

>> Shellae Dietrich (MDH): For the chat, Catherine?

>> Catherine Lloyd (moderator): Yes, please.

>> Shellae Dietrich (MDH): Okay, I am a former counselor from Allina 2 East and work as an inpatient CD counselor for another hospital. We turn to Allina 2E as a safe placement for our patients struggling with addiction and who need the highest level of care, a level of care we can't provide. Hearing the decision to close 2E was painful. However, hearing they were no other plans for restructuring was horrifying. EDs and county detox cannot hand the level of care 2E provides. Normal hospital floors cannot not provide the special care needed for someone struggling with addiction. I hope that a restructure will be seriously considered because it's just not the patients that need a 2E.

>> Catherine Lloyd (moderator): Okay. And would you please introduce yourself? Your name?

>> Jim Abeler (Anoka, MN): Well, Thank you. I debated speaking or not. Jim Abeler, I'm the senator from Anoka and I have sat through too many of these discussions, but Mayo and all the rest. And first, I want to thank all the public and the nurses and the staff for coming. Your system is profound. I want to thank the Department of Health for coming. They're very dedicated. They don't have a lot of power. I tried to give them more power to have to approve closures like this or the Mayo Clinic where they closed at Albert Lea, you know, pregnancy center and all that.

I also want to commend the people at the table. Mike and your crew are good doctors and all of you really care about this. But I want to remind everybody in the public, the decision makers are not in this room. You know the person behind the curtain, there's a curtain there the decisions are all made behind there. I have -- I know Mike pretty well, but I am sure the rest of these folks agonize about this decision as you do, as does the public, as does the people that are -- we're all middle managers.

And health care has really gone off the rails. And so, if you are talking about the corporate side, that is the part -- the people you want to talk to probably aren't even listening tonight. Maybe they are, Mike. I don't know. I hope so. But we are worried about the impact of this. And if they listen, they're taking notes. Their job is to the Department of Health, provide a meeting to people can talk. I wish that the Mayo Clinic before they close a place in some greater Minnesota thing would have a meeting like this and say, "How is it going to work?". I wish Allina would sit down, have a meeting like this and say, "How is it going to work?" and listen to all the expertise. You have centuries of experience in this room here and you're not all that at all. We have decades, at least, of experience. I just want to point out to you we all care about this and just wanted to point out what they cannot do up there. But that doesn't -- just the outcry needs to be, what's going on with corporate medicine and what is happening and what is happening to the quality. In America we spend the most money per person for mediocre outcomes and there's so many middle players that just take the money.

So, anyway, god bless your work. Thank you for what you do, Department of Health, administration, thank you.

>> Catherine Lloyd (moderator): Thank you so much. Allina?

>> Terry (Jordan, MN): I'm from Jordan and hearing everybody's comments tonight, I come in and I speak at 2E. I volunteer my time. We drive from Jordan during the work week and find care for our family so that we can share our experience, strength, and hope.

This hearing, this has been sad because I have been following along in the recovery in our community. I am a person in long-term recovery, and we have so many different crises that are happening that are out of our control as people in recovery. I am fortunate enough to be where I am in my recovery that I have a stable

household, but there are so many people out there that don't have housing, that don't have support systems, that don't know where to go.

As somebody that's also faced other issues with health where I tried to deal with coordinated care and it is disjointed, I don't know who to turn to, which doctor? I am going to the primary care, now a specialist doctor over here. They are trying to give me a shot where I don't need a shot and then going back to my primary care and then I'm going to a pain clinic. The same thing is happening in recovery. We don't know where to turn to now and with this being the last in the state of this level of care and knowing that's just taken away. I mean, I am a person that I am now two years free of cancer to tell me I no longer have that level of care if it comes back, do you know how scary that is for a human being to go through that? And to say, I'm sorry, that's not available to you? Maybe you can go, and you can sit in this place where we don't have the right level of care, but we can try to piecemeal it together for you. That's scary and people are going to die because of this. And so, it may not be because of this but people are going to die, and I want to make sure that that is clearly stated out there. And it makes me sad because it's hard burying your friends.

That is all I have to say.

>> Catherine Lloyd (moderator): We do have one online comment if we could pass the microphone over.

>> Shellae Dietrich (MDH): So, for the comment that came in the chat, what are the…

>> Catherine Lloyd (moderator): Yes.

>> Shellae Dietrich (MDH): Oh, Catherine, are you ready for the comment in the chat?

>> Catherine Lloyd (moderator): Yes, please.

>> Shellae Dietrich (MDH): Okay, What are the plans for the unit after closing? If you don't know yet, how long will it take for you to give us an answer? I don't know if it's a simple answer. Is making the unit smaller an option? How many employees are affected?

>> Catherine Lloyd (moderator): Allina?

>> Allina Health Team: Right now, we don't have immediate plans, so, you know it's obviously more complicated. We have to look at it as the unit closes. I think, Joe, you mentioned a little bit about what we want to do, but at this moment, no, we don't.

>> Allina Health Team: We are willing to care for individuals on the medical unit, and we will need to do the discharge planning to residential or outpatient from there.

>> Robin: I'm Robin. I work at the hospital in the ED. I just have a couple of questions. We understand your plan that you are going to close the unit; you're going to ship these patients off to the medical units. But this is the question. Do you think they're going to get the same type of care that they receive on 2 East that they do on the medical units?

>> Allina Health Team: Will that be treatment on the medical units? It will be their detox, their medical detox. And so, I do have confidence in the care team on the medical units and actually we care for many patients every day that are going through withdrawal. And it will be our job to work with them while they're on the medical unit to get them to the residential program or that outpatient program, whichever is the level that they request. And then meet the criteria for.

>> Robin: I do have another question. I hear you, but we've already heard from the care counselors. We've heard from some of the staff there. We haven't heard from any of the medical unit nurses who've said what kind of care they can deliver. Joe, do you know what type of ratios that are on the units, on how frequently they can round? Because we do. I mean, we have mind protocols that the nurses in the ED and 2 East are familiar with that can take hourly rounding. Hourly rounding to check to make sure that someone isn't going into seizure, someone isn't going to acute detox. So, I guess I am wondering, do you know how frequently these med SURG nurses able to do exactly what you're saying? It won't be rehab, but it'll be detox. So, what is going to be the success and the rounding on these nurses taking on this high, acute -- because we don't change ratios. I get to take care of how many patients? Do you know how many patients a nurse takes care of on three to 11?

>> Allina Health Team: Yeah, I'll take that. From the floor perspective, I want to say, no, that is kind of outside the scope. Well, I mean, we're focusing on -- just focusing on is 2 East on the closure. As far as the ratios on the floor, that is something we can talk about that outside of this.

>> Robin: You are telling us that is where the care is going, and you don't even know how many patients I am going to be taking care of. I can tell you how many patients. Five patients to six patients. I don't know if they're going to get that type of care that these people are needing. I am just wondering if you recognize that.

>> Allina Health Team: There are patients today that we can't admit to the unit for medical withdrawal because they're too sick. They remain on the medical unit because of the limitations of the unit today. So, we're actually taking a different level of patient on 2 East and the sicker patients are staying on medical today, so we are caring for them and will continue to care for them. And anybody that comes into the hospital that does not meet the criteria to go to one of the detox facility wills go to the medical unit.

>> Robin: I do work in the ED and many times when I call the detox units, as has been expressed, it's full. I mean, I am not sure when the last time admin has had to pick up a phone call and say, "Hey, I got a question. Do you…? Can you take?" They want to know if it's a boy or girl. They want to know if they are diabetic. They want to know the age. They want to know the mental status. How many times they said "No, we can't take them, robin."

The next question I have is, are the counselors sticking around so the acute care managers or the nurses on the floor have these resources that you're just pawning off -- not you, I don't mean it personally. I just mean the system. And we know that you guys aren't making money, we know its money driven. We're just wondering, were there other options?

So, I've got two questions. Other options before we had to sever the head to the last remaining unit like this? And are the counselors sticking around?

>> Allina Health Team: Physicians and counselors that they choose to can interview for those positions, and they are counselor positions.

Go online. We'll defer to them first.

>> Catherine Lloyd (moderator): Okay, team MDH, go ahead please.

>> Shellae Deitrich: One more comment. First question came in the chat as said above. Were there other options considered for 2E? As a former employee, they are not once -- not once did leadership sit down with

the front line of the unit and ask for suggestions, options, etc. It was always leaders who are hardly seen or heard from taking the unit in multiple directions with little success. Much feedback was always given by staff, but there was never follow-up from leaders. The leaders often didn't present themselves on the unit to the patient or the staff. The 2E staff is stellar, as you have heard all night long. Did the consideration of changing focus for the unit as has been suggested for the past several years by staff?

>> Catherine Lloyd (moderator): Allina Health, did you have any?

>> Allina Health Team: And from the staff, I am not sure where that has changed. That is the reason for admitting more detox patients to the unit.

>> Catherine Lloyd (moderator): Thank you. Next speaker up there. Please go ahead.

>> Member of Pubic (Jordan, MN): Terry and I got choked up and couldn’t continue speaking because I was going to cry. So, I'm from Jordan, if I didn't tell you that. Grew up here, though, obviously. What I need you to understand is tonight on a school night, on a work night, I drove an hour here and an hour back and I do that every second Wednesday. You know why? Because it's important and I understand what you guys are saying. But what I want you to consider is a couple of things. When Dellwood closed and the same thing was said that you're saying right now, a lot of those outpatient treatment centers closed. A lot of those sober people closed, and I’ve had to bury a lot of people. Hearing the same message, that it wasn't going to happen, so it's going to happen is my opinion, from my experience.

Like, look man, I understand, but here's the deal. I also worked for Emon, worked at 1800 Chicago. I was a sober house manager and ran a sober house company and, like I mentioned before, I was the president of 2218. All these places I stayed too long, past my mental, the empathy. I stayed too long because it was important. This is important. I understand that, look, man, people are going to die, like my wife said. This is a level of care, and all honestly, treatment should be a year long. People should be in inpatient treatment for a year. I understand there's not funding for that, but it should be.

Because, like, my first year of recovery this time when I listened to people after I got out of here, therapy, like, dude, I did therapy five days a week. ART, every type of therapy. Trauma therapy. I was in treatment for four hours. And that was after two inpatient treatments that started here. Like, not enough is being done. And I understand that you're not responsible. I have seen your guys' faces. I love your suit, by the way. And look, man, it's just like impress upon the people who actually can do something. We have a senator here. Look, man, it's dark times. And a lot of people are going to die if we don't do something. We need to wake up. And I understand you guys aren't killing people. I get that. But it's not good enough. Thank you, again.

>> Catherine Lloyd (moderator): Allina?

>> Member of Public: Community member. So, I have two questions. One, and I wanted to get this out earlier. What is the plan for anybody unhoused seeking treatment? Homeless. For people that are homeless.

>> Allina Health Team: I wish I could speak to that topic, but that's outside of our area.

>> Member of Public: It's not, though. I was unhoused when I came to your program. You helped me to get through this program and set up an outpatient that would actually provide housing. With housing being such a critical issue that our state is currently plagued with, I think this is something that we should actually think about. And with that being said, my last question is, what can we do to fight this process? I mean, I’ve kind of

gained an understanding that this seems like it's pretty concrete, but there is usually something that can be done. And I know that you guys would probably understand how best we could as a community come together and do what we can to stop it. So, I would like to know what that answer is.

>> Allina Health Team: I appreciate that question. And I would encourage you to, as Senator Abeler said, I think there's conversations to continue to have at the capital around this.

>> Member of Public Thank you.

>> Catherine Lloyd (moderator): Do you have any comments online or questions? To our MDH team.

>> Shellae Dietrich (MDH): No, nothing online.

>> Catherine Lloyd (moderator): There's nothing online? No chats?

>> Shellae Dietrich (MDH): Nope.

>> Catherine Lloyd (moderator): Anybody else have? Did everybody get an opportunity to speak? Okay. There's one person coming down yet.

>> Kay: Hi. My name is Kay. I am part of SEIU. My question was not answered online, and I was questioning, how many employees are affected? Affected with this whole thing? How many are affected by the close down with 2 East?

>> Allina Health Team: I can tell you that we are unable to comment on specifics of who is impacted. I can tell you that we provided transition resources as we go forward working with the unit. So, we can't comment on specific people and that. Okay?

>> Kay: And a smaller portion, was it an option? Like making the unit smaller or anything?

>> Allina Health Team: They have been running the unit at a much smaller -- I mean, going from 24 beds to an average daily census of 10 has just been too cost prohibitive for us to run the unit. And recognizing that the subset of medical detox patients that we were taking can be cared for in a medical bed, that left about three patients a day that for treatment, which was very shortened by health plans, and they would be better served for longer-term treatment within a residential facility.

>> Kay: Sorry, let me clear it up. So, there are some other floors that have smaller units, Okay. I have been to 2 East before. Can't you cut the unit in half to make it a smaller portion? Just like you guys do at 3 North.

>> Allina Health Team: It's not financially feasible to run it that way.

>> Kay Okay. Thank you.

>> Catherine Lloyd (moderator): We've got two on -- one on floor and one in the -- do you want to go ahead?

>> Public Member: You really answered her question because just because you're only running at 10 patients, obviously you have a whole lot of employees that aren't able to -- you're spending a lot of money. But if you cut the employees in half, the amount, you should be able to still keep it open, correct?

>> Allina Health Team: Those are the factors involved, and Joe talked about some of those, like reimbursement how that has gone down as well. It's not just one thing; it's a multitude of things. So, I mean, we hear you. We wish it was that easy, but it's not. It's a multitude of things that are impacted.

>> Public Member: Okay. So, the other question is, then, this is a done deal. So, there is nothing anybody can do about it, right? You're just going to shut it down, period?

>> Allina Health Team: Correct. After three years of analyzing this, we have come to that difficult decision to close.

>> Public Member: So, there's no point in us even being here.

>> Allina Health Team: What is?

>> Public Member: What is our input giving to you? I don't get it.

>> Catherine Lloyd (moderator): Please, Allina, please?

>> Allina Health Team: Yeah, I think this is important for us to hear. So, there's a point and I think it's important -- I will say it in my closing comments, but yes, there is a point to it because at least we get to hear from the community.

>> Catherine Lloyd (moderator): I think we're finishing up. Maria?

>> Maria King (MDH): There looks like this gentleman has a question and then we have one more, okay?

>> Catherine Lloyd (moderator): Okay, we have one more, so we'll go with this gentleman here and then we have one comment online and then we'll pass it over to Allina for their closing.

>> Public Member: I know when we heard of the closing, it was depressing because it wasn't from any managers or anyone higher up. We were hearing it from other people, from different hospitals, and out in the community, which I don't know how that got out, but I didn't think that was a good way to find out. But the day after we found out and we were brought into the community room for a meeting with you, and we had asked you if there was a reason why, if we're only had 10 patients, like you said, sometimes six I have seen this week, but we have patients coming to our floor who saying we have called three times and they keep telling us that you are full. So, I know Dr. Zhang said that she was going to talk to you, and you were going to work with someone in the emergency room, the physicians and whoever is running that part of it. Has any of that happened where I think my question to you was, it wouldn't make any financial or common sense to close a unit that is full, but yet nothing is being done to keep us full if we're turning patients away that need the kind of help that is covered by insurance. They are the patients that are needing long-term antibiotics because we do mental health. We do medical as well. So, I don't know what we're not doing, except we don't usually send them to anywhere but SCU, but we're doing the same type of IVs and different procedures on our floor.

But I don't know why -- and we've asked 1,000 times about any kind of advertising. I know it took people on our unit, in our floor, took them 20 minutes to find our website. And this is their website that they're running. So, people in the community if you're a normal person who is just looking in the thing, let alone someone who is in a crisis, you make it nearly impossible for somebody to look up and find Allina Health Addiction Services.

And like I said, once they finally find that, and then they get to the emergency room or whatever, then they're being told, we're full. And we have six patients there. We're just sitting there waiting for somebody to come, waiting for admits. We're constantly asking the intake coordinator; do you have anything? Do you have anything? Nope, nothing, but they're all turned away in the emergency room. So, has anything been done about that?

>> Allina Health Team: That was a strategy for a number of years that actually the counselors were looking for patients within the emergency departments starting at Mercy and Unity and then the system and reaching out to the staff within the ED to have them assessed for 2 East. The other step in that is that it's the one unit that you have to call the insurance company to get them to authorize the admission. And so, at times we have patients that are presented to us and the insurance company declines the admission for treatment, but they would accept the admission for medical withdrawal. And if we identify that they have needs for antibiotics and that the days have been paid for that have changed. And they are directing us to patients that need to be admitted to the medical floor for the medical care. That is where we have seen that change over the last 10 years.

>> Public Member: I can't speak to that. I would have to ask the intake office why we're being reported as full. Question?

>> Catherine Lloyd (moderator): Question. Comment. Can I get the -- I'll get the person online here. Okay team.

>> Shellae Dietrich (MDH): Yes, we have a couple of comments that came online.

I am a previous kidney transplant coordinator at Abbott. I want to provide clarification about the circumstances of the transplant program closure. This was not as simple as being unable to fill a single coordinator position. It started with upper management and Abbott decided to terminate their contract with Kidney Specialists of Minnesota and hire their own Allina Health nephrologist. With this change, the medical care of the transplant patients and the programmatic responsibilities of the program were shifted to the new nephrologists. These physicians were grossly underqualified. Staff became concerned about quality of care and ultimately the safety of patients. We have a small but mighty transplant program with eight dedicated transplant coordinators who are passionate about transplant. We ultimately sought employment elsewhere due to the changes implemented by Allina. Nothing needed to change.

>> Catherine Lloyd (moderator): Allina?

>> Allina Health Team: We did hire our own nephrology team. They were qualified. I am not going to comment on people's decisions to change jobs.

>> Catherine Lloyd (moderator): Okay. Did we have anything else online?

>> Shellae Dietrich (MDH): Let's see. We have one more online.

Minnesota Statutes require the hospital include in the notice the decrease in personnel and or relocation of personnel to a different unit, hospital, or hospital campus caused by the proposed cessation or curtailment or relocation. I am confused why they won't answer the previous question about the number of staff impacted.

>> Catherine Lloyd (moderator): Okay. Maria, she’s got that.

>> Maria King (MDH): I think the question is about the statute at subdivision 1D. And it says a notice under this subdivision must be provided to patients, hospital personnel, the public, local units of government, the Commissioner of Health. And then it talks about posting the notice. I have seen that. It talks about providing notice to the Commissioner of health. We have seen that. Providing written notice to the local health department. That also we have seen. Six says notifying all personnel currently employed in the unit, hospital, or campus impacted by the proposed cessation, curtailment or relocation. A description of the proposed

cessation of operations, curtailment, relocation of health services, etc., and then any decrease in personnel or relocation of personnel to a different unit hospital, hospital, or hospital campus. So, what they are asking is how you've notified your staff and what the decrease in staffing is going to be?

>> Allina Health Team: Staff are divided up and met with staff and then communicated to those that the non-nursing staff we took accountability for and reached out to them via phone -- contact if they weren't working. And then our nursing leadership took responsibility for notifying the nursing staff.

>> Allina Health Team: And I think you said it as well. We met personally with them.

>> Chelsea: Just to conserve time. I am Chelsea, coming to you as a community member today. I believe you stated at the beginning there were 24 beds, but you've been only operating in about half. What is going to happen with either those beds? Are you going to convert to a different type of bed to fill or what's going to happen with the space? And I also have another question after this.

>> Allina Health Team: For the unit, it is a unique unit.

>> Chelsea: So, If I suggest it will just sit empty is what you are saying for right now? It will stay empty. Okay.

And my other question is, according to the statute, it says that you should be identifying the three nearest available health facilities where patients may obtain the health services provided by the unit, hospital, or hospital campus impacted. For the community members here in the room and myself, if I was trying to seek the type of care that 2 East provides, where are the three nearest facility where is they can go to seek that type of care?

>> Allina Health Team: If they require medical detox, which was the majority of the patients that would be admitted to a medical bed. For those that require treatment, we would be reaching out to the residential facilities or outpatient, depending on the level of care.

>> Chelsea Thank you.

>> Allina Health Team: And I would offer is that the patient, in the changes in treatment access, now get to choose the level of care, and they get to choose the location. We need to abide by their wishes.

>> Catherine Lloyd (moderator): So, this concludes the public comment period. We want to thank you so much, everyone, for your questions, for your comments, for your perspectives, for your stories. I'm glad -- we're glad you're here and that we were able to conduct this on behalf of Allina. And with that, I am going to pass it over to Allina for closing comments and then to our director Maria King. Thank you.

>> Allina Health Team: First, I would like to say that I took a lot of notes as I was going through there.

I do agree, this is important. I think it's important for us to hear and I do appreciate it. I definitely want to say all of you were very well spoken. And I do really appreciate the courtesy that you came across. I think that was important. So, thank you on that.

I know all of us up here do care deeply. We appreciate your comments, your thoughts, and your feelings and your true experiences. That definitely comes across, especially as it relates to what we we're talking about tonight. And we hear you up here. I hear you. And I think I heard you know, "How is it going to work?" and we talked a lot about that, but that doesn't mean we can't do things better. So, as we go forward, a lot of what we

heard today, we can take forward and make sure we do it the right way. So, thank you. It made a difference to us, so we appreciate it.

>> Maria King (MDH): Okay, great. Thank you, everybody, for attending tonight and for your comments. Very thoughtful, poignant comments. We appreciate that and we appreciate you, Allina, for your responses. If there were additional questions that came in before we discontinued questions, we will send those to you. And I think it's the same thing that I am looking at and see one or two here, but I think they are the same thing. So, we post a transcript of this -- we post this. you have until tomorrow, I believe, or the public if you are listening, to ask questions and then we try and seek response from Allina and we do post the transcript.

So, under the statute, Minnesota Statute Section 144.555 we, again, remind you that we have the authority to hold the meeting and to inform the public, as Senator Abeler said, but we don't have the authority to change, delay, or prevent the changes.

You can provide those feedback or comments on the hearing website, again, until 11:59 p.m. tomorrow, and a transcript of the meeting will be made publicly available in 10 days. We want to thank you, again. Have a safe drive home. I heard some of you traveled a distance, as did I. And we thank you for that and wish you a good night and thank you for your time tonight.

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