MAYO CLINIC

# Community Health Needs Assessment 2026-2028 Implementation Plan

**Mayo Clinic Health System in Barron**


# Introduction

**Mayo Clinic**

Guided by our integrated Practice, Research and Education mission, Mayo Clinic is committed to innovating treatments and cures and providing compassionate care, expertise and answers to patients around the world.

We are focused on transforming healthcare, ensuring the best possible care is available to those in need and enabling more people to heal at home. Our researchers relentlessly pursue breakthroughs that yield earlier diagnoses and new cures, and we are educating the next generation of healthcare professionals, including allied health and the physician workforce.

In 2025, Mayo Clinic cared for patients from every U.S. state and 140 countries, reflecting a model of care that combines deep community roots with global expertise. Across the communities it serves, Mayo Clinic invests in prevention and education, while providing highly specialized care for serious, complex and rare conditions. Mayo Clinic encompasses three destination medical center campuses, as well as other clinics and hospitals, with locations in Arizona, Florida, Minnesota and Wisconsin. Further extending our reach, Mayo Clinic provided over a million digital outpatient appointments in 2025.

**Mayo Clinic Health System**

Mayo Clinic Health System (MCHS) provides quality healthcare to local communities by bringing the Mayo Clinic Model of Care closer to home. MCHS consists of 45 clinics, 16 hospitals and other facilities across multiple communities in Minnesota and Wisconsin. MCHS providers bring the knowledge and expertise of Mayo Clinic to these communities and surrounding areas to ensure our patients receive world-class healthcare. MCHS serves more than 600,000 patients each year and is recognized as one of the most successful community healthcare systems in the U.S.

MCHS is elevating and redefining community and rural healthcare. With more than 100 clinical specialties (medical and surgical services), patients have access to a full spectrum of healthcare options. To best meet the unique needs of the communities, patients receive quality healthcare at MCHS and have access to highly specialized care at Mayo Clinic's campus in Rochester, Minnesota.

The Bold. Forward. strategy centers on establishing MCHS as a category-of-one community health system by 2030. This strategic approach focuses on people and communities and is supported by three key pillars: Cure, Connect, and Transform. This framework aims to reimagine care in an evolving healthcare landscape, ensuring that diverse patient needs are met through advanced in-person services and innovative digital solutions.

**Mayo Clinic Health System in Barron**

Mayo Clinic Health System Northland in Barron (MCHS in Barron) is a 25-bed critical-access hospital in Barron, Wisconsin. Founded in 1959, it is dedicated to promoting health and meeting the healthcare needs of its patients.

MCHS in Barron is part of the Northwest Wisconsin region of MCHS, which includes hospitals in Eau Claire, Bloomer, Menomonie, and Osseo. MCHS in Barron supports the community through inpatient and outpatient services, as well as health and wellness. Although MCHS in Barron serves patients from several communities in northwestern Wisconsin, the majority are from Barron County. For the purposes of MCHS in Barron's CHNA, the community is defined as Barron County.

In 2024, MCHS in Barron contributed $123,500 through philanthropic donations to support programs such as the Boys & Girls Club of Barron County, Benjamin's House Emergency Shelter, Barron County Developmental Services, Rice Lake Area Free Clinic, St. Vincent de Paul Kitchen and Food Pantry and local school districts.

Health education is also communicated through numerous blog postings, newsletter articles and informal presentations. Through online tracking and other measures, it's estimated that we reached an additional 5,000 residents by providing health information on topics affecting immediate health issues and offering helpful tips on general wellness.

The MCHS Community Health Needs Assessment (CHNA) process advances and strengthens our commitment to community health and wellness activities by focusing on high-priority community needs and bringing additional ones to light.

The primary input into the assessment and prioritization process was the 2024 Barron County Community Health Assessment, produced by Barron County Public Health and the Community Health Assessment Steering Committee. This report was created through a joint effort by area healthcare organizations, the Barron County Health Department, and the Barron County Community Coalition. In addition, written comments related to the previous CHNA would be considered; however, no written comments were received. This effort, led by the Community Health Assessment Steering Committee, began with the goal of evaluating community health to enhance the quality of life for all community members.

# Prioritized Health Needs

After completing an extensive analysis of the Barron County Community Health Assessment data and County Health Rankings—and in alignment with our expertise and resource capacity—Mayo Clinic Health System has identified three top health priorities for strategic action.

These top three health priorities are:

**1. Mental Health**

**2. Substance Misuse**

**3. Access to Healthcare, Food, Housing**

# Community Health Implementation Plan Overview

## Priority 1 Summary: Mental Health

### CURRENT SITUATION AND DATA

Access to mental healthcare is a significant concern in Barron County. It was ranked the number one health priority on the Community Health Assessment survey, with 17% of respondents identifying poor mental health as the most concerning health behavior. Also, 16% of adults reported experiencing 14 or more mentally unhealthy days per month. The county also faces a substantial provider shortage: the population-to-mental-health-provider ratio is 960:1—more than double the Wisconsin state ratio of 420:1—indicating limited availability of mental health services and heightened barriers to care.

### STRATEGIES

**Expand access to mental health services and resources**

**Foster wellbeing, connectivity and resilience across the life span**

### DESIRED IMPACT

Strengthen community mental health by expanding education, supporting partner organizations, and increasing access to resources, while continuing programs that build social connection and collaboration. Engaging staff in coalitions and partnerships will further enhance the community's capacity to promote mental well being and achieve sustained, coordinated impact.

## MENTAL HEALTH

This focus area encompasses the services and support required to manage our thoughts, actions, and emotions as we navigate life. Mental health is crucial for personal well-being, nurturing family and interpersonal relationships, and making meaningful contributions to society. Conditions affecting mental health include, but are not limited to, depression, anxiety, and post-traumatic stress disorder.

### Strategy 1: Expand access to mental health services and resources

| ACTION | INPUTS | ANTICIPATED OUTCOMES |
|---|---|---|
| Provide financial support and subject-matter experts for community-based services that meet people where they are and offer tailored support. | Collaboration:<br>• Lakeland Family Resource Center<br>• School districts<br>• Barron County Centerpoint Events<br>Resources:<br>• Financial | Annually, 4 subject matter experts provide community-based education<br>80% of funded partners report that their ability to serve their clients has increased due to our support |
| Create outreach educational materials and promote awareness of mental health resources, programs and services for public distribution. | Collaboration:<br>• Not applicable<br>Resources:<br>• Staff time | Create baseline in year 1 and in year 2-3, increase the availability of educational materials for mental wellness |

**Strategy 2: Foster wellbeing, connectivity and resilience across the lifespan**

| ACTION | INPUTS | ANTICIPATED OUTCOMES |
|---|---|---|
| Host intergenerational community wellness events that build connections using evidence-based curricula such as Strong Bodies and Strong Seniors. | Collaboration:<br>• ADRC of Barron and Rusk Counties<br>Resources:<br>• Staff time | 70% of attendees report feeling more connected as a result of our programs |
| Ensure leaders and staff have active roles in community coalitions, partnerships and board membership | Collaboration:<br>• Boys and Girls Clubs of Barron County<br>• Barron Chamber of Commerce<br>• Northwood Technical College<br>Resources:<br>• Staff time | Increase staff participation in partnership/coalition meetings |

# Priority 2 Summary: Substance Misuse

## CURRENT SITUATION AND DATA

In Barron County, drug use, misuse, and overdose is the top health behavior concern among Community Health Assessment respondents, with 25% identifying it as the most pressing issue. Alcohol use is also a significant worry, ranked third, with 17% of respondents citing it as the behavior of greatest concern. County-level data reflect these issues: 22% of adults report binge or heavy drinking, and early alcohol use among youth is notably high—38% of young people have tried alcohol before age 13, more than double the state estimate of 17%.

## STRATEGIES

**Promote prevention and early intervention initiatives for youth**

**Support policy, education, and community awareness strategies to decrease Substance Misuse**

## DESIRED IMPACT

To strengthen community knowledge and understanding of substance misuse, expand collaboration across partners, enhance safe medication practices, improve outcomes for individuals participating in prevention and recovery programs, and increase meaningful engagement with residents through coordinated outreach and warm handoff services.

## SUBSTANCE MISUSE

Substance misuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. It involves using these substances in a way that negatively impacts one's health, well-being, or daily functioning. Substance misuse can lead to addiction, health problems, and other serious issues.

### Strategy 1: Promote prevention and early intervention initiatives for youth

| ACTION | INPUTS | ANTICIPATED OUTCOMES |
|---|---|---|
| Ensure leaders and staff have active roles in community and school-based alcohol and other drug abuse initiatives | Collaboration:<br>• Barron County Community Coalition<br>Resources:<br>• Staff time | Increase staff participation in partnership/coalition meetings |
| Deliver educational presentations to parents and community groups about recognizing early signs of substance misuse | Collaboration:<br>• School Districts<br>Resources:<br>• Staff time | 70% of attendees report increased understanding of substance misuse related objectives |
| Offer outreach at the Day Resource Center and other community hubs to connect unhoused people with recovery support and treatment access. | Collaboration:<br>• Barron County Centerpoint Event<br>Resources:<br>• Staff time | Within 3 years, engage 200 individuals through outreach, with warm hand-off services within Mayo |

**Strategy 2: Support policy, education, and community awareness strategies to decrease Substance Misuse**

| ACTION | INPUTS | ANTICIPATED OUTCOMES |
|---|---|---|
| Provide public education campaigns, with the assistance of pharmacy staff, about safe medication use, proper disposal, and overdose prevention | Collaboration:<br>• Barron County Community Coalition<br>Resources:<br>• Staff Time | Increase in Mayo's participation in disposable opioid bags |
| Provide support and assistance to external organizations that address substance misuse | Collaboration:<br>• Barron County Family Recovery Court<br>Resources:<br>• Financial<br>• Staff Time | At least 70% of participants enrolled in funded programs demonstrate improvement in one or more indicators related to substance use |

# Priority 3 Summary: Access to Healthcare, Food, Housing

## CURRENT SITUATION AND DATA

Affordability and access to basic needs remain major challenges in Barron County. One in five Community Health Assessment respondents identified affordable healthcare as their top clinical care concern, and 10% reported being unable to afford their medications. Also, while many households are above the federal poverty line, 30% still lack sufficient income to cover basic necessities according to the 2024 ALICE report. Financial strain also affects housing and food security, with 15% of survey respondents saying they do not have enough money for safe, affordable housing and adequate food.

## STRATEGIES

**Improve access and reduce barriers to health care services**

**Reduce barriers that prevent residents from achieving wellness and long-term self-sufficiency**

**Increase equitable access to basic needs**

## DESIRED IMPACT

To improve access to essential health and social services, strengthen community awareness and navigation of available resources, enhance residents' stability and self-sufficiency, and build sustained cross-sector partnerships that support long-term wellbeing and reduce avoidable healthcare utilization.

## ACCESS TO HEALTHCARE, FOOD, HOUSING

Equitable access to basic needs such as healthcare, food, and housing is crucial for a community's overall well-being and development. It ensures that all members can receive preventive care, treatment for illnesses, and mental health support, leading to a healthier population and improved quality of life. Access to these basic needs also promotes economic stability, ensuring people can work, children can attend school, and families can thrive, contributing to economic growth.

### Strategy 1: Improve access and reduce barriers to health care services

| ACTION | INPUTS | ANTICIPATED OUTCOMES |
|---|---|---|
| Create and offer Primary Care On Demand training for community members | Collaboration:<br>• ADRC of Barron and Rusk Counties<br>• Senior Centers<br>• Public Libraries<br>• Barron County Centerpoint Event<br>• Business community (employers)<br><br>Resources:<br>• Staff Time | • Increased awareness of Primary Care on Demand<br>• By year 2, will have developed a tangible item for people to have on hand to help navigate PCOD |

**Strategy 2: Reduce barriers that prevent residents from achieving wellness and long-term self-sufficiency**

| ACTION | INPUTS | ANTICIPATED OUTCOMES |
|---|---|---|
| Participate in community health events to support vulnerable populations | Collaboration:<br>• Barron County Centerpoint events<br>Resources:<br>• Staff Time | Within 2 years, at least 75% of attendees at health events report increased awareness of available health and social resources |
| Partner with local organizations and the Health Equity Coordinator to provide transportation vouchers or volunteer ride programs for medical appointments | Collaboration:<br>• Carepool<br>Resources:<br>• Staff Time | 80% of patients receiving transportation support successfully complete their medical appointments |
| Advocate policy changes at the county or state level that increase access to affordable housing and address other barriers | Collaboration:<br>• Community Connections to Prosperity<br>Resources:<br>• Staff Time | Develop sustained partnerships with at least five cross-sector stakeholders (public health, housing, social services, and local government) to advance housing initiatives |
| Engage with the Center for Health Equity and Community Engagement Research to explore ways to use the Mobile Clinic | Collaboration:<br>• Not applicable<br>Resources:<br>• Staff Time | Create a feasibility plan for use of the mobile clinic. |
| Fund organizations with early intervention or prevention programs (case management) | Collaboration:<br>• Benjamin's House Emergency Shelter<br>• Barron County Salvation Army<br>Resources:<br>• Financial<br>• Staff Time | At least 70% of participants enrolled in funded programs demonstrate improvement in one or more social or health stability indicator |

### Strategy 3: Increase equitable access to basic needs

| ACTION | INPUTS | ANTICIPATED OUTCOMES |
|---|---|---|
| Identify high-need areas and implement targeted interventions addressing housing, food, and transportation barriers. Partner with local organizations and the Health Equity Coordinator to help access resources. | Collaboration:<br>• Not applicable<br>Resources:<br>• Staff Time | At least 50% of participants will be connected to one or more social services (housing, mental health, addiction recovery, or insurance enrollment) |
| Engage staff internally to support local efforts in reducing food insecurity | Collaboration:<br>• St. Vincent De Paul Food Pantry and Kitchen<br>• Local food pantries<br>• Community Connections to Prosperity<br>Resources:<br>• Staff Time | After 3 years, at least 300 staff members have participated in one food insecurity activity |
| Provide support and assistance to external organizations that address basic needs and access to care | Collaboration:<br>• Rice Lake Area Free Clinic<br>• Barron County Centerpoint Events<br>Resources:<br>• Financial<br>• Staff Time | At least 70% of participants enrolled in funded programs demonstrate improvement in one or more health stability indicators related to access to care or basic needs |
| Support efforts to grow the Community Health Worker program | Collaboration:<br>• Not applicable<br>Resources:<br>• Staff Time<br>• Financial | Develop and sustain care coordination and community resource collaborations |

# Summary of health needs not addressed

Additional health needs identified in the 2025 Community Health Needs Assessment such as: access to childcare, jobs and the economy (having enough income to live on), access to dental care and improved resources to age at home will be addressed by Mayo Clinic Health System in Barron as organizational capacity and resources permit, or by community agencies and organizations whose missions, expertise and resources are more appropriately aligned to respond to those specific priorities.

# Additional Mayo Clinic resources that benefit community health

### BUILDING A HEALTHIER WORLD

At Mayo Clinic, we think big and act boldly to improve the health of communities and accelerate equality and diversity in healthcare. We share our knowledge globally, impact policy and partner with others to create lasting — and much-needed — change for a healthier world.

### IMPROVING HEALTH EQUITY

We partner with community organizations to end health disparities through educational programs, personalized healthcare and community-engaged research. We're accelerating recruitment of diverse investigators and clinical trial participants to eliminate bias in medicine and science and ensure more cures for all. We're strengthening our pipelines for healthcare professionals and leadership development. We're also using our Mayo Clinic Platform to make innovative care accessible for all.

Through our extensive research and education efforts, Mayo Clinic brings the breadth and depth of its expertise in all specialties of medical practice to all communities we serve. Since much of our research takes place in and around our locations, our local communities oftentimes are the first to benefit from practice improvements developed from new discoveries.

## OVERARCHING MAYO CLINIC RESOURCES THAT BENEFIT LOCAL HEALTH NEEDS INCLUDE:

**Biomedical Research at Mayo Clinic**

Mayo Clinic research programs encompass thousands of active and new studies to improve the prevention and treatment of disease. Research teams at Mayo Clinic comprise experts from multiple disciplines and Mayo Clinic sites. Mayo Clinic brings our unique expertise and integrated, multidisciplinary approach to medicine to benefit community health. For more information, visit Research at Mayo Clinic.

**Mayo Clinic Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery**

The Kern Center for the Science of Health Care Delivery analyzes and coordinates resources to improve care delivery models and increase value for patients. Advanced care models are applied to our local communities first.

For more information, visit the Kern Center for the Science of Health Care Delivery.

## CENTER FOR CLINICAL AND TRANSLATIONAL SCIENCE (CCATS)

Mayo Clinic's CCaTS works to speed up the translation of research results into therapies, tools and patient care practices that improve community health. CCaTS makes connections, finds best practices, bridges gaps, and engages the community in medical research and education expertise. For more information visit: http://www.mayo.edu/ctsa/ and http://www.mayo.edu/ctsa/community.

Explore more about our community engagement.

## JOINT COMMISSION REQUIREMENTS

The Joint Commission (TJC) is an independent, not-for-profit organization that "improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value."12

These new requirements have been identified to reduce health care disparities in ambulatory health, behavioral health and human services, critical access hospitals and accreditation programs. They include:

| **Standard LD.04.03.08:** | **REDUCING HEALTH CARE DISPARITIES FOR THE [ORGANIZATION'S] [PATIENTS] IS A QUALITY AND SAFETY PRIORITY.** |
|---|---|
| Requirement EP 1: | The [organization] designates a person(s) to lead activities to reduce health care disparities for the [organization's] [patients].<br><br>Note: Leading the [organization's] activities to reduce health care disparities may be an individual's primary role or part of a broader set of responsibilities |
| Requirement EP 2: | The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.<br><br>Note: [Organizations] determine which health-related social needs to include in the [patient] assessment. Examples of a [patient's] health-related social needs may include the following:<br>• Access to transportation<br>• Difficulty paying for prescriptions or medical bills<br>• Education and literacy<br>• Food insecurity<br>• Housing insecurity |
| Requirement EP 3: | The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].<br><br>The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].<br><br>Note 1: [Organizations] may focus on areas with known disparities identified in the scientific literature (for example, [Hospital/Critical Access Hospital: organ transplantation, maternal care, diabetes management; Ambulatory Health Care: kidney disease, maternal care, diabetes management; Behavioral Health Care: treatment for substance abuse disorder, restraint use, suicide rates]) or select measures that affect all [patients] (for example, experience of care and communication).<br><br>Note 2: [Organizations] determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following:<br>• Age<br>• Gender<br>• Preferred language<br>• Race and ethnicity |
| Requirement EP 4: | The [organization] develops a written action plan that describes how it will address at least one of the health care disparities identified in its [patient] population. |
| Requirement EP 5: | The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities. |
| Requirement EP 6: | At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress |

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