MAYO CLINIC

Community Health Needs Assessment 2026-2028 Implementation Plan

Mayo Clinic Health System in Bloomer

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 Bloomer

Mayo Clinic Health System – Chippewa Valley in Bloomer (MCHS in Bloomer) is a 25-bed critical access hospital in Bloomer, Wisconsin. Since 1961, the hospital has been dedicated to promoting health and meeting the healthcare needs of our patients. In 2011, the hospital became known as Mayo Clinic Health System – Chippewa Valley in Bloomer, continuing its long-standing commitment to providing personalized and compassionate care to patients in the communities it serves.

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

In 2024, MCHS in Bloomer contributed $94,000 through philanthropic donations to support programs such as the Boys and Girls Club, United Way, River Source Family Center, Chippewa Valley YMCA, public libraries, school districts and healthcare college scholarships.

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 6,000 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 Chippewa County Community Health Assessment (CHA), produced by the Community Health Assessment Planning Partnership Committee. The CHA was conducted collaboratively by the CHA Planning Partnership Committee (also referred to in this report as the CHA partners). This report was created through a joint effort by area healthcare organizations, the Chippewa County Health Department, United Way of the Greater Chippewa Valley and the Eau Claire Health Alliance. This partnership was established to optimize resource coordination and use while reducing duplicative efforts.

Prioritized Health Needs

After completing an extensive analysis of the Chippewa 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

Mental health continues to be a significant concern in Chippewa County, with 41% of survey respondents reporting that mental health contributes to many other community issues and 29% noting limited resources available to address needs across all levels. Suicide rates are higher than the state average, with 20 deaths per 100,000 residents compared to Wisconsin's rate of 15 per 100,000, and access to care remains limited, as reflected in a population-to-provider ratio of 1,060 to 1—more than double the statewide ratio of 420 to 1.

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: • River Source Family Resource Center • School districts • Open Door Free Clinic Resources: • Financial	Annually, 4 subject matter experts provide community-based education 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: • Not applicable Resources: • 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: • Bloomer Senior Center Resources: • 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: • United Way of the Greater Chippewa Valley • Big Brothers, Big Sisters of Northwestern Wisconsin • Chippewa Valley Technical College Resources: • Staff time	Increase staff participation in partnership/coalition meetings

Priority 2 Summary: Substance Misuse

CURRENT SITUATION AND DATA

Alcohol and tobacco use continue to present significant challenges in Chippewa County. Nearly half of CHA survey respondents (48%) reported that alcohol misuse negatively affects family life, and over one third (36%) indicated that alcohol misuse is a normalized part of the local culture. Also, 28% of adults reported binge or heavy drinking in the past 30 days, and 19% of adults are current smokers—exceeding both state and national rates of 16%.

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: • Chippewa County Voices in Prevention Resources: • 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: • Chippewa County Voices in Prevention • School Districts Resources: • 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: • Hope Village Resources: • 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: • Chippewa County Voices in Prevention Resources: • Staff Time	Increase in Mayo's participation in disposable opioid bags
Provide support and assistance to external organizations that address substance misuse	Collaboration: • Chippewa County Voices in Prevention Resources: • Financial • 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

Many Chippewa County residents face significant barriers to meeting their basic needs. Over half of CHA survey respondents (52%) reported that healthcare costs prevent them from receiving recommended care, and 50% said their wages are not keeping pace with the cost of living. According to the 2023 United Way ALICE report, 30% of residents earn above the federal poverty line, yet still cannot afford basic necessities. Eight percent of the population also lacks adequate access to food, underscoring persistent challenges related to economic stability and food security.

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: • Senior Centers • Public Libraries • Business community (employers) Resources: • Staff Time	• Increased awareness of Primary Care on Demand • 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: • Hope Village • Open Door Free Clinic Resources: • 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: • Carepool Resources: • 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: • Chippewa Falls Area Chamber of Commerce Resources: • 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: • Not applicable Resources: • Staff Time	Create a feasibility plan for use of the mobile clinic.
Fund organizations with early intervention or prevention programs (case management)	Collaboration: • Hope Village • WestCAP • Western Dairyland Resources: • Financial • 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: • Not applicable Resources: • 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: • Feed My People Food Bank • Local food pantries Resources: • 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: • Open Door Free Clinic • Hope Village • Bloomer Community Clothes Closet Resources: • Financial • 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: • Not applicable Resources: • Staff Time • 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: low-quality or lack of public transportation, Health care is difficult to access, lack of access to childcare or unaffordable childcare and lack of affordable or high-quality health insurance, will be addressed by Mayo Clinic Health System in Bloomer 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]. 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. 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: • Access to transportation • Difficulty paying for prescriptions or medical bills • Education and literacy • Food insecurity • 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]. The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients]. 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). Note 2: [Organizations] determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following: • Age • Gender • Preferred language • 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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