



Community Health Needs Assessment 2026-2028 Implementation Plan

Mayo Clinic Health System in Mankato





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 Mankato

MCHS in Mankato is a 272-bed acute-care hospital in Mankato, Minnesota. It is part of the Mayo Clinic Health System, which includes hospitals in Minnesota and Wisconsin. MCHS Mankato also provides primary care at the Mankato Eastridge Clinic and outpatient services at Madison East Health Center and The Pond on Madison.

Dedicated to putting the needs of our patients first, MCHS in Mankato promotes health and wellness in the community through inpatient and outpatient services, education through blog postings, articles and presentations, staff volunteerism, community giving and charity care.

In 2024, MCHS in Mankato provided over \$7.6 million in charity care and contributed more than \$350,000 in community giving grants to organizations, such as Feeding Our Communities Partners, Mankato Youth Place, Partners for Housing, and YWCA Mankato.

In addition, the organization shared health-related education through programs at the Children’s Museum of Southern Minnesota and VINE Adult Community Center, and supported efforts to get communities active through activities, such as the Mankato Marathon and virtual programs like Journey to Wellness.

Annually, the hospital organizes various employee drives to donate items, including a food drive and a holiday sharing tree drive. In addition, staff coordinates three employee blood drives

held on the hospital campus in partnership with the American Red Cross each year. Employees are actively involved in the community, and our staff engaged in over 75 community volunteer projects last year.

Mayo Clinic Health System in Minnesota used a systematic process to evaluate the health needs of our communities and determine health priorities.

The primary quantitative input into the assessment and prioritization process was the Southern Minnesota Needs Assessment data report, created by Joe Visker, Ph.D., Minnesota State University-Mankato. This report analyzes existing data gathered from various sources, such as census data, government reports, health department statistics and school surveys.

The primary qualitative input into the process was community feedback collected through a key informant survey, in which 19 leaders provided feedback on the top health concerns. Local public health departments reviewed and provided input on the survey questions during development. In addition, a community health prioritization activity was held with stakeholders from local government, business and nonprofit leaders, including an in-person community stakeholder prioritization event on March 20th with over 60 community stakeholders in attendance. Community health surveys distributed by Blue Earth County, Le Sueur County, Nicollet County, and the Greater Mankato Inclusivity Study results were also reviewed and provided insight.





Prioritized Health Needs

After completing an extensive analysis of the Blue Earth, Nicollet and Le Sueur County's 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. Access to Care

3. Basic Needs that Influence Health

Community Health Implementation Plan Overview

Priority 1 Summary: Mental Health

CURRENT SITUATION AND DATA

Blue Earth County is the hub for services in the region. There is a high demand for outpatient services in the area, limited psychiatric prescriber availability, rural access barriers and increased socioeconomic and demographic pressures for services.

STRATEGIES



Expand access to mental health services and resources



Foster wellbeing, connectivity and resilience across the life span

DESIRED IMPACT

The combined strategies aim to create a community where people of all ages can easily access mental health services, feel connected to supportive networks, and build the resilience needed to thrive. By expanding access to education, resources, and care—while strengthening partnerships across schools, nonprofits, healthcare, and local coalitions—this work seeks to reduce barriers to mental health support, increase early intervention, and improve overall wellbeing in Blue Earth, Nicollet, and Le Sueur counties. The long term impact is a region where mental health needs are met proactively, stigma is reduced, and individuals and families experience measurable improvements in wellness, stability, and quality of life.

MENTAL HEALTH

This focus refers to the services and support needed to address how we think, act and feel as we cope with life. Mental health is essential for personal well-being, caring for family, maintaining interpersonal relationships, and making meaningful

contributions to society. Mental health conditions may include, but are not limited to, depression, anxiety and post-traumatic stress disorder. This focus area will also include substance use.

Strategy 1: Expand access to mental health services and resources

ACTION	INPUTS	ANTICIPATED OUTCOMES
Collaborate with community partners to provide subject matter experts for community-based programs and services.	Collaboration: <ul style="list-style-type: none"> • VINE Faith in Action • Schools • Non-profit agencies • Service Clubs Resources: <ul style="list-style-type: none"> • Staff Time 	Provide subject matter experts for at least 6 community-based programs or events during reporting period.
Develop and distribute outreach educational materials and promote awareness of mental health and substance misuse resources, programs and services	Collaboration: <ul style="list-style-type: none"> • Community Events • Local Nonprofits Resources: <ul style="list-style-type: none"> • Newsletter • MCHS Website • Staff Time 	Increase community awareness of mental health and/or substance misuse resources by annually distributing educational materials at a minimum of 5 community outlets.
Provide in-kind support to make access to mental health services more easily available.	Collaboration: <ul style="list-style-type: none"> • The Child & Family Advocacy Center of South Central Minnesota. • Greater Mankato Mental Health Hub & Youth Mental Health/ Suicide Prevention Committee • South Central Crisis Center Resources: <ul style="list-style-type: none"> • In-Kind Space • Staff Expertise and Support 	Provide a minimum of \$5,000 in in-kind support annually. In-kind space at Eastridge Clinic for The Child & Family Advocacy Center of South Central Minnesota to allow them to have a neutral place to meet with families and children. In-kind space at Mankato Emergency Department for South Central Crisis Center to be integrated and more accessible to patients and staff for referrals.

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

ACTION	INPUTS	ANTICIPATED OUTCOMES
<p>Develop, coordinate and promote Mayo Clinic and MCHS wellness programs</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Local schools – Mankato Area Public Schools • Employers <p>Resources:</p> <ul style="list-style-type: none"> • Staff experts • Giveaways for Wellness Week • Mayo Clinic and MCHS websites • MCHS Wellness Programs 	<p>Classrooms have a better sense of healthy habits and wellness resources after completion of Wellness Week program.</p> <p>Promote at least 5 wellness programs during reporting period.</p>
<p>Ensure leaders and staff have active roles in community coalitions, partnerships and board membership</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Nonprofit organizations • Youth Mental Health & Suicide Prevention Committee • Mankato/North Mankato Age-Friendly Communities Coalition • Mankato Substance Use Disorder Advocacy Committee <p>Resources:</p> <ul style="list-style-type: none"> • Staff time 	<p>Participate in at least 4 partnerships or coalitions to help community work move forward</p>
<p>Provide financial resources to external organizations that improve mental health and address substance misuse</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Local nonprofits <p>Resources:</p> <ul style="list-style-type: none"> • Community Grants 	<p>Ensure 80% of community funding decisions are aligned with defined CHNA prioritized health needs.</p>

Priority 2 Summary: Access to Care

CURRENT SITUATION AND DATA

Access to healthcare across Blue Earth, Nicollet, and Le Sueur counties reflects a mix of strong regional medical assets—especially Mayo Clinic Health System—and persistent rural barriers that affect affordability, transportation, and availability of specialized services. The picture that emerges is a region with high quality care nearby, but uneven ability for residents to reach and use it effectively.

STRATEGIES



Improve access to health care services



Reduce barriers to health care services

DESIRED IMPACT

This work aims to create a region where all community members can easily navigate to reach and benefit from high-quality healthcare, no matter where they live or what resources they have. By strengthening primary care access, expanding virtual and mobile options, improving internal referral pathways, and partnering with schools, nonprofits, and public health, these strategies work together to remove financial, geographic, and informational barriers that prevent people from getting timely care. The long term impact is a healthcare system that is more connected, more equitable, and more responsive, leading to earlier prevention, higher screening and treatment rates, and measurable improvements in overall community health and wellbeing.

ACCESS TO CARE

This focus refers to the ability and ease of accessing healthcare and community services. Access to care considers barriers such as transportation, knowledge and education about available services, and ease of access to care through outreach and virtual

options. By focusing on access, we aim to reduce disparities, improve health outcomes, and ensure that every person—regardless of background or circumstance—can live a healthier, more empowered life.

Strategy 1: Improve access to healthcare services

ACTION	INPUTS	ANTICIPATED OUTCOMES
Offer Primary Care On Demand training for community members	Collaboration: <ul style="list-style-type: none"> • Community Locations - Community Center, Library • Business community (employers) Resources: <ul style="list-style-type: none"> • Mayo Materials • Staff time 	Increased awareness of Primary Care on Demand By year 2, will have developed a tangible item for individuals to have on hand to help navigate Primary Care on Demand
Provide care and resources to patients with financial barriers	Collaboration: <ul style="list-style-type: none"> • Transportation Providers (VINE, TRUE Transit) Resources: <ul style="list-style-type: none"> • Charity Care • Transportation assistance • Resource materials • Staff Time 	Provide materials in patient areas Increased staff knowledge of available resources Increase in utilization of transportation services for patients with financial barriers.
Explore methods for Internal Referral Coordination	Collaboration: <ul style="list-style-type: none"> • Not applicable Resources: <ul style="list-style-type: none"> • Staff Time • Training Materials 	Improve staff coordination and continuum of care to better serve our patients.
Explore virtual care hubs in rural communities	Collaboration: <ul style="list-style-type: none"> • Community Centers • Libraries • City/County Resources: <ul style="list-style-type: none"> • Space • Equipment • Supplies 	Reduce transportation barriers for patients who live in rural areas.

Strategy 2: Reduce barriers to healthcare services

ACTION	INPUTS	ANTICIPATED OUTCOMES
Provide education and opportunities to reduce preventative health and cancer screening gaps	Collaboration: <ul style="list-style-type: none"> • Public Health • WellShare International • Local Nonprofits • VINE Faith in Action • Schools Resources: <ul style="list-style-type: none"> • Staff • Equipment • Supplies • Materials • Financial Support 	Increased patient compliance through education and increased opportunities for care Reduce preventative health gaps and increase cancer screening rates
Provide at least 4 mobile health unit events/activities per year	Collaboration: <ul style="list-style-type: none"> • Public Health • WellShare International • Nonprofits Resources: <ul style="list-style-type: none"> • Staff • Mayo Mobile Health Unit • Mayo Clinic CHAMP Grant 	Improved access to care due to reduction of transportation barrier and familiarity with mobile health unit
Family Medicine Residency program provides community outreach	Collaboration: <ul style="list-style-type: none"> • Connections Shelter • St. Peter Free Clinic • Project Community Connect • Children’s Museum of Southern MN • VINE/Walk with a Doc Resources: <ul style="list-style-type: none"> • Staff • Equipment • Supplies 	Provide outreach services in partnership with at least five organizations annually to improve access to care
Provide outreach services in partnership with at least five organizations annually to improve access to care	Collaboration: <ul style="list-style-type: none"> • Local Nonprofits • Language Service Organizations Resources: <ul style="list-style-type: none"> • Staff • Language Services • Financial support for language interpretation • Translated Materials 	Decreased language barriers and increased patient compliance

Priority 3 Summary: Basic Needs that Influence Health

CURRENT SITUATION AND DATA

Access to basic needs across Blue Earth, Nicollet, and Le Sueur counties reflects a mix of strong regional nonprofit infrastructure and persistent gaps tied to income, housing stability, transportation, and food security. The counties share many of the same service providers and challenges, but the depth of need is shaped by rural geography and limited local resources in smaller communities.

STRATEGIES



Increase equitable access to basic needs



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

DESIRED IMPACT

This work aims to ensure that all people and families in Blue Earth, Nicollet, and Le Sueur counties have equitable access to the essential resources that support health, stability, and long term wellbeing. By expanding connections to housing, food, transportation, and social services; strengthening partnerships with community based organizations; and increasing the use of coordinated referral tools, these strategies seek to reduce barriers that keep residents from meeting basic needs and achieving lasting self sufficiency. The long term impact is a community where basic needs are met more consistently, care is easier to navigate, and residents experience greater security, resilience, and opportunity.

BASIC NEEDS THAT INFLUENCE HEALTH

This focus area refers to the non-medical factors that influence health outcomes. These conditions are where people are born, grow, work, live, and age—examples include access to food and

housing. Addressing patients’ basic needs has been shown to improve their health outcomes.

Strategy 1: Increase equitable access to basic needs

ACTION	INPUTS	ANTICIPATED OUTCOMES
Identify and implement targeted interventions to connect patients to resources addressing housing, food and resource assistance	Collaboration: <ul style="list-style-type: none"> • Local Nonprofits Resources: <ul style="list-style-type: none"> • Staff, including Health Equity Coordinator and Community Health Workers 	Track and increase the number of participants who identify they would like support 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 or other identified SDOH concern	Collaboration: <ul style="list-style-type: none"> • ECHO Food Shelf • Feeding Our Communities Partners • Local Nonprofits Resources: <ul style="list-style-type: none"> • Staff • Materials 	After 3 years, at least 250 staff members participate in one food insecurity activity
Provide financial resources to external organizations that address basic needs or access to care	Collaboration: <ul style="list-style-type: none"> • Local Nonprofits Resources: <ul style="list-style-type: none"> • Financial Support – Community Giving 	Ensure 80% of community funding decisions are aligned with defined CHNA prioritized health needs
Support efforts to grow the Population Health programs & goals	Collaboration: <ul style="list-style-type: none"> • Local Nonprofits • WellShare International Resources: <ul style="list-style-type: none"> • Staff, including Health Equity Coordinator and Community Health Workers 	Develop and sustain care coordination and community resource collaborations

<p>Increase use of findhelp and CareConnect for connection to community resources through training and outreach</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Local Nonprofits • Findhelp <p>Resources:</p> <ul style="list-style-type: none"> • Staff, including Health Equity Coordinator, Community Engagement and Community Health Workers • Supplies 	<p>At least 3 trainings during reporting period</p>
<p>Coordinate clinic garden at Eastridge for food insecure patients</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • South Central Food Recovery <p>Resources:</p> <ul style="list-style-type: none"> • Staff • Supplies (Seeds, Weeding Tools, etc) • Materials • Refrigerator 	<p>Make access to healthy food more accessible by having produce and other healthy food onsite at the clinic for food insecure patients to access.</p>

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: <ul style="list-style-type: none"> • Project Community Connect Resources: <ul style="list-style-type: none"> • Staff • Supplies/Equipment 	Increased access to and awareness of healthcare services and resources
Partner with local organizations and Social work to provide transportation vouchers or volunteer ride programs for medical appointments	Collaboration: <ul style="list-style-type: none"> • VINE Faith in Action • Regional transportation providers Resources: <ul style="list-style-type: none"> • Staff • Financial Resources 	Increased healthcare referrals to community-based transportation organizations for patients who identify they need transportation assistance
Improve the health literacy of community partners, the people they serve and our internal staff	Collaboration: <ul style="list-style-type: none"> • Public Health • Nonprofits Resources: <ul style="list-style-type: none"> • Staff • Financial Resources • Training instructor/presenter 	Provide 2 basic health literacy training courses with community partners during reporting period
Participate in Regional Transportation Coordination Efforts	Collaboration: <ul style="list-style-type: none"> • City/County Government • Nonprofit Organizations Resources: <ul style="list-style-type: none"> • Staff • Financial Resources 	Raise awareness of current transportation resources Improve transportation resource navigation across borders



Summary of health needs not addressed

Other needs that were strongly considered were substance abuse and chronic disease. These needs will be addressed through our selected health concerns – mental health, access to care and basic needs that influence health- but given limited resources and other organizations working to address these different needs, they will not be addressed as selected health concerns in this report. Substance Abuse can and may be addressed under mental health.



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:	<p>The [organization] designates a person(s) to lead activities to reduce health care disparities for the [organization’s] [patients].</p> <p>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</p>
Requirement EP 2:	<p>The [organization] assesses the [patient’s] health-related social needs and provides information about community resources and support services.</p> <p>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:</p> <ul style="list-style-type: none"> • Access to transportation • Difficulty paying for prescriptions or medical bills • Education and literacy • Food insecurity • Housing insecurity
Requirement EP 3:	<p>The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization’s] [patients].</p> <p>The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization’s] [patients].</p> <p>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).</p> <p>Note 2: [Organizations] determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following:</p> <ul style="list-style-type: none"> • Age • Gender • Preferred language • Race and ethnicity
Requirement EP 4:	<p>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.</p>
Requirement EP 5:	<p>The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities.</p>
Requirement EP 6:	<p>At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress</p>

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