Community Health Needs Assessment 2026-2028 Implementation Plan

Mayo Clinic Health System in Waseca

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 Waseca

Mayo Clinic Health System (MCHS) in Waseca is a 16-bed, critical-access hospital in Waseca, Minnesota. It is part of the Mayo Clinic Health System, which includes hospitals in Minnesota and Wisconsin.

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

In 2024, MCHS in Waseca provided over $1 million in charity care. In addition, the hospital supported health and wellness in the community by partnering with high schools and higher-education institutions to introduce students to careers in rural healthcare, and invested over $25,000 in health and wellness programs, including the Waseca Area Neighborhood Service Center Food Shelf, Big Brothers Big Sisters of Southern Minnesota, and Bethlehem Inn of Waseca.

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. This report was created by Joe Visker, PhD, Minnesota State University Mankato. This report includes an analysis of 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 input collected through a key informant survey, in which four leaders identified 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 May 5, 2025, with over 20 community stakeholders in attendance. A community health survey distributed by Waseca County was also reviewed, providing insight.

Prioritized Health Needs

After completing an extensive analysis of the Waseca 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. Access to Care

3. Basic Needs that Influence Health

Community Health Implementation Plan Overview

Priority 1 Summary: Mental Health

CURRENT SITUATION AND DATA

National and statewide trends show increasing concern about mental health, and Waseca County mirrors this pattern. A recent analysis highlights that mental health has become a top health concern for adults, with more than half of U.S. adults identifying it as their primary health issue. Factors identified through the Waseca County Community Health Assessment include economic stressors, transportation limitations and healthcare access barriers, including cost and insurance gaps.

STRATEGIES

Expand access to mental health services and resources

Foster wellbeing, connectivity and resilience across the lifespan

DESIRED IMPACT

This work aims to ensure that people of all ages in Waseca County can easily access mental health services, understand available resources, and feel supported in their overall well-being. By expanding community education, increasing visibility of mental health programs, strengthening partnerships with schools, nonprofits, and local organizations, and investing in prevention and early intervention efforts, these strategies seek to reduce stigma, improve access, and build resilience across the life span. The long term impact is a community where mental health needs are met earlier, support networks are stronger, and people experience measurable improvements in wellness, connection, 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: • Waseca Area Senior Citizens Center • Schools • Non-profit agencies • Service Clubs Resources: • Staff Time	Provide subject matter experts for at least 3 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: • Community Events • Local Nonprofits Resources: • 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 3 community outlets.

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

ACTION	INPUTS	ANTICIPATED OUTCOMES
Develop, coordinate and promote Mayo Clinic and MCHS wellness programs	Collaboration: • Local schools – Waseca Area Public Schools • Employers Resources: • Staff experts • Giveaways for Wellness Week • Mayo Clinic and MCHS websites • MCHS Wellness Programs	Classrooms have a better sense of healthy habits and wellness resources after completion of Wellness Week program. Promote at least 3 wellness programs during reporting period.
Ensure leaders and staff have active roles in community coalitions, partnerships and board membership	Collaboration: • Nonprofit organizations • Youth Mental Health & Suicide Prevention Committee • Waseca County Suicide Prevention Resources: • Staff time	Participate in at least 2 partnerships or coalitions to help community work move forward
Provide financial resources to external organizations that improve mental health and address substance misuse	Collaboration: • Local nonprofits Resources: • Community Grants	Ensure 80% of community funding decisions align with the defined CHNA-prioritized health needs.

Priority 2 Summary: Access to Care

CURRENT SITUATION AND DATA

Access to healthcare in Waseca County reflects a combination of strong local clinical resources, a committed public health system, and persistent rural barriers that shape how easily residents can obtain care. The county benefits from a Mayo Clinic Health System hospital and clinic, a full-service public health department, and state-supported insurance programs, yet transportation, cost, and provider availability continue to influence access.

STRATEGIES

Improve access to health care services

Reduce barriers to health care services

DESIRED IMPACT

This work seeks to ensure that every resident in Waseca County can access high quality, culturally responsive healthcare without facing preventable barriers. By increasing awareness of Primary Care On Demand, strengthening internal referral pathways, expanding virtual and mobile care options, reducing language and financial obstacles, and partnering with schools, nonprofits, and public health, these strategies aim to create a system where care is easier to navigate, more equitable, and more connected across community settings. The long term impact is a community where preventive care is more consistent, chronic conditions are managed earlier, and residents experience better health outcomes through reliable access to the services they need.

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: • Community Locations - Senior Center, Library • Business community (employers) Resources: • 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: • Transportation Providers (SMART Transit) Resources: • 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: • Not applicable Resources: • Staff Time • Training Materials	Improve staff coordination and continuum of care to better serve our patients.
Explore virtual care hubs in rural communities	Collaboration: • Community Centers • Libraries • City/County Resources: • 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: • Public Health • Local Nonprofits • Schools Resources: • 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 2 mobile health unit events/activities per year	Collaboration: • Public Health • City/Government • Nonprofits Resources: • 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.
Increase understanding and compliance for patients who have a primary language other than English.	Collaboration: • Local Nonprofits • Language Service Organizations Resources: • 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

Waseca County's basic needs landscape shows a community with active local support systems, but also persistent gaps tied to income, housing stability, food access, and transportation. Waseca County has a strong network of nonprofits and public programs, but demand for basic needs support remains high. Residents frequently rely on emergency assistance to maintain housing, access food, and secure transportation. The county's rural geography and economic pressures amplify these challenges, making coordinated community partnerships essential.

STRATEGIES

Increase equitable access to basic needs

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

DESIRED IMPACT

This work seeks to ensure that all residents of Waseca County have equitable access to the essential resources that support health, stability, and long term independence. By strengthening connections to housing, food, transportation, and social services; engaging staff and community partners in addressing social determinants of health; expanding care coordination; and improving health literacy, these strategies aim to reduce the barriers that keep people and families from achieving wellness and self sufficiency. The long term impact is a community where basic needs are met more consistently, residents can navigate resources with confidence, and vulnerable populations 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 addressing housing, food and resource assistance.	Collaboration: • Local Nonprofits Resources: • 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: • Waseca Neighborhood Service Center Food Shelf • Local Nonprofits Resources: • Staff • Materials	After 3 years, at least 30 staff members participate in one food insecurity activity
Provide financial resources to external organizations that address basic needs and access to care	Collaboration: • Local Nonprofits Resources: • 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: • Local Nonprofits Resources: • Staff, including Health Equity Coordinator and Community Health Workers	Develop and sustain care coordination and community resource collaborations
Increase use of findhelp and CareConnect for connection to community resources through training and outreach.	Collaboration: • Local Nonprofits • Findhelp Resources: • Staff, including Health Equity Coordinator, Community Engagement and Community Health Workers • Supplies	Increase in CareConnect utilization from 2025 baseline. At least 2 trainings during reporting period.

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: • Local Nonprofits Resources: • 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: • SMART Transit • Regional transportation providers Resources: • 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: • Public Health • Nonprofits Resources: • 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: • City/County Government • Nonprofit Organizations Resources: • 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:	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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