



Community Health Needs Assessment 2026-2028 Implementation Plan

Mayo Clinic Health System in Fairmont





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 (MCHS) in Fairmont

Mayo Clinic Health System (MCHS) in Fairmont is a 57-bed, acute-care hospital in Fairmont, Minnesota. It is part of Mayo Clinic Health System in Minnesota, which includes hospitals in the south-central and southeast portions of Minnesota and the west-central and southwest portions of Wisconsin.

Dedicated to putting the needs of our patients first, MCHS in Fairmont 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, Mayo Clinic Health System in Fairmont provided over \$1.6 million in charity care and over \$10,000 in community grants to support access to physical activity and healthy food, and to help families meet basic needs.

The organization promoted healthcare careers through collaboration with area schools and higher education institutions. We supported health-related educational programs around topics of addressing mental health, substance abuse, annual wellness checks, vaccinations, resiliency and healthy eating. Fairmont also hosted community wellness challenges through the Journey to Wellness program. Health education is also communicated through community social media partners such as the Martin County Empower Coalition, Mayo Clinic Health System Hometown Health blog postings, Chamber of Commerce e-newsletter articles, and presentations led by physicians and clinical subject-matter experts at local community events and outreach opportunities.

Mayo Clinic Health System in Fairmont supports and participates in the Martin County Stronger Together Coalition, a collaborative of over 30 community partners focused on improving health

equity and health outcomes. Strong partnership is also maintained with the Martin County Public Health Statewide Health Improvement Plan (SHIP) and Empower, a substance abuse and prevention coalition in Martin County.

Annually, the hospital organizes staff giving campaigns to donate items to local food shelves, schools and community programs. In addition, staff coordinate 1-2 staff blood drives, which are held on the hospital campus in partnership with the American Red Cross each 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. 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 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 coalition meeting led by Public Health on April 29, 2025, with 20 people in attendance. A community health survey distributed by Faribault & Martin County Public Health was also reviewed and provided insight.





Prioritized Health Needs

After completing an extensive analysis of the Faribault and Martin Counties 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

Martin County faces a combination of **high-mental health need** and **structural access challenges** common to rural Minnesota. Screening data, public health indicators and statewide trends all point to increasing demand for mental health services, the need for expanded access points and the importance of addressing social determinants that shape mental health outcomes.

STRATEGIES



Expand access to mental health services and resources



Foster wellbeing, connectivity and resilience across the lifespan

DESIRED IMPACT

Improve the mental health and resilience of Martin County residents by expanding access to community based services, increasing awareness of available resources, and strengthening partnerships that support wellbeing across all ages. Through education, in-kind support, and coordinated collaboration, more people are connected to timely mental health care, experience greater understanding of wellness practices, and demonstrate measurable improvements in mental health and substance use outcomes.

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, interpersonal relationships and 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
<p>Collaborate with community partners to provide subject matter experts for community-based programs and services.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Schools • Bravo Zulu House • Non-profit agencies • Service Clubs • Community Committees/ Coalitions <p>Resources:</p> <ul style="list-style-type: none"> • Staff Time 	<p>Six subject matter experts provide community-based education during reporting period.</p>
<p>Develop and distribute outreach educational materials and promote awareness of mental health and substance misuse resources, programs and services.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Community Events • Local Nonprofits • Service Clubs • Community Committees and Coalitions <p>Resources:</p> <ul style="list-style-type: none"> • MCHS display and/or flyer • MCHS Website • Staff Time 	<p>Increase community awareness of mental health and/or substance misuse resources by annually distributing educational materials at a minimum of three community outlets.</p>
<p>Provide in-kind support to make access to mental health services more easily available.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Local Nonprofits • Community Committees and Coalitions <p>Resources:</p> <ul style="list-style-type: none"> • In-Kind Space • Horizon Homes • Local Pastoral Care • Staff Expertise and Support 	<p>Provide a minimum of \$1,000 in in-kind support annually.</p>

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

ACTION	INPUTS	ANTICIPATED OUTCOMES
<p>Coordinate and promote Mayo Clinic and MCHS wellness programs.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Local schools – Fairmont Area 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 4 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"> • Fairmont Stronger Together Coalition • EMPOWER • Nonprofit organizations • Opioid Settlement Coalition • Bureau 14 <p>Resources:</p> <ul style="list-style-type: none"> • Staff time 	<p>Participate in at least 2 partnerships or coalitions.</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 align with the defined CHNA-prioritized health needs.</p>

Priority 2 Summary: Access to Care

CURRENT SITUATION AND DATA

Access to healthcare in Martin County reflects the realities of a rural service environment: strong public health infrastructure, reliance on state assistance programs, and persistent barriers related to geography, transportation, and provider availability. The picture that emerges from available data and county resources shows both strengths and ongoing challenges.

STRATEGIES



Improve access to health care services



Reduce barriers to health care services

DESIRED IMPACT

Ensure that all Martin County residents can access timely, affordable, and culturally responsive health care by expanding community awareness, strengthening care navigation, and reducing structural barriers such as transportation, language, and preventive care gaps. Through coordinated partnerships, innovative care models, and targeted outreach, individuals are better able to understand their care options, complete needed screenings and appointments, and experience improved health outcomes across the lifespan.

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 – Lakeview Methodist Senior 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 (Prairie Lakes Transit, Care 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
<p>Provide education and opportunities to reduce preventative health and cancer screening gaps.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Family Med Residency • Schools • Apple Tree Dental • Public Health • Financial Support • Nonprofits <p>Resources:</p> <ul style="list-style-type: none"> • Staff Time • Supplies & Materials • Equipment • Financial Support 	<p>Increased patient compliance through education and increased opportunities for care.</p> <p>Reduce preventative health gaps and increase cancer screening rates.</p>
<p>Explore mobile health unit presence at local events/activities</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Public Health • SHIP • Nonprofits • Schools <p>Resources:</p> <ul style="list-style-type: none"> • Staff • Mayo Mobile Health Unit • Mayo Clinic CHAMP Grant 	<p>Improved access to care due to reduction of transportation barrier and familiarity with mobile health unit.</p>
<p>Increase understanding and compliance for patients who have a primary language other than English.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Local Nonprofits • Language Service Organizations <p>Resources:</p> <ul style="list-style-type: none"> • Staff • Language Services • Financial support for language interpretation • Translated Materials 	<p>Decreased language barriers and increased patient compliance.</p>

Priority 3 Summary: Basic Needs that Influence Health

CURRENT SITUATION AND DATA

Martin County's basic needs environment is shaped by economic strain, aging housing, and rural access barriers, and by strong public health and human services infrastructure. Addressing housing affordability, transportation, and access to food and financial supports will be central to improving residents' stability and well-being.

STRATEGIES



Increase equitable access to basic needs



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

DESIRED IMPACT

Strengthen the stability, well-being, and long-term self-sufficiency of Martin County residents by expanding equitable access to basic needs and reducing the structural barriers that limit wellness. Through targeted interventions, cross sector partnerships, and improved navigation of community resources, more individuals and families are connected to essential supports—such as housing, food, transportation, and health literacy—resulting in greater economic security, improved health outcomes, and a more resilient community.

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"> • Heaven's Table Food Shelf • Salvation Army Emergency Shelf • Local Nonprofits • Schools Resources: <ul style="list-style-type: none"> • Staff • Materials 	After 3 years, 150 members participate in one food insecurity activity.
Provide financial resources to external organizations that address basic needs and 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 • Public Health 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.

Strategy 1: Increase equitable access to basic needs (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES
<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>Increase use of findhelp and CareConnect for connection to community resources through training and outreach.</p> <p>At least 3 trainings during reporting period.</p>
<p>Coordinate produce garden at MCHS Fairmont Hospital Community Garden for food insecure patients.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Bomgaars of Fairmont • Hy-Vee of Fairmont • Local Nonprofits <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"> • Local chamber and nonprofit activities 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"> • Care Transit • Prairie Lakes Transit • 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 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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MC4776-30rev0526