



Community Health Needs Assessment **2026-2028** Implementation Plan

Mayo Clinic Health System in Austin and Albert Lea





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 Austin and Albert Lea

Mayo Clinic Health System's Southeast Minnesota region operates four hospitals and eleven clinics located in a 100-mile radius around, but not including, Rochester, Minnesota. MCHS hospitals are in Albert Lea, Austin, Cannon Falls, Lake City and Red Wing. The Southeast Minnesota region is staffed by 243 physicians and three residents, treating the needs of 449,308 patients. Altogether, Southeast Minnesota has 2,725 staff members (as of September 2024).

Mayo Clinic Health System in Austin and Albert Lea (MCHS in Austin and Albert Lea) consists of two hospital facilities. One is in Albert Lea, Minnesota (Freeborn County), and the other is in Austin,

Minnesota (Mower County). The facilities operate under one hospital license and offer a broad range of inpatient, outpatient and specialty services in southern Minnesota, including a cancer center, physical medicine and rehabilitation center and inpatient and outpatient drug and alcohol treatment facilities.

MCHS partners with community stakeholders in Freeborn and Mower Counties to conduct the Community Health Needs Assessment. Most patients seen at MCHS in Austin and Albert Lea live in Mower and Freeborn Counties. For this CHNA, the community is defined as Freeborn and Mower counties.



Mayo Clinic Health System in Austin



Mayo Clinic Health System in Albert Lea

Executive Summary

BACKGROUND

The [Patient Protection and Affordable Care Act](#) (PPACA or ACA), a U.S. federal statute that was enacted on March 23, 2010, added requirements for non-profit organizations that operate hospital facilities. The healthcare reform bill requires non-profit hospitals to complete a Community Health Needs Assessment and Community Health Implementation Plan that addresses local, prioritized health needs.

To adhere to the requirements placed into effect by the IRS, tax-exempt hospitals must:

- Conduct a CHNA every three years
- Create and adopt an implementation strategy to meet the needs of the community identified by the assessment

The IRS requires a CHNA to:

- Define the community it serves
- Assess the health needs of that community
- Solicit and consider input received from the community, including those with expertise in public health and people from, or representing, medically underserved, low-income, and minority populations
- Document the CHNA in a written report that is adopted by a hospital facility
- Make the CHNA report available to the public

The [2025 Community Health Needs Assessment](#) (CHNA) for Mayo Clinic Health System in Austin and Albert Lea represents a rigorous, collaborative effort to evaluate and address the health needs of Mower and Freeborn counties in Minnesota. This assessment fulfills federal requirements under the Affordable Care Act (ACA) and IRS Section 501(r)(3) and guides the hospital's strategic investments to improve community health outcomes.

PURPOSE AND PROCESS

The process involved systematic reviews of regional assessments and data sets, stakeholder engagement, mailed and digital surveys, key informant interviews, and collaboration with public and private organizations. The framework was based on the American Hospital Association's Community Health Assessment Toolkit, ensuring a comprehensive, multi-step approach.

This report is to supply an updated assessment of Southeast Minnesota's population health needs and identify priorities for the years 2026-2028. The identified community health needs will be utilized to drive and inform strategies through implementation and action plans.

MCHS is dedicated to intentional collaboration with community stakeholders to develop and implement programs and participate in activities to improve community health and address social drivers of health (SDoH).

KEY FINDINGS

Demographics: Freeborn and Mower County serve approximately 70,924 residents, with notable trends including a projected 12% growth in the 65+ population by 2028 and a 4% decline in adults aged 18–64. The region remains predominantly White, but there is a growing Hispanic population (6% overall), and Mower County has a higher percentage of foreign-born residents (12%) compared to Freeborn (3.8%). Median household income is below the state average; over half of households earn less than \$74,999 annually.

Health Challenges: The leading causes of death are heart disease and cancer in both counties. Chronic illnesses (including diabetes and COPD) are especially prevalent among older adults, low-income residents, and racial/ethnic minorities.

Social Drivers: Social drivers of health in Mower and Freeborn Counties include economic instability, housing and food insecurity, limited transportation, gaps in behavioral health services, and demographic shifts. These factors are strongly linked to chronic disease rates, access to care, and overall community well-being.

COMMUNITY PRIORITIES

Access to Care: There are significant gaps in healthcare access and quality, especially for underserved populations.

Mental Health (including Substance Misuse): Behavioral health needs and substance misuse are prominent concerns, with gaps in available services.

Chronic Disease and Contributing Factors: Chronic illnesses such as heart disease, cancer, and diabetes are leading causes of death. Social drivers of health (SDoH) like income, housing, and education contribute to these outcomes.

For each priority, the plan identifies evidence-based strategies and actionable initiatives designed to improve health behaviors, outcomes, and environments across Mower and Freeborn County and the surrounding service area.

NEXT STEPS

Implementation will be carried out in collaboration with clinical teams and community-based organizations, with an emphasis on reducing barriers for underserved and vulnerable populations. Strategies include improving access to affordable services (including financial assistance and navigation support), expanding flexible care models (such as digital and mobile options), strengthening community partnerships and referral pathways, and increasing community capacity through workforce development and community health worker engagement.

The plan aligns with the [Mower County Implementation Plan](#), [Freeborn County Implementation Plan](#), [Minnesota State Health Improvement Plan \(CHIP\)](#) and [Healthy People 2030](#) objectives to ensure local efforts contribute to broader state and national health goals.

The four areas of work highlighted in this document will include:

- **Community Health:** Initiatives, programs, or actions focused on improving the overall health and well-being of community members.
- **Community Investment:** Resources, funding, or partnerships dedicated to supporting community health, infrastructure, and access to care.
- **Community Events:** Activities, gatherings, or outreach efforts organized to engage residents, promote health awareness, and foster community connections.
- **Staff Engagement:** Programs and opportunities for healthcare staff to participate in community efforts, support initiatives, and collaborate with local organizations.

Progress will be monitored through defined processes and outcome measures tied to each priority area, supported by routine reporting and ongoing evaluation. Findings will be used to refine strategies over the 2026–2028 period, strengthen sustainability, and communicate impact to internal and external stakeholders.



Prioritized Health Needs

After careful assessment and consideration, it was concluded that MCHS in Austin and Albert Lea would focus on the following three priorities:

- 1. Access to Care**
- 2. Mental Health (including Substance Misuse)**
- 3. Chronic Disease and Contributing Factors**

Community Health Implementation Plan Overview

Priority 1 Summary: Access to care

Access to care was cited as a healthcare need in Freeborn and Mower Counties, with 52% of key informants ranking it in their top five areas of concern. Feedback from focus groups varied from fear of losing local services to affordability and availability, confusion about where to seek care for various conditions, and the lack of mental health resources.

The primary concern expressed by most interviewees was education about what services are available, being able to be seen at a reasonable time, navigating the system, distance to travel for services and specialty providers available in the community (obstetrics delivery and behavioral health). One person indicated a perception of access problems for people who believe they need something they may not indeed require. Interviewees reported not seeking care due to high costs, difficulties in obtaining appointments or experiencing delays, and poor customer service.

Residents representing broad community groups expressed concern about available resources, communication barriers and accessing resources (such as transportation). Some interviewees spoke of bias against poor people and a lack of inclusion. Cultural differences, fewer opportunities and fear of victimization were also listed.

ACCESS TO CARE GOALS, STRATEGIES & INITIATIVES

Mayo Clinic Health System's goal is to ensure access to comprehensive, quality healthcare for community members that is safe, affordable, timely and coordinated.

LEGEND

- **Community Health:** Initiatives, programs, or actions focused on improving the overall health and well-being of community members.
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ACCESS TO CARE

Strategy 1: Improve access and reduce barriers to healthcare services

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Provide financial assistance to reduce health care cost barriers to care for low-income individuals</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> Freeborn Co. United Way Mower Co. United Way Albert Lea Area Schools Austin Area Schools Parenting Resource Center of Austin Senior Resources of Freeborn County <p>Resources:</p> <ul style="list-style-type: none"> FindHelp Charity Care Social Work Teams Care Management Population Health 	<p>Establish referral workflows with at least 3 community-based organizations (CBOs) serving low-income/underserved residents</p> <p>Provide financial assistance/charity care navigation and complete referrals for eligible individuals</p> <p>Document and report on the number of connections made to cost-assistance resources (e.g., FindHelp programs, charity care, sliding-fee services)</p>	<p>Reduce the proportion of people who can't get medical care when they need it – AHS-04</p> <p>Increase the proportion of people with a usual source of care – AHS-07</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> # of referral workflows established with CBOs # of financial assistance/charity care navigation encounters # of connections/referrals completed to cost-assistance resources
<p>Expand awareness for Primary Care on Demand</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> United Way of Freeborn County United Way of Mower County <p>Resources:</p> <ul style="list-style-type: none"> Social Work Teams Care Management Population Health Primary Care on Demand Team MCHS CE Team Nursing Team 	<p>Create and distribute Primary Care on Demand education materials (print and/or digital) tailored for community partners</p> <p>Conduct outreach/education with partner organizations (e.g., briefings, tabling, or classes) to increase awareness and appropriate use</p> <p>Develop a simple “how to access Primary Care on Demand” quick-reference guide for community members (steps, eligibility, what to expect)</p>	<p>Increase the proportion of adults who get recommended evidence-based preventative health care – AHS-08</p> <p>Increase the use of telehealth to improve health services – AHS-RO2</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> # of education materials/quick-reference guides created # of outreach/education touchpoints with partner organizations # of individuals supported in accessing Primary Care on Demand (when available)

Strategy 1: Improve access and reduce barriers to healthcare services (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Expand the use of the Mobile Health Unit</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Taste of Nations <p>Resources:</p> <ul style="list-style-type: none"> • Mobile Mammography • Mobile Health Unit • Residency Program 	<p>Increase the number of Mobile Health Unit community stops in underserved locations (including preventive screenings and education as available)</p> <p>Establish recurring coordination with partner sites (e.g., health departments/CBOs) for scheduling, outreach, and follow-up referrals</p> <p>Track and report service outputs (e.g., visits completed, screenings provided, referrals made to primary care/specialty care/social services)</p>	<p>Reduce the proportion of people who can't get medical care when they need it – AHS-04</p> <p>Increase the proportion of people with a usual source of care – AHS-07</p> <p>Increase the proportion of adults who get recommended evidence-based preventative health care – AHS-08</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of Mobile Health Unit community stops/locations served • # of visits/screenings completed • # of referrals made for follow-up care and/or social services
<p>Address rising prescription medication costs</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Freeborn County and Mower County Public Health <p>Resources:</p> <ul style="list-style-type: none"> • Social Work Teams • Care Management • Population Health • Pharmacy 	<p>Provide medication cost-assistance navigation (e.g., manufacturer assistance, discount programs, formulary alternatives) for eligible patients</p> <p>Connect patients to community resources and pharmacy supports that reduce out-of-pocket costs</p> <p>Track and report the number of medication assistance connections completed and/or cost-saving interventions identified</p>	<p>Reduce the portion of people who cannot get prescription medicines when they need them – AHS-06</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of medication cost-assistance navigation encounters • # of connections to assistance programs/discount resources • # of cost-saving interventions identified (when available)

Strategy 1: Expand Access to Mental Health Services and Resources (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Address transportation barriers to and from appointments</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Smart Transit • Senior Resources of Freeborn County <p>Resources:</p> <ul style="list-style-type: none"> • Find Help • Mobile Mammography • Mobile Health Unit • Social Work Teams • Care Management • Population Health • Community Health Workers 	<p>Implement/refine a transportation resource pathway (screening for need, referral process, and community partner handoffs)</p> <p>Provide navigation support (e.g., CHW/social work) to connect patients to available transportation options for medical visits</p> <p>Track and report transportation assistance provided (e.g., referrals completed, rides arranged, vouchers distributed) and related access barriers identified</p>	<p>Reduce the proportion of people who can't get medical care when they need it – AHS-04</p> <p>Increase the proportion of people with a usual source of care – AHS-07</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of transportation screenings/referrals completed • # of transportation supports arranged (e.g., rides, vouchers) (when available) • # of patients receiving navigation support for transportation
<p>Provide financial support for community-based services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Increase the number of internal funds provided to the community addressing access to care</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded (access to care-related) • Total dollars distributed • % of grantees submitting required deliverables/reporting
<p>Create outreach educational materials and promote access to care resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • MCHS displays • Collateral • Smartsheet 	<p>Promote opportunities through partner channels (schools, colleges, workforce partners) and at recruitment events</p> <p>Maintain/update materials at least annually or as programs change</p> <p>Track and report outputs (e.g., materials created/updated, distribution channels used, and outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of distribution locations/partner channels used (e.g., schools, colleges, workforce partners) • # of outreach touchpoints/events where materials were shared (when tracked) • # of materials distributed (print and/or digital) (when tracked)
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Funds • Smartsheet 	<p>Increase the number of leaders and staff engaged in organizations that address access to care</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held (access to care) • # of meetings attended or supported • # of coalition deliverables/actions contributed to

Strategy 2: Simplify health education and build understanding

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Partner to provide digital access and care navigation</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Freeborn County and Mower County Public Health <p>Resources:</p> <ul style="list-style-type: none"> • Social Work Teams • Care Management • Population Health • MCHS CE Team • Nursing Team • Community Health Workers 	<p>Deliver digital access and care-navigation support with partners (e.g., scheduled help sessions at the library/ CBO sites)</p> <p>Create and distribute a simple digital-access “how-to” guide (MyChart/portal basics, telehealth visit steps, where to get help)</p> <p>Track and report outputs (e.g., number of navigation encounters completed, telehealth set-ups supported, and referrals to care management/social work)</p>	<p>Increase the proportion of adults who get recommended evidence-based preventive health care – AHS-08</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of digital-access “how-to” guides/materials created or updated • # of digital-access/ navigation sessions completed • # of telehealth set-ups supported
<p>Increase the resources for the updating of language services including translation efforts and interpretation service</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Language services team • Office of Health Equity and Inclusion 	<p>Expand availability and use of interpretation services (in-person/phone/video as applicable) for patients with limited English proficiency</p> <p>Translate and refresh priority patient-facing materials (e.g., appointment instructions, care navigation handouts, consent/ education materials) based on community need</p> <p>Track and report outputs (e.g., number of interpretation encounters supported, materials translated/updated, and languages prioritized)</p>	<p>Reduce the proportion of people who can’t get medical care when they need it – AHS-04</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of interpretation encounters supported • # of materials translated/ updated • # of languages prioritized/ covered (annual list)

Strategy 2: Simplify health education and build understanding (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Continue to utilize the social drivers of health questionnaire and support the CBOs that are registered in FindHelp for referrals to community resources</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • United Way of Freeborn & Mower County <p>Resources:</p> <ul style="list-style-type: none"> • FindHelp • Social Work • Care Management • Population Health 	<p>Continue routine use of the social drivers of health (SDOH) questionnaire in participating settings to identify priority needs</p> <p>Generate and complete referrals to community resources through FindHelp (including warm handoffs when needed)</p> <p>Support CBOs registered in FindHelp (e.g., outreach for updates, helping maintain accurate service listings and referral pathways)</p> <p>Track and report outputs (e.g., number of SDOH screenings completed, referrals submitted, and follow-up/closed-loop confirmations when available)</p>	<p>Increase the proportion of people with a usual source of care – AHS-07</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of SDOH screenings completed • # of FindHelp referrals submitted • # of closed-loop follow-ups confirmed (when available)

Strategy 3: Expand community health worker and navigation support

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Increase the number of CBOs in FindHelp</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> Austin and Albert Lea area CBOs <p>Resources:</p> <ul style="list-style-type: none"> FindHelp 	<p>Conduct outreach to priority CBOs to onboard them into FindHelp (orientation, account set-up, and basic listing requirements)</p> <p>Support CBOs in maintaining accurate FindHelp listings and referral pathways (e.g., periodic updates, service changes, eligibility/contact info)</p> <p>Track and report outputs (e.g., number of CBOs onboarded, listings updated, outreach touchpoints completed, and referral activity when available)</p>	<p>Increase the proportion of people with a usual source of care – AHS-07</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> # of new CBOs onboarded/added in FindHelp # of outreach/support touchpoints with CBOs (updates, listing maintenance) # of FindHelp listings created/updated # of referrals initiated/completed via FindHelp (when available)
<p>Continue the relationship with St. Clare Health Mission with the utilization of their Community Health Worker</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> Community Health Workers 	<p>Establish/maintain a CHW referral and documentation workflow with St. Clare Health Mission (intake, eligibility, handoffs, and points of contact)</p> <p>Provide CHW navigation encounters for community members (needs assessment, care planning, appointment support, and resource navigation as applicable)</p> <p>Generate and support referrals/linkages to medical care, behavioral health, and social services (including warm handoffs when feasible)</p> <p>Track and report outputs (e.g., number of CHW encounters, referrals/linkages supported, and follow-ups completed toward closed-loop connection when available)</p>	<p>Increase the proportion of people with a usual source of care – AHS-07</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> # of CHW navigation encounters completed (through St. Clare partnership) # of individuals served (unduplicated count, when available) # of referrals/linkages to medical care, behavioral health, or social services supported (when available) # of follow-ups completed toward closed-loop connection (when available)

Strategy 3: Expand community health worker and navigation support (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Research grant funding opportunities to support further MCHS community health worker engagement</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • IMAA • Social Work • Population Health 	<p>Maintain a grant opportunity pipeline for CHW/community navigation (routine scans, funder calendar, and internal go/no-go process)</p> <p>Develop and submit grant proposals (including partner coordination, budgets, and required narratives/ attachments)</p> <p>Implement and support funded CHW engagement activities when awarded (e.g., staffing support, training, outreach, and reporting requirements)</p> <p>Track and report outputs (e.g., number of opportunities identified, applications submitted, dollars requested/ awarded, and funded deliverables completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grant opportunities identified (CHW/ community navigation) • # of grant applications submitted • Total dollars requested and/or awarded (when available) • # of funded CHW engagement activities/ roles supported (when applicable) • # of funded deliverables/ reporting milestones completed (when applicable)

Strategy 4: Expand telehealth and remote patient monitoring

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Increase the use of the Mobile Medicine</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Mobile Mammography • Mobile Health Unit 	<p>Increase the number of Mobile Medicine visits completed for patients who face access barriers (as available through program scope)</p> <p>Establish/maintain referral and scheduling workflows with partner sites serving underserved populations</p> <p>Track and report outputs (e.g., visits completed, locations served, and referrals made for in-person follow-up when needed)</p>	<p>Increase the proportion of adults who get recommended evidence-based preventive health care – AHS-08</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of partner sites served • # of referral/scheduling workflows established with partner sites • # of referrals made for in-person follow-up (when available)

Strategy 5: Strengthen workforce recruitment and career pathways

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Explore upstream solutions to create opportunities and pathways for students and new graduates within the organization</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Riverland Community College • Naeve Nurses Alumni • Naeve Auxiliary <p>Resources:</p> <ul style="list-style-type: none"> • Residency Team • Nursing Team • Workforce Development 	<p>Identify and pilot pathway opportunities for students/new graduates (e.g., internships, clinical rotations, apprenticeships, residencies, or training tracks as applicable)</p> <p>Host or participate in recruitment and hiring touchpoints with partner schools (e.g., career fairs, information sessions, interview days)</p> <p>Implement onboarding/transition supports for new graduates when feasible (e.g., preceptor pairing, mentorship touchpoints, resource guides)</p> <p>Track and report outputs (e.g., pathway initiatives launched, participants, partner programs engaged, and hires when available)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of pathway initiatives launched or expanded (e.g., internships, rotations, residencies, training tracks) (when applicable) • # of student/new graduate participants • # of partner schools/programs engaged • # of recruitment/hiring touchpoints with partner schools (e.g., career fairs, info sessions, interview days) • # of onboarding/transition supports delivered (e.g., preceptor pairings, mentorship touchpoints) (when applicable) • # of students/new graduates hired or placed into roles (when available)
<p>Provide financial support for community-based services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Award internal community benefit/grant funding to organizations expanding healthcare workforce development (e.g., training programs, career pathways, certification support, recruitment/retention initiatives)</p> <p>Define grant scope, expected deliverables, and reporting requirements for funded partners</p> <p>Provide consultation/technical support to partners when feasible (e.g., program design, evaluation, or connections to subject matter experts)</p> <p>Track and report outputs (e.g., grants awarded, dollars distributed, partners supported, and deliverables completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded (workforce development-related) • Total dollars distributed • % of grantees submitting required deliverables/reporting • # of workforce development deliverables completed by funded partners (when available)

Strategy 5: Strengthen workforce recruitment and career pathways (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Create outreach educational materials and promote awareness of access to care resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • MCHS displays • Collateral • Smartsheet 	<p>Develop and distribute workforce/career pathway materials (print and/or digital) (e.g., “careers at MCHS” overview, training programs, how to apply, internship/residency options)</p> <p>Promote opportunities through partner channels (schools, colleges, workforce partners) and at recruitment events</p> <p>Maintain/update materials at least annually or as programs change</p> <p>Track and report outputs (e.g., materials created/ updated, distribution channels used, and outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of workforce-related resource materials created/updated • # of distribution locations/partner channels used (e.g., schools, colleges, workforce partners) • # of outreach touchpoints/events where materials were shared (when tracked) • # of materials distributed (print and/or digital) (when tracked)
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Funds • Smartsheet 	<p>Maintain active participation by leaders/ staff in workforce coalitions, partnerships, and boards</p> <p>Contribute to coalition deliverables (e.g., workforce planning, pipeline events, shared recruitment initiatives, or policy recommendations) as applicable</p> <p>Support at least one workforce-related event or initiative annually when feasible (host, sponsor, or provide speakers)</p> <p>Track and report outputs (e.g., seats held, meetings attended, and deliverables/ actions supported)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held (workforce development) • # of meetings attended or supported • # of coalition deliverables/actions contributed to • # of workforce-related events/initiatives supported (hosted, sponsored, or staffed) (when applicable)

Priority 2 Summary: Mental Health Including Substance Misuse

The World Health Organization defines well-being as a state in which every person realizes their potential, can cope with the normal stresses of life, can work productively and can contribute to their community. Based on input from the community, a priority will be placed on promoting strategies to enhance mental well-being with a particular focus to reducing isolation, building resilience and improving mental health for all.

Mental Health and substance misuse continue to be reported as a top community health issue in Freeborn and Mower Counties, with 18 out of 21 key informants ranking it in their top 5 concerns. Multiple mental health concerns were mentioned, including but not limited to anxiety, panic attacks, depression, suicide, drug abuse, addiction and drugs (opioids/vaping), PTSD, and abuse. Access to mental health providers (and primary care), affordability and the lack of mental health education (how to access care and what level of care) were mentioned.

Overcoming stigma and access to care were the most frequently mentioned concerns. A lack of resources, particularly for adolescents, and a general lack of understanding were noted. Specific mental health issues were called out, among them post-traumatic stress disorder (PTSD), stress, bullying, drugs, maintaining mental wellness, crisis services and support services for cancer patients.

MENTAL HEALTH INCLUDING SUBSTANCE MISUSE GOALS, STRATEGIES & INITIATIVES

Mayo Clinic Health System's goal is to address the community's mental health and/or substance abuse health needs through prevention, screening, assessment, and treatment.

LEGEND

- **Community Health:** Initiatives, programs, or actions focused on improving the overall health and well-being of community members.
- **Community Investment:** Resources, funding, or partnerships dedicated to supporting community health, infrastructure, and access to care.
- **Community Events:** Activities, gatherings, or outreach efforts organized to engage residents, promote health awareness, and foster community connections.
- **Staff Engagement:** Programs and opportunities for healthcare staff to participate in community efforts, support initiatives, and collaborate with local organizations.

Strategy 1: Expand youth mental health supports

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Provide financial support for community-based services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Albert Lea & Austin public schools • Austin Aspires <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Track and report outputs (e.g., number of grants awarded, dollars distributed, partner organizations supported, and key deliverables reported)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded • Total dollars distributed • % of grantees submitting required deliverables/ reporting
<p>Create outreach educational materials and promote awareness of mental health resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • MCHS displays • Collateral • Smartsheet 	<p>Develop and distribute mental health/substance misuse resource materials (print and/or digital) for community members and partner organizations</p> <p>Promote resources through community channels (e.g., tabling/events, school communications, partner newsletters, or clinic/ community locations)</p> <p>Track and report outputs (e.g., materials created, distribution locations/ partners, and outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of resource materials created/updated • # of distribution partner sites/locations • # of outreach touchpoints/events where materials were shared
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Funds • Smartsheet 	<p>Maintain active participation by leaders/ staff in behavioral health coalitions, task forces, and boards addressing mental health and substance misuse</p> <p>Contribute to coalition deliverables (e.g., planning, policy recommendations, event support, or workgroup leadership) as applicable</p> <p>Track and report outputs (e.g., number of coalition/ board seats held, meetings attended, and roles/actions completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held • # of meetings attended or supported • # of coalition deliverables/actions contributed to

Strategy 1: Expand youth mental health supports (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Providing professional presentations in the community to help educate on the mental health/substance use topics</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Behavioral Health • Albert Lea & Austin public schools <p>Resources:</p> <ul style="list-style-type: none"> • MCHS Displays • Collateral 	<p>Deliver professional/ community presentations on mental health and substance use topics (e.g., stigma reduction, resources, prevention, overdose response) for schools and community audiences</p> <p>Develop/maintain standardized slide deck(s) and handouts for community education and update annually as needed</p> <p>Track and report outputs (e.g., number of presentations delivered, partner sites served, attendance estimates, and materials distributed)</p>	<p>Reduce the proportion of people who misused prescription drugs in the past year – SU-12</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of presentations delivered • Attendance estimate (# of participants reached) • # of partner sites/ audiences served

Strategy 2: Expand access to mental health services and resources

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Continue partnership with Fountain Center</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Naeve Health Care Foundation <p>Resources:</p> <ul style="list-style-type: none"> • Behavioral Health 	<p>Sustain delivery of peer support specialist services through Fountain Center partnership (peer encounters and care coordination as available)</p> <p>Provide/maintain substance use care provider support and clinic supervision capacity (as defined in partnership scope)</p> <p>Track and report outputs (e.g., peer support encounters, individuals served, referrals to treatment/recovery supports, and partner deliverables)</p>	<p>Increase the proportion of people who need alcohol and/or drug treatment who got treatment in the past year – SU-01</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of peer support encounters completed • # of individuals served • # of referrals to treatment/recovery supports
<p>Further develop the Opioid Stewardship program</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Freeborn & Mower County Public Health <p>Resources:</p> <ul style="list-style-type: none"> • Behavioral health • Pharmacy 	<p>Implement Opioid Stewardship program activities (e.g., safe prescribing education, guideline updates, and clinical decision support as applicable)</p> <p>Collaborate with county/community partners on prevention and harm-reduction efforts (e.g., medication take-back promotion, naloxone access education, and referral pathways to treatment)</p> <p>Track and report outputs (e.g., stewardship trainings delivered, clinical areas reached, and process measures monitored such as prescribing and follow-up/referral activity)</p>	<p>Reduce the proportion of people who misused prescription drugs in the past year – SU-12</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of stewardship trainings/education sessions delivered • # of departments/clinics reached • Selected process measures monitored (per stewardship dashboard)

Strategy 2: Expand access to mental health services and resources (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Provide financial support for community-based services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Increase the number of internal funds provided to the community addressing access to care</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded (access to care-related) • Total dollars distributed • % of grantees submitting required deliverables/ reporting
<p>Create outreach educational materials and promote awareness of mental health resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Behavioral health • Pharmacy 	<p>Promote opportunities through partner channels (schools, colleges, workforce partners) and at recruitment events</p> <p>Maintain/update materials at least annually or as programs change</p> <p>Track and report outputs (e.g., materials created/ updated, distribution channels used, and outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of distribution locations/partner channels used (e.g., schools, colleges, workforce partners) • # of outreach touchpoints/events where materials were shared (when tracked) • # of materials distributed (print and/or digital) (when tracked)
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Funds • Smartsheet 	<p>Increase the number of leaders and staff engaged in organizations that address Mental health and/or Substance Misuse</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held (Mental health and/ or Substance Misuse) • # of meetings attended or supported • # of coalition deliverables/actions contributed to

Priority 3 Summary: Chronic Disease and Contributing Factors

The definition of chronic disease is “conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.”

Chronic diseases such as [heart disease](#), [cancer](#), and [diabetes](#) are the leading causes of death and disability in the US. They are also leading drivers of the nation’s \$4.9 trillion in annual healthcare costs.

Three in four American adults have at least one chronic condition, and over half have two or more chronic conditions.

- Among adults ages 65 and older, more than 90% have at least one chronic condition.
- Among midlife adults ages 35–64, more than 75% have at least one condition.
- Among younger adults ages 18–34, 60% have at least one condition.
- Many preventable chronic diseases are caused by a short list of risk behaviors: smoking, poor nutrition, physical inactivity, and excessive alcohol use.

Chronic disease prevention focuses on keeping people healthy, engaging and empowering people and communities to choose healthy behaviors and reduce the risk of developing diseases. Empowering people to manage lifestyle factors can help prevent the onset and progression of chronic diseases. Areas of emphasis include substance misuse and obesity/overweight, especially as it relates to the multi-cultures in Freeborn and Mower Counties.

CHRONIC DISEASE AND CONTRIBUTING FACTORS SUMMARY GOALS, STRATEGIES & INITIATIVES

Mayo Clinic Health System’s goal is to provide comprehensive, quality healthcare for community members experiencing chronic disease, including screenings, patient self-management, and education.

LEGEND

- **Community Health:** Initiatives, programs, or actions focused on improving the overall health and well-being of community members.
- **Community Investment:** Resources, funding, or partnerships dedicated to supporting community health, infrastructure, and access to care.
- **Community Events:** Activities, gatherings, or outreach efforts organized to engage residents, promote health awareness, and foster community connections.
- **Staff Engagement:** Programs and opportunities for healthcare staff to participate in community efforts, support

Strategy 1: Increase child and adolescent immunizations

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Partner with the quality department along with nursing to improve childhood and adolescent immunization</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Austin Aspires <p>Resources:</p> <ul style="list-style-type: none"> • Quality • Nursing 	<p>Implement/improve immunization outreach workflows with nursing/ quality and community partners (e.g., reminder/recall, school/clinic coordination, scheduling support)</p> <p>Provide vaccine education materials and/or outreach touchpoints for families (as feasible through school/ community channels)</p> <p>Track and report outputs (e.g., outreach touchpoints completed, education materials distributed, and immunizations administered or scheduled when available)</p> <p>Increase vaccination rates among children and adolescents</p>	<p>Reduce the proportion of children who get no recommended vaccines by age 2 years — IID-02</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of immunization outreach touchpoints completed (reminders, school/clinic coordination) • # of education materials distributed / partner sites reached • # of immunizations administered or appointments scheduled (when available)
<p>Provide financial support for community-based services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Award internal community benefit/grant funding to organizations addressing chronic disease prevention/ management and contributing factors (e.g., screening access, nutrition, physical activity, health education)</p> <p>Define grant scope, expected deliverables, and reporting requirements for funded partners</p> <p>Track and report outputs (e.g., number of grants awarded, dollars distributed, and key deliverables completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded (chronic disease/ immunization-related) • Total dollars distributed • % of grantees submitting required deliverables/ reporting

Strategy 1: Increase child and adolescent immunizations (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Create outreach educational materials and promote awareness of chronic disease and contributing factors resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • MCHS displays • Collateral • Smartsheet 	<p>Develop and distribute chronic disease prevention materials (print and/or digital) focused on immunizations and preventive care (e.g., where to get vaccinated, reminders, FAQs)</p> <p>Promote materials through schools, clinics, and community partner channels</p> <p>Track and report outputs (e.g., materials created/updated, distribution partner sites/locations, outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of materials created/updated (immunization/preventive care) • # of distribution partner sites/locations • # of outreach touchpoints/events where materials were shared
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Funds • Smartsheet 	<p>Maintain active participation by leaders/staff in coalitions, task forces, and boards advancing immunizations, preventive care, and chronic disease prevention</p> <p>Contribute to coalition deliverables (e.g., community campaigns, planning efforts, shared referral pathways, or event support) as applicable</p> <p>Track and report outputs (e.g., seats held, meetings attended, and actions/deliverables supported)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held (immunizations/prevention) • # of meetings attended or supported • # of coalition deliverables/actions contributed to

Strategy 2: Increase patient cancer screening

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Partner with the Commission of Cancer and Quality for screening events and opportunities</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Naeve Health Care Foundation • Hormel Institute <p>Resources:</p> <ul style="list-style-type: none"> • Quality 	<p>Plan and deliver cancer screening events/ opportunities with partners (e.g., breast, colorectal, lung screening outreach as applicable)</p> <p>Provide screening education, eligibility guidance, and scheduling/ navigation support to reduce barriers</p> <p>Track and report outputs (e.g., number of events held, individuals reached, screenings completed/ scheduled, and referrals for follow-up when needed)</p>	<p>Increase the proportion of adults who get screened for lung cancer – C-03</p> <p>Increase the proportion of females who get screened for breast cancer – C-05</p> <p>Increase the proportion of adults who get screened for colorectal cancer – C-07</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of screening events/ opportunities held • # of individuals reached/ receiving navigation support • # of screenings completed or scheduled; # of follow-up referrals (when available)
<p>Provide financial support for community-based services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Award internal community benefit/grant funding to organizations increasing cancer screening access and navigation (e.g., transportation support, education, outreach, follow-up support)</p> <p>Define grant scope, expected deliverables, and reporting requirements for funded partners</p> <p>Track and report outputs (e.g., number of grants awarded, dollars distributed, and key deliverables completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded (cancer screening/ navigation-related) • Total dollars distributed • % of grantees submitting required deliverables/ reporting

Strategy 2: Increase patient cancer screening (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Create outreach educational materials and promote awareness of chronic disease and contributing factors resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • MCHS displays • Collateral • Smartsheet 	<p>Develop and distribute cancer screening education materials (print and/or digital) describing eligibility, how to schedule, and what to expect (breast/colorectal/lung as applicable)</p> <p>Promote screening opportunities through partner channels (CBOs, clinics, events, and community locations)</p> <p>Track and report outputs (e.g., materials created/updated, distribution partner sites/locations, outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> # of screening education materials created/updated # of distribution partner sites/locations # of outreach touchpoints/ events where materials were shared
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Funds • Smartsheet 	<p>Maintain active participation by leaders/ staff in coalitions, task forces, and boards focused on cancer prevention and screening access</p> <p>Contribute to coalition deliverables (e.g., screening campaigns, navigation improvements, event support, or workgroup leadership) as applicable</p> <p>Track and report outputs (e.g., seats held, meetings attended, and actions/ deliverables supported)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held (cancer prevention/ screening) • # of meetings attended or supported • # of coalition deliverables/actions contributed to

Strategy 3: Expand chronic disease screening and education

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Continue to build upon primary care and nursing efforts including screenings, fasting glucose, blood pressure, and vaccination</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Hormel Institute <p>Resources:</p> <ul style="list-style-type: none"> • Family Medicine • Nursing 	<p>Deliver chronic disease screening and education touchpoints through primary care/nursing and partner sites (e.g., blood pressure checks, glucose screening, vaccines as applicable)</p> <p>Provide patient education and self-management resources (e.g., blood pressure education, diabetes education referrals, preventive care guidance)</p> <p>Track and report outputs (e.g., screenings completed, abnormal results identified with follow-up/referrals, and education encounters provided)</p>	<p>Increase control of high blood pressure – HDS-05</p> <p>Increase the proportion of people with diabetes who get formal diabetes education – D-06</p> <p>Increase the proportion of adults with subjective cognitive decline who have discussed their symptoms with a provider – DIA-03</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of screening encounters completed (e.g., BP checks, glucose screening, vaccines as applicable) • # of abnormal results identified with follow-up/referrals supported (when available) • # of education encounters and/or referrals to diabetes education/self-management resources
<p>Provide financial support for community-based organizations</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Award internal community benefit/grant funding to organizations supporting chronic disease prevention/management (e.g., screening events, education, self-management supports, nutrition/physical activity initiatives)</p> <p>Define grant scope, expected deliverables, and reporting requirements for funded partners</p> <p>Track and report outputs (e.g., number of grants awarded, dollars distributed, and key deliverables completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded (chronic disease screening/education-related) • Total dollars distributed • % of grantees submitting required deliverables/reporting

Strategy 3: Expand chronic disease screening and education (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Create outreach educational materials and promote awareness of chronic disease and contributing factors resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • MCHS displays • Collateral • Smartsheet 	<p>Develop and distribute chronic disease education materials (print and/or digital) focused on risk reduction and self-management (e.g., blood pressure, diabetes, preventive care)</p> <p>Promote materials through partner channels and incorporate into screening/ education touchpoints</p> <p>Track and report outputs (e.g., materials created/ updated, distribution partner sites/locations, outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of chronic disease education materials created/updated • # of distribution partner sites/locations • # of outreach touchpoints/events where materials were shared
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Funds • Smartsheet 	<p>Maintain active participation by leaders/staff in coalitions, task forces, and boards focused on chronic disease prevention and health equity</p> <p>Contribute to coalition deliverables (e.g., community education campaigns, screening access improvements, or workgroup leadership) as applicable</p> <p>Track and report outputs (e.g., seats held, meetings attended, and actions/ deliverables supported)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held (chronic disease prevention) • # of meetings attended or supported • # of coalition deliverables/actions contributed to

Strategy 4: Increase availability of healthy nutritious food in the community

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Continue working with Clinical Dietetic department to advance initiatives</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Dietetics/Diabetes education 	<p>Provide nutrition and weight management education/ resources through clinical dietetics/diabetes education (e.g., counseling, classes, or referrals as available)</p> <p>Increase awareness of available weight management and nutrition support options and how to access them</p> <p>Track and report outputs (e.g., counseling encounters/ classes delivered, referrals to weight management/ diabetes education, and materials distributed)</p>	<p>Increase the proportion of health care visits by adults with obesity that include counseling on weight loss, nutrition, or physical activity – NWS-05</p> <p>Increase cholesterol treatment in adults – HDS-07</p> <p>Internal tracking:</p> <ul style="list-style-type: none"> • # of nutrition/weight management counseling encounters or classes delivered • # of referrals to dietetics/ diabetes education/ weight management programs • # of nutrition/food-access materials distributed (when applicable)
<p>Provide financial support for community-based services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Award internal community benefit/grant funding to organizations improving access to healthy foods and nutrition supports (e.g., food pantry partnerships, SNAP/ WIC enrollment support, healthy cooking education, food access initiatives)</p> <p>Define grant scope, expected deliverables, and reporting requirements for funded partners</p> <p>Track and report outputs (e.g., number of grants awarded, dollars distributed, and key deliverables completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of grants awarded (food access/nutrition-related) • Total dollars distributed • % of grantees submitting required deliverables/ reporting

Strategy 4: Increase availability of healthy nutritious food in the community (continued)

ACTION	INPUTS	ANTICIPATED OUTCOMES	MEASUREMENT
<p>Create outreach educational materials and promote awareness of chronic disease and contributing factors resources, programs and services</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • MCHS displays • Collateral • Smartsheet 	<p>Develop and distribute nutrition and food-access education materials (print and/or digital) (e.g., healthy eating on a budget, where to access food resources, dietetics/diabetes education options)</p> <p>Promote materials through community partners and clinic/community locations</p> <p>Track and report outputs (e.g., materials created/updated, distribution partner sites/locations, outreach touchpoints completed)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of nutrition/food-access education materials created/updated • # of distribution partner sites/locations • # of outreach touchpoints/events where materials were shared
<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"> • Non-applicable <p>Resources:</p> <ul style="list-style-type: none"> • Internal Grants • Smartsheet 	<p>Maintain active participation by leaders/ staff in coalitions, task forces, and boards focused on food security, nutrition, and healthy environments</p> <p>Contribute to coalition deliverables (e.g., food access initiatives, policy/ advocacy efforts, event support, or workgroup leadership) as applicable</p> <p>Track and report outputs (e.g., seats held, meetings attended, and actions/ deliverables supported)</p>	<p>Internal tracking:</p> <ul style="list-style-type: none"> • # of coalition/board seats held (food security/ nutrition) • # of meetings attended or supported • # of coalition deliverables/actions contributed to



Summary of health needs not addressed

MCHS in Austin and Albert Lea analyzed the local health need outcomes identified in the CHNA and chose strategies and initiatives where the organization could make the greatest impact and effect change in our communities.

With a narrowed vision of the local priorities, MCHS in Austin and Albert Lea will be able to:

- Set goals and measurable objectives to guide evidence-based policies, programs, and other actions to improve health and well-being.
- Supply accurate, prompt, and accessible data that can drive targeted actions to address regions and populations that have poor health or are at elevated risk for poor health.

- Foster impact through public and private efforts to improve health and well-being for all ages and the communities in which they live.
- Share and support the implementation of evidence-based programs and policies that are replicable, scalable, and sustainable.
- Stimulate research and innovation toward critical research, data, and evaluation needs.

The health needs not addressed will be addressed by the hospital based on available resources and/or by other agencies/ organizations within the community that are better aligned to address those needs.



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.”

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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