



# Community Health Needs Assessment 2026-2028 Implementation Plan

Mayo Clinic Health System – Cannon Falls, Lake City, Red Wing





# 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 Cannon Falls, Lake City and Red Wing

Mayo Clinic Health System (MCHS) serves the communities of Red Wing, Cannon Falls, and Lake City, providing essential hospitals, clinics, specialty, and long-term care services across Goodhue County and portions of Wabasha and Pierce Counties. Together, these sites function as critical access points for care, supporting both individual patient needs and broader population health across southeastern Minnesota and neighboring Wisconsin communities.

### Hospital Services

- MCHS in Cannon Falls is a 15-bed critical access hospital with a hospital-based clinic, supported by 12 clinical providers and 27 traveling specialists. Services primarily support residents of Cannon Falls and the surrounding Goodhue County communities.
- MCHS in Lake City includes an 12-bed critical access hospital, hospital-based clinic, and a 90-bed long-term care center, with additional clinic services in Plainview. Eight providers and 28 traveling specialists serve patients from Goodhue and Wabasha Counties.
- MCHS in Red Wing is a 50-bed hospital with a multispecialty clinic and senior living community. The site employs 65 clinical providers and 60 specialists, serving Goodhue County and parts of Pierce County and Wabasha County.

### Summary Insights

**Cannon Falls:** The smallest of the three cities, Cannon Falls has the highest median household income and the lowest poverty rate. Its population skews older and is predominantly White, with limited racial diversity.

**Lake City:** With a population just over 5,000, Lake City has the oldest median age and a household income slightly below that of Cannon Falls. It shows a slightly higher poverty rate than Cannon Falls and is predominantly White, with small Asian and Hispanic populations.



New Prague Inpatients by Cannon Falls



Mayo Clinic Health System in Lake City



Mayo Clinic Health System in Red Wing

**Red Wing:** A mid-sized city with a relatively younger population and moderate-income levels. It has the highest poverty rate among the three cities and a more diverse racial composition, including notable Hispanic and Black populations.

### Community Role and Partnerships

MCHS plays a key role in advancing community and population health through prevention, early identification of health needs, and coordination of care. Each community served has unique demographic and socioeconomic characteristics, including differences in age, income, racial composition, and poverty levels. MCHS collaborates with community partners to address these differences and promote equitable access to care.

Key partnerships include Goodhue County Health and Human Services, United Way of Goodhue, Wabasha, and Pierce Counties, Three Rivers Community Action, and regional public health departments. These collaborations support shared planning, community engagement, and implementation of strategies that address social, environmental, and health-related factors affecting community health.

### Summary Community Health Needs Assessment (CHNA)

MCHS conducts a Community Health Needs Assessment every three years in each community where a hospital is located. In 2025, MCHS in Cannon Falls, MCHS in Lake City, and MCHS in Red Wing partnered with local public health agencies and community organizations to complete a joint CHNA.

The assessment used multiple data sources, including a random mailed community survey, targeted outreach to underrepresented populations, key informant interviews, and feedback collected through community engagement activities. This approach ensured representation from diverse and at-risk populations and provided insight into social and environmental health concerns.



# Prioritized Health Needs

Through this collaborative process, three shared priority areas were identified across the communities served:

These top three health priorities are:

- 1. Mental Health**
- 2. Chronic Health Conditions and Contributing Factors**
- 3. Access to Healthcare**

# Community Health Implementation Plan Overview

## Priority 1 Summary: Mental Health

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### CURRENT SITUATION AND DATA

According to Healthy People 2030, about half of all people in the US will be diagnosed with a mental disorder at some point in their lifetime. Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected by these conditions. Mental Health was the top health concern mentioned in key informant interviews, with 84% of those interviewed identifying it as a top issue. The most frequent concerns related to mental health included access to mental healthcare, understanding and outside influences that impacted the health and wellness of the community.

### DESIRED IMPACT

Improve access to care and understanding of mental health by providing education, resources, collaboration, and advocacy within the community.

### STRATEGIES



**Expand access to mental health services and resources**



**Foster wellbeing, connectivity and resilience across the life span**



**Increase equitable access to basic needs**

## MENTAL HEALTH

This focus area encompasses the services and support required to manage our thoughts, actions, and emotions as we navigate life. Mental health is crucial for personal well-being, nurturing family and interpersonal relationships, and making

meaningful contributions to society. Conditions affecting mental health include, but are not limited to, depression, anxiety, and post-traumatic stress disorder.

### Strategy 1: Expand access to mental health services and resources

ACTION	INPUTS	ANTICIPATED OUTCOMES
Collaborate with community partners to expand community-based mental health programs and services.	Collaboration: <ul style="list-style-type: none"> <li>• County Public Health</li> <li>• Non-profit Agencies</li> <li>• CARE Clinic</li> <li>• School District</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Medical Staff</li> </ul>	Provide resources and subject matter experts to at least 6 community-based mental health programs during the reporting period.
Develop and distribute mental health educational resources.	Collaboration: <ul style="list-style-type: none"> <li>• County Public Health</li> <li>• Non-profit Agencies</li> <li>• CARE Clinic</li> <li>• School District</li> <li>• Chamber of Commerce</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Staff</li> <li>• Newsletter</li> <li>• MCHS Website</li> </ul>	Increase community awareness of mental health resources by annually distributing educational materials at 6 or more community outlets.
Provide financial or in-kind opportunities to organizations that address mental health.	Collaboration: <ul style="list-style-type: none"> <li>• Non-profit Agencies</li> <li>• Service Clubs</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Grants</li> <li>• MCHS Contributions</li> </ul>	Annually provide financial or in-kind support to a minimum of 5 external agencies that address mental health.

**Strategy 2: Foster wellbeing, connectivity, and resilience in the community.**

ACTION	INPUTS	ANTICIPATED OUTCOMES
<p>Promote Mayo Clinic and MCHS wellness programs.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> <li>• Educational Institutions</li> <li>• Non-profit agencies</li> <li>• Media outlets</li> <li>• School District</li> </ul> <p>Resources:</p> <ul style="list-style-type: none"> <li>• MCHS programs</li> <li>• MCHS Medical Staff</li> </ul>	<p>Promote at least 5 wellness programs during the reporting period.</p>
<p>Participate in community wellness education events, programs or outreach activities that foster wellbeing.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> <li>• Community organizations</li> <li>• School District</li> <li>• Healthcare organizations</li> </ul> <p>Resources:</p> <ul style="list-style-type: none"> <li>• MCHS Medical Staff</li> <li>• Mental Health Material</li> </ul>	<p>Reach at least 700 community members per year through community wellness education events, programs or outreach activities.</p>
<p>Ensure leaders and staff have active roles in community coalitions, service clubs, and community boards.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> <li>• United Way</li> <li>• Service Clubs</li> <li>• Chamber of Commerce</li> <li>• Non-profit Organizations</li> </ul> <p>Resources:</p> <ul style="list-style-type: none"> <li>• MCHS Medical Staff</li> </ul>	<p>Maintain or increase the number of staff who are in active leadership roles in the community.</p>

**Strategy 3: Increase mental health knowledge and youth mental health programs.**

ACTION	INPUTS	ANTICIPATED OUTCOMES
Collaborate with community organizations to offer mental health training.	Collaboration: <ul style="list-style-type: none"> <li>• United Way</li> <li>• Public Health</li> <li>• School District</li> <li>• County Public Health</li> <li>• HOPE Squad</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Medical Staff</li> </ul>	Provide training to at least 75 community members and students by the end of 2028.
Support youth and peer-led education programs.	Collaboration: <ul style="list-style-type: none"> <li>• YMCA</li> <li>• School District</li> <li>• RiseUp Red Wing</li> <li>• COMET</li> <li>• Screenagers</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Medical Staff</li> </ul>	Partner with at least 3 community organizations or school-based groups annually to deliver mental health education.

## Priority 2 Summary: Chronic Disease and Contributing Factors

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### CURRENT SITUATION AND DATA

Chronic health conditions, including overweight, obesity, diabetes, heart disease, and stroke, affect many people and are among the leading causes of death in the US. According to Healthy People 2030, some racial and ethnic minorities are more likely to have obesity, which increases their risk of chronic diseases like diabetes, heart disease, and stroke. Though these conditions are common, “they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment ... Teaching people to recognize symptoms is key to helping more people get the treatment they need” (Healthy People 2030). Chronic health condition was the second health priority; statistics indicate that nearly 79% of Goodhue County adults are categorized as overweight or obese, and heart disease is the leading cause of death (2020- 2024).

### DESIRED IMPACT

Reduce the burden of chronic health conditions by improving risk factor management, increasing awareness of chronic disease, and supporting prevention efforts, particularly among populations with higher rates of overweight, obesity, and heart disease.

### STRATEGIES



**Improve awareness of chronic health conditions through education and access to resources**



**Expand immunizations and preventive care**



**Promote nutrition and physical activity**

## CHRONIC DISEASE AND CONTRIBUTING FACTORS

### Strategy 1: Improve awareness of chronic health conditions through education and access to resources.

ACTION	INPUTS	ANTICIPATED OUTCOMES
Collaborate with community partners to host educational sessions addressing chronic disease risk factors.	Collaboration: <ul style="list-style-type: none"> <li>• CARE Clinic</li> <li>• County Public Health</li> <li>• Hiawatha Valley</li> <li>• Three Rivers Community Action</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Medical Staff</li> </ul>	Increase awareness of chronic diseases by providing 3 educational presentations annually.
Develop and distribute chronic disease educational resources	Collaboration: <ul style="list-style-type: none"> <li>• County Public Health</li> <li>• Non-profit agencies</li> <li>• Hiawatha Valley</li> <li>• Three Rivers Community Action</li> <li>• CARE Clinic</li> <li>• School Districts</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Communications/Design Team</li> <li>• MCHS Social Worker</li> <li>• Newsletter</li> <li>• MCHS Website</li> </ul>	Reach 7,000 residents through outreach efforts during the reporting period.
Develop multilingual health education materials.	Resources: <ul style="list-style-type: none"> <li>• MCHS Language Services</li> </ul>	In partnership with Language Services, produce five new multilingual education resources by the end of the reporting period.

**Strategy 2: Support policy, education, and community awareness strategies to decrease Substance Misuse**

ACTION	INPUTS	ANTICIPATED OUTCOMES
Partner with schools and employers for on-site immunization and screening.	Collaboration: <ul style="list-style-type: none"> <li>• School District</li> <li>• Area Businesses</li> <li>• County Public Health</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Staff</li> </ul>	Annually hold on-site immunizations and screenings at 3 school districts.
Partner with public health to improve community access to immunizations and preventive care.	Collaboration: <ul style="list-style-type: none"> <li>• Public Health</li> <li>• Community Partners</li> <li>• CARE Clinic</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Education</li> <li>• MCHS Medical professionals</li> <li>• MCHS Quality</li> </ul>	Participate in 2 community education sessions per year.

**Strategy 3: Promote nutrition and physical activity.**

ACTION	INPUTS	ANTICIPATED OUTCOMES
Expand access to nutritious foods through community-based programs.	Collaboration: <ul style="list-style-type: none"> <li>• City Park and Recreation</li> <li>• County Public Health</li> <li>• Veggie Rx</li> <li>• Community Gardens</li> <li>• School Districts</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Wellness</li> <li>• MCHS Grant Funding</li> <li>• MCHS Staff</li> </ul>	Increase the number of community gardens, Veggie Rx programs and school pantries.
Improve access to healthy food through funding, education and food drives	Collaboration: <ul style="list-style-type: none"> <li>• Local Food Shelves</li> <li>• United Way</li> <li>• Veggie Rx</li> <li>• School District Marketplace</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Staff food drives</li> <li>• MCHS Grant Funding</li> </ul>	Host an annual food drive and provide financial support to local food shelves.
Increase community physical activity opportunities through partnerships and program promotion.	Collaboration: <ul style="list-style-type: none"> <li>• Local YMCA</li> <li>• Community Park and Recreations</li> <li>• Educational Institutes</li> <li>• County Public Health</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Dieticians</li> <li>• MCHS Physical Therapy Department</li> <li>• MCHS Staff</li> <li>• MCHS Wellness Programs</li> </ul>	Increase staff participation in community wellness initiatives and promote physical activity programs during the reporting period.

## Priority 3 Summary: Access to Healthcare

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### CURRENT SITUATION AND DATA

High-quality healthcare helps prevent disease and improve quality of life. Healthy People 2030 states that some people don't receive the healthcare services they need because they lack health insurance or live too far from providers. Interventions to increase access to healthcare services, such as lowering costs, expanding insurance coverage, and increasing telehealth use, can help more people get the care they need. Barriers such as cost, transportation, distance and language limit access to care.

### STRATEGIES



**Reduce community-identified barriers to access healthcare for all populations**



**Increase community knowledge of care options**



**Expand both virtual and in-person access points across rural and underserved areas**

### DESIRED IMPACT

Ensure access to comprehensive, high-quality healthcare for community members in Cannon Falls, Lake City, Red Wing, and the surrounding area, that is safe, affordable, timely, and coordinated.

## ACCESS TO HEALTHCARE

### Strategy 1: Reduce community-identified barriers to access healthcare for all populations.

ACTION	INPUTS	ANTICIPATED OUTCOMES
<p>Promote virtual care options at community events.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> <li>• County Health and Human Services</li> <li>• Goodhue, Wabasha and Pierce County United Way</li> </ul> <p>Resources:</p> <ul style="list-style-type: none"> <li>• MCHS staff</li> <li>• MCHS patient portal</li> <li>• MCHS website</li> </ul>	<p>Increased utilization of the virtual care option.</p>
<p>Provide transportation or volunteer rides.</p>	<p>Collaboration:</p> <ul style="list-style-type: none"> <li>• Transportation organizations</li> <li>• Volunteer community programs</li> <li>• County Public Health</li> </ul> <p>Resources:</p> <ul style="list-style-type: none"> <li>• MCHS Financial Support</li> <li>• MCHS Staff</li> </ul>	<p>Increase patient transportation options through community collaborations and financial support.</p>

**Strategy 2: Increase community knowledge of care options.**

ACTION	INPUTS	ANTICIPATED OUTCOMES
Distribute multilingual materials to community partners, area businesses and non-profit agencies	Collaboration: <ul style="list-style-type: none"> <li>• Goodhue, Wabasha and Pierce County United Way</li> <li>• Food Shelves</li> <li>• County Public Health</li> <li>• Three Rivers Action Center</li> <li>• Hiawatha Valley</li> <li>• CARE Clinic</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Language Services</li> <li>• MCHS Staff</li> </ul>	Improve awareness of mental health knowledge through partnerships during the reporting period.
Offer presentations to community groups and service clubs	Collaboration: <ul style="list-style-type: none"> <li>• Rotary</li> <li>• Kiwanis</li> <li>• Chamber of Commerce</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Medical Staff</li> </ul>	Provide 6 community group presentations during the reporting period.

**Strategy 3: Expand both virtual and in-person access points across rural and underserved areas.**

ACTION	INPUTS	ANTICIPATED OUTCOMES
Promote virtual care options through community events and presentations	Collaboration: <ul style="list-style-type: none"> <li>• County Public Health</li> <li>• Community partners</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS Staff</li> </ul>	Increase Primary Care On Demand and virtual care utilization by 10% during the reporting period
Increase the use of FindHelp and CareConnect through internal and external referrals	Collaboration: <ul style="list-style-type: none"> <li>• CARE Clinic</li> <li>• Community-based organizations</li> </ul> Resources: <ul style="list-style-type: none"> <li>• MCHS practice support</li> <li>• MCHS Social Workers</li> </ul>	Increase utilization of referral platforms.



# Summary of health needs not addressed

## **Health Needs Not Addressed**

Understanding that all individual health and wellness efforts are interconnected with the environment, culture, people, policies, systems and programs, it's important to continue to weave in the lesser referenced issues with the priority areas. Identifying the top three areas to address will assist our community partners serving specific groups when seeking funding, determining the relevance of programming, and shaping future direction for their organizations.

Through the assessment process, the following needs were mentioned, but not addressed directly in this Community Health Needs Assessment:

### **Social Isolation and Discrimination**

People's relationships and interactions with family, friends, co-workers, and community members can majorly impact their

health and well-being. Positive home, work, and community relationships can help reduce adverse health impacts. Some people face discrimination, bullying, and social isolation and often do not get the support they need to achieve optimal health. MCHS can support programs and collaborate with organizations that focus on social isolation and discrimination through community engagement and education.

### **Socioeconomic Factor – Housing**

While this is not an area of MCHS's expertise or direct influence, it is important to the community, and we will therefore play a supporting role. MCHS can support programs and collaborate with organizations that focus on housing, such as Three Rivers Community Action and Goodhue County Health & Human Services. MCHS will also engage in United Way's Poverty Simulation to increase awareness of the effects of poverty on 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.”<sup>12</sup>

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"> <li>• Access to transportation</li> <li>• Difficulty paying for prescriptions or medical bills</li> <li>• Education and literacy</li> <li>• Food insecurity</li> <li>• Housing insecurity</li> </ul>
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"> <li>• Age</li> <li>• Gender</li> <li>• Preferred language</li> <li>• Race and ethnicity</li> </ul>
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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