Community Health Implementation Strategy / Improvement Plan

Aspirus Merrill Hospital

Aspirus Tomahawk Hospital

2026-2029



Acknowledgements

Aspirus Merrill Hospital and Aspirus Tomahawk Hospital are grateful for the time and dedication of the Lincoln County Health Department and the many community stakeholders who provided input. We aim to continue the longstanding collaboration with local community partners to improve the community's health.

Respectfully,



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Executive Summary

Background

After completing a Community Health Needs Assessment in late 2025 through early 2026, Aspirus Merrill Hospital and Aspirus Tomahawk Hospital developed an Implementation Strategy to address local needs.

Priorities

Through the Community Health Needs Assessment process, Aspirus Merrill Hospital and Aspirus Tomahawk Hospital prioritized the following community health issues:

- Mental Health and Emotional Well-Being
- Healthy Lifestyles (especially food security)
- Community Resources for Older Individuals

Process

The hospitals drafted and then shared an Implementation Strategy with community partners, including the Lincoln County Health Department.

Aspirus is using a Results-Based Accountability (RBA) framework to structure their plan. Strategy identification criteria included:

- Alignment with the end result (indicator)
- Evidence-base
- Feasibility
- Organizational capacity

Results

The hospitals will be carrying out the strategies included in this plan over the next three years.

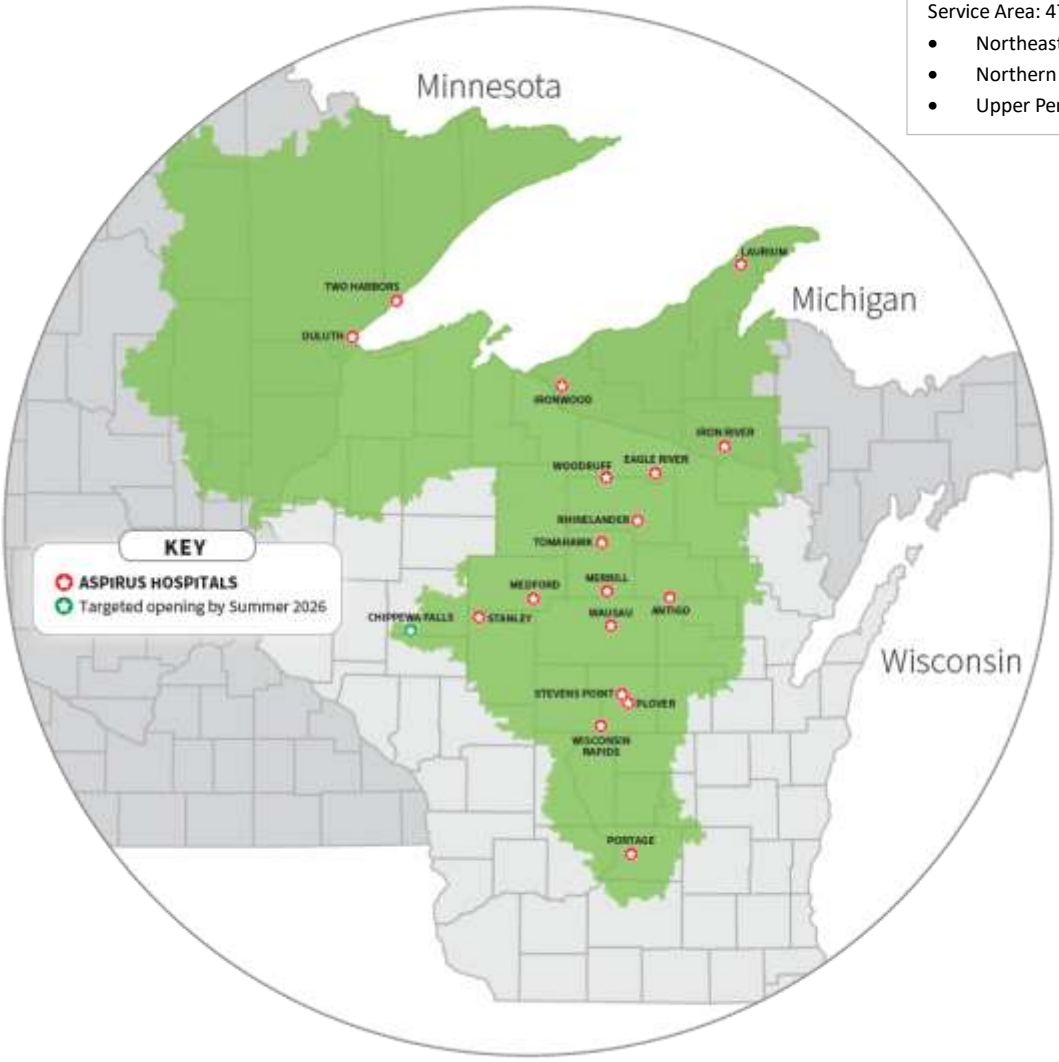
Aspirus Profiles

Aspirus Health

Aspirus Health is a nonprofit, community-directed health system based in Wausau, Wisconsin, serving northeastern Minnesota, northern and central Wisconsin and the Upper Peninsula of Michigan. The health system operates 19 hospitals and 130 outpatient locations with nearly 14,000 team members, including 1,300 employed physicians and advanced practice clinicians. Learn more at aspirus.org.

Service Area: 47,517 square miles

- Northeastern Minnesota
- Northern and Central Wisconsin
- Upper Peninsula of Michigan



Aspirus Merrill Hospital and Aspirus Tomahawk Hospital

Aspirus Merrill Hospital and Aspirus Tomahawk Hospital are committed to providing local access with high quality health care. They have the opportunity to keep care local and strengthen access to primary and specialty care.

Aspirus Merrill Hospital

Aspirus Merrill Hospital is a critical access hospital that provides primary and specialty services to Merrill and rural Lincoln County. Services include inpatient hospital care, 24/7 emergency department, urgent care as well as surgery, imaging, laboratory, and rehabilitation services.

Aspirus Tomahawk Hospital

Aspirus Tomahawk Hospital provides primary and specialty services to Tomahawk and rural Lincoln County through a critical access hospital. Other services include inpatient hospital care, 24/7 emergency department/urgent care as well as surgery, imaging, laboratory, and rehabilitation services.

About the Implementation Strategy

For Aspirus, the Implementation Strategy (IS), and the corresponding community health needs assessment (CHNA), is one way to live our mission – to heal people, promote health and strengthen communities – and reach our vision – being a catalyst for creating healthy, thriving communities.

Definition / Purpose

A CHNA is "a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize, plan and act upon unmet community needs."[1] The value of the CHNA lies not only in the findings but also in the process itself, which is a powerful avenue for collaboration and potential impact. An Implementation Strategy is "the hospital's plan for addressing community health needs, including health needs prioritized in the CHNA and through other means".[2]

Compliance

The completion of an Implementation Strategy – and a corresponding needs assessment – is a requirement for both hospitals and health departments. For non-profit hospitals, the requirement originated with the Patient Protection and Affordable Care Act (ACA). The IRS Code, Section 501(r)(3) outlines the specific requirements, including having the final, approved report posted on a public website. Additionally, CHNA and Implementation Strategy activities are annually reported to the IRS.

In Wisconsin, local health departments are required by Wisconsin State Statute 251.05 to complete a community health assessment and create a plan every five years. The statute indicates specific criteria must be met as part of the process.

[1] Catholic Health Association of the United States, https://www.chausa.org
[2] Catholic Health Association of the United States, *A Guide for Planning & Reporting Community Benefit*

Final Prioritized Needs

Based on community input, health data, and multiple additional criteria, Aspirus Merrill Hospital and Aspirus Tomahawk Hospital identified three priority health needs for focused action.

- Mental Health and Emotional Well-Being
- Healthy Lifestyles (especially food security)
- Community Resources for Older Individuals

Needs Not Selected

The needs prioritized by the hospitals were the same needs Live Well Lincoln identified.

General Approach to Implementation

Aspirus is using the results-based accountability (RBA)[3] framework for the Implementation Strategy. In the RBA model, *population-level* results and indicators identify the community-wide well-being that is desired. The *program-level* strategies and performance measures identify what Aspirus and their partners plan to do. That said, improving community well-being will take many resources and substantial policy, system and environmental change.

The next six pages include, for each of the three prioritized needs, a 1-page overview of the need and a 1-page RBA plan. The plans:

- Are described at a general level; plans with more specificity will be created annually.
- Reflect the time period July 1, 2026 – June 30, 2029.
- Reflect intended efforts; circumstances may affect the completion of the efforts.
- May be modified over time.

[3] Clear Impact, https://clearimpact.com/results-based-accountability/

Mental Health and Emotional Well-Being

Why is it Important?

More than 1 in 5 adults in the United States (59.3 million people in 2022) has a mental illness.[1] Mental health and physical health are closely related, with a correlation between some physical chronic illnesses and poor mental health.[2] Some risk factors include lack of access to education, income, employment and housing; adverse childhood experiences (ACEs); social isolation; drug or alcohol use.[2] Untreated mental health issues can contribute to issues such as family conflicts, problems with drugs or alcohol, weakened immune system, some chronic diseases and more.[3]

Alcohol and drug use are leading causes of preventable deaths.[4] Alcohol is the most frequently used substance in the United States (ages 12+).[4] The number of alcohol-attributed deaths due to excessive alcohol use in the United States increased by 29% in the span of 5 years, from 138K in 2016-2017 to 178K in 2020-2021.[4] Short term risks and long-term impacts of excessive alcohol use include: violence; unintentional injuries (e.g., falls); cancer; high blood pressure; long term memory problems and more.[5]

Sources: (1) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/mental-illness. Accessed on 2/20/2025. (2) Centers for Disease Control and Prevention, https://www.cdc.gov/mental-health/about/index.html. Accessed on 2/20/2025. (3) Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968. Accessed on 2/20/2025. (4) Centers for Disease Control and Prevention, https://www.cdc.gov/alcohol/facts-stats/index.html. Accessed on 2/23/2025 and then revisited on 3/29/2026. (5) Centers for Disease Control and Prevention, https://www.cdc.gov/alcohol/about-alcohol-use/index.html. Accessed on 4/5/2026.

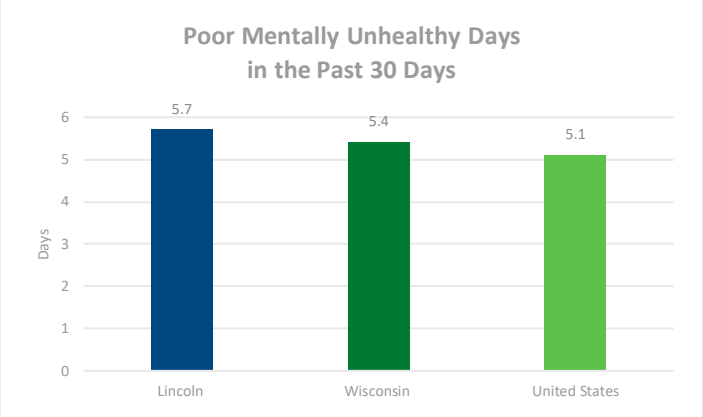
Disparities and Inequities

Disparities and inequities can show where interventions would be most beneficial.

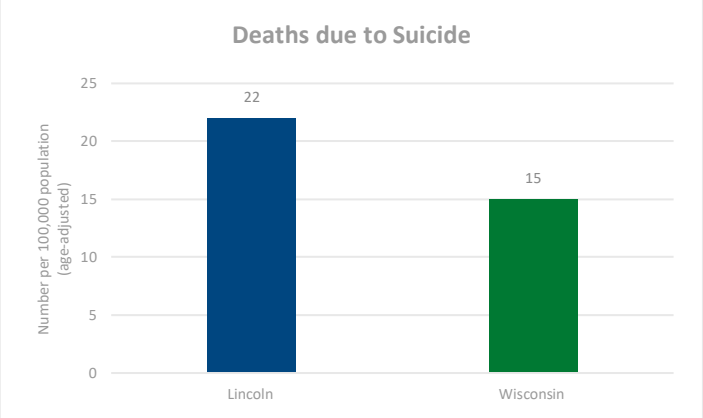
- Individuals in marginalized groups are more likely to have poor mental health.[1]
- The likelihood of depression decreases as education levels increase.[2]
- Depression is higher for women compared to men.[2]
- The suicide rate for men is four times the rate for women.[3]
- Over 55 percent of the students who identified in each of the following groups reported having anxiety: LGB; female; with food insecurity; with low grades; who are Hispanic; who have a multi-racial background.[4]

Sources: (1) Macintyre, A., Ferris, D., Gonçalves, B.et al. What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action. Palgrave Commun4, 10(2018). https://doi.org/10.1057/s41599-018-0063-2. (2) Centers for Disease Control and Prevention, https://www.cdc.gov/mmwr/volumes/72/wr/mm7224a1.htm. Accessed on 2/21/2025. (3) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/suicide#part_2557. Accessed on 2/21/2025. (4) Wisconsin Youth Risk Behavior Survey Summary Report (2021), Summary Report: 2023 Wisconsin Youth Risk Behavior Survey. Accessed on 3/23/2026.

Data Highlights



Source: County Health Rankings and Roadmaps (2025 data release).



Source: County Health Rankings and Roadmaps (2025 data release).

Additional Data

- Percentage of teens and young adults ages 16-19 who are neither working nor in school: 11% Lincoln County; 5% Wisconsin (Source: 2025 County Health Rankings and Roadmaps)
- Percentage of adults reporting they always, usually or sometimes feel lonely (2022): 33% Lincoln County; 32% Wisconsin. (Source: 2025 County Health Rankings and Roadmaps)

Community Perceptions & Challenges

Community Key Informant Interview highlights include:

- Law enforcement, schools, and community organizations all reported frequent mental health-related interactions, including behavioral challenges among children and adolescents.
- Social isolation and declining social connectedness were identified as growing challenges across age groups.

Mental Health and Emotional Well-Being

Program Accountability		Population Accountability	
Strategy	**Performance Measure -- Quantity, Quality and Effect --**	**Indicator**	**Result**
Improve suicide prevention care practices	• % of patients who screened positive for suicide risk • % of patients who screened positive for suicide risk and a safety plan was completed	Decreased number of individuals who die by suicide (Baseline: 22 deaths per 100,000 population (2018-2022). Source: County Health Rankings and Roadmaps)	All community members are mentally well
Conduct mental health-related classes, trainings and events (e.g., QPR, CALM)	• # of trainings • # of participants • Evaluation results (by training/program)		
Improve access to mental health resources and care navigation	• Completion and annual update of an environmental assessment of Aspirus and community mental health resources. • # of behavioral health resources available within the Findhelp platform. • # of mental health resource cards shared		
Increase awareness / Reduce stigma	• # of suicide prevention education and awareness events led or supported by Aspirus • # of media spots, likes and views for awareness events (e.g., May Mental Health Month and September Suicide Prevention Month) that were led or supported by Aspirus • Raise Your Voice Clubs measures		
Contribute to local coalitions	• Campaign descriptions (e.g., social connectedness)		
Reduce risk (harm reduction and tertiary prevention)	• % of emergency room patients screened for risky alcohol use • # of safe storage devices distributed • # of individuals referred to a recovery coach (Merrill)		

Collaborative Partners	Aspirus Resources
Live Well Lincoln / Healthy Minds Coalition • Lincoln County Health Department • Lincoln County Social Services • Aging and Disability Resource Center (ADRC) • T.B. Scott Free Library (Merrill) • Tomahawk Public Library Other • NAMI for Raise Your Voice Clubs • Merrill EMS (Community Paramedic Program)	• Funding through Aspirus Community Benefit dollars • Staff time – coalition participation, event planning and promotion, presentations, resource identification • Space – hosting support groups and meetings • Space – hosting operations space for non-profit agencies that serve individuals with low income, including the food pantry (Merrill) • Clinical services and related infrastructure – providing direct care, supporting the FindHelp platform and related resource development

Healthy Lifestyles (especially food insecurity)

Why is it Important?

Poor diet and unhealthy weight place an individual at risk for an array of health consequences, including cardiovascular diseases. Food insecurity is the "limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways". Currently in the United States, 35% of adults and 17% of youth are obese, and 14% of households are food insecure.

Previous research on the relationship between food insecurity and dietary patterns has linked food insecurity with a lower consumption of healthy food groups and poor diet quality, particularly with regard to fruit and vegetable intake. Past work on food insecurity and obesity has yielded mixed evidence of associations, especially for children and adult men, while stronger evidence for an adverse association has been noted in women.

Excerpted verbatim from: Morales ME, Berkowitz SA. The Relationship between Food Insecurity, Dietary Patterns, and Obesity. Curr Nutr Rep. 2016 Mar;5(1):54-60. doi: 10.1007/s13668-016-0153-y. Epub 2016 Jan 25. PMID: 29955440; PMCID: PMC6019322.

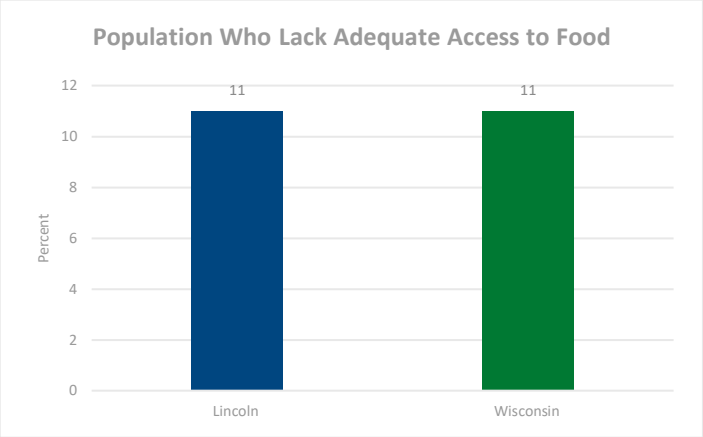
Disparities and Inequities

Disparities and inequities can show where interventions would be most beneficial.

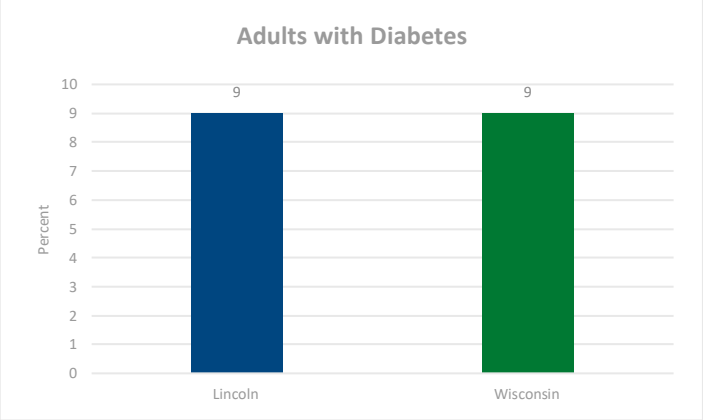
Rates of obesity and chronic disease are generally significantly higher among racial and ethnic minorities and low-income populations. In many cases, disparities are linked with wide-reaching factors such as access to resources including healthy foods, safe places for physical activity, healthcare, and equitable opportunities for education, housing, employment and transportation.

Source: Verbatim from *Wisconsin Nutrition, Physical Activity and Obesity State Health Plan*, page 94

Data Highlights



Source: County Health Rankings and Roadmaps (2025 data release).



Source: County Health Rankings and Roadmaps (2025 data release).

Additional Data

- Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch: 41% Lincoln County; 40% Wisconsin (Source: 2025 County Health Rankings and Roadmaps)

Community Perceptions & Challenges

Community Key Informant Interview highlights include:

- The rising cost of living was one of the most frequently cited concerns. Inflation has significantly impacted households' ability to meet basic needs, including food, housing, childcare, and healthcare. These financial pressures are increasingly viewed as fundamental drivers of health outcomes rather than solely economic challenges.

Healthy Lifestyles (especially food insecurity)

Program Accountability		Population Accountability	
Strategy	**Performance Measure**	**Indicator**	**Result**
Develop a consistent social drivers of health (SDOH) screening workflow	• FindHelp integration in Epic • % of patients screened • % of closed loop referrals • # of resources being shared through the after-visit summary • # of staff/user trainings	Decreased food insecurity (Baseline: 11% in 2022. Source: County Health Rankings and Roadmaps) Number / % of patients who reported that the food they bought didn't last and didn't have enough money to get more (patients) Number / % of patients who worry their food would run out and don't have enough money to get more	All residents of the Aspirus service area reach optimal nutritional health
Strengthen FindHelp	• # of scheduled 'refreshes' • # of new resources • # of community partner trainings / workshops		
Continue the Community Paramedicine Program (Merrill)	• # of patients served • # of patients who were connected to resources • Examples of success		
Provide food resources	• # of pounds of food gleaned (Merrill) • # of Fruit and Vegetable Prescription (FVRx) vouchers redeemed • $$ of farmers market coupons • Explore a food insecurity coalition or network • Support WIC referrals		

Collaborative Partners	Aspirus Resources
• Live Well Lincoln Leadership Group – Lincoln County Health Department; Lincoln County Social Services; Aging and Disability Resource Center • Nutrition Coalition – HealthFirst (WIC provider); ADRC, health department • Local farmers markets • Merrill EMS (Community Care Paramedic Program) • Food pantry	• Funding through Aspirus Community Benefit dollars • Staff time – coalition participation, event planning and promotion, presentations, resource identification • Space – hosting support groups and meetings • Clinical services and related infrastructure – providing direct care, supporting the FindHelp platform and related resource development • In-kind food repurposing program (Merrill)

Community-Centered Resources for Older Adults

Why is it Important?

By 2060, almost a quarter of the U.S. population will be age 65 or older. Older adults are at higher risk for chronic health problems like diabetes, osteoporosis, and Alzheimer's disease. In addition, 1 in 3 older adults fall each year, and falls are a leading cause of injury for this age group. Physical activity can help older adults prevent both chronic disease and fall-related injuries.

Older adults are also more likely to go to the hospital for some infectious diseases — including pneumonia, which is a leading cause of death for this age group. Making sure older adults get preventive care, including vaccines to protect against the flu and pneumonia, can help them stay healthy.

… [C]aregivers of people with health conditions or disabilities influence the health of the people they're caring for in many different ways. It's important to make sure caregivers have the resources and support they need to keep themselves and the people they're caring for healthy.

Sources: Excerpted nearly verbatim from Healthy People 2030 – Older Adults and Caregiving;

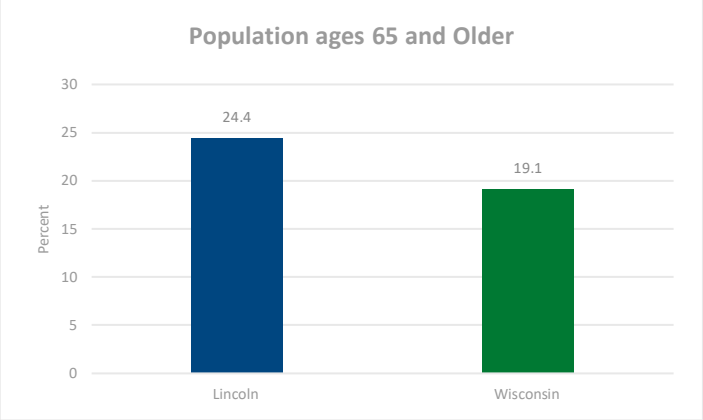
Disparities and Inequities

Disparities and inequities can show where interventions would be most beneficial.

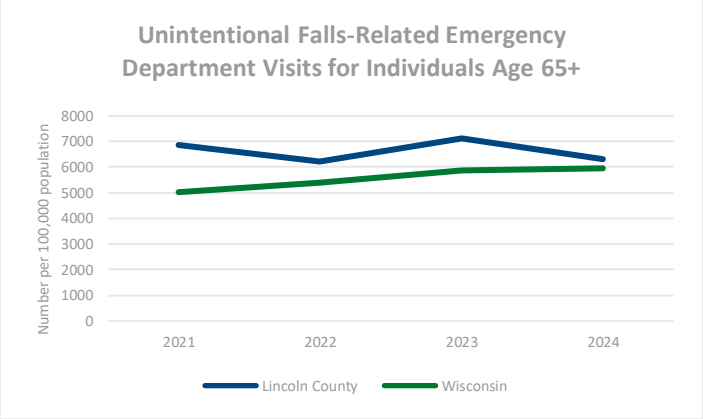
- Alzheimer's disease disproportionately affects individuals who are African American or Hispanic.
- Individuals with lower socioeconomic status are more likely to live shorter lives.
- Women are more likely to live longer than men.
- Women are more likely to develop osteoporosis or depressive symptoms or to report functional limitations as they age.
- Men are more likely to develop heart disease, cancer or diabetes.
- Social environmental factors such as residential segregation, discrimination, immigration, social mobility, work, retirement, education, income, and wealth can also have a serious impact on health and well-being. Economic circumstances can determine whether an individual can afford quality health care and proper nutrition from early life into old age. Individual and family financial resources and health insurance often determine whether an older adult enters an assisted living facility or nursing home or stays at home to be cared for by family members.

Source: National Institutes on Aging; some verbiage is verbatim.

Data Highlights



Source: County Health Rankings and Roadmaps (2025 data release).



Source: Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, https://www.dhs.wisconsin.gov/wish/index.htm, Injury-Related Emergency Department Visits Module, accessed 2/3/2026.

Additional Data

- Percentage of adults reporting that they always, usually or sometimes feel lonely: 33% Lincoln County; 32% Wisconsin. (Source: County Health Rankings and Roadmaps (2025 data release))

Community Perceptions & Challenges

Community Key Informant Interview highlights include:

- Social isolation and declining social connectedness were identified as growing challenges across age groups. Older adults experiencing isolation were repeatedly highlighted, especially those who are homebound or difficult to reach despite existing resources. At the same time, some positive momentum was noted, including increased community events and the role of libraries, schools, and enrichment centers in fostering connection.

Community-Centered Resources for Older Adults

Program Accountability		Population Accountability	
Strategy	**Performance Measure**	**Indicator**	**Result**
Ensure coordinated and patient-centered, equitable care for older individuals	• Age-Friendly Measure screening in place • Screening dashboard in place • # of referrals	Percent of patients screened through the Age-Friendly Measure Decreased rate of falls-related ED visits for individuals age 65+ (Baseline: 6305 per 100,000 population (2024). Source: Wisconsin Interactive Statistics on Health) Percent of discharged patients with advance directives on file	High quality life for every older adult
Continue the Community Care Paramedic Program (Merrill)	• # of patients served • # of patients who were connected with resources • Examples of success		
Conduct community trainings and workshops	• # of participants in falls prevention workshops • # of participants in strength and balance classes		
Increase the number of patients with advance directives	• # of 1:1 Honoring Choices appointments (meetings with community members or patients to complete an advance directive) • # of Honoring Choices classes		
Strengthen the relationship between ADRCs and Aspirus clinical staff	• # of discharge planners aware of ADRC resources • Partnership with ADRCs		

Collaborative Partners	Aspirus Resources
• Aging and Disability Resource Center • Lincoln County Health Department • Lincoln County Social Services Department • Merrill EMS (Community Care Paramedic Program)	• Funding through Aspirus Community Benefit dollars • Staff time – coalition participation, event planning and promotion, presentations, resource identification • Space – hosting support groups and meetings • Clinical services and related infrastructure – providing direct care, supporting the FindHelp platform and related resource development

System Priorities and Health Equity

Aspirus' community health efforts include the above efforts along with system strategies and growing attention to health equity.

System Priorities

In addition to addressing locally-identified community health priorities, Aspirus identifies and addresses system-level priorities. These system-level priorities emerge through a process that considers: the shared priorities of the 19 Aspirus hospitals; internal momentum; existing effective strategies; funding opportunities.

For 2026-2029, Aspirus' system-level priorities are: behavioral health; food navigation; healthcare access and navigation. When there is overlap between locally-identified and system-identified priority areas, Aspirus strategies are part of the Implementation Strategy/Plan. When system-identified priorities are not part of a local Strategy/Plan, some Aspirus system strategies may still be implemented locally.

Health Equity

Research shows that social and economic factors (social drivers) are significant 'upstream' contributors to individuals' and communities' health outcomes. Social and economic conditions influence disease risk, access to care, and health outcomes long before individuals enter the healthcare system.

In clinical settings, Aspirus hospitals and clinics are gathering social drivers of health data as a way to understand how to tailor care to better meet the unique needs of each patient, leading to improved health equity and better health outcomes. Using aggregated patient-level social drivers' data can assist in understanding the root causes of complex health issues to improve access to preventative and chronic care services. Linking patient level SDOH data and community level data can provide stronger clinical-community linkages to help connect healthcare providers, community organizations and public health agencies.

Aspirus implements The Joint Commission Elements of Performance (NPG.04.01.01). This process includes: assessing patients' health-related social needs; providing information about community resources; identifying disparities, and; implementing strategies to improve disparities.

Approval by the Hospital Board

The Implementation Strategy report was reviewed and approved by the Board of Directors for:

- Aspirus Merrill Hospital on October 21, 2026.
- Aspirus Tomahawk Hospital on October 20, 2026.

Conclusion

Aspirus Merrill Hospital and Aspirus Tomahawk Hospital are proud to share this plan for community health improvement.

Appendix: Strategies by Hospital

The tables below describe which strategies are planned for which hospitals.

Mental Health and Emotional Well-Being	Merrill Hospital	Tomahawk Hospital
Improve suicide prevention care practices	X	X
Conduct mental health-related classes, trainings and events (e.g., QPR, CALM)	X	X
Improve access to mental health resources and care navigation	X	X
Increase awareness / Reduce stigma	X	X
Contribute to local coalitions	X	X
Reduce risk (harm reduction and tertiary prevention)	X	X

Healthy Lifestyles (especially food insecurity)	Merrill Hospital	Tomahawk Hospital
Develop a consistent social drivers of health (SDOH) screening workflow	X	X
Strengthen FindHelp	X	X
Continue the Community Paramedicine Program	X	--
Address food insecurity	X	X

Community-Centered Resources for Older Adults	Merrill Hospital	Tomahawk Hospital
Ensure coordinated and patient-centered, equitable care for older individuals	X	X
Continue the Community Care Paramedic Program	X	--
Conduct community trainings and workshops	X	X
Increase the number of patients with advance directives	X	X
Strengthen the relationship between ADRCs and Aspirus clinical staff	X	X

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