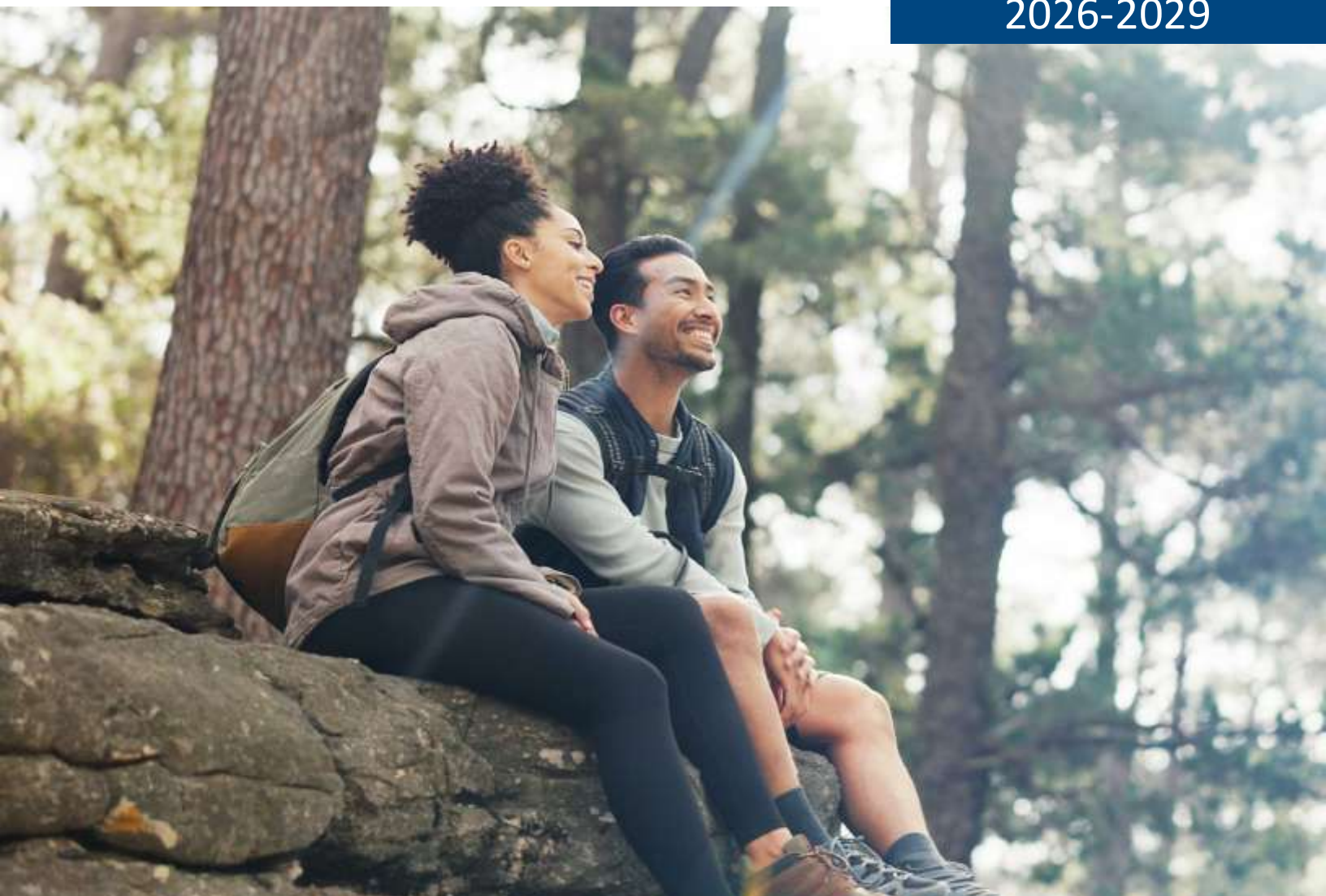
Community Health Implementation Strategy / Improvement Plan

Aspirus Wausau Hospital

2026-2029



Acknowledgements

Aspirus Wausau Hospital is grateful for the time and dedication of nearly one hundred community stakeholders involved in the LIFE – Local Indicators for Excellence – process. This Implementation Strategy would not be possible without their contributions. Aspirus Wausau Hospital would also like to thank the LIFE Executive Committee – the Marathon County Health Department; the United Way of Marathon County; Aspirus – and the larger Steering Committee. Addressing these complex community health issues must involve the entire community, and we appreciate the commitment of so many individuals and agencies. We look forward to continued collaboration as we move forward with this plan.

Respectfully,

Jeff Wicklander
SVP and President, Wisconsin Central Region
Aspirus Wausau Hospital

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Executive Summary

Background

Aspirus Wausau Hospital's Implementation Strategy (IS) is aligned with the Marathon County LIFE – Local Indicators For Excellence – process. The LIFE process is conducted every three years and serves as the community's assessment and corresponding plan. Aspirus, along with the Marathon County Health Department and the United Way of Marathon County, is on the LIFE Executive Committee. The Executive Committee, along with the Steering Committee, shape the LIFE process.

Process

Aspirus Wausau Hospital 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

Priorities

Aspirus Wausau Hospital applied the Results-Based Accountability model to the following community health issues:

- Behavioral Health
- Aging in Community
- Workforce

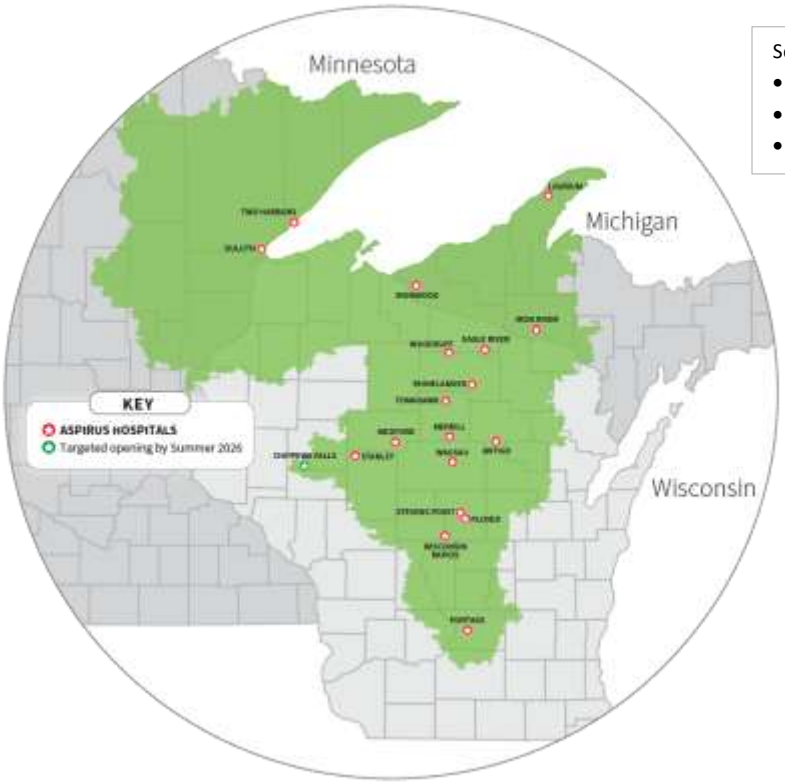
Results

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

Aspirus Health and Aspirus Wausau Hospital

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 Wausau Hospital

Aspirus Wausau Hospital is committed to providing local access with high quality health care and has the opportunity to keep care local and strengthen access to primary and specialty care.

It is the flagship of the Aspirus health system and provides primary, secondary, and tertiary care services as a regional referral center. Specialty referral service emphasis exists in cardiology and cardiothoracic surgery, orthopedics, Level II trauma center, and oncology. Aspirus Wausau Hospital provides world-class cardiovascular care in addition to leading-edge cancer, trauma, women's health, and spine and neurological care.

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 Wausau Hospital identified three priority health needs for focused action.

- Behavioral Health (inclusive of mental health and substance use)
- Aging in Community
- Workforce

Needs Not Selected

Of the five top issues brought to the Aspirus Wausau Hospital Senior Leadership Team, two were not prioritized: housing and civil engagement.

Housing is a complex issue outside of the core operations of the hospital. Housing can be a barrier to positive mental and physical health, healthy aging and workforce development. Through that lens, and through Aspirus' commitment to addressing social drivers of health through screening and referrals, Aspirus will be part of community efforts to address housing.

Aspirus is committed to ongoing civil engagement as part of a healthy community. Aspirus' Government Affairs efforts include connecting with local and state officials and supporting meaningful policies that advance the health of our patients and communities. Aspirus will continue to support those efforts, however, it does not have the capacity or expertise to lead on civil engagement.

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/

Behavioral Health

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.

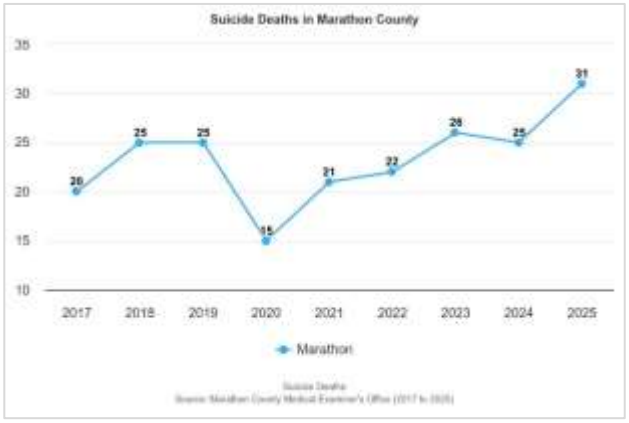
Disparities and Inequities

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

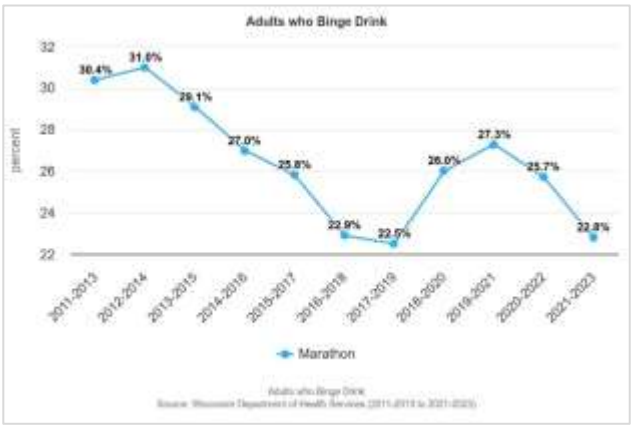
- Individuals in marginalized groups are more likely to have poor mental health.[1]
- The likelihood of depression decreases as education levels increase.[2]
- Depression is higher for women compared to men.[2]
- The suicide rate for men is four times the rate for women.[3]
- Over 55 percent of the students 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: Marathon County PULSE Marathon County Pulse :: Stories :: 2026 LIFE Report Health & Wellness accessed 4/12/2026.



Source: Marathon County PULSE Marathon County Pulse :: Stories :: 2026 LIFE Report Health & Wellness accessed 4/12/2026.

Additional Data: Marathon County Pulse :: Stories :: 2026 LIFE Report Health & Wellness

Community Perceptions & Challenges

Survey Results and Calls to Action Descriptions

- The top issues identified by survey respondents in the Health and Wellness category were: mental health; overweight & obesity; excessive alcohol use.
- Mental health challenges are increasing across Marathon County, with recent data showing higher suicide deaths and more teens experiencing suicidal thoughts and attempts. Depression and anxiety rates are also climbing, signaling an urgent need for accessible mental health care for people of all ages.
- Everyone in the community can play a role by checking in on friends and neighbors, knowing the warning signs of suicide and knowing how to connect individuals to crisis care.

Behavioral Health

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:16 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)		
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		
Improve access to resources	• 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		

Collaborative Partners	Aspirus Resources
• Health Department • Mental Health Collaborative • Mental Health Consortium • School Districts	• 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

Aging in Community

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.[2] 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;

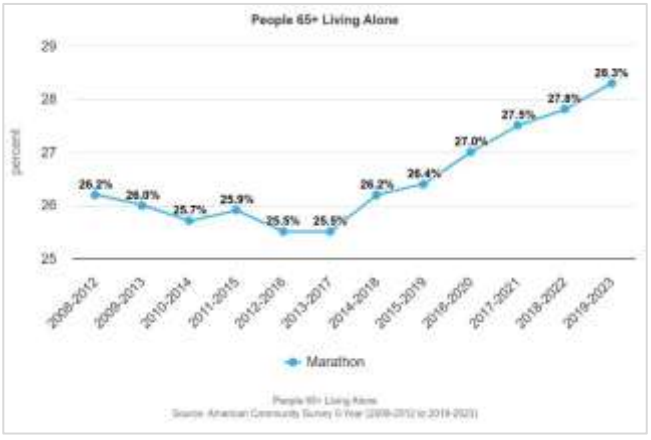
Disparities and Inequities

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

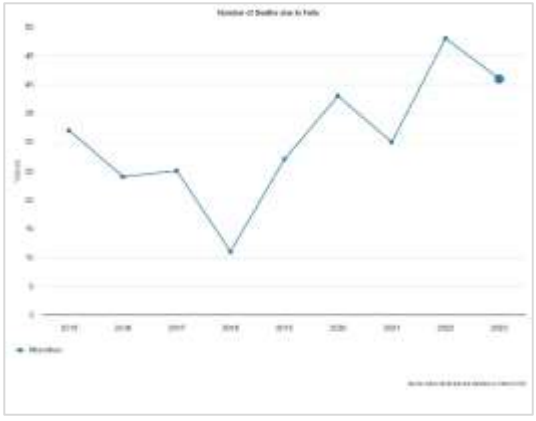
- Alzheimer's disease disproportionately affects individuals who are African American or Hispanic.
- Individuals with lower socioeconomic status are more likely to live shorter lives.
- Women are more likely to live longer than men.
- Women are more likely to develop osteoporosis or depressive symptoms 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: Marathon County PULSE Marathon County Pulse :: Stories :: 2026 LIFE Report Connected accessed 4/12/2026.



Source: Marathon County PULSE Marathon County Pulse :: Indicators :: Number of Deaths due to Falls :: County : Marathon accessed 4/12/2026.

Additional Data

- Marathon County renters age 65 and older were significantly more likely to spend 30% or more of their income on rent (66% for ages 65+; 42.9% overall).

Community Perceptions & Challenges

Survey Results and Calls to Action Descriptions

- The eighth issue identified by survey respondents in the Health and Wellness category was: availability of elder care.
- The expanding senior population is placing greater demands on services, funding, staffing, and emergency response. Falls among older adults are contributing to higher rates of hospitalizations, emergency visits, and Emergency Medical Services (EMS) calls—likely linked to more seniors living alone for longer. Better systems of care are needed.

Aging in Community

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: 4095 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 Paramedic Program	• # 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 Centers • Wausau Fire Department • Health Department • Aging Coalition • Habitat for Humanity	• 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

Workforce

Why is it Important?

People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.

Employment programs, career counseling, and high-quality child care opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

Source: Excerpted verbatim from Healthy People 2030 – Economic Stability - Healthy People 2030 | odphp.health.gov

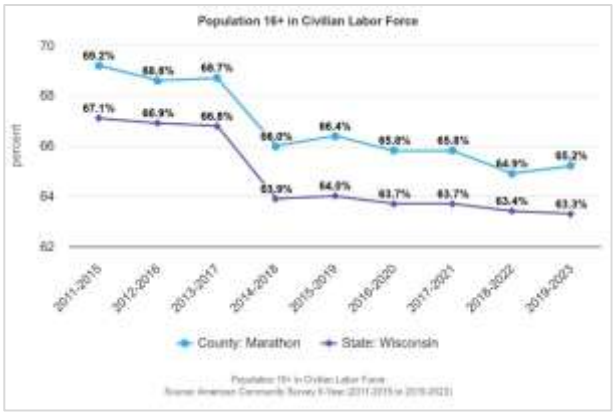
Disparities and Inequities

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

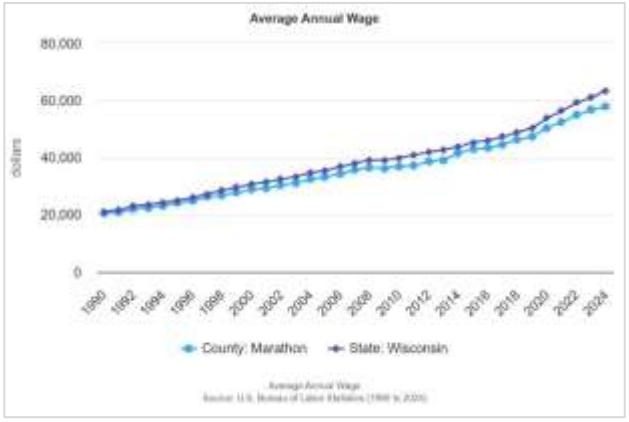
- There is a 14.9% wage differential between white workers and black workers that is not explainable by geography (e.g., South versus North), education and experience.[1]
- Women earn an estimated 82 cents for every dollar then men earn. This gender pay gap is greater: in the private sector; in self-owned incorporated businesses; for those with less than a high school diploma; those with a bachelor's degree.[2]
- The direct care workforce (e.g., personal care aides, home health aides and nursing assistants) are disproportionately women and women of color.[3]
- The median hourly wage is $13.00 for women of color, white women, men of color, white workers, Black/African American workers, and Hispanic/Latino workers in the direct care workforce. The median hourly wage for white men and workers of another race is $13.50.[3]

Sources: (1) Understanding black-white disparities in labor market outcomes requires models that account for persistent discrimination and unequal bargaining power, by Valerie Wilson and William Darity, Jr. Economic Policy Institute. Understanding black-white disparities in labor market outcomes requires models that account for persistent discrimination and unequal bargaining power | Economic Policy Institute (2) Women in the Workforce: The Gender Pay Gap Is Greater for Certain Racial and Ethnic Groups and Varies by Education Level | U.S. GAO accessed 4/12/2026. (3) Direct Care Worker Disparities: Key Trends and Challenges Direct-Care-Worker-Disparities-2022-PHI.pdf accessed 4/12/2026. Some language above is directly quoted from the sources.

Data Highlights



Source: Marathon County PULSE Marathon County Pulse :: Stories :: 2026 LIFE Report Economic Environment accessed 4/12/2026.



Source: Marathon County PULSE Marathon County Pulse :: Stories :: 2026 LIFE Report Economic Environment accessed 4/12/2026.

Additional Data: Marathon County Pulse :: Stories :: 2026 LIFE Report Economic Environment

Community Perceptions & Challenges

Survey Results and Calls to Action Descriptions

- The top issues identified by survey respondents in the Education and Environment category were: affordable housing; access to childcare; living-wage jobs.
- Marathon County needs a long-term workforce strategy that attracts skilled workers and retains local talent by expanding early exposure to career pathways and training opportunities.
- Local employers lag behind statewide compensation trends, affecting pay, benefits, and the ability to retain skilled workers. Marathon County employers must raise wages and benefits to stay competitive in Wisconsin.

Workforce

Program Accountability		Population Accountability	
Strategy	**Performance Measure -- Quantity, Quality and Effect --**	**Indicator**	**Result**
Workforce training and education	• # of scholarships given • $$ provided to current staff to further their education	% total employment change	Age-adjusted employment rate
Health careers-related outreach	• # of health careers presentations • # of recruitment events		
Leadership programs	• # of enrollees in Emerging Leaders • Leadership on local academic boards or advisory committees (e.g., NTC)		
NTC / QTT Academy (therapists in training)	• Network of students and supervisors • Supervision • Shared learning • Building local connections / relationships		
Clinical training pipeline	• # of external hires • # of internal transfers • # of student clinical placements		

Collaborative Partners	Aspirus Resources
• Chamber of Commerce • Higher education institutions • Internal HR and recruitment partners • Mental Health Collaborative	• 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 Wausau Hospital on October 21, 2026.

Conclusion

Aspirus Wausau Hospital is proud to share this plan for community health improvement.

Aspirus Wausau Hospital
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Wausau, WI 54401

aspirus.org

ASPIRUS®
HEALTH