Sheboygan County
Health Needs Assessment
A summary of key stakeholder interviews

2026

This report was prepared by JKV Research, LLC.

This report was commissioned by Aurora Health Care, HSHS St. Nicholas Hospital, Sheboygan County Health & Human Services Division of Public Health, Noble Community Clinics, United Way of Sheboygan County and the University of Wisconsin-Madison Extension - Sheboygan County.

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Introduction

Key stakeholders who represent diverse sectors of Sheboygan County were interviewed to better understand the needs of residents.

Between February 12 and April 16, 2026, 34 key stakeholders participated. Some interviews included multiple people but were counted as single interviews for identification. See Appendix C for a complete list of participants.

As shown in the table below, a variety of community populations were represented. A majority (71%) of stakeholders indicated they served all populations. In addition, several wanted to clarify their served population by specifying an "other." Most informants (65%) selected one population served.

Table 1. Community/Population Served (More Than One Response Accepted)

	Count
All populations	24
People experiencing low income	9
Youth	8
People from racial and ethnic groups	7
People that identify as LGBTQIA+	7
Rural communities	4
Seniors (65+)	3
Other specific populations	6
-BIPOC, food and housing insecure populations -College students -Homeless -Immigrants and refugees, other adults, parents -Pregnant mom – children ages birth to 5, families -Veterans and their families	

All informants were made aware that participation was voluntary and that responses would be shared with JKV Research for analysis and reporting. Members from the team interviewed the key stakeholders and entered responses into Survey Monkey for analysis.

Social Determinants of Health (SDOH):

- Top Rank, Second Rank
- Existing strategies to address this health issue – what is working well?
- What are the barriers/challenges to addressing this issue? What could we do differently?
- What additional strategies are needed to address this issue?
- Who are the key groups in the community that we could partner with to improve community health?
- Is there a subgroup or population where we could focus our efforts? (Ex: age, gender, race, ethnicity, income level, access or functional needs, neighborhoods, etc.)
- If the community rallied behind one major effort to radically improve this issue, what would that initiative be?

Health Conditions/Behaviors:

- Top Rank, Second Rank
- Existing strategies to address this health issue – what is working well?
- What are the barriers/challenges to addressing this issue? What could we do differently?
- What additional strategies are needed to address this issue?

- Who are the key groups in the community that we could partner with to improve community health?
- Is there a subgroup or population where we could focus our efforts? (Ex: age, gender, race, ethnicity, income level, access or functional needs, neighborhoods, etc.)
- If the community rallied behind one major effort to radically improve this issue, what would that initiative be?

Additional Questions/Comments

- Do you have any additional comments you would like to share?

This qualitative data, while useful, has limitations. The sample was developed by team members to represent Sheboygan County. Inadvertent exclusions may have an impact on the results. Use this in conjunction with quantitative research data.

Key Findings

1) The top tier social determinant of health (SDOH) was safe & affordable housing. The next tier included access to social services and accessible, affordable & quality health care. The third tier included economic stability & employment; social connectedness & belonging; and food insecurity. Barriers/ challenges that crossed multiple SDOHs included lack of affordable housing/housing instability, lack of accessible resources, high-cost burden of healthcare, financial instability, long wait list/timely care or lack of collaboration. Key partners included nonprofits, government agencies, collaborations/ partnerships, employers, public sector/community centers and health care providers/systems. Populations to focus on varied somewhat, but people with low income crossed all SDOHs while minorities or people of color, people who were homeless, youth, the elderly or “everyone” crossed several. To improve the issues, more collaborating, more safe and affordable housing/mixed-income housing, better communication/awareness of resources or increasing accessibility to resources were listed.
2) The top tier health condition/behavior was mental health & mental conditions (anxiety, depression). The next tier was alcohol use & abuse (underage drinking, binge drinking, DWI). The third tier included drug use & abuse (prescription drug misuse, street drug use including marijuana, cannabis, Delta8 and weed) and chronic diseases. Barriers/challenges across several health conditions/behaviors included stigma or long wait list/timely care. Key partners included nonprofits, health care providers/ systems, mental health providers, government agencies, behavioral health providers and schools. Youth, “everyone” or people with low income were listed as the most affected populations in several health conditions/behaviors. To improve the issues, increasing accessibility to resources, increasing awareness, education, collaborations/coalitions, increasing the number of mental health providers or more provider empathy were listed.

A. Social Determinants of Health Rankings

Key stakeholders were asked to select the top *two* social determinants of health in the community they serve. Table 2 indicates the selected determinants and the number of key stakeholders who ranked it as the top social determinant of health. See Appendix A for definitions. The top six social determinants of health are listed in detail. The remaining determinants are limited in the amount of information available.

Table 2. Social Determinants of Health Rankings

	2026 Count (n=34)	
	Top 2	Number 1
Safe and Affordable Housing	16	7
Access to Social Services (Welfare programs, Housing Assistance, etc.)	11	4
Accessible, Affordable and Quality Health Care	10	4
Economic Stability and Employment	8	7
Social Connectedness and Belonging	6	2
Food Insecurity	5	2
Family Support	3	3
Affordable Childcare	3	2
Racism and Discrimination	2	0
Accessible and Affordable Transportation	1	1
Community Violence and Crime	1	1
Environmental Health (Clean air, safe water, etc.)	0	0
Other Social Determinants of Health	2	1

General Themes

The top tier social determinant of health (SDOH) was safe & affordable housing. The next tier included access to social services and accessible, affordable & quality health care. The third tier included economic stability & employment; social connectedness & belonging; and food insecurity. Barriers/challenges that crossed multiple SDOHs included lack of affordable housing/housing instability, lack of accessible resources, high-cost burden of healthcare, financial instability, long wait list/timely care or lack of collaboration. Key partners included nonprofits, government agencies, collaborations/partnerships, employers, public sector/community centers and health care providers/systems. Populations to focus on varied somewhat, but people with low income crossed all SDOHs while minorities or people of color, people who were homeless, youth, the elderly or “everyone” crossed several. To improve the issues, more collaborating, more safe and affordable housing/ mixed-income housing, better communication/awareness of resources or increasing accessibility to resources were listed.

Top Social Determinants of Health Summaries

☑ Safe and Affordable Housing

Sixteen key stakeholders' interview rankings included safe and affordable housing as a top social determinant of health, and seven ranked it number one.

Existing Strategies: Safe and affordable housing/mixed-income housing was the most often cited existing strategy followed by collaborations/coalitions or nonprofit programs. Government services, social support agencies or keeping workers employed were listed next. Finally, accessibility of resources, funding, corporate buy-in, senior living facilities, housing that allows for long-term stability or landlord training were also listed as existing strategies. Lakeshore CAP, Section 8, St. Vincent de Paul, United Way, ARPA funds, Salvation Army, Economic Development Corporation, Habitat for Humanity, Partners for Community Development, Sunnyside and New Builds Growth Safely were specifically listed.

Barriers/Challenges Addressing Issues and Could Do Differently: Lack of affordable housing available was the most often cited barrier and challenge to address safe and affordable housing. Long wait list, financial instability, lack of finding accessible resources, lack of landlord accountability, a past eviction, or unmet criteria for state/federal programs were listed next. Poor quality of long-term care, lack of senior residential housing, lack of family support, fear of isolation, a criminal record, lack of funding or lack of collaboration were also listed as barriers/challenges. Safe and affordable housing/mixed-income housing was most often cited as what could be done differently followed by increasing awareness. More collaborating or government services were listed next. Finally, offering higher wages and benefits, more corporate buy-in, social support agencies, transitional/supportive housing to stabilize people before independent living, more pressure on landlords to keep up with safety codes, education to better understand housing needs or resolving issues such as conflict resolution/mediation were also listed as what could be done differently.

Additional Strategies Needed: More safe and affordable housing/mixed-income housing was the most often cited additional strategy needed followed by more collaborations. A needs assessment or government services were listed next. More funding, more corporate buy-in, increasing awareness of the housing needs, more nonprofit involvement, landlord training or education were also listed. Finally, increasing accessibility of resources, more affordability, flexible programming/competency-based education, increasing wages without losing benefits, incentivizing landlords and developers, city ordinance to set minimum monthly rental amount, housing that allows for long-term stability, following safety protocols, schools active as community participants or allowing nonresidents to seek county services were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included nonprofits followed by housing authority. Government agencies and public sector/community centers were listed next. Housing coalitions, employers, emergency shelters, landlords/property managers, economic development agencies/Chamber of Commerce, city planner/administrator and health care providers/systems were also listed. Finally, elected officials/government leaders, policymakers, realtors, financial institutions, neighborhoods/communities, public health department, adult living facilities, law enforcement, granting agencies/funding, the faith-based community, social workers and "everyone" were also listed as key partners. Lakeshore CAP, Salvation Army, Safe Harbor, St. Vincent de Paul and Uptown Socials were all specifically mentioned.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were households with low- to mid-income, near or below poverty level. People who were homeless or currently living in shelters or transitional housing, the elderly, the middle class, families or "everyone" were listed next. Finally, young adults, the middle-aged, young families, single adults/living alone, single parents, mothers, family

members of hospice patients, people with mental health issues, with chronic health condition, minorities or people of color, with cultural differences or who identify as LGBTQ+ were also listed populations.

One Major Effort to Improve Issue: Building more safe and affordable housing/mixed-income housing/ workforce housing was listed as a major effort to improve the issue. Expanding collaborations, transitional/ supportive housing to stabilize people before independent living, more nonprofit involvement or incentivize landlords to rent to vulnerable populations were listed next. Finally, more funding, a needs assessment, a comprehensive recovery campus/training center, understanding job skills that are needed and barriers to employment, offering higher wages and benefits, more corporate buy-in, developers taking a risk on people, senior living facilities, housing that allows for long-term stability, another year-round homeless shelter or schools active as community participants were also listed as major efforts to improve the issue.

☑ Access to Social Services

Eleven stakeholders' interview rankings included access to social services (welfare programs, housing assistance, etc.) as a top social determinant of health, and four ranked it number one.

Existing Strategies: Collaborations, government services or nonprofit programs were the most often cited existing strategies. Navigators, accessibility of resources or awareness were listed next. Mental health professionals with officers, community programs, social support agencies or safe and affordable housing/ mixed-income housing were also listed as existing strategies. Neighbors Together, LCHC and United Way were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: Lack of finding accessible resources was the most often cited barrier and challenge addressing access to social services followed by long wait list/timely care. A lack of affordable housing available or lack of collaboration of organizations who serve the same populations were listed next. Finally, financial instability, lack of transportation options, stigma, lack of access to mental health facilities/staff, lack of crisis stabilization center, closing of inpatient behavioral health services, people with criminal records, language/cultural barriers, a past eviction were also listed as barriers and challenges. More collaborating, transitional/supportive housing to stabilize people before independent living, increasing education or meeting people where they are at were cited as what could be done differently.

Additional Strategies Needed: More collaborating, navigators/connectors or safe and affordable housing/ mixed-income housing were the most often cited additional strategies needed followed by more funding. Finally, increasing accessibility of resources, crisis management, closed-loop referrals, alternative housing with communal space, universal housing terminology across all entities, more health care providers, several services in one location, parent/family involvement, community campaigns, education, meeting people where they are at or youth mentoring were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included government agencies followed by nonprofits. Public sector/community centers, health care providers/systems, public health department, law enforcement, collaborations/partnerships, emergency shelters and schools were listed next. Finally, multidisciplinary teams, community leaders, elected officials/government leaders, policymakers, housing authority, first responders, judicial system, granting agencies/funding, colleges/technical schools, social workers and "everyone" were also listed as key partners.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were households with low- to mid-income, near or below poverty level. People who were homeless or transient were listed next. Finally, underemployed/unemployed or underinsured/uninsured, the elderly, new parents,

single parents, families, people with mental health issues, with substance use disorders, who were victims of violence or minorities/people of color were also listed populations.

One Major Effort to Improve Issue: Expanding collaborations, having navigators, accessibility to resources or awareness of resources were listed as major efforts to improve the issue followed by utilizing technology or meeting people where they are at. Finally, providing a continuum of care, more funding, closed-loop referrals, safe and affordable housing/mixed-income housing, incentivizing landlords to rent to vulnerable population, transitional/supportive housing to stabilize people before independent living, rent-to-own model that includes building equity/education/support to become eligible for homeownership or more health care providers were also listed major efforts. Second Chance was specifically mentioned.

☑ Accessible, Affordable and Quality Health Care

Ten key stakeholders' interview rankings included accessible, affordable and quality health care as a top social determinant of health, and four ranked it number one.

Existing Strategies: Nonprofit programs were the most often cited existing strategy. Collaborations/coalitions, funding, government services, social support agencies, providers accept Medicare/Medicaid, bilingual translators/interpreters or meeting people where they are were listed next. Finally, navigators, a needs assessment, telehealth, mental health services, wellness call follow-ups, corporate buy-in, health care providers, free health care services/programs, volunteers, transportation options or rural reach programs were also listed as existing strategies. Federal Qualified Health Clinic, Lakeshore Community Health Care (Noble), ACA Medicaid expansion and Families and Neighbors Together were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: Financial instability was the most often cited barrier and challenge addressing accessible, affordable and quality health care. High-cost burden of health care, lack of insurance, lack of finding accessible resources, bad experiences/feeling judged, long wait list/timely care, poor access to health care, lack of facilities/staff or language/cultural barriers were listed next. Finally, health care doesn't accept all forms of insurance, long travel time, an increase in food pantry patrons, Medicare plans are not equitable, employers' lack of understanding of employees' financial struggles, stigma, too much misinformation, lack of funding or finding time to access care were also listed as barriers and challenges. Community campaigns or meeting people where they are were most often cited as what could be done differently. Affordability, a needs assessment, decreasing stigma, more mental health services, training, more health care providers, free screenings, timely care, increasing education or increasing rural reach were also listed as what could be done differently.

Additional Strategies Needed: Increasing the number of health care providers/staff was the most often cited additional strategy needed followed by more affordability or government services. Increasing accessibility of resources, increasing awareness, education, meeting people where they are at or more empathy were listed next. Finally, more funding, a needs assessment, increasing the number of mental health staff, increasing behavioral health services, nurse/clinic at place of employment, community programs, social support agencies, more safe and affordable housing/mixed-income housing, expanding health care entities, hospice/palliative care, several services in one location, community campaigns, pop up clinics or break the tradition of alcohol at all events were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included health care providers/ systems followed by nonprofits. Collaborations/partnerships, employers, public health department, schools, public sector/community centers, neighborhoods/communities and government agencies were listed next. Finally, community leaders, employees, emergency shelters, crisis workers, mental health providers,

hospice/palliative care, law enforcement, transportation services and the faith-based community were also listed as key partners.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were households with low- to mid-income, near or below poverty level. Youth, minorities/people of color or "everyone" were listed next. Finally, the underemployed/unemployed or underinsured/uninsured, people who lack health care knowledge or accessibility, teens, young adults, the middle-aged, families, hospice/palliative patients, people with mental health issues, with chronic health condition, with special needs/disabilities, who were homeless/transient, rural residents or anyone who is vulnerable were also listed populations.

One Major Effort to Improve Issue: Expanding collaborations or having navigators/connectors were listed as major efforts to improve the issue followed by increasing accessibility of health care resources or increasing awareness of resources. A needs assessment, decreasing stigma of receiving services, offering higher wages and benefits, having a nurse/clinic at place of employment, employee-assistance programs/employer-based clinics, more health care providers, stopping insurance from deciding high costs, free screenings, timely care, having bilingual translators/interpreters, increasing rural reach or more provider empathy were also listed as major efforts. Paradigm was specifically mentioned.

Economic Stability and Employment

Eight stakeholders' interview rankings included economic stability and employment as a top social determinant of health, and seven ranked it number one.

Existing Strategies: Collaborations/coalitions or nonprofit programs were the most often cited existing strategies. A needs assessment, government services or education were listed next. Accessibility of resources, funding, safe social groups, keeping workers employed, corporate buy-in, school/community gardens, community programs, healthy eating/healthy nutrition options, library programs, warming shelters, safe and affordable housing/mixed-income housing, food pantries or developing skills/support for long-term self-sufficiency were also listed existing strategies. Inspire Sheboygan, Economic Development Corporation, Business Education Partnership, Big Brothers Big Sisters, Salvation Army, Community Café and Meals on Wheels were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: Financial instability was the most often cited barrier and challenge addressing economic stability and employment. Basic needs not being met or lack of adequate transportation options were listed next. Finally, lack of job preparation/qualifications/training, poor pay, lack of childcare options, lack of equal job opportunities, lack of affordable housing available, temporary housing which leads to transportation or sustainability challenges, businesses not offering good insurance/ benefits or keeping employees as part time/hourly without benefits, stigma, mental health, people with criminal records, limited resources or lack of finding accessible resources were also listed as barriers and challenges. Offering higher wages and benefits were most often cited as what could be done differently. A needs assessment, trying new approaches or more safe and affordable housing/mixed-income housing were also listed as what could be done differently.

Additional Strategies Needed: A needs assessment or increasing awareness were the most often cited additional strategies needed. More corporate buy-in to support employees, more safe and affordable housing/mixed-income housing or increasing transportation options were listed next. Finally, more collaborations, flexible programming/competency-based education, providing longer childcare hours for shift workers, employee-assistance programs/employer-based clinics, social support agencies, policy changes, transitional/supportive housing to stabilize people before independent living or education were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included employers and nonprofits followed by collaborations/partnerships. Economic development agencies/Chamber of Commerce, elected officials/government leaders, government agencies and communication systems were listed next. Landlords/ property managers, crisis workers, mental health providers, people who recovered, substance use disorder providers, public sector/community centers, day center groups, libraries, food banks, public health department, the faith-based community and community advocates/advocacy groups and were also listed as key partners.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were households with low- to mid-income, near or below poverty level. Minorities or people of color were listed next. Finally, people living in low-income housing, sober housing, youth, the elderly, people with substance use disorders, with no transportation, refugees/immigrants, who identify as LGBTQ+, veterans, young professionals or "everyone" were also listed populations.

One Major Effort to Improve Issue: A needs assessment was listed as a major effort to improve the issue followed by more collaborating, affordability, offering higher wages and benefits or safe and affordable housing. Finally, having navigators/connectors, accessibility to resources, mental health residential treatment, general mental health services, understanding job skills needed and barriers to employment, keeping workers employed, policy changes, landlords accepting vouchers, more health care providers, community campaigns or education were also listed as major efforts.

☑ Social Connectedness and Belonging

Six stakeholders' interview rankings included social connectedness and belonging as a top social determinant of health, and two ranked it number one.

Existing Strategies: Safe social groups/third spaces, the YMCA or nonprofit programs were the most often cited existing strategies. Navigators/connectors, accessibility of resources, mental health screening/school-based services, community programs, fitness centers/working out, dedicated space for people over 50 to work out, positivity, promoting inclusion, libraries or schools active as community participants were also listed as existing strategies. LGBTQ Alliance, Veteran Services, American Legion, VFW, Uptown Generations and Uptown Socials were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: Social media's influence was the most often cited barrier and challenge addressing social connectedness followed by feelings of not belonging or limited free time to connect. Suicide ideation, lack of education around mental health care, lack of relationships, isolation during winter weather, lack of finding accessible resources, the "me first" mentality, lack of collaboration, technology/AI, lack of things to do or multiple interconnected social determinants of health were also listed barriers and challenges. More collaborating was the most often cited as what could be done differently. Decreasing alcohol as a cultural norm, safe social groups, peer coaching/recovery coaches/support groups or finding root causes were also listed as what could be done differently.

Additional Strategies Needed: More funding or increasing awareness were the most often cited additional strategies needed. Increasing accessibility of resources, trying new approaches, having safe social groups, more government services, phone free zones, promoting inclusion, less technology or a community center for young adults were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included neighborhoods/communities, communication systems, diverse and inclusive groups and nonprofits. Collaborations/partnerships, employers, Human Resources, youth programs, parents/families, schools, crisis workers, public sector/community centers,

service clubs, wellness programs, libraries, rec departments and safe third places were also listed as key partners.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were minorities or people of color followed by young adults or who identify as LGBTQ+. Households with low- to mid-income, near or below poverty level, youth, 20- to 40-year-olds, the middle-aged, the undiagnosed, refugees/ immigrants, people with intersecting identities, veterans or "everyone" were also listed populations.

One Major Effort to Improve Issue: Support of existing services was listed as a major effort to improve the issue. Increasing accessibility to resources, more funding, trying new approaches, having trained people who understand adverse childhood and community experiences, employee-assistance programs/employer-based clinics, increasing awareness, involving people with lived experiences, student programs or having a teen center were also major efforts listed.

Food Insecurity

Five key stakeholders' interview rankings included food insecurity as a top social determinant of health, and two ranked it number one.

Existing Strategies: Nonprofit programs were the most often cited existing strategy. Collaborations/coalitions, school nutrition programs, funding or community programs were listed next. Navigators/connectors, accessibility of resources, healthy eating/healthy nutrition options, government services, social support agencies, food assistance programs, health care providers, nutrition education, community events or developing skills/support for long-term self-sufficiency were also listed as existing strategies. Backpack lunches for weekends, WIC, Meals on Wheels, Connecting Café, Hope Café, HMMA and Nourish were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: Lack of finding accessible resources for rural residents or lack of collaboration were the most often cited barriers and challenges addressing food insecurity. Unhealthy food is easy/convenient/cheap, lack of adequate transportation options or geography were also listed barriers and challenges. More healthy eating/healthy nutrition options or nonprofit involvement were most often cited as what could be done differently. More collaborating, funding, policy changes, increasing awareness, more education or increasing rural reach were also listed as what could be done differently.

Additional Strategies Needed: Expanding collaborations, more funding, a needs assessment, school nutrition programs, community gardens, community programs, more healthy eating/healthy nutrition options or education were the most often cited additional strategies needed. Increasing accessibility of resources, more affordability, cultural appropriate foods for ethnic groups, policy changes or increasing awareness were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included collaborations/partnerships and nonprofits. Communication systems were listed next. Community leaders, elected officials/government leaders, policymakers, employers, schools, public sector/community centers, farmers, granting agencies/ funding and the faith-based community were also listed as key partners.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were households with low- to mid-income, near or below poverty level, youth or minorities/people of color. The elderly, 20- to 40-year-olds, young families, people with substance use disorders, who were homeless/transient or veterans were also listed populations.

One Major Effort to Improve Issue: Raising awareness was listed as a major effort to improve the issue followed by healthy food education. Expanding collaborations, involving people who have lived with food insecurity with those who support food programs, increasing empathy, reducing stigma, increasing accessibility to resources, daycare nutrition programs, school nutrition programs, community gardens, healthier eating/nutrition options in food programs, having bilingual translators/interpreters or promoting inclusion were also listed major efforts.

Remaining Social Determinants of Health

The remaining social determinants of health are listed below along with barriers/challenges addressing issues, key group partnerships to improve community health, populations to focus efforts and one major effort to improve the issue. Please be aware of the limited number of key stakeholders who listed these as one of their top two rankings.

☑ Family Support

Three stakeholders' interview rankings included family support as a top social determinant of health, and three ranked it number one.

Lack of collaboration, lack of awareness of accessible resources or lack of information were cited as barriers/ challenges. Collaborations, schools, mental health providers, inpatient and outpatient facilities, health care providers/systems, public health department, social services, first responders, government agencies and nonprofits were listed as top key partners. Family Resource Center, United Way, Community Partnership for Children, Family Connections, Mental Health America, Aging and Disability Resource Center (ADRC) were specifically identified as key partners. Populations to focus efforts on were youth, the sandwich generation, young families or "everyone." Expanding collaborations, increasing awareness of caregiver resources, increasing community awareness, a needs assessment to find root causes and develop community-informed solutions, more mental health services, decreasing stigma of asking for assistance, prevention work, more mental health and development screeners, expanding home visits, family involvement or parent education programs were listed as major efforts to improve the issue.

Affordable Childcare

Three stakeholders' interview rankings included affordable childcare as a top social determinant of health, and two ranked it number one.

High-cost burden, financial instability, few open daycare slots, poor pay, high operating costs for providers, high workforce turnover or financial support programs ending soon were cited as barriers/challenges. Employers, economic development agencies/Chamber of Commerce, childcare providers, schools, community organizations, public health department, government agencies, the faith-based community, granting agencies/funding and nonprofits were listed as top key partners, with Community Partnership for Children specifically mentioned. Populations to focus efforts on were households with low- to mid- income or near/below poverty level, families or "everyone." Expanding collaborations, offering higher wages/benefits to childcare employees, financial support for people who need childcare services, a needs assessment or a community-wide childcare system with integrated services were listed as major efforts to improve the issue.

Racism and Discrimination

Two stakeholders' interview rankings included racism and discrimination as a top social determinant of health, and zero ranked it number one.

Lack of collaboration, too much responsibility put on schools or small groups to teach diversity/inclusion or lack of knowledge in creating community inclusion were cited as barriers/challenges. Community advocates/ advocacy groups and nonprofits were listed as top key partners. Populations to focus efforts were minorities or people of color, who identify as LGBTQ+, people with intersecting identities, who were transgender or "everyone." Increasing accessibility to resources, trying new approaches, building it into the county's strategic plan or a needs assessment were listed as major efforts to improve the issue.

☑ Accessible and Affordable Transportation

One stakeholder's interview ranking included accessible and affordable transportation as a top social determinant of health, and they ranked it number one.

Not enough local options and no extended area options were listed as a barrier/challenge. Populations to focus efforts were the elderly or people with special needs/disabilities. Expanding transportation options, more funding or volunteers were listed as major efforts to improve the issue.

Community Violence and Crime

One stakeholder's interview ranking included community violence and crime as a top social determinant of health, and they ranked it number one.

Loss of funding, crimes with technology, school delinquency, staffing changes/turnover in nonprofits, judicial system or law enforcement were cited as barriers/challenges. Employers, landlords, health care providers/ systems, law enforcement, judicial system and nonprofits were listed as top key partners. Safe Harbor was specifically mentioned as a key partner. Populations to focus efforts were youth, employers, employees or economic development agencies/Chamber of Commerce. Increasing awareness for children on what a safe environment looks like, youth mentoring, more support for teachers, defining healthy relationships or decreasing truancy were listed as major efforts to improve the issue.

B. Health Conditions/Behaviors Rankings

Key stakeholders were asked to select the top *two* health conditions/behaviors in their service area. Table 3 indicates the conditions/behaviors that were selected as well as the number of key stakeholders who selected it as the top condition/behavior. See Appendix B for definitions. The top four health conditions/behaviors are listed in detail. The remaining conditions/behaviors are limited in the amount of information available.

Table 3. Health Conditions/Behaviors Rankings

	2026 Count (n=34)	
	Top 2	Number 1
Mental Health and Mental Conditions (Anxiety, Depression)	30	21
Alcohol Use and Abuse (Underage Drinking, Binge Drinking, DWI)	10	7
Drug Use and Abuse (Prescription Drug Misuse, Street Drug Use including Marijuana, Cannabis, Delta8 and Weed)	7	1
Chronic Diseases (Diabetes, Heart Disease)	5	0
Nutrition and Healthy Eating	3	1
Physical Activity and Exercise	3	0
Suicide	3	0
Dementia and Alzheimer's Disease	1	1
Sexually Transmitted Infections (including HIV)	1	1
Unintentional Injuries (Falls, Motor Vehicle Crashes, Poisoning)	1	1
Asthma and Other Breathing Issues	0	0
Cancer	0	0
Cigarette Smoking and Other Tobacco Use	0	0
Infant Mortality	0	0
Infectious Diseases (West Nile Virus, Tuberculosis, Measles, COVID-19)	0	0
Lead Poisoning	0	0
Oral Health	0	0
Vaping/Juuling and E-Cigarette Use	0	0
Other Health Concern or Behavior	4	1

General Themes

The top tier health condition/behavior was mental health & mental conditions (anxiety, depression). The next tier was alcohol use & abuse (underage drinking, binge drinking, DWI). The third tier included drug use & abuse (prescription drug misuse, street drug use including marijuana, cannabis, Delta8 and weed) and chronic diseases. Barriers/challenges across several health conditions/behaviors included stigma or long wait list/timely care. Key partners included nonprofits, health care providers/systems, mental health providers, government agencies, behavioral health providers and schools. Youth, "everyone" or people with low income were listed as the most affected populations in several health conditions/behaviors. To improve the issues, increasing accessibility to resources, increasing awareness, education, collaborations/coalitions, increasing the number of mental health providers or more provider empathy were listed.

Top Health Conditions/Behaviors Summaries

☑ Mental Health and Mental Conditions

Thirty key stakeholders' interview rankings included mental health and mental conditions (anxiety, depression) as a top health condition/behavior, and 21 ranked it number one.

Existing Strategies: Mental health services, although not enough, were the most often cited existing strategy followed by nonprofit programs. Mental health screening/school-based services, having a mental health professional with officers, government services, awareness programs, collaborations/coalitions, accessibility of resources or 24/7 availability of mental health care were listed next. Stigma reduction, behavioral health services, employee-assistance programs/employer-based clinics, telehealth, substance abuse outpatient care, education, mental health professional in emergency department, safe social groups, peer coaching/recovery coaches/support groups, community programs, health care providers or offering empathy were also listed. Finally, funding, mental health insurance coverage, early intervention, corporate buy-in, accepting Medicare/ Medicaid, encouraging routine health care visits/preventive care, hospice/palliative care, curtailing social media, increasing positivity, promoting inclusion or meeting people where they are at were also listed as existing strategies. Mental Health America, United Way PATH, Boys & Girls Club, LCHC, Rogers Behavioral Health, Youth Mental Health Network, ARPA funding, HSHS and 988 were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: Lack of access to facilities/staff was the most often cited barrier and challenge to address mental health. Long wait list/timely care for mental health was listed next followed by stigma, health insurance barriers, lack of knowledge of where to go for help or the closing of inpatient behavioral health services. Lack of education around mental health care, lack of crisis stabilization center, high-cost burden of mental health care, language/cultural barriers, lack of finding accessible resources or lack of collaboration were also listed. Finally, high-cost burden of health care, long travel time, homelessness, lack of affordable housing available, unemployment, suicide ideation, mental health provider doesn't accept Medicaid/Medicare, lack of long-term mental health facilities, social drivers of mental health, lack of mental health professional with law enforcement, fractured relationships, lack of family support, social media influence, lack of funding, technology/AI, limited personal time or denial were also listed as barriers and challenges. More mental health providers were most often cited as what could be done differently. Having navigators, increasing accessibility to resources, making mental health care more affordable, more funding, a needs assessment, more outpatient care, mental health screening/school-based services, crisis management, increasing 24/7 mental health services, safe social groups, peer coaching/recovery coaches/ support groups, training, early intervention, increasing awareness, transitional/supportive housing to stabilize people before independent living, more education, incentives to go into the profession or increasing rural reach were also listed as what could be done differently.

Additional Strategies Needed: More mental health providers were the most often cited additional strategy needed followed by expanding collaborations. Increasing accessibility of resources, more funding, decreasing stigma, more mental health services or increasing awareness were listed next. More mental health screening/ school-based services, having trained people who understand adverse childhood and community experiences, education, professional incentives, meeting people where they are at, a needs assessment, crisis management, family counseling, training, community programs, health care providers, parent/family involvement, community campaigns or student programs were also listed. Finally, more affordability, supporting existing services, including mental health in health care screening, telehealth, law enforcement de-escalation, 24/7 availability of mental health care, more mental health insurance coverage, sober housing environment, safe social groups, finding the root cause, early intervention, more corporate buy-in, employee-assistance programs/employer-based clinics, walking paths/parks/recreation, keeping active, healthy eating/healthy nutrition focus, government services, nonprofit programs, timely care, involving people with lived experiences,

more mental health support for young children, social media limitations, parent programs, community events, schools active as community participants, more provider empathy, more case managers or more advocacy were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included nonprofits and health care providers/systems followed by mental health providers. Behavioral health providers, government agencies, schools and crisis workers were listed next. Collaborations/partnerships, employers, law enforcement, elected officials/government leaders, public health department, communication systems, substance use disorder providers, first responders and the faith-based community were also listed. Finally, policymakers, youth/teens, parents/families, neighborhoods/communities, granting agencies/funding, community advocates/advocacy groups, social workers and "everyone" were also listed as key partners. Mental Health America, United Way PATH, Rogers Behavioral Health, Rainbow Kids, Family Resource Center, Elevate and HSHS were specifically mentioned.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were "everyone" followed by youth. Households with low- to mid-income, near or below poverty level were listed next. People who were elderly, families, parents, with mental health issues, minorities/people of color or rural residents were also listed. Finally, people living in low-income housing, teens, mothers, males, people with intersecting identities, who are transgender, nonprofit staff or employers were also listed populations.

One Major Effort to Improve Issue: Increasing accessibility to resources was listed as a major effort to improve the issue. Increasing the number of mental health providers or expanding collaboration were listed next. Decreasing stigma, increasing awareness, timely care, more funding, increasing mental health services, 24/7 availability or group homes for mentally ill residents were listed next. Finally, navigators, focusing on a continuum of care, supporting existing services, trying new approaches, increasing mental health residential treatment, increasing mental health inpatient care, mental health screening/school-based services, having a mental health professional with officers, crisis management, low-barrier mental health stabilization center, professional training, early intervention, more non-medication help, nonprofit involvement, universal health care, free screenings, early prenatal care, community campaigns, education or more provider empathy were also major efforts listed.

☑ Alcohol Use and Abuse

Ten key stakeholders' interview rankings included alcohol use and abuse (underage drinking, binge drinking, DWI) as a top health condition/behavior, and seven ranked it number one.

Existing Strategies: Government services, awareness programs, criminal justice system involvement or education were the most often cited existing strategies followed by collaborations/coalitions, accessibility of resources, substance abuse outpatient care, peer coaching/recovery coaches/support groups, prevention work, community programs, nonprofit programs or community campaigns. Finally, safe social groups, decreasing stigma, early intervention, warming shelters, non-alcoholic drinks are becoming trendy or offering alternatives to incarceration were also listed as existing strategies. Drug Court, Mental Health America, Samaritan, Lighthouse, Underage Drinking Task Force and Response Substance Use Team were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: It's part of culture was the most often cited barrier and challenge addressing alcohol use and abuse. Too many bars, stigma of needing help, difficulty of addiction or easy product availability were listed next. Mental health, long wait list/timely care for mental health, high-cost burden of care or lack of buy-in of the problem were also listed as barriers and challenges. Increasing awareness or more education of the problems of alcohol were most often cited as what could be done differently. A needs assessment, changing the attitude that alcohol is a cultural norm, restricting/

reducing alcohol access, dry social groups, promoting alternatives or breaking culture traditions/beliefs were also listed as what could be done differently.

Additional Strategies Needed: Increasing awareness or breaking cultural norms of alcohol were the most often cited additional strategies needed followed by more mental health services, dry social groups, more nonprofit involvement or education. Finally, increasing accessibility of resources, crisis management, behavioral health services, having trained people who understand adverse childhood and community experiences, family counseling, lower bar density, peer coaching/recovery coaches/support groups, trending non-alcoholic drinks alternatives, addressing vaping, having accessible tools for personal use to test for impairment, involving social support agencies, criminal justice system, people with lived experiences, more mental health support for young children, social media limitations, community campaigns, promoting alternatives or more advocacy were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included restaurants/bars and nonprofits. Support groups or health care providers/systems were listed next. Collaborations/partnerships, economic development agencies/Chamber of Commerce, emergency shelters, behavioral health providers, treatment facilities, people who recovered, substance use disorder providers, tavern league, neighborhoods/ communities, public health department, law enforcement, judicial system, government agencies and communication systems were also listed as key partners.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on was youth. "Everyone" was listed next. Households with low- to mid-income, near or below poverty level, teens, young adults, the middle-aged, the elderly, families, people who were homeless/transient or college students were also listed populations.

One Major Effort to Improve Issue: Increasing awareness was listed as a major effort to improve the issue followed by increasing accessibility to resources or more education. A needs assessment, more mental health services, providing safe social groups, having accessible tools for personal use to test for impairment, transitional/supportive housing to stabilize people before independent living, involving the criminal justice system, breaking cultural norms or advocacy were also mentioned as major efforts.

☑ Drug Use and Abuse

Seven key stakeholders' interview rankings included drug use and abuse (prescription drug misuse, street drug use including marijuana, cannabis, Delta8 and weed) as a top health condition/behavior, and one ranked it number one.

Existing Strategies: Collaborations/coalitions, peer coaching/recovery coaches/support groups, offering incarceration alternatives, government services, nonprofit programs or criminal justice system involvement were the most often cited existing strategies. Substance abuse residential treatment facilities, outpatient care, awareness programs, health care providers, parent/family involvement or education were also listed as existing strategies. Drug Endangered Children Protocol, Lighthouse Recovery and Pathways were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: Stigma, people's lack of substance abuse knowledge/education or lack of finding accessible resources were the most often cited barriers and challenges addressing drug use and abuse. Lack of access to facilities/staff, the difficulty of addiction or being involved in the criminal justice system were also listed as barriers and challenges. Increasing the number of substance use disorder services was most often cited as what could be done differently. Increasing accessibility to resources or community campaigns were also listed as what could be done differently. DARE or Say No to Drugs were specifically mentioned.

Additional Strategies Needed: Education was the most often cited additional strategy needed. Increasing accessibility of resources, decreasing stigma, 24/7 availability of substance abuse care, prevention work, offering alternatives to incarceration or increasing awareness of the problem were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included nonprofits followed by schools, treatment facilities, support groups, neighborhoods/communities and government agencies. Mental health providers, behavioral health providers, health care providers/systems, law enforcement, judicial system, communication systems, the faith-based community and professionals were also listed as partners. Lighthouse Recovery, Rogers Behavioral Health and Samaritan Hands were specifically mentioned.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were households with low- to mid-income, near or below poverty level or teens. Youth, the middle-aged, minorities/ people of color or "everyone" were also listed populations.

One Major Effort to Improve Issue: Increasing awareness was listed as a major effort to improve the issue followed by more professional empathy. Increasing accessibility to resources, increasing the number of substance abuse residential treatment facilities as well as substance abuse providers, finding the root cause for substance abuse, community campaigns, education or schools active as community participants were also mentioned as major efforts.

☑ Chronic Diseases

Five key stakeholders' interview rankings included chronic diseases as a top health condition/behavior, and zero ranked it number one.

Existing Strategies: Healthy eating/healthy nutrition education was the most often cited existing strategy followed by prevention work, community programs, nonprofit programs or timely care. Collaborations, telehealth, substance use disorder services, support groups, health insurance coverage, nurse/clinic at place of employment, employee-assistance programs/employer-based clinics, school nutrition programs, wellness incentives, keeping active, dedicated space for people over 50, health care providers or encouraging routine health care visits/preventive care were also listed as existing strategies. Nourish, UW-Extension, the Rec Department, Meals on Wheels greenhouse and Nourish were specifically mentioned.

Barriers/Challenges Addressing Issues and Could Do Differently: High-cost burden of health care, convenient and unhealthy food is easier than preparing healthy food, lack of education around nutrition/physical activity or lack of collaboration were the most often cited barriers and challenges addressing chronic diseases. Unhealthy lifestyles, poor access to health care, financial instability, lack of transportation options or unsafe neighborhoods were also listed as barriers and challenges. Patient-centered aftercare, prevention work, more non-medication help, farmers market, increasing awareness or more provider empathy were most often cited as what could be done differently.

Additional Strategies Needed: Expanding collaborations, a needs assessment or more healthy eating/healthy nutrition options were the most often cited additional strategies. Increasing accessibility of resources, support groups, prevention work, early intervention, community programs, keeping active, social support agencies, increasing awareness, more safe and affordable housing/mixed-income housing, encouraging routine health care visits/preventive care, increasing the number of health care providers/staff needed, involving people with lived experiences, education, increasing transportation options or meeting people where they are at were also listed as additional strategies needed.

Key Group Partnerships to Improve Community Health: Top key partners included health care providers/ systems and nonprofits followed by government agencies. Schools, neighborhoods/communities, farmers and public health department were listed next. Finally, collaborations/partnerships, youth/teens, caregivers, mental health providers, adult living facilities, first responders, affected persons, the faith-based community, community advocates/advocacy groups and colleges/technical schools were also listed as key partners.

Subgroups or Populations to Focus Efforts: The most often cited populations to focus efforts on were youth. Households with low- to mid-income, near or below poverty level, the middle-aged or the elderly were listed next. People who were homeless/transient, 20- to 40-year-olds, minorities or people of color, people with cultural differences, rural residents or all vulnerable populations were also listed populations.

One Major Effort to Improve Issue: More affordability was listed as a major effort to improve the issue followed by healthy eating/health nutrition options, free screenings or more education. Prevention work, early intervention, keeping active, government services, encouraging routine health care visits, community campaigns, meeting people where they are at or more provider empathy were also mentioned as major efforts.

Remaining Health Conditions/Behaviors

The remaining health conditions/behaviors are listed below along with barriers/challenges addressing issues, key group partnerships to improve community health, populations to focus efforts and one major effort to improve the issue. Please be aware of the limited number of key stakeholders who listed these as one of their top two rankings.

☑ Nutrition and Healthy Eating

Three key stakeholders' interview rankings included nutrition and healthy eating as a top health condition/ behavior, and one ranked it number one.

Economic stability, limited accessibility and affordability of nutritious and fresh food, lack of transportation or FoodShare policy changes in work hours and refugee status were cited as barriers/challenges. Elected officials/ government leaders, nonprofits, collaborations/partnerships, employers, schools, grocery stores, health care providers/systems, community-based organizations and transportation services were listed as top key partners. Populations to focus efforts were households with low- to mid-income, near or below poverty level, youth, the elderly, mothers, minorities/people of color or veterans. Expanding collaborations, more affordability, an economic stability needs assessment with coordinated and structural solutions, trying new approaches, decreasing stigma, finding root cause of poverty, promoting community gardens, policy changes, increasing awareness, community campaigns or advocacy were listed as major efforts to improve the issue.

☑ Physical Activity and Exercise

Three key stakeholders' interview rankings included physical activity and exercise as a top condition/behavior, and zero ranked it number one.

Limited access to physical activities, lack of self-motivation, amount of personal time needed, lack of physical activity, want a pill to fix health issues, lack of awareness, limited income for memberships, seasonal issues, decrease in vaccination rates or lack of employer wellness incentives were cited as barriers/challenges. Nonprofits, collaborations/partnerships, employers, schools, YMCA, private gyms/fitness centers, service clubs, health care providers/systems, insurance companies, the faith-based community, farmers markets, United Way and colleges/technical schools were listed as top key partners. Populations to focus on were youth, the middle-aged, the elderly or veterans. Collaborations, support of existing services, increasing awareness, increasing

accessibility to resources, a needs assessment, education, more nonprofit involvement, community campaigns, education, employee-assistance programs/employer-based clinics, wellness incentives or keeping active were listed as major efforts to improve the issue.

Suicide

Three key stakeholders' interview rankings included suicide as a top condition/behavior, and zero ranked it number one.

Lack of access to facilities/staff, stigma, lack of voluntary care sites, stigma towards minorities or stigma for asking for help were cited as barriers/challenges. Collaborations/partnerships, crisis workers, mental health providers, behavioral health providers, support groups, substance use disorder providers, health care providers/ systems, affected persons and nonprofits were listed as top key partners. Mental Health America, LCHC, Rogers and Elevate were specifically listed partners. Populations to focus on were youth, young children, people with intersecting identities, transgender or "everyone." Increasing the number of mental health providers, decreasing stigma, increasing awareness or education were listed as major efforts to improve the issue.

Dementia and Alzheimer's Disease

One key stakeholder's interview ranking included dementia and Alzheimer's disease as a top condition/ behavior, and they ranked it number one.

Caregiver denial, early diagnosis is challenging, Medicare guidelines or stigma were cited as barriers/challenges. Collaborations/partnerships, health care providers/systems, government agencies and advocacy groups were listed as top key partners. Populations to focus on were 30- to 50-year-olds. Increasing awareness, support of Walk to End Alzheimer's and Dementia Care Network were listed as major efforts to improve the issue.

Sexually Transmitted Infections

One key stakeholder's interview ranking included sexually transmitted infections, including HIV, as a top condition/behavior, and they ranked it number one.

Communication with patients or lack of awareness were cited as barriers/challenges. Neighborhoods/ communities and the public health department were listed as top key partners. Populations to focus on were affected persons or people who do not know how easy testing is. Increasing accessibility to resources as well as increasing awareness were listed as major efforts to improve the issue.

Unintentional Injuries

One key stakeholder's interview ranking included unintentional injuries as a condition/behavior, and they ranked it number one.

Staffing challenges in assisted living facilities or lack of knowledge about falls were cited as barriers/challenges. Volunteers or education about risks of falls/injuries were cited as what could be done differently. Day center groups, nonprofits and health/fitness clubs were listed as top key partners. Populations to focus efforts on were the elderly. Physical strengthening and education about risks of falls/injuries were listed as major efforts to improve the issue.

C. Additional Questions/Comments

Key stakeholders were asked to provide any additional comments.

Additional Comments

One key stakeholder reported there is a reoccurring theme/cycle of employment, housing stability and mental health or substance use and abuse. Two key stakeholders mentioned that efforts towards the unhoused population should meet them where they are at. The Salvation Army, warming centers and YMCA were specifically mentioned as perfect opportunities for more resources and outreach to connect them to services.

One key stakeholder mentioned that currently some people are not seen or heard and are considered a community burden and met with stigma and prejudice. Finally, a key stakeholder stressed the importance of normalizing and talking about death and advanced care planning to have the tools and resources when needed.

Appendix A: Social Determinants of Health Definitions

Accessible and Affordable Transportation: This category focuses on ensuring all individuals have reliable means to reach essential services, employment opportunities, and engage in their communities.

Accessible, Affordable and Quality Healthcare: This category emphasizes the importance of ensuring that healthcare services are accessible to all individuals, regardless of their socioeconomic status, and that healthcare costs are affordable and not a barrier to receiving necessary medical care, and emphasizes the importance of providing high-quality healthcare services that meet established standards, ensuring effective treatments, patient safety, and positive health outcomes.

Access to Social Services: This category focuses on ensuring individuals have equitable access to a range of social services like welfare programs, counseling, housing assistance, and support networks to address their needs.

Affordable Childcare: This category centers around the availability and affordability of quality childcare services, including early childhood education, to support working parents and ensure the well-being and development of young children.

Community Violence and Crime: This category addresses the prevention of community violence and crime, focusing on strategies such as community policing (developing relationships with community members), crime prevention programs, and fostering safe and supportive neighborhoods.

Economic Stability and Employment: This category focuses on promoting economic stability by ensuring employment opportunities, livable wages, job training programs, and social safety nets to reduce financial insecurity and its impact on health.

Environmental Health (Clean Air, Safe Water, Etc.): This category addresses the importance of a clean and safe environment, including access to clean air, safe drinking water, waste management, and the mitigation of environmental hazards.

Family Support: This category recognizes the significance of providing support systems and resources to families, including parenting education, childcare assistance, financial aid, and programs that strengthen family bonds.

Food Insecurity: This category addresses the issue of insufficient access to nutritious food, highlighting the importance of ensuring individuals and communities have consistent access to affordable and healthy food options.

Racism and Discrimination: This category recognizes the negative impact of racism and discrimination on health and well-being, highlighting the importance of promoting equality, combating systemic racism, and fostering inclusive communities.

Safe and Affordable Housing: This category emphasizes the importance of safe and affordable housing options, addressing homelessness, housing discrimination, and housing-related health risks to promote stable and healthy living environments.

Social Connectedness and Belonging: This category recognizes the significance of social connections, community engagement, and a sense of belonging in promoting mental and physical well-being, and it focuses on initiatives that foster social support networks and reduce social isolation.

Appendix B: Health Conditions/Behaviors Definitions

Alcohol Use and Abuse: Refers to the excessive or problematic consumption of alcohol and related consequences like underage drinking, binge drinking or driving while intoxicated.

Asthma and Other Breathing Issues: Relates to airway inflammation and tightening, shortness of breath and coughing as chronic conditions due to factors such as allergens, irritants, infections and pollutants.

Cancer: A disease defined by uncontrollable cell growth with potential spread to other parts of the body.

Chronic Diseases: Denotes long-term medical conditions that typically progress slowly and persist over an extended period, such as heart disease and diabetes.

Cigarette Smoking and other Tabacco Use: Encompasses the use and addiction to tobacco products such as cigarettes, cigars, and chewing tobacco.

Dementia and Alzheimer's Disease: Refers to conditions resulting in gradual decline in memory or complete memory loss that impacts cognition and affects daily living.

Drug Use and Abuse: Relates to the excessive or misuse of substances in amounts or by methods that are harmful to the individual.

Infant Mortality: Refers to issues related to difficult pregnancies or childbirth, and the postpartum period that affects the health and development of infants before their first birthday.

Infectious Diseases: Encompasses diseases that can be transmitted from one person to another, or from an animal to a person, or from a surface or food, such as measles, West Nile, COVID-19 or salmonella.

Lead Poisoning: Pertains to acute or chronic absorption of lead into the body.

Mental Health and Mental Conditions: Relates to emotional, psychological, and behavioral well-being, including conditions such as depression, anxiety and bipolar disorder.

Nutrition and Healthy Eating: Refers to dietary choices associated with foods that provide essential nutrients to maintain or improve overall health.

Oral Health: Pertains to the overall health and well-being of the mouth, teeth, and gums, including practices like regular brushing, flossing, and dental check-ups.

Physical Activity and Exercise: Defined as bodily movement that expends energy through structured and repetitive movement.

Sexually Transmitted Infections: Refers to infections or diseases spread from one individual to another through sexual activity.

Suicide: Refers to the act of intentionally taking one's own life.

Unintentional Injuries: Encompasses injuries that occur without intent, such as falls, motor vehicle crashes or accidental poisoning.

Vaping/Juuling and E-Cigarette Use: Denotes the use and addiction to inhaling vapors emitted from electronic smoking devises.

Appendix C: Key Stakeholder List

Organization	Title	Name
Anchor of Hope Health Center	Jacky Drewry & Liz Hildebrandt	CEO & Nurse Manager
Big Brothers Big Sisters Shoreline	Denise Wittstock	Chief Executive Officer
Boys & Girls Club of Sheboygan	Christina Singh	CEO
City of Sheboygan Fire Department	Michael Lubbert	Assistant Chief
Family Connections	Michelle Christus	CCR&R Program Director
Family Resource Center	Kristin Cooper	Executive Director
Fresh Meals on Wheels	Allison Thompson	CEO
Growing Generations - Sheb Human Rights Association	Melanie Dippel	Director
Head Start	Amanda Nagle	Family Development Manager
Lakeshore CAP	Colleen Homb	Executive Director
Lakeshore College	Tanya Boman	VP of Student Services
Lakeshore Community Health Care (Noble Clinics)	Tiffany Chamberlain - Post	Clinic Site Manager
Mental Health America	Julie Preder	Executive Director
Partners for Community Development	Karin Kirchmeier	Chief Executive Officer
Planned Parenthood of Wisconsin	Jeremy Stephany	Center Manager
Random Lake School District	Michael Trimberger	Superintendent
Rogers Behavioral Health	Keagan Rhynas	Director Of Operations
Salvation Army	Krysta Berger	Director of Social Services
Sharon S. Richardson Hospice	Charmaine Conrad	Chief Operating Officer
Sheboygan Area School District	Jacob Konrath	Superintendent
Sheboygan County	Craig Stewart	Director, Veterans Services
Sheboygan County	Joel Urmanski	District Attorney
Sheboygan County Administration	Alayne Krause	County Administrator
Sheboygan County Chamber of Commerce	Deidre Martinez	Chief Executive Officer
Sheboygan County Department of Health & Human Services	Sarah Mueller	Child & Family Services Manager
Sheboygan County Food Bank	Patrick Boyle	Executive Director
Sheboygan County Health & Human Services	Matthew Strittmater	Department Director
Sheboygan County Interfaith Organization	Lisa Stephan	Executive Director
Sheboygan County LGBTQ Alliance	Jamie Smidt	Steering Council Member
Sheboygan County Medical Examiner's Office	Desarae Rohde	Medical Examiner
Sheboygan County YMCA	Mike Gustafson and Matt Mueller	CEO and Branch Director
Sheboygan Housing Authority	Melody Hermann	Executive Director
Sheboygan Police Department	Kurt Zempel	Chief of Police
Sheboygan Sheriff Department	Matthew Spence	Sheriff