

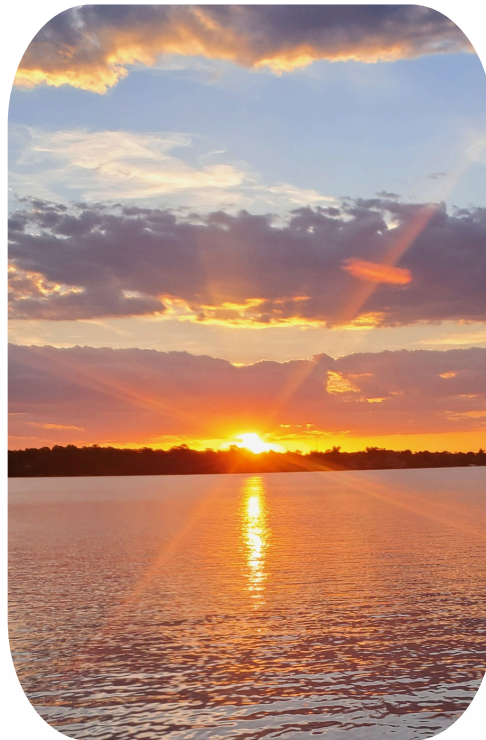
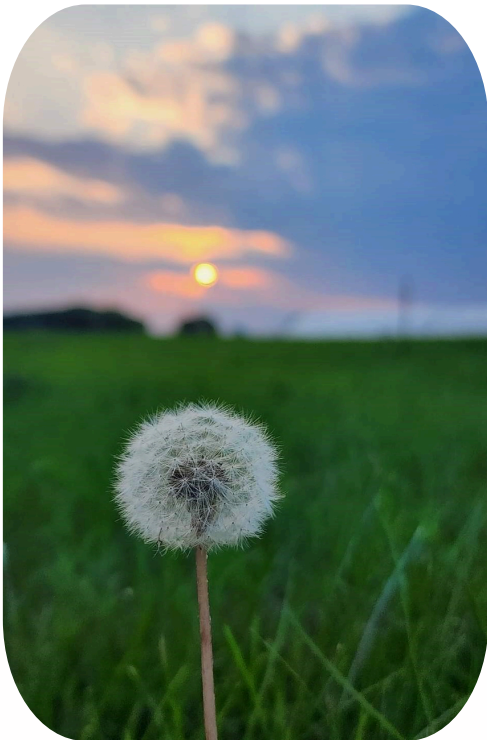
HORIZON



Public Health
Prevent. Promote. Protect.

H O R I Z O N P U B L I C H E A L T H **ANNUAL REPORT**

2 0 2 4



Serving:

Douglas, Grant, Pope,
Stevens, and Traverse Counties

LETTER FROM THE ADMINISTRATOR



It is my pleasure to present the 2024 Annual Report for Horizon Public Health. This report reflects our ongoing efforts, the challenges we've faced, and the progress we've made over the past year as we worked to protect and promote the health and well-being of our community.

Public health is a collective endeavor, and this year once again underscored the importance of strong partnerships, community engagement, and a dedicated team. From providing essential services—such as immunizations, maternal and child health programs, and environmental health inspections—to supporting individuals in living their healthiest lives, reducing youth substance use, or supporting a family in their end-of-life journey, our department remained committed to improving the lives of all residents in Douglas, Grant, Pope, Stevens, and Traverse Counties.

Among the many highlights in this year's report, we are proud to share the progress made across each of our program areas and in advancing our Community Health Improvement Plan (CHIP) priorities: increasing access to care, improving mental well-being and reducing substance misuse, and addressing chronic disease risk factors. At the heart of our efforts is a commitment to data-informed decisions and continuous improvement, guided by community feedback.

As we look ahead, our focus remains on building a healthier, more resilient community. We are deeply grateful for the support of our community members, local leaders, healthcare partners, and the dedicated public health staff who make this work possible.

Thank you for taking the time to review this report. We welcome your feedback and invite you to stay engaged with us. Here's to a future filled with good health and continued progress!

Warm regards,

A handwritten signature in black ink that reads "Ann E. Stehn". The signature is fluid and cursive.

ANN STEHN, EMPA, PHN
ADMINISTRATOR

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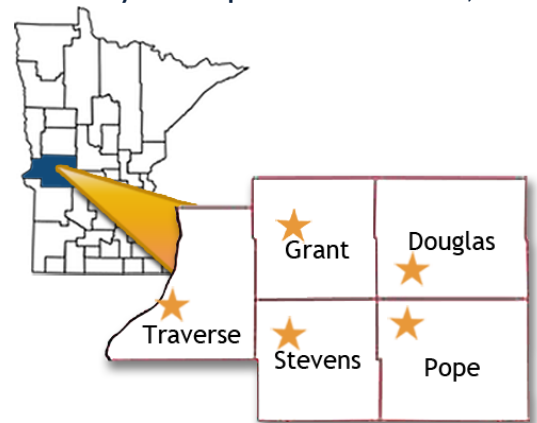
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MISSION, VISION, AND GUIDING PRINCIPLES

This annual report serves as a comprehensive reflection of our successes, the impactful programs we've implemented, and the exceptional work carried out by our dedicated teams. We invite you to delve into the pages of this document, not only to gain insights into the dynamic landscape of public health but also to join us in celebrating the achievements of our teams. Your support and engagement are invaluable as we collectively champion a healthier, more resilient community for all.

Vision

To have healthy and resilient communities in Douglas, Grant, Pope, Stevens, and Traverse Counties.



Horizon Public Health offers a wide variety of programs and services designed to enhance the health and well-being of individuals, families and communities in our five-county service area.

Mission

To promote, protect, and improve the health and well-being of all people in our communities.

Guiding Principles

- Collaboration:**
Building and nurturing individual and community partnerships.
- Inclusion:**
Cultivating and supporting a sense of belonging for all people.
- Integrity:**
Serving our communities with dignity, compassion, and quality.
- Innovation:**
Improving the public's health using science, best practices, and community wisdom.

ACCREDITATION, PERFORMANCE MANAGEMENT AND COMMUNITY ENGAGEMENT

Accreditation

In February 2021, Horizon Public Health became a fully accredited health department through the Public Health Accreditation Board (PHAB). This recognition affirms our commitment to delivering the 10 Essential Public Health Services, maintaining a strong organizational infrastructure, and promoting systems and conditions that support optimal health for all. Accreditation reflects our dedication to continuous quality improvement, evidence-based practices, and ensuring our services meet the needs of our communities effectively and equitably.



Using Results-Based Accountability to Measure Performance and Drive Impact

In 2024, Horizon Public Health fully integrated Results-Based Accountability (RBA) into both our Community Health Improvement Plan (CHIP) and internal performance measures. This framework strengthens our ability to make data-driven decisions, increase transparency, and advance equity, while supporting our ongoing compliance with PHAB standards.



Through RBA, Horizon Public Health:

- Defines clear outcomes to align efforts with measurable goals.
- Tracks progress using both quantitative and qualitative data, including disaggregated data to identify health disparities.
- Focuses on the impact of our work, not just activities.
- Engages partners and residents in co-creating solutions that foster community well-being.
- Ensures continuous improvement through an adaptable, living CHIP.

Progress on our CHIP priorities—including mental health, substance use, and overall well-being—is transparently tracked through our public-facing Clear Impact Scorecard, available on our website. This tool allows both the community and internal teams to monitor results in real-time, reinforcing accountability and trust while guiding timely adjustments to strategies.

Enhancing Transparency & Accountability

By embedding Results Based Accountability into performance management, Horizon Public Health demonstrates continuous quality improvement, evidence-based decision-making, and transparency—key elements of PHAB accreditation. The [Clear Impact Scorecard](#), available on our website, tracks progress on critical health issues such as mental health, substance use, and overall well-being. By reinforcing accountability, fostering community trust, and driving measurable health improvements, it also ensures ongoing alignment with national public health standards.

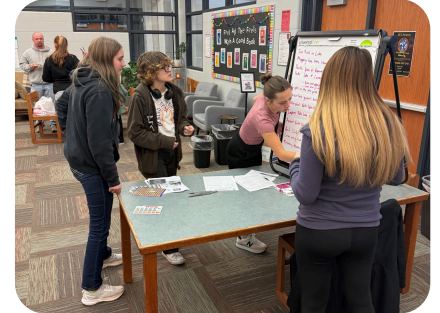
[CLICK HERE](#)

**Clear Impact
Scorecard**

ACCREDITATION, PERFORMANCE MANAGEMENT AND COMMUNITY ENGAGEMENT

Elevating Community Voice through Engagement

To ensure those most impacted by health challenges shape the solutions, Horizon Public Health prioritized community engagement and qualitative data collection in 2024 through Participatory Action Research. We facilitated community conversations and focus groups with 100+ adults and 50+ students across the region, identifying local priorities to guide action.



Key Community-Identified Issues:

- Transportation barriers
- Limited awareness of resources and mental health services
- Lack of welcoming spaces for youth and seniors to connect

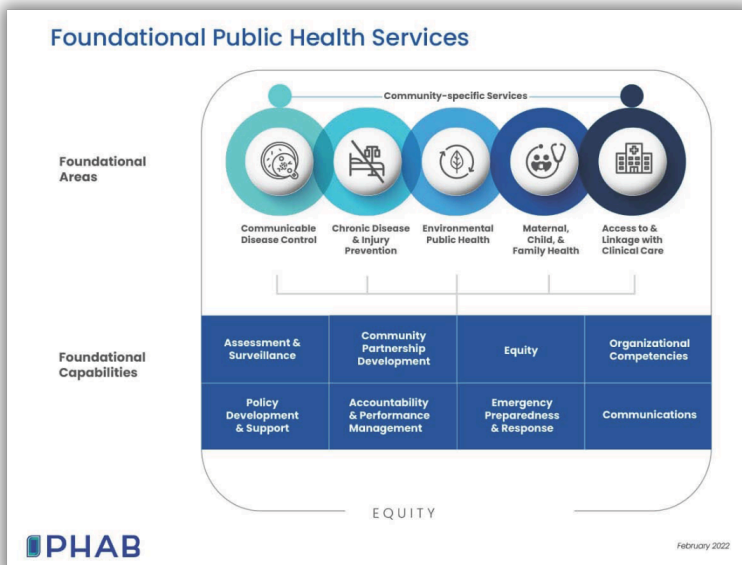
50+ students reached through community conversations

Co-Created Solutions:

- GIS mapping to improve access to local resources (coming in 2025!)
- Partner collaboration to address transportation challenges
- Secured funding to support youth priorities, including spaces, programs, and healthy food
- Engagement with senior centers to strengthen services and long-term sustainability

These insights are now embedded into our CHIP strategies and have supported successful funding efforts, including receiving a Minnesota Department of Health Infrastructure Grant and a Blandin Foundation Grant. By centering community voices and lived experiences, Horizon remains committed to co-creating solutions that promote health and well-being across our region.

Foundational Public Health Services



In 2024, Horizon Public Health continued to strengthen the **Foundational Public Health Services (FPHS)** by investing in core capabilities that support the health of all residents. This included enhancing our capacity in areas such as community engagement, data and health assessment, communications, and policy development. By reinforcing these essential services, Horizon ensures we are equipped to address current and emerging public health challenges, advance health equity, and provide consistent, high-quality services across our region.

COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN

Horizon Public Health’s Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) serve as the foundation for improving health and well-being. These guiding frameworks ensure that public health efforts are data-driven, community-centered, and focused on addressing the most pressing health challenges.

- The **CHA (2022)** identified key health concerns and opportunities by analyzing local data and gathering input from residents, stakeholders, and community partners.
- The **CHIP (2023-2028)** builds on these findings with a strategic, five-year plan that prioritizes Access to Care, Community Resilience, and Chronic Disease Prevention. Through collaborative efforts, CHIP initiatives aim to:
 - Improve health outcomes by addressing barriers to healthcare access.
 - Strengthen community resilience by enhancing mental well-being and support systems.
 - Reduce health disparities through prevention and education programs.

By leveraging partnerships and a collective impact approach, Horizon Public Health and its stakeholders work together to create sustainable solutions that promote healthier communities for all.

Horizon Community Partner Leadership Team (CLT)

The Community Partner Leadership Team (CLT) has more than 70 stakeholders committed to advancing public health initiatives across Douglas, Grant, Pope, Stevens, and Traverse counties. Representing a diverse range of sectors—including healthcare, non-profits, education, government, mental health, business, faith communities, law enforcement, human services, and local residents—the CLT ensures that community health improvement efforts are collaborative, equitable, and impactful.



The CLT plays a key role in guiding the implementation and evaluation of the Community Health Improvement Plan (CHIP) by:

- Providing strategic leadership to address community health priorities.
- Sharing insights and expertise to refine public health strategies.
- Fostering cross-sector partnerships to strengthen local health initiatives.
- Ensuring accountability and progress tracking through data-driven decision-making.

COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN

CLT Impact in 2024

Throughout the year, the CLT held six meetings, creating a platform for meaningful collaboration among community leaders. These meetings helped:

- ✓ Introduce the Clear Impact Scorecard, a tool for tracking CHIP metrics, progress, and transparency.
- ✓ Provide strategic direction for Participatory Action Research (PAR), ensuring it remains actionable and aligned with regional health priorities. Discussions identified systemic barriers and community-driven solutions to improve mental well-being and health care access.
- ✓ Cross-sector collaboration, exploring ways to align programs, leverage funding, and enhance community engagement.
- ✓ SHIP-funded initiatives supporting healthy eating, active living, and tobacco-free communities, including school wellness, community fitness, and tobacco reduction efforts.
- ✓ MESCH program's efforts to expand outreach in 2024, including strengthened referrals through clinics, Child Protection, and mental health services.

By bringing together diverse perspectives and expertise, the CLT continues to drive system-wide change and improve health outcomes for residents across the region.

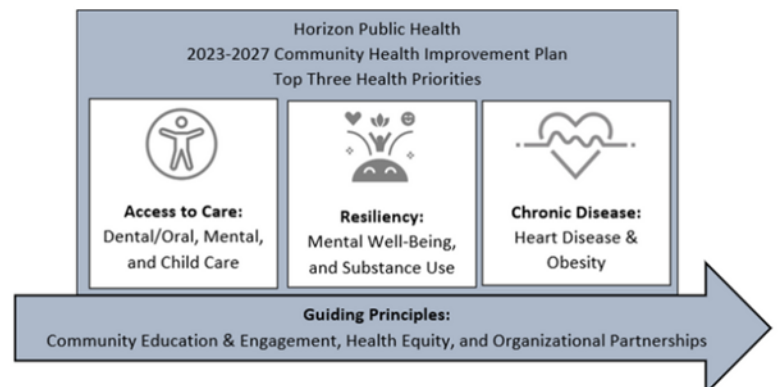
2024 CHIP Highlights

The CHIP Action Plan was updated in October 2024 and approved by the Horizon Community Health Board, to incorporate Results Based Accountability (RBA). Developed in collaboration with the Community Partner Leadership Team, RBA enhances the plan by providing a clear, data-driven framework for tracking progress on health initiatives. This approach enables the document to be updated as needed, adapting to emerging challenges and continuously working towards comprehensive health outcomes.

The 2024 CHIP Amendments are:

- ◀ Updated goals for each priority area, including what successes look like and how progress is measured.
- ◀ Additional local policy recommendations.
- ◀ Updated outcomes with measurable statements that define results or changes to achieve.
- ◀ Additional baseline/data sources.
- ◀ Updated community partners to assets and resources, highlighting the broader strengths, contributions, and tools each partner brings to support efforts.
- ◀ Updated action steps.

CHIP Link



COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN

Access to Care

Goal: All have access to care in the Horizon Public Health service area.

Access to Care - Dental

Goal: All people have access to preventative dental screenings.

All people have access to preventative dental screenings.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of youth on Medicaid in the HPH service area receiving preventative dental screenings	2023	24.5%	→ 1	-5% ↘
% of adults in the HPH service area over the age of 65 and in Managed Care that receive preventative dental screenings	2024	32.0%	↘ 1	-5% ↘



Key activities:

- The Early Childhood Dental Network is a collaborative effort to educate children and their caregivers about the importance of oral health and to increase access to dental care for children ages 0-5 on Minnesota Health Care Programs or uninsured. This group continues to lead and steer this work across our communities. In 2024 this group expanded their outreach dental clinics to include the schools of Ashby, Morris, Starbuck, Elbow Lake and Wheaton.
- Grass roots efforts, led by Vivie (formally Knute Nelson) is working to explore opportunities, ideas, and challenges with expanding oral health care for our aging population. Caring Hands Dental Clinic is working to grow their work force to full capacity and explore options for reinstating and expanding regional dental outreach services. Vivie is working with metro locations to continue seeking staff and funding to expand rural locations.
- Ongoing dental education about healthy eating, routine check-ups and more on social media, Installment and given to those under 5 during WIC and other HPH visits.

Access to Care - Mental Health

Goal: All community members can access mental health resources.

All community members can access mental health resources.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of adults in the HPH service area who report no delay in accessing mental health care	2020	86.5%	↘ 1	-4% ↘
% of 8 th graders in the HPH service area who report they have access and feel comfortable talking to a counselor or social worker at school	2022	58%	→ 0	0% →



Key activities:

- Identified community groups across the service area to implement action steps: SCOPE (5-county Suicide Prevention Coalition), Lakes Area Age Friendly, and the Substance Misuse and Suicide Prevention Coalition.
- Utilized Participatory Action Research to gather qualitative data insights from individuals with lived experiences which focus on mental health care access.
- MDH Infrastructure Grant award. A portion will enhance community collaboration to incorporate geographic information systems mapping (GIS) for visual representation of mental health resources in the community.
- Statewide Health Improvement Partnership activities ([see pgs. 27-28](#)).

COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN

Access to Care

Goal: All have access to care in the Horizon Public Health service area.

Access to Care - Child Care

Goal: All families can access and utilize childcare when needed.

All families can access and utilize child care when needed.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
# of licensed child care slots needed in the HPH service area	2024	5,825	↗1	4% ↗
Support and engage with innovative coalitions working to develop 'right-sized solutions' to increase supply of high-quality child care.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
# of new child care slots created in the HPH service area	2023	110	→0	0% →



Key activities:

- **Douglas/Alexandria Area:**

After the Rural Child Care Innovation Program (RCCIP) grant ended in Spring 2024, efforts shifted to forming an early childhood task force and launching a two-year plan to continue innovative strategies. The Alexandria Area Economic Development Commission is working with West Central Initiative to fund a project manager to lead early childhood projects. Priorities include repurposing spaces for childcare, creating an early care and development foundation, supporting the childcare workforce, and promoting high school program enrollment in early childhood education.

- **Grant County:**

In July 2024, Grant County received an RCCIP grant to address childcare shortages through local, workforce-driven solutions. Community engagement, including Spring 2025 Town Halls, will help guide sustainable strategies.

- **Stevens County:**

Stevens County added 72 licensed childcare slots in 2023 by constructing 6 pods. Despite progress, demand remains high. The county continues to seek funding for more pods and is working with providers to grow the model.

- **Pope County:**

Pope County secured \$1.875 million in Congressionally Directed Spending to support a new childcare facility through the Lakes Area Enrichment Center.

- **Traverse County:**

A local committee is pursuing grants to expand childcare access. After an initial building plan fell through, efforts continue to find renovation options and recruit providers. A Childcare 101 meeting showed low attendance, but the group remains focused on long-term solutions as a key provider nears retirement.

COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN

Community Resiliency

Goal: All community members experience positive mental well-being and live free from the harms of substance misuse and abuse.

Community Resilience - Mental Well-Being

Goal: All community members experience positive mental well-being.

All adults and youth have positive mental well-being.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of 9 th graders in the HPH service area who reported that the community cared about them 'quite a bit' or 'very much'	2022	32%	↓1	-21%↓
% of adults experiencing positive mental health every day	2020	62%	→0	0%→

[Mental Well-Being Scorecard Link](#)

Key activities:

- Statewide Health Improvement Partnership (SHIP)/ Health Education projects ([see pages 27-28](#)).
- Horizon Public Health engaged 64 adults and 47 students in community conversations to identify key priorities across the region. Common themes include improving transportation, expanding access to resources, enhancing mental health support, and creating more inclusive community spaces. Residents highlighted the need for better healthcare access, youth and senior-focused programs, and safe, welcoming public spaces.

Community Resilience - Substance Use

Goal: All community members are free of substance misuse and abuse.

All community members are free of substance misuse and abuse.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of 11 th graders in the HPH service area who have not used alcohol, marijuana, and/or drugs in the past year	2022	63%	↑2	11%↑
% of adults who are free from substance misuse and abuse	2020	92.3%	→0	0%→

Build capacity for community partners to address stigma, risk, harm reduction, and protective factors from substance misuse and abuse.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of 9 th graders in the HPH service area who feel they have a trusted adult to talk to	2022	87.9%	↓1	-1%↓
% of HPH community partners around substance misuse and abuse	2024	59	↑1	18%↑
# of activities/events completed to support substance misuse and abuse (HPH led)	2024	80	→0	0%→

[Substance Use Scorecard Link](#)

The Healthy Voices Healthy Choices Coalition is implementing strategies to decrease substance use and increasing the understanding of the harmful effects of alcohol, commercial tobacco/vapes, cannabis/marijuana and prescription drug misuse among youth.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of 8 th , 9 th , and 11 th grade students who have not used alcohol, marijuana, or vapes.	2023	92%	↑2	6%↑
% of 8 th , 9 th , and 11 th grade students who perceive harm using alcohol, marijuana, or vapes.	2023	68%	↑1	0%→

COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN

Community Resiliency

Goal: All community members experience positive mental well-being and live free from the harms of substance misuse and abuse.

Community Resilience - Substance Use

Goal: All community members are free of substance misuse and abuse.

Key activities:

- Established community-led coalitions and initiatives focused on substance use prevention and opioid efforts.
- Horizon Public Health (HPH) coordinates Opioid Settlement funds across its five-county region through local Opioid Advisory Councils. In 2024, counties held regular meetings to review data, assess needs, and allocate funds per the State of Minnesota MOU. Investments focused on treatment, prevention, and other services, with strong support for community-based initiatives:
 - Douglas County: \$264,361 | 11 projects
 - Grant County: \$21,396 | 3 projects
 - Pope County: \$24,654 | 5 projects
 - Stevens County: \$73,637.55 | 3 projects
 - Traverse County: \$95,062 | 7 projects
- HPH received a 4-year Youth Suicide and Substance Prevention Grant from the MN Department of Health to expand youth mental health and substance misuse prevention efforts (ages 10-24).
- Additional efforts include:
 - Partnering with local governments to provide public health guidance as cannabis becomes legal in 2025.
 - Enhancing messaging to dispel the myth that most youth use substances, while promoting healthy, substance-free celebrations.
 - Engaging parents to support youth education and healthy development as prevention strategies.
 - Creating leadership opportunities for youth, including advocacy training, Day at the Capitol, peer education, media campaigns, and well-being projects.
 - Offering skill-building and adult-youth conversations to prevent substance use.
 - Implementing alternatives-to-suspension and targeted education for youth violating school drug policies.



COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN

Chronic Disease

Goal: All community members have the opportunity to achieve optimal health. Link to chronic disease scorecard:

Chronic Disease

All community members have the opportunity to achieve optimal health.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of 8 th graders in the HPH service area who reported being active 5 or more days/week for at least 60 min/day	2022	55%	↘2	16%↗
% of adults who report they have never had high blood pressure/hypertension or pre-hypertension	2020	63.4%	↗1	21%↗

Patients of healthcare organizations are referred to the most effective resources for their health and wellbeing needs.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
% of patients screened for social determinants of health at annual and preventative visits	HY2 2024	71.3%	↗2	1089%↗
% of providers who "Agree" or "Strongly Agree" they can refer their patients to effective programs and resources for chronic illness and factors influencing overall health	2024	67.0%	→0	0%→



Strategies are identified to improve physical activity and healthy eating in the workplace, healthcare, and community.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
# of community partners engaged in active transportation initiatives	2023	47	→0	0%→
% of women with infant children in the Horizon Public Health WIC program who choose to breastfeed	2024	85.3%	↗1	2%↗

Key activities:

- SHIP/Physical Activity; Elbow Lake Bike Share, Morris Community Garden, Food Assessment, Breastfeeding projects (baby café, baby bistro, workplace lactation room projects)
- Through the PrimeWest Health Community Reinvestment Grant Horizon partnered with healthcare organizations to create a standardized screening for Social Determinants of Health, a new clinical community linkage as a referral pathway to community resources, and implemented the use of Nutrition Stability Boxes and the Food Rx program ([see page 26](#))



Stevens Community Medical Center Food Rx Program

PUBLIC HEALTH COMMUNICATIONS

Goal: Increase awareness and engagement with public health information by 20% by December 2025.

2024

HIGHLIGHTS

- Successfully completed a two-year Communications Infrastructure Grant from the Minnesota Department of Health.
- Gained approval from the Horizon Community Health Board for a Strategic Roadmap for Communications.
- Streamlined internal and external communications processes and procedures for improved efficiency and clarity.
- Launched a Communications Committee to help guide and align messaging across the organization.
- Expanded social media reach by adding LinkedIn to existing platforms.

Communication Performance Measures

Total # of Facebook/Instagram Posts **598**

Total # Reached by Facebook Posts **128,816**

Total # Reached by Instagram Posts **5,975**

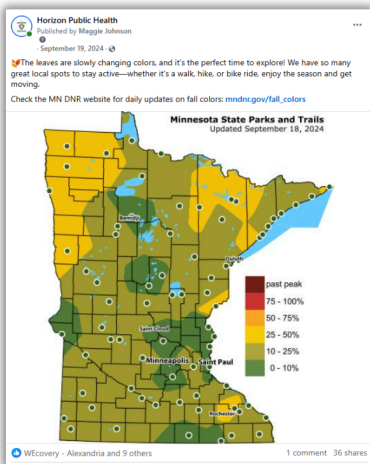
Total # of Facebook Page Followers Gained **105**

Total # of Instagram Page Followers Gained **81**

2024 YEAR END DATA

TOP PERFORMING CONTENT

Facebook Reach – 43,359



Facebook Reach – 5,965



Horizon Public Health utilizes website analytics to assist us in monitoring user interactions with our website.

69,147 Total # of Website Page Views

58% Increase of Website Page Views from Q4 2023 to Q4 2024

Connect with us



http://



horizonpublichealth.org

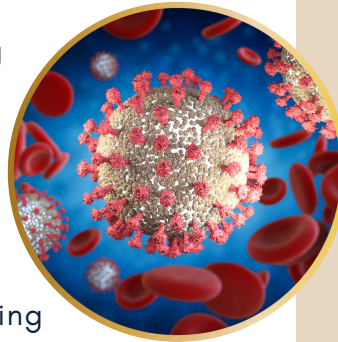
DISEASE PREVENTION & CONTROL

The primary goal of a disease prevention and control program is to protect the health of individuals and communities by reducing the risk of illness, complications, and outbreaks. Prevention efforts focus on stopping diseases before they occur through proactive strategies, such as vaccinations, education, screenings, and promoting healthy behaviors.

Primary Prevention: Preventing the onset of disease through immunizations, healthy lifestyle promotion, and environmental safety measures.

Secondary Prevention: Detecting diseases early through screenings and interventions to prevent progression.

Tertiary Prevention: Managing existing conditions to prevent complications and improve quality of life.



Top 10 Reportable Diseases for Horizon Public Health

- Chlamydia
- Hospitalized Influenza
- Gonorrhea
- Lyme Disease
- Salmonella
- Strep Group B
- S. Pneumoniae, Invasive
- Cryptosporidium
- Histoplasmosis
- Campylobacter



Here are the key highlights of our efforts in disease prevention across the region, along with important data points to keep you informed.

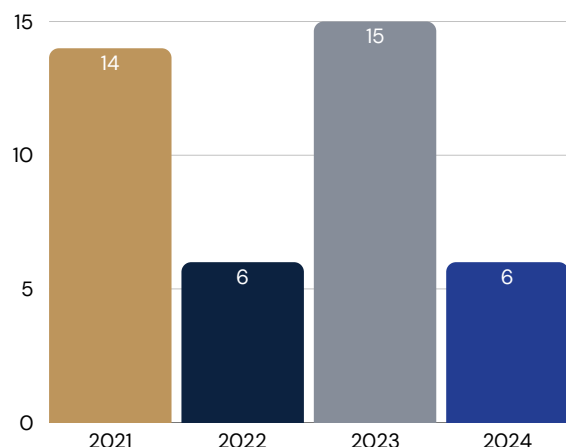
Lead Referrals

Lead exposure can be prevented. The best protection is by learning about the risks and taking simple steps to make your home safer.

of children referred for lead case management services: 6

By county: Douglas-3, Grant-2, Pope-1

High Lead Referrals by Year

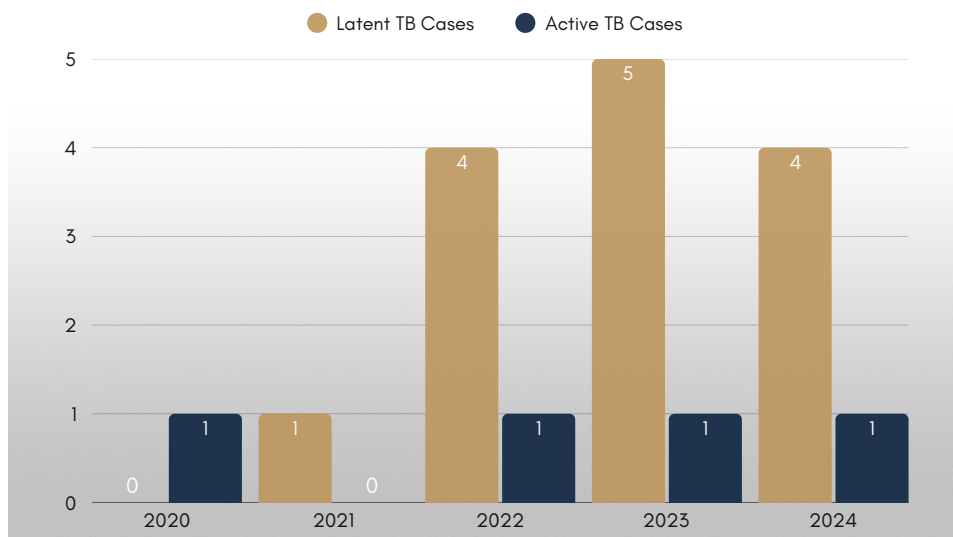


DISEASE PREVENTION & CONTROL

Disease Investigation and Follow-up

Tuberculosis (TB) is caused by a bacteria known as mycobacterium tuberculosis. The bacteria most often attacks the lungs, but it can attack any part of the body including the kidney, spine or brain. Not everyone infected becomes sick, but if TB disease (infectious TB) is not treated properly, it can be fatal.

TB Cases by Year



MnVFC Site Visits

HPH ensures vaccine safety and program compliance through site review visits conducted with healthcare facilities participating in the MN Vaccines for children (MnVFC) program. These visits include a thorough review of key areas such as:

- Annual staff training documentation
- Backup plans to protect and store vaccines during emergencies, such as power outages or equipment failures
- Vaccine eligibility documentation
- Appropriate billing practices
- Proper vaccine storage and handling, including temperature log reviews

These visits promote best practices, safeguard vaccine integrity, and support high-quality immunization services across the region.

Tuberculosis

Public Health serves as the lead agency for investigations when a case of active, infectious tuberculosis (TB) is identified in the community, ensuring timely response, prevention of further transmission, and coordination of care.

In 2024, HPH responded to **1 Active TB case** and **4 Latent (Noninfectious) TB cases.**

➤ **Total site visits completed in 2024: 9**

DISEASE PREVENTION & CONTROL

Primary Prevention: Testing and Vaccination

Testing

We distributed over-the-counter (OTC) COVID-19 tests across all HPH offices and extended support to businesses and community partners upon request. Recipients included daycares, libraries, county and human services agencies, supported employment and developmental achievement centers, group homes, assisted living facilities, homebound individuals, and hospice patients.

County Jail Vaccinations

HPH has maintained its relationship with the Douglas County jail and continues to be able to offer adult vaccines to inmates through the Uninsured and Underinsured adult vaccine (UUAV) program. **In 2024, HPH provided 60 immunizations to inmates at the Douglas County jail, who otherwise would likely not have access to vaccines.**

Refugee Health

Public Health plays a vital role in supporting newly arrived refugees and immigrants by connecting them with essential healthcare services. This includes coordinating required appointments for TB testing, health examinations, and assisting with follow-up care, such as dental services and immunizations. **In 2024, HPH received 15 referrals from the Minnesota Department of Health.**

Vaccination

➤ # of vaccine clinics: **58**

The vaccine clinics played a vital role in ensuring access to routine and seasonal vaccinations.

Community members supported:

- Uninsured and underinsured individuals
- Residents and staff of nursing homes, assisted living facilities, and adult foster care homes
- School staff and students
- Individuals residing in the county jail
- Horizon employees, as well as County and Human Services staff

➤ # of vaccines administered: **685**

➤ # of flu vaccines: **210**

➤ # of COVID vaccines: **151**

April 2024: Successfully launched a **vaccine reminder texting program** to improve communication with parents, providing timely notifications when children are due for routine immunizations. This initiative enhances prevention efforts by promoting on-time vaccinations and ensuring children stay up to date with recommended immunization schedules.



DISEASE PREVENTION & CONTROL

Community Recovery Grants

Local grants were awarded to community partners through a request for proposal (RFP) process to address identified recovery needs across the region. Funded projects included:



Growing Back Strong – The Alexandria Senior Center tackled loneliness and isolation by launching three initiatives that promoted volunteerism, social connection, and lifelong learning: a Fix-It Clinic pilot project, expanded Sunday music offerings, and a collaborative *Safety for Seniors* event.

Mental Health & Wellbeing Keynote – Alomere Health hosted keynote speaker Allison Massari to support healthcare workers.

Health & Safety Training – Browns Valley Health Center provided workshops on essential skills, including CPR, first aid, and crisis training.

Bilingual Wellbeing Series – Conexiones partnered with Dr. Corey Martin, founder of the *BounceBack Project*, to deliver a four-part community wellbeing series.

Mental Health First Aid – Vivie (formerly Knute Nelson) provided adult mental health first aid trainings for employees and the community.

Education Campaign – Safe Families for Children led a public awareness campaign focused on mental health, resilience, preventative care, ACEs prevention, healthy habits and coping strategies.

Resilience Support– Stevens County Human Services engaged a licensed psychologist to provide trauma-informed support to their employees.

PUBLIC HEALTH EMERGENCY PREPAREDNESS

Timeline of Preparedness Exercises or *Real Events Supported by, Participated in, or Led by Public Health

2024

JAN-FEB

- **Northstar Manor Apartment Explosion:** Hoffman
- **School planning meetings:** Stevens County
- **Family Assistance Center Workshop:** Grant, Pope and Traverse County

MAR-APR

- **Highly Pathogenic Avian Influenza- first case identified in a Goat,** Stevens County
- **Medical Response and Surge Exercise:** with Alomere, Lake Region Hospital, Sanford Wheaton Medical Center, and Stevens Community Medical Center
- **School Planning Meetings:** Stevens County
- **Boil Water Advisory,** City of Hoffman

MAY-JUN

- **Safety for Seniors Event,** Alexandria Senior Center
- **HPH Case Management Program Storm Response Discussion-Based Exercise**

JUL-AUG

- **Glenwood Retirement Village electrical panel fire and evacuation**
- **Alomere Health - Hazardous Substance Discussion-Based Exercise,** Alexandria
- **Open Line (Radio)- National Preparedness Month**

SEP-OCT

- **Pope County Senior Expo,** Glenwood
- **Fire Department Open House,** Alexandria
- **Hospice of Douglas County, a division of Horizon Public Health: Cyber Attack Discussion-Based Exercise**

NOV-DEC

- **Using Incident Command Structure in a Public Health Response training and exercise-Hepatitis A Outbreak and Storm Response**

MINNESOTA RESPONDS VOLUNTEERS



MNResponds is Minnesota's volunteer registry for health and non-health professionals who are ready to assist during public health emergencies and community needs. Volunteers can support vaccination clinics, disaster response efforts, and community outreach, depending on their skills and availability.

MNResponds volunteers in HPH service area:

- Douglas-136
- Grant-38
- Pope-40
- Stevens-41
- Traverse-22



Senior Expo in Glenwood

In 2024, the West Central region conducted a call down drill as a test to identify which volunteers would be available to help in a real situation. The volunteer response rate was as follows:

- Douglas: 42%
- Grant: 51%
- Pope: 36%
- Stevens: 50%
- Traverse 67%



*The 4 responses to real events are highlighted

PUBLIC HEALTH EMERGENCY PREPAREDNESS

Health Alert Network (HAN):

A means of rapidly exchanging information in an efficient and reliable method between the Minnesota Department of Health, local public health, and community partners during disease outbreaks or other public health emergencies.

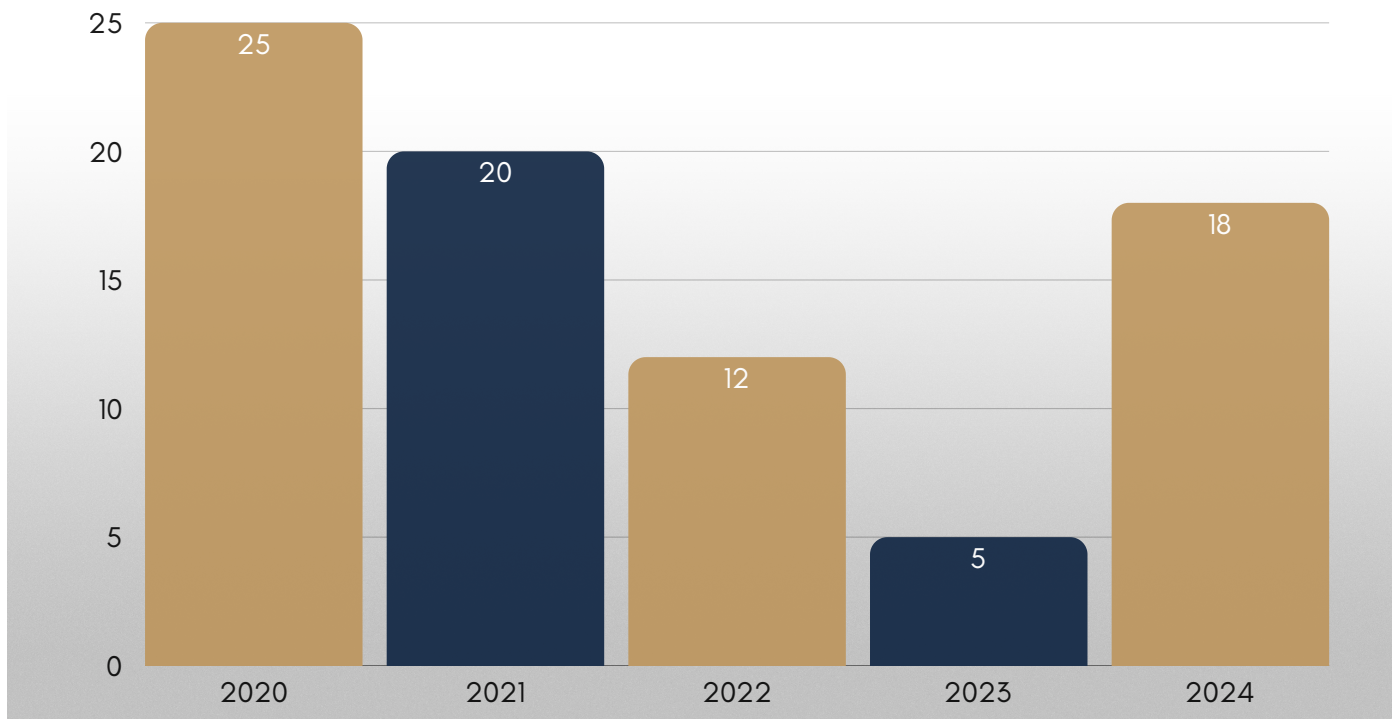


Total Received and Disseminated in 2024:

18
Health Alerts

- Syphilis in pregnancy
- Travel-associated measles-MN at risk for more
- Campylobacter Outbreak in Hennepin and Ramsey among MSM
- Infantile Krabbe result requires immediate action
- National Increase in invasive meningococcal disease serogroup Y
- Doxycycline for Prevention of STIs
- Avian Influenza testing in Minnesota
- Report Suspect Measles cases immediately
- Meningococcal cases and travel to the Kingdom of Saudi Arabia
- Travel-associated measles
- Outbreaks of Pertussis in MN
- Measles-Possible Community Transmission in MN
- Shortage of Becton Dickinson BACTEC Blood Culture bottles
- Increase in Human Parvovirus B19
- Metro Measles Outbreak and vaccine recommendations
- Marburg Virus outbreak in Rwanda-Actions for Minnesota
- Shiga toxin-producing E. Coli in patients with bloody diarrhea
- Pertussis Exceeds 2,000 in MN

Health Alerts by Year



CHILD AND TEEN CHECKUPS

Child and Teen Checkup (C&TC) Outreach is a program designed to ensure that children and adolescents enrolled in Medicaid or related health programs receive regular preventive health screenings. The outreach efforts focus on connecting families with medical, dental, vision, and mental health services to promote early detection and treatment of health issues.

The goal of the program is to improve overall child and teen health by increasing access to comprehensive checkups, vaccinations, and developmental assessments, ultimately supporting long-term well-being and reducing health disparities.



○ C&TC OR collaborated with parents of **7,314** children and young adults (birth-21 years old) to ensure timely well-child checkups with their primary care provider.

○ # of outreach/ events HPH staff attended: **17**



○ A total of **15,360** contacts were made via phone, letter or face-to-face, visits with Medicaid eligible families in our counties to promote well-child checkups and provide assistance as needed to ensure access to care.

○ Staff provided follow-up with families on **146** referrals made by child's healthcare provider during a C&TC visit.

Media Campaigns



MATERNAL AND CHILD HEALTH

○ HPH partners with the Minnesota Department of Health to work with parents of babies born with birth defects through the Birth Defects Information System (BDIS) and Early Hearing Detection Intervention (EHDI).

16 families were assessed and connected with resources through BDIS and EHDI.



○ HPH partners with PrimeWest Health to complete assessments and referrals for PrimeWest members who are pregnant and considered high risk.

34 prenatal women were assessed and offered referrals to services.



○ HPH offers a quarterly breastfeeding class to mothers and birth partners during their third trimester.

14 mother and birth partner couples attended the breastfeeding classes in 2024.



Follow Along Program (FAP):

FAP is a fun and simple way to receive guidance about how your child is hearing, moving, seeing, playing, talking, learning, growing, and acting. It is also an easy way to find out about other services you may want for your child.

ASQ-3: Assesses communication, gross and fine motor skills, problem solving, and personal-social skills.
ASQ-SE: Assesses social and emotional skills.

○ Car Seat Education

142

car seats were distributed to children ages 8 years and younger with education provided to their parents and caregivers.



➤ PrimeWest Prenatal Assessment questions help us better serve our high-risk, pregnant PrimeWest families.

Some important assessment components include:

- Client's overall health and well-being
- Pregnancy complications
- Domestic violence
- Mental health
- Medications
- Tobacco use
- Alcohol and drug use
- Client participation and referrals to resources such as WIC, Childbirth Classes, and Family Home Visiting

118

New clients signed up for FAP in 2024



376

ASQ-3 questionnaires received



311

ASQ-SE questionnaires received



22

Help Me Grow referrals made by FAP nurses



670

Total amount of children that participated in FAP

EVIDENCE BASED HOME VISITING

Maternal Early Childhood Sustained Home Visiting (MECSH):

MECSH provides individualized, home-based services focusing on parent education, maternal health and well-being, family relationships, and goal setting. Home visiting begins either prenatally or postpartum and continues until the child turns age two.

HPH partners with Countryside Public Health to provide MECSH to 10 counties.

Goals:

- Improve transition to parenting by supporting mothers through pregnancy
- Improve maternal health and well-being by helping mothers to care for themselves
- Improve mental health and development by helping parents to interact with their children in developmentally supportive ways
- Develop and promote parents' aspirations for themselves and their children
- Improve family and social relationships and networks by helping parents to foster relationships within a family and with other families and services



Screenings & Referrals

CAREGIVERS

Depression/anxiety screenings completed: **145**



Mental health referrals completed: **18**



Clients participating in MH services: **66**



Total intimate partner violence screenings completed: **117**

- Referrals: **2**

CHILDREN

ASQ-3 developmental screenings completed: **240**



ASQ-SE social emotional screenings completed: **161**



Help Me Grow referrals: **9**



Children receiving ECSE service: **20**



160 Families served



149 Children served



836 Visits completed

TRADITIONAL FAMILY HOME VISITING

The traditional family home visiting program at HPH offers prenatal, postpartum, and ongoing home visiting for children up to age 3. Registered nurses provide support and education to families specific to each individual family's interests and needs in areas of:

- Child development/Milestones
- Parenting
- Health/Well-being
- Nutrition
- Safety/Injury Prevention
- Family needs and community resources
- Supporting parent's aspirations
- Breastfeeding education and support

101	Families served
96	Children served
316	Visits completed



Screenings & Referrals

CAREGIVERS

Depression/anxiety screenings completed:	103
Mental health referrals completed:	6
Clients participating in MH services:	16
Total intimate partner violence screenings completed:	96
• Referrals:	1

CHILDREN

ASQ-3 developmental screenings completed:	44
ASQ-SE social emotional screenings completed:	24
Help Me Grow referrals:	5
Children receiving ECSE service:	15

HOME VISITING PREVENTATIVE SERVICES

Horizon Public Health home visiting nurses provide safe sleep assessments and education to parents and caregivers prenatally, when the child is born, and as needed until the child is 12 months of age. When parents or caregivers are in need of a safety-approved portable crib, our nurses can refer them to a partner agency to receive a crib at no cost to them. This service is made available through grant funding.



Horizon Public Health Family Home Visiting Video

[WATCH VIDEO](#)

92 home safety assessments were completed by HPH nurses in 2024.



HPH nurses provided safe sleep education to **152** families in 2024.

13 families received a safety-approved portable crib.



A **home safety checklist** is used by our home visiting nurses as a teaching tool for parents and caregivers. Homes have many safety risks. By completing home safety assessments, our nurses can help families address safety concerns. Some examples of this are listed below:

- Safe storage of vitamins, medications, plastic bags, cleaning supplies, energy drinks, etc.
- Proper storage of small appliances in the kitchen
- Small toys or objects found within baby's reach
- Carbon monoxide and smoke detectors
- Heavy or unstable pieces of furniture
- Child-safe windows
- Exposed outlet covers
- Old or peeling paint on walls and windows
- Long cords on found on window blinds or drapes

35 children were seen at a C&TC clinic

C&TC screening by age: **35**



3 were full C&TCs uninsured/head start (HS) - remaining were screenings completed to met HS requirements.

lead/hgb test: **34**

WOMEN, INFANTS, AND CHILDREN

Women, Infants, & Children (WIC) provides:

- Individualized nutrition education and counseling
- Vouchers to purchase nutritious foods from local grocery stores
- Referrals to health care and other services

WIC serves:

- Pregnant, breastfeeding, or postpartum women
- Infants up to one year of age
- Children up to age five

Goals:

- To improve access to nutritious food options for at risk populations
- To improve outcomes regarding growth and anemia in populations serviced
- To promote support of breastfeeding and extending duration of breastfeeding among populations served

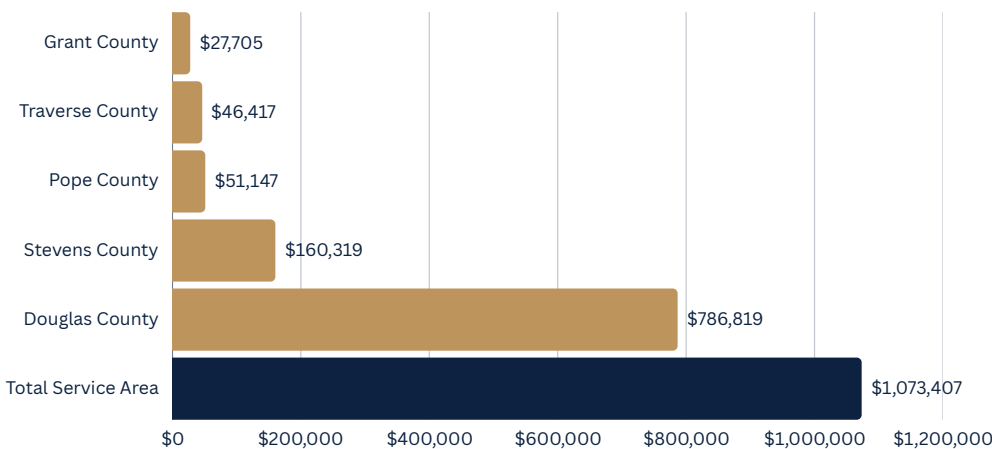


The WIC team served on average **1,296** participants per month in 2024.

Healthy WIC Food Packages include:

- Milk, cheese, and yogurt
- Fresh and frozen fruits and vegetables
- Whole grains
- Cereal
- Eggs
- Peanut butter and beans/lentils
- 100% juice
- Infant formula and baby foods
- Salmon/tuna options for breastfeeding women

WIC Benefits Redeemed in HPH Service Area



HEALTH EDUCATION

Horizon Public Health's Health Education team is made up of five full-time health educators, an AmeriCorps member, and dedicated program support staff working together to improve the health and well-being of our communities. The team actively assesses community needs, designs and delivers programs, and advances policy, systems, and environmental (PSE) changes to ensure meaningful, lasting improvements in community health.

Through the management of 11 grant-funded programs, the team addresses a wide range of priority areas, including healthy eating, physical activity, mental well-being, substance misuse and cannabis prevention, health equity, traffic safety, and tobacco and e-cigarette prevention. By partnering with schools, workplaces, and community organizations, our Health Education team empowers residents of all ages to make healthier choices and build stronger, safer communities.

HIGHLIGHTS



○ **Supportive breastfeeding spaces** help working parents balance their careers and their children's health. SHIP partnered with workplaces to enhance lactation spaces and assisted businesses in becoming recognized as Breastfeeding-Friendly Workplaces through the State of Minnesota. These efforts showcase employer commitment to families and create healthier, more inclusive work environments.

○ **PrimeWest Health Community Reinvestment Grant - Strengthening Healthcare Partnerships to Address Social Drivers of Health**

Horizon Public Health has partnered with leading healthcare providers across our five counties to enhance health and wellness through a collaborative grant initiative. This effort focuses on standardized screening for social determinants of health, strengthening clinical-community linkages, and addressing food insecurity. As a result, food insecurity screenings at annual healthcare visits increased from an average of 6% in Q4 2023 to 71% in Q4 2024—a 65% improvement which will support connecting patients to essential resources



○ **The Food RX program**, launched in August, continues to grow as an exciting partnership between Horizon Public Health, Glacial Ridge Health System, Stevens Community Medical Center, and Sanford Wheaton. Designed to address food insecurity and promote healthier eating habits, this initiative connects individuals with nutritious foods prescribed by healthcare providers. Through ongoing collaboration, we are enhancing the overall well-being of our community by providing accessible, healthy food options that support medical treatment and disease prevention.



○ **Youth-Led Community Priorities:** Following the facilitation of student community mapping, Horizon hosted a Town Hall at Browns Valley School, engaging students and community leaders to collaboratively prioritize and allocate \$10,000 in funds toward student-identified projects to improve mental well-being. The group unanimously selected creating a youth space in the public library and exploring sustainable opportunities to foster youth voice in community decision-making.

HEALTH EDUCATION



Partnered with Diamond Waves and Wags Car Wash in **Alexandria** to host a “Buckle Up and Save” event. Drivers who came through the car wash wearing their seatbelts received 50% off any car wash. MN State Patrol was also present and provided education on the MN Child Passenger Safety Law. ▼

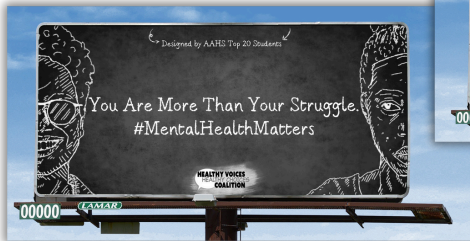


In March 2024, the youth tobacco prevention groups attend a **Day at the Capitol** event in St. Paul, where VPA students learned about the legislative process and spoke with their legislators about tobacco and vape prevention.

▲ In October 2024, the **VPA groups**, along with Discovery Middle School’s **VIBE students**, attended the Horizon-run Fall Retreat at Luther Crest Bible Camp to learn about teambuilding, being a positive advocate, and how vape and tobacco use impacts our environment. Additionally, students spent time on Luther Crest’s high ropes course!



Worked with the **City of Elbow Lake** to implement a Community Bike Fleet. The fleet consists of 5 bicycles that can be checked out for free through an app system. They are located at the Athletic Park in Elbow Lake and are available to use from Spring to Fall. ◀



◀ In April 2024, students at **Alexandria Area High School** designed billboards to reduce stigma related to mental health. These billboards were placed in high-traffic areas in Alexandria during the month of May (mental health awareness month).

In 2024, the **Stevens County Community Garden** flourished into a vibrant space for fresh food access, education, and connection. With strong community partnerships and growing community engagement, the garden has become a welcoming gathering place, strengthening both food security and well-being for years to come.

VIBE, a middle school youth group from **Discovery Middle School**, spoke to 5th graders at 5th Grade Safety Day about the harms of vaping and the importance of not using harmful substances. They also spoke about their personal experiences with peer pressure and how to navigate it. ▼



HEALTH EDUCATION

In April and May of 2024, the **Healthy Voices Healthy Choices Coalition** partnered with VIBE to host 2 “fairs” to share healthy coping strategies for students to practice when stressed. These were deemed a huge success.

Three thriving vape prevention youth groups (VPA) are ongoing at **Ashby Public School, Brandon-Evansville High School, and West Central Area Secondary School**. Student members of these groups plan and run events for their classmates that focus on vape education and prevention work. Events during the school year included a Do Not “Do-nut” Vape event at Brandon-Evansville, tabling at double-header WCA basketball games, and vape/tobacco trivia at Ashby Public School.



SHIP supported food access efforts in **Browns Valley** by expanding the library’s seed library, giving community members more opportunities to grow their own food. Enhancements to the local food shelf, including new shelving and a cooler, improved storage and access to fresh, nutritious options, strengthening local food security and sustainability.



Creation of the **five county Substance Misuse and Suicide Prevention Coalition**, with representation from schools, mental health organizations, elected officials, higher education and more.

Guiding Local Cannabis Policy & Education - provided public health recommendations to cities and counties developing adult-use cannabis ordinances, ensuring policies prioritize youth prevention and community health and safety. Additionally, we offered education to local leaders and the public on cannabis regulations, health impacts, and youth prevention.

In Grant County, student listening sessions were held in Barrett, Elbow Lake, Hoffman, Wendell, Herman, Ashby, and Kensington to hear directly from youth about how their communities could better support them and their mental wellbeing. Following these conversations, youth had the opportunity to present their ideas to the school board and city council members, ensuring their voices were heard by local decision-makers.

A common theme across all sessions was the desire for a safe, welcoming space for youth to gather, sparking the idea of creating a youth center. Other priorities included improving parks, upgrading school equipment, and creating more spaces for arts and crafts.

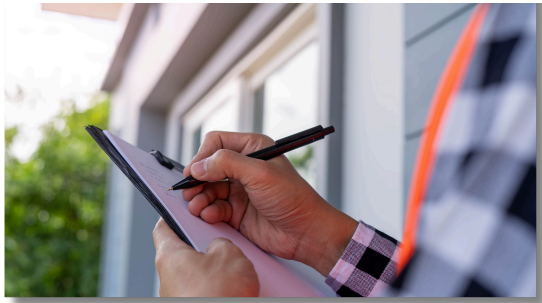
Horizon Public Health, in partnership with the Grant County Collaborative and local community members, is now working to turn these ideas into action and create meaningful spaces that support youth well-being.

Delivered **community training** on administering naloxone to reverse opioid overdoses, as well as on the Healthy Outcomes from Positive Experiences (HOPE) Framework, which emphasizes the role of positive childhood experiences in building resilience and helping youth thrive.



ENVIRONMENTAL HEALTH

The Environmental Health team consists of two full-time registered sanitarians and one support staff. The team works to identify health and safety risks and enforce environmental regulations. They work closely with food, pool and lodging establishments in Douglas and Pope County to license, inspect, and make corrective actions to improve safety. This team is responsible for a host of other duties including conducting foodborne



illness outbreak investigations and providing community education on radon, mold, safe drinking water, and other environmental health topics.

2024 HIGHLIGHTS



Licensed **463**
food, pool, and lodging
establishments

.....

Completed **433**
food, pool, and lodging
inspections

.....

Licensed **142**
Private Vacation Home
Rentals

.....

Completed **90**
Private Vacation Home
Rental inspections

.....

Issued **92**
permits for special events

Investigated **6** foodborne illness
complaints

Conducted **3** laboratory
confirmed foodborne illness
outbreak investigations in
partnership with the Minnesota
Department of Health

Investigated **12** public health
nuisance complaints across the
Horizon Service area

58 % of public health nuisance
complaints received involved mold

Distributed **177** radon testing
kits to families

HOME & COMMUNITY BASED SERVICES

The Horizon Public Health case management team, made up of registered nurses and social workers, partners with individuals and their families or guardians to provide person-centered care through home and community-based services. The process begins with a comprehensive assessment focused on the whole person, available to anyone regardless of financial eligibility.

Our certified assessors identify individual needs and preferences, connecting them with services and supports that can enhance health and well-being. They also discuss eligibility for publicly funded programs and assist with enrollment if desired.

Based on the assessment, a personalized care plan is developed, outlining recommended services such as personal care assistance, homemaking, home-delivered meals, emergency response pendants, employment supports, or transitions to assisted living or foster care.

Once a person is determined eligible for a publicly funded program, our case managers and care coordinators connect them to the appropriate services and supports. These authorized services are based on assessed health and safety needs, align with program guidelines, and reflect the individual's choices.

Case managers provide information on available resources, assist with referrals as needed, support informed decision-making, and help individuals work toward their personal goals. The care plan is regularly reviewed and adjusted throughout the year as goals and needs evolve, with an annual assessment conducted to update services and provider preferences.



Person-Centered Practices and Principles:

A way of ensuring people who receive supports and services have the same rights and responsibilities as other people. This includes having control over their lives, making their own choices and contributing to the community in a way that makes sense for themselves.

(Minnesota Department of Human Services, 2019)

Connecting Clients to Services*

- Adult day services
- Assisted living
- Chore services
- Consumer directed community supports**
- Employment support
- Home-delivered meals
- Homemaker
- Equipment and supplies

**Individual has flexibility and responsibility in service planning when choosing consumer directed community supports (CDCS)

*services provided under Minnesota disability and elderly waivers

449

449 initial, county of residence, and pre-admission screenings completed in 2024.



440

the under 65 case management team managed an average of 440 clients on a monthly basis.



952

the over 65 case management team managed an average of 952 clients on a monthly basis.

HOSPICE OF DOUGLAS COUNTY

Mission Statement:

We honor the lives of patients and families with individualized care, providing dignity and support as they journey through end of life.



Highlights from 2024

- **Started 2 additional grief support groups**
- **Resumed the Palliative Care Program**
- **Resumed the Volunteer appreciation dinner**
- **Provided multiple presentations and education in the community on hospice**
- **Produced a hospice education video**



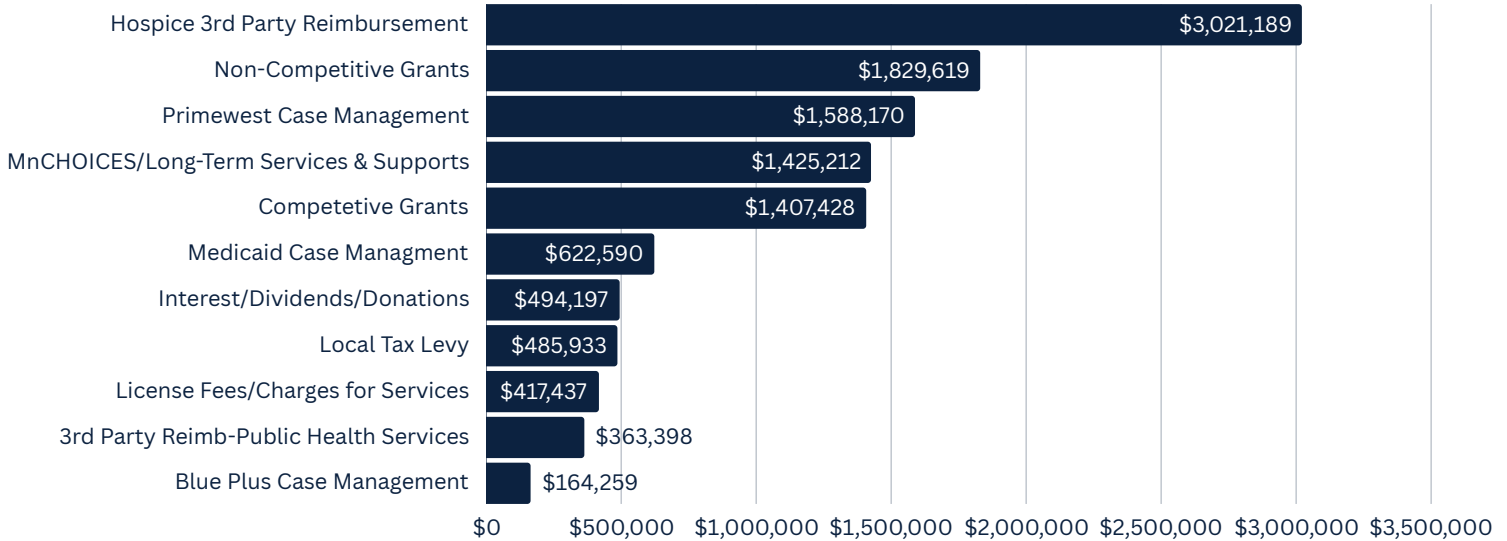
**Number of patient days billed in 2024*



Hospice Social Workers provide comfort and support to patients and family members.

FINANCIAL SUMMARY

2024 Horizon Public Health Revenue Sources



The 2024 financial summary for Horizon Public Health features a strong, diversified revenue base. Competitive grant funding has increased for the second consecutive year, highlighting Horizon’s ongoing commitment to securing external resources for community initiatives. Non-competitive grant funding also saw an increase in 2024 and continues to play a crucial role in maintaining Horizon’s financial stability.

Additionally, our Case Management, Long-Term Services & Supports, and Hospice programs not only provide essential services to our communities but also enhance the diversity of our revenue streams. Other sources of income include reimbursements for Public Health services, license and client fees, as well as various miscellaneous revenues such as donations, interest, and dividend earnings. Notably, the local tax levy allocation from Horizon’s five member counties remains a small percentage of the funding needed for Horizon’s operations.

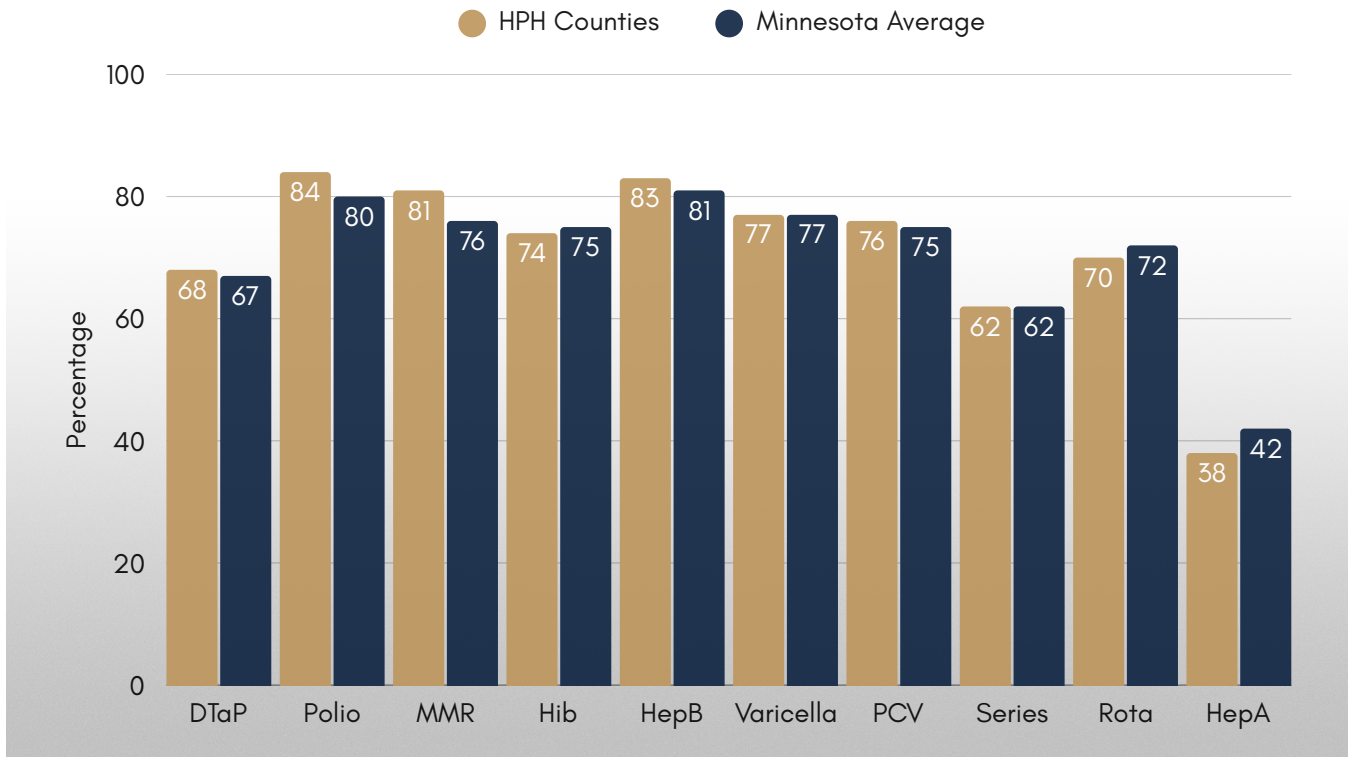


Public Health funding is crucial for local health departments to address community health needs, improve health outcomes, and protect residents from preventable diseases and health risks.

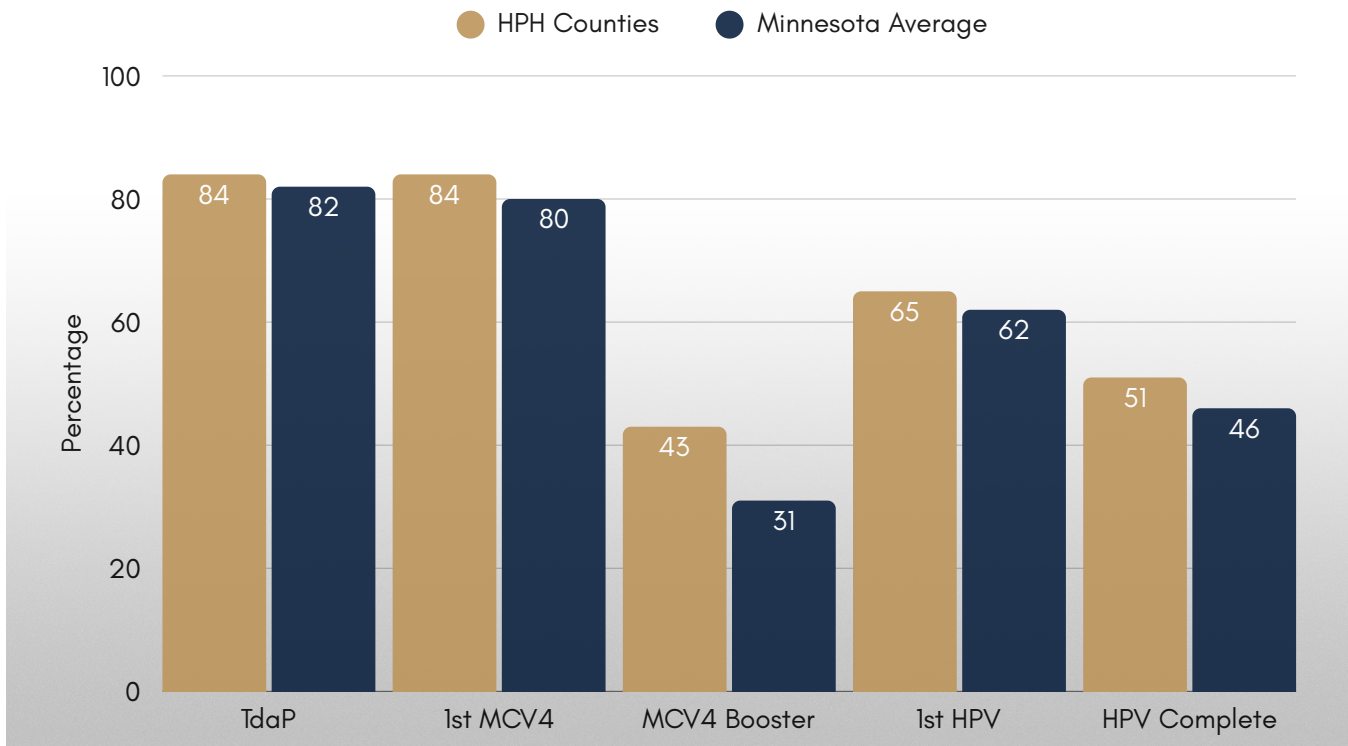
ADDITIONAL DATA

DISEASE PREVENTION & CONTROL

Immunization Rates - Up to Date by 24 Months



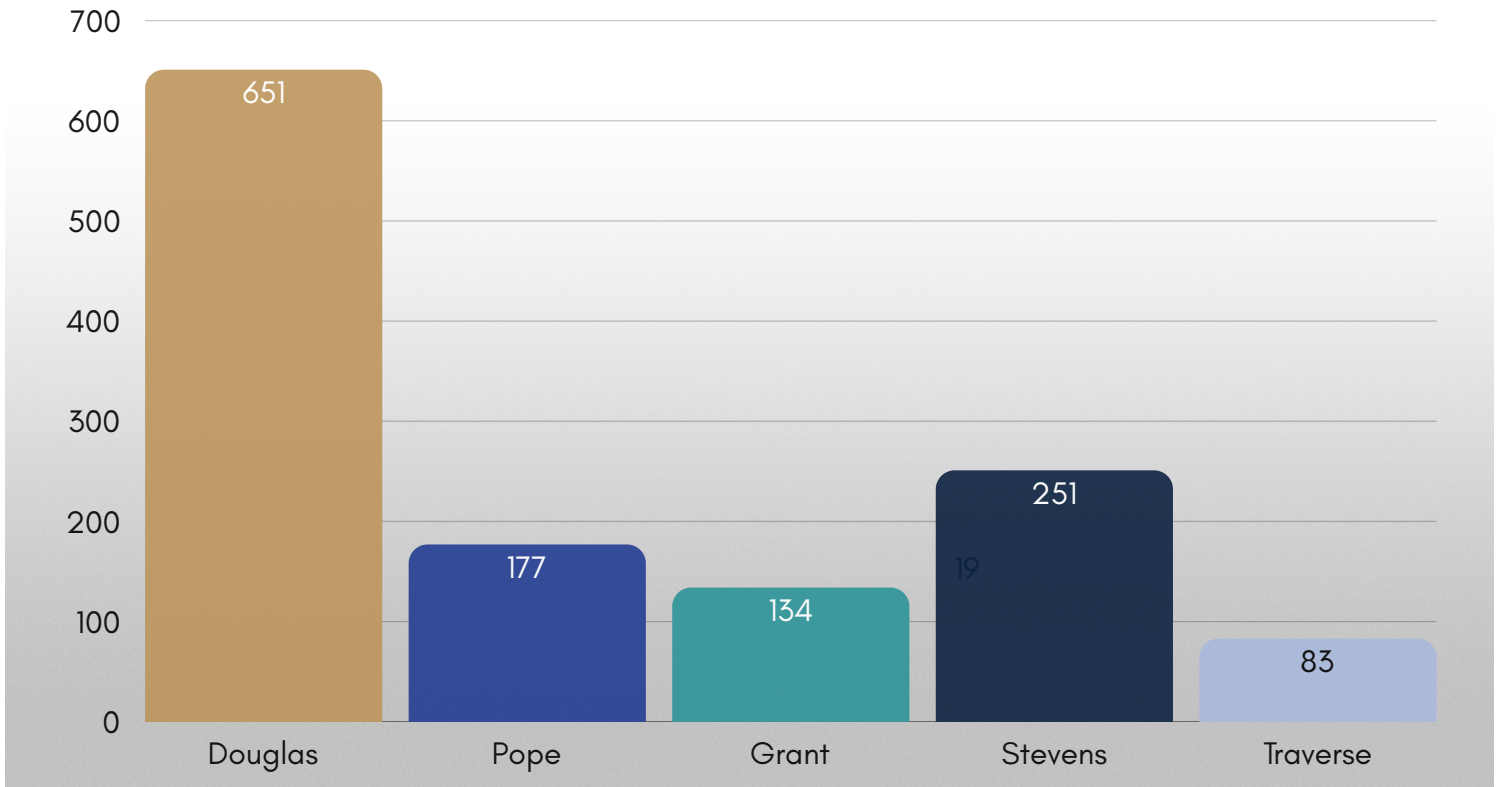
Immunization Rates - Up to Date Adolescent



ADDITIONAL DATA

WOMEN, INFANTS, AND CHILDREN

Average Monthly WIC Participants by County



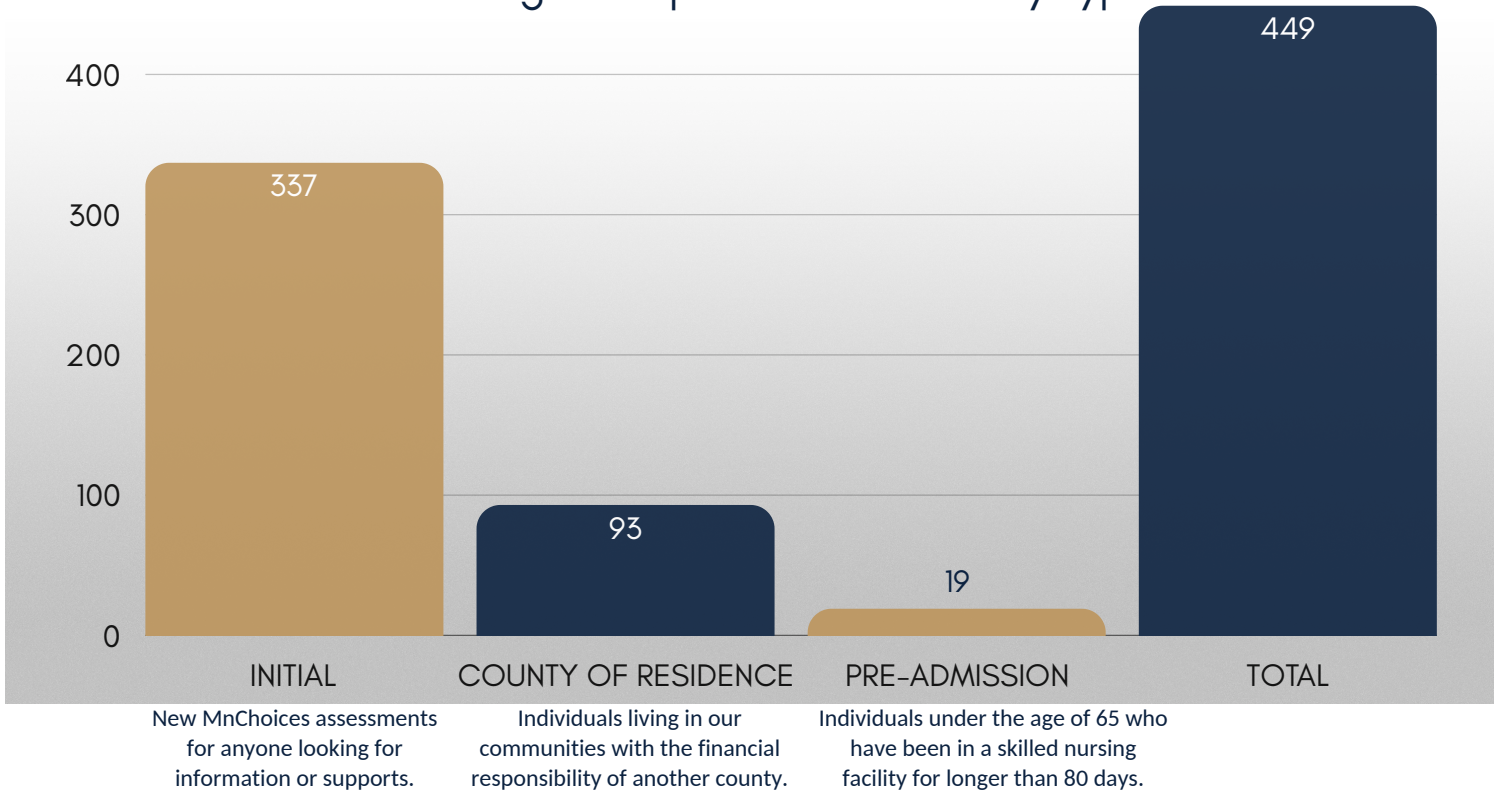
WIC Participants Per Month



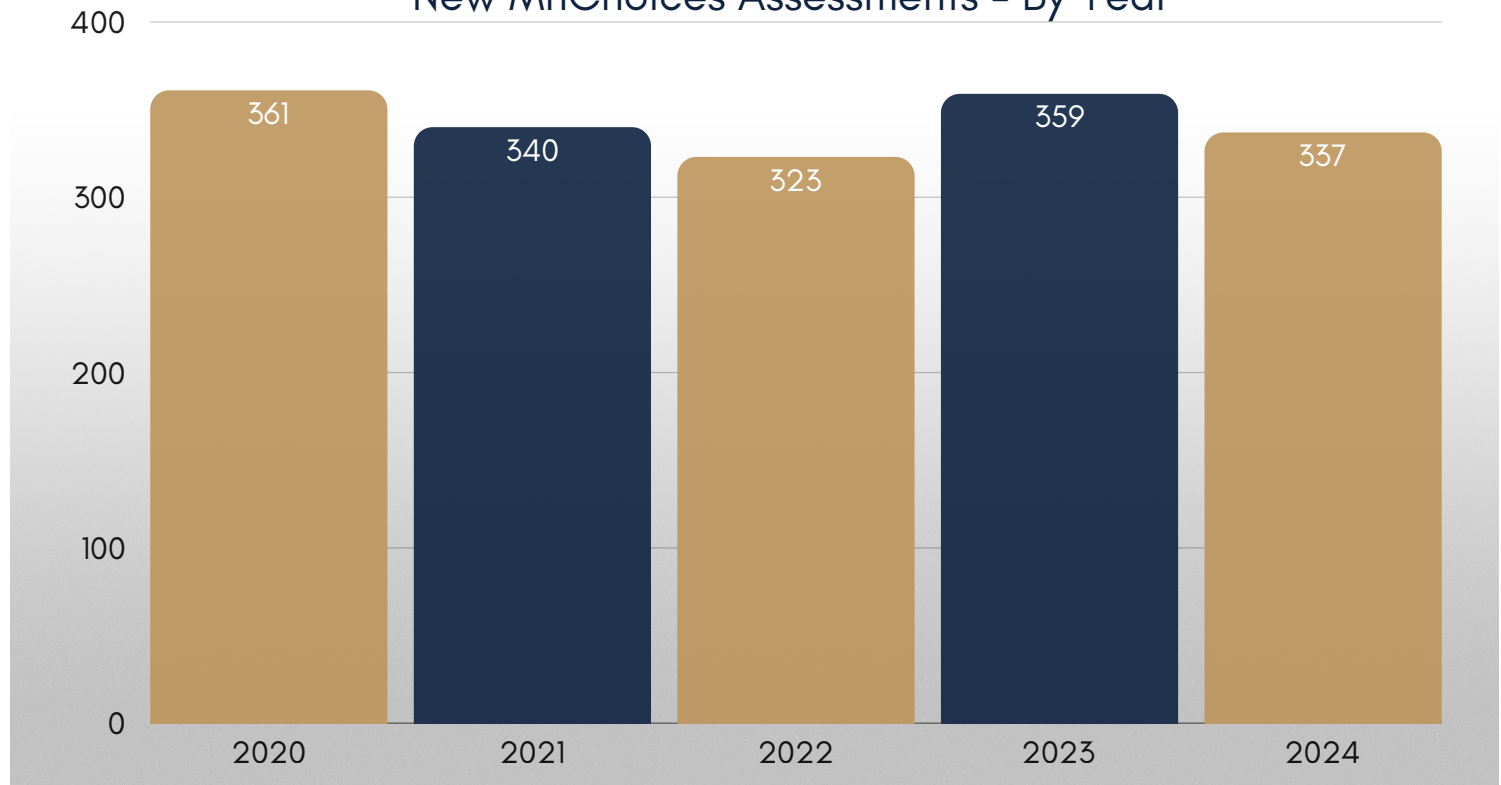
ADDITIONAL DATA

HOME & COMMUNITY BASED SERVICES

Screenings Completed in 2024 - By Type



New MnChoices Assessments - By Year

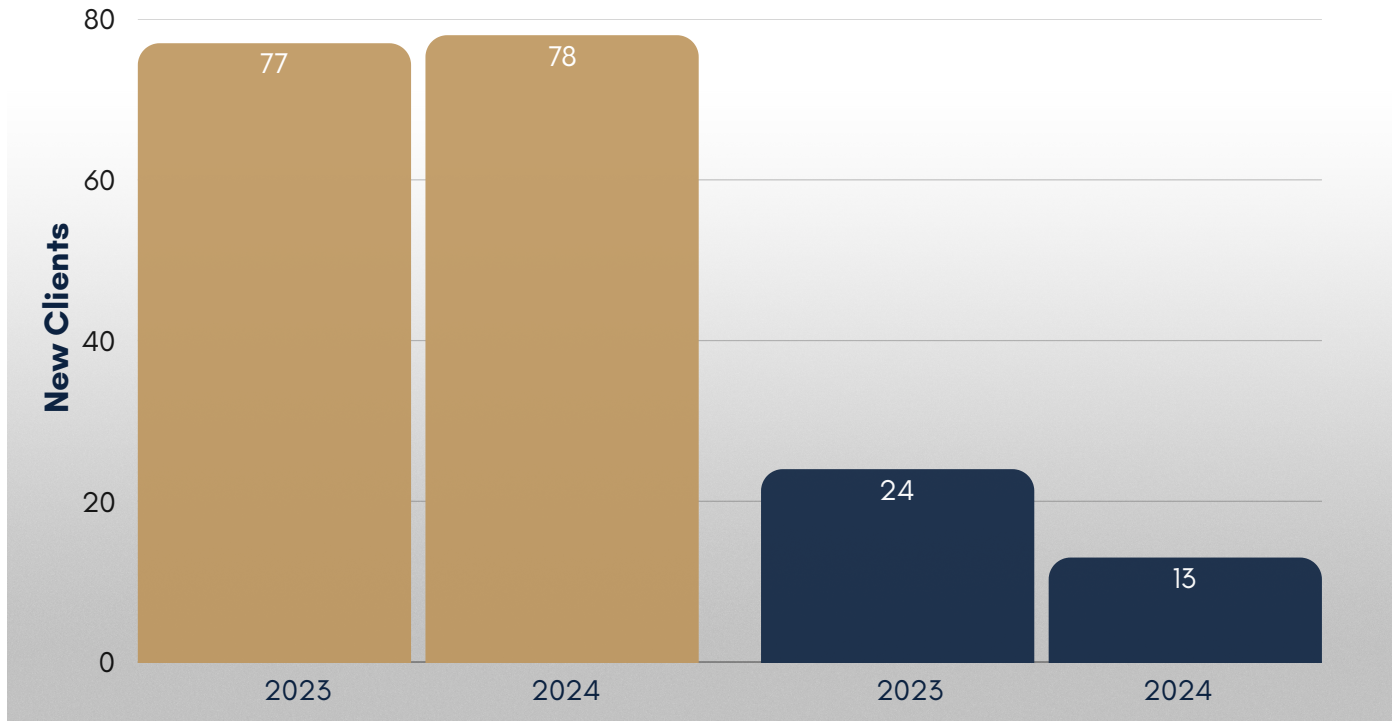


ADDITIONAL DATA

HOME & COMMUNITY BASED SERVICES

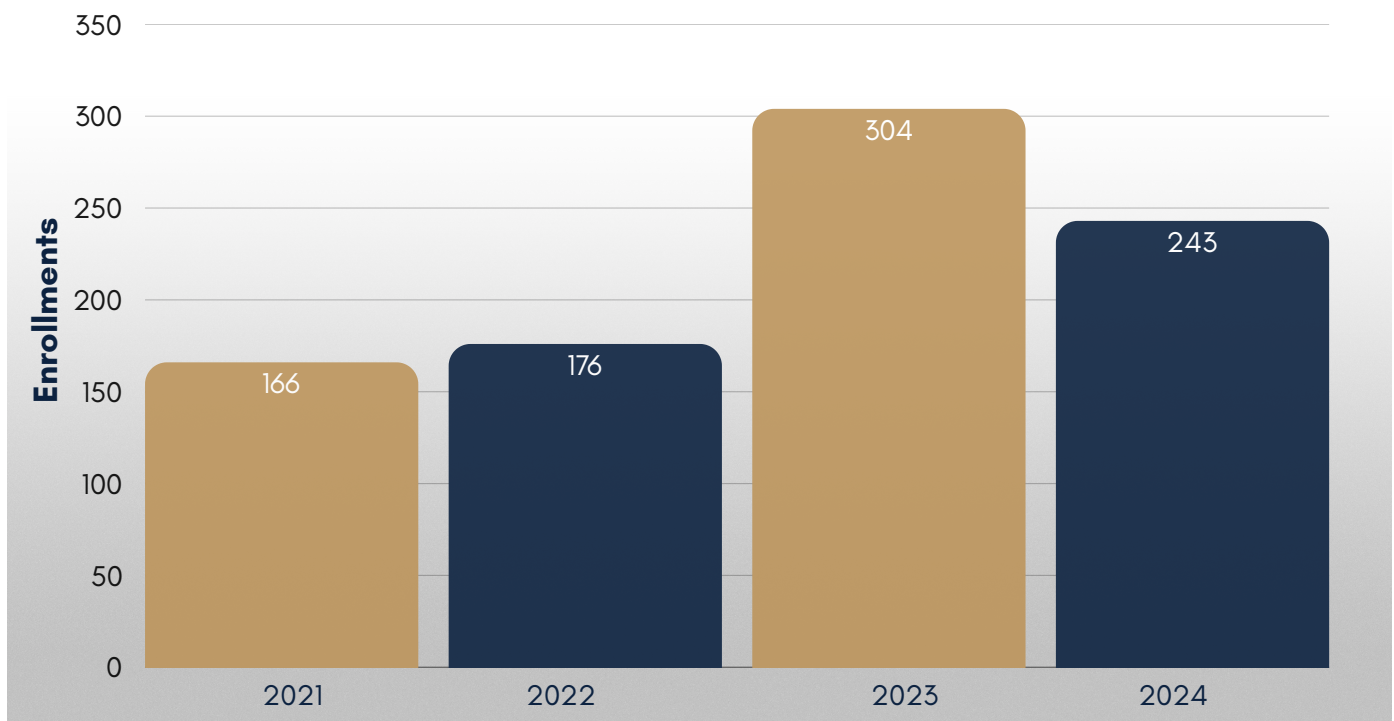
New Clients Open to an Aging Program from a MNChoices

● From the screening process ● Transfers into the HPH counties



Over 65 Managed Care Enrollments - By Year

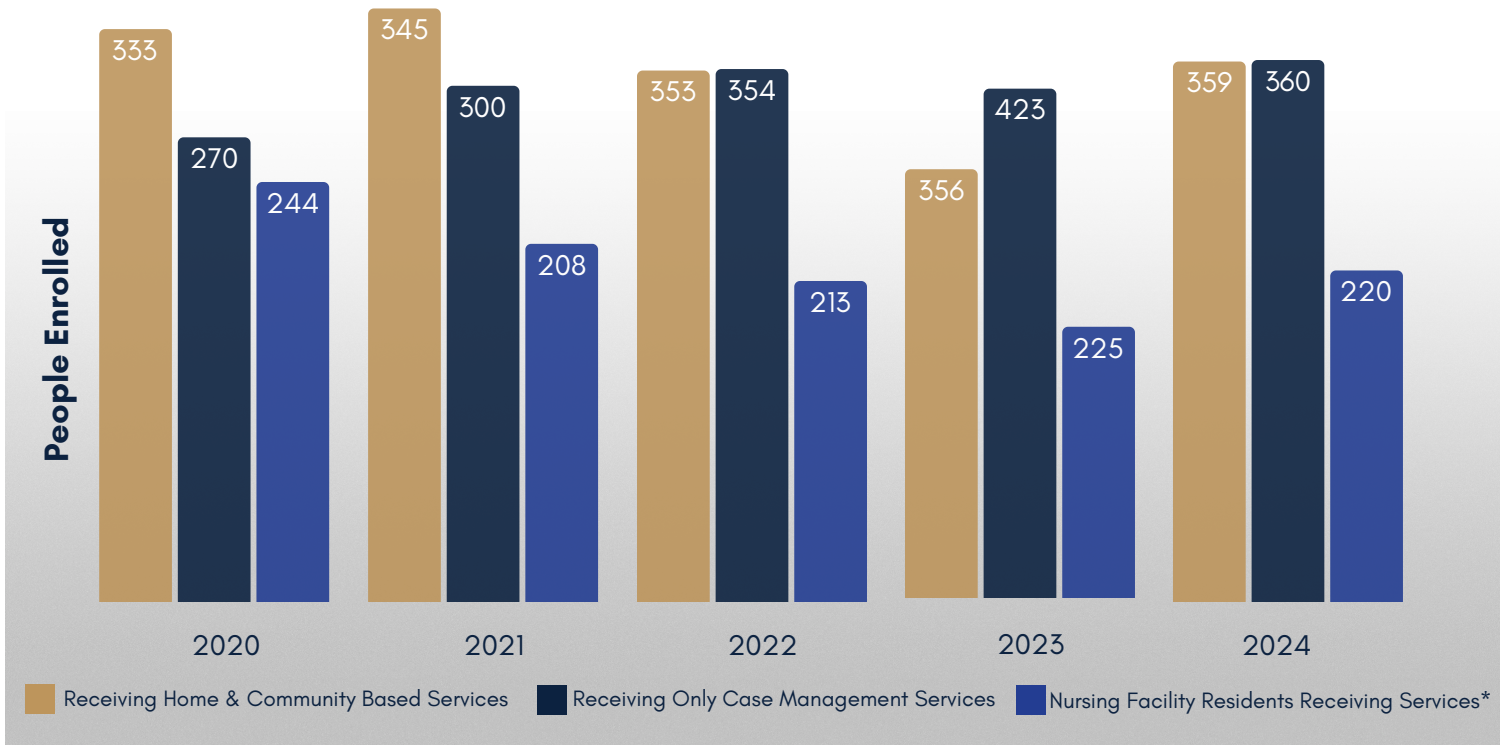
● 2021 ● 2022 ● 2023 ● 2024



ADDITIONAL DATA

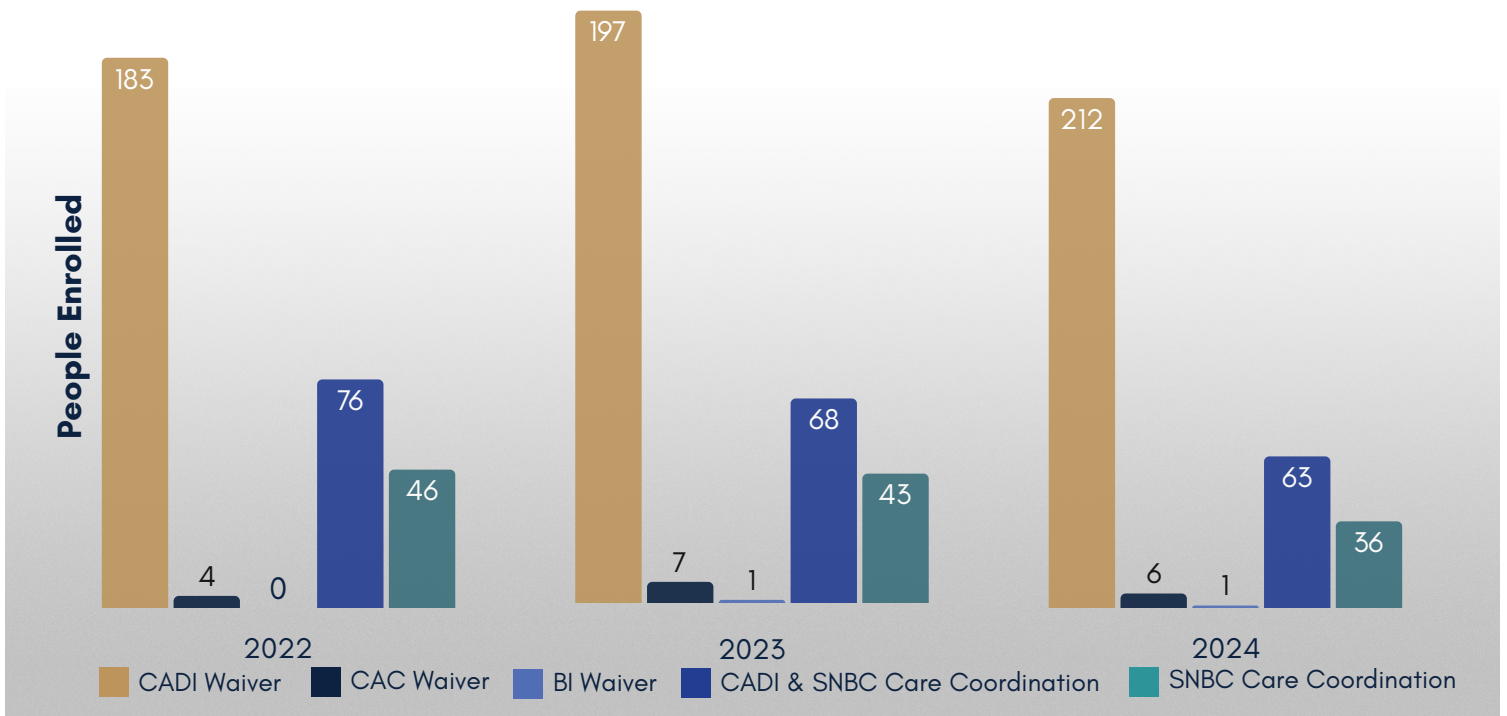
HOME & COMMUNITY BASED SERVICES

Over 65 Long Term Care Enrollment Yearly Average



*Nursing facility residents receiving medical assistance through managed care

Persons Under Age 65 Served Monthly by Program Type

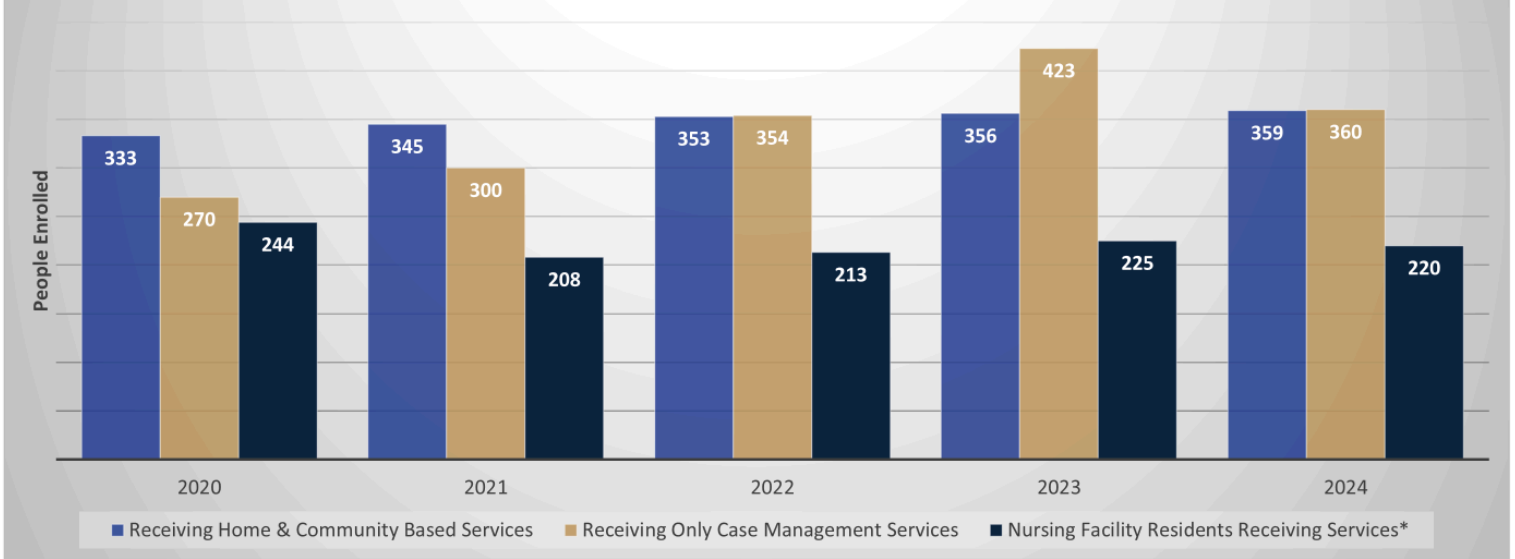


CADI (Community Access for Disability Inclusion) CAC (Community Alternative Care) BI (Brain Injury) SNBC (Special Needs Basic Care)

ADDITIONAL DATA

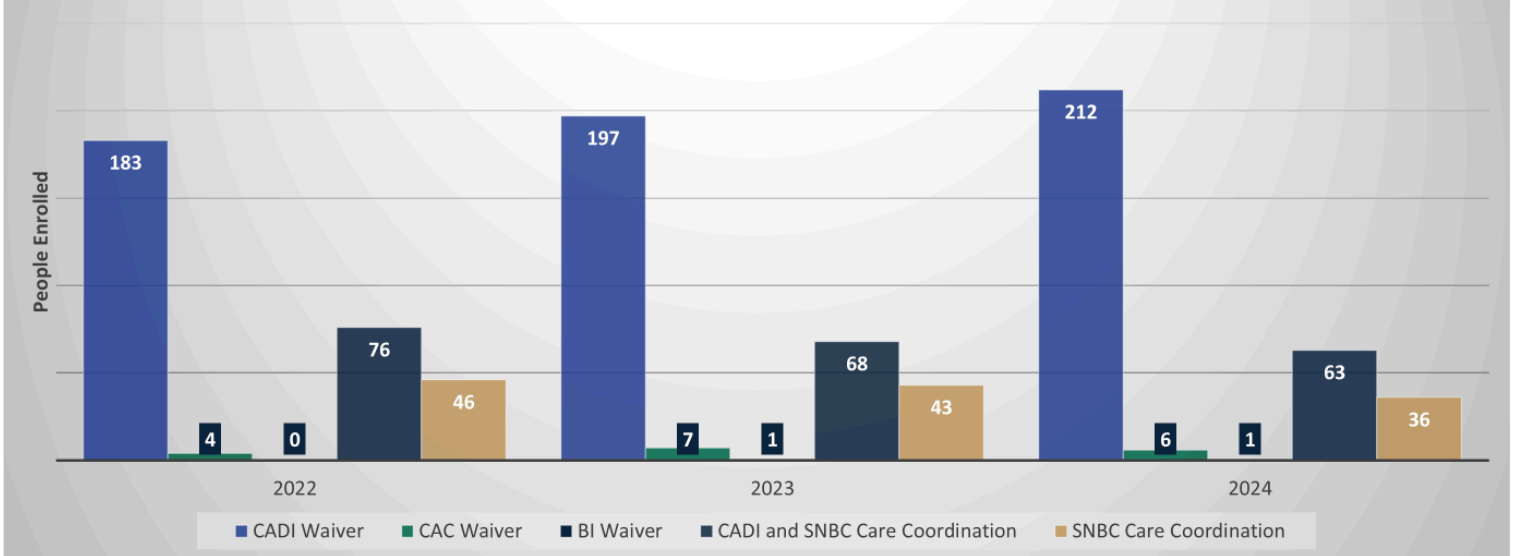
HOME & COMMUNITY BASED SERVICES

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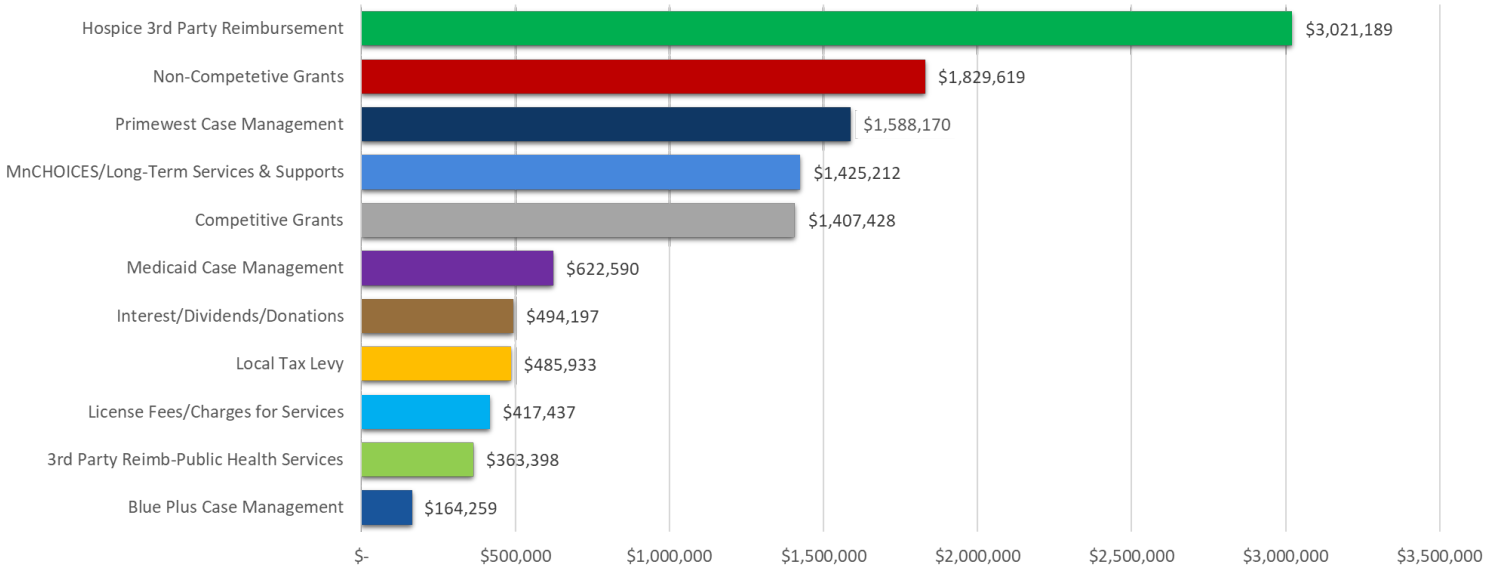


CADI (Community Access for Disability Inclusion) CAC (Community Alternative Care) BI (Brain Injury) SNBC (Special Needs Basic Care)

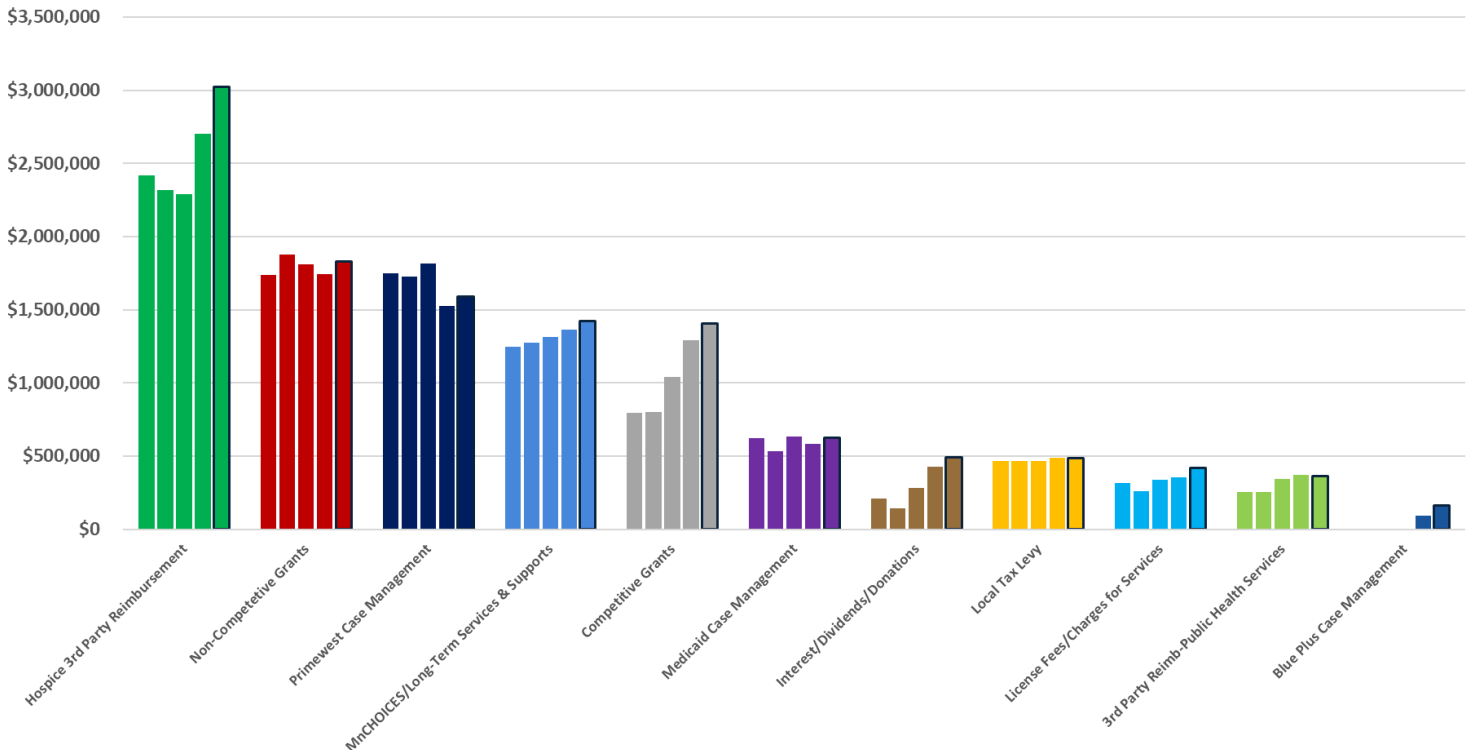
ADDITIONAL DATA

FINANCIAL SUMMARY

2024 Horizon Public Health Revenue Sources



2020-2024 Horizon Public Health Revenue Sources



Always striving to promote and protect the health of all citizens, Horizon Public Health offers a wide variety of programs and services designed to enhance the health and well-being of individuals, families and communities in our five county service area.



HORIZON



Public Health
Prevent. Promote. Protect.



Horizon Public Health

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