

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

# ANNUAL REPORT

2025

  
**HORIZON**



**Public Health**  
Prevent. Promote. Protect.



**Serving the counties of:**

Douglas, Grant, Pope, Stevens, and Traverse

# LETTER FROM THE ADMINISTRATOR



It is an honor to share the 2025 Annual Report for Horizon Public Health. This report highlights the work accomplished over the past year, the challenges we have navigated, and the continued commitment to improving the health and well-being of our community.

Throughout the year, our team remained focused on delivering essential public health services while responding to evolving community needs. From immunizations and family health programs to environmental health and prevention efforts, our work touches individuals and families at every stage of life. Whether supporting healthier choices, addressing substance use, or walking alongside individuals and families during life's most difficult moments, we are dedicated to meeting people where they are with compassion and expertise.

This report also reflects progress in our key priority areas, including expanding access to care, strengthening mental well-being, reducing substance misuse, and addressing chronic disease risk factors. These efforts are guided by our Community Health Improvement Plan and informed by data, collaboration, and the voices of those we serve.

Looking forward, we remain committed to building on this momentum and continuing to strengthen the health of our communities. This work would not be possible without the partnership of community members, local leaders, healthcare providers, and our dedicated staff, whose passion and professionalism drive our mission each day.

Thank you for your interest in and support of our work. We invite you to explore this report, share your feedback, and stay connected as we continue working toward a healthier future for all.

Warm regards,

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

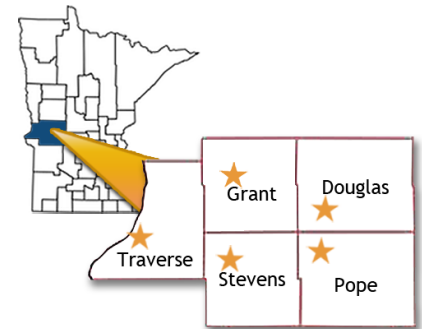
**ANN STEHN, EMPA, PHN**  
**ADMINISTRATOR**

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# 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.



## Guiding Principles

### Vision

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

### Mission

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

- **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.



# POPULATION HEALTH ASSESSMENT, PLANNING & ACCOUNTABILITY

## Population Health at Horizon Public Health

In 2025, Horizon Public Health advanced population health by strengthening its understanding of community conditions, engaging residents and partners, and using data to guide action. Through an integrated approach to assessment, planning, and performance management, Horizon supported measurable improvements in health and well-being across Douglas, Grant, Pope, Stevens, and Traverse counties.



## Accreditation & Continuous Improvement

Horizon Public Health remained accredited by the Public Health Accreditation Board (PHAB) in 2025 and continued its commitment to continuous quality improvement through a strong performance management and quality improvement (PMQI) system. Accreditation supports Horizon's ability to deliver the 10 Essential Public Health Services and ensures accountability, transparency, and consistent use of best practices.



In 2025, Horizon Public Health initiated preparation for reaccreditation in 2026, beginning work to compile and align documentation demonstrating conformity with approximately 117 PHAB measures across all accreditation domains. Ongoing population health assessment, performance management, and quality improvement activities conducted throughout the year strengthened Horizon's readiness for reaccreditation and reinforced alignment with national public health standards.

## Using Results-Based Accountability

Throughout 2025, Horizon Public Health used Results-Based Accountability (RBA) as a core framework to connect population health outcomes with internal performance management. RBA provided a consistent structure for translating data into action while supporting transparency and shared accountability.

- For population health and CHIP monitoring, RBA was used to track external measures reflecting community conditions and well-being. These measures supported evaluation of whether strategies were contributing to improved outcomes and reduced disparities across the five-county service area.
- For internal performance management, RBA supported monitoring of program activities, grant deliverables, and organizational priorities. Internal performance measures were used to assess effectiveness, guide quality improvement efforts, and inform leadership decision-making and resource allocation.

By applying RBA to both external and internal measures in 2025, Horizon strengthened its ability to implement population health strategies effectively and support continuous improvement.

# POPULATION HEALTH ASSESSMENT, PLANNING & ACCOUNTABILITY

## Community Health Assessment: Elevating Community Voice

Horizon Public Health's Community Health Assessment (CHA) process provided critical insight into community experiences, needs, and priorities in 2025. A major accomplishment during the year was the completion of Horizon's Population Health Survey, conducted once every five years to better understand resident perspectives across the region.

The survey gathered information on physical and mental health, access to care, stress and well-being, substance use, social connection, and social drivers of health such as transportation, housing stability, and food access. This effort complemented existing quantitative data by centering community voice and lived experience.

Findings from the 2025 Population Health Survey will inform future planning, resource allocation, and evaluation efforts and will serve as a key foundation for Horizon Public Health's next Community Health Assessment in 2027.

## Community Health Improvement Plan: Turning Data into Action

Horizon Public Health's Community Health Improvement Plan (CHIP) (2023-2027) continued to translate assessment findings into coordinated action in 2025. The CHIP focuses on three priority areas: Access to Care, Community Resilience, and Chronic Disease Prevention.

- In 2025, Horizon updated CHIP data and indicators to reflect the most current available information, strengthening the ability to monitor progress, guide action, and support shared accountability among partners.
- The Community Partner Leadership Team (CLT) played a key role throughout the year by supporting collaboration, data-informed decision-making, and progress monitoring across sectors.
- A significant CHIP milestone in 2025 was the launch of CredibleMind, a free, 24/7 digital mental health and well-being platform available to all residents in Horizon's five-county service area. CredibleMind expanded access to evidence-based mental health resources by reducing barriers such as cost, wait times, transportation, and stigma. Platform engagement began being monitored as part of CHIP performance tracking to assess reach and impact.

Together, these accomplishments demonstrate how Horizon Public Health used data, community engagement, and partnership in 2025 to translate population health information into meaningful action.



**CredibleMind**

[horizonpublichealth.crediblemind.com](https://horizonpublichealth.crediblemind.com)

# POPULATION HEALTH ASSESSMENT, PLANNING & ACCOUNTABILITY

**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.

# POPULATION HEALTH ASSESSMENT, PLANNING & ACCOUNTABILITY

## 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 children under the age of 5, on Medicaid in the HPH service area receiving preventative dental screenings	2024	26.2%	↗ 1	2% ↗
% of adults in the HPH service area over the age of 65 and in Managed Care that receive preventative dental screenings	2025	31.7%	↘ 2	-6% ↘

[Dental Scorecard Link](#)

**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	2025	78.0%	↘ 2	-13% ↘
% of 8 <sup>th</sup> graders in the HPH service area who report they have access and feel comfortable talking to a counselor or social worker at school	2025	61%	↗ 1	7% ↗

[Mental Health Scorecard Link](#)

**Access to Care - Mental Health** Goal: All community members can access mental health resources.

Develop and implement a GIS map to provide visual representation of mental health resources.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
# of CredibleMind mental health platform users	Q4 2025	863	↘ 1	-15% ↘

[Mental Health Scorecard Link](#)

**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	2025	981	↘ 1	-6% ↘

[Child Care Scorecard Link](#)

The **Current Trend Column** shows the direction of values. **Green arrow** = good direction, **Red Arrow** = bad direction. The number indicates how many periods the trend has continued.

The **Baseline % Change Column** shows the percent change from the baseline. **Green arrow** = good direction, **Red arrow** = bad direction.

# POPULATION HEALTH ASSESSMENT, PLANNING & ACCOUNTABILITY

## 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 <sup>th</sup> graders in the HPH service area who reported that the community cared about them 'quite a bit' or 'very much'	2025	37%	↗1	-9%↘
% of adults experiencing positive mental health every day	2025	62%	↘2	-11%↘

[Mental Well-Being Scorecard Link](#)

### Community Resilience - Mental Well-Being

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

Engage youth in Grant and Traverse Counties to build stronger relationships in the community	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
# of youth engaged in new or expanded leadership opportunities (HPH led)	Q4 2025	149	↗2	-47%↘
# of activities completed in the community (HPH led)	Q4 2025	39	↗2	70%↗

[Mental Well-Being Scorecard Link](#)

### 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 9th graders in the HPH service area who feel they have a trusted adult to talk to	2025	92.0%	↗1	4%↗
% of 11th graders in the Horizon Public Health service area who have NOT used alcohol, marijuana, and/or drugs in the past year	2025	62%	↘1	9%↗
% 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 HPH community partners around substance misuse and abuse	2025	82	↗2	64%↗
# of activities/events completed to support substance misuse and abuse (HPH led)	Q4 2025	55	↘3	-31%↘

[Substance Use Scorecard Link](#)

# POPULATION HEALTH ASSESSMENT, PLANNING & ACCOUNTABILITY

## 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 <sup>th</sup> graders in the HPH service area who reported being active 5 or more days/week for at least 60 min/day	2025	60%	↗ 1	28% ↗
% of adults who report they have never had high blood pressure/hypertension or pre-hypertension	2025	60.2%	↘ 1	15% ↗

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 2025	64.0%	↗ 1	967% ↗
% 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	2025	70.0%	↗ 0	0% ↗

[Chronic Disease Scorecard Link](#)

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	2025	13	↘ 1	-72% ↘
% of women with infant children in the Horizon Public Health WIC program who choose to breastfeed	2024	85.3%	↗ 1	2% ↗

CLICK HERE 

**Clear Impact  
Scorecard**

# PUBLIC HEALTH COMMUNICATIONS

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

## 2025 HIGHLIGHTS

- Launched the *Horizon Hub*, a new staff intranet to enhance internal communication and collaboration.
- Expanded social media presence with the addition of TikTok, increasing reach across key audiences.
- Rebranded digital platforms, including a new website URL ([horizonphmn.gov](http://horizonphmn.gov)) and updated staff email addresses to [@horizonphmn.gov](mailto:@horizonphmn.gov).
- Implemented large-scale organic and paid digital campaigns focused on priority public health topics, including substance use prevention (including cannabis), mental health, Child and Teen Checkups, emergency preparedness, Family Home Visiting, and postpartum care.
- Increased production of social media content, including videos and posts that highlight staff and their work in the community.

### Communication Performance Measures

**1,092** Total # of Facebook/Instagram Posts

**114.98%** Increase of Facebook Organic Views from Q1 2025 to Q4 2025

**89.01%** Increase of Facebook Ad Views from Q1 2025 to Q4 2025

2025 YEAR END DATA

### TOP PERFORMING CONTENT

Facebook Views - 42,456

Food Shelves		
Common Ground Coffee House	(320) 291-4239	514 NewHome St. Alexandria
Free Little Pantry (located at Free Methodist Church)	(320) 763-5395	4022 8th Ave E. Alexandria
Dunwooch Food Shelf	(320) 392-8411	1205 Lake St. Alexandria
Sally's Pantry (located at The Church in the Pines)	(320) 363-4990	3902 Minnesota Hwy 27. Alexandria
Browns Valley Food Shelf	(320) 495-2467	106 4th St S. Browns Valley
Grant County Food Shelf	(318) 685-4076	101 Hwy 79 E. Elbow Lake
Pope County Meals & Hands	(320) 454-5408	204 4th Ave NW. Glenwood
Hoffman-Kennings Area Food Shelf	(701) 440-3936	300 3rd St S. Hoffman
Stevens County Food Shelf	(320) 581-2454	710 Iowa Ave. Morris
Wheaton Food Shelf	(320) 422-7777	15 10th St S. Wheaton

Facebook Views - 13,074

**85,237** Total # of Website Page Views in 2025

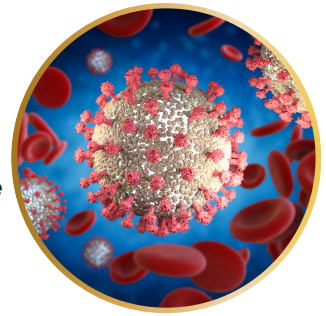
**23%** Increase of Website Page Views from 2024 to 2025

Connect with us

<http://horizonphmn.gov>

# DISEASE PREVENTION & CONTROL

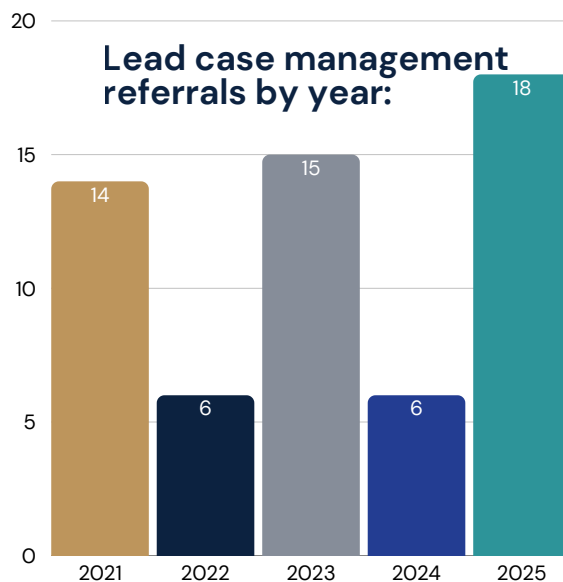
**The primary goal of a disease prevention and control program** is to protect the health of individuals and communities by reducing the risk of illness, complications, and outbreaks. Prevention efforts focus on stopping diseases before they occur through proactive strategies, such as vaccinations, education,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



**Here are key highlights of our efforts to support disease prevention work across the region, including relevant data points to stay informed.**

## Lead Referrals

Lead exposure is preventable, yet it remains one of the most common environmental hazards for children. Deteriorating lead-based paint in older homes continues to be the primary source of exposure in the United States. Universal blood lead testing is recommended at 12 and 24 months of age to identify exposure early, as lead can impact learning, behavior, and IQ. Horizon Public Health provides case management services, ranging from educational mailings to in-home visits, to support affected families. For most children and adults exposed to lead, identification and elimination of the source of lead is the primary intervention.



## Top 10 Reportable Diseases for Horizon Public Health by Year

2024 Data

- COVID-19
- Chlamydia
- Influenza-Hospitalized Cases
- Lyme Disease
- Pertussis
- Gonorrhea
- Salmonella
- S. Pneumoniae, Invasive
- Histoplasmosis
- Campylobacter

➤ **Environmental risk assessments help identify lead-based paint and lead contaminated dust hazards in the homes.**

**5** children had a home risk assessment completed by MDH

➤ **# of children referred for lead case management services in 2025: 18**

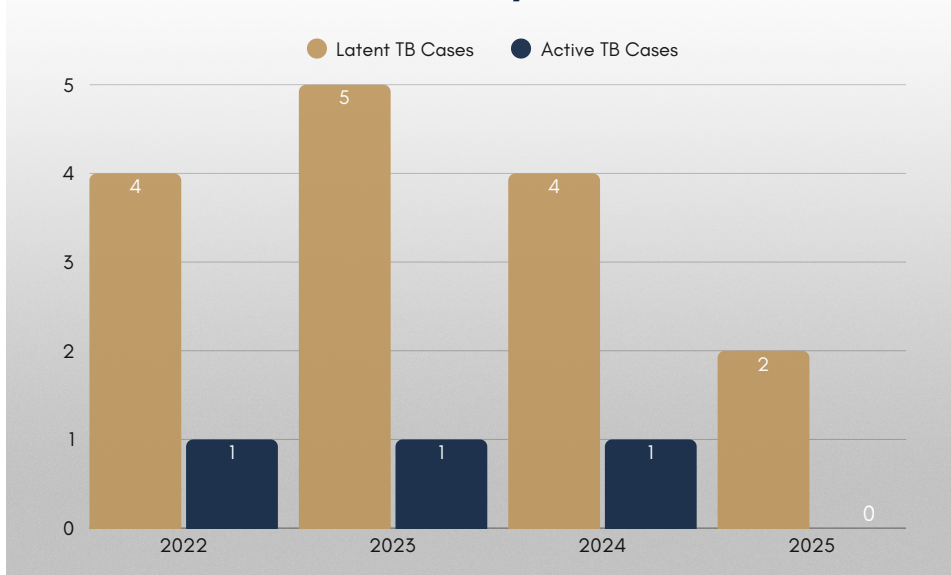
# DISEASE PREVENTION & CONTROL

## 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.

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 2025, Public Health staff provided case management and medication support to 3 individuals with latent TB infection to ensure safe treatment and successful completion of their medication.

### TB Cases by Year



## Vaccinations

### 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
- 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.

### Vaccinations administered across all age ranges:

- # of vaccines administered: **685**
- # of clinics held in office: **44**
- # of mobile clinics: **22**

- Total site visits completed in 2025: **11**

# DISEASE PREVENTION & CONTROL

## Healthy Kids Project

- **Partnership & reach:** In partnership with Minnesota Department of Health and the Alexandria School District, Healthy Kids offers voluntary participation to families of 3–6-year-olds at Early Childhood Screening sites, rotating through one metro and one non-metro region each year in a five-year cycle.
- **What families do & what's tested:** Families complete a survey and provide a child urine sample, which is tested for six groups of chemicals—metals, pesticides, phthalates, flame retardants, environmental phenols, and air pollution chemicals—and receive results with exposure–reduction guidance, referrals for high levels when needed, a thank–you gift card, and a free private well test kit.

- **Funding:** Supported by the Centers for Disease Control and Prevention State Biomonitoring Cooperative Agreement and the Minnesota Legislature.

- **Participation:** Approached 134 families; 86 agreed to participate; 76 families were fully recruited and able to provide samples.

- **Initial Follow-up findings:**

- **24 arsenic cases required follow-up (0 from Alexandria)**

- Most re-tests so far were lower
    - Likely related to high frequency rice consumption, also a link with seaweed

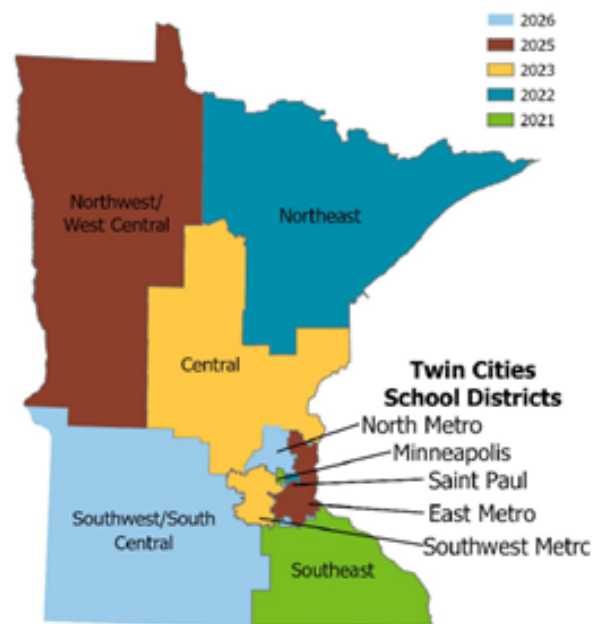
- **11 manganese cases (2 from Alexandria)**

- Re-tests so far were lower
    - Most frequently related to diet, want to rule out environmental sources i.e. private wells

- Interpretation: Exposures were most often linked to dietary sources and were not considered a health concern

- Next steps: Full analysis of results will be available and distributed to families in Spring 2026.

Healthy Kids Minnesota Program regions



# PUBLIC HEALTH EMERGENCY PREPAREDNESS

## Preparedness Exercises, Real Events, and Outreach/Education Activities Supported by, Participated in, or Led by HPH in 2025

JAN

- HPH Communications and Risk Communications Plan: Communications and Preparedness staff education, review, and revisions
- West Central MN Responds Volunteer emergency notification test – 37% response rate

FEB

- HPH Power Outage Exercise: Operation “In the Dark”

MAR

- Family Assistance Center Planning Meeting
- Medical Response & Surge Exercise with Healthcare partners (Alomere; Lake Region Hospital; Sanford Wheaton Medical Center; Stevens Community Medical Center)
- Attended and evaluated Measles Exercise for Partnership4Health
- Deep Freeze Disaster Medical Response Surge Exercise-Alomere

APR

- Alexandria Rail-Based Exercise, Douglas County
- Family Assistance Center Planning Meeting
- Family Assistance Center Workshop, Stevens County
- Minnewaska Lutheran Home Exercise, Pope County
- Thank you post cards sent to MN Responds volunteers

MAY

- American Red Cross Shelter Training Planning Meetings
- HPH Medical Countermeasures Plan: Disease Prevention and Preparedness Staff Education, Review and Revisions
- West Central MN Responds Volunteer Lunch and Learn (Topics: Administering Epinephrine and Narcan)

JUN

- High Winds Event, Stevens County
- HPH Medical Countermeasures Plan: Disease Prevention and Preparedness staff Education, Review and Revisions
- Active Threat Response & Recovery Functional Exercise, Stevens County
- HPH All-Staff American Red Cross Shelter Training
- Douglas County TRIAD Senior Expo

JUL

- Flash Flooding, Stevens County
- HPH Medical Countermeasures Plan: Disease Prevention Staff Education, Review and Revisions
- West Wind Village Nursing Home Exercise, Stevens County
- HPH Preparedness Retreat and Strategy Planning

AUG

- Support Flood Response, Stevens County
- I Luv U Guys Foundation Training
- HPH Measles Outbreak Exercise Planning
- Coffee with a Cop: Information sharing and collecting for a vulnerable population registry, Pope County
- “Open Line” presenter for National Preparedness Month with Douglas County Emergency Manager

SEP

- Potential Hazardous/Environmental Health Exposure, Pope County
- HPH Medical Countermeasures Plan: Disease Prevention and Preparedness Staff Education, Review and Revisions
- Pope County Senior Expo
- Systems Down Cyber Threat Exercise with HPH Hospice of Douglas County program
- Community Night Out, Stevens County

NOV

- HPH preparedness staff initial training on the vulnerable population registry, known as the CARE List
- HPH Measles Multi-County Outbreak Tabletop Exercise
- Stop the Bleed Training for West Central MN Responds Volunteers, Clay County

DEC

- Gas Leak, Douglas County
- County Evacuation and Re-Entry Coordination Exercise, Douglas, Grant, Pope, Stevens and Traverse Counties



# 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.

## MNResponds volunteers in HPH service area:

- Douglas-146 (2024: 136) ↑ 10
- Grant-40 (2024: 38) ↑ 2
- Pope-41 (2024: 40) ↑ 1
- Stevens-42 (2024: 41) ↑ 1
- Traverse-24 (2024: 22) ↑ 2

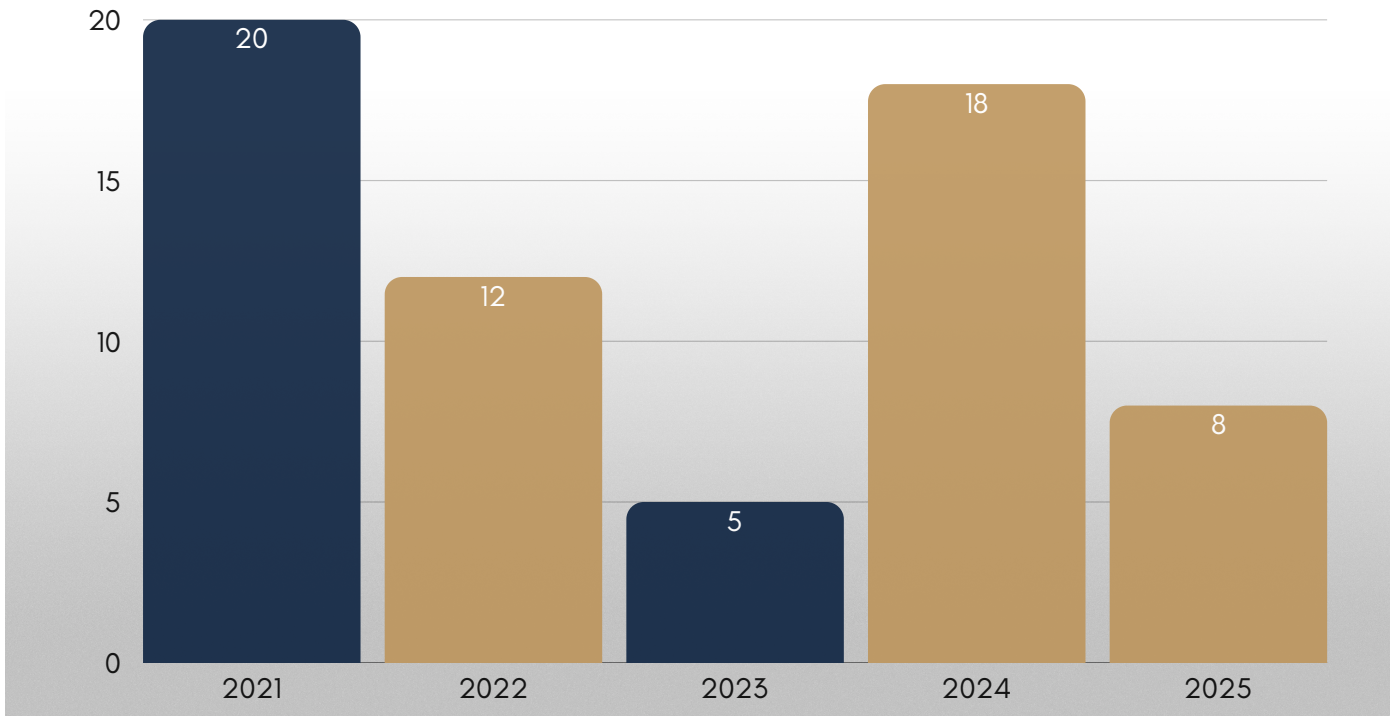
MNResponds is Minnesota's volunteer registry for health and non-health professionals who are ready to assist during public health emergencies and community needs.

## Total Received and Disseminated in 2025: **8** Health Alerts

- Avian Influenza A (H5N1) Testing in Hospitalized Patients
- Influenza-Associated Acute Necrotizing Encephalopathy
- Measles Cases in Twin Cities
- Increase in Tularemia in Minnesota
- Sedative Associated Overdoses
- New Measles Cases in Twin Cities Area
- Infant Botulism Outbreak Linked to Infant Formula
- First Reported Marburg Virus Outbreak in Ethiopia



## 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 Participation Rate by County and Year					
	2020	2021	2022	2023	2024
DOUGLAS	49%	52%	48%	50%	53%
GRANT	42%	49%	47%	48%	49%
POPE	45%	45%	41%	42%	47%
STEVENS	47%	49%	54%	56%	59%
TRAVERSE	41%	42%	42%	39%	50%
STATE RATE	45%	51%	49%	50%	51%

➤ **6,948** C&TC OR partnered with **parents of** (birth-21 years old) to remind them to get their child in for well child checkups with their primary care provider.

➤ **Contacts by phone, letter or in person** with Medicaid eligible families in our counties to promote well child checkups and assist them, if needed, to get in for those checkups: # of reminder letters sent, follow up calls made: **6,570**



➤ **17** # of trainings to key partners and community **events attended:**

➤ **Trainings:** Glacial Ridge Clinic, Browns Valley Clinic, Starbuck Medical Clinic, Sanford Alexandria, Sanford Wheaton, Alexandria Clinic

➤ **Community events:** Alexandria Community Night Out, Brandon-Evansville Baby Shower, Grant County Family Night, SCMC Fall into Health, Alexandria Community Baby Shower

➤ **Number of referrals made** by the child's healthcare provider during a C&TC visit, for which HPH staff provided follow-up with the family: **155**

➤ **Social Media Viewers** **127,223**  
The number of accounts that viewed C&TC ads at least once.

➤ **Social Media Views** **747,569**  
The number of times C&TC ads were played or displayed.

## Social Media Campaigns



# MATERNAL AND CHILD HEALTH

## Child Passenger Safety Program

Horizon Public Health promotes child safety through its Child Passenger Safety Program, offering education, car seat checks, and car seat distribution to eligible families in the community at no cost.

**Certified Child Passenger Safety Specialists** are available to answer questions and ensure car seats are properly installed and appropriate for each child. During car seat checks, specialists assess:

- Seat condition, including defects and recall status
- Appropriateness for the child’s age and size
- Proper installation and fit with the vehicle’s safety belt system

In **2025, a total of 158 car seats** were distributed to families in need, improving access to essential safety equipment and reducing financial barriers.

### Car seats are available for:

- Expecting families preparing for a new baby
- Infants outgrowing rear-facing carrier seats
- Toddlers transitioning from convertible seats
- Children ages 4-8 in need of booster seats



Car seats are provided to individuals covered by **PrimeWest Health, Blue Plus, or Medical Assistance**, helping ensure all children can travel safely regardless of income.

This program supports injury prevention efforts by increasing proper car seat use and equipping families with the tools and knowledge needed to keep children safe while traveling.

## 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.

➤ 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 (EHD).

**10** families were assessed and connected with resources through BDIS and EHD.

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

**73** prenatal women were assessed and offered referrals to services.

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

**17** mother and birth partner couples attended breastfeeding classes.

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

<b>104</b>	:	<b>337</b>	:	<b>267</b>	:	<b>29</b>	:	<b>666</b>
New clients signed up for FAP in 2025		ASQ-3 questionnaires received		ASQ-SE questionnaires received		Help Me Grow referrals made by FAP nurses		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: **159**



Mental health referrals completed: **21**



Clients participating in MH services: **21**



### CHILDREN

ASQ-3 developmental screenings completed: **232**



ASQ-SE social emotional screenings completed: **157**



Help Me Grow referrals: **14**



Total program graduates in 2025: **36**

**157** Families served



**148** Children served



**1090** 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



## Screenings & Referrals

### CAREGIVERS

Depression/anxiety screenings completed: **71**



Mental health referrals completed: **10**



Clients participating in MH services: **20**



### CHILDREN

ASQ-3 developmental screenings completed: **75**



ASQ-SE social emotional screenings completed: **48**



Help Me Grow referrals: **9**



Children receiving ECSE service: **10**

**102** Families served



**101** Children served



**326** Visits completed

# HOME VISITING PREVENTATIVE SERVICES

Horizon Public Health continues to support families through its **Free Universal Postpartum Visit Program**, ensuring every family has access to early guidance and care following the birth of a new baby.

Through referrals from local birth centers, public health nurses provide **1-2 in-home visits** to assess the health and well-being of both parent and infant while offering education and support during this critical transition period.

In **2025, 53 families** accepted and received postpartum visits, reflecting strong community engagement and trust in this service.

## Key services include:

- Infant weight checks to monitor early growth and development
- Breastfeeding support to promote successful feeding practices
- Parenting education and connection to community resources
- Home and infant safety promotion
- Screening for postpartum depression and anxiety to support maternal mental health

This program plays a vital role in strengthening family health outcomes, promoting early intervention, and connecting families with ongoing community supports.

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.



**94** **home safety assessments** were completed by nurses.

**115** families were provided **safe sleep education**

**24** families received a safety-approved **portable crib**.

**52** children were seen at a **C&TC clinic**

**26** C&TC screenings completed

**5** were full C&TCs uninsured/head start (HS) - remaining were screenings completed to meet HS requirements.

**52** lead tests completed.



**Horizon Public Health Postpartum Video**

**WATCH VIDEO**



# WOMEN, INFANTS, AND CHILDREN

Women, Infants, & Children (WIC) provides:

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

The WIC team served an average of **1,385** participants per month.

WIC serves:

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

Healthy WIC Food Packages include:

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

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



WIC Staff Photo - 2025



## WIC Benefits Redeemed in the HPH Service Area



# HEALTH EDUCATION

Horizon Public Health's Health Education team is composed of six full-time health educators and dedicated program support staff who work 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 **13** grant-funded programs, the team addresses a wide range of priority areas, including healthy eating; physical activity; mental well-being and suicide prevention; substance misuse and cannabis prevention; health equity; traffic safety; and tobacco and e-cigarette prevention. By partnering with schools, workplaces, and community organizations, the Health Education team empowers residents of all ages to make healthier choices and build stronger, safer communities.

## HIGHLIGHTS

Through the **Blandin Foundation Rural Placemaking grant**, Horizon Public Health supported community-led events and strategies in Grant County that activated shared spaces and brought youth and families together through arts, recreation, and prevention-focused programming. These efforts strengthened community connections and fostered a sense of belonging for youth.

In Grant County, from 2022 to 2025, there was a **23% increase** in the number of students who reported feeling cared for "quite a bit" or "very much" by adults in the community.



Youth Art Experience



Minnewaska Safe & Welcoming Committee

### PrimeWest Health Community Reinvestment Grant

In partnership with all five major healthcare system partners, Horizon Public Health scaled standardized social determinants of health screening in 2025 to reach over 40,000 individuals, identifying more than 1,500 patients experiencing food insecurity. The launch of Food Rx and Nutrition Stability Box programs strengthened clinical-community referral pathways and sustainable food access, with **181 patients enrolled in Food Rx** and an average BMI reduction of 0.44 percent, demonstrating positive health outcomes.



Let's Go Fishing Event

Horizon received a five-year grant called **Communities that Care (CTC)**. The CTC grant is a prevention framework designed to reduce youth-related issues in the community. These issues may include youth substance use, violence, bullying, mental health concerns, and other challenges affecting young people. The Communities that Care grant, which is being implemented in **Pope County and Minnewaska Area Schools**, follows a five-phase process that involves collecting data specific to youth in the Pope County community and using that information to address identified needs.



Presenting cannabis education to local leaders

The **Cannabis Substance Use Prevention (CSUP)** coordinator has provided cannabis education and ordinance support to all **5 county local governing boards**, helping communities adopt and update local cannabis ordinances that align with state law and public health practices.

# HEALTH EDUCATION

## HIGHLIGHTS CONTINUED



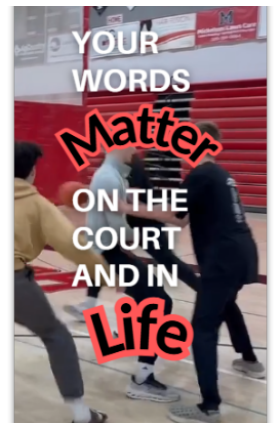
VPA Team Photo

The Vape Prevention and Awareness (VPA) youth group planned and completed **13** youth-led events during 2025.

**35** students from Brandon-Evansville, Ashby, and West Central Area Schools were involved in VPA in 2025.

Through funding from the **Opioid Settlement and the Substance Misuse and Suicide Prevention Grant**, youth at West Central Area Schools engaged in meaningful conversations about the mental health challenges they are experiencing.

Building on themes identified in the listening sessions, **14** students chose to create and film videos focused on reducing mental health stigma, highlighting the pressures of being a student-athlete, and promoting kindness throughout their school community.



West Central Area Schools Mental Health Videos

In partnership with Grant County Sheriff's Office and Grant County Toward Zero Deaths, Horizon Public Health supported **Safety Town at Ashby School.**



With support from a SHIP grant, **Chokio-Alberta Public School** made big strides in student wellness! One exciting change—a newly transformed space just for student counseling; a cozy comfortable, and welcoming area where **mental health matters.**

Through the **Statewide Health Improvement Partnership (SHIP)**, access to physical activity was expanded by adding shared-use community bike fleets.

**3** new community bike fleets (15 bikes total) added in Osakis, Brophy Park (Alexandria), and Wheaton

Hands-on education in pedestrian and bicycle safety was received by **30** kindergarten students.



Wheaton Bikes



Osakis Bikes



Brophy Park Bikes (Alexandria)

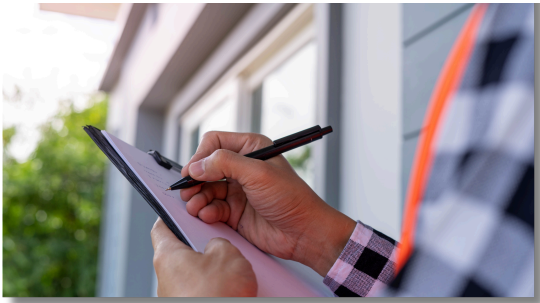
Through interactive learning in a mini "town," students built foundational skills that promote lifelong safety habits and active transportation.



# 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.



## 2025 HIGHLIGHTS

Licensed **467**  
food, pool, and lodging  
establishments

.....

Completed **467**  
food, pool, and lodging  
inspections

.....

Licensed **153** Private  
Vacation Home Rentals, a  
96% increase in 5 years

.....

Licensed and  
inspected **44**  
pools and spas

.....

Issued **77**  
permits for special events

Investigated **9** foodborne illness  
complaints

Conducted **12** food, pool and  
lodging Plan Reviews for new  
construction, remodels and additions  
to licensed establishments.

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

**33** % of public health nuisance  
complaints received involved mold

# HOME & COMMUNITY BASED SERVICES

The Horizon Public Health case management team, comprised of registered nurses and social workers, partners with individuals and their families or legal guardians to deliver person-centered care through home and community-based services. The process begins with a comprehensive MNChoices assessment, which takes a holistic approach to understanding the individual and is available to anyone residing in our communities at no charge.



Case Management Team

During the assessment, our certified assessors meet with individuals and their families to identify strengths, needs, and preferences, and then provide information and make recommendations about services and supports that can enhance health, independence, and overall 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 that outlines recommended services and supports, which may include assistance with personal care, homemaking, home-

delivered meals, emergency response pendants, employment supports, or transitions to assisted living or foster care.

Once eligibility for a publicly funded program is established, our case managers and care coordinators facilitate access to desired services and supports. Authorized services are determined by assessed health and safety needs, adhere to program guidelines, and reflect the individual's preferences and choices.

Case managers provide ongoing support by sharing information about available resources, coordinating referrals, promoting informed decision-making, and assisting individuals in working toward their personal goals. The care plan is reviewed and adjusted as needs or goals change, with an annual reassessment conducted to confirm continued eligibility and to update preferences with services and providers.

## 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](#)

[Link](#)

## 529

529 initial, county of residence, and reside in SNF (under age 65) screenings complete in 2025.

## 445

the under 65 case management team managed an average of 445 clients on a monthly basis.

## 918

the over 65 case management team managed an average of 918 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 2025

- **January** - Hospice Educational Video Released
- **February** - Helen Feda named Minnesota Hospice and Palliative Care Volunteer of the Year
- **May** - Hospice Volunteer Appreciation Dinner
- **July** - Received Hospice Honors for a 5-star satisfaction rating from the families of our Hospice patients.
- **August** - Annual Butterfly Release



*Hospice of Douglas County Staff - September 2025*

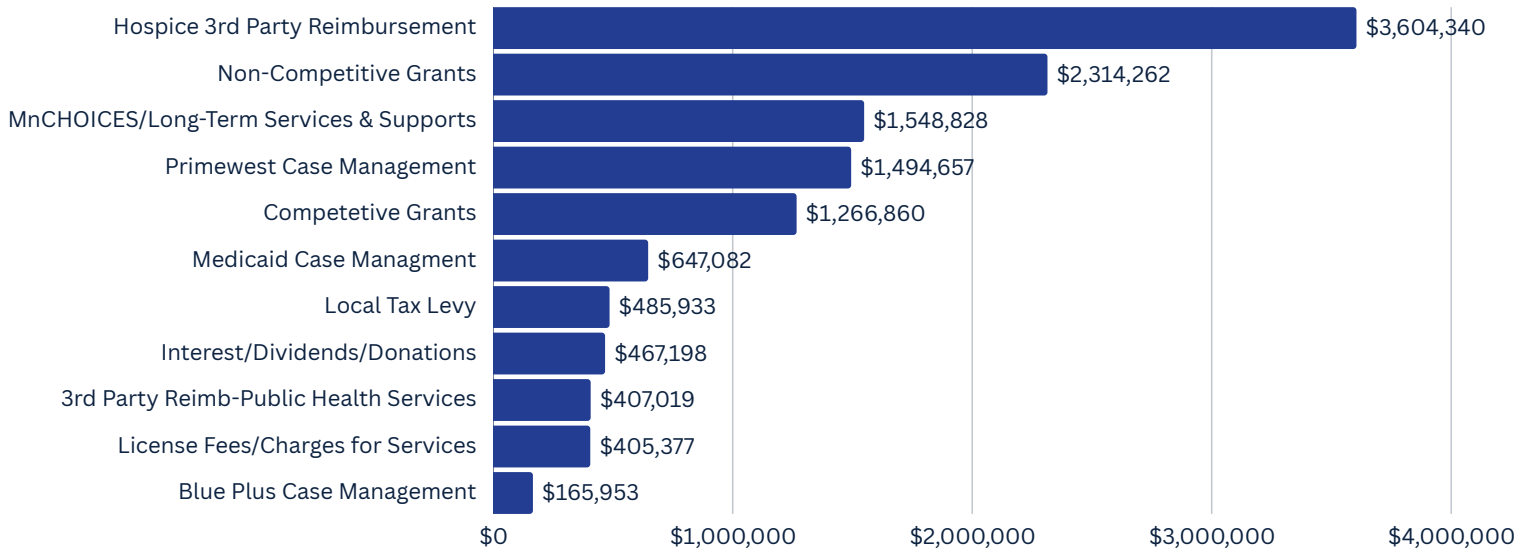
<b>136</b>
Admissions
.....
<b>13,026</b>
Total # of Patient Days Billed
.....
<b>2,787</b>
Nurse Visits on Weekdays
.....
<b>198</b>
Nurse Visits on Weekends

***"They may forget what you said, but they will never forget how you made them feel."***

*- Carl W. Buechner*

# FINANCIAL SUMMARY

## 2025 Horizon Public Health Revenue Sources



The 2025 financial summary for Horizon Public Health continues to reflect a strong and diversified revenue base. Total revenues increased to \$12,807,509, demonstrating steady organizational growth and continued demand for services. Grant funding remains a significant contributor to Horizon’s financial health. In 2025, total grant revenue reached \$3,581,122 an increase from 2024. Non-competitive grants saw a substantial rise to \$2,314,262 while Competitive grant funding experienced a slight decrease from the previous year totaling \$1,266,860.

Horizon continues to maintain a broad mix of program-generated revenue. Hospice services remain the largest single revenue source at \$3,604,340, followed by MnChoices/Long-Term Services & Supports and PrimeWest Case Management. Medicaid Case Management and other public health service reimbursements also contribute significantly to overall revenue. This diversity strengthens financial stability while supporting essential services across the region.



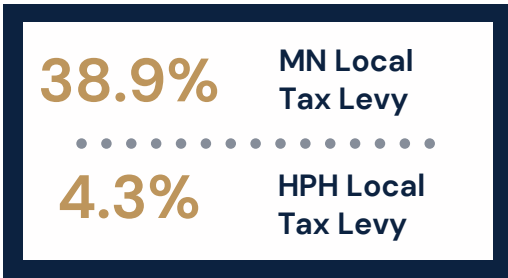
# FINANCIAL SUMMARY

2024 MN Local Public Health System Funding		
Funding Source	Dollars	% of total funding
Local Tax Levy	\$192,149,721	38.9%
Other Federal Funds	\$92,272,120	18.7%
Other State Funds	\$58,006,434	11.7%
Other Fees	\$31,449,223	6.4%
Medicaid	\$34,069,460	6.9%
Local Public Health Grant	\$28,303,424	5.7%
Other local funds	\$21,162,617	4.3%
Medicare	\$8,004,933	1.6%
Private Insurance	\$7,773,365	1.6%
Federal TANF	\$7,211,100	1.5%
Federal Title V	\$6,451,117	1.3%
Foundational (FPHR)	\$4,161,522	0.8%
Client Fees	\$2,990,313	0.6%
<b>Total</b>	<b>\$494,005,349</b>	<b>100.0%</b>

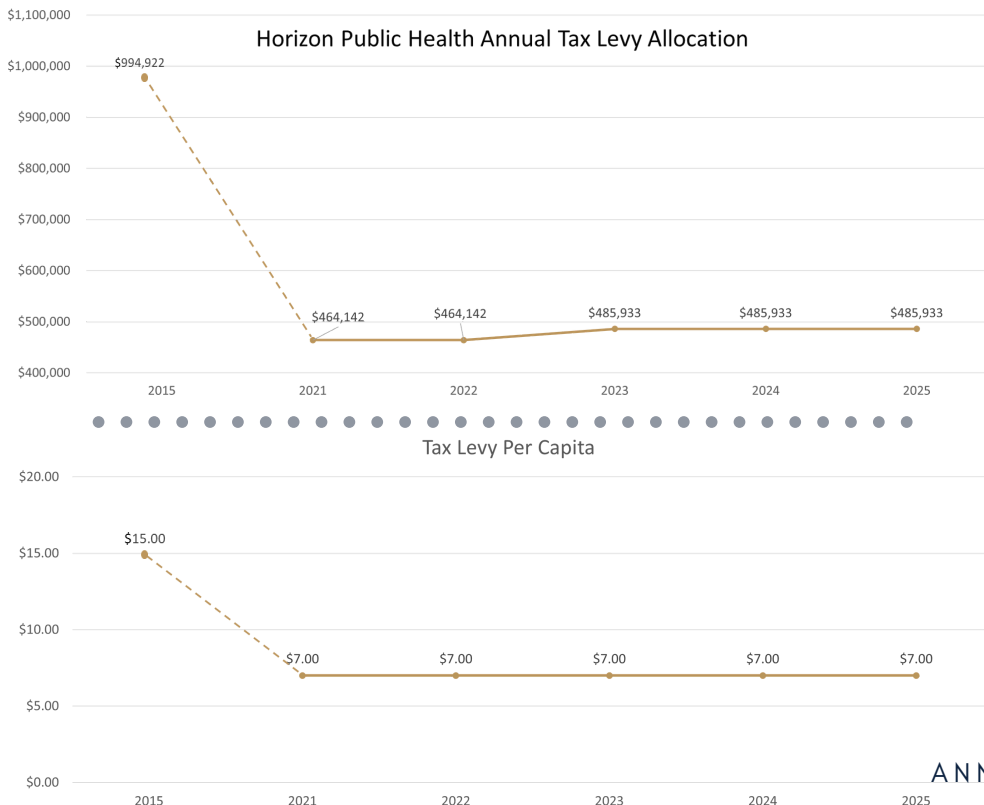
2024 Horizon Public Health Funding		
Funding Source	Dollars	% of total funding
Medicare	\$2,889,721	25.9%
Medicaid	\$2,315,827	20.7%
Other State Funds	\$1,985,307	17.8%
Other Federal Funds	\$1,630,351	14.6%
Other local funds	\$732,496	6.6%
Local Tax Levy	\$485,933	4.3%
Local Public Health Grant	\$438,360	3.9%
Other Fees	\$377,420	3.4%
Foundational (FPHR)	\$100,776	0.9%
Federal Title V	\$91,022	0.8%
Federal TANF	\$83,820	0.7%
Private Insurance	\$31,737	0.3%
Client Fees	\$12,170	0.1%
<b>Total</b>	<b>\$11,174,940</b>	<b>100.0%</b>

\*2024 MN Local Public Health System Funding is the most current data for comparison.

\*Data does not include COVID-19 funding or expenditures.



MN Local Public Health funding data is collected annually from all Community Health Boards in MN. In 2024, local tax levy dollars continue to be the number one funding source for Local Public Health systems across MN making up 38.9% of total annual funding. Horizon Public Health, however, maintains a significantly lower reliance on local tax support (4.3%) due to its diversified funding model.

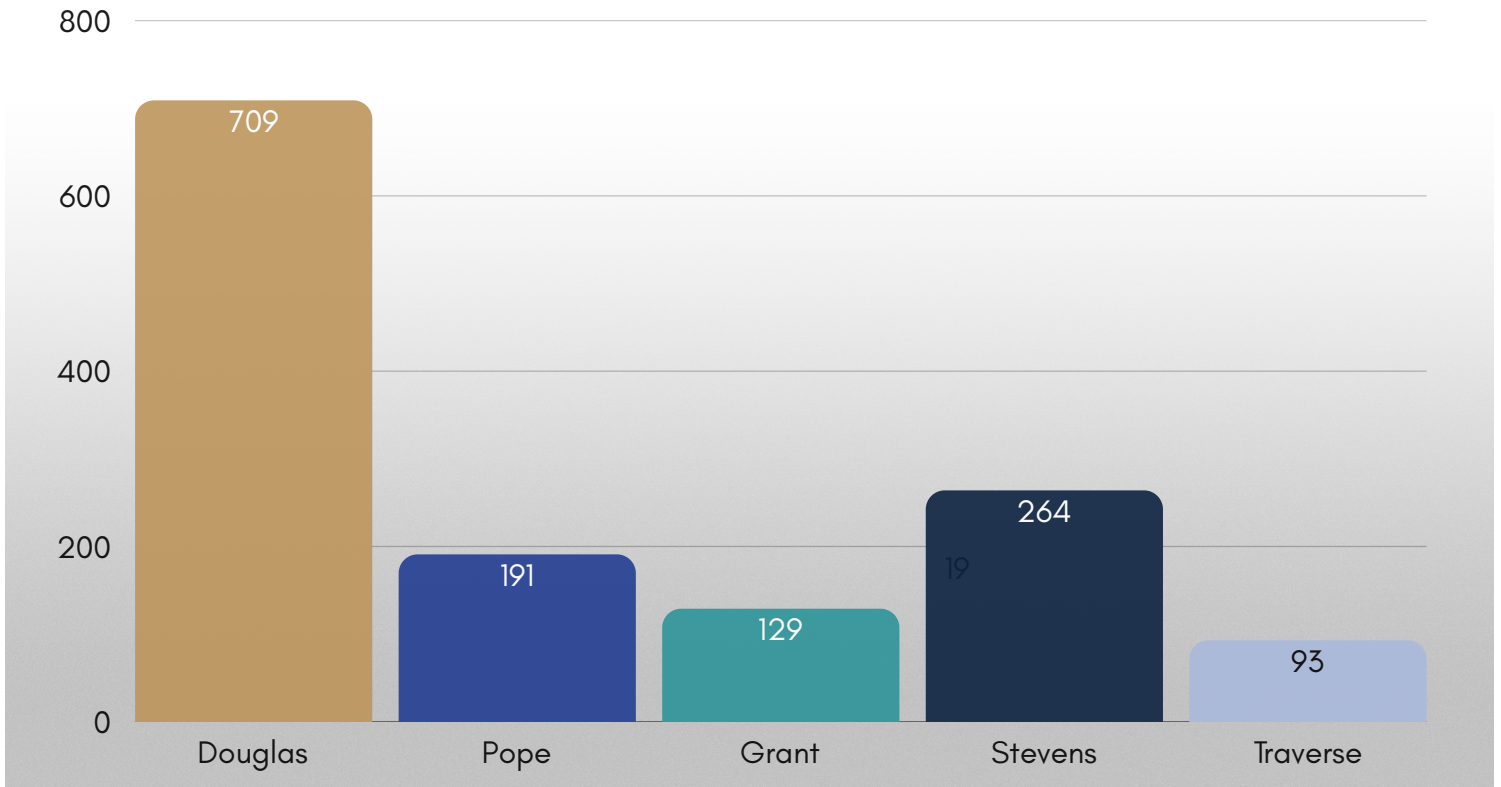


Horizon Public Health received 4.3% of its revenue from local tax levy support in 2024, totaling \$485,933. Horizon’s ability to leverage grants, service reimbursements, and program revenue allows the organization to minimize the burden on local taxpayers while still delivering comprehensive public health services.

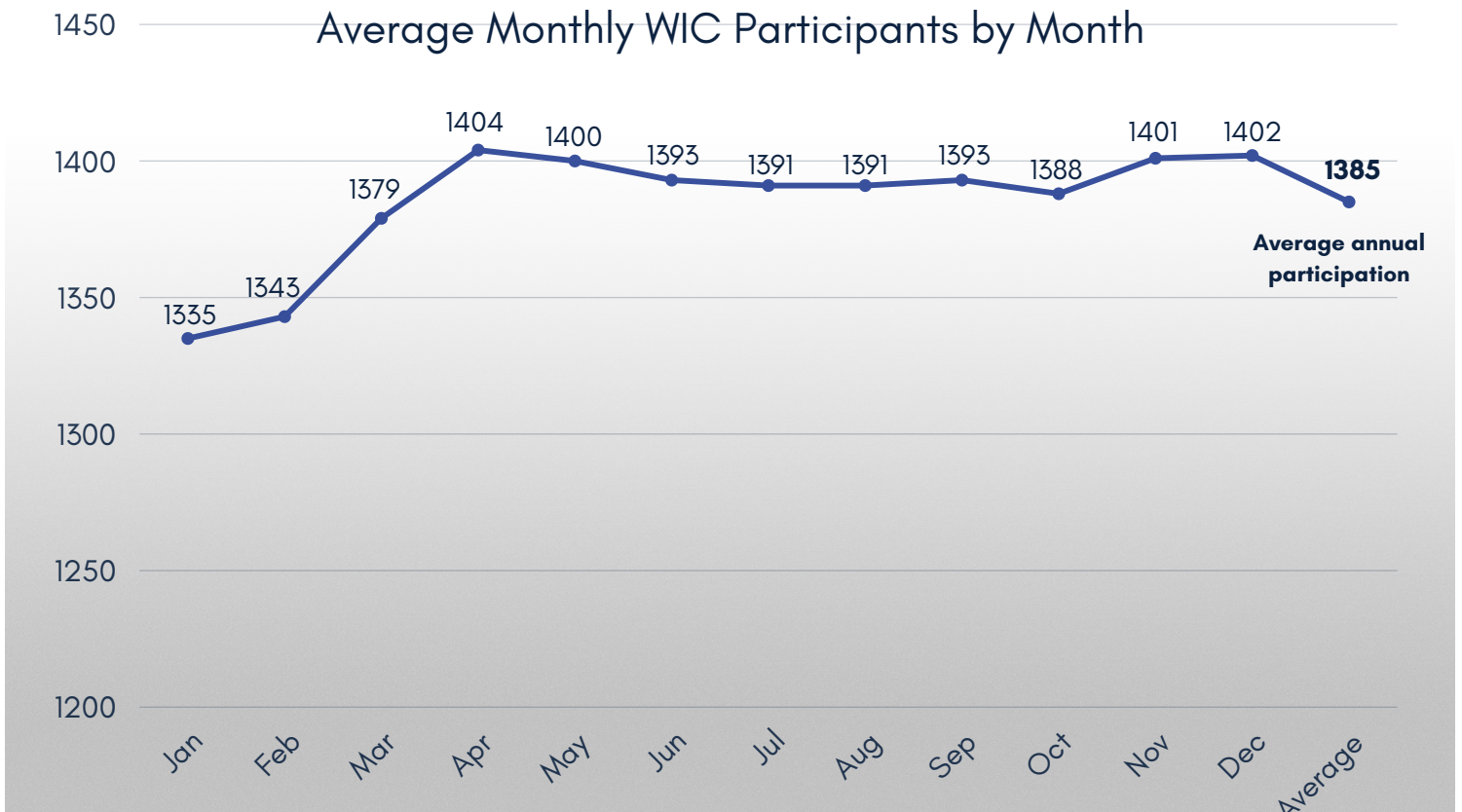
# ADDITIONAL DATA

## WOMEN, INFANTS, AND CHILDREN

Average Monthly WIC Participants by County



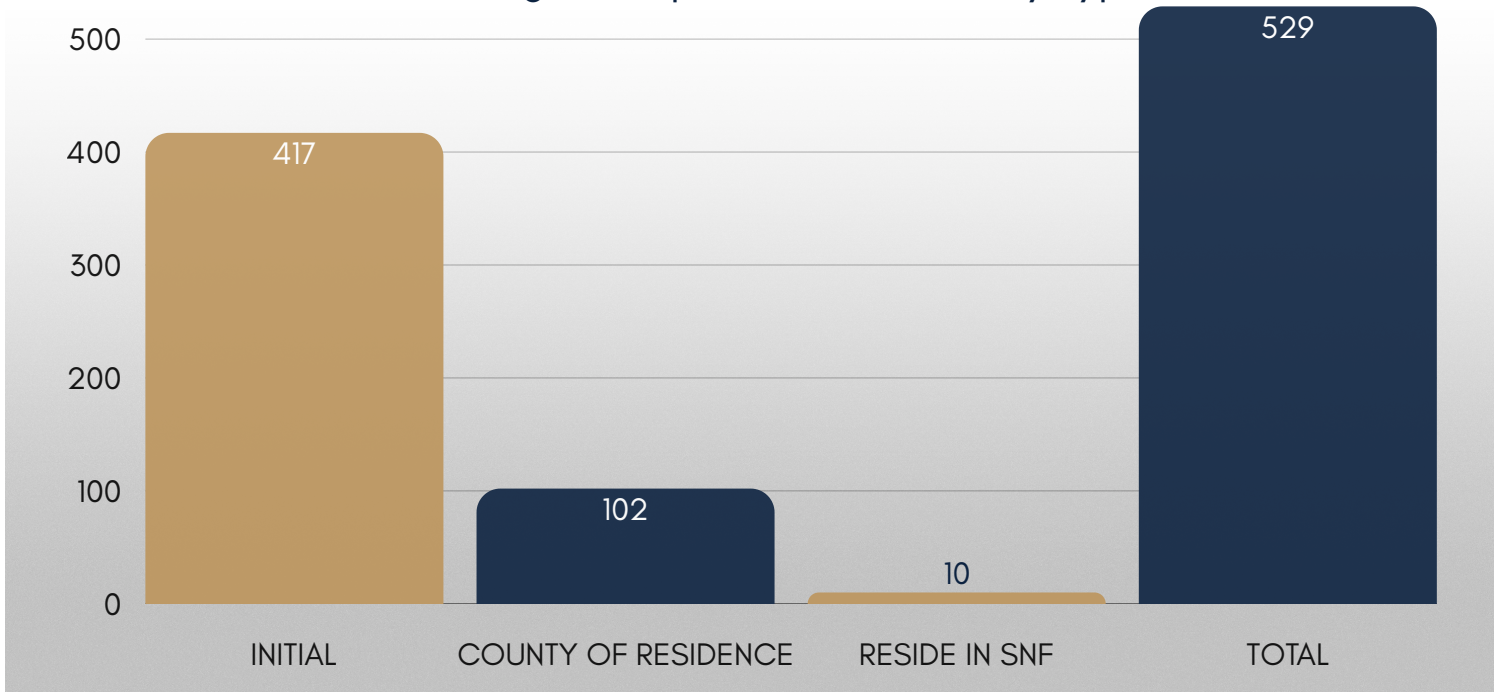
Average Monthly WIC Participants by Month



# ADDITIONAL DATA

## HOME & COMMUNITY BASED SERVICES

Screenings Completed in 2025 - By Type

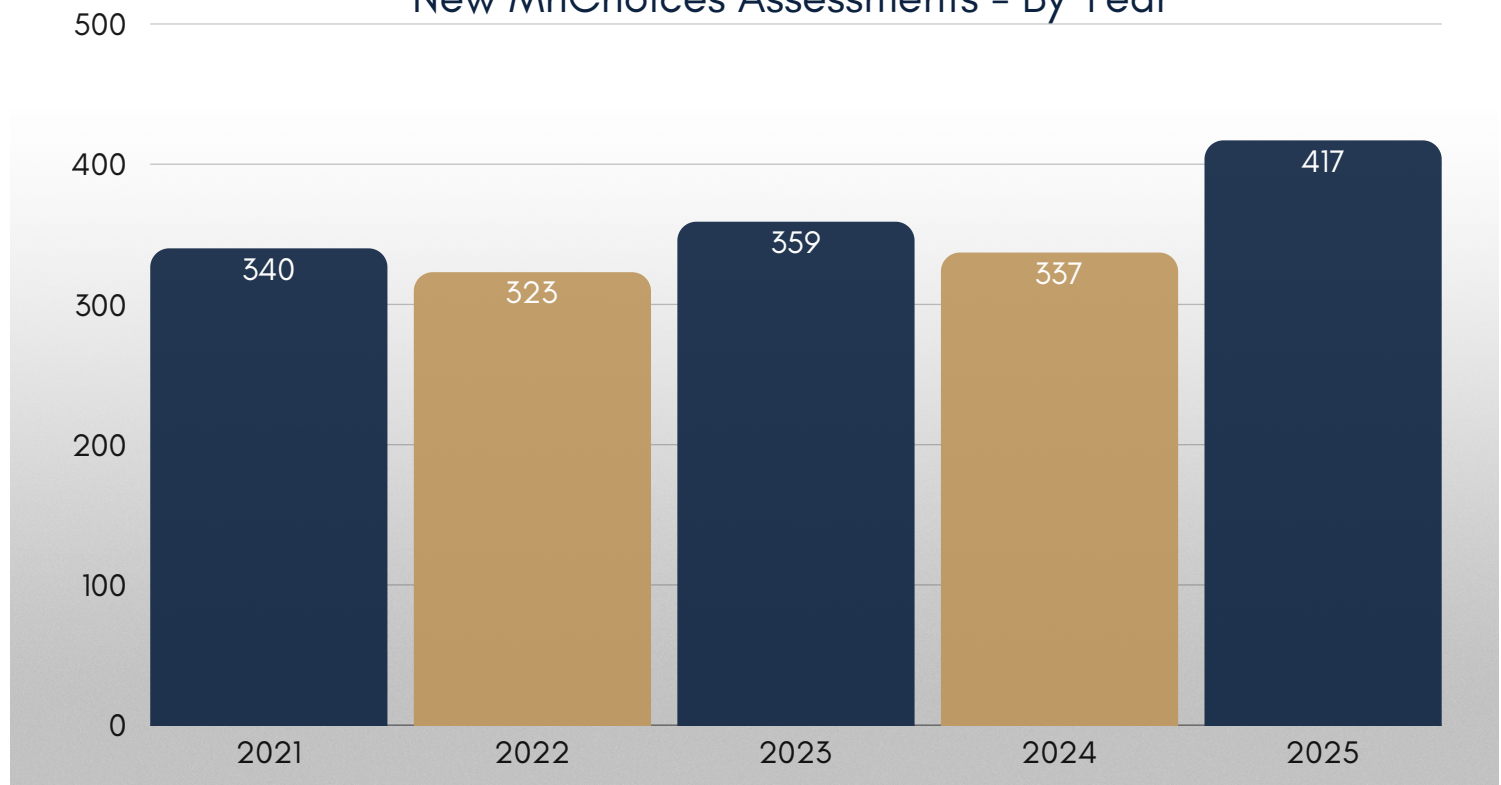


New MnChoices assessments for anyone looking for information or supports.

Individuals living in our communities with the financial responsibility of another county.

Individuals under the age of 65 who have been in a skilled nursing facility (SNF) for longer than 80 days.

New MnChoices Assessments - By Year

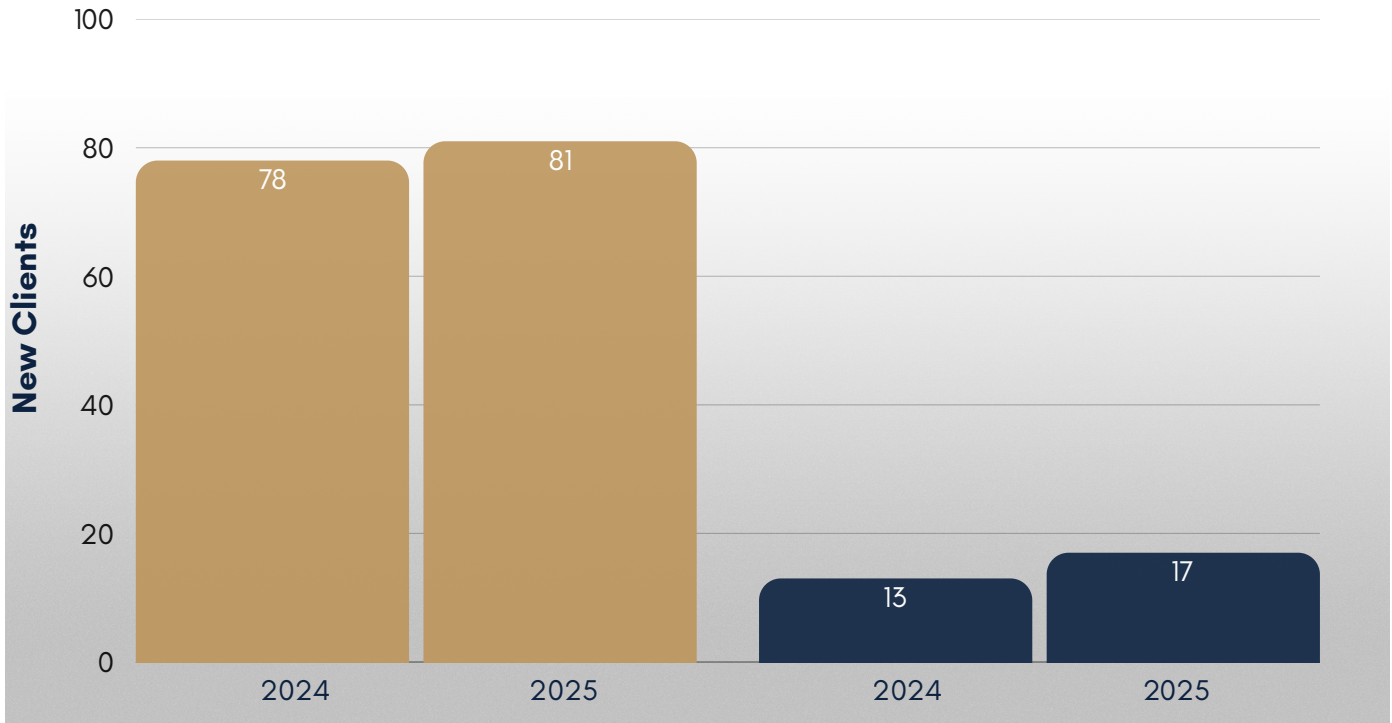


# ADDITIONAL DATA

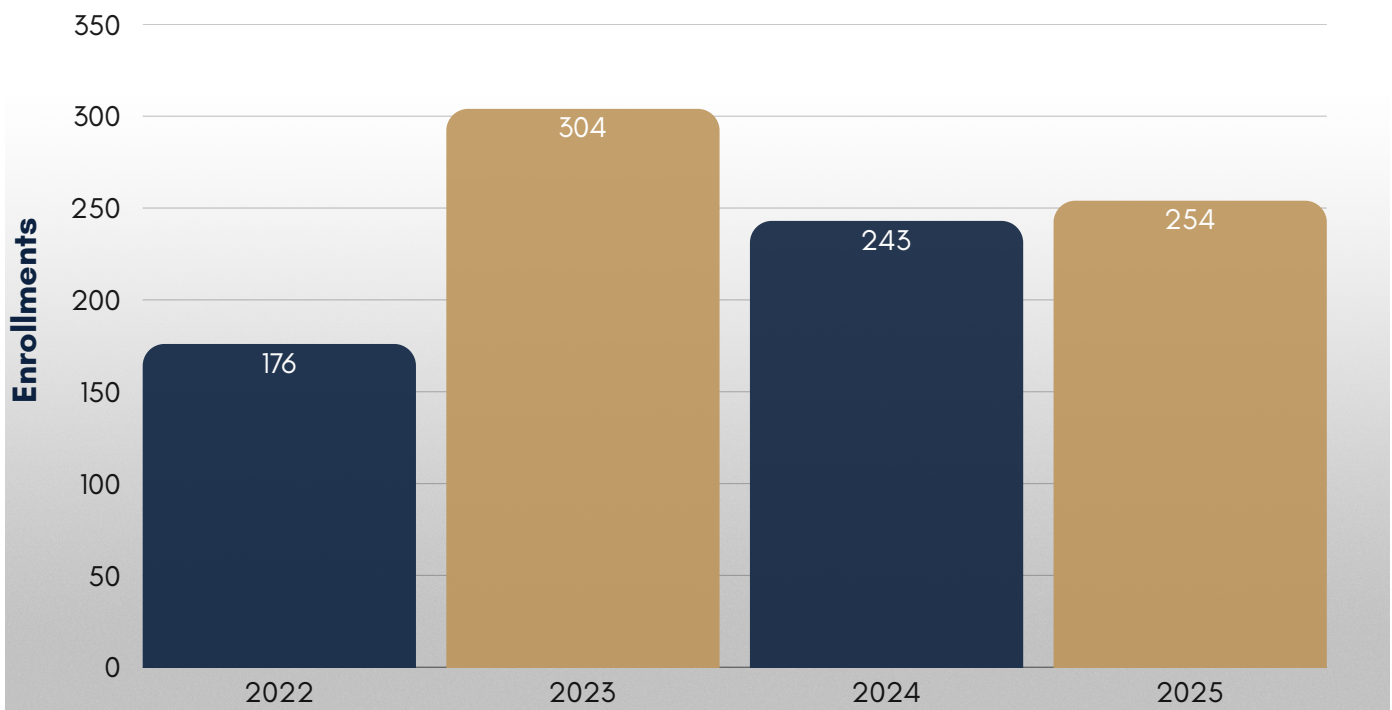
## HOME & COMMUNITY BASED SERVICES

### New Clients Open to an Aging Program from a MNChoices

● From the screening process   ● Transfers into the HPH counties



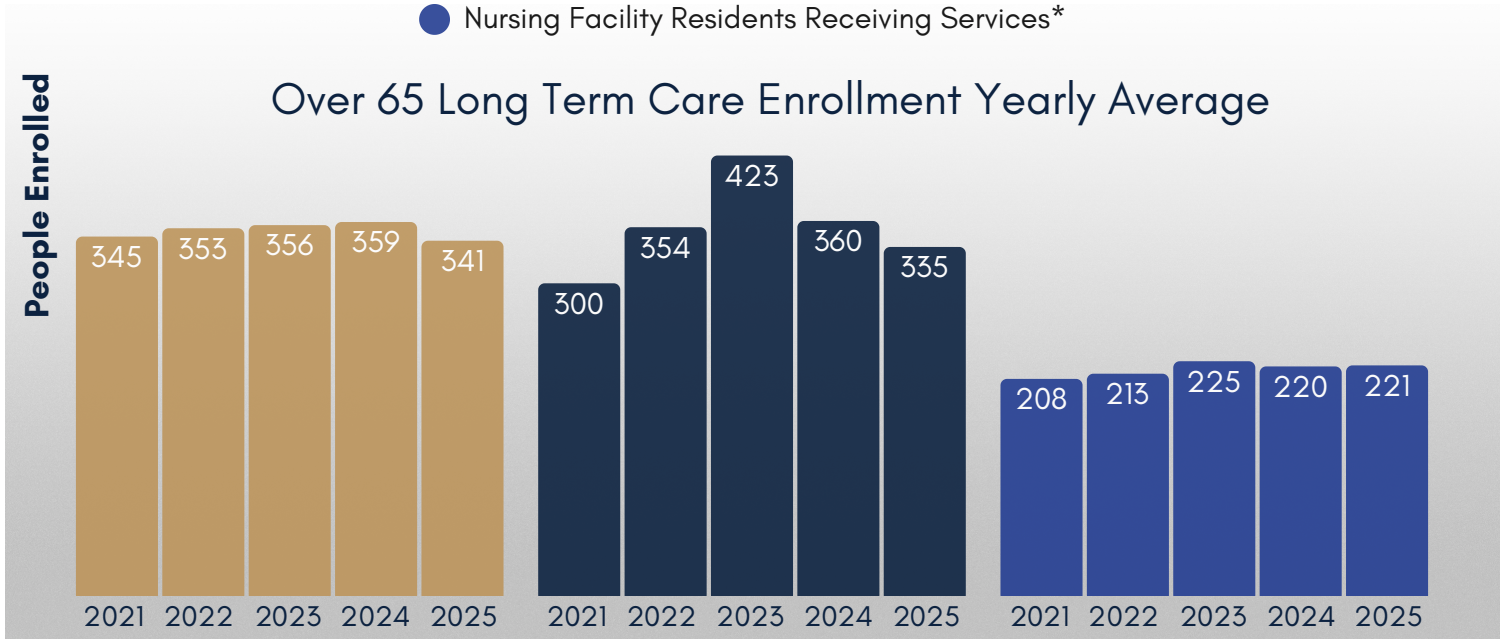
### Over 65 Managed Care Enrollments - By Year



# ADDITIONAL DATA

## HOME & COMMUNITY BASED SERVICES

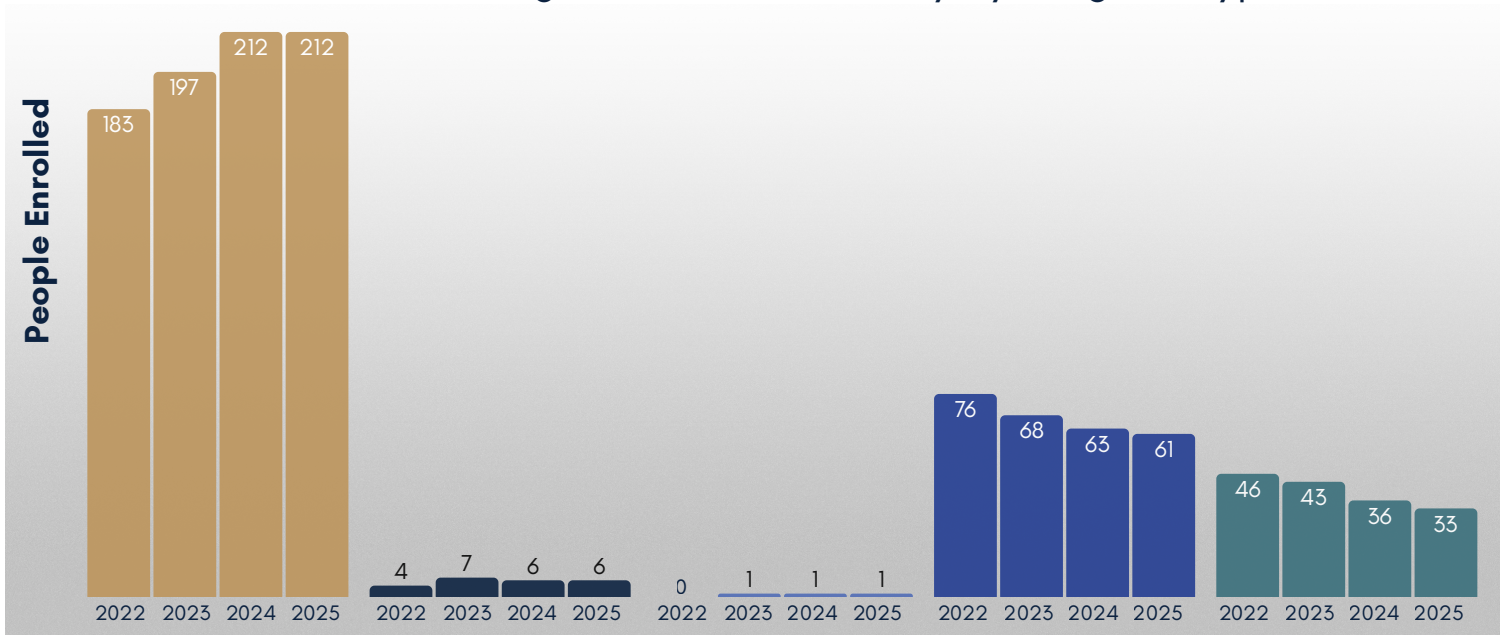
- Receiving Home & Community Based Services
- Receiving Only Case Management Services
- Nursing Facility Residents Receiving Services\*



\*Nursing facility residents receiving medical assistance through managed care

- CADI Waiver
- CAC Waiver
- BI Waiver
- CADI and SNBC Care Coordination
- SNBC Care Coordination

### Persons Under Age 65 Served Monthly by Program Type

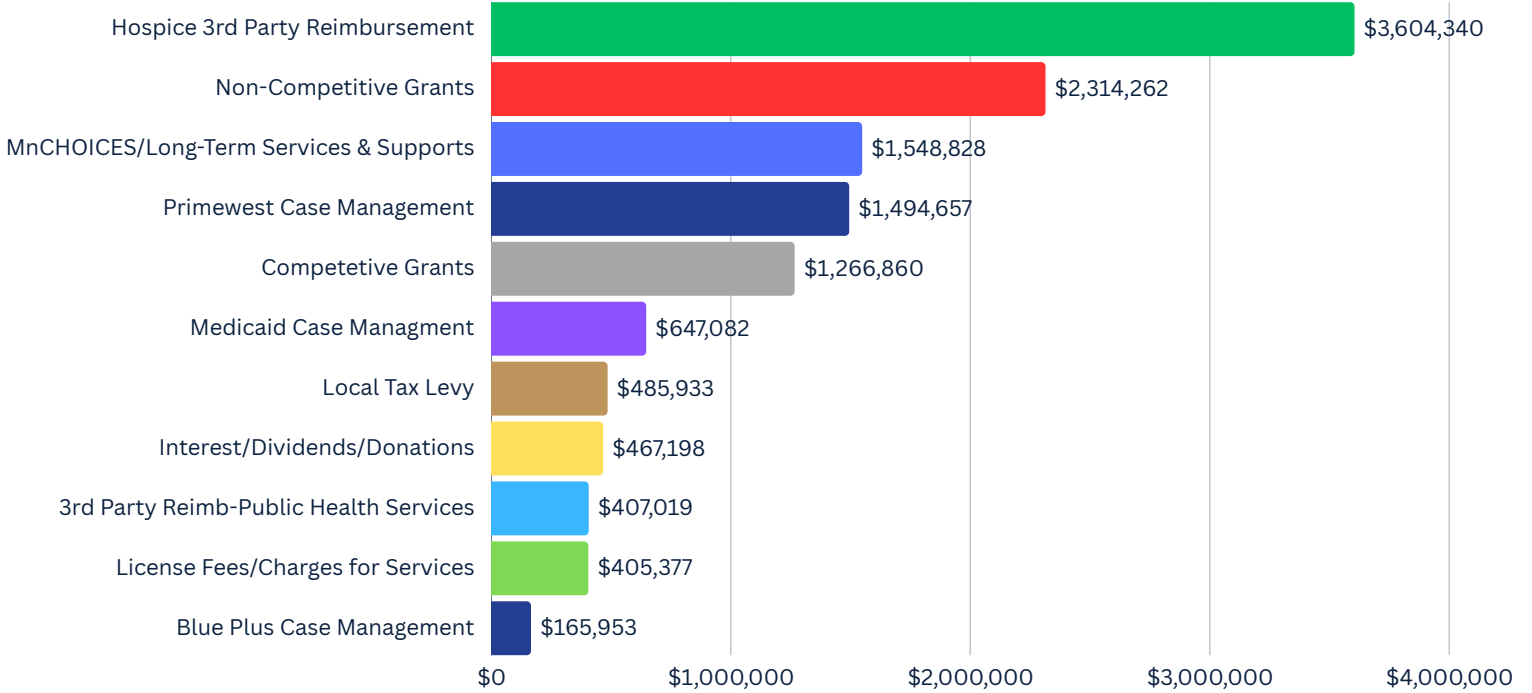


CADI (Community Access for Disability Inclusion) CAC (Community Alternative Care) BI (Brain Injury) SNBC (Special Needs Basic Care)

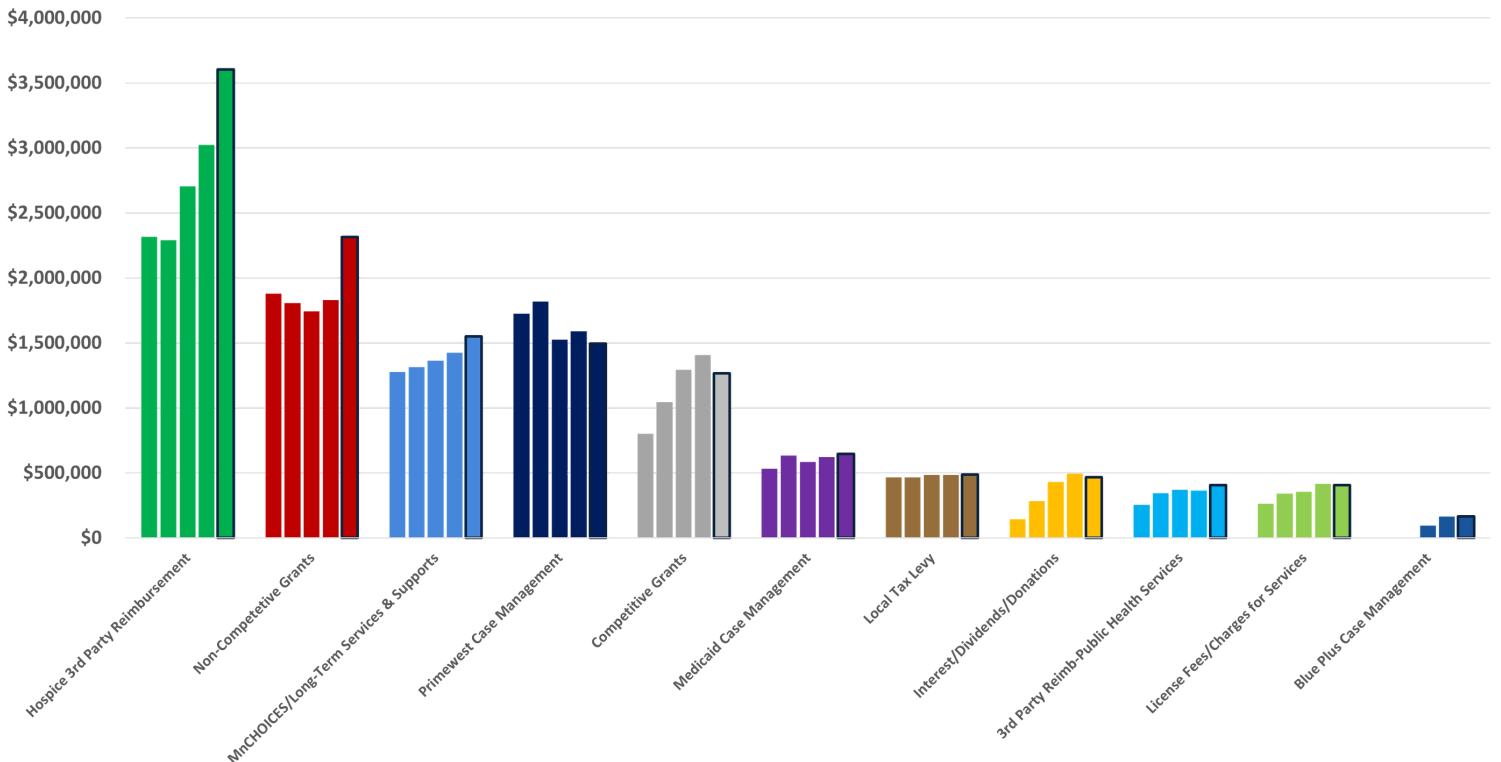
# ADDITIONAL DATA

## FINANCIAL SUMMARY

### 2025 Horizon Public Health Revenue Sources



### 2021-2025 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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