2026 - 2028

GLACIAL RIDGE HOSPITAL
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COMMUNITY HEALTH IMPLEMENTATION STRATEGY

Approved by Glacial Ridge Hospital Board of Directors

JANUARY 26, 2026

2026–2028 COMMUNITY HEALTH IMPLEMENTATION STRATEGY

Glacial Ridge Hospital's CHNA team adopted Horizon Public Health's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) as the foundation for the 2025 CHNA and the 2026–2028 Implementation Strategy. This approach reflects an intentional decision to align with established, public health–led priorities informed by community partners, rather than create duplicative strategies.

Because the current CHIP concludes in 2027, Glacial Ridge Hospital will align its 2028 Implementation Strategy with Horizon Public Health's next CHIP through an addendum once it is released. This coordinated approach strengthens countywide efforts, supports continuity of ongoing initiatives, and ensures consistent priorities across shared partners.

The 2026–2028 Implementation Strategy focuses on the three priority areas identified through the CHA/CHIP process: Access to Care**,** Chronic Disease and Obesity, and Community Resilience**.** The GRHS icon on the CHIP identifies areas where Glacial Ridge Hospital is actively engaged in collaborative efforts with Horizon Public Health. Progress and actions related to these priorities will be reported in the hospital's next scheduled Community Health Needs Assessment in 2028.

Glacial Ridge Hospital staff participate in Horizon Public Health's Community Partner Leadership Team and related workgroups that guide planning, implementation, and evaluation of community health initiatives. Through this shared work, the hospital, public health, and community partners coordinate strategies and resources to improve the health and well-being of Pope County residents.

Community Health Improvement Plan 2023-2027

HORIZON Public Health
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Horizon Public Health

Douglas, Grant, Pope, Stevens, and Traverse Counties

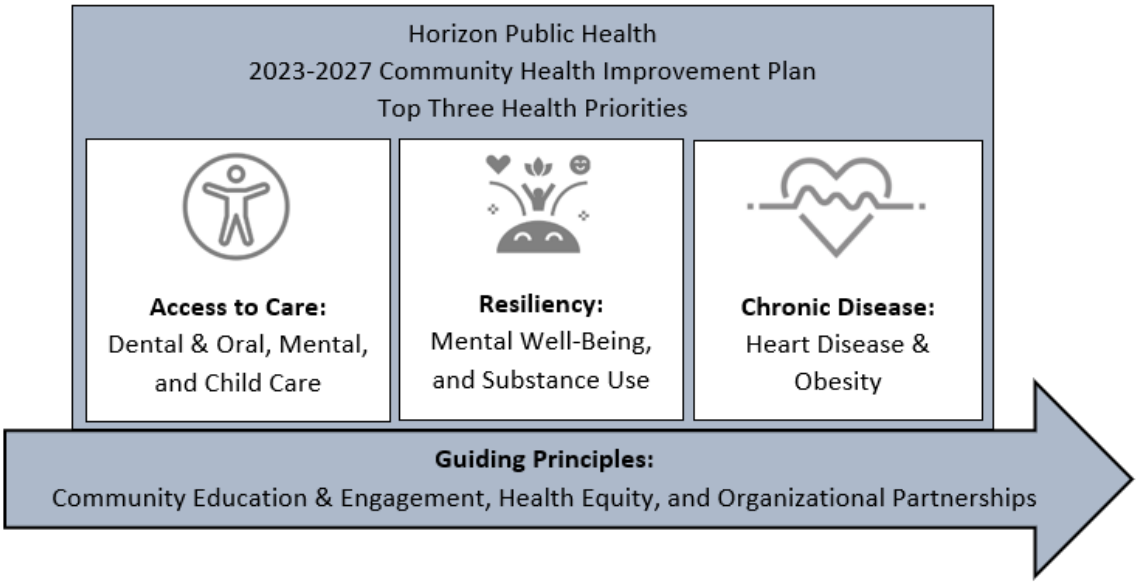
Approved by the Horizon Public Health Community Health Board
March 13, 2023
Updated October 14, 2024

Horizon Public Health

EXECUTIVE SUMMARY

Local public health in Minnesota seeks to improve the health of the people living in its jurisdiction through community health assessments and community health improvement plans. Horizon Public Health realizes that planning process and plans related to the community, need to engage the community intentionally and authentically.

Horizon Public Health convened a Community Partner Leadership Team (CLT) consisting of a wide representation of community sectors to ensure a community-infused assessment and planning process. The CLT used the Mobilizing for Action through Planning and Partnerships framework to complete a Community Health Assessment (CHA) which assisted in identifying health priorities to complete a Community Health Improvement Plan (CHIP). The CLT identified the following as the top health priority areas for 2023-2027 CHIP:



This CHIP guides the community in the development of initiatives, strategies, and polices aimed at addressing the top three priority areas. Over the past five years, workgroups and partners implemented strategies from the 2019-2022 CHIP. They achieved successes and developed strong partnerships even in the face of the COVID-19 pandemic. The 2023-2027 CHIP builds on these community achievements and challenges.

The CLT's role does not end with the drafting of this plan. This team will implement, monitor, and update the CHIP as well as ensure alignment with other local plans to better address the many factors that influence health. The CHIP relies on strong partnerships and highlights the critical role of community partners in improving health outcomes in the communities that Horizon Public Health serves.

The National Public Health Accreditation Board (PHAB) standards require local public health agencies to participate in or lead a collaborative process that engages community to produce a CHA and a CHIP. MN Statute 145A also requires local public health agencies in Minnesota to update and revise such a plan at least every five years.

If you have any questions, please contact:

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Using Results Based Accountability to Drive Impact & Equity

The Action Plan was updated and approved by the Horizon Community Health Board on October 14, 2024, to reflect how Horizon Public Health, in collaboration with the Community Partner Leadership Team, actively monitors progress through the incorporation of Results Based Accountability (RBA). This approach was chosen to enhance the CHIP by aligning it with its guiding principles of community education and engagement, health equity, and organizational partnerships.

RBA strengthens community education and engagement by providing a clear, transparent framework that tracks the impact of health initiatives. By measuring both the quantity and quality of efforts, the public is better informed about the effectiveness of programs, fostering deeper community involvement and trust in public health efforts. Community members and stakeholders can more easily participate in decision-making processes, ensuring their voices shape health initiatives.

This data-driven approach of RBA helps to highlight where gaps in services exist, allowing the CHIP to continuously adapt, as a living document, to address those inequities and work toward fair and inclusive health outcomes. By embedding RBA into the CHIP, Horizon Public Health reinforces its commitment to our guiding principles, ensuring that the plan not only tracks progress but also continues to engage the community, address health disparities, and strengthen partnerships for a healthier future.

Results Based Accountability

Results-Based Accountability (RBA) is being applied to the Horizon Public Health Community Health Improvement Plan (CHIP) to create a focused, data-driven approach in addressing community health challenges. By integrating RBA into the CHIP, Horizon Public Health ensures that resources are effectively used, community health outcomes are improved, and the overall strategy is adaptable to emerging challenges and opportunities:

1. **Defining Clear Outcomes**: RBA starts with identifying desired results, ensuring all efforts align with clear and measurable goals.
2. **Using Data to Track Progress**: RBA relies on quantitative and qualitative data to assess the current state of community health and measure progress toward specific goals. Regular data collection allows for real-time adjustments to strategies.
3. **Focusing on Impact**: Instead of just tracking activities, RBA emphasizes the actual impact on the community. This ensures that strategies are not just being implemented but are making a difference in key health areas.
4. **Engaging Community Partners**: Through RBA, community stakeholders, including the Community Partner Leadership Team, actively collaborate to ensure that all initiatives are aligned and that resources are used efficiently.
5. **Continuous Improvement**: RBA encourages ongoing evaluation and feedback, allowing for adjustments to the CHIP based on what's working and where improvements are needed.

Tracking Progress:

As part of the RBA framework, the Community Health Strategist will update the Clear Impact Scorecard, which will be available on the Horizon Public Health website. This scorecard will track key health measures, providing transparent, real-time data on progress toward CHIP goals. By regularly updating the scorecard both internal teams and the broader community can easily monitor the impact of initiatives and track improvements in areas like mental health, substance use, and overall community well-being. This transparency supports accountability, fosters community engagement, and allows for timely adjustments to strategies based on data trends and outcomes.

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

1. All people have access to preventative dental screenings.
2. All community members can access mental health resources.
3. All families can access and utilize child care when needed.

Problem/Issue Statement:

Access to care is of vital importance to maintain optimal health, increase life expectancy, and improve quality of life. Access to care was selected as a significant health need to be addressed due to its impact on individual health outcomes, as well as the economic vitality of the community. The pandemic led to delays in care and continues to have an impact on mental health. Multiple strategies are needed to address rural workforce shortage gaps potentially exacerbated by the COVID-19 pandemic.

Dental and Oral Health Care: To improve access to health care there is a need to recruit more providers and specialists to care for the elderly and young children. A strategy to increase access to dental care for older adults with Medicaid coverage, particularly those in long-term care facilities or with transportation barriers is necessary. Ongoing education to parents about preventative services and care prior to children getting their first tooth and permanent teeth is another important strategy.

Mental Health Access: Over one-third of residents (36-46%) reported experiencing poor mental health one or more days in the past month with 14-23% of adults having experienced depression or anxiety. Mental health is a critical component of overall health and multiple strategies are needed to ensure individuals experiencing challenges can connect with others easily for support and treatment. Local actions may focus on increasing access for youth and residents who have experienced trauma or other Adverse Childhood Experiences (ACEs).

Child Care Access: The lack of child care access is continuing to negatively impact our community through employment, income, and community vitality. Reductions in child care options present challenges for working parents and require creative strategies.

Short-Term Outcomes:

Increase awareness of specifically targeted access gaps, through data and public communication strategies.

Intermediate Outcomes:

An increase in individuals receiving care and attending (first) visits.

Long-Term Outcomes:

A reduction in reporting of delays in care. Individuals can receive the care they need.

Local Policy Recommendations:

- Mandatory fluoride varnish application policies
- Encourage mental health care into primary care practices
- Health system integration & collaboration agreements

Alignment with State and National Priorities:

- Minnesota State Oral Health Plan 2020-2030 (1)
- Recommendations on Strengthening Mental Health Care in Rural Minnesota (2)
- Rural Child Care Solutions: From the Ground Up (3)
- Mental Health First Aid (4)
- Make it OK (5)

Dental and Oral Care

Goal: All people have access to preventative dental screenings.

Strategy: Early Childhood Dental Network, PrimeWest Health, and Horizon Public Health will work to increase access to dental care by developing strategies to provide preventative care and dental treatment in clinical and non-traditional settings.

Outcome Objectives:

- By 2027, increase annual preventative dental screenings by 5% for those under the age of 5.
- By 2027, increase annual preventative dental screenings by 7% for those 65 and older on Medical Assistance.

Baseline Data/Source:

- Minnesota Department of Health, 2019 Annual Preventative visits 3-5 year old's: Douglas 49%, Grant 54%, Pope 48%, and Traverse 28%.
- Annual MN Healthcare plan benchmark goal for annual visits is 55%. Horizon Public Health, age 65+, PrimeWest range; Douglas 40% (high), Pope 32% (low)

Asset and Resources:

Early Childhood Dental Network, PrimeWest Health, Early Childhood Initiatives.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023; Identify baseline data to identify gaps in care for children under the age of 5.	Early Childhood Dental Network
By December 31, 2023 and ongoing: Identify oral health educational materials for prioritized populations, including: parents who have children under the age of 5, immigrants, individuals over the age of 65 and their caretakers, and people with special health care needs.	Early Childhood Dental Network PrimeWest Health Horizon Public Health
By July 31, 2024 and annually: Collect data to monitor progress and identify best practice solutions. Share material and information through identified networks.	Horizon Public Health Supervisors Dental Health Coalitions
By December 31, 2024 and ongoing: Identify and implement best practice strategies to address prenatal care and oral health of children's first visit, to parents through WIC and Child and Teen Check Up visits.	Horizon Public Health
By March 31, 2024 and ongoing: Support and implement annual strategies identified by the Early Childhood Dental Network and PrimeWest Health to improve oral health for identified populations (under 5 and over 65 on MA).	Early Childhood Dental Network PrimeWest Health
By March 31, 2025: Identify, support and promote oral health strategies in non-traditional settings such as; tele-dentistry in long-term care, head start, WIC clinics, correctional, early childhood center, schools, etc.	Early Childhood Dental Network PrimeWest Health
Ongoing: Support funding opportunities identifying barriers to improve oral health education, school sealant programs, and community water fluoridation for residents in Horizon Public Health counties.	Horizon Public Health Supervisors Horizon Public Health Administrators

Mental Health Care

Goal: All community members can access mental health resources.

Strategy: Identify and implement best practices aimed at reducing mental health stigma, increasing mental health awareness, and improving mental health status by increasing partnerships and awareness of mental health services through the communities.

Outcome Objectives:

- By 2027, increase by 10% the number of 8th graders who report access to and feel comfortable speaking with a counselor or social worker at school.
- By 2027, increase by 10% the number of adults who report no delay in accessing mental health care.

Baseline Data/Source:

- 2022 MN Student Survey: 8th graders reporting they have access ranged from 45-71%.
- 2020 SHIP Survey: 71% of adults reported a delay in mental health care (1. Didn't think it was serious, 2. Cost 3. COVID-19 pandemic related)

Asset and Resources:

Suicide Prevention Coalition (SCOPE), Mental Health Taskforces, Local Advisory Councils, Transportation Advisory Council, Stevens County Building Community Resilience, Lakes Area Age Friendly, Community Impact Coalition.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023: Work groups will be identified through existing coalitions, groups, and individuals with lived experiences to implement the proposed action steps below. Set schedules for reoccurring meetings.	Horizon Public Health Strategist
By December 31, 2023: Improve access to care by promoting innovative outreach strategies, including 988, mobile crisis, and peer-to-peer interventions.	Identified Coalition(s) HPH Communications Committee
By March 31, 2024 and ongoing: Support training and implementation of Mental Health First Aid programs at identified worksites.	Connected Communities Horizon Public Health
By March 31, 2025: Compile resources about mental health access availability for individuals and families.	Identified Coalition(s) HPH Communications Committee
By December 31, 2025: Identify innovative strategies such as; calm rooms, school well-being curriculum, and/or social connectedness initiatives to be incorporated at worksites, schools, and community buildings to improve non-traditional mental health services.	Identified Coalition(s)
By June, 2025 and ongoing: Develop and implement a GIS map to provide visual representation of mental health resources.	Identified Coalition(s)
Ongoing: Promote Child and Teen Check Up services to children. Work with local providers to identify innovative promotional strategies to encourage and increase annual exams. Support regional and local solutions for individuals and families experiencing mental health needs.	Horizon Public Health Strategist Horizon Public Health Supervisors Horizon Public Health Administrators

Quality Child Care
Goal: All families can access and utilize child care when needed.
Strategy: Working to understand child care needs across the region and implement solutions to increase the availability of child care.
*Horizon Public Health is supporting the work in the community to achieve the below objective.

Outcome Objectives:

- By 2027, increase the number of licensed child care providers in Horizon Public Health counties by 20%.

Baseline Data/Source:

- 2020 MN Department of Human Services, West Central MN needs a 39% growth in licensed child care capacity to fill the shortfall.
- Between 2015 and 2020, West Central MN licensed child care availability decreased by almost 600.

Asset and Resources:
Stevens County Child Care Committee, Alexandria Area Child Care Committee, Early Childhood Initiatives.

Action Steps:	**Lead Person/Agency Responsible:**
By July 31, 2023 and ongoing: Support and engage with local innovative coalitions working to develop 'right-sized solutions' to increase the supply of high-quality child care in rural communities. Remain a part of the planning and implementation process.	Identified Child Care Coalitions Horizon Public Health Nurse
Ongoing: Attend meetings to support and drive innovative ideas. Identify local data (when available), community concerns, and ideas to engage and empower solutions.	Horizon Public Health Nurse Horizon Public Health Strategist
Ongoing: Identify and recruit community members, including those with lived experiences, and community business organizations to attend child care coalitions/ meetings to share their perspectives on issues, challenges, and identify solutions.	Identified Child Care Coalitions
Ongoing: Share information from the progress of the coalition(s) with identified community partners and leaders to ensure the success of the projects.	Identified Child Care Coalition Horizon Public Health Strategist
By December 2027: Implementation of strategies that were identified in the planning of the project.	Identified Child Care Coalitions

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

1. Adults and youth have positive mental well-being.
2. All community members are free of substance misuse and abuse.

Problem/Issue Statement:

Breaking the cycle of adversity and trauma must include building hope and resilience for children and families. Adverse Childhood Experiences (ACEs) can increase a person's risk for chronic stress and use of adverse coping mechanisms can result in lifelong chronic illness such as depression, heart disease, obesity, and substance abuse. Mental health and substance use disorders are the leading disease burden in the United States.

In the Horizon Public Health counties, over one-third of residents reported experiencing poor mental health for one or more days in the past month with 14-23% of adults having experienced depression or anxiety. Data showed notable changes in self-reported mental health conditions and drug overdoses between 2016 and 2020. COVID-19 continues to have an impact on the prevalence of anxiety and depression, contributing to poor mental health.

Short-Term Outcomes:

Increased awareness in community members about trauma informed care and Adverse Childhood Experiences (ACEs).

Intermediate Outcomes:

Community members recognize trauma and are able to assist others in getting help.

Long-Term Outcomes:

Communities have capacity to promote and protect mental health by adopting policies and/or procedures which are trauma informed.

Local Policy Recommendations:

- Policies that would provide more support for mental health and addiction services.
- Policies that would further destigmatize and decriminalize substance use disorders.

Alignment with State and National Priorities:

- ACEs Aware, ACE Training and Education (11)
- Resilience in Action (12)
- SAMHSA Trauma and Guidance for a Trauma-Informed Approach (13)
- Zero Suicide (14)
- Minnesota Department of Health, Thrive (15)
- National Association of Counties, Opioid (16)
- Colorado Health Institute, Opioid Crisis Blueprint (17)
- Substance Abuse and Mental Health Services (18)

Mental Well-Being

Goal: All adults and youth have positive mental well-being.

Strategy: Build resilience in individuals, families, and in the community through the development and implementation of policies, practices and environmental changes.

Outcome Objectives:

- By 2027, increase by 10% the number of youth reporting that adults in the community care for them.
- By 2027, increase by 10% the number of adults experiencing positive mental health every day.

Baseline Data/Source:

- 2022 MN Student Survey: 13-26% of 8th graders reported 2+ ACEs. 18-27% of 8th graders who reported that the community cared about them 'quite a bit'.
- 2020 SHIP Survey: 54-64% of adults report zero days of 'not good mental health'.

Asset and Resources:

Suicide Prevention Coalition (SCOPE), Mental Health Taskforces, Local Advisory Councils, Transportation Advisory Council, Stevens County Building Community Resilience, Early Childhood Initiatives, Lakes Area Age Friendly, Community Impact Coalition, Connected Community, COPEWELL Project.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023: Work groups will be identified through existing partnerships and coalitions to adopt proposed action steps. Reoccurring meetings will be scheduled.	Horizon Public Health Strategist Identified Coalition(s)
By December 31, 2023: Develop a high-level summary of new health assessment findings on the topics of ACEs reports, substance use and mental health data. Share with identified coalitions/work groups and partners.	Horizon Public Health Strategist
By March 31, 2024: Conduct surveys, focus groups, and/or conversations with youth and those adults age 65 and older to learn more about social isolation, adverse community environments and identified needs.	Community Resilience Work Group
By March 31, 2024 and ongoing: Identify and share local stories that promote mental well-being. Examples will highlight positive impacts of community/individuals/families/worksites, etc. Share stories to MN Thrive Network.	Community Resilience Work Group
By December 31, 2025: Engage youth to build stronger relationships in the community.	Community Resilience Work Group
By December 31, 2025: Utilize SHIP to promote positive mental health throughout worksite wellness programs by implementing at least 5 best practice programs annually.	SHIP Coordinator
By December 31, 2027: Annually complete at least three community Resilience-Building Interventions	ACE Trainers, Community trainers
Ongoing: Capitalize on community events to promote programs and strategies to increase resiliency.	Community Resilience Work Group

Substance Use

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

Strategy: Create a resilient community that understands behavioral health issues, including the influence of trauma on mental health and substance use disorders.

Outcome Objectives:

- By 2027, increase by 10% the number of 11th grade students report no substance use in the past year.
- By 2027, increase by 10% the number of adults who do not experience substance misuse and abuse.

Baseline Data/Source:

- 2022 MN Student Survey: 11th graders who reported using alcohol, marijuana and/or drugs in the past year range from 5-19%. 11th grader's perception of using alcohol, marijuana, and/or other drugs in the past year is higher than actual use.
- 2020 SHIP Survey: 10% of adults reported 'heavy drinking' and 24% reported 'binge drinking' in the past 30 days. 7% reported using marijuana, opioids, stimulants, or illegal substances in the past 30 days.

Asset and Resources:

Suicide Prevention Coalition (SCOPE), Mental Health Taskforces, Local Advisory Councils, Transportation Advisory Council, Stevens County Building Community Resilience, Lakes Area Age Friendly, Community Impact Coalition.

Action Steps:	**Lead Person/Agency Responsible:**
By June 30, 2023: Establish substance use work groups to steer the opioid settlement memorandum of understanding (MOU). Set schedules for regular ongoing meetings.	Horizon Public Health Strategist
By September 30, 2023: Develop a fair and transparent work plan and process for deciding where and how to spend the Opioid Settlement MOU by the identified work groups.	Horizon Public Health Strategist Identified Coalitions
By December 31, 2023 and ongoing: Identify and launch educational campaigns to address stigma, risk, harm reduction, and protective factors from substance use and misuse.	Identified Coalitions
By December 31, 2023 and ongoing: Partner with schools and youth groups to promote stress management and resiliency in regards to preventing youth substance use.	Drug Free Communities Grant Identified Coalitions
By December 31, 2023 and ongoing: Identify and promote resources available for treatment and recovery for those in addiction and working on recovery.	Identified Coalition(s)
By December 31, 2027: Implement at least five best practice strategies, in identified at-risk settings/communities with at least one comprehensive policy that outlines strategies for prevention and/or harm reduction in underserved and/or marginalized communities.	Identified Coalition(s)
Ongoing: Monitor legislation, funding, and reform changes occurring at the state and national level that may impact public health work happening locally.	Horizon Public Health Strategist Horizon Public Health Administrators

Goal: All community members have the opportunity to achieve optimal health.

Problem/Issue Statement:
Heart disease is the leading cause of death in Horizon Public Health counties. The percentage of adults with high blood pressure is higher in each county than the statewide average, while diabetes rates are higher than the state average in all but Stevens County. With heart disease as the leading cause of death and high blood pressure rates higher than the statewide average, a combination of strategies needs to be considered to encourage heart health.

The rising obesity trend is one of the multiple factors contributing to poor heart health. Behaviors such as excessive eating and physical inactivity can affect a person's weight. However, outside influences such as the absence of health education, food insecurity, and one's environment can also be factors.

Increasing opportunities for physical activity and access to healthy foods can help establish healthy behaviors to reduce obesity rates. Greater access to affordable, healthy food and access to physical activity options can help residents make good choices that result in lower rates of chronic disease and better weight control.

Short-Term Outcomes:
Improve cross-organization communication and collaboration to better serve communities.

Intermediate Outcomes:
Physical activity and healthy eating are being documented in electronic records.

Long-Term Outcomes:
Availability of prescriptions and community linkage for physical activity and healthy eating for patients with identified risk factors.

Local Policy Recommendations:

- Policies that implement Exercise is Medicine with Healthcare providers.
- Policies that implement Food Rx with Healthcare providers as a standardized screening and referral.
- Implement standardized, universal screenings for social determinants of health at all primary care visits (partnering with healthcare partners).

Alignment with State and National Priorities:

- Exercise is Medicine, American College of Sports Medicine (7)
- Healthy Food as Medicine (8)
- Park Rx (9)

Chronic Disease

Goal: All community members have the opportunity to achieve optimal health.

Strategy: Increase access to evidence-based prevention programs aimed at reducing the onset of heart disease.

Outcome Objectives:

- By 2027, Increase by 5% the number of youth who report being active 5 or more days/week for at least 60 min/day
- By 2027, Increase by 5% the number of adults who have never had high blood pressure/hypertension or pre-hypertension.

Baseline Data/Source:

- 2022 MN Student Survey: 28-53% of 8th graders reported being overweight or obese, 14-24% reported being active 5 days/week for at least 60 min./ day.
- 2020 SHIP Survey Data: 32% of adults reported a diagnosis of high blood pressure/hypertension or pre-hypertension. 12% of adults reported a diagnosis diabetes or pre-diabetes. 70% of adults reported being overweight/obese. 84% of adults participate in physical activities or exercise during the past 30 days.

Asset and Resources:

Believers in Breastfeeding (BIB) Coalition, Healthcare providers, Food Banks, Food Shelf.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023: Research, identify, and create a list of available services for those living with chronic disease. Identify partners to support and share information	SHIP Coordinator Horizon Public Health Strategist
By December 31, 2023: Identify local healthcare providers to collaboratively implement policies around universal and standardized social determinants of health screenings in primary care visits.	SHIP Coordinator
By December 31, 2023: Identify local data to create a dashboard (Clear Impact) to track chronic disease and heart disease strategies. Identify communication plans, methods, and partners to share information.	Horizon Public Health Strategist HPH Communications Committee
By December 31, 2025: Develop a referral network between medical providers and available programs and resources for managing chronic illness.	SHIP Coordinator
By June 30, 2024: Identify active transportation barriers in schools, housing, and/or neighborhoods to advocate for funding opportunities. Advertise bike and walking paths throughout communities.	SHIP Coordinator
By December 31, 2025: Implement a community linkage model to increase access to physical activity and increase consumption of healthy foods. (Exercise is Medicine and Food Rx)	SHIP Coordinator Healthcare Providers
By December 31, 2027: Educate pregnant and postpartum women about the benefits of breastfeeding and provide ongoing support. Promote nutrition education to encourage healthy eating habits early in life.	Horizon Public Health WIC
By December 31, 2027: Identify innovative strategies to grow the number and capacity of SHIP worksite policies to include physical activity and access to healthy eating.	SHIP Coordinator Worksite Wellness Coordinators

References:

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3. Rural Child Care Solutions: From the Ground Up. https://www.ruralmn.org/rural-child-care-solutions-from-the-ground-up/
4. Mental Health First Aid training. https://www.mentalhealthfirstaid.org/
5. Make it OK. Org. https://makeitok.org/
6. Rural Child Care Innovation Program. https://www.ruralchildcare.org/
7. Exercise is Medicine, American College of Sports Medicine. https://www.exerciseismedicine.org/
8. Healthy Food as Medicine, https://www.2harvest.org/what-we-do/programs-services/foodrx
9. Park Rx. https://www.parkrx.org/
10. Trauma-Informed Care. https://efaidnbmnnnibpcajpcglclefindmkaj/https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
11. ACEs Aware. https://www.acesaware.org/learn-about-screening/training/
12. Resilience in Action. RAND.org. https://www.rand.org/well-being/community-health-and-environmental-policy/centers/resilience-in-action.html
13. SAMHSA Trauma and Guidance for a Trauma-Informed Approach. https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884
14. Zero Suicide. https://zerosuicide.edc.org/
15. Minnesota Department of Health Thrive. https://www.health.state.mn.us/communities/mentalhealth/mnthrives.html
16. National Association of Counties, Opioid Solutions Center. https://www.naco.org/resources/opioid-solutions-center
17. Colorado Health Institute, Opioid Crisis Blueprint, https://www.coloradohealthinstitute.org/research/colorado-opioid-crisis-response-blueprint
18. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/behavioral-health-equity