

COMMUNITY HEALTH IMPROVEMENT PLAN

2026–2031 | Becker & Clay Counties

A Community-Driven Plan for Healthier People, Stronger Communities



Public Health

Prevent. Promote. Protect.

Partnership4Health

Clay and Becker Counties



**HEALTHY
PEOPLE**



**STRONGER
COMMUNITIES**



**THRIVING
PLACES**



**BRIGHTER
FUTURES**

EXECUTIVE SUMMARY

A community-driven plan for measurable progress

Partnership4Health Community Health Board (P4H), a joint entity of Becker County and Clay County public health departments, is responsible for developing a Community Health Improvement Plan (CHIP). It includes using data gathered through a comprehensive Community Health Assessment (CHA) and involving community partners in the planning and implementation of the CHIP.

Prior to 2026, Partnership4Health Community Health Board was a joint entity between four counties: Becker, Clay, Otter Tail and Wilkin. The Community Health Assessment was completed as a 4-county entity. This CHIP document addresses the current 2-county Partnership4Health Community Health Board of Becker and Clay Counties.

The CHIP is a shared roadmap for improving health in Becker and Clay Counties. It translates findings from the 2025 Community Health Assessment into coordinated action by local public health, health care, human services, schools, local government, community organizations, employers, residents, and other partners.

2026-2031 priorities

These priorities reflect Community Health Assessment findings and community partner input

Mental Health & Transportation

Mental Health

Goal: Improve mental health and well-being by making support easier to find and use, increasing opportunities for connection and strengthen coordination across organizations, and improving understanding of crisis-response resources.

- Increase awareness of mental health resources.
- Strengthen how local organizations coordinate referrals, prevention, crisis response, and community support.
- Increase community connection and belonging, with attention to protective factors across the lifespan.

Transportation

Goal: Improve equitable access to daily needs, services, food, health care, school, work, and community life through community-informed planning, mobility options, and cross-sector coordination.

- Assess transportation gaps and equity using resident and partner input.
- Reduce transportation-related resource access barriers through mobile strategies.

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COMMUNITY HEALTH ASSESSMENT AT A GLANCE

A shared evidence base for action

The [2025 Community Health Assessment \(CHA\)](#) provided a comprehensive look at the health status of our region, highlighting key issues. It reflects the health landscape in our communities and is intended to be used as a strategic tool to guide planning and resource allocation for Partnership4Health and community partners.

Top health concerns identified

- Access & affordability to healthcare
 - Affordable housing
- Community engagement & supports
 - Mental health
- Quality of childcare, daycare & preschool
 - Transportation

To develop a comprehensive understanding of health across our region, the Community Health Assessment used a mixed-methods approach that included both quantitative data, qualitative data, and community input. Together, these methods provided a well-rounded understanding of the health status, needs, and strengths of our counties, and ensured that the voices of our communities were central to the assessment process.

- Quantitative Data:
 - Data was gathered from a range of publicly available and local sources to assess health outcomes, risk factors, demographics, and social determinants of health. This included indicators related to demographics, health conditions and outcomes, health behaviors, and healthcare and social services, education, community conditions, and economics.
- Qualitative Data & Community Input:
 - Direct input from residents and stakeholders was gathered through a community survey and focus groups. These methods helped capture lived experiences and community perspective.
 - A large survey was conducted throughout our counties. Sanford Health, alongside local healthcare partners, created a community survey that was shared widely in 2023. Sanford Health is the largest rural health system in the United States and has multiple facilities throughout Partnership4Health. That survey was conducted across a four-county area of Becker, Clay, Otter Tail and Wilkin for a total of 1,723 respondents. Becker County had 247 respondents and Clay County had 666 respondents.
 - P4H led five focus groups throughout Becker and Clay Counties with a total of 35 participants. Participants repeatedly identified healthcare access and affordability, transportation, and community engagement/supports as top concerns. Participants also encouraged organizations to simplify messaging and make services easier to find.

BECKER & CLAY COUNTY COMMUNITY PROFILE

Our two counties share regional systems and partnerships, but the geography and demographic profiles differ in ways that matter for CHIP implementation.

The information presented below represents data from the [CHA](#).

BECKER COUNTY	CLAY COUNTY
• Population: 34,995 (2023) • 70.9% rural / 29.1% urban • 20.8% age 65+ • 86.6% White • 6.0% American Indian or Alaska Native • 3.1% speak a language other than English at home	• Population: 64,975 (2023) • 74.2% urban / 25.8% rural • 13.0% age 65+ • 88.6% White • 4.8% Black or African American; 4.8% Hispanic or Latino • 7.9% speak a language other than English at home

US Census Bureau, 2023

HOW PRIORITIES WERE SELECTED

From assessment to action

Community partner participation

Minnesota Statute 145A requires that community participation in the development of the CHIP take place. To meet those requirements, four 2026 strategy meetings included 33 community partner organizations, and 68 community partner staff were completed. 21 P4H staff provided input through an additional survey.

Partners provided feedback through small group discussion with a note taker at each table, large group discussion, dot voting activities, and follow-up forms.

1

2023-2025: CHA

Review data, survey results, focus groups, assets, and areas of opportunity.

2

June 2026: CHIP Priority meetings

Community partners discussed the six CHA concerns and voted on where coordinated action was most needed and feasible.

3

July 2026 Strategy meetings

Partners reviewed local assets, barriers, and strategies to include in the CHIP.

4

July 2026 Partnership4Health staff input

P4H staff reviewed the community recommendations from community partner meetings and determined which strategies will be used in this CHIP. Considerations included the needs they see in our community through their work and their knowledge of feasibility, equity, existing work, funding, and appropriate public health roles.

5

Fall/Winter 2026 Implementation Begins

Workgroups will refine measurable objectives, leads, partners, and performance measures; progress will be reviewed and updated over time. Workgroups will use updated data to inform workplans, such as a large community survey (CHA) which will be completed in early-mid 2027.

IMPLEMENTATION & MONITORING

A living plan with shared ownership

The CHIP is intended to guide action from September 30, 2026 through September 30, 2031. Strategy leads and partners can revise activities as conditions, funding, data, and community needs change.

Workgroups

Priority-specific workgroups will move selected strategies into implementation.

Clear roles

Identify a lead or co-lead and clarify the roles of each partner and purpose of the workgroups.

Shared workplans

Track action step, target date, lead organization, resources needed, partners, measures, and progress notes.

Progress Updates

Workgroups to decide on regular schedule of meetings; document barriers, decisions, data updates, and strategy revisions. Meeting information will be kept in a shared drive for partners and the information can be used in annual updates to the Partnership 4 Health Community Health Board and broader community.

Equity review

Workgroups will use an equity process to continuously assess who is not being reached and how geography, language, cost, culture, disability, and digital access affect participation.

Evaluation

Use both quantitative measures and qualitative methods. The workgroups will choose an evaluation model such as Results Based Accountability or Ripple Effect Mapping to describe systems change and community impact.

MENTAL HEALTH

Goal: Support mental well-being through resource awareness, coordinated systems, community connection, and timely response.

Why this is important

Adult depression prevalence was 22.4% in Becker County and 26.0% in Clay County in 2023. These statistics represent the probability of adult depression within the county populations based on survey data among adults who responded yes to having ever been told by a doctor, nurse, or other health professional they had depressive disorder.

The Minnesota Student Survey also shows substantial levels of depressive symptoms and suicidal ideation among students. At the same time, strong relationships with parents, trusted adults, schools, and communities are protective factors that can reduce risk.

Mental Health: What the Data and Community Told Us

Mental health remained a pressing concern in the CHA and 2026 CHIP conversations. Partners emphasized prevention, resource awareness, culturally responsive access, school and youth needs, system coordination, social connection, and understanding current crisis-response capabilities.

22.4%	26.0%
Becker adult depression prevalence	Clay adult depression prevalence

PLACES: Local Data for Better Health, Centers for Disease Control and Prevention

Adverse Childhood Experiences (ACES)

Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences that a young person may face before the age of 18. ACEs include multiple forms of abuse, neglect, and a range of household adversities experienced by others in the youth's home that the youth witnesses, such as mental health issues, substance misuse, or domestic violence. ACEs are common, and by the age of 18, most people will experience at least one ACE. In addition, ACEs tend to be interrelated and occur in clusters. The more ACEs an individual experiences, the higher the likelihood that person will develop health problems, like substance misuse, type 2 diabetes, cancer, cardiovascular problems, and depression. The health effects can arise in childhood, or well into adulthood. However, ACEs are not destiny, and certain protective

factors can have a positive buffering effect on adverse outcomes. Similar to ACEs, they are also powerful and cumulative: more protective factors can better protect against the effects of ACEs.

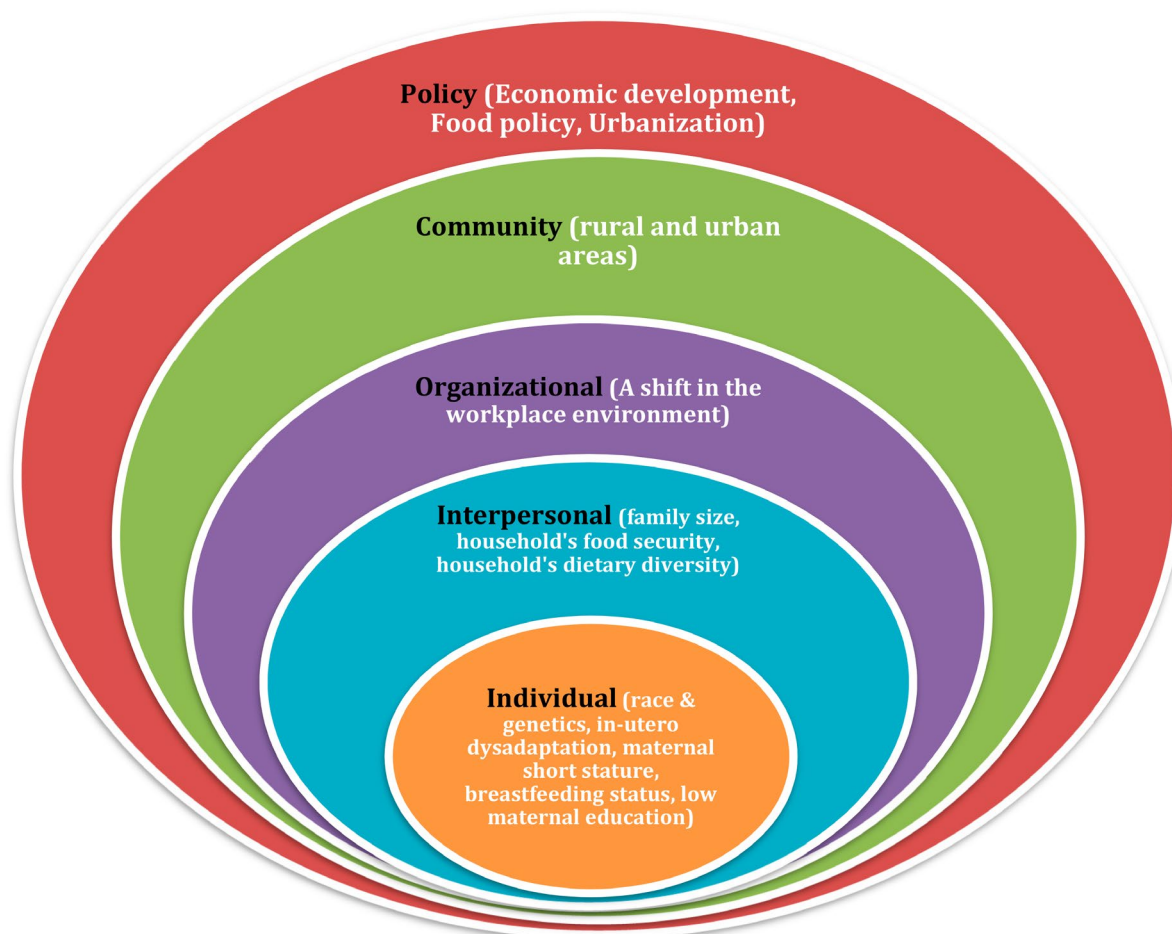
ACEs data shown here represents the CHA, using from the 2022 Minnesota Student Survey (MSS) of 8th, 9th, and 11th graders.

Prevalence of ACES:

- Of the 700 Becker County 8th, 9th, and 11th graders, 51% reported experiencing at least one ACE.
- Of the 1,525 Clay County 8th, 9th, and 11th graders, 45% reported experiencing at least one ACE.
- Minnesota state average: 47%
- About half of adolescents experiencing any ACEs report more than one. (ACEs tend to cluster.)

Protective factors matter

The [CHA](#) highlights that supportive relationships and connection can buffer negative outcomes, even among youth who have experienced adversity. Focusing on protective factors can improve resilience in your community. Protective factors are characteristics at the biological, psychological, family, community or cultural levels that precede and are associated with a lower likelihood of negative outcomes such as substance use and mental health issues. Shown in the Social-Ecological Model, below, CHIP workgroups will use a lens of recognizing that human behavior and health outcomes are based on a layered approach of influence.



Community-selected mental health strategy areas

Community partners who participated in the CHIP planning meetings throughout 2026 used dot-voting activities to select the strategies to be included in the CHIP. The votes shown below represent the results. Following community partner input, P4H staff narrowed the results to either primary strategies or sub-strategies. Primary strategies are the overall focus of the CHIP workgroups, while sub-strategies ensure a specific focus will be used within the overall strategy.

Strategy area	Votes	Role
Awareness of resources	39	Primary Strategy
Organizations working together / knit interventions	33	Sub-strategy
Community connections	18	Primary Strategy
Community navigators	17	Sub-strategy
CredibleMind	16	Sub-strategy
Mental health crisis response	16	Sub-strategy

MENTAL HEALTH STRATEGY 1: INCREASE AWARENESS OF RESOURCES

Community partner voting: 39 votes

People can only use services they know about and can understand. Resource-awareness work focuses on making local supports visible, current, plain-language, and easy to navigate for residents and referral partners.

What this could look like

- Create and maintain a shared mental health resource list with contact information, eligibility, service area, languages, referral process, and crisis information.
- Designate a lead organization or shared governance process responsible for keeping the resource list current.
- Create a community communication plan and materials that can be used by both P4H and community partners, such as: across public health, health care, human services, schools, recovery services, shelters, and community organizations.
- Use plain language, multiple communication channels, and positive community norms messaging.

Sub-strategies

Community navigators — 17 votes

Inventory existing navigator, community health worker, peer, care coordination, and outreach roles; clarify referral and follow-up pathways; promote navigator availability using trusted and culturally responsive messengers.

CredibleMind — 16 votes

Promote the Partnership4Health CredibleMind resource; educate staff and partners so they can refer confidently; track outreach and utilization; clarify that digital self-help complements, rather than replaces, clinical and crisis services.

Crisis response awareness — 16 votes

Clarify current mobile crisis resources, eligibility, hours, capacity, geographic coverage, and when EMS or law enforcement may be needed. Use frontline feedback to distinguish awareness gaps from true capacity gaps.

MENTAL HEALTH STRATEGY 2: STRENGTHEN COMMUNITY CONNECTIONS

Community Connections – 18 votes

Social connection, belonging, and supportive relationships are protective factors for mental well-being. Community-connection strategies create low-barrier ways for people to build relationships before, during, and after periods of stress. The audience of this strategy is community members.

Potential actions

- Strengthen community supports, family resource centers, peer groups, and culturally responsive gathering spaces.
- Create welcoming entry points that are not limited to clinical settings.
- Connect youth, families, older adults, newcomers, people in recovery, and other populations with trusted networks.
- Inventory existing community assets and build on them rather than creating parallel programs.
- Partner with libraries, schools, parks and recreation, faith communities, cultural organizations, recovery groups, and community centers.
- Integrate resource awareness and navigator support into community-connection activities.
- Emphasize a sense of safety & belonging.

Sub-Strategy: Knit Local Mental Health Interventions Together – 33 votes

Mental health needs cross organizational boundaries. CHIP partners identified a need for continued conversations across agencies. The audience for this sub-strategy is the staff of community organizations working to improve mental health.

Potential actions

- Create shared resources rather than separate, duplicative directories.
- Clarify referral, warm-handoff, escalation, and follow-up pathways across organizations.
- Create recurring partner learning and networking opportunities focused on mental health system coordination.
- Map the mental health continuum from prevention through crisis response and recovery to identify gaps, duplication, and weak handoff points.
- Clarify who will convene and facilitate the collaborative structure; P4H may serve as convener, backbone, or co-lead rather than sole owner.

Potential measures

Number and diversity of participating organizations; shared referral pathway adoption; partner confidence in making referrals; number of learning sessions; documented system gaps and action items; percent of action items completed on schedule.

TRANSPORTATION

GOAL: *Improve equitable access to daily needs, services, food, health care, school, work, and community life.*

Why this is important

Access to daily transportation received an average rating of 2.7 out of 5 in the community survey, the second-lowest rating among community service and well-being factors. Focus group participants named transportation among the top health-related issues and called for more options and better accessibility. Rural distance, limited walkability, cost, driver availability, and awareness of services affect access to care, food, employment, education, childcare, and community life.

Transportation: What the Data and Community Told Us

- Residents need clearer, easier-to-find information about transportation options and eligibility.
- Solutions should be designed with the people who depend on them.
- Community input and local data are needed to identify who is not being served and why.
- Low-cost, accessible, multilingual, and locally available options were repeatedly emphasized.
- Many strategies require shared ownership across public health, transportation providers, employers, local government, health care, human services, and community organizations.

Community-selected transportation strategy areas

Community partners who participated in the CHIP planning meetings throughout 2026 used dot-voting activities to select the strategies to be included in the CHIP. The votes shown below represent the results. Following community partner input, P4H staff narrowed the results to either primary strategies or sub-strategies. Primary strategies are the overall focus of the CHIP workgroups, while sub-strategies ensure a specific focus will be used within the overall strategy.

Strategy area	Votes	Role
Transit-oriented development	27	Sub-strategy
Mobile Food Pantries (changed to Mobile Community Resources)	25	Primary Strategy
Enhance Volunteer Driver Programs	22	Sub-strategy
Transportation Equity Assessment	22	Primary Strategy
Active Transportation	19	Sub-strategy

TRANSPORTATION STRATEGIES: COMMUNITY-INFORMED OPTIONS

Mobile Community Resources – 25 votes

Through the CHIP Planning process, the desire for mobile community resources was repeatedly discussed. At the time of the community partner dot-voting activity, mobile community resources was specific to mobile food pantries. Following this activity and further discussion, this topic broadened to Mobile

Community Resources, since transportation affects many areas of life surrounding the top priorities identified in the CHA.

Emerging Priority: Mobile Food Pantry

In particular, a need for greater food access was identified as an emerging priority for the CHIP. This emerging priority arose by conversations led by community partners during CHIP planning meetings. A workgroup will be developed to focus on the creation of a mobile food pantry(s).

Currently, Becker and Clay County do not have regularly operating mobile food pantries. Bring food closer to residents who face transportation barriers, treating food access and transportation as linked issues.

Potential actions

- Identify a host organization (food pantry)
- Identify public locations for distribution
- Find funding sources
- Coordinate food access with transportation planning and outreach
- Develop a plan for funding, frequency, and measures of community use

Currently operating mobile community resources:

Family Resource Center: A community-led, family informed collaborative network of partners focused on strengthening protective factors for Clay County's growingly diverse families.

Becker County Transit

- On-Demand public transportation shuttle for all community members in Becker County within a 10-mile radius of Detroit Lakes. Shuttles pick up and drop off at locations requested by the rider. Shuttle drivers are trained to assist those with mobility difficulties by helping people from their front door to the shuttle.
- Becker County Human Services works closely with Becker County Transit to assist clients.

Family Healthcare: Mobile Units & Spud Care Clinic

- The mobile unit is utilized at schools in Clay County (Moorhead and Dilworth-Glyndon-Felton school districts) to provide services to students. Dental cleanings, dental restorative services, and vision exams are provided.
- The mobile van is also used for seasonal vaccinations.
- Family Healthcare Spud Care clinic is housed within the Moorhead Career Academy and primarily serves Moorhead Area Public Schools students, though is open to the community. Though not a mobile service, it brings healthcare to a convenient location for many families.

Great Plains Food Bank Pop Up Food Pantries: Periodically, the Great Plains Food Bank offers pop up food pantries in Clay County.

TRANSPORTATION STRATEGIES: ASSESSMENT & ACTIVE MOBILITY

Transportation Equity Assessment — 22 votes

Assessment first: understand the landscape

CHA data shows that transportation is priority within our community with a variety of areas of focus for a CHIP workgroup. CHIP community partners identified a variety of efforts to improve transportation. To assist in narrowing the focus of the transportation CHIP workgroup, a Transportation Equity Assessment will be completed

A transportation equity assessment can be a key information-gathering strategy, potentially with separate approaches for community members and organizations. Assessment questions can emphasize the strategies discussed at CHIP partner meetings. Existing CHA transportation questions should be reviewed before collecting new data to avoid duplication.

Potential actions

- Develop community member and organization assessments that build upon existing CHA data.
- Gather community feedback through methods such as surveys and community meetings to ask what transportation people use now and what they would use.
- Ask about service gaps, access barriers, destinations, scheduling, cost, and awareness.
- Gather direct input from rural residents, older adults, people with disabilities, people with low incomes, people without cars, and others who depend on transportation services.

The assessment will include data collection regarding the proposed strategies from community partners from prior CHIP planning discussions:

Transit-Oriented Development — 27 votes

Coordinate land use, housing, services, and transportation so people can reach daily needs with less dependence on a private vehicle.

- Identify the current transit-oriented development landscape and gaps.
- Build on Statewide Health Improvement Partnership (SHIP) knowledge and current community projects.
- Strengthen collaboration among public health, planning, housing, transportation, and community development partners.
- Educate P4H staff about the health implications of transit-oriented development.

Enhance Volunteer Driver Programs — 22 votes

- Recruit additional volunteer drivers and improve communication about the need for drivers.
- Clarify and streamline referrals, eligibility, scheduling, and advance-notice requirements.
- Explore non-emergency medical transportation, veteran access, needed stops beyond medical care, and possible private-pay expansion.
- Consider partnerships for rideshares.

Active Transportation — 19 votes

Walking, bicycling, and other human-powered mobility can improve access while supporting physical activity, social connection, and safer community design.

- Support safe active commutes to school for children and families.
- Explore bike donation programs, additional bike racks, and bike repair stations.
- Continue SHIP work related to the Heartland Trail.
- Include accessibility for wheelchairs and scooters in active transportation planning.

ACTION PLANNING FRAMEWORK

The following template will be used by workgroups to document and track actions. The action plans will be added to the CHIP following those discussions.

Action plan template

Action step	Target date	Lead	Resources	Partners	Progress / measure
Example: Workgroups create workplan using this CHIP.					
Example: Identify key partners, set schedules, etc.					

COMMUNITY PARTNERS

The organizations below were involved in the CHIP planning process.

Continued implementation will require both these partners and additional organizations.

Becker County Commission	Becker County Human Services
Becker County Public Health	Becker County Transit
Beth's Place Recovery	Blue Cross Blue Shield
Churches United for the Homeless	City of Moorhead
City of Moorhead Police Department	Clay County Commission
Clay County Public Health	Clay County Social Services
Community Action Partnership Lakes & Prairie / Head Start	Community Connect Center
Creating Community Consulting	Creative Care for Reaching Independence (CCRI)
Daystar Recovery Center	Early Childhood Dental Network
Essentia Health	Ethnic Self-Help Alliance for Refugee Assistance (ESHARA)
Eventide	Family Healthcare
Immigrant Development Center	Kurdistani Diaspora Center of Minnesota
Lakeland Mental Health	Laker Prep Early Childhood Center
Medica / UCare	Minnesota Department of Health
Moorhead Area Public Schools	New Roots Midwest
Regional Dental Access Coordinator	United Way of Cass Clay
University of Minnesota Extension	

A special thank you to all people involved in the creation of this CHIP document.

CHIP workgroups will use this document as a guide. If you would like to be involved, please contact:

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TOGETHER, WE CAN BUILD HEALTHIER, MORE CONNECTED COMMUNITIES.