Strategies Addressing Health Disparities in Minnesota's Black Communities

Humphrey School Capstone Report

The Hubert H. Humphrey School of Public Affairs
The University of Minnesota

Hannah Lichtsinn
Tracy Pederson
Jonathan Rogers
Aaron T. Rose

PA 8081 Capstone Workshop
Leading Organizational and Community Change
Instructor: Jeannie Entenza, Professor

Summer, 2025
Partner Organization: University of Minnesota Extension

HUMPHREY SCHOOL OF PUBLIC AFFAIRS
UNIVERSITY OF MINNESOTA

Abstract

Our capstone project examined strategies to address persistent health disparities affecting Black communities in Minnesota, with a focus on improving cardiovascular outcomes through enhanced community–clinical linkages. While Minnesota is often ranked among the healthiest states in the nation, Black Minnesotans have a shorter average lifespan and are more likely than White Minnesotans to be hospitalized for heart disease, stroke, and diabetes. Partnering with the University of Minnesota Extension, our research used a mixed-methods approach that included a literature review, observation of a community listening session, and in-depth interviews with Community Health Workers (CHWs). The analysis identified structural barriers to positive health outcomes—including underfunded programs, workforce shortages, and systemic racism—while also highlighting effective interventions, such as hub healthcare models, faith-based initiatives, and frameworks that connect clinical care with community resources. Interviews with CHWs underscored the importance of trust, culturally relevant communication, access to high-quality healthcare, and the importance of health literacy. Recommendations to the University of Minnesota Extension for improving outcomes include strengthening trust-building practices, expanding shared infrastructure, developing inclusive data systems, securing sustainable funding partnerships, leveraging technology to improve coordination, and investing in community-rooted models such as care hubs and CHW networks. By centering community voices and aligning resources with culturally informed practices, these strategies aim to close gaps in care, improve patient engagement, and reduce chronic disease disparities.

Keywords: racial health disparities, cardiovascular disease, social drivers of health, community-clinical linkages, Minnesota, Black communities, community health workers, hub healthcare models, systemic racism

Table of Contents

Executive Summary

Our capstone project explores strategies to improve heart-health outcomes for Black Minnesotans through stronger community-clinical linkages. Undertaken in partnership with the University of Minnesota Extension and set in motion by a grant from the Minnesota Department of Health, the project focuses on the role of Community Health Workers (CHWs) and other healthcare providers in addressing persistent health disparities.

Drawing on a comprehensive literature review, community listening sessions, and interviews with CHWs, we identified both systemic barriers and successful models that influence access to culturally relevant, equitable care. The findings highlight the importance of CHWs as trusted liaisons, the need for culturally responsive training, and the value of integrating community knowledge into healthcare practice.

We identified actionable recommendations for strengthening the infrastructure that connects clinical systems with community resources. These include programmatic, policy, and training strategies designed to support more effective, inclusive, and sustainable models of care in Minnesota's Black communities.

Background

Our capstone addresses the persistent health disparities experienced by Black communities in Minnesota, particularly in relation to heart disease. Despite advances in medical care, significant inequities remain in both preventative and health outcomes, driven by a complex set of social and structural factors. These disparities have drawn increased attention to the role of community-clinical linkages as a potential strategy for improving health equity.

The impetus for this work was a grant awarded to the University of Minnesota Extension by the Minnesota Department of Health through its *Creating Community-Clinical Linkages to Health* initiative. The grant supports efforts to improve heart health in Black communities by strengthening the connection between clinical care and community-based resources and providing culturally relevant training for healthcare providers. The focus of linking clinical care with community resources reflects a growing recognition that improving heart health requires addressing the broader social and environmental conditions that influence health outcomes.

The Office of Disease Prevention and Health Promotion defines these broader social and environmental conditions as social determinants or drivers of health (SDOH). These include safe housing, transportation, and neighborhoods; access to education, employment, and income; availability of nutritious foods and opportunities for physical activity; environmental conditions; discrimination and violence; and language and literacy skills.

Many individuals impacted by SDOH face barriers to healthy living—such as limited access to healthy foods, low health literacy, and historical racial bias—which increases the risk of chronic

conditions like heart disease, diabetes, and obesity. Strengthening the link between healthcare systems and community resources is a critical step in addressing these barriers.

For this project, we collaborated closely with the Extension to determine key focus areas, review current practices, and develop actionable recommendations grounded in field insights and policy analysis. We led a multi-faceted research effort to identify the barriers to healthcare faced by Black Minnesotans and formulate recommendations to improve health outcomes. For our research, we attended listening sessions, conducted interviews CHWs, and carried out an in-depth literature review on heart health disparities and models of community-clinical linkage.

In collaboration with Extension staff, the research emphasized finding both "positive" and "negative" stories—examples of success and areas of breakdown—to inform the design and implementation of future programs. Our recommendations are grounded in this research and the thematic analysis that followed, with particular attention to culturally relevant insights and the lived experiences of Black Minnesotans navigating clinical and community systems.

Three primary questions guided our research:

1. *What are systems-level influences on access to equitable, culturally relevant healthcare by the Black community in Minnesota?*
2. *How can healthcare providers, including CHWs, be part of the solution?*
3. *Which systems are working well with lower-income Black communities?*

By examining both the barriers the Black community faces and successful models of community-clinical collaboration, this project stives to contribute meaningful insights in the ongoing work of reducing health disparities in Minnesota. The findings are intended to support the development of culturally responsive practices and to strengthen the infrastructure connecting healthcare systems with the communities they serve. Together, this foundation provides the basis for deeper exploration.

Literature Review

Our literature review examines the current literature on the state of health disparities in Black communities in the United States and in Minnesota and the linkages between health disparities and SDOH. The literature shows there continues to be significant disparities in health outcomes between Black and White populations in Minnesota.

Our literature review aimed to answer these questions:

- What are the linkages between health disparities and SDOH?
- What is the role of community resources, including CHWs, in addressing SDOH in Black communities?
- Which current models integrate community and clinical resources to address health disparities?

Disparities in Health Outcomes

Though Minnesota is consistently rated as one of the healthiest states in the nation (Forbes, 2024), it is also home to some of the largest disparities in health (Commonwealth Fund, 2021). In 2019, the average life expectancy in the United States was 78.9 years for White Americans and 75.3 years for Black Americans (GBD US Health Disparities Collaborators, 2022). In Hennepin County, Minnesota—where Minneapolis is located—the life expectancy for White Minnesotans in 2020 was 81.5 years and 75.3 years for Black Minnesotans (County Health Rankings, 2022).

Closer examination of health outcome and quality data in Minnesota reveals disparities both in health outcomes and in the quality of care received by Black and White Minnesotans. The Minnesota Department of Health (MDH) reports information on the rates of hypertension, high cholesterol, and diabetes by race (table 1), with higher rates of hypertension and diabetes in Black Minnesotans.

Table 1. Rates of Chronic Illnesses in MN by Race (MDH)

Rates of Chronic Illnesses in MN by Race		
	Black/African American	*White*
Hypertension	35.2%	27.6%
Diabetes	13.6%	8.6%
High Cholesterol	26.9%	29.0%

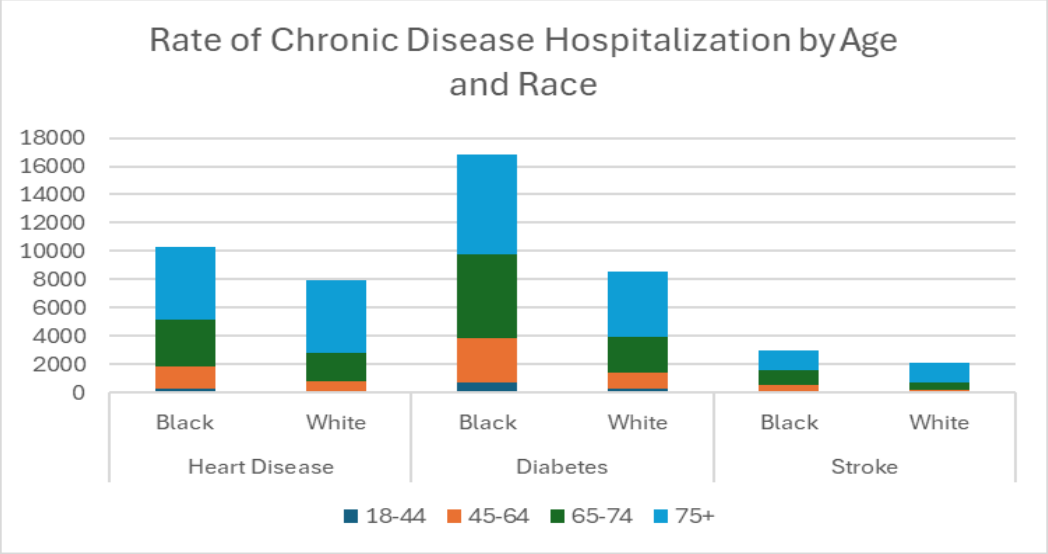
Data from MDH further demonstrates the impact that these and other chronic illnesses have on Minnesotans (Table 2 and Chart 1). In 2023, Black Minnesotans were more likely than White Minnesotans to be hospitalized for heart disease, diabetes, and stroke across most age groups. Notably, the disparity in hospitalization rates was most profound in younger adults.

Compared to White adults, Black adults aged 18-44 were nearly 2.5 times more likely to be hospitalized with heart disease, 2.7 times more likely to be hospitalized for diabetes, and 2.3 times more likely to be hospitalized for stroke. In older adults the disparity between White and Black Minnesotans disappears for both heart disease and stroke, but this is likely impacted by the shorter life expectancy overall for the Black population in Minnesota (MDH, 2023).

Table 2. Rate per 100,000 of Chronic Disease Hospitalization by Age and Race (MDH)

Rate of Chronic Disease Hospitalization by Age and Race						
Age Group	*Heart Disease*		*Diabetes*		*Stroke*	
	Black	White	Black	White	Black	White
18-44	246	95	752	274	61	26
45-64	1581	739	3140	1181	493	198
65-74	3361	1941	5867	2523	1070	529
75+	5143	5155	7106	4591	1355	1365

Chart 1: Rat per 100,000 of Chronic Disease Hospitalization by Age and Race (MDH)

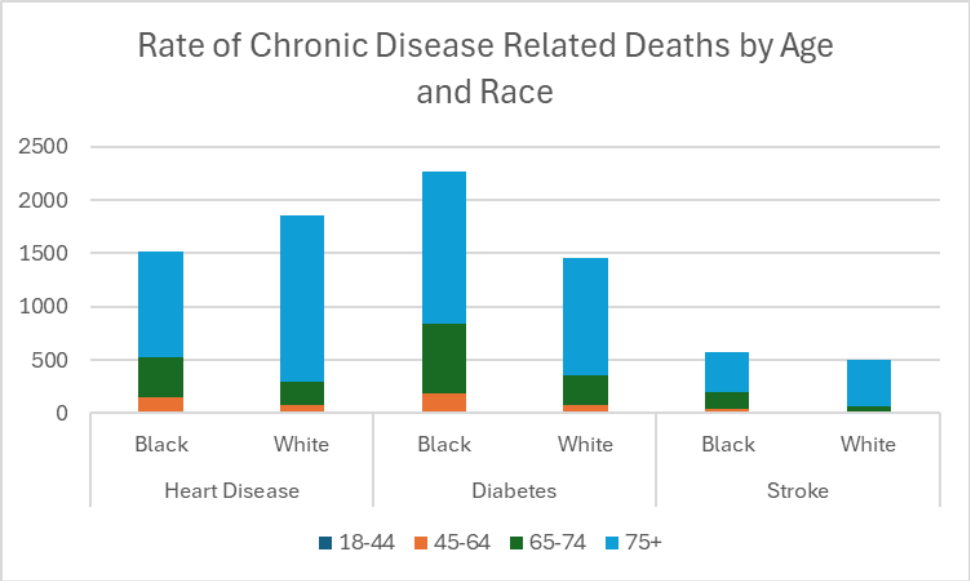


Similar disparities exist in cause of death in Minnesota (Table 3 and Chart 2). Rates of chronic disease related deaths are higher in Black Minnesotans compared with age-matched White Minnesotans in most categories. Specifically, among Minnesotans ages 45-64, Black people are 1.9 times more likely to die from heart disease than White people, 2.4 times more likely to die from diabetes, and 2.5 times more likely to die from a stroke (MDH, 2023).

Table 3: Rate per 100,000 of Chronic Disease Deaths by Age and Race (MDH)

Rate of Chronic Disease Related Deaths by Age and Race						
Age Group	*Heart Disease*		*Diabetes*		*Stroke*	
	Black	White	Black	White	Black	White
18-44	15	7.6	14.4	5.5	3.2	1.3
45-64	135.7	69.6	174.5	70.4	37.2	14.6
65-74	371.4	218.6	650.9	276.6	154.5	56.4
75+	994.6	1564	1430.3	1102.6	381.9	427

Chart 2: Rate per 100,000 of Chronic Disease Related Deaths by Age and Race



The non-profit Minnesota Community Measurement (MNCM) collects data on healthcare process and outcome measures in Minnesota through a centralized data repository. All healthcare organizations in the state submit data on various measures related to preventive care and chronic disease management. MNCM then reports on findings and trends each year. In the most recent report, they found significant disparities for Black Minnesotans in 13 out of 18 measures. Of note, when compared with White Minnesotans, Black Minnesotans were 16%

less likely to be screened for colon cancer, 10.2% less likely to have optimally managed diabetes, and 10.4% less likely to have optimal management of vascular disease (MNCM 2023.)

Social and Economic Disparities

Many factors contribute to the disparities detailed above, including social and economic circumstances. According to the Minnesota Department of Employment and Economic Development (DEED), 2022, 72.5% of residents in the Minneapolis-St. Paul metropolitan area identified as White and 10.1% as Black. Demographic analyses demonstrate significant differences between these two groups. Only 16.2% of Black residents have obtained a bachelor's degree or higher, compared with 34.2% of Whites. Median income for Black households was $53,001 compared with $101,862 for White households. Black families are also four times more likely to live below the poverty level than White families—22.4% compared with 5.6% (DEED, 2024).

These disparities are especially impactful because of the relationship between income, education, and health. According to a 2023 report from MDH, Minnesotans earning less than $25,000 had rates of diabetes that were more than three times higher than for Minnesotans earning $150,000 or more. People with less than a high school education had nearly double the rate of diabetes compared to people who had graduated college.

Similar disparities exist in rates of stroke. The rate of stroke among Minnesotans earning less than $25,000 was more than four times higher than for those earning more than $150,000. It was 1.8 times higher for those who didn't graduate high school compared with college

graduates. Rates of heart attack were more than four times higher for those earning less than $25,000 compared to those earning more than $150,000 and nearly twice as high for those who didn't graduate high school compared to those who graduated college (MDH Health status Among Minnesota Adults, 2025).

Effects of Racism on Health

For this project, we used the definition of structural racism as the systems, policies, and institutions that foster racial discrimination (Bailey et al, 2017). This includes but is not limited to the ongoing economic legacy of slavery creating wealth disparity, and the impact of discriminatory housing and education policies which lead to disparities in opportunity (Bailey et al, 2017). In their review of the impact of racism on health, Bailey and colleagues describe the direct relationship between structural racism and the current disparities in wealth and educational attainment in Black communities.

As mentioned above, the literature shows clear associations between lower educational attainment, lower income, and poorer health. Structural racism is the difference between White and Black Minnesotans in their ability to attain economic and educational success and therefore contributes to higher rates of heart disease, diabetes, and stroke.

Interpersonal racism, specifically the implicit or explicit bias of healthcare providers, is also a potential contributor to disparities in health experienced by Black Minnesotans. A 2015 meta-analysis reviewed 333 studies investigating the impact of racism on health, with 81.4% of the studies conducted in the United States. The studies found a strong association between the

reported experience of interpersonal racism and poorer health. This was more notable for poorer mental health, but it also found an impact on physical health (Paradies, 2015). Another study specifically examining the association of perceived racism and rates of stroke found that women who had previously reported experiencing interpersonal racism had a higher likelihood of eventual stroke (Sheehy, 2023).

Race Concordance

Several studies examine the impact of race concordance—the provider and patient belonging to the same race—in healthcare settings. The impact of racial concordance on health outcomes is inconclusive (Anthony, 2011). However, Black patients report lower quality communication from non-Black physicians (Shen, 2016).

According to the most recent Physician Workforce report from MDH, only 2.4% of physicians in the Minneapolis-St. Paul metropolitan area are Black, compared to 10.1% of the population. Black nurses represent 5% of the nurses in the state. State level data is not available for CHW's, but a report from the National Association of Community Health Workers shows that 10% of CHWs in the West North Central region, including MN, identify as Black, which more closely aligns with the demographics of the local community (NACHW CHW survey, 2021).

Addressing Disparities in Health

Numerous programs and policies have attempted to reduce health disparities in the United States. With a growing understanding of the relationship between socioeconomic status and health, many of these interventions have focused on SDOH. Health systems and providers have

implemented programs and launched initiatives to address health disparities, but as seen in the data above, racial differences in disease screenings and treatment persist. This suggests a new approach is needed.

Community Caregivers

Community caregivers play a pivotal role in providing culturally appropriate information and education impacting health outcomes and can assist in addressing SDOH affecting the Black community. Our literature review examined the effects of three types of caregivers working in Black community: CHWs, doulas, and the African American Health Ministry Committee. These providers and resources can often bridge gaps in communication and reduce barriers that prevent individuals from seeking and obtaining needed care (Morrison et al., 2019).

These resources are unique because they are in and of the community, not an external body or system entering into the community. This empowers community and removes barriers that impact healthcare access. Differing from traditional healthcare providers, these community resources focus not only on acute and chronic health concerns, they holistically address the person, their environment, and a long-term health outcome (Morrison et al., 2017).

CHWs

CHWs are vital in successfully addressing barriers and gaps in healthcare resources in the Black community, and they help mitigate severe SDOH, including food insecurity and unstable housing, by delivering health education, providing emotional support, and referring community members to healthcare services (Peretz et al., 2020).

As trusted members of the Black community, CHWs navigate cultural and language barriers that impact the healthcare accessibility while also building relationships and providing a continuity of care that is difficult to obtain in traditional healthcare environments for the Black community. As a result, CHWs can influence quality-of-life measures for those who are currently receiving treatment (Adams et al., 2021). However, while CHWs have been found to be effective in helping the Black community, challenges with sustainable funding create a barrier (Peretz et al., 2020).

The value and effectiveness of CHWs is being recognized. In Minnesota, CHWs are trained health educators working with Minnesota Health Care Programs (Medicaid) members to provide diagnosis-related patient education services and care management services. CHW services that provide patient education for health promotion and disease management are covered by Medicaid if provided under the supervision of a physician, dentist, advanced practice registered nurse, certified public health nurse, mental health professional or registered nurse. CHWs must have completed an approved community health worker curriculum through a Minnesota state college or university and meet screening requirements. (MDH, 2023).

Beginning January 1, 2024, Medicare began providing coverage for Community Health Integration (CHI) services, a new program aimed at addressing SDOH and integrating community-based resources with clinical care when “a SDOH need is a barrier to diagnosis or treatment” (Medicare.gov, 2025). Additionally, several commercial insurance plans provide coverage for services provided by CHWs, but it is limited and not required.

Doulas

Doulas are important in addressing Black maternal and infant health. They provide a postpartum continuum of care throughout pregnancy, childbirth, and beyond, facilitating an intersection between healthcare systems and mothers (Thomas et al., 2023). Their shared racial, cultural, and experiential backgrounds with expectant mothers allow doulas to build a trusting relationship and provide advocacy to their clients (Wint et al., 2019). Doulas help challenge the institutional biases prevalent in healthcare systems by encouraging informed consent and respectful treatment while allowing mothers to advocate for themselves (Thomas et al., 2023).

While they play an important role in the pregnancy care and the health of mothers, implementation of doula programs often faces systemic barriers, such racism and limited resources affecting programs' sustainability and effectiveness (Wint et al., 2019). However, some programs and health plans have started to recognize the value of the care and services doulas provide and have started to include coverage for doula services as part of their benefit sets.

African American Health Ministry Committees

African American health ministry committees address SDOH by offering service-delivery mechanisms that are culturally appropriate. African American health ministry committees consistently promote church-based health and improved quality of life for adults and children through health and nutrition screenings (Rock et al., 2020).

Church-based health committees integrate nutrition and health education and offer volunteers and community members who access their services the ability to participate in activities that increase their health and wellness awareness. Some strategies used by health ministry committees include organizing available resources to encourage healthcare participation focused on the immediate health needs, especially for diseases like diabetes and obesity. This encourages togetherness and offers social supports to the Black community as they cope with demands that influence their lives and increase the psychological distress that Black Americans experience.

African American health ministry committees encourage practices that allow their members to appreciate their well-being in relation to the environment they live in, emphasizing the importance of community involvement and participation (Hacker et al., 2022). Consequently, these practices help the Black community to develop accessible and community-oriented health practices that contribute to their well-being and strive to promote health inequities.

Effectiveness of Community Health Resources

A key element of CHW effectiveness is their ability to integrate into the community and to work outside the formal health system. The trust CHWs earn with community members helps to reduce access barriers and improve outcomes, as seen in their pandemic response, with targeted community engagement and strategic communication efforts (Bhaumik et al., 2020).

Community resources, like CHWs, optimize patient access to care by helping remove or address systemic barriers including cost, transportation, and scheduling. With improved access, patients

are more likely to meet healthcare goals. Community resources can then delve further into the social determinants of health within the local communities (Gichaga et al., 2021).

CHWs also improve communication between healthcare systems, providers, and the Black community by fostering improved health literacy. Health-related materials are often ambiguous, complex, and culturally irrelevant, leading to low health literacy which may impede decision making. (Coleman et al., 2023). Institutions and stakeholders with community health messages work to ensure messaging is unambiguous.

The information disseminated must be culturally relevant to the community's lived experience and easy to comprehend. Health messaging should boost the confidence of the communities in making health decisions (Muvuka et al., 2020). Communicating effectively to the Black community about healthcare will enhance health literacy, helping enable the community to become better able to make more informed decisions about their health.

Another benefit CHWs provide is long-term engagement rather than episodic or short-term interventions. They engage with patients for over an extended period and adopt a healthcare model that meets immediate needs while addressing future health concerns. This allows healthcare workers and community members to develop a stable relationship, contributing to a positive change in people's adherence to prescribed regimens or preventive measures. It gives healthcare workers an opportunity to adjust interventions concerning the family's changing health literacy and needs over time (Morrison et al., 2019).

Challenges Facing CHWs

Funding and Payment

The largest barriers that undermine the outreach and sustainability of community health resources, and CHWs in particular, involve funding and payments. Although CHWs are vital to addressing health disparities in the Black community, they remain underfunded. This funding deficit is reflective of the systematic issue of underfunding that exacerbates the increasing burden placed on health programs (Gichaga et al., 2021).

Furthermore, the lack of political support for this work and the fragmentation of resources both create barriers to developing sustainable healthcare delivery systems, which are critical for impactful long-term health outcomes and universal health access (Gichaga et al., 2021).

The lack of sufficient funding puts healthcare systems at risk during public health emergencies like pandemics. Inadequate wages and inconsistent funding make put these critical resources at risk (Bhaumik et al., 2020).

Worker Shortages and Capacity Limits

Worker shortages and capacity limits also present obstacles. CHWs face a deficit in workforce availability, which can impact their capacity to provide foundational and timely services to vulnerable populations. Training shortages and a lack of institutional backing for CHW recruitment and retention contribute to a reduced workforce (Adams et al., 2021). adds to work-related stress for existing CHWs, impacting their capacity to provide effective and detailed care to individuals and communities.

Informal Networks and Data Systems

The lack of formal networks and organized data-collection systems for community resources prevents proper evaluation of interventions. This impacts the development of an evidence-based interventional approach, making it difficult to perform a proper program evaluation to determine how these initiatives impact community success. The lack of formalized metrics presents a challenge when trying to secure ongoing funding (Hacker et al., 2022). It also affects the scalability and replication of successful interventions and promotes more underperformance and inefficiencies in addressing SDOH.

Current Models

The research presents models that have been effective in linking community and clinical services addressing health disparities experienced by the Black community in Minnesota. Our research paid particularly close attention to three successful program models. The Hub model is a framework that effectively integrates community and clinical resources to enhance access to healthcare in the Black community. Another model, the ConNECT framework, focuses on the importance of health literacy and inclusion to make health information available to a wider audience. It aims to bridge the gap between the clinic and the community and highlights the need for targeted clinical care interventions that address the underlying components needed specifically for Black communities (Menon, et al, 2019). Another existing model, FAITH!, centers on faith-based community networks that assist in ensuring that people receive adequate information about their health, resulting in improved access to healthcare and healing (Austin & Harris, 2011).

Hub Models

Hub models of care provide centralized linkages of both community and clinic-focused services designed to improve access and delivery of healthcare to the Black community. A hub model centralizes the flow of resources, care providers, and services into a single point of access for an individual dealing with multiple structural barriers (Chappel et al., 2022).

These hub delivery models of care implement approaches that consider SDOH, such as housing and education, in the planning of care and treatment (Austin & Harris, 2011). As part of the delivery model, hub-focused care provides a single source for care designed with the patient at the center, reflecting their cultural and socioeconomic needs to build an environment conducive to improved health.

By implementing community-based care into clinical practice, hub models are focus not only on eliminating health outcome disparities but building cultural competence for healthcare providers, expanding accessibility and building respect for cultural values (Austin & Harris, 2011).

The hub model highlights partnership and collaboration between community organizations and clinical providers to achieve an effective healthcare delivery system. Included in this model are partnerships in which community and clinical providers function collaboratively in a common space to fulfill general health and social welfare demands (Manis et al., 2022). This multipronged approach combines cultural responsiveness and medical know-how to address health inequalities in Black communities.

Hub models provide access to housing resources, educational opportunities, and other programs that impact on health in a clinical setting. Therefore, hub models increase healthcare quality, ensure that healthcare interventions address socio-cultural challenges unique to Black communities, and promote equitable access to health care (Manis et al., 2022).

Hub models deliver positive, measurable impacts on health outcomes and access to care in Black communities. Hub models improve healthcare delivery, particularly for chronic diseases, integrating SDOH into patient care plans (Chappel et al., 2022). The establishment of care within a single model that includes both clinical and social services allow for improved access to other resources by eliminating barriers in multiple areas.

Integrated models in which community health workers build relationships with individuals allows for greater engagement, and the insights and understanding gained from working within the community promote trust and collaborative efforts toward developing and achieving a plan of care (Logan & Castañeda, 2020). Data shows hub models improve healthcare delivery, especially in relation to health equity, and the expansion of their use will address healthcare disparities.

The use of hub models in Minnesota is underway. The Juniper community care hub integrates social care and healthcare for older adults, bringing together more than 40 different medical and community service providers (Trellis, 2024). Another hub, the MN Disability Hub, is a free state resource network providing a centralized location where Minnesotans with disabilities

and their families can find information about healthcare, Social Security benefits, housing, and other community services.

ConNECT Framework

The ConNECT model is an integrative framework connecting clinical healthcare to community resources, impacting health disparities. This framework offers individualized care interventions sensitive to the socioeconomic needs and cultural context of patients (Menon et al., 2019). ConNECT focuses on making research inclusive and information universally available and accessible.

The ConNECT framework is based on five principles:

1. Integrating CONtext: emphasizing the importance of understanding and addressing the impacts of SDOH to tailor interventions and care for individuals and communities.
2. Fostering a norm of inclusion: advocating for consistent inclusion of diverse and marginalized groups in research, clinical practice, and policy development.
3. Ensuring equitable diffusion of innovations: focus on ensuring broad sharing of information on health innovation, information, and interventions.
4. Harnessing communication technology: emphasizing the use of electronic devices and the internet to enhance health communication.
5. Prioritizing specialized training: stressing the importance of education, training, and mentorship for health professionals and researchers that integrates health equity.

With the collaborative engagement of community organizations, the ConNECT model defines strategic targeted approaches for healthcare delivery that involves education, prevention, and management of diseases that are more prevalent in Black communities, like heart disease and diabetes. The model not only focuses on personalized care delivery approaches but also offers guidance for more effective sharing of research outcomes to increase health literacy.

The integration of community knowledge and clinical he ConNECT model contribute to a collaborative and comprehensive approach for healthcare delivery that matches patients' needs, promoting equitable access to healthcare resources and positively impacting health outcomes (Menon et al., 2019).

Additionally, the ConNECT framework allows for appropriate collaboration with various community organizations to address intervention appropriateness from both historical and cultural perspectives. It uses a community-engaged research design that contributes to its implementation and dissemination potential through targeted steps (Menon et al., 2019). Engagement is focused on building trust with community research partners to integrate local knowledge and adjust or refine intervention delivery for better health outcomes.

This partnership is based on a common equity health vision delivered through a customized education and prevention approach focused on the socioeconomic challenges and cultural needs of Black communities (Austin & Harris, 2011). They promote increased community engagement, increase health literacy, and improve healthy behaviors.

The ConNECT framework reduces systemic healthcare disparities using context-appropriate solutions that address cultural incompetence and implement healthcare interventions sensitive to the socioeconomic and cultural conditions in the community (Menon et al., 2019). The ConNECT framework encourages concordance between public health and clinical initiatives. This bridging of multiple healthcare services improves healthcare delivery and promotes equitable health outcomes (Felipe et al., 2019).

As the framework's synthesis encourages connection, it allows for far more collective health engagement and health literacy at both the community and individual levels (Menon et al., 2019).

FAITH! Initiative

The FAITH! initiative utilizes the power of faith-based organizations in the Black community to address health disparities. FAITH! use churches as the key community institution for providing health education, screenings, and wellness programs. The ubiquitousness of places of worship and the trust they have in the Black community making services widely available and more readily utilized (Parker, 2023). The approach is based on Black churches trustworthiness in the community, thus increasing individuals' involvement and interest in health activities.

Utilizing existing trusted community networks, the FAITH! initiative disseminates culturally sensitive information and resources for health and well-being, provides preventive care, and address chronic diseases. The FAITH! initiative provides immediate benefits the Black community while creating a long-lasting and sustainable impact (Parker, 2023).

The FAITH! program applies community-based approaches that engage faith-based organizations as influencers in addressing SDOH. The program maintains partnerships with healthcare facilities and providers, integrating health information and services in a church setting. FAITH! strategies include weight-loss programs, wellness initiatives, and collective, community-based approaches to mitigate obesity, the leading health challenge in the Black community (Lofton et al., 2023).

One of the successes of the initiative is the introduction of the FAITH! App, which has helped improve cardiovascular health in Black communities through mobile interventions (Brewer et al., 2019). The initiative also integrated culturally appropriate cardiovascular health education and services within church settings that were successful in creating trust within the community (Austin & Harris, 2011). Despite this, there is a need to improve the program's accessibility by eliminating the technological gap to enhance the adoption and participation among varying demographics. If these aspects are taken into consideration, the success of the FAITH! Initiative can be widespread, thus assisting the populations in achieving a sustainable improvement in their health outcomes.

Research Methodology

We utilized mixed-methods approach in our research—including a literature review, community listening sessions, and in-depth interviews—to capture both quantitative trends and qualitative insights grounded in lived experiences. Our methods were developed with attention to context, partnership, and practical application. Based on input from the Extension team, we defined the population of interest as non-immigrant Black Minnesotans living in the Minneapolis-St. Paul metropolitan area.

Our research process emphasized collaboration, reflection, and transparency, with a focus on culturally informed analysis and practical application. This foundation supported the development of targeted recommendations aligned with the needs of Minnesota's Black communities and the goals of the University of Minnesota Extension.

Literature Review and Secondary Data Analysis

To provide a foundation for analysis, we conducted a targeted literature review focused on key questions identified in collaboration with the University of Minnesota Extension:

- What are systems-level influencers on access to equitable, culturally relevant healthcare by the Black community in Minnesota?
- How can healthcare providers, including Community Health Workers, be part of the solution?
- Which systems are working well with lower income Black communities?

The literature review was conducted concurrently with interviews and was not directly shaped by the outcomes of our analysis of the interviews. Instead, it served as a parallel line of inquiry to provide context, data benchmarks, and policy framing.

The literature review was organized into four thematic areas:

1. Defining the current state of health disparities affecting Black Minnesotans, particularly in relation to cardiovascular disease and stroke.
2. Examining the root causes of these disparities, including the role SDOH.
3. Exploring the function of CHWs and other community-based support systems in addressing SDOH in Black communities.
4. Identifying models for effectively integrating clinical and community resources to reduce health disparities.

State and federal data were used where available, with the most current demographics cited, including data collected in 2023. To maintain relevance, the review focused on U.S.-based research published within the past ten years, except for one older study included due to its direct relevance.

The literature review offered critical context and quantitative benchmarks that informed the interpretation of qualitative findings. Where applicable, themes identified in interviews were cross-referenced with published data to reinforce consistency and reliability. For example,

disparities in hypertension and cholesterol screening that emerged during interviews aligned with publicly reported health data for Minnesota's Black population.

Community Listening Session Observation

Prior to conducting interviews, members of the team attended a community listening session facilitated by the Extension program. The session centered on experiences, frustrations, and recommendations surrounding community health, systems navigation, and care delivery in Minnesota.

The team observed the session, taking detailed notes and focusing on language, tone, and recurring themes. This session provided valuable qualitative context and was later analyzed alongside interviews and literature review findings to identify alignment, divergence, and future recommendations.

In-Depth Interviews with Community Health Workers

A central component of the research was a series of semi-structured interviews with CHWs Black communities in Minnesota. Seven interviews were conducted in June and July 2025, with each session lasting approximately 45 minutes. All participants either identified as Black themselves or worked closely with Black communities in their professional roles. Six of the seven participants were recommended by the University of Minnesota Extension. The seventh participant was independently contacted by the research team. All interviewees were volunteers, and no financial compensation was offered for their participation.

Interviews began with a relationship-centered introduction to foster openness and comfort. The established connection with the Extension helped create a modest foundation of trust, and this rapport supported rich, meaningful conversation despite time constraints.

Interview questions were open-ended and designed to explore five key areas:

- Definitions of the "Black community" in Minnesota as understood by the interviewee
- Community health needs, particularly related to cardiovascular disease
- Barriers to accessing care
- Strengths and assets within the community
- Connections (or disconnections) between the community and medical institutions

(Our complete list of questions is in Appendix A.)

All interviews were transcribed and de-identified to ensure confidentiality. A basic qualitative coding process was applied to extract recurring themes, considering both frequency and intensity of responses. This enabled the integration of quantitative indicators (e.g., number of respondents referencing "trust" or "stigma") and qualitative excerpts (e.g., compelling quotes illustrating a theme). Manual coding and thematic analysis were used to identify recurring themes throughout our interviews.

Data Strategy

Across both the interviews and literature review, the team employed a deliberate mixed-methods strategy to combine depth of narrative with measurable evidence. Qualitative data from interviews and the community listening session were analyzed for patterns, insights, and

personal stories that reflected the lived experience of Black Minnesotans. Quantitative data, including demographic statistics and program outcomes, provided broader context for public health implications.

This mixed approach helped ensure that narrative and statistical insights informed one another, supporting a more nuanced and grounded understanding of community-clinical dynamics.

Research Foundations and Analytical Framework

The research approach was grounded in public affairs and policy evaluation practices, with an emphasis on community engagement, ethical integrity, and practical applicability.

Core guiding principles included:

- Bardach's "Eightfold Path" for structured policy analysis.
- Ethical approaches to community-based research.
- Cultural humility and reflexivity in interpretation.
- Equity and trust as core values in public health practice.

These principles shaped the project's design, implementation, and recommendations. Together, these strategies provided a multi-layered understanding of the systems, relationships, and lived experiences shaping health outcomes for the Black community. By combining data with community voice and applying an equity-centered framework, the team aimed to produce findings that were both analytically sound and practically meaningful for use by the Extension and its partners.

Analysis and Discussion

Throughout our seven interviews, we identified several recurring themes surrounding barriers to healthcare for Black Minnesotans: access to high-quality medical care, communication, community, cultural identity, trust, empathy, and health literacy. Both trust and access were discussed in each of the interviews, with trust emerging as the most prominent theme throughout—and one of the largest individual barriers to healthcare in the Black community.

Communication, empathy, health literacy, and cultural identity each appeared as major themes in five of the interviews.

During our conversations, interviewees consistently told is that effective care cannot be separated from the social and relational context in which it occurs. Interviewees repeatedly emphasized the need for providers and healthcare systems to slow down and truly connect with individuals, communities and the lived experience that affects people's health.

Interview themes

Trust

All interviewees identified trust and the lack of bidirectional trust as a primary factor impacting the ability of the Black community to fully engage with the healthcare system. Trust, interviewees said, was critical for beginning to alleviate longstanding barriers to healthcare. They described trust as something that must be earned over time and maintained through consistency, culturally relevant communication, and meaningful relationships. Our interviewees often described how an erosion of trust can lead to dire consequences.

One Black interviewee's negative healthcare experiences due to her race had real life-and-death consequences for her.

"When I was going to have my babies … They didn't believe I was in labor at all," she said, describing how a nurse caused her a great deal of pain by going against standard protocol in her assessment. Even with mistreatment, the interviewee felt there was no recourse to protect herself.

"We couldn't complain. There was no place to complain. Who is checking on patients? And then I don't want them to do anything to my baby, so I kept quiet," she said. Eventually, her distress got to the point that the interviewee, who was in active labor, had to call her own physician to advocate for her care.

"We called our doctor, who then called [the hospital]—and she was a Black doctor, [a] woman—she called [the attending physician] and she said, 'You need to be careful, these are healthcare people. They know what they're talking about." After enlisting the aid of her doctor, the interviewee's care dramatically improved.

Our CHW interviewees frequently cited a bidirectional mistrust—healthcare providers not believing the symptoms and experiences described by Black patients, and Black patients having an inherent distrust of a system that has repeatedly failed them.

"Trust is the first big barrier—if people don't trust the system or the provider, nothing moves forward," one interviewee said. She urged the importance of providers believing their patients and taking concerns seriously, "Be vested in listening to the experiences of people and believe them … Have a feedback system that holds people accountable."

Negative experiences—along with a system that has consistently marginalized Black voices—have eroded the Black community's trust in healthcare providers, interviewees said.

"People trust their pastors or their faith leaders more than they trust their providers and the clinic," an interviewee said. "The one thing that was alarming to me was the lack of trust in the Black community [for healthcare providers]. I've been doing this a long time and I was unaware of the … degree of the lack of trust in the Black community with healthcare providers."

Interviewees identified ways that the healthcare community has repeatedly and systemically failed Black people and created an environment of mistrust. "In communities, mistrust becomes barriers," an interviewee said, describing the historic injustices that have led to the mistrust, including "the Tuskegee experiment, the Guatemala STD experiment, the involuntary sterilization of Native American women."

Access to High-Quality Healthcare

Access to high-quality healthcare was another theme that frequently recurred throughout our interviews. Barriers to access included a lack of transportation—compounded by poor public transit infrastructure in Black neighborhoods, complications with health insurance, long wait

times, provider availability misalign with patients' work or caregiving responsibilities, and the scarcity of culturally competent providers in Black neighborhoods.

One CHW recounted the experiences of a Black provider who moved from a private practice into community healthcare to better serve marginalized patients. "The system is not a friend to the community. He said when he was at the private practice, he would spend 15 minutes [completing billing work for each patient] … and his [clinical] services were between half an hour and 45 minutes for anyone that walked through the door," the interviewee said.

However, when the provider began practicing in a community clinic, that ratio was flipped on its head. "He would spend 45 minutes to an hour billing, and the people who came in might get 10 to 15 minutes of service. [With publicly funded health insurance] there were codes for every little thing, whereas the private insurance provided a kind of a base of service," she said. "It sets up the system for not only fraud, but a disenfranchisement of communities that really needed to be served better."

The byzantine insurance-coding process decreased the face-to-face access patients had with this provider, with much of his day wrapped up in complex administrative tasks. This decrease in access was harmful to patients' health. "The … outcomes were worse. [And] the reason why? It was built into the system that was disconnected from the needs of the community and also the people who work in the community."

Other CHWs described how affordability acts as a major barrier to access in the Black community. “Am I going to pay for food? Am I going to pay for housing that is unaffordable. Am I going to pay for daycare? People are put in these positions: ‘What am I going to pay for? What's going to be important to me?’” she said. “Healthcare, a lot of times, is going to be put on the back burner.”

Access to healthy food, too, is a barrier to wellbeing, with nutritious food being difficult to find in many Black communities that are often home to food deserts. “The doctor said you need to be eating this, but you can't even afford that, so where are the food resources?” she said. “Let's look at the price of fruit. Fresh fruit, it's just not an option on food stamps.”

Health Literacy

Another barrier frequently mentioned throughout our interviews was health literacy. Interviewees stressed the need for clear, culturally relevant healthcare information that meets people where they are at, with one CHW linking the health-literacy disconnect to historic racism and injustice.

“Coming out of slavery, white pastors did not want the Black pastors to learn to read the Bible. [White pastors] wanted to give their messages to [Black pastors], and so they could hand-tailor those messages,” she said. “I'm giving it as an example, because I think that's what happens. You can have pieces and slices of information, but not strong, intentional information that's shared that says, ‘We want you to know and learn this.’”

Interviewees described a bureaucratic community healthcare system that frequently uses acronyms and jargon when communicating with patients, obfuscating core messages. “I don't think there's ever been kind of a strong information sharing at different levels to the community that really meets the needs of the community,” she said, describing gaps in healthcare knowledge. “There’s a disconnect between eating fries every day and high cholesterol. “We have to use our community partners to make change.”

The development of strong health literacy, interviewees said, shores up Black people’s ability to advocate for their own health and creates an environment in which healthy habits thrive within the Black community.

Communication

The disconnect in information sharing goes beyond health literacy and the use of jargon. A lack of trusted messengers within the community, and a healthcare-communications system designed for White communities present major barriers to care for Black Minnesotans.

CHWs noted that the ways healthcare systems and government agencies communicate lacks resonance in Black communities. “Just because you put something on a website doesn’t mean people know that it’s there,” one interviewee said. “Communication has been the major deterring or dividing factor, because the way people with resources communicate is not how the other communities receive information.”

The responsibility of effective communication falls on CHWs, too, one interviewee said, noting both historic and personal distrust for healthcare providers within the Black community. “Are we listening openly?” she said. “Are we reflecting what the person said? Because if there's always just a slight miss between what the person says and means, or feels like they're open enough to say, because they have their own reticence about speaking out because of their own past experience, it's very hard for us to get to the point of getting into a collaboration. That can make a difference.”

That lack of communication has been persistent, she said, and it is a barrier to making positive change. She stressed the need for trusted messengers already within the community, saying “We have to use our community partners to make change.”

“We also have not historically done a very good job … of asking and believing in the question, ‘What would make a difference for you?’” she said. “If we do not listen, if we do not believe that everyone’s opinion or experience has value, we limit our understanding to the point of [not] being able to make change.”

Community

Interview participants reiterated the vital role of community in healthcare. Embedding healthcare resources within trusted community spaces—churches, recreation centers, nonprofits, local businesses, and informal networks—are needed to increase credibility, disseminate accurate information and secure widespread buy-in. CHWs consistently focused on the need to work within the community, meeting people at places like bowling alleys and

laundromats, while also relying on the community to be a source of strength for fighting healthcare barriers.

“Communities of color are very resilient,” an interviewee said. “They're adaptable. And we make do with what we've been given. And we have survived, although we're referring very low on the health spectrum and the social spectrum, just because of all of the adverse effects. But I think that there should be a different approach for us. We need to be brought to the table.”

Community and communication go hand-in-hand, one interviewee said, addressing the need to secure Black community leaders as trusted messengers of healthcare information. “You have to create leaders in these communities and support the leaders. [They are already] there, because a lot of Black people are leading the work. They are doing the work, they're just not recognized,” she said.

Another CHW decried the governmental programs’ unsuccessful use of external consultants to address healthcare barriers in the Black community, rather than listening to the community itself. “You just hire someone else to try to solve it, so you have this top-heavy feel of where the funding goes,” she said. “Listen to the community. They have the solutions, they know what's happening.”

Empathy and cultural identity

The themes of empathy and cultural identity were also mentioned throughout our interviews, carrying a great deal of weight. A shared cultural identity among patients and providers was

described as helpful, but not essential. What mattered most was cultural humility and the willingness to learn.

One CHW described her own difficulty finding a provider that would truly listen to her and empathize with her concerns, describing her own Black identity as a barrier. “As a Black woman, you can immediately tell when someone is just looking down on you, and it's not a good feeling,” she said. “I've changed doctors quite a bit until I found the ones that I feel, ‘Okay, this one is listening. They're hearing.’ I got the best care when I got the doctor who looked like me and took time.”

But other interviewees placed less emphasis on racial concordance between patient and provider, instead stressing the power of empathy. “You don’t have to be Black to care for Black patients—but you do have to care enough to learn,” one interviewee said. Another interviewee, along similar lines, described the need for cultural understanding in healthcare. “I don’t expect them to know everything about my culture,” she said. "I do expect them to ask.”

Discussion

There are clear disparities in health outcomes and health screenings between Black and White communities in Minnesota. These disparities lead to an increase in rates of chronic disease, including heart disease, diabetes, and stroke at younger ages in Black Minnesotans, with higher rates of hospitalization and death. This mirrors similar disparities that exist throughout the United States. There is a robust body of literature discussing possible causes of these disparities, suggesting that they are related to disparities in socioeconomic status, access to

care, as well as lower quality care due to interpersonal racism. Historic injustices against Black people in the United States, including by health care systems, also contributes to mistrust of these systems in Black communities.

Community-based interventions have been suggested as a potential intervention to mitigate these disparities in health by improving the connection between patients, healthcare systems, and other resources in the community. Hub, ConNect, and Faith! models have been described as effective methods to bridge the divide between these entities.

In the past decade, CHWs have had a growing role in facilitating the connection between patients, their providers, and community resources. CHWs have been shown to improve patient outcomes by addressing and overcoming barriers to care such as securing transportation, improving communication between healthcare providers and their patients, and effectively connecting patients with trusted resources in the community. CHWs also work to grow health literacy and improve patients' trust in their care by bridging the gap between patients and their providers.

An analysis of interviews done with CHWs working and living in Minnesota illuminated the existence of these disparities. Interviewees consistently identified a bidirectional lack of trust between Black Minnesotans and their healthcare providers as a key barrier to Black Minnesotans achieving their health goals. Specifically, they discussed the general feeling of distrust of the system as a whole related to historical mistreatment of Black Americans by healthcare systems and a difficulty being able to trust individual providers due to negative

experiences when seeking care. Some of these negative experiences were related to a feeling of being unheard, with providers were either not listening or not understanding what they were trying to communicate. On some occasions, interviewees even described times when providers simply provided low quality care.

In addition to challenges with communication and trust, interviewees also described structural barriers Black Minnesotans face accessing care. Many of these barriers are related to poverty and decreased access to on-demand transportation, healthy food, and the scheduling flexibility required to attend visits. The complexity of navigating the healthcare system was also noted as a challenge, as was the type of communication used to outreach to patients as this often did not match the way that Black community members best receive information.

These findings align with what we found in the literature review, but they suggest that in addition to addressing structural barriers to health and healthcare, a key area of focus should be on building trust between Black patients and their healthcare providers. Building trust will be a complex task and requires improved communication and collaboration. CHWs are uniquely situated to facilitate this trust-building process through their position in the community and their position as an intermediary between patients and their providers. A key strength of incorporating CHWs into community and clinical teams is their ability to help patients navigate complex systems while building and maintaining relationships between patients and their providers. This suggests that they serve a critical role in improving the health outcomes for Black patients.

Limitations and Recommendations for Further Research

Time Constraints

The primary limitation of this project was time. This project was conducted over a summer term, limiting its duration to approximately three months. This short duration limited the amount of research and analysis we were able to conduct. In addition to conducting research, our team spent time on important administrative and relational tasks, including building rapport with our clients at the Extension program, organizing schedules as a group, and attending class sessions. These responsibilities further reduced the time available for data collection and deeper analysis.

Further research could occur over a longer period. A longitudinal study may prove useful in identifying generational trends affecting Black communities' barriers to healthcare, examining additional resources, programs, and initiatives making a positive impact, and …and evaluating the effectiveness of policy interventions aimed at reducing these barriers over time.

Building Trust

Although we conducted a significant number of interviews and attended a community listening session, one of the essential components of building trust—particularly in communities historically underserved by research and healthcare institutions—is consistency over time. Because of the project's short duration, our relationships with interviewees had to develop quickly. We prioritized deep, respectful introductions and active listening, but the kind of long-

term trust that supports sustained partnership and community-guided insights could not be fully established within this timeline.

Future researchers could continue building trust within the community to facilitate additional interviews. Valuable data could be attained and evaluated expanding qualitative interviews to members of the Black community, providers, policymakers, community leaders, and other stakeholders invested in removing barriers to healthcare in the Black community. As healthcare, culture, and socioeconomic status can be a highly personal and private issue, building trust between researchers and interviewees is paramount for gaining the most accurate, insightful information.

Scope

Due to time constraints, we focused primarily on interventions for heart disease, which was the focus of the grant. There are other diseases, such as diabetes, that are especially prevalent in the Black community, but we did not focus on these. Additionally, we limited the models we examined to more common ones, including hub-based and faith-based community interventions. We also reviewed another model that focused on improving health literacy. Exploring a broader range of interventions may have yielded additional insights had more time and capacity been available.

Positionality and Cultural Understanding

As four White graduate students, our team members are not part of the Black community, and our findings may reflect that. It is likely that another group of individuals with different backgrounds would bring different experiences and generate additional insights. We also recognize that our cultural understanding shapes how we interpret data, frame challenges, and propose solutions. While we bring significant experience from working in public service and in equity-driven, cross-cultural contexts, we acknowledge both the limitations and strengths of our perspective. We approached this work with humility and a strong commitment to listening, while remaining aware that our role as researchers is inherently shaped by our identities.

Our research revealed persistent barriers and promising strategies for improving heart-health outcomes in Black communities across Minnesota. While many of the themes identified—such as trust, access to high-quality healthcare, funding, and data infrastructure—are complex and interdependent, they also present opportunities for coordinated action. The recommendations below build upon our research, offering practical next steps for public health leaders, policymakers, funding bodies, and community organizations. Together, these strategies aim to support more equitable, responsive, and sustainable approaches to community health.

Clarify Population Definitions Within Research and Grantmaking

A foundational step in equity-driven research is the clear and intentional definition of population categories. In the context of this and similar studies, it is critical to ask: What do we mean when referring to “Black” communities? Does this include African American descendants

of slavery? Recent African or Caribbean immigrants? Multiracial individuals? Other diasporic groups?

These distinctions matter. They reflect differences in history, culture, language, lived experience, and health outcomes. Cultural literacy is essential for researchers and institutions aiming to engage respectfully and effectively with diverse communities. Although this project did not have the scope to fully explore these complexities, future research, funding initiatives, and policy programs should address these questions early in the design phase. Clearer definitions can improve data accuracy, relevance of community engagement, and the overall impact of health interventions.

Address Program Longevity and Continuity of Trust

Sustainable community health initiatives require more than initial funding or a single trusted leader. A key area for further research is how programs can maintain momentum and retain community trust when grant cycles end or personnel changes. Relationships built through CHWs, or program leaders can be deeply personal and rooted in sustained care and shared experience. When those individuals leave, community members may feel abandoned, and trust may erode. Future research should explore models for institutional memory, leadership succession, and team-wide approaches to empathy and cultural humility. Funding models should prioritize long-term investment and relationship-centered design.

Recommendations

Build Trust

Building and maintaining trust remains central to the success of health interventions in Black communities. We recommend that public health efforts continue to prioritize culturally responsive communication, relational care, and long-term community presence. Trust is not a one-time achievement; it must be sustained through consistency, empathy, and respect.

Based on our interviews, there are many ways to build trust—often nuanced and deeply rooted in context. Some involve providers "looking like" the communities they serve. Others depend on cultural fluency, geographic proximity, long-term care relationships, or the simple and powerful act of deep listening. Many of these strategies fall beyond the scope of this paper, but they surfaced repeatedly in conversations with CHWs. Interviewees emphasized that trust is built over time through presence, humility, and meaningful engagement.

Future work should continue to explore trust not as a soft concept, but as a core component of effective, equity-centered health care.

Improve Health Literacy for Patients, Providers, and Communities

Health literacy is a shared challenge across all levels of the healthcare system. Future research should examine ways to make health information more accurate, accessible, and culturally relevant. Approaches may include the use of trusted messengers within Black communities, enhanced communication strategies, and co-designing health education programs with the communities they serve to incorporate shared language, values, and traditions. There is ample

opportunity to develop culturally tailored health literacy programs grounded in Black community experiences and embedded within medical and public health systems.

Strengthen Community-Embedded Health Programs and Linkages

Expanding health access and equity may require embedding services within trusted cultural and community institutions—such as Black churches, recreation centers, or other identity-affirming spaces. These environments offer both physical locations and longstanding relational trust, cultural continuity, and local leadership. Embedding care coordination, education, or prevention efforts in these settings may improve uptake and long-term engagement. To sustain these efforts, future research should examine best practices for linking interventions to broader healthcare infrastructure without compromising cultural autonomy or community trust.

Connect to or Develop a Hub Model

Among the interventions reviewed, hub models emerged as particularly effective for aligning clinical, public health, and community-based resources. The Minnesota Disability Hub offers a statewide network that connects individuals to critical services such as housing, transportation, Social Security, and Medical Assistance—all at no cost. Another example is Juniper, a community care hub that coordinates over 40 organizations to support aging adults with grocery delivery, transportation, and connections to healthcare providers.

We recommend engaging with these existing hubs to learn from their operational models, explore avenues for partnership, or consider joining as collaborators. Strengthening integration

through hub structures offers a promising strategy for improving access, coordination, and long-term impact across health and social-services systems.

Identify New Funding Sources

Innovative funding mechanisms and creative use of both public and private investments are essential to addressing the financial barriers affecting community health resources—challenges that may become more pronounced with the implementation of the 2025 Big Beautiful Bill Act. Health plans and their affiliated foundations share a commitment to improving health outcomes and reducing disparities, while also possessing access to significant infrastructure, funding streams, and data systems. This positions them as potential partners in supporting, piloting, and scaling interventions such as CHW programs.

Additionally, both Medicare and Medicaid already reimburse for CHW services, presenting an underutilized resource within Minnesota's public health ecosystem. We recommend building a cross-sector coalition—including both public agencies and private organizations—focused on improving health equity for underserved communities. Such a coalition could identify new funding pathways, support strategic investments, and advocate for policy changes that sustain and expand CHW-led models of care.

Involve State Agencies and Expand Shared Infrastructure

Future work should explore the role of state-level institutions, such as the MDH and the Minnesota Department of Human Services, in supporting local and community-based interventions. One key recommendation is the development of a centralized, accessible

database to house information on community health initiatives, performance data, and shared learning. Such a tool could reduce duplication of efforts, improve coordination, and strengthen accountability across systems.

Consider incorporating the use of technology to streamline routine administrative tasks that burden CHWs, allowing them to spend more time with patients. Technology generative artificial intelligence can simplify complex health information into more accessible language and these tools are already widely available. Public health and community organizations can collaborate to share skills and build the capacity of CHWs and volunteers, extending the reach and impact of health services.

Improvements to data collection systems would also support measurement of community health resources and their efficacy, which is crucial for policy advocacy. One recommendation is establishing systems that are not only standardized but also adaptable—designed to fit within existing community practices and support timely, relevant data collection that reflects real-world health trends.

This may include a shift to centralized data collection or partnerships with digital medical record providers, allowing for optimized data processes, integrated analysis, and real-time insights to support targeted interventions. Community involvement in designing such systems would help ensure cultural relevance, build trust, and improve both engagement and data accuracy.

Community-based resources play a vital role in addressing SDOH within the Black community by serving as trusted mediators between community members and health systems. These resources employ culturally relevant strategies to deliver services that promote health literacy and sustainable behavior change. However, inconsistent funding, limited workforce capacity, and informal data systems hinder their effectiveness. Without investment in infrastructure and operational support, the full potential of these resources to advance health equity remains unrealized. Ongoing financial support and system improvements will be necessary to ensure that community-based health services can continue playing a meaningful and comprehensive role in population health.

Leverage Technology

Advancements in technology, including AI, offer new pathways to connect individuals and communities to care. Future research should examine how digital platforms can support real-time referrals to community programs, match patients with culturally aligned providers, and facilitate communication between CHWs and healthcare teams. AI tools could also help surface hyperlocal resources tailored by language, culture, or clinical need. These tools must be developed with attention to equity, privacy, and usability, in partnership with the communities they intend to serve.

Final Summary

Black Minnesotans continue to experience disproportionately poor heart health outcomes, shaped by a complex web of social, economic, and structural factors. These disparities are deeply rooted in historical inequities, systemic racism, limited access to culturally responsive care, and the under recognition of community expertise in health systems. This project explored how more equitable, community-centered, and structurally informed approaches can begin to close these gaps.

Across listening sessions, interviews, and the literature review, several themes surfaced repeatedly: the foundational role of trust, the need for clear and respectful communication, the power of cultural understanding and identity, and the importance of long-term connection between healthcare systems and communities. CHWs emerged as essential links, grounded in place, relationships, and the lived experience necessary to support meaningful change.

Our recommendations reflect these insights. They include expanding shared infrastructure, developing inclusive data systems, exploring sustainable funding partnerships, and investing in community-rooted models such as care hubs and CHW networks. Above all, they underscore that relationship-based care and equity-centered planning are essential to any lasting health system transformation.

Improving heart health outcomes for Black Minnesotans requires structural attention, not just clinical solutions. It is a question of trust, access, recognition, and accountability—requiring sustained commitment across agencies, providers, and communities alike.

References

Adams, L. B., Richmond, J., Watson, S. N., Cené, C. W., Urrutia, R., Ataga, O., Dunlap, P., & Corbie-Smith, G. (2021). Community health worker training curricula and intervention outcomes in African American and Latinx communities: a systematic review. Journals.Sagepub.com, 48(4), 516–531. https://doi.org/https://doi.org/10.1177/1090198120959326

Austin, S., & Harris, G. (2011). Addressing health disparities: The role of an African American health ministry committee. Social Work in Public Health, 26(1), 123–135.

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural

racism and health inequities in the USA: Evidence and interventions. The Lancet, 389(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X

Bhaumik, S., Moola, S., Tyagi, J., Nambiar, D., & Kakoti, M. (2020). Community health workers for pandemic response: a rapid evidence synthesis. Gh.Bmj.Com, 5(6). https://gh.bmj.com/content/5/6/e002769

Brewer, L. C., Hayes, S. N., Jenkins, S. M., Lackore, K. A., Breitkopf, C. R., Cooper, L. A., & Patten, C. A. (2019). Improving cardiovascular health among African-Americans through mobile health: the FAITH! app pilot study. Journal of General Internal Medicine, 34(8), 1376–1378. https://link.springer.com/article/10.1007/s11606-019-04936-

5?linkId=65164635&error=cookies_not_supported&code=7f5f4d4d-a00a-4395-acd7-e90f9ec57b1e

Centers for Medicare and Medicaid Services. (2025). Community health integration services. https: medicare.gov/coverage/community-health-integration-services.

Chappel, A., Cronin, K., Kulinski, K., Whitman, A., DeLew, N., Hacker, K., Bierman, A. S., Meklir, S. W., Monarez, S. C., Johnson, K. A., & Whelan, E. M. (2022). Improving health and well-being through community care hubs. Health Affairs Forefront. https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs?fbclid=IwAR2cAEKhKlDnc1LejmT7kXR8ivZsm0s39DbgUvYAF-g-UB3Y1n2AtlQHbZQ

Coleman, C., Birk, S., & DeVoe, J. (2023). Health literacy and systemic racism—using clear communication to reduce health care inequities. Jamanetwork.Com, 183(8), 753–754. https://doi.org/10.1001/jamainternalmed.2023.2558

Commonwealth Fund. 2021. Achieving Racial and Ethnic Equity in U.S. Health Care. https://www.commonwealthfund.org/publications/scorecard/2021/nov/achieving-racial-ethnic-equity-us-health-care-state-performance.

County Health Rankings. 2022. Life Expectancy: Minnesota, 2022. https://www.countyhealthrankings.org/health-data/minnesota?measure=Life%20Expectancy%2A&year=2022.

Cruz, T. H., FitzGerald, C. A., Quintana, V., Barnes, J., Sanchez, K. E., Hirschl, M., Lavender, A., & Caswell, L. (2022). Healthy Here: A promising referral system model for community–clinical linkages to prevent chronic disease. Health Promotion Practice, 23(1_suppl), 153S-163S. https://journals.sagepub.com/doi/abs/10.1177/15248399221111192

DeHaven, M. J., Gimpel, N. A., Gutierrez, D., Kitzman-Carmichael, H., & Revens, K. (2020). Designing health care: A community health science solution for reducing health disparities by integrating social determinants and the effects of place. Journal of Evaluation in Clinical Practice, 26(5), 1564–1572. https://onlinelibrary.wiley.com/doi/abs/10.1111/jep.13366

Disability Hub MN. (n.d.). Home. Disability Hub MN. https://disabilityhubmn.org/

Felipe, R. A., Plescia, M., Peterman, E., Tomlin, H., Sells, M., Easley, C., Ahmed, K., & Presley-Cantrell, L. (2019). A public health framework to improve population health through health care and community clinical linkages: the ASTHO/CDC Heart Disease and Stroke Prevention …. Preventing Chronic Disease, 16, E124. https://pmc.ncbi.nlm.nih.gov/articles/PMC6745896/

Forbes Advisor. n.d. States with the Least Healthy (and Healthiest) Populations, Ranked. https://www.forbes.com/advisor/life-insurance/states-ranked-least-healthy-populations/.

GBD US Health Disparities Collaborators. 2022. “Life Expectancy by County, Race, and Ethnicity in the USA, 2000–19: A Systematic Analysis of Health Disparities.” The Lancet 400 (10345): 25–38. https://doi.org/10.1016/S0140-6736(22)00876-5.

Gichaga, A., Masis, L., Chandra, A., Palazuelos, D., & Wakaba, N. (2021). Mind the global community health funding gap. Ghspjournal.Org, 9(Supplement 1), S9–S17. https://doi.org/10.9745/GHSP-D-20-00517

Hacker, K. M., MPH, Auerbach, J. M., Ikeda, R. M., MPH, Philip, C. M., MPH, Houry, D. M., MPH, & SDOH Task Force. (2022). Social determinants of health—an approach taken at CDC. Journal of Public Health Management and Practice, 28(6), 589–594. https://doi.org/10.1097/PHH.0000000000001626

Islam, N., Rogers, E. S., Schoenthaler, A., Thorpe, L. E., & Shelley, D. (2020). A cross-cutting workforce solution for implementing community–clinical linkage models. American Journal of Public Health, 110(S2), S191–S193. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2020.305692

Jerant, Anthony, Klea D. Bertakis, Joshua J. Fenton, Daniel J. Tancredi, and Peter Franks. 2011. “Patient–Provider Sex and Race/Ethnicity Concordance: A National Study of Healthcare and Outcomes.” Medical Care 49 (11): 1012–1020. https://doi.org/10.1097/MLR.0b013e31823688ee.

Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return On Investment: A return on investment analysis …. Healthaffairs.Org, 39(2). https://doi.org/10.1377/hlthaff.2019.00981

Knowles, M., Crowley, A. P., Vasan, A., & Kangovi, S. (2023). Community health worker integration with and effectiveness in health care and public health in the United States. Annual Review of Public Health, 44(1), 363–381. https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-071521-031648

L., Hamilton, K. K., Kushi, L. H., Caan, B. J., Kibbe, D., Black, J. D., Wiedt, T. L., … Doyle, C. (2020). American Cancer Society guideline for diet and physical activity for cancer prevention. CA: A Cancer Journal for Clinicians, 70(4), 245–271. https://doi.org/10.3322/caac.21591

Lofton, H., Ard, J. D., Hunt, R. R., & Knight, M. G. (2023). Obesity among African American people in the United States: a review. Obesity, 31(2), 306–315. https://onlinelibrary.wiley.com/doi/abs/10.1002/oby.23640

Logan, R. I., & Castañeda, H. (2020). Addressing Health Disparities in the Rural United States: Advocacy as Caregiving among Community Health Workers and Promotores de Salud. International Journal of Environmental Research and Public Health, 17(24), 9223. https://www.mdpi.com/1660-4601/17/24/9223

Manis, D. R., Bielska, I. A., Cimek, K., & Costa, A. P. (2022). Community-informed, integrated, and coordinated care through a community-level model: A narrative synthesis on community hubs. In Healthcare Management Forum (Vol. 35, Issue 2, pp. 105–111). SAGE Publications. https://journals.sagepub.com/doi/abs/10.1177/08404704211046604

Menon, U., Ashing, K., Chang, M. W., Christy, S. M., Friberg-Felsted, K., Rivas, V. G., Gwede, C. K., Lu, Q., Meade, C. D., Sly, J., & Wang, M. (2019). Application of the ConNECT framework to precision health and health disparities. Nursing Research, 68(2), 99–109. https://journals.lww.com/nursingresearchonline/fulltext/2019/03000/Logistic_Regression_in_Nursing_Research.4.aspx

Menon, U., Cohn, E., Downs, C. A., Gephart, S. M., & Redwine, L. (2019). Precision health research and implementation reviewed through the conNECT framework. Nursing Outlook, 67(4), 302–310. https://www.sciencedirect.com/science/article/pii/S0029655419300867

Minnesota Community Measurement (MNCM). 2025. Health Care in Minnesota: Summary Report on Quality, Disparities, and Cost. https://mncmsecure.org/website/Reports/Community%20Reports/Summary%20Report/2023MY_Summary%20Report_QDC.pdf.

Minnesota Department of Employment and Economic Development. n.d. Twin Cities Metro Regional Disparities by Race and Origin. https://mn.gov/deed/assets/24-02TC_tcm1045-341196.pdf.

Minnesota Department of Health. (2019, June). Overview of the physician workforce, Minnesota physician workforce, 2019 (Community-based physician workforce report) [PDF]. https://www.health.state.mn.us/data/workforce/phy/docs/cbphys.pdf

Minnesota Department of Health. (2022, October 3). Minnesota's registered nurse workforce 2020 (Registered Nurse Workforce Report) [PDF]. Retrieved from https://www.health.state.mn.us/data/workforce/nurse/docs/2020rn.pdf.

Minnesota Department of Health. 2023. Health Status Among Minnesota Adults, 2023: Behavioral Risk Factor Surveillance System (BRFSS). https://www.health.state.mn.us/data/mchs/pubs/healthstatus-brfss-2023.pdf.

Minnesota Department of Health. 2023. Heart Disease, Stroke, and Diabetes Hospitalizations in Minnesota. https://www.health.state.mn.us/diseases/chronic/cdhospdata.html.

Minnesota Department of Health. 2023. Heart Disease, Stroke, Hypertension, and Diabetes Deaths in Minnesota. https://www.health.state.mn.us/diseases/chronic/cdmortalitydata.html.

Minnesota Department of Human Services. (2023). Community Health Worker. ttps://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_140357.

Morrison, A. K., Glick, A., & Yin, H. S. (2019). Health literacy: implications for child health. Pediatrics In Review, 40(6), 263–277. https://doi.org/10.1542/pir.2018-0027

Muvuka, B., Combs, R. M., Ayangeakaa, S. D., Ali, N. M., Wendel, M. L., & Jackson, T. (2020). Health literacy in African-American communities: Barriers and strategies. HLRP: Health Literacy Research and Practice, 4(3), e138–e143. https://doi.org/10.3928/24748307-20200617-01

National Association of Community Health Workers (NACHW). 2021. CHW Survey: Diversity of the Community Health Workforce. https://nachw.org/wp-content/uploads/2023/06/CHW_diversity.pdf.

Office of Disease Prevention and Health Promotion. (n.d.). Social determinants of health. Healthy People 2030. U.S. Department of Health and Human Services. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

Paradies, Yin, Jehonathan Ben, Nadia Denson, Amanuel Elias, Naomi Priest, Alex Pieterse, et al. 2015. "Racism as a Determinant of Health: A Systematic Review and Meta-Analysis." PLOS ONE 10 (9): e0138511. https://doi.org/10.1371/journal.pone.0138511.

Parker, V. (2023). Faith-Based Interventions. In Black Health in the South (p. 79). books.google.com. https://books.google.com/books?hl=en&lr=&id=Fo2AEAAAQBAJ&oi=fnd&pg=PA79&dq=faith!+initiative+improving+Black+health+outcomes&ots=uxeNNbREYT&sig=idxDpAS9NEXNh_jpFEiPqePI-M8

Peretz, P. J., Islam, N., & Matiz, L. A. (2020). Community health workers and Covid-19—addressing social determinants of health in times of crisis and beyond. Mass Medical Soc, 383(19), e108. https://doi.org/10.1056/NEJMp2022641

Rock, C. L., Thomson, C., Gansler, T., Gapstur, S. M., McCullough, M. L., Patel, A. V., Andrews, K. S., Bandera, E. V., Spees, C. K., Robien, K., Hartman, S., Sullivan, K., Grant, B.

Samuel-Hodge, C. D., Gizlice, Z., Allgood, S. D., Bunton, A. J., Erskine, A., Leeman, J., & Cykert, S. (2020). Strengthening community-clinical linkages to reduce cardiovascular disease risk in rural NC: feasibility phase of the CHANGE study. BMC Public Health, 20, 1–10. https://link.springer.com/article/10.1186/s12889-020-8223-x

Sheehy, Sarah, Hugo J. Aparicio, Julie R. Palmer, et al. 2023. "Perceived Interpersonal Racism and Incident Stroke Among US Black Women." JAMA Network Open 6 (11): e2343203. https://doi.org/10.1001/jamanetworkopen.2023.43203.

Shen, Megan J., Emily B. Peterson, R. Costas-Muñiz, et al. 2018. "The Effects of Race and Racial Concordance on Patient–Physician Communication: A Systematic Review of the Literature." Journal of Racial and Ethnic Health Disparities 5: 117–140. https://doi.org/10.1007/s40615-017-0350-4.

Tavakoly Sany, S. B., Behzhad, F., Ferns, G., & Peyman, N. (2020). Communication skills training for physicians improves health literacy and medical outcomes among patients with hypertension: a

randomized controlled trial. BMC Health Services Research, 20, 60. https://doi.org/10.1186/s12913-020-4901-8

Thomas, K., Quist, S., Peprah, S., Riley, K., Mittal, P. C., & Nguyen, B. T. (2023). The experiences of Black community-based doulas as they mitigate systems of racism: A qualitative study. Journal of Midwifery & Women's Health, 68(4), 466–472. https://doi.org/10.1111/jmwh.13493

Trellis. (2024, March 25). A promising new model: Community care hubs. Trellis Connects. https://trellisconnects.org/a-promising-new-model-community-care-hubs/

Wint, K., Elias, T. I., Mendez, G., Mendez, D. D., & Gary-Webb, T. L. (2019). Experiences of community doulas working with low-income, African American mothers. Health Equity, 3(1), 109–116. https://doi.org/10.1089/heq.2018.0045

Appendix A

Introductory Notes Ahead of Interviews

Before starting the interview, we briefly introduced ourselves as students from the Humphrey School of Public Affairs, and as individuals (15 seconds or so each) working on a capstone project in partnership with the University of Minnesota Extension. We shared the following points with each participant:

- We would be asking approximately 10–12 questions over the course of 45 minutes.
- Their insights would help inform training modules and a written report shared with the Extension team.
- No audio or video would be recorded—only an automatic transcript of the conversation would be generated.
- Their name and role might be included unless they preferred anonymity.
- We acknowledged our own positionality as graduate students from diverse backgrounds and invited participants to correct or challenge the assumptions embedded in our questions.
- We noted that the focus of the study included Black communities—particularly "foundational" communities with ancestral ties to enslaved people in the United States, and Black women in Minnesota.
- We asked if participants had any reservations or preferences about how their responses would be used and reminded them that they could revise their preferences at any time.

Interview Questions

1. Could you start by sharing a bit about your own journey—how you came into healthcare or community health work, and what keeps you connected to it?
2. To better understand the depth and diversity of the communities we are learning from: How do you describe your identity—for example, in terms of race, gender, or anything else that feels important to how you move through the world?
3. What does it mean to you personally to serve the Black ("foundational") community in a healthcare role? How has that shaped your approach?
4. In your experience, how do social and environmental factors—like housing, food, stress, or access—show up in the everyday health of your patients or clients?
5. What does it look like when someone in your care needs help beyond what a clinic typically provides? How do you try to respond, and what systems are (or are not) there to support you?
6. Can you describe a moment when a relationship—between you and a patient, or between systems and community—made a difference?
7. Have you seen examples of referral systems or cross-organizational partnerships that actually help people connect with the support they need? What makes those work?
8. Thinking about health education—whether for patients, providers, or CHWs—what approaches have you seen work well?
9. What makes training culturally relevant in practice, not just in name?
10. If we were creating a new training module for healthcare workers serving Black communities, what kinds of content, stories, or tools would you want included?

11. Are there models, programs, or practices—local or national—that you think others should be paying attention to?
12. What barriers or points of frustration have you seen in trying to deliver or access care that truly meets the needs of Black Minnesotans?
13. What kinds of academic articles, community-based reports, or lived-experience resources would you recommend for our student team to explore as we continue this work?
14. Finally, is there anything we haven't asked that you feel is important to share—about your work, your community, or the systems around your work?

Appendix B

Selected Quotations from Interviews

Trust

"It is still difficult sometimes when you go to see a doctor and they are not believing."

"So, the barriers that I see…it's really respect and trust. And knowing the community. Without really knowing your, or knowing your true needs. So, there's a lack of relationship and I think that's the biggest barrier in all the circles of what it means to serve communities better."

"If the doctor also came from those communities, that would be, like, ideal, because then they know what's going on in the community, they're easily accessible."

"Especially as a Black woman. You can immediately tell when someone is just looking down on you, and it's not a good feeling, so I'm like, I don't want to go there. So, I've changed doctors."

"I don't want them to do anything to my baby or any… so I'm… I keep quiet."

"Maybe something the hospital could do is to really. Listen, like, be vested in listening to the experiences. Of people and believe them, not excuse it, not sit down, play it, but listen, like. Have a feedback system that and holds people accountable, like, for real."

“We cannot erase what has happened…we have to embrace it as our history and take accountability on it but be transparent and walk through it. So, for example, I teach about understanding lupus for CHWs. It includes clinical trials, clinical trial disparities, so we address it on the community level. It’s the mistrust, it’s the minimum, it’s the gaps in care, the access in care, not even having the knowledge of clinical trials and the effectiveness.”

“We address [mistrust] at the provider level. What do the providers believe? What is their access? What is their knowledge? We also look at the infrastructures and what to the infrastructure support? In communities, mistrust becomes barriers. They’re readily on the forefront of that. There are examples around and I walk the through the Tuskeegee experiment, the Guatemala STD experiment, the [in]voluntary sterilization of native American women. And then we walk through the anecdotal and systemic things that have been put in place for protection - patient’s bill of rights or home care bill of rights.”

“People trust their pastors or their faith leaders more than they trust their providers and the clinic.”

“The one thing that was alarming to me was the lack of trust in the Black community [with healthcare providers]. I’ve been doing this a long time and I was unaware of the amount of lack of trust, the degree of the lack of trust in the Black community with healthcare providers.

“You know, like, there just seems to be this barrier.

“To believe when someone comes in. So, it's a huge barrier then, when I come and I'm saying I have this symptom, and I'm not believed. Oh, this is what's happening with me, and I'm not believed, or the… whatever they are thinking.”

“Especially as a Black woman. You can immediately tell when someone is just looking down on you, and it's not a good feeling, so I'm like, I don't want to go there. So, I've changed doctors.”

“And so, when people look at you as being authentic, they're more willing to trust you. And so CHWs, because we are the people of the people and for the people, we are the trusted messengers. But we don't want to be the gatekeepers…and we don't want to open doors for unintentional harm, because people can come in with great projections and great intentions, but unintentional harm can be done.”

“And healthcare workers… I was part of a group, they did, listening sessions with the Black community. And the one thing that was alarming to me was the lack of trust in the Black community. And I guess I’ve been doing this a long time, and I was unaware of the degree of the lack of trust in the Black community with healthcare providers….”

“Trust is the first big barrier—if people don’t trust the system or the provider, nothing moves forward”

“The biggest frustration is providers not listening—I tell people, if they don’t feel heard, change providers.”

“Listening without judgment- that is the key to trust. Lots of people do not step forward due to SHAME, and do not step forward because of JUDGMENT.”

Communication

“Change how we communicate, listen to people. How do you like to receive information? Where do you receive it from?”

“And bringing people along. And also helping them know that just because you put something on a website doesn't mean people know that it's there, and that has been. Communication has been the major deterring. Or dividing factor, because the way. People with the resources, um. Communicate is not how the other communities receive information.”

“So, yeah, I think just look at the strengths in the communities, how they communicate, how come things work when they run.”

“How can we help? And not just a $50 gift card, but where we're actually knowing people, talking to people. Finding out what's going on, and sometimes people make choices that are their own choices, and they decide, but there's other ways we can help… maybe people don't want to walk in a dangerous neighborhood. But maybe if they could take their children to the Science Museum for free, they would walk around the science museum, and not only will they

promote, you know, developmental milestones for their children, but they would do some movement, right?"

"...just because you put something on a website doesn't mean people know that it's there, and that has been. Communication has been the major deterring. Or dividing factor, because the way. People with the resource communicate is not how the other communities receive information."

"Be vested in listening to the experiences. Of people and believe them, not excuse it, not sit down, play it, but listen, like, have a feedback system that holds people accountable."

"With populations at risk. Um, and listen to them and say… one of the couple of the things that I've found to be most effective is to truly partner with those people, and the things that we could do as a public health agency … the result of that was that people were served by individuals that they could relate to. So, I think we have to use our community partners to make change."

"Are we listening openly? Are we reflecting what the person said? Because if there's always just a slight miss between what the person says and means, or feels like they're open enough to say, because they have their own reticence about speaking out because of their own past experience, it's very hard for us to get to the point of getting into a collaboration. That can make a difference."

“And I think we also have not historically done a very good job as white providers of asking and believing in the question … ‘What would make a difference for you?’”

“I have an open-door policy, pretty much, and so I'm always asking questions of the community, I'm always engaged with the community, but the community also reaches out to me for various health topics and things like that.”

“I always wanted to know what happened after these listening sessions. So, what did you do with this information? I… and the thought came to my mind just… what follow-through did they have, and what implementation did they have of that information, if that makes sense. And so, I think that’s the… that’s the barrier that we have, is we get this information, and a lot of stuff that happens in a Black community is… grant-funded. And so, what happens when that grant ends? You know, and what is the follow-through of that?”

“Then it’s education [as a barrier]—there’s often a gap in clear, respectful communication about care, rights, and options.”

Empathy

“I have found the ones [doctors] that I feel, okay, this one is listening, they're hearing.”

“Um, especially public health, should be based on knowledge. And when you get knowledge, you're able to truly have empathy. And a bigger space to make change versus, you know, saying in a scenario on a written paper, whoa, this is what happened to this community. This is what

we think should be the solution. Because everyone's different, too. And I wanted to give a precursor, too. These are my opinions, and these are my thoughts, so it's not gonna be based out of my job, you know, or anyone else. It's just, you know, so it's just me."

"You learn to care, and I think there's a factor there. If you don't care for people, even… it just becomes a job."

"Biggest frustration is providers not listening—I tell people, if they don't feel heard, change providers."

Health Literacy

"And bringing people along. And also helping them know that just because you put something on a website doesn't mean people know that it's there, and that has been. Communication has been the major deterring. Or dividing factor, because the way. People with the resources, um. Communicate is not how the other communities receive information."

"The community-level workforce to understand about what preeclampsia is. And I think, you know, there's a disconnect. You know, there's words that go out, there's a lot of acronyms that go out from the state and others. And the information isn't broken down into, like, a health literacy lens that you know, this is what you need to watch out for. You don't have to be an expert, but these are the signs that when you need to refer. And help maybe that family do that referral. So, I think, no, I don't think there's ever been kind of, um. A strong information. Sharing at different levels to the community. Um, that really meets the needs of the

community. And I think I mentioned to you, too, one of the things that bothers me more recently, I learned that. Coming out of slavery, that the white pastors did not want the Black pastors to learn to read the Bible. They wanted to give their messages to them. And so, they could hand-tailor those messages And so the authority came from not, um, authority of what reality was, you know, the Bible, but it came from choosing over information based on an individual. And I'm giving it as an example, because I think that's what happens."

"There's so little true understanding of why things happen. There's this, like, disconnect. People think that you're born with this, or even education, right? I mean there is a disconnect. Between eating fries every day and high cholesterol."

"Education is the single most significant health determinant. And now, more than ever." Absolutely, I am also in a teaching capacity, so either I'm teaching the community, or I'm teaching professionals…We cannot erase what has happened…and so we have to embrace it as our history."

"Well, if you're looking at different workforce groups—such as the doula workforce, the community health workforce, the home visiting workforce—I don't think any of them are well equipped to handle some of the needed information.. They do get some information and some training, but many times there's a disconnect from the accurate information that comes from sources like the CDC or from nursing training, where you get real, specific information. For example, we're doing modules on preeclampsia, and those modules are being created because

of the need for the community-level workforce to understand what preeclampsia is. I think there's a disconnect."

"There are words and a lot of acronyms that go out from the state and others, but the information isn't broken down through a health literacy lens—like, "this is what you need to watch out for." You don't have to be an expert, but these are the signs to watch for, and here's when you need to refer, and maybe help that family do that referral."

"So, I don't think there's ever been a strong system of information sharing at different levels to the community that really meets the needs of the community. One of the things that bothered me more recently—I learned that, coming out of slavery, the white pastors did not want the Black pastors to learn to read the Bible. They wanted to give their messages to them, so they could hand-tailor those messages. And so, the authority didn't come from the reality of the Bible, but from controlling and shaping the information through individuals. I'm giving that as an example because I think that's what happens. You can have pieces and slices of information, but not strong, intentional information that's shared with the message: "We want you to know and learn this. We want you to also know your scope of work and what lane you can be in to support the community."

"The relationships that should drive the work—especially in public health—should be based on knowledge. And when you gain knowledge, you're able to truly have empathy and a bigger space to make change. Versus just saying, in a written scenario, "Well, this is what happened to

this community, and this is what we think should be the solution." Because everyone's different, too."

Access to High-Quality Healthcare

"And, um, and then now I work with the county. Developing their first community engagement program. And so, listening to the communities. Addressing some of those systems, policies, and practices that keep people from. Um, getting the programs and. Services and resources that the county offers, but people just don't know about them."

"Complexity limiting true access: [A Black doctor] said the system is not a friend to the community. He said when he was at the private practice. He would spend 15 minutes Billing. Right?...So he spent 15 minutes billing…the Long Beach community that were financially challenged. He would spend 45 minutes to an hour billing. And the people who came in might get 10 to 15 minutes of service. And he said, because there were codes for every little thing whereas a private insurance provided a kind of a base of service based on the service. So, you didn't have to code for every little thing. And he said it sets up the system for not only fraud, but a disenfranchisement of communities that really needed to be served better."

"Complexity limiting true access: When the system becomes so complex that all it's about is the system. Then the people who really, you know, um… are needing, kind of, the services get… inferior services. So, you know, when it comes to, you know, how to serve people, um… I think it should be where… It is equal. It is equal. And I think that private insurance should learn from, I should say public insurance should learn from private insurance. Why can you spend 15

minutes in the private insurance world, and an hour, up to an hour, and then… And the public. And it's all funding. Anyway, I don't know if I answered your question."

"Complexity limiting true access: When we make things so complex and so many hurdles, I battled it. I was in a… quite an alarming meeting this morning with a supervisor. I'm giving you, please don't share this with the whole world, but…"

"Yeah, the doctor said you need to be eating this, but you can't even afford that, so where are the food resources? So, we connect people to, um, the food resources closest to them."

"And you have to wait as a client. For 30 minutes to make an appointment and you're paying your cell phone minutes. And you're out in minutes at the end of the month. It's not acceptable. We cannot have it be that way. And that's a simple doorway. To say, if you're trying to get people into clinic services, and they have to wait for you because of your systems."

Cultural Understanding

"I really… Started to educate myself on what it means to be Black in this country.

"It seems difficult for people in the healthcare, and I mean especially white doctors. Um, and sometimes nurses, but now nurses, we have… the field has really diversified. To believe or to take seriously, or to…. You know, like, there just seems to be this barrier."

“So, we need more doctors and … nurses and healthcare providers that look like us. Because sometimes we don't know even… the way we describe pain is different from how other people describe pain. Uh, it's just a cultural, sometimes, thing, and so you're made to seem like you don't know what you're talking about. But you know what you're saying, but it's not understood.”

“Then you start to live with people. You see them as people.”

“Training requirements are a barrier for Black CHMs when each grant program has new training requirements. I battled with, they want to mandate some… trainings. And I said, why would we mandate trainings when we have, um, a low number of Black workforce and tribal workforce and Hispanic, Latino?”

“I started to understand the cultural differences. Um, first of all, even just understanding what being Black is, because we [immigrants] don't refer to ourselves as Black when we come in here, and people are telling me, ‘You know, you're Black.’ You're like, ‘No, I'm not.’”

“No matter even how dark you are, you're like, no! Um, because that's not how we introduced ourselves or saw ourselves when we came up, but then, now, as you begin to learn and understand the culture and everything, and your own experience is a Black experience, so I really started to educate myself on what it means to be Black in this country.”

“Cultural considerations needs to be taken into. Um, consideration that, you know, based on our culture and our belief system, we may respond differently. To medicine and treatment and diagnosing.”

“Do we really have the answer? And what… who in this room can help us? And I think we also have not historically done a very good job.”

“Serving the Black community in this role feels personal—it’s not just a job, it’s a responsibility.”

Community

“And, um, and then now I work with the county. Developing their first community engagement program. And so, listening to the communities. Addressing some of those systems, policies, and practices that keep people from. Um, getting the programs and. Services and resources that the county offers, but people just don't know about them.”

“So, we have to address… listen to the community. They have the solutions, they know what's happening.”

“So, you have to create leaders in these communities and support the leaders even are usually there, because a lot of Black people are leading the work. They are doing the work, they're just not recognized.”

“If the doctor also came from those communities, that would be, like, ideal, because then they know what's going on in the community, they're easily accessible.”

“I think maybe something that gets sometimes left out is…. Identifying the strengths in the Black community. Like, identifying them and valuing them. And making them mainstream, because there's so much…”

“There's so much The Black community has to offer. They have solutions to things because of their lived experience, like valuing that lived experience and. Not just valuing it, but, like. Putting money to it.”

“So, yeah, I think just look at the strengths in the communities, how they communicate, how come things work when they run.”

“Um, so the barriers that I see, correct? Um, yeah, it's really respect and trust and knowing the community. I think, you know, so much of what happens within people groups are, you know, um… We want to give you something. Without really knowing you or knowing your true needs. And… so, there's a lack of relationship, and I think that's the biggest barrier in all the, I want to say, circles of what it means to serve communities better. People really don't know people from other communities. And, you know, when I first started at the state, I said, um, how can you understand how to even put together anything if you don't know the needs of the community from where the community comes from? And I don't think it's just, you know, bringing up, you know, just a $50 gift card to bring communities at the table. I think it has to be really getting in

a place of, I want to say, somewhere embedding. You know, where there's a bowling league, where everyone gets to know people in a different angle. Go to a laundromat, you know? I mean, that's… I'm just telling you, that's what I did to get to know a community. I have a washer and dryer. But we moved in a new community, and I wanted to know the real community, so I went to a laundromat, you know? I just think, you know, find a store that's not on your side of town."

"That might not feel as, um, you know, if it doesn't feel, like, totally safe to you, it probably doesn't feel safe to other people if… If, you know, if you're experiencing that too, and get to know the same cashier. You'll get to know, and she'll start talking to you about Life that's around the city, or in… so I just think it's this disconnect of knowing, and when you don't know. You really don't trust, right? And the relationships that really should drive Um, you know, the work."

"If you don't know the community, is it really the factor of care?"

"Sometimes I think when, especially when you're looking at you know, governmental work, you know, when there's problems and issues, rather than really searching for true answers from the community, many times. You just hire someone else to try to solve it. And then, so you have this top-heavy feel of where the funding goes, rather than reaching back into Um, to say, do we have solutions that'll be a lot less cost-wise, money-wise, and then also. More relevant. And I say that because you know, um… And you learn to care."

“Well, I think the importance of going into community where they are, and I think if we're public health workers. Um, we have to be connected somehow to all communities that were served.”

“And so, if there's one takeaway, I would say. Um, if you're a public servant in any capacity, and your taxpayer-funded, you need to know your community.”

“Know the community. Um, trying to find the spaces that, you know, you might be uncomfortable. But then you have to think, um, the same uncomfortability that you might feel going into their space, they feel coming into, say, the doctor's office, or to… a clinic. So, it's good to feel uncomfortable when it comes to trying to help people and growing with people, so…”

“Listen to the community. They have the solutions, they know what's happening.”

“My mother was very community-activated, very community-engaged. And she was my first inspiration…but my parents were also suffering with debilitating chronic conditions, which most of my family were. but to see my… my parents themselves struggle with their health. and their health conditions, along with system barriers, but also be on the front line of change was really inspiring to me. Even today, you know, in my old community…they still talk about the phenomenal work that my mother did.”

“I am from the Black community. I identify as a U.S.-born African American woman. I would say that was my first population of people that I provided services for, um, so I understand, my community, I understand a lot of my community needs, although they're evolving, the needs and very complex.”

“So, we were able to understand it a little bit better and take it back to our community. Because my mom used to host community events, she was on the PTA, um, she knew how, uh, we were broken up in precincts, and so we would have aldermen. And so, she knew how to go down and get things to happen in our community.”

“Well, I would say that the communities of color are very resilient. They're adaptable. And we make do with what… we've been given. And we have survived, although we're referring very low on the health spectrum and the social spectrum, just because of all of the adverse effects.”

“But I think that there should be a different approach for us. We need to be brought to the table.”

“Um, it's not that we're being resistant, it's just that it doesn't fit with our value system and our customs, so embracing that, that we're an individualized community. Um, and then we do have sensitive needs. I think it should be a collective effort and an inclusive effort that, um, we should be invited to the table, especially when making decisions about our health and our communities and our health outcomes.”

“So, the barriers that I see, it’s really respect and trust and knowing this community. I think so much of what happens within people and groups is that we want to give something without really knowing the people or their true needs. And so, there’s a lack of relationship. I think that’s the biggest barrier in all the circles of what it means to serve communities better. People really don’t know people from other communities.”

“When I first started at the state, I said, “How can you understand how to even put together anything if you don’t know the needs of the community or where the community comes from?” And I don’t think it’s just about bringing up a $50 gift card to get communities to the table. I think it has to be about really getting in—embedding yourself somewhere. You know, like where there’s a bowling league, where everyone gets to know people from a different angle. Go to a laundromat. I mean, that’s—I’m just telling you—that’s what I did to get to know a community. I have a washer and dryer, but we moved to a new community, and I wanted to know the real community. So, I went to a laundromat.”

“I just think—find a store that’s not on your side of town. One that might not feel totally safe to you. If it doesn’t feel safe to you, it probably doesn’t feel safe to others either. And if you’re experiencing that too, go there. Get to know the same cashier. You’ll start to know her, and she’ll start talking to you about life around the city. So, I just think it’s this disconnect of knowing. And when you don’t know, you really don’t trust.”

“Serving the Black community in this role feels personal—it’s not just a job, it’s a responsibility

Education needs to happen in the community, not just with caregivers—everyone needs to know what's out there and how to get help."

SDOH

"Yeah, the doctor said you need to be eating this, but you can't even afford that, so where are the food resources? So, we connect people to, um, the food resources closest to them."

"Talk with our cities and, um, to provide spaces, to have community gardens. So that people can grow their own vegetables, and generally, people tend to eat better, too, that way. So, we've been successful with that, working with the cities."

"And then transportation is huge. So, if people do not have transport, no matter how much you say, go see the doctor, or go do this and that, they are not able to."

"Uh, if those resources are not in those. And then what you'll find is that in a lot of the Black communities, because of disinvestment that happened years ago, that sometimes these things are just not available. They don't have those fresh vegetables; they don't have whatever."

"You know, so this is fresh, and they're putting her surgery off. Um, for, like, a month. Um, and again, why is that? Um, you know, she obviously has, um, public insurance, she's in Michigan, you know. Um, but it bothers me because my husband, his comment was. She doesn't matter to the system. It doesn't matter. So, she can die, and it's just less one… less person to pay for."

“And then what you'll find is that in a lot of the Black communities, because of disinvestment that happened years ago, that sometimes these things are just not available. They don't have those fresh vegetables; they don't have whatever.”

“Education is the single most significant health determinant. And now, more than ever.”

“I've been a proponent that education is the… such a significant determinant of health in terms of how you deal with a system, how you come across…”

“Because people have to figure out what they're gonna pay for. Am I gonna pay for food? Am I gonna pay for housing that is…. Unaffordable. Am I going to, you know, am I going to pay for daycare? So people are put in these positions on what. What am I going to pay for? What's going to be important to me? Um, and so…. That's what happens, is you… people are going to pay for what's important to them, and healthcare is not always important to them.”

“I have a disabled niece who lives in a group home. She works at—well, she’s given the opportunity to work at— an adult daycare facility, doing things like making cards. She’s high-functioning—still disabled, but high-functioning. But because she works, she’s also paying a high deductible at her group home, so she barely has money to get her hair done, go to the grocery store, or get special things she needs. I think that’s a barrier—a barrier for a Black

person who's disabled. She probably makes $800 a month, but her rent is $1,500 or $1,700. And that's based on a federal poverty guideline. "

"And you have to wait as a client. For 30 minutes to make an appointment And you're paying for your cell phone minutes. And you're out in minutes at the end of the month. It's not acceptable. We cannot have it be that way. And that's a simple doorway. To say, if you're trying to get people into clinic services, and they have to wait for you because of your systems."

"If people don't have stable housing or enough food, their health can't come first."

"And financial [as a barrier]—cost is always a factor, even with insurance, people still worry about what they'll owe."

Racism and Bias

"I trained community health workers, so we talk about some of this, so people can understand. And it's always amazing to me that people are hearing this for the first time. Yeah, they didn't know Minnesota wasn't like this, or…. And I tell them, watch that video, Jim Crow of the North, then you'll understand what's going on in Minnesota. They're like, what?"

"Uh, if those resources are not in those. And then what you'll find is that in a lot of the Black communities, because of disinvestment that happened years ago, that sometimes these things are just not available. They don't have those fresh vegetables; they don't have whatever."

"So, you have to create leaders in these communities and support the leaders even are usually there, because a lot of Black people are leading the work. They are doing the work, they're just not recognized."

"It seems difficult for people in the healthcare, and I mean especially white doctors. Um, and sometimes nurses, but now nurses, we have… the field has really diversified. To believe or to take seriously, or to…. You know, like, there just seems to be this barrier."

"So, we need more doctors and…. Nurses and healthcare providers that look like us."

Because also, they [Black healthcare workers] need support navigating these same systems.

"Especially as a Black woman. You can immediately tell when someone is just looking down on you, and it's not a good feeling, so I'm like, I don't want to go there. So, I've changed doctors."

"My personal background, I was born in Chicago, I come from light-skinned Black parents, which, you know, it's really interesting, because what does that mean? Um, it means that, you know, sometimes people will think, you know, I come from dual communities, but I was actually raised, um, kind of in different communities, but not based on my race. It was where my parents moved. But we were raised as Black, right? So, with that, um, we moved from Chicago, very city-urban. To rural area."

“I was raised in an all-Black church, and back in the day, churches were naturally segregated…When I went to college I decided to cross a line, and…me and a girlfriend, who were Black, we went to a White church. That was the first introduction, really officially into the White world.”

“The system was not built for us. It wasn’t meant for people of color. We were woven into the system, and so we’re fighting upstream.”

“It seems difficult for people in the healthcare, and I mean especially white doctors … to believe or to take seriously. You know, like, there just seems to be this barrier to believe when someone comes in. So, it's a huge barrier then, when I come and I'm saying, ‘I have this symptom,’ and I'm not believed.”

“And I think we also have not historically done a very good job as white providers of asking and believing in the question … ‘What would make a difference for you?’”

“Serving the Black community in this role feels personal—it’s not just a job, it’s a responsibility.”

“I ran a clinical lab, I worked with the bone marrow registry, so I've always worked with other allied professionals or other clinicians. I learned that care was not always equitable for all those that were receiving care.”

Positive Programs and Initiatives Cited by Interviewees

- Appetite for Change
- The Cultural Wellness Center
- Queens Village
- Open Road Fund
- Nurse-Family Partnership
- Cancer Alliance/Minnesota Masonic Cancer Center
- Neighborhood Health Source
- Stair Step Foundation

Appendix C

Word Cloud from Interview Transcripts