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Measuring Clients' Satisfaction and Trust in Community Health Workers: Results From a Cross-Sectional Survey

Slawa Rokicki[1], Sang Hee Won[2], and Leslie Kantor[1]

Abstract

Background: Community health workers (CHWs) are widely deployed in the United States to support the health of underserved communities, yet little is known about the extent to which clients of CHWs are satisfied with the services they receive and their level of trust with their CHWs. We assessed levels of trust, satisfaction, and feelings of empowerment of clients served by CHWs.

Methods: We conducted a cross-sectional survey among clients of CHWs employed at health care and community-based organizations throughout New Jersey between June and July 2024. Client trust was measured using the Trust in CHWs Scale, assessing subscales of health care competence and respectful communication. Satisfaction was measured using a 4-point Likert scale. Empowerment was measured using the Influence of CHWs on Empowerment Scale. We used multiple linear regression models to examine predictors of client trust in CHWs.

Results: Seventy-five participants completed the survey (89% women; 37% Latino; 40% Black; 17% White). Among participants, 100% reported that they trusted the information their CHW provides, 97.4% were very or somewhat satisfied with the services they received, and 89% reported that they can make better decisions about their health because of their interactions with their CHWs. While overall levels of health care competence (mean 3.3 out of 4) and respectful communication (mean 3.4 out of 4) were high, housing insecurity, being uninsured, and being disabled were associated with significantly lower scores on subscales. Clients who had more frequent interactions with their CHWs had greater levels of trust in their CHWs.

Conclusions: In the current era of medical mistrust, our findings support CHWs as essential public health workers who promote trusted health information to underserved communities. Unmet social needs, such as housing insecurity, may lower clients' assessment of satisfaction and trust in CHWs. Findings underscore the importance of alignment and integration of CHW programs with health and social care systems to address the social determinants of health.

Keywords

community health workers, trust, empowerment, health disparities, public health

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In the last decade, investments into community health workers (CHWs) in the United States (U.S.) have grown rapidly.[1,2] Both federal and state funding have expanded the infrastructure supporting CHW programs, with rapid development following the COVID-19 pandemic.[2,3] Nearly 60 000 CHWs were employed across the U.S. in 2023.[4] CHWs have supported programs across a wide range of populations and health domains, including in maternal and child health, chronic disease, infectious disease, mental health, aging, and cancer.[5]

The core roles and competencies of CHWs are diverse and include care coordination, direct health services, outreach, coaching and social support, advocating for individuals and communities, conducting individual and community assessments, and providing culturally appropriate health education and information.[6] CHWs are also increasingly integrated into health systems to act as liaisons between medical providers and communities.[1,7] To work effectively in these roles, CHWs must build rapport and trust with their clients and communities through consistent engagement, shared cultural experiences, and respectful, client-centered care.[8]

[1]Rutgers School of Public Health, Piscataway, NJ, USA
[2]Won Consulting, Inc., Irvington, NY, USA

Corresponding Author:
Slawa Rokicki, Department of Health Behavior, Society, and Policy, Rutgers School of Public Health, 683 Hoes Lane West, 3rd Floor, Piscataway, NJ 08854, USA.
Email: slawa.rokicki@rutgers.edu

Despite the widespread deployment of CHWs and their expanding scope of work, little is known about the extent to which clients of CHWs are satisfied with the services they receive and their level of trust with their CHWs. Previous studies that have elicited patient perspectives about CHWs have mainly focused on the acceptability and feasibility of CHW-led health interventions.[9-12] Some qualitative studies have explored the role of trust between clients and their CHWs, emphasizing the need for specific strategies and trainings for CHWs to more effectively build trust.[8,13,14] One quantitative study of clients receiving HIV care from CHWs found that clients reported positive experiences of care and that they felt empowered to engage in their care.[15] However, there is scant research which measures client satisfaction and trust with CHWs more broadly, across different client populations with various health and social needs. Such research is critical to develop appropriate training programs and maximize the effectiveness of CHWs.

In this study, we conducted an online, cross-sectional survey of clients served by CHWs across the state of New Jersey (NJ) to assess clients' trust and satisfaction with CHWs and the influence of CHWs on clients' feelings of empowerment. We also examined demographic and socioeconomic predictors of client trust in CHWs.

Methods

Data Collection

This study was conducted as part of a larger evaluation of a statewide training program and hub for CHWs. In the evaluation, CHWs were trained through the NJ Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI), a standardized CHW training and certificate program in the state. CHWs were trained on 13 core competencies and a range of health conditions and social service needs including topics such as social determinants of health, chronic diseases, mental health and stress, and domestic violence.[16] The CLG-CHWI program emphasizes the role of CHWs in providing education, promoting healthy behaviors, and connecting community residents to health, social and community services. The program has graduated over 1000 CHWs since 2020, and CHWs are now employed in a range of organizations in every county of New Jersey, including federally qualified health centers and other free clinics, family resource and social services organizations, and maternal and child health non-profit organizations.

This study's sampling frame consisted of all clients who had ever received services from CHWs trained through the CLG-CHWI and employed in New Jersey. Duplicates of last name, email, and phone number were removed, as were individuals with invalid or missing phone numbers, resulting in 1440 unique clients. To be eligible for the study, participants had to be 18 years of age or older and had to have received at least 1 visit from a CHW in the last 3 months.

The survey was developed in collaboration with state partners and CHW organizations who take part in the CHW hub, with the aim of measuring client experiences with CHW services. Between June and July 2024, participants were recruited using an online bulk text messaging service with a text message that described the study and provided a web link to the survey. Recruitment texts were sent in both English and Spanish to all participants; up to 3 reminder texts were also sent within the study period. The online survey was available in both English and Spanish; participants chose their preferred language on the landing page of the survey. The Spanish survey and recruitment texts were translated by a clinical research coordinator, whose native language is Spanish and who has professional experience in translation services. Participants who completed the survey received a $25 Amazon e-gift card. Ethical approval for all study procedures were provided by Rutgers University Institutional Review Board.

Measures

The primary outcome for this analysis was a measure of client trust in CHWs, measured by a 10-item validated scale.[17] The score was divided into 2 sub-scales: health care competence and respectful communication. Health care competence items related to CHWs' knowledge, time spent with client, confidentiality, and quality of care (eg, "how often have you felt the CHW knew as much as s/he should about a health topic?"). Respectful communication items related to how their CHW listened to them, treated them, and made them feel (eg, "how often has the CHW treated you with respect?"). Items were measured on a 4-point Likert scale and summary scores for each subscale were calculated by assigning values of 1 ("never") to 4 ("all of the time") and calculating the mean. Supplemental Appendix Table S1 provides details of the scale items.

Secondary outcomes included satisfaction with CHW services, empowerment, and trust in the health care information that the CHW provides. Satisfaction was measured on a 4-point Likert scale by asking participants how satisfied or dissatisfied they were with the services their CHW most recently provided.[18] Empowerment was measured using the 5-item Influence of CHWs on Empowerment Scale which assesses clients' perceptions of the effect their CHWs have on 5 health-related empowerment behaviors (eg, "I can better make decisions about my health and my children's health because of my interactions with CHWs").[18] Participants rated how strongly they agreed or disagreed with each statement based on a 4-point Likert scale. Trust in information provided by CHWs was measured on a 4-point Likert scale by asking participants how strongly they agree or disagree with the following statement: "I trust the health information that my CHW provides."

Independent variables included demographic and socioeconomic characteristics, including age, gender, race/ethnicity, education, insurance status, marital status, employment, whether English is spoken at home, whether respondent has a child under 5 years old, sexual orientation, employment, self-rated health, last time saw a health professional, food insecurity, and housing insecurity. Food security was measured using the National Survey of Children's Health item: "Which of these statements best describes the food situation in your household in the past 12 months."[19] Response options included (1) "I could always afford to eat good nutritious meals," (2) "I could always afford enough to eat but not always the kinds of food we should eat," (3) "Sometimes I could not afford enough to eat," and (4) "Often I could not afford enough to eat." Housing insecurity was measured via a 1-item question drawn from the Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities Model, which asked "What is your living situation today?"[20] Responses included (1) "I have a steady place to live," (2) "I have a place to live today, but I am worried about losing it in the future," and (3) "I do not have a steady place to live." Level of engagement with CHWs was measured 2 ways: the number of CHWs a client met in the past 3 months and the number of times a client communicated with a CHW in any way (eg, in-person, phone, text) in the last 3 months.

Statistical Analysis

We included the responses of all participants who completed the survey and who did not skip the questions on client trust. We used descriptive statistics to assess demographic and socioeconomic characteristics of our sample and levels of trust, satisfaction, and empowerment. We calculated summary scores for the individual items and overall subscales of healthcare competence and respectful communication. We used simple linear regression models to examine the relationship between level of engagement with CHWs and subscale scores. We used multiple linear regression models to examine the relationship between demographic and socioeconomic variables and subscale scores, simultaneously.

We did not have any demographic information about the non-participants. Therefore, to examine the extent of nonresponse bias, we used data from Pregnancy Risk Assessment Monitoring System to compare the demographics of participants to a population we expect would likely be eligible for CHW services: women who gave birth between 2016 and 2022, who were aged 18 and over, who reported receiving the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), a safety net program for lower-income women who are pregnant, and who reported that a home visitor came to their home either during pregnancy or after the baby was born.[21] We chose this comparison population because organizations that participated in the CHW hub have a strong focus on maternal and child health: nearly 90% of our client participant sample were women, and 76% reported having a child aged 0 to 5, which is the eligibility age for WIC. We compared characteristics of age, race and ethnicity, education, insurance, and marital status for female study participants with this comparison population using Pearson chi-squared tests for categorical variables and 2-sample *t*-tests for binary variables.

Results

Of the 1440 individuals who were recruited, 218 opened the survey link, 78 completed the survey, and 75 provided responses on client trust (Supplemental Appendix Figure S1). Table 1 presents the demographic characteristics of the respondents. Most respondents (89.3%) were women. Among respondents, 37.3% were Latino, 40.0% were Black, 17.3% were White, and 5.3% were other (non-Hispanic) race. The majority of participants (60.0%) had Medicaid/NJ Family Care or Tricare insurance, while 18.7% were uninsured. Among participants, 14.7% had fair or poor health, 33.3% reported that they sometimes or often could not afford enough to eat, and 9.3% reported that they did not have a steady place to live while 26.7% had a place but were worried about losing it. Among respondents, 49.3% had met with 1 CHW in the past 3 months, while 33.3% met with 2, and 10.7% met with 3 or more. Most clients (56.0%) interacted with their CHW between 2 and 5 times over the past 3 months, while 16.0% only interacted once and 25.3% interacted more than 5 times.

Supplemental Appendix Table S2 shows how female study participants compare to the population of women who had recently given birth in NJ who reported receiving home visiting services and WIC. Results showed these groups were overall demographically similar, but there were some differences. Groups were similar across race and ethnicity ($P=.343$), insurance status ($P=.294$), and marital status ($P=.052$). However, the comparison population was slightly younger and had lower education ($P<.001$). In particular, study participants were more likely to have some college/associate's degree (46%) compared to the comparison population (23%), though few in either group had a bachelor's degree or more (15% of participants and 12% of comparison group).

Table 2 shows measures of trust, satisfaction, and empowerment among study participants. All respondents reported that they strongly agreed (40%) or agreed (60%) that they trusted the health information that their CHW provides (Table 2). The vast majority (97.4%) reported that they were very satisfied (70.7%) or somewhat satisfied (26.7%) with the services that they received on their last visit. In the empowerment scale, between 87 and 91.5% of respondents agreed or strongly agreed with the items.

Figure 1 shows the mean scores for the sub-scales of the client trust index, measured out of a maximum score of 4.

Table 1. Client Demographic Characteristics (N = 75).

Client characteristics	n (%)
Gender	
Man	8 (10.7)
Woman	67 (89.3)
Age	
18-34	41 (54.7)
35-44	23 (30.7)
45+	11 (14.7)
Race-ethnicity	
Latino	28 (37.3)
Black	30 (40.0)
White	13 (17.3)
Other	4 (5.3)
Education	
High school or less	28 (37.3)
Some college/associate's degree	34 (45.3)
College degree or higher	13 (17.3)
Insurance	
Private	16 (21.3)
Medicaid/NJ Family Care	45 (60.0)
Uninsured	14 (18.7)
Marital status	
Married/committed relationship	38 (50.7)
Not married	37 (49.3)
Has at least 1 child ages 0-5	
Yes	57 (76.0)
Sexual orientation	
Straight	64 (85.3)
Bisexual, gay/lesbian, or other	11 (14.7)
Employment	
Working—full-time or part-time	38 (50.7)
Unemployed and looking for work	20 (26.7)
Disabled and not working	4 (5.3)
Other (homemaker, on leave, student, or retired)	13 (17.3)
Speaks English at home	
No	34 (45.3)
Yes	38 (50.7)
Prefer not to answer	3 (4.0)
Health status	
Fair, poor, or don't know	11 (14.7)
Good, very good, or excellent	64 (85.3)
Last time saw a health professional	
In past year	65 (86.7)
Not in past year or don't know	10 (13.3)
Food security	
I could always afford to eat good nutritious meals.	24 (32.0)
I could always afford enough to eat but not always the kinds of food I should eat.	22 (29.3)
Sometimes or often I could not afford enough to eat	25 (33.3)
Prefer not to answer	4 (5.3)
Housing situation	
I have a steady place to live	46 (61.3)
I have a place to live today but I am worried about losing it	20 (26.7)
I do not have a steady place to live	7 (9.3)
Prefer not to answer	2 (2.7)
Number of CHWs interacted with (past 3 months)	
1	37 (49.3)
2	25 (33.3)
3 or more	8 (10.7)
I don't know	5 (6.7)
Number of times communicated w/CHW in any way (past 3 months)	
1	12 (16.0)
2-5	42 (56.0)
More than 5	19 (25.3)
I don't know	2 (2.7)

(contiuned)

Table 2. Measures of Trust, Satisfaction, and Empowerment Among Clients of CHWs.

Measures	n/N (%)
Trust: "I trust the health info my CHW provides"	
Strongly agree	30/75 (40.0)
Agree	45/75 (60.0)
Disagree	0
Strongly disagree	0
Satisfaction: "At your most recent visit, how satisfied were you with the services you received from the CHW?"	
Very satisfied	53/75 (70.7)
Somewhat satisfied	20/75 (26.7)
Somewhat dissatisfied	0
Very dissatisfied	1/75 (1.3)
Prefer not to answer	1/75 (1.3)
Influence of CHWs on Empowerment:[a] "Because of my interactions with my CHW: . . ."	
I can make better decisions about my health and/or my children's health	64/72 (88.9)
I can better share health info with others	65/71 (91.5)
I can better get the care I need from my clinic or hospital	60/69 (87.0)
I can better improve my clinic and/or health system	61/68 (89.7)
I can better contribute to my community	62/71 (87.3)

[a]Includes both "agree" and "strongly agree" responses.

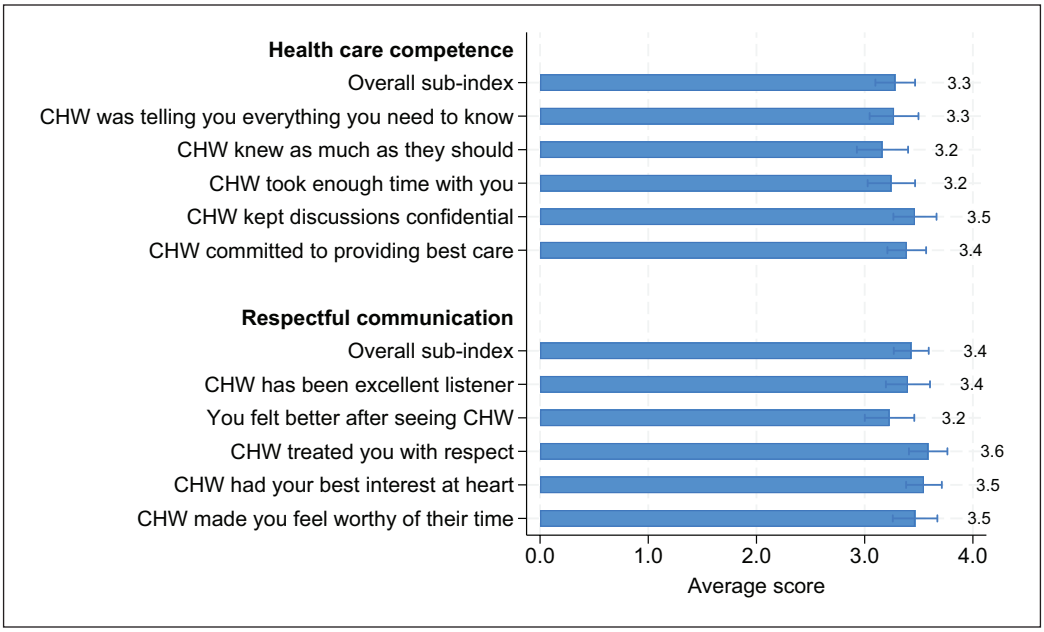

Figure 1. Mean score for individual items and overall sub-scale for measures of CHW health care competence and respectful communication.

The mean health care competence score was 3.3 (SD 0.80) and the mean respectful communication score was 3.4 (SD 0.70). Means of individual items varied between 3.2 and 3.6. Across items, results indicated the lowest scores for "CHW knew as much as they should," "CHW took enough time with you," and "You felt better after seeing your CHW," while the highest score was for "CHW treated you with respect."

Figure 2 shows differences in overall sub-scale scores by level of engagement with the CHW. While the number of CHWs a client engaged with was not associated with trust scores, having 2 to 5 or more than 5 interactions with the CHW in the past 3 months were both significantly ($P < .05$) associated with higher scores for each subscale, compared to only 1 interaction.

Table 3 presents the factors that predict client scores of CHW health care competence and respectful communication. Having a child under 5 was associated with a significantly higher rating of CHW competence, while being disabled and being worried about losing housing were associated with lower ratings of competence. For respectful communication, having a child under the age of 5 and having some college education (compared to high school education or less) were associated with significantly higher scores, while being uninsured and being worried about losing housing were associated with significantly lower scores. The magnitude of coefficients was large in relative terms: worry about housing was associated with reductions in both health care competence and respectful communication scores of greater than 20% each.

Discussion

In this cross-sectional survey of client experiences with CHWs, we found that clients reported high levels of trust in their CHWs, as measured across domains of health care competence and respectful communication, as well as overall satisfaction with services. We found that clients who had more frequent interactions with their CHWs had greater levels of trust in their CHWs. Similarly high levels of trust in CHWs were reported in lower-income countries including Kenya, Haiti, and Bangladesh when using the same validated tool as in this study.[17] However, our study is one of the first to quantitatively measure client trust of CHWs in the U.S., and we include clients with varying health and social needs and using services of CHWs employed by a wide range of health and social organizations across New Jersey.

A core strength of CHWs is that they are trusted members of the community who are uniquely positioned to build trust with their clients. While our study found that higher rates of CHW interactions were positively associated with higher levels of trust among clients, the trusting nature of the relationship between clients and their CHWs could also be driving the number of interactions. The positive association observed in this study is consistent with previous research that shows that sustaining trust over time facilitates continued engagement between clients and CHWs.[22]

Our results suggest that unmet social needs may lower clients' trust in their CHW. In particular, uninsurance, disability status, and housing instability were associated with significantly lower clients' assessment of CHWs' health

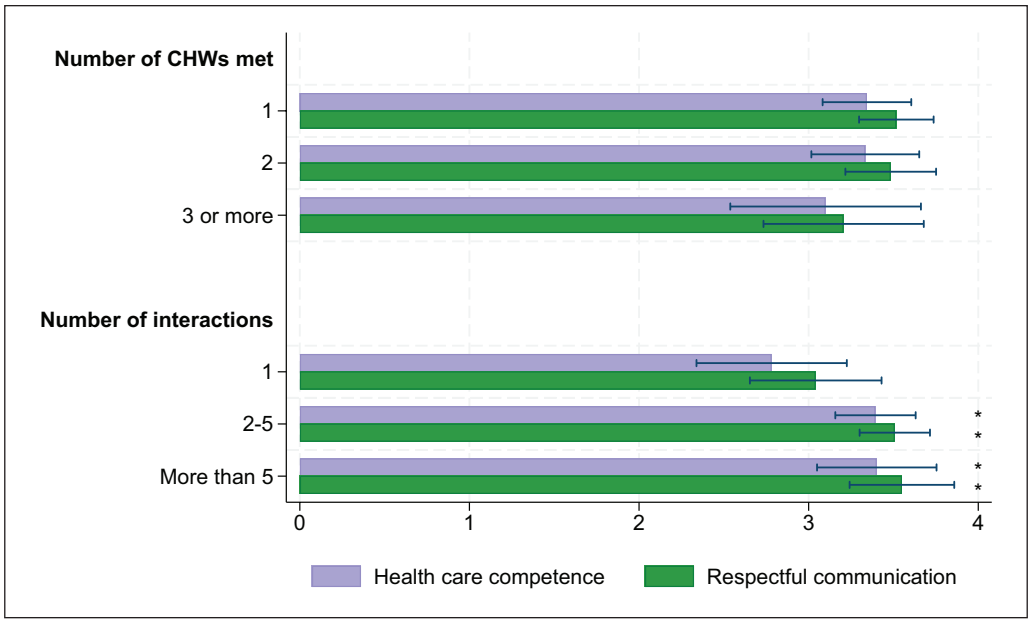

Figure 2. Differences in client assessment of health care competence and respectful communication by level of engagement over the past 3 months with CHWs. Measures of engagment are in reference to the past 3 months.
*Indicates *P*-value for difference from reference (1 interaction) is $<.05$.

care competence and respectful communication. Linking clients to social programs such as public insurance and affordable housing is a fundamental role of CHWs.[1] Yet, lack of availability of and coordination with other social services and programs are structural challenges that can hinder CHWs' efforts.[23] A study examining client satisfaction with CHWs working in HIV care teams also found that clients who were unhoused had lower levels of satisfaction with CHWs.[24] Policies and strategies to increase access to affordable housing, in collaboration with CHW efforts, are needed to address housing insecurity and promote health.[25] For example, research has found that when home visiting programs are integrated with other cross-sector community services via shared relationships and communication, the likelihood of referrals to housing and other social services is greater.[26] Further research is needed to examine how alignment and integration of CHW initiatives into health and social care systems impacts CHW program effectiveness and client trust.[27]

Our study contributes important evidence on the value of CHWs in providing education to communities wary of the traditional medical system. Recent polls show deep declines in public trust of doctors and other medical personnel: between June 2023 to January 2025, the percentage of people who said they have a great deal or a fair amount of trust in their own doctors fell from 93% to 85%.[28] Qualitative research has explored the unique ability of CHWs to build trusting, respectful relationships with communities and bridge gaps in care through effective communication.[8,13,14] Our quantitative findings support this trusting bond between CHWs and their clients, with 100% of participants reporting that they trusted the information their CHW provided.

Our findings also have implications for policies to maximize effectiveness of CHW programs. Studies on the effectiveness of CHW programs have shown large and positive impacts on client health, including promoting equitable access to care, addressing social determinants of health, and improving health outcomes in underserved communities.[1,29] Our study found that clients who had greater interaction with their CHWs had higher ratings of trust, underscoring the importance of consistency and engagement. However, CHW programs often have challenges with sustainability and retention, and CHWs have reported stress, high workload, and burnout.[30-33] Policies that aim to improve organizational support, pay satisfaction, and job security may help to reduce CHW turnover and prevent interrupted services for communities, yet research is sparse.[31] Future research should investigate the role of supportive workplace policies in improving CHWs' motivation and productivity, as well as in facilitating client engagement, trust, and wellbeing.[34]

Limitations

This study has limitations. While we used previously validated instruments to measure client trust and empowerment, these instruments have only been validated in low-income countries. Our sample included clients from a broad range of organizations that employed CHWs in New Jersey. However, our response rate of 5.2% was at the lower end of the range of response rates reported in a recent

Table 3. Demographic Predictors of Client Trust.

	(1)	(2)
Predictors	Health care competence	Respectful Communication
Age (ref: <35)		
35-44	−0.197 (0.228)	−0.101 (0.198)
45+	0.763 (0.394)	0.531 (0.342)
Gender = woman (ref: man)	−0.201 (0.379)	−0.314 (0.329)
Race and ethnicity (ref: White)		
Latino	−0.232 (0.319)	−0.292 (0.277)
Black	−0.324 (0.281)	−0.407 (0.244)
Other	0.163 (0.434)	0.236 (0.377)
Education (ref: high school or less)		
Some college/associate's degree	0.264 (0.190)	0.404* (0.165)
College degree or higher	−0.308 (0.259)	−0.370 (0.225)
Insurance (ref: private)		
Medicaid/NJ family care	−0.323 (0.251)	−0.312 (0.218)
Uninsured	−0.580 (0.318)	−0.626* (0.276)
Marital status = not married	0.294 (0.192)	0.256 (0.167)
Has at least 1 child ages 0-5	0.825* (0.329)	0.648* (0.286)
Sexual orientation = bisexual, gay/lesbian, or other	−0.010 (0.263)	−0.188 (0.229)
Employment (ref: working full time or part time)		
Unemployed and looking for work	−0.203 (0.224)	0.263 (0.194)
Disabled and not working	−1.155* (0.453)	−0.339 (0.394)
Other (homemaker, on leave, student, or retired)	−0.084 (0.252)	−0.534* (0.219)
Speaks English at home = No	−0.012 (0.186)	−0.027 (0.161)
Health status = fair, poor, or don't know	0.168 (0.280)	0.085 (0.243)
Last time saw a health professional = not in past year or DK	−0.639 (0.339)	−0.581 (0.295)
Food security (ref: I could always afford to eat good nutritious meals.)		
I could always afford enough to eat but not always the kinds of food I should eat.	0.028 (0.224)	0.118 (0.195)
Sometimes or often I could not afford enough to eat	0.068 (0.259)	0.006 (0.225)
Housing situation (ref: I have a steady place to live)		
I have a place to live today but I am worried about losing it	−0.762** (0.236)	−0.722*** (0.205)
I do not have a steady place to live	−0.179 (0.345)	−0.350 (0.300)
Observations	75	75

Results from multiple linear regression models.
***$p < 0.001$, **$p < 0.01$, *$p < 0.05$.

meta-analysis of online surveys, which may have increased the risk of nonresponse bias. Those who participated may have been particularly motivated to complete the survey, and therefore, not representative of CHW clients in NJ. For example, respondents who already had positive attitudes towards their CHWs may have been more inclined to participate, and thus findings on rates of satisfaction and trust with CHWs may be skewed higher on average. To assess this issue, we compared characteristics of study participants to the NJ birthing population who reported receiving WIC and home visiting services, a reasonably comparable population to those who would be eligible for CHW services. We found that our sample was demographically very similar; however, they reported slightly higher education than the comparison group. As those with some college/associate's degree education had higher ratings of respectful communication, the response bias may lead to overestimating the overall degree of trust in CHWs. Further research on the experiences of clients using larger samples is needed. Findings may also not be generalizable to other states.

In an effort to increase reach of the study across NJ, reduce participant burden, and minimize costs, we used an online survey mode for data collection with incentives for survey completion.[35] However, limited access for those

without reliable internet may have affected inclusiveness of the study.[36] Previous studies have found that multiple survey modes are effective in increasing response rates and representation of vulnerable patient groups compared to a single mode.[37]

To recruit participants, we used a text messaging service to send information about the study and a web link to the survey, and we sent messages in both English and Spanish. We did not send emails to clients since few had email addresses listed and to minimize duplicate responses from those that did. Recruitment text messages were sent from a phone number listed as Rutgers University rather than from specific clinics or their CHWs, as we did not have this information and we wanted to ensure anonymity to increase respondents' comfort in responding to the survey questions. However, recipients may have felt distrustful of text messages received from unknown numbers. Future research should explore additional strategies for recruitment of lower-income populations when using online surveys such as pre-contacting potential respondents and making phone calls to remind participants about the survey to yield higher response rates.[38,39]

Lastly, since we could not connect the client to their individual CHWs, we did not have information about the CHWs' scope of work, which can vary widely by employer. Future research should consider evaluating CHW-client pairs to understand more about the CHW services provided and their impact on clients.

Conclusions

In this cross-sectional online survey, clients who received services from CHWs reported high levels of trust in their CHWs, high ratings of CHWs' health care competence and respectful communication and positive feelings of empowerment due to their interactions with their CHWs. In the current era of medical mistrust, these findings support CHWs as essential public health workers who promote trusted health information to underserved communities. This study also found that unmet social needs, such as housing insecurity, are associated with lower client assessment of trust and satisfaction with their CHW. This may be due to the complexity of needs that such clients face, which pose additional barriers to establishing trusting relationships with CHWs. Our findings underscore the importance of alignment and integration of CHW programs with health and social care systems to address the social determinants of health.

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ORCID iD

Slawa Rokicki https://orcid.org/0000-0001-9176-373X

Ethical Considerations

Ethical approval for all study procedures were provided by Rutgers University Institutional Review Board.

Consent to Participate

All participants provided written informed consent to participate.

Consent for Publication

Not applicable

Author Contributions

Slawa Rokicki: Conceptualization, Formal analysis, Visualization, Investigation, Writing—Original Draft, Writing—Reviewing and Editing; **Sang Hee Won:** Project administration; Investigation, Writing—Review and Editing; **Leslie Kantor:** Writing—Review and Editing.

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Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data Availability Statement

Data are available upon request from the corresponding author.

Supplemental Material

Supplemental material for this article is available online.

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