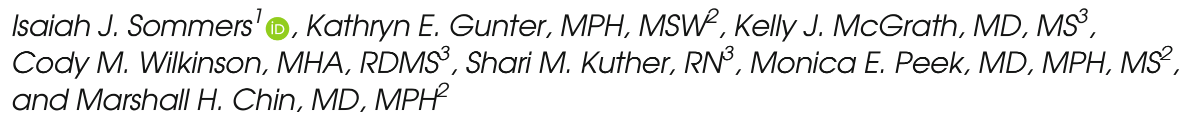
Trust Dynamics of Community Health Workers in Frontier Food Banks and Pantries: a Qualitative Study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BACKGROUND: Medical mistrust has had devastating consequences during the COVID-19 pandemic, particularly in rural communities. Community Health Workers (CHWs) have been shown to build trust, but there is little research on trust-building by CHWs in rural communities.

OBJECTIVE: This study aims to understand the strategies that CHWs use to build trust with participants of health screenings in frontier Idaho.

DESIGN: This is a qualitative study based on in-person, semi-structured interviews.

PARTICIPANTS: We interviewed CHWs (*N*=6) and coordinators of food distribution sites (FDSs; e.g., food banks and pantries) where CHWs hosted a health screening (*N*=15).

APPROACH: Interviews were conducted with CHWs and FDS coordinators during FDS-based health screenings. Interview guides were initially designed to assess facilitators and barriers to health screenings. Trust and mistrust emerged as dominant themes that determined nearly every aspect of the FDS-CHW collaboration, and thus became the focus of interviews.

KEY RESULTS: CHWs encountered high levels of interpersonal trust, but low institutional and generalized trust, among the coordinators and clients of rural FDSs. When working to reach FDS clients, CHWs anticipated confronting mistrust due to their association with the healthcare system and government, especially if CHWs were perceived as "outsiders." Hosting health screenings at FDSs, which were trusted community organizations, was important for CHWs to begin building trust with FDS clients. CHWs also volunteered at FDS locations to build interpersonal trust before hosting health screenings. Interviewees agreed that trust building was a time- and resource-intensive process.

CONCLUSIONS: CHWs build interpersonal trust with high-risk rural residents, and should be integral parts of trust building initiatives in rural areas. FDSs are vital partners in reaching low-trust populations, and may provide an especially promising environment to reach some rural community members. It is unclear whether trust in individual CHWs also extends to the broader healthcare system.

KEY WORDS: trust; community health worker; food bank; food pantry; rural; frontier.

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INTRODUCTION

In rural communities, medical mistrust has had devastating consequences during the COVID-19 pandemic.[1] Medical mistrust is constituted of the main components of trust: interpersonal trust (trust in known others), generalized trust (trust in unknown others), and institutional trust (trust in broader institutions such as government and healthcare).[2] Rural communities have long had low trust in public and government institutions, which is associated with low rates of healthcare utilization, disease screening, vaccination, and adherence to treatment,[3–6] and with higher rates of medical and psychiatric conditions.[7–9] This has exacerbated rural health disparities in access to care, rates of chronic disease, and life expectancy.[10–12] During the COVID-19 pandemic, mistrust in government and healthcare is thought to be the main driver of vaccine hesitancy and poor adherence to public health guidance,[13, 14] contributing to high rates of COVID-19 infection and death in rural areas.[1] There is therefore an urgent need to understand the dynamics of trust, and strategies to build trust, in rural communities.

Small rural communities tend to have strong interpersonal bonds and high levels of social participation, but low institutional and generalized trust.[15] Leveraging the interpersonal trust of rural communities may improve preventive health behaviors and ultimately health outcomes in the short term. Community Health Workers (CHWs) are defined by being trusted members of the communities they serve,[16] and cultivation of interpersonal trust is central to their role.[17–20] CHW programs have been shown to improve vaccination rates,[21, 22] medication adherence, and healthcare utilization,[23] which are particularly hindered by medical mistrust. CHW programs

may therefore be valuable components of trust-building initiatives in rural areas.

Mistrust is distinct from distrust. Distrust signifies suspicion toward a specific individual or organization, based in either vicarious or direct experience with them. Mistrust on the other hand refers to a "general sense of unease toward someone or something"[24] without necessarily naming who is not trusted. Both mistrust and distrust are often rooted in historic and present-day structural inequities such as poverty, discrimination, and compromised access to healthcare.[24] The majority of research on medical mistrust has focused on urban communities of color, migrant populations, and members of the LGBTQ community.[3, 25, 26] There is comparatively little research on medical mistrust within rural, predominantly White populations. Furthermore, to our knowledge, there are no qualitative studies on the trust dynamics for CHWs in rural communities in the USA.

In this paper, we studied CHWs working within food distribution sites (FDSs), such as food banks and pantries, in rural Idaho. Our initial goal was to understand the facilitators and barriers behind this collaboration. Early in the course of our interviews, however, trust and mistrust emerged as dominant forces driving nearly every aspect of the collaboration. We shifted our focus to examine the strategies that CHWs employ to mitigate institutional mistrust and generate interpersonal trust with FDS clients in rural Idaho.

METHODS

Study Setting and Activities

St. Mary's Health and Clearwater Valley Health consist of two critical access hospitals, eight primary care clinics, and four physical therapy clinics. Their catchment area includes Clearwater, Idaho, and Lewis counties in North-Central Idaho. With a population density of 2.5 people per square mile, this medically isolated frontier region has high rates of chronic medical and mental health conditions, poverty, unemployment, lack of insurance, and food insecurity.[27–29] Because their patients face many barriers to healthcare, St. Mary's Health and Clearwater Valley Health rely on non-clinical interventions to reach many community members who may not routinely utilize healthcare services.

St. Mary's Health and Clearwater Valley Health employ a team of six CHWs, including a CHW Lead who oversees the CHW team. Among other responsibilities, CHWs lead health screening events at community organizations and events, during which they test for chronic disease risk factors, assess social needs and insurance status, and provide health education and referrals. In 2018, CHWs began planning and performing health screenings at FDSs in addition to other community sites, with the goal of identifying community members with elevated social and medical risk factors. St. Mary's Health and Clearwater Valley Health conducted a preliminary program evaluation in August, 2019, at which time CHWs had conducted health screenings at seven FDSs. FDS screening participants were 93% White, and had higher rates of obesity, diabetes, hypertension, public or no insurance, and lack of a regular provider, compared with those screened at non-FDS sites.

Study Participants

All six St. Mary's Health and Clearwater Valley Health CHWs and 15 FDS coordinators were interviewed for this study. Eight FDSs collaborated with CHWs for health-related activities, such as health screenings or distribution of health resources, and were selected for this study. FDS coordinators were not shared across multiple FDS sites. Five FDSs were run by two or three volunteers, and in those cases all volunteers were interviewed together. Therefore, a total of eight FDS interviews were performed. Because the transcript could not distinguish between individuals in the same interview, we analyzed all participants in a given interview in aggregate.

Three FDSs were run by a church or senior center, and were coordinated by the leader(s) of their respective organizations. Two FDSs were hosted at rented or donated space and led by community volunteers. Three FDSs were Mobile Food Pantries, which involved FDS clients picking up food directly from an Idaho Food Pantry truck in a local parking lot. Mobile Food Pantries did not include permanent locations for food storage and were led by community volunteers. One Mobile Food Pantry did not host screenings for logistical reasons but was interviewed to explain why a screening was not feasible. Self-reported demographic information was not required from participants to reduce the amount of personal information requested of interviewees.

Data Collection and Analysis

CHWs and FDS coordinators participated in 30–60-minute, semi-structured interviews using separate interview guides for CHWs and FDS coordinators. Both interview guides were based on the Consolidated Framework for Implementation Research, and were designed to assess logistical and organizational factors influencing the CHW-FDS collaboration. Questions focused on describing the FDS client population and the health screening's planning, execution, impact, facilitators, and barriers. Once the study team arrived on site, however, it was clear that questions about formalized processes were not relevant to the structure of the CHW and FDS collaboration. Interview questions nevertheless prompted spontaneous reflections from participants on topics including trust and mistrust. As a result, the study team decided that no revision to the interview guide was necessary.

Each interview was audio-recorded and transcribed verbatim. Two authors (I.S. and K.G.) initially reviewed five interview transcripts and generated a codebook through an iterative process of comparing codes, resolving differences, and refining the codebook. Emergent themes of trust and lack of trust spanned three topics: interpersonal trust, generalized trust, and

institutional trust. Interpersonal trust appeared as an independent concept, while generalized and institutional mistrust were almost exclusively cited together and were therefore coded together.

Upon completion of the codebook, co-authors (I.S. and K.G.) independently coded all remaining transcripts and discussed coding discrepancies to reach consensus. Qualitative analysis was performed using NVivo Pro 12 software. This study was approved by the University of Chicago Institutional Review Board.

RESULTS

Both CHWs and FDS coordinators described the FDS client population as being reclusive, socially and geographically isolated, and unlikely to utilize medical services due to inability to afford care and mistrust in the healthcare system. As a result, they cited challenges with reaching FDS clients outside of the FDS setting because they were unlikely to congregate or participate in other community spaces (Table 1; 1e). In addition, they described FDS clients as having high rates of unmet medical and social needs (Table 1; 1a–d). Because they reached a high need population that could not be engaged elsewhere, all six CHWs echoed the theme: at FDSs, “we’re reaching the people that need us” (Interviewee 21, CHW).

Generalized and Institutional Mistrust

Both CHWs and FDS coordinators anticipated confronting mistrust among FDS clients: “[FDS clients] don’t trust government people, anybody dealing with government. And they don’t trust strangers” (Interviewee 03, CHW). Interviewees did not explicitly name the object of distrust, but did describe a general mistrust in strangers and institutions. Therefore, the authors refer to lack of trust as mistrust, rather than distrust. CHWs felt they had to overcome mistrust in outsiders and “strangers,” and mistrust in institutions such as the healthcare system. Interviewees frequently encountered FDS clients’ hesitancy to participate in health screenings due to this institutional and generalized mistrust (Table 1; 2b). Institutional mistrust particularly served as a barrier to social needs screenings; half of the CHWs avoided performing social needs assessments due to concerns that questions about social needs would arouse institutional mistrust. One CHW assumed that FDS clients “might be wondering ‘why is she asking me about this kind of stuff?’” and that it would take “a conscious shift” to start focusing on social needs (Interviewee, 11, CHW) (Table 1; 2c).

CHWs and FDS coordinators described the FDS as a trusted community organization (Table 1; 2d). FDS coordinators intentionally built trust with their clients by “ helping to develop their self-worth and dignity. Letting them know that they’re loved by somebody. Letting them know that they have a safe place where they can talk” (Interviewee 19, FDS Coordinator). CHWs observed that FDS clients were more likely to engage with and trust them in a safe environment like the FDS: “In the food bank, they feel comfortable. They feel welcome. It’s kind of like I’m on their territory” (Interviewee 11, CHW) (Table 1; 2e). FDS coordinators were confident that CHWs would earn trust from FDS clients through their continued presence at FDSs:

> Of course [the CHW-FDS collaboration is] going to help build trust because they're going to see [the CHWs] and they're going to know that they're trying to help. It may take a long time. It's like the trust that we have with our clients…They've been with us a long time. (Interviewee 19, FDS Coordinator)

In addition, the leadership roles of FDS coordinators helped CHWs deepen their connection with the community. An added benefit of partnering with FDSs was “connecting with the movers and shakers, the people that are very active in the community…that’s been the best connection because they know everybody” (Interviewee 01, CHW).

Interpersonal Trust

CHWs focused on developing relationships built on strong interpersonal trust. All six CHWs volunteered at FDSs to first build relationships and trust with FDS coordinators and FDS clients *prior* to planning or implementing health screenings. CHWs denied receiving any formal or explicit directive to volunteer, but rather understood that in a small town this was required to initiate collaboration:

> You have to develop a trust pattern with them. They’ll get their box of food and they’ll leave…They’ll come back the next time. Then they’ll talk to you and then you develop a relationship with them. It’s a slow process. But being with them for two, two and a half years now, they know me, they know a couple of the other gals out here and they know that their things are kept private. (Interviewee 03, CHW) (Table 1; 3b)

Interviewees recognized that health screenings would be slow to make a tangible impact due to the incremental process of cultivating trust. One FDS coordinator stressed the need for “persistence” and warned that “if we try to gauge our results on an event or two, we’ll be disappointed and quit too early” (Interviewee 04, FDS Coordinator). Several CHWs also reported that the time spent volunteering could be excessive and detracted from time spent on other job responsibilities (Table 1; 3e).

Trusting personal relationships also formed the basis of social needs screening. Rather than perform formalized social needs screenings, CHWs organically learned about social needs of FDS clients through personal relationships built over time. Similarly, FDS coordinators cited the close ties within small communities as their source of information about the

Table 1 Interview Themes and Quotes

Topic	Theme (# interviews referenced)	Example quote
1) Characterization of FDS[†] Clients	1a) Lack of insurance (*N*=7), ability to afford medical care (*N*=12)	"Because those are the people on the fringe. They may be people who have part-time jobs, but they don't qualify for Medicaid or they may – there are quite a few seniors, people not as senior as me, but people in their 60s who utilize food bank but they're too young for Medicare. But they can't afford insurance. So I think it's a more vulnerable population." (Interviewee 09, CHW*) "Lot of people can't afford to go to a doctor unless they're on Medicaid. But there's some of them that they'll go through that, slip through that crack." (Interviewee 10, FDS Coordinator)
	1b) Social needs: housing/utilities (*N*=10), transportation (*N*=3)	"I don't think there's enough housing for our lower income people…The minute there's an empty spot in that senior housing over here, it's [taken]." (Interviewee 16, FDS Coordinator)
	1c) Mental health (*N*=8) and substance use/addiction (*N*=2)	"Mental health, big time.…Questions like how do you deal with an Alzheimer's person that's wandering the street? That's not my job." (Interviewee 16, FDS Coordinator)
	1d) Chronic disease: hypertension (*N*=12), diabetes (*N*=12)	"If we had healthcare workers that came up it might help with most of the people around here, especially the more older ones or diabetics….People with high blood pressure." (Interviewee 07, FDS Coordinator)
	1e) FDS clients socially isolated (*N*=10), difficult to reach through healthcare (*N*=10) or non-FDS community services (*N*=6)	"They're more private. Again, they're cautious. A lot of people that live around here live in the back country for a reason, whether that be social, legal. And so not really joiners, but you give them some free food, they will be there. So there's really no other place that I can contact them." (Interviewee 01, CHW) "They're surviving day to day. The last thing that they really think about unless they need immediate attention is making those regular appointments." (Interviewee 20, CHW) "Even the health fairs that we have set up and done in the past I don't remember this population going through." (Interviewee 21, CHW)
2) Institutional and Generalized Mistrust	2a) Institutional mistrust felt by FDS clients (*N*=10)	"There are a lot of people that live in the hills and they live there for a reason. Because they don't want government and they don't, you know, they don't want people prying." (Interviewee 09, CHW)
	2b) FDS clients unwilling to participate in health screenings due to mistrust (*N*=9)	"'Do I still get my food if I screen wrong? Is it going to show that I had three beers already? What are you screening for?' More so in people that are more closed as far as what they share with people for various reasons." (Interviewee 01, CHW)
	2c) Mistrust posed barrier to social needs screening (*N*=3)	"If I were a person coming for a screening, I would not trust me to start talking about my housing situation." (Interviewee 09, CHW)
	2d) FDS as trusted community organizations (*N*=9)	"They trust the people at the food bank…It's just a safe place. And I think the people that run the food banks work really hard at trying to make it that way for the people to come in." (Interviewee 11, CHW)
	2e) CHWs leverage trust in FDS to facilitate screenings (*N*=3)	"They've already showed up. They're offering to sit down and visit with you whether that be over lunch or over the screening table. And you hear these things that they need and you connect them with those resources. It's a really good opportunity." (Interviewee 01, CHW)
	2f) FDS facilitates connections to community (*N*=9)	"This food bank connection has helped me make connections that I would not have made with people otherwise. Just the leaders in the community...they've been a real help to point me in the direction to get help with other things besides just food and medical questions." (Interviewee 11, CHW)
3) Interpersonal Trust	3a) CHWs have preexisting personal ties to community they serve (*N*=3)	"There's a lot of building relationships just by being out there and being seen. And that's why it's really important for the community health worker to be from a specific region, from a community. They know you already." (Interviewee 01, CHW)
	3b) Volunteering builds trust (*N*=10)	"You have to develop a trust pattern with them. They'll get their box of food and they'll leave…They'll come back the next time. Then they'll talk to you and then you develop a relationship with them." (Interviewee 03, CHW)
	3c) Social needs identified through preexisting relationships	"The personal aspect of being a small community, that we actually know who we're distributing to. And as a city council person, I know we have… senior citizens on fixed incomes and maybe families that are on fixed incomes or being supplemented some way through government distribution another way." (Interviewee 02, FDS[†] Coordinator)
	3d) Screenings simple to plan (*N*=10), impose low burden (*N*=8)	"It really wasn't a big deal to set it up. It was just almost like, 'Hey, I'm coming to town on such and such a date and I'll be there a half hour early. Can you accommodate that?' 'Yep, we can.' 'OK, we'll see you then.'" (Interviewee 11, CHW)
	3e) Excessive time needed to build relationships (*N*=7)	"I'd like more time to volunteer….I know we can only spend so much time volunteering at the food banks. You can't be at every one of them." (Interviewee 03, CHW)
	3f) Informal FDS structure can be unstable (*N*=6)	"Originally Idaho Food Bank had a mobile pantry that came here, and for whatever reason, they chose not to do that any longer. And when we found out that they were no longer going to do that, then we opened this because we didn't want our folks to go hungry." (Interviewee 19, FDS)

**CHW - community health worker*
[†]FDS - food distribution site

social needs of their clients: "living in this small community, everybody knows those people that are really struggling. And we watch out for them" (Interviewee 08, FDS Coordinator) (Table 1; 3c).

CHWs and FDS coordinators reported that personal relationships and interpersonal trust formed the basis of their collaboration. Nearly all FDS organizations were volunteer-run, and collaboration with CHWs was informal and guided by the personal relationships between individual CHWs and FDS coordinators. Interviewees felt that a relationship-driven collaboration made it simple to plan and implement health screenings with little to no burden on either the CHW or the FDS coordinators. Once the CHW had volunteered, FDS-based health screenings were planned often within a single email or conversation (Table 1; 3d). On the other hand, the informal organizational structure of FDSs made them vulnerable to closure due to changes in leadership, funding, or space. Transitions in FDS leadership also required CHWs to invest additional time building relationships with the new leadership team (Table 1; 3f).

DISCUSSION

In this study, we initially set out to examine the logistical factors impacting health screenings in frontier Idaho FDSs. In the process of asking about implementation, however, we realized that trust and relationships determined nearly every aspect of the FDS-CHW collaboration. Our focus shifted to the trust dynamics that CHWs navigated in order to reach a population with significant medical and social needs who utilize frontier FDS services.

FDS-based health screenings were characterized by strong interpersonal trust, but low generalized and institutional trust. Trust was perceived as lower among FDS clients than screening participants in other community spaces, such as health fairs or pharmacies. CHWs attributed this mistrust to their institutional affiliation with the healthcare system, especially if they were from a different town or did not have a pre-existing personal relationship. This is consistent with prior qualitative research on trust in CHWs, which broadly showed that CHWs build interpersonal trust but not necessarily trust in the broader healthcare system.[17–20] A patient's history of discrimination based on race or sexuality,[20] perceptions of the healthcare system as being incompetent,[30] or suspicion of the financial motivations of healthcare organizations[31, 32] can prevent CHWs from cultivating institutional trust. These studies were done in countries with different healthcare delivery systems, however, or among historically marginalized populations in the USA. In contrast, among this predominantly White rural population, institutional mistrust appears to be related to general suspicion of "outsiders," rather than racism or incompetence of the healthcare system. Future research should study how CHW programs can be designed specifically to address the root causes of institutional mistrust among rural white populations.

Our study also adds to the existing literature on CHWs and trust by examining how partnerships with community-based organizations contribute to trust building. FDSs provided a necessary environment for CHWs to cultivate trust with a generally low-trust population. FDSs were run by local volunteers and community leaders, and benefitted from the interpersonal trust between individual clients and FDS coordinators. Additionally, FDSs did not arouse institutional mistrust due to their informal and relationship-driven structure. By embedding health screenings within the FDS, CHWs could initiate a relationship with FDS clients due to their association with a trusted organization. CHWs then cultivated interpersonal trust through volunteering, mitigating mistrust in them as "outsiders" and representatives of the healthcare system. This interpersonal trust facilitated participation in screenings for chronic disease, but it is unclear whether it facilitated social needs screenings, or whether this interpersonal trust could eventually translate to increased institutional trust.

Our study identified several important takeaways for healthcare providers attempting to build trust in rural communities. First, it strengthened the evidence that CHW programs are important for building trust in low-trust populations. Second, trusted organizations with personal ties to their community, such as FDSs, are vital partners in the effort to reach low-trust rural populations. These organizations may engage high-risk individuals who are unlikely to appear in other community spaces, and provide the only opportunity to reach many community members. Third, healthcare providers must be prepared to make significant investments of time and resources to build interpersonal trust during the initial stages of outreach in rural and frontier communities. Upfront investment in rural CHW programs often yields positive returns in the form of reduced emergency and inpatient expenditures.[33] Fourth, because of their informal and relationship-based organizational structure, frontier FDSs are easily threatened by changes in space, funding, and personnel. Logistical barriers or closure of an FDS can interfere with healthcare workers attempting to build trust in rural communities. Therefore, providers and policy makers should consider ways to strengthen rural FDS infrastructure. Finally, healthcare and government institutions must be very cautious when partnering with or providing support to a trusted community organization, as their involvement inherently risks directing institutional mistrust toward these vital rural organizations.

This study has several limitations. The study was not designed to examine trust, but instead studied it as an emergent theme. We did not use trust theory or social capital as a framework for designing our interview guide, and we did not assess generalized, interpersonal, or institutional trust with validated questionnaires. In addition, mistrust in outsiders and healthcare prevented us from interviewing FDS clients directly. We based our understanding of trust dynamics in rural FDSs on the perceptions of CHWs and FDS coordinators. Our sample

size was also small, due to the fact that the study took place in a sparsely populated region. As a result, there are likely elements of the trust dynamics among frontier FDSs that we failed to detect or that may have been biased. Future research should address these limitations by employing validated tools to assess interpersonal, generalized, and institutional trust. Researchers should survey a larger sample size of FDS clients in addition to coordinators and CHWs, being mindful of the impact of institutional mistrust on survey and interview responsiveness.

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Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. **Mueller JT, McConnell K, Burow PB, Pofahl K, Merdjanoff AA, Farrell J.** Impacts of the COVID-19 pandemic on rural America. PNAS. 2021;118(1). https://doi.org/10.1073/pnas.2019378118.
2. **Kim SH, Kim S.** Particularized trust, institutional trust, and generalized trust: an examination of causal pathways. Int J Public Opin Res. 2021;33(4):840-855. https://doi.org/10.1093/ijpor/edab021.
3. **Jaiswal J.** Whose responsibility is it to dismantle medical mistrust? Future directions for researchers and health care providers. Behav Med. 2019;45(2):188-196. https://doi.org/10.1080/08964289.2019.1630357.
4. **Powell W, Richmond J, Mohottige D, Yen I, Joslyn A, Corbie-Smith G.** Medical mistrust, racism, and delays in preventive health screening among African-American men. Behav Med. 2019;45(2):102-117. https://doi.org/10.1080/08964289.2019.1585327.
5. **Hall MB, Vos P, Bess JJ, et al.** Cervical cancer screening behaviors and perceptions of medical mistrust among Rural Black and White Women. J Health Care Poor Underserved. 2018;29(4):1368-1385. https://doi.org/10.1353/hpu.2018.0101.
6. **Williamson LD, Bigman CA.** A systematic review of medical mistrust measures. Patient Education and Counseling. 2018;101(10):1786-1794. https://doi.org/10.1016/j.pec.2018.05.007.
7. **Lochner KA, Kawachi I, Brennan RT, Buka SL.** Social capital and neighborhood mortality rates in Chicago, Soc Sci Med. 2003;56(8):1797–805.
8. **Lindström M, Rosvall M.** Two theoretical strands of social capital, and total, cardiovascular, cancer and other mortality: a population-based prospective cohort study, SSM-Population Health. 2019;7:100337.
9. **Bassett E, Moore S.** Social capital and depressive symptoms: the association of psychosocial and network dimensions of social capital with depressive symptoms in Montreal, Canada. Soc Sci Med. 2013;86:96–102.
10. **O'Connor A, Wellenius G.** Rural–urban disparities in the prevalence of diabetes and coronary heart disease. Public Health. 2012;126(10):813-820. https://doi.org/10.1016/j.puhe.2012.05.029.
11. **Pink G.** Rural Health Snapshot (2017). North Carolina Rural Health Research Program. 2017. http://www.shepscenter.unc.edu/download/14853/
12. **Singh GK, Siahpush M.** Widening rural-urban disparities in life expectancy, U.S., 1969-2009. Am J Prev Med. 2014;46(2):e19-e29. https://doi.org/10.1016/j.amepre.2013.10.017.
13. **Yuan H, Long Q, Huang G, Huang L, Luo S.** Different roles of interpersonal trust and institutional trust in COVID-19 pandemic control. Soc Sci Med. Published online December 22, 2021:114677. https://doi.org/10.1016/j.socscimed.2021.114677.
14. **Alcendor DJ.** Targeting COVID vaccine hesitancy in rural communities in tennessee: implications for extending the COVID-19 Pandemic in the South. Vaccines. 2021;9(11):1279. https://doi.org/10.3390/vaccines9111279.
15. **Lindström M.** Social capital, the miniaturisation of community and self-reported global and psychological health. Soc Sci Med. 2004;59(3):595-607. https://doi.org/10.1016/j.socscimed.2003.11.006.
16. APHS. Community Health Workers. https://www.apha.org/apha-communities/member-sections/community-health-workers. Accessed 10 Jan 2022.
17. **Watkins JA, Griffiths F, Goudge J.** Community health workers' efforts to build health system trust in marginalised communities: a qualitative study from South Africa. BMJ Open. 2021;11(5):e044065. https://doi.org/10.1136/bmjopen-2020-044065.
18. **Boyd LM, Mehra R, Thomas J, Lewis JB, Cunningham SD.** Features and impact of trust-based relationships between community health workers and low-resource perinatal women with chronic health conditions. Matern Child Health J. 2021;25(12):1866-1874. https://doi.org/10.1007/s10995-021-03242-z.
19. **Kok MC, Kea AZ, Datiko DG, et al.** A qualitative assessment of health extension workers' relationships with the community and health sector in Ethiopia: opportunities for enhancing maternal health performance. Hum Resour Health. 2015;13(1):80. https://doi.org/10.1186/s12960-015-0077-4.
20. **Topp SM, Tully J, Cummins R, et al.** Building patient trust in health systems: A qualitative study of facework in the context of the Aboriginal and Torres Strait Islander Health Worker role in Queensland, Australia. Soc Sci Med. 2022;302:114984. https://doi.org/10.1016/j.socscimed.2022.114984.
21. **Patel AR, Nowalk MP.** Expanding immunization coverage in rural India: A review of evidence for the role of community health workers. Vaccine. 2010;28(3):604-613. https://doi.org/10.1016/j.vaccine.2009.10.108.
22. **Pati S, Ladowski KL, Wong AT, Huang J, Yang J.** An enriched medical home intervention using community health workers improves adherence to immunization schedules. Vaccine. 2015;33(46):6257-6263. https://doi.org/10.1016/j.vaccine.2015.09.070.
23. **Jack HE, Arabadjis SD, Sun L, Sullivan EE, Phillips RS.** Impact of community health workers on use of healthcare services in the United States: a systematic review. J Gen Intern Med. 2017;32(3):325-344. https://doi.org/10.1007/s11606-016-3922-9.
24. **Griffith DM, Bergner EM, Fair AS, Wilkins CH.** Using mistrust, distrust, and low trust precisely in medical care and medical research advances health equity. Am J Prev Med. 2021;60(3):442-445. https://doi.org/10.1016/j.amepre.2020.08.019.
25. **Benkert R, Cuevas A, Thompson HS, Dove-Meadows E, Knuckles D.** Ubiquitous yet unclear: a systematic review of medical mistrust. Behav Med. 2019;45(2):86-101. https://doi.org/10.1080/08964289.2019.1588220.
26. **Hall MA.** Researching medical trust in the United States. J Health Organ Manag. 2006; 20(5):456-467. https://doi.org/10.1108/1477726-=0610701812.
27. Community Health Needs Assessment, FY 2020-2022, Essentia Health, St. Mary's Hospital (Cottonwood). St. Mary's and Clearwater Valley Hospitals and Clinics. https://smh-cvh.org/wp-content/uploads/2020/02/Community-Health-Needs-Assessment-FY2020-2022-St.-Marys.pdf. Accessed 6 July 2019.
28. Community Health Needs Assessment, FY 2020-2022, Essentia Health – Clearwater Valley Hospital (Orofino). St. Mary's and Clearwater Valley Hospitals and Clinics. https://smh-cvh.org/wp-content/uploads/2019/11/Community-Health-Needs-Assessment-FY2020-2022-ClearwaterValley.pdf. Accessed 6 July 2019.
29. Map the Meal Gap 2018: Overall Food Insecurity in Idaho by County in 2016. Feeding America, Idaho Food Bank. https://idahofoodbank.org/wp-content/uploads/2018/05/ID_AllCountiesMMG_2016_Final.pdf. Accessed 28 June 2019.
30. **Enguita-Fernàndez C, Alonso Y, Lusengi W, et al.** Trust, community health workers and delivery of intermittent preventive treatment of malaria in pregnancy: a comparative qualitative analysis of four sub-Saharan countries. Global Public Health. 2020;0(0):1-15. https://doi.org/10.1080/17441692.2020.1851742.
31. **Abelson J, Miller FA, Giacomini M.** What does it mean to trust a health system?: A qualitative study of Canadian health care values. Health

Policy. 2009;91(1):63-70. https://doi.org/10.1016/j.healthpol.2008.11.006.

32. **Druetz T, Kadio K, Haddad S, Kouanda S, Ridde V.** Do community health workers perceive mechanisms associated with the success of community case management of malaria? A qualitative study from Burkina Faso. Soc Sci Med. 2015;124:232-240. https://doi.org/10.1016/j.socscimed.2014.11.053.

33. **Berini CR, Bonilha HS, Simpson AN.** Impact of community health workers on access to care for rural populations in the United States: a systematic review. J Community Health (2021). https://doi.org/10.1007/s10900-021-01052-6.

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