North Carolina
Community Health Worker Program Inventory
Summary Tables

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Introduction: In 2014, representatives from the NC Department of Health and Human Services (DHHS) joined together to initiate a Community Health Worker (CHW) Committee. The DHHS CHW Committee was tasked with gathering information about the current use of CHWs in North Carolina and to identify potential future direction.

In early 2015, the CHW DHHS committee, under leadership from the Chronic Disease and Injury (CDI) Section, with assistance from the UNC Healthy Solutions Team, developed and administered a NC CHW Program Inventory Survey to program supervisors. Results from the survey are included in this document.

The results are organized into five categories: A) Organizational Demographics; B) Scope of CHW Services; C) CHW Skills, Abilities, and Training; D) Funding of CHWs, Compensation, Recruitment, Supervision and Retention; and E) Challenges, Benefits and Evaluation/Monitoring of CHWs.

NC Department of Health and Human Services Community Health Worker (NC DHHS CHW) Committee:

- Division of Public Health
  - Chronic Disease and Injury Section
  - Epidemiology Section
  - Women's and Children's Health Section
  - Office of Minority Health & Health Disparities
- Division of Aging and Adult Services
- Division of Medical Assistance
- Division of Mental Health/Developmental Disabilities/Substance Abuse Services
- Office of Rural Health
- Community Care of North Carolina

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NORTH CAROLINA CHW PROGRAM INVENTORY EXECUTIVE SUMMARY

OVERVIEW: A total of 117 participants responded to the invitation to complete the survey (40.3% Response Rate). Section A represents information collected at the organizational level (n=56 organizations). Participants who supervised multiple CHW programs were asked to answer a series of questions at the program level. 131 programs were identified by respondents. 84 programs have complete information (64% of identified programs). Number of responses are presented in each table for each question as appropriate. Sections B through E represent information collected at the program level (n=131 programs).

A. ORGANIZATIONAL DEMOGRAPHICS (TABLES 1-7)

1. **RESPONSE RATE** - 117 participants responded to the invitation to complete the survey (40.3% Response Rate), representing 56 unique organizations.
2. **ORGANIZATION TYPE** - Over half (55%) of participating organizations identified as a non-profit.
3. **IDENTIFIED PROGRAMS** - Participants who supervised multiple CHW programs were asked to answer a series of questions at the program level. Through this process, 131 programs were identified with 84 programs having complete information (64% of identified programs). Participants reported an average of 2.2 programs working with CHWs.
4. **CHW PROPOSED DEFINITION** - 41% of participant responses were very supportive of the proposed CHW definition. 49% were generally supportive of the CHW definition, and 11% disagreed with some aspect of the CHW definition.

B. SCOPE OF CHW SERVICES (TABLES 8- 19)

1. **STAFFING –** Part-time volunteer staffing were most common for CHW responding programs (39%), followed by fulltime paid CHWs (30%). The average number of part-time volunteer was 6.7 (range 0-30) and fulltime CHWs was 3.6 per program (range 0-54).
2. **PROGRAM DURATION** - The average amount of time that a program has existed is 10.4 years (range 0 – 52 years) and the median amount of time a program has operated is 5 years.
3. **PROGRAM PURPOSE** - The most commonly reported program purpose is access to care/services (35%), followed by primary prevention (19%), direct care or services and supports (17%) and secondary prevention (15%).
4. **HEALTH TOPIC** - The most commonly reported health topic addressed by CHW Programs was chronic disease (51%), followed by mental health (47%), nutrition (42%), and unintentional injury (41%).
5. **ACTIVITY TYPE** - Almost all (90%) of CHW Programs reported supporting positive health behaviors, and over three quarters organize group education and social support (80%), provide health promotion and education (80%), and support community advocacy and organizing (80%).
6. **REFERRALS** - Most programs (88%) provided non-medical referrals, health care referrals (82%), and mental health referrals (72%).
7. **POPULATIONS SERVED –** Across the responding programs the most commonly reported ethnicity served were African American (74%), Hispanic or Latino (64%), and Caucasian (63%). The most common age groups were 19-64 year olds (63%) and 65 and older (55%). Almost three quarters of the programs served low income (76%) and women (72%) populations.
8. **LANGUAGE** - Most of the responding CHW programs (94%) provided services in the native language of the populations they serve. English (91%) and Spanish (57%) were the most commonly reported languages.
9. **PROGRAM SETTINGS** - Most of the responding CHW programs worked within a regional area (e.g., multiple counties) (46%). The most commonly reported setting was community (42%) followed by housing units (27%) and clinical settings (20%).
10. **PROGRAM REACH** - Most of the responding CHW programs (40%) reported reaching 101-500 individuals on an annual basis.

C. WORKFORCE - CHW SKILLS, ABILITIES, AND TRAINING (TABLES 20-26)

1. **TRAINING** - Most of the responding CHW programs (90%) had access to trainings. Trainings were provided by internal staff (83%) and external organizations (76%). The most commonly reported number of training hours provided was more than 3 days (41%) and required annual certification (58%).
2. **BOARD OVERSIGHT** - Most of the responding CHW programs were supervised by a board (70%).
3. **TRAINING BARRIER** - The most commonly reported barrier for training was limited to no funding for training (76%), followed by lack of curriculum materials/lack of training resources/lack of competency-based training (35%).
4. **PERCEIVED IMPORTANCE OF SKILLS AND TRAINING PROVIDED** – Participants reported how important specific CHW skills were to their program (scale unimportant 1- important 6) and asked if they provided skill training. Estimated training needs are possibly met for 8 of the 15 skills and there may be a training gap for 7 of the 15 skills.

D. FUNDING OF CHWS, COMPENSATION, RECRUITMENT, SUPERVISION AND RETENTION (TABLES 27-34)

1. **FUNDING SOURCE** - Most of the responding CHW programs (60%) received funding from state government, followed by federal government (52%). The most commonly reported form of compensation to CHW staff was an annual salary with benefits (42%), followed by hourly salary (40%).
2. **RECRUITMENT METHODS** - The most commonly reported method for recruitment was recommendations for other CHWs (60%) followed by targeted solicitation (28%).
3. **SUPERVISION** - Most supervisors (45%) reported provided 1-2 hours of supervision per week. Most supervisors (91%) reported that they had sufficient time for providing supervision.
4. **RETENTION TIME** - Almost half (53%) of the programs reported a retention time among CHW staff of 1-4 years. The most commonly reported retention method was targeting dedicated passionate individuals (75%), followed by financial incentives (46%) and realistic job preview (44%).

E. CHALLENGES, BENEFITS AND EVALUATION/MONITORING OF CHWS (TABLES 35-38)

1. **RETENTION CHALLENGE** - Participants were asked to rate retention challenge(s) on six point scale (never a challenge – 1 to frequently a challenge – 6). The most commonly reported challenge was lack of stable funding (average 4.0), followed by lack of public understanding (average 4.0), and shortage of qualified applicants (average 3.8).
2. **CHW BENEFITS TO PROGRAM** - The most commonly reported benefits from responding CHW programs were success on reaching hard to reach target populations (80%), followed by improved health outcomes (78%), reduced health care costs (51%) and cost savings for our organizations (e.g., personnel costs) (50%).
3. **EVALUATION AND MONITORING** - Most of the responding CHW programs reported conducting some form of monitoring and/or evaluation, including: recording number and type of patient served (67%); satisfaction survey/assessment from clients (65%); tracking impact and/or outcomes (60%); performance evaluation (55%) and summarizing, analyzing and reporting on impact/outcomes (49%). More than one third (37%) of responding CHW Programs expressed a willingness to share additional evaluation materials available for review.

NORTH CAROLINA CHW PROGRAM INVENTORY SUMMARY TABLES

A. ORGANIZATIONAL DEMOGRAPHICS (at the organizational level)

The number of respondents answering questions in *Section A* range from 59 to 117.

Table 1. Response Rate for CHW Program Inventory

Category	*N*	*%*
Valid Emails/Invitations Sent	290	--
Total Survey Response	117	40.3%
Finished Survey	*57*	*19.7%*
Partially Completed Survey	*48*	*16.6%*
Opted Out/Self Removed	*4*	*1.4%*
Email withdrawal	*8*	*2.8%*
Total Non-Responsive	173	59.7%
Bounced Emails	*13*	

Proposed NC CHW Definition

A CHW is a frontline worker who is a trusted member of, and/or has an unusually close understanding of, the community served. This trusting relationship enables the CHW to serve as a link between health/social services and the community in order to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW will often share ethnicity, language, socioeconomic status and life experiences with the community members s/he serves.

A CHW also builds capacity at the individual and community level by increasing health knowledge and self-sufficiency through a range of activities. A CHW provides culturally appropriate health education and information and may provide:
Interpretation and translation services;

- Assistance to people in receiving the care they need;
- Informal counseling and guidance on health behaviors;
- Advocacy for individuals and community health needs; and
- Some direct services such as first aid and blood pressure screening.

A CHW is a lay member of the community who works, either for pay or as a volunteer, in association with the local health care system and public health system in both urban and rural environments.

Table 2. Agreement to proposed CHW definition (scale not agree 0 – completely agree 100; n=77).

Range	*#*	*%*	*Combined #s*
Range 0-10	2	3%	11%
Range 11-20	0	0%	
Range 21-30	0	0%	
Range 31-40	0	0%	
Range 41-50	1	1%	
Range 51-60	2	3%	
Range 61-70	3	4%	
Range 71-80	38	49%	49%
Range 81-90	9	12%	40%
Range 91+	22	29%	
Total count	77	100%	100%

Thematic Qualitative Feedback for Comments on suggested NC CHW Definition (n=44)

- Agree with definition (n=21)
- Suggestions for inclusion of additional services (n=11)
- Terminology Clarification/change (n=5)
- Other/nonspecific to definition (n=6)
- Don't Know (n=1)

Table 3. Type of Organization Responding to Survey (N=78).		
Organization type	*N*	*%*
Nonprofit	43	55%
Local Agency/Department	11	14%
Clinic and/or Federally Qualified Health Center (FQHC)	11	14%
State Agency/Department	5	6%
Local Management Entity/Managed Care Organization	3	4%
Hospital	3	4%
Community-based Organization	2	3%
Tribal Government/Organization	0	0%
Faith-based Organization	0	0%

Table 4. Organizations that Currently use CHWs (N=76).		
Response	*N*	*%*
Yes	64	84%
No	12	16%

Table 5. CHW Program Distribution based on CHW Manager Response to Survey (N=59).		
Program #	*N*	*%*
1 Program	25	42%
2 Programs	14	24%
3 Programs	9	15%
4 Programs	7	12%
5 Programs	2	3%
6 Program	1	2%
7 Programs	1	2%
Total # Programs	131	**
Average # Programs	2.2	**

Table 6. Number of Programs Identified.	
Total	131

Table 7. Likelihood of Current non-users to use CHWs in future (N=12).		
Response	*N*	*%*
Very Likely to Somewhat Likely	8	67%
Unlikely to Very Unlikely	2	17%
Not Applicable	2	17%
Total #	12	100%

Sections B, C, D, and E represent information collected at the CHW Program Level. Respondent responses for these sections ranged from 68 to 101.

B. SCOPE OF CHW SERVICES (at the program level)

Table 8. Distribution of Paid and Volunteer Workforce (N=100).

Employment Status	*Average # of CHWs per program (SD)*	Range (low)	*Range (high)*	*Total # of CHWs Across Program Respondents*	*% of CHW workforce in survey response*
# of paid CHWs-# Full-time	3.6 (6.5)	0	54	249	30%
# of paid CHWs-# Part Time	3.4 (2.1)	0	8	151	18%
# of volunteer CHWs-# Full-time	10.6 (16.4)	0	50	117	14%
# of volunteer CHWs-# Part Time	6.7 (6.0)	0	30	326	39%

Table 9. Length of Program (N=92).

Average Years (SD)	10.4 years (10.5)
Range Years	0 to 52 years
Median Months	60 months
1-12 Months	11 programs
13-24 Months	7 programs
25-36 Months	10 programs
37-60 Months	20 programs
60+ Months	44 programs

Table 10. Program Purpose (N=99).

Purpose	*N*	*%*
Access to care/services	35	35%
Primary prevention (i.e., protection from developing disease)	19	19%
Direct care or services and supports	17	17%
Secondary prevention (i.e., halt/slow progression of disease/limit long term effect)	15	15%
Tertiary prevention (i.e., minimize the negative effects of disease and prevent disease related complications)	10	10%
Other	3	3%
Community development	0	0%

Program Purpose Other - prevent isolation, provides health promotions, and screenings, provides nutritious daily meal, healthy living and aging programs; Three levels of Prevention and access to care; Program hasn't started yet

Table 11. Distribution of Health Topics Addressed by CHW Programs (N=96). *Average number of topics per CHW Program: 6.4 (5.8) Range 0-30 topics per CHW Program*		
Health Topic	*N*	*%*
Chronic Disease *Diabetes (n=41; 46%)* *Cardiovascular Disease (n =36; 40%)* *Asthma (n =29; 32%)* *Cancer (n= 29; 32%)* *Sickle Cell Disease (n =15; 17%)* *Other (n=5; 6%)*	46	51%
Mental health	42	47%
Nutrition	38	42%
Unintentional Injury *Assault (e.g., Physical Violence, Child Abuse, Maltreatment, Sexual Violence) (n=33; 37%)* *Self-inflicted/ Self-Harm (n= 14; 16%)* *Other (n= 1; 1%)*	37	41%
Physical activity	35	39%
Alcohol/substance use disorder prevention and treatment	31	34%
Weight loss	26	29%
Intentional Injury *Falls (n=23; 26%)* *Motor Vehicle (n= 6; 7%)* *Sports (n =5; 6%)* *Burns (n = 4; 4%)* *Other (n = 0; 0%)*	26	29%
HIV/AIDS prevention	25	28%
Older adult health (e.g., Alzheimer's, Osteoporosis, Falls Prevention, Arthritis)	24	27%
Acquired/physical or developmental disability	21	23%
Environmental health	20	22%
Sexual/reproductive health (e.g., family planning)	19	21%
Tobacco cessation	16	18%
Immunizations	16	18%
Maternal Child Health *Prenatal care (n = 10; 11%)* *Secondhand smoke prevention (n =7; 8%)* *Low birth weight (n = 6; 7%)* *Infant health (n = 6; 7%)* *Breastfeeding (n = 4; 4%)*	16	18%
Other	14	16%
Oral health	12	13%
Occupational health	10	11%

Health Topic Chronic Disease Other (1) – CDSMP covers many possible health issues; any chronic illness; chronic pain; All; Chronic Disease Self-Management

Health Topics Intentional Other (2) – opioid misuse/abuse

Health Topics Unintentional Other (3) – N/A

Health Topic All Other (4) - Trauma (n=4); Affordable Care Act (n=2); homelessness (n= 2); caregivers; Utilization of Primary Care for chronic/acute health problems; Access to Health Insurance: Medicaid, Health Choice, Health Care Exchange; Refers Families to health and support services; connecting to community resources-housing, jobs, etc.; Importance of Health Insurance

Table 12. CHW Program Activities (N=92).		
Activity	*N*	*%*
Support positive health behaviors	83	90%
Organize group education and social support	74	80%
Provide health promotion and education	74	80%
Support community advocacy and organizing	72	78%
Facilitate access to medical services (e.g., doctor/clinic visits)	68	74%
Facilitate access to social services (e.g., housing, nutritional assistance, referrals)	66	72%
Conduct outreach and enrollment	66	72%
Provide informal counseling	59	64%
Support medication adherence	50	54%
Provide interpretation and translation services	42	46%
Provide transportation	41	45%
Assess home environment for appropriate living situation for healthy behaviors and outcomes	27	29%
Visit homes to help with daily routine	15	16%
Other	1	1%

CHW Activity Other - attend court sessions with clients

Table 13. CHW Program Referral Services (N=91 responses) 76 [84%] CHW Programs provide referral services.		
Referral Service	*N*	*%*
Non-Medical (e.g. food stamps, housing, employment)	67	88%
Health Care	62	82%
Mental Health	55	72%
Dentist	37	49%
Other	18	24%

Other referral - Legal (n=10); Education (n=3); Spiritual support (n=2); Health Insurance Enrollment (n=2); other behavioral health services; referrals to home office for assistance to client; Food pantry, clothing closet; haven't started meeting

Table 14. Population Group(s) Served by CHW Programs (N=87).		
Population Group	*N*	*%*
Ethnicity/Race Groups		
Black or African American	64	74%
Hispanic or Latino	56	64%
Caucasian	55	63%
No specific race/ethnicity	33	38%
American Indian/Alaska Native	25	29%
Asian American	20	23%
Native Hawaiian or Other Pacific Islander	13	15%
Other	4	5%
Age Groups		
0 – 10 years	15	17%
11 - 18 years	24	28%
19- 64 years	55	63%
65+ years	48	55%
No specific age	29	33%

Table 14. Population Group(s) Served by CHW Programs (N=87).		
Population Group	*N*	*%*
Other Groups		
Low income	66	76%
Women	63	72%
Men	60	69%
Rural populations	57	66%
People with disabilities	43	49%
Uninsured	41	47%
Gay, Lesbian, Bisexual, and/or Transgender	40	46%
People with mental health needs	38	44%
Families	35	40%
People with substance use disorders	32	37%
People for whom English is not their first language	32	37%
Homeless	30	34%
Children	28	32%
Farmworkers and families	21	24%
No Specific Population Group	19	22%
Pregnant women	13	15%
Other	5	6%

Population group other ethnicity/race - bi-racial; other races/ethnicities; any; other races/ethnicities (n=2)
Population group other - Living with HIV; Immigrants/refugees; Community Leaders; anyone living with chronic illness (n=2)

Table 15. CHW Program Support Language of Population Served. (N=101).		
Response	*N*	*%*
Yes	58	57%
Mixed	37	37%
No	6	6%

Table 16. Languages of CHW Programs (N=101).		
Language	*N*	*%*
English	86	91%
Spanish	54	57%
American Sign Language	4	4%
Other	3	3%
Native American Tribal language	2	2%
French	1	1%
Chinese	1	1%
Vietnamese	1	1%
Tagalog	1	1%
Hmong	1	1%

Languages other – Russian (n=3), Ukrainian

Table 17. CHW Program Geographic Region (N=92).		
Area Served	*N*	*%*
Region (e.g., multiple counties)	42	46%
Single County	38	42%
Single Town/City	9	10%
Statewide	2	2%

Table 18. CHW Program Outreach Settings (N=92).		
Setting	*N*	*%*
Community	66	42%
Housing Units	43	27%
Clinical	32	20%
Worksite	14	9%
Other	2	1%

Settings other – First Responding to 911 calls; law enforcement office, court, ER, schools

Table 19. Annual Population Reach for CHW Programs (N=92).		
Population Number	*N*	*%*
0-100 individuals	26	28%
101-500 individuals	37	40%
501 -1000 individuals	8	9%
>1001 individuals	21	23%

C. CHW SKILLS, ABILITIES, AND TRAINING (at the program level)

Table 20. Access to Trainings (N=92).		
Response	*N*	*%*
Yes	84	90%
No	9	10%

Table 21. Provider of CHW Trainings (N=84).		
Trainer Origin	*N*	*%*
Internal staff	70	83%
External organization	64	76%
Parent organization/funder	31	37%

Table 22. Training Hours Provided on an Annual Basis (N=82).		
Time	*N*	*%*
0 hours	4	5%
1-8 hours	18	22%
2-3 days	26	32%
More than 3 days	34	41%

Table 23. Annual Training Requirements (e.g., Certificate) (N=88).		
Response	*N*	*%*
Yes	51	58%
No	37	42%

Table 24. CHW Program Receives Board or Administrative Supervision (N=89).		
Response	*N*	*%*
Yes	62	70%
No	27	30%

Table 25. Training Barriers for CHW Programs (N=68).		
Barrier	*N*	*%*
Limited to no funding for training	52	76%
Lack of curriculum materials/lack of training resources/lack of competency-based training	24	35%
CHW turnover	20	29%
No barriers	18	26%
Inadequate capacity to offer training	9	13%
Limited education of CHWs	9	13%
Other	7	10%

Training barriers other - Distance/time to training location (n=6); language (n=2); In process of recruitment

Table 26. CHW Program Perceived Skills Importance Compared to Skill Set Training Provided by CHW Program.[a] *(Ranked by importance.)*

CHW Skill	*Skill Importance Level Very unimportant (1) – Very Important (6)*			*NA*	*% Providing Training (n=84)*	*Training Need Consideration*
	1 & 2	*3 & 4*	*5 & 6*			
1. Knowledge base of issues (n= 92)	24%	6%	70%	38	76%	Appears to Meet Need
2. Knowledge base of services (n= 91)	17%	17%	66%	44	73%	Appears to Meet Need
3. Topic specific certification (n= 88)	34%	20%	46%	18	46%	Appears to Meet Need
4. Teaching skills (n= 91)	16%	6%	78%	27	42%	Possible Gap
5. Organizational skills (n= 92)	16%	12%	73%	41	43%	Possible Gap
6. Group facilitation skills (n= 92)	13%	16%	70%	31	58%	Possible Gap
7. Data reporting/technology skills (n= 92)	12%	19%	70%	23	50%	Possible Gap
8. Services coordination skills (n= 90)	19%	14%	67%	33	42%	Possible Gap
9. Capacity building skills (n= 92)	16%	22%	63%	41	38%	Possible Gap
10. Statistical analysis skills (n= 92)	23%	41%	36%	12	18%	Possible Gap
11. Cultural awareness and cultural competency (n= 90)	25%	6%	69%	54	83%	>50% of respondents said N/A
12. Communication skills (n= 91)	29%	6%	66%	56	67%	>50% of respondents said N/A
13. Confidentiality skills (n= 92)	42%	0%	58%	68	73%	>50% of respondents said N/A
14. Advocacy skills (n= 92)	29%	19%	52%	50	69%	>50% of respondents said N/A
15. Building rapport (n= 92)	34%	21%	45%	63	58%	>50% of respondents said N/A

[a] Survey did not assess specific quality or length of training provided.

D. FUNDING OF CHWS, COMPENSATION, RECRUITMENT, SUPERVISION, AND RETENTION (at the program level)

Table 27. Fiscal Support/Funding of CHW Programs (N=92).		
Funder	*N*	*%*
State government	55	60%
Federal government (including Medicaid/Medicare)	48	52%
Private foundation	29	32%
Local government	23	25%
Non-profit organizations	20	22%
Other	14	15%
Our CHWs are volunteers or do not receive financial support.	12	13%
Insurance companies	2	2%

Financial support other - Individual donors support (n=3); United Way; Grant Funds (n=2); Fund raising (n=2); Hospitals (n=2); Partnering organizations; Unrestricted funds; Faith Community; The AAA

Table 28. Financial Compensation Methods for CHW Programs (N=91).		
Payment Method	*N*	*%*
Annual salary with benefits	38	42%
Hourly salary	36	40%
Stipend or lump sum	*22*	24%
Volunteer (they do not receive any monetary compensation, including gift cards and/or incentives)	21	23%
Reimbursement for travel	20	22%
Gift cards/incentives	9	10%
Other	5	5%
Annual salary without benefits	4	4%

Payment other – Memos of Understanding (n=2); Hourly salary with benefits; contract; Scholarships

Table 29. Manager Response: Do CHWs Have Additional Source(s) of Income (N=92).		
Response	*N*	*%*
Don't Know	37	40%
None	31	34%
Other part-time work	19	21%
Other full-time work	5	5%

Table 30. Recruitment Methods Used by CHW Programs (N=96).		
Method	*N*	*%*
Recommendations from Others	78	60%
Targeted Solicitation	37	28%
Online/social media	21	16%
Paid Advertisements (e.g., Flyers/Posters/Brochures)	11	8%
We have no formal recruitment efforts	9	7%
Other	3	2%

Recruitment method other - Service learning programs (n=2); Faith communities connection

Table 31. Hours of Supervision Provided on a Weekly Basis by CHW Programs (N=95).		
Time	*N*	*%*
Less than 1 hour	14	15%
1-2 hours	43	45%
2 -4 hours	15	16%
5+ hours	15	16%
Other	8	8%

Hours of supervision other - these volunteers may volunteer their services 1-2 times a month; none; provided before & during workshop; when needed; Monthly meetings and ongoing support; none, unless they are coordinating or leading a workshop; none

Supervision Problems Presented by Opened Ended Response Themes (N=66)

1. Scheduling/availability of CHWs (n=17)
2. Limited time to properly supervise and support staff (n=14)
3. None/Not Applicable (N=12)
4. Lack of internal coordination/support/awareness to maximize shared/overlapping work (n=6)
5. Limited Funding CHWs (n=5)
6. Lack of data collection skills (n=5)
7. Transportation (n=3)
8. Limited knowledge and experience in the program they lead (n=3)
9. Lack of self-care and mini-burn outs are common (n=3)
10. Retention (n=4)
11. Maturity/Lack of boundaries with client population (n=3)
12. They are volunteers so they are not obligated to continue with the program (n=2)
13. Just starting (n=2)
14. Language barrier (n=2)
15. Capacity Building / Training (n=3)
16. Adhering to the program requirements (n=2)
17. Don't Know (n=2)
18. Low pay

Table 32. Sufficient Time for Supervision Across CHW Programs (N=97).		
Response	*N*	*%*
Yes	88	91%
No	9	9%

Table 33. Retention Time for CHW Programs (N=89).		
Time	*N*	*%*
Less than 6 months	3	3%
6-11 months	5	6%
1-4 years	47	53%
5-10 years	31	35%
Greater than 10 years	3	3%

Table 34. Retention Methods Used by CHW Programs (N=87).		
Retention Method	*N*	*%*
Target dedicated passionate individuals	65	75%
Financial incentives/ payments/benefits	40	46%
Realistic job preview	38	44%
Professional development (e.g., providing Continuing Education Units [CEUs], school credit)	36	41%
Recognition ceremonies/certificate of appreciation	26	30%
Other	11	13%

Retention methods other - Positive and flexible work environment (n=3); Not sure (n=2); summer internship; contracts with host agencies; Continuous empowerment of CHWs; participation in the larger process

E. CHALLENGES, BENEFITS AND EVALUATION/MONITORING OF CHWS (at program level)

Table 35. Retention Challenges of CHW Programs (N=85) ***average number of challenges per program 7.9 (1.6)***				
Challenge	*Not Applicable*	*Never (1) to Sometimes (3)*	*Often (4) to Frequently (6)*	*Avg*
Lack of stable funding	21%	30%	49%	4.0
Lack of public understanding of the benefits of CHWs	10%	37%	53%	4.0
Shortage of qualified applicants	9%	38%	54%	3.8
Turnover	8%	46%	46%	3.5
CHW services not being reimbursable	7%	53%	40%	3.2
Inadequate staff time supervising CHWs	0%	63%	37%	3.3
Lack of training resources	0%	62%	38%	3.3
Inadequate skill/experience supervising CHWs	0%	72%	28%	3.1
Mistrust/competition from other health care workers	2%	65%	33%	3.0

Table 36. Benefits of CHW Programs (N=88).		
Benefit	*N*	*%*
Success on reaching hard to reach target populations	70	80%
Improved health outcomes	69	78%
Reduced healthcare costs	45	51%
Cost savings for your organization (e.g., personnel costs)	44	50%
Increased medication and treatment regimen adherence	34	39%
Other	8	9%

Benefits of CHW Programs other - building a population of empowered survivors in our community; indirectly improved health outcomes by creating access; access to healthcare services and disease prevention; prepares young people from diverse populations to go into healthcare for the long-term; public awareness of the issue and specific knowledge of how to keep children safe; building a population of empowered survivors in our community.

CHW Contributions for Accomplishments (N=43)

1. Their work is invaluable/can't be done without them (n=7)
2. Assist in reaching difficult populations (n=7)
3. Reached more people with less staff (n=7)
4. They are trusted, respected (n=7)
5. Indirectly improved health outcomes by creating access to primary care (e.g., enrollment, referrals) (n=6)
6. Bridge connections across community and organization(s) (n =6)
7. Successful outcomes of programs (n=6)
8. Share skills and/or knowledge (n=5)
9. Organizational guidance (n=2)
10. Recruitment (n=2)
11. Fundraising
12. Available 24/7/365
13. Not Applicable (n = 2)

Table 37. Evaluation/Monitoring Methods Used by CHW Programs (N=88).

Method	*N*	*%*
Number and type of patients served	59	67%
Satisfaction survey/assessment from clients	57	65%
Tracking impact and/or outcomes (e.g. tracking referrals)	53	60%
Performance evaluation	48	55%
Summarizing, analyzing and reporting on impact/outcomes	43	49%
Satisfaction survey/assessment from CHWs	16	18%
Cost savings	8	9%
Other	2	2%

Evaluation Monitoring other - Program has not started yet (n= 2)

Additional Evaluation/Monitoring Information

37% of the responding CHW Programs reported willing to provide additional information for evaluation/monitoring methods.