MICHIGAN COMMUNITY HEALTH WORKER ALLIANCE

In coordination with the MiCHWA Evaluation Work Group

COMMUNITY HEALTH WORKER SURVEY 2023: FINAL EVALUATION REPORT

July 14, 2023

Prepared by the University of Michigan School of Social Work Program Evaluation Group

SCHOOL OF SOCIAL WORK
PROGRAM EVALUATION GROUP
UNIVERSITY OF MICHIGAN

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EVALUATION TEAM

The development, dissemination, and analysis of the 2023 Community Health Worker Survey was undertaken by the MiCHWA CHW Survey Team, including the individuals noted below. Members of the MiCHWA Evaluation Work Group provided input and feedback at key points in the project.

2023 CHW Survey Team

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The Michigan Community Health Worker Alliance promotes the integration of community health workers (CHWs) into health and human services organizations throughout Michigan through coordinated changes in policy and workforce development. For more information, see https://www.michwa.org/.

The University of Michigan School of Social Work Program Evaluation Group (PEG) partners with public and private organizations to provide evaluation training, consulting, and data analysis services. For more information, see https://ssw.umich.edu/research/program-evaluation.

EXECUTIVE SUMMARY

CHW Survey Background and Overview

The 2023 Community Health Worker Survey is the second statewide survey of CHWs in Michigan conducted by the Michigan Community Health Worker Alliance (MiCHWA) with support from the Michigan Department of Health and Human Services (MDHHS) and its Centers for Disease Control and Prevention (CDC) grant funding. The survey was disseminated electronically between March and April 2023. The final dataset consisted of 262 responses. *(See page 8.)*

Key Findings

Three overarching themes emerged from the survey findings. First, low pay and perceptions of limited upward mobility are top concerns for many CHWs. Second, CHW positions appear to have a high level of vulnerability from two different angles. On the one side, more than half of CHWs reported some level of job insecurity with respect to security of funding. On the other side, large numbers of CHWs report feelings of burnout due to the emotional toll of the position. The third theme that emerged is the wide diversity in the nature of CHW roles, including large variations in caseloads and counties served. *(See Summary and Implications, page 41.)*

CHWs in Michigan

Eighty-seven percent of the CHWs identified as women. Just over half identified as White and approximately one-third identified as Black. Nearly all CHWs reported at least some post-high school education, with the largest group indicating completion of a bachelor's degree. The vast majority of survey respondents, 88%, reported being in a paid, full-time role as a Community Health Worker.

Individuals responding to the survey reported working for a total of 121 unique organizations. The five most common organization settings were community-based organizations or nonprofits, federally qualified health centers, health systems, and local health departments. The majority of CHWs reported working in a single county with 18 CHWs reporting working in five or more counties. *(See page 10.)*

CHW Roles

CHWs reported engaging in an average of 16 sub-roles either "often" or "very often." There were three sub-roles that more than half of respondents said they engage in very often:

1. Connecting to resources and advocating for basic needs (Role 5, sub-role b; 62%)
2. Motivating and encouraging people to obtain care and other services (Role 4, sub-role b; 58%)
3. Meeting basic needs (Role 7, sub-role c; 53%)

When asked about average caseload of clients actively served at any one time, more than two-thirds reported serving 60 clients or fewer. However, caseloads varied substantially by organization setting, with CHWs at Medicaid Managed Care Organizations serving an average of more than 4000 clients. *(See page 15.)*

CHW Salaries and Job Security

CHWs reported compensation ranging from $14.05 to $38.00 an hour, with an average of $21.37. The median wage was $20.09, meaning that half of survey respondents were earning less than this amount. Many CHWs expressed concerns with low pay in open-ended comments. Furthermore, nearly two-thirds of respondents indicated they at least sometimes felt inclined to quit because of the rate of pay. Finally, although many factors impact perceptions of job security, more than half of CHWs reported some level

of job insecurity. In a related concern regarding the stability of CHW positions, approximately 30% of CHWs reported often or very often feeling burnt out due to the difficulty of connecting clients to needed resources, whether because of limits of the program or because of clients not following through with the resources offered. *(See page 26.)*

Team Integration and Career Development

While the large majority of CHWs agreed that they have opportunities to develop their professional skills, far fewer agreed that they had opportunities to advance their careers. Most CHWs felt comfortable working with other providers to address client needs but far fewer felt that other providers had a strong understanding of their role as a CHW. *(See page 34.)*

CHW Training and Continuing Education

More than four out of five CHWs indicated they had completed the MiCHWA 126-hour core-competency based training program either before or after being hired as a CHW. Three-quarters of CHWs said that their employer requires them to maintain CHW continuing education credits. When asked from which sources they had received continuing education training, MiCHWA was by far the most common response. *(See page 36.)*

CHW Advocacy

In looking at level of agreement with statements related to policy advocacy, there was a decline in CHW engagement in all advocacy-based activities in 2023 compared to 2021. The sharpest decline was in those reporting that "people who influence change in my community seek my opinion and participation." *(See page 39.)*

MiCHWA's Member Registry

The majority of survey respondents reported they were registered in the MiCHWA CHW Registry. Among those registered, the largest number reported accessing the Registry every couple of months. The CEU opportunity listings were by far the most frequently accessed component of the Registry. *(See page 40.)*

SECTION 1: OVERVIEW

Survey Background

MiCHWA has conducted a CHW Employer Survey biannually since 2014, including the most recent survey in 2022, with support from the Michigan Department of Health and Human Services (MDHHS) and its Centers for Disease Control and Prevention (CDC) grant funding. In order to better understand CHWs' experiences first-hand, MDHHS suggested that MiCHWA administer a survey directly to CHWs in 2020. MiCHWA conducted the first Community Health Worker (CHW) Survey in 2021. This 2023 CHW survey was designed to update and extend the data, information, and lessons from the first survey, and address new topics of interest. If resources allow, MiCHWA plans to continue surveying CHWs on a biannual basis for the foreseeable future.

Summary of Methods

Survey Instrument

The 2023 CHW Survey was adapted from the 2021 CHW Survey instrument, which was developed by adapting questions both from previous CHW Employer Surveys and from CHW surveys in other U.S. states and soliciting input from CHWs. We made numerous improvements to the 2023 CHW Survey. The series of questions on CHW roles was extended to ask about each sub-role individually and with greater specificity (five-point frequency scale instead of three-point frequency scale). The question on CHW compensation was improved to ask CHWs about their exact rate of pay, rather than a range. We included additional responses in the question on sources of continuing education to improve consistency. The questions related to the MiCHWA CHW Member Registry were improved to add additional response options on frequency of use and to learn why people were not registered in or not using the CHW Member Registry. One matrix-style question on the 2021 CHW Survey on perceptions of value was replaced by two single-response questions from the national CHW Common Indicators Project on peer understanding of the CHW role and peer communication about participants' needs.

We also added several new questions to the 2023 CHW Survey. These included questions on referrals made to lifestyle change programs, client caseloads, interest in potential activities to support the emotional well-being of CHWs, inclinations to leave the CHW profession, feelings of burnout, and personal health status. Finally, several survey sections were eliminated to ensure that the survey could typically be completed in 15 minutes or less. The final instrument consisted of between 47 and 51 questions, depending on survey branching, and included a maximum of seven open-ended questions.

Pilot Testing

The MiCHWA Evaluation Workgroup reviewed and provided edits on early drafts of the survey. Once a complete draft of the survey was developed, three CHWs volunteered to pilot-test the questions. These individuals completed the survey while on a video call with a Program Evaluation Group (PEG) team member. At the end of each of the seven main survey sections, PEG team members asked, first, if there were any questions that were hard to answer and, second, if any questions or phrases were confusing or unclear. At the end of the survey, PEG team members asked the pilot-testers three additional questions to capture overall feedback and comfort level with the survey. Several minor edits were made to the survey instrument based on the feedback given in this process. MiCHWA provided each of the pilot-testers two CEU credits in recognition of their time.

Survey Distribution

The 2023 CHW Survey was distributed electronically using Qualtrics© software between March 20th and April 17th, 2023. MiCHWA Executive Director sent the survey link to all contacts in the organization's CHW Network and Employer databases. MiCHWA staff also posted the survey to the MiCHWA Member Registry, Facebook, Instagram, and Twitter. Multiple reminders to complete the survey were sent through each of these communication channels.

Survey Sample

Of an initial 344 survey responses, 54 responses were eliminated due to being less than 25% complete; 21 were eliminated either because the individual reported not serving as a CHW (19 people) or because the title given reflected a role inconsistent with a CHW position (2 people); and 3 were eliminated because they were repeat responses from individuals who had already completed the survey. The final dataset consisted of 262 respondents, including 19 partial responses and 243 complete responses. The number of respondents (N) varies by question throughout the report since not everyone responded to every question. Some findings also highlight a subset of respondents, such as employed CHWs.

Analysis

Data were exported from Qualtrics© into Excel. After the data were cleaned, the data were imported into IBM SPSS Statistics© Version: 28.0.1.0 (142). The evaluation team then used SPSS to calculate descriptive statistics, including counts, percentages, and means. Cross-tabulations were calculated for key variables of interest. Content analyses were performed on the open-ended response to identify themes. Where warranted, comparisons were made between the data and findings from the 2022 CHW Employer Survey or the 2021 CHW Survey.

Quotations from open-ended responses are included throughout the report to shed light on the perspective and experience of CHWs. Quotations were selected for their relevance to the topic and to illustrate a range of viewpoints. The quotations do not necessarily represent the viewpoint of anyone beyond the individual respondent and should not be interpreted as themes unless otherwise stated. Most of the quotations come from the three open-ended questions at the end of the survey that invited 2023 Community Health Worker Survey respondents to share anecdotes of accomplishments, impacts MiCHWA has had on their careers, and concerns about the CHW field.

Limitations

While we have made comparisons in several instances between the 2023 CHW Survey responses and the 2021 CHW Survey responses as well as between the 2023 CHW Survey responses and the 2022 CHW Employer Survey responses, these should be interpreted cautiously since they do not represent the same respondents. We also do not know to what extent the sample in this survey is representative of all CHWs employed in Michigan since there is no comprehensive list of all CHWs in the state. Findings should be interpreted with this limitation in mind.

Strengths

This survey and associated report also have several strengths. The larger number of responses than in the 2021 CHW Survey help provide a more robust picture of CHWs in Michigan. Survey responses also reflect all areas of the state and a range of organization types. Lastly, revised questions, including more detailed questions on roles and new questions on caseloads, burnout, and resources for emotional support, provide new insights.

SECTION 2: RESULTS

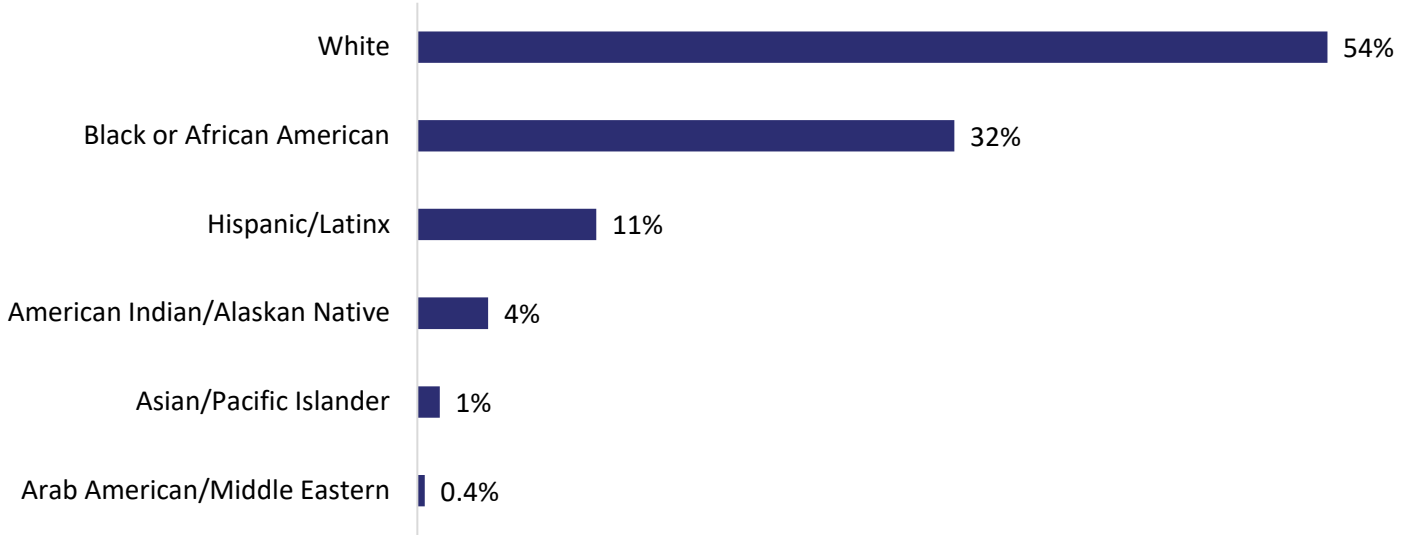
CHWS IN MICHIGAN

CHW Demographics

Through survey responses, CHWs identified the gender and races/ethnicities that best described them. Eighty-seven percent of the CHWs identified as women (*n* = 202), 13 percent identified as men (*n* = 30), and one person identified as non-binary. The two most prevalent racial/ethnic identities were White and Black, as shown in Figure 1. Three people wrote in their racial and ethnic identity as follows: Afghan, Ethiopian Israel, and African.

According to the American Public Health Association (APHA), a **Community Health Worker (CHW)** is a frontline public health 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 liaison, link, or intermediary between health or social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. While people in this role use many different titles, this report uses the term Community Health Worker (CHW) to refer to everyone serving in this role.

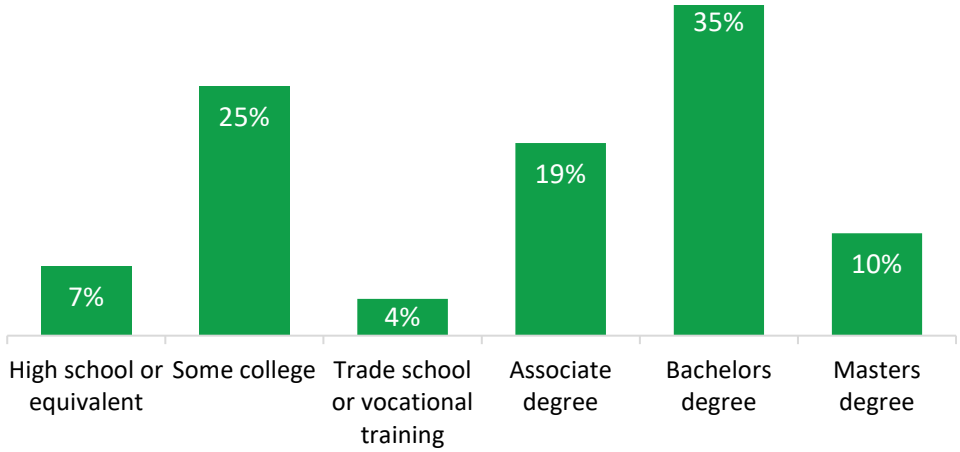
Figure 1. CHWs' Racial and Ethnic Identities (N = 226



With regards to education, nearly all CHWs reported at least some post-high school education, with the largest group indicating completion of a bachelor's degree. (See Figure 2.)

Medicaid Managed Care Organizations employed the largest proportion of CHWs with bachelor's or master's degrees. More than 80% of CHWs at Medicaid Managed Care Organizations had at least a four-year degree (82%), compared to about a third of CHWs at Federally Qualified Health Centers, Health Systems, and Local Health Departments and about half of CHWs at community-based Organizations or non-profits.

Figure 2. CHWs' Education Level (N = 243)

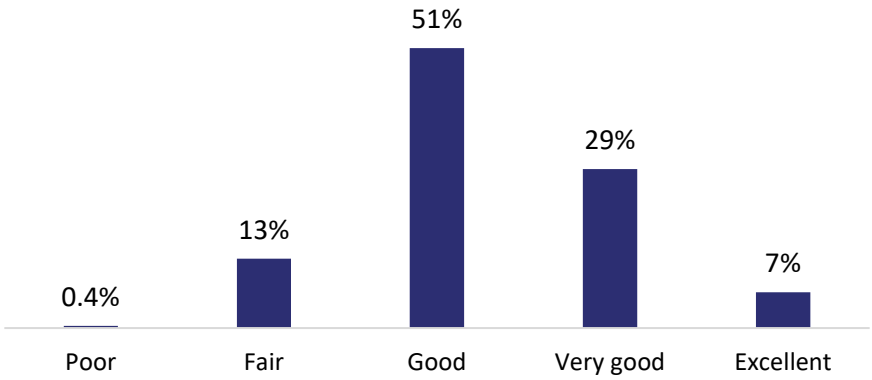


CHW Employer Survey Comparison

In the 2022 MiCHWA CHW Employer Survey, the majority of CHW employers (73%) reported that a high school diploma or GED was the highest level of required education. Only eight programs required a higher education degree, either an associate degree (five programs) or a bachelor's degree (three programs). With 64% of CHWs reporting having an associate degree or higher, the findings from the two surveys together indicate that in many cases CHWs may have more education than required for their position.

Perceived health status, which is a metric in the CHW Common Indicators project, provides insight on the overall well-being of the CHW workforce. The majority of CHWs reported good health or better. Thirty-one people indicated their health was "fair" and one person said "poor." (See Figure 3.)

Figure 3. CHWs' Health Status (N = 244)



Position Status

The vast majority of survey respondents, **88%, reported being in a paid, full-time role** as a Community Health Worker. An additional 7% reported being in a paid, part-time role. Four individuals said they worked on an "on call" basis and seven individuals said they volunteered, including five who did so full-time.

Years in CHW Role

Individuals responding to the survey reported **being in the CHW role for an average of 4.3 years**,[1] with a maximum of 35 years. Fifty people, or nearly 20%, reported being in the role for less than a year. This represents a similar proportion compared to 2021, when 17% of respondents reported serving as a CHW for less than a year. This may indicate that the field is continuing to grow. On the other end of the spectrum, 35 people (14%) reported serving as a CHW for ten years or more.

A Note on Comparisons

The report makes comparisons between the 2023 CHW Survey responses and the 2021 CHW Survey responses as well as between the 2023 CHW Survey responses and the 2022 CHW Employer Survey responses. However, these comparisons should be interpreted cautiously since they do not represent the same set of respondents or the same proportions of respondents from different organization types. Furthermore, employers' responses represent all of the CHWs that they employ or supervise, whereas CHWs' responses represent their individual experiences.

[1] This figure uses 0.5 years for everyone who reported being in the role for less than a year.

Position Titles

Survey respondents reported 42 unique position titles. **"Community Health Worker" was by far the most common title, reported by 63% of respondents.** Figure 4, below, shows all titles reported by two or more people. Other titles named in the survey are shown in Appendix A, Table 2 on p. 46.

Figure 4. Position Titles. *(Size is approximately proportional to number reported.)*

When asked in an open-ended question if there any concerns either in the field of CHWs or within MiCHWA, one person expressed concern about the lack of consistency in the titles associated with the role, saying:

CHW Perspectives

"At some point, I feel as though it may be necessary to find a core term for CHW. My current role is called a Community Health Navigator. This may confuse people in truly understanding the role and similarities with other positions, with different titles."

Languages of Service Delivery

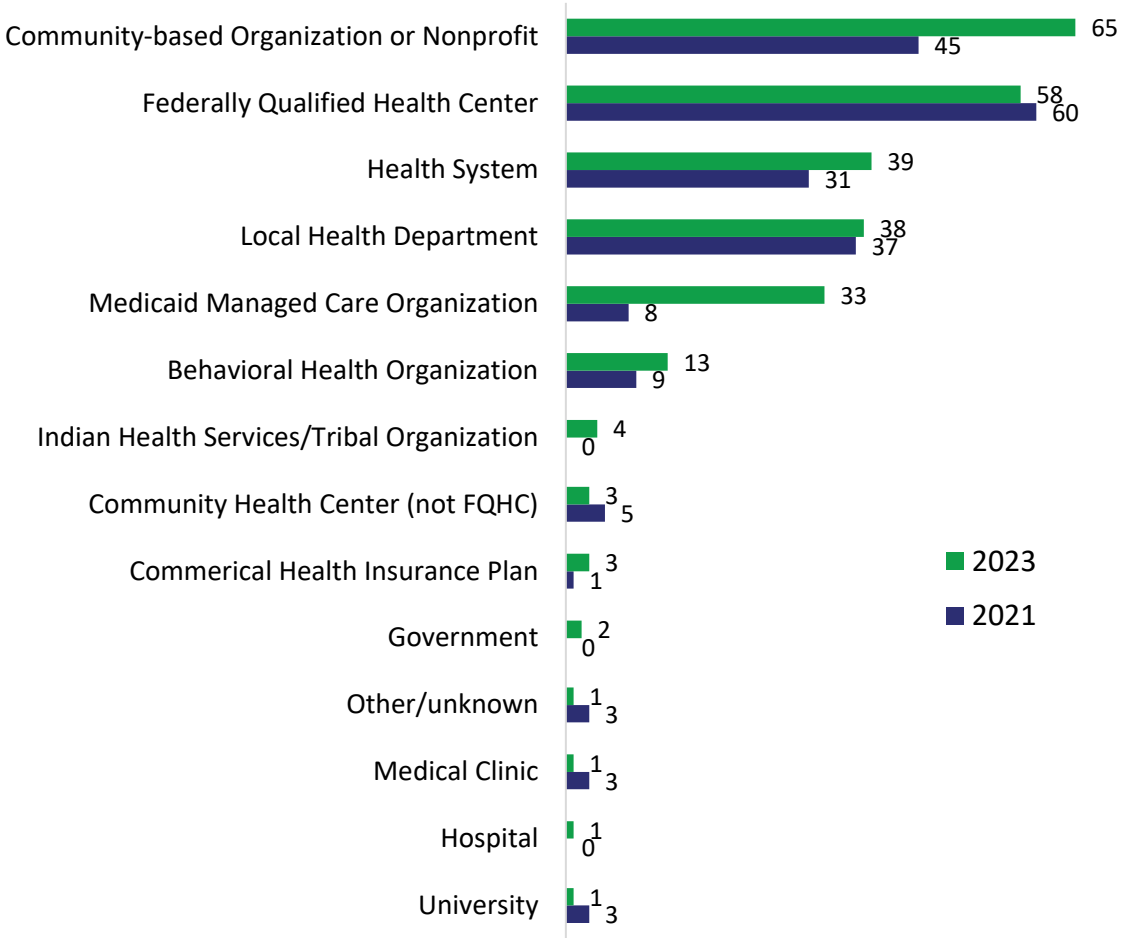
In addition to providing services in English, 31 people (12%) said they provide CHW services in Spanish. Other languages in which respondents reported providing services were:

- Arabic – 3 people
- Hmong – 2 people
- Slavic languages – 1 person
- Swahili, Kinyarwanda and Kirundi – 1 person
- Vietnamese – 1 person

Organization Types and Settings

Individuals responding to the survey reported working for **a total of 121 unique organizations**.[2] Figure 5 shows that, compared to 2021, there were notable increases in the number of responding CHWs from community-based or nonprofit organizations and from Medicaid Managed Care Organizations.

Figure 5. Number of CHWs by Organization Setting for 2023 (N = 262) and 2021 (N = 205)



A Note on Organization Settings

The survey team classified organization settings using the organization name given by the survey respondent. While many organizations could fall in more than one category, the counts in Figure 3 and throughout the report are not duplicated. We chose a single category for each organization based on what best described the setting.

In the remainder of the report, "community-based organizations" refers to all non-profit organizations, regardless of size, which do not otherwise fit in one of the listed settings.

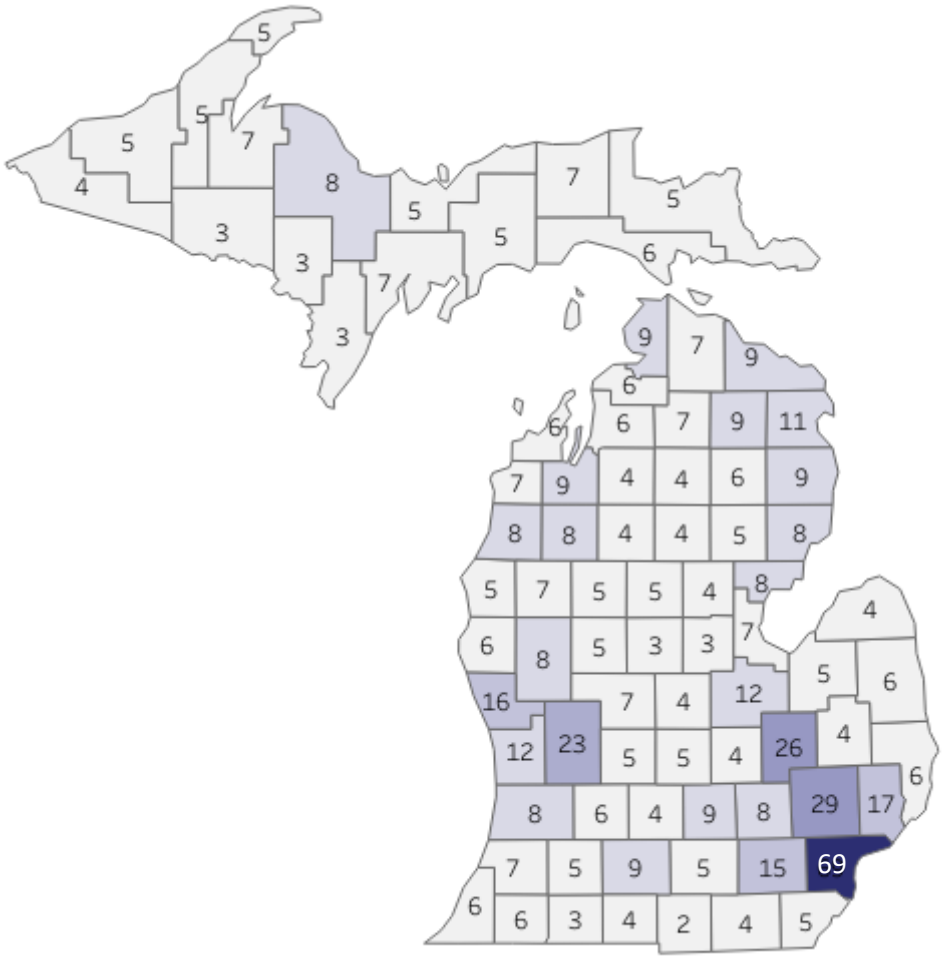
[2] Two respondents did not provide the name of their organization.

Location of CHW Service Delivery

CHWs reported working in an average of 2.7 counties each. **Nearly two-thirds of respondents reported working in a single county** (64%, *n* = 155). Eighteen CHWs (7%) reported working in five or more counties, including two CHWs reporting working in all 83 of Michigan's counties.

The number of CHWs working in Wayne County was more than double any other county. The next most frequent counties were Oakland, Genesee, and Kent, each with between 23 and 29 CHWs providing services. Hillsdale County had the fewest CHWs, with only the two CHWs who provide services statewide reporting doing work there.

Figure 6. Number of CHWs Providing Services by County (N = 244)



CHW ROLES AND ACTIVITIES

CHWs were asked how often they engaged in the sub-roles associated with the ten core CHW roles specified by the Community Health Worker Core Consensus (C3) Project.[3] While the 2021 MiCHWA CHW Survey asked only about the ten core roles, the 2023 CHW Survey asked about each of the 36 sub-roles and included examples of each to facilitate a common understanding (see Appendix B, page 51).

"Sub-roles" are more specific activities that fall under the broader roles or role categories.

CHWs reported engaging in an average of 16 sub-roles either "often" or "very often," with a range from zero sub-roles to all 36. There were three sub-roles that more than three-quarters of respondents said they engage in often or very often:

1. Connecting to resources and advocating for basic needs (Role 5, sub-role b; 84%)
2. Motivating and encouraging people to obtain care and other services (Role 4, sub-role b; 82%)
3. Meeting basic needs (Role 7, sub-role c; 76%)

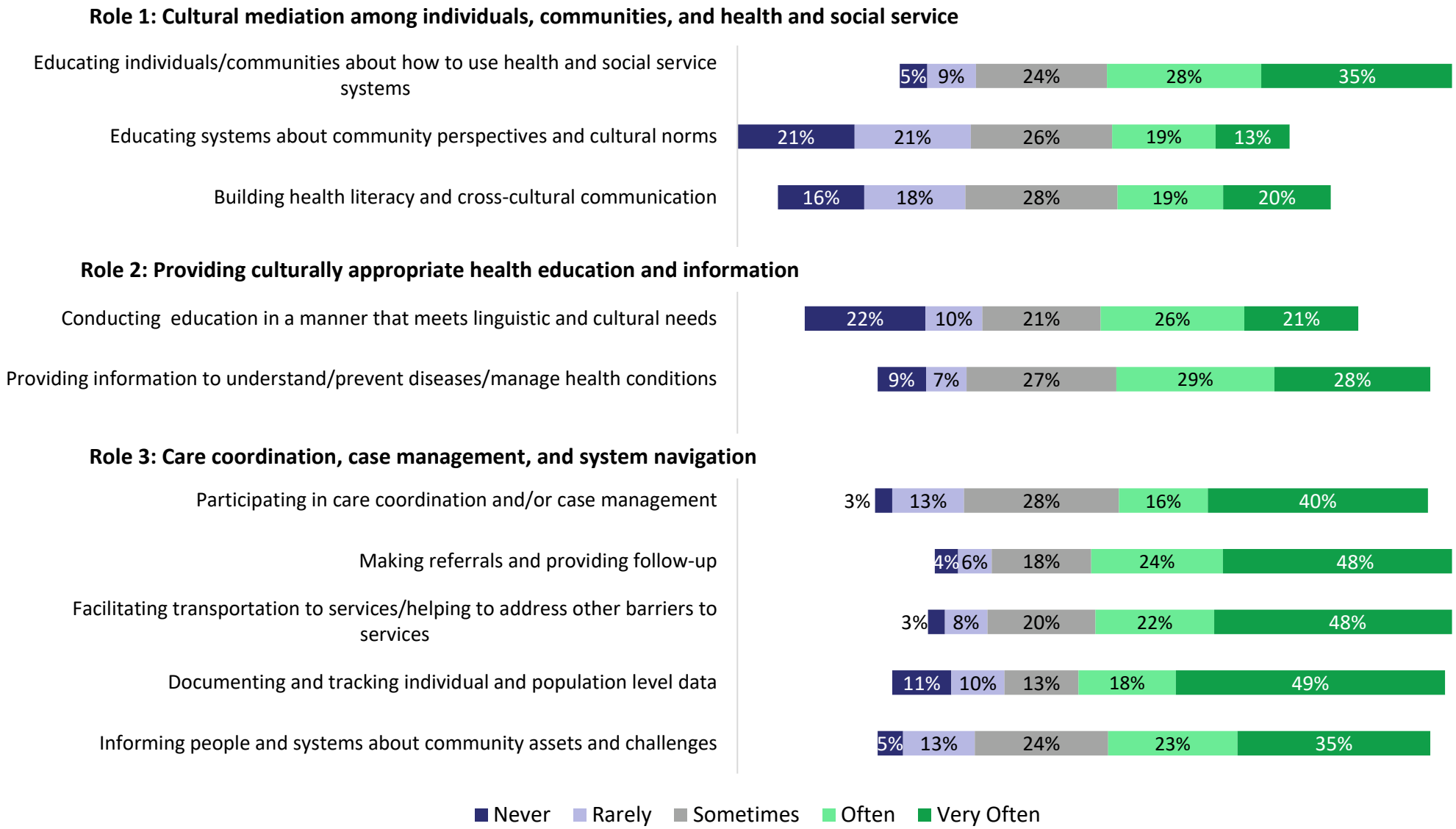
At least half of respondents said they engaged in 13 additional sub-roles often or very often.

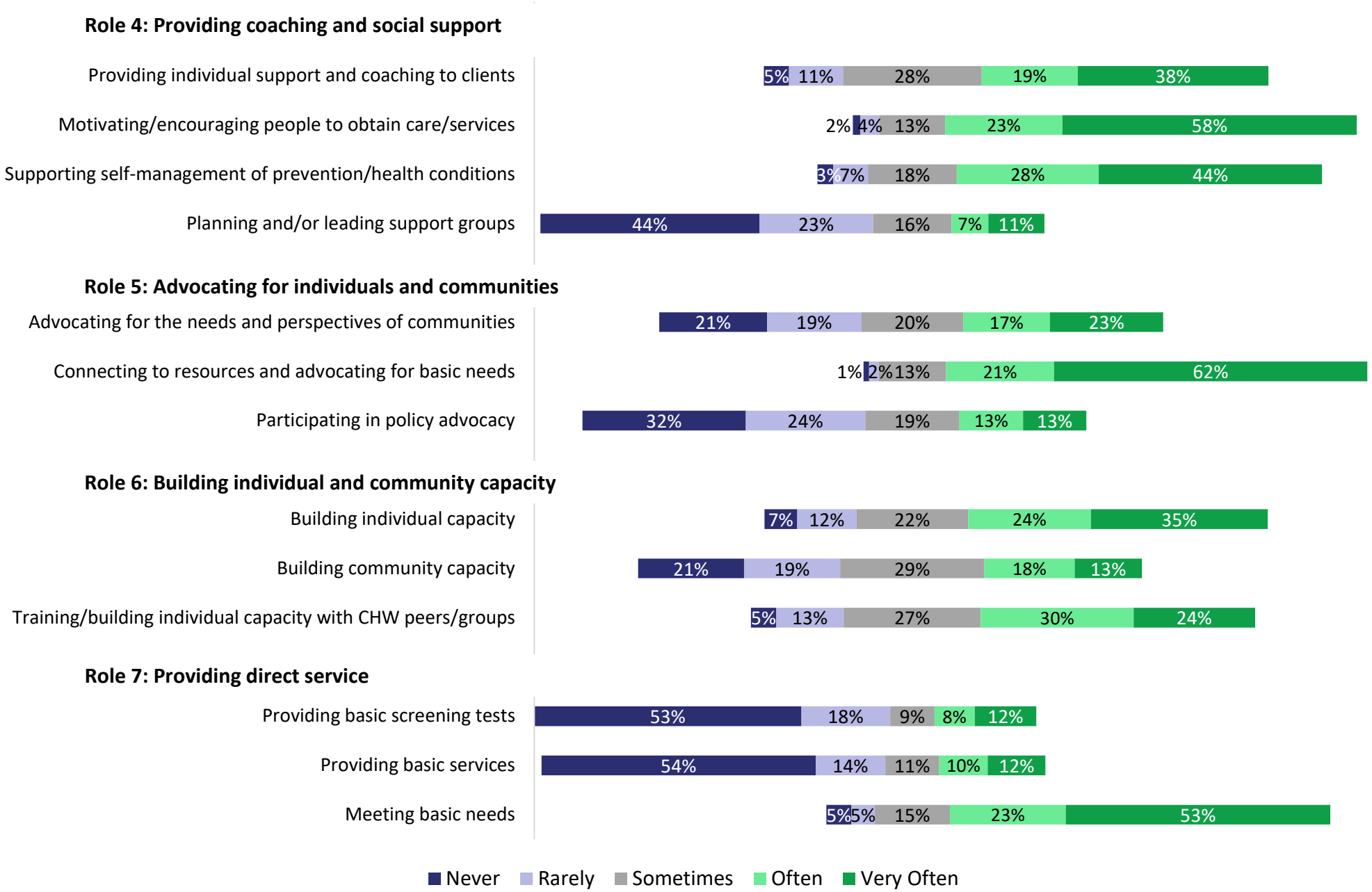
1. Supporting self-management of prevention/health conditions (Role 4, sub-role c; 73%)
2. Making referrals and providing follow-up (Role 3, sub-role b; 72%)
3. Facilitating transportation to services and/or helping to address other barriers to services (Role 3, sub-role c; 70%)
4. Documenting and tracking individual and population level data (Role 3, sub-role d; 66%)
5. Educating individuals/communities about how to use health and social service systems (Role 1, sub-role a; 63%)
6. Follow-up on health and social service encounters (Role 9, sub-role b; 61%)
7. Building individual capacity (Role 6, sub-role a; 60%)
8. Informing people and systems about community assets and challenges (Role 3, sub-role e; 58%)
9. Providing individual support and coaching to clients (Role 4, sub-role a; 57%)
10. Providing information to understand/prevent diseases/manage health conditions (Role 2, sub-role b; 57%)
11. Participating in care coordination and/or case management (Role 3, sub-role a; 56%)
12. Training/building individual capacity with CHW peers/groups (Role 6, sub-role c; 54%)
13. Case-finding/recruitment of people to services and systems (Role 9, sub-role a; 51%)

Figure 7 shows the frequency of engagement in all sub-roles. Overall, CHWs reported the greatest level of engagement in the sub-roles related to *Role 3: Care coordination, case management, and system navigation* and reported the lowest level of engagement in the sub-roles related to *Role 10: Participating in evaluation and research*. Within some of the core roles, engagement in the sub-roles varied widely. For example, within *Role 7: Providing direct service*, a large number of CHWs reported frequently meeting basic needs but few CHWs reported conducting screening tests or providing basic services on a regular basis.

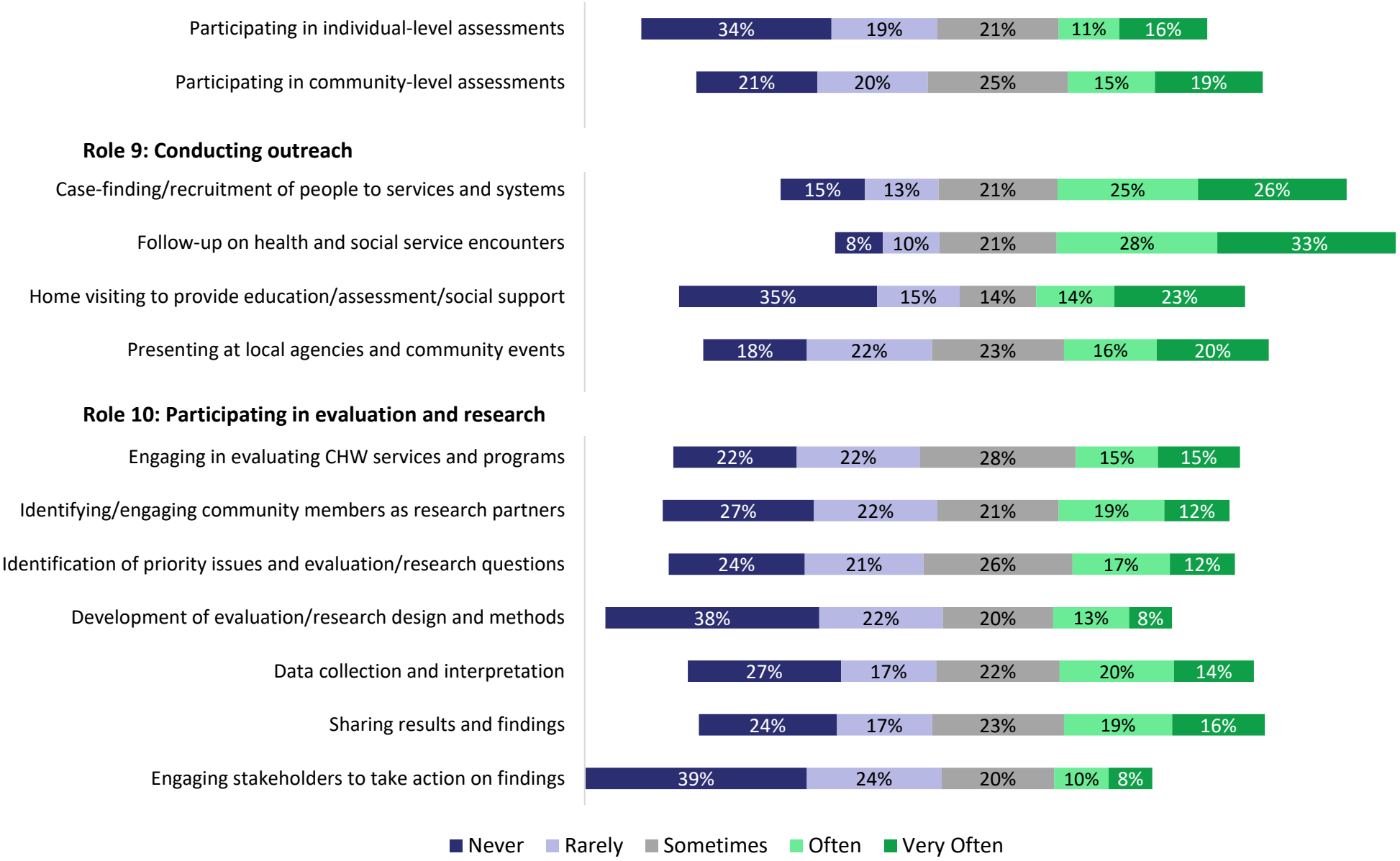
[3] For more information on Community Health Worker Roles, see https://www.c3project.org/roles-competencies.

Figure 7. Frequency of Engagement in CHW Roles (N = 262)




Role 4: Providing coaching and social support
Providing individual support and coaching to clients
5%
11%
28%
19%
38%
Motivating/encouraging people to obtain care/services
2%
4%
13%
23%
58%
Supporting self-management of prevention/health conditions
3%
7%
18%
28%
44%
Planning and/or leading support groups
44%
23%
16%
7%
11%
Role 5: Advocating for individuals and communities
Advocating for the needs and perspectives of communities
21%
19%
20%
17%
23%
Connecting to resources and advocating for basic needs
1%
2%
13%
21%
62%
Participating in policy advocacy
32%
24%
19%
13%
13%
Role 6: Building individual and community capacity
Building individual capacity
7%
12%
22%
24%
35%
Building community capacity
21%
19%
29%
18%
13%
Training/building individual capacity with CHW peers/groups
5%
13%
27%
30%
24%
Role 7: Providing direct service
Providing basic screening tests
53%
18%
9%
8%
12%
Providing basic services
54%
14%
11%
10%
12%
Meeting basic needs
5%
5%
15%
23%
53%
Never
Rarely
Sometimes
Often
Very Often

Role 8: Implementing individual and community assessments



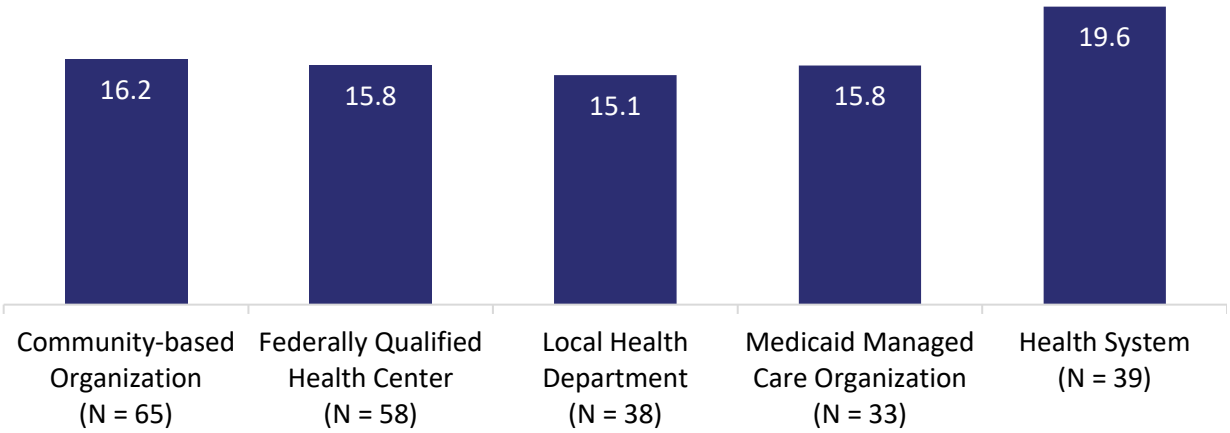
CHW Employer Survey Comparison

The employers responding to the 2022 MiCHWA CHW Employer Survey reported a higher level of engagement for the CHWs they supervised in almost all 36 sub-roles. On average, compared to the CHWs, 10% more of the employers reported that the CHWs in their program engaged in each sub-role often or very often.

The largest discrepancies were related to *Role 1: Cultural mediation among individuals, communities, and health and social service systems*, where the proportion of employers reporting frequent engagement in these sub-roles was 33 percentage points greater, on average, than the proportion of CHWs reporting frequent engagement. On the other hand, a slightly smaller proportion of employers reported frequent CHW engagement in the sub-roles related to *Role 10: Participating in evaluation and research*. For a full comparison, see Appendix A, Table 3.

The average number of sub-roles played often or very often was, for the most part, consistent across organization settings (15-16 sub-roles). CHWs based at Health Systems were the only group that appeared to have a somewhat higher average number of sub-roles played frequently (19.6), as shown in Figure 8.

Figure 8. Average Number of Roles Played Often/Very Often by Organization Setting



When respondents were asked, in an open-ended prompt, to share an example of something they accomplished in the role of a CHW that made an important difference for the individuals, families, organization or community served, the most common theme related to connecting people to services. Other themes were increasing access to resources, advocating for community needs, providing emotional support, utilizing personal lived experience, and facilitating care coordination. Selected examples of these themes are illustrated on the following page.

Figure 9. Selected Examples of Impacts CHWs Have Made

CHW Perspectives

Connecting to services

"Assisted with one of our patients that was struggling with homelessness, no income and other barriers, patient was living in a tent for a long time. Now, has shelter, food, behavioral health services, and assisted patient with filing for disability and was approved for Supplemental Security Income."

Increasing access to resources

"I've taken the lead in developing a new partnership between an elementary/middle school and the Food Bank of Eastern Michigan. We were able secure funding to start a food pantry at the school to make sure kids have food for the weekend if needed and/or snacks while at school."

Advocating for community needs

"Being invited to serve on two Board of Directors is a wonderful accomplishment as a CHW. I feel my CHW voice is heard. MY knowledge through training and community experience is respected. The important difference: when they hear my voice, they hear the voice of the people and community I serve."

Providing emotional support

"Overall, I am a good listening ear for those who are used to being ignored. I know this based on comments I receive from many of our members that I serve. They are grateful to have someone listen to them and feel understood. Sometimes this is all they need, beyond receiving physical assistance/resources."

Utilizing lived experience

"I have been in recovery for 4 years. Many of the clients I work with are many I used to actively use drugs within my addiction. Since taking on my role as CHW, I've been able to provide hope that change can happen but also help clients who have been in similar situations as I was. I've been able to provide a support to clients I wish I could have had in my addiction."

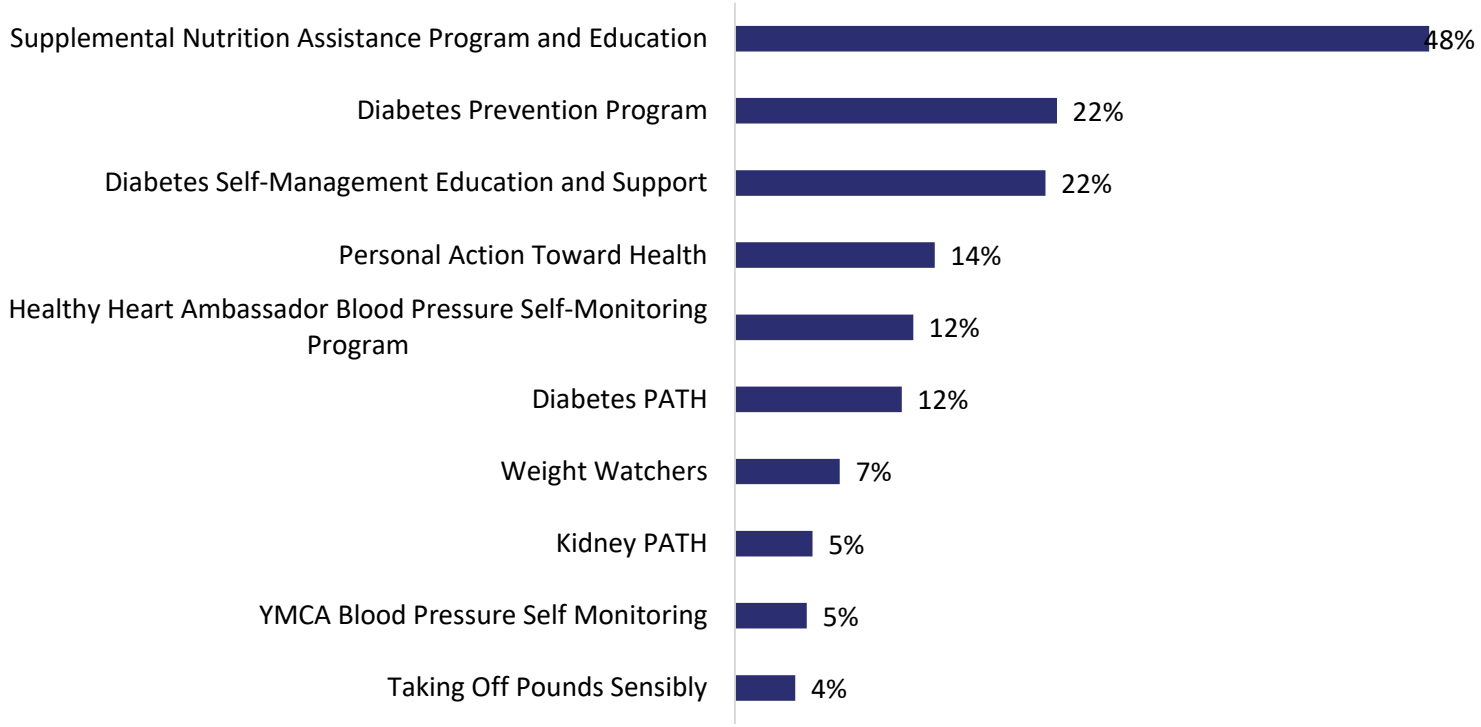
Facilitating care coordination

"Being able to assist the Hispanic population that don't have insurance or have a language barrier and being able to get them there preventative testing done. Just being able to get them checked before anything has fully develop is amazing."

Referrals

The 2023 CHW Survey asked CHWs, for the first time, whether they made referrals to a series of listed lifestyle change programs. **Nearly half of respondents reported making referrals to Supplemental Nutrition Assistance Program Education (SNAP-Ed)**, as shown in Figure 10. Approximately one-third of CHWs reported not making any referrals and another third, approximately, (30%, *n* = 78) reported referring to just one program. Twenty-one CHWs said they made referrals to five or more programs, including five that referred to all ten listed programs.

Figure 10. Percent of CHWs Making Lifestyle Change Program Referrals (N = 259)



CHW Caseloads

CHWs were asked to estimate the average caseload of clients they actively served at any one time. **More than two-thirds reported serving 60 clients or fewer** (68%, *n* = 176), as shown in Figure 11. At the other end of the spectrum, six CHWs wrote in that they were serving more than 500 clients, including as many as 100,000. Open-ended comments showed that the concept of an average caseload does not apply to all CHWs. Eleven people wrote that they do not have a caseload and another four wrote in that their caseload varies too widely to be able to estimate an average.

Figure 11. Number of CHWs by Average Caseload of Clients Actively Serving (N = 259)

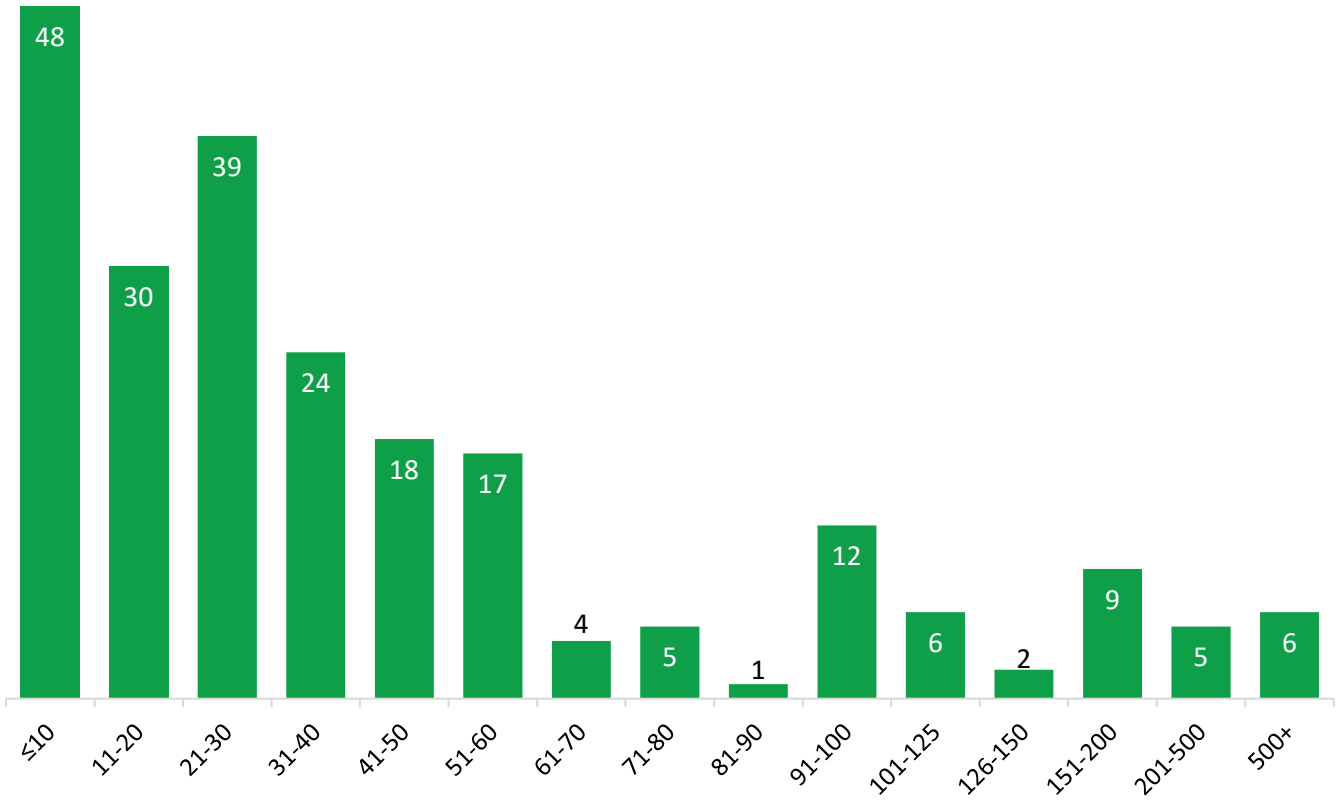
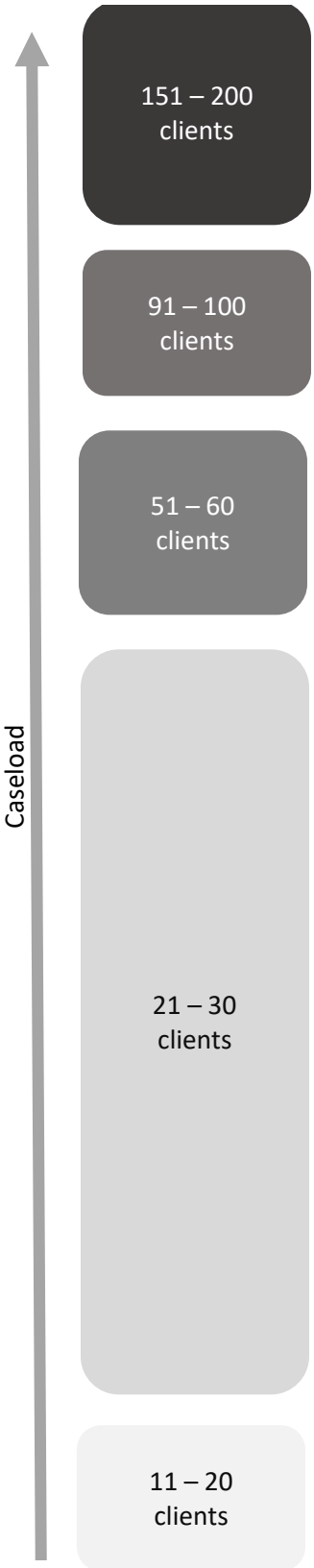


Figure 12 shows selected descriptions CHWs gave of their roles alongside the average caseload they reported. The descriptions demonstrate some of the reasons that specifying a caseload is difficult, including engaging with clients in different capacities, no ongoing contact with clients, and sharing client rosters with other CHWs.

Figure 12. Average Caseloads and Selected Illustrative Quotes



"The caseload depends on who accepts assistance. Our company assigns 5,000 members for every 1 CHW. Each day about 30 people are contacted and a limited number request assistance with services. Additionally, inbound calls from members are received for additional assistance. The caseload is manageable for the time being."

"In my current role, I am more of an outreach CHW who determines needs/assists with some of the needs and then if applicable refers members out to an assigned CHW for more extensive assistance."

"I work in the Medicare team with [organization] and when I get a referral, I work with the member maybe once or twice. At times I will stay with a member for a few weeks, but I don't normally keep a caseload."

"I have a caseload of 25 - 30 clients, also I am in a program where we basically help [Health Plan] with a list of 200 calls per month to know if they are receiving Food Assistance or if they have the need to find food or other resources. I also participate in a grant granted by the Health Dept to help refugees with vaccines and other resources."

"Typically, I see 8-10 clients in their home weekly and then conduct follow up phone calls with each of them so some weeks I can see the 8-10 clients in their home and have 24-30 follow up phone calls."

"Being a CHW that is attached to a Pediatrics department at a FQHC, the caseload can be atypical compared to other CHWs who may maintain a more consistent and ongoing roster such as with hypertension or diabetes management programs. Working with children also means working with the family which more closely resemble social work and case management."

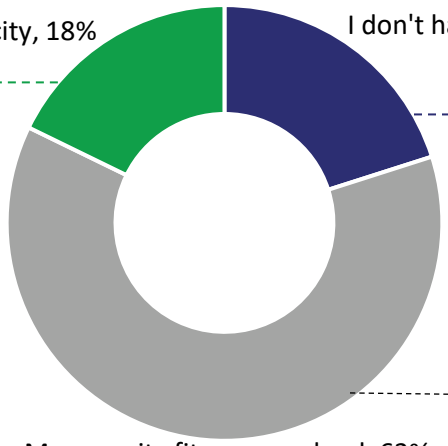
"I work in the emergency department and meet with 10-20 patients a day. I will evaluate and make referrals to other CHW's to follow up if needed, I have limited capacity to follow up in my current role."

As shown in Figure 13, **the majority of responding CHWs (62%) indicated that their capacity fits the number of clients they are actively serving**. However, about one-fifth of responding CHWs indicated they had capacity to serve more clients and approximately the same proportion indicated they do not have enough capacity to adequately serve all of their current clients.

Figure 13. Perceived Capacity Relative to Caseload (N = 259) and Illustrative Comments

"Caseload is mainly low-income families that need assistance with health insurance, housing, utilities, and food. They also need help applying for these services. There are also a few elderly clients that need assistance with the online process of applying for assistance. Currently, my caseload is too low for the time that I have available due to the program being new in our area. We are being told that a typical caseload for a FT CHW is between 40-60 clients. I, however, feel that is actually low, especially for our area. A caseload of a 100 is more what I would have in mind for a normal caseload and feel that is definitely a doable caseload."

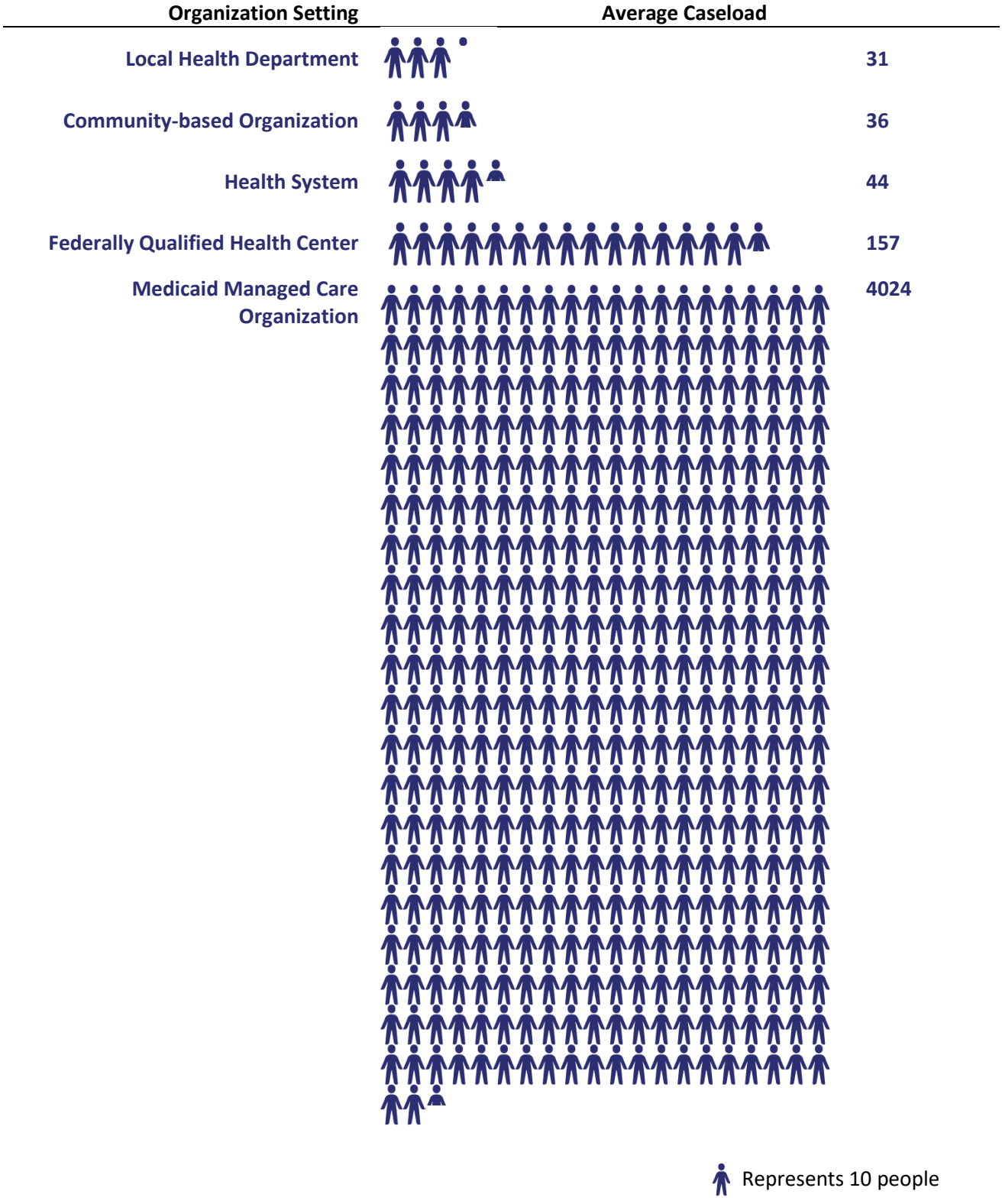
"[I] have a caseload of 100 consumers. This is excessive to what can be accomplished with 1 CHW and still provide the 1 on 1 work that needs to be done with each consumer."



"It's a blessing to serve a population I was once a part of."

Caseloads varied substantially by organization setting, as shown in Figure 14. Average caseloads for CHWs based in local health departments, community-based organizations, and health systems ranged from the low-30s to the mid-40s. In contrast, average caseloads for CHWs at Federally Qualified Health Centers were nearly triple this, with an average of 157, and average caseloads for CHWs at Medicaid Managed Care Organizations were nearly ten-fold higher, with an average of 4024.

Figure 14. Average Caseload by Organization Setting

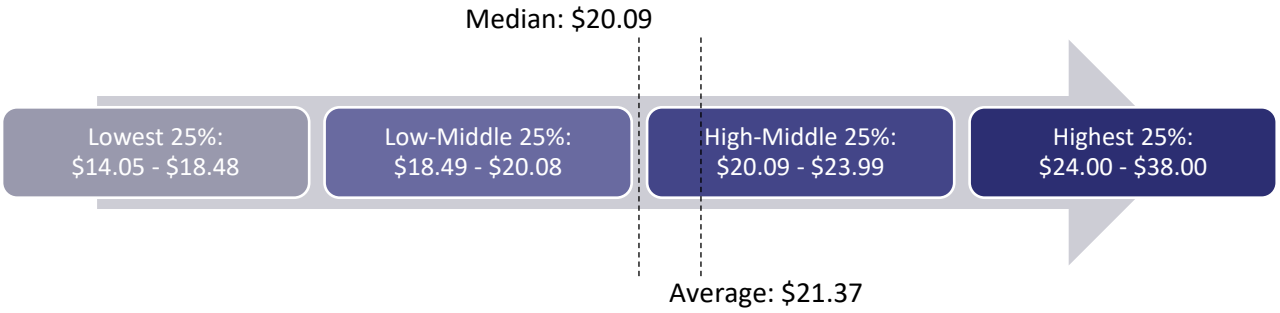


CHW SALARIES AND JOB SECURITY

CHW Compensation

CHWs were asked to share either their hourly rate of pay or their annual salary. There were 114 people that reported an hourly rate, 22 people that reported an annual salary, and 71 people that reported *both* an hourly rate and an annual salary.[4] After excluding two outliers,[5] **reported compensation ranged from $14.05 to $38.00 an hour, with an average of $21.37**. Figure 15 shows the hourly rate ranges when respondents are divided into four equal groups (quartiles). The median of $20.09 means that half of respondents were making less than $20.09 per hour. A quarter of respondents reported wages of $18.48 or less per hour.

Figure 15. CHW Compensation Ranges (N = 207)



Among the responses to the open-ended question on concerns relevant to CHWs, **low pay was by far the most prominent theme**, mentioned by 21 of the 59 people who listed a concern. Some of these comments are shown below.

Figure 16. Selected Comments Expressing Concern with Low Pay

CHW Perspectives

"The level of pay for individuals who serve as CHW is not sufficient for the work they perform. CHW are often at risk while serving at risk populations. Many CHWs go above and beyond to ensure the need of their clients are met."

"I am currently being paid $27 an hour under a grant. If hired internally, my pay would decrease to between $14-$24 max. We do hard work to not be paid more."

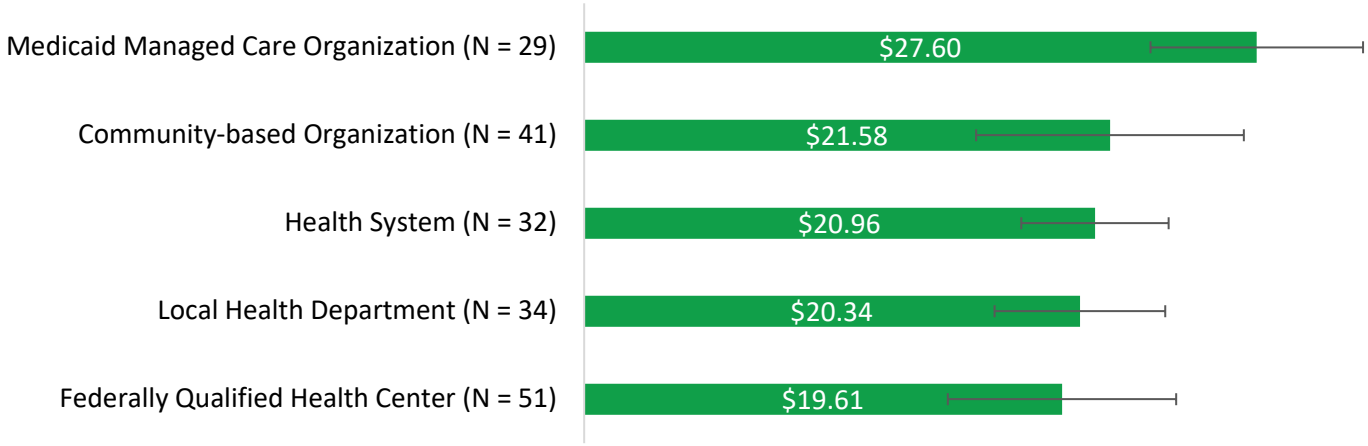
"We are more of a provider then a worker. Would be nice if pay scale reflected that. It can be very discouraging when you are helping others but you yourself are struggling."

[4] Because some respondents reported both an hourly rate and an annual salary, we were not able to determine the proportion of respondents with each of these compensation structures. However, to maximize our ability to compare compensation across the largest number of respondents, we utilized the response for hourly rate for all those who reported hourly rate or both an hourly rate and salary. For those who only reported an annual salary, we converted the figure reported to an hourly rate based on a 40-hour work week.

[5] Two extreme outliers were excluded from the compensation analyses: $46.20/hour and $48.00/hour.

Survey findings pointed to some variation in compensation by organization setting, as shown in Figure 17. While average rate of pay and standard deviation[6] were similar for four out of the five organization settings, CHWs at Medicaid Managed Care Organizations reported a higher rate of pay on average.

Figure 17. CHW Average Compensation and Standard Deviation by Organization Setting



2021 and 2023 Comparison

Dividing the salary and hourly rate responses into the wage categories used in the 2021 MiCHWA CHW Survey allows for a comparison across the two survey years, as shown in Figure 18.[7] Although sample sizes are small, this figure indicates increases in the proportion of CHWs paid at $22.50 per hour and above across all five organization types shown. However, the increase in the proportion of CHWs in this highest earning category was most notable at Medicaid Managed Care Organizations.

Together Figures 17 and 18 show that wages at Medicaid Managed Care Organizations are notably higher than wages at other settings. The increase in the proportion of respondents from Medicaid Managed Care Organizations in the 2023 survey sample means that the wages from the CHWs in these organizations drove up overall averages across the sector.

[6] Standard deviation is a measure that is used to show how close the data points are to the mean or average. When the standard deviation is high, there are more data points farther away from the mean. When the standard deviation is low, the data points are clustered more closely towards the mean.

[7] This figure converts the annual salary responses to the 2021 Survey into hourly rates for a more complete comparison.

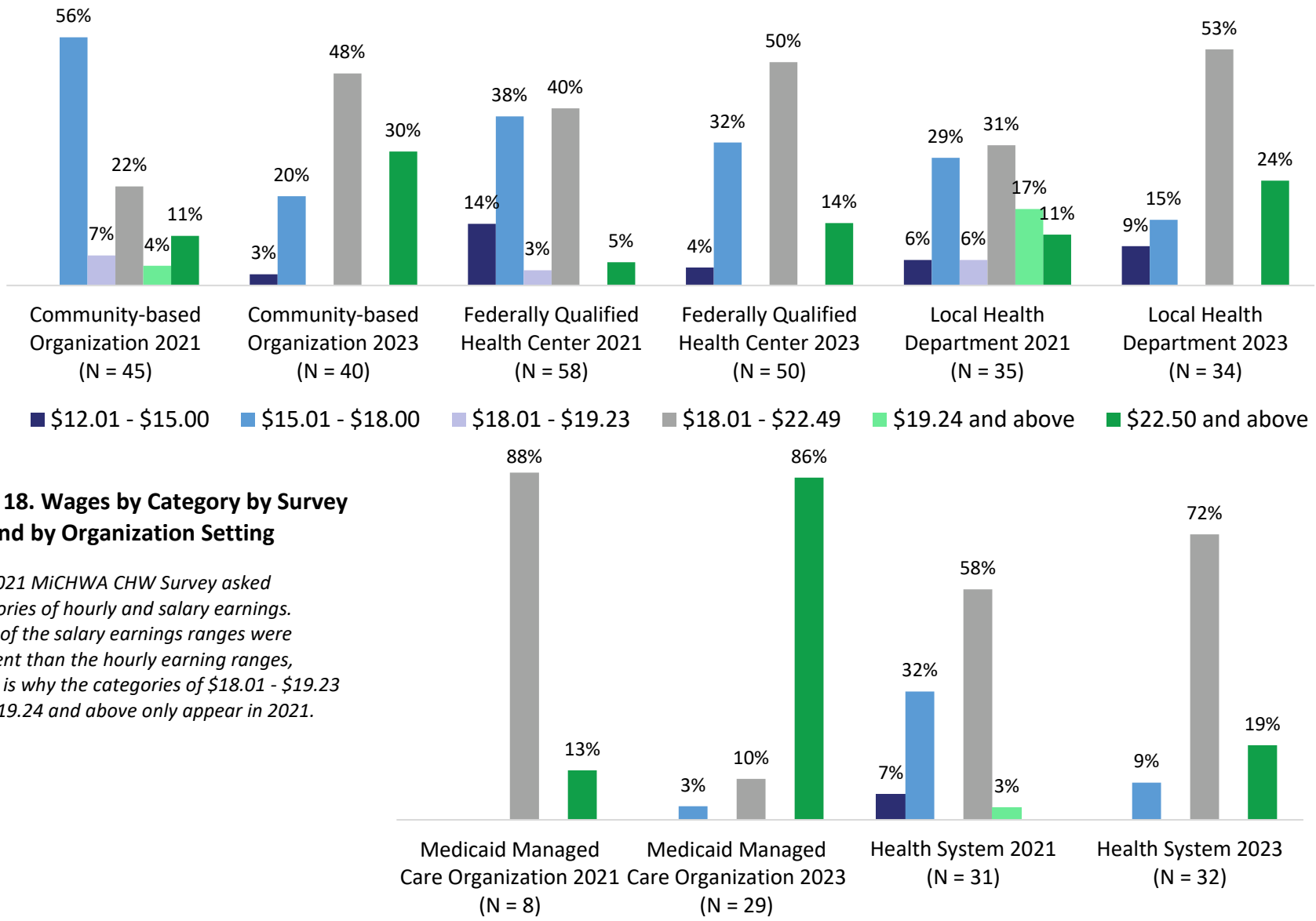
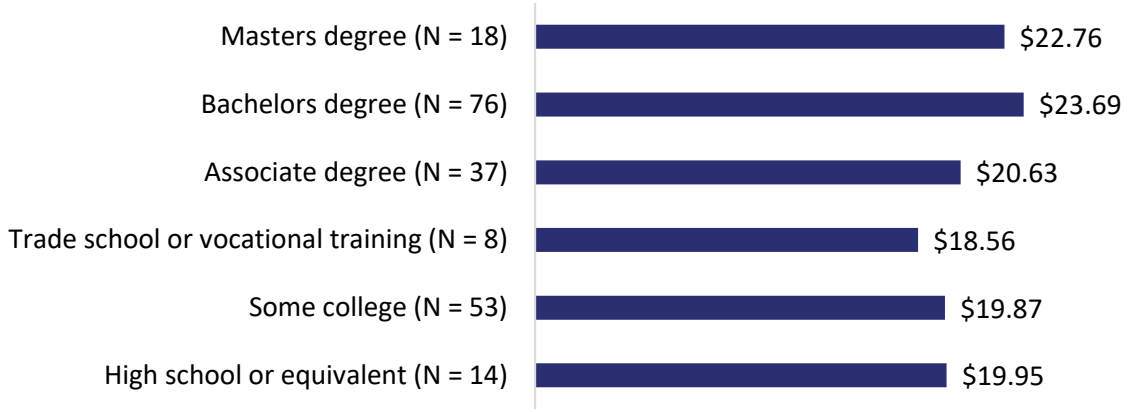


Figure 18. Wages by Category by Survey Year and by Organization Setting

The 2021 MiCHWA CHW Survey asked categories of hourly and salary earnings. Some of the salary earnings ranges were different than the hourly earning ranges, which is why the categories of $18.01 - $19.23 and $19.24 and above only appear in 2021.

Pay rate also varied by level of education. As shown in Figure 19, the average hourly rate was highest for CHWs with bachelor's and master's degrees and lowest for those who had not completed a college degree. The average hourly rate did not differ meaningfully between the CHWs with a high school degree and the CHWs with some experience in college. It is not clear, however, whether these differences in rate of pay reflect differences in roles or whether compensation increases within a given role or position if a CHW has a higher level of education.

Figure 19. Wages by Category by Survey Year and by Organization Setting



We did not find any relationship between racial and ethnic identity and rate of pay. Average compensation was nearly identical for CHWs identifying as White and CHWs identifying as Black, Asian, American Indian, Latinx, or Arab American.

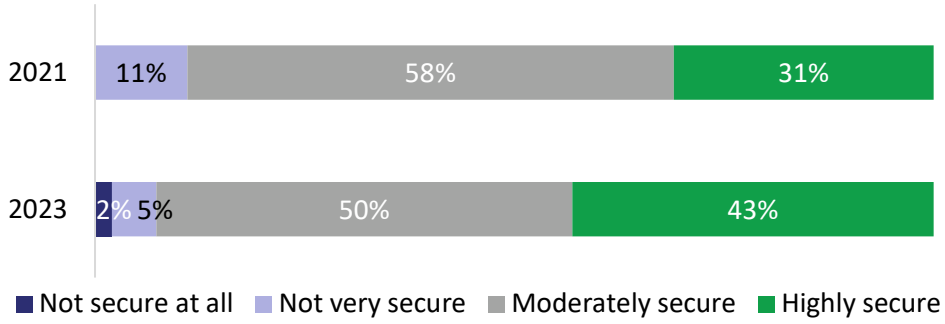
Similar to 2021 CHW Survey findings, we did not find a consistent relationship between pay rate and ability to provide services in other languages. The eight people who reported providing CHW services in either Arabic or another language named by the respondent had a slightly higher average pay rate. However, the 25 people who reported providing services in Spanish had an average pay hourly rate about $1.00 lower than other respondents.

Layoffs and Job Security

Thirteen CHWs said they had been laid off or furloughed because project funding had ended, including one person who was laid off more than two times. This proportion of survey respondents (5%) is similar to the proportion that reported being laid off in 2021 (7%). Also following the pattern seen in 2021, the CHWs who reported being laid off had served as a CHW for a greater number of years, on average. Compared to an average of 4.2 years for those who had never been laid off, the 12 people who had been laid off once or twice had been CHWs for an average of 5.8 years and the one person who was laid off more than twice had been a CHW for 22 years. In other words, serving as a CHW for a longer period of time may increase the likelihood of being laid off at some point.

The survey asked CHWs to "rate the security of your job at this time." The proportion of CHWs who reported feeling their job was "highly secure" increased from the 2021 survey responses, as shown in Figure 20.[8] However, much of this increase could be attributable to the larger number of responses from CHWs at Medicaid Managed Care Organizations in the survey sample, since 100% of the CHWs at these organizations reported either a moderate or high level of job security. In contrast, **CHWs at Community-Based Organizations or Nonprofits reported the lowest level of job security**, with 16% of CHWs saying they felt not at all or not very secure. (For full comparisons by organization setting, see Appendix A, Table 4, pp. 49.) Across the whole survey sample, more than half of CHWs reported some level of job insecurity.

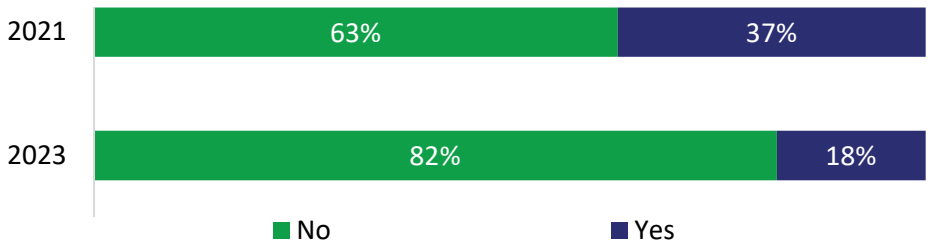
Figure 20. CHWs' Perception of Job Security in 2021 (N = 220) and 2023 (N = 246)



Additional Jobs

A total of 44 people reported working for pay in a position other than as a CHW. Of these, 37 were also paid, full-time CHWs, two were paid, part-time, three were on-call only, and two volunteered. The proportion of CHWs who indicated that they have a second job dropped in half compared to the proportion seen in 2021. In other words, as seen in Figure 21, proportionally fewer CHWs reported working a second job. However, some of this decrease could be due to a change in question language. In 2021, multiple people described working on tasks unrelated to their CHW role but within the same position. In 2023, the survey clarified that the question was only asking about distinct positions at separate worksites.

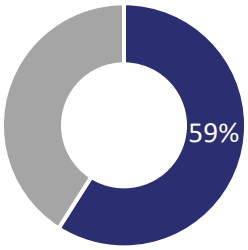
Figure 21. Percent of CHWs with a Second Job in 2021 (N = 220) and 2023 (N = 246)



[8] "Not secure at all" was not included as a response option on the 2021 survey.

The most common reason for working a second job was to earn additional money. Among the 44 people with a second job, nearly 60% said they work at another job to supplement their income as a CHW, as shown in Figure 22. We did not, however, find any meaningful difference in the average compensation rate for those who reported working a second job and those who did not. Other reasons for holding a second job included Community Health Work not being their primary occupation (11 people) or that they volunteered as a CHW (5 people).

Figure 22.Percent of CHWs who have a Second Job in order to Supplement Their Income (N = 44)



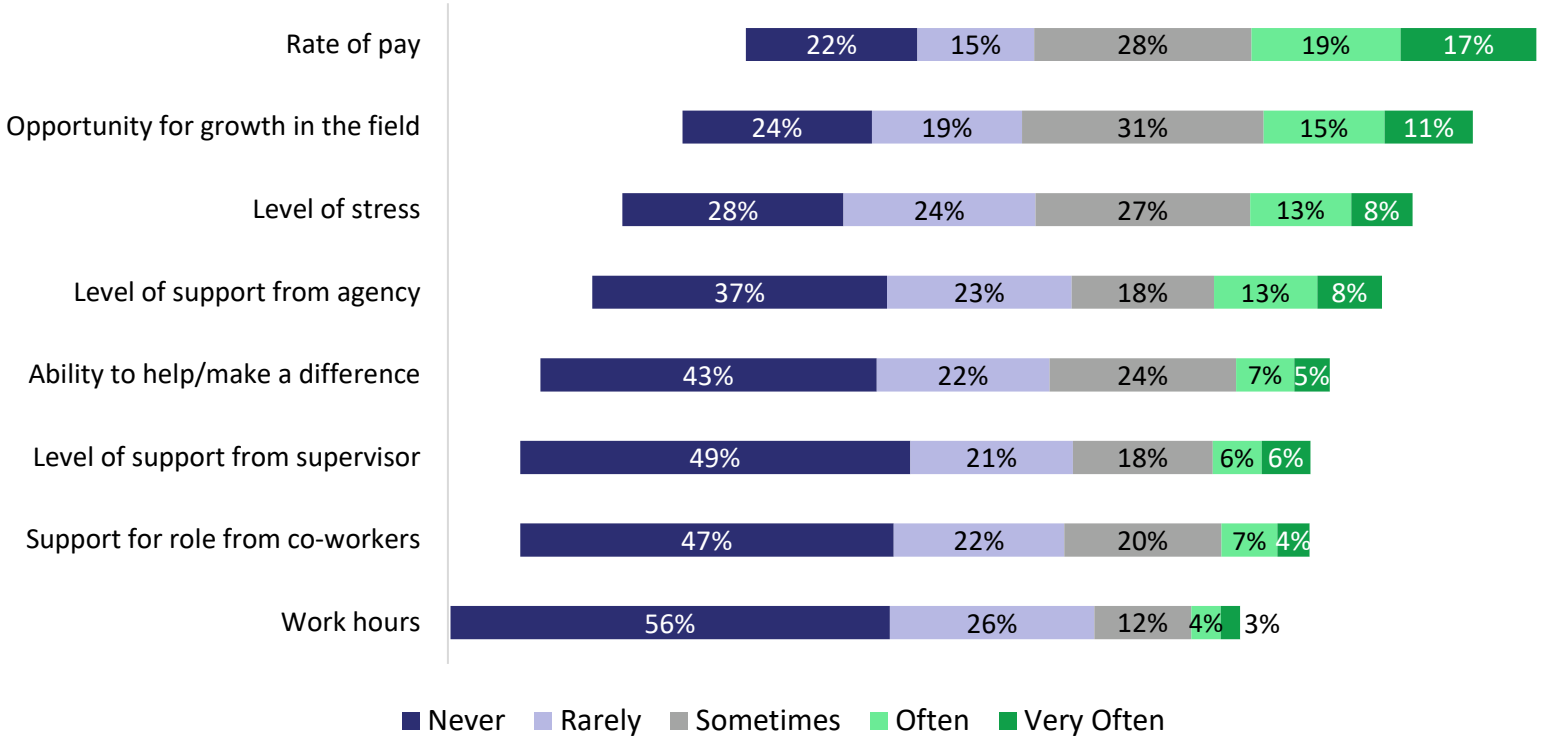
CHW Perspectives

"Upskilling, paying for university, and maintaining an okay standard of living is not feasible with current pay. More and more employers in the American workplace require increasing levels of education, skills, and training that they are not willing to share in the cost of."

Sustainability of CHW Positions

When asked to select potential reasons for leaving the CHW profession in the 2021 MiCHWA CHW Survey, more than half of respondents selected low pay and job burnout. In order to better understand the prevalence and potential impact of these feelings, the 2023 CHW Survey asked CHWs to indicate how often they felt inclined to quit in relation to these and other factors. **Nearly two-thirds of respondents indicated they at least sometimes felt inclined to quit because of the rate of pay,** including more than a third who felt inclined often or very often. (See Figure 23.) Feeling inclined to quit because of the limited opportunities for growth in the field was also prevalent, with 27% of CHWs reporting this often or very often.

Figure 23. Frequency of Feeling Inclined to Quit by Factor (N = 237)



Many of the descriptions given in relation to "other" factors helped illuminate the factors listed, such as those shown below in Figure 24. The three new factors listed, each named by one person, were a lack of training, lack of job security, and a feeling of isolation from not being able to interact with peers.

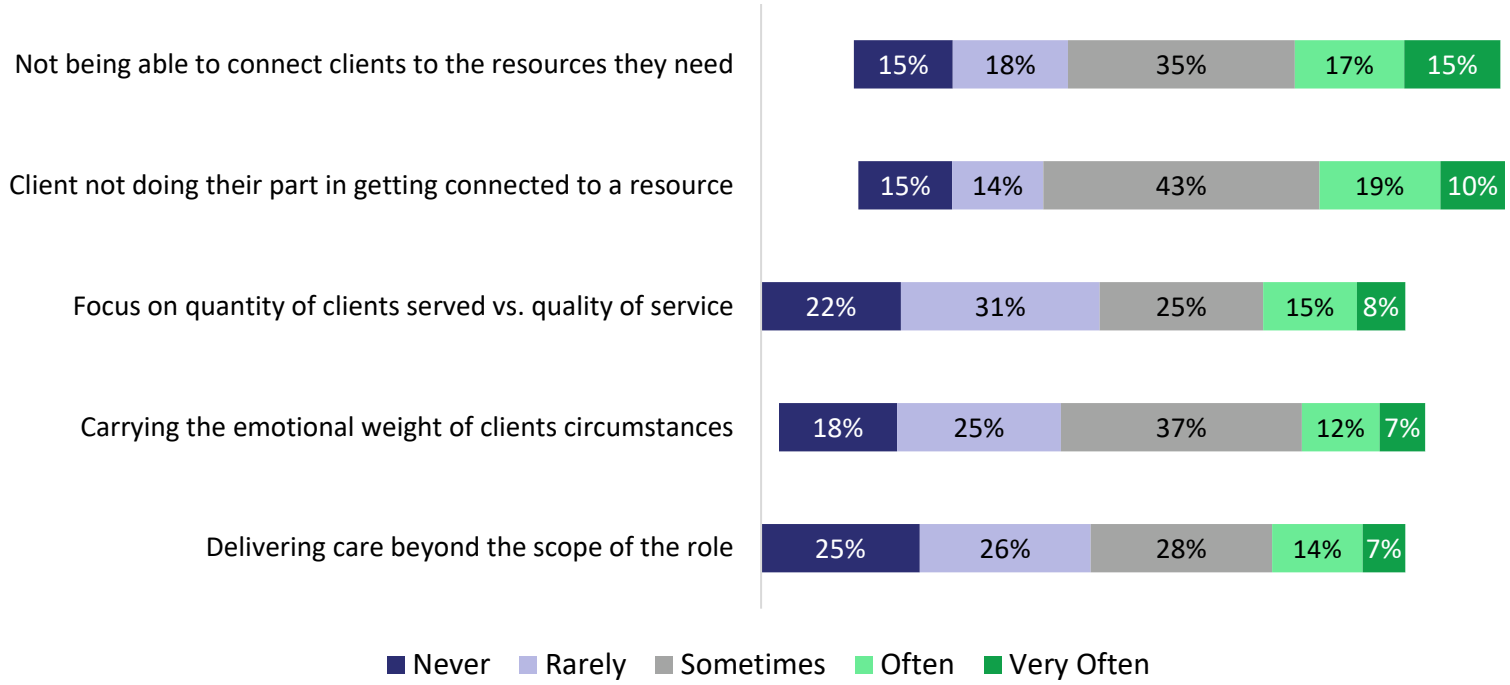
Figure 24. CHW Comments on Factors Leading to Inclination to Quit

Building on unpublished data from a qualitative study conducted with Michigan CHWs in 2022, the 2023

CHW Survey also asked, for the first time, about CHWs' experiences of burnout. Responses showed that approximately 30% of CHWs reported often or very often feeling burnt out due to the difficulty of connecting clients to needed resources, whether because of limits of the program or because of clients not following through with the resources offered. In the open-ended question on concerns relevant to CHWs, five people also commented on the challenge of not having adequate resources to help clients.

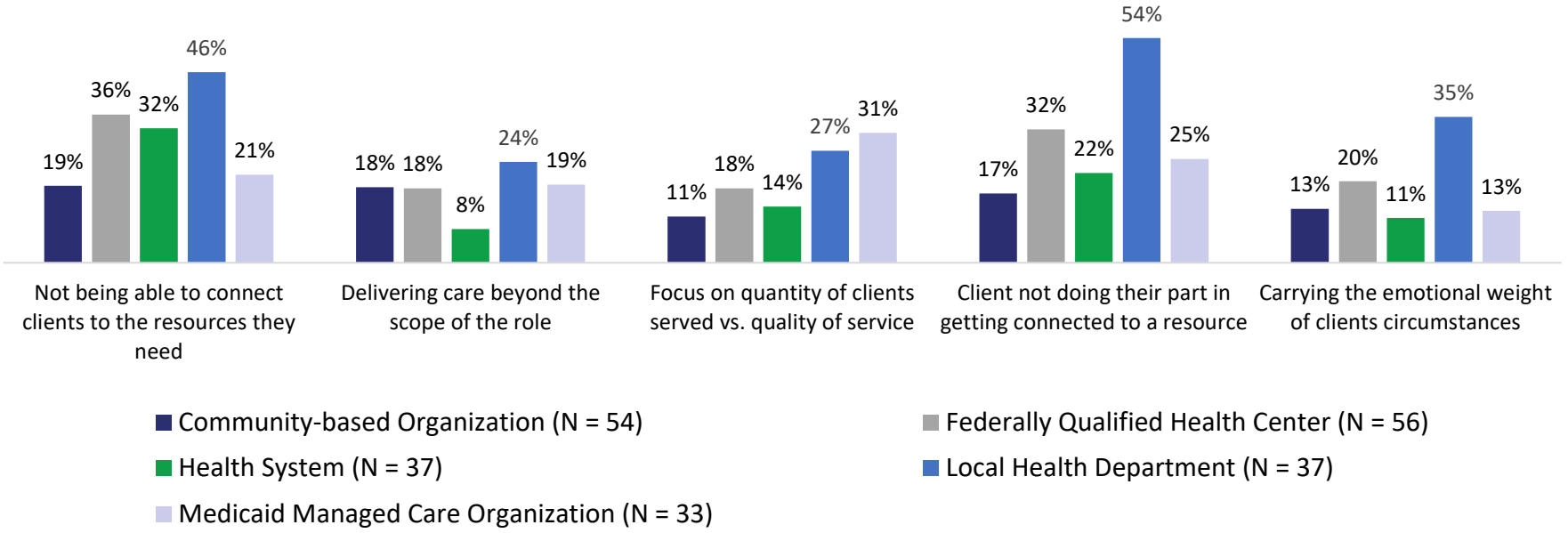
Figure 25 also shows that approximately one-fifth of CHWs reported often feeling burnt out due to the other named factors. While 15 people reported at least sometimes feeling burnout due to other factors, only three people wrote in descriptions of these other factors: "affordable housing is a huge issue;" "high level of need from clients;" and "inefficiency and ineffectiveness of the program."

Figure 25. Frequency of Feeling Overwhelmed or Burnt Out by Factor (N = 242)



To better understand factors driving feelings of burnout, we compared CHWs who indicated feeling burnt out either often or very often to those who did not. We saw minimal differences in the number of sub-roles played frequently or in the average compensation rate. The CHWs who reported burnout had served in the role for a slightly shorter time period than those who did not report burnout, indicating that people less prone to burnout may remain in the field for a longer period of time. We also saw that the CHWs who reported burnout had lower average caseloads, which may relate to a deeper level of emotional engagement with each client. The most notable differences between CHWs experiencing burnout often or very often and those who did not report those feelings, were by organization setting, as shown in Figure 26. For four out of the five factors, CHWs at local health departments were more likely to report experiencing burnout.

Figure 26. Percent of CHWs Feeling Overwhelmed or Burnt Out Often or Very Often by Factor and Organization Setting



The number of counties served also related to feelings of burnout. **Across all five factors, the CHWs who said they "often" or "very often" felt burnt out served a greater average number of counties.** The largest difference was in carrying the emotional weight of clients' circumstances, with those indicating frequently feeling burnt out for this reason serving an average of 3.8 counties compared to an average of 2.4 counties for those who did not.

The open-ended question at the end of the survey on concerns relevant to CHWs surfaced another factor that may lead to burnout or an inclination to quit for some CHWs: personal safety. **Five people described concerns related to personal safety** when visiting clients. For example, one person said:

CHW Perspectives

"The only concern would be physical safety for the CHWs when going into homes. We go into homes by ourselves and sometimes there are some unsafe environments."

TEAM INTEGRATION AND CAREER DEVELOPMENT

When asked to respond to six statements related to opportunities for career advancement, **the large majority of CHWs agreed that they have opportunities to develop their professional skills.** However, far fewer CHWs agreed they had opportunities to for more direct career advancements. As shown in Figure 27, less than half of respondents agreed that any of the other listed opportunities were available and about one quarter of respondents disagreed. (Other respondents not represented in the graph indicated they were neutral on these statements.)

2021 and 2023 Comparison

The percentages of CHWs agreeing with the career advancement statements were very similar to the percentages agreeing in 2021. However, the percentages of CHWs disagreeing in 2023 were higher for all but one item, which was nearly unchanged. For example, 26% of CHWs disagreed that there were good opportunities for advancement in the profession in 2023, whereas 16% of CHWs disagreed in 2021. (For the full comparison, see Appendix A, Table 5, p. 50.)

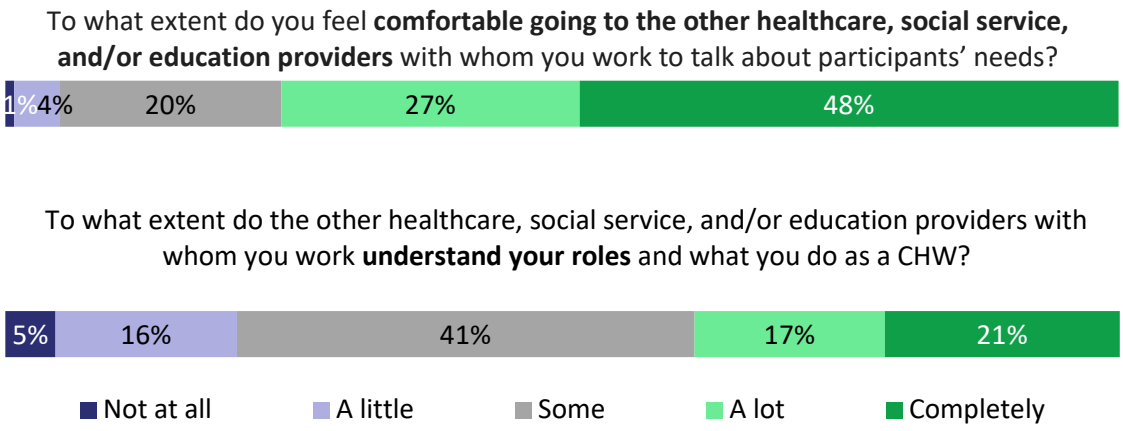
Figure 27. CHW Agreement with Career Advancement Statements (N = 250)

The 2023 Survey included two new questions relating to the extent of CHWs' integration into care teams. The findings show that three-quarters of responding CHWs reported feeling comfortable (either "a lot" or "completely") going to other providers to discuss participants' needs. On the other hand, just over one-third of CHWs had the same level of confidence that the providers they work with understand their role as a CHW. (See Figure 28.) In open-ended comments about concerns in the field, six people expressed frustration with a lack of understanding of their roles among both providers and community members. For example, one person said:

CHW Perspectives

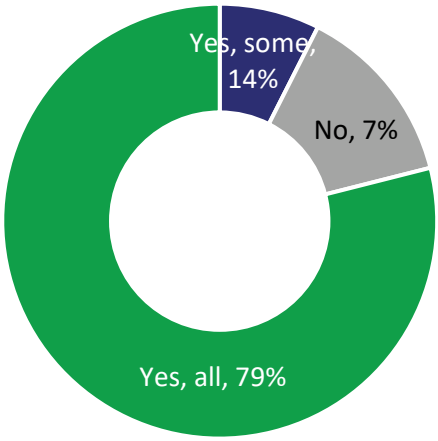
"CHW's are often underutilized and given clerical tasks (i.e., data entry or appt reminder calling) that leave little time for actual patient needs assessment or assistance."

Figure 28. Indicators of CHW Integration (N = 246)



The 2023 CHW Survey also included a new question about the extent to which CHWs record information within electronic health records or similar participant tracking systems. Three people said such a system does not exist and 18 people said "not applicable." Among the 228 CHWs who indicated their organization has a tracking system, the majority said they are able to input all relevant information. (See Figure 29.) Only 17 people (7%) reported not being able to record any client information in a tracking system.

Figure 29. CHW Utilization of Participant Tracking Systems (N = 228)



Are you able to record information about your clients in your employers' main participant tracking form/system (e.g., electronic health record)?

CHW TRAINING AND CONTINUING EDUCATION

MiCHWA Core-Competency Based Training

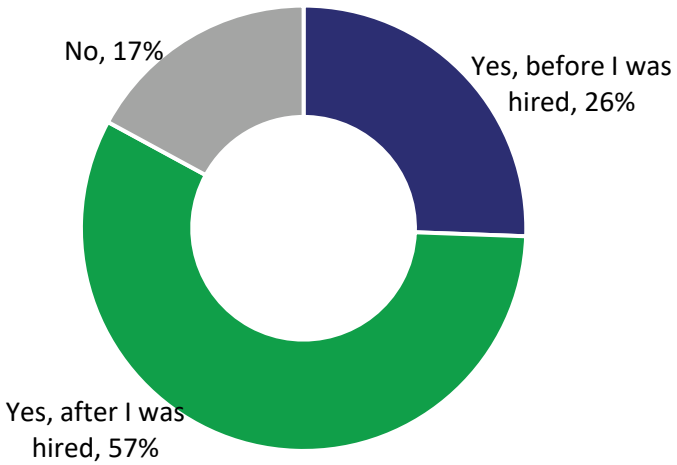
More than four out of five CHWs indicated they had completed the MiCHWA 126-hour core-competency based training program either before or after being hired as a CHW (83%, *n* = 214), as shown in Figure 30.

Of the 44 people reporting they had not completed the MiCHWA core-competency training, the largest number (64%, *n* = 27) indicated they had not completed any certification core-competency training. Nine people said they received MiCHWA certification through a grandparenting process. Two people reported completing core-competency training in other states and two people reported completing core-competency trainings from other organizations after being hired.

2021 and 2023 Comparison

A slightly smaller proportion of respondents indicated completing the MiCHWA 126-hour core-competency based training program either before or after being hired in 2023 (83%) than in 2021 (92%). However, **the proportion of respondents indicating they completed the training before being hired doubled from 2021 (13%) to 2023 (26%)**.

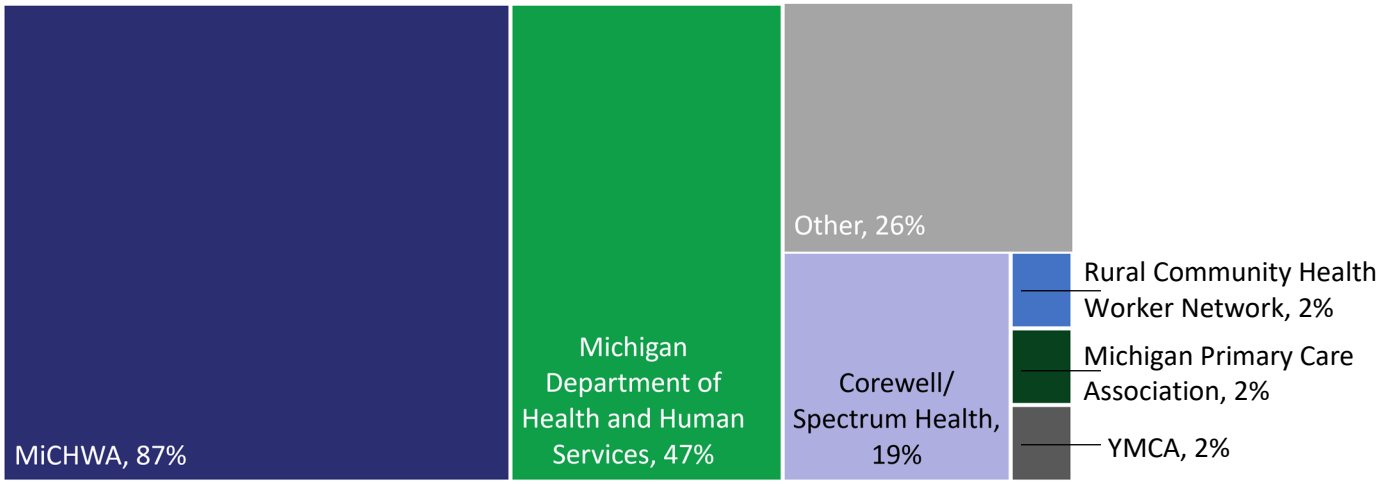
Figure 30. Completion of the MiCHWA Core-Competency Based Training Program (N = 258)



Continuing Education

Three-quarters of CHWs said that their employer requires them to maintain CHW continuing education credits (75%, *n* = 191). When asked from which sources they had received continuing education training, MiCHWA was by far the most common response, as shown in Figure 31.[9] In addition, nearly half of respondents said they had received continuing education from the Michigan Department of Health and Human Services. All of these findings are similar to those from the 2021 MiCHWA CHW Survey. (See Appendix A, Table 6, p. 50.)

Figure 31. Sources of Continuing Education (N = 240)



Collectively, 35 people named 28 different organizations from which they had received continuing education. In addition, six people described general sources of education, such as "online trainings," and five people indicated their employer provided internal trainings.

The final question in the Continuing Education Section, which was new to the 2023 Survey, asked about interest in potential MiCHWA-sponsored activities to support emotional well-being. While MiCHWA does not currently offer any of these activities, they hope to use the responses for planning purposes. The two activities that generated the greatest interest were, first, quarterly or semi-annual networking and social events for CHWs across Michigan and, second, opportunities to learn of other CHWs' experiences throughout the state, as shown in Figure 32. Figure 33 shows additional activities that CHWs suggested.[10]

[9] The Michigan Victims Advocacy Network (MiVAN) was listed as a source of continuing education in the survey instrument but was only selected by one person and is not represented in Figure 31. The Michigan Primary Care Association and the Rural Community Health Worker Network were not listed as options in the survey but were each noted by four people and are therefore included in the figure.

[10] The activities listed without a number were each mentioned by one person.

Figure 33. CHW Interest in Activities to Support Emotional Well-Being (N = 241)

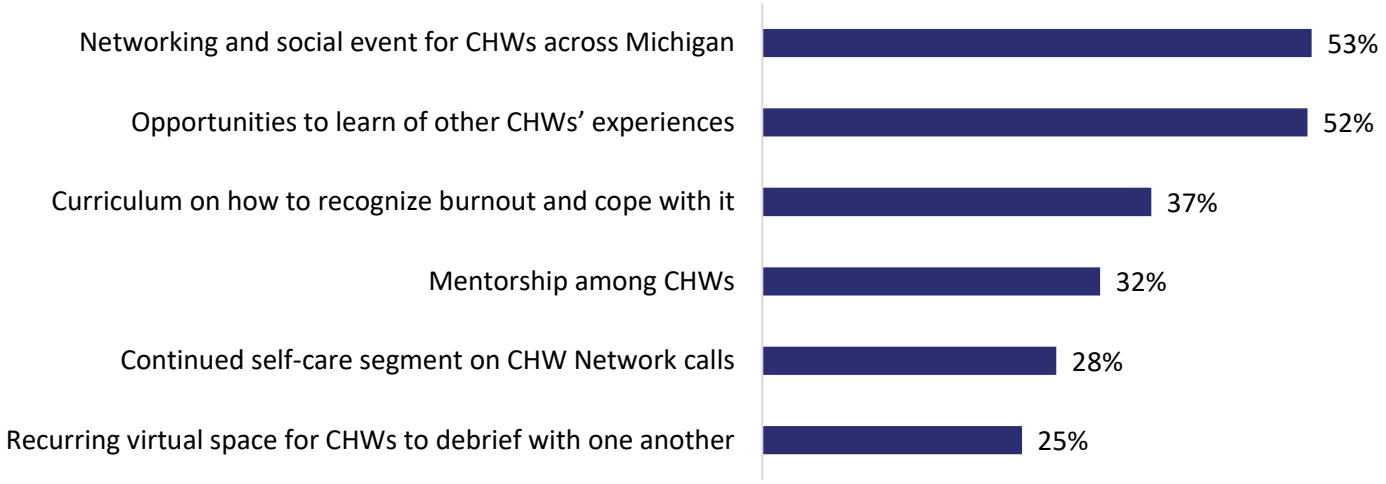
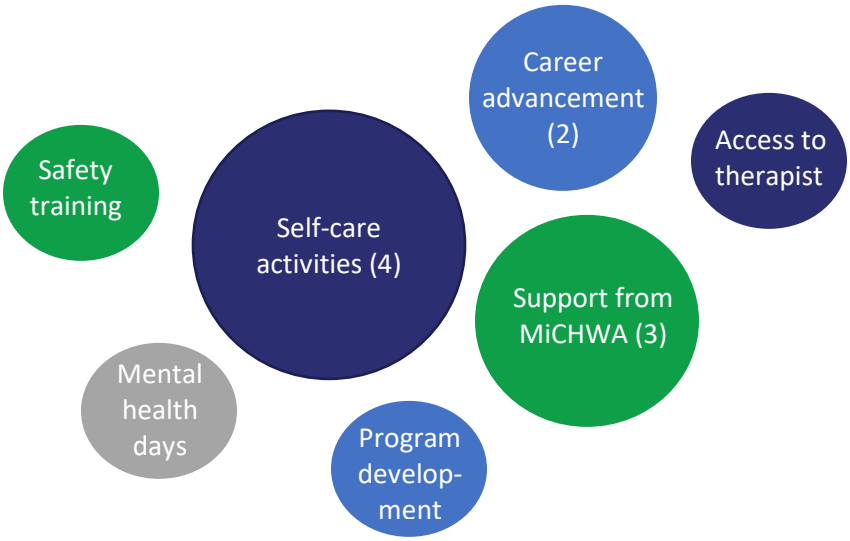


Figure 32. CHWs' Suggestions for Activities to Support Emotional Well-Being



CHW Perspectives

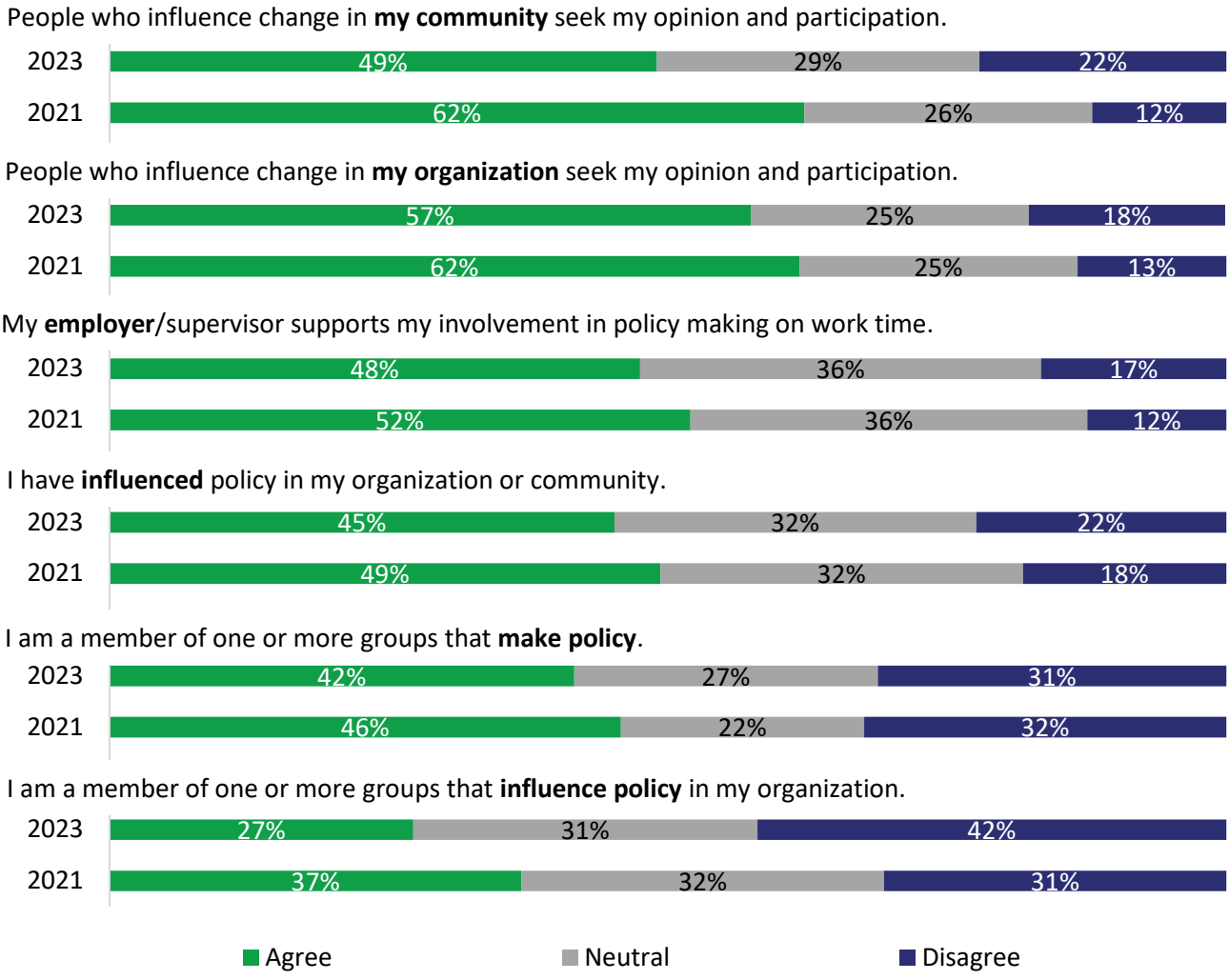
"A program that CHWs could speak to a therapist. We work in a field where difficult things happen, and it would be nice to have something available to help deal with them. I personally dealt with a situation within the first month on the job that was completely devastating, and it actually made me reconsider this position. My employer did provide counseling for the employees involved but I don't know if everyone's employer offers that assistance."

CHW ADVOCACY

The survey asked CHWs to indicate their level of agreement with six statements related to advocacy. Findings show there was a decline in CHW engagement in all advocacy-based activities in 2023 compared to 2021. The declines were particularly evident among those reporting that "people who influence change in my community seek my opinion and participation" (13 percentage point decline) and being a member of groups that influence policy in their organization (10 percentage point decline).

For the purposes of this survey, **"advocacy"** is defined as trying to bring about change in a policy and or practice. Policies are defined as sets of rules for what to do in particular situations.

Figure 34. CHW Engagement with Policy in 2023 (N = 250) and 2021 (N = 225)



MICHWA'S MEMBER REGISTRY

The majority of survey respondents (85%, *n* = 218) reported they were registered in the MiCHWA CHW Registry. Similarly, in 2021, 93% of respondents reported being in the Registry.

Among those registered, the largest number reported accessing the Registry every couple of months, as shown in Figure 35. **The CEU opportunity listings were by far the most frequently accessed component of the Registry**, as shown in Figure 36. Among the 24 people who said they were in the Registry but never accessed it, the most common reasons were lack of perceived utility and time constraints.

The **MiCHWA CHW Registry** is a membership database through which MiCHWA maintains a record of CHWs who have achieved "MiCHWA certification status" by successfully completing the MiCHWA Core-Competency-based training or having a combination of comparable experience and training. CHWs may also register with non-certified status. The MICHWA registry also has a membership for CHW employers.

Figure 35. Frequency of Registry Use (N = 218)

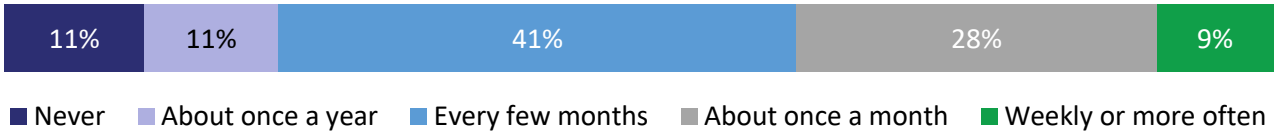
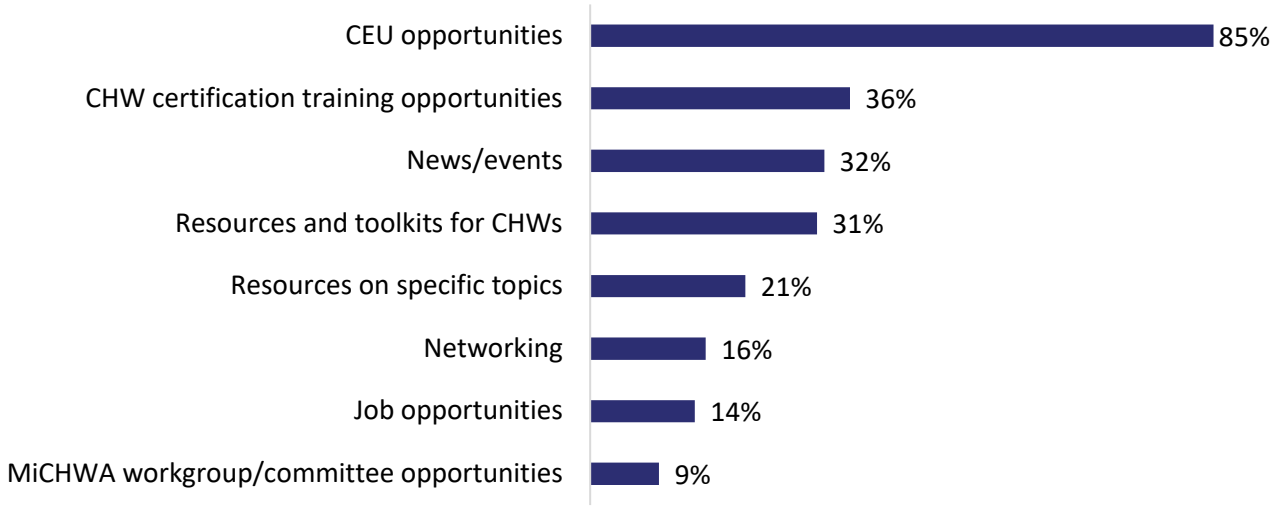


Figure 36. CHW Utilization of MiCHWA Registry Components At least Monthly (N = 203)



Among the 39 people who said they were not in the registry, the most common reason, listed by 24 people, was not being aware of the registry. Five people said they did not see a benefit to registering and five people said the cost of registering was a barrier. In write-in responses, one person said they did not renew their membership and two people said it was not required by their employer.

When asked how the registry could be improved, 20 people gave suggestions, many of which related to either offering more CEUs or improving the process for recording CEUs. Another 20 people indicated they had experienced difficulties using the registry or getting in contact with MiCHWA staff. Nine people indicated they were satisfied with the registry.

SECTION 3: SUMMARY AND IMPLICATIONS

Consistent with the 2021 CHW Survey Report, the 2023 CHW Survey shows a **clear theme of dissatisfaction with pay and perceptions of limited upward mobility for CHWs**. On the positive side, there were some limited signs of wage increases compared to 2021. The five most strongly represented organization types all showed increases in the proportions of CHWs earning $22.50 per hour or more. However, the increase was much greater at Medicaid Managed Care Organizations and the proportion of CHWs in the highest earning category was much higher at Medicaid Managed Care Organizations. More than eight out of ten CHWs at Medicaid Managed Care Organizations were in the highest earning category compared to three out of ten CHWs at the organization type with the next highest proportion of CHWs in the highest earning category. In other words, the rate of pay and growth in pay rate is inconsistent across organization types.

Across all respondents, the median reported wage was $20.09, which falls below what is considered a living wage in Michigan for a household with two working adults and one child.[11] Survey findings clearly show that large numbers of CHWs are unsatisfied with their current level of earnings. Low pay dominated the list of concerns when CHWs were asked to share any concerns relevant to the field of CHWs. Furthermore, when asked about factors that may lead them to leave the CHW field, nearly two-thirds of CHWs indicated they at least sometimes felt inclined to quit because of the rate of pay. More than a third in this group reported this inclination often or very often. Finally, although the proportion of CHWs reporting working a second job appeared to decrease from 2021, the fact that the majority of those working a second job are doing so to supplement their income speaks volumes.

Survey findings also show that CHW compensation does not consistently account for the value, skills and hazards associated with the role. Although CHWs may be tasked with reaching non-English speaking communities, the wages of CHWs who provide services in multiple languages did not differ meaningfully from overall average wages. This indicates that bilingual CHWs do not appear to be compensated for their skill set, which was also seen in the 2021 MiCHWA CHW Survey Report. The CHW role is often emotionally demanding and intense (see section on burnout below). Furthermore, several survey respondents expressed personal safety concerns associated with conducting home visits, a common activity for many CHWs. Yet the risks associated with the job are not compensated with commensurate wages. Finally, the large number of different roles that CHWs play and the compelling stories of impacts they shared in open-ended comments demonstrate the critical role CHWs play in individuals' lives.

Potential strategies for addressing the concerns with low pay rates include workshops to help CHWs navigate human resources and advocate for themselves and educational materials on the value of CHWs as part of multidisciplinary teams. Other ways of advocating at an organizational or policy level for higher pay should also be considered.

The second theme from the survey is the need to address the **security of CHW positions**, both with respect to the sustainability of funding and CHWs' risk of burnout. On the one hand, the proportion of CHWs who reported feeling their job was "highly secure" went up, with a 12-percentage point increase from 2021 to 2023. However, this could be a reflection of changes in the survey sample composition rather than change in the sector writ large. Furthermore, over half of CHWs reported some level of job

[11]Glasmeier, Amy K. Living Wage Calculator. 2023. Massachusetts Institute of Technology. https://livingwage.mit.edu. The living wage in Michigan for a household with two working adults and one child is estimated at $20.40.

insecurity and CHWs in some organization settings appeared more vulnerable than others. CHWs at Community-Based Organizations or Nonprofits reported the lowest level of job security, with 16% of CHWs saying they felt not at all or not very secure. At the other end of the spectrum, all of the CHWs based at Medicaid Managed Care Organizations reported either a moderate or high level of job security. Funding for CHW positions is written into the contracts with Medicaid Managed Care Organizations, which leads to a high level of stability in those settings.

The 2023 CHW Survey, for the first time, included questions on CHWs' experiences with feelings of burnout. Approximately 30% of CHWs reported often or very often feeling burnt out due to the difficulty of connecting clients to needed resources, whether because of limits of the program or because of clients not following through with the resources offered. In other words, it appears that both because of limited program resources and lack of client engagement with available resources, many CHWs do not feel as effective as they would like to be, which can be emotionally draining. These findings could also indicate that CHWs experienced burnout from the COVID-19 pandemic at similar levels to what other healthcare professionals experienced.[12] The high emotional burden of the job may also compromise the ability to advocate, leading to the low engagement in advocacy activities seen in the survey findings.

In light of these challenges, MiCHWA has an opportunity to sponsor activities to support CHWs' emotional well-being. The two activities that generated the greatest interest among survey respondents were, first, quarterly or semi-annual networking and social events for CHWs across Michigan and, second, opportunities to learn of other CHWs' experiences throughout the state. While neither of these activities will directly increase availability and uptake of resources for clients, they can provide occasions for CHWs to share with and emotionally support one another. Another way to address burnout could be to include the topic of burnout and strategies for addressing it, such as reflective supervision, in CHW supervisor training.

The final theme evident in the survey findings is the **diversity of CHW positions**. Questions on caseloads, roles and counties served all indicate a wide range in the nature of day-to-day tasks and activities. Some CHWs serve 10 or fewer clients in a single county at any given time while others are responsible for following-up with thousands of people spread across a multi-county region or even the entire state. Roles that serve large numbers of people and/or large geographic areas may be quite distinct from the "classic" CHW role of building strong and enduring ties with individual clients in a local community. Our findings about diversity of positions can serve as a springboard for discussions about what it means to be a CHW, and whether and how this is changing over time. Ultimately, the goal is to ensure that all CHWs are provided the support that they need for success in their roles, and to acknowledge the many forms that the CHW role can take, while retaining the core notion of what makes CHWs a unique and valuable type of health care worker.

[12] Morgantini, L. A., Naha, U., Wang, H., Francavilla, S., Acar, Ö., Flores, J. M., ... & Weine, S. M. (2020). Factors contributing to healthcare professional burnout during the COVID-19 pandemic: A rapid turnaround global survey. PloS one, 15(9), e0238217.

APPENDIX A: DATA TABLES

Table 1. Number of CHWs Reporting Providing Services by Michigan County

County and CHW Count									
Alcona	9	Clare	5	Iosco	8	Marquette	8	Otsego	7
Alger	5	Clinton	5	Iron	3	Mason	5	Ottawa	12
Allegan	8	Crawford	4	Isabella	3	Mecosta	5	Presque Isle	9
Alpena	11	Delta	7	Jackson	5	Menominee	3	Roscommon	4
Antrim	6	Dickinson	3	Kalamazoo	5	Midland	3	Saginaw	12
Arenac	8	Eaton	4	Kalkaska	4	Missaukee	4	Sanilac	6
Baraga	7	Emmet	9	Kent	23	Monroe	5	Schoolcraft	5
Barry	6	Genesee	26	Keweenaw	5	Montcalm	7	Shiawassee	4
Bay	7	Gladwin	4	Lake	7	Montmorency	9	St. Clair	6
Benzie	7	Gogebic	4	Lapeer	4	Muskegon	16	St. Joseph	3
Berrien	6	Grand Traverse	9	Leelanau	6	Newaygo	8	Tuscola	5
Branch	4	Gratiot	4	Lenawee	4	Oakland	29	Van Buren	7
Calhoun	9	Hillsdale	2	Livingston	8	Oceana	6	Washtenaw	15
Cass	6	Houghton	5	Luce	7	Ogemaw	5	Wayne	69
Charlevoix	6	Huron	4	Mackinac	6	Ontonagon	5	Wexford	8
Cheboygan	7	Ingham	9	Macomb	17	Osceola	5		
Chippewa	5	Ionia	5	Manistee	8	Oscoda	6		

Table 2. Additional Position Titles *(Each title was listed by one person.)*

Position Title
Peer Support
Certified Recovery Coach
Family Health Outreach Worker
Advance Care Planning Care Management Coordinator
Care Coordinator
Certified Community Health Worker
CHW and Team Lead
CHW/Peer Recovery Coach (working towards certification)
Clinical Social Worker
Clubhouse Assistant through Clubhouse International.
Community Health Worker and Enrollment Specialist
Community Tech Worker
Constituent Services Director
Coordinator
Enabling Services Coordinator
HIV Prevention Program Manager
Housing Coordinator
Intake Manager
Lead Community Health Worker
Medical Case Manager
Parent Coach
Parent Coach/CHW
Patient Navigator
Peer navigator, certified peer support, certified recovery coach
Peer Services Manager
Personal Health Technician
Public Health Tech
Self-sufficiency advisor/CHW
Sr. Program Development Manager - CHW

Table 3. Comparing CHW and CHW Employer Responses on Frequency Sub-Role Engagement

Sub-Role	% Often or Very Often		
	Employers 2022	CHWs 2023	Difference
Cultural mediation among individuals, communities, and health and social service systems			
Educating individuals and communities about how to use health and social service systems	63%	92%	30%
Educating systems about community perspectives and cultural norms	32%	63%	30%
Building health literacy and cross-cultural communication	39%	77%	39%
Providing culturally appropriate health education and information			
Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community	47%	80%	33%
Providing necessary information to understand and prevent diseases and to help people manage health conditions	57%	78%	22%
Care coordination, case management, and system navigation			
Participating in care coordination and/or case management	56%	77%	21%
Making referrals and providing follow-up	72%	86%	15%
Facilitating transportation to services and/or helping to address other barriers to services	70%	85%	16%
Documenting and tracking individual and population level data	66%	73%	6%
Informing people and systems about community assets and challenges	58%	77%	19%
Providing coaching and social support			
Providing individual support/coaching to clients	57%	89%	32%
Motivating and encouraging people to obtain care and other services	82%	97%	15%

Sub-Role	% Often or Very Often		
	Employers 2022	CHWs 2023	Difference
Supporting self-management of disease prevention and management of health conditions	73%	78%	6%
Planning and/or leading support groups	18%	18%	0%
Advocating for individuals and communities			
Advocating for the needs and perspectives of communities	40%	75%	35%
Connecting to resources and advocating for basic needs	84%	88%	4%
Participating in policy advocacy	25%	26%	1%
Building individual and community capacity			
Building individual capacity	60%	77%	18%
Building community capacity	31%	50%	19%
Training and building individual capacity with CHW peers, groups of CHWs	54%	38%	-17%
Providing direct service			
Providing basic screening tests	20%	39%	18%
Providing basic services	21%	49%	28%
Meeting basic needs	76%	72%	-4%
Implementing individual and community assessments			
Participating in design, implementation, and interpretation of individual-level assessments	26%	36%	10%
Participating in design, implementation, and interpretation of community-level assessments	34%	18%	-16%
Conducting outreach			
Case-finding/recruitment of individuals, families, and community groups to services and systems	51%	66%	15%
Follow-up on health and social service encounters with individuals, families, and groups	61%	77%	16%

Sub-Role	% Often or Very Often		
	Employers 2022	CHWs 2023	Difference
Home visiting to provide education, assessment, and social support	37%	53%	17%
Presenting at local agencies and community events	36%	38%	1%
Participating in evaluation and research			
Evaluating CHW services and programs	29%	26%	-3%
Identifying and engaging community members as research partners, including community consent	30%	21%	-10%
Identification of priority issues and evaluation/research questions	29%	21%	-8%
Development of evaluation/research design and methods	21%	11%	-10%
Data collection and interpretation	34%	27%	-7%
Sharing results and findings	36%	23%	-13%
Engaging stakeholders to take action on findings	17%	17%	0%

Table 4. Percent of CHWs by Perception of Job Security and by Organization Setting

	Not secure at all	Not very secure	Moderately secure	Highly secure
Community-based Organization (N = 57)	4%	12%	44%	40%
Federally Qualified Health Center (N = 56)	0%	4%	54%	43%
Health System (N = 38)	0%	5%	47%	47%
Local Health Department (N = 37)	5%	5%	57%	32%
Medicaid Managed Care Organization (N = 33)	0%	0%	46%	55%

Table 5. CHW Perspectives on Advancement Opportunities in 2023 (N = 249) and 2021 (N = 230)

Career Advancement Statement	Percent CHWs 2021			Percent CHWs 2023		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
I have opportunities for promotion at my organization.	22%	37%	40%	28%	32%	40%
There are good opportunities for advancement in the CHW profession	16%	43%	42%	26%	32%	42%
I have opportunities to assume leadership roles.	20%	38%	42%	26%	29%	45%
I have opportunities for pay raises as I continue in my work as a CHW.	25%	32%	43%	24%	32%	44%
I have opportunities to continue to develop my professional skills.	5%	17%	78%	7%	17%	75%

Table 6. Continuing Education for 2021 (N = 232) and 2023 (N = 240)

Continuing Education Topic	Percent CHWs	
	2021	2023
Employer requires maintaining CHW continuing education credits	71%	75%
Had received continuing education from MiCHWA	95%	87%
Had received continuing education from Michigan Department of Health and Human Services	40%	47%

APPENDIX B: CHW ROLE DESCRIPTIONS

In your current position, how often do you engage in the following roles related to...?	
Sub-Role	**Example**
Role 1: Cultural mediation among individuals, communities, and health and social service systems	
Educating individuals and communities about how to use health and social service systems	Helping undocumented clients find safe places for health care
Educating systems about community perspectives and cultural norms	Providing training to service providers on the cultures of clients served
Building health literacy and cross-cultural communication	Helping service providers use words and ideas that will be understood by their clients
Role 2: Providing culturally appropriate health education and information	
Conducting health promotion and disease prevention education in a manner that matches language and cultural needs of participants or community	Conducting classes for people with high blood pressure
Providing necessary information for people to understand and prevent diseases and manage health conditions	Educating clients with diabetes about diabetes-related health care
Role 3: Care coordination, case management, and system navigation	
Participating in care coordination and/or case management	Helping people navigate the electronic portals of health care systems
Making referrals and providing follow-up	Ensuring a client received a referral
Facilitating transportation to services and/or helping to address other barriers to services	Helping clients enroll in transportation services
Documenting and tracking individual and population level data	Conducting an SDOH screening
Informing people and systems about community strengths/assets and challenges	Participating in community partner meetings
Role 4: Providing coaching and social support	
Providing individual support and coaching to clients	Providing education on chronic disease management

Motivating and encouraging people to obtain care and other services	Ensuring clients set and attend appointments
Supporting self-management of disease prevention and management of health conditions	Sharing educational resources with clients
Planning and/or leading support groups	Leading support groups for pregnant and postpartum women
Role 5: Advocating for individuals and communities	
Advocating for the needs and perspectives of communities	Participating in City Council meetings
Connecting people to resources and advocating for basic needs	Helping clients enroll in programs that meet basic needs
Participating in policy advocacy	Communicating with lawmakers
Role 6: Building individual and community capacity	
Building individual capacity	Conducting motivational interviewing
Building community capacity	Hosting community events
Training and building individual capacity with CHW peers and among groups of CHWs	Participating in training or co-learning with other CHWs
Role 7: Providing direct service	
Providing basic screening tests	Conducting glucose monitoring
Providing basic services	Measuring blood pressure
Meeting basic needs	Helping clients obtain food
Role 8: Implementing individual and community assessments	
Participating in design, implementation, and interpretation of individual-level assessments	Conducting home safety assessments
Participating in design, implementation, and interpretation of community-level assessments	Conducting community needs assessments
Role 9: Conducting outreach	
Case-finding/recruitment of individuals, families, and community groups to services and systems	Researching client histories for potential referrals to health programs
Follow-up on health and social service encounters with individuals, families, and community groups	Ensuring client follows provider instructions

Home visiting to provide education, assessment, and social support	Determining if home care is needed
Presenting at local agencies and community events	Presenting information about the community for partner organizations
Role 10: Participating in evaluation and research	
Engaging in evaluating CHW services and programs	
Identifying and engaging community members as research partners, including community consent processes	
Identification of priority issues and evaluation/research questions	
Development of evaluation/research design and methods	
Data collection and interpretation	
Sharing results and findings	
Engaging stakeholders to take action on findings	

APPENDIX C: SURVEY INSTRUMENT

2023 MiCHWA CHW Survey

The goal of this survey is to gather information that MiCHWA can use to better meet the needs of CHWs and to shape MiCHWA's CHW policy and financing agenda.

According to the American Public Health Association (APHA), a Community Health Worker (CHW) is a frontline public health 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 liaison, link, or intermediary between health or social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. In Michigan, CHWs are known by many different titles, such as Promotor/a, Certified Peer Support Specialist, and Outreach and Enrollment Worker.

If your role fits the APHA definition, you have any of the above titles or others that are similar, and you are currently working or volunteering in this position, you are eligible to complete this survey.

Note: the survey questions use the term "CHW" to refer to anyone in the role described above.

By continuing, you voluntarily agree to participate in the survey.

1. Are you currently working or volunteering in Michigan as a CHW or in an equivalent position?

- ○ Yes
- ○ No *(If no, please disregard this survey. Thank you for your time.)*

PART 1: CHW POSITION DESCRIPTION

2. What is the name of the organization where you work as a CHW?

_____

3. What is your primary title for your role as a CHW?

- ○ CHW
- ○ Peer Support
- ○ Certified Peer Support Specialist
- ○ Certified Recovery Coach
- ○ Promotor/a
- ○ Community Health Advocate
- ○ Community Health Outreach Worker
- ○ Community Outreach Worker
- ○ Community Health Worker
- ○ Community Neighborhood Navigator
- ○ Family Health Outreach Worker
- ○ Health Coach
- ○ Maternal Child Health Worker
- ○ Outreach and Enrollment Worker
- ○ Veteran Liaison
- ○ Other (please specify) _____

4. How many years have you worked or volunteered as a CHW?
If one year or more, please use a whole number.

- ○ Less than 1 year
- ○ _____ years

5. In which language(s) are you able to deliver services?
Check all that apply.

- ☐ English
- ☐ Spanish
- ☐ Arabic
- ☐ Other (please specify) _____

PART 2: CHW ROLES

6. In your current position, how often do you engage in the following roles related to **cultural mediation among individuals, communities, and health and social service systems?**

	Never	Rarely	Sometimes	Often	Very Often
Educating individuals and communities about how to use health and social service systems *(example: helping undocumented clients find safe places for health care)*	○	○	○	○	○
Educating systems about community perspectives and cultural norms *(ex. providing training to service providers on the cultures of clients served)*	○	○	○	○	○
Building health literacy and cross-cultural communication *(ex. helping service providers use words and ideas that will be understood by their clients)*	○	○	○	○	○

7. In your current position, how often do you engage in the following roles related to **providing culturally appropriate health education and information?**

	Never	Rarely	Sometimes	Often	Very Often
Conducting health promotion and disease prevention education in a manner that matches language and cultural needs of participants or community *(ex. conducting classes for people with high blood pressure)*	○	○	○	○	○
Providing necessary information for people to understand and prevent diseases and manage health conditions *(ex. educating clients with diabetes about diabetes-related health care)*	○	○	○	○	○

8. In your current position, how often do you engage in the following roles related to **care coordination, case management, and system navigation?**

	Never	Rarely	Sometimes	Often	Very Often
Participating in care coordination and/or case management *(ex. helping people navigate the electronic portals of health care systems)*	○	○	○	○	○
Making referrals and providing follow-up *(ex. ensuring a client received a referral)*	○	○	○	○	○
Facilitating transportation to services and/or helping to address other barriers to services *(ex. helping clients enroll in transportation services)*	○	○	○	○	○
Documenting and tracking individual and population level data *(ex. conducting an SDOH screening)*	○	○	○	○	○
Informing people and systems about community strengths/assets and challenges *(ex. participating in community partner meetings)*	○	○	○	○	○

9. In your current position, how often do you engage in the following roles related to **providing coaching and social support?**

	Never	Rarely	Sometimes	Often	Very Often
Providing individual support and coaching to clients *(ex. providing education on chronic disease management)*	○	○	○	○	○
Motivating and encouraging people to obtain care and other services *(ex. ensuring clients set and attend appointments)*	○	○	○	○	○
Supporting self-management of disease prevention and management of health conditions *(ex. sharing educational resources with clients)*	○	○	○	○	○
Planning and/or leading support groups *(ex. leading support groups for pregnant and postpartum women)*	○	○	○	○	○

10. In your current position, how often do you engage in the following roles related to **advocating for individuals and communities?**

	Never	Rarely	Sometimes	Often	Very Often
Advocating for the needs and perspectives of communities (*ex. participating in City Council meetings)*	○	○	○	○	○
Connecting people to resources and advocating for basic needs *(ex. helping clients enroll in programs that meet basic needs)*	○	○	○	○	○
Participating in policy advocacy *(ex. communicating with lawmakers)*	○	○	○	○	○

11. In your current position, how often do you engage in the following roles related to **building individual and community capacity?**

	Never	Rarely	Sometimes	Often	Very Often
Building individual capacity *(ex. conducting motivational interviewing)*	○	○	○	○	○
Building community capacity *(ex. hosting community events)*	○	○	○	○	○
Training and building individual capacity with CHW peers and among groups of CHWs *(ex. participating in training or co-learning with other CHWs)*	○	○	○	○	○

12. In your current position, how often do you engage in the following roles related to **providing direct service?**

	Never	Rarely	Sometimes	Often	Very Often
Providing basic screening tests *(ex. conducting glucose monitoring)*	○	○	○	○	○
Providing basic services *(ex. measuring blood pressure)*	○	○	○	○	○
Meeting basic needs *(ex. helping clients obtain food)*	○	○	○	○	○

13. In your current position, how often do you engage in the following roles related to **implementing individual and community assessments?**

	Never	Rarely	Sometimes	Often	Very Often
Participating in design, implementation, and interpretation of individual-level assessments *(ex. conducting home safety assessments)*	○	○	○	○	○
Participating in design, implementation, and interpretation of community-level assessments *(ex. conducting community needs assessments)*	○	○	○	○	○

14. In your current position, how often do you engage in the following roles related to **conducting outreach?**

	Never	Rarely	Sometimes	Often	Very Often
Case-finding/recruitment of individuals, families, and community groups to services and systems *(ex. researching client histories for potential referrals to health programs)*	○	○	○	○	○
Follow-up on health and social service encounters with individuals, families, and community groups *(ex. ensuring client follows provider instructions)*	○	○	○	○	○
Home visiting to provide education, assessment, and social support *(ex. determining if home care is needed)*	○	○	○	○	○
Presenting at local agencies and community events *(ex. presenting information about the community for partner organizations)*	○	○	○	○	○

15. In your current position, how often do you engage in the following roles related to **participating in evaluation and research?**

	Never	Rarely	Sometimes	Often	Very Often
Engaging in evaluating CHW services and programs	○	○	○	○	○
Identifying and engaging community members as research partners, including community consent processes	○	○	○	○	○
Identification of priority issues and evaluation/research questions	○	○	○	○	○
Development of evaluation/research design and methods	○	○	○	○	○
Data collection and interpretation	○	○	○	○	○
Sharing results and findings	○	○	○	○	○
Engaging stakeholders to take action on findings	○	○	○	○	○

16. Do you make or facilitate referrals to any of the following programs?
Check all that apply.

- [ ] Diabetes Prevention Program (DPP)
- [ ] Diabetes Self-Management Education and Support (DSMES)
- [ ] Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (HHAP)
- [ ] Personal Action Toward Health (PATH)
- [ ] Diabetes PATH
- [ ] Kidney PATH
- [ ] Supplemental Nutrition and Assistance Program and Education (SNAP-ED)
- [ ] Taking Off Pounds Sensibly (TOPS)
- [ ] Weight Watchers
- [ ] YMCA Blood Pressure Self-Monitoring
- [ ] Other _____
- [ ] NA - I do not make referrals.

17. What is the average caseload of clients you are actively serving?

- ○ 10 or fewer
- ○ 11-20
- ○ 21-30
- ○ 31-40
- ○ 41-50
- ○ 51-60
- ○ 61-70
- ○ 71-80
- ○ 81-90
- ○ 91-100
- ○ 101-125
- ○ 126-150
- ○ 151-200
- ○ Other:_____

18. How would you describe the average caseload of clients you are actively serving compared to your capacity?

- ○ I do not have enough capacity to adequately serve all my current clients
- ○ My capacity fits the number of clients I am actively serving
- ○ I have additional capacity to actively serve more clients

19. Do you want to share anything more about your typical or ideal caseload?

_____

_____

_____

PART 3: TRAINING and CONTINUING EDUCATION

20. Have you successfully completed the MiCHWA 126 hour core-competency based training program?

- ○ Yes, before I was hired as a CHW *(Skip to Question 23.)*
- ○ Yes, after I was hired as a CHW *(Skip to Question 23.)*
- ○ No *(If no, please answer Question 22.)*

21. Have you either received MiCHWA certification via a grandparenting process or completed a different CHW core-competency based training program?
Check all that apply.

- ☐ Before I was hired as a CHW I completed (please specify) _____
- ☐ After I was hired as a CHW I completed (please specify) _____
- ☐ I received MiCHWA certification via a grandparenting process
- ☐ None of the above

22. Does your employer require that you maintain CHW continuing education credits?

- ○ Yes
- ○ No

23. From which of the following sources have you received continuing education training?
Check all that apply.

- [ ] MiCHWA
- [ ] Michigan Department of Health and Human Services (MDHHS)
- [ ] Michigan Victims Advocacy Network (MiVAN)
- [ ] Corewell/Spectrum Health
- [ ] YMCA
- [ ] Other (please specify)_____

24. What MiCHWA-sponsored resources or activities to support emotional well-being would you be most interested in?
Select up to 3.

Note: these are not currently available, but your responses will be helpful for planning purposes.

- [ ] Recurring virtual space for CHWs to debrief workday with one another (drop-in)
- [ ] Quarterly or semi-annual networking and social event for CHWs across Michigan
- [ ] Opportunities to learn of other CHWs' experiences throughout the state
- [ ] Continued self-care segment on CHW Network calls
- [ ] Curriculum on how to recognize burnout and cope with it
- [ ] Mentorship among CHWs
- [ ] Other (please specify)_____

PART 4: MiCHWA MEMBER REGISTRY

25. Are you registered in the MiCHWA Member Registry?

- ○ Yes
- ○ No *(Skip to Question 29.)*

26. Approximately how often do you use the MiCHWA Member Registry?

- ○ Weekly or more often
- ○ About once a month
- ○ Every few months
- ○ About once a year
- ○ Never *(Skip to Question 30.)*

27. Which of the following components of the MiCHWA registry do you use on a regular basis (at least once per month)?
Check all that apply.

- ☐ Job opportunities
- ☐ Networking
- ☐ CEU opportunities
- ☐ CHW certification training opportunities
- ☐ News/events
- ☐ Resources on health conditions, social determinants of health, policy, etc.
- ☐ Resources and toolkits for CHWs
- ☐ MiCHWA workgroup/committee opportunities

28. How could the MiCHWA registry be improved to better meet your needs as a CHW?

_____

_____

_____

_____

_____

Answer if you said "No" to Question 25:

29. What are your reasons for not registering in the MiCHWA CHW registry?
Check all that apply.

- ☐ I was not aware of the registry.
- ☐ I do not see a benefit to registering.
- ☐ The cost of registering is a barrier.
- ☐ Other _____

Answer if you said "Never" to Question 26:

30. What are your reasons for not using the MiCHWA CHW registry?

_____

_____

_____

_____

_____

PART 5: TEAM INTEGRATION and CAREER DEVELOPMENT

31. Please indicate how much you agree or disagree with the following statements regarding career advancement.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have opportunities for promotion at my organization.	○	○	○	○	○
There are good opportunities for advancement in the CHW profession.	○	○	○	○	○
I have opportunities to continue to develop my professional skills.	○	○	○	○	○
I have opportunities for pay raises as I continue in my work as a CHW.	○	○	○	○	○
I have opportunities to assume leadership roles.	○	○	○	○	○

32. To what extent do the other healthcare, social service, and/or education providers with whom you work understand your roles and what you do as a CHW?

- ○ Not at all
- ○ A little
- ○ Some
- ○ A lot
- ○ Completely
- ○ Not Applicable

33. To what extent do you feel comfortable going to the other healthcare, social service, and/or education providers with whom you work to talk about participants' needs?

- ○ Not at all
- ○ A little
- ○ Some
- ○ A lot
- ○ Completely
- ○ Not Applicable

34. Are you able to record information about your clients in your employers' main participant tracking form/system (ex. electronic health record)?

- ○ No
- ○ Yes, some
- ○ Yes, all
- ○ Does not exist
- ○ Not Applicable

35. Please indicate how much you agree with the following statements regarding advocacy.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
As part of my job, people who influence change in my community seek my opinion and participation.	○	○	○	○	○
As part of my job, people who influence change in my organization seek my opinion and participation.	○	○	○	○	○
As a part of my job, I am a member of one or more groups/organizations that make (develop or enact) policy for my community, city, county, state, or tribe.	○	○	○	○	○
My employer/supervisor supports my involvement in policy making on work time.	○	○	○	○	○
I am a member of one or more groups that influence policy in my employing organization.	○	○	○	○	○
I believe that as a CHW, I have influenced policy in my organization or community.	○	○	○	○	○

PART 6: PAYMENT, SUSTAINABILITY, AND LIVING WAGES

36. Which of the following best describes your work status as a CHW?

- ○ Paid, full time (at least 30 hours per week)
- ○ Paid, part time (less than 30 hours per week)
- ○ As needed/on-call only
- ○ Volunteer, full time
- ○ Volunteer, part time

37. What is your current hourly rate or annual salary?
Please complete one or the other in US $.
Note: MiCHWA uses this data to track changes in average CHW income over time and for advocacy.

- ○ Hourly Rate _____
- ○ Annual Salary _____

38. How often have you been laid off or furloughed because CHW project funding ended?

- ○ Never
- ○ 1-2 times
- ○ More than 2 times

39. How would you rate the security of your job at this time?

- ○ Highly secure
- ○ Moderately secure
- ○ Not very secure
- ○ Not secure at all

40. Do you currently have a paid position with an employer outside of your work as a CHW?

- ○ Yes
- ○ No

41. What are the reasons you have a paid position with an employer outside of your work as a CHW?
Check all that apply.

- ☐ Community health work is not my primary occupation.
- ☐ I work at another job to supplement my income as a CHW.
- ☐ I volunteer as a CHW.
- ☐ Other _____

42. How often, if at all, do you feel inclined to leave the CHW profession due to the following factors?

	Never	Rarely	Sometimes	Often	Very Often
Work hours	○	○	○	○	○
Rate of pay	○	○	○	○	○
Ability to help/make a difference	○	○	○	○	○
Level of support from supervisor	○	○	○	○	○
Level of support from agency	○	○	○	○	○
Opportunity for growth in the field	○	○	○	○	○
Level of stress	○	○	○	○	○
Support for role from co-workers	○	○	○	○	○
Other	○	○	○	○	○

43. How often, if at all, do you feel overwhelmed or burnt out due to the following factors?

	Never	Rarely	Sometimes	Often	Very Often
Not being able to connect clients to the resources they need	○	○	○	○	○
Delivering care beyond the scope of the role	○	○	○	○	○
Focus on quantity of clients served vs. quality of services	○	○	○	○	○
Client not doing their part in getting connected to a resource	○	○	○	○	○
Carrying the emotional weight of clients' circumstances	○	○	○	○	○
Other	○	○	○	○	○

PART 7: DEMOGRAPHICS

44. How would you describe your race and/or ethnicity?
Check all that apply.

- ☐ American Indian or Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Black or African American
- ☐ Hispanic/Latinx
- ☐ White
- ☐ Arab American/Middle Eastern/North African
- ☐ Not listed _____
- ☐ Prefer not to say

45. Of the following, which best describes your gender?

- ○ Man
- ○ Woman
- ○ Non-binary
- ○ Not listed _____
- ○ Prefer not to say

46. What is your highest level of education?

- ○ High school or equivalent
- ○ Some college
- ○ Trade school or vocational training
- ○ Associate degree
- ○ Bachelor’s degree
- ○ Master’s degree
- ○ Doctoral degree

47. How would you describe your health in general?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

48. Which county or counties do you work in?
Check all that apply.

- [ ] Alcona
- [ ] Alger
- [ ] Allegan
- [ ] Alpena
- [ ] Antrim
- [ ] Arenac
- [ ] Baraga
- [ ] Barry
- [ ] Bay
- [ ] Benzie
- [ ] Berrien
- [ ] Branch
- [ ] Calhoun
- [ ] Cass
- [ ] Charlevoix
- [ ] Cheboygan
- [ ] Chippewa
- [ ] Clare
- [ ] Clinton
- [ ] Crawford
- [ ] Delta
- [ ] Dickinson
- [ ] Eaton
- [ ] Emmet
- [ ] Genesee
- [ ] Gladwin
- [ ] Gogebic
- [ ] Grand Traverse
- [ ] Gratiot
- [ ] Hillsdale
- [ ] Houghton
- [ ] Huron
- [ ] Ingham
- [ ] Ionia
- [ ] Iosco
- [ ] Iron
- [ ] Isabella
- [ ] Jackson
- [ ] Kalamazoo
- [ ] Kalkaska
- [ ] Kent
- [ ] Keweenaw
- [ ] Lake
- [ ] Lapeer
- [ ] Leelanau
- [ ] Lenawee
- [ ] Livingston
- [ ] Luce
- [ ] Mackinac
- [ ] Macomb
- [ ] Manistee
- [ ] Marquette
- [ ] Mason
- [ ] Mecosta
- [ ] Menominee
- [ ] Midland
- [ ] Missaukee
- [ ] Monroe
- [ ] Montcalm
- [ ] Montmorency
- [ ] Muskegon
- [ ] Newaygo
- [ ] Oakland
- [ ] Oceana
- [ ] Ogemaw
- [ ] Ontonagon
- [ ] Osceola
- [ ] Oscoda
- [ ] Otsego
- [ ] Ottawa
- [ ] Presque Isle
- [ ] Roscommon
- [ ] Saginaw
- [ ] Sanilac
- [ ] Schoolcraft
- [ ] Shiawassee
- [ ] St. Clair
- [ ] St. Joseph
- [ ] Tuscola
- [ ] Van Buren
- [ ] Washtenaw
- [ ] Wayne
- [ ] Wexford

PART 8: CHW and MiCHWA IMPACTS

49. We invite you to share an example of something you have accomplished in your role as a CHW that you feel has made an important difference for the individuals, families, organization or community you serve.

_____

_____

_____

_____

_____

50. How has MiCHWA made a difference for CHWs? (ex. for you professionally, for the CHW workforce, etc.)

_____

_____

_____

_____

_____

51. Are there any concerns either in the field of CHWs or within MiCHWA you would like to address?

_____

_____

_____

_____

_____

52. MiCHWA would like to build a database of CHW contact information for future surveys. Would you be willing to share a work and/or personal email address?
All contact information is confidential information and will not be shared.

- ○ Work Email _____
- ○ Personal Email _____

53. If you would like a CEU certificate, please provide your name below.

CEU certificates will be sent after the survey closes, by the end of April 2023.

Name_____

Thank you!