MiCHWA

MICHIGAN COMMUNITY HEALTH WORKER ALLIANCE

In coordination with the MiCHWA Evaluation Work Group

COMMUNITY HEALTH WORKER SURVEY 2025: FINAL EVALUATION REPORT

August 2025

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

SCHOOL OF SOCIAL WORK
PROGRAM EVALUATION GROUP
UNIVERSITY OF MICHIGAN

For more information, please visit https://michwa.org.

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EVALUATION TEAM

The development, dissemination, and analysis of the 2025 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.

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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/.

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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 2025 Community Health Worker Survey is the third 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 5 and April 14, 2025. The final dataset consisted of 269 responses. *(See page 11.)*

Key Findings

Project team members, in conjunction with feedback from Evaluation Work Group members, identified seven key topics from the 2025 CHW Survey findings. *(See page 60.)*

- There are several positive signs in the Community Health Worker field that demonstrate its expanding impact and reach, including a growing diversity of organizations employing CHWs.
- While many organizations are just beginning to implement Medicaid reimbursement for CHWs, initial indications show no major changes in CHW roles.
- Pay remains a big concern. Although median wages have increased, dissatisfaction persists, especially among more educated CHWs, and wage disparities remain across employer types.
- Many CHWs have more education than is required for their roles, which raises questions about whether CHWs reflect the communities they serve and whether employers are more likely to hire CHWs with post-secondary degrees.
- There are several sustainability concerns for CHW positions, including high rates of burnout and many CHWs reporting frequent thoughts of quitting.
- Referrals to lifestyle change programs are lower than in 2023, though reasons are unclear, indicating the need for continued monitoring of a potential trend.

- Rural CHWs face unique barriers to both service delivery and funding due to geographic challenges and Medicaid policies that prohibit reimbursement for services provided by phone.

CHWs in Michigan

Eighty-six percent of CHWs identified as women. The two most prevalent racial and ethnic identities were White and Black. The majority of CHWs reported at least some post-high school education, with the two largest groups indicating some college and completion of a bachelor's degree. The vast majority of survey respondents, 84%, reported being in a paid, full-time role as a Community Health Worker. On average, CHWs reported working in their role for 4.7 years.

Individuals responding to the survey reported working for a total of 149 unique organizations. The five most common organization settings were community-based organizations, federally qualified health centers, local health departments, behavioral health organizations, and health systems. Nearly two-thirds of respondents reported serving a single county and 24 CHWs reported serving five or more counties. *(See page 22.)*

CHW Roles

CHWs reported engaging in an average of 13 sub-roles frequently. The three most common sub-roles were consistent between 2025 and 2023:

1. Motivating and encouraging people to obtain care and other services (Role 4, sub-role b; 72%)
2. Connecting to resources and advocating for basic needs (Role 5, sub-role b; 71%)
3. Meeting basic needs (Role 7, sub-role c; 70%)

Close to half of respondents (48%) reported not making referrals to any of the lifestyle change programs named on the survey, such as the Supplemental Nutrition Assistance Program Education and the Diabetes Prevention Program, and the proportion of CHWs making referrals was lower for nine of the ten programs in 2025 than in 2023. When asked about their enrollment in Michigan's Community Health Automated Medicaid Processing System (CHAMPS), which is a requirement in order for CHWs to bill Medicaid for services, 39% of CHWs said that they are enrolled. As employers implement Medicaid billing, which covers

specific services, such as health system navigation and resource coordination, but not others, such as case management or advocacy, some CHWs may see changes in their roles. At the time of the survey, only 12 people reported that they had seen a change in their role and only one person expected to see a change. *(See page 31.)*

CHW Salaries and Job Security

CHWs reported compensation ranging from $12.00 to $40.00 an hour, with an average of $22.08 and a median of $21.99. In 2025, there were proportionally more CHWs making $22.50 or more and proportionally fewer CHWs making between $15.01 and $18.00 compared to previous survey years. However, nearly two-thirds of respondents still indicated they at least sometimes felt inclined to quit because of the rate of pay. The proportion of CHWs who reported feeling their job was “highly secure” was less than half of the proportion seen in the 2023 survey responses. *(See page 34.)*

Team Integration and Career Development

The large majority of CHWs agreed that they had opportunities to develop their professional skills. However, proportionally fewer CHWs agreed they had opportunities for pay raises, leadership roles, advancement in the profession, or promotions: between half and just under two-thirds of respondents agreed that these opportunities were available.

When asked about their perceived value within their organization, the majority of CHWs either agreed or strongly agreed that they are valued at their organization and that their role is important to the overall success of their organization’s programs. Most CHWs felt comfortable working with other providers to address client needs; but, as seen in 2023, far fewer felt that other providers had a strong understanding of their role as a CHW. *(See page 48.)*

CHW Supervision

Over two-thirds of CHWs rated their supervision quality as good or excellent. Approximately 55% said their supervisor had no previous experience as a CHW. Most CHWs agreed that their supervisors understood the strengths and needs of the communities they serve and that their supervisors encourage their professional growth. *(See page 51.)*

CHW Training and Continuing Education

Almost all CHWs (94%) indicated they had completed the MiCHWA 126-hour core-competency based training program either before or after being hired as a CHW. The majority of CHWs (83%) said that their employer requires them to maintain CHW continuing education credits. *(See page 53.)*

CHW Advocacy

Results aligned with those from previous survey years, with the largest proportions of CHWs agreeing that people who influence change in their organization seek their opinion and the smallest proportions agreeing they were part of one or more groups that influence policy at their organization. *(See page 56.)*

MiCHWA's Member Portal

Almost all survey respondents (97%) reported they were registered in the MiCHWA CHW Member Portal. *(See page 57.)*

MiCHWA's Impact

Survey respondents' comments on ways that MiCHWA has provided support for their roles fell into five themes. *(See page 58.)*

1. Education opportunities
2. Professional growth
3. Connections with other CHWs
4. Advocacy
5. Recognition of the CHW role

SECTION 1: INTRODUCTION

Survey Background

The 2025 Community Health Worker Survey is the third 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. MiCHWA has conducted a CHW Employer Survey biannually since 2014, with the most recent survey in 2024. In order to better understand CHWs' experiences first-hand, MiCHWA first administered a survey directly to CHWs in 2021 with support from MDHHS. MiCHWA has since conducted the Community Health Worker (CHW) Survey biannually, alternating with the CHW Employer Survey. This 2025 CHW survey was designed to update and extend the data collected in 2021 and 2023 and address new topics of interest. If resources allow, MiCHWA plans to continue surveying CHWs on a biannual basis.

Survey Instrument

The 2025 CHW Survey was adapted from the 2023 CHW Survey instrument. We made a few changes to several of the previous survey questions. These included adding items regarding CHW's concerns about personal safety while providing services; reducing the response options on CHW roles from five categories of frequency to three (to reduce respondent burden); and asking CHWs who completed a core-competency based training outside of MiCHWA to choose from a list of training organizations rather than writing in their responses.

We also added new questions to the 2025 CHW Survey. These included a question on degree required for the CHW's current position, two questions about Michigan Medicaid Policy (MMP) 23-74, which was introduced in January 2024 to expand Michigan Medicaid reimbursement for CHW services, two Likert-scale questions about CHWs' perceived value of their role, and a question asking CHWs how often they feel dismissed or devalued by other providers because of their racial, ethnic, or cultural background. We added a new section with four questions related to the overall quality, experience, knowledge and support provided by CHWs' supervisors. Lastly, we removed questions on CHW caseload and on the MiCHWA Member Portal.

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, four 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 nine 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 one CEU credit in recognition of their time.

Survey Distribution

The 2025 CHW Survey was developed using Qualtrics© software. The survey was distributed between March 5th and April 14th, 2025. The MiCHWA Executive Director sent the survey link to all contacts in the organization's CHW Network, Employer databases, and previous survey respondents who shared their email addresses. MiCHWA staff also posted the survey to the MiCHWA Member Portal, Facebook, Instagram, and Twitter. Multiple reminders to complete the survey were sent through each of these communication channels. We randomly selected ten survey respondents to receive a $50 electronic gift card.

Survey Sample

Of an initial 673 survey responses, we eliminated 404 invalid responses. We categorized responses as invalid if they were less than 50% complete, if the respondent indicated not currently working as a CHW or in an equivalent position, if the respondent reported spending half or more of their time in a supervisory role, or if the response appeared fraudulent. In instances where the same individual completed the survey multiple times, we eliminated the second response. After receiving many survey responses following social media promotion, we used the following criteria to determine potentially fraudulent responses, which were then eliminated from the dataset.

- Longitude and Latitude outside of Michigan
- Nonexistent organization name

- Survey duration under 300 seconds
- Open-ended responses matched that of other respondents
- Open-ended responses sounded inauthentic, AI-generated, or noted computer-based translation
- Email address contained long sequence of letters and numbers
- Email address contained a name that did not match the respondent's name

The final dataset consisted of 269 respondents, including 28 partial responses and 241 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 CHWs employed full time.

Analysis

Data were exported from Qualtrics© into Microsoft Excel. After the data were cleaned, the data were imported into IBM SPSS Statistics© Version: 30.0.0.0 (172). 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 2021 and 2023 CHW Surveys and the 2024 CHW Employer 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 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 2025 CHW Survey responses and the 2023 and 2021 CHW Survey responses, as well as

between the 2025 CHW Survey responses and the 2024 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 2025 sample size was comparable to 2023, both of which were larger than 2021, helping provide a robust picture of CHWs in Michigan. Survey responses also reflect all areas of the state and a range of organization types. Lastly, revised and new questions, including questions on the Michigan Medicaid Policy, supervisors' roles, and CHWs' perceptions of their role value and relevance within their organizations, provide new insights.

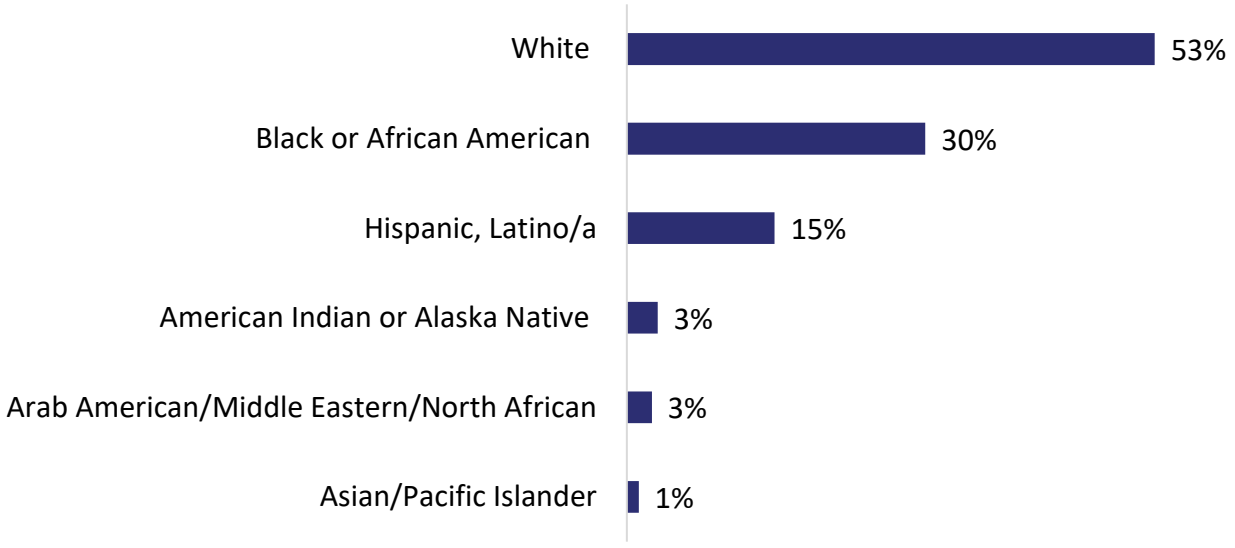
CHWS IN MICHIGAN

CHW Demographics

Eighty-six percent of the CHWs identified as women, 12 percent identified as men, and one percent identified as non-binary. The two most prevalent racial and ethnic identities were White and Black, as shown in Figure 1. Four people wrote in their racial and ethnic identity as follows: Ethiopian Israelite, German American, Middle Eastern Arab, and Ukrainian.

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.

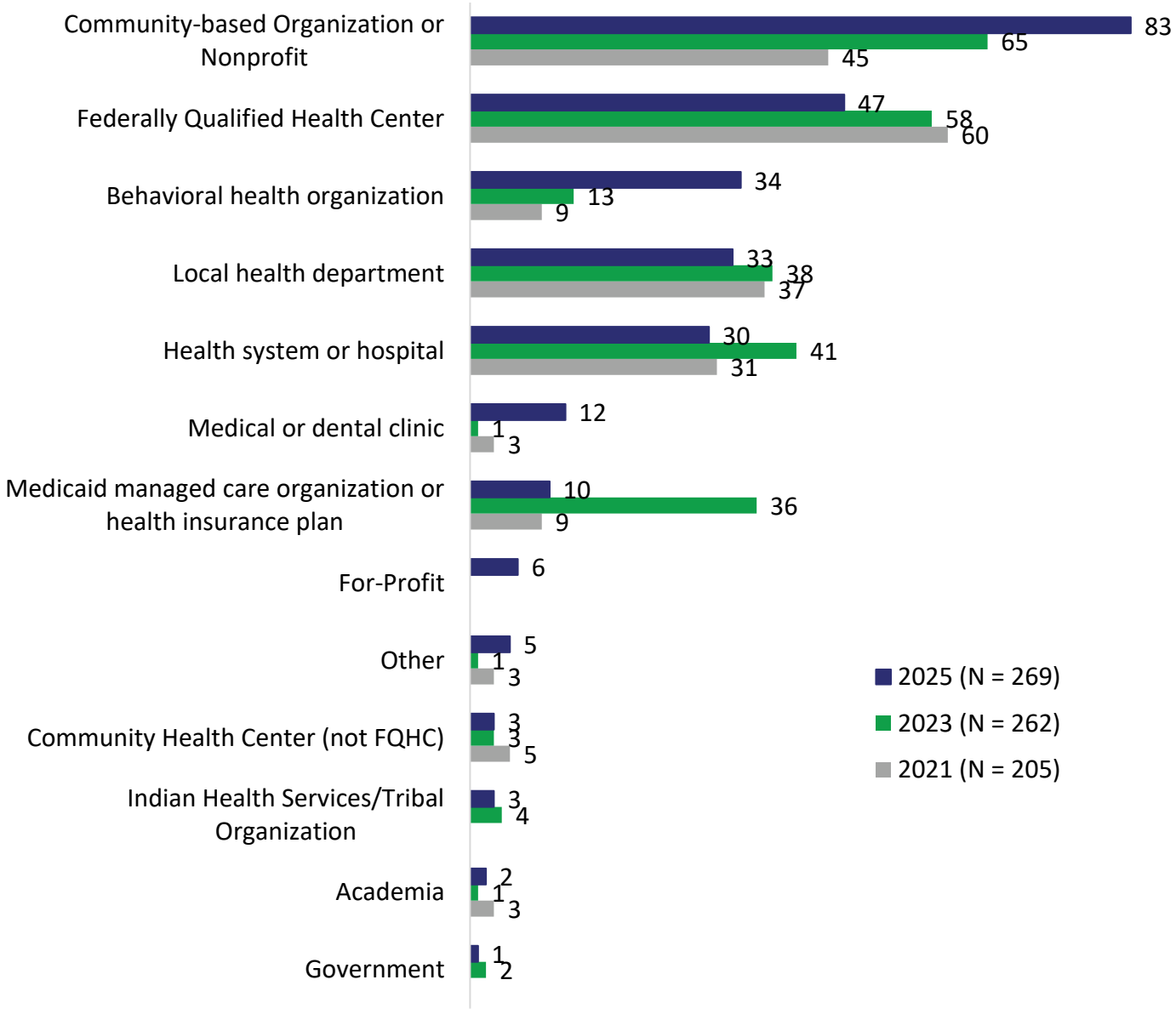
Figure 1. CHWs' Racial and Ethnic Identities (N = 243)



Organization Types and Settings

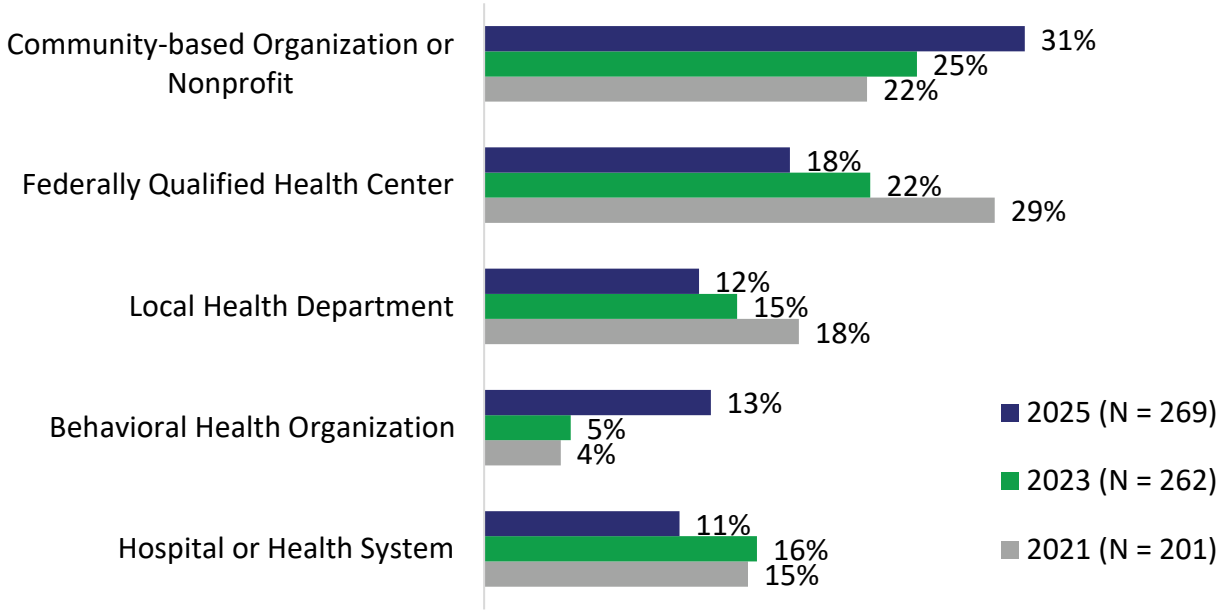
Individuals responding to the survey reported working for **a total of 149 unique organizations**. Figure 2 shows that, compared to 2021 and 2023, there were more CHWs from community-based or nonprofit organizations and from behavioral health organizations. The number of CHWs from Medicaid managed care organizations was similar to the number in 2021 after increasing in 2023. In 2025, a new category was added, "For-Profit," to capture CHWs working at private companies outside of the other categories.

Figure 2. Number of CHWs by Organization Setting and Survey Year



Compared to the previous two surveys, in 2025 proportionally more CHWs in the sample were employed by community-based organizations and behavioral health organizations. In contrast, CHWs employed by federally qualified health centers (FQHCs), local health departments and health systems comprised smaller proportions of the sample than in the previous two surveys.

Figure 3. Proportion of CHWs by Survey Year for the Five Most Frequent Organization Settings



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 2 and throughout the report are not duplicated. We chose a single category for each organization based on what best described the setting.

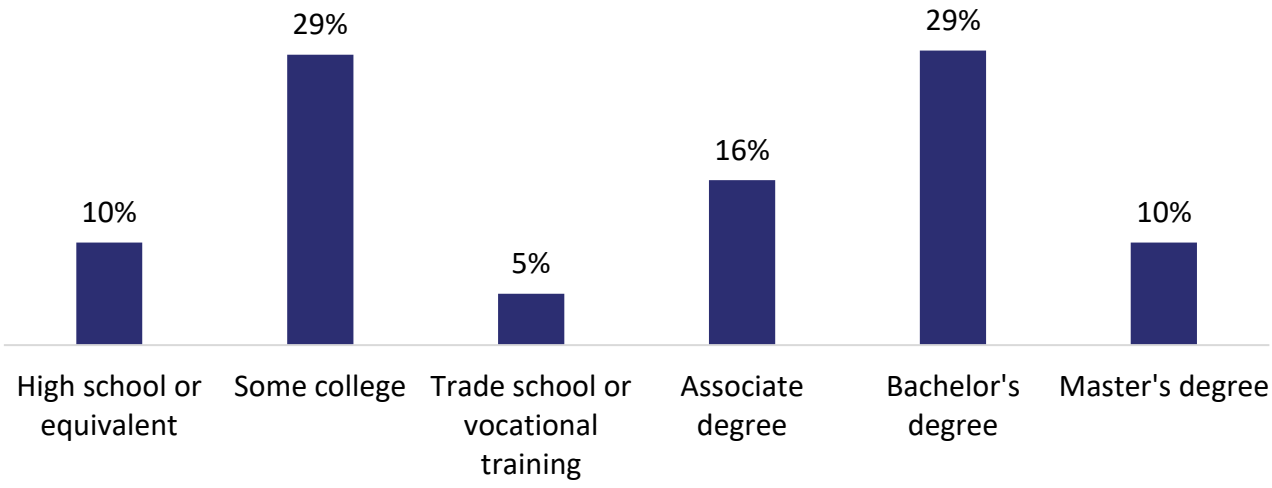
In the remainder of the report, "community-based organizations" refers to all non-profit organizations, regardless of size, which do not otherwise fit in one of the listed settings.

A Note on Comparisons

The report makes comparisons between the 2025 CHW Survey responses, the 2023, and 2021 CHW Survey responses as well as between the 2025 CHW Survey responses and the 2024 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 typically pertain to all of the CHWs that they employ or supervise, whereas CHWs' responses represent their own individual experiences.

With regards to the highest level of education obtained, **the majority of CHWs reported at least some post-high school education**, with the two largest groups indicating some college and completion of a bachelor's degree. (*See Figure 4.*) In 2025, 39% of CHWs reported a bachelor's degree or higher compared to 45% reporting a bachelor's degree or higher in 2023. Both of these figures are higher than the state average for Michigan, in which 32% of adults age 25 years or older have at least a bachelor's degree.[1]

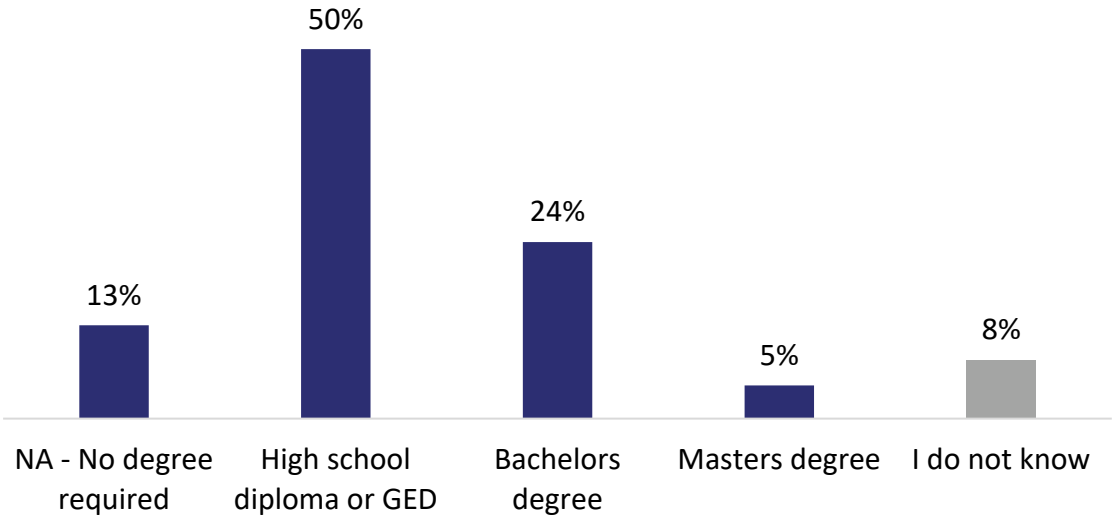
Figure 4. CHWs' Education Level (N = 256)



[1] U.S. Census. Percent of persons age 25 years+ with a bachelor's degree or higher, 2019-2023.

As shown in Figure 5, 29% of CHWs reported that their employer requires either a bachelor's degree or master's degree for their position. In contrast, findings from the 2024 MiCHWA CHW Employer Survey showed only 1% of employers reported required a bachelor's degree and no employers required a master's degree.

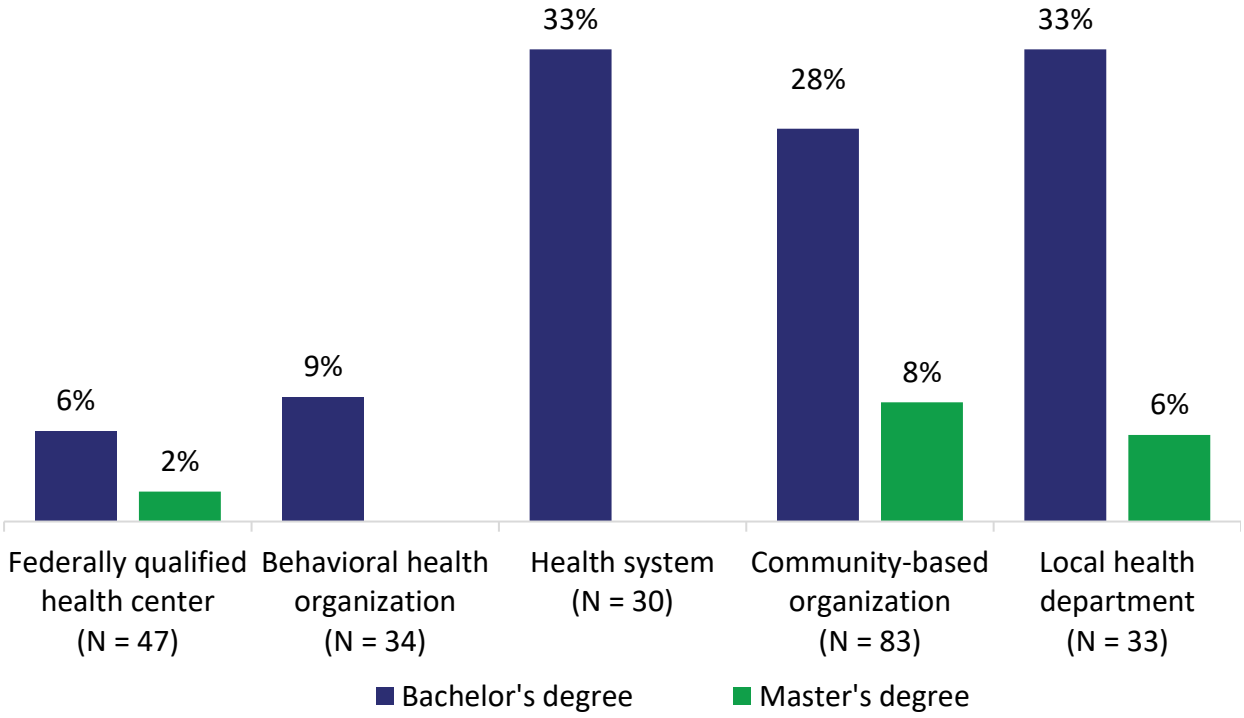
Figure 5. CHW Position Degree Requirements (N = 269)



The findings from the CHW Survey indicate that, **in many cases, CHWs may have more education than required for their position**. In survey results, 94% of the CHWs who reported that their employer had no degree requirement had at least some post-secondary education. Similarly, 82% of the CHWs who reported that their employer requires a high school degree for their position indicated they have some post-secondary education. *(See Figure 1 in Appendix A for a full comparison between degree requirements and CHWs' level of education.)*

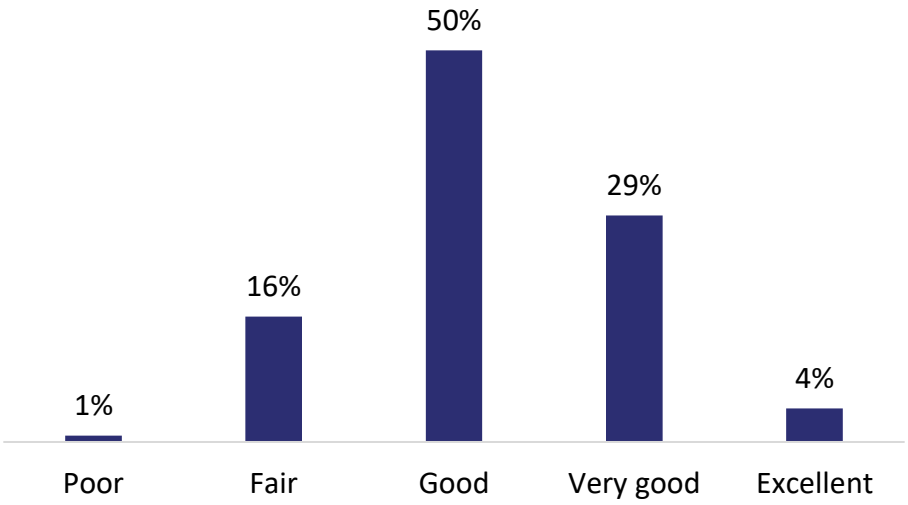
We found some differences in degree requirements by organization setting. While upwards of one in three CHWs at health systems, community-based organizations, and local health departments said a college degree was required for their position, fewer than one in ten CHWs at FQHCs and behavioral health organizations reported the same. These differences are shown in Figure 6. We did not find a consistent pattern between degree required and years of service as a CHW.

Figure 6. CHW Position Degree Requirements by Organization Setting



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, as shown in Figure 7. Forty-one people indicated their health was “fair” (16%) and two people said “poor” (1%).

Figure 7. CHWs’ Health Status (N = 256)



Position Status

The vast majority of survey respondents, **84%, reported being in a paid, full-time role** as a Community Health Worker. An additional 10% reported being in a paid, part-time role. Seven individuals said they worked on an "on call" basis and ten individuals said they volunteered, including three who did so full-time. Just over 8% of respondents indicated they had a supervisory role requiring less than half of their time.

Years in CHW Role

Individuals responding to the survey reported **working in the CHW role for an average of 4.7 years,**[2] with a maximum of 35 years. Fifty-three people, or 20%, reported being in the role for less than a year. This represents a similar proportion to that seen in both 2023 and 2021, when 20% and 17% respondents, respectively, reported serving as a CHW for less than a year. The fact that approximately one-fifth of CHWs are new to the field each survey year could indicate that the field is continuing to grow or that it has a high turnover. On the other end of the spectrum, 36 people (13%) in 2025 reported serving as a CHW for ten years or more.

Languages of Service Delivery

In addition to providing services in English, 40 people (15%) said they provide CHW services in Spanish, and 9 people (3%) provide services in Arabic. Others wrote in that they provide services in the following languages:

- German – 3 people
- American Sign Language – 2 people
- Chinese – 2 people
- Romanian – 1 person
- Vietnamese – 1 person

[2] This figure assumed 0.5 years for everyone who reported being in the role for less than a year and rounded all responses to the nearest half year.

Position Titles

While survey respondents reported a wide range of different position titles, **"Community Health Worker" was by far the most common title, reported by 67% of respondents.** Survey respondents reported a total of 46 other unique position titles, including 12 additional titles listed as response options and 34 unique titles respondents wrote-in. Figure 8, below, shows the position titles from the 89 respondents who reported a title other than "Community Health Worker."

Figure 8. Position Titles

Location of CHW Service Delivery

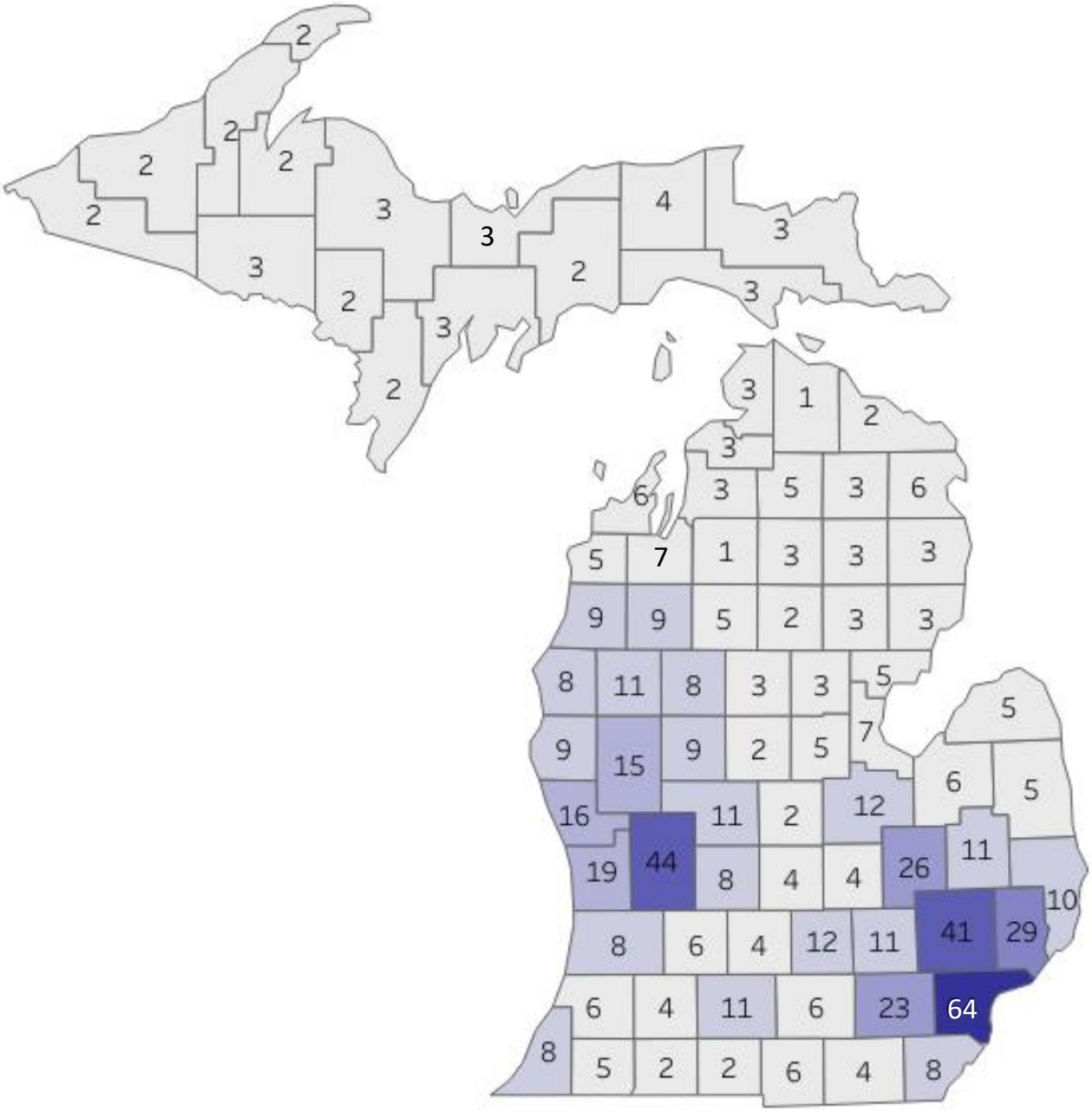
CHWs reported serving an average of 2.4 counties each. **Nearly two-thirds of respondents reported serving a single county** (64%, *n* = 172). Twenty-four CHWs (9%) reported serving five or more counties, including one CHW reporting serving all 83 of Michigan's counties.

Wayne County had the highest number of CHWs that reported providing services in that county. Wayne was followed by Kent, Oakland, Macomb, and Genesee counties, which each had between 26 and 44 CHWs providing services. Cheboygan and Kalkaska County had the fewest CHWs, with only the single CHW providing services statewide reporting serving those areas.

Wayne, Kent, and Genessee had the most CHWs that reported serving a single county. Between 34 and 19 CHWs, representing between 73% and 53% of the CHWs providing services in those counties, were dedicated solely to serving those counties. On the other end, Oakland and Macomb counties had the highest number of CHWs that reported serving five or more counties. In these locations, only 22% (*n* = 9) and 7% (*n* = 2), respectively, of the CHWs providing services in Oakland and Macomb counties were dedicated solely to serving those counties.

Eighteen counties were served only by CHWs that reported serving five or more counties. In other words, these counties did not have any CHWs dedicated solely to serving their communities. Thirteen of the 15 Upper Peninsula counties were in this group (Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Keweenaw, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft) as well as five counties in the Lower Peninsula (Cheboygan, Kalkaska, Oscoda, Roscommon, and Sanilac). *(For the list of how many CHWs reported providing services in each county, see Table 1 in Appendix A).*

Figure 9. Number of CHWs Providing Services by County (N = 268)



CHW ROLES AND ACTIVITIES

As in previous survey years, 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],[4]

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

In 2025, **CHWs reported engaging in an average of 13 sub-roles frequently**. In comparison, the equivalent average was 16 sub-roles in 2023. Looking at individual sub-roles, most sub-roles had a smaller proportion of CHWs reporting frequent engagement and a larger proportion of CHWs reporting occasional engagement compared to 2023. In 2025, there were 11 sub-roles that at least 50% of CHWs reported playing frequently, with a maximum proportion of 72%. In contrast, in 2023, there were 16 sub-roles that at least 50% of CHWs reported playing frequently, including three played frequently by 75% or more and a maximum of 84%. It is not clear whether these changes are artifacts of the survey process, such as the change in response options or changes in the sample composition, or if they reflect changes in the work of CHWs in the state.

Despite these differences, the three most common sub-roles were consistent between 2025 and 2023:

- Motivating and encouraging people to obtain care and other services (Role 4, sub-role b; 72%)
- Connecting to resources and advocating for basic needs (Role 5, sub-role b; 71%)
- Meeting basic needs (Role 7, sub-role c; 70%)

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

[4] The 2025 format changed from the 2023 format. The 2023 survey included five frequencies for each sub-role: never, rarely, sometimes, often, and very often. The 2025 survey included three frequencies: never, occasionally, and frequently. Where there are comparisons between the two years, the "never" and "rarely" responses from 2023 correspond with the "never" responses from 2025, the "sometimes" responses from 2023 correspond with the "occasionally" responses from 2025 and the "often" and "very often" responses from 2023 correspond with the "frequently" responses in 2025.

CHW Perspectives

"I have had the privilege of assisting patients with various social determinants of health, addressing barriers that impact their well-being beyond medical care. Through my work, I've consistently seen how access to clean clothing is a critical yet often overlooked factor influencing a person's dignity, health, and overall quality of life. Seeing this gap, I developed an outreach initiative to provide laundry care assisting those in need."

"I assist clients on a daily basis with connecting to resources that they need such as food, housing, home repairs, heat and electricity."

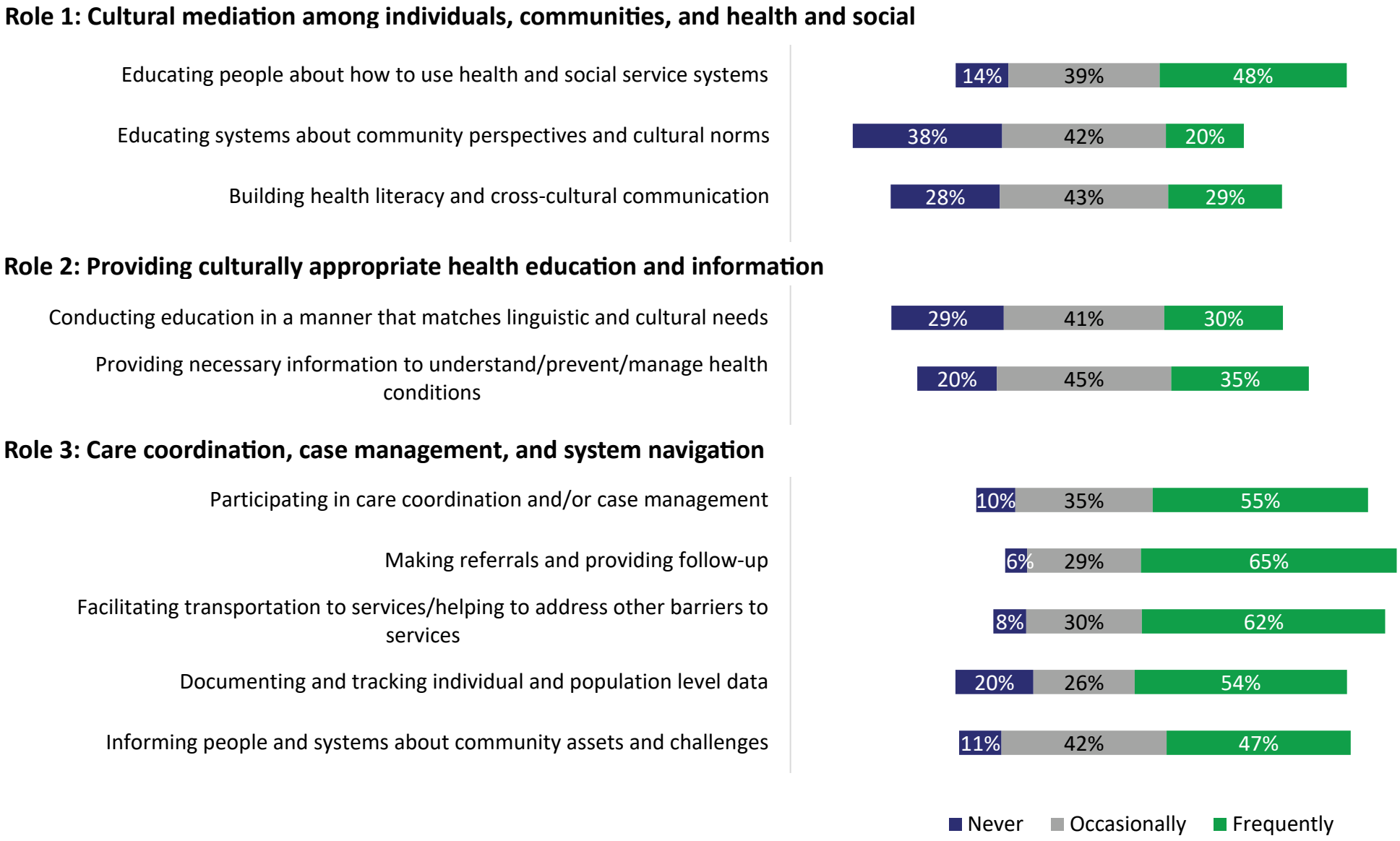
"I often call CHW the hands and feet of providers. CHWs are in the patient's world. CHWs see many complex issues that the provider may not understand. CHWs have special access to the patient's life that is often left out at a health care professional's appointment."

For additional description of ways that CHW support clients, see Appendix D, on page 96.

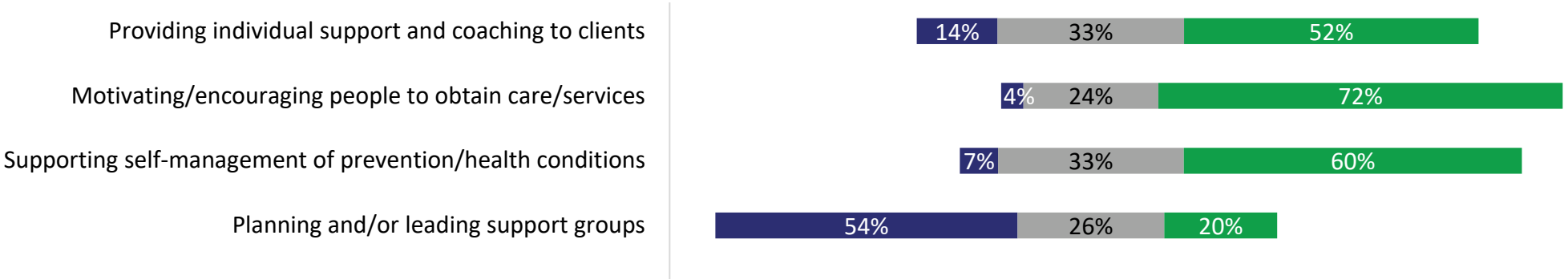
The top ten sub-roles and their respective frequencies of engagement are shown in Figure 10. Figure 11 shows the frequency of engagement in all sub-roles. The relative frequency of engagement in sub-roles was largely consistent with 2023. As seen in previous surveys, CHWs reported the greatest level 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*.

Figure 10. Top 10 CHW Sub-Roles by Frequency of Engagement (N = 251)

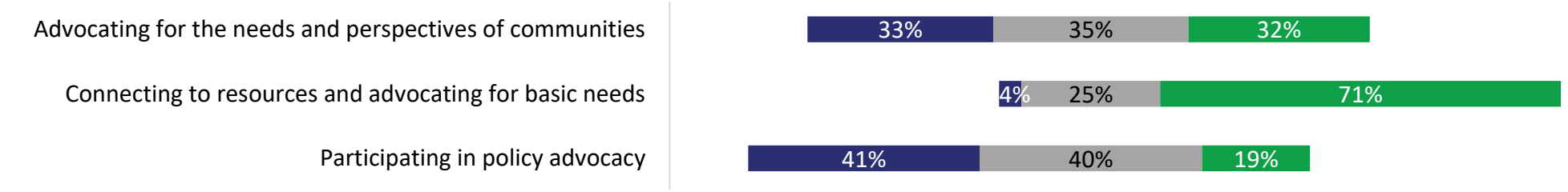
Figure 11. Frequency of Engagement in CHW Roles (N = 251)



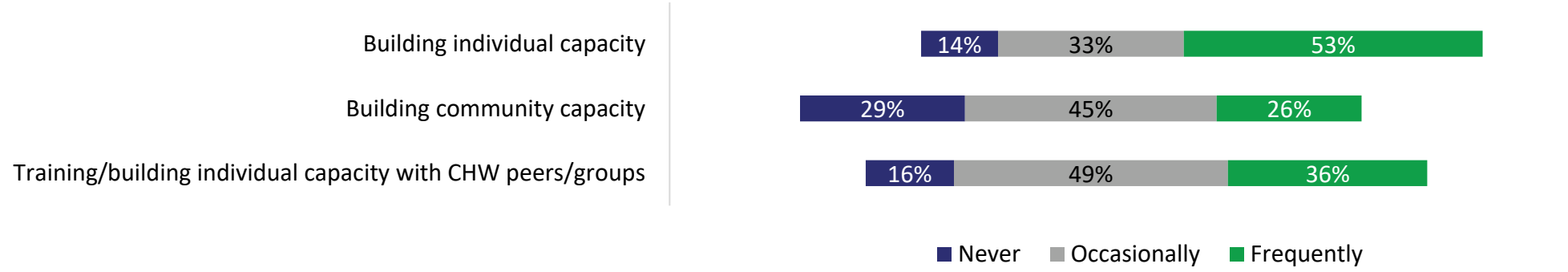
Role 4: Providing coaching and social support



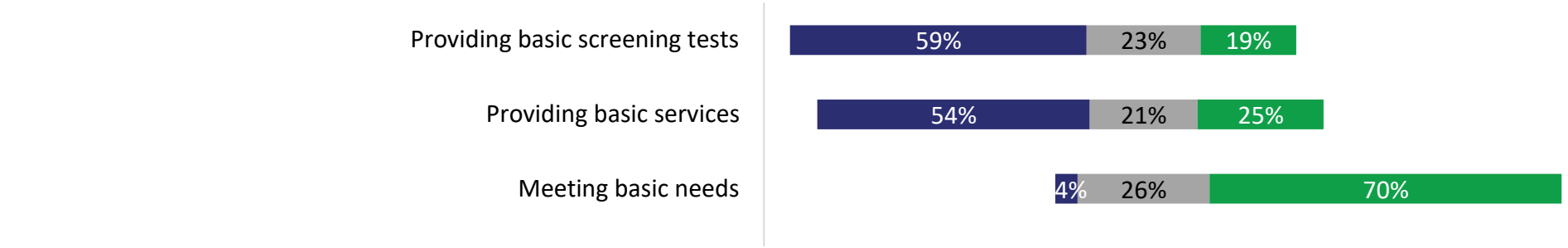
Role 5: Advocating for individuals and communities



Role 6: Building individual and community capacity

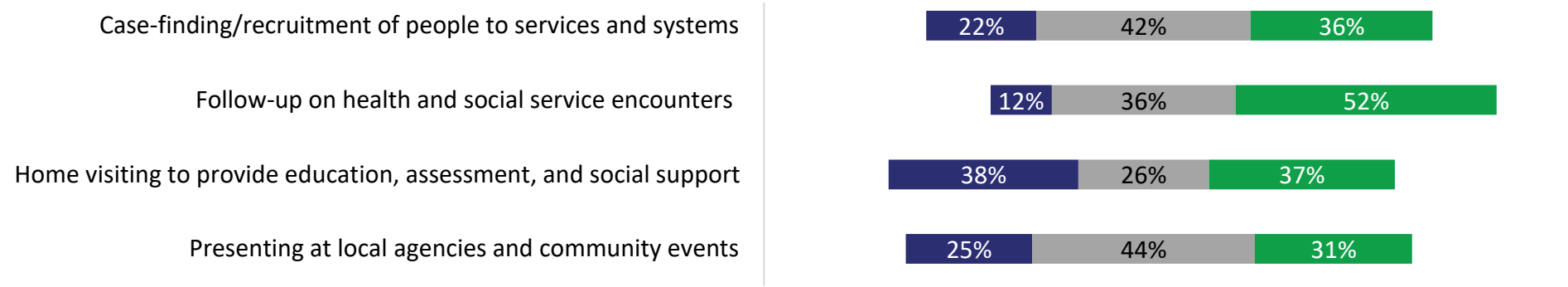


Role 7: Providing direct service



Role 8: Implementing individual and community assessments

Role 9: Conducting outreach



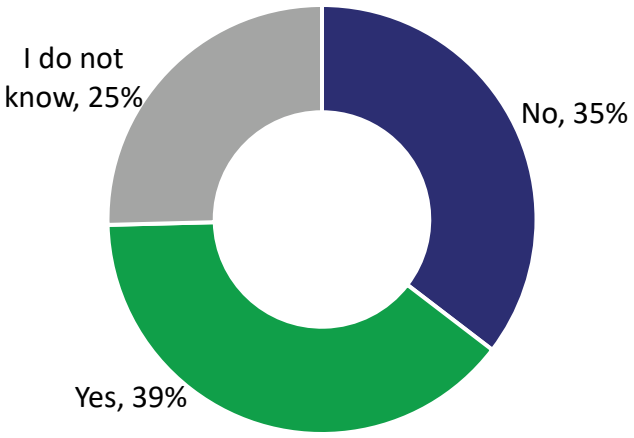
Role 10: Participating in evaluation and research

Billing Status

The 2025 CHW Survey included two questions to understand the uptake and implications of the Michigan Medicaid Policy (MMP) 23-74, which took effect January 1, 2024. This policy established eligibility criteria for CHWs to be recognized as Medicaid providers, allowing reimbursement of state plan covered CHW services, including health system navigation and resource coordination; health promotion, and education; screening; and assessment. In order to bill for services, a CHW must first be enrolled as a "Rendering/Servicing-Only Provider" in Michigan's Community Health Automated Medicaid Processing System (CHAMPS).

As an indicator of eligibility to bill, the survey asked CHWs to indicate whether they were enrolled in CHAMPS. Responses show that **39% of CHWs (*n* = 105) reported enrollment in CHAMPS**. For comparison, as of March 31, 2025 (approximately the midpoint of the survey distribution timeline), a total of 349 Community Health Workers were enrolled in CHAMPS.

Figure 12. CHW CHAMPS Enrollment (N = 268)



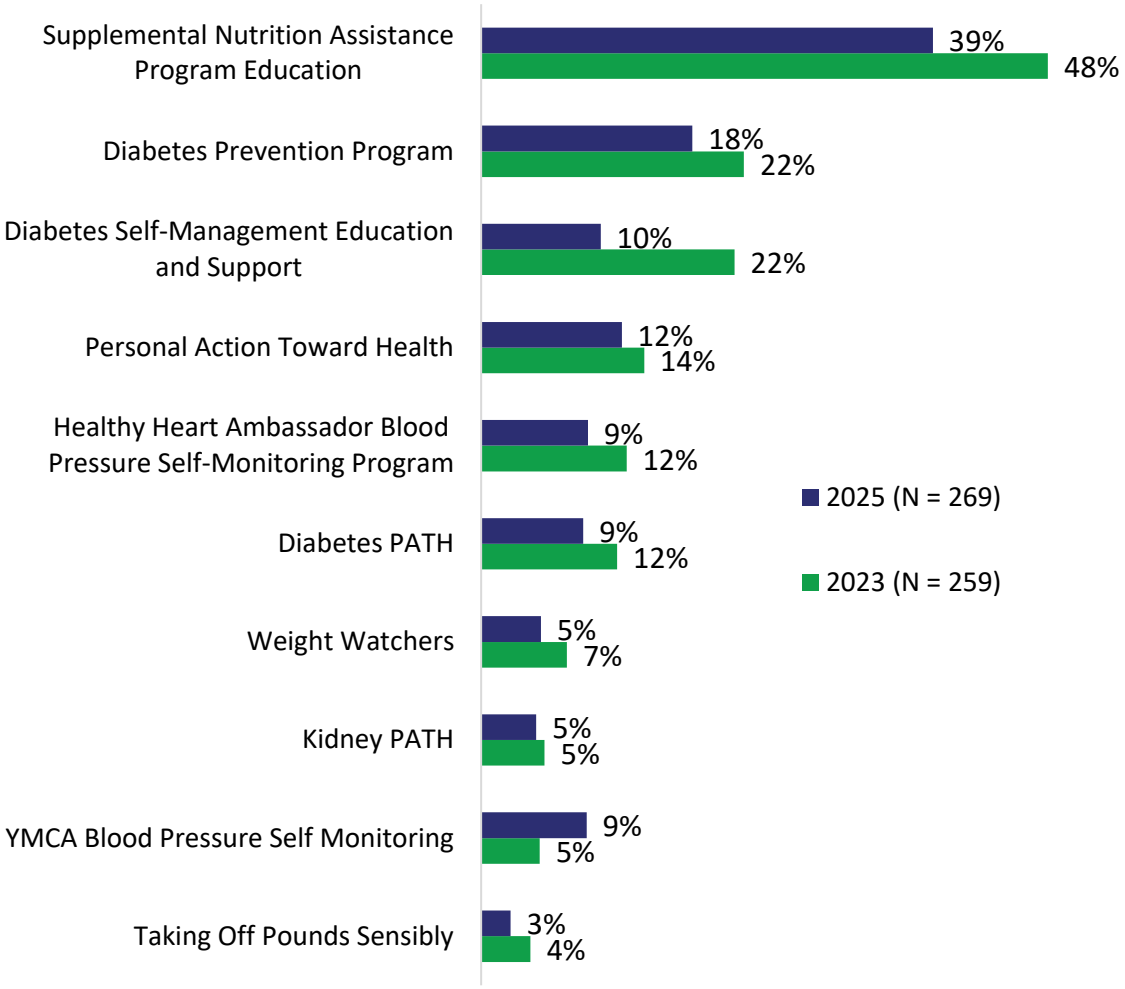
As employers implement Medicaid billing, which excludes coverage of some typical CHW roles, such as case management, advocacy, community outreach, and evaluation, some CHWs may start to shift towards more reimbursable roles. To understand this possibility, the survey also asked CHWs “How, if at all, has your

role changed (or do you expect your role to change) because of this change in Medicaid policy?" Of the 89 people who indicated they are enrolled in CHAMPS and answered this question, only 12 people shared they had seen a change in their role and only one person expected to see a change. Among those who reported a change, the most common response, shared by five people, was a change in administrative duties related to billing and documentation. The low number of people reporting a change in role could reflect the fact that many employers are still building the infrastructure and processes for CHW billing.

Referrals

As in 2023, the 2025 CHW Survey asked CHWs whether they made referrals to a series of listed lifestyle change programs. **Close to half of respondents (48%) reported not making referrals to any of the listed programs.** The Supplemental Nutrition Assistance Program Education (SNAP-Ed) remained the most commonly referred program in 2025, as seen in Figure 13. However, with the exception of the YMCA Blood Pressure Self Monitoring program, the proportion of CHWs making referrals was lower for all listed programs in 2025 than in 2023. While one person reported making referrals to all ten listed programs, the largest group of CHWs (29%) reported referring to a single listed program.

Figure 13. CHW Referrals to Lifestyle Change Programs by Survey Year

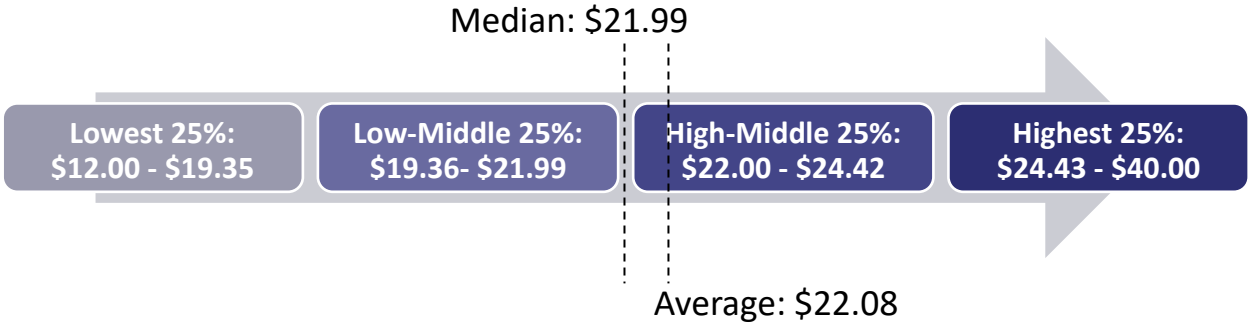


CHW SALARIES AND JOB SECURITY

CHW Compensation

CHWs were asked to share either their hourly rate of pay or their annual salary. There were 213 people who reported an hourly rate and 42 people who reported an annual salary. After excluding one outlier and converting salaries to an equivalent hourly rate,[5,6] **compensation ranged from $12.00 to $40.00 an hour, with an average of $22.08,** up slightly from the 2023 average of $21.37. Figure 14 shows the hourly rate ranges when respondents are divided into four equal groups (quartiles). The median of $21.99 means that half of respondents were making less than $21.99 per hour. A quarter of respondents reported wages of $19.35 or less per hour.

Figure 14. CHW Compensation Ranges (N = 254)



CHW Perspectives

"I'm happy with my job but it's difficult to live off $40k a year. I would like to increase my income to at least $60k to function and be comfortable."

[5] One extreme outlier was excluded from the compensation analyses: $50/hour.

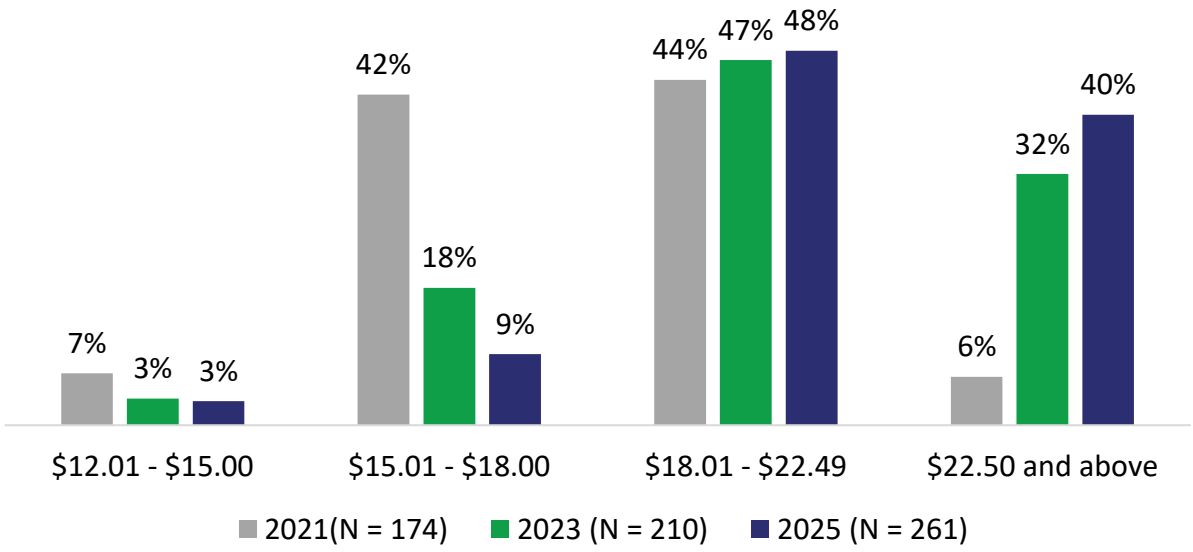
[6] This and the following figure convert the annual salary responses into hourly rates for a more complete analysis.

Who was in the top wage bracket?

The three individuals who reported an hourly wage between $35.00 and $40.00 had been working as a CHW for as recently as less than a year and as long as seven years. One of these CHWs worked for a government agency, one for a local health department, and one was self-employed. The education level for this group also varied. One of the CHWs had a bachelor's degree and one an associate's degree; the third did not report education level. None of these individuals reported having a supervisory role.

Dividing the salary and hourly rate responses into the wage categories used in previous MiCHWA CHW Surveys allows for a comparison across the three survey years, as shown in Figure 15. In the 2025 CHW survey, there were proportionally more CHWs making $22.50 or more and proportionally fewer CHWs making between $15.01 and $18.00 compared to previous survey years.

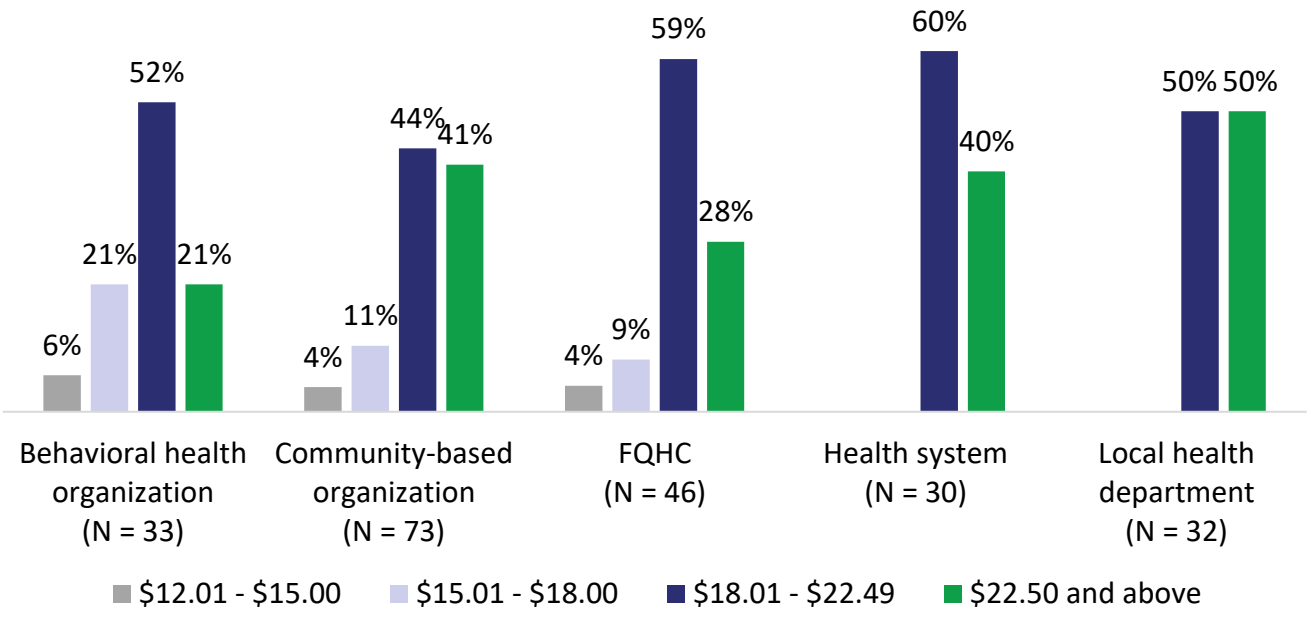
Figure 15. Pay Rate Category by Survey Year



When comparing pay rates among the five most common employer settings in the survey sample, health systems and local health departments had the highest average hourly pay rates, with rates of $23.20 and $23.50 respectively.

Community-based organizations and FQHCs had similar average pay rates of $21.85 and $21.52 respectively, while behavioral health organizations had the lowest average pay rate of $19.75. These differences in pay can also be seen in the distribution of pay rate categories by setting (Figure 16), where local health department and health system have the highest percentage of individuals in the two top pay rate categories.

Figure 16. Pay Rate Category by Setting



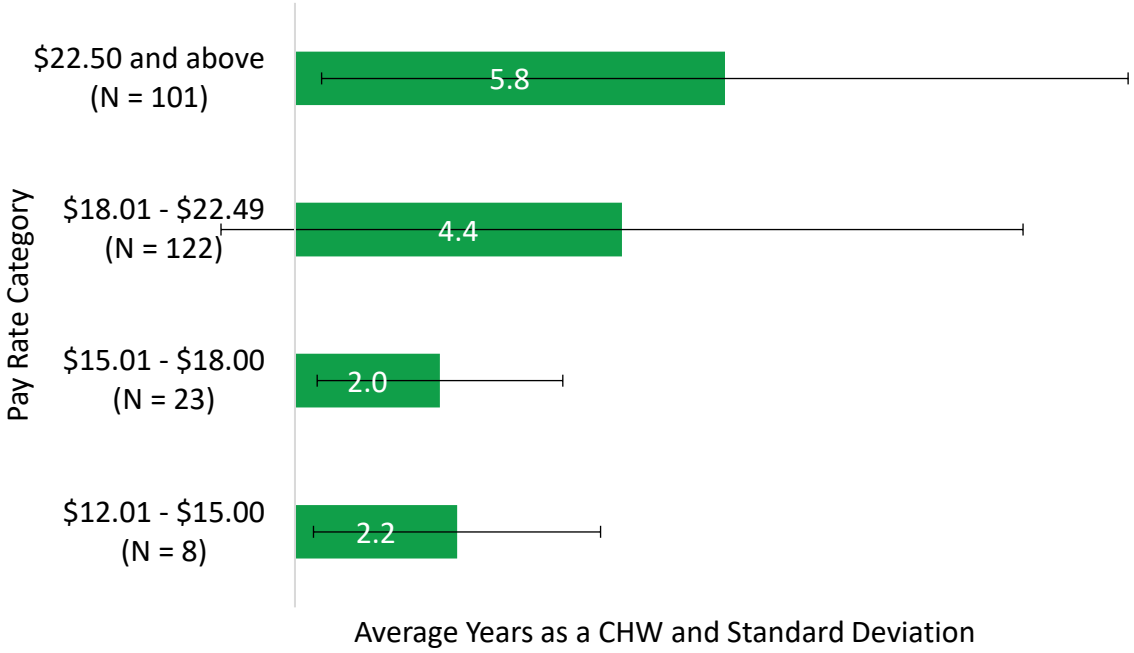
CHW Perspectives

"I wish there were more that can be done so that there aren't huge pay disparities amongst CHWs. Those working privately or for hospital systems are earning way more than those working in a CBO or FQHC."

When looking at pay rates by number of years as a CHW, the CHWs in the two lowest pay categories had fewer years in the role, on average, as shown in Figure 17. While the average number of years as a CHW was higher for the two highest pay categories, there were many more CHWs in these pay categories and these groups had large ranges in years as a CHW, from less than a year to 27 or 28 years. The standard deviation bars reflect these large ranges.

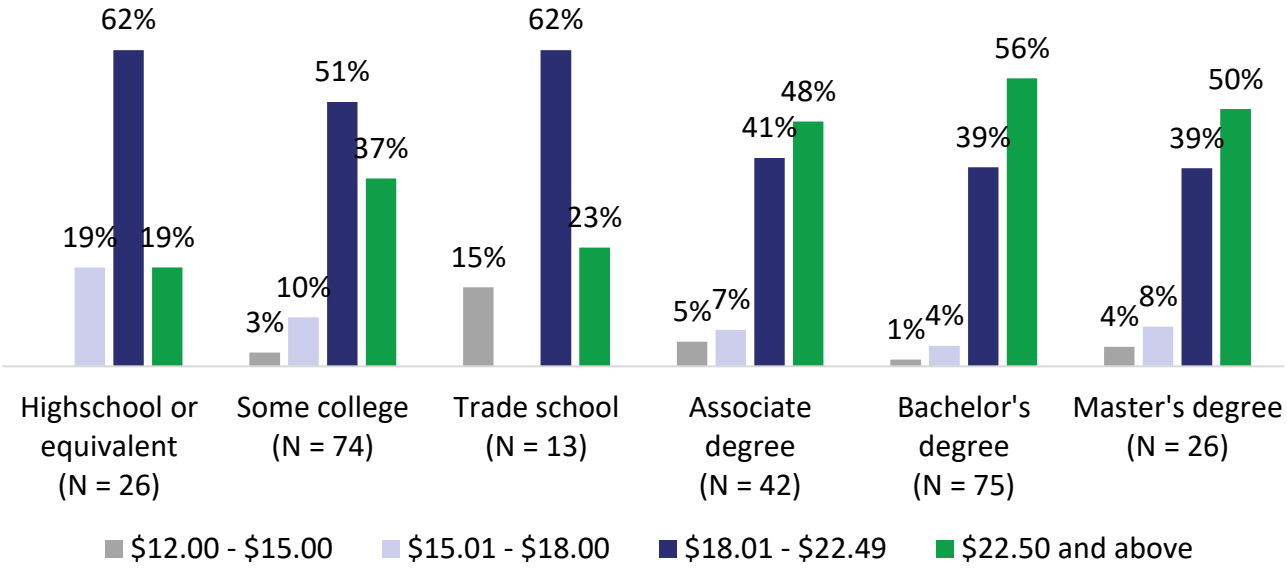
The relationship between pay rate and years of service as a CHW is also complicated by the fact that we do not know from the data collected whether or not the CHWs in the sample have changed jobs within the CHW field or stayed in the same position.

Figure 17. Pay Rate by Average Years as a CHW



Pay rate also varied by level of education. As shown in Figure 18, the proportion of CHWs at the highest pay range was largest among those with bachelor's degrees and smallest among those who did not have any post-secondary education. Although the sample sizes were not comparable, the average hourly rate for CHWs with a master's degree ($22.47) and CHWs with a bachelor's degree ($23.37) were both higher than the average hourly rate for CHWs with a high school education ($20.49) and for CHWs with some college ($21.18).

Figure 18. Pay Rate by Education



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, Latino/a, or Arab American. Similarly, we did not find a relationship between pay rate and supervisory responsibilities. The average pay rate for the twenty CHWs who spent at least some of their time in a supervisory role[7] was very similar to that of other respondents.

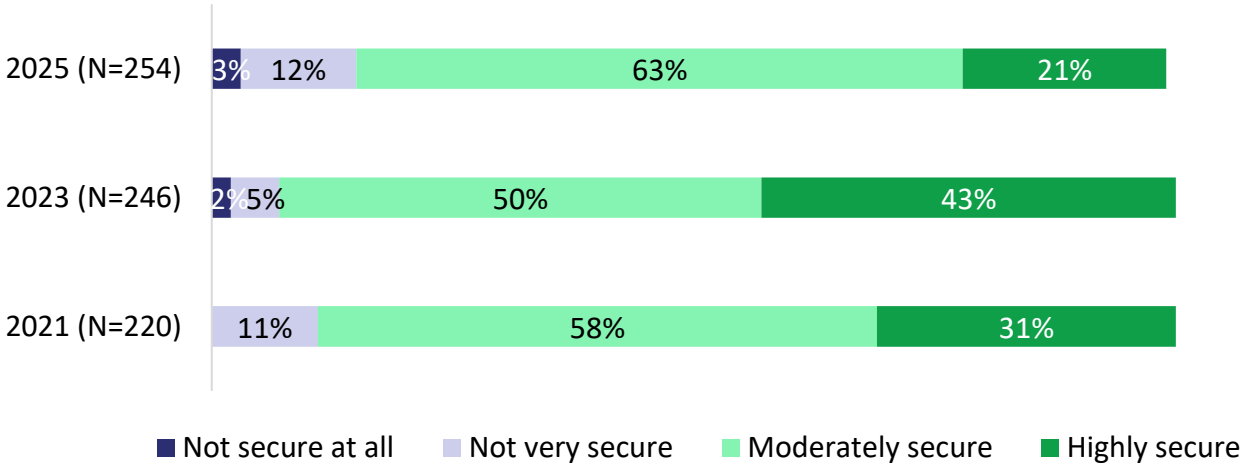
[7] CHWs who spent half or more of their time in a supervisory role were screened out from the survey.

Layoffs and Job Security

Twenty CHWs said they had been previously laid off or furloughed, including three people who had been laid off more than two times. This proportion of survey respondents (8%) is larger than the proportion that reported being laid off in 2023 (5%). In previous surveys, the CHWs who had been furloughed or laid off at least once had, on average, worked as a CHW for longer than those who had never been laid off. However, in 2025, the 17 CHWs who reported one or two layoffs had worked as a CHW for fewer years, 3.8 years on average. By comparison, the CHWs who had never been laid off had an average of 4.7 years as a CHW. The three CHWs who reported being laid off more than twice had been CHWs for 9.2 years on average.

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" was less than half of the proportion seen in the 2023 survey responses, as shown in Figure 19.[8] Also, in 2025, the proportion of CHWs that reported feeling their job was "not very secure" was more than twice as large as the proportion in 2023. These changes in perceptions of job security could be attributed to the timing of the survey. Responses were collected between March 5th and April 14th, 2025, a time when federal funding and policy changes may have affected CHW programs.

Figure 19. CHWs' Perception of Job Security by Year



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

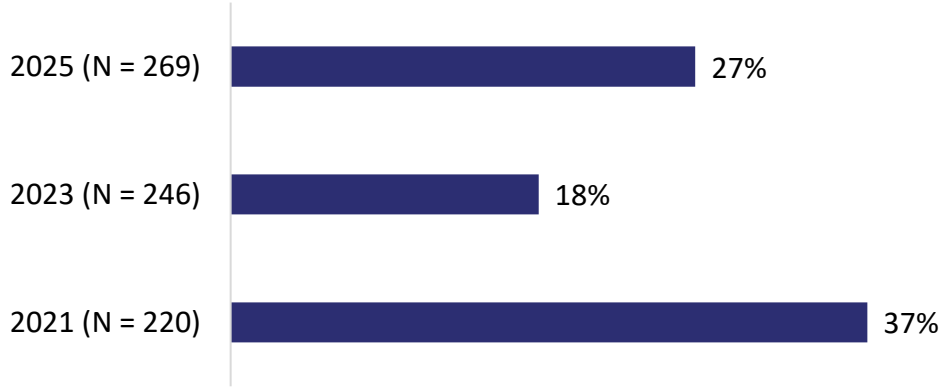
CHW Perspectives

"My concerns are over continued funding as the Navigator grant I work under is ending."

Additional Jobs

A total of 72 CHWs (27%) reported working for pay in a position other than as a CHW. Of these, 51 (71%) were also paid, full-time CHWs; thirteen (18%) were paid, part-time; four (6%) were on-call only; and four (6%) volunteered. The proportion of CHWs who indicated that they have a second job was larger than in 2023 but smaller than in 2021, as seen in Figure 20.

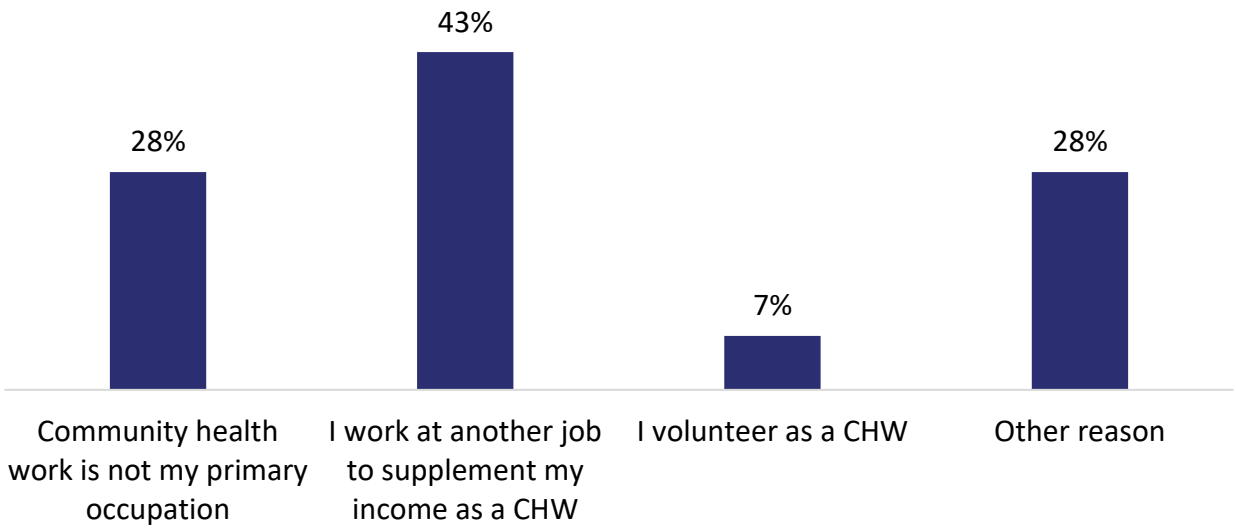
Figure 20. Percent of CHWs with a Second Job by Year



The most common reason for working a second job was to earn additional money. Among the 72 people with a second job, 43% said they worked at another job to supplement their income as a CHW, as shown in Figure 21. This group represented 12% of the total survey sample. In other words, approximately one in ten CHWs reported working a second job to supplement their income. The average compensation rate for those who reported working a second job ($21.91) was nearly equivalent to that of people that did not report working a second job ($22.15).

Other reasons for holding a second job included that Community Health Worker was not their primary occupation (20 people) or that they volunteered as a CHW (5 people). Sixteen people wrote responses explaining why they work a second job. The reasons given among this group included not feeling secure in their CHW position due to instability of grant funding and personal circumstances, such as working as a caregiver for a relative.

Figure 21. Reasons for Working a Second Job (N = 72)



Sustainability of CHW Positions

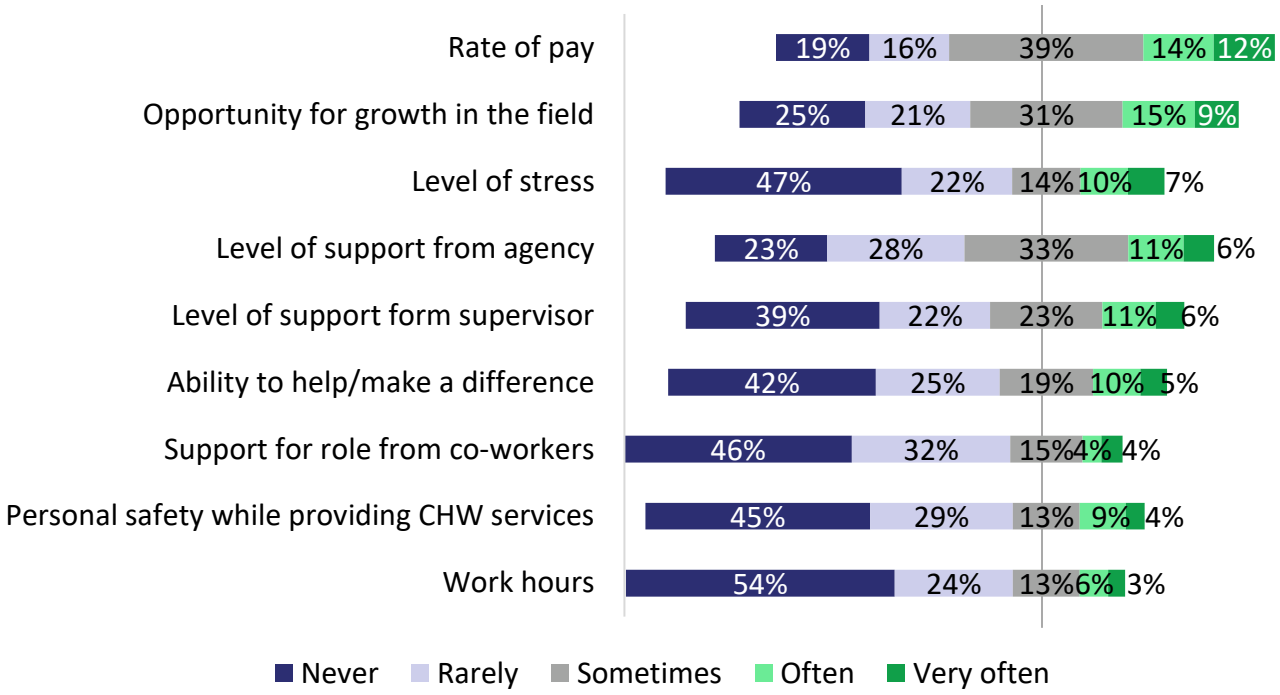
CHWs were asked to indicate how often they felt inclined to quit in relation to the factors listed in Figure 22. As with the 2023 CHW Survey, **nearly two-thirds of respondents indicated they at least sometimes felt inclined to quit because of the rate of pay,** including 26% who felt this inclination often or very often. The inclination to quit because of the pay rate was more prominent among those with a bachelor's or master's degree: 36% in this group said they often or very often were inclined to quit because of the rate of pay. In comparison, 21% of those with no more than an associate degree felt the same.

Feeling inclined to quit because of the limited opportunities for growth in the field was also prevalent, with 24% of CHWs reporting this often or very often. This

proportion is also in line with results from the 2023 survey. *(For the full comparison, see Table 2 in Appendix A).*

Fourteen CHWs wrote in reasons they at least sometimes feel inclined to quit. Four people mentioned a lack of resources or funding concerns, including challenges with connecting clients to external agencies, concerns related to future lack of resources due to changes in federal policies and funding, and concerns that funding will be cut. A few CHWs shared personal reasons, including interest in establishing their own non-profit, pursuing an LBSW, and perceived limitations of the CHW role after becoming a social worker and counselor. Other factors listed were frustrations with other CHWs, having to self-advocate (e.g. create their own job description, scope, protocols, and procedures), and workplace bullying or emotional abuse from co-workers.

Figure 22. Frequency of Feeling Inclined to Quit by Factor (N = 262)



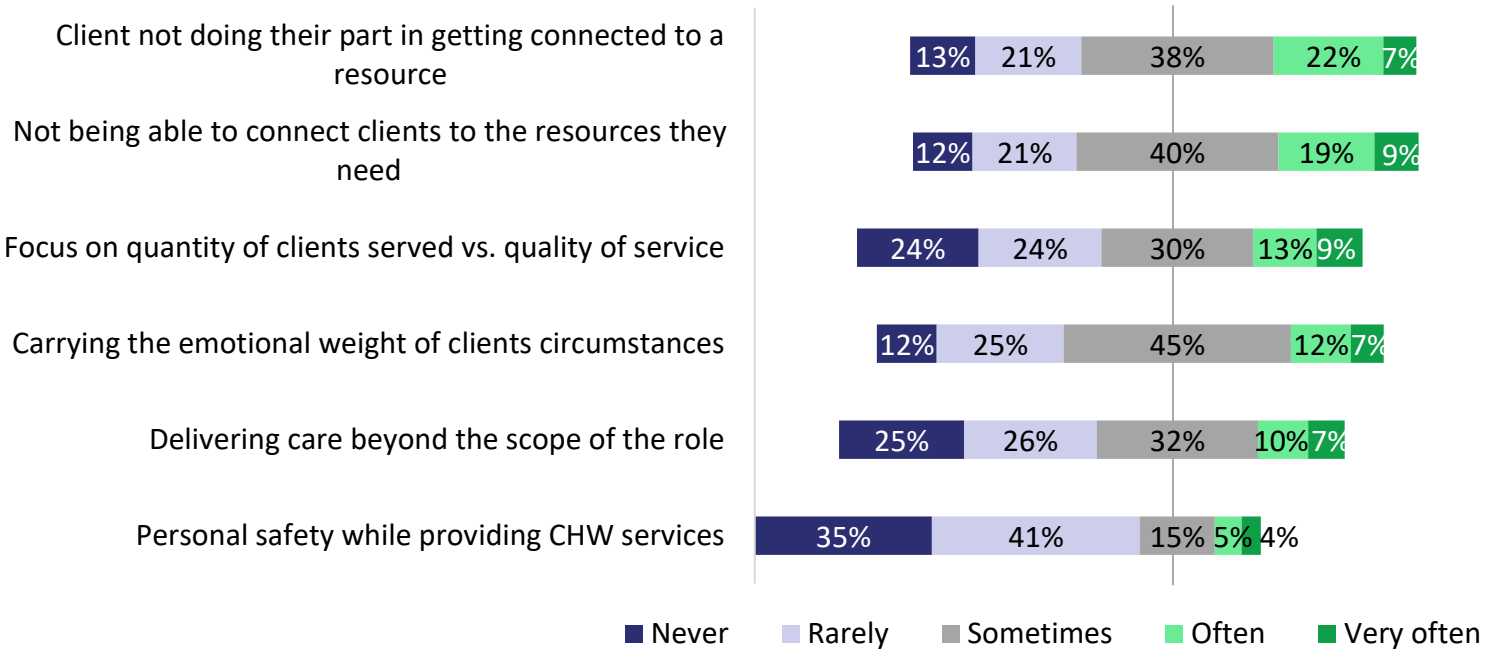
The CHW Survey also asked about CHWs' experiences of burnout. The **largest proportion of CHWs reported feeling burnt out often or very often because of clients not following through with the resources offered**. The potential for burn out related to personal safety was new in the 2025 survey. The proportions of

CHWs who reported feeling burnt out often or very often was very similar to the proportions in 2023 for the other five factors.

CHW Perspectives

"There is an inherent amount of risk to home visiting CHWs and community-based CHWs and not all agencies have the capacity for 2 person teams for home/community visits. I think there should be an increase in funds for companies to be able to hire more CHW support staff, (and pay increases for CHW staff), to provide the supportive structure for safety that our CHWs deserve as we work in the community to serve our most vulnerable population."

Figure 23. Frequency of Feeling Overwhelmed or Burnt Out by Factor (N = 262)



CHWs shared a few additional factors contributing to feeling overwhelmed or burnt out. The factors listed, each named by one person, were experiencing the loss of a client, lack of community support, feeling restricted by management on what the CHW can or cannot do to support clients, having to prioritize billable

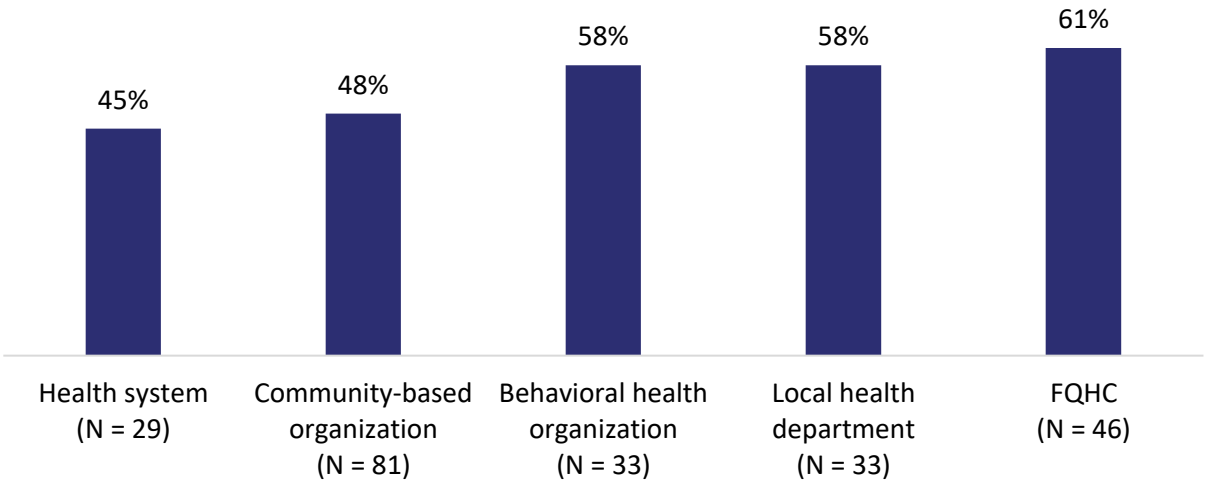
services over general well-being, and difficulty obtaining emergency services for clients.

CHW Perspectives

"We form deep connections with those we serve, making it essential to have grief support when a patient passes. I believe we often lack structured support in processing loss and I believe MiCHWA could help provide resources such as peer discussion or debriefing sessions."

Proportionally fewer CHWs working in health systems reported regularly feeling burnt out compared with other work settings, as shown in Figure 24. More than half of CHWs working in local health departments, behavioral organizations, and FQHCs reported regularly feeling burnt out due to one or more factors.

Figure 24. Percentage of CHWs by Setting Reporting Feeling Burnt Out Often or Very Often by One or More Factors

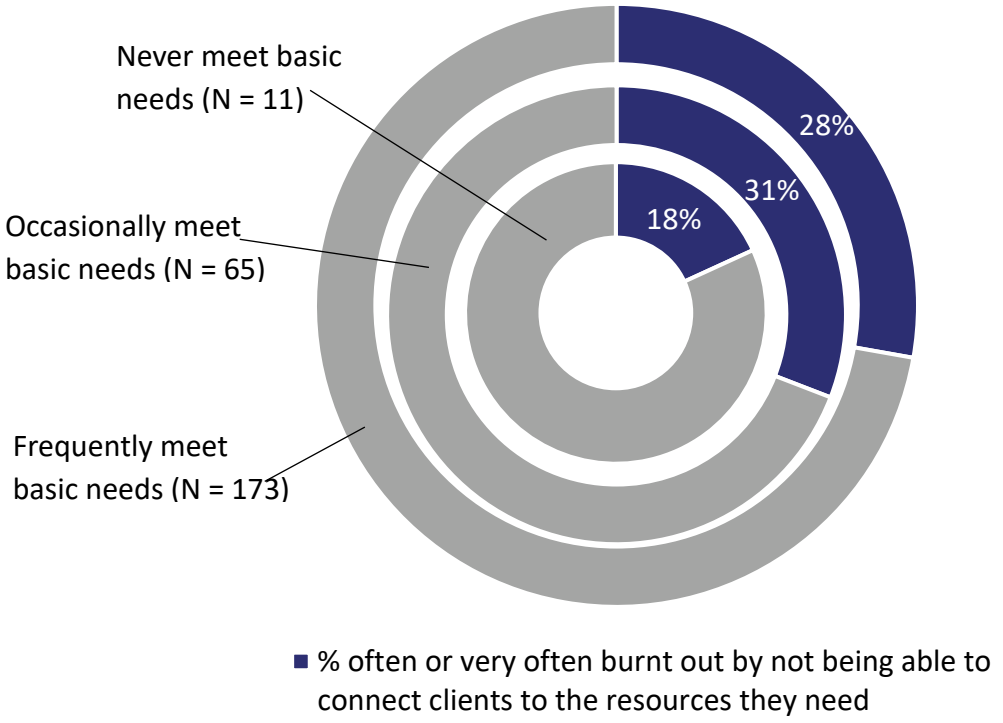


We did not find a strong relationship between the number of burnout factors CHWs experienced often or very often and the number of counties served. Approximately 54% of CHWs serving one county reported feeling burnt out often

or very often for at least one reason compared to 52% for CHWs serving two or more counties.

We explored the relationship between burnout factors and nine of the CHW sub-roles[9] that are most directly related to meeting the needs of individual clients with the assumption that these roles would be more likely to lead to burn out. Among the relationships we assessed, the only pattern we found was that CHWs regularly engaged in meeting basic needs (Role 7, sub-role c) were more likely to experience burn out often or very often from not being able to connect clients to the resources they need. This pattern, which indicates how the lack of resources increases the difficulty of CHWs' work, is shown in Figure 25.

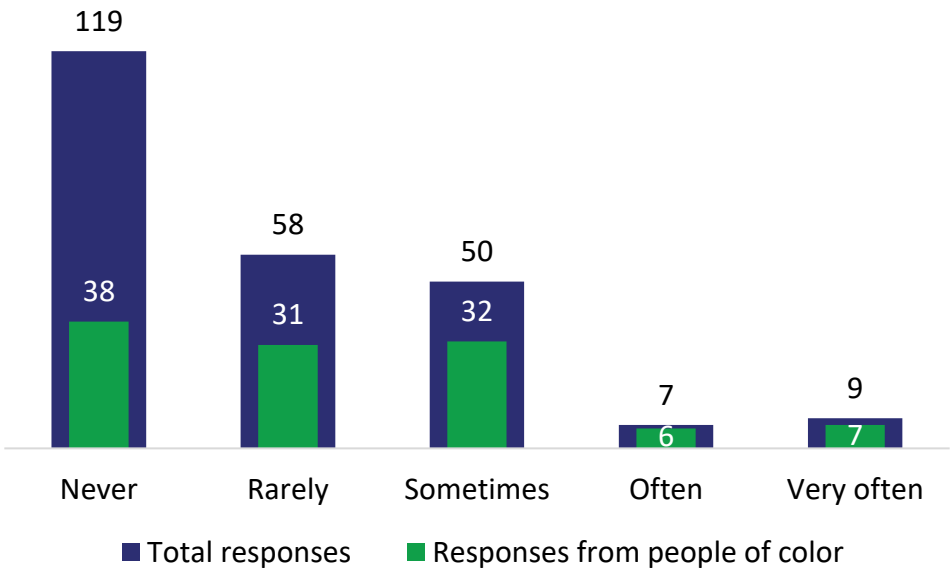
Figure 25. Differences in Burn Out Related to Connecting Clients to Resources by Frequency of Engagement with Meeting Basic Needs (N = 249)



[9] The nine roles were: 1) Making referrals and providing follow-up; 2) Facilitating transportation to services and/or helping to address other barriers to services; 3) Providing individual support and coaching to clients; 4) Motivating and encouraging people to obtain care and other services; 5) Supporting self-management of disease prevention and management of health conditions; 6) Connecting to resources and advocating for basic needs; 7) Meeting basic needs; 8) Follow-up on health and social service encounters with individuals, families, and community groups; 9) Home visiting to provide education, assessment, and social support

A new question in the 2025 CHW Survey asked respondents to share how often they have felt dismissed or devalued by the other providers with whom they work because of their racial, ethnic or cultural background. Overall, half of respondents shared that they have never felt dismissed or devalued because of their background. However, **responses from people of color comprised 13 of the 16 respondents who felt devalued often or very often**. The counts for each response are shown in Figure 26 for both all respondents that shared their race and for people of color. Comparing by percentage, 11% of the people of color in the survey reported feeling often or very often dismissed because of their background compared to 2% of White respondents.

Figure 26. Frequency of Feeling Dismissed or Devalued because of Racial, Ethnic, or Cultural Background (N = 243)



CHWs shared comments related to concerns in the CHW field. The following figure highlights the top themes among the concerns shared as well as the number of comments in each theme.

Figure 27. Top Themes within Concerns in the CHW Field

Other concerns mentioned by CHWs include role sustainability and the political environment, each mentioned by four people, and personal safety mentioned by three people. A few CHWs suggested ways MiCHWA could support the CHW field. Two people suggested MiCHWA create a CHW degree program. Other ideas, each mentioned by one person, included creating a county-level directory to facilitate intra-county connections, providing HIV training, establishing a MiCHWA main office in Lansing, training supervisors, and offering financial assistance for CHW training.

TEAM INTEGRATION AND CAREER DEVELOPMENT

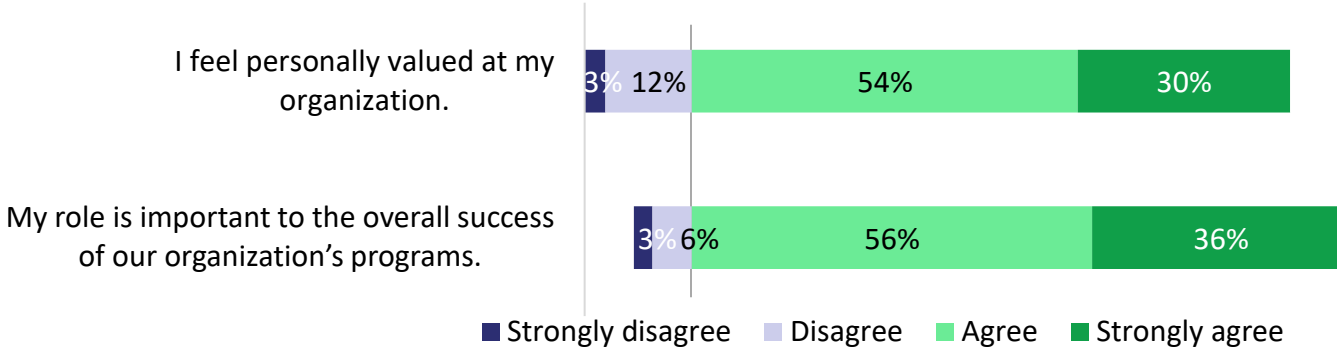
When asked to respond to six statements related to opportunities for career advancement, **the large majority of CHWs agreed that they have opportunities to develop their professional skills.** However, fewer CHWs agreed they had opportunities for pay raises, leadership roles, advancement in the profession or promotions. As shown in Figure 28, between half and just under two-thirds of respondents agreed that these opportunities were available.

The percentages of CHWs agreeing with the career advancement statements were all larger than the percentages of CHWs agreeing in 2023. In the 2025 survey, the neutral option was removed, which may have contributed to these changes.

Figure 28. Percent of CHWs Agreeing they Have Career Advancement Opportunities (N = 269)

In 2025, the survey asked CHWs to respond to two new statements related to their perceived value within their organization. As seen in Figure 29, **the majority of CHWs either agreed or strongly agreed that they are valued at their organization and that their role is important to the overall success of their organization's programs**. While still a small proportion, more CHWs disagreed that they were personally valued at their organization than that their role was important.

Figure 29. CHWs' Perception of Value at their Organization (N = 267)



CHW Perspectives

"I introduced an SDOH evaluation and more precise targeting of resource referrals for clients to my organization. I implemented the pilot and a fully functional system that is now a regular part of our services."

"When I call various medical facilities and mention that I'm CHW, their tone seems to change and they are willing to assist me and my clients."

When asked questions related to their integration into care teams, **approximately a third of CHWs felt other providers understood their role well.** Recently conducted focus groups exploring CHW relationships within care teams in Michigan corroborate this finding. This study found many social workers, providers, and case managers lacked understanding of CHWs' role in clinical and non-clinical settings.[10] Despite the fairly low level of role understanding, **nearly three-quarters of CHWs felt comfortable discussing participants' needs with other providers.** These proportions, shown in Figures 30 and 31, were largely similar to the proportions seen in 2023.

[10] Patterson, C. (2025) CHW Relationships with Clinicians and Care Teams: Interprofessional Collaboration. University of Michigan Future Public Health Leaders Program.

Figure 30. Extent to which Other Providers Understand CHWs' Roles and Work (N = 267)

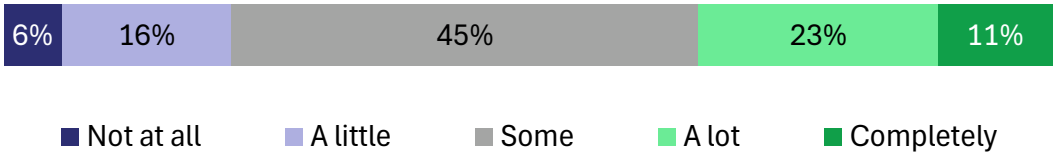
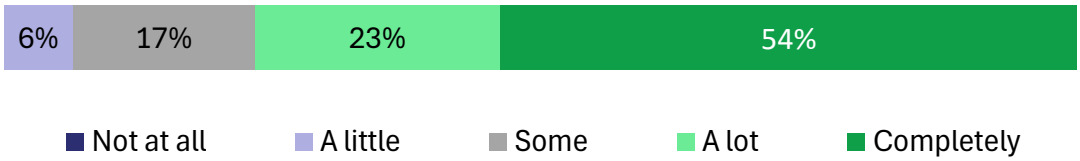
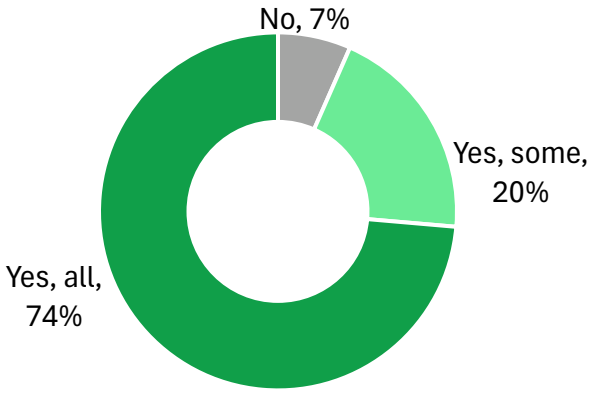


Figure 31. Extent to which CHWs are Comfortable Going to Other Providers to Discuss Participants' Needs (N = 267)



As in 2023, CHWs responded to a question about the extent to which they are able to record information within electronic health records or similar participant tracking systems. The large majority said they are able to input all relevant information (See Figure 32), although the proportion was slightly lower than the 79% who reported this in 2023.

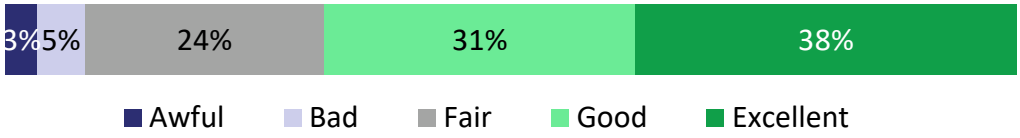
Figure 32. CHWs' Ability to Record Client Information in their Employers' Main Participant Tracking System (N = 243)



CHW SUPERVISION

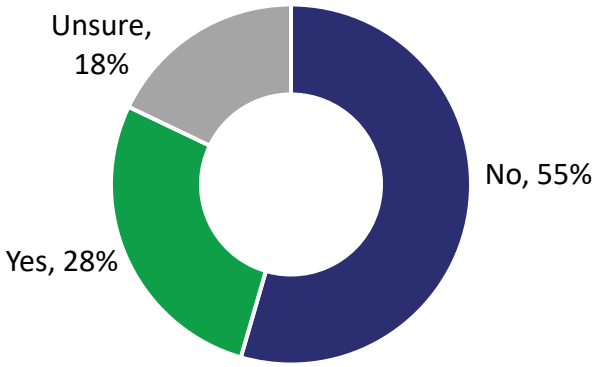
The 2025 survey included a new set of questions to capture CHWs' perspectives on their supervisors. First, CHWs rated the overall quality of their supervision in the last 30 days. **Over two-thirds of CHWs rated their supervision quality as good or excellent**, as seen in Figure 33.

Figure 33. CHWs' Rating of Overall Supervision Quality in the Last 30 Days (N = 257)



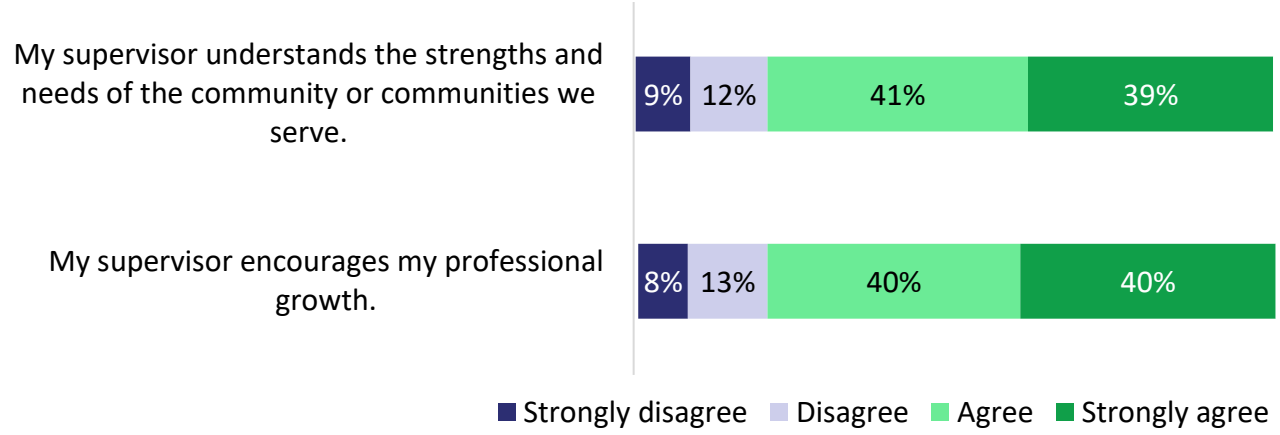
CHWs also reported whether their supervisor had previous experience as a CHW. The largest proportion, 55%, said their supervisor had no previous experience as a CHW.

Figure 34. Does Your Supervisor Have Previous Experience as a CHW? (N = 257)



Despite the absence of previous CHW experience for the majority of supervisors, most CHWs agreed both that their supervisors understand the strengths and needs of the communities they serve and that their supervisors encourage professional growth, as seen in Figure 35.

Figure 35. CHWs' Perception of Supervisor Qualities (N = 257)



CHW Perspectives

"MiCHWA needs to provide supervisor or manager training. Perhaps a micro credential training or a CHW supervisor certification."

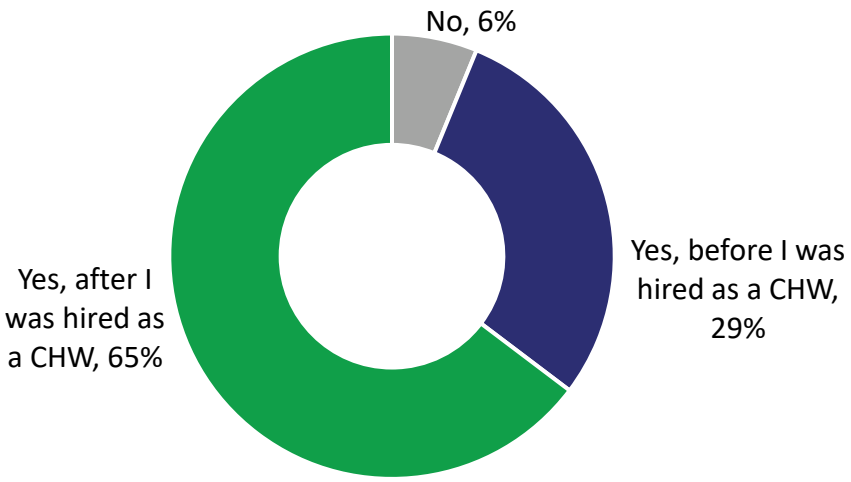
CHW TRAINING AND CONTINUING EDUCATION

MiCHWA Core-Competency Based Training

Almost all CHWs (94%) indicated they had completed the MiCHWA 126-hour core-competency based training program either before or after being hired as a CHW, as shown in Figure 36. This proportion was larger than in 2023 (83%). The difference was largely driven by a greater proportion of CHWs completing the training after being hired, with 65% in 2025 and 57% in 2023.

Of the 17 people who had not completed the MiCHWA core-competency based training program, six had received certification via a grandparenting process. Seven people completed a core-competency based program from another entity. Four people had not completed any core-competency based program.

Figure 36. Completion of the MiCHWA Core-Competency Based Training Program (N = 275)

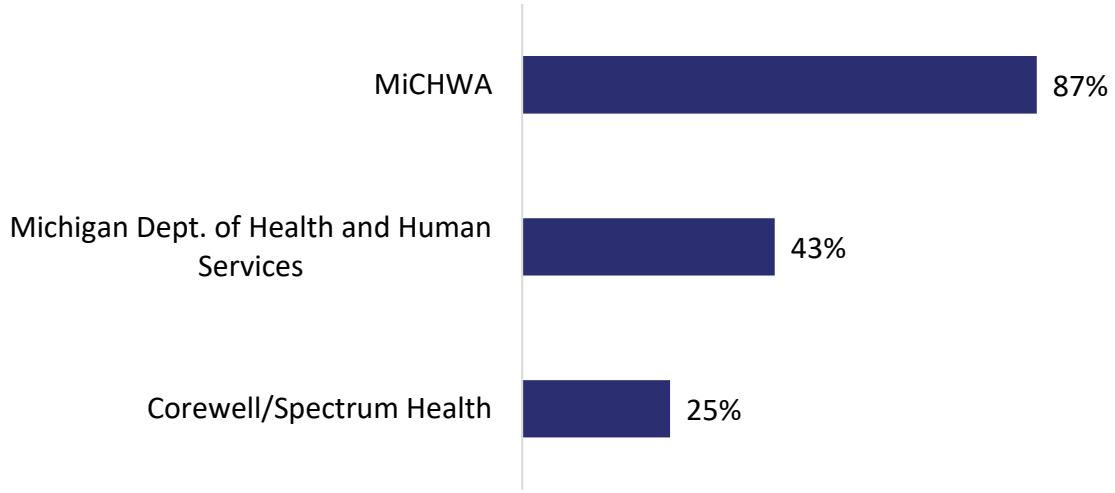


Continuing Education

The majority of CHWs (83%) said that their employer requires them to maintain CHW continuing education credits, a slightly larger proportion than in 2023 (75%). When asked from which sources they had received continuing education training, MiCHWA was by far the most common response, as shown in Figure 37.

In addition, more than 40% of respondents said they had received continuing education from the Michigan Department of Health and Human Services. The prevalence of these two organizations as sources of continuing education was similar to proportions seen in the 2023 and 2021 MiCHWA CHW Surveys.

Figure 37. Sources of Continuing Education (N = 268)



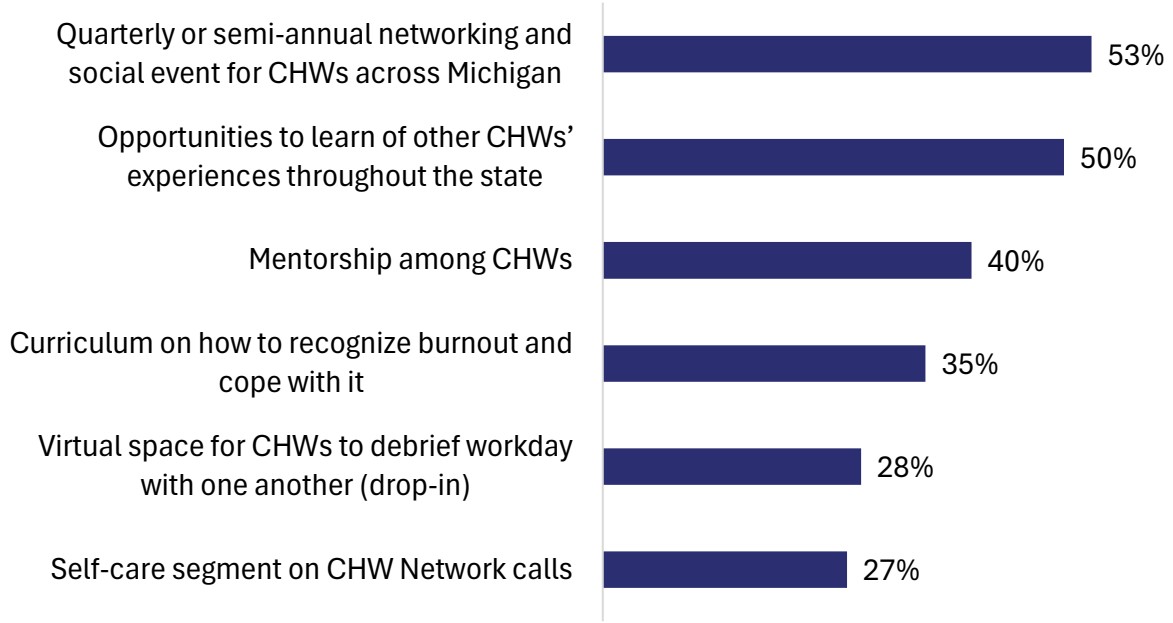
Collectively, 68 people named 50 different organizations from which they had received continuing education beyond those listed in the survey. In addition to the sources in Figure 37, seven people received continuing education from YMCA and three from the Michigan Victims Advocacy Network (MiVAN). Nine people described general sources of education, such as "online trainings," and three people indicated their employer provided internal trainings.

CHW Perspectives

"MICHWA has provided me with numerous opportunities. I've gained valuable training, ongoing education, and CEUs to maintain my certifications and stay updated. I've also connected with amazing individuals who share my mindset."

The final question in the Continuing Education Section asked about interest in potential MiCHWA-sponsored activities to support emotional well-being. While MiCHWA does not currently offer all of these activities, their goal was 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 and, second, opportunities to learn about other CHWs' experiences throughout the state**, as shown in Figure 38. These were also the top-selected options in the 2023 MiCHWA CHW survey. Additional activities CHWs suggested included more localized meetings for CHWs serving in specific counties, support for grieving the loss of a patient or community member, and guidance on how to legitimize one's role and scope.

Figure 38. CHW Interest in Activities to Support Emotional Well-Being (N = 254)



CHW ADVOCACY

The survey asked CHWs to indicate their level of agreement with six statements related to advocacy. Results align with those from previous survey years, with **the largest proportions of CHWs agreeing that people who influence change in their organization seek their opinion** and the smallest proportions agreeing they were part of one or more groups that influence policy at their organization, as seen in Figure 39.

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 39. CHWs' Perception of Advocacy Roles (N = 269)

MICHWA'S MEMBER PORTAL

MiCHWA maintains a CHW Member Portal, which is distinct from the Michigan Medicaid CHW Registry maintained by the state. **Almost all survey respondents (97%) reported they were registered in the MiCHWA CHW Portal**. However, since the survey was distributed to portal members, this percentage may not reflect the rate of membership for CHWs in Michigan broadly.

The proportion of CHWs in the member portal was even higher than in 2023 and 2021, where 87% and 93% of respondents said they were registered, respectively. Of the eight people that said they were not registered, six said they were not aware of the portal, and two said they planned to register. One of these two shared that they were having issues registering but did not specify further.

The **MiCHWA CHW Portal** 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.

MICHWA'S IMPACT

As with previous survey years, CHWs shared comments about the support MiCHWA has provided to their roles. The following figure highlights the top themes and the number of comments in each theme.

Figure 40. Top Themes in MiCHWA's Support for CHWs

Education Opportunities

(*n* = 63)

"The training is amazing. I have a master's degree and a long professional history, but this work is very new to me and has its own set of challenges. I am much more confident after my training and with continued professional development."

Professional Growth

(*n* = 30)

"MiCHWA has opened doors of learning opportunities. Becoming a Board Member, it has challenged my self-doubt about not being enough to represent CHWs. However, I have the experience, have studied, observed, asked questions. I know I am well able to represent CHWs."

Connections with other CHWs

(*n* = 19)

"I enjoy connecting with other CHWs and MiCHWA provides the platform to do so. It is nice to have other CHWs to connect with for resources or to share struggles."

Advocacy

(*n* = 16)

"When I started as a CHW the community and health care systems had no idea what a CHW was and how helpful they are to the community. MICHWA has made the state agencies recognize and see the value of CHWs in the community."

Recognition of CHW role (*n* = 23)

"MiCHWA has made a great difference in advocating to make known the important roles CHWs play in the healthcare of not only individual clients but in whole communities as well as the important roles we have in assisting providers with client care."

In addition to these themes, five people noted that MiCHWA has helped with personal growth. Other types of support or value provided by MiCHWA included increased trust with clients, events, mentorship, the MiCHWA website, and help with locating resources, each mentioned by one respondent.

SECTION 3: SUMMARY AND IMPLICATIONS

Project team members, in conjunction with feedback from Evaluation Work Group members, identified seven key topics from the 2025 Community Health Worker Survey findings that are relevant to policies and practices within the sector and will be important to continue to monitor in the years ahead.

First, survey findings showed **several positive signs in the Community Health Worker field that demonstrate its expanding impact and reach**. CHWs are based at a growing diversity of organizations, allowing them to integrate more seamlessly into various community settings and address localized health needs effectively. The survey also demonstrated that CHWs continue to reach all 83 counties in the state, as was also seen in the 2023 CHW Survey.

Both the number of roles CHWs report playing and their comments on ways they have impacted clients show that CHWs are meeting a wide range of needs with a particular emphasis on helping clients obtain healthcare services, connecting people to resources, and addressing basic needs such as food and housing. CHWs are also helping reach diverse populations, collectively providing services in seven different languages in addition to English.

The **second** key topic is the uptake and implications of the Michigan Medicaid Policy (MMP) 23-74, which took effect January 1, 2024. This policy created a pathway for reimbursement of certain CHW services, such as health system navigation and resource coordination. It is clear the implementation of this policy is still in its infancy – the 2024 MiCHWA CHW Employer Survey showed substantial portions of employers were preparing to bill for CHW services. Even so, the 2025 CHW Survey provides initial insights into the implications of Medicaid reimbursement for CHWs.

More than a third of CHWs responding to the survey (39%) reported enrollment in Michigan's Community Health Automated Medicaid Processing System (CHAMPS), which is required to bill for services. Most of the CHWs enrolled in CHAMPS had not experienced any notable changes in their roles in relation to the new Medicaid policy. As more organizations employing CHWs implement the Medicaid reimbursement policy, **it will be important to continue to monitor the level of**

participation in reimbursement of CHW services and any related shifts in the roles CHWs play.

Third, CHW pay remains a critical topic. On the one hand, we have seen a gradual increase in the rate of pay since 2021 for most CHWs. However, the cost of living has also increased substantially over this time.[11] And while, in contrast with the 2023 CHW Survey, the median 2025 CHW pay rate of $21.99 was *above* the living wage for a household with two working adults and one child, the median was well below the living wage for households with children and one working adult.[12] Furthermore, there were discrepancies between different types of employers, with average pay at health systems and local health departments well above averages at community-based organizations, FQHCs, and behavioral health organizations. And while we saw modest relationships between both rate of pay and years of service and rate of pay and education, the relationships were inconsistent and included notable variations. For example, even though average pay was greater with greater levels of education, twenty-five percent of the CHWs making $18.00 or less had a bachelor's or master's degree. Importantly, despite the increases in pay rate, **pay dissatisfaction has remained the major driving force in thoughts of resignation, particularly among those with higher education**, who may feel inadequately compensated for their qualifications.

The **fourth** key topic is CHWs' level of education. The previous two CHW surveys have consistently shown that not only do **many CHWs have more education than is required for their roles** but the portion of CHW's with a bachelor's degree or higher exceeds the state average. This calls into question whether CHWs are reflecting the communities they serve as intended. It is possible that the high education levels indicate a skew in the survey sample, since those with college degrees may be more likely to participate in surveys. Another possible explanation is that CHW employers are deliberately hiring candidates with college degrees, even if not required by the organization's policy. Alternatively, CHWs may be

[11] According to the United Way, costs of household essentials (housing, child care, food, transportation, health care, and basic technology) increased by 8.4% annually from 2021 to 2023: https://www.unitedforalice.org/costs-over-time/michigan

[12] Glasmeier, Amy K. Living Wage Calculator. 2025. 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.

leveraging their employment to further their education while working as a CHW. The available data does not reveal whether CHWs started their positions with a degree or whether they achieved a degree while working. It also does not show whether CHWs see a degree as a way to advance to a different type of position. We did find that the CHWs with a bachelor's or master's degree were more likely to report being inclined to leave the CHW field because of the rate of pay.

Comprising the **fifth** key topic, the 2025 CHW Survey findings point to a **range of concerns related to the sustainability of CHW positions.** Perceptions of job insecurity appear to have increased since the 2023 CHW Survey. This may reflect the turbulence and uncertainty in both federal agencies and federally funded grant programs in the initial months of the current federal administration.

In another sign of concern, approximately **55% of CHWs reported often or very often feeling inclined to quit** in relation to one or more factors with rate of pay and opportunity for growth topping the list. Similarly, **53% of CHWs reported often or very often feeling burnt out** in relation to one or more factors, with clients not doing their part to get connected to a resource and not having access to the resources clients need as dominant concerns. Also concerning was the greater prevalence among CHWs of color of feeling dismissed or devalued because of their racial, ethnic or cultural background compared to their white counterparts. While the proportions reporting this feeling were small among both groups, the proportion among respondents of color was more than five times higher than the proportion among white respondents.

Sixth, the **proportions of CHWs referring clients to lifestyle change programs were noticeably lower in 2025** than in 2023. The decreases were steepest for the Supplemental Nutrition Assistance Program Education (SNAP-Ed) program, even though the survey was administered prior to the federal decision to eliminate SNAP-Ed funding after October 1, 2025. While we cannot determine from the survey whether referral rates reflect lack of program availability, lack of program awareness, or a focus on other priorities, the generally low referral rates point to an opportunity for MiCHWA to promote awareness of available training resources on lifestyle change programs.

Though the survey did not ask about referrals to other programs and resources, recent state and federal cuts to public health and safety net programs are likely to lead to further decreases in referral rates both to lifestyle change programs and health and social support resources more generally. We also know anecdotally that many CHWs report struggles related to housing referrals, an area where the need far exceeds available resources. In addition to continuing to track referrals, including a question on housing referrals in future surveys could further shed light on the challenges in this area.

Finally, survey findings hint at ways that **rural communities face distinct hurdles in the CHW sector**. Thirteen of the fifteen counties in the Upper Peninsula, as well as several counties in the northeast Lower Peninsula, were served only by CHWs that reported serving five or more counties. In other words, the **CHWs in these places cover large areas, limiting access to services for residents in these communities**.

Some CHW employers, both in the 2024 MiCHWA CHW Employer Survey Report and through MiCHWA's Evaluation Work Group, have shared challenges filling CHW positions, particularly in rural areas, which may contribute to the low number of CHWs based in rural counties. Anecdotally, we also know that CHWs in the U.P. and other rural areas more often rely on phone meetings with clients due to the logistical constraints posed by greater distances. Phone-based meetings, however, are not eligible for Medicaid reimbursement. This policy, therefore, risks cutting access to an important source of sustainable funding for CHW services in rural areas.

Within the community health worker sector, there are several emerging trends that will be important to monitor going forward, including the expansion of CHW positions into new settings and the level of participation in reimbursement of CHW services and any related shifts in the roles CHWs play. The survey findings also reveal **multiple topics that warrant further study**. Additional research could shed light on why some CHW employers require a bachelor's degree or higher for their CHW positions; whether and why some CHWs seek higher education before or after they are hired as CHWs; and the impact of higher education on CHW pay levels, roles, satisfaction and retention in the CHW position, and connection to the communities they serve.

Additionally, while we know some CHWs deliver services in multiple languages, we do not know how working with clients from other cultures or other countries impacts CHW roles, activities, caseload, or job satisfaction. Finally, further investigation could help explain factors behind lifestyle change program referral rates, including the full scope of the referrals CHWs make, and which care team members make what types of referrals.

As the sector continues to adapt to the Medicaid reimbursement policy and the evolving public health funding landscape, among other changes, addressing CHWs' concerns and recognizing the many roles they play will be crucial in ensuring CHWs can continue to effectively serve their communities.

APPENDIX A: DATA TABLES

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

County and CHW Count									
Alcona	3	Clare	3	Iosco	3	Marquette	3	Otsego	5
Alger	3	Clinton	4	Iron	3	Mason	8	Ottawa	19
Allegan	8	Crawford	3	Isabella	2	Mecosta	9	Presque Isle	2
Alpena	6	Delta	3	Jackson	6	Menominee	2	Roscommon	2
Antrim	3	Dickinson	2	Kalamazoo	4	Midland	5	Saginaw	12
Arenac	5	Eaton	4	Kalkaska	1	Missaukee	5	Sanilac	5
Baraga	2	Emmet	3	Kent	44	Monroe	8	Schoolcraft	2
Barry	6	Genesee	26	Keweenaw	2	Montcalm	11	Shiawassee	4
Bay	7	Gladwin	3	Lake	11	Montmorency	3	St. Clair	10
Benzie	5	Gogebic	2	Lapeer	11	Muskegon	16	St. Joseph	2
Berrien	8	Grand Traverse	7	Leelanau	6	Newaygo	15	Tuscola	6
Branch	2	Gratiot	2	Lenawee	4	Oakland	41	Van Buren	6
Calhoun	11	Hillsdale	6	Livingston	11	Oceana	9	Washtenaw	23
Cass	5	Houghton	2	Luce	4	Ogemaw	3	Wayne	64
Charlevoix	3	Huron	5	Mackinac	3	Ontonagon	2	Wexford	9
Cheboygan	1	Ingham	12	Macomb	29	Osceola	8		
Chippewa	3	Ionia	8	Manistee	9	Oscoda	3		

Table 2. Comparing 2023 (N = 237) and 2025 (N = 262) Frequencies of Feeling Inclined to Quit by Factor

Factor	Never		Rarely		Sometimes		Often		Very Often	
	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025
Work hours	56%	54%	26%	24%	12%	13%	4%	6%	3%	3%
Rate of pay	22%	19%	15%	16%	28%	39%	19%	14%	17%	12%
Ability to help or make a difference	43%	47%	22%	22%	24%	14%	7%	10%	5%	7%
Level of support from supervisor	49%	42%	21%	25%	18%	19%	6%	10%	6%	5%
Level of support from agency	37%	39%	23%	22%	18%	23%	13%	11%	8%	6%
Opportunity for growth in the field	24%	25%	19%	21%	31%	31%	15%	15%	11%	9%
Level of stress	28%	23%	24%	28%	27%	33%	13%	11%	8%	6%
Support for role from co-workers	47%	45%	22%	29%	20%	13%	7%	9%	4%	4%
Personal safety while providing CHW services		46%		32%		15%		4%		4%

Table 3. Comparing 2023 (N = 242) and 2025 (N = 262) Frequencies of Feeling Overwhelmed or Burnt Out by Factor

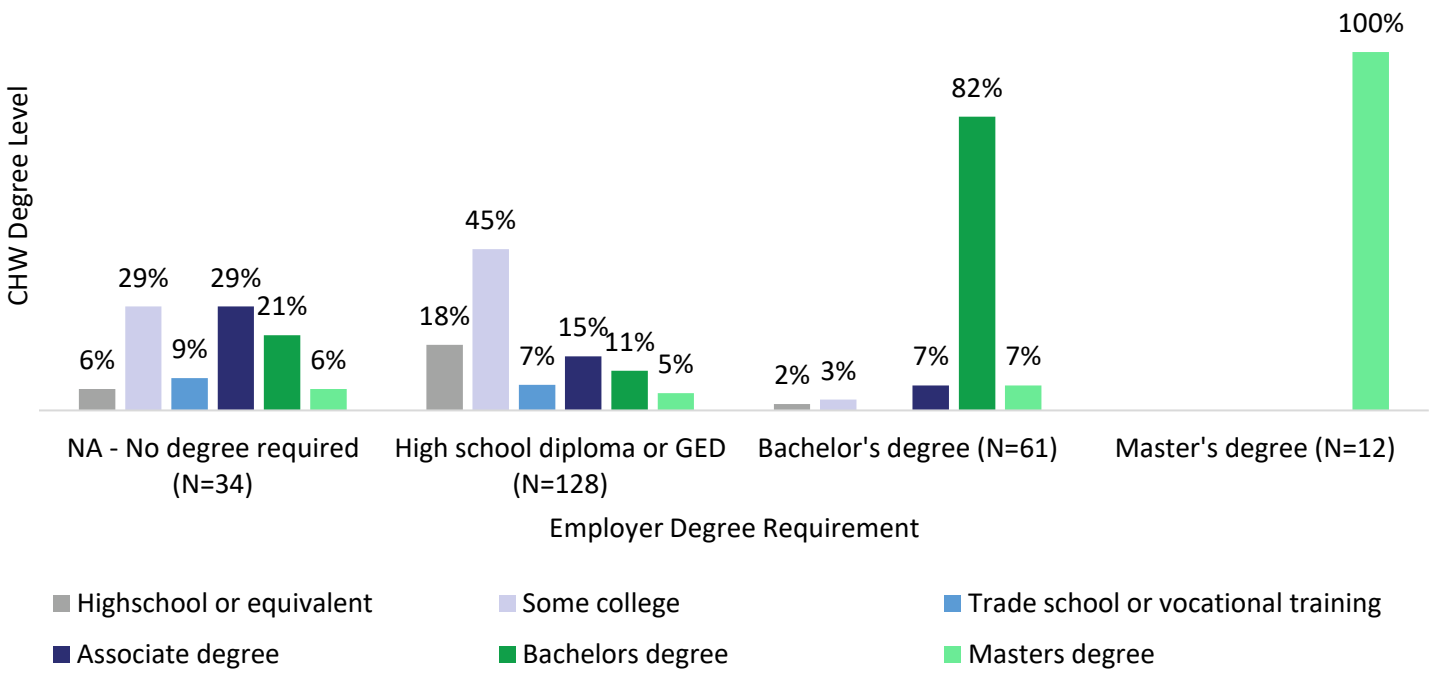
Factor	Never		Rarely		Sometimes		Often		Very Often	
	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025
Not being able to connect clients to the resources they need	15%	12%	18%	21%	35%	40%	17%	19%	15%	9%
Delivering care beyond the scope of the role	25%	25%	26%	26%	28%	32%	14%	10%	7%	7%
Focus on quantity of clients served vs. quality of service	22%	24%	31%	24%	25%	30%	15%	12%	8%	9%
Client not doing their part in getting connected to a resource	15%	13%	14%	21%	43%	38%	19%	21%	10%	7%
Carrying the emotional weight of clients' circumstances	18%	12%	25%	25%	37%	45%	12%	12%	7%	7%
Personal safety while providing CHW services		35%		41%		15%		5%		4%

Table 4. Number of CHWs by Position Titles

Position Title	Number of Respondents
Community Health Worker	179
Certified Peer Support Specialist	10
Community Health Advocate	7
Community Neighborhood Navigator	7
Community Health Outreach Worker	6
Community Outreach Worker	4
Outreach and Enrollment Worker	4
Certified Recovery Coach	3
Health Coach	3
Family Health Outreach Worker	2
Peer Support	2
Maternal Child Health Worker	1
Promotor/a	1
Other:	39

- Community Health Representative (3)
- Care Coordinator (2)
- Community Connector (2)
- Success Coach (2)
- Behavioral Health Home Coordinator
- Behavioral Health Specialist
- Care Coordinator/Care Management
- Career and Life Skills Facilitator
- Case Manager
- Certified Alcohol and Drug Counselor (CADC)
- Child and Family Advocate
- Community Assistance Manager
- Community Connector/ Housing Specialist
- Community Health Palliative Care at Home
- Doula
- Good Samaritan
- Health and Wellness Coordinator
- HIV SPECIALIST
- Homelessness Ministries Coordinator
- Inbound Call Center Sales Representative
- Independent Living Specialist
- Manager of Community Collaboration
- Member Service Coordinator & MICHWA Certified CHW
- Mental Health Programming Coordinator
- Outreach and Navigation
- Outreach Specialist
- Perinatal Peer Counselor/Navigator
- Program and Outreach Manager
- Public Policy & Outreach Specialist
- Recreational Therapist
- Residents service coordinator
- Resource Specialist
- Self Sufficiency Advisor
- Service Provider

Figure 1. CHW Position Degree Requirements vs. Level of CHWs Education (N = 269)



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

INTRODUCTION

Why a 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.

What is a CHW?
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.

How long will this survey take?
The survey will take 10-15 minutes of uninterrupted time. If you start the survey and want to finish it at a later time, first finish the questions on your current page and then click the *Save and Continue* button. You can resume the survey by clicking on the same link you received and by using the same browser and device you used to start the survey.

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 (PLEASE DISREGARD THE REST OF THE SURVEY.)

2. Do you supervise other CHWs?
   - ○ Yes, I spend at least half of my time in a supervisory role. (PLEASE DISREGARD THE REST OF THE SURVEY.)
   - ○ Yes, I spend less than half of my time in a supervisory role.
   - ○ No, I do not have a supervisory role.

PART 1: CHW POSITION DESCRIPTION

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

   _____

4. What is your primary title for your role as a CHW?
   - ○ Certified Peer Support Specialist
   - ○ Certified Recovery Coach
   - ○ Community Health Advocate
   - ○ Community Health Outreach Worker
   - ○ Community Health Worker
   - ○ Community Neighborhood Navigator
   - ○ Community Outreach Worker
   - ○ Family Health Outreach Worker
   - ○ Health Coach
   - ○ Maternal Child Health Worker
   - ○ Outreach and Enrollment Worker
   - ○ Peer Support
   - ○ Promotor/a
   - ○ Veteran Liaison
   - ○ Other, please specify: _____

5. 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

○ More than 1 year, please specify:_____

6. 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

7. In which language(s) are you able to deliver services?
   Check all that apply.
   - ☐ English
   - ☐ Spanish
   - ☐ Arabic
   - ☐ Other, please specify: _____

8. What is the highest degree required for your position?
   - ○ NA – No degree required
   - ○ High school diploma or GED
   - ○ Bachelor's degree
   - ○ Master's degree
   - ○ *I don't know*

9. Are you enrolled as a "Rendering/Servicing-Only Provider" in Michigan's Community Health Automated Medicaid Processing System (CHAMPS)?
   - ○ Yes
   - ○ No
   - ○ *I don't know*

Effective January 1, 2024, Michigan Medicaid Policy (MMP) 23-74 established eligibility criteria for Community Health Workers to be recognized as Medicaid providers, allowing reimbursement of state plan covered CHW services, including health system navigation and resource coordination; health promotion, and education; screening; and assessment.

10. How, if at all, has your role changed (or do you expect your role to change) because of this change in Medicaid policy?

11. 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
- ☐ *NA - I do not make referrals to any of these programs.*

PART 2: TRAINING and CONTINUING EDUCATION

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

- ○ Yes, before I was hired as a CHW (Skip to Question 14)
- ○ Yes, after I was hired as a CHW (Skip to Question 14)
- ○ No

13. If "No", have you either received MiCHWA certification via a grandparenting process or completed a different CHW core-competency based training program?

Check all that apply.

- ☐ Academy of International Education
- ☐ CROWD at SUHI
- ☐ Everyday Life Consulting
- ☐ Fresh Coast Institute
- ☐ Indian Health Services
- ☐ I PHI
- ☐ LifeLearner Institute
- ☐ Meridian Health Plan of Michigan
- ☐ MultiCultural Council of America
- ☐ Nation Outside
- ☐ Pathways Community Care HUB Institute
- ☐ Practice Transformation Institute (PTI)
- ☐ Wider Circle
- ☐ I received MiCHWA certification via a grandparenting process
- ☐ None of the above

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

- ○ Yes
- ○ No

15. From which of the following sources have you received continuing education training?

Check all that apply.

- ☐ MiCHW
- ☐ YMCA
- ☐ Michigan Victims Advocacy Network (MiVAN)
- ☐ Corewell/Spectrum Health
- ☐ Michigan Department of Health and Human Services (MDHHS)
- ☐ Other, please specify:_____
- ☐ *NA - I have not received continuing education training*

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

Select up to 3.

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

- ☐ 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
- ☐ Self-care segment on CHW Network calls
- ☐ Curriculum on how to recognize burnout and cope with it
- ☐ Mentorship among CHWs
- ☐ Other, please specify:_____

PART 3: MiCHWA MEMBER PORTAL

17. Are you registered in the MiCHWA Member Portal?

- ○ Yes (Skip to Question 19)
- ○ No

18. If "No", what are your reasons for not registering in the MiCHWA CHW Portal? Check all that apply.

- ☐ I was not aware of the portal.
- ☐ I do not see a benefit to registering.
- ☐ The cost of registering is a barrier.
- ☐ Other, please specify:_____

PART 4: TEAM INTEGRATION and CAREER DEVELOPMENT

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

	Strongly Disagree	Disagree	Agree	Strongly Agree
I have opportunities for pay raises as I continue in my work as a CHW.	○	○	○	○
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 to assume leadership roles.	○	○	○	○

Strongly Disagree Disagree Agree Strongly Agree

20. Please indicate how much you agree or disagree with the following statements about feeling valued at your organization.

	Strongly Disagree	Disagree	Agree	Strongly Agree
I feel personally valued at my organization.	○	○	○	○
My role is important to the overall success of our organization's programs.	○	○	○	○

21. 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*

22. 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*

23. Are you able to record information about your clients in your employers' electronic health record or similar system?

- ○ No
- ○ Yes, some
- ○ Yes, all
- ○ *NA - our organization does not have electronic health records or a similar system*

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

	Strongly Disagree	Disagree	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 during 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.	○	○	○	○
	Strongly Disagree	Disagree	Agree	Strongly Agree

PART 5: PAYMENT, SUSTAINABILITY, AND LIVING WAGES

25. 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

26. What is your current hourly rate or annual salary?

Please complete one or the other (not both) in US $.

Note: MiCHWA uses this data to track changes in average CHW income over time and for advocacy.

Hourly Rate:_____

Annual Salary:_____

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

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

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

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

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

- ○ Yes
- ○ No (Skip to Question 31)

30. If "Yes", 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, please specify:_____

31. 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
Level of support from supervisor	○	○	○	○	○
Level of support from agency	○	○	○	○	○
Rate of pay	○	○	○	○	○
Support for role from co-workers	○	○	○	○	○
Work hours	○	○	○	○	○
Opportunity for growth in the field	○	○	○	○	○
Level of stress	○	○	○	○	○
Ability to help/make a difference	○	○	○	○	○
Personal safety while providing CHW services	○	○	○	○	○
Other, please specify:_____	○	○	○	○	○

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

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

33. How often do you feel dismissed or devalued by the other healthcare, social service, or education providers with whom you work because of your racial, ethnic, or cultural background?

- ○ Never
- ○ Rarely
- ○ Sometime
- ○ Often
- ○ Very Often

PART 6: SUPERVISION

34. Please rate the overall quality of the supervision you received within the last 30 days.

Include administrative and clinical supervision.

- ○ Awful
- ○ Bad
- ○ Fair
- ○ Good
- ○ Excellent

35. Does your supervisor have previous experience as a Community Health Worker?

- ○ Yes
- ○ No
- ○ I don't know

Thinking of the person you consider to be your primary supervisor over the past 30 days, please indicate your level of agreement with the following items.

36. My supervisor encourages my professional growth (e.g., by regularly supporting your pursuit of training opportunities, your attendance at conferences, or your development of leadership skills).

- ○ Strongly disagree
- ○ Disagree
- ○ Agree
- ○ Strongly agree

37. My supervisor understands the strengths and needs of the community or communities we serve.

- ○ Strongly disagree
- ○ Disagree
- ○ Agree
- ○ Strongly agree

PART 7: DEMOGRAPHICS

These questions allow MiCHWA to understand the diversity of the CHW workforce and to describe the characteristics of the people who completed the survey. All survey responses are confidential. No identifying information will be publicized.

38. How would you describe your race and/or ethnicity?

Check all that apply.

- ☐ American Indian or Alaskan Native
- ☐ Arab American/Middle Eastern/North African
- ☐ Asian/Pacific Islander
- ☐ Black or African American
- ☐ Hispanic/Latino(a)
- ☐ White
- ☐ Prefer to self-identify:_____
- ☐ Prefer not to say

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

- ○ Man
- ○ Woman
- ○ Non-binary
- ○ Prefer to self-identify:_____
- ○ Prefer not to say

40. 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

41. How would you describe your health in general?

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

PART 8: CHW ROLES

42. 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	Occasionally	Frequently
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)	○	○	○

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

	Never	Occasionally	Frequently
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, tabling at events or educating clients)	○	○	○
Providing necessary information for people to understand and prevent diseases and manage health conditions (ex. educating clients with diabetes about diabetes-related health care)	○	○	○

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

	Never	Occasionally	Frequently
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)	○	○	○

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

	Never	Occasionally	Frequently
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)	○	○	○

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

	Never	Occasionally	Frequently
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)	○	○	○

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

	Never	Occasionally	Frequently
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)	○	○	○

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

	Never	Occasionally	Frequently
Providing basic screening tests (ex. conducting glucose monitoring)	○	○	○
Providing basic services (ex. measuring blood pressure)	○	○	○
Meeting basic needs (ex. helping clients obtain food)	○	○	○

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

	Never	Occasionally	Frequently
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)	○	○	○

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

	Never	Occasionally	Frequently
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)	○	○	○

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

	Never	Occasionally	Frequently
Engaging in evaluating CHW services and programs	○	○	○
Identifying and engaging community members as research partners, including community consent processes (explaining a proposed study and asking for agreement to participate)	○	○	○
Presenting at local agencies and community events	○	○	○
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	○	○	○

PART 9: CHW and MiCHWA IMPACTS

52. 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.

53. How has MiCHWA made a difference for CHWs (e.g., for you professionally, for the CHW workforce, etc.)?

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

55. Would you like to provide your email for any of the following purposes?
Check all that apply.

All contact information is confidential and will not be shared.

- ☐ For MiCHWA to build a database of CHW contact information for future surveys
- ☐ To be entered in a raffle to win one of ten $50 electronic gift cards.

If you selected one or both follow-up purposes above, please provide the following:

Full Name:_____

Work Email:_____

Personal Email:_____

Michigan Community Health Worker Alliance

IN THEIR OWN WORDS: WHAT DO CHWS DO?

CHWs' descriptions of their accomplishments in the 2025 MiCHWA CHW Survey show the many different roles they play.

Ways CHWs Serve Clients Directly

CHWs meet basic needs.

"I have been able to help someone move into an apartment after they were living in their car, secure SNAP benefits and improve their health."

CHWs connect people to medical care.

"I assisted community members who lost their Medicaid coverage during re-determination with procuring medication through a patient prescription assistance program."

CHWs connect people with resources.

"I have connected individuals to many resources that they were not aware of or knew how to access."

CHWs help with chronic disease management.

"I helped pediatric patients manage type 2 diabetes, reversing symptoms to live normal healthy lives.

CHWs coordinate patient education.

"We have teamed up with 3 hospitals in our area to educate patients upon discharge and to help connect them with community resources."

CHWs work with providers to connect with people personally.

"I often call CHW the hands and feet of providers. CHWs are in the patient's world. CHWs see many complex issues that the provider may not understand. CHWs have special access to the patient's life that is often left out at a health care professional's appointment."

CHWs make health screenings accessible.

"We have events to do screenings at affordable rates for patients with and without insurance. We also have a mammogram van which allow us to take it to our counties that have issues with transportation."

CHWs use their personal experience to help others.

"As a person living with HIV, who had a pretty rough diagnostic story, I am honored to be able to provide rapid and instant HIV testing and access/linkage to PrEP (a medication to prevent HIV) to my community members. I get hugs, people cry, I've cried, etc. Every time has been worth it - to make sure what happened to me doesn't happen to anyone else I come into contact with."

CHWs reach people in multiple languages.

"As a bilingual I am blessed to communicate with Hispanic communities and help them with resources and direct them to the right place."

CHWs provide emotional support.

"My current role as it stands is more than providing resources, and assisting with navigating community supports. I strive to be the comfort and calming presence that we all need."

CHWs listen to people.

"Many individuals I work with have stated that they had never spoken to anyone about their mental health struggles before, and having the space to share was very impactful for them."

CHWs design new programs to fill resource gaps.

"I helped create a home repair program partnering with Habitat for Humanity."

CHWs empower people to take charge of their health.

"One of my accomplishments is to assist families by being a great advocate for them and teaching them how to advocate for themselves, giving them the confidence to take control of their own health and communicate clearly with providers."

Ways CHWs Increase Organizations' Impact

CHWs educate other care team members.

"I have had the opportunity to bring substance abuse disorder information and knowledge to the CHW team I'm on, and the whole organization. I have been able to educate others on Narcan, and now all the CHWs carry Narcan, and we can give it to our clients who want or need it."

CHWs conduct evaluation.

"I have organized focus groups to collect information about our services and those of our referral partners. Based on this feedback, I am working with parents to connect them to community opportunities and help them share their viewpoints as community experts."

CHWs improve organizational practices.

"I introduced a social determinants of health evaluation and more precise targeting of resource referrals for clients to my organization and implemented a pilot and fully functional system that is now a regular part of our services."

CHWs engage community members in shaping programs.

"I am currently researching information regarding action councils and their creation in order to form an action council for my specific program. Once created, this action council will play a large role in how my program relates to and interacts with our community."

CHWs develop outreach materials.

"I developed a "Call Us First" program for my office. I developed a brochure, a button for staff, educational materials, and training."

CHWs coordinate events.

"I helped with spearheading the first CHW conference at Corewell Health."

CHWs educate others about their role.

"I created a PowerPoint presentation that educates on what a CHW is, what we do and why it is important, to share with providers and support staff at the FQHC in which I work."

To learn more about MiCHWA, please visit www.michwa.org or contact info@michwa.org.

MiCHWA