Michigan Community Health Worker Alliance

In coordination with the MiCHWA Evaluation Work Group

Community Health Worker Employer Survey 2026: Final Evaluation Report

September 18, 2026

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

For questions about this report, please contact MiCHWA Executive Director Kareem Baig (kbaig@michwa.org) or email info@michwa.org.

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Evaluation Team

The development, dissemination, and analysis of the 2026 Community Health Worker Employer 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.

2026 CHW Survey Team

Kareem J. Baig, Michigan Community Health Worker Alliance
Miranda Bargert, Michigan Community Health Worker Alliance
Kathryn Colasanti, University of Michigan School of Social Work Program Evaluation Group
Flavio Di Stefano, University of Michigan School of Social Work Program Evaluation Group
Mary Janevic, University of Michigan School of Public Health
Angel Keyes, Michigan Community Health Worker Alliance
Edith C. Kieffer, University of Michigan School of Social Work
Mia Thompson, Michigan Community Health Worker Alliance

MiCHWA

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/.

SCHOOL OF SOCIAL WORK
PROGRAM EVALUATION GROUP
UNIVERSITY OF MICHIGAN

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

SURVEY BACKGROUND AND METHODS OVERVIEW

(See pages 10-13.)

Since the first statewide survey in 2014, MiCHWA has conducted the Community Health Worker (CHW) Employer Survey on a biennial basis to gain a better understanding of CHWs and their programs statewide. MiCHWA distributed the 2026 survey to all known contacts of Michigan-based organizations employing CHWs. The survey was open from March 19 through June 5, 2026. The final dataset consisted of **110 programs from 86 unique organizations**, a sample slightly smaller than in 2024 but larger than in 2022.

An important limitation of this report is that we do not know how representative the survey sample is in terms of either the total number of CHW programs in Michigan or the distribution of programs across settings. However, the 2026 sample was the second largest in survey history, geographically distributed across the state, and consistent with previous survey waves in organization type and setting.

RESULTS

Characteristics of CHW Employers *(See pages 14-18.)*

Nearly half of responding employers (44%) reported their organization had a single program employing CHWs and the large majority (81%) reported three or fewer CHW programs. The three most prevalent organization settings were consistent between 2026 and 2024: Federally Qualified Health Centers, local health departments, and community-based organizations.

Characteristics of CHW Programs *(See pages 19-24.)*

Responding employers collectively employed **a total of 543 CHWs in a total of 488 full-time equivalent positions**, providing **a lower bound on the true number of CHWs in Michigan**. All Michigan counties were served by at least five CHW programs in the 2026 sample and each county was served by at least one local or

regional program. Over **70% of respondents reported that some or all of their CHWs served rural areas.**

CHW Roles *(See pages 25-33.)*
Using a new, streamlined set of questions about CHW roles, the survey identified **CHWs' three most frequent roles** as:

1. Assessing clients' social needs (89%),
2. Helping clients secure, navigate, and adhere to healthcare and social services (82%),
3. Building client capacity and self-efficacy (71%).

Providing support for obtaining public benefits was another prominent CHW role, reported by 95% of employers. Support occurred most often through explaining eligibility requirements and policies, providing referrals to government offices and websites, and helping with paperwork completion.

CHW Funding and Sustainability *(See pages 34-55.)*
The biggest changes in the funding landscape were the **lower level of federal government grants and the higher level of general organization funding in 2026** compared to 2022 and 2024. These changes may have led to a larger proportion of employers concerned with funding uncertainty than in any other survey wave since 2018: **nearly three in four employers reported concern with funding uncertainty.**

CHW Workforce *(See pages 56-60.)*
More than half of employers (58%) saw no changes in the number of CHW positions in the past year and close to two-thirds of employers (64%) expected to see the same number of CHW positions in the coming year. **Fifteen of the 17 employers** who explained the reasons for fewer CHW positions **described concerns with funding**, including grants ending and uncertainty in funding sources.

CHW Training *(See pages 61-64.)*

Most programs (71%) required CHW core-competency training after hire rather than before hire or not at all. Half of employers reported utilizing MiCHWA's 166-hour CHW Core Competency-Based training program to fulfill requirements.

CHW Salaries *(See pages 65-68.)*

The average hourly rate was $21.87 and the average salary was $48,299. While wages were higher than the previous three surveys, more than half of employers (54%) reported **the most common pay rate was under $22.07 per hour, which falls below the living wage in Michigan for one adult living alone without children**.

CHW Supervision *(See pages 69-71.)*

Close to a third of CHW supervisors had CHW certification and more than a fourth had worked as a CHW. **Half of employers (49%) indicated the CHW supervisor had a master's degree.** Over two-thirds of respondents expressed interest in a comprehensive CHW supervisor training if offered by MiCHWA in the future.

MiCHWA Member Portal *(See pages 72-74.)*

About half of responding employers shared that their program or organization was **registered as a CHW employer in the MiCHWA Member Portal and Registry**. Among those not registered, lack of awareness was the dominant reason.

SUMMARY AND IMPLICATIONS *(See pages 75-79.)*

The 2026 MiCHWA CHW Employer Survey depicts a Michigan CHW workforce increasingly integrated into health, human-service, and community settings. Collectively, survey findings point **to four key insights and four areas for future exploration**.

Key Insights

1. **CHWs are performing broad, cross-system functions.** Survey findings reinforce the ways in which CHWs operate between systems to support clients holistically. Their roles depend on many of the characteristics that

make CHWs distinct: lived experience, community connection, trust, cultural responsiveness, advocacy, and relationship-centered practice.

2. **The workforce appears relatively stable in the near term, but program sustainability remains uncertain.** While current staffing appears relatively stable, employers' confidence in program sustainability remains fragile.
3. **New CHW Medicaid reimbursement pathways represent meaningful progress, but implementation is uneven.** Three dimensions of implementation reveal gaps—employers' access to funding pathways, the adequacy of the funding model in supporting full program sustainability, and the diverse architecture, or composition, of the CHW landscape which reveals a need for differentiated support across organization settings.
4. **Changes in public benefit programs could increase the importance of CHW roles while destabilizing program funding.** Upcoming changes to federal benefit programs enacted through H.R. 1 are likely to mean that CHWs will spend even more time helping clients navigate enrollment requirements. At the same time, fewer Medicaid recipients and increases in uncompensated care could risk the closure of rural hospitals and other CHW programs.

Recommendations for Next Steps

1. **Document Rural CHW Services.** More information is needed to understand geographic variation in the number of CHWs compared to community need and differences between rural-focused and urban-focused CHW programs.
2. **Understand Burnout Prevention Strategies.** A deeper investigation of the strategies employers shared to prevent CHW burnout could reveal best practices and support cross-organizational learning.
3. **Explore Education Requirements.** Survey findings create an opportunity to assess alignment between the skills employers expect from post-secondary education or degrees and current CHW core-competency training.
4. **Identify CHW Training Needs.** Further inquiry could shed light on the constraints and disincentives among the nearly 20% of employers who do not require CHWs to complete core competency training either before or after hire. Additional data collection could also illuminate how training could support CHW advancement to supervisory roles.

SECTION 1: OVERVIEW OF METHODS

SURVEY BACKGROUND

Since a first pilot survey in 2012, MiCHWA has been a national leader in regular data collection to build a robust understanding of the CHW sector in Michigan. Following the first statewide survey in 2014, MiCHWA has conducted the Community Health Worker (CHW) Employer Survey on a biennial basis to gain a better understanding of CHWs and their programs statewide. The 2026 CHW Employer survey provides updated data on the CHW sector across the state in order to inform state-level policy, shape MiCHWA's programmatic and advocacy work, and empower the growing coalition of CHW stakeholders across Michigan with a detailed and timely picture of the sector.

All surveys have been supported by the Michigan Department of Health and Human Services. Previous support came through the 1815 and 1817 Centers for Disease Control and Prevention funding to state health departments. This current iteration is funded by MDHHS under the CDC-RFA-DP-23-0004: The National Cardiovascular Program initiative, with additional support provided by a Michigan Health Endowment Fund grant and the W.K. Kellogg Foundation.

SUMMARY OF METHODS

Survey Instrument

The 2026 survey instrument maintained many of the same items in previous surveys to facilitate comparison. At the same time, the survey team added questions on emerging topics of interest and made some modifications to previous questions to enhance clarity.

The final questionnaire consisted of 60 questions. Given the importance of reducing respondent burden, the survey team has continued to reduce the length over time and, while still long, the 2026 instrument is the most concise to date. Previous versions ranged from 69 questions in 2024 to 114 questions in 2020. Thirteen of the 2026 survey questions asked for an open-ended response, though

the majority of these were optional questions asking for any remaining comments about each main survey topic. The survey, which could be completed over multiple sessions, was administered through Qualtrics ©, a web-based survey platform.

At the end of the survey, respondents were asked for the best contacts for any additional CHW programs housed at their organization. If the respondent wanted to complete a survey for an additional program, they were directed to a separate survey link that included only the program-level questions so that questions pertaining to the organization did not have to be answered again.

Survey Distribution

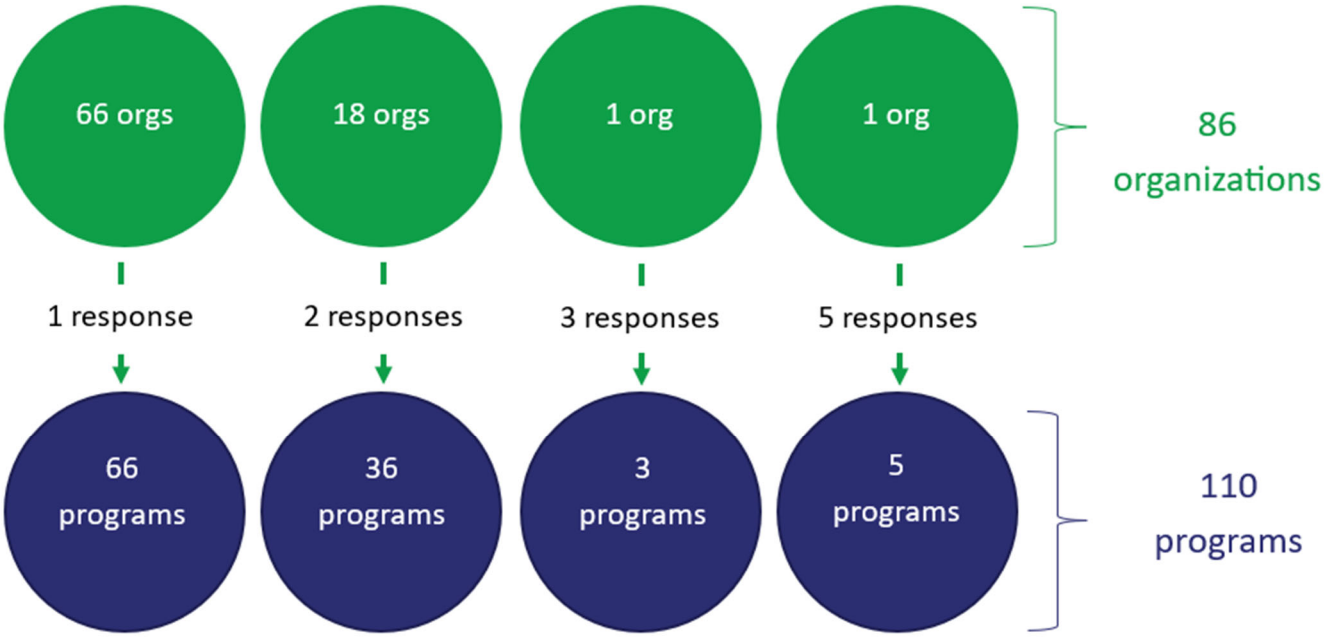
MiCHWA team members distributed a link to the survey through a range of mechanisms intended to reach as many organizations employing CHWs in Michigan as possible. Distribution mechanisms included outreach to all local health departments, Federally Qualified Health Centers, community mental health facilities, and CHW employer associations in the state; emails to MiCHWA listservs, work group and committee members, previous survey respondents, and member portal registrants; and social media promotion. Team members also followed up with personal emails and phone calls to known contacts. Additional reminders were sent to people who had started but not completed the survey. The 2026 Community Health Worker Employer Survey was open for completion from March 19 through June 5, 2026.

Survey Sample

Of the 110 survey responses in the sample, 89 responses (81%) were 100% complete, resulting in a survey attrition rate of 19%. Survey responses less than 30% complete were removed from the sample.

The final survey sample included 86 unique organizations. Twenty organizations completed the survey for multiple programs, as shown in Figure 1, resulting in a final sample size of 110 programs. This survey sample is slightly smaller than in 2024 (115 programs) but larger than in 2022 (88 programs).

Figure 1. Survey Sample



Analysis

We exported data from Qualtrics© into Excel for cleaning and then to SPSS for analysis. Analysis consisted primarily of descriptive statistics, including frequencies, means, and cross-tabulations. We performed content analysis on the open-ended responses to identify both primary themes and relevant insights. The survey team reviewed themes to ensure they were clear, discrete, and reflective of the comments shared. We included quotations from open-ended responses throughout the report to help illuminate the perspective of CHW employers. Unless otherwise noted, the quotations do not necessarily represent the viewpoint of anyone beyond the individual respondent and should not be interpreted as themes. We reviewed many of the themes and interpretations in the report with the MiCHWA Evaluation Work Group, a volunteer-based advisory group made up of a diverse array of CHWs, CHW employers, and CHW allies that offers guidance to MiCHWA on evaluation-related projects.

Limitations

An important limitation of this report is that we do not know how representative the survey sample is in terms of either the total number of CHW programs in Michigan or the distribution of programs across settings. The 86 responding organizations reported hosting a total of 244 CHW programs but completed the survey for 110 programs. This means there are at least 134 known CHW programs unrepresented in the survey sample.

Lastly, the survey is limited in that distribution relies heavily on MiCHWA's existing network of contacts and, therefore, is likely less reflective of CHW employers who are newer, smaller, or are otherwise less likely to have connections with MiCHWA.

Strengths

The 2026 survey consisted of a large sample with nearly as many responses as the previous wave and widespread geographic distribution across the state. Continued consistency in many survey items provides insights on trends in the sector since 2020. The sample composition has also been largely consistent with regards to organization type and setting across the previous three employer surveys, enhancing the validity of comparisons between different survey years. New survey items provide insights on emerging topics of interest, including CHW service in rural areas, CHWs' support for public benefit enrollment, and employers' strategies for preventing CHW burnout. Finally, a large number of open-ended comments on many different topics provide depth, richness, and nuance that complement the quantitative findings.

SECTION 2: RESULTS

CHARACTERISTICS OF CHW EMPLOYERS

Number of CHW Programs

Nearly half of responding employers (44%) reported their organization had a single program employing CHWs and the large majority (81%) reported three or fewer CHW programs. An additional 16 responding organizations (19%) reported having between four and twelve programs that employ CHWs.

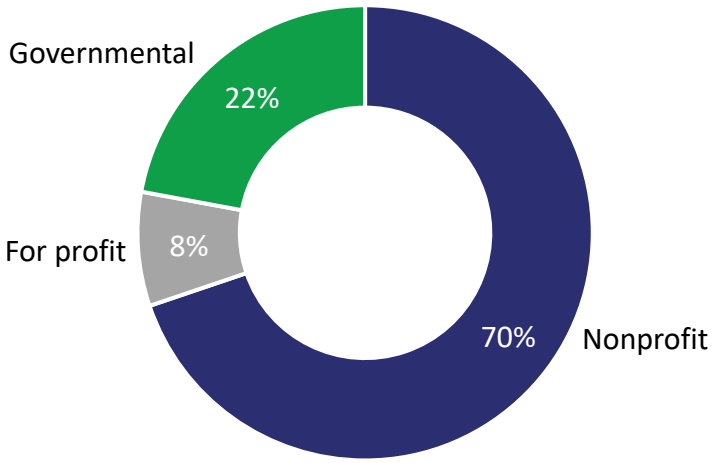
Organization Types and Settings

As in previous survey years, the **majority of CHW employers were based at non-profit organizations** (*see Figure 2*). The proportions across all three organization types were similar to those seen in the 2024 CHW Employer Survey, with a slightly larger proportion of non-profit employers (70% in 2026 compared to 66% in 2024) and slightly smaller proportions of governmental and for profit employers (22% and 8% in 2026, respectively, vs. 25% and 10% in 2024).

For the purposes of this report, a **Community Health Worker Program** includes both formal, named programs and organizations that employ CHWs. An organization may have multiple CHW programs with different objectives and focus areas or may incorporate CHW roles into other types of programs.

When asked about the number of programs at their organization, survey respondents were told to count programs that employ one or more CHWs along with non-CHW team members but to exclude CHW programs that their organization fully contracts out to another organization.

Figure 2. Organization Type (*N*=86)



The three most prevalent organization settings were consistent between 2026 and 2024: Federally Qualified Health Centers, local health departments, and community-based organizations (*Figure 3*).

Beyond the listed organization settings, respondents included an Area Agency on Aging, a community violence organization, an impact community-based organization, an association of independent CHWs, and an FQHC association that also directly staffs CHWs. While there was one tribal organization in both the 2022 and 2024 survey samples and one prepaid in-patient health plan in the 2024 sample, neither of these organization settings were represented in the 2026 survey sample.

Figure 3. Organization Setting (*N*=86)

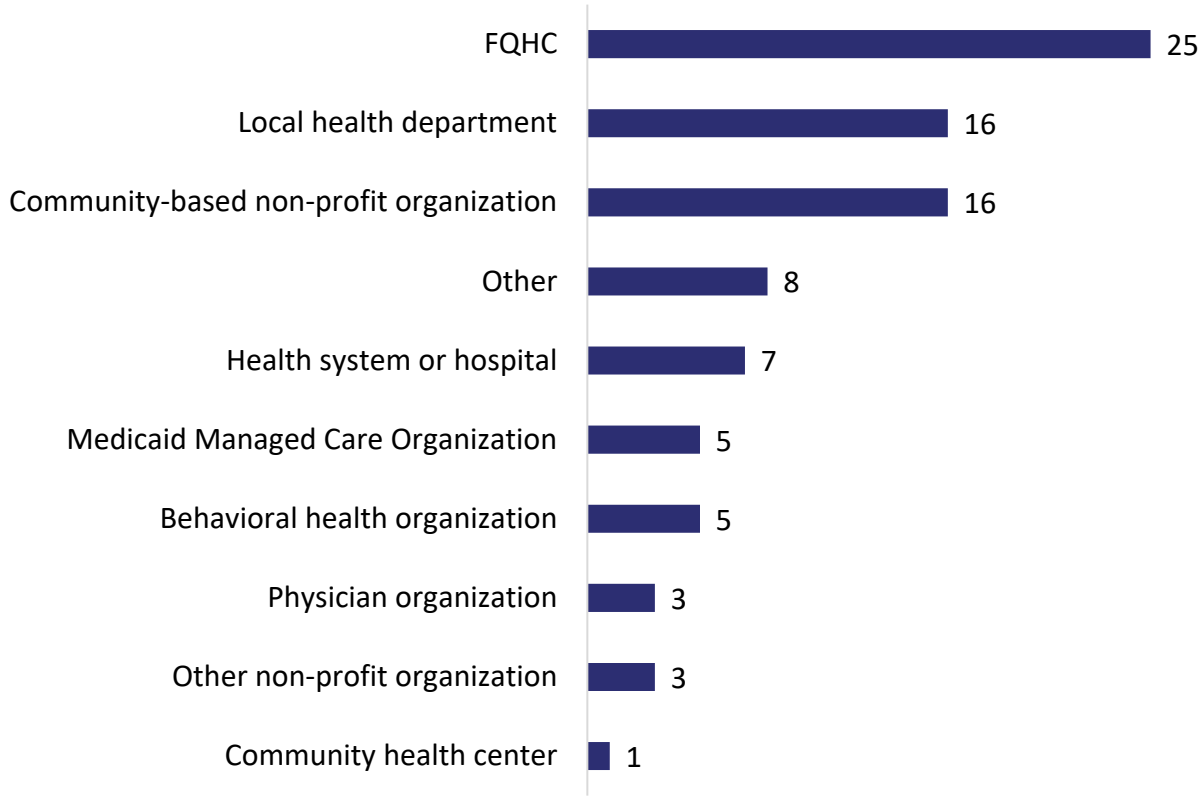
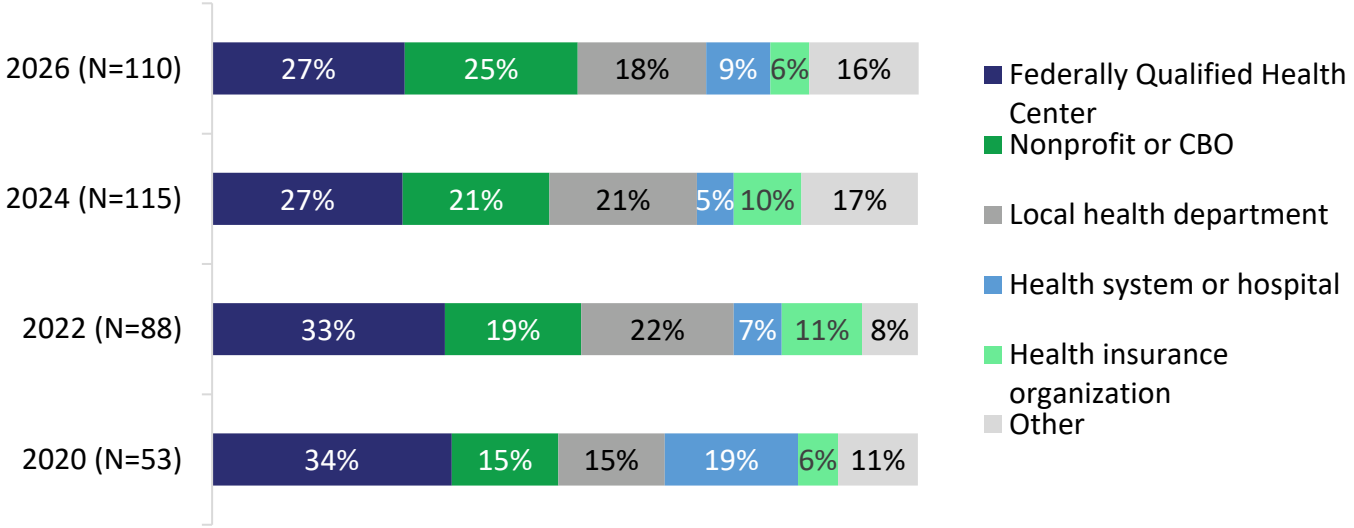


Figure 4. Proportion of Programs by Organization Setting and Survey Year



Contracts for CHW Services

In order to capture a more complete picture of contracting arrangements, the 2026 survey asked responding employers about both directions of contracts for CHW services: 1) organizations contracting other entities to provide CHW services to their clients and 2) organizations housing CHWs paid for and contracted by an external organization. The majority of responding organizations (63%) were not utilizing either form of contract. **About a quarter of responding organizations reported that some or all of the CHWs housed at their organization were working under a contract from one or more external organizations** (*Figure 5*). A smaller proportion (15%) reported that their organizations were contracting with another organization to provide CHW services to their clients. Four organizations reported utilizing both types of contract arrangements: contracting with another organization to provide CHW services to their clients and housing CHWs contracted by an external organization.

Figure 5. Proportion of Organizations by Contract Arrangements (*N*=86)

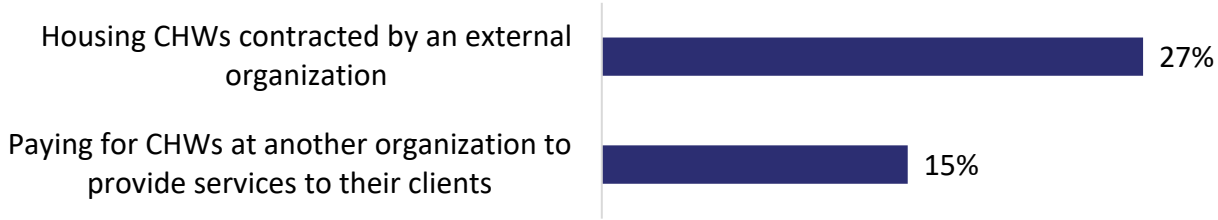
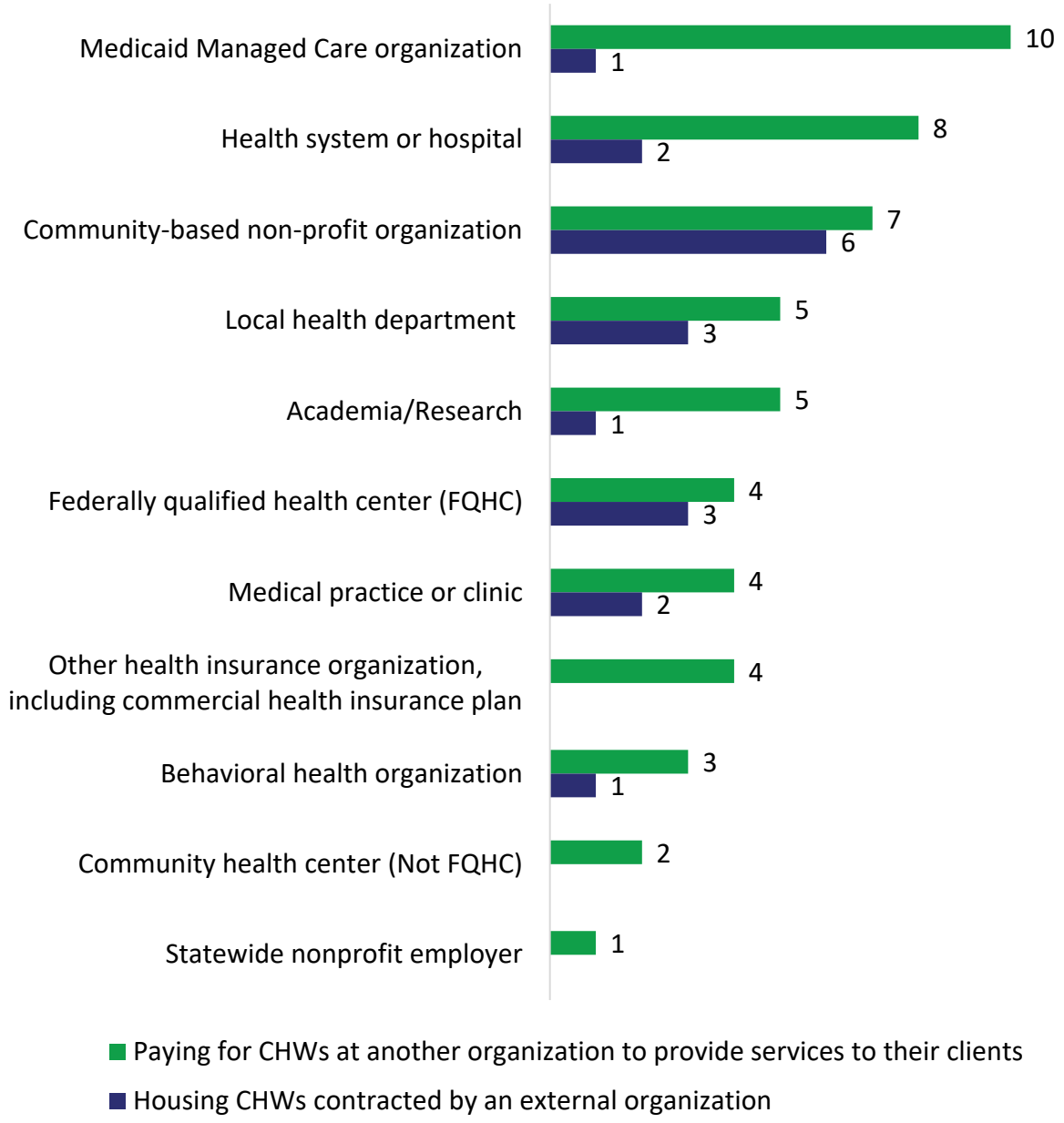


Figure 6 shows the types of organizations utilizing both of these contract arrangements. **Medicaid Managed Care Organizations were the most prevalent organization setting paying for CHWs at another organization** to provide services to their clients. Community-based nonprofits were the most prevalent organization setting housing CHWs contracted by an external organization.

Figure 6. CHW Service Contracting Relationships by Organization Type



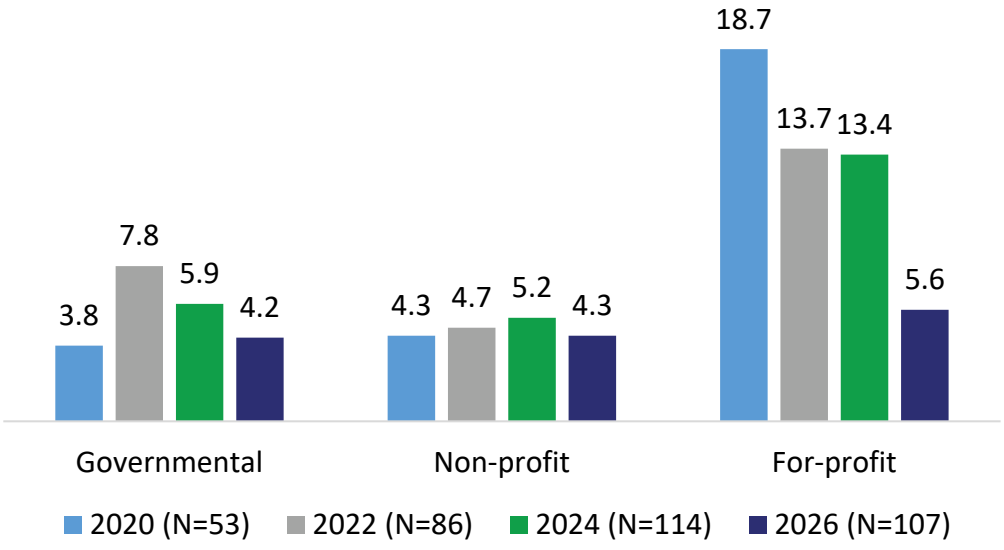
CHARACTERISTICS OF CHW PROGRAMS

Number of CHWs and Employment Status

The 107 employers providing the number of CHWs employed in their program reported employing **a total of 543 CHWs in a total of 488 full-time equivalent positions**. Given the limitations of the survey sample, **this figure is a lower bound on the true number of CHWs in Michigan**. For comparison, in 2024, 115 programs reported employing a total of 825 CHWs.

In 2026, both the average number of full-time, paid CHWs and the average total number of CHW employees were lower than in 2024 (4.3 and 5.1, respectively, compared with 6.0 and 7.2). The lower average number of full-time CHW employees in 2026 compared to previous survey waves held true across all organization types, though was especially prominent in for-profit organizations, as seen in Figure 7.

Figure 7. Average Number of Full-Time CHWs per Program by Organization Type



The large majority of the CHW positions reported were full-time, paid positions (see Table 1). Five programs reported only having volunteer CHWs, including one program with 12 full-time volunteer CHWs and 14 part-time volunteer CHWs.

Table 1. Number of CHW Employees Across Programs by Position Type (*N*=107)

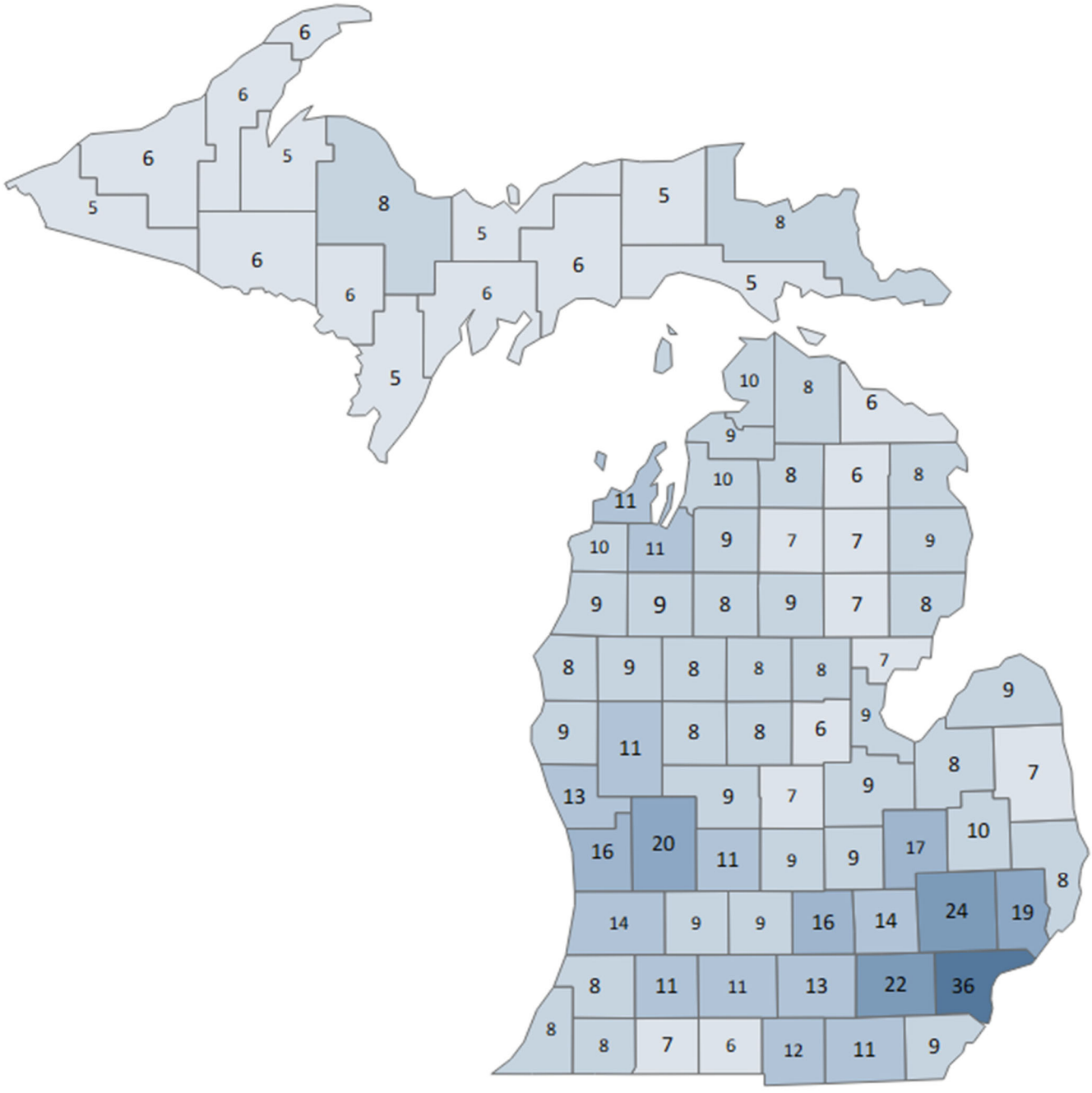
Category	Total	Max per Program
Full-Time Paid	462	48
Part-Time Paid	52	7
Full-Time Volunteer	13	12
Part-Time Volunteer	16	14

Counties Served by CHW Programs

The large majority of responding CHW programs (85%) reported serving fewer than ten counties, including **44% of programs serving a single county**. Eight programs reported serving between 11 and 23 counties, one program served 37 counties, and five programs, all based at statewide organizations, reported serving more than 70 of the state's 83 counties. *(For the full distribution, see Figure 46 in Appendix A on p. 82.)* Collectively, the average was seven counties served per program, one county higher than in 2024.

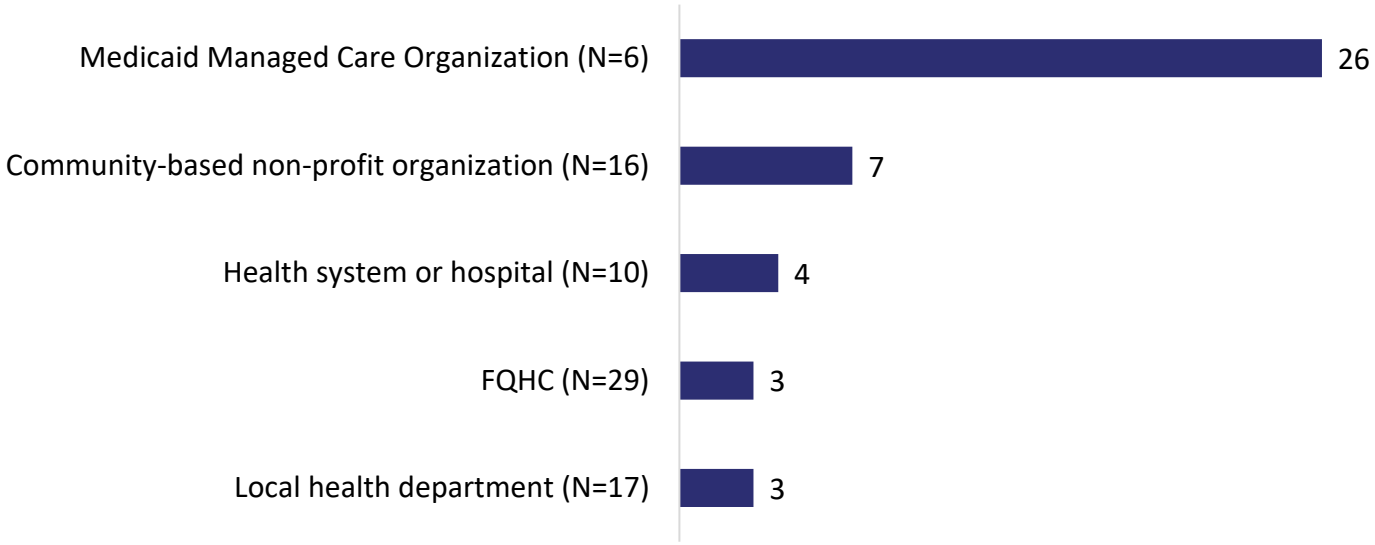
The two counties served by the largest number of programs were Wayne and Oakland, served by 36 and 24 programs respectively. **All Michigan counties were served by at least five CHW programs** in the 2026 sample. Unlike in previous survey years, there were no counties served solely by programs serving more than 70 counties, meaning that **each county was served by at least one local or regional program**. *(For the number of CHW programs in all counties, see Figure 8, below, and Table 4 in Appendix A on p. 82.)*

Figure 8. Number of CHW Programs by County in Survey Sample (*N*=110)



Across organization types, on average, **CHW programs in Medicaid Managed Care Organizations served the highest number of counties** (see Figure 9). FQHCs and local health departments had the lowest average number of counties served per program with each serving three counties.

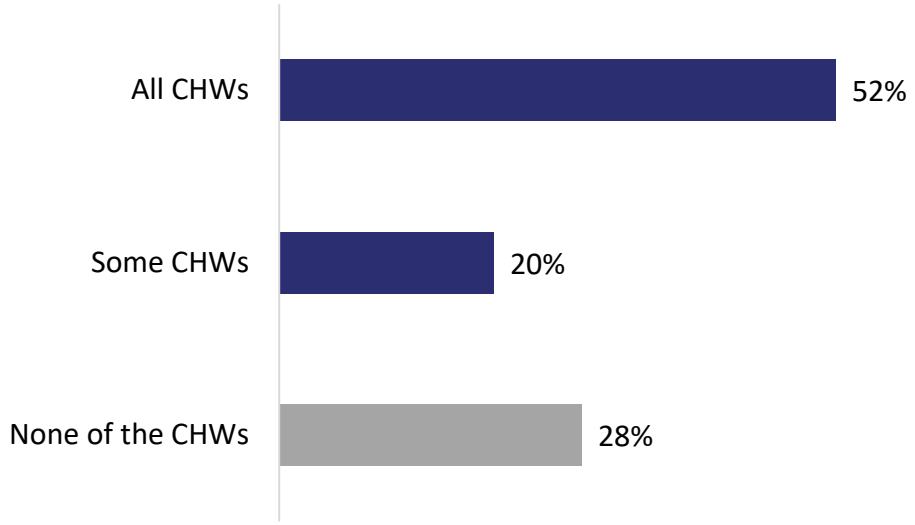
Figure 9. Average Number of Counties Served per CHW Program by Organization Setting



CHWs in Rural Areas

A new question in this year's survey asked organizations to share what proportion of their CHW workforce serves rural areas of Michigan. The survey intentionally omitted a specific definition of rural to allow respondents discretion to assign this label as appropriate for their community context. **Over 70% of respondents reported that some or all of their CHWs serve rural areas.**

Figure 10. Percentage of CHW Programs with All, Some or None of the CHWs Serving Rural Areas (*N*=110)



We found that programs with CHWs serving rural areas covered far more counties on average than the programs where none of the CHWs served rural areas, as shown in Figure 11.

Figure 11. Average Number of Counties Served by Programs with All, Some, or None of the CHWs Serving Rural Areas

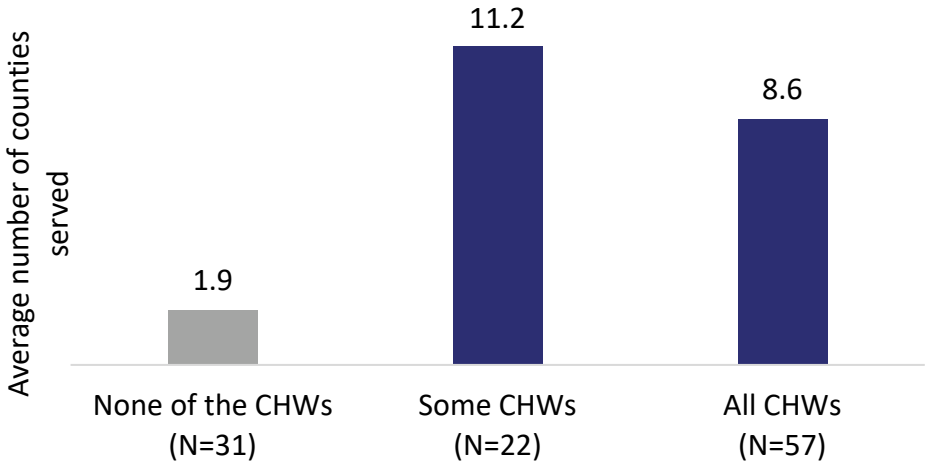
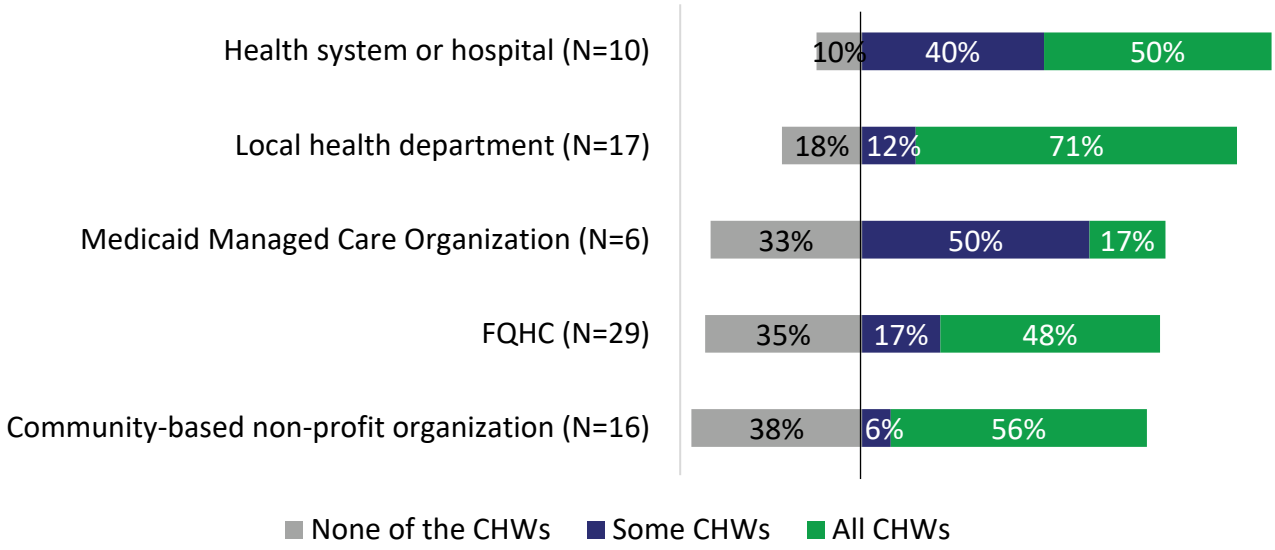


Figure 12 shows the proportions of CHWs serving rural areas by organization setting. While health systems had the largest combined proportion of some and all CHWs serving rural areas, local health departments had the largest proportion of all CHWs serving rural areas.

Figure 12. Programs with All, Some, and None of the CHWs Serving Rural Areas by Organization Type (*N*=97)



CHW ROLES

CHW Roles and Activities

Rather than use the 36 CHW roles identified by the Community Health Worker Core Consensus (C-3) project, as in previous survey waves, the survey team developed a new, shorter set of questions on eight CHW roles. The team made these changes both to reduce survey length and improve data quality by eliminating redundant, overlapping, or unclear items.

Three roles stood out for the large proportion of the programs' CHWs engaging in the role often or very often:

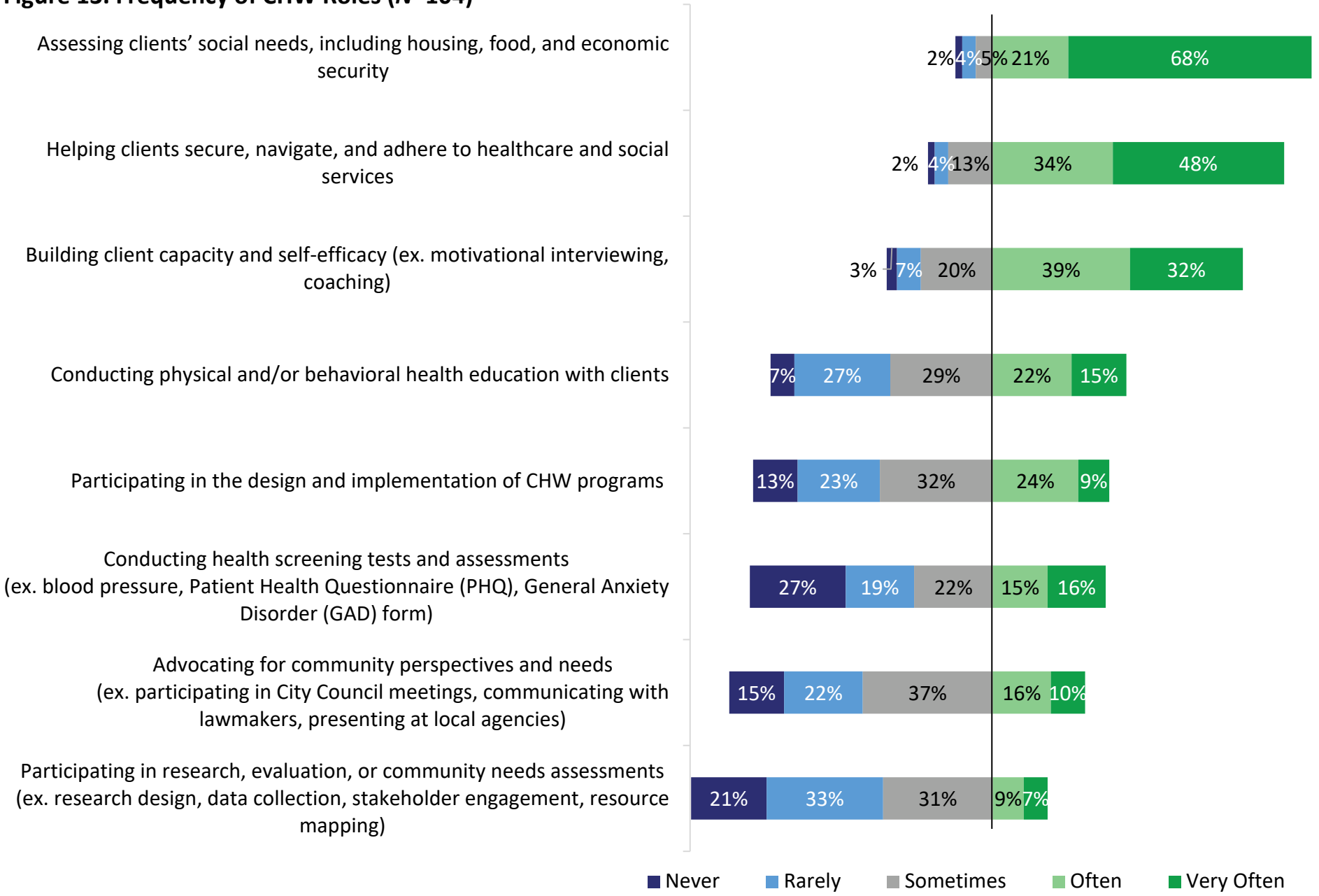
1. Assessing clients' social needs, including housing, food, and economic security (89%)
2. Helping clients secure, navigate, and adhere to healthcare and social services (82%)
3. Building client capacity and self-efficacy (71%)

The research and advocacy roles were far less common, with 26% and 16% of employers, respectively, reporting CHWs engaged in these activities often or very often. Of the eight listed roles, employers reported CHWs engaging in an average of four roles often or very often.

A few employers described other roles and activities CHWs perform beyond those listed. These included team meetings, learning about local resources, and sharing case reviews with other CHWs or care team members.

Despite the change in question language, the most frequent roles reported in 2026 generally aligned with the most frequent roles in 2024, where care navigation and building capacity were among the top roles. *(See Table 5 in Appendix A on p. 83) for the full comparison of role frequency between survey years.)*

Figure 13. Frequency of CHW Roles (*N*=104)



Employer Perspectives

"Our CHW is… very busy with unmet needs and limited access to dental care in rural Northern Michigan."

- Local Health Department Employer

"Our CHW works with our school nurse team. The nurses refer students/families to the CHW for various reasons. Follow up on failed vision and hearing screenings, assisting families with getting the appropriate appointments, food insecurity, homelessness, transportation, no insurance and other barriers to care. Our CHW works with many families that only speak Spanish. The CHW helps families navigate the health system and empowers them to advocate for themselves."

- Health System Employer

"Our CHW performs emergency department follow-up calls encouraging patients to call their doctor first and making sure needs are met. She also provides outreach to patients who have SDOH needs. She educates care managers on local resources."

- Physicians' Organization Employer

"CHWs at [agency] serve in a clinical support role. They assist in conducting blood pressure (BP) monitoring and enrolling patients in Home BP monitoring program. They conduct Retinavue exams. They assist with patient transportation by eligibility. They provide 1:1 resources to patients as needed. They partner with the U of M mobile mammography unit for monthly breast cancer screenings and with Loaves and Fishes for the monthly food bank. They perform regular outreach to all patients to maintain access and continuity of care."

- FQHC Employer

One of the local health department employers described how the vision for a CHW role is far more limited within some Medicaid Health Plans than they would like to see and called on the CHW sector to help demonstrate the value underlying the full scope of CHW roles.

Employer Perspectives

"Within Medicaid health plans, we were recently informed by one contractual provider that the plan only needs to demonstrate approximately $41,000 in spending to justify a single CHW. However, this threshold does not fully account for the time, effort, and scope of work involved. It primarily supports screening activities conducted over the phone, rather than the more resource-intensive, relationship-based, face-to-face services that often drive deeper impact.

Aligning expectations and reimbursement more closely with the full scope of CHW work—including direct service delivery—would help ensure sustainability and better reflect the true value of these services."

- Local Health Department Employer

Alongside calling for a focus on demonstrating the return on the investment in CHW services, one employer cautioned that if this is only approached at the program level, CHWs will bear the burden in ways that could be harmful and misleading.

Employer Perspectives

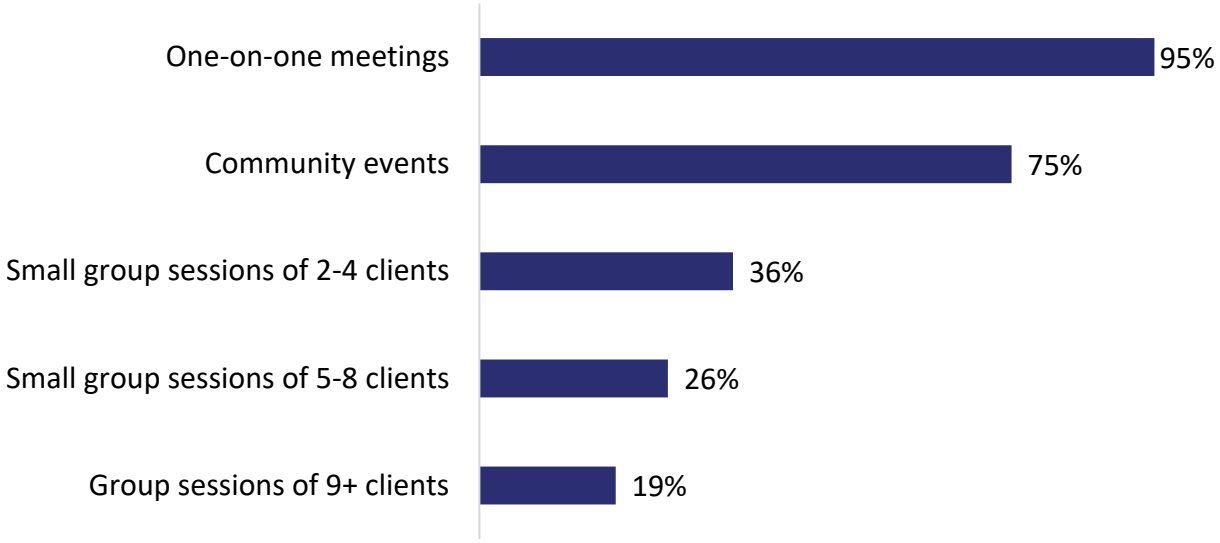
"The current requirements to continuously demonstrate value can unintentionally contribute to burnout and ethical strain, particularly when frontline staff feel they must constantly validate their work in ways that do not always align with the lived experience of the communities they serve."

- Local Health Department Employer

Client Engagement

One-on-one meetings were the most common way CHWs reported providing client services, followed by community events. About 42% of employers reported the program's CHWs met with clients in a group setting of any size. In addition to the types of interaction listed, three employers noted the program's CHWs met with clients in a clinical setting alongside other care team members. One employer shared that client engagement occurs during a monthly food pantry and through tenant organizing.

Figure 14. Types of Client Interactions (*N*=110)



Among those meeting one-on-one with clients, interactions via phone and in the program's office were the most common (*Figure 15*). More than 80% of employers indicated CHWs used each of these formats at least to some extent and reported, on average, that approximately one-third of meetings take place in each of these formats (*Figure 16*). On average, 61% of one-on-one meetings occurred in person. On the other hand, eleven CHW programs reported that between 80-100% of CHW's one-on-one meetings with clients occurred by phone. Beyond the listed formats, employers also shared that CHWs engaged with clients via text message, email, mail, and electronic health portals.

While group meetings were far less common than one-on-one meetings**, among those who met with groups of clients, the most common formats were at the program's office or in a community setting**, such as a school or library. When looking at meeting formats and settings according to whether a program's CHWs serve rural areas, the biggest difference was in the use of the program's office to hold meetings. On average, CHWs serving urban areas utilized the program's office more often than CHWs serving rural areas for both one-on-one meetings (40% vs. 31%) and group meetings (51% vs. 41%).

Figure 15. Use of Meeting Formats and Settings

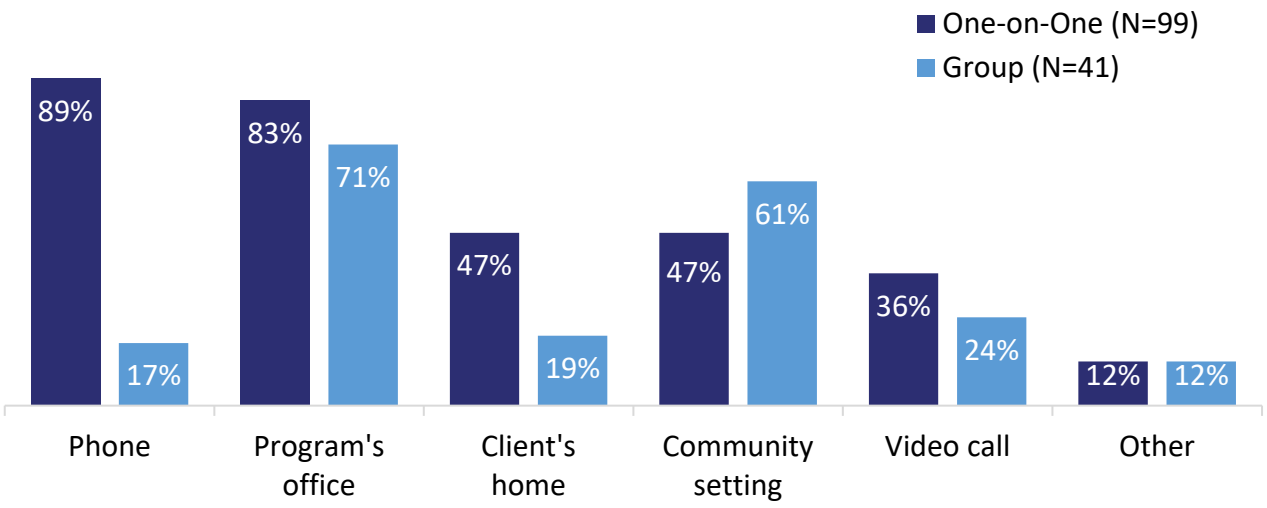
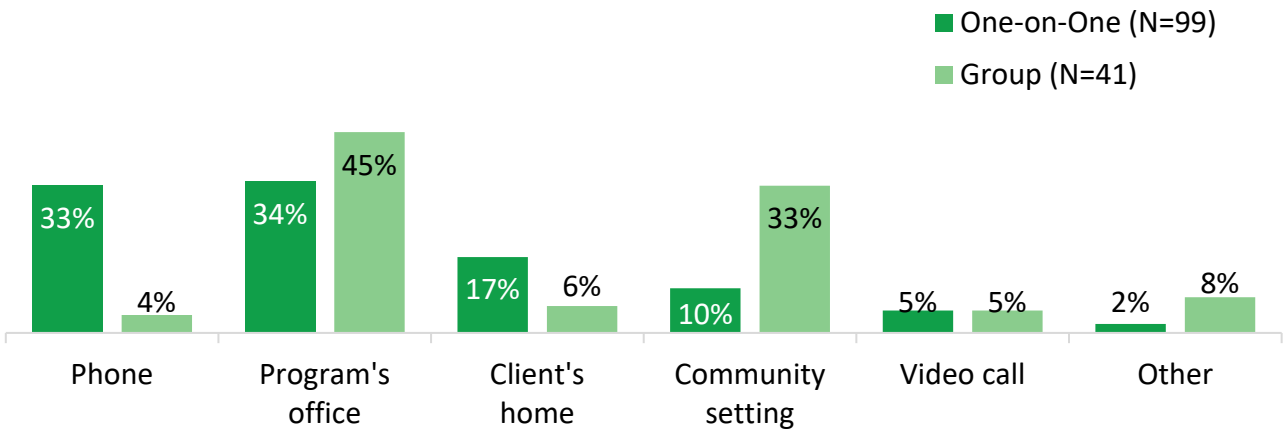


Figure 16. Percentage of Meetings by Format and Setting



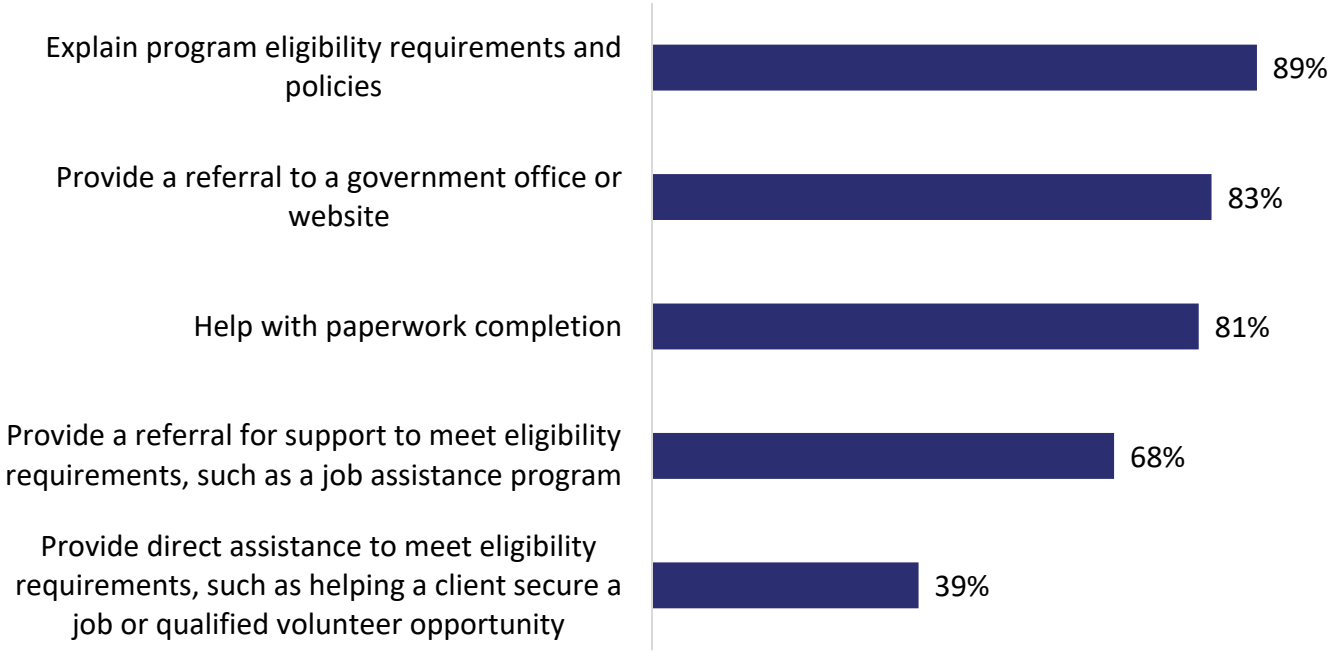
Public Benefit Enrollment Support

The survey asked in what ways, if any, the program's CHWs provide support for public benefit program enrollment and re-enrollment, such as SNAP, Medicaid, WIC, or TANF. **All but five employers reported CHWs in their program provided at least one type of public benefit support (95%).** As shown in Figure 17, the three most common types of public benefit supports were:

1. Explaining eligibility requirements (89%)
2. Providing referrals to government offices, or websites (83%)
3. Helping with paperwork completion (81%)

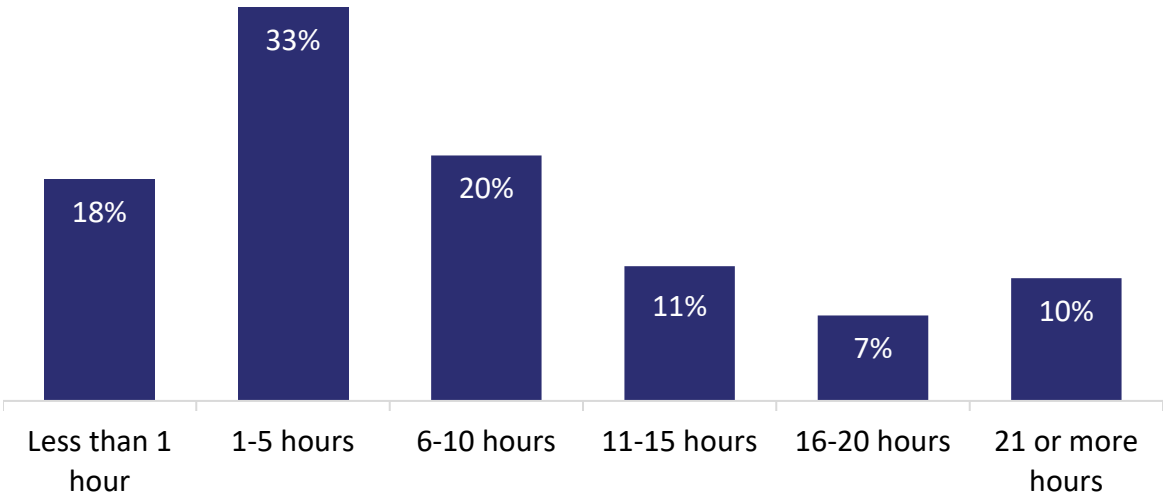
In addition to the listed support types, one employer noted all the CHWs in their program were Mi Bridges Navigators. Others noted CHWs upload documentation, raise awareness of Medicaid renewal, and refer clients to other community-based organizations, or teams within their organization, for enrollment support.

Figure 17. Types of Public Benefit Support Provided by CHW Programs (*N*=104)



Half of employers (51%) reported that the program's CHWs spend, on average, five or fewer hours supporting public benefit enrollment each week. The nine employers who reported CHWs spend more than half of their work week on public benefit enrollment support were spread across six different organization settings, including three at an FQHC, and two at a local health department.

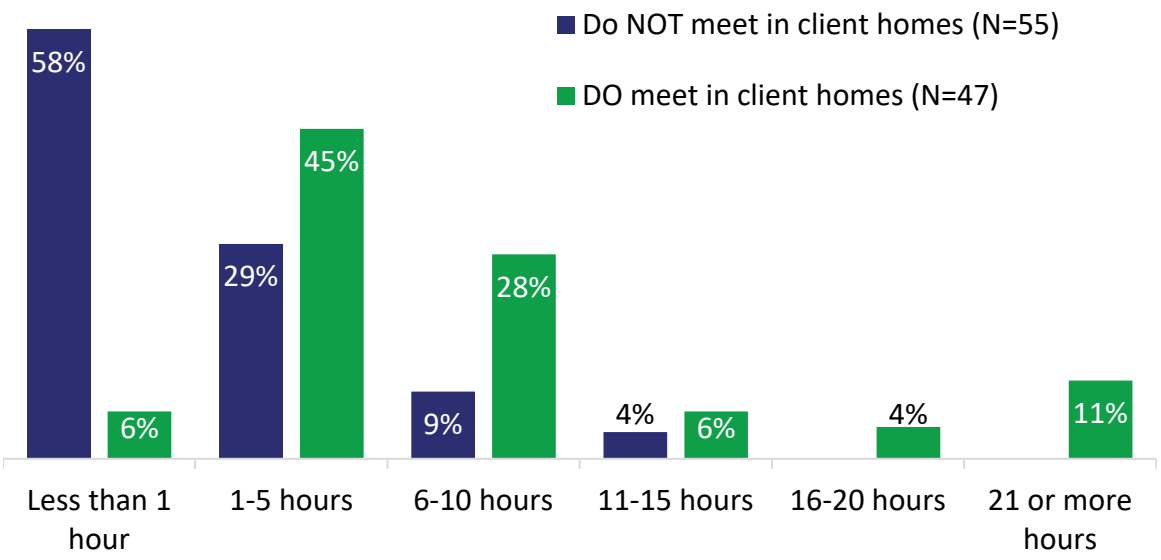
Figure 18. CHWs' Average Weekly Time Spent Supporting Public Benefit Enrollment (*N*=98)



Driving Time

In looking at the average amount of time employers reported CHWs spent driving for job-related duties each week, we found differences between the CHWs who met in clients' homes and those who did not. In both groups, half or more of employers reported CHWs drove five or fewer hours each week. However, **21% of employers with CHWs meeting in clients' homes reported drive time of over ten hours each week compared to just 4% among employers with CHWs who did not meet in clients' homes.**

Figure 19. CHWs' Average Weekly Time Spent Driving for Job-Related Duties for those who Do and Do Not Meet in Clients' Homes

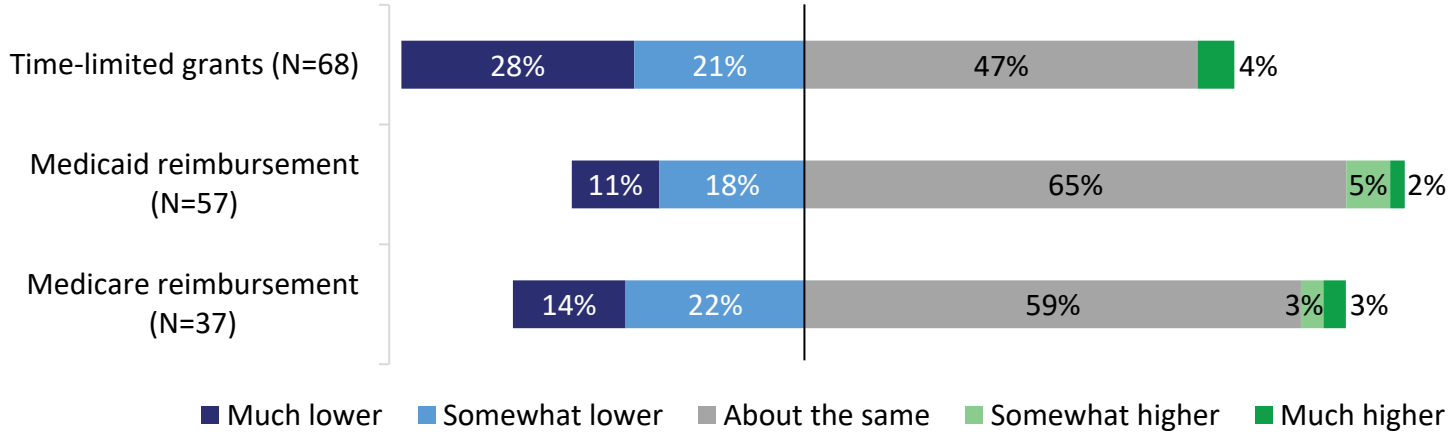


CHW FUNDING AND SUSTAINABILITY

A new question on the 2026 survey asked employers how the level of three CHW program funding sources (time-limited grants, Medicaid reimbursement, and Medicare reimbursement) had changed in the past year. Figure 20, which includes only the subset of organizations receiving funding from each named source, shows **nearly half of the employers who had time-limited grants saw decreases in funding levels in the past year**. Increases in funding were not common: between four and seven percent of employers reported increases in funding levels for each of these three funding sources.

Funding sustainability in this context refers only to the source of the funding and its likelihood of renewal. It does not refer to the broader sustainability of the CHW program and its ability to maintain CHW services or positions. The survey team categorized the funding sources listed in the survey as either "less sustainable" or "more sustainable" based on typical likelihood of renewal.

Figure 20. Employer-Reported Changes in Funding Level for CHW Programs in the Past Year for Select Sources



One employer explained how changes and instability in their CHW program funding affects who they can serve.

Employer Perspectives

"We are very much at a tipping point. We can no longer support the funding model used this year. Our organization was gracious to cover a few months while we secure additional funding opportunities. We are awaiting this funding determination to determine if we will stay universal in who we can serve or need to put parameters on who we can serve based on insurance and/or income status."

- Local Health Department Employer

The survey asked CHW employers to report the portion of CHW program funding coming from each of 15 listed categories, with an option to name additional sources. Following the analysis of previous years, the survey team classified these sources as "more" or "less" sustainable. Figures 21 and 22 show, first, the percent of CHW programs reporting funding from each of the "less sustainable" sources and, second, the average portion of funding from these sources.[1] Likewise, Figure 23 shows the percentage of CHW programs reporting funding from "more sustainable" sources and Figure 24 shows the average portion of funding.

All four graphs include the four most recent survey waves. The 2026 survey separated Medicaid reimbursement fee for service under the Medicaid Coverage of Community Health Worker (CHW)/Community Health Representative (CHR) Services policy (MMP23-74) from other Medicaid reimbursement payment methods. For this reason, there is no earlier data available for the "other Medicaid reimbursement" category.

[1] The average percent of funding was calculated for all responding programs, rather than for only the programs that reported funding from a given source.

Figure 21. Percentage of CHW Programs Reporting "Less Sustainable" Funding Sources by Survey Year

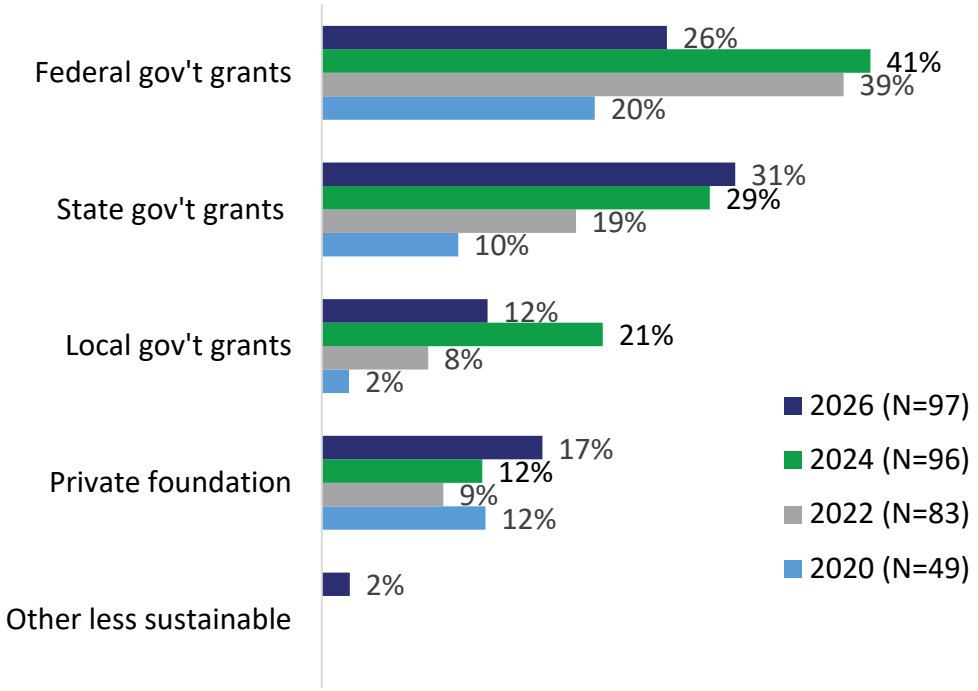


Figure 22. Average Proportion of Funding from "Less Sustainable" Sources by Survey Year

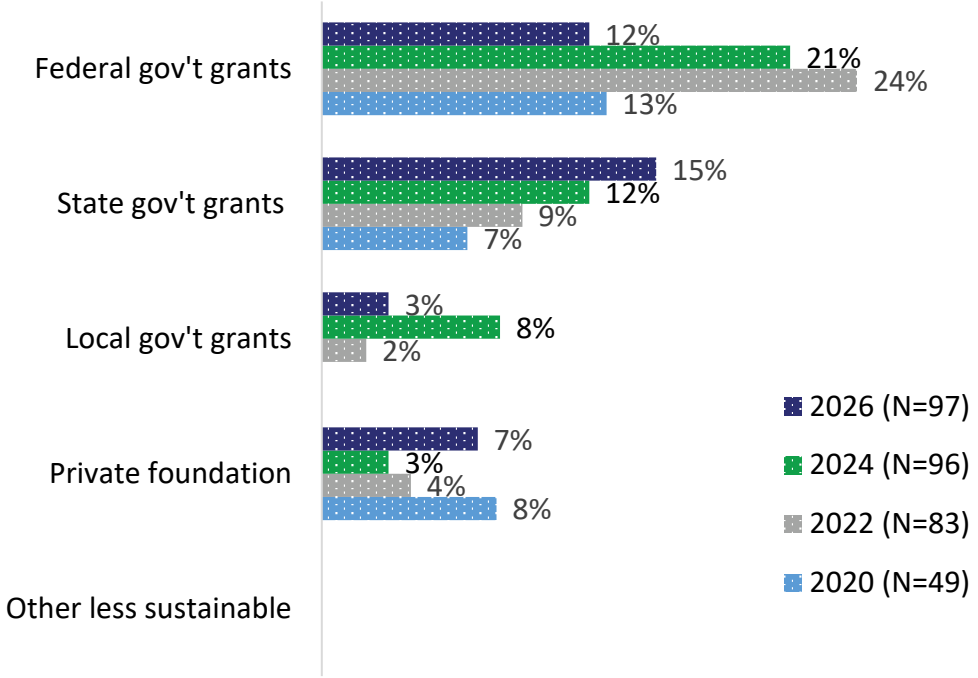


Figure 23. Percentage of CHW Programs Reporting "More Sustainable" Funding Sources by Survey Year

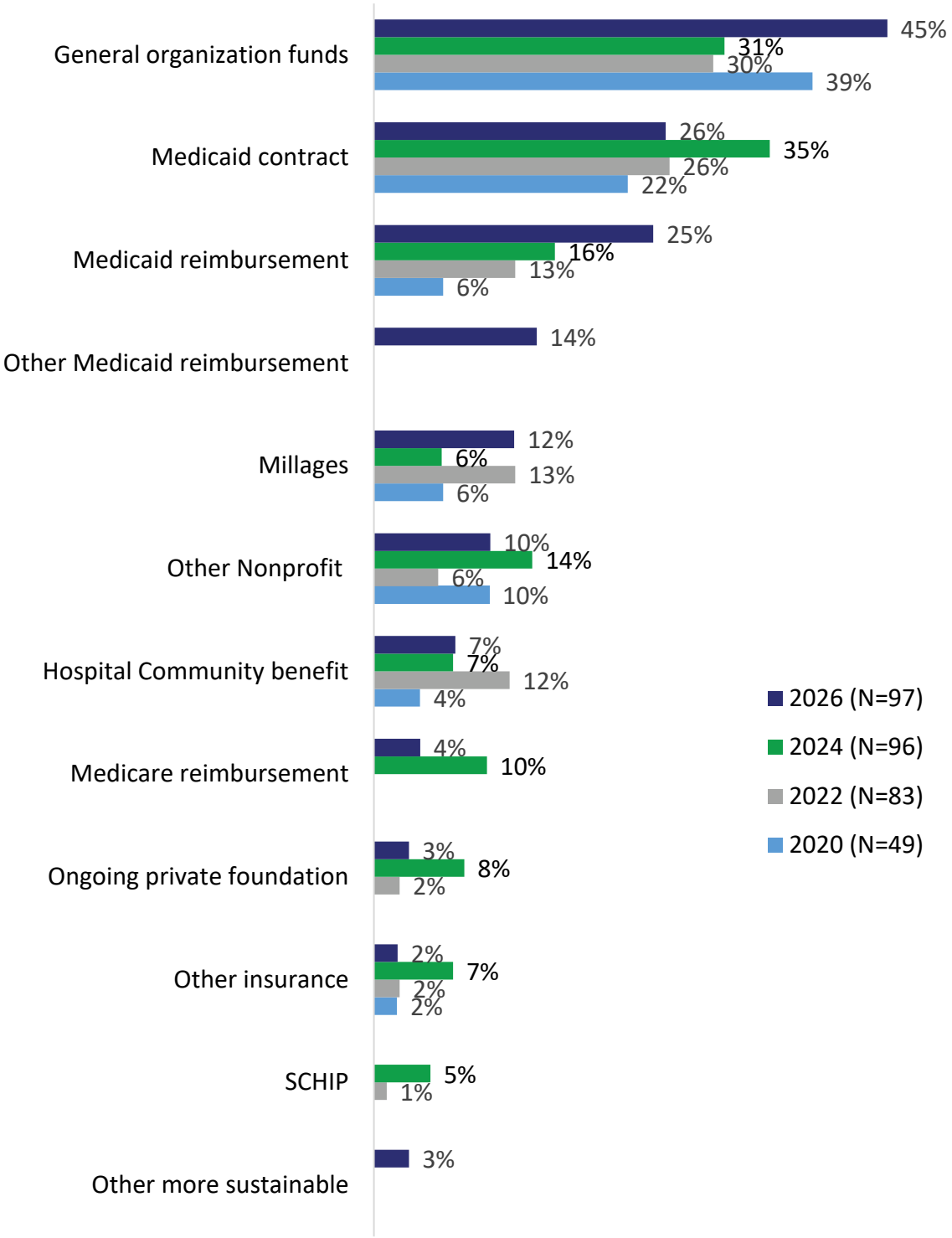
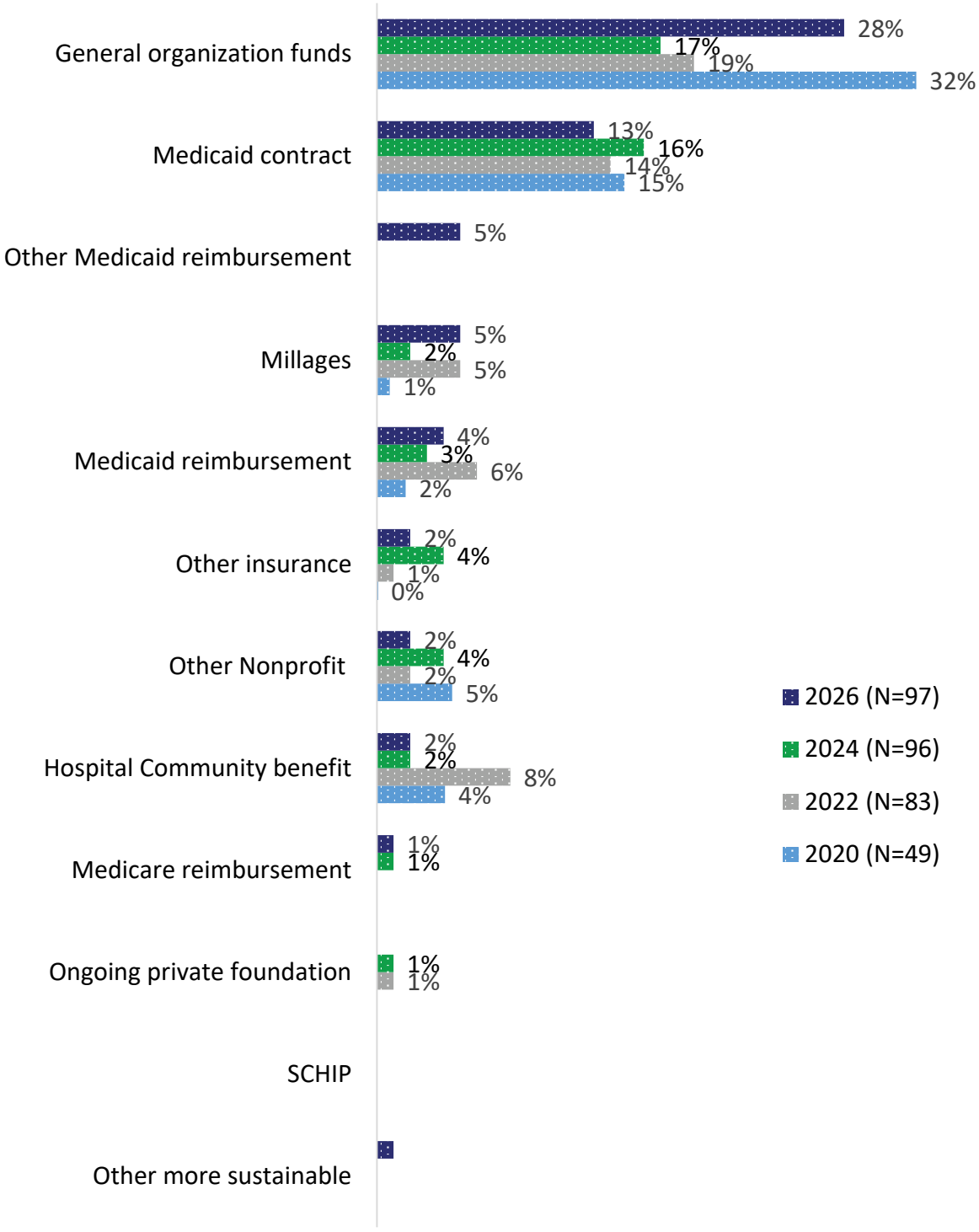


Figure 24. Average Proportion of Funding from "More Sustainable" Sources by Survey Year



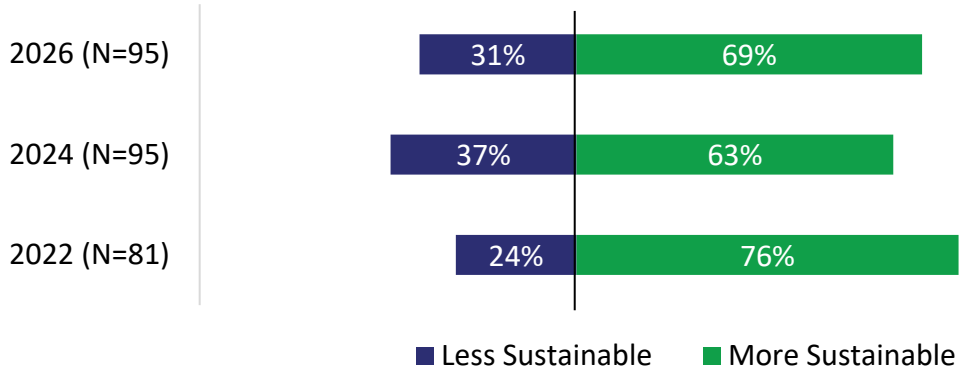
In 2026, fewer programs reported receiving federal and local grant funding and the average portion of program funding was lower than in 2024. Conversely, more programs in 2026 reported time-limited private foundation grants and the average proportion of funding from this source was more than twice the 2024 proportion.

Among the more sustainable funding sources, the percentage of programs reporting receiving funding and the average portion of funding were **higher in 2026 for general organization funds and millages than in 2024**.[2] In a similar positive trend, the proportion of programs solely reliant on less sustainable funding sources was smaller in 2026 (20%) than in 2024 (30%). Among the 97 programs reporting funding, 19 indicated 100% of their funding came from less sustainable sources. Within this group, the largest number were housed at nonprofit organizations (11 programs), followed by local health departments (4 programs).

Figure 25 shows sustainability of funding sources in relation to the total number of paid CHW positions reported by respondents in the previous three survey waves. **Collectively, 69% of CHW positions were supported by more sustainable funding sources in 2026.**

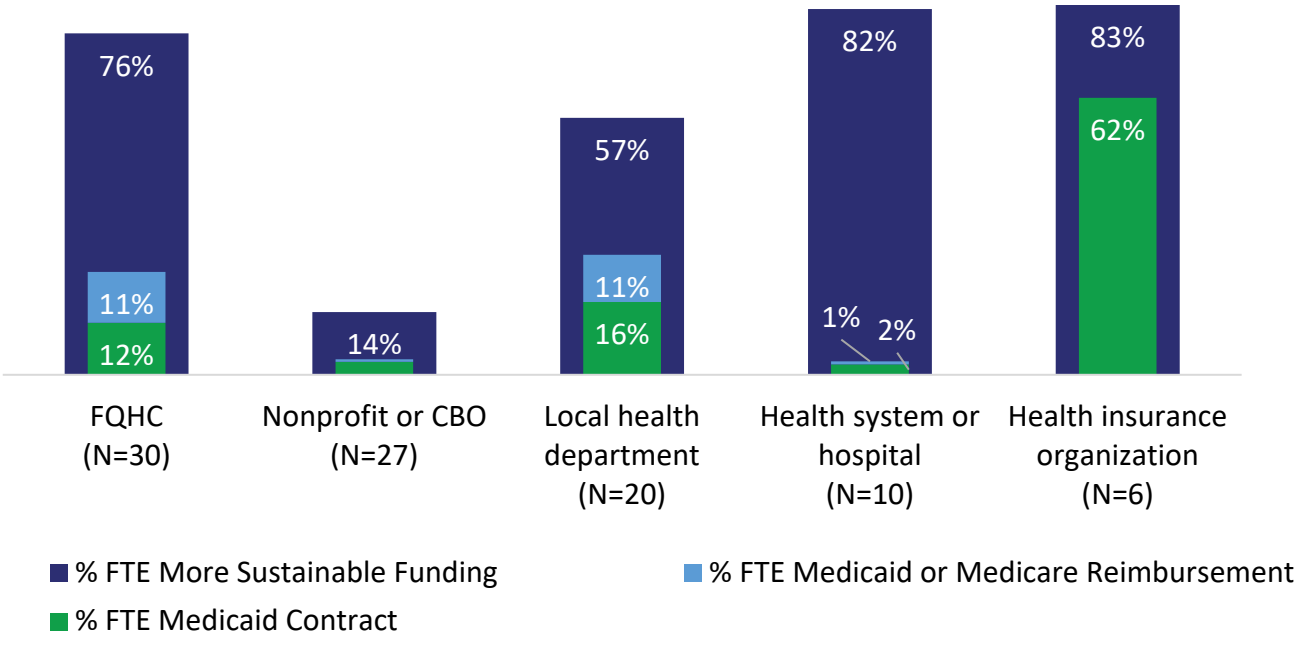
[2] The 2026 survey asked about three categories of Medicaid funding (Medicaid health plan contracts, Medicaid reimbursement fee for service under MMP23-74, and other Medicaid reimbursement methods) whereas the previous surveys asked about two categories (contacts and reimbursement). The additional response option may account for some of the changes seen in Medicaid funding between 2026 and 2024.

Figure 25. Percentage of Paid Full-Time CHW Positions by Level of Funding Sustainability and Survey Year



The proportion of paid CHW positions supported by more sustainable funding varied by organization setting. Figure 26 shows, on the one hand, between 73% and 83% of CHW positions were supported by more sustainable funding at FQHCs, health systems, and health insurance organizations. On the other hand, the proportions were lower at local health departments and far lower at nonprofit organizations.

Figure 26. Percentage of Paid Full-Time CHW Positions by Category of Funding and Organization Setting

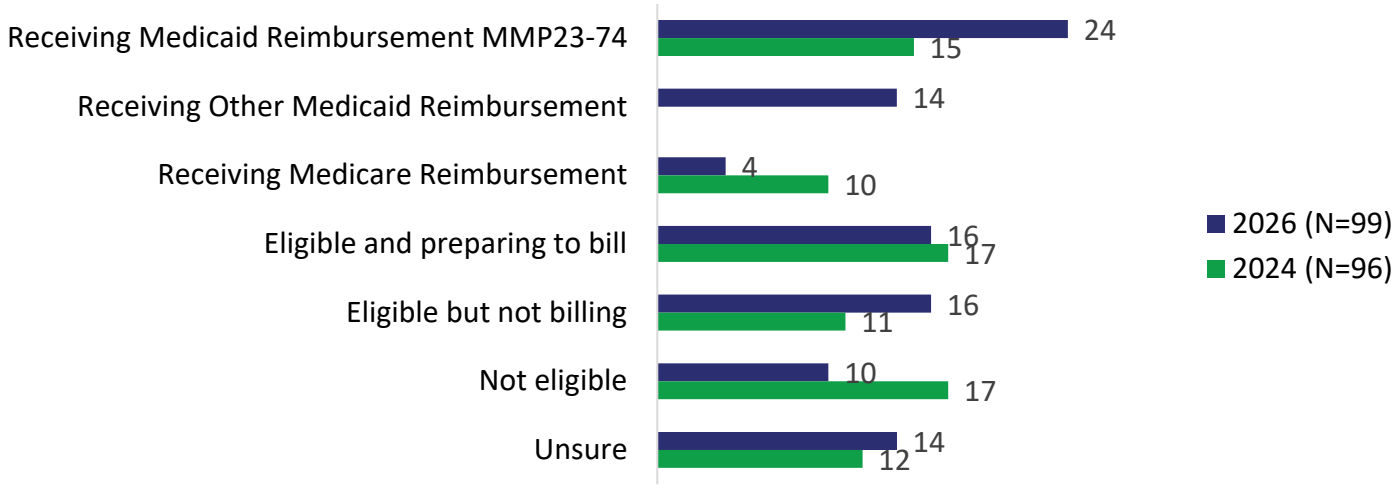


Billing for State and Federal Benefit Programs (e.g. Medicaid/Medicare)

Forty-three of 99 CHW programs reported receiving a portion of their funding from one or more of the listed state and federal benefit programs: Medicaid health plan contract (26%), Medicaid reimbursement – fee for service under MMP23-74 (25%), other Medicaid reimbursement models (14%),[3] Medicare reimbursement (4%), and State Children's Health Insurance Program (5%). Among the programs not currently receiving funding from any of these sources (56%), equal numbers were preparing to bill and were eligible to bill but not yet doing so. Nearly as many responding employers were unsure of their billing status.

The organizations reporting they were not eligible to bill included an FQHC, a community health center, two non-profits, a health system, two Medicaid Managed Care Organizations, and an impact community-based organization. This diversity of organization settings indicates there are multiple factors impacting the ability to bill for CHW services. **The number of employers unsure about their billing status indicates an opportunity for education on reimbursement policies.**

Figure 27. Billing Status of Programs by Survey Year



[3] The 2026 survey asked about MMP23-74 reimbursement separate from other reimbursement payment models but the 2024 survey asked about all Medicaid reimbursement together.

Under the Michigan Medicaid Policy MMP 23-74 (implemented January 1, 2024), organizations must have a Type 2 National Provider Identifier (NPI) code and individual CHWs must have a Type 1 NPI to be eligible to bill.[4] Since most community-based organizations are not registered with a Type 2 NPI, these organizations can only bill for CHW services through an affiliation with another health clinic or provider organization.

Employers were asked whether their programs had any barriers preventing them from billing for CHW services or successfully submitting claims under Medicaid and Medicare. Seven themes emerged from the responses, as shown in Table 2. Among the barriers shared, four themes dominated:

1. Lack of understanding of the policy and necessary procedures (*N*=10)
2. Burdensome administrative processes (*N*=8)
3. Provider referral requirement (*N*=8)
4. Low reimbursement rate (*N*=7)

A few employers also mentioned that their receipt of Medicaid health plan contract funds complicates their ability to bill for CHW services. This lack of clarity highlights the need for guidance from the state on how these funding mechanisms can operate in tandem.

[4]National Provider Identifiers (NPIs) are assigned by the National Plan and Provider Enumeration System, maintained by Health and Human Services Center for Medicare and Medicaid Services (CMS).

Table 2. Themes in Barriers to Billing Medicaid and Medicare for CHW Services

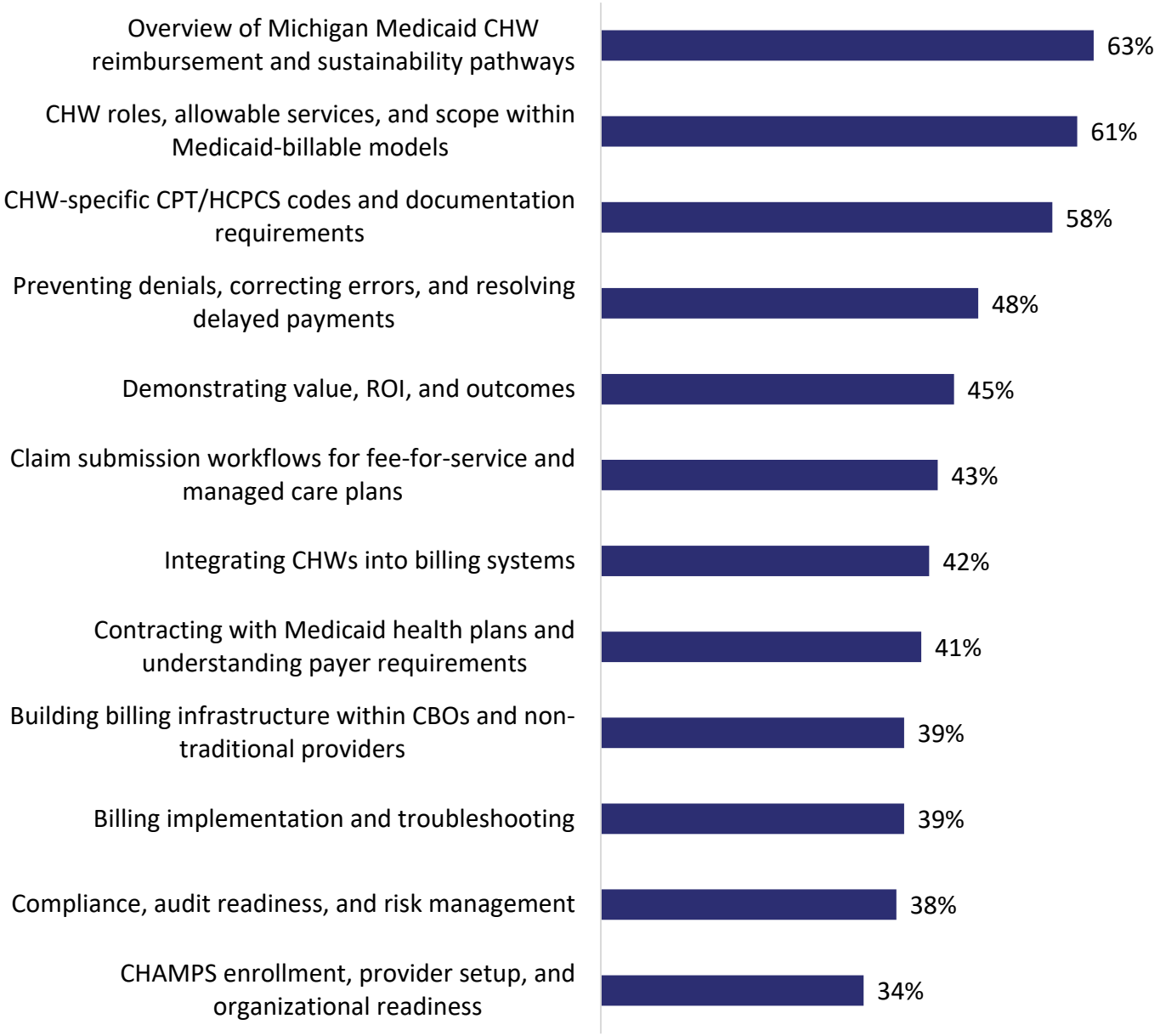
Theme	N	Representative Comment
Lack of understanding of the policy and procedures	10	"We are not sure how the billing process actually works." *- Community-based Nonprofit Employer*
Burdensome administrative processes	8	"In the past, we have worked with Medicaid reimbursement programs. It was a lengthy, cumbersome process." *- Community-based Nonprofit Employer*
Provider referral requirement for Medicaid and Medicare	8	"Medicare requires services to be routed through the primary care physician, which is challenging given frequent provider changes within networks." *- Local Health Department Employer*
Low reimbursement rate	7	"Medicaid reimbursement rates cover only about 40% of the true cost of a CHW, and it is increasingly difficult to find funding for the uncovered portion of the cost." *- Local Health Department Employer*
CHWs' phone meetings are not covered	4	"A large portion of care coordination and family support activities take place over the phone. Current billing structures do not adequately recognize these interactions, limiting CHWs' ability to bill for the services they provide." *- Community-based Nonprofit Employer*

Theme	N	Representative Comment
Denial of payment	4	"Many of our claims with [payer] are being rejected." *- FQHC Employer*
EMR/EHR licensing cost	3	"Our current electronic health record requires individuals who bill for services to have a license for the EHR. The cost of the license is over $700 per CHW which is more than we would bill at $10 each 15 min. visit. We have not started billing at this time but are looking at how we can do that successfully without losing income." *- FQHC Employer*

Many employers expressed a **high level of interest in training and technical assistance topics related to Medicaid billing and claim submission**, if they were to become available from MiCHWA. More than half of employers reported interest in eight of the 12 listed topics and collectively, employers reported interest in seven different topics on average. As shown in Figure 28, the three topics with the greatest interest were:

1. Overview of Michigan Medicaid CHW reimbursement and sustainability pathways (63%)
2. CHW roles, allowable services, and scope within Medicaid-billable models (61%)
3. CHW-specific CPT/HCPCS codes and documentation requirements (58%)

Figure 27. Employers' Interest in Medicaid Billing Training and Technical Assistance Topics (*N*=95)



Program Sustainability Concerns

Comparing program sustainability concerns over the previous five employer surveys shows that funding uncertainty has consistently been the dominant concern and may be increasing. **The proportion of employers concerned with funding uncertainty was higher in 2026 than any other time since 2018, with nearly three in four employers noting this concern**. Alson concerning, the proportion of programs which indicated they had no sustainability concerns dropped in half between 2022 and 2024 (from 27% to 12%) and then again dropped in half between 2024 and 2026 (from 12% to 6%). The six organizations reporting no sustainability concerns in 2026 spanned five different setting types, revealing no clear pattern by setting.

While the proportion of employers concerned with CHW burnout was also greater in 2026 than in 2024, the other four listed concerns were shared by a smaller proportion of employers in 2026 than in 2024.[5]

In describing other sustainability concerns beyond those listed, four employers mentioned the low rate of CHW pay. One person each noted that reimbursement for CHW services is too low to justify the administrative burden, changes to MDHHS Policy and Medicaid Contracts, a lack of internal funding to train existing staff as CHWs, and insufficient funding for the community resources CHWs refer to clients.

[5] The comparison between the 2020 responses and other survey years should be interpreted cautiously because in 2020 the survey software was inadvertently set up to limit respondents to selecting a maximum of three of the six listed answer choices. This means that 2020 responses for some items may be an undercount.

Figure 28. Percent of Programs with Sustainability Concerns by Survey Year

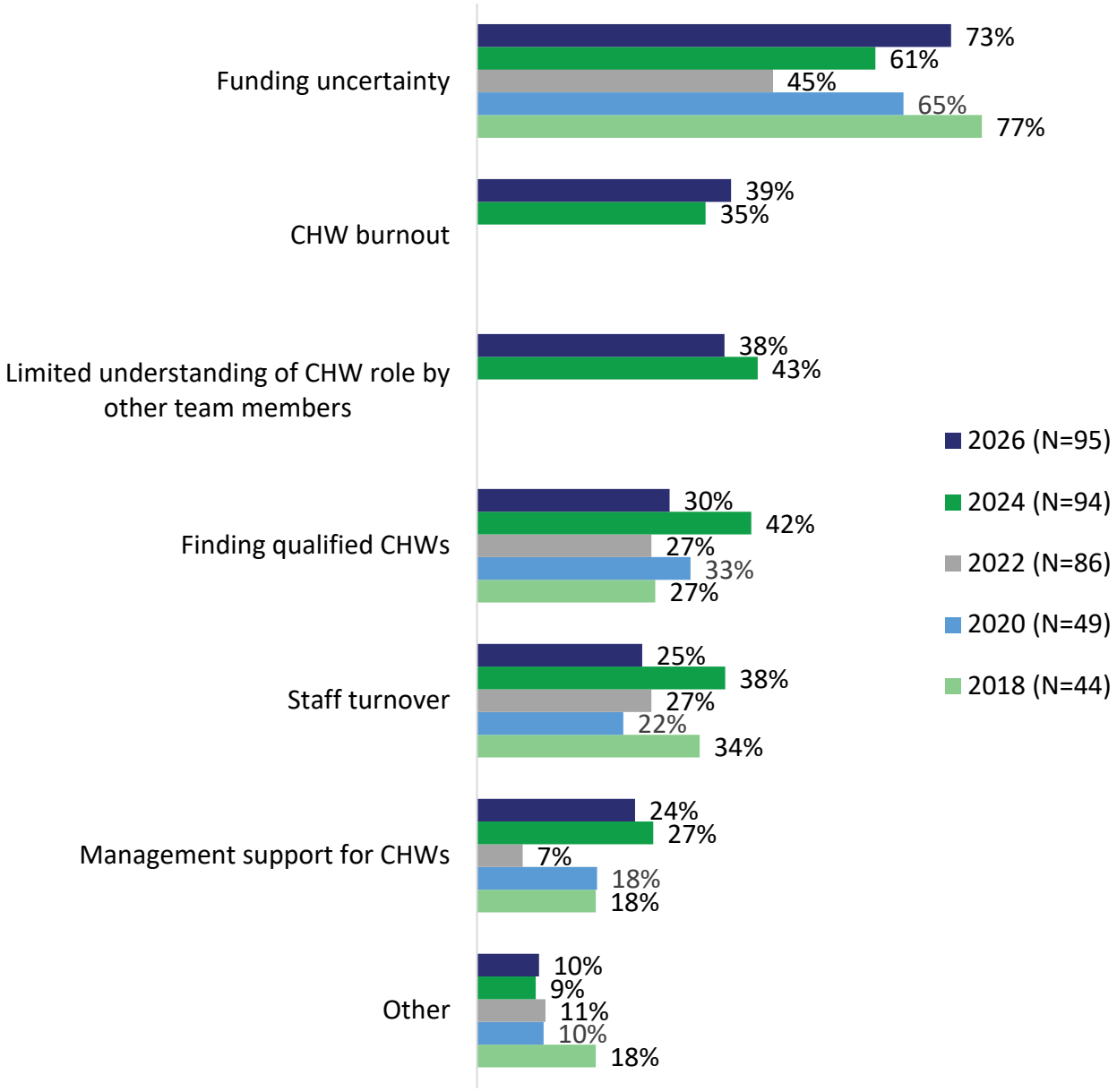
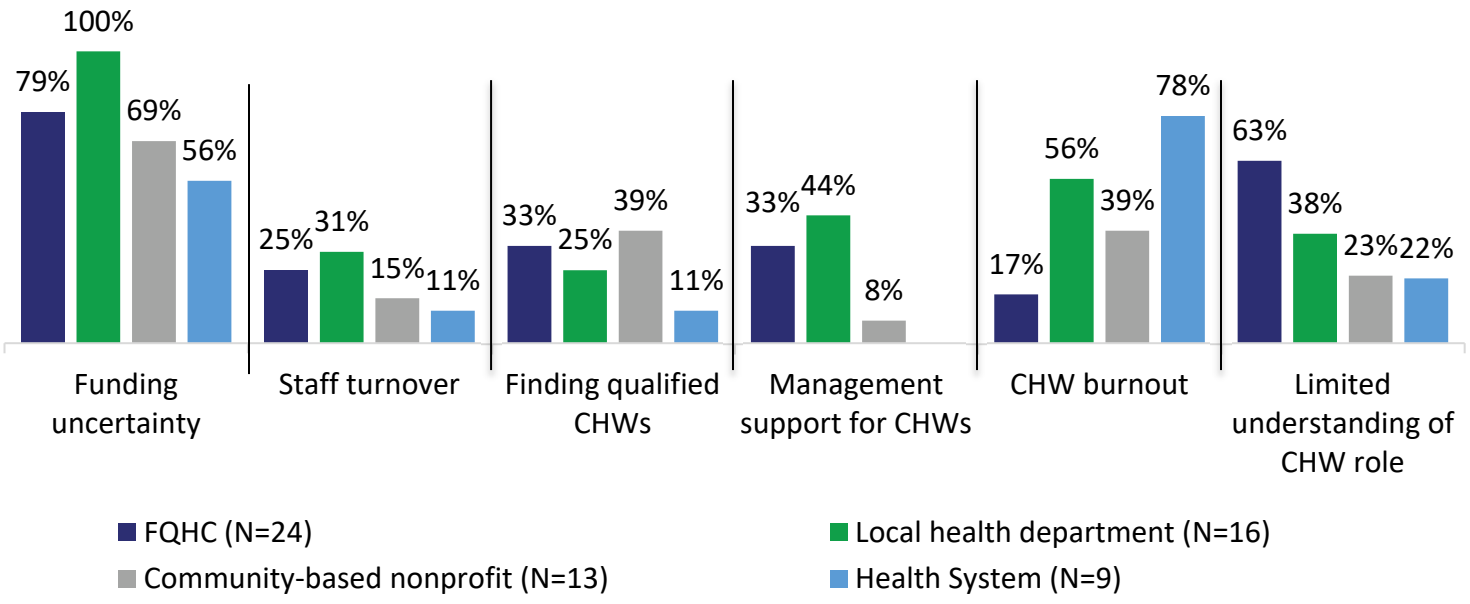


Figure 30 shows that the frequency of sustainability concerns varied by organization setting. **Local health departments had the largest proportion of those concerned with funding uncertainty.** Health systems had the smallest proportion of those concerned with funding uncertainty but the largest proportion of those concerned with CHW burnout.

Figure 30. Sustainability Concerns by Organization Setting



Some employers shared comments related to the **challenge of finding qualified CHWs**, one noting the growing scope of the role and another noting the low-wage prospects, especially compared to similar roles.

Employer Perspectives

"CHWs have to be a jack of all trades in a world that is increasingly more complicated. It is more difficult to fill the role of CHW than ever before. The barriers faced by people in our community increase every day."

– Statewide Nonprofit Employer

"The current cost structure of CHW certification training is disproportionate to the compensation offered upon completion, creating significant workforce sustainability challenges for small nonprofits and community-based organizations. When prospective CHWs can pursue Certified Nursing Assistant training at a comparable cost and enter the workforce with higher hourly wages, stronger benefits packages, greater overtime potential, and broader employment opportunities, the CHW career pathway becomes increasingly difficult to compete with. This disparity makes it exceptionally challenging for smaller organizations to attract qualified candidates, retain trained staff, and invest meaningfully in their professional growth ultimately undermining the long-term stability of the CHW workforce at the community level."

- Community-based Nonprofit Employer

Funding Strategies

The survey asked employers to share their thoughts on **funding strategies the CHW sector should seek out** to support CHW programs. Table 3 shows the strategies suggested by two or more employers.

Table 3. Employers' Suggested Funding Strategies for the CHW Sector

Theme	N
Establish CHW reimbursement mechanisms with commercial payers	5
Allow CHWs to bill Medicaid directly without a medical provider	4
Identify CHW training resources	3
Increase the Medicaid CHW reimbursement rate	3
Streamline the administrative processes required for CHW reimbursement	3
Expand Medicare reimbursement options	2
Revise the reimbursement model • Funding for FTE and not fee for service • Push for inclusion of CHWs in value-based payment models • Work with MDHHS to formalize CHW billing codes and provider recognition (shift from grant funded extras to core reimbursement for providers) • Partner with Medicaid Managed Care plans to fund CHWs as part of care management teams	2
Identify funding to establish reimbursement infrastructure	2
Seek diverse funding for CHW programs	2
Demonstrate the return on investment for CHW roles	2

Two employers elaborated on the **importance of developing sustainable funding models for CHWs housed in community-based organizations**.

Employer Perspectives

"Community-based organizations have the cultural competence and expert staff working in their respective communities and built systems of support for CHWs. It's very important to help them figure out billing pathways to sustain CHWs and advocate for CBOs to be eligible to bill within Medicaid/Medicare billing requirements."

- Community-based Nonprofit Employer

"The role of CHWs in the community has expanded far beyond the traditional medical model in which CHWs primarily worked within clinics and hospitals. Increasingly, CHWs are employed by community-based and non-profit organizations that address social determinants of health and provide critical support services to families.

For CHW programs to become truly sustainable, reimbursement and billing models must also expand beyond the traditional healthcare framework. Non-profit organizations, which are often serving the highest-need populations, require more accessible and flexible funding mechanisms to build and sustain CHW programming.

Currently, the Medicaid billing enrollment and implementation process is both complex and costly. As a result, many non-profit organizations are unable to take advantage of Medicaid billing opportunities because they cannot navigate the administrative burden and 'red tape,' or they lack the financial resources necessary for setup and ongoing compliance."

- Community-based Nonprofit Employer

Sustainability Strategies

As in previous surveys, employers were asked to indicate whether or not their program engaged in a range of individual-based and organization-based sustainability strategies. **Approximately half or more of responding employers indicated engaging in all 12 listed sustainability strategies** (*See Figure 31*). On average, the individual CHW strategies were more common than the organizational strategies and the frequency of most strategies was similar to previous years. The proportions of employers building a business case for CHWs and planning for how to retain CHWs in the event of funding loss have been successively greater over the past three surveys, which could reflect an unstable funding environment. The proportion of employers paying for CHWs' conference registrations dropped nearly 20 percentage points in 2026, which may likewise reflect funding constraints.

Burnout Prevention Strategies

For the first time, the 2026 survey asked employers to explain the ways in which they try to prevent CHW burnout. Of the 56 employers who indicated their organization supports CHWs in preventing and recovering from burnout, **48 employers described the strategies utilized**. Figure 32 shows the types of strategies mentioned by at least two employers. The four most common strategies were:

1. Provide regular management support (*N*=19)
2. Offer and encourage CHWs to take paid time off (*N*=16)
3. Offer flex time (*N*=11)
4. Establish limits on work beyond CHWs' role or scope (*N*=11)

Figure 29. Programs Engaging in CHW Sustainability Strategies by Survey Year

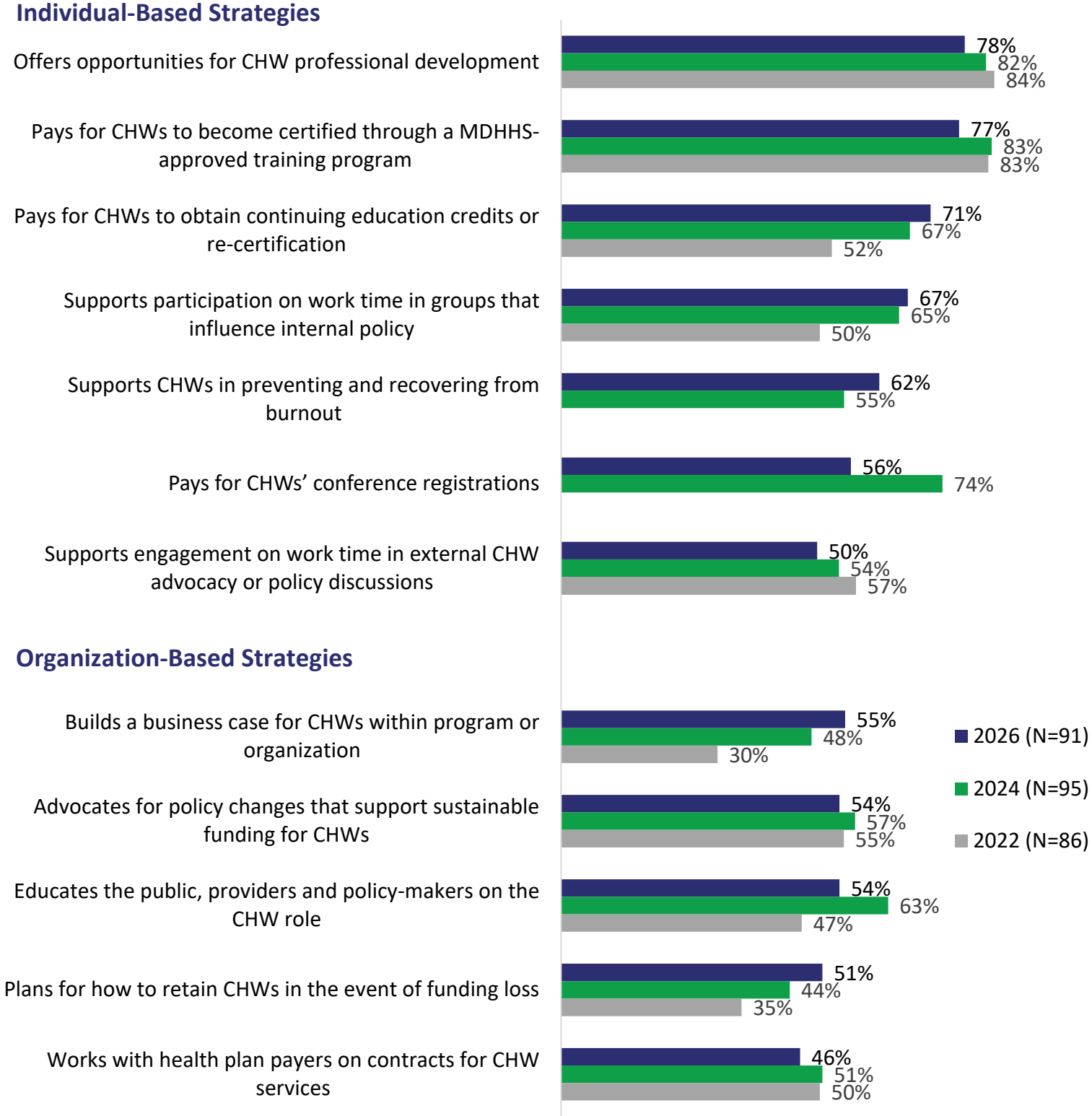


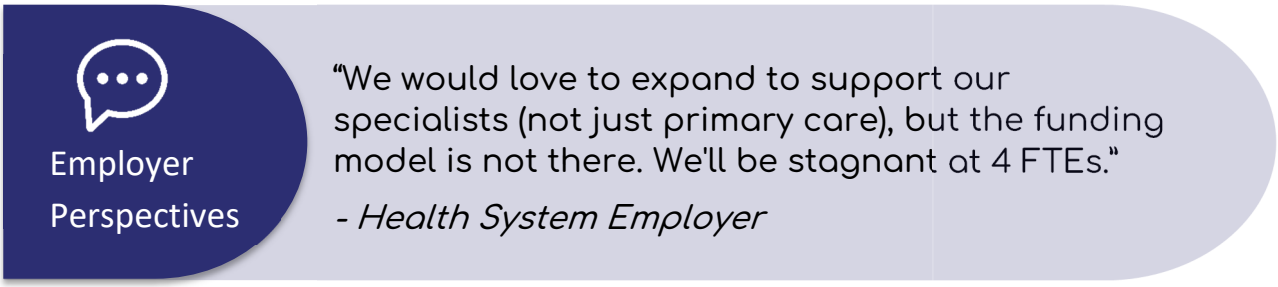
Figure 30. Employers' Use of Burnout Prevention Strategies (*N*=48)

CHW WORKFORCE

Changes in CHW Program Size

When asked about historical and expected changes in the number of CHWs, employers gave a picture of overall stability. **More than half of employers (58%) saw no changes in the number of CHW positions in the past year** (*Figure 33*) and close to two-thirds of employers (64%) expected to see the same number of CHW positions in the coming year (*Figure 34*). Modestly fewer employers both experienced and expected growth in the number of CHW positions in 2026 than in 2024.

Among the CHW programs that decreased in size, funding was the dominant concern. **Fifteen of the 17 employers** who explained the reasons for fewer CHW positions **described concerns with funding**, including grants ending and uncertainty in funding sources.



On the other hand, five of the 19 employers whose CHW programs grew in the previous year noted that increased funding made this possible. Furthermore, nine employers who expected more CHW positions in the upcoming year mentioned anticipated funding, including the Rural Health Transformation grants and reimbursable CHW services.

Beyond the influence of funding, three employers shared that the growth in CHW positions came from providing CHW certification to existing staff, including peer recovery coaches. Seven employers noted that the number of CHW positions increased because of program need and expansion.

Figure 31. Changes in the Number of CHW Positions in the Past Year

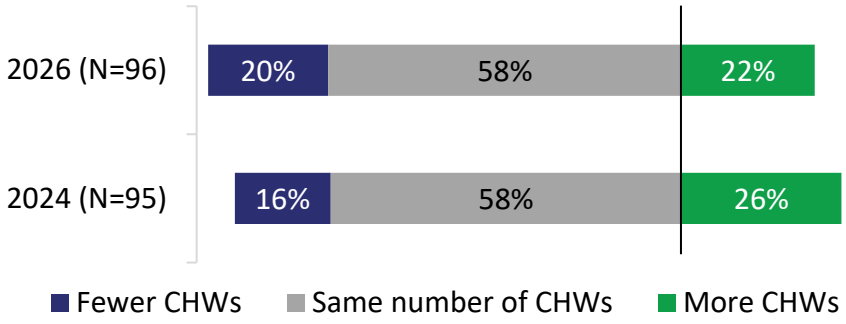
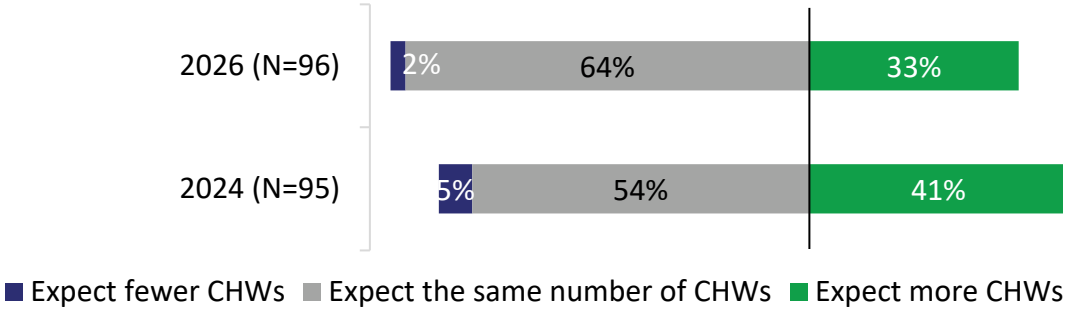


Figure 32. Anticipated Changes in the Number of CHW Positions in the Coming Year

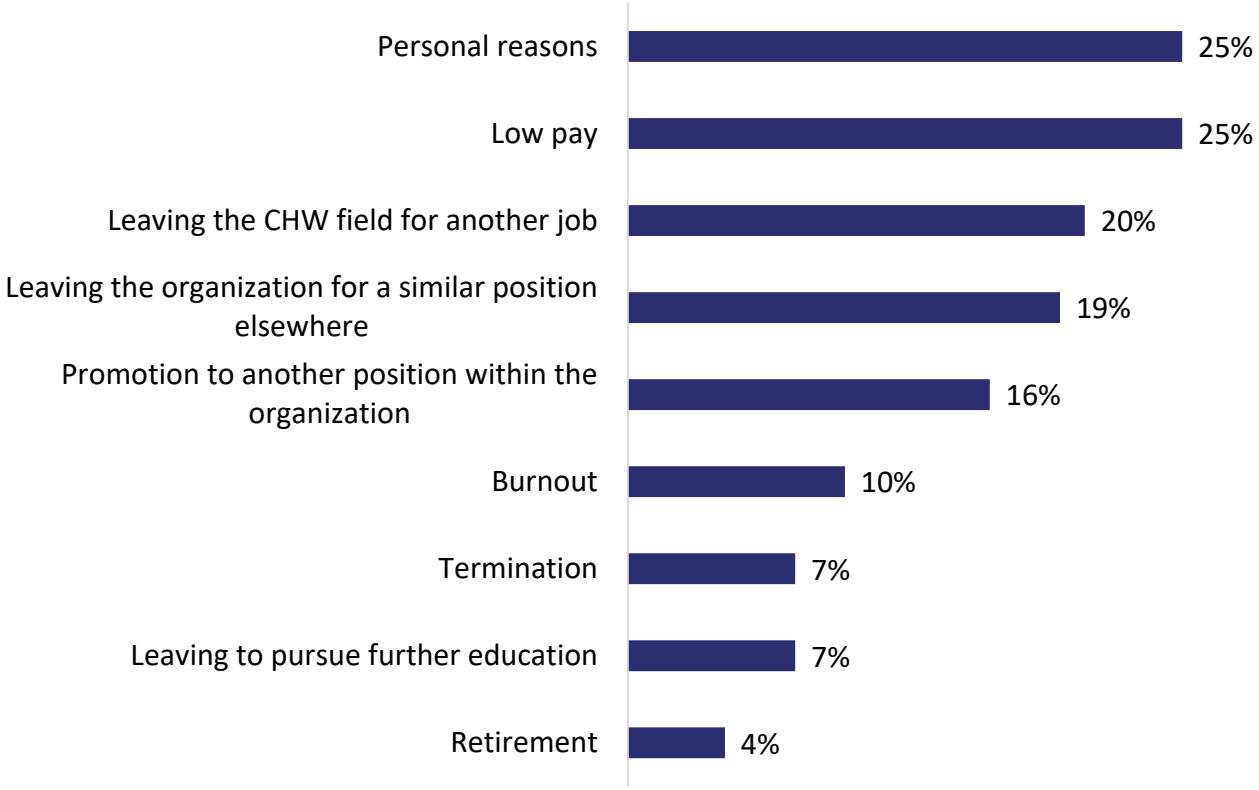


CHW Turnover

Half of responding employers reported that no CHWs left their position in the preceding 12 months. The other half of responding employers reported between one and ten CHWs leaving their position, equating to a turnover rate between 0.5% and 400%. The overall average turnover rate was 29%. Among the 49 employers with at least one CHW leaving their position, the average turnover rate was 56%.

When asked to select up to three of the most common reasons for CHWs leaving their position, the largest proportion of employers selected personal reasons and low pay, followed by leaving the CHW field, and leaving for a similar position elsewhere (*See Figure 35*).

Figure 33. Frequency of CHWs' Reasons for Leaving their Position (*N*=94)



One of the Health System employers described how CHW compensation relates to turnover. Another employer described the importance of hiring CHWs with a commitment to the client community as a strategy for minimizing turnover.

Employer Perspectives

"Low salary is a big factor in retaining amazing CHWs. It's difficult to sustain them when they are using the same resources that they are referring their families to."

- Health System Employer

"When hiring for the Community Health Worker (CHW) role, we prioritize individuals who demonstrate compassion and a strong commitment to making a meaningful impact in the communities they serve. As a result, we maintain a very low turnover rate among our CHWs."

- FQHC Employer

Educational Requirements

The majority of employers (70%) reported that a high school diploma or the equivalent is the highest level of education required for CHWs. Fifteen employers said their organization requires CHWs have some postsecondary education, including seven requiring an associate degree and five requiring a bachelor's degree. No one required a master's degree. When asked to share reasons for requiring a bachelor's degree, four noted that equivalent years of experience would also fulfill the college degree requirement. One FQHC employer said social work competency was expected.

Employer Perspectives

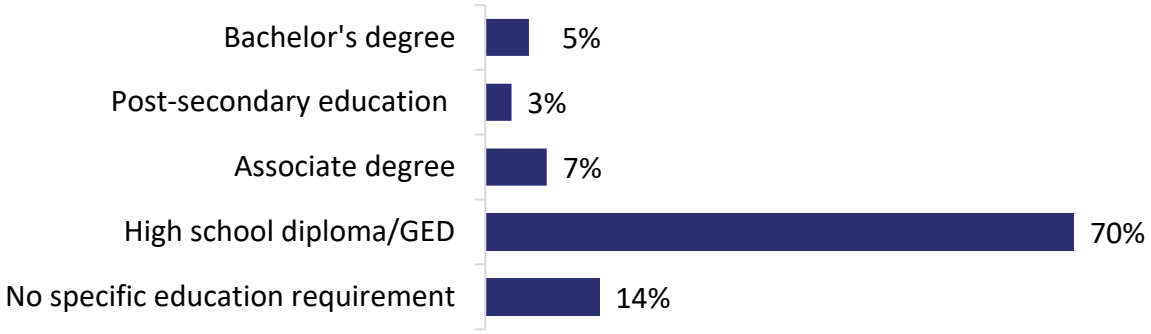
"Most of our Case Manager positions in the organization require a Bachelor's degree because that has been the standard for years. Recently, if the grant doesn't require the position to have that degree, we have taken lived and professional experience in lieu of a degree."

- Nonprofit Organization Employer

"CHWs who work for governmental agencies and hospitals need a fair amount of technological skill and good writing skills, for documentation in electronic medical records and navigation of multiple computer programs. Many people with only a high school degree cannot manage this."

- Local Health Department Employer

Figure 34. Education Requirements for CHW Positions (*N*=96)



Criminal Records

Following the patterns seen in both 2022 and 2024, **just under half of employers (47%) reported that they consider individual circumstances when deciding whether or not to exclude employment of CHWs with a criminal record** if they are otherwise qualified. More than one third (35%) were unsure of their organization's policy on this issue. This means **up to half of employers may not consider hiring CHWs with justice-involved backgrounds.**

In open-ended comments, several employers noted they are unable to hire CHWs with criminal records because of grant requirements or requirements of partner organizations. On the other hand, one employer noted that prior justice involvement can be an asset.

Employer Perspectives

"We cannot hire those with criminal record for this position because the schools will not approve them to work in their settings."

- FQHC Employer

"Lived experience is crucial to CHW work. I believe most criminal backgrounds should be not only considered, but sometimes valued. I actually oversee a total of 10 CHWs. One of the programs is within the jail. Credibility is given to those who know what it's like to be in a jail setting. They give incarcerated community members hope."

- Local Health Department Employer

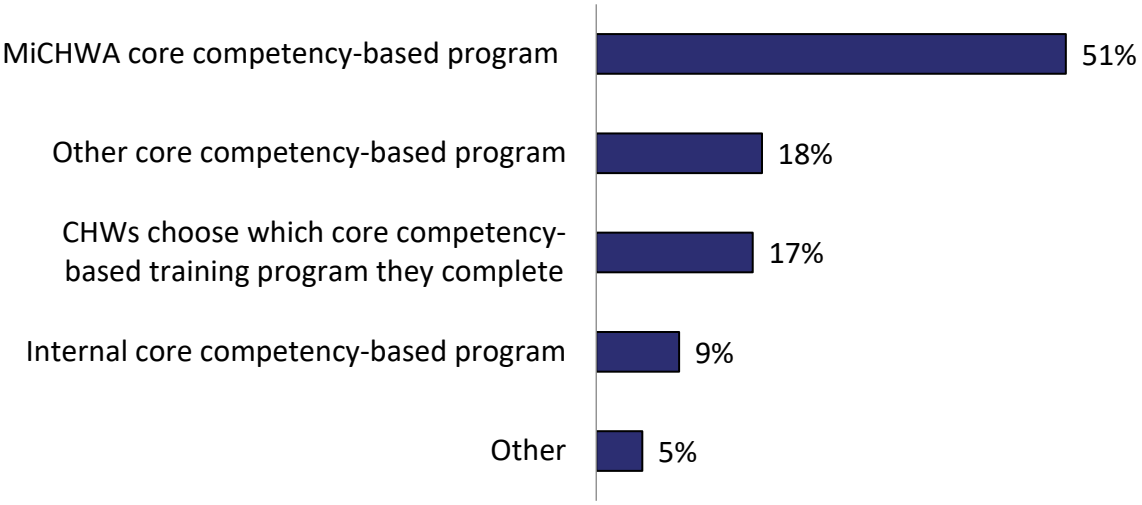
CHW TRAINING

CHW Core Competency-Based Training Requirements

Employers reported whether CHW-specific training is required for CHWs before hire into the program, or after being employed. **Most programs (71%) required training after hire**, while some (10%) required training before hire. Eighteen programs (19%) indicated that they do not require any core-competency training before or after the CHW is hired. This group included eight non-profit organizations, six local health departments, two FQHCs, and two health systems.

Among the programs with a training requirement, **half of employers (51%) indicated that new CHWs are required to complete MiCHWA's 166-hour CHW Core Competency-Based training program**. Three employers noted they utilize multiple training programs, including the MiCHWA program. One of these three shared "which course we use depends on timing of sessions and when it is offered."

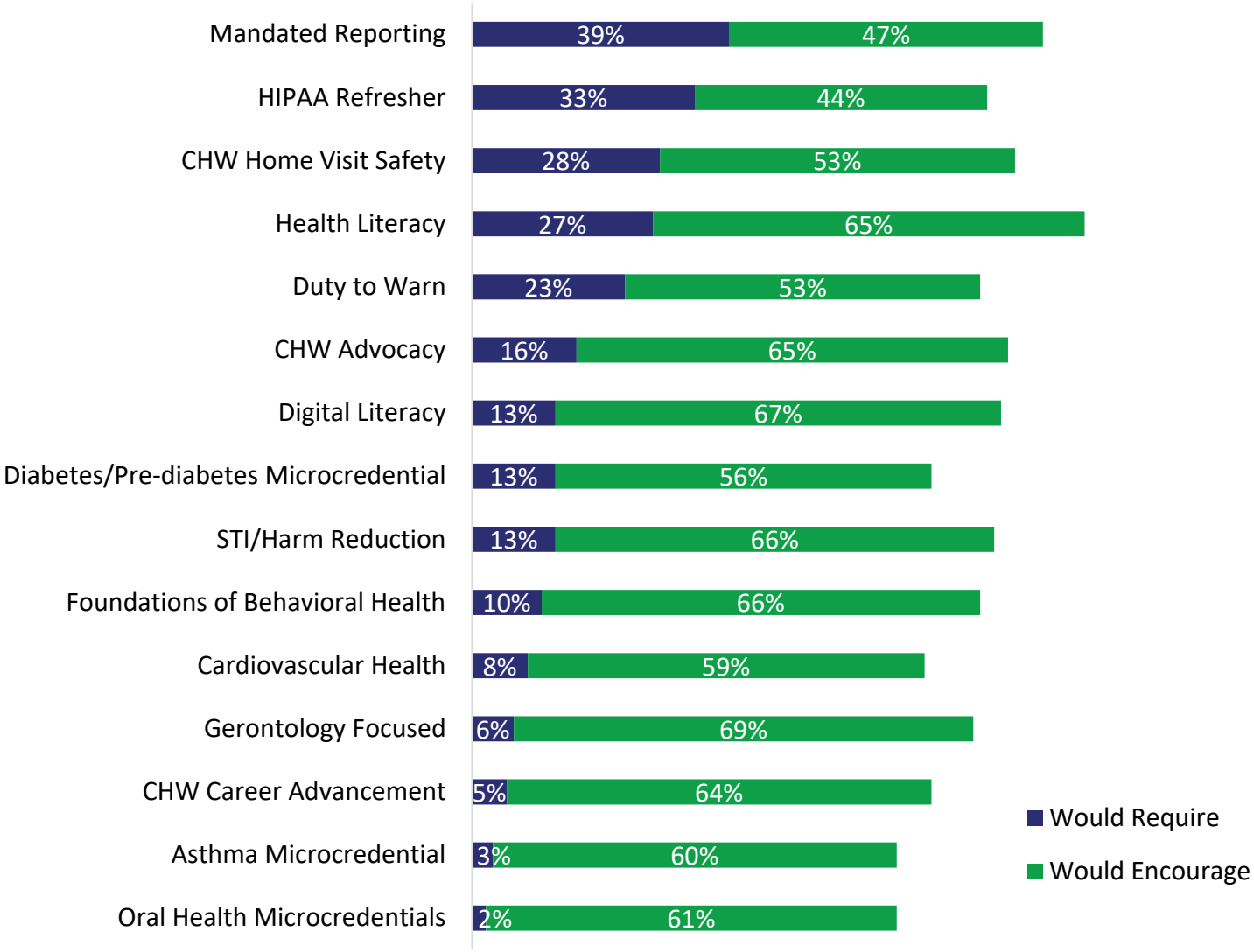
Figure 35. Frequency of Core-Competency Trainings Fulfilling Training Requirements (*N*=78)



Continuing Education

Employers were asked which continuing education opportunities they would require or encourage for the program's CHWs. As shown in Figure 38, **employers were most likely to require mandated reporting and HIPAA training.** Across all topics, employers were more likely to encourage than require CHW participation. Four topics were selected as likely to be encouraged by at least two-thirds of employers: Gerontology (69%), digital literacy (67%), behavioral health (66%), and Sexually transmitted infections (STI)/Harm reduction (66%).

Figure 36. Continuing Education Opportunities that Employers Would Require and Encourage for CHWs (*N*=96)



In open-ended comments, several employers noted their organizations provide a wide range of training opportunities internally. Other employers noted that securing funding for ongoing CHW training is challenging. One employer argued that CHWs need training responsive to national events and policy changes.

Employer Perspectives

"As funding decreases, it becomes increasingly difficult for agencies to support ongoing training opportunities, CHW certification programs, and CEU requirements... Many CHW staff come from communities with lived experience and are already working to make ends meet. In these cases, the financial responsibility often shifts heavily to the employer to supplement professional development costs. When turnover occurs, those investments are lost, further increasing overall system costs.

Given this context, it would be helpful to explore stronger partnership opportunities with MICHWA at an agency level that go beyond access to CHW workforce information... There may be value in identifying ways to reduce costs for trainings, support group learning opportunities, or develop shared training models that are more accessible and sustainable for agencies. This type of collaboration could help strengthen workforce stability while reducing long-term turnover and replacement costs."

- Local Health Department Employer

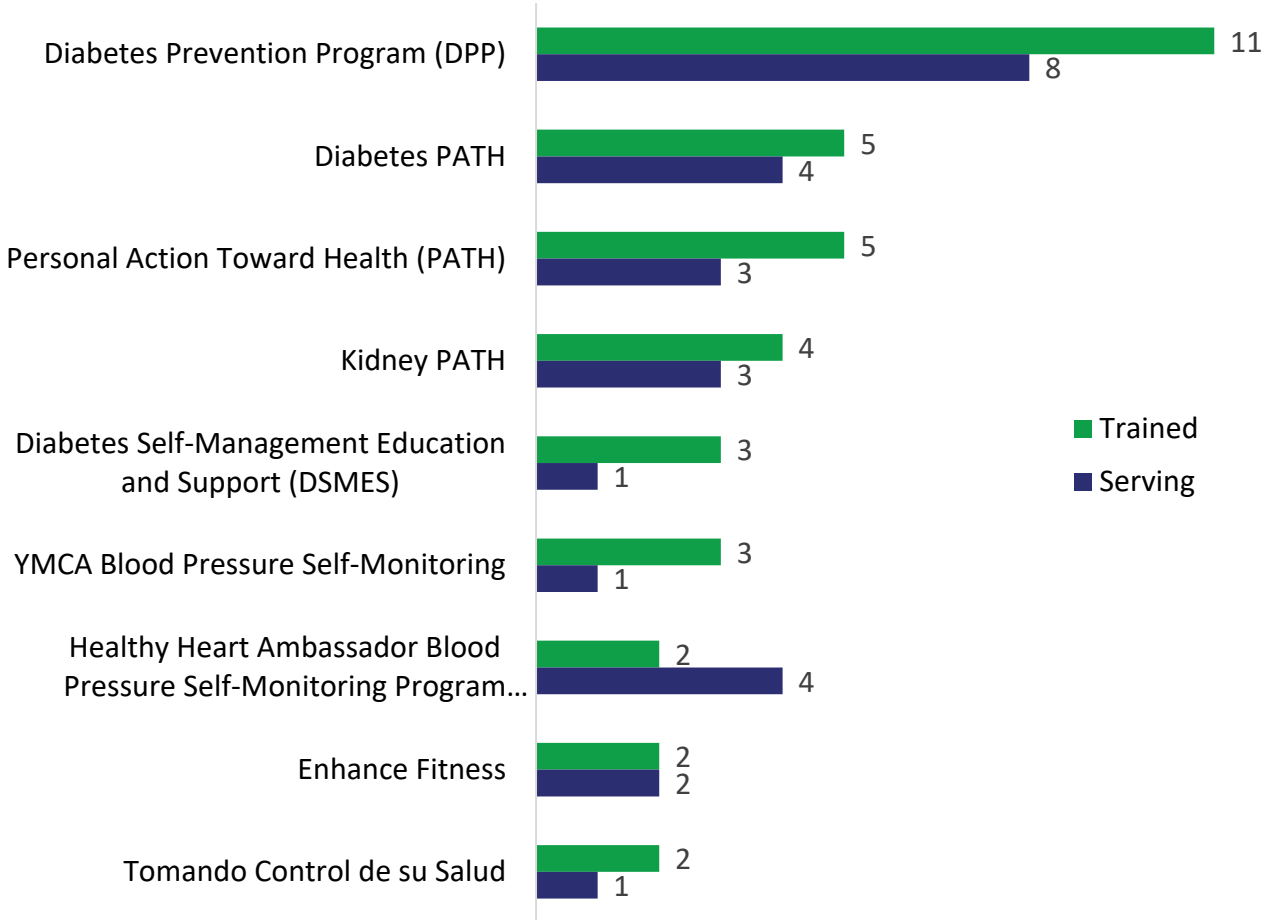
"Behavioral health trainings support CHWs in client work but often fall short in preparing them for major community-level changes, like SNAP and MDHHS policy shifts or housing funding cuts. Recently, CHWs have navigated complex situations, including families impacted by ICE and Epstein files trigger adults reporting past sexual [harm]. Creating structured spaces for CHWs to have training on how to process or manage these environmental and national stresses alongside their day-to-day responsibilities would strengthen resilience, reduce burnout, and enhance their effectiveness in the field."

- Local Health Department Employer

Evidence-based Lifestyle Change Programs

Employers were asked about the program's CHWs' involvement in evidence-based lifestyle change programs in two ways: whether CHWs were trained as leaders or master trainers and whether they had served as leaders or co-leaders in the past year. **The large majority of programs (76%) reported that none of the program's CHWs were trained as leaders of the listed lifestyle change programs.** An even larger proportion of employers (81%) reported that none of their CHW program's CHWs had served as leaders or co-leaders of the listed lifestyle change programs in the past 12 months. Among the CHW programs involved in lifestyle change programs, the Diabetes Prevention Program (DPP) was the most common. Eleven employers (12%) reported that CHWs were trained in the DPP program and eight employers (9%) reported CHWs had served as a DPP leader.

Figure 37. Number of Programs with CHWs Trained and Serving as Leaders in Evidence-Based Lifestyle Change Programs (*N*=85)



CHW SALARIES

Survey respondents were asked, first, to share the payment structure for the program's CHWs (hourly or salary) and then, for each payment structure, the minimum, the maximum, and the average or most common rates. Hourly wages continue to be the most common compensation structure for CHWs, with **71% of employers reporting hourly compensation** compared to 23% reporting salary-based compensation. Five employers reported utilizing both compensation structures.

Hourly rates ranged from $16.00 to $35.00; annual salaries ranged from $35,000 to $92,000.[6] Figures 40 and 41 show that the average hourly rates and salaries for the lowest paid CHWs, the highest paid CHWs, and the CHWs at the most common rate across an organization[7] are all **higher than the previous three surveys.**

[6] The pay rates reported by three employers were statistical outliers (greater than two standard deviations from the mean) and were excluded from the averages reported in Figures 40-41. The excluded data consisted of two employers reporting a maximum hourly rate of $35 and one employer reporting $69,700, $76,000, and $92,000 for minimum salary, most common salary, and maximum salary respectively. The mean maximum hourly rate was $25.42 +/- $3.78 with the outliers and $25.02 +/- $$3.29 without the outliers. The mean maximum salary was $59,502 +/- $12,289 with the $92,000 outlier and $56,794 +/- $7,793.15 without the outlier.

[7] These terms – lowest paid, highest paid, and most common rate – refer to the pay range reported by individual employers for a specific CHW program. Each survey respondent was asked to share the minimum pay, the most common pay, and the maximum pay for the CHWs employed by the program. Figures 40 and 41 show the average values among these responses.

Figure 38. Average Hourly Rates by Survey Year

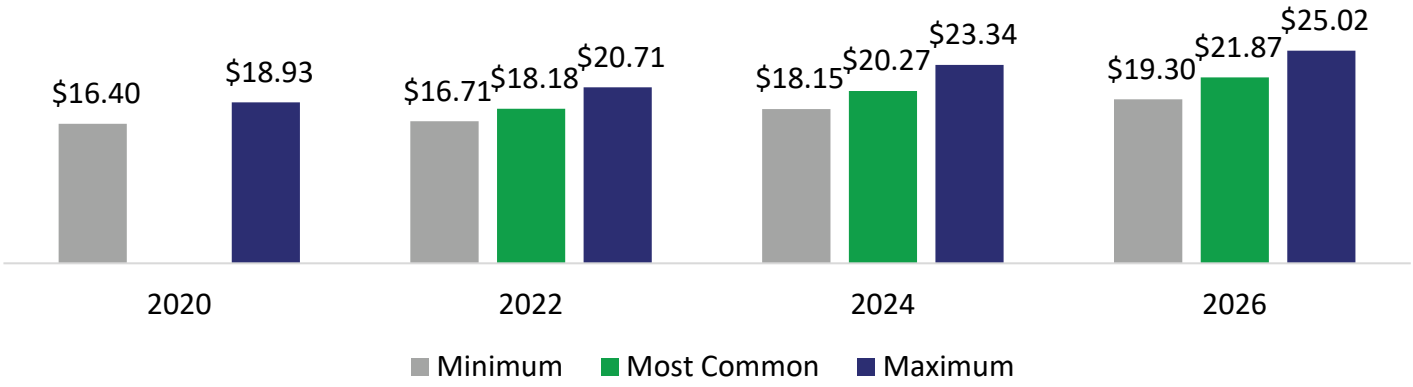


Figure 39. Average Salaries by Survey Year

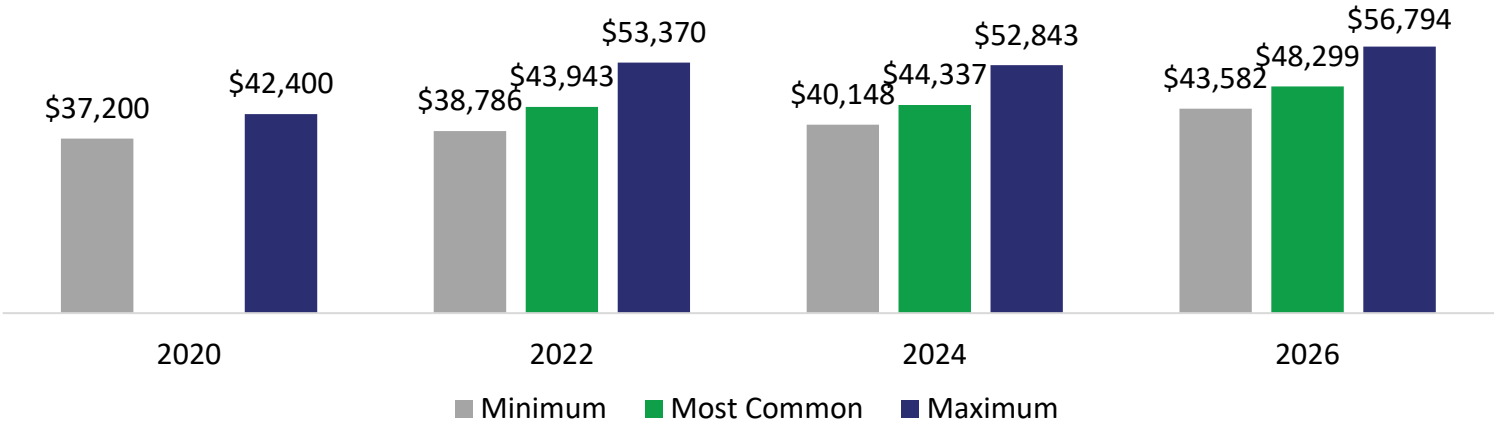
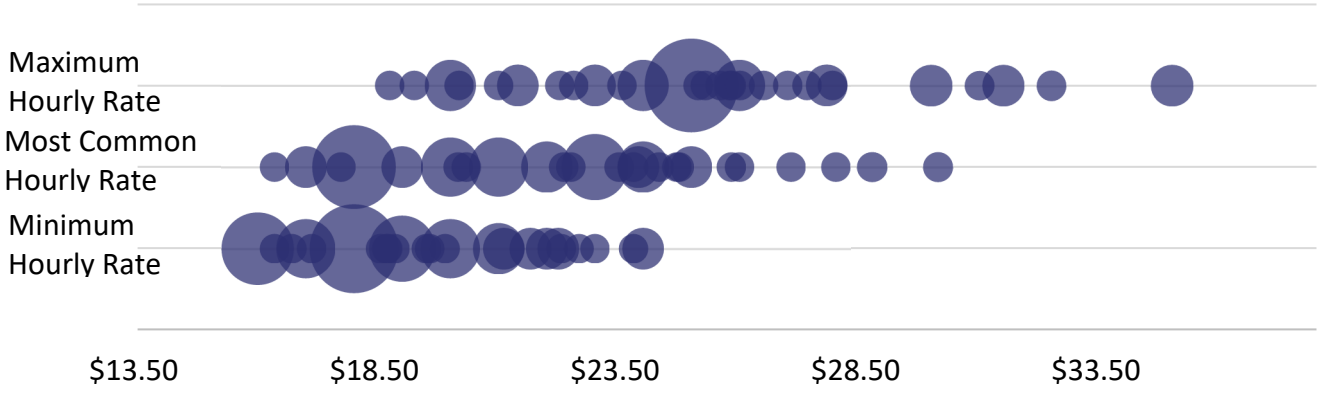


Figure 42 shows the full distribution of hourly rates among responding employers. Eight employers reported maximum hourly rates above $30.00 per hour, including one employer that also had a most common hourly rate above $30.00. Overall, 128 of 157 **(82%) reported hourly rates of $25.00 per hour or less**.

Figure 40. Distribution of Hourly Rates (*N*=52)

The bubbles represent hourly rate responses. The larger the bubble, the larger the number of employers reporting payment at the given hourly rate.

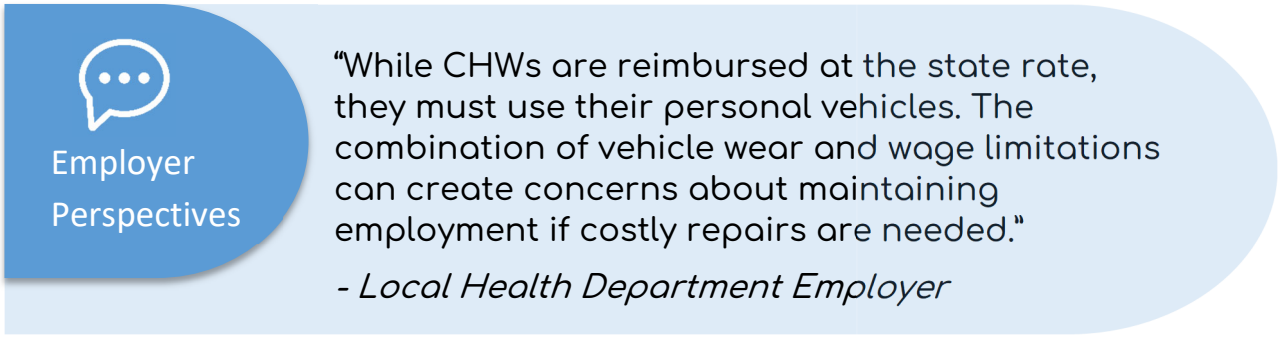


Among all employers that provided pay rates,[8] **54% reported the most common pay rate was under $22.07 per hour, which was below the living wage in Michigan for one adult living alone without children in 2026**.[9] Close to one-fourth of reported pay rates fell below $18.80 per hour, which is half of the ALICE Household Survival Budget for Michigan for a family of four with two adults and two children.[10] In other words, CHWs at this pay rate were not making enough to cover the minimum costs of household necessities, even with another working

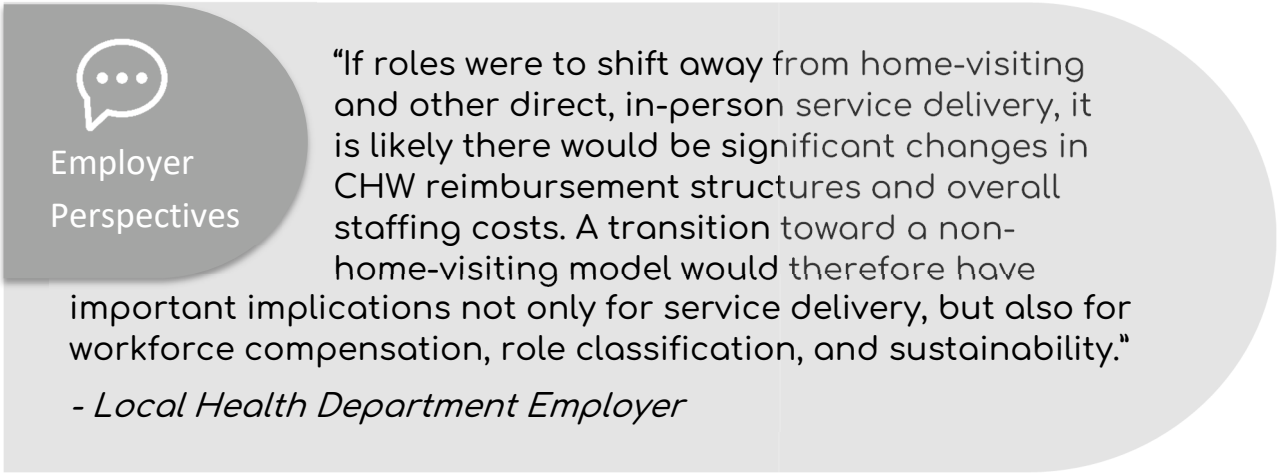
[8] Salaries were converted to hourly rates for the purpose of this analysis. If no most common rate was provided, then an average was calculated from provided minimum and maximum rates. If only a single pay rate was provided, this number was used.
[9] Living Wage Institute: https://livingwage.mit.edu
[10] United For ALICE. (2026). "The State of ALICE in Michigan: 2026 Update on Financial Hardship." https://www.UnitedForALICE.org/Michigan

adult in the household. As in previous survey years, the average CHW pay rate was similar across organizational settings.

In open-ended comments, six employers noted the need to increase CHW wages. One local health department employer further explained how the expectation that CHWs use personal vehicles for work can exacerbate frustration with low wages.



Additionally, three employers commented on the relationship between union agreements and CHW compensation. One employer specified that the pay rates are set by the union with predetermined step increases. Another noted the union specifies all CHWs make the same at hire. The third employer noted how the union allows for differential compensation based on the scope of work and described how CHW compensation would change if the service delivery model changed.



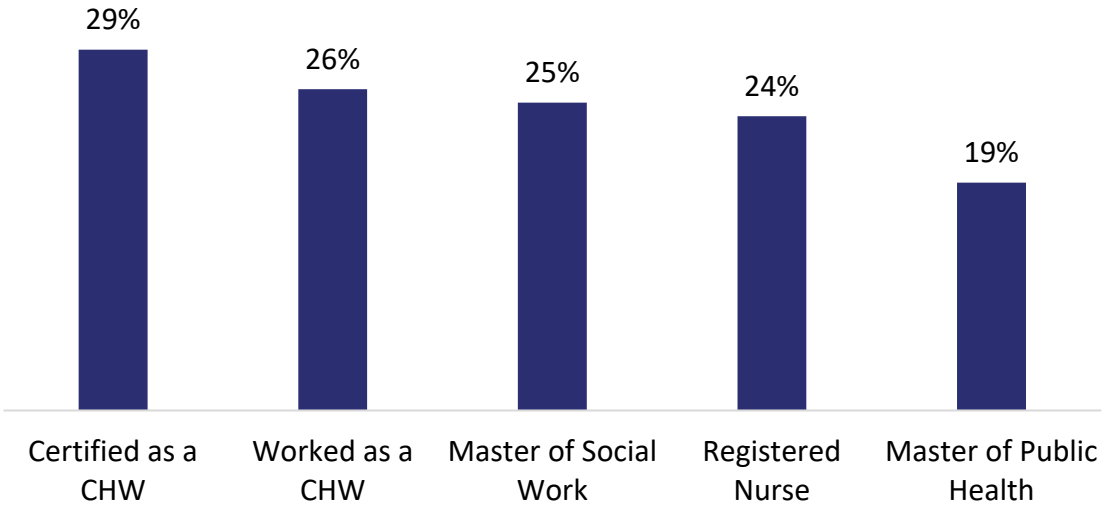
CHW SUPERVISION

Supervisor Credentials

Understanding CHW supervisors' background and education can provide insights on the credentials CHWs need to advance to a supervisor role as well as the skillsets and experiences CHW supervisors bring to their position. Survey respondents were asked to select all the relevant credentials of the individual(s) that provide supervision for the program's CHWs. **The most common credential, reported by 29% of employers, was CHW certification, followed closely by CHW work experience (26%)** (*See Figure 43*).

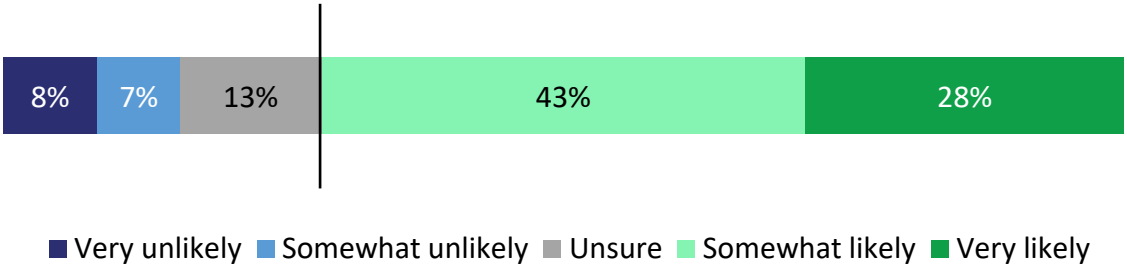
In addition to the listed responses, ten employers reported other work experiences, such as community work, a clinical programs director role, or a site manager role. Five reported specific certifications or credentials, including certified prevention specialist, certified substance use disorder counselor, registered dental hygienist, and nursing credentials. Three employers reported a master's degree in business administration, three reported a bachelor's or master's degree in healthcare administration, three reported a bachelor's or master's degree in psychology, two reported a bachelor's in social work, and one reported requiring a master's degree in social work, public health, or equivalent work experience. Overall, across write-in responses, 11 employers reported that supervisors had a bachelor's degree. Between the listed responses and write-in responses, **half of employers (49%) indicated the CHW supervisor had a master's level degree.**

Figure 41. Percentage of CHW Supervisors by Credential (*N*=87)



In previous employer surveys, respondents were asked to share which training topics CHW supervisors were required to complete and which topics were not required but of interest. In this year's survey, respondents reported the likelihood of their participation in a fee-based multi-session class on CHW supervisor training offered by MiCHWA. While one employer shared they would likely not be able to participate due to lack of funding, **over two-thirds of respondents reported that they would be somewhat or very likely to participate in a comprehensive CHW supervisor training.**

Figure 42. Likelihood of Participation in CHW Supervisor Training (*N*=95)



In open-ended responses, four employers emphasized that CHW supervisors should have professional experience relevant to the roles covered by CHWs. Examples included case management and community-facing work. A few employers described the CHW supervision structures, with one noting the value of multiple levels of supervision and cross-team collaboration.

Employer Perspectives

"Case management experience has been a valuable asset. While public health often emphasizes medical care, CHW work is deeply integrated with human services. Understanding CHWs' roles from a case management perspective—whether in nursing or social work—enhances support for those in the field and strengthens the services they provide."

- Local Health Department Employer

"It is helpful to have direct patient or community member assistance experience as a supervisor, to have a better understanding of the challenges and impacts of the role. It also helps to feel confident about the training or resources CHWs receive and rely on."

- Federally Qualified Health Center Employer

"Currently, CHWs report to their respective site managers, and the COO collaborates closely with the managers to provide program oversight. We also hold quarterly meetings that bring together all CHWs, site managers, and program leadership. These meetings provide an opportunity to review data, share ideas and best practices, and plan for upcoming events. This structured approach, along with strong collaboration across teams, has helped foster a highly effective and cohesive program."

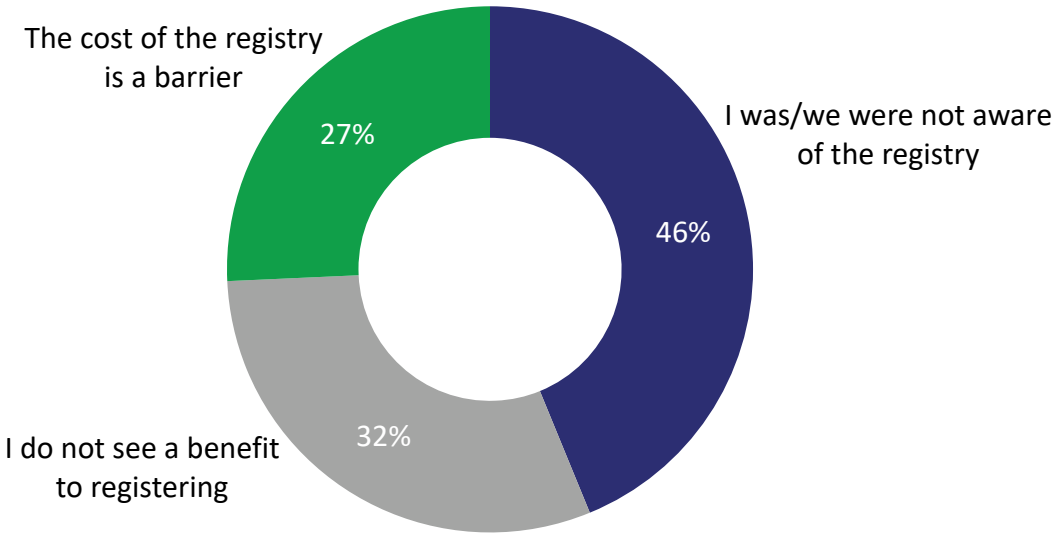
- Federally Qualified Health Center Employer

MiCHWA MEMBER PORTAL

About half (51%) of responding employers shared that their program or organization was registered as a CHW employer in the MiCHWA Member Portal and Registry. Twenty-eight percent reported they were not registered and another 22% indicated they were unsure. Among the 23 programs that reported they were not registered, a lack of awareness of the registry was the dominant reason (46%). In an open-ended response, one person noted that their organization had only hired 1.5 certified CHWs and these individuals did not request Member Portal registration.

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

Figure 43. Reasons for not Registering in the MiCHWA Member Portal (*N*=22)



Suggestions for Organizational Membership Features

Employers were asked what organizational membership features they would like to see added to the MiCHWA Member Portal and respondents shared a range of suggestions. Participants pointed to a need to improve the overall navigation and usability of the registry. **The most commonly suggested new features were a way to access records to verify certifications, review CHWs' continuing education units, and track training records.** Respondents also expressed a desire for a directory of other local CHW organizations, which would allow programs to refer clients, collaborate, and connect with other professionals in the field. Additionally, employers suggested functionality for CHWs to share resources with one another, as well as access to toolkits that would allow the registry to serve as a resource library.

Employer Perspectives

"Membership could also support stronger workforce connection by linking CHWs to broader peer networks, support groups, and shared learning communities. This would help reduce isolation, strengthen practice, and promote ongoing professional development across organizations."

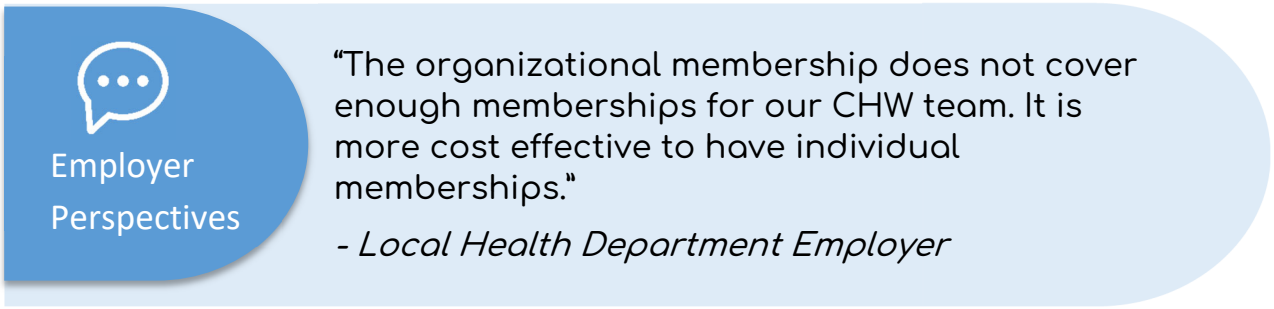
- Local Health Department Employer

Employer Perspectives

"CHW resources and tool kits that are interactive and searchable, i.e. care plan templates, intake forms, SDOH forms; region specific referral directories, editable resources; allow members to upload and share their own tools."

- Physician's Organization Employer

Beyond specific portal features, respondents raised concerns about group membership plans, noting that individual plans were at times more cost-effective and that transitioning from individual to group plans presented difficulties. Other comments included requests for organization- or group-level training opportunities, improvements to group memberships to accommodate more employees, and connecting group opportunities to discounted rates to improve affordability. One respondent also suggested the possibility of allowing internal CEUs to qualify for CHW credit.



SECTION 3: SUMMARY AND IMPLICATIONS

The 2026 MiCHWA CHW Employer Survey depicts a Michigan CHW workforce increasingly embedded across health, human-service, and community settings and provides insights at a time when Michigan has developed substantial CHW recognition and policy infrastructure. The survey sample – 110 programs from 86 organizations – is the second largest in survey history. Furthermore, survey respondents represented all 83 counties, providing a robust picture of employers' experiences. Collectively, survey findings point to **four key insights and four areas for future exploration**.

KEY INSIGHTS

1. CHWs are performing broad, cross-system functions.

The 2026 survey findings reinforce the ways in which CHWs operate between systems to support clients holistically, helping people move between healthcare, social services, public benefits, transportation, food resources, housing supports, and other systems that organizations may administer separately but that individuals and families experience simultaneously. **The top three roles** – assessing clients' social needs, helping clients obtain services, and building client capacity – **all relate to facilitating access to services**, a key component of the American Public Health Association's CHW definition. CHWs in 95% of programs meet with clients one-on-one and **61% of these meetings, on average, occur in person**. CHWs are also heavily involved in supporting clients' participation in public benefit programs. **Nearly all employers (95%) reported the program's CHWs provided at least one type of public benefit support** and 28% said CHWs spend more than ten hours a week supporting public benefit enrollment.

In short, the day-to-day activities of CHWs on the ground depend on many of the characteristics that make CHWs distinct: lived experience, community connection, trust, cultural responsiveness, advocacy, and **relationship-centered practice**. As Michigan creates more formal credentialing, reimbursement, training, documentation, and employer infrastructure around CHWs, the workforce will

become more institutionalized. While this professionalization will strengthen the CHW role, it will be crucial to ensure that CHWs are supported in performing the breadth of roles that distinguish the workforce.

2. The workforce appears relatively stable in the near term, but program sustainability remains uncertain.

A majority of employers reported no change in the number of CHW positions over the previous year (58%) and **anticipated the same number of CHW positions** in the coming year (64%). Furthermore, over two-thirds of CHW positions (69%) were supported by funds categorized as sustainable (higher than in 2024, lower than in 2022). On the other hand, nearly half of the employers with time-limited grants saw decreases in funding levels in the past year and **nearly three in four employers were concerned with funding uncertainty**. We saw lower levels of federal and local government funding alongside greater reliance on time-limited private foundation grants and general organization funding. And while we have categorized general organization funding as "more sustainable" in our analysis, organizational priorities can change at any time and, in some cases, as articulated by at least one respondent, may have been used as a stop-gap measure. **Employers' sustainability concerns were also high**: the percentage reporting no sustainability concerns fell to 6%, after declining from 27% in 2022 to 12% in 2024.

In summary, while **current staffing appears relatively stable, employers' confidence in program sustainability remains fragile**. The coexistence of relatively stable staffing and historically high funding uncertainty suggests these are different dimensions of sustainability and a stable headcount does not necessarily mean stable infrastructure.

3. Formal CHW reimbursement pathways represent meaningful progress, but implementation is uneven.

While the proportion of programs utilizing Medicaid reimbursement in 2026 was greater than in 2024, the change in contribution to programs' budgets was negligible.

The barriers employers shared related to obtaining reimbursement for CHW services, whether through the Michigan Medicaid Policy (MMP) 23-74 (implemented January 1, 2024), other Medicaid payment models, or Medicare, point to three separate but related dimensions of reimbursement implementation:

Access to funding pathways. A majority of employers (56%) were not currently utilizing public-benefit funding, whether because they were preparing to bill, eligible but not billing, ineligible, or unsure of their status. The barriers to being able to bill reported most frequently included a **lack of understanding of the policy and procedures, burdensome, and often unaffordable, administrative processes, and the requirement to bill through a healthcare provider**. With employers reporting interest in an average of seven different billing-related technical assistance topics, there is substantial demand for implementation assistance. These findings suggest that **CHW workforce development increasingly needs an employer-capacity component** alongside individual worker preparation.

Adequacy of the funding model. Findings highlighted the gaps between the reimbursement model and full program sustainability, which involves far more than the time associated with a billable encounter. Some employers advocated for an increase in the reimbursement rate. Others spoke of the need to broaden the scope of reimbursable services to better align with full scope of CHW work, including telephone-based care coordination, travel, and community-based work. Some employers noted that securing funding for ongoing CHW training is challenging, creating a barrier to program growth and sustainability. Low pay for CHW positions also remains a concern. While average hourly rates were more than a dollar higher than in 2024, many CHWs were not earning enough to make ends meet.

The convergence of employer-reported reimbursement barriers, compensation concerns, operating costs, and nonbillable CHW activities suggests a **need for more detailed cost and financing analyses** of CHW

programs. This could include understanding the actual cost of CHW employment across organizational settings, what portion of costs different reimbursement mechanisms support, what activities remain outside claims-based models, and the funding models organizations use to fill such gaps.

Architecture of the CHW landscape. This dimension offers a lens on the degree to which the funding environment allows different types of organizations realistic ways to sustain CHW employment. Survey findings indicate the sustainability environment is not uniform across employer settings. **Community- based nonprofit CHW programs may be especially vulnerable to unstable funding**. The proportion of CHW programs at CBOs has been successively greater with each survey wave, yet these programs reported the lowest levels of "more sustainable" funding. Despite the degree to which CHWs across organization settings are invested in connecting clients to public benefits, only local health departments are eligible for Medicaid outreach funding, which reimburses activities that improve access and utilization of Medicaid via a 50/50 match of local dollars contributed.[11] Furthermore, current reimbursement mechanisms largely overlook community-based organizations, who rarely have direct connections with approved billing providers. Facilitating connections between CBOs and billing providers and revising policy to allow CBOs to bill for CHW services directly would increase utilization of MMP 23-74 and support the sustainability of CBO-based CHW programs.

4. Changes in public benefit programs could increase the importance of CHW roles while destabilizing program funding.

This report offers a picture of the CHW sector prior to the implementation of most changes to federal benefit programs enacted through H.R. 1, known as the One Big Beautiful Bill Act. Starting in January 2027, Medicaid will add work requirements and enrollees will need to recertify eligibility every six months

[11]Michigan Department of Health & Human Services: Medicaid Outreach Program

(instead of annually).[12] These changes, alongside the expanded Supplemental Nutrition Assistance Program (SNAP) work requirements that have already taken effect, are **likely to mean that CHWs will spend even more time helping clients navigate enrollment paperwork** and eligibility requirements. Even more concerning, some analyses have estimated that nearly 40% of Michigan adults eligible for Medicaid could lose coverage because of the new requirements.[13] This would make CHWs' role of connecting clients to the care they need even more difficult. Furthermore, fewer people receiving Medicaid coverage along with the expected reductions in federal Medicaid revenue going to states will likely lead to **increases in uncompensated care that will risk the closure of rural hospitals, clinics, and other programs employing CHWs**.[14]

RECOMMENDATIONS FOR NEXT STEPS

Findings from new and revised questions in the 2026 survey shed light on additional dimensions of CHW programs in Michigan, revealing opportunities for further data collection to expand our understanding.

1. Document Rural CHW Services.

With new questions on CHWs' service in rural areas, the 2026 survey provides initial insights on the frequency of responding programs' engagement with rural communities. We learned that, **in most programs (70%), at least some CHWs are serving rural areas**. In more than half of programs, all CHWs are serving rural areas. Notably, programs with CHWs serving rural areas provide services in a

[12]Michigan Department of Health and Human Services. Changes to Medicaid and Supplemental Nutrition Assistance Program (SNAP). Available from: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Food-Assistance/SNAP-PER/SNAP_Medicaid-FAQ.pdf

[13]Citizens Research Council of Michigan (2025). Federal Medicaid Cuts Will Have Big Consequences in Michigan. June 2025, Memorandum 1180. Available from: https://crcmich.org/PUBLICAT/2020s/2025/Memo1180-Federal_Medicaid_Cuts_Will_Have_Big_Consequences_in_Michigan.pdf

[14]Ignaczak, N. (2025). "As Medicaid cuts loom, are Michigan's community health workers in jeopardy?" Planet Detroit, July 23. Available from: https://planetdetroit.org/2025/07/medicaid-cuts-threaten-chws/

substantially higher number of counties on average than in programs where none of the CHWs serve rural areas. The implications of this apparent discrepancy in the number of counties served are not yet clear. **Further exploration is needed to identify and understand any geographic variation in the number of CHWs compared to the level of community need**. The 2026 survey data also creates opportunities to explore differences between rural-focused and urban-focused CHW programs in terms of roles, funding levels, program composition, modes of service delivery, and other areas.

2. Understand Burnout Prevention Strategies.

Employers' responses to an open-ended question on strategies to prevent CHW burnout offer a basis for exploring the variation within and efficacy of different strategies. While the top four strategies – management support, PTO, flex time, and work boundaries – are arguably core components of any healthy work culture, **further investigation may reveal nuances specific to the CHW sector**. This deeper investigation could also provide a basis for developing burnout prevention best practices and supporting cross-organizational learning.

3. Explore Education Requirements.

While most employers (84%) either require that CHWs have a high school education or have no specific degree requirement, a new question explored the **reasons why some employers require CHWs to have a bachelor's degree**. The responses included a desire for technological skill, writing skills, or social work competency, as well as general hiring standards. These findings create an opportunity to assess alignment between the skills employers expect from post-secondary education or degrees and current CHW core-competency training. Further exploration of this topic could also reveal whether degree requirements hinder hiring CHWs who have strong connections and shared life experiences with the community they are serving.

4. Identify CHW Training Needs.

Further data collection could shed light on the **constraints and disincentives among the nearly 20% of employers who do not require CHWs to complete core**

competency training either before or after hire. Additional investigation could also illuminate how training could support CHW advancement to supervisory roles. Findings showed 49% of supervisors had a master's level degree, 26% had worked as a CHW, and 29% were certified as a CHW, indicating that few CHWs will have a path to a supervisor role without pursuing further education.

CONCLUSION

In conclusion, the 2026 MiCHWA CHW Employer Survey findings offer an updated picture of the CHW profession in Michigan. Though, as with previous surveys, we do not know the degree to which the sample represents the full population of CHW employers in the state, we do know the 2026 sample was equivalent in size to 2024 and the sample composition has been largely consistent with regards to organization type and setting across the three previous survey waves. These survey findings provide MiCHWA and other partners with insights to draw on in developing resources and services to support CHWs and lay a foundation for identifying policy recommendations to advance the CHW workforce in Michigan and beyond.

APPENDIX A: DATA TABLES

Figure 46. Percentage of CHW Programs by Number of Counties Served

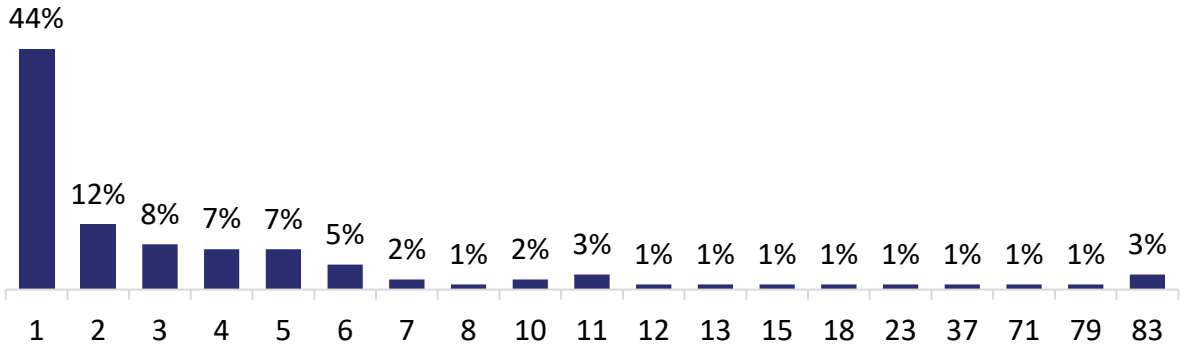


Table 4. Number of CHW Programs Serving Michigan Counties

County and Program Count									
Alcona	9	Clare	8	Iosco	8	Marquette	8	Otsego	8
Alger	5	Clinton	9	Iron	6	Mason	8	Ottawa	16
Allegan	14	Crawford	7	Isabella	8	Mecosta	8	Presque Isle	6
Alpena	8	Delta	6	Jackson	13	Menominee	5	Roscommon	9
Antrim	10	Dickinson	6	Kalamazoo	11	Midland	6	Saginaw	9
Arenac	7	Eaton	9	Kalkaska	9	Missaukee	8	Sanilac	7
Baraga	5	Emmet	10	Kent	20	Monroe	9	Schoolcraft	6
Barry	9	Genesee	17	Keweenaw	6	Montcalm	9	Shiawassee	9
Bay	9	Gladwin	8	Lake	9	Montmorency	6	St. Clair	8
Benzie	10	Gogebic	5	Lapeer	10	Muskegon	13	St. Joseph	7
Berrien	8	Grand Traverse	11	Leelanau	11	Newaygo	11	Tuscola	8
Branch	6	Gratiot	7	Lenawee	11	Oakland	24	Van Buren	8
Calhoun	11	Hillsdale	12	Livingston	14	Oceana	9	Washtenaw	22
Cass	8	Houghton	6	Luce	5	Ogemaw	7	Wayne	36
Charlevoix	9	Huron	9	Mackinac	5	Ontonagon	6	Wexford	9
Cheboygan	8	Ingham	16	Macomb	19	Osceola	8		
Chippewa	8	Ionia	11	Manistee	9	Oscoda	7		

Table 5. Comparison of Role Descriptions and Frequency in 2024 and 2026

2024 Role and % Very Often		2026 Role and % Very Often	
Participating in individual-level assessments	17%	Assessing clients' social needs, including housing, food, and economic security	68%
Connecting to resources and advocating for basic needs	72%	Helping clients secure, navigate, and adhere to healthcare and social services	48%
Meeting basic needs	67%		
Making referrals and providing follow-up	66%		
Motivating/encouraging people to obtain care/services	65%		
Facilitating transportation to services/helping to address other barriers to services	63%		
Participating in care coordination and/or case management	57%		
Educating individuals/ communities about how to use health and social service systems	54%		
Follow-up on health and social service encounters	42%		
Case finding/recruitment of people to services and systems	30%		
Supporting self-management of prevention/health conditions	53%	Building client capacity and self-efficacy (ex. motivational interviewing, coaching)	32%

2024 Role and % Very Often		2026 Role and % Very Often	
Providing individual support and coaching to clients	48%		
Building individual capacity	45%		
Providing basic screening tests	15%	Conducting health screening tests and assessments (ex. blood pressure, Patient Health Questionnaire (PHQ), General Anxiety Disorder (GAD) form)	16%
Conducting education in a manner that meets linguistic and cultural needs	39%	Conducting physical and/or behavioral health education with clients	15%
Providing information to understand/prevent diseases/manage health conditions	46%		
Educating systems about community perspectives and cultural norms	20%	Advocating for community perspectives and needs (ex. participating in City Council meetings, communicating with lawmakers, presenting at local agencies)	10%
Participating in policy advocacy	14%		
Informing people and systems about community assets and challenges	33%		
Advocating for the needs and perspectives of communities	24%		
		Participating in the design and implementation of CHW programs	9%

2024 Role and % Very Often		2026 Role and % Very Often	
Data collection and interpretation	15%	Participating in research, evaluation, or community needs assessments (ex. research design, data collection, stakeholder engagement, resource mapping)	7%
Participating in community-level assessments	12%		
Engaging in evaluating CHW services and programs	11%		
Sharing results and findings	11%		
Identification of priority issues and evaluation/research questions	10%		
Identify/engaging community members as research partners	9%		
Development of evaluation/ research design and methods	9%		
Engaging stakeholders to take action on findings	6%		
Documenting and tracking individual and population level data	55%		
Home visiting to provide education/assessment/social support	32%		
Building health literacy and cross-cultural communication	29%		

2024 Role and % Very Often		2026 Role and % Very Often	
Training/building individual capacity with CHW peers/groups	25%		
Building community capacity	20%		
Presenting at local agencies and community events	18%		
Planning and/or leading support groups	16%		
Providing basic services	14%		

APPENDIX B: SURVEY INSTRUMENT CHANGES

The 2026 survey added specificity when asking about types of contract arrangements for CHW services as well as a follow-up question to identify the organization settings engaged in the contracts. The survey team developed new questions to capture:

- The type (e.g. one-on-one or small group) and modality (e.g. in person or phone) of client engagement
- The nature of and time spent in roles related to supporting public benefit program enrollment and re-enrollment
- Time spent driving for job-related duties
- The proportion of the program's CHWs providing services in rural areas
- Changes in the level of funding from time-limited grants, Medicaid reimbursement, and Medicare reimbursement
- Interest in potential training and technical assistance topics related to Medicaid billing and claim submission
- Credentials of CHW supervisors

The survey team, in conjunction with the EWG, developed revised CHW role questions to reduce respondent burden, minimize redundancy, and increase clarity.

The survey team added two new open-ended questions to capture additional depth on two topics of interest:

- Strategies the organization uses to support CHWs in preventing and recovering from burnout
- Reasons for requiring CHWs to have a higher education degree if employers reported this requirement.

Finally, the 2026 survey simplified questions on CHW training requirements and the MiCHWA Member Portal and Registry, as well as updated the list of potential continuing education topics.