Michigan Community Health Worker Alliance ***In coordination with the MiCHWA Evaluation Advisory Board***

Community Health Worker Employer Survey 2018: Final Evaluation Report

June 30, 2018

Centers for Disease Control and Prevention Grant 1305 in coordination with the Michigan Department of Health & Human Services

For questions about this report, please contact MiCHWA Project Director Priscilla Hohmann (priscilla@michwa.org) or email info@michwa.org.

Community Health Worker Employer Survey 2018: Final Evaluation Report

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EXECUTIVE SUMMARY

Purpose of Survey & Methods

This report provides final results of the 2018 Community Health Worker Employer Survey for a broad audience that includes the Michigan Department of Health and Human Services (MDHHS), the Centers for Disease Control and Prevention (CDC), and CHW stakeholders throughout Michigan.[1] The survey, conducted in March 2018, was designed, conducted, and analyzed by the Michigan Community Health Worker Alliance (MiCHWA), with guidance from its Evaluation Advisory Board. Results from the 2018 survey update those from similar surveys conducted in 2014 and 2016, providing a current picture of who is employing Michigan's CHWs, the education and training of Michigan's CHW workforce, the work CHWs are doing in Michigan, how CHWs positions are sustained, and how the CHW field has evolved. The survey, which was open to all Michigan-based CHW employers, was distributed online to representatives of 57 distinct CHW employer organizations through MiCHWA's existing mailing list database, Web-based media, and partner mailing lists. The employer representative was asked to respond on behalf of all CHW programs from that organization. Ultimately, a denominator of 65 known CHW employers was used for calculating response rate. . Forty-four distinct organizations responded to the survey for a response rate of 67.7%.

Key Findings from the 2018 Survey

What types of organizations employ CHWs in Michigan, where are they located, how many CHWs do they employ, and why do they employ CHWs?

- At least 44 organizations employ CHWs in Michigan. This is an underestimate since not all CHW employing organizations responded to the survey.
- Responding CHW employing organizations reported 91 CHW programs serving 62 counties in Michigan. Kent (13), Wayne (6), Newago (5) were the counties with the most CHW programs reported by participants. Page 10 lists the number of CHW programs by county.Over half of CHW programs are located in community-based organizations (27.3%) and federally qualified health centers (25.0%).
- Most CHWs are employed full time (93.2%) with an average of 11.5 CHWs per agency. • In total, there were 485 CHWs represented in the survey, including 459 full time and 26 part time CHWs. This is an undercount of CHWs in Michigan since not all CHW employers responded. • The most common reasons these organizations employ CHWs were the effectiveness of CHWs, to improve health outcomes and for community services and outreach.

Whom do CHWs serve, what issues do they address, what are their roles and functions, and where and how do they deliver services in Michigan?

- The average number of clients per year served by CHWs in responding organizations was 1,211, with a median number of 430 clients.
- The average caseload for an individual CHW was 57 clients per year, with a median number of 42 cases per year.
- CHWs work with diverse populations, e.g. 90.9% work with black individuals and 84.1% work with white individuals, respectively. Almost all CHWs are working with adults (88.6%) and young adults (86.4%).

[1] See Appendix D for copy of survey.

- Special populations include uninsured (79.5%) and homeless clients (75%) and individuals who do not have a medical home/primary care provider (68.2%).
- Specific health issues addressed include: health literacy, nutrition, physical activity, oral health, diabetes, and hypertension.
- The most commonly-cited roles included: conducting outreach (81.1%), providing coaching and social support (79.5%), and advocating for individuals and communities (79.5%). • CHWs go deep into communities to reach clients, with 70% of CHW programs delivering services in clients' homes. Other common service sites included shelters (39.6%), health centers (39.6%), public housing units (36.4%), private clinics or medical practices (36.4%), and schools (36.4%). • Service delivery occurs most often in one-on-one meetings that take place in person (95.5%) or via telephone (81.8%).

What are the education expectations and hiring requirements of CHWs in Michigan? • Most organizations required a high school diploma or GED prior to hiring (77.3%). Other common requirements include the ability to read and write in English (90.9%) and background checks (85.4%).

- Most organizations (54.5%) did not have specific requirements for desired minimum years of experience.

How are CHWs trained in Michigan?

- Respondents reported that on average, 2.7 CHWs from their organization will need core competency-based training over the next year (range: 0-19). Most programs do not currently require any training prior to hiring CHWs (75.0%). However, most (68.2%) require the MiCHWA CHW core competency-based training while employed as a CHW.

How do organizations support CHW employment, including integration, compensation and supervision?

- Most programs indicted that their CHWs work as part of a multidisciplinary team (52.3%). Of those that indicated working on a multidisciplinary team, most worked with social workers/behavioral health specialists (88.5%) or registered nurses (74.2%).
- CHWs are most often compensated on an hourly basis (79.2%) with the average rate of $15.92 per hour. Of those that receive a salary, the average compensation was $35,490. • Additional benefits include pay raises and increases in compensation (86.4%), which are determined through annual performance reviews or yearly evaluations.
- Most CHW supervisors spend 25-50% of their time supervising CHWs. Fewer than half of CHW supervisors received training (45.5%). Specific challenges in supervision included: CHWs located in different places than their supervisor (40.9%), needing more guidelines (22.7%), and not enough time for supervision (22.7%).
- Essential CHW supervision practices included communication and general support. Specific types of communication strategies include: clear expectations about the roles, frequent contact, and integrated meetings. Support strategies included: promoting self-care by addressing burn out and stress, strength-based coaching, and mentoring.

How are CHW positions funded and sustained in Michigan?

- CHW employers in Michigan have a diverse set of grant-based funding mechanisms for CHWs, including federal grants (47.7%), state grants (36.4%), and private foundation grants (31.8%).

- Just over one-third of CHW services are reimbursed by insurers or other payers (34.1%). Of those that are reimbursed, the majority are reimbursed by Medicaid managed care (22.7%). See Section F.2 for more detailed funding strategies, including billing codes used.
- Common challenges reported were: funding uncertainty (77.3%), staff turnover (34.1%), and finding qualified CHWs (27.3%).

How do CHWs contribute to evidence-based lifestyle programs?

- Just over half (n=25, 56.8%) of programs did not have CHWS who were trained as leaders of evidence-based lifestyle programs and most were not currently serving as leaders or co-leaders of such programs (68.2%). PATH (18.2%) and Chronic PATH were the most commonly cited programs that CHWs were trained to lead.

How has the CHW field evolved in Michigan?

A comprehensive table with changes since 2014 is available in Appendix C. These trends are based on comparisons across the three statewide surveys (2014, 2016, and 2018).

In 2014 there were 37 respondents, 55 in 2016, and 44 in 2018. However, it must be noted that, unlike in 2018 when each employer was asked to respond for all of its programs, in 2014 and 2016, respondents represented each CHW program. Thus, 2018 does not represent a decline in the response rate. Across all years, most organizations responding to the survey identified themselves as community based organizations and federally qualified health centers. There has also been consistency in where CHWs deliver services, with the most common locations being in clients' homes across all years. Overall, there has been a dramatic increase in the number of counties CHWs serve in Michigan from 11 (13%) in 2014 to 62 (74.7%) in 2018.

The majority of organizations employ CHWs in full-time positions. Organizations reported a total of 459 full-time CHWs and 26 part-time employees in 2018, which is an increase from 2014 when 301 CHWs were reported in the state. This is an undercount of CHWs in Michigan since not all organizations employing CHWs responded. Since 2014 there has been a steady growth in the number of CHWs reported per organization with 9.7 in 2014, 10.2, and 11.5 this year. Across all years, CHWs have consistently served primarily adults and young adults with the majority serving racially diverse populations.

Salaries have also increased over the years. In 2014, the most commonly reported hourly rate was $12 per hour or an annual range between $25,000-$58,000. In 2018, the hourly rate increased to $15.92 per hour or an average of $35,490 (range $21,000 to $46,00) per year.

CHW education requirements have also increased steadily since 2014, with the large majority of organizations requiring a high school diploma or GED (77.3%, up from 59% in 2014 and 65.5% in 2016). Other requirements include core competency-based training after the point of hire. In 2016, 37.8% of organizations required MiCHWA training (no details about whether it was required before or after hire). In 2018, 11.4% of organizations required MiCHWA training before hiring CHWs, and 68.2% required MiCHWA training after hire. Background checks have consistently been required across all years. Notably, when asked about sustainability issues, 27.3% cited finding qualified CHWs as a challenge.

Since 2016, when asked about supervision, most CHWs are supervised by social workers or registered nurses. Across all years, nurses were the most common CHW supervisors. However, in 2018 there were a wide variety of additional supervision qualifications. Qualitative responses about essential practices for supervision also shifted between 2016 and 2018. While communication was a common theme in both years, new themes emerged in 2018, including support, and formal supervisor training. Additional categories not previously included in 2016 included respect, flexibility, and evaluation.

While diminishing somewhat, funding uncertainty continues to be a major challenge to CHW sustainability across years. In 2014, 91% of respondents noted funding as a barrier. In 2016, 87% of respondents cited funding as a challenge. This year, 77.3% cited funding as a challenge. Funding mechanisms have shifted slightly with 50% of organizations reporting state funding in 2016 to only 36.7% reporting state grants. The most frequently reported source of funding for CHWs in 2018 was federal grants (47.7%).. More programs also reported funding through private foundations in 2018 compared to 2016 (34.1% vs. 25.0%). In 2018, 34.1% of organizations reported reimbursement by an insurer compared to 26.4% in 2016.

In qualitative responses to the question about why organizations employ CHWs, common themes in both 2016 and 2018were the CHW's experience with client populations and communities, ability to address social determinants of health, and cultural competence. New responses in 2018 included a strong focus on CHW's effectiveness, ability to improve health outcomes, and ability to connect to communities through service and outreach. These qualitative changes may indicate an important shift in how CHWs are perceived by organizations throughout the state, possibly demonstrating a better understanding of the role CHWs have in care teams.

SURVEY BACKGROUND

Why MiCHWA?

MiCHWA works with CHWs and their programs statewide. With a network of over 800 participants, MiCHWA distributed this survey to organizations throughout Michigan with CHWs or CHW programs. MiCHWA staff and management team members have extensive experience conducting community based participatory research, including surveys. As the research arm of MiCHWA, the Evaluation Advisory Board oversaw the project and worked directly with the MDHHS Survey Team. MiCHWA has previously administered statewide CHW employer surveys in 2014 and 2016.

Why MDHHS?

The Michigan Department of Health and Human Services (MDHHS) Diabetes Prevention and Control Program and the Heart Disease and Stroke Prevention Unit sought to complete a statewide assessment of CHWs as part of their Centers for Disease Control and Prevention (CDC) grant (CDC-RFA-DP13-1305). This created a natural, collaborative opportunity for MiCHWA and MDHHS to work together on the CHW program survey. MiCHWA and MDHHS (formerly MDCH) previously partnered on the 2014 and 2016 CHW employer surveys.

Survey Development

The CHW Employer Survey was designed, conducted, and analyzed by MiCHWA under contract with MDHHS. The 2018 CHW Employer Survey was designed to answer a number of questions:

- What types of organizations employ CHWs in Michigan, where are they located, how many CHWs do they employ, and why do they employ CHWs?
- Whom do CHWs serve, what issues do they address, what are their roles and functions, and where and how do they deliver services in Michigan?
- What are the education expectations and hiring requirements of CHWs in Michigan? • How are CHWs trained in Michigan?
- How do organizations support CHW employment, including integration, compensation, and supervision?
- How are CHW positions funded and sustained in Michigan?
- How do CHWs contribute to evidence-based lifestyle change programs?
- How has the CHW field changed in Michigan since 2014?

This survey builds on previous surveys conducted in 2014 and 2016. In July 2014, MiCHWA conducted the first survey of employers and managers of CHWs to gain a better understanding of CHWs and their programs statewide. The MiCHWA Evaluation Advisory Board recommended this survey be administered every two years to assess CHW program sustainability and identify CHW growth trends. The CHW Program Survey was developed after reviewing the 1998 National Community Health Advisor Study, the 2007 HRSA Community Health Worker Workforce Survey, and previous versions of the MiCHWA Employer Survey. The present survey and evaluation builds off of previous surveys and lessons learned. To maintain continuity, many of the questions were not changed.

SECTION 1: METHODS

Survey Instrument

The Employer Survey instrument was developed following review of existing survey tools and gathering stakeholder feedback from MiCHWA, MDHHS, and others. The final 60-item survey consisted of open and close-ended items. The survey was transferred to an electronic survey format using Qualtrics©, a web-based survey tool used by the University of Michigan. MiCHWA evaluation staff members solicited feedback from Evaluation Advisory Board members who provided comments about the content, flow, and usability of the electronic survey.

Survey Distribution

An employer-specific mailing list was created, totaling 103 individual email addresses from 57 unique organizations. These individuals were identified as CHW program managers, supervisors, or other staff from organizations that may employ CHWs. Additionally, the Michigan Primary Care Association distributed the survey to their member lists or through social media. MiCHWA further promoted the survey on its website, social media, and through its listserve that includes 823 individuals. Survey launch and reminder emails were sent to MiCHWA's mailing February 16th, March 6th, March 12th, and March 20th and were sent to the employer list on February 16th and March 5th.

Because the survey was disseminated widely, MiCHWA staff were unable to identify the total number of individuals or organizations who received the survey. However, survey instructions specified that one

person per employer organization complete the survey. If an organization had multiple CHW programs, we requested that the respondent answer for the organization and include all CHW programs in a single response.

The survey was initially scheduled to close March 9th, 2018. Upon reviewing the number of responses, the MiCHWA Evaluation Advisory Board chose to extend the survey open period. All data in this report reflect surveys received when the survey closed on March 31st, 2018.

Response Rate

A total of 69 surveys were initiated. We excluded surveys that were blank, organizations that were not Michigan-based or had no reported CHWs in Michigan, those that were not currently employing or working with CHWs, and those with significant missing data. For partially completed, unique surveys, answers were kept for surveys in which at least 40% of questions were answered. In total, the following data respresent 44 unique respondents. In some cases, despite our instruction, programs housed by different organizations completed surveys separate from the larger organization. Evaluators verified that there was no duplication in responses in these situations. The response rate denominator (N=65) is the total known CHW programs from MiCHWA records. Thus, the 44 unique organization responses represented a response rate of 67.7%.

Analysis

Once the online survey closed, data were exported from Qualtrics© into Excel. After the data were cleaned, descriptive statistics, including counts, percentages, means, and standard deviations were used to describe the quantitative data. Qualitative responses were compiled and reviewed independently by two coders for themes. Themes were based on 2016 data and new/emerging areas unique to 2018 responses.

SECTION 2: RESULTS

A. What types of organizations employ CHWs in Michigan, where are they located, how many CHWs do they employ, and why do they employ CHWs?

A.1. Types of CHW Employers

Over half of CHW programs are provided by employers who identified as community-based organizations (12, 27.3%) or federally qualified health centers (11, 25.0%). Local health departments were the third most frequent type of employer (9, 20.5%).

What types of organizations employ CHWs?

	n	%
Community-based organization	12	27.3
Federally qualified health center (FQHC)	11	25.0
Local health department	9	20.5
Hospital/Medical clinic (non- FQHC)	5	11.4
Other[a]	3	6.8
Community health center (non-FQHC)	2	4.5
Government agency (not local health		

department) 1 2.3

Health insurance plan 1 2.3

[a]Community Collaborative Program, free clinic, state health department

A.2. Location of CHW Programs in Michigan

The responding organizations reported a total of 91 CHW programs in Michigan. CHW programs reported serving 62 unique counties in Michigan. Kent (13), Wayne (6), and Newyago (5) were the most common program locations reported among participants. Twenty-one of Michigan's 83 counties had no reported CHW program operating in their boundaries. Note: This is likely an underestimate since not all organizations with CHW programs responded to the survey. NR indicates no response recorded.

Alcona 1 Cheboygan 1 Houghton 1 Lenawee 1 Muskegon 4 Sanilac NR Alger NR Chippewa NR Huron 1 Livingston 1 Newaygo 5 Schoolcraft 1 Allegan 3 Clare NR Ingham 2 Luce NR Oakland 2 Shiawassee 2 Alpena 1 Clinton 1 Ionia 1 Mackinac NR Oceana 4 Tuscola 1 Antrim 2 Crawford 1 Iosco 1 Macomb 2 Ogemaw NR Van Buren 1 Arenac NR Delta NR Iron 1 Manistee 2 Ontonagon 1 Washtenaw NR Baraga 1 Dickinson 1 Isabella NR Marquette 1 Osceola 1 Wayne 6 Barry 1 Eaton 1 Jackson NR Mason 3 Oscoda NR Wexford 2 Bay 1 Emmet NR Kalamazoo 3 Mecosta 2 Otsego 1 Benzie 2 Genesee 4 Kalkaska 1 Menominee 1 Ottawa 4 Berrien 2 Gladwin NR Kent 13 Midland 1 Presque Isle NR Branch 1 Gogebic NR Keweenaw 1 Missaukee 1 Roscommon NR Calhoun 2 Grand Traverse 2 Lake 3 Monroe 1 Saginaw 3 Cass 2 Gratiot 1 Lapeer 3 Montcalm 4 St. Clair NR Charlevoix 2 Hillsdale 1 Leelanau 2 Montmorency NR St. Joseph 1

A.3. Why employ CHWs?

Respondents were asked to identify why their organization employs CHWs. The most common responses included: because of the effectiveness of CHWs, to improve health outcomes, and for community services and outreach. Example quotes are provided. Specific responses, grouped by theme are provided in the Appendix.

Examples of **CHW effectiveness** included:

- "Because they are the true change agent that has the ability to break the cycle of poverty." • "The research that we have conducted using a CHW model has shown that patients lower their A1c when they receive CHW services. The ACA and HRSA recommended use of CHWs in outreach and enrollment."
- "They are assets to the organization; reflect the people we serve."

Examples of **improving health outcomes** included:

- "To help eliminate barriers to accessing health care services in our community." • "Well-being and enhancements for individual livelihood through health, education and treatment."
- "To improve health outcomes/quality of life and decrease health costs."

Examples of **community service and outreach** included:

- "To further public health support and for community support resources."
- "It is our mission to serve vulnerable populations, provide outreach to those populations, and work in partnership to improve health outcomes."

A.4. Number of CHW Programs

There were a total of 91 CHW programs reported by responding organizations.

A.5. Number of CHWs in Programs

The majority of organizations (93.2%) employed full time CHWs, with an average of 11.48 CHWs per organization (range of 1-45). Nearly 40% of organizations employed part-time paid CHWs with 1.53 per organization, a few had full-time volunteer (9.1%) or part-time volunteer (11.4%). In total, there were 485 CHWs with 459 full time and 26 part-time CHWs.

B. Whom do CHWs serve, what issues do they address, what are their roles and functions, where and how do they deliver services in Michigan?

B.1. Populations Served and Issues Addressed by CHW Programs

Respondents were asked to identify who their program serves, as defined by race, health issues, other specific issues, age of population, and special populations. The most commonly served populations included black and Hispanic/Latino individuals (40, 90.0%). CHWs work with adults, youth and children but higher percentages work with adults (39, 88.6%) and young adults (33, 86.4%). The special population with which CHWs work most frequently are uninsured individuals (35, 79.5%) and homeless individuals (33, 75.0%).

Demographic Characteristics of Populations Served by CHW Organizations

What populations do your CHWs serve?

Race n %

Black 40 90.9
Hispanic/Latino 40 90.9
White 37 84.1
American Indian 29 65.9
Asian 26 59.1
Arab/Middle Eastern 26 59.1
Hawaiian/Pacific Islander 26 59.1
Other 5 11.4

Age Groups n %

Adults (26-64) 39 88.6
Young adults (19-25) 38 86.4
Youth (6-18) 33 75.0
Children (0-5) 32 72.7
Seniors (65+) 30 68.2
Special Populations n %
Uninsured 35 79.5
Homeless 33 75.0
Individuals without a medical home/primary care provider 30 68.2
Pregnant women/infants 28 63.6
Frequent ED users 27 61.4
Immigrants 27 61.4
Isolated rural residents 24 54.5
Migrant workers 21 47.7
Other 4 9.1
Note: county-level data can be obtained from MiCHWA upon request

Health Issues Addressed by CHWs by Top Three Counties

CHWs address a wide range of ***health*** topics. Unfortunately, because of the way the question was asked, we are not able to provide totals for all counties at this time so these results are presented for the three counties with the most CHW programs. County specific information may eventually be available upon request. The same limitation applies to social issues below. The most common health topics addressed by programs in Kent County included health literacy (6 programs, 61.5%), nutrition (n=8, 61.5%), and physical activity (n=8, 61.5%). In Wayne Country, topics included diabetes, hypertension, heart disease, nutrition, asthma, material/child health, and physical activity (all= 4, 66.7%), in Newaygo, the top health issue was diabetes (4, 80%).

What specific health issues do your CHWs address (by counties with the most CHW programs)?*	**Kent**		**Wayne**		**Newaygo**	
	n	**%**	**n**	**%**	**n**	**%**
Diabetes	7	53.8	4	66.7	4	80
Obesity	4	30.8	3	50.0	2	40
Hypertension	5	38.5	4	66.7	2	40
Mental/Behavioral health	6	46.2	2	33.3	1	20
Heart disease	5	38.5	4	66.7	3	60
Health literacy	8	61.5	3	50.0	1	20
Nutrition	8	61.5	4	66.7	1	20
Asthma	5	38.5	4	66.7	2	40
Maternal/Child health	5	38.5	4	66.7	1	20
Physical activity	8	61.5	4	66.7	2	40
HIV/AIDS	4	30.8	2	33.3	1	20
Infant mortality	4	30.8	3	50.0	1	20
Oral health	4	30.8	3	50.0	1	20
Cancer	3	23.1	1	16.7	1	20
Other	2	15.4[a]	2	33.3[b]	2	40[c]

[a]Chronic Obstructive Pulmonary Disease (COPD), Infant education
[b]Lead prevention, pediatric preventive care
[c]No specific focus

The top social issue CHWs addressed in Kent county were connecting clients to resources (n=13, 100%). Other common social issues included establishing/maintaining health insurance, connecting to medical homes, and health services (n=11, 84.6%). In Wayne county, 100% of CHW organizations reported connecting to resources. Other common social services included food security, transportation, connecting to medical homes (n=4, 66.7%). In Newaygo, CHWs commonly connected individuals to services and established/maintained health insurance (n=4, 80%).

What specific social issues do your CHWs address (by counties with the most CHW programs)?*	Kent		Wayne		Newaygo	
	n	%	n	%	n	%
Connecting to resources	13	100.0	6	100.0	4	80

Housing	10	76.9	3	50.0	3	60
Employment	9	69.2	2	33.3	3	60
Food security	10	76.9	4	66.7	3	60
Education	10	76.9	2	33.3	3	60
Income	8	61.5	2	33.3	3	60
Transportation	8	61.5	4	66.7	3	60
Establishing/maintaining health insurance	11	84.6	6	100.0	4	80
Immunizations	8	61.5	3	50.0	2	40
Connecting to medical home/PCP	11	84.6	4	66.7	3	60
Human services	9	69.2	3	50.0	3	60
Health services	11	84.6	3	50.0	2	40
Other	1	7.7	1	16.7	0	0

*The tables provide information about health topics and social issues based on the three counties with the highest number of respondents. Due to the format of the question we were unable to provide totals for each type of health issue at this time. County specific information can be provided upon request.

B.2. CHW Roles

Respondents were asked to report the roles CHWs play in their organization according to the CHW Core Consensus (C3) roles. The most commonly reported roles included: conducting outreach (36, 81.1%), providing coaching and social support (35, 79.5%), and advocating for individuals and communities (35, 79.5%).

What roles do CHWs play in your organization?	n	%
Conducting outreach	**36**	**81.8**
Follow-up on health and social services	33	75.0
Presenting at local agencies and community events	31	70.5
Home visiting	28	63.5
Case-finding and recruitment of individuals	23	52.3
Advocating for individuals and communities	**35**	**79.5**
Connecting to resources and advocating for basic needs	35	79.5
Advocating for the needs and perspectives of communities	24	54.5
Conducting policy advocacy	8	18.2
Providing coaching and social support	**35**	**79.5**
Motivating and encouraging people to obtain care and other services	35	79.5
Providing individual support and coaching	32	72.7
Supporting self-management of health	28	63.6
Planning and/or leading support groups	15	34.1
Care coordination/system navigation	**34**	**77.3**
Making referrals and providing follow-up		

31 70.5

Facilitating transportation to services and helping address other barriers to services 30 68.2 Documenting and tracking individual and population level data 27 61.4 Participating in care coordination and/or cancer management 26 59.1 Information and systems about community assets and challenges 26 59.1 **Providing appropriate education/information 32 72.7** Health promotion and disease prevention education 29 65.9 Providing necessary information to understand and prevent disease 27 61.4 **Cultural mediation 24 54.5** Educating individuals about health/social systems 24 54.5 Building health literacy and cross-cultural communication 17 38.6 Educating systems about community 12 27.3 **Building individual and community capacity 23 52.3** Building individual capacity 22 50.0 Training and building individual capacity 16 36.4 Building community capacity 9 20.5 **Providing direct service 18 40.9** Meeting basic needs 17 38.6 Providing basic screening tests 11 25.0 Providing basic services 4 9.1 **Implementing individual/community assessments 17 38.6** Participating in individual-level assessments 16 36.4 Participating in community-level assessments 9 20.5 **Participating in evaluation and research 14 31.8** Engaging in evaluating CHW services and programs 10 22.7 Data collection and interpretation 10 22.7 Sharing results and findings 9 20.5 Identifying and engaging community members as research partners 6 13.6 Identification of priority issues and evaluation/research questions 6 13.6 Engaging stakeholders to take action on findings 5 11.4 Development of evaluation/research design and methods 4 9.1

B.3. CHW Titles

Three-quarters of respondents reported using “community health worker” as their title. Over one-third of respondents reported using some other title instead of, or in addition to, this title. Titles with 1 response are listed in the table footnote.

What titles do CHWs go by?

	n	**%**
Community health worker	33	75.0
Other[a]	13	29.5
Outreach and enrollment worker	6	13.6

Community health outreach worker 4 9.1 Community outreach worker 4 9.1 Promotore/a 4 9.1 Patient navigator/navigator 4 9.1 Certified peer support specialist 3 6.8 Early Intervention Services worker 3 6.8 Community health advocate 2 4.5 Health coach 2 4.5 Recovery coach 2 4.5 Care Coordinator 2 4.5 [a]Asthma educator, Health aid, Veteran liaison, Lay Leader
Lifestyle Coach, Case manager, Community connector,

Community coordinator, Community health navigator, Community health technician, Medical case manager, Navigation specialist, Parent coach, and Health aid

B.4. Settings Where CHW Services Are Delivered

The majority of CHWs deliver services in client homes (31, 70.5%). CHWs also commonly deliver services in public housing units (16, 36.4%) and other non-profit organizations (15, 34.1%).

Where do CHWs deliver services?

	n	%
Client home	31	70.5
Shelters	17	39.6
Community health center	17	39.6
Public housing unit	16	36.4
Private clinic or medical practice	16	36.4
School	16	36.4

Other non-profit organizations	15	34.1
CHW program location	13	29.5
Hospital	13	29.5
Community events	11	25.0
Free clinic	11	25.0
Client worksite	10	22.7
On the street	9	20.5
Teen centers	8	18.2
Migrant camp	7	15.9
Health maintenance organization	3	6.8
[a]Other	3	6.8

[a]Faith based organization, on-site, wherever is most convenient

B.5. How CHWs Deliver Services

CHWs deliver services during one-on-one meetings in person (42, 95.5%) and through one-on-one meeting by telephone calls (36, 81.8%), and text messages (22, 50%).

How do CHWs deliver services?	n	%
One-on-one meetings in person	42	95.5
One-on-one meetings by telephone calls	36	81.8
One-on-one meeting through text messages	22	50.0
Email or other electronic communication	20	45.5
Group class or sessions	18	40.9
One-on-one through video communication (FaceTime or Skype)	4	9.1

B.6. Average Number of Clients CHWs Serve per Year

The average number of clients served per year by CHW programs was 1,211 (100 to 6323) with a median number of 430.

B.7. Average CHW Caseload per Year

The average caseload for an individual CHW was 57 clients per year (17-300) with a median number of 42 cases per year.

C. What are the education expectations and hiring requirements of CHWs in Michigan?

C.1. Education Expectations

Most organizations (34, 77.3%) required a high school diploma or GED as a requirement before CHWs could be hired. An Associate's degree or more was required by 15.8% of organizations. No organization

required a master's degree or more education.

What are pre-employment educational requirements?	n	%
High School Diploma/GED	34	77.3
Bachelor's degree	3	6.8
No specific requirement	4	4.5
Associate's degree	2	4.5
Some College	0	0
Master's degree	0	0
PhD/MD	0	0

C.2 Other Hiring Requirements

Other requirements included ability to read and write in English (40, 90.9%) and background checks (38, 85.4%). Even if all other hiring requirements are met, 50% of programs reported that they would exclude CHWs due to criminal backgrounds. Most organizations preferred that CHWs have prior experience with the population or community served (36, 81.8%), prior health or health related experience (33, 75.0%), and prior experience as a community resident (25, 56.8%). However, most programs did not require a specific minimum years of experience (24, 54.5%).

What are other hiring requirements for CHWs?	Required		Preferred		Not Required	
	n	%	n	%	n	%
Ability to read and write in English	40	90.9	3	6.8	0	0
Prior health or health related experience	2	4.5	33	75.0	8	18.2
Prior experience as a community resident	7	15.9	25	56.8	11	25.0
Prior experience with target population or community	4	9.1	36	81.8	3	6.8
Background check prior to hire	38	85.4	3	6.8	2	4.5

What is the desired minimum prior experience for CHWs?	n	%
No specific req.	24	54.5
< 1 year	3	6.8
1 year	5	11.4
2 years	5	11.4
3 years	0	0
4+ years	2	4.5

D. How are CHWs trained in Michigan?

D.1. CHW Training Requirements

Most programs do not currently require any training prior to hiring CHWs (n=33, 75.0%). Five programs (11.4%) require MiCHWA core competency-based training prior to employment. Most organizations require MiCHWA core competency-based training while employed as a CHW (n=30, 68.2%). Another 11.3% require a different core competency-based training, and 40.1% require other training.

Respondents reported that on average, 2.7 CHWs from their organization will need core competency based training over the next year (range: 0-19).

What type of training is required *before* hire?	n	%
None required	33	75.0
Successful completion of the 126-hour MiCHWA CHW core competency based training program	5	11.4
Other[a]	5	11.4

What type of type of training is required *while employed* as CHW?	n	%
Successful completion of the 126-hour MiCHWA CHW core competency based training program	30	68.2
Other[b]	18	40.1
Other core competency-based training[c]	5	11.3
None	4	9.1

[a]MHP Salud, other respondents did not provide details about training requirements

[b]Grant-specific training, onboarding, ongoing internal training, trauma training, breast feeding, CPR, Pathways, diabetes education, others did not provide details about training requirements

[c]County Health Plan, MHP Salud, others did not provide details about training requirements

D.2. Continuing Education Topics

Continuing education topics of interest included: motivational interviewing (6), setting boundaries with patients (6), chronic disease courses (diabetes, asthma) (3), social determinants of health and cultural competency (3), advocacy (2), group facilitation (2), trauma-informed care (2), adverse childhood event screening (1), behavioral health (1), C3 aligned (1), and documentation (1).

E. How do organizations support CHW employment, including integration, compensation, and supervision?

E.1. CHW Integration

Most programs indicted that their CHWs work as part of a multidisciplinary team (n=23, 52.3%). Of those that indicated working on a multidisciplinary team, most worked with social workers/behavioral health specialists (n=31, 88.5%), registered nurses (n=26, 74.2%), case managers (24, 68.6%) and primary care providers (21, 60.0%).

Do any CHWs at your organization work on a multidisciplinary team?

	n	%
All	23	52.3
Some	12	27.3
None	8	18.2

If yes, who else works on the team with the CHWs?

	n	%
Social worker/Behavioral health specialist	31	88.5
Registered nurse	26	74.2
Case manager	24	68.6
Primary care provider	21	60.0
Other CHWs	17	48.6
Medical assistants	13	37.1
Dietitian/Nutritionist	12	34.4
Other	3	8.5

E.2. CHW Benefits

Most CHWs are compensated on an hourly basis (35, 79.2%). The average hourly rate was $15.92 (range of $7-$20). The average compensation was $35,490 (range of $21,000 to $46,000). In addition, most CHWs are eligible for pay raises or other increases in compensation (38, 86.4%). These raises are determined in the following ways: annual performance reviews or yearly evaluations, cost of living increases, and union contracts.

What benefits do CHWs receive?

	n	%
Health insurance	36	81.8
Mileage reimbursement	35	81.8
Sick leave	34	77.3
Vacation accrual	33	75.0
Personal leave	33	75.0
Pension or retirement	28	63.6
Tuition assistance	17	38.6
Other[a]	11	25.0
Educational leave	3	6.8
Commuter subsidy	3	6.8
Child care	2	4.5
None	1	2.3

[a]401K, life insurance, dental, vision, bereavement time off, cell phone subsidy, employee sponsored 403(b), accommodations for higher education, money toward

continuing education, PTO

E.3. CHW Supervision

Most organizations reported that CHW supervisors spend between 25-50% of their time supervising CHWs.

Total amount of time spent on supervision (% total job time)	n	%
100% (only job responsibility is supervision)	5	11.4
51-99%	8	11.4
25-50%	10	22.7
11-24%	8	18.2
6-10%	5	11.4
<5%	4	9.1

Supervisor Characteristics

Respondents identified supervisors by professional background or current position. The most common professional backgrounds of CHW supervisors were registered nurse (19, 43.2%), social worker (16, 36.4%) and Master's in Public Health (10, 22.7%). Eight organizations (18.2%) reported that their CHWs were supervised by a senior CHW.

Who directly supervises CHWs at your organization?	n	%
Registered nurse	19	43.2
Other[a]	18	40.9
Social worker	16	36.4
Master of Public Health	10	22.7
Senior CHW	8	18.2
Dietician/nutritionist	2	4.5

[a] Behavioral Health Specialist, CEO, Health Home Coordinator, Masters in Counseling, Masters in Childhood Education, Master in Psychology, Master of Public Administration, Non-CHW paraprofessional supervisor, PhD, Program Director/Coordinator, Health educator, Quality manage, Primary care provider

Supervisor Training

Supervisors were chosen because of their: knowledge/skills relevant to the program (n=35, 79.5%), background experiences in relevant fields (n=27, 61.4%), strong supervisory experience (n=26, 59.1%), and experience with outreach (n=22, 50%). About half of CHW supervisors received some CHW-specific training.

Why were these CHW supervisors chosen?

	n	%
Knowledge/skills relevant to the program	35	79.5
Background experiences in relevant fields	27	61.4
Strong supervisory experience	26	59.1
Experience with outreach/social/health programs	22	50.0
Clinical expertise	20	45.5
Experience in the field with CHWs	14	31.8
Other[a]	4	9.1

[a]Part of community, default, understanding of role and community

Have supervisors received CHW specific training?

	n	%
Yes	20	45.5
No	21	47.7

Supervision Challenges

Most organizations reported that they have sufficient resources for CHW supervision. Challenges related to supervising included: CHWs being located in different places than their supervisor (18, 40.9%), more guidelines needed (10, 22.7%) and not enough time for supervision (10, 22.7%). Respondents suggested additional training on CHW supervision (26, 59.1%) and group training with other CHW supervisors (26, 59.1%).

Does your organization have sufficient resources for CHW supervision?

	n	%
Yes	30	68.2
No	10	22.7

What are the challenges your organization faces in regard to CHW supervision?

	n	%
CHWs are mobile/located in different places	18	40.9
More supervisory guidelines are needed	10	22.7
Not enough time for supervision	10	22.7
CHW and supervisor have conflicting schedules	7	15.9
Too many employees reporting to one		

supervisor 4 9.1 Other[a] 3 6.8 [a]CHWs and supervisors have multiple roles, more funder guidelines and expectations

What additional supports would be valuable to your supervisors?

	n	%
Training on supervision of CHWs	26	59.1
Group training with other CHW supervisors	26	59.1
Peer networking with other CHW supervisors	21	47.7
Training on supervision in general	15	34.1
Other	4	9.1

Supervision Strategies

Survey respondents were asked their opinion about essential supervision strategies for CHWs. Essential CHW supervision practices included communication and general support. Specific types of communication strategies include: clear expectations about the roles, frequent contact, and integrated meetings. Support strategies included: promoting self-care by addressing burn out and stress, and strength-based coaching and mentoring. All responses, grouped by theme are provided in the Appendix.

F. How are CHW positions funded and sustained in Michigan?

F.1. Funding Mechanisms

The most frequent funding mechanisms for CHW positions included: federal grants (21, 47.7%), state grants (16, 36.4%), and private foundations (14, 31.8%).

How are your CHWs funded?

	n	%

Federal grants 21 47.7
State grants 16 36.4
Private foundations 15 34.1
Local grants 14 31.8
Health plan contracts 8 18.2
Self-generated organization revenue 7 15.9
General organization fund 6 13.6
[a]Other 5 11.4
Community benefit 5 11.4
Other public funding 5 11.4
Other non-profit 4 9.1
Internal competitive grants 1 2.3

[a]Fund balance, grants/donations, Pay for success, Funded through rural health clinics, responded other but did not include details

F.2. Insurance/Payer Related Reimbursement Strategies

Most CHW respondents reported no reimbursement for CHW services from an insurer or other payer (n=25, 56.3%). Of those that are reimbursed by an insurer, the majority reported being reimbursed by Medicaid managed care organizations (MMCOs) (10, 66.7%). Seven organizations reported having contracts with Medicaid managed care organizations and 7 reported that they were in discussion with MMCOs), the most frequent of which were Priority Health Choice and McLaren Health Plan.

Are CHW services reimbursed (in part or full) by an insurer or other payer?

n %

Yes 15 34.1 No 25 56.3

What insurance/payers?

Medicaid managed care 10 66.7
[a]Other 3 20 Medicaid 2 13.3
State Children's Health Insurance 2 13.3 Private Health Insurance 1 6.7

[a]MI Care Team, MDHHS, Pay for Success

Do you have any agreements with Medicaid managed care organizations to pay for CHW services?

n %

Yes 7 15.9
No, but in discussions 7 15.9
No 26 59.1

If yes (or in discussions), with which one(s)?

Priority Health Choice 6 13.6
McLaren Health Plan 5 11.4

HAP Midwest Health Plan 1 2.3
Harbor Health Plan 1 2.3
Molina Healthcare 1 2.3
Meridian Health Plan 1 2.3
UnitedHealth Care Community Plan 1 2.3
Aetna Better Health 1 2.3

What payment models are being used?

Other[a] 14 31.8
Service based payments 10 22.7
Per member per month for clinical care team (including CHW) 9 20.5
Outcome based or value based payment for specific health outcomes per member 8 18.2
Bundled payment for services, including CHW 6 13.6
Per member per month for CHW 1 2.3

[a]grant funded (4), none, unsure

Six different billing codes were used by organizations. These included: 99490, S9445 with diagnosis code Z71.9, G9001 and 98966, 98967, 98968, 99486.

Code	**Description**	**Element**
99490	Minimum 20 minutes of clinical staff time, directed by a physician or other qualified health care professional per calendar month	Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Comprehensive care plan revised, or monitored
S9445	(diagnosis code Z71.9, G9001, 98966) established, implemented,	Health Services Pt education, NOC non=physician
98966	Telephone services	Document any care management or coordination service provided over the telephone or by other real-time interactive electronic communication; 5-10 minutes

98967	Telephone services	Document any care management or coordination service provided over the telephone or by other real-time interactive electronic communication; 11-20 minutes
98968	Telephone services	Document any care management or coordination service provided over the telephone or by other real-time interactive electronic communication; 21-30 minutes
99486	Transitional Care	Transitional care management services with high medical decision complexity (face-to face visit within 7 days of discharge)

F.3. Organization Challenges Related to Sustainability of CHW Employment Notable challenges to CHW sustainability included: funding uncertainty (34, 77.3%), staff turnover (15, 34.1), and finding qualified CHWs (12, 27.3%).

What are your organization's top three concerns regarding sustainability of CHW employment?	**n**	**%**
Funding uncertainty	34	77.3
Finding qualified CHWs	12	27.3
Staff turnover	15	34.1

Non-acceptance of CHW role by other team members	10	22.7
Management support	8	18.2
Other[a]	8	18.2

[a]Ability to provide competitive wages, funding when not a Medicaid billing partner, other staff not knowing how to use skills and understand CHW responsibilities, policies that support reimbursement for CHWs both in clinical and community settings, no standard models

Organizations work to promote CHW sustainability primarily through offering professional development opportunities (n=33, 75%) and through providing education about the role of CHWs (n=29, 65.9%). Other ways included: working with payers and building an internal business case.

How does your organization work to promote CHW sustainability?	n	%
Offering professional development opportunities	33	75.0
Providing education on the CHW role	29	65.9
Working with payers on contracts for CHW services	14	31.8
Building a business case internally	13	29.5
Not at this time	4	9.1
Other[a]	3	6.8

[a]Advocacy for policy changes, support MPCA advocacy, MI care team

G. How do CHWs contribute to evidence-based lifestyle change programs?

Just over half of CHW programs did not have CHWS who were trained as leaders of evidence-based lifestyle programs (n=25, 56.8%), and most were not currently serving as leaders or co-leaders of programs (68.2%). PATH (n=8, 18.2%) and Chronic PATH were the most commonly cited evidence-based lifestyle programs that CHWs lead.

	Are any CHWs currently trained as leaders of these programs?		Currently serving as leaders or co-leaders?	
	n	%	n	%
Diabetes Prevention Program	3	6.8	2	4.5
PATH	8	18.2	4	9.1
Chronic PATH	6	13.6	1	2.3
Diabetes				

PATH 7 15.9 5 11.4 Other[a] 5 11.4 2 4.5 None 25 56.8 30 68.2 Tomando Control de su Salud 2 4.5 1 2.3 [a]ARTAS, Bodyworks, CLEAR, SISTA, Breastfeeding peer counselors, MiCHWA certificate instructor, MOB, DPP

PATH: Personal Action Toward Health
This is the Michigan name for the Stanford Chronic Disease Self-Management Program. PATH exists to help people manage their long-term health conditions. PATH has been tailored to specific conditions, resulting in Diabetes PATH, Chronic PATH, and Kidney PATH. Additionally, Tomando Control de su Salud is a Spanish-only version of PATH.

DPP: Diabetes Prevention Program
DPP is a CDC-recognized program that works with high-risk individuals on preventing diabetes.

Tomando Control de su Salud
This a self-management education intervention for Spanish-speaking people with a variety of chronic health conditions.

SECTION 3: APPENDICES

Appendix A: Why Employ CHWs

Why does your organization employ CHWs?
Theme 2018 Responses 2016 Responses
Effectiveness of CHWs

(N=10)

Improve
Health
Outcomes

(N=7)
• XX employs CHWs because they are the true change agent that has the ability to break the cycle of poverty.
• CHWs are integral to positively influencing population health. • The organization believes in the power and influence that CHWs have in working with the people we serve.
• The research that we have conducted using a CHW model has shown that patients lower their A1c when they receive CHW services. The ACA and HRSA recommended use of CHWs in outreach and enrollment.
• Their impact and trust building ability.
• They make versatile employees and value innovation and out-of-the box thinking … Their ability to connect with clients. Additionally, they have often used the same systems they are navigating clients through (peers/gatekeepers).
• They are a valuable asset, they are more effective at communicating with patients and getting patients engaged in their healthcare. • They are assets to the organization; reflect the people we serve • They are valuable and essential to our success
• We recognize the value of CHWs and their role in population health • Improve health outcomes and reduce cost of care.
• To help eliminate barriers to accessing health care services in our community.
• To help improve the health of individuals within the community, health equity and access strategy
• To improve health outcomes/quality of life and decrease health costs. • TO IMPROVE PATIENT OUTCOME & COMPLIANCE

Not identified in 2016 Not identified in 2016

Community Service &
Outreach

(N=7)

Bridge to Care (N=4)

Program
Specific
Reasons

(N=4)
• To do home visits to help clients manage their chronic illnesses in turn reducing E.D. visits.
• Well-being and enhancements for individual livelihood through health, education and treatment.
• As a local health department, it is our mission to serve vulnerable populations, provide outreach to those populations, and work in partnership to improve health outcomes.
• Because we provide service to communities.
• Outreach

• To further Public Health support and for community support resources
• To help patients
• To provide CHW services in the community
• To provide peer to peer support to encourage positive health outcomes
• Bridges gap between the clinic and patient at home. • Bridge between clinical and behavioral health care
• Connects healthcare to community
• To help connect patients to social/community resources treating the patient and disease as a whole

• As part of our CHIR work
• For Strong Beginnings Program
• MiCHAP
• The work we do is community health work
Not identified in 2016

Not identified in 2016

• Mandatory part of the project to begin with. Now, organization sees the value and hires because of this.
• The reasons vary by program and their specific needs, which include referring community members to our programs and services,
providing basic services such as blood pressure screenings, glucose screenings and height and weight measurement, providing health
education, resources and referrals. It is also cost effective to employee CHWs.

Experience with Client Populations and

Communities (N=3)

• Trusted community liaisons
• Valuable asset to the community, true champions for change, and understanding of the gaps amongst the communities they serve. • We serve very impoverished communities where the knowledge of the CHW with regards to resources is hugely beneficial to our patients.
• To provide ongoing support to schools that we service through the Community Education Initiative that's in place

• To provide the community we serve with advocates that are equipped to remove barriers, connect clients to necessary care and help the clients we serve reach their goals for health and well-being
• To engage, recruit and retain vulnerable population into critical, client-centered, health and social services
• CHWs are able to reach people where providers are not. They build relationships and those personal relationships give patients and community members a sense of hope and the desire to want to do better. If not for their sake, for the sake of making their CHW proud. They feel like someone cares, and we do.
• It is the best way to reach the community and make lasting change. We've been using this model for over 30 years and we strongly believe it is a successful way to improve health in under served communities.
• So many reasons! They have life experience and personal expertise that enable them to 1) engage vulnerable families that might otherwise be reluctant to participate in our program, 2) develop long-term trust relationships, 3) connect them to needed resources and services including mental health and treatment for substance use disorder. Their unique professional roles complement and enhance the roles of other

Cost-Effective (N=3)

To Address Social
Determinants of Health

(N=2)

Cultural
Competence (N=1)

• Cost efficient
• Cost-effective way of reaching clients
• They are cost effective, multi-dimensional, flexible, willing to work non-traditional hours outside of the office.

• To address social determinants of health
• To support our mission and address SDOH in an intentional, measurable way

• To better serve our communities and to promote the CHW model as a culturally appropriate way to address community health
professionals such as RNs and SWs. They serve as peer mentors and as role models. They serve as advocates for their clients and as bridges between the formal complex health system and community members.

Not identified in 2016

• Bridge the gap from home to health care • We believe it's in the best interest of our patients and over time will have a strong impact on improving health outcomes
• To help the community get on the road of becoming healthy

Billing, Funding

(N=1)
• To prepare the agency to be able to bill for services • Grant funded project • Program funding through MPCA and better
patient outcomes
• Grants such as Linkages, 1422, and MiPCT. We
are looking at employing more because they
have proven to be very valuable.

*Note: all response are verbatim from the original survey; identifying information has been removed

Appendix B: Essential CHW Supervision Practices

In your experience, what are essential practices or strategies for supervising CHWs? Theme 2018 Responses 2016 Responses

Communication (N=13)

• Clear communication on expectations; direction regarding boundaries and roles of the CHW.
• Frequent contact and check ins
• INTEGRATED MEETINGS
• Frequent communication; Program Updates. • Monthly meetings as well as frequent communication via email, skype, phone.
• Open communication, ethical practices
• People skills are needed most, being inclusive, encouraging feedback from staff.
• Engage them [CHWs] in developing and revising programs and protocols … Conduct regular case management sessions.
• Regular one-on-one supervision, clear quantifiable expectations, having CHW check in with supervisor at the end of the day, sharing calendars.
• Be consistent with one-on-one meetings and be available for questions on a regular basis.
• Video conference supervision; open communication. • We have strong and knowledgeable CHW's that effectively function at a high independent role. Monthly meetings, meeting when there is a need or collaboration is needed.
• Weekly program meetings, individual level consult with employee, spreadsheets for tracking client progress and provider outreach, using goals to guide weekly/monthly employee activities, peer networking/resource sharing, building direct partnerships with key providers/systems/resources.
• Being open, listening to their experiences/viewing them as the expert in their work with families in combination with the need to be accountable for funders, your time, programmatic expectations, etc.
• Having an open door policy, good communication and knowledge of the communities that the CHWs are working within to help assist as needed.
• Be flexible, have open communication and multiple avenues for doing so, provide them with the tools they need, be consistent
• Good communication / Multidisciplinary approach / Written processes to clarify needs
• Understand the life experiences of CHWs. Provide clear guidance on setting boundaries. Offer frequent feedback. Always be constructive. Set high expectations. Be aware of micro-aggressions; differentiate between intentions and impact. • Respect, patience, kindness, open mind to suggestions; CHWS work very independently and reach out as needed, and as any concern arises.

Support

(N=9)

Supervisor & Organizational Training

(N=3)

Community Knowledge & Engagement

(N=3)

• CHWs need ongoing support. CHWs need to feel heard and their concerns should be addressed. CHW work, much like social work, can be draining and, without the opportunity for self-care, can cause burnout.
• Availability, supportive within scope of service, EMR which supports data driven decision making.
• Making CHW's feel valued as well as their work. • Address stress and burn-out.
• Promote their status as CHWs who have their pulse on the community and can thus bring greater understanding of the patient to the rest of the care team.
• Strength based, resilience, coaching and mentoring • Understanding of secondary trauma, focus on employee strengths.
• Utilize strengths perspective and coaching approach. • Be willing to get in the trenches with CHW if/when needed.
• Need to understand what programs we should partner with and be trained to be a part of i.e. MIAPP, MI Bridges, ACA Marketplace, etc.
• Prior Public Health Supervision Training
• There needs to be education throughout the organization on what the responsibilities of a CHW are. If this was more widely understood there could be more indirect supervision vs. formal supervision.
• Understanding the cultural norms of the community that the CHWs are servicing.
• Knowledge and continuous community interactions and engagement, participate in community meetings, serve on various community committees, continuous education and grant funding to support other programs and initiatives.
• Community engagement
Not identified in 2016

Not identified in 2016

- Keeping current with the changes resources of the community
- Broad based knowledge of public health and community resources.
- Understanding community needs

Consistency

(N=3)

Respect

(N=3)

Flexibility

(N=3)

Evaluation

(N=2)

CHW Training & Education

(N=2)
• Roles are defined.
• Clear expectations for their job.
• Understanding role and scope of work for CHWs, having protocols in place that defines roles and expectations

• CHWs are extremely knowledgeable in their field and well respected in their community. They should be respected in their professional setting as well.
• Grace. Awareness of other approaches to decision making.
• Respecting them [CHWs] as people, not just employees. • Flexibility, understanding of barriers to resources, being able to be flexible in management style of remote staff, being able to travel with CHW in the field.
• Flexibility… trusting relationships with the CHWs. • Flexibility; autonomy of CHWs.
• Implement process for evaluating work that is being done inside and outside of the office.
• Regular performance reviews, which in turn requires method of monitoring performance that is user-friendly. Supervision of CHWs improved considerably once we established a data-reporting system within Quickbase that was easy to use for CHWs and allowed for easy monitoring of productivity and performance.
• We had our employees take the CHW training so the agency can bill in the future. Supervision has essentially not changed since staff have become CHW trained. This may change when we start billing.
• Having clear guidelines, understanding scopes of service and specifying targets
• Clear expectations, structure and organization, availability of supervisor, frequent feedback, supportive team environment
• Regular reflective supervision with each CHW on an individual basis.
• Time to meet and discuss work including problem solving and solutions to dilemmas

Not identified in 2016

Not identified in 2016

Not identified in 2016

• Complete and customized training at our Agency • I seek out free educational or training opportunities for staff to attend. I encourage participation in MiCHWA.

Team Work (N=2)
• Provide ongoing education for CHWs so that they become proficient in their roles. Provide CHWs opportunity to practice the techniques needed to perform effectively.
• Importance of Teamwork and Accountability. • Conduct regular team-building opportunities.
• Good teamwork and group goals • Stressing the importance of team work

Experience (N=1)

Other
(N=1)
• Those in supervisory roles having experience as a CHW. • Outreach experience is essential for a supervisor • Experience having been a CHW. Understanding of public health issues and barriers to health care. Being able to be a mentor and developing employees, especially since we only require a high school diploma.

• To make sure of evidence base • Supervisors have to be able to balance the financial needs of the program as a whole against the needs of clients.
And they have to be able to motivate the CHWs because their jobs are very difficult.
• Flexibility and the ability to delegate and lead by example. CHW's jobs are community and field based and a supervisor should set an
• example of the standards that they expect the CHW's to abide by (timeliness, trustworthy, accountable etc.).
• Having the right fit, good relationship between the CHW and supervisor
• Use a coaching model - Ask how, why, etc.
• Allow self-initiative
*Note: all response are verbatim from the original survey; identifying information has been removed

Appendix C: Changes Since 2014

In 2014 there were 37 respondents, 55 in 2016, and 44 in 2018. Across all years, most organizations responding to the survey identified themselves as community-based organizations and federally qualified health centers. There has also been consistency in where CHWs deliver services, with the most common locations being in client homes across all years. Overall, there has been a dramatic increase in the number of counties CHWs serve in Michigan from 11 (13%) in 2014 to 62 (74.7%) in 2018.

The majority of organizations employ CHWs in full time positions. There were a total of 459 full time CHWs and 26 part-time employees in 2018, which is an increase from 2014 when 301 CHWs were reported in the state. Since 2014, there has been a steady growth in number of CHWs reported per organization with 9.7 in 2014, 10.2, and 11.5 this year. Across all years, CHWs have consistently served primarily adults and young adults with the majority serving racially diverse populations.

Salaries have also increased over the years. In 2014, the most commonly reported hourly rate was $12 per hour or an annual range between $25,000-$58,000. In 2018, the hourly rate increased to $15.92 per hour or an average of $35,490 (range $21,000 to $46,00) per year.

CHW education requirements have also increased steadily since 2014, with the large majority of organizations requiring a high school diploma or GED (77.3%, up from 59% in 2014 and 65.5% in 2016). Other requirements include core competency-based training after the point of hire. In 2016, 37.8% of organizations required MiCHWA training (no details about whether it was required before or after hire). In 2018 11.4% of organizations required MiCHWA training before hiring CHWs and 68.2% required MiCHWA training (68.2%). Background checks have consistently been required across all years. Notably,

when asked about sustainability issues, 27.3% cited finding qualified CHWs as a challenge.

Since 2016, when asked about supervision, most CHWs are supervised by social workers or registered nurses. Across all years, nurses were the most common CHW supervisors; however, in 2018 there was a wide variety of additional supervision qualifications. Qualitative responses about essential practices for supervision also shifted between 2016 and 2018. While communication was a common theme in both years, new themes emerged in 2018, including support, and formal supervisor training. Additional categories not previously included in 2016 included respect, flexibility, and evaluation.

While diminishing somewhat, funding uncertainty continues to be a major challenge to CHW sustainability across years. In 2014, 91% of respondents noted funding as a barrier. In 2016, 87% of respondents cited funding as a challenge. This year, 77.3% cited funding as a challenge. Funding mechanisms have shifted slightly with 50% of organizations reporting state funding in 2016 to only 36.7% reporting state grants (the majority reported federal grants in 2018). More programs also reported funding through private foundations in 2018 compared to 2016 (34.1% vs. 25.0%). In 2016, 26.4% of organizations were reimbursed by an insurer or other payer compared to 2018 where 34.1% of organizations reported being reimbursed by an insurer.

Qualitative responses about why organizations employ CHWs shifted from 2016 to 2018. Common themes across both years was the CHW's experience with client populations and communities, ability to address social determinants of health, and cultural competence. New responses in 2018 included a strong focus on CHW's effectiveness, ability to improve health outcomes, and ability to connect to communities through service and outreach. These qualitative changes may indicate an important shift in how CHWs are perceived by organizations throughout the state, possibly demonstrating a better understanding of the role CHWs have in care teams.

2014 2016 2018

What type of agencies employ CHWs in Michigan and where are they located?

What functions do CHWs serve in Michigan?

• The 37 programs represented in this survey were found in 11 Michigan counties. • About one-third of programs (n=12, 32%) were located in Wayne County, which includes Detroit. The next largest number of programs were found in Kent County (n=9, 24%), which includes Grand Rapids and Washtenaw

County (n=9, 14%), which includes the Ann Arbor/Ypsilanti area. • The majority of agencies self-identified as community-based service providers (n=23, 62%). The most common services agencies provide to clients include case management (n=23, 64%), individual and family services (n=22, 61%), social advocacy (n=18, 49%), primary care (n=17, 47%), and psychological services (n=16, 44%).

• The majority of programs who took the survey (71%) had between 0-10 CHWs in their programs with an average of 9.7 CHWs (SD=10, range 1-40).
• Respondents reported the following major themes about what their CHW programs do: provide social interaction, system navigation including outreach and enrollment, prevention work, care coordination and care management, research, address health disparities, and provide patient education. Providing
• The largest number of employers report CHWs serving in urban areas (n=41, 74.5%).
• The most frequent locations for CHW service delivery were client's home (n=41, 74.5%) and the agency location (n=39, 70.9%).
• Employers most frequently identified themselves as community-based organizations (n=14, 25.5%), federally qualified health centers (n=14, 25.5%), hospital/medical clinics (n=9, 16.4%) government agency (n=7, 12.7%), and health insurance plan (n=6, 10.9%).

• The most frequently reported races/ethnic groups served were black (n=51, 92.7%) and white (n=51, 92.7%). • Most agencies serve adults ages 26-64 (n=50, 90.9%) and young adults ages 19- 25 (n=42, 76.4%).
• The special populations most frequently identified that CHWs serve include individuals without a medical home or primary care provider (n=37, 67.3%), homeless (n=35, 63.6%), uninsured (n=35, 63.6%), frequent ED users (n=33, 60.0%),
• At least 44 organizations employ CHWs in Michigan. This is likely an underestimate since not all CHW employing organizations responded to the survey.
• CHW organizations reported 91 programs serving 62 unique counties in Michigan. Kent (13), Wayne (6), Newago (5) were the counties with the most CHW programs reported by participants.
• Over half of CHW programs are located in community-based organizations (27.3%) and federally qualified health centers (25.0%).
• Most CHWs are employed full time (93.2%) with an average of 11.5 CHWs per agency.
• In total, there were 485 CHWs represented in the survey with 459 full time and 26 part-time CHWs.
• The average number of clients per year served by CHW organizations was 1,211 with a median number of 430 clients.
• The average caseload for an individual CHW was 57 clients per year with a median number of 42 cases per year.
• CHWs work with diverse populations, which primarily include black (90.9%), Hispanic/Latino (90.9%) and white individuals (84.1%). Most often CHWs are working with adults (88.6%) and young adults (86.4%).

social/emotional support and addressing the social determinants of health were highlighted by many.
• Primary reasons for employing CHWs included: their ability to engage and establish trust in community, their work as "cultural brokers," first-hand knowledge of the program, cost effectiveness and sustainability, funding requirements, and demonstrated effectiveness.
• CHW programs (n=31) reported a total of 301 full-time, part-time, and volunteer CHWs.
• The majority of respondents (n=22, 63%) selected "Community Health Worker" as the title used for CHWs in their programs. • Over half of programs reported addressing major health issues that include diabetes, nutrition, obesity, heart disease, and physical activity.
• Over half of programs reported addressing social issues including connecting to resources and food security; almost half of programs also reported addressing housing, employment, and education assistance.
• The majority of CHW programs work with uninsured populations (n=19, 68%) and individuals without medical home/primary care providers (n=18, 64%); half of the agencies work with pregnant women and infants (n=14, 50%).
• The most frequently reported hourly rate was $12 (n=9), with an hourly range of $10-
and pregnant women/infants (n=32, 58.2%).
• Employers report CHWs address social issues that include connecting to resources (n=51, 92.7%), connecting to medical home/PCP (n=46, 83.6%), health services (n=46, 83.6%), food security (n=45, 81.8%), transportation (n=45, 81.8%), establishing/maintaining health insurance (n=42, 76.4%), human services (n=41, 74.5%), and housing (n=40, 72.7%). • Most CHWs work in multidisciplinary teams (n=42, 74%) which include social workers/behavioral health specialists (n=37, 88.1%) and registered nurses (n=37, 88.1%).
• The majority of agencies employ full time CHWS (85.2%). The average organization employs 10.2 CHWs (SD=21.4).
• Most organizations report that their CHWs serve large numbers of clients. This is an overall annual organization average for clients served by CHWs, distinct from average CHW caseload. More than 85% of organizations reported that their CHWs serve more than 100 clients, including 30.9% of organizations serving 101-500 clients, 25.4% serving 500-1000 clients and 30.9% serving more than 1000 clients. At any given time, the average caseload for CHWs per year is 41-60 clients (n=15, 28.3%).
• Special populations include uninsured (79.5%) and homeless clients (75%) and individuals who do not have a medical home/primary care provider (68.2%).
• Specific health issues addressed include: health literacy, nutrition, physical activity, oral health, diabetes, and hypertension.
• The most commonly-cited roles included: conducting outreach (81.1%), providing coaching and social support (79.5%), and advocating for individuals and communities (79.5%).
• CHWs go deep into communities to reach clients, with 7 in 10 delivering services in clients' homes. Other
common service sites included shelters (39.6%), health centers (39.6%), public housing units (36.4%), private clinics or medical practices (36.4%), and schools (36.4%).
• Service delivery occurs most often in one-on-one meetings that take place in person (95.5%) or via telephone
(81.8%).

Who are CHWs in Michigan, in terms of education, training, and demographics?

How are CHWs trained in Michigan?

$28. Annual salaries ranged from $25,000- $58,000. CHW benefits include sick leave (n=23, 89%), health insurance (n=23, 89%), mileage reimbursement (n=22, 85%), personal leave (n=22, 85%), and vacation accrual (n=21, 80%).

• About two-thirds of programs (68%) indicated that they have sufficient resources for CHW supervision.

• The majority of programs reported that they require CHWs to have a minimum of high school diploma/GED (n=19, 59%). A majority (n=13, 77%) of programs did not require that CHWs have prior health related experience.

• Virtually all programs offer program specific training for their CHWs (n=30, 97%). Most programs (n=27, 82%) also offer competency-based training for their CHWs, which was led by a variety of academic, state, and not-for-profit organizations.

• The majority of programs (n=24, 80%) do not require continuing education for their CHWs.
• Ninety percent of respondents indicated an interest in learning more about continuing education.
• Most employers report Community Health Worker as the title for CHWs in their agency (n=38, 69.1%).
• The majority of employers report requiring a high school diploma or GED for CHWs in their agency (n=36, 65.5%). • Other CHW employment requirements included a background check (n=50, 90.9%) and ability to read and write in English (n=48, 87.3%).
• Preferred requirements for CHW employees include prior community experience (n=39, 70.9%) and prior experience with the target population (n=36, 65.5%).
• Most employers do not have a specific minimum requirement for years of experience (n=30, 54.5%).

• Most employers do not require CHW training prior to hire (n=32, 86.5%). • Nearly half of the respondents report that their CHWs had completed the MiCHWA CHW training (n=21, 38.9%) or
• Most organizations required a high school diploma or GED prior to hiring (77.3%). Other common requirements include the ability to read and write in English (90.9%) and receiving a background check (85.4%).
• Most agencies did not have specific requirements for desired minimum years of experience (54.5%).

• Respondents reported that on average, 2.7 CHWs from their organization will need core competency-based training over the next year (range: 0-19). Most programs do not currently require any training prior to hiring CHWs (75.0%).

How do

agencies

support CHW employment?

• Over half (n=17, 52%) of CHW programs were funded through federal agency grants with current support ranging from 6 months to 5 years.
were currently taking part in the training (n=6, 11.1%).

• Most CHWs are paid by salary (n=36, 66.7%) with the majority being paid $40,000-$45,000 per year. Of those who are paid hourly (n=14, 25.9%), the majority receive $15-$20 per hour. • The majority of CHWs are eligible for compensation increases (n=42, 82.9%). • The most common CHW employee benefits include health insurance (n=45, 81.8%), mileage reimbursement (n=45, 81.8%), personal leave (n=38, 69.1%), sick leave (n=38, 69.1%), vacation accrual (n=38, 69.1%), and pension/retirement plan (n=30, 54.5%).
• Most CHWs are supervised by nurses (n=29, 55.8%) or social workers/behavioral health specialists (n=24, 46.2%).
• The most frequent challenges for supervision include CHWs being in different locations than their supervisors (n=19, 45.2%), more supervisory guidelines are needed (n=12, 28.6%), and not enough time for supervision (n=11, 26.2%).
However, most require MiCHWA CHW training while employed as a CHW (68.2%).
• Most programs indicted that their CHWs work as part of a multidisciplinary team (52.3%). Of those that indicated working on a multidisciplinary team, most worked with social workers/behavioral health specialists (70.5%) or registered nurses (59.1%).
• CHWs are most often compensated on an hourly basis (79.2%) with the average rate of $15.92 per hour. Of those that receive a salary, the average compensation was $35,490.
• Additional benefits include pay raises and an increase in compensation (86.4%), which are determined through annual performance reviews or yearly evaluations.
• Most CHW supervisor spend 25-50% of their time supervising CHWs. Training for supervisors occurred for less than half of supervisors (45.5%). Specific challenges in supervision included: CHWs being located in different places than their supervisor (40.9%), more guidelines needed (22.7%), and not enough time for supervision (22.7%).
• Essential CHW supervision practices included communication and general support. Specific types of communication strategies include: clear expectations about the roles, frequent

To what extent and how are CHW positions sustained in Michigan?

• The largest reported barrier to sustaining CHWs in the program was funding uncertainty (n=26, 87%).
• In order to increase CHW sustainability, most programs provided ongoing support or training for CHWs (n=29, 91%) and professional development for the CHWs (n=21, 66%).
• CHWs are primarily funded by state grants (n=26, 50.0%) or federal grants (n=20, 38.5%).
• Health plan contracts fund CHWs from 17.3% (n=9) of organizations.
• To-date, fewer than 20% of organizations report funding CHWs from self-generated revenue or agency general funds (n=7, 13.5%). CHWs are not typically reimbursed by insurers (n=39, 73.6%).
• Of the 14 organizations reporting that their CHW services are at least partially reimbursed by insurer/payers, the most common payer is Medicaid and/or Medicaid Managed Care (n=9, 64.3%). • The top three CHW sustainability concerns for agencies are funding uncertainty (n=41, 80.4%), finding qualified CHWs (n=27, 52.9% and staff turnover (n=20, n-39.2%).

contact, and integrated meetings. Support strategies included: promoting self-care by addressing burn out and stress, strength-based coaching, and mentoring.
• Michigan has a diverse set of grant based funding mechanisms for CHWs, including federal grants (47.7%), state grants (36.4%), and private foundation grants (31.8%).
• Just over one-third of CHW services are reimbursed by insurers or other payers (34.1%). Of those that are reimbursed, the majority are reimbursed by
Medicaid managed care (22.7%). • Common challenges reported were: funding uncertainty (77.3%), staff turnover (34.1%), and finding qualified CHWs (27.3%).

How do CHWs contribute to evidence based lifestyle?

Not asked • Personal Action Toward Health (PATH) (n=17, 30.9%) and Diabetes PATH (n=17, 30.9%) are the two most common
programs where CHWs are trained as
leaders.
• Of those trained in PATH, 30.8% (n=17)
are currently serving as leaders or co
Most programs did not have CHWS who were trained as leaders of evidence-based lifestyle programs (n=25, 56.8%) and most were not currently serving as leaders or co leaders of programs (68.2%). PATH (n=8, 18.2%) and Chronic PATH were the most

leaders; of those working in Diabetes PATH, 20.0% (n=11) are currently serving as leaders or co-leaders. commonly cited evidence-based lifestyle programs that CHWs lead.

Appendix D: Survey Instrument

2018 MiCHWA CHW Employer Survey Date extended to Friday, March 30th!

The Michigan Health Worker Alliance (MiCHWA), in partnership with the Michigan Department of Health & Human Services (MDHHS) with funding from the Centers for Disease Control and Prevention (CDC) is conducting its third biennial Community Health Worker (CHW) Employer Survey. The survey goal is to provide updated information about the current CHW workforce and employment environment to shape our CHW policy and financing agenda in Michigan. The survey will provide crucial data to help state and local officials, health and human service organizations and payers and CHW employers to better understand the growing CHW workforce and CHW activities statewide.

Participation in this survey is voluntary. However, complete responses will increase the validity and

value of the survey data. We estimate that the survey will take approximately 25 minutes to complete.
We request that one person per employer organization complete this survey. If your organization has multiple CHW programs, we ask that the respondent answer for your organization as a whole and include all programs in a single response.

IMPORTANT NOTE: Our online survey (Qualtrics) does not allow saving and returning to the survey. Therefore, we have emailed you a copy of the survey and strongly recommend you print it out and gather the survey responses in advance of electronic completion as you will likely need to refer to your administrative staff or organization records to retrieve the necessary information. This should also speed survey completion.

Specific agency names and contact information will be removed from results and will not be associated with summarized data. Survey participants who request follow-up information will receive requested information. All participants will be notified when summarized results are available. Please contact Program Director Priscilla Hohmann at phohmann@umich.edu or call 734- 998-6042, if you have questions. This survey was granted exempt from review status by the University of Michigan Institutional Review Board.

The survey now closes on Friday, March 30th, 2018. Take the survey here.

Why this survey? Why now?

The survey is designed to answer questions such as:

- Who are CHWs in Michigan serving, and what issues are they addressing?
- What criteria are used by CHW employers to refer people to CHW services?
- What roles and functions do CHWs serve in Michigan?
- Who are CHWs in Michigan, in terms of education, training, and demographics?
- How are CHWs trained in Michigan? What are their training needs?
- How do employing organizations support CHW employment and professional development?
- Who supervises CHWs in Michigan, and what are their challenges and needs?
- How are CHW positions financed and otherwise sustained in Michigan?

- How do CHWs contribute to evidence-based lifestyle change programs?
- How have the responses to these questions changed since 2014 and 2016?

SECTION 0: SCREENING

This survey is to be completed by one person from your organization who is most knowledgeable about CHWs in your organization.

1. **Does your organization currently employ at least one CHW?**
   - **Yes** (please take to the rest of the survey)

- **No** (Your organization is not eligible to complete the survey. If your organization only contracts for CHW services, please forward the link to the person most knowledgeable about CHWs in each of the organizations with whom you contract. (Include updated link to survey here.)

SECTION 1: Organization Information

2. **What is the name of your organization?**

3. **What is your organization type?** (Choose the **one type** that most applies)
   - Academia/Research
   - Advocacy group
   - Community-based organization
   - Federally qualified health center (FQHC)
   - Community health center (Not FQHC)
   - Medical practice
   - Hospital/Medical clinic (Not FQHC)
   - Health insurance plan
   - Local health department
   - Government organization (not local health department)
   - IHS/Tribal organization
   - Other (Please specify)

4. **How many CHWs does your organization employ for each of the following**? (Please write in the number of CHWs for each type of employment.)
   - Full-time Paid (30-40 hours a week): _____
   - Full-time Volunteer: _____
   - Part-time Paid (less than 30 hours a week) _____
   - Part-time Volunteer: _____

SECTION 2: CHW DELIVERY OF SERVICES

5. **In what county or counties do the CHWs that you employ deliver services?** (Check **all** that apply)

Alcona Cheboygan Houghton Lenawee Muskegon Sanilac Alger Chippewa Huron Livingston Newaygo Schoolcraft Allegan Clare Ingham Luce Oakland Shiawassee Alpena Clinton Ionia Mackinac Oceana Tuscola Antrim Crawford Iosco Macomb Ogemaw Van Buren Arenac Delta Iron Manistee Ontonagon Washtenaw Baraga Dickinson Isabella Marquette Osceola Wayne Barry Eaton Jackson Mason Oscoda Wexford Bay Emmet Kalamazoo Mecosta Otsego
Benzie Genesee Kalkaska Menominee Ottawa

Berrien Gladwin Kent Midland Presque Isle Branch Gogebic Keweenaw Missaukee
Roscommon Calhoun Grand Traverse Lake Monroe Saginaw
Cass Gratiot Lapeer Montcalm St. Clair
Charlevoix Hillsdale Leelanau Montmorency St. Joseph

6. **How many CHWs that you employ are delivering services in each of the chosen counties listed above?** (*List separately for each county.)*

a**. What health issues do CHWs that you employ address in each county?** (Check each health issue listed below that the CHWs that you employ address, identifying which county for each health issue.)

- Heart disease
- Hypertension
- Diabetes
- Nutrition
- Physical Activity
- Obesity
- Cancer
- Asthma
- Mental/Behavioral health
- HIV/AIDS
- Infant mortality
- Maternal/Child Health
- Health Literacy
- Oral health
- Other (Please specify)

b. What other issues do CHWs that you employ address in county X? (Check each issue listed below that the CHWs that you employ address, identifying which county for each issue.)

- Connecting to resources

- Housing
- Employment
- Food Security
- Education
- Income
- Transportation
- Establishing/maintaining health insurance
- Immunizations
- Connecting to a medical home and/or primary care provider
- Human services
- Health services
- Other (Please specify)

7. How many different CHW programs does your organization have?

8. For each CHW program, what criteria does your organization use to refer people to CHW services? If you have more than one program, answer the question for each program, numbering each program

separately. (Free response)

EG: Program 1: Criteria: _____

Program 2: Criteria _____

SECTION 3: POPULATIONS SERVED

Which population(s) do CHWs that your organization employs serve? *(If your organization has multiple CHW programs or multiple populations served by different CHWS, include all populations served by CHWs employed by your organization)*

9. Race/ethnicity (if applicable) (Check **all** that apply)
- Black or African American
- American Indian and Alaska Native
- Asian
- Native Hawaiian and Other Pacific Islander
- White
- Hispanic or Latino
- Arab American/Middle Eastern Descent
- Other: (Please specify)

10. Age groups (Check **all** that apply)
- Children (0-5)
- Youth (6-18)
- Young adults (19-25)
- Adults (26-64)
- Seniors (65+)

11. Special populations (Check **all** that apply)
- Pregnant women and infants

- Immigrants
- Migrant workers
- Isolated rural residents
- Homeless
- Uninsured
- Frequent ED users
- Individuals without a medical home/primary care provider
- Other (Please specify)

12. **What is the total number of individual clients/patients served in 2017 by all the CHWs employed by your organization?** *(Free response)*

13. **What is the average client/patient caseload per CHW employed by your organization? If this is not applicable to your CHWs, please pick N/A.** *(Please respond with the average caseload at*

*any given time; **not** total clients per year) (Free response)*

14. **Please indicate how many of the CHWs employed by your organization regularly work on a multidisciplinary health care team?**

- None
- Some
- All

If some or all, who else works on the multidisciplinary team with the CHWs regularly employed by your organization? (Check all that apply)

- Primary Care Provider (physician, nurse practitioner, physician assistant)
- Registered Nurse
- Social Worker/Behavioral Health Specialist
- Dietitian/Nutritionist
- Case Manager
- Medical Assistants
- Other CHWs
- Other: (Please specify)

15**. What roles do CHWs play in your organization?** *(Qualtrics will be formatted so respondents will check off sub-roles by category. We will code role on the back end of analysis.)*

Role	**Sub-Roles**
Cultural Mediation among Individuals, Communities, and Health and Social Service Systems	a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate) b. Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication

Providing Culturally Appropriate Health Education and Information	
	Advocating for Individuals and Communities
Care Coordination, Case Management, and System Navigation	
	Building Individual and Community Capacity
	Providing Direct Service
Providing Coaching and Social Support	
	Implementing Individual and Community

Assessments a. Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease) a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping to address other barriers to services d. Documenting and tracking individual and population level data e. Informing people and systems about community assets and challenges a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (including chronic disease) d. Planning and/or leading support groups	a. Advocating for the needs and perspectives of communities b. Connecting to resources and advocating for basic needs (e.g. food and housing) c. Conducting policy advocacy a. Building individual capacity b. Building community capacity c. Training and building individual capacity with CHW peers and among groups of CHWs a. Providing basic screening tests (e.g. heights & weights, blood pressure) b. Providing basic services (e.g. first aid, diabetic foot checks) c. Meeting basic needs (e.g., direct provision of food and other resources) a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environmental assessment) b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)
Conducting Outreach	a. Case-finding/recruitment of individuals, families, and community groups to services and systems b. Follow-up on health and social service encounters with individuals, families, and community groups c. Home visiting to provide education, assessment, and social support d. Presenting at local agencies and community events

Participating in Evaluation and Research	a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community consent processes c. Participating in evaluation and research: i) *Identification of priority issues and evaluation/research questions* *ii) Development of evaluation/research design and methods* *iii) Data collection and interpretation* *iv) Sharing results and findings* *v) Engaging stakeholders to take action on findings*
Other	

16. Where do CHWs employed by your organization deliver services? (Check all that apply)

- CHW program's location
- Client's home
- Client's work site
- Community events
- Private clinic or medical practice
- Community health center
- Free clinic
- Hospital
- Health maintenance organization
- Public housing unit
- School
- Migrant camp
- On the street
- Shelters
- Teen centers
- Other Non-profit organization
- Other: (Please specify)

17. How do CHWs employed by your organization deliver services? (Check **all** that apply)

- One-on-one meetings in person
- One-on-one meetings by telephone call
- One-on-one meeting through text message
- One-on-one through video communication, including FaceTime or Skype
- Group classes or sessions
- Email or other electronic communication
- Other: (Please specify)

SECTION 4: CHW CHARACTERISTICS & DEMOGRAPHICS

18. What are the job title or titles of CHWs employed by your organization? (Check **all** that apply)

- Advocate
- Certified Peer Support Specialist
- Recovery Coaches
- Community Health Advocate
- Community Health Outreach Worker
- Community Outreach Worker
- Community Health Worker
- Community Neighborhood Navigator
- Early Intervention Services (EIS) Worker
- Family Health Outreach Worker

- Health Aid
- Health Coach
- Lay Leader Lifestyle Coach
- Maternal Child Health Worker
- Outreach and Enrollment Worker
- Promotor/a
- Veteran liaison
- Volunteer veteran
- Other (Please Specify)

19. What educational requirement must CHWs meet to be hired by your organization?

- No specific education requirement
- High School Diploma/GED
- Some College
- Associate's Degree
- Bachelor's Degree
- Master's Degree
- PhD/MD

20. What language(s) must your CHWs be fluent in? (Please include all that apply.)

- English
- Spanish
- Portuguese
- Arabic
- Other (Please specify) _____

The following questions are related to hiring **PREFERENCES.** Please identify each of the following qualities as either *Not Required*, *Preferred*, or *Required*.

Not Required Preferred Required

21. Ability to read and write English Not Required Preferred Required

22. Prior health or healthcare related experience Preferred Required

23. Prior experience as a resident of the community they serve
Not Required Preferred Required Not Required

24. Prior experience working with the target population or community If yes, how many years of prior experience working with the community or target population(s) are required for the CHW position in your organization?
Not Required Preferred Required

- No specific year requirement
- Less than 1 year
- 1 year

• 2 years
• 3 years
• 4+ years

25. Background check prior to hire Not Required Preferred Required

26. Does your organization exclude employment of all CHWs with a criminal record if otherwise qualified?

• Yes
• No

SECTION 5: CHW TRAINING

27. Indicate what type(s) of CHW-specific training are required for CHWs *before* hire by your organization. Please select all that apply.

• Successful completion of the 126-hour MiCHWA CHW Core Competency-Based training program
• Other CHW Core Competency-Based training program (Please specify organization delivering it)
• Other CHW training: (Please specify type of training and organization delivering it) • None required

28. Indicate what types of CHW-specific training is required for CHWs *while employed* by your organization.

• Successful completion of the 126-hour MiCHWA CHW Core Competency-Based Training Program
• Other CHW Core Competency-Based Training Program (please specify organization delivering it)
• Other CHW Training: (Please specify type of training and organization delivering it) • Program-specific or organization-specific training for specific position. (Please describe) • None required

29. In the next 12 months, how many CHWs does your organization expect will need CHW core competency-based training? (Free response)

30. What topics would you be interested in having for CHW continuing education? *(Free response)*

SECTION 6: ORGANIZATION LEVEL SUPPORT

31. Are CHWs employed by your organization paid by an hourly rate or salary? •
Hourly rate
• Salary

If hourly, please enter *your hourly rate* for CHWs.

If salary, please enter your best estimate for CHW *salaries*.

32. Are CHWs employed by your organization eligible for pay raises or other increases in compensation?

- Yes
- No

How are CHW pay raises or other increases in compensation determined? *(Free response)*

33. Which of the following benefits do CHWs employed by your organization receive? (Check <u>all</u> that apply)

- ○ Child care
- ○ Commuter subsidy
- ○ Educational leave
- ○ Health insurance
- ○ Mileage reimbursement
- ○ Parking
- ○ Pension or retirement plan
- ○ Personal leave
- ○ Sick leave
- ○ Tuition assistance
- ○ Vacation accrual
- ○ Other: (Please specify)
- ○ None

SECTION 7: CHW SUPERVISION

34. How much FTE of supervisor's time is allocated to supervision of CHWs?

- ○ Less than 5%
- ○ 6-10 %
- ○ 11%-24%
- ○ 25-50%
- ○ 51% -99%
- ○ 100% Only job responsibility is supervision of CHW

35. What types of professionals supervise CHWs at your organization? (Check **<u>all</u>** that apply)

- ○ Primary Care Provider (physician, nurse practitioner, physician assistant) ○ Registered Nurse
- ○ Social Worker
- ○ Master of Public Health
- ○ Dietitian/Nutritionist
- ○ Senior-level or Lead CHWs

- Other: (Please specify)

36. Why were these CHW supervisors chosen? (Check **all** that apply)

- Experience in the field with CHWs
- Knowledge/skills had relevance to the goals and objectives of CHW services in your organization
- Experience with CHW programs, outreach programs, social programs, or health programs
- Strong supervisory experience
- Clinical expertise
- Background experience in social work, nursing, and/or public health
- Other: (Please specify)

37. Have the CHW supervisors at your organization received any kind of training specific to supervising CHWs?

- Yes
- No

If yes, what kind of CHW specific training have they received? (Free response)

38. What additional supports or continuing training would be valuable to your CHW supervisors?

- Group education or training with other CHW supervisors
- Training on supervision of CHWs
- Training on supervision in general
- Peer networking with other CHW supervisors
- Other: (Please specify)

39. Does your organization have sufficient resources for CHW supervision?

- Yes
- No

40. What are the challenges your organization faces in regards to CHW supervision?

- Not enough time for supervision
- CHW and supervisor have conflicting schedules
- CHWs are mobile/ located in different places than supervisor(s)
- More supervisory guidelines are needed
- Too many employees reporting to one supervisor
- Other: (Please specify)

41. In your experience, what are essential practices or strategies for supervising CHWS? These may be best practices in your organization or your personal perspective. *(Free Response*)

SECTION 8: CHW SUSTAINABILITY

42. Why does your organization employ CHWs? (Free response)

43. How are your CHWs funded? (Check **all** that apply)

- Federal organization/government grant(s)
- State organization/government grant(s)
- Local organization/government grant(s)
- Other public funding
- Health plan contracts
- Private foundation(s)
- Other Non-profit organization(s)
- Self-generated organization revenue
- Community benefit
- Internal competitive grant(s)
- General organization fund (not time-limited)
- Other (specify)

44. Are services provided by CHWs at this organization being reimbursed or paid for, in part or in full, by an insurer or other payer?

- Yes
- No

Please check all insurers or other payers that apply:

- State Children's Health Insurance Program (SCHIP)
- Medicaid Managed Care
- Other Medicaid (please specify)
- Medicare
- (Private) Health insurance
- Other (Please specify)

45. Do you have any contracts or agreements with Medicaid managed care organizations to pay for CHW services?

(Note: MiCHWA will not share any contract information, except de-identified in aggregate.)

- Yes
- No, but we are in discussions with one or more health plans

If yes, with which ones? (Check all that apply)

- Aetna Better Health of Michigan
- Blue Cross Complete of Michigan
- Harbor Health Plan
- HAP Midwest
- McLaren Health Plan

- Meridian Health Plan of Michigan
- Molina Healthcare of Michigan
- Priority Health Choice
- Total Health Care

• United HealthCare Community Plan
• Upper Peninsula Health Plan

46. What payment model(s) are being used to support the CHWs your organization employs?

(check all that apply) (*Checkboxes*)

• Per member per month payment for the CHW only
• Per member per month payment for the clinical care team, including the CHW • Outcomes-based or value-based payment forspecific health outcomes per member • Bundled payment for services, including those of the CHW
• Service-based payment
• Other (write in_____):

47. Has your organization been reimbursed for care coordination services provided by CHW using any of the following codes? (Check all that apply)

• CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
• CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge
• CPT Code 99490 – Chronic care management for a patient with multiple chronic conditions (at least 20 minutes of time spent with patient per month)
• CPT Code 99487 – Complex chronic care management for a patient with multiple chronic conditions (60 minutes of time spent with patient per month)
• 99489 – Each additional 30 minutes of time spent per month with patient on complex chronic care management services
• None of the above, our CHWs have not been reimbursed for care coordination services.

48. Is your organization using any OTHER specific billing codes to receive reimbursement for CHW services?

• No
• Yes (If yes, which codes? (Write in here: _____)

49. What are your organization's top <u>three</u> concerns when it comes to longevity and sustainability of CHW employment?

o Funding uncertainty
o Staff turnover
o Finding qualified CHWs
o Management support for CHWs
o Non-acceptance of CHW role by other team members
o Other (please specify)

50. How does your organization work to support and/or to promote CHWs and their long-term sustainability? (Check **<u>all</u>** that apply)

o Offering opportunities for CHW professional development (e.g., in-services/ trainings/

career path development)
- Providing education on the CHW role
- Working with health plan payers on contracts for CHW services
- Building a business case internally
- Other (Please specify)

SECTION 9: LIFESTYLE CHANGE PROGRAMS

51. Are any of the CHWs at your organization <u>currently trained</u> as leaders or master trainers of the following evidence-based lifestyle change program(s)? (Check **<u>all</u>** that apply) ○ Diabetes Prevention Program (DPP)
- Personal Action Toward Health (PATH)
- Chronic PATH
- Diabetes PATH
- Kidney PATH
- Tomando Control de su Salud
- Enhance Fitness
- Bodyworks
- Other: _____
- None

52. Have any of the CHWs at your organization served (or are currently serving) as leaders or co-leaders in the following evidence-based CHW program(s) in the past 12 months? (Check **<u>all</u>** that apply)
- Diabetes Prevention Program (DPP)
- Personal Action Toward Health (PATH)
- Chronic PATH
- Diabetes PATH
- Kidney PATH
- Tomando Control de su Salud
- Enhance Fitness
- Bodyworks
- Other: _____
- None

53. Would your organization like materials about any of the following programs or about how individuals can become leaders of these programs? (Check **<u>all</u>** that apply)
- Diabetes Prevention Program (DPP)
- Personal Action Toward Health (PATH)
- Chronic PATH
- Diabetes PATH
- Kidney PATH
- Tomando Control de su Salud
- Enhance Fitness

- Bodyworks
- Other: _____
- None

If you indicated interest in any of the above programs, please provide your contact information. Contact information provided below will not be associated with other survey responses or included on any survey reports.

- Name
- Program Name
- Email
- Phone Number

SECTION 10: FOLLOW-UP MATERIALS

MiCHWA members value supporting CHWs statewide. The following questions gauge your interest in a variety of CHW-related opportunities. If you are interested in any of the opportunities listed or would like someone to follow-up with you, please leave your information in the designated box. This information will be disconnected from the remaining part of the survey and not included with or associated with your responses.

54. What would you like to know about the CHW workforce in Michigan and/or nationally? • How CHW services are being financed
• Current status of CHW certification in Michigan
• What evidence exists for CHW impact
• How CHWs can serve on a health care team
• Other (Please specify)

55. Would you like more information about MiCHWA?
• Yes
• No

56. Would you be interested in learning more about the MiCHWA CHW core competency-based Training program, and/or continuing education opportunities for CHWs, including training events or other informational sessions?
• Yes
• No

57. Would you be interested in learning about MiCHWA's CHW Registry for CHWs and employer?
MiCHWA CHW Registry employer accounts provide employers with the opportunity to post jobs, search for CHW-related training, network with CHWs/CHW Employers/Training Organizations, and recruit potential job candidates. Employers pay a yearly fee for registry access and can purchase accounts for CHW staff.
• Yes
• Maybe; I would like to learn more about the registry.
• No

58. Are you interested in resources for CHW supervisors?

- Yes
- No

59. Would you be willing to provide a CHW job description that is used by your organization? MiCHWA is currently compiling a collection of CHW job descriptions. Any organization identifying information will be removed from the description before it is shared outside of MiCHWA staff. If yes, we will contact you for a copy.)

- Yes
- No

If you indicated that you would like more information about the CHW registry, supervisor resources, or follow-up materials, please provide your contact information and what information you'd like to receive. Contact information provided below will not be associated with other survey responses or included on any survey reports.

- Name
- Program Name
- Email
- Phone Number

60. Is there anything else you would like to share that would be helpful for MiCHWA to know? (*Free response.*)

SECTION 11: CLOSING REMARKS

Thank you for participating in the MiCHWA CHW Employer Survey. We appreciate your thoughtful responses as we learn more about CHWs in Michigan.

If you requested follow-up or materials, you will be contacted soon regarding these requests. All survey inquiries may be made to MiCHWA's Program Director, Priscilla Hohmann at info@michwa.org.

Learn more about MiCHWA and the MICHWA CHW Employer Surveys on our website: http://www.michwa.org/chw-employer-surveys/