MICHIGAN COMMUNITY HEALTH WORKER ALLIANCE

In coordination with the MiCHWA Evaluation Advisory Board

COMMUNITY HEALTH WORKER EMPLOYER SURVEY 2020: EVALUATION REPORT

October 1, 2020

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

SCHOOL OF SOCIAL WORK
PROGRAM EVALUATION GROUP
UNIVERSITY OF MICHIGAN

For questions about this report, please contact MiCHWA Executive Director Janée Tyus (*jtyus@michwa.org*) or email info@michwa.org.

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EVALUATION TEAM

MiCHWA's Evaluation Advisory Board oversaw the project and worked directly with the Survey Team, which included staff from MiCHWA[1] and the University of Michigan School of Social Work's Program Evaluation Group (PEG).[2] Report authors are designated with an asterisk (*).

MiCHWA Evaluation Advisory Board

Katie Commey, Michigan Department of Health and Human Services
Lynne Foucrier, Michigan Department of Health and Human Services
Laurie Gustafson, Henry Ford Health System
Deidre Hurse, Oakland University William Beaumont School of Medicine
* Mary Janevic, University of Michigan School of Public Health
* Edith C. Kieffer, University of Michigan School of Social Work
Shannon Lijewski, Everyday Life Consulting
Lori Noyer, Ingham Health Plan Corp.
*Caylin Rathburn-Smith, Michigan Community Health Worker Alliance
Melissa Riba, Center for Health Research and Transformation
Leeanne Roman, Michigan State University
Tiffany Stone, Michigan Association of Health Plans
Trevor Strzyzykowski, Michigan Public Health Institute
Kelly Strutz, Michigan State University
Clare Tanner, Michigan Public Health Institute
Monica Trevino, Michigan Public Health Institute
* Janée A. Tyus, Michigan Community Health Worker Alliance
Adrian Zeha, Michigan Department of Health and Human Services

Program Evaluation Group

* Kathryn Colasanti, University of Michigan School of Social Work Program Evaluation Group
* Hidaya Zeaiter, University of Michigan School of Social Work Program Evaluation Group

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

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

EXECUTIVE SUMMARY

Survey Background

MiCHWA has conducted CHW Employer surveys biennially since 2014, with funding support from the Michigan Department of Health and Human Services. The 2020 Community Health Worker Survey was open from May 1 to June 30, 2020 to all Michigan-based CHW programs that MiCHWA could identify. The final dataset included **53 CHW programs** from 47 organizations. Respondents were asked to **report data as of March 1, 2020** (prior to pandemic-related changes), except for a small set of COVID-19 specific open-ended questions.

CHW Locations

Respondents reported **at least one CHW program in 75 of Michigan's 83 counties**, compared to at least one CHW in 62 counties reported by the respondents to the 2018 survey. The largest number of programs served only one county (38%) and 89% served fewer than ten counties. The counties with the largest number of programs were Wayne (14 programs), Kent (10 programs), and Macomb (9 programs). The increase in the number of counties with CHW programs in 2020 appears to be influenced, in part, by the presence of CHWs hired or contracted by Medicaid Health Plans throughout the state.

CHW Roles

Among the 36 sub-roles of the ten core CHW roles specified by the Community Health Worker Core Consensus (C3) Project, survey results showed **CHWs working in an average of 23 sub-roles**. CHWs in all programs **connected clients to resources and advocated for basic needs** and **motivated and encouraged people to obtain care and other services.** The frequency of some sub-roles varies substantially between organization settings. For example, only 20% of responding health systems had CHWs engaged in building community capacity, whereas 100% of responding community-based organizations and Medicaid health plans had CHWs in this role.

Program Sustainability

Two-thirds of programs (65%) receive more than half of their funding from sources considered more sustainable by the Centers for Disease Control and Prevention (CDC). However, less sustainable funds are common: **Time-limited grants (regardless of source) were the most common source of funds (41%, *n* = 20).** The programs receiving time-limited funds relied on the time-limited sources for 77% of their funding. Many programs (65%) were **concerned with funding uncertainty**.

CHW Certification, Training, and Continuing Education

The top two strategies for promoting long-term program sustainability were **paying for CHWs to become certified** (76% of programs) and offering opportunities for CHW professional development (74%). CHW programs reported many benefits to CHW certification. Between 78% - 98% of programs agreed either completely or somewhat with each of ten different statements regarding the benefits of certification. **While only 10% of employers require the MiCHWA Core Competency-Based training before CHWs are hired, 78% require the training after hire.** Approximately half of programs (54%) require continuing education for their CHWs, in keeping with MiCHWA requirements for certification renewal. Six of these programs mentioned utilizing MiCHWA webinars to meet these expectations.

Changes in CHW Programs in Response to COVID-19

The most common change in response to the COVID-19 Pandemic, as of June 2020, was to CHW program service delivery mode: **37 programs increased telehealth services**. **Eight programs reduced**

client services because of the pandemic. On the other hand, **seven programs described responding to new client needs**, such as securing food or medication. Fifteen programs described changes in where CHWs deliver services, including **eight programs that ceased home visits** and six programs where CHWs began conducting porch drop-offs. Last, **three programs stated that CHWs were furloughed**.

Educational and Other Hiring Requirements

Most CHW programs (92%) required CHWs to have a **high school diploma or a GED**. Most employers also required that CHW read and write **English** (92%), pass a **background check** (92%), have a **driver's license** (88%), and **own a car** (65%). The percentage of programs requiring the MiCHWA Core-Competency-Based training after hire increased from 68% in 2018 to 78% in 2020.

CHW Earnings

CHW hourly rate earnings ranged from $12.00 - $27.00, with an **average minimum of $16.40 and an average maximum of $18.93**. County health plan organizations had the lowest average hourly minimum and maximum. Health departments offered the highest average hourly maximum.

CHW Supervisor Training

CHWs are supervised by people with a wide range of credentials and role titles. Most programs (74%) reported providing supervisors with **training on CHW roles and responsibilities** as well as social determinants of health (68%) and cultural competency (64%). Nine programs reported that supervisors do not receive any training specific to supervising CHWs. The most common challenge faced by supervisors was being located in a different place than CHWs (36%).

Evaluation, Monitoring, and Quality Improvement

Most programs (80%) **track the number and type of clients served** and over half of programs (53%) conduct satisfaction surveys or assessments with clients. While most programs (78%) reported **using a social determinants of health (SDOH) screening or assessment tool,** there was little consistency in the tools programs are using; the PRAPARE being the most common at 20% of programs. The majority of programs reported collecting data on indicators of general social support (82%) and of general health status (76%).

Survey Strengths and Limitations

This survey report has several strengths and limitations. Strengths include that **survey items have been refined over time**, cover a broad array of topics, and are designed to facilitate comparisons between states. Additionally, over 50 responses to the survey were received despite the fact that it was implemented during the first peak of the COVID-19 Pandemic in Michigan.

Limitations include the fact that we **do not know what proportion of all CHW programs in Michigan are represented in this data**, nor what types of respondent bias may be present. Furthermore, comparisons to 2018 or prior surveys are limited in this report due to changes in survey items over time as well as variance in the respondent pool.

Implications and Next Steps

The implications for MiCHWA from these findings include continuing to support CHW core-competency training, pursuing sustainable funding mechanisms for all CHW programs, and working toward more uniform evaluation indicators of CHW programs. This report will be disseminated widely and findings will later be shared through infographic summaries for specific stakeholders. The survey instrument will be refined for use in the 2022 survey.

SECTION 1: OVERVIEW

Survey Background

After a pilot survey in 2012, MiCHWA conducted the first full survey of employers and managers of CHWs programs in 2014 to gain a better understanding of CHWs and their programs, statewide. The MiCHWA Evaluation Advisory Board recommended that this survey be administered every two years to assess CHW program sustainability and identify CHW trends. This 2020 survey thus builds on previous editions of the survey administered in 2014, 2016, and 2018. While the core content areas have largely been consistent across these biennial surveys, specific items have changed with each wave based on evolving stakeholder needs and to improve the way key information is collected. All surveys have been supported by the Michigan Department of Health and Human Services, through 1815 and 1817 Centers for Disease Control and Prevention funding to state health departments.

Summary of Methods

Survey Instrument

The survey instrument was adapted from the 2018 CHW Employer Survey. In 2020, several new sections were added to the survey. For example, items were adapted from the Common Indicators survey[3] regarding program evaluation and monitoring. Items were also added regarding changes brought about by the COVID-19 Pandemic. In addition, we modified or expanded a number of previous items and/or response options. Similar surveys from several other states were reviewed in the survey development process and survey items assessing CHW employer beliefs about the value of CHW certification were derived from a survey conducted by the Massachusetts Department of Public Health.

The recommendations within the 2018 Survey report and input from the EAB were used to further modify the survey when needed. Thus, not all items are comparable between 2020 and 2018. Additionally, as had been done in 2016, the 2020 Survey was designed to be completed by each program supervisor/coordinator instead of the organization on behalf of all of its programs. After pilot-testing and subsequent modifications, the final survey consisted of 114 questions (96 close-ended questions and 18 open-ended questions), which could be completed over multiple sessions. Respondents were instructed to complete the entire survey reflecting their CHW program as of March 1, 2020 (pre-pandemic), unless otherwise specified. The survey was administered through Qualtrics © a web-based survey platform. See Appendix B for a copy of the instrument.

Survey Distribution

MiCHWA distributed this survey to organizations throughout Michigan that it had identified as likely to have Community Health Workers (CHWs) or CHW programs. To do this, MiCHWA reviewed and updated its 2018 survey distribution list, other MiCHWA lists of known CHW employing organizations, and lists of state and local health departments, Federally Qualified Health Centers, Area Agencies on Aging and Medicaid Health Plans. As a result, the 2020 distribution list included 168 people. A link to the electronic survey was distributed online to CHW program supervisors or, if unknown, to the organization directors through MiCHWA's existing mailing list. The 2020 Community Health Worker Employer Survey was open for completion from May 1 to June 30, 2020 and reminder notices were sent regularly.

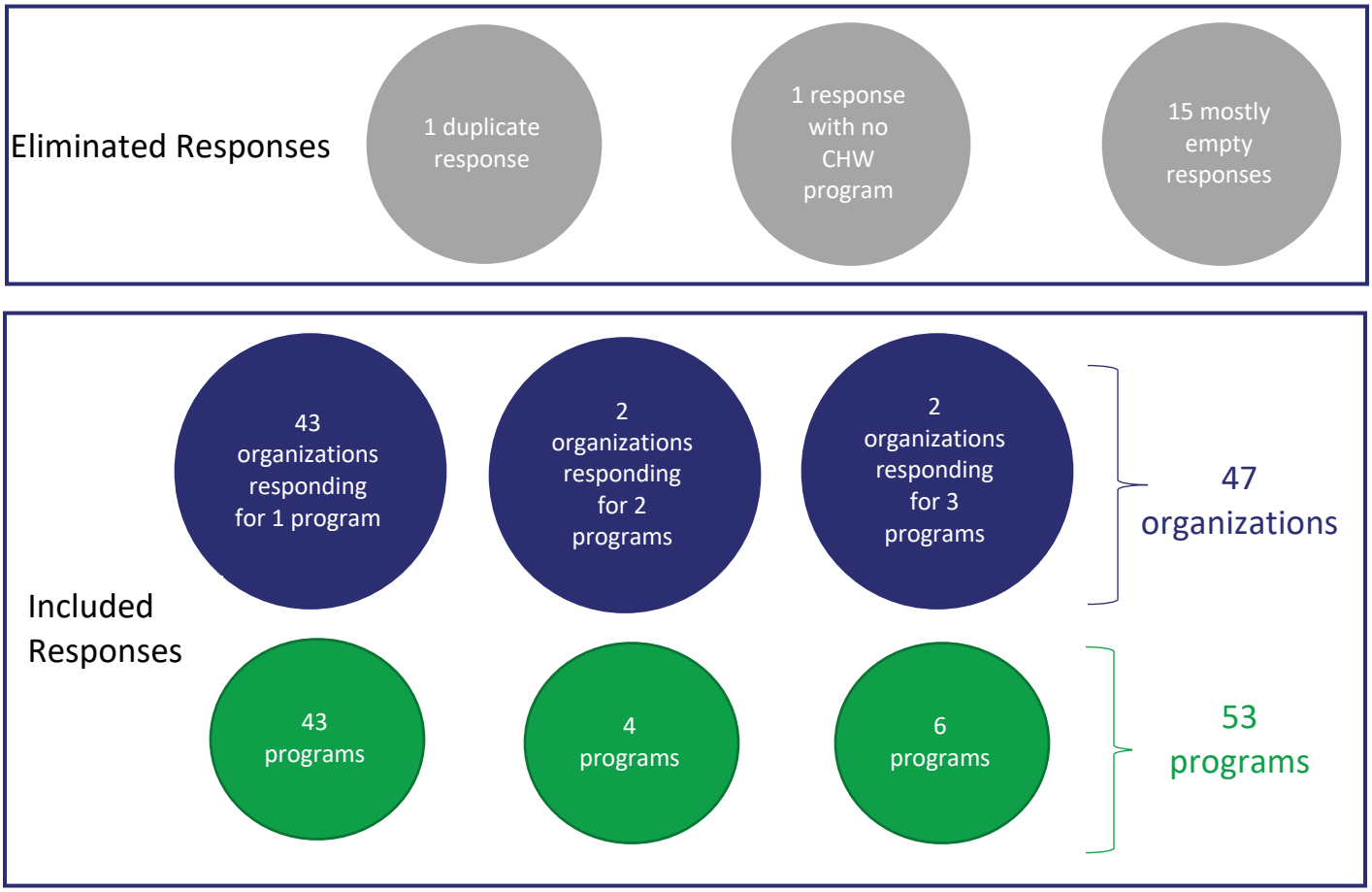
[3] See: https://www.michwa.org/wp-content/uploads/MiCHWA-2019-CHW-Common-Indicators-Survey-Report-07-22-2019.pdf

Survey Sample

Fifteen responses that had little usable data were excluded from the analysis. We also eliminated one duplicate response and one response from an organization that did not have a CHW program.

The final dataset included 47 organizations representing 53 programs (see Figure 1). Two organizations responded for two programs and two organizations responded for three programs. Of the 53 program responses, 49 were complete and 4 were partially complete. Therefore, the sample size (N) varies, and is reported by question. Because we do not know the total number of CHW programs in Michigan, we are unable to calculate what proportion responded to this survey; nor can we determine how representative the survey sample is of all CHW programs in the state. The survey attrition rate was 28% (of the 68 initiated responses, 19 were incomplete).

Figure 1. Summary of Data Sample



Analysis

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. Cross-tabulations were calculated for key variables of interest. A content analysis was performed on the open-ended responses to identify primary themes. Themes were reviewed independently by two evaluators to ensure a thorough analysis and minimize individual

bias. Differences between evaluators in the classification of themes were discussed until consensus was reached.

Quotations from open-ended responses are included throughout the report to help illuminate the perspective of CHW employers. Quotations were selected to illustrate a range of perspectives and opinions. The quotations do not necessarily represent the viewpoint of anyone beyond the individual respondent and should not be interpreted as themes. The quotations come primarily from the final set of survey questions which asked for any other comments on CHW training, employment, scope of practice, and funding/sustainability. For complete sets of quotations, organized by question, see Appendix A, Table 47, page 94.

Limitations

Comparisons to 2018 or prior surveys are limited in this report due to changes in survey items over time. These changes were made both to reflect new conditions and to make improvements in items and response options. Moreover, the group of programs responding varies somewhat with each survey wave, which could lead to differences in findings that reflect different sample compositions rather than genuine change over time. We are not able to track change within specific CHW programs over time. In 2020, some specific responses may have been influenced by the COVID-19 Pandemic, although we asked respondents to answer most items based on the pre-pandemic status of their program, estimated to be March 1, 2020. Nonetheless, where items are the same or very similar to 2018, we have included some comparisons with that wave, which should be interpreted in light of the caveats mentioned above.

Because a definitive, comprehensive list of CHW programs in Michigan does not exist, we do not know what proportion of all CHW programs in Michigan are represented in this data, nor what types of respondent bias may be present. Some counties with known CHW presence are not reflected in the data since some known employers did not respond to the survey. For the same reason, any estimate of the total number of CHWs in Michigan represents a lower bound on the true number. Furthermore, the fact that the survey was fielded during the first peak of the COVID-19 pandemic and the shelter-in-place period, the response rate was almost certainly lower than it would have been otherwise.

Because of a programming error, we are unable to provide a post-pandemic estimate of the number of CHWs employed by CHW programs. Three responding programs indicated that they had furloughed or laid off CHWs in an open-ended question. This may be an underestimate. Additionally, we have anecdotal evidence that other CHW programs that did not respond to the survey had also furloughed CHWs.

Strengths

This survey also has a number of strengths. Survey items have been refined over time and were further pilot-tested to elicit accurate data. We were able to obtain over 50 responses to the survey, though it was implemented during a strict shelter-in-place period at the first peak of the COVID-19 Pandemic in Michigan, when many CHW employers were experiencing severe disruptions. We gathered information about a broad array of topics, making survey data useful to multiple stakeholders. Finally, some of our items were similar or the same as on CHW program surveys in other states, facilitating between-state comparisons.

SECTION 2: RESULTS

RESULTS: CHW EMPLOYERS

Number of CHW Programs and Program Duration

Respondents were asked to report the number of CHW programs run by their organization. A total of 43 organizations[4] reported that their organizations have a total of 78 CHW programs, not all of which are represented in the survey.[5] The **majority of responding organizations (77%, *n* =33) reported having a single CHW program.** The total number of CHW programs reported per organization ranged from one to nine. Although we sought separate responses from each program, these results indicate that not all programs are represented in the survey results. On average, employers had employed CHWs for 6.4 years, with a range of 9 months to 25 years.

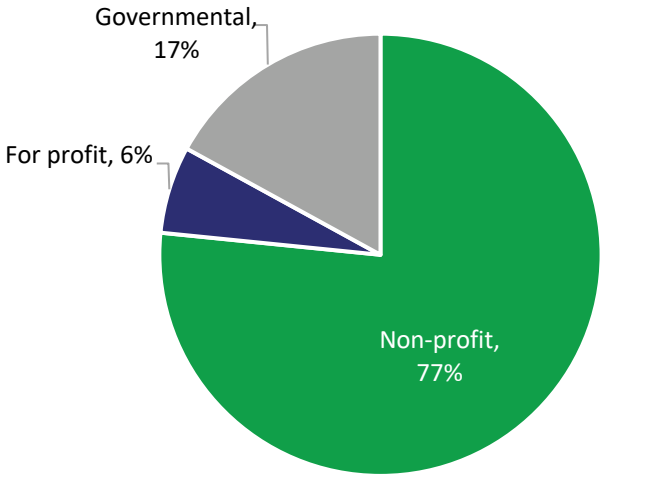
Six organizations indicated that they had CHW programs that are no longer active. Of these, one organization indicated that the programs are now operating under different agencies. For verbatim responses, see Appendix A, Table 11, page 60.

Organization Types and Settings

The **majority of CHW employers were non-profit organizations** (77%, *n* = 36) (see Figure 2). Three employers were for-profit organizations and eight were governmental, all of which were local health departments.

To determine organizational setting, respondents were asked to select from 13 options or specify another organization setting. The **most common organization setting was a Federally Qualified Health Center** (FQHC) (see Figure 3). Other frequent responses were local health departments, community-based organizations, and health systems. Figure 4 shows the organization settings within each of the organization types. For the full set of responses, see Appendix A, Table 3, page 48.

Figure 2. Organization Type (N = 47)



[4] Several of the 47 survey respondents represented the same organization as another respondent. Therefore, their responses to the number of programs across the organization were duplicative of the response from another respondent. Four responses that met these criteria were removed from the analysis of this question.

[5] Respondents were asked to give the number of programs within their organizations. This number is higher than the number of programs in the dataset since not all employers completed the survey for all of their programs.

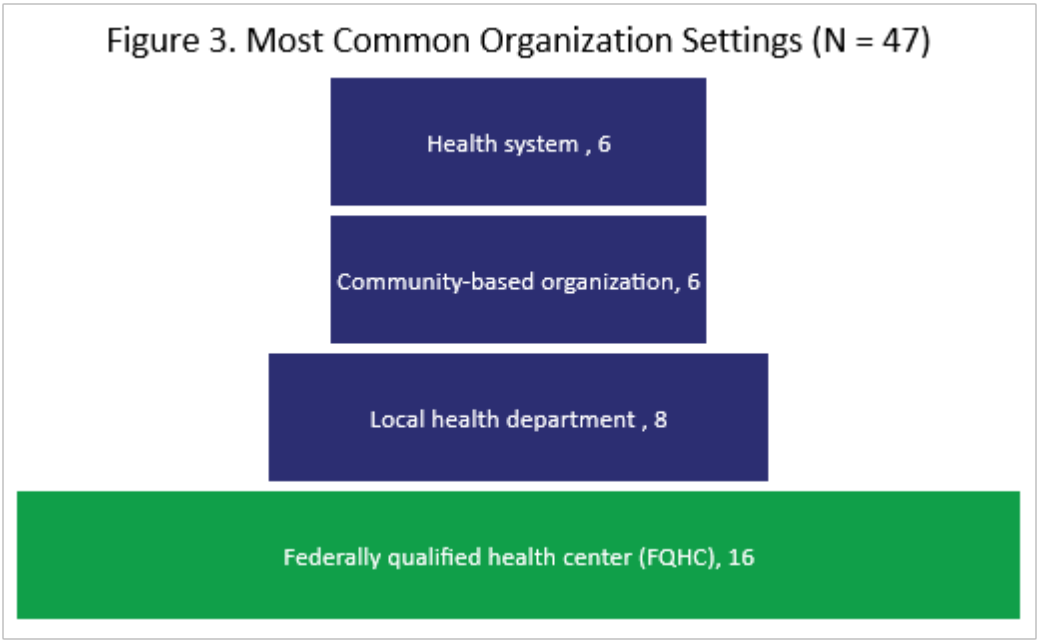


Figure 4. Organization Settings by Type of Organization (N = 47)

For-profit (3)	Governmental (8)	Non-profit (36)
•Medicaid managed care organization/Medicaid health plan (2) •Other: Complex Care Management	•Local health department (8)	•FQHC (16) •Health system/hospital (7) •Community-based organization (6) •County health plan (3) •Academia •Community health center •Medicaid managed care organization/Medicaid health plan •Other: Area Agency on Aging

RESULTS: CHW PROGRAMS

Number of CHWs and Full-time/Part-time Status

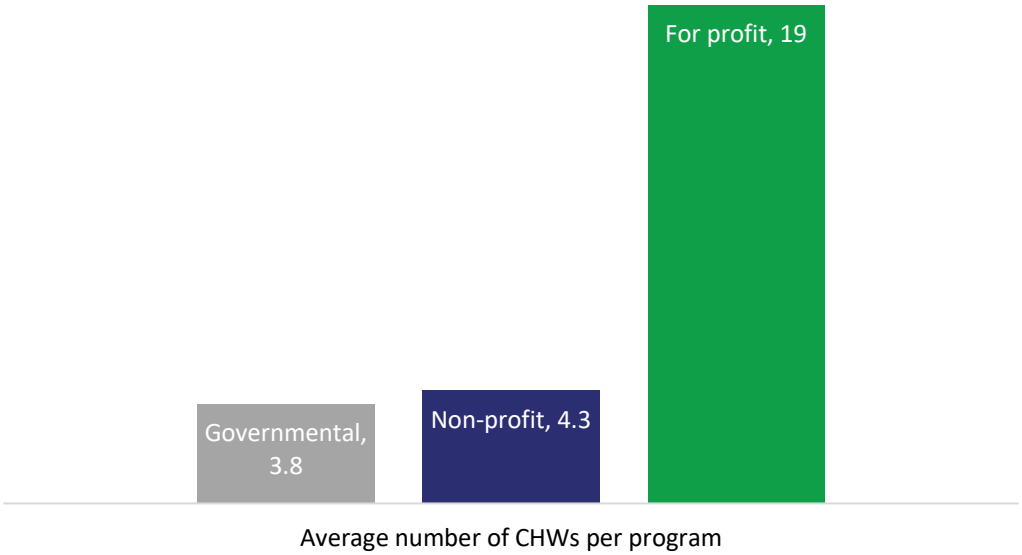
As of March 1, 2020, responding **programs reported a total of 268 CHWs** with 241 full-time paid, 26 part-time paid, and 1 full-time volunteer. The majority (90%) were full-time, paid positions.

268 CHWs
90% full-time, paid positions

On average, programs had 5 CHWs, including both full- and part-time. Comparing the average number of CHWs per program by organization type shows that **for-profit organizations tend to employ more CHWs** (see Figure 5). However, there were only three for-profit organizations in the dataset, two of which were health plans. Health plans have specific CHW-to-member ratios under their MDHHS contracts which likely influenced this result.

Nearly all (92%, *n* = 49) of the 53 programs employed full-time CHWs. On average, the programs had 4.5 full-time, paid CHWs (range of 1 to 30). More than half of the programs, (57%, *n* = 30) had between one and three full-time, paid CHWs. Ten programs (19%) employed part-time CHWs. Seven of these ten programs employed either one or two part-time, CHWs.

Figure 5. Average Number of CHWs by Organization Type (N = 53)



COVID-19 Changes

Changes in CHW staffing in response to COVID-19

When asked about CHW program changes in response to the COVID-19 pandemic, **three programs reported that CHWs were furloughed or laid off**.[6] The first program stated CHWs were furloughed on April 22, 2020, with an undetermined return date. The second employer stated that eight of ten CHWs were laid-off but that they were in the process of recalling a few CHWs as they began to re-open for face-to-face visits. The third employer stated that a position was left unfilled and that CHWs were laid-off for a few weeks.

CHW Location by County

Respondents were asked to indicate all of the Michigan counties where the CHWs in their program deliver services. Collectively, **responding programs had a presence in 75 of Michigan's 83 counties**. On average, there were four CHWs providing services per county (range of 0 to 14) (see Figure 6). Eight counties, all in the Upper Peninsula, did not have any reported CHWs providing services. This finding, however, is based only on the programs responding to the survey.

Each program served an average of 6 counties (range of 1 to 68). The largest number of programs served only one county (38%, *n* = 20) and the vast majority of programs served fewer than ten counties (89%, *n* = 47). The two programs serving the largest number of counties with CHW services (65 counties and 68 counties) were both Medicaid Managed Care Organizations.

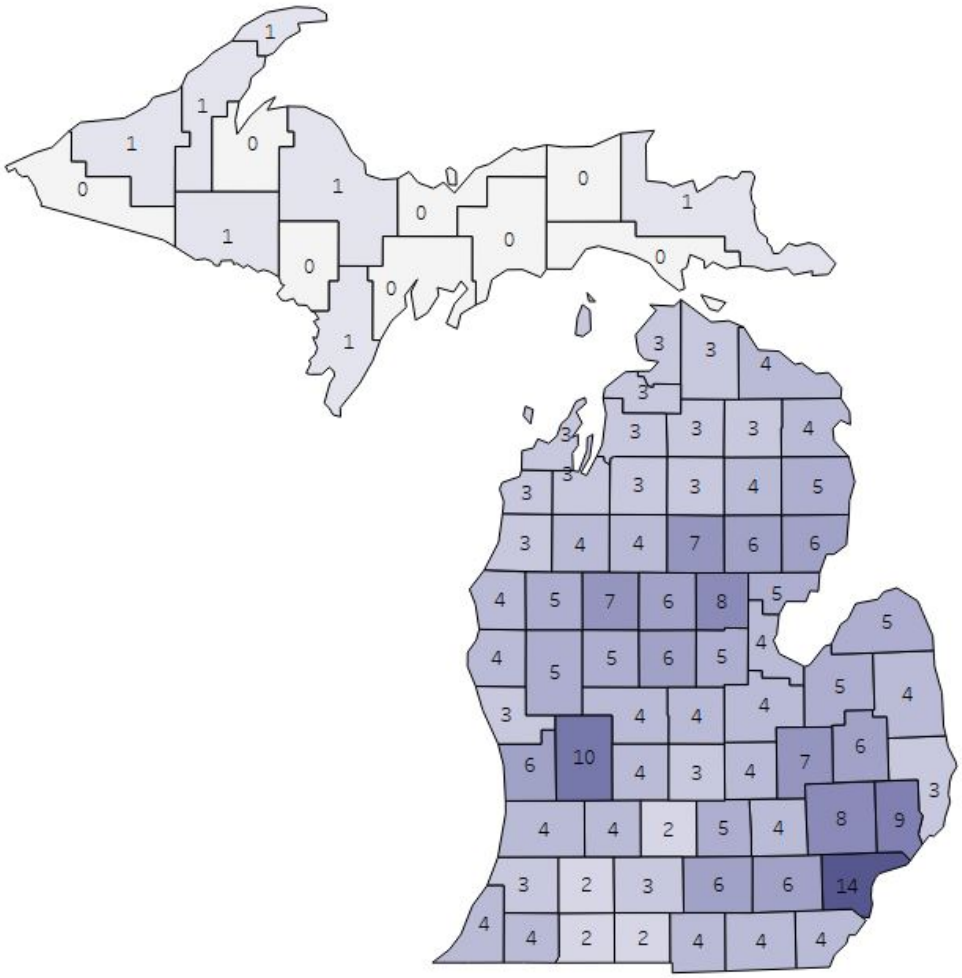
The following five counties were served by the largest number of CHW programs:

- Wayne County – 14 programs
- Kent County – 10 programs
- Macomb County – 9 programs
- Oakland County – 8 programs
- Gladwin County – 8 programs

For the number of CHW programs in all counties, see Figure 6 and Appendix A, Table 4, page 49. For more information on the number of counties served by each program, see Table 5, page 49.

[6] The use of the terms "furloughed" and "laid-off" in this section reflects the language used by the survey respondent.

Figure 6. Number of CHW Programs by County (N = 53)



Changes in CHW Location by County

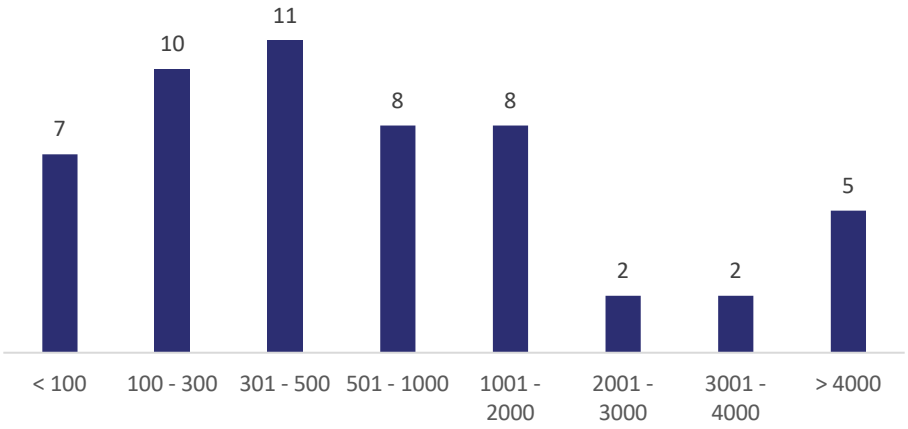
In the 2018 survey, 91 CHW programs collectively indicated a presence in 62 of 83 Michigan counties. At that time, there were 21 counties without any identified CHW programs. The counties with the highest number of CHW programs in 2018 were Kent (13 programs), Wayne (6 programs), and Newaygo (5 programs). All other counties had four or fewer CHW programs. The increase in the number of counties with CHW programs in 2020 appears to be influenced, in part, by the presence of CHWs hired or contracted by Medicaid Health Plans, throughout the state.

2018 and 2020 Comparison

Average Number of Clients Served per CHW Program

The majority of programs (83%, *n* = 44) served 2,000 or fewer clients across all of their CHWs in 2019. The largest numbers of programs indicated serving either **between 100 and 300 clients** or **between 301 and 500 clients** (see Figure 7).

Figure 7. Number of Clients Served by Number of Programs (N = 53)



Populations Served

Respondents were asked to identify all the populations that their program served, as of March 1, 2020, as defined by race, age, and special populations. Almost all CHW programs served adults (ages 26 – 64) and most served young adults and seniors (Table 1). Only 54% reported serving children (ages 0-18). **Almost all programs reported serving non-Hispanic, White populations and approximately three-quarters of programs reported serving Black and Latino populations**. For the full set of responses, see Appendix A, Table 12, page 61.

Table 1. Most Commonly Served Populations (percent of programs) (N = 53)

Populations by Race	Populations by Age	Special Populations
• White (92%) • Black (77%) • Latino (73%)	• Adults (96%) • Young adults (85%) • Seniors (81%)	• Individuals without a primary care provider (65%) • Uninsured individuals (64%) • People with diabetes (64%) • Homeless individuals (62%) • People with obesity (62%)

CHW Roles and Sub-Roles

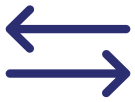
Respondents were asked to report which of 36 sub-roles that program CHWs play within the ten core CHW roles specified by the Community Health Worker Core Consensus (C-3) project:[7]

1. Cultural Mediation among Individuals, Communities, and Health and Social Service Systems
2. Providing Culturally Appropriate Health Education and Information
3. Care Coordination, Case Management, and System Navigation
4. Providing Coaching and Social Support
5. Advocating for Individuals and Communities
6. Building Individual and Community Capacity
7. Providing Direct Service
8. Implementing Individual and Community Assessments
9. Conducting Outreach
10. Participating in Evaluation and Research

See Appendix A, Table 7, pages 54-56 for the list of 36 sub-roles and responses. Almost all program's CHWs fulfilled at least one sub-role within each of the ten core roles. The two **most common sub-roles, selected by 100% of responding programs, were 1) connecting to resources and advocating for basic needs and 2) motivating and encouraging people to obtain care and other services** (see Figure 8). The two least common roles, selected by fewer than 20% of responding programs, were 1) providing basic services and 2) providing basic screening tests (see Figure 8). Altogether, the CHWs in each program play an average of 23 different sub-roles (range of 11 – 34).

CHWs play an average of 23 different sub-roles in their communities

"In our office we have care managers that handle the health management stuff with education, I as the CHW handle everything else that no one has answers to. System navigation. Local funding ins and outs. Just the real person face to face someone can talk to. Take all the fluff away that's what a CHW does in our office. We handle the real-life people face outside the health system."



2018 and 2020 Comparison

Changes in CHW Roles and Sub-Roles

Overall, **the number of sub-roles played by CHWs has increased since 2018**. In 2018, each sub-role was reported by an average of 44% of the CHW programs. In 2020, each sub-role was reported by an average of 63% of the CHW programs. Figure 9 shows the six sub-roles with the greatest increase in engagement between 2018 and 2020. For the full comparison, see Appendix A, Table 7, page 54.

[7] For more information about the C-3 project, see: https://www.c3project.org/about. For the C3 checklist of roles and sub-roles, see: https://0d6c00feeae1492b8e7d80acecb5a3c8.filesusr.com/ugd/7ec423_cb744c7b87284c75af7318614061c8ec.pdf

Figure 8. Most and Least Frequent CHW Sub-Roles in Each C-3 CHW Core Role (N = 53)

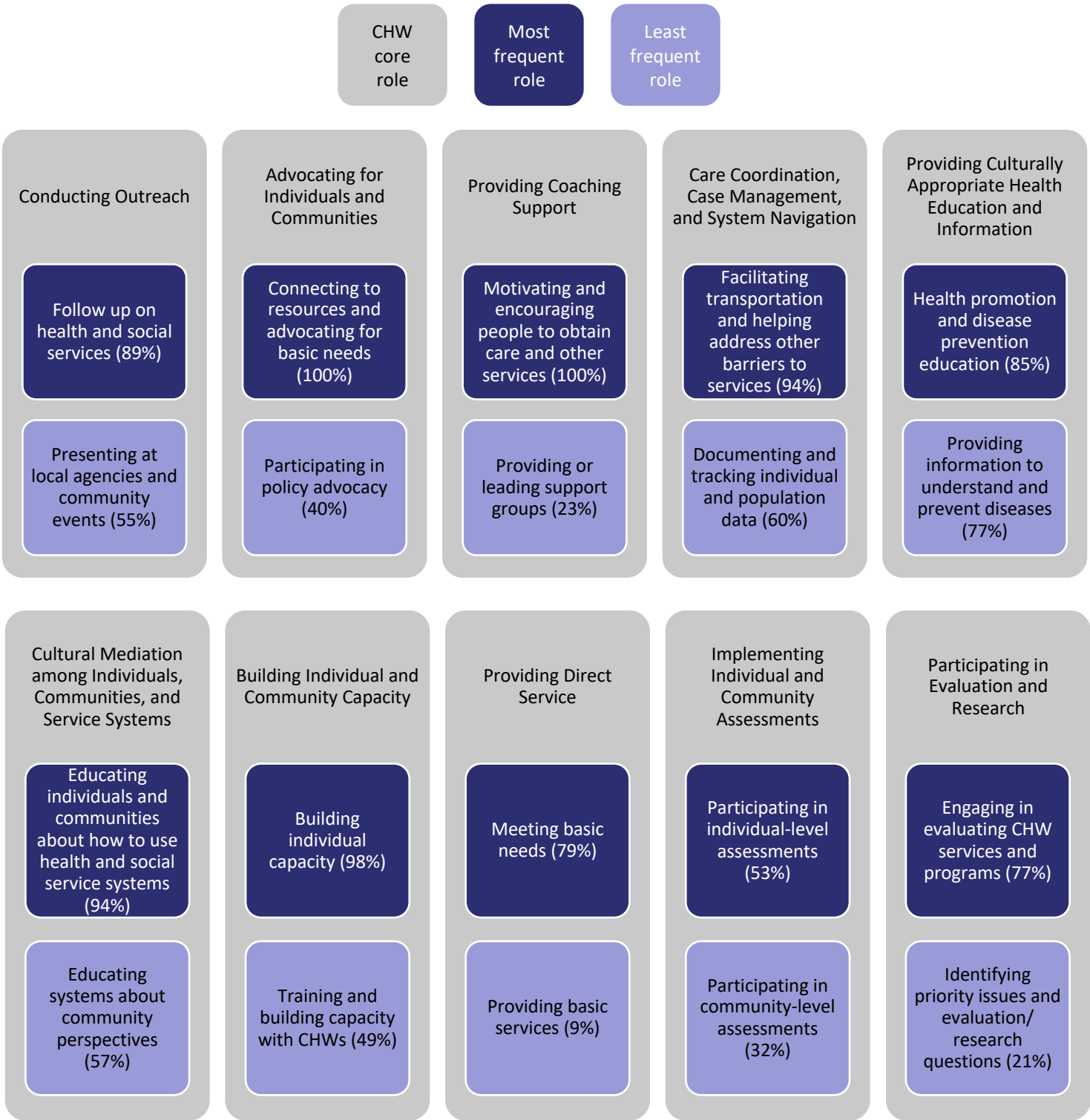
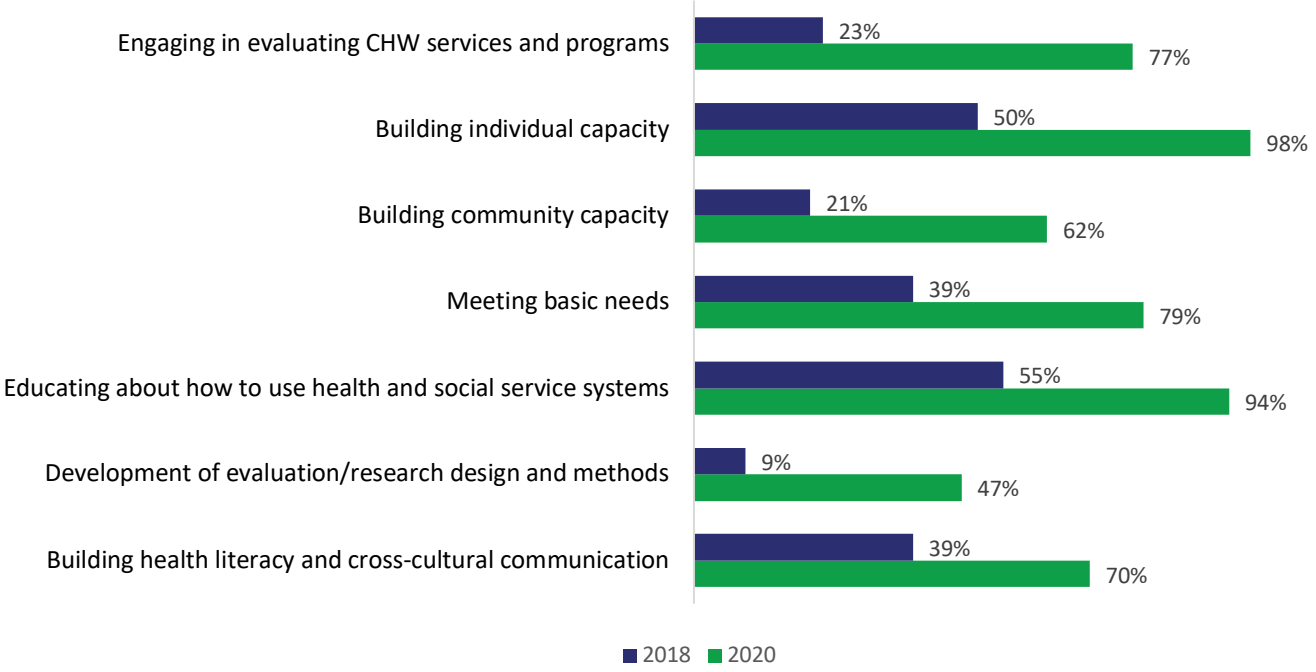


Figure 9. Sub-roles with the Greatest Increase in Engagement Since 2018 (N = 53)



COVID-19 Changes

Changes in roles or activities in response to COVID-19

CHW programs described multiple changes in CHW roles or activities in response to the COVID-19 pandemic. **Eight programs reduced their client services,** including putting the program on hold, suspending groups classes, and reducing or eliminating home visits. On the other hand, **seven programs indicated CHWs were responding to new client needs** arising from the pandemic. This included helping clients secure food, delivering food and medication to clients' homes, providing Spanish translation services, and addressing mental health concerns. One stated that the CHW program was providing COVID-19 funds for hotel rooms.

Several CHW programs also indicated conducting COVID-19 specific activities. **Six programs indicated conducting COVID-19 education.** Four programs were conducting phone-based SDOH assessments or screenings. Four programs were conducting COVID-19 testing and three programs were conducting COVID-19 screening. Three programs indicated providing support to other staff, such as helping staff with resilience activities. Two programs stated that CHWs were participating in more trainings.

Sub-roles by Organization Setting

Table 2 shows that **the frequency of some sub-roles varies substantially between organization settings**. For example, CHWs in community-based organizations, county health plans and Medicaid health plans were much more likely to participate in individual-level assessments than CHWs in FQHCs, health systems, or health departments. As another example, only 20% of responding health systems had CHWs engaged in building community capacity, whereas 100% of responding community-based organizations and Medicaid health plans had CHWs in this role.

Table 2. Differences in Sub-Role Engagement by Organization Setting

Setting	N	Number and % of Programs Engaging in the Following Sub-Roles			
		Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community	Participating in design, implementation, and interpretation of individual-level assessments	Engaging in evaluating CHW services and programs	Building community capacity
FQHCs	19	14 (74%)	7 (37%)	15 (79%)	11 (58%)
Health Systems	10	9 (90%)	4 (40%)	7 (70%)	2 (20%)
Health Departments	7	7 (100%)	3 (43%)	5 (71%)	6 (86%)
Community-Based Organizations	7	7 (100%)	6 (86%)	7 (100%)	7 (100%)
County Health Plans	4	3 (75%)	4 (100%)	1 (25%)	2 (50%)
Medicaid Health Plans	3	3 (100%)	3 (100%)	3 (100%)	3 (100%)
Other	3	2 (67%)	1 (33%)	3 (100%)	2 (67%)

Multi-disciplinary Teams

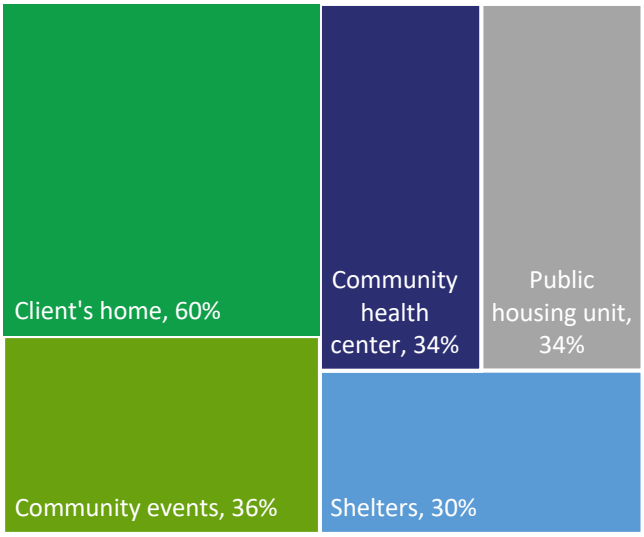
Most CHWs work with multi-disciplinary teams (87%, *n* = 46). Based on descriptions of the teams in an open-ended question, **three-quarters of programs (74%, *n* = 39) had healthcare-based teams** that

included members such as physicians, nurses, psychologists, pharmacists, and MSWs. Five programs described teams with community-based partners, such as local shelters, social services and other community organizations. Three of the five teams with community-based partners were also considered healthcare-based teams, because they also included members such as physicians, or nurses. For the full set of responses, see Appendix A, Table 8, page 57.

Service Settings

CHW programs deliver services in an average of 5 different settings, with a range of 1 to 15 settings for each program. By far, the **most common service setting was the client's home** (60%, *n* = 32). This was followed by community events, public housing units, community health centers, and shelters, which were each selected by between 30-35% of programs (see Figure 10). For the full set of responses, see Appendix A, Table 9, page 59.

Figure 10. Most Common Service Delivery Settings (N = 53)



COVID-19 Changes

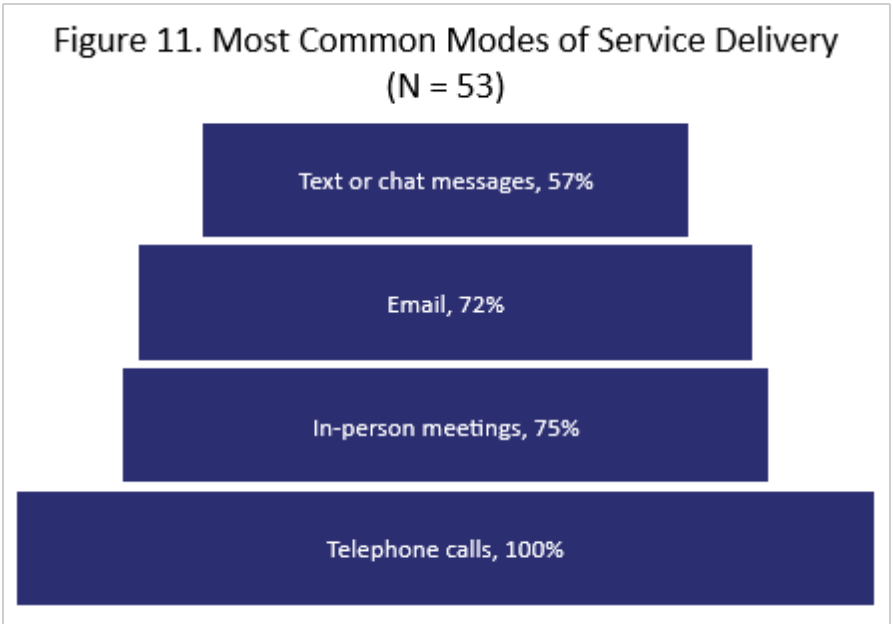
Changes in service settings in response to COVID-19

Fifteen CHW programs described changes in where CHWs deliver services in response to the COVID-19 pandemic. **Eight programs said that they stopped home visits.** Six of these programs said that CHWs are now conducting porch drop-offs of food, medication, and other supplies or resources. One program said that CHW services have now been more restricted to clients' homes as clients are sheltering in place.

Mode of Service Delivery

CHWs in responding CHW programs utilize an average of 3.8 different modes of service delivery, with a

range of 1 to 7. **All programs indicated that CHWS use telephone calls to deliver services.** Approximately three-fourths of programs also use email and in-person meetings. Fewer than half of programs indicated using video communication, in-person group classes, and virtual group classes (see Figure 11). For the full set of responses, see Appendix A, Table 10, page 60.



COVID-19 Changes

Changes in mode of service delivery in response to COVID-19

Shifting to delivering CHW services by phone or virtual platforms was by far the most common change in response to the COVID-19 pandemic: **37 programs (70%) increased telehealth services**.[8] Most of these programs were providing services via telehealth exclusively. A few were engaging in minimal home visits or other socially distant meet-ups with clients. For the full set of responses on all changes in response to COVID-19, see Appendix A, Table 6, page 50.

RESULTS: CHW FUNDING AND SUSTAINABILITY

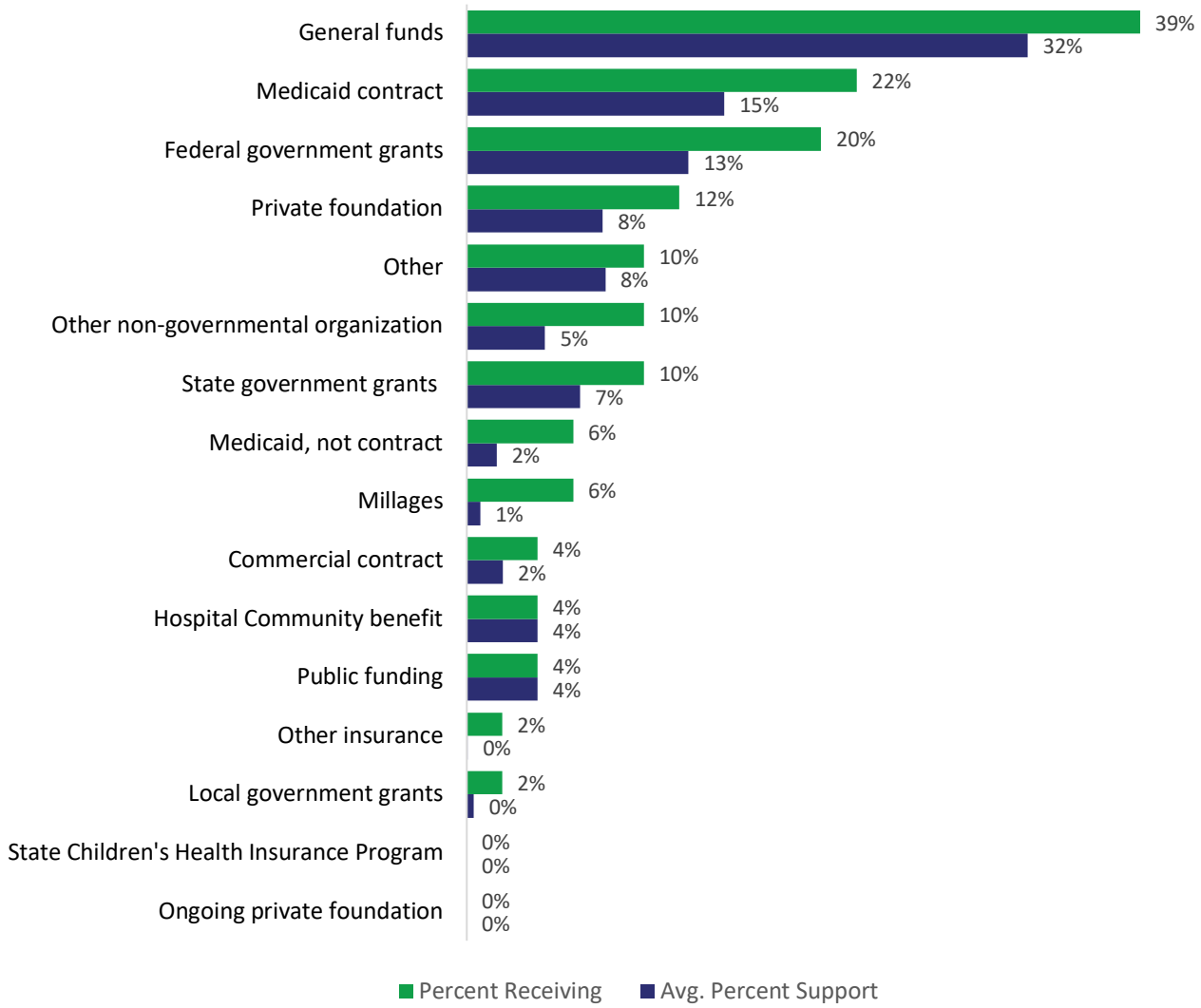
[8] We are using the term "telehealth" in accordance with the definition from the Health Resources Services Administration, which defines telehealth as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration." Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. For more information, see https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine.

Funding Sources

Employers were asked to indicate the percentage of support for the CHW program coming from different funding types. Figure 12 shows the percentage of programs receiving funds from each of the funding sources (green bars). The figure also shows the average percentage of funding support across all responding programs (blue bars).[9] **General organization funds represented both the most common source of funds (39%, *n* = 19) and the highest average percent support (32%)**.

"The CHW was originally hired for the connection to care program. Once the program was not refunded, the CHW was hired full-time to stay at MyCare."

Figure 12. Funding Type by Prevalence and Level of Support (N = 49)

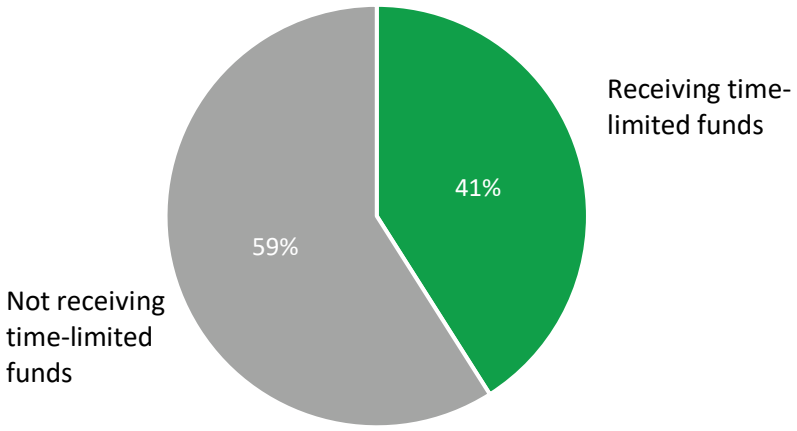


However, **as a group, time-limited grants (regardless of source) were the most common source of funds.** Figure 13 shows that 41% (*n* = 20) of programs indicated receiving time-limited funds, compared

[9] Programs were asked to note the percent of the CHW program budget covered by each funding source. The average was calculated by dividing the sum of percent funding by all 49 programs responding to the question. One program noted that the funding percentages given were "strictly a guess." This may be the case for other programs as well.

to 59% (*n* = 29) of programs not receiving any time-limited funds.[10] On average, these 20 programs were receiving 77% of their funding from time-limited sources (range of 33% to 100%). For the full set of responses on funding sources, see Appendix A, Table 14, page 64.

Figure 13. Percent of Programs Receiving Time-Limited Funding (N = 49)



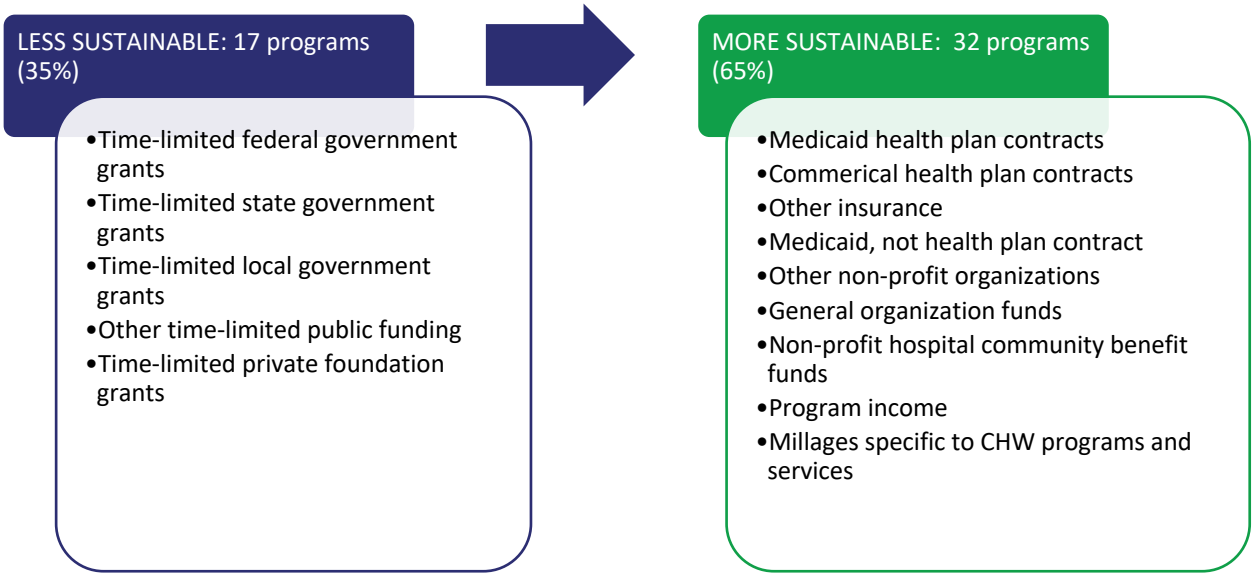
Funding Sustainability

Some funding types are more sustainable than others. Time-limited grants are generally the least

[10] The following funding types were designated as time-limited: 1) time-limited federal government grant(s); 2) time-limited state government grant(s) (excludes Medicaid); 3) time-limited local government grant(s); 4) other time-limited public funding; and 5) time-limited private foundation(s) funding.

sustainable, while general organization funds and program income tend to be the most sustainable. Figure 14 offers an approximate categorization of funding types by level of sustainability as classified by the Michigan Department of Health and Human Services, based on guidance from the Center for Disease Control. The figure also shows the number of programs in each category, based on the source of the majority of their funds.[11] According to this categorization, **about two-thirds of programs (65%) receive the majority of their funding from more sustainable sources.**

Figure 14. Level of Funding Sustainability (N = 49)



[11] Programs were categorized as less sustainable if 50% or more of their funding came from a time-limited funding source.

Funding Sustainability by Region

Figure 15 classifies Michigan counties into ten different regions.[12] Figure 16 shows that, based on survey responses, some regions of Michigan have a higher number of CHW programs and a higher proportion of programs receiving a majority of their funds from sources with higher sustainability. While the Upper Peninsula and the Southwest areas of the state have a relatively small number of CHW programs, all of their programs receive a majority of their funds from higher sustainability sources. **The Detroit Metro area has the largest number of programs and a relatively high proportion, 13 out of 17 (76%) classified as higher sustainability.** The Northwest has the largest proportion of programs 3 out of 7 (43%) classified as lower sustainability.

Figure 15. Michigan Regions

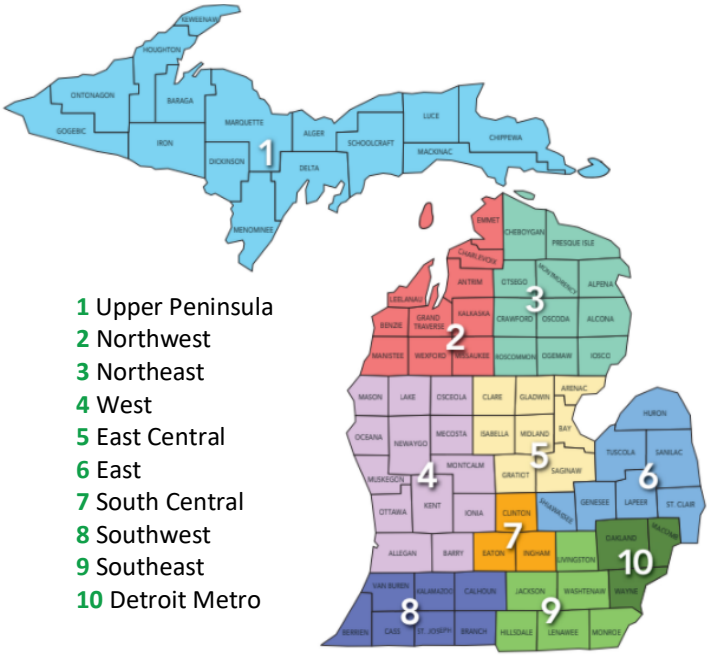
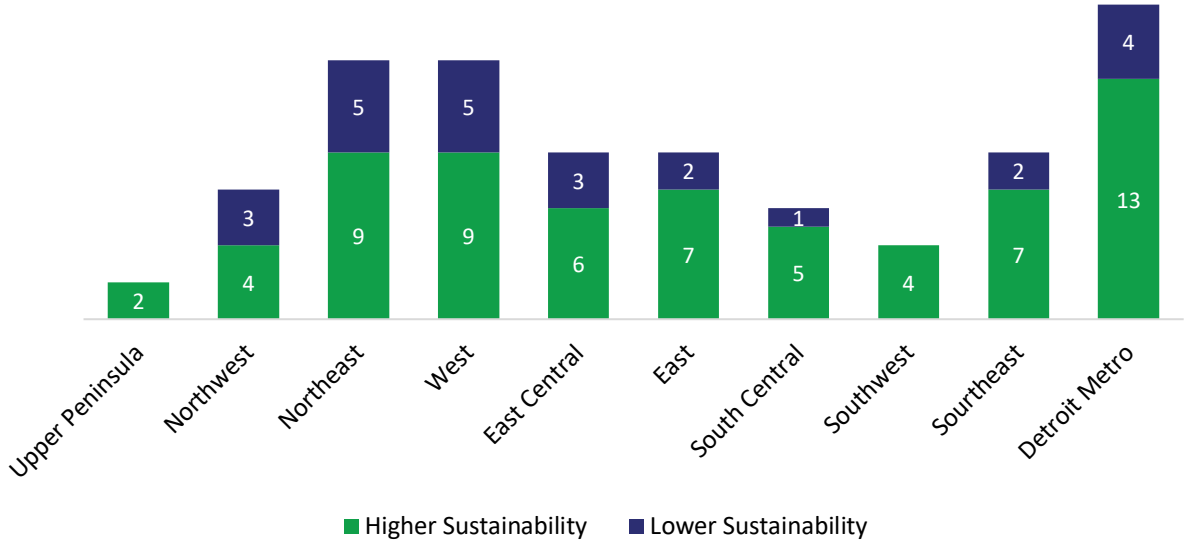


Figure 16. Number of Programs by Funding Sustainability Source and Michigan Region (N = 50)



[12] The Michigan Economic Development Corporation designated these regions. For more information, see https://www.michiganbusiness.org/services/partners/#cdc.

Program Sustainability Concerns[13]

CHW employers were asked to indicate the CHW program's concerns when related to the longevity and sustainability of CHW employment. While three programs noted that they had no concerns, **nearly two-thirds of programs were concerned with funding uncertainty**. Other top concerns were finding qualified CHWs, staff turnover, and management support (see Figure 17).

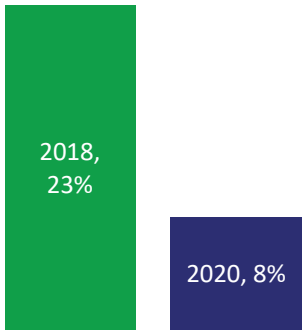
Figure 17. Top Sustainability Concerns (N = 49)

2018 and 2020 Comparison

Changes in Program Sustainability Concerns

Overall, levels of sustainability concerns were similar to those in 2018. In 2018, funding uncertainty was also a concern for most programs (77%, *n* = 34). This was followed by staff turnover (34%, *n* = 15) and finding qualified CHWs (27%, *n* = 12). However, the percentage of programs indicating **non-acceptance of the CHW role as a barrier to sustainability decreased notably, from 23% in 2018 (*n* = 10) to 8% in 2020 (*n* = 3)** (see Figure 18). For the full set of 2018 and 2020 responses, see Appendix A, Table 18, page 68.

Figure 18. Change in Percent of Programs Concerned with Non-Acceptance of CHW Role



[13] Responses to this question should be interpreted cautiously because while the question asked CHW employers to check all of the concerns that applied, the survey software was inadvertently set up to limit them to only three of the six listed answer choices. This means that responses are likely an undercount.

The **most common strategies to promote CHWs** and their long-term sustainability were **paying for CHWs to become certified** (76%, *n* = 37) and offering **opportunities for CHW professional development** (74%, *n* =36). Two programs indicated that they are not currently using any strategies to promote program sustainability. For the full set of responses, see Appendix A, Table 19, page 69.

Respondent Comments on Funding and Sustainability

"Funding for CHWs remains an issue. The importance and value of the work of CHWs is vital to the health of our communities."

"It would be nice to see more funding open up for CHW programs. Expansion of CHW in all working fields or just breaking down barriers of other programs perspective of a CHW's for the lifelong Sustainability CHW need to be talked about more the public eye and supported by the state governments."

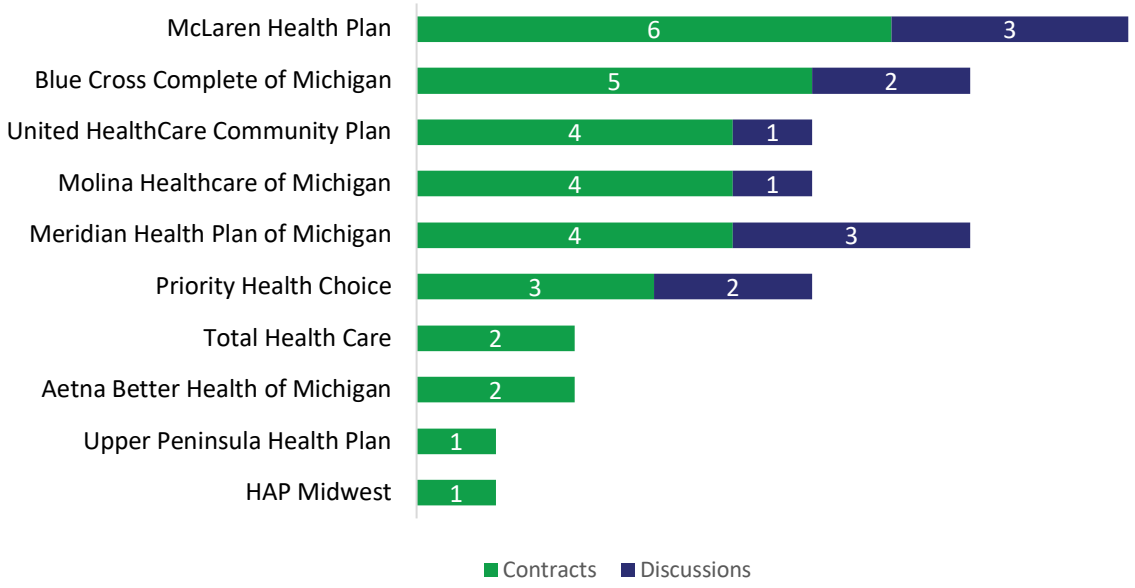
"Continued advocacy and coordination with health plans will only continue to help the profession grow stronger and more sustainable."

CHW Program Contracts with Medicaid Health Plans

Fourteen CHW programs indicated that their CHW program currently contracted with one or more health plans (range of 1 to 6 health plans). These results should be interpreted cautiously, however, since nine programs selected the "I don't know" response option for this question, indicating that not all respondents had complete information on contractual arrangements. Of the 14 programs reporting contracts, 9 contracted with a single health plan. Of the 14 programs contracting with health plans, only three indicated that the contract requires CHWs to be MiCHWA certified. Five CHW programs indicated they were currently discussing a contract with one or more health plans (range of 1 to 4 health plans).

Of the ten state-approved Medicaid health plans, the largest number of programs had a contract with McLaren Health Plan (*n* = 6), followed by Blue Cross Complete of Michigan (*n* = 5) (see Figure 19). As noted, these figures may undercount both contracts and discussions with Medicaid health plans since not all CHW programs responded and some respondents were unsure of their contracting arrangements. For the full set of responses, see Appendix A, Table 15, page 65.

Figure 19. Contracts and Discussions with Health Plans According to Respondents (N = 49)



2018 and 2020

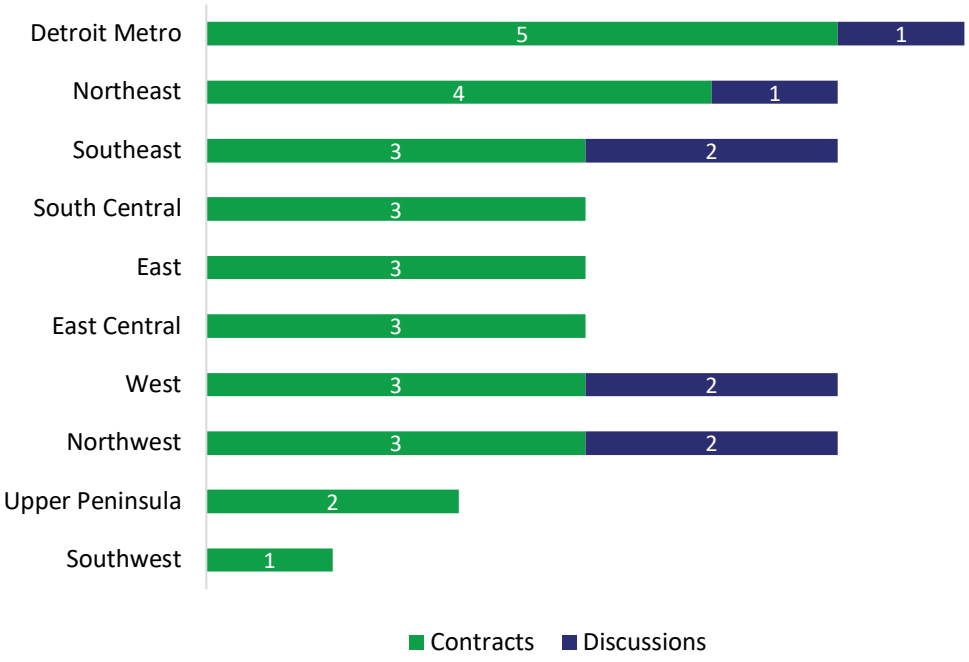
Changes in CHW Program Contracts with Health Plans

In 2018, seven programs indicated they had agreements with Medicaid managed care organizations to pay for CHW services. This means there was **a 100% increase in the number of programs with health plan contracts between 2018 and 2020.** Also, in 2018, an additional seven programs indicated they did not have agreements but were in discussions with Medicaid managed care organizations. In 2018, the largest number of programs had agreements or were in discussion with Priority Health Choice (6 programs) and McLaren Health Plan (5 programs).

Contracts and Discussions by Region

There was **at least one CHW program with a health plan contract serving all ten regions of the state**. (See page 27 for a map of Michigan regions.) The Detroit Metro region had the largest number of CHW programs with health plan contracts (see Figure 20). Table 16 in Appendix A, page 66 also shows the number of active health plan contracts in each region, in addition to the number of CHW programs with contracts.

Figure 20. Number of CHW Programs with Health Plan Contracts and Discussions by Region



Payment Models

Survey respondents were asked which payment models, such as per member per month, fee-for-service-based, or outcomes-based, were being used to support CHW sustainability. **Most programs did not use any of the listed payment models** and responded "does not apply" (69%, *n* = 34). The most frequently selected payment model was fee-for-service based hourly or per unit reimbursement (*n* = 7). Several programs reported payment model discussions in progress. For the full set of responses, see Appendix A, Table 17, page 67.

Billing Codes

The survey listed billing codes known to the MiCHWA Evaluation Advisory Board, divided into care coordination or care management service codes and other codes. Details for the codes were provided within the survey instrument (see survey question 80, Appendix B, page 138). When asked if the CHW program has been reimbursed for care coordination and care management services provided by CHWs, **only two programs indicated using codes listed in the survey** related to these services. One program indicated using CPT code 99495 (transitional care management services with moderate medical decision complexity) and one program indicated using 98966 (telephone assessment and management service provided by a qualified non-physician health care professional). Of the 49 programs who answered the

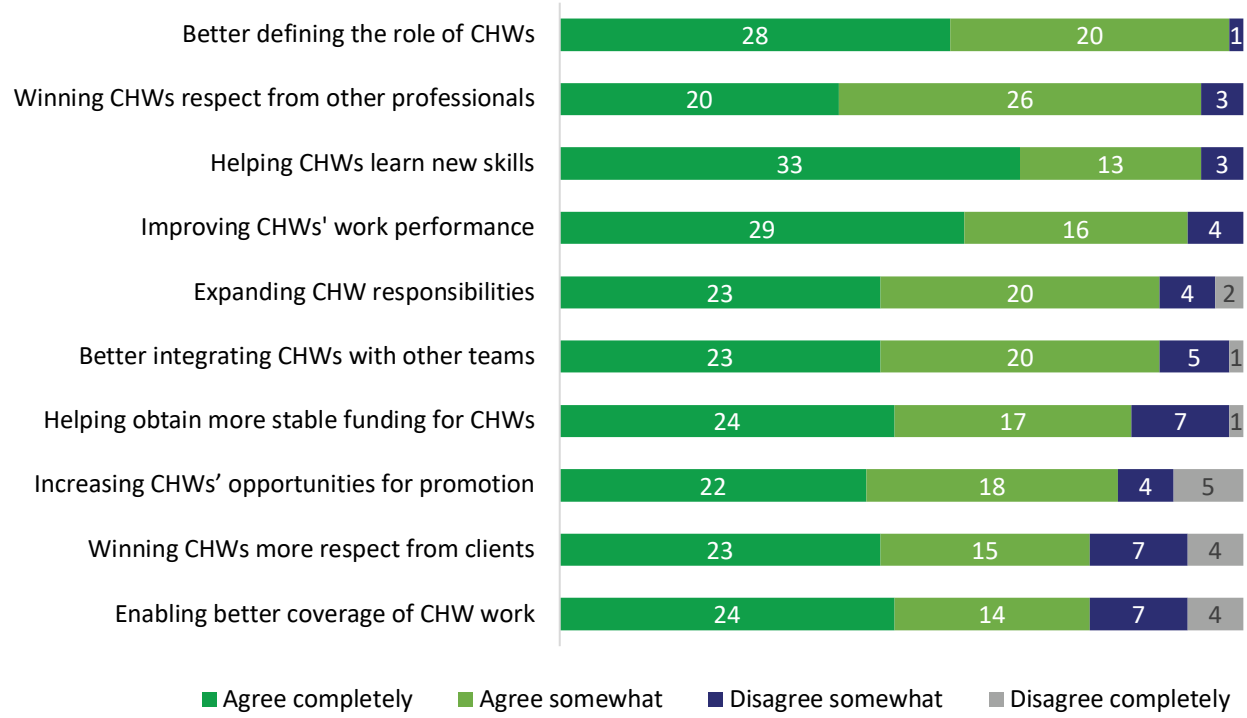
question, 35 (71%) responded “does not apply” and 12 (25%) responded “none of the above.”

When asked about any other billing codes used to receive reimbursement for CHW services, two programs indicated using S9445 with diagnosis code Z71.9, G9001 and 98966. One program stated that they may use this code in the future without the Z code modifier.[14] One program indicated using G9001 and G9006. Another program indicated using T1017. The remaining programs answering the question either responded “does not apply” (74%, *n* = 36) or none (16%, *n* =8).

CHW Certification

Respondents were asked to indicate their level of agreement with a series of specific statements related to the perceived value of state-recognized CHW certification to the CHW program. Overall, programs expressed a high level of agreement with the statements. **Between 38 (78%) and 48 (98%) programs agreed either completely or somewhat with each statement** (see Figure 21.) The value of state-recognized certification in better defining the role of CHWs was the statement with the highest level of overall agreement (98%). Helping CHWs learn new skills was the statement with the largest number of programs completely agreeing (*n* = 33). For the full set of responses, see Appendix A, Table 30, page 79.

Figure 21. Perceived Benefits of CHW Certification (N =49)

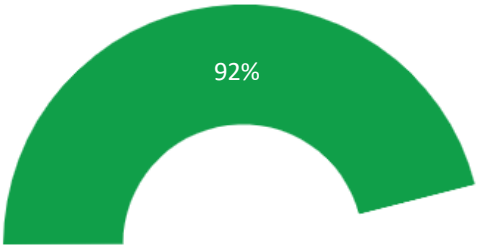


[14] The Z code modifier refers to the "reasons of encounter" that the billing office utilizes along with a "primary diagnosis code that describes the illness or injury" as mandated by the Medicare Administrative Contractor (MAC) in the United States. For more information, see: https://www.quickmedclaims.com/2015/09/introducing-the-z-codes/.

RESULTS: CHW HIRING

Educational Requirements

Most CHW programs (92%, *n* = 48) require CHWs to have a high school diploma or a GED. Two programs stated they had no specific education requirement. Only one program required a bachelor's degree. One program indicated that while a college degree is not required it is either preferred or has been standard practice. For detailed responses see Appendix A, Table 20, page 70.



92% of programs **require CHWS have a high school diploma** or GED.

Other Hiring Requirements and Preferences

Most employers *required* that CHWs read and write English, pass a background check, have a driver's license, and own a car available for work related travel (Figure 22). Other qualifications, such as fluency in a specific language or work experience in healthcare, were required by fewer than 10% of responding programs. The most common hiring *preferences* were experience working with the target population, work experience in a health or healthcare setting, peer or lived experience with a health issue, holding a current certificate from a CHW training program, and fluency in Spanish (see Figure 23). For a complete list of responses on hiring requirements and preferences, see Appendix A, Table 21, page 70.

Figure 22. Most Common Hiring Requirements (N = 50)

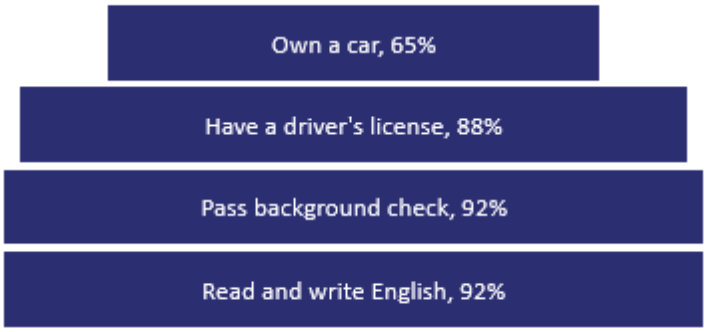


Figure 23. Most Common Hiring Preferences (N = 50)

Criminal Records

Most CHW employers (75%, *n* = 39) indicated that their programs do not exclude employment of CHWs with a criminal record if otherwise qualified. Of the thirteen programs that reported excluding employment of all CHWs with a criminal record, ten provided an explanation. Five programs considered individual circumstances, such as the length of time since the offense or the nature of the charges. Another five programs did not consider individual circumstances, stating a very firm commitment to the hiring of individuals without any criminal records or felony history. For the verbatim text, see Appendix A, Table 22, page 71.

RESULTS: CHW TRAINING

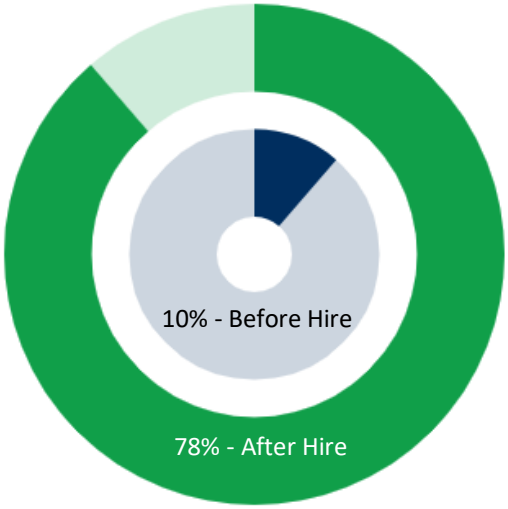
Training Before Hire

The **majority of CHW programs do not require any training before CHWs are hired**. The 126-hour MiCHWA CHW Core Competency-Based training program was the most frequently required of the training programs – five programs (10%) required this before hire. Three programs, including one of the programs requiring MiCHWA training, required two different trainings before hire. For complete responses, see Appendix A, Table 23, page 73.

Training After Hire

Most programs (78%, *n* = 39) require the MiCHWA Core Competency training after hire (see Figure 24). In addition, one program indicated that all CHWs are MiCHWA-Certified. Nine programs required another core competency-based training program (responses varied). Eight programs required other types of CHW training after hire (responses varied). Only four programs indicated they did not require any training after hire. For complete responses, see Appendix A, Table 24, page 73.

Figure 24. Programs Requiring MiCHWA Core Competency Training (N = 50)



2018 and 2020 Comparison

Changes in CHW Training

In 2018, five programs (11%) required the MiCHWA Core Competency-Based training *before* hire, the same number as in 2020. However, **the percentage of programs requiring this training *after* hire increased from 68% (*n* = 30) in 2018 to 78% (*n* = 39) in 2020.** The percentage of programs requiring a different type of training[15] after hire decreased notably from 40% (*n* = 18) in 2018 to 16% (*n* = 8) in 2020.

Anticipated Core Competency Training Needs

Over the next 12 months (approximately July 2020 – June 2021), 28 CHW programs **anticipated needing CHW core competency training for a total of 83 individuals**.[16] For complete responses, see Appendix A, Table 25, page 75.

[15] Based on responses to "other" rather than to "other core competency-based training." The latter increased slightly from 11% (*n* = 5) in 2018 to 18% (*n* = 9) in 2020.

[16] For programs that gave a range of CHWs, the midpoint was used. One program responded "yes" to the question of how many CHWs would need training in the next 12 months. This response was coded as one CHW.

"We need continuous access to training and program building initiatives."

Respondent Comments on Training

"The cost of the CHW training and location have been a deterrent to not having another CHW within our agency."

"CHW trainings should be offered by more entities so that the CHW receives a diverse set of trainings rather than just receiving trainings from one or two resources."

COVID-19 Changes

COVID-19 Related Training

Two-thirds of CHW programs (67%, *n* = 33) offered COVID-19 related training for their CHWs. Of the 16 programs that did not, 8 programs were planning to offer a COVID-19 related training. Based on explanations of trainings that respondents gave, we identified four categories of COVID-19 related training.

- **Basic:** 19 programs offered trainings on the basics of COVID-19 or described general COVID-19 related training, without identifying a specific topic.
- **Client needs:** 4 programs offered trainings related to client needs during COVID-19 or the process of identifying COVID-19 patients. Examples included health screenings and SDOH screening tools and discussion with clients.
- **Safe contact:** 3 programs indicated safe contact training or training of how to properly interact with clients.
- **Self-care:** 2 programs mentioned that their CHW program offered trainings related to stress and social and emotional well-being.

For the full set of responses regarding COVID-19 training, see Appendix A, Tables 26 and 27, pages 75-76.

Continuing Education

Approximately half of programs (54%, *n* = 27) require continuing education for their CHWs. Of these, the majority (85%, *n* = 23, which comprises 46% of all programs in the sample) offer continuing education opportunities for their CHWs. Based on written descriptions of the continuing education opportunities offered, 12 programs indicated providing continuing education through external programs. Six of these programs mentioned utilizing MiCHWA webinars. Five of the 27 programs requiring continuing education indicated providing internal continuing education. For verbatim responses, see Appendix A, Table 28, page 77.

"CHWs often take advantage of the webinars and trainings put out by MiCHWA."

When asked about topics of interest for CHW continuing education, programs gave a range of responses. **Ten programs indicated interest in HIPAA training**.[17] Seven programs named Motivational Interviewing (MI) as topic of interest. Four programs stated interest in COVID-19 related topics, along with topics of coping with the COVID-19 pandemic and "other center responses to the pandemic and CHWs." Four programs also indicated interest in topics concerning case management. Other topics were mentioned by one or two programs. For the full set of responses, see Appendix A, Table 29, pages 78-79.

MiCHWA CHW Registry

The MiCHWA CHW Registry is a membership database through which MiCHWA maintains a record of CHWs who have achieved "MiCHWA certification status" by successfully completing the MiCHWA Core-Competency-based training or having a combination of comparable experience and training. CHWs may also register with non-certified status. The MICHWA registry also has a membership for CHW employers. **Nearly all programs (93%, *n* = 47) reported being aware of the MiCHWA CHW Registry.**

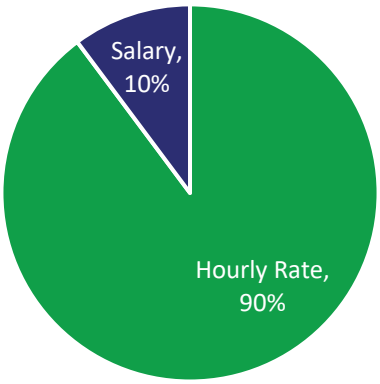
[17] HIPPA refers to the Health Insurance Portability and Accountability Act of 1996, a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

RESULTS: CHW SALARY AND BENEFITS

Average Earnings

The great **majority of responding CHW programs pay CHWs hourly** (90%, *n* = 44) (see Figure 25). Based on the ranges provided by respondents, hourly rate earnings ranged from $12.00 - $27.00, with an average minimum of $16.40 and an average maximum of $18.93. Median values were similar.

Figure 25. Payment by Hourly Rate vs. Salary (N = 49)



CHW Earnings

	Average Minimum	Average Maximum
Hourly Rate	$16.40	$18.93
Salary	$37,200	$42,400

	Median Minimum	Median Maximum
Hourly Rate	$16.00	$18.34
Salary	$33,000	$40,000

2018 and 2020 Comparison

Changes in Average Earnings

Survey responses show that **average CHW earnings increased since 2018**. In 2018, the average hourly rate was $15.92 and the average salary was $35,490. In 2020, the average hourly rate was $17.67 and the average salary was $39,800.[18]

"I would like to see a pay scale that reflects the worth of a CHW and the specialized skills they have [that] no one in the office could compare to."

Respondent Comments on Pay Scale

"With CHW Employment the salary should be higher. Once a CHW completes certification, there should be a salary increase for all CHW's. All agencies should budget for salary increases for retention and moral purposes."

[18] These averages reflect the midpoint of the salary and hourly rate ranges provided by survey respondents.

Average Earnings by Organization Type and Setting

When comparing hourly rate by organization type, for-profit organizations offered the highest average hourly rate and non-profits offered the lowest average hourly rate (see Figure 26). Looking at the more detailed category of organization setting shows that county health plans had both the lowest average hourly minimum and lowest average hourly maximum. **Health departments offered the highest average hourly maximum** (see Figure 27).

Figure 26. Hourly Rate by Organization Type (N = 50)

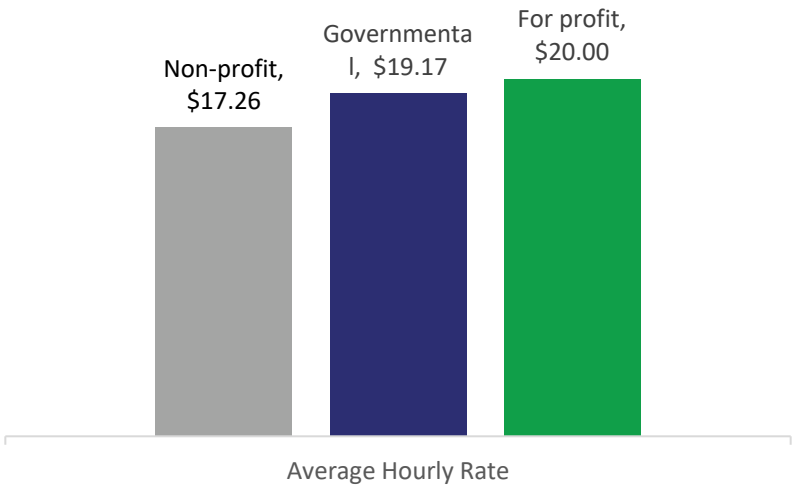
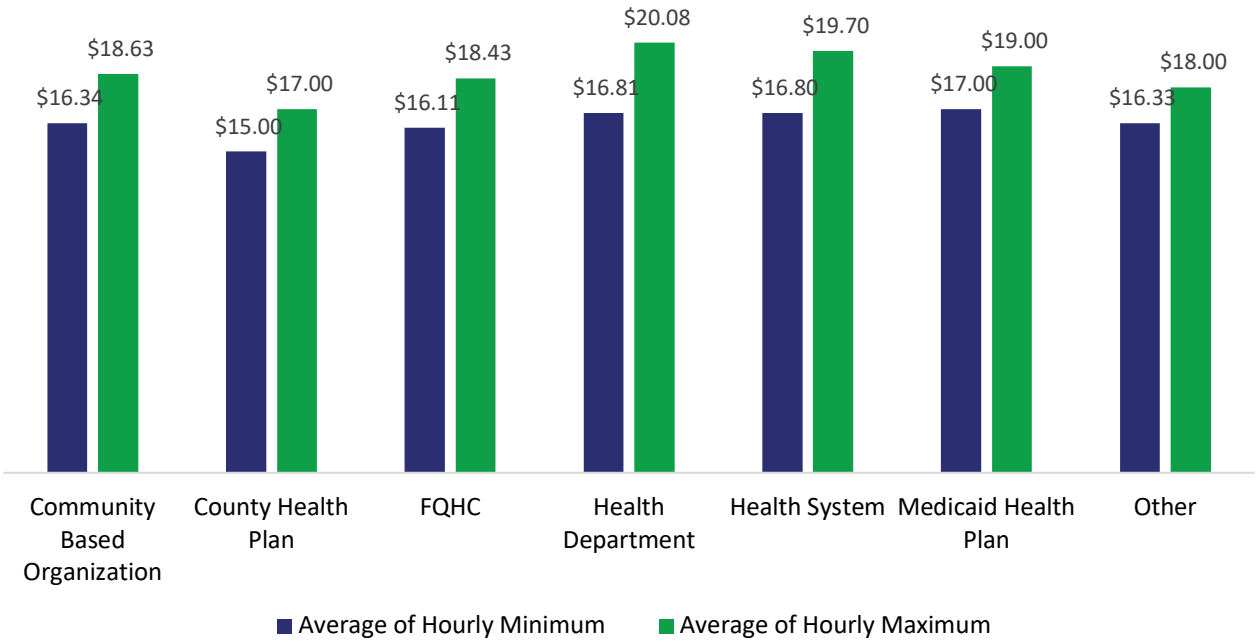


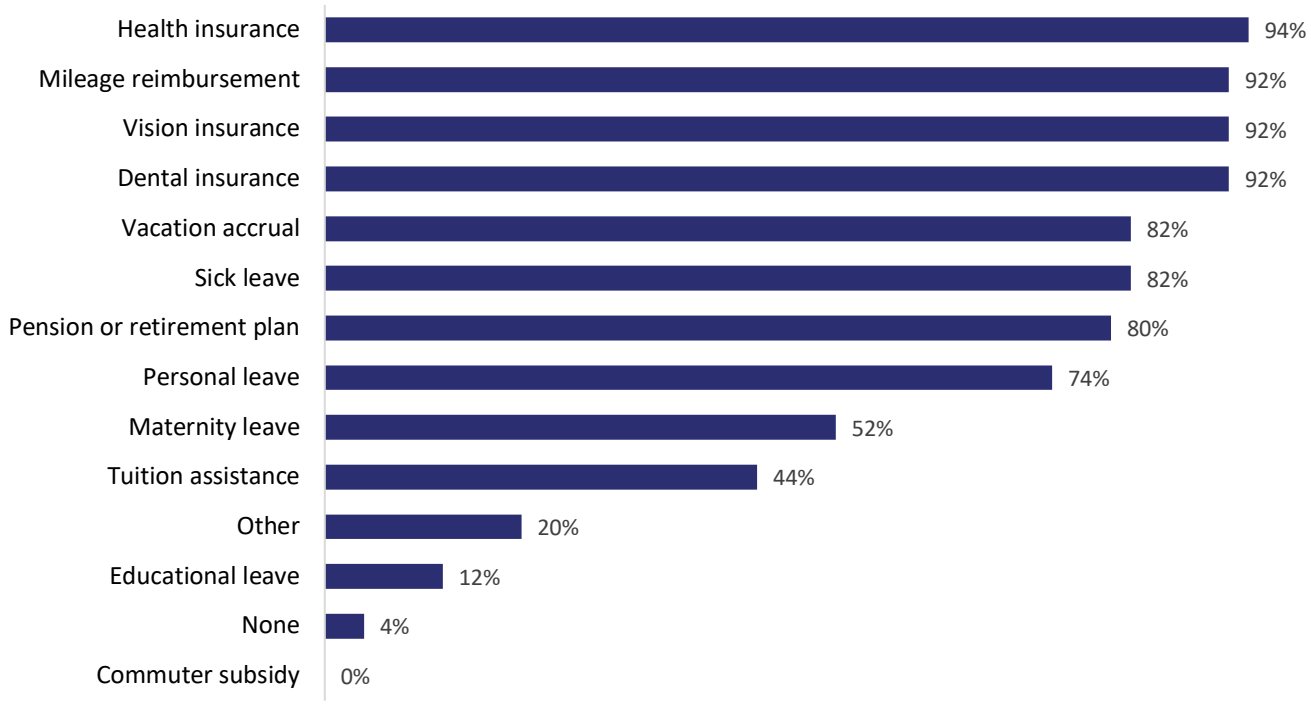
Figure 27. Average Hourly Rates by Organization Setting



Raises and Benefits

Of the 50 programs responding, 49 (98%) indicated that CHWs are eligible for raises or other increases in compensation. While two programs noted they did not provide any benefits, **on average programs offered more than eight (8.2) different benefits to CHWs.** Health insurance, dental insurance, vision insurance, and mileage reimbursement were all offered by more than 90% of programs (see Figure 28). Three programs, however, clarified that benefits are not available to all employees (e.g., contingent employees and part-time employees do not receive benefits) or that some benefits are optional and paid for by the employee. Less common benefits were tuition assistance (44%, *n* = 22) and educational leave (12%, *n* = 6). For the full set of responses, see Appendix A, Table 31, page 80.

Figure 28. Percentage of Programs Offering Different Benefits (N = 50)



RESULTS: CHW SUPERVISION

Based on survey responses, CHWs are supervised by people with a **wide range of credentials and role titles**. The most frequent credential for supervisors was **Registered Nurse (RN)** (40%, *n* =20) and the most frequent role title was **Program Manager or Director** (36%, *n* = 18). For the full set of responses, see Appendix A, Tables 32 and 33, pages 81 and 82.

CHW Supervisor Training

The largest number of programs (74%, n = 37) were providing supervisors with **training on CHW roles and responsibilities** (see Figure 29). Nine programs stated supervisors do not receive any training specific to supervising CHWs. For the full set of responses, see Appendix A, Table 34, page 83.

Figure 29. Most Common Topics of Trainings for Supervisors (N = 50)

Interest in Additional Training

When asked what additional supports or continuing training opportunities would be valuable to supervisors, responses varied. While 16 programs indicated that no additional trainings were needed, the remaining 34 programs described a range of topics including:

- 14 – General supervision trainings
- 3 – Integrating CHWs within multi-disciplinary teams
- 3 – CHW roles
- 2 – HIPAA[19]
- 2 – Billable services

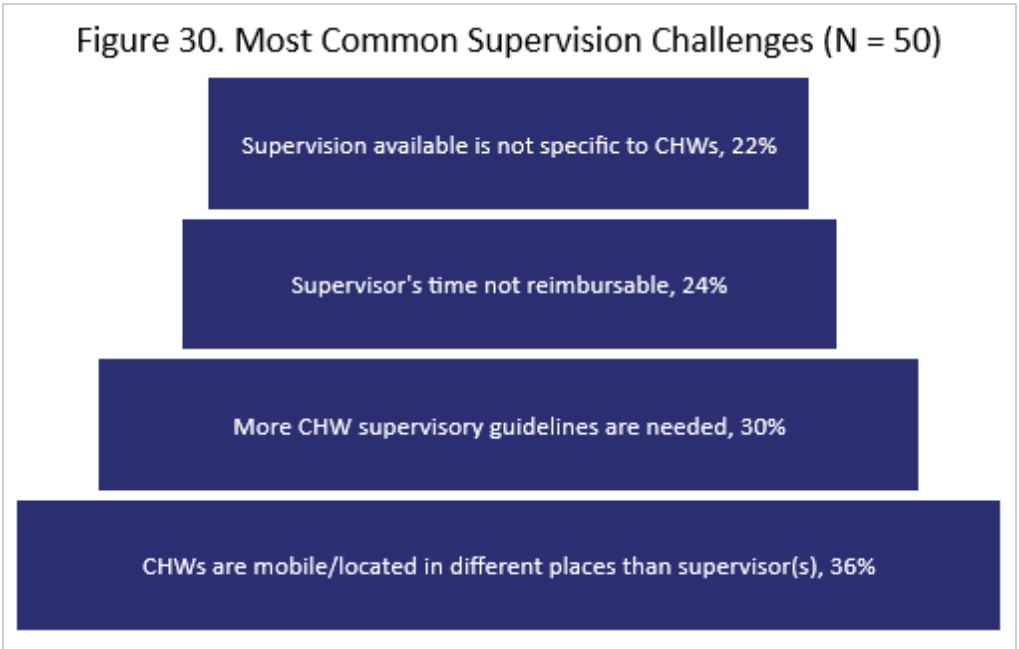
"Any additional training support is good. It is hard to supervise not being a past CHW."

For the full set of responses, see Appendix A, Table 35, page 84.

[19] HIPPA refers to the Health Insurance Portability and Accountability Act of 1996, a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Supervision Challenges

When asked what challenges the CHW program faces in CHW supervision, 36 programs (72%) selected at least one challenge. Just over one-third of programs (36%, *n* = 18) found it **challenging to have CHWs in different locations than the supervisor(s).** Almost as many programs (30%, n = 15) stated that **more CHW supervisory guidelines are needed** (see Figure 30). For the complete set of responses, see Appendix A, Table 36, page 85.

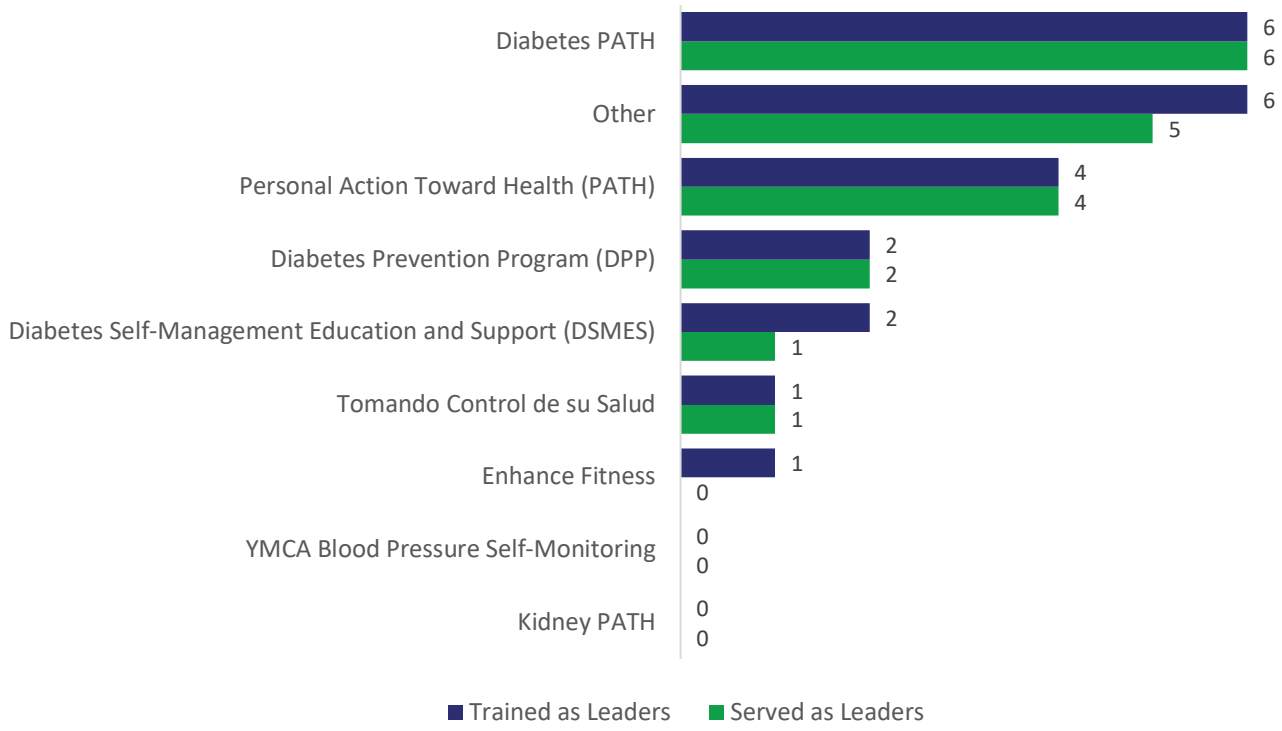


RESULTS: LIFESTYLE CHANGE PROGRAMS

The **majority of programs (78%, *n* = 38) did not have CHWs currently trained as leaders or master trainers of evidence-based lifestyle change programs.** Similarly, most programs (82%, *n* = 40) did not have CHWs who had served or were currently serving as leaders of lifestyle change programs.

Of the 11 programs that had CHWs trained in lifestyle change programs, seven programs had CHWs with training in more than one program. Six of those programs also had CHWs serving as leaders of more than one program. The most common lifestyle change program for both having been trained as a leader and having served as a leader was Diabetes PATH (see Figure 31).

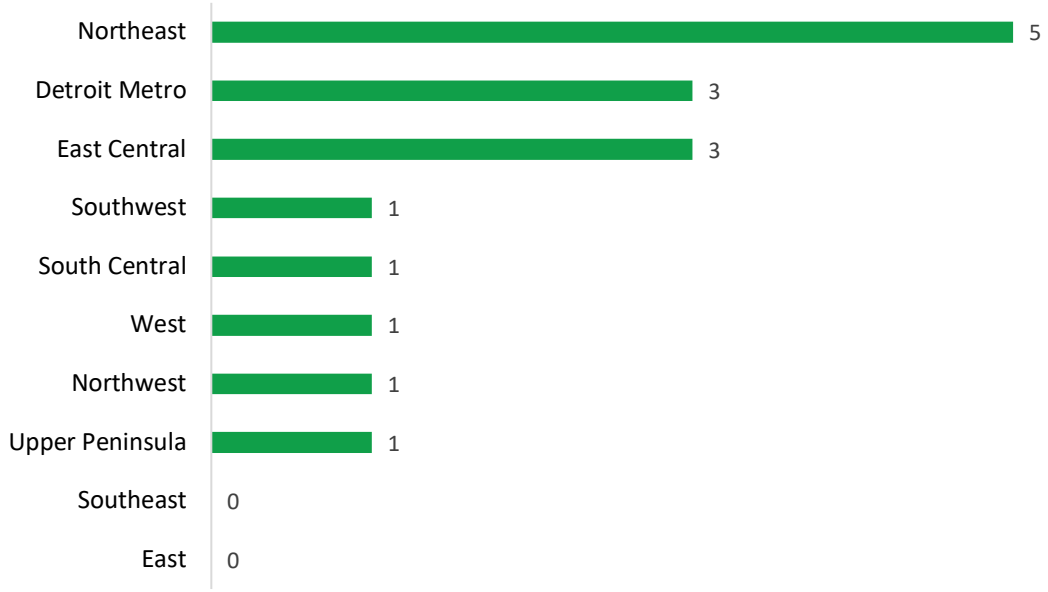
Figure 31. Number of Programs with CHWS Trained and Serving as Leaders of Lifestyle Change Programs (N = 49)



Lifestyle Change Programs by Region

Figure 32 shows that the **11 programs that reported having CHWs trained in lifestyle change programs are not evenly distributed across the state**. Nearly half of these programs have CHWs serving counties in Northeast Michigan. None of these 11 programs reported having CHWs serving in Southeast or East Michigan.

Figure 32. Number of Programs with CHWs with Lifestyle Change Program Training



RESULTS: CHW EVALUATION, MONITORING, AND QUALITY IMPROVEMENT

Evaluation and Monitoring Strategies

CHW programs were asked to indicate the types of evaluation and monitoring they conduct. Most programs (80%, *n* = 39) **track the number and type of clients served**. Over half of programs (53%, *n* = 26) conduct satisfaction surveys or assessments with clients. However, five programs did not select any of the listed strategies, implying that they are not conducting any evaluation or monitoring. For the full set of responses, see Appendix A, Table 39, page 88.

Social Determinants of Health Screening

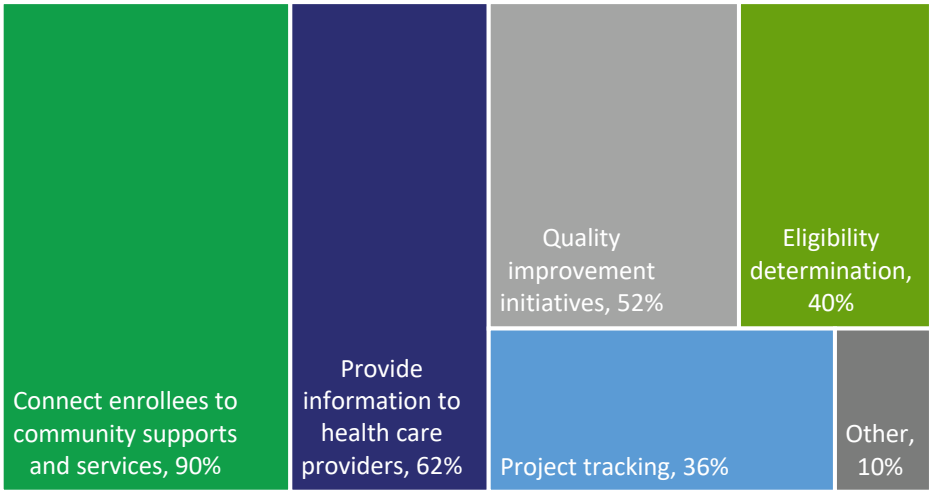
The majority of programs (78%, *n* = 43) reported **using a social determinants of health (SDOH) screening or assessment tool**. However, there was little consistency in the tools programs are using. **Ten programs (20%) indicated using PRAPARE**.[20] An additional ten programs said they used a tool developed by the Community Health Innovation Region (CHIR).

The largest number of programs (36%, n = 18) indicated that they use an "other" SDOH assessment tool Based on written responses, at least eight of these programs are using **internally developed tools,** two of which indicated their plans to transition to the PRAPARE. Five programs reported using more than one tool. Of the programs using an SDOH tool, six programs did not name or select any tool. For the full set of responses, see Appendix A, Table 40, page 89.

Nearly all programs (90%, *n* = 45) stated **using SDOH data to connect enrollees to community supports and services**. Other common uses of SDOH data were providing information to health care providers and for quality improvement initiatives (see Figure 33). For the full set of responses, see Appendix A, Table 41, page 90.

[20] This is the Protocol for Responding and Assessing Patients' Assets, Risks, and Experiences (PRAPARE). It was implemented in a national effort to assist health centers and providers in the process of data collection to properly "understand and act on their patient's social determinants of health" as indicated by the National Association of Community Health Centers. For more information, see: https://www.nachc.org/research-and-data/prapare/.

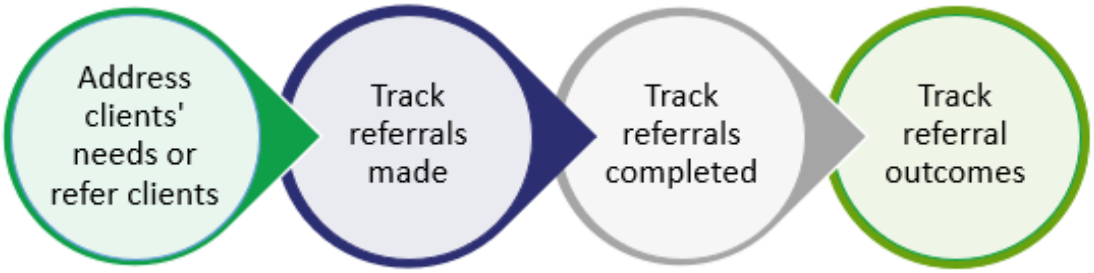
Figure 33. Programs' Uses of SDOH Data (N = 49)



CHW Program Referrals

Employers were asked about the extent to which CHW programs engage in four different activities related to referrals – addressing clients' needs or making referrals, tracking referrals made, tracking referrals completed, and tracking referral outcomes (see Figure 34).

Figure 34. Types of Referral Activities

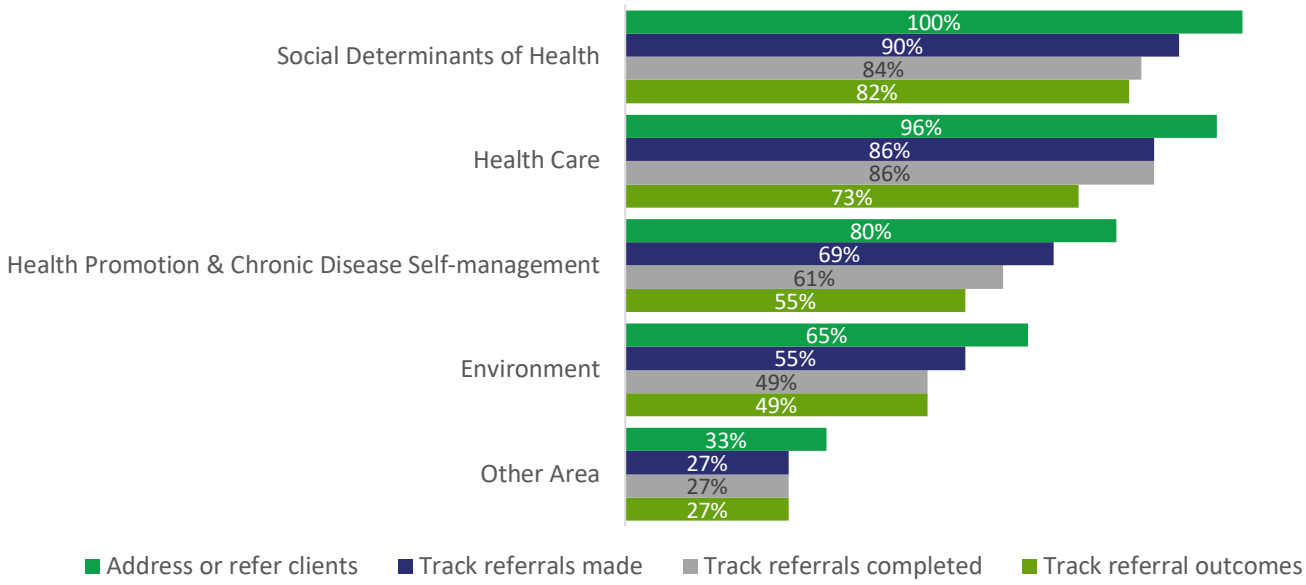


The survey asked about each of these activities in the following topic areas:

- Social Determinants of Health (e.g., housing, transportation, food access, income assistance, etc.)
- Environment (e.g., environmental remediation, referral for warming/cooling stations, disaster relief, etc.)
- Health Care (e.g., primary care, dental care, mental/behavioral health, medication assistance, perinatal/infant/well-child care, etc.)
- Health Promotion/Chronic Disease Self-Management (e.g. tobacco, diabetes, asthma, heart disease, HIV/AIDS, nutrition/physical activity, etc.)
- Other (please specify)

For all topic areas, the majority of programs track whether they address or refer clients, with the percentages declining with each additional level of tracking across all service areas. Overall, **tracking was most frequent for social determinants of health**, followed in declining order by health care, health promotion and disease prevention and the environment (see Figure 35). Sixteen programs also described other areas in which they addressed or referred needs. Many of these related to one or more aspects of social determinants of health, followed by behavioral health. For the full set of responses, see Appendix A, Table 42, page 91.

Figure 35. CHW Program Referrals (N = 49)



CHW Program Use of Indicators

Employers were asked whether they collected data from clients on indicators of general social support, general health status, and general empowerment or activation as part of assessment, risk stratification, or to measure an outcome. Most **programs indicated asking clients questions related to general social support (82%) and general health status (76%), while fewer than half assessed general empowerment** (see Figure 36). In the written descriptions of the instruments or questions used, most programs provided general descriptions. Among those that named specific tools, Pathways[21] was the most frequently mentioned (named by three to four programs in each topic area). For the full set of responses, see Appendix A, Table 43, page 92.

[21] For more information on Pathways, see: https://pchi-hub.com/

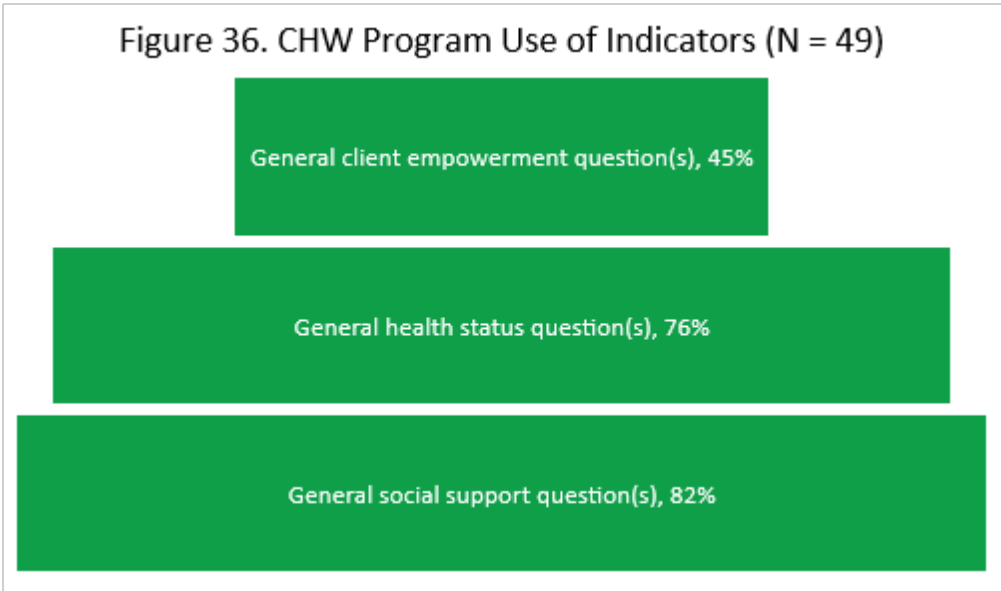


Figure 36. CHW Program Use of Indicators (N = 49)
General client empowerment question(s), 45%
General health status question(s), 76%
General social support question(s), 82%

SECTION 3: SUMMARY, IMPLICATIONS, AND NEXT STEPS

The 2020 MiCHWA CHW Employer Survey found continuing expansion of CHW programs and services throughout Michigan; increasing diversity of CHW roles; and increasing employer use and support for MiCHWA core competency-based training and continuing education offerings for their CHW workforce. The value of CHW certification was supported by most CHW employers. Many CHW programs reported receiving a proportion of their support from more sustainable payment mechanisms such as Medicaid health plan contracts and organization funds. However, a lower sustainable payment mechanism, reliance on time-limited grants was still common and two-thirds of programs reported concern about funding uncertainty. CHW employers reported paying CHWs an average of $16.40/hour, ranging from $13-$27. Most CHW employers reported that while they train CHW supervisors in the CHW roles within their organization, they identified little additional training and several training needs. Most programs conduct at least some client monitoring, assessment and evaluation activities. The most common are tracking how many clients are served and their characteristics, as well as some form of social determinants of health assessment. However, there was little commonality across programs in measures and tools used to do so.

The 2020 survey was conducted amidst the COVID-19 pandemic. Some known CHW employers were unable to respond to the survey due to the pandemic, however, respondents included health departments, federally qualified health centers, community-based organizations, health plans and health systems. Respondents were asked to report data that reflected their situation as of March 1, 2020 (pre-pandemic), except when the items specifically asked about changes due to the pandemic. In response to these questions, some employers reported increased use of telehealth by CHWs, decreasing or eliminating home visits, responding to new client needs and assisting with the COVID-19 response. Some reported furloughs of their CHW workforces.

Findings from the 2020 survey have several key implications for MiCHWA's operations and activities and local and state policies related to CHWs.

- MiCHWA related implications are:
    - To continue to develop and support CHW core competency-based training and continuing education opportunities, statewide, including adapting delivery strategies needed in light of both the COVID-19 pandemic and the geographic spread of CHWs throughout the state.
    - To maintain its focus on educating policymakers in support of state-wide sustainability efforts, including sustainable funding mechanisms for all CHW programs, and state recognition of MiCHWA's role in assuring CHW core competencies are met through MiCHWA-recognized training and certification.
    - To work toward more uniform evaluation indicators of the contributions and outcomes of CHW programs (e.g., encourage use of common CHW program evaluation measures in Michigan, in consultation with the national Common Indicators project).
    - To consider offering supervisor training for CHW employers.

Despite the impact of the COVID-19 pandemic, this report has highlighted that CHWs play a growing diversity of roles, although community capacity building was a much less frequent role except for those employed by community organizations. MiCHWA and its partners should consider strategies for

promoting the traditional roles of CHWs, including community capacity building, in diverse environments.

The report has also found both challenges to the CHW workforce and employers, and potential opportunities for growth, brought on by the COVID-19 pandemic, including furlough, changing roles and service locations. It will be important for MiCHWA and stakeholders to monitor the ongoing impact on the CHW workforces and educate employers and policy makers about the need for increasing the CHW workforce, and the roles of CHWs in both addressing pandemic related needs and the increasing health and social needs of the communities they serve.

The 2020 CHW Employer Survey Evaluation Report will be disseminated to the MiCHWA Board, CHWs, MDHHS, survey respondents and various CHW stakeholder groups via the MiCHWA website, newsletter, and email. The report findings will later be shared through one-page infographic summaries tailored to specific stakeholder groups. Finally, the survey instrument and distribution list will be refined for use in the 2022 survey. MiCHWA will use participatory approaches with stakeholder groups to elicit feedback on survey findings, and to guide strategy development.

APPENDIX A: DATA TABLES

CHW EMPLOYERS

Organization Settings

Table 3. What organization settings employ CHWs? (N = 47)		
	n	**%**
Federally qualified health center (FQHC)	16	34.0%
Local health department (county, district, or city)	8	17.0%
Community-based organization (other)	6	12.8%
Health system (e.g., Henry Ford Health System, Spectrum Health System)	6	12.8%
Medicaid managed care organization/Medicaid health plan	3	6.4%
Non-profit County Health Plan	3	6.4%
Academia/Research	1	2.1%
Community health center (non-FQHC)	1	2.1%
Hospital	1	2.1%
IHS/tribal organization	0	-
Medical clinic	0	-
Behavioral health organization	0	-
Commercial health insurance plan	0	-
Dental practice or clinic	0	-
Other: • Area Agency on Aging • Complex Care Management Organization	2	4.3%

CHW PROGRAMS

Table 4. In what county or counties do the CHWs that the CHW program employs deliver services? (N = 53)											
Alcona	5	Cheboygan	3	Houghton	1	Lenawee	4	Muskegon	3	Shiawassee	4
Alger	0	Chippewa	1	Huron	5	Livingston	4	Newaygo	5	St. Clair	3
Allegan	4	Clare	6	Ingham	5	Luce	0	Oakland	8	St. Joseph	2
Alpena	4	Clinton	3	Ionia	4	Mackinac	0	Oceana	4	Tuscola	5
Antrim	3	Crawford	3	Iosco	6	Macomb	9	Ogemaw	6	Van Buren	3
Arenac	5	Delta	0	Iron	1	Manistee	3	Ontonagon	1	Washtenaw	6
Baraga	0	Dickinson	0	Isabella	6	Marquette	1	Osceola	7	Wayne	14
Barry	4	Eaton	2	Jackson	6	Mason	4	Oscoda	4	Wexford	4
Bay	4	Emmet	3	Kalamazoo	2	Mecosta	5	Otsego	3		
Benzie	3	Genesee	7	Kalkaska	3	Menominee	1	Ottawa	6		
Berrien	4	Gladwin	8	Kent	10	Midland	5	Presque Isle	4		
Branch	2	Gogebic	0	Keweenaw	1	Missaukee	4	Roscommon	7		
Calhoun	3	Grand Traverse	3	Lake	5	Monroe	4	Saginaw	4		
Cass	4	Gratiot	4	Lapeer	6	Montcalm	4	Sanilac	4		
Charlevoix	3	Hillsdale	4	Leelanau	3	Montmorency	3	Schoolcraft	0		

Table 5. Sum of number of counties in which CHWs deliver services (N = 53)		
Number of counties served	**Number of programs**	**Percent of programs**
1 county	20	37.7%
2 counties	7	13.2%
3 counties	9	17.0%
4 counties	7	13.2%
5 counties	1	1.9%
6 counties	3	5.7%
10 counties	1	1.9%
13 counties	1	1.9%
17 counties	1	1.9%
32 counties	1	1.9%
65 counties	1	1.9%
68 counties	1	1.9%

Changes in CHW Programs in Response to COVID-19

Table 6. In response to the COVID-19 pandemic, please describe 1) any changes related to CHW roles and/or activities; 2) any changes in where the CHW program's CHWs deliver services; and 3) any changes in how the CHW program's CHWs deliver services.[22]
49 programs described at least one change in response to the COVID-19 pandemic
Changes in CHW staffing:
Programs that furloughed CHWs (n = 3):
We have stopped home visiting and furloughed 8 of 10 CHWs (lay-off status). We are recalling a few CHWs as we are re-opening for more face-to-face visits.
A position was left unfilled until May 29th, and temporary layoffs were done including CHWs for a few weeks.
They were furloughed on April 22nd. Return date TBD.
Changes in roles or activities:
Programs reducing services (n = 8):
CHWs focused solely on screening members for SDOH needs and making referrals based on the findings. CHWs ceased meeting with members face to face on March 13, 2020. [Health Plan] is not currently participating in community programs as of March 13, 2020.
CHW roles have gone down to essential services at this time. [where deliver services] via telephone. reduces services and via telephone.
CHWs do not go into homes currently.
[Deliver services] in the FQHC only. No group classes or sessions, limited in person.
Now doing very few home visits, only done when absolutely necessary with supervisor approval.
They are involved with roles at our drive through test sites, a position was left unfilled until May 29th, and temporary layoffs were done including CHWs for a few weeks. In person classes and support groups are suspended for now.
We had to put the program on hold during COVID19.
Reassigned to other sites.
Programs addressing new client needs (n = 7):
We no longer are just focused on integration of health services for diabetes and other disease prevention. We are helping our patients secure food thought the Food Box Distribution Program.
CHWs were used in response to COVID-19 to check in with patients that were at high risk for complications to see how they were doing, and to check on any basic needs that needed to be met.
CHW 's are helping isolated families access resources. For home bound individuals, this has expanded to include pantry porch drops and prescription pickups. During COVID, our CHW program has also aided in additional Spanish translation services.
Food Pantry; Delivering medications; Delivering food & other resources; COVID-19 funds (hotel rooms). Increase in home services. RX delivery; food delivery.
Since COVID-19 have 3 full-time CHW's working in Community Connections to help address referrals related to COVID-19 basic need issues. CHW's have been heavily involved in the aging population agencies for food insecurity identification and then distribution. Unemployment assistance and mental health concerns have been large problems seen in Northern Michigan.
Many clients have had increasing difficulties meeting needs and have had additional family stressors. Staff

[22] While these were asked as separate questions, respondents mixed comments about roles, service settings, and modes of service in their responses to the questions. Therefore, responses are reported together.

are being pulled into many different areas.
Helping pts. access prescriptions.
Programs conducting COVID-19 education (n = 6):
Participate in Covid-19 Patient Education.
We no longer are just focused on integration of health services for diabetes and other disease prevention. addressing misconceptions and myths about the virus in attempts to raise awareness and promote overall well-being.
Providing education about COVID and testing procedures and around mask wearing.
Heavy focus on COVID related health education.
Explaining COVID-19 and updates
Providing information and support to patients
Programs conducting SDOH screening (n = 4):
CHWs focused solely on screening members for SDOH needs and making referrals based on the findings.
Implemented phone screenings for SDOH.
The CHW role has not changed but patients are being identified for services through a COVID-19 SDOH screening tool that is administered to all COVID+ patients being discharged from the hospital and those who are being contacted by the health department for contact tracing.
We are also enhancing the role of the CHW in this program to include SDOH assessments and follow up.
Programs conducting COVID-19 testing (n = 4):
We also provide lab testing, including Covid-19 testing kits and education, working with the health departments on positive test follow up services.
Our CHW's our now focused on getting our patients tested for COVID-19
They are involved with roles at our drive through test sites.
When we are out in the community, we have been supporting COVID-19 testing events.
Programs conducting COVID-19 screening (n = 3):
Asking Screening Questions
Door screenings (symptoms and temperature).
We have been given times to cover COVID-19 screening.
Programs providing staff support (n = 3):
The CHW are also helping staff with resilience activities. Staff are being pulled into many different areas.
Increased peer support
Supporting staff in completing cleaning procedures.
Programs attending trainings (n = 2):
Attending lots of trainings and webinars
Increased participation in webinars/trainings.
Changes in service settings:
Programs that completely stopped in-home visit (n = 8):
Our program has been unable to fully see clients as we were able to previously but continue to attempt to meet client needs.
No home visits are made currently.
We have stopped home visiting. Our organization is just starting to plan for re-opening to more face-to-face visits once employee and patient protection/infection control measures can be fully implemented.
CHWs are only working telephonically--not visiting people in the community or their homes. CHWs are not delivering services in homes--though we hope this will change
The CHW no longer go into the home but will again eventually.
[Program] suspended home visiting in keeping with the Governor’s Executive Orders. To slow the spread of

the virus, we have postponed ALL non-essential home visiting at this time. However, CHAP is tracking anyone that requires a home visit and will resume that portion of client engagement when safe to do so.
CHWs do not go into homes currently.
No home visiting at this time.
Programs conducting porch drop offs (n = 6):
Doing deliveries of basic needs with no member contact.
Doing porch drop offs for needed supplies.
CHWs have done porch drop off and socially distant meet ups to give clients resources if needed.
CHW 's are helping isolated families access resources. For home bound individuals, this has expanded to include pantry porch drops and prescription pickups. During COVID, services are primarily over the phone and porch drops of resources. Services are primarily teleservices or porch drops.
Food Pantry; Delivering medications; Delivering food & other resources; COVID-19 funds (hotel rooms). Increase in home services. RX delivery; food delivery.
Supplies dropped off on porch.
Programs restricting services to clients' homes (n = 1):
Delivery of services have been more restricted to client's homes because they are sheltering in place.
Changes in mode of service delivery:
Programs that transitioned to telehealth (n = 37):
CHW no longer completing home visits. All contact has been providing telephonic support. CHW working from home and delivering services remotely. Using video chat; more telephonic support than normal. Client visits being conducted telephonic and remotely.
CHW's have temporarily moved to telephonic outreach and they are doing deliveries of basic needs with no member contact. no home visiting at this time.
Currently offering virtual visits with individuals.
Work remotely, delivered education via phone/virtually. Working remotely and provide services over the phone/virtual calls. No direct person contact. Visits are done over the phone.
CHW roles have gone down to essential services at this time. [where deliver services] via telephone. reduces services and via telephone.
Due to the COVID-19 Pandemic, [program] staff worked remotely from home but is still fully operational. [program] suspended home visiting in keeping with the Governor's Executive Orders. Due to the COVID-19 Pandemic, [program] staff are currently working remotely from home. To slow the spread of the virus, we have postponed ALL non-essential home visiting at this time. However, [program] is tracking anyone that requires a home visit and will resume that portion of client engagement when safe to do so. The [other program] group continues to provide lead education and assist clients with completing a Lead Safe Home Application telephonically. Home visits for [other program] clients will resume when MDHHS deems it safe to do. CHWs do not delivery or instruct about car seats.
We are utilizing phone more than before.
CHW is now hosting meetings via Zoom (orientation, participating in gaining access to telehealth). Most meetings are hosted via teleconference. Will need to ramp up to in-person meetings. Still providing services through all channels except in-person meetings.
Telephone, mail, and on-site resource pick-up only. No in-person.
Increase in phone encounters versus face to face.
Decrease in face to face, more phone calls.
Implemented phone screenings for SDOH. More phone contacts.
CHWs are working from home and conducting most of their functions telephonically. Some functions are still being addressed in the community. CHWs are providing more services telephonically from their homes,

although some are still provided in the community.
Our program has been unable to fully see clients as we were able to previously but continue to attempt to meet client needs. Doing more work telephonically from home. Increase in telephonic work and no in home visits.
Telephone encounters have increased due to COVID-19 pandemic.
Using mail, fax, telephone, email.
Transition to telehealth with stay at home orders. Pulled back to office setting. Less in person more calls.
Telephonic only
Working remotely and conducting DM education over the phone and virtually. Delivered over the phone or virtually. Work is performed remotely.
The CHW no longer go into the home but will again eventually. The CHWs have been working mainly from home completing their assessments and follow ups telephonically. Telephone calls.
Providing services via tele health. No home visits are made currently. Only tele-health services now.
All services are currently remote, however usually we strive for 2/3 of visits to be face-to-face. As mentioned above, currently all [program services] is being performed remotely. It is the standard to complete 2/3 of visits face-to-face. Currently, remote work only.
CHWs role in [program] has not changed. CHWs conduct [CHW program] virtually (Zoom) we used to do in person but since COVID everything is over the phone or another virtual platform.
We have been moving a lot of our outreach and intervention to virtual. Included but not limited to [program] moving to virtual group prenatal care. CHWs have also been adopting hybrid method of work where they are working from home and in office, depending on specific department. All correspondences are done over the or over other virtual platforms.
CHWs are only working telephonically--not visiting people in the community or their homes. CHWs are not delivering services in homes--though we hope this will change.
The CHW visits have transitioned to virtual visits via phone and video. Outreach to outside locations has decrease or stopped. Only using 2 CHWs currently to help provide resource information, follow-up for MI Care Team visits. Major switch to telehealth visits rather than face-to-face visits. Our organization is just starting to plan for re-opening to more face-to-face visits once employee and patient protection/infection control measures can be fully implemented.
Unable to perform face to face visits, heavy focus on COVID related health education. unable to deliver services face to face in any settings. No in person.
In person classes and support groups are suspended for now.
No contact
No direct on contact
Our research is transitioning to completely digital. The effects of this change on the CHW are unknown at this time. CHW will be delivering services digitally via skype. In-person meetings have been changed to the digital services.
Changes to CHW roles/activities include working remotely from home, no face to face client engagement. No in person meetings.
No in person contact during COVID-19.
Currently we are mostly providing services remotely rather than in home visitation. Until COVID visits were mostly in person. Now visits are almost exclusively done remotely.
All communication has been completed by phone.
Virtual visits, videos, text and phone calls.
Services are primarily teleservices or porch drops.

CHW Roles and Sub-Roles

Table 7. What roles do CHWs play in your organization? (N = 53)			
	n 2020	% 2020	% 2018
Conducting outreach			
Follow-up on health and social services	47	88.7%	75.0%
Presenting at local agencies and community events	29	54.7%	70.5%
Home visiting	34	64.2%	63.5%
Case-finding and recruitment of individuals	38	71.7%	52.3%
Advocating for individuals and communities			
Connecting to resources and advocating for basic needs	53	100%	79.5%
Advocating for the needs and perspectives of communities	40	75.5%	54.5%
Conducting policy advocacy	21	39.6%	18.2%
Providing coaching and social support			
Motivating and encouraging people to obtain care and other services	53	100%	79.5%
Providing individual support and coaching	52	98.1%	72.7%
Supporting self-management of health	41	77.4%	63.6%
Planning and/or leading support groups	12	22.6%	34.1%
Care coordination, case management, and system navigation			
Facilitating transportation to services and helping address other barriers to services	50	94.3%	68.2%
Making referrals and providing follow-up	48	90.6%	70.5%
Documenting and tracking individual and population level data	32	60.4%	61.4%
Participating in care coordination and/or cancer management	43	81.1%	59.1%
Information and systems about community assets and challenges	42	79.2%	59.1%
Providing culturally appropriate health education and information			
Health promotion and disease prevention education	45	84.9%	65.9%
Providing necessary information to understand and prevent disease	41	77.4%	61.4%

Table 7. What roles do CHWs play in your organization? (N = 53)			
	n 2020	% 2020	% 2018
Cultural mediation among individuals, communities, and health and social service systems			
Educating individuals and communities about how to use health and social service systems	50	94.3%	54.5%
Building health literacy and cross-cultural communication	37	69.8%	38.6%
Educating systems about community perspectives and cultural norms	30	56.6%	27.3%
Building individual and community capacity			
Building individual capacity	52	98.1%	50.0%
Building community capacity	33	62.3%	20.5%
Training and building individual capacity with CHW peers and among groups of CHWs	26	49.1%	36.4%
Providing direct service			
Meeting basic needs	42	79.2%	38.6%
Providing basic screening tests	10	18.9%	25.0%
Providing basic services	5	9.4%	9.1%
Implementing individual and community assessments			
Participating in individual-level assessments	28	52.8%	36.4%
Participating in community-level assessments	17	32.1%	20.5%
Participating in evaluation and research			
Engaging in evaluating CHW services and programs	41	77.4%	22.7%
Data collection and interpretation	19	35.8%	22.7%
Sharing results and findings	21	39.6%	20.5%
Identifying and engaging community members as research partners	18	34.0%	13.6%
Identification of priority issues and evaluation/research questions	11	20.8%	13.6%
Engaging stakeholders to take action on findings	13	24.5%	22.7%
Development of evaluation/research design and methods	25	47.2%	9.1%

Table 8. Please indicate whether the CHW program's CHWs regularly work within a multidisciplinary team. If yes, please explain:
YES = 46 programs (86.8%); NO = 7 programs (13.2%) **41 programs provided an explanation**
Health care sector teams:
The [program] is for all clients within the health department that are pregnant or have young children. The CHW works with clerks, technicians, peer counselors, nurses, dietitians and social workers on a regular basis.
They work as part of the care team.
CHWs are part of a Population Health Management program that includes physicians, nurses, psychologists, MSWs, pharmacists and LPNs.
Work in a team with doctors, nurses, pharmacists, occupational therapists and social workers.
The CHW's work closely work the Social Workers/Integrated Case Managers
We receive referrals from the providers, as well as the community at large. We work closely with Behavioral Health and Nurse Case Managers.
CHW's are part of a client services team that also includes social workers.
Registered Nurse and potential Social Worker.
CHW are integrated into the health care team and provide warm handoffs, patient education and referrals.
The CHWs work on a multidisciplinary team that consists of social workers and RNs.
CHW's work closely with RN's and MSW's as well as provider offices, health plan associates, other community organization representatives.
CHW's work closely with RN's and MSW's as well as provider offices, health plan associates, other community organization representatives.
MI Care Team includes Medical Provider, Care Management Nurse, Integrated Behavioral Health Specialist (LMSW), Medical Assistant, Pharmacist, Dietitian, and Community Health Worker.
They are part of the behavioral health team, work with therapists, health providers, dentists, nurses and other staff.
Prior to the COVID-19 pandemic, our CHW worked in the Emergency Department alongside RN's and doctors.
Working with Nurse
We work with a supervising nurse and others to discuss specific cases.
CHWs work closely with dentists, physicians, nurse care managers, and medical assistants to assist in care coordination.
Our program has RN and SW support to our Community Health Workers for complex needs and navigation.
Case Manger nurse, CHW
Nurse and CHW
Nurse, social worker and CHW
Our CHWs are part of the Case Management team, which regularly consults with other departments on shared patients.
CHWs coordinate with medical and social services agencies in Livingston and Washtenaw County through shared IT platform, care notes, and assessments.
CHWs are integrated into clinical teams to work on clients holistically.
CHWs work with Certified Nurse midwives as co-facilitators of Group Prenatal Care.
Community Connections team includes MSW and RN with CHW's. The CHWs are part of a care team which consists of physicians, nurse practitioners, nurses, and medical assistants.
Total care team approach. Warm hand offs from provides to follow up on anything social determinants of health or uninsured all are referred to CHW for application process.

CHW are a part of the Care Team at each of our clinics.
Collaboration with PCP, Care Manager, Care Connector and Behavioral Health.
With medical and dental providers, behavioral health staff, and continuum of care personnel.
Each CHW is part of a provider team as well as working with pharmacy, behavioral health and OB specialty department
CHW program is run alongside our care management program. We employ 2 RN care managers as well; work is also delegated by the care management team to connect patients to community resources.
Our CHW works as part of a team consisting of medical assistants, health coaches, staff nurses, nurse care managers, nurse practitioners, and physicians.
Support the Medication Assisted Program (provider, therapist, MAT program manager), provide support as a peer recovery coach, serves as a certified application counselor, and a MI Bridges navigator
Our CHW team is comprised of Nurses, Social Workers and traditional CHWs. They work together to serve our clients. They also work with staff of Medical Homes and other agencies to provide services and access and use the services of those agencies.
The CHW's work with our Medical providers, Behavioral Health, and dental programs insuring full scope of care is provided to our patient population. We also have WIC programs, and make referral to external agencies, and enroll in insurance products.
The CHW works with Social workers, nurses, clerks, and dietitians.
MSW's, RN's
Community-based teams:
I am a social worker and provide clinical supervision. We collaborate with clinicians in our health centers, jail employees, and mental health professionals both in our jail and community. We have a partnership with local shelters where we send two staff two times a week to provide services to shelter clients.
CHWs coordinate with medical and social services agencies in Livingston and Washtenaw County through shared IT platform, care notes, and assessments.
Community Based Team
CHW program is run alongside our care management program. We employ 2 RN care managers as well, work is also delegated by the care management team to connect patients to community resources.
Support the Medication Assisted Program (provider, therapist, MAT program manager), provide support as a peer recovery coach, serves as a certified application counselor, and a MI Bridges navigator.

Service Settings

Table 9. Where do the CHW program's CHW's deliver services? (N = 53)		
	n	**%**
Client's home	32	60.4%
Community events (including outdoor events)	19	35.8%
Community health center (FQHC or non FQHC health center)	18	34.0%
Public housing unit	18	34.0%
Shelters	16	30.2%
Private clinic or medical practice	12	22.6%
Hospital	12	22.6%
School	11	20.8%
On the street (e.g. to reach homeless individuals)	11	20.8%
Other non-profit organization not specified above	11	20.8%
CHW Program offices, if none of the above locations	11	20.8%
Client's work site	10	18.9%
Free clinic	8	15.1%
Migrant camp	6	11.3%
Health maintenance organization (HMO) offices	3	5.7%
Teen centers	3	5.7%
Other: • "Churches, community centers and various community agencies" • "Health department location" • "Libraries and other community locations (including McDonald's or coffee shops)" • "Local health department" • "Medical Center" • "Medical Homes as needed" • "Mobile medical and dental units in both rural and urban settings" • "Patient request i.e. fast food restaurant, home porch, where patient requests" *Note: 6 programs selected other, but 8 programs described additional locations.*	6	11.3%

Mode of Service Delivery

Table 10. How do the CHW program's CHWs deliver services? (N = 53)		
	n	**%**
Telephone calls	53	100.0%
In-person meetings[23]	40	75.5%
Email	38	71.7%
Text or chat messages	30	56.6%
One-on-one through video communication	19	35.8%
Group classes or session in person	12	22.6%
Group classes or sessions through video communication	5	9.4%
Other:[24] • "Electronic Health Record" • "Patient portal communication (rarely)"	2	3.8%

Inactive Programs

Table 11. Has your organization ever had one or more CHW program(s) that are no longer active? If yes, please explain:
YES = 6 programs (12.8%); NO = 41 programs (87.2%) **6 programs provided an explanation**
"[Organization] served as a HUB for Pathways to Better Health for 4 agencies. Currently, three of the agencies are still providing CHW services (Ingham, Ottawa, Mid-Michigan Health Dept). Only Barry-Eaton Health Department has ceased operations in August 2017."
"Funding ended for all previous interventions."
"Michigan Pathways to Better Health was the first CHW program that we participated in."
"We had a program funded by MPCA that is no longer active."
"WE CARE[25] has hired 3 CHW's. One left the team shortly after joining. Another left the team to pursue a degree and the last is still with the team."
"Unknown"

[23] One person described in-person meetings occurring "at libraries, restaurants, community centers etc."
[24] Two "other" responses were excluded from this count based on written information that did not describe a unique mode of service delivery.
[25] The Social Interventions Research & Evaluation Network (SIREN) defines WE CARE (Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education) as a clinic-based screening tool consisting of 12-questions developed especially for pediatric settings. It assesses 6 main domains, including: parental educational attainment, employment, childcare, risk of homelessness, food security, and household heat and electricity. For more information, see [https://sirenetwork.ucsf.edu/tools-resources/mmi/we-care].

Populations Served

Table 12. Which population(s) are regularly represented among the CHW program's clientele? (N = 52)		
	n	**%**
Non-Hispanic White	48	92.3%
Black or African American	40	76.9%
Hispanic or Latino	38	73.1%
American Indian or Alaska Native	20	38.5%
Arab American/Middle Eastern Descent	19	36.5%
Native Hawaiian and other Pacific Islander	10	19.2%
Other Race: • "Chinese " • "Vietnamese"	3	5.8%
Adults (26 – 64)	50	96.2%
Young adults (19-25)	44	84.6%
Seniors (65+)	42	80.8%
Children (0-18)	28	53.8%
Individuals without a Primary Care Provider	34	65.4%
Uninsured individuals	33	63.5%
People with Diabetes	33	63.5%
Homeless individuals	32	61.5%
People with Obesity	32	61.5%
History of frequent Emergency Department (ED) use	31	59.6%
People with Hypertension	31	59.6%
People with Heart Disease	29	55.8%
History of frequent hospitalization	26	50.0%
People with Asthma	24	46.2%

Table 12. Which population(s) are regularly represented among the CHW program's clientele? (N = 52)		
Pregnant women and infants	20	38.5%
Isolated rural residents	19	36.5%
Incarcerated and returning individuals	19	36.5%
People with Cancer	18	34.6%
Immigrants/refugees	15	28.8%
Farm or migrant workers	14	26.9%
People with HIV AIDS	13	25.0%
Sexual minorities (i.e., LGBTQ individuals)	12	23.1%
Other special populations: • "All MHP members" • "Children with elevated blood lead levels, pregnant women with lead risk exposure in their homes and adults and children in need of a connection to their Dental Home" • "Differently abled (deaf, blind), non-native English speaking" • "Geriatric" • "Homebound" • "Patients with two or more chronic conditions" • "Undocumented"	8	15.4%

CHW FUNDING AND SUSTAINABILITY

Funding Sources

Table 13. What percentage of the CHW program is supported by each of the following funding sources? (N = 49)		
Funding Type	**Average % support over all programs[26]**	**Average % support over programs receiving funding type[27]**
General organization funds (not time-limited)	32.3%	83.3%
Medicaid health plan contract	14.8%	66.1%
Time-limited federal government grant(s)	12.8%	62.6%
Time-limited private foundation(s) funding	7.8%	64.0%
Time-limited State government grants (excludes Medicaid)	6.5%	64.0%
Other non-profit organization(s)	4.5%	44.2%
Other time-limited public funding: • "Northern Michigan Health Consortium"	6.1%	100.0%
Millage(s) specific to CHW programs/services	0.8%	12.7%
Medicaid Outreach[28]	1.7%	28.2%
Non-profit hospital Community benefit funds	4.1%	100.0%
Commercial health plan contract	2.1%	51.0%
Time-limited Local government grant(s)	0.4%	20.0%
Other insurance: • "Delta Dental contract"	0.1%	3.0%
Medicaid, not health plan contract / Medicaid, fee for service	-	-
Ongoing private foundation funding	-	-

[26] This column is calculated by dividing the sum of percent funding by all 49 programs responding to the question.
[27] This column is calculated by dividing the sum of percent funding by the number of programs who receive that type of funding (column 2).
[28] Medicaid Outreach is the funds that MDHHS Medicaid has approved for Medicaid-related outreach, enrollment and service coordination. These services are not billed as fee-for-service, rather they go through a cost-settlement process. The health departments report their outreach activities and cost, then work with the department to obtain the federal match.

State Children's Health Insurance Program (SCHIP)	-	-
Other: • "employer pay to participate model" • "funded by operating revenues" • "HRSA" • "program income" • "CHW was originally hired for the connection to care program. Once the program was not refunded, CHW was hired full-time to stay at MyCare"	5.9%	78.2%

Table 14. Number and Percent of Programs Receiving Funding Types

Funding Type	n	%
General organization funds (not time-limited)	19	38.8%
Medicaid health plan contract	11	22.4%
Time-limited federal government grant(s)	10	20.4%
Time-limited private foundation(s) funding	6	12.2%
Time-limited State government grants (excludes Medicaid)	4	10.2%
Other non-profit organization(s)	5	10.2%
Other time-limited public funding: • "Northern Michigan Health Consortium"	3	6.1%
Millage(s) specific to CHW programs/services	3	6.1%
Medicaid Outreach[29]	3	6.1%
Non-profit hospital Community benefit funds	2	4.1%
Commercial health plan contract	2	4.1%
Time-limited Local government grant(s)	1	2.0%
Other insurance: • "Delta Dental contract"	1	2.0%
Medicaid, not health plan contract / Medicaid, fee for service	0	-

[29] Medicaid Outreach is the funds that MDHHS Medicaid has approved for Medicaid-related outreach, enrollment and service coordination. These services are not billed as fee-for-service, rather they go through a cost-settlement process. The health departments report their outreach activities and cost, then work with the department to obtain the federal match.

Ongoing private foundation funding	0	-
State Children's Health Insurance Program (SCHIP)	0	-
Other: • "employer pay to participate model" • "funded by operating revenues" • "HRSA" • "program income" • "CHW was originally hired for the connection to care program. Once the program was not refunded, CHW was hired full-time to stay at MyCare"	5	8.2%

Health Plans

Table 15. With which health plans is the CHW program currently contracting or in discussions with? (N = 49)

	Number of Programs Contracting	Number of Programs in Discussion
McLaren Health Plan	6	3
Blue Cross Complete of Michigan	5	2
Meridian Health Plan of Michigan	4	3
Molina Healthcare of Michigan	4	1
United HealthCare Community Plan	4	1
Priority Health Choice	3	2
Total Health Care	2	-
Aetna Better Health of Michigan	2	-
HAP Midwest	1	-
Upper Peninsula Health Plan	1	-

Table 16. Number of CHW Programs with Health Plan Contracts and Discussions and Number of Contracts by Region			
	Number of Programs Contracting (N = 14)	**Number of Programs in Discussion (N = 5)**	**Number of Contracts**
Detroit Metro	5	1	9
Northeast	4	1	9
Northwest	3	2	3
West	3	2	4
East Central	3	0	7
East	3	0	7
South Central	3	0	7
Southeast	3	2	7
Upper Peninsula	2	0	1
Southwest	1	0	1

Payment Models

Table 17. What payment modes are being used to support the CHW program's CHWs? (N = 49)		
	n	**%**
Does not apply	34	69.4%
Fee-for-Service based hourly or per unit reimbursement	7	14.3%
Per member per month payment for the clinical care team, including the CHW	2	4.1%
Per member per month payment for the CHW only	1	2.0%
Outcomes-based or value-based payment for specific health outcomes per member	1	2.0%
Bundled payment for services, including those of the CHW	1	2.0%
Other: • "Case rate" • "In discussion with per member/month [health plan] and Outcome based payments [two other health plans]" • "Payment for FTEs of CHWs." • "Payment through MI Care Team provides monthly payment for enrolled Medicaid patients as long as monthly visit/contact is made by member of the MI Care Team. If no visit, payment must be returned." • "We could use a lot more assistance to set up contractual agreements and new sources of payments." • "We pay our own CHW employees."	6	12.2%

Program Sustainability

Table 18. What are the CHW program's concerns when it comes to longevity and sustainability of CHW employment? (N = 49)				
	2020		2018	
	n	%	n	%
Funding uncertainty	32	65.3%	34	77.3%
Finding qualified CHWs	16	32.7%	12	27.3%
Staff turnover	11	22.4%	15	34.1%
Management support for CHWs	9	18.4%	8	18.2%
Non-acceptance of CHW role by other team members	4	8.2%	10	22.7%
No concerns	3	6.1%		
Other: • "Burnout" • "Hiring additional staff to cover growing needs" • "Program longevity" • "Reimbursement by insurance companies for long term sustainability" • "Told we are not billable"	5	10.2%	8[30]	18.2%

[30] 2018 "other" responses not listed

Table 19. How does the CHW program work to support and/or promote CHWs and their long-terms sustainability? (N = 49)		
	n	**%**
Pay for CHWs to become certified	37	75.5%
Professional development	36	73.5%
Continuing education	32	65.3%
Policy changes	25	51.0%
Business case	25	51.0%
Public education	22	44.9%
Health plan contracts	17	34.7%
Retention plan	15	30.6%
Not at this time	2	4.1%
Other	0	-

CHW HIRING

Educational Requirements

Table 20. What, if any, minimum educational requirement MUST CHWs meet to be hired by the CHW program? (N = 53)		
	n	**%**
High School Diploma or GED • "GED/HS Diploma and They also will be required to become certified as a CHW (MiCHWA)." • "Minimum credential required to provide the service i.e. Nurses RN; SW BSW; CHW: high school diploma."	48	92.3%
No specific education requirement	2	3.8 %
Bachelor's Degree	1	1.9%
Other • "Although college is not required, all of our CHWs have at least an associate's degree."	1	1.9%

Other Hiring Requirements & Preferences

Table 21. Which of the following qualities are required, preferred, or not required?

	Required		Preferred		Not Required		N
	n	%	n	%	n	%	
Ability to read and write English	46	92.0%	3	6.0%	1	2.0%	50
Fluent in Spanish	2	4.0%	20	40.0%	28	56.0%	50
Fluent in Arabic	0	-	3	6.4%	44	93.6%	47
Fluent in another language	0	-	1	5.9%	16	94.1%	17
Hold a current certificate from a CHW training program	5	9.8%	25	49.0%	21	41.2%	51
Work experience in a health or healthcare experience setting	3	5.9%	42	82.4%	6	11.8%	51
Peer/lived experience	0	-	33	64.7%	18	35.3%	51
Target population	5	9.8%	43	84.3%	3	5.9%	51
Background check	46	92.0%	0	-	4	8.0%	50
Driver's license	45	88.2%	2	3.9%	4	7.8%	51
Own a car	33	64.7%	8	15.7%	10	19.6%	51

Three programs described other requirements:

- “Access to a car and auto insurance”
- “Drug testing”
- “Valid Auto Insurance”

Criminal Records

Table 22. Does the CHW program exclude employment of all CHWs with a criminal record, if otherwise qualified. If yes, please explain:
YES = 13 programs (25.0%); NO = 39 programs (75.0%) **11 programs provided an explanation**
Programs considering individual circumstances (n = 5):
"We must have all staff pass a criminal background check. individual circumstances could still be considered."
"Depends on what the criminal record is, how long ago it occurred"
"Possibly, depending on the background check details."
"Depends on the charges"
"All employees of the health center are excluded unless it is a traffic offense"
Programs not considering individual circumstances (n = 5):
"We do not hire employees who cannot pass the background check"
"[Program] does not hire persons with a history of a felony."
"The agency does not hire those with a criminal record"
"CHW's provide support to individuals in their own home unsupervised."
"We deal with sensitive information, ss numbers other info that needs to be protected."
Unknown reason (n = 1):
"I'm not sure."

CHW TRAINING

Training Before Hire

Table 23. Indicate what type of CHW-specific training is required for CHWs *before* hire by the CHW program? (N = 50)		
	n	**%**
None required	42	84.0%
Successful completion of the 126-hour MiCHWA CHW Core Competency-Based training program	5	10.0%
Other CHW Core Competency-Based training program: • "CHW hub hires and trains all CHW for our system." • "Internal program, ongoing throughout employment so there is never really a completion date." • "Motivational Interviewing, Group Facilitation, HIPAA and Privacy Training"	3	6.0%
Other CHW training: • "Disease Management, Integrating CHWs in the Health Care Team, Nutrition and Food Training, Referrals and Community Organization Training, Recruitment and Warm Handoffs, Diabetes Management/Chronic Disease Management" • "I provide the training needed to do our program" • "We have an extensive CHW training program that exceeds MDHHS requirements."	3	6.0%

Training After Hire

Table 24. Indicate what type of CHW-specific training is required for CHWs *while employed* by the CHW program? (N = 50)		
	n	**%**
Successful completion of the 126-hour MiCHWA CHW Core Competency-Based training program	39	78.0%
Other CHW Core Competency-Based training program: • "As of this year Pathways are all MiCHWA trained." • "Continuation of the following: Disease Management, Integrating CHWs in the Health Care Team, Nutrition and Food Training, Referrals and Community Organization Training, Recruitment and Warm Handoffs, Diabetes Management/Chronic Disease Management " • "Diabetic Path"	9	18.0%

Table 24. Indicate what type of CHW-specific training is required for CHWs *while employed* by the CHW program? (N = 50)		
• "DM education, case management, health literacy, motivational interviewing, CBPR, popular education, group facilitation, and other health issues faced by people with diabetes." • "Internally developed training program delivered by internal staff" • "MIHP specific training" • "Pathways HUB model and CHW training" • "They receive ongoing training and regulator meetings with all the other CHWs in the system." • "UnitedHealthcare based national training programs, many local training programs, trauma informed care, motivational interviewing disease specific trainings, health equity, cultural appropriateness, just to name a few"		
Other CHW training: • "classes to maintain certification" • "COVID-19 Training Contact Tracing Disaster Relief" • "DWC training" • "MMAP (Michigan Medicare Medicaid Assistance Program) MMAP, INC. Yes, there is certification involved." • "MMAP, MiBridges, and CAC" • "Most of our staff are also certified peer recovery coaches" • "The CHW completed WE CARE content training along with the MiCHWA training."	8	16.0%
None[31]	5	10.0%

[31] One "other" response was recoded to "none", since it was not a training: "My CHWs work with nursing students so they learn a lot about health care just working with them."

Anticipated Core Competency Training Needs

Table 25. In the next 12 months, how many CHWs does the CHW program expect will need CHW core competency-based training? (N = 50)		
	n	**%**
0 CHWs	22	44.0%
1 CHW	11	22.0%
1.5 CHWs	2	4.0%
2 CHWs	5	10.0%
3 CHWs	1	2.0%
3.5 CHWs	2	4.0%
4 CHWs	3	6.0%
5 CHWs	1	2.0%
6 CHWs	2	4.0%
20 CHWs	1	2.0%

COVID-19 Related Training

Table 26. Has the CHW program offered COVID-19 related training for the program's CHWs? (N = 49)		
	n	**%**
Yes	33	67.3%
No	16	32.7%
If no, do you plan to offer it?		
Yes	8	
No	7	

Table 27. Has the CHW program offered COVID-19 related training for the CHW program's CHWs? If yes, please explain:
YES = 33 programs (67.3%); NO = 16 programs (32.7%) **24 programs provided an explanation**
Programs offering basic training (n = 19):
There was a webinar that took place in March.
Basics of COVID-19, safe practices, health disparities, resource identification, telehealth, etc.
Many trainings and webinars have been available for CHWs to participate in and thus they have received lot of COVID-19 trainings.
All employees have received COVID-19 related training including infection control, use of PPE, etc.
Access to CDC guidelines after explanation of pandemic.
CHWs have had a COVID 101 from one of our chief public health officers
CHWs received COVID 101 training from the systems chief public health officer
In house training provided as well as an education provided by pathway institute and approved by our medical provider.
PPE donning and doffing was offered.
As the only CHW I have informed myself with COVID-19 and anything I would been to know.
per state mandate
Not specific to CHW but organizational trainings on COVID
Organization training and webinars on COVID
organizational education and webinars
All employees of the organization received COVID training
organization webinars/meetings, process change and protocol education
The CHW's have received training through webinars and CHASS Center. The webinars come from MICHWA and various entities.
We have NetLearning programs and our Clinical Systems Department provided training as well as utilizing materials from the CDC.
Staff training on preparedness and operations, discussion of operations and impact, management of cases due to pandemic.
Programs offering trainings on COVID-19 screening, testing, or assisting patients (n = 4):
CHWs are required to complete a COVID-19 health screening at each call.
The CHWs are provided ongoing training regarding COVID-19 guidelines and precautions. They have been trained to assist patients who have been referred for social needs identified through the COVID-19 SDOH screening tool.
All team member has been educated about the COVID-19 pandemic and have been trained within center-specific protocols regarding prevention, education, screening, testing and reporting.
Internal training as to Covid-19, how to discuss with clients and elements of health education to address. Access to discussion guidelines and Michigan and CDC resources.
Programs offering safe contact trainings (n = 3):
Training on safe contact with clients.
Contact training
contact training
Programs offering self-care trainings (n = 2):
MIHP offered a COVID-19 dealing with the stress and changes update
Social and Emotional Well-Being during COVID-19; Respiratory Illness FAQ's

Continuing Education

Table 28. Please provide examples of continuing education opportunities the CHW program offers.
Among the 27 programs that require continuing education, 23 programs (85.2%) offer continuing education and 4 programs (14.8%) do not offer continuing education. 22 programs provided an explanation
Programs offering MiCHWA training (with and without other programs) (n = 6):
Through MiCHWA and other online platforms.
CHW's often take advantage of the webinars and trainings put out by MiCHWA
Webinars through MiCHWA can be done on paid time.
Completion of MiCHWA webinars on paid time.
MiCHWA webinars on paid time.
Through MICHWA and other related conferences from MDHHS & MPCA.
Programs offering other external continuing education opportunities (n = 6):
Our Anytime Learning site has hundreds of courses, our Population Health Management training program is extensive and ongoing
Share opportunities offered through partner agencies.
District Health Department # 10 is supportive of CEU opportunities for staff. Local and low-cost opportunities are preferred.
Monthly CHW specific webinars offered through Rural CHW Network membership.
Community gatherings, articles, conferences and webinars.
Human Trafficking from area expert, agency updates, motivational interviewing.
Programs offering internal continuing education opportunities (n = 5):
Speakers on different topics at staff meetings. i.e. mandated reporting
In-services
In-services, in-house trainings
In house training and in-services
Topics that relate to FQHC's, SDOH's, MPCA, etc.

Table 29. What topics would the CHW program be interested in having for CHW continuing education (e.g., HIPAA training)?
38 programs responded to this question
HIPAA (n = 10) (responses not shown)
Motivational interviewing (n = 7) (responses not shown)
COVID-related trainings (n = 4) (responses not shown)
Case management (n = 4) (responses not shown)
Chronic disease (n = 5)
Chronic disease, general (n = 2) (responses not shown)
Hypertension
Diabetes
Self-management goal setting
General training interest (n = 4)
Any applicable trainings are welcomed
Any of the annual required trainings are appreciated.
The programs being offered by MiCHWA now are perfect and we have been taking advantage of them!
Anything not related to COVID-19. I enjoy other webinars that focus on CHW as a whole, that the Rural Community Health Worker Network (RCHWN) put on.
Mental health first-aid, behavioral health, and trauma-informed care (n = 3) (responses not shown)
Self-care (n = 2) (responses not shown)
Other topics (n = 28):
Active listening
Billing education
Building relationships with community partnerships
Capacity building are core competencies with largest training gaps
Client empowerment strategies
Communication
Continue to expand on reproductive health training
Cultural Competency
Dealing with difficult people
Development planning
Emotional intelligence
Enabling services
Group facilitation
Homelessness
How to document in a client's chart
Human subjects
Infection control practices, how to stay safe in a client's home
Managing CHWs
Mandated reporting
Medical terminology for CHW's
Patient engagement and commitment
Popular education
Primary care team integration
Professionalism

Reaching clients successfully in non-traditional ways
Resilience
Role advocacy and outreach
Wrap services
None or unsure (n = 6): (responses not shown)

CHW SALARY AND BENEFITS

CHW Certification

Table 30. Please indicate the extent to which you agree or disagree with each statement. CHW certification will help the CHW program by. . . (N = 49)

	Agree completely		Agree somewhat		Disagree somewhat		Disagree completely	
	n	%	n	%	n	%	n	%
Helping CHWs learn new skills	33	67.3%	13	26.5%	3	6.1%	0	-
Improving CHW's work performance	29	59.2%	16	32.7%	4	8.2%	0	-
Better defining the role of CHWs	28	57.1%	20	40.8%	1	2.0%	0	-
Helping obtain more stable funding for CHWs	24	49.0%	17	34.7%	7	14.3%	1	2.0%
Enabling better coverage of CHW work through insurance or other payer	24	49.0%	14	28.6%	7	14.3%	4	8.2%
Better integrating CHWs with other teams	23	46.9%	20	40.8%	5	10.2%	1	2.0%
Expanding CHW responsibilities	23	46.9%	20	40.8%	4	8.2%	2	4.1%
Winning CHWs more respect from the individuals they serve	23	46.9%	15	30.6%	7	14.3%	4	8.2%
Increasing CHWs' opportunities for promotion within your organization	22	44.9%	18	36.7%	4	8.2%	5	10.2%
Winning CHWs respect from other professionals	20	40.8%	26	53.1%	3	6.1%	0	-

Raises and Benefits

Table 31. Which of the following benefits do the CHW programs CHWs receive? (N = 50)		
	n	**%**
Health insurance	47	94.0%
Dental insurance	46	92.0%
Vision insurance	46	92.0%
Mileage reimbursement	46	92.0%
Sick leave	41	82.0%
Vacation accrual	41	82.0%
Pension or retirement plan	40	80.0%
Personal leave	37	74.0%
Maternity leave	26	52.0%
Tuition assistance	22	44.0%
Educational leave	6	12.0%
None	2	4.0%
Commuter subsidy	0	-
Other: • "Annual bonus, 401, EAP, disability and life insurance, full range of corporate benefits" • "FMLA" • "Life insurance, financial planning" • "Life insurance; parking coverage; cell phone subsidy; certification and licensure support; supervision" • "Long/short term disability" • "Quarterly wellness days/activities" • "Share in company profits" • "Volunteer time off, innovation time, wellness time, flexible scheduling" • "We provide a cell phone, laptop and office supplies." • "Yearly bonus of $1000 payed out at $500 in the June and $500 in December"	10	20.0%

CHW SUPERVISION

Table 32. Who provides supervision for the CHW program's CHW? (N = 50)		
	n	**%**
Credentials		
Registered Nurse	20	40.0%
Master of Social Work	15	30.0%
Master of Public Health	10	20.0%
MiCHWA-Certified Community Health Worker	3	6.0%
Other: • "And Nursing students" • "Bachelor Degreed" • "Bachelor's of Social Work" • "Licensed BSW" • "Both Lead CHW and Executive Director" • "CADC" • "Certified Case Manager" • "CERTIFIED PREVENTIONIST, BACHELORS OF SCIENCE" • "LLP. LPC" • "Master in library science, with 10 years experience in public health and health insurance field. There is also clinical consultation with a person who has a master in education." • "Master of Arts - Community Counseling" • "Master of Business Administration/ Healthcare Management" • "Masters of Health Administration" • "MiCHWA trained but certification no longer current" • "Operations Mgr" • "Pharmacist"	17	34.0%

Table 33. Who provides supervision for the CHW program's CHW? (N = 50)		
	n	%
Roles		
Program Manager/Director	18	36.0%
Clinical Supervisor	13	26.0%
Social Worker	12	24.0%
Case Manager	11	22.0%
Project Director	5	10.0%
Community Health Worker	4	8.0%
Executive Director	4	8.0%
Project Coordinator	4	8.0%
Practice Manager	3	6.0%
Team Leader	2	4.0%
Dietician/Nutritionist	1	2.0%
Primary Care Provider	1	2.0%
Volunteer Coordinator	0	0.0%
Other: • "Care Management Department Manager" (3 programs) • "Chief Operating Officer" • "Client Services Supervisor" • "Clinic Manager" • "Community Services Manager/Outreach/Migrant Health" • "Director of Operations" • "Nonclinical supervisor" • "Outreach Supervisor" • "Quality Manager"	11	22.0%

CHW Supervisor Training

Table 34. What type of training do the CHW supervisors receive? (N = 50)		
	n	**%**
CHW roles and responsibilities	37	74.0%
Social determinants of health	34	68.0%
Cultural competency and/or diversity	32	64.0%
Community engagement	25	50.0%
How to integrate CHWs on healthcare teams	20	40.0%
Supervisors do not receive any training specific to supervising CHWs	9	18.0%
Other: • "As an MPH and the associate director of operations and enabling services, I provided support to health center staff on all categories listed above. Generally, supervisors do not receive this specific training." • "Attendance to NCFH Conference" • "CHW Supervisor Workshop offered through [CHW employer organization]" • "Completed MiCHWA CHW training in the past, certification not current" • "MiCHWA trained, certification not current" • "Specific supervisory trainings put on monthly by the health department, not always specific to CHW's." • "Supervision purpose, functions, roles, techniques"	7	14.0%

Interest in Additional Training

Table 35. What additional supports or continuing training would be valuable to the CHW supervisors?[32]
50 programs responded to this question
General CHW Supervision Training (n = 14):
Any (n = 2)
How to supervise CHWs, dealing with difficult people.
Effective ways to manage CHWs, dealing with difficult people, how to supervise mobile team.
Training specific to remote supervision.
Any additional training support is good. It is hard to supervise not being a past CHW.
Specific training for Supervisors of CHWs
Supervisor training to supervise CHWs
Guidelines for supervising CHWs
Supervisors should be required to complete a specific number of training hours before they can have a CHW deployed.
CHW productivity management
Any supervisor training that can be provided is beneficial, particularly around home visiting.
Continuous oversight training geared towards understanding how to best support CHW work.
Role delegation
Multidisciplinary Teams (n = 3):
How it integrate CHWs in to health teams
Maximizing integration with Care Teams
How to integrate CHW into healthcare teams
CHW Role (n = 3):
Overview of what the CHW does and expected to do
CHW Roles and Responsibilities
Understanding CHW Core Competencies
Billable Services (n = 2):
When we will be billable
Billing and reimbursement
HIPAA (n = 2):
Medical boundaries, HIPAA
CHW credentialing; HIPAA
Other Topics (n = 8):
Case Management and Care Coordination, Home Visitation Program, Smoking Cessation, Chronic Disease Management, Research and Data.
Community collaboration, Human Trafficking
Peer network of CHW Supervisors
CHW credentialing; HIPAA; community collaboration, Human Trafficking
Community engagement
How to evaluate the effectiveness of the CHW intervention
Working with non-professional staff
Perhaps continuing training around supporting non-clinical professionals
None, N/A, or Unknown (n = 17) *(responses not shown)*

[32] Responses that fell into multiple categories were split into multiple rows

Supervision Challenges

Table 36. What are the challenges the CHW program faces in regards to CHW supervision? (N = 50)		
	n	**%**
CHWs are mobile/ located in different places than supervisor(s)	18	36.0%
More CHW supervisory guidelines are needed	15	30.0%
Supervisor's time not reimbursable through established contracts/agreements'	12	24.0%
Supervision available is not specific to CHWs	11	22.0%
Not enough time for supervision	6	12.0%
CHW and supervisor have conflicting schedules	5	10.0%
Resources insufficient to provide CHW supervision'	1	2.0%
Other: • "Supervisor is not a CHW herself" • "Differences in opinions"	2	4.0%

LIFESTYLE CHANGE PROGRAMS

Table 37. Are any of the CHW program's CHWs currently trained as leaders or master trainers of the following evidence-based lifestyle change program(s)? (N = 49)		
	n	**%**
None	38	77.6%
Diabetes PATH	6	12.2%
Personal Action Toward Health (PATH)	4	8.2%
Chronic Pain PATH	2	4.1%
Diabetes Prevention Program (DPP)	2	4.1%
Diabetes Self-Management Education and Support (DSMES)	2	4.1%
Tomando Control de su Salud	1	2.0%
Enhance Fitness	1	2.0%
Kidney PATH	0	-
YMCA Blood Pressure Self-Monitoring	0	-
Other: • "Mental Health First Aid; MMAP; MiBridges; CAC" • "Mental Health First Aid; Non violent crisis intervention; Human trafficking; Aces; Clinical Community Linkages" • "Mi Salud" • "Safe Sitter"	4	8.2%

Table 38. Have any of the CHW program's CHWs served (or are currently serving) as leaders or co-leaders in the following evidence-based CHW program(s) in the past 12 months? (N = 49)		
	n	**%**
None	40	81.6%
Diabetes PATH	6	12.2%
Personal Action Toward Health (PATH)	4	8.2%
Chronic Pain PATH	3	6.1%
Diabetes Prevention Program (DPP)	2	4.1%
Diabetes Self-Management Education and Support (DSMES)	1	2.0%
Tomando Control de su Salud	1	2.0%
Kidney PATH	0	0.0%
Enhance Fitness	0	0.0%
YMCA Blood Pressure Self-Monitoring	0	0.0%
Other: • "Mi Salud" • "Safe Sitter"	2	4.1%

CHW EVALUATION, MONITORING, AND QUALITY IMPROVEMENT

Evaluation and Monitoring Strategies

Table 39. Please select the types of evaluation/monitoring that the CHW program conducts. (N = 49)		
	n	**%**
Number and type of clients served	39	79.6%
Satisfaction survey/assessment from clients	26	53.1%
Satisfaction survey/assessment from CHWs	16	32.7%
Cost savings	15	30.6%
Other: • "Chronic Heath Conditions" • "cost savings study to Medicaid being conducted by the state" • "response time to meet patient needs"	3	6.1%
5 programs (10.2%) did not select any of the listed strategies		

Social Determinants of Health Screening

Table 40. Please select which 'social determinants of health' screening and/or assessments tool(s) you use. (N = 49)		
	n	%
Protocol for Responding to and Assessing Patients' Assets, Risk, and Experiences (PRAPARE)	10	20.4%
Community Health Innovation Region (CHIR) developed	10	20.4%
Pathways	4	8.2%
Meaningful Use 2 or 3 (EHR)	2	4.1%
Patient Centered Assessment Method (PCAM)	0	-
Other: • "Organization's assessment however preparing to use PRAPARE" • "Allscripts homegrown tool transitioning to embedding PRAPARE" • "Blending of PRAPARE, Pathways and CHIR developed" • "Created own questionnaire" • "Internal created assessment" • "Internally developed" • "made it up" • "self developed" • "We have our own tool" • "Community developed screener embedded in eHR and access via HUB for all community organizations." • "Jackson CHIR" • "PCMH standards" • "SDoH screening built into our EMR. I don't know what the name of it is." • "SDoH survey integrated into systems EMR" • "SDoH tool" • "Accountable Health Communities"	18	36.7%

Table 41. How does the CHW program use social determinants of health data? (N = 49)		
	n	%
Connect enrollees to community supports and services	45	90.0%
Provide information to health care providers	31	62.0%
Quality improvement initiatives	26	52.0%
Eligibility determination	20	40.0%
Project tracking	18	36.0%
Not applicable	1	2.0%
Other: • "CMS federal research study" • "Financial support of community resources" • "risk stratification" • "To drive the community health needs assessment and improvement plan." • "We collect some data, but not a separate SDOH Tool"	5	10.0%

CHW Program Referrals

Table 42. Does the CHW program track referrals in the following areas? (N = 49)				
	Address or refer clients n (%)	Track referrals made n (%)	Track referrals completed n (%)	Track referral outcomes n (%)
Social Determinants of Health	49 (100.0%)	44 (89.8%)	41 (83.7%)	40 (81.6%)
Health Care	47 (95.9%)	42 (85.7%)	42 (85.7%)	36 (73.5%)
Health Promotion & Chronic Disease Self-management	39 (79.6%)	34 (69.4%)	30 (61.2%)	27 (55.1%)
Environment	32 (65.3%)	27 (55.1%)	24 (49.0%)	24 (49.0%)
Other Area: • Behavioral health and mental health (3) • Housing (2) • OBGYN, needs for pregnant women, needs for support partners of pregnant women (2) • Dental • Substance use • Addresses all unmet needs that impact healthcare • Any need identified. Internet connectivity, cell phone payments, doghouse, pet food, hygiene supplies, laundry supplies etc. • Domestic violence resources, baby gear resources, educational resources • Early childhood services • Food insecurity • Connection to job resources, access to local community partners to address needs as necessary • Lots • They try as needed to make connections. • We track every referral we make in our database and whether that referral was completed, attended etc.	16 (32.7%)	13 (26.5%)	13 (26.5%)	13 (26.5%)

CHW Indicators

Table 43. Does the CHW program use the following indicators as part of assessment, risk stratification, or to measure an outcome? (N = 49)		
	YES	
	n	%
General social support question(s)	40	81.6%
General health status question(s)	37	75.5%
General client empowerment or activation question(s)	22	44.9%

Table 44. What general health instrument or question(s) are used?
31 programs responded to this question
General instruments or questions (n = 20):
Intake form (2 responses)
We utilize their current and past medical histories.
Primary care provider, dental health provider, ER visits, health insurance provider.
Primary care provider, primary care usage, ER usage, insurance provider, dental provider, dental insurance.
Regarding wellbeing, their feeling on their health, client competencies.
*In the past month, did poor mental health keep you from doing your usual activities like work, school or a hobby? *In the past month, did poor physical health keep you from doing your usual activities like work, school or a hobby?
How are you feeling? Have you had any recent changes to your health?
General feeling. B/P, BS, SPO2 levels.
We ask about chronic conditions, have them indicate how stressed they are; whether they use substances; do they have a PCP and dentist; taking any Medications.
Inquire about chronic health conditions, PCP, health coverage.
We ask about Chronic Health conditions, health coverage, PCP etc.
How would you rate your general health?
Screening tools on general health.
Organization intake form
Internally developed assessments
Community assessment tool
Regarding wellbeing, their feeling on their health, client competencies.
Intake questionnaire
Substance Use/depression screening
Pathways-based instruments (n = 4):
No formal instrument but client unique and specific questions as to their current health and care needs especially if we are following up on ED use making a connection to a medical / dental home, scheduling or reminding of an appointment. Use the guidance of program pathways.
CHIR created and Pathway model assessment questions.
We use a Pathways checklist that covers each of these areas.
Pathway Information
Other external instruments (n = 2):
We use a tool in epic.
WE CARE Research specific.
SDOH instruments or questions (n = 2):
Social Determinants of Health Questionnaire
SDOH screening question
Not sure or unknown (n = 4): *(responses not shown)*

Table 45. What social support instrument or question(s) are used?
29 programs responded to this question
General instruments or questions (n = 12):
We utilize social determinants of health questionnaires as well as social service questionnaires from our Social Work team.
Internally developed assessment
Organization intake form
Intake form/questionnaire (3 responses)
Questions are asked in regard to cost of care, income, food, housing, child & elder care needs, education & training needs, transportation, utilities, ED use.
Transportation, education, living situation, other social support agency assistance, food insecurity, support partner hep, family member incarceration, domestic violence, safe living environment, previous infant death, other children, previous birth outcomes.
Other support programs, in-home support, spouse or fam member incarcerated, living situation, other children, transportation.
Who helps you with things? Who can you talk to?
Screening tools specific to social supports currently used.
Who do you Identify as the people that support you?
Community assessment tool
SDOH instruments or questions (n = 4):
We utilize social determinants of health questionnaires as well as social service questionnaires from our Social Work team.
Social Determinants of Health Questionnaire
Review all SDOH plan of care at each encounter
What needs do you have related to SDOH?
Pathways-based instruments (n = 3):
No formal instrument but client unique and specific questions as to their current social supports, isolation, needs arising from barriers to connecting to medical or dental homes or resulting in ED utilization. Use the guidance of program pathways.
Pathway institute model.
Pathway information.
Other external instruments (n = 7):
PRAPARE Screening
PRAPARE
Template in NextGen[33]
Templates in NextGen

[33] NextGen® KBM (knowledge based model) templates consists of the standards NextGen HER software system. This service allows for customizable templates created specific to a patient's past medical history, family history, chronic illnesses, medications, and allergies. For more information, see http://www.itentive.com/solutions/customization/templates/.

Competencies as developed by the Coleman Model.[34]
We use a tool in epic
WE CARE Research specific
Not sure or unknown (n = 3) *(responses not shown)*

Table 46. What client empowerment and/or activation instrument or question(s) are used?
14 programs responded to this question
General instruments or questions (n = 5):
Intake form (2 responses)
Goal setting tool
Follow up on assigned duties to client
Utilize motivational interviewing to determine client's readiness to change
Pathways-based instruments (n = 3):
Pathway information
Pathway institute model
No formal instrument but client unique and specific questions as to their current social supports, isolation, needs arising from barriers to connecting to medical or dental homes or resulting in ED utilization. Use the guidance of program pathways.
Other external instruments (n = 4):
We use a tool in epic.
Through Coleman Model
Patient Activation Measure
WE CARE Research specific
Not sure or unknown (n = 2) *(responses not shown)*

[34] The Coleman Model is better-known as the Care Transitions Measure (CTM-15 ®) Tools is a 15-item measure that assesses the quality of care transitions through a patient-centered approach and stands to be effective as a performance measurement tool. For more information, see: https://caretransitions.org/all-tools-and-resources/

Table 47. Please share any other comments you may have about the following:
9 programs provided comments on one or more of the following topic areas
CHW Training (n = 9):
We need continuous access to training and program building initiatives.
The cost of the CHW training and location have been a deterrent to not having another CHW within our agency.
Will there be virtual training available due to COVID-19 and if not, will a training be held in the Flint area in the near future?
More availability for classes.
We are always open to low cost opportunities for both CHW's and coordinators/supervisors.
The MiCHWA training provides a great foundation for CHW professional development
MiCHWA training is dry and the materials that are straight from the book and not realistic to CHW in everyday working life around MI. I think the emphasis on just one supported CHW state training is not the right way to approach supporting CHW. I would like to see a National guideline to core competencies competition to get CHW on the same page across the board rather than state to state doing their own thing. I feel the MiCHWA CE's and recertification is very rough and not clear most CHW do not understand. I would like to see the $30 MiCHWA fee be more transparent and really look like a state certification if that is made to be payed to have a current CHW. Everyone should be able to access the info in order to check a CHW current standing.
The course through MICHWA is very complete.
CHW trainings should be offered by more entities so that the CHW receives a diverse set of trainings rather than just receiving trainings from one or two resources. With COVID-19 happening we should look at what other states and countries are doing and provide them with those trainings virtually.
CHW Employment (n = 5):
We hope to continue with additional funding.
Any continued advocacy on behalf of the profession is always good.
It is a main priority to continue to work for CHW sustainable in the state of Michigan.
All medical facility should have more information on employing CHWs, Churches and other non-profits even United ways. I think CHW's could use more coverage in the market of employment. I would like to see a pay scale that reflects the worth of a CHW and the specialized skills they have they no one in the office could compare to.
With CHW Employment the salary should be higher. Once a CHW completes certification, there should be a salary increase for all CHW's. All agencies should budget for salary increases for retention and moral purposes.
CHW Scope of Practice (n = 4):
Our staff are integrated into programs as clerks, peers and technicians.
Continued advocacy of the profession is always good.
The CHW scope of practice is constantly increasing with the professionalism of the occupation.
Seems like MiCHWA supports the CHW that are providing clinical support like Diabetes education. I see little support for CHW that are doing social determinate of heath, i.e. Homelessness, bill managements/making poor financial decisions, Lifestyle environmental poor housing conditions, mental illness and how to relate to the general public. The mental health toll it takes on individual CHW's and the ones that are also fighting social determents of health. Personally, in our office we have care managers that handle the health management stuff with education, I as the CHW handle everything else that no one has answers to. System navigation. Local funding ins and outs. Just the real person face to face someone can talk to. Take all the fluff away that's what a CHW does in our office. We handle the real-life people face outside the health system.

CHW Funding and Sustainability (n = 7):
We need funding
Funding is always a concern.
Continued advocacy and coordination with health plans will only continue to help the profession grow stronger and more sustainable.
Funding for CHWs remains an issue. The importance and value of the work of CHWs is vital to the health of our communities.
Very close to securing contracts with 2 more managed health plans. One as per member per month, one as outcome based. Also switching current ffs contract to outcome based.
I would be nice to see more funding open up for CHW programs. Expansion of CHW in all working fields or just breaking down barriers of other programs perspective of a CHW's for the lifelong Sustainability CHW need to be talked about more the public eye and supported by the state governments.
Managed Care needs to reimburse for CHW services.

APPENDIX B: SURVEY INSTRUMENT

2020 Employer Survey FINAL WITHOUT BLOCKS

Start of Block: Program 1 Questions

Q1 **Michigan Community Health Worker Alliance Employer Survey 2020**

Introduction

The Michigan Community 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 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, payers and CHW employers to better understand the growing CHW workforce and CHW activities statewide.* Your responses to individual survey items will remain confidential. *The final report will be distributed to you and posted for the public.*

For your convenience, 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 some items may require that you refer to your administrative records to retrieve the necessary information. This should also speed survey completion. **We recognize that the status, roles and service delivery locations and approaches of your CHW workforce may have changed with the onset of the COVID-19 pandemic. We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified. Additional questions ask about CHW-related needs in response to COVID-19.**

The survey closes on May 29th, 2020.

This survey should take up to an hour to complete. Please note that you can exit the survey at any point and your responses will be saved. If you want to return to the survey at a later time, click the original link you were sent. Once you submit the survey, you cannot make any changes to your responses.

Due to skip patterns and how questions are designed, the numbering of the survey may appear incorrect. This is not something you should be concerned about.

Community Health Worker Definition

A Community Health Worker (CHW) is defined by the American Public Health Association as “a frontline public health worker who is a trusted member and/or has an unusually close

understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."

The CHW Core Consensus (C3) Project further defines common roles of a CHW: Providing a cultural bridge among individuals, communities, and hearth and social service systems (act as bridge between providers and patients); Providing culturally appropriate health education and information (health education/health promotion); Providing care coordination, case management, and system navigation (assuring access to care); Providing coaching and social support (provide one-on-one guidance to patient to help manage his/her health); Advocating for individuals and communities (speaking up for the health needs of those served); Building individual and community capacity (teaching those served how to manage their own health needs); Providing direct service (e.g. taking blood pressure, diabetic foot care, etc.); Implementing individual and community assessments (to determine needs and/or identify risks); Conducting outreach (home visiting to provide education, assessment, and social support)

In Michigan, CHWs are known by many titles, which include but are not limited to: Certified Peer Support Specialist, Recovery Coach, 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 Coach, Maternal Child Health Worker, Outreach and Enrollment Worker, Promotor/a, Veteran liaison, etc.

Page Break

Q2
Please note that you can exit the survey at any point and your responses will be saved. If you want to return to the survey at a later time, click the original link you were sent.

Page Break

Q3 What is the name of your **organization/agency**? (This is the parent organization or agency in which the CHW program may be housed)

_____

Q4 What is your **first and last** name?

_____

Q5 What is your email address?

_____

Q6 What is your phone number? If you have an extension, please enter it in the next question.

_____

Q7 Phone extension:

_____

Q8 What is your role in the organization?

_____

Page Break

Q9 Based on the definition and description of CHW roles, does your organization currently employ at least one CHW?

- ○ Yes (please complete 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 organization with whom you contract.)

Q10 How long has your organization employed CHWs?

_____

Q11 Has your organization ever had one or more CHW program(s) that are no longer active?

- ○ Yes
- ○ No

Q12 If yes, please explain:

_____

Q13 You have been taken to the end of this survey because you indicated that your organization does not employ CHWs. Please share the survey link with any organizations and/or programs that you know of, in Michigan, that employ CHWs.

We appreciate your time regardless.

Please click 'Next' to end this survey.

Page Break

Q14
Organization/Agency Information
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

The following questions ask about the **full address** of your organization/agency.

Q15 Organization/agency street number:

_____

Q16 Organization/agency street name:

_____

Q17 Organization/agency **building/suite/office/floor:**

_____

Q18 Organization/agency PO Box (if applicable):

_____

Q19 Organization/agency **city:**

_____

Q20 Organization/agency **zip code:**

_____

Page Break

Q21
Organization/Agency Information
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

What is your organization/agency type? (check one)

- ○ Nonproft, non-governmental
- ○ For profit
- ○ Governmental

Q22 What is your organization SETTING? (Choose the one setting that most applies)

- ○ Academia/Research
- ○ Federally qualified health center (FQHC)
- ○ Community health center (Not FQHC)
- ○ Community-based organization (other)
- ○ Local health department (county, district, or city)
- ○ IHS/tribal organization
- ○ Medical clinic/practice
- ○ Hospital
- ○ Health system (e.g., Henry Ford Health System, Spectrum Health System)
- ○ Behavioral health organization
- ○ Commercial health insurance plan
- ○ Medicaid managed care organization/Medicaid health plan
- ○ Dental practice or clinic
- ○ Other (please specify below):

_____

Q23 How many different CHW programs does your organization have?

_____

Page Break

Q24
Program Information
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

In this section, we are seeking information about each individual CHW program in your organization.

Please complete the rest of this survey for the CHW program that you oversee or supervise. At the end of the survey, you be prompted to either 1) repeat the survey if you are responding for a second CHW program; 2) exit the survey if this is the only CHW program that you are responding for; 3) exit because someone else is responding for other CHW programs.

Program #1 Name:

_____

Q25 Program address (if different than organization/agency address):

- ○ **Yes,** the program address is different than the organization/agency address
- ○ **No**, the program address is not different than the organization/agency address

Q26 Program **street number**:

_____

Q27 Program **street name**:

_____

Q28 Program **building/suite/office/floor**:

_____

Q29 Program PO Box (if applicable):

_____

Q30 Program **city**:

_____

Q31 Program **zip code**:

_____

Page Break

Q32
Program Information
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

How many CHWs does the CHW program employ for each of the following?
(Only fill out the number of CHWs for applicable categories)
_____ Full-time paid (30-40 hours a week)
_____ Full-time volunteer
_____ Part-time paid (less than 30 hours a week)
_____ Part-time volunteer

Q33
Program Information
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

In what **county or counties** do the CHWs that the CHW program employs deliver services?
(Check all that apply)

Q34 What is the approximate total number of individual clients/patients served in 2019 by all the CHW program's CHWs? (check one)

- ○ Less than 100
- ○ 100-300
- ○ 301-500
- ○ 501-1000
- ○ 1001-2000
- ○ 2001-3000
- ○ 3001-4000
- ○ Over 4000

Q35 Please indicate whether the CHW program's CHWs regularly work within a multidisciplinary team.

- ○ Yes
- ○ No

Q36 If yes, please explain:

_____

_____

_____

_____

_____

Page Break

Q37

Community Health Worker Roles/Scope of Practice
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

The National Community Health Worker Core Consensus (C3) Project developed the following roles and sub-Roles to help define and monitor CHW scope of practice and guide development and assessment of CHW core competencies, curricula, training and policies. Please indicate which roles and related sub-roles that the program CHWs play.

Please select all sub-role(s) the CHW program's CHWs play in relation to **Cultural Mediation among Individuals, Communities, and Health and Social Service Systems**.

- [ ] Educating individuals and communities about how to use health and social service systems (including understanding how systems operate)
- [ ] Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards)
- [ ] Building health literacy and cross-cultural communication

Q38 Please select all sub-role(s) the CHW program's CHWs play in relation to Culturally Appropriate Health Education and Information.

- [ ] Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community
- [ ] Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)

Q39 Please select all sub-role(s) the CHW program's CHWs play in relation to **Care Coordination, Case Management, and System Navigation.**

- [ ] Participating in care coordination and/or case management
- [ ] Making referrals and providing follow-up
- [ ] Facilitating transportation to services and helping to address other barriers to services
- [ ] Documenting and tracking individual and population level data
- [ ] Informing people and systems about community assets and challenges

Q40 Please select all sub-role(s) the CHW program's CHWs play in relation to **Providing Coaching and Social Support.**

- [ ] Providing individual support and coaching
- [ ] Motivating and encouraging people to obtain care and other services
- [ ] Supporting self-management of disease prevention and management of health conditions (including chronic disease)
- [ ] Planning and/or leading support groups

Q41 Please select all sub-role(s) the CHW program's CHWs play in relation to **Advocating for Individuals and Communities.**

- [ ] Advocating for the needs and perspectives of communities
- [ ] Connecting to resources and advocating for basic needs (e.g. food and housing)
- [ ] Participating in policy advocacy

Q42 Please select all sub-role(s) the CHW program's CHWs play in relation to **Building Individual and Community Capacity.**

- [ ] Building individual capacity
- [ ] Building community capacity
- [ ] Training and building individual capacity with CHW peers and among groups of CHWs

Q43 Please select all sub-role(s) the CHW program's CHWs play in relation to **Providing Direct Service.**

- [ ] Providing basic screening tests (e.g. heights & weights, blood pressure)
- [ ] Providing basic services (e.g. first aid, diabetic foot checks)
- [ ] Meeting basic needs (e.g., direct provision of food and other resources)

Q44 Please select all sub-role(s) the CHW program's CHWs play in relation to **Implementing Individual and Community Assessments.**

- [ ] Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environmental assessment)
- [ ] Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)

Q45 Please select all sub-role(s) the CHW program's CHWs play in relation to **Conducting Outreach.**

- [ ] Case-finding/recruitment of individuals, families, and community groups to services and systems
- [ ] Follow-up on health and social service encounters with individuals, families, and community groups
- [ ] Home visiting to provide education, assessment, and social support
- [ ] Presenting at local agencies and community events

Q46 Please select all sub-role(s) the CHW program's CHWs play in relation to **Participating in Evaluation and Research.**

- [ ] Engaging in evaluating CHW services and programs
- [ ] Identifying and engaging community members as research partners, including community consent processes
- [ ] Development of evaluation/research design and methods
- [ ] Data collection and interpretation
- [ ] Identification of priority issues and evaluation/research questions
- [ ] Sharing results and findings
- [ ] Engaging stakeholders to take action on findings

Page Break

Q47
Community Health Worker Roles/Scope of Practice
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

In response to the COVID-19 pandemic, please describe any changes related to CHW roles and/or activities (refer to questions 34-43):

_____

Q48
Where do the CHW program's CHWs deliver services? (Check **all** that apply)

- [ ] Client's home
- [ ] Client's work site
- [ ] Community events (including outdoor events)
- [ ] Private clinic or medical practice
- [ ] Community health center (FQHC or non FHQC health center)
- [ ] Free clinic
- [ ] Hospital
- [ ] Health maintenance organization (HMO) offices
- [ ] Public housing unit
- [ ] School
- [ ] Migrant camp
- [ ] On the street (e.g., to reach homeless individuals)
- [ ] Shelters
- [ ] Teen centers
- [ ] Other (non-profit organization not specified above)

- [ ] CHW program offices, if none of the above locations
- [ ] Other (please specify):

_____

Q49 **In response to the COVID-19 pandemic, please describe any changes in where the CHW program's CHWs deliver services (refer to question 48):**

_____

Q50 How do the CHW program's CHWs deliver services? (Check **all** that apply)

- [ ] In-person meetings
- [ ] Telephone calls
- [ ] Text or chat messages
- [ ] Email
- [ ] One-on-one through video communication, including FaceTime or Skype
- [ ] Group classes or sessions- in person
- [ ] Group classes or sessions, through video communication
- [ ] Other (please specify):

_____

Q51

In response to the COVID-19 pandemic, please describe any changes in how the CHW program's CHWs deliver services (refer to question 50):

_____

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Q52
Populations Served
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

Which population(s) are regularly represented among the CHW program's clientele? (Check **all** that apply)

- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian and Other Pacific Islander
- ☐ Non-Hispanic White
- ☐ Hispanic or Latino
- ☐ Arab American/Middle Eastern Descent
- ☐ Other (Please specify):

_____

- ☐ Children/adolescents (0-18)
- ☐ Young adults (19-25)
- ☐ Adults (26-64)
- ☐ Seniors (65+)
- ☐ Farm or migrant workers
- ☐ Immigrants/refugees
- ☐ History of frequent Emergency Department (ED) use

- [ ] History of frequent hospitalization
- [ ] Homeless individuals
- [ ] Individuals without a Primary Care Provider
- [ ] Isolated rural residents
- [ ] Sexual minorities (i.e., LGBTQ individuals)
- [ ] Pregnant women and infants
- [ ] Uninsured individuals
- [ ] Incarcerated and returning individuals
- [ ] People with HIV AIDS
- [ ] People with Heart Disease
- [ ] People with Hypertension
- [ ] People with Diabetes
- [ ] People with Cancer
- [ ] People with Asthma
- [ ] People with Obesity

☐ Other special populations (please specify): _____

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Q53 Employment Characteristics **We request that you complete the entire survey reflecting the CHW workforce as of <u>March 1, 2020, unless otherwise specified.</u>**

What, if any, minimum educational requirement **must** CHWs meet to be hired by the CHW program? (check one)

- ○ No specific education requirement
- ○ High School Diploma/GED
- ○ Associate's Degree
- ○ Bachelor's Degree
- ○ Other (please specify): _____

Q54 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
Ability to read and write English	○	○	○
Spanish	○	○	○
Arabic	○	○	○
Other language (please specify):	○	○	○
Hold a current certificate from a CHW training program.	○	○	○
Work experience in a health or healthcare experience setting.	○	○	○
Health or healthcare related experience e.g., peer/lived experience with chronic illness, recovery	○	○	○
Current or prior resident of the community they serve.	○	○	○
Experience working with the target population or community they serve.	○	○	○
Background check prior to hire.	○	○	○
Valid driver's license for work-related travel.	○	○	○
Own a car for work-related travel.	○	○	○
Other (please specify):	○	○	○

Q55 Does the CHW program exclude employment of all CHWs with a criminal record, if otherwise qualified?

- ○ Yes
- ○ No

Q56 If yes, please explain:

_____

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Q57
CHW Training
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

Indicate what type(s) of CHW-specific trainings are required for CHWs ***before*** hire by the CHW program. (Check **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 name of training program, if any, and organization delivering it, and if it includes a certificate of completion): _____
- ☐ Other CHW training (Please specify name of CHW training, if any; type of training, the organization delivering it, and if it includes a certificate of completion): _____
- ☐ None Required

Q58 Indicate what type(s) of CHW-specific trainings are required for CHWs ***while employed*** at the CHW programs. (Check **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 name of training program, if any, the organization delivering it, and if it includes a certificate of completion): _____

☐ Other (Please specify name of training program, if any, the organization delivering it, and if it includes a certificate of completion):
_____

☐ None Required

Q59 In the next 12 months, how many CHWs does the CHW program expect will need CHW Core Competency-based training?

_____

_____

_____

_____

_____

Q60 Has the CHW program offered COVID-19 related training for the CHW program's CHWs?

○ Yes

○ No

Q61 If yes, please explain:

_____

Q62 If no, do you plan to offer it?

- Yes
- No

Q63 What topics would the CHW program be interested in having for CHW continuing education (e.g., HIPAA training)?

_____

Q64 Does the CHW program require continuing education for its CHWs?

- Yes
- No

Q65 If yes, does the CHW program offer continuing education opportunities for its CHWs?

- Yes
- No

Q66 If yes, please provide examples of continuing education opportunities the CHW program offers:

_____

Q67 Is the CHW program aware of the MiCHWA CHW Registry?
MiCHWA's CHW Registry is a voluntary statement database of CHWs and CHW Employers in Michigan. It is also the mechanism through which MiCHWA certifies CHWs who have achieved CHW Core Competencies through CHW core-competency based training.

- ○ Yes
- ○ No

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Q68
CHW Salary and Benefits
We request that you complete the entire survey reflecting the CHW workforce as of <u>March 1, 2020, unless otherwise specified.</u>

Are CHWs employed by the CHW program paid by an hourly rate or salary?

- ☐ Hourly Rate
- ☐ Salary
- ☐ Not applicable

Q69 Please enter the CHW hourly rate range (please enter the dollar amount including decimals e.g., $18.00-$20.00)

_____

Q70 Please enter the salary range for CHW salaries (please enter the dollar amount including decimals e.g., $18,000.00-$20,000.00).

_____

Q71 Are the CHW program's CHWs eligible for pay raises or other increases in compensation?

- ○ Yes
- ○ No

Q72 Which of the following benefits do the CHW program's CHWs receive? (Check all that apply)

- [ ] Commuter subsidy
- [ ] Educational leave
- [ ] Health insurance
- [ ] Dental insurance
- [ ] Vision insurance
- [ ] Mileage reimbursement
- [ ] Pension or retirement plan
- [ ] Personal leave
- [ ] Sick leave
- [ ] Tuition assistance
- [ ] Vacation accrual
- [ ] Maternity leave
- [ ] Other (Please specify): _____
- [ ] None

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Q73
CHW Supervision
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

Who provides supervision for the CHW program's CHWs? Please complete both credentials and role titles categories. (Check **all** that apply, in each category).

- ☐ Registered Nurse
- ☐ MiCHWA-Certified Community Health Worker
- ☐ Master of Social Work
- ☐ Master of Public Health
- ☐ Other (please specify):

_____

- ☐ Case Manager
- ☐ Social Worker
- ☐ Community Health Worker
- ☐ Dietician/Nutritionist
- ☐ Executive Director
- ☐ Practice Manager
- ☐ Primary Care Provider
- ☐ Program Manager/Director
- ☐ Project Coordinator

- [ ] Project Director
- [ ] Team Leader
- [ ] Volunteer Coordinator
- [ ] Clinical Supervisor
- [ ] Other (please specify): _____

Q74 What type of training do the CHW supervisors receive? (Check **all** that apply)

- [ ] CHW roles and responsibilities
- [ ] How to integrate CHWs on healthcare teams
- [ ] Cultural competency and/or diversity
- [ ] Community engagement
- [ ] Social determinants of health
- [ ] Other (please specify): _____
- [ ] Supervisors do not receive any training specific to supervising CHWs

Q75 What additional supports or continuing training would be valuable to the CHW supervisors?

_____

Q76 What are the challenges the CHW program faces in regard to CHW supervision? (Check **all** that apply)

- [ ] Supervision available is not specific to CHWs
- [ ] Supervisor's time not reimbursable through established contracts/agreements'
- [ ] Resources insufficient to provide CHW supervision'
- [ ] Not enough time for supervision
- [ ] CHW and supervisor have conflicting schedules
- [ ] CHWs are mobile/ located in different places than supervisor(s)
- [ ] More CHW supervisory guidelines are needed
- [ ] Other (please specify):

_____

- [ ] None of the above

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Q77
CHW Sustainability
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

What percentage of the CHW program is supported by each of the following funding sources? (Include percent for all that apply)
Be sure to total your percentages to no more than 100%.
Time-limited federal government grant(s) : _____
Time-limited State government grant(s) (excludes Medicaid) : _____
Time-limited Local government grant(s) : _____
Other time-limited public funding (please specify): : _____
Time-limited private foundation(s) funding : _____
Other non-profit organization(s). e.g., United Way, American Cancer Society : _____
Non-profit hospital Community benefit funds : _____
Ongoing private foundation funding : _____
Millage(s) specific to CHW programs/services : _____
General organization funds (not time-limited) : _____
Medicaid health plan contract : _____
Commercial health plan contract : _____
Medicaid, not health plan contract (please specify): : _____
State Children's Health Insurance Program (SCHIP) : _____
Other insurance (please specify): : _____
Other (please specify): : _____
Total : _____

Q78 Which health plan(s) does the CHW program currently contract with? (Check **all** that apply) *NOTE: *MiCHWA will not share any contract information, except de-identified in aggregate.*

	Contract		Currently in Discussion		**If you answered yes to having a contract** with _____ plan, please list whether or not that contract requires CHWs to be MiCHWA certified (successfully completing MiCHWA core competency-based training).	
	Yes	I don't know	Yes	I don't know	Yes	No

Aetna Better Health of Michigan	☐	☐	☐	☐	☐	☐
Blue Cross Complete of Michigan	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐

Q79 What payment model(s) are being used to support the CHW program's CHWs? (Check all that apply)

- [ ] Does not apply
- [ ] 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 for specific health outcomes per member
- [ ] Bundled payment for services, including those of the CHW
- [ ] Fee-for-Service-based hourly or per unit reimbursement
- [ ] Other (please specify): _____

Q80 Has the CHW program been reimbursed for care coordination services provided by CHWs using any of the following codes? (Please check **all** that apply)

- [ ] Does not 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
- [ ] 98960 – Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
- [ ] 98961 – Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
- [ ] 98962 – Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
- [ ] 98966 – Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the

previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment

☐ GO511 – services previously billed as CPT 99490 or 994987

☐ GO512 – Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric CoCM), 60 minutes or more of clinical staff time for psychiatric CoCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

☐ None of the above, our CHWs have not been reimbursed for care coordination services

Q81 Is the CHW program using any OTHER specific billing codes to receive reimbursement for CHW services?

- [ ] Does not apply
- [ ] 99490
- [ ] S9445 with diagnosis code Z71.9, G9001 and 98966
- [ ] 98967
- [ ] 98968
- [ ] 99486
- [ ] None
- [ ] Other (please specify):

_____

Q82 What are the CHW program's concerns when it comes to longevity and sustainability of CHW employment? (Check **all** that apply)

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

_____

Q83 How does the CHW program work to support and/or to promote CHWs and their long-term sustainability? (Check all that apply)

- [ ] Pay for CHWs to become certified
- [ ] Pay for CHWs to obtain continuing education credits of re-certification
- [ ] Offering opportunities for CHW professional development (e.g., in-services, trainings, career path development)
- [ ] Providing education on the CHW role to public, providers and policy-makers
- [ ] Advocating for policy changes that support sustainable funding for CHWs
- [ ] Working with health plan payers on contracts for CHW services
- [ ] Building a business case for CHWs within program or organization
- [ ] Plan for how to retain CHWs in the organization in the event of funding loss
- [ ] Other (Please specify): _____
- [ ] Not at this time

Q84 Below are some statements regarding the value of state-recognized CHW certification to the CHW program. Please indicate the extent to which you agree or disagree with each statement.

	Disagree completely	Disagree somewhat	Agree somewhat	Agree completely
Better defining the role of CHWs	○	○	○	○
Helping CHWs learn new skills	○	○	○	○
Improving CHWs' work performance	○	○	○	○
Expanding CHW responsibilities	○	○	○	○
Winning CHWs more respect from the individuals they serve	○	○	○	○
Winning CHWs respect from other professionals	○	○	○	○
Better integrating CHWs with other teams	○	○	○	○
Helping obtain more stable funding for CHWs	○	○	○	○
Enabling better coverage of CHW work through insurance or other payer	○	○	○	○
Increasing CHWs' opportunities for promotion within the organization	○	○	○	○

Q85
Lifestyle Change Programs
We request that you complete the entire survey reflecting the CHW workforce as of <u>March 1, 2020, unless otherwise specified.</u>

Are any of the CHW program's CHWs **currently trained** as leaders or master trainers of the following evidence-based lifestyle change program(s)? (Check **all** that apply)

- [ ] Diabetes Prevention Program (DPP)
- [ ] Diabetes Self-Management Education and Support (DSMES)
- [ ] Personal Action Toward Health (PATH)
- [ ] Diabetes PATH
- [ ] Kidney PATH
- [ ] Tomando Control de su Salud
- [ ] Enhance Fitness
- [ ] YMCA Blood Pressure Self-Monitoring
- [ ] Other (Please specify):

_____

- [ ] None

Q86 Have any of the CHW program's CHWs **served (or are currently serving)** as leaders or co-leaders in the following evidence-based CHW program(s) in the past 12 months? (Check **all** that apply)

- ☐ Diabetes Prevention Program (DPP)
- ☐ Diabetes Self-Management Education and Support (DSMES)
- ☐ Personal Action Toward Health (PATH)
- ☐ Diabetes PATH
- ☐ Kidney PATH
- ☐ Tomando Control de su Salud
- ☐ Enhance Fitness
- ☐ YMCA Blood Pressure Self-Monitoring
- ☐ Other (Please specify): _____
- ☐ None

Q87 If you are interested in any of the following programs, please use the links and contact information provided to learn more.

Diabetes Prevention Program (DPP) Personal Action Toward Health (PATH) Diabetes PATH Kidney PATH Tomando Control de su Salud Enhance Fitness YMCA Blood Pressure Self-Monitoring Diabetes self-management education and support (DSMES)

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Q88 CHW Evaluation, Monitoring/Quality Improvement**We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.**

Please select the types of evaluation/monitoring that the CHW program conducts. (Check **all** that apply)

- ☐ Tracking impact and/or outcomes
- ☐ Satisfaction survey/assessment from CHWs
- ☐ Satisfaction survey/assessment from clients
- ☐ Number and type of clients served
- ☐ Cost savings
- ☐ Other (please specify): _____

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Q89
CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

Does the CHW program use a 'social determinants of health' screening and/or assessment tool?

- ○ Yes
- ○ No

Q90 If yes, please select which 'social determinants of health' screening and/or assessments tool(s) you use. (Check **all** that apply)

- ☐ Protocol for Responding to and Assessing Patients' Assets, Risk, and Experiences (PRAPARE)
- ☐ Patient Centered Assessment Method (PCAM)
- ☐ Pathways
- ☐ Meaningful Use 2 or 3 (EHR)
- ☐ Community Health Innovation Region (CHIR) developed (please specify):
- ☐ Other (please specify): _____
- ☐ I don't know

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Q91
CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

How does the CHW program use social determinants of health data? (Check **all** that apply)

- ☐ Not applicable (organization does not record social determinants of health data)
- ☐ Eligibility determination
- ☐ Connect enrollees to community supports and services
- ☐ Provide information to health care providers
- ☐ Project tracking
- ☐ Quality improvement initiatives
- ☐ Other (please specify): _____

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Q92
CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

We are interested in learning about the extent to which the CHW program tracks referrals in the following areas: Social determinants of health Environment Health care Health promotion/chronic disease self-management Other
The next set of questions will ask about referral processes in the CHW program.

Q93 Does the CHW program address or refer clients related to needs in the area of **social determinants of health** (e.g., housing, transportation, food access, income assistance, etc.)?

- ○ Yes
- ○ No

Q94 For the area of social determinants of health, does the CHW program...

	Yes	No
Track referrals made (e.g., organization received referral)	○	○
Track Referrals Completed (e.g., client connected to service)	○	○
Track the Outcome of Referrals Addressed (e.g., social or health service need met)	○	○

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Q95
CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified

Does the CHW program address or refer clients related to needs in the area of environment (e.g., environmental remediation, referral for warming/cooling stations, disaster relief, etc.)?

- ○ Yes
- ○ No

Q96 For the area of **environment**, does the CHW program...

	Yes	No
Track referrals made (e.g., organization received referral)	○	○
Track Referrals Completed (e.g., client connected to service)	○	○
Track the Outcome of Referrals Addressed (e.g., social or health service need met)	○	○

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Q97
CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

Does the CHW program address or refer clients related to needs in the area of health care (e.g., primary care, dental care, mental/behavioral health, medication assistance, perinatal/infant/well-child care, etc.)?

- ○ Yes
- ○ No

Q98 For the area of **health care**, does the CHW program...

	Yes	No
Track referrals made (e.g., organization received referral)	○	○
Track Referrals Completed (e.g., client connected to service)	○	○
Track the Outcome of Referrals Addressed (e.g., social or health service need met)	○	○

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Q99
CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

Does the CHW program address or refer clients related to needs in the area of health promotion/chronic disease self-management (e.g., tobacco, diabetes, asthma, heart disease, HIV/AIDS, nutrition/physical activity, etc.)?

- ○ Yes
- ○ No

Q100 For the area of **health promotion/chronic disease self-management**, does the CHW program...

	Yes	No
Track referrals made (e.g., organization received referral)	○	○
Track Referrals Completed (e.g., client connected to service)	○	○
Track the Outcome of Referrals Addressed (e.g., social or health service need met)	○	○

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Q101
CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

Does the CHW program address or refer clients related to needs in any other areas?

- ○ Yes (please specify): _____
- ○ No

Q102 For the **other** area, does the CHW program...

	Yes	No
Track referrals made (e.g., organization received referral)	○	○
Track Referrals Completed (e.g., client connected to service)	○	○
Track the Outcome of Referrals Addressed (e.g., social or health service need met)	○	○

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Q103

CHW Evaluation, Monitoring/Quality Improvement
We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

We are interested in learning whether the CHW program uses the following indicators as part of assessment, risk stratification, or to measure an outcome.

	Yes	No
general health status question(s)	○	○
general social support question(s)	○	○
general client empowerment or activation question(s)	○	○

Q104 Please specify what general health instrument or question(s) are used.

_____

Q105 Please specify what social support instrument or question(s) are used.

_____

Q106 Please specify what client empowerment and/or activation instrument or question(s) are used.

_____

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Q107 Do you have a second CHW program, that you oversee or supervise, that you'd like to fill out the survey for?

- ○ Yes (you will be taken to program 2 questions)
- ○ No

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Q108

Additional Information

We request that you complete the entire survey reflecting the CHW workforce as of March 1, 2020, unless otherwise specified.

This section aims to gather any additional information that you may want to share with us regarding the organization, program, and/or Community Health Worker Profession.

Please share any other comments you may have about the following categories:

Q109 CHW Training:

_____

_____

Q110 CHW Employment:

_____

_____

Q111 CHW Scope of Practice:

_____

_____

Q112 CHW Funding and Sustainability:

_____

_____

Q113 Other:

_____

_____

Q114 MiCHWA is currently compiling a collection of CHW job descriptions. If you are willing to provide a CHW job description that is used by the CHW program, please upload the job description below. Any file format is acceptable.

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Q115 Thank you for participating in the 2020 MiCHWA CHW Employer Survey! We greatly appreciate your responses as we learn more about CHWs in Michigan.

All survey inquiries may be made to MiCHWA staff at info@michwa.org

Learn more about MiCHWA and this survey on our website, here.

Please click 'Next' to end this survey.

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