

Findings from the 2025 Community Health Worker and Employer Surveys in Minnesota

Using CHWCRE Common Indicators to provide a snapshot of the state of the CHW workforce

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A Word about Language: Part of the mission at the CHW Center for Research and Evaluation (CHW-CRE) is to build capacity among CHWs to be actively involved in and to lead research and evaluation about the CHW profession. Often, knowing words and phrases that are used in research and evaluation can facilitate this leadership and involvement. Therefore, though we have generally tried to use language in this report that is accessible to all, in cases where we felt it might be necessary or helpful, we have used research and evaluation terminology and concepts and defined them in a call-out box or in the text. We welcome your thoughts and comments about this practice.

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Executive Summary

Background

The Statewide CHW Survey and CHW Employer Survey were developed to advance Minnesota's coordinated effort to strengthen the Community Health Worker (CHW) workforce by establishing consistent, statewide metrics and creating a reliable system for monitoring workforce trends over time. These surveys are driven by the need to promote the use of common indicators, fill longstanding data gaps, and generate a shared evidence base that supports CHW workforce planning, system integration, and policy advancement.

Methodology

The Statewide CHW and CHW Employer Surveys were based on the CHW Center for Research and Evaluation (CHWCRE) Common Indicators and adapted for Minnesota specific workforce and policy contexts. Surveys were distributed through a multichannel outreach approach from September to November 2025. Quantitative data were cleaned, analyzed, and organized into tables and figures in Excel. Qualitative data were reviewed by two investigators and analyzed using Gemini. Investigators compared automated themes to manual summaries and refined them as needed.

Key Findings

Findings are organized according to three of the four guiding questions in the [Minnesota Community Health Worker Statewide Measurement Plan \(PDF\)](#). When comparing responses from CHWs and employers, it is important to keep in mind that CHWs and employers did not represent the same organizations; therefore, their answers are not expected to be consistent.

What did it take to achieve these efforts?

Community Health Worker Workforce

- One hundred and one (101) CHWs responded to the CHW survey.
- Slightly less than half of respondents (42.6%) have a Minnesota CHW Certificate.

- Fifty (50) percent of respondents lived within the Twin Cities metropolitan area.
- The largest number of respondents (34.7%) were in the 41-50 age category.
- Almost 90 percent of respondents (87.13%) identified as female.
- Approximately one-third of the respondents identified as White (32.7%). The next largest percentages identified as Hispanic, Latino, or Latin origin (22.8%) and Black, African, or African American (21.8%).
- English was the most commonly mentioned language of proficiency (named by 86.1% of respondents).
- A total of 30.7% respondents identified with a specific community (e.g., ethnic, refugee, disability, rural, LGBTQIA).
- In terms of organization type, 39.6% reported working in a health system or community-based clinic, 20.8% reported working in a community-based organization, 18.8% reported working in a local public health agency, and 5% worked in other healthcare providers which includes oral health, mental health and substance use; the remainder (15.8% reported, 'other').

Vulnerable Populations Served by CHWs

- CHW respondents most often mentioned “People with Disabilities” (mentioned by 68% of respondents) and “Uninsured/Uninsured Persons/Families” (66% of respondents) as vulnerable populations served at their employment setting.
- The most common vulnerable populations mentioned by employers were Uninsured/Underinsured persons/families (mentioned by 76% of respondents) and Children or Adolescents (76% of respondents).

Community Health Worker Employers

- Thirty-four (34) employers responded to the Employer survey.
- The largest percentage of employer respondents (44.1%) reported working for a health system or community-based clinic. Equal percentages (20.6%) reported working for a community-based organization or local public health agency.

Are CHWs working under the conditions required for their work to be effective?

Wages, Benefits and Opportunities for Advancement

- Among CHW respondents:
 - The median reported hourly rate was \$26.00/hour, while the median starting hourly rate was \$22.18. According to the [MIT Living Wage Calculator](#), the living wage for one adult and one child in 2026 in Minnesota is \$44.13/hour.
 - Benefits most commonly received include vacation (89% of respondents), sick leave (85% of respondents), and transportation or mileage reimbursement (81% of respondents).
 - Sixty-one point four (61.4) percent reported being eligible for promotion or “step-up.”
- Among employer respondents:
 - The median hourly reported wage was \$26.50/hour for full-time CHWs.
 - Benefits most commonly provided include vacation, family leave, sick leave, and dental insurance, all at 94%.
 - Eighty-five point three (85.3) percent of employers reported CHWs being eligible for step-ups or promotions.

CHW Primary Job Responsibilities

- Sixty-four (64) percent of respondents indicate they address social determinants of health (SDOH).
- Other commonly mentioned job responsibilities include Advocacy (64%), Outreach (62%), and Education (60%).
- Least frequently mentioned responsibilities include Assessment (33%), Research and Evaluation (33%), Cultural Mediation (32%) and Transportation (26%).

CHW Involvement in Decision- and Policy-Making

- Of all the items included in this scale, respondents were least likely to report being members of groups that influence policy in their own organizations (average score = 2.5).
- They were most likely to report having identified the people and organizations that influence change in their communities (average score = 3.4).

CHW Integration into Teams

- On the Relational Coordination Scale (1), the highest average score concerned the frequency with which respondents communicate with other providers about program participants. The lowest score was for the item that measured other providers' knowledge about CHWs' work with program participants.
- On the Influence of Racism and Other Forms of Discrimination on CHW Integration Scale, all average scores were above 3, indicating relatively low levels of discrimination experienced by CHWs based on race/ethnicity or culture.
- Approximately three-quarters of respondents (75.3%) Agree or Strongly Agree that other providers understand their role as a CHW, while 91.1% Agree or Strongly Agree that they feel comfortable talking with other providers about participants' needs.
- Eighty-six point one (86.1) percent of respondents indicated that they have access to adequate, dedicated workspace and 71.3% have access to the main data system for participant tracking.

Supportive and Reflective Supervision

- More than 60% of respondents rate the quality of their individual and group supervision as Good or Excellent.
- A majority of respondents (56.5%) report that CHWs participate on hiring panels for supervisors at their organizations.
- The average overall score for the Supervisor Characteristics scale was 3.37 out of 4, indicating a high level of satisfaction with supervisor characteristics.

What policies can the state enact to strengthen the workforce?

Program level policies

- A majority of employers (70.6%) reported using the APHA definition or a similar definition that had been based upon the APHA definition.
- CHW core roles most commonly included in the scope of work were "Conducting Outreach" and "Care Coordination," both mentioned by 94% of respondents.
- The largest number of respondents said that roles are excluded because their programs are either new or in the midst of rapid expansion. Other reasons for not including all the core roles included: capacity issues or lack of time;

reserving specific tasks (like assessments) for licensed providers; not providing “direct service”; and having constraints based on the funding source.

- Seventy-three point five (73.5) percent of employers reported that they require that CHWs have or get a CHW Certificate. Financial barriers, lack of time, and family responsibilities were mentioned as constraints on their ability to enact this requirement.
- Employer respondents indicate that 86.7% of current CHW employees have a Certificate. This is substantially higher than the 42.6% of CHW respondents who reported having a CHW Certificate. This could be due to many things, including differences in the organizations represented by CHWs and employers.
- More than half of respondents (55.9%) reported that they have no sustainable sources of funding. Slightly over 20% get Medicaid reimbursement using CHW education codes. Smaller percentages (14.7%) have sustainable public funding, other health plan reimbursement, or some other form of sustainable funding.

Recommendations

Recommendations for Employers

1. **Establish clear CHW career pathways.** Creating multi-tiered CHW classifications will allow CHWs to advance without leaving the profession.
2. **Ensure thriving wages for CHWs & supervisors.** The current median CHW wage (\$26/hour reported by CHW respondents and \$26.50 reported by Employer respondents) falls around \$18/hour short of the MIT Living Wage for a parent and child in Minnesota (\$44.13/hour). Living wage floors are needed for CHW positions, and CHW Supervisor salaries should be aligned with other clinical managers, not tied to lower CHW base wages.
3. **Utilize collaborative data collection methods.** Establishing encounter-based data collection, data sharing across CHW workplace settings, and using robust consistent measures of CHW performance and success are essential to tell an accurate story of workforce achievements statewide.

Recommendations for Employers, Policymakers, & Organizations

4. **Create a statewide CHW supervisor training program.** CHW Supervisor trainings based on the CHW-CRE Reflective Supervision Indicator and the [National C3 Council Roles and Competencies](#) should be adopted, as should pathways that explicitly encourage and prepare CHWs to promote into supervisor roles themselves.
5. **Create billing technical assistance (TA) workgroups.** Significant technical hurdles prevent organizations from billing third party payers. A statewide TA workgroup to identify and navigate billing barriers can help move the workforce closer to financial sustainability.
6. **Invest in the creation of a statewide CHW data dashboard and reporting system.** This system, if regularly updated, can guide resource investments and support the long-term goal of building a stronger, more responsive, and culturally grounded CHW workforce.

Recommendations for the Minnesota Community Health Worker Alliance (MNCHWA)

7. Work with policymakers to launch a CHW statewide council. Building on MNCHWA's leadership, a formal statewide council should be established to communicate directly with policymakers and advocate for infrastructure improvements.

8. Conduct regular comprehensive workforce assessment. By systematically monitoring key performance indicators such as retention rates, inclusion of core CHW roles, the effectiveness of new career ladders, and the health and wellbeing of the workforce, the integrity of the profession can be maintained, and sustainability goals can be achieved.

Background

The Statewide CHW Survey and CHW Employer Survey were developed to advance Minnesota's coordinated effort to strengthen the Community Health Worker (CHW) workforce by establishing consistent, statewide metrics and creating a reliable system for monitoring workforce trends over time. These surveys are driven by the need to promote the use of common indicators, fill longstanding data gaps, and generate a shared evidence base that supports CHW workforce planning, system integration, and policy advancement.

The [Minnesota Community Health Worker Statewide Measurement Plan](#) emphasizes that baseline data are essential for assessing workforce growth, implementation models, and CHW impact, and identifies the surveys as core tools for capturing this information from both CHWs and their employers. By collecting statewide quantitative and qualitative data on CHW roles, working conditions, demographics, and employer needs, the surveys aim to inform decision-making across state agencies, health systems, funders, and educators, and to ensure that CHWs themselves remain central to shaping evaluation and infrastructure development. Ultimately, the survey findings can serve as foundational inputs for Minnesota's planned statewide data dashboard and reporting system. (See Recommendations.)

To analyze the data and report the survey findings, the Minnesota Community Health Worker Alliance (MNCHWA) and the Minnesota Department of Health (MDH) partnered with the CHW Center for Research and Evaluation (CHW-CRE). Formerly known as the CHW Common Indicators Project, the mission of CHW-CRE is to conduct and promote CHW-led research and evaluation that uses common indicators and participatory practices.

More information about the CHW-CRE can be found on the CHW-CRE website at www.chwcre.org.

Methodology

Survey development

The development of the Statewide CHW Survey and CHW Employer Survey was grounded in the nationally recognized CHW-CRE Common Indicators, which provide standardized, CHW-vetted measures for assessing CHW workforce conditions, outcomes, and systems supports. The Common Indicators (CI) were created through nearly a decade of collaborative work between CHWs, researchers, and program staff across the country, resulting in a set of measures that capture CHW roles, workplace conditions, compensation, supervision, team integration, and policy contexts. These indicators also provide recommended question wording, response options, and analytic approaches for both CHW- and employer-facing surveys, ensuring that data collected can contribute to a growing field of aligned, comparable CHW workforce research (4,10).

While using common indicators is important because it allows us to compare CHW workforce conditions across the US, the CHW-CRE recommends that all studies or surveys of CHWs need to take into account the local and historical context and ask additional questions that are important to CHWs in any given region at a given time.

Building on the CI foundation, Minnesota made some adaptations to reflect state-specific workforce conditions, terminology, and policy environments, while preserving alignment with CI intent and measurement structure. Minnesota's modifications ensured relevance to the state's CHW certificate system, employer models, supervision structures, and CHW roles across diverse settings. In addition, the surveys integrated essential demographic and employment variables required by Minnesota's Statewide Measurement Plan. The CHW and CHW Employer surveys will be conducted every two years and will contribute to reporting through the planned CHW data dashboard.

The resulting survey instruments maintain full fidelity to the CHW-CRE Common Indicator framework, including indicators related to CHW compensation, benefits, and advancement; enactment of CHW core roles; involvement in decision-making; team integration; and supportive supervision for CHWs, as well as employer-facing items addressing policy and systems change. These evidence-based indicators ensure national comparability while Minnesota-specific adaptations ensure

responsiveness to local context, making the surveys robust tools for guiding statewide workforce planning, investment, and policy development.

Survey dissemination

The Statewide CHW Survey and the CHW Employer Survey were disseminated using an extensive, multi-channel outreach strategy spanning September through November of 2025. The CHW Survey benefitted from repeated email promotions from MNCHWA and MDH, presentations during CHW Learning Circles, inclusion in the MNCHWA newsletter, and presence at key events such as the Many Faces Conference and the Rural CHW Conference, followed by targeted email follow-ups. The CHW Employer Survey, launched in early October 2025, was disseminated similarly. It was featured at events, shared during the Supervisor Round Table, and included in both the October and November MNCHWA newsletters, ensuring strong alignment between outreach efforts for both surveys. Together, this coordinated communication strategy ensured ongoing opportunities for CHWs and their employers to engage with the surveys, supporting robust participation statewide.

Survey analysis

Quantitative Data

Survey responses were downloaded into an Excel spreadsheet for data cleaning, recoding, and analysis. Data tables and figures were produced in Excel. We calculated means (averages) for survey questions overall and then *stratified* the answers to questions about wages and integration by location, racial group, and organization type. We did not try to assess the likelihood that the

In the language of statistics, to “stratify” means to divide the responses of a group by some characteristic, such as age or race/ethnicity, so we can assess whether responses differed systematically from group to group.

differences we saw could have occurred by chance (for example, by calculating p-values), since respondents to the survey were not a random sample of all CHWs and CHW employers working in Minnesota.

For the purposes of analysis, we divided self-identified race/ethnicity into two categories: White and BIPOC (Black, Indigenous and People of Color), where White

respondents were individuals who responded only “White” to the race/ethnicity question and BIPOC includes individuals who self-identified as other race/ethnicities, including in combination with “White.” In line with recent science in the field of data justice, in cases where respondents identified two or more racial identities, we categorized them by the least common race they identified (2).

There were questions in both surveys that asked respondents to select from a list of “organization types” the option that best described their employer. There were 15 options provided to respondents, which were condensed into five categories: Community-based organization (Community-based organization, Faith-based organization), Health system and community-based clinic (Community clinic, Hospital/health system, Medical clinic), Local public health agency (Local public health agency), Other healthcare providers (Mental health provider, Oral health provider, Substance use organization), and Other organizations (Educational institution, For-profit organization, Managed care organization, Other, State agency, Tribal nation). The five categories were used for analysis related to organization type throughout the report.

Location was collected as zip code and then categorized as either being within or outside of the Twin Cities’ seven-county metropolitan area for stratified analysis.

For survey questions that are intended to function as scales, if not all items were worded in the same direction (i.e., from negative to positive), we reversed the order of responses to make it easier to interpret the responses. For some scalar variables like “CHW involvement in policy- and decision-making,” we created new *variables* that combined all the items in the scale and calculated average scores stratified by the demographic variables.

A variable is any characteristic, number or quantity that can be measured or counted. These things “vary” from person to person, thus the name, “variable.” The characteristics, opinions, and feelings we measure in surveys are often referred to as “variables.”

Qualitative Data

We began with a thorough examination of the data to identify themes and high-impact “anchor quotes” that represented the core successes and frustrations that respondents expressed. We then processed the raw data using Gemini to group responses, including ambiguous responses (e.g., “N/A,” “test,” or “workday”). We compared the resulting automated categories against our initial manual summary. Where nuance was missed -- such as the technical struggle of clinics filing claims for reimbursement -- the prompts were adjusted. Based on inconsistencies, we asked more targeted questions to “drill down” into sub-themes, such as distinguishing between *Financial Barriers* (lack of money) and *Capacity Barriers* (lack of staff time). We exercised independent judgement about the categorization of some items.

Results

Measurement Plan Question: What did it take to achieve these efforts?

Characteristics of CHW Respondents

One hundred and one (101) individuals responded to some or all of the survey questions. Below, we indicate the total number of respondents (n) for each question.

Because of the relatively small number of respondents to the survey, as well as the fact that the respondents do not represent all the CHWs in Minnesota, it is important to interpret all the data reported below with caution. An apparent difference between two groups could be the result of chance rather than an actual difference in the underlying population.

Respondent Characteristics of Employment

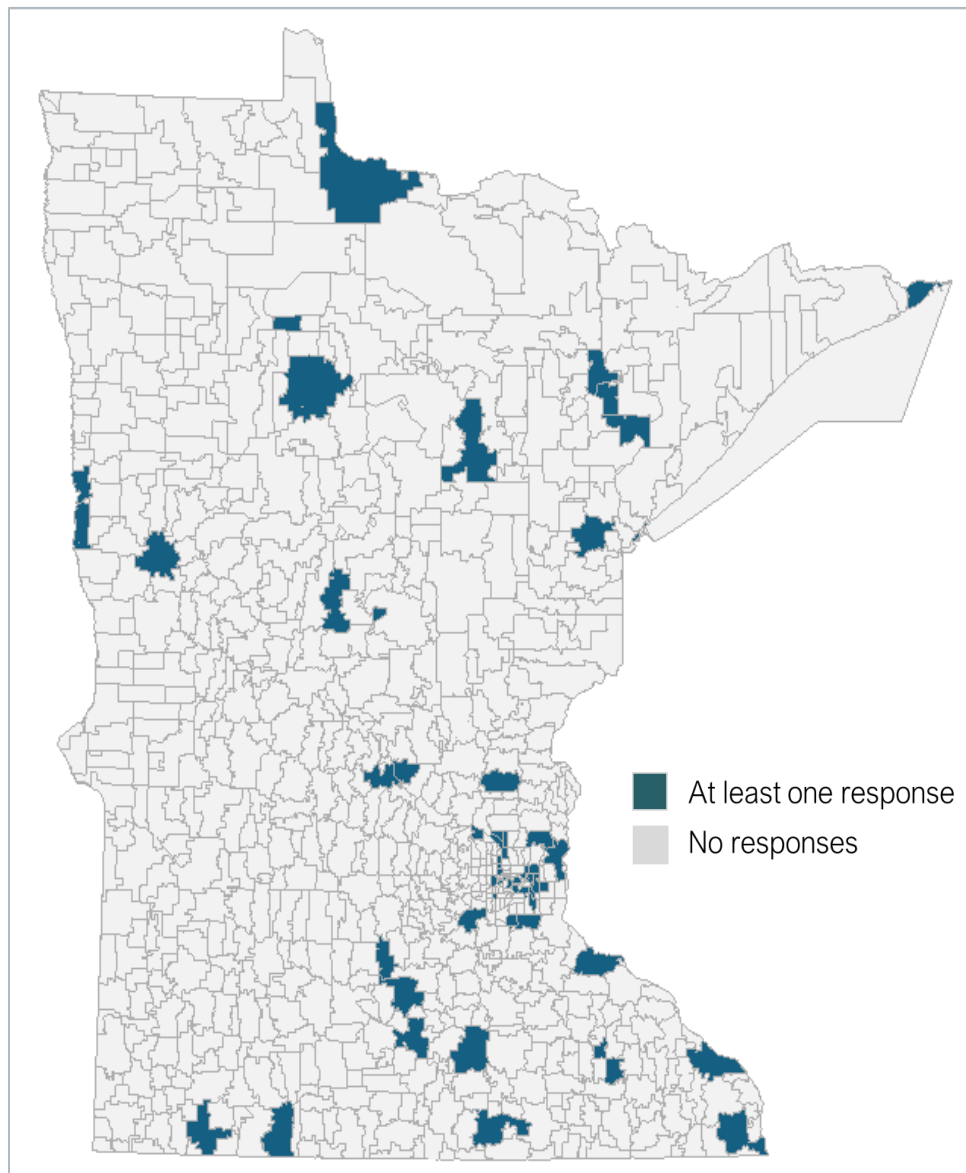
Respondents were able to “check all that apply” from a list of options that included where they work, the title they use, whether they have a Minnesota CHW certificate, and other characteristics related to their employment. (See Supplemental Table 1 in the Appendix.)

As the table shows, the majority of respondents (61%) currently work as a CHW in Minnesota and their title includes “Community Health Worker.” Slightly less than half of respondents (42.6%) have a Minnesota CHW certificate.

Location of residence

Ninety-eight (98) of the 101 respondents included in the sample provided a ZIP code for their home address. The respondents reported 66 unique ZIP codes with all but two respondents residing in Minnesota. All respondents included in the analysis were matched to the county corresponding to their ZIP code and then categorized as being within or outside the Twin Cities seven-county metropolitan area. Forty-nine respondents (50%) lived within the Twin Cities metropolitan area, while 47 (48%) lived outside of the metropolitan area and two (2%) lived outside of the state. See Figure 1 for a map of respondents' locations.

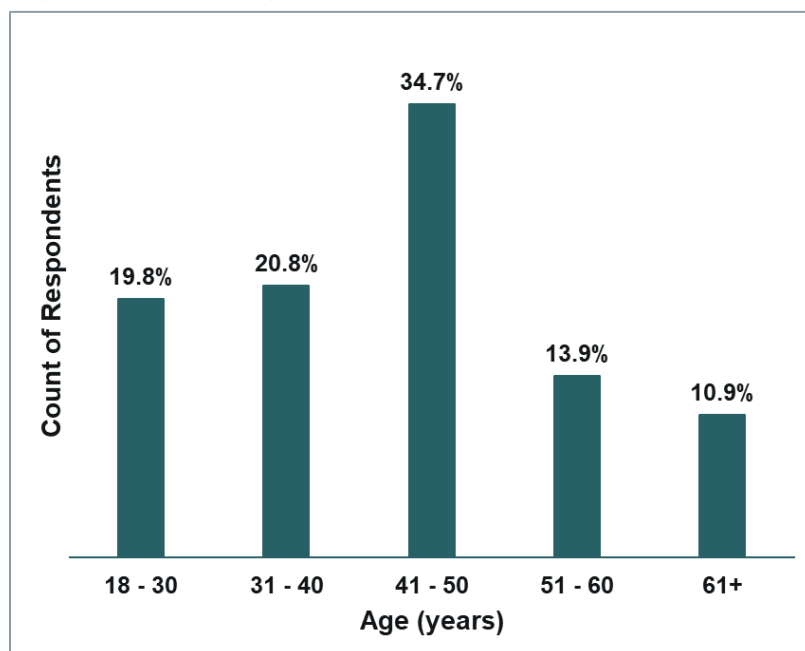
Figure 1. Map of Zip Codes with Respondents ($n=98$)



Age

Respondents were asked to choose an age category (Figure 2). The largest number of respondents (34.7%) were in the 41-50 category. Approximately three quarters (75.3%) reported being 50 or younger.

Figure 2. CHW Age in Years (*n*=101)



Gender

Eighty-eight respondents (87.13%) identified as female with the remaining respondents identifying as male (9.90%), agender (.99%), or preferring not to respond (1.98%).

Race

Respondents were asked to choose all races with which they identified from a list; they could also write in an “other” response or choose not to answer. The “rarest group method” (2) was used to identify a primary racial identity for all respondents. Approximately one-third of the respondents self-identified as White (32.7%). The next largest percentages identified as Hispanic, Latino, or Latin origin (22.8%) and Black, African, or African American (21.8%). Six individuals chose not to answer. A breakdown by race is provided in Table 1.

Table 1. Racial Identities of Respondents (n=101)

Racial Groups	Number	Percent
White	33	32.7%
Hispanic, Latino, or Latino origin	23	22.8%
Black, African, or African American	22	21.8%
American Indian or Alaska Native	9	8.9%
Prefer not to answer	6	5.9%
East Asian	3	3.0%
Other Asian	3	3.0%
South Asian	1	1.0%
Another race	1	1.0%

Language proficiency

An open-ended question asked respondents to identify language(s) in which they are proficient. As shown in Table 2, the largest percentage of respondents (86.1%) named “English.” The “Other” category was made up of seven languages with one response each (Arabic, Cambodian, Haitian Creole, Japanese, Karen, Krio, and Swahili). Because respondents were able to name more than 1 language, the total percentage is greater than 100%.

Table 2. Respondent Language Proficiencies (n=101)

Languages	Number	Percent
English	87	86.1%
Spanish	25	24.8%
Somali	6	6.0%
American Sign Language	4	4.0%
French	3	3.0%
Hmong	2	2.0%
Ojibwe	2	2.0%
Other	7	6.9%

Other community identities

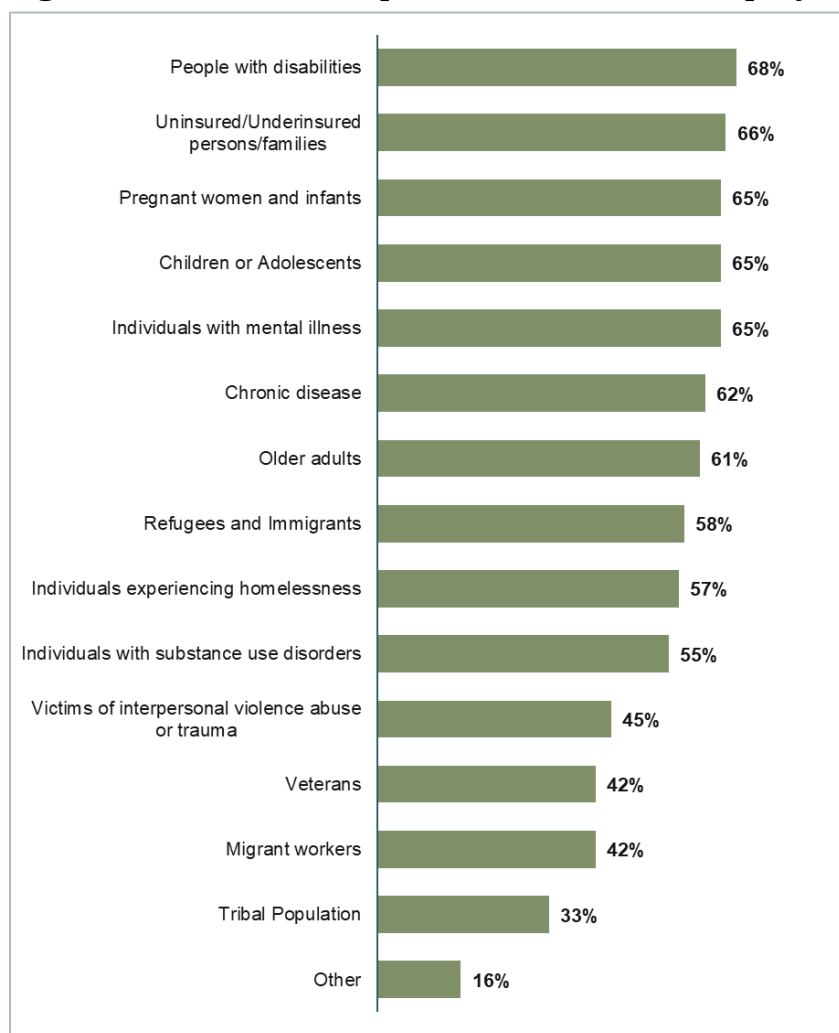
Respondents were asked if they were a member or had an affiliation with any specific community (e.g., ethnic, refugee, disability, rural, LGBTQIA). A total of 30.7% (n=101) respondents identified with a specific community. The most common communities identified were the disability community, specific ethnic

groups or tribes, the rural community, the LGBTQIA+ community, and the refugee community.

Vulnerable Populations Served at Employment Setting

Respondents were asked to select from a list all the vulnerable populations served at their employment setting. Figure 3 shows that CHW respondents most often mentioned “People with Disabilities” (mentioned by 68% of respondents) and “Uninsured/Uninsured Persons/Families” (66% of respondents).

Figure 3. Vulnerable Populations Served at Employment Setting (*n*=101)



Respondent Organization Type

Respondents were asked to identify an organizational type for their current CHW employer. As described in the methods, organization types were collapsed for reporting. As shown in Table 3, 39.6% of respondents reported working for a health

system or community-based clinic, while 20.8% of respondents reported working for a community-based organization, and 18.8% reported working for an LPH agency.

Table 3. Respondent Organization Type (n=101)

Organization Type	Number	Percent
Health system or community-based clinics	40	39.6%
Community-based organization	21	20.8%
Local public health agency	19	18.8%
Other healthcare providers	5	5.0%
Other	16	15.8%

Characteristics of CHW Employers

A total of 35 people responded to the Employer survey. One person was excluded because they were not a CHW employer.

Respondent Roles

Respondents were asked to identify their role in their organization (Table 4). They were able to choose multiple responses. As shown in Table 5, 70.6% of respondents identified as a CHW supervisor. Other substantial percentages identified as organizational administrators (29.4%) and CHW program administrators (26.5%).

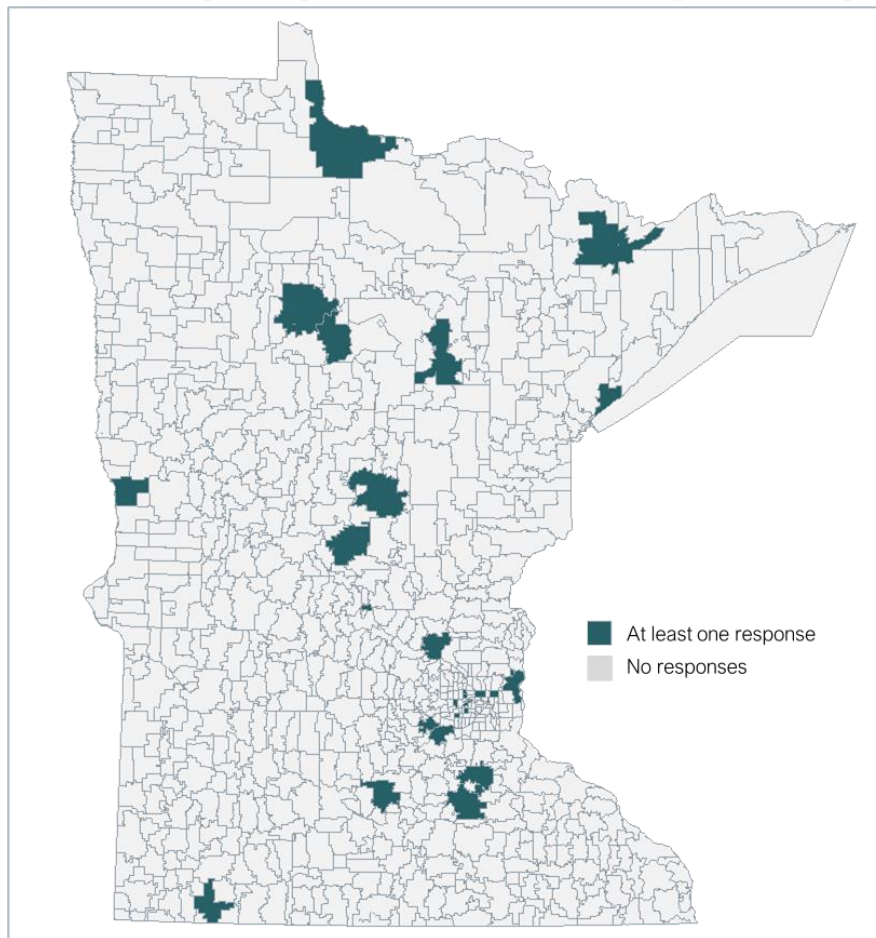
Table 4. Respondent Roles (n=34)

Respondent Roles	Number	Percent
CHW supervisor (I directly supervise CHWs)	24	70.6%
Organizational administrator in an organization with a CHW program	10	29.4%
CHW program administrator	9	26.5%
Certificate holding CHW	4	11.8%
CHW mentor	3	8.8%

Organization Zip Code

Respondents were asked to identify the zip code in which their organization is located. Figure 4 provides a map locating respondent organizations by zip code.

Figure 4. Map of Zip Codes with a CHW Employer Respondent ($n=34$)



Organization Type

Respondents were asked to identify their organization type using the same list used in the CHW survey. Organizations were collapsed using the same system. As shown in Table 5, the largest percentage of respondents (44.1%) reported working for a health system or community-based clinic. Equal percentages (20.6%) reported working for a community-based organization or local public health agency.

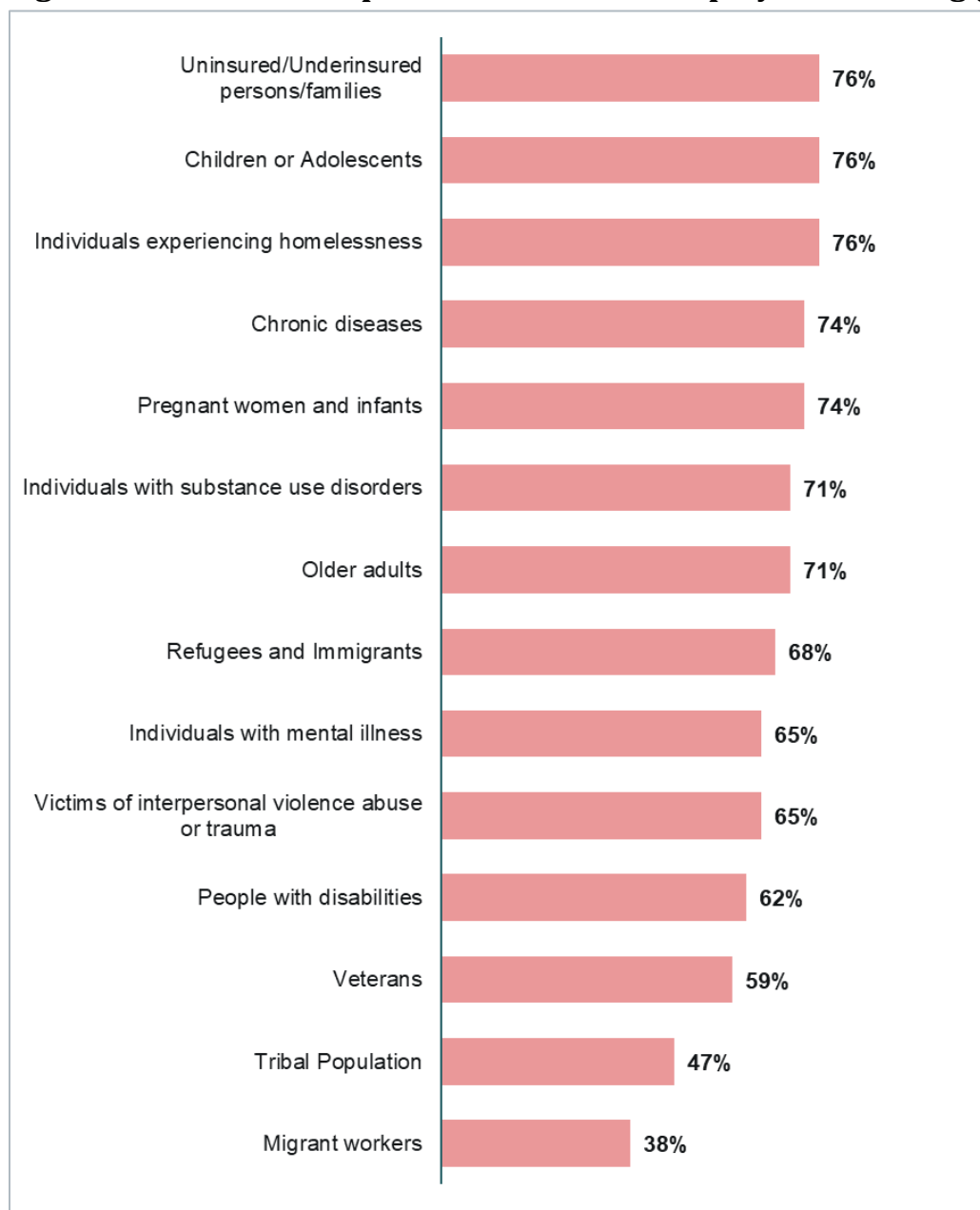
Table 5. Respondent Organization Type ($n=34$)

Organization Type	Number	Percent
Health system or community-based clinic	15	44.1%
Community-based organization	7	20.6%
Local public health agency	7	20.6%
Other	5	14.7%

Vulnerable Populations Served at Employment Setting

Mirroring the CHW survey, respondents were asked to select from a list all the vulnerable populations served at their employment setting. Figure 5 shows that the most commonly mentioned populations are Uninsured/Underinsured persons/families (mentioned by 76% of respondents) and Children or Adolescents (76% of respondents). While the first group was also among those most often identified by CHWs, the second group was not.

Figure 5. Vulnerable Populations Served at Employment Setting (*n*=34)



Measurement Plan Question: Are CHWs working under the conditions required for their work to be effective?

CHW Responses

Wages, benefits, and opportunities for advancement (Indicator #1)

Common Indicator #1 assesses CHW wages, benefits, and opportunities for advancement; it includes versions for CHWs and employers.

Wages

Respondents were asked to provide information about their current and starting hourly rate and their current and starting annual salary (Table 6). The vast majority of respondents reported hourly rate, so all responses were converted to this format. (This calculation is also easiest to analyze and compare since the number of hours worked and overtime rates are often unknown.) The median current hourly rate was \$26.00/hour, while the median starting hourly rate reported was \$22.18/hour. According to the [MIT Living Wage Calculator](#), the living wage for one adult and one child in 2026 in Minnesota is \$44.13/hour. (We report the median hourly rate here because it is less sensitive to extreme values.)

Table 6. Current Hourly Wage and Starting Hourly Wage (*n*=97)

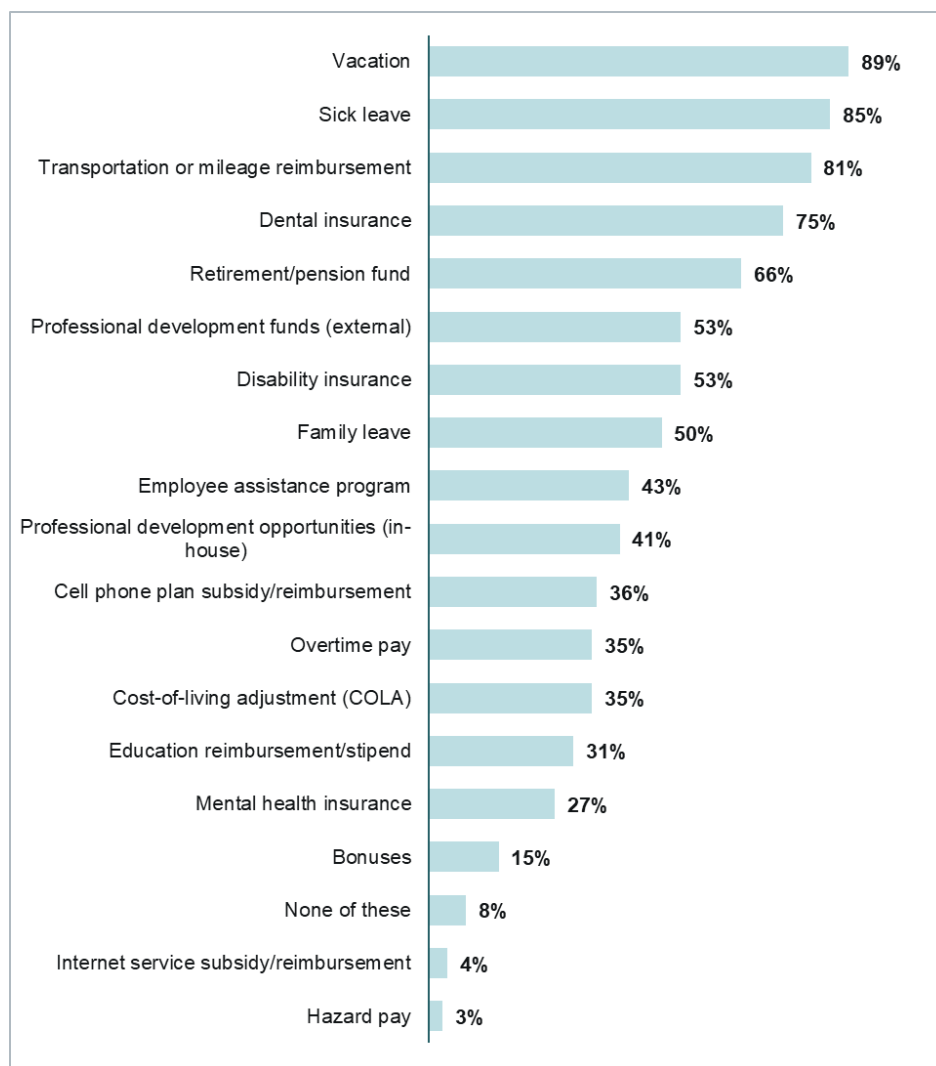
Group (<i>n</i>)	Starting Hourly Salary (\$)			Current Hourly Salary (\$)		
	Average	Median	Range	Average	Median	Range
All respondents (97)	23.83	22.18	14-75	28.78	26.00	15-75
All respondents without highest 5 outliers (92)	22.56	22.00	14-40	26.84	26.00	15-40
Respondents not currently working as a CHW (16)	28.66	25.50	14-75	32.36	28.01	15-75
CHWs with a certificate/UMPI/NPI (46)	24.53	23.48	14-75	31.39	29.00	20-75

CHWs without a certificate (51)	23.19	22.00	14-50	26.42	25.00	15-57
CHWs living in the 7-county metro area (46)	25.40	24.00	14-75	30.75	29.00	15-75
CHWs living outside the 7-county metro area (51)	22.40	21.00	14-45	27.00	24.95	15-73

Benefits

The survey asked respondents to identify benefits received from their employer, including dental, disability, and mental health insurance; overtime pay; and sick leave. (“Health insurance” was unintentionally deleted from the CI list.) Figure 6 shows the percentage of respondents who receive a given benefit. Benefits most commonly received by respondents include vacation (89% of respondents), sick leave (85% of respondents), and transportation or mileage reimbursement (81% of respondents). Benefits that respondents are least likely to receive include hazard pay (3% of respondents) and internet service subsidy (4% of respondents).

Figure 6. Benefits Received (*n*=101)



Opportunities for advancement

Among our respondents, 61.4% were eligible for promotion or “step-up.”

Qualitative responses about wages, benefits, and opportunities for advancement

Common Indicator #1 includes four open-ended questions about wages, benefits and opportunities for advancement. Two concern desired changes in level of pay and amount and type of benefits. One question requests experience with promotion or step-up pathways, while a final question gives respondents an opportunity to share anything else they wish to share about compensation, benefits and opportunities for advancement.

Tables 7-10 provide a numerical overview of responses to these questions from the Minnesota survey. Table 8 (“No Change” Responses) suggests that almost 70% of respondents would like to see changes in their pay and work hours.

Table 7. “No Change” Responses (*n*=101)

Question Topic	“No Changes” Responses	Percent
Pay & Work Hours	32	31.7%
Benefits	49	48.5%
Promotion/Step-up Pathways	9	8.9%

The range of reported and suggested hourly pay rates (Table 9) ranged from \$19/hour to \$36/hour, with \$25/hour being the most common recommendation for a starting rate, and \$30 being the most commonly recommended target rate or rate for CHWs with higher degrees.

Table 8. Suggested and Reported Hourly Pay Rates (*n*=101)

Hourly Rate	#	Primary Context in Responses
\$19	1	Reported as a current rate; described as "inadequate."
\$20	2	Reported as current pay or a baseline for Certificate holders.
\$25	3	Most common recommendation for a fair starting wage.
\$28	1	Suggested as a target starting rate.
\$30	3	Suggested as a target rate or for those with higher degrees (BS).
\$33	1	Reported as an actual current starting rate at one organization.
\$36	1	Suggested as an ideal starting wage with annual increases.

In their responses to this question, several respondents spoke about CHWs’ dedication to their work and stated that the quality and complexity of the work should be reflected in the wage level. In the words of one respondent:

CHWs do the hardest jobs and they [are] paid the lowest wage based on the upper management and it is not okay. I have been working for 6 [years] as a CHW and ... gained \$4 dollars!!! Getting [a] few cents every year is not cover[ing] the cost of living!

Other respondents spoke about the flexible hours that are necessary for the CHW profession and suggested paying overtime. In the subsequent question, one

participant expressed a desire to be paid a salary rather than hourly, which probably would also confer more flexibility.

The data suggest that slightly more than half of respondents would like to see changes in benefits. Some of the benefits respondents would like to receive (Table 10) include health and medical insurance, paid time off, and education and training. Less frequently, respondents requested better mental health and self-care support, disability insurance, retirement plans, and opportunities for flexible or remote work. Notably, several respondents mentioned working on contract or as a consultant and thus not receiving benefits.

Table 9. Summary of Benefit Change Requests (*n*=101)

Key Theme / Keyword	#	Primary Context in Responses
No Changes / Satisfied	50	Nearly half of the respondents indicated they wanted no changes or were satisfied (e.g., "no changes," "none," "my benefits are amazing").
Health & Medical Insurance	11	Includes requests for dental/vision, employer-paid premiums, affordable family insurance, and coverage for part-time workers.
Time Off (PTO, Sick, Leave)	11	Includes requests for more vacation, separate sick/PTO banks, paid holidays, and access to FMLA or family leave.
Education & Training	9	Includes requests for professional development funds, scholarship funding, education stipends, and help with coursework.
Pay & Wages	5	Despite the question being about benefits, some requested wage increases, raises after certification, or moving from hourly to salary.
Mental Health & Self-Care	3	Specific requests for better mental health support and discounts on self-care or wellness services.
Disability Insurance	3	Requests for disability coverage or insurance that is "usable."
Retirement / 401K	2	Requests for investment plans, 401K options, and retirement savings contributions.
Flexibility / Remote Work	1	A request for flexible hours or the ability to work remotely.

On the question about experience with the promotion/step-up pathway, almost a quarter of respondents (*n*=22) stated some version of the idea that there is “nowhere to go” or “nothing above CHW,” echoing similar responses from CHWs respondents around the country over the last three decades. To these responses we

can add the responses of four additional CHWs, who said they were “stuck” in their current positions because they lack formal degrees. The fact that 16% of respondents (n=17) expressed satisfaction with their role and/or salary is heartening and shows that “a better world is possible.” Also encouraging were the six respondents who said their workplaces have successfully implemented tiered positions or mentorship. Two respondents spoke specifically to the need for more support for Deaf CHWs.

Table 10. Summary of Career Pathway Feedback (n=101)

Category	#	Primary Context in Responses
Lack of Pathway / No Growth	22	Respondents frequently stated there is "nowhere to go" or "nothing above CHW" except for management roles that require different degrees.
No Changes / Satisfied	17	These respondents are either happy with their current role or feel the current system of raises is sufficient.
New Employee / Too Early	15	A large segment of the workforce is "too new" (less than a year) to have experienced or understood the promotion process.
Desire for Transparency / Structure	6	Workers requested a "structured process" or "more transparency" on how to move from a CHW 1 to a CHW 2 or Coordinator.
Existing Ladders / Mentorship	6	Some organizations have successfully implemented tiered roles (CHW 1, 2, 3) or mentorship programs to help new hires.
Union / Merit / Automatic Raises	5	In these cases, growth is defined by pay increases via union contracts or longevity rather than title changes.
Degree/Education Barriers	4	Several CHWs noted they are "stuck" because they lack a Bachelor's degree, even if they have decades of experience.
Barriers for Deaf CHWs	2	Specific mentions of unique hiring and promotion barriers faced by the Deaf community within healthcare facilities.

In response to the final open-ended question in this section, several respondents mentioned their particular situations (e.g., being a consultant) not being taken into account and thus having to give incorrect answers to questions.

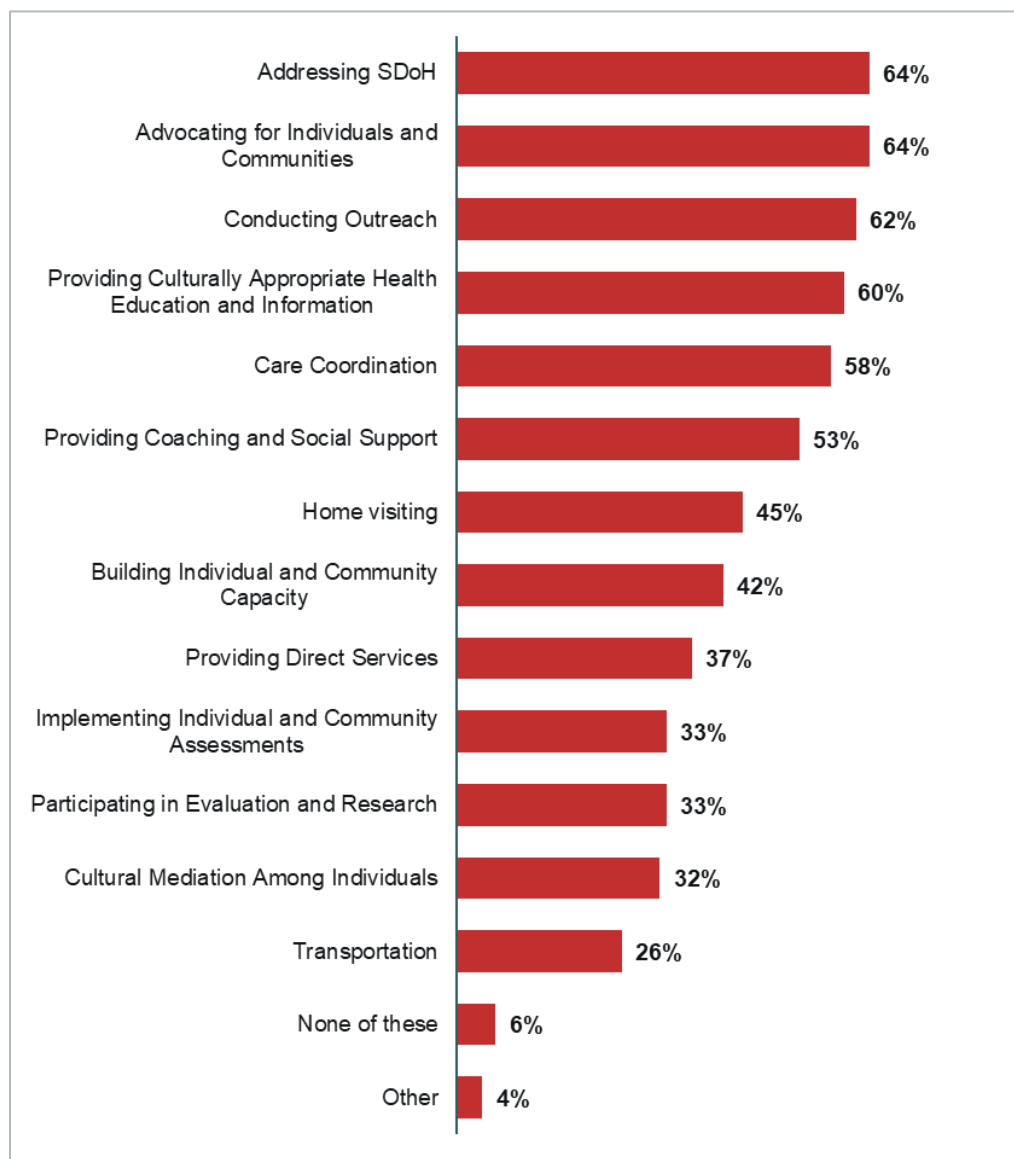
Primary CHW Job Responsibilities (based on Indicator #2)

Indicator #2 assesses to what extent CHWs are playing a full range of the 10 roles identified in a series of national studies including the *National Community Health Advisor Study* (9) and the *CHW Core Consensus Report* (5). In the Minnesota CHW Survey, these data were collected somewhat differently from how they have been collected in statewide surveys in the past.

The survey asked respondents to indicate the primary job responsibilities of CHWs in their organization. In addition to the 10 Core Roles of CHWs, the Minnesota survey added “Screening for, providing resources, and addressing Social Determinants of Health (SDOH),” “Home visiting,” “Transportation,” “None of these,” and “Other.” Results are provided in Figure 5.

Sixty-four (64) percent of respondents indicate they address SDOH (Figure 7). Other commonly mentioned job responsibilities include Advocacy (64%), Outreach (62%), and Education (60%). As we have seen in other statewide and national surveys, least frequently mentioned responsibilities include Assessment (33%), Research and Evaluation (33%), and Cultural Mediation (32%) and, in this survey, Transportation (26%).

Figure 7. Primary job responsibilities of CHWs at their organization (*n*=101)



Involvement in decision- and policymaking (Indicator #4)

Common Indicator #4 measures the degree to which CHWs report being involved in decision- and policymaking, both within and outside of their organizations. It is intended to function as a scale. Respondents are asked to indicate how much they agree with 6 statements, using four response options of “Strongly Disagree,” “Disagree,” “Agree,” and “Strongly Agree,” coded with numeric values of 1 to 4. An average of these scores is taken, with a maximum possible score of 4 and minimum of 1.

Across the six items, the average score in this sample was 2.93. As we have seen in four states and one national sample (2,5,6,9), respondents were least likely to report being members of groups that influence policy in their own organizations (average score = 2.5). Also predictably, they were most likely to report having identified the people and organizations that influence change in their communities (average score = 3.4).

Figure 8. CHW Involvement in Decision- And Policy-Making; mean score by statement (*n*=101)

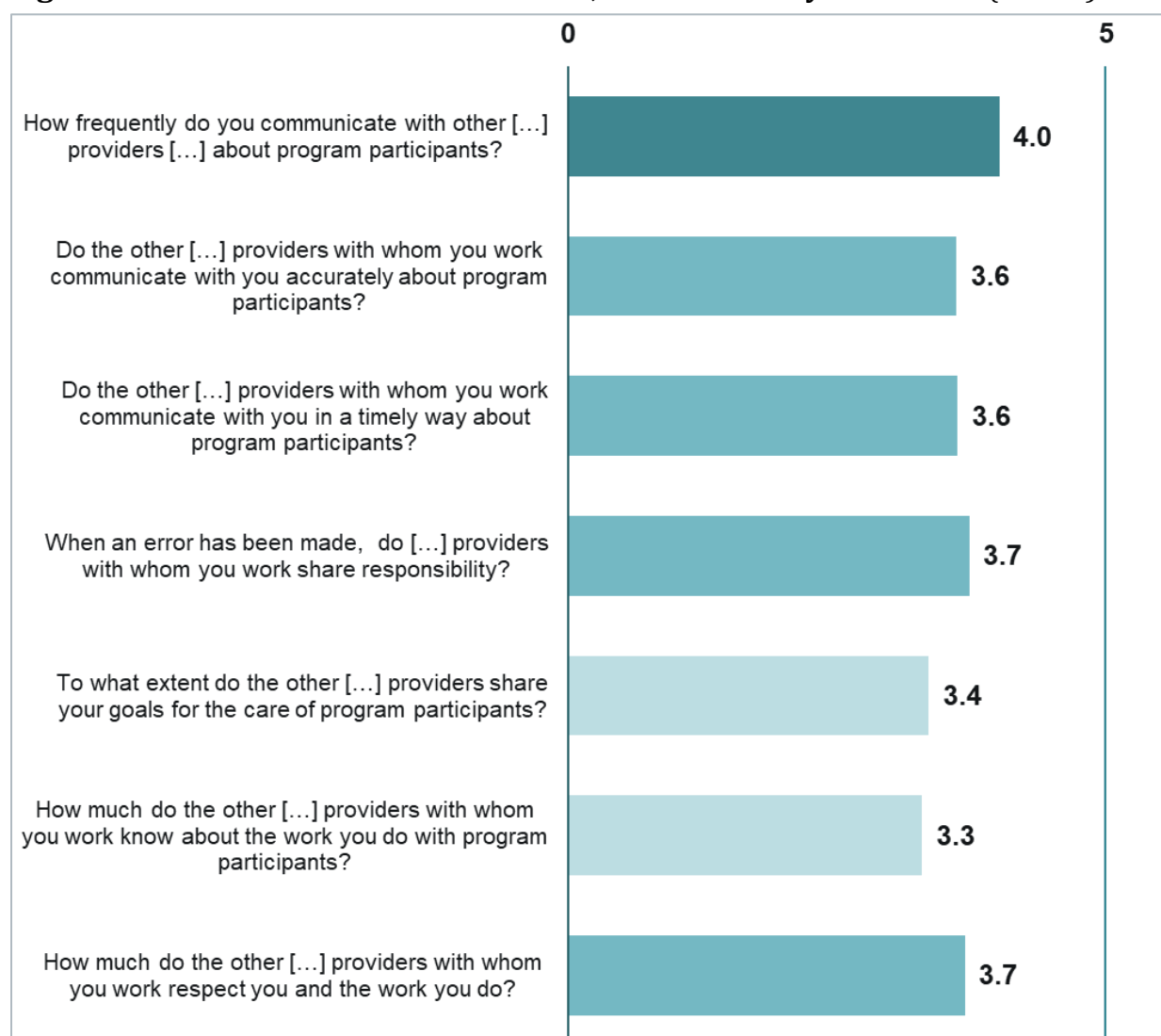


Integration into teams (Indicator #5)

Common Indicator #5 includes three sub-measures of integration into teams. First, respondents are asked to respond to the Relational Coordination Scale (1), with some modifications. Each question in the Relational Coordination Scale (RCS) provides five response options that are coded 1 to 5. The one item that is worded negatively was reversed so that more positive or desirable answers are associated

with higher scores. Figure 9 shows averages for the overall sample. The highest average score for this scale concerned the frequency with which respondents communicate with other providers about program participants. The lowest score was for the item that measured other providers' knowledge about CHWs' work with program participants.

Figure 9. Relational Coordination Scale; mean score by statement (*n*=101)



The second sub-measure within Indicator #5 is a novel scale designed to measure the impact of discrimination based on race/ethnicity or culture on integration into teams. It uses a four-level Likert scale from “Strongly Disagree” (4) to “Strongly Agree” (1). Figure 10 shows results for all respondents and indicates relatively low levels of discrimination based on race/ethnicity or culture for the sample as a

whole. Figure 11 shows results stratified by race/ethnicity (White and BIPOC respondents). As expected, and as seen in previous studies, BIPOC respondents were more likely to report racism and other forms of discrimination than White respondents. The difference was most marked for having to be the voice of their race/ethnicity or culture.

Figure 10: Influence of Racism and Other Forms of Discrimination on CHW Integration Scale; mean score by statement (*n*=101)

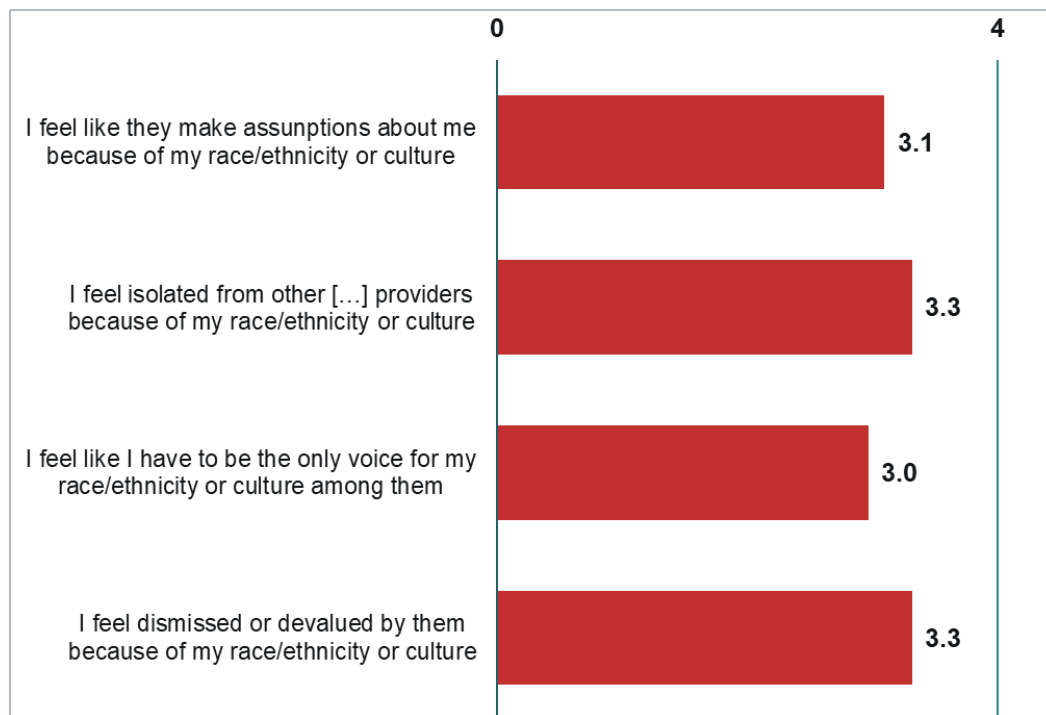
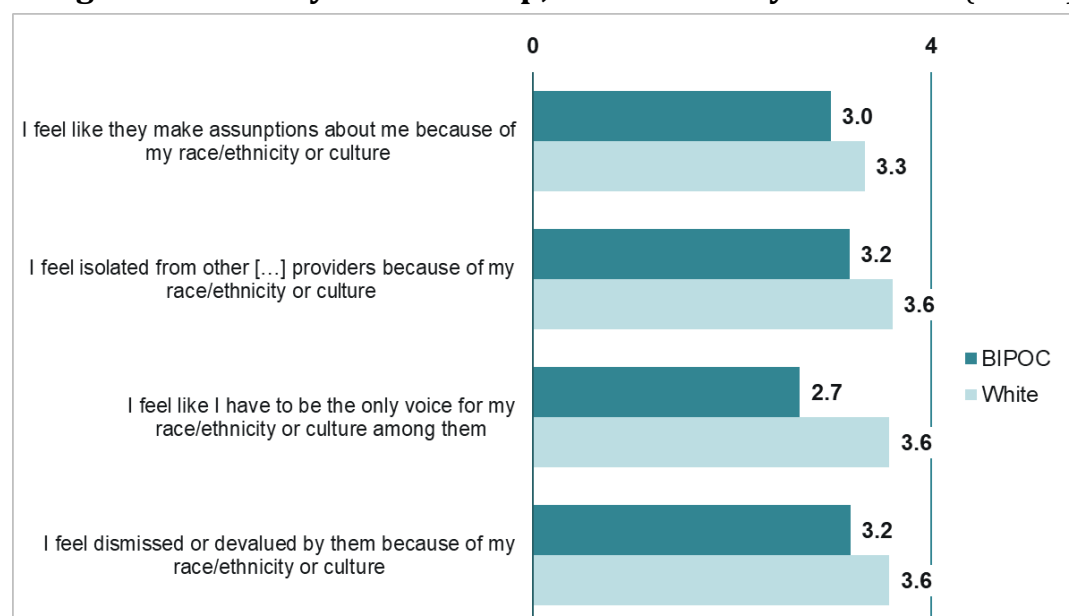


Figure 11: Influence of Racism and Other Forms of Discrimination on CHW Integration Scale by Racial Group; mean score by statement ($n=101$)



Two questions that are not part of a scale ask respondents to rate on a 4-point Likert scale from Strongly Disagree to Strongly Agree how well other providers understand their role as a CHW and how comfortable they feel talking with other providers about participants' needs. On these questions, 75.3% answered "Agree" or "Strongly Agree" that other providers understand their role as a CHW, while 91.1% answered "Agree" or "Strongly Agree" that they feel comfortable talking with other providers about participants' needs.

Finally, Indicator #5 inquiries about concrete workplace conditions that can promote or inhibit integration, specifically, CHWs' access to chart in the employers' main participant tracking system (e.g., electronic medical record), and whether or not they are provided with adequate physical space to conduct their work. Eighty-six point one (86.1) percent of respondents indicated that they have access to adequate, dedicated workspace and 71.3% have access to the main data system for participant tracking.

Supportive and reflective supervision (Indicator #12)

The CHW version of Indicator #12 has four parts: 1) type of supervision provided (administrative, clinical or both); 2) supervision quantity; 3) supervision quality,

and 4) supervisor characteristics. All four parts of the Indicator were used in this survey.

Among this group of respondents, 57.4% have separate clinical and administrative supervision. A total of 67.3% feel the quality of their *individual* supervision is Good or Excellent; the average amount of individual supervision is 4.1 hours/month, with a median of 2 and a range 0 to 25. A total of 62.4% feel the quality of their *group* supervision is Good or Excellent; the average amount of group supervision is 2.9 hours/month, with a median of 1 and a range 0 to 32. In answer to a question about whether CHWs participate on hiring panels for supervisors at their organization, 56.5% of CHWs indicated that they do.

For Part 4 of the indicator, CHWs were asked to respond to seven items characterizing supervision by their “primary supervisor during the past thirty days,” with answers on a 4-point Likert scale from “Strongly Disagree” (1) to “Strongly Agree” (4). The average overall score was 3.37. Figure 12 shows the average response by question. Average question-specific scores exceeded 3.0 for all questions except for questions asking if the supervisor has participated in training about the CHW profession (2.9).

Figure 12. Supervisor Characteristics; mean score by statement (n=101)



Employer Responses

Wages, benefits, and opportunities for advancement (Indicator #1)

The employer version of Common Indicator #1 was used to gather information about CHW wages, benefits, and opportunities for advancement.

Wages

Responding employers reported 173 paid CHWs, with an average of 5.1 CHWs per organization and a median of 2 and a range of 1 to 28. Of those, 85.3% reported that CHWs were eligible for promotions and step-ups.

The average hourly rate reported by employers was \$27.02/hour and the median was \$26.50/hour. For part-time CHWs, the average hourly wage was \$19.89. This figure is substantially higher than the average wage of \$22.33/hour reported by CHWs in the national CHW survey conducted as part of the CDC program, CHWs for COVID Response and Resilient Communities (Wiggins et al., in press). It is also higher than the figure of \$25.40/hour reported by the U.S. Bureau of Labor Statistics in 2024, which is based on data provided by employers.

Benefits

Respondents were asked to report on the benefits they provide to CHWs. Figure 13 shows the percentage of respondents who provide a given benefit to full-time CHWs. Benefits most commonly provided by respondents include vacation, family leave, sick leave, and dental insurance, all at 94%. Benefits that respondents are least likely to offer include internet service subsidy (3%) and bonuses (9% of respondents). Sick leave and vacation top the list of benefits offered to part-time CHWs (Figure 14); transportation or mileage reimbursement and family leave are also offered to more than 50% of part-time CHWs.

Figure 13. Benefits Offered to Full-Time CHWs (*n*=34)

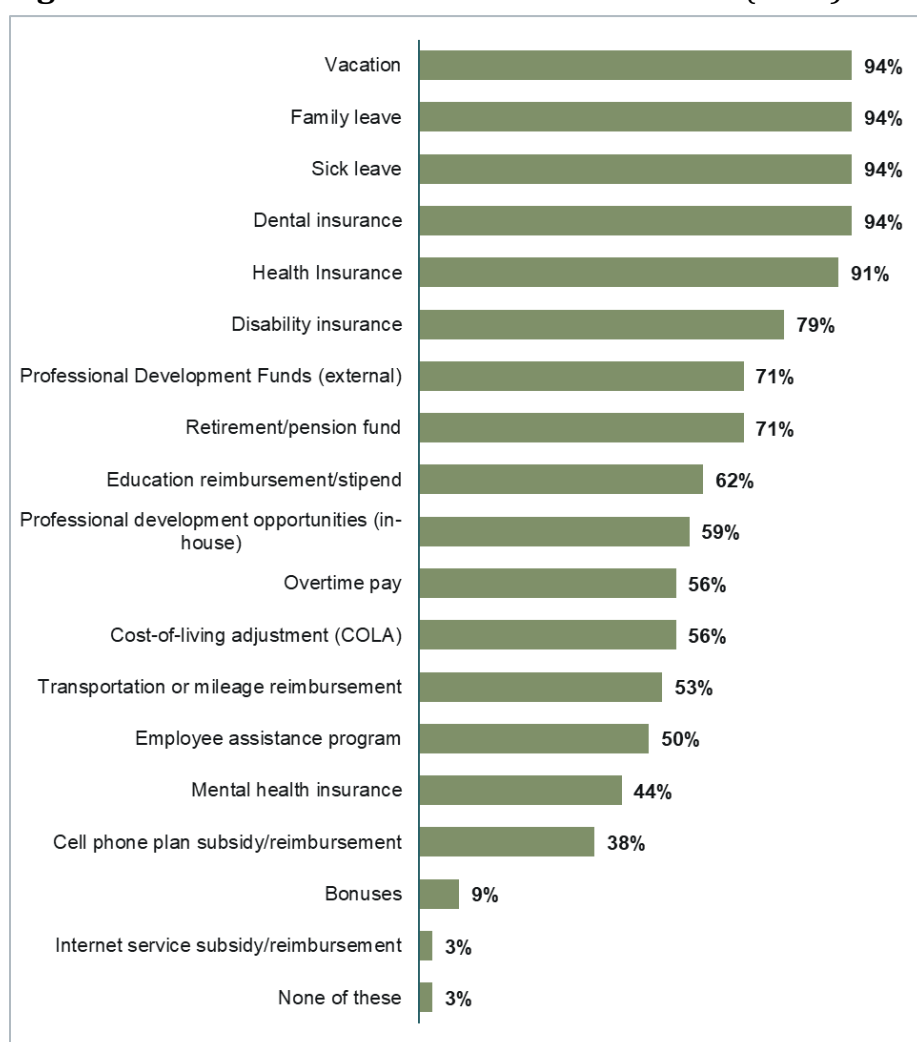
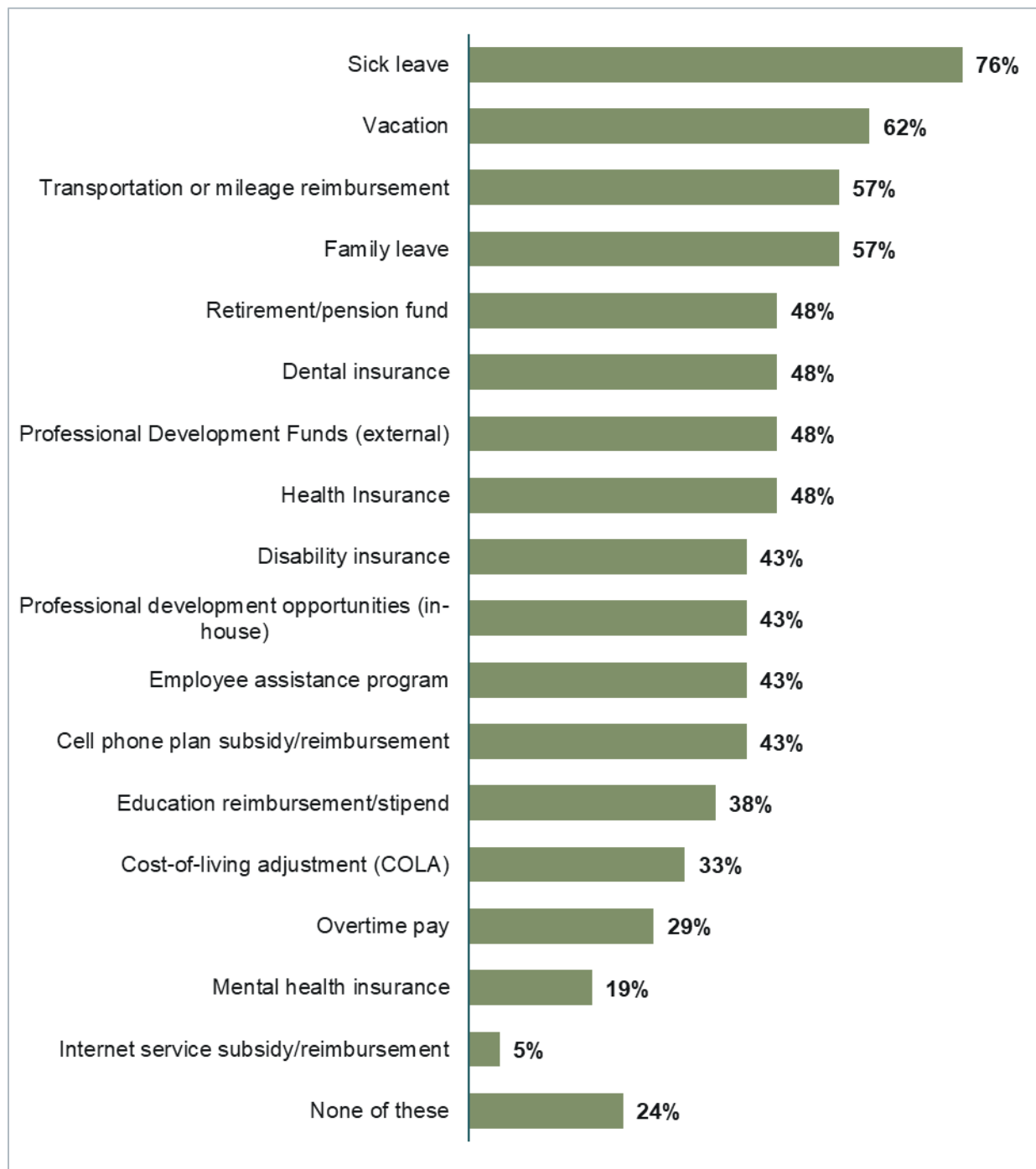


Figure 14. Benefits Offered to Part-Time CHWs (*n*=20)



Measurement Plan Question: What policies can the state enact to strengthen the workforce?

Policy and Systems Change (Indicator #10)

Common Indicator #10 measures policy and systems change; it includes versions for CHW programs and state health departments. The program version was included in the Employer survey. All 34 respondents completed the questions for Indicator #10.

Defining the CHW Role

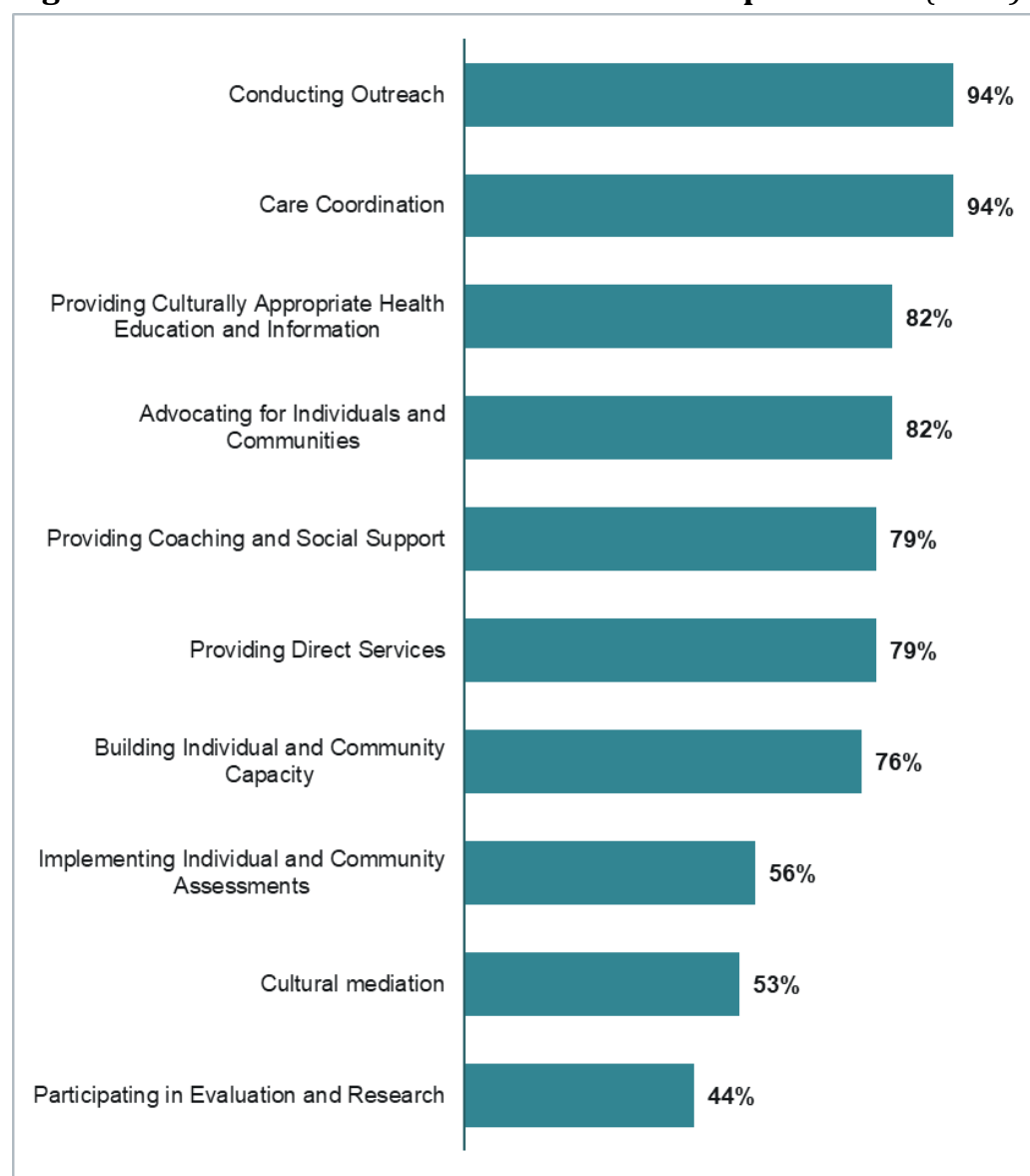
Common Indicator #10 begins by asking CHW employers how they define the CHW role within their organization. The first question asks them if their organization has a written definition of a CHW, and it specifically asks if they utilize the [American Public Health Association \(APHA\) definition](#). The responses to this question are summarized in Table 11. A strong majority of employers (70.6%) reported using the APHA definition or a similar definition that had been based upon the APHA definition. When asked why their organizations were not using the APHA definition in an open-ended follow-up question, two respondents provided organizational definitions. Three respondents said they were unsure, two said the question was not applicable, and one said they did not understand the question. One respondent mentioned that union constraints limit their ability to use the APHA definition.

Table 11. Organization Definition of a CHW (n=34)

Response	Number	Percent
Verbatim or similar to American Public Health Association (APHA) definition	24	70.59%
Other definition (not based on APHA definition)	7	20.59%
No definition at all	3	8.82%

In the next set of questions, CHW employers were asked which of the 10 core roles of CHWs (5) were included in the scope of work or job description for CHWs at their organization. Figure 15 summarizes the responses to this question. The roles most commonly included in the scope or work were “Conducting Outreach” and “Care Coordination,” both mentioned by 94% of respondents. Note that whereas the CHW version of this question was modified to add additional activities, this one was not.

Figure 15. Core Roles Included in the CHW Scope of Work (*n*=34)



When employers were asked an open-ended follow-up question about why they did not include all 10 roles, they reported that roles were excluded because they were outside of the scope or capacity of their program, they were covered by other positions in the organization, or they were simply not needed. The largest number of respondents (7) said that roles are excluded because their programs are either new or in the midst of rapid expansion. Other reasons for not including all the core roles included: capacity issues or lack of time (6); reserving specific tasks (like assessments) for licensed providers (5); not providing “direct service” (3); and having constraints based on the funding source (3).

Support for obtaining a CHW Certificate

Minnesota's CHW Certificate is a standardized 16-credit academic certificate offered through accredited institutions; while not required for employment, it *is* required for Medicaid reimbursement in Minnesota and is anchored in a statewide, competency-based curriculum that includes five core courses and an internship, with the same credential granted regardless of where it is completed. In the CHW and employer surveys, we specifically asked about the *Minnesota CHW Certificate* rather than using the standard terminology from the CHW-CRE Common Indicators, reflecting Minnesota's unique reliance on an academic certificate rather than a standalone certification model.

Respondents were asked to provide information about their organization's policies and practices around CHWs obtaining a Certificate. The first question asked employers if they require that CHWs they hire have or get a CHW Certificate; 73.5% reported that they do.

Next, they were asked what affects the organization's ability to require that the CHWs they hire have completed the CHW Certificate either before or after they are hired. The most common response to the question about factors affecting the organization's ability to require the CHW Certificate was financial barriers, including high cost of the program and low salary or wages for the role. Time and family responsibilities were also mentioned as constraints. Some organizations use scholarships to help CHWs obtain a Certificate after hire, while others are pursuing reimbursement or billing, presumably to make the Certificate more viable. Two respondents said their organizations do prefer that CHWs have the Certificate but can't require it due to barriers to entry.

A follow-up question asked whether the organization supports CHWs in completing the CHW Certificate and whether CHWs were able to use office space/supplies to complete class work. Table 12 summarizes responses.

Table 12. Support Provided to CHWs to Complete CHW Certificate (*n*=34)

Supports	Number	Percent
Allow CHWs to use office space/supplies to complete class work	22	64.7%
Act as the CHW's Field Placement Site for their Certificate	22	64.7%
Secure funding to pay for the entire program cost	19	55.9%

Allow paid time to complete classwork	19	55.9%
Secure funding to pay for part of the program cost	4	11.8%
We only hire Certificate-holding CHWs	4	11.8%
Reduce FTE for CHWs completing the program	2	5.9%
Other	2	5.9%
None of the above	1	2.9%

Employers were also asked if they keep track of the number and percentage of CHWs employed by their organization who have completed a CHW certificate. A total of 70.6% track this information. Respondents were asked to indicate the number of CHWs currently employed by their organization who have completed the CHW certificate. They reported 150 trained CHWs with a Certificate (86.7% of the total.)

Finally, employers were asked whether they require that CHW supervisors participate in training about the CHW model/profession and/or training specific to supervision of CHWs. They were asked what affects their ability to adopt such as requirement. The most common responses were that programs and/or positions are too new to have experienced a need for supervisor training (5); lack of capacity and time constraints (5); and feeling that requirements aren't needed because supervisors already have experience and/or knowledge (4). Two respondents mentioned they either keep up to date or choose to do the training on their own.

Sustainable Funding for CHW Programs

Employers were asked about sustainable sources of funding for their CHW program or programs. More than half (55.9%) reported that they have no sustainable sources of funding. Slightly over 20% get Medicaid reimbursement using CHW education codes. Smaller percentages (14.7%) have sustainable public funding, other health plan reimbursement, or some other form of sustainable funding (Table 13).

Table 13. Sources of Sustainable Funding for CHW Programs (*n*=34)

Funding Type	Number	Percent
None of the above	19	55.9%
Medicaid Reimbursement/CHW Education Codes	7	20.6%
Sustainable public funding sources	5	14.7%
Other health plan reimbursement	5	14.7%
Other	5	14.7%

FQHC prospective payment systems	3	8.8%
Healthcare reform related Alternative Payment Structures	2	5.9%
Pathways Community Hub Institute or Community Care Hub reimbursement models	1	2.9%
Blended/braided funding	1	2.9%
Internal financing by providers in anticipation of ROI	1	2.9%

Respondents were asked what their organization has done in the last year to increase the percentage of CHW salaries covered by sustainable payment mechanisms. The largest number of respondents (8) expressed continuing heavy reliance on state, local and CDC grants. On the other hand, seven respondents described their active efforts to set up billing systems for Medicare, Medicaid, and waivers; several are consulting with “CHW Solutions.”

Five respondents bemoaned administrative or system barriers to filing for reimbursement. In the words of one respondent:

We have worked tirelessly with payers to find ways to file claims--our systems only file dental Medicaid claims and payers require Medical claim forms. we have invested hundreds of staff hours to sort this out--with no success.

Another respondent said, “[We] tried billing but [it was] not effective,” while a third said, “[The] barrier is not having funding to set up [a] relationship and billing with organizations such as CHW Solutions to provide Medical Director oversight and billing.”

On a hopeful note, one respondent stated that their organization had decided to support CHW salaries through their organizational budget because of the value that CHWs add to their organization:

We operate in a total cost of care model. If we were to bill for CHWs, it would increase our expenses. We fully cover the cost of our CHW employees like all other employees because they are valuable members of our team. They contribute heavily to our shared savings in our health plan contracts.

Other comments

A final question gave respondents the option to share any additional comments. Respondents took this opportunity to express concerns that CHW pay does not meet the cost of living and that CHW supervisors are underpaid compared to those who supervise Registered Nurses (RNs) or Social Workers. They requested higher reimbursement rates and easier billing; to be able to bill for barrier reduction and not just education; for strategies to prove the added value of CHWs to skeptical leadership; for a workgroup to brainstorm how to best track CHW program outcomes; and for help working with Human Resources to create a tiered job classification system for CHWs.

One respondent spoke movingly about the mismatch that exists between, on the one hand, the skills CHWs have and the training infrastructure that exists and, on the other hand, between the services that can be reimbursed and the activities and services that are actually needed.

The system needs to re-open providing a certificate by credential option--requiring the 17-credit course in higher ed is not affordable and the curriculum does not align well with the actual work. Many people in our community are beyond capable and have been doing this work for years--they should be measured on their credentials rather than required to pay for, and spend a year, [doing] entry-level course work. The scope of services eligible for reimbursement should be expanded to incorporate the help patients actually need to reduce barriers to care--not limited to health education. Billing needs to be more accessible to non-medical providers.

Finally, one respondent expressed her gratitude to the MNCHWA Director of Programs, writing “Great job, Rachel!”

Key Findings

Taking into account the limitations of a relatively small sample size and the fact that this was not a random sample of all the CHWs or CHW employers in Minnesota, below is a summary of our findings. Findings are organized according to three of the four guiding questions in the [Minnesota Community Health Worker Statewide Measurement Plan](#). When comparing responses from CHWs and employers, it is important to keep in mind that CHWs and employers did not represent the same organizations; therefore, their answers are not expected to be consistent.

What did it take to achieve these efforts?

Community Health Worker Workforce

- One hundred and one (101) CHWs responded to the CHW survey.
- Slightly less than half of respondents (42.6%) have a Minnesota CHW Certificate.
- Fifty (50) percent of respondents lived within the Twin Cities metropolitan area, while 50% lived outside that area.
- The largest number of respondents (34.7%) were in the 41-50 category.
- Almost 90 percent of respondents (87.13%) identified as female.
- Approximately one-third of the respondents identified as White (32.7%). The next largest percentages identified as Hispanic, Latino, or Latin origin (22.8%) and Black, African, or African American (21.8%).
- The most commonly mentioned language of proficiency (named by 86.1% of respondents) was English, followed by Spanish (24.8%), Somali (6.0%) and ASL (4.0%). There were an additional ten languages mentioned with 1-3 respondents each.
- A total of 30.7% respondents identified with a specific community (e.g., ethnic, refugee, disability, rural, LGBTQIA).
- In terms of organization type, 39.6% of CHW respondents reported working for a community-based organization, and 18.8% of respondents reported working for a local public health agency.

Vulnerable Populations Served by CHWs

- CHW respondents most often mentioned “People with Disabilities” (mentioned by 68% of respondents) and “Uninsured/Uninsured Persons/Families” (66% of respondents) as vulnerable populations served at their employment setting.
- The most common vulnerable populations mentioned by employers were Uninsured/Underinsured persons/families (mentioned by 76% of respondents) and Children or Adolescents (76% of respondents).

Community Health Worker Employers

- Thirty-four (34) employers responded to the Employer survey and reported employing a total of 173 paid CHWs.

- The largest percentage of employer respondents (44.1%) reported working for a health system or community-based clinic. Equal percentages (20.6%) reported working for a community-based organization or local public health agency.

Are CHWs working under the conditions required for their work to be effective?

Wages, Benefits and Opportunities for Advancement

- Among CHW respondents:
 - The median reported hourly rate was \$26.00/hour, while the median starting hourly rate was \$22.18. According to the [MIT Living Wage Calculator](#), the living wage for one adult and one child in 2026 in Minnesota is \$44.13/hour.
 - Benefits most commonly received include vacation (89% of respondents), sick leave (85% of respondents), and transportation or mileage reimbursement (81% of respondents).
 - 61.4% reported being eligible for promotion or “step-up.”
- Among employer respondents:
 - The average hourly reported wage was \$27.02/hour for full-time CHWs.
 - Benefits most commonly provided include vacation, family leave, sick leave, and dental insurance, all at 94%.
 - Eighty-five point three (86.3) percent of employers reported CHWs being eligible for step ups or promotions.
-

CHW Primary Job Responsibilities

- Sixty-four (64) percent of respondents indicate they address SDOH.
- Other commonly mentioned job responsibilities include Advocacy (64%), Outreach (62%), and Education (60%).
- Least frequently mentioned responsibilities include Assessment (33%), Research and Evaluation (33%), and Cultural Mediation (32%) and Transportation (26%).

CHW Involvement in Decision- and Policy-Making

- Respondents were least likely to report being members of groups that influence policy in their own organizations (average score = 2.5).

- They were most likely to report having identified the people and organizations that influence change in their communities (average score = 3.4).

CHW Integration into Teams

- On the **Relational Coordination Scale** (1), the highest average score concerned the frequency with which respondents communicate with other providers about program participants. The lowest score was for the item that measured other providers' knowledge about CHWs' work with program participants.
- On the **Influence of Racism and Other Forms of Discrimination on CHW Integration Scale**, all average scores were above 3, indicating relatively low levels of discrimination experienced by CHWs based on race/ethnicity or culture.
- Approximately three-quarters of respondents (75.3%) Agree or Strongly Agree that other providers understand their role as a CHW, while 91.1% Agree or Strongly Agree that they feel comfortable talking with other providers about participants' needs.
- Eighty-six point one (86.1) percent of respondents indicated that they have access to adequate, dedicated workspace and 71.3% have access to the main data system for participant tracking.

Supportive and Reflective Supervision

- More than 60% of respondents rate the quality of their individual and group supervision as Good or Excellent.
- A majority of respondents (56.5%) report that CHWs participate on hiring panels for supervisors at their organizations.
- The average overall score for the Supervisor Characteristics scale was 3.37 out of 4, indicating a high level of satisfaction with supervisor characteristics.

What policies can the state enact to strengthen the workforce?

Program level policies

- A majority of employers (70.59%) reported using the APHA definition or a similar definition that had been based upon the APHA definition.

- CHW core roles most commonly included in the scope or work were “Conducting Outreach” and “Care Coordination,” both mentioned by 94% of respondents.
- The largest number of respondents said that roles are excluded because their programs are either new or in the midst of rapid expansion. Other reasons for not including all the core roles included: capacity issues or lack of time; reserving specific tasks (like assessments) for licensed providers; not providing “direct service”; and having constraints based on the funding source.
- 73.5% of employers reported that they require that CHWs have or get a CHW Certificate. Financial barriers, lack of time, and family responsibilities were mentioned as constraints on their ability to enact this requirement.
- Employer respondents indicate that 86.7% of current CHW employees have a Certificate. (This is substantially higher than the 42.6% of CHW respondents who reported having a CHW Certificate. This could be due to many things, including differences in the organizations represented by CHWs and employers.)
- More than half of respondents (55.9%) reported that they have no sustainable sources of funding. Slightly over 20% get Medicaid reimbursement using CHW education codes. Smaller percentages (14.7%) have sustainable public funding, other health plan reimbursement, or some other form of sustainable funding.

Comparison to other jurisdictions

Wages, Benefits and Opportunities for Advancement

- At \$28.78/hour, the average wage reported by CHWs in Minnesota was higher than the average hourly wage of \$22.90 reported in 2023 by CHWs in New Hampshire (8), the average hourly wage of \$26.70 reported in 2024 by CHWs in Oregon (6), and the average hourly wage of \$22.33 reported in a federal sample from 2024 (11).
- At \$27.02/hour for full-time CHWs, the average wage reported by employers in Minnesota was higher than the average hourly wage of \$25.40 reported by the US Bureau of Labor Statistics, which is based on data provided by employers (11).
- The availability of benefits for CHWs in Minnesota was somewhat lower than what has been reported in previous surveys using the Common Indicators. Whereas high percentages of CHWs responding to the New Hampshire (8) survey reported having access to vacation (97%) and dental insurance (88%), the corresponding percentages for Minnesota CHWs were 89% and 75% respectively. For the federal sample (11), the percentages were 77% and 69%, respectively.

- Sixty-one point four (61.4) percent of Minnesota CHWs reported being eligible for promotions or “step-up.” Corresponding percentages for the federal sample (11), New Hampshire (8), and Oregon (6) were 42%, 69%, and 47%, respectively.

CHW Involvement in Decision- and Policymaking

- Results for “CHW Involvement” follow a pattern established by results from Oregon, Illinois, and the federal sample (6,8,11). In all four cases the highest scores were for CHWs having identified people and organizations that influence change in their communities, while the lowest average scores were for CHWs influencing policy in their own organizations.

Influence of Racism and Other Forms of Discrimination on Integration

- On the Influence of Racism and Other Forms of Discrimination on CHW Integration Scale, the average scores indicated that the CHW respondents experienced low levels of discrimination based on race/ethnicity within their workplace teams. To compare items means in this survey to item means in previous surveys, it is necessary to reverse values so that they are comparable. (The directionality of the scale was changed since its last use.) Doing that conversion, we see that item means for this scale in this study (which ranged from 1.68 to 2.03 for all respondents) were higher than means for New Hampshire (1.44 to 1.59) and Illinois (1.4 to 1.7), lower than those for Oregon (1.90 to 2.09), and had a larger range than the federal sample (1.71 to 1.90).

Supervisor Attitudes

- Scores for “Supervisor Attitudes” were generally positive in this survey (range = 2.9 to 3.5) and similar to those reported in New Hampshire (range = 3.0 to 3.6), Oregon (range = 3.0 to 3.4) and Illinois (range = 3.0 to 3.2). The range was larger and dipped lower than the federal sample (range = 3.33 to 3.45) (8,6,11).

Recommendations

Recommendations for Employers

1. Establish clear CHW career pathways

Survey findings suggest that CHWs experience few opportunities to advance in their careers, with employers often creating job descriptions that limit CHW professional growth opportunities. Nearly 25% of CHW respondents noted there is currently “nowhere to go” for them relative to their positions. Employers should move away

from terminal job descriptions and consider creating tiered classifications (e.g., CHW I, CHW II, CHW III, CHW Supervisor) with clear competencies and growth tracks for each level. Hiring and promotion should also value years of service and community expertise instead focusing solely on formal education. This would allow for merit-based raises and opportunities for professional growth and promotion without requiring CHWs to leave the profession or get a higher degree.

2. Ensure thriving wages for CHWs & CHW supervisors

The current average wage (\$28.78/hour) for CHWs is nearly \$15/hour below the MIT Living Wage for a parent and child in Minnesota (\$44.13/hour). Respondent data also suggest that organizational structures can "drag down" supervisor pay because it is tied to the lower pay scale of the CHW team -- which is also lower than other professionals across the organization. Employers should enact living-wage floors for CHW positions, especially those funded through state grants or Medicaid reimbursement, which are more amenable to state control. Compensation for CHW supervisors should be aligned with other clinical management roles (like RN or Social Work supervisors) based on management responsibilities and years of experience, rather than the base rate of the supervisees. This will ensure that experienced supervisors and CHWs who promote into leadership are fairly compensated while reducing the "supervisor gap" identified in the data.

3. Utilize collaborative data collection methods and systems

Instead of perpetuating (or "continuing with") fragmented, siloed data collection efforts, Minnesota has an opportunity to establish standardized data collection using encounter-based tracking. Collecting consistent measures developed with and by CHWs at regular intervals facilitates aggregation of data for meaningful, contextualized insights. These insights are essential for demonstrating the value of CHW roles, telling a complete story of workforce achievements, and advocating at the organizational and state level for additional investments in the workforce.

Recommendation for CHW Employers, Policymakers, and CHW Organizations

4. Create a statewide CHW supervisor training program

Supervision of CHWs requires a unique blend of strategic oversight, performance management and community understanding. In the CHW survey, "other providers'

knowledge" of CHW work was the lowest-scoring item on the Relational Coordination Scale. Reflective supervision by supervisors who understand the core CHW roles and integrate those roles across their programs will lead to better staff retention, job performance and more successful program outcomes. Minnesota should adopt and scale training opportunities for supervisors that focus on the CHW-CRE Reflective Supervision Indicator and the CHW Core Roles established by the [National C3 Council](#) to better support CHW staff. Additionally, CHWs should be given opportunities to develop their supervisory skills while in their current positions and promotion should be structured in ways that encourage CHWs to become CHW supervisors themselves.

5. Create billing technical assistance (TA) workgroups

Employers responding to the survey reported significant technical hurdles, such as software not communicating with billing portals or systems that cannot process non-medical claims. Minnesota should launch a statewide TA workgroup or community of practice specifically for non-medical CHW employers (e.g., dental clinics, community-based organizations) to identify barriers to billing for CHW services and engage proactively with the State Medicaid Office to navigate and address these challenges. This workgroup could reduce the administrative burden that currently prevents many organizations from successfully seeking reimbursement and help establish funding mechanisms to sustain these roles. The workgroup should create awareness of and utilize existing mechanisms available for Medicaid billing and resources such as the CHW Billing Toolkit and the Technical Assistance and Billing Peer Learning Groups. Research suggests that CHWs are most effective when a close relationship with the community is maintained; this is often easier when CHWs work in community-based organizations (6). By establishing opportunities for organizations that may not be accustomed to billing third-party payers to successfully receive reimbursement, community connection and alignment can be preserved and protected.

6. Invest in the creation of a statewide CHW data dashboard and reporting system

A centralized, statewide CHW data dashboard and reporting system could transform fragmented efforts into a unified, evidence-based narrative that demonstrates the vital impact of Community Health Workers across Minnesota. By aggregating real-time data on workforce demographics, geographic distribution, and key health

outcomes (such as reductions in emergency department visits and successful navigation of social determinants of health) this platform would provide key information to demonstrate CHW effectiveness and advocate for sustainable funding. A dashboard could also be designed with a culturally grounded lens and integrate community-specific insights, to ensure the system remains responsive to the unique trust-based relationships CHWs maintain while guiding strategic resource investments to the regions with the greatest health needs.

Recommendations For MNCHWA

7. Work with policymakers to launch a CHW statewide council

CHWs in Minnesota have already made significant gains for the profession through MNCHWA's leadership, intentional organizing and advocacy. By establishing a statewide council to communicate directly with leaders and policymakers and advocate for workforce improvements and investments at the state level, this workforce could see structural improvements that will build the infrastructure for lasting workforce success.

Priority issues for this council could include:

- **Revise existing certificate program** to include a "Certificate by Credential" pathway to honor the expertise of the existing workforce that may face financial or time barriers to traditional 16-credit college programs.
- **Explore CHW certification**, which could facilitate the integration of CHWs into more complex billing models and protects the scope of practice against "role creep" by other disciplines.

In addition to topics included in the Recommendation, the Council should consider the following questions:

- What percentage of CHW positions are embedded within organizations' permanent operating budgets?
- Do current data collection systems support encounter based data collection? If not, what would it take in terms of organizational capacity and willingness to adapt these systems?

8. Conduct regular, comprehensive workforce assessments

Regular assessments provide the necessary evidence base to identify emerging workforce needs and measure the direct impact of policy shifts. Minnesota can establish a unified, statewide data infrastructure through robust and regular CHW data collection efforts. By

systematically monitoring key performance indicators such as retention rates, the effectiveness of new career ladders, and the health and wellbeing of the workforce, this comprehensive system could enable the profession to increase strength and sustainability.

Conclusion

Minnesota already serves as a national leader in formalizing and building awareness of the CHW role. Key benchmarks have included the establishment of the CHW Certificate in 2005 and the passage of legislation in 2007 allowing CHWs to bill for services under Minnesota Medicaid Programs, and expansion of coverage of services to align with the MN CHW Scope of practice in 2024. In 2025 MNCHWA and MDH launched a process to create a Sustainability Roadmap, Logic Model and Measurement Plan. They have implemented those plans via four workgroups that comprise multiple stakeholders including funders, employers, state agency staff and CHWs. These workgroups will strive to ensure that policy decisions continue to be grounded and accountable to the daily reality of CHWs across the state.

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Appendices

Supplemental Tables

Supplemental Table 1. Respondent Characteristics of Employment (n=101)

Characteristics	Number	Percent
I currently work as a CHW in Minnesota, my title includes "Community Health Worker"	62	61.4%
I have a Minnesota CHW Certificate	43	42.6%
I have an NPI number as a CHW	21	20.8%
I work in a related field (e.g. public health or healthcare) but not in a CHW role	16	15.8%
I am currently enrolled in CHW Certificate classes	16	15.8%
I currently work as a CHW in Minnesota, my title does not include "Community Health Worker"	9	8.9%
I am not currently employed as a CHW, but I am looking for a CHW job	9	8.9%
I supervise other CHWs	8	7.9%
I manage a CHW program	6	5.9%
I have a UMPI number as a CHW	5	5.0%
I currently work as a CHW outside of Minnesota	3	3.0%
I am a Community Health Representative (CHR)	1	1.0%

Survey Instrument: CHW Employer Survey

Survey Instrument: CHW Survey

Minnesota Statewide CHW Employer Survey 2025

What is your organization's Zip Code?

What year did the CHW program at your organization start?

What is your role at your organization? (Check all that apply)

- ☐ CHW supervisor (I directly supervise CHWs)
- ☐ CHW program administrator
- ☐ CHW mentor
- ☐ Certificate holding CHW
- ☐ CHW without a CHW Certificate
- ☐ Organizational administrator in an organization with a CHW program
- ☐ Other

How many paid CHWs currently work at your organization?

How many volunteer CHWs currently work at your organization?

Please list each salary or hourly rate level for CHWs in your organization, how many CHWs are working at each level and the total FTE at each level:

Do you offer the following benefits to your FULL TIME CHWs? (check all that apply)

- ☐ Health Insurance
- ☐ Dental insurance
- ☐ Disability insurance
- ☐ Mental health insurance
- ☐ Family leave
- ☐ Sick leave
- ☐ Vacation
- ☐ Transportation or mileage reimbursement
- ☐ Cell phone plan subsidy/reimbursement
- ☐ Internet service subsidy/reimbursement
- ☐ Employee assistance program
- ☐ Retirement/pension fund
- ☐ Bonuses
- ☐ Hazard pay

- Overtime pay
- Education reimbursement/stipend
- Cost-of-living adjustment (COLA)
- Professional development funds (e.g., funds or paid time for participation in external professional associations and attending conferences and trainings)
- Professional development opportunities (in-house)
- None of these

Do you offer the following benefits to your PART TIME CHWs? (check all that apply)

- Health Insurance
- Dental insurance
- Disability insurance
- Mental health insurance
- Family leave
- Sick leave
- Vacation
- Transportation or mileage reimbursement
- Cell phone plan subsidy/reimbursement
- Internet service subsidy/reimbursement
- Employee assistance program
- Retirement/pension fund
- Bonuses
- Hazard pay
- Overtime pay
- Education reimbursement/stipend
- Cost-of-living adjustment (COLA)
- Professional development funds (e.g., funds or paid time for participation in external professional associations and attending conferences and trainings)
- Professional development opportunities (in-house)
- N/A, we do not employ part-time CHWs
- None of these

Are CHWs eligible for promotions/step-ups with pay increases at your place of employment?

- ☐ Yes
- ☐ No

Does your organization have a written definition of a CHW? (APHA definition: (<https://www.apha.org/apha-communities/member-sections/community-health-workers>))

- ☐ Verbatim or similar to American Public Health Association (APHA) definition. Similar = the APHA definition was the basis but some wording has been changed
- ☐ Other definition (not based on APHA definition)
- ☐ No definition at all

(If 'No definition at all' is selected above) Please briefly explain what affects your organization's ability to use the APHA or similar definition of a CHW. If your organization uses a different definition, please write the definition.

Does your organization include each of the following 10 core roles in its CHW scope of work and/or job description? (check all that apply)

- ☐ Cultural Mediation Among Individuals, Communities, and Health & Social Service Systems
- ☐ Care Coordination, Case Management, and System Navigation
- ☐ Advocating for Individuals and Communities
- ☐ Providing Direct Services
- ☐ Conducting Outreach
- ☐ Providing Culturally Appropriate Health Education and Information
- ☐ Providing Coaching and Social Support
- ☐ Building Individual and Community Capacity
- ☐ Implementing Individual and Community Assessments
- ☐ Participating in Evaluation and Research
- ☐ None of the above

Please briefly explain why any of these roles are not included, to the best of your knowledge.

Does your organization require that CHWs you hire have or get a CHW Certificate?

- ☐ No
- ☐ Yes, we only hire certificate holding CHWs
- ☐ Yes, we require CHWs who do not have the Certificate get the certificate after hire

If 'no' is selected above: Please briefly explain what affects your organization's ability to require that CHWs you hire have completed the CHW Certificate either before or after hire.

Does your organization provide or support your CHWs in completing the CHW Certificate program? (Check all that apply)

- ☐ N/A, we only hire Certificate holding CHWs
- ☐ Secure funding to pay for part of the program cost
- ☐ Secure funding to pay for the entire program cost
- ☐ Allow paid time to complete classwork
- ☐ Allow CHWs to use office space/supplies (e.g. work computer, desk, internet etc.) to complete class work
- ☐ Act as the CHW's Internship/Field Placement Site for their Certificate
- ☐ Reduce FTE for CHWs completing the program
- ☐ None of the above
- ☐ Other

Does your organization keep track of the number and percent (%) of CHWs employed by your organization who have completed CHW Certificate?

- ☐ Yes
- ☐ No

Does your organization require that CHW supervisors participate in training about the CHW model/profession and/or training specific to supervision of CHWs?

- ☐ Yes
- ☐ No

If 'no' is selected above: What affects your organization's ability to adopt such a requirement.

Which of these sustainable CHW Payment mechanisms does your organization currently use?

- Medicaid Reimbursement, CHW Education Codes (98961-98962)
- Medicaid Reimbursement, Community Health Integration codes (G0019, G0022, G0511)
- Medicaid Reimbursement, other billing codes encompassing CHWs (e.g. health care home, behavioral health home, asthma-based home visiting, etc.)
- Medicaid Reimbursement but unsure of exact codes
- Medicare Reimbursement
- Other health plan reimbursement (e.g. commercial plans, employer plans, etc.)
- MCO Contracts
- Pathways Community Hub Institute or Community Care Hub reimbursement models
- Healthcare reform related Alternative Payment Structures (e.g. value based care contracts, Accountable Care Organizations, Integrated Health Partnerships, etc.)
- Internal financing by providers in anticipation of ROI
- FQHC prospective payment systems
- Tax funding, Levies, or other sustainable public funding sources
- Other
- None of the above

What percentage of your organization's CHW program salary/benefit costs are supported through sustainable CHW payment mechanisms? (Percentage)

For more details, refer to the list above of sustainable CHW payment mechanisms based on a list compiled by the National Association of Community Health Workers (NACHW), and review NACHW's 2020 report on sustainable financing, available at <https://nachw.org/wp-content/uploads/2020/10/SustainableFinancingReportBriefJuly2020.pdf>

Please briefly explain what your organization has done in the past year to increase the percentage of CHW salary/benefit costs covered by sustainable funding, including progress made, successes, barriers and challenges. Here you can also identify sustainable funding mechanisms not included in the list above, which your organization uses to fund CHW salaries/benefits

What is your organization type?

- Community clinic or FQHC
- Community-based organization
- Educational institution
- Faith-based organization
- For-profit organization
- Hospital
- Health System (hospital and clinics)
- Clinic or clinic system (non-FQHC)
- Local public health agency
- Managed care organization
- Mental health provider
- Oral health provider
- Social services agency
- State agency
- Substance use organization
- Tribal Nation
- Other

Select Type(s) of Vulnerable Populations Served at your organization:

- Pregnant women and infants
- Children or Adolescents
- Chronic disease (diabetes, hypertension, cardiovascular health, asthma....)
- Individuals experiencing homelessness
- Individuals with mental illness
- Individuals with substance use disorders
- Migrant workers
- Older adults
- People with disabilities
- Refugees and Immigrants
- Tribal Population
- Uninsured/Underinsured persons/families
- Veterans
- Victims of interpersonal violence abuse or trauma
- Other

What support do you need to help create or maintain CHW positions within your organization?

Identify how CHWs will add value to our organization and to meet the needs of the population we serve.

- How to set up a new CHW position within our organization
- How to integrate a CHW as a part of a well-established team
- How to financially sustain (e.g., fund, bill) a CHW position.
- How to create the CHW role
- How to implement a supportive supervision and program management structure
- How to effectively recruit a CHW
- Best hiring practices for CHWs
- How to increase CHW retention
- How to create on-the-job training for CHWs (e.g., creating a CHW registered apprenticeship program)
- Strategies for CHW career development (e.g., CHW specialty training)
- How to track CHW program outcomes (e.g., measure, document)
- None of the above
- Other

Is there anything else you'd like to tell us? (If you marked 'other' in an above question, give details here)

Consent

By checking this box, I give permission to the Minnesota Community Health Worker Alliance to include my responses in a public report that includes all other responses and does not include any identifying information.

Minnesota Statewide CHW Survey 2025

Please check all that apply:

- ☐ I currently work as a CHW in Minnesota, my title includes "Community Health Worker"
- ☐ I currently work as a CHW in Minnesota, my title does not include "Community Health Worker"
- ☐ I am a Community Health Representative (CHR)
- ☐ I am a Promotora
- ☐ I currently work as a CHW outside of Minnesota
- ☐ I have a Minnesota CHW Certificate
- ☐ I am currently enrolled in CHW Certificate classes
- ☐ I have an NPI number as a CHW
- ☐ I have an UMPI number as a CHW
- ☐ I am not currently employed as a CHW, but I am looking for a CHW job
- ☐ I supervise other CHWs
- ☐ I manage a CHW program
- ☐ I work in a related field (e.g. public health or healthcare) but not in a CHW role

Address:

Zip Code

CHW Pay and Benefits:

What is your current hourly rate?

What was the starting hourly rate at your current job?

What is your current annual salary?

What was the starting salary at your current job?

Does your employer currently offer you the following benefits? (check all that apply)

- ☐ Dental insurance
- ☐ Disability insurance
- ☐ Mental health insurance

- Family leave
- Sick leave
- Vacation
- Transportation or mileage reimbursement
- Cell phone plan subsidy/reimbursement
- Internet service subsidy/reimbursement
- Employee assistance program
- Retirement/pension fund
- Bonuses
- Hazard pay
- Overtime pay
- Education reimbursement/stipend
- Cost-of-living adjustment (COLA)
- Professional development funds (e.g., funds or paid time for participation in external professional associations and attending conferences and trainings)
- Professional development opportunities (in-house)
- None of these

Are you eligible for promotions/step-ups with pay increases at your place of employment?

- Yes
- No

Please describe any changes you would like to see in the level of pay you receive and/or the number of hours you work as a CHW. If there are no changes you would like to see, you can respond with, “no changes.”

Please describe any changes you would like to see in the benefits you receive (or do not receive) as part of your employment as a CHW. If there are no changes you would like to see, you can respond with, “no changes.”

Please describe your own experience with the promotion/step-up pathway (or lack of one) at your current place of employment, and any changes you would like to see.

CHW Involvement in Decision and Policy Making

Thinking about your job as a CHW, please indicate how much you agree or disagree with the following statements: (Strongly disagree, Disagree, Agree, Strongly agree)

As part of my job, I have identified the people or organizations that influence change in my community.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

As part of my job, people who influence change in my community seek my opinion and participation

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

As a part of my job, I am a member of one or more groups/organizations that make (i.e., develop and/or enact) policy for my community, city, county, state, or tribe.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

My employer/supervisor supports my involvement in policy making on work time.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly

I am a member of one or more groups that influence policy in my employing organization.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

I believe that as a CHW, I have influenced policy in my organization or community.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Relational Coordination Scale

Thinking about other healthcare, social service, and/or education providers with whom you work, please respond to the following statements:

How frequently do you communicate with the other healthcare, social service, and/or education providers with whom you work about program participants?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Often
- ☐ Constantly

Do the other healthcare, social service, and/or education providers with whom you work communicate with you in a **TIMELY** way about program participants?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Often
- ☐ Constantly

Do the other healthcare, social service, and/or education providers with whom you work communicate with you **ACCURATELY** about program participants?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Often
- ☐ Constantly

When an error has been made about program participants, do the other healthcare, social service, and/or education providers with whom you work blame others rather than sharing responsibility?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Often
- ☐ Constantly

To what extent do the other healthcare, social service, and/or education providers with whom you work SHARE YOUR GOALS for the care of program participants?

- ☐ Not At All
- ☐ A Little
- ☐ Some
- ☐ A Lot
- ☐ Completely

How much do the other healthcare, social service, and/or education providers with whom you work KNOW ABOUT the work you do with program participants?

- ☐ Not At All
- ☐ A Little
- ☐ Some
- ☐ A Lot
- ☐ Completely

How much do the other healthcare, social service, and/or education providers with whom you work RESPECT you and the work you do with program participants?

- ☐ Not At All
- ☐ A Little
- ☐ Some
- ☐ A Lot
- ☐ Completely

Influence of Discrimination on CHW Integration Scale

Thinking about other healthcare, social service, and/or education providers with whom you work, please respond to the following statements: (Strongly disagree, Disagree, Agree, Strongly agree)

I feel isolated from the other healthcare, social service, and/or education providers with whom I work because of my race/ethnicity or culture.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

I feel like I have to be the only voice for my race/ethnicity or culture amongst the other healthcare, social service, and/or education providers with whom I work.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

I feel dismissed or devalued by the other healthcare, social service, and/or education providers with whom I work because of my race/ethnicity or culture.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

I feel that the other healthcare, social service, and/or education providers with whom I work make assumptions about me because of my race/ethnicity or culture.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

Care Team Understanding of CHW Role:

The other healthcare, social service, and/or education providers with whom I work understand my roles and what I do as a CHW.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

I feel comfortable going to the other healthcare, social service, and/or education providers with whom I work to talk about participants' needs.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

Do you have access to record information about your participants in your employers' main participant tracking form/system?

- ☐ Yes
- ☐ No

Does your employer provide you with adequate, dedicated space where you can work (e.g., meet with participants, complete paperwork, make phone calls, access a computer, etc.)?

- ☐ Yes
- ☐ No

CHW Supervision:

Does your current position distinguish between administrative and clinical supervision?

- ☐ Yes
- ☐ No

How many hours of individual (one-on-one) supervision were provided to you in the last 30 days? (if your current position distinguishes between clinical and administrative, indicate how many hours for each type of supervision).

How many hours of group supervision (supervision conducted with more than 1 CHW) were provided to you in the last 30 days? (if your current position distinguishes between clinical and administrative, indicate how many hours for each type of supervision).

Please rate the overall quality of the individual supervision you received within the last 30 days (including administrative and/or clinical supervision). Select one:

- ☐ Awful
- ☐ Bad
- ☐ Fair
- ☐ Good
- ☐ Excellent

Please rate the overall quality of the group supervision you received in the last 30 days (including administrative and/or clinical supervision). Select one:

- ☐ Awful
- ☐ Bad
- ☐ Fair
- ☐ Good
- ☐ Excellent

My supervisor appreciates my role as a CHW

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

- Not Applicable

My supervisor advocates for the role of CHWs with upper management (staff who rank above the supervisor)

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Not Applicable

My supervisor has training in the CHW profession

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Not Applicable

My supervisor encourages my professional growth (e.g. by regularly encouraging me and/or accepting my suggestions within supervision sessions to pursue training opportunities, attend conferences, develop leadership skills, etc.)

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Not Applicable

My supervisor understands the strengths and needs of the community/communities we serve

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Not Applicable

My supervisor understands that improving health requires addressing racism and other forms of oppression

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Not Applicable

In my organization, CHWs participate on hiring panels when CHW supervisors are selected.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Not Applicable

General Information:

How old are you?

- ☐ 18-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ 61+

What is your gender?

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Agender
- ☐ Transgender
- ☐ My gender is not listed.
- ☐ Prefer not to answer.

What is your race?

- ☐ American Indian or Alaska Native
- ☐ East Asian (i.e. Chinese, Asian Indian, Korean, Japanese, etc.)
- ☐ South Asian (i.e. Indian, Nepalese, Afghan, Pakistani, Bangladesh, Bhutanese, Maldivian, Sri Lankan, etc.)
- ☐ Other Asian
- ☐ Black, African, or African American
- ☐ Hispanic, Latino, or Latino origin
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other race
- ☐ Prefer not to answer

Are you a member or do you have affiliation with any specific community (ex: ethnic, refugee, disability, rural, LGBTQIA)?

What language(s) are you proficient in?

How do you best describe your current CHW employer?

- ☐ Community clinic
- ☐ Community-based organization
- ☐ Educational institution
- ☐ Faith-based organization
- ☐ For-profit organization
- ☐ Hospital/health system
- ☐ Local public health agency
- ☐ Managed care organization
- ☐ Medical clinic
- ☐ Mental health provider
- ☐ Oral health provider
- ☐ Social services agency
- ☐ State agency
- ☐ Substance use organization
- ☐ Other

Select Type(s) of Vulnerable Populations Served at Employment Setting:

- ☐ Pregnant women and infants
- ☐ Children or Adolescents
- ☐ Chronic disease (diabetes, hypertension, cardiovascular health, asthma....)
- ☐ Individuals experiencing homelessness
- ☐ Individuals with mental illness
- ☐ Individuals with substance use disorders
- ☐ Migrant workers
- ☐ Older adults
- ☐ People with disabilities
- ☐ Refugees and Immigrants
- ☐ Tribal Population
- ☐ Uninsured/Underinsured persons/families
- ☐ Veterans
- ☐ Victims of interpersonal violence abuse or trauma
- ☐ Other

What are the primary job responsibilities of CHWs in your organization? For more info see: Roles & Competencies | CHW Core Consensus Project and MN CHW Scope

- Cultural Mediation Among Individuals, Communities, and Health & Social Service System
- Providing Culturally Appropriate Health Education and Information
- Care Coordination, Case Management, and System Navigation
- Screening for, providing resources, and addressing Social Determinants of health
- Providing Coaching and Social Support
- Providing Direct Services (e.g. health related screenings such as blood pressure, provision of food or other physical resources)
- Conducting Outreach (e.g. case finding, phone outreach, community events)
- Home visiting
- Advocating for Individuals and Communities
- Building Individual and Community Capacity
- Implementing Individual and Community Assessments
- Participating in Evaluation and Research
- Transportation
- None of these
- Other

Is there anything else you'd like to tell us? (If you marked 'other' in an above question, give details here)

Consent

By checking this box, I give permission to the Minnesota Community Health Worker Alliance to include my responses in a public report that includes all other responses and does not include any identifying information.