

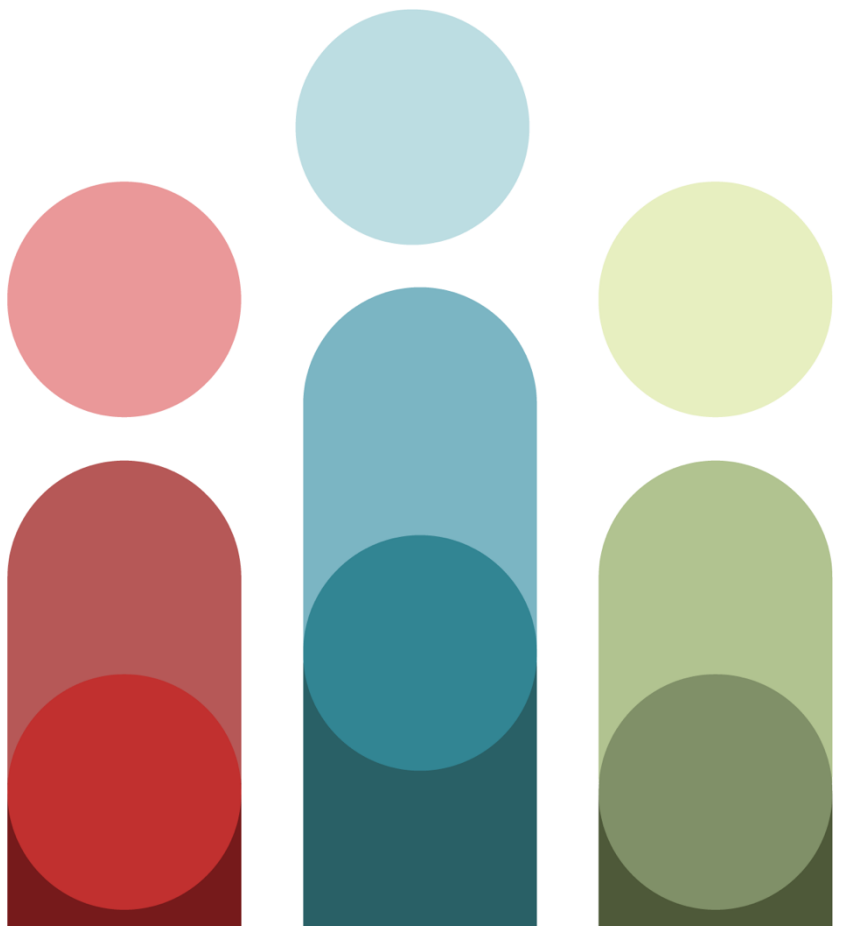
Community Health Workers (CHWs) in New Hampshire

Results of a statewide workforce survey conducted by the Southern New Hampshire Area Health Education Center and the CHW Center for Research and Evaluation



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A Word about Language: Part of our mission at the CHW Center for Research and Evaluation is to build capacity among CHWs to be actively involved in and to lead research and evaluation about the CHW profession. Sometimes, knowing certain 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

In 2023, the Southern New Hampshire Area Health Education Center (SNHAHEC) conducted a statewide survey of Community Health Workers (CHWs). The goals of the survey were to:

- Understand the CHW perspective on the status of the CHW workforce in New Hampshire
- Gather information that New Hampshire and the region can use to better meet the needs of CHWs and support the critical CHW workforce
- Collect data to inform advocacy, funding, and policy change efforts related to the CHW workforce.

To conduct the survey, SNHAHEC partnered with the CHW Center for Research and Evaluation (CHW-CRE). The CHW-CRE has developed a set of workforce indicators that can be operationalized in statewide surveys to assess key workforce conditions.

Methodology

The survey was developed jointly by staff at the Southern New Hampshire AHEC and staff at the CHW-CRE and was based on the CHW workforce indicators developed by the CHW-CRE. The survey was conducted between July 19, 2023, and August 31, 2023. A link to the online survey was disseminated via a QR code shared in an in-person meeting (23 respondents) and via email to members of the SNHAHEC and New Hampshire CHW Coalition distribution lists (48 respondents). In person participants had the option to complete the survey on paper or using the Survey Monkey link. Incentives of \$20 were offered to all participants.

Key Findings

Taking into account the small sample size and the fact that this was not a random sample of all the CHWs in New Hampshire, below is a summary of our key findings.

Time in the Workforce

- Excluding three respondents with over 15 years in the workforce, survey respondents averaged 2.1 years as a CHW. This figure is consistent with the fact that many new CHWs were hired during the Covid-19 pandemic.

Race/Ethnicity

- 60% of respondents were White, while 30% identified as members of communities we grouped together as BIPOC (Black, Indigenous and People of Color) and 10% responded “Other” or did not answer the question.
- Differences in how respondents identified their own race/ethnicity and the race/ethnicity of communities they serve indicate that BIPOC communities are often being served by CHWs who do not share their race/ethnicity.

Wages, Benefits and Opportunities for Advancement

- The average annual wage for respondents to the survey was \$22.90/hour. This compares to a living wage for one adult and one child in all New Hampshire counties of \$30.01/hr. to \$38.56/hr.
- In open-ended responses, respondents requested a living wage that is in line with the cost of living and the work being done, which involves playing multiple roles and working outside the boundaries of a 9-5 workday. The most frequently requested benefits were health insurance and more time off for self-care. A total of eleven respondents reported few to no opportunities for advancement within their current role.

CHW Core Roles

- With reference to the 10 core roles of CHWs, respondents were *least* likely to say they “Often” play the following roles: “Participate in Evaluation and Research,” “Provide Cultural Mediation,” and “Implement Individual and Community Assessments.”
- CHWs with more time in the workforce and CHWs who we grouped together in the category of “Black, Indigenous, and People of Color” were more likely to play some infrequently played roles, most notably cultural mediation and also participating in research and evaluation and implementing individual and community assessments, when compared to CHWs with less time in the workforce and CHWs who identified as White.

Involvement in Policy- and Decision-Making

- Respondents were least likely to report being members of groups that influence policy in their own organizations. They were most likely to report having identified the people and organizations that influence change in their communities.

Integration into Teams

- On the Relational Coordination Scale (RCS - Gittel et al. 2010; 2015), 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' willingness to take responsibility when a mistake has been made.
- Respondents we grouped together into the BIPOC category responded less positively to all items in the RCS than did respondents who identified as White.
- In open-ended responses, respondents identified lack of appreciation for the CHW role and lack of time as the primary barriers to being included in a team, and good communication and a constellation of flexibility, openness, and respect as the principal facilitators for inclusion.
- On a new scale designed to measure the impact of discrimination based on race/ethnicity or culture on integration into teams (Sanchez-Lloyd, personal communication), respondents who we grouped together in the BIPOC category gave higher scores (indicating more discrimination) on every item in this indicator than did respondents who identified as White.
- Ninety-five percent of respondents indicated that they have adequate physical space to conduct their work and 89.7% can chart in the employers' tracking systems.

Supportive and Reflective Supervision

- CHWs with less than 2 years in the workforce were *more likely* than CHWs with more time in the workforce to report 5 hours or less per month of supervision (68% vs. 43%).
- CHWs who reported working in hospitals were *most likely* to report getting 15 hours or more of supervision every month, compared to CHWs working in other types of organizations.

Recommendations

For Southern New Hampshire AHEC:

- To increase response rates for future surveys, consider leaving the survey open longer, sending more reminders, and/or emphasizing the value of completing the survey for CHWs in New Hampshire.

For CHW employers:

- Increase the congruency between CHWs and the communities they serve in New Hampshire by hiring more CHWs who identify as Black, Indigenous, and People of Color.
- Increase wages, benefits, and opportunities for advancement for CHWs in New Hampshire. Most CHW respondents are making less than a living wage by New Hampshire standards. Respondents provided clear guidance about what they want in a salary and benefit package.
- Provide more opportunities for CHWs to influence policy in their own organizations.
- Assure that CHWs, and especially those who are newer to the workforce, receive sufficient supportive and reflective supervision, which supports their personal and professional growth.

For CHW employers, policymakers, and CHW organizations:

- Ensure CHWs can be optimally effective by supporting them to play a full range of roles, including roles as cultural mediators, researchers, and evaluators.
- Increase awareness about the CHW role among both colleagues and communities in order to facilitate integration and decrease feelings of being dismissed or devalued.

Background

The Southern New Hampshire Area Health Education Center (SNHAHEC) has promoted initiatives related to Community Health Workers (CHWs) since 2005. SNHAHEC developed the first CHW training program in New Hampshire in 2013 and was a founding member of the New Hampshire CHW Coalition in 2015. Nearly 400 CHWs have been trained by SNHAHEC in the past decade and have gone on to work for a variety of employers, including community-based organizations (CBOs), federally qualified health centers (FQHCs), health departments, and hospitals. SNHAHEC has also helped create CHW peer-mentoring and support opportunities to uphold the CHW principles of self-determination, advocacy, and community empowerment. SNHAHEC partners with the North Country Health Consortium, current home of the New Hampshire CHW Coalition, to promote and support the CHW workforce.

The environment for CHWs in New Hampshire has changed significantly since training began. In recent years there has been an increasing focus on building awareness about CHWs, promoting CHW certification, and sustaining CHW positions. In 2021, SNHAHEC identified funding, including Equity Grant funding from the US Centers for Disease Control and Prevention (CDC) to bring two trainings about the CHW Common Indicators (a set of standard process and outcome measures for CHW practice, see below) to CHWs and program staff in New Hampshire. The goals of the trainings were to describe the CHW Common Indicators and explore opportunities to assure CHWs are well supported to provide care and address health inequities in New Hampshire.

In 2023, recognizing that funding constraints and limited advancement opportunities have led some New Hampshire CHWs to pursue other types of employment, and that an assessment of the current make-up of the workforce was critical to building strategies to recruit and retain CHWs, SNHAHEC conducted a statewide survey of CHWs using the CHW Common Indicators. The goals of the survey were to:

1. Understand the CHW perspective on the status of the CHW workforce in New Hampshire
2. Gather information that stakeholders and policy makers in New Hampshire and the region can use to better meet the needs of CHWs

3. Collect data to inform advocacy, funding, and policy change efforts related to the CHW workforce.

To conduct the survey, SNHAHEC partnered with the CHW Center for Research and Evaluation (CHW-CRE). With funding from the CDC, the CHW-CRE (formerly, the CHW Common Indicators Project) has developed a set of workforce indicators that can be operationalized in statewide surveys to assess key workforce conditions including compensation, benefits, and advancement; integration of CHWs onto teams; involvement of CHWs in policy- and decision-making; roles conducted; and supportive and reflective supervision.

The CHW Common Indicators (CI) were developed through a participatory process that began in 2015 and included identification of 11 key *constructs*; a literature review to identify existing measurement approaches for each construct; and the creation of detailed performance measures using a template provided by the CDC. Constituent feedback on the draft indicators was obtained through a combination of focus groups, individual interviews, and a virtual Summit. Proposed versions of the indicators were then piloted in multiple sites. Changes were made based on lessons learned, both during the initial development phase and during the piloting phase. CHW leadership was centered at each phase of the process, from the initial organizing meeting in 2015 to the current organizational structure, which includes a majority CHW Leadership Team, a four-person CHW Council, a Researchers Council, and an Advisory Group.

More information about the CHW-CRE, as well as the [CHW Common Indicators Grid](#) and the [Guide to Using the CHW Common Indicators](#), can be found on the CHW-CRE website, at www.chwcre.org.

A “construct” is an abstract idea that we might want to measure. “Constructs” can also be thought of as “concepts.” For example, “empowerment” and “social support” are constructs that CHWs can influence through their work. Constructs do not have fixed, objective meanings, so in order to measure them, we first have to define them.

Although previous surveys in Michigan and Illinois had used versions of the CI workforce indicators, the New Hampshire survey represents the first full-scale use of the CHW

workforce indicators in a statewide CHW survey.¹ An important benefit of using common indicators in statewide surveys (as in other data collection efforts) is the ability to make comparisons regarding workforce conditions for CHWs across states and regions.

Another factor makes this survey important at this time. Viewed through an historical lens, we are just beginning to be able to report reliably on the CHW workforce around the US. Factors which have made this difficult in the past include the variety of titles used to refer to CHWs, which contributes to the difficulty of conducting a census survey (i.e., a survey of all the CHWs in a given location) or identifying a representative sample of CHWs. Increasing coalescence around the CHW title since the 1990s, combined with the increasing organization of CHWs into local, state, and national professional organizations, is starting to facilitate dependable workforce assessments.

While using common indicators is important because it allows us to compare CHW workforce conditions across the US, it is a principle of the CHW-CRE that all studies or surveys of CHWs also need to take into account the local and historical context and ask additional questions that are of importance to CHWs in any given region at a given time. This practice was followed in this survey, by collecting specific demographic information and adding additional questions that were important to CHWs and CHW employers in New Hampshire in 2023 when the survey was conducted.

Methodology

Survey development

The survey was developed jointly by staff at the SNHAHEC and staff at the CHW-CRE and was based on the CHW workforce indicators developed by the Center. For the purpose of this survey, we collected Indicator #2 (Enactment of the 10 Core Roles of CHWs) differently from the standard way of collecting this indicator. Rather than asking CHWs to log all roles played in each encounter with program participants, we asked respondents whether they played each of the 10 core roles “often,” “sometimes,” or “never.”

To the workforce indicator questions, we added demographic questions including age, title, years as a CHW, and community membership. Based on current recommendations to

¹ The CI workforce indicators were also used in the 2024 CHW Survey developed by Arizona State University for the CDC’s CHWs for COVID Response and Resilient Communities Project.

broaden the race/ethnicity categories included in the US Census and to do away with the “ethnicity” distinction for Latinx populations (Mathews et al., 2017), we combined race and ethnicity and included race/ethnicity categories in addition to those included in the census that were based on New Hampshire demographics. When choosing a race/ethnicity, respondents were able to “choose all that apply.” Following research that recommends placing more sensitive questions near the end of a survey (Geisen, E., 2018), we placed questions about racial/ethnic and community identification at the end of the survey, along with a question about the respondent’s residence zip code and type of employing organization. A copy of the survey is available [here](#).

Survey administration

The survey was conducted between July 19, 2023, and August 31, 2023. Incentives of \$20 were offered to all participants. It was estimated that the survey would take between 10 and 20 minutes to complete online. A link to the online survey was disseminated via a QR code shared in an in-person meeting (23 respondents) and was also sent via email to members of the SNHAHEC and New Hampshire CHW Coalition distribution lists (48 respondents). In person participants had the option to complete the survey on paper or using the Survey Monkey link. Paper survey results were then entered into Survey Monkey.

Survey analysis

Survey responses were downloaded from Survey Monkey into an Excel spreadsheet. Quantitative responses were then transferred to R (r-project.org) for analysis. Figures were produced in Excel.

We calculated means (averages) for survey questions overall and then *stratified* the answers by time as a CHW (years), age (years), race/ethnicity, and organization type. We did not try to assess the likelihood that the 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 working in New Hampshire. For ease of interpretation, percentages were rounded to the nearest whole number.

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 from group to group.

For questions where the answers were continuous whole numbers, we divided the sample at numbers that produced groups of comparable sizes. 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.” To protect confidentiality, we suppressed cell sizes smaller than 4, except for the “Other” category. In line with recent science in the field of data justice, in cases where respondents identified two or more racial/ethnic identities, we categorized them by the least common race/ethnicity they identified (Mays et al., 2003).

The question on place of employment (“Organization”) allowed respondents to indicate more than one organization type. To create mutually exclusive categories, we identified the five options that were most commonly selected (community-based organization - 27%, hospital - 22%, federally qualified health center - 20%, family resource center - 15%, and local health department - 13%) and made them our primary categories for organization type. If respondents selected more than one of the five primary categories, they were placed into what we determined to be the most specific category. If respondents did not select any of the five most common organization types, they were placed into the “Other organizations” category.

Stratified sample sizes are shown in Table 1 in the Appendix. The table also includes the number of non-responses for each stratifying *variable*. Unique organization types are indicated in Table 2 in the Appendix.

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.”

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.

The analysis process for the qualitative data combined open-ended ethnographic coding and a close-ended process governed entirely by the survey questions. After a close reading of the qualitative data, we created a codebook that largely mirrored the questions in the survey, and then counted quotations that related to each code. Finally, we created 3 tables with codes and illustrative quotes for each code. Tables 6-8 are included in the Appendix.

Results

Characteristics of CHW Respondents

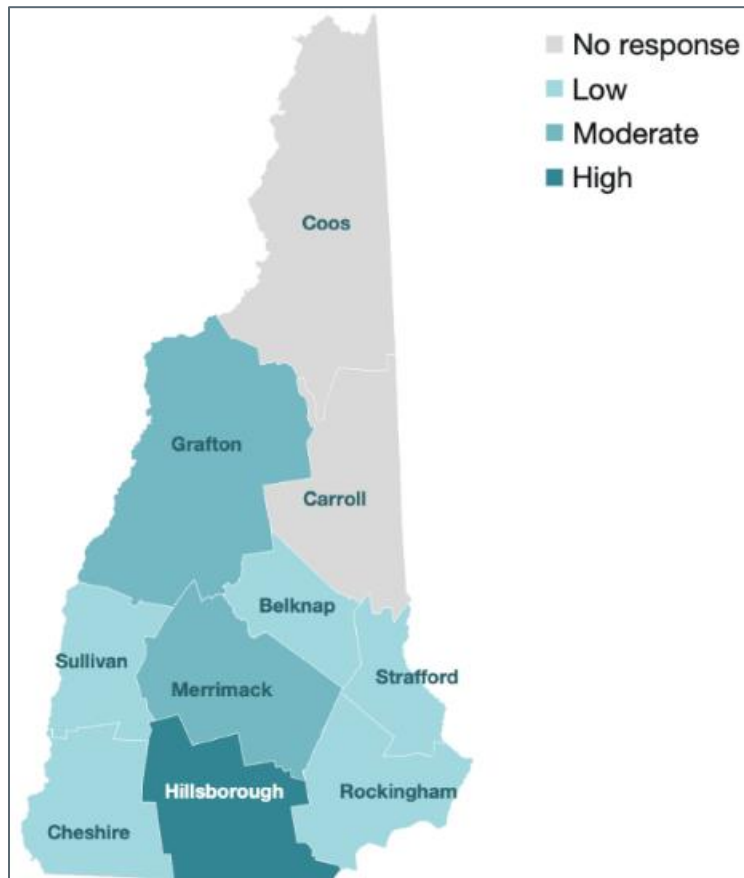
Seventy-one individuals responded to some or all of the survey questions. Two individuals answered “no” to a screening question about whether they identified as CHWs and were excluded from the analysis. Eight additional individuals responded to seven questions or less, and one individual reported living and working in a zip code outside of New Hampshire. These respondents were also excluded, leaving a total of 60 individuals whose responses were used for analysis. The 60 respondents did not respond to every question, but non-response was limited and not systematic (meaning it did not constitute a pattern). Below, we will indicate the total number of respondents (n) for each question.

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

Location of workplace (per zip codes by county)

The 60 respondents included in the sample provided 24 unique work ZIP codes in eight of New Hampshire's ten counties. All respondents included in the analysis were successfully matched to the county corresponding to their zip code. The largest numbers of respondents came from Hillsboro (33), Grafton (12), and Merrimack (7) counties.

Figure 1. Map of Survey Response Rate by County ($n=60$)



Title

Respondents had the option to choose from a list of pre-defined titles (“Certified Peer Support Specialist”, “Community Health Representative,” “Community Health Worker (CHW),” “Family Health Outreach Worker,” or “Recovery Coach”) or, if their title was not listed, to write in a title. Thirty-eight respondents chose a pre-defined title, while 12 wrote in a title, and 10 did both. We classified titles by the open-text response only when respondents did not check a pre-defined title.

As the table shows, the majority (65%) of respondents identified their title as “Community Health Worker.

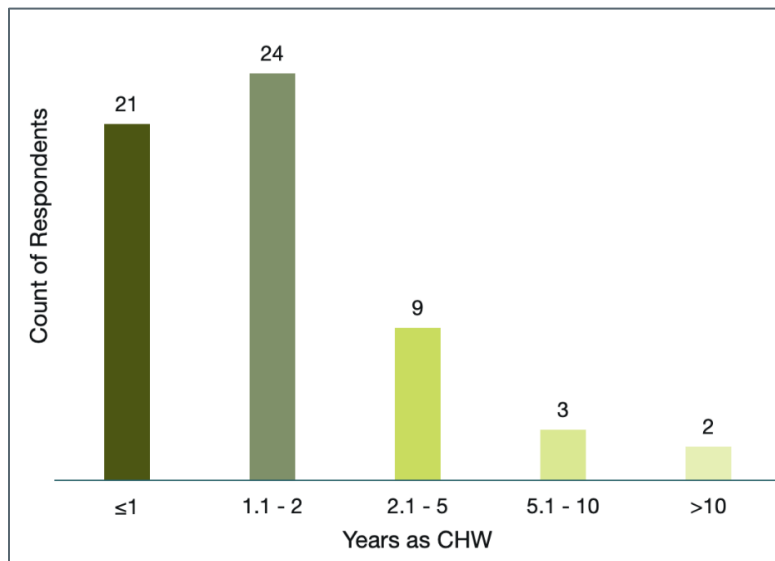
Table 3. Titles by Number and Percentage

Title	Number	Percent
Community Health Worker (CHW)	39	65
CHW Supervisor	4	6.7
“Other” Navigator	3	5
Community Health Resource Specialist	2	3.3
Community Health Representative	2	3.3
CHW Certified Medical Assistant	2	3.3
Certified Peer Support Specialist	2	3.3
Resource Navigator	1	1.7
Recovery Coach	1	1.7
Population Health Senior Program Manager	1	1.7
Family Resource Center Coordinator	1	1.7
Community Health Worker Team Lead	1	1.7
Behavioral Health Case Manager	1	1.7

Time as a CHW

On average, respondents reported having worked for 3.0 years as a CHW. The range of years worked was .25 to 40 years. Omitting two individuals with over 15 years as a CHW, the average number of years as a CHW was 2.1. This is consistent with other current averages being reported around the country (Adkins et al., 2023), and consistent with the fact that many new CHWs were hired during the COVID-19 pandemic. Twenty-one individuals in this group (35%) have been working in their position as a CHW for one year or less.

Figure 2: Years as a CHW (*n*=59)



Age

The average age of respondents was 42 years, and the range was 23-63 years. One person did not respond to the age question.

Figure 3. CHW Age in Years ($n=59$)

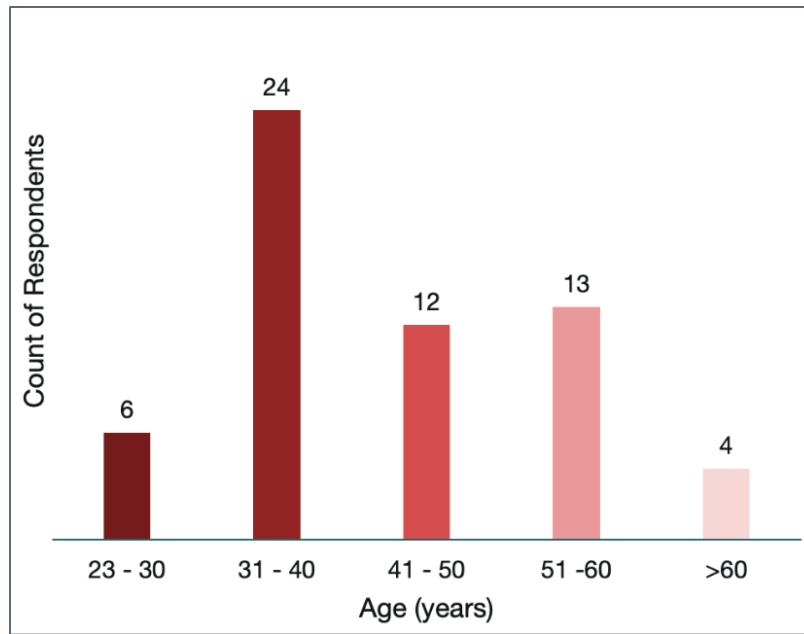
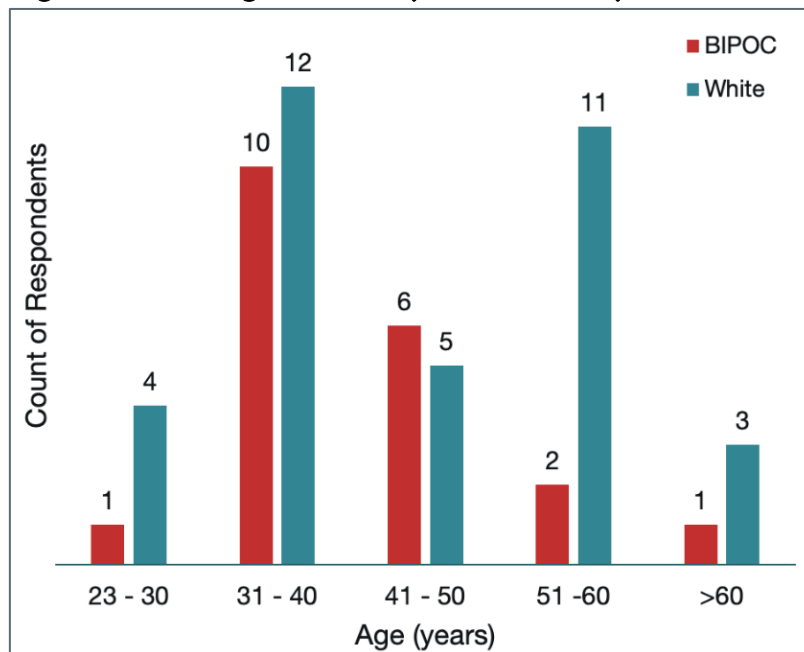


Figure 4. CHW Age in Years by Race/Ethnicity ($n=55$)



White respondents were, on average, older (mean = 43.6 years) than BIPOC respondents (mean = 39.9 years).

Race/ethnicity

More than half of the respondents self-identified as White race/ethnicity only (n=36). Four individuals did not respond to the race/ethnicity question. A breakdown by race/ethnicity is provided in Table 4.

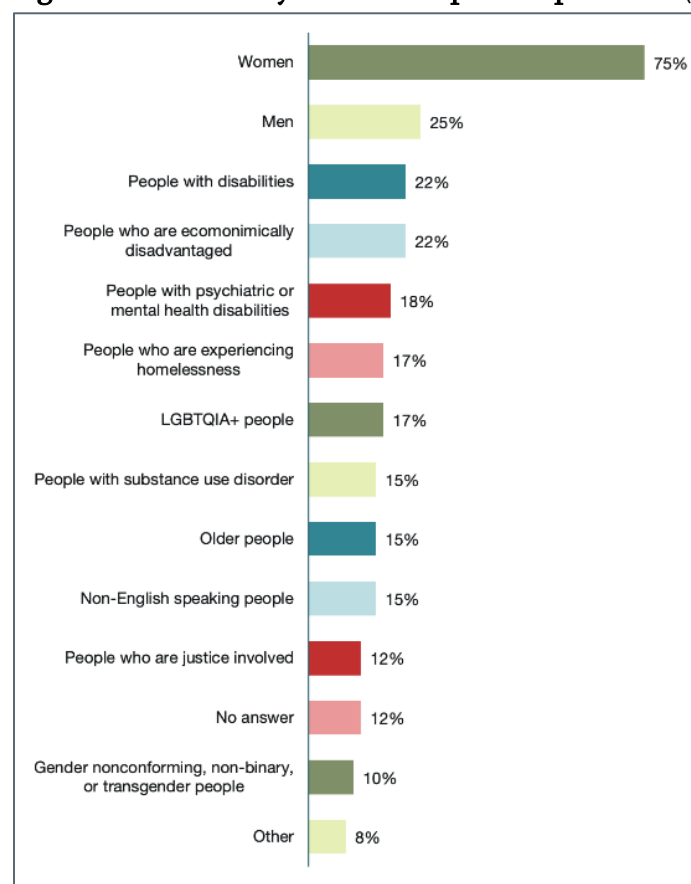
Table 4. Race/Ethnicity of Respondents (n=60)

Race/ethnicity	Number	Percent
White	36	60
Hispanic/Latino/a/x	12	20
African American/Black/African	6	10
No response	4	7
Other	2	3
TOTAL	60	100

Other community membership

Respondents were also asked to identify their membership in communities defined in other ways. They could choose as many as they wished.

Figure 5. Community Membership of Respondents (n=60)



The most commonly mentioned communities were “Women” (mentioned by 75% of respondents), “Men” (25% of respondents), and “People with Disabilities” (22% of respondents). Other communities named by at least 10% of respondents are shown in Figure 5.

Characteristics of Communities Served by CHW Respondents

Respondents were asked to describe the communities they serve by both race/ethnicity and other community membership, using the same categories they used to describe their own race/ethnicity and other community membership.

Figure 6 shows that the most commonly served racial/ethnic communities are White (mentioned by 85% of respondents), Hispanic/Latino/a/x (73% of respondents), and African American/Black (63% of respondents).

Figure 6. Race/Ethnicity of Communities Served (*n*=60)

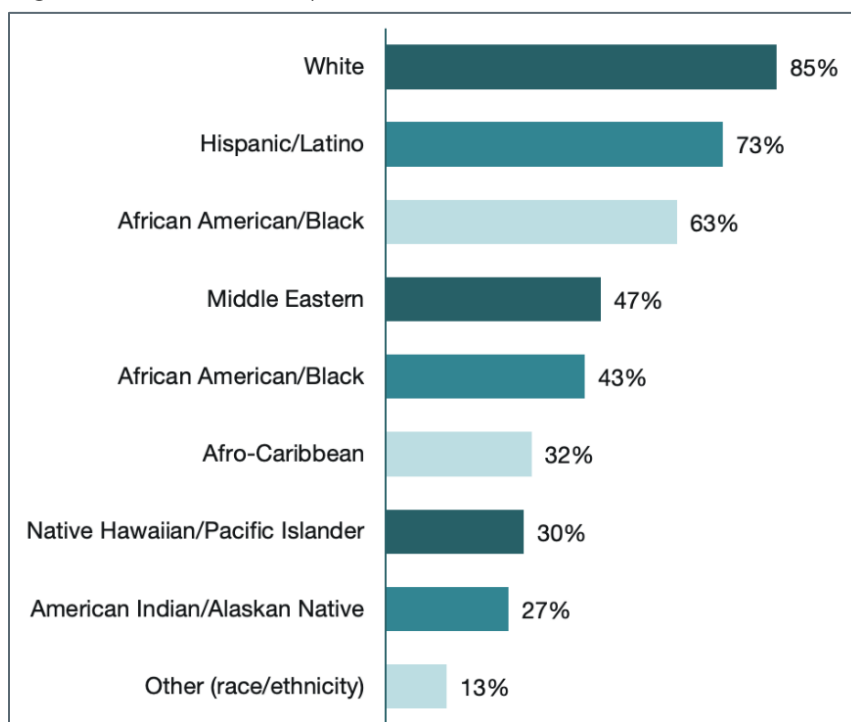
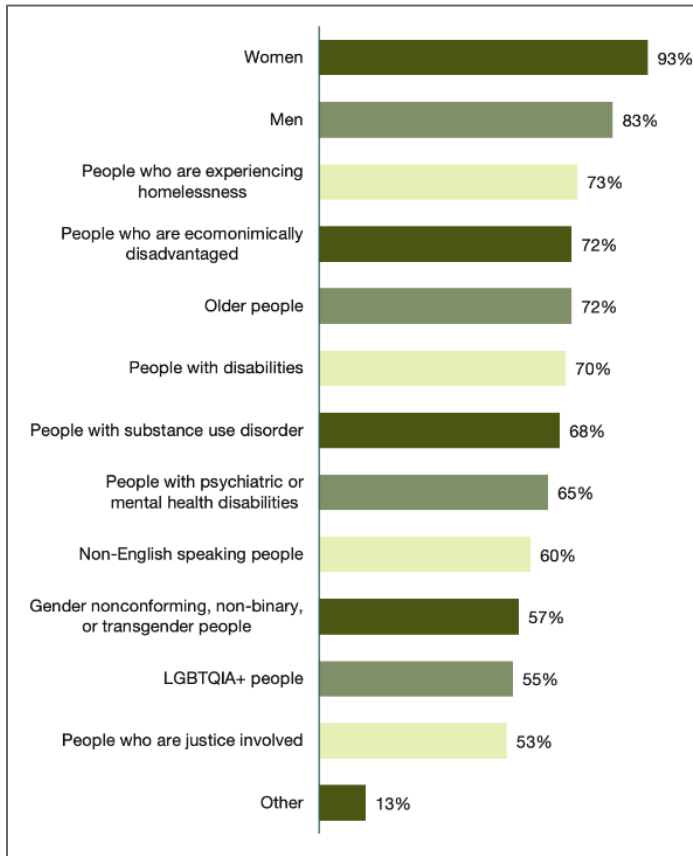


Figure 7 shows how commonly CHWs in New Hampshire serve communities that are defined in other ways. Communities most often mentioned by survey respondents included women (93% of respondents), men (83% of respondents), and people who are experiencing homelessness (73% of respondents.)

Figure 7. Community Membership of Communities Served ($n=60$)



From these statistics, we can infer that members of BIPOC communities are often being served by CHWs who do not share their race/ethnicity.

Conditions for the CHW Workforce in New Hampshire

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

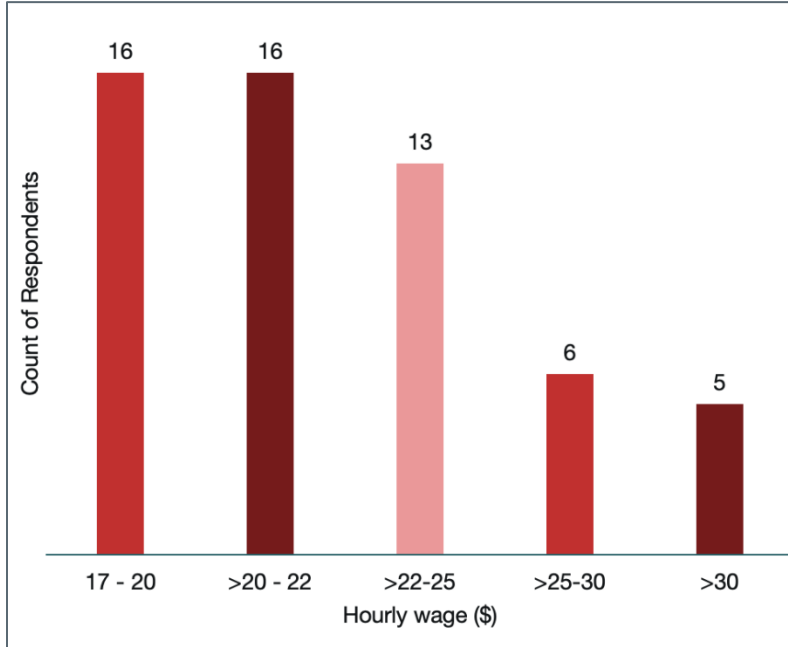
Common Indicator #1 assesses CHW wages, benefits, and opportunities for advancement; it includes versions for CHWs and employers. The version for CHWs was included in this survey.

Wages

Respondents were asked to provide information about their hourly or annual wages. For individuals who reported an annual salary, we computed an hourly wage as the annual salary divided by 2080 (number of working hours in a year). The average annual wage was \$22.90/hour. This compares to a living wage for one adult and one child in all New

Hampshire counties of \$30.01/hr. to \$38.56/hr. The range of reported hourly wages was from \$17 to \$54 dollars per hour.

Figure 8. Hourly Wages (*n*=56)



Respondents who reported their race/ethnicity as White were paid an average of \$23.50/hour, whereas respondents who we grouped together as BIPOC were paid, on average, \$22.20/hour.

Figure 9. Hourly Wage by Race/Ethnicity (*n*=52)

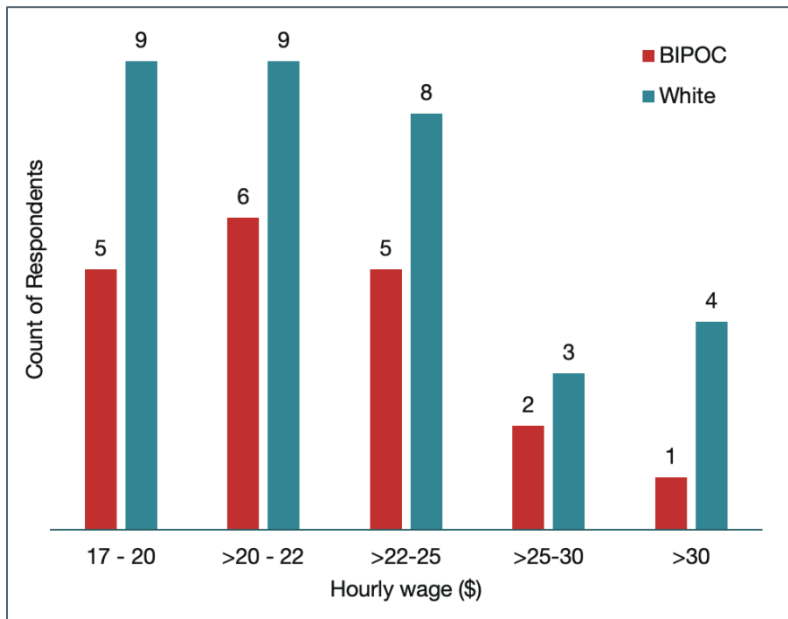


Table 5 shows the mean hourly wage by type of employing organization. To come up with more representative averages and ranges, we excluded one outlier (\$54/hour at a CBO.) Based on our categorization of organization types, average hourly wage is highest at hospitals (\$23.20/hour) while the lowest hourly wages are at Family Resource Centers, CBOs, and Local Health Departments (\$22.00/hour for both).

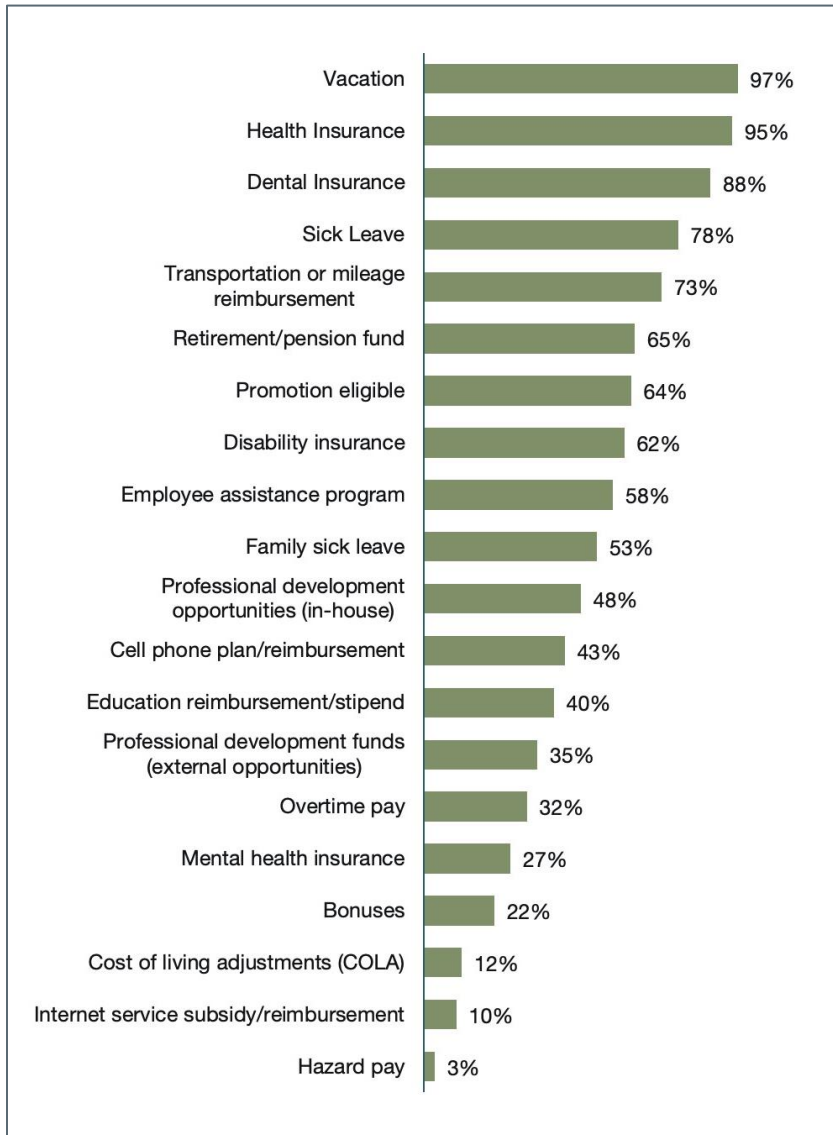
Table 5. Hourly Wage by Organization Type

Organization	Responses	Mean	Min	Max	No response
Community based organization	10	22.0	17.0	33.3	0
Family resource center	9	22.0	17.8	27.0	0
FQHC	9	22.2	20.0	25.0	1
Hospital	10	23.2	18.8	31.7	1
Local health department	8	22.0	20.0	26.0	1
Other organizations	13	22.6	17.0	31.2	1

Benefits

The survey asked respondents to identify benefits received from their employer, including insurance, overtime pay, and sick leave. Figure 10 shows the percentage of respondents who receive a given benefit. Benefits most commonly received by respondents include vacation (97% of respondents), health insurance (95% of respondents), and dental insurance (88% of respondents). Benefits that respondents are least likely to receive include hazard pay (3% of respondents) and internet service subsidy (10% of respondents).

Figure 10. Benefits Received (*n*=60)



Opportunities for advancement

Among our respondents, 63.8% were eligible for promotion or “step-up.” Two CHWs did not respond to this question.

Desired changes in wages, benefits, and opportunities for advancement

Finally, respondents were asked three separate open-ended questions about any changes they would like to see in their wages, benefits, or opportunities for advancement. Respondents requested a living wage that is in line with the cost of living and the work being done, which involves playing multiple roles and working outside the boundaries of a 9am-5pm workday.

In the words of one respondent:

“I recently helped someone with car repairs. They work at a gas station making more than me. They don't have to deal with the vicarious trauma that I do in my position and [do] not have to have a degree to do the job. I'd like to see my pay increase to at LEAST \$23/hour.”

The most frequently requested benefits were health insurance and more time off for self-care. A total of eleven respondents reported few to no opportunities for advancement within their current role, while three respondents did report satisfaction with opportunities for growth. Table 6 in the Appendix provides a summary of themes and illustrative quotations.

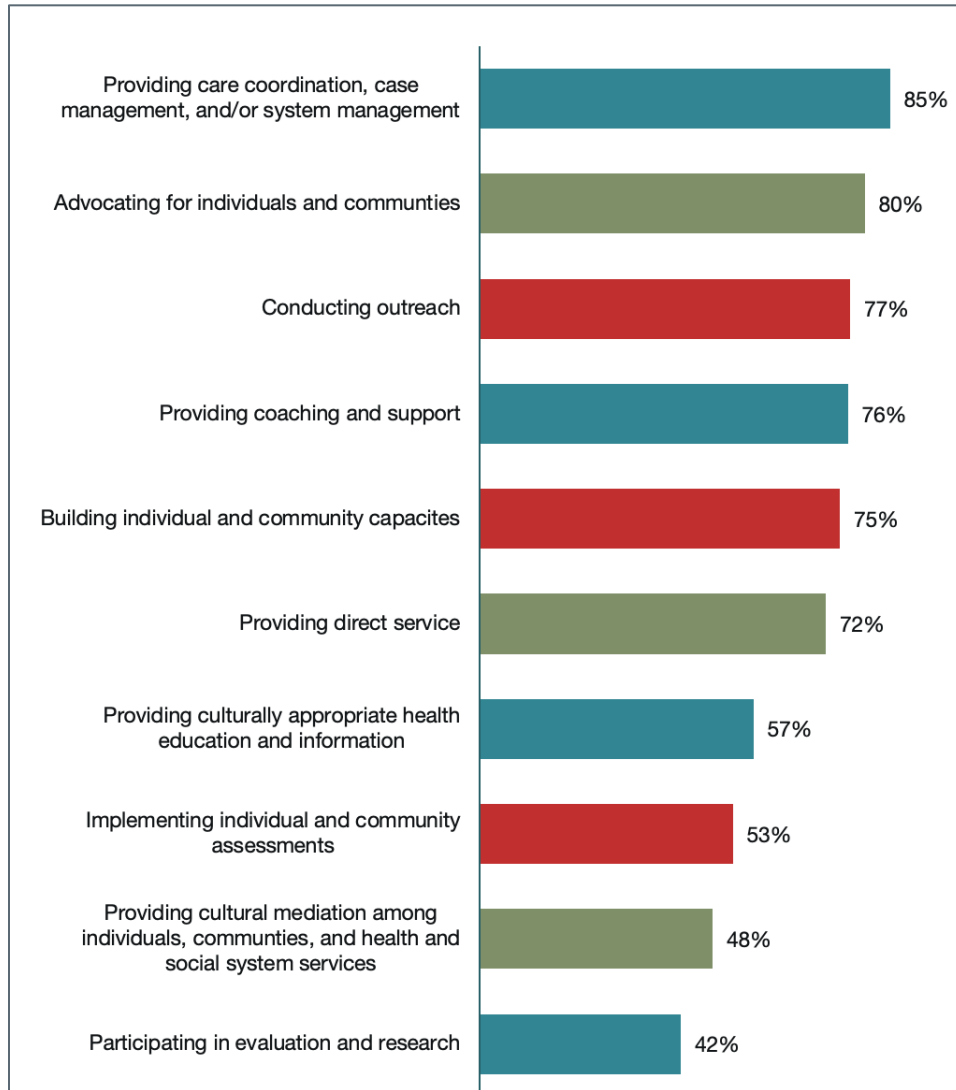
Enactment of the 10 core roles (Indicator #2)

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 (Wiggins & Borbón, 1998) and the CHW Core Consensus Report (Rosenthal et al., 2018). As mentioned under “Methodology,” we made changes to the indicator to make it possible to collect it in a statewide survey.

The survey asked respondents to indicate whether they complete the ten core roles “Often,” “Sometimes,” or “Never.” For almost all roles, all survey respondents checked one of the three check boxes. Figure 11 shows the percent of respondents within each position category who complete the roles “Often,” where the denominator is the total respondents to that question.

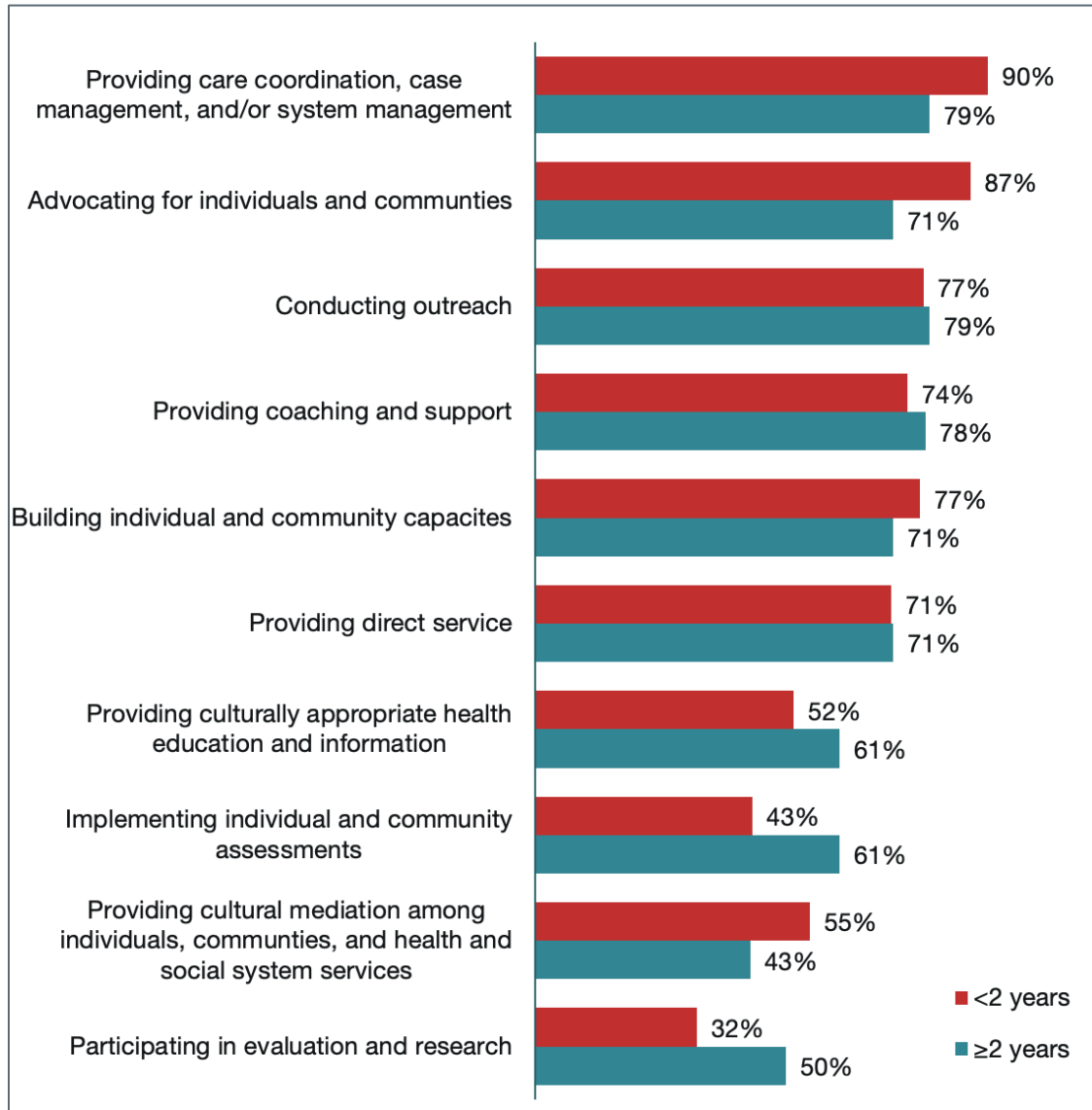
Approximately one half or fewer of respondents indicated that they often “Participate in Evaluation and Research,” “Provide Cultural Mediation,” and “Implement Individual and Community Assessments.”

Figure 11. Core Roles Played “Often” by Respondents (n=60)



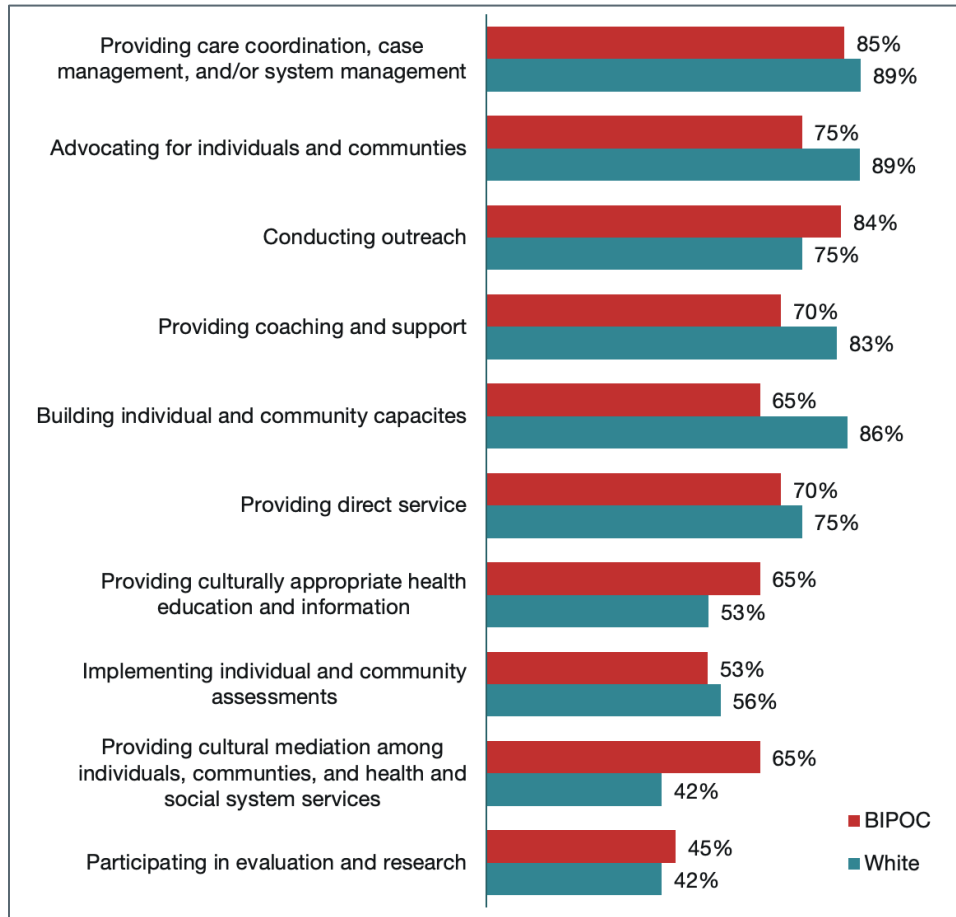
The findings illustrated in Figure 12 provide support for a statement that is often made by CHWs and longtime allies, specifically, that the push to reimburse (and thus monetize) CHW roles is leading to a narrowing of the roles CHWs play. While CHWs with less than 2 years in the workforce tend to play some common roles more often than CHWs with more than 2 years in the workforce, this trend evens out or reverses when we reach some less frequently played roles, such as “participating in research and evaluation,” implementing individual and community assessments,” and “providing culturally appropriate health education and information.” In these cases, CHWs with more time in the workforce are more likely to play these roles “Often” compared to CHWs with less time in the workforce.

Figure 12. Core Roles Played “Often” by Respondents, by Time in the Workforce (*n=60*)



This trend was somewhat replicated when we looked at the Indicator #2 data by race/ethnicity. As Figure 13 shows, whereas respondents identifying as White are somewhat more likely to play the more commonly-played roles, CHWs who we grouped together as BIPOC are generally more likely to play the less-commonly played roles.

Figure 13. Core Roles Played “Often” by Respondents, by Race/Ethnicity (n=56)



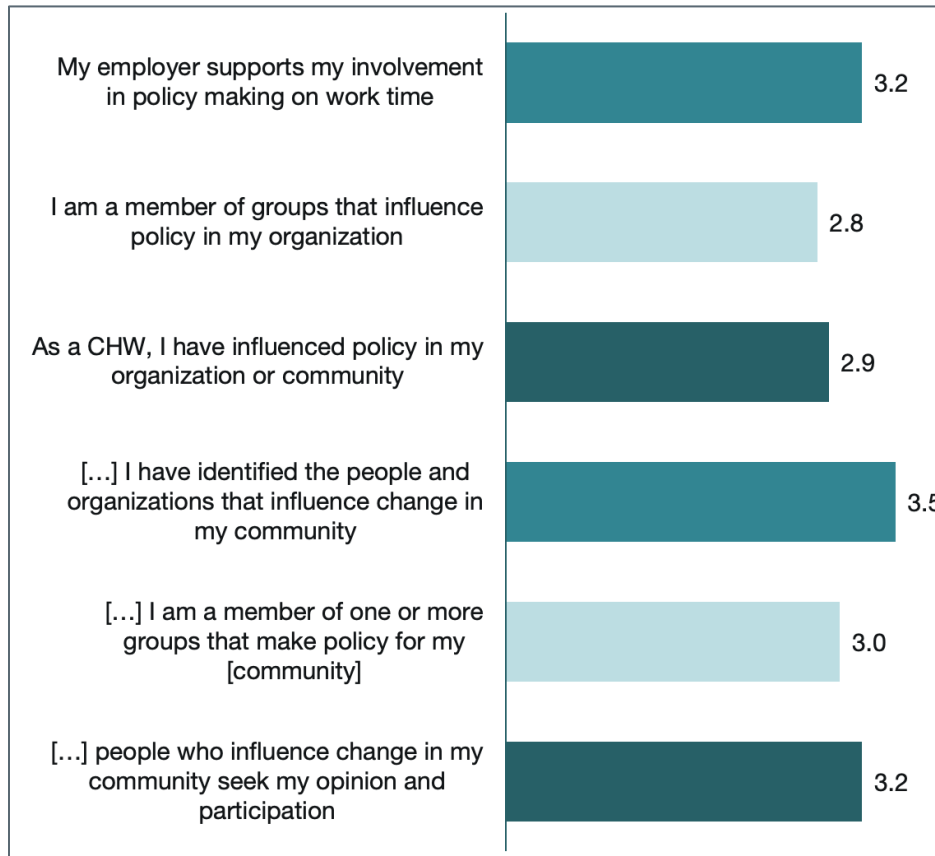
Involvement in decision- and policymaking (Indicator #4)

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 1.

Across the six items, the average score in this sample was 3.1. Two individuals did not respond to the question “As a part of my job, I am a member of one or more groups/orgs that make (i.e., develop and/or enact) policy for my community, city, county, state, or tribe.” One individual did not respond to “As part of my job, people who influence change in my

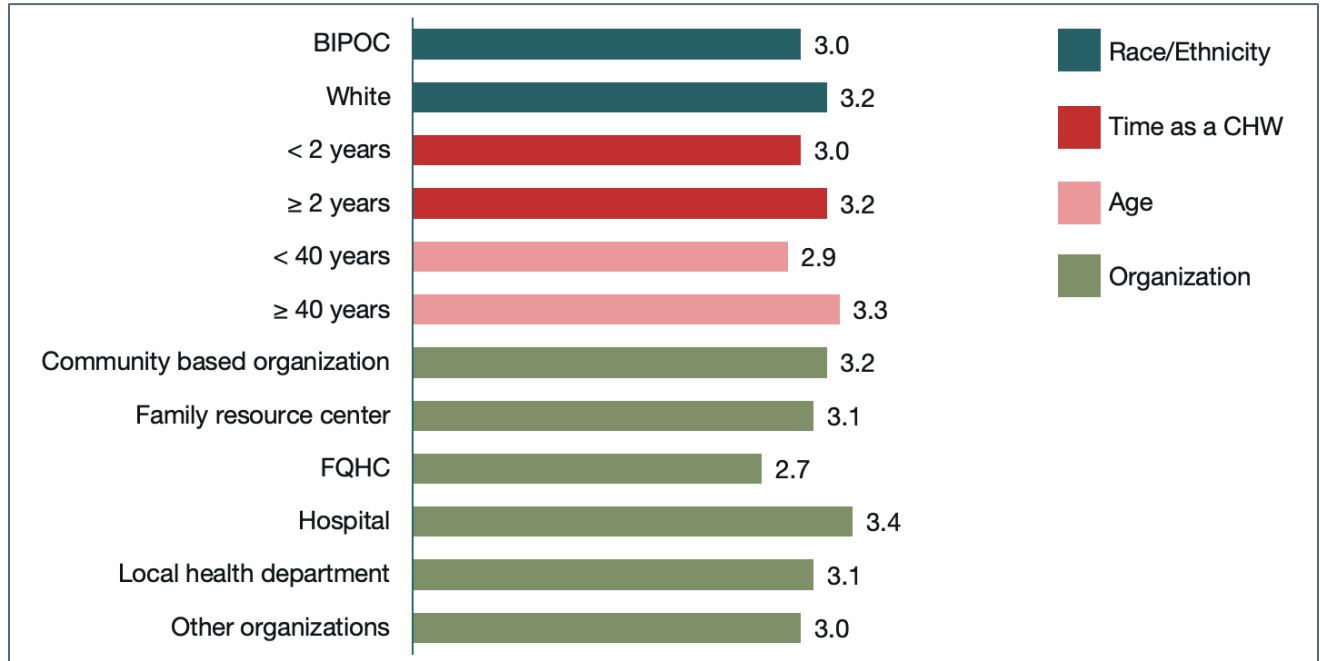
community seek my opinion and participation” and to “I am a member of one or more groups that influence policy in my employing organization.” Interestingly, respondents were least likely to report being members of groups that influence policy in their own organizations (average score = 2.8). They were most likely to report having identified the people and organizations that influence change in their communities (average score = 3.5).

Figure 14. CHW Involvement in Decision- And Policymaking (*n=60*)



We combined all the items in this scale into one variable and stratified by the demographic categories. As might be expected, CHWs who were 40 years old and above and CHWs with more time in the workforce were somewhat more likely to report being involved in decision- and policymaking than CHWs under 40 and with less time in the workforce. Respondents who we grouped into the BIPOC category were marginally less likely to be involved in decision- and policymaking than CHWs who identified as White. Interestingly, among our respondents, CHWs who worked for hospitals were more likely to be involved in decision- and policymaking than CHWs who worked for other types of organizations.

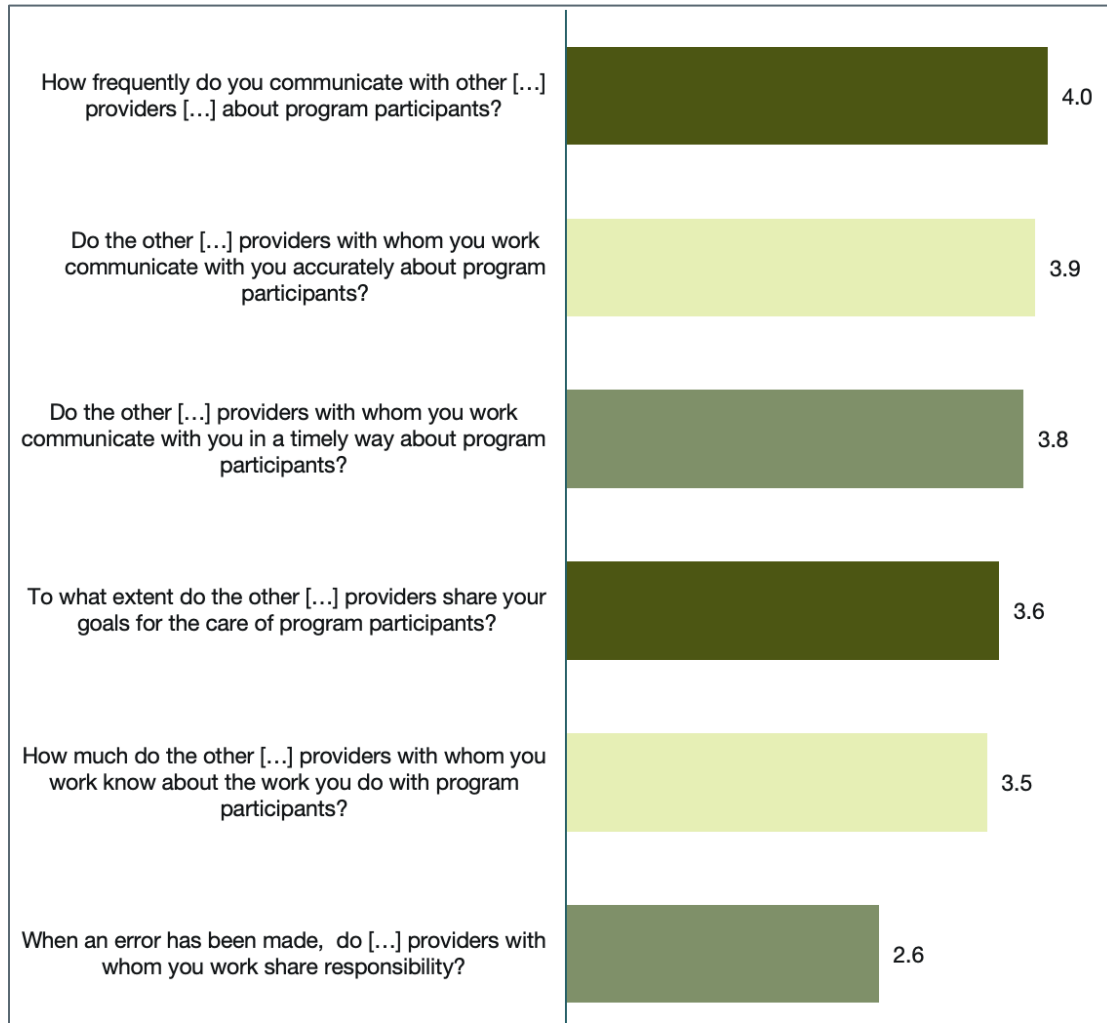
Figure 15. CHW Involvement in Decision- and Policymaking by Race/Ethnicity, Time In The Workforce, Age, and Organizational Location (*n=60*)



Integration into teams (Indicator #5)

Common Indicator #5 includes three sub-measures of integration onto teams. First, respondents are asked to respond to the Relational Coordination Scale (Gittel et al. 2010; 2015), with some modifications. Each question in the Relational Coordination Scale (RCS) provides five response options 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 16 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’ willingness to take responsibility when a mistake has been made.

Figure 16. Relational Coordination Scale (n=59)



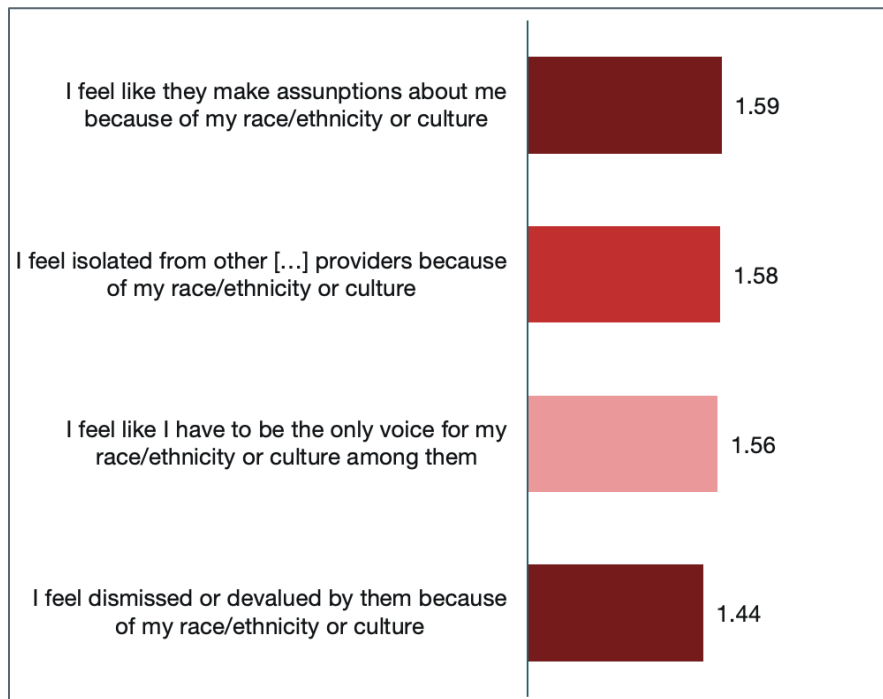
Respondents we grouped together into the BIPOC category responded less positively to all items in the RCS than did respondents who identified as White. Scores per item by time in the workforce varied inconsistently, while scores by age were exactly the same, with the exception of one item, where the difference was small. CHWs who worked for FQHCs and hospitals tended to provide higher scores on almost all items.

A follow-up open-ended question specific to New Hampshire asked participants what makes it harder or easier to be included on a team. Respondents identified lack of appreciation for the CHW role and lack of time as the primary barriers to being included in a team, and good communication and a constellation of flexibility, openness, and respect as the principal facilitators for inclusion. In the words of one respondent, “Something that makes it hard [to be included in a team] is that certain people in positions that are higher look down upon the

CHW role compared to theirs.” A summary of themes and illustrative quotations is provided in Table 5 in the Appendix.

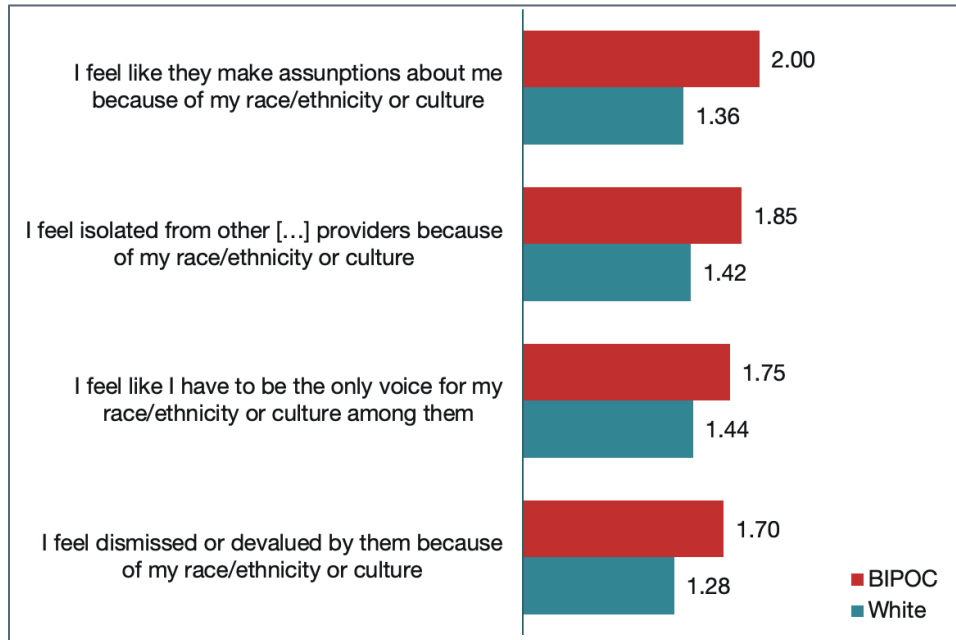
The second sub-measure within Indicator #5 is a novel scale designed to measure the impact of discrimination based on race/ethnicity or culture on integration into teams (Sanchez-Lloyd, personal communication). It uses the same four-level Likert scale from “Strongly disagree” (1) to “strongly agree” (4). Figure 17 shows results for all respondents and indicates relatively low levels of discrimination based on race/ethnicity for the sample as a whole.

Figure 17: Impact of Discrimination on Integration (n=59)



Respondents who we grouped together in the BIPOC category gave higher scores on every item in this indicator than did respondents who identified as White, which suggests that this newly-created scale may be effective in assessing discrimination by race/ethnicity and culture.

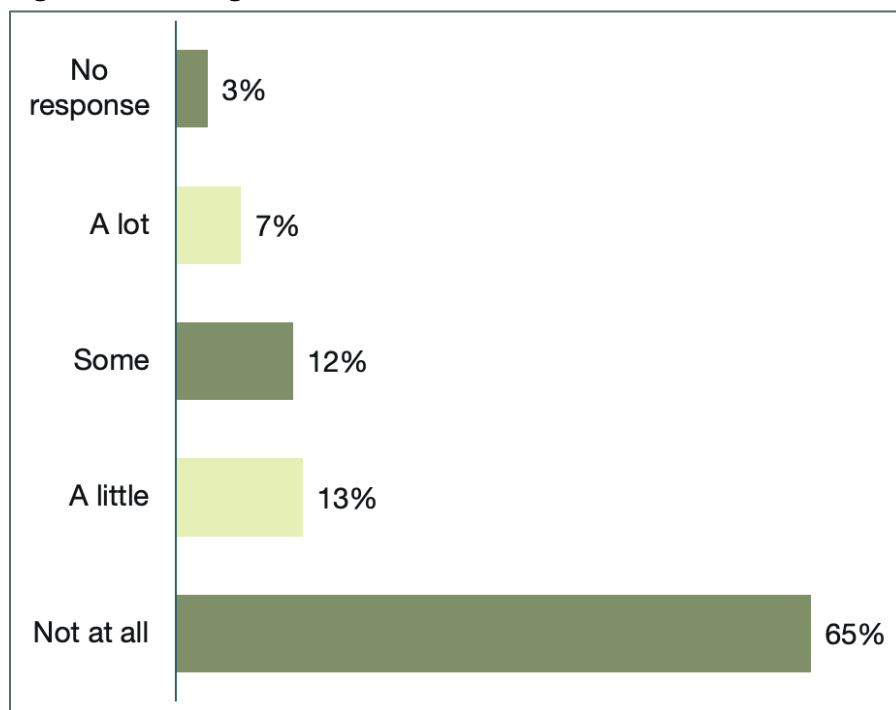
Figure 18. Impact of Discrimination on Integration, by Race/Ethnicity (n=56)



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. Ninety-five percent of respondents indicated that they have access to space and 89.7% can chart in the employers’ tracking systems. Two individuals (3.3%) did not respond to these questions.

Two questions specific to New Hampshire were included to assess additional factors related to integration. One question investigated how often respondents “feel dismissed or devalued by other professionals” with whom they work (Figure 23). Overall, less than 7% of respondents reported feeling dismissed or devalued “a lot.” There were differences by race/ethnicity. While only 3% of White CHWs reported feeling dismissed or devalued “a lot,” 9.7% of respondents who we grouped together as BIPOC reported this feeling. Ten percent of respondents with less than 2 years in the workforce reported feeling dismissed or devalued “a lot,” whereas only 3.6% of CHWs with more than 2 years in the workforce reported this feeling.

Figure 19. Feeling Dismissed or Devalued (n=58)



A follow-up open-ended question asked respondents, if they felt dismissed or devalued by other professionals, why this was so. The most common response was a lack of understanding or valuing of the CHW role. As one CHW stated, “They don't understand my work description and they think that I [am] just an Interpreter within our organization and I just advocate for my race.” Other common responses included ageism, in one instance combined with linguistic discrimination, and a lack of team support.

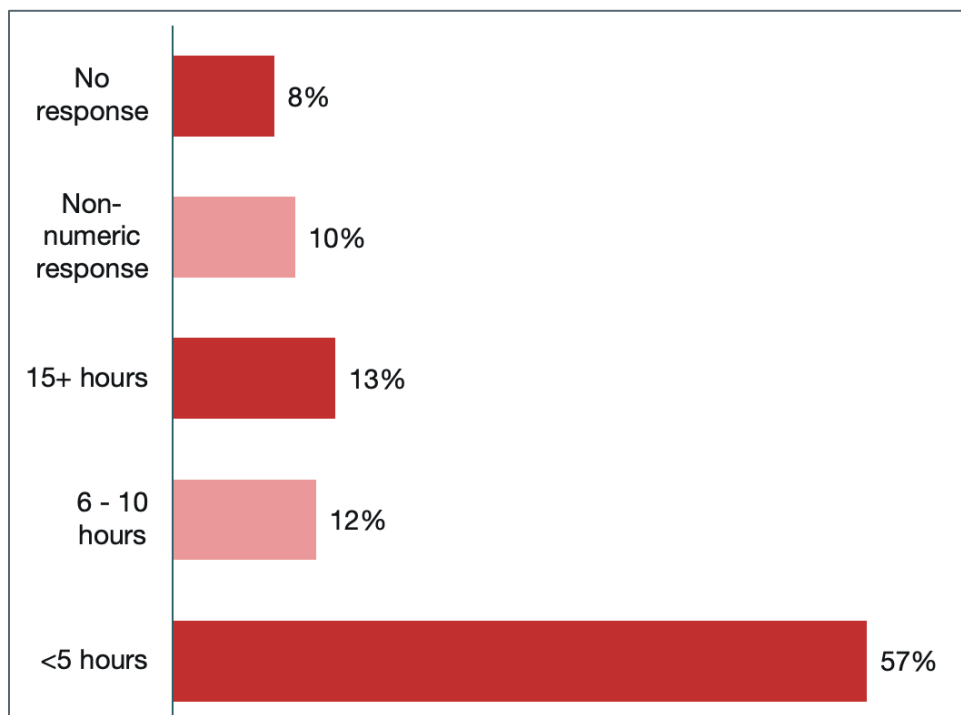
Other themes arising from the open-ended question included a strong desire for opportunities for CHWs to meet and learn from one another, and a widespread appreciation for and celebration of the CHW role, despite the obstacles. Further information can be found in Table 8 in the Appendix.

Supportive and reflective supervision (Indicator #12)

The CHW version of Indicator #12 has three parts: 1) supervision quantity; 2) supervision quality, and 3) supervisor characteristics. Parts 1 and 3 were used in this survey. Part 1 asked respondents to estimate “How many hours of supervision were provided to you in the last 30 days?” Five respondents did not respond to that question, while six provided a non-numeric value (“Frequently,” “No direct, manager available,” and “As much as needed”), and the remaining 49 respondents indicated they participated in supervision for between zero and

over 120 hours over the past thirty days. Figure 20 summarizes the distribution of hourly amounts provided by respondents and shows that 57% of respondents reported receiving five hours or less of supervision per month. Contrary to what one might hope, CHWs with less than 2 years in the workforce were *more likely* than CHWs with more time in the workforce to report 5 hours or less per month of supervision (68% vs. 43%). Differences by age and race/ethnicity were small. CHWs who reported working in hospitals were most likely to report getting 15 hours or more of supervision every month, compared to CHWs working in other types of organizations.

Figure 20. Supervision Hours per Month (*n*=60)



For Part 3 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 3.3. Figure 21 shows the average response by question. Average question-specific scores exceeded 3.0 for all questions except for questions asking if CHWs are included on hiring panels for CHW supervisors (2.7) and if the supervisor has participated in training about the CHW profession (3.0). We observed some differences between BIPOC and White respondents: BIPOC respondents were more likely to indicate that their supervisors have participated in training about the CHW profession and to work in organizations where

CHWs participate on hiring panels. We did not see notable differences by age or time in the workforce.

Figure 21. Supervisor Characteristics (*n=59*)



Discussion

A summary of our key findings and a list of recommendations can be found below. Limitations of the survey include a small sample size and non-representative sample. The small sample size and inability to administer the survey multiple times made it impossible to test the internal consistency and reliability of the indicators that are intended to function as scales. Testing for internal consistency reliability and consistency will occur in the context of the CCR CHW Survey.

Key Findings

Taking into account the small sample size and the fact that this was not a random sample of all the CHWs in New Hampshire, below is a summary of our key findings.

Time in the Workforce

- Excluding three respondents with over 15 years in the workforce, survey respondents averaged 2.1 years as a CHW. This figure is consistent with the fact that many new CHWs were hired during the Covid-19 pandemic.

Race/Ethnicity

- 60% of respondents were White, while 30% identified as members of communities we grouped together as BIPOC (Black, Indigenous and People of Color) and 10% responded “Other” or did not answer the question.
- Differences in how respondents identified their own race/ethnicity and the race/ethnicity of communities they serve indicate that BIPOC communities are often being served by CHWs who do not share their race/ethnicity.

Wages, Benefits and Opportunities for Advancement

- The average annual wage for respondents to the survey was \$22.90/hour. This compares to a living wage for one adult and one child in all New Hampshire counties of \$30.01/hr. to \$38.56/hr.
- In open-ended responses, respondents requested a living wage that is in line with the cost of living and the work being done, which involves playing multiple roles and working outside the boundaries of a 9-5 workday. The most frequently requested benefits were health insurance and more time off for self-care. A total of eleven respondents reported few to no opportunities for advancement within their current role.

CHW Core Roles

- With reference to the 10 core roles of CHWs, respondents were *least* likely to say they “Often” play the following roles: “Participate in Evaluation and Research,” “Provide Cultural Mediation,” and “Implement Individual and Community Assessments.”
- CHWs with more time in the workforce and CHWs who we grouped together in the category of “Black, Indigenous, and People of Color” were more likely to play some infrequently-played roles, most notably cultural mediation and also participating in research and evaluation and implementing individual and community assessments, when compared to CHWs with less time in the workforce and CHWs who identified as White.
- Involvement in Policy- and Decision-Making: Respondents were least likely to report being members of groups that influence policy in their own organizations. They were most likely to report having identified the people and organizations that influence change in their communities.

Integration into Teams

- On the Relational Coordination Scale (RCS - Gittel et al. 2010; 2015), 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' willingness to take responsibility when a mistake has been made.
- Respondents we grouped together into the BIPOC category responded less positively to all items in the RCS than did respondents who identified as White.
- In open-ended responses, respondents identified lack of appreciation for the CHW role and lack of time as the primary barriers to being included in a team, and good communication and a constellation of flexibility, openness, and respect as the principal facilitators for inclusion.
- On a new scale designed to measure the impact of discrimination based on race/ethnicity or culture on integration into teams (Sanchez-Lloyd, personal communication), respondents who we grouped together in the BIPOC category gave higher scores (indicating more discrimination) on every item in this indicator than did respondents who identified as White.
- Ninety-five percent of respondents indicated that they have adequate physical space to conduct their work and 89.7% can chart in the employers' tracking systems.

Supportive and Reflective Supervision

- CHWs with less than 2 years in the workforce were *more likely* than CHWs with more time in the workforce to report 5 hours or less per month of supervision (68% vs. 43%).
- CHWs who reported working in hospitals were *most likely* to report getting 15 hours or more of supervision every month, compared to CHWs working in other types of organizations.

Recommendations

For Southern New Hampshire AHEC:

- To increase response rates for future surveys, consider leaving the survey open longer, sending more reminders, and/or emphasizing the value of completing the survey for CHWs in New Hampshire.

For CHW employers:

- Increase the congruency between CHWs and the communities they serve in New Hampshire by hiring more CHWs who identify as Black, Indigenous, and People of Color.
- Increase wages, benefits, and opportunities for advancement for CHWs in New Hampshire. Most CHW respondents are making less than a living wage by New Hampshire standards. Respondents provided clear guidance about what they want in a salary and benefit package.
- Provide more opportunities for CHWs to influence policy in their own organizations.
- Assure that CHWs, and especially those who are newer to the workforce, receive sufficient supportive and reflective supervision, which supports their personal and professional growth.

For CHW employers, policymakers, and CHW organizations:

- Ensure CHWs can be optimally effective by supporting them to play a full range of roles, including roles as cultural mediators, researchers, and evaluators.
- Increase awareness about the CHW role among both colleagues and communities in order to facilitate integration and decrease feelings of being dismissed or devalued.

Conclusion

Several unique factors aligned to make this first-of-its-kind CHW survey in New Hampshire possible. First, SNHAHEC initiated a collaboration with the CHW-CRE to use CHW process indicators with New Hampshire CHWs working in both urban and rural contexts. Existing CHW organizing efforts led by SNHAHEC supported strong survey response rates, as environments to listen and respond to needs vocalized by CHWs had already been cultivated. The survey timing and integration into these existing spaces has provided new data resources, aimed at supporting and sustaining the workforce. These survey results, which help build a deeper understanding of the makeup and working conditions of New Hampshire CHWs,

should be used to enhance existing CHW efforts and emphasize to CHW constituents and allies the need for centering CHW voices to ensure proven CHW health improvement outcomes are realized. A CHW employer survey, to be conducted in Summer 2024, and re-administration of this survey to CHWs in subsequent years will help demonstrate areas of success, growth, and continued progress towards the development of a robust CHW workforce in New Hampshire to support community health.

Next Steps

The timing is right to promote the role and impact of Community Health Workers in New Hampshire. There is a strong effort to advocate for CHW certification and explore opportunities for addressing CHW sustainability. SNHAHEC will continue to work with CHWs and stakeholders to provide information to support policy and systems that acknowledge the tremendous healing power of CHWs.

SNHAHEC will host an in-person CHW Connect meeting to share information with CHWs and engage them in a dialogue about the research findings. We will actively engage CHWs in identifying future funding opportunities. The planning and design of the NH CHW Employer Survey will soon be underway. If you have questions, or would like to get involved in these efforts, please contact Paula Smith at psmith@snhahec.org.

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Appendices

Table 1. Stratified sample sizes

Stratifying variable	Variable level	Respondents (%)
Age	<40 years	30 (50%)
	>=40 years	29 (48.3%)
	No response	1 (1.7%)
Organization	Community based organization	11 (18.3%)
	Family resource center	9 (15%)
	FQHC	9 (15%)
	Hospital	10 (16.7%)
	Local Health Department	8 (13%)
	Other organizations	13 (21.7%)
	No response	0 (0%)
Race/ethnicity	BIPOC	20 (33.3%)
	White	36 (60%)
	No response	4 (6.7%)
Time as CHW	<2 years	31 (51.7%)
	>=2 years	28 (46.7%)
	No response	(1.7%)

Table 2. Unique organization types

Organization	Number of respondents	Percent of respondents
Community based	16	26.7
FQHC	12	20
Primary care	3	5
School	4	6.7
Rural health clinic	1	1.7
Health insurance provider	3	5
Hospital	13	21.7
Local health department	8	13.3
Family resource center	9	15
Public health network	4	6.7
University	0	0
Other	7	11.7

Table 6. Desired Changes in Wages, Benefits and Opportunities for Advancement

Theme	No. of mentions	Illustrative quotations
Compensation in line with cost of living	5	<p>“Without a raise every year and the cost of living increasing, employees need to find other careers to be able to afford their own personal finances.”</p> <p>“There are some years we don't get a raise. Raises are the same across the board. But we are required to set goals each year and don't get compensated. Workload has increased or other duties added and not compensated.”</p>
Compensation in line with the work done, including playing multiple roles and working outside normal work hours	5	<p>“We do not only take on the work during our paid hours but many times spend unpaid hours thinking of ways to help others or reaching out to make connections and building relationships.”</p> <p>“I recently helped someone with car repairs. They work at a gas station making more than me. They don't have to deal with the vicarious trauma that I do in my position and [do] not have to have a degree to do the job. I'd like to see my pay increase to at LEAST \$23/hour.”</p>
Living wage/enough to work only one job without subsidies	3	<p>“I would like to make enough money to support my son ... I'm a single mother. My rent is subsidized and I still get subsidized childcare. I would like to make enough to 100% support myself and my son with no help.”</p> <p>“Making a living in [today's] world on \$17 an hour is hard, and we are helping people better their lives”</p>
Health insurance or better health insurance	7	<p>“I personally would benefit from counseling services, but my high deductible is a barrier to care.”</p>
Self-care days/more time off	7	<p>“I would like to see self care days added into our benefits. All my vacation days get used for my children and other people. It's important to take care of ourselves so we can take care of others”</p> <p>“[I] would like more vacation/ sick time as my position is very taxing emotionally at times and [I] feel that [a] paid week off each quarter is greatly needed to prevent burn out.”</p> <p>“I would like to receive vacation time and a health insurance option. Again I help people find insurance, jobs and so forth but I can't afford my own insurance.”</p>
Opportunities for promotion	11	<p>“No way to grow here”</p> <p>“There is no step-up. I work for a very small non-profit that is barely able to afford me let alone a 2nd me. But there needs to be more than just me to support our 10 towns.”</p> <p>“While our facility offers room for growth, I cannot see myself being promoted in the line of work that I do now.”</p>

		“I haven't seen or heard of any promotions or step-ups in the CHW role at my current place of employment. That is something that is a turn-off for me.”
Satisfaction with opportunities for growth	3	“This is my second step up in 5 years. I'm happy where I am now.” “I have had the opportunity to step up to the center coordinator role as well as community health worker. I am on track for management.”

Table 7. Things that make it harder to be included in a team

Theme	No. of mentions	Illustrative quotations
Lack of understanding/appreciation for the CHW role	6	“Something that makes it hard is that certain people in positions that are higher look down upon the CHW role compared to theirs.” “My team is great [but] some people don't believe that community health worker or CRSW are skilled positions.” “People in this area are just starting to learn what a CHW does and those that do [know] are just getting used to reaching out to us and starting to think about how they can utilize [us].”
Lack of time	6	“The amount of meetings I attend and the amount of referrals coming in at the moment. We also have constant staffing shortages and needing to rehire and train new staff.” “Availability and accessibility is very hard, every one is very busy and a lot of places are operating in full capacity. But everyone is trying.”
Things that make it easier to be included in a team		
Theme	No. of mentions	Illustrative quotations
Good/open communication	5	“Truth. Honest information sharing without fear of termination or job insecurity”
Flexibility/openness/respect	4	“Being open to everyone's view has made our team work so well together. we listen to each other and collaborate to give patients the best care possible.” “It's easy to be on a team when that team works well together-people's opinions are respected and everyone is heard.”
Monthly/regular meetings	3	

Table 8. Reasons respondents feel devalued

Theme	No. of mentions	Illustrative quotations
Lack of understanding/v aluing of the CHW role	6	“They don't understand my work description and they think that I [am] just an Interpreter within our organization and I just advocate for my race.” “... sometimes it feels as if they see CHWs as ‘the help.’”
Ageism (sometimes combined with linguistic discrimination)	3	“I feel overlooked due to my age. I work with people who are twice my age and my opinion doesn’t seem to matter.” “Sometimes due to my accent and sometimes my age ...”
Lack of team support	2	“[There] are certain staff positions that continue to create barriers for me to do outreach” “Not listening to me and just dismissing me like what I [say] or do or think isn't important and I need to do it their way”
Other themes		
Theme	No. of mentions	Illustrative quotations
Desire for opportunities for CHWs to meet and learn from one another	9	Frequent suggestions included all-day meetings that start with a code of care and include speakers/panel discussion/fishbowl, breakout sessions where CHWs could discuss regional issues, learn about resources** by region**, and network. Requested topics included mental health**, burnout, self-care, cultural sensitivity/awareness, boundaries, harassment, and best practices. One respondent suggested including activities like dance/salsa classes, singing, bingo networking, storytelling.
I love being a CHW (and...)	5	“I enjoy my job everyday!” “LOVE my Role as a CHW” “I am passionate and love the work we do” “I really enjoy being a CHW, however I think we need to be appreciated more for the difference we can make.”