Community Health Workers' Perspectives on Career Advancement and Job Satisfaction: Indiana, March–August 2024

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Objectives. To explore perspectives on career advancement and job satisfaction among community health workers (CHWs) in Indiana.

Methods. From March to August 2024, we conducted a cross-sectional survey of 282 CHWs in Indiana that captured perspectives on career development, burnout, and inclination to leave the profession using Likert scale and open-ended questions. We conducted descriptive mixed methods analyses and examined associations between outcomes and employer type.

Results. Half of CHW respondents reported burnout and considered leaving the CHW profession on a monthly basis; they said there were few opportunities for career advancement. Respondents expressed frustrations with pay, upward mobility, professional recognition, and organizational support, which varied by organizational setting. The positive impact on patients and communities was a strong motivator to remain in the profession.

Conclusions. CHWs face uneven career paths and high burnout and intention to leave the profession in Indiana.

Public Health Implications. Improving career pathways and organizational support through federal, state, and employer workforce policies and initiatives are essential for strengthening the CHW workforce. These policies and initiatives should be undertaken in partnership with CHWs. (*Am J Public Health*. 2026; 116(9):1436–1444. https://doi.org/10.2105/AJPH.2026.308487)

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Community health workers (CHWs) are community-based public health professionals who bridge gaps in access and coordinate care, address social determinants of health, reduce health care costs, and improve health outcomes for marginalized communities.[1,2] The Bureau of Labor Statistics estimates that the CHW workforce will grow 13% between 2023 and 2033, and recent national and state policy reforms create new mechanisms to integrate CHWs into health and social care systems.[3] In 2024 for the first time, the Medicare Physician Fee Schedule included reimbursement for services in which CHWs address social determinants of health,[4] and more than half of states allow reimbursement for CHW-provided services under state Medicaid plans.[5]

A robust body of literature exists on job satisfaction and burnout among health professionals such as physicians and nurses,[6–8] but less is known about CHWs. CHWs are a unique cadre in the health workforce who likely experience specific workplace challenges.[9,10] CHWs work with people who have significant health and social needs, which can expose CHWs to secondary trauma and burnout.[11] In many settings, pay is low, pathways for promotion are limited, and positions rely on grant funding, creating funding cliffs and job insecurity.[12] Moreover, CHWs are from the communities that they serve and confront many of the same vulnerabilities as their clients.[13]

It is imperative to understand CHWs' perspectives about their profession and working conditions to inform policies and initiatives to support this critical workforce.[14] In this mixed methods study, we explored Indiana CHWs' perspectives on career advancement, burnout, and leaving the profession.

METHODS

As of May 2023, the Bureau of Labor Statistics estimated that there were 980 CHWs employed in Indiana.[15] The Indiana Community Health Workers Association was established in 2013 to support CHWs through advocacy, education, and evidence-informed practices and policy. Indiana became the second state to allow Medicaid reimbursement of CHW services through a state plan amendment in 2018, but use has been low owing to complex billing procedures and insufficient reimbursement rates.[16]

Study Design

We conducted a statewide cross-sectional survey of CHWs in Indiana, which we adapted from an existing tool,[17] pilot tested with CHWs, and distributed in partnership with the Indiana Community Health Workers Association and investigators who led a CHW needs assessment in 2020. The final survey included 56 questions across 8 survey domains.

We describe findings related to CHWs' perspectives on career advancement and job satisfaction. Findings related to other survey domains are reported elsewhere.[18] We assessed perspectives on career advancement (5 questions), burnout (8 questions), and leaving the CHW profession (8 questions) using Likert scale questions. The survey included 6 open-ended questions about career advancement, pay and benefits, and workplace challenges and strategies.

Individuals aged 18 years or older who self-identified as a CHW using the American Public Health Association's definition were eligible. The survey was anonymous and administered electronically via REDCap (Vanderbilt University, Nashville, TN). To recruit participants, we created a public web page and sent invitations through an Indiana Community Health Workers Association listserv of 1700 individuals certified as CHWs (who were not necessarily working as CHWs) and through 11 CHW employers across Indiana. These organizations included health departments, health care systems, community-based organizations, and a community health coalition, and we identified them through public records and interviews conducted as part of a separate project. As an incentive, participants could enter a raffle for a $100 gift certificate. We collected data between March and August 2024.

Analysis

We conducted a mixed methods analysis using a convergent parallel design, analyzing quantitative and qualitative data separately and then integrating them for interpretation. For quantitative data, we calculated descriptive frequency counts and percentages. We calculated mean scores for each domain if all or only 1 question was missing in a domain by summing nonmissing values and dividing by the number of available values. We scored questions in the career advancement domain from 1 (strongly disagree) to 5 (strongly agree) and questions about burnout and leaving the profession from 1 (never) to 5 (very often). We summarized a mean score for each domain separately with mean and SD by employer type (government, health/academic, or social/community organization) and compared it using 1-way analysis of variance. We made pairwise comparisons from analysis of variance using the Fisher protected least significant difference with a significance level of 5%. We tested internal consistency within domains using the Cronbach α and tested correlations between the 3 domains. We performed all analyses using SAS version 9.4 (SAS Institute, Inc., Cary, NC).

We used qualitative content analysis to analyze open-ended survey responses.[19,20] Three authors (M. L. S., M. R. T., and J. T. J.) reviewed text data separately to identify preliminary codes using both deductive and inductive strategies. Over 6 weeks, the team refined the coding framework employing a constant comparison approach.[21] We identified, organized, and discussed themes for each question and then compared them across questions. We used member checking to support interpretation. We identified quotations through consensus to illustrate dominant themes, and except in 1 instance, each quotation is from a unique participant, who we identify by gender, age, and employer type. We provide additional quotations alongside relevant codes, themes, and interpretation in Figure A (available as a supplement to the online version of this article at http://www.ajph.org).

RESULTS

A total of 282 CHWs participated in the study. A majority of participants identified as female (92%) and non-Hispanic Black/African American (39%) or non-Hispanic White (38%). The mean age

was 41 years (Table 1). Most (82%) respondents were full-time paid employees and had a median of 2 years of experience. CHWs worked under various titles and settings in all 92 Indiana counties; 46% worked in Marion County (which includes Indianapolis). Information about respondents' employment setting, pay, roles, and responsibilities is reported elsewhere.[18] There was a steep drop-off in responses to qualitative questions; 62% of participants responded to at least 1 free-text question, and 18% responded to all 6 questions. The demographics of participants who responded to qualitative questions were not significantly different from those who did not, except for age, with older participants more likely to respond.

Perspectives on Career Advancement

Less than half of respondents agreed or strongly agreed that there were opportunities for pay raises (39%), for promotion at their organization (44%), for advancement in the profession (42%), and for assuming leadership roles as CHWs (49%; Table 2). Opportunities for advancement included supervision of other CHWs, but these roles often required further education and different scopes of work. As stated by 1 respondent:

> The only opportunities for promotion or movement are to supervise other CHWs, which doesn't really exist in my organization. . . . As we aren't required to have a degree, that limits us from promotion and the only "promotion" or pay increase is to do a non-CHW job like case management. (woman, aged 27 years, community/social services organization)

Respondents felt more positive about opportunities to develop professional skills, but in many cases, this did not lead to pay increases or promotions, which 1 participant described as "lateral transitions" (woman, aged 40 years, health/academic organization). Several respondents described the impact of COVID-19–related funding, with 1 participant noting:

> My employer is currently downsizing our outreach department due to budget cuts, as COVID grants are disappearing and nonprofit agencies are reducing the workforce back to prepandemic levels. This will affect our services to the community, as well as affecting my ability to move up in my agency. (woman, aged 44 years, health/academic organization)

Recommendations for career development included organizations creating specific positions for CHWs that used their skills (respondents listed "team lead," "supervisor," and "manager") and supporting additional training, including certification and degree programs.

Experiences of Burnout

Approximately half of participants (51%) expressed feeling burned out at least monthly owing to the emotional weight of their clients' circumstances. Several respondents framed the emotional toll of their work to highlight that CHWs, while taking care of others, needed support themselves, with 1 participant saying:

> This work is mentally and physically exhausting and incredibly rewarding. I would like to see us serve ourselves while also serving others! We cannot pour from an empty cup. As we are caring for those in dire need, who is caring for the well-being of the CHW? (nonbinary, aged 38 years, health/academic organization)

More than half (53%) of participants reported feeling burned out owing to not being able to connect clients to resources. Participants felt that either they were not equipped, empowered, or connected to resources to support clients, especially to address social determinants of health, or resources simply did not exist. One participant described how this made them feel like their work was "pointless . . . because the resources for the [client] needs are just not available" (male, aged 26 years, employer missing). More than 60% of participants reported burnout from clients "not doing their part" in connecting to resources, but this did not emerge in qualitative data. Participants highlighted the need for organizational support for CHW wellness programs, counseling, and more supportive supervision to address issues of burnout, but in most organizations this level of organizational support and resources was lacking.

Perspectives on Leaving the Profession

The most common contributors to feeling inclined to leave the CHW profession were pay and job-related stress, with almost half of respondents (49% and 48%, respectively) considering these as reasons to leave the position on at least a monthly basis. Low pay was often contrasted with the underrecognized value and skills that CHWs brought to their organizations, teams, and communities. One respondent

TABLE 1— Study Participant Characteristics: Community Health Workers Survey, Indiana, March–August 2024

	Frequency, No. (%) or Median (Interquartile Range)
Age, y (n = 281)	
18–24	23 (8.2)
25–34	65 (23.1)
35–44	76 (27.0)
45–54	63 (22.4)
55–64	45 (16.0)
≥ 65	9 (3.2)
Gender (n = 274)	
Women	254 (92.7)
Men	18 (6.6)
Nonbinary	2 (0.7)
Race/Ethnicity (n = 277)	
Non-Hispanic Black/African American	107 (38.6)
Non-Hispanic White	105 (37.9)
Hispanic/Latino	37 (13.4)
> 1 race	19 (6.9)
Asian	4 (1.4)
Preferred not to say	4 (1.4)
Arab American	1 (0.4)
Education level (n = 279)	
High school/general equivalency development	20 (7.2)
Some college	78 (28.0)
Trade school	11 (3.9)
Associate's degree	50 (17.9)
Bachelor's degree	87 (31.2)
Master's degree	31 (11.1)
Doctorate degree	2 (0.7)
Employer type (n = 279)	
Health/academic	139 (49.8)
Community/social service	87 (31.2)
State/local government	30 (10.8)
> 1	12 (4.3)
Not affiliated with an organization	7 (2.5)
Other	4 (1.4)
Position title (n = 282)	
Community health worker	140 (49.6)
Community health outreach worker	24 (8.5)
Patient navigator	17 (6.0)
Community health advocate	11 (3.9)
Health educator	11 (3.9)
Other	79 (28.0)
Years of experience (n = 275)	2 (0.5–5)

TABLE 2— Perspectives on Career Advancement, Burnout, and Leaving the Profession: Community Health Workers Survey, Indiana, March–August 2024

	Frequency, No. (%) of Responses				
Domain	**1**	**2**	**3**	**4**	**5**
Career advancement[a] (n = 233)					
I have opportunities for promotion at my organization.	22 (9.4)	41 (17.6)	67 (28.8)	69 (29.6)	34 (14.6)
There are good opportunities for advancement in the CHW profession.	14 (6.0)	38 (16.3)	83 (35.6)	70 (30.0)	28 (12.0)
I have opportunities to continue to develop my professional skills.	3 (1.3)	9 (3.9)	41 (17.6)	123 (52.8)	57 (24.5)
I have opportunities for pay raises as I continue in my work as a CHW.	20 (8.6)	40 (17.2)	81 (34.8)	66 (28.3)	26 (11.2)
I have opportunities to assume leadership roles.	21 (9.0)	32 (13.7)	66 (28.3)	81 (34.8)	33 (14.2)
Reasons for feeling overwhelmed or burned out[b] (n = 216–220)					
Not being able to connect clients to resources they need	57 (25.9)	46 (20.9)	70 (31.8)	38 (17.3)	9 (4.1)
Delivering care beyond the scope of the role	72 (32.9)	41 (18.7)	63 (28.8)	29 (13.2)	14 (6.4)
Focus on quantity of clients over quality of services	79 (36.6)	34 (15.7)	55 (25.5)	33 (15.3)	15 (6.9)
Client not doing their part in connecting to resources	50 (22.8)	34 (15.5)	80 (36.5)	41 (18.7)	14 (6.4)
Carrying the emotional weight of clients' circumstances	53 (24.1)	56 (25.5)	64 (29.1)	35 (15.9)	12 (5.5)
Lacking adequate supervision	125 (57.6)	51 (23.5)	25 (11.5)	13 (6.0)	3 (1.4)
Feeling underappreciated	89 (40.6)	43 (19.6)	46 (21.0)	25 (11.4)	16 (7.3)
No opportunity to provide input	109 (50.2)	46 (21.2)	39 (18.0)	13 (6.0)	10 (4.6)
Reasons for feeling inclined to leave the profession[b] (n = 219-222)					
Work hours	141 (63.5)	38 (17.1)	30 (13.5)	9 (4.1)	4 (1.8)
Rate of pay	69 (31.5)	43 (19.6)	56 (25.6)	32 (14.6)	19 (8.7)
Ability to help/make a difference	126 (57.5)	43 (19.6)	33 (15.1)	6 (2.7)	11 (5.0)
Level of support from supervisor	120 (54.3)	39 (17.6)	34 (15.4)	14 (6.3)	14 (6.3)
Level of support from organization	102 (46.2)	43 (19.5)	38 (17.2)	25 (11.3)	13 (5.9)
Opportunity for growth in field	87 (39.4)	51 (23.1)	48 (21.7)	24 (10.9)	11 (5.0)
Level of stress	68 (30.6)	48 (21.6)	58 (26.1)	28 (12.6)	20 (9.0)
Support from coworkers	116 (52.3)	40 (18.0)	34 (15.3)	15 (6.8)	17 (7.7)

Note. CHW = community health worker.
[a]Rated on a Likert scale of 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree.
[b]Rated on a Likert scale of 1 = never, 2 = rarely (1–2 times in past year), 3 = sometimes (monthly), 4 = often (weekly), or 5 = very often (daily).

captured the complex interplay of these factors, saying:

> I feel as though I do not make enough [money] for everything that I do for [employer blinded] as well as what we do in the community. I feel as though we do not get raises, and we stay right where we are. . . . I don't think they see everything that we do. I am fearful because we are grant sponsored and our jobs will run out in May of 2025. (woman, aged 34 years, hospital/clinic).

The precarity of CHW positions contributed to job-related stress and was highlighted by respondents' own social vulnerabilities. As 1 CHW said:

> Currently I cannot afford my own place due to my low hourly wage and the increase in cost of living. I live with my elderly mother to survive. After caring for the community at work, I have to care for my mother after work. Caregiver fatigue occurs weekly for me. . . . I feel like I'm dealing with an internal ethical battle of wanting to make more money to provide for myself and family but also wanting to help others live better and healthier lives. (nonbinary, aged 38 years, health/academic organization)

To address prominent issues of attrition, participants stressed the importance of educating employers about the roles and value of CHWs. As 1 CHW stressed, "I have many roles as a CHW. . . . I suggest getting more information out in the communities and [to] employers about the versatility and functions of what a CHW is capable of"

(woman, aged 62 years, health/academic organization). Participants also stressed that CHWs needed to be seen as in a "professional role" to receive more "respect" and "acceptance" from employers and others and for CHWs to be given more leadership opportunities. The lack of opportunities to hold leadership positions and provide input led to feeling that those "making decisions" did not fully understand community needs and perspectives. As 1 CHW stated, "[they should] spend about two weeks with me to see the needs of those that we work with on a daily basis" (woman, aged 51 years, health/academic organization).

Differences by Employer Type

Perspectives on career advancement and burnout differed by employer type, whereas intention to leave the profession did not (Table 3). CHWs working for state and local health departments were significantly more likely to have positive views of opportunities for career advancement than were CHWs working in health or academic and community or social service organizations. We found that CHWs working in health departments were significantly less likely to report being overwhelmed or burned out.

Performance and Correlation of Measures

There was good internal reliability between survey items in all domains, with Cronbach α values of 0.86 for career advancement, 0.87 for burnout, and 0.89 for intention to leave the profession. A higher score for career advancement was negatively correlated with scores for burnout ($r = -0.28$; $P < .001$) and intention to leave the profession ($r = -0.42$; $P < .001$), meaning that respondents who reported more opportunities for career advancement reported less burnout and lower inclination to leave the profession. A higher burnout score was positively correlated with intention to leave the profession ($r = 0.66$; $P < .001$). The significant emotional and psychological toll and high-stress nature of CHW work was a primary theme in qualitative data that contributed to burnout and intention to leave the profession.

DISCUSSION

This study contributes to understanding the challenges facing CHWs in Indiana, many of which likely extend to CHWs across the United States. Burnout and turnover have myriad deleterious effects on the CHW workforce, their clients, and their employers.

Among 1014 CHWs who completed the national 2021 Public Health Workforce Interests and Needs Survey, 28% reported a desire to leave the profession in the next 5 years, up from 25% in 2017.[11] Consistent with our findings, the survey found that the desire to leave the profession was associated with being dissatisfied with pay, organizational support, opportunities for career advancement, and job security. Although our study was not designed to explore compassion fatigue, it emerged qualitatively as an important driver of burnout among CHWs, as they are frequently and uniquely exposed to the trauma and lived experiences of their clients.[10,22] High levels of turnover and funding cliffs may increase pressure on CHWs, requiring them to take on additional work and exacerbating burnout. Based on this study, we provide several recommendations to strengthen and empower the CHW workforce.

Identify and Disseminate Best Practices for Employers

Our findings call for significant expansion of resources and best practices that employers can use to support their CHW workforce.[23] These resources are emerging, but there is limited evidence of their impact on CHW careers and job satisfaction and adoption by employers.

TABLE 3— Career Advancement and Job Satisfaction Outcomes by Employer Type: Community Health Workers Survey, Indiana, March–August 2024

Summary Score Domain	Overall, Mean ±SD Score (no. responses)	Employer Type, Mean ±SD Score (No. Responses)			*P*
		Community/ Social Service	Health/Academic	Government	
Career development	3.4 ±0.9 (217)	3.2 ±0.8 (72)	3.4 ±0.8 (115)	3.9 ±0.9 (30)	<.001
Inclined to leave the profession	2.1 ±0.9 (207)	2.2 ±0.0 (66)	2.1 ±0.9 (112)	1.7 ±0.9 (29)	.13
Feeling overwhelmed or burned out	2.3 ±0.9 (203)	2.3 ±0.9 (64)	2.4 ±0.9 (110)	1.8 ±0.8 (29)	.005

For example, the URAC Community Health Worker Program Accreditation provides resources for employers on CHW training, supervision, professional development, and organizational resources. In South Carolina, its CHW Credentialing Council in partnership with the state's CHW professional association and other partners created a 3-tiered certification program alongside example job descriptions for employers, with plans to educate employers on implementing tiers with appropriate salary increases in their organizations. Data from these programs can inform future workforce initiatives and policy, and more studies of organizational characteristics and strategies that promote CHW well-being and job satisfaction are needed.[24]

Invest in Career Pathways

There is an urgent need for organizations to invest in career pathways for CHWs that provide opportunities for promotions and salary increases while still fulfilling core CHW responsibilities. Our findings are consistent with a National Association of Community Health Workers survey in which CHWs identified higher wages, prioritization of lived experience over formal education, professional development and training opportunities, and retention of the CHW title as the most important factors in developing career pathways.[25] Career development pathways should value lived experiences and connections with communities as central professional identities while not excluding those without formal education and credentialing.[26,27] Several employers and credentialing councils across the United States are piloting and implementing career advancement models for CHWs based on years of experience, training and certifications, competencies and scopes of practice, and mentorship of other CHWs.[25] For example, the Penn Center for Community Health Workers offers 2 career tracks for CHWs in their program, with 1 focused on direct care and service to clients and a second focused on advocacy, community engagement, management, and 4 promotion levels.

Ensure Training and Adequate Preparation

Major stressors for CHWs in this study were not being able to connect clients to resources, clients not doing their part in care, and delivering care beyond their scope. CHWs support individuals facing multiple vulnerabilities and navigate complex health and social systems. Previous qualitative work reveals the structural barriers that CHWs face in their work that hinder connecting individuals with resources, even with CHW support.[28] These findings support strong systems- and policy-based training for CHWs to navigate structural barriers and identify solutions. In our study, CHWs working for state and local health departments were less likely to report challenges in linking clients to resources. One local health department with an established CHW program was overrepresented in our survey, which may in part explain the finding that these CHWs had more positive views of career advancement and less burnout. Ensuring appropriate scopes of work and caseloads, mental health support, and trauma-informed training are critical to addressing burnout and turnover.

Expand Ways to Measure Value and Impact

Finally, although we highlighted key challenges facing the CHW workforce in Indiana, CHWs reported many positive aspects of their work and profession. These aspects were grounded in the intrinsic value many CHWs found in serving clients and communities and "compassion satisfaction," which can serve as motivators to stay in the profession and protect against burnout.[10,22] Several CHWs stressed that the true value of their work to clients, communities, and organizations had yet to be fully realized and appreciated by organizations, social care systems, and researchers. Cost-effectiveness studies using clinical endpoints such as reductions in hospital visits are often cited to advocate for CHWs; however, from the perspective of CHWs in our study, these ignored the many other benefits to individuals served by CHWs and the ripple effects in communities beyond clinical care.[2] Methods to identify and incorporate these outcomes will help to better evaluate the value and impact of CHWs on individual and community health and as "forces of change."[29]

Limitations

There are several limitations to this study. First, this was a cross-sectional survey of CHWs in Indiana. Although we attempted to sample broadly, there is no central registry of CHWs in Indiana so estimating the reach and representativeness of the survey was difficult. There were fewer respondents employed in government settings and overrepresentation from 1 local health department. Still, we believe that our survey sample is robust, with respondents coming from across the state and participation consistent with other published workforce surveys.[17,30] We followed best practices for surveying the CHW workforce, including pilot

testing with CHWs and engaging the state's professional body.[31]

Second, we adapted questions from a tool that the Michigan Community Health Worker Alliance developed and used for their biannual CHW survey. We did not validate questions on career advancement, burnout, and intention to leave the profession, and standardized measures are needed. Strategies to enhance the robustness of these measures in this setting included pilot testing of the instrument, internal consistency testing, and supplementing quantitative findings with qualitative insights. We conducted sensitivity analyses to ensure that participants who responded to free-text questions were not significantly different from those who did not.

Third, the survey was available only in English and only electronically. It is possible that non-English speakers and those who do not have access to a computer or the Internet were underrepresented. It is also possible that individuals could have participated in the survey more than once; to prevent duplicate responses, we reviewed surveys for matching demographic information (we did not identify any duplicate surveys). Lastly, respondents were allowed to skip survey questions, resulting in missing data; however, the response rate we received suggests overall CHW willingness to provide input on workforce development.

Public Health Implications

There has been increasing attention to CHWs as a critical cadre of the health workforce in the United States. Evidence on the effectiveness of CHWs on reducing the cost of care and moving "upstream" to tackle social determinants of health and health disparities is widely reported.[2] Policy reforms expanding funding for CHW workforces at federal and state levels, including reimbursement through Medicare and Medicaid and the Health Resources and Services Administration's CHW training program, are important steps forward.[32] Our study shines a light on key challenges and opportunities to further bolster the CHW workforce. Insights from CHWs on opportunities for career advancement and working conditions are critical to inform workforce initiatives and investments by federal and state organizations and employers.

Promising strategies identified in our study based on recommendations from CHW participants include educating and partnering with state, local, and employer organizations to define CHW roles, building new career ladders and pathways, and enhancing organizational support for navigating structural barriers and trauma-informed training and care for CHWs. Living and competitive wages are critical, but health system payors' reimbursement for CHW services remains far below what is needed.[33] Initiatives to strengthen the CHW workforce by states, employers, and CHW organizations provide important opportunities for research and to inform policy at local and national levels.[34] Central to these efforts must be ensuring CHW career paths, fair pay, and support in carrying out the important and difficult work of community health. AJPH

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CONTRIBUTORS

M. L. Scanlon and D. K. Litzelman led the conceptualization and design of the study and drafted the article. M. R. Thomas and J. T. Jackson contributed significantly to qualitative data analysis and drafting the article. Q. Tang led the analysis and interpretation of quantitative survey data. J. D. Gonzalvo, Y. Ruiz, and M. Hart provided significant input on study design, data interpretation, and critical review and revision of the article. All authors read and approved the final version of the article.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to report.

HUMAN PARTICIPANT PROTECTION

This study was approved by the Indiana University institutional review board (IRB protocol: 21790).

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