American Journal of Qualitative Research
2026, Vol. 10 No. 3, pp. 269-282
https://doi.org/10.66815/ajqr/18699

AMERICAN JOURNAL OF QUALITATIVE RESEARCH
ISSN: 2576-2141

Community Health Worker Motivation in the U.S.: A Descriptive Qualitative Research Study

Dennis Kirimi
Pathways HUB Community Action, Akron, OH, USA

Sheryl L. Chatfield[1]
Kent State University College of Public Health, Kent, OH, USA

ABSTRACT
Community Health Workers (CHWs) play a critical role in improving access to preventive services for lower resourced, underrepresented individuals, although most research in the U.S. is focused on program efficacy rather than CHW motivation and job satisfaction which may play a role in higher than ideal turnover among CHWs. The purpose of this research was to investigate motivation of U.S. based CHWs to develop recommendations for recruitment, retention and professional development. The constructs of competence, autonomy and relatedness from self-determination theory were used to frame data gathering and analysis. Fifteen practicing CHW participants in seven focus groups described their thoughts regarding motivations, challenges, and career growth. Qualitative analysis revealed four themes: Preparing for the CHW Role; Navigating the CHW Role; Thriving in the CHW Role; Reflecting on the CHW Role. Key findings within themes included CHWs were motivated to enter the profession as a result of having similar lived experiences to clients they served, and experienced ongoing motivation from contributing to health improvement in their home communities. While CHWs described profound challenges related to client needs and limited resources, participants experience competence in navigating challenges and were often autonomous in their work although some felt loss of control when client needs surpassed available resources. The growing need for CHWs may be addressed through an expansion of available training so CHWs can train and work in their home communities. A modified residual market scheme with private health insurers may have potential to facilitate viable and economically beneficial expansion of CHW practice.
KEYWORDS: Community health workers; Focus groups; Qualitative; Motivation; Self-determination theory; health disparities; healthcare financing

Approximately six out of ten Americans live with at least one chronic disease, including heart disease, cancer, or diabetes. These diseases comprise the leading causes of death and disability and are the drivers of high health care costs in the U.S. (Centers for Disease Control and

[1] Corresponding author: Sheryl L. Chatfield, PhD., Associate Professor, College of Public Health, Kent State University, Moulton Hall, 800 Hilltop Drive, Kent, OH, USA 44242. Email: schatfi1@kent.edu

Prevention [CDC], 2019). Benjamin (2011) observed the combination of prevention and management of chronic diseases has potential to greatly reduce the direct and indirect costs associated with chronic disease in the U.S. However, additional challenges are presented by the structure of the healthcare system, where quality of and access to care varies based on a range of individual and environmental factors including income level, type of insurance, geography, and demographic characteristics (Sommers et al., 2017).

One potential strategy for reduction of the negative consequence of chronic disease is provided by increased access to Community Health Workers (CHWs), who are charged with providing support to at-risk individuals. CHWs have potential to improve access to preventive care, and to facilitate reduction in hospitalization and re-hospitalization rates (Sharma et al., 2019).

Despite the increasing value of CHWs in the U.S., Jones et al. (2022) described the profession as characterized by highly variable pay rates and instability of income. The latter is exacerbated when positions rely on limited duration grant funding, or when only part time positions are available. Along with this, according to Jones et al., the 2021 turnover rate among CHWs, combining departure and transfer into other positions, was estimated at 12%, a rate that is substantially higher than the rate of just over 9% reported for all other occupations. The typically low level of compensation may play a profound role in turnover, as the median annual income for U.S-based CHWs is roughly $10,000 less than all other occupations (Jones et al., 2022). Kirkland et al. (2024), using a subset of responses to a national public health workforce survey, concluded that intent to leave a CHW position among U.S.-based CHWs was primarily associated with dissatisfaction with perceived organizational support, concerns about job security, and pay.

U.S.-based CHWs have identified service delivery challenges which complicate their ability to engage in practice. These include lack of integration into the primary care setting, increased demand for technology skills, such as familiarity with data entry and retrieval needed to interact with electronic health records, lack of structured working space, and lack of essential clinical skills needed to facilitate effective interaction with other members of care teams. When not addressed, the lack of training and high demand associated with CHW practice may lead to poor performance and further contribute to concerningly high turnover rates (Chapman et al., 2017). Despite high turnover, however, a substantial number of CHWs accrue lengthy tenures in their positions. This suggests the presence of other motivating factors beyond compensation and working conditions.

Multiple researchers in the global south have explored how CHWs view their practice. Steege et al. (2020) asserted factors including career progression and access to better resources could improve retention among CHWs in Mozambique. Relatedly, Oladeji et al. (2022) concluded CHWs in Ethiopia desired supportive management, and career mentoring and progression opportunities. However, there has been limited focus in the U.S. on how the performance of CHWs is affected by individual factors such as personal fulfillment, job satisfaction, and the capacity to facilitate empowerment of communities (Kangovi et al., 2014). Instead, performance and efficacy of CHW-provided programming in the U.S. is conventionally evaluated ~~user end~~ via assessment of impact or practice on patient and community health (Kangovi et al., 2014; Weaver & Lapidos, 2018). Identifying and gaining understanding of CHW perceptions of internal factors has potential to influence CHW motivation, which might reduce turnover and critically impact program outcomes (Weaver & Lapidos, 2018).

To encourage workforce retention and address the continuing need for CHWs to address anticipated increases in chronic disease rates, it is a critical to better understand the context and conditions in which U.S.-based CHWs work (Covert, 2019). . This understanding might support CHWs in improving their performance and realizing their potential from their own perspective

(Kok, 2011), and, in turn, can facilitate program success. To this end, documenting the lived experiences of CHWs can provide better understanding of these essential care workers and their motivations for remaining in the workforce, despite previously described challenges associated with compensation and context of work.

Clearly any exploration of CHW motivation in the U.S. would benefit from use of a design that elicits CHWs' own descriptions of the intersection of their lives and their profession, acknowledges CHWs' lived experiences, and so contributes development of crucial theoretical insights and associated practical implications – especially in terms of informing policy development that seeks to integrate CHWs into the broader public health workforce (Logan, 2018). Relatedly, use of qualitative methods, including interview research, which have potential to elicit retrospective narratives of CHWs practice and their lives, may illuminate their perceptions of working relationships among CHWs, communities, and health institutions, and, in turn, enhance the ability of programs to serve communities effectively (Maes et al., 2014).

Theoretical Framework

This present research study is framed within the self-determination theory (SDT) of human motivation and personality that concerns people's inherent growth tendencies and innate psychological needs, identified as competence, relatedness and autonomy (Deci & Ryan, 1985). Using group interviews with community pharmacists, Walker et al. (2024) found SDT a useful framework for exploring issues related to burnout and motivation. This suggests SDT is an appropriate theoretical framework to guide research focused on the context and conditions for CHWs, another community-based health profession. Therefore, the specific research question to be addressed, reflecting the intersection of the problem, purpose, framework, and key findings described from relevant international research is: how do CHWs in the U.S. describe their motivation for their practice across the span of their career?

Methods

Qualitative Approach

~~After~~ Descriptive qualitative research can build or refine theory inductively to offer in-depth understanding of people's perception of their day-to-day situations in particular settings (Sandelowski, 2000). For this descriptive study, explorative and interpretative approaches to data gathering and analysis were employed. Focus group interviews, the method used, offer the advantage of spontaneous interactions and common reflections which can enhance new insights and so yield enriched range of information compared to individual interviews (Gundumogula & Gundumogula, 2020).

Participants and Informed Consent

Focus group participants were recruited among CHWs working in Northeast Ohio. Participants provided prior written consent and verbal consent during group interviews. A university institutional review board approved the research prior to recruitment.

A final total of 15 participants were recruited. These included 11 female and 4 male participants. Of participants, 12 were Black or African American, one was White and two were Latino or Hispanic CHWs. Duration of work experience included: four to six years of work

experience (12 CHWs), one to three years (two CHWs) more than six years' experience (one CHW). Four participants were ages 27 to 34, six participants were ages 35 to 42, five participants were ages 43 to 50.

Focus Group Process

A semi-structured focus group interview guide was developed based on review of previous research, refined as needed to reflect the research aims and address the research questions. Face validity (Stokes, 2010) was assessed through expert review by individuals with methods and subject matter experience.

A total of seven focus groups took place between 2021 and 2023, with 3-5 CHWs per group. Due to modification of processes as a result of the COVID-19 pandemic, in 2022 and 2023, focus group interviews were reconvened with the original participants, to ensure information reflected typical working conditions. All focus groups were conducted virtually using Zoom platform and moderated by the first author; average duration was 60 minutes.

Data Processing and Analysis

Interviews were audio recorded, and complete anonymized transcriptions were produced. Data followed a general strategy of engaging in cycles of coding to develop higher order categories and themes (Saldaña, 2016). Quirkos (2023) data analysis software and Microsoft Excel were used to facilitate data analysis. The first cycle consisted of application of open codes, using summarizing words or phrases based on the data itself (Gibbs, 2007). Next, pattern coding was used to derive higher order categories or concepts from clusters of similar codes (Saldaña, 2016). Pattern codes were condensed using processes including subsumption, abstraction, contextualization, and functional methods, described by Smith et al., (2022). The condensed pattern codes suggested a process-based theme structure. ~~which~~ Theme and subtheme labels were further refined to illustrate participant lived experiences in an authentic and accessible way, while addressing the purpose of the research.

Ethical Considerations

This research was approved by The Kent State University Institutional Review Board as file number 21-027. All participants were given study and consent information to review prior to participation. All participants who contributed data which informed this report provided written informed consent prior to enrollment in the study.

Results

The results of qualitative data analysis are presented as four main themes with three to five associated subthemes for each. Subthemes are evidenced and illustrated by excerpts. Table 1 shows themes, subthemes, and example excerpts.

Table 1
Themes, Subthemes and Excerpts

Theme/ Subthemes	**Example Excerpts**
Preparing for the CHW role	
Growing into the CHW profession	*"I ended up having to raise my siblings…"*
Applying lived experiences to the CHW role	*"…encountering social determinants of health in so many different forms. . .throughout my life"*
Accessing community resources	*"I'm connected with [organization] that supply me a lot of stuff like food…"*
Navigating complexities of the CHW role	
Experiencing pandemic-associated challenges	*"Everybody went through like a super crisis, like everybody lost their job at one time, kids were out of school at the same time."*
Managing pay-related challenges and workforce strain while serving high-risk populations	*"Right now, I am doing the job of about four people." "I actively get help get them connected to car seats, cribs . . . housing resources. . women's shelter . . . children's service issues, school issues. . ."*
Continually working	*"How do we get our supervisors and the powers to be to understand that everything can't be Monday through Friday, nine to five, because that's not when real life happens?"*
Integrating in the health system	*"…they think you don't have as much value or worth that you're bringing to the table"*
Thriving in the CHW role	
Encouraging behavior changes through lived experiences	*"For me, it was my own experience being a single mother and having to navigate applying for all the services and finding all the resources that I needed."*
Mastering communications skills and strategies	*Those skills and tools are applicable in every aspect of your life . . .being able to effectively communicate with other human beings is a must."*
Providing services for diverse populations	*"When I became aware of the astronomical number of Black women and babies that were dying in childbirth, that's when I wanted to pivot and come into this field."*
Learning quality improvement	*[quality improvement processes are like] "smoke detectors, that signifies danger of fire"*
Reflecting on the CHW role	
Pursuing other avenues to career growth	*I had to quit [a good paying job] because they wouldn't let me finish school. So, then I joined AmeriCorps. . .and they*

	offered it to me to become a community health worker while I was in their program."
Experiencing extrinsic and intrinsic motivators	*"I know this is a calling for me. . . this is much greater than a paycheck . . .that's what motivates me . . . "*
Experiencing fulfillment in CHW practice	*"As long as I know I'm able to help . . . ten moms out then I feel good about that and then I just keep on going."*

The subthemes associated with *Preparing for the CHW Role* reflect data describing CHW entry into and initial experiences as health resource providers.

In the subtheme *Growing into the CHW profession*, CHWs described their cultural beliefs, chronic health conditions, disabilities, and life experiences similar to the people in the community they service. CHWs typically work with communities experiencing health inequities and perform activities and are uniquely positioned to engage in task such as outreach, community education, informal counseling, social support, and advocacy. One described how their early life comprised an extended training period:

> I have been a community health worker since I was about six years old, realistically speaking. I just wasn't getting paid for the work that I did.. . .so therefore, I ended up having to raise my siblings and became a teen mother at a very early age.

Other participants described their previous experiences as clients while some CHWs continue to experience the same needs as their clients. One CHW described the irony of providing support while still requiring support: "I'm dealing with X Y & Z [myself], and. . . I'm supposed to wake up every day and make these contacts with these patients and give them all these resources that I might not qualify for...".

CHWs also found themselves *Applying lived experiences to the CHW role.* One CHW recounted how needing social services inspired her to help others:

> The question I asked myself was, 'why would I be good enough to be one?' And I think the answer to that is having lived experience with chronic health issues and encountering social determinants of health in so many different forms and capacities throughout my life.

Effective CHWs are highly knowledgeable about *Accessing community resources* to meet their clients' needs. One described: "I'm connected with [organization] that supply me a lot of stuff like food. Anytime, if I tell them . . . 'I need this for my clients,' . . .they tell me . . . 'Come any day, you'll get what you need.'" CHWs are also personally committed to anticipating the need of their clients: "Some of [the resources I need], I have already in my stock . . .[and] I go to my stock or my balance and get them what they need, like diapers, like clothes."

The subthemes associated with the theme *Navigating the Complexities of the CHW Role* include accounts of CHWs navigating the unique challenges and complexities within CHW practice on an ongoing basis. The first set of focus group interviews also captured unique challenges associated with the COVID-19 pandemic, captured in the subtheme *Experiencing ~~challenges associated with the COVID-19~~ pandemic-associated challenges..*

The pandemic exacerbated the myriad existing health disparities among CHW clients, with increased difficulties associated with lack of food, housing, transportation, and access to the internet. Pandemic-associated requirements in Ohio resulted in suspension of home visiting and loss of face-to-face interaction with clients. This crippled the CHWs' ability to conduct adequate client needs assessments. Nevertheless, CHWs sought innovative approaches including virtual

meetings, phone calls, and face-to-face meetings at public places such as libraries while adhering to social distancing guidelines.

CHWs reflected on how the pandemic affected their work. One CHW observed: “people being pulled into programs for either contact tracing, clearly being pulled into doula, being pulled in other directions within your agency.” One CHW expressed the heightened need for client support: “Everybody went through like a super crisis, like everybody lost their job at one time, kids were out of school at the same time,” while emergent priorities impacted available funding. One CHW described: “One of the biggest challenges is all of the funding running out during COVID . . .we've lost all our rent assistance funding . . . food pantries offering delivery to clients have stopped.”

CHWs difficulty of continually earning a wage both livable and appropriate for the work was discussed in the subtheme *Managing pay-related challenges and workforce strain while serving high risk populations*. One described: "I make enough to survive, but I also want to get food stamps with my clients.” Another discussed the stressful combination of high workload and poor pay: “Right now, I am doing the job of about four people.” The frustration from poor pay led to another CHW expressing desire to move on professionally: “I am surviving and I'm not thriving. So, I need to do something else.”

CHWs highlighted complex needs for basic social and health care which emerge in the course of their practice:

> And I see anywhere from 15 to 20 patients, and I supply food to those families and. . .I actively help get them connected to car seats . . . help them get connected to housing resources. . . [or]women's shelter, depending upon their situation. Helping with children's services issues, school issues for their children, a lot of case management.

In the subtheme *Continually working,* participants in this research reported working long hours including weekends to meet their clients’ needs; one CHW expressed need for their supervisors to understand CHWs work and accessibility to clients is beyond the typical working days and hours: “How do we get our supervisors and the powers to be to understand that everything can't be Monday through Friday, nine to five, because that's not when real life happens?” Another CHW noted: “the two babies that we did lose in the course of the three and a half years I've been a [HEALTH SYSTEM] employee [happened] in the evening and on the weekend”. Because of the fear of what might happen to their clients, CHWs end up availing themselves to the clients even after hours; “It's an unbelievable job that everybody is doing to commit their time to help their clients . . .it's [being] available all the time.”

CHWs described some of the structural challenges associated with *Integrating in the health system,* due to lack of recognition as a part of the care team. One CHW described: “…they think you don't have as much value or worth that you're bringing to the table,” although, as another CHW described: “it is a very vital role in connecting the community to the medical professionals.”

The set of subthemes within *Thriving in the CHW role* focused on CHWs competencies relating to skills enhancement, use of sophisticated communication strategies, and providing and assessing appropriate services.

CHWs shared their practice of *Encouraging* (client) *behavior changes through lived experience*: “For me, it was my own experience being a single mother and having to navigate applying for all the services and finding all the resources that I needed.” Another started his work of caring for others in a refugee camp: “I saw a lot of people missing care and I devoted myself to help them, like taking them to the hospital, trying to connect them with some of the resources that were around in the camp.”

CHWs invest time and hone their listening skills to build rapport, critical to understanding individual client needs, captured in the subtheme *Mastering communications skills and strategies.* One described: "Motivational interviewing was a serious game changer for me personally. Those skills and tools are applicable in every aspect of your life . . .being able to effectively communicate with other human beings is a must."

Trust in the community is an important asset in linking community to health systems. One of the CHWs' social functions is building trust with the community by offering empathy, compassion, and building trust of their clients. One described "...not pushing them too far if you can feel that it's an uncomfortable topic, showing empathy and reassuring them." CHWs consistently cited these values as the key to success in their roles.

CHWs in this research were engaged in *Providing services for diverse populations.* They continually addressed the health needs of targeted Medicaid and Medicare participants who are pregnant, pediatric, adolescent, have complex chronic conditions, and may have additional behavioral or physical health needs. One CHW who is a second generation of an immigrant family, gives back to her community by providing interpretation to address language barriers. She described: "I'm the only child of a single immigrant mother, so the language barrier has always been something that I've seen firsthand." CHWs are assigned clients in various programs including re-entry programs. One described: "I'm . . .working with women who are pregnant, who are incarcerated, and trying to connect to them with services, provide education. . . trying to find help for when they come out, or if they come out." One CHW described how awareness of health and racial disparities in public health drew them to the profession: "When I became aware of the astronomical number of Black women and babies that were dying in childbirth, that's when I wanted to pivot and come into this field."

Data collection and documentation in electronic health records is key to CHW role. For participating CHWs, they are *Learning quality improvement* through an ongoing process which communicates personalized feedback on the completeness of the required documentation monthly, through scorecards. One CHW characterized the quality improvement process as being like: "smoke detectors, that signifies danger of fire" by promptly identifying and offering opportunities to correct deficiencies in data gathering and documentation.

The fourth and final set of subthemes captured CHWs' impressions while *Reflecting on the CHW Role.* In addition to acquiring a wide range of experiences and skills, CHWs value the importance of formal education and career advancement and are *Pursuing additional avenues to career growth.* These include completing additional certification courses and engaging in continuing education to maintain their CHW certification and advance their career." One current CHW chose to leave a well-paying job which did not support her goal to complete formal education. "I had a really good paying job. . . and I had to quit because they wouldn't let me finish school. So, then I joined AmeriCorps [making less money but receiving educational support]...and they offered it to me to become a community health worker while I was in their program." Others have completed certifications to enhance their CHW professional practice, including certifications in lactation and grief counseling and university credentials such as graduate degrees.

CHWs shared their motivation to do their work based associated with *Experiencing intrinsic and extrinsic motivators.* One described the CHW role as transcending the notion of a career: "I know this is a calling for me. . . this is much greater than a paycheck . . .that's what motivates me . . . "

One CHW described how addressing community needs was personally motivating:

> For me, it's just pretty much that I serve women just like myself. I'm from, of course, the community. I live in a community. I have clients that live

> probably right around the corner from me. I'm seeing them in a grocery store and we're just going through the same issues. But I guess what helps is the fact that if I learned of more resources, [I could] better support them.

CHWs described *Experiencing fulfillment in the CHW role,* being passionate about their work, feeling a sense of contentment, feeling successful when the needs of the families they serve were met which families demonstrated by increasing independence. Speaking about the program participants, one CHW said "As long as I know I'm able to help . . . ten moms out then I feel good about that and then I just keep on going." Another explained that despite the challenges to being in the role, "the pros outweigh the cons." CHWs find pleasure when they support the most vulnerable populations to gain self-sufficiency as described here: "I'm just happy to see them being able to get out of the shelter and settle."

Discussion

This descriptive qualitative research study, framed within the constructs of competency, autonomy, and relatedness from SDT (Deci & Ryan, 1985), aimed to explore CHWs motivation to perform their role throughout the span of their careers. The results were expressed in a thematic structure and provided insight into the unique role of CHWs in addressing social inequities for diverse and at-risk individuals in their communities while at times continuing to navigate similar challenges themselves. Key concepts identified in the results include the critical role of lived experience, including priority on applied experiences as sources of professional advancement, the value of insider knowledge gained from the combination of lived experience and community and resource knowledge, and seeing CHW work as a calling and not just a vocation. In this section we consider these in comparison with prior research and discuss implications for practice and policy.

For some CHWs who participated in this research, their authentic lived experiences contributed more than formal education to their career advancement Thriving for some CHWs means creatively recombining the lived experiences they brought to the role with skills acquired through CHW training and experiences accrued while in the role. Related to the notion of continuing to expand lived experiences through CHW practice, Smithwick et al. (2023) reported CHWs engaged in the profession value and advocate for opportunities to participate in mentorship, program design, and advocacy, and rated participation in these activities as more important factors when considering desire and preparation for advancement than formal education.

Congruent with findings reported by Lucio et al. (2012), CHWs in this research presented passionate and intimate knowledge of social and health services within their community. This knowledge was facilitated through lived experiences and further developed through efforts to provide diverse services for diverse populations, although it remains solidly rooted in being a member of the communities being served. Fakunle and Hernandez Delgado (2026) described ~~the~~ how lack of trust in healthcare systems by some members of ethnic minorities, rooted in awareness of past unethical practices, led to apprehension about healthcare services. CHWs in this research described awareness of disparate outcomes and commitment to use their insider status in combination with professional skills, to facilitate health improvements. Consistent with this, Strachan et al. (2012) suggested community perception of ownership of CHW-facilitated programs is a predictor of program and individual perceptions of success.

Viewed through the lens of SDT (Deci & Ryan, 1985) CHWs experienced competence with respect to performing job tasks which resulted from their own lived experience combined with strategies developed while working in the profession, although CHWs described threats to autonomy and relatedness, other key precursors of motivation. Many CHWs described working

long and non-standard hours, which when characterized as a matter of choice rather than requirement, illustrated a perception of autonomy. That said, as human science researchers, we are aware that burnout can occur when overtime becomes an expectation rather than a choice, and do not view voluntary overtime as a sustainable solution to under resourcing. In SDT-framed research with community pharmacists, Walker et al. (2025) identified facilitators of burnout, including insufficient staffing, unrealistic expectations, and excessive challenge, which had a negative impact on autonomy, relatedness and competence, respectively.

Some CHWs described the value of engaging with those from other communities, to share experiences and empathize with others' challenges. CHWs also described a credibility gap when interacting with medical professionals, who might not appreciate CHW contributions due to contrasting training and practice priorities. For some CHWs, being recognized as an authentic part of the client care team would provide another meaningful dimension of relatedness.

Finally, participants described how the profession was more than a vocation. One characterized her work as a calling rather than a job. Similarly Logan (2018) and Ormel et al. (2019) identified intrinsic motivation as a key factor in retention for both paid and volunteer CHWs.

Implications for Practice and Policy

Results of this research suggest CHWs value ongoing affiliation with their communities, in contrast to some other professionals who look to acquisition of credentials as a means to explore professional development beyond their home community. The transition of some CHWs from client to service provider suggests this is a viable professional development path and may help address increased need for CHWs in the U.S. In states such as Ohio, training toward CHW certification is offered in workshop and university course formats although the small number of approved programs are centered around the major urban areas including Columbus, Toledo, Cleveland, Dayton, and Cincinnati (Ohio Board of Nursing, n.d.).

In Ohio and throughout the U.S., wider availability of programs outside of the major metropolitan areas, via hybrid or traveling programs could help expand CHW services while training people in their communities. However, a resource base is required to fund an expanded and/or traveling CHW training scheme. The expenses associated with current programming, which at times offers fee waivers, may be only partially defrayed by payment of fees or tuitions and may require additional support from organizational and institutional grants or other support.

Our recommendation for healthcare policy makers to expand training for CHWs in communities is to consider alternative funding through commercial insurers. U.S. based private health insurers primarily cover sick care and, although some rely on government insurance including Medicare and Medicaid, or the insurance marketplace are providers for private coverage, the majority of Americans with health insurance receive group coverage through employers (Vankar, 2024). Health insurance providers typically benefit when health care costs are low or decreases. Therefore, we suggest investigation of a unique means of funding expanded training and expansion of CHW services, in their respective home communities, via a modified residual market plan involving health insurers. Typical residual market plans impact property and liability insurers by requiring companies to provide a portion of high-risk coverage in return for providing selective coverage (Insurance Information Institute, 2015). We propose a modified plan where private health insurers who provide health insurance coverage in a state through employee and group plans, are required to contribute a modest proportion of premiums to a CHW training and compensation fund.

Effective CHWs demonstrate how the combination of local credibility and insider knowledge is critical to promoting health equity and improving health outcomes by serving as

linkage between the community and healthcare system. Given potential reductions to government insurance and government supported programs and interventions, CHWs' direct and indirect contributions to chronic disease prevention and management are going to be more essential in the foreseeable future.

Author Contributions

DK conceptualized and designed the study, conducted and transcribed the interviews and wrote the first draft of the manuscript. DK and SC participated in data analysis and interpretation and collaboratively developed this report.

Funding

No funds, grants, or other support were received during the preparation of this manuscript.

Institutional Review Board Statement

This research was approved by The Kent State University Institutional Review Board as file number 21-027.

Informed Consent Form

Written and verbal informed consent were provided by all study participants before contributing data to this research.

Data Availability Statement

Additional details about analysis processes and de-identified data are available in response to reasonable requests addressed to the corresponding author.

Acknowledgements

We wish to express our profound thanks to the Community Health Workers who contributed their time and insights to this qualitative research study.

Conflicts of Interest

The authors have no relevant financial or non-financial interests to disclose.

Artificial Intelligence Statement

No artificial intelligence or other large language models were used in any way in the research which informed this report, or in composing the report itself.

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Notes on Contributors

Dr. Dennis Kirimi is a population health leader and Director of the Pathways HUB Community Action, focusing on Community Health Worker (CHW)-led approaches to addressing Social Determinants of Health. His work aligns community-based organizations with payer systems through value-based reimbursement, performance measurement, and data-driven strategies. He has led multi-county implementation of the Pathways HUB model, strengthening CHW care coordination for high-risk populations. His research emphasizes CHW workforce sustainability, including career pathways, wellbeing, and system-level approaches to advancing SDoH outcomes.

Dr. Sheryl L. Chatfield is Associate Professor of Public Health and Co-Coordinator of the Graduate Certificate in Qualitative Research at Kent State University, Kent, Ohio, USA. Her research interests include community-based promotion of physical and mental health, and teaching and learning qualitative research methods. She has published research on physical activity, technology and mental health, mixed methods designs, qualitative secondary analysis, and quality and ethical considerations in qualitative inquiry.

ORCID

Dr. Dennis Kirimi, https://orcid.org/0009-0009-4023-2918
Dr. Sheryl L. Chatfield, https://orcid.org/0000-0002-0894-7469