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CHRT

Incorporating Community Voice into a Statewide Initiative, Experiences from the Field

Selected APHA Program: Community Health Planning and Policy Development
Topic: Public-Private Partnership to Improve Community Health

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Introduction

In 2020, the **Center for Medicare & Medicaid Services (CMS)** awarded the **Michigan Department of Health and Human Services (MDHHS)** a five-year project to enhance data exchange capabilities and reduce health disparities in Michigan. **The Center for Health and Research Transformation (CHRT)** joined as a partner to support 7 regional health collaboratives and facilitate a learning community. The project recognized the absence of community voice in the initial health IT design, emphasizing the importance of integrating these perspectives to meet user needs and improve health outcomes.

Description of Evidence

CHRT, with assistance from the RHC learning community, established a Community Council (CC) to involve community health workers and Medicaid recipients in project governance. Each of the seven regions nominated one to two individuals for the CC. From this selected group, two members serve as voting members on the executive committee.

In 2024, MDHHS established the Community Information Exchange (CIE) Advisory Committee to implement a statewide CIE governance structure. In 2025, the CIE Advisory Committee worked closely with representation from the regional health collaboratives and subject matter experts across the state to launch a Community Voice Subgroup at the state-level, including consideration of how local governance structures- like the CC- will develop into an effective governing model for CIE in Michigan.

Description of Program Outcomes

The learning community was crucial for the identification and recruitment of participants who could provide grassroots-level insights. The initiative placed community voice at the forefront of decision-making by involving those directly impacted as community health workers, clients, and Medicaid recipients.

Conclusion

The creation of the CC identified the importance of community input in shaping initiatives that advance community goals. The regional nomination strategy proved valuable for the council's development and sustainability.

Recommendation for Practice

The statewide Community Council has successfully amplified the community voice and paved the way for their continued involvement in future initiatives. Other states can learn from this process of identifying and recruiting community members to serve on their statewide council.

CHRT/RHC - Why We Embarked on Elevating the Community Voice

CHRT formed the Michigan Regional Health Collaborative Community Council to center lived experience, including the voices of Medicaid recipients, at the heart of our decision-making. This was both a foundational promise to the Michigan Department of Health and Human Services (MDHHS) and a core element of our governance philosophy. By collaborating with our original six regional partners across Michigan in FY24, we sought to ensure the council truly reflects the diversity of perspectives found statewide. Through this structure, we aimed to elevate community voices, foster authentic partnerships, and—most importantly—incorporate their insights into the development of a robust statewide Community Information Exchange (CIE) initiative. We believe this collaborative approach will lead to meaningful improvements in how information is shared, ensuring that the CIE is shaped by, and benefits, the statewide communities it serves. Beginning in our project year 2025, we added the Northern Michigan Public Health Alliance as region 7 to the RHC Learning Network and Community Council.

7 Regional Partners

- Greater Flint Health Coalition
- Livingston and Washtenaw Counties' MI Community Care (MICC)
- Muskegon County, Access Health
- Southeastern Michigan Health Association (SEMHA)
- Kent County, Health Net
- The Jackson Collaborative Network, Jackson Care Hub
- Northern Michigan Public Health Alliance (Alliance)

Importance of Establishing a Community Council

Previous studies found that community advisory boards, as they are most commonly referred to, had a meaningful impact on outcomes related to improving public health and specifically community population outcomes.[1]There were several studies that held a community advisory board/community council, and their feedback aided to form the process improvements necessary for program development and integration into the larger system-level structure.[2,3] Community councils and advisory committees serve as crucial strategies for community engagement in health research and various organizational initiatives and elevating the community voice.1 These committees aim to gather community input, guidance, and perspectives on projects, thereby enhancing the local relevance of research efforts, ensuring methods align with local beliefs, and promoting cultural and social relevance.[3] While organizations are not obligated to adopt their advice, these committees often provide invaluable experience and expertise, facilitating communication and highlighting the contributions of all stakeholders. Funding bodies like the Patient-Centered Outcomes Research Institute (PCORI) and the National Institutes of Health Clinical and Translational Science Awards (CTSA) Program underscore the value of CABs in research translation and application[4]

Despite their recognized importance, the existing literature on CCs often lacks detailed guidance on implementing recommended practices, leading to issues such as inconsistent attendance, gender imbalance, and political infighting.[5] To address this gap, guidelines have been developed, such as those co-created with the Hopi Tribe, which structure the CC process into three stages: Formation, Operation, and Sustainability and Evaluation.[1] These guidelines offer practical tools like interactive worksheets to help academic and community partners define mandates, recruit diverse members, establish clear roles and expectations, and plan for sustainability and evaluation. Key elements for functional and effective community council include clearly defining their aims and objectives, strategically recruiting members (ideally 5-10, representing community diversity, locally and regionally), identifying roles, providing compensation or recognition, offering orientation and team-building sessions, and establishing clear operational procedures that prioritize equity and regular self-evaluation.[2] We emphasize that community councils should not be the sole mechanism for broader community participation, but part of an integrated governance structure.

Background on RHC Learning Network

The Promotion of Health Equity (PHE) project originally sought to enhance the quality of life for individuals in Michigan by addressing health disparities and coordinating healthcare and social services among Medicaid beneficiaries and underserved populations in seven regions. Through collaboration with MDHHS, Michigan Medicine and MIHIN, the project focused on integrating community health workers and infrastructure to improve health outcomes, increase community engagement, and foster equity by using pilots to develop a statewide Community Information Exchange. The project focused on promoting the best practices for community-based service provider integration, while ensuring that the lived experiences of Medicaid beneficiaries inform governance and service delivery processes.

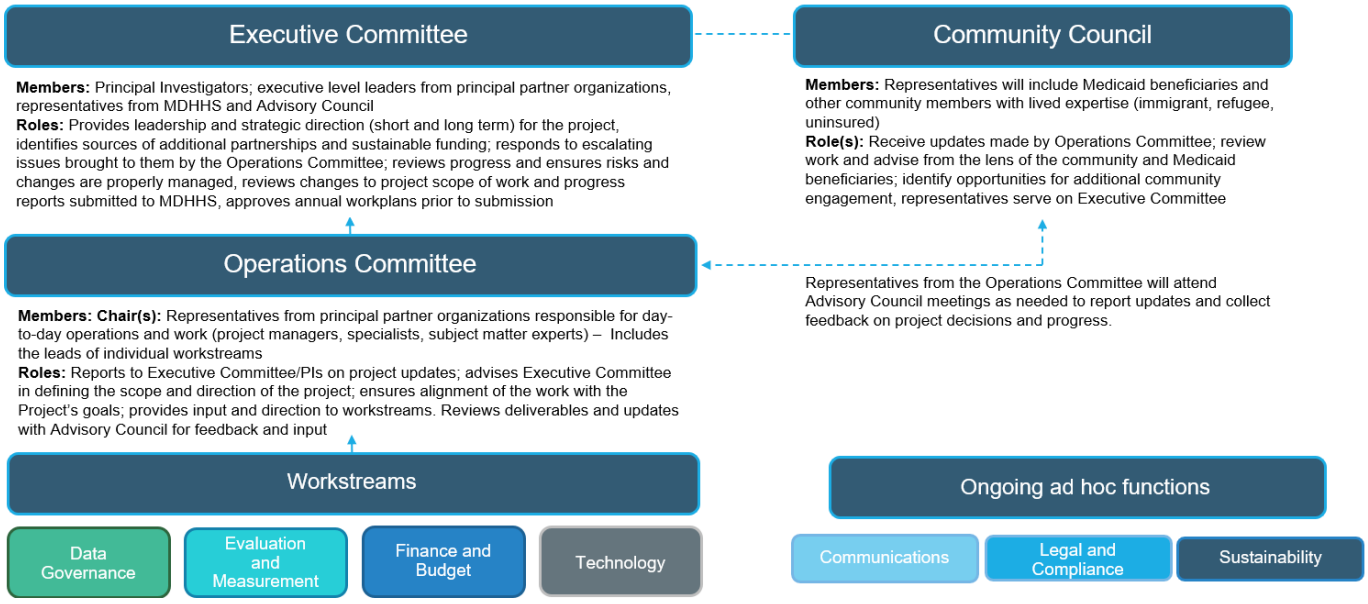
The goals of PHE for the RHCs were the following:

- Improved health outcomes for Medicaid beneficiaries and underserved populations through better coordination of healthcare and social services.
- Increased community engagement and trust by incorporating the lived experiences of participants in program governance and service delivery.
- Enhanced capacity for addressing social determinants of health through the development of a statewide Community Information Exchange infrastructure.

The Inception of the RHC Community Council

The original governance structure through the Promotion of Health Equity incorporated the community voice at the same reporting level as our executive committee. (PHE Governance Structure). This structure can be found in our PHE Governance Framework and in Figure 1 listed below (See PHE Governance Structure Figure 1 below):

High-Level PHE Governance Framework Figure 1:



Utilization of an Input Group: As part of our commitment to meaningful community engagement in the development of our Community Council, we convened three listening sessions with members of our Regional Health Collaborative (RHC) Learning Network. The purpose of these sessions was to collect actionable feedback and recommendations on how to build an inclusive and effective council. Based on input from the Learning Network, we formed a short-term advisory group consisting primarily of community health workers representing diverse regions across the state. This group played a pivotal role in shaping the council's structure and ensuring that regional voices and lived experience would guide the priorities of the established RHC Community Council.

Recruitment strategy

To ensure broad and meaningful representation in the formation of our Community Council, we began by engaging our original six regions to recommend participants—primarily community health workers with strong community ties. These individuals were invited to join a short-term input group and completed an attestation confirming their commitment to actively participate in three, 90-minute working sessions held in February 2024.

The Michigan Medicine team joined these sessions to present the overarching governance structure and to emphasize the significant role participants would play—not only within the Community Council but across various groups and committees within the PHE governance framework. The valuable insights and recommendations offered by these regional representatives were instrumental in shaping both the structure and focus of the Community Council, and demonstrated the importance of inclusive, community-driven engagement in statewide initiatives. After gathering valuable recommendations from the initial input group, we shared these insights with each of our Regional Health Collaboratives (RHCs) through a presentation during one of our Learning Network monthly meetings**.** To further guide the recruitment process, we provided RHCs with a clear set of criteria, emphasizing the inclusion of community health workers who are actively engaged in community information exchange efforts, as well as individuals with lived experience, including Medicaid recipients. This targeted approach was designed to ensure that the Community Council would meaningfully reflect the voices and expertise most critical to the success of our statewide Community Information Exchange initiative.

The CHRT team composed a commitment letter outlining essential components of the PHE program, including a description of the initiative, a list of participating organizations, details about council membership, and expectations for participation. The letter also highlights key aims for active involvement, describes available support and compensation policies, and includes a section for council members to formally acknowledge their commitment by signing. Further details regarding the group's established expectations can be found in the commitment letter.

Support and Compensation Policy Statement

Community Council members were supported by CHRT contract and finance team and CHRT's facilitator/ project manager, who provided orientation and served as the primary point of contact throughout the program. The Council operated with independence, ensuring that members had the opportunity to freely contribute their ideas, perspectives, and expertise to inform the program's strategies and activities. Participation was compensated at a rate of $50 per hour, with anticipated time commitments communicated to members in advance.

Implementation

CHRT's facilitator worked alongside the appointment of two co-chairs from the existing members to help lead our quarterly hour and a half session. Each session had a segment, which included updates from the facilitator and pre-selected topics with guest speakers. We addressed pertinent topics, such as Medicaid cuts and had guest speakers present important information to the members. Members asked questions and engaged in meaningful discussion with our guest speakers and facilitator. Two members were elected to participate in the PHE Executive Committee. For the implementation of this initiative, involvement in the Executive Committee was limited, as the project evolved into two segments: Community Information Exchange and Health Care Digital Management. As our work with MDHHS continued to grow, MDHHS shared an interest in adopting the RHC Community Council strategy into their CIE governance structure. What made this group unique and successful was truly the statewide approach of recruiting members from the regions (regional health collaboratives) across the State of Michigan.

CHRT was initially tasked under the PHE Governance structure to develop a community advisory council. During the initial year of implementation and the feedback given that their level of decision making was more than an advisory council, the name changed to Community Council with agreement from the Community Council members.

Summary

The establishment of the statewide RHC Community Council gave visibility to the need to incorporate the community voice within the MDHHS HIT Community Information Exchange Governance structure that reports under the Health Information Technology Commission. Because of this awareness, a new committee, the CIE Community Voice Subgroup, was formed. CHRT emphasized the value of lived experience and community input within the Community Information Exchange activities in partnership with MDHHS.

Bridge to the development of the MDHHS CIE Community Voice Subgroup

The Michigan Department of Health and Human Services (MDHHS) Health Information Technology Commission (HITC) CIE Advisory Committee recognized the need for a high degree of accountability in processes for consumers to express concerns and share feedback. Thus, the Community Voice Subgroup was established to ensure that community members are central to state-level decision-making and implementation of community information exchange.

Through the Community Voice Subgroup, MDHHS aims to center the interests and lived experiences of people served and create trustworthy mechanisms by which consumers' feedback and concerns can be shared. The Community Voice Subgroup will help guide the CIE Advisory Committee on the importance of integrating community voice into state-level policy development and effective implementation of CIE.

The Community Voice Subgroup convenes consumers, caregivers and guardians of services from a CIE, individuals representing an organization implementing CIE strategies and other health information and CIE players. It serves as a space for community members to share their ideas and experiences to help shape community information exchange (CIE) initiatives and help improve how health care and social services can work together to advance care coordination and improve health outcomes.

The Community Voice Subgroup aims to evolve the CIE Task Force's Consumer Bill of Rights and provide a feedback process for consumers to express their perspectives; consult with on-the-ground organizations on community voice integration and share experiences across local and regional councils; and provide guidance to the CIE Advisory Committee and its relevant subgroups.

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