City of Portland, Maine Public Health Division

Social Determinants of Health Accelerator Plan

Contents

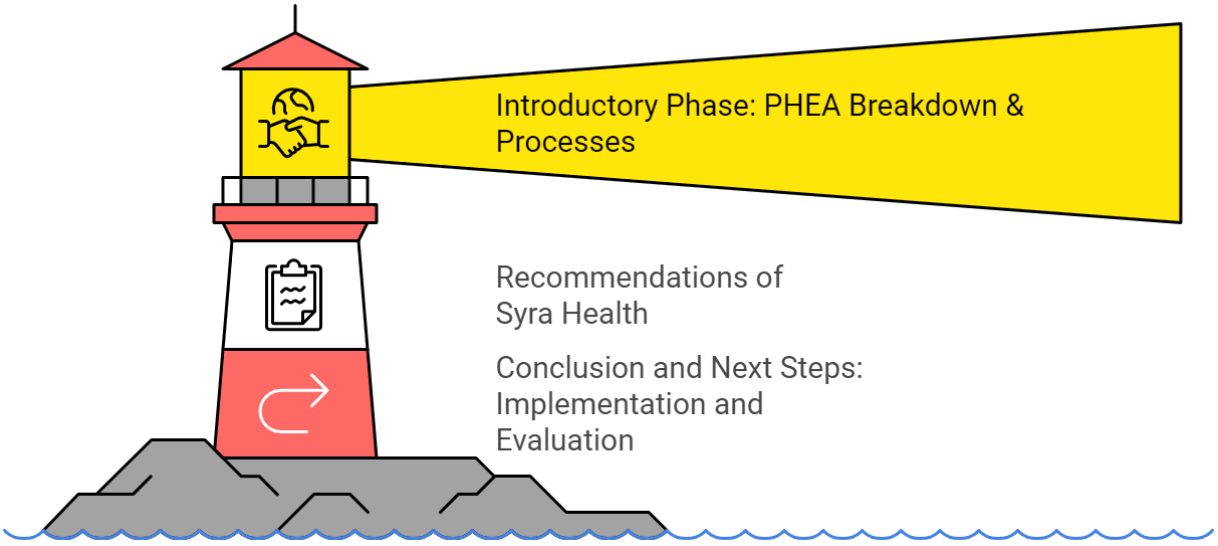
What Did We Do? A Summary of the Processes and Health Equity Approach

Syra Health Corp. (NASDAQ: Syra), a healthcare technology company powering better health by providing meaningful solutions had the privilege of serving the City of Portland Public Health (PPH) as the health equity consultant. Syra Health co-led the development of the Social Determinants of Health (SDOH) plan in close partnership with PPH with a thorough and inclusive process. The approach to Closing the Gap: Social Determinants of Health Accelerator Plan was to first survey and gather firsthand testimony of those community members that makeup Greater Portland to formulate the narrative of the SDOH Accelerator Plan. Next, Syra Health conducted comprehensive research and gathered valuable insights from the seven committees that comprised the Portland Health Equity Alignment, also known as the "Alignment" : Achieving Health Equity for Older Persons, Community and Faith-Based Advisory, Student and Academic Advisory, Community Health Worker, Clinical Advisory, Social Determinants of Health, and Monitoring, Evaluation, and Grants; through regular scheduled committee meetings and office hours held directly with the Syra Health team during July through September, 2024.

By engaging each of these groups, Syra Health ensured that a broad range of perspectives and experiences were considered in the formulation of the Accelerator Plan. These meetings also provided an opportunity for open discussion about each committee's priorities and ongoing initiatives, as well as the broader Alignment. Additional insights were gathered through various methods, including surveys, committee breakouts, and direct meetings with the City of Portland Public Health Leadership Team, fostering collaboration and a deeper understanding of the community's needs. The third phase was conducting a thorough literature review of health equity accelerator plan best practices, followed by the incorporation of Syra Health expertise and experience in the Social Determinants of Health (SDOH),

health equity training, and development of health education materials. The fourth and final phase consisted of collaborating on finalizing the recommendations and suggested activities of the Portland Health Equity Alignment with the City of Portland Leadership Team and the Portland Health Equity Alignment Leadership Team.

The Portland Health Equity Social Determinants of Health Accelerator Plan is structured to capture the authentic collaboration between the Portland Health Equity Alignment and Syra Health. The Plan designed to promote health equity and provide a structured guide that extends the work and momentum of Greater Portland's Health Equity Alignment. The theme of the overall document is to serve the community as a continual working document, where integral aspects of improvements such as evaluation are encouraged. The working document is organized into three sections that can be conceptualized based on the following graphic:



- Introductory Phase: highlights the details of the Portland Health Equity Alignment, committee overviews, the shared vision and mission of the Portland Health Equity Alignment, a background of the Greater Portland area, a background on the health equity consultant (Syra Health), and information on member organizations of the Portland Health Equity Alignment. Key process flows and approaches used by the health equity consultant are also highlighted.

- Recommendations of Syra Health: discusses the recommendations made by Syra Health based on committee meetings, priorities and responsibilities, and suggested actions for Portland Health Equity Alignment moving forward. The recommendation section provides optional activities for each of the seven respective committees: Achieving Health Equity for Older Persons (AHEOP), Community Health Worker (CHW), Clinical Advisory, Community and Faith-Based Advisory (C&FB), Monitoring Evaluation & Grants (MEG), Social Determinants of Health (SDOH), and Student & Academic Advisory to promote health equity across Greater Portland and is not intended to replace ongoing committee initiatives.

- Conclusion and Next Steps: provides implementation and evaluation suggestions that build upon the initial framework of the document, offering actionable strategies and measurable outcomes

aimed at improving health equity across Greater Portland. This section proposes long-term sustainability and evaluation planning efforts, focusing on strategies to maintain successful programs beyond initial funding that will build community capacity. Throughout this section, the Plan offers actionable, measurable steps to address the Social Determinants of Health, and improve health equity in Greater Portland.

The Portland Health Equity Alignment

The Portland Health Equity Alignment, previously known as The Minority Health Program (MHP) Stakeholder Alignment, is a collaborative initiative to advance both health and social equity by addressing the community needs and emerging issues of Greater Portland.[1] Founded by Nelida Berke in 2018, the Portland Health Equity Alignment partners with representative organizations, spanning from Greater Portland's underserved populations in ethnic and minority communities, refugee and immigrants, faith-based organizations, nonprofit organizations, clinical and social services, law enforcement agencies, public and private agencies, government entities, and schools and universities.[1]

The Portland Health Equity Alignment's mission is to establish a statewide front to advance both health and social equity through five means of engagement in:

The Portland Health Equity Alignment envisions a healthy community that values diversity and ensures access to quality healthcare, social services, and resources for healthy living.[1] Community wellness is defined as a process that includes community-based planning, tailored health interventions, empowerment, and a supportive network.[1] The ideal vision promotes access to healthy foods and safe spaces for physical activity. Collaborating with community members and organizations, the initiative focuses on addressing health and social priorities for minority populations.

1 Berke, N. (2019). *Minority Health Program Stakeholder Alignment*. City of Portland, Maine. Retrieved from Nelida-Berke-Portland-Health-Equity-Alignment.pdf.

The Portland Health Equity Alignment: Committee Breakdown

The Portland Health Equity Alignment organizational members convene quarterly, where individuals are expected to join at least one of the committees.[2] Committees meet monthly or bimonthly, following each respective committee's chair's decision. The 2024 Quarterly Meeting Schedule was as follows:

- Winter Quarterly Meeting → February 7th
- Spring Quarterly Meeting → June 10th
- Fall Quarterly Meeting → September 10th
- Winter Quarterly Meeting → December 19th
- Closing the Gap Grant:
  Fully developed SDOH Accelerator Plan → December 31st

The Portland Health Equity Alignment consists of seven established committees, with the addition of an eighth committee. The seven committees that currently make up the Portland Health Equity Alignment are the Achieving Equity for Older Persons (AHEOP) Committee, the Community Health Workers (CHWs) Committee, the Clinical Advisory Committee, the Community and Faith-Based Advisory Committee (C&FB), the Monitoring, Evaluation, and Grant (MEG) Committee, the Social Determinants of Health (SDOH) Committee, and the Student and Academic Advisory Committee.[2] The addition of a Policy Advisory Committee is currently in progress.

The Portland Health Equity Alignment is a supported organization that is made up of member partners from over 75 different organizations, and is represented by more than 135 currently active members.[2] At the core of the Portland Health Equity Alignment are the Community and Faith-Based Advisory Committee and the Community Health Workers Committee, driving the collaboration forward.[2] As the Portland Health Equity Alignment continues to develop and add more member representatives and partnerships, the commitment to collaborative approaches fuels its ongoing initiatives in support of health equity amongst Mainers. Through the City of Portland's Health Equity Program, Community Health workers (CHWs) are compensated for their time devoted to committee and organizational engagement.[2] Collaboration efforts aim to make significant strides toward achieving health and social equity for everyone.

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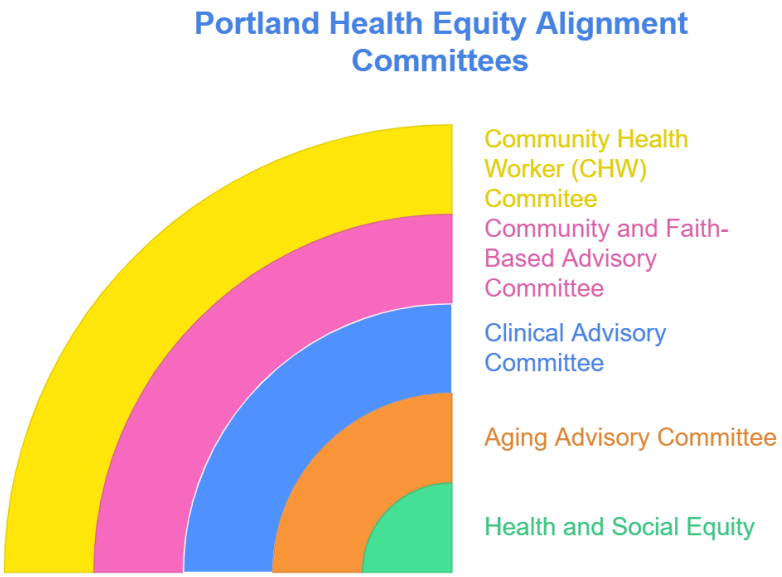
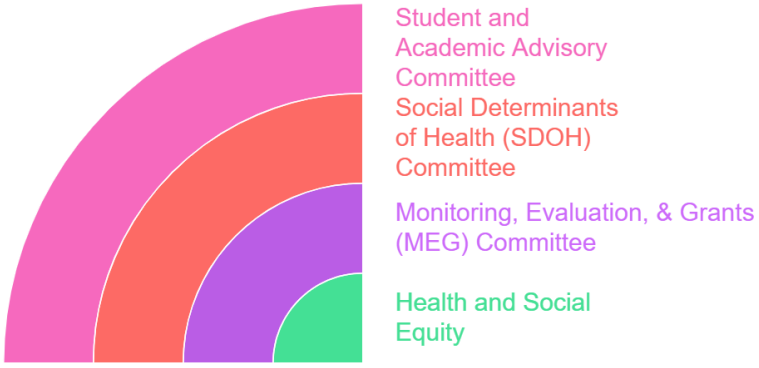
1 Berke, N. (2019). *Minority Health Program Stakeholder Alignment*. City of Portland, Maine. Retrieved from Nelida-Berke-Portland-Health-Equity-Alignment.pdf.
2 City of Portland, Maine. Portland Health Equity Alignment: Public Health. (2024). City of Portland, Maine. Retrieved from City of Portland, Maine: Portland Health Equity Alignment (civilspace.io).

The Portland Health Equity Alignment: Committee Breakdown

The seven dedicated committees are focused on addressing specific challenges to achieving health equity within Greater Portland. These committees bring together diverse contributors, including community members, health professionals, and advocates, to collaborate on community wellness initiatives. Each of the seven committees stems from the Community Needs Assessments (such as an annual survey administered to community residents to learn the population's health needs). These committees bring together a diverse group of partners, including community members, health professionals, and advocates, to collaborate on community wellness initiatives[1]. Through their collective efforts, the committees work to create targeted solutions aimed at improving well-being and reducing disparities, with the goal of fostering a more equitable and healthy community.





1 Berke, N. (2019). *Minority Health Program Stakeholder Alignment*. City of Portland Maine. Retrieved from Nelida-Berke-Portland-Health-Equity-Alignment.pdf.

The Portland Health Equity Alignment: Leadership

The Portland Health Equity Alignment, previously known as The Minority Health Program (MHP) Stakeholder Alignment, is a collaborative initiative to advance both health and social equity by addressing the community needs and emerging issues of Greater Portland. Founded by Nelida Berke in 2018, the Portland Health Equity Alignment partners with representative organizations, spanning from the Greater Portland's underserved populations in ethnic and minority communities, refugee and immigrants, faith-based organizations, nonprofit organizations, clinical and social services, law enforcement agencies, public and private agencies, government entities, and schools and universities. Leadership Team members as May of 2024:

Name	Agency/Organization	Title	Committee
Jeff Aalberg	Day One	Committee Chair	Clinical
Skylar Bergeron	Portland Public Health - Health Equity	PPH Liaison	Student & Academic
Nélida Berke	Portland Public Health - Health Equity	PPH Liaison, Founder	Community Health Workers
Maureen Clancy	Portland Public Schools – Multilingual & Multicultural Center	Committee Chair	Community & Faith-Based
Rachel Gallo	University of Southern Maine (USM) - Catherine Cutler Institute	Committee Chair	Monitoring, Evaluation, & Grants
Barbara Ginley	MaineHealth, Community Health for Greater Portland	Committee Chair	Social Determinants of Health
Kirsten Goodrich	City of Portland HHS – Strategic Planning	PPH Liaison	Monitoring, Evaluation, & Grants
Amanda Hutchins	Portland Public Health – Prevention Programs	PPH Liaison	Social Determinants of Health
Val Johnstone	Portland Public Health – Tobacco & Lead Prevention	PPH Liaison	Community & Faith-Based
Mardochee Mbongi	COCOMaine	Committee Chair	Community & Faith-Based
Hayley Prevatt	Portland Public Health – Research & Evaluation	Committee Chair	Monitoring, Evaluation, & Grants

Axels Samuntu	Maine Community Health Workers (MECHW)	Committee Chair	Community Health Workers
Marie Sheffield	Bridge2Belong	Committee Chair	Student & Academic
Ann Tucker	Greater Portland Health	Committee Chair	Clinical
Kathy Vezina	Maine Council on Aging (MCOA)	Committee Chair	Achieving Health Equity for Older Persons
Megan Walton	Southern Maine Agency on Aging (SMAA)	Committee Chair	Achieving Health Equity for Older Persons
Jane Winarta	Portland Public Health – SDOH/Healthy Eating Active Living	Syra Health Liaison	Social Determinants of Health

1 Berke, N. (2019). *Minority Health Program Stakeholder Alignment*. City of Portland, Maine. Retrieved from Nelida-Berke-Portland-Health-Equity-Alignment.pdf.

2 City of Portland, Maine. (2024). *Portland Health Equity Alignment: Public Health*. Retrieved from City of Portland, Maine: Portland Health Equity Alignment (civilspace.io).

Health Equity Consultant – Syra Health

At Syra Health, we are steadfast in our commitment to pioneering innovative approaches to advance health equity. Our team recognizes that addressing chronic diseases requires a multifaceted strategy that incorporates population health management, statistical analysis, Geographic Information Systems (GIS) and asset mapping, community profiles, and a deep understanding of Social Determinants of Health (SDOH).

Since 2021, our team has been at the forefront of managing the State Epidemiological Outcomes Workgroup (SEOW) in Indiana, an initiative by the Indiana Family and Social Services Administration. Our role involves overseeing the collection, analysis, and reporting of critical epidemiological data on substance use and mental health. The SEOW, comprising experts from over 16 state agencies, focuses on monitoring and addressing substance misuse and mental health issues statewide, using epidemiological data and evidence-based practices to enhance overall physical and mental wellness. This work is supported by a block grant, crucial for sustaining and advancing these vital public health initiatives.

Health equity is commitment and practice embedded in all projects we undertake within our organization. We understand that health disparities often stem from deeper Social Determinants of Health, such as socioeconomic status, environment, and access to healthcare. Our approach involves comprehensive research into these determinants, utilizing an evidence-based methodology to assess local health trends accurately. This enables us to identify and address the unique challenges faced by diverse populations, ensuring that our solutions are not only effective but also equitable. By prioritizing health equity, our team aims to create new strategies and tailor existing practices to be inclusive, culturally sensitive, and responsive to the specific needs of all community members, particularly those most vulnerable at risk.

Syra Health harnesses the power of Geographic Information Systems (GIS) and asset mapping to visualize and analyze spatial data, providing valuable insights into the distribution of healthcare resources and Social Determinants of Health. Through GIS mapping, we identify areas with limited access to care and strategically deploy resources to address gaps in service provision. Asset mapping allows us to leverage existing community assets and partnerships to maximize the impact of our interventions.

Our team recognizes the importance of understanding the unique needs and dynamics of the communities we serve. Through the development of detailed community profiles, we compile demographic data, health indicators, and Social Determinants of Health to create comprehensive portraits of local populations. These profiles serve as the foundation for our tailored interventions, ensuring that our efforts are culturally sensitive, relevant, and effective in addressing the specific challenges faced by each community.

Background

City of Portland Community Background

Portland's population is predominantly White, comprising 79.8% of its residents, with Black individuals making up 10.0%, Asians 4.7%, Hispanics 2.5%, and other races 3.0%[3]. Geographically, racial groups are concentrated, with White residents more prevalent in the western areas and Black citizens in the eastern regions[3]. Understanding this demographic makeup is crucial for understanding the Social Determinants of Health that influence chronic illness outcomes within the community.

The demographic composition of Portland mirrors broader patterns observed in Maine, where varying levels of racial and cultural diversity are evident across cities and towns. While Portland's demographic profile aligns somewhat with Maine's overall composition, it significantly diverges from the more diverse populations found in other parts of the United States, as reported by the Statistical Atlas of 2024. Portland exhibits a lower proportion of Hispanic and Asian populations compared to national averages, highlighting the necessity for targeted health equity initiatives tailored to these demographic characteristics[4].

Portland boasts a diversity score of 76 out of 100, indicating higher diversity compared to many other US cities, with the northeast section being the most diverse within Portland itself[3]. However, diversity is not evenly distributed across the city, leading to areas in the western parts of Portland having limited racial and ethnic diversity. Recognizing these demographic nuances is vital for developing effective public health strategies to address chronic diseases. The disparate distribution of racial and ethnic groups in Portland can affect healthcare accessibility, the availability of culturally competent care, and the prevalence of specific Social Determinants of Health.

The Maine Shared Community Health Needs Assessment provides a comprehensive overview of health equity in Portland, Maine, with a significant focus on Social Determinants of Health (SDOH). The report highlights how Social Determinants of Health, such as economic stability, education, social context, healthcare access, and neighborhood environment - shapes health outcomes and contributes to health inequities among different populations in Portland[5]. Greater Portland’s median household income of $66,109 and uninsured rate of 7.0% (2017-2021), demonstrates the interconnectedness of social factors, health outcomes, and health equity[5].

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3 BestNeighborhood.org. (2024). *Race, Diversity, and Ethnicity in Portland, ME*. BestNeighborhood.org. Retrieved from The Best Neighborhoods in Maine by Home Value | BestNeighborhood.org.
4 Statistical Atlas. (2024). *Overview of Maine*. Statistical Atlas. Retrieved from The Demographic Statistical Atlas of the United States - Statistical Atlas.
5 Maine CDC. (2024). *Portland City Health Profile: Maine Shared Community Health Needs Assessment*. Maine CDC. Retrieved from Portland City Health Profile FINAL 9.11.2024.pdf.

Pursuing health equity in Greater Portland requires acknowledging and mitigating economic barriers and systemic inequities. Social Determinants of Health, including education, inadequate housing, and transportation, contribute to continual health disparities[5]. Limited access to healthcare due to lack of insurance coverage or high costs, coupled with transportation issues and geographic disparities, particularly in rural areas, prevent many individuals from receiving necessary medical care[5]. Lastly, communication gaps between healthcare providers and Mainers, cultural and language differences of residents, and the lack of accessibility for people with disabilities create additional barriers to effective healthcare delivery[5] – where 1 in 10 Mainers do not have health insurance[6].

5 Maine CDC. (2024). *Portland City Health Profile: Maine Shared Community Health Needs Assessment*. Maine CDC. Retrieved from Portland City Health Profile FINAL 9.11.2024.pdf.
6 Portland Public Health Division, City of Portland, Health and Human Services Department. (2020). *Health of Portland Report*. Portland Public Health Division. Retrieved from HOP 2019.

Partnerships

Multi-Organizational Members of the Portland Health Equity Alignment

The following chart provides an overview of the member organizations associated with the Portland Health Equity Alignment. The chart is designed to offer a clear understanding of each group's roles in advancing health equity in the region. This interactive guide allows you to navigate based on the organization's name, whether they provide direct services, and whether they are listed on the MaineHealth *Find Help* platform. By exploring these categories, the goal is to easily identify relevant organizations and their specific contributions to supporting health equity across Greater Portland.

Organization	Entity	Direct Services	MaineHealth FindHelp
AARP	Non-profit	Yes	Yes
Adoptive & Foster Families of Maine	Community-Based	Yes	No
Alzheimer's Association, Maine Chapter	Non-profit	Yes	No
Angolan Community of Maine	Community-Based	Yes	No
Bates College	Education	No	No
Baxter School of Deaf	Education	No	No
Boys and Girls Club of Maine	Education	Yes	Yes
Bridge2Belong	Non-profit	Yes	No
Catholic Charities Maine	Non-profit	Yes	Yes
Catholic Charities Maine - Refugee Health Promotion Program	Non-profit	Yes	Yes
Catholic Charities Maine - Refugee Wellness & Health Equity	Non-profit	Yes	Yes
Center for Grieving Children	Non-profit	Yes	No
City of Portland - Parks & Recreation	Local Government	Yes	No
City of Portland Community Policing - Parkside	Community-Based	Yes	No
City of Portland HHS - Office of Elder Affairs	Local Government	Yes	No
City of Portland HHS - Resettlement Program	Community-Based	Yes	No
City of Portland HHS - Strategic Planning	Community-Based	No	No

Organization	Entity	Direct Services	MaineHealth FindHelp
City of Portland Housing & Urban Development (HUD)	Local Government	Yes	No
City of Portland Office of Economic Opportunity (OEO)	Community-Based	No	No
City of Portland Parks & Recreation - 62+ Program	Community-Based	No	No
COCOMaine	Community-Based	No	Yes
COP Exec/City Manager's Office - Sustainability Associate	Non-profit	No	No
Cross Cultural Community Services (CCCS)	Local Government	No	No
Cross Cultural Community Services / Portland City Council	Local Government	No	No
Cross Cultural Community Services/Maine Legislature	Local Government	No	No
Cumberland County Food Security Council	Philanthropy	No	No
Cumberland County Public Health - Director	Philanthropy	No	No
Cumberland County Public Health - Healthy Eating Active Living	Philanthropy	No	No
Cumberland County Public Health - Substance Use Prevention	Philanthropy	No	No
Daniel Hanley Center for Health Leadership	Non-profit	No	No
Day One	Provider	Yes	Yes
Democracy Maine	Non-profit	No	No
Disability Rights Maine	Non-profit	No	No
Equality Maine/Network for Older Adults	Community-Based	No	No
Gateway Community Services	Education	Yes	Yes
Good Shepherd Food Bank	Non-profit	Yes	Yes
Greater Portland Health	Provider	Yes	Yes
Greater Portland Health - CHW	Provider	Yes	Yes
Greater Portland Immigrant Welcome Center	Provider	Yes	Yes

Organization	Entity	Direct Services	MaineHealth FindHelp
Hope Acts / Quality Housing Coalition (QHC)	Non-profit	Yes	Yes
Immigrant Welcome Center	Education	Yes	Yes
Organization	**Entity**	**Direct Services**	**MaineHealth FindHelp**
Immigrants Community Integration	Community-Based	No	No
In Her Presence	Community-Based	Yes	Yes
International Institute of New England (IINE)	Non-profit	Yes	No
International Institute of New England (IINE) - Unaccompanied Children's Program	Non-profit	Yes	No
Kennebunk Committee on Aging	Voluntary	No	No
Locker Project	Non-profit	Yes	Yes
Maine Access Immigrant Network (MAIN)	Community-Based	No	No
Maine Association for New Americans (MANA)	Community-Based	No	No
Maine CDC - Cumberland County District Liaison	Community-Based	No	No
Maine CDC - Office of Population Health Equity (OPHE)	Non-profit	Yes	No
Maine Community Health Workers (MECHW)	Community-Based	No	No
Maine Council on Aging (MCOA)	Community-Based	No	No
Maine Department of Education	Education	No	No
Maine DHHS Aging Services	Community-Based	No	No
Maine Equal Justice	Non-profit	No	No
Maine Health - Pediatrics	Provider	Yes	Yes
Maine Health Access Foundation (MEHaf)	Philanthropy	No	No
Maine Immigrant Rights Coalition (MIRC)	Community-Based	Yes	No
Maine Senate	Local Government	No	No
Maine State Breastfeeding Coalition		Yes	No
MaineHealth	Provider	Yes	Yes

MaineHealth - Access to Care Coverage Team	Provider	Yes	Yes
Organization	**Entity**	**Direct Services**	**MaineHealth FindHelp**
MaineHealth - Access to Care New Mainer Initiative	Provider	Yes	Yes
MaineHealth - Care Partners	Provider	Yes	Yes
MaineHealth - Community Health Improvement	Provider	No	Yes
MaineHealth - Community Health; StrengthenME project	Provider	No	Yes
MaineHealth - Family Medicine	Provider	Yes	Yes
MaineHealth - Geriatrics	Provider	Yes	Yes
MaineHealth - Interpreter & Cross-Cultural Services	Provider	Yes	Yes
MaineHealth - Maine Behavioral Healthcare	Provider	Yes	Yes
MaineHealth - Maine Shared Community Health Needs Assessment (CHNA)	Provider	No	No
MaineHealth - Oncology Social Work	Provider	No	No
MaineHealth - Physician's Assistant	Provider	Yes	No
MaineHealth - Population Health	Provider	No	No
MaineHealth - Preventive Medicine	Provider		No
MaineHealth - Preventive Medicine (CHW)	Provider	No	No
MaineHealth - SDOH	Provider	No	No
MaineHealth - Social Work	Provider	Yes	No
MaineHealth Healthy Aging Director	Provider	No	No
MaineHealth Preventive Medicine / Portland Public Health Clinic	Provider	No	No
MaineHealth, Community Health for Greater Portland	Provider	No	No
Mainely Teeth	Non-profit	Yes	Yes
Mano en Mano	Community-Based	Yes	No
Med Help Maine	Non-profit	Yes	No
New England Arab American Organization (NEAAO)	Community-Based	Yes	Yes
New Mainers Public Health Initiative (NMPHI)	Community-Based	No	No
Northeastern University Roux Institute	Academia	No	No
Organization	**Entity**	**Direct Services**	**MaineHealth FindHelp**

Northern Light Health	Provider	Yes	Yes
Northern Light Mercy Hospital	Provider	Yes	Yes
Office of U.S. Representative Chellie Pingree (ME-01)	Local Government	No	No
Opportunity Alliance - Senior Volunteers Program	Non-profit	Yes	Yes
Opportunity Alliance - WIC	Non-profit	Yes	Yes
Peer Workforce Navigator	Non-profit	No	No
Portland Fire Department	Local Government	Yes	No
Portland Housing Authority	Non-profit	Yes	Yes
Portland Public Health - Cities Readiness Initiative	Education	No	No
Portland Public Health - Clinical Services	Education	No	No
Portland Public Health - Harm Reduction	Education	No	No
Portland Public Health - Health Equity	Education	No	No
Portland Public Health - Health Equity (CHW)	Education	No	No
Portland Public Health - Healthy Eating Active Living (HEAL)	Education	No	No
Portland Public Health - Immunization	Education	No	No
Portland Public Health - Maternal Child Health	Education	No	No
Portland Public Health - Prevention Programs	Education	No	No
Portland Public Health - Research & Evaluation	Education	No	No
Portland Public Health - SDOH/Healthy Eating Active Living (HEAL)	Education	No	No
Portland Public Health - STD Clinic	Education	No	Yes
Portland Public Health - Tobacco & Lead Prevention	Education	No	No
Portland Public Health - Tobacco Prevention	Education	No	No
Portland Public Schools	Education	No	No

Portland Public Schools - Multilingual & Multicultural Center	Education	No	No
Organization	**Entity**	**Direct Services**	**MaineHealth FindHelp**
Preble Street	Education	Yes	Yes
Presente! Maine	Community-Based	Yes	Yes
Quality Housing Coalition (QHC)	Non-profit	Yes	Yes
Roman Catholic Diocese of Portland - Hispanic Ministry (Retired)	Faith	No	No
Southern Maine Agency on Aging (SMAA)	Non-profit	No	Yes
Southern Maine Community College (SMCC)	Education	No	No
Spurwink	Community-Based	Yes	Yes
State of Maine Governor's Office of Policy Innovation and the Future - Cabinet on Aging	Government	No	No
The Locker Project	Community-Based	Yes	Yes
United Way of Southern Maine	Academia	No	No
University of Maine - Health Science	Academia	No	No
University of New England (UNE)	Academia	No	No
University of New England (UNE) - AgingME: Geriatrics Workforce Enhancement Program (GWEP)	Academia	No	No
University of Southern Maine (USM)	Academia	No	No
University of Southern Maine (USM) - Catherine Cutler Institute	Academia	No	No
University of Southern Maine (USM) - Nursing	Academia	No	No
University of Southern Maine (USM) - Population Health and Health Policy Program	Academia	No	No
University of New England (UNE) - Strategic Partnerships	Academia	No	No
Violence Against Women Act Measuring Effectiveness Initiative (VAWA MEI)	Philanthropy	No	No

Walk in Peace	Community-Based	No	No
Williams Temple	Faith	No	No

Shared Approach

Shared Mission of the Portland Health Equity Alignment

The vision of the Portland Health Equity Alignment is as follows: "*A healthy community where diversity within the community is respected and valued; everyone has access to quality healthcare, social services, and resources required for a healthy lifestyle; and there is a sense of community wellness*"

The mission of the Portland Health Equity Alignment is to provide a platform for a collaborative effort to advance health and social equity by addressing community needs raised by community members and/or emerging issues.

The mission of the Social Determinants of Health Accelerator Plan is to operationalize a collaborative leadership team in the City of Portland Public Health, that aligns diverse committee members and committees to effectively address health disparities and inequities in Greater Portland. This Plan is also dedicated to implementing targeted actions that improve chronic disease outcomes for Black/African American and Hispanic communities in Greater Portland. By tailoring interventions to meet the unique needs of these populations, The City of Portland Public Health and Syra Health seek to create equitable access to resources, support, community initiatives- ultimately fostering healthier communities for all.

Goals and Outcomes

The SDOH Accelerator Plan for Greater Portland aims to accelerate action that will lead to improved chronic disease outcomes among Black or African American individuals and Hispanic individuals, of any race, experiencing health disparities and inequities. Key goals include reducing barriers to healthcare access, improving housing and transportation, enhancing community-clinical linkages and social connectedness, and addressing environmental factors that contribute to chronic disease. Specific outcomes will focus on increasing the number of culturally competent healthcare providers, language and training around cultural competency, expanding broadband internet access for those without, expanding transportation options to medical facilities and throughout Greater Portland, improving access to sustainable housing, decreasing medical distrust among international populations, and operationalizing the Portland Health Equity Alignment to better collaborate as an entity for the forwardness of health equity. The plan will also prioritize building sustainable partnerships between current Alignment organizations, community organizations, and local government agencies to ensure coordinated efforts in addressing Social Determinants of Health (through the implementation of the newly founded ***Policy Committee***). Throughout implementation, ongoing evaluation and monitoring will be crucial goals, with regular assessments of progress towards the defined metrics and measures (as outlined in a later section: **Recommendations for the Portland Health Equity Alignment – Committee Breakdown**), community engagement levels, and the effectiveness of interventions of Committee and Leadership Team action items. This approach will allow for continuous improvement and adaptation of strategies to best meet the evolving needs of Greater Portland's diverse population, ultimately in support

Identifying Processes and the Approach

The Closing the Gap with Social Determinants of Health Accelerator Plan project officially kicked off with the June 10th Spring Quarterly Meeting in which Syra Health sent two health equity consultants to attend the in-person quarterly meeting. The engagement with Alignment members was facilitated by two Syra Health consultants and focused on conversation around health equity initiatives in Greater Portland. Prior to the meeting, a pre-survey was distributed to Alignment members to assess their understanding of their committees' priorities, goals, and objectives – as well as the broader mission of the Portland Health Equity Alignment. This preliminary step was important in gathering insights about the diverse backgrounds and representation within the community, as well as historical factors that have shaped the social context of Greater Portland.

During the quarterly meeting, the health equity consultants facilitated group discussion, encouraging Alignment members to share their experiences and perspectives on the community-clinical linkages and social connectedness, particularly among Black and Hispanic populations. This was an opportunity for Alignment members to reflect on how systemic factors have influenced health disparities and to explore the specific challenges faced by communities in Greater Portland to achieve health equity. The facilitators emphasized the importance of recognizing historical injustices and the ongoing impact of the Social Determinants of Health in shaping health outcomes.

The next round of Alignment member engagement conducted by Syra Health consisted of group discussions to gain a committee perspective of what the Portland Health Equity Alignment wishes to achieve through the SDOH Accelerator Plan and what the Portland Health Equity Alignment wishes to see, post implementation. Equity and Community were the top two selected social constructs as areas of achievement of the SDOH Accelerator Plan, while improved health outcomes and trust were two areas Alignments members identified as impacts for their community populations. The conversation then shifted toward identifying effective strategies that members would like to see employed to enhance community engagement and social connectedness.

Syra Health also set out to gather additional information from underrepresented committee members, as further outreach would be necessary to ensure their voices would be included in the Plan. Committee members expressed significant interest in the maps presented, particularly one illustrating broadband access, which connected well with earlier slides on community issues and demonstrated a strong engagement with the material.

The mapping was particularly pertinent to the Social Determinants of Health committee, which identified broadband access for residents as a critical concern. The website diversitydatakids.org was used to present difference in child opportunity factors associated with health across demographic factors to revealed health equity disparities in Greater Portland, sparking substantial discussion and involvement among participants (see Child Opportunity Index (COI) | diversitydatakids.org for more). Key discussion points raised included broadband access and medical distrust, both of which emerged as significant concerns among committee members.

Using appropriate online platforms while addressing challenges related to public accessibility and communication gaps within healthcare settings were also primary concerns.

Syra Health consultants also engaged Alignment members in a Word Cloud activity, which was effective in generating considerable discussion around health equity priorities. Syra Health and the Portland Health Equity Alignment proposed a follow-up virtual session, which received unanimous support from participants at the end of the meeting. Further discussions with the Portland Health Equity Alignment highlighted their keen interest in the virtual session, suggesting internal deliberations before scheduling to ensure alignment on objectives and outcomes. This virtual session would be designed to allow everyone to participate conveniently, addressing unanswered questions and potentially discussing collaboration with the City of Portland for their insights.

By the end of the meeting, there was a palpable sense of consensus among Alignment members about the need for targeted interventions that address the health equity needs of Black and Hispanic communities in Greater Portland. The consultants effectively synthesized the group's feedback, ensuring that diverse voices were heard and that actionable recommendations emerged from the discussions. This collaborative process not only strengthened relationships among Alignment members but also laid the groundwork for a unified approach to improving health outcomes and promoting equity across the region. Ultimately, the meeting highlighted the vital role of Alignment member engagement in developing a comprehensive and inclusive health equity strategy, reinforcing the commitment of all participants to work together towards a healthier, more equitable community.

Syra Health conducted a series of virtual follow-up sessions after their quarterly meeting, which spanned from June to August. These meetings focused on engaging Alignment members from the various committees to explore two critical questions: 1) How does medical distrust act as a barrier to the success of the Social Determinants of Health (SDOH) Plan; and 2) What are the implications of limited broadband access for underserved populations. Medical distrust and limited broadband access are significant barriers to health equity that could impede the success of the Accelerator Plan implementation, particularly for underserved populations of Greater Portland. Medical distrust among Black (and international populations) is deeply rooted in historical contexts and injustices. Ongoing disparities may deter persons of color from fully engaging in healthcare initiatives. Disparities amongst digital connectivity can similarly hinder access to telehealth services and online health resources[7]. The Social Determinants of Health Accelerator Plan looks to establish trust within Mainers by addressing medical distrust, broadband access, and health equity initiatives. Through discussions of these topics with Alignment members, Syra Health aimed to foster deeper understanding and collaborative solutions to address these pressing issues within the community.

7 National Library of Medicine (NIH). (2023). *Race, Healthcare, and Health Disparities: A Critical Review and Recommendations for Advancing Health Equity*. NIH. Retrieved from Race, Healthcare, and Health Disparities: A Critical Review and Recommendations for Advancing Health Equity - PMC.

Summary of Findings Committee Meeting Follow-ups

Meeting Attendance/Participation

On June 10th, the count of the Survey Monkey link was 41. Prior to, the official count utilized in the survey findings to the committee members was 37. The count officially stands at 43 participants. Despite the number of incremental increases, the data remains consistent. QR codes were provided to encourage more survey participation. The final count for attendance was 58, not including the two guest attendees from Syra Health. By committee attendance there were:

- Achieving Health Equity for Older Persons (AHEOP) – 11
- Community Health Workers (CHWs) – 7
- Community & Faith-Based Advisory – 7
- Clinical Advisory – 10
- Monitoring, Evaluation & Grant Committee – 4
- Social Determinants of Health – 14
- Student and Academic Advisory– 3

Quarterly Meeting Introduction

Regarding committee member participation, the Social Determinants of Health Committee, Achieving Health Equity for Older Persons, Community Health Workers, and Faith-Based Advisory had the highest attendance, each with around 10 to 15 participants. Syra Health proposes to seek out additional information for any of the committees that were underrepresented, as additional outreach might be needed to ensure their voices are included in the Plan. Committee members were very interested in the maps, particularly one showing broadband access. This tied in well with previous slides on the community, indicating a high level of engagement and relevance of the material presented.
The mapping was especially relevant to the Social Determinants of Health committee, which had highlighted broadband as a major concern. Usage of the website *diversitydatakids.org*, to analyze demographic data by ethnicity, identified areas with limited opportunities. This detailed analysis generated significant discussion and engagement among the participants.

The initial word cloud questions were successful as there was a lot of engagement by committee members. Comprehensively, time constraints prevented sharing responses for the second round, although these were documented on sheets provided. Both Syra Health and the Portland Health Equity Alignment suggested a virtual session, which garnered unanimous support from participants at the meeting's close. Discussions with the Portland Health Equity Alignment revealed their strong interest in the virtual session, proposing initial internal deliberations before scheduling the virtual meeting to ensure alignment on objectives and outcomes. The virtual breakout session will serve as a meeting where everyone can participate at their convenience, in which questions that weren't addressed and possibly discussing the idea with the City of Portland to gather their perspective on it.

Some key discussion points that were raised during the quarterly meeting include broadband access and medical distrust emerged as significant concerns among committee members.

The logistical aspects of organizing breakout sessions for the upcoming virtual meeting, are to coordinate group discussions effectively using platforms. The dissemination of information and the challenges of accessibility faced by the public, frustrations over communication gaps, and collaboration within healthcare settings. Syra Health proposes incorporating concept mapping and Venn Diagram exercises into potential virtual sessions, leveraging existing data to guide their structure.

Breakout Session: Share Your Committee's #1 Priority

Community Health Workers

Supporting the aging community involves understanding their unique needs and challenges. Cultural competency plays a crucial role in ensuring that services and support are tailored to meet the diverse cultural backgrounds within the aging population. By incorporating cultural competency into programs and services, we can better address the specific needs of older adults from various cultural backgrounds, promoting inclusivity and enhancing the quality of care provided.

Achieving Health Equity for Older Persons

Ensuring that services are inclusive for vulnerable populations is essential for increasing access to wound visits as individuals become more informed about wound care. By prioritizing inclusivity and tailoring services to meet the needs of vulnerable groups, such as the aging community, we can enhance access to wound care visits. Providing education and awareness about wound care not only empowers individuals to take better care of their wounds but also promotes proactive healthcare practices.

Social Determinants of Health

The biggest concern is that housing is a significant need that has not been fully addressed in any needs assessments and community health improvement plans. Mapping these assets and needs is a top priority. Public health plays a crucial role in addressing these issues by advocating for safe and affordable housing for the Portland population, conducting research to understand housing-related health disparities, and collaborating with community partners to develop solutions. Improving access to information and fostering connections within the community are key steps in addressing housing needs effectively. By enhancing communication channels and providing resources, public health professionals can help bridge the gap and support individuals in accessing housing-related services and information.

Community & Faith-Based Advisory

Providing cultural competency training to individuals who act as connectors within different committees is essential for promoting understanding and collaboration among diverse cultural groups. By offering this training, connectors can effectively navigate cultural differences, foster inclusive communication, and build strong relationships within the committees. This approach

ensures that all committee members feel valued and respected, leading to more productive and harmonious teamwork.

Clinical Advisory

Exploring Health Infonet, a data exchange software used by multiple organizations, with hopes for sharing information and ensuring continuity of care. Dealing with various EHRs/EMRs and different healthcare providers can lead to duplicate testing and barriers in information exchange. Creating an ideal system to track patients across the state for optimal care is crucial. Aligning emergency response plans with healthcare to respond in a unified manner is essential for effective coordination during crises. By streamlining data exchange, promoting interoperability, and enhancing communication between healthcare providers and emergency responders, we can improve patient outcomes and emergency response efficiency.

Student & Academic Advisory

Establishing a summer institute for educators to address the sense of belonging for children, especially those who have resettled, in a diverse school district. With 30-40% diversity in the schools in the Portland area, it's crucial to focus on intercultural community education, DEI work, and supporting teachers who might feel like they don't belong. Creating a summer program for this purpose is a great initiative. Offering stipends to teachers for a week-long training can help incentivize participation. However, Maine is one of the lowest ranked states with respect to the teacher salaries. Because of this, legislation has passed bills supporting raising their salaries. Next steps include securing the necessary funding to assist. Conducting a survey to assess the skills and expertise of educators can help tailor the training program effectively. Building connections with faith-based organizations can enhance inclusivity, and accommodating everyone's schedules for the training sessions is vital for maximum participation.

Monitoring, Evaluation, and Grant

Enhance the dissemination, discussion, and inventory of data, followed by establishing a repository to facilitate the easy sharing and access of data among team members and partners. Establishing regular virtual or in-person meetings will provide opportunities for committee members to discuss data insights, trends, and action plans. Additionally, creating a directory that includes the demographics and partners the MEG Committee works with to help organize and access relevant information efficiently. To bridge gaps between organizations and committees, it’s crucial to identify and leverage committee priorities. Actively searching for grants and funding opportunities can further support collaboration and project development.

Breakout Session: Word Cloud Activity

Prompt 1: When you think of the SDOH Accelerator Plan, what are two words that come to mind regarding what we wish to achieve? (Listed top 2 responses, followed by the next most popular)

- **Equity**
- **Community**
- **Access**
- **Accessibility**
- **Awareness**
- **Collaboration**
- **Community**
- **Health Equity**
- **Improved Communication**
- **Social Justice**

Prompt 2: What types of impacts would you like to see in your populations because of the SDOH Accelerator Plan? (Listed top 2 responses, followed by the next most popular)

- **Improved Health Outcomes**
- **Trust**
- **Access**
- **Belonging**
- **Happier Healthier People**
- **Housing**
- **Involvement in their Communities**
- **Policy Change**
- **Power Sharing**
- **Reducing Barriers**
- **Solutions**
- **System Change**

Community Health Workers

Prompt 1: Equity & Community

The Community Health Workers (CHWs) Committee plays a crucial role in community health, supported by strong community ties and a deep understanding of local dynamics. Equity is fundamental for promoting community well-being, advocating for equal access to healthcare and addressing disparities to ensure fairness in healthcare delivery. Collaborative efforts across diverse communities enhance advocacy and communication for equitable health outcomes. Awareness campaigns amplify community voices, visibility, and education, fostering safe environments for advocacy. Culturally tailored interventions contribute to improved health outcomes, bolstering self-efficacy, and increasing healthcare providers' cultural competence and patient safety practices. CHWs' frontline presence builds trust in public health systems by ensuring equitable access to healthcare resources.

Prompt 2: Improved Health Outcomes & Trust
The goal of improving health outcomes is to address the visible disparities. This includes lowering rates of chronic conditions, integrating Community Health Workers (CHWs) into healthcare teams, and providing culturally and linguistically appropriate interventions such as: using plain language, enhancing self-efficacy and advocacy, and increasing provider cultural awareness are also important. Implementing patient safety practices and ensuring appropriate medical testing regardless of economic status, race, or educational background are critical steps. Building trust amongst the people is also essential, as there is a clear distrust between communities and resources - a problem highlighted during the COVID-19 pandemic. CHWs play a crucial role in building this trust, serving as frontline public health professionals who bridge the gap between communities and healthcare systems. The committee believes that the SDOH plan can make a significant difference. Data related to all aspects of policy change are essential in describing how to achieve improved health outcomes and trust.

Achieving Health Equity for Older Persons

Prompt 1: Equity & Community
The Aging Committee identified several challenges related to equity and community needs, including barriers like complex systems and navigation, poverty issues, language barriers (English not being the first language), and lack of awareness about available resources. There's a strong call for increased collaboration among organizations to improve coordination and trust, as well as better accessibility to information technology and non-tech modes (such as paper) for disseminating information. Effective communication is emphasized as crucial, along with understanding the needs of vulnerable populations through an intersectional lens.

Prompt 2: Improved Health Outcomes & Trust
The committee aims for measurable improvements in health outcomes, promoting overall well-being and fostering a healthier community. Trust in the system and equitable access to services are identified as critical factors for achieving progress, although measuring these outcomes can be challenging. There's a strong advocacy for power sharing within systems to drive systemic change, emphasizing that equitable distribution of power can lead to broader improvements in health and access.

Social Determinants of Health

Prompt 1: Equity & Community
The SDOH Committee focuses on broad and inclusive solutions beyond traditional environmental concerns. Committee members are aware of inequities within communities and are determined to set benchmarks for achieving equitable outcomes. Discussions highlight the shift from broad approaches to more targeted strategies. The emphasis is placed on empowering communities with resources for sustainable growth and self-determination strategies. Strengthening community bonds is an essential factor, with an understanding that community health and quality of life are improved through the theme of social connectedness. Collaboration is an aspect identified as crucial to bridging gaps and implementing practical solutions to achieve equitable outcomes.

Prompt 2: Improved Health Outcomes & Trust
The committee's focus on improved health outcomes includes strategies for chronic disease prevention, mental health support, and addressing specific health disparities such as: diabetes, heart disease, minority health, maternal health, and oral health. the Portland Health Equity Alignment emphasizes the importance of reliable data and direct community input through focus groups. Building trust within communities is identified as pivotal for sourcing accurate data and increasing participation in health initiatives.

Community & Faith Based Advisory

Prompt 1: Equity & Community
The Community & Faith-based Advisory Committee emphasizes the importance of fostering a sense of community in Portland, while acknowledging and respecting the diversity of smaller communities within. Reaching equity involves improved communication, especially since most Portland elementary schools qualify for Title 1, highlighting a significance in socio-economic disparities. Issues such as segregation, preferences, and assumptions based on accents or the need for interpreters, limit access to rights and information, like Individualized Education Programs (IEPs). There is a strong need for education and awareness to combat these inequities. Social justice requires addressing the distrust created by systemic issues, such as the alarming statistic that 30% of pregnant Black women are dying from childbirth.

Prompt 2: Improved Health Outcomes & Trust
The committee notes that achieving improved health outcomes is challenging without addressing systemic issues. There is a pressing need to enforce system changes and establish a policy committee to ensure alignment with evidence-based practices. Measures, such as trauma-informed care, are crucial. The committee stresses the importance of preventive care and education about different healthcare options, noting that access continues to persist regardless of cultural competence if people cannot reach providers. The focus must shift from treating illnesses to promoting overall health.

Clinical Advisory

Prompt 1: Equity & Community
The Clinical Advisory Committee is focused on ensuring easy and equitable access to the healthcare system, addressing issues such as complex forms and lack of community resources. Simplifying application processes with a unified form is seen as crucial for helping individuals feel integrated into both healthcare and the broader community. Improved communication and understanding within the community are essential, particularly in centering the voices of those most impacted by inequities. Collaboration is key to enhancing access and fostering health equity by addressing interconnected issues like housing, transportation, and healthcare. Progress, defined by collaborative efforts and qualitative data collection, can help alleviate medical distrust. Pairing healthcare providers with Community Health Workers (CHWs) is suggested to aid in navigating and reducing medical distrust through consistent community storytelling.

Prompt 2: Improved Health Outcomes & Trust
The committee identifies medical distrust as a significant barrier to improved health outcomes, exacerbated by inconsistent messages from providers and implicit bias. Negative experiences in emergency rooms, medication confusion, and lack of resources contribute to this distrust. System-wide changes are needed to support providers in delivering consistent, clear messaging, including notes in multiple languages and simplified communication. Enhancing trust through these measures is essential for improving health outcomes.

Student and Academic Advisory Committee

Prompt 1: Equity & Community
The Student & Academic Advisory Committee emphasizes the importance of a shared understanding of "equity," which is more about the feeling of belonging and being valued within the community than something easily measurable. Equity is defined as the ability to belong to and contribute to the community, which is fostered through representation, intercultural curriculum, and a sense of belonging. The committee stresses that children do not thrive unless they feel they matter, underscoring the significance of a supportive and inclusive environment as reflected in systems like the Youth Risk Behavior Surveillance System (YRBSS).

Prompt 2: Improved Health Outcomes & Trust
Building trust is crucial and is facilitated through relationships and mutual learning. Effective communication about how the education system works and maintaining ongoing dialogue between school and home are essential for fostering trust. These elements help ensure that students and families feel connected and understood within the academic community.

Monitoring, Evaluation, and Grant

Prompt 1: Equity & Community
The Monitoring, Evaluation, and the Grant Committee (MEG) is focused on defining equity in a way that embodies the mission of the PHEA. The committee notes the visible change and influx of persons from both out of the state and county, highlighting the dilemma of Portland to focus on economy and tourism, versus maintaining a sense of community. The committee acknowledges access and accessibility are key to achieving equity, requiring collaboration and improved communication to overcome disconnected systems. Effective teamwork and the removal of barriers to collaboration and communication are essential for creating a cohesive community.

Prompt 2: Improved Health Outcomes & Trust
The committee notes building trust is also critical, as there is a clear distrust between communities and resources. The committee believes that the SDOH Accelerator Plan can make a significant difference.

Discussion

In this summary of findings, Syra Health focuses on the active participation and engagement between the Portland Health Equity Alignment, Committee Chairs, and Committee Members. Based on the breakout discussion sessions, two key discussion takeaway points in **broadband access** and **medical distrust**, emerged as critical issues- prompting the proposal and unanimous support for a joint virtual session. The prioritized committee themes of the SDOH Accelerator Plan are equity, community, improved health outcomes, and trust-building. Additionally, committees are focused on cultural competency, addressing barriers and accessibility in healthcare and delivery and medical distrust, and housing needs. Noting the student and teacher success specifically, the Student & Academic Advisory committee underscored the importance of belonging and intercultural education and bridging the gap between educator disparities.

Conclusion

In conclusion, the committee participation and engagement served as noteworthy information to drive the development of the SDOH Accelerator Plan. To address the interest surrounding mixed committee collaboration, virtual sessions were suggested and received unanimous support. The themes emphasized throughout each committee of equity, community, and trust are testament to the two discussion topics of interest: broadband access and medical distrust. Overall, Syra Health and the Portland Health Equity Alignment's collaborative approach will address the deliverable towards to the SDOH Accelerator Plan.

Recommendations: The Portland Health Equity Alignment

To effectively address the health disparities and inequities faced by Black and/or African American and Hispanic communities in Greater Portland, the following recommendations of Syra Health are designed to guide efforts in implementing the Social Determinants of Health Accelerator Plan. These recommendations are rooted in collaborative strategies, community input, and evidence-based practices. By focusing on tailored interventions and fostering partnerships among Alignment members, we aim to create impactful and sustainable changes that improve chronic disease outcomes and promote overall community wellness. Each recommendation outlines actionable steps to ensure that our initiatives are responsive to the specific needs of the target populations, thereby advancing our mission of health equity and inclusivity.

Social Connectedness

In brief, social connectedness in the Greater Portland context, refers to how community members in the broader macrosystem connect to respective community organizations (such as the Portland Health Equity Alignment), social networks, schools, groups, and any group-related organizations[8]. Family, friends, school, and community support of any individual has a profound effect on health[8].

Recommended Strategies

Aligning health equity barriers with social connectedness and community clinical resources involves a multifaceted approach that addresses systemic inequities while fostering strong community ties. First, it's essential to identify health equity barriers through data collection that focuses on demographics, access to care, socioeconomic status, and specific health outcomes. Engaging community members to understand their experiences and challenges is also crucial. Enhancing social connectedness can be achieved by building community networks that create platforms for residents to interact, such as support groups and social events. Partnering with local organizations, schools, and faith-based groups can further facilitate these connections.

8 Science Direct. *Social Connectedness*. Journal of Adolescence, 2021. (2021). Science Direct. Retrieved from Social Connectedness - an overview | ScienceDirect Topics.

Integrating community clinical resources involves ensuring that clinical services are accessible and culturally competent. This may include mobile clinics, telehealth options, and employing Community Health Workers. Collaborating with healthcare providers to establish referral systems and integrated care models that address both physical and social needs is vital. Promoting health literacy through education programs can help community members navigate healthcare systems more effectively, using clear and culturally relevant messaging to improve understanding and engagement.

Advocacy for policy changes is another key aspect, focusing on addressing Social Determinants of Health like housing, employment, and education, which are integral to achieving health equity. Seeking funding to support community-based programs that tackle health disparities and enhance social connectivity is important as well. Finally, regular monitoring and evaluation of programs allow for the assessment of their effectiveness, and utilizing feedback from community members can help adapt strategies for continuous improvement. By fostering strong community ties and ensuring equitable access to healthcare, we can create healthier, more resilient communities.

Community-Clinical Linkages

In brief, community-clinical linkages in the Greater Portland context, refers to connections between how community members interact with the broader clinical sector to improve health within the community. Community-clinical linkages are rooted in evidence-based approaches to preventing and managing chronic disease[9].

Recommended Strategies

Developing community clinical linkages is crucial. This involves creating partnerships between healthcare providers, community organizations, and social services. Establishing referral systems can help ensure that individuals receive comprehensive care that addresses both medical and social needs. For example, integrating mental health services with primary care can help address issues that disproportionately affect marginalized populations.

9 CDC. *Community-Clinical Linkages: Implementing an Operational Structure with a Health Equity Lens*. (2020). CDC. Retrieved from Community-Clinical Linkages: Implementing an Operational Structure with a Health Equity Lens.

Enhancing accessibility to clinical services is another important aspect. This can include offering services in community settings, utilizing mobile clinics, and implementing telehealth options to reach those who may have transportation or mobility challenges. Ensuring that clinical staff are culturally competent and reflective of the community they serve is also vital for building trust and encouraging utilization of services.

Promoting health literacy within the community can empower individuals to navigate healthcare systems more effectively. Educational programs tailored to the community's specific needs can provide information on available resources, preventive care, and chronic disease management.

Advocating for policy changes that address Social Determinants of Health—such as housing, education, and employment—can further reduce barriers to health equity. Collaborating with local policymakers and key community contributors to create supportive environments is crucial for sustained impact.

Finally, it's essential to monitor and evaluate the effectiveness of community clinical linkages in addressing health equity barriers. Gathering feedback from key community contributors can inform ongoing improvements and adaptations to strategies, ensuring they remain relevant and effective.

Broader Guidance

Describe the recommended strategies for the Portland Health Equity Alignment moving forward regarding actionable steps to take as an organization.

1 Central Data Repository

Creating a Portland Health Equity Alignment central data repository involves several steps to guarantee accessibility. When considering the creation of a data hub, it's important to consider the following questions regarding the data streams:

- **What are the data streams of public data/private data (individual level data/aggregated)?**
- **How often are the data streams being updated? Weekly? Monthly? Quarterly?**
- **Does the Portland Health Equity Alignment want the data hub for Portland Health Equity Alignment members only or should this information be given to the public?** **If the data hub is for public use, does the Portland Health Equity Alignment have rules and regulations for data suppression (individual level data)? **
- **What is the Portland Health Equity Alignment's ideal use case for a hub of data streams?**

Firstly, the Portland Health Equity Alignment should define the purpose of the repository and identify the types of data that will be stored. Next, select an appropriate platform or technology that meets your organization's needs, considering factors such as scalability, security, and ease of use. Once the platform is chosen, establish a data governance framework to define roles, responsibilities, and data management policies, ensuring data integrity and compliance with regulations.

Following this, gather and organize existing data from various sources, cleaning and standardizing it to eliminate duplicates and inconsistencies. This step is crucial for ensuring that the repository contains high-quality information. After the data is prepared, begin the implementation process by setting up the repository structure, including categories, tags, and metadata to facilitate easy searching and retrieval.

Once the repository is established, it's important to populate it with the organized data, ensuring that it is uploaded correctly and is accessible to users. Afterward, conduct thorough testing to identify any issues and ensure the system operates smoothly. Finally, train users on how to navigate and utilize the repository effectively, providing documentation and support as needed. Regularly review and update the repository to accommodate new data and evolving needs, ensuring it remains a valuable resource for your organization. Some purposes identified are creating a central depository for organizational reference when applying for grants.

2 Greater Portland Outreach

Effective community engagement is crucial for fostering trust and collaboration between health initiatives and the communities they serve. the Portland Health Equity Alignment plays a vital role in addressing health disparities; however, there is a pressing need to improve the dissemination of information regarding its updates and projects to community members who may not be directly involved in the Portland Health Equity Alignment. Many residents may remain unaware of ongoing efforts, initiatives, and opportunities for participation, which limits their ability to engage meaningfully with health equity work.

To enhance communication, the Portland Health Equity Alignment should develop a comprehensive outreach strategy that utilizes various channels to reach diverse community members. This could include regular newsletters, social media updates, community forums, and partnerships with local organizations that have established connections within underserved populations. By actively promoting transparency and providing clear, accessible information about current projects, timelines, and outcomes, the Portland Health Equity Alignment can foster greater awareness and engagement.

Moreover, soliciting feedback from community members about their preferred communication methods can ensure that information is not only disseminated but also tailored to meet the specific needs of different groups. Engaging community members in this way not only empowers them but also cultivates a sense of ownership over health initiatives, which can lead to increased participation and support.

In summary, improving communication about the Portland Health Equity Alignment's projects is essential for building a more inclusive and engaged community. By prioritizing outreach and actively involving residents in the conversation, the Portland Health Equity Alignment can strengthen its impact and effectiveness in promoting health equity throughout the region.

3 Addition to the Alignment: The Policy Committee

The addition of the Policy Committee is a new organization, tasked with influencing and steering our policy framework. Committed to fostering transparency, inclusivity, and effectiveness, our goal is to ensure that our policies align with our fundamental values and address the dynamic needs of our Alignment members. By drawing on a wide range of perspectives and expertise of newly appointed Co-Chair, Deqa Dhalac, the aim is to strive towards policies that promote sustainability and health and social equity. This section will outline the Policy Committee's primary objectives, goals, and priorities to guide forward moving efforts to advocate for all Mainers.

Below, please see the three sections outlining the newly incorporated **Policy Committee**. The sections will focus on the Committee objectives, goals, and priorities as identified and decided upon in collaboration with the Portland Health Equity Alignment Founder, the newly appointed Policy Committee Chair, and the health equity consultant Syra Health. Committee priorities are designed to follow the Portland Health Equity Alignment nomenclature surrounding the "Explore & Respond" and "Monitor & Be Ready" initiatives.

Objectives

Policy Committee Establishment: Objectives

Launch public health awareness campaigns on the top 3 social determinants of health (housing, transportation, and education) to educate communities about their importance and how to improve these factors with community support.

Collaborate and educate both the Portland Health Equity Alignment and Greater Portland community members on new and established policies by local/state legislators that address key social determinants such; housing, transportation, healthcare (physical, mental, emotional, spiritual, dental, vision, oral), education, employment, social services, and immigration legal services.

Collaborate with the Monitoring, Evaluation, and Grant Committee (MEG), backed by the input of the Portland Health Equity Alignment, to conduct comprehensive assessments and identify critical social determinants of health that impact the community.

In collaboration with the Community Health Workers Committee (CHWs), ensure that immigrants and/or New Mainers receive legal, health, and social services and work to train CHWs to points Immigrants and New Mainers to helpful services of Greater Portland.

Goals

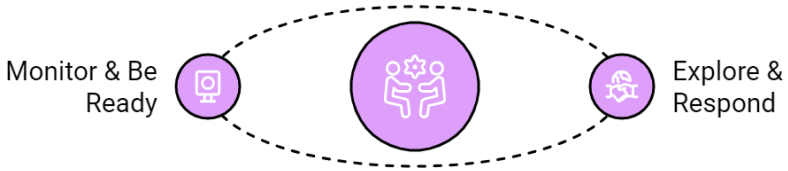
Promote equal representation for all citizens and ensure that policies and decisions address the needs of diverse groups supported by the Portland Health Equity Alignment

Policy Committee Establishment: Goals

Engage with the community to raise awareness and support for policies that impact housing, transportation, and education.

Collaborate with the Portland Health Equity Alignment Leadership Team for recruitment and development purposes of the Policy Committee

Policy Committee Establishment:
Priorities



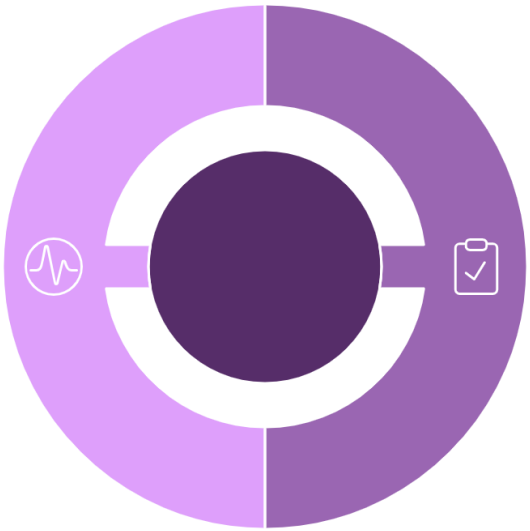
Explore & Respond

Promote collaborative efforts among government agencies, community organizations, private sectors, and public partners.

Foster and maintain partnerships with partners across multiple sectors (i.e., housing, education, employment, transportation) to support current efforts to address social determinants of health.

Monitor & Be Ready

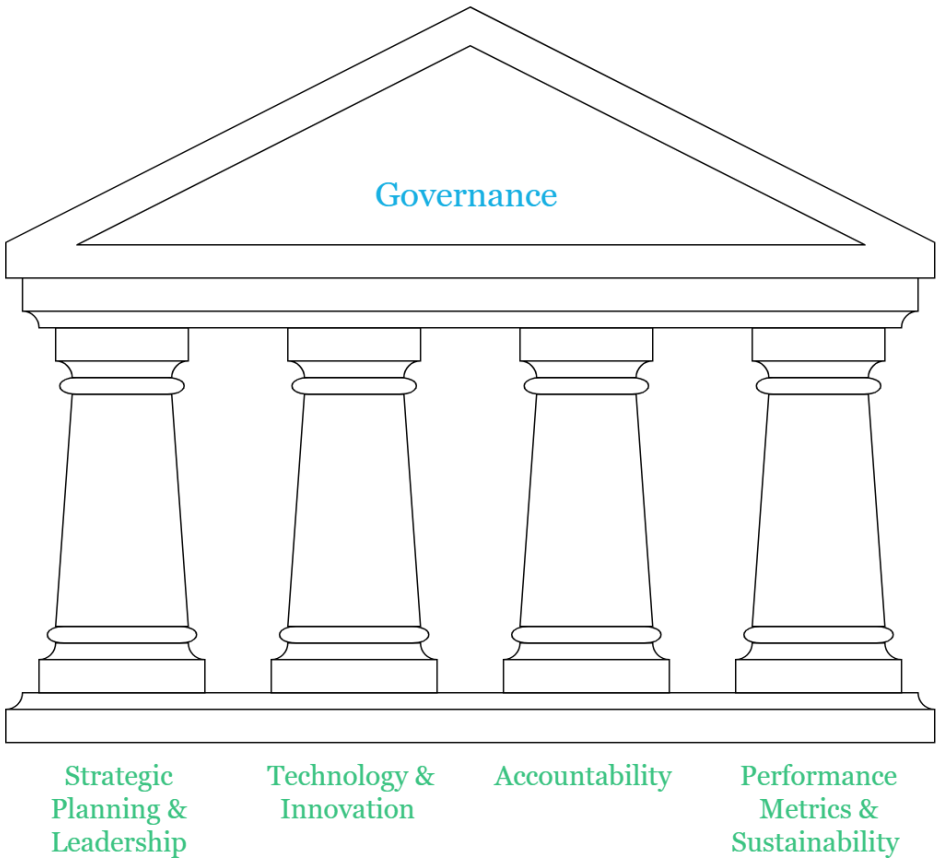
Support the collection of data on social determinants of health and their effects on community health outcomes and inform The Alignment when a bill is needed for support.



Regularly review, report, and lobby on policy outcomes and decisions.

4 Portland Health Equity Alignment: Structured Governance

Effective governance is essential to the long-term success of any organization, and moving forward, will provide the framework for the Portland Health Equity Alignment in the four pillars of: Strategic Planning & Leadership, Innovation & Technology, Accountability, and Performance Metrics & Sustainability. By fostering leadership structures and processes, governance helps organizations to navigate future challenges and builds trust within the organizational networks. The Portland Health Equity Alignment Leadership Team, working with the Policy and MEG Committees, will lead the governance of the Portland Health Equity Alignment. One recommended approach is to utilize the below suggested ‘‘**Structured Governance”** as a system to help define clear goals. Organizational boards will be strengthened by prioritizing the achievement of these goals and ensuring the maintenance of effective systems and processes[10]. This strategy also will foster productive relationships with leaders, resulting in tangible outcomes in growth and social impact[10].



Pillar	Identified Barrier Addressed	Responsibility	Detailed Measures
1. **Strategic Planning & Leadership**	**Defining and achieving long term goals**	**Portland Health Equity Alignment Leadership Team**	The important theme behind Strategic Planning and Leadership is democracy. Within The Alignment, regardless of their role, members should be expected to collaborate effectively across committees, take responsibility for committee action items, empower colleagues, and contribute to maintaining a healthy democracy of the Alignment. Organizations should strive to achieve, not just in the leadership room, but also in the workplace and with the members of the entity[11]. Governance is defined as guiding, making crucial decisions, and working together toward shared objectives[11]. Healthy interactions between Alignment members allows committee members to actively participate in reflecting on and shaping change within their organization. Every member has the right to be involved in the decision-making processes. The Leadership Team must work to create a shared understanding among committee members regarding the strategic decisions of committee action items and steps moving forward. Shared ownership and democracy are central to what distinguishes an organization from general working/committee groups[11].
2. **Technology & Innovation**	**Development, implementation, access to information, and ease of use**	**Portland Health Equity Alignment Leadership Team**	The Leadership Team should draw from innovative tools including technology and online platforms to stay up to date with moving parts outside of the organization and to address both sustainability and ease of use for process flows. The Leadership Team should collaborate with the Monitoring, Evaluation, and Grants Committee to establish ArcGIS mapping for future projects. The Leadership Team should consider focusing on several key areas to enhance the effectiveness of the Monitoring,

Evaluation, and Grants Committee's work. First, it is essential to determine the most appropriate type of mapping for visualizing the Portland Health Equity Alignment. For example, heat maps will offer a valuable tool in visualizing coverage gaps in health service distribution of MaineHealth FindHelp.

The Leadership Team should also consider data visualization approaches to effectively represent the various features of organizations on the map. Integrating PowerBI with data sources is recommended to facilitate deeper data analysis. Through designing dashboards that show key metrics and relationships, the Leadership Team can ensure that the maps and data work in tandem to deliver insights to promoting health equity in Greater Portland.

The Leadership Team should work with the MEG Committee to identify which Key Performance Indicators, or KPIs, to monitor if they align with Portland Health Equity Alignment organizational objectives. Offering interactive visualizations should also be prioritized, as they will allow users to explore the data in more depth and gain a fuller understanding of health inequities in Greater Portland. Integrating ArcGIS maps into PowerBI dashboards will provide a comprehensive view of the data for all committee members to utilize. The Leadership Team should focus on ensuring the smooth coordination between the two platforms by using automated data refresh processes.

For the Leadership Team, it is also important to define the level to which there is interaction between the maps and other visualizations, such as using different symbols and colors to represent various organization types or focus areas. This interactivity will help committee members and Greater Portland community

				residents to interpret the data and make informed decisions. Another consideration is the selection of base maps and additional layers to be included. The Leadership Team should explore these options in parallel with the MEG Committee, such as incorporating pop-ups to display detailed information about each organization or creating multiple map views to highlight different aspects of the data. Finally, the implementation of these mapping solutions should begin with importing organization location data into ArcGIS. From there, base maps and relevant layers should be created, along with the necessary geographic features and boundaries. This process will ensure that the maps are accurate, informative, and aligned with the committee's objectives. Through these recommendations, the leadership team can guarantee that future ArcGIS mapping efforts will support the monitoring, evaluation, and decision-making processes, ultimately driving more effective outcomes.
3. **Accountability**	**Ownership and communication, preventing neglect or passed on without completion**	**Portland Health Equity Alignment Leadership Team**	Accountability is essential for the success of the Portland Health Equity Alignment, as it ensures both committee members and the Leadership Team are aligned with the organization's goals, responsibilities, and expectations. Accountability involves setting clear expectations, assigning specific responsibilities, and regularly checking on progress[12]. One effective model for creating accountability is through Policy Governance. Policy Governance is utilized as an approach to establishing role clarity, maintaining focus, and ensuring that all members are held responsible for their contributions[11]. The Policy Governance Model, also known as the Carver Model, is a comprehensive system for organizational governance developed by

Dr. John Carver[12]. This model is designed to empower boards of directors to fulfill their accountability obligations effectively[12]. Within the Policy Governance Model, organizational purpose, called ENDS, are clearly separated from other operational matters, MEANS, with a strong focus on achieving the organization's purpose[12]. The ENDS refer to main goals or the overall purposes of The Alignment. The MEANS serve as the methods used to achieve those goals. The model makes sure that the organization's purpose (ENDS) is the top priority, while other issues, like how to go about achieving those goals (MEANS), are handled separately. The goal is to maintain focus on achieving the purpose, while making sure the methods used are appropriate and follow certain rules.

A key aspect of this governance approach is the requirement to "speak with one voice," where dissent is expressed before a vote but decisions, once made, should not be undermined[12]. The Leadership Team should establish rules for delegating authority to staff and for evaluating performance based on set criteria in collaboration with the MEG Committee. Policy Governance deliverance in delegation, ensures clear accountability and eliminates confusion about who is responsible for meeting the team’s expectations[12].

Evaluation is focused on whether the board's expectations have been met. By clearly defining these expectations, the board can more easily assess performance, reducing the need for excessive paperwork. Additionally, by specifying their information needs and demanding accurate performance reports, the Leadership Team has control over the data they receive, eliminating the need for committee members to anticipate one another’s needs.

				Many executive boards and organizations have effectively used Policy Governance to create clear structures of responsibility. This model can be equally valuable within the Portland Health Equity Alignment. By incorporating Policy Governance, the Portland Health Equity Alignment can benefit from a structured framework that reinforces accountability and empowers members to take ownership of their roles. This model encourages transparency and trust, as organization members understand their specific duties and are held responsible for meeting expectations. It also promotes a culture of collaboration, ensuring that members actively contribute to the collective effort to address public health and environmental challenges. Moreover, accountability through Policy Governance helps keep the organization focused on its core objectives. Regular monitoring and evaluation ensure that tasks are completed on time, responsibilities are fulfilled, and the organization continues to progress toward its long-term goals. By holding members accountable, the Portland Health Equity Alignment can also identify areas for improvement and ensure that resources are being used effectively and efficiently.
4.	**Performance Metrics & Sustainability Usage**	**Short and Long term focus, failure to adapt, lack of direction**	**Portland Health Equity Alignment Leadership Team**	To ensure the sustainability and effectiveness of the Portland Health Equity Alignment, it is crucial to manage expectations and track the performance of coalition initiatives. This process involves identifying and prioritizing committee member success, understanding their own perspectives and concerns with issues raised by committee members, and engaging with committee members in planning efforts to address respective committee and Alignment action items[11]. Leadership engagement will also support managing diverse interests and potential communication barriers by developing tailored communication approaches, negotiating conflicting

	interests, and maintaining trust through transparent and consistent communication. Measuring performance and sustainability of these actions entails setting SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals for sustainability initiatives and conducting regular sustainability check-ins to measure performance and results are also essential[11]. By integrating these practices, the Leadership Team can foster continuous improvement, demonstrate accountability to Greater Portland, and ensure the long-term sustainability the organization.

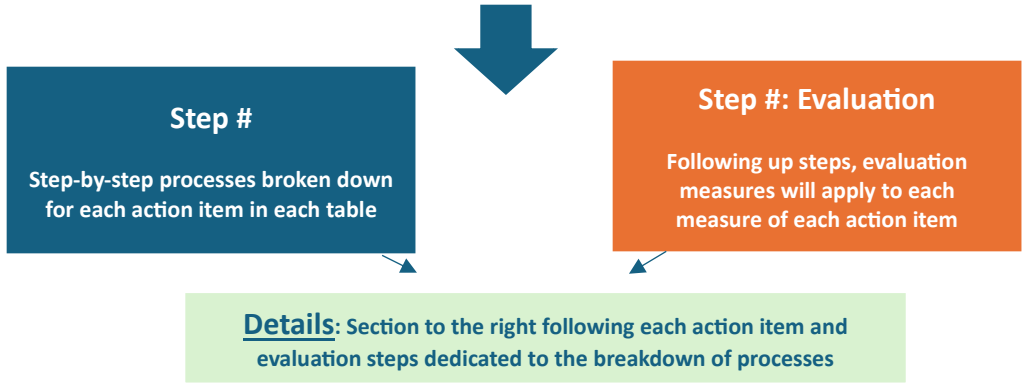
10 Clune, W., Zehnder, A. (2018). *The Three Pillars of Sustainability Framework: Approaches for Laws and Governance*. Scientific Research. Retrieved from The Three Pillars of Sustainability Framework: Approaches for Laws and Governance.
11 Khan, Humera. (2011). *A Literature Review of Corporate Governance*. ResearchGate. Retrieved from (PDF) A Literature Review of Corporate Governance.
12 Carver, John. (2016). *The Policy Governance Model*. PolicyGovernance.com. Retrieved from The Policy Governance® Model - an Overview.

Flow Chart: Recommendation and Processes by Committee

This section provides a detailed overview of the various committees, their respective roles, and the action items they have identified. The committees listed below are tasked with specific goals or projects, and the associated tables will outline the key action items, responsible parties, timelines, and status updates.

Following the table, we will provide a step-by-step process for addressing each action item, as well as recommendations for successfully executing these tasks. This structure is designed to ensure clarity, accountability, and effective tracking of progress as the committees work toward their objectives.

Action	Barriers	Responsibility	Construct	Measure	Duration
Action items identified by Syra Health based on Committee research and surveys	Barriers addressed based on identified hurdles to health equity and healthy living	The respective Committee(s) to which the action items and steps will be responsible for (can include the Leadership Team)	Does the action item identified address social connectedness, community-clinical linkages, or both	What are the evaluation pieces for measuring successes	The time commitment that needs to be allocated to respective tasks



	Barrier	Reported by Committee	Date
1.	Barriers to religious rites not properly administered	Community & Faith-based	7/26/24
2.	Unaccompanied minors in healthcare settings	Community & Faith-based	7/26/24
3.	Central access to data	Monitoring, Evaluation, & Grants	7/30/24
4.	Central location of resources	Monitoring, Evaluation, & Grants	7/30/24
5.	Implementation	Monitoring, Evaluation, & Grants	7/30/24
6.	Sustainability	Monitoring, Evaluation, & Grants	7/30/24
7.	Barriers to client and patient understanding of qualifications for coverage versus insurance	Community Health Workers	8/2/24
8.	Immigrants do not seek sexual and reproductive services	Community Health Workers	8/2/24
9.	Proficiency in English	Community Health Workers	8/2/24
10.	Undocumented residents hesitant to seek medical services	Community Health Workers	8/2/24
11.	Fears of deportation if individual receives medical treatment	Community Health Workers	8/2/24
12.	Broadband and internet access	Social Determinants of Health	8/5/24
13.	Digital literacy	Social Determinants of Health	8/5/24
14.	Limited technological infrastructure available to the public	Social Determinants of Health	8/5/24
15.	Spread of misinformation on	Clinical	8/14/24

pregnancy and maternal care		
16. High C-section rates	Clinical	8/14/24
17. Misinformation of NICU experiences	Clinical	8/14/24
18. Misinformation on EHR/EMR usage	Clinical	8/14/24
19. English proficiency related to medical records access	Clinical	8/14/24
20. Medication effectiveness	Clinical	8/14/24
21. Waitlist and appointment duration	Clinical	8/14/24
22. Cultural humility and competency training	Student & Academic	8/29/24
23. Social isolation	Achieving Health Equity for Older Persons	8/21/14
24. Ageism	Achieving Health Equity for Older Persons	8/21/14
25. Transportation challenges	Achieving Health Equity for Older Persons	8/21/14
26. Cultural humility and competency training	Student & Academic	8/29/24
27. Miscommunication between educators and students	Student & Academic	8/29/24

Achieving Health Equity for Older Persons Committee (Aging)

This section provides a detailed overview of action items recommended by Syra Health for the Achieving Health Equity for Older Persons (AHEOP) Committee. These recommended actions are based on Syra Health's continued collaboration with Portland Public Health and the Alignment to identify tasks to address the barrier(s) presented.

Following the table, please see the step-by-step process for addressing each action item, moving from ongoing tasks, to suggested actions, as well as measurable efforts for successfully executing these tasks. Committee action items depicted as light blue text are specific items related to ongoing initiatives of the Student & Academic Advisory Committee. **Text in black are the suggested action items of Syra Health**.

	Action	Barriers Addressed	Responsibility	Construct	Measures	Duration
1.	Promote awareness of BIPOC and LGBTQ+ community members about older adult services and benefits to increase access to services, especially behavioral health	Lack of awareness and information, cultural competency, and trust Fear of discrimination	AHEOP, Clinical	Both Social Connectedness	Change over time in number of individuals accessing behavioral health services Collaborate with the Cross Cultural Community Services to engage with organizations that serve BIPOC and LGBTQ+ populations to evaluate perceptions the outreach and educational materials	Ongoing

2.	Establish relationships between older Mainers and healthcare provider systems	Barriers to establishing relationships between doctors and patients to build trust	AHEOP, Clinical	Community-Clinical Linkages	Client and patient provider hesitancy to seek/provide services	Ongoing
		Barriers to trust forming with age, and not trusting health systems in general		Community-Clinical Linkages	Client and patient willingness to use recommended treatment options	
		Barriers to reducing the perception among clients/patients that their voices are not being heard		Community-Clinical Linkages	Overall feedback from client/patient satisfaction surveys (feedback loops)	
		Dismantling the popular consensus of providers seeing appointments as “checklist items”		Social Connectedness	Client and patient appointment duration	
		Consensus amongst the international population is that providers are not familiar with their world		Social Connectedness	Focus groups with clients/patients on how they experience the care setting	

3.	Increase peer, intergenerational, and general community connection for older adults by providing opportunities for increased engagement	Social isolation and loneliness due to physical distance from family and friends, mobility issues, or loss of loved ones	AHEOP	Social Connectedness	Social Connectedness surveys	Ongoing
4.	Strengthen services for older adults and provider's knowledge about cultural awareness and humility. Connect with CHWs so they are more knowledgeable about services for older adults	Older adults accessing healthcare and older adult services due to language barriers, cultural differences, or lack of understanding of the healthcare system CHW training includes limited information about services for older adults Ageism	AHEOP, CHW	Social Connectedness	Monitor the frequency of referrals, enrollments, or requests for services from these populations	Ongoing
5.	Increase access to home visits & integrated case management	Eliminate the need to travel long distances or navigate transportation challenges	AHEOP, CHW	Community-Clinical Linkages	Number of individuals accessing home visits and integrated case management services	Ongoing

		Eliminate persons with chronic conditions or complex medical needs may require continuous, coordinated care in person Social isolation			Number of people served by home visits and case management before and after implementation	
6.	Identify & evaluate funding opportunities	Expand service offerings and ensure that the services provided meet the demand in the community.	AHEOP	Both	Funding distribution across different services (e.g., housing, home care, transportation services, behavioral health services)	Ongoing

Syra Health's Recommendations for Future Consideration:

This section provides a detailed overview of action items recommended by Syra Health for the Achieving Health Equity for Older Persons (AHEOP) Committee to consider for future recommendations.

1.	Connect patients with the appropriate provider based on gender preference	Client and patient shock and comfortability with providers of the opposite sex (feeling more relatable with providers of the same sex) Medical mistrust in providers and healthcare systems	AHEOP	Community-Clinical Linkages Community-Clinical Linkages	Patient engagement and satisfaction (through one-on-one interviewing, focus groups, and surveys) Number of Mainers seeking healthcare services and utilization of treatment options	Ongoing
2.	Mitigate harm in environments where clients and patients are dismissed; Implement follow-up procedures for older adult populations	Appointment duration and checklist environments Lack of clear communication of clients/patients regarding follow-up appointments	AHEOP, CHWs, Clinical	Social Connectedness Community-Clinical Linkages	Conduct focus groups and community breakout sessions to explore themes of underlying medical distrust Increase in follow-up appointment attendance	Ongoing

Action Plan for Enhancing Health Communication and Relationship Building in Healthcare Services

step-by-step processes and details in light blue in this action section are AHEOP Committee current initiatives

Action: BIPOC and LGBTQ+ community members become more knowledgeable about aging services and benefits, and therefore they increase their access to such services, especially behavioral health services (Ongoing)

In the fall of 2023, the Cross Cultural Community Services (CCCS), in collaboration with the Maine Council on Aging (MCOA), facilitated focus groups with seven diverse aging community groups and organized a retreat that included representation of aging service providers from the Maine Office of Aging and Disability Services, the City of Portland Office of Elder Affairs, the Southern Maine Agency on Aging (SMAA), Catholic Charities, and other interested parties. In the winter of 2024, CCCS merged with the City of Portland Health Equity Program Aging Alignment Advisory Committee, also known as the **Achieving Health Equity for Older Persons (AHEOP, Aging) Committee**.

Aim 1

Develop a Centralized Resource to Enhance Cultural Competency

Details

- **Contributors:** AHEOP Members
- **Steps:**
  - Increase the understanding of available programs and services including organizations that have offered cultural awareness training and centralized information on where to find programs): AARP, AAA, insurance, SSI benefits, MaineCare, hospice, and transportation.
  - Provide follow-up support to access services: healthcare, housing, and other supportive services.
- The existing partner for this action item is Southern Maine Agency on Aging (SMAA), with additional support from Park Danforth and Maine Trans Net.

Aim 2

Create a List of Partners Already Increasing Their Understanding of Available Programs

Details

- **Contributors:** AHEOP Members
- **Steps:**
  - Identify opportunities to engage with organizations that have not implemented cultural awareness trainings or initiatives to improve accessibility and equity for diverse communities (e.g. AARP, Transportation services, and insurance providers).

Aim 3

Increase Volunteer Engagement from Within Specific Communities to Serve Their Communities

Details

- **Contributors:** Southern Maine Agency on Aging (SMAA), with additional support from CCCS, Bishop Coleman, Maine Immigrant Rights Coalition, Maine Access Immigrant Network.
- **Steps:**
  - Collaborate with trusted leaders within specific communities (e.g., religious leaders, cultural ambassadors, local activists) to promote the importance of volunteerism. These leaders can help raise awareness and motivate others to engage in volunteer activities that support their community's needs.

Aim 4

Building Relationships

Details

- **Contributors:** The current lead on this action Southern Maine Agency on Aging (SMAA), with additional support from CCCS, Bishop Coleman, Maine Immigrant Rights Coalition, Maine Access Immigrant Network.
- **Steps:**
  - Provide opportunities to build and maintain relationships among providers and aging community members (such as through site visits and other informational networking sessions).

Aim 5: Evaluation

Data

Details

- **Key Metrics:**
  - The current lead is Megan Walton with SMAA to work on and compile the necessary data metrics.

Action: Establish relationships between Mainers and healthcare provider systems (Ongoing)

Aim 1

Enhance Health Communication

Details

Campaign of Trust: Tailor health communications to meet the cultural and linguistic needs of Maine's diverse populations, and persons of all age groups.

- **Contributors:** AHEOP Members
- **Steps:**
  - Develop materials in multiple languages, use culturally relevant images and references, and partner with trusted community leaders or organizations to disseminate information.
  - Use websites, social media, text messages, and mobile apps to share information about healthcare access, services, and upcoming community health events.
  - Launch targeted health education campaigns on topics like preventive care, vaccinations, mental health, and substance abuse.

Aim 2: Evaluation

Monitor Change in Client and Patient Provider Hesitancy

Details

- **Contributors:** AHEOP Members
- **Steps:**
  - Assess change in the number of individuals accessing social services for older people visiting primary care providers for regular check-ups or preventive care.
  - Assess number and frequency of preventive services being accessed, such as screenings, vaccinations, and wellness checks.

Aim 3: Evaluation

Monitor Client and Patient Willingness to Use Recommended Treatment Options

Details

Assess patient satisfaction through surveys, focus groups and interviews. Ask about client/patient feelings towards treatment options, and feelings toward the recommended treatment. Questions include:

- "How do you feel about the treatment option I've recommended?"
- "What concerns do you have about starting this treatment?"
- "How confident are you in the effectiveness of this treatment?"

Action: Increase peer, intergenerational, and general community connection for older adults by providing opportunities for increased engagement (Ongoing)

Aim 1

Diverse Networking

Details

- **Action Lead:** Equality Maine (social), MCOA, CCCS
  - EQME: piloting an intergenerational mutual aid support system, "chore services"
- **Contributors:** SMAA, AARP, City of Portland, Bishop Coleman (space)
  - **Partners:** Catholic Charities Homemaker program, The Third Place.
- **Steps:**
  - Research and compile a list of existing culturally diverse networking/social activities in greater Portland to increase awareness, participation, and learn where the gaps are.

Aim 2

Disseminate Existing Events

Details

- **Action Lead:** CCCS, EQME, MCOA
- **Contributors:** Maine Association of New Americans (MANA)
- **Steps:**
  - Support, promote, and disseminate existing events (virtual & print, multiple languages, on multiple agency sites like agewisemaine.org/ Amjambo Africa/findhelp.org) for older persons.

Aim 3

Disseminate Existing Events II

Details

- **Action Lead:** CCCS, MCOA, community leaders, volunteers, and BIPOC-led organizations.
  - Look at the focus group and retreat notes/ report.
- **Contributors:** SMAA, AARP, MANA
- **Steps:**
  - Evaluate the existing barriers, which include transportation, access, language options, cost, pre-booking requirements, location, and eligibility, so older persons can independently access services.

Aim 4: Evaluation

Disseminate Existing Events

Details

- **Key Metrics:**
  - Assess the growth of peer, intergenerational, and overall community connections for older adults with qualitative and quantitative data.
  - Monitor the success of programs or initiatives that create opportunities for involvement, helping to build stronger social bonds among seniors.

Action: Strengthen services for older adults and provider's knowledge about cultural awareness and humility. Connect with CHWs so they are more knowledgeable about services for older adults (Ongoing)

Aim 1

Increase Networking

Aim 2

Increase Networking II

Aim 3

Increase Training

Details

- **Contributors:** Zoe Shaloul, NEAAO
- **Steps:**
  - List community events for providers to attend to create more networking opportunities.

Details

- **Action Lead:** City of Portland Alignment, CCCS
  - Look at focus group responses
- **Contributors:** SMAA exchange network group, LEI (MLTCOP, Portland Housing Authority)
- **Steps:**
  - Create and administer a survey to see if AHEOP organizational services are accessible and culturally appropriate: language access, hiring practices, serving the needs of BIPOC/LGBTQ+ persons.

Details

- **Action Lead:** City of Portland Alignment, CCCS Look at focus group responses
  - Assess accessibility, (e.g. Is this training session open to the public? Who's doing the outreach, registration, or training for AHEOP members?)
- **Contributors:** Ben, State of ME CHW, Maine Access Immigrant Network (MAIN)
- **Steps:**
  - Offer EDI training, include the experience of refugees and immigrants, and address ageism for medical providers (look at overall CHW training from the state).

Aim 4

Enhance MCOA Leadership

Aim 5: Evaluation

Evaluate Real-World Application

Details

- **Action Lead:** MCOA
- **Contributors:** AHEOP Members
- **Steps:**
  - Explore the MCOA Leadership Exchange on Aging (LEA) training program to increase the number of community members' education about ageism and services.

Details

- **Key Metrics:**
  - Assess CHW's (and other providers') comprehension and practical application of services for older adults, cultural awareness and cultural humility, and the application of these concepts in real-world situations.

Action: Increase access to home visits & integrated case management (Ongoing)

Aim 1

Increase Management Services

Details

- **Action Lead:** SMAA, MCOA
- **Collaborators:** AHEOP Members
    - Collaborate with the PHEA Leadership Team and the CHW Committee to develop a plan to increase case management services to older persons.

Aim 2

Increase Management Services II

Details

- **Action Lead:** COP Office of Elder Affairs, SMAA
- **Collaborators:** CCCS
- **Steps:**
    - Review the City of Portland Office of Elder Affairs and/or the SMAA case management services programs as a model.

Aim 3: Evaluation

Increase Management Services II

Details

- **Action Lead:** COP Office of Elder Affairs, SMAA
- **Collaborators:** CCCS
- **Steps:**
    - Track the availability of case management services for older persons, especially those in underserved or hard-to-reach populations.

Action: Identify & evaluate funding opportunities (Ongoing)

Aim 1

Identify and submit local, state, and federal grants to sustain AHEOP's work

Details

CCCS received the MCOA CHEF grant and will use the funds to help organize informational sessions with the community.

- **Action Lead:** MCOA, SMAA, OADS
- **Collaborators:** AARP, CCCS
    - **Partners:**
        - Elizabeth Gattine, State Office of Innovation and Future, Permanent Commission
- **Steps:**
    - AHEOP will work to search for and submit local, state, and federal grants to sustain the work and the goals of AHEOP.

Aim 2: Evaluation

Increase Sustainability

Details

- **Key Metrics:**
    - Measure percentage of submitted grant resources through the central data resource of the Portland Health Equity Alignment (PHEA).

Action: Connect patients with the appropriate provider based on gender preference (Ongoing)

Aim 1

Establish a Diverse Provider Network

Details

Steps:

- Collaborate with the Clinical Advisory Committee and Community Health Workers Committee to recruit and retain providers spanning from diverse gender identities and backgrounds reflective of the diverse communities in Greater Portland.
- Create a matching/pairing system to ensure community members are represented.

Aim 2: Evaluation

Monitor Patient and Engagement Satisfaction

Details

Key Metrics:

- Calculate patient retention and loyalty rates over time.
- Track the number of patient/client referrals from existing patients.
- Conduct one-on-one interviews and focus groups to gather insights from community members.

Aim 3: Evaluation

Assess any Change in Mainers Seeking Healthcare Services and Utilization of Treatment Options

Details

Key Metrics:

- Track the number of outpatient visits, admissions, and ER visits over time (assess visits over time for a historical overview).
  - Rely on EMR/EHR systems, data from the CDC, state and local health departments, or from Medicare and Medicaid.
- Track appointment wait times for primary care seeking opportunities.

Action: Mitigate harm in environments where clients and patients are dismissed; Implement follow-up procedures for older adult populations (Ongoing)

Aim 1

Implement Proactive Communication Strategies and Address Potential Barriers

Details

Contributors:

Steps:

- Set clear expectations for provider behavior from the outset.
- Use patient-practitioner care agreements to outline mutual responsibilities.
- Provide reminders of expectations when issues first arise.
- Assess for Social Determinants of Health affecting compliance.
- Offer resources and referrals to help overcome obstacles.
- Consider cultural and linguistic factors in patient interactions.

Aim 2

Improve Appointment Management

Details

- **Contributors:** AHEOP Members
- **Steps:**
  - Collaborate with providers to implement reminder systems to reduce no-shows and to offer flexible scheduling options when possible.
  - Collaborate with providers to develop a fair policy for handling missed appointments.

Aim 3: Evaluation

Conduct Focus Groups and Community Breakout Sessions to Explore Underlying Themes of Medical Distrust

Details

- **Key Metrics:**
  - Create a set of open-ended questions or prompts to guide the discussions. Interview guides should aim to uncover underlying themes, motivations, and perceptions.
  - Facilitate the focus groups and breakout sessions with patients and providers according to the discussion guide.

Community Health Workers (CHWs) Committee

This section provides a detailed overview of action items recommended by Syra Health for the Community Health Workers (CHWs) Committee. These recommended actions are based on Syra Health's continued collaboration with Portland Public Health and the Alignment to identify tasks to address the barrier(s) presented.

Following the table, please see the step-by-step process for addressing each action item, moving from ongoing tasks, to suggested actions, as well as measurable efforts for successfully executing these tasks. **Text in black are the suggested action items of Syra Health**.

	Action	Barriers Addressed	Responsibility	Construct	Measures	Duration
1.	Develop insurance literacy content to promote understanding about the distinctions between coverage (what services are provided) and insurance (the financial aspects)	Barriers to client and patient understanding of qualifications for coverage versus insurance	CHWs, Clinical	Community-Clinical Linkages	Number of community insurance literacy education/workshops and analysis of pre - and post- tests	1-2 years

2.	Engage with school boards and policymakers to emphasize the importance of inclusive sexual health education that respects diverse cultural perspectives	Barriers to immigrants not seeking proper sexual and reproductive services	CHWs, Student & Academic, MEG	Social Connectedness	STI and pregnancy metrics (e.g. incidence); surveys and focus groups with immigrant populations who seek care to assess need and understand/address barriers.	1-2 years
3.	Educate undocumented older adults about available healthcare resources, benefits, and rights	Barriers to limited proficiency in English Fears of deportation	CHWs, C&FB, AHEOP	All	CHW and social worker interview/feedback assessments	Ongoing
4.	Workshops centered around immigration status, legal pathways, and access to healthcare benefits	Undocumented Mainers in Greater Portland and hesitancy to healthcare services	CHWs, C&FB, Clinical, SDOH	All	MaineCare versus Free Care Coverage – evaluation of scope of utilized resources	5-6 years

5.	Work with local and state policymakers to advocate for policies that improve access to healthcare for undocumented individuals	Fears of deportation associated with seeking medical care	CHWs, C&FB, Policy	All	Healthcare and health care services	Ongoing

Building Stronger Communities: Recommendations for Advancing Community Health Workers

Action: Develop content to explain the distinctions between coverage (what services are provided) and insurance (and the financial components) (1-2 years)

Aim 1

Promote Community Member Insurance Literacy

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
    - Community health workers can offer insurance literacy programs to define *coverage* versus *insurance*.

Aim 2: Evaluation

Community Engagement and Workshops Focusing Education (pre and post-tests)

Details

The need to measure community engagement and the effectiveness of workshops that focus on education can be approached through a combination of qualitative and quantitative methods.

- **Key Metrics:** Total number of trainings offered, attendance, and pre and post-tests for assessing changes in knowledge, attitudes, and behaviors because of trainings.

Action: Engage with school boards and policymakers to emphasize the importance of inclusive sexual health education that respects diverse cultural perspectives (1-2 years)

Aim 1

Values and Beliefs

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
    - Engage with community members of representing diverse populations to better understand the religious demographics of Greater Portland populations.
    - Approach the topics of sex and sexuality gently and in a way that aligns with existing (cultural) values. CHW Committee needs to approach the topic gently and in a way that aligns with existing values.
    - Support sexual education best practices and combat gender-based violence by raising community awareness, providing anti-violence resources, and creating safe spaces for survivors.

Aim 2

Culturally Sensitive Language Models

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
  - Adopt neutral language that avoids judgment or moralizing, especially when sharing about premarital sex and contraception.
  - Avoid “right and wrong concepts”, and focus on health, well-being, and personal responsibility.
  - For the young populous, focus on respect, forming intentional relationships.
  - For older populations, gradually introduce topics like consent, reproductive health, and responsible decision-making.

Aim 3

Debunking Myths

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
  - Address misconceptions about sex and safe sex practices, sexual health, and contraceptive means.
  - Address myths by using culturally appropriate examples (from respective cultural and religious) and provide clear, scientifically accurate information.

Aim 4

Incorporate Family Education

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
  - Offer opportunities for parental/guardian feedback and involvement in parent workshops or information sessions so parents/guardians themselves can become familiar with the curriculum and feel more comfortable supporting their children's learning.

Aim 5: Evaluation

STI and Pregnancy Metrics

Details

- **Key Metrics:**
  - Prevalence Rates: The total number of people diagnosed with a specific STI as a rate per 100,000 people.
  - Incidence Rates: The number of new cases of an STI diagnosed over a specific period (i.e. monthly) within a population.
  - Demographic Breakdown: Breakdown of age, gender, sexual orientation, and ethnicity.
  - Pregnancy Rate: The number of pregnancies in the community per 1,000 women of reproductive age.
  - Teen Pregnancy Rate: The number of pregnancies among young women and women under 20 per 1,000.
  - Unintended Pregnancy Rate: The proportion of pregnancies that are unplanned.

Action: Educate undocumented older adults about available healthcare resources, benefits, and rights (1-2 years)

Aim 1

Disseminate Current Knowledge of the Alignment to the Public Community

Details

The Alignment (PHEA) has a wealth of expertise that can be of benefit to the undocumented citizens of Greater Portland. There is a pressing need for the organization to enhance its efforts in sharing this valuable information with the public. The PHEA can ensure that undocumented individuals are better informed about the opportunities available to them, including access to healthcare, education, and legal support.

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
  - Educate undocumented older adults about available healthcare resources, benefits, and rights within one year, start by identifying key communities and understanding their specific needs through surveys or focus groups.
  - Empower community leaders to advocate for healthcare rights and work with policymakers to improve access.

Aim 2: Evaluation

CHW and Social Worker Interview/Feedback Assessments

Details

- **Key Metrics:**
  - **<u>Scenario-Based Questions</u>:** Present hypothetical situations to undocumented older adults to assess how individuals would handle real-life challenges to gauge their practical knowledge and decision-making skills.
  - **<u>Performance Metrics</u>:** Use quantitative data such as the number of patients served, follow-up rates, and outcomes achieved.

Action: Workshops centered around immigration status, legal pathways, and access to healthcare benefits (5-6 years)

Aim 1

Target Audience and Expert Input

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
  - Administer a needs assessment to determine which populations may benefit most from immigration status, legal pathways, and access to healthcare benefits workshops (e.g., immigrants, New Mainers, refugees, entire organizations, and/or the general community (including Mainers).
  - Collaborate with the newly formed Policy Committee and work with immigration lawyers, professionals in the Clinical Advisory Committee, and social workers to provide accurate and up-to-date information.

Aim 2: Evaluation

Track Education Workshops Offered and Learning Growth

Details

- **Key Metrics:**
  - Immigration status, legal pathways, and access to healthcare benefits workshops offered, attendance, and pre-post learning growth
  - Survey coverage for MaineCare vs. Free Care to identify coverage gaps.

Action: Work with local and state policymakers to advocate for policies that improve access to healthcare for undocumented individuals (Ongoing)

Aim 1

Monitor Legislative Process

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
  - **Track Legislation**: Follow bills and proposals related to healthcare access for undocumented individuals.
  - **Testify at Hearings**: Attend public hearings and, if possible, testify about the importance of expanding healthcare access for undocumented individuals. Use personal stories, data, and research to support your argument.

Aim 2: Evaluation

Quality of Care

Details

- **Contributors:** Community Health Workers (CHWs)
- **Steps:**
  - Monitor clinical effectiveness of healthcare services through clinical outcomes, such as recovery rates, complication rates, mortality rates, and patient improvement after treatment:
    - Patient survival rates, rates for chronic conditions, and rates of hospital readmission.

Aim 3: Evaluation

Accessibility of Care

Details

- **Contributors:**
- **Steps:**
    - Track wait times for appointments, the geographic distribution of healthcare facilities and proximity to care, and the availability of services during off-hours.
    - Monitor affordability of care such as the percentage of the population with insurance coverage (factor in Free Care) and the cost of services.

Clinical Advisory Committee

This section provides a detailed overview of action items recommended by Syra Health for the Clinical Advisory Community Committee. These recommended actions are based on Syra Health's continued collaboration with Portland Public Health and the Alignment to identify tasks to address the barrier(s) presented.

Following the table, please see the step-by-step process for addressing each action item, moving from ongoing tasks, to suggested actions, as well as measurable efforts for successfully executing these tasks. **Text in black are the suggested action items of Syra Health**.

	Action	Barriers Addressed	Responsibility	Construct	Measures	Duration
1.	Enhance trust and knowledge factors about the purpose and benefits of prenatal medicine among expecting parents in Maine	Barriers to impressions and spread of misinformation on pregnancy and maternal care	Clinical, CHWs	Community-Clinical Linkages	Track misinformation spread through social media analysis (i.e. Instagram, Reels, TikTok, Snapchat)	2-3 years
		High C-section rates within certain	Clinical, CHWs	Community-Clinical Linkages	Conduct a data analysis of birth records and	

		healthcare systems in Maine NICU concerns over the spread of misinformation through informal communication	Clinical, CHWs	Community-Clinical Linkages	dissemination of findings to the public Collect survey and focus group data from patient navigators, social workers and patients on misinformation	
2.	Raise awareness and ensure that developmental delays are taken seriously - facilitating access to necessary treatments options for children and adolescents	Difficulties in motor functioning, mental impairment, and social skills	Clinical, CHWs	Social Connectedness	Conduct structured observations, monitoring/ assessment of motor functioning, mental and social skills; identify needs and support successful youth and family referrals to treatment	2-3 years
3.	Promote trust and understanding	Misconceptions about health and personal information	Clinical, CHWs	Community-Clinical Linkages	Track workshop attendance; Conduct pre/post assessments to	Ongoing

	among Mainers regarding the security of their information by sharing how HIPAA regulations interact with immigration status through education workshops for community members and a media campaign	is shared and the implications for immigration status			measure knowledge gained about health information and privacy; collect data over time to track the evolution of community understanding	
		Language differences can prevent individuals from accessing accurate information	Clinical, CHWs	Community-Clinical Linkages	Track Mainers' utilization of translation services and frequency of reported problems accessing translating services	
		Fear of sharing health information could negatively affect immigration status	Clinical, CHWs		Construct feedback mechanisms to monitor rates at which community members express their fears in information sharing	
		Struggle to find reliable sources of information about their rights and protections	Clinical, CHW, MEG		Conduct community resource mapping	
4.	Build an understanding	Community members not receiving tangible	Clinical, CHWs	Community-Clinical Linkages	Assess perceptions and satisfactions with	Ongoing

	of Western medicine	medication believe appointment was unsuccessful			patients after appointments	
		Medication effectiveness and response time	Clinical, CHWs	Community-Clinical Linkages	Clinical outcomes assessments before and after medication administration	
		Allocation of different medications for the same health issue (fear in "inequity" of treatment)	Clinical, CHWs	Community-Clinical Linkages	Success rate of community forum engagements	
5.	Optimize patient care delivery and improve healthcare access by increasing # of healthcare providers	Waitlists and patient-provider interaction time	Clinical	Community-Clinical Linkages	Track recruitment of nurse practitioners and physician assistants	5-6 years

Enhancing Trust and Communication Factors Recommendations for Improving Outcomes

Action: Enhance trust and knowledge factors about the purpose and benefits of prenatal medicine among expecting parents in Maine (2-3 years)

Aim 1

Baseline Surveying

Details

- **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapist, Social Workers, CHWs
- **Steps:**
  - Survey current levels of awareness, access, and utilization of prenatal care services among all expecting parents in Greater Portland.
  - Include questions to narrow in on gaps in knowledge in purposeful prenatal care that are ongoing or are needed.
  - Identify barriers to Mainers accessing prenatal care in population subsets and based on geographical locations, financial limitations, and cultural factors.

Aim 2

Involve Healthcare Providers

Details

- **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapists, Social Workers, CHWs

Aim 2

Involve Healthcare Providers

Details

- **Steps:**
  - Identify a Working Group of family doctors, pediatricians, midwives, obstetricians, and public health officials to create messaging within clinic settings about prenatal care and trust.
  - Collaborate with the Achieving Health Equity for Older Persons Committee also working on community messaging about trust factors.
  - Collaborate with the Community and Faith-Based Committee to bridge the gap between in religious stigma related to seeking treatment services.

Aim 3: Evaluation

Track Misinformation Spread Through Social Media Analysis (i.e. Instagram, Reels, TikTok, Snapchat

Details

- **Key Metrics:**
  - Use TikTok or other social media platforms and other analytic tools to track public content.

Action: Raise awareness and ensure that Developmental Delays are taken seriously - facilitating access to necessary treatments options for adolescents (2-3 years)

Aim 1

Communal Awareness Focus

Details

- **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapists, Social Workers, CHWs
- **Steps:**
    - Educate community members in workshops and social media campaigns about developmental delays through informational initiatives that raise awareness and understanding.
        - Focus on common developmental delay such as autism, attention-deficit disorders (ADD), and speech and language disorders.
    - Highlight the importance of inclusion and showcase the strengths of individuals with developmental disabilities, such as during Developmental Disabilities Awareness Month in March.
    - Collaborate with the Student & Academic Advisory Committee to implement early screening programs in schools.
    - Create and distribute resources that explain the various treatment options available, including physical therapy, occupational therapy, and speech and language therapy services offered in Greater Portland.

Aim 2

Raise Community Resources

Details

- **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapists, Social Workers, CHWs
- **Steps:**
    - Establish support groups for international families with treatment hesitancy to share experiences and information about treatment options.
    - Collaborate with the MEG Committee to develop a resource directory of local services, specialists, and support programs for families of adolescents with developmental delays.

Aim 3: Evaluation

Communal Awareness Focus

Details

- **Key Metrics:**
    - Conduct early identification tracking to determine the average number of diagnoses in Greater Portland.
    - Track the number of referrals made to early intervention services or specialists for adolescents with suspected developmental delays. In Greater Portland.
    - Track the percentage of eligible adolescents receiving early intervention or special education services.
    - Utilize the medical personnel in the Clinical Community and The Alignment to gather input through surveys and focus groups from pediatricians and other providers on their knowledge of screening guidelines.
    - Collaborate with the Student & Academic Advisory Committee to analyze data from schools on the number of students identified with developmental delays and the number receiving support services.

Action: Create a sense of trust and understanding and among Mainers regarding the security of their information - how HIPAA regulations interact with immigration status (Ongoing)

Aim 1

Educate Greater Portland Communities

Details

- **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapists, Social Workers, CHWs
- **Steps:**
    - Collaborate with the Community Health Workers Committee to educate both The Alignment and community members and staff about Maine's privacy laws and HIPAA regulations, emphasizing that immigration status can be considered protected health information such as through workshops and trainings.
    - Provide multilingual resources explaining patient rights and privacy protections to ensure all communities have access to this information.
    - Collaborate with the Alignment Leadership Team and member community organizations to host informational sessions on health privacy rights, focusing on immigrant communities.

Aim 2

Legal Services

Details

- **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapists, Social Workers, CHWs

Aim 2

Legal Services

Details

- **Steps:**
  - Collaborate with the newly formed Policy Advisory Committee and legal experts to navigate the complexities of HIPAA and immigration law – especially on how the two intersect.
    - Seeking legal services professionals can provide reliable guidance, help individuals navigate the healthcare system, and alleviate fears and ensuring trust.
  - Connect with local immigrant advocacy groups and legal aid organizations is to ensure that accurate information is distributed, and individuals receive the support they need regarding the handling of their health data.

Aim 3: Evaluation

Mainers' Utilization of Translation Services and Frequency of Reported Problems Accessing Translating Services

Details

- **Key Metrics:**
  - Collaborate with the newly formed Policy Committee to monitor the number of healthcare facilities and providers adhering to HIPAA regulations regarding immigration status as protected health information.
  - Track the number of complaints filed with the US Department of Health and Human Services Office of Civil Rights regarding unauthorized disclosure of immigration status.
  - Track the number and attendance of informational sessions held in immigrant communities about health privacy rights.
  - Track any legal actions or penalties related to HIPAA violations involving immigration status disclosure.

Action: Build an Understanding of Western Medicine (Ongoing)

Aim 1

Educational Program Components to Consider

Details

- **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapists, Social Workers, CHWs
- **Steps:**
  - Highlight how clinical evidence can diagnose specific diseases or conditions.
  - Explore the development of modern medical technologies and treatments.
  - Emphasize treating specific symptoms systems rather than taking a holistic approach.
  - Demonstrate the integration of complementary practices into Western medicine from certain elements of Eastern medicine.
  - Emphasize ethical principles of Western medical practices - Patient Confidentiality and the Hippocratic Oath.
  - Emphasize the role of preventive medicine and public health initiatives of Western medical practices.

Aim 2: Evaluation

Educational Program Components to Consider

Details

- **Key Metrics:**
  - Evaluate the effectiveness of education and outcomes of symptom-specific treatments vs. holistic approaches.

Aim 2: Evaluation	Details

Educational Program Components to Consider	• **Key Metrics:**
	  ○ Disseminate the evidence supporting the effectiveness of treatments in Western Medicine settings.
	  ○ Assess the cost-effectiveness of preventive medicine, and the impact on health outcomes.

Action: Optimize patient care delivery and improve healthcare access (5-6 years).

Aim 1	Details

Optimizing Delivery	• **Contributors:** Doctors, Physicians, Nurses, Practitioners, Physician Assistants (PAs), Therapists, Social Workers, CHWs
	• **Steps:**
	  ○ Gather data on current patient care processes, healthcare access levels, and patient outcomes.
	  ○ Determine the geographic areas where patients experience delays, inadequate care, or poor health outcomes.
	  ▪ Analyze patient data, conduct surveys and focus groups, and gather feedback from both patients and healthcare providers. Typical areas to explore include extended wait times for appointments or procedures, deficiencies in care coordination, restricted access to specialized services, and delays in diagnosis or treatment.

Aim 2: Evaluation	Details
Optimizing Healthcare Delivery	• **Key Metrics:** ○ Triangulate data collection (both quantitative and qualitative data) to optimize healthcare delivery; the Clinical Advisory Committee should collaborate with the MEG Committee on this initiative.

Community & Faith-Based Advisory Committee

This section provides a detailed overview of action items recommended by Syra Health for the Community & Faith-Based Advisory Committee. These recommended actions are based on Syra Health's continued collaboration with Portland Public Health and the Alignment to identify tasks to address the barrier(s) presented.

Following the table, please see the step-by-step process for addressing each action item, moving from ongoing tasks, to suggested actions, as well as measurable efforts for successfully executing these tasks. **Text in black are the suggested action items of Syra Health**.

	Action	Barriers Addressed	Responsibility	Construct	Measures	Duration
1.	Expand spiritual team in healthcare settings	Barriers to religious rites not properly administered	C&FB, Clinical	Social Connectedness	Collaborate with local religious leaders to discuss barriers congregants face when accessing rites in healthcare settings	2-3 years
		Connecting Mainers to proper spiritual and religious sects based on preference	C&FB, Clinical, CHWs	Social Connectedness	Work together with churches and spiritual organizations and leaders to communicate spiritual care needs in healthcare settings	

2.	Pair unaccompanied minors with trained peer mentors for practical advice on navigating general care and overcoming feelings of isolation	Barriers to adolescents and youth in Greater Portland seeking services	C&FB, CHWs	Social Connectedness	Track appointment attendance with primary caregivers/peer mentors Offer a feedback survey to generate the value, strengths, and weaknesses of the program to participants (adolescents, caregivers and mentors)	Ongoing

Unity in Healthcare and Faith: Recommendations for Connecting Faith in Healthcare

Action: Expand the spiritual care team (2-3 years)

Aim 1

Clinical Setting Collaboration

Details

- **Contributors:** Clergy, Spiritual Care Coordinators, Social Workers, Nurses, Doctors, Volunteers
- **Steps:**
    - Support collaboration between spiritual care providers and religious leaders to provide a holistic and culturally competent approach to healthcare.
    - Create a set of protocols for how spiritual care team members and clinicians can integrate existing healthcare planning with the holistic experience.

Aim 2

Recruitment

Details

- **Contributors:** Clergy, Spiritual Care Coordinators, Social Workers,
- **Steps:**
    - Ensure recruitment of religious leaders and lay persons to represent the spiritual demographics of Greater Portland.
    - Ensure access to religious texts or sacred objects that clients and patients may find comforting within clinical/healthcare settings.

Aim 2

Recruitment

Details

- **Steps:**
  - Ensure access to religious texts or sacred objects that clients and patients may find comforting within clinical/healthcare settings.

Aim 3

Encouraging Religious Practices in Healthcare Settings

Details

- **Contributors:** Clergy, Spiritual Care Coordinators, Social Workers, Nurses, Doctors, Volunteers
- **Steps:**
  - Support the practice of prayer and meditation throughout specific times of the day (according to individual religious preferences).
  - Ensure dietary restrictions are available to each client/patient based on religious preference.
  - Work with the Clinical Advisory Committee to make sure traditional healing practices are supported alongside a patient's care experience.
  - Support each healthcare setting in Greater Portland to dedicate resources and rooms for religious practices.

Aim 4

Social Care Experience

Details

- **Contributors:** Clergy, Spiritual Care Coordinators, Social Workers, Nurses, Doctors, Volunteers
- **Steps:**
    - Incorporate religious values in the care plan of every individual.
    - Ensure that social care team and social workers are incorporated into patient care plans to be considered for decision making processes.

Aim 6: Evaluation

Collaborate with Local Religious Leaders to Discuss Barriers Congregants Face When Assessing Rites in Healthcare Settings

Details

- **Key Metrics:**
    - Gather input from healthcare physicians and social workers to assess their awareness and understanding of religious needs and practices and perceived barriers to providing spiritual care through surveys and focus groups/listening sessions.
    - Regularly assess patient satisfaction with spiritual care.
    - Formulate regular assessments to evaluate the effectiveness of the collaboration between healthcare providers and religious leaders.
    - Disseminate strengths and weaknesses garnered from each assessment to key partners.
    - Formulate plans that address weaknesses and check for progress on subsequent assessments.

Aim 7: Evaluation

Monitor Church and Spiritual Organizations Insights Based on Leader Feedback

Details

- **Key Metrics:**
  - Gather relevant insights and analyze it for practical applications in healthcare settings or community engagement.
  - Ask local spiritual leaders questions about:
    - How often are religious leaders providing feedback or insights?
    - Is the feedback actionable, relevant, and detailed?
    - Is there tangible change in how our Greater Portland healthcare systems respond to religious/spiritual needs based on this feedback?
  - If feedback from religious/spiritual leaders leads to specific change, track how those changes impact patient outcomes and client/patient satisfaction.

Action: Pair unaccompanied minors with trained peer mentors for practical advice on navigating prenatal care and overcoming feelings of isolation (Ongoing)

Aim 1

Recruitment of Peer Mentors

Details

- **Contributors:** Trusted leaders in the community, Academic Advisors, Student Leaders, College Students, Volunteers
- **Steps:**
    - Identify individuals in Greater Portland who can serve as trained peer mentors. Individuals need to have navigated through the health system successfully and has the capacity to build trust with healthcare seeking (paired) individuals.
    - Train peer mentors as needed on measures pertinent to overcoming identified barriers such as prenatal care, communication, and trust factors.

Aim 2

Pair Unaccompanied Minors with Peer Mentors

Details

- **Contributors:** Trusted leaders in the community, Academic Advisors, Student Leaders, College Students, Volunteers – **Unaccompanied Minors**
- **Steps:**
    - Conduct interviews or surveys with the minors to understand their specific needs, preferences, and interests. These could include emotional needs, academic challenges, or specific cultural adjustments.
    - Collect information on each minor's background, language skills, interests, and any issues they may be facing.
    - Match peer mentors and minors based on shared interest and commonalities.

Aim 3: Evaluation

Monitor Church and Spiritual Organizations Insights Based on Leader

Details

- **Key Metrics:**
  - Collect data, analyze, and generate actionable next steps on the language and themes used by spiritual leaders in self-care, spiritual healing, and social care for dissemination when interacting with youth.

Monitoring, Evaluation, and Grants Committee

This section provides a detailed overview of action items recommended by Syra Health for the Monitoring, Evaluation & Grants Committee. These recommended actions are based on Syra Health's continued collaboration with Portland Public Health and the Alignment to identify tasks to address the barrier(s) presented.

Following the table, please see the step-by-step process for addressing each action item, moving from ongoing tasks, to suggested actions, as well as measurable efforts for successfully executing these tasks. Committee action items depicted as light blue text are specific items related to ongoing initiatives of the Student & Academic Advisory Committee. **Text in black are the suggested action items of Syra Health**.

	Action	Barriers Addressed	Responsibility	Construct	Measures	Duration
1.	Lead Discussion about CHNA findings	Significant understanding of CHNA findings	MEG	Both	Understanding of needs assessment findings	1 year (Summer 2025)
2.	Create a data inventory for the Alignment	Barriers to a central repository of data for member accessibility	MEG, Policy	Social Connectedness	Analyze data patterns and committee member usage	1-2 years (Winter 2025)
3.	Support the Student & Academic 2026	Cultural humility and cultural competence	MEG, Student & Academic	Both	Educator participation and student success factors	1-2 years (Summer 2026)

	Summer Institute	for teachers in Greater Portland				
4.	Map current organizations of the PHEA (MaineHealth FindHelp)	Barriers to conducive and central location for all resources and member organizations of the PHEA Alignment	MEG, CFB, LT	Social Connectedness	Data resource visits and accessibility metrics	Ongoing
5.	Identify the specific healthcare needs of immigrant and non-immigrant populations in Greater Portland (impact of increased population due to COVID)	Closing the gap of available resources to immigrants, non-immigrants (Mainers and Non-Mainers)	MEG, CHWs, CFB, Policy	Both	Resource allocation	Ongoing
6.	Implement the SDOH Accelerator Plan	Barriers to health, social, economic, legal, environmental, historical, housing, and transportation accessibility	MEG, LT	Both	Monitor the implementation and support other committees with their evaluation needs	Ongoing
7.	Evaluate the SDOH	Sustainability of the Social	MEG, LT	Both	Collect data on Indicators of	Ongoing

Accelerator Plan	Determinants of Health Accelerator Plan Barriers to adjustments and success factors of the Accelerator Plan Barriers to awareness for the broader scope of the Alignment	community resilience, social cohesion, access to resources. Identify patterns and areas of improvement Engage with the community outside of the Alignment

Establish Alignment Scope and Measures: Recommendations for Evaluation

step-by-step processes are detailed in light blue as Monitoring, Evaluation, and Grants Committee current initiatives

Action: Lead Discussion about CHNA findings (1 year, Summer 2025)

The Monitoring, Evaluation, and Grants Committee seeks to inform committee members on the Maine Shared Community Health Needs Assessment (CHNA). Maine CHNA is a collaborative effort between Maine CDC. Central Maine Healthcare, Northern Light, MaineGeneral Health, MaineHealth, and Maine Community Action Partnership. Discussion leads responsible for updating the committee are **Heather Drake** and **Rachel Gallo**.

Aim 1

Simplify CHNA Language and Findings

Details

- **Contributors:** Research Analysts, Research Associates, Public Health Officials, Healthcare Providers
- **Steps:**
  - Create a shared resource for community health needs assessment (CHNA) reports, engage broader Maine's communities, and support data-based improvements for Maine residents.
    - Consider breaking down the robust findings into clear and concise summaries tailored specifically for the MEG Committee members.

Aim 2: Evaluation

Understanding of Needs Assessment Findings

Details

- **Key Metrics:**
  - Ask participating members to provide feedback on how the needs assessment has been communicated and share ways items can help the PHEA moving forward.

Action: Create a data inventory for the Alignment (1-2 years, Winter 2025)

The Monitoring, Evaluation, and Grants Committee, seeks to inform committee members on the Maine Shared Community Health Needs Assessment (CHNA). Maine CHNA is a collaborative effort between Maine CDC. Central Maine Healthcare, Northern Light, MaineGeneral Health, MaineHealth, and Maine Community Action Partnership. Discussion leads responsible for updating the committee are **Heather Drake** and **Rachel Gallo**.

Aim 1

Define the Primary Purpose of Creating the Data Inventory

Details

- **Contributors:** MEG Committee
- **Steps:**
  - Provide a comprehensive overview of all data assets for better data governance and management.
  - Identify key stakeholders and their requirements. For example, reach out to the different committees within the PHEA to see what the ideal use case is for a centralized datahub and how they can use it to align with their goals and strategies. Below are some questions to consider throughout the journey:
    - What kind of data do they want to be captured (public data that is frequently checked, data collected by the Alignment)?
    - How often do we want the data to be updated (monthly, yearly, biyearly)?
    - How would you want the centralized data hub to function (would you want a dashboard with visualizations of the pertinent data, a repository of the raw data)?
  - Set clear goals and success criteria for the inventory.
    - For example, completeness of inventory (% of data assets cataloged), accuracy of data, improved data accessibility.

Aim 2

Form a Cross-Functional Team

Details

- **Contributors:** MEG Committee
- **Steps:**
  - Determine what skills and expertise are required for the team to create the data inventory based on the project scope and objectives.
  - Take stock of the current data streams. It's important to communicate with other committees to understand the data streams they use, and then assign someone to collect and share that data with the MEG committee.
  - Establish a data dashboard.
    - Consider whether a MEG Committee member holds knowledge to build out a tangible dashboard, or if there is a need to find more people with that skill set and how funding would be obtained (i.e. utilization of a grant)?
  - Assign roles and responsibilities to MEG team members.
    - If grant funding needs securing, assign MEG committee members to search for grants and apply for related items.

Aim 3

Develop a Project Plan

Details

- **Contributors:** MEG Committee
- **Steps:**
  - Create a timeline with milestones and deliverables (Gantt chart that allows for flexibility when applicable).
  - Define communication channels and reporting structures (outline frequency of communication, method of communication, and who needs to be there for the established communications).

Aim 4: Evaluation

Conduct Quality Assurance

Details

- **Key Metrics:**
  - Review validated data sources, check for accuracy and comprehensiveness.
  - Cross-reference MEG data with known data sources, conduct random spot checks, and keep track of percent of data assets cataloged.

Aim 5: Evaluation

Perform Gap Analysis

Details

- **Key Metrics:**
  - Identify any missing information from data sources.
    - For example, go through the data sources and make sure the data is comprehensive.
  - Develop plans to address gaps in the data inventory.
    - Determine which gaps should be addressed first.

Aim 6: Evaluation

Assess Compliance

Details

- **Key Metrics:**
  - Evaluate the inventory against regulatory requirements.
    - Determine which regulatory requirements are most relevant to our data inventory GDPR, CCPA, HIPAA, or industry-specific regulations.
  - Ensure the data inventory supports compliance reporting and audits.
    - Include compliance-specific metadata fields, link inventory entries to relevant regulations, and generate compliance reports directly from the inventory.

Aim 7: Evaluation

Measure Against Objectives

Details

- **Key Metrics:**
  - Compare the completed inventory against initial project goals and assess its effectiveness in supporting data centralization efforts.

Aim 8: Evaluation

Gather Feedback

Details

- **Key Metrics:**
  - Solicit input from key users to identify areas for improvement or expansion.

Aim 9: Evaluation

Develop Maintenance Plan

Details

- **Key Metrics:**
  - Establish processes for keeping the inventory up-to-date and assign responsibilities for ongoing management and updates
    - For example, a member would need to oversee ensuring that the links to the data sources are updated at the designated update frequencies.

Below, please see the step-by-step recommended actions of **Syra Health** to consider as the next working steps to the three-part facilitated meeting series aimed at involving stakeholders from education, health, and community services to help prepare Greater Portland's education systems to focus on health equity, belonging, and resilience.

Action: Map current organizations of the Alignment (MaineHealth FindHelp) (Ongoing)

Aim 1

Outline the Goals of Mapping the Alignment Organizations

Details

- **Contributors:** MEG Committee
- **Steps:**
  - Determine what specific insights should be gained from mapping the Alignment organizations.
  - Determine how this mapping will contribute to our overall mission and goals.
  - Below are some questions to consider in desired outcomes of mapping:
    - Visualize geographic distribution of member organizations
    - Identify areas of overlap or gaps in service coverage
    - Analyze resource allocation across different regions or focus areas
  - Determine the key performance indicators (KPIs) will we use to measure success:
    - Geographic Coverage:
      - Number of organizations per geographic area
      - Population served per organization within defined regions
    - Organizational Alignment:
      - Number of collaborative projects between PHEA members
    - Resource Allocation:
      - Distribution of funding across geographic areas
      - Ratio of administrative costs to program expenses per organization
    - Operational Efficiency:
      - Reduction in duplicate efforts across organizations

Aim 2

Operationalizing a Team

Details

- **Contributors:** MEG Committee
- **Steps:**
    - Assemble a team of relevant personnel, including data analysts, MaineHealth FindHelp specialists, a project manager, and representatives from participating organizations.
    - Conduct a thorough assessment of available data sources (i.e, organization details, locations, and other metrics)
    - Things to consider:
        - What types of data do we need to collect for effective mapping? Are there any data gaps that need to be addressed?
        - Organization details (name, mission, focus areas)
        - Geographic data (addresses, service areas)
        - Program information (types of services, target populations)
        - Financial data (budget allocations, funding sources)

Aim 3

Create a Dictionary with Demographics and MEG Partners

Details

- Utilize FindHelp to create a directory of the direct service providers involved in the Alignment (**Leads: Rachel Gallo, Danielle Parsons)**
    - Support a Winter 2025 training on FindHelp.
    - Incorporate detailed demographics/membership information from the Community and Faith-Based Committee (**Leads: Rachel Gallo, TBD**).
    - Determine best methods for collecting information on non-direct service providers.

Aim 4	Details

MaineHealth FindHelp	• **Key Metrics:**
	  ○ Create a project plan:
	  ▪ Develop a timeline, allocate resources, and assign responsibilities to team members.
	  ○ Clean data:
	  ▪ Ensure data quality by removing duplicates, correcting errors, and standardizing formats.

step-by-step processes and details in below are for any ArcGIS Mapping consideration in the future for the Monitorina. Evaluation. and Grants Committee to think about

Aim 5 (Optional)	Details

GIS Mapping	• What types of maps will be most useful for visualizing the Alignment?
	  ▪ Example: heat maps showing concentration of organizations or services.
	  ○ How can we effectively represent different attributes of organizations on the map?
	  ▪ Example: Use different symbols and colors to represent. organization types or focus areas
	  ○ What base maps and additional layers should we include?
	  ▪ Examples: Implement pop-ups to display detailed information about each organization and create multiple map views to highlight different aspects of the data.
	• Implement mapping:
	  ▪ Import organization location data into ArcGIS
	  ▪ Create base maps and layers
	  ▪ Add relevant geographic features and boundaries

Aim 5 (Optional)

GIS Mapping

Details

- Promote data visualization
  - Connect PowerBI to your data sources
  - Design dashboards and reports to showcase key metrics and relationships
    - Things to consider:
      - What key metrics and relationships should we highlight in our dashboards? – should be based off of the KPIs
      - How can we create interactive visualizations that allow for deep exploration?
  - Integrate ArcGIS maps into PowerBI dashboards for a comprehensive view.
    - Things to consider:
      - How can we seamlessly integrate ArcGIS maps into PowerBI dashboards?
        - Set up automated data refresh processes to keep ArcGIS and PowerBI in sync
      - What level of interactivity should exist between maps and other visualizations?

Aim 5 (Optional)

Alignment Analysis

Aim 6: Evaluation

Data Resource Visits and Accessibility Metrics

Details

- Use the visual tools to identify patterns, gaps, and potential areas for improved alignment among organizations.
- Refine iteratively: Continuously improve the maps and dashboards based on user feedback and emerging needs.
    - Things to consider:
        - How often should we update the data and visualizations?
        - What process should we use to gather and implement user feedback?

Details

- Consider the following:
    - User testing: Conduct sessions with partners to gather feedback on the usability and effectiveness of the maps and dashboards.
    - Metric analysis: Assess how well the mapping project meets its initial objectives using predefined key performance indicators (KPIs).
    - Impact assessment: Evaluate how the mapping tool has influenced decision-making and improved alignment among organizations.
    - Identify areas for improvement: Based on feedback and analysis, determine aspects of the mapping that need refinement or expansion.
    - Future planning: Develop a roadmap for maintaining and enhancing the mapping tools over time.
    - Knowledge sharing: Document lessons learned and best practices to inform future mapping initiatives.

Action: Identify the specific healthcare needs of immigrant and non-immigrant populations in Greater Portland (impact of increased population due to COVID) (Ongoing)

Aim 1

Steering

Details

- **Contributors:** MEG Committee
- **Steps:**
  - As a part of MEG, form a steering committee: Key considerations:
    - How many members should the committee have for optimal efficiency?
      - Include representatives from Greater Portland Health, local hospitals, public health departments, immigrant advocacy groups, and community organizations.
      - Ensure diverse representation to capture various perspectives.
    - What specific roles and responsibilities should committee members have?
      - Assign specific roles such as chair, data analyst, community liaison, and project manager.

Aim 2

Scope and Objectives

Details

- **Contributors:** MEG Committee
- **Steps:**
    - What are the geographic boundaries of Greater Portland for this assessment?
    - Which specific immigrant populations should we focus on?
- Identify major immigrant groups in the area and ensure their inclusion.
- What key health areas should we prioritize in our assessment?
    - Focus on areas such as primary care, mental health, chronic diseases, and preventive care.
    - Include COVID-19 impact as a separate category in the assessment.

Aim 3

Compile Needs Assessments into a Central Location

Details

- **Contributors:** MEG Committee
- **Steps:**
    - Once the data are gathered, organize the data for easy reference and analysis.
        - For example, categorize needs assessments based on themes such as financial, educational, technological or by the partners, PHEA members (e.g., students, employees, community members, specific populations).
    - Establish a centralized location to save material digitally via:
        - A shared drive or document management system (e.g., Google Drive, Microsoft OneDrive).
        - A project management platform (e.g. Jira).
        - A database or custom software solution.

Aim 4

Secure Funding and Resources

Details

- Consider the following:
  - What is our budget for this needs assessment?
  - Are there grants available for this type of project?
  - How many staff members and volunteers do we need?

Aim 5

Data Analysis Strategy

Details

- Consider the following:
  - Who will be responsible for data analysis?
  - What software or tools will we use for analysis?
    - Examples: SPSS, R
  - How will we ensure data privacy and security?
    - Example: Implement strict data privacy protocols, including data anonymization.
  - How will we identify and prioritize health needs?
    - Example: Develop a prioritization matrix considering factors like severity, community priority, and disparities.

Aim 6

Community Member Engagement Plan

Details

- Consider the following:
  - How will we engage community members throughout the process?
  - What methods will we use to gather community input?
    - Use a variety of methods including town halls, focus groups, and online surveys.
  - How can we ensure participation from hard-to-reach populations?
    - Partner with trusted community organizations to reach marginalized populations. (Potentially could leverage CHWs)
- How will we communicate progress and findings to the community?
  - Develop a communication plan including regular updates and a final report dissemination strategy.

Aim 7: Evaluation	Details

Resource Allocation	• Draft a comprehensive report:
	  ○ Summarize methodology, findings, prioritized health needs, and recommendations.
	  ○ Include data visualizations and comparisons.
	  ▪ Comparative data to highlight disparities between immigrant and non-immigrant populations (emphasize the impact of COVID-19, as well)
	• Partner review:
	  ○ Present draft findings to the steering committee and key partners.
	  ○ Gather feedback and make necessary revisions.
	  ▪ Use a structured feedback form to collect and organize input.
	• Finalize and disseminate the report:
	  ○ Incorporate all feedback into a final report.
	  ○ Distribute the report to relevant organizations, policymakers, and make it publicly available.
	  ○ Comparative data to highlight disparities between immigrant and non-immigrant populations (emphasize the impact of COVID-19, as well).
	  ○ Website publication, email distribution, community presentations, and media releases.
	  ○ Create different versions of the report (e.g., full report, executive summary, fact sheets) for various audiences.
	• Establish ongoing monitoring:
	  ○ Create a system to track progress on addressing identified needs.
	  ○ Plan for regular updates and reassessments

Action: Implement the SDOH Accelerator Plan (Ongoing)

The following suggested action items for the Implementation of the Social Determinants of Health Accelerator Plan is also reflected in the Implementation section of the SDOH Accelerator Plan.

Aim 1	Details

PHEA In-Depth Walk Through	• **Contributors:** MEG Committee
	  ○ Educate the broader PHEA Alignment committee members and frontline staff on Social Determinants of Health (SDOH), screening tools, and referral processes is crucial for improving health outcomes and addressing health disparities.
	  ▪ Train staff on various screening tools, such as PRAPARE and the Accountable Health Communities Screening Tool, helps identify individuals at risk due to these factors.
	  ○ Utilize a referral process for connecting patients with appropriate community resources, such as food assistance or mental health services.
	  ○ Clear referral protocols, follow-up systems, and partnerships with community organizations are key to ensuring that patients receive the support they need.
	  ○ Provide ongoing education, leadership support, and collaboration to create a culture where staff feel empowered to address SDOH and improve patient care
	  ○ Consistently and frequently evaluate the program.
	  ○ Work with the PHEA Leadership Team to regularly review the overall progress of committee action items.
	  ○ Adjust strategies and committee action items based on incoming data, success factors, and community feedback.

Action: Evaluate the SDOH Accelerator Plan (Ongoing)

The following suggested action items for the Implementation of the Social Determinants of Health Accelerator Plan is also reflected in the Implementation section of the SDOH Accelerator Plan.

Aim 2	Details
Evaluation 	• Conduct regular assessments, such as quarterly progress reviews for each committee and an annual comprehensive evaluation of the entire Accelerator Plan, to help maintain accountability and foster continuous improvement. • Continuously measure each committee's specific outcomes for focus areas: ○ **AHEOP:** Increase access to information about services that help and support older adults, increase access to home visits and integrated case management. ○ **Community Health Worker:** Ensure culturally competent services by providing cultural competence trainings to support the AHEOP Committee and providers for aging populations. ○ **Clinical:** Explore use of HealthInfoNet, including barriers to using it, organizations not using it, education; Emergency Response Plan: TB Screening. ○ **Community & Faith-Based:** Identify and connect with faith-based organizations, set up a roadmap for other committees to share their work and ask for feedback.

Aim 1	Details
Evaluation	○ **Monitoring, Evaluating, & Grants:** Provide opportunities to disseminate, discuss, and inventory data, create a directory with the demographics and partners MEG works with**.** ○ **Social Determinants of Health**: Healthy Homes: Map readiness and responsiveness of ongoing efforts to address housing, promotion of MECDC Community Care Referral system. ○ **Student & Academic:** Support ongoing professional training & development, residency program for educators.

Social Determinants of Health Committee

This section provides a detailed overview of action items recommended by Syra Health for the Social Determinants of Health (SDOH) Committee. These recommended actions are based on Syra Health's continued collaboration with Portland Public Health and the Alignment to identify tasks to address the barrier(s) presented.

Following the table, please see the step-by-step process for addressing each action item, moving from ongoing tasks, to suggested actions, as well as measurable efforts for successfully executing these tasks. Committee action items depicted as light blue text are specific items related to ongoing initiatives of the SDOH Committee. **Text in black are the suggested action items of Syra Health**.

	Action	Barriers Addressed	Responsibility	Construct	Measures	Duration
5.	Create a Community Information Exchange Platform	Communication, access to information, and health literacy	Social Determinants of Health, Clinical	Social Connectedness	Track usage across different socioeconomic groups based on demographics	1-2 years
6.	Expand Digital Equity and Broadband Access	Barriers to broadband and internet access	Social Determinants of Health	Social Connectedness	Persons seeking internet services in Greater Portland	Ongoing

7.	Support the Healthy Homes Initiative	Housing needs	Social Determinants of Health	All	Increase to accessible housing for Greater Portland	Ongoing
8.	Collaborate with local libraries to extend computer usage options and digital literacy hosting	Limited internet and broadband literacy in New Mainers and immigrants	Social Determinants of Health	Social Connectedness	Digital literacy assessments through practical skills	Ongoing
9.	Establish a coalition alongside iEnglish Project	Limited infrastructure in existence for Greater Portland	Social Determinants of Health, Leadership Team	Social Connectedness, Community-Clinical Linkages	ArcGIS mapping of community members with increased accessibility versus no change	5-6 years
10.	Promote the Community Care Referral (CCR) system	Coordination of Care	Social Determinants of Health	All	Track changes in individuals utilizing the CCR system	Ongoing

Bridging Gaps: Key Recommendations for Addressing Social Determinants of Health

step-by-step processes and details in blue in this action section are SDOH Committee current initiatives

Action: Create a Community Information Exchange Platform (1-2 years)

The Social Determinants of Health Committee is focused on information exchanges that promote SDOH and/or consumer engagement, as well as, highlighting digital equity's role in health.

Aim 1	Details
Promotion and Education of HealthInfoNet (HIN)	• **Goals**: ○ Increase awareness of HIN and its benefits, especially among healthcare providers and community partners.

Aim 2	Details
SDOH Integration	• **Goals**: ○ Determine what SDOH data HIN participants are comfortable sharing and how it might be stored. ○ Support incorporating SDOH data into HIN to create a more holistic patient information exchange.

Aim 3

FindHelp Platform Optimization

Details

- **Participants:** SDOH Committee, MEG Committee
- **Goals**:
  - Focus on closing the loop, ensuring that referrals and services tracked in the system are fully utilized.

Aim 4

Digital Equity and Broadband Expansion

Details

- **Goals**:
  - Continue building coalitions and expanding digital skills programs to ensure people can access the internet, afford devices, and participate in telehealth.
    - Upcoming place-based grants (e.g., $250K minimum) in 2025 will help further expand these efforts.

Aim 5: Evaluation

Track Usage Across Different Socioeconomic Groups Based on Demographics

Details

- **Key Metrics**: Measures usage based on the following sociodemographic factors:
  - **Income**: Measure based on low-, middle-, or high-income brackets.
  - **Race and Ethnicity**: Include all relevant subgroups consistent with the American Community Survey.
  - **Age Groups**: Utilize statistics by age grouping based on the American Community Survey.
  - **Gender**: Include all subgroups consistent with the American Community Survey.
  - **Employment Status**: Compare usage by employed versus unemployed individuals.

Action: Digital Equity and Broadband Expansion (Ongoing)

Aim 1

Introducing the Digital Health Equity Initiative

Details

- **Contributors:** SDOH Committee
  - Engage with the PHEA on an introduction of the Digital Health Equity Initiative and the populations who will benefit from the initiative.

Aim 2: Evaluation

Persons Seeking Internet Services in Greater Portland

Details

- **Key Metrics:**
  - Support the development of skills associated with specific tasks. These tasks emphasize a "how to demonstrate" application of digital tools and communication in everyday situations. Consider the following potential tasks:
    - **File Management**: How to properly organize, save, and retrieve files.
    - **Communication:** How to write and send emails, using instant messaging, and communicating via video calls.
    - **Productivity Software**: Proficiency in common office tools such as word processors, spreadsheets, and presentation software.
    - **Online Security**: Understanding how to protect personal information online and noticing attempts at security such as phishing.

Action: Healthy Homes Initiative (Ongoing)

Aim 1

Support the Healthy Homes Initiative

Details

- **Goals:**
  - Assess current housing initiatives to identify gaps, evaluate how well-prepared Greater Portland is to scale, and determine the ability to respond to evolving challenges.
  - Identify housing needs with such metrics as availability of affordable and quality housing, across demographic factors such as race, income, or disability, along with health status and chronic conditions, such as respiratory issues, injury, and mental health.
  - Collaborate with housing authorities, urban planners, and policymakers to ensure that housing solutions not only meet affordability standards but also promote overall health and well-being.
  - Advocate for health-conscious policies, conducting research to demonstrate the links between housing and health, and guiding communities in addressing inequities

Action: Collaborate with local libraries to extend computer usage options and digital literacy hosting (Ongoing)

Aim 1

Identify Key Libraries and build Relationships

Details

- **Contributors:** SDOH Committee
- **Steps:**
  - List local libraries throughout Greater Portland and match them to areas with identified gaps in broadband service and accessibility that may collaborate on the initiative.
  - Establish relationships between library directors and staff members to discuss collaborations of extending computer access time for residents and increase digital health literacy.

Aim 2

Partnership Agreements and Contact Personage

Details

- **Contributors:** SDOH Committee
- **Steps:**
  - For each library, draft out an agreed upon memorandum of understanding (MOU) that outlines the roles of members of the SDOH Committee and selected contact persons of each library and specifies goals, responsibilities and expectations for both parties.
  - Appoint contact persons for communication efforts moving forward for both the SDOH Committee and the libraries.

Aim 3

Implement Curriculum and Develop Workshops

Details

- **Contributors:** SDOH Committee
- **Steps:**
  - Develop a curriculum that addresses the basic computer literacy needs of community members. Curriculum best practices include basic computer skills, practicing internet safety, and safe digital communication means.
  - Develop a workshop and training schedule for guest attendees to participate. Consider evenings and weekend sessions based on participant need and convenience to promote attendance.

Aim 4

Community Outreach and Engagement

Details

- **Contributors:** SDOH Committee
- **Steps:**
  - Market the workshops utilizing the communication streams of the Portland Health Equity Alignment website, other social media channels (i.e. Facebook, Instagram, & SnapChat), newspapers, flyers, and community events.

Aim 5

Monitor and Evaluation of the Action Item

Details

- **Contributors:** SDOH Committee
- **Steps:**
  - After each workshop and training event, offer a brief voluntary participant questionnaire to gather feedback from participants to gauge overall effectiveness and identify areas of improvement.
  - Track attendance and participation in the workshops by gathering data from both the SDOH Committee and the libraries.

Aim 6: Evaluation	Details
Digital Literacy Assessments Through Practical Skills	• **Key Metrics:** ○ Conduct pre- and post-self-efficacy assessments asking participants their confidence to complete practical applications of what they learn and ask them to carry out these tasks at the end of the workshops, such as asking them to create or edit documents, navigate a website, or troubleshoot a technical problem, as well as create a presentation and share it via email.

Action: Promotion of the Community Care Referral (CCR) system (Ongoing)

Aim 1	Details

Organizational Partnerships
 
	• **Contributors:** SDOH Committee
	• **Steps:**
	  ○ Collaborate with local organizations in Greater Portland to spread awareness of the Community Care Referral (CCR) Programs.
	  ▪ Partner with community organizations, health clinics, schools, and local businesses to share information.
	  ○ Offer to provide workshops for organizations to help educate the community.
	  ▪ Identify influencers or community leaders who can advocate for the CCR system and will further amplify the message and encourage broader support.

Aim 2

Training the Alignment

Details

- **Contributors:** SDOH Committee
- **Steps:**
  - Organize training sessions for PHEA members who will be directly correlated with the CCR system.
    - Sessions should cover features, functionalities, and best practices for using the system.
  - Provide support materials such as frequently asked questions (FAQs) to allow users to navigate the system with ease.
  - Establish a help desk for the PHEA and community members in Greater Portland.

Aim 3: Evaluation

Application

Details

- **Key Metrics:**
  - Assess whether training materials are effective through shadowing and monitoring participants in their environments as they use the CCR system.
  - Track participants' real-world application use of the CCR system during care referrals or community outreach activities.

Student & Academic Advisory Committee

This section provides a detailed overview of action items recommended by Syra Health for the Student & Academic Committee. These recommended actions are based on Syra Health's continued collaboration with Portland Public Health and the Alignment to identify tasks to address the barrier(s) presented.

Following the table, please see the step-by-step process for addressing each action item, moving from ongoing tasks, to suggested actions, as well as measurable efforts for successfully executing these tasks. Committee action items depicted as light blue text are specific items related to ongoing initiatives of the Student & Academic Advisory Committee. **Text in black are the suggested action items of Syra Health**.

	Action	Barriers Addressed	Responsibility	Construct	Measures	Duration
1.	Greater Portland Equity in Health and Education Systems (PEHE)	Barriers to student learning/achievement	Student & Academic	All	Hold 2026 Summer Institute Training (Student Academic Performance (i.e. grades, test scores)	1-2 years
2.	2026 Summer Institute Training	Cultural humility and cultural competence for teachers in Greater Portland	Student & Academic, MEG	Social Connectedness	Reduce student absenteeism	Ongoing
		Funding	Student & Academic, MEG	All		

					Monitor financial success of the 2026 Summer Institute	
3.	Develop and distribute key educational materials in multiple languages to ensure clarity and accessibility for all families.	Barriers to miscommunication amongst educators and student populous (66 languages in school system)	Student & Academic	Social Connectedness	Assess student language proficiency levels and correlate these with their reported experiences in understanding communication from educators	Ongoing
4.	Translate school communications to newsletters/ announcements	Barriers to translation services and dissemination	Student & Academic, LT	All	Document cases of misinformation	Ongoing

Navigating Success: Recommendations for Enhancing Student & Academic Excellence

step-by-step processes are detailed in light blue as Student & Academic current initiatives

Action: Greater Portland Equity in Health and Education Systems (PEHE) (1-2 years)

The Student and Academic Advisory Committee is focused on integrating health equity, cultural humility, and intercultural resilience into Greater Portland's educational systems to address social determinants of health and foster inclusive, equitable learning environments.

Overview of the PEHE Series

The PEHE series is a three-part facilitated meeting initiative designed to engage partners across education, health, and community services in preparing Greater Portland's education systems to prioritize health equity, belonging, and resilience. These meetings lay the groundwork for actionable steps, culminating in the 2026 Summer Institute Training, which will serve as an annual event to advance these priorities.

Aim 1	Details

Establish Foundation of Connection in the Community	• **Contributors:** Parents, Community Health Outreach Workers, service providers, students, language partners, and school representatives.
	• **Steps:**
	  ○ Introduce qualitative stories and quantitative findings related to health equity and social determinants of health (SDOH) in Greater Portland schools.
	  ○ Discuss challenges and opportunities in fostering belonging and health equity within schools.
	  ○ Introduce the Prepare Your Health framework to emphasize preparedness and resilience in educational settings.
	  ○ Host a keynote by cultural leaders from the asylum-seeking community on the importance of respect, belonging, and health equity for resilience and success.

Aim 1

Establish Foundation of Connection in the Community

Details

- **Key Metrics**:
  - Facilitate small group discussions to:
    - Reflect on how health equity and belonging intersect with student achievement.
    - Explore strategies for inclusive communication, cultural modeling, and resource access in education.
  - Synthesize participant input to identify foundational themes for a summer institute curriculum.

Aim 2

Build Resilience, Vision, and Equity

Details

- **Contributors:** Educators, administrators, students, cultural leaders, and community partners.
- **Steps**:
  - Explore intercultural community problem-solving strategies and resilience- building practices.
  - Develop a collective vision for equitable and prepared education systems.
  - Integrate health equity principles into the vision and strategic priorities for schools.
- **Key Metrics**:
  - Introduce concepts such as cultural humility, open-hearted listening, and equity-driven resilience.
  - Facilitate discussions on:
    - How schools can address health inequities during emergencies (e.g., access to care, communication barriers, and resource disparities).
    - Best practices for fostering inclusion, such as culturally responsive teaching and community-driven solutions.

Aim 3

Plan for Needs Assessment and Strategic Equity Initiatives

Details

- **Contributors:** Educators, administrators, students, cultural leaders, and community partners.
- **Steps**:
  - Identify barriers to equity in education, such as through surveys and focus groups that assess:
    - Access to translation services and multilingual resources.
    - Gaps in culturally responsive teaching practices.
    - Infrastructure to support social connectedness and resilience.
    - Access to culturally relevant resources for families.
    - Partnerships to increase cultural competence and preparedness training for educators.
    - Peer support networks and family engagement programs.
  - Develop a strategic framework for the summer institute to address training needs and ensure sustainability.

Aim 4: Evaluation

Launch the 2026 Summer Institute

Details

- **Key Metrics:**
  - Assess the success of the 2026 Summer Institute to advance the systemic integration of health equity and resilience into Greater Portland schools.
  - Possible metrics include:
    - Strength of intercultural relationships and sense of belonging across the education system.
    - Sustainability of framework for addressing inequities and enhancing student outcomes.

Aim 5: Evaluation

Cultural Competence and Humility

Details

- **Key Metric:**
  - Assessing educator self-efficacy and use of tools to address cultural diversity and systemic inequities.

Aim 6: Evaluation

Health Equity Integration

Details

- **Key Metric:**
  - Total school staff trainings offered and attendance focusing on addressing SDOH through education and partnerships with health organizations.

Aim 7: Evaluation

Intercultural Resilience and Belonging

Details

- **Key Metric:**
  - Survey (e.g. with school climate measures) school community safety, sense of safety, inclusion, connectedness and belonging.

Step 8: Evaluation

Preparedness and Leadership

Details

- **Key Metrics:**
  - Assess educator self-efficacy to respond effectively to public health and societal challenges.

Action: Establish the 2026 Summer Institute Training (Ongoing)

Below, please see the step-by-step recommended actions by **Syra Health** to consider as the next working steps to the three-part facilitated meeting series aimed at involving partners from education, health, and community services to help prepare Greater Portland's education systems to focus on health equity, belonging, and resilience.

Aim 1	Details
Finalizing the Curriculum 	Finalize the specific skills and knowledge of the Summer Institute that teachers and academic members will primarily focus on. Current initiatives lie in cultural competency and humility training. Suggested topics include components of culture; values, beliefs, norms, role of historical factors, non-verbal/verbal communication factors, systems of power vs. privilege, and emphasizing a 'how to' seek guidance. • **Contributors:** Teachers, administrators, students, cultural leaders, and community leaders • **Steps:** ○ Establish a timeline and announce the coalition partnership to the public.

Aim 2	Details
Logistics 	Finalize the Summer Institute training experiences, and if sessions will be in-person only, or will the consensus be hybrid and/or virtual. • **Contributors:** Teachers, administrators, students, cultural leaders, and community leaders • **Steps:** ○ Create training institute experiences

Aim 2

Logistics

Details

- **Steps:**
  - Establish dates for the 2026 experience based on Greater Portland school academic calendar and teacher availability.
  - Provide multiple/flexible options for all teachers and academic personnel to be present.

Aim 3

Registration

Details

- **Contributors:** Teachers, administrators, students, cultural leaders, and community leaders
- **Steps:**
  - Create a registration system for management of academic personnel sign-ups. Student & Academic Committee to provide participating members with information about the training, scheduling, relevant materials, and any prerequisite items required.

Aim 4

Execute the Training

Details

- **Contributors:** Teachers, administrators, students, cultural leaders, and community leaders
- **Steps:**
  - Decide the duration, specific dates and times for each session.
  - Allocate the necessary resources and prepare a budget.
  - Identify what resources are required—such as instructors, materials, or technology—and ensure the program is financially feasible.
  - Implement the plan by promoting the program, opening registration, and delivering the planned sessions.

Aim 5: Evaluation

Student Academic Performance and Absenteeism (i.e. grades, test scores)

Details

- **Key Metrics:**
  - Student academic performance in classes/schoolwork.
  - Student performance on national and state standardized test scores.
  - Student participation and engagement in classroom activities (e.g., Active listening, asking questions, and engaging in group discussion serve as evaluation)
  - Student attendance.

Aim 6: Evaluation

Financial success of the 2026 Summer Institute

Details

- **Key Metrics:**
  - Total income generated from the 2026 Summer Institute project.
  - Estimate a profitability margin for future efforts should leftover funds be available.
  - Benchmark success through the return of investment of the program and for forward sustainability.

Action: Develop and distribute key educational materials in multiple languages to ensure clarity and accessibility for all families (Ongoing)

Aim 1

Informed Language Needs

Details

- **Contributors:** Translators, teachers, administrators, students, cultural leaders, and community leaders
- **Steps:**
  - Gather information through surveys and focus groups from families in Greater Portland about language preferences and cultural diversity.

Aim 2

Develop Educational Content

Details

- **Contributors:** Translators, teachers, administrators, students, cultural leaders, and community leaders
- **Steps:**
  - Draft the educational material (English first).
  - Ensure trainings are culturally appropriate for a diverse population and meets the cultural needs of Greater Portland families based on the most cultures and focus group findings.

Aim 3

Translate Educational Content

Details

- **Contributors:** Translators, teachers, administrators, students, cultural leaders, and community leaders
- **Steps:**
  - Assess the accessibility, inclusivity, and effectiveness of drafted materials particularly in multicultural or diverse settings.
  - Consult with the Leadership Team, community leaders, and host local consultations with administrators and educators in Greater Portland to ensure linguistic and cultural appropriateness of educational content once drafted and revised as needed.

Aim 4: Evaluation

Assessments of Student Language Proficiency Levels and Correlate These with Their Reported Experiences in Understanding Communication from Educators

Details

- **Key Metrics:**
  - Assess language skills, such as speaking (such as with presentations), listening (such as with role playing), reading, and writing assignments.

Action: Translate school communications to newsletters/announcements (Ongoing)

Aim 1

Translate Educational Content

Details

- **Contributors:** Translators, teachers, administrators, students, cultural leaders, and community leaders
- **Steps:**
  - Ask a bilingual staff member, or a native speaker to review the content.
  - Request final approval from the committee chair and/or connected school partner on the translated materials before they are shared.

Aim 2: Evaluation

Document cases of misinformation

Details

- **Key Metrics:**
  - Set criteria for language accuracy and 'misinformation'.
  - Collaborate with academic professionals to review educational content.
  - Assess community member information literacy with surveys to determine if community members can distinguish reliable and unreliable sources.

Implementation Plan

Secure a budget for an implementation plan spanning across a timeframe of completion (6 years)

Syra Health is committed to providing suggestions for an implementation plan that aligns with best practices and addresses the specific needs of the City of Portland Public Health Division, the Alignment Leadership Team, Alignment Committee members, additional key contributors, and all who make up the Greater Portland community. Syra Health's approach will leverage evidence-based resources, data-driven insights, personal and collaborative inputs to create actionable steps that promote effective execution and sustainability. By focusing on clear objectives and measurable outcomes, Syra Health aims to equip the City of Portland, Maine Public health Division, our partners, to navigate the complexities of implementation.

The initial work plan for the City of Portland, Maine, is a three-year framework set to commence on January 1, 2025. Once implementation begins, the Plan should be revised to include target completion dates and assign responsible parties for each tactic. Champions will be designated for achieving each goal within the Plan and will be responsible for engaging local partners to carry out activities and providing updates to the coalition during quarterly meetings.

This plan is designed to be flexible and responsive as it unfolds. There are no simple solutions to dismantling the long-standing structural barriers to equitable health in Portland. Given the complexity of these challenges, our shared goal is to positively influence Social Determinants of Health (SDOH) while ensuring the inclusion of diverse community voices. The plan will specifically focus on enhancing community clinical linkages and fostering social connectedness among residents, recognizing that these elements are vital for improving health outcomes.

Detailed SDOH Accelerator Plan Implementation & Evaluation Framework

The details of the implementation framework can be viewed through a structure of pillars, where each pillar addresses Syra Health's recommended approach to implementation. The recommended pillars of implementation are as follows: Education & Training, Cross-Committee Collaboration & Community Engagement, and Data Infrastructure.

The Education and Training Framework is designed to highlight important themes related to SDOH, including understanding SDOH, screening and surveying, intervention through implementation efforts of the SDOH plan, and how to manage them. The first pillar, **Education & Training**, involves developing standardized training programs that provide an overview of fundamental SDOH concepts; continuing to identify the local health disparities of Greater Portland, working to improve cultural competency of all Mainers, continuing to establish community engagement for dissemination purposes, and data collection protocols (already identified by the Portland Health Equity Alignment (PHEA)[12]. An important component of the education pillar is to establish an implementation timeline, assign committee chair and/or member responsibilities, and continue to pool the necessary data frameworks for PHEA use.

12 Gru, I., Bunce, A., Davis, J. (2021). *Initiating and Implementing Social Determinants of Health Data Collection in Community Health Centers*. NIH. Retrieved from Initiating and Implementing Social Determinants of Health Data Collection in Community Health Centers - PubMed.

The main goal is to establish and maintain strong coordination across all SDOH Accelerator Plan initiatives and across all PHEA Committees. These efforts will ensure Alignment resources are maximized through regular collaboration and communication. The following are core objectives of the second pillar, **Cross-Committee Collaboration**:

Core Objectives

1. **Create efficient communication channels and protocols across committees**
2. **Establish standardized resource sharing and allocation processes**
3. **Develop clear decision-making procedures to pair with the Leadership Team's Governance structures**
4. **Implement effective progress tracking**
5. **Foster collaborative culture and shared accountability**

The second pillar emphasizes the importance of structured intra-Alignment collaboration. The PHEA Alignment continues to excel at respective Leadership Team meetings with Committee Chairs and the broader Alignment, where the PHEA Leadership should work to focus on committee crossover cooperation. In order to facilitate effective collaboration, the PHEA Leadership Team should encourage that each committee defer to other committees with respective expertise to achieve particular objectives, especially tasks that require the added help of additional committees. Another aspect of communication is to ensure community engagement with Mainers through effective messaging to guarantee Greater Portland understands the capacity to which the PHEA serves.

The final pillar, **Data Infrastructure**, is crucial for tracking progress and proving the impact of the Portland Public Health SDOH Accelerator Plan. Following Syra Health's recommended activities for both the PHEA Leadership Team and the MEG Committee, building data infrastructure entails developing a centralized data repository with the necessary functions of security integration and reporting.

Regular assessments will help measure the impact of interventions on health outcomes and disparities. Using both quantitative (e.g., numbers and figures) and qualitative data (e.g., personal stories) will provide a full picture of how well the implementation process is working. Involving community members in the evaluation process will ensure that the findings are meaningful and culturally relevant. Over time, as PHEA uses the evaluation results to help organizations improve and update their goals, the SDOH Accelerator Plan will continue to evolve and adapt to shifting community needs and new barriers to achieving health equity in Greater Portland.

Evaluation

MEG Collaboration and Leadership Role

Throughout the duration of the Closing the Gap Grant, Syra Health and the MEG Committee conducted regular meetings to advance the SDOH Accelerator Plan. These collaborative meetings have focused on key evaluation metrics, the aggregation of data, and the facilitation and navigation of the SDOH Accelerator Plan. The goal is to position the MEG Committee as the primary leader in facilitating the Plan, with support from the PHEA Leadership Team. Evaluation efforts will center on several critical areas, including the successful navigation of committee action items outlined in the table, the effectiveness of communication and collaboration amongst the PHEA Alignment, and the uniformity of objectives across the Plan. Key success metrics will be tracked, identifying areas where action items are achieving intended outcomes and where adjustments may be continued for momentum and progress.

This collaboration aims to assess the effectiveness and impact of collaborative strategies, while identifying opportunities for improvement and adaptation. By leveraging the expertise of the committee, we will evaluate performance metrics, analyze funding allocation, and ensure that our objectives align with community needs and health priorities.

Education & Training Program Effectiveness

Measuring the effectiveness of the education and training pieces is crucial for ensuring that PHEA is adequately prepared to implement the SDOH Accelerator Plan initiatives. Key metrics include completion rates by role and training type, time to completion against targets, and training session attendance rates. These metrics will provide insights into the engagement and participation levels of Alignment members. Resource utilization rates and technical platform performance are important indicators of the efficiency and accessibility of the training programs. The learning environment and organizational support play significant roles in training effectiveness, making these metrics particularly relevant[13].

Outcome Metrics

The MEG Committee's evaluation framework for the SDOH Accelerator Plan in Greater Portland should incorporate both quantitative outcome metrics and qualitative data analysis to provide a comprehensive assessment of the Plan's effectiveness.

Measuring the improvement in knowledge and skills is crucial for assessing the effectiveness of the education and capacity building efforts. Pre/post training knowledge scores and practical skills assessment results provide quantitative evidence of learning outcomes. Certification achievement rates and competency demonstration scores offer objective measures of Alignment member proficiency. Role readiness ratings and performance evaluation scores help gauge the practical application of learned skills in real-world scenarios. Applied learning measures can track how effectively Alignment members and other key contributors are implementing SDOH concepts in their daily work. The effectiveness of the knowledge management and support systems is crucial for sustaining SDOH efforts. Knowledge retention rates and information accessibility scores measure how well Alignment members and other key contributors can access and retain critical information. Best practice adoption rates and cross-functional collaboration levels indicate the spread of effective strategies across the organization. Resource sharing effectiveness and innovation implementation rates demonstrate the organization's ability to adapt and improve. Sustainability indicators help assess the long-term viability of the SDOH initiatives.

Qualitative Data Collection

Qualitative data provides rich, contextual information that complements quantitative metrics. Key contributor surveys and feedback forms offer insights into the experiences and perceptions of those individuals implementing the SDOH Accelerator Plan. Focus group discussions and individual interviews allow for in-depth exploration of specific issues or successes. Direct observation reports provide unbiased assessments of program implementation. Community feedback sessions ensure that the voices of those being served are heard. Alignment member and other key contributor interviews offer perspectives from various partners involved in the SDOH initiatives.

Gathering quantitative data, which involves using numbers and figures, promotes understanding of how well committees are working together. This includes utilizing system analytics and metrics to track the usage of digital tools for communication and document sharing, measuring performance tracking data to determine whether goals are met on time, and examining resource utilization logs to assess how shared resources like key support individuals and funding are utilized across committees. Additionally, the tracking of committee meetings will provide insights into meeting efficiency by looking at attendance rates and action item completion, while progress tracking systems will show how well committees are moving toward their goals. By employing these methods, the committee can obtain a clearer picture of cross-committee coordination effectiveness, allowing them to identify trends and measure progress.

Cross-Committee Collaboration

To effectively evaluate the Cross-Committee Coordination pillar of the SDOH Accelerator Plan for Greater Portland, the MEG Committee should implement a comprehensive framework focusing on process metrics. This approach aligns with best practices in public health evaluation and incorporates insights from recent research on measuring cross-functional team success and collaboration effectiveness. Cross-cultural communication effectiveness can be assessed through various interaction metrics. Cultural incident reduction rates help track progress in minimizing culturally insensitive events. Community engagement levels and service accessibility improvements indicate the broader impact of cultural competency initiatives of the Greater Portland community.

Communication Effectiveness

Measuring communication effectiveness is crucial for ensuring smooth coordination across committees. Key metrics include cross-committee meeting attendance rates and protocol compliance by committee, which provide insights into engagement levels and adherence to established procedures.

13 Rural Health Information Hub. (2024). *Evaluation Frameworks*. RHIhub. Retrieved from Evaluation Frameworks - Rural Care Coordination Toolkit.

Digital platform utilization rates and response times for information requests help assess the efficiency of information sharing.
Documentation of completion rates and escalation protocol adherence are important indicators of how well committees are following established communication processes. Emergency communication response times are critical for evaluating the PHEA's ability to handle urgent situations effectively.

Resource Sharing

Efficient resource sharing is essential for maximizing the impact of the SDOH Accelerator Plan. Resource allocation request fulfillment rates and utilization across committees provide insights into how effectively resources are being distributed and used. Resource availability rates help assess whether committees have access to the tools and support they need to carry out their responsibilities effectively. Shared resource opportunities can also help with the decision-making process. The effectiveness of cross-committee decision making is crucial for the success of the SDOH Accelerator Plan. Decision cycle completion times and Alignment member and other key contributor participation rates provide insights into the efficiency and inclusiveness of the decision-making process. Implementation tracking accuracy helps ensure that decisions are being carried out as intended.

MEG Committee Leadership

Tracking progress is crucial for ensuring that cross-committee coordination efforts are on schedule and meeting set objectives. Key metrics for progress tracking include reporting compliance rates, milestone tracking accuracy, data submission timeliness, review meeting completion, action plan development rates, issue resolution times, and dashboard update frequency. These metrics provide insights into how well committees are following established processes and timelines. In terms of measuring outcomes, measuring the effectiveness of coordination efforts is essential for understanding the impact of cross-committee collaboration. Important metrics in this category include cross-committee initiative completion rates of action items (both ongoing and recommended by Syra Health), implementation successes, and the effectiveness of communication and information exchange. These metrics help to evaluate how well committees work together to achieve common goals and optimize resources across the PHEA. Additionally, assessing committee member appreciation is essential for understanding the perceived effectiveness of cross-committee coordination. Key metrics for this evaluation include committee member satisfaction scores, Leadership engagement levels, Alignment member feedback ratings, partner collaboration effectiveness, community input integration, cross-functional team performance, and support service satisfaction. These metrics provide valuable insights into how well coordination efforts meet the needs and expectations of various key contributors, including committee members, Leadership, Alignment members, partners, and the community. By implementing this comprehensive evaluation framework, the MEG Committee can effectively track both the processes and outcomes of cross-committee coordination efforts. This approach allows for continuous improvement of the SDOH Accelerator Plan in Greater Portland, ultimately enhancing the effectiveness of SDOH initiatives and their impact on the community.

Quarterly assessments should provide a detailed storyline of how efficiently the Alignment is making progress. These storytelling efforts should feature detailed performance analysis, examining trends and patterns in cross-committee collaboration. Additionally, a progress achievement analysis should be conducted to measure advancements towards established committee goals. The annual comprehensive review offers a holistic evaluation of cross-committee coordination over the year. This review should

assess overall coordination effectiveness, examining long-term trends and the impact of coordination efforts on the SDOH Accelerator Plan's objectives. The meeting tracking and communication efforts should be evaluated to identify areas for improvement in facilitating cross-committee communication.

Funding & Sustainability Efforts

Funding for addressing SDOH in Portland, Maine, will require a variety of combined resources. The goal is to apply for and receive funding for efforts towards addressing SDOH and barriers to access health equity in Greater Portland. These efforts support achieving the high priorities set by The Alignment with respect to housing, transportation, healthcare, education, employment, social services, and immigration legal services. Our goal is to secure funding for areas such as systems coordination, full-time equivalents (FTE), coalition expenses, and training. A key federal funding opportunity is the CDC Closing the Gap grant, which focuses on reducing health disparities. Additional federal sources may include the National Association of Chronic Disease Directors and the White House. State and local funding can further support these efforts by providing participant stipends, incentives, supplies, and media resources. State funding sources could include the Maine Department of Health and Human Services and the Maine Health Access Foundation. Local funding opportunities may come from organizations such as the Portland Community Chamber or MaineHealth. However, since many local sources require a 501(c)(3) designation to apply, the Alignment would need to partner with an eligible organization to pursue these funds.

Operationalizing the Alignment

Conduct a Needs Assessment

Conducting a comprehensive needs assessment is a crucial step for organizations aiming to understand and address the specific requirements of their target population. This process involves systematically gathering and analyzing data to identify gaps between current conditions and desired outcomes. By engaging key contributors and incorporating diverse perspectives, a needs assessment provides valuable insights that inform strategic planning and resource allocation. Ultimately, a needs assessment supports the development of programs and services that are tailored to meet the authentic needs of the community, leading to more effective interventions and improved outcomes overall. In an ever-changing landscape, a thorough needs assessment is essential on a regular cadence for making ongoing informed decisions that drive meaningful impact.

To conduct a comprehensive needs assessment, it is crucial to evaluate current capabilities and identify gaps in resources, skills, and knowledge. Engaging key contributors to gather insights on challenges and priorities will provide a deeper understanding of community needs and perspectives. Building strategic partnerships with local organizations, healthcare providers, and community groups will further enhance this process, allowing for the leveraging of resources and expertise while establishing networks that facilitate knowledge sharing and support. Additionally, investing in training and capacity building is essential; providing targeted training for Alignment members and key contributors on SDOH concepts and best practices will improve skills in key areas such as data collection, community engagement, and program evaluation.

This holistic approach will not only strengthen the needs assessment process but also will ensure that it effectively addresses the multifaceted challenges faced by the community.

Initiate the Implementation Plan

Following the proposed guidance of Syra Health (see section*: Implementation Plan*, **pg. 148**), the Alignment should adhere to the components that make up the implementation process including but not limited to: providing a roadmap for PHEA purposes' success, outlining the executive summary, highlighting the SMART (Specific, Measurable, Achievable, Relevant, and Time) goals of the overall Plan, identifying target audiences, providing a description of strategies and activities, noting key timeline goals, setting aside the proper allocation of resources, delineating roles and responsibilities for committees and Alignment members, and tracking progress. An effective Implementation plan has detailed action-oriented steps, outlining specific strategies and responsibilities for all involved members. The priorities of an implementation plan are to establish quick wins of the Alignment, while generating movements towards long-term goals. To ensure resources are directed toward high-impact areas, it is essential to address foundational gaps, especially in regions or sectors where disparities exist. The focus is often on underserved communities such as Black and Hispanic populations, where targeted interventions can make a significant difference in addressing these gaps and improving outcomes. By concentrating efforts on these areas, we can work toward achieving greater equity and better support for marginalized groups.

Establishing Data and Evaluation Frameworks

Syra Health, in collaboration with the MEG Committee (see section: *MEG Collaboration and Crossover*, **pg. 150**) highlights the importance of establishing a central data repository for member organizations of the Alignment. The data repository will be essential for scalability as the Alignment continues to grow in members and member organizations, simplifying reports and conducting analyses, fostering collaboration within all committees, aiding in quick decision-making situations with easily accessible information and improving overall efficiency as the Alignment continues forward movement. To foster a culture of collaboration, the PHEA needs to implement systems for data collection and analysis to monitor progress and outcomes. Evaluation findings will be used to inform decision-making and adjust strategies as needed. Additionally, open communication and teamwork is crucial both within PHEA and with its partners.

Engagement with the City of Portland

As part of the implementation process, continual engagement with members of the City of Portland is crucial to ensure community buy-in and relevance. Currently the effort of the Alignment includes sending out a monthly newsletter for organizational members involved to keep them current on ongoing initiatives and progress of PHEA. When considering the relevance of communication with community members, there are several reasons as to why residents of the City of Portland need to be informed, including: building trust, enhancing community engagement, listening to diverse perspectives, fostering sustainability, promoting accountability and effective communication, gathering resources, and providing an opportunity for feedback and improvement.

From the perspective of building trust amongst PHEA and the broader Alignment, Syra Health identified a major gap in medical distrust between community members and providers. Considering the goals of PHEA with member organizations for Greater Portland in mitigating health inequities, being able to bridge this gap is central to overcoming medical distrust as a deterrent to seeking healthcare services. Involving community members in the implementation plan will help them to feel valued, and in turn will garner their support and willingness to engage with PHEA and member organizations along with their respective initiatives. Involving community members will also help in planning and modifying implementation as needed, ensuring community member relevance and buy-in. When members see their voices reflected in the planning, they are more likely to take ownership and engage actively.

Greater Portland is a diverse city in which having a range of perspectives is vital to PHEA initiative decision-making processes. Diversity enriches discussions by bringing in varied experiences, cultural backgrounds, and viewpoints, which can lead to more innovative solutions and a deeper understanding of the community's needs. When community engagement initiatives reflect this diversity, they are more likely to resonate with different groups, fostering trust and collaboration. Moreover, inclusive engagement helps to identify and address the unique challenges faced by underrepresented populations, ensuring that their voices are heard, and their needs are prioritized. This relevance is particularly important to developing programs and policies that are equitable and responsive, as it allows for tailored approaches that reflect the specific circumstances of various community segments. Ultimately, embracing diversity not only strengthens community ties but also enhances the effectiveness of initiatives aimed at improving overall well-being and quality of life.

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