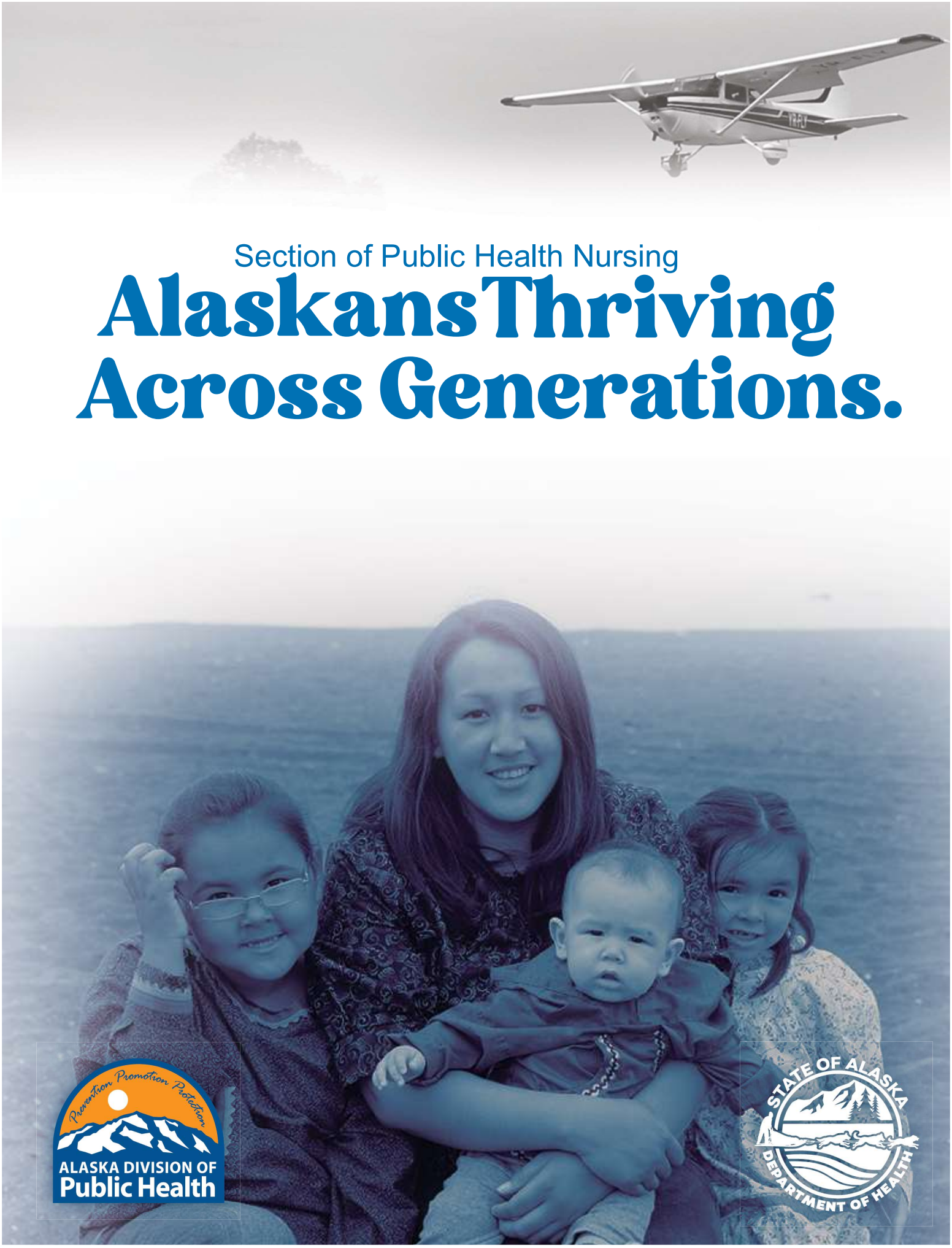


Section of Public Health Nursing

Alaskans Thriving Across Generations.

Prevention Promotion Protection

ALASKA DIVISION OF Public Health

STATE OF ALASKA DEPARTMENT OF HEALTH

Section of Public Health Nursing

FY 2025-2028 Strategic Plan

Introduction

Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences (APHA, Public Health Nursing Section, 2013).

We actively partner with individuals, communities, and systems to reduce disease and improve health. Public health nurses can work on any health-related issue affecting the community. We emphasize primary prevention as we address social, physical, environmental, and other determinants of health.

Our work occurs in clinics, homeless shelters, health fairs, at coalition meetings, in offices, on the phone, in villages, schools, at home visits, and social service agencies.

The *SOPHN Fiscal Year 2025-2028 Strategic Plan* serves as a roadmap to guide our section's activities over the next three years.

Background

A strategic plan results from a deliberate assessment and decision-making process to define the current state of an organization and plan for its future. The plan establishes the direction for the organization by providing a common understanding of the vision, mission, guiding principles, goals, and objectives. The plan communicates these essential organizational components to all employees and stakeholders to help that will move the organization forward.

A strategic plan is not intended to be rigid or left on a shelf. It is intended to be incorporate into everyday activities and serve as a guide that can be edited and adjusted as information and resources evolve.

The *SOPHN FY 2025-2028 Strategic Plan* builds on the previous strategic plans adopted by the section. Due to the impact of the COVID Pandemic on priorities, workforce, and institutional infrastructure, the SOPHN's last strategic plan ended in 2021, although the priorities continued to be relevant beyond that date.

Definitions

In order to assure all staff are using consistent language in the new strategic plan, the following definitions are available to guide our shared understanding.

Vision:	Futuristic view regarding the ideal state or conditions that the organization aspires to change or create. (NACCHO)
Mission:	The organization's purpose; what the organization does and why. (NACCHO)
Guiding Principles:	Phrases that express the organization's attitudes and values about responsibilities and quality; how people are treated; and, the way in which services are delivered.
Strategic Plan:	A document based on an analytical process that communicates an organization's priority goals and objectives. It is a "living" document used to provide a framework for decision making about activities and allocation of resources. It is not all things to all people and does not define every activity or goal in an organization.
Priority Program Areas:	A priority set of related activities and functions with a particular aim (e.g. Immunization Program)
Strategy:	A plan of action to achieve a major or overall aim.
Goal:	Object of a person's ambition or effort; an aim or desired result.
Objective:	Measurable actions to achieve an overall goal.
Measures:	A standard unit used to express the size, amount, or degree of something.
Activities:	A thing that a person or group does or has done in order to make progress on a goal, program, or objective.
Action Plan:	A planning document that lists what steps must be taken to achieve an objective or goal. An action plan usually specifies the particular activity to be done, the individual responsible for doing the activity, and when the activity is to be accomplished. (E.g., who, what, and by when.)

Strategic Planning Workgroup Process and Methods

Due to the amount of staff turnover during the pandemic, it was determined a larger group of participants would be recruited. Our work was conducted using a participatory leadership model. Participants were recruited from each of the four regions of the Section, as well as from the management team, the office assistant staff, the informatics team, and the consultant team.

Strategic Plan Workgroup Members:

Harmony Armstrong- Information System Coordinator	Darcee Perkins- PHN 2, Nome
Julie Bunch- PHN 3, Kenai	Dawn Rabitaille- Office Assistant 1, Mat-Su
Shelly Foint-Anderson, PHN4, Fairbanks	Amber Rand- PHN 3, Delta Junction
Claire Geldhof- PHN 3 (Itinerant), Juneau (Co-Chair)	Bridget Roughneen, Nurse Consultant 2
Tracy Grenier- Office Assistant 4, Juneau	Colette Textor- PHN 3, Fairbanks
Sarah Hargrave- PHN 5, Southeast (Chair)	Shawnisty Webber- Office Assistant 2, Homer
Zach White- Research Analyst 3, Southeast	

Strategic Planning Framework

As a basis for the process, the Strategic Planning Workgroup used a model presented by the Region V Public Health Training Center. Team chairs reviewed a series of four one-hour webinars that introduced a seven-phase framework to guide strategic planning efforts. The link to register for this training is available in the references section of this document.

Getting Set Up for Success	Defining Who We Are	Defining Our Challenge	Setting our Course	Putting the Pieces Together	Making it Happen	Keeping the Plan Relevant
Phase 1	**Phase 2**	**Phase 3**	**Phase 4**	**Phase 5**	**Phase 6**	**Phase 7**
Get Ready: Plan to Plan	Articulate Mission, Vision, Values	Assess the Situation	Agree on Strategic Priorities	Write the plan; document and commit	Implement the plan	Evaluate and monitor

Findings

The Strategic Plan Workgroup conducted an extensive assessment (Phase 3). The team broke into three groups: key informant interviews; staff survey; and "fact finders" or the team tasked with reviewing health metrics for Alaska.

Key Informant Interviews:

For the key informant assessment, the team conducted interviews with: Dr. Zink, Heidi Hedberg, Joe McLaughlin, Lindsey Kato, Theresa Welton, Tracy Dompenling, Director for the Division of Behavior Health, Sarah Aho, Tari O'Connor, and Gene Wiseman. We developed a set of short questions, held the interviews, transcribed them, coded, and then themed them.

The coded analysis shows that the Section's strengths included the importance of our local presence, and our passionate staff. Most interviewees highlighted the value of the local public health center's link between their local communities and other state offices. Several interviews noted how the SOPHN is skilled at meeting people where they are.

Key informant interviews noted that SOPHN needs to continue to invest in helping to bridge gaps in care for many Alaskans, especially in the realms of vaccine provision, STI services, substance misuse prevention, and TB care. In addition, there was consensus that SOPHN needs to continue to work on communicating and messaging, enhancing local partnerships and collaborations. As part of the Division's efforts, it was felt that SOPHN needs to play a more active role in addressing vaccine mistrust and misinformation.

Finally, most interviewees noted that SOPHN needs to continue to place emphasis on building a strong workforce, both in terms of filling positions that have been vacant for extended periods, as well as continuing to train staff.

“Fact Finders” Review:

The Fact Finders workgroup was tasked with reviewing Alaska-specific health metrics and coming back with recommendations that may need SOPHN attention statewide.

In reviewing the Healthy Alaskans 2020 score card, the Fact Finders workgroup found that half of the indicators were not met in 15 different health topics. They also noted that there continue to be significant differences between rural and urban health outcomes. A poorer health equity index ranking was particularly noted in the Northwestern and Southwest areas of the State.

They workgroup identified a few significant gaps between SOPHN program activities and Alaska morbidity and mortality. Accidents and suicide are both in the top 10 causes of death in Alaska, however programming around these issues is very sparce within the SOPHN.

Staff Survey:

The final assessment group was tasked with developing and implementing a survey for SOPHN staff. The survey ran from mid-December to about mid-January with 69 responses.

Staff responses indicated that the SOPHN’s strengths lay in our caring attitude, collaboration, teamwork, and cooperation with our local partners and clients. Staff noted appreciation for the increase in regular staff-meetings, and indicated a strong preference for those to continue. Staff also mentioned the appreciation of the Section’s efforts to streamline training and paperwork.

The staff survey noted several opportunities for improvement. These opportunities include: increasing work/life flexibility and recognition; the need for improved onboarding and training; a strong desire to get away from RPMS; and the need to improve service delivery in the areas of maternal/child health and behavioral health issues. Finally, there were several comments about a need for staff roles and scope to be clarified post-pandemic.

We asked staff to share the top 5 issues in their communities. The results were consistently substance misuse, mental health, STIs, immunization rates, and tuberculosis.

Within the survey, we also included some questions that have been used in the past or could be replicated in ongoing surveys as indicators of communication and satisfaction. These included:

- “I feel like I have a mechanism to communicate my needs and ideas within SOPHN.”
    - 60.29% indicated they agreed or strongly agreed.

- "How would you rate staff morale within your SOPHN work environment?"
    - 31.88% said very good or excellent; 36.23% said good.
- "How likely are you to recommend the Section of Public Health Nursing to family and friends as a great place to work?"
    - 65% said they were likely or very likely to recommend the Section.

Vision Statement

A vision statement provides a clear picture of our ideal organization's efforts and what it will look like if our teams are successful in working together to achieve that vision (Gurley et al., 2015). Effective vision statements are concise and provide lofty, yet measurable language so that organizations know when the vision has been achieved, or when it should be adjusted to better meet the needs of the organization (Pekarsky, 2007). The SOPHN vision statement is:

Alaskans thriving across generations.

This vision statement inspires current and future work to support Alaskans across the lifespan to improve health outcomes across all generations.

Mission Statement

A mission statement is a written statement that captures the organization's fundamental, unique and enduring purpose (Alegre et al., 2018). The SOPHN mission statement is:

Partnering with Alaskans to protect and improve the health and wellbeing of communities.

Guiding Principles

The guiding principles were developed using the prior guiding principles, the Scope and Standards of Public Health Nursing, and the Word Cloud exercise done at the Section all-staff in December 2023.

Section Of Public Health Nursing

Guiding Principles

Strategic Planning Development 2024

Compassionate

We care for individuals and populations “Where they are” with respect, empathy, and cultural congruence.

Responsive

We are guided by community health assesments and input, answering to health improvement needs with intention and unwavering commitment to the populations we serve.

Equitable

Following the Public Health Nursing Scope and Standards, social justice is the moral foundation of our practice. We integrate environmental and social determinants of health into our services, so all Alaskans have a fair opportunity to obtain their full health potential.

Trustworthy

We act professionally, with honesty and kindness. We follow-through on commitments.

Collaborative

With local and statewide partners, we address individual and community needs to advance the health of the public.

Evidence-Based

We use research, science, and data to guide service delivery models that improve health outcomes. We allocate our resources in a manner that emphasizes primary prevention.

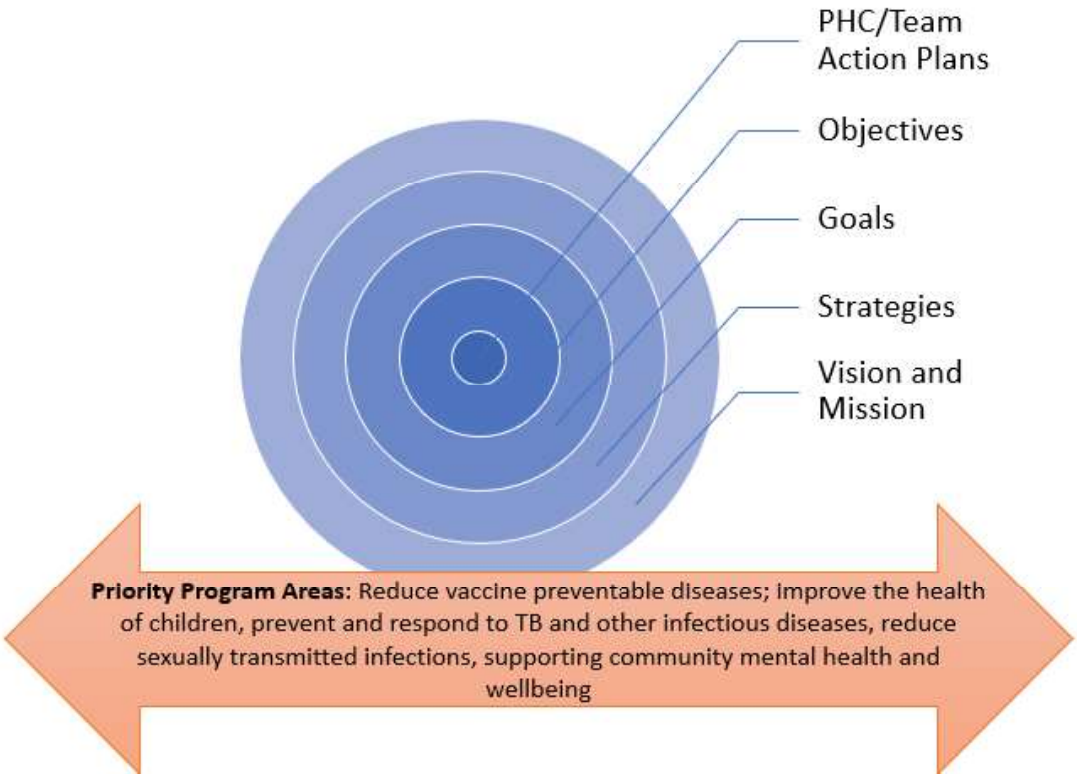
Strategies

As described above, there are multiple findings from each assessment group. Upon analysis, a sub-team of the Strategic Planning Workgroup grouped findings into three overarching themes: the importance of local and statewide engagement activities; the need to measure and share results of our work; and the need to continue investment in our workforce. The Strategic Planning Workgroup defined these three strategies as follows:

1. **Impact: We aim to improve our ability to measure our successes around key public health issues and tell the story of our impact.**
2. **Engagement: We aim to increase collaboration with local and State of Alaska partners to enhance local collective impact.**
3. **Workforce: We foster a strong workforce and a workplace culture that provides development opportunities that align with the public health needs of Alaska, and the Core Competencies for Public Health Professionals.**

Goals and Objectives

Each of the three strategies has more specific goals and objectives for the Section's work over the next three years. The goal statements remain broad, while the objectives provide the details. Many (but not all) objectives have specific metrics or activities associated with them.



Impact	
Goal Statement	**Summary of Objectives**
Goal 1: Continuously and systematically improve the delivery of public health nursing services.	Quality improvement processes
Goal 2: Decrease STI rates within communities.	Link at-risk populations to services, increase screening, increase point of care testing options
Goal 3: Improve availability of local-level data to inform local public health nursing interventions.	Improve community-level data access
Goal 4: Prevent disease and promote the physical, mental, and social health of children through on-time pediatric preventative screening and immunizations.	Increase well-child checks and school screenings, improve immunization rates
Goal 5: Sharing "wins" of our workforce, engagement, impact.	Develop progress dashboards, harness stories of impact, revise weekly report, explore academic partnership
Engagement	
Goal 6: Increase collaborative engagement between SOPHN and local agencies, DPH Sections, and Statewide partners to provide coordinated, comprehensive care within priority program areas.	Partner on priority program areas, primary prevention efforts, CHAs/CHIPs
Goal 7: Increase outreach for PHN-delivered safety net services and collaborative activities to serve populations experiencing vulnerability around the priority program areas.	Increase delivery of safety net services meeting the client "where they are"
Goal 8: Increase the visibility of the local public health centers in individual and community-based services.	Strategize with PIO, enhance local messaging, improve website
Goal 9: Develop section-wide programmatic activities to protect and promote individual and community mental health.	Form a section wide team to develop interventions; participate in local coalitions.
Workforce	
Goal 10: Professional development aligns with Core Competencies for Public Health Professionals and the priority program areas.	Training opportunities for CPH exam, P&P, QI; Integrate strategic plan into evals, support mentoring
Goal 11. Increase the skills of the workforce to act as Chief Health Strategists.	Training in meeting facilitation, cross sector partnerships.
Goal 12: Enhance recruitment and retention	Recruitment postings, partner with University, retention strategies
Goal 13: Streamline and re-build SOPHN guiding documents and trainings.	Well-child training, training updates in priority program areas, PHN Academy, core documents current.
Goal 14: Data modernization	Implement Netsmart, contact tracing software, and direct observed treatment application
Goal 15: Assure all staff have an understanding of job responsibilities and scope.	Review PDs, update as needed.

Impact: We aim to improve our ability to measure our successes around key public health issues and tell the story of our impact.

Priority program areas: Reduce Vaccine Preventable Diseases; Improve the Health of Children; Prevent and Respond to Tuberculosis and other Infectious Diseases; Reduce Sexually Transmitted Infections; Community Mental Health and Wellbeing

(M)= Measure

(A)= Activity Step

Goal 1: Continuously and systematically improve the delivery of public health nursing services.

Objective 1: Re-institute routine and periodic training in process improvement methodologies within the organization.

*Objective 2: Embed plan-do-study-act (PDSA) processes and projects into Section and health center operations.

Goal 2: Decrease STI rates within communities.

*Objective 1: Increase STI screening, and rescreening at public health centers.

- All public health centers use a reminder recall system for STI and reproductive health services. (Use creative strategies around needs of populations experiencing vulnerabilities)

*Objective 2: Improve access to STI and reproductive health services by enhancing linkages to care in the community among at-risk populations.

- Partner with community organizations to facilitate linkage to care for STI testing and treatment (syringe service programs, substance use disorder treatment facilities, emergency departments, pharmacies, retail clinics, school-based health centers, faith-based organizations) (A)

Objective 3: Increase the percentage of middle and high schools that use an evidence-based reproductive health curriculum.

- Select and implement a standardized evidence-based reproductive health education curriculum for use in local community schools across the entire Section (e.g. FLASH) (A)
- #school boards having approved EB curriculum presented by PHN (M)

*Objective 4: Increase STI positivity rates through targeted outreach to populations experiencing vulnerabilities.

- Increase # of syphilis cases identified through testing (M)
- Increase % positivity for CT/GC at the health center level (M)

Objective 5: Modernize testing and treatment methodologies to meet clients “where they are”

- Increase off-site testing opportunities (A)
- All PHCs have point-of-care syphilis tests, HIV tests, Hep C, CT/GC tests by 06/30/2026 (Met/Not Met) (M)

Goal 3: Improve availability of local-level data to inform local public health nursing interventions

Objective 1: Systematize community-level immunization rates data for SOPHN VacTrAK via User Agreement.

Objective 2: Systematize community or census-level STI case counts and rates for SOPHN.

Objective 3: Identify and build EHR report templates that will be able to inform practice and processes.

Objective 4: Implement processes to drive PDSA cycles around local public health interventions and share results of these efforts.

Objective 5: Identify relevant social determinant of health data sources and use the data to drive community health improvement through promotion of protective factors.

Goal 4: Prevent disease and promote the physical, mental, and social health of children through on-time pediatric preventative screening and immunizations.

*Objective 1: Staff use evidence-based practices to address health misinformation and improve health literacy among families of children

- Identify and implement tools and strategies to impact vaccine hesitancy at individual and community level (A)

Objective 2: Modernize pediatric screening tools to improve efficiency and decrease barriers to care.

- Adopt point-of-care testing for lead screening (A)
- Adopt photoscreeners for vision screening

*Objective 3: Increase childhood immunization rates at the local level.

- Increase % of 15 year olds up-to-date on HPV (M)
- Increase % of 2 years olds up-to-date per 4/3/1/3/3/1/4 (M)
- % of kindergartners up-to-date on school-required vaccinations (M)
- All health centers have a process in place for childhood immunization reminder recall (Met/Not Met) (A,M)
- # of PHCs using SMS in electronic health record (M)

*Objective 4: Utilize PDSA cycle to identify partners and strategies to improve child physical, mental and social health based on local assessment

- # of PDSA projects around immunization services (M)

Objective 5: Establish Section-wide process to support well-child checks based on data from Medicaid Due-List

- #kids behind in particular age group per geographic area (M)

Objective 6: With WCFH, support local school districts in completion of hearing and vision screening (through direct screening, train the trainer, or policy development).

- Increase number of children with hearing and vision screening completed by PHNs (M)
- Provider training to school district staff/volunteers on hearing and vision screening (A)
- Increase the number of schools who have staff trained to do hearing and vision screening (M)

Goal 5: Sharing the "wins" of our workforce, engagement, impact strategies.

Objective 1: Develop and implement dashboards of progress toward priority program areas.

Objective 2: Develop and implement a qualitative collection tool for stories of impact.

Objective 3: Revise the weekly report template to focus on the outcomes and "why" of activities.

Objective 4: Explore partnership with academia to understand the impact of public health nursing in Alaska.

*= Objectives that PHCs can use to develop an action plan around in FY 2025

Engagement: **We aim to increase collaboration with local and State of Alaska partners to enhance local collective impact.**

(M)=Measure

(A)= Activity

Priority program areas: Reduce Vaccine Preventable Diseases; Improve the Health of Children; Prevent and Respond to Tuberculosis and other Infectious Diseases; Reduce Sexually Transmitted Infections; Community Mental Health and Wellbeing

Goal 6: Increase collaborative engagement between SOPHN and local agencies, DPH Sections, and Statewide partners to provide coordinated, comprehensive care within priority program areas.

*Objective 1: Partner with correctional facilities on STI treatment, contact investigation for STI and active TB, and care needs after release.

- Formal partnership (e.g. MOA) with DOC (met/not met) (M)

*Objective 2: Partner with division and local agencies for TB prevention, treatment, case management and targeted testing efforts

- Support testing strategies through implementation of IGRA testing at all public health centers (met/not met, # screened, %positive) (A,M)

*Objective 3: Partner with community organizations to facilitate local primary prevention strategies for:

- Suicide prevention, interpersonal partner violence, mental health care, and substance misuse prevention efforts (A)
- Accidental injury and death (A)
- Infectious diseases (TB, STI) (A)
- Enhancing community protective factors (A)

*Objective 4: Develop innovative partnerships with non-DPH partners: Department of Corrections, DEED, Alaska State Troopers (accident/injury prevention, opioids, preparedness activities r/t climate change and disaster, Fish and Game) to address priority program areas.

- #MOUs/Letters of agreement (develop documentation process) (A,M)

Objective 5: Formalize partnership with the Healthy and Equitable Teams Unit to increase collective impact for local community health assessments (CHAs) and community health improvement plans (CHIPs)

- MOA (met/not met) (M)
- # of communities served by PHN that have a CHA in place (with HEC) (M)
- # of communities served by PHN that have a CHIP in place (with HEC) (M)

Objective 6: Formalize partnership with Chronic Disease Prevention and Health Promotion to increase local collective impact for substance use prevention

- MOA with CDPHP (met/not met) (M)

- SOPHN staff support tobacco prevention programming at the local level in partnership with CDHP(A)
- # of schools with InDepth program due to SOPHN support (M)
- Substance Misuse workgroup collaborative- goal setting around community protective factors (A)

Objective 7: Formalize partnership with the Section of Women, Children, and Family Health to increase local collective impact for children and women's health.

- MOA with WCFH (met/not met) (M)

Goal 7: Increase outreach for PHN-delivered safety net services and collaborative activities to serve populations experiencing vulnerability around the priority program areas.

*Objective 1: Identify and plan strategies to improve health outcomes among populations in communities served by PHNs who experience: barriers to health services; health related social needs; significant life transitions (e.g., graduating from high school/college, leaving incarceration, loss of health insurance, new to town, new immigrants, seasonal workers, persons experiencing homelessness).

- Connect with other local agencies serving populations experiencing vulnerability (partner at events) (A)
- "Pop-up clinic" events (A, M)
- Off-site educational events (count of educational event) (M)
- Count of new partnerships (M)

Goal 8: Increase the visibility of the local public health centers in individual and community-based services.

Objective 1: Initiate public information campaign with PIO on accessibility of public health centers for safety net services.

Objective 2: Improve the SOPHN website

- Establish small working group to engage with PIO (A)
- Online clinical scheduling ability (with new EHR) (Met/Not met) (A, M)

*Objective 3: Local messaging for sharing public health updates with community partners

- E.g. distribution list for partners (A)
- Social media contract with PIO for geo-fencing (not individual PHC accounts) (A)

Goal 9: Develop section-wide programmatic activities to protect and promote individual and community mental health and enhance protective factors.

Objective 1: Form a team to review literature for appropriate Public Health Nursing interventions at the individual and community level to support community mental health and enhance protective factors.

*Objective 2: Participate in local and statewide partnerships that are coordinating to advance community mental health and decrease substance misuse, suicide, interpersonal

partner violence, and mental health crises, while working to enhance community protective factors.

*= Objectives that PHCs can begin developing an action plan around in FY 2025

Workforce: **We foster a strong workforce and a workplace culture that provides development opportunities that align with the public health needs of Alaska, and the Core Competencies for Public Health Professionals.**

Priority program areas: Reduce Vaccine Preventable Diseases; Improve the Health of Children; Prevent and Respond to Tuberculosis and other Infectious Diseases; Reduce Sexually Transmitted Infections; Enhance Protective Factors in the Community; Community Mental Health and Wellbeing

(M)= Measure

(A)= Activity Step

Goal 10: Professional development aligns with Core Competencies for Public Health Professionals and the priority program areas.

Objective 1: Increase public health professional development opportunities for all staff.

- Increase the number of staff who take and pass the Certified in Public Health Exam (qualified staff) (M)
- Increase the number of public health training opportunities for non-nursing staff (A)
- % of non-nursing staff who have completed a job-related training on a public health topic in the year (M)

Objective 2: Align performance evaluation learning objectives and SMART goals to public health competencies, Strategic Plan goals and objectives.

- Each staff person has at least 1 goal around public health competencies; and, 1 goal around Strategic Plan goals and objectives (M)

Objective 3: Assure staff are aware of content outlined in policies and procedures

- 100% of staff have automated SharePoint email reminders for new announcement and content (M)
- All new policy/procedure, medical directive or process changes are SharePoint announcements (A)
- Assure regular reports to management team on compliance with Moodle trainings (A)

Objective 4: Continue investment in mentoring models to assure competency and skill development.

- Continue data entry mentoring for all new office assistant 2 positions doing RPMS data entry (# mentored/quarter; # available mentors) (M)
- Continue PHN Academy mentoring; (# mentored/quarter; # available mentors) (M)
- Invest in ongoing professional development support and team-building for PHN3s as formal and informal mentors (annual professional development meeting and # of PHN3s attending). (A)

Objective 5: Improve workforce skills in continuous quality improvement to accelerate impact.

- All staff receive training in use of the Plan-Do-Study-Act (PDSA) cycle (A)
  - % of staff who completed PDSA training in the FY (M)

Goal 11: Increase the skills of the workforce to act as Chief Health Strategists.

Objective 1: Develop skills in meeting facilitation, agenda setting, collaborative partnership development, public speaking, and team-building.

- # and type of trainings provided, # of staff in attendance (M)

Objective 2: Increase availability of training around systems and strategic thinking, community engagement, and cross-sectoral partnerships.

- PH WINS data (M)

Goal 12: Enhance recruitment and retention

Objective 1: Continue to explore and implement retention strategies.

- Continue to advocate for bonuses and leave allowance through Letters of Agreement as budget allows. Met/Not Met (M)

Objective 2: Develop and implement annual staff communication surveys.

- Assess whether staff feel they have the training and resources to be successful in their positions (A)
- Regularly assess and improve the standard question to greater than 60%: "I feel like I have a mechanism to communicate my needs and ideas within SOPHN" (M)
- Assess opportunities to improve staff well-being and morale in the workplace (A)
- Communicate findings with management team and support the implementation of improvements to address findings at the local, regional, and section level (count of interventions to improve, measure results with survey) (A,M)
- % of staff with > 3years work in SOPHN (M)

Objective 3: Improve recruitment quality and timeliness.

- Reduce time from new vacancy to job being posted on WorkPlace Alaska (M)
- Maintain vacancy rate at less than or equal to 18% (M)
- Sustain and expand SHARP funding for hard-to-fill positions (A)
- Develop strategy for recruitment of itinerant positions (A)
- Engage with schools of nursing for job fairs and speaking engagements (A)
- SLT to regularly share updates and strategies for improving administrative reimbursement (A)

Objective 4: Develop partnerships with university systems and other agencies for student placements.

- Alaska Pacific University for student placements in rural communities (A)

- Number of UAA student placements each FY (M)
- Number of AHEC student placements each FY (M)
- Consider more flexibly PHN staffing modalities: expanding number of PHN 1/2 flex positions; part-time positions; adjust work schedules (A)

Goal 13: Streamline and re-build SOPHN guiding documents and trainings.

Objective 1: Redesign and implement well child training and services across the Section.

Objective 2: Staff receive regular training on updates to practice in the priority program areas.

- Training on sexuality, gender, and bias (A)
- Best practices for STI counseling, testing, and treatment (A)
- Increase number of staff providing partner services (M)

Objective 3: PHN Academy bi-annually to assure integration into the public health nursing specialty.

- (Met/Not Met; # of PHN students completing)

Objective 4: Maintain an efficient infrastructure to assure standardization of practices

- 100% of medical directives, policies and procedures are current at the start of each FY according to the review cycle (M)

Goal 14: Data modernization

Objective 1: Train all staff on Netsmart

- Procure Netsmart by 07/31/2024 (M)
- All PHCs on Netsmart by 02/28/2025 (M)
- Establish training and support structure through 06/30/2025 (A, M)

Objective 2: Identify, procure and implement training on electronic direct observed therapy (DOT) application.

Objective 3: Identify, procure and implement training on electronic case investigation and contact tracing application.

Goal 15: Assure all staff have an understanding of job responsibilities and scope.

Objective 1: Review position descriptions, update if needed.

Objective 2: Clarify roles and responsibilities between SOPHN staff and other Sections working from the public health center.

Objective 3: Assure staff understand their individual roles and responsibilities as they pertain to health center and the SOPHN Strategic Plan (see Goal 1, Objective 1).

Monitoring and Evaluation

Several strategies remain under development for monitoring and evaluation.

1. A dashboard of key indicators is under development, and a component of the Strategic Plan Impact strategy.
2. The Weekly Report format will be revised by the PHN 5 team, to better mirror the new Strategic Plan.
3. Public health center, and team action plans will be incorporated onto SharePoint and updated at least quarterly to track and communicate progress.

Tools to Apply the Strategic Plan

A Section-wide presentation will be provided and recorded in early FY25. Following the Section-wide presentation, a subset of the Strategic Plan Workgroup will provide facilitated workshops for each public health center.

Each public health center will review the content of the three strategies and determine what goals and objectives are relevant to the unique needs of individuals and communities they serve. Each public health center will document the goals and objectives they have chosen to work on within an action plan template, which will be stored on SharePoint and be updated at least quarterly.

An example for the imaginary community of "Tir na nOg" is shown below.

	Public Health Center:	**Tir na nOg**		
Selected Theme:	Impact			
Selected Goal& Objective:	Goal 2 Objective 2: Improve access to STI and reproductive health services by enhancing linkages to care in the community among at-risk populations.			
Target Program Areas: Reduce Vaccine Preventable Diseases; Improve the Health of Children; Prevent and Respond to Tuberculosis and other Infectious Diseases; Reduce Sexually Transmitted Infections; Enhance Protective Factors in the Community; Community Mental Health and Wellbeing				
Lead:				
Action Steps	**Person Responsible**	**Due by when:**	**Metric**	**Status**
1. Reach out to local emergency department director to set up brief meeting to discuss local referal process for STI cases	Sally Swampbucket	11/1/2024	CSD entry/ outcome	ED Director on leave until 12/1/24.
2. Reach out to syringe exchange program to discuss system of referral	Mother Goose		CSD entry/ outcome	

- Goals and objectives matched by priority program area are available in a separate Excel document.

“Elevator Speeches” for Sharing SOPHN Work

We are often frequently called upon to explain what SOPHN does, or to describe our primary activities. Below are several small snippets that may be helpful in communicating with community partners and other stakeholders across the State. You are welcome to use these as they are or adjust them to your specific purpose and audience.

- *What is SOPHN working on for Alaskans?*

“The SOPHN works daily to promote and protect health in our Alaskan communities. We provide safety net clinical services for Alaskans in urban and rural areas, as well as work collaboratively with communities to improve population health. Currently, we are actively working to assure our workforce is fully able to engage with communities on a variety of public health issues and community factors that drive population health. In alignment with the Division, we support local work around key issues including tuberculosis, sexually transmitted infections, immunization services, and collaborating to address substance misuse among others.”

Alternately, for something shorter, you could use:

“In our 2025-2028 plan, the SOPHN is focusing on 3 **strategies**: stronger *engagement* with local and statewide partners, enhancing the skills and abilities of our *workforce* to serve Alaskans, and measuring and communicating how SOPHN *impacts* the public's health across multiple program areas.”

Resources and References

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