ASSOCIATION OF STATE AND TERRITORIAL DIRECTORS OF NURSING

STRATEGIC PLAN 2008-2011

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ASSOCIATION OF STATE AND TERRITORIAL DIRECTORS OF NURSING

VISION

Healthy people living in healthy communities through excellence in public health nursing leadership.

MISSION

To protect and promote the health and safety of the public through:

- Public policy efforts;
- Leadership development; and
- Advocacy for the preparation, practice and role of public health nursing.

2008 – 2011 STRATEGIC GOALS AND OBJECTIVES

1.0 Grow and diversify the ASTDN membership.
  - 1.1 Re-evaluate membership classes, rights and privileges by benchmarking with like organizations as a part of bylaws review to increase flexibility in membership recruitment and retention and support of ASTDN.
  - 1.2 All 50 states and territories' public health nursing leaders/official representatives are members of ASTDN.
  - 1.3 Increase associate membership by 200 percent.
  - 1.4 Develop membership-marketing materials that promote the value and benefits of membership in ASTDN (What's in it for me)?
  - 1.5 Disseminate membership promotion materials through new and expanded distributions channels.

2.0 Establish ASTDN infrastructure to enhance the ability of the association in fulfilling its vision, mission and strategic goals.
  - 2.1 Secure external administrative services for the association.
    - 2.1.1 Review options and make a recommendation to the executive committee.
    - 2.1.2 Select option and implement transition plan.
  - 2.2 Improve the efficiency and effectiveness of the association's governing systems and processes to be more flexible in responding to its dynamic environment and members needs, preference and desires (e.g., bylaws, etc.).
  - 2.3 Establish physical office headquarters.
  - 2.4 Establish and fill Executive Director/CEO position for ASTDN.

3.0 Develop strategic relationships with key organizations to accomplish the vision, mission and strategic goals of ASTDN.
  - 3.1 Evaluate opportunities to work with ASTHO and other targeted organizations.
  - 3.2 Evaluate opportunities to work with federal agencies e.g., CDC, HRSA, USPHS, AHRQ, Office of Chief Nurse, etc.
  - 3.3 Evaluate opportunities to work with NACCHO.

3.4 Evaluate opportunities to work with other professional associations such as ANA, APHA, American Red Cross and other voluntary organizations.
3.5 Evaluate opportunities to work with academia.

4.0 Serve as an authoritative, credible voice for public health nursing in public policy arenas.
4.1 Identify public policy priorities and develop platform statements, position papers, and etc. for dissemination to various audiences.
4.2 Build strategic alliance on targeted population issues with targeted groups.
4.3 Enhance the capacity of ASTDN to maximize public policy efforts.
4.3.1 Messaging and spokesperson training to increase member engagement in public policy activities.
4.3.2 Establish infrastructure to support the association's public policy activities.

5.0 Prepare public health nursing workforce to perform optimally in an environment with increasing accountability and complexity.
5.1 Provide leadership development opportunities.
5.2 Develop competency measurements.
5.2.1 Self-assessment tools.
5.2.2 Peer-to-Peer assessment tools.
5.2.3 Supervisor assessment tools.
5.3 Collect and disseminate success stories focusing on contributions and return on investment of public health nursing.
5.4 Apply evidence based research to practice.
5.5 Implement mentoring and other peer support activities.
5.6 Promote national standards.

BACKGROUND – EXTERNAL TRENDS

1. Individuals, organizations and governments experiencing declining resources.
2. Less economic security domestically as well as globally.
3. Increased costs of Medicaid, Medicare, and concerns about future of Social Security.
4. Political climate is dynamic, upcoming election and possible change in administration – global (decisions at national level, impact or implemented at the local level).
5. Americans aging, more retiring but continue to work due to financial constraints, and society is more diverse.
6. Workforce is reflective of the population (e.g., increased generational issues, multicultural, etc.)
7. Businesses put up barriers to employees continuing to work for the company after retirement e.g., cannot come back to work for 6 months (government). Experiencing turnover of senior employees that result in loss of knowledge/institutional memory.
8. More transparency asked of businesses, mergers, outsourcing, manufacturing moving out of the country, now service oriented marketplace.
9. Health disparities resulting from access issues to quality and cost effective care, may not be starting at the same point on health continuum as other groups, changing health status of the U.S. population e.g., obesity epidemic.
10. Gap in research and application to practice.
11. Funding for health care delivery, access in decreasing, decreasing number of health care providers – mix and match not consistent with health needs, now called Human Resources for health.
12. Continue to have wars, clashes, and oppression globally, lack of safety and security, increased violence, meanness, more self-centered, less safe.
13. Class divide – lack of opportunities, educational issues (e.g., standardization, need for life long learning, etc.).
14. Shrinking world – glocal.
15. Environmental concerns e.g., safe water, pollution, climate and workplace hazards.
16. Religions/cultures – lack of acceptance, desire for power.
17. Lack of personal privacy.
18. 24/7.
19. Glamorization of public health issues, negative reinforcement.
20. No longer see the melting pot and integration/assimilation in society, workforces and workplaces affected.
21. Work arrangement options e.g., home office, telecommuting, flextime, part-time, shared work offices/projects.
22. Depersonalization of society – less face-to-face interaction.
23. Technology has improved ability to connect with rural parts of the country.
24. Public health leadership roles – increasing political appointments, governor designated – create tension with public health science professionals and evidence-based practice.
25. Distrust of government, dislike, lack of confidence at all levels (e.g., local, state, regional and federal).
26. More federal programs are being assumed by private, non-profit organizations.
27. Increased regulatory environment, burden to business, more anti-business perceptions.

28. Competition – positive for alliances/collaborative activities, negative related to revenue and share of the marketplace, and can be wasted time.
29. Growing role of philanthropy – fund-raising.
30. What is public health? What is the role of public health – confusion among the public, public health themselves, policy (government), fundraisers – population needs, safety net for primary health care.

INTERNAL TRENDS

1. ASTDN incorporated in Georgia as a 501 c 6 non-profit corporation.
2. Public health nursing leaders, representing the states and territories are the primary membership class (voting class) – a possible universe of 57. Dues are $300. The state/territory is the member and the primary member is appointed by the state/territory. Membership is voluntary and not all states/territories belong to ASTDN. It is an organizational membership not individual.
3. A state/territory decides who will be the representative and assigns someone.
4. Some states do not send the same person every year, no continuity.
5. Degree of participation varies within the association. 80/20 rule applies, 20 percent do the work, only 5 to 15 percent are willing to serve in leadership positions.
6. Associate (non-public health nursing leaders) member class does not vote. Dues are $35.
7. Alumni (retired) membership class does not vote. Dues are $35.
8. ASTDN needs administrative support (e.g., public policy implementation).
9. Attendees to the annual conference say that it is a good experience. There is a board link with the hosting state.
10. Lack of control over states/territories' representatives, travel support, participant selection. Wondered if State Health Offices had travel support to ASTHO?
11. Need for continuity on executive committee, perhaps 2-year term for president, evaluate governance structure and required resources.
12. Current governing body consists of officers and 3 at-large members for a total of 8 and 6-7 regional representatives. CDC project has an advisory board and there are 6-7 committees.
13. Associate member class includes educators, program managers, and state nursing consultants, non-RNs and supporters of the purposes of the association.
14. More often nursing directors are being replaced by non-RN nurses and have non-nursing titles. Rationale is they are not providing direct services.
15. Academics have limited or no connection with public health. Decreased knowledge.
16. Salaries are non-competitive.
17. Current role of public health nursing vs. future role, there is tension around salaries as well as other issues (e.g., non-RN).
18. Advocacy.
19. Turf battle with environmental.
20. Decreased supply of qualified candidates.
21. Need curricula that are population focused.
22. Demand/value and ROI for public health nursing are needed for the marketplace.
23. Nurse – public health nurse, caring profession and predominantly women affect identity, value, compensation, etc. Workforce development is needed.

24. Accreditation - public health agency.
25. Competition with AMA and other disciplines.
26. Broaden the legislative agenda of the Public Policy Committee – support with implementation is necessary to be successful.
27. Leadership Development Role – further opportunities to build understanding and knowledge of trends such as emergency preparedness, culture competence, diversity, health disparities, funding resource, public health nursing policy, and orientation to public health nursing role. Provide opportunities for networking.
28. Non-primary members out number primary members at meetings.
29. ASTDN is viewed as a leader on public health nursing issues, competencies by the general nursing community e.g., Quad Council. (Broad nursing perspective). However, there can be mix messages among various audiences.
30. What are members' perceptions of ASTDN? What does participation mean to members? What is the value proposition of membership?
31. There is no known record of ASTDN ever having conducted a customer satisfaction survey.
32. Competition: APHA nursing section, associate members – community health nursing educators, other ASTHO affiliates, State public health nursing associations, and Association of Nurse Executives (AONE).
33. Eleven states have no primary member of ASTDN.
34. Barriers to participation – supervisors, resources, personal time, quality of life, etc.
35. Continuing education providers – non-profits, associations, and for profits.
36. Revenue streams - members' dues, and non-dues revenue including federal government cooperative grants, and annual meeting.
37. ASTDN contract obligations and independent contractor obligations.
38. Long history of no central place, keeper of the records.
39. Answers to the question, "What's in it for me?"
    a. Knowledge, sharing, do my job better.
    b. Mentor.
    c. Public health nursing and broader nursing issues, policy formation.
    d. Leadership
    e. Opportunity to add my voice to the larger voice of public health nursing and public health – collective voice.
    f. Prior organizational experience, contribute to ASTDN.
    g. Transition/orientation to the role.
    h. Stay connected with nursing's core values.
    i. Gain experience.
    j. Support role.
    k. Annual report and annual meeting.
    l. Fun, family, community – celebrate.
    m. Supplement annual meeting with regional meetings/narrower focus.

MEGA TRENDS (LEADING EDGE)

1. Lack/loss of public health nursing leader role in states/territories even though there may be one down in the organizational chart, removed from the state health office, or being moved out, not a seat at the table.
2. National accreditation/certification of public health workers and agencies – quality improvement and accountability.
3. Workforce development
    a. Recruitment – pipeline.
    b. Retention – ongoing competencies.
    c. Financial incentives.
    d. Succession planning.
4. Shifting model – health care system, public health and public health nursing role and contribution.
5. U.S. is 33rd in the world for health status. Spend more on health care than in other countries including end of life.

ASTDN STRENGTHS, WEAKNESSES, THREATS AND OPPORTUNITIES

Strengths

1. Represent U.S., a large geographic area.
2. Core group consists of competent members and leaders.
3. Unique niche within health care system.
4. National voice – Quad Council, opinions sought.
5. Position of authority.
6. Good alliances/partnerships.
7. Represent single/largest component of public health workforce – voice of other public health associates.
8. Established in 1935.
9. Well-rounded group, run all by volunteers.
10. Produces good documents.
11. Find a home here – acceptance/community/respect (mutual).
12. People interested in joining.
13. List serve available to pose questions/responses.
14. Website.
15. Great conference.
16. ASTHO Affiliate.

Weaknesses

1. Small based of volunteers, small membership.
2. Have full time jobs, often the public health nursing director.
3. Lack of diversity (e.g., age, culture, ethnic, etc.)
4. Change in leadership position at ASTHO, ASTDN affected negatively. Decrease visiability, decrease representation, and lack of administrative responsiveness (champion).
5. Lack of diversity of funding sources.

6. Lack of administrative/management structure to support the organization.
7. Organization membership not individual, too narrowly defined.
8. Need to be a bigger, stronger voice for public health.
9. Evidence based practice/ratios for public health/delineating the value of public health nursing leaders.
10. Need well-crafted positions/position descriptions, collect success stories.
11. Need capacity grants (e.g., mentoring, epidemiology, advocacy).
12. Connect with CDC prevention goals and pull together with the nursing community.
13. Nurse/family readiness.

Threats
1. Accountability/competency – external forces that control roles.
2. Financial situation.
3. Volunteer driven organization and no administrative coordination support.
4. Consideration of legal/risk management issues e.g., contracts.
5. Will we be around?
6. Desire to get more members – short-term gains and long-term consequences.
7. Lack of marketing.
8. ASTDN doesn't have public health in its name. Don't know who we are?

Opportunities
1. Learn from other ASTHO affiliates – chronic disease group, have expressed interest in helping.
2. Enhance policy analysis abilities – cast the net wider, also product development.
3. Public health accreditation – projected application capabilities in 2011.
4. Certification for the generalist in public health nursing.
5. Public health nurses – potential membership (community health/public health),
6. Funds to establish infrastructure, need to take action.
7. Collaborations with other organizations e.g., chronic disease willing to help.

PARKING LOT

1. What defines a public health leader?
2. Review bylaws not only membership classes, but also the entire document to enhance ability of ASTDN to be more responsive and effective in achieving vision, mission and strategic goals.
3. Establish a 501 c 3.

January 29, 2008