Doctor of Public Health in Leadership Program

Strategic Plan Implementation: A Case Study of Barriers, Facilitators, and Change

By

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I: Background and Problem Statement

a. Introduction

Strategic planning is a leadership tool widely used by profit-based, non-profit, and governmental organizations, based on decisions the organization has made about strategic priorities for the near future - usually the next three to five years. Strategic planning's purpose is to "understand the environment, define organizational goals, identify options, make and implement decisions as well as to evaluate actual performance" (Drucker, 1980, p61). Local Health Departments (LHDs), the focus of this research, use strategic planning to provide a "roadmap" to shape and guide action and purpose. (Bryson, 2004). The "roadmap" provides LHDs and their stakeholders with a clear picture of the future of the department, how it will obtain that future position or vision, the methods by which it will succeed, and the measures to indicate progress and success (NACCHO, 2012).

The successful strategic plan will provide an LHD with numerous positive outcomes to improve the quality and quantity of health for their community. These outcomes range from increased program performance, better use of resources, understanding programs and program context, improved decision making, better stakeholder communication, and political support for programs (CDC, 2008). It is hard to argue that each of these outcomes would not provide for a better delivery of public health. Ultimately, a strategic plan, if done well, creates a better organization (Baldwin, 2013). However, a strategic plan can only create a better organization when that a strategic plan is successful—and the only successful strategic plan is one that is implemented (Poister, 2005). A major failing of strategic planning has been poor implementation. Stories abound of strategic plans, long deliberated over, that sit on shelves. Implementation is the ultimate test of effective strategic plans. But what is implementation? How

can a plan be considered “implemented” and are there ways to reduce failure of implementation? One way research can help reduce failure of implementation is to better understand the barriers and facilitators to implementation. Currently, there is little known of LHDs barriers or facilitators to implementation. The current Public Health Accreditation Board standards include review of whether an LHD applying for accreditation has an implemented strategic plan. For this author, an implemented plan is one that allows the LHD to improve process, health or programs for its community.

The research proposed herein explores, as an action research case study, the efforts of one LHD, Ohio’s Toledo-Lucas County Health Department, (TLCHD) working towards accreditation to implement its strategic plan. Through the lens of a case study, this research will look at the challenges of implementing: 1) a strategic plan, and 2) a process that assesses and reports on completion of actions steps and objectives of the plan. In addition, the research will look to document how implementation work changes the way public health is delivered or why it did not change. Furthermore, this research will document the barriers and facilitators to implementation as noted by one LHD, thereby reducing failure of implementation. Currently, there is little known about LHDs barriers or facilitators to implementation. The current Public Health Accreditation Board standards include review of whether an LHD applying for accreditation has an implemented strategic plan. For this author, an implemented plan is one that allows the LHD to improve process, health or programs for its community. This study will add to the literature regarding impelling or impeding factors to successful implementation at the LHD level.

From an operational LHD perspective it is hoped that the research can demonstrate an effective use of the personnel resources that are needed to implement a strategic plan, through

providing a possible process to track, evaluate and document outcomes and show that implementation of a strategic plan can change public health.

Chapter I provides the study objectives, discusses the background to strategic plan implementation and why is it important to understand the process. Additionally, Chapter I will discuss the role PHAB accreditation plays in the implementation process and presents an overview of the TLCHD and its strategic plan implementation process/status. The Chapter II literature review provides insight into strategic plan implementation, its facilitators and barriers and other specific information to support the study. Chapter III presents the study design, including the methods for data collection and analysis.

b. Study Objectives

The proposed action research will address the following objectives:

1. Identify the facilitators and barriers to strategic plan implementation at an LHD seeking PHAB accreditation.
2. Understand if and/or how the LHD employees use the implemented strategic plan to change the way they do their jobs.
3. Understand and document the procedure for implementing a strategic plan.

c. Background and Context

Why study strategic plan implementation? Local-level public health is at a pivotal point with diminishing funding sources and larger programmatic demands. Over the next several years, pressures will be exerted on departments from many different directions. These pressures include funding, accountability for evidence-based programs, response to novel diseases in communities, and workforce issues (Graham, 2010). Public health agencies can limit or even stop negative impacts by developing and utilizing strategies that change conditions

(Weeramanthri & Bailie, 2015). One tool that public health professionals can use to meet these challenges is implementing a strategic plan.

Poister (2005) states an implemented strategic plan generates many positive outcomes such as a clear identity, better decision making, and clear goals; it is fundamental to the management of an LHD (NACCHO, 2010). If a plan is not implemented opportunities are missed for program performance, appropriate use of resources, understanding programs and program context, improved decision making, better stakeholder communication, and political support for programs (CDC, 2008). What, then, may be causing LHDs to fail in the implementation of their strategic plans? Understanding some of the barriers and facilitators that affect LHD implementation of their strategic plans can help to improve the chance of success in the process. Also, what influences from mandated PHAB demands such as evaluation and participation in the implementation process support success or failure?

Creating a strategic plan requires adopting processes that have not been operationalized by many local health departments. This is evidenced by only 53% of LHDs having completed a strategic plan in the last 5 years (NACCHO, 2017). Even more of a concern is that there is little research that exists regarding the success of implemented plans (Hahn & Powers, 2010). With little guidance or research how can LHDs be expected to reduce the chance of implementation failure? If Carlopio and Harvey's data of 50% failure rate of strategic plans is extrapolated to LHDs, it is leaving a gap in guidance and improvement known to be generated by implementation (Carlopio & Harvey, 2012). Given these statistics and gaps, there is significant room for improvement and potential for public health to expand its impact and effectiveness resulting from more LHDs not only completing a strategic plan but implementing one.

Importance of Implemented Strategic Plans for Ohio and Others. Ohio is the only state in the U.S. that has mandated that all local health departments (LHDs) receive accreditation from the Public Health Accreditation Board (PHAB) by the year 2020 (ODH, 2017). As of December 2017, only 18 out of 100+ Ohio LHDs had been accredited (PHAB, 2017). One major prerequisite to be accredited is that the department must have an implemented strategic plan (PHAB 2017). For many who have attempted implementation of a strategic plan they understand that it can be difficult. Difficultly lies in many areas from lack of personnel to complete proposed work, poor plan design, lack of or no communication and a myriad of other concerns that result in barriers to implementation. Others have less difficulty – why? The reason can lie in facilitators that may enhance the ability to implement a plan and reduce the barriers that deter implementation. Facilitators and barriers that were found in organizations other than LHDs will fully be discussed in Chapter II. Unfortunately for LHDs, there has been little to no discipline-specific literature and/or guidance of what the barriers or facilitators for LHDs consist of.

Also required by PHAB Accreditation is reporting on the status of the plan. Status of the plan is the work accomplished on the goals and objectives of the plan, what change was created by the work or, if there was no change, what did the department do to adjust the plan if needed. change. It is not enough that outcomes be documented and reported but do those outcomes result in better delivery of public health and if there is not-why? Ohio is an ideal location for this study because of the mandate to be accredited by PHAB. Here the study is likely to capture a broader array of facilitators and barriers than if only studied in locations with voluntary strategic planning.

Challenges for local public health departments. In the U.S., LHDs are key front-line public health organizations that address challenges in the communities in which Americans live and work. It is the LHD that fully understands and can respond to local challenges; the LHD has an intimate knowledge of its population, is well versed in local environmental conditions, and can influence workforce development. It can also monitor local socioeconomic conditions and tailor programs to meet those conditions, unlike state or federal agencies that view public health problems in a larger, less specific framework. For the purposes of this study, the main challenges for local public health departments are 1) defining public health; 2) diversity of LHDs regarding size and structure; 3) the PHAB requirements and process, and 4) implementation.

For most people, both inside and outside the discipline, defining public health is difficult. For many centuries, public health has been charged to protect and strengthen the health of the public – a broad and all-encompassing responsibility. In the U.S., several levels of government are responsible for managing public health. Each level – federal, state, tribal and local – has its own roles and responsibilities, although the roles are intertwined. At the local level, public health is expected to protect and promote health in the communities in which they serve. Local public health is given this authority from its state, often through the state constitution (PHAB, 2015). This authority allows LHDs to function operationally and deliver a variety of public health services to communities (PHAB, 2015). These are all issues that the multitude of LHDs, whatever their size, must deal with.

The 2013 National Profile of Local Health Departments is a nationwide study that provides a comprehensive description of LHD structure and processes (PHAB, 2013). From this study it was determined that 2,800 LHDs were engaged in the delivery of local public health programs to their communities (NACCHO, 2013). Of those 2,532 departments included in the

survey, 1,943 were truly locally-governed health departments. The remainder were units of their state health agency (402) or had shared governance (187) (NACCHO, 2013).

The NACCHO survey found that LHDs are responsible for the health of 97% of the country's population (NACCHO, 2017) and directly carry out numerous complex services, of which the most frequently provided are communicable/infectious disease surveillance, childhood and adult immunizations, tuberculosis testing and screening, environmental health surveillance, food facility safety education and inspection, population-based nutrition services, and school/daycare center inspections (NACCHO, 2013).

The size of the health departments varies. Of the LHDs, 61% are small departments that collectively serve only about 10% of the U.S. population. When looking at large departments (500,000+ population), they make up only about 5% of LHDs but together serve 49% of the population (NACCHO, 2013). Of these departments, there is a slight difference in services that are provided. For example, smaller departments (serving 50,000 people or fewer) that could be considered rural might provide services that urban departments may not, such as blood lead screenings, BMI screenings, specific clinical services, home health care, and WIC (NACCHO, 2013). Urban departments are more likely to administer environmental programs, provide permits, conduct inspection, and administer regulatory programs (NACCHO, 2013). Rural to urban departments function through a budget and expenditures. Expenditures on services vary between urban and rural departments but also within the departments individually. For instance, departments with 50,000 or less population size spent $670,000 and $2,180,000 annually. Comparatively, LHDs that serve a population of 1 million spent $30,000,000 to $97,200,000 (NACCHO, 2013). From an operational perspective, these ranges and variations are immense, and they affect what goals and how priorities are implemented by an LHD (NACCHO, 2013).

Stressing the differences further, for LHDs who serve less than 50,000 people, the average number of full-time equivalent employees (FTE) (usually 40-hour workweek) is 9.3, for those serving between 50,000 and 500,000 the FTE is 74, and for 500,000+ populations, the average FTE is 352. As for leadership, 10% of top executives work part-time while 25% of leaders for all LHDs are over 60 years of age. Furthermore, 55% of leaders have a masters or doctorate (NACCHO, 2013).

Every LHD has its own public health delivery structure which could include individuals, non-profit entities, private entities, and other key stakeholders (NACCHO, 2005). These stakeholders typically form the strategic planning committee. In this process, the LHD is responsible for developing the strategic plan (including its services and activities), for evaluating its performance and outcomes, and for making any necessary corrections. Furthermore, PHAB requires that when creating the strategic plan, the LHD considers steps to implement related public health priorities of the Community Health Improvement Plan (CHIP) included in the LHD's strategic plan (NACCHO, 2005; PHAB, 2013). The specific structure of the strategic planning group might vary depending on factors such as time, resources, available stakeholders, and the overall composition of the team. Ideally, the team that guides the process should be a mix of board members, senior staff, and key stakeholders; incorporating key stakeholders requires the LHD to acknowledge that not all team members will be familiar with the operations of the department (Bowman, 2008). While familiarity with daily operations may vary, each team member needs to understand the larger issues facing their LHD (NACCHO, 2005).

It is important that the strategic planning group bring together the committee members' skills and critical thinking to form a functional plan. Each team member needs to understand the strategic planning process; that is, they should share a mental model of how strategic plan

implementation can transform an organization. A shared understanding will allow the group to reach consensus on specific elements of the plan and debate implementation strategies (Senge, 1990).

Much of what has been stated about forming groups, using stakeholders and assessment to implement a strategic plan, follows the bigger picture of PHAB Accreditation. Moreover, the prerequisites for accreditation include not only the production of a strategic plan, but evidence of its implementation; for departments with new strategic plans, they must provide a detailed evaluation plan indicating that a procedure for implementing the plan and evaluating progress is in place (PHAB standard 5.3) (PHAB, 2015).

A major failing of strategic planning has been poor implementation. LHDs have been now doing SP for several decades driven by a) the expectation that LHDs adopt more businesslike practices, (NACCHO, 2012), b) the PHAB requirement, and c) explicit expectations of funding and governance bodies (State HDs). LHDs have followed the experience of the business and non-profit sectors in doing strategic planning but have adapted it to their unique needs, like other sectors. It's not unreasonable to expect that the LHDs will experience some implementation failure of other sectors. Frustratingly, there is much more guidance in the literature for strategic planning development than strategic planning implementation. Implementation guidance emerged as a problem with implementation. There is little guidance for LHDs, and a need to understand the facilitators and barriers to implementation more prospectively if the history of the business/non-profit sector is to be avoided. This study will attempt to do that for TCRHD.

PHAB's Role in LHD Strategic Planning The accreditation process is useful because it forces LHDs to look critically at strategic planning and implementation. Due to the accreditation

demands LDHs have a roadmap of what is required. PHAB has allowed LHDs to become more standardized on how they conducts and deliver public health including strategic plan implementation. It has done this through a comprehensive process.

The Public Health Accreditation Board (PHAB) manages accreditation through a process termed voluntary public health department accreditation, or PHAB accreditation for short. PHAB provides solid guidance on how a public health entity can improve services to its community, and it also offers a means to measure and evaluate how a health department delivers its services. Specifically, the standards and measures are divided into 12 domains. Domains 1-10 address the ten essential public health services:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems (CDC, 2014).

Domain 11 addresses management and administration, and Domain 12 addresses governance. Standards are for health departments to meet or surpass and to validate whether the standard is met (PHAB, 2013). For clarification, domains with standards can be found in Appendix A.

In relation to strategic plan implementation, the directive resides in Domain 5 - Developing Public Health Policies and Plans. This domain includes Standard 5.3 - Develop and Implement a Health Department Organizational Strategic Plan, and Measure 5.3.3A - Implement Departmental Strategic Plan. This measure requires documentation for implementation that shows progress toward satisfying the goals and objectives contained in the strategic plan. Once accredited, these reports are required by PHAB on an annual basis (PHAB, 2013). Other standards and measures inside Domain 5 also deal with strategic planning and are useful to understand how and why strategic plans are implemented. The requirements of the strategic plan for PHAB Domain 5.3 are as follows: mission, vision and value statement, strategic priorities, goals and objectives, consideration of key support functions for efficiency and effectiveness, identification of key external factors or trends, identification of strengths and weaknesses, and link to health department's health improvement plan and quality improvement plan. The importance of the PHAB domains is that they provide the LHD with a foundation for a strategic plan to be built upon. As with any process, both planning and accreditation take time and resources (PHAB, 2013). For the Toledo-Lucas County Health department this holds true.

The Toledo-Lucas County Health Department. According to the 2013 survey of local health departments, the TLCHD has a population of about 435,000 and would be placed in the survey's category of health departments of 200,000 to ½ million population (NACCHO, 2013). These types of LHDs account for about 8% of the total (2,532) LHDs in the United States. The

population type served by LHDs in this range accounts for about 41% of the total population of the U. S. According to the National Public Health Survey Report, the TLCHD is considered a medium-sized health department (NACCHO, 2013). Lucas County is the sixth largest county in Ohio and the sixth largest health department in Ohio. In addition, the workforce of the TLCHD includes about 155 employees, comparative with about 7% of other LHDs.

TLCHD Strategic Plan: Background & Overview Prior to 2013, when TLCHD began to explore becoming accredited and creating a new strategic plan, there had not been a new strategic plan since 2002, a large gap of 11 years. Currently, the TLCHD submitted for PHAB accreditation in August 2017 and is now on its second strategic plan since 2013. The administration and board are committed not only to accreditation but also to strategic plan implementation. The following is an excerpt from the 2016 TLCHD Annual Strategic Plan Annual Report presented to TLCHD's Board. There are several critical points here: 1) This is a 3-year strategic plan that plays an intricate role in TLCHD reaching PHAB Accreditation. 2) The strategic planning committee, the group which developed the plan, met between August 2016 and February 2017 to create an operational strategic plan; and 3)The plan was generated using the Community Health Assessment, Community Improvement Plan, a Strength/Weakness/Opportunity/Threat analysis and other internal data such as budget and organizational staffing. The product was the selection of eight different priorities that the plan will address. These eight priorities can be found in Figure 1. To evaluate where the department is in relation to completion of the plan, a monthly reporting system is in place. These monthly reports are to review the documents for:

- Progress made towards each objective's targets;
- Barriers or facilitators encountered;

- Proposed adjustments to timeframes or targets;
- What has TLCHD learned? (TLCHD, 2017)

One important aspect of the overview, that is not discussed within the overview, is the number of priorities that were originally suggested for the plan. During the initial selection phase there were 14 different priorities that the planning group wished to address. Through extensive conversation with the planning committee it was finally decided that only eight of the original 14 priorities would be addressed in the plan. As Health Commissioner, I advocated for six due to time and resource constraints. However, after further work on objectives by the committee members and staff, the committee found a comfort level that the eight-objective plan could be successfully implemented.

i. TLCHD Strategic Planning Process

The text below has been extracted from the TLCHD comprehensive strategic plan and is included to frame the discussion of the process.

> "Beginning in May 2016, the Toledo-Lucas County Health Department (TLCHD) embarked on the journey to develop a comprehensive strategic plan that would renew its vision for the future and establish the agency's strategic initiatives for the next three years. Strategic Planning is fundamentally central to effectively improving the health and wellbeing of all people in Lucas County. This process plays an integral role in TLCHD's pursuit of national accreditation sponsored by the Public Health Accreditation Board (PHAB). PHAB recognizes the importance of critically examining TLCHD's department's operations alongside the status of TLCHD's community's health and using that information to decisively map the path to a healthier Lucas County. PHAB defines strategic planning as the deliberate decision-making process that sets the direction for

TLCHD's organization and, through common understanding of TLCHD's mission, vision, priorities and objectives, provides a template from which employees and stakeholders can make decisions that move the department and TLCHD's community forward (PHAB, 2014).

Facilitated internally, the 2017-2020 Strategic Plan is built on a framework that details the responsibilities, priorities, and objectives TLCHD plans to achieve, how to achieve them, and how TLCHD will know if they have been successful. It serves as a guide for making decisions regarding the allocation of resources, and for taking action to pursue TLCHD's strategic priorities (PHAB, 2014). From August 2016 to February 2017, the Strategic Planning Committee met monthly to draft the structure of this plan through careful review of staff and stakeholder feedback; data from the most recent Community Health Assessment & Community Health Improvement Plans; the results of internal and external SWOT Analyses; and other pertinent data sources. The Committee then selected the priorities that will set TLCHD's agency and community on a course for improved health outcomes and a healthier Lucas County.

The Strategic Planning Committee compared Lucas County's County Health Rankings data against their Community Health Assessment & Health Improvement Plans, an early draft of the Environmental Health Assessment, demographic data for TLCHD's jurisdiction, all SWOT results, and other internal data. The Committee then proposed the following eight strategic priorities and objectives to align the department's work and focus for the next three years (TLCHD, 2017 pgs. 2, 10)."

"The 2017-2020 Strategic Plan is a living document intended to direct the focus of both TLCHD staff and Board of Health members over the next three years. This plan will

evolve over time to meet the changing needs of the community and to incorporate new data and information as it becomes available. In collaboration with their Community Partners, a new Community Health Assessment and Community Health Improvement Plan are on the horizon and updated information from both will be used to evaluate their priorities and objectives.

The full Strategic Work Plan will be reviewed and updated on an annual basis to ensure continued progress towards their stated mission, vision, and department goals. Progress made, or barriers encountered on individual Goals, Objectives, and Action Steps will be reported monthly in Strategic Planning Committee Meetings.

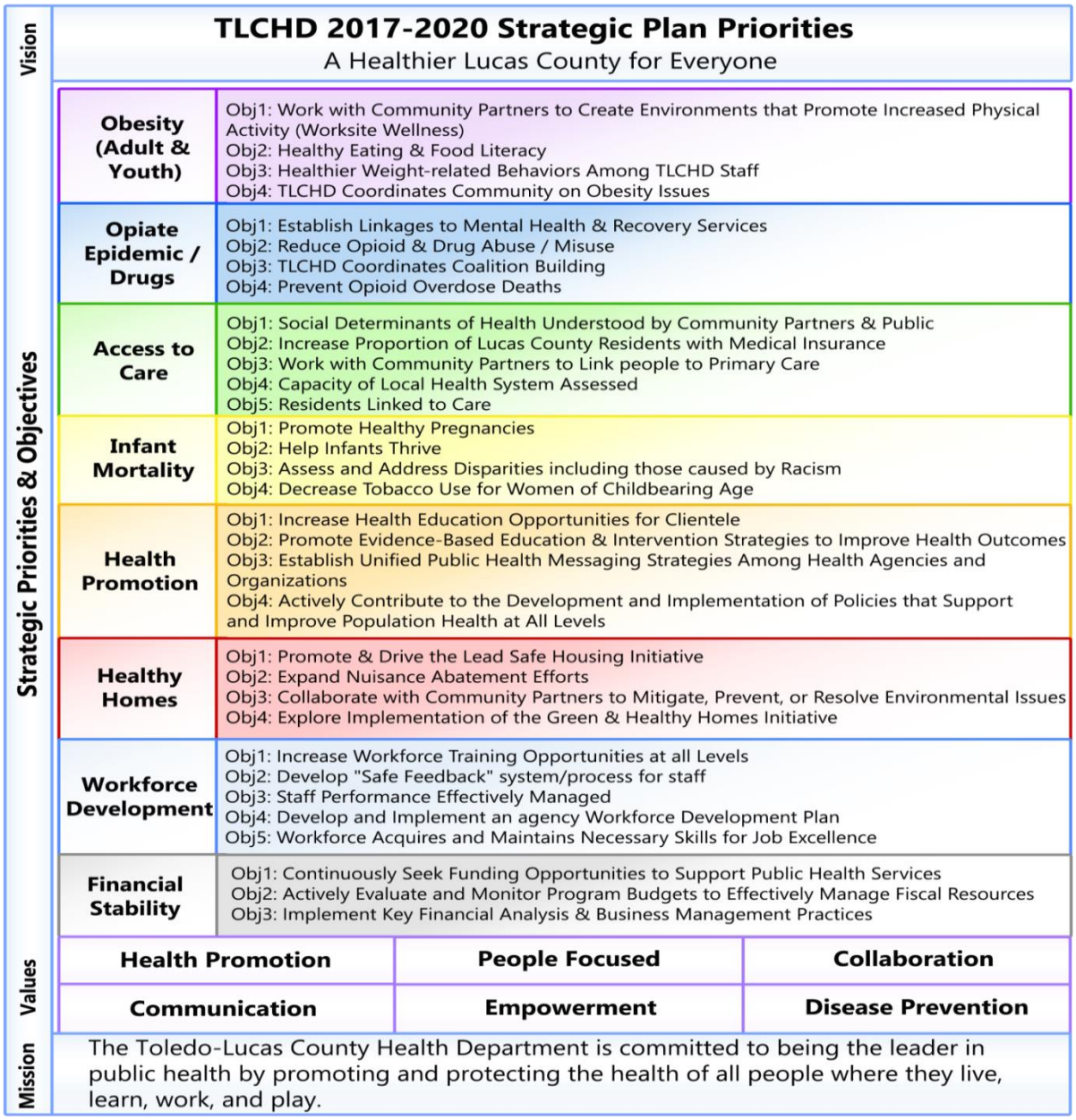
Key considerations for monthly reports will include:

- Progress made towards each objective's targets
- Barriers or facilitators encountered
- Proposed adjustments to timeframes or targets
- What has TLCHD learned?" (TLCHD, 2017 pg. 32)

Figure 1 visually presents the process mentioned above by displaying the priorities and objectives for the strategic plan. Figure 2 indicates those who were involved in the creation of the plan and who sit on the implementation committee; they represent a cross-section of the department's staff and leadership. The process to develop the strategic plan started in May of 2016 with SWOT analysis, which included external partners. The partners were Advanced Specialty Hospital of Toledo; American Cancer Society; Anthony Wayne Local School; Arrowhead Behavioral Health; Department of Neighborhoods, City of Toledo; Flower Hospital; Harbor Behavioral; Mercy Health; Mental Health Recovery Services Board of Lucas County;

ProMedica; St. Charles Hospital; St. Luke's Hospital; Success Mile Academy; and Toledo Hospital (TLCHD, 2017 pg. 33). Additional tasks included a review of the mission statement (August 2016), the final selection of the eight strategic priorities (January 2017), and a final board approved plan (February 2017). The summary of the process can be seen in the flow diagram below (Figure 3).

Figure 1. TLCHD Strategic Plan Priorities, 2017 - 2020



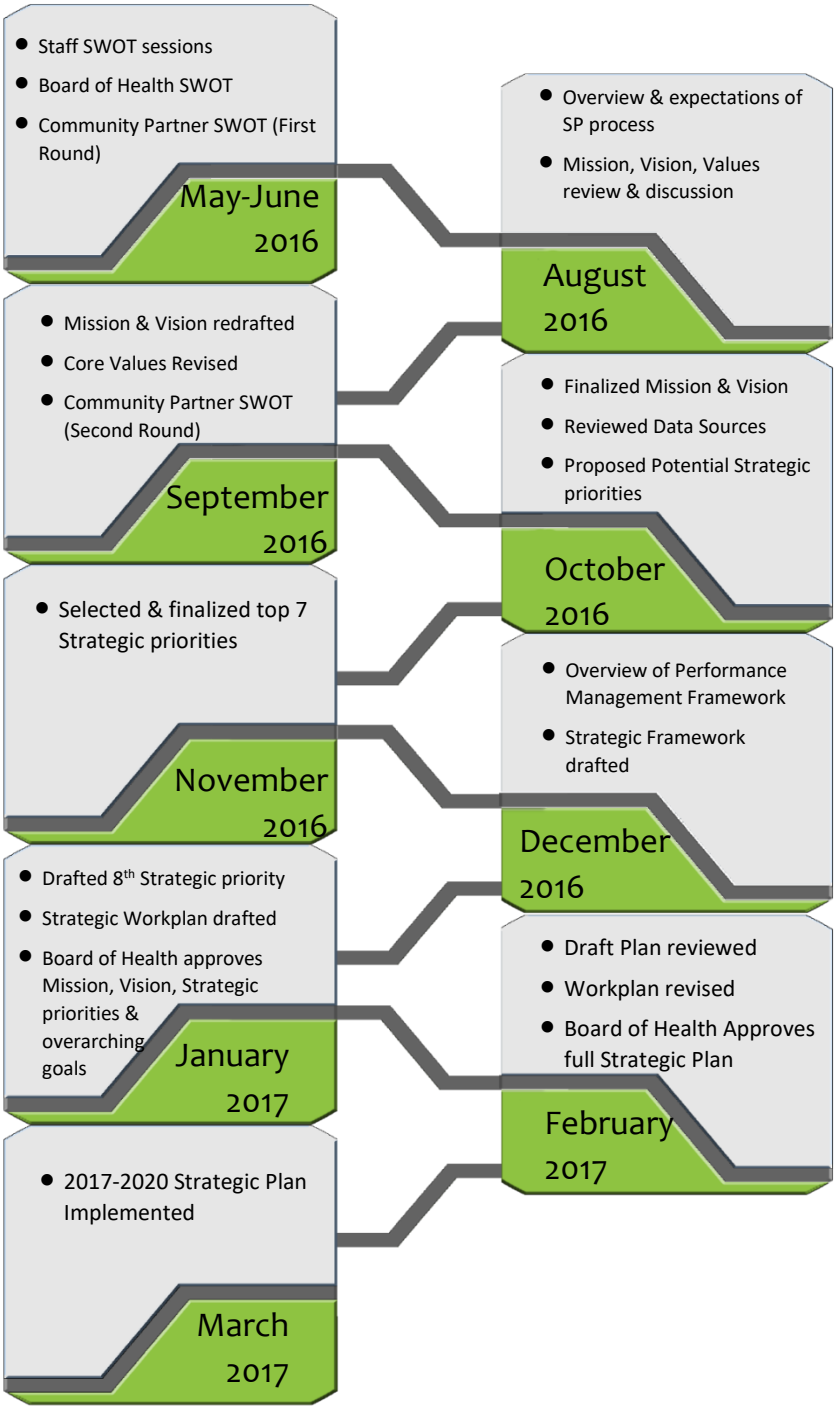
(TLCHD, 2017)

Figure 2. Members of the TLCHD Strategic Plan Implementation Committee

Position	Division
President	Board of Health
Strategic Planning Committee Chair	Board of Health
Health Commissioner	Administrative Services
Quality Assurance Coordinator	Administrative Services
Sanitarian-In-Training	Environmental Health & Community Services
WIC Supervisor	Health & Outreach Services
Program Coordinator for Healthy Start	Health & Outreach Services
Interim Director of Nursing & Health Services	Health & Outreach Services
Environmental Health Senior Clerk	Environmental Health & Community Services
Secretary	Environmental Health & Community Services
Supervisor of Epidemiology & Disaster Preparedness	Environmental Health & Community Services
Public Health Nurse- Healthy Start	Health & Outreach Services
Program Coordinator for HIV	Health & Outreach Services
Director of Health Promotion & Policy Integration	Administrative Services
Director of Administrative Services / CFO	Administrative Services
Network Service Technician	Administrative Services
Public Health Nurse- Lead Case Manager	Environmental Health & Community Services
WIC Senior Clerk	Health & Outreach Services

(TLCHD, 2017)

Figure 3. **Flow Diagram of TLCHD strategic planning Timeline**



(TLCHD, 2017)

Creating the priorities. Figure 3 maps the process to implement TLCHD's strategic plan. The creation of the final eight priorities began in May 2016 and continued until the end of the process in January 2017. During this time, many meetings were held by the strategic planning committee. The committee consisted of a cross-section of departmental personnel as well as two board members. The lead person responsible for the strategic planning process and implementation was Brandon Palinski, the Toledo-Lucas County Health Department Coordinator for PHAB, Strategic Planning and Quality Improvement. He was the individual responsible for scheduling and leading all meetings as well as keeping the committee on task with the process of planning. Choosing priorities was a group effort with this researcher, as Health Commissioner, having an equal voice as all others on the committee. To reach consensus on priorities, analyses of documents such as the SWOT, Community Health Improvement Plan (CHIP), Community Health Assessment and any other pertinent information was collated by the Coordinator and presented to the committee. These discussions allowed the committee to narrow down pertinent strategic issues the department should address. For instance, the CHIP indicated that work was needed to reduce infant mortality in Lucas County, and so it became a strategic plan priority. This type of work went on until the eight priorities were selected. As stated earlier there were originally 14 priorities that were decided on but after discussion this was reduced to eight. After the eight priorities were selected, it was necessary to craft objectives in order to address each priority. Each of the eight priorities have differing objectives as well as a differing number of objectives. These objectives were created by the priority champion, the staff member responsible for that priority, which went back to staff in the department who were subject matter experts or interested in the priority. The draft objectives for each of the priorities were brought back to the committee for final acceptance and then placed in the plan. Once this work was

complete the entire draft plan was reviewed and presented to the board for approval and implementation.

Implementing the priorities. Over the course of several meetings, the Committee discussed how to begin work on the eight strategic priorities. They decided initially that a select few of the priorities should be worked on, while the remainder would be addressed later. After deliberation, the committee decided against favoring a few select priorities and instead appointed a priority champion for each of the eight priorities. These champions would be responsible for overseeing the work done by staff on the priority, documenting the progress made on the objectives, and reporting the information back to the committee. The following is the breakdown of domain champions for each of the priorities:

1. Obesity -- Director of WIC and Secretary of WIC
2. Opiate Epidemic/Drugs -- Director of Nursing and Assistant Director of Environmental Health
3. Access to Care -- Electronic Health Records Officer and FQHC/Biostatistician Coordinator
4. Infant Mortality -- Supervisor of Healthy Start
5. Health Promotion -- Supervisor of Health Promotion and Policy Integration
6. Workforce Development -- PHAB Coordinator
7. Fiscal Stability -- Health Commissioner
8. Healthy Homes - Director of Environmental Health (as of January 2018;1-7, TLCHD, 2017)

The Implementation Committee also functioned as TLCHD's Planning Committee. Meetings are held once a month. During this time, the champions review progress on the facilitators/barriers to completing the objectives, lessons learned, and the evidence-based outcome to the work performed. They can make suggestions on how to overcome barriers, discuss the outcomes, and have input on any of the points brought to the group by the champions. Monthly reports are submitted using a standardized reporting form (Appendix B). The work from the monthly reports and findings from the discussions are compiled for quarterly reports to the Board of Health, placed on the TLCHD website, and disseminated to staff and stakeholders (TLCHD, 2017). The strategic planning process for the TLCHD has used many steps to obtain an implemented plan. However, as seen at the TLCHD and used in the proposal there are five phases.

Time and Resources. For most LHDs, much like TLCHD, time and resource expenditures for accreditation and strategic plan implementation become issues for LHD leadership. If LHDs are to improve their delivery of public health and see measurable results in their jurisdictions, these concerns must be redefined as valued benefits. One way this investment of time in strategic planning and implementation can be made more efficient is through better understanding of how to effectively implement a strategic plan. Furthermore, LHDs need to understand the value of implementing a strategic plan as an essential part of their mission. The primary concern with accomplishing the above listed priorities is that there is almost no defined LHD understanding on how the work will be accomplished. The understanding of how implementation upholds the mission began to change, for this author, in the summer of 2015.

Pilot Study In the summer of 2015, the TLCHD conducted a pilot study on their 2014-2016 strategic plan. The concept was to gain knowledge of strategic plan implementation and to identify and support any ongoing change in the department. I also wanted to make sure that I would be able to successfully collect and qualitatively analyze information on learning, as well as document barriers and facilitators related to strategic plan implementation. Additionally, I was interested in how evaluation was integrated into strategic plan implementation and the extent to which the evaluation process impacted strategic plan implementation and long-term changes in the LHD. I also wanted to test and practice a preliminary version of a focus group interview guide as an individual interview guide. The interview guide contained seven general lines of inquiry and allowed for open discussion using probes. The seven questions were:

1. Tell me about your involvement in the strategic planning process and how it got started.
2. Can you tell me if anything surprised you in the final plan?
3. After you completed the final plan, what did you implement first? How did you decide what to implement first?
4. What process was used to implement the strategic plan? How were you involved in the implementation of the strategic plan? What were the successful aspects of implementation? What were the challenging aspects about implementation?
5. What roles did objectives play in the implementation process? Did objectives ever change from the completed strategic plan to the implementation of the plan?
6. What role did PHAB play in the implementation of your strategic plan? Prior to the PHAB mandated strategic plan implementation, how did leadership in the LHD talk about -

the work of the LHD – was implementing a strategic plan discussed? [PROBE: Can you give examples of key words or phrases used?]

7. Is there anything else that you would like to discuss regarding implementation of your strategic plan?

Finally, I wanted the opportunity to become familiar with the process of coding and analyzing qualitative data in general. The environmental scan consisted of three 30-minute in-depth semi-structured interviews: one person in leadership at the LHD, one person in middle management, and one person considered to be line staff. Interviews were audio recorded and notes were taken. Interview tapes were transcribed using Dragon Speak software. Each transcript was cleaned and further refined using the notes that had been taken during the interview. Transcripts were loaded into Atlas TI and coded using a coding rubric, adding codes as necessary.

The environmental scan of the TLCHD found that barriers, facilitators and learning from the strategic plan implementation process can be documented. Furthermore, on a departmental and leadership level, the organization learned from implementing a strategic plan and, as a leader, I gained a better understanding of processes and procedures that influence success within my department related to strategic plan implementation.

These lines of inquiry successfully produced data on specific barriers and facilitators related to successful strategic plan implementation. It also yielded data regarding key factors related to creating a helpful process. Additionally, I learned how the strategic plan implementation process changed the work culture at the LHD. The findings from the environmental scan are briefly summarized in Table I below.

Table I shows that one barrier was communication. The finding was that there was a lack of communication regarding the implementation of the strategic plan from management to staff. While leadership knew what was implemented, staff was not informed. This was an impeding issue to proper implementation. Another barrier was the length of plan. From interviews it was found that having over 70 different objectives was too many to adequately address and evaluate. This caused confusion with what was done and a sense that there was nothing being accomplished relative to implementation. The last barrier was that the plan was aligned with PHAB measures, rather than the specific needs of the LHD. The premise for the strategic plan was to become accredited by utilizing the 12 domains to set priorities and objectives. This may have been aligned with what the department wanted to do as far as meeting accreditation standards but did not identify and address specific needed strategic solutions as a good strategic, implementable plan is meant to do.

Facilitators were also found, one of which included the stakeholders that developed the plan. The results of the interviews found that there was a good cross-section and correct individuals at the table to develop and implement the plan. From past planning there was a lack of stakeholder input or presence such as upper leadership. During the planning and implementation phase of the strategic plan, upper management was there to give input, guidance and validity to the process. This was not only felt to be a facilitator but was a necessity to implement the plan. Interview themes also suggested that the construction of the plan was a facilitator. Past plans were created in a silo without much thought to implementation. However, the plan was created through a committee that had a cross-section of leadership and not just a select few. By doing this, the committee generated objectives that would satisfy PHAB in a way that could be operationalized. Another facilitator that interviewees reported was the use of a

SWOT. The SWOT is a tool used extensively in strategic planning. SWOT or a Strength, Weakness, Opportunity Threat analysis allows a planning team to ascertain what the SWOTs are for each initiative or program. One issue derived from the SWOT data gave insight into the department's fiscal/budgeting program: a new computer software program or a complete overhaul of the fiscal/budgeting process was needed. There was the possible threat of not knowing the current fiscal health of the department. The opportunity was the potential to purchase as new computer program for budgeting. The weakness was that the current system was tied to the county and would be difficult to upgrade. The strength was the recognition that a new process was needed.

Table I: Barriers and Facilitators Identified during the Environmental Scan

Barriers	Facilitators
Length of plan – too many goals, narrative too long and unwieldy Example: From interviews it was found that having over 70 different objectives was too many to adequately address and evaluate.	SWOT-Strength Weakness Opportunities and Threats Example: Through the SWOT it was found that a new fiscal/budgeting program was needed either computer or new process. There was the possible threat of not knowing what the current fiscal health was of the department. The opportunity was that there was the potential to purchase as new computer program for budgeting. The weakness was the current system was tied to the county and would be hard to switch it easily. The strength was it was recognized that a new process was needed. This is just one example of when the SWOT was considered a facilitator to strategic plan implementation.
Aligning the plan with PHAB Measures (rather than identified needs of the LHD) Example: The premise for the strategic plan was to become accredited through the utilizing the 12 domains to set priorities and objectives.	Appropriate stakeholders at planning and implementation meetings (Upper, Leadership/Board Members/Staff-frontline, coordinators, supervisors) Example: From past planning there was a lack of stakeholder input or presence such as upper leadership. During the planning and implementation phase upper management was there to give input, guidance and validity to the process.
Communication Example: It was found that there was a lack of communication regarding the implementation of the strategic plan from management to staff.	Construction of the Plan Example: Past plans were created in a silo without much thought to implementation. However, the plan was created to focus work on objectives that were to satisfy PHAB so to become accredited.

Lessons learned from the pilot study. Several conclusions can be formed from the pilot study. The first conclusion is that barriers/facilitators and procedure and practice changes from implementing a strategic plan can be documented using qualitative analysis. While many barriers

and facilitators were easy to recognize, others needed to be teased out from the interviews. However, additional exploration is needed to document the facilitators and barriers to implementation. For the proposed action research study, a decision was made to facilitate the identification of barriers and facilitators to implementation via systematic documentation and document review, followed by group discussion of the results, rather than via individual interviews. It was also found that each of these barriers and facilitators identified in the environmental scan interviews have been documented, either exactly (ex. Communication) or more globally (alignment with assessed needs), in literature from other disciplines, if not in public health. This is further detailed in Chapter 2 under "Barriers and Facilitators." The literature review conducted and described in Chapter 2 made it possible to identify a set of *a priori* codes that can be used for content analysis of implementation committee reports, in order to systematically document the barriers and facilitators encountered in TCLHD's implementation of their strategic plan.

d. Problem Statement and Study Questions

Strategic plans are extremely important and useful in guiding departments to reach new goals to improve public health (Heide et al., 2002). Unfortunately, for many departments, the strategic planning and implementation process becomes merely a formality and is not recognized as needed (O'Regan & Ghobadian, 2007). That is, the strategic planning process often stops with the strategic plan as something to put on the shelf, or, at most, a set of objectives and action steps that are given to managers and staff as directives, but with little monitoring of whether those directives have actually been followed, and the plan implemented, let alone why objectives have been implemented or not. This is not a problem particular to local health departments (LHDs). Business literature on strategic plans shows that many plans "sit on the shelf" and are not

implemented, even though the value of strategic thinking for structuring action and the value of periodic re-assessment of planned objectives in light of actual outcomes is well understood (Carlopio and Harvey 2012). With many (or a majority) of plans being unimplemented, understanding some of the barriers that affect implementation efforts may help to facilitate strategic plan implementation.

Only one state (Ohio) is mandating that their LHDs submit to PHAB for accreditation, and thus have to develop as well as implement strategic plans. With no known literature on strategic plan implementation for LHD, this presents an opportunity to collect information on one LHD's experience.

LHDs applying for PHAB accreditation have been faced with not only the challenge of developing a strategic plan but also demonstrating that they have implemented their strategic plan (required 1-year implementation report). Previous LHD experience in reporting on grant-funded activities has traditionally emphasized meeting targets versus strategic change from implementation. Also, little time is spent on reflection and learning. PHAB's emphasis on QI and improvement/ strategic change does attempt to shift this thinking and apply methods used in other sectors (health care, business) to LHDs. Little is known, however, about how or whether this shift is occurring. Examining how an LHD develops and applies the action steps, reporting, monitoring and evaluation processes necessary to comply with the PHAB requirement to implement a strategic plan should provide an understanding of what barriers and facilitating factors affect implementation, and whether this process shifts the way the LHD conducts its business.

It is logical that an implemented plan can have positive effects on public health leadership capacity, provide clear guidance on what the LHD does and why it does it, and improve the overall delivery to enhance the quality and duration of life for those it serves. To accomplish this task, LHDs need to understand how they can avoid barriers, enhance facilitators, and learn from implemented strategic plans.

Study Questions

This study's overarching research question is as follows: How does the Toledo Lucas County LHD, considered as a case, view strategic plan implementation and how is that plan influenced to be successful? To obtain data on implementation of its strategic plans, these questions were stipulated at the outset of the research:

What are the facilitating factors and barriers to LHD's strategic plan implementation?

Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes and how do they make them?

What do LHD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan?

In order to identify facilitating factors and barriers, the progress towards implementation, measured through work done (or not) on the objectives and action steps specified in the strategic

plan must also be assessed, adding 1a. to the above. This also supported gathering the evidence for question 2 and the systematic process of review or the implementation of the LHD's strategic plan referred to in question 3.

1.a. Within the priority areas specified by the strategic plan, what objectives and associated action steps have been accomplished?

This study goes beyond a purely descriptive case study to a case study with an exploratory aspect. The exploratory aspect is the applicability of the facilitators and barriers to strategic plan implementation developed in the business literature (see Chapter 2), to identify which of them are applicable to this LHD case and may be applicable to other LHD cases as well.

e. Leadership Implications and Relevance

This study will add to public health leadership knowledge by examining the factors that contribute barriers or facilitators to strategic plan implementation and how the plan affects learning. Documenting, understanding and publishing the results should increase the probability of leadership of other LHDs creating an implemented plan.

The proposed case study research is the research phase of an action research project designed to present recommendations to TLCHD's Board to improve the implementation of TCHLD's strategic plan. It is hoped that findings from the TLCHD case study can be useful to other LHDs as they implement their own strategic plans. Furthermore, the research may assist leaders who are pursuing and obtaining Public Health Board Accreditation. Since an implemented strategic plan is required, the findings should provide LHDs with additional tools for and insight into implementing their strategic plan, as required for accreditation. Finding

barriers and limiting them is important for LHDs so they do not waste resources, spend time on concepts that are barriers, and understand that implementation is important if the plan is to be successful. This research should also provide leadership insight into how the department staff thinks, talks, and changes perceptions or procedures resulting from the plan implementation. With this knowledge, local LDH leaders can reasonably assume that the work on their strategic plan can change the way their LHD accomplishes its work.

f. Summary: Importance of Studying LHD Strategic Planning Implementation

The importance of strategic planning within disciplines other than public health is documented (MDH, 2013). However, within local public health, there is little information or evidence of the barriers, facilitators, or whether local leaders perceive strategic plan implementation important in the changing practices of public health services (Hahn & Powers, 2010). It is vital for public health leaders to have assurance that what they do during strategic plan implementation is necessary and worthy of spending the resources to complete. Documenting and providing local leaders with processes and tools to employ and avoid will offer positive outcomes. The first is reassurance that implementation gives public health a process that truly improves the delivery of public health. The second is that understanding what enhances and does not enhance the process could reduce resource costs to departments by avoiding processes that act negatively on implementation. Local public health needs evidence and guidance on implementation if it is to avoid potential problems and change the culture of public health to respond to future threats.

II: Conceptual and Analytical Framework

Introduction

The strategic plan implementation process at the LHD level has barriers and facilitators that respectively prevent and allow success. There is relatively little research on what the barriers and facilitators are to implementation of strategic plans, specifically in LHDs. This chapter will summarize the documented literature for LHDs, and because of the dearth of LHD-specific literature, will expand its reach to similar contexts, such as other government agencies, nonprofits, and private businesses. The literature helps us to understand that in order for strategic planning to be considered successful, an evaluation of the implementation process, including documentation of outcomes, or lack thereof, and reflections on what worked or did not work about the process, should yield changes to the way work is conducted at the LHD (see conceptual model, p. xx). To be truly effective, we must not only "measure what matters," but analyze, re-strategize, and re-implement. The conceptual model reframes strategic plan implementation by synthesizing the TLCHD pilot study and the knowledge gained from the literature review, with a particular focus on the work of Henry Mintzberg, who described the process of implementing a strategic plan as "realized, unrealized, and emergent."

b. Literature Review

This literature review was prepared by consulting several search engines: Web of Science, PubMed, ABI/Inform Global, and Google Scholar. The following search terms used were: " [strategic planning OR strategic planning local health departments OR strategic planning implementation] AND [strategic planning implementation facilitators and barriers OR facilitators and barriers strategic planning OR strategic planning PHAB]." In addition to reviewing articles directly found in this search, relevant articles cited in the articles identified via the initial search

were also reviewed, as well as literature from NACCHO. Major relevant themes and points from the literature found are discussed below.

Strategic Plan Implementation Barriers and Facilitators. While there is a dearth of strategic plan implementation literature for LHDs, other disciplines such as business management, organizational development, and public administration have studied strategic plan implementation in for-profit businesses, non-profit organizations, and government agencies (outside of public health). In order to take a holistic view of the barriers and facilitators from this literature review, I created tables that are divided by each barrier and facilitator, providing the source and main points for each one. Table XVIII and Table XIX in Appendix C provide information on the categories of barriers and facilitators found in this literature. The articles cited have been reviewed for evidence on barriers and facilitators; the nature of the barriers and facilitators, and these specific barriers and facilitators have been categorized into more general constructs Figure 4 or themes that may be applicable to strategic plan implementation in the LHD context. These constructs will be used in coding the barriers and facilitators documented in the monthly implementation reports of TLCHD (see Chapter III). Tables VI (barriers) and table V (facilitators) also give the full citations and the evidence sources. Table XX (Facilitators) and Table XXI (barriers), in Appendix C are summary tables that detail the overall number of sources, cited authors, and evidence sources.

Figure 4-*Constructs*

Timely Action
Coordination/Communication
Roles/Responsibilities
Competing Priorities
External Factors
Attitudinal Factors
Evaluation/Performance Management
Organizational Culture
Skills/Alignment of Skills
Strategic Planning/Alignment of Goals
Budget/Resources
Involvement of Managers/Staff

A total of seven sources were utilized for facilitators, while ten sources were used for barriers. One source had both facilitators and barriers documented, for a total of 16 sources. The works cited span 30 years from 1987 to 2017. Most of the facilitator literature comes from non-profits and businesses with some governmental review. Barrier evidence is derived mainly from businesses literature, with a few governmental and non-profit works. There is no peer-reviewed LHD literature on barriers and facilitators to implementation; none was found. However, there is a citation from one LHD. This document is not peer-reviewed but describes the barriers and facilitators found by one LHD. Based on my observations during my career as a public health

practitioner working in an LHD, as well as my pilot data collection for this study, I hypothesize that LHDs have similar facilitators and barriers as those found in this literature review. The twelve constructs described here (factors that can be either barriers or facilitators, see below) are likely to be applicable to LHD plan implementation as well.

In reviewing the list of barriers and facilitators to implementation of strategic planning, I found that they could be summarized by 12 different documented factors in the literature, which could be either barriers or facilitators, depending if they are present or absent. I will use these as constructs and codes for the coding of implementation reports proposed in Chapter III. Table II details the barrier/facilitator, such as timely action, and which author or authors supported the construct as a barrier or facilitator. This proposed study will examine these 12 constructs (see Table II) in relation to data from the TLCHD case and compare that data to the constructs, through content analysis and coding. Again, a more detailed explanation of the information and full citation can be found in Table XVIII and Table XIX.

From the literature review and as shown in Table II, barriers were found to relate to 12 general categories or constructs while facilitators correlated to 10 of the same 12 constructs. The first column shows the type (construct) relating to barrier or facilitator. The earlier tables (Tables XVIII and XIX) detail the constructs (such as communication/coordination) summarizing the specific evidence cited in the articles and give specific examples that support each general construct or category.

The existing evidence from the business and organizational development literature reviewed shows that barriers and facilitators to implementation of a strategic plan are often different sides of the same underlying factor. For example, if lack of timely action is a barrier, the opposite (timely action) can be a facilitator to implementation. Thus, the identified barriers

and facilitators can be paired and summarized as general underlying factors affecting implementation, and these posited underlying factors can then be treated as constructs to be applied in the proposed study of factors potentially relevant to effective implementation of the strategic plan in a local health department. Even though evidence from cited peer-reviewed literature was found for only 10 of the 12 proposed general facilitators (the inverse of these 12 general barriers for which there was evidence in the reviewed literature), the remaining two potential facilitators may still be relevant to the proposed research. The use of these factors in analysis for this study will be discussed in Chapter III. Briefly, the 12 general identified constructs, which could be barriers or facilitators depending on what is present or absent, will be used to code the data relevant to the proposed case study of strategic plan implementation in a local health department, with additional codes for whether the factor is operating as a barrier or facilitator.

Table II: Constructs: Barriers and Facilitators

Barriers/Facilitator Construct	Cited as a barrier	Cited as a facilitator
Timely Action	Al-Ghamdi, 1998 O'Regan & Ghobadian, 2007 Mendenhall, 2013 Bryson, 2011 Henry County, 2017	
Coordination/Communication	Al-Ghamdi, 1998 Nazemi & Asadi, 2015 O'Regan & Ghobadian, 2007 Heide et al., 2002 Henry County, 2017	Mittenthal, R., 2002 Blatstein, I. M., 2012
Roles/Responsibilities	Al-Ghamdi, 1998 Hrebinak, 2006 Nazemi & Asadi, 2015 Heide et al., 2002 Hrebinak, 2006 Latif et al., 2013 Henry County, 2017	Reed, R., & Buckley, M. R.,1988 Blatstein, I. M., 2012
Competing Priorities (Barrier) Keeping Momentum Despite Competing Priorities (Facilitator)	Al-Ghamdi, 1998 O'Regan & Ghobadian, 2007	Mittenthal, R., 2002
External Factors	Nazemi & Asadi, 2015 O'Regan & Ghobadian, 2007	
Attitudes	Nazemi & Asadi, 2015 Latif et al., 2013 Elbanna & Fadol, 2016	Saunders, M., Mann, R., & Smith, R., 2008 Mittenthal, R., 2002

Barriers/Facilitator Construct	Cited as a barrier	Cited as a facilitator
Evaluation/Performance Management	Nazemi & Asadi, 2015 Latif et al., 2013 Henry County, 2017	Saunders, M., Mann, R., & Smith, R., 2008 Mittenthal, R., 2002 Reed, R., & Buckley, M. R. ,1988 Henry County,2017
Organizational Culture	Nazemi & Asadi, 2015 Mendenhall, 2013 Latif et al., 2013 Bryson, 2011	Mittenthal, R., 2002
Skills/Alignment of Skills	Al-Ghamdi, 1998 Nazemi & Asadi, 2015 O'Regan & Ghobadian, 2007Henry County, 2017	Henry County, 2017
Strategic Planning/Alignment of Goals	Nazemi & Asadi, 2015 Mendenhall, 2013 Hrebinak, 2006	Mittenthal, R., 2002 Reed, R., & Buckley, M. R.,1988
Budget/Resources	Nazemi & Asadi, 2015 Mendenhall, 2013	Saunders, M., Mann, R., & Smith, R., 2008
Involvement of Managers/Staff	Nazemi & Asadi, 2015 Heide et al., 2002 Latif et al., 2013 Elbanna & Fadol, 2016	P.C. Nutt, 1987 Mittenthal, R. 2002 Danmus & Wooten, 2002 Blatstein, I. M., 2012

Barriers

The constructs for which evidence was found in the literature, in Table II, will be described below, first as barriers, then as facilitators.

Lack of Timely Action Lack of timely action was found by some authors to be a barrier to implementation as implementation took longer than they planned (O'Regan & Ghobadian, 2007) (Al-Ghamdi, 1998). When major problems of implementation are not identified by management quickly, it causes implementation setbacks (Al-Ghamdi, 1998). This barrier is further clarified when individuals in the organization do not exhibit urgency to implement the strategic plan and *impeding* takes place (Nazemi & Asadi, 2015). Overall, Mendenhall supports time as a barrier when there is failure to expeditiously do what is needed to be done for implementation (Mendenhall,2013). Not only does lack of timely action prove to be a barrier, but so does timing of implementation. If the timing of implementation is not right for reasons such as lack of data, resources or varied other issues it can result in a barrier (Bryson, 2011). For LHDs, Anne Goon suggested that development of program specific measures and action plans took longer than required and the department waited too long to plan for the 2018 performance measures. Another example of lack of timely action occurred at the Henry County Health Department, when managers did not utilize the set 60-day action planning process. This caused execution and oversight issues that impacted implementation (Goon, 2017). This lack of urgency may come from a misunderstanding of the need for implementation which could be from lack of coordination or communication.

Poor Coordination/Communication breakdowns can be seen as barriers when problems that require top management involvement are not communicated with staff quickly enough or when only vague criteria of standards and measures are given to staff (Al-Ghamdi, 1998). In addition, when goals of the plan are not communicated, it results in little understanding of those goals, which can then impede implementation (O'Regan & Ghobadian, 2007). When considering communication, it not only allows staff to understand what is being asked of them or what they

should know, it also results in management understanding what is taking place in the organization. Lack of sharing implementation information in all directions can result in managers not knowing who is responsible or accountable, resulting in an implementation barrier (Al-Ghamdi, 1998). From the literature it is also noted that when staff don't know how the plan affects them, due to poor communication from managers, impediments to the plan's execution occur (Heide et al., 2002).

Another barrier is communication regarding coordination. When communication about coordination efforts of implementation in an organization are ineffective or they break down a barrier can exist (Nazemi & Asadi, 2015; O'Regan & Ghobadian, 2007). Of more concern with implementation is when goals are not well understood by staff (O'Regan & Ghobadian, 2007) or when there are vague criteria for standards and measures communicated to staff by leaders (Al-Ghamdi, 1998). O'Regan and associates state the issue with communication succinctly in that poor communication regarding implementation within an organization is an impediment (O'Regan & Ghobadian, 2007). In the LHD setting, the lack of communication was found when both staff and managers lacked understanding of which performance measures were to be carried into the next cycle period (Goon, 2017). In addition, Goon suggested that managers did not seek out assistance regarding performance management completion. This caused a concern with implementing the strategic plan. Ultimately, communication and coordination are a role and responsibility of leadership.

Unclear Roles/Responsibility Heide and associates suggest barriers can be created when there are unclear roles/responsibilities and accountability by managers regarding implementation (Heide et al., 2002). Another example of this barrier is not having guidelines or a model to guide implementation efforts, resulting in management's inability to let staff know what to do

(Hrebinak, 2006). Another way a barrier is produced is from lack of training. Both Al-Ghamdi (1998) and Latif et al. (2013) state that a barrier to implementation arises with lack of training and instruction form leadership/mangers to staff regarding implementation of the plan, or as Al-Ghamdi (1998) suggests, when key tasks of implementation and activities were insufficiently defined by management. Training directed by management for staff is not the only barrier resulting from lack of training. Management's lack of training is also an impediment to implementation. This is stressed when managers are not trained to face out-of-the-ordinary or strange situations during implementation (Nazemi & Asadi, 2015). An example of the lack of training in LHDs is that managers waited for the Health Commissioner to Gantt chart their work when they should have done the charting themselves (Goon, 2017).

Competing Priorities Within any organization there are opportunity costs when doing business. This can be a barrier when competing activities take away from work on implementation (Al-Ghamdi, 1998). For instance, a barrier to implementation from a competing priority is when a crisis causes a distraction from implementation (O'Regan & Ghobadian, 2007). Other competing priorities could be having to run a levy campaign, moving into a new building, or myriad other priorities that act as barriers.

External Factors External factors that affect implementation can vary. For instance, Nazemi & Asadi (2015) suggest that the rapid changing of variables and/or quick changing of external rules puts pressure on those in the organization, so they cannot respond appropriately to implementation needs. These variables could be concerns such as current market price of raw materials or customer satisfaction. The concept of external factors playing a role in creating a barrier is also supported by O'Regan's work where external factors such as politics or

stakeholders (involvement/noninvolvement in implementation) can be a barrier (O'Regan & Ghobadian, 2007).

Attitudes Barriers can be created from personal attitudes or feelings within or around an organization. This is evidenced when there is a real or perceived loss of power by managers because of implementation (Nazemi & Asadi, 2015). Managers may be hesitant or even obstructionist to implementation. This is also supported by the work of Latif et al. (2013) in that managers are opposed to the change in their own power that results from changes due to strategic plans, so managers create their own barriers for implementation (Latif et al., 2013). This is evidenced when managers do not share information because they are afraid of implementation reducing their resources or position (Elbanna & Fadol, 2016). Another attitudinal barrier is when there is no motivation by managers to try new things or they cannot change the way they view and undertake strategic plan implementation (Nazemi & Asadi, 2015). When there is lack of trust and support at the various levels of the organization, it creates an environment for a barrier to implementation (Mendenhall, 2013). Another barrier created by personal feelings is when participants do not believe in the implementation process (Elbanna & Fadol, 2016) or more specifically, when managers do not think the plan will make a difference (Nazemi & Asadi, 2015). Managers play a large role in implementation and can create barriers. For instance, when consent regarding implementation is lacking from managers and others formulating the plan it impedes implementation (Nazemi & Asadi, 2015). In general, a lack of commitment to implementation from management is a barrier (Latif et al., 2013). Additionally, when managers avoid risk-taking during implementation due to possible poor results, such as not meeting objectives, it can be an impeding force (Nazemi & Asadi, 2015).

Lack of Insufficient Evaluation/Performance Management In the work by Latif et al. (2013) it was found that when there is no evaluation of employees conducting implementation work it can cause a disconnect to a reward system, which could result in a possible barrier. This concept is further supported by examining the barrier created when there is little or no reward for managers tackling implementation (Nazemi & Asadi, 2015). Another barrier noted in the literature, linked to evaluation or performance management, is when there is a lack of regular checks by managers to ensure employees accomplish their tasks (Latif et al., 2013). When performance standards and measurements are not well-defined, which should be found and rectified at some point in the process, they become barriers (Nazemi & Asadi, 2015). Anne Goon's report suggested that a barrier to implementation was a lack of a formal evaluation process that created procrastination, and then resulted in projects not being completed (Goon, 2017). Another barrier occurred when Quality Improvement Teams did not follow documentation requirements resulting in almost every project missing documentation.

Organizational Culture One barrier related to culture is when the plan does not fit with the makeup of the organization (resources/personnel/structure) it can have a negative impact on implementation (Nazemi & Asadi, 2015). This is also supported by Bryson (2011) in the idea that when plans are inadequate or inappropriate for the organization it can impede successful completion of a plan (Bryson, 2011). Implementation of a plan also relies on the culture of the organization to support implementation. If the organization does not support implementation of the strategic plan it hinders implementation (Latif et al., 2013). This concept is further strengthened by Mendenhall (2013) in that failure by those in the organization to develop values and culture to support the plans causes a barrier. Culture of an organization comes from its leadership. If leadership does not value implementation, the plan is bound to be hampered. This

theory is echoed by Nazemi and Asadi's assertion that leaders' failure to understand the culture of the organization, how the organization operates, and employees interact, impedes implementation (Nazemi & Asadi, 2015). Perhaps one of the most pointed culture barriers is ethical/legal problems. Mendenhall (2013) found that ethical/legal problems such as using "produced" budget data instead of "real" data is a barrier to implementation. This falsification (ethical/legal barrier) of data is not just for budgets but also for any data used during implementation.

Lack of Skills/Mis-aligned Skills A barrier is created when the skills and ability on any level do not align with the implementation strategy for the strategic plan (Nazemi & Asadi, 2015). Furthermore, lack of skills as a barrier, occurs when the ability of employees is insufficient to implement the plan (Al-Ghamdi, 1998). This is supported by O'Regan and Ghobadian, who suggested that employees who lacked the capabilities to implement the plan are also an impediment (O'Regan & Ghobadian, 2007). At the LHD level, it is suggested that a lack of knowledge in how to utilize data measurement was a challenge to implementation (Goon, 2017).

Lack of Effective Strategic Planning/Mis-Alignment of Goals When leadership does not align the plan to the strategic direction of the organization it can impede implementation. (Nazemi & Asadi, 2015) Furthermore, if the strategy that is implemented is disconnected from the real world it can reduce the likelihood of implementation (Nazemi & Asadi, 2015). Barriers also result when the plan that is implemented is not in line with what the organization faces (Nazemi & Asadi, 2015). The barrier of the plan not in line with the organization could be the result of poor or vague strategy generated from a lack of direction, capabilities and skill sets of employees (Hrebinak, 2006). Nazemi and Asadi assert that when the goals of the individual or their agenda are not in line with the organization, a barrier is formed (Nazemi & Asadi, 2015). This barrier to

goal or agenda-setting is further supported by Mendenhall (2013) when there is setting of unrealistic goals.

Insufficient Budget/Resources A lack of budget or resources for implementation is a barrier. This is noted when there is a lack of connection between the plan and budget (top management does not allocate funds for implementation) (Nazemi & Asadi, 2015) and further supported by Mendenhall (2013) who says that when there is not sufficient funding to support implementation a barrier can exist. Lack of funding can result in a lack of resources to implement the plan. Lack of resources could also be due to other issues such as not anticipating the need or timing to obtain that resource. Whatever the cause of the lack of resources, it can result in a barrier to implementation (Mendenhall, 2013).

Lack of Involvement of Managers and/or Staff If there is insufficient involvement of top managers or organizational staff at strategy formulation stage, it can hamper implementation (Nazemi & Asadi, 2015; Elbanna & Fadol, 2016). Beyond staff or managers, if all employees are not working towards implementation, it becomes a barrier to strategic plan implementation (Nazemi & Asadi, 2015). Participate during the creation of the plan could also be a barrier during implementation (Latif et al., 2013). Participation may be a barrier, and consistent participation is also a concern. It was found that when managers are replaced, due to resignation, dismissal or transfer, implementation is impeded due to not having consistent support for implementation (Nazemi & Asadi, 2015).

Facilitating Factors

In this section, factors that facilitate implementation are described. Table XIX: Construct Facilitators/Citation/Evidence Summary contains information on facilitating factors in the same manner that Table XVIII discussed barriers to successful strategic plan implementation.

Communication/Coordination Both Blatstein (2012) and Mittenthall (2002) suggest that communication and/or coordination can facilitate implementation. For example, LHDs that plan together as a team can forge a shared understanding of what is important when implementing the plan, thereby leading to successful implementation (Blatstein, 2012). Coordination/ communication as a facilitator is also supported when staff and board members coordinate and work together, not in "silos," to facilitate success of implementation (Mittenthall, 2002). Goon, from the LHD perspective, describes the importance of sharing quarterly reports, which results in everyone knowing the status of the plan. Staff knowing the results serves as a facilitator as it allows the department to adhere to action steps for implementation.

Keeping Momentum Despite Competing Priorities Mittenthal (2002) suggests that organizations understand that other issues will compete during implementation, but those organizations that keep momentum for implementation despite competing priorities were more successful. For example, the TLCHD from November 2017 to July 2018 has transformed the role, structure, and programmatic delivery of the department. Transformation is due to the separation of individual clinical services from TLCHD, and a refocus on the delivery of public health programs. The refocusing caused competing priorities in the areas of budgets, staffing and time spent on separation which, in turn, has led to a lower level of effort on strategic planning. However, leadership and staff have been successful in moving forward the implementation of the plan, lessening the impact of shifting resources from strategic planning to the separation efforts.

Attitudes As noted in the discussion of barriers, in any process that involves human interaction, one's beliefs and feelings have impact. This is also true when examining factors that can facilitate successful strategic plan implementation. Senior leadership must be involved in the process for a variety of reasons. Mittenthall (2002) explains that the vision of LHD leadership is

key to success. Nanus (1992) states that this vision must be shared with the department; staff needs to understand the current status and the leadership's vision of how the strategic planning process and plan implementation will transform it. Do they envision changes in priorities? In organizational structure? In staff configurations? While specific changes may not be clear until the process is in its final stages, staff needs to be apprised of the scope of change. Mittenthal (2002) also states that through consistent involvement in the implementation process, leadership can add their thoughts and ideas and consistently communicate the importance of the strategic plan process and implementation. When the staff understands that leadership supports implementation, they are more likely to buy into the work of implementation.

Saunders et al. (2008) agree that by sharing their vision of transformation, leadership facilitates staff buy-in for the process and buy-in then generates a feeling of ownership over the process by individual employees. "By communicating and promoting organizational vision to subordinates, and getting their acknowledgment of the vision, it is possible to influence their work behavior and attitude" (Tsai Y, 2010, pg. 9).

In summary, for attitudes to act as facilitators, there must be an active link between leadership and staff, one in which leadership seeks out staff buy-in for successful plan implementation. Leadership plays a key role through sharing its vision and maintaining communication throughout the process.

Sufficient Evaluation/Performance Management The literature review found that feedback from staff and other stakeholders to management is imperative for successful implementation (Saunders et al., 2008). Mittenthall (2002) suggests that successful implementation stems from reviewing the implementation work of others to gain an understanding of their successes and failures and then constructing an organization-specific plan based on those practices. The

possibility for successful implementation is also improved when performance evaluations of employees is linked to successful implementation as a reward (Reed & Buckley, 1988).

Organizational Culture Mittenthall (2002) also suggested that successful implementation is more likely when organizational personnel are prepared for and embrace changes within the organization. If an LHD has a track record of seeing change as a positive and individuals are not stuck to old ways of doing things, the chances for successful implementation are improved.

Effective Strategic Planning/Alignment of Goals Reed and Buckley (1998) say that proper goal setting increases the chances of successful implementation. For example, if activities included in the plan require an increase in the budget, the plan should include a goal to find new monies to support implementation. Mittenthall (2002) suggests that organizations that develop a strategic plan with objectives aligned with what the organization deems important have a better chance of successful implementation. For example, if an LHD wants to focus on public health programs and not individual medical care, the plan should not include a strategic goal to increase its individual medical care budget and decrease public health programming budgets.

Adequate Budget/Resources. Departments that set aside funding to support and complete the strategic plan priorities have a greater chance at success. Budgeting for implementing the ideas developed during the process is key to implementing those ideas (Saunders et al., 2008).

Involvement of Leadership and Staff. The literature review found that increased participation by board members, managers, and staff increase the likelihood of successful implementation. Dahmus & Wooten (2012) and Mittenthall (2002) suggest that in non-profit organizations, board involvement serves as a facilitator. Involvement fosters comfort with the implementation process, and provides opportunities to share insights and recommendations, all of which have a positive impact on implementation.

Nutt (1987) suggests when leaders become more involved, they create an environment that increases the chances of successful implementation. Mittenthall (2002) suggests that when senior leadership is involved, the staff will recognize the leaders' vision and commitment and will know that implementation is supported. Blatstein (2012) also found that the involvement of leadership is key and that while delegation can be a sign of good leadership, in this case, delegation cannot replace the involvement of LHD leadership. A leader cannot expect others to do the work without the leader's involvement. For example, while the meeting schedule for the strategic plan implementation committee was being set, several committee members wanted to meet once a quarter while others suggested meeting twice a month. I was able to foster a compromise of monthly meetings, acknowledging both positions, while keeping my own goals in mind.

Sufficient Skills/Alignment of Skills. Successful plan development and implementation requires staff members who can contribute specific expertise to the process. Saunders et al. (2008) point out that having individual staff members who can facilitate a group discussion, who are expert in creating data tables, or who are good at developing policy greatly increases chances for success. In terms of skill alignment, it is important to refrain from errors such as placing the individual with good data table skills in the position of group facilitator. Misalignment of skills slows down the process and can lead to staff demoralization. In the LHD setting, Goon (2017) supports sufficient skills as a facilitating factor in and of itself. She states that when her staff received training and used that training, it added to completing tasks in the strategic plan.

The literature review documented a variety barriers and facilitators to strategic plan implementation. To clarify, many barriers are created when staff, management, and stakeholders are not involved in the pre-implementation process (Nazemi & Asadi, 2015. Elbanna & Fadol,

2016. Latif et al., 2013. Heide et al., 2002). Inversely, involvement increases success (Blatstein, 2012. Dahmus & Wooten, 2012. P.C. Nutt, 1987. Mittenthall, 2002). This is also true during the evaluation and strategic planning phases. Sound evaluation and/or strategic planning can facilitate successful implementation (Reed & Buckley, 1988. Saunders et al., 2008. Mittenthall, 2002) whereas when these phases are weak, successful implementation is more difficult (Latif et al., 2013.Nazemi & Asadi, 2015).

The literature review cited other factors that can function as either barriers or facilitators, depending on how they function in the specific setting. These include attitude, organizational culture, competing priorities, and adequate budget/resources. Taking a holistic view of the literature, almost any barrier can become a facilitator, or a facilitator can be a barrier.

It is important to note that, in the literature, information on barriers and facilitators to strategic planning does not come from the experiences of LHDs engaged in the strategic planning process. The peer-reviewed literature reviews the experiences in business, non-profit and governmental sectors. Based on the literature, I suggest that LHDs experience similar barriers and facilitators in the areas of timely action, communication/coordination, roles/responsibilities, competing priorities, external factors, attitudinal factors, organizational culture, skill, strategic planning/goals, budget/resources, and involvement and evaluation. To further understand how these barriers and facilitators are related to LHD implementation, the process at the LHD can to be studied by using the constructs identified from the literature as factors in implementation, as codes for content analysis of reporting documents. Constructs relating to barriers and facilitators are included in the concept map in Figure 5.

Using Mintzberg for Evaluating Implementation of Strategic Plans: Realized/Unrealized and Emergent Outcomes of Strategic Plan Implementation. Strategic

plan implementation follows a blueprint developed through a process. During that planning, strategies are developed and agreed upon to reach or complete an objective. Objectives, as suggested by NACCHO, are "short to intermediate outcome statements [that] are specifically tied to the goal. Objectives are clear, measurable and communicate how a goal will be achieved." NACCHO, 2010, pg 67). In the same document, goals are discussed as… "the long-term change we plan to achieve, and objectives describe how goals will be met." (NACCHO, 2010, pg 51). For the purposes of this research, implementation as an aspect of strategic planning is the focus. Henry Mintzberg asserts that there are three primary aspects of how strategies are implemented in practice: realized, unrealized, and emergent (Mintzberg et al., 2009). Mintzberg's framework offers the TLCHD case study a barometer for implementation outcomes. A description of the three strategy implementation outcomes follows.

Realized strategies are those strategies set during the planning cycle that were implemented without deviation – this follows the "blueprint" model. For example, to decrease the cases of mumps by 20% in a community, the strategy could be to increase the number of vaccinated school-aged children. The task is to vaccinate each child in the public-school system who is not already vaccinated. Following the plan, each of the children that were not vaccinated received a vaccination. Vaccinations increased the number of vaccinated school children. Increased vaccinated children allowed the strategy to be realized.

When a strategy is unmet, not completed, or unobtained, it is termed "unrealized." For example, using the same example of mumps, if the students were unvaccinated due to a shortage of vaccine, the strategy was unrealized. Realized and unrealized strategy outcomes are straightforward. Either the strategy was completed or was not completed. In the case of unrealized strategies, it is important to discover why the strategy was unrealized and what the

barriers to successful implementation were, so that the implementation process can potentially be corrected, or the initial goals reconsidered. However, when a strategy is not realized as originally envisioned, it could also take another form, described by Mintzberg as "emergent" (Mintzberg et al., 2009).

Recognizing emergent outcomes of strategies is not as simple as recognizing realized or unrealized strategies. Emergent strategies are those that may have started as a set strategy, but were changed, added to, or discontinued. Using the mumps example again, the initial strategy contains the assumption that not all the public-school students are vaccinated. What if this assumption is challenged when the implementers learn that all the public-school students are vaccinated, but that there is an external challenge from adult returnees from travel abroad who have brought mumps infections into the community? Learning this, a new strategy could be generated to decrease the mumps rates. In this fictitious example, the community has business ties with China where adult community members travel frequently. The new strategy is to make sure that all adults traveling to China are vaccinated. This is a new, or “emergent” strategy, a new way to achieve the previously stipulated goal of decreasing mumps infections by 20%. The steps to implementing this new strategy would include vaccinating all adults before travel. The emergent strategy then becomes realized if it is implemented and if there are decreased mumps rates (Mintzberg et al., 2009).

For the proposed study, Mintzberg’s framework will be used to understand the state of each of the strategies involved in TLCHD’s implemented strategic plan. The plan uses a strategic priority such as obesity, with an explicit goal and specified objectives with action steps. These action steps are work that is required to meet the objective, goal, and the strategic priority.

From the strategic priority of obesity, the goal is to reduce the percentage of people in Lucas County with a Body Mass Index above 30 One objective is a healthier weight-related behavior among TLCHD staff (TLCHD, 2017). To accomplish this work, one action step is to turn the remodeled basement in the health department into a workout facility for the staff.

Using Mintzberg's concept and the obesity example, the outcome of the strategy could be unrealized. For example, if the basement was not turned into a workout facility and each of the other action steps were not realized, then the objective was not met, the goal was not obtained, and the obesity strategic priority was not realized as planned. It is proposed that each of the eight priority areas in the TCHLD strategic plan and their outcomes will be reviewed after the first year of implementation, to determine what resulting strategies were realized, unrealized and/or emergent, when compared to the action steps in the initial plan.

a. Conceptual Framework

A conceptual model or framework as suggested by Miles and Hubermann (1994) "lays out the key factors, constructs or variables, and presumes relationships among them" (p. 440). Furthermore, they look at a conceptual framework as a "must" for the proposed research and for the researcher as such that they "need to know how they are constructing 'theory' as analysis proceeds because that construction will . . . inevitably influence and constrain data collection, data reduction, and the drawing and verification of conclusions" (Miles and Hubermann, 1994, p. 434). For the proposed study, the Conceptual Framework found in Figure 4 accomplishes what Miles and Huberman suggest by drawing constructs and variables around the process of implementation of an LHD strategic plan. This framework incorporates the local TLCHD process and Mintzberg's frame of realized, unrealized, and emergent, to describe

strategic plan implementation outcomes. This framework can be applied to any number of LHDs attempting strategic plan implantation. The process for any LHD to implement a strategic plan may differ at the organizational level, but the overall progression of implementation will follow a similar process. Below the process is detailed to understand where implementation 'lives' in the strategic planning process.

Initially, the local health department uses tools, processes, and procedures to create a plan. In the concept model, the constructs and/or components are delineated within the panel connected by an arrow. At the beginning of strategic planning, each LHD (organization) must form a committee to create a strategic plan. This group may consist of any number of stakeholders (membership) who will guide the process and make decisions. For LHDs, the type and number of stakeholders could impel or impede the strategic plan implementation process. In addition to PHAB measures for strategic plan implementation, other tools and concepts may be used to generate a completed plan.

No matter what aspects, tools, or concepts are used to create a plan, the outcome of this planning work is to set organizational objectives. LHD strategic plan objectives are meant to address issues or gaps found from the work accomplished during the strategic planning stage. Delivering on these objectives constitutes implementation of the strategic plan.

In implementation, the plan becomes operationalized by staff. The implementation work is then evaluated and adjusted if needed. The process can be cyclic: the LHD will implement the plan, discuss and assess the work done, evaluate that work, reprioritize, learn from the process, and potentially require more planning to create another objective. However, if the LHD does not encounter issues in making those objectives operational, there may be facilitators that allowed progression. During the process, some objectives may not become operational, and this would

suggest a barrier to implementation. For the LHD to have a full picture of what objectives are being completed and which are not, objectives must be evaluated. Evaluation, and how it is accomplished, may differ between LHDs, but the outcome of evaluation will be the same for all LHDs—namely an accounting of the progress of the plan.

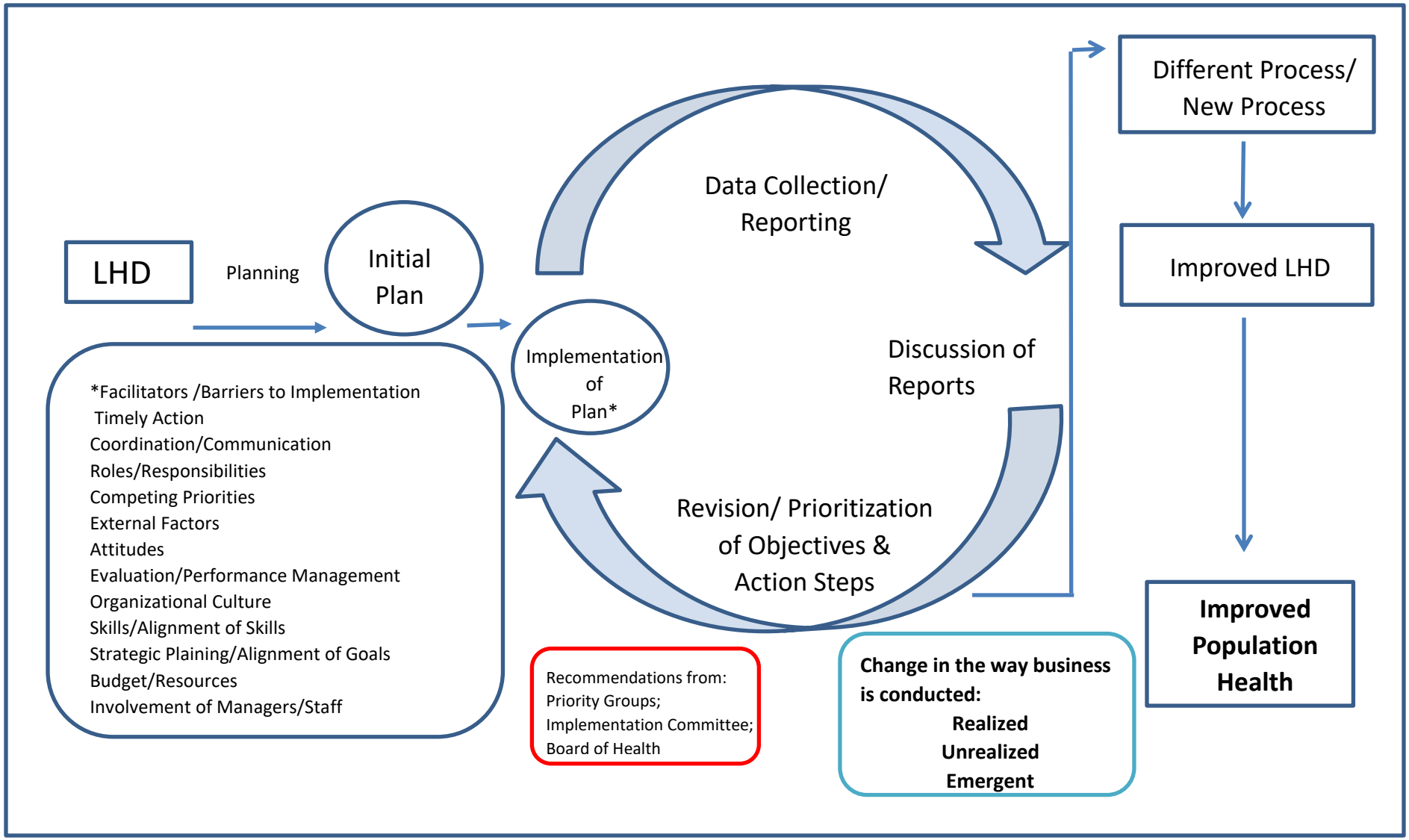
Evaluation of the implemented objectives allows for the LHD to gauge if the objective is effective for what it was developed to address strategically—in Mintzberg's terms, if the objective has been "realized." The LHD must gauge if the objective is accomplishing what it was originally created to address. If an objective is being fully addressed from the evaluation of the objective's output, that objective can then be considered "realized." If objectives do not deliver the outcome they were developed to address, they are "unrealized." These objectives must be modified or dropped from the strategic planning implementation process.

Next the organization must use the evaluation of the objective to find where the implementation was lacking, if an LDH chooses to modify an objective, and if modified, go back into the implementation process. Once a gap is found, the objective can be modified from the original concept as developed during the strategic planning process. The cycle of evaluation begins again for this new objective, and if it is successful, then it will become an implemented or "realized" objective. If the objective is not successful or "unrealized," it may go through additional cycles or be dropped from the plan. This process of evaluation and accepting or modifying an objective is important not only for bringing a strategic plan to completion but also for improving the delivery of public health. One important aspect of improving public health that this dissertation research investigates is the concept of learning from the strategic plan implementation.

Whatever the outcome of the plan, whether realized, unrealized, or emergent, it is here that a change to a current or new program, process or procedure that resulted from the plan implementation can be identified. This is where learning from the work done can be found.

LHD strategic plan implementation allows for the organization to change operations, thoughts, or actions that result in different practices or procedures in the department. When these changes take place, the LHD often shifts from an old way of practicing public health to a new a way of doing public health. This “new way” comes from what the organization has learned by implementing and evaluating the strategic plan, which can produce an improved LHD and thus improved population health.

Figure 5: Conceptual Framework Implementation Concept Map



III. Study Design, Data, and Methods

A. Research Design

Case Study within an Action Research Design

The proposed research was designed as a single case study within an action research project: the collection of data following a case study model was designed to answer research questions useful to the TLCHD Board. The final step in the action research will be to present recommendations based on the findings of the case study research to the TLCHD Board. The use of a case study model was appropriate because it investigates a phenomenon, providing and ensuring academic rigor while asking "how" and "why" questions. Additionally, a case study design does not require control over events and can study a phenomenon as it unfolds. A case study design is preferable in those situations. (Yin 2009) The point of this research was to describe what happened, but also provide a description of the facilitating factors and barriers encountered and, as such, is a descriptive case study (Yin, 2009). As noted in Chapter 1, this study also has an exploratory aspect, exploring whether the facilitating factors and barriers to strategic plan implementation extracted from the business literature reviewed in Chapter 2 are applicable to the case of a local health department implementing its strategic plan.

Action Research in itself does not mandate a particular methodology for collecting and analyzing data. It was originally envisaged that the Yin (2009) model for case study would guide data collection and analysis, with triangulation between multiple sources of data. Minutes from meeting notes were originally designated as an additional data source to the document review of the monthly reports. However, the meeting notes were sparse in most cases and where available were used primarily as supporting evidence for the coding of the monthly reports, rather than a separate data source.. As the project evolved, the implementation of the research came closer to a case study as defined by Cresswell (2018), where data can come primarily from

a single method or source with interpretation supported by participant observation, and methods other than triangulation can be used for strengthening validity. This research used a second coder, who reviewed all the quantitative and qualitative coding done by the lead researcher, to strengthen validity, and also used member checking through the FDGs and the written feedback forms FDG participants filled out as a key strategy to support validation and correction of the preliminary findings.

The main data source for the analysis was the monthly reports received from the priority area action groups, for the 13 month period June 2017-June 2018. As detailed below, earlier data from the TCHLD 2/2017 Strategic Plan, the revised 8/2017 Strategic Plan, and the Annual Implementation Report for 2017 were also reviewed and coded for barriers and facilitators, as well as reviewed for changes in objectives within the plan, giving a baseline for the analysis of the monthly reports to identify barriers and facilitating factors to implementation as well as measure progress in implementation through the documentations of the action steps specified and accomplished according to the plan's objectives.

Action Research Approach

An action research approach was chosen due to its ability "to contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously;" (Gilmore, et al., pg 161, 1986). Moreover, it was a sound approach for the research and researcher (Baum et al., 2006). Furthermore, it had an identified problem, orderly collection of data, reflection, analysis, action from findings and redefinition of the problem. That method allowed pursuing increased knowledge for improving strategic plan implementation while the researcher was a participant in the process (Kemmis & McTaggart, 1988, p). Overall, the researcher and LHD sought to increase the effectiveness of strategic plan

Action research could accommodate to the necessity for the researcher,as TLCHD Commissioner, to be a key part of the implementation process. Action research allowed the researcher to work with the participants to better the implementation process and improve the use of TLCHD's strategic plan for better public health outcomes. It also allowed for considerable reflection on and redefinition of the problem with multiple stakeholders in the TCHLD strategic plan implementation process, including the Board, the Implementation Committee, and the managers and staff involved in the priority area action groups.

As is appropriate for an Action Research design, the case study was accomplished and directed within an Action Research frame, with a stakeholder group co-designing the research questions, approving the implementation of the research, and designated as the client to whom final results of the research will be presented (Stringer 2013). Once the researcher became the Commissioner for TCHLD (6/16), an action research frame became necessary for several reasons: 1) an initial plan to conduct a multiple case study via collecting data from multiple health departments became impractical due to the demands of the job; and 2) as Commissioner, the researcher was a participant observer and needed to conduct the research within a framework that would allow for his role as a participant, and utilize its advantages, while providing checks on the biases that come with that positions. From the beginning, the TCHLD Board of Health acted as the stakeholder group overseeing this research, as it evolved. Initial meetings to discuss dissertation research with TCHLD Board of Health occurred in 2014 while the researcher was Director of Environmental Health and Community Services for TCHLD. In late 2017 the researcher met with the Board to review and discussion the desired research questions for the research and plans for the content analysis for barriers, facilitators, and progress.

Another meeting with the Board occurred in November 2019, to review and approve the plans for the facilitated discussion groups (that was when Workforce Development was selected as one of the four priority action areas). Throughout the research process, there have been 1-3 Board members serving on the Implementation Committee, which the researcher meets with approximately every other month; these Board members have kept in touch with the research as it has unfolded, and served as the liaison for the researcher to the TLCHD Board.

Development of Recommendations

After the dissertation is concluded, the final recommendations based on the evidence collected will be presented to the TLCHD Board. The table in Appendix N gives the steps followed in developing the final recommendations, from the evidence gathered from document review and content analysis, to the preliminary recommendations based on that evidence presented by the researcher to the priority area action groups in the FDG format and the corrections from the member-checking by those groups, and then the further member checking from the implementation committee, to the final corrections and synthesis resulting in the recommendations that will be presented to the TLCHD Board.

Case Selection The unit of study for the proposed case study research is the Toledo-Lucas County Health Department (TLCHD) in Toledo, Ohio. Currently, the researcher is the Health Commissioner at the Toledo-Lucas County Health Department, where they implemented a strategic plan and sought accreditation. The researcher had already established an active collaboration of staff and could stress the importance of co-learning as an aspect of the research process (O'Brien, 1998).

Toledo Lucas County Health Dept as a case is both supported and limited by its position in Ohio, where all the LHDs are now mandated to go through PHAB accreditation, and thus are required to document implementation of strategic plans. Approximately 1/3 of the departments in Ohio are now accredited. TCHLD is the 6th largest department and is one of last larger departments to be accredited. As a suburban/urban department, underfunded relative to staffing all the mandated and grant required programs and services, let alone emerging challenges (e.g. Coronavirus), the lessons learned from TLCHD has potentially benefit other similarly challenged health departments. The researcher has had inquiries from other LHD leaders in Ohio, who are very interested in his work as a potential model that other departments can follow to review implementation of their strategic plans, and involve staff as well as managers in that process.

The initial content analysis phase of the proposed research would explore all eight strategic priorities from the TLCHD strategic plan. As discussed earlier in this proposal the eight priorities are:

1. Obesity
2. Opiate Epidemic/Drugs
3. Access to Care
4. Infant Mortality
5. Health Promotion
6. Workforce Development
7. Fiscal Stability
8. Healthy Homes (TLCHD, 2017)

The collaborative relationship strengthened the case for using an action research approach, as it ensured that participation in the proposed research would be of benefit to the department and community as the action research process and the documentation required could facilitate implementation efforts at TLCHD.

Research Questions and Research Phases

Efforts to acquire knowledge on factors that influenced, and were created from, the implementation of a strategic plan are multifaceted. As stated in the concept model in Figure 5, this study was broken down into three research phases.

Quantitative and qualitative content analysis of strategic plans, the 2017 implementation report, and the monthly priority area reports (June 2017-June 2018) was used to manage and summarize the data to answer research questions 1, 1a, and 2. Research question 3 was answered using Facilitated Discussion Groups and evaluation forms administered to them following the discussion. The Facilitated Discussion Groups however primarily served as member checking for the researcher's preliminary findings based on the content analysis from the monthly reports.

To reiterate, the research questions were as follows:

1. What are the facilitating factors and barriers to LHD's strategic plan implementation?

    1.a. Within the priority areas specified by the strategic plan, what objectives and associated action steps have been accomplished?

2. Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes and how do they make them?

3. What do LHD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan?

In order to identify facilitating factors and barriers, the progress towards implementation, measured through work done (or not) on the objectives and action steps specified in the strategic plan must also be assessed, adding 1a. to the above. This also supported gathering the evidence for question 2 and the systematic process of review or the implementation of the LHD's strategic plan referred to in question 3.

Question 1 was addressed using 12 facilitating factors and barriers identified from a systematic review of 16 articles found in a search of the management literature on implementation of strategic planning from 1987-2017 (see chapter 2). The monthly reports from June 2017- June 2018 (13 months) for the eight priority areas from TLCHD's (Toledo Lucas County Health Dept) current strategic plan were reviewed and coded using the a priori facilitating factors and barriers identified, utilizing a quantitative content analysis approach to count and rank the factors overall and per each of the eight of the priority areas. (See Neuendorf 2019 and White and Marsh 2006 on content analysis) Excel spreadsheets were used to tabulate and sum the factors documented as present per priority area and overall.

Question 1a was addressed through the document review and quantitative content analysis of the monthly reports, by coding for the presence or absence of accomplishment of the specified objectives and action steps as documented in the monthly reports. . This coding was noted and managed via Excel, and tabulated and summed per priority area. A Pearson's correlation analysis was also done to explore relationships between the numbers of facilitating factors and barriers and the progress in implementation as measured by accomplished action steps.

Prior to the review of the accomplishment of the objectives and action steps in the monthly reports, TLCHD's initial (1/17) and revised (6/18) strategic plan were also reviewed to determine if there were changes in the specified objectives and action steps. It was originally planned that the PHAB accreditation report on implementation would also be reviewed, as it was expected that this report would document areas of accomplishment or areas to be improved, but when the report was received it simply said that the implementation requirement had been met, so there was no content to review.

Question 2 was addressed by a qualitative content analysis (White and Marsh 2006) of the activity documented in the monthly reports, focusing on categories based on Henry Mintzberg's approach to strategic planning and implementation: realized, unrealized, and emergent strategies (see chapter 2), operationalized for this study as objectives and their associated action steps that were accomplished as in the plan (realized), not accomplished (unrealized), or unplanned actions and new objectives that were added as the work evolved (emergent). Furthermore, comments on lessons learned were extracted out of the monthly reports. To address Question 2, qualitative categories were used to compare and contrast findings, rather than frequencies, as in quantitative content analysis.

Preliminary findings from the review of the monthly priority area reports, utilizing the quantitative and qualitative content analysis, were presented to groups representing managers and staff active in 4 of the 8 priority areas (Obesity, Opiates, Healthy Homes, and Workforce Development) for member checking (as a validation strategy) and discussion. These 4 areas were chosen to reflect a range of success and challenges in implementing the objectives and action steps specified in the strategic plan. Workforce Development was substituted for Infant Mortality, which was initially selected by the researcher, at the request of the action research stakeholders, the TCLHD Board (see below on action research). Systematic questions in a facilitated discussion group format, led by the researcher and assisted by note-takers, were employed to review and correct the initial findings from the review and analysis of the monthly priority area reports, with each group commenting on the report for its own priority area. Following these four discussion groups, the Implementation Committee, the managerial body at TLCHD responsible for overseeing the strategic plan implementation, was also convened as a facilitated discussion group to further review the findings, revised and synthesized by the researcher following the feedback from the four priority action facilitated discussion groups (FDGs).

Question 3 was addressed using the FDGs, adding further questions beyond the member checking of the document review and analysis, asking the participants to reflect on what was learned through the systematic review of the implementation of the objectives and action steps in the strategic plan and the facilitators and barriers to that implementation, and the discussion thereof, and give their recommendations for moving forward. Analysis of the responses was structured using these questions (see the FDG guide in appendix and Chapter 4). Question 3

was also further addressed using a written, anonymous evaluation form asking for feedback on the process of the FDGs and the content of what was discussed (see Chapter 4 for reported results).

A. Research Phase 1 – Document Review – Data Sources and Analysis

The first phase was a document review of strategic planning material from 02/17 to 06/18 from Toledo-Lucas County Health Department's Strategic Planning Implementation Committee. This included the 2/17 TLCHD Strategic Plan, the revised 2/18 TLCHD Strategic Plan, and the 2017 (submitted January 2018) TLCHD Annual Implementation Report.

Original and Revised Strategic Plan. The 8/2018 revised plan was compared to the original plan from 2/2017, to determine if any objectives or action steps were added or subtracted. Furthermore, barriers and facilitating factors were coded (using as a priori codes the 12 barriers and facilitators extracted from the business literature reviewed in Chapter 2) to serve as a baseline for the coding of the barriers and facilitators in the monthly reports.

. It was originally planned that the PHAB accreditation report on implementation would also be reviewed, as it was expected that this report would document areas of accomplishment or areas to be improved, but when the report was received it simply said that the implementation requirement had been met, so there was no content to review.

Annual Report. This document was the 2017 TLCHD Annual Strategic Plan Implementation Report (reviewing the calendar year 2017). The document was reviewed to ascertain any differences between the original strategic plan, the revised strategic plan, and the implemented plan, in terms of objectives, as well as to code for facilitating factors and barriers, to provide a

baseline for the review of facilitators and barriers in the monthly reports from June 2017-June 2018. .

B. Research Phase 2: Content Analysis of Monthly Strategic Plan Priority Area reports.

Monthly Reports. Monthly Reports were used by the priority champions to document the work done on the priorities. Reports used in the proposed study were from 06/28/17 to 06/01/18. Appendix B is a blank monthly report. Appendix E is an example of a completed report. Information from the document was entered into a Microsoft Excel spreadsheet (see Appendix D). Furthermore, a systematic review of the Monthly Reports provided insight into the LHD's lessons learned and information on processes used to evaluate were completed. Analysis included quantitative assessment of the relationship of steps to outcomes to understand if completing the steps produced outcomes. Quantitative summaries also indicated the presence or lack of work accomplished during certain months or for specific priorities. Furthermore, lessons learned were qualitatively summarized (for question 2), drawing on the documentation in the reports for each priority area. Analysis included linking lessons learned and facilitators and barriers to understand any relationship. This data was then be compared to each of the priorities to understand any similarities or differences.

Additionally, these reports captured the facilitators and barriers for each priority's objectives, which were placed in an Excel Spreadsheet. One sheet was for barriers and the other for facilitators, utilizing the 12 *a priori* codes derived from the literature review described in Chapter II. A "1" was placed in the data table matrix when a code applied from the barriers and facilitators reported on the monthly report for a specific priority area (see appendix G), from the monthly reports for June 2017 to June 2018. Data tables were organized and summed to obtain

the data needed to summarize the types of barriers and facilitators found for each priority area and to compare among priority areas. This data was used to understand the TLCHD experiences with facilitators and barriers to effective implementation of the strategic plan. Data was analyzed using *a priori* coding (appendix G) and it was envisaged that emergent coding would be utilized if content warrants sub codes or additional codes. No emergent codes were needed; the a priori codes were sufficient to categories the barriers and facilitators found.

Beyond coding and summarizing barriers and facilitators (research question 2) in order to answer research questions 2 and 3, additional analyses were conducted: the theory of change, implicit as well as explicit, for each priority area were extracted by reviewing the objectives and action steps included in the monthly report, and compared to the original strategic plan. Lessons learned were summarized for each priority area and compared among priority areas. Progress reported in completing action steps from the 2017 strategic plan were quantitatively and qualitatively summarized. Furthermore, the progress in action plans were coded using Mintzberg's categories of realized, unrealized, and emergent strategies. Mintzberg's concept of strategies are TLCHD's objectives and action steps used to reach a strategic plan goal. These results were summarized for each priority area. Finally, assessment of the progress or lack of progress in the objectives as measured by action steps completed, and the analysis of the comparison between realized, unrealized, and emergent strategies for each priority area, would provide the basis for preliminary recommendations for further implementation or revision of the objectives for each priority area. These findings and the preliminary recommendations for four out of the eight priority areas would then be used as the basis for Phase 2 of the research for this Action Research project.

C. Research Phase 3 –Facilitated Priority Area Group Discussion

Phase 3 used facilitated discussion groups as member-checking on the researcher's preliminary findings based on document review and content analysis. Four priority area facilitated discussion groups (FDGs) were conducted, with managers and staff involved in four out of the eight priority areas: obesity, opiates, healthy homes, and workforce development. A fifth facilitated discussion group was conducted following the synthesis of the feedback from the priority area groups, with the Implementation Committee. These groups utilized a facilitated discussion technique. This process utilized a facilitator to oversee and move open-ended question discussions along. Questions made inquiry into what those participating in the groups knew and felt about TLCHD's strategic plan implementation. The facilitated priority area group discussions were not traditional focus group discussions. They were group discussions that were part of an action research cycle, reporting back the researcher's results to an internal stakeholder group for comment and validation. This type of member checking (feedback process) provided increased accuracy and credibility to the findings. The group discussion used three distinct summaries of four different priority areas of the TLCHD strategic plan implementation. The results from the discussions were used to validate data obtained from Phase 1, recommendations on moving forward with the priority area and lessons learned from implementing the strategic plan.

Selection of Priority Areas. The priority areas for facilitated priority area group discussion were selected by several criteria. First, the total number of barriers and facilitators were used for selection. Both the barriers and facilitators were added together, and the areas were ranked 1-8 with from highest (1) to lowest (8). The second criteria for selection was the amount of progress made for each area as found by summing the number of action steps worked on. Progress was ranked as with facilitators/barriers criteria from 1 to 8. The third criteria was if the area was a priority of the next strategic planning cycle. From an action researcher's perspective, it was more

important to gain knowledge of a priority area that was continued than one that was not. Gaining additional insight into those areas which were to be continued would afford TLCHD with a higher possibility and greater efficiency of that area being implemented. In contrast, there may have been validity to studying areas that would not be a next cycle priority, but it would not have the same impact or efficiency as gaining additional understanding of those areas TLCHD wished to move forward with over those that they did not. Final selection would be the two highest yielding ranking, and two of the lowest yielding areas would be used for the four facilitated priority area group discussions. However, if the final priority areas were not deemed critical to TLCHD for public health or departmental reasons another area would be selected over the areas that meet the original criteria. Opiate Priority Area was chosen due to the high ranking of work done while obesity was chosen due to the limited work done. Healthy Homes was chosen due to the higher amount of work completed and deemed critical due to expected growth for a Healthy Homes program. Finally, Workforce Development was chosen due to the slightly lower amount of work completed but also the critical need by TLCHD to enhance and enact workforce development processes.

Researcher as Facilitator. The facilitator of the groups was the researcher. There were several reasons for this. The first is that the researcher had intimate knowledge of data from Phase 1 and the strategic plan implementation. Phase 1 data (progress made in implementation and facilitators and barriers of each area) was provided and discussed with each group. These discussions needed an extensive explanation of some data which another facilitator could not provide. The consent process and ground rules for the discussion, plus the presence of note-takers who would work with the facilitator, would mitigate against bias that might be introduced by the relationship of the researcher to the staff of the department participating in these

discussions. Finally, with the researcher acting as the facilitator he ensured that all information was documented.

The Facilitated Group Discussion participants had questions posed to them during each of the summary sessions. The questions were designed to engage participants while member-checking through gathering insight into how the participants thought about implementation and findings by the researcher from the earlier, content analysis phases of the research. The summary sessions questions used can be found in appendix H (Staff Discussions) and appendix I (Implementation Committee). Table III in the Data Sources/Collection column presents what documents were reviewed and who would be participants in the groups.

Ground Rules for Discussion. The following was stated prior to the group discussion. The facilitated priority area group discussions would take around two hours to complete, and no incentive would be provided in exchange for your participation. Your participation in this research is voluntary. You have the right to withdraw at any point during the discussion, for any reason, and without any prejudice. If you would like to contact the Principal Investigator in the study to discuss this research, please e-mail Dr. Eve Pinsker at epinsker@uic.edu. It is expected that if you disagree with the findings or points of discussion to voice your opinion. If you agree with the findings, your opinion should also be voiced as well. Finally, we are here to improve the implementation of strategic plans to better public health. Your honest responses and involvement with the discussion will improve the possibility of improvement of strategic plan implementation.

For the implementation committee, both a personal invitation and an email was sent and stating that those willing to participate in the facilitated group discussion should report to the board room at the specified time and date.

Structure of discussions. The facilitated priority area groups discussions were scheduled for two hours each (four groups at two hours for eight hours total). Participation in the discussion groups was voluntary, had informed consent, and ground rules for the discussions were presented as explained later in this chapter. Both note-taking and an audio record of the group meetings would document the facilitated priority area group discussions. Note-taking was completed by two clerical staff. One staff member used a large group post-it note paper to document findings during the discussion. The post-it was in view of all those in the facilitated priority area group to ensure group concurrence with posted material. The second note taker documented both verbal and non-verbal reactions of participants as the conversation was held. The audio recording was transcribed as a backup. As each group was preparing to begin discussions, each participant was asked to fill out a brief survey. This survey would include gender, age, experience with the strategic plan, and involvement with the priority area (see appendix J).

The facilitated priority group sessions were broken into three different summary discussions utilizing a PowerPoint presentation.

1) summary of progress made and not made in implementing that priority, and the facilitators and barriers found;

2) summary of the lessons learned from implementing that priority;

3) summary of the recommendations coming out of the analysis.

The summary sessions followed a specific process and order. The summary explanations were as follows:

Summary 1. The facilitator distributed the power point presentation of progress made and not made as well as the facilitators and barriers found from Phase 1 work. Next, the PowerPoint of the summary of work was presented. After the presentation, there was time to ask clarifying

questions on material which was unclear or needed further explanation. The group asked to comment on if they agree with the summary in relation to their experience or if they had additions or revisions they would make. The order that these comments were made was first of progress made, then facilitators, and finally on the barriers.

Summary 2 Lessons Learned. The next summary session was on lessons learned. The group's session started with the facilitator asking for the group's reflection on lessons learned from implementing the priority area. After this was complete, there was a written summary distributed and discussion of what the researcher found as lessons learned from Phase 1. From this discussion, the facilitator asked participants for comments/reactions, including lessons learned about the theory of change, what people expected to happen, and their assumptions about why that would happen. Questions are:

1. What have we learned from/about how to implement this priority?
2. Did things happen the way you thought they would, and if not, why not?
3. Reflecting on the barriers and facilitators you/we discussed earlier, what is the most important things you/we learned that we did not know before? Was there any prior knowledge or assumptions you/we had before that was confirmed or strengthened?
4. Has the implementation of the plan impacted everyday operations or thinking? If it has what are some examples? If it has not, why?

Summary 3 Recommendations. The facilitator began by asking for the group's recommendations to the discussions and findings from the first two summaries. The statement to begin discussion was:

> "Considering what we have already said about the progress that has and has not been made, and about barriers and facilitators, and lessons learned about implementing this priority area of our strategic plans, what are your recommendations about what TLCHD should do to proceed with this priority area going forward?"

After the group gave their recommendations, the facilitator gave his recommendations as found from analysis of Phase 1 data. The group asked to comment on the researcher's recommendations to get their reactions/additions and revisions.

Before ending the discussion group the facilitator ensured all information was captured by notetakers.

D. Research Phase 4

After the end of each facilitated discussion group, a separate anonymous evaluation form was distributed. The evaluation asked four questions.

1. Do you think this type of discussion is useful for future evaluations? Why?
2. What do you think of this type of facilitation?
3. What changes would you make to the facilitation process?
4. Other comments?

Results from this evaluation form were summarized, and a thematic analysis was conducted (see Appendix O) to synthesize the results, and provide support for recommendations on the process of implementing evaluation as part of the action research cycle supporting more effective implementation going forward. .

<u>Participatory Evaluation</u>

Participatory Evaluation (Patton 2014) is another lens that became important for this research, as it evolved. The degree of interest and enthusiasm on the part of staff as well as managers for participating in the FDGs that were the final phase of this research was not envisaged at the start. This was evidenced by the positive comments in the written evaluation forms returned (see Chapter 4 and Appendix O) as well as comments during the FDGs themselves. The utilization of the FDGs, with both managers and staff members from the priority areas as participants, as providing member-checking on the findings regarding implementation of the strategic plan objectives and the barriers and facilitating factors to that implementation, and the further discussion of recommendations to moving forward, fits well within a participatory evaluation model, as well as an action research model. The excitement about a wide swath of participants, staff as well as management, being involved fits a participatory evaluation model better than an action research model with a small stakeholder group. The desire of staff in TCHLD to utilize something like participatory evaluation moving forward, are demonstrated in the comments received in written feedback from the participants (see Chapter 4).

Action Research Cycle

Figure 6 below is the summation of the research and reporting cycle for this dissertation. The figure shows the start of the cycle of data collection, continues to the reports to the 4 Priority Area FDGs, the incorporation of their feedback and revisions, then the report to the implementation committee Facilitated Discussion and the incorporation of their comments and recommendations with the initial findings. Following the synthesis of this data and feedback in the dissertation, it is planned to present the resulting findings and recommendations to the TLCHD Board. Presumably the action research cycles will continue as the recommended action and study/research steps are followed after that, with the Board's approval and support.

Appendix N shows the identification of themes from the initial findings that fed into the initial recommendations presented to the Priority Area FDGs, and the subsequent revisions of those recommendations based on their feedback, followed by the presentation to the Implementation Committee and further revision to produce the recommendations presented in this dissertation and that will be presented to the TLCHD for their review and consideration for action.

Following Figure 6, the Measurement Table (Table III) summarizes the data sources and methods of analysis and steps taken for validation, by the relevant research questions and constructs.

Figure 6: Implementation Reporting Cycle

TABLE III: Measurement Table

Research Questions &Constructs	Data Sources	Methods	Validation
1. What are the facilitating factors and barriers to LHD's strategic plan implementation Constructs: 12 Facilitating Factors and Barriers identified from the literature, used as a priori codes	Monthly reports from all 8 priority areas in the TCHLD strategic plan, June 2017-June 2018. Not all areas reported each month. See table.	Quantitative content analysis of the TLCHD monthly priority area reports (all 8 areas), utilizing 12 a priori codes identified from systematic review of management literature (see Ch 2). Excel spreadsheets were used to tabulate and sum.	Review by 2nd coder. Discussion with FGDs representing each of the 4 selected priority action areas confirmed or disconfirmed preliminary findings from quantitative content analysis of reports
1.a. Within the priority areas specified by the strategic plan, what objectives and associated action steps have been accomplished? Constructs: Implemented Strategies (Objectives & associated action steps) Lessons Learned	Monthly Reports from all 8 Priority Action Groups.	Quantitative content analysis of the activity documented in the monthly reports for all 8 priority areas focusing on action steps accomplished per objective as a measure of progress. Spearman coefficient analysis of relationship between barriers, facilitators, and number of action steps. Counting of reported lessons learned.	Review by 2nd coder. Discussion with FGDs representing each of the 4 selected priority action areas confirmed or disconfirmed preliminary findings from quantitative content analysis of reports Also, for #1 and 1a, exploration of relationships between progress as measured by action steps and numbers of facilitating factors or barriers.
2. Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes and how do they make them? Realized, Unrealized, and Emergent	Changes in the work (revisions in the objectives or action steps) were documented from the monthly priority action areas. This research question was focused on 4 selected priority areas: Obesity,	Document review of monthly priority area reports for 4 selected areas (Obesity, Opiates, Healthy Homes, and Workforce Development) utilizing qualitative content analysis to extract and categorize objectives &	Discussion with FDGs representing each of the 4 selected priority action areas confirmed or revised and extended preliminary findings from qualitative content analysis of reports. Findings were further confirmed or extended by the FDG with the

Research Questions &Constructs	Data Sources	Methods	Validation
Strategies (from Mintzberg)	Opiates, Healthy Homes, and Workforce Development. In a 2nd phase, the preliminary analysis was presented to Facilitated Discussion Groups (FDG) for each of the 4 priority areas for discussion, followed by a 5th FDG with members of the Implementation Committee.	associated action steps as realized, unrealized, or emergent. Qualitative summarizing of lessons learned Thematic analysis (hand coding) of recommendations and revisions to recommendations (see Appendix N)	Implementation Committee. Recommendations based on preliminary findings vetted by Priority Area FDGs, then revised by researcher and further vetted by Implementation Committee, and then finalized by researcher following feedback (see Appendix N)
3. What do LHD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan? Constructs: 12 Factors –Barriers, Facilitators Realized/ Unrealized/ Emergent Strategies Evaluation Participatory Evaluation (emergent)	Discussion with FDGs reflecting on the review process, Written and anonymous evaluation forms administered after the FDGs, to get feedback on the content of the discussion and the format of the FDGs and the process of reviewing implementation progress or lack thereof including the use of the FDGs themselves. .	Discussion questions used to not only guide discussion but organize and synthesize the responses. Summary of the written open-ended responses to the evaluation forms, and thematic analysis (hand coding) of evaluation findings, to synthesize conclusions and recommendations (see Appendix O)	Comparison between written feedback and comments in FDG notes and recordings.

Comments on Analysis Plan

In addition to summaries of lessons learned included in the monthly reports, a review of what was learned through implementation was conducted through categorizing included action steps documented in the monthly reports as associated with priority area objectives, by utilizing Mintzberg's concepts of *Realized, Unrealized and Emergent* strategies (Mintzberg et al, 2009). Action steps that were completed as written were *realized* while those that were not completed were *unrealized.* Both were documented. Steps that were adjusted or changed were termed *emergent* and were documented as such along with the alternate actions step that resulted. Furthermore, to answer Research Questions 2 and 3, implicit as well as explicit theory of change was extracted from the objectives and action steps in the monthly reports and compared to the original strategic plan and its supporting documents (e.g. meeting notes) as well as the realized, unrealized and emergent strategies coded for in the monthly reports. Theory of Change-related questions were then discussed in the facilitated discussion groups, to validate any findings relating to changes in the Theory of Change and how it was documented or talked about, related to the priority areas discussed.

The discussion of lessons learned about implementation and the analysis of realized, unrealized, and emergent objectives was related to the theory of change which could be explicit or implicit. Theory of change, for this research, takes the assumptions about how change should happen embedded in the strategic plan before any action steps were implemented and compares that to the progress for steps. The work completed has an outcome, but often that outcome reveals a significant interrelation to many other factors that bring about the outcome, that may or may not have been initially envisaged (Tapin & Clark, 2012); these initially unknown factors can contribute to Mintzberg's "unrealized" and "emergent" strategies. The process of assessing

progress in implementing a strategic plan, then, should involve reviewing the initial assumptions made about how change would occur and making those explicit if they had not been so, so that those assumptions can be examined and revised if needed going forward. . The concern for explicit or implicit assumptions has been described in “Evidence Planning: Implicit and Explicit Assumptions” from the Open University in the UK (Open Learn 2017). Explicit assumptions are those assumptions that have been expressed and shared. This would include explanations of the rational for the objectives and steps of the strategic plan prior to implementation. The result from the review work was documentation of challenges to the initial assumptions and/or learning found by examining the monthly reports. The priority area descriptions have explicit assumptions about expected change from the strategic plan and from monthly reports but also may be affected by implicit assumptions from the managers, leaders, and staff involved.

To verify data obtained was correct and accurate a second coder was utilized. The designated coder served at the time of the study as the Toledo-Lucas County Health Department's (TLCHD) Quality Assurance Coordinator and Public Health Accreditation (PHAB) Coordinator. Including all aspects of PHAB Accreditation, this individual was also responsible for facilitating strategic planning efforts in the Health Department. The reasons for choosing this individual as the second coder were that the proposed research codes were from TLCHDs reports and other documents which the second coder had intimate knowledge of, including the structure, design, and rationale of stated reports and data. Furthermore, he had operational knowledge and responsibility for implementation of the plan. This culminated in extensive experience with the material being coded and translates into a more efficient, accurate and effective second coding.

Spearman’s rank-order correlation was used to understand the relationship between data found from analysis of the monthly reports. Spearman rank-order correlation statistically

attempted to understand the strength and direction of the relationship between two random variables (Archambault, 2000). For the purpose of the proposed study, the statistical calculation was used to understand the strength and direction between three variables. The first was the progress of work done on the plan per priority area objectives compared to facilitators. The second was the same progress data but would be compared to barriers. It was proposed that the results would provide evidence of a correlation between the progress of the plan compared to facilitators and/or barriers.

Facilitated Priority Area Group Discussions were used as member-checking validation of the researcher's preliminary findings. . The Facilitated Priority Area Group Discussions Guide is featured in Appendix K This included eliciting any divergences as well as convergences with researcher's findings and recommendations from stated lessons learned, facilitators/barriers and realized, unrealized, and emergent objectives. A report was completed from the findings from the facilitated group's discussions. The report was a merging of differing, corrected or added findings from group analysis of the facilitated work. Revisions would then be made, if warranted, to the report. This report was then presented to the Implementation Committee.

Analysis from the committee also included divergent as well as convergent feedback to the synthesized findings and recommendations presented to them by the researcher following the incorporation of feedback from the Priority Area discussion groups. The Implementation Committee Group Discussion Guide is featured in Appendix K. Following this meeting with the Implementation Committee, final recommendations presented in this dissertation were synthesized and will also be presented to the Toledo Lucas County Board of Health. Appendix N presents the thematic analysis used to amend preliminary findings and recommendations and synthesize the final recommendations.

Triangulation and Integration of Data Analysis Across Sources. Initial analysis in Phase 1 came from documented facilitators/barriers, outcomes, and met objectives from the monthly report. To demonstrate, document, and analyze any additional areas of action, the monthly reports were reviewed for steps taken by the participants to adjust the implementation of the plan. This data was triangulated with the facilitated priority area group, implementation committee, and the researcher's findings. Relationships among facilitators/barriers; learning documented through evidence from changes in organizational practices, policies, and changes in evaluation and monitoring reported outcomes or other changes related to following PHAB mandates for strategic plan implementation was explored using the proposed codebook. Following the analyses of the groups, the initial analysis from the monthly reports was reviewed to find patterns and common themes using added emergent coding from Phases 1 and 2 of data collection and analysis. The common *a priori* codebook, including the designation of realized, unrealized and emergent strategies, as well as the coding for barriers and facilitators, supported integration of the analysis across multiple data sources.

H. Validity Considerations. Regarding validation of data collected and outcomes, the study used member checking (the facilitated discussion groups, with the priority area action groups and the Implementation Committee). . Furthermore, integration of data analysis across sources (initial strategic plans and annual report and the monthly reports) was supported using a common codebook, with *a priori* codes. Comparing findings across the eight priority areas strengthened testing of posited relationships among the coded factors.

As a action research case study aimed at improving the quality of TCHLD's strategic plan implementation, validity concerns have been given full consideration. The researcher and those being studied could and should influence the outcome of the phenomena being studied, but

that did not preclude bias from the researcher during facilitated discussion as well as in the interpretation of the notes from the discussion, document review, and analysis.

There were several validity concerns. The first was researcher bias. The researcher had been employed at the leadership level at the LHD level for almost two decades. This provided him with insight into the strategic plan implementation process and PHAB accreditation at local LHDs. He witnessed LHD facilitators and barriers to strategic plan implementation, and understood the limitations LHDs face when conducting strategic planning. At the time of the study, he was responsible for implementing the strategic plan proposed to be studied, which could influence informants by asking leading questions during the facilitated priority area group discussion. He guarded against this bias in several ways. First, the researcher did not ask leading questions, and secondly, as facilitator was mindful that he properly conduct the discussion to portray neutral and consistent body language and tone of voice as not to lead participants. Lastly, the note-takers were trained to help implement ground rules for discussion and be empowered to signal the facilitator if they see any problems, and a recess was taken if necessary.

Measurement bias was another issue. To limit this, he used audio recordings and written notes taken by two other individuals. Discussion of notes took place before the end of the session and within 24 hours afterwards. This discussion was held with both note-takers at the same time. This session served as a peer-debriefing validity check on the notes and preliminary findings from the discussion. Since both note-takers and the facilitator were present, this provided a check on the accuracy and completeness of the notes captured during the discussion groups. The words of each interviewee were transcribed by a third party to limit any biases. The transcript recording was only used as a backup to notes taken during the discussion groups.

Interpretation bias was limited through open-ended questions that did not cause directional answers; these fully covered the area of research for questions. In addition, a second coder other than the researcher was used to review the findings of the facilitators and barriers. Any discrepancies with the findings by the researcher and second coder were discussed, and an agreement of final data was made.

Another issue that could pose a problem of researcher bias, as noted above, was when the researcher was also the interviewees' superior, they may feel uncomfortable answering the questions. However, with knowledge of those who participated and their wish and dedication to improve implementation of the plan, the agreement, supported by the discussion ground rules, that the only way to improve was to have critical conversations, limited the issues of the facilitator being their superior. The one main reason why participants' reluctance to answer truthfully was limited could be linked to the culture the researcher is instilling with staff. Employees were encouraged to voice their opinions as well as disagree in a constructive manner with their superiors. That this culture of open discussion is indeed emergent is seen in the divergent as well as convergent feedback given to the researcher in the facilitated discussion groups.

I. Limitations

Several limitations exist when attempting to answer the proposed research questions. One, the findings described the experience of one health department and what affects its experience. The findings may not necessarily be generalizable to other departments due to different sizes, locations, or budgets. Time issues are also a concern since this study took place in only a slice in time. Another limitation was the PHAB version used may change, and the next version may or may not have or demand the same standards. Ohio demanded exemplary public health through

state code that all LHDs be accredited by 2020, which may not be the same in other states. Mandated accreditation may suggest more adherence to specifics about evaluation and improvements than other departments that were not mandated to be accredited. The researcher's position in the department may have been a limitation as well as a strength in that he had full access to data and the ability to convene stakeholders, while other LHDs may not have had an individual in such a position. By going into details, the researcher hopes that other LHDs would be able to judge their issues as they too respond to PHAB mandates on the implementation of strategic plans.

J. Generalization or Transferability of Findings to other Local Health Departments.

The proposed research of one LHD, seeking accreditation, that "submitted" its strategic plan and awaiting site review, should be transferable to other LHDs in Ohio and other LHDs nationally. As noted through a literature review, not every LHD has the same issues, programs, or departmental makeup. However, PHAB accreditation strategic planning demands and suggested processes are the same for everyone seeking accreditation. For Ohio LHDs, this transferability is the strongest as the LHDs must adhere to PHAB mandates by the year 2020, have similar programs due to legislation and grants awarded to many of the LHDs. Although some patterns of realized, unrealized, or emergent strategies may be unique to TLCHD, the process to be followed requires resources common to other LHDs, and if findings are useful to TLCHD this process can be a model for other LHDs to follow in reviewing their implemented (or not) strategies and embedded action steps. Transferability of findings on barriers and facilitators to other Ohio LHDs is expected due to the similar barriers/facilitators that exist within this group. As the report of this case study is disseminated to other Ohio LHDs as well as LHDs outside Ohio, other LHDs will be able to make their own judgements about transferability

or applicability to their cases. The construct validity from the grounding in the literature and the common practice context of PHAB as well as the typical characteristics of TLCHD supports the potential of this transferability.

K. Thesis Products

The thesis documented facilitators and barriers along with learning connected with implementation of the TLCHD strategic plan. The final work product will include the recommendations for moving forward with implementation and improving implementation practice presented in Chapter 5, in a form utilizable by the TLCHD Board.

IV. RESULTS

Chapter IV reports the results from the multiple phases of this study, including:

a. Document review of the original and revised strategic plans (2/17 and 8/17) for changes to original priorities and action steps, and the alignment of strategic priorities with objectives
b. Document review comparing the proposed objectives and action steps in the strategic plan to the 2017 annual report (called the Annual Strategic Plan report) covering December 2017 to January 2018 (TLCHD Annual Report for 2017, produced in January 2018)
c. Document review utilizing quantitative content analysis of the 2017 TCHLD Annual Strategic Plan Report
d. Document review utilizing quantitative content analysis for monthly reports on all 8 Priority Areas included in the TCHLD Strategic Plan, for the period from June 2017 to June 2018. This includes tabulations of the frequencies and rank of the coded instances of facilitators and barriers as well as the documented progress on objectives and their constituent action steps.
e. Statistical analysis using Pearson Correlation of the relationships between coded facilitators, barriers, and progress as measured by action steps completed in the monthly reports from June 2017-June 2018.
f. A summary of the quantitative and qualitative content analysis results from the review of the monthly reports from June 2017-June 2018 for 4 selected priority action areas (see Chapter 3) , including Obesity, Opiates, Healthy Homes, and Workforce

Development, as presented to the Facilitated Discussion Groups held in December 2019. This section of the chapter includes:

- A report on the participant demographics of the Facilitated Discussion Groups
- For each of the 4 selected priority areas:
    i. Key findings from the quantitative content analysis on high frequency barriers and facilitators and on objectives and action steps accomplished
    ii. Categorization (qualitative content analysis) of actual steps taken into realized, unrealized, and emergent strategies, as compared to the strategic plan
    iii. Preliminary findings from the researcher based on the monthly reports with regard to lessons learned and recommendations for moving forward, as presented to the FDGs
    iv. The responses from the FDGs, their confirmation, disconfirmation and/or extension and revision of the preliminary findings and recommendations. This is organized by the questions presented to them for structuring the discussion and analysis of the responses (see Chapter 3; the questions are also included in the text of this subsection).
    v. Responses from the final presentation made to the Implementation Committee after the responses from the 4 Priority Area Facilitated Discussion Groups were recorded, compiled, and synthesized; the Implementation Committee served as a fifth and final Facilitated

Discussion Group. The final recommendations will be subsequently presented to the TCHLD Board of Health (following the close of dissertation research).

g. Evaluation of the Facilitated Discussion Group process: members of the FDGs filled out anonymous, written evaluation forms giving feedback on the process. This information was used to assess participant reaction to the process of participating in assessment and evaluation of the progress in implementing the TCHLD strategic plan, as relevant to Question 3 of this research. This will be further discussed in Chapter 5.

The document review set the foundation for understanding the revision of the strategic plan and the implementation of the plan during the period studied. The monthly implementation reports were instrumental in exploring the main research question of what the barriers and facilitators to strategic plan implementation are. Furthermore, the monthly reports provided insight into work completed on objectives from the plan and lessons learned resulting from implementation. This information assisted in exploring the three research questions. The first question (on facilitators and barriers to strategic plan implementation) is reflected in the sections c,d, and e of Chapter IV, with the data from quantitative content analysis of the 2017 Annual Strategic Plan Report and the monthly reports from June 2017-June 2018, with discussion across all 8 priority areas, also including the presentation of data by priority areas. The specification and the history of the objectives to be accomplished as listed in TLCHD's strategic plan, as reported in sections a, b, and c below, was required in order to understand the baseline for assessing progress towards those objectives and to compare priority areas where more progress was made with those where less progress was made. This is part of the answer to the second research

question on changes in the way TCHLD staff and leaders see and accomplish their work (see below): a quantitative assessment of progress made via action steps within objectives measures what changes were made in TCHLD's work as the staff and managers the strategic plan. This second research question, including the component on the way managers and staff talk about their work, is also addressed in the discussion of the qualitative data from the 4 selected priority area monthly reports, as presented to the Facilitated Discussion Groups (FDGs) for confirmation and or correction (validation through member checking) and presented here in section f. below. The third question on learning from systematic review and evaluation is addressed through the presentation of the data from the evaluation questionnaires administered to the members of the FDGs, as well as comments during the discussion itself; this is presented in section g below.

Further interpretation and discussion of the evidence responding to the research questions will be discussed in Chapter V. The following are the three research questions.

1. What are the facilitating factors and barriers to the LHD's strategic plan?

2.. Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes, and how do they make them?

3. What do LHD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan?

Background: Comparing the Initial Strategic Plan (2/17), Revised Strategic Plan (8/17), and the 2017 Annual Strategic Plan Report

a. Document Review-Strategic Plans (2/17 original and 8/17 revised)

Results of the reviews and content analysis of the monthly reports on the implementation of TLCHD's strategic plan from 6/17 to 6/18 will be given below in section d. In order to

understand how the objectives and action steps in the monthly reports were arrived at, the objectives contained in the original strategic plan, dated 2/17, were compared with the revised strategic plan dated 8/17, through a review of both documents and the supplementary records (notes from implementation committee). One objective was added, and none were deleted. After discussions the implementation committee added an objective for decreasing tobacco use for women of childbearing years to the revised strategic plan. This objective was created when a staff nurse noted the need under the Infant Mortality Priority Area. The complete account of this change can be found in appendix P with Table XXIV, showing the evolution of the strategic plan from the 2/17 to the 8/17 version.

b. Comparing objectives and action steps in the TCHLD 2017 Annual Strategic Plan Report to the August 2017 TCHLD Revised Strategic Plan

The TLCHD Strategic Plan 2017 Annual Strategic Plan Report of 3/18 (covering work in 2017, from 1/17 to 12/17) was also reviewed and the resulting findings and information can be found in appendix P. The review provided insight into the implementation process of 2017. Although the report covered the calendar year of 2017, action work by priority area groups, corresponding to the 8 priority areas described in the report (see Chapter 1) did not start until the middle of the year. There were no changes in any action steps or objectives given between the revised strategic plan of 8/17 and the TCHLD 2017 Annual Strategic Plan Report.

c. Barriers and Facilitators mentioned in the 2017 Annual Strategic Plan Report

A quantitative content analysis approach was used to systematically code barriers and facilitating factors mentioned in this 2017 Annual Strategic Plan, using the twelve a priori codes for barriers and facilitators developed from the literature review in Chapter 2, as a baseline for the barriers and facilitators analysis of the 6/17 – 6/18 monthly reports. Mentions of these barriers and facilitators in the 2017 Annual Strategic Plan were coded and summed in Excel spreadsheets.

Results can be found in Table XXXI appendix P, along with the ranking of those barriers and facilitators in Table XXXII in the same appendix. No emergent coding was developed for the Annual Strategic Plan Report material; the a-priori coding was adequate to analyze the documents. (This was true for the facilitators/barriers coding of the monthly reports also, see below).

The three top barriers found were 1) involvement of managers and staff, 2) evaluation/performance management, and 3) budget/resources. The three top facilitators found were 1) coordination/communication, 2) involvement of managers/staff, and skills/alignment of skills. In comparison the three top facilitators for all priority areas (adjusted for monthly reports submitted) were 1) Involvement of Staff and Managers, 2) External Factors, and 3) Coordination/ Communication. The top three barriers were 1) Budget/Resources, 2) External Factors, and 3) Timely Action. The interesting finding is that external factors were found to be ranked high as both a facilitator and barrier for monthly reports but was not in the top three ranked for the 2017 Annual Strategic Plan Report. The most likely cause of lower ranking for the annual report and higher in the monthly reports are the large number of action steps needing external factors to complete those steps, and the specificity of reporting about these in the monthly reports as the work was actually implemented. . More work was done after the reporting timeframe of the annual report due to slow implementation from logistics and setting up a reporting system the first several months of 2017. Furthermore, much of the early work of the priority areas did not need as much external support.

d. Quantitative Content Analysis of Monthly Reports (June 2017-June 2018): Barriers, Facilitators, and Work Completed (Action Steps)

Moving from reviewing the 2017 annual report, specific information on progress in implementation of the strategic plan and well as barriers and facilitating factors for such progress (research questions 1 and 2) was sought through quantitative content analysis of the monthly reports across all 8 priority areas from June 2017 to June 2018 (a 13 month period). The reports were coded for facilitators and barriers, using the developed a priori codes. No emergent coding was required due to a-priori coding defining the barriers and facilitators adequately. Action steps completed per objective were used as a measure of progress, and the resulting calculations tabulated. Statistical analysis using the Spearman's Coefficient explored relationships between facilitators, barriers, and progress as measured by actions steps completed (see section e. below). Lessons learned as documented in the reports were also tabulated and counted. Qualitative analysis of lessons learned was later employed (see section f. below) and the researcher's preliminary conclusions tested and extended via the Facilitated Discussion Groups (section f.).

The monthly reports from each of the 8 priority action areas were coded for the identified (from the literature review) barriers and facilitators, to respond to question 1: What are the facilitating factors and barriers to the LHD's strategic plan? There are limitations to the data that need to be described, deriving from changes from the initial assumption that each priority area was supposed to report every month.

Description of the Reporting Process

Initially, it was envisaged that each priority area would be reported on each month, with the Champion from that area responsible. From May to June 2018, discussions by those responsible for strategic plan implementation centered on whether eight priorities were too many. Concerns ranged from the amount of work that goes into each priority to employees' time devoted to addressing priorities. The issue of time it takes to report was already addressed once

by the committee. Early in 2017, the committee had decided that each priority should not be reported on each month, as originally agreed by the committee. It was noted in conversations during several committee meetings, in early 2017, that reporting out each priority (8) every month was time consuming.

These conversations resulted in changing reporting to four priorities one month and the other four the next month. The concept of reducing the number of priorities from eight to something fewer is that, with fewer priorities, more time and work can be devoted to the implementation process. Furthermore, as discussed among staff, more time would allow staff to prepare monthly reports with additional detail. It is plausible too many priority areas were selected to be worked on, which requires resources that TLCHD may not possess. However, it is also plausible that agency leadership did not hold responsible parties accountable for work completion and reporting. This is supported by the division of four priorities reporting one month and four the following month not occurring as noted in Table IV.

TABLE IV: Number of Months Priorities were Reported (June 2017-June 2018)

Number of Months Priorities were Reported	
Priority	Months Reported
Opiates	7
Health Promotion	6
Workforce	6
Obesity	4
Healthy Homes	4
Access	3
Infant Mortality	2
Fiscal Stability	2

Out of thirteen possible months, only eight months had monthly reports documented. The rotation of four priorities one month and four the next, should result in seven reports for four

areas and six reports for the remaining four areas. However only one met the seven-month report level and two met six months (Opiate, Health Promotion and Workforce Development, respectfully). While Obesity and Healthy Homes had four, Access to Care reported three and Infant Mortality and Fiscal reported only two out of the potential six months as noted in Table IV. Again, leadership did not push for the work and/or reporting to be done. Leadership did have a competing factor which took considerable resources and time. During 2017 and 2018, accreditation material was being gathered and submitted to PHAB. The same personnel responsible for strategic plan implementation were also responsible for PHAB Accreditation.

Lower than projected monthly reports can be contributed to TLCHD conducting PHAB Accreditation work and submitting for accreditation the last half of 2017. The process and work product needed for accreditation is detailed in Chapter 1 and 2. In general, the department put a considerable amount of resources into the paperwork and documents required for PHAB accreditation and took away from both times to work on strategic planning and development of monthly reports. Further, the PHAB Coordinator needed to cancel several monthly meetings, which further limited reporting. Access to Care's lack of work and reporting can be related to most clinic operations being suspended at the TLCHD as the Access to Care Priority was linked to clinic operations. Fiscal priority was low in reporting months due to issues with the internal budgeting process and staffing concerns. Work was redirected from strategic planning to daily

operations of the fiscal department. With little to report, the fiscal priority submitted material for just two months out of the potential six.

Results of the quantitative content analysis of facilitators and barriers (Research question 1):

Table XXXIII (appendix S) documents the 12 facilitating and barrier codes used to define facilitators and barriers. Samples of the coded text taken from the monthly reports, specifying priority area and objective, are given to illustrate the coding and content analysis process. The frequencies given in Table V and the following tables are the results of this quantitative content analysis, tabulating the numbers of instances of the a priori codes in the specified priority areas and time periods.

i. Facilitators

As noted in Table V, the top five most noted facilitators (adjusted for number of monthly reports) were Involvement of Managers and Staff, External Factors, Coordination/Communication, Skills/Alignment of Skills, and Budgets/Resources. There are some differences, as well as similarities, between the rankings of facilitators found in the monthly report vs the annual report. The differences could be due to the progress of the implementation process, as well as the improved information stemming from a more granular approach to collecting data based on monthly reports from involved managers, which more closely reflects the actual implementation process on the ground. External factors did not appear in the top three facilitators in the codes from the 2017 Annual Strategic Plan Report. Involvement of Managers/Staff, coordination/communication and skills/alignment of skills were mentioned as the top facilitators in the 2017 annual report, and they still come out in the top five

in the monthly reports . Involvement of Managers/Staff as a facilitator is documented as a leading factor in successful implementation of a plan resulting from past practice of the department. Past leadership did not stress the need for managers and staff to be an intricate part of the implementation process. However, the current administration expects both managers and staff to be involved in implementation and monitors involvement by these entities.

External factors was more highly ranked as a facilitator in the monthly reports as compared to the 2017 annual report. . Much of what the TLCHD is attempting to implement requires outside participation or support for successful implementation of objectives. Without enough funding or resources, implementation of a plan would be difficult. The monthly reports noted this, to the point that budget and resources was ranked as the fifth highest facilitator. Skills and Alignment of Skills was ranked fourth. It was noted that receiving, giving, or having the proper training or the person with the skills in the right position was a facilitator to implementation. Furthermore, TLCHD is stressing the need for additional skills and use of those skills to effectively complete tasks at the department. This may carry over to the implementation process. Evaluation/Performance Management was ranked low as a facilitator when looked at across all the priority areas, and adjusted for the number of monthly reports, although it was mentioned frequently as a facilitator for Opiates and Workforce Development, showing unevenness across the priority areas in this factor. Attitudinal Factors was sixth. This could be linked to the current culture change within the department, begun but still ongoing, as leadership stresses commitment to strategic plan implementation. The remaining facilitators are roles and responsibility, organizational culture, strategic planning/alignment of goals, timely action and competing priorities. The low ranking assigned to competing priorities may be due to the possibility that competition for resources, budget, or time may be thought of as barriers. For

example, working on a foodborne outbreak would cause a competing factor for resources and personnel, detracting from implementation of the strategic plan objectives.

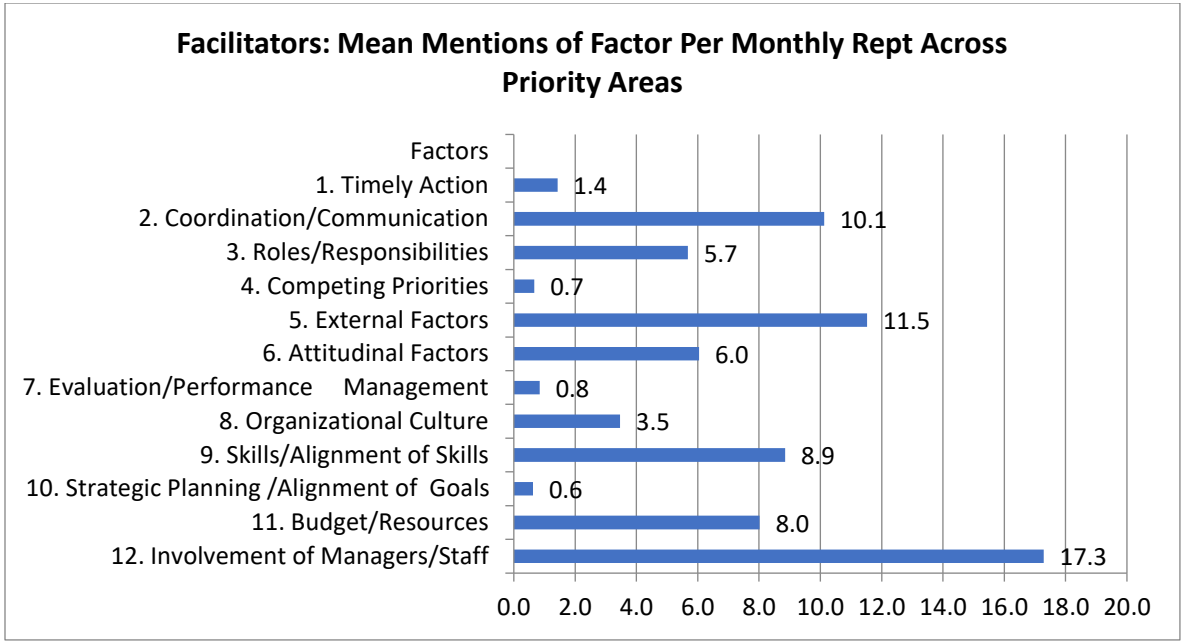
Table V gives the priority areas with the number of objectives of the facilitating codes mentioned for each code and corresponding priority area. In addition, the number of priority areas where that code was noted is also documented. For example, Timely Action, as a facilitator, was found in two mentions within objectives (could be the same objective in different months) in priority areas Opiates and Fiscal Stability. Competing Priorities was noted in two priority areas (Health Promotion and Healthy Homes). Organizational Culture was observed for three priorities (Opiates, Workforce Development and Fiscal Stability). External Factors was noted in four areas (Opiates, Infant Mortality, Health Promotion and Healthy Homes). Attitudinal Factors was found in five priority areas (Opiates, Infant Mortality Health Promotion, Workforce Development and Fiscal Stability) as well as Roles and Responsibilities (Obesity, Opiates, Access to Care, Infant Mortality, Health Promotion, Workforce Development and Fiscal Stability). Evaluation and Performance Management was found in six areas (Opiates, Access to Care, Health Promotion, Healthy Homes, Workforce Development and Fiscal Stability). Skills and Alignment of Skills was found in six areas (Obesity, Opiates, Access to Care, Infant Mortality, Workforce Development and Fiscal Stability). Strategic Planning and Alignment of Goals was found in four areas (Opiates, Healthy Homes, Workforce Development, Fiscal Stability). Budget and Resources was found in all but one area, Health Promotion. Both Coordination and Communication and Involvement of Managers and Staff was found in all eight areas. The five factors that were noted in the most objectives for facilitators were Coordination and Communication, Involvement of Managers and Staff, Budget and Resources, Skills and Alignment of Skills, and Evaluation and Performance Management (TLCHD, 2017).

The number of times priority areas were found to have facilitating factors are noted in Table V. Two factors which were found in all 8 priority areas were Coordination/ Communication and Involvement of Mangers/Staff, one factor Budget Resources was reported in 7 areas and Evaluation/Performance Management and Skills/Alignment of Skills was reported in 6 areas. Two factors, Attitudinal and Roles/Responsibilities. were reported in 5 areas, External Factor was reported in 4 areas, Organizational Culture was reported in 3, while Competing Priorities and Timely Action were reported in 2 areas.

The number of months priorities were reported are noted in Table IV, above, as discussed in the background on reporting relevant to limitations on the data. Infant Mortality and Fiscal Stability were reported in 2 months, Access to Care (3) Obesity and Obesity and Healthy Homes (4) Health Promotion (6) and Opiates (7) of the 8 total possible reports.

TABLE V: Facilitators to Strategic Plan Implementation in Monthly Reports, June 2017-June 2018

Code	Priority Areas with Number of Mentions of Barriers (mean no. of mentions per reported month)								#Monthly Reports Factor Reported In	Total Mentions of Factor across Priority Areas	Total mean mentions of factor per monthly rept across priority areas
	Obesity	Opiates	Access	Infant Mortality	Health Promotion	Healthy Homes	Workforce Development	Fiscal Stability			
1. Timely Action	0 (0)	3(0.43)	0(0)	0(0)	0(0)	0(0)	0(0)	2(1.00)	2	5	1.43
2. Coordination/Communication	1 (.25)	26(3.71)	4(1.33)	3(1.5)	12(2.00)	2(0.5)	2(0.33)	1(0.50)	8	51	10.12
3. Roles/Responsibilities	5 (1.25)	6(0.85)	0(0)	0(0)	10(1.67)	1(0.25)	1(0.16)	3(1.50)	5	25	5.68
4. Competing Priorities	0(0)	0(0)	0(0)	0(0)	1(0.17)	2(0.50)	0(0)	0(0)	2	3	0.67
5. External Factors	0(0)	34(4.85)	0(0)	6(3.00)	16(2.67)	4(1)	0(0)	0(0)	4	60	11.52
6. Attitudinal Factors	0(0)	12(1.71)	0(0)	1(0.50)	2(0.33)	0(0)	9(1.50)	4(2.00)	5	27	6.04
7. Evaluation/Performance Management	0(0)	11(1.57)	1(0.50)	0(0)	2(0.33)	2(0.50)	10(1.67)	1(0.50)	6	28	0.845
8. Organizational Culture	0(0)	1(0.14)	0(0)	0(0)	0(0)	0(0)	5(0.83)	5(2.50)	3	11	3.47
9. Skills/Alignment of Skills	1(1.25)	10(1.43)	2(0.67)	3(1.5)	0(0)	0(0)	6(1)	6(3.00)	6	28	8.85
10. Strategic Planning /Alignment of Goals	0(0)	3(0.42)	0(0)	0(0)	0(0)	3(0.75)	2(0.33)	2(1.00)	4	10	0.625
11. Budget/Resources	2(0.50)	13(1.85)	3(1)	3(1.5)	0(0)	6(1.50)	4(0.67)	2(1.00)	7	33	8.02
12. Involvement of Managers/Staff	11(4.75)	9(1.28)	3(3)	1(0.50)	22(3.67)	3(0.75	10(1.67)	10(1.67)	8	69	17.29
Number of Months Reported for Each Priority	4	7	3	2	6	4	6	2		350 Total Mentions of Factors Found	


Facilitators: Mean Mentions of Factor Per Monthly Rept Across Priority Areas
Factors
1. Timely Action
2. Coordination/Communication
3. Roles/Responsibilities
4. Competing Priorities
5. External Factors
6. Attitudinal Factors
7. Evaluation/Performance Management
8. Organizational Culture
9. Skills/Alignment of Skills
10. Strategic Planning /Alignment of Goals
11. Budget/Resources
12. Involvement of Managers/Staff
1.4
10.1
5.7
0.7
11.5
6.0
0.8
3.5
8.9
0.6
8.0
17.3
0.0 2.0 4.0 6.0 8.0 10.0 12.0 14.0 16.0 18.0 20.0

ii. Barriers

The 346 coded instances of barriers are documented in Table VI detailing the codes mentioned per priority, the top five as noted in Table VI are Budget/Resources, Evaluation/Performance Management, External Factors, Timely Action, and Coordination/Communication. The annual report also provided a similar top five but in a slightly different ranking. Budget and Resources are a barrier when there is little to no funding or resources to implement objectives. For example, when there is no funding for purchasing medications to reverse opiate overdoses, it is hard to meet implementation steps to reduce overdose deaths. Not having information or tracking of performance is a barrier. For example, no evaluation on who should receive data on deaths in the community is a barrier. Coordination/Communication is a barrier when there is a lack of either. TLCHD found that there was a lack of information flow from local hospitals to TLCHD. Reliance on outside groups is a barrier when they do not deliver work or resources to implement the plan. Timely action is a barrier when there is a time constraint to accomplish a step within the plan. For example, too much time between meetings of the implementation committee becomes a barrier. The twelfth barrier noted, Roles/Responsibilities, was seen eight different times in the monthly reports. It may be possible that this was not a barrier due to administration making sure that those doing the work are the best suited for the roles and responsibilities.

Table VI lists the priority with the number of objectives for each of the barrier codes and areas. In addition, the number of priority areas where that code was noted is documented. Roles and Responsibilities was found in two different priority areas (Health Promotion and Workforce Development). Strategic Planning and Alignment of Goals was identified in four areas (Opiates, Infant Mortality, Healthy Homes and Fiscal Stability). Involvement of Managers and Staff was also noted in four areas. Organizational Culture was noted in five different areas (Obesity,

Opiates, Infant Mortality, Health Promotion, and Workforce Development). Attitudinal Factors and Competing Priorities were found in six areas (Opiates, Infant Mortality, Health Promotion, Healthy Homes, Workforce Development and Fiscal Stability) (TLCHD, 2017). Evaluation and Performance Management was seen in six different areas which did not include Obesity and Access to Care. Skills and Alignment of Skill was seen in six different areas which did not include Obesity and Access to Care. Competing Priorities was not seen in two areas: Access to Care and Healthy Homes. Coordination and Communication and External Factors and Budget Resources were observed in all priority areas excluding Health Promotion and Fiscal Stability respectfully. Finally, Timely Action was noted in all eight areas.

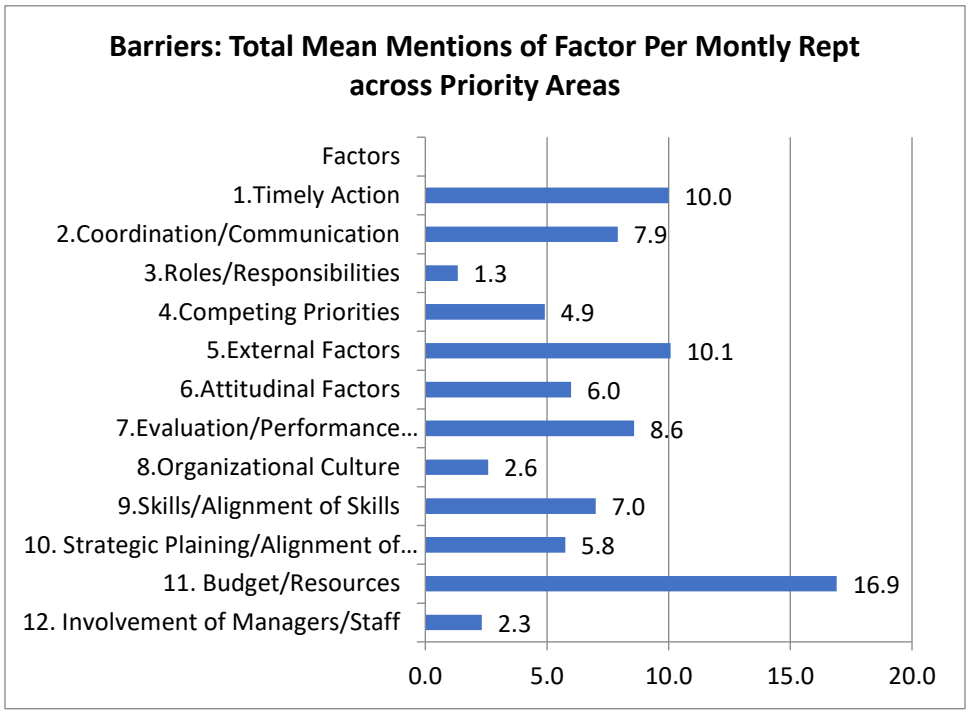
The top four factors with the most areas reported in were Timely Action (8), Coordination and Communication (7), External Factors (7), and Budget and Resources (7). The fifth spot is held by four different factors in six different areas. This spot is shared by Obesity and Access to Care where the factors of Skills and Alignment and Evaluation and Performance Management were not seen. This is due to Access to Care being limited in reporting and few barriers noted due to the lack of reporting. These factors were also shared by Obesity. This is due to limited need for skills or alignment of skills for the objective worked on and in return no barriers were found. Also, there was not evaluation or performance management needed to complete the objective worked on.

The number of months priorities were reported are noted in Table VI. Infant Mortality and Fiscal Stability were reported in 2 months, Access to Care (3), Obesity and Obesity and Healthy Homes (4), Health Promotion (6) and Opiates 7 months of the 8 total possible reports.

TABLE VI: Barriers to Strategic Plan Implementation in Monthly Reports, June 2017-June 2018

Barriers – Total: 346

Code	Priority Areas with Number of Mentions of Barriers (mean no. of mentions per reported month)								#Priority Areas Reported In	Total Mentions of Factor across Priority Areas	Total mean mentions of factor per monthly rept across priority areas
	Obesity	Opiates	Access	Infant Mortality	Health Promotion	Healthy Homes	Workforce Development	Fiscal Stability			
1.Timely Action	1(0.25)	13(2.16)	2(0.67)	1(0.50)	3(0.50)	3(0.75)	10(1.67)	7(3.50)	8	40	10
2.Coordination/Communication	2(0.50)	16(2.67)	1(0.33)	2(1.00)	13(2.16)	3(0.75)	3(0.50)	0(0)	7	40	7.91
3.Roles/Responsibilities	0(0)	0(0)	0(0)	0(0)	4(0.67)	0(0)	4(0.67)	0(0)	2	8	1.34
4.Competing Priorities	3(0.75)	2(0.33)	0(0)	1(0.50)	6(1.00)	0(0)	11(1.83)	1(0.50)	6	24	4.91
5.External Factors	1(0.25)	18(3.00)	3(1.00)	6(3.00)	10(1.67)	4(1.00)	1(0.16)	0(0)	7	43	10.08
6.Attitudinal Factors	1(0.25)	11(1.83)	0(0)	2(1.00)	1(0.16	1(0.25)	9(1.50)	0(0)	6	25	5.99
7.Evaluation/Performance Management	0(0)	14(2.33)	0(0)	4(2.00)	3(0.50)	3(0.75)	18(3.00)	3(1.50)	6	45	8.58
8.Organizational Culture	1(0.25)	4(0.67)	0(0)	2(1.00)	1(0.16)	0(0)	3(0.50)	0(0)	5	11	2.58
9.Skills/Alignment of Skills	0(0)	8(1.33)	0(0)	4(2.00)	4(0.67)	2(0.50)	3(0.50)	4(2.00)	6	25	7
10. Strategic Plaining/Alignment of Goals	0(0)	3(0.50)	0(0)	7(3.50)	0(0)	1(0.25)	0(0)	3(1.50)	4	14	5.75
11. Budget/Resources	5(1.25)	19(3.16)	3(1.00)	3(1.50)	0(0)	10(2.50)	6(1.00)	13(6.50)	7	59	16.91
12. Involvement of Managers/Staff	4(1)	1(0.16)	0(0)	0(0)	2(0.33)	0(0)	5(0.83)	0(0)	5 [sic?]	12	2.32
Number of Months Reported for Each Priority	4	6	3	2	6	4	6	2		346 Total Mention of Barriers Found	


Barriers: Total Mean Mentions of Factor Per Montly Rept across Priority Areas
Factors
1.Timely Action
2.Coordination/Communication
3.Roles/Responsibilities
4.Competing Priorities
5.External Factors
6.Attitudinal Factors
7.Evaluation/Performance…
8.Organizational Culture
9.Skills/Alignment of Skills
10. Strategic Plaining/Alignment of…
11. Budget/Resources
12. Involvement of Managers/Staff
10.0
7.9
1.3
4.9
10.1
6.0
8.6
2.6
7.0
5.8
16.9
2.3
0.0
5.0
10.0
15.0
20.0

e. Statistical Analysis and Progress as measured by Action Steps (research question 1a)

Spearman's Rho analysis was used to compare progress of priority area steps to facilitators and then barriers. "Spearman's Rho measures the strength and direction of the relationship between two variables" when comparing four or more variables (Social Sciences Statistics, 2018). "The Spearman rank correlation test does not carry any assumptions about the distribution of the data and is the appropriate correlation analysis when the variables are measured on a scale that is at least ordinal" (Statistical Solutions, 2019).

Table VII (Work Completed Per Objective) documents the amount of work on Progress, Facilitators and Barriers for all eight priorities. The work (action steps taken) completed were comments made for facilitators, barriers and progress found in the priority area for each objective. Three of the areas could not be quantitatively studied. Two areas not studied were Obesity and Fiscal Stability which had insufficient data to conduct the statistical analysis. Access to Care was not studied due to the closing of the TLCHD clinic and also did not have sufficient data to run the analysis. Mean action steps per objective is to document work accomplished per objective. Progress was obtained by reviewing documented information on action steps completed in the monthly reports. Barriers and facilitators were also obtained from the monthly reports, reviewed, coded and then summed per priority area, objective, action steps and factor. Table VII shows that Opiates had the most work completed—the most progress. Obesity had the least amount of work completed. Note as stated earlier that Access to Care was discontinued as a viable priority area for the strategic plan due to clinic closure.

Table VII: Work Completed per Objective

Work Completed per Objective			
Priority/#Objectives	Progress (Measured by Action Steps Completed)	Mentions of Facilitators per Objective	Mentions of Barriers per Objective
Obesity			
Obj 1	19	20	18
Obj 2	0	0	0
Obj 3	0	0	0
Obj 4	0	0	0
Total across objectives	19	20	18
Mean per Objective	4.75	4.00	3.60
Access to Care			
Obj 1	2	2	0
Obj 2	12	10	7
Obj 3	2	0	0
Obj 4	1	0	2
Total across objectives	17	12	9
Mean Action Steps per Objective	4.25	3.00	2.25
Fiscal Stability			
Obj 1	3	9	11
Obj 2	7	19	12
Obj 3	4	8	8
Total across objectives	14	36	31
Mean Action Steps per Objective	4.66	12.00	10.33
Opiates			
Obj 1	8	16	22
Obj 2	15	28	13
Obj 3	16	31	38
Obj 4	24	53	36
Total across objectives	63	128	95
Mean per Objective	15.75	32	23.75
Healthy Homes			
Obj 1	7	6	10
Obj 2	3	3	3
Obj 3	8	9	12
Obj 4	1	4	2
Total across objectives	19	22	27
Mean per Objective	4.75	5.50	6.75

Work Completed per Objective			
Priority/#Objectives	Progress (Measured by Action Steps Completed)	Mentions of Facilitators per Objective	Mentions of Barriers per Objective
Infant Mortality			
Obj 1	4	6	17
Obj 2	5	8	10
Obj 3	3	2	1
Obj 4	3	1	4
Obj 5	15	17	32
Total across objectives	30	34	64
Mean per Objective	6.00	6.80	12.80
Health Promotion			
Obj 1	7	14	11
Obj 2	4	9	3
Obj 3	4	6	4
Obj 4	17	36	29
Total across objectives	32	65	47
Mean per Objective	8.00	16.25	11.75
Workforce Dev			
Obj 1	14	15	21
Obj 2	11	9	13
Obj 3	10	16	17
Obj 4	14	7	16
Obj 5	4	2	6
Total across objectives	53	49	73
Mean per Objective	10.60	9.80	14.60

Table VIII has the priority area, objectives, and progress per objectives, facilitators, and barriers. Next to the data is the results of the, p value, rho, t-statistic and Spearman Coefficient. The findings in Table VIII document five priorities. Of the other three priorities, Obesity and Fiscal Stability had insufficient data and Access to Care work stopped early in implementation to conduct quantitative analysis. The Spearman Coefficient analysis found that only two priorities, Opiates and Healthy Homes had any relationships between progress as measured in action steps

accomplished per objective and either facilitators or barriers, with p values that were statistically significant. Opiates (p= 0.0) shows a relationship between progress and facilitators, Healthy Homes showed a relationship between progress and barriers. No other priority areas had relationships between barriers or facilitators to action steps taken that were found to be statistically significant.

From the associations noted it appears that where high complexity was found (many actions steps per objectives) there seems to be some correlation of facilitators and barriers. These findings suggest the more work done the more correlation. The relationship of Opiates facilitators to action steps were found to be statistically significant as noted above. The finding could be due to the concept that the Opiate program is relatively successful. The success is due to the processes, discussions, partnerships and resources the priority area used, as noted in the Opiates priority action discussion group (see below). When the mentioned factors were enhanced (not barriers) there more work done. The relationship of the Healthy Homes barriers to action steps being statistically significant could be due to the issues of the lead ordinance lawsuit. As discussed, earlier the Toledo Lead Ordinance was put on hold while an appeal was made in the court system. The inability to move lead issues forward, despite action steps being taken, as noted in the Healthy Home Priority area discussion, may have been linked to the court case, and the corresponding barriers noted, as well as barriers related to Healthy Homes being a new program at TLCHD. As noted in the table, all other priority areas showed no statistical significance for association between progress and either barriers or facilitators noted.

Table VIII: Priority Area, Objectives, and Progress Per Objectives, Facilitators, and Barriers

	Progress/Objective #s	Facilitators	Barriers	Statistical Results Facilitators	Statistical Results Barriers
	Obesity	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data
	Fiscal Stability	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data
	Opiate			Spearman 1 rho 1 t-stat 82191237.01 p-value 0.001 Statistically significant association	Spearman 0.08 rho 0.8 t-stat 1.885618 p-value 0.2 No significant association
Obj 1	8	16	21		
Obj 2	15	28	13		
Obj 3	16	31	37		
Obj 4	24	53	36		
	Healthy Homes			Spearman. 0.8 rho 0.8 t-stat 1.885618083 p-value 0.2 No significant association	Spearman 1 rho 1 t-stat 67108864 p-value 2.22E-16 .p<0.001, Statistically significant Association
Obj 1	7	6	10		
Obj 2	3	3	3		
Obj 3	8	9	12		
Obj 4	1	4	2		
	Infant Mortality			Spearman 0.894427191 rho 0.894427191 t-stat 2.828427125	Spearman 0.894427 rho 0.894427 t-stat 2.828427

				p-value	0.105572809	p-value	0.105573
Obj 1	4	6	17				
Obj 2	5	8	10				
Obj 3	3	2	1				
Obj 4	3	1	4				
				p=0.1055 Not Statistically Significant		p=0.1055 Not Statistically Significant	
	Health Promotion			Spearman	0.995917141	Spearman	0.948683
				rho	0.948683298	rho	0.948683
				t-stat	4.242640687	t-stat	4.242641
				p-value	0.051316702	p-value	0.051317
Obj 1	7	14	11				
Obj 2	4	9	3				
Obj 3	4	6	4				
Obj 4	17	36	29				
				p=0.0513 Not Statistically Significant		p=0.0513 Not Statistically Significant	
	Workforce Dev			Spearman	0.948683298	Spearman	0.948683
				rho	0.20519567	rho	0.615587
				t-stat	0.36313652	t-stat	1.352963
				p-value	0.740581942	p-value	0.268998
Obj 1	14	15	21				
Obj 2	11	9	13				
Obj 3	10	16	17				
Obj 4	14	7	16				
Obj 5	4	2	6				
				p=0.74 Not Statistically Significant		p=0.26 Not Statistically Significant	

Lessons Learned

Research Question/s: 2. Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes, and how do they make them?

Monthly reports, submitted to TLCHD's Implementation Committee for review, conveyed that lessons were learned as noted in Table IX. "Lessons learned" are taken from the comments placed on the form under the Objective Outcomes section labeled on the report form, with the instruction "indicate what has been learned about the action step." All areas had at least one lesson learned. Opiates (53) had the most; this could be attributed to this area having the most amount of work (action steps) completed out of the eight areas. Infant Mortality (1) had the least. With infant mortality being a major issue within Lucas County this finding is unexpected. It could be due to the lack of documentation and reporting by those responsible for the area and lack of action steps addressed. Healthy Homes (7) is another unexpected finding. This area should have several lessons learned. Access to Care had eight lessons documented. This low number is attributed to the closure of the FQHC (clinic operations) and not having the ability to document lessons learned. Workforce Development (10), Obesity (14), Fiscal Stability (24), and Health Promotion (32) were noted from review of the monthly reports. It should be noted as with comparing progress to facilitators and barriers, a Spearman Rho analysis was conducted on progress to lessons learned. The only statistically significant priority found for association was obesity. The finding for obesity could be due to the limited number of objectives addressed. The possible reason for not finding an association between progress made and lessons learned could be the lack of noting lessons learned.

TABLE IX: Lessons Learned

Obesity	14
Opiates	53
Access to Care	8
Infant Mortality	1
Healthy Homes	7
Health Promotion	32
Workforce Development	10
Fiscal Stability	24

Some of the examples of statements made for lessons learned are: Workforce Development finding that running ads and promotions on the day of vaccinations works well. For Obesity, there needs to be "thinking outside of the box" when it comes to the incentives that the board will approve. This was for incentives for employees to use the departmental workout room. Another example of lessons learned was from Health Promotion. It was learned that there needs to be additional dialogue to promote the sharing of information on upcoming events. Utilizing the monthly reporting structure not only allows documentation of the lessons learned, but these lessons have been used to change the way the department does business. For example, when the lesson of sharing information was documented in Health Promotion, this caused the health commissioner to discuss with directors and supervisors the need to share information

about upcoming events. The discussion has produced more sharing of information by staff posting events on the website and social media.

All priority areas had at least one outcome noted. Outcomes are defined as if the objective action step has been met. Table X depicts the number of steps in the objectives that have been met or partially completed. Met or partially completed is when an action step was completed, or work was done to an extent although additional work would be needed to complete the step. An example is: for Health Promotion, an outcome is that a director will start to work on reaching out to staff regarding upcoming events and Opiates had several outcomes documented as ongoing, which means that work continues for that step or objective.

Table X: Number of Action Steps Met/Partially Met per Objective and Percentage

Priority Area	Number of Objectives	Number of Action Steps	Average Number of Actions Steps Met or Partially Completed	Percentage of Action Steps Met or Partially Completed
Obesity	4	25	4	16.00%
Opiates	4	13	8	61.50%
Access to Care	5	20	5	25.00%
Infant Mortality	4	21	2	10.50%
Healthy Homes	4	24	11	52.38%
Health Promotion	4	11	6	54.54
Workforce Development	5	25	15	60.00%

Fiscal Stability	3	13	6	46.00%

f. Results for Selected Four Priority Areas: Obesity, Opioids, Healthy Homes and Workforce Development: Review of Realized, Unrealized, and Emergent Objectives and Associated Action Steps (Strategies) and Member Checking of All Content Analysis Results

Following the quantitative content analysis of the facilitators and barriers in the June 2017-June 2018 monthly priority area reports, a qualitative content analysis was done to examine the realized, unrealized, and emergent objectives and action steps (strategies), following Mintzberg's approach to strategic planning and implementation discussed in Chapter 2. This analysis responded to research question 2, *Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes, and how do they make them?* After that analysis as well as the earlier content analysis on facilitators and barriers was completed (research question 1), facilitated discussion groups (FD for each of four selected priority areas (Obesity, Opiates, Healthy Homes, and Workforce Development; see chapter 3 for selection rationale) were used as member checking for the data gathered from the document review and content analysis of the June 2017-June 2018 monthly reports, asking managers and staff involved in each of those priority areas whether the findings on barriers, facilitators, and progress on objectives and action steps via work accomplished (or not), and the researcher's initial interpretation of this data, agreed with their own perceptions. Furthermore, the FDG's provided additional data on how the TCHLD managers and staff talked about their work, relevant to research question 2. Discussion and comments on the preliminary findings of this research became a participatory evaluation process (Patton 2008), with the FDG participants becoming enthusiastic about the chance to add their own voices to the leadership's discussion of the implementation of TCHLD's strategic plan. Reactions to the process, as well as the

opportunity to anonymously give further comments, were documented in a written evaluation form given to the FDG participants following the discussions, with results described in section g. below, pursuant to research question 3, *What do LHD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan*?. Furthermore, a demographic survey was given to the FDG participants prior to each FDG session, to document the aggregate characteristics of participants, including age, gender, employment years, and education level, and describe the "members" of TCHLD who were providing member-checking.

For ease in following the FDG comments on the preliminary findings for each of the priority areas, the preliminary findings are given below by priority area, followed by a summary of the comments from the FDGs, giving confirmation, disconfirmation, and extension of the researcher's preliminary findings. In the subsections below for each of the four priority areas selected for this deeper analysis and member-checking, the major barriers and facilitators from the preliminary quantitative content analysis (summarized above across all eight priority areas) are described for each priority area, as well as the number and content of "lessons learned," labeled "objectives met," from the monthly reports (that space in the report was used for comments on lessons learned). Furthermore, the data reported below per priority area also includes the preliminary findings from the review of the monthly reports, using qualitative content analysis, categorizing the implemented objectives and associated action steps according to Mintzberg's categories of realized, unrealized, and emergent. Following the description of all of these preliminary findings for each priority area, the reactions of the participants in the FDG for that priority area are described and their confirmation, disconfirmation or revision of those

findings is summarized by the questions posed to them (see appendix H for the questions posed to the FDGs, also used to organize the member-checking data).

Thus, monthly reports were reviewed for common and unique lessons learned as described by the priority areas studied, and the barriers and facilitating factors from the content analysis described specifically as extracted from each of the four selected priority areas.. The component of question 2 inquiring about changes in TCHLD work as a result of strategic plan implementation was answered through documenting work completed (or not), and categorized in terms of realized, unrealized, and emergent objectives, through the review of the monthly reports for each of the four selected priority areas plus the confirmation/disconfirmation/revision of those preliminary findings from the participants in the FDGs. Furthermore, documentation of the FDG discussions contributed to the component of question 2 addressing how TCHLD managers and staff changed the way they discussed their work.

Finally, after presenting preliminary findings from the content analyses of the monthly reports specific a given priority area, the researcher presented his initial recommendations based on those findings on how implementation of the strategic plan could be improved – recommendations for moving forward. These recommendations, per the specific priority area, were also presented to each of the four priority area FDGs and member-checked, with the participants adding their own revisions and extensions to the researcher's initial recommendations. For each priority area below, the initial findings of the researcher as presented to the discussion groups are described, followed by a description of the responses from the facilitated discussion groups, organized by the questions that were used to facilitate the discussion and organize the findings (confirmation, correction, extension of the researcher's initial findings) from those responses.

Following the four FDGs for the four selected priority areas, the researcher synthesized his preliminary finding, with the FDG participants' revisions from member-checking, including recommendations for future action, and presented this synthesis to the Implementation Committee for further member checking and correction. The Implementation Committee, as described in Chapter 1, includes the 1-3 Board members, all the (eight) priority area leads (champions), select front line staff members, and the staff coordinator responsible for strategic planning. The Board members on the Implementation Committee, as noted in Chapter 3, served as liaison to the Action Research stakeholder group that was the primary client for this study. The results from the Implementation Committee – the fifth FDG – will also be described below. The analysis of the recommendations, from the researcher's preliminary recommendations based on findings to the revisions of those recommendations in each of the priority area focus groups, to the reactions and revisions by the Implementation Committee, to the researcher's final synthesis, is summarized in Table XXIII (Appendix N).

Findings by Four Selected Priority Areas with Member-Checking Discussion from Facilitated Discussion Groups

The findings and FDG discussion reported by selected priority area (Obesity, Opiates, Healthy Homes, and Workforce Development) are given below, and cover responses to both research questions 1 and 2, below:

1. What are the facilitating factors and barriers to the LHD's strategic plan?
2. Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes, and how do they make them?

The demographic data on participants in the FDGs will be given first, to provide context helpful in interpreting the reactions given from those participants, and reflecting that FDG participants represented a range of the levels of experience and positions of staff and managers at TLCHD.

Five facilitated discussion group (FDG) sessions were conducted between December 3, 2019-December 18, 2019, averaging over 90 minutes per session. Four of the sessions covered the selected priority areas of the strategic plan, and, as noted above, one was held with the Implementation Committee. A total of 26 different, see Table XI, TLCHD staff participated in the sessions. The researcher, with leading group discussion experience, was the facilitator for each session. Prior to the session, each of the groups were given a demographic survey at the beginning of the session. The survey was administered to capture information such as education level, why they were involved with implementation, number of years employed by TLCHD and age of those participating in the discussion groups. Table XII provides the demographic information. At the end of the session, evaluation forms were distributed to enable the participants to give anonymous, written feedback on the process as well as the content of the discussions. That information is summarized in the final section of this chapter.

The TLCHD staff who participated in the quality improvement project were members of each selected priority group and the Implementation Committee. Each participant provided their unique views and a rich understanding of the implementation as a member of the priority area or committee. Table XI below describes the number of participants in each of the sessions.

TABLE XI: Facilitated Discussion Group Participants

Facilitated Discussion Group Session	Participants
Implementation Committee	6
Healthy Homes	9
Workforce Development	3
Obesity	4
Opiates	4
Total	26

Demographics of Facilitated Discussion Group (FDG) Sessions

The demographic breakdown is described in Table XII below. This data includes the four priority action area groups plus the Implementation committee. The gender of the participants were 10 males and 16 females. Of those, 25 participants were over the age of 28. Education levels of the participants found 25 with secondary education, and 12 of those having a master's degree. One individual was designated as having an associate degree. Work division participation was divided amongst the Division of Environmental Health (11), Health Promotion (7), Nursing Division (5) and Administration (3). There were three questions relating to the priority area discussions, not provided to the Implementation Discussion group as they were specific for priority areas only (n=20). For these question,(as noted in Table XII), on a scale of 1-10, with 1 being none and 10 being most, participants were asked to state their involvement with the priority and strategic plan. The first question was, "how much involvement have *you* had with the strategic plan other than the priority area we are discussing today?" For the 26 participants, the, the average response was 5.05, with 3 of those indicating they were a 1. For the second question, "how much involvement have *you* had with the strategic plan area we are discussing today?" The average was 6.45, with two stating they were not involved with the plan. The final question, "how much experience did *you* have with the priority area topic before working on the area?" the average was 6.85, with no participants selecting one or no experience. When asked why they were working on the priority area, eight stated they were a responsible party of the priority, five were interested in the priority, three were assigned, and one was other. There were three that selected more than one reason why they were on the priority area. For example, a supervisor could have been not only the responsible party for that priority area but

interested in working on the area and furthermore could have been told to (assigned) to work on the area.

TABLE XII: Demographics of Facilitated Discussion Groups

	Number of respondents to the corresponding question
Gender	
Male	10
Female	16
Age	25 were 28 years or older
Education	13 with at least a BS -12 With a Masters
Employment	18 participants had over 5 years of employment with 8 between 5-10 with 6 less than 5
Work Division	11 Environmental
	5 Nursing
	3 Administration
	7 Health Promotion
How much involvement have you had with the strategic plan other than the priority area we are discussing today?	Average 5.05
How much involvement have you had with the strategic plan area we are discussion today?	Average 6.45
How much experience did you have with the priority area topic before working on the area?	Average 6.85
Reason for working on the Priority	
Responsible Party	8
Interested Party	5
Assigned to area by leadership	3
Other	1
Chose multiple	3

Adhering to participant's confidentiality, the participants' responses are discussed such that they cannot be tied to any one individual within any session. In the discussion groups, the participants were asked to share not only views on barriers and facilitators but also lessons learned from implementation. Further, they were asked to state recommendations that should or could be done in future implementation processes. Finally, they were asked to comment on the FDG process used and if it was helpful or not helpful.

The Facilitated Discussion Group process and material was designed to obtain feedback and responses from those who worked on the priority groups and the Implementation Committee to the researcher's initial findings. From the point of view of case study guidelines for data collection and analysis, this process represented validation through member-checking. From the point of view of action research, the Facilitated Discussion Groups involved a larger swathe of TCHLD's staff and management than had previously been actively involved in strategic planning or assessing the implementation of strategic planning.

In addition to the findings from the quantitative content analysis of the barriers and facilitators for implementation of the strategic plan for each priority area (of the four chosen) the researcher presented to the Facilitated Discussion Groups a qualitative summary of the content of the lessons learned presented in the monthly reports, with his initial synthesis of factors contributing to the accomplishment of action steps or the lack thereof. Furthermore, before presentation to the discussion groups, a further step was taken in qualitative content analysis of the monthly reports: an analysis of realize, unrealized, and emergent objectives relative to the initial strategies in the strategic plan (as per Mintzberg's approach to strategic planning, discussed in Chapter 2).

The researcher, as part of documenting progress or lack thereof in each priority area and presenting his findings to the Facilitated Discussion Groups, described the factors influencing what was implemented from the strategic plan and what was not, and compared that to the initial assumptions, both implicit and explicit, embedded in the strategic plan, so that his findings regarding any changes in expected outcomes and changed needed in assumptions about how to proceed with implementation could be discussed and, if needed, corrected or revised by the

participants in the Facilitated Discussion groups. Exploration of assumptions, changes and other relevant outcomes came from the facilitated discussions group findings. Specifically, when asked the questions "Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes, and how do they make them?" Discussion was driven by the original documentation review on realized, unrealized and emergent strategies as seen in Tables XIII-XVI. Analysis consisted of looking for common themes, ideas or comments given by facilitated discussion group participants during the group sessions. Responses from this question of any changes or relevant findings was documented and analyzed. The findings were compiled and synthesized with other comments from this study to form recommendations. These recommendations can be found in Table XXII appendix N for the study. These discussions were also used as validation of the information presented. The information was taken from the monthly report and the check of accuracy and appropriateness was needed and given by participants. The following sections use excerpts and wording from the Toledo-Lucas County Strategic Plan (TLCHD, 2017).

i. Obesity

The Obesity priority was reported on four times, but only one of the four objectives was worked on. Reporting on only one objective could be a reason for the low number of facilitators (19) and barriers (16) documented. The leading facilitators in the Obesity priority are Involvement of Managers/Staff (9) and Roles/Responsibility (5). The only objective worked was creating healthier weight-related behaviors among TLCHD staff. Accomplishing steps associated with this objective requires involvement from all levels of staff in the department and specific staff roles and responsibilities need to be established. For instance, one step in the objective is for the Health Commissioner to support a department workout room. Additionally, a supervisor

developed the plan to implement health improvement for the staff before the creation of the strategic plan.

The barrier of Budget/Resources (4) and Involvement of Managers and Staff (4) were the highest number of barriers reported. Budget/Resources for creating a workout room required funding for equipment and renovation of a room. Further, the resource of a room to house the workout facility was needed.

Objective Overview

Table XXVIII below documents the realized, unrealized, and emergent strategies for each of the four objectives in the Obesity Priority. Appendix L provides additional insight into each objective and corresponding step. Review of objectives for the Obesity Priority is as follows.

For Objective 1: Healthier Weight-Related Behaviors among TLCHD Staff, (TLCHD, 2017) the thinking was that the creation of a workout room in the department would accomplish several aims. The first was that a readily accessible room would create an environment where staff would work out and keep a healthy weight. Further, if the department set up the process and system to create a workout room internally, the department would then assist other agencies with the development of a workout facility. Finally, Objective 1 needed to be close to completion to begin work on the other three objectives.

For Objective 2, Healthy Eating & Food Literacy, the goal was for the Action Steps to increase healthy eating habits and understanding of healthy versus unhealthy food choices (TLCHD, 2017). This aim would be accomplished by adding a full-time health educator to increase healthy eating habits. Further, to increase the availability of healthy foods, additional

healthy corner stores would be secured. Healthy corner stores are those that emphasize selling nutritious foods as opposed to unhealthy foods such as typical convenience store items.

For Objective 3, Work with Community Partners to Create Environments that Promote Increased Physical Activity (Worksite Wellness), TLCHD would work with partners to create an environment that promotes physical activity (TLCHD, 2017). The creation of the setting for physical activity was to be linked to the community improvement plan and other assessments that were contributing factors affecting lack of activity. This information would be reported to other organizations, so they could design their programs to increase physical activity.

Objective 4, TLCHD Coordinates Community on Obesity Issues, was created to coordinate the continuation of healthy stores (TLCHD, 2017). If TLCHD obtained additional funding, then, using those funds to develop new stores would allow for more healthy corner stores in Lucas County.

Objective Work Noted

Only Objective 1, Healthier Weight-related Behaviors Among TLCHD Staff, had work attempted and/or completed (TLCHD, 2017). No objectives were realized, but as Table XIII indicates, work was completed. A survey of staff was then completed.to ascertain how many employees had gym memberships. The survey and Objective 1 work would hopefully be used to gain support and implement sound weight and healthy eating practices. Much like Objective 3, there was no change in behaviors for healthier behaviors. No other work was realized, and no emergent strategies were found.

Table XIII: Realized, Unrealized, and Emergent Strategies for the Obesity Priority Objectives

Obesity
Comparison of Intended Strategy:
Objective 1
Realized
The Realized strategy for Objective 1 was that the survey was completed to find out how many staff participate in a gym membership. Membership rates for the employees at TLCHD was 50%. However, completion of the strategy did not result in any further action steps.
Unrealized
Objective 1 was to have healthier weight related behaviors of TLDHC Staff. It was also to be used as a pilot program and springboard to gain support and implement sound weight and healthy eating practices in the community. Neither step was realized. There was no guidance that TLCHD could provide for other agencies for a Healthy Weight Program as laid out in the strategic plan. Also, there was no real staff change in behavior for healthier weight behaviors.
Emergent
Not Seen
Objective 2
Realized
Not Seen
Unrealized
This was not Realized due to the objective steps not being worked on. The reason for this is due to objective one not being completed.
Emergent
Not Seen
Objective 3
Realized
Not Seen
Unrealized
This was not Realized due to the objective steps not being worked on. The reason for this is due to Objective 1 not being completed.
Emergent
Objective 4
Realized
Not Seen
Unrealized
We This was not Realized due to the objective steps not being worked on. The reason for this is due to Objective 1 not being completed.
Emergent
Not Seen

While work on the objective was being undertaken, the TLCHD fiscal position did not allow for such expenditures. Funding that may have been used for a workout room was needed to pay for contractual services within the department. Staff learned from the work completed that the steps were not as simple to complete as originally thought. For example, renovating a room for a workout facility stalled due to decisions on what type of equipment and what space to use within the department. Further, looking for incentives for staff to use the workout room is not straightforward. The idea that the board can authorize a monetary incentive may not be feasible. It is also not clear what other types of incentives may work. Staff realized that an "out of the box" solution to the incentive question will have to be employed. Further, discussion with staff by those responsible for the Obesity area found that many staff say they would participate in a workout program. However, as seen when a walking program is implemented by the TLCHD, not many participate. This can be further supported by a survey to see if staff would participate in a County Wellness program offered to all county employees.

The wellness program reimburses 50% of a gym membership when enrolled in the program. The survey results showed that only 17.24% of the respondents participate in the reimbursement program and only 50% of the employees belong to a gym. Reviewing the remaining objectives, armed with knowledge of workloads of staff and partnerships in the community, shows that these objectives are extremely difficult to fulfill. For example, developing an ordinance or policy for the entire county to adopt regarding Healthy Eating Goals is an enormous task for a county population of over 430,000. Creating a county-wide "ordinance" is being tried with the T-21 program to increase the age to purchase tobacco products from 18 to 21 years of age (TLCHD, 2017). It is meeting stiff resistance as of the writing of this dissertation. Obesity ordinances would most likely meet a similar fate. For

outcomes of work completed there were few documented. However, what was documented as an outcome was that surveys were completed, and steps continue to be worked on.

This priority area had a shift in thinking from the first day of implementation to the last day of documentation. Originally, from the discussions during the creation of the strategic plan, it was thought the many steps agreed upon could be implemented. Some of these, as mentioned already, are creating a workout facility within the department, developing and passing an ordinance county-wide for Healthy Eating Goals, developing a report prioritizing causative, contributing factors affecting lack of physical activity/obesity, and others as noted from TLCHD's implementation report (TLCHD, 2017). However, the current state of the priority area and its evaluation revealed a pattern shift in how to reach implementation. Pattern shifts resulting from the learning gained during evaluation dictates that a new approach or process is needed to reach a goal. For example, it is known that only one out of four objectives were worked on over the reporting period. The lack of work comes from several areas such as completing work on steps were not as easy as originally thought or "out of the box" thinking is needed to complete a step. Both stop or at least slow implementation. From discussions between myself and the coordinator it was noted that the amount of time to complete many of the steps should be lengthened. Further, there were too many steps for this priority area. The pattern shift from evaluation of this area is that the steps were either too complicated, too much work for staff, too many in number or too short of a timeframe to finish.

Discussions between myself and the coordinator resulted in bringing back the priority area to the committee to see if a readjustment of number of steps, types of steps, or complexity of work for completion of the steps is needed. One possible discussion point for the committee is several of the steps that have not been worked on require external partners. It may be prudent to

critically examine if some of the steps should be left untouched due to external partners being a facilitating factor for completion of the step. For example, the TLCHD is to form an alliance/coalition to develop county-wide worksite wellness programs and activities (TLCHD, 2017). The major step and work to complete this step is to form the committee and let them work to meet the step.

In general, work has been accomplished to implement a small portion of this priority area. However, due to the limited number of steps and objectives worked on, limited data exists on the monthly reports. With the lack of work and several of the objectives being perhaps too difficult to implement for various reasons, the area should be reviewed for possible restructuring of objectives and steps to implement the priority area. From the researcher's point of view, this priority area is low for production and completeness of attempted work. For example, time was mentioned as a barrier for employees to participate in county wellness program. What is the actual barrier? Was the barrier the time not allowed for staff to participate or is it when they could sign up for program or time to participate in a survey? More attention to detail and specifics in reporting will help with evaluation. Finally, with only one of four objectives worked on, there is a lack of production for this priority area.

Facilitated Discussion Group—lessons learned results

1. What have we learned from/about how to implement this priority?

The Obesity Priority area members discussed that there *"needs to be a more collaborative process with more staff (cross-section) of the department at the table."* They felt that the Obesity Priority Area involves all of the department and not just the small segment they had working on the priority. The group *"wished they would've known that they could re-write or re-tool the*

objectives." They did not know that they could change objectives to better match what was needed. They further felt that there *"needs to be a more formalized process to create and assign the work, priorities, and objectives."* The group was not involved from the start with the creation of the priority area and did not realize the formal process that was used to create the priority area. They felt that *"overall, they think the process has evolved the way that they need do implementation."*

2. Did things happen the way you thought they would, and if not, why not?

Participants stated, *"Overall this discussion today did get to what we needed, which was the evaluation of what we did through the facilitated discussion."* The group did not expect this type of evaluation session and was pleased with the process and outcome. The group had no idea what to expect regarding the implementation of the plan.

3. The question "Does this align with your own experience - why or why not? Can you give some examples to support your reflections?" provided several different comments but reflected similar answers to the barriers/facilitators and lessons learned.

> *"We've been meeting relatively monthly for quite a while now, but we need to formalize the work a little bit more. We've taken some steps to get there. We have had agendas sign-in sheets and things like that, but as far as the actual work involved and addressing priorities and things like that, we need to formalize more. Staff needs to be more engaged and educated on the process, for barriers/facilitators and lessons learned the findings to align with what they experience."*

4. Reflecting on the barriers and facilitators to implement the action steps from the strategic plan relevant to this priority area that we have just discussed, what are the most important things we have learned that we didn't know before? Were there any prior knowledge or assumptions you had before that you have come to question? Were there prior assumptions you had that were confirmed or strengthened? Please explain.

The group found that they *"need to have more staff involved"* in the implementation process. It was further discussed *"to have routine updates of what is taking place with implementation."* It was also found that that group did not know they could change objectives if needed, so they stated *"there needs to be the knowledge that the plan can be changed when needed."* Finally, there was a comment that we need to *"just to keep this evaluation process going."*

5. Has the implementation of the plan impacted everyday operations or thinking involved in your work in this health department? If it has what are some examples? If it has not, why?

The group commented that they *"think the group has evolved and that they did change."* What they evolved into was *"a very action-oriented group."* This impacts the department from the aspect that this group transformed from a non-action-oriented group to one that understands they are now working to complete tasks.

6. Considering what we have already said about the progress that has and hasn't been made, and about barriers and facilitators, and lessons learned about implementing this priority

area of our strategic plans, what are your recommendations about what this health department (TLCHD) should do to proceed with this priority area going forward?

The group stated that they would recommend that *"more staff [are] involved"* in the implementation process. Further, there needs to be a reporting process so that everyone in the department and in other priority groups can *" understand what everyone else is doing"* for implementation. Finally, the current monthly report is a bit *"clunky"* and needs to be revisited to make it more user-friendly.

ii. Opiates

During the development phase of the strategic plan, the original reason for the Opiate Epidemic/ Drug priority was to accomplish two issues through coalition-building and prevention processes. The first was to prevent the use of opiates and the second to decrease mortality due to opiate overdoes. The title of the priority area is Opiate Epidemic/Drugs.

Opiates was reported on seven times with 100% objectives and steps worked on. This area had the most facilitators (121) and barriers (99) documented of the eight priority areas. External Factors (29) and Coordination/Communication (23) were the two most noted.

The TLCHD has a very robust system for Opiate Reduction and Coordination in place. There are over 70 different agencies and 200 people coordinated by the TLCHD to respond to opiate issues in Lucas County. The work done is mainly by external partners and is likely why the External Factor facilitator was so prevalent. Another example of why External Factor was high is the needle exchange program established by the collaboration and supported by the mental health board and the University of Toledo's Ryan White Program. The Needle Exchange Program began in 2017 and was designed to attack several issues in the community. The fist was to have "clean" needles for opiate users. Clean needles potentially decrease the spread of

bloodborne diseases like HIV/AIDS and Hepatitis B. The program was also designed to offer, if the customers so choose, the assistance and resources to become drug free. Finally, the program could provide training and supply of Narcan to the Opiate-using community. Narcan is the reversal drug for opiate and opiate-like overdoses and can be administered by anyone through a nasal dissemination.

Coordination/Communication plays a role in Opiate priority implementation seen by the number of times the factor was noted. For example, when looking to increase sharing opiate use and other data with coalition members, Information-Sharing by agencies' partners was a contributing factor. Further, there is importance of Communication and Coordination with the number of partners who are involved is an important facilitator. The larger the group the harder communication and coordination could be. However, at TLCHD the Opiate Coalition has been a "uniter" for processes such as sharing data. Barriers of Budget and Resources (19) is not unexpected. To provide services for prevention, tracking, and response to the opiate issue requires both funding and resources. Funding comes from grants the TLCHD has been awarded. Resources, for example, are partners sharing what they can provide to combat the opiate issues. Without them it is hard to implement measures to decrease the opiate concern.

External Factors (16) was not only found as a facilitator but also a barrier which is not unexpected. With the great number of agencies and the work that needs to be done, there are external factors that hamper implementation. For example, not having timely data from hospitals. Information such as patient demographics, underlying conditions and even address. However, there are often legal issues which place a hold on sharing information. The hold is to make sure information being released does not violate confidentiality rules. The health department is not part of the hospital system and does not have automatic legal ability to obtain or share patient

information. Often information must be scrubbed of identifiable information before it can be sent to the TLCHD. Reducing time of hospitals to report to TLCHD is a concern that must be addressed for a quick response to opiate issues. Quicker response can mean saving lives and planning better to reduce opiate concerns in Lucas County.

Realized, Unrealized, Emergent

Table XIV documents the realized, unrealized, and emergent strategies for each objective for the Opiate Epidemic/Drugs Priority Area. The discussion of each of those objectives and conditions of the strategies is below. For additional insight into each objective appendix, L states the objective with the corresponding action steps.

For Objective 1, Establish Linkages to Mental Health & Recovery Services, the original thinking for the objective was twofold (TLCHD, 2017). First, the work was linked to grant deliverables, so it would assist in completing those objectives. This concept also applies to the other three objectives. The second objective was to solve the opiate issue through the involvement of the community partners. The opiate collation, with over 200 participants from over 70 different agencies and organizations, would be the venue to link those in need to resources and to discuss the ever-changing issues with opiate use. Further, data from hospitals and other sources was missing. The objective looked to collect and create a baseline of opiate-related problems. This data would allow for placing resources where they are most needed instead of a "shotgun" approach. Further, the data would assist in obtaining additional funding.

Objective 2, Reduce Opioid & Drug Abuse / Misuse, was going to be addressed primarily by implementing a syringe access program (TLCHD, 2017). The program exchanges used needles of drug users for new needles. The new process would accomplish two things: 1)Reduce

the spread of infectious diseases associated with needle use. With clean needles, there is a reduced chance of spreading illness linked to used needles. 2) where addicted people could receive help either stop using or prevent the use of opiates.

For Objective 3, TLCHD Coordinates Coalition Building, the objective was to increase the types of data collected and increase the sharing of that data (TLCHD, 2017).

Objective 4, Prevent Opioid Overdose Deaths, was designed to increase training on Naloxone, the antidote to opiate overdose (TLCHD, 2017). Further, increasing the number of Naloxone kits within Lucas County would increase the availability of the lifesaving treatment at the street level.

Objective Work Noted

Objective 1, Establish Linkages to Mental Health & Recovery Services, had some realization but was not completed. The work centered around being able to create outreach activities and building relationships. Unrealized work was mainly due to data collection difficulties and the use of data. There were no emergent strategies.

Objective 2, Reduce Opioid & Drug Abuse / Misuse, did realize work in establishing a syringe access program and educational material for the program was developed and distributed (TLCHD, 2017). Finally, a contract was secured with the local university to fund the syringe access program. There was an emergent strategy of realizing a need for an additional needle exchange clinic. Further, the way the objective was written, there could never be a realization of all steps due to having to enter into a yearly contract for the needle exchange program .

Objective 3, TLCHD Coordinates Coalition Building, did not have a strategy realized (TLCHD, 2017). The objective being unrealized is due to the same data as in Objective 2 as well

as the need for additional funding and staff to complete the community assessment for the needle exchange program. There was an emergent strategy of dealing with data. There needs to be an improved approach for data sharing of and the ability to analyze the obtained data.

Objective 4, Prevent Opioid Overdose Deaths, was not completed, but the planned step of Naloxone distribution Naloxone was completed (TLCHD, 2017). Also, staff were trained for Naloxone admiration. The unrealized strategies center around not completing the training for resource officers on the assessment. As noted, there is also a lack of staff and funding to conduct the training. Two other issues are not establishing the protocol for notifying agencies when there is an opiate issue in Lucas County and not understanding how to use the current data to identify an opiate crisis.

TABLE XIV: Realized, Unrealized, and Emergent strategies for the Opiate Priority Objectives

Opiates
Objective 1
Realized
The objective was not realized but several of the steps have been put into action. Establishment of relationships has grown stronger since the implementation of the strategic plan. This is mainly due to the TLCHD outreach activities, such as the needle exchange and Naloxone training, that has provided the opportunity for securing new relationships to combat the epidemic. These relationships come from the need to work with agencies that TLCHD did not before the needle exchange program and Naloxone training.
Unrealized
The collection of baseline data for overdoses from hospital systems and others has not been realized. This is due to the complexities of obtaining data such as collection or the collection of data by agencies is not uniform and there is a trust factor by some agencies when it comes to how the data will be used.
Emergent
Not Seen
Objective 2
Realized
The establishment and implementation of a syringe access program was completed. Also, the development of educational material and distribution of that material was realized. Further, the contract with the local university was finalized to secure funding for the needle exchange program.
Unrealized
Not seen
Emergent
The emergent strategy is that additional clinics are needed within Lucas County. It is known that the current clinic location and hours are barriers for some of the population that needs the services. All action steps are ongoing and can never be deemed completed. For example, before the current contract for needle exchange activities ends, a new contract must be in place for services to continue.
Objective 3
Realized
Not Seen
Unrealized
Assessing community needs for data and evaluating the effectiveness of the sharing of data has not been realized. The reason is that the community data needs assessment that has not been completed. The reasons it has not been completed are lack of funds, staff and time. TLCHD needs to find additional funding and designate staff and their time to complete the assessment.
Emergent
The sharing of data among opiate coalition members has started but there are concerns that must be addressed before complete implementation. First, data must become consistent on how and when it is shared. Secondly, TLCHD needs to create capacity for analyzing the data it currently has and receives from partners. Once this is completed a consistent and timely sharing of data can be put in place.
Objective 4
Realized
The objective has not been completed but the distribution of Naloxone kits to first responders, the public, and staff has been completed. Further, training of staff in administration of Naloxone has been completed.

Unrealized
The survey of the School Resource officers to assess gaps in training has not been completed. The main issues for completion are lack of staff to conduct the survey and funding for costs associated with the survey. Also, the establishment of critical indicator protocols for notifying the agencies when they are required to respond to an opiate issue is not completed. The main issue is how to use the current data to identify a crisis, so the proper agency can be notified.
Emergent
Not seen

Work also provided for lessons to be learned. For example, a greater amount of data collected would provide a better picture of opiate issues in Lucas County. Additional data includes the number of opiate overdose reversals due to Narcan, other than in a hospital setting. Specifically, what are the number of Narcan reversals done by friends, family, and other opiate users on a weekly basis? Another example of a lesson learned was the TLCHD staff are uniquely positioned within the community to recognize and respond to an opiate overdose. The TLCHD has several staff that can teach how to administer Narcan in a county where there is a lack of trainers. Further, with the TLCHD staff's interaction and partnerships with a great number of agencies and organizations within the county, it would be simple for the TLCHD to provide education on Narcan. Another lesson is that the public is interested not only in the Opiate Crisis, but in being part of the solution. An example of this is Naloxone training has been given at fourteen library-based programs in Lucas County and 164 Naloxone kits have been distributed to different agencies. This priority area did not shift much from the first day of implementation to the last day of documentation. The work done by the group adhered to the steps and did have successes. There has been no discussion by those working on the priority to adjust steps or objectives. They continue to work on all steps and objectives.

However, there are reasons why this priority area is so well worked on. Opiate use and the issues of overdose are a priority for many communities and especially Lucas County. This

would suggest that there is a willingness to work on this priority by not only the TLCHD, but all the community partners, in order to solve the crisis. The two co-champions of this priority area are extremely well versed in the subject, one being the Director of Nursing, with a background in Emergency Medicine and responses to disaster events. The other is the Assistant Director of Environmental Health who is responsible for data collection, epidemiology, and writing several grants for responding to opiate use. These two individuals are facilitating factors. This could be why there is a great deal of work completed for this area. Finally, many of the steps in the strategic plan and objectives were either being worked on at the time of the strategic plan creation or about to be worked on. Work already started prior to the implementation of the plan provides direction prior to implementation which allows more efficient and effective work over those areas with less or no prior work.

Discussion between myself and the coordinator resulted in continuing with this area as written but with input from the committee on changes as they see fit. What the coordinator has noted is that the report leads for this priority have done an overall great job fleshing out objectives, but the reporting of data has been less structured and serves as a barrier to gleaning meaning and trends over time. From this observation we will revisit the reporting form and provide additional training on how to properly fill out and provide information for monthly reports.

In general, from the researcher's perspective this priority area has been worked and reported on well. What is noted is this area has two highly skilled and well-versed staff working on the opiate topic. From my vantage point the reason why so much work has been accomplished on this priority is the skill level and background of the co-champions. Also, what has been observed is that many of the steps that have been worked on have external partners either

responsible for the completion of the step or external partners are linked to the step. External patterns, for this priority, has provided for work accomplished on the steps. Finally, I think one major lesson learned is each of the priorities can and should meet the reporting requirements of six a year.

Facilitated Discussion Group

1. What have we learned from/about how to implement this priority?

The group stated that there is a *"need for more people at the table to work on the priority."* Participants say that the group is too small for the work required but also that even though there may be staff assigned to the priority, only a select few do the work consistently. This group did not know that they could change or re-work objectives to be in line with outcomes needed. They stated that *"objectives need to be updated,"* but they did not know they could. Participants found that factors are important, but staff did not focus on the facilitators when they were working on objectives. It was stated that *"staff could do a better job of focusing on facilitators."* The last comment dealt with leadership and how leadership enhances or inhibits implementation. They stated that with *"management change-over, it has helped with employees being able to work on the plan implementation."* Before the management change, staff working on the priority area would only report out on work completed, and they never were given the ability or direction on the work they should do. Management did most of the work on the priority area.

2. Did things happen the way you thought they would, and if not, why not?

This group did not have any set assumptions. They did feel the discussion group allowed them to not only talk about issues and accomplishments but want more evaluation sessions as conducted for this research.

3. "Does this align with your own experience - why or why not? Can you give some examples to support your reflections?" provided several different comments that were similar to the comments when discussing barriers/facilitators and lessons learned.

The group stated that *"there is more work needed in addressing priorities and things that need to formalize more-such as training on the implementation, the process of evaluation, and what needs to be evaluated."* For *"barriers/facilitators and lessons learned the findings did align with what they experience."*

4. Reflecting on the barriers and facilitators to implement the action steps from the strategic plan relevant to this priority area that we have just discussed, what are the most important things we have learned that we didn't know before? Were there any prior knowledge or assumptions you had before that you have come to question? Were there prior assumptions you had that were confirmed or strengthened? Please explain.

The group discussed that there *"needs to be better defining of barriers and facilitators to help them increase their ability to identify what they are."* Participants stated there *"need to more meetings like this one and communication of what is happening with implementation."* More meetings and communication were further supported by the *"need to have routine updates on the status of the plan and outcomes associated with the work completed."* It was also found that *"one person (past leadership) decided what to report on and requested info from staff on that specific thing. There was no other opportunity for input by staff."* This limited the staff from being as

involved as they should. The last comment concerned receiving input from staff either on a monthly report or in a discussion group. The group discussed, *"if you want to have input, you must establish a structure to receive it, and that measurement of objectives need to set before any plan is finalized."* The group statements go to the need to have a set process that is on a prescribed timeframe to evaluate implementation. and that measurements must be in place before the implementation process begins. In actuality, the measurement should be decided on during the creation of the strategic plan.

5. Has the implementation of the plan impacted everyday operations or thinking involved in your work in this health department? If it has what are some examples? If it has not, why?

The process of implementation has impacted the department and staff through the change in management. The group stated *that "management change-over has helped, and that the new management is listening to staff more"* with implementation. What was said was that *"since they did not get good direction from their leadership, they had to implement the objectives through their ideas."* This last comment showed a negative impact before the change in management of the department. Staff wasted time and was inefficient since they had little to no direction on implementation.

6. Considering what we have already said about the progress that has and hasn't been made, and about barriers and facilitators, and lessons learned about implementing this priority area of our strategic plans, what are your recommendations about what this health department (TLCHD) should do to proceed with this priority area going forward?

Recommendations from the Facilitated Discussion Group for Opiates were that the department needs to *"bring more people to the table,"* and that group must be *"team-oriented"* to

implement the plan. Also, the group commented on the *"need to meet and evaluate the plan more often."* From meeting more often, it satisfies, as the group discussed, *"the need to have more opportunities to give input."* Finally, the group recommends that TLCHD create additional *"reporting of results and progress of implementation."* What the department needs to find a way to allow, as the group talked about, is the *"understanding [of] what everyone else is doing"* with their portion of implementation.

iii. Healthy Homes

Document Review

The creation of the Healthy Homes Priority area was for two reasons. The first was that Environmental Staff felt they were being looked over for strategic planning and participation in driving the future of the department. In the past, the Environmental Division was considered a secondary priority to the clinical work done by the department. Environmental Staff felt this sublimation of their work was continuing. The second reason was due to the concerns of the staff but, more importantly, the issue of ensuring a safe and healthy environment for Lucas County.

Healthy Homes was reported on four times with 20 out of 22 steps and three out of four objectives worked on. Of the facilitators (22) the two most documented factors were Budget/Resources (7) and External Factors (4). Healthy Homes is a strategic priority that is a newer program. Much of the work requires discussions with external partners and reliance on them to aid with work on the steps. Without them, much of the work could not be completed. Opiates, Health Promotion, and Healthy Homes all have External Factor as a facilitator. Budget/Resources is a facilitator due to the additional monies TLCHD obtained from the city for the lead program. There are also several agencies that provide resources such as education that TLCHD utilizes.

Barriers (22) with high point values were Budget/Resources and External Factors (4). Much like External Factor being a facilitator, they are also barriers for Healthy Homes. For example, when you rely on outside partners as this area does, it can cause barriers to implementation when they do not deliver needed data or work. For Budget/Resources as a barrier, the examples are a need to determine cost for programs and the uncertain departmental budget for 2018. These hamper the implementation of the plan and can be a reason for the value of this factor.

Realized, Unrealized, Emergent

Table XV below documents the realized, unrealized, and emergent strategies for each of Healthy Homes' four objectives. Each of the objectives is summarized below for achievements of any realized objectives. For additional insight into each objective appendix, K states the objective with the corresponding action steps.

Objective Overview

For Objective 1, Promote & Drive the Lead Safe Housing Initiative, the strategy was developed for the City of Toledo's Lead Ordinance and explains why TLCHD wanted to promote the initiative (TLCHD, 2017). The aim of the ordinance was to decrease childhood lead poisoning through a property maintenance program of cleaning, painting, and repair of rental properties. These activities contribute to reducing lead poisoning of children. Several of the steps were developed from "scratch," such as the lead clearance technician course and educational materials specific for the ordinance — each of these steps would be simultaneously implemented. Appendix L provides additional insight into each objective and corresponding step

Objective 2, Expand Nuisance Abatement Efforts, was created to expand efforts to improve public health issues such as rodent issues, poor upkeep of property, and environmental issues such as livestock/urban agricultural issues, to name a few (TLCHD, 2017). It was originally thought that if staff were added to address the nuisance issues, it would build a stronger program by having the ability to address all complaints quickly.

Objective 3, Collaborate with Community Partners to Mitigate, Prevent, or Resolve Environmental Issues, was created to assess the environmental problems in the community and use that data to influence the legislature to assist with programs to solve environmental health issues within Lucas County (TLCHD, 2017).

Objective 4, Explore Implementation of the Green & Healthy Homes Initiative, was developed to explore the implementation of Green and Healthy Homes, a national program that uses inspections, education, and remediation to break the cycle of unhealthy homes that cause unhealthy conditions within homes (TLCHD, 2017). Originally the idea of this objective was to create the foundation for a permanent program at TLCHD

Objective Work Noted

Objective 1, Promote & Drive the Lead Safe Housing Initiative, had realized (as some steps worked on), unrealized, and emergent strategies. "The emergent strategy was after learning of the lead ordinance, on hold due to the court system determining it was unconstitutional; the department developed a voluntary lead program." This program was to fill the void left by the city ordinance on hold (TLCHD, 2017).

Objective 2, Expand Nuisance Abatement Efforts, did not see any objectives or corresponding steps addressed. Further, there was no reflection on developing alternate strategies (TLCHD, 2017).

Objective 3, Collaborate with Community Partners to Mitigate, Prevent, or Resolve Environmental Issues, did have some work completed, but no objectives fully realized. There were no emergent strategies (TLCHD, 2017).

Objective 4, Explore Implementation of the Green & Healthy Homes Initiative, an initiative to improve the housing conditions, did have work completed, but the objective was not realized (TLCHD, 2017). The department did begin taking part in the Green and Healthy Homes Collaborative, but as noted, the role of the department was unrealized. The emergent strategy was "from the resulting lawsuit, TLCHD has created a voluntary program for all properties (rental and owner-occupied) wishing to be inspected for lead issues. Furthermore, the program looks to assess other environmental hazards, such as mold within the dwelling. Assessment is through the New Healthy Homes Program." The strategy emerged due to attempting to create a synergy of the voluntary lead program while working to be more involved with the Green and Healthy Homes initiative.

TABLE XV: Realized, Unrealized, and Emergent Strategies for Healthy Homes' Objectives

Healthy Homes
Comparison of Intended Strategy to Strategy Reflected in Implementation
Objective 1
Realized
The objective was not realized, but one step was completed. TLCHD held lead ordinance training at 9 different sites.
Unrealized
The other steps were not realized. Educational materials have been developed, but the material was not displayed at locations where they were needed. Work continues to find and secure locations to display the material. The remainder of the steps have been stopped due to the lawsuit suspending the implementation of the City's Lead Ordinance and will only restart, in the current form, if the appeal is won by the city.
Emergent
The emergent strategy, with the stoppage of work on the ordinance, is focus on the development of the department's own Healthy Homes Program with lead safe housing (city ordinance) as the foundation. This is taking many parts of the ordinance and implementing them through a voluntary process. Work has started on the voluntary program but there has been only slight interest in the program at the time of document review.
Objective 2
Realized
Not seen.
Unrealized
The concept of hiring of part-time legal aid and a generalist to expedite nuisance complaints is not feasible due to funding constraints. Additionally, funding for the generalist was not secured through restructuring which will be occurring outside the timeframe of document review.
Emergent
Not seen.
Objective 3
Realized
The objective was not realized but two of the steps were completed. Step 4, to develop a database of community partners was realized. Step 5 to develop a stakeholder list was also completed.
Unrealized
The remaining steps were not completed, such as Step 3 which sought funding to conduct Healthy Town Hall Meetings, or Step 3b, which looked to develop Healthy Town Hall Meetings. It is unknown why these steps were not be completed. Additional information is needed.
Emergent
Not seen.
Objective 4
Realized
The objective was not realized but the department is a part of the Green and Healthy Homes Collaborate and has participated in the initial kickoff event.
Unrealized
The TLCHD is still working on its role for the Green and Healthy Home Initiative. Work continues with stakeholders to determine that role.

Emergent
From the resulting lawsuit TLCHD has created a voluntary program for all properties (rental and owner occupied) wishing to be inspected for lead issues. Furthermore, the program looks to assess other environmental hazards such as mold within the dwelling. This will be done through the New Healthy Homes Program.

Lessons Learned include the complexity of the budgeting process and available funds. Further, there are parents unaware of the facts about lead poisoning and the need to have their children screened. Not all groups come with the same agenda regarding lead poisoning. The area appears to have a balance between facilitators and barriers. This could be due to the newness of the topic and the iterative process of implementing a new program. With work just beginning, it would seem plausible that there would be a similar number of barriers and facilitators. The balance could also be due to not all steps and objectives being worked on. The number of steps worked on could be due to court action on the lead ordinance. TLCHD and the City of Toledo created a city-wide ordinance to reduce lead poisoning in children through preventive maintenance of rental properties. This preventive maintenance would include making sure there is no peeling paint, lead dust is not present in the home, and that other areas where children can be poisoned are painted or encapsulated. The ordinance was enacted and being adhered to until a lawsuit to stop the lead ordinance was filled and eventually was won by the plaintiffs (Landlords). With the lawsuit won by the landlords the ordinance and all activity associated with the ordinance was stopped until an appeal can be won.

Discussions with the coordinator brought to light that some action steps are too large or outside TLCHD's capacity to impact through our efforts. Also, the legal injunction, for the city lead ordinance, stopped progress of the lead-related action steps.

From the analyst's perspective with a comprehensive background in environmental health issues, the steps and objectives can be implemented. However, they can only be implemented if there is a considerable amount of work on the steps and external partners assistance to complete the steps. As for the steps that deal with lead and the city ordinance, these will have to be reworked or put on hold until the appeal is completed. The change in thinking for this area comes from the issue of legal issues of the city's lead ordinance. It was never considered that the ordinance would be put on hold due to a lawsuit. Now the implementation team must revisit these steps and either adjust them, delete them, or place them on hold until the final verdict of the lawsuit. One of the observations during the implementation process was that the Environmental Director and his staff have assigned meetings to work on and monitor this priority area.

Facilitated Discussion Group Findings

1. What have we learned from/about how to implement this priority?

The Healthy Homes Priority Area felt "*there needs to be a mix of other staff for this priority."* The group discussed and was adamant that additional staff are needed to assist in completing the objectives. This group also found early on that they needed to change the original objective and action steps in the objective. This group found that they could change strategies, *"emergent strategies were found to be used with the discarding of original objectives then creating new objectives."* This group needed to revamp the original objectives due to the lack of alignment of those objectives with current state of environmental health at that time. The group discussed that from the process used, they *"have a better understanding of what the group should be looking at to evaluate and report back on."* Finally, the group felt that *"there should be more evaluations done, and the evaluation was productive."* The group realized that the process used to discuss implementation was not only different from what they have done in the past but that it

was productive. The other aspect of the finding was that this group wants not only to continue evaluations but have additional evaluations.

2. Did things happen the way you thought they would, and if not, why not?

The process of implementation was not apparent to the group. However, from the completion of the facilitated discussion, the process became clearer. The group felt that the sessions were needed and a good use of time. They initially thought that the session was not going to be productive. As for the implementation process, they did not have set thoughts on how it was supposed to go or not go.

3. The question "Does this align with your own experience - why or why not? Can you give some examples to support your reflections?" provided several different comments and were similar to comments when discussing barriers/facilitators and lessons learned.

There was an alignment with their experience as a priority area but not overall strategic planning. Staff needs more education on the strategic plan and its implementation. It was found by the group's comments that staff, when they hear strategic planning, *"gloss over"* and do not engage, and there is a need for barriers/facilitators and lessons learned from the findings to align with what they experience.

4. Reflecting on the barriers and facilitators to implementing the action steps from the strategic plan relevant to this priority area that we have just discussed, what are the most important things we have learned that we didn't know before? Were there any prior knowledge or assumptions you had before that you have come to question? Were there prior assumptions you had that were confirmed or strengthened? Please explain.

The group commented on the factor of Roles/Responsibilities. They felt maybe the staff didn't understand all the roles. They weren't defined. Discussion found there needs to be training on identifying the factors. Another comment made was, *"management needs to be excited to engage staff and get buy-in from staff and employees. There must be buy-in to the plan and implementation."* This concept was discussed as requiring that leadership do a better job at promoting not only describing what strategic plan implementation is to the staff. Also, the administration must act and speak not to diminish or degrade the idea of implementation of the process of implementation. The group felt that there are not enough staff convinced that implementation is essential. Leadership must change that. One way to change that impression from staff is that there *"needs to be more/better communication so that all staff understand their role and other roles."* Leadership must not only talk about implementation positively but they must frame the conversation to employees so they know what they should be doing and what they are accountable to do. The group feels that there is a *"need to have routine updates on the status of the plan and outcomes associated with the work completed"* for all staff. This will not only promote the implementation process to staff, but staff will know that there is work being done. The last comment was on the group's changing of objectives from the original objectives to the current objectives. The group discussed liking that *"they had an original strategic plan but had the freedom to evaluate and change it to meet the needs."* The ability to change the plan created a sense of ownership since they had a hand in creating the work they were to do.

5. Has the implementation of the plan impacted everyday operations or thinking involved in your work in this health department? If it has, what are some examples? If it has not, why?

The group discussed if the work they did impacted the health department. The answers were mixed. Some of the group stated that the work did impact the department as noted by *"yes,*

the work allowed us to identify issues and keep moving forward." Another comment was, *"we need staff buy-in and need to address the barriers of Healthy Homes implementation."* This comment indicates that the plan impacts the department by not having enough staff involved in implementation and that there is a process that hinders the department to move forward as quickly as it should. Two negative comments noted showed that at least some participants did not think implementation impacts the department. The first is *"no, PHAB did more."* This comment may be accurate but could lend to the fact that leadership has not done enough to promote implementation. The other comment links to the last comment in that *"no, results weren't communicated."* Since there was not adequate communication of the work on implementation, there is little understanding by staff of the impact the plan has on the department.

6. Considering what we have already said about the progress that has and hasn't been made, and about barriers and facilitators, and lessons learned about implementing this priority area of our strategic plans, what are your recommendations about what this health department (TLCHD) should do to proceed with this priority area going forward?

The group felt that it is vital to improving the next implementation cycle. For this, the group discussed to *"have general Environmental Health strategic objectives that involve all groups."* The discussion found the participants felt that it was important to have other staff from each division at the table when the Environmental Health objectives are created and implemented. There is the feeling that there is enough cross-work from other programs, even if they are not strictly environmental, that those employees could enhance the environmental portion of the plan. For example, Shots for Tots is the department's immunization program. They see thousands of families who could have environmental issues in their homes. Shots for Tots

could be the gateway to help those families with environmental issues in their homes. Another comment for future cycles, was that the committee *"needs to report findings out"* of the implementation work. The staff does need to know the status of the implementation so they can play a part in the implementation. The group wants to *"meet more (if the meetings are productive) and allow more time for reflection on the plan."* The group feels that the process used for this research was productive and they want to tell their stories and allow for others to have knowledge and input into what they are doing:

> *"Review of the implementation work was helpful to explain how/why it all works supports the preceding concept. It shows employees why this is important and also the progress. It also empowers them to be part of the process."*

The group thinks it may be a good idea for the next cycle of implementation to *"track barriers/facilitators for the overall program as well as objective-specific."* The group would like a method to use the barriers and facilitators to evaluate the entire implementation process. The final comment found that some participants felt that the implementation was a *"slow process, and the original monthly report document was difficult to understand."* The recommendation for this is that the monthly report, even though it has been changed and may be easier to use, needs to be re-examined and made more user-friendly.

iv. Workforce Development

The decision to create a Workforce Development priority area was to not only improve the Human Resource process within the department but also create a more robust Workforce Development program. Both concepts are to improve the hiring and retention of employees. Workforce Development was reported for six months with all objectives and steps worked on. The two highest-ranked barriers (69) were Evaluation/Performance Management (18),

Competing Priories (10), and Timely Action (10). Workforce Development has been a work in progress for several years at TLCHD. In the past, staff and management have had difficulties with adhering to systems that evaluate current processes or performance at the department. This seems to continue to be the case. Documentation in the monthly reports found that there is inconsistent evaluation for trainings provided and no central location or set standards for evaluations. For example, there has been no established standard evaluation form for trainings and presentations. When and if evaluations are completed, they will not provide consistent and uniform data without a standardized form. Competing priorities seems to be a plausible barrier for Workforce Development. Workforce Development has not been a priority for the department as has Infant Mortality, Opiates, or even Healthy Homes. One reason is that Workforce Development does not generate revenue as do other priority areas. Work on revenue-generating tasks and programs takes precedence over Workforce Development, which is the competing factor. Another example is the development of the workforce development plan. The workforce plan guides the department in how, what, when, where and why TLCHD staff should be trained. The Strategic Plan Coordinator is also responsible for the development for the plan. Due to PHAB and other tasks worked on by the coordinator the resulting time constraints have not allowed the plan to be finalized. Further, the department has been attempting to become accredited, has closed its clinics, and has had to lay off over 30 individuals. Further, time constraints have hindered the ability for staff to complete steps, for policy development, and to properly onboard new employees. Time issues could be from the reduced staff numbers or inefficiencies in the way the department does business. They could also be from staff/managers not valuing workforce development or performance management.

The highest documented facilitators were Evaluation/Performance Management (11) and Involvement of Staff/Managers (11). Involvement of Staff/Managers is noted as a facilitator, which is understandable. Over the last two years, TLCHD Administration has been supporting involvement of staff and managers for strategic plan implementation, budgeting, and other aspects of operations at the department. Involvement of Staff/Managers is demonstrated by the supervisors being openly interested in receiving training and standard guidance for managing their subordinates. Also, due to understanding the importance of Workforce Development and the PHAB Accreditation, requirements for workforce development administration fully supports this priority area. Evaluation/Performance Management is another facilitator which is plausible as a high factor relative to this priority. The department has placed emphasis on performance management and evaluation, both due to PHAB and the need to have measurable outcomes for grants. For example, staff and supervisors are eager to utilize an evaluation process that provides meaningful feedback and accurately captures performance. Further, the department has recently submitted for grants that require data that workforce development can provide.

Realized, Unrealized, Emergent

Table XVI Realized, Unrealized, and Emergent Strategies for Workforce Development. The area uses five objectives to create and ensure sound hiring and retention of employees at TLCHD.

Objective Overview

Objective 1, Increase Workforce Training Opportunities at all Levels, was created to develop and implement training sessions and processes for all levels of employees (TLCHD, 2017). Those trained would include new hires to those almost ready to retire and union and

nonunion staff. Further, it was necessary for the new hire interviewing process to be revised. Relative to hiring, the onboarding process of new employees was required to be updated and implemented by all employees. The onboarding process is essential because new employees only have a first impression of the department once. The sound onboarding process makes the first impression the best it can be. Appendix L provides additional insight into each objective and corresponding step.

Objective 2, develop "Safe Feedback" system/process for staff, was developed to create morale surveys, evaluations, and suggestion boxes for staff to have a safe feedback process (TLCHD, 2017).

Objective 3, Staff Performance Effectively Managed, was created to train leadership on effective management strategies and develop a supervisor's handbook for uniform practices for managing employees (TLCHD, 2017). Further, it was decided that evaluations of the manager's use of uniform practices was needed to successfully implement a performance management system. Finally, it was thought that an employee handbook should be produced so that all employees would have access to agency policies and procedures. All these activities focused on accomplishing one thing: to improve employee performance.

Objective 4, Develop and Implement an Agency Workforce Development Plan, was created to ensure that a workforce development plan is not only developed but measured and evaluated (TLCHD, 2017).

Objective 5, Workforce Maintains & Acquires Necessary Skills for Job Excellence, was to created to ensure that employees track of continuing education units (TLCHD, 2017). It would not only document the training the employees obtained but also what trainings or certification

each employee is required to have. With the size and scope of the department, there are numerous employee certifications that are different depending on the unit they work in and what they operationally accomplish. By having a system in place that automatically tracks and sends reminders to staff and management about when and what trainings are needed, it saves time and effort. Most importantly, leadership can better set a training plan in place for a full year. The goals was for this plan to be customized for each employee.

Objective Work Noted

No objectives were fully realized, but some work was completed. Objective 1, Increase Workforce Training Opportunities at all Levels, realized work of being consistent in hiring and onboarding new employees at TLCHD. Other work completed was standardizing the interview process for new hires (TLCHD, 2017). Further, training provided to new staff was determined to be mental health, first aid, and Bridges out of Poverty. There was no other work noted or emergent strategies.

Objective 2 ,Develop "Safe Feedback" system/process for staff, was to work on creating and sending out an employee satisfaction survey, but the data was not analyzed. A priority was making sure the satisfaction survey is analyzed for the department. There were no emergent strategies (TLCHD, 2017).

Objective 3, Staff Performance Effectively Managed, had no work completed and no emergent strategies. It is not known why, even though Performance Management was a priority for leadership (TLCHD, 2017).

Objective 4, Develop and Implement an agency Workforce Development Plan, had no findings for realized, unrealized, or emergent strategies (TLCHD, 2017).

Objective 5, Workforce Maintains & Acquires Necessary Skills for Job Excellence, had no realized or emergent strategies. However, their reason found for not realizing this objective was it was not a current priority of the organization (TLCHD, 2017).

TABLE XVI: Realized, Unrealized, and Emergent Strategies for Workforce Development

Workforce Development
Comparison of Intended Strategy to Strategy Reflected in Implementation
Objective 1
Realized
The objective was not completed. However, several steps were worked on such as being consistent, through a set procedure, with hiring and on-boarding processes. On-boarding is training new employees about not only their specific position duties but how operations are done within the department. Other steps included revising the interview process to be more standard and provide several different trainings to staff such as mental health, first aid, and Bridges out of Poverty. The thought was to start treating hires as the future and not just new employees.
Unrealized
Not Seen
Emergent
Objective 2
Realized
There has been a survey produced and responses obtained. However, the data has not been analyzed. The staff feedback is still being looked at through an electronic means and not paper feedback forms. However, this objective continues to be viewed as a priority for the department. Staff feedback is extremely important.
Emergent
Not Seen
Objective 3
Realized
Not Seen
Unrealized
Nothing has been worked on for this objective. It is unknown why there has been a lack of work on this section. It originally was extremely important to not only leaders but also staff. More data is needed to determine the status of why work was not completed.
Emergent
Not Seen
Objective 4
Realized
This objective has been realized.
Unrealized
Emergent
Objective 5
Realized
Not Seen
Unrealized

This objective has had no progress. The main reason for no progress is that this is not a current priority within the organization.
Emergent
Not Seen

Several lessons learned were noted. One lesson was the need to refocus the satisfaction survey to develop and understand baseline data. Another lesson is the area is being worked on by all divisions and has been driven by PHAB Accreditation. Much of the work being done on this area was in a planning cycle for years but has only recently seen significant work completed due to the implementation of plan. For example, the Employee Handbook is almost complete, but has been a project since 2004. Another reason for work done on this area is that the champion is also the PHAB and Strategic Plan Coordinator. Being the coordinator for both PHAB and the Strategic Plan is his work function and is why he is employed. This creates a solid link from not only being the subject matter expert but also being more efficient and effective during implementation. This results in a greater amount of work accomplished than over an area such as Obesity or Access to Care.

Overall the pattern shift from implementation to the day of documentation is that more emphasis needs to be placed on this priority, not only to complete the strategic plan, but for the success of the department. If staff are highly trained to do their jobs it results in more effective and efficient public health.

From discussion with the coordinator several points have been noted. There is no dedicated staff to drive workforce development and the staff who work on the priority do not have enough time to devote to Workforce Development. As stated earlier, Workforce

Development is a lower priority for the coordinator. Finally, both position descriptions and evaluations are not updated or completed regularly.

From an analyst's perspective the priority area has done well with addressing steps. Prior to the strategic plan implementation there was almost no movement on workforce development. The former Human Resources Director either did not know how to move Workforce Development forward or did not want to. However, the newly hired Human Resources Director does understand Workforce Development and is moving projects forward. I believe that since this priority area was being worked on and planned for priority to implementation it has allowed for greater success. Also, with the champion of the priority area being responsible for the daily work, it allows for increased work done in the area. This is similar to the areas of Opiates and Health Promotion where a good deal of work has been done.

Facilitated Discussion Group

1. What have we learned from/about how to implement this priority?

The group felt that there needs to be *"more people to work on the priority area."* This group felt that there was not enough emphasis put on working on this priority. The group discussed that *"more evaluation of the implementation material is needed."* There needs to be additional meetings like the one the group participated in. The group agreed with the lessons learned but said that *"it was probably the correct thought at the time, but since the research, it has not turned out that way."*

2. Did things happen the way you thought they would, and if not, why not?

The group did not have any idea how the implementation would take place. However, from the implementation of the last strategic plan, the group knew it would be different. The past

strategic plan implementation was more like long-term planning than what the current plan was like. The current plan has a more strategic aspect to it with some long-term planning. The group commented that the evaluation done today was needed and needed to continue.

3. The question "Does this align with your own experience - why or why not? Can you give some examples to support your reflections?" provided several different comments that were similar to the discussion of barriers/facilitators and lessons learned.

"The lessons learned, barriers, and facilitators do align with experience. However, the process is much like every meeting I go to, I find something new that I was supposed to do that I didn't know about." The implementation has similar issues.

The group talked about the Roles/Responsibilities factor. They stated, *"[the] workforce plan didn't have defined roles or responsibilities for implementation (no clear coordinator/mover),"* which was an issue. The group discussed a *"need to share information about the work on the plan with staff and other priority groups."* Do to the fact that the lead for this area is the Coordinator for Strategic Planning this group has knowledge the plan can be changed and is supported by the group there is "the knowledge that the plan can be changed when needed."

4. Reflecting on the barriers and facilitators to implementing the action steps from the strategic plan relevant to this priority area that we have just discussed, what are the most important things we have learned that we didn't know before? Were there any prior knowledge or assumptions you had before that you have come to question? Were there prior assumptions you had that were confirmed or strengthened? Please explain.

There was not response. 5. Has the implementation of the plan impacted everyday operations or thinking involved in your work in this health department? If it has, what are some examples? If it has not, why?

The group stated *that "Yes, it has, in reinforcing what work needed completion for multiple fronts such as implementation and evaluation of the strategic plan."* The group also stated that it had impacted the department because *"implementing the plan has started to forecast how we can implement the next plan."*

6. Considering what we have already said about the progress that has and hasn't been made, and about barriers and facilitators, and lessons learned about implementing this priority area of our strategic plans, what are your recommendations about what this health department (TLCHD) should do to proceed with this priority area going forward?

The main recommendations from this group is that there should not be a stand alone Workforce Development Priority area and that the strategic plan must be broadened to make it more of a diverse plan and not be so specific. For example if there is an environment priority area that area should not just deal with a healthy home but more of a healthy entire environment. This then can allow for other divisional personnel to be involved to solve other problems related to the environment such as access to nutritional foods which would be addressed by the Division of Health Services.

Implementation Committee Facilitated Discussion Group

Research Question/s:

1. What are the facilitating factors and barriers to the LHD's strategic plan?

2. Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes, and how do they make them?

3. What do LHD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan?

The implementation committee met on December 17, 2019, to discuss nine questions regarding their views on the material presented to them. The material consisted of a PowerPoint of the four priority area discussion groups' findings. The presentation was provided to potential participants ahead of time. The outcomes for the questions posed are as follows:

Question/Answers Implementation Committee

1. Do you agree with the findings? Why/why not?

The response from the participants was that that they *"agree,"* and one participant stated, *"the one concept that comes out of their group decision was that he thought he was in tune with his staff and listening to them but from the discussion, [it was] not as well as he thought."* Another comment from the committee was, *"the difference of opinions that came out of it was fantastic and I was amazed about the great discussion and information."*

2. What are your thoughts on what was concluded from the priority area discussion groups?

From the discussion, it was found that *"next time the evaluation will be useful because now they know what info is being asked for."* If the current evaluation process is kept then it would provide a better understanding of what material and discussion is needed. The committee

commented that there should be *"expectations tied to whoever is working on the plan."* The group was suggesting that those assigned to work on the priority areas are held accountable for the work. One issue that was discussed was that *"there was no uniform way to measure things in the objectives."* The clarification from the group was that the measurement process and needs *"should be defined during the Strategic Plan development."* The last comment was that one participant stated they *"didn't see the benefit of the report at the time but do now that we had this discussion."* This is linked to the previous comment about creating the measurement of the work during strategic plan creation. Staff should know ahead of time how their work will be evaluated.

3. Can you provide and additional recommendations?

The committee did not have any additional recommendations

4. What did you learn from the implementation of the four priority groups?

One comment regarding the communication of the process noted *"needing to communicate the importance of the process to staff."* This is not just communication about the findings from an evaluation but just the strategic planning process in general.

5. Do you agree in relation to your experience or do you have additions or revisions?

One interesting comment from a participant was, *"I just kept throwing darts at the wall. Nobody told me I wasn't supposed to do that. I was throwing darts and should have been playing ping pong."* The participant was describing that he was somewhat being methodical in doing strategic plan but not as exact as he should have been. He now knows that implementation cannot just hope to get results but getting the results that are needed to understand what is complete and how that affects public health.

6. What have we learned from/about how to implement the strategic plan?

The comments from this questions were, *"this plan I think was a good initial structure to come off what we've done in the past or what we haven't done in the past, but in a lot of places we drilled down super far and I heard from different staff that some of that drill down was an issue."* This indicated that staff did not understand what was being asked of them. The next comment, *"so it was just difficult in that how do we measure this? I think that needs to be a part of the next strategic plan. If there is an objective and an activity with it, we need to say, okay, this is how we are going to measure."* Finally, *"all of us agreed that with everything going on and PHAB and all that, meaning priority, strategic planning, and goals took a backseat at times".*

7. Did things happen the way you thought they would, and if not, why not?

No comments were made by the committee.

8. Overall, does it align with your own experience and observations that the following four barrier factors show up as the most frequent relative to work accomplished for the entire strategic plan? Why or why not? Please give examples to support your response.

Comments on this question noted the factor of Timely Action. The committee stated that *"sometimes how we do action could be due to over work."* The group felt that they were too busy doing other work, either daily operations or PHAB, that kept them from doing implementation. The other discussion point was External Factors. Comments and ideas included *"we were impeded by the lead lawsuit," "we have great external partners who help,"* and often, *"we*

depend on others to do the work." The committee discussed Evaluation and Performance management in this way:

> *"We had a way to capture progress but not an explanation or a rationale for why we were capturing it that way versus another way or how it would be used to further what we were doing. So, I don't think that understanding and that explanation of its purpose was as clear as it could have been".*

The comment focused on monthly reporting, and staff did understand why the process was used over another method or one that we may already use for tracking another program. The most telling and simplifying comment and was on Budget/ Resources. The comment was, *"I mean budget resources, that's a gimme that doesn't need to be talked about that much."* The comment really states that, without funding, completing steps and objectives is a barrier.

9. Overall does it align with your own experience and observations that the following 4 facilitating factors show up as the most frequent relative to work accomplished for the entire strategic plan? Why or why not? Please give examples to support your response.

The responses to this question dealt with the factor of Coordination/ Communication. The participants stated that this is a facilitator, ie *"we have good partnerships"* both internally and externally, that create an environment that supports this factor. The next facilitator was Budget/Resources. They stated that the facilitating aspect of this factor is *that "we have a lot of in-kind resources."* In-kind resources are employees' time, supplies, or information (data) we can provide to grants or outside partners. TLCHD may not have monetary resources they can bring to an issue, but they have substantial in-kind support.

g. Evaluation of the Process

As noted above (and in Chapter 3), at the end of the five group discussions (the four priority action FDGs plus the Implementation Committee) an evaluation survey was provided for participants to express their feelings and ideas about future evaluation sessions, how the facilitator conducted the sessions and any additional comment the participants in the discussion group sessions had about both process and content. This was in response to research question 3: What do TCHLD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan?

Three questions were posed: Q1 Do you think this type of discussion is useful for future evaluations? Why? Q2 What do you think of this type of facilitation? Q3 What changes would you make to the facilitation process? Findings of responses to these questions can be found in Appendix O: Evaluation Findings Table XXIV. Two of the most interesting findings were 1) the respondents stated that they felt that the conversations during the group discussion were "open and honest" and 2) that they felt the process needs to continue. Participants' perception that the process was open and honest is relevant to the issue of bias. One bias issue of this study dealt with the researcher being the supervisor of participants. The comments of the discussion was open and honest (from an anonymous evaluation) by seven individuals or 26% of respondents lends credence to the interpretation that the participants were not impeded in responding honestly to the questions by the presence of their supervisor as facilitator. Further, beyond what was specifically reported in the written evaluations, other comments heard by the researcher, the coordinator, and other staff indicated that participants appreciated the opportunity to voice their opinions and that the researcher (their supervisor) is good at facilitating dialogue of staff. This is also supported by the revisions and corrections to the preliminary findings that the

participants in these discussions gave. The groups were not silent or withholding in giving their opinions, even when they differed from those of their supervisor. The supervisor was not surprised at the open discussion and dialogue during the group discussions. The below table XVII describes the responses from the evaluation. The responses contribute to how implementation and evaluation of implementation will be completed in the future and that leaders and staff do learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan. Three questions were used to explore the ideas and feelings pertaining to the evaluation process conducted.

Question 1

Do you think this type of discussion is useful for future evaluations? Why?

It was found that 24 of the 26 participants stated that *yes,* they felt the discussion is useful for future evaluations. There were zero, *no* responses and several responders stated the discussion was open and honest and that it was helpful to understand the process. Discussion and feedback were mentioned in several ways. For example: *"the discussion allows us to know where we were at in the process when we responded, and the improvements made since the responses were given."* Another was that all facets were discussed and staff was engaged, sharing feedback, and administration was listening. Another comment was that the *"discussion fosters feedback that is not likely to be collected anywhere else and encourages reflection in real-time."* Other comments that support the process were, *"it helps us refocus our efforts to achieve better results"* and "it helped dial down the barriers and re-instill the importance of the objectives." It is leadership's belief that by doing the evaluation as designed and the Health Commissioner completing the facilitation, there is now a desire by staff to conduct further and improved evaluations of not only the strategic plan but also other programs in the department.

Question 2

What do you think of this type of facilitation?

The second question about the desire and possibility of using a similar type of evaluation practice found one comment was that *"I liked it,"* other comments talked about it as an "*open communication and discussion pertaining to the implementation work*." "*The discussion also provided clear objectives speaking to specific goals, actions, and evaluations."* Further, this "*type of open and consistent communication with staff at every level lets staff knows the WHY of implementation."* Another comment that was very supportive was, the process was *"thought-provoking and informative."* Additionally, another comment was that "*for the first time being involved in a strategic plan, I found this process to be enlightening." "It helped to show the benefits of strategic planning."*. From the leadership perspective these comments are not usually associated with this type of work at TLCHD. It suggests that the department staff is beginning to see the importance of this type of process.

Question 3

What changes would you make to the facilitation process?

The question provided insight into how the process needs to be changed and supported to be even better. Administration needs to provide support, follow up and reporting of actions found to staff after meetings. One comment stated that "*evaluations should occur closer in time to the specific period being evaluated."* Further, ensure that staff and supervisors have access to appropriate reference materials (reports from period, etc.) either before or during evaluation as *"with so many processes there is the need to make sure the communication crystal clear: What the goals are, where we desire to go, and why"* was one comment made by a participant. Also, if

"*the communication is such that there is clear direction, and information on how to implement the plan it should not create as many barriers.* One comment that should resonate with any leader is that "*meetings should be kept at one hour and quarterly since everyone has different demands on their time and staff will not resist attending."* If we can keep meetings "*to a short period of time on a quarterly basis it we would be more effective."* Participants also stated that, "*evaluations should be done more often, yearly or every six months."*. In addition, staff "*need to be more involved with the priority areas and communication is important."* Finally, *"this evaluation should be used moving forward and* at least one participant is" *"looking forward to the next plan."*

In general, the findings support several conclusions. The first is that the evaluation process used is not only useful but must continue with select changes to improve it. Staff expressed the desire to evaluate and measure not only the strategic plan work but also other programs in the department.

TABLE XVII: Evaluation Responses

Note: responses to questions are reported separately, the rows do not reflect individual responses.

Q1 Do you think this type of discussion is useful for future evaluations? Why? Yes-24 No-0	**Q2 What do you think of this type of facilitation?**	**Q3 What changes would you make to the facilitation process?**
Open and Honest-Multiple	Important to meet	Need administration support and follow-up
helpful to understand the process-Multiple	like it	action report following meeting
explains getting to goals	open communication	more people involved
get input from a wide range of people	encouraged open discussion and buy in	make aware of subject before meeting

it helps us refocus our efforts to achieve better results.	open discussion	provide the SP and details before the meeting
understanding the evaluation process will undoubtedly make the next step in the process easier for those involved.	effective/culture shift/connection/collective (team)	more staff need to be involved
helped dial down the barriers and re-instill the importance of the objectives	good for gathering input	Eric needs to be the facilitator
it helps clarify what and why we are doing strategic planning.	good to hear other opinions	do more often
It fosters feedback that is not likely to be collected anywhere else and encourages reflection in real-time	helpful, needed more often	do this as an entire department
as long as the purpose and process is clearly understood will speak to all staff at every level, the direction that the department is going, what each individual will need to contribute in order to meet agreed upon objectives.	able to give input, structured	provide the plan before the meeting
however, always open to other types. Staff overall has a much better understanding of evaluations and the importance.	gets everyone thinking, good to hear what others are thinking	stick to time limit, more staff involved
all facets were discussed & staff was engaged and sharing sharing feedback and admin was listening	meeting was productive	need more diverse staff
as long as the purpose and process is clearly understood.	easy to share and be open	rotate staff for different perspective
will speak to all staff at every level, the direction that the	good to have diverse group	would've been nice to see examples tied to the instances to have a better understanding of where the responses come from, I lacked a frame of reference
department is going, what everyone will need to contribute in order to meet agreed upon objectives.	helps to understand	no answer

understanding the evaluation process will undoubtedly make the next step in the process easier for those involved	open dialogue	have it occur closer in time to the specific period being evaluated, make sure staff/supervisors have access to appropriate reference materials (reports from period, etc.) either before or during evaluation
however, always open to other types. Staff overall has a much	Clear objectives speaking to specific goals, actions, and evaluations. Open and consistent communication with staff at every level. Staff must know the WHY	Make sure the communication is crystal clear: What the goals are, where we desire to go, and why. Once the communication is stated clearly, the direction, and how to implement should not create as many barriers. Meetings should be kept at one hour and quarterly. Everyone has different demands on their time and staff will not resist attending if we can keep to a short period of time on a quarterly basis.
better understanding of evaluations and the importance.	It encourages discussion and staff are able to really see the big picture.	Better preparation for the evaluation and when developing the objectives keep the evaluation piece in mind. Also, how we can measure the various outcomes.
it helps us refocus our efforts to achieve better results.	For the first time being involved in a strategic plan, I found this process to be enlightening. It helped to show the benefits of an SP.	Evaluations should be done more often, yearly or every 6 months.
it helps clarify what and why we are doing strategic planning.	It works, but it takes time to understand how the process works.	I tend to get summative fatigue in meetings like this. With so many objectives to cover, I found myself losing focus for those discussed at the end.
	It is thought-provoking and informative.	Rotate staff in each area to decrease burn out and increase different ideas and buy-in from all.
		Staff needs to be more involved with the priority areas and communication is important. Evaluation should be used moving forward.

		Communicate our successes.
		Looking forward to the next plan.

Summary

In the previous work much has been discussed and reported on of the findings for the barriers/facilitators, lessons learned, and the usefulness of evaluating the implementation of a strategic plan. The method used to study TLCHD's process, staff and completed work has provided both a deep understanding of the process used by TLCHD while providing factual data to address the developed research questions. Leaders in local public health should find value in the reported findings to create the environment for a smoother and more effective implementation of their strategic plan and the tools to change the way their staff think and do their jobs. In the next Chapter, Chapter V, benefits from the findings for leadership in other departments will be discussed.. Further, the discussion will recommend how the processes and findings used in this research may be used to benefit public health.

V. Discussion

The strategic planning process and implementation are essential to any organization, including local health departments. Bryson is correct when he states the plan is the "roadmap" to shape and guide the action and purpose of an organization (Bryson, 2004). Further, that plan provides stakeholders with a clear picture of the future of the department, how it will obtain that future position or vision, the methods by which it will succeed, and the measures to indicate progress and success (NACCHO, 2012). These words ring true and can improve the delivery of public health when strategic plans are implemented. The downfall of a plan comes when the plan is not implemented; the only successful plan is one that is implemented (Poister, 2005). Lack of implementation can come from a variety of different factors within a health department or from external factors that influence the success of the plan. It is crucial and imperative that local public health understands these variables as well as how their plan can improve the delivery of public health within their jurisdiction. This dissertation explored some of the potential variables and usefulness of understanding what was accomplished by implementing a strategic plan.

To explore and frame the importance of an implemented strategic plan, the facilitators and barriers to implementation, and how evaluation of implementation can affect a department's implementation of a strategic plan, the remaining chapter is organized as follows: The general discussion will entail an overview on results. This section is followed by a revised conceptual framework and the discussion of research findings. Finally, the chapter will conclude with a discussion on limitations and leadership implications.

a. General Discussion

In today's public health, there is little understanding of what factors suppress or enhance implementation. One reason is the limited to nonexistent literature of strategic plan

implementation at the local health department level. Another is the dearth of information on what an evaluated implementation can achieve for a department. An action research case study of barriers and facilitators to strategic plan implementation and how implementation influences a local health department was the base method to gain a detailed understanding of the phenomenon of strategic plan implementation. This qualitative research method provided a more significant examination and understanding of corresponding elements found in the literature (*a priori* factors) and possible new (emergent) factors. Further, this study documented if an evaluation process to implementation could be useful to other like departments. The use of the action research case study was instrumental in answering research questions to gain the knowledge described in this chapter.

Action research is a sound approach for the research and researcher (Baum et al., 2006). Furthermore, it has an identified problem, orderly collection of data, reflection, analysis, action from findings and redefinition of the problem. This method allows pursuing ideas, which increases knowledge for improving strategic plan implementation while the researcher is a participant in the process (Kemmis & McTaggart, 1988). The benefit of using this type of method for this study is multi-faceted. First, the researcher, who is also the Health Commissioner, was a part of the implementation process as a researcher while implementation was taking place and was part of solutions to everyday problems associated with implementation.

Further, the ability to create feedback loops with employees was vital to both understanding the problems and positives of the implementation phenomenon. It also was a check and balance to reported findings through the discussion groups employed. As a Health Commissioner who views research at the local health department level both as a necessity to document and obtain feedback in a peer review manner while also using that research as a

marketing tool to showcase work, action research is an excellent way to satisfy both needs. From the dissertation research work, action research was a process that allowed the collection of data, provided an avenue to make changes to processes while collecting data, and a way to capture the work done at the local health department level. All without sacrificing time to adjust poor operations, take personnel out of the data collection, facilitation, or evaluation of the process and still have a robust and rich data set that can have meaningful results as with this study. Most importantly, it allows staff to provide their feedback in a non-threating manner.

Five facilitated discussion groups with a total of 27 Toledo-Lucas County Staff and Board Member were presented the findings of the department's monthly implementation reports. Four of the five groups were specific to priority areas in the strategic plan while the last was the four priority groups studied. The fifth discussion group was the Implementation Committee for TLCHD's implementation of its strategic plan. In addition, four of the remaining priority areas' barriers and facilitators were presented to the Implementation Committee. Questions used were slightly different from the priority groups to the Implementation Committee, as noted in Appendix I. The questions asked were developed so as not to elicit a yes/no response but gather rich information through open discussion. These open-ended questions looked to evoke feelings, ideas, concurrence, divergence, and emergent ideas of facilitators' barriers, lessons learned, and overall evaluation of/for implementation.

The results of group discussions are themes that came out of this research. They address the overall research question linked to the barrier and facilitating factors associated with implementation. The analysis was interesting as it not only examined the ability to document impeding or impelling factors but also defined the type of factors. Further, the themes and concepts found from the discussions also address the two additional questions; the first dealing

with whether leaders and staff make changes in their work or talk as the implementation of the plan occurs. The major themes offer insight into identifying how leaders and staff change the way they do business and how they view evaluation in identifying those changes, which addresses the second question regarding how leaders and staff learn from the evaluation.

Facilitated Discussion Groups and document review supported findings in the literature of business management and other disciplines on factors involved in strategic plan implementation. No unforeseen facilitators and barriers to implementation, not already seen from the literature, emerged from the analysis of this data. However, through the analysis of monthly reports as well as the feedback on the initial analysis from the facilitated discussion groups, this research documented the presence and relevance of the barriers and facilitators to implementation of strategic planning found in the interdisciplinary literature to local health departments. Further, how lessons learned influence changes in thinking and/or operations has identified specifically how local health departments employees can change and evolve their practice through participating in strategic plan implementation; this is important to demonstrate the usefulness and value of strategic plan implementation. Also, describing the process of documenting changes and what has not changed, using the framework provided by the objectives and actions steps with a strategic plan, and discussing this as an organization as a process of evaluation and monitoring adds to the collective knowledge of how departments can view and use evaluation and monitoring to document and support improvement in their practice. Specific findings from this research, including barriers and facilitators, lessons learned, and evaluation results for TLCHD, are documented in appendices A and O, and were discussed in the previous chapter.

b. Revised conceptual framework

The original conceptual framework for this research has only one revision and one yet-to-be-determined long-term outcome. The revision is the utilization of recommendations from the Board of Health proposed findings. This was not needed due to the inability of the board to provide a critique or recommendation due to a lack of exposure to the implementation of the findings. The yet-to-be-determined long-term outcome is improved population health. This study could not determine if there was a positive, neutral, or negative impact on the overall community's health. Otherwise, the process and theory of change depicted in the concept map, Figure 5 in Chapter II, is still a good fit for the results of this study.

c. Discussion of Research Findings

A primary focus of this dissertation research was to find factors (facilitators/ barriers) that influence the implementation of a strategic plan and then document those for others to understand. It was presumed that if those barriers were decreased and facilitators increased, a plan would be successful, fewer resources used, and the plan would be implemented more quickly. In the overarching sense, this still holds true. However, it became evident that just knowing these factors was not enough to accomplish the aims mentioned. To that extent, it was found that the secondary aspects of this study, to understand if implementation of a strategic plan does change thinking and/or operations and whether evaluation of the plan allows learning by those guided by the plan, play an essential role in understanding those factors that impel or impede a plan and whether the plan itself is successful for the department and community. To have prior knowledge when reviewing the material below, all findings from the discussion groups were vetted and validated during the implementation committee group discussion. The four selected priority areas, Obesity, Opiates, Healthy Homes, and Workforce Development had attendance at the implementation committee session where their comments and concerns voiced

during their session was presented. The conclusions presented here are based on the initial findings from the researcher revised and amended through the facilitated discussion groups (The four priority area groups plus the Implementation Committee).

Findings

Question: 1. What are the facilitating factors and barriers to the LHD's strategic plan?

i. Facilitators/Barriers

The methods and process used did find both facilitators and barriers to LHD's strategic plan implementation. In reviewing the list of barriers and facilitators to implementation of strategic planning, twelve different documented factors were found in the literature that could be both defined and documented through the methods of this research. The three top-ranked facilitators(based on the mentions across priority areas adjusted by the number of monthly reports) were Involvement of Staff and Managers, External Factors, and Coordination and Communication(See Table V). The next closest factor were Skills/Alignment of Skills an Budget/Resources. All were noted and discussed by staff as facilitators. When compared to the literature, External Factors was noted to be found to be of higher importance. The level of importance given in the literature, is here measured through the number of authors that mentioned those barriers or facilitators. Figure 7 describes the rank of the factors and the number of authors that mentioned the factor as cited in Chapter II. External Factors was not mentioned by any of the authors cited as a facilitator. However, it was an important facilitator for TLCHD. It is possible this facilitator was found at a higher frequency by TLCHD, but a low number of authors cited in the literature, due to the extensive need of outside factors to implement TLCHD's action steps. For example, external factors were stakeholder's input and fiscal resources to run the needle exchange program (Opiate Priority) and the City of Toledo was the

gatekeeper to enforcing the lead program (Healthy Homes) which required TLCHD to work with the city closely. Other citied work may not have mentioned external factors as a facilitator due to the type of implementation work in those disciplines. This may be a difference between local public health department work and the work of the for-profit and nonprofit organizations described in the business literature.

It should be noted that External Factors was ranked high both as a barrier and facilitator. It is no surprise external factors was both a facilitator and barrier due to the fact that TLCHD's implementation involved many outside stakeholders and process which either influenced or impeded implementation of many action steps. Budget and Resources, External Factors, and Timely Action were the top three barriers (Table VI). Budget and Resources and External Factors were more highly ranked in the monthly reports than in the (business) literature on implementation, which again makes sense considering the constraints of local health department work. Evaluation, Coordination/Communication and skills/Alignment of Skills were the next most cited barriers (per monthly report) and are also well represented in the literature reviewed. One interesting factor (Roles/Responsibilities) was noted by seven different sources but was only ranked low in the TCHLD findings. Discussion of it did come up in the FDGs, however, e.g. there *"needs to be more/better communication so that all staff understands their role and other roles,"* and staff felt maybe *"the staff did not understand all the roles. They were not defined."* A more accurate understanding of this factor by staff may increase the mentioning of this factor in the monthly reports. The monthly reports, when analyzed with content analysis, provided the ability to compile facilitators/barriers, but it was found that the face to face discussion and comments in the FDGs provided a deeper understanding and definition of the factors found, supporting the effectiveness of a face-to-face, participatory evaluation approach.

Figure 7 Ranked Factors vs Authors Cited			
Rank of Facilitator	Facilitator	Authors	Number of Authors
1	Involvement of Managers/Staff (17.3)	P.C. Nutt, 1987 Mittenthal, R. 2002 Danmus & Wooten, 2002 Blatstein, I. M., 2012	4
2	External Factors (11.5)	None	0
3	Coordination and Communication (10.1)	Mittenthal, R., 2002 Blatstein, I. M., 2012	2
Rank of Barrier	Factor	Authors Cited	Number of Authors
1	Budget/Resources (16.9)	Nazemi & Asadi, 2015 Mendenhall, 2013	2
2	External Factors (10.1)	Nazemi & Asadi, 2015 O'Regan & Ghobadian, 2007	2
3	Timely Action (10.0)	Al-Ghamdi, 1998 O'Regan & Ghobadian, 2007 Mendenhall, 2013 Bryson, 2011 Henry County, 2017	5
4	Evaluation and Performance Management (8.6)	Nazemi & Asadi, 2015 Latif et al., 2013 Henry County, 2017	3
5	Coordination/Communication (7.9)	Al-Ghamdi, 1998 Nazemi & Asadi, 2015 O'Regan & Ghobadian, 2007 Heide et al., 2002 Henry County, 2017	5

The use of the reporting process and methods can be reproduced at any other local health department with a few adjustments to the monthly reporting form, as noted by at least one staff

member when they indicated the reporting form was a little *"clunky"* and needed to be adjusted some. It is also reasonable to suggest that using the same process could find additional barriers and facilitators not discovered by this work.

2. Do leaders and staff make changes in their work and the way they talk about their work as they implement the plan? What are these changes, and how do they make them?

iii. Lessons Learned

From the findings of this study, the process used can and does document that leaders and staff do make changes in their work and the way they talk about public health from implementing the plan. When presented with the lessons learned, from the monthly reports, all participants agreed that they were appropriate and in line with their understanding. Participants did state that by implementing the plan, it allowed them to forecast how to implement the next plan. An emergent concept was the *"challenge is completing the day-to-day work while still concentrating on the process implementation."* For most participants in the group discussion, they did have some discussion that they did talk differently and change business practices due to implementation, but they did not really understand the concept of how it changed the way they worked or talked. The issue is that reflecting on how implementation changes the way business is done or thought about is not done except at the time of evaluation. It would be necessary, for future implementation efforts, for staff to have a better understanding on how and how often to reflect on lessons learned. This reflection needs to be frequent between formal evaluations, rather than solely during evaluation. Further, a more formal method of capturing those changes to operations or thinking by staff is needed. One interesting comment by a participant and affirmed by another in the Healthy Homes Priority Area was they felt *"PHAB accreditation work did more to change the way they do their job or talk about public health"* than did strategic plan implementation. PHAB seems to have impeded strategic plan implementation for TLCHD.

While PHAB accreditation requires the development and implementation of a strategic plan, and therefore strategic plan implementation is part of the PHAB accreditation process, it does not necessarily feel that way to our LHD managers and staff. The documents PHAB measures require for accreditation review was sometimes seen as detracting from the business of actually implementing the action steps outlined in the strategic plan, as evidenced by such comments as *"more time and effort was put into PHAB Accreditation than strategic plan implementation"* and another participant stated that they *"got more (learned more) out of PHAB then strategic planning."* The statement that drives the competing factor and a reason why more implementation was not done was *"staff's priority was PHAB and not strategic planning."*

So while from the perspective of leading a LHD, PHAB review could be seen as a facilitator pushing the process, in order to meet PHAB requirement for accreditation, strategic planning implementation, and bringing more reflective thinking and strategy to the daily actions of a LHD, from the perspective of those filling out the required forms and paperwork it was sometimes seen more as a distractor from the actual business of implementing the strategic plan. If the PHAB measure of an implemented strategic plan was not satisfied during the initial PHAB review, more attention would have been paid to the plan's implementation. However, since this was already a delivered measure and other measures still needed to be submitted, an opportunity cost was observed where PHAB accreditation rather than implementation was the priority.

Moving forward, more explicit connection between the bureaucratic requirements of PHAB review and the reflective questions those requirements should inspire, e.g. "What objectives and action steps in our strategic plan were actually implemented? Why or why not?" as was beginning to be opened in the facilitated discussion groups discussed in Chapter IV, can be helpful in mediating this tension.

As for the methods used in this study to satisfy TLCHD's or any other departments reaccreditation needs for strategic plan implementation, it definitely serve as a guide. The deliverables for PHAB reaccreditation can be found in Table XXII appendix M. Table XXII also explains how the methods and process used for this study can help satisfy reaccreditation measures. For example, the guidance for reaccreditation for 1c is "a description of the process for reassessing and revising department priorities" (NACHHO, 2016). This element could be satisfied if the department used the conceptional framework implementation concept map from this study. Each guidance point for PHAB reaccreditation is provided a corresponding "solution" to address that guidance point as noted in Table XXII.

iv. Realized/Unrealized/Emergent

Overall, the most important and prominent aspect to understanding and improving TLCHD's strategic plan implementation was categorizing the objective and steps as realized, unrealized and emergent and then discussing the implementation with the priority area group. As discussed in Chapter II, Henry Mintzberg asserts that there are three primary aspects of how strategies are implemented in practice: realized, unrealized, and emergent (Mintzberg et al., 2009). TLCHD's evaluation of their implemented plan objectives followed and found Mintzberg's categories. This process provided crucial insight into what objectives were completed, not completed, or changed in the objective/action steps from the original depiction. The most expansive emergent change in objective/work from the original strategic plan was seen in the Healthy Home Priority Area. In discussion within the Division of Environment Health, staff found that they could not implement the priority as written. Their emergent strategy was to change all the objectives and action steps in their priority. The revision of the priority area's objectives and steps was done after the initial priority area was developed and before the start of implementation of the new objectives and steps. The priority work would not have been

successful without this thorough revision. One of the, if not the most valuable finding was that those groups implementing other priorities did not know that they could adjust or change, even though leadership supported changes, objectives or action steps as needed. This is an important finding and confirms that, as Henry Mintzberg discusses, emergent strategies are more important than deliberate strategy (Mintzberg, 1994). If TLCHD is to improve implementation of their plan and public health delivery, they need knowledge and ability for emergent strategies to be formed and implemented.

Another lesson learned was that emergent strategies can be documented, discussed, and evaluated using the methods and process of this research. The Obesity Priority Area stated they had *"no idea that they could change the objectives or step"* and the Opiate Area said as individuals implementing the objectives, they *"could not change those objectives"* or their steps. Furthermore, staff could change the way they did business, e.g. the steps they had initially projected to accomplish objectives, not only with each other but with outside agencies. TLCHD's needle exchange program needed to add another clinic and clinic site but did not know how they could accomplish the tasks. It was thought that TLCHD's general revenue fund might support the new clinic. However, this was not a viable option. The Opiates Priority Area needed to secure a contract for a current needle exchange clinic and approached the funder. The emergent strategy was the funder, after the negation of the contract, and TLCHD discussed the need for another clinic. The emergent strategy was approaching the current funder for additional assistance with another clinic which was never discussed prior to the additional ask for assistance. Overall the researcher learned that the process used to track, document, understand and evaluate lessons learned did accomplish what it set out to do. It evaluated lessons learned and ascertained if TLCHD learned from implementation or did not learn (did it or did it not

change business or thinking). However, refinement is needed in how staff understands how the strategic plan changes the way they think and do their jobs. They need more reflection on how, why, and what implementation is allowing change.

The process that has been observed and captured is an adaptive approach to strategic planning and implementation. To reach an outcome the implementation was neither deliberate or emergent, but both, and there was learning. What did happen and will continue depends on the emergent strategy and process being engrained in the behaviors of staff at TLCHD. These actions to create emergent strategies and understand those strategies will become more embedded in the process of implementation until it is second nature to staff and leadership at TLCHD (Mintzberg, 1994).

3. What do LHD leaders and staff learn from a systematic process of review or evaluation of the implementation of an LHD's strategic plan?

v. Participatory Evaluation

As this action research project unfolded, it became clear that the involvement of multiple levels of staff in TLCHD, through their participation in the Facilitated Discussion Groups, filled the criteria for participatory evaluation (Patton 2008) of the current state of implementation of TLCHD's strategic plan. It presented the initial findings of the researcher based on the review of the monthly reports to staff for informational purposes, active feedback, and correction and adjustment as needed.

The participatory evaluation provided a richer understanding and linkage to facilitators and barriers and lessons learned than simply reviewing monthly reports. It helped clarify what and why we are doing strategic planning. The Facilitated Discussion Groups did several things that would not have happened without them, or if it did, to a much lesser extent. They brought

frontline staff together with superiors and directors to discuss implementation and provide feedback. Further, it allowed staff of all levels to voice their concerns and give input in a non-threating environment of how implementation could be done better. What ultimately was proven from bringing these groups of staff together was to verify that the process and methods used in the research were sound to evaluate and assess implementation of TLCHD's strategic plan.

vi. Staff Evaluation

Staff had extremely positive comments about the participatory evaluation process that supports further use of the process. They felt it was *"good for gathering input/helpful,"* it is *"needed more often,"* and it *"gets everyone thinking."* Some of the more productive aspects of the results from the evaluation are that it is *"good to hear what others are thinking"* and *"helps to understand it helps us refocus our efforts to achieve better results."* All of these comments support that TLCHD should continue with the participatory evaluation process and that it cannot afford not to, with the type of positive results obtained.

vii. Internal Issues

The most common barrier to implementation was the need for more staff to be involved in understanding the process and what the outcomes are with the implementation, particularly the ones completing work required for implementation. There is also the need for a more diverse group to be involved with each priority area. The type of diversity needed is that employees from differing divisions need to be involved with priority areas that they are directly responsible for. For example, those in Environmental Health should be involved in a priority area relating to the Nursing Division and staff from the Nursing Division should be involved with strategic planning in the Environmental Health Division. Another barrier is the need to evaluate work closer to when that work was completed. The material evaluated for this research was several months old.

As noted by comments from the group discussions, the evaluation process would be better if the actual evaluation is closer to when the work (action steps) is completed or being evaluated. After several months of the work not being evaluated or reviewed, that work may not be as vivid to form the best evaluation findings. However, there could be barriers to this process such as not having enough time to review monthly reports to understand the work done, not having enough reflection time between implementations, and reporting the facilitated discussion (evaluation) which was the most important aspect of the evaluation process. The facilitated discussion groups provided rich information for not only realized/unrealized and emergent analysis of objectives and steps but also functional operations. These functional operations examples are the desire by staff to conduct more evaluations in a similar manner as the Facilitated Discussion Groups, the need for reporting of findings back to staff, and the need to have more communication of work being done between divisions. One aspect of the internal analysis that should continue is the quantitative content analysis of facilitators and barriers. Without some quantifiable means to understand what factors affect implementation the most and in which priority or priorities then enhancing the facilitators or decreasing the barriers may be difficult. The last is that leadership, from supervisor to Health Commissioner, must be more involved in the processes. They must not direct the work better and be a more prominent supporter of the strategic plan and its implementation.

d. Revisiting the Concept Map as a Blueprint for Future Action

The original concept map has several changes from the original design. The research conducted revealed that there needs to be additional training for staff before the implementation of the plan can begin. There needs to be adaptive management for effective strategic plan implementation.

Adaptive management, in the case of strategic plan implementation, means that leadership is trained on how to respond to uncertain implementation issues iteratively to have the best decisions made. In essence, leadership must use staff input, their own experiences, and formal training on strategic plan implementation to attack often wicked problems public health faces. Before implementation begins, the staff must know that they can change objectives and action steps. These changes may be due to the need to align with the current conditions in real-time, change in direction due to new information or guidance, or simply the original objectives or action steps were poorly designed.

Another change to the concept map is that there must be training on how to report and what to report from implementation priority groups before any implementation begins and periodically during the implementation process. Finally, that reporting must be on consistent intervals, and the culminated work on those reports should be evaluated at a minimum every six months. The evaluation process and outcome need to fit into the action research cycle. What was documented in the reports should be discussed at TLCHD's monthly reporting session in the Implementation Committee, but a facilitated discussion group process of those reports, with broad participation from all levels of staff involved in the work of the priority areas, should take place every six months.

The research found by participatory evaluation documented from facilitated discussion group process showed both rich and unique findings. As noted in the change to the concept map, the middle box in the center of the action research cycle, the group discussions were found by staff and leadership to be open and honest. Further, they provided a safe environment for all levels, frontline to the director level, to voice their ideas and opinions. Research findings found local public health has more external factors that influence implementation than other

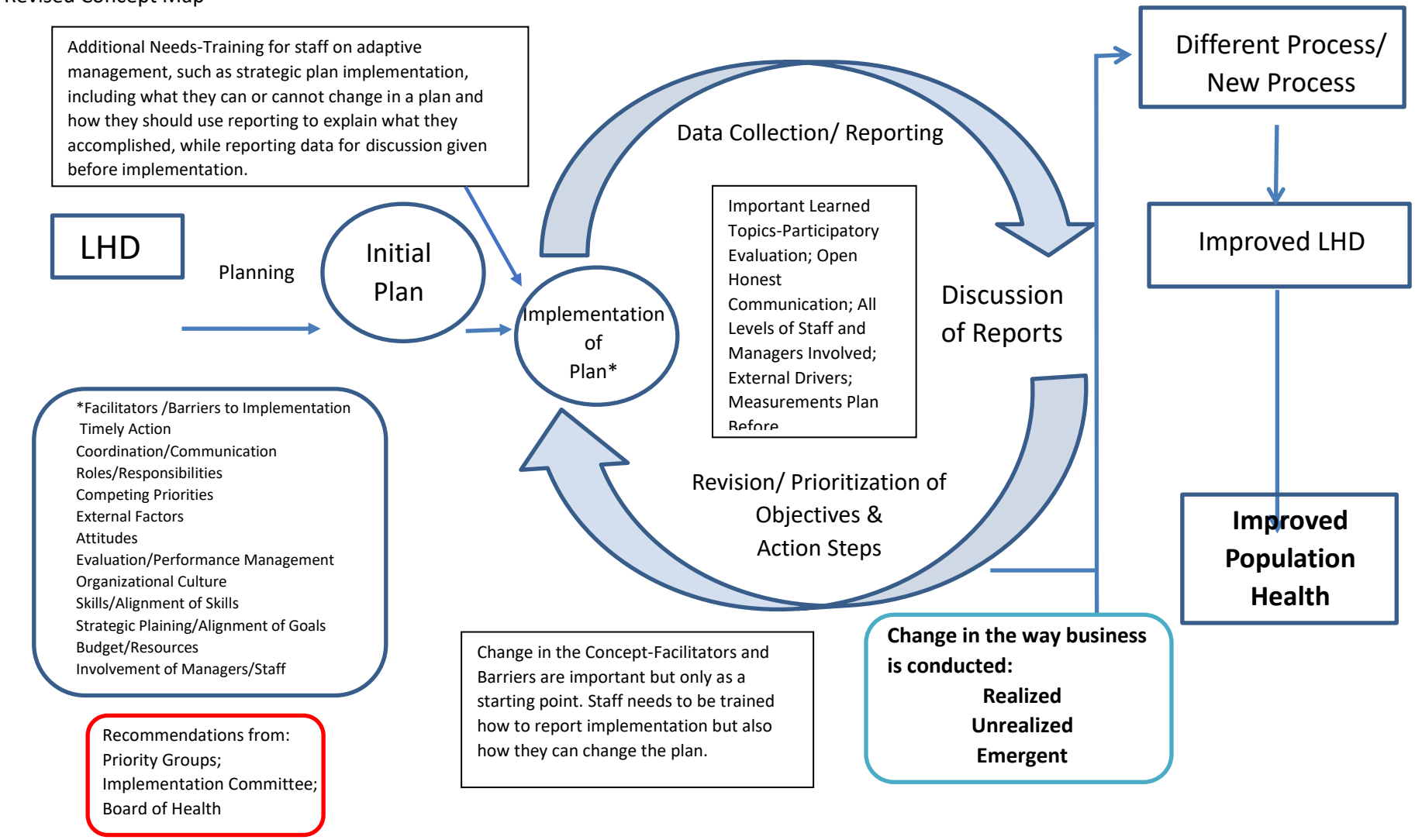
disciplines. Discussing the pressure of these external factors can be better understood and, if needed, responded to by staff experiencing those pressures. One interesting change to the concept map is that it notes measurements that will be done on action steps should be decided on before implementation. However, this does not mean the measures cannot be changed or adjusted if seen not to be appropriate for the gathering of needed information.

The final change to the concept map is the identification of facilitators and barriers and the progress by review of monthly reports. For the research done, the process needed to document facilitators and barriers was time-consuming and impractical to conduct on an on-going basis. It served the purpose, however of validating that the facilitating factors and barriers extracted from the (largely business derived) literature were applicable to the LHD context. No new emergent categories were added, although the process allowed for that; therefore, the construct validity of these facilitators and barriers can be assumed going forward. Facilitators and barriers to implementation for LHDs are and will be essential to document and understand. Understanding how and why these factors function comes more from the facilitated discussion groups than from the monthly reports. However, documentation of the facilitators and barriers to the monthly reports is still needed and provides a needed structure for follow-up group discussion. Reporting can be streamlined and made efficient if there were drop-down boxes that could be clicked and add a comment. The information then could be quickly collected or even collected in real-time.

The information then would be discussed at the group discussions for a more detailed, in depth understanding of the issues presented, that goes beyond “What?” questions answerable through the reports to posing and responding to “So What” and “Now what?” questions. The monthly report is adequate to document and detail the progress of implementation. However, the

monthly report, as already discussed with factors and barriers, needs to be made more efficient and effective. Reporting should be moved from handwritten to a fully electronic system. The system should enable users to easily collate and search the information.

Revised Concept Map



viii. Leadership Implications

Table XXIII (see appendix N) shows the links between the evidence and the recommendations. The researcher reviewed evidence across the priority areas for recommendations, looking for common themes relevant to recommendations and action steps that could be implemented. First, recommendations based on the review of the monthly reports by the researcher were identified. Then the revisions and amendments made to the recommendations based on initial findings by the FDGs and Implementation Committee were reviewed and incorporated into the final recommendations presented here. These findings will be presented to the TLCHD Board of Health.

ix. Recommendations for TLCHD

As noted in Table XXIII (appendix N), there are 15 different recommendations, of which 13 can be considered those that TLCHD should look to address. The recommendations are:

Organizing the Implementation Work

1. Priority groups should have a diversified team that is made up of staff from each division.
2. There needs to be a better effort to report on completed or not completed material for strategic plan implementation.
3. TCHLD leadership needs to create the opportunity and atmosphere to have managers and staff associated with the priority areas meet more and evaluate the work done.
4. More staff need to be involved (assigned) to the priority areas so the workload of completing objectives is not only on a select few.
5. The Health Commissioner needs to make sure they are involved with implementation but more importantly all leadership staff are involved.
6. For the next strategic plan the priorities should be reviewed for proper alignment with the direction of the department. Also, the plan should take into consideration the current views of staff on how to implement the plan as much as possible.

7. Going forward, the monthly reports need to be reviewed and discussed, assessing not only what has been accomplished but what learning has taken and is taking place within TLCHD.

Training Needed

8. Support better training of TCHLD managers and staff on how strategic plans are constructed and adapted, so set objectives can be changed if needed.
9. The monthly report process needs to be reviewed and changed to make it more user friendly. Also, the champions need additional training on how to use the monthly report. This includes training on how barriers and facilitating factors are defined and reported on, as well as lessons learned.
10. There needs to be a better training process to show staff not only why implementation is important but also why the evaluation and learning aspect of implementation is as if not more important.
11. Action Participatory Research should be instilled within TLCHDs culture. Training and use of AR should begin immediately, and connected to further refinement and training on specific tools used, e.g. the components within the monthly reports.

Research and Reflection

12. Conduct further activities to reflect on and understand how barriers and facilitating factors, lessons learned, and the practice of Facilitated Discussion Groups are each required to fully understand what impedes and impels implementation.
13. Explore how the participatory evaluation process utilized for this research can be used to evaluate other public health programs.
14. Further research using the same methods, involving other local health departments, is needed. These departments should be both like TLCHD as well as ones that differ in size and structure.
15. Emphasize to other departments how using the current tracking and evaluation methods can help to satisfy PHAB reaccreditation requirements.

All 15 recommendations are important and will be presented to the TLCHD Board of Health, but several recommendations rise to a higher priority. The first is the need for more individuals to be involved in the implementation process. It was clear by comments from the priority groups that there must be more staff and leadership involved in the implementation process. Another important recommendation is more systematic analysis of the implementation work done, and

then also to report the findings of that work to staff in participatory discussions, so staff can give feedback. Staff stated that better measurements of work need to be developed for each objective and specific for each of those objectives. Further, reporting of work completed or work not completed must be placed in a report given to staff so they are aware of implementation efforts. Several staff stated that the researcher should be the one that conducts future Facilitated Discussion Group evaluations. It would be the researcher's desire to be the individual who conducts all future group discussions however this may be impractical. One aspect that has already been discussed and begun being implemented is workforce development of both directors and supervisors in how to lead Facilitated Discussion Groups. It is anticipated that eventually those in leadership could conduct and lead group discussions after training. It would be appropriate and interesting to carry on further quantitative studies of barriers and facilitators but of more important to evaluation of implementation would be the summaries of lessons learned and the realized/unrealized/emergent piece. This would include identification of evidence supporting why some actions steps happened and others did not. The last major recommendation is the continuation of the evaluation methods used for the discussion groups and an increased frequency of evaluation, as noted by participants of the Facilitated Discussion Group sessions. As Health Commissioner, an increased frequency is both feasible and desirable. The frequency should be no less then every six months and as frequently as once a quarter. More discussion and examination of unforeseen issues with any additional timeframe needs to be had before a final recommendation can be made.

The remaining two recommendations are driven by TLCHD but are for other local health departments. It is important for TLCHD and the researcher to discuss the methods used to gain insight into both the good and bad of its strategic plan implementation with other departments.

Methods include action research, with multiple cycles of designing reporting forms, reviewing reporting forms, basing recommendations on that review, then presenting the review and recommendations. Further, a systematic documentation and review of monthly reports, using content analysis and the realized/unrealized/emergent categories to analyze what action steps occurred as planned and what did not, and how that affected what objectives from the strategic plan were achieved or not is needed. Also, a participatory evaluation via presenting analysis of monthly reports to a diverse group of staff for discussion and feedback is required. Hopefully through the clear understanding of the methods and findings, other departments can benefit from TLCHD's efforts but also verify and possibly add to the findings from this research. As TLCHD promotes the use of the methods of the research to similar and dissimilar departments it will assist in verifying and adding to the research. The second recommendation deals with emphasizing to other departments that using the methods described could help satisfy PHAB reaccreditation requirements and make it easier to comply with those deliverables.

Self-Reflection: My Observations from My Perspective as a Public Health Leader

As the UIC DrPH program teaches the value of systematic self-reflection for public health leadership practice, I want to take the opportunity here to present my own reflections from my perspective as a public health leader, who has had the privilege of serving as Commissioner of the Toledo Lucas County Health Department since June 2016. Leadership in public health has always been a full contact sport. Every day is a battle to protect those we are entrusted to protect, maneuver over, around, and through internal and external political issues, and handle the operational minutia and thirty thousand-foot problems occurring on almost a daily basis while trying to learn and grow as a leader. If this tactical work does not seem like enough bruising activity, we at the same time have to think how our actions and plans will affect public health

strategically. All these reasons led me to choose to do my dissertation research on Strategic Plan Implementation at the local health department level. My intent was to help myself and my peers take pressure off the strategic plan process.

My original stance and ideas regarding strategic plan implementation changed immensely over the time spent working on my Doctorate in Public Health. Being a former disaster planner, I knew the plan was not the important thing. The most important aspect is bringing a group of people together to have discussions, develop objectives and solutions to problems, but more importantly, building relationships and common ideas along with trust during the planning process. These relationships and common ideas are what makes a successful plan. But what about implementation? As stated in my dissertation, LHD plans, as well as other discipline's completed plans, sit on the shelf. If they are worked on, they are simply a check box in some excel spreadsheet. This is not good enough for public health, but how could it be simplified and made easier for leaders to implement their plan while also learning and documenting how they changed public health in their community? That is what a plan is supposed to do, change public health for the better.

My original thought was to increase the understanding of the barriers and facilitating factors to implementation. For me it was clear, find those factors and report on them so that I and other public health leaders could enhance the facilitators and reduce the barriers. In return, the process of implementation would improve. I still firmly believe each department needs to know their factors influencing the implementation process. However, simply knowing that, for example, communication is a barrier or facilitator to implementation is not enough. It truly goes back to what was stated earlier, that successful planning is not about the plan, but about the planning process where there is discussion and evaluation of ideas and use of a process to craft

the plan. To effectively have and implement a strategic plan, there must be the same process. There must be time to discuss the barriers, facilitator, lessons learned, amount of progress and what those implementing the plan are thinking. I cannot stress enough: if a structured evaluation is completed in an environment that allows for open and honest discussion, there is more rich understanding and direction than one could imagine. The cautionary statement is that whoever facilitates the evaluation discussion must be one that does not intimidate or unduly sway those giving their opinions.

What I found to be the most helpful and powerful is the facilitated group discussions. It was surprising how much more information I obtained not only about myself, my upper leadership, my middle leadership, as well as my frontline staff, but as important the state of implementation. I learned that I need to do better at not just thinking that work on implementation was being done appropriately, but also that staff is involved. It was excellent to see that all staff actually enjoyed the process of discussion and evaluation of implementation. Structuring a discussion group with scripted questions and taking a semi-structured approach to follow up questions, and allowing responsiveness to the expressed concerns and understandings of participants, allows for extensive and robust understating of the entire process and gauging how staff feel about the implementation process. The discussion groups also changed my mind on facilitators and barriers and their role in implementation. Yes, understanding those factors is important but it is not simply reviewing the documented facilitators or barriers. The in-depth discussion brings to life those factors to more fully respond to the issues that are impeding or enhancing implementation.

I respectfully suggest that the in-depth process I used to obtain my data was not only beneficial for strategic plan implementation evaluation and documentation, but also can be used

for other programs or processes we use in public health. The participatory action research used in my research allowed my staff and myself to be a part of the process, change the process, and provided a sound way to document and report implementation, but more importantly provide a structured way to improve the delivery of public health trough the comments documented by staff. The process can be modeled at any level of public health, while adjusting for those unique issues other departments have. From my perspective, the model I used will also do what I consider imperative for public health - document what we do in a rigorous, research-structured manner that can be shared so it can be peer reviewed. This is the aim of "action research" – it is both action that can make a difference locally as well as "research" that can be built on by others. We in public health, as a whole, do not tell our stories of success. Using this process could provide us a vehicle to do just that in an efficient and effective manner.

I would like to close this reflection as a leader who is constantly in a learning mode and looks to use already developed processes and models to make my department better. I hope I created a model that other leaders in public health will find useful either in totality or to create their own process. No matter what, we as public health leaders must find ways to engage staff, improve our processes, know and fix our shortcomings and tell our stories. I wish you all the best.

e. What Did We Know and Know Now?

As Peter Drucker stated: Strategic planning's purpose is to "understand the environment, define organizational goals, identify options, make and implement decisions as well as to evaluate actual performance" (Drucker, 1980, p61). From the work and findings of this research, there is alignment with Drucker. Participants stated that *"there should be more evaluations done and the evaluation that was done today was productive,"* which aligns with the evaluation and

identity options which Drucker describes. Further, it was noted that the statement *"objectives need to be updated"* goes to identify organizational goals that Drucker also stated. The methods and end results of the research of TLCHD's implemented plan align with what Drucker states is the purpose of strategic planning.

Bryson's comments that the use of strategic planning provides a "roadmap" to shape and guide action and purpose (Bryson, 2004) also aligns with the work of this research. The "roadmap" is that the process and findings provide LHDs and their stakeholders with a clear picture of the value of evaluation of strategic plan implementation. The methods also can show the future of the department, how it will obtain that future position or vision, the methods by which it will succeed, and the measures to indicate progress and success (NACCHO, 2012). The action research findings documented that not only does staff want an additional evaluation of their work but also that more staff are needed to be a part of implementation for the next cycle. Further, the work provided several recommendations to improve the implementation process. TLCHD has found and is following their "roadmap" as Bryson describes.

As Poister (2005) states, an implemented strategic plan generates many positive outcomes such as a clear identity, better decision making, and clear goals; it is fundamental to the management of an LHD (NACCHO, 2010). Furthermore, the action research process used here to study implementation generated positive outcomes and better decision making. This leads to the question, without an explicit action research or evaluation process, does an implemented strategic plan generate such favorable results as better decision making and clear goals? Does simply "implementing" in the sense of following a strategic plan as if it were a recipe, without systematically reflecting on what worked and what did not, produce positive outcomes? Clearly, the changes in the action steps that were made in several of the priority areas, such as Healthy

Homes prior to implementation, Healthy Homes after implementation and Obesity after implementation, show that the strategic plan could not be implemented without revision, and it is not clear if better decision making could be simply a result of having and implementing a strategic plan, without the reflective or evaluative component introduced in this case. It would seem that some feedback loop (such as pictured in the concept map in Chapter II) needs to be introduced for better decision making to take place. This is linked to the findings in this case on the feedback loop and who should be involved: that staff want to evaluate themselves more, they demanded that more staff are involved, and that management needs to be a bigger part of the implementation process. With this information, as well as the other outcomes of the evaluation of implementation, leadership has a better picture of what is needed for an even better process for the next strategic planning cycle.

I would be remiss if I did not mention that ultimately, a strategic plan if done well, creates a better organization (Baldwin, 2013). However, a strategic plan can only create a better organization when that strategic plan is successful—and the only successful strategic plan is one that is implemented (Poister, 2005). A strategic plan done well is often defined by the amount of work completed. If that criterion is accepted, in this case the review of implementation of original objectives and action steps showed it was more of a failure. However, successful plans are not merely those that have the most tasks checked off. What an action research and participatory evaluation approach to TLCHD's plan did was create a better organization by using evaluation to find not only what was completed and not completed, but more importantly by incorporating the feedback from multiple levels of staff. Through this process, staff buy-in was supported in the process of implementing the strategic plan and reviewing what worked, what did not, and what was learned from the initial round of implementation of this plan.

The Facilitated Discussion Group sessions were a crucial part of this process. The rich and robust feedback by staff found many things that were being done well and those processes that were not and needed to be changed and added significantly to the original findings by the researcher from content review of the monthly reports. Ultimately Poister's comment that the only successful strategic plan is one that is implemented, must be extended given TLCHD's experience because it is clear that, at least in a complex environment where it is unlikely that things will work out exactly as planned, a strategic plan must not just be implemented but periodically evaluated. And TLCHD's experience, as documented in the staff's reactions during the Facilitated Discussion Group sessions and in their comments on the evaluation forms on those sessions, shows that there are clear benefits to a specifically *participatory* evaluation process. And that process, together with the strategic plan and its implementation, does have the power to change how an LHD conducts its work.

f. Will it make it easier to comply with PHAB?

The action research, data collection, and evaluation used for this research will assist in complying with PHAB Measure 5.3. Table XXII Appendix M provides that guidance. The table copies the exact wording for the measure's requirement and guidance. The alignment of this research documents how the researcher's work, findings, and evaluation process satisfy the required deliverables for accreditation of measure 5.3. For example, reaccreditation requires member organizations to: "Describe the department's process used to continually track the implementation of the strategic plan and revise it as needed." (NACCHO, 2017). Complying with measure 5.3 would be satisfied using the research methods prescribed in this study, including the monthly reports and the systematic review process followed for analyzing them and using participatory evaluation to validate and correct the analysis. The remaining

requirements for reaccreditation can also be considered in alignment with the methods and evaluation depicted in this study.

i. Track and Revise the Strategic Plan

It would be appropriate to state there may be many ways to effectively follow the PHAB guidance, but the procedure used in this action research does have the potential to achieve what PHAB requires for implementing strategic plans and reporting on that implementation. However, for some parts of study methods, such as the content analysis of the barriers and facilitators, to check alignment with the literature might not be necessary for the purposes of following the PHAB guidelines. Also, the in-depth review of past work with the strategic plan may also not be needed. The process and methods used not only proved to be systematically sound in evaluating the implementation of TLCHD's strategic plan but were well-received by staff and leadership of TLCHD. The participants were able to define, as noted by comments made during group discussion, barriers and facilitators they encountered and are motivated to continue and enhance the evaluation process. Additionally, the same process and methods are being examined for potential use in evaluation of all departmental programs employed at TLCHD. The one significant change to properly revise the strategic plan is to educate all those involved in implementation so that they can change objectives and steps to complete those objectives if needed. Even though leadership supported and allowed all priority areas to change objectives and steps there was not common knowledge to all groups. The revision or need to revise and tracking is not done in a vacuum or not within a system. As was reported by the Opiate group their Directors was the only one to decide on if there were any changes to objectives or steps but also the staff did not know they could change what was in the plan. As noted by the Obesity area, they did not know whether they could also change what was in the plan. Workforce Development did know that they could adjust the plan as needed but this is due

to the lead of the group also being the Coordinator for PHAB and Strategic Planning. This person understands the many different facets of strategic plan development and implementation including the ability to change the plan as needed. Finally, Healthy Homes already knew that changes, including wholesale change of the plan could be done. That system is already in place through reviewing monthly reports, discussions at the implementation meetings, and finally, through group discussions as used for this research.

ii. Staff Engage and Share the Responsibility

Staff engagement is essential for not only TLCHD's process and any other local health department who is implementing, tracking and reviewing a strategic plan. Staff engagement furthers understanding across the department of the strategic plan and effectively shares the responsibility for implementing and updating the plan. Participants stated during a group discussion that they want more staff at the *"table"* to discuss and do the work but also to have *"a plan to empower and engage staff"* through involvement with implementation.

g. The Process of Reassessing and Revising Priorities

The implementation of the plan will continue to be tracked using monthly reports and implementation committee meetings where discussion on current barriers and facilitators are being seen. These can be discussed then and, if possible, knocked down and enhanced. Further, any emergent ideas, needs, or solutions will be discussed that the entire group can learn, lend support, or assist in framing the emergent knowledge to better address implementation and public health. There will be group discussions for evaluations at least twice a year. Reporting back to the board every three months on the current status of the implementation process will be done at that month’s board meeting. Finally, there are advantages to using systematic research methods to assure evidence-based practice, or something like that, but the coupling of systematic research methods with a more participatory and action approach is what makes this process more

viable for building a LHD that is a learning organization. This is supported by Senge in a Local Health Department that works to expand their ability to have results they wish to have and where emergent ways of doing things and thinking are fostered and want to learn to see the big picture as a collective (Senge, 1990).

h. Unanticipated Changes in Priorities

When emergent strategies for implementation are found, the most crucial aspect is to share that information with the implementation committee and anyone in the department who may directly be impacted. For instance, if the emergent strategy in the Priority for Healthy Homes is to increase home visiting by nurses, the Division of Nursing would be asked to participate in the discussion of the strategy. It would be a combined effort of those involved to 1) make sure the strategy was implementable, 2) make sure there was enough funding to accomplish the activities needed, and 3) decide whether the emergent strategy can be measured during evaluation. Overall the implementation of the plan should not be limited by any idea, resource, or barrier. Emergent strategies or changes to implementation must be embraced and employed when appropriate and able.

i. Take-Aways for other Health Departments

Identifying shortcomings, experience from being in a position, and knowing how to improve a process often breed success. From the researcher's background and public health experiences, the methods and findings from this research will engender success at TLCHD. Whether it is the addition of staff to the implementation process, identification of barriers to implementation, or only the increased discussion among and with staff on implementation, it will culminate in the potential for success on many levels. There is a story and lessons for other local health departments that can lend to their ability to increase success for strategic plan implementation, accreditation, and reaccreditation for PHAB as well as a potential change in

how strategic planning is viewed by staff. The importance of implementing a strategic plan is not based on whether the plan has met all the objectives and steps but gaining insight into whether there have been improvements to the delivery of public health. More important is how staff view the strategic plan and if they are lockstep with the path the department is taking. This can be determined by following or adjusting the work documented in this research. However, the only way that improvements can be made is through evaluation of the plan. Yes, review of documents and tracking of outcomes are essential, but the interactive evaluation of discussing the outcomes, process, and needs by and from staff is the most essential aspect of the entire process. Without the interaction and voicing of options, issues, barriers, facilitators, and lessons learned by those doing the work or affected by it, the implementation will simply be a plan that is more of a check-off then a useful guiding tool for a local health department. One essential aspect of evaluations are that new ideas and processes can emerge, which may provide solutions to issues facing implementation. Another is that staff feel empowered and rewarded when they can tell their stories and have the chance to enact their ideas for better implementation.

j. Evidence from Others in Ohio

The author has had the chance to discuss this research, findings, and potential usefulness of the work and research. There has been positive feedback on what the benefits could be for public health. One Local Health Department Environmental Director stated, “In the past, I did not have much experience with strategic plan implementation, but I am now involved heavily with the process. Knowing what the facilitators and barriers to implementation should help me understand how to have a more successful plan.” Another positive discussion was with an Assistant Health Commissioner who stated, "I think local health departments will benefit by knowing not only the facilitators and barriers to implementation but also have a process of evaluation that they can take and model it for their department. Further, that process should make

PHAB reporting easier for reaccreditation". One Health Commissioner stated that he looks forward to the final presentation of all aspects of the study but specifically the evaluation of the plan's implementation."

k. Limitations

As noted in Chapter three, many of the limitations are still are accurate. The study used only one case (local health department), which may not allow for a generalization of findings. Further, this single case was a suburban/urban department serving a medium population size county. It would be important to see if findings are similar or replicated at departments of differing sizes and service type. Another limitation is that the local health department being studied was seeking PHAB Accreditation during data collection. Not only may future versions of PHAB Accreditation deliverables demand the same standards, but Ohio required all health departments to be accredited by 2020. The demand for accreditation for local health departments may not be required by other states. Mandated accreditation may suggest more adherence to specifics about evaluation and improvements than other departments that are not mandated to be accredited. Another limitation is that the study was only over a twelve-month time period, and a more extended timeframe of study could provide a deeper understanding of the phenomena studied. The researcher's position, as health commissioner, in the department, may be a limitation due to staff not wanting to disagree with recommendations or direction given. Finally, another limitation is the possible lack of understanding or lack of definition of what is a facilitator or barrier. Additional training on what factors are and how they are defined may negate this limitation.

With the PHAB accreditation process, there were required work processes, documents, and explanations that TLCHD needed to generate. These documents and explanations were the

focus of work within the department, which took time away from implementation. Further, key employees for the strategic plan implementation were also the same employees who were addressing the needs of accreditation. Also, TLCHD already completed the measure for strategic planning and did not need to work on the strategic plan measure. This resulted in placing implementation work on hold, and those key personnel switched to accreditation work, which became the priority. Further, staff involvement was often limited to the strategic planning priority leads, and since they, as well as other staff, were working on accreditation, there was little to no staff available to work on implementation. Further, staff involvement for the strategic planning measure was limited to the Priority Leads. These staff members were also tasked with accreditation items, and therefore, availability for implementation was not possible. The monthly report will change to be more user-friendly, but still will be used.

l. Strengths

Several strengths were recognized from the evaluation of TLCHD's strategic plan implementation. A few of these are that evaluation of the plan was not placing blame but attempting to understand what is needed to improve the implementation process and success of the strategic plan. From the feedback it was found that Facilitated Discussion Groups are extremely useful to better understand implementation of the plan and staff found that there can be open and honest communication during evaluation sessions. The implementation process of strategic planning at TLCHD was not simply a checkoff but was an iterative process resulting in emergent thoughts and actions from the participatory evaluation process. Finally, the biggest strength was that each participant wanted to make changes in every aspect of implementation to improve public health in the TLCHD jurisdiction.

m. Implications for TLCHD Leadership

The implication for TLCHD leaders from work completed and findings from the

evaluation process are several-fold. The three most significant implications are: 1) leadership must involve additional employees in the implementation process and especially during the facilitated group discussions, 2) measurable standards must be set for reporting to staff and others all work completed on objectives and 3) for the evaluation process there must be additional evaluations every year, so those evaluations are closer to the actual work done.

n. Implications for Research

Regarding adding to the literature on strategic plan implementation and facilitators and barriers to implementation, with little to no literature on the barriers and facilitators to strategic plan implementation specifically in local health departments (LHDs), along with what and how evaluation of a strategic plan can be done at the LHD level, the findings and recommendations will provide for the beginning of such material. The other addition to the literature is the action research and participatory evaluation approach demonstrated in this case shows one way to support the ability to discuss how an LHD as an organization can learn from strategic plan implementation and can document that learning. Other LHDs can gain insight into how to perform an evaluation of their plan and accurately document what has been learned by the LHD as an organization as a short-term result of the implementation.

o. Next Steps

The next step for this study is to present findings to the TLCHD board of health and obtain their feedback. We also need to continue the process of reporting and evaluating TLCHD's strategic plan implementation as developed here. Furthermore, we also need to improve on the process and methods, using the findings from future evaluations of TLCHD's strategic plan implementation, as the implementation and its review continues and as we extend the participatory discussion to additional priority areas. Future evaluations of TLCHD's strategic plan implementation will be used to expand on the research and findings from the work of this

dissertation. Further, it is hoped that the public health literature and practice will benefit not just from this work at TLCHD but also by having other LHDs conduct the evaluation of strategic planning implementation for their own departments. This will also add to the literature and continue telling the story of strategic plan implementation at the LHD level.

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VI. REFERENCES

Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: the British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248

Alexander, L. D. (1985). Successfully implementing strategic decisions. Long Range Planning, 18(3), 91-97. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/0024-6301(85)90161-X

Andrews, R., Boyne, G. A., Law, J., & Walker, R. M. (2011). Strategy implementation and public service performance. Administration & Society, 43(6), 643-671. doi:10.1177/0095399711412730

Baldwin, H. T. *Thinking strategically first makes strategic planning work.* Retrieved 9/25, 2013, from http://humanresources.about.com/od/strategicplanning1/a/thinking_plan.htm

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. Journal of Epidemiology and Community Health, 30(10), 854-857. http://doi.org/10.1136/jech.2004.028662

Blatstein, I. M. (2012). Strategic planning: Predicting or shaping the future? Organization Development Journal, 30(2), 31-38. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=77293189&site

Bogdan, R.C. & Biklen, S. K. (2006). Qualitative research for education: An introductory to theory and methods. (5th ed.). Needham Heights, MA: Allyn and Bacon.

Bowman, S. (2008). Creating a strategic planning team. Retrieved 10/14, 2014, from http://www.conscious-governance.com/creating-a-strategic-planning-team.html

Bryson, J. M. (2004). The future of public and nonprofit strategic planning in the united states. Public Administration Review, 70, s255-s267. doi:10.1111/j.1540-6210.2010.02285.

Bryson, John M. (2011). Strategic Planning for Public and Nonprofit Organizations: A guide to strengthening and sustaining organizational achievement. (4th ed.) San Francisco, CA: Jossey-Bass.doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.evalprogplan.2007.12.001

Carlopio, J., & Harvey, M. (2012). The development of a social psychological model of strategy implementation. International Journal of Management, 29(3), 75-85. Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/1040874380?accountid=14552

CDC. (2008). *Using evaluation to improve programs strategic planning.* Retrieved 10/14, 2013, from http://www.cdc.gov/healthyyouth/evaluation/pdf/sp_kit/sp_toolkit.pdf

CDC. (2014). The Public Health System and the 10 Essential Public Health Services. Retrieved 08/28. 2017 from https://www.cdc.gov/nphpsp/essentialservices.html

Dahmus, L., & Wooten, L. P. (2012). The board room: Barriers to strategic planning and how to transcend them. Nonprofit World, 30(5), 8-10. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=79913243&site=ehost-live&scope=site

Devlin, G. (1989). How to implement a winning strategy. *European Management Journal, 7*(3), 377-383. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/0263-2373(89)90134-5

Drucker, P. F. (Ed.). (1980). *Managing in turbulent times.* (1st ed.). NY: Harper and Row.

Elbanna, S., & Fadol, Y. (2016). An Analysis of the Comprehensive Implementation of Strategic Plans in Emerging Economies: The United Arab Emirates as a Case Study. *European Management Review*, *13*(2), 75-89. doi:10.1111/emre.12068

Graham, H. (2010). Where Is the Future in Public Health? The Milbank Quarterly, 88(2), 149–168. http://doi.org/10.1111/j.1468-0009.2010.00594.

Gilmore Thomas, Jim Krantz and Rafael Ramirez, (1986) "Action Based Modes of Inquiry and the Host-Researcher Relationship," Consultation 5.3 (Fall 1986): 161.

Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.

Hahn, W., & Powers, T. L. (2010). Strategic plan quality, implementation capability, and firm performance. Academy of Strategic Management Journal, 9(1), 63-81. Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/521183787?accountid=14552

Hakim, Catharine, Research Design:Strategies and Choices in the Design of Social Research, 1987: London, Unwin Hyman, pages 61 - 75.

Hargreaves, M. (2018). Leveraging Systemic Change: Evaluating What Works. Retrieved from https://drive.google.com/file/d/1JbPiQzfdpH_b-OQPEw5HJZEiI3Seq8wv/view

Heide, M., Grønhaug, K., & Johannessen, S. (2002). Exploring barriers to the successful implementation of a formulated strategy. Scandinavian Journal of Management, 18(2), 217-231. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/S0956-5221(01)00007-0

Hrebinak, L. (2006). Obstacles to effective strategy implementation. *Organizational Dynamics*, *35*(1), 12-31. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.orgdyn.2005.12.001

Kemmis, S. and McTaggart, R., (eds.) (1988). The action research planner. Victoria: Deakin University Press.

Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2). 16-21.

Liedtka, J. (2000). Strategic planning as a contributor to strategic change: A generative model. European Management Journal, 18(2), 195-206. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/S0263-2373(99)00091-2

Lorange, P., & Vancil, R. F. (1976). How to design a strategic planning system. Boston, etc: Harvard University Graduate School of Business Administration.

Mendenhall, M. (2013). *Strategic planning failure.* Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded source book (2nd ed.). Newbury Park, CA: Sage. Google Scholar

Minnesota Department of Health. (2013). How to: Strategic plan. Retrieved 10/05, 2013, from http://www.health.state.mn.us/divs/opi/pm/lphap/stratplan/howto.html

Mitnzberg, H. (1994, Jan-Feb). The fall and rise of strategic planning. *Harvard Business Review*, 107-114.

Mintzberg, H. Ahlstrand, B. and Lampel, J. (2009). "Strategy Safari: Your Complete Guide Through the Wilds of Strategic Management," 2nd Edition, Pearson Education Limited, Upper Saddle River, 2009.

Mintzberg, Henry. (1994). The rise and fall of strategic planning : reconceiving roles for planning, plans, planners. New York : Toronto :Free Press ; Maxwell Macmillan Canada,

Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From:http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf

Nanus, B. (1992). Visionary leadership: Creating a compelling sense of direction for your organization. San Francisco: Jossey-Bass.

Nutt, P.C.(1987). Identifying and appraising how managers install strategy, Strategic Management Journal, 8, 1-14 (1987).

NACCHO, (2005). Operational definition of a local health department. Washington, DC: NACCHO.from:http://www.naccho.org/uploads/downloadableresources/OperationalDefinitionBrochure-2.pdf

NACCHO, (2010). Developing a Local Health Department Strategic Plan: A How to Guide. from;http://www.naccho.org/topics/infrastructure/accreditation/upload/strategicplanningguidefinal.pdf

NACCHO, (2012). Strategic Plan: A How-To Guide Adapted from Developing a Local Health Department Developing a Tribal Health Department Strategic Plan: A How-To Guide Strategic Plan: A How-To Guide, National Association of County and City Health Officials.

www.naccho.org/uploads/downloadable.../Tribal-Strategic-Planning-Guide.pdf

NACCHO, (2013). The 2013 National Profile of Local Health Departments. January, 2014. from http://www.naccho.org/topics/infrastructure/profile/upload/2013-National-Profile-of-Local-Health-Departments-report.pdfhttp://www.phaboard.org/about-phab/public-health-accreditation-background/

NACCHO, (2017). The 2016 National Profile of Local Health Departments. Retrieved from http://nacchoprofilestudy.org/wp-content/uploads/2017/10/ProfileReport_Aug2017_final.pdf

O'Brien, R. (1998). An Overview of the Methodological Approach of Action Research. Overview of
Action Research Methodology. Retrieved February 28, 2012, http://www. web.net/~ robrien/papers/arfinal.html

ODH. (2017). Ohio's Smoke-Free Workplace Act. Retrieved from: https://www.odh.ohio.gov/en/smokefree/sflaw/sflaw1

Open University, (2018). Evidence Planning Implicit and Explicit Assumptions. Retrieved (November 01, 2018) from https://www.open.edu/openlearncreate/mod/oucontent/view.php?id=80450&section=2.1

O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.

Patton, M. Q. (2008). Utilization-focused evaluation (4th ed.). Thousand Oaks, CA: Sage Publications.

PHAB Accreditation Board. (2011). *Standards and measures.* Retrieved 11/15, 2013, from http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf

PHAB. (2013). Public health accreditation board-benefits. Retrieved 10/04, 2013, from http://improveph.org/about/faq.asp#benefits

PHAB Accreditation Board. (2013). Accreditation-getting started. Retrieved 10/08, 2013, from http://www.phaboard.org/accreditation-overview/getting-started/

PHAB Accreditation Board. (2014). *Standards and measures.* Retrieved 08/16, 2014, from http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf

PHAB Accreditation Board. (2015) Retrieved 11/06, 2015,from http://www.phaboard.org/wp-content/uploads/Guide-to-Accreditation-final_LR2.pdf

PHAB. (2016). Guide to National Public Health Department Reaccreditation: Process and Requirements. Retrieved 07/08/17, from www.phaboard.org/wp-content/uploads/Guide-to-Reaccreditation-FINAL.pdf

PHAB Accreditation Board. (2017). Accreditation Activity as of August 7, 2017. Retrieved 08/20/17, from http://www.phaboard.org/news-room/accreditation-activity/

Poister, T. H., & Streib, G. (2005). Elements of strategic planning and management in municipal government: Status after two decades. *Public Administration Review, 65*(1), 45-56. doi:10.1111/j.1540-6210.2005.00429.x

http://www.phaboard.org/about-phab/public-health-accreditation-background/

Reed, R., & Buckley, M. R. (1988). Strategy in action—Techniques for implementing strategy. Long Range Planning, 21(3), 67-74. 10.1016/0024-6301(88)90035-0

Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908

Schell, Charles (1992) "The Value of Case Study as a Research Strategy". Manchester Business School (2009)

Senge , P. M. (1990). The Fifth Discipline: The Art and Practice of the Learning Organization . New York : Currency/Doubleday , 1990.

Social Sciences Statistics. (2018) Spearman's Rho Calculator. Retrieved 02/18 from https://www.socscistatistics.com/tests/spearman/default2.aspx

Statistical Solutions. (2019). Correlation (Pearson, Kendall, Spearman) retrieved(05/2019) from https://www.statisticssolutions.com/correlation-pearson-kendall-spearman/

Thomas, J., Sussman, S., & Henderson, J. (2016). Understanding "Strategic Learning": Linking Organizational Learning, Knowledge Management, and Sensemaking. Organization Science, 12(3), 331-345. Retrieved from http://www.jstor.org.proxy.cc.uic.edu/stable/3086012

Thompson, D. (2012). Leveraging learning to improve disaster management outcomes. *International Journal of Disaster Risk Science, 3*(4), 195-206.

Toledo-Lucas County Health Department (2017). 2016-2019 Strategic Plan.

Toledo-Lucas County Health Department (2018). Strategic Planning Implementation.

Tsai, Y. Relationship between Organizational Culture, Leadership Behavior and Job Satisfaction. *BMC Health Serv Res* 11**,** 98 (2011). https://doi.org/10.1186/1472-6963-11-98

Weeramanthri, T. S., & Bailie, R. S. (2015). Grand Challenges in Public Health Policy. Frontiers in Public Health, 3, 29. http://doi.org/10.3389/fpubh.2015.00029

Yin, R. K. (2009). Case study research: Design and methods (4th ed.). Los Angeles, Calif: Sage Publications.

VI. Bibliography

Altier, W. J. (1991). Strategic thinking for today's corporate battles. Management Review, 80(11), 20. Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/206693649?accountid=14552

Argote, L and Miron-Spektor, E. "Organizational learning: from experience to knowledge." Organization Science 22.5 (2011): 1123-1137.

Berry, F. S. (1994). Innovation in public management: The adoption of strategic planning. *Public Administration Review, 54*(4), 322-330. Retrieved from http://www.jstor.org/stable/977379

Bialek, R., Moran, J., McCoy, K., Riley, W., & Shirley, L. (2009). Your pandemic flu plan for fall 2009. *PHF,*

Bolman, L.,& Deal, T. (1991). *Reframing Organizations. Artistry, choice, and leadership.* San Francisco: Jossey-Bass.

Bolman, L., & Deal, T. (2008). *Reframing organizations :Artistry, choice, and leadership*. San Francisco: Jossey-Bass. From:

Bowman, S. (2008). *Creating a strategic planning team b.* Retrieved 10/14, 2014, from http://www.conscious-governance.com/creating-a-strategic-planning-team.html

Business Dictionary (2014). Long Term Planning.http://www.businessdictionary.com/definition/long-term-planning.html

Cronshaw, S. F., & McCulloch, A. N. A. (2008). Reinstating the lewinian vision: From force field analysis to organization field assessment. *Organization Development Journal, 26*(4), 89-103. Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/197998674?accountid=14552

Harari, O. (1995). Good/bad news about strategy. *Management Review, 84*(7), 29. Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/206681008?accountid=14552

Heifetz, R.A., Linsky, M., & Grashow, A. (2009) The practice of adaptive leadership: Tools and tactics for changing you organization and the world. Cambridge, MA: Harvard Business Press.

Hrebinak, L. (2006). Obstacles to effective strategy implementation. *Organizational Dynamics, 35*(1), 12-31. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.orgdyn.2005.12.001

Hurt, F. (1998). Implementing great new ideas through the use of force-field analysis (part three of a series). *Direct Marketing, 61*(1), 54-56. Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/212778856?accountid=14552

Iowa State University Extension and Outreach. (2014). *Force field analysis.* Retrieved 11/01, 2014, from http://www.extension.iastate.edu/communities/force-field-analysis

Kohl, J. (2006). Mental models that block strategic plan implementation. *Reflections, 7*(1), 30-42. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=buh&AN=21175477&site=ehost-live

Londeix, B. (1995). Deploying realistic estimation (field situation analysis). *Information and Software Technology, 37*(12), 665-670. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/0950-5849(96)81743-5

Lorange, P., & Vancil, R. F. (1976). How to design a strategic planning system. Velazquez, L. E., Esquer, J., Munguía, N.,E., & Moure-Eraso, R. (2011). Sustainable learning organizations. The Learning Organization, 18(1), 36-44. doi:http://dx.doi.org/10.1108/09696471111095984

Luthra, C. (2013). *Strategic planning definition.* Retrieved 10/20, 2013, from http://www.businessdictionary.com/definition/strategic-planning.html#ixzz2iHjUV2Cv

Mendenhall, M. (2013). *Strategic planning failure.* Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html

NACCHO, (2010). Developing a Local Health Department Strategic Plan: A How to Guide.

from;http://www.naccho.org/topics/infrastructure/accreditation/upload/strategicplanningguidefinal.pdf

NACCHO. (2012). *MAPP basics - introduction to the MAPP process, 2012.* Retrieved 11/1, 2013, from http://www.naccho.org/topics/infrastructure/mapp/framework/mappbasics.cfm

O'Reilly, C. A., Caldwell, D. F., Chatman, J. A., Lapiz, M., & Self, W. (2010). How leadership matters: The effects of leaders' alignment on strategy implementation. *The Leadership Quarterly*, *21*(1), 104-113. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.leaqua.2009.10.008

O'Brien, R. (1998). An Overview of the Methodological Approach of Action Research. Overview of

Action Research Methodology. Retrieved February 28, 2012, http://www. web.net/~ robrien/papers/arfinal.html

Ott, C., KZatz, D., Thomas, G. & Plenert, G. (2014). *Strategy implementation.* Retrieved 10/2, 2014, from http://www.referenceforbusiness.com/management/Sc-Str/Strategy-Implementation.html

Palmer, I., & Dunford, R. (1996). Reframing and organizational action: The unexplored link. *Journal of Organizational Change Management*, *9*(6), 12-25. Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/197598779?accountid=14552

Pellegrinelli, S., & Bowman, C. (1994). Implementing strategy through projects. *Long Range Planning*, *27*(4), 125-132. doi:http://dx.doi.org.proxy.cc.uic.edu/10.1016/0024-6301(94)90062-0

PHAB. (2013). *Public health accreditation board-benefits.* Retrieved 10/04, 2013, from http://improveph.org/about/faq.asp#benefits

PHAB Accreditation Board. (2011). *Standards and measures.* Retrieved 11/15, 2013, from http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf

PHAB Accreditation Board. (2013). Accreditation-getting started. Retrieved 10/08, 2013, from http://www.phaboard.org/accreditation-overview/getting-started/

PHAB Accreditation Board. (2015) Retrieved 11/06, 2015,from http://www.phaboard.org/

Poister, T. H., Pitts, D. W., & Hamilton Edwards, L. (2010). Strategic management research in the public sector: A review, synthesis, and future directions. *American Review of Public Administration, 40*(5), 522-545.

Preuss, P. (2008). *School leader's guide to root cause analysis using data to dissolve problems*. New Yourk: Routledge.

Public Health Accreditation Board. *PHAB definition.* Retrieved 9/25, 2013, from http://www.phaboard.org/accreditation-overview/what-is-accreditation/

Public Health Accreditation Board. (2013). *Welcome to the public health accreditation board-accreditation background.* Retrieved October 4, 2013, 2013, from http://www.phaboard.org/about-phab/public-health-accreditation-background/

Roback, P. (2011). *2011-2013 Washington county strategic plan* (Plan). Washington County Wisconsin:

Scriven, M. (1973). The methodology of evaluation. In B. R. Worthen and J. R. Sanders Educational Evaluation: Theory and Practice. Belmont, CA:Wadsworth.

Shams, A. (2011). Can accreditation work as a tool for quality improvement in public health? A critical review. (M.P.H., The University of Texas School of Public Health). *ProQuest Dissertations and Theses,* Retrieved from http://search.proquest.com.proxy.cc.uic.edu/docview/843227271?accountid=14552

Worthen, Blaine R. And James R. Sanders. (1987).Educational Evaluation: Alternative Approaches and Practical Guidelines New York: Longman.

VII. Appendices

Appendix A: Domain and Standards taken from PHAB (PHAB, 2017)

DOMAIN 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community **Standard 1.1: Participate in or Lead a Collaborative Process Resulting in a Comprehensive Community Health Assessment** **Standard 1.2: Collect and Maintain Reliable, Comparable, and Valid Data that Provide Information on Conditions of Public Health Importance and On the Health Status of the Population** **Standard 1.3: Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors that Affect the Public's Health** **Standard 1.4: Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions**
DOMAIN 2: Investigate health problems and environmental public health hazards to protect the community **Standard 2.1: Conduct Timely Investigations of Health Problems and Environmental Public Health Hazards** **Standard 2.2: Contain/Mitigate Health Problems and Environmental Public Health Hazards** **Standard 2.3: Ensure Access to Laboratory and Epidemiologic/Environmental Public Health Expertise and Capacity to Investigate and Contain/Mitigate Public Health Problems and Environmental Public Health Hazards** **Standard 2.4: Maintain a Plan with Policies and Procedures for Urgent and Non-Urgent Communications**
DOMAIN 3: Inform and educate about public health issues and functions **Standard 3.1: Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness** **Standard 3.2: Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences**
DOMAIN 4: Engage with community to identify and address health problems **Standard 4.1: Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes** **Standard 4.2: Promote the Community's Understanding of and Support for Policies and Strategies that will Improve the Public's Health**
DOMAIN 5: Develop public health policies and plans **Standard 5.1: Serve as a Primary and Expert Resource for Establishing and Maintaining Public Health Policies, Practices, and Capacity** **Standard 5.2: Conduct a Comprehensive Planning Process Resulting in a Tribal/State/Community Health Improvement Plan** **Standard 5.3: Develop and Implement a Health Department Organizational Strategic Plan** **Standard 5.4: Maintain an All Hazards Emergency Operations Plan**
DOMAIN 6: Enforce public laws **Standard 6.1: Review Existing Laws and Work with Governing Entities and Elected/Appointed Officials to Update as Needed** **Standard 6.2: Educate Individuals and Organizations on the Meaning, Purpose, and Benefit of Public Health Laws and How to Comply** **Standard 6.3: Conduct and Monitor Public Health Enforcement Activities and Coordinate Notification of Violations among Appropriate Agencies**
DOMAIN 7: Promote strategies to improve access to health care **Standard 7.1: Assess Health Care Service Capacity and Access to Health Care Services** **Standard 7.2: Identify and Implement Strategies to Improve Access to Health Care Services**
DOMAIN 8: Maintain a competent public health workforce **Standard 8.1: Encourage the Development of a Sufficient Number of Qualified Public Health Workers** **Standard 8.2: Ensure a Competent Workforce through Assessment of Staff Competencies, the Provision of Individual Training and Professional Development, and the Provision of a Supportive Work Environment**
DOMAIN 9: Evaluate and continuously improve processes, programs, and interventions **Standard 9.1: Use a Performance Management System to Monitor Achievement of Organizational Objectives** **Standard 9.2: Develop and Implement Quality Improvement Processes Integrated Into Organizational Practice, Programs, Processes, and Interventions**
DOMAIN 10: Contribute to and apply the evidence base of public health **Standard 10.1: Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions** **Standard 10.2: Promote Understanding and Use of the Current Body of Research Results, Evaluations, and Evidence-Based Practices with Appropriate Audiences**
DOMAIN 11: Maintain administrative and management capacity **Standard 11.1: Develop and Maintain an Operational Infrastructure to Support the Performance of Public Health Functions** **Standard 11.2: Establish Effective Financial Management Systems**

DOAMIN 12: Maintain capacity to engage the public health governing entity

Standard 12.1: Maintain Current Operational Definitions and Statements of the Public Health Roles, Responsibilities, and Authorities

Standard 12.2: Provide Information to the Governing Entity Regarding Public Health and the Official Responsibilities of the Health Department and of the Governing Entity

Standard 12.3: Encourage the Governing Entity's Engagement In the Public Health Department's Overall Obligations and Responsibilities

Appendix B: Monthly Report

TOLEDO-LUCAS COUNTY HEALTH DEPARTMENT
Stay informed. Stay healthy.

2017-2020 Strategic Plan Progress Report

Name of person completing report: Click here to enter text. **Date:** Click here to enter a date.

☐ Access to Care	☐ Obesity (Adult & Youth)	☐ Infant Mortality	☐ Health Promotion
☐ Workforce Development	☐ Financial Stability	☐ Opiate Epidemic/Drugs	☐ Healthy Homes

Objective Number *(Check the appropriate objective)* ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Start Date: Enter Date
End Date: Enter Date

Note any proposed adjustments to time frames or target dates: Click here to enter text.

Action Step #	Progress	Facilitators	Barriers	Objective Outcome	Objective Met
E.g., 1, 1a, 2, 2a, 3, 3a etc.	What progress has been made toward each objective/ action step's target?	What Facilitators have been identified that are contributing to the action step's success?	What Barriers have been identified that are impeding the action step's success?	Indicate what has been learned about the objective.	Has the objective has been met? Indicate Yes or No and provide explanation for any unmet objective.
1	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
1a	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
1b	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose a #	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose a #	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Page **1** of **1**

Appendix C: Constructs and Citations for Barriers and Facilitators

Table XVIII: Construct Barriers/Citation/Evidence Summary

Barriers (Factors) Number of References	**References**	**Source of Evidence**
Lack of Timely Action-9		
Lack of Early Identification of Problems: When major problems of implementation are not identified by management early it becomes an issue to implementation.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.
Inability to Manage Rapid Change: Inability of an organization to manage rapid change can be a barrier.	Hrebinak, L. (2006). Obstacles to effective strategy implementation. Organizational Dynamics, 35(1), 12-31. doi: http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.orgdyn.2005.12.002	Business- Data was from two different surveys of educational programs for mangers and executive.
Lack of Urgency: Those in the organization do not realize the urgency of strategic plan implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Implementation Taking Longer than Expected: When implementation takes more time than originally anticipated it becomes a barrier.	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business United Kingdom

Barriers (Factors) Number of References	References	Source of Evidence
Implementation Taking Longer than Expected: Implementation taking more time than originally allocated can be considered a barrier.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	"Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.
Expeditiously do what is Needed: Failure to expeditiously do what is needed to be done.	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html	Business review of Xerox, Hewlett Packard
Development of Program Specific took longer than expected: Development of program-specific performance measures and action plans took an additional four months to implement.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Waited too Long to Plan: Waited too long to start planning the 2018 performance measures.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.

Barriers (Factors) Number of References	References	Source of Evidence
Did not adhere to the 60-Action Plan: Mangers did not use the 60-day action planning which resulted in poor execution and oversight of the implementation process.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Poor Coordination/Communication-10		
Poor Communication with Staff: Problems requiring top management involvement were not communicated to staff fast enough causing a barrier.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.
Lack of understanding of Goals by Staff: When the goals are not well understood by staff there develops a barrier.	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business United Kingdom
Poor Communication within Organization: Management's vague criteria of standards and measures for implementation not communicated by management to staff.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.

Barriers (Factors) Number of References	References	Source of Evidence
Poor communication/ coordination information sharing: Poor sharing of information about implementation can result in managers not knowing who is responsible / accountable for implementation.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.
Lack of Staff Understanding: Staff lack of understanding how the strategic plan implementation affects them due to poor communication from managers to staff.	Heide, M., Grønhaug, K., & Johannessen, S. (2002). Exploring barriers to the successful implementation of a formulated strategy. Scandinavian Journal of Management, 18(2), 217-231	Business -Cruise line looking at Restaurant Department vs Kitchen Department implementation
Poor Communication General: Poor communication regarding implementation within an organization.	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business United Kingdom
Poor Coordination: Coordination of implementation activates in the organization was not effective enough.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Coordination: When coordination of implementation breaks down it causes an issue with implementation.	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business United Kingdom

Barriers (Factors) Number of References	**References**	**Source of Evidence**
Lack of Understanding: Staff and managers were unsure about what performance measures would be carried into the next year.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Lack of Communication: Mangers did not ask for QI help regarding performance management completion.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Unclear Roles/Responsibility-7		
Lack of Models: Staff Not Knowing What to Do: Not having guidelines or a model to guide implementation efforts can result in management inability to let staff know what to do.	Hrebinak, L. (2006). Obstacles to effective strategy implementation. Organizational Dynamics, 35(1), 12-31. doi: http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.orgdyn.2005.12.002	Business- Data was from two different surveys of educational programs for mangers and executive
Unclear Responsibility: Unclear responsibility and accountability by managers becomes a hindrance to implementation.	Heide, M., Grønhaug, K., & Johannessen, S. (2002). Exploring barriers to the successful implementation of a formulated strategy. Scandinavian Journal of Management, 18(2), 217-231	Business -Cruise line looking at Restaurant Department vs Kitchen Department implementation

Barriers (Factors) Number of References	**References**	**Source of Evidence**
Insufficient training and instruction to staff: Training and instruction from leadership to others about implementing the plan were insufficient.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic plan decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.
Lack of Training: Lack of training and instruction to employees by managers.	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2). 16-21.	Business -Review of business in general - SBUs Strategic Business Units was the acronym used to describe the type of business (Firms)
Managers' Lack of Needed Skills: Insufficient managerial training where managers are not trained to face the out of the ordinary or strange situations during implementation becomes a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Unclear tasks/roles for staff: Key tasks of implementation and activities were insufficiently defined by management.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.

Barriers (Factors) Number of References	**References**	**Source of Evidence**
Unclear tasks: Managers waited for the Health Commissioner to Gantt chare their work when they should have accomplished this process.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Competing Priorities-2		
Competing Activities, Priorities: Competing activities to implementation are barriers.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group. ***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97.
Crisis: Crisis which causes distraction from implementation are barriers.	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business United Kingdom
External Factors-3		
External Stakeholders (including political factors): External Factors such as politics or stakeholders (involvement/ noninvolvement) can be a barrier.	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business United Kingdom

Barriers (Factors) Number of References	References	Source of Evidence
Rapid Change in Environment: The rapid changing of variables affecting the organization can become a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Stability with Regulations: Rapid change in external rules puts pressures on those in the organization so they cannot respond appropriately to implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Attitudinal Factors-11		
Managers' Fear of Losing Power: The real or perceived loss of power because of implementation by managers causes opposition to implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Fear of losing power: Opposed to the change in their own power that results from change due to strategic plan. So, they create their own barriers for implementation.	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2).16-21.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Barriers (Factors) Number of References	References	Source of Evidence
Lack of Managers' Motivation for Change: A barrier to implementation can be formed when there is no motivation by managers to do new things for implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Managers' Lack of Willingness to Change: If managers cannot or do not change the way they view and undertake strategic plan implementation, that's a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Trust/Support across Staff Levels in Organization: Failure to trust and support each other at the various levels of the organization creates an environment for a barrier to implementation.	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html	Business review of Xerox, Hewlett Packard
Lack of Staff Commitment to Process: When consent is lacking from managers and others formulating the plan it impedes implementation	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack Belief in the Process: When participants do not believe in the process of implementation	Elbanna, S., & Fadol, Y. (2016). An Analysis of the Comprehensive Implementation of Strategic Plans in Emerging Economies: The United Arab Emirates as a Case Study. European Management Review, 13(2), 75-89. doi:10.1111/emre.12068	Public Entitles-United Arab Emirates-500 questionnaires where 23 returned by public organizations in the United Arab Emirates

Barriers (Factors) Number of References	References	Source of Evidence
Lack of Buy-in/ Support from Managers: Managers do not think the plan will make a difference impedes implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Commitment from Management: Lack of commitment to implementation from management is a barrier.	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2). 16-21.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Risk Avoidance by Managers: When managers avoid risks due to possible poor results it hampers implementation	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Communication: Managers not sharing information because they are afraid of uncertainty due to implementation reducing their resources or potential loss of their position.	Elbanna, S., & Fadol, Y. (2016). An Analysis of the Comprehensive Implementation of Strategic Plans in Emerging Economies: The United Arab Emirates as a Case Study. European Management Review, 13(2), 75-89. doi:10.1111/emre.12068	Public entitles-United Arab Emirates-500 questionnaires where 23 returned by public organizations in the United Arab Emirates
Lack of Evaluation or Insufficient Evaluation/Performance Management -6		
Lack of Employee Evaluation or Rewards: No evaluation of employees doing implementation work causes a disconnect to a reward system, results in a possible barrier.	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2) 16-21.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Barriers (Factors) Number of References	References	Source of Evidence
Little or No Rewards to Involved Managers: Little or no reward to managers doing implementation creates a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Effective Staff Oversight: Lack of regular checks to ensure employees accomplish their tasks is an impediment.	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2). 16-21.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Unclear Performance Standards: When performance standards and measurements are not well defined, they become barriers.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Formal Evaluation: Lack of formal evaluation process created procrastination and projects not being completed.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Lack of Following Documentation: QI teams did not follow documentation requirements as outlined in the QI Plan which resulted in incomplete document for almost all projects.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.

Barriers (Factors) Number of References	References	Source of Evidence
Organizational Culture-6		
Leaders' failure to understand Organizational Culture: Failure of leaders to understand the culture of the organization-how the organization operates, and employees interact impedes implementation.	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html	Business review of Xerox, Hewlett Packard
Lack of Supportive Organizational Culture: Lack of culture that supports implementation is an impediment to implementation.	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2). 16-21.	Business
Lack of Values Supporting Plan: Failure by those in the organization to develop values and culture to support the plans is a barrier	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html	Business review of Xerox, Hewlett Packard
Lack of Fit with Organizational Culture: When the plan does not fit with the makeup of the organization (resources/personnel/structure) it can have a negative impact on implementation	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Barriers (Factors) Number of References	References	Source of Evidence
Lack of Fit with Organizational Culture: Plans are inadequate or inappropriate.	Bryson, J. M. 1. (2011). *Strategic planning for public and nonprofit organizations: A guide to strengthening and sustaining organizational achievement* (Fourth ed.). San Francisco: Jossey-Bass.	Authors work as depicted in published book
Ethical and Legal Problems: Failure to prevent ethical/legal problems such as using manufactured budget data instead of actual.	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html	Business review of Xerox, Hewlett Packard
Lack of Skills/Mis-Aligned Skills-4		
Employees' Lack of Needed Skills: The ability for employees to do the implementation can be a barrier.	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248	Business - Britain -Surveys to 100 businesses in the Bradford Area with 6 implementation problems identified in 70 percent of the sample group.***replicates and extends Alexanders study Alexander, L. (1985), "Successfully implementing strategic decisions". Long Range Planning Vol. 18 No 3, pp. 91-97
Lack of Needed Staff Skills: Employees lacked capabilities to implement the plan	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business United Kingdom
Lack of Needed Skills, Multiple Levels in Organization: When the skill set and ability on any level do not align with the implementation strategy it causes a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Barriers (Factors) Number of References	**References**	**Source of Evidence**
Lack of Knowledge of Data Measurements: QI teams struggled with data measurements	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Health Department-Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Lack of Effective Strategic Planning/Mis- Alignment of Goals-6		
Unrealistic Goals: Setting of unrealistic goals.	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html	Business review of Xerox, Hewlett Packard
Lack of Fit of plan to Organization's Strategic Direction: When leadership does not align the plan to the strategic direction of the organization it can imped implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Poor Plan: If the strategy that is implemented is disconnected from the real world it can be a barrier. The plan needs to be in line with what the organization faces.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Barriers (Factors) Number of References	References	Source of Evidence
Poor or Vague Strategy, Staff Lack of Needed Skills: Poor or vague strategy limits the ability for implementation due to not having the direction, capabilities and skill sets of employees to implement the plan.	Hrebinak, L. (2006). Obstacles to effective strategy implementation. Organizational Dynamics, 35(1), 12-31. doi: http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.orgdyn.2005.12.002	Business- Data was from two different surveys of educational programs for mangers and executive
Lack of Alignment of Individual Employee Goals with Organizational Goals: When the goals of the individual or their agenda are not in line with the organization's it can be a barrier to implementation of the strategic plan.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Knowledge of Best Practices: Management not thinking that strategic planning is a well-defined or scientific discipline.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Insufficient Budget/Resources-4		
Budget, due to lack of allocation by top management: The lack of connection between plan and budget (top management does not allocate funds for implementation) it can be a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Barriers (Factors) Number of References	References	Source of Evidence
Budget Issues: Lack resources to execute the plan is a barrier.	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html	Business review of Xerox, Hewlett Packard
Budget Issues: When there is not sufficient funding to support implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Information systems challenges: Lack of software and hardware platforms can become an issue when implementing a strategic plan.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Involvement of Managers and/or Staff-8		
Insufficient Involvement of Top Managers in Strategy Formulation: If there is insufficient involvement of top managers at strategy formulation stage it hampers implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Involvement of Multiple Levels of Staff: When there are not different levels of the organizational staff involved with the implementation it becomes a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Barriers (Factors) Number of References	References	Source of Evidence
Lack of Staff Involvement: Lack of participation by employees in the implementation process is a concern to implementation.	Elbanna, S., & Fadol, Y. (2016). An Analysis of the Comprehensive Implementation of Strategic Plans in Emerging Economies: The United Arab Emirates as a Case Study. European Management Review, 13(2), 75-89. doi:10.1111/emre.12068	Public entitles-United Arab Emirates-500 questionnaires where 23 returned by public organizations in the United Arab Emirates
Lack of Staff Involvement/ Participation: When all employees are not working towards implementation it becomes an issue to strategic plan implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Lack of Employee Involvement during creation of the plan: Lack of participation of employees during the creation of the plan can cause a barrier during implementation.	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2). 16-21.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique.
Lack of Involvement of Multiple Levels of Staff: When there are not different levels of the organizational staff involved with the implementation it becomes a barrier.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique
Unclear responsibility in new tasks: Lack of routine and unclear responsibility by employees.	Heide, M., Grønhaug, K., & Johannessen, S. (2002). Exploring barriers to the successful implementation of a formulated strategy. Scandinavian Journal of Management, 18(2), 217-231	Business -Cruise line looking at Restaurant Department vs Kitchen Department implementation

Barriers (Factors) Number of References	References	Source of Evidence
Turnover of Top Managers: When managers are replaced implementation is impeded due to not having, he supports for implementation.	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Govt-Implementing a plan at the Mashhad Electric Energy Distribution Company. -Panel of 11 top executives - qualitative study and a semi-structured interview based on snowball technique

Table XIX: Construct Facilitators/Citation/Evidence Summary

Facilitating Factors Number of References	**References**	**Source of Evidence**
Communication/Coordination-2		
Collaborative Internal Teams: Those planning plan together as a team, which can cause a shared understanding of what is important when implementing the plan.	Blatstein, I. M. (2012). Strategic planning: Predicting or shaping the future? Organization Development Journal, 30(2), 31-38. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=77293189&site	From one Non-profit but the author draws on experience from facilitation of strategic planning in two different large companies 4,000-20,000 people and three small 20-100 people
Staff and Board member collaboration: Staff and board members who implement together (not in silos) is a facilitator.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit
Attitudinal Factors-2		

Facilitating Factors Number of References	**References**	**Source of Evidence**
Leaders Influence: When senior management's vison on how to gain buy-in creates a value of ownership by employees it allows for easier implementation.	Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908	Group work with managers responsible for implementing strategic initiatives was followed by case studies of seven organizations via-in-depth semi-structured interviews. A survey questionnaire strengthened the validly of the constructs of strategy deployment that was identified in the case analyses
Vision from Senior Leadership: Senior leadership must be actively involved in implementation process, so they can add their vison and commitment to the process and thus have other staff know the process is supported.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit
Sufficient Budget/Resources-1		
Budgeting for Needed Resources: Budgeting for strategic ideas involved in implementation is a facilitator.	Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908	Group work with managers responsible for implementing strategic initiatives was followed by case studies of seven organizations via-in-depth semi-structured interviews. A survey questionnaire strengthened the validly of the constructs of strategy deployment that was identified in the case analyses

Facilitating Factors Number of References	References	Source of Evidence
Reports Worked Well: Quarterly reports worked well to adhere to action steps.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.
Involvement of Managers and Staff-6		
Leader Involvement: When leaders become more involved in the implementation process it creates an environment for success.	P.C. Nutt. (1987). Identifying and appraising how managers install strategy, Strategic Management Journal, 8, 1-14 (1987).	Strategic planning projects in 68 different organizations were studied to identify implementation tactics. Organizations that provided clinical education for students served as the data base. The CEO, COO, or CFO in each organization all agreed to participate. The participating organizations included hospitals, and other non-profit or third-sector organizations, such as charities and professional societies, and governmental agencies.
Vision from Senior Leadership: Senior leadership must be actively involved in implementation process, so they can add their vison and commitment to the process and thus have other staff know the process is supported.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit

Facilitating Factors Number of References	References	Source of Evidence
Organizational Leadership Involvement: Leadership that is involved in the implementation process, and not simply delegates the planning to subordinates, improves the chances of success.	Blatstein, I. M. (2012). Strategic planning: Predicting or shaping the future? Organization Development Journal, 30(2), 31-38. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=77293189&site	From one Non-profit but the author draws on experience from facilitation of strategic planning in two different large companies 4,000-20,000 people and three small 20-100 people
Manager Involvement: Success is of implementation is found when managers become involved and takes charge to create the environment conducive to implementation.	P.C. Nutt. (1987). Identifying and appraising how managers install strategy, Strategic Management Journal, 8, 1-14	Strategic planning projects in 68 different organizations were studied to identify implementation tactics. Organizations that provided clinical education for students served as the data base. The CEO, COO, or CFO in each organization all agreed to participate. The participating organizations included hospitals, and other non-profit or third-sector organizations, such as charities and professional societies, and governmental agencies.
Staff, Board members, Other Stakeholder Involvement: Plans that have stakeholders with at least staff, board members, clients and partners input are more successful.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit

Facilitating Factors Number of References	References	Source of Evidence
Board involvement: Getting the board involved and comfortable with the strategic planning and implementation.	Dahmus, L., & Wooten, L. P. (2012). The board room: Barriers to strategic planning and how to transcend them. Nonprofit World, 30(5), 8-10. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=79913243&site=ehost-live&scope=site	Reviewed the board of one small non-profit entity. This was observations before and during strategic planning was of a small private school in the southern region of the United States.
Lack of/ Insufficient Evaluation/Performance Management-4		
Feedback from staff, outside stakeholders: Managers stated that feedback from staff and other stakeholders is imperative to implementation.	Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908	Group work with managers responsible for implementing strategic initiatives was followed by case studies of seven organizations via-in-depth semi-structured interviews. A survey questionnaire strengthened the validly of the constructs of strategy deployment that was identified in the case analyses
Employee Performance Evaluation and Recognition: The use performance evaluation linked to successful implementation as a reward.	Reed, R., & Buckley, M. R. (1988). Strategy in action—Techniques for implementing strategy. Long Range Planning, 21(3), 67-74. 10.1016/0024-6301(88)90035-0	Business-The European business units (SBU) Manufacturer of large valves in the oil and petrochemical industries.
Regular Evaluation of Progress: Board of directors find that regular evaluation of the progress is an impelling factor for implementation.	Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908	Group work with managers responsible for implementing strategic initiatives was followed by case studies of seven organizations via-in-depth semi-structured interviews. A survey questionnaire strengthened the validly of the constructs of strategy deployment that was identified in the case analyses

Facilitating Factors Number of References	References	Source of Evidence
Recognition and Use of Best Practices: Successful implementation stems from the review of success and failure of others relative to strategic planning and constructing an organization specific plan from best practices.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit
Clear Roles / Responsibility-2		
Collaborative Internal Teams: Those planning plan together as a team which can cause a shared understanding of what is important when implementing the plan.	Blatstein, I. M. (2012). Strategic planning: Predicting or shaping the future? Organization Development Journal, 30(2), 31-38. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=77293189&site=ehost-live&scope=site	From one Non-profit but the author draws on experience from facilitation of strategic planning in two different large companies 4,000-20,000 people and three small 20-100 people
Staff and Committee Involvement: Employees and or committees that are empowered to make decisions on strategic planning have more successful plans.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit
Effective Strategic Planning/Alignment of Goals-2		
Clear Goal Setting, Clear Communication: Use of goal setting to increase communication impels implementation.	Reed, R., & Buckley, M. R. (1988). Strategy in action—Techniques for implementing strategy. Long Range Planning, 21(3), 67-74. 10.1016/0024-6301(88)90035-0	Business-The European business units (SBU) Manufacturer of large valves in the oil and petrochemical industries.

Facilitating Factors Number of References	References	Source of Evidence
Strategically Aligned Objectives: Organizations that have developed a strategic plan that has objectives strategically aligned with what the organization deems important have a better chance at successful implementation.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit
Keeping Momentum Despite Competing Priorities (Facilitator)-1		
Focus on progress despite competing priorities: Organizations that showed more success in implementation realized that other issues will compete during implementation but kept momentum, during the process.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit
Organizational Culture-4		
Positive Attitudes Towards Organizational Change: Organizations that have success with implementation are those that prepare and embrace changes within the organization.	Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-Profit

Facilitating Factors Number of References	**References**	**Source of Evidence**
Values of staff and organization: Values of the staff and organization, such as "alliance of staff and partners in action planning and training programs", can positively influence alignment with implementation.	Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908	Group work with managers responsible for implementing strategic initiatives was followed by case studies of seven organizations via-in-depth semi-structured interviews. A survey questionnaire strengthened the validly of the constructs of strategy deployment that was identified in the case analyses
Sufficient Skill/Aligned Skills-2		
Support for Staff Learning: Learning through the gain of knowledge and skills, then applied to implementation, may be a positive influence on implementation.	Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908	Group work with managers responsible for implementing strategic initiatives was followed by case studies of seven organizations via-in-depth semi-structured interviews. A survey questionnaire strengthened the validly of the constructs of strategy deployment that was identified in the case analyses
Training: Use of LEAN BootCamp or online training provided tools to the QI teams.	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Understanding that a strategic plan is only useful when implemented, this report of the work during the first 6 months of the 2016-2018 strategic plan adheres to PHAB Measure 5.3.3. and allows the Henry County Health Department to implement and evaluate their plan.

TABLE XX: Facilitating Factors: Sources, Authors and Evidence

Number of Sources	Authors	Evidence Source
7	Saunders, M., Mann, R., & Smith, R. (2008). Implementing strategic initiatives: a framework of leading practices. International Journal of Operations & Production Management, 28(11), 1095-1123. doi:10.1108/01443570810910908	Business
	P.C. Nutt. (1987). Identifying and appraising how managers install strategy, Strategic Management Journal, 8, 1-14 (1987).	Non-profits, charities, hospitals, governmental agencies
	(Mittenthal, R. (2002). Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders. TCC Briefing Paper, From: http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf	Non-profits
	Dahmus, L., & Wooten, L. P. (2012). The board room: Barriers to strategic planning and how to transcend them. Nonprofit World, 30(5), 8-10. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=79913243&site=ehost-live&scope=site	Non-profits
	Reed, R., & Buckley, M. R. (1988). Strategy in action—Techniques for implementing strategy. Long Range Planning, 21(3), 67-74. 10.1016/0024-6301(88)90035-0	Business
	Blatstein, I. M. (2012). Strategic planning: Predicting or shaping the future? Organization Development Journal, 30(2), 31-38. Retrieved from http://ezproxy.bgsu.edu:8080/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=77293189&site	Non-profits and business
	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Public Health

TABLE V: Barriers Factors: Sources, Authors and Evidence

Number of Sources	Authors	Evidence Source
9	Al-Ghamdi, S. M. (1998). Obstacles to successful implementation of strategic decisions: The British experience. European Business Review, 98(6), 322-327. Retrieved from http://rave.ohiolink.edu/ejournals/article/329388248.	Business
	Hrebinak, L. (2006). Obstacles to effective strategy implementation. Organizational Dynamics, 35(1), 12-31. doi: http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.orgdyn.2005.12.002	Business
	Nazemi, S., Asadi, S.T., (2015). Barriers to strategic planning implementation; case of: Mashad electrical distribution company. Procedia-Social and Behavioral Sciences, 207, 2-9.	Business/Government
	O'Regan, N. & Ghobadian, A. (2007, Jan-Apr). Formal strategic planning: Annual rain dance or wheel of success? Strategic Change, 16(1/2), 11-22.	Business
	Mendenhall, M. (2013). Strategic planning failure. Retrieved 11/1, 2013, from http://www.referenceforbusiness.com/management/Sc-Str/Strategic-Planning-Failure.html.	Business
	Heide, M., Grønhaug, K., & Johannessen, S. (2002). Exploring barriers to the successful implementation of a formulated strategy. Scandinavian Journal of Management, 18(2), 217-231.	Business
	Latif, B., Gohar, F. R., Hussain, A. & Kashif, M. M. (2013). Barriers to Effective Strategic Planning. International Journal of Management and Organizational Studies, 1(2). 16-21.	Business
	Elbanna, S., & Fadol, Y. (2016). An Analysis of the Comprehensive Implementation of Strategic Plans in Emerging Economies: The United Arab Emirates as a Case Study. European Management Review, 13(2), 75-89. doi:10.1111/emre.12068.	Public entities (government)
	Bryson, J. M. 1. (2011). Strategic planning for public and nonprofit organizations: A guide to strengthening and sustaining organizational achievement (Fourth ed.). San Francisco: Jossey-Bass.	Non-profits
	Goon, A. (2017). Henry County Health Department 2016-2018 Strategic Plan: Progress Report (pp. 1-39, Rep.). Napoleon, Ohio: Henry County Health Department.	Local Public Health

Appendix D: Document Review Template

Document Review

Document	A-priori Barrier	Other Barriers	A-priori Facilitator	Other Facilitators	A-priori Evaluation	Evaluation Outcome	Evaluation Process	Change In Plan
Implemented Strategic Plan								
Final Strategic Plan								
Implementation Committee Notes								
Priority Lead Report								
Annual Report								
PHAB Accreditation Report								

Appendix E: Monthly Report to the Implementation Committee Used for Quarterly Report to the Board

Example of Excel Data Table

Priority	Objective	Progress	Facilitators	Barriers	Lessons Learned (OL)	Outcome
HP	1	Only events that have been sent to the HPPI Director have been promoted.	Staff who have passed on information on upcoming events.	Lack of communication of upcoming events by the coordinators to the HPPI Director.	Reminder emails may be an appropriate suggestion to ensure upcoming events are promoted.	NA
HP	1a	Website has been updated with few events, social media has been reflective of this as well.	Supervisors and Program Coordinators who pass along upcoming event info.	Lack of communication of upcoming events by the coordinators to the HPPI Director.	Supervisors and Program Coordinators must communicate upcoming event or provide updates to the calendar on website.	NA

Appendix F: Example of Data Collection

Combined Barriers		Objective 1								
		Step 1	Step 1a	Step 2	Step 2a	Step 2b	Step3	Step 3a	Step 3b	Total
06/17	Timely Action									0
	Coordination/ Communication									0
	Roles/ Responsibilities									0
	Competing Priorities									0
	External Factors									0
	Attitude Factor									0
	Evaluation/ Perf. Management									0
	Organizational Culture									0
	Skills/ Alignment of Skills									0
	Strat Planning/ Alignment of Goals									0
	Budget/ Resources									0
	Involvement of Managers/ Staff									0
Total agreed		0	0	0	0	0	0	0	0	0
07/17	Timely Action									0
	Coordination/ Communication									0
	Roles/ Responsibilities									0
	Competing Priorities									0
	External Factors									0
	Attitude Factor									0
	Evaluation/ Perf. Management									0
	Organizational Culture									0
	Skills/ Alignment of Skills									0

	Strat Planning/ Alignment of Goals									0
	Budget/ Resources									0
	Involvement of Managers/ Staff									0
Total agreed		0	0	0	0	0	0	0	0	0
09/17	**Timely Action**									0
	Coordination/ Communication									0
	Roles/ Responsibilities									0
	Competing Priorities									0
	External Factors									0
	Attitude Factor									0
	Evaluation/ Perf. Management									0
	Organizational Culture									0
	Skills/ Alignment of Skills									0
	Strat Planning/ Alignment of Goals									0
	Budget/ Resources									0
	Involvement of Managers/ Staff									0
Total agreed		0	0	0	0	0	0	0	0	0
12/17	**Timely Action**									0
	Coordination/ Communication									0
	Roles/ Responsibilities									0
	Competing Priorities	1								1
	External Factors									0
	Attitude Factor						1			1
	Evaluation/ Perf. Management									0
	Organizational Culture						1			1

	Skills/ Alignment of Skills									0
	Strat Planning/ Alignment of Goals									0
	Budget/ Resources			1						1
	Involvement of Managers/ Staff				1					1
Total agreed		1	0	1	1	0	2	0	0	5
02/18	**Timely Action**									0
	Coordination/ Communication						1			1
	Roles/ Responsibilities									0
	Competing Priorities	1								1
	External Factors									0
	Attitude Factor									0
	Evaluation/ Perf. Management									0
	Organizational Culture									0
	Skills/ Alignment of Skills									0
	Strat Planning/ Alignment of Goals									0
	Budget/ Resources		1							1
	Involvement of Managers/ Staff									0
Total agreed		1	1	0	0	0	1	0	0	3
04/18	**Timely Action**								1	1
	Coordination/ Communication						1			1
	Roles/ Responsibilities									0
	Competing Priorities	1								1
	External Factors						1			1
	Attitude Factor									0
	Evaluation/ Perf. Management									0

	Organizational Culture									0
	Skills/ Alignment of Skills									0
	Strat Planning/ Alignment of Goals									0
	Budget/ Resources	1	1						1	3
	Involvement of Managers/ Staff						1	1		2
Total agreed		2	1	0	0	0	3	1	2	9
05/18	**Timely Action**									0
	Coordination/ Communication									0
	Roles/ Responsibilities									0
	Competing Priorities									0
	External Factors									0
	Attitude Factor									0
	Evaluation/ Perf. Management									0
	Organizational Culture									0
	Skills/ Alignment of Skills									0
	Strat Planning/ Alignment of Goals									0
	Budget/ Resources									0
	Involvement of Managers/ Staff									0
Total agreed		0	0	0	0	0	0	0	0	0
06/18	**Timely Action**									0
	Coordination/ Communication									0
	Roles/ Responsibilities									0
	Competing Priorities									0
	External Factors									0
	Attitude Factor									0

	Evaluation/ Perf. Management									0
	Organizational Culture									0
	Skills/ Alignment of Skills									0
	Strat Planning/ Alignment of Goals									0
	Budget/ Resources									0
	Involvement of Managers/ Staff						1			1
Total agreed		0	0	0	0	0	1	0	0	1

Appendix G: Code Book

The following codes will be used for focus group interviews and document review as needed.

Barrier Codes

Timely Action-Comments voiced that actions or decisions regarding implementation were slow or non-existent which hampered facilitation. *(e.g. The implementation committee would meet only once a quarter even if they were needed to make decisions monthly.)*

Coordination/Communication-Comments made that there was little coordination or communication between groups or to groups. *(e.g. Leadership never sent emails to all staff discussing strategic plan implementation. e.g. Leadership would not ensure or even care if staff worked together.)*

Roles/Responsibilities-Comments that discuss staff or others do not know or use their roles/responsibilities for implementation. *(e.g. Staff do not know who is responsible for specific implementation aspects of the plan.)*

Competing Priorities-Comments that suggest that competing priorities hampered implementation. *(e.g. The Hep A outbreak during implementation took up so much time the implementation committee did not meet for 6 months.)*

External Factors-Comments that are negative to facilitation when dealing with external factors. *(e.g. No external stakeholders were available during the implementation process.)*

Attitudinal Factors-Comments made that individual attitudes negatively affected implementation. *(e.g. The health commissioner though that implementation of the plan was a waste of time.)*

Evaluation/Performance Management-Comments that do not support individual evaluation of those implementing the plan to increase their desire to continue the needed work or negative comments made about evaluation of outcomes of implementation. *(e.g. Staff were never*

evaluated on their performance of reaching strategic plan objectives, so they were not enthusiastic about the process. e.g. The process to evaluate outcomes was a waste of time since only one person was doing the evaluation.)

Organizational Culture-Comments that the department was not working together or talking about the process of implementation positively. *(e.g. Staff did not like the idea of spending time working on implementation and no leaders wanted to address the issue.)*

Skills/Alignment of Skills-Comments made that those working on the plan did not have the ability or skills to implement the plan or that those implementing the plan were not the correct individuals due to their abilities. *(e.g. It was not important that a supervisor was working on the objective of improving leadership because he has only been a supervisor for a week.)*

Strategic Plaining/Alignment of Goals-Comments that the goals were not appropriate for the department. *(e.g. Lack of road salt in September is a strategic priority for the department.)*

Budget/Resources-Comments that the objectives and priorities were not accounted for in the budget or resources. *(e.g. For reduction in opiate use there was no funding in the budget to place users in treatment programs.)*

Involvement of Managers/Staff-Comments made that staff or mangers were not involved in the implementation process or comments made were of managers and staff hampered implementation. *(e.g. The health commissioner was never at an implementation committee meeting.)*

Evaluation/Performance Management-Comments made that either support or do not support the concept of evaluation during strategic plan implementation. In this study, evaluation is defined as the process that reviews some implementation outcome which allows the work to be assessed, continued, adjusted, or discarded. *(e.g. During the first evaluation of the strategic plan it was found that the objective of decreasing obesity in the community by 50% in six months was not*

realistic. That objective was changed to a decrease in obesity within the community by 5% in two years.)

Facilitator Codes

Timely Action-Comments voiced that quick actions or decisions regarding implementation helped facilitation. *(e.g. The implementation committee would meet as soon as an issue arose in which needed an immediate decision.)*

Coordination/Communication-Comments made about coordination or communication between groups or to groups enhanced implementation. *(e.g. Leadership sent emails to all staff weekly discussing strategic plan implementation. e.g. Leadership made sure that staff worked together.)*

Roles/Responsibilities-Comments that discuss staff or others knew or used their roles/responsibilities for implementation positively. *(e.g. Staff knew that they are responsible for specific implementation aspects of the plan.)*

Competing Priorities (Keeping Momentum Despite Competing Priorities)-Comments that suggest that competing priorities were noted, and they were addressed so not to hamper implementation. *(e.g. Yes, there was a Hep A outbreak during implementation, but overtime was given to work on implementation.)*

External Factors-Comments that are positive to facilitation when dealing with external factors. *(e.g. There were multiple stakeholders involved in the implementation process.)*

Attitudinal-Comments made that individual attitudes positively affected implementation. *(e.g. The health commissioner was always positive about meeting on a monthly basis to make sure the plan was being implemented.)*

Evaluation/Performance Management-Comments that support individual evaluation of those implementing the plan so to increase their desire to do the work or comments made about evaluation of outcomes that enhanced implementation. *(e.g. Staff were evaluated on their*

performance of reaching strategic plan objectives and were rewarded with a certificate of achievement for their work. e.g. The process to evaluate outcomes changed process of data collection in the department.)

Organizational Culture-Comments that supported the department working together or talking about the process of implementation positively. *(e.g. Staff did not like the idea of spending time working on implementation but after several meetings the staff understood how important implementation was to the department. From this they changed their minds that their time was well spent implementing the plan.)*

Skills/Alignment of Skills-Comments made that those working on the plan had the ability or skills to implement the plan or that those implementing the plan were the correct individuals due to their abilities. *(e.g. It was important that a supervisor was working on the objective of improving leadership because she was certified in supervision leadership.)*

Strategic Plaining/Alignment of Goals-Comments that the goals were appropriate for the department which increased the likely hood of implementation. *(e.g. Decreasing infant mortality is a primary mission of the department and is why it is a priority.)*

Budget/Resources-Comments that the objectives and priorities were accounted for in the budget or resources to make sure they were accomplished. *(e.g. For reduction in opiate use there was $10,000 placed in the budget for treatment programs)*

Involvement of Managers/Staff-Comments that due to involvement of staff or managers the implementation of the plan was successful. *(e.g. Every staff member completed a SWOT survey.)*

APPENDIX H: Meeting Agenda for Priority Area Facilitated Discussion Group

"Strategic Plan Implementation: A Case Study of Barriers, Facilitators, and Change"

Priority Area Facilitated Discussion Group

Agenda

The groups thoughts on barriers/facilitators and lessons learned.

Presentation of de-identified themes and findings from the Phase 1 review and Priority Group Discussion Session.

Conduct a facilitated discussion regarding how these themes resonate with the participants. Ask questions such as:

General questions for each group:

1. What have we learned from/about how to implement this priority?
2. Did things happen the way you thought they would, and if not, why not?

Discussion will then continue for the findings relevant to the priority area covered by the present work group, as follows.

For each factor below, please tell me:

3. Does this align with your own experience - why or why not? Can you give some examples to support your reflections?
4. Do you have additional comments or revisions regarding what we have learned about these factors?

Obesity

a. Involvement of Managers and Staff was a frequent Facilitator.
b. Budget Resources was a frequent Barrier
c. Timely Action, Competing Priorities, External Factors, Attitudinal Factors, Evaluation/Performance Management, and Organizational Culture were infrequent Facilitators.
d. Roles/Responsibilities, Evaluation, Skill and Alignment of Skills, and Strategic Planning Alignment of Goals were infrequent Barriers

Opiates

a. Coordination and Communication was a frequent Facilitator.
b. Budget Resources and External Factors were frequent Barriers
c. Competing Priorities and Organizational Culture were infrequent Facilitator
d. Roles and Responsibilities and Involvement of Managers and Staff were infrequent Barriers

Healthy Homes

a. Can you discuss why Budget Resources was a frequent Facilitator?
b. Can you discuss why Coordination/Communication was a frequent Barrier?
c. Can you discuss why Timely Action, Roles and Responsibilities, Attitudinal Factors, and External Factors were infrequent Facilitators?
d. Can you discuss why Roles and Responsibilities, Competing Priorities, Organizational Culture and Involvement of Staff and Managers were infrequent Barriers?

Infant Mortality

a. Can you discuss why External Factors was a frequent Facilitator?
b. Can you discuss why Strategic Planning/Alignment of Goals and External Factors were frequent Barriers?
c. Can you discuss why Timely Action, Roles and Responsibilities, Competing Priorities, Evaluation/Performance Management, Organizational Culture, Strategic Planning/Alignment of Goals were infrequent Facilitators?
d. Can you discuss why Roles and Responsibilities, and Involvement of Managers and Staff were infrequent Barriers?

The discussion will then continue with the following questions.

5. Reflecting on the barriers and facilitators to implementation of the action steps from the strategic plan relevant to this priority area that we have just discussed, what are the most important things we have learned that we didn't know before? Were there any prior knowledge or assumptions you had before that you have come to question? Were there prior assumptions you had that were confirmed or strengthened? Please explain.
6. Has the implementation of the plan impacted everyday operations or thinking involved in your work in this health department? If it has what are some examples? If it has not, why?
7. Considering what we have already said about the progress that has and hasn't been made, and about barriers and facilitators, and lessons learned about implementing this priority area of our strategic plans, what are your recommendations about what this health department (TLCHD) should do to proceed with this priority area going forward?

Appendix I: Meeting Agenda for Implementation Committee Facilitated Discussion Group

"Strategic Plan Implementation: A Case Study of Barriers, Facilitators, and Change"

Implementation Committee Facilitated Group Discussion

Agenda

The groups thoughts on barriers/facilitators and lessons learned.

Presentation of de-identified themes and findings from the Phase 1 review and Priority Group Discussion Session.

Conduct a facilitated discussion regarding how these themes resonate with the participants. Ask questions such as:

1. Do you agree with the findings? Why/why not?
2. What are your thoughts on what was concluded from the priority area discussion groups?
3. Can you provide additional recommendations for these 4 priority areas?
4. What did you learn from the implementation of the 4 priority groups?
5.

Presentation of the remaining four priority group findings of Phase 1 review.

Conduct a facilitated discussion regarding findings of the four areas that were not a facilitated group discussion.

1. Do you agree in relation to your experience or do you have additions or revisions?
2. What have we learned from/about how to implement the strategic plan?
3. Did things happen the way you thought they would, and if not, why not?

Overall does it align with your own experience and observations that the following 4 barrier factors show up as the most frequent relative to work accomplished for the entire strategic plan? Why or why not? Please give examples to support your response.

Timely Action

External Factors

Evaluation/ Perf. Management

Budget/ Resources

Overall does it align with your own experience and observations that the following 4 facilitating factors show up as the most frequent relative to work accomplished for the entire strategic plan? Why or why not? Please give examples to support your response.

Coordination/ Communication

Involvement of Managers/ Staff

External Factors

Attitude Factor

Appendix J : Demographics

"Strategic Plan Implementation: A Case Study of Barriers, Facilitators, and Change" Democratic Survey

Demographics

Q1 Demographics-Gender

Female

Male

Q2 Demographics-Age

18-28

29-39

40-50

51-61

62+

Q3 Demographics-Education

GED/High School

2-year associates degree

4-year BA/BS College

Master's Degree (other than Public Health)

Master's in Public Health

Doctorate (PhD, DrPH)

Doctorate (Medical, Veterinary)

Other

Q4 Demographics-Years of Employment at TLCHD

Less than 1 Year

1- 3

3-5

5-10

10-15

15 plus

Q5 Demographics-Which Division do you work in?

Environmental

Nursing (This might be more recognizable as Health Services/Outreach)

Administration (Vital Stats, Billing, Fiscal)

Health Promotion/Policy Integration

Q6 How much involvement have you had with the strategic plan other than the priority area we are discussing today?

None Some Full

1 2 3 4 5 6 7 8 9 10

Q7 How much involvement have you had with the strategic plan area we are discussion today?

None Some Full

1 2 3 4 5 6 7 8 9 10

Q9 How much experience did you have with the priority area topic before working on the area?

None Some Full

1 2 3 4 5 6 7 8 9 10

Q8. Please circle the best reason why you are working on the priority area?

Responsible for the topic per daily work assignment

Interested party

Was just assigned to the area by leadership

Appendix K: Priority Area Information Sheet for Facilitated Discussion Groups

Priority Area Information Sheet for Facilitated Discussion Groups
Strategic Plan Implementation: A Case Study of Barriers, Facilitators, and Change Evaluation Project

About this evaluation
The primary purpose of the evaluation is to discuss improvements to the implementation of TCLHD's strategic plan. Additionally, this work will be used for a dissertation project and the results from the discussion will be summarized in doctoral work. Information reported will be without any personal identifiers. The choice to participate in the evaluation is entirely voluntary and will be yours to make.

Procedure
The evaluation procedure has four distinct sections. The first is a basic demographic survey of participants. The second is a presentation of data collected from TLCHD's implementation reporting forms. The third is a facilitated group discussion with the priority group members. General questions asked during the discussion will be seeking your opinions on data collected from monthly reporting forms. The last section is a short evaluation questionnaire about the discussion process.

Participation
There will be five different, facilitated group discussions. Four will focus on the four strategic priority areas of Healthy Homes and Environment, Obesity (Adult & Youth), Opiates Epidemic/Drugs, and Infant Mortality. The fifth will focus on the implementation committee. Participation in the evaluation is being sought to improve the implementation process of strategic plans through honest feedback and engagement to better public health. The time commitment for these sessions is estimated to be less than two hours and while desired, participation remains strictly voluntary. At any time, you may leave the meeting if you so choose. Finally, know that your evaluation of TLCHD's strategic plan implementation process will both provide vital information to improve our process and ensure PHAB (Public Health Accreditation Board) required best practices are in place.

Data Collection and Use
Prior to facilitated discussion, a survey will collect basic demographic information, including gender, age, experience with the strategic plan, division worked in the department and involvement with the implementation process. The information will be used to understand the characteristics of the group of people giving feedback in the discussion, to ensure the data is coming from people with diverse organizational perspectives. The data collected will have no unique identifiers attached.
Discussion groups: Notes from the facilitated discussion groups will capture overall discussion points but will not have any identifiers attached. Notes will be destroyed after the completion of the dissertation. To ensure accuracy of the summary notes, the discussions will also be audio recorded and may be transcribed. The audio recordings will be destroyed following the conclusion of the dissertation. Any transcripts that did capture an identifier or name will have those names or other unique identifiers removed. If any participant requests a comment not be recorded, the recording will be stopped or paused. No logged information, from the surveys, the discussions, or the session evaluation forms, will be linked to identify individuals.

Taking part in this requested work is voluntary and has minimal to no risk
The product of the work will not have any identifiers or names associated with it. For example, a specific quote by an evaluation participant will not be associated with his/her name, position, or area of employment. Your participation in this evaluation is optional. Choosing to say "no" to this evaluation process or stopping participation at any time will not carry any ramifications to you professionally or personally. Furthermore, the purpose of this evaluation is not to focus on any individual's responsibilities or blame for previous actions, but to assess progress as a department.

Evaluation will also look to identify additional steps necessary for effectively moving forward with implementation of the TLCHD strategic plan.

Evaluation products and dissemination

The findings from the facilitated priority area group discussions will be reviewed at the Implementation Committee. Responses by implementation committee participants will be used to verify, change, or add to the data presented by the evaluator, as adjusted from the findings of the facilitated priority area discussion groups. Results from the Implementation Committee discussion groups and priority area groups will then be used to create a report that will be presented to the Toledo-Lucas County Health Board of Health. Findings and reports may also be publicly disseminated as presentations or journal articles outside of the TLCHD.

Contacts for further information

If you have any questions about this evaluation project, you may contact Eric Zgodzinski at zgodzine@co.lucas.oh.us. You may also contact dissertation supervisor Dr. Eve Pinsker at the University of Illinois at Chicago at epinsker@uic.edu or 773-802-4802.

Priority Area Information Sheet for Facilitated Discussion Group Implementation Committee
Strategic Plan Implementation: A Case Study of Barriers, Facilitators, and Change
Evaluation Project

About this evaluation
The primary purpose of the evaluation is to discuss improvements to the implementation of TCLHD's strategic plan. Additionally, this work will be used for a dissertation project and the results from the discussion will be summarized in doctoral work. Information reported will be without any personal identifiers. The choice to participate in the evaluation is entirely voluntary and will be yours to make.

Procedure
The evaluation procedure has four distinct sections. The first is a basic demographic survey of participants. The second is a presentation of data collected from TLCHD's implementation reporting forms. The third is a facilitated group discussion with the priority group members. General questions asked during the discussion will be seeking your opinions on data collected from monthly reporting forms. The last section is a short evaluation questionnaire about the discussion process.

Participation
There will be five different, facilitated group discussions. Four will focus on the four strategic priority areas of Healthy Homes and Environment, Obesity (Adult & Youth), Opiates Epidemic/Drugs, and Infant Mortality. The fifth will focus on the implementation committee. Participation in the evaluation is being sought to improve the implementation process of strategic plans through honest feedback and engagement to better public health. The time commitment for these sessions is estimated to be less than two hours and while desired, participation remains strictly voluntary. At any time, you may leave the meeting if you so choose. Finally, know that your evaluation of TLCHD's strategic plan implementation process will both provide vital information to improve our process and ensure PHAB (Public Health Accreditation Board) required best practices are in place.

Data Collection and Use
Prior to facilitated discussion, a survey will collect basic demographic information, including gender, age, experience with the strategic plan, division worked in the department and involvement with the implementation process. The information will be used to understand the characteristics of the group of people giving feedback in the discussion, to ensure the data is coming from people with diverse organizational perspectives. The data collected will have no unique identifiers attached.
Discussion groups: Notes from the facilitated discussion groups will capture overall discussion points but will not have any identifiers attached. Notes will be destroyed after the completion of the dissertation. To ensure accuracy of the summary notes, the discussions will also be audio recorded and may be transcribed. The audio recordings will be destroyed following the conclusion of the dissertation. Any transcripts that did capture an identifier or name will have those names or other unique identifiers removed. If any participant requests a comment not be recorded, the recording will be stopped or paused. No logged information, from the surveys, the discussions, or the session evaluation forms, will be linked to identify individuals.

Taking part in this requested work is voluntary and has minimal to no risk
The product of the work will not have any identifiers or names associated with it. For example, a specific quote by an evaluation participant will not be associated with his/her name, position, or area of employment. Your participation in this evaluation is optional. Choosing to say "no" to this evaluation process or stopping participation at any time will not carry any ramifications to you professionally or personally. Furthermore, the purpose of this evaluation is not to focus on any individual's responsibilities or blame for previous actions, but to assess progress as a department. Evaluation will also look to identify additional steps necessary for effectively moving forward with implementation of the TLCHD strategic plan.

Evaluation products and dissemination

The findings from the facilitated priority area group discussions will be reviewed at the Implementation Committee. Responses by implementation committee participants will be used to verify, change, or add to the data presented by the evaluator, as adjusted from the findings of the facilitated priority area discussion groups. Results from the Implementation Committee discussion groups and priority area groups will then be used to create a report that will be presented to the Toledo-Lucas County Health Board of Health. Findings and reports may also be publicly disseminated as presentations or journal articles outside of the TLCHD.

Contacts for further information

If you have any questions about this evaluation project, you may contact Eric Zgodzinski at zgodzine@co.lucas.oh.us. You may also contact dissertation supervisor Dr. Eve Pinsker at the University of Illinois at Chicago at epinsker@uic.edu or 773-802-4802.

Appendix L: Additional Information on Objectives and Steps for the Four Selected Priority Areas

HEALTHY HOMES

Strategic Priority: Healthy Homes & Environment
Action Step Objective 1: Promote & Drive the Lead Safe Housing Initiative
1: Explore the need for, and create as necessary, a curriculum about the Toledo Lead Ordinance separate from the Lead Clearance Technician Course for members of the public who are only seeking information on the ordinance
2: Assess through follow-up the intentions of all students who have completed the Lead Clearance Technician Course
2a: Compile roster of students who plan to pursue state licensure and by when
2b: Revise class schedule based on demand and supply of local lead inspectors
2c: Develop Lead Clearance Technician Course Refresher (with approval from ODH)
3: Explore methods for increasing screening and data reporting for childhood lead testing from local medical providers
3a: Develop provider educational materials that highlight importance of screening and sharing that information
Action Step Objective 2: Expand Nuisance Abatement Efforts
1: Seek funding to employ an additional Generalist to handle nuisance issues in Lucas County
2: Seek funding for part-time legal aid dedicated to handling department's nuisance abatement issues
Action Step Objective 3: Collaborate with Community Partners to Mitigate, Prevent, or Resolve Environmental Issues
1: Assess unmet needs for Lucas County residents living in unsafe living conditions and develop report.
1a: Seek funding to develop and complete assessment
1b: Use assessment report to determine what social services agencies/groups that we should engage based on the needs determined by the assessment.
2: Seek partnership with social service agencies/groups to assist the Environmental Health Division to help address social determinants of health related to childhood lead poisoning and other environmental social issues.
3: Develop various types of media to promote Health Homes & Environment that reaches all citizens of Lucas County (i.e. Radon, indoor air quality, Sewage O&M, etc.)
3a. Research other Health Departments and agencies to find most effective method to reach our citizens
3b: Hire an EH educator for all of our programs
4: Develop database of community partners the department regularly interacts with on environmental issues and establish protocol to touch base at appropriate intervals
5: Explore and develop stakeholder workgroup to create handouts/informational toolkits for residents the department interacts with on housing issues
5a: Approach A.B.L.E., Legal Aid of Western Ohio, Property Investment Network, Lucas Metropolitan Housing Authority, Zoning & Building and others
Action Step Objective 4: Explore Implementation of the Green & Healthy Homes Initiative
1: Actively participate in the Toledo Community Foundation's (TCF) Green & Healthy Homes initiative
1a: Participate in kickoff event on March 9, 2017
1b: Establish role of Health Department in the Green & Healthy Homes Initiative and develop close collaboration with TCF

(TLCHD, 2017)

OPIATES

Strategic Priority: Opiate Epidemic/Drugs
Action Step Objective 1: Establish Linkages to Mental Health & Recovery Services
1: Initiate dialogue with community partners regarding linking individuals in need to mental health/recovery service organizations
1a: Collect baseline data from hospital systems and other sources
Action Step Objective 2: Reduce Opioid & Drug Abuse / Misuse
1: Establish and Implement Syringe Access Program (SAP)
1a: Develop & distribute education materials to target population and through social media
1b: Finalize contract with the University of Toledo Medical Center
Action Step Objective 3: TLCHD Coordinates Coalition Building
1: Increase data sharing with Opiate Coalition members
1a: Assess community needs for data and establish mechanism/format for sharing
1b: Evaluate effectiveness and modify sharing frequency as needed
Action Step Objective 4: Prevent Opioid Overdose Deaths
1: Naloxone information and kits distributed to first responders, public, staff
1a: Train staff in Naloxone administration/use
1b: Query School/Campus Resource Officers and enforcement officers to assess gaps in training on Naloxone administration/use
1c: Establish a set of critical indicators and the protocol(s) for notification of appropriate agencies
2: Partner with MHRSB to provide education to providers and Lucas County Families

(TLCHD, 2017)

OBESITY

Strategic Priority: Obesity (Adult & Youth)
Action Step Objective 1: Healthier Weight-related Behaviors Among TLCHD Staff
1: Turn remodeled basement into a workout facility
1a: Develop report on possible layout for basement workout facility and required resources/investment
2: Implement staff health improvement plan (SHIP)
2a: Develop staff health improvement plan (SHIP) with established performance criteria
2b: Expand the plan to all County-wide agencies that wish to participate in their own facilities
3: Develop & Implement Activities with wellness incentives for employees
3a: Research and implement healthy weight challenges & competitions
3b: Work increase staff participation in County Wellness Program
Action Step Objective 2: Healthy Eating & Food Literacy
1: Nutritional Assessment / Education (Clinics address this as a clinical quality measure)
2: Seek funding to employ full-time health educator dedicated to increasing healthy eating and access through corner stores, healthy retail checkout, double up coupons
3: Develop Draft of Healthy Eating Goals Policy with community stakeholders (inner city, city, county)
3a: Promote adoption and implementation of policy or ordinance

4: Work to Increase # of stores participating in selling fresh produce & healthy foods
4a: Provide Education on importance of healthy food retail to community including stakeholders, business owners, residents
5: Investigate, develop, and utilize staff and digital media for healthy eating presentations
5a: Provide dietetic education and resources to patients
5b: Seek and secure appropriate IT infrastructure/tools for presentations/videos
Objective 3: Work with Community Partners to Create Environments that Promote Increased Physical Activity (Worksite Wellness)
1: Review Current & Previous Community Health Assessments and Community Health Improvement Plans
1a: Develop report prioritizing causative & contributing factors affecting lack of physical activity / obesity
1b: Assess what services organizations & agencies are currently providing
2: Form Obesity Alliance/Coalition with community partners to develop county-wide Worksite Wellness programs/activities
2a: Identify, engage and align community partners and groups
2b: Seek funding for development of program/activities
Action Step Objective 4: TLCHD Coordinates Community on Obesity Issues
1: Develop and implement plan for continuation of the PICH grant's activities- Healthy Corner Store initiative
1a: Apply for funding to sustain and continue the Healthy Corner Store Initiative's activities

(TLCHD, 2017)

WORKFORCE DEVELOPMENT

Strategic Priority: Workforce Development
Action Step Objective 1: Increase Workforce Training Opportunities at all Levels
1: Develop/ Revise/ Implement consistent and inclusive Hiring & On-boarding process
1a: Assess and revise interview process as necessary"
1b: Review & Revise On-boarding orientation; -When and how do we welcome new staff? -How do we cultivate a great first impression as an Employer?
2: Provide Bridges Out of Poverty Training to All Staff
3: Provide Mental Health First Aid Certification to all Staff
4: Provide C.O.P.E. training to all staff
Action Step Objective 2: Develop "Safe Feedback" system/process for staff
1: Revise and implement Annual Employee Satisfaction/Morale Survey
2: Assess methods for continuous collection of staff feedback
2a: Establish Standard Evaluation form for trainings and presentations
2b: Assess location of suggestion boxes & market their use internally
Action Step Objective 3: Staff Performance Effectively Managed
1: All employees in management or supervisory positions receive training on effective management strategies and processes
1a: Develop Supervisor's Handbook for uniform management practices (discipline, performance reviews, working with challenging employees, effective meetings, motivating employees etc.)
1b: Research & compile appropriate and available trainings
1c: Implement training schedule for management from Workforce Development Plan
2: Performance Evaluation Process Reviewed & Revised
3: All Position Descriptions reviewed and updated
4: Staff are engaged in the development of programmatic performance measures
5: Develop Employee Handbook containing information on appropriate agency policies & procedures and human resource functions.
Action Step Objective 4: Develop and Implement an agency Workforce Development Plan
1: Develop or assign staff group to oversee Workforce Development plan implementation
1a: Revise WFD Plan Annually
2: Implement WFD Plan goals and objectives
3: Develop / implement process for uniform tracking of employee trainings and credentials
Action Step Objective 5: Workforce Maintains & Acquires Necessary Skills for Job Excellence
1: Develop or assign staff group to oversee Workforce Development plan implementation
1a: Revise WFD Plan Annually
2: Implement WFD Plan goals and objectives
3: Develop / implement process for uniform tracking of employee trainings and credentials

(TLCHD, 2017)

Appendix M, Table XXII: PHAB Alignment with Methods PHAB Version 1.5 Measure 5.3		
Requirements	Guidance	Alignment with Method
1. Implementation of the Strategic Plan is tracked, and the plan is revised, as needed (PHAB, 2017)	1. Describe the department's process used to Continually track the implementation of the strategic plan and revise it as needed. The narrative must include: a. A description of how the health department's staff at various levels and across the department are engaged with a shared responsibility to implement and update the strategic plan. b. A description of how the implementation of the plan is tracked. c. A description of the process for reassessing and revising department priorities. d. A description of how unanticipated changes in priorities, level of resources, and/or opportunities are factored into the strategic plan implementation and revision. e. A description of the process for reviewing and updating the plan. (PHAB, 2017)	The use of the research method will satisfy number one. Using the methods, with proposed recommendations to adjust the implementation process (i.e. involve more staff), cam address 1a. The use of the annual reporting process with the addition of the implementation evaluation findings as the research methods documented will address 1b. The use of the process, as described in the conception framework implementation concept map, will satisfy 1c. Use of and reporting of the evaluation process with the additional training specifically that objectives can be changed and the process to change them will address 1d. Use of Action Research with the methods described and utilized for this research will satisfy 1e.

Appendix N: Findings and Recommendations
TABLE XXIII: Findings and Recommendations

Note: The table has 5 columns with either summations from finding work or recommendations. The color-coded material is for organizational purposes to place similar statements in overarching categories to then create recommendations. The key shows which colors and summaries correspond to which findings. For example, the light blue text is diversifying staff in all priority areas while yellow text is comments about needing more staff participating in priority groups. The first column is the researcher's findings and second is the priority group's comments on those findings. These two columns were compared across all studied priority areas and then recommendations were synthesized from those findings (see third column). The fourth column are comments from the implementation committee discussion on those synthesized recommendations. These then were incorporated into the recommendations presented in the third column and final and complete recommendations were constructed which are found in the last column.

Findings and Recommendations				
Key Light Blue-Regarding diversifying divisional staff involved in priority areas Brownish-Need to report findings Yellow-Need more staff participating in priority groups Green-Need for more evaluation meetings Red Letters-About needing to be able to change objectives Green Letters-Evaluation Grey-Why the process is important and understand the process/Barriers facilitators Purple-Feeling about the process Red-Measuring the process Blue-My findings or recommendations Purple Letters-Reduction of finding to a Summary				
Findings from the Initial Review	**Priority Group Facilitated Discussion Groups Revisions/Extensions**	**Comparison of Recommendations across Priority Area Discussion Groups (Unique or in Common)**	**Recommendations from Implementation Committee**	**Final Recommendations**
The largest barrier to this area was the lawsuit.	**Priority Group** There needs to be a mix of other staff for	Researchers Recommendations: 1.Priority groups should	**Need to communicate the importance of the**	1.Priority groups should have a diversified team that is made up of staff from each division.

The lawsuit was a barrier. It was never considered that the ordinance would be put on hold due to a lawsuit. External issue that was not expected. Revisit all objectives to see if they still can be implemented and further if they are still relevant. Complete the assessment of unmet needs for adults living in unsafe conditions. Reassess current actions steps and objectives to determine if they are needed as written. Hire a generalist. Need to have staff understand the process of implementation especially that they can change objectives and steps as needed.	this priority. Need to report findings out. Meet more (if they are productive) and more time for reflection on the plan •Show employees the progress and empower them to be part of the process There was an assumption about the evaluation process that it was going to be useless or a waste of time. That opinion changed to one of the most productive meetings the staff participated in. Need to keep the evaluation process going. There should be more evaluations done and the evaluation that was done was productive	have a diversified team that is made up of staff from each division. 2.There needs to be a better effort to report on completed or not completed material for strategic plan implementation. 3.Create the opportunity and atmosphere to meet more and evaluate the work done. 4.Have better training on how strategic plans are constructed to include how set objectives can be changed if needed. 5.The monthly report process needs to be reviewed and changed to make it not only more user friendly but also additional training on how to use the monthly report. This includes training on barriers and facilitators in definition but also how they should be reported	**process to staff.** **Need to have a plan to empower/ engage other people to be involved.** **Help them engage their peers** **The one that came out of our session is from my point of view, my staff and listening to them, I thought the difference of opinions that came out of it. I was amazed.** **I just kept throwing darts at the wall. Nobody told me I wasn't supposed to do that. I was throwing darts and should have been playing ping pong.** **This plan I think was a good initial structure to come**	2.There needs to be a better effort to report on completed or not completed material for strategic plan implementation. 3.Creating the opportunity and atmosphere to meet more and evaluate the work done. 4.Have better training on how strategic plans are constructed to include how set objectives can be changed if needed. 5.The monthly report process needs to be reviewed and changed to make it not only more user friendly but also additional training on how to use the monthly report. This includes training on barriers and facilitators in definition but also how they should be reported on. 6.There needs to be a better training process to show staff why implementation is important but also the evaluation aspect of implementation is as if not more important. 7. Need to have more staff involved (assigned) to the priority areas so workload of completing objectives are not only on a select few.

	Emergent strategies were found to be used with the discarding of original objectives then creating new objectives. Have a better understanding of what the group should be looking at to evaluate and report back on. Need to fully identify the barriers/ facilitators to help see the bigger picture Some felt that they didn't identify all the barriers or facilitators because they are used to taking on additional work and "just getting it done" no matter what. Show employees why this is important.	on. 6.There needs to be a better training process to show staff why implementation is important but also the evaluation aspect of implementation is as if not more important.	**off what we've done in the past or what we haven't done in the past, but in a lot of places we drilled down super far and I heard from different staff that some of that drill down was an issue.** **So, it was just difficult to measuring. I think that needs to be a part of the next strategic plan. If there is an objective and an activity with it, we need to stay, okay, this is how we are going to measure.** **With everything going on and PHAB and all that meaning priority, strategic planning and goals kind of took a backseat at**	8.The Health Commissioner needs to make sure they are involved with implementation but more importantly all leadership staff are involved. 9.For the next strategic plan the types and specific priorities should be reviewed for proper alignment with the direction of the department. Also, the plan should be created in a way it takes into consider and applies the current view of staff on how to implement the plan as much as possible. 10. Need to provide training on how to understand, identify and document lessons learned. 11. Lessons learned need to be reported on and assessed to what learning has taken and is taking place within TLCHD. 12. Action Participatory Research should be instilled within TLCHDs culture. Training and use of AR should begin immediately. 13. Conduct further activities to understand how factors, lessoned learned and the practice of Facilitated Discussion Group are each required to fully understand what impedes and

			Times **We can, we can use this evaluation method as the basis for how we design our next strategic plan.** **Yeah, I agree. The evaluation helped to better focus and needs to continue.** **The data presented was on target and it captured our work very well.** **Next time the evaluation will be useful because now they know what info is being asked for.**	impels implementation. 14. Explore how the evaluation process utilized for this research can be used to evaluate other public health programs. 15. Further research using the same methods, involving other local health departments, is needed. These departments should be both like TLCHD as well as ones that differ in size and structure. 16. Emphasize to other departments how using the current tracking and evaluation methods to satisfy PHAB reaccreditation requirements.
Priority Group: **Opiates** The data issue and not having the ability to share the data as needed is a major deficiency to implementation of the area.	**Priority Group: Opiates** Need to be more team-oriented Need more opportunity to give			

Barrier of having the ability to share the data obtained. but the reporting of data has been less structured and serves as a barrier to gleaning meaning/trends over time. From this observation we will revisit the reporting form and provide additional training on how to properly fill out and provide information for monthly reports. Training issues as a facilitating factor. The committee revisit the action steps pertaining to sharing of data between agencies to understand if the current action steps can create the desired outcomes. -The need to develop additional action steps for prevention to stop the use of opiates. Ability to know that objectives can be changed.	input Report results/progress out Need more people at the table to work on the priority Objectives need to be updated Staff could do a better job of focusing on facilitators Management is an important player in all facets of implementation and need to be involved Once barrier or facilitator is identified, then what? Employees feel stuck Need mechanism to fix or go around Need Management to coordinate responsibility			

	to move forward Enhance facilitators If plan isn't working, employees need to be empowered and engaged to be able to fix it. Need more meetings and communication "If you want input you have to establish a structure to receive it" One person decided what to report on and requested info from staff on that specific thing, there was no other opportunity for input Need to better define barrier and facilitator to help them better identify what they are. Need to have more involvement from staff and			

	leadership in the implementation process. Management change-over has helped New management is listening to staff more Keep the facilitation for the upcoming evaluations the same but do it more often. Need to communicate the importance of the process to the staff Need more staff involved Need to have a plan to empower/engage other people to be involved. Help them engage their peers			

Priority Group: Obesity More attention to detail and specifics in reporting will help with evaluation and understanding what outcome there are from implementing the strategic plan. Continue with documenting and then communicating lessons learned. Overall it is important to understand lessons learned and to document those lessons.	**Priority Group: Obesity** Need to communicate the importance of the process to staff. Need to understand what everyone else is doing Needs to be a more collaborative process with more variety at the table Wished they would've known that they could re-write or re-tool the objectives Overall, they feel like the process has evolved the way that they do things Need to have more staff involved The report format is "clunky" and needs some attention.			

Priority Group: **Workforce** Obtaining feedback from staff is being done but is inconsistent with staff surveys not being undertaken since the end of 2017. The development of a tracking system for trainings and certifications is not completed and has become a lower priority for the department but still is a desire to implement. Leadership needs to create the environment for staff to voice their opinions. Need to develop and implement a tracking system for workforce development. The priority needs to be reviewed with the Human Resources Director's involvement. His professional experience with workforce development and now several months on the job he needs to provide alternative actions steps.	**Priority Group**: **Workforce** Need to have more employees involved and not just a function of Human Resources Broadening the entire Strategic Plan (not being so specific) will work if we can show/measure progress. Need to understand what everyone else is doing More people are needed to work on the priority area This maybe shouldn't be a priority in the next SP because we need a group that is regularly developing, monitoring, and tracking.			

Overall the area needs to be more of an emphasis with the entire staff. It is a priority for all directors. This is because all employees need training to either accomplish their jobs or become better at their jobs. Leadership must ensure that all staff have the capability and capacity to work on and be involved with workforce development.				

Appendix O, TABLE XXIV: Evaluation Findings

These are the evaluation questions for all FDGs. I again color-coded like responses.

Q1

Yellow-Types of discussion open and honest

Green-The evaluation process

Q2

Yellow-need to meet more often

Green-Regarding input or dialogue

Blue-Meeting was productive/effective process

Grey-Feeling about the process

Red-

Q3

Green-need to follow up on what was done on implementation

Blue-More staff needed

Brownish-Information needed before evaluation

Red-Facilitation needs

Q1 Do you think this type of discussion is useful for future evaluations? Why?	**Q2 What do you think of this type of facilitation?**	**Q3 What changes would you make to the facilitation process?**
Yes-24 No-0	Important to meet	Need administration support and follow-up
Open and Honest-Multiple same answer	like it	action report following the meeting
helpful to understand the process-Multiple same answer	open communication	more people involved
explains getting to goals	encouraging open discussion and buy-in	make aware of the subject before the meeting
get input from a wide range of people	open discussion	provide the SP and details before the meeting
	effective/culture shift/connection/collective (team)	more staff need to be involved
it helps us refocus our efforts to achieve better results.	good for gathering input	Eric needs to be the facilitator

understanding the evaluation process will undoubtedly make the next step in the process easier for those involved.	good to hear other opinions	do more often
helped dial down the barriers and re-instill the importance of the objectives	helpful needed more often	do this as an entire department
it helps clarify what and why we are doing strategic planning.	able to give input, structured	provide the plan before the meeting
It fosters feedback that is not likely to be collected anywhere else and encourages reflection in real-time	gets everyone thinking, good to hear what others are thinking	stick to the time limit, more staff involved
as long as the purpose and process are clearly understood will speak to all staff at every level, the direction that the department is going, what each individual will need to contribute in order to meet agreed-upon objectives.	meeting was productive	need a more diverse staff
however, always open to other types. The staff overall has a much better understanding of evaluations and the importance.	easy to share and be open	rotate staff for a different perspective
all facets were discussed & staff was engaged and sharing sharing feedback and admin was listening	good to have a diverse group	would have been nice to see examples tied to the instances to have a better understanding of where the responses come from, I lacked a frame of reference
	helps to understand	no answer
	open dialogue	have it occur closer in time to the specific period being evaluated, make sure staff/supervisors have access to appropriate reference materials (reports from the period, etc.) either before or during the evaluation

Appendix P Background

Background: Document Review-Comparing Plan to the 2017 Annual Strategic Plan Report

Document review provided data on the process and outcome of implementing the TLCHD's strategic plan. The first set of documents reviewed were the 02/17 (original) and the revised 08/17 strategic plans. These plans were compared through a review of each section for changes to original priorities, objectives, action steps, timeframes, performance metrics, and target goals as written. The only change found from the original to the revised plan was the addition of an objective for decreasing tobacco use for women of childbearing years, along with three action steps. The implementation committee added this objective and created the action steps after a TLCHD staff nurse noted the need under the Infant Mortality Priority. This nurse has worked in and around pediatrics and childhood programs for most of her career. She correctly worked with potential and current mothers to discontinue smoking. The nurse went to the Director of Nursing and the Supervisor for the Infant Mortality program and lobbied to add the objective, "Decrease Tobacco Use for Women of Childbearing Age." (TLCHD, 2017). The decision to incorporate the new objective was due to the historical knowledge of pregnant women who smoke in Lucas County, the training and professional experience of the Objective by the public health nurse, and the outcome of the Community Health Assessment of Lucas County for smoking rates. The process that created the new objective, as well as the original and revised objectives, is detailed in Chapter 2. Chapter 2 also outlines the process for approval of final objectives. The final decision to incorporate the objective could only be made by majority approval of the Implementation Committee. The new objective was added by following the above-outlined procedure. Table XXV shows the priorities with all objectives to be met. As noted in the table, Objective 4 under Infant Mortality is the objective that was added to create the revised strategic plan.

TABLE XXV: Strategic Plan Priorities with Objectives, 8/17 TCHLD revised strategic plan

Strategic Priorities with Objectives	
Strategic Priority: Obesity	**Strategic Priority: Opiate Epidemic / Drugs**
Objective 1: Healthier Weight-related Behaviors Among TLCHD Staff	Objective 1: Establish Linkages to Mental Health & Recovery Services
Objective 2: Healthy Eating & Food Literacy	Objective 2: Reduce Opioid & Drug Abuse / Misuse
Objective 3: Work with Community Partners to Create Environments that Promote Increased Physical Activity (Worksite Wellness)	Objective 3: TLCHD Coordinates Coalition Building
Objective 4: TLCHD Coordinates Community on Obesity Issues	Objective 4: Prevent Opioid Overdose Deaths
Strategic Priority: Access to Care	**Strategic Priority: Infant Mortality**
Objective 1: Social Determinants of Health Understood by Community Partners & Public	Objective 1: Promote Healthy Pregnancies
Objective 2: Increase Proportion of Lucas County Residents with Medical Insurance	Objective 2: Help Infants Thrive
Objective 3: Work with Community Partners to Link people to Primary Care	Objective 3: Assess and Address Disparities including those caused by Racism

Objective 4: Investigate Capacity of Local Population Health System	Objective 4: Decrease Tobacco Use for Women of Childbearing Age **********
Objective 5: Residents Linked to Care	
Strategic Priority: Health Promotion	**Strategic Priority: Healthy Homes**
Objective 1: Increase Health Education Opportunities for Clientele	Objective 1: Promote & Drive the Lead Safe Housing Initiative
Objective 2: Promote Evidence-Based Education & Intervention Strategies to Improve Health Outcomes	Objective 2: Expand Nuisance Abatement Efforts
Objective 3: Establish Unified Public Health Messaging Strategies Among Health Agencies and Organizations	Objective 3: Collaborate with Community Partners to Mitigate, Prevent, or Resolve Environmental Issues
Objective 4: Actively Contribute to the Development and Implementation of Policies that Support and Improve Population Health at All Levels	Objective 4: Explore Implementation of the Green & Healthy Homes Initiative
Strategic Priority: Workforce Development	**Strategic Priority: Financial Stability**
Objective 1: Increase Workforce Training Opportunities at all Levels	Objective 1: Continuously Seek Funding to Support Public Health Services
Objective 2: Develop "Safe Feedback" system/process for staff	Objective 2: Actively Monitor and Evaluate Program Budgets to Effectively Manage Fiscal Resources

Objective 3: Staff Performance Effectively Managed	
Objective 4: Develop and Implement an agency Workforce Development Plan	
Objective 5: Workforce Maintains & Acquires Necessary Skills for Job Excellence	
	******* Addition to the revised plan from the original plan**

(TLCHD, 2017)

The second stage of document review was comparing the strategic plan to the 2017 Annual Strategic Plan Report. The annual report is as summary of the monthly monitoring reports that detail the successes and gaps of implementing the strategic plan objectives. It was developed and implemented through a process described in Chapter I, that covers all eight priority areas. TLCHD's PHAB Coordinator is responsible for organizing, monitoring, and overseeing strategic plan implementation, creation of the annual report, and for tracking and ensuring completion of the monthly report.

Background on Monthly Report

The original monthly report was used for one month and was changed slightly to clarify and simplify the report. The original report had "objective outcomes" and "objectives met" categories in the reporting columns. Changing the two categories to "Lessons Learned" and "Outcomes" achieved clarification and simplification. Each of the eight priority areas was assigned a "champion" who is responsible for that priority. The champions responsible for the program are those responsible for the program connected to the priority. Those responsible for the eight priorities with objectives and progress steps range from departmental directors to staff. Table XXVI shows the priority areas and the title of the Champion. The champions are not solely responsible for the work done, but depend on their teams. For example, the Champion for Healthy Homes, a federal program to reduce environmental issues related to poor health outcomes, is the Director for Environmental Health. Most of his staff have a direct role in implementing the Healthy Homes portion of the strategic plan. For example, individual employees create educational pamphlets while others are conducting Healthy Homes inspections. Information on implemented, barriers/facilitators, lessons learned, or outcomes reported to the Champion. Champions' transfers the information given by the employees to the monthly report or the monthly report is filled out by the staff and sent to the Champion. The completed report is sent (electronically) to the coordinator. The coordinator then organizes the reports so that the Implementation Committee can review the material at their scheduled meeting. At the meeting, the reports are discussed, and any inconsistencies or questions are addressed. If there is further work to be completed, before final acceptance, uncompleted work is addressed, and the report brought back to the committee for review. The coordinator gives brief updates to the board during their scheduled board meetings from committee discussions and reports data. The creation of the Annual Strategic Plan Report begins before the end of the calendar year.

TABLE XXVI: Priority Areas and Title of Champion (2017- present)

Responsible for Priority Area	
Priority Area	**Tile**
Obesity (Adult & Youth)	Supervisor
Opiate Epidemic / Drugs	Director
Access to Care	Staff
Infant Mortality	Supervisor
Health Promotion	Director
Healthy Homes	Director
Workforce Development	Coordinator
Financial Stability	Director

(TLCHD, 2017)

c. Annual Strategic Plan Report

From December 2017 to January 2018, the annual report on the implementation process was drafted using the monthly reports and findings. It was found that the Annual Report and the Revised Strategic Plan had the same Priorities, Objectives and Steps. The information for the report was provided to the Coordinator through the implementation monthly monitoring reports and discussions during the implementation committee meetings. All priorities were reported, with 26 of 32 objectives showing progress (meaning that at least some of the action steps within

the objective were worked on and reported interim outcomes). Table XXVII indicates the objectives that were reported, and the percentage of objectives addressed during 2017. Five of the eight priorities had 100% of the objectives acted on. For two (Access to Care and Healthy Home) of the eight, 80% and 75% were addressed, respectfully, while obesity had only 25% addressed. One possible reason that not all objectives had progress is because the priority area was not ready for the work to be completed (timeframes). This logic is supported by the statement within that 2017 annual report that "the annual report only documented objectives with reportable progress that were *scheduled to be worked on in 2017* (TLCHD, 2018) [emphasis added]."

TABLE XXVII: Strategic Plan Objectives Reported (Jan 2017 - Dec 2017)

Strategic Plan Annual Report Document Review Jan 2017-Dec 2017 Objectives Reported with percentage of Objectives addressed			
Priority Area	Objective Reported	Total Objectives	Percentage Objectives Reported
Obesity (Adult & Youth)	1	4	25% (4)
Opiate Epidemic / Drugs	1,2,3,4	4	100% (0)
Access to Care	1,2,3,5	5	80% (1)
Infant Mortality	1,2,3,4	4	100% (0)
Health Promotion	1,2,3,4	4	100% (0)
Healthy Homes	1,3,4	4	75% (1)
Workforce Development	1,2,3,4,5	5	100% (0)
Financial Stability	1,2,3	3	100% (0)

Work after the 2017 annual report, From December 2017-June 2018

Review of the monthly reports from December 2017 to June 2018 found that more objectives were worked on for one priority area, Healthy Homes, with objectives reported from 75% to 100%, while Obesity (25%) and Access to Care (80%) remained at the same level in the annual report. This is because no additional work was completed on Access to Care after December 2017. While Obesity never addressed any of the remaining three objectives, this was partially due to work in objective 1 needing to be completed before work in the other objectives could be started. The remaining areas already had all objectives that were being implemented. Table XXVIII shows the Monthly Report data for objectives.

TABLE XXVIII: Monthly Report Data for Objectives

Strategic Plan Monthly Report Jan 2017-Dec 2017 Objectives Reported with percentage of Objectives addressed			
Priority Area	Objective Reported	Total Objectives	Percentage Objectives Reported (Not Reported)
Obesity (Adult & Youth)	1	4	25% (3)
Opiate Epidemic / Drugs	1,2,3,4	4	100% (0)
Access to Care	1,2,3,5	5	80% (2)
Infant Mortality	1,2,3,4	4	100% (0)
Health Promotion	1,2,3,4	4	100% (0)
Healthy Homes	1,2,3,4	4	100% (0)
Workforce Development	1,2,3,4,5	5	100% (0)
Financial Stability	1,2,3	3	100% (0)

Action steps with work undertaken, as documented in the monthly reports, is shown in Table XXIX. Action steps are those items that have been defined through the strategic planning process as work that should be accomplished to achieve the objective it is linked to. For example, the Healthy Home priority area Objective 1 states “Promote and Drive the lead safe housing initiative.” For that objective, step 2a is to compile a roster of students who plan to

pursue state licensure and their completion dates. The step in each objective is what must be operationalized. The Opiate and Health Promotion priorities had 100% of the steps acted on while Workforce Development (64%) and Fiscal Stability had (76%), Infant Monthly priority (66.6%), Workforce Development 64%, Access to Care at 60%, Healthy Homes 31.8% and Obesity had only 24%. The reason for low percentage of the Obesity Steps is that the remaining steps are either more complex or are not due to be worked on until later in the implementation process. For example, in Objective 2-Step 4, "work to increase the number of stores participating in selling fresh produce and healthy foods," requires extensive work with external partners and the desire by store owners to sell healthier foods (TLCHD, 2017).

TABLE XXIX: Steps with Work Accomplished per Priority, Jan-Dec 2017

Steps with work accomplished per Priority for Jan 2017-Dec 2017			
Priority Area	Number of Steps	Steps Reported to be worked on	Percentage of Steps Addressed Per Priority
Obesity (Adult & Youth)	25	6	24%
Opiate Epidemic / Drugs	13	13	100%
Access to Care	20	12	60%
Infant Mortality	21	14	66.6%
Health Promotion	11	11	100%
Healthy Homes	22	7	31.8%
Workforce Development	25	16	64%
Financial Stability	13	10	76%

By June 2018, the number of priorities which had 100% of the steps addressed went from two, Opiate and Health Promotion, to three with Workforce Development (64% to 100%) as noted in Table XXX. While Healthy Homes moved from 31.8% to 91%, Fiscal Stability from 76% to 92% and Obesity from 24% to 32%. Access to Care (60%) and Infant Mortality (66.6%) did not increase from December 2017. Access to Care had no reports in 2018, which is why no additional steps were documented. Both Obesity and Fiscal Stability reported once in 2018, but still did not increase in steps addressed. There are several possible reasons that not all steps were attempted for the eight priorities. The first is that steps were not scheduled to be worked on until a later date. For example, in Healthy Homes a lead clearance technician refresher course needed to be developed by 1/2019. For Obesity, TLCHD Staff's weight loss plan would be expanded to other county government offices by 1/2020. The second possible reason is that workload for staff did not allow them to be attentive to conducting activities for the steps. Healthy Homes sought funding to develop and complete a needs assessment of living conditions for those 18-59 years of age. The Environmental Division is shorthanded and could not address this step without more staff. Infant Mortality's low number of steps worked can be partially attributed to the champion not reporting work on steps that were completed. Discussions with staff revealed that certain steps have been addressed but were simply not documented in the monthly reports.

TABLE XXX: Steps with Work Accomplished per Priority ending June 2018

Steps with work accomplished per Priority ending June 2018			
Priority	Number of Steps	Actual Steps Reported	Percentage of Steps Addressed Per Priority
Obesity (Adult & Youth)	25	8	32%
Opiate Epidemic / Drugs	13	13	100%
Access to Care	20	12	60%
Infant Mortality	21	14	66.6%
Health Promotion	11	11	100%
Healthy Homes	22	20	91%
Workforce Development	25	25	100%
Financial Stability	13	13	92%

Review of 2017 Annual Strategic Plan Report with Content Analysis of Facilitators and Barriers table XXXI.

The 2017 Annual Strategic Plan Report was also reviewed and coded for facilitators and barriers to successful implementation of the strategic plan, using the a priori codes and code definitions found in Appendix G and developed from the literature supporting the codes found in

Chapter 2. There are twelve significant codes for facilitators and barriers with no sub codes. The twelve codes documented in Tables XVIII and XIX depict either a facilitator or, inversely, a barrier to implementation when problematic or insufficiently present (e.g communication/coordination is a facilitator if noted as a positive factor contributing to success, a barrier if noted as problematic and contributing to lack of success; timely action is a facilitator if present and a barrier if insufficient. The coding reflects the positive or negative judgements given in the report. All coding was reviewed by a second coder).

Priorities and Objectives worked on with the instances of barriers and facilitators are documented in Table XXXI. Two objectives, Obesity (#1) and Infant Mortality (#4), had no facilitators noted, while all other objectives did have at least one facilitator documented. Opiate (#2), Access to Care (#1,2,5), Infant Mortality (#1,3), Health Promotion (#1,2,3), Healthy Homes (#2,3,4,5) and Fiscal Stability (#1,2) had no barriers in working to meet those objectives. Other than the possible reasons already discussed, the annual report only sought to report on those areas or objectives which had substantial work completed or only objectives which were designated to be worked on during the timeframe of the report (February 2017 to December 2017).

Table XXXII shows a review of the annual report for instances of facilitator codes. Of the 52 coded instances of facilitating factors across all the codes; coordination and communication were found most often (11 times). Occurrences of other facilitators included involvement of managers and/or staff (8), skills and/or alignment of skills (7), external factors and budget and resources (5), organizational culture (4), roles and responsibilities and competing priorities (3), attitudinal factors and strategic plan and/or alignment of goals (2). Timely action and evaluation and/performance management were recorded once in the annual report. Table

XXXII also shows the annual report documented only 14 barriers. The involvement of managers and staff (3) was the lead barrier. Other barriers included evaluation and/or performance (2), budget and/or resources (2), timely action (1), coordination and/communication (1), roles and/or responsibilities (1), competing priorities (1), external factors (1), attitudinal factors (1), skills and/or alignment of skill (1) with both organizational culture and strategic planning and/or alignment of goals at zero.

TABLE XXXI: 2017 Annual Strategic Plan Report Barriers and Facilitators

Strategic Plan Annual Report Barriers and Facilitators		
Priority	Barriers-a-priori code Objective Factor	Facilitators-a-priori Code Objective per Factor
Obesity Total Number of Objectives (4) Objectives Addressed (1)	(1) Involvement of Managers/Staff (1) Organizational Culture (1) Budget/Resources	
Opiate Epidemic / Drugs Total Number of Objectives (4) Objectives Addressed (4)	(1) Budget/Resources (3) Coordination/Communication (3) Timely Action (4) Skills/Alignment of Skills (4) External Factors (4) Attitude Factor (4) Evaluation/Performance Management	(1,2,3,4) Coordination/ Communication (1,3,4) Roles/ Responsibilities (1,4) External Factors (2) Planning/ Alignment of Goals (4) Involvement of managers/staff (4) Organizational Culture (4) Skills Alignment of Skill (4) Budget Resources
Access to Care Total Number of Objectives (4) Objectives Addressed (4)		(1,2) External Factors (1) Coordination/ Communication (2,5) Evaluation/ Performance Management (5) Skills/Alignment of Skills -Evaluation/ Performance Management
Infant Mortality Total Number of Objectives (4) Objectives Addressed (4)	(2) Evaluation/Performance Management (2) Roles/Responsibilities (4) Involvement of managers/Staff (4) Competing Priorities	(1,2) Coordination/Communication (1,3) Skills/Alignment of Skills (2) External Partners (3) Involvement of Managers/Staff
Health Promotion Total Number of Objectives (4) Objectives Addressed (4)	(4) Involvement of Managers/Staff	(1,) Skills/Alignment of Skills (1) Involvement of Managers/Staff (2) Coordination/Communication (3) Roles/Responsibilities
Healthy Homes Total Number of Objectives (4) Objectives Addressed (4)		(1) Involvement of Managers/Staff (1) Skill/Alignment of Skills- (1) Budget/Resources (3) External Factors (3) Strategic Planning/Alignment of Goals
Workforce Development Total Number of Objectives (4) Objectives Addressed (4)	(1) Involvement of Managers/Staff	(1,2,5) Involvement of Managers/Staff (1,3,4) Skills/Alignment of Skills (1) Coordination/Communication (3) External Factors (3,4,5) Roles/Responsibilities- (3) Evaluation/Performance Management

Financial Stability Total Number of Objectives (4) Objectives Addressed (4)		(1) Budget/Resources (1,2) Involvement of Managers/Staff (2) Skills/Alignment of Skill

Table XXXII: Rank Listing of Factors for Barriers and Facilitators, 2017 Annual Strategic Plan Report

Rank Listing of Factors for Barriers and Facilitators		
Rank Listed	**Facilitators with number of mentions (X)**	**Barriers with Number of Mentions (X)**
1	Coordination/Communication (11)	Involvement of Managers/Staff (3)
2	Involvement of Managers/Staff (8)	Evaluation/Performance Management (2)
3	Skills/Alignment of Skills (7)	Budget/Resources (2)
4	External Factors (5)	Timely Action (1)
5	Budget/Resources (5)	External Factors (1)
6	Organizational Culture (4)	Coordination/Communication (1)
7	Roles/Responsibilities (3)	Roles/Responsibilities (1)
8	Competing Priorities (3)	Competing Priorities (1)
9	Attitudinal Factors (2)	Attitudinal Factors (1)
10	Strategic Plaining/Alignment of Goals (2)	Skills/Alignment of Skills (1)
11	Timely Action (1)	Organizational Culture (0)
12	Evaluation/Performance Management (1)	Strategic Plaining/Alignment of Goals (0)

Appendix S: Facilitating Codes Monthly Reports
TABLE XXXIII: Twelve Facilitating Codes with Sample Coded Text from the Monthly Reports

Code	Example of Text Coded from the Monthly Report (Priority area and Objective) Facilitators	Example of Text Coded from the Monthly Report (Priority area and Objective) Barriers
1.Timely Action	1. Epicenter alerts are automatic, but only triggered when a certain threshold is met. (Opiate Obj 1) 2. Data and information sharing by agency partners. (Monthly reports from the Needle exchange program.) (Opiates Obj 3)	1. Intervals between meetings (Healthy Homes Obj 4) 2. Patients not submitting supplemental documentation in a timely fashion for continuous coverage. (Access to Care Obj 2)
2.Coordination/ Communication	1. TLCHD has a long-standing collegial relationship with MHRSB and the various agencies that they fund. (Opiates Obj 1) (TLCHD, 2017) 2. Grant requirements, grant award, community awareness, and great partnerships (Infant Mortality Obj 2)	1. Information is not flowing from hospitals to TLCHD on a regular basis. (Opiates Obj 1) 2. Time constraints of BOH Members to be trained. (Health Promotion Obj 4)
3.Roles/Responsibilities	1. The HWC is pushing to come to a workable solution for this effort. (Obesity Obj 1) 2. Administration is willing to remove roadblocks and try new processes. (Workforce Development Obj 1)	1. Agencies unaware of the HD's role regarding Health in Policies. (Health Promotion Obj 4) 2. Staff isn't utilizing the calendar on the homepage to promote events. (Health Promotion Obj 1)
4.Competing Priorities	1. Other initiatives (GHHI & Lead Coalition) are in place with scheduled meeting. (Healthy Homes Obj 4) 2. Other initiatives that we participate in have already developed community groups for data base. (Health Home Obj 4)	1. Staff changes that resulted in a delay of plan development and assessment. (Health Promotion Obj 2) 2. Coffee with the Commissioner has been delayed as other priorities have taken precedence. (Workforce Development Obj 2)

5.External Factors	1. Community Support for Harm Reduction Initiatives, funding from UTMC's Ryan White Program and MHRSB. (Opiate Obj 2) (TLCHD, 2017) 2. Many members of the stakeholders are citizens that have called with concerns about the O&M Program. They are actively engaged with the process (Healthy Homes Obj 3)	1. Obtaining data from other entities on a routine/regular basis. (Opiates Obj 1) 2. Getting those who have a voice to be heard. (Health Promotion Obj 4)
6.Attitudinal Factors	1. TLCHD Administration and BOH strongly supports the Naloxone training initiatives. (Opiates Obj 4) 2. Fiscal personnel are motivated to correct budget issues and set a path for solvency. (Fiscal Stability Obj 2)	1. Single CEU tracking system may not be feasible (instead relying on individual programmatic areas to ensure it happening. Current known barriers include the frequency of meetings, maintaining momentum and making sure updated process are backed by top leadership. (Workforce Development Obj 5) 2. Trust, criminal investigations (Opiates Obj 1)
7. Evaluation/Performance Management	1. Community engagement and participation in the Coalition. (Fiscal Stability Obj 2) 2. IT; Directors wanting this real-time data; current fiscal issues (Fiscal Stability Obj 1	1. Lack of data that is actionable. (Opiates Obj 3) 2. Distribution of data? To whom? How? Identification of "need to know" vs "want to know" (Opiates Obj 3)
8.Organizational Culture	1. Leadership supports seeking out all types and avenues of funding; Staff are willing to seek funding; Office of Grants Management supports these activities. (Fiscal Stability Obj 2) 2. Fresh HR Admin perspective and experience. (Workforce Development Obj 1)	1. Not sharing events with Dir of HPPI or on website. (Health Promotion Obj 1) 2. Approval for staffing and filling positions. (Opiates Obj 2)
9.Skills/Alignment of Skills	1. Front desk staff is appropriately identifying patients that are uninsured and connecting them with a Navigator. (Access to Care Obj 2) 2. Health Department health services staff is required to complete cultural competency training in addition to annual trainings for Limited English Proficient	1. Trying to get all political leaders to understand the importance and significance of T21. (Health Promotion Obj 4) 2. Other employees outside of Health Services and Environmental Health do not have regularly scheduled meetings-coordinating training challenge. (Opiates Obj 4)

	(LEP) and Hearing Impaired (HI). (Infant Mortality Obj 1)	
10. Strategic Plaining/Alignment of Goals	1. The Opioid Coalition continues to provide a "common goal" for the data-driven agencies to unite around. (Opiates Obj 1) 2. Fiscal staff; Need-change the operational and historical way the budget is developed (Fiscal Stability Obj 1)	1. Concern for how the information will be used and managed. (Opiates Obj 3) 2. Federally Qualified Health Center split off. (Infant Mortality Obj 1)
11. Budget/Resources	1. MHRSB has been exceptionally generous and assist TLCHD with funding for Naloxone kits for many of our educational programs. (Opiates Obj 4) 2. (Use of) Existing free program (Access to Care Obj 5)	1. Number of individuals agencies, and parties required to review and execute contracts. (Opiates Obj 2) 2. Budget is not clearly defined. (Healthy Homes Obj 2)
12. Involvement of Managers/Staff	1. The Committee that worked on the healthy recipe challenge. (Obesity Obj 1) 2. One room is already set up for classes. (Obesity Obj 1)	1. Development of the handbook has been a slow road. The approval process has served as a major barrier. (Workforce Development Obj 3) 2. Performance measure to track this has not yet been established. (Workforce Development Obj 1)

VIII. Curriculum Vitae

Eric J. Zgodzinski, M.P.H., R.S., CPH, DrPHc

Employment History

Toledo-Lucas County Health Department (TLCHD), Toledo, OH

November 2001 – Present

Health Commissioner

June 2016-Present

Deputy Health Commissioner

May 2016-June 2016

Director of Community and Environmental Health Services

February 2012 – June 2016

Director of Community Services Response and Preparedness and the Northwest Ohio Regional Public Health Coordinator

January 2008 – February 2012

Supervisor-Health Services including Nursing/Epidemiology and Homeland Security

May 2005 – January 2008

Supervisor-Community Services including Environmental Health / Epidemiology and Homeland Security

November 2001 – May 2005

- Currently leads over 120 employees
- Is responsible for all programmatic issue in a department with a budget of over 17 million dollars
- Restructured and implemented new medical billing practices for TLCHD

- Instituted and instituting programs to assist in changing culture within the department such as “Dialogue for Change” and workforce development courses such as “Conflict Resolution”
- Revamped and implementing new budgeting and expenditure processes to ensure delivery of public health services
- Responsible for obtaining PHAB Accreditation-Submitting August 2017
- Leads and is responsible for the TLCHD Strategic Plan implementation
- Working to implement a bottom up decision making system for programmatic and departmental issues
- Local authority for all Ohio Revised Codes pertaining to public health

TLCHD Past Contributions

- Responsible for all Environmental Programs and Community Response issues for TLCHD
- Responsible for the Northwest Ohio Regional Public Health Coordination for Disaster Preparedness
- Ensures that the TLCHD has strategic vison through strategic planning
- Responsible for all aspects of the TLCHD’s H1N1 Pandemic Flu Response
- Implemented the current QI program at TLCHD
- Directed the disaster response and epidemiological programs at the TLCHD
- Assembled and supervised a departmental wide Public Health Response Team to conduct surveillance and follow up of infectious disease outbreaks
- Directed the Western Lucas County Health Clinic and increased the daily number of clinic patients seen
- Created a 501c3 in conjunction with TLCHD “The Fund for Public Health in Lucas County”
- Lead over 23 staff, members in multiple Health Services programs: School Nursing, Help Me Grow, BCMH, Sixty Plus, Childcare Consultation, Clean Indoor Air, Child Fatality, Injury Prevention, Staff Development, Shots for Tots, IAP, TB Outreach, Communicable Disease, Tobacco Prevention, Epidemiology, Homeland Security, MRC
- Proven sound cost methodology utilization and budgeting of programs
- Lead the Office of Vital Statistics for the TLCHD
- Lead the creation of the TLCHD’s Pandemic Flu plan and response
- Formed the community round table for the implementation of the Lucas County Pandemic Flu Educational Campaign
- Developed and organized the hour-long PBS documentary that aired September 2005 titled “Are We Prepared”
- Developed and oversaw the Regional Coordination for Domestic Preparedness for the Northwest Ohio Public Health Region
- Developed and supervised Smallpox Phase 1 response
- Successfully supervised and guided staff in multiple environmental programs: solid waste, food safety, animal bite, sewage, water, clean indoor air and other generalist programs

Bowling Green State University, Bowling Green, OH – Adjunct Assistant Professor (part-time) September 2003 to present

- Public Health Management 6040
- Environmental Sanitarian 3011
- Leadership, Human Resources and Marketing 6020

Owens Community College, Perrysburg, OH – Adjunct Professor (part time)

May 2009 to 2011

- Conducted courses related to Disaster Preparedness and Epidemiology
  Pandemic Flu Preparedness

Cuyahoga County Board of Health, Cleveland, OH – Senior Sanitarian

December 1992 to November 2001

- Participated in the organization and implementation of the Household Sewage Permitting Program
- Designed and implemented water quality sampling projects
- Created and presented public educational seminars on water quality, solid waste, food safety issues and other environmental programs
- Responsible for food safety issues in the seventh largest city in Ohio including over 700 food safety inspections a year
- Collaborated with local, state and federal agencies in closure of the radioactive contaminated Bert Avenue Site in Newburgh Heights, Ohio
- Developed and maintained a solid waste scrap tire program
- Inspected and was responsible for over 23 solid waste facilities
- Conducted regulatory functions for state and local environmental laws in food safety, solid waste and pollution control
- Gained extensive working knowledge of epidemiological studies and community health while participating as a member of the enteric team and responding to several large scale outbreaks

Education

Doctorate in Public Health-Enrolled and attending as a part of the Fall 2011 DrPH Cohort at the University of Illinois at Chicago. Anticipated maturation date 05/20

Master of Public Health – Northwest Ohio Consortium for Public Health – 2001 (Bowling Green State University, Medical College of Ohio, University of Toledo)
concentration in Public Health Administration – Scholarly Project “What role, if any, does faith play in decision making within public health programs”

Bachelor of Arts – Thiel College, Greenville, PA – 1991, major in Biology

Professional Qualifications

Certified in Public Health, 2011

Active Registered Sanitarian, State of Ohio, 1995, Registration number 2305

Pandemic Flu Community Preparedness Training

CDC-National Pharmaceutical Stockpile Training at the Nobel Army Hospital

40 Hour OSHA trained for workplace hazards

Department of Justice Weapons of Mass Destruction Train the Trainer

Serve Safe Trainer for certification of food safety professionals

ICS 100, 200, 300, 400, 700, 800

Honors

Outstanding Service Award from Owens Community College, 2004

Northwest Ohio Environmental Health Association Sanitarian of the Year Award, 2003

Publications

Fallon, LF and Zgodzinski, EJ. *Essentials of Public Health Management, Third Edition,* Sudbury, MA, Jones and Bartlett, 2011, ISBN-10: 1449618960

Fallon, LF and Zgodzinski, EJ. *Essentials of Public Health Management, Second Edition,* Sudbury, MA, Jones and Bartlett, 2008, ISBN: 0763756814

Fallon, LF and Zgodzinski, EJ. *Essentials of Public Health Management*. Sudbury, MA, Jones and Bartlett, 2005, ISBN: 0763731536

IPHEP "Transitional Medical Model" poster 2011

"Disasters: Are We Prepared?" WGTE Documentary Subject Matter Coordinator

Presentations

Presenter 2019- OEHA Spring Conference-"History of Public Health"

Presenter 2017-OEHA Spring Conference-"Leadership a Full Contact Sport"

Presenter 2015 – Combined Conference – "Leadership and the 2014 Algal Bloom Event"

Presenter 2015 – OEHA Spring Conference Algal Blooms

Presenter 2015 – NEHA 2015 “Environmental Issues Regarding Drinking Water and Algal Blooms”

NACCHO Disaster Preparedness Summit 2013 – “Emergency Messaging for the Electronic Age”

IPHEP 2011 – “Transitional Medical Model”

NALBOH 2005 – “Marketing Public Health”

NALBOH 2001 – “Forum on Masters in Public Health Education”

National Conference Medical Reserve Corp 2004 – “Management of Medical Volunteers”

TLCHD District Advisory Council 2005 – “Public Health Program Review”

TLCHD District Advisory Council 2004 – “Managing and Administering Public Health Preparedness”

TLCHD Legislative Breakfast 2004 – “Developing and implementing a Medical Reserve Corp”

NACCHO Preparedness Summit 2007 – “Pandemic Are You Prepared”

Professional Service

Governor Appointment to the Ohio Manufactured Home Commission, Term 2015-2017

Association of Ohio Health Commissioners

Ohio Environmental Health Association:

President, 2014-2015

Northwest Director, 2004

Chairperson of the Bioterrorism Committee, 2003

Chairperson of the Disaster Preparedness Committee, 2001

Interest and Volunteer Positions

Erie and Ottawa County Board of Mental and Health and Addiction

President – 2010 to 2011

Vice President – 2009 to 2010

Committee Member – 2007 to 2011

Ottawa County Ducks Unlimited Committee

Co-Treasurer – 2009 to Present

Committee Member – 2007 to Present

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