

ON BECOMING A CHIEF HEALTH STRATEGIST

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DEDICATION

This paper is dedicated to local health departments who serve to promote and protect the health of their communities.

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ON BECOMING A CHIEF HEALTH STRATEGIST

The vision for Public Health 3.0 includes a call to embrace the concept of health departments becoming chief health strategists. This term refers to public health organizations that possess the capacity and competency to take a leadership role in improving the health of communities. Although the practices of a chief health strategist have been defined, research is silent on “how” health departments can become proficient chief health strategists. The purpose of this study is to determine how local health departments can assimilate the role of chief health strategists within their communities.

A qualitative multiple case study was designed to research this question. Eighteen local health directors from Wisconsin were selected and functioned as key informants. Semi-structured interviews were conducted, and participants completed a chief health strategist competency self-assessment survey and provided organizational documents. The key informant interview guide created for this study was developed using the five domains of the Consolidated Framework for Implementation Research (CFIR).

Key findings of the study found four major themes that impact an organization’s ability to provide population health services and function as a proficient chief health strategist. The identification of facilitators and barriers to change and recommendations for change from the key informants served as the basis for the development of a plan for change. The plan for change was guided by John Kotter’s eight-step process of creating change model.

Valerie A. Yeager, DrPH, MPhil

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LIST OF ABBREVIATIONS

CDC	Centers for Disease Control
CFIR	Consolidated Framework for Implementation Research.
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
CHS	Chief Health Strategist
IOM	Institute of Medicine
NACCHO	National Association of County and City Health Officials
NACo	National Association of Counties
PHLF	Public Health Leadership Forum
PHAB	Public Health Accreditation Board
WALHDAB	Wisconsin Association of Local Health Departments & Boards
WPHA	Wisconsin Public Health Association

CHAPTER 1: INTRODUCTION

Background

Public Health 3.0 represents a continuation of the evolution of public health practice. Released in 2016 by the U.S. Department of Health and Human Services, the white paper “Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure” (2016) calls for “a new era of enhanced and broadened public health practice that goes beyond traditional public health department functions and programs” (p.11). The report suggested three primary issues were acting to stall or inhibit improved population health: (1) race/ethnicity disparities, (2) the need to address social determinants of health, and (3) an underfunded public health system (p. 4). Five recommendations were identified to move in this new direction and address barriers to improved population health, including sufficient funding for public health, engaging in cross-sector partnerships, support for continued accreditation of governmental health departments, and making timely, reliable, granular-level, and actionable data available to communities (p. 5). The final recommendation is that public health leaders assimilate the chief health strategist role for their communities. The report states, “Public health leaders should embrace the role of Chief Health Strategist for their communities – working with all relevant partners so that they can drive initiatives including those that explicitly address upstream social determinants of health” (p. 5).

The Public Health Leadership Forum (PHLF), in their report, “The High Achieving Governmental Health Department in 2020 as the Chief Health Strategist” (2014), developed a vision and articulated the role of a health department to function as a chief health strategist. The impetus for the concept of a chief health strategist was due to

various factors, including changes in the health care needs of the population, changing demographics, an information and data revolution, and that non-health sectors will be important partners in addressing chronic diseases (p. 3). The Forum envisions a health department that will continue offering and improving programs such as infectious disease, environmental health, and emergency public health preparedness. However, the report suggests, “departmental representatives will be more likely to design policies than provide direct services; will be more likely to convene coalitions than work alone; and be more likely to access and have real-time data than await the next annual survey” (p. 4). The Forum identified seven practices for high-achieving organizations becoming chief health strategists (pp. 5-21).

Problem Statement

The U. S. Department of Health and Human Services and the Public Health Leadership Forum have provided a vision and have articulated the role of a chief health strategist by identifying seven public health practices. This has provided the “what is” a chief health strategist and the role it needs to play in a 21st-century governmental health department. However, the reports are largely silent on “how” health departments, particularly local health departments, transform or re-position their departments to assimilate the role of a chief health strategist.

Purpose

This research study examines how local health departments transform their departments to function as proficient chief health strategists in their communities. Through a multiple case study method, the organizational change efforts by local health

departments are examined and provide a cross-case analysis of strategies employed, successes and failures, barriers, enhancers to change, and recommendations.

Research Questions

The multiple case study uses semi-structured key informant interviews with the leadership of local health departments and departmental documentation. Specifically, the primary research question is:

How can local health departments assimilate the role of chief health strategist within their organizations?

The following sub-questions are used to elucidate this primary research question:

Why are local health departments seeking to become effective chief health strategists in their community? What are the drivers?

What organizational and leadership strategies are being employed within local health departments to assimilate the role of a chief health strategist?

Which strategies have succeeded? Which have failed? Why?

What challenges and barriers were identified when trying to re-position health departments to align with the chief health strategist role?

What factors were found to enhance or facilitate the transition from a traditional health department to a department that functions as a chief health strategist?

What recommendations do public health leaders in the study have for local health departments trying to become effective chief health strategists in their communi

Significance of Study

As indicated above, the barriers to the practice of public health in the 21st century include addressing health disparities, a practice that focuses on traditional public health

services and not upstream social determinants of health, and the lack of adequate funding for public health.

The National Association of County and City Health Officials (NACCHO) has reported that over the past decade, local health departments have lost approximately 56,000 jobs, and departmental budgets were significantly reduced over that period (NACCHO, 2018). Local health departments of all sizes have not recovered from the effects of the Great Recession of 2008. Given this lack of financial support, local health departments may need to re-prioritize their services to the community, including clinical services, and change the roles and responsibilities of staff to focus on population health. Organizational change in health departments that seeks to assimilate the role of a chief health strategist in the communities they serve will transform their public health practice as envisioned by Public Health 3.0.

This research study examines how local health departments are transforming their departments to function specifically as proficient chief health strategists in their communities, one of the recommendations in Public Health 3.0.

CHAPTER 2: LITERATURE SEARCH

Introduction

The transformation of a local health department's public health practice from traditional practice to practice aligned with the vision of Public Health 3.0 can be challenging. This chapter (1) explores the origins and concepts behind a chief health strategist, (2) introduces a framework from implementation science to identify the facilitators and challenges for a local health department becoming a proficient chief health strategist, and (3) identifies challenges to the transition to population health services.

Public Health Practice in the Era of Public Health 3.0

Public Health 3.0 provides the latest phase in the evolution of public health practice in the United States. As Figure 1 indicates, for almost 200 years, public health practices have been designated as Public Health 1.0, and health departments have successfully responded to threats of communicable disease and environmental hazards. During this period health departments led vaccination campaigns and communicable disease programs that eliminated threats of typhoid, polio, and many other diseases. There were also great gains in environmental health sanitation that provided safe food and water, improved air quality, and reduced exposure to other environmental hazards.

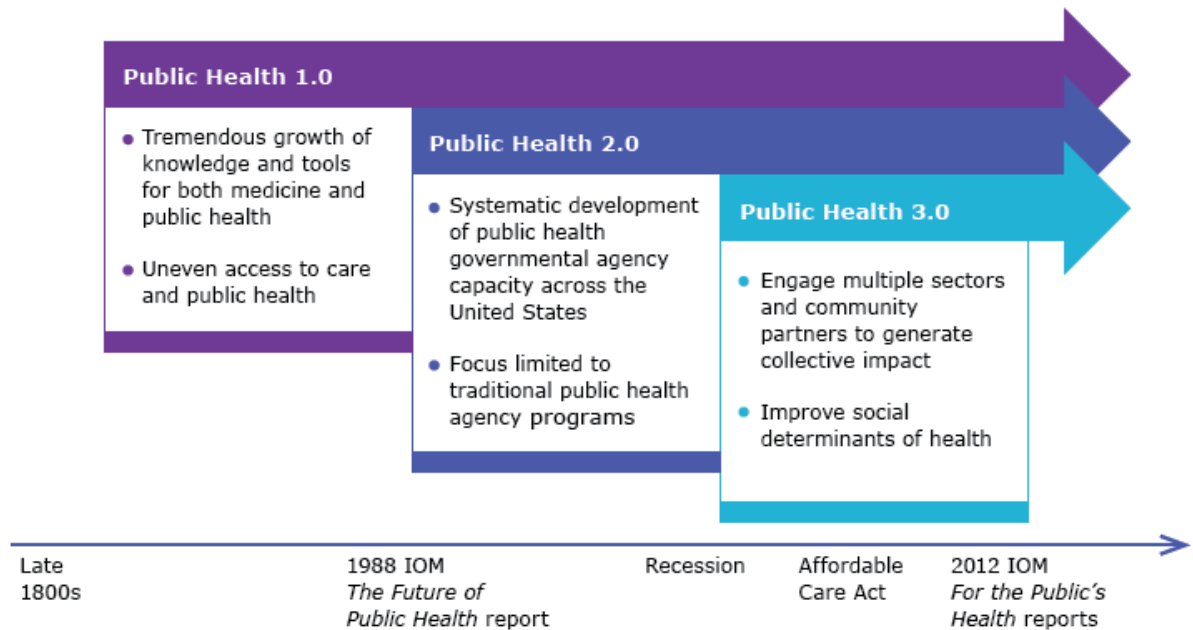


Figure 1: Public Health 3.0 (Source: DeSalvo, et.al, 2017).

Despite these gains in improved health, a 1988 Institute of Medicine (IOM) report, “The Future of Public Health,” concluded that the public health system had fallen into disarray and recommended a vision for public health that focused on populations from a systems perspective (1988). This seminal report resulted in a true paradigm shift in the role of government in public health. The report recommended a new mission for public health and defined it as “the mission of public health is fulfilling society’s interest in assuring conditions in which people can be healthy (p. 7)”. The governmental role in public health also changed with the recommended core functions of public health, which are assessment, policy development, and assurance. Six years later, these core public health functions were further defined and articulated in the 10 Essential Services of Public Health.

Public Health 3.0 represents a continuation of the evolution of public health practice. Released in 2016 by the U.S. Department of Health and Human Services, the white paper, *Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure*, calls for “a new era of enhanced and broadened public health practice that goes beyond traditional public health department functions and programs” (2016). The report identifies five recommendations to move in this new direction, including sufficient funding for public health, engage in cross-sector partnerships, support continued accreditation of governmental health departments, and make timely, reliable, granular-level, and actionable data available to communities (p. 5). The final recommendation is that public health leaders embrace the chief health strategist role for their communities and drive initiatives that address “up-stream” social determinants of health (p. 5).

Chief Health Strategist

This new role of “chief health strategist” was developed and articulated by the Public Health Leadership Forum. In the report “The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist,” the Forum described a chief health strategist as an organization that provides leadership in a community to improve health (2014). The report primarily addresses state and local health departments functioning as chief health strategists, however, the concept of a chief health strategist could extend to community health care systems and non-governmental organizations such as United Way. The report recommends the continuance of successful public health programs such as environmental health, communicable disease control, and emergency public health responses. However, when adopting the role of a chief health strategist, the health department’s role will change in other ways. As indicated in the

report, a health department “will be more likely to design policies than provide direct services; will be more likely to convene coalitions than work alone; and be more likely to access and have real-time data than await the next annual survey” (p. 4). Health departments functioning as a chief health strategists will also lead community health promotion efforts in partnership with health care organizations and various diverse community-based organizations.

The report identified seven practices that high achieving health departments functioning as chief health strategists will demonstrate with proficiency (pp. 5-20). These practices are:

- Adopt and adapt strategies to combat the evolving leading causes of illness, injury, and premature death.
- Developing strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.
- Chief health strategists will identify, analyze, and distribute information from new, big, and real-time data.
- Build a more integrated, effective health system through collaboration between clinical care and public health.
- Collaborate with a broad array of allies – including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities.
- Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems.
- Work with corresponding federal partners – ideally, a federal chief health strategist – to effectively meet the needs of their communities.

In 2019, the National Association of County and City Health Officials' Workforce and Leadership Development Workgroup released a set of chief health strategist competencies that further articulates the seven practices of a high achieving health department functioning as a chief health strategist. The competencies were further divided into measurable skills and activities to guide health departments in becoming proficient chief health strategists. These skills and activities have been organized into a self-assessment tool (See Appendix A) that can assess a health department's progress in reaching proficiency in the practices of a chief health strategist.

Consolidated Framework for Implementation Research

Implementation science has emerged as a method for formative evaluation in health services research. As described by Peters, "implementation research has its origins in many disciplines and is defined as scientific inquiry into questions concerning implementation – the act of fulfilling or carrying out an intention. In health research, these intentions can be policies, programs, or individual practices (collectively called interventions)" (Peters et al., 2013). One of the more commonly used models in implementation science is the Consolidated Framework for Implementation Research (CFIR). This framework comprises five domains with 39 implementation constructs that can affect implementation outcomes "that provides a structure by which to systematically assess context within which implementation occurs" (Bauer et al., p.6 2015).

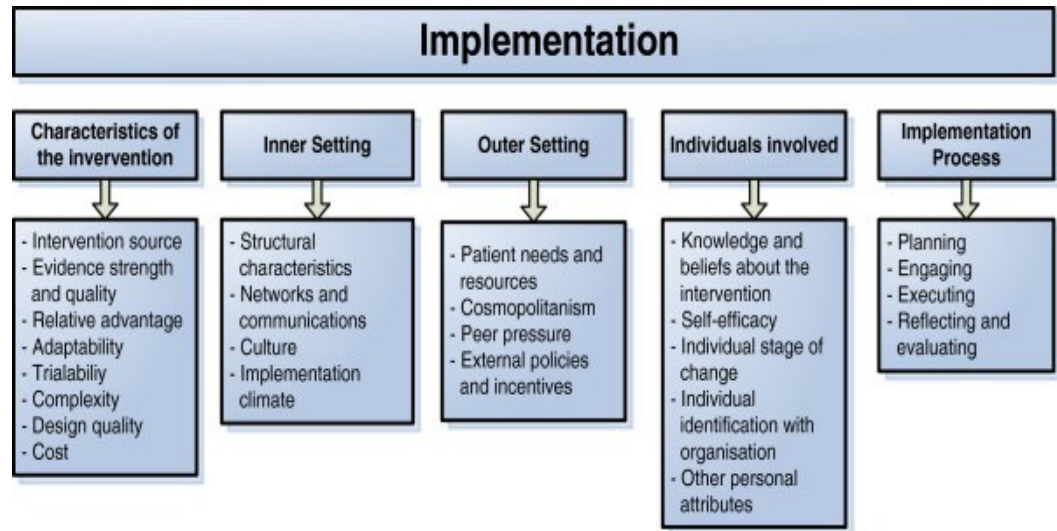


Figure 2: CFIR Domains and Constructs (Source: Ament, et al., 2012).

CFIR is used in various health services program evaluations, including research focusing on community and public health promotions and interventions. Three examples of community health implementation evaluated using CFIR are:

- A qualitative study on the barriers, facilitators, and implementation strategies of a faith-based “Faith in Action” program to promote promotora-led physical activity (Haughton et al., 2020). A semi-structured interview guide was developed, and 18 key informant interviews were conducted. The study found that the barriers and facilitators were identified in the CFIR domains of characteristics of individuals, the inner setting, and the outer setting.
- A cross-sectional study to assess the organizational factors that facilitate the implementation of health promotion programs by Latino faith-based organizations (Allen, et al., 2020). The study used the CFIR inner setting domain focusing on the constructs of organizational readiness, implementation climate, and organizational culture. Thirty-four faith-based organization key informants (often the congregation pastor) were surveyed by phone, online, or in person. A

descriptive analysis of the responses was developed. The results indicated that Latino faith-based organizations possess important constructs to implement health programs in their congregations.

- A qualitative research study on the barriers and facilitators of implementing three evidence-based practices to improve rates of colorectal cancer screening in a Federally Qualified Health Center (Lam et al., 2021). A 14-question semi-structured interview template was developed guided by all 5 CFIR domains and all 39 constructs. Sixteen key informant interviews were conducted with staff. Findings identified seven barriers and five facilitators in the implementation of the three evidence-based interventions to improve colorectal cancer screening.

Although the CFIR framework is commonly used to study community health programs, there is a paucity of information about the use of CFIR in studying organizational change within state and local health departments. No publications were found where the CFIR model aligned with public health practice as described in Public Health 3.0 and the concept of becoming a chief health strategist. The CFIR framework could provide a comprehensive identification of facilitators and barriers to organizational change within local health departments given the full array of perspectives on implementing change provided by the five CFIR domains and their associated constructs.

Challenges in the Transition to Population Health Services

As local health departments act to align their public health practice to one envisioned in Public Health 3.0, there are several challenges they need to overcome in their attempts at organizational transformation.

Capacity and Resources

Often, for a health department to assimilate the chief health strategist role, additional investment in new resources and capacity is required. This need for the acquisition of new resources, often in the form of new health department personnel with skills in community health assessment and planning, data management, and community engagement, provides significant challenges.

The resource challenge for local health departments has been severe since the recession of 2008. Local units of government were hit particularly hard by the recession, which put significant pressure on their financial status and the services offered to residents. During the height of the recession, the National Association of Counties (NACO) surveyed members in 2010 and found that 64% of the counties that responded anticipated a revenue shortfall (NACO, 2010). A similar survey of NACO members in 2011 found that 65% of respondents anticipated shortfalls from their adopted annual budgets (NACO, 2011). The top two reasons cited for these shortfalls were reductions in state or federal aid (51%) and a continued decline in property tax revenue (36%).

Local health departments did not escape the fiscal crisis that adversely affected the finances of local units of government. In a 2011 survey of local health departments by the National Association of County and City Health Officials, 41% of respondents indicated that their current department budget was lower than the previous year. The same percentage of health departments (41%) predicted that their budgets would further decrease in the next fiscal year (NACCHO, 2012). In a subsequent survey by NACCHO, the magnitude of the economic recession was realized with a reported local health department job loss of 43,900 individuals due to layoffs and attrition, with 41% of

departments experiencing some workforce reduction (NACCHO, 2013a). In Wisconsin, which is the focus of this study, a NACCHO report indicated that 29% of local health departments experienced a loss of staff due to layoffs or attrition, and 12% of departments reported that reduced staff time was implemented with a cutback in hours and/or through the imposition of furloughs (NACCHO, 2013b).

The recession has also impacted the services provided by health departments. In a 2013 research brief, NACCHO also reported on the cuts to public health programs, with 49% of local health departments nationally reporting cuts in at least one health department program and 18% experiencing cuts in three or more programs. (NACCHO, 2013b) The data for Wisconsin health departments indicated that 64% of departments experienced cuts to at least one program, and 14% reported cuts to three or more programs. In their 2012 survey of health departments, NACCHO researchers reported that the top three program areas experiencing cuts were immunizations (20%), maternal and child health services, and emergency preparedness with 15% of health departments reporting that services were reduced or eliminated (NACCHO, 2013a).

Post-recession data indicates that funding, staffing, and services have not rebounded since the end of the recession. The declines have moderated somewhat; however, moving forward to the vision and recommendations in Public Health 3.0, overall local health department per capita expenditures decreased 30% from \$80 in 2008 to \$56 in 2019 (NACCHO, 2020). In addition, local health departments lost 21% of their workforce over the same period (p. 54).

Capacity concerns also involve specific knowledge and skills within organizations to provide population-level services. The PH WINS 2021 workforce survey identified

training interests and needs consistent with a chief health strategist's seven public health practices. These training needs among supervisors, managers, and executives included systems and strategies management (59%), community engagement (53%), change management (47%), and cross-sector partnerships (43%) (de Beaumont Foundation, 2022).

Changes in Health Department Services

At the same time, health departments were grappling with the scarcity of resources to maintain health department services, and there were calls to move away from direct services and reposition to a role of providing population health services. Fraser and Castrucci (2017) recommended strategies to reposition state health agencies, including moving from programs to populations, from clinics to community, and from patients to policies. The current NACCHO policy on clinical services also recommends potentially moving away from clinical services to develop capacities to be an effective community (chief) health strategist. The policy states, “Local health departments, their communities, and governing boards must take a localized approach to determine what clinical services are appropriate while making strides towards addressing emerging public health issues” (NACCHO, 2022, p.2).

There are indicators that local health departments are reducing direct services such as blood pressure and well-child clinics in favor of population-based epidemiology and surveillance programs, as indicated in Table 1.

Table 1

Percentage of Health Departments Directly Providing Services (2008-2016).

Service	2008	2016	Change Since 2008
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Epidemiology & Surveillance Programs			
Syndromic Surveillance	40%	61%	22%
Behavioral Risk Factor Surveillance	33%	45%	12%
Chronic Disease Surveillance	39%	49%	10%
Environmental Health Surveillance	75%	85%	10%
Health Screening Programs			
High Blood Pressure Screening	68%	54%	-14%
Well Child Clinic	41%	29%	-11%
Diabetes Screening	45%	34%	-11%
Cardiovascular Disease Screening	35%	25%	-10%
Cancer Screening	42%	32%	-10%

Source: Robin and Leep (2017).

Reducing personal health or clinical services from a department's service set can strain relationships with community-based organizations and healthcare system partners who are expected to provide those discontinued health department services. Also, there can be strained relationships and resistance within departments from staff whose roles and responsibilities may change.

Examples of health department transformations

There have been attempts by local health departments to re-align the department's services from direct services toward services related to population health. The literature cites both successes and failures in these endeavors as summarized below.

In 1996, the Amarillo Health Department underwent a major redesign that removed most personal health services from the department's operations (Pierce, et al., 1998). The primary focus of the department's services was in the areas of communicable disease control, monitoring health status, identifying health problems, and health promotion. The expectation was that more effort and increased resources could be directed to community health. A 10-year retrospective case study determined that there was virtually no growth in the essential services provided by the department. (Richardson, et al., 2012)

In 2010, the New Orleans Health Department made a significant transformation in how it delivered public health services to the residents of the City of New Orleans. A new vision for the department centered on three objectives: (1) advance the health department into the 21st century, (2) bring a data-driven approach to strengthening the local health care system, and (3) embed a "health-in-all policies" philosophy within local decision-making (RWJF, 2010). A major part of the transformation included decisions on who should be providing direct clinical services as clinics and hospitals were being rebuilt post-Hurricane Katrina, with an ultimate decision to support and shift direct services to the New Orleans area's private and not-for-profit healthcare systems. This has been largely viewed as a success.

Another local health department significantly changed its public health practice due to the great recession. During the budget deliberations in the fall of 2010, the Kane County Health Department brought forth a transformation plan that transferred personal health care services that had been traditionally performed by health department staff to area federally qualified health centers (Kuehnert & McConnaughay, 2012). The plan included a 50% reduction in the Kane County Health Department workforce. The three strategic themes that the public health system developed through community stakeholder meetings were (1) excelling at public health practice, (2) effective communication, and (3) mobilizing community partnerships. However, this restructuring of the department and reduction of services was met with significant opposition from the employee's union and some community members.

In a research study, Ryan-Ibarra (Ryan-Ibarra, et.al 2019) interviewed seven local health departments to identify facilitating factors that guided their health departments to transition from direct clinical service provision to population-level interventions addressing determinants of health. The study identified eight key elements for an effective transition: partnerships/leadership, vision/goals, communication, community engagement, interventions, data/evaluation, workforce issues, and sustainability.

Conclusion

Public Health 3.0 envisions local health departments as proficient chief health strategists in their communities. “How” departments become chief health strategists is an important research question to answer in achieving that vision. This research proposal provides knowledge and insight into the facilitators, barriers, and strategies to become proficient chief health strategists.

CHAPTER 3: METHODOLOGY

Analytical Approach to the Study

A multiple case study design was used for this study. Yin (2009, p. 8) provides guidance by posing three conditions to consider when selecting a study method: (a) the type of research questions posed, (b) the extent of control the investigator has over the actual events, and (c) the degree of focus on contemporary as opposed to historical events. For this study, the research question is “how and why”; it requires no control over behavioral events and focuses on a contemporary event. Yin would recommend a case study based on these criteria.

The bounded system in this case study consisted of county and city-county local health departments in Wisconsin. For consistency, only one state was chosen for the study, and Wisconsin was representative of those states facing hardship during the economic recession and having lost government-funded positions (NACCHO, 2018). In addition, county and city-county health departments in Wisconsin are under the same mandates for services and functions as required by statutes and administrative rules (Wis. Admin. Code, DHS.140.04 (2) (a)). Finally, local government units in Wisconsin have been under a unique set of statutory mandates limiting spending and local tax levies (Wisconsin Department of Revenue). This unique political and fiscal environment provides consistency for the population under study.

Data Sources and Data Collection

Merriam and Grenier identified three sources of data for qualitative research studies: interviews, observations, and documents (2002, p. 12). They also state, “If at all possible, researchers are encouraged to use more than one method of data collection as

multiple methods enhance the validity of the findings” (p. 12). Three sources of data were collected from directors in this study: (1) key informant interviews, (2) departmental documents, including organizational charts and strategic plans, and (3) a completed chief health strategist competency self-assessment tool from NACCHO. These three data sources will provide data triangulation, which is important for case study research. Yin (2009, pp. 116-117) states that with triangulation of data sources, you “collect information from multiple sources but aimed at corroborating the same fact or phenomenon.”

Participant Recruitment

There are 69 county-based local health departments in Wisconsin. The unit of study for the project consisted of a subset of 30 (43.5%) county and city-county local health departments in Wisconsin. Health departments that have transformed or are transforming their departments in the spirit of Public Health 3.0 and the role of chief health strategist were considered for participation in this study. Identifying those departments was determined in three ways: (1) departments that have openly signaled that they are working toward becoming proficient chief health strategists through activities such as conference presentations (WALHDAB, 2019), (2) health departments that are accredited by the Public Health Accreditation Board (PHAB) or are currently undergoing preparation for accreditation (Public Health Accreditation Board), and (3) directors from Wisconsin Department of Health (DOH) Services regional offices functioning as key informants in identifying health departments that are working toward organizational change or are preparing for PHAB accreditation. The selection of PHAB-accredited health departments is predicated on the fact that chief health strategist

competencies are largely based on the PHAB standards and measures. The five state regional offices conduct audits of departments in their regions and advise, mentor, and provide technical support to assist local health departments in improving their public health practice (Wisconsin Department of Health Services).

As Creswell (2007, p126-127) described, purposeful sampling was used to select the final health departments for the study. Samples were selected to ensure representation from all five state health regions and a balance between urban and rural health departments. A “request for study participation” email was sent to prospective departments (See Appendix B). Departments agreeing to participate were asked to complete a NACCHO CHS self-assessment (See Appendix A) approximately one week before a scheduled interview and provide a copy of their current organizational chart strategic plan, if available. The rationale for the CHS self-assessment before the interview is twofold: (1) the interviewer will know some of the challenges and barriers in advance and be prepared to focus on certain domains and constructs, and (2) completing the assessment will refresh the participant’s experience in organizational transformation within their department. Participants were sent a study information sheet outlining the study's purpose, protections, and responsibilities. (See Appendix C)

Eleven health departments initially participated in the study. Key informant interviews were conducted using a semi-structured research guide (See Appendix D) incorporating the seven chief health strategist practices identified by the PHLF and a consolidated framework (CFIR) for advancing implementation that examines implementation from five perspectives (domains) and an array of constructs. Sub-questions inquiring about organizational and leadership strategies employed, successes

and failures, and barriers and enhancements identified to facilitate change assisted in elucidating the primary research question. An additional seven health departments were recruited to participate in the study. A modified research guide (See Appendix E) was utilized that also incorporated the CFIR framework and sub-questions that identified strategies employed, successes and failures, and barriers and facilitators. After reviewing a draft of the research methodology, the committee recommended that the modified interview guide contain more open-ended questions and capture more demographic data about the departments and directors. All interviews were conducted using Zoom technology, and transcripts were prepared using Otter.ai software. Interview guides and a Zoom interview invitation were sent in advance to participants. Transcripts were subsequently reviewed for accuracy and to deidentify the respondents. The total interview time was 13.5 hours and ranged from 29 minutes to 104 minutes with an average time of 45 minutes.

Wisconsin local health departments are distributed into 5 Wisconsin Division of Public Health (DOH) regions (See Figure 3).

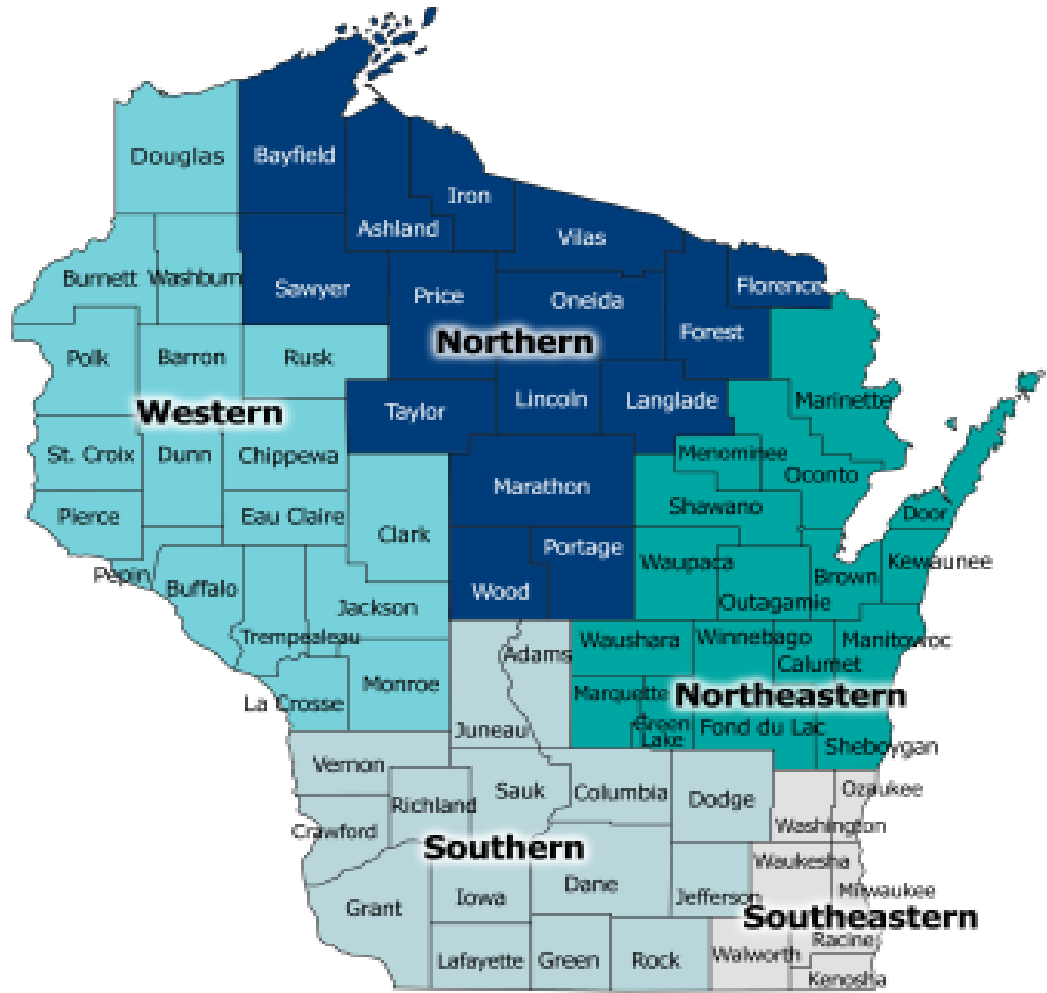


Figure 3: Wisconsin Division of Health Public Health Regions (Source, DOH)

The geographic distribution of local health departments participating in the study is summarized in Table 2. In organizing the study, attempts were made to select departments from each of the five public health regions. Of the 18 health departments participating in this study, the northern (33.3%) and western (27.8%) regions contained the most participants. There was also attempts for fair representation between urban vs. rural counties. Urban counties provided 10 (55.5%) of the participating departments, and rural counties provided 8 (44.5%) of the study's departments.

Table 2

Descriptive Statistics of Health Department Geographic Locations

LHD Characteristics	Category	(n=18), No. (%)
Wisconsin DOH Region		
	Northeastern	2 (11.1)
	Northern	6 (33.3)
	Southeastern	2 (11.1)
	Southern	3 (16.7)
	Western	5 (27.8)
Geographic Location		
	Rural	8 (44.5)
	Urban	10 (55.5)

The descriptive profile of health departments participating in the study is summarized in Table 3. The profile includes the size of the populations served, the number of employees in the departments, and accreditation designation by the Public Health Accreditation Board (PHAB). Departments are also categorized as free-standing departments of health in their county structure or divisions within a larger human service department.

The department's jurisdiction size (population) ranged from very small (less than 25K) to very large (500k – 999.9k), with the majority (61.1% ranging between 50k – 249.9k. Similarly, the number of employees in the departments ranged from very small (5 – 9) to a large department (200+), with the majority (72.2% ranging between 10 – 49 employees.

There was nearly an even split between accredited health departments (10) and non-accredited health departments (8).

Two-thirds of the study's organizations were departments and have reporting structures directly to the county board or county executive/administrator. One-third of the

organizations were divisions of a larger human services department, and the reporting structure was to the director of human services.

Table 3

Descriptive Profile of Health Departments in Study

LHD Characteristics	Category	(n=18, No. (%))
Jurisdiction Size (Population Served)	Less than 25K	2 (11.1)
	25K – 49.9K	3 (16.8)
	50K – 99.9K	4 (22.2)
	100K – 249.9K	7 (38.9)
	250K – 299.9K	1 (5.5)
	500K – 999.9K	1 (5.5)
	Number of Employees	
	5 - 9	1 (5.5)
	10 - 24	8 (44.5)
	25 - 49	5 (27.8)
	50 - 99	3 (16.7)
	200+	1 (5.5)
PHAB Accreditation		
	Yes	10 (55.5)
	No	8 (44.5)
Organization Structure		
	Department	12 (66.7)
	Division (Human Services)	6 (33.3)

The respondents for the health departments were current or former directors of their organizations. The former directors had either recently retired (1) or had taken new positions (3) but were leading their organizations during the transformation to population health services. The demographic characteristics of the directors interviewed for the study are summarized in Table 4.

All but one director had an advanced degree, and the largest number of directors (44,5%) had advanced training specifically in public health. The majority of directors

(61.5%) in the study were registered nurses. As to the tenure of directors, there was an even distribution with no majority.

Table 4

Descriptive Statistics of Local Health Department Directors

Director Characteristics	Category	(n=x), No. (%)
Tenure in Department		(n=18), No. (%)
	1-3 yrs.	2 (11.1)
	4-7 yrs.	3 (16.7)
	8-15 yrs.	5 (27.8)
	16+ yrs.	8 (44.4)
Tenure as Director		(n=18), No. (%)
	1-3 yrs.	4 (22.2)
	4-7 yrs.	5 (27.8)
	8-15 yrs.	5 (27.8)
	16+ yrs.	4 (22.2)
Education Level		(n=21), No. (%) *
	BSN	1 (4.8)
	MA	1 (4.8)
	MPH/MSPH	9 (42.8)
	MS	4 (19.0)
	MSN	5 (23.8)
	PhD	1 (4.8)
Registrations/Certifications		(n=13), No. (%)
	CHES	2 (15.4)
	RD	2 (15.4)
	RN	8 (61.5)
	RS	1 (7.7)
*Note: Several key informants received multiple degrees		

Data Analysis Framework

A stepwise process based on the 6-step thematic analysis approach developed by Braun and Clarke (2006) was used to analyze the key informant data collected in the study.

Step 1 Data Familiarization. A complete read-through of the transcripts to promote accuracy and deidentify names and organizations as Braun and Clarke state, “It is vital that you immerse yourself in the data to the extent that you are familiar with the depth and breadth of the content (Braun and Clarke, 2006, p.87).

Step 2 Generating Initial Codes. Initial (a priori) codes were created based on the CFIR domains incorporated into the interview guides. New codes and sub-codes were developed based on the systematic review of the transcripts. Coding was assisted by the use of NVivo software.

Step 3 Searching for Themes. Codes and sub-codes were collated into potential themes based on the frequency tables (files and references) produced by NVivo.

Step 4 Reviewing Themes. Preliminary themes were reviewed and refined to ensure that there are enough data to support them. Some preliminary themes were collapsed into larger groups.

Step 5 Defining and Naming Themes. The themes and sub-themes were defined and supported with sample quotes from respondents. Four themes emerged from this process:

1. Rationale for Change.
2. External Forces of Change.
3. Internal Forces of Change.
4. Process of Implementation

Step 6 Producing the Report. The final set of themes and sub-themes were incorporated into a key findings table (Table 5) and is used as the format for discussing the data in Chapter 4 – Results.

Ethical Considerations

An IRB for this study was approved by the Indiana University Institutional Review Board (Protocol #22050). A 30–45-minute interview was conducted virtually using Zoom technology and was recorded with the participant's permission. Participants were informed that they could choose not to answer any questions and can stop the interview anytime. The names of the participants and their organizations were not shared with anyone, and only the investigator had access to information that linked participants to the responses. Records of the interview were stored electronically in password-protected files. If an interview was recorded, a transcript was made using Otter.ai software. Any hardcopy information linked to participant responses to the interview was stored in a locked storage site. Transcripts and other hardcopy information will be destroyed, and audiotapes will be erased after the project is completed.

Feasibility

The concept of a health department seeking to assimilate the role of a chief health strategist is not new in Wisconsin. Sessions at state conferences and webinars have provided basic chief health strategist concepts and departments interviewed were able to provide their perspectives on becoming proficient chief health strategists (WPHA). The time commitment for completing the competency self-assessment and sitting for an interview was minimal, and there was no reimbursement for participating.

Validity Considerations

Yin recommends four tests to establish the quality of empirical social research: construct validity, internal validity, external validity, and reliability. (Yin, 2009, p. 40) Construct validity was met by using multiple sources of evidence. As previously

described, data came from department documents, a self-assessment tool, and key informant interviews, which allowed for triangulation of the data, a process described by Yin as satisfying construct validity (p. 116). Reliability was achieved by using a semi-structured interview template and the NACCHO self-assessment tool. Internal validity was not achieved because the study was exploratory and not explanatory. Finally, the study was not generalizable and did not meet external validity requirements.

Researcher Bias

The researcher was cognizant of potential bias in the collection and analysis of the data. The researcher in this case study is a former local health director who made budgetary decisions and adopted organizational strategies for a health department. Personal opinions, strategies, experiences, and recommendations were not included in the interview sessions.

CHAPTER 4: RESULTS

A chief health strategist self-assessment, key informant interviews, and supporting documents were obtained from participants in this research project. This information was instrumental in identifying how best a local health department can assimilate the role of a chief health strategist within their communities. The key findings are presented in this chapter.

Key Informant Interviews

Table 5

Key Findings

Themes and Sub-Themes	Definitions	Example Quotes
Rationale for Change		
Public Health 3.0	Vision for Public Health 3.0 provided motivation for change.	Facilitator. “. So I think for me, my interest is in Public Health 3.0, addressing more of the root causes and working on policy system change,” (Respondent 6)
PHAB Accreditation	Seeking PHAB accreditation acted as a driver toward population health services	Facilitator. ” But I think really the key to some more substantive change in this department was really jumping into public health accreditation, and the framework that existed with that national standard of work.” (Respondent 2)
Chief Health Strategist Proficiency	Respondents viewed this model as a good fit for leading health in the community.	Facilitator. “You know, being a chief health strategist is a good fit for us. Because we're not necessarily needed to provide a lot of direct services, those direct services are being

		provided by other organizations so we can focus a little bit more on that overall health strategy.” (Respondent 6)
External Forces of Change		
Governance - County Board	Respondents discuss levels of support for resources and changes in service.	Barrier. “On our board, they have very strong goals and strategies and sometimes they don't align with public health, necessarily, alignment due to maybe not understanding public health. I would say not understanding and maybe not believing in public health.” Respondent 16)
Governance - Board of Health	Sets direction for public health practice in the health department	Barrier. “Yeah, I mean, I think that with the board of health, some of the challenges were, they did not understand or recognize the nuances of community, upstream prevention approaches, and they really are more about, oh, you need to give a vaccine. That's what you do. You give vaccines, you provide WIC services, you provide reproductive health, all of the very hands-on things that we provide, which we still do, but it's really their knowledge and the inability to understand a bigger picture of public health”. (Respondent 5)
Community Stakeholders	Respondents discussed the support for health	Facilitator. “I think, actually, it's welcomed right now, and a part of it,

	<p>departments to become chief health strategists.</p>	<p>I think, is because we're so limited on staffing in our northern area of the state, they welcome public health coming in and providing extra support. And it seems like the leadership, they look to us for that leadership piece, they're not able to provide it, and they welcome that we are actually helping them by being that, you know, chief health strategists in the community, and I think there's support for public health and they listen to what we have to say.” (Respondent 16)</p>
<p>Internal Forces of Change</p>		
<p>Culture for Change</p>	<p>Respondents discussed the readiness for change in their departments and the reasons for resistance.</p>	<p>Facilitator. “Now I really find myself at one of the nimblest organizations I've ever worked in. I wouldn't say people are go with the flow, but I think people are also a lot more adaptable to change, and I think we're a lot more thoughtful about change than we have been in the past.</p> <p>Barrier. “I think most of the staff that struggled with the direction change, at least initially, it was probably mostly around the fact that they were, they were programs or services that the individual was really comfortable with. And having it feel like it was being taken away from them caused some strain. And, right or</p>

		wrong, most of those individuals then did choose to move on to different jobs or career paths.” (Respondent 7)
Structural Characteristics of Organization	Respondents discuss how they have structured their departments and obtain critical positions for population health services.	Facilitator. “But I wouldn't say that we've gotten like, fully new positions since I've been here. Rather, what we've been able to do instead is reimagine positions that existed into something radically different and more focused on population outcomes.” (Respondent 13)
Process of Implementation		
Process Planning	Respondents provide their strategies and approaches to initiating change.	Facilitator. “Thinking back for that, you know, educating our board, you know, particularly our board of health, educating my direct report, the county executive, you know, and bringing forth opportunities that moved us in that direction was another opportunity.” (Respondent 11)
Strategic Planning	Respondents relate on how strategic planning has acted as a vehicle to implement organizational change.	Facilitator. “So in our first strategic plan after I started, we really reimaged some of our care coordination work to be more about partnerships and linkages to care, rather than us providing the care itself. So that became a priority area that was primarily led by public

		health nurses, and I think that really allowed them, for the first time, to see themselves in that chief health strategist role, which I think was really useful.” (Respondent13)
Recommendations	Respondents share advice an recommendations to peers who are contemplating change.	Facilitator. “I think starting from a place of shared values.” (Respondent 2)

Eighteen local public health directors were interviewed to provide their experiences in reshaping their departments to becoming chief health strategists in their communities. The directors provided valuable information on their rationale for becoming chief health strategists, facilitators, and barriers to change, as well as recommendations to peers seeking to become chief health strategists.

In describing the frequency of comments toward any of the sub-themes, the terms “several” and “some” are used. If half or more than half of the interviewees commented on a particular construct or sub-construct, the term “several” is used; when less than half respond, the term “some” is used (Yeager, et.al, 2022). In addition, the sub-themes indicate the number of respondents (n=_) that discussed issues in the sub-theme during the interview. The following is an in-depth analysis of the interview findings.

Theme: Rationale for Change

The rationale for change examined the motivation and drivers for change. All respondents indicated that they took steps to reorganize their departments and services to focus on population health services consistent with Public Health 3.0. Three sub-themes

emerged as drivers as to why health departments transitioned their public health practice toward population health services. The sub-themes were (1) Public Health 3.0, (2) Public Health Accreditation, and (3) Chief Health Strategist Proficiency.

Sub-Theme: Public Health 3.0 (n=11)

Public Health 3.0 lays out a vision for a 21st-century health department focused on prevention and upstream determinants of health. Several respondents focused on the need for public health practice to address more root causes of poor health outcomes and work toward policies that have a larger population impact.

A sample of the respondent quotes include:

Facilitator. “I think for me, to start off with is that, you know, community conditions matter. And, and we, in public health know that we cannot do it alone. And so, you know, embracing a model that engages community, in more upstream methods to improve health is really where we want to put our efforts.” (Respondent 11)

Facilitator.” I was regularly seeing people struggling with more than just food, you know, they were struggling with things like housing and, you know, employment, and those were really driving their health outcomes a little bit more than the type of milk that their child was drinking when they turned age two. So I think for me, my interest is in Public Health 3.0, addressing more of the root causes and working on policy system change,” (Respondent 6)

Sub-Theme: PHAB Accreditation (n=9)

The National Public Health Accreditation Board (PHAB) accredits state, local, and tribal health departments based on a comprehensive set of standards and measures. In this study cohort, there were ten departments that were currently accredited and one that was preparing for accreditation. Most respondents (9/11) indicated that accreditation was either the primary impetus to transition to population health services or used as a guide to organizational transformation.

A sample of the respondent quotes include:

Facilitator. ” But I think really the key to some more substantive change in this department was really jumping into public health accreditation, and the framework that existed with that national standard of work.”

(Respondent 2)

Facilitator. ” I would attend conferences, and I would learn about research talking about, you know, systematic impact. What would make it really impactful, and feeling like we weren't headed in that direction, and feeling like that, really, to make an impact in a county of our size, we needed to do that. Individual services weren't enough. Direct services weren't enough. So, a huge part of my drive, and a huge part then when I interviewed for this job, is I said, if you hire me, I will modernize public health using accreditation as the tool. That was when I said that's if you get me, that's what you're going to get.” (Respondent 12)

Facilitator. ” Yeah. I mean, I think it was a combination of, you know, coming into this position and seeing opportunities for modernization, and also reevaluating, having the ability to kind of reevaluate our place and stance in the community, and looking at what was provided clinically and what was really being recommended in terms of Public Health 3.0. and we did really use PHAB as a guidebook to help us determine what that could look like.” (Respondent 15)

Sub-Theme: Chief Health Strategist Proficiency (n=14)

The concept of a chief health strategist is a health department that gains proficiency in seven public health practices and has the capacity and competency to step forward as a leader in improving health in a community. Assimilating the role of a chief health strategist was one of the drivers of change in health departments in this study to transition to population health services. Some of the respondents indicated that assimilating the role of chief health strategist was a good fit for their organization, and others indicated that incorporating the chief health strategist concept into their health departments enhanced their ability to lead efforts to improve the health of their communities.

A sample of the respondent quotes include:

Facilitator. “You know, being a chief health strategist is a good fit for us. Because we're not necessarily needed to provide a lot of direct services, those direct services are being provided by other organizations so we can focus a little bit more on that overall health strategy.” (Respondent 6)

Facilitator. “Just really taking the lead within our community and trying to drive change. And I think, for me, when we started really recognizing the impact that the social determinants of health have on population health and the things that people sometimes still consider not to be public health, like, you know, if you think about housing, incarceration, income, education, you know, it's early on, you know, that's not public health, that we got to stay in our lane, but it is public health, and we recognize that and we can't fix it on our own. Those issues are broad, and it takes a lot of partners, but somebody has to drive and lead all of that work. And I think that's where the chief health strategist comes in.” (Respondent 9)

Facilitator. “I think that I heard the term chief health strategist from Public Health 3.0, after we started our initial accreditation process. And so it just to me, it, you know, it just linked. It just seemed like that was right, that was just in alignment with what we were learning.” (Respondent 15)

Theme: External Forces of Change

The CFIR outer setting identifies the entities outside of a health department that may have an effect of either facilitating or acting as a barrier to attempts to become a chief health strategist.

Sub-Theme: Governance

Local health departments in Wisconsin are governed by two entities: (1) the county board and (2) the board of health.

County Board (n=10)

The county board determines the county's official policy, including enacting ordinances, passing resolutions, and creating the county budget and tax levy. County boards also determine departmental structure and positions. Several respondents indicated

that county boards were barriers to health departments focusing more on population health services. There was opposition to departmental changes due to cost or budget constraints and a lack of knowledge of, or value for, public health. Some directors were able to garner support for public health initiatives after educating the board and selecting the best time for introducing new programs or services.

A sample of respondent quotes include:

Facilitator. “I honestly have been incredibly fortunate. There will always be one or two from the county board that may not have voted in favor of some of the things within the health department. But overall, we really have been incredibly successful, and there have not been a lot of barriers that were placed. Timing for us really was a huge factor in it.”
(Respondent 14)

Barrier. “On our board, they have very strong goals and strategies and sometimes they don't align with public health, necessarily, alignment due to maybe not understanding public health. I would say not understanding and maybe not believing in public health.” Respondent 16)

Barrier. “They were trying to re-envision an entire health department that used to be providing personal care, used to just do vaccines, that used to be very patient oriented, and they couldn't understand what our purpose was in serving the entire population. So there was a lot more advocacy and educational opportunities that we had to offer them in order for them to really buy in on it.” (Respondent 14)

Board of Health (n=11)

Boards of health in Wisconsin are largely advisory bodies; however, they have responsibility for conducting periodic community health assessments (CHAs) developing community health improvement plans (CHIPs) and setting the direction for public health practice. Several respondents indicated that boards of health were barriers to practices that were more focused on population health services. These barriers often were not due to active opposition to departmental changes but rather a lack of knowledge about

contemporary public health practice and the mindset that public health only provides traditional public health services (e.g., vaccinations, WIC, etc.). Some respondents found their boards supportive of change after explaining and educating about the practice of public health as envisioned in Public Health 3.0.

A sample of respondent quotes include:

Facilitator. “So, I think the board finally sees how you can build a program, but you still have to wait for the results, which kind of goes back to that Public Health 3.0 model, like it doesn't happen overnight. You got to build it. You got to nurture it. You got to keep ensuring there's equity. To include everybody who can be included, if they choose to be included.” (Respondent 18)

Facilitator. “I'm super lucky that we got a board of health that really bought into my vision for the health department when I kind of explained the Public Health 3.0 model and explained like, this is where public health has been but this is where we are going. They were kind of all about it, and they were willing to, which is so hard as a community leader, to stop some services in order to really take advantage of this strategist role instead. So, our board has been super supportive. (Respondent 13)

Barrier. “Yeah, I mean, I think that with the board of health, some of the challenges were, they did not understand or recognize the nuances of community, upstream prevention approaches, and they really are more about, oh, you need to give a vaccine. That's what you do. You give vaccines, you provide WIC services, you provide reproductive health, all of the very hands-on things that we provide, which we still do, but it's really their knowledge and the inability to understand a bigger picture of public health”. (Respondent 5)

Barrier. “Yeah, that also took a lot of ongoing education, you know, just same as we had to do internally with our own staff, bringing them up to speed on Public Health 3.0, helping them understand the idea of a chief health strategist and what that looks like, and how that can look locally, again, getting over the hump on the things that they maybe didn't initially view as things that we should be focused on or working on, because they didn't used to be considered public health, that kind of getting past the heart disease and stroke and, you know, education stuff to like real things

that are the real deal in our communities that people are struggling with that, are more around the social determinants.” Respondent 9)

Sub-Theme: Community Stakeholders (n=15)

Respondents commented on the many community networks of health services providers and the level of cooperation with community stakeholders. Several respondents indicated very good working relationships with community partners. This included acknowledging the role of a health department functioning as a chief health strategist and their leadership in improving health in communities, including during the emergence of COVID-19. Community partners also worked with health departments to identify service providers who would fill service gaps when the health department transitioned out of providing services. However, some respondents indicated that community providers posed as barriers in the transition of traditional public health services out of the department.

A sample of respondent quotes include:

Facilitator. “I think, actually, it's welcomed right now, and a part of it, I think, is because we're so limited on staffing in our northern area of the state, they welcome public health coming in and providing extra support. And it seems like the leadership, they look to us for that leadership piece, they're not able to provide it, and they welcome that we are actually helping them by being that, you know, chief health strategists in the community, and I think there's support for public health and they listen to what we have to say.” (Respondent 16)

Facilitator. “I know in some communities; health was crucified during COVID-19. We, at times, came a little close to that, just barely, but really, COVID found us in the driver's seat, and it was and we were put in the driver's seat by community partners, our constituents and citizens were like, public health, we need guidance, what is going on. And all of a sudden, we went from the thought of, you know when public health works nobody knows about it to wow, like, do you want us to drive the bus? (Respondent 18)

Barrier. “You know, for example, the health department had previously been involved in home visiting programs, and we were one of multiple organizations providing home visiting services in the county. And so the decision was made to transition the health department away from home visiting services, and instead focus more on population health services. And, you know, I think from the community partner perspective, they maybe didn't see how our work to focus on population health could actually alleviate the burden that families experience were, you know, needing that more one-on-one home visiting service.” (Respondent 6)

Barrier. “With our healthcare partners here in _____ County. Just excellent relationships. But still, even when it comes to some of the stuff they're doing, it's not always, you know, it's not as easy to influence when it's within their wheelhouse versus ours.” (Respondent 12)

Theme: Internal Forces of Change

The CFIR Inner Setting examines the factors within an organization that affect a change plan. Respondents in this study identified two sub-themes that function as both facilitators and barriers to organizational change: (1) the culture of an organization and (2) its structural characteristics.

Sub-Theme: Culture for Change (n=17)

This sub-theme examined the climate for change as health departments transition to a practice based more on population health than on traditional public health services. Several respondents indicated that they currently have a culture that promotes change. There was a mixed response on the part of respondents as to the receptivity of change in the direction of population health services. Several respondents indicated that there was a readiness for change. Conversely, some respondents indicated resistance and barriers to change initially and in segments of the organization that had been providing direct services.

A sample of the respondent quotes include:

Facilitator. “Yeah, I don't think it was that much of a stretch. You know, when I came on board in 2009, there already was this strong culture within the heart health department and understanding of, you know, for us to be effective, we needed to work across, you know, what is the social ecological model.” (Respondent 4)

Facilitator. “So having staff buy in, but also having staff have those skills and that experience. and when we were making that transition, we really had a strong workforce that had the ability to, and the ability and the capacity to make that change.” (Respondent 5)

Facilitator. “Now I really find myself at one of the nimblest organizations I've ever worked in. I wouldn't say people are going with the flow, but I think people are also a lot more adaptable to change, and I think we're a lot more thoughtful about change than we have been in the past. We've also had a fair amount of staff turnover in the last six years, just due to like, retirements and people moving on, and I think we've done a good job of hiring people that are really critical thinkers and pretty adaptable. So I think right now, our culture around adaptability is really fantastic, but it was not that way six years ago.” (Respondent 13)

Facilitator. “There's also an organizational culture here that has a lot of pride in being a strong health department. So having a structure to kind of show to prove that we were continuing to work on this journey of being a strong health department, I think, helped create culture, it was a culture that helped create some of that change.” (Respondent 2)

Facilitator. “I'd say our culture is conducive for change. And there's a readiness for change. Where we have an opportunity is strengthening our change management skills as the organization so that the changes are more palatable, not just necessarily more palatable, but that people feel a little bit more involved and engaged in the change, and that we can make sure those changes are sustained.” (Respondent 6)

Barrier. “And sometimes not even the interest, I would say there's a segment of nurses that just wanted to, you know, help moms that were pregnant and didn't really care about, you know, okay, if we serve 100 women this year, how does that impact birth outcomes among that cohort, but also at a population level?” (Respondent 4)

Barrier. “I think most of the staff that struggled with the direction change, at least initially, it was probably mostly around the fact that they were, they were programs or services that the individual was really comfortable

with. And having it feel like it was being taken away from them caused some strain. And, right or wrong, most of those individuals then did choose to move on to different jobs or career paths.” (Respondent 7)

Barrier. “And we had a couple of staff initially, too, who just, they just could not come around from wanting to focus on the individual. That was tough, too and we ended up losing a couple staff along the way, which ended up to be better for everybody else, Things just kind of work themselves out,” (Respondent 9)

Sub-Theme: Structural Characteristics of the Organization (n-17)

This sub-theme focuses on the structure of the organization and the types of positions in the department that provide the competency and capacity to deliver population health services consistent with a proficient chief health strategist.

Several respondents took deliberate steps to reorganize their departments, often creating new divisions. In reviewing the organizational charts that respondents submitted, the new divisions names included “Community Health,” “Population Health Services,” “Strategic Initiatives,” and “Planning, Policy, and Evaluation.” These new divisions were populated with positions that worked on community assessment and planning, community engagement, health equity, communications, and policy.

Another strategy was to reclassify health department positions. Reclassification is one way to get staff members into positions that will work in population health services. Some respondents reclassified traditional positions when vacant and provided new job titles and descriptions, often creating a position called “public health specialist.”

Like the reclassification strategy of revising position descriptions of vacant positions, several respondents indicated that filling vacant positions with individuals possessing skills in population health facilitated their plans to restructure the department. Vacancies were viewed as opportunities to change the makeup of the organization.

A sample of the respondent quotes include:

Facilitator. “But I wouldn't say that we've gotten like, fully new positions since I've been here. Rather, what we've been able to do instead is reimagine positions that existed into something radically different and more focused on population outcomes.” (Respondent 13)

Facilitator. “I guess they call it an opportunity through retirements or people leaving the workforce that may not fill that exact position but instead, look at filling a position more in line, I won't say just your public health specialist, but more in line with those pop health services that you want to achieve.” (Respondent 2)

Facilitator. “So, HR worked with me to reclassify and make a whole new public health strategist specification that they'd never had before. I recrafted each of the positions to be a public health strategist, depending upon their focus. So in the substance use realm, we instead of making them education and outreach Narcan specialists we made them public health strategists and when the asthma specialist left that I used that opportunity to transfer that over so that whoever we hired as the new person would be a public health strategist.” (Respondent 8)

Facilitator. “I'll be honest, you know, we're good grant writers, and we get a lot of grants. And when we focus our energies on grants, we focus them in areas that community health specialists are more skilled to lead because you're working with coalitions and you're working with partners, and you are striving to make change at the community level. And so, yes, to answer that question, in a different way and what I alluded to earlier, is, I feel that community health specialists are more skilled and bring in different abilities than, say, a public health nurse. And so we are strong in community health specialists.” (Respondent 5)

Barrier. “We have, you know, our capacity, our resources, everything is always so limited. So we didn't have the funding to bring on a bunch of new positions, it was more a transition into these positions over time.” (Respondent 9)

Barrier. “part of the challenge was people didn't want to go back to school. Believe it or not, I would offer it I'd say, I will pay for this course. I could not get some people to take anything. They just were like, no, I'm not at that point in my career anymore. I don't want to spend my time that way. Yeah, so it was more of just waiting for people to leave and repurpose their position” (Respondent 1)

Theme: Process of Implementation

The CFIR process domain focuses on planning, engaging, and executing the implementation of organizational change. The respondents identified three sub-themes as important contributors of organizational change in health departments.

1. **Process Planning:** the strategies, plans and approaches initiated in the process of implementation.
2. **Strategic Planning:** the use of strategic planning as a vehicle for implementation.
3. **Recommendations for Change:** Recommendations to peers seeking to initiate change in their public health practice.

Sub-Theme: Process Planning (n=15)

This sub-theme examines the strategies and approaches initiated in the process of implementation. Respondents indicated a number of actions taken in planning for implementation. Some departments concentrated on educating staff, board members, and stakeholders about the direction of population health services. Some respondents used preparation for PHAB accreditation to make changes in the organization. Some used continued communication of the vision and concept of population health services to staff and the community. All of these actions were felt to facilitate implementation.

A sample of the respondent quotes include:

Facilitator. “So I think having that right vision and being able to take it into implementable steps, I think that has carried us along. I think the other piece is that we have some really strong champions in our partners, and that they're willing to come along with us when we come up with these new and different ideas.” (Respondent 7)

Facilitator. “Thinking back for that, you know, educating our board, you know, particularly our board of health, educating my direct report, the county executive, you know, and bringing forth opportunities that moved us in that direction was another opportunity.” (Respondent 11)

Facilitator. “I understood where I am, _____ County tends to be a fiscally conservative county and so to avoid any confusion that this is just an

additional cost or that this was luck, I really leaned in on the elements of it, around quality improvement, around performance management, around the return on investment. If you do these things, you're going to see less cost here. So I really tried to find, when speaking to those, the values that I knew were important to them,” (Respondent 12)

Facilitator. “I think, certainly increasing slowly over time communications with the community to build additional awareness of the role.” (Respondent 11)

Sub-Theme: Strategic Planning (n=10)

This sub-theme refers to the use of strategic planning in implementation. Fourteen of the key informants provided their department’s strategic plans. All of the plans contained goals and objectives around workforce development, and several of the plans identified goals and objectives for partnership development and community engagement. Several respondents indicated that strategic planning acted as a “vehicle” for reorganization and facilitated the process.

A sample of the respondent quotes include:

Facilitator. “One was, we did a strategic plan. And I think it was the timing of it, I can't remember. But it was pre COVID, a few years before COVID, I think really helped cement the direction we were going. And it gave us an opportunity as a department to align together to articulate. It also involved our board of health, which I think also was important in terms of them participating, to see the direction that we were going.” (Respondent 4)

Facilitator. “It was the gasoline that started the vehicle because like that was that October, the first October of COVID, where we were just finished the reorganization had just finished explaining the vision. And then the strategic plan was where I got the buy in, of all staff.” (Respondent 8)

Facilitator. “So in our first strategic plan after I started, we really reimagined some of our care coordination work to be more about partnerships and linkages to care, rather than us providing the care itself. So that became a priority area that was primarily led by public health

nurses, and I think that really allowed them, for the first time, to see themselves in that chief health strategist role, which I think was really useful.” (Respondent13)

Sub-Theme: Recommendations for Change (n=14)

In this sub-theme, respondents were asked to provide recommendations for organizational change to peers who were interested in moving toward population health services and becoming proficient chief health strategists. Several respondents offered recommendations to peers who are seeking to become chief health strategists. The recommendations included investing in data, starting small, knowing your assets, getting buy-in from leaders and partners, and starting from a place of shared values.

A sample of the respondent quotes include:

Facilitator. “I think just one being bold and like putting a stake in what we knew needed to happen. Creating leadership capacity to support it. Investing in workforce development.” (Respondent 10)

Facilitator. “One, it's about communication, talking to your community.” (Respondent 18)

Facilitator. “I think starting from a place of shared values.” (Respondent 2)

Facilitator. “I would say, know what your assets are.” (Respondent 4)

Facilitator. “You need to make sure your plans are aligned with Public Health 3.0, you need to assess your community in more areas than just one. You need to have a commitment to data and infrastructure, you need to have that culture shift, where everybody is on board about change and change management and being okay with that. You need to have performance management. And you need to utilize clear communication to reach all populations.” (Respondent 5)

Descriptive Profile of Study Participants.

One aspect of the key informant interviews included the collection of demographic data on both the health departments and health directors participating in the study. Data collected on health departments included geographic locations, size of jurisdictions, number of employees, PHAB accreditation, and whether or not they are free-standing health departments in the county structure or a division within a larger human services department. Information collected on the directors included their department tenure, total years and years as director, education level, and any certifications or registrations.

As to the characteristics of the health directors, respondents did not indicate that their level of education or tenure in the department positively or negatively affected their ability to initiate any transformational change in their department.

Respondents did reflect on two aspects of their departments that functioned as facilitators or barriers to moving their public health practice toward population health services and assimilating the role of chief health strategist.

The first issue was being an accredited health department. To achieve accreditation, departments must demonstrate accomplishment by a peer review in a number of standards and measures, including those considered to be population health services. In addition to demonstrating achievement in the standards and measures, those standards and measures acted as a guidebook for organizational change. PHAB standards and measures also closely align with the practice of a proficient chief health strategist. As two respondents stated:

Facilitator. “But I think really the key to some more substantive change in this department was really jumping into public health accreditation, and

the framework that existed with that National standard of work.”
(Respondent 2)

Facilitator. “Yeah, I mean, I think it was a combination of coming into this position and seeing opportunities for modernization, also reevaluating our place and stance in the community, looking at what was provided clinically and what was really being recommended in terms of Public Health 3.0., and we really did use PHAB as a guidebook to help us determine what that could look like.” (Respondent 15)

Respondents from rural and northern regions of the state indicated barriers to hiring staff critical to the delivery of population health services due to their geographic location. As one respondent stated:

Barrier. “So right now we’re having a little bit of an issue in our county. We’re having a hard time hiring so that has been a little bit of a barrier for us. I have been trying to hire a nurse for two years.” (Respondent 16)

Chief Health Strategist Self-Assessment

Participants in this study were requested to complete a chief health strategist self-assessment for their departments. Fifteen directors completed the assessment. The assessment focuses on the seven practices of a proficient chief health strategist. It measures the department's skill competency and the activities taken by the department in respect to the practices.

The assessment scores for each practice were averaged and are listed in Appendix A. In reviewing the results, four items relevant to this study were found to be either less than competent or not currently performing.

Less than competent skill competency

1. 2E: Utilizes knowledge to tie sources of power/power differentials to health inequity when developing strategies to address health inequity in community health improvement planning.

2. 4D: Influences policies that encourage integration of physical healthcare, behavioral healthcare, social determinants of health and new payment models that improve individual health and population health while lowering costs and eliminating disparities.

Not currently performing activities.

1. 4A: Uses data to assess the impact of local, state, and federal healthcare reform policies on improving community health by improving efficiencies and increasing quality of care to reduce disparities.
2. 5A: Uses data to assess the impact of health reform policies on community health.

The low self-reported scores in these four competencies focus primarily on addressing health inequality, social determinants of health, and reducing disparities.

Actions to address these issues fall within a health department's population health services. Some respondents identified this lack of capacity to address health equity.

A sample of the respondent quotes include:

Barrier. “And so, health equity, maybe as an example of some in our organization really understand how health equity is woven throughout all of what we do. And others really need concrete learning to kind of understand how it impacts day to day, if that makes sense.” (Respondent 2)

Barrier. “So, one of the areas that we have struggled in, and do somewhat still continue to struggle in, is around health equity. We have tried twice now to really better integrate health equity into our strategic plan, but we still have some staff members that really are uncomfortable with that terminology. So we had a we had a session during our last strategic plan where we talked about social justice and health equity, and then staff had some opportunities to give anonymous feedback about how they felt about the equity, inclusion and belonging statement that we created as a health. Department, and a few staff members said they you know, I'm annoyed that we have to do this. I'm mad. I think it's ridiculous. I think we should treat all people the same, which, again, that goes back to like a misunderstanding about the concept, no matter how many trainings that we've done as a department.” (Respondent 13)

CHAPTER 5: PLAN FOR CHANGE

This chapter focuses on a plan to transform a local health department to become a proficient chief health strategist. Chapter 4 identified a host of facilitators and barriers as health departments were transforming their organizations and public health practices to align with the vision of Public Health 3.0. This effort represented the daunting task of applying concepts of change management and change leadership to their organizations. The framework for this plan for change uses Kotter's Eight-Step Process of Creating Major Change model. (Kotter, 1996, p. 21).

Survey the Challenge

Prior to initiating Kotter's eight stages of creating change, it is important to step back and obtain a clear picture of the situation, identifying all parts of the challenge and how they interact. Heifetz and Linsky (2002) use the metaphor of getting off the dance floor and on the balcony to see the entire dance. They state, "achieving a balcony perspective means taking yourself out of the dance, in your mind, even for a moment. The only way you can gain a clearer view of reality and some perspective on the bigger picture is by distancing yourself from the fray. Otherwise, you are likely to misperceive the situation and make a diagnosis, leading you to misguided decisions. (p. 53). The authors go to say, "If you want to effect what is happening, you must return to the dance floor." (p. 53)

Kotter's Eight-Stage Change Process

The Kotter eight stage change process consists of 8 steps:

Step 1: Establishing a sense of urgency.

Step 2: Creating the guiding coalition.

Step 3: Developing a vision and strategy.

Step 4: Communicating the change vision.

Step 5: Empowering broad-based action.

Step 6: Generating short-term wins.

Step 7: Consolidating gains and producing more change.

Step 8: Anchoring new approaches in the culture.

Kotter (p. 22) grouped the eight-stage process into three distinct sections. Steps one through four “help defrost a hardened status quo. If change was easy, you wouldn’t need all that effort.” (p. 22). Steps five through seven are where the new practices are introduced. Step eight builds the new practice into the culture of the organization.

Establishing a Sense of Urgency

A transformation of an organization often needs an event, crisis-related or not, to move from complacency to action toward a new direction. Public health has recently experienced several crisis-related incidents that could be termed a “wake-up call” such as pandemic influenza (H1N1) in 2009 and COVID-19. One director in the study stated, “So really COVID-19, I would have to say was the thing that pushed both more of a collective impact, strategizing with partners, and that work within the community, you know, the marginalized communities that public health should be focusing on” (Respondent 8).

There are also non-crisis initiatives that can spark organizational change. Departments preparing for PHAB accreditation must create and implement new systems and plans into their organization, including strategic plans, workforce development plans, quality improvement plans, and completing community health assessments and

improvement plans. One director indicated that accreditation preparation stimulated action, “I feel like accreditation really was a role in moving us forward” (Respondent 5). Also, periodic reviews of goal achievement in adopted community health improvement plans can result in changes on how the organization can produce better health outcomes.

Introduction of Strategic Planning

Several health directors indicated that their department’s strategic plans were very helpful in facilitating reorganization. As one director noted, “It was the gasoline that started the vehicle. And then the strategic plan was where I got the buy-in of all staff” (Respondent 8). Bryson (2011, p. 8) offers that strategic planning, in part, can be helpful for the purposes of producing considerable judgment among key decision-makers about desirable and acceptable missions, goals, strategies, and actions along with complementary initiatives, such as new, changed, or terminated policies, programs, and projects, or even overall organizational design”.

For purposes of this implementation plan, strategic plans will be used as “vehicles” in which to address the remaining seven (2 through 8) steps of Kotter’s stages of change.

Creating the Guiding Coalition

The initial step in strategic planning processes is recruiting a team to develop the overall planning effort. Selection of team members is critical and should include leadership, staff representation of all of the divisions and programs, including staff members who may be viewed as resisters of change. Team formation should also look outside the organization and recruit key community partners and board members. All of these individuals will have an impact on the transformation of the department.

Developing a Vision and Strategy

Strategic planning often involves the creation of a shared vision for the plan and acts to provide a focus for the team moving forward. Senge (1990, p. 206) describes a shared vision as, “at its simplest level, a shared vision is the answer to the question, what do we want to create”. Creating a vision for what a proficient chief health strategist looks like may be difficult to conceptualize. The “what do we want to create” is a department that demonstrates proficiency in the practice of a chief health strategist, giving it the capacity to lead a community to better health. The NACCHO Chief Health Strategist Self-Assessment tool can be used to conceptualize the future infrastructure needed to be a proficient chief health strategist (NACCHO). The assessment tool can also be the basis for establishing strategic goals, including workforce development, and can establish baselines for measuring achievement over time.

Communicating the Change Vision

The strategic planning team will develop goals consistent with the shared vision. The goals will highlight areas of the department’s infrastructure that need increased capacity and improvement. Developing these goals and distributing them to staff will effectively communicate the department's vision and proposed direction. The vision and goals will also be distributed during meetings with board members and community stakeholders.

Empowering Broad-Based Action

Kotter (p. 21) focuses attention in this step on getting rid of obstacles, changing systems or structures that undermine the change vision, and encouraging risk-taking and nontraditional ideas, activities, and actions. At this stage, the planning team develops

measurable objectives/strategies with identified actions to meet those objectives and with assigned responsibility and timelines.

An example from one of the participating health department's strategic plans can illustrate actions that can occur during this step:

Goal 1: Regain a passionate, resilient, and energized workforce.

Strategy 2.1: In the Workforce Development and Employee Engagement Plan (WDEEP) implements best practices for employee engagement, workforce development, recruitment, retention, work/life balance, developing a sense of purpose, and employee well-being.

Strategy 2.2: Conduct core competency assessments to understand whether staff have skills needed to perform their job functions.

Generating Short-Term Wins

Short-term wins can build momentum for continued change within organizations.

These gains can be communicated to staff, community partners, and board members.

Short-term wins can be located in the following areas:

1. Annual reports identifying activities related to chief health strategist proficiency.
2. Annual reviews of the department's strategic plan.
3. Periodic reviews of the goals and objectives in the community health improvement plan.
4. Repeat chief health strategist self-assessment, looking for gains in closing gaps in practice ratings.

Consolidating Gains and Producing More Change

Kotter (1996 p. 21) identifies three actions to take in consolidating and producing more gains:

1. Using increased credibility to change all systems, structures, and policies that don't fit together and don't fit the transformation vision.

2. Hiring, promoting, and developing people who can implement the change vision.
3. Reinvigorating the process with new projects, themes, and change agents.

This is a time for departments to take advantage of opportunities to hire or reclassify staff with skills in performing population health services. This is also a step where the organization's structure can change, potentially creating divisions or units dedicated to infrastructure or population-level services.

Anchoring New Approaches in the Culture.

This is the step where shared values and group norms that emerged over the course of the reorganization are sustained. Kotter (1996 p. 157) provides guidance on sustainability:

1. Comes last, not first. Most alterations in norms and shared values come at the end of the transformation process.
2. Depends on results. New approaches usually sink into a culture only after it's very clear that they work and are superior to old methods.
3. Requires a lot of talk. Without verbal instruction and support, people are often reluctant to admit validity of new practices.
4. May require turnover. Sometimes the only way to change a culture is to change key people.

Conclusion

Kotter's eight-step model (1996, p.21) is seminal work around change management and leadership. The model goes deeper than changes to an organizational chart, reporting structures, or position descriptions. The model centers on building a strong foundation of a shared vision that will unite the organization around a reimagined health department and assure success in sustaining the changes made in public health practice and services.

CHAPTER 6: DISCUSSION

Purpose of Study

The purpose of this study was to examine how local health departments in Wisconsin are transforming their departments to function as chief health strategists in their communities. Several reports referenced in this paper have provided a vision and articulated the role a chief health strategist needs to play in a 21st century governmental health department, however, the reports are silent on how health departments are transforming their organizations to become proficient chief health strategists. The aim of this research study is to determine how local health departments can assimilate the role of a chief health strategist within their organizations.

Key Insights

Rationale for Change – Why Become a Chief Health Strategist?

Directors provided a number of reasons for initiating efforts to transform their departments. These included their response and performance during the COVID-19 pandemic, the availability of health care from the Affordable Care Act residents sought services elsewhere, and current preparation for PHAB accreditation. However, at the core, these health directors felt that refocusing on the provision of population health services such as upstream prevention, health equity, and social determinants of health would provide better health outcomes in their communities. The chief health strategist model provides the capacity to transform public health practice to include population health services.

Culture of Change

In the study several respondents indicated that they had a positive culture for change that facilitated a move toward a practice that includes population health services, although there was resistance at the start of transformation. One director reflected on their experience, “And so there was definitely some resistance there, especially in a transition from direct service to population health services, it takes time to retool staff, train them, include them in, you know, a vision of helping many people instead of just one” (Respondent 11). Resistance subsided as the transformation continued, mostly due to staff who did not accept the change to population health services and left the workforce either through retirement or seeking other employment elsewhere. This led to a change in culture, more open to changes in their organization’s public health services.

Strategic Planning

In developing processes for change in their organizations, directors found that using concepts related to strategic planning provided a vehicle for implementing change. This strategic planning process assisted in developing a shared vision for staff and community partners and engaged and empowered them to act. During the interviews, one director stated, “Okay, this is my big picture, what I want to do, now let’s define how we are going to get there, and the strategic planning process was exactly how we were able to do that” (Respondent 9).

Perceptions of Public Health Services

A prevailing perception on behalf of board members and the public is that public health provides traditional health services to the community, including immunizations, blood pressure screening, and home visitation. In addition, those perceptions include the

notion that public health is only for populations falling through cracks in the healthcare system. There is a need to address this perception and promote and communicate the concept of population health services.

Health Department Structure

One of the key aims in transforming a health department into a proficient chief health strategist is to restructure the organization by adding new, skilled staff who can function effectively in a population health services model. The following strategies emerged, along with identified challenges, to recruit and retain new key health department personnel:

1. Positions funded from the county tax levy. Funding new positions from the annual local tax levy provides stability for retaining positions. However, a number of barriers occur when obtaining approval and funding for new positions. One of the major funding challenges for local governments in Wisconsin is a series of levy limits and spending controls. If additional funding is available in an annual budget, there is intense competition from other departments, such as public safety and public works in seeking these funds. A direct request from the county board for funding new positions was not an option in the study. As one director stated, “Because on thing that is really specific to _____ County is they will not increase tax levy, and like, they will not give you more tax levy even if you have the best idea on earth” (Respondent 1).
2. Replacement and reclassification of positions. Several directors chose to reclassify existing positions or create new positions that would be a better fit for providing population health services. When a vacancy occurs in the organization,

the vacant position is either reclassified with a new position description or a new position is created. It was common to change the position descriptions of health educators from traditional roles and responsibilities to those that include community health assessment and planning, community engagement, communications, and coalition building when filling vacancies. New positions created were often termed public health specialists, epidemiologists, communication specialists, and health planners. There are challenges to this strategy due to implementation only when a position becomes vacant, which could take years. Also position authority for a department was often frozen and would not allow an increase in positions.

3. Grant funding of positions. All directors interviewed employed a strategy of hiring new staff with skills in population health services through grant funds. The most common grant funding sources were public health preparedness, COVID-19, and ARPA funds. Health departments had success in filling positions using these grant funds; however were cognizant that these funding streams may be reduced or eliminated completely. As one director stated, “But most of those positions that you see are ones that could be gone tomorrow, unfortunately, so that’s a barrier” (Respondent 2).

Sustainability of Restructured Organizations

The health departments in this study have largely been successful in restructuring their departments, securing both capacity and competency to focus on population health services and demonstrate proficiency in the practices of a chief health strategist. However, these revised structures and new positions are at risk due to the current

methods of funding at the local public health level. Local funding from tax levies can be in jeopardy when county budgets are in a deficit. County board calls for personnel cuts can be worsened when bargaining groups are in place and seniority may dictate which positions are eliminated. Newer staff hired to provide population health services could be the first to go.

A much larger risk is reducing or eliminating federal grants to support public health. Local public health generally considers federal funding to be “soft money”. Directors in this study often used preparedness funding, COVID-19 grants, and American Rescue Plan Act (ARPA) funds to support positions. These funds may be at risk due to failure at reauthorizations or are in place only through continuing resolutions.

Wisconsin ranks poorly in public health funding, ranking 44th in public health per person spending. (Geressu and Yeung, 2022) With state controls on county tax levies and spending and federal funding potentially at risk, Wisconsin public health officials are initiating an effort to provide sustainable state funding for a core set of public health services, including the infrastructure to perform population health services. The initiative is called Wisconsin Public Health Forward (WALHDAB, b) and has three strategic aims:

1. Funding: create sustainable funding for public health infrastructure to support foundational capabilities and areas.
2. Workforce: support a capable, diverse, and inclusive workforce.
3. Legal authority: clarify public health ability to prevent and control communicable diseases.

Adding state funding would greatly increase the stability of the organizational structure that supports a local public health department functioning as a proficient chief health strategist.

Strengths and Limitations of Study

One limitation is that directors were interviewed about events in their health departments that may have occurred a number of years prior to the interview. Recall of specifics or examples may have been difficult to provide during the key informant interview, resulting in recall bias.

Another limitation was the study only focused on health departments in Wisconsin. This makes the study difficult to be generalizable for health departments in other states that operate under different public health systems and with different public health authorities.

A strength of this study is the use of the CFIR model. This framework allowed the researcher to look at an issue from a number of perspectives or “lenses”. Also, the use of CFIR constructs appeared to be an appropriate means to create an effective key informant interview guide.

Further Study

As noted in the Key Findings, there is a movement in Wisconsin and other states to make a case for core public health funding from their governor and legislature. Several states have achieved success in obtaining funding for core public health services and infrastructure, most notably Ohio, Washington, Oregon and more recently Indiana. A study similar to this chief health strategist study could be used to identify facilitators and barriers to achieving success in obtaining core public health funding.

Conclusion

In 2016 the U. S. Department of Health and Human Services laid down a challenge to local health departments to enter the 21st Century in “a new era of enhanced public health practice that goes beyond traditional public health department functions and programs” (2016). Included in this challenge is a call to embrace the role of a chief health strategist. Acceptance of the challenge will tax health director’s administrative acumen, organizational leadership, and knowledge of contemporary public health practice. However, health departments that aspire to be proficient chief health strategists will have the capacity and competency to be effective leaders in their communities and improve health outcomes of the populations they serve.

APPENDIX A

Chief Health Strategist Competency Self-Assessment

Public Health 3.0 has set a vision for public health practice for the 21st century. Part of that vision is the recommendation that local health departments become chief health strategists and lead their communities to improved health. Subsequent reports have identified seven practices that high achieving health departments functioning as chief health strategists will demonstrate with proficiency. These practices are:

Adopt and adapt strategies to combat the evolving leading causes of illness, injury, and premature death.

- Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.
- Chief health strategists will identify, analyze, and distribute information from new, big, and real time data.
- Build a more integrated, effective health system through collaboration between clinical care and public health.
- Collaborate with a broad array of allies – including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities.
- Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems.
- Work with corresponding state and federal partners to effectively meet the needs of their communities.

This self-assessment reflects your proficiency as a chief health strategist. It measures both the skill competency of your department and the activities taken by your department

as a proficient chief health strategist. A more detailed description of the 7 chief health strategist practices can be found in the publication, “The High Achieving Governmental Health Department in 2020 as a Community Chief Health Strategist” by the Public Health Leadership Forum. (<https://www.resolve.ngo/site-healthleadershipforum/hd2020.htm>)

For the following skills, please rate your level of proficiency
<p>Please select what you believe is your current level of proficiency regarding the following skills.</p> <p>(1) Novice</p> <p>(2) Advanced Beginner</p> <p>(3) Competent</p> <p>(4) Proficient</p> <p>(5) Expert</p>

Question	Competency (Skill)	Score (n=15) Mean/Mode
	PRACTICE #1: Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death.	
1A	Collaborates with community partners and stakeholders for population health improvement planning.	4.4/4
	PRACTICE #2: Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.	
2A	Advocates for efforts that increase health equity and address social justice.	3.1/3
2B	Supports community residents, partners, and allies that advocate to eliminate systemic inequities within a community.	3.5/4

2C	In collaboration with community leaders, communicates and addresses the variances in health status experiences by certain community populations.	3.7/4
2D	Develops strategies collaboratively with communities to promote health and well-being strategies that incorporate health equity.	3.5/4
2E	Utilizes knowledge to tie sources of power/power differentials to health inequity when developing strategies to address health inequity in community health improvement planning.	2.6/2
	PRACTICE #3: Chief health strategists will identify, analyze and distribute information from new, big, and real time data sources.	
3A	Understands applications of different data sources.	3.7/4
3B	Conveys clear, informative, and jargon free data and information to professionals and the public using a variety of approaches and information technology application.	3.8/4
	PRACTICE #4: Chief Health Strategists will leverage the specific types of resources, collaborations, and best practices that can be utilized, to build more integrated and effective health system, within their respective jurisdictions.	
4A	Promotes the roles and value of governmental public health in working with healthcare providers to improve the health of a community.	3.9/4
4B	Advocates for healthcare strategies that work toward the improvement of population health, controlling costs and eliminating disparities.	3.6/4
4C	Assesses the roles and responsibilities of governmental and non-governmental organizations in providing clinical programs and services to improve the health of a community.	3.9/4
4D	Influences policies that encourage integration of physical healthcare, behavioral healthcare, social determinants of health, and new payment models that improve. individual	2.7/3

	health and population health while lowering costs and eliminating disparities.	
4E	Identifies opportunities for integrated healthcare systems to develop shared measures that address the social determinants of health.	3.1/3
	PRACTICE #5: Collaborate with a broad array of allies, including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities.	
5A	Promotes the role of community partners, particularly consumers, neighborhood organizations, and nonprofit organizations in collaborations to improve population health and eliminate health disparities.	4.0/4
5B	Communicates the roles of local governmental public health when interacting with public and private partners at the local, state, national, and global levels to influence the health of populations at all levels.	4.2//4
5C	Engages diverse community perspectives in developing, implementing, and evaluating policies, programs, and services that affect the health of the community.	3.8/4
5D	Leverages key intergovernmental relationships and collaborations to implement public health interventions.	3.8/4
	PRACTICE #6: Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems.	
6A	Advances a culture of health equity within the agency.	3.3//4
	PRACTICE #7: Work with corresponding state/region partners – ideally, a federal Chief Health Strategist to effectively meet the needs of their communities.	
7A	Advocates for community needs to government agencies with authority to address specific community health needs.	3.3/4

For the following activities, please rate your level of engagement

Please select the appropriate answer for your level of engagement with this activity.

- (1) Not performing
- (2) Not performing, but planning to within the next 6 months
- (3) Somewhat/sometimes performing: Depends on context/project/situation or is partially implemented, or implemented with ongoing issues that prevents full utility.
- (4) Fully performing: Is part of daily operations or is fully implemented in a manner that is beneficial/usable to the agency and staff.
- (5) Unsure

Question	Competency (Activity)	Score (n=15) Mean/Mode
	PRACTICE #1: Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death	
1A	Incorporates current events, crises, and emerging health trends in community health assessment (CHA) and surveillance.	3.8/4
1B	Incorporates evidence in decision-making that affects the health of a community.	3.8/4
1C	Ensures the adoption, implementation, and evaluation of a community health improvement plan (CHIP).	4.0/4
	PRACTICE #2: Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.	
2A	Ensures the adoption of strategies, policies, and programs into the community health improvement plan (CHIP) that seek to combat the root causes of health inequity.	3.7/4

2B	Support efforts of agencies and individuals, including community members and grassroots organizations, to support community resilience.	3.5/3
2C	Uses emerging demographic patterns to inform our agencies' data driven plans.	3.3/3
2D	Contribute to a new evidence base through sharing of ideas, practices and work towards more cohesive practices efforts with populations.	3.3/3
2E	Identifies and uses <i>existing and new data sources</i> to better understand the social, political and economic factors that contribute to health inequities.	3.1/3
	PRACTICE #3: Chief health strategists will identify, analyze and distribute information from new, big, and real time data sources.	
3A	Promotes the use of new and innovative information technology.	3.1/3
3B	Identifies real-time data collection methods appropriate to the public health context.	3.1/3
3C	Ensures organizational capacity and capability to accurately analyze community data.	3.3/4
	PRACTICE #4: Chief Health Strategists will leverage the specific types of resources, collaborations, and best practices that can be utilized, to build more integrated and effective health system, within their respective jurisdictions.	
4A	Uses data to assess the impact of local, state, and federal healthcare reform policies on improving community health by improving efficiencies and increasing quality of care to reduce disparities.	2.3/1
	PRACTICE #5: Collaborate with a broad array of allies, including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities.	

5A	Uses data to assess the impact of health reform policies on community health.	2.9/3
5B	Shares public health data with community partners so that they can be active collaborators in community health improvement efforts.	3.7/4
	PRACTICE #6: Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems.	
6A	Develops new strategies, including but not limited to, the use of social media for communicating information to influence behavior and improve community health.	3.5/4
6B	Uses a performance management system for planning and quality improvement.	3.7/4
6C	Uses financial analysis methods for organizational improvement.	3.0/4
6D	Develops, monitors, and evaluates an organizational strategic plan that includes steps to implement portions of the community health improvement plan.	3.9/4
	PRACTICE #7: Work with corresponding state/region partners – ideally, a federal Chief Health Strategist to effectively meet the needs of their communities.	
7A	Supports collaborative analysis of current-and-coming federal policies that may have an impact on the health of communities, in collaboration with the federal community chief health strategist.	2.1/1
7B	Tracks legislation on national, state, and local levels for direct and indirect impact on LHD practice and health of the community.	3.1/3

APPENDIX B

Request for Study Participation

Dear _____

I would like to invite you to participate in a study to understand how local health departments can best assimilate the role of a chief health strategist within their communities. This study is being conducted in conjunction with a doctoral program at the University of Indiana – Fairbanks School of Public Health.

The purpose of this study is to better understand how a local health department gains proficiency as a chief health strategist and will rely on the experience of your department and the other local health departments in Wisconsin. Information gained from these interviews will be used to develop an implementation guide to assist local health departments in becoming proficient chief health strategists.

I am recruiting directors from local health departments in Wisconsin for brief interviews as part of the study. The interviews will be approximately 30-45 minutes and will be conducted using Zoom technology. Participants would also be asked to complete a chief health strategist self-assessment tool for their departments and submit their most current annual departmental budget and organizational chart, if available.

No individual departments, individuals, or other identifiers will appear in the study report or the implementation guide.

Please let me know if you would be willing to participate and we can schedule a time at your convenience.

I thank you for your consideration of this request to participate in the study.

Terry Brandenburg, MPH, CPH

APPENDIX C

Indiana University Study Information Sheet for Research on becoming a Chief Health Strategist

You are being asked to participate in a research study. Scientists do research to answer important questions that might help change or improve the way we do things in the future. This document will give you information about the study to help you decide whether you want to participate. Please read this form, and ask any questions you have, before agreeing to be in the study.

All research is voluntary. You can choose not to take part in this study. If you decide to participate, you can change your mind later and leave the study at any time. You will not be penalized or lose any benefits if you decide not to participate or choose to leave the study later.

The purpose of this study is to better understand how a local health department gains proficiency as a chief health strategist and will rely on the experience of your department and the other local health departments in Wisconsin. Information gained from these interviews will be used to develop an implementation guide to assist local health departments in becoming proficient chief health strategists.

We are asking you if you want to be in this study because as a local health officer in Wisconsin you have been identified as making changes to your department consistent with the vision for a 21st century health department and therefore could provide insights into your experience in gaining proficiency in the practice of a chief health strategist, adding capability in your organization, and changes made to your organization. The study is being conducted by Valerie Yeager, DrPH, Principal Investigator, and Terry Brandenburg, MPH, Co-Investigator and is affiliated with IUPUC – Fairbanks School of Public Health.

If you agree to be in the study, you will do the following things. Health directors will participate in one semi-structured key informant interview approximately 30-45 minutes in length using Zoom technology. Interviews will be recorded with participants permission and transcribed. Participants will be requested to complete an on-line chief health strategist self-assessment tool. Completion of the assessment will take approximately 15-20 minutes. Participants will also be requested to submit their department's current annual budget and organizational chart, if available. Future contacts with participants for additional information or clarifications will only occur with participant's permission.

Before agreeing to participate, please consider the risks and potential benefits of taking part in this study. You may feel uncomfortable while answering questions during the interview or completing the self-assessment. You can skip any questions that make you feel uncomfortable or that you don't want to answer. There is a risk someone outside the study team could get access to your research information from the study. More information about how we will protect your information to reduce this risk below. We don't think you will have any personal benefits from taking part in this study, but we hope to learn things that will help researchers in the future.

You will not be paid for participating in this study, also there is no cost to participate in the study.

We will protect your information and make every effort to keep your personal information confidential, but we cannot guarantee absolute confidentiality. No information which could identify you will be shared in publications about this study. All electronic data containing identifiable information will be collected and stored in encrypted, password protected files. A non-networked personal computer used to collect and store data will have password protection. All written/paper records linked to participant responses will be stored in a locked cabinet. Transcripts will be destroyed, and audio files will be erased after the project is completed.

Your personal information may be shared outside the research study if required by law. We also may need to share your research records with other groups for quality assurance or data analysis. These groups include the Indiana University Institutional Review Board or its designees, and state or federal agencies who may need to access the research records (as allowed by law).

If you have questions about the study or encounter a problem with the research, contact Terry Brandenburg, MPH, at (414)327-6498.

Appendix D

Qualitative Interview Guide for Local Health Departments Assimilating the Role of Chief Health Strategist in their Communities. (Cohort 1)

Introduction

Thank you again for agreeing to participate in this interview. The purpose of this study is to better understand how a local health department gains proficiency as a chief health strategist and will rely on the experience of your department and other health departments in Wisconsin. Information gained from these interviews will be used to develop an implementation guide to assist local health departments in becoming proficient chief health strategists. I would like to reiterate a few important items on participant privacy from the previously distributed study information sheet. Names and organizations will not be shared. Records of interviews will be stored electronically in password protected files. Transcripts will be destroyed, and audiotapes erased after the project is completed.

Prior to our call I sent a chief health strategist self-assessment tool to complete. This tool measures your proficiency in the 7 practices and related competencies of a chief health strategist. Completion of the survey should assist your reflection on your experience in transforming your department consistent with the vision for a 21st century health department. The interview questions examine the facilitators and barriers toward becoming a chief health strategist from 5 different perspectives or “lenses”.

I would like to record our conversation from this Zoom session. I can stop recording the conversation at any time if requested. Also, you may choose to not answer any questions and can stop the entire interview at any time.

Do I have your permission to begin recording our conversation?

Interview Questions

Public Health 3.0:

1. Could you tell me why you have undertaken actions in your organization to re-position your department in line with the vision as articulated in Public Health 3.0?
2. What were the drivers for these actions?

Characteristics Domain:

1. Is being a proficient CHS consistent with your vision for a 21st Century health department?
2. Is being a CHS a good fit for your organization?
3. Did you feel that the concept of a CHS was adaptable by your organization?

Process Domain:

1. What organizational and leadership strategies did you employ in your department to assimilate the role of a proficient CHS?
2. What strategies succeeded? Why?
3. What strategies failed? Why?

Outer Setting Domain:

1. Could you help me identify the various challenges and barriers from entities outside of your department when you implemented strategies to re-position your department to align with the role of a CHS? Governance bodies (County Board, City Council, Board of Health)? Community stakeholders? The general public?

Inner Setting-Organization Domain:

1. Was the organizational culture in your department conducive to change?
2. Was there a readiness for change in your department?
3. Could you help me identify capacity challenges or barriers related to the CHS practices?
 - a. Accurately assess and plan for community health improvement.
 - b. Effectively implement plans for health improvement of under-served populations.
 - c. Identify, analyze, and distribute information from new, big, and real time data.
 - d. Collaborate with clinical partners.
 - e. Collaborate with community health system partners.
 - f. Maintain state-of-the-art business, accountability and financing systems.
 - g. Collaborate with state and federal partners.

Inner Setting-Individual Domain:

1. Were there any challenges or barriers encountered from an individual employee perspective?

Transformation:

1. What factors were found to enhance or facilitate the transition from a more traditional health department to a department that functions as a CHS?
2. What recommendations do you have for health departments trying to become proficient chief health strategists in their communities?

Conclusion:

This is the end of my questions. May I contact you again with follow-up questions or for clarifications?

Thank you again for the time today to provide your experience and recommendations in re-positioning your department into a proficient chief health strategist. This information will be invaluable in helping to develop a guide to assist local health departments trying to become proficient chief health strategists in the communities they serve.

APPENDIX E

Qualitative Interview Guide for Local Health Departments Assimilating the Role of Chief Health Strategist in their Communities. (Cohort 2)

Introduction

Thank you again for agreeing to participate in this interview. The purpose of this study is to better understand how a local health department gains proficiency as a chief health strategist and will rely on the experience of your department and other health departments in Wisconsin. Information gained from these interviews will be used to develop an implementation guide to assist local health departments in becoming proficient chief health strategists. I would like to reiterate a few important items on participant privacy from the previously distributed study information sheet. Names and organizations will not be shared. Records of interviews will be stored electronically in password protected files. Transcripts will be destroyed, and audiotapes erased after the project is completed.

Prior to our call I sent a chief health strategist self-assessment tool to complete. This tool measures your proficiency in the 7 practices and related competencies of a chief health strategist. Completion of the survey should assist your reflection on your experience in transforming your department consistent with the vision for a 21st century health department. The interview questions examine the facilitators and barriers toward becoming a chief health strategist from 5 different perspectives or “lenses”.

I would like to record our conversation from this Zoom session. I can stop recording the conversation at any time if requested. Also, you may choose to not answer any questions and can stop the entire interview at any time.

Do I have your permission to begin recording our conversation?

Interview Questions

Introduction:

1. Could you tell me a little about your background and how long you have been in your current position?

Public Health 3.0:

2. Could you tell me why you have undertaken actions in your organization to re-position your department in line with the vision as articulated in Public Health 3.0?
3. What were the drivers for these actions?

Chief Health Strategist: A health department that has proficiency in the 7 practices of a chief health strategist can function as a leader to improve health in their communities.

4. Could you describe why being a proficient chief health strategist is consistent with your vision for a 21st Century health department?
5. From your experience could you describe how adaptable the chief health strategist model was for your department?

Process for change:

6. What organizational and leadership strategies did you employ in your department to assimilate the role of a proficient chief health strategist?
7. To what extent was your department's strategic plan useful in implementing changes in your organization to become a proficient chief health strategist?

External Environment:

8. Could you help me identify the various facilitators and barriers from entities outside of your department when implementing strategies to re-position your department to align with the role of a chief health strategist? Governance bodies (County Board, Board of Health)? Community stakeholders? The general public?

Internal Environment:

9. Could you tell me about the culture of your organization with respect to change?
10. Could you describe your department's readiness for change when moving more toward population health services and the practices of a chief health strategist?
11. Prior to this interview I asked you to complete a self-assessment on the 7 practices and related competencies of a chief health strategist. Can you tell me if gaining proficiency in any practice areas was challenging and how you attempted to correct any capacity deficiencies.
 - a. Accurately assess and plan for community health improvement.
 - b. Effectively implement plans for health improvement of under-served populations.
 - c. Identify, analyze, and distribute information from new, big, and real time data.
 - d. Collaborate with clinical partners.
 - e. Collaborate with community health system partners.
 - f. Maintain state-of-the-art business, accountability and financing systems.
 - g. Collaborate with state and federal partners.
12. Could you describe any challenges or barriers encountered from an individual employee's perspective.

Transformation:

13. Looking back at your efforts to move toward the vision of Public Health 3.0, what factors were found to enhance or facilitate the transition from a more traditional health department to a department that functions as a chief health strategist?
14. What recommendations do you have for health departments trying to become proficient chief health strategists in their communities?

Conclusion:

This is the end of my questions. May I contact you again with follow-up questions or for clarifications?

Thank you again for the time today to provide your experience and recommendations in re-positioning your department into a proficient chief health strategist. This information will be invaluable in helping to develop a guide to assist local health departments trying to become proficient chief health strategists in the communities they serve.

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CURRICULUM VITAE

Terry L. Brandenburg

Education

- DrPH, Global Health Leadership, Indiana University, earned at Indiana University-Purdue University Indianapolis, January, 2025.
- MPH, Public Health Leadership, University of North Carolina-Chapel Hill, 2007.
- MPA, Health Care Administration, University of Wisconsin-Oshkosh, 1992.
- MBA, Operations Management, University of Wisconsin-Oshkosh, 1982.
- BS, Environmental & Public Health, University of Wisconsin-Eau Claire, 1977.

Post-Graduate Training

- Fellow, CDC National Public Health Leadership Institute, 1996-97.

Licensure/Certification

- Certification in Public Health (CPH), National Board of Public Health Examiners, 2008-Present.
- Registered Sanitarian (RS), Wisconsin Department of Regulation and Licensing, 1978-Present.

Professional Experience

- Director, MPH Program, Medical College of Wisconsin, Milwaukee, Wisconsin, 2011-2022.
- Interim Director, Advancing a Healthier Wisconsin Endowment, Medical College of Wisconsin, Milwaukee, Wisconsin, 2018-2019.

- Health Commissioner, West Allis Health Department, West Allis, Wisconsin, 1988-2011.
- City Health Officer, Appleton Health Department, Appleton, Wisconsin, 1984-1988.
- Environmental Sanitarian, Appleton Health Department, Appleton, Wisconsin, 1977-1984.

Publications (Select)

- Madamala, K.; Young, N.; Giese, L.; Brandenburg, T.; Zahner, S. Current and Planned Shared Service Arrangements in Wisconsin Local and Tribal Health Departments. *J Public Health Management and Practice*, 2014, 20(6), 640-646.
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Grants

- Primary Academic Partner: Medical College of Wisconsin, Advancing a Healthier Wisconsin. Endowment from July 2013 to June 2015. “Networked for Action – Eau Claire County Health Data Web-Portal for Community Change”, \$200,000.
- Primary Academic Partner: Medical College of Wisconsin, Advancing a Healthier Wisconsin Endowment from July 2015 to December 2017. “Transforming Eau Claire: Designing a Healthy Community”, \$250,000.

Professional Presentations (Select)

- National Association of County and City Health Officials, New Orleans, LA. July 2018, Speaker: Public Health is a Highway, Let's Steer it a Better Way: Defining, Promoting and Assessing Chief Health Strategist Competencies for Local Public Health Leadership.
- National Association of Local Boards of Health, Cleveland, OH. August 2017, Speaker: Transforming Eau Claire: Designing a Healthy Community.
- National Network of Public Health Institutes - A National Conference of Leaders in Public Health Quality Improvement, Washington, DC, September 2010, Speaker: Accreditation, QI, and Domain 9: Building Capacity and Seeking the Holy Grail.
- American Society for Public Administration Conference, Milwaukee, WI. April 2005, Speaker: Innovations in Improving Health at the Local Level.
- American Public Health Association Annual Conference, Washington, DC. November 2004, Panelist: Public Health Code of Ethics: Issues and Challenges for Current Practice.

Professional Appointments (Select)

- Turning Point Program, Public Health Statute Modernization Collaborative: National Advisory Committee, Member, 2001 – 2004.
- Wisconsin Public Health Council, 2015 – Present, Chair, 2020-2022.
- Wisconsin Legislative Council: Special Committee on Health Care Access, Member, 2010.

- State of Wisconsin, Office of the Insurance Commissioner: Medical College of Wisconsin, Consortium on Public and Community Health, Member, 2002 - 2010.

Professional Affiliations (Select)

- National Association of County and City Health Officials: Member, 1998 – Present; Board of Directors, 2005 – 2009; Audit Committee Chair, 2007 – 2009; Survive and Thrive Program, Mentor, 2008 – 2009 and 2013; Workforce and Leadership Development Committee, Member, 2010 – 2014 and 2017 – 2020, Committee Co-Chair, 2018 – 2020.
- Public Health Accreditation Board: Site Visitor, 2011- 2019, Workforce Think-Tank 2011; Accreditation Improvement Advisory Committee, 2013 – 2016.
- National Public Health Leadership Society: Board of Directors, 2001 – 2008; Board Chair, 2003.

Honors and Awards (Select)

- Medical College of Wisconsin, Graduate School of Biomedical Science: Outstanding Graduate Educator award, 2017, 2019.
- Wisconsin Public Health Association: Distinguished Service to Public Health Award, 2002.
- Wisconsin Environmental Health Association: Environmental Health Professional of the Year, 1995.
- National Environmental Health Association: Certificate of Merit Award, 1992,