# *Idaho's Public Health Workforce: Changes and Challenges Since 9/11*

*Having an adequate, well-trained workforce is vital in preparing for public health emergencies of all kinds, including acts of bioterrorism.*

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Without a competent workforce, a public health agency is as useless as a new hospital with no health care workers, according to Gebbie, Merrill, and Tilson, in an article in the November/December 2002 issue of *Health Affairs*. Their comment succinctly summarizes the critical role played by the public health workforce in meeting the ever-expanding demands placed on public health as a result of the attacks of September 11, 2001, and the subsequent anthrax scare. Prior to the attacks, national and state attention to and funding of the public health system was on the wane. Bloche and Gostin wrote, in an article in the *Los Angeles Times*, Nov. 4, 2001, that in the 40 to 50 years prior to 2001, the American view of health made a shift from seeking population-based approaches for disease control to viewing health as an individual matter with technology and patient autonomy as primary values.

The effect of this gradual change in priority for health funding was accentuated by the failure of the public health system to mount a prepared, coordinated response in the wake of the anthrax incidents in September 2001. In other words, Bloche and Gostin maintain, the neglect of our public health infrastructure "primed us to fail."

Since those tragedies in 2001, federal funding for public health has increased almost exponentially. The threat of bioterrorism has placed public health "in the driver's seat," as federal dollars allocated to the individual states have created an unprecedented opportunity to strengthen the public health infrastructure at the local and regional levels.

Indeed, this development creates a scenario that looks to be extremely positive for public health now and into the future. Despite the expanded funds for public health, however, some storm clouds might yet be on the horizon. Newton's third law of motion states that "Every action has an equal and opposite reaction." Experience shows that this law also holds true for government actions as well as moving objects. For example, the dollars from the Centers for Disease Control and Prevention are earmarked (restricted) for public health positions to build capacity in public health preparedness and bioterrorism, an action that potentially decreases the dollars available for more traditional public health programs. This is particularly true if cash-strapped states cut dollars from their regular appropriations for public health because their legislators think that "the feds are now picking up the tab" for public health programs.

## *Idaho's experience*

Idaho's public health history mirrors that of the nation. Prior to 9/11, most district health departments in Idaho struggled to support even the most basic services. Public health took a back seat to other pressing needs. Many districts were forced to seek grant funds from other sources to supplement their efforts aimed at providing a comprehensive set of public health services.

After 9/11, it became abundantly clear that our public health system needed additional resources in order to respond effectively to infectious disease outbreaks and bioterrorism incidents. In 2002, Idaho received more than $8.5 million, through the U.S. Department of Health and Human Services Bioterrorism Preparedness Grant Program, to better prepare public health systems and hospitals in the event of a bioterrorism incident. Idaho public health systems received $7,880,688 and Idaho hospitals received $751,285.

Although this influx of money enhanced capacity at each of the district health departments in Idaho and in Idaho's Division of Health (*see box on page 7 for a list of Idaho's health districts*), it also brought challenges to workforce development, particularly in the areas of recruitment, retention, training, management, and resources.

The authors conducted key informant interviews with each of the seven district health department directors and the administrator of the Idaho Division of Health to determine what workforce development challenges they have faced since 9/11, and what additional public expectations have been created.

## *Recruitment*

With the influx of federal dollars into Idaho's public health districts, many agency directors were able to hire new staff focused on public health preparedness and planning, epidemiological investigations, enhancement of rapid communication technology, public information, workforce development, and most recently, coordination of hospital response planning.

Recruitment experiences varied among the districts, with some directors (typically in more urban settings) reporting that they didn't experience anything out of the ordinary and others, particularly in rural areas, reporting difficulty in recruiting qualified staff.

With the nationwide nursing shortage, it should come as no surprise that positions requiring experienced nurses were among the most difficult to fill. This issue seems to be exacerbated by the low salaries the health districts are able to offer nurses compared to the salaries offered by hospitals and other health care facilities.

Generally, districts filled their new or vacant positions by recruitment from outside the agencies, by internal reorganization, or by both. Internal reorganization, in some cases, created hard-to-fill voids in existing programs. In addition, directors faced difficulty turning new employee replacements, who often did not have public health backgrounds, into public health professionals.

The State Division of Health has had no problem recruiting qualified applicants, although the administrator anticipates some difficulties, particularly in the laboratory arena, as the state gears up for public health preparedness related to chemical exposures in addition to biological exposures. These problems might be due less to the lack of qualified applicants than to the availability of enough dollars to pay the salaries these professionals can command in the private sector.

## *Retention*

Most districts and the State Division of Health reported no problems with turnover (any turnover seemed to be in the nursing area), despite shifting job responsibilities and the added program responsibilities in public health response. Some credited the slow economy for reducing turnover, and others mentioned an increased sense of patriotism and renewed commitment among employees. Several reported the need for internal reorganization to handle the influx of new bioterrorism staff hired with federal money at the same time the state budget shortfalls require trimming staff in other program areas. The state budget shortfalls also resulted in a freeze of all staff salaries, now going on three years. This may result in retention issues as the economy improves.

## *Training*

Some districts reported that they had no continuing education or mentors to help new staff adapt. Often newly hired staff brought new knowledge and skills to their organizations, but no background in public health. Some districts reported that they have never provided orientation and training in a well-organized manner. Lack of staff dedicated to training has resulted in lack of comprehensive assessment of or planning for training needs.

Several district directors thought that training needs had increased dramatically even before the addition of training in public health preparedness and bioterrorism. For example, the advent of the use of technology in and of itself has created a large demand on training time. Every new piece of equipment, movement to a different software system, or the addition of software programs and requirements for database management and reporting, requires training and infringes on the already limited time available to train on program-specific needs, to cross-train in other public health areas, or to enhance management and leadership skills.

Recently, district focus groups identified barriers to training in Idaho, and attention to training issues has been enhanced through involvement with the Northwest Collaborative for Workforce Development. In addition, Idaho has conducted an assessment of competencies and needs for emergency preparedness training for local public health staff, and each district has established a workforce development specialist position. The districts are using additional federal resources to increase core competencies of district staff through access to training.

One result of the state's involvement in the Northwest Collaborative for Workforce Development was this summer's public health institute, held in McCall in August. The institute focused on integrating the strategic planning functions of the State Division of Health and local health districts and identifying, clarifying, and integrating the roles and responsibilities of each organization. The anticipated outcome is that professionals from each

### *Idaho's Seven Health Districts*

**Idaho Division of Health**
Administrator: Richard Schultz
**North Central District Health**
Director: Carol Moehrle
**Panhandle Health District**
Director: Jeanne Bock
**Southwest District Health**
Director: Eugene Gunderson
**Central District Health**
Director: Kathy Holley
**South Central District Health**
Director: Cheryl Juntunen
**Southeastern District Health**
Director: Ed Marugg
**District Seven Health Department**
Director: Richard Horne

health district and those from the state will better understand how they can work together to address the public health needs of the state. The institute will also serve to identify areas where duplication can be minimized, unique roles can be maximized, and a true integrated public health system can be enhanced.

### *Management*

The rapid addition of new staff and increased expectations by the local communities and the state regarding their ability to respond to threats of bioterrorism or a chemical terrorism incident have placed burdens on our organization and challenges for Idaho's public health workforce. In some instances, this influx of new staff has put a strain on reporting lines within the health districts. Because program managers and supervisors may lack knowledge and skills in their new areas of responsibility, their ability to mentor or coach new employees can be hindered.

The State Division of Health has used management performance measures for six years, and although the measures are continually evolving, managers and programs that are consistently using the system have strengthened their leadership ability and their ability to assess the success of their programs. However, the Idaho Department of Health and Welfare (IDHW), housing the Division of Health, uses management approaches that are skewed toward the human services side (an important side to be sure). This difference in measurement philosophies can sometimes compromise the more program-specific, scientific measurement approach often needed by the Division of Health.

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### *Resources*

Although most districts welcomed the influx of additional resources, most are also concerned about the sustainability of the preparedness efforts. In particular the directors are concerned about the length of the federal funding commitment. Some districts view the new funding as an opportunity to enhance the core competencies of their staff while the funding exists, but most worry about retaining their staff once the funding disappears. As Jeanne Bock, director of the Panhandle Health District, said, "I have reservations about hiring a group of classified employees when I'm not sure I can continue with them. If preparedness funding doesn't continue, we will be sorely hurt. It will be difficult for the organization to recover because we are institutionalizing them into our system."

One district is also facing a resource challenge the new federal money does not address; it has outdated technology and an outdated facility with no room for expansion.

Of course, the additional resources are also welcomed at the state level, but in spite of the increased resource allocations, a problem may soon surface regarding the number of public health workers. Due to the need to tighten the state budget this past year, the Idaho legislature capped the number of positions that the Department of Health and Welfare can have. The ironic result well might be that although federal dollars are available for the districts to hire more public health professionals, at the state level a shortage is brewing.

### *Public expectations*

Most district directors agreed that public expectations of local public health systems have increased, some due to media influences and others due to the districts' increased efforts in public awareness. The terrorism events triggered an opportunity for collaboration and coordination among public health systems, hospitals, law enforcement, and other disaster services. Most district directors and the state health division director agree that the unique organizational structure employed by Idaho (seven districts and a single state agency) has greatly enhanced the ease with which responses can be made and coordinated among these various public agencies. In addition, Idaho's emphasis on local control has allowed continued positive relationships between the districts and their constituencies.

The effect of the terrifying events of 9/11 and the subsequent anthrax letter threats have dramatically changed the nature of local public health agencies. Although the influx of federal resources is a welcome relief, budget shortfalls at the state level have resulted in a freeze on salaries. These shortfalls haven't resulted in any cuts in services so far, but they will probably soon affect the ability to retain good staff and may result in the elimination of positions while loading more work on existing personnel.

The public health directors will continue to work together with the state and other partners to meet the challenges of sustaining funding, attracting qualified employees, and meeting the public's increased expectations. The silver lining to the worries prompted by increased expectations is the improved communication between local public health districts and state and local partners, increased interest in public health by community members, and new, long-needed resources to improve Idaho's public health system capacity to respond to all public health threats.

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