WSALPHO

WASHINGTON STATE ASSOCIATION OF LOCAL PUBLIC HEALTH OFFICIALS

Local Public Health Workforce Report

2023

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This report provides an overview of what is needed to maintain our local public health workforce and workforce development needs, including those that are most critical to local health jurisdictions.

Introduction

The Washington State Association of Local Health Officials (WSALPHO) is pleased to share its first-ever local health workforce report. We thank local health jurisdiction leadership and staff, who contributed and supported this effort during a time of intense workload, demanding public pressure, and tumultuous uncertainty. Thank you for prioritizing this effort and sharing the realities each of your agencies are facing. We are grateful for your openness and vulnerability. Our appreciation extends to other public health partners who have shared data, provided feedback, and have worked with WSALPHO in addressing this complex and multi-faceted issue. We are grateful for your partnership and continued commitment to building and maintaining a robust local public health workforce in Washington State.

Capable and qualified professionals are needed to fully actualize modernization and innovation efforts.

Workforce challenges are not new phenomena in public health. Long before the COVID-19 pandemic, local health jurisdictions (LHJs) faced budget cuts which led to the loss of job positions and staff. Rural counties have struggled to fill positions like nurses or sanitarians for years. In many respects, the infrastructure that is most in need of modernization and strengthening in public health is not data or technology but the people behind these tools. Capable and qualified professionals are needed to fully actualize modernization and innovation efforts.

This report will provide an overview of the larger bucket

areas needed to maintain our local public health workforce and workforce development needs, including those that are most critical to local health jurisdictions. Recognizing that local health jurisdictions are part of a larger state and federal public health system, the report will also identify federal, state, and local strategies and policy recommendations that can support and enhance local workforce infrastructure.

Our report includes a variety of sources of information. Local health jurisdictions completed a workforce survey in the Spring of 2022. We're also using national survey data where Washington LHJs provided input. While not representative of just Washington State, these surveys reflect many local experiences among LHJ leadership and staff. Many of the recommendations in the report have been informed from feedback and discussions with LHJ leadership, WSALPHO subject matter committees, and WSALPHO partners.

There are 35 local health jurisdictions in Washington State, serving all 39 counties.

Overview of Local Health Jurisdictions

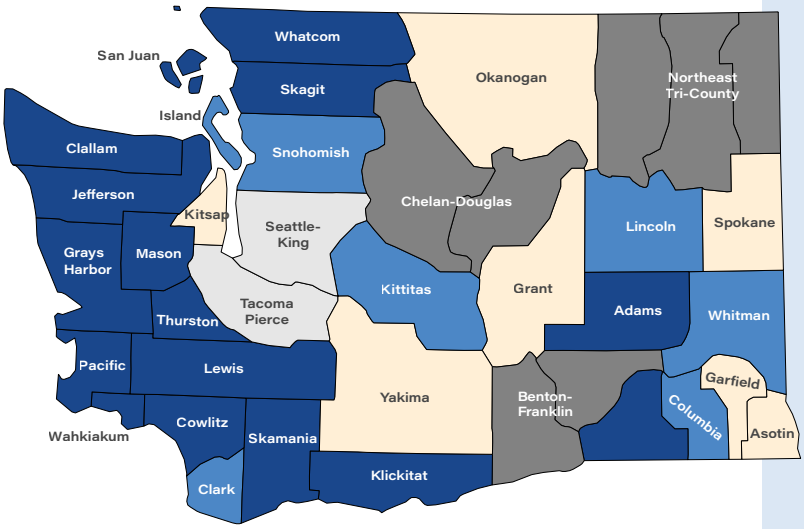
Local health jurisdictions are a critical part of Washington's public health system. LHJs have several statutory duties that direct them to investigate disease outbreaks, prevent illness and injury, respond to emerging threats, and control health hazards. LHJs provide a range of essential public health services such as: Administering immunizations, implementing opioid response taskforces, conducting restaurant inspections, ensuring clean water systems, and connecting people to healthcare. Each of these programs has a wide-reaching impact on communities, helping create vibrant and thriving places to call home.

LHJs provide essential public health services, with wide-reaching impacts on Washington communities.

Washington State's governmental public health system is decentralized and comprises the Washington Department of Health, Washington State Board of Health, tribes, and local health jurisdictions. In addition to these four parts, many community-based organizations also work to reach and support communities and populations in Washington.

There are 35 local health jurisdictions in Washington State that cover the 39 counties. 22 of these LHJs are under county governance as either a health department or a health and community services agency. 11 LHJs are districts, 3 of which are multi-county health districts. Districts are semi-autonomous to county government and operate outside

of county organization and budget. The two largest LHJs in Washington are combination city-county health departments, representing both the largest cities (Seattle and Tacoma) as well as the counties (King and Pierce, respectively).

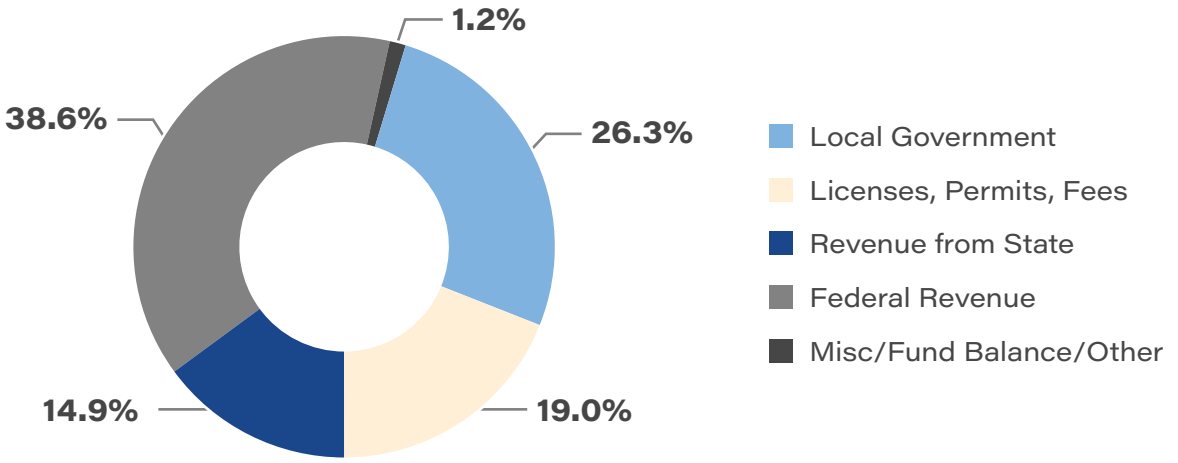


LHJs are primarily funded with local revenue (local tax revenue and fees collected for services), state appropriations, and state and federal grants. LHJs are governed by a local board of health which includes membership of local elected officials, medical professionals, community members, and tribal representatives.

SUMMARY - 2020 EXPENDITURES BY FUNDING

SOURCE; ALL LHJS

SOURCE: 2020 LHJ EXPENDITURE REPORT



Source: WA Department of Health, 2020, Local Health Jurisdiction Public Health Expenditure Report

FPHS funding has been a historic investment for local public health.

Foundational Public Health Services and System Transformation

Workforce development is intimately linked to Washington's effort to rebuild and transform its governmental public health system through the Foundational Public Health Services (FPHS). FPHS and modernization began a decade ago in 2010 with an initial call to action titled *Agenda for Change*.[1] The first action plan was published in 2012 and further refined in 2015 and 2018, respectively. This action plan outlined recommendations and a plan to ensure that all Washingtonians, regardless of where they live, will have access to a core set of public health programs and services – the FPHS.

A 2018 baseline assessment identified **$450 M** per biennium needed to fill current FPHS gaps in programs and services.

The system has reached several milestones in the last five years toward fully funding and implementing FPHS. A 2018 baseline assessment identified $450 M per biennium needed to fill current FPHS gaps in programs and services. Since 2017, FPHS funding has slowly increased over time, with the 2022-2023 biennium appropriation totaling $175 M. In 2019, the State Legislature codified FPHS into statute, as well as a funding decision-making process that requires agreement between state and local public health agencies as well as tribal consultation.

FPHS funding has been a historic investment for local public health. It has empowered LHJs to bring back positions cut from budget recessions and add new capacity and programming. There is a system-wide need to address the workforce needs of incoming staff that are new to public health, new to Washington's public health system, or filling new roles within LHJs. However, as much as FPHS has been transformative for LHJs in strengthening the local workforce, it is one facet of a very complex issue.

Overall, public health funding has been on the decline for years and has created an insufficient public health system at all levels.

Current Challenges and Contexts

- Ongoing patterns of decreased public health funding
- Funding that is inconsistent, intermittent, and reactive instead of proactive
- Funding that is categorical
- Increased demands from emerging threats and emergencies
- Politicization of public health issues
- Post-COVID workforce attrition

The last three years have highlighted the increased demand for public health to be nimble and adaptive to emerging threats and emergencies.

Overall, public health funding has been on the decline for years and has created an insufficient public health system at all levels. Cuts to federal funding are challenging in two ways: Local health jurisdictions experience the trickle-down effect where federal and state programs absorb the bulk of the funding, and funding becomes more and more categorical. This means locals receive less federal funding over time, and that funding is more rigid in scope. For example, post 9-11, Congress began bioterrorism and public health response funding. Initially, this provided a half-time to a full-time position in local health and additional regional support officers to conduct several activities, including planning around mass vaccination, extreme weather events, mass casualty and fatality, and all-hazard response. However, over time, this funding has eroded to the point where most local

departments have funding to cover only a small portion of staff but are still required to maintain all the federal deliverables. In Washington State, dedicated state public health funding was cut in 2009 and has remained stagnant since (apart from FPHS funding). Local funding is also volatile and subject to economic environments and competing local government operations.

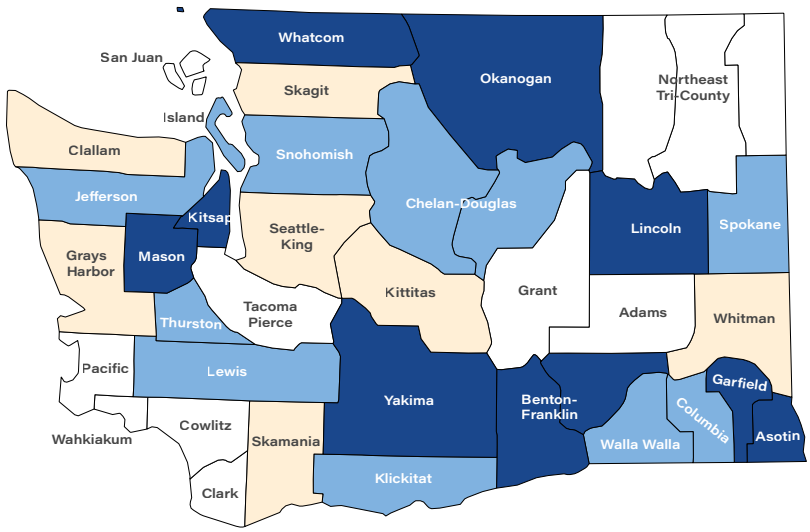
Fluctuating and categorical funding has had a negative impact on LHJs over time, forcing a scarcity and jurisdictional-focused mindset. Categorical funding that "boxes" funding into specific program areas, such as maternal and child health, HIV case management, or tobacco prevention, often inhibits an LHJ's ability to make cross-programmatic investments like new technology or communications staff. It also creates situations where local needs and priorities identified through community health assessments do not align with funding requirements, creating challenges in meeting local needs and having the appropriate resources.

The last three years have highlighted the increased demand for public health to be nimble and adaptive to emerging threats and emergencies. Concurrently with the COVID-19 panic, LHJs also responded to three wildfire seasons, massive flooding and extreme winter events, the monkeypox pandemic, and an increasing behavioral and mental health crisis. All of these are above public health's "normal" book of business, putting further strain on resources and capacity. Often, emergencies and crises do come with some relief, as evidenced by the influx of COVID-response funding, but this funding is short-lived and reactionary. LHJs received support to ramp up staff efforts, but rather than maintain a proactive readiness, they are experiencing a funding cliff when resources are divested from the system. Further, public health is emerging as the convening leader for several social issues, from climate change to evolving chronic disease trends and eliminating health disparities and inequity.

Public health has a long history of taking on controversial and political issues, from the early days of tobacco control and the AIDS/HIV epidemic of the 1980s and 90s, to the public outcry over masking and vaccination

policies of the pandemic. However, the politicization of public health issues has become more polarizing in recent years. Opposition to long-standing public health strategies such as isolation and quarantine or vaccination has permeated and hindered LHJs ability to work with communities. While this certainly existed before the COVID-19 pandemic, LHJs experienced this in a new magnitude through public protests, personal threats, and social media misinformation and disinformation campaigns. This has created challenges in working with communities where government involvement might clash with individual choice or political issues.

Last, we are entering a make-or-break point for the public health workforce. The stress and high intensity of responding and working through the last three years have taken their toll on the physical, emotional, and mental well-being of public health professionals. Many LHJ staff have left their positions, either by taking early retirements, seeking employment in the private sector, or pursuing new professional opportunities. These departures exist in all levels of LHJs, from front-line staff to executive leadership, and from staff hired within the last five years to long-tenured public health staff. While not always the single factor for leaving, burnout is certainly a recurring factor in nearly all departures. Since January 2020, over 60% of LHJ leadership (administrators and health officers) have left their positions. While it is normal to have a couple of local leaders leave each year, this high number is alarming.



LHJ LEADERSHIP VACANCIES & TURNOVER SINCE JANUARY 2020

UPDATED: 12/8/22

- Administrator/Director
- Health Officer
- Both Positions

Local public health departments across the United States have scaled up rapidly in the past three years as they responded to the COVID-19 pandemic.

National Perspective

Local public health departments across the United States have scaled up rapidly in the past three years as they responded to the COVID-19 pandemic, resulting in new and expanded responsibilities while maintaining the core programs and services that keep their communities healthy. The pressures placed on local public health departments during the COVID-19 pandemic caused intense stress and strain on a workforce system that was already experiencing underfunding, staffing shortages, and an aging workforce. The number of employees in local public health agencies has declined by more than 15% in the last decade. Federal, State, and local elected officials alike have not responded proactively to requests for additional funding to bolster the shrinking workforce and stabilize public health infrastructure.[2] In addition to the current shortage of staff and strained infrastructure, it is estimated that the public health workforce in the United States will need to grow by 80% to provide a minimum set of health services to the country, which includes 54,000 additional FTEs to local health departments.[3]

The public health workforce in the United States will need to grow by 80% to provide a minimum set of health services to the country

The 2021 Public Health Workforce Interests and Needs Survey (PH WINS) was conducted between September 2021 and January 2022 and surveyed over 137,000 state and local governmental public health workers. Results from this survey

indicate that 72% of governmental public health employees participated in the COVID-19 response in some way which has demonstrated a significant impact on workforce trends. The COVID-19 pandemic contributed to increased stress and burnout, as well as post-traumatic stress symptoms. Nationally, 32% of state and local public health employees said they are considering leaving their organization in the next year, 5% to retire, and 27% for another reason. 44% of state and local public health employees said they are considering leaving in the next five years. Among those who said they're considering leaving, 39% said the pandemic has made them more likely to leave. As well as the pandemic, other reasons for leaving their organizations included pay, work overload/burnout, lack of opportunities for advancement, stress, and organizational climate/culture.[4]

In Washington state, the landscape of how local public health agencies fit into the structure of each county varies significantly.

State/Local Perspective

In Washington state, the landscape of how local public health agencies fit into the structure of each county varies significantly. Washington's 35 local health jurisdictions (LHJs) are structured as follows: A district separate from the county (11, some districts include multiple counties), a department of the county government (22), or a city/county department (2) (see map on page 6).

Each composition of LHJ presents unique challenges and benefits. For example, districts must cover expenses that are absorbed by county functions in those LHJs that are county departments, including, but not limited to, HR, IT servers and support, and fiscal management. Districts can pull city funding into their budgets, which is something county departments cannot do. County departments are subject to county prioritization and more intense scrutiny but are typically more financially stable. Multi-district counties also navigate competing local government interests but are better poised to serve mobile populations who move across county borders regularly for services.

In addition to the national PH WINS survey, WSALPHO accessed Washington LHJ data for agencies that participated in partnership with the University of Washington's Northwest

Training was identified as an area of potential improvement for the local public health workforce with 23.7% of respondents reporting that they do not feel their training needs are assessed

Center for Public Health Practice (NWCPHP). Staff from 16 Washington LHJs participated in the 2021 PH WINS survey, including 12 that are classified as small or medium LHJs.5 Washington's local public health workforce is somewhat new to public health practice, with 37.9% of respondents reporting their tenure in the field as between 0-5 years. 67.1% of respondents also reported that they have been in their specific public health role less than 5 years. Training was identified as an area of potential improvement for the local public health workforce with 23.7% of respondents reporting that they do not feel their training needs are assessed and 24.3% of respondents reporting that they do not feel that they have sufficient training to fully utilize the technology needed for their work.

Compared to the national data, the percentage of respondents who were considering leaving their position in the next year was slightly higher in Washington at 33%. The top reasons for considering leaving included; stress, work overload/burnout, organizational climate and culture, lack of opportunities for advancement, and pay. For those respondents intending to stay at their organization, the top reasons for staying included; benefits, job stability, flexibility (e.g. flex hours, telework), job satisfaction, and pride it organization and its mission.

Top 5 Reasons for Considering Leaving Organization	
Work overload/burnout	15.9%
Stress	13.2%
Org. Climate and Culture	12.2%
Lack of Opportunities for Advancement	11.1%
Pay	9.6%

Top 5 Reasons for Staying at Organization	
Benefits	47.1%
Job Stability	36.2%
Flexibility (e.g., flex hours/ telework)	35.3%
Job Satisfaction	33.4%
Pride in Org. and its Mission	33.0%

Additional information related to the Washington-specific PH WINS results can be found in the Appendix.

LHJs cannot compete with state agency salaries and are often limited in their ability to offer incentives or restructure salaries to retain staff.

Challenges to Building a Local Workforce

Many LHJs are housed in aging facilities that do not have enough space to accommodate the staff they already have, resulting in LHJs having to be strategic about what positions they do recruit for due to limited facility space. County governments often prioritize programmatic operations over capital improvements, so investments in improved, more spacious facilities for LHJs take a long time to achieve. Safe, modern, and spacious working spaces contribute to recruitment and retention issues. LHJs are also experiencing recruitment and retention issues due to the rising costs of housing in their communities. There are also inconsistent and limited remote/hybrid workplace policies amongst LHJs, preventing some LHJs from being able to capitalize on a broader recruitment pool while others do not have this opportunity.

The cycle of continual employee turnover makes it challenging for LHJs to advance their work and sustain capacity and expertise in their agencies.

Another barrier that LHJs report experiencing (especially within the past three years) is the trend of employees leaving LHJs for state agency employment. During the COVID-19 pandemic, many state agencies instituted remote work policies, which increased the ability to recruit employees from around the state rather than just the Olympia area. LHJs

cannot compete with state agency salaries and are often limited in their ability to offer incentives or restructure salaries to retain staff. There have been many examples of state agencies hiring staff from LHJs, particularly in rural communities that already struggle with recruitment. A common trend LHJs have encountered is that when new graduates without work experience are hired, they then dedicate resources to train and orient them, only to have a state agency recruit that individual after a few months of work. The cycle of continual employee turnover makes it challenging for LHJs to advance their work and sustain capacity and expertise in their agencies. While this cycle has always existed, it has become particularly exacerbated in recent years due to state agencies' remote work policies.

Similarly, there is a long-standing pattern where smaller, more resource-strapped LHJs hire inexperienced individuals and invest heavily in their training, only to have them be recruited by more resource-rich LHJs or system partners after a few years. This is especially relevant on the eastern side of the state, where LHJs echo the sentiment of feeling like a "training ground" for LHJs and system partners in western Washington.

This pattern is especially relevant to be aware of now due to the limitations it imposes on ongoing efforts to build and strengthen the local public health systems. When resources are spent in a cycle of recruitment, training, and vacancy, it severely hampers the ability of local health to improve their capacity and services to keep up with the demands of increasing populations and emerging public health threats. This includes holding back the potential of the state's Foundational Public Health Services (FPHS) efforts, which provide funds to the entire governmental public health system intended to "both reinforce current governmental public health system capacity and implement service delivery models allowing for system stabilization and transformation."[6]

Another challenge that LHJs face is limiting the pools of qualified individuals available for hire through their own restrictive hiring criteria. Many LHJs are attempting to be more intentional in their hiring practices so

that the demographics of their staff represent and reflect the communities and populations they serve. Urban LHJs are doing great work in analyzing and evaluating how to recruit and retain staff who represent BIPOC and LGTBQA+ communities. A number of rural LHJs are focusing on a "grow our own" framework, building their own workforce and future leadership by hiring people who want to commit to the agency mission and the communities they live in, regardless of education. While urban and rural LHJs are approaching diversifying their workforce in different ways due to variations in recruitment pools and community demographics, there are common efforts to improve the diversity of their workforce that are hindered by standardized hiring practices and strict qualification criteria.

WSALPHO surveyed LHJs to collect information including staffing numbers, salary ranges, pay scale structure, recruitment practices, and benefits offered.

LHJ Workforce Survey

- There is a good deal of concern over losing staff and being unable to adequately replace them.
- Administrators recognize some key reasons they have a hard time hiring, but frequently are stymied by their local government's staffing policies or unwillingness to fund practices that would attract quality staff.
- The positions that have been most difficult to hire consistently included public health nurses and staff with management or leadership experience.
- Most felt that their inability to pay enough compensation is and will continue to erode their retention.

Nearly two-thirds of respondents identified inadequate salary or compensation among their greatest concerns related to staff retention over the next five years.

In spring and early summer of 2022, WSALPHO conducted a survey of LHJs to collect information related to employment numbers, salary ranges, pay scale structure, recruiting practices, and benefits. LHJ administrators received the online survey and, as appropriate, worked with other department or county staff to complete it. With 32 of 35 LHJs responding, the response rate was approximately 91.4%.

When asked about which types of staff positions have been most difficult to hire, nearly all respondents identified nurses or public health nurses, and about half identified people with management and leadership experience. In several follow-up conversations, administrators emphasized the difficulties their

LHJs faced when experienced managers were lost due to the inability to compete with benefits or salaries offered at other agencies or organizations. The detriment of leadership turnover was compounded by being unable to recruit equivalent replacements. Gaps in management create a bloated span of responsibility, increasing the workload on those individuals who must take up the slack.

The other most common staff categories that had been difficult to hire included: Environmental health specialists, administrative support, fiscal/accounting support, epidemiologists, and mental/behavioral health professionals.

Nearly two-thirds of respondents identified inadequate salary or compensation among their greatest concerns related to staff retention over the next five years. The other top concerns included burnout, the cost of housing, and anticipated retirement of tenured staff, and the loss of institutional knowledge.

With data from the survey, WSALPHO produced a salary survey report to share back to the LHJs. This report included salary ranges, medians, and averages for nine common role categories for public health staff. Several administrators found it helpful to compare their pay scales to other LHJs to help make the case for budgeting competitive salaries.

Recruitment Trends

The prospect of remote work has come to the forefront in the past couple of years.[7] Workers and employers have gotten used to operating in a remote or hybrid capacity. Employers with policies that allow or encourage this are more desirable to many job-seekers, particularly new and young professionals. When asked about whether their agency would continue to provide mobile or remote work options over the next few years, nearly half had very limited or no options for remote work. About a fifth of the respondents indicated they would continue to have partial or full remote work options, and a third indicated that "select members" of their staff would have a partial or full option. Some LHJs and associated county governments have embraced remote work as a successful cost-saving practice through COVID-19. Others are reverting to traditional on-site, mostly from the direction of their county leaders, who are uncomfortable with newer, less traditional approaches.

- Nearly three-quarters of responding LHJs put the full range of what a person in each role could make, regardless of the actual amount or range that a successful candidate would be offered.
- Only five LHJs show the salary ranges a candidate could realistically expect for their offer.

- Advertising of new position postings mostly happens on a passive, convenience basis, shared on the agency or local government websites, with about three-quarters of responding LHJs also posting to a third-party website such as Indeed, LinkedIn, or Craigslist.
  - About half also do some outreach to local affiliates or partners.
  - Several rely on county HR to recruit and are not involved.
  - Two LHJs reported that they used professional recruiters.
- Those respondents who commented on recruitment practices cited not having the time, personnel, or money to do more for recruitment.

WSALPHO hopes that they may help establish a case for county leaders and boards of health to better understand the needs of their public health workforce and take action to support it.

Recommendations

Recognizing that not all LHJs have control over all the actions identified here, WSALPHO hopes these recommendations will help establish a case for county leaders and boards of health to better understand the needs of their public health workforce, and take action to support it.

The National Network of Public Health Institutes identifies these five broad recommendations to improve the public health workforce:[8]

- Increase & diversify recruitment
- Provide needed training
- Improve retention
- Create staff reserves to augment the workforce during public health emergencies
- Develop leaders who exemplify Public Health 3.0 principles

WSALPHO's General Recommendations:

Evaluate options for recruiting and carefully analyze the impact that their current recruiting practices are having on LHJs

Continue FPHS investments and expand FPHS funding to continue to support the public health workforce, development of pipelines for staff and careers, and creation of commissions and task forces.

Create system-wide strategic workforce development plans that include hiring practice and salary incentive needs and enhancements.

Share successes like policies, job descriptions, workforce development plans, etc. through WSALPHO and other forums.

Recruitment & Retention

Develop pipelines for staff and career advancement.

- Expand internship and fellowship opportunities

Establish a loan repayment program for public health staff dedicated to working in the public sector.

Create opportunities for leadership development (potentially using FPHS funds).

Evaluate staff salary scales to ensure the organization can be competitive with neighboring counties and like-sized agencies.

Take steps to reduce or eliminate cumbersome, bureaucratic hiring processes that might unintentionally be reducing or turning away applicants/candidates.

Increase transparency about actual on-hire salary ranges on job postings and during the recruitment process.

Establish policies that allow for remote/hybrid work.

- Consult other existing policies for inspiration/proof of concept.
- Educate decision-makers by showing examples, and demonstrating where cost savings come in by updating their hiring policies.

Engage more directly in the recruitment process

by moving away from passive recruitment.

- Post and advertise positions out-of-state.
- Utilize Washington State Public Health Association's new tool for sharing public health job opportunities.
- Ensure space in the county or department budget to accommodate active recruitment.

Develop guidance on career ladders for public health. [9]

Provide scholarships and paid internships with diversity, equity, and inclusion as priorities. [9]

Identify the supports needed for the optimal mental health of public health staff. [9]

Training

Develop peer networks and communities of practice (FPHS).

Encourage and provide leadership development (FPHS).

Succession

Prepare plans and taking pro-active steps to be prepared for staff members' departures.

Encourage work sharing, so there is no single point of failure in institutional knowledge when one person who is the only one that knows a job leaves it.

Equity in Workforce

Evaluate hiring practices that may be hindering efforts to recruit a workforce that is more representative of the community served.[10]

Engage with local colleges to discuss their public health curricula, and collaborate to identify opportunities. to demonstrate what career paths in local public health could look like.[10]

Develop and leverage partnerships with local community-based organizations.

Assess organizational culture and make changes as needed to ensure the workplace is culturally competent and supportive of all staff.[10]

The local public health system anticipates that **workforce development will be one of the most critical issues for LHJs in the next ten years.**

Current Workforce Efforts

The local public health system anticipates that workforce development will be one of the most critical issues for LHJs in the next ten years. Recognizing this was an emerging issue back in 2021, WSALPHO began identifying opportunities and target areas of focus, pulling in several state and private partners into a larger collective effort. This includes a coordinated system approach with our partners at the Washington State Department of Health (DOH), deepening connections and relationships with higher and secondary education institutions, and leveraging private partners with other associations such as the Washington State Public Health Association (WSPHA).

Already, there is work underway. A job posting site was developed in 2021 with DOH and WSPHA to provide a "one-stop" place for job seekers pursuing government or community-based public health employment. WSALPHO provided input into DOH's CDC Workforce Development grant application, ensuring that local needs would be prioritized with dedicated workforce funding. Student intern opportunities are evolving through improved relationships with higher education programs including the UW School of Public Health and Washington State University's new public health program.

An additional effort to onboard and orient new and incoming local board of health members was implemented in late summer of 2022 with plans to continue an annual and virtual training program.

Through FPHS funding, several workforce efforts are also underway, including; a large-scale system assessment of workforce skill needs and training gaps, the development of a training curriculum and virtual platform, and the development of communities of practice to strengthen peer networks. These efforts aim to address multiple target areas simultaneously, including employee retention, mentoring and training, and succession planning and leadership development. An additional effort to onboard and orient new and incoming local board of health members was implemented in late summer of 2022 with plans to continue an annual and virtual training program. These efforts come at a pivotal time for our system. It indicates large support for building and strengthening the local workforce from elected officials, state policymakers, our partners, and LHJs themselves. It is a sign of hope that through partnership, coordination, and additional resources, LHJs will be able to remain an effective force for modernization and positive health outcomes for our communities.

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Appendices

WA PH WINS Additional Information

- **General Demographics**
  - 836 respondents from 16 LHJs
  - 77.4% of respondents identify as female
  - 13.5% of respondents identify as Hispanic/Latino
- **21.2% of respondents stated that they were very dissatisfied (5.6%) or somewhat dissatisfied (15.6%) with their level of pay.**

Racial Category With Which Respondents Most Identified	
White	77.2%
Asian	8.1%
Two or more races	6.0%
Black or African American	5.4%
American Indian or Alaska Native	1.4%
Native Hawaiian or other Pacific Islander	0.5%

Age of Respondents	
<21	0.2%
21-30	12.0%
31-40	25.7%
41-50	23.1%
51-60	17.2%
61+	11.1%

Tenure in Position	
0-5 years	67.1%
6-10 years	11.8%
11-15 years	6.6%
16-20 years	4.1%
21 or above	7.3%

Tenure in Public Health Practice	
0-5 years	37.9%
6-10 years	16.1%
11-15 years	11.6%
16-20 years	8.9%
21 or above	19.7%

WSALPHO 2022 Workforce Survey Raw Data (including salary information):
https://www.dropbox.com/s/nlq64om0z5ew251/Survey%20Raw%20Data.xlsx?dl=0

WSALPHO 2022 Workforce Survey Questions
https://www.dropbox.com/s/31qg9jldex1gaaf/WSALPHO%20Workforce%202022%20Survey%20Questions.pdf?dl=0