

About the Lawrence Douglas County Health Department

Lawrence-Douglas County Health Department is an academic health department located in Lawrence, Kansas, with approximately 40 full-time employees. Divisions of the Lawrence-Douglas County Health Department include community health, clinical health, environmental health, and health informatics. For this case study, we interviewed Dr. Vicki Collie Akers, Ph.D., MPH, who currently serves as the Director of Policy and Planning and Associate Professor in the Department of Population Health at the University of Kansas School of Medicine. At the time of policy implementation and development of the community compensation plan, Dr. Vicki Collie-Akers served as a member of the community health team of the health department. The compensation plan was developed as part of the Community Health Improvement Plan.



Proposing the Policy

The proposition of the Lawrence-Douglas Health Department (LDHD) to move forward with the development of a community compensation plan emerged from the department's community health team, who elevated the need for providing a standard way of compensating members of the community for their partnership in program and initiative planning and development. The concept was elevated through their division and the health department's leadership eventually was approved by the LDHD executive team.



Community Compensation Practices Before the Policy

Prior to the implementation of the community compensation policy, the LDHD had a strong history of identifying resources within grants and program budgets to build in gift cards to compensate members of the community in exchange for their time and subject matter expertise in focus groups and surveys. Community compensation, however, was not systematically incorporated in every program where the community was engaged, and, in cases, the department recognized that the compensation process and system was likely not recognizing the scale of the community's contribution to their work. Members of the community health team at the LDHD began to understand the need to more deeply engage the community and considered what their responsibilities around this type of engagement would be. Over time, the LDHD engaged in more staff training for equity practices and then began looking toward incorporating more equitable practices in the health department, from which the community compensation policy emerged.



Policy

The timeframe of policy development to policy adoption at the LDHD was a fairly short one at approximately six months, however, components of the policy, including compensation amounts and some procedures have changed in the years since policy adoption and continue to be updated and refined. Department leadership and the executive team were favorable to the policy, and the finance team, a key team engaged already in vendor compensation and payments, was already familiar with general the processes needed for processing W-9s and payment protocols for members of the community.

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Considerations and Challenges

In General, the LDHD has encountered few challenges in implementing their compensation policy.

One of the key challenges noted in our interview with Dr. Collie-Akers was ensuring the grant or program had the appropriate funding level or budget for compensating community members. In new budgets and new grant programs, they note that it is key that there are steps taken during the planning process to ensure sufficient available funds for community compensation.

In addition to budget limitations, Dr. Collie-Akers noted that the finance team's preferred method of payment (checks to community members) can introduce some barriers. Some members of the community may have more urgency around getting their checks; addresses can change frequently; they must have an up-to-date W-9, among other considerations.



Internal and External Responses to the Policy

Dr. Collie-Akers noted that the LDHD, since the implementation of the policy, has been able to develop and sustain connections to people with lived experience more than they ever have before. Before the policy, the department had good connections with a few key individuals from more marginalized communities, but since incorporating a policy and systems change around compensation, the department now has a wider breadth of connection to more people who experience discrimination or marginalization. In addition to more sustained engagement, the department has received positive responses to their policy when applying for grants, especially as some grant programs require community contributions to be compensated. Having a solid and systematic history of community compensation has been supportive in their application efforts to grant programs that require it.

Take-Aways and Additional Notes



Dr. Collie-Akers reported that codifying community compensation as a department policy should not be understated – that this is what creates the groundwork to include community compensation as a standing budget item. Having a policy rather than just a practice of community compensation also helps increase accountability across staff and departments. Otherwise, compensation may be up to individual people and how they personally prioritize community compensation.

Dr. Collie-Akers also notes that the timing in which the LDHD implemented their policy was advantageous as there was a high level of readiness in the department at the time, which could ebb and flow in health departments as local, state, and federal political environments and administrations change.

Compensation rates for members of the community from the LDHD are similar to rates paid to staff members of the community health division. The department also used the Massachusetts Institute of Technology's (MIT) living wage calculator, as well as what local living wages were in their local community to develop and amend compensation rates.