POLICY BRIEF TOOLKIT

A guide for researchers on writing policy briefs

Center for Health Economics and Policy
INSTITUTE FOR PUBLIC HEALTH AT WASHINGTON UNIVERSITY

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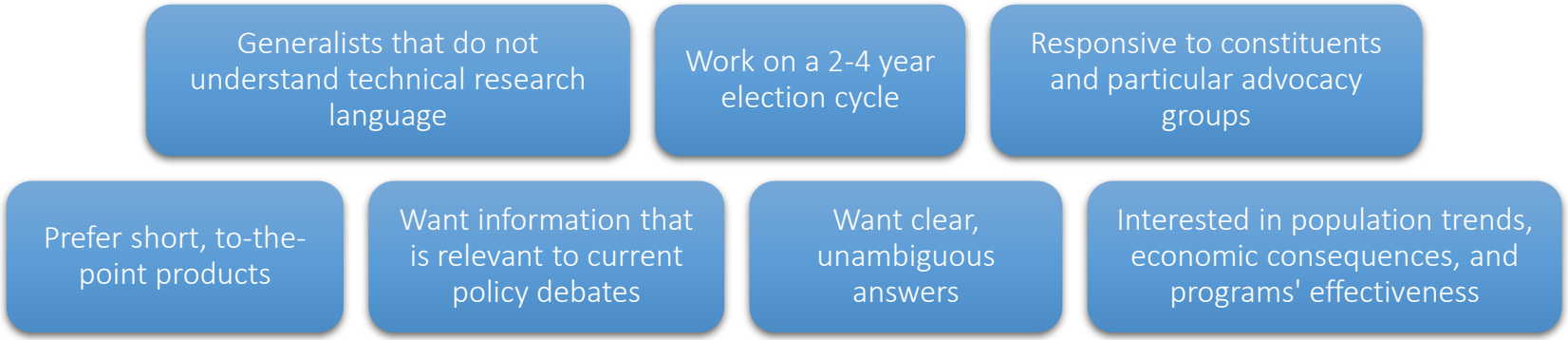
Overview

Researchers are often not familiar with how to disseminate their findings to policymakers; however, there is an important place for research in the policymaking process. “Health services research when appropriately funded, coordinated and disseminated plays a critical role in addressing problems related to the nations’ health care system,” according to the Coalition for Health Services Research.[1] Some even argue that findings need to be communicated effectively to policymakers and other health care stakeholders to maximize the return on public investment in research.[2]

Policy briefs can be an effective dissemination tool especially when targeting non-expert readers who rely on the credibility of the authors.[3] Briefs should be focused and written in an easy-to-read, objective format. Policy briefs conclude with an evidence-based policy recommendation; although, recommendations should not extend beyond the evidence.[4]

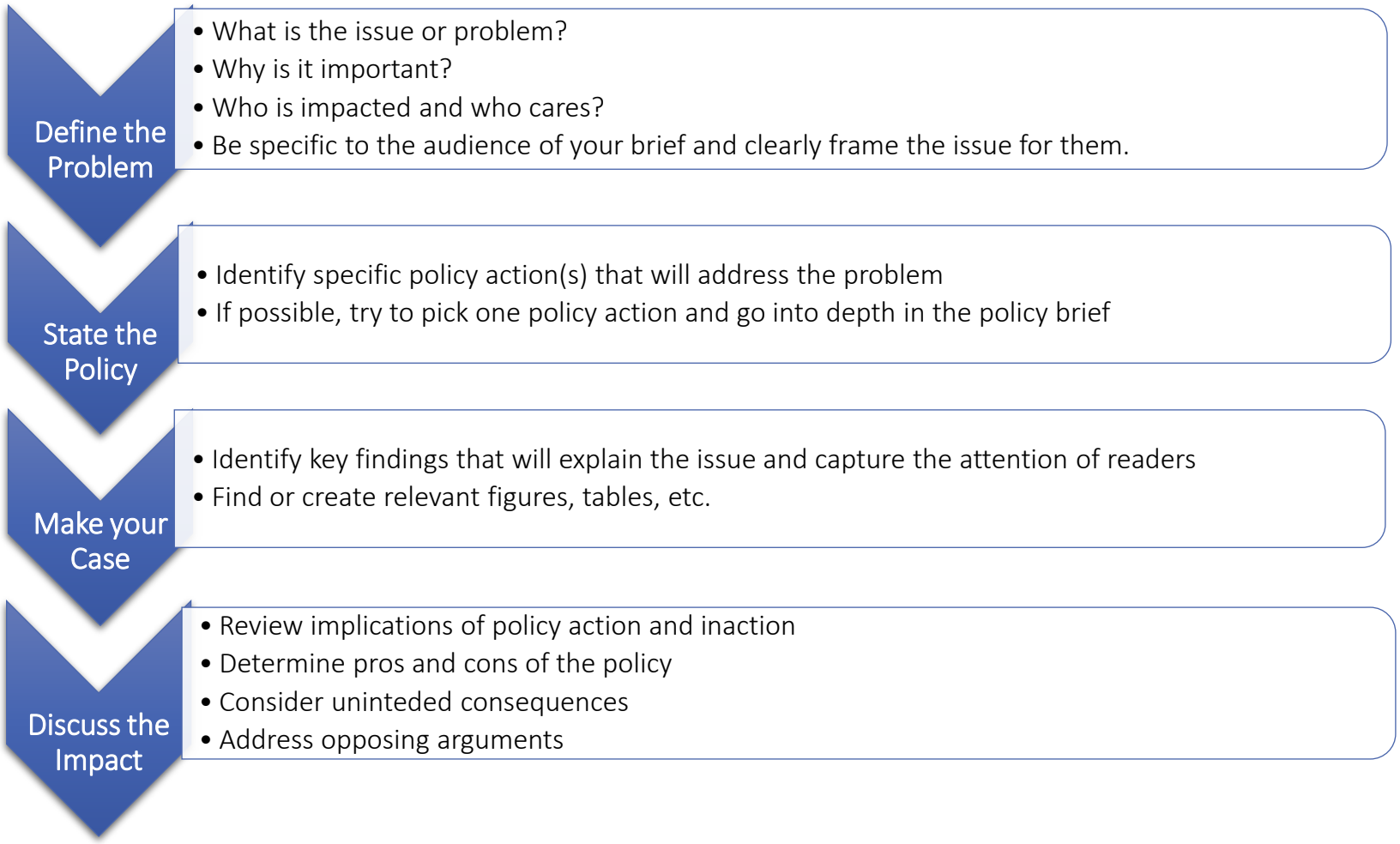
Know your Audience

Researchers must first identify and understand their audience. Below are things to remember about policymakers.[5]



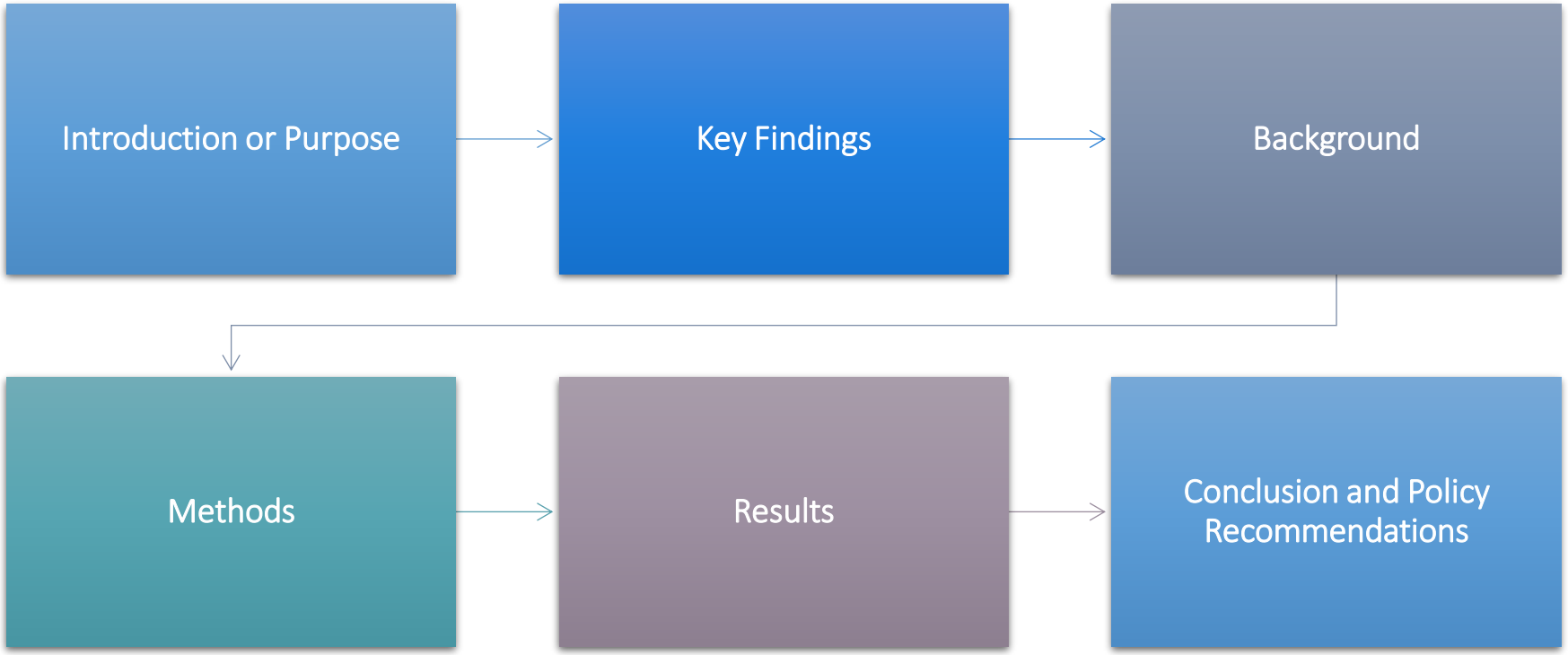
Writing Preparation

It is helpful to outline the key objective and arguments before writing. The below guide can be used for the preparation process.[4]



Structure of Policy Briefs

Below is the general outline of sections that are included in a policy brief. More details and examples of each section are included in the next pages of toolkit.



Introduction

State the purpose of the brief and give the reader an understanding of the issue's importance and urgency.

Purpose

From October 2013—before implementation of the Affordable Care Act (ACA)—to November 2016, Medicaid enrollment grew by 27 percent. However, very little attention has been paid to date to how changes in Medicaid enrollment vary within states across the rural-urban continuum. This brief reports and analyzes changes in enrollment in metropolitan, micropolitan, and rural (noncore) areas in both expansion states (those that used ACA funding to expand Medicaid coverage) and nonexpansion states (those that did not use ACA funding to expand Medicaid coverage). The findings suggest that growth has been uneven across rural-urban geography, and that Medicaid enrollment growth is lower in rural counties, particularly in nonexpansion states.

A bulleted list of key findings may also help capture interest at the beginning of the policy brief.

Key Findings

- Medicaid growth rates in metropolitan counties in nonexpansion states from 2012 to 2015 were twice as large as in rural counties (14 percent compared to 7 percent).
- In contrast, the differential in growth rates between metropolitan, micropolitan, and rural counties was much less dramatic in expansion states (growth rates of 43 percent, 38 percent, and 38 percent, respectively).
- Analysis at the state level shows much variability across the states, even when controlling for expansion status. For example, some states with an above-average rural population, such as Tennessee and Idaho, had higher-than-average enrollment increases, with strong rural increases, while other states with similar proportions of rural residents, such as Nebraska, Oklahoma, Maine, and Wyoming, experienced enrollment decreases in micropolitan and/or rural counties.

Source: Clips from Barker, A. et al. (2017). "Changing Rural and Urban Enrollment in State Medicaid Programs." *RUPRI Center for Rural Health Policy Analysis.* No. 2017-2. Retrieved from http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2017/Changing%20Rural%20and%20Urban%20Enrollment%20in%20State%20Medicaid%20Programs.pdf

Background

Add context and/or history that is needed in order to understand the issue that is detailed in the remaining policy brief.

Background and Motivation

Since its passage in 1965, Medicaid has become the largest U.S. health insurance program, covering over 72 million Americans in January 2016.[1] Medicaid, which has historically covered low-income children, parents, pregnant women, and the elderly and disabled, provides its beneficiaries with acute and long-term health care coverage. The ACA included funding for states to expand the coverage of their Medicaid programs to include all individuals up to 138 percent of the Federal Poverty Level (FPL). However, in June 2012, the Supreme Court ruled mandatory Medicaid expansion unconstitutional, making Medicaid expansion optional to states.[2] Many states began to increase eligibility standards in accordance with the ACA, with a total of 25 states and the District of Columbia participating in the expansion at the start of 2014. Two additional states expanded Medicaid in 2014, and three more states expanded in 2015, bringing the total to 29. Currently, 31 states and the District of Columbia have adopted Medicaid expansion, while 19 states have not It is worth noting that this gradual pattern of adoption is similar to that of the original introduction of Medicaid: in 1967, 26 states adopted the program, with 11 more adopting within the first three years; however, the final state to adopt the Medicaid program did not do so until 1982.[3]

Methods

Briefly describe the methods and data sources that are used for the analysis. Typically, complex data analysis methods should not be used in policy briefs as the audience will likely not be familiar with those techniques. If your journal article uses complex methodology such as multivariate regression, use the most significant variables to create 2-dimensional charts or graphs.

Data and Methods

County-level enrollment data were obtained either online or by request from the individual states' Medicaid offices, allowing analysis of changes in Medicaid enrollment by metropolitan status post-ACA. Using those sources we were able to obtain Medicaid enrollment totals by county for 40 states—22 Medicaid expansion states and 18 nonexpansion states—for December 2012, which was immediately prior to expansion even by states that chose early adoption, and December 2015.[8] These data were available in a majority of the states studied; however, in several states, only monthly fiscal year averages, total enrollment counts for the whole year, or data from other months were available.[9] State-level percent change in Medicaid enrollment between 2012 and 2015 was calculated as an average of the percentage change by county in each state in both years. We repeated these calculations by Medicaid expansion and rural status (rural, micropolitan, and metropolitan) and report county-level averages.[10]

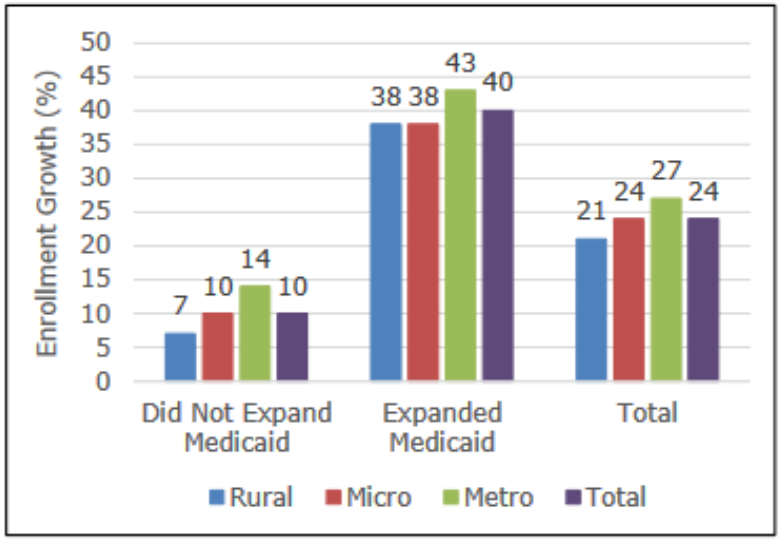
Results

Strategically utilize visuals such as graphs, charts, and maps to display research findings. Whenever possible, include results and implications for local areas (states, counties, congressional districts, etc.) that are relevant for the audience.

Results

Descriptive analyses showed substantial differences in Medicaid enrollment growth based on expansion and rural status (Figure 1). Prior to the ACA, annual growth was 1.1% in expansion states and 0.5% in nonexpansion states.[11] On average, growth rates in expansion states were almost 4 times greater than in nonexpansion states (40 percent as compared to 10 percent). In general, rural areas experienced lower enrollment growth than micropolitan areas, which in turn had lower enrollment than metropolitan areas, an effect present in both expansion and nonexpansion states. However, the difference in enrollment between micropolitan and rural areas in expansion states was not substantial. The difference in enrollment growth patterns across geography between expansion and nonexpansion states is perhaps a surprising finding, and should be analyzed further. Table 1 shows similarly dramatic state-by-state differences within each expansion category. For example, some highly rural nonexpansion states—in particular Maine, Nebraska, Oklahoma, and Wyoming—experienced Medicaid enrollment *decreases* in rural and/or micropolitan regions in the 2012-15 period.

Figure 1. Average County-Level Medicaid Enrollment Growth, 2012-15



Conclusion

Conclude the policy brief by reiterating the most important findings and interpret the "real-world" meaning behind them. State policy recommendations that are supported by the research findings and include rebuttals to anticipated arguments against the recommendation.

Discussion

Medicaid enrollment has increased rapidly in both expansion and nonexpansion states since the passage of the ACA. Gains were larger in expansion states and in metropolitan areas, with the geographic differential more pronounced in nonexpansion states and in states without SBMs. While this study is descriptive, and thus the causal reasons behind these changes are not established, some areas in particular need further exploration. Potential reasons for low enrollment in rural populations in non-expansion states include limited outreach or lesser presence of ACA navigators in rural areas, less interest in or knowledge about seeking out ACA coverage on the part of parents (since many children have been newly enrolled in Medicaid/CHIP as their parents go through this process), backlogs in processing of Medicaid applications, and bureaucratic roadblocks created by states to control costs and reduce the woodwork effect.[13] Enrollment differences could also be a result of variations in HIM outreach efforts that have had spillover effects, an idea supported by the high enrollment changes in some SBMs (California, Colorado, Kentucky, Idaho, Oregon, and Washington). Similar enrollment differences by rural status exist in HIMs,[14,15,16] which suggests the possibility that enrollment differences are affected by broader political and social factors. Nonexpansion also implies that the state is budget-conscious and may not be interested in Medicaid outreach. Variations in outreach efforts between rural and urban areas within nonexpansion states may be due to the fact that most outreach in nonexpansion states is funded privately and charitably, and such groups are less likely to have the means to implement efforts cost-effectively in rural areas where the population is less concentrated. Socioeconomic differences between urban and rural areas (e.g., income, poverty) may also play a role. However, state-level variation exists even among states that are predominately rural, suggesting that at the policy level, best practices gleaned from states with higher enrollment rates could be implemented in states with lower enrollment rates.

Writing Style Tips

- Use well-written titles that reflect key takeaways and entice readers to continue.
- Do not write as though the policy brief is the same as a mini journal article.
- Use lay language. Do not use jargon or scientific terms.
- Avoid superfluous pictures.
- Explore using sidebars, text boxes, bullet points, numbered lists to improve readability.
- Write in the third person.
- Don't be too heavy-handed. Opt for words like "may, might" etc.
- Be concise. Briefs for legislators should be no more than 2 pages and others no more than 4 pages.
- Consider adding a personal story to supplement research findings and capture the policymaker's interest.
- Include references and sources for additional information.
- Include contact information for authors as well as website for future publications.

Example Policy Briefs

- Center for Health Economics and Policy https://publichealth.wustl.edu/health-economics/policy-briefs/
- Health Affairs http://www.healthaffairs.org/healthpolicybriefs/
- Kaiser Family Foundation http://kff.org/search/issuebriefs
- Urban Institute https://www.urban.org/policy-centers/health-policy-center/publications
- RUPRI Center for Rural Health Policy Analysis http://www.public-health.uiowa.edu/rupri/publications/policybriefs.html

Additional Resources

- Center for Health Economics and Policy is available to help researchers develop their policy briefs.
- Research to Action, "How to Plan, Write and Communicate an Effective Policy Brief: Three Steps to Success." https://www.researchtoaction.org/wp-content/uploads/2014/10/PBWeekLauraFCfinal.pdf
- Rural Health Research Gateway, "Dissemination of Rural Health Research: A Toolkit." https://www.ruralhealthresearch.org/toolkit

References

[1] AcademyHealth. Placement, Coordination, Funding of Health Services Research within the Federal Government. AcademyHealth report. Washington, DC: AcademyHealth; 2005.
[2] Grande, D. et al. (2014). "Translating Research for Health Policy: Researchers' Perceptions and Use of Social Media." *Health Affairs, 33*(7). doi: 10.1377/hlthaff.2014.0300
[3] Masset, E. et al. (2013). "What is the Impact of a Policy Brief? Results of an Experiment in Research Dissemination." *Journal of Development Effectiveness, 5*(1). doi: 10.1080/19439342.2012.759257
[4] Wong, S., Green and Bazemore. (December 2016). "How to Write a Health Policy Brief." *American Psychological Association, 35*(1). doi: 10.1037/fsh0000238
[5] Zervigon-Hakes AM. (1995). "Translating Research Findings into Large-Scale Public Programs and Policy." *The Future of Children, 5*(3). doi: 10.2307/1602374
[6] Barker, A. et al. (2017). "Changing Rural and Urban Enrollment in State Medicaid Programs." RUPRI Center for Rural Health Policy Analysis. No. 2017-2. Retrieved from http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2017/Changing%20Rural%20and%20Urban %20Enrollment%20in%20State%20Medicaid%20Programs.pdf