“On the fly!”: Establishing the Need for and Capacity to Develop HPV Evidence-Based Policy Communication Tools

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Research Team

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What is Evidence-Based Policy Communication (EBPC)?

Background

- Race and economic disparities in cervical cancer incidence and death have persisted for years
- We can reduce or eliminate cervical cancer with HPV vaccination, screening, and treatment
- The policy climate is bad: few HPV vax requirements, little state funding for screening
- But state cervical cancer plans lack policy development and engagement capacity
- Can we engage the public and our partners in policy communication?

Goal: To Increase Adoption of Evidence-Based Cervical Cancer Policy Briefs

- Integrated public health and policy evidence
- Validated messaging algorithm
- Piloted integrated policy brief for feasibility and effectiveness (per Brownson et al)

- Web interface developed to facilitate use based on pilot feedback
- Repository of briefs developed from other communities to facilitate social influence
- Effectiveness studies among users and policy brief recipients

- Needs assessment to understand and classify potential users and demand
- Continually adapt technology innovation to meet evolving need and user capacities
- Utilize social and professional networks to help drive demand

Study Objectives

1. Understand conceptualization of policy and evidence-based policy communication (EBPC)
2. Identify likely users of EBPC focused on HPV in Indiana
3. Identify the potential capacity to develop an online EBPC tool focused on HPV

LOGO HERE

Title here – to the point -

Subtitle here, date

Public health significance of cervical cancer and HPV in jurisdiction

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Key message #1

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Call out box for statement or important facts(s)

Potential figure/visual depicting key point

Key message #2

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The ASK – What has to be done and by whom?

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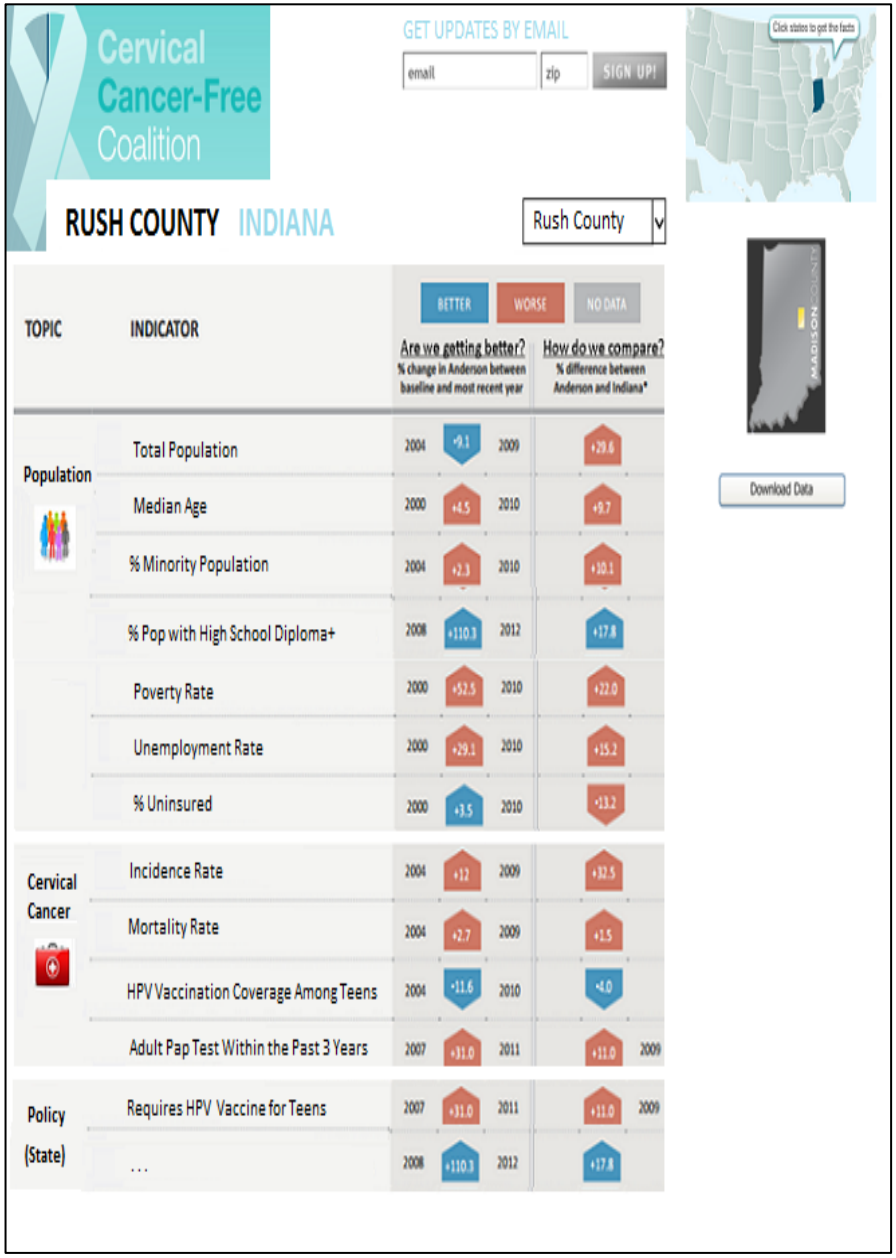

Our Sample

27 interviews with 30 key informants in Indiana
From October to December 2015

Interview Sample	Interview Count
State Association	7 (25.9%)
Community Organization or Coalition	6 (22.2%)
Clinicians/Researchers	6 (22.2%)
Local Government	2 (7.4%)
Industry	2 (7.4%)
Individual Advocates	2 (7.4%)
State Government	1 (3.7%)
Elected Official	1 (3.7%)
Total	27 (100%)

How did they Conceptualize Policy & EBPC?

- Most of the sample did **not** know what EPBC was or what it could look like
- **Conflation** of **public policy** with hospital policy, physician and parent behavior, private payer behavior
- **Conflation** of **policy communication** with **education** about HPV or vaccine

Conceptualization of Policy & EBPC

- Accurate Conceptualization of Policy and Policy Behaviors: State Legislation
- Administrative Action (Governor, Medicaid, ISDH)
- Advocacy Coalition Engagement/Grass Roots Engagement

Audiences:
Some Understanding that Grass Roots should Engage in Policy Behavior (Advocate for a Policy position). Others use Grass Roots just to Educate their Base.

Affiliates, Coalition, Partner Organizations, Legislators

Conflation of Public Policy with Hospital Policy, Physician and Parent Behavior, and Private Payor Behavior

Conflation of Policy Communication with Education about HPV or Vaccine

Audience: Doctors, Researchers, School Boards, Nurses, Public, Payors

Accurate Description of EBPC

Policy Activity, Capacity, & Use of Evidence

- **Range** from **minimal** policy engagement to **full-time**
- Evidence **ranged** in delivery, type, and framing
- Capacity for EBPC for HPV was often **limited** by time, authority, knowledge, and efficacy

Current Policy Communication Activity

Advocacy Engagement of the Base:

- Educational push out; tracking legislation, updates
- Advocacy behavior ask
- Advocacy (inc media) consultation
- Provision of evidence for communication or models
- Aggregating evidence and to disseminate to base/members/affiliates
- Range of base control over content and delivery

Examples of EBPC:

- Policy Briefs and 'report cards'
- Puts evidence in testimony
- Verbal statements (testimony not left behind)
- "Leave behinds" (pictures and bullet points); examples of evidence based practices
- Work group recommendations or organization policy statements

Advocacy Behavior 'asks':
- Letter to editor
- Media interview
- Call or email to policy maker

Evidence

Framing:

- Around policy solutions
- Cancer, not sex
- As local as possible

Delivery:

- Story/narrative of human impact
- Facts/figures
- Images of real people
- Infographics
- Accessible (not too technical)
- Source credibility (audience specific)

Types:

- Fiscal impact
- Comparative (by county or states), ranks
- Epidemiology (incidence, dx stage)
- Effectiveness of solutions (vax, R/R, screening)
- Audience specific and relevant
- Local and state wide; rural/urban

Capacity for EBPC

(Generally and for HPV specifically)

Use vs. Development Capacity:

- No time
- No authority
- No knowledge
- Low self/org efficacy

Current Policy Communication Activity

Advocacy Base Potential:

- None
- Learning
- Potential if training
- Engages when asked
- Statewide network of members or affiliates

Organizational Policy Capacity:

- National infrastructure
- Policy FTE(s)
- Policy interns
- Policy committee (board level)
- Organizational culture
- Issue culture (Tobacco)
- Coalitions w/policy interest
- Individuals w/ interest
- Membership in policy oriented coalition

Potential Users by Capacity & Proximity to Policy Process

In policy process full time	In policy process as needed	Called directly into poiicy process by others	Participates third party (letters, emails)	Minimal participation in policy process <1x since 2013	Capacity for EBPC Development	Capacity for EBPC Use	Totals (% total)
5		2			High*	High	7(25.9)
				1	High	Low	1(3.7)
1	2	1			Medium	High	4(14.8)
1		1		3	Medium	Medium	5(18.5)
1			1		Low	High	2(7.4)
		2		1	Low*	Medium	3(11.1)
1				4	Low	Low	5(18.5)
9(33.3)	2(7.4)	6(22.2)	1(3.7)	9(33.3)			

*political or organization limits to participation in policy process or in development of materials

What do you think we learned?

Lessons Learned

1. An online, user-built policy brief may not be used by most people (**too much, too hard, no time**)
2. **BUT**, pre-developed, fresh EBPC tools might be used (how many, what focus, ???)
3. Need for more structured learning opportunities – **We need to teach our peeps**!