What Policymakers Want

A Guide for Evaluators

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Introduction and Purpose

Evaluators and policymakers seek to answer the most practical questions about a program, system or policy: What does it do? Does it do what was intended? How much does it cost, to whom? How does the cost compare with the benefit, to whom? How does it compare with alternatives? What problems remain to be solved? Evaluators and policymakers also share a frustration that knowledge and policy too often pass like ships in the night. The right information never seems to be in the right place at the right time.

While some policymakers making decisions on a particular issue may have only a political or personal agenda, most want to make the best decision they can, within whatever constraints they may face. They are open to all sorts of information: anecdotal experience, interest group positions, consumer demands, political pressures, public opinion, as well as impartial research and analysis. Some seek out objective analysis as a matter of course, particularly on issues for which they have ongoing responsibility. Others view objective analysis as no more valuable than any other kind of information, and utilize it only where it supports their particular agenda.

Politics or self-interest may outweigh research findings and dictate results. But solid, well supported answers to policy questions can powerfully influence decisions. They can deter outcomes that contradict known fact or experience. They

can suggest solutions to policy problems. And they can shape the underlying base of knowledge and understanding about an issue[1].

Many sources **inform** the policy process and the policy maker. The purpose of this Guide is to help evaluators become more effective **informers.**

Development of the Guide

The Evaluation Center@HSRI commissioned the Policy Resource Center (PRC) to produce *What Policymakers Want* as a resource for evaluators. PRC convened three meetings to explore evaluative information needs, each concentrating on a particular policymaker audience: Federal legislators and staff, Federal executive agencies, State legislators and staff. Medicaid Section 1115 Waivers was selected as a topic to focus discussion that would be of immediate, priority interest to all groups. A background briefing paper on the Waivers was prepared and distributed to participants, along with an agenda of discussion questions, prior to each meeting. Reports of each meeting were prepared; this Guide draws some practical conclusions from all three.

Acknowledgments

The author would like to recognize the contributions of several individuals who made this report possible. Two PRC Policy Associates did much of the preliminary work. Cynthia Folcarelli was primarily responsible for convening and preparing the report on the meeting of state legislators and for writing the background briefing

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[1]See for example Weiss, Carol H., Circuitry of Enlightenment: Diffusion of Social Science Research to Policymakers. Knowledge, v.8, no. 2, pp. 274-281 (December 1986).

COMMUNICATING WITH POLICYMAKERS

Any effective communication requires sensitivity and responsiveness to the interests and communication style of the intended audience. Communicating with policymakers[2] is no different. It is up to evaluators to translate their findings and knowledge into a form that gains the attention and consideration of policymakers. Remember that they have the power and responsibility to make a decision with or without what evaluators would consider sufficient knowledge. Otherwise, no matter how important, elegant, and powerful your work may be, you are unlikely to be heard.

However, to be most effective, it is also important to factor in the different interests, responsibilities, and pressures affecting policymakers in different positions. The three groups discussed here represent those most likely to use or commission evaluative studies.

Congress

Congressmen and Senators are, first, advocates for the constituents they represent, bringing constituent concerns and views to bear on federal legislative decisions. They have a responsibility also to recognize and assess details and implications that will affect not only their own constituents but their entire state and the nation as a whole, whether or not their constituents have raised concerns about limited funds among seemingly unlimited needs. Constituents, lobbyists, the

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[2]General references to policymakers throughout this paper include both authorized decisionmakers (elected or officiallly appointed) and their staff. Where important differences occur, distinctions are explained.

press, colleagues, and a host of others (most with strong opinions) aggressively demand their attention constantly on an endlessly shifting array of issues and decisions.

All members have staff; however a single legislative aide may be responsible for national defense, foreign affairs, human rights, immigration, science and technology, telecommunications, transportation, agriculture, housing and trade. Rarely does he or she have time to acquire technical sophistication or even to research a specific subject that arises, unless the member has a significant political or personal interest in that issue.

Those who chair committees or subcommittees on behalf of the majority party have dedicated staff responsible for matters within that committee's jurisdiction. (The ranking minority member, on behalf of the other party, generally has a small proportion of the committee staff allotment.) However, a single Appropriations subcommittee, with a handful of staff, has jurisdiction over all of the programs in the Departments of Labor, Health and Human Services, and Education. This span of responsibility effectively limits the practical ability of members and staff to learn the intricacies of most agencies, programs, or issues within their purview.

However, most committees suffer from the opposite problem, fragmentation of authority and attention. Mental health issues fall within the responsibility of multiple committees and subcommittees, none of which is set up to view the whole of national mental health policy, much less how it interacts with various

other policies and systems[3]. Members and staffers face institutional pressures to narrow their focus.

Policymakers who work on committees for a number of years can develop highly sophisticated understanding of only a few subjects. Generally these select subjects reflect the judgments of the chair and his or her party about the political importance of the issue: the amount of funding involved, whether the average voter cares about it, and whether it is part of an overall party strategy or message. In addition, each committee chair or ranking member (and, to a lesser extent, each member of a committee or subcommittee) typically has a few issues that are especially important to him or her. These may reflect the vital interests of their district or state, or key constituents. For example, a congressman representing a district with many large medical teaching facilities will have an interest in their continued access to research funding and service reimbursement, while a senator from a state with many tobacco farmers has a particular interest in any issue involving smoking. Or, the policymaker may have a personal interest in a given issue, such as a family member who suffers from depression or a constituent who has succeeded in bringing alive an issue like loss of health insurance. These interests frequently motivate an individual policymaker in their choice of committee assignments.

Given the enormous flow of legislative decisions, members and their staffs typically can focus on any one issue for a very brief period of time. Unless they are involved in the development of a bill, they may have absolutely no information

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[3]See Appendix for current committees.

about the subject until the day (or even the moment) it is brought up for a vote in committee or on the floor. Even on bills where they have an ongoing concern, they have to shoehorn work on that bill into a schedule crammed with other decisions and issues, as well as the myriad representational duties they perform. And even committee staff who know they will be responsible for a regular reauthorization bill later in the session or next year generally cannot devote much attention or time to that matter until it actually comes up on the committee docket or agenda. They simply have too many immediate issues to handle. As a result it is difficult to attract interest for information on any issue that is not on the immediate Congressional agenda. Whole industries of "public affairs specialists" are devoted to gaining such attention, often with limited success.

A change in majority party—as has happened several times in the past fifteen years—means replacement of the chair, many committee members, and most committee staff with people who have different priority issues and/or must climb a steep learning curve about the matters within the committee's jurisdiction. Evaluators, along with everyone else seeking to inform or influence policy decisions, need to learn about the interests of the new complement of committee members and staff members in their areas of concern.

In addition to their own staffs, committees and individual members can request information and analysis from executive agencies. This avenue is used more or less, depending on whether the legislator and the President are of the same political party or share common views. Individual members, particularly committee chairs, may request analyses or reports from the Secretary of agency

head. Not infrequently, appropriations bills or reauthorization legislation will include mandates for specific reports to be produced and transmitted to Congress. For example, P.L. 99–660, the State Mental Health Planning Act, included a requirement for an annual report to Congress on states' progress in implementing their plans. Or, the Congress may incorporate in legislation a one-time mandate for a special report on a topic of immediate interest, such as health insurance for people with serious mental illnesses[4].

Congress also has established research and analytic agencies to provide informational and assessment support, e.g., the Congressional Reference Service (CRS) of the Library of Congress and the General Accounting Office (GAO). (The Office of Technology Assessment was recently abolished.) The CRS does not conduct evaluations, but maintains a staff of specialists who are able to write policy-analytical reports on almost any topic. The GAO does conduct evaluative studies. In both cases, the limited capacity means that they can respond to only a portion of the requests.

A plethora of lobbyists and interest groups vie to provide information, both solicited and unsolicited. While this function is easily caricatured in the press, it serves an essential purpose in an institution with limited time to handle so many issues of such complexity. Congressmen and their staffs depend on such information, while recognizing the biases and interests it reflects. Effective lobbyists and interest group representatives learn early that influence depends on trust; misleading a policymaker is a sure way to forfeit an issue or cut short a career.

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[4]See Appendix for an example.

Finally, Congressmen and Senators and their staffs tend to rely on key advisors. These may be colleagues known to have significant interest and expertise on an issue (as Senator Domenici has in mental health), or particular lobbyists they trust to provide advice on a wide variety of issues (not only on those for which they actively lobby), or experts from a university or organization based on their state or district with whom they or their staff have developed relationships.

Changes in national policy focus and in the Congress itself over the past twenty years have significantly altered the way Congress obtains and uses information. During the 1970s activist committee chairs developed staffs with significant expertise, and might spend several years exploring a particular issue such as community mental health services—holding hearings, commissioning legislative agency studies, requesting or mandating executive branch studies. During the 1980s emphasis shifted to the very large budget issues, e.g. defense v. domestic spending, and the reversals in majority party on the Senate side led to significant staff turnover. The 1994 election further accelerated this trend.

The aftermath of the 1994 election dramatically illustrates the magnitude of change that can occur with little or no warning. Many members of the 103rd Congress (1993-94) of both parties saw access to healthcare as a central issue and sought information about ways to expand access without exacerbating rates of spending growth. The new majority in the 104th Congress, however, saw reducing the size, scope, and spending of the Federal government as more important than expanding access. These differing interests lead to quite different questions, and to the prominence of quite different experts and sources of information. In addition,

when the majority party in the House of Representatives changed, the new leadership instituted a system giving a much smaller role to committees and greater influence to the central leadership. As a result of all these changes, many issues such as those involved in mental health policy received significantly less in-depth study.

The current political agenda determines what questions Congressional policymakers will have an interest in at any particular moment in time. The external forces driving the legislative process make it virtually impossible for Congressional policymakers to anticipate information needs very far in advance. The context of congressional debate changes frequently, rapidly and without warning. This means that among the myriad issues for which a particular member or staff person has responsibility, only one or two very specific questions need answers at a given moment in time. These usually reflect a pressing political problem raised by important interests or the media, or the need to vote on a particular measure. Rarely do they concern long-standing theoretical questions.

With few exceptions, then neither members nor their staff have the time to develop a sophisticated understanding of the programs they oversee. They often depend on interest groups to assess policy options, reasoning that a known bias is easy to interpret. They tend to rely on a circle of trusted advisors—among their legislative colleagues, knowledgeable individuals they have come to know, friends, lobbyists, and key constituents—for advice on any particular issue.

STATE LEGISLATURES

State legislators, like Congressmen and Senators, are responsible first to their constituents. The interests of a district which may, for instance, depend economically on a state hospital, must loom large for any legislator. While Congress is a full-time job—the frequent recesses most often provide opportunities for members to spend time attending events and meeting with constituents back in their districts or state—many state legislators work at least part-time in another occupation. Most legislatures are in session only part of the year, usually from January through spring or summer, and some meet only every other year.

Their span of responsibility is narrower than that of the federal Congress (e.g., less worry about foreign and defense policy). However, the depth and constancy of interest in issues can be far greater. State legislators have ver direct responsibility for many services provided by the state involving both state and federal dollars and they tend to hear very quickly from their constituents if there is a problem caused either by the policy or its implementation. Such problems do not wait for a multi-year reauthorization cycle, but can erupt at any time. Legislators in the great majority of states also have fewer staff and other supportive resources to enable them to respond.

Most legislators other than committee chairs have little opportunity to commission major studies. They do devise surveys, particularly for their own constituents. However, most states now have some type of legislative service bureau that can conduct or commission studies on issues before the legislature. They may also provide staff assistance to committees on particular issues.

State legislative committees are far less segmented than the elaborate Congressional subcommittee structure. A member who serves on a state health and human resources committee, for example, may have responsibility for virtually all departments and programs affecting such services. This can provide far more incentive as well as opportunity to look at system-wide or cross-system impacts. Reports that detail how a given program operates are better received if they place the program in context, discussing how it fits into the larger system and policy initiatives.

As increasing responsibility resides at the state level, legislators have become more immersed in the detail of program and policy implementations. Given limited resources, and political pressures to reduce taxes or at least avoid increasing them, legislators have grown increasingly interested in very concrete answers:

- **Input:** What is the program, what is it doing, what does it cost?
- **Output:** What does the program produce, for whom?
- **Outcomes:** Does the program solve the problem or make a measurable difference?

To answer these questions, state legislators and staffs are interested in all kinds of information and actively seek different viewpoints. They want to know the source of information or data, in order to judge its applicability. They tend to view reports as more reliable if generated by entities without a vested interest in presenting a particular program or reform in a positive light. In area of Medicaid managed care, for example, they may question the usefulness of evaluative data produced by the managed care organizations, while accepting as largely reliable any data collected from consumers and families. They are particularly

interested in "first hand" information, the experience of consumers, families, service providers and others on the "front lines" of the service system. Interestingly, they are also concerned with the "silent consumer" and what happens to people who are not in reports because they have fallen out of the program or system for one reason or another.

At least three types of information are highly valued in evaluating programs. **Anecdotal evidence** includes testimonials of individual experiences, and can put a "human face" on the issue. **Surveys** can provide assessments from a broad range of users or stakeholders or taxpayers, although their usefulness depends on the perceived objectivity of the group devising the survey questions. **Hard data**, such as statistics and other objective information, is important, but not more so than the other types. Legislators are also interested in comparative information (across counties and states), or reports from other states, particularly those nearby or sharing similar characteristics.

They are quite philosophical about the limited availability of "hard" information, and quite comfortable with their ability to sift wheat from chaff. They do not always trust the state executive agencies to provide accurate or complete information because those agencies have both political and bureaucratic interests that may lead them to tilt toward a particular answer. Still, they would like to know about and receive copies of any reports done in their areas of interest, and in fact some state legislatures have attempted to mandate that all state-funded evaluations or other reports be sent to the legislative service bureau.

In sum, state legislators and their staff, like their federal counterparts, have very little time to spend on any one issue. They must rely on external resources for information to help them evaluate what is going on and what options they have. They are particularly wary of relying on reports produced by or for state executive agencies. They must be highly selective of the information to which they pay attention, and tend to select those they feel they can trust.

FEDERAL AGENCIES

Unlike the legislature, which may pay little attention to a program once enacted until the next time it comes up for reauthorization or appropriations (or a significant problem comes to light), the executive branch has responsibility for implementing and monitoring programs over an extended and continuous period. Further, executive agencies are established in statute with missions that are broad and national in scope, beyond the specific programs that may be in force at a particular time. Their evaluation needs, then are more continuous, more predictable, and generally more deliberately designed than those of legislative policymakers. Over the last thirty years, evaluation has become an integral function of executive branch agencies, and many have developed highly sophisticated programs.

Like Congress, federal agencies are interested primarily in national implications, broadly applicable findings, and comparative information across states. At the same time, they often have distinct missions, cultures and program/population responsibility. Evaluations, therefore, seek generalizable answers across very different situations, but are designed for and primarily useful to the

sponsoring agency. The differing approaches or three federal agencies to the evaluation of Medicaid 1115 Waivers illustrates the point.

The Health Care Financing Administration's (HCFA) primary mission as a third-party payer for general healthcare services to the broad low-income population requires large-scale, systems evaluations primarily concerning financing issues and low-income beneficiaries, not the impact on or specific illnesses or providers. HCFA has relatively simple interests in the 1115 Waiver: Will the waiver program cost less (or at least no more) than the previous system? Does the waiver improve access to health care, or at least maintain the same level? Are Medicaid beneficiaries better off (or at least no worse off) under the waiver? The answers to these global questions will determine whether the program is deemed a success and continued or replicated, or a failure to be reversed and avoided by other states.

Particular programmatic components of a state's healthcare system (such as mental health) are interesting only to the extent that they contribute to a deeper understanding of the answers to these global questions. HCFA-sponsored evaluations of the 1115 Waiver programs, therefore, did not address questions about the particular population of individuals with mental illnesses.

In contrast, the Secretary of Health and Human Services (HHS) has responsibility and interests spanning the entire array of possible target populations, as well as the overall operation of the healthcare system and its relationship with other human services systems. The Office of the Assistant Secretary for Planning and Evaluation's (ASPE) evaluation priorities reflect the political choices of the incumbent President and Secretary at any given time. With an interest in the range of people

with long-term disabilities (including those resulting from mental illness),ASPE might, as an example, be interested in supplementing the broad HCFA study of the 1115 Waivers to increase the sample size for this target population in order to learn how the new programs affect them.They might also ask:Is there more or less cost-shifting, more or less integration? What are the "flags" to look for indicating a system failure? These questions could lead to targeted, "commando" studies designed to answer a strategically important, relatively narrow question. However, the knowledge gained about mental health clients or any other particular element of the long-term disability target group would be limited.The focus would rather be on large system changes, such as the impact of limiting choice.

Public Health Service agencies (within HHS) have a statutory mission to focus on particular populations. The Substance Abuse and Mental Health Services Administration(SAMHSA) needs specific studies on the impact of 1115 Waiver programs on people with mental health and/or substance abuse disorders. SAMHSA will certainly benefit from the general results of the broad HCFA study and the ASPE sampling approach, but to understand the impact of the Waiver programs on its area of responsibility will require supplementing further with quite specific questions about this population and the provider system dedicated to serving them.

These agencies will also be likely to want "commando" studies focusing on the particular concerns of the populations for which they are responsible or the service provider system they currently rely on.What will happen to psychosocial rehabilitation centers under a particular waiver program? What will happen to dually diagnosed clients {of any variety), who may be the most likely to be denied service

or shifted into other systems? Are there critical indicators (for success or failure) that can be understood and explained clearly? These are smaller and more manageable studies, with relatively clear concepts and established methodologies. However, the plethora of possible studies raises questions about the duplication involved in designing and supporting them and the difficulty of fitting the various results into an overall policy perspective for the agency or for other policy decisionmaking.

Federal agencies have a permanent professional staff structure as well as political leadership that changes with the election cycle. Many include trained evaluators along with other individuals with significant training, experience and knowledge about the substantive programs under their authority. Despite these significant advantages, however, federal executive branch officials, like legislators operate within severe time constraints. Broad areas of responsibility, limited staffing, and constant demands from the executive and bureaucratic hierarchy mean that even well-prepared and capable staff have little time to keep up with the literature or even to read entire studies. Often they must rely on external sources not only to conduct evaluations, but to help them design studies or analyze and interpret the results.

Federal executive branch officials have both formal and informal channels for obtaining evaluation help to answer their questions. Professional evaluators (as well as other federal staff) maintain their ties to professional organizations, try to read the literature, and attend occasional conferences, and often develop elaborate

networks of people on whom they call for advice or participation on particular issues.

Not surprisingly, federal officials probably pay the greatest attention to studies that they design or commission, which are targeted to their specific questions. Evaluators must go through the formal process of responding to contract or grant announcements, and writing a competitive proposal. Those who have become a part of the network, however, are likely to benefit from greater understanding of the goals of the project and from having their previous work known and well-regarded by those judging the proposals.

POLICYMAKERS, IN SUMMARY

Legislative (federal and state) policymakers need to know, first, how an issue affects both the needs of their constituents and the needs of the whole state or nation. Most important, legislative branch officials must be highly selective of the information to which they pay attention. Bombarded by analyses and information from a plethora of sources, they select those they feel they can trust because the source:

- shares the policymaker's agenda;
- has known biases, and a reputation for providing honest data that is not misleading;
- is a trusted colleague or long-standing friend;
- is an expert or personal contact whose advice has proved helpful in the past; or
- is a constituent or political supporter whose views must be taken into account.

Federal executive branch policymakers, on the other hand, focus first on the program or population for which they have direct responsibility (often leaving little attention for collateral but highly interactive effects), and second on the particular priorities and policy objectives laid down by the current leadership. They must also watch for any issue that has the potential to undercut that leadership or "cost my boss his job." They may, the, have a greater opportunity to focus on particular programs or populations over an extended period, yielding questions more easily addressed through evaluation studies. However, their timeframes— while lavish in comparison with those of most legislators—are far more stringent than most evaluation methodologies allow. And the conflicting demands on their time make it difficult for even trained professional evaluators in these roles to keep up with the literature or read full studies. They tend to place higher value on methodologically sound studies than the more overly political legislative environments do.

For all policymakers, most issues have a relatively brief window of opportunity—somewhat longer for the executive branch than the legislative, but in any event far shorter than the optimal period for planning and conducting evaluation studies. Few have the luxury of trying to understand an issue and its context fully; they must instead concentrate on answering the key questions that are at issue in the immediate decision. If evaluators want their knowledge to be useful and to be used in this process, it is up to them to translate from one world to the other.

The "ideal source", then, provides or translates information into a form that:

- answers a precise question defined by the policymaker;
- specifies assumptions and biases, upfront;
- is concise and easy to use; and
- is instantaneously accessible as needed

HOW CAN EVALUATORS BECOME EFFECTIVE SOURCES OF POLICY INFORMATION?

Our goal is not to teach evaluators to be lobbyists. Rather, the purpose here is to provide some guidance to enable evaluators to assure that the fruits of their labor—the findings of well-conceived and well-conducted studies—will have as much impact as possible. There are "Five fundamentals" for evaluators who would like to improve their effectiveness in communicating with policymakers:

- **Make it Brief, Clear, and Simple**
- **Make it Timely**
- **Make it Relevant**
- **Make it Familiar**
- **Make it Routine**

The following suggestions and the illustrative examples (appended) provide ideas for building these fundamental rules into the course of evaluation work.

1. **Make it Brief, Clear, and Simple.** Policymakers rarely have the time or inclination to read a full study or discuss any matter in depth. As one policymaker (a trained evaluator) put it: "Consumption of studies is almost anecdotal." Few policymakers are experts in the particular subject matter of most decisions they make. They are less interested in the nuances and probabilities and more interested in practical, bottom line results. Boil it down and make it vivid. See Attachment A for an example. Suggestions:

- For every study write a "policy abstract" summary (1-2 pages) that focuses clearly on the key findings and their implications for particular practical policy issues and describes methodology last and in the briefest possible way (e.g. one sentence) if at all. This abstract can be used for many

purposes, such as informing policymakers about your results or contributing to clearinghouse collections for easy accessibility.

- Where possible, include anecdotal illustrations or quotes from interviews in reports, to bring analytic results alive for lay readers and connect the study with real world experience.

2. **Make it Timely.** Policymakers usually have a limited time frame for any particular issue, and may have little or no flexibility. If information is not available when needed, they will make the decision without it. Whether a policymaker can use a given piece of information depends to a very large extent on timing. Information about an issue not on the current agenda rarely receives notice. For example:

The best time to inform Congress about program and evaluation knowledge is at the very beginning of a debate on legislation pertaining to that issue. Because of the ongoing press of business on Capitol Hill, information provided too early will be lost in the shuffle. Information provided during the heat of debate, for instance immediately prior to a major mote on the issue, will be received skeptically (unless it precisely supports the policymaker's position). The window of opportunity closes abruptly after a vote, as people move on to the next major subject of debate.

State legislators, on the other hand, may want different kinds of information at different times. In many states there are long periods between legislative sessions, when interested legislators often take the time to explore issues of interest in more depth, and may be eager to learn about an in-depth study, or to meet with you to discuss finding.

Federal executive branch policymakers may be more open to information whenever it is available. They may be willing to meet with you to discuss a study when you are in Washington, or at a conference. They may accept and file copies of reports even if they do not have time to read them. However, when an issue is thrust upon them for decision, they are most likely to pick up a telephone and call people they know to find out about what information of evaluations are available.

The most important thing evaluators can do is accept and be responsive to the short timelines that may be required in evaluations. And be prepared to react immediately—on request—from any of the contacts you maintain among people working in the policy arena (see No. 4 below).

- Complete work for policy-oriented clients on time.
- Try to design projects with a report of interim results that could be used in case an issue moves more quickly than expected and cannot wait until the project is complete.
- Maintain a file of brief synopses of your past and current findings.
- For any report that you believe has particular policy relevance, write up and have available a "policy implications" summary.
- Develop and practice the technique of explaining technical findings in lay language, for example take a training course in media interviews.

3. **Make it Relevant.** Policymakers typically want information that bears directly on a particular current problem or decision. While some may be interested in more general or background information, most view this as a luxury they cannot afford. Understand the environment in which they are operating. Keep up a general understanding of national, state and local policy environment, as well as the progress of particular issues affecting mental health.

- Read the best newspaper for your state and city.

- Read the *National Journal* and *State Legislatures*.

- Read the *Washington Post* and *NY Times.*

- Get on the mailing list for informational publications as well as funding opportunities from federal and state agencies in your areas of interest.

- Read selected newsletters from national organizations. In addition to any professional or citizen groups you may belong to, consider joining a couple of groups whose newsletters and mailings are likely to provide a broader context in which to understand specific issues. Examples: Center on Budget and Policy Priorities, Children's Defense Fund.

- In designing evaluation studies and proposals, focus on issues of enduring policy interest and impact to provide a context for the specific issues in the study.

- For example, try to include elements such as differences among states or counties, system level change as well as individual impact, cost information, quality and outcomes. If these are included in the design, it will be easier to develop policy-focused summaries of results. Some of the specific questions legislators ask may provide some guidance. (See Attachment B)

4. **Make it Familiar.** Policymakers have learned to rely on particular sources for information. They are more likely to encounter and to give credence to information that comes from a known source, whether organizations they have worked with over time and come to trust, constituents or personal contacts, certain news or trade media. They may accept or easily allow for known bias or viewpoints. Personal contacts who provide information on both sides of an argument and who respond very quickly to an information request are highly valued.

Network, network, network, network. Become a known and trusted source of information and analysis. Make sure your name, areas of expertise/

interest, and relevant work are available through appropriate systems or collections.

- Develop relationships with people (staff or volunteers) in key mental health organizations at the national and state level in your areas of interest, and make sure they know about your work.

- Send these contacts a copy of brief descriptions of your past and current work related to issues you think they would be interested in (e.g. Cost of community-based services, effectiveness of different models of care), and copies of report summaries as they are completed.

- Develop a contact with the local office of your Congressman and Senators, as well as your state Representatives and Senators. As a constituent, you have an advantage in developing an ongoing relationship. Be sure these individuals know you, your areas of expertise, and your work. Encourage them to use you and an informal advisor in your areas. Send them copies of summaries and reports selectively; they should not be overwhelmed.

- Develop contacts with key legislative staff, e.g. legislative services commissions, committees with responsibility for mental health issues. Be sure to include members of both majority and minority parties if possible. Share with them any results (your own or others') that relate directly to specific issues for which they have responsibility. Results from similar states are particularly valued.

- Send executive summaries or highlights of findings to heads of both caucuses, and to committee members.

- Send copies of your reports and publications, including an executive summary, to the Mental Health Policy Resource Center Library, so that people searching for information about immediate policy issues will locate it.

- Join the public policy committees of one or more nonprofit organizations based in your city or state and use your knowledge to help shape their work (or simply volunteer to provide expert information). Encourage them to call on you for help on issues in your area of expertise.

FROM LAW TO LAW

To illustrate a common path taken by a policymaker request for information, and how the resulting study can be packaged and repackaged, this attachment uses as an example a Congressional request for background information about insurance problems for mental health and substance abuse.

1. The Congressional request is made through the most official channel: A study is mandated in legislation, Section 708 of the Alcohol, Drug Abuse, and Mental Health Administion Reorganization Act of 1992.

Sec. 708. REPORT BY SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
     ADMINISTRATION.

   (a) Interim Report. —Not later than 6 months after the date of the enactment of this Act, the Administrator of the Substance Abuse and Mental Health Services Administration shall compile and directly transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate an interim report that includes the following information:

   (1) A compilation and summary of the scientific literature and research concerning the provision of health insurance, by both public and private entities, for substance abuse (including alcohol abuse) and mental health services.

   (2) A review of the scientific literature evaluating the medical effectiveness of substance abuse (including alcohol abuse) and mental health services.

   (3) An examination of past practices and emerging trends of health insurance coverage for substance abuse (including alcohol abuse) and mental health services, including an examination of trends in copayments, lifetime coverage maximums, number of visits, and inclusion of exclusion of such services.

   (4) An identification of issues attendant to and analysis of barriers to health insurance coverage for substance abuse (including alcohol abuse) and mental illness services. Such analysis shall include a discussion of how substance abuse (including alcohol abuse) and mental health services would be affected by the various health care reform under consideration in Congress.

   (5) An examination of the issues attendant to limitations placed on the use of Medicaid program funds for adults receiving substance abuse (including alcoholism services) and mental health services in intermediate care residential settings.

   (b) Final Report. —Not later than October 1, 1993, such Administrator shall compile and transmit directly to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report that identifies the relevant policy issues and research questions that need to be answered to address current barriers to the provision of substance abuse and mental health services. The Administrator shall design a research and demonstration strategy that examines such barriers and tests alternative solutions to the problems of providing health services. As soon as practicable but not later than January 1, 1994, the Secretary shall initiate research and demonstration projects that, consistent with the information contained in the reports required under this section, will study the issues identified with, and possible alternative mechanisms of, providing health insurance and treatment services for substance abuse (including alcohol abuse) and mental illness.

legislators, a suggestion can be made that the client form a group of legislators to add credibility and respond to that user group.

Some additional suggestions for routine activities that will increase the accessibility of your work include:

- Plan a policy-related dissemination strategy as an element of project plan. For example, identify appropriate policy-oriented dissemination channels journals, newsletters, online systems) and routinely send them an appropriate version of the write-up or release announcement.

- Consider using an experienced policy writer and/or editor to prepare and format materials for a policy audience. Build this expense into project budgets.

- Participate in Internet and World Wide Web sites that maintain information in your area of interest. (See Attachment C.) Set up links if possible, so that users can find your work easily.

- Participate in efforts to develop a cumulative bank of studies that would be easily accessed as needed.

- Be open to new forms of media, multi-media and learn to produce versions of your reports in such formats.

- Let people know what evaluation is being done (or is "on the shelf"). Develop a set of very basic informational materials on any policy issue related to your area of interest, based not only on your own work but on the best work n the field. Think of your audience as the citizen or layperson who is not involved with the issue.

CONCLUSION

The most important thing to remember about providing information to people in the policy process is that you are the one attempting to gain a hearing. They do not have to listen. Therefore, the responsibility is also yours for learning how to communicate effectively and for providing materials or information in the most effective way and at appropriate times. The reward is the knowledge that your work will be more likely to have an impact beyond your immediate client or your peer group, and to help shape the mental health system of the future.

FROM LAW TO LAW

To illustrate a common path taken by a policymaker request for information, and how the resulting study can be packaged and repackaged, this attachment uses as an example a Congressional request for background information about insurance problems for mental health and substance abuse.

1. The Congressional request is made through the most official channel: A study is mandated in legislation, Section 708 of the Alcohol, Drug Abuse, and Mental Health Administion Reorganization Act of 1992.

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Sec. 708. REPORT BY SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
     ADMINISTRATION.
   (a) Interim Report. —Not later than 6 months after the date of the enactment
of this Act, the Administrator of the Substance Abuse and Mental Health Services
Administration shall compile and directly transmit to the Committee on Energy
and Commerce of the House of Representatives and the Committee on Labor and
Human Resources of the Senate an interim report that includes the following
information:
        (1) A compilation and summary of the scientific literature and research
     concerning the provision of health insurance, by both public and private
     entities, for substance abuse (including alcohol abuse) and mental health
     services.
        (2) A review of the scientific literature evaluating the medical
     effectiveness of substance abuse (including alcohol abuse) and mental health
     services.
        (3) An examination of past practices and emerging trends of health
     insurance coverage for substance abuse (including alcohol abuse) and mental
     health services, including an examination of trends in copayments, lifetime
     coverage maximums, number of visits, and inclusion of exclusion of such
     services.
        (4) An identification of issues attendant to and analysis of barriers to
     health insurance coverage for substance abuse (including alcohol abuse) and
     mental illness services. Such analysis shall include a discussion of how
     substance abuse (including alcohol abuse) and mental health services would
     be affected by the various health care reform under consideration in
     Congress.
        (5) An examination of the issues attendant to limitations placed on the
     use of Medicaid program funds for adults receiving substance abuse
     (including alcoholism services) and mental health services in intermediate
     care residential settings.
   (b) Final Report. —Not later than October 1, 1993, such Administrator shall
compile and transmit directly to the Committee on Energy and Commerce of the
House of Representatives and the Committee on Labor and Human Resources of the
Senate a report that identifies the relevant policy issues and research
questions that need to be answered to address current barriers to the provision
of substance abuse and mental health services. The Administrator shall design a
research and demonstration strategy that examines such barriers and tests
alternative solutions to the problems of providing health services. As soon as
practicable but not later than January 1, 1994, the Secretary shall initiate
research and demonstration projects that, consistent with the information
contained in the reports required under this section, will study the issues
identified with, and possible alternative mechanisms of, providing health
insurance and treatment services for substance abuse (including alcohol abuse)
and mental illness.
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2. The study was conducted in two parts, one for mental health and one for substance abuse, each through a separate contract. The full report of the mental health part alone ran to 259 pages.

3. Following submission of the contracted product, and with the permission of the client, key parts of the study were repackaged as a series of separate reports in booklet form. The tables of contents are reproduced here to provide an example of highlighting issues that emerged from the study. The executive summary of one booklet is also reproduced as an example of boiling down findings for a policy audience.

4. The booklets were distributed to policymakers in the the executive and legislative branch and to national organizations as background material during the debate over healthcare reform.

Insurance and Mental Health:
Issues in Financing and Coverage

Barriers in Current Policy and Practice

By

Gail K. Robinson

Cynthia Folcarelli

Jim Havel

Karen Hoehn

and

Yael Schy

CONTENTS

Insurance
and
Mental Health:
The Insurance Landscape

By
Gail K. Robinson
Cynthia Folcarelli
Jim Havel
Karen Hoehn
and
Yael Schy

CONTENTS

The Efficacy
of
Mental Health Services:
A Review of the Literature

By
Cindy Brach

CONTENTS

IMPLICATIONS OF THE EFFICACY LITERATURE

As healthcare reformers look to the efficacy literature to guide coverage decisions, some general implications of the research to date bear emphasis.

- Most treatments are efficacious with some groups of patients.

- A showing that a particular treatment is efficacious does not in itself provide guidance as to which patients will respond well to that treatment.

- While most treatments are found to be more efficacious than no treatment, distinguishing between similar types of treatment has been difficult. Since there is no definitive treatment for any particular mental health condition, the available research does not support limiting coverage to particular treatments for particular mental health conditions.

- Less costly alternatives can prove to be as efficacious as standard methods of care. The literature suggests the importance of specific incentives for utilizing established alternatives and for developing new alternatives.

- Unless mental health measures are included in health-care services research on effectiveness and outcomes, the impact of mental disorders, such as depression, on health status measures of functioning and well-being will not be recognized or understood.

Some themes common to many of the studies are not fully developed in a review emphasizing findings. For example, longer follow-up periods revealed a lessening of treatment effects; that is, the effects eroded over time, sometimes even returning patients to their pretreatment condition. This observation, which held for the spectrum of mental health treatments, underlines the crucial role of followup and continuity of care in mental health treatment.

This review is limited by the existing literature on mental health treatment. It exposes several gaps in the research. Filling in these gaps would be extremely valuable in developing healthcare and financing policies over time. The following topics are among the most critical to address:

- The efficacy of mental health treatments for patients who are not severely mentally ill;

- The efficacy of mental health treatments as provided by different professionals (e.g., psychiatrists, psychologists, psychiatric nurses, social workers, counselors, paraprofessional mental health workers);

- The efficacy of alternative mental health treatments, such a psychoeducation and new forms of psychosocial rehabilitation;

- The effectiveness of mental health treatments as they are administered in the real world, as opposed to efficacy in clinical trials; and

- The interaction between health and mental health status and treatments and their impact on the efficacy and effectiveness of each.

During the last several years, there has been growing recognition, in both the scientific and political arenas, of the significance of health status in examining the relationship between treatment interventions and health outcomes.[147.148] Although the early applications of health status measures were limited to indicators of mortality, life expectancy, and hospital readmission rates, current research focuses on developing and applying more complex and multidimensional measures of health status, including patient functioning and well-being.[65] Quality-of-life is a particularly important—and particularly difficult to define—outcome measure for research on treatment for patients with chronic mental or physical illness, reflecting the fact that medicine has had to become increasingly concerned with easing chronic dysfunction and pain instead of curing acute illness.[241]

- Mental health disciplines can make an essential contribution to outcomes research that incorporates patient values concerning quality of life and patient preferences concerning services utilization into investigations of the relationship between services/treatment and health status.[200]

There is notable consensus among researchers and leading experts that the public and political expectations about outcomes and effectiveness research providing guidance or solutions for the problems of cost-containment in healthcare are overly optimistic. Researchers repeatedly provided evidence that short-term, quick answers to questions

concerning the cost-effectiveness of healthcare services are rear and of limited value.[118] Despite the desire to generate timely answers, outcomes and effectiveness research requires a long-term commitment to allow for the gradual accrual of results.[1,222]

- Though outcome research potentially can provide valuable information to both policymakers and clinicians, it is premature to expect it to provide solutions to the problems of cost-containment.

SOME QUESTIONS LEGISLATORS ASK ABOUT PROGRAMS AND POLICIES

INPUT: WHAT IS THE PROGRAM, WHAT IS IT DOING, WHAT DOES IT COST?

- What is the state's investment in funding and other resources for the program or policy?

- What are its cost/benefit and cost/effectiveness?

- How do administrative costs compare to direct service costs?

- If savings are achieved, where do those funds go (e.g., additional profit to a private contractor, tax cuts for citizens, additional services)?

OUTPUT: WHAT DOES THE PROGRAM PRODUCE, FOR WHOM?

- Is the anticipated service actually being provided?

- How easy or difficult is it to obtain the service?

- How many units are being provided; how many people are being served?

- How much does each service or activity cost?

- What parts of the state (regions, cities, counties, congressional districts, state legislative districts) are served will or poorly?

- Are the services of high quality?

- Who is falling out of the system (as well as who is being served)?

- Are appropriate culturally sensitive services provided to particular populations?

Outcomes: Does the program solve the problem or make a measurable difference?

- What is the impact of program or policy on participants, and to what extent has it met its goals and objectives?

- What positive difference does the program make in the lives of its clients and others? Has it solved the client's problem?

- If not, or if the problem is not amenable to total solution, has it helped in some measurable way?

- Have program changes, or other policy decisions had negative consequences?

- What are the impacts on the clients' family or the community?

- Are key indicators of quality being met?

- How do changes in one program or system affect another—for example, are clients migrating between systems, or moving out of all systems as a result of changes in one program or system?

CONGRESSIONAL COMMITTEES

The committee memberships listed here are current during the 105th Congress (1997-1998). All listings are in order by seniority within their own party. The lists do not include all Congressional committees that handle mental health issues, only those with the greatest ongoing responsibility. While rosters change from time to time reflecting unexpected resignations or other shifts, major changes occur following each election, every two years. In order to keep up:

- Know who your state's Senators and Congressional Representatives are, and where each id from. Visit them when you are in Washington. Read about their particular interests and initiatives. Try to develop an acquaintance with their district local staff.

- Know what committees have responsibilities for your areas of interest, and who are the leaders of those committees. Focus on members of the committees from your state, or neighboring states, and learn about their interests.

- The general address for mail to the Congress will get to the appropriate place:

  Name   Name
  Committee (if applicable)   Committee (if applicable)
  U.S. Senate   U.S. House of Representatives
  Washington, DC 20515-3519   Washington, DC 20510-1901

House and Senate Appropriations Committees oversee the 13 annual appropriations bills that fund the discretionary activities of the Federal Government - everything other than entitlements such as Social Security, Medicare and Medicaid. The relevant subcommittee and its staff are the chief experts responsible for essentially all funding for the Department of Health and Human Services, among others.

The **House Commerce Committee** and its Subcommittee on Health and the Environment, and the Senate **Labor and Human Resources Committee** are the authorizing committees for all specific programs in mental health, including NIMH research and CMHS block grants and services programs. The House Committee is also responsible for Medicaid.

The **House Ways and Means Committee** and **Senate Finance Committee** are responsible for Medicare, and the Senate Committee is also responsible for Medicaid.

HOUSE COMMITTEE ON APPROPRIATIONS

Republicans (33)

1. LIVINSGTON (R, -LA) Chairman
2. McDADE (R-PA)
3. REGULA (R-OH)
4. LEWIS (R-CA)
5. PORTER (R-IL)
6. ROGERS (R-KY)
7. SKEEN (R-NM)
8. WOLF (R-VA)
9. DeLAY (R-TX)
10. KOLBE (R-AZ)
11. PACKARD (R-CA)
12. CALLAHAN (R-AL)
13. WALSH (R-NY)
14. TAYLOR, CHARLES (R-NC)
15. HOBSOM (R-OH)
16. ISTOOK (R-OK)
17. BONILLA (R-TX)
18. KNOLLENBERG (R-MI)
19. MILLER (R-FL)
20. DICKEY (R-AR)
21. KINGSTON (R-GA)
22. PARKER (R-MS)
23. FELINGHUYSEN (R-NJ)
24. WICKER (R-MS)
25. FORBES (R-NY)
26. NETHERCUTT (R-WA)
27. NEUMANN (R-WI)
28. CUNNINGHAM (R-CA)
29. TIAHRT (R-KA)
30. WAMP (R-TN)
31. LATHAM (R-IA)
32. NORTHUP (R-KY)
33. ADERHOLT (R-AL)

Democrats (27)

1. OBEY (D-WI) Ranking Minority Leader
2. YATES (D-IL)
3. STOKES (D-OH)
4. MURTHA (D-PA)
5. DICKS (D-WA)
6. SABO (D-MN)
7. DIXON (D-CA)
8. FAZIO (D-CA)
9. HEFNER (D-NC)
10. HOYER (D-MD)
11. MOLLOHAN (D-WV)
12. KAPTUR (D-OH)
13. SKAGGS (D-CO)
14. PELOSI (D-CA)
15. VISCLOSKY (D-IN)
16. FOGLIETTA (D-PA)
17. TORRES (D-CA)
18. LOWEY (D-NY)
19. SERRANO (D-NY)
20. DeLAURO (D-CT)
21. MORAN (D-VA)
23. OLVER (D-MA)
24. PASTOR (D-AZ)
25. MEEK (D-FL)
26. PRICE (D-NC)
27. EDWARDS (D-TX)

Labor, Health and Human Services, Education Subcommittee

Republicans (8)

1. PORTER (R-IL) Chairman
2. YOUNG (R-FL)
3. BONILLA (R-TX)
4. ISTOOK (R-OK)
5. MILLER (R-FL)
6. DICKEY (R-AR)
7. WICKER (R-MS)
8. NORTHUP (R-KY)

Democrats (6)

1. OBEY (D-WI) Ranking Minority Leader
2. STOKES (D-OH)
3. HOYER (D-MD)
4. PELOSI (D-CA)
5. LOWEY (D-MY)
6. DeLAURO (D-CT)

Senate Committee on Appropriations

Republicans (14)	Democrats (12)
1. STEVENS (R-AK) Chairman	1. BYRD (D-WV) Ranking Minority Leader
2. COCHRAN (R-MS)	2. INOUYE (D-HA)
3. SPECTER (R-PA)	3. HOLLINGS (D-SC)
4. DOMENICI (R-NM)	4. LEAHY (D-VT)
5. BOND (R-MO)	5. BUMPERS (D-AR)
6. GORTON (R-WA)	6. LAUTENBERG (D-NJ)
7. McCONNELL (R-KY)	7. HARKIN (D-IA)
8. BURNS (R-MT)	8. MIKULSKI (D-MD)
9. SHELBY (R-AL)	9. REID (D-NM)
10. GREGG (R-NH)	10. KOHL (D-WI)
11. BENNETT (R-UT)	11. MURRAY (D-WA)
12. CAMPBELL (R-CO)	12. DORGAN (D-ND)
13. CRAIG (R-ID)	
14. HUTCHISON (R-TX)	

Labor, Health and Human Services, Education Subcommittee

Republicans (8)	Democrats (7)
1. SPECTER (R-PA) Chairman	1. HARKIN (D-IA) Ranking Minority Leader
2. COCHRAN (R-MS)	2. HOLLINGS (D-SC)
3. GORTON (R-WA)	3. INOUYE (D-HA)
4. BOND (R-MO)	4. BUMPERS (D-AR)
5. GREGG (R-NH)	5. REID (D-NV)
6. FAIRCLOTH (R-NC)	6. KOHL (D-WI)
7. CRAIG (R-ID)	7. MURRAY (D-WA)
8. HUTCHISON (R-TX)	

House Committee on Commerce

Republicans (28)

1. BLILEY (R-VA) Chairman
2. GILLMOR (R-OH)
3. TAUZIN (R-LA)
4. OXLEY (R-OH)
5. BILIRAKIS (R-FL)
6. SCHAEFER (R-CO)
7. BARTON (R-TX)
8. HASTERT (R-IL)
9. UPTON (R-MI)
10. STEARNS (R-FL)
11. PAXON (R-NY)
12. KLUG (R-WI)
13. GREENWOOD (R-PA)
14. CRAPO (R-ID)
15. COX (R-CA)
16. DEAL (R-GA)
17. LARGENT (R-OK)
18. BURR (R-NC)
19. BILBRAY (R-CA)
20. WHITFIELD (R-KY)
21. GANSKE (R-IA)
22. NORWOOD (R-GA)
23. WHITE (R-WA)
24. COBURN (R-OK)
25. LAXIO (R-NY)
26. CUBIN (R-WY)
27. ROGAN (R-CA)
28. SHIMKUS (R-IL)

Democrats (23)

1. DINGELL (D-MI) Ranking Minority Leader
2. WAXMAN (D-CA)
3. MARKEY (D-MA)
4. HALL (D-TX)
5. RICHARDSON (D-NM)
6. BOUCHER (D-VA)
7. MANTON (D-NY)
8. TOWNS (D-NY)
9. BROWN (D-OH)
10. GORDON (D-TN)
11. FURSE (D-OR)
12. DEUTSCH (D-FL)
13. RUSH (D-IL)
14. ESHOO (D-CA)
15. KLINK (D-PA)
16. STUPAK (D-MI)
17. ENGEL (D-NY)
18. SAWYER (D-OH)
19. WYNN (D-MD)
20. GREEN (D-TX)
21. McCARTHY (D-MO)
22. STRICKLAND (D-OH)
23. DeGRETTE (D-CO)

Health and Environment Subcommittee

Republicans (16)

1. BILIRAKIS (R-FL) Chairman
2. HASTERT (R-IL)
3. BARTON (R-TX)
4. UPTON (R-MI)
5. KLUG (R-WI)
6. GREENWOOD (R-PA)
7. DEAL (R-GQ)
8. BURR (R-NC)
9. BILBRAY (R-CA)
10. WHITFIELD (R-KY)
11. GANSKE (R-IA)
12. NORWOOD (R-GA)
13. COBURN (R-OK)
14. LAZIO (R-NY)
15. CUBIN (R-WY)
16. *BLILEY (R-VA)

Democrats (13)

1. BROWN (D-OH) Ranking Minority Leader
2. WAZMAN (D-CA)
3. RICHARDSON (D-NM)
4. TOWNS (D-NY)
5. DEUTSCH (D-FL)
6. STUPAK (D-MI)
7. GREEN (D-TX)
8. STRICKLAND (D-OH)
9. DeGETTE (D-CO)
10. HALL (D-TX)
11. FURSE (D-OR)
12. ESHOO (D-CA)
13. *DINGELL (D-MI)

* Ex-officio. voting member

Senate Committee on Labor and Human Resources

Republicans (10)

1. JEFFORDS (R-VT) Chairman
2. COATS (R-IN)
3. GREGG (R-NH)
4. FRIST (R-TN)
5. DeWINE (R-OH)
6. ENZI (R-WY)
7. HUTCHINSON (R-AR)
8. COLLINS (R-MA)
9. WARNER (R-VA)
10. McCONNELL (R-KY)

Democrats (8)

1. KENNEDY (D-MA) Ranking Minority Leader
2. DODD (D-CT)
3. HARKIN (D-IA)
4. MIKULSKI (D-MD)
5. BINGAMAN (D-NM)
6. WELLSTONE (D-MN)
7. MURRAY (D-WA)
8. REED (D-RI)

Senate Committee on Finance

Republicans (11)

1. ROTH, WILLIAM (R-DE) Chairman
2. CHAFEE (R-RI)
3. GRASSLEY (R-IA)
4. HATCH (R-UT)
5. D'AMATO (R-NY)
6. MURKOWSKI (R-AK)
7. NICKLES (R-OK)
8. GRAMM (R-TX)
9. LOTT (R-MS)
10. JEFFORDS (R-VT)
11. MACK (R-FL)

Democrats (9)

1. MOYNIHAN (D-NY) Ranking Minority Leader
2. BAUCUS (D-MT)
3. ROCKEFELLER (D-WV)
4. BREAUX (D-LA)
5. CONRAD (D-ND)
6. GRAHAM (D-FL)
7. MOSLEY-BRAUN (D-IL)
8. BRYAN (D-NM)
9. KERREY (NE)

Subcommittee on Health Care (former Medicaid and Medicare subcommittees)

Republicans (8)

1. GRAMM, PHIL (R-TX) Chairman
2. ROTH (R-DE)
3. CHAFEE (R-RI)
4. GRASSLEY (R-IA)
5. HATCH (R-UT)
6. D'AMATO (R-NY)
7. NICKLES (R-OK)
8. JEFFORDS (R-VT)

Democrats (7)

1. ROCKEFELLER (D-WV) Ranking Min. Leader
2. BAUCUS (D-MT)
3. CONRAD (D0ND)
4. GRAHAM (D-FL)
5. MOSELEY-BRYAN (D-IL)
6. KERREY (D-NE)
7. BRYAN (D-NV)

House Committee on Ways nand Means

Republicans (23)

1. ARCHER (R-TX) Chairman
2. CRANE (R-IL)
3. THOMAS (R-CA)
4. SHAW (R-FL)
5. JOHNSON (R-CT)
6. BUNNING (R-KY)
7. HOUGHTON (R-NY)
8. HERGER (R-CA)
9. McCRERY (R-LA)
10. CAMP (R-MI)
11. RAMSTAD (R-MN)
12. NUSSLE (R-IA)
13. JOHNSON (R-TX)
14. DUNN (R-WA)
15. COLLLINS (R-GA)
16. PORTMAN (R-OH)
17. ENGLISH (R-PA)
18. ENSIGN (R-NV)
19. CHRISTENSEN (R-NE)
20. WATKINS (R-OK)
21. HAYWORTH (R-AZ)
22. WELLER (R-IL)
23. HULSHOF (R-MO)

Democrats (16)

1. RANGEL (D-NY) Ranking Minority Leader
2. STARK (D-CA)
3. MATSUI (D-CA)
4. KENNELLY (D-CT)
5. COYNE (D-PA)
6. LEVIN (D-MI)
7. CARDIN (D-MD)
8. McDERMOTT (D-WA)
9. KLEEZKA (D-WI)
10. LEWIS (D-GA)
11. NEAL (D-MA)
12. McNULTY (D-NY)
13. JEFFERSON (D-LA)
14. TANNER (D-TN)
15. BECERRA (D-CA)
16. THURMAN (D-FL)

Health Subcommittee

Republicans (8)

1. THOMAS (R-CA) Chairman
2. JOHNSON (R-CT)
3. McCRERY (R-LA)
4. ENSIGN (R-NV)
5. CHRISTENSEN (R-NE)
6. CRANCE (R-IL)
7. HOUGHTON (R-NY)
8. JOHNSON (R-TX)

Democrats (5)

1. STARK (D-CA) Ranking Minority Leader
2. CARDIN (D-MD)
3. KLEEZKA (D-WI)
4. LEWIS (D-GA)
5. BECERRA (D-CA)

INTERNET/WORLD WIDE WEB SITES

Keeping up with the policy environment and the specific interests of various policymakers is always a challenge. However, the advent of the Internet and particularly the World Wide Web is beginning to make a real difference. These resources sre generally updated much more frequently than printed references, and they are designed for "cross-referencing" and referrals through web links.

While new sites are developing all the time, here is a core reference list that will also provide links to individual state or agency sites ant to new information as it becomes available.

General Information Sources, Government and Politics

Fedworld		http://www.fedworld.gov
Federal Information Exchange		http://www.fie.com/www/us_gov.ghtm
PoliticsUSA	Nat'l Journal/American Polit. Net.	http://politicsusa.com
PIE Online	Policy Information Exchange	http://www.pie.org

Congress

GAO	General Accounting Office	http://www.gao.gov/index.htm
Thomas	Library of Congress	http://www.thomas.loc.gov/
U.S. Senate	http://www.senate.gov	
U.S. House	http://www.house.gov	

Executive

White House	http://www.whitehouse.gov	
GPO	Government Printing Office	http://www.access.gpo.gov/
DHHS	Department of Health and Human Services	http://www.os.dhhs.gov/
SAMHSA	Substance Abuse and MH Services Administration	http://www.samhsa.gov
CMHS	Center for Mental Health Services	http://www.samhsa.gov/cmhs.htm
NIMH	National Institute of Mental Health	gopher://www.gopher.nimh.nih.gov
HCFA	Health Care Financing Administration	http://www.hcfa.gov
PHS	Public Health Service	http://phs.os.dhhs.gov/phs/phs.htm
AHCPR	Agency for Health Care Policy and Research	http://www.ahcpr.gov
KEN	Nat'l MH Services Knowledge Exchange Network	http://www.mentalhealth.org

States

NASIRE	Nat'l Assoc. of State Information Resources Execs.	http://www.state.ky.us/nasire/ NASIREhome.html
NCSL	National Conference of State Legislatures	http://www.ncls.org
WICHE	Western Interstate Conference on Higher Education	http://www.wiche.edu
State and local government on the Net		http://www.piperinofo.com/piper/ state/states.html

PRC/The Evaluation Cneter @ HSRI