

2

Get the Story, Get It Right

If we want to do better, we need to know better. And knowing better begins with knowing what problems we most need to solve.

What Are the Right Questions?

Policymakers face an endless stream of decisions, and even more boundless swells of information. Few government programs are simple. Government's managers can't drive within narrow lanes to solve any of their important problems. Navigating this world is exceptionally complex, and doing better requires better answers to the right questions. There are five fundamental questions for which policymakers need good answers:¹

1. *Hindsight*. What does the past teach us about the future?
2. *Foresight*. How can we make good decisions to produce the best results?
3. *Results*. What have we accomplished—and how can we do better?
4. *Risk*. What challenges do we face that could undermine what we want to do?
5. *Resilience*. How can we bounce back when, inevitably, bad things happen?

Let's look at each of these five questions—and the kinds of evidence that can help us answer them so we can learn better.

Hindsight

One of the best ways to know the best answer to the problems we face is to learn lessons from what's happened before. Evidence from programs in the past can provide powerful clues about the best decisions for the future.

Program evaluation is the tool for doing this.² It systematically looks at how public programs have worked in the past, what results they produced, and how well the results matched the goals policymakers intended. In Rialto, California, for example, the police department equipped its officers with cameras. The result: the number of complaints against officers dropped by 88 percent in a twelve-month period, and officers' use of force went down by 60 percent. The police chief concluded that the cameras were the cause.³

The evidence certainly seems strong. But how could the department know for sure that it was the use of cameras that drove the numbers down? All of the officers began wearing cameras. Without a control group of officers without cameras but working the same duty, careful analysts would point out, it would be very hard to know the precise cause.

That's why researchers hold *randomized controlled trials* (RCTs) as the gold standard for evidence. In these studies, analysts follow the basic approach of medical researchers. They assess a program's results by randomly assigning those taking part in the program into two groups: one group receives the program's treatment (whether it's a job training program or a different way of running probation), and another group is as identical as possible—except it doesn't receive the program's treatment. Analysts examine the results to determine whether those who get the treatment (the experimental group) get better results than those who don't (in the control group). Random assignment helps control for differences in results that could be explained by *who* takes part in a program; for example, if released prisoners with the best education volunteer for a new probation program, they might have an easier time staying out of jail because their education might help them get better jobs.

But, of course, it's often hard to randomly assign individuals to programs. It can be hard to treat different individuals in the same neighborhood differently (for example, in experimenting with different strategies for garbage pickup). It can be hard to deny treatment to some individuals for the purpose of creating control groups (for example, when a dangerous disease breaks out and experts think they have a vaccine that could save victims). It can be expensive to do RCTs, the results take time to develop, and policymakers are often eager to press ahead with programs they deeply believe in. Imagine a policymaker saying publicly, "I have a great idea for a program. I'm going to spend a lot of money on it. I really think it's going to work. But half of you can't get it because you're in the control group." There are strategies to resolve this challenge, but developing the very best research tools can often prove quite difficult in the very real world of politics.

One of the highest hurdles to jump in sharpening our hindsight is simple: policymakers are often attracted to ideas, and once they sink their teeth into them, it's often hard to let go. A premier example is the "Scared Straight" program, which grew out of the efforts in the 1970s to reduce juvenile crime. Kids who get picked up for offenses are sent for a day to adult prisons, where they get the full "in your face" treatment from prisoners, guards, and counselors. There's everything from prison chow and inmates screaming to threats of violence and the chance to wear prison uniforms for the day. "If you keep on your path," the program suggests, "here's the life you can expect to live." Policymakers have loved the program for decades—and so, too, has television. It started with a 1978 documentary, which won an Academy Award. Sequels followed, as did a long-running television series on the A&E cable network, starting in 2011. *Beyond Scared Straight* was a ratings winner for the network, and the Spike network picked up reruns. It was engaging television. And policymakers were hooked. Didn't it make sense that exposing kids to prison would make them want to do everything they could to avoid it in the future?

Researchers took a careful look at this program and concluded that it had a big impact. "Scared Straight" actually *increased* crime among the kids who went through the program. As Assistant Attorney General for the Office of Criminal Justice Programs Laurie O. Robinson and the Office of Juvenile Justice and Delinquency Prevention's acting administrator, Jeff Slowikowski, put it in 2011, "'Scared straight' is not only ineffective but is potentially harmful."⁴ How could they be so sure? A team of researchers led by Anthony Petrosino, Carolyn Turpin Petrosino, and John Buehler explored randomized controlled trials on the program and concluded, "Simply put, participating in the program was *associated with an increase in crime*."⁵ Some of the evidence is shaky. Other studies produce solid conclusions. But the overall picture is clear: "Scared Straight" is an effective program—for increasing crime (see Table 2.1).

That hasn't stopped policymakers or worried parents. One Georgia parent said, "I tried to do everything I could do as a parent," before sending her sons to the local sheriff's office for a "scared straight" experience. The television show continued to convince parents, especially desperate ones, that the program might give their kids a chance. "It's a strong thing in America that we believe that being tough on people, punishing people, coercing them—basically forcing them to behave the way we want them to behave—it will somehow work," explained Jeffrey Butts, a criminology expert at John Jay College. "We get a lot of folks that will bring their kids by and say kind of the same thing," one senior official in Georgia's Richmond County Sheriff's Office explained. "They'll say 'I can't make this kid do anything, you guys need to scare them.'" So scare them they do—even though the evidence says that the results are likely to be more kids committing more crimes.⁶ Knowing better doesn't necessarily always lead to doing better, even when the knowing comes from the gold standard of policy research.

TABLE 2.1 • Evidence on the Effectiveness of “Scared Straight”

Program	Number of participants	Results	Other information
Michigan (1967)	60	43 percent of program group committed another crime versus 17 percent of control group	Report is brief, with few details
Illinois (1979)	161	17 percent of program group had new contacts with police versus 12 percent of control group	Results not statistically significant, but outcomes negative
Michigan JOLT Program (1979)	227	Little difference between program group and control group	
Virginia Insiders Program (1981)	80	At six months: 41 percent of program group back in court versus 39 percent of control group, but results not statistically significant	Little difference between the two groups, but large dropout rate for program: 55 percent at 12 months
Texas Face-to-Face Program (1981)	160	After six months: control group outperformed each of three treatment groups assigned to prison orientation and/or counseling. Delinquency rates: <ul style="list-style-type: none"> • Control: 28 percent • Orientation, counseling: 39 percent • Orientation only: 36 percent • Counseling only: 39 percent 	None of the findings are statistically significant

Program	Number of participants	Results	Other information
New Jersey “Scared Straight” Program (1982)	82	After six months: 11 percent of control group committed new crimes versus 41 percent of program group	Difference statistically significant
California SQUIRES Program (1983)	108	After 12 months: 67 percent of control group rearrested versus 81 percent of program group	Program participants rearrested stayed out of the system a bit longer: 4.1 months versus 3.3 months for control group
Kansas Juvenile Education Program (1986)	52	No difference	
Mississippi Project Aware (1992)	176	Little difference at 12 and 24 months	

Source: Adapted from Anthony Petrosino, Carolyn Turpin Petrosino, and John Buehler, “Scared Straight” and Other Juvenile Awareness Programs for Preventing Juvenile Delinquency (Oslo, Norway: Campbell Systematic Reviews, 2004), https://www.campbellcollaboration.org/media/k2/attachments/Scared_Straight_R.pdf.

Foresight

Analysts also try to help policymakers through forecasts about the future. They build complex models, based on past data, to predict the future. Nowhere is this more important than in economic policy. The growth of the economy not only is important in its own right. It also powerfully shapes government spending. Lower economic growth tends to drive spending up (because more citizens get government benefits) and revenues down (because there is less income to tax and money to spend). Forecasting the budget—especially the size of the federal deficit—thus depends heavily on the foresight of the forecasters.

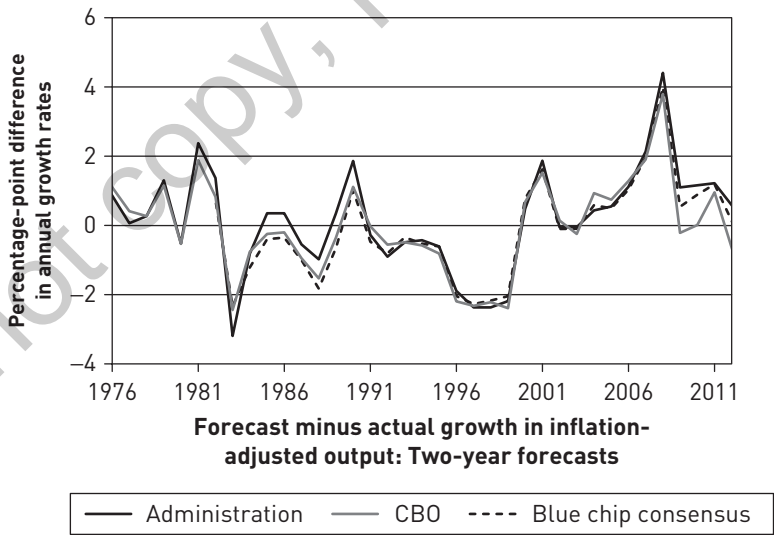
But how accurate are these forecasts? In dealing with the federal budget, there are two major government teams: one working for the president, in the Office of Management and Budget (OMB), and the other working for Congress, in the Congressional Budget Office (CBO). These are some of the best economic forecasters in the world. They do very well—but they don’t always get their forecasts right. Of course, it’s a mistake to frame the issue that way. *Nobody* gets these

complicated issues right all the time. Rather, there are three questions that matter most. First, do the forecasters get it mostly right, most of the time? Second, are some forecasters better than others? And third, when they get it wrong, what difference does it make?

It's possible to answer the first two questions together. OMB and CBO almost always come within just 2 percent of the actual economic growth. Most of the time they're within 1 percent. In an economy as large and complex as the United States, and with as many global forces pushing on the economy, that's remarkable. Moreover, as Figure 2.1 shows, one tends to do about as well as the other—and, for that matter, they do about as well as the very best private-sector forecasters. When they miss, they tend to miss at about the same level in about the same direction.

What difference do the errors make? Most of the time, not much—and the errors tend to even out over time. But at the beginning of Barack Obama's presidency, as the figure shows, all the forecasters—government as well as private—missed their forecasts of economic growth by large margins. All of them forecast that the 2008 economic downturn would be much less severe than it turned out to be. Obama used those forecasts to make his plans. He miscalculated in those plans because the forecasters miscalculated in their forecasts.

FIGURE 2.1 • Accuracy in Forecasting: Forecast Economic Growth Minus Actual Growth



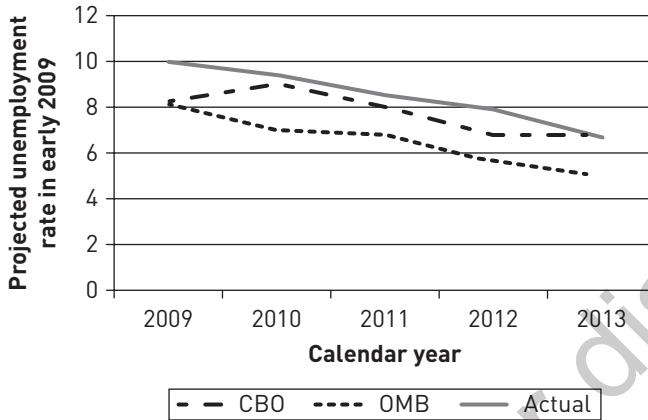
Source: "Growth in Inflation-Adjusted Output: Two-Year Forecasts." Congressional Budget Office, *CBO's Economic Forecasting Record: 2015 Update* (February 12, 2015), <https://www.cbo.gov/publication/49891>.

That had a huge impact on the first years of the Obama administration. On taking office in January 2009, the president had a clear strategy.⁷ The economy was in free fall, so he would take his lumps early and then move out briskly with new policy plans as the economy recovered. The recession, his administration believed, would be nasty but short. The plan was to pump money out fast, through a stimulus program, and then follow quickly with the administration's policy agenda, especially health-care reform. It smelled like a good plan, especially since it would help Obama regain momentum going into the 2012 presidential campaign, and his advisers believed that the economic forecasts would support the effort. The forecasters got the first part of the equation right. The recession was nasty. But the recovery was painfully slow. That led to the "jobless recovery," as analysts christened it, and it plagued Obama well into his second term.

But this wasn't a forecasting error by just the president's own economists. Nearly everyone missed the jobless recovery. In early 2009, the Office of Management and Budget projected an unemployment rate for the year at 8.1 percent. The non-partisan Congressional Budget Office's forecast was a bit higher, at 8.3 percent. Private economists didn't do much better. The top fifty-five forecasters surveyed by the *Wall Street Journal* were even more optimistic—they thought unemployment would be 8.5 percent. In fact, unemployment for the year was 9.9 percent. The longer-term forecasts also missed the mark. In early 2009, OMB estimated that unemployment would drop to 5.6 percent by 2012. CBO was more bearish, with an estimate of 6.8 percent. But both forecasts were well short of the actual unemployment rate of 7.9 percent (see Figure 2.2).

And how did they miss it? CBO's own analysis is instructive.⁸ A quarter of the error came from a downturn that turned out to be even nastier than expected—but two-thirds came from a "reassessment of trends": CBO, along with most forecasters, just didn't see the emergence of the post-recession "new normal," with relatively slow economic growth and even slower job creation. The world had changed, at least for the medium term, and most of the forecasters didn't see it coming.

The computers didn't tell the forecasters that the world had changed. And the errors helped cook Obama's political goose before he was even sworn in. If the consensus economic forecasts had panned out, he would have been able to campaign for reelection in 2012 as a second Franklin D. Roosevelt who turned the nasty downturn around. Democrats running in 2014 would have been talking to a much happier electorate. He would have had a much more open field for policy initiatives instead of having the jobless recovery hanging around his political neck. At least for a while, the conventional wisdom was that Obama had lost his political mojo. This constellation of forces fueled the Republicans' takeover of Congress in 2014, and it set the stage for the epic fight for the middle class that helped shaped the 2016 presidential election. Hillary Clinton would have been able to connect with happy voters, and Donald Trump would not have had large, angry legions to tap into. All this flowed from how most private and public economists missed the call in late 2008.

FIGURE 2.2 • Unemployment Forecasts by OMB and CBO

Sources: Office of Management and Budget, *Budget of the United States Government: Analytical Perspectives—Fiscal Year 2010* (2009); Congressional Budget Office, *Budget and Economic Outlook: 2009–2019* (February 2009); Bureau of Labor Statistics, *Labor Force Statistics from the Current Population Survey* (Washington, D.C.: U.S. Department of Labor).

Note: Spring 2009 forecasts for unemployment for each of the next five calendar years, compared with actual unemployment.

We struggle to get foresight into what's going to happen. A lot of the time, we do pretty well. But sometimes the models fall short, and when this happens, the results can be large and devastating.

Results

Taking long looks back and making long predictions into the future aren't enough for policymakers. They need to be constantly alert to what's happening with the programs they run: to see trends as they are emerging, detect problems creeping into the system, find opportunities to do things better, and strengthen the implementation of government programs. This is the broad area of *performance management*: monitoring the operation of programs through sophisticated measures, in as close to real time as possible, and using that information to improve operations.⁹

For example, cities ranging from Louisville to Chicago have put restaurant inspection data online, so diners can see whether the spots where they eat are safe. The *New York Times* website has displayed a map showing the grades that restaurants received in their last inspection, and the inspection grades must be posted in the window of the restaurant, so diners know the safety of the establishment before they walk through the door. For example, it's possible to search on the map of central Manhattan and find all the restaurants with a grade of C on the city's

A-B-C scale (with A being the highest; see Figure 2.3). The evidence not only helps consumers. It also helps the city target its inspection efforts. At the federal Centers for Disease Control and Prevention, the PulseNet system allows the agency to track the outbreak of food-borne illnesses so it has an early warning of emerging problems—and can respond quickly.¹⁰

This strategy came from a dinner in a swank New York restaurant on a winter night in 1994. A seasoned New York City transit cop, Jack Maple, sketched out a plan—on a napkin—to revolutionize the city’s crime-fighting. Four principles, he said, could drive improvements:

1. Accurate and timely intelligence
2. Rapid deployment
3. Effective tactics
4. Relentless follow-up and assessment

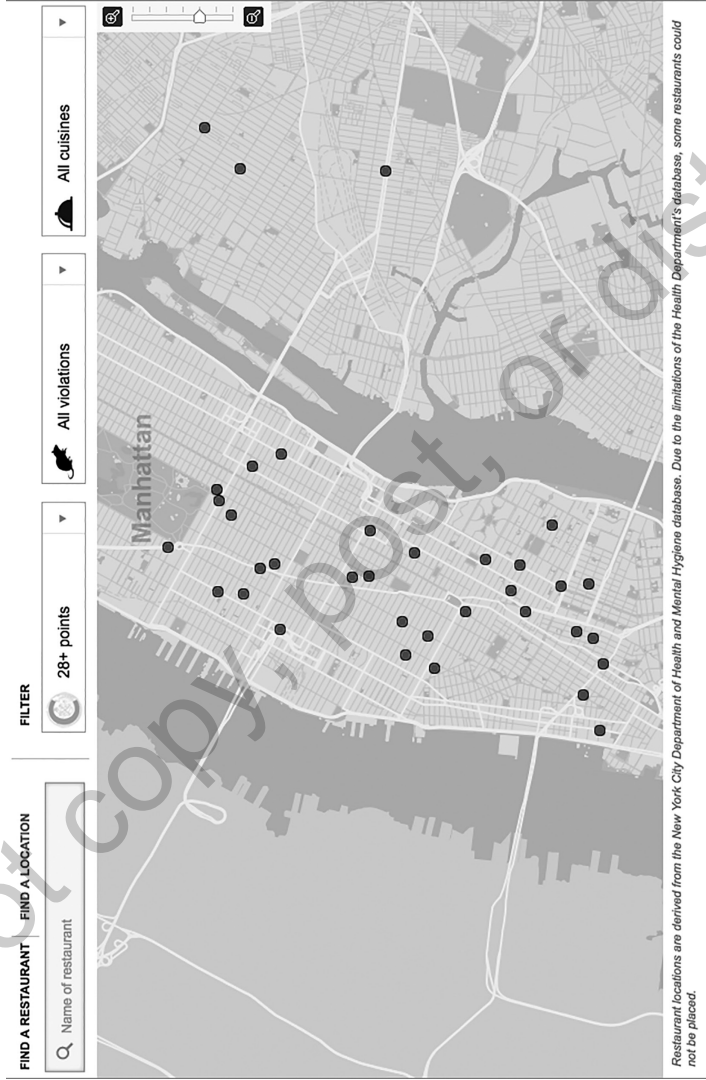
The plan, christened CompStat, was data-driven at its core. The “accurate and timely intelligence” shifted the NYPD to compiling long lists of crimes to place-specific maps, which plotted crimes as they happened instead of on reports months later. It moved the system from pins on a wall to sophisticated computer-based mapping. And in 2016 it took an additional step, with a new generation of reporting, which allowed the NYPD to track crimes block by block and to report up-to-date crime rates on the city’s website so its planners—and all citizens—could see the data (see Figure 2.4). CompStat, in turn, drove a vast revolution in improving the implementation of public programs by mapping what’s happening, and doing it in real time. It was based on the premise that better policy was nothing without better results—and that the backbone of producing better results was knowing more, faster, about what was happening.

Results, after all, are what matter most. So the key lies in being able to track them—in real time and in a clear picture.

Risk

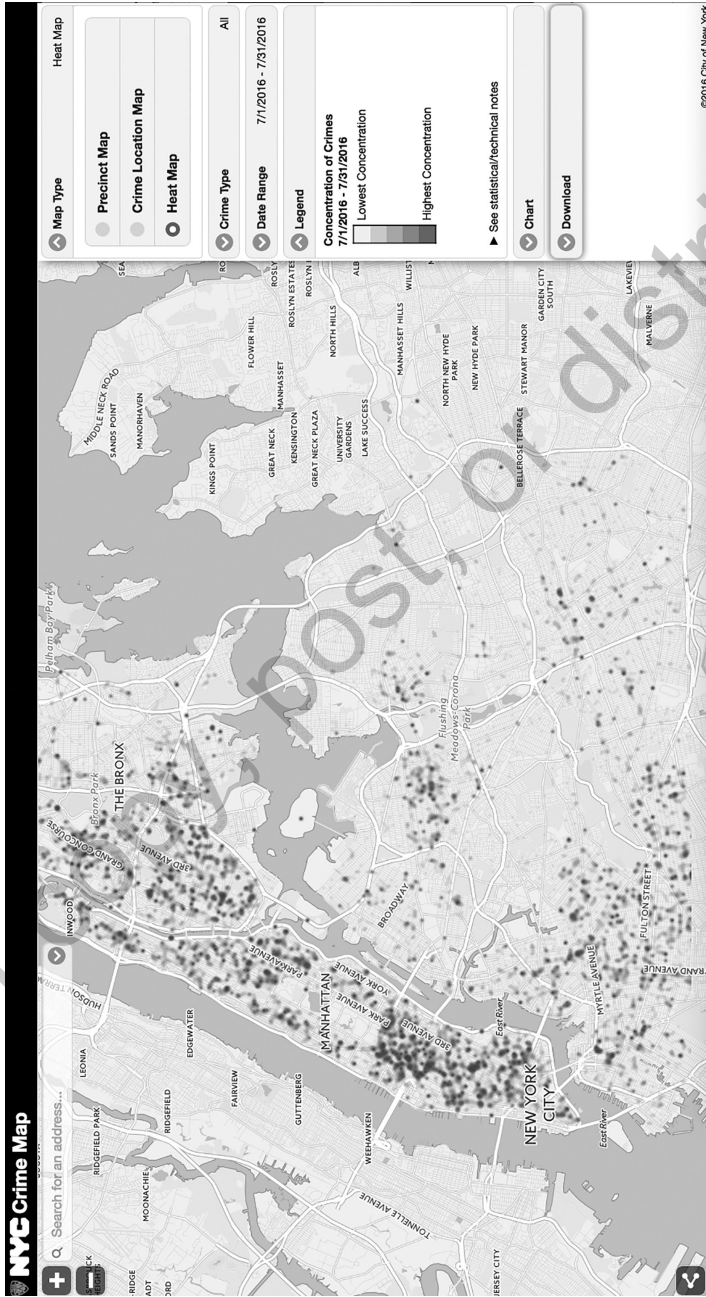
In August 2016, Michigan officials arraigned Liane Shekter Smith, the official formerly in charge of drinking water for the Michigan Department of Environmental Quality (MDEQ), for “willful neglect of duty.” Between April 2014 and October 2015, complaints mounted about water in Flint. In February 2016, the state fired her for poor performance. Governor Rich Snyder, without referring to Smith by name, said that “some DEQ actions lacked common sense and that resulted in this terrible tragedy in Flint.” Six months later, an investigator told the court that Smith had “intentionally misled and took affirmative steps to conceal from her supervisors at the MDEQ and the public the safety and severe health risk associated with using the water.”¹¹

FIGURE 2.3 • New York Restaurants with a Grade of C



Source: Jeremy White, "New York Health Department Restaurant Ratings Map," *New York Times* (screenshot on August 5, 2016), http://www.nytimes.com/interactive/dining/new-york-health-department-restaurant-ratings-map.html?_r=0.

FIGURE 2.4 • New York City Crime Map

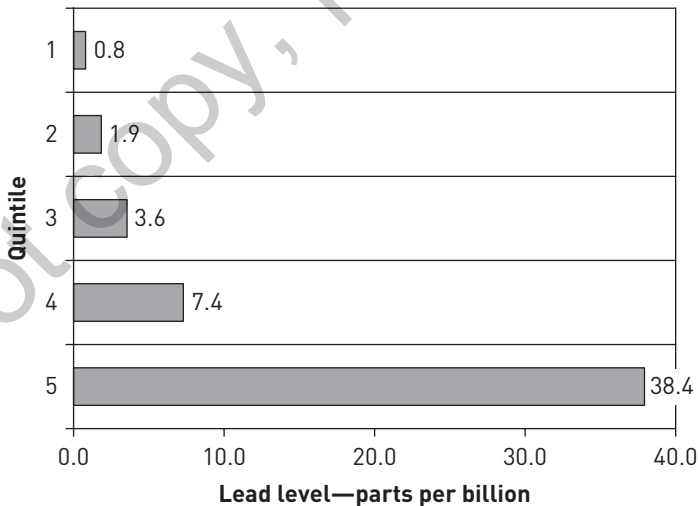


Source: New York City Police Department. Map is for the month of July 2016. The darker the color, the higher the crime rate in the neighborhood. See <https://maps.nyc.gov/crime>.

In April 2014, Flint switched from getting its water from the Detroit Water and Sewerage Department to the Flint River. Almost immediately, some residents began complaining that the water had a bad taste. At first, state and local officials argued that the water was safe. It took months for investigators to conclude that the water, in fact, had high levels of lead, which entered the bloodstreams of some of the city's children. Lead has been found to cause behavioral and health problems in children, and there's no known treatment. In Flint, 40.1 percent of the water sampled in 272 homes had lead at 5 parts per billion (ppb). Ten percent of the homes had levels of 25 ppb, well above the U.S. Environmental Protection Agency's 15 ppb limit that requires an intervention. Some homes were higher than 100 ppb—and in one home, the level was astronomical: more than 1,000 ppb, according to a study undertaken by Virginia Tech scientists, who helped break the story.¹²

The average lead level was 10.6 ppb, but one of every eight homes had lead above the EPA's standard of 15 ppb. Figure 2.5 shows the distribution of the homes in the study by quintile (that is, broken down in 20 percent ranges, with the lowest quintile being the first 20 percent of the homes in the sample and the highest quintile being the last 20 percent of the homes). The top quintile of homes, on average, had lead levels of 38.4 ppb, more than twice the EPA's limit. This was, to put it simply, a huge public health crisis.

FIGURE 2.5 • Lead Exposure Levels in Flint Water Supply



Source: "[Complete Dataset] Lead Results from Tap Water Sampling in Flint, MI," Flint Water Study (December 1, 2015), <http://flintwaterstudy.org/2015/12/complete-dataset-lead-results-in-tap-water-for-271-flint-samples>.

It was a tragedy that so many children had been exposed to such high levels of lead. This was a problem that they would have to deal with for the rest of their lives. But it was a tragedy that could have been foreseen, since lead exposure in drinking water is a known issue. The EPA has set lead and copper limits in drinking water since 1991. If lead in the drinking water exceeds the 15 ppb level in more than 10 percent of the water taps, federal regulations require water suppliers to take action. In Flint, the number was 16 percent. Experts later concluded that the problem could have been completely prevented had the community used corrosion controls in the new system. An engineering professor at the University of Michigan, Glenn Daigger, said, “That is absolutely something that should be provided.”¹³

The result was a huge problem. Children had been exposed to lead in their drinking water. State officials looked the other way as evidence about the problem mounted. Scientists plaintively called for action as their tests showed high levels of lead. Installing the corrosion prevention system in advance would have prevented the problem. Experts in the field have long known about the risks of lead in drinking water, and they’ve known that corrosion protection systems can effectively treat it. But the state and local officials decided not to install such a system.

In short, this was a failure of risk management: the process by which experts assess a decision, in advance, to determine what problems might result from the decision. Sometimes risks are obvious only after they occur.¹⁴ But anticipating risk is very often possible. So, too, is avoiding it—or, at least, reducing the costs of problems when they occur. Experts point to six steps:

1. *Get the leaders on board*, since nothing can happen at all unless the top officials are committed to looking down the road and preventing problems before they happen.
2. *Identify risks*, especially by establishing a culture inside the agency to look for risks instead of trying to duck potential problems for fear of criticism.
3. *Assess risks*, particularly by building an understanding of what causes the risks and what the organization needs—in budgets, information technology, expertise, and other resources—to attack them.
4. *Develop an action plan* by creating a response to risks that fits the organization’s mission and culture.
5. *Monitor risks* so that organizations and their leaders are not surprised and so they can detect and prevent problems while they are still small and more manageable.
6. *Communicate about risks*, to both elected officials and citizens, so that more transparency into operations increases confidence that the organization can tackle the problems it faces.¹⁵

In Flint, officials did not work thoroughly to identify risks in advance. When evidence began to surface about lead in the drinking water, they first ignored it, then were not sure whether to believe it. Only when outside investigators produced proof did they begin communicating about the risks and begin to act—and by then it was too late. Children had absorbed lead into their bodies and it will not go away. In contrast, the U.S. Transportation Security Administration has an aggressive risk-management system that focuses on identifying the full range of risks that could get in the way of its ability to protect flyers when they board airplanes. The National Institute of Standards and Technology even surveyed its top executives to determine their appetite for risk, which helped the organization determine how much risk it was likely to be able to take on—and where a somewhat lower appetite for risk among top managers made it harder for the organization to innovate fast enough to stay ahead of tough, complex technology issues. Working hard in advance to identify risk—and then equipping the organization to deal with it and staying ahead of a quickly changing world—can help government organizations perform much better. It can also help avoid actions like the ones that crippled Flint’s water system.

Resilience

An important part of knowing is learning how to bounce back when things go wrong—and try as we might, they inevitably do. No one intended for government at all levels to stagger in responding to Hurricane Katrina in 2005, and the Obama administration surely never intended for its flagship health-care program, the Affordable Care Act, to fall flat on its face at its launch in 2013.¹⁶ But smart policymakers know that, try as hard as they might to answer the first four questions, it is hard to escape the fifth: What to do when things go wrong?¹⁷

No one wants to imagine that failure can occur, let alone plan for it. NASA’s long-term flight director Gene Kranz, in fact, wrote a book titled *Failure Is Not an Option*.¹⁸ The movie *Apollo 13* made Kranz and his slogan famous, as NASA worked furiously to bring back the crew flying in a badly damaged spacecraft. But smart policymakers know that no program completely succeeds in fulfilling everything we want it to do and that failure is often not only an option—it sometimes is inescapable. Some of that, especially in public programs, is because our ambition leads us to reach far (sometimes too far). Some of that is because we can never completely answer these questions. Foresight is surely never perfect, and hindsight is only 20–20 when it’s too late. It’s hard to know what results we’re producing or what risks we’re taking. When the first four questions fail, policymakers must turn to *resilience*. As Judith Rodin explains in her book *The Resilience Dividend: Being Strong in a World Where Things Go Wrong*, “Resilience is the capacity of any entity—an individual, a community, an organization, or a natural system—to prepare for disruptions, to recover from shocks and stresses, and to adapt and grow from a

disruptive experience.” And the stronger an entity’s resilience, the better it’s able to bounce back when bad things happen. That, she says, is the “resilience dividend.”¹⁹

Resilience is a tough challenge to attack. Big problems often bring big risks, and when they lead to failures they cause even larger recriminations (“How could you have allowed that to happen?” and “Why weren’t you smart enough to see this coming?”). Spending money in advance, like fortifying the levees in New Orleans to prevent massive flooding after Hurricane Katrina’s onslaught in 2005, can seem like a waste if there’s no imminent crisis. Building political support to look far down the road, to tackle little problems before they become big ones, can be hard for politicians whose vision stretches only to the next election. (This is a spinoff of the economists’ notion of discounting: citizens value benefits now more than benefits down the road.) But there’s one inescapable fact: it’s almost always cheaper to spend a little money in advance to help avoid or mitigate problems, than to clean them up after they explode. For instance, the Global Resilience Partnership concluded that 47 percent of all weather-related disasters are due to flooding alone.²⁰ It’s impossible to stop all floods, but careful planning of projects like dams, drainage, and levees can go a long way toward reducing the damage when big storms occur.

For example, in 2004, just a year before Katrina savaged New Orleans, the Federal Emergency Management Agency ran a simulation of the impact of a big storm, christened “Hurricane Pam” for the exercise, on the region. The exercise predicted that such a storm would push water over the levees and submerge much of New Orleans.²¹ For example, after Hurricane Katrina’s devastating assault on New Orleans in 2005, the Federal Emergency Management Agency did a careful review of the areas of the city most at risk for flooding in another storm. The result was a new set of maps, produced in 2016, which highlighted the neighborhoods that could find themselves under water in a fierce storm—and where homeowners would be required to buy flood insurance (see Figure 2.6). But this new review also raised big questions for some New Orleans residents, because FEMA removed many neighborhoods from the flood plain. New flood control systems built after Katrina offered residents much more protection, and FEMA took them into account in drawing the maps. That was good news for the city, which was working hard to lure home buyers back into areas that Katrina had devastated, and many developers had lobbied hard to shrink the flood plain. Analysts warned, however, that the shrunken flood zone didn’t necessarily mean that homeowners should drop their insurance. Another Katrina-sized storm could damage their homes yet again and, without insurance, they could face devastating losses. Resilience means planning for risks and taking the best actions to minimize their costs, on questions where there seldom are black-and-white answers. In a city like New Orleans, however, where so much of the land is near or below sea level, deciding where to draw the line is a difficult and contentious decision.

FIGURE 2.6 • FEMA Flood Information Portal Risk Map of New Orleans



Source: Federal Emergency Management Agency.

It's not easy, either politically or economically, to plan for resilience. But the tale of Katrina shows that we often know enough to do better—and that doing better sooner is a lot cheaper than trying to catch up after disasters strike. It's just hard to build the case, both politically and budgetarily, to do what needs to be done.

What Is a Good Answer?

We started this chapter by asking: What are the right questions? There are five: hindsight, foresight, results, risk, and resilience. But as we explore them, what

are good answers? As we'll see in the chapters that follow, good answers not only help us with these five issues. They also help us deal with three big, overarching puzzles:

- *Silos of information.* The key to effective problem solving, as we've seen in this chapter, is information. But too often, the information we have is trapped in "silos of information," as G. Edward Deserve puts it—evidence generated within individual agencies and programs and that often fails to connect with larger problems.²² No problem that matters any longer fits inside any one agency or program.²³ If we're going to find good answers, we need information that isn't trapped in agency or programmatic silos. We'll explore how to help evidence escape and drive good decisions.
- *Provide convincing answers to important questions.* In part, this is a problem of doing good research that meets the standards of careful analysis. Randomized controlled trials, for example, provide a guide for how to assess which results are real. So, too, do the significance tests that accompany data analysis. But, more broadly, we need evidence that is convincing, that provides solid answers to the questions that policymakers are asking—or need to ask—in ways that give them confidence to move forward. We've built the foundation for attacking the problem in this chapter, and we'll explore it in more detail in the chapters to come.
- *Deal with values.* In the end, answering each of these five big questions means sorting out the values that policymakers—and citizens—believe in. Evidence can help shape these values. Values, on the other hand, are often the prism through which policymakers look at evidence. One of the most important contributions that good evidence makes is to bring greater power and transparency to this fundamental puzzle. What values are we trying to advance with the policy decisions we make? How well are we doing to advance those values? Are there things we could do to improve our results?

Greater transparency through better evidence can help us attack these questions better. It can, of course, also heighten political tensions by shining a bright light on value conflicts that otherwise might have more comfortably stayed hidden below the surface. Sometimes policymakers don't really *want* to know the answer to these questions because the answers can force them to resolve more difficult problems. But as trust in government plummets and budgetary resources get tighter, burying tough problems only tends to make the big challenges worse. And with a bit of skill and some occasional luck, knowing better can help everyone involved work through these tough questions. In the next chapter, we'll explore how *telling the story* can help contribute to this process.

Notes

1. For an exploration of several of these questions, see G. Edward Deseve, *Enhancing the Government's Decision-Making: Helping Leaders Make Smart and Timely Decisions* (Washington, DC: Partnership for Public Service, 2016), http://www.businessofgovernment.org/sites/default/files/Enhancing%20the%20Government's%20Decision-Making_0.pdf.
2. See, for example, Kathryn E. Newcomer, Harry P. Hatry, and Joseph S. Wholey, *Handbook of Practical Program Evaluation*, 4th ed. (San Francisco: Jossey-Bass, 2015).
3. Ian Lovett, "In California, a Champion for Police Cameras," *New York Times* (August 21, 2013), <http://www.nytimes.com/2013/08/22/us/in-california-a-champion-for-police-cameras.html?smprod=nytcore-ipad&smid=nytcore-ipad-share>.
4. Laurie O. Robinson and Jeff Slowikowski, "Scary—and Ineffective: Traumatizing at-Risk Kids Is Not the Way to Lead Them away from Crime and Drugs," *Baltimore Sun* (January 31, 2011), http://articles.baltimoresun.com/2011-01-31/news/bs-ed-scared-straight-20110131_1_straight-type-programs-straight-program-youths.
5. Anthony Petrosino, Carolyn Turpin Petrosino, and John Buehler, "Scared Straight" and Other Juvenile Awareness Programs for Preventing Juvenile Delinquency (Oslo, Norway: Campbell Systematic Reviews, 2004), 34, https://www.campbellcollaboration.org/media/k2/attachments/Scared_Straight_R.pdf.
6. Elly Yu, "At 'Wit's End': Scared Straight Programs Remain Popular among Parents Despite Warnings," *Juvenile Justice Information Exchange* (May 9, 2014), <http://jjie.org/at-wits-end-scared-straight-programs-remain-popular-among-parents-despite-warnings/106811>.
7. This section is based on my essay "Obama's Pre-Cooked Goose," *Washington Monthly* (January 22, 2015), <http://washingtonmonthly.com/2015/01/22/obamas-pre-cooked-geese>.
8. Congressional Budget Office, *Revisions to CBO's Projection of Potential Output since 2007* (Washington, DC: Congressional Budget Office, February 2014), 3, <http://www.cbo.gov/publication/45150>.
9. For an analysis of performance management systems, see Robert D. Behn, *The PerformanceStat Potential: A Leadership Strategy for Producing Results* (Washington, DC: Brookings Institution, 2014).

10. See Centers for Disease Control and Prevention, PulseNet, <https://www.cdc.gov/pulsenet>.
11. Jim Lynch, "DEQ Fires Worker Who Supervised Flint's Water," *The Detroit News* (February 5, 2016), <http://www.detroitnews.com/story/news/michigan/flint-water-crisis/2016/02/05/flint-water-crisis/79888340>; Jim Lynch and Jacob Carah, "Attorney: Ex-State Water Regulator 'Did Nothing Wrong,'" *The Detroit News* (August 3, 2016), <http://www.detroitnews.com/story/news/michigan/flint-water-crisis/2016/08/03/flint-water-court/88005426>.
12. "Lead Testing Results for Water Sampled by Residents," <http://flintwaterstudy.org/information-for-flint-residents/results-for-citizen-testing-for-lead-300-kits> (from the intensive analysis performed by Virginia Tech scientists led by Dr. Jeffrey Parks).
13. Lynch, "DEQ Fires Worker Who Supervised Flint's Water."
14. Stephan Braig, Biniam Gebre, and Andrew Sellgren, *Strengthening Risk Management in the U.S. Public Sector* (Washington, DC: McKinsey & Company, May 2011), 1, https://www.mckinsey.com/~media/mckinsey/dotcom/client_service/Risk/Working%20papers/28_WP_Risk_management_in_the_US_public_sector.ashx.
15. U.S. Government Accountability Office, *Enterprise Risk Management: Selected Agencies' Experience Illustrates Good Practices in Managing Risk* (December 2016), <http://gao.gov/assets/690/681342.pdf>.
16. For the story of how this happened, see Donald F. Kettl, *System under Stress: The Challenge to 21st Century Governance*, 3rd ed. (Thousand Oaks, CA: CQ Press, 2013); and John Tozzi, "How Healthcare.gov Botched \$600 Million Worth of Contracts," *Bloomberg* (September 15, 2015), <http://www.bloomberg.com/news/articles/2015-09-15/how-healthcare-gov-botched-600-million-worth-of-contracts>.
17. See Louise K. Comfort, Arjen Boin, and Chris C. Demchak, eds., *Designing Resilience: Preparing for Extreme Events* (Pittsburgh: University of Pittsburgh Press, 2010).
18. Gene Kranz, *Failure Is Not an Option: Mission Control from Mercury to Apollo 13 and Beyond* (New York: Simon & Schuster, 2009).
19. Judith Rodin, *The Resilience Dividend: Being Strong in a World Where Things Go Wrong* (New York: Public Affairs, 2014), 3.
20. Global Resilience Partnership, <http://www.globalresiliencepartnership.org>.
21. Federal Emergency Management Agency, "Hurricane Pam Exercise Concludes" (July 23, 2004),

<http://www.fema.gov/news-release/2004/07/23/hurricane-pam-exercise-concludes>.

22. Deseve, *Enhancing the Government's Decision-Making*, 22.

23. Donald F. Kettl, *The Next Government of the United States: Why Our Institutions Fail Us and How to Fix Them* (New York: Norton, 2009).

Do not copy, post, or distribute