

Panelists:

James Bell

Please note: The following is a direct transcription and has not been edited.

James Bell: My name is James Bell. And I'm a Program Evaluator by trade. I was at the Urban Institute in the 1970s. And I was part of a multidisciplinary group that developed logic modeling and evaluability assessment and other tools that became kind of ubiquitous in evaluation.

And after five or six years at the Urban Institute, I ended up kind of accidentally, it wasn't really worth great intent starting a private group that did the same thing, pursued multidisciplinary evaluations, strategies that involve logical modeling, strategies that involve combining disciplines, clinical disciplines, social science disciplines, even law and other areas that operations research that were part of trying to understand how programs work and how you evaluate their outcomes.

I was always the person that was obsessed with the independent variable, people talk about outcomes and outcomes are great. But, is the independent variable actually working? How does that really work? Can we really scribe outcomes to the independent variable? So, that has always been something that I've been fascinated by and when we talk about cost evaluation, we think of dollars. But, the reality is to evaluate cost, you actually have to evaluate how labor is distributed and used because labor drives costs, without understanding how labor is distributed, you can't be very precise about how costs are distributed.

So, at the end of the day, you spend most of your energy as well, I'll talk through in a little bit later, you spend most of your energy trying to understand how labor is distributed. So that then you can assign a value to that labor and call it cost.

The assigning value part is not the tricky part; the tricky part is getting a handle on how labor is actually used. And that is something that we're not very good at, we're not very good in medicine, which is a field I work in a lot, we're less good in the Child Welfare arena and other human service arenas where we don't have such elaborate billing systems, at least in medicine we have claims, of course claims have their own issues, but we at least have claims. In Child Welfare, we've really only have a few items that are easy to associate a cost with like foster care reimbursement payment or something like that.

So, I'll give you a little background on my interest in cost, I was always, as I say, obsessed with the independent variable. And as I moved through my career, I got more involved with health economists because it became clear that in medical science and health services research effectiveness and cost effectiveness had to be understood with regard to the cost side and the effectiveness side.

So, I was fortunate enough to work with a lot of really esteemed health economists, macro people and micro people, people that took claims, data and reconstructed what actual experience and episode was like for an individual, patient, people that try to analyze new interventions and understand what the cost effectiveness was. So, I've had the benefit of those experiences for over 25 years just working with great economists. What we're doing in Child Welfare is just really borrowing a lot of the same ideas and trying to bring them into the Child Welfare arena.

So, what are we really interested in? Well, cost evaluation informs program management and policy decision making, everybody wants to know is it worth it? How much does it cost? Do I have the money that to pay for it? And any new intervention or new change to a program has some associated cost. And people want to know what that might be. For example, there's a lot of emphasis on the evidence based interventions and people want to know the future adopters want to know whether the evidence based service model, how much it cost? What's it going to really take to implement this new program? What's it going to take to run it? How much effort and how much labor do I need to devote to it?

So, those are basic reasons, there are lot of kind of ancillary reasons, but the two drivers are really to inform program management and policy decision making to make good rationale choices about how we use our resources.

What are the basic terms, well, costs we think of as a dollars. So, it's the amount of dollars spent. But cost immediately starts breaking down into pieces into big chunks. Well, one chunk is the direct cost. I'm seeing a client, the cost of my time for the 45 minutes, I spent with the client is a direct cost. Now, maybe I collaborate with a clinician, a psychologist, a child psychologist that I'm talking to about this particular case or maybe I talk and work with a substance abuse treatment expert or mental health expert to talk to about the case with the features and characteristics of the parent.

Those, all those discussions, all of that effort is direct, it's directly applicable to that case. But, at the same time, there are other costs, there's a management team making sure that the infrastructure that I'm working within is working, making policy level decisions, there's facilities, there's a lot of other aspects of cost that are not direct. So, we immediately make distinction between direct and indirect costs.

There's other kinds of cost to, because when we really think about cost, we might say well, there's a cost to the client, you know, the clients time is worth something, so that's a cost, there's opportunity cost, I did my, I used my labor this way, what it would have been, would it have been better more then official, more efficient to use it in other way.

So, there are issues, but the key first level concerns are, direct versus indirect. And so, those direct costs are, cost that can be assigned to a particular case, it's almost always labor is the main driver. But there are things like transportation, there are other costs like

reimbursement and foster care, other things that could be assigned directly to a case. And then there are indirect costs that aren't identified specifically to a particular case.

Fringe benefits for the workers, you know, for the caseworkers and the staffs are an indirect cost, they're not assigned to a specific case. So, they're composed of cost categories, if you've seen a budget, you know, the budgets typically breakdown by personal, they might have a fringe benefit line, they might have a facilities and equipment line, they might have a supply line, they might have a telecommunications or supply line. But, budgets tend and we call those things line items. So, budgets tend to breakdown by lines, which is fine that's how budgeting works.

But, we don't necessarily know and can't starting out with the budget, we can't disaggregate the personal line by, how much of that effort went to a specific case or even to a specific function necessarily. We might have the budget by units in the agency. But, we, and we have an idea of how much each person cost in a budget, in the budget detail. But, we don't have an assign to meaningful programmatic activities or categories.

These are really, usually called line items and they're recorded on budgets and financial statements. As I said and I'll repeat many, many times labor is what the driver is, labor is the driver for cost and service of health and human service programs.

So, what are the methods, well, the first method is really straightforward and really powerful, this is another, you know, kind of mantra that I have. And that is that often times we skip over simply describing something empirically, we want to jump to some sophisticated multivariate model. And often times, we miss obvious straightforward important things that have either policy or program management importance because we didn't really look at them descriptively. We said, okay, I'll turn it over to the status station or the multivariate modeler and they'll figure out what variables go in and we'll do some kind analysis. But, there are a lot of descriptive things that would be powerful if we just saw that.

So, the first thing at least from kind of my point of view and what I preach is that the first thing is to really look at descriptively what you found, what is that say intuitively, we can analyze it more in depth. But, what are we actually finding descriptively, can we describe the cost? And we then want to understand how cost distributed across categories. And we can analyze cost usually at two levels. Today we're talking about case level cost analysis. But, there is a movement because it's a lot less expensive to try to analyze cost with the program level. And maybe, we'll talk about that later, but I'm going to stay with case level for this, for the current discussion.

Well, we all hear about cost effectiveness analysis and in health services research and medical research, the definition for effectiveness is a randomized controlled trial, it is that's the standard, you can't even do effective cost, effectiveness analysis unless you have the results of a randomized controlled trial that meets high level criteria. So, that standard is relaxed a lot, in a lot of fields. But, we throw around in terms like cost effectiveness kind of arbitrarily and we should be reasonably clear that effectiveness

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means that you've ruled out, you know, counterfactual, you've ruled out that this effect didn't happen by chance, but happened because of an intervention and that requires a kind of controlled trial.

So, anyway, but we still throw the term around. Ideally, you want to have measure of effectiveness and then you can calculate the cost per unit of effect. So, if it's a decrease in child maltreatment events, we can end up trying to figure out what the cost per saved maltreatment event really is or in other words what the saving is for preventing a maltreatment event. We can conceivably go there with cost effectiveness analysis.

Cost utility analysis is like cost effectiveness analysis except effectiveness is measured in changing mortality, survival. Now this came out of a health services research field because we understood, we start to understand about 20 years ago that there were a lot of improvements in life that were improvements, but weren't being captured by mortality statistics. So in other words, I work a lot in HIV and I've been heavily involved in research in HIV with regard to treatment in here and since the Meds came out in the early 90s late 80s.

And what we understood right away was that these Meds were radically improving lives of people that to Meds. They not only did they not die but their quality of life was greatly improved. So, HIV medications are the single most powerful medical intervention in the history of man.

And the reason for that is the number of quality adjusted life years that have been saved by those medications, today and people are still living. So, what we think about in health services is we talk about quality of life adjusted years. So, we started working in this area in cancer research in the 80s, when we realized that new treatments, even though they weren't saving lives necessarily, the life expectancy of colon cancer patient wasn't decreasing. But the quality of that person's life was improving dramatically for their survival years.

So, instead of going into a nursing home because of the surgery because the surgery made them in content, they came out with micro surgery, were back at work within a month or two and had a few years of relatively high quality life before cancer actually claimed their life, if they were died of cancer. So, all that became understood and that's why this whole cost utility analysis then became very important in health services research.

Cost benefit analysis is really monetizing the benefit. So, you can compare the cost versus the monetize value of the benefit. So we'll talk about that. Benefits are expressed in monetary units, which allows for easier comparison of results across programs. So, if you have a bunch of different kinds of outcomes or different kinds of effects and you monetize the effects then you can say, oh, over here I'm getting a higher cost benefit ratio actually a lower cost benefit ratio, like cost is lower and my benefit is high, so good. So, that's and we can look across programs that has a lot of implication for policy.

And return on investment analysis, we're now investing 1.4 billion in home visitation programs, a hundred, these are things I'm working on, a hundred million in shortening foster care space. Well, at the end of the day, we'd like to know what the return on that investment was, and there's ways to talk about that, it's the way you would manage a big initiative, you want to know at the end of the day, we put in this much money. Well, what's the difference? Why do we think about when we think about return on investment? Drug companies do this all the time, they think about the cost that went into basic research to create the drug, the cost that went into clinical trials to prove the drug with safe and efficacious.

And then those costs are rolled in with the cost of creating of manufacturing the drug, distributing the drug, selling the drug. So, it's a really global picture of investment, it doesn't just start. So, if we have an intervention in Child Welfare like home visitation where people have been spending years and years studying and developing evidence and models to really understand the return on investment, we want to understand the whole investment up to that point where we're seeing a return on that investment, not just the cost of operating one particular program and one particular setting. So, it's a much more global perspective on cost. Obviously, it's not as precise as measuring cost effectiveness, but it takes those kinds of measures and tries to treat them in a higher level.

So, why collect case level, cost data. Well, first of all, the assumption that all cases cost the same even if there's supposedly receiving the same intervention is totally bogus. We can prove that. And I'll show you data. So, that's a start. So, if cases vary widely in terms of their costs then it's important to understand what predicts that, what are the drivers of that variation and reduce research in HIV aids, we find that the high cost patients aren't necessarily the most successful patients. And then in fact, some very low cost patients succeed very well.

And so, then we learn that we should just get out of the way that's some of the low cost patients don't need, you know, a huge intervention and social support, a huge intervention and ancillary support services, they just need to be in power to pursue those services and their costs are relatively modest. Other patients seem to need a lot of extra support to be our focal point in my work is adherence to HIV medications. Some people need somebody standing over them directly observing them taking the Meds, others simply need to be educated and they will take care of themselves.

So, those costs are wildly different even though the outcome is the same and even though the programs they try to intervene are very similar, what you wouldn't want to do what we call directly observed therapy standing over somebody to make sure they take their Meds for every patient, if you don't have to. And by understanding the variation in cost per case we're able to back into strategies that say hey, this is where we should spend the money, these people don't need as much money because they're engaged, they're self fulfilling, they're pursuing it on their own, it's very respectful actually, it's actually very paternalistic to think that everybody needs the same thing.

So, the other thing is, measuring at the case level allows to get inside the black box of an intervention to understand what's happening at the case level is really opening up what's, what kind of, what dose of service did each case receive that's a very powerful in and up itself. So, that allows us to use as a variable in outcome analysis, the dose of the intervention, so in other words if you've got more did it make any difference?

I just explained an example where getting more didn't mean, necessarily make that much difference, you could have gotten less and still had a good outcome, those kinds of analytic results have huge implications for how you setup and run programs, how you run agencies, how you distribute caseloads that's kinds the kind of information that you get out of case level cost data. And it can improve our ability to do multivariate statistical analysis because now we have more refined variable of the intervention because typically we assign people and we say, these people got it, these people didn't. And we do analysis that are called intent to treat, which means we compare the average for the group that got it to the average for the group that didn't get it. And what usually happens is there's no effect or the effect is very module.

And we're stuck, if there's no effect and we spent \$10 million figuring this out or that there's no effect, I mean, how is that helpful. If we measure inside the black box, we might be able to figure out that the intervention did in fact work for some people, but on average it didn't work. And we can isolate what those cases look like, what the treatments were for those particular clients and we can say, oh, the next step is to focus on that. And not include people who would doesn't work for, that's a simple strategy. We now always have this figured out and measuring in new areas, measuring the services received at the case level allows us to do that kind of analysis.

So, what do we do when we try to measure, we have to start defining meaningful categories, we have to identify types of services. And we think of those in terms of modes, was it face to face? Was it by telephone? Was it, you know, with the client present, without the client present? We think about the distinction between services that are done with the client present and services are done on behalf of the client, they're still direct in that sense. But, they're not, the client isn't actually present.

Every program has to be broken down into what those components are, you know, the typical human service program has some level of assessment engagement in the front end, some level of treatment planning and case planning, some level of counseling and support and follow up, and then continuing kind of maintenance in management of the case over an extended period in time. And possibly a termination of an intervention, maybe it reduces down to a monitoring level.

What we know all cases go through certain basic stages, but in every intervention, if it's a home visiting program, if it's a foster care prevention program, if it's child mild treatment prevention program, there are different sets of activities combined in different ways and that's what makes them unique. And we're all struggling to find the magic bullet that will help in all these domains.

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But, we have to understand what those activities and what those activities are that are required to run a program. We also have to breakout the administrative activities because administration is part of how programs operate and that's part of the cost.

So, what we do, well, we try to rely on cancer estimates of staff time utilization, labor, devoted to each activity for each case. And then, we try to multiply the labor or proxy for the labor by the dollar value of the labor, but not just the direct compensation, the loaded rate for that labor, what's loaded rate mean? Loaded rate is the compensation, the fringe benefits, the overhead and other costs that make it possible for that, let's say hour of labor to be delivered or allocated and used to work with the case. So, we try to calculate those and that yields a cost per unit of service, we add up all the units of service in that yields a cost per case.

So, we really, we are trying to get out how much does it really cost for a case, but the building block, the critical building block and hard piece is getting the labor. And nobody wants to do that, it's onerous. And we've tripped over this for decades, there are budget analyses, they don't really get out how labor is used on a case level. There are time and motion studies to figure out caseload sizes and things like that, but they don't really get that for into how activities are configured within a particular case, they're for different purpose.

The right way is to actually keep track of time, but that's incredibly onerous and burdensome to caseworkers, in other words, most agencies if you walk up and say, hey, we're going to ask that as part of this evaluation, you keep track of how you spent time on each case, the reception is very warm.

But, if we can, that's the ideal. Now, we're back, there are back ways to back up from that using focus groups to identify units of effort and using other proxies of effort to try to back into how much labor was expended. But, the ideal way, is to actually be able physically observe and which we can't do. But, stepping back from that to have reliable valid code, coding of how time was used. So, I've been involved in situations where we actually were able to convince agencies to keep track of their time for a period in time, so in other words it was onerous, but it didn't last too long. And that was incredibly valuable.

Speaker: Did you find that social workers that they...

James Bell: Yeah.

Speaker: Did you find that the social workers, did they tend to report accurately? Because, you know, I would think they would have the tendency to overstate or understate some activities than others.

James Bell: Yeah. Well, you know, it's hard to go back and then that is a flow, I mean, it's hard to go back and validate. But, it's also possible when you collect enough data to start understanding whether there's; you have to assume everybody is lying in the same

direction. And well, that's possible there could bias, if you have enough data, it starts to shakeout that you have a certain norms that are cropping up around activities.

So, in area like Child Welfare where we don't know that much, I think it's an important for step, it's just expensive. Now, I'm working on writing a report where we documented 1.77 million minutes. And I can distribute all those minutes across about 40 activities and about 2 or 300 cases. And I can understand exactly what's going on from a labor utilization perspective for those cases, but that meant about 80 people had to keep track of their time over a year. That meant they had to code each case, code each increment of time they spent with the case, but they were very diligent and did it. And we were very comfortable that they understood the rules and they seemed to do a good job of tracking. And we'll come to the example of that in a little while.

Speaker: I wouldn't think it would be so hard to get people to do this. I have to do this on a daily basis for me job.

James Bell: I know, and do I have to say time-out though because of this whole microphone thing, so, make your comment.

Speaker: Do you have any insights as to why it's hard to get people to do this because I mean for my job, I have to build everything that I do, it's a part of my job description. And I don't know, I mean, yes, it's kind of annoying. But, it's not overly burdensome, do you have any insidious to why people –

James Bell: Well, I think the distinction is that a lot of people work in environments where that's not their tradition. And they're busy and it's a new requirement, I mean, we once at a time study at NIH Intramural Research of use time. And it was a most unreliable time data I'd ever seen and the guys filled out the cards to make, look like rats and mice and Christmas trees, I mean, they obviously did not, it was outside their culture to keep track of their time and they were not going to do it and we did a little experiment to see if they could do it. And their bosses said we need this, we need this to prove to Congress that we need more equipment and equipment will save us time and energy and all those other stuff and they refused, I mean, you know, they were passive aggressive, yes. Maybe you can help with the – yeah, okay. Thank you.

Speaker: I believe some of the reasons if the initiative, if your pay is not based on what you have to tick tock on any kind of given day or sheet of paper, you're less likely to worry about it because I think the other DOAs, well, I work at state level and we use time studies, random moment time studies to distribute cost back to the federal government. Workers are not really concerned, they don't understand they've got, we ask them to do 10 or 11 things in the same moment at the same hour everyday.

So, when they have to pick and choose, do I go make a child safe, do I follow up with a contact or do I sit here and worry about what I just did in marking on piece of paper? So, we've tended to be a little more accurate because it's now in the system and it actually comes up when they enter into the this ICWA system, it pops up for them to document

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their time that day, back in the day when we use paper forms, we would get photo copied forms because, same thing every month, you know, because they would just fill out a times day, photocopy and send it in. So, that then gets a driving force to as if you're pay is not based on what you've got a document, you're less likely to worry about it.

Speaker: So, I'm sorry, I came in on, do you remember the term? I've got some more.

James Bell: So, yeah, it's a culture issue too, you know, as people, this is not part of what they normally do, so then it seen as a burden. So, then you have to incentivize in someway. So, but now we spent a lot of time looking for ways to get around that problem and that's why the idea of focus groups and interviews to try to isolate the amount of labor for specific times of activities is one of the ways we're moving forward.

And there is something happening in the United States that's based on work that's been done in Great Britain and it's called the cost calculator. And this is being tried in California and its being tried with funding under NIMH. And they're basically trying to create algorithms that will assign cost based on activities that occur within the case level.

So, as part of the work I'm doing and something called the permanency innovations initiative. I'm working on the cost, pardon me, the cost study for that, but in one county in California, they're trying to adapt and adopt the cost calculator from Great Britain and tested to see because if it's a successful tool then that's a saves a lot of burden.

But in an area where don't know much, we're going to have to systemic some burden to learn enough to be able to even make sure that the focus group results make sense because we're asking people to clump things in a focus group rather than actually observing and recording how they spend time. So, it's a little different approach.

Here is an example of desegregation of activities for the University Of Maryland Baltimore Campus, family connections intervention. This was an evidence based child maltreatment prevention intervention, the children's bureau funded a replication in eight sites, we went in and we convinced the grant Ts, the replication sites to collect detail data for one year, you know, for one year observation period to test whether was worth it and we bargained, we said, why you want to have to collect this other data during that year. So, we try to minimize the burden by trading some burden, you know, taking some burden away and adding some burden, of course the burden we had it was greater.

But, this starts to breakout activities and you can see there's service activities conducted with the client and I'm sorry I don't have the slide that shows the definitions of what each of these means. But, you can see counseling and support, at the end of the day. We know a lot of effort goes into that that's a big activity, services that are conducted on behalf of the client that means, a client isn't physically there, advocate without the client, schedule, travel, consult collaborate with other agency staff, case conferencing. When I worked in HIV the patients that I work with, all have HIV and little more bit psychiatric in addiction issues. So, they all meet criteria for HIV, they all meet criteria for DSM-IV

psychiatric condition, and they all meet criteria for DSM-IV drug or alcohol dependence. So, they're pretty severely symptomatic.

So, in order to treat a patient like that, you have to spend a lot of time across disciplines and specialties, the infectious disease docs and the psychiatrist and the addiction medicine specialists all have to work together with the social workers actually and the pure counselors to handle and help that patient.

And so, a lot of the work for every minute that somebody spends with that patient there's a three or four minute spent on behalf of that patient. So, and nobody pays for that because the way reimbursement is setup is about the face to face time, it doesn't even account for in general behind the scenes time that it takes to help manager complex case, well, Child Welfare cases are complex cases, no Child Welfare case presents with only one issue, I mean, you know, it's the same idea, they're all complex, complex symptomologies complex structures of issues that have to be addressed in some order and in some way. And it necessarily involves collaboration among case workers and different specialties.

So, this tries to break that down. These are administrative activities, well, you can see that, there some of them are really related to the caseworker, but not as a specific case like supervision, team meetings and some of them are pretty far removed from the actual case. But they're still necessarily, I mean, you still have to have an infrastructure, you still have to have management decision making, you still have to have the allocation of resources across units, you still have to have all those things, you still have to fight the policy brush fires, those are all part of the infrastructure.

So, these activities were ways of breaking down family connection into pieces. So, when we try to collect data, the best and most important source are the people that are actually doing the work because it's not what's written in the manual that's a starting point, it's what actually happens. So, we want to know what happens and what are meaningful categories at the worker level? We want to try you ask about try to convince caseworkers, the only way and we've done this in several different fields.

The way to convince caseworkers is for them to see the value and if they can see the value and they can get the feedback, the data itself is usually very valuable, it helps them case plan, it helps them manage their caseload, if you can setup a system that shows that feedback loop that shows the value of the information is going to be generated and how to help them do their job that's the strongest incentive structure you can build that's tough to do, but if you can't that's important.

Obviously, you don't want them being likely NIH intramural researchers and being passive aggressive, they've got to buy into it to make it work. So, you've got to try to build that commitment that's really the foundation for quality because the people don't want to do with the quality is going to be poor, if they're willing to do it or even engaged in doing it, the quality will be better.

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And then also, we're big believers and the people on the front line know and can interpret the data often times better than the social scientist doing the evaluation. So, when I do AIDS projects, I have like 58 patients, they review everything, they have tons of insides, they have tons of ideas about how and you should collect the data, how to engage people in data collection patients, they have a lot of inside. So, caseworkers have a lot inside, front line workers have a lot of inside, you can't just step over them if you're an evaluator, in fact it's incredibly rude and obnoxious to do that, they are living it, they have inside, you need to tap into that. That's a big mistake that a lot of evaluation staff make is they don't really capitalize on the inside that's available at the front line worker level or the supervisory level in the evaluations that they're doing.

So, we need to measure in some kind of the timeframe, you know, and the example I'm going to use today, we set, can you do this for a year, you know, so it was like one year. And then we had to get ready, so that then we had to come up with all the definitions, come up with all the forms, train everybody, get everybody organized to collect this data before their flag went down at the beginning of the year.

We have to ask questions, you know, when we pick a time period, we have to ask questions about things that might affect the results seasonal variations, you know, things that might be evident in a particular thing we're evaluating that would be important in selecting the time period.

So, I've already talked about this, I'll kind of skip over a bit. The key items are personal and non personal, we'll talk about non personal space utilities, travel those kinds of things and in kind services. In HIV, there's a tremendous amount of volunteer support. So, when we measure cost for HIV services, we try to capture the amounts of volunteer support that are provided to cases because that's a cost, that's part of the largest social cost.

And the time of the client or participant, I mean, if you've got someone that's spending a day in a training that's a client that's a cost of them, so that's part of the whole class to the intervention. So, we try to understand that.

It's important to understand exactly, if we're going to look at case level, cost data is important to understand when somebody entered a program when they leave it, it's very important to understand some of the key characteristics about the case because at the end, we want to do an analysis about what predicts different levels of cost, usually the biggest predictor is some factor associated with the client.

So, if we're looking at long term foster care, if a kid is, had a very unstable history of foster care entering a new intervention that's probably going to be a pretty powerful predictor of how they will do, host talk after that intervention has concluded, if they have serious emotional disturbances, that's probably going to be a big predictor. So, we want to know those things, we want to know the entry characteristics.

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Now, if you're doing an evaluation, you want to know that for other reasons, but if you're doing cost evaluation and not another evaluation, you'd still want to know those entry characteristics, it's really any variables that are expected to influence cost or influence the outcomes or the variables that we want to capture.

We have to prepare the staff, procedures, training, a pilot test period, shake the bugs out, a system of data collection, monitoring in management, you can't ask people to, the best way is to make data collection is real time as possible, make it as easy as possible. But, sometimes that's not as feasible, but that's the ideal.

Rules for coding, you know, what do all these activities really mean, when do you use this code versus that code that has to be worked out, you have to track, you have to have ID systems for staff and clients. When we measured family connections, we measured for each staff person that worked on the case. So, and if two people were working with the client at the same time then we can know that two people worked on it, and we knew which two people they were because the two people might have different costs. So, we try to figure that out, and you have to develop a plan for how frequently information on time is going to be reported.

So, here is a form that was used for family connections, every time there was an encounter with a client or on behalf of the client, a form was filled out. And it had codes, it had the encountered date, it had the duration and minutes. So, people worked in five minute increments even they work like high price lawyers, high price lawyers charged by five minute increments, if you're paying 700 bucks an hour every five minutes counts.

So, they had to hear to that top standard, they had to identify the mode, face to face, phone, written other, they had to identify the location, home, at the agency, and some of the, you know, outlet community, there's a program that I work within New York City that basically intercepts AIDS patients out in the community, they're hard to engage patients. So, they're very skilled that going into the community, intercepting people in parks, intercepting them at homeless shelters, intercepting them at food, centers. So, they can capture that and then the focus of the service was it use, was it dealt, and was it both.

Every time there was an encounter, one of these forms was filled out. And I can't remember the number of these forms, but it's, you know, tens of thousands. So, you also needed data repository to keep all the stuff and it has to be organized, it has to be organized by case, by worker, et cetera, et cetera. So, you can assign the cost eventually.

So, you end up with the database that's starts to look like this, there's a staff person, you can see, you know, the staff persons name as there we'd have a code, the case ID, the data, the service, the location of the service, the mode. And how many minutes were spent in different activities. So, you can imagine what this database would like, would have all the activities as fields and that would plug in the numbers of minutes in each of those activities. Then you could do an analysis where you could sort by staff person, you

could sort by case, you could sort by activity and you could figure out how much was invested in labor in each of these categories of activities.

So when we were finished we had a, like as I say about 1.77 million minutes. And that was only for a year and it was relatively small intervention, minutes, you know, add up very quickly.

And then you need the system of data quality and you know you talked about how do you know its reliable well there is a lot of internal validity checks we can program in, we can go back and we did go back and look at case records and say that this makes sense, does the case record look like the record that we are seeing, you know, it's not a one to one match because case records don't document us thoroughly as encounter records, but it's way of you know after saying they traveled.

And in the encounter records in tendency because most of the cases are more than 25miles from the agency and they didn't even leave the office that day then that raises real red flags about the validity of the data. So we can do some of that, you know, verification through samples but we can't check every case, but we can check every case statistically for logic error checks once we have the data. You know we talked about completeness, we asked supervisors to check and validate there is a whole system in place to make sure the data is...

Speaker: Where is this public agency?

James Bell: Yeah, these were child welfare, they were, oh yeah, go ahead. I'm sorry.

Female: That's okay.

James Bell: Well the question was where these public agencies. Well, they were agencies that provide child welfare services. So they were not necessarily your county child welfare bureau whatever that might be called in your local county, they might, that would be the agency that was under contract revive services for that bureau. So they weren't government employees as I think the key issue.

Well, and there are lot of challenges, child welfare arena has relatively unstable workforce compared to other arenas, so you have staff turnover, you have what we call data collector drift people just start to anticipate and they get bored and even when we do really elaborate clinical interviews with certified interviewers and video tape all the interviews, we still see drift, so you know there is going to be drift, so you have to have ways of reminding people to get back on course, you have to do quality control checks and you have to get the data back on course. There is you know just unexpected influences budgets, you know, budgets cut back sort of severe and a lot of areas and people are preoccupied by whether they are going to have a job. And so keeping the track of data falls down there list of important things to do and it's much harder to enforce any standards of data collection.

So they are contextual factors and then there are multiple sights you know most of the time when you are doing this you are trying to collect data across more than one agency or of it's a single agency it might have multiple service delivery sights, when we do this an HIV we always try to use the language of the local agency, there is a lot of you know behavioral groups so it might be the Thursday afternoon group or might be the purple Tuesday group.

Well, we use that language because training people to go oh, that's a pure led group therefore I should quote it as pure led group, is to honor us. We just say we go and we say okay what, how do you named your activities, and we use those names then we say oh that's a pure led group, oh that's a psychiatrist led small group focusing on managing depression symptomology or that's and it's pure education group. So we go and after the fact go out in the field and make sure we understand what all those groups are so we can create a cross walk but we don't try to make people use our terms because that's another barrier to getting accurate data and increases the burden.

Here everybody was working on the same replications so there was a common language even though the sides were spread across the country they were all trying to do the same thing so we could use a common form.

And then accounting for overhead will fringe benefits usually are established those rates, overhead rates are tricky most organizations have them sometime they are misleading, sometimes they're not. The cost of using creating rates is much greater so often times we just fall back to using the established rates, you know, at the end of the day I think it's not as important to know the overhead rates as it is to know what these direct cost are because if you are sitting in Kansas and you are going to replicate this model and you know that it's going to take X thousands hours a year per hundred cases for to provide these services, then you can decide and you have a better sense of what your cost structures are really like, if these are all masters level certified case workers then you know what that cost is and you know what your overhead is, it's just more if possible for you to built that up.

So from an evaluation perspective its good to know these administrative cost, but from future adoptive perspective you just need to know what those direct cost are because your cost structures is going to be different if you are in Manhattan you are going to be paying more, for rent, for labor, for all those things. If you are in Alabama you are going to be paying less, that's just the variation across regions in cost structures. So that has to be dealt with and, and but, but it isn't always you know it's not as quite an important as we sometimes think it is.

So what do we do in analysis, well I think I already hinted to this we want to understand descriptively what happened first and then work our way up to multi variant models in which the first levels of analysis are always cost as dependent variable what predicts cost, what is associated with cost and then we want to use cost as a deep independent variable in outcome analysis, thus spending more gets you a better outcome. Though that's a pretty basic question so we want to use that data in a couple of different ways, but at the

end of the day we want to focus on the relationship between per cost case and per cost outcome or and, per case outcome. So in another words we want to understand that relationship between cost and outcomes because that's what's going to inform decisions.

When I first started being an evaluator my job was to evaluate community team policing for the Ford Foundation that was an effort to put police officers out in the community to improve their network within the community both as crime prevention and follow up, we did it, we did an evaluation in which we actually tracked the activities of police officers and detectives and as the by product of the evaluation we discovered that they sent detectives to every incident to follow up, but they only added evidence in less than 5% of the incidents. So why are we sending them they take 80% or 60% of the police budget but they don't add any evidence they don't.

So we basically then started a new program called managing criminal investigations and the whole idea was to take, to reduce, to specialists, playing close detective works in other words then going to follow up on a bicycle theft makes no sense unless somebody knows who did it, unless they have a picture of who did it, there is not much solvability there. And that's really what crime is all about but by really looking descriptively where we start starting to understand that for some principles apply in other areas I mentioned the HIV cases where little interventions still produces big outcome if you know what kind of person you should back away from, other people need a lot of multi disciplinary intervention in order to be successful, in order to add hear to HIV and I'm sure its true in child welfare as well. So we try to work over way up to the statistical modeling but we should go through a process to get there.

You know we wanted people on the ground to be involved in the analysis there is always when you are looking across multiple sides there's always a lot of nervousness about sharing data and disobliging data so you have to work out data sharing and you have to work out privacy, you have to work out all those issues. You have to work out rules for publications if you are an evaluator you know everybody is always you know who is going to publish what, that has to be worked out ahead of time or you have to have a mechanism to do it so that there aren't, I work on a lot of big multi site cooperative research program funded by NIH.

And one of the biggest issues is if you got 50 principles investigators involved you have got 50 different publication agendas and they are all vying and so we have to set up rules, nobody can publish until certain things are done because you don't want the literature portraying the results of the big you know \$40 million cooperative research program from different perspective until you have resolved how you are actually going to analyze it.

When you analyze data that has clinical data and economic data in it you are actually using two, somewhat inconsistent or incompatible models of statistics biostatistics and econometrics aren't exactly the same, so you have to even blame those things so you don't want to start coming out with findings little piece meal findings that are going to be

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contradictory to the similar analysis. So you have to set up rules, you have to set up topics and let people have a committee that approves the publications.

Now that's you know that's for NIH and that's for health services research but the same principles would apply in child welfare research and evaluation.

So once we actually have all these data we start doing certain utilization analysis in which you have the types of units of labored that where developed here is some data you know the illustrative data this is just showing you duration and minutes of different types of activities. I think what's important is that you see that only about the quarter of the time actually went to direct and that's kind of consistent what we thought we see in the HIV world so that means about a minute of every 4 every minutes is spent on the direct service to the client, nobody want, that's kind of the elephant in the room that nobody wants to really deal with.

But that's the reality, here we can see direct versus indirect for a comparison and intervention group you know obviously they are very high the intervention is new and that took a lot of indirect effort because it was a new intervention you are coaching, you are collaborating across different, disciplines it was a more intensive intervention and care as usual which was comparison group so you see higher levels of total minutes.

You can break minutes down by different categories to see where the effort is going I'm standing in your way. You can see that counseling and support is the main thing which is what you would expect you know you wouldn't expect that transportation would beating a lot of the budget you would expect, that accessing advocating with providing counseling and support would be the main activities and they are validate through that kind of an example.

This is at the case level you can see there are multiple people involved in the case then represented by the three different colors, so you can start to understand who is involved and what kind of activities they are involved in if you are running an agency or you are running a unit this is useful information. This is really interesting because you can start to see how cases vary overtime this is how many minutes of service cases I think its 5 or 6 cases each line is a case but you can see how many minutes each case got per month and during that intervention and you can see its not like a steady straight line, and that's part of why it's so tricky to estimate cost and manage case loads, it's not that uniform.

I mean there is a trend in there and you can plot what the standard case looks like, but you can see there is a lot of variation. There is, a couple of cases at the bottom that just track along and go up. There is, a couple of cases that go up fast and then track down to the bottom and then nothing happens. So there is a lot of crises, there is a lot of inconsistency, there is a lot of you know, statistical volatility in the patterns of use of services.

So we can get all these information, we can understand the clients, we can understand the staff, we can understand what kind of qualification went into that labor, because of their

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more highly trained, they are going to be more expensive, we can understand their salaries and compensation. And we can establish unit cost factors, in other words in this project we establish the loaded rate for each person and so once we knew all the minutes we could multiply the minutes by the rate and figure out the cost, those are compensation rates for staff, how they build up. And so then we go on and continue doing these steps.

So I'm going to stop there I went longer than I had hoped, but I think, this is a new issue in child welfare. We haven't spent a lot of time, we have done random moment surveys, we have had cost analysis, components of evaluations, often times the cost analysis is focused at the program level, it hasn't tried to get down to the case level, so this is relatively you know new problem for the child welfare area. So we struggling with how we can approximate case level cost without the burden of timekeeping, that's really where the challenges because we can't do that on very large scale.

The burden is too high, and the cost is too high, but it's useful to have some of that data, in a data we got this particular project will be very helpful in helping us frame how we would approximate time keeping with focus groups and test peoples ideas for using, I think the big current big idea is to use focus groups a front line workers to identify units of service that they are providing under a particular program and talk about the duration and the amount of effort that goes into that unit. And then if there is convergence, if there is agreement good.

If there is a wild disagreement then you would follow up with interviews and observations to try to understand how that particular service varies in this there are way we can defined it as such in other words if a seriously emotionally disturbed kid is part of the case and the service is always 4 times more when that's a part of the case, then we can we can deal with that. But we can't deal without if you don't know in the way we are trying to do it now is to use focus groups to talk to staff, that's the model that has emerged as the less expensive alternative to actually keep in track of time.

Then we would ask people and this is what we are doing, we are asking people to simply track the units which is a lot easier, you know, we can show them a screen and say, how many units did you provide to this case, so it's just a check of, it's a much quicker, much easier but it still burdensome. It's not as burdensome as keeping track of time, as precisely as we did with the U&B family connections project but it's, it's still keeping track of units of service then we can assign time to the units, anybody else got any ideas because this is the issue and that's why I thought a round table would be nice. We can talk about your experiences in weather strategies for trying to deal with this. So you have been involved in cost, have you, what if you tried let's getting you the microphone.

Speaker: I work in the Vegas, in North Carolina.

James Bell: Okay.

Speaker: And I think you were providing some technical or JDA, providing technical support and all of this.

James Bell: Yeah.

Speaker: A number, of issues one of which is that the, in using average cost, the cost are highly eschewed.

Speaker: Right

Speaker: That is the, there are very small number of cases that take a substantial amount of time and the bulk of the cases take only a few minutes in processing that into the extent that you have shrewdness when you start looking at the average cost you kind of mask a lot of those things.

Speaker: Right.

James Bell: And the difficulty is coming up and being able to track exactly how much time you spent on each one of the cases. And I think fortunately North Carolina is I think the only state that requires 100% recording of minutes for they do cost allocation unlike other states where they do random moments sampling, North Carolina has worked with day sheet, but the problem with that is the important thing is the day sheet first be turned on the time, so it can be data entered. And second that its sounds that total number of minutes to 40 hours a week. So then you divide things up across there and they frequently who've done as supposed to being done daily or hourly or you know there is a couple of times a day we fill it out, at the end of the week I'm saying who did I see this week and how much time did I spend on it, because again our primary focus is on providing services.

Speaker: Right.

James Bell: Answering the phone, meeting with the supervisor, getting all the paper work turned in, getting the placement reports making sure all the other things. And then finally saying how did, I spend my time in that, so it was a difficult in terms of trying to do that. The other thing was in breaking down the granularity of what it, what type of services in North Carolina the service is reported in broad categories like CPS investigation.

Yeah, in home services in case management and sometimes certain case management activities are not recorded at the case level, they are at the child level. They record were investigation in an home services are at the child level or not accounted forward to you, you know case management is aggregate is average to cross all of your cases. So there are difficulties in terms of doing that, but the other thing where you actually paying for something like maintenance cost through out of home services are easy to track in terms of being able to go through that.

Speaker: Yeah, they leave the auditable trail that.

James Bell: Yes.

Speaker: That you can pick up on.

James Bell: Yeah, anything that you have that there were check is written is easier much easier to follow in terms of doing that.

Speaker: Well, that's goods. So then in North Carolina they actually track time but I would assume that problem one or the other problems mean you mentioned some of the problems but, would be just the granularity of the tracking

James Bell: Yes, right.

Speaker: You know I spent X hours on case X Y Z.

James Bell: Yes.

Speaker: But not much specificity about what that actually involved in.

James Bell: Yeah, in terms of in home services there is like we kind of talk in child welfare, we talk about in home services and kind of this well it could be this, it could be this and it could this or something else. But sir, there is this broad category of in home services and we don't know exactly what of those, what we actually provide is part of services and there is variation by child, there is variation across units within units and there is variation certainly across county's in terms of being able to do that.

But I think the important thing is trying to find out what types of, what works and I think also the activity, you get the cost set up, how those cost play back into particular outcomes for children that you didn't really address specifically because we're running out of you know running short of time about doing that. But I think that's the real key, do you get better result if you spend 20 hours per month for a home services for 3 months versus 10 hours of in home services for 2 months.

Speaker: That's right. And but then the other thing too is it the nature of the child that actually required you to do that or if that you had the resources to be able to, to come up and do that.

James Bell: That's right. I mean, I think that you know my partner Alice Kay who is the Maven in our firm for child welfare, you know, I'm just like a health guy that helps out in child welfare. But she always talks about child welfare as you know, it's like the shack with really nice sun porch and what she means by that is that they really aren't resources underneath to support the services that are actually needed, but we talk a lot about these kind of veneers of new ideas and you know magic bullets that were going to you know slap on the front of this poorly foundation and poorly constructed house, because we just don't have the resources to do all the right things.

And I think, it's a catch 22 because it's the exact time when you should spend the energy and effort that it takes to figure this out, because you could achieve efficiencies, you could achieve presumably you could achieve better results with the same resources. But in order to do that you have to figure this out.

Speaker: Right.

James Bell: And in order to figure this out you have to burden already over burden people. So it's this kind of dynamics that makes it hard because, in medicine we have claims, now claims have issues, but we have claims. In policing they are the most well documented, they are better documented than anybody, because every minute is tracked on the radio, when I did police studies we just took the radio tape and broke it down and we could reconstruct the whole police forces activities within a given timeframe and how much went into each activity because they report, they all have like a 100 codes.

Speaker: What was the code for the doughnut shops?

Speaker: I don't know. My kids told me the code for being Marijuana was 420. So but because they have, one of my sons is a skate boarder and he is always appearing at these, he is, you know, pearl skate boarder and he is always appearing at things like Himp Fest and Seattle. And there are this big signs 420 and I said what's that, he said well that's the police code for Marijuana.

Then the police chief, I went to one of these the police chief in Seattle got up and basically said that was the lowest priority, lower than parking tickets in the city of Seattle and that person is now the head of the office of drug control policy which is interesting transition. And I probably shouldn't be saying with the microphone on, okay yes.

Speaker: The whole focus of cost and what's happening in case level is really the best place to go because if we get the cost level per case, you can get the program cost by just aggregating case cost.

James Bell: That's right. The focus of changing and this is not been the slow shift it started back in like the 90's with the federal government wanting to know rather than quantity, quality. And how do you take quantitative data and get qualitative results out of it is the problem, or not the problem but the, the struggle with that we try to go with rather than just reporting that we spend X number of dollars and we serve this many redheaded kids, this many left handed blue eyed kids or whatever which is always been the norm.

Is there anybody getting better, what happened to these people, what happened to the families that's another issue too when you start trying to spend cost or you are looking at a family as a case, do you go down to the child level. What is it you know how far down do you need to go, you have to have that standard in order to start with, then also like a lot of those items that you might have mentioned up here now I'm not concerned it's not that I've no concern about the clients time.

Speaker: Right.

James Bell: But I'm not going to worry about putting a cost to that, that's for social studies people that's why we got contractors and if...

Speaker: That's right

James Bell: And consultants to worry about the bigger policy issue of peoples times I know it's valuable, but you know, it's what got to be done. My concern is what public resources are we taking by getting money through federal grants and state dollars and then how are we turning that back in as far as the outcomes that we want to see in the services that we deliver.

Speaker: Right.

James Bell: Also what are the important items of cost to look at or is it worth going down to the Nth degree to see a lot of can we just group someone as other, what are the important components that actually can be quantified and then turned into qualitative data to show whether a difference is being made or an outcome is being met, you know, it's all a balancing act in a lot of ways as to what you pick and choose, but the most important thing is in my opinion is if you take a model, you stick with it and then you do not try to change in midstream the items of cost. A lot of times in child welfare the only difference between going services like a early intervention family support or family preservation activity as a frequency and intensity of cost, the service delivery is the same like visitation or in supervision in home you know supervision.

If the family is fairly well functioning and it looks like it was a risk problem here we may send in supervised home supervision parenting whatever you want to call it, home maker services couple times a week, those things services at the families not getting any better after a while obviously you up those to 5 or 6 times a week. Now you are in a different round, but it's a same service. So trying to understand when you are talking about program areas like is this early intervention family support, is this family preservation.

When I first entered this child welfare arena I had trouble understanding, because I'm a business person understanding why cost one day were this and cost next day were this but then when I started understanding the child welfare continue, continue and from early intervention throughout the life of a child welfare case, it became understandable how easy it is to not know where you are at, and what you are actually I'm providing the same service but what am I doing here, if I had to take a sub to the program level, am I doing early intervention? Am I doing family prayers, I mean which one am I doing?

And those were basically following the federal office, you know definitions or the broader of program areas we look at. Cost are also relevant when you mentioned that about the what's cost effective one place is not cost effective another, you know, researcher from the brisk has come to DC for NIH conferences mandated as part of the

federal program granny's working on he goes back, turns in his expense reports and some accountant in Omaha says how did you spend the \$120 in DC eating in one day and the answer is well it's easy if you skip lunch.

Speaker: Yeah.

James Bell: You know because \$120 in Omaha goes loss further than \$120 in Washington. So trying to and we are all involved in this and I know we are certainly are trying to quantify like to the out of home visitation cost and what are providers doing, the out of state cost and the travel time and just trying to bring all this stuff together so to we have some idea of are we getting a benefit out of the money that's being spent.

Speaker: That's right.

James Bell: And I'm trying to find even a base to start from is a concept in government at least to even go there, they provide you over here is providing you need documents at your time because we will come back to you as a state agency of federal government and if you haven't document that time guess what you are going get dying because you build for which you can't document in your case notes or your case records that you actually provide the service, so we put on sometimes government we put owners out here.

Speaker: Right. That isn't necessarily able to quantify that same burden back on our own selves.

James Bell: That's right. But I think in the area where we are talking about in child welfare I mean the problem is we don't have a well defined base here. So it's really I mean, this chart helps us to improve the base because we can see on this chart that some of the parts are pretty short. So maybe we don't need to measure all those parts, maybe we can clump those parts, if we see across all cases that in this intervention they are always small then why are we burdening people with collecting math portion, why don't we just you know start to assign that portion.

If the big variation is in counseling and support for an advocate with then that tells us then that's something we do need to track more, you know, routinely at the case level, but we can't get there if you don't have some of this kind of data to start to make those choices. When we started doing the work on HIV the survey was 2000 items to keep track of it, not only the clinical but the cost outcomes but over iteration we kept reducing it, reducing it, reducing it to core elements that we needed and could justify empirically the burden kept going down and down and down, and the value of the data actually went up and up, because we had simpler models because we were able to empirically document why we made those choices.

Now it's interesting and this is, I think something that needs to be done in child welfare, we need to really figure out the social cost and benefits of child welfare services when we entered the field with HIV what we call multiply diagnosed or triply diagnosed patients the conventional wisdoms was, well these were mostly almost drug addicts and people

with severe psychiatrist symptomology and you know there is nothing we can do, they are not going to be able to overtake the HIV meds in fact in Omaha they were denied meds in the early stages, because it was fear that if they took the meds and didn't comply were, or here to the treatment a mutant strain of HIV would evolve, which is possible.

It turns out that, that group with proper support can take the HIV meds better than the average heart patients. The non impaired HIV patients is the most complacent patient of any patient, but in impaired HIV patient one would come with psychiatric and addiction disorders that has been approved to take the meds some people never get to that because they are so impaired psychiatrically that they, they just can't you know only and directly observe therapy situation can they take the meds, but among those who are pretty impaired by what society would think are normal standards the adherence rate is, as high as normal heart patience as average heart patience. So we proved that they could take the meds.

Second thing is we proved that it was cheaper to serve them and treat them then it was to let them go, by letting these people go we documented it cost between 85 and 100,000 a year. Emergency room visits unnecessary inpatient hospital stays in Incarceration crisis interventions the cost range between 85 and 100,000.

Speaker: *[Indiscernible] [01:19:21]*

James Bell: Now that's just their cost, social cost, what we call the social costs. That then we had to actually understand all those costs which was a huge expensive effort but once stabilize that same person with the cost would go down to between 15 and 20,000 for the medical care for standard HIV care and continuing some psychiatric and addiction support. So that is a huge savings, a huge social savings.

Once that was known then the interesting actually serving those clients in a, in those patience in an organized way went up, we've never done anything close to that in child welfare, we have never really sat and down and done the study that understands how the services are distributed what predicts engagement and retention and services for a large cohort, what outcomes are actually accrued what's the relationship between the inter characteristics, the doses and types of services received and the outcomes. That would allow us to have that kind of a discussion. We have little pieces, but as a feel we don't have that picture.

Speaker: You also have, you talked about variables the barriers perceived or real, a perceived barriers such as education.

James Bell: Right.

Speaker: I expect if I don't I'm not cognoscente that just because want to take this demographic information this person has a high school education what does that really mean that doesn't mean that necessarily functioning at that level, all right.

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Speaker: And how do I take that into consideration I cant just say you know well we have proven with people with this level of education seem to understand and do better, not necessarily if we don't understand that what the barriers maybe they might have that level of education but they didn't get the level of knowledge to let them function at that level.

Speaker: Right. They might have a 3rd grade reading level.

Speaker: Yes, or whatever to able interpret things so you got to try to say how do you get in there and quantify that to torment then into a qualitative.

Speaker: Right.

Speaker: Answer to just across the board you say it was biases that this is where we should be or there were people there because they choose to be there. Downtown behind the Hyatt Downtown if you walk to box up there is a homely shelter right in the shadow of our nations capital.

James Bell: That's right.

Speaker: People sitting on the streets. How many of them, if you went around ask them, do you want to be here, it's up their choice, you know, not realize we're all take actions but you know, are you here because your ability to make yourself in a better situation is lacking was purely physical addiction to drugs and alcohol that got you here, a minimal payment why, but I doubt.

James Bell: Or circumstances.

Speaker: Any evidence would say yes I just I love my head down on this curve this evening and going to sleep, so what are all those barriers or factors systemic factors that got him there and then individual factors that got him there.

James Bell: Right. Well, are there any other questions or comments?

Speaker: Where do you see this field go?

Speaker: Well I mean...

James Bell: Let you get the microphone. The question was were do you see this field going, well there is continued interest in case level cost and I think that's evident in the inclusion of cost evaluation components in evaluations, you know there is I mean with the waver programs you had the budget neutrality issue, but that was kind of a different cattle of fish, the waver started what 15 years ago somewhere around that time and one of the conditions of a waver was that it be cost neutral.

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So that drove cost evaluation in the waver world, but in like we did the national and then designed the national evaluation of family preservation in the 90's, cost wasn't part of the consideration. I mean everybody knew that it took more effort and obviously cost more to pursue the home builders' family preservation model, but nobody actually spent much energy trying to measure it, it wasn't on the screen, the outcomes were on the screen but nothing else was on the screen from a policy perspective.

Now almost every evaluation we do they at least ask for some aspect of cost and often times, it's at the programmatic level and we didn't about that today but you can improve programmatic level evaluation, cost evaluation by just getting people the break labor down into big categories, I mean it's a big improvement over just having a line item called personnel. So if they can report back that this proportion of the effort of the staff was spent on these kinds of activities and this proportion was spent on those kinds of activities.

Well that's not the most valid reliable data in the world but it's a start and it's not burdensome. So with a lot of Children's Bureau guarantee programs that we support like the implementation in NRC centers you know we setup a spreadsheet that each guarantee breaks down there programmatic effort in the big categories. So that's a step in the right direction, but personally I'm obsessed at the cost, at the case level. Because I think we learned so much about how programs actually work, in addition to being able to document what the cases are, the costs are. And most importantly, how variable they are? How they just are not uniformed and in order to manage you have to know the non uniformity and you have to adjust to it. At least from a...

Speaker: Wait, we're just about out of time here. And we do have to cut it because of the recording purposes so.

James Bell: Yeah.

Speaker: The follow up thing is looking at the ability to, if you're at a case level connect cost to the outcome.

James Bell: That's right.

Speaker: Say, you can say, you know, this intervention cost \$2,000 for a family and this outcome, this will cost 10,000.

James Bell: Right.

Speaker: And then, so we're saying oh wow, well you achieved the same outcomes at drastically different costs. Instead of having that drive, instead of having some of those decisions...

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James Bell: That's right. And that's where we always want to go with thought. Because just having a thought itself you're going to always work, now you want to use that's an independent variable in outcome analysis. Because it's...