



# **Connecticut's Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center**

## **FY 2018 Annual Report**



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This report was developed for the Connecticut Department of Children and Families (DCF) by the Child Health and Development Institute of Connecticut (CHDI).

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We wish to acknowledge the following CHDI staff that have worked on the TF-CBT Coordinating Center and this report, including Kyle Barrette, Ashley Nelson, Carrie Shaw, Laurie Valentine, and Jeff Vanderploeg.

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## **Executive Summary**

The Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center (“Coordinating Center”), is located at the Child Health and Development Institute (CHDI). Funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch’s Court Support Services Division, the overall goal of the Coordinating Center is to improve access to evidence-based outpatient behavioral health treatment for children suffering from exposure to violence, abuse, and other forms of trauma. Using implementation science and economies of scale, Coordinating Center supports a network of 43 TF-CBT providers throughout Connecticut. The Coordinating Center provides training, credentialing, implementation support, site-based consultation, data collection and reporting, and ongoing quality improvement. This report summarizes the work of the Coordinating Center for state fiscal year 2018 (July 1, 2017 through June 30, 2018), though a delay in contracting meant that work was delayed by several months.

### ***Highlights of FY 18:***

- This was the tenth year of TF-CBT implementation in CT; cumulative totals therefore reflect a decade of work and commitment on the part of DCF, CSSD, CHDI, provider agencies, and other supporting partners
- TF-CBT was provided at 43 agencies covering a total of 95 sites
- 310 clinicians provided TF-CBT, including 44 newly trained in TF-CBT during the fiscal year, who delivered 27,952 TF-CBT sessions to 1,589 children
- Project Coordinators completed 89 site-based consultation visits that addressed TF-CBT as well as other EBPs offered by agency teams
- 30.3% of TF-CBT clinicians practiced another EBP, which means enhancement in clinicians’ skill sets and increased reach of EBPs
- 50.4% of children getting an EBP through partnership with CHDI received TF-CBT
- 96% of caregivers were satisfied with the TF-CBT treatment children received
- 62.9% of children demonstrated significant and reliable symptom reduction; these outcomes were equitable across races, ages, and sexes
- TF-CBTs online database, EBP Tracker, was better-aligned with DCF’s Provider Information Exchange (PIE) system to reduce data entry burden and enable better tracking of EBP cases and comparison with children receiving treatment as usual in outpatient care

### ***Key Recommendations:***

- Increased training in assessments so that clinicians have more options and flexibility when measuring symptom reduction while still documenting the positive outcomes

- Develop a plan for a Coordinating Center that works to identify, disseminate, support, and integrate EBPs and outpatient care including TF-CBT. Such a Center could have a broader impact on the children's behavioral health system and could test and implement population-based strategies and models (e.g. for all children seen in OPCCs) through use of standardized assessment measures (measurement based care) and clinical and organizational strategies that are relevant for all children (e.g. engagement, behavioral rehearsal, use of supervision, self-care).
- Adding advanced trainings and booster trainings to ensure new and existing TF-CBT clinicians have the support they need to sustain their implementation of the model
- Revise sustainability funding allocation formulas to recognize the investments agencies make in their clinicians' training and professional development
- Further develop and refine the integration between EBP Tracker and PIE, and clarifying data definitions and supporting enhanced use of data quality monitoring and data use for ongoing quality improvement, so that children are able to be linked and tracked across systems while reducing the data entry burden on agencies
- Continue to plan for and provide consultation to sites that works to support and integrate the work of TF-CBT with other EBPs and treatments that children receive in outpatient care

## **Overview**

The overall goal of the Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center is to improve access to evidence-based outpatient behavioral health treatment for children suffering from exposure to violence, abuse, and other forms of trauma. Funded by DCF and CSSD, the Coordinating Center uses economies of scale to create centralized support for the statewide network of 43 TF-CBT providers through the following primary functions:

- 1) Training, consultation, and credentialing
- 2) Implementation support and quality improvement
- 3) Data collection and reporting
- 4) Administration of performance-based sustainment funds
- 5) Expanding TF-CBT for youth in the juvenile justice system, and
- 6) Improving coordination and collaboration between providers, child welfare, and juvenile justice to ensure access to services.

This report summarizes the work of The Connecticut Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center (“Coordinating Center”), funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch’s Court Support Services Division (CSSD), for state fiscal year 2018 (July 1, 2017 through June 30, 2018). The Coordinating Center is located at the Child Health and Development Institute (CHDI) of Connecticut. The overall goal of the Coordinating Center is to expand the availability and quality of trauma-focused treatment for children through dissemination and sustainment of TF-CBT at Connecticut agencies. CHDI integrates knowledge about implementation science, evidence-based practices, childhood trauma, and children’s mental health to achieve this goal together through our partnerships with treatment developers, community-based agencies, and state systems.

## **Background**

TF-CBT is an evidence-based, short-term, family-centered behavioral health treatment for children aged 3-18 suffering from exposure to traumatic events, including physical abuse, sexual abuse, domestic or community violence, accidents, or disasters. TF-CBT is indicated for children who are suffering from traumatic stress symptoms related to trauma exposure, including symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety.

From 2007-2010, DCF funded a statewide dissemination of TF-CBT across community behavioral health agencies in Connecticut. CHDI was selected as the Coordinating Center for this initiative, called the Connecticut TF-CBT Learning Collaborative. CHDI utilized the Institute for Healthcare Improvement’s Breakthrough Series Collaborative quality improvement model to train staff from 16 community behavioral health agencies in TF-CBT. Upon completion of the learning collaboratives in 2010, CHDI and DCF identified the need to provide statewide

infrastructure to sustain TF-CBT across the behavioral health agencies trained in the learning collaboratives. In 2010, the Coordinating Center was established at CHDI to provide this support.

Additionally, DCF was awarded a federal grant in 2011 by the Administration on Children and Families to improve trauma-informed care for children in the child welfare system called The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT). The Coordinating Center now provides support to thirteen additional agency teams that implemented TF-CBT through CONCEPT from 2012-2014.

In FY14, the Coordinating Center was expanded to provide additional support for this growing network of TF-CBT providers. This expansion included development of a statewide data collection and reporting system, sustainment funding for TF-CBT providers, additional training, and additional implementation support. Through a contract renewal in FY18, this work continued along with a greater emphasis on integrating TF-CBT with other EBPs.

This report covers the work of the Coordinating Center for FY 18. Due to delays in contract approval, work did not begin until August 2018 and therefore operations of the Coordinating Center were suspended for two months.

## **Goals**

The primary goals for the Coordinating Center are to:

- (1) Provide access to TF-CBT for all Connecticut children suffering from trauma
- (2) Ensure that high-quality TF-CBT is provided
- (3) Ensure significant improvements in child outcomes for children receiving TF-CBT

## **Activities and Deliverables**

The Coordinating Center has worked to support the TF-CBT implementation goals through the following activities carried out in FY18.

### **1. Training, Consultation, & Credentialing**

- Our internal national trainer provided two clinical trainings in November 2017 and March 2018.
- Contracted with a national trainer to provide a 1-day TF-CBT Advanced clinician training attended by 26 credentialed clinicians.
- Coordinated with a national TF-CBT Trainer or Consultant to provide 6 series of clinical consultation calls (60 total calls) for 73 clinicians, 47 completed in FY18, the remaining are still enrolled in calls that will complete in FY19.
- Coordinated registration, attendance, and CEUs for New Clinician Training (49 participants) and the consultation call groups (49 registrations)
- Maintained a statewide TF-CBT clinician credentialing process and requirements to increase the number of clinicians that complete all training and case requirements; 186 active clinicians were either Connecticut credentialed or nationally certified by the end of FY 18
- Maintained TF-CBT agency credentialing criteria and process to ensure that agency teams meet minimum quality requirements required to continue participation in the statewide network of providers; all eligible agencies met the credentialing criteria
- Maintained a training record database to track training and consultation attendance of all TF-CBT staff, as well as other credentialing requirements for all TF-CBT clinicians; in FY 18 there were 310 active clinicians
- Prepared regular training and case data tables for each provider with updates on individual clinician credentialing status
- Convened ninth annual statewide EBP Conference, an evolution of the original TF-CBT Conference, for 391 participants from community providers, DCF, CSSD staff, and other partners in the initiative.

### **2. Implementation Support, Quality Improvement, & Technical Assistance**

- Produced reports for two QI performance periods based on developed TF-CBT QI Indicators and Benchmarks
- Utilized a QI process of implementation consultation based on emerging implementation science field and needs of agencies
- Developed agency-specific QI plans using SMARTER Goals focused on agency performance on QI benchmarks and strategies to improve access, quality and service delivery
- Performance Improvement Plans were developed with two low-performing agencies

- Provided 89 in-person implementation consultation support visits and 82 phone calls with providers to ensure sustainment of high quality services
- Supported 4 new providers that applied to begin implementation of TF-CBT
- Convened 3 Senior Leader Advisory Meetings with goals focusing on agency needs to support implementation and strategies to improve TF-CBT access, quality, and outcomes statewide; expanded the committee to include additional representatives from TF-CBT agencies that did not attend a learning collaborative and to Senior Leaders from additional treatment models
- Implemented and convened 3 Coordinator meetings focusing on sharing implementation and successful meeting strategies
- Provided updates to all TF-CBT participants through a monthly Data Dashboard
- Distributed additional TF-CBT books, materials, and resources to all TF-CBT teams

### **3. Data Systems**

- Continued development and maintenance of a secure, HIPAA compliant, online database (EBP Tracker) that meets the needs of the increasing number of TF-CBT providers and the children and families they serve
- Oversaw the migration of EBP Tracker to DCF's servers, which reduced hosting costs for the system and brought EBP Tracker onto the same platform as Provider Information Exchange (PIE)
- Built a "bridge" between PIE & EBP Tracker so that identified data fields can push from PIE to EBP Tracker for matched cases, reducing the burden of duplicate data entry in the two systems
- EBP Tracker provides real-time scoring and reports of individual client assessments and progress, more timely and accurate data for providers and stakeholders, includes CBITS, Bounce Back, ARC, and MATCH-ADTC access and has the capacity for additional EBP models to be included
- Continued improvements to EBP Tracker have been made based upon agency feedback and as possible with available funding
- Maintained a public directory site that provides a searchable, public listing of TF-CBT providers through EBP Tracker ([tinyurl.com/ebpsearch](http://tinyurl.com/ebpsearch))
- Monitored, maintained, and provided technical assistance for online data entry for all TF-CBT providers
- Provided site-based data assistance and reports as requested

### **4. Agency Sustainment Funds**

- Administered performance-based financial incentives to improve capacity, access and quality care.

- While these financial incentives are intended to partially offset the increased agency costs of providing an evidence-based practice, agency leadership reports that they do not adequately cover the costs of providing TF-CBT (See Financial Incentive document in Appendix A for details)
- Developed, executed, and managed contracts with each of the 32 TF-CBT providers eligible for financial incentives to detail implementation expectations, data sharing, and financial incentive details
- Analyzed and reported financial incentives for each agency for two 6-month performance periods.
- Distributed \$488,554 in performance-based sustainment funds to agencies (44.4% of total contract funds)

## TF-CBT Continues to be Sustained Across the State

A decade after initial implementation, TF-CBT continues to be delivered to children impacted by trauma. In FY 18, TF-CBT was available **at 95 sites across 43 provider agencies**. There were **310 active TF-CBT clinicians**, including **44 clinicians newly trained** during the fiscal year. By the end of the reporting period, **45 new TF-CBT team members were credentialed in TF-CBT**. The overall **penetration rate was 6.1%** (i.e. 6.1% of children receiving outpatient services in participating agencies were receiving TF-CBT). Figure 1 below shows the sites providing TF-CBT in FY 18 as well as the rates of service delivery. Altogether, **27,452 sessions of TF-CBT were provided** during the fiscal year.

In FY 18, 1,598 children had an intake and assessment for TF-CBT; **1,471 (92.1%) children went on to begin treatment and received at least one session of TF-CBT**. Children were 59.4% female, 40.3% male, 0.1% intersex, and 0.2% other. The race/ethnicity breakdown for children served was 41.5% White non-Hispanic, 40.4% Hispanic, 13.9% Black non-Hispanic, and 4.2 Other race non-Hispanic. In FY18, **34.4%** of children served had current DCF involvement.

Figure 1. Map of TF-CBT Sites and Children Served

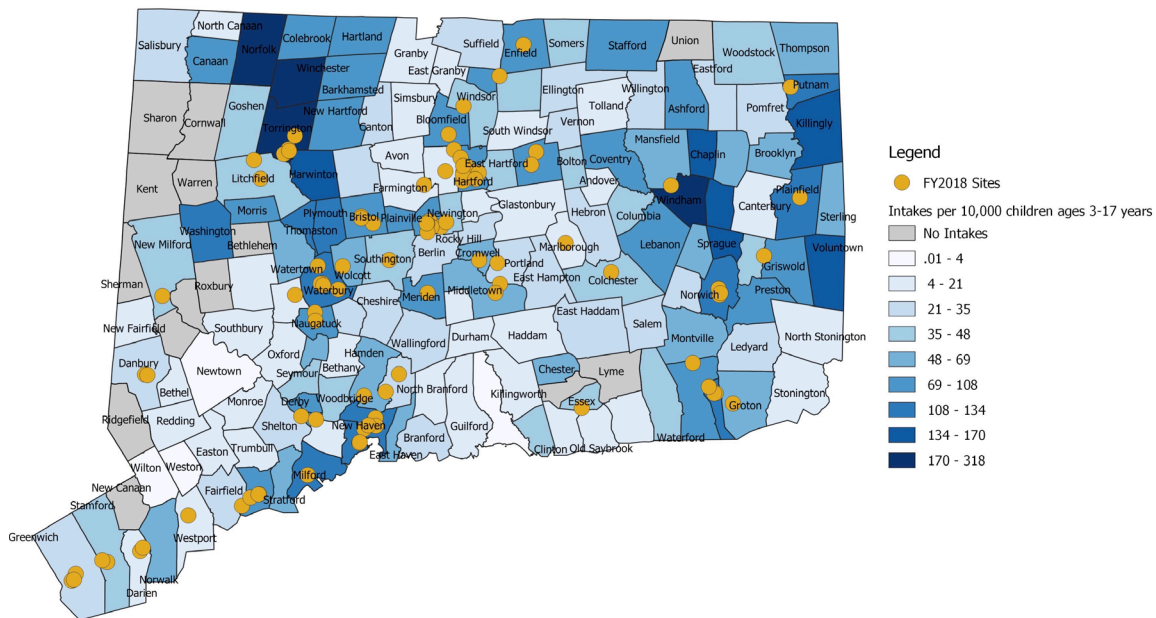


Table 1 below highlights the trends in TF-CBT access across the past four fiscal years as well as cumulative numbers from FY 08-FY 18. The number of agencies offering TF-CBT has continued to increase over the four year period. The number of children receiving TF-CBT (at least one session) decreased 6.4% from FY 17 to FY

18. While the number of children receiving TF-CBT has decreased slightly over time, these reductions have aligned with the introduction of additional EBPs available. This is a trend discussed in the following section, but can also be noted in the penetration rate numbers for agencies. TF-CBT makes up a significant amount of the EBPs offered, but agencies and clinicians are increasingly offering other EBPs.

As the work with agencies and clinicians expands from a narrow focus on TF-CBT to a broader approach that incorporates the overall level of EBPs offered, the TF-CBT Coordinating Center increasingly is concerned with the quality of TF-CBT delivered and finding the best ways to manage multiple EBPs. Later sections document the work of the Coordinating Center on ensuring the deliver of TF-CBT with high fidelity. One example is the number of sessions shown in Table 1; with 27,455 sessions across 1,471 children, a child on average received 18.7 sessions in FY 18. This is comparable to the average in FY 17 of 19.3. Both of these years had much higher average number of sessions than FY 15 & FY16.

The number of clinicians on TF-CBT teams decreased 6.3% from FY17 to FY18, a drop in similar magnitude to the number of children seen. Partially this is due to a lower number of new clinicians. Given the stage of sustainability TF-CBT is in, there are relatively few new agencies and primarily demand for training to address attrition in agencies to maintain capacity rather than to expand. Also, due to delay in contract starts in FY18, there were only two clinical trainings provided instead of three.

**Table 1: TF-CBT Access**

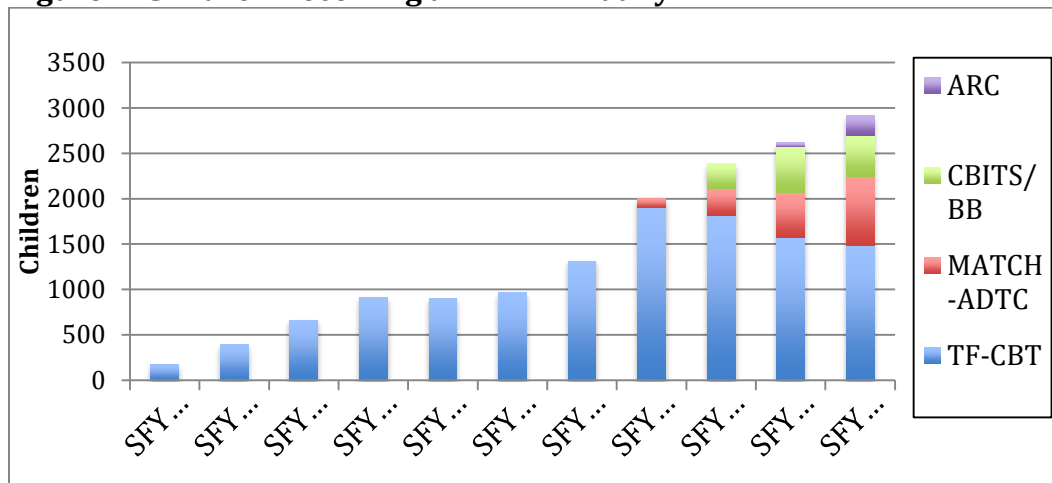
	FY15	FY16	FY17	<b>FY 18</b>	Cumulative Since 2007
Providers of TF-CBT	36	37	42	<b>43</b>	44
TF-CBT Penetration Rate	7.7%	7.1%	6.5	<b>6.0%</b>	N/A
Children Served: TF-CBT	1,902	1,820	1,572	<b>1,471</b>	8,884
# TF-CBT sessions	20,764	27,016	30,330	<b>27,452</b>	105,562
Avg # of sessions per child	10.9	14.8	19.3	<b>18.7</b>	
Children with DCF inv.	36.2%	35.1%	34.0%	<b>34.4%</b>	N/A
New TF-CBT Clinicians	115	89	83	<b>44</b>	781
Clinicians Providing TF-CBT	330	369	331	<b>310</b>	733
#Credentialed/Certified	37	108	79	<b>45</b>	286

### **TF-CBT is Part of an Array of EBPs Agencies Offer**

The implementation and success of TF-CBT helped in part to support the expansion to additional models to further meet the needs of children in CT. CHDI began coordinating trainings and data support in four other models over the past four years including Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Disorder (MATCH-ADTC), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Bounce Back!, and Attachment, Self-Regulation, and Competency (ARC). Each of the models provides clinicians with

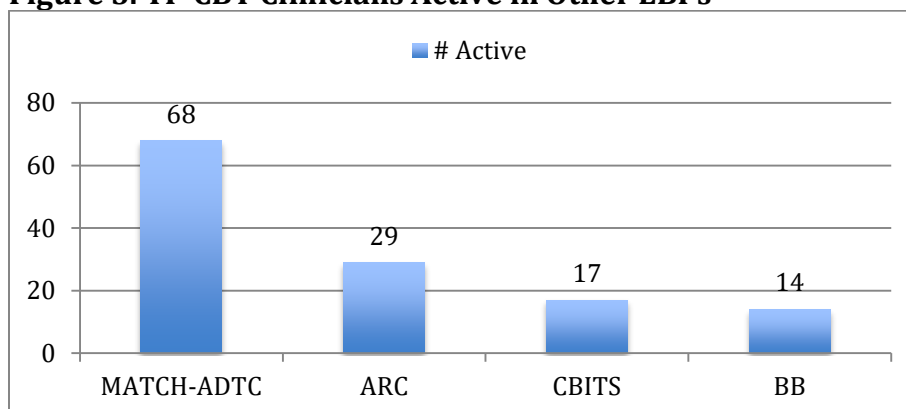
different skill sets and training in multiple models allows agencies and clinicians to provide EBPs to a larger target population. For example, MATCH-ADTC can be used for children with or without trauma symptoms. ARC is similar to TF-CBT in terms of targeting trauma, but ARC is often preferred for very young children. In FY18, **2,919 children received an EBP** supported by CHDI; **just over half, 50.4%, of those children received TF-CBT**. As can be seen in Figure 2 below, the number of children receiving an EBP has risen steadily over time. TF-CBT has been the largest share of EBP cases, though as MATCH-ADTC and ARC increase dissemination they are accounting for an increasingly large share of EBP cases.

**Figure 2. Children Receiving an EBP Annually**



Clinicians are also increasingly trained in multiple models. In FY 18, 94 (30.3%) of TF-CBT clinicians were active in at least one other EBP. Of the 94 clinicians, 65 (69.1%) were active in one additional model, 24 (25.5%) were active in two additional models, and 5 (5.3%) were active in three additional models. The most common model for a TF-CBT clinician to be trained in was MATCH-ADTC with 68 clinicians trained in both models. For other models, 29 TF-CBT clinicians were trained in ARC and 17 were trained in CBITS (14 were trained in BounceBack! in addition to CBITS).

**Figure 3. TF-CBT Clinicians Active in Other EBPs**



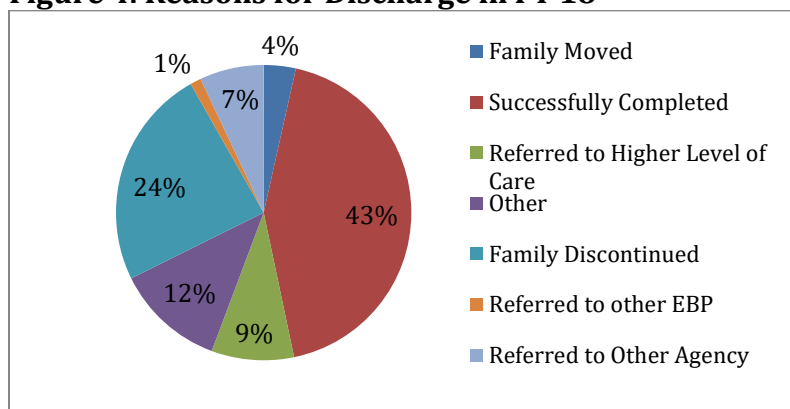
## Clinical Implementation & Quality Improvement

### *Successful Completion is the Most Common Discharge Reason in TF-CBT*

During the fiscal year, 973 children ended their TF-CBT treatment episode. Figure 4 shows the breakdown of reasons for discharge. Four hundred (41.1%) of the children discharged from TF-CBT because the clinician rated them as having successfully completed. There were no significant differences across race/ethnicity groups in terms of successful completion of TF-CBT ( $\chi^2 (3)=6.053, p=.109$ ). The most common reason for discharge after successful completion was “family discontinued”, which was the case for 24% of families. The remainder were discharged or transferred for a variety of reasons including being referred to a higher level of care, referral to another EBP, and the family moving away.

Positive outcomes were observed even when clinicians indicated a reason for discharge other than successful. Of the 573 children who left discharged for a reason other successful completion of the model, 240 (41.9%) did experience symptom reduction. Outcome data is presented in later sections, but it is important to note that even when cases did not successfully complete the model, many children still had improvements the dose of TF-CBT they received.

**Figure 4. Reasons for Discharge in FY 18**



### *Quality Improvement Successes with TF-CBT*

In addition to tracking discharge reasons, CHDI reports on TF-CBT quality improvement (QI) indicators twice annually. The definition and explanations of each of the 8 QI indicators are in Appendix B and the prepared reports showing each provider's results over the two FY18 performance periods are included in Appendix C and Appendix D. Agencies are expected to meet at least four of eight benchmarks in any given performance period. The general pattern of improved performance detailed below suggests that as more clinicians become trained and agencies continue to provide TF-CBT to the children in their the quality of treatment remains high and has in fact continued to increase in most areas.

The QI indicators were consistent for FY 17 and FY 18, allowing us to compare

performance on consistently-measured metrics for a two-year period. Table 2 below shows the four performance periods together along with the benchmark for each indicator. Some of the indicators have been long-standing measures of TF-CBT quality and have been consistently exceeded. For example, engagement rates are extremely high and have remained that way over time. Trauma narrative completion is another indicator that is consistently above the targeted benchmark. Benchmarks for these items might be revised in the next reporting period to ensure they are relevant. Other long-standing indicators, such as caregiver satisfaction rates, use of components, and caregiver involvement, continue to be useful and have benchmarks that are sufficiently high but attainable.

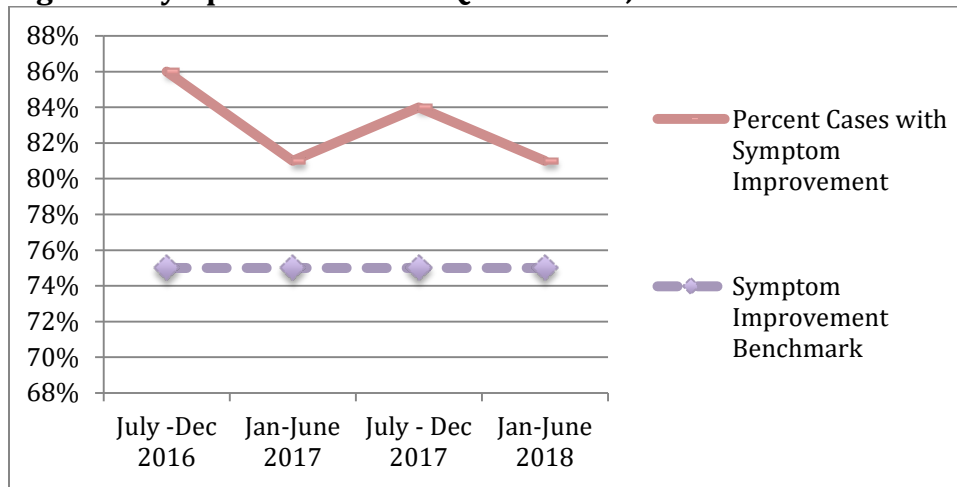
**Table 2. TF-CBT Quality Indicators FY17-FY18**

<b>QI Indicator</b>	<b>FY 17</b>		<b>FY 18</b>		<b>Benchmark</b>
	<b>PP1</b>	<b>PP2</b>	<b>PP 3</b>	<b>PP4</b>	
Caregiver Satisfaction	70%	73%	80%	75%	<b>70%</b>
Engagement	93%	90%	91%	91%	<b>55%</b>
Caregiver Involvement	69%	65%	65%	64%	<b>65%</b>
2 visits/month	66%	68%	71%	75%	<b>65%</b>
TN Complete	53%	48%	52%	55%	<b>35%</b>
All Components + 8 Sessions	38%	30%	32%	36%	<b>30%</b>
Cases with Assessment Data	71%	71%	71%	70%	<b>70%</b>
Symptom Improvement	86%	81%	84%	81%	<b>75%</b>

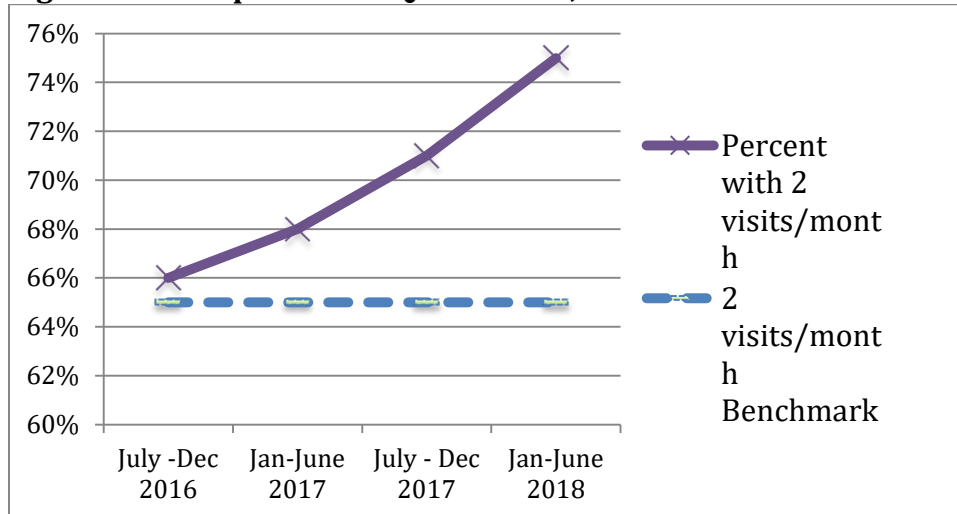
Three indicators were introduced at the start of FY 17 as new targets to monitor: average of 2 visits/month, cases with assessment data, and cases with symptom reduction. Given these were not tracked previously, it is particularly relevant to follow the shifts in performance once they were added to reports and discussed in site visits. The number of cases receiving at least two visits per months rose steadily from 66% at the start of FY17 to 75% at the end of FY18. It appears the explicit focus on and monitoring of number of visits had a positive impact on children receiving TF-CBT sessions with sufficient frequency.

Cases with assessment data was an indicator that did not change over the period of time when it was monitored. Use of assessments is a key part of evidence-based practice and assessments has driven CHDI's work with agencies. The 70% benchmark was based on historical data and it would appear that agencies were ensuring they received this data even before it was tracked. Finally, symptom reduction was introduced as an indicator in FY 17 once we had data systems designed to efficiently track and monitor. A benchmark of 75% was set based on historical data; that benchmark has consistently been exceeded by agencies though there are fluctuations across performance periods. Percent of cases with symptom reduction and percent of cases averaging two or more visits per month are shown in Figures 5 & 6 below, graphed over the performance periods of FY 17 and FY 18 and shown against the established benchmark.

**Figure 5. Symptom Reduction QI Indicator, FY 17-FY 18**



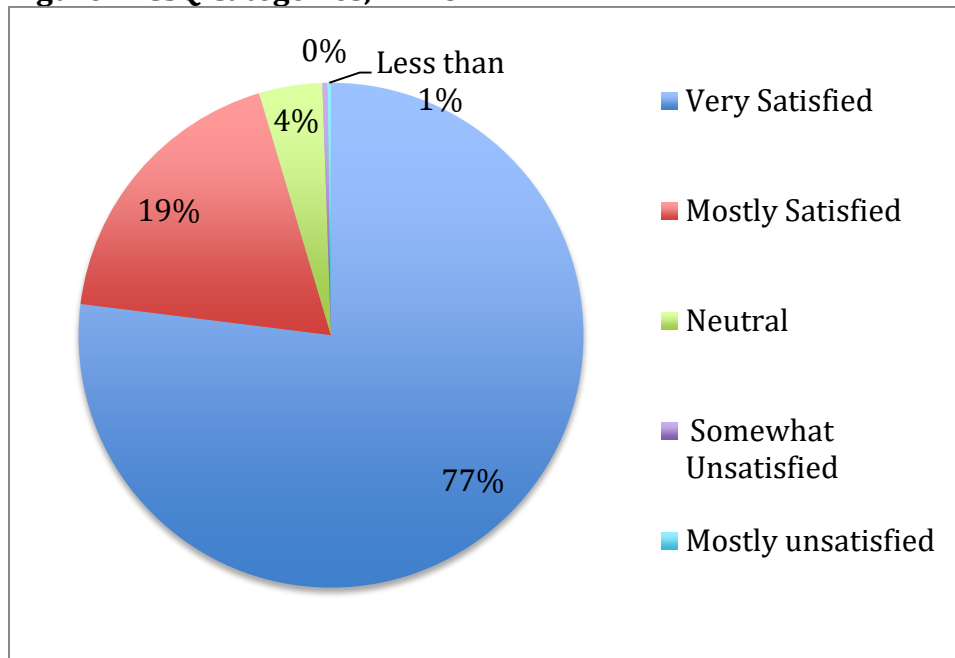
**Figure 6. Visits per Month QI Indicator, FY17-FY18**



### ***Caregivers are Highly Satisfied with TF-CBT Treatment***

Caregivers report high levels of satisfaction with TF-CBT treatment. In FY 18, there were 912 Caregiver Satisfaction Questionnaires completed. The results of the response to the question “Overall, I am satisfied with my child’s treatment” are illustrated in Figure 7 below with 96% indicating mostly or very satisfied with treatment.

**Figure 7. CSQ Categories, FY 18**



## Child Outcomes

### ***Overview of Assessment in TF-CBT***

Children receiving TF-CBT are assessed with a variety of measures selected to provide information on trauma history and severity of symptoms. At intake, children and their caregivers are each asked to complete the Trauma History Screen (THS), the Child PTSD Symptom Scale (CPSS-IV), the Short Moods and Feelings Questionnaire (SMFQ), and the Ohio Scales for Problem Severity & Functioning. Then, every 90 days to discharge, each assessment (except the THS) is re-administered to monitor progress and track symptom change.

Each of the measures is listed along with the construct it measures and a summary of intake and discharge scores in Table 3 below. Also indicated in the table, where applicable, are the numbers of children whose score placed them in the clinical or critical range on a particular measure at intake and how many of those had moved out of that range by the last assessment. Change scores are given for each measure broken out by these two groups (those who started in the clinical range and those that did not). This is an important factor in examining change scores because greater change is possible and expected for children who enter with higher scores.

**Table 3: Descriptives and Change Scores for all Assessment Measures**

Assessment Name	Construct Measured	Above Cutoff	Intake Mean (S.D.)	Last Mean (S.D.)	Change Score	t-score	Remission
THS Child (n=959)	Exposure to potentially traumatic events	n/a	6.84 (3.68)	n/a	n/a	n/a	n/a
THS Caregiver (n=937)		n/a	5.62 (3.27)	n/a	n/a	n/a	n/a
CPSS Child (n=637)	Trauma symptoms	412 (65.7%)	20.67 (10.78)	11.88 (10.31)	-8.79**	20.40	248/412 (60.2%)
CPSS Caregiver (n=552)		307 (55.6%)	18.32 (10.66)	10.27 (9.02)	-8.05**	17.74	187/307 (61.1%)
SMFQ Child (n=636)	Depressive symptoms	352 (55.3%)	9.57 (6.55)	5.79 (5.74)	-3.78**	15.19	197 (56.6%)
SMFQ Caregiver (n=554)		n/a	9.97 (6.38)	5.84 (5.67)	-4.13**	15.11	n/a
Ohio Problem Severity Child (n=340)	Severity of internalizing/externalizing behaviors	139 (41.8%)	23.56 (16.30)	16.56 (14.71)	-7.00**	7.87	79/139 (59.1%)
Ohio Problem Severity Caregiver (n=506)		198 (39.1%)	22.84 (15.57)	16.75 (13.74)	-6.09**	9.33	111/198 (56.1%)
Ohio Functioning Child (n=340)	Child's adjustment and functioning	77 (23.4%)	54.19 (14.58)	59.77 (14.19)	5.58**	-7.35	50/77 (65.3%)
Ohio Functioning Caregiver (n= 506)		181 (35.8%)	49.47 (15.53)	55.45 (14.67)	5.98**	-8.92	109/181 (60.2%)

\*\* indicates significance  $p < .01$

### ***How is Change Measured in TF-CBT?***

Symptom reduction can be assessed on trauma symptoms, depressive symptoms, problem severity, or functioning. Each of these dimensions can have both a child and a caregiver report. When presenting symptom reductions, we use two methods to summarize changes. The overall change scores, using t-tests, are presented as a general measure of significant shifts across all children served from intake to discharge. These are represented in the change scores in Table 3 above.

Additionally, the Reliable Change Index (RCI) is also used. An overview of the RCI with explanations on how and why it is used is included in Appendix E. The RCI assigns a measure-specific point reduction threshold that represents significant change. The benefit of the RCI is that it provides a metric for measuring the significance of change for any individual child whereas the t-test looks at the significance of change on the aggregate. The relevant cut-off values for the measures used in this report are in Table 4.

**Table 4: RCI Values**

<b>Measure</b>	<b>Full RCI</b>	<b>Partial RCI</b>
CPSS Child Report	11	6
CPSS Caregiver Report	10	5
SMFQ Child Report	7	4
SMFQ Caregiver Report	6	3
Ohio Problem Severity (All Reporters)	11	6
Ohio Functioning (All Reporters)	8	4

Finally, not all children are elevated across all measures at intake. The intake and ongoing assessments cover a variety of potential symptoms and problem areas. When a child does not have elevated scores at intake, that indicates the child might not necessarily need improvement in that area and other measures and symptoms are the focus of treatment. When a child has a sub-clinical score at intake, they do not have the same potential for change as they begin with lower scores and the range of improvement is limited. Therefore, for each measure, we break out improvements by those in the clinical vs. sub-clinical ranges.

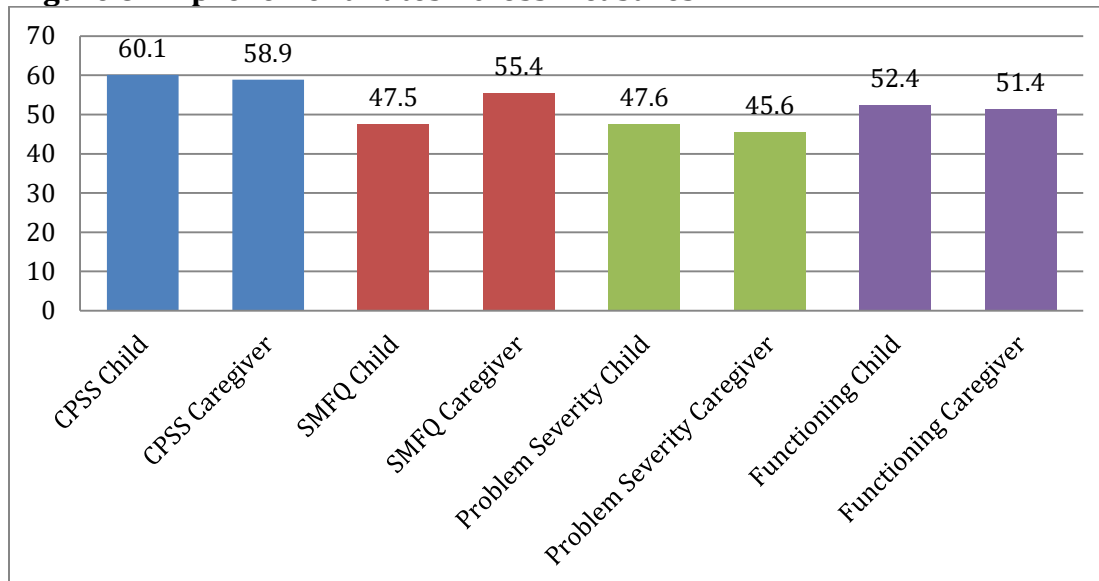
### ***Children Enter TF-CBT with Significant Trauma Histories***

At intake, children and caregivers report completing the Trauma History Screen (THS). This provides the total number of types of potentially traumatic events a to which a child has been exposed. As can be seen in Table 3 above, children report being exposed to an average of 6.84 different types of events and caregivers report an average of 5.62 events. While there is no post-test or change across time on the THS, this information is included here as it provides an indication of the significance of the trauma histories the children have experienced, which is important contextual information in interpreting the other assessment measure scores.

### ***Children Improve Across Multiple Domains***

Children receiving TF-CBT were assessed on four measures, each with child and caregiver report versions. When children were assessed at two or more time points, change scores were calculated and RCI values were used to see the percentage of children who experienced reliable change. Figure 8 below shows the relative rates of improvement across the measures. The highest rates of improvement were on the CPSS. Given the high rates of trauma exposure for this population as indicated on the THS at intake (an average of nearly seven events by child report and over five events by caregiver report), the higher rates of improvement on trauma symptoms is an important and positive outcome. Improvements were not limited to the CPSS. More than half of children also experienced improvement on the Ohio Functioning scales and on the caregiver report of depression. Problem Severity scores and child-reported depression had rates of improvement ranging from 45.6% to 47.6%.

**Figure 8. Improvement Rates Across Measures**

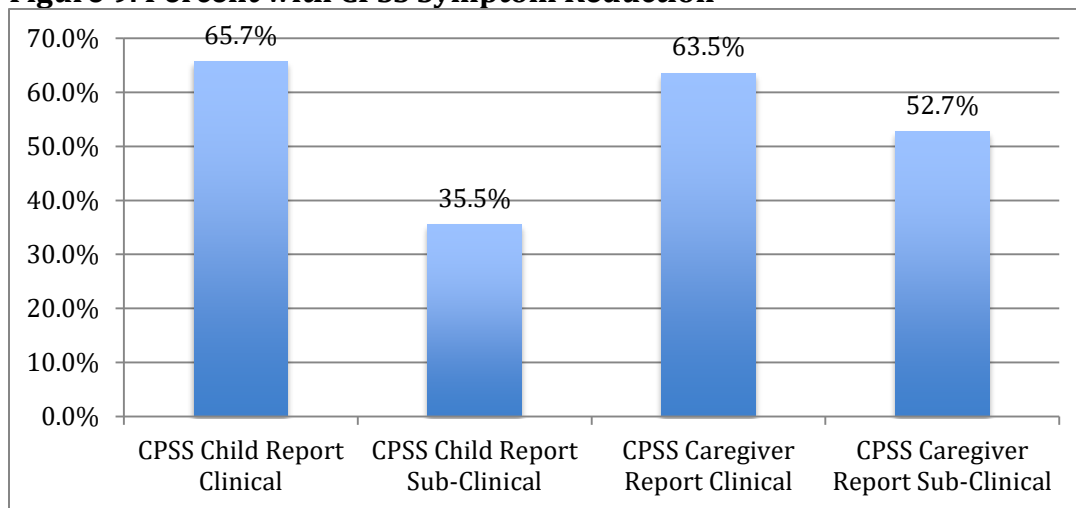


### ***The Greatest Change is in Reduction of Trauma Symptoms***

Child PTSD symptoms are measured by the Child PTSD Symptom Scale (CPSS-IV; Foa, Johnson, Feeny, & Treadwell, 2001). The CPSS is a 17-item instrument used to measure post-traumatic stress disorder severity in children. There are two versions: a child self-report and a caregiver report. For FY18 CPSS-IV child report change scores were available for 637 children. In the full sample, 383 (60.1%) demonstrated some level of improvement (either partial, reliable, or clinically

significant). That number is higher for those who began with scores (n=412) above the clinical cut-off; in that group **65.7% experienced trauma symptom reduction**. For children whose scores were below the threshold, 35.5% experienced symptom reduction. For the caregiver report of the CPSS, 543 children had data and of those 58.9% experience symptom reduction. For the 307 who began above the clinical cut-off, 63.5% experienced symptom reduction; for those below, 52.7% had a reduction in symptoms. Figure 9 shows the percentage with symptom reduction broken out by report and clinical and sub-clinical groups.

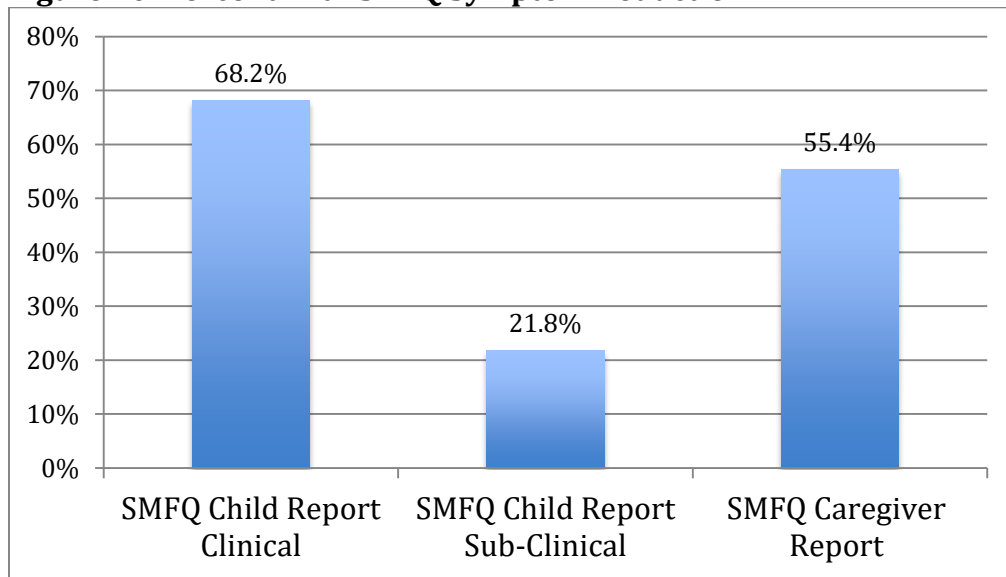
**Figure 9. Percent with CPSS Symptom Reduction**



### ***Children in TF-CBT Experience Reductions in Depression***

Child depression symptoms are measured by the Short Mood and Feelings Questionnaire (SMFQ; Angold et al., 1995). The SMFQ has 13-items and there are two versions: a child self-report and a caregiver report. Measure descriptives for the first and last reporting period are in Table 3 above. For FY18 SMFQ child report change scores were available for 636 children; of these 302 (47.5%) demonstrated some level of improvement (either partial, reliable, or clinically significant). Figure 8 shows the levels of change separately for those that began in the clinical range and those that did not. For those that began in the clinical range, **68.2% had significant improvement**; for those in the sub-clinical range at intake, 21.8% had significant reduction. Comparing the magnitude of change to the CPSS-IV, sub-clinical depression scores were less likely to lower than sub-clinical trauma symptom scores. This suggests the SMFQ is an important measure for those with co-occurring depression and trauma symptoms but many children present without needing to target depression. The SMFQ does not have clinical cut-offs for the caregiver version; of the 554 children assessed on the SMFQ Caregiver, 55.4% experience a reduction in symptoms. These are illustrated in Figure 10 below.

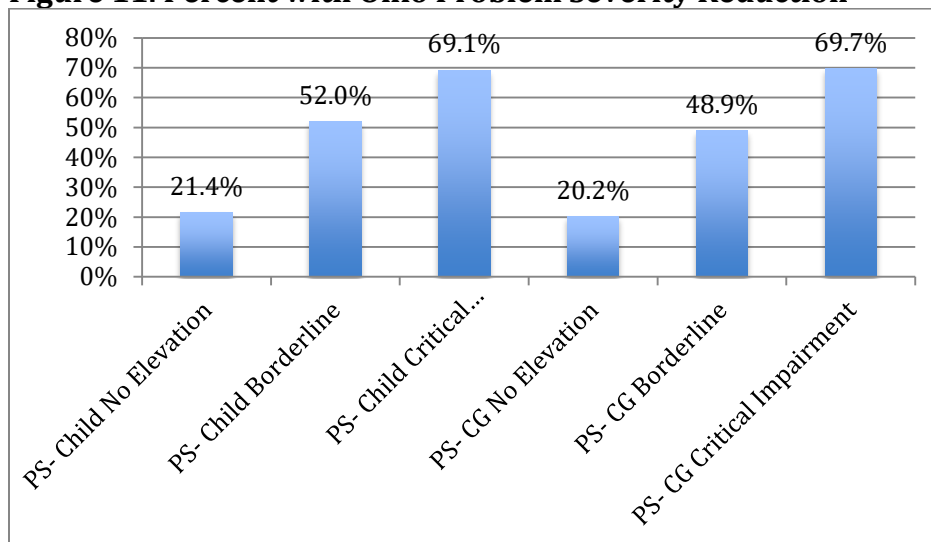
**Figure 10. Percent with SMFQ Symptom Reduction**



***Problem Severity was Lowered, From Child and Caregiver Perspective***

The Ohio Youth Problem Severity scale (Ogles, Melendez, Davis, & Lunnen, 2001) measures the degree of problems a child is currently experiencing. In TF-CBT the child and caregiver reports are collected. Ohio Problem Severity- Child Report scores were available for 340 children. Of the full sample, 47.6% had improvement; 40.8% scored in the critically impaired range and 22.0% scored in the borderline range at intake. Of the youth scoring in the critical impairment range, **69.1% had reliable improvement**. For the caregiver report, 506 children had data for comparison. Overall, 44.7% had symptom reduction; 39.1% scored in the critically impaired range and 17.8% scored in the borderline range at intake. Youth scoring in the critical impairment range, **69.7% had reliable improvement**. Rates of improvement across groups and reporters are shown in Figure 11.

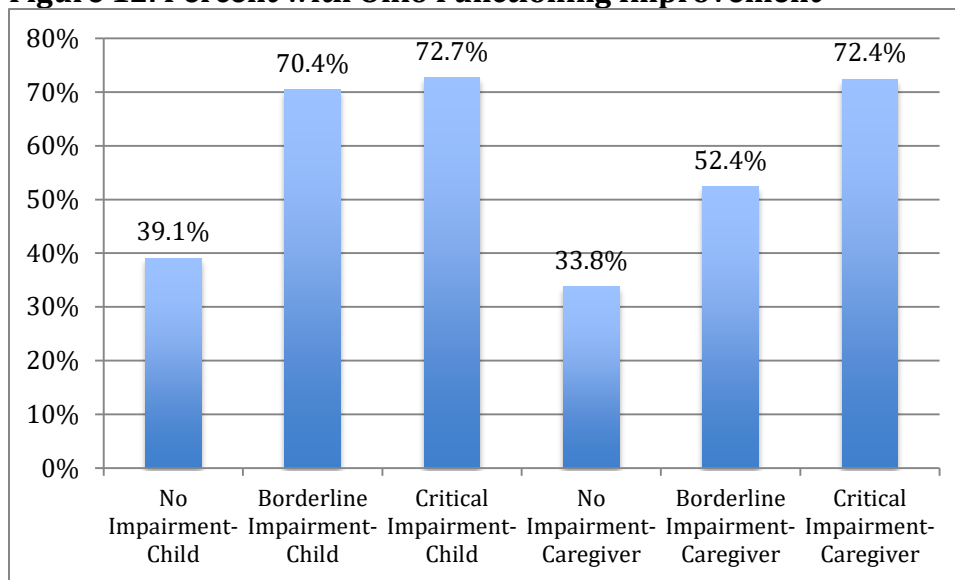
**Figure 11. Percent with Ohio Problem Severity Reduction**



### ***Children Experienced Increases in Child Functioning***

The Ohio Youth Functioning scale measures the degree to which a child's problems affect their day-to-day activities. Ohio Problem Severity- Child Report scores were available for 340 children. Of the full sample, 52.3% had improvement. Of the sample, 22.6% scored in the critically impaired range and 17.9% scored in the borderline range at intake, lower than the comparable rates on the Problem Severity Scale. Of the youth scoring in the critical impairment range, **72.7% had reliable improvement**. For the caregiver report, 506 children had data for comparison. Overall, 51.3% had symptom reduction; 35.8% scored in the critically impaired range and 20.4% scored in the borderline range at intake. Of youth scoring in the critical impairment range, **72.4% had reliable improvement**. Rates of improvement across groups and reporters are shown in Figure 12.

**Figure 12. Percent with Ohio Functioning Improvement**



### ***Clinical Improvements are Equitable Across Groups***

In addition to documenting the overall rates of symptom reduction and functional improvement, it is important to monitor if any subgroups are experiencing disproportionate outcomes. Multiple regressions were performed to explore the effect of race categories, age, and sex on discharge scores, controlling for initial scores. Nearly all of the findings were insignificant, suggesting that there were not differences in groups on symptom reduction or functional improvement. Details of the tests can be found in Appendix Z, but the significant findings are presented here.

**Age.** On two measures, the CPSS-IV child report and the Ohio Problem Severity child report, older youth left TF-CBT with significantly higher scores than their younger counterparts. This age discrepancy was only on the reports from the children themselves; the caregiver reports of child trauma symptoms and problem severity did not show this effect. On the CPSS-IV, youth had slightly higher scores ( $\beta=0.278$ ) for each additional year of age [ $t(1)=6.458$ ,  $df=1$ ,  $p=.011$ ]. On the Ohio Problem Severity, youth had an increase of over half a point ( $\beta =0.581$ ) for each additional year of age [ $t(1)=2.039$ ,  $p=.042$ ].

**Sex.** There were no significant differences between males and females on any of the scores, after controlling for initial scores, race/ethnicity, and age.

**Race.** The only differences between racial groups was that Black youth had lower scores (reflecting lower symptoms) on three measures: CPSS-IV child report ( $\beta=-3.371$ ,  $t(3)=-2.161$ ,  $p=.031$ ), CPSS-IV caregiver report ( $\beta=-3.891$ ,  $t(3)=2.326$ ,  $p=.020$ ), and the SMFQ child report ( $\beta=-1.877$ ,  $t(3)=-2.173$ ,  $p=.096$ ).

## **Highlighting the work with CSSD**

Since 2014, CHDI has worked with the Court Support Services Division (CSSD) of the Judicial Branch and the Department of Children and Families (DCF) to improve trauma-informed services for justice-involved youth in Connecticut by increasing the identification of youth's trauma history and symptoms, and engaging youth evidence-based trauma treatments. As part of this work, CHDI has provided training to Juvenile Probation Officers and staff from the Child Youth Family Support Centers (CYFSC) across the state in the use of the Child Trauma Screen (CTS) and the process for referring youth to trauma services, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Additionally, CHDI has worked to build partnerships between Juvenile Probations officers and local behavioral health providers to ensure a clear process for screening, referral and treatment. CHDI collects and analyzes data on the Child Trauma Screen (CTS) and TF-CBT treatment for youth involved in the justice system.

Appendix F is an overview of the work specific to juvenile justice completed during the year. During FY18, 846 justice-involved youth were screened for trauma by probation officers and CYFSC staff using the CTS. Of those screened, 72% reported exposure to traumatic events, underlining the high rates of trauma exposure among justice-involved youth and the importance of trauma screening for this population. Of those youth with identified trauma exposure, 64% were referred for treatment services including TF-CBT, other mental health services, and in-home services. During the fiscal year, 48 justice-involved youth received TF-CBT services, with 81% completing treatment and 92% reporting satisfaction with treatment. Justice involved youth receiving TF-CBT in FY18 experienced clinically significant reduction in their PTSD and Depression symptoms, with a mean reduction 7.8 points on PTSD assessments and a mean reduction of 3.8 points on Depression assessments.

In an effort towards establishing a trauma-informed system within Connecticut's juvenile justice system, CHDI worked closely with CSSD in FY18 to conduct a trauma informed evaluation of one residential facility for juvenile offenders. The purpose of the evaluation was to identify the extent to which the facility's policies and practices were trauma-informed and to make recommendations for improvement. The evaluation included meetings with program managers, a staff survey, focus group discussions, and a systematic review of facility policies by CHDI staff. CHDI compiled its findings and recommendations and submitted to CSSD in a comprehensive report. Plans are currently in place to conduct a similar evaluation with a second residential facility in FY19.

## **Recommendations**

The following recommendations are made for continued support of the TF-CBT statewide network:

### **1. Coordinating Center:**

- Continue to provide training and consultation opportunities for clinicians in all areas of the state, clinical settings other than outpatient clinics, and in private practice and school-based settings
- Expand training and consultation for clinicians to include advanced training and booster training
- Incorporate booster training into credentialing process so that newly-trained TF-CBT clinicians receive the additional support and skill development they need to ensure their sustained practice of TF-CBT
- Provide training opportunities on use of standardized assessments in clinical practice
- Provide culturally and linguistically appropriate clinical tools in electronic format (built into EBP Tracker)
- Where appropriate, consolidate data and quality improvement reports to provide more efficient feedback and consultation to agencies
- Continue to collect relevant financial data and support adequate reimbursement rates for the implementation and sustainability of TF-CBT and other EBPs
- Develop consultation model that will address QI needs of each agency and will include multiple treatment models
- Calculate and administer sustainability funds with revised categories that reimburse for staff time missed at trainings on timely data entry in addition to performance-based metrics
- Calculate individual active clinician status twice annually and provide that information to each agency
- Continue to develop capacity of EBP Tracker to produce reports at the client, clinician, agency and statewide levels

### **2. System:**

- Develop strategies for linking or integrating EBP Tracker and PIE to eliminate redundancies. Opportunities to create efficiencies are likely to exist since both systems were developed by the same contractor.
- Continue funding performance-based sustainment funds to improve capacity, access, and quality of care; financial incentives are intended to partially offset the increased agency costs of providing an evidence-based practice

- Consider strategies for implementing a more sustainable approach to integrate performance-based payments into reimbursement rates and/or DCF contracts with OPCCs directly.
- Support collaboration among child welfare, juvenile justice, and TF-CBT providers to monitor and coordinate referrals and care for children receiving TF-CBT.
- Provide education to child welfare staff about the value of evidence-based treatment and TF-CBT for youth with behavioral health services, how to determine the type of treatment a child is receiving, and how to advocate for evidence-based treatment.
- Develop a plan for a Coordinating Center that works to identify, disseminate, support, and integrate EBPs beyond TF-CBT. Such a Center could have a broader impact on the children's behavioral health system and could test and implement population-based strategies and models (e.g. for all children seen in OPCCs) through use of standardized assessment measures (measurement based care) and clinical and organizational strategies that are relevant for all children (e.g. engagement, behavioral rehearsal, use of supervision, self-care).
- Embed the cross-system work of TF-CBT, along with data on utilization and outcomes, within relevant statewide committees and councils, including but not limited to: the Behavioral Health Plan Advisory Board; the Juvenile Justice Policy and Oversight Committee (JJPOC); and the Behavioral Health Partnership Quality Access and Policy Subcommittee.

### **3. Providers:**

- Develop sustainability plans and provide clinical staff the needed resources for implementation of multiple evidence based treatment models
- Use EBP Tracker reports to monitor case data entry as well as receive more timely feedback on agency performance.
- Develop QI strategies that will increase focus on child outcomes, symptom reduction, and successful completion of treatment
- Agency Senior Leaders report the inadequacy of provider incentives to cover the cost of providing evidence based practices, and need to continue to advocate for adequate reimbursement rates to sustain EBPs

## Appendix A: Sustainability Funding Plan for Fiscal Year 2018

This document summarizes the plan for awarding sustainability funds to TF-CBT agencies beginning July 1, 2017. Provider incentives are awarded twice a year: based on performance January 1-June 30 and July 1- December 31. Sustainability funds are dependent on DCF funding. Due to the fact that the exact amount available varies, the plan is based on percentages and points that can be adjusted for any amount.

Currently, only TF-CBT agencies are eligible for sustainability funds. However, this plan was designed to apply across treatment models and incentives general best practices in delivering any EBP to children in outpatient settings.

### Agency Eligibility

TF-CBT agencies will be eligible for sustainability funds if they are:

- 1) Credentialed as an agency
- 2) Have met 50% of the Quality Improvement benchmarks in either the current or previous reporting period (i.e., failure to meet the QI benchmarks for two consecutive periods would disqualify an agency from receiving incentive money.

### Implementation and Child Outcomes Distribution

The available money will be allocated according to performance of an agency based on aggregated case data. Due to the amount of money varying in each performance period, calculations will be done in points.

Cases eligible to earn points in any given performance period are those that ***closed*** in that period. All of their case data, including data from before the performance period, will then be used to calculate the points.

Points are calculated based on the following categories:

- Engaged (40 points): Cases that have 4 or more sessions
- Satisfaction (20 points): Cases that completed a CSQ with a total score of 4.3 or higher
- Symptom Reduction (40 points): Given for cases that meet the reliable change benchmark (full or partial RCI) for reduction of symptoms on ***at least one*** assessment measure (currently the CPSS Child, CPSS Caregiver, SMFQ Child, SMFQ Caregiver). NOTE: Forty points is the maximum for a case to earn. If a case meets this benchmark on more than one assessment, they still only get 40 points.

Taken together, these categories allow for each case to be worth 100 points.

- There will be an adjustment for cases that are considered complex due to the presence of risk factors. Cases deemed to be “complex” will earn an additional 10 points in the engagement and symptom change and categories and 5 points in the satisfaction category if they meet

the criteria. This would allow for a potential 125 points to be earned for each complex case.

- This is to recognize that certain benchmarks may be more difficult for certain cases to meet; rather than attempting to change the benchmark for these cases, we are instead providing additional points for the complex cases that meet each benchmark in recognition of the potential difficulties clinicians might have
- A case is considered complex when two or more of the following factors are indicated: DCF Involvement, JJ involvement, Suspended/Expelled, IEP, Arrested/Detained/Incarcerated, Alcohol or other drug use, Evaluated in ER, or Medically complex

## Appendix B: QI Overview & Definitions

### QI Overview

The indicators provided in this report cover the period from July- December 2016. Some definitions have changed since the last reporting period. A complete list of the current definitions is included as well as a brief overview of the major changes.

The QI indicators and definitions are color-coded to make them easier to interpret.

Color	Indicators	Description
Green	-Penetration Rate -# Clinicians Credentialed	These indicators are based on agency-wide data in the given period
Red	-% Satisfied with Treatment	This indicator is based on all CSQs completed in the quarter, on open and closed cases
Blue	-Engaged -Caregiver Involvement -Cases with 2 visits/month -Trauma Narrative Complete -% Successfully Completed with All Required Components -Cases with Assessment Data	These indicators are based only on cases that <i>closed</i> in the QI period; Assessment Only cases are not counted in these numbers.
Orange	-Cases with Symptom Improvement	This indicator is calculated on cases that <i>closed</i> in the QI period <i>with assessment data</i>

### Definitions that Changed:

- **% Satisfied with Treatment:** Prior QI reports only looked at CSQ data on closed cases, using the last CSQ completed. Instead, going forward QI data will be based on all CSQs completed in the quarter (open or closed cases). It is now based on a percentage, *with a benchmark of 70% of cases having a score of 4.3 or above.*
- **% Cases with 2 Visits/Month:** This is a new indicator based on looking at historic data and finding that cases that were seen at least twice a month on average were more likely to have successful completion and positive outcomes. *The benchmark is 65% of closed cases.*
- **% Cases with Assessment Data:** This indicator replaces the previous indicator of "Assessments Up-to-Date; this is now calculated on closed cases and is the percentage of cases that had enough assessment data (i.e. at least two administrations) to calculate change on PTSD or depression symptoms. *The benchmark is 70% of closed cases.*
- **% with Symptom Improvement:** Cases that meet the definition of reduction in symptoms (full or partial RCI) on at least one of the following measures: Child CPSS, Caregiver CPSS, Child SMFQ, or Caregiver SMFQ. *The benchmark is 75% of closed cases.*

**In order to be credentialed, agencies must meet the following benchmarks:**

- 1) Penetration rate
- 2) Credentialed clinician
- 3) Four of the remaining eight indicators

**QI Definitions**

<sup>a</sup> Penetration Rate	Proportion of Annual TF-CBT cases in total outpatient caseload in agencies or programs offering TF-CBT [ <b>Note:</b> For agencies that do not meet this benchmark for the year, an estimated penetration rate is calculated for the July to December period]
<sup>b</sup> # Clinicians Credentialed	Number of clinicians in agency who have completed state credentialing or national certification at any point in time
<sup>c</sup> Percent Satisfied	Percentage of CSQs completed in the period that had an average of 4.3 or above
<sup>d</sup> # of Closed Cases	Cases that closed during the reporting period, excluding Assessment Only cases
<sup>e</sup> Engaged	Percentage of closed cases that had at least 4 sessions
<sup>f</sup> CG Involved	Percentage of closed cases in which 33% of session time included a caregiver
<sup>g</sup> 2 Visits/Month	Percentage of closed cases that averaged two or more visits per month
<sup>h</sup> TN Complete	Percentage of cases that completed a trauma narrative
<sup>i</sup> Successfully Completed with All Required Components	Cases that closed during the reporting period which: a) had at least 8 sessions b) were indicated as successful by clinician c) completed all required treatment components
<sup>j</sup> Cases with Assessment Data	Percentage of closed cases that had enough assessment data (i.e., at least two administrations) to calculate change on child PTSD or depression symptoms
<sup>k</sup> Symptom Improvement	Percentage of cases that had a reduction in symptoms (at least partial RCI) on at least one of the following measures: Child CPSS, Caregiver CPSS, Child SMFQ, and Caregiver SMFQ (out of cases that had assessment data)

## Frequently Asked Questions

### **What requirements must be met for an individual clinician to be credentialed?**

An individual clinician must attend the 2-day clinical training, 75% of a consultation call group, and have two cases that meet the credentialed case requirements (one of which must have caregiver involvement). A credentialed case must:

- be indicated as successful by the clinician at discharge
- have at least 8 sessions
- completed all of the required PRACTICE components
- have a complete baseline and at least one complete follow-up assessment

### **How much change is needed for a score to count as symptom reduction?**

CPSS Child: -6 points  
SMFQ Child: -4 points

CPSS Caregiver: -5 points  
SMFQ Caregiver: -3 points

### **What are the required treatment components?**

For cases **with a caregiver** involved

(1) Psychoeducation; (2) Parenting Skills; (3) Relaxation; (4) Affective Expression and Modulation; (5) Cognitive Coping and Processing; (6) Trauma Narrative; (7) Conjoint Child-Parent Sessions; and (8) Enhancing Future Safety.

For cases **without caregiver** involved

(1) Psychoeducation; (2) Relaxation; (3) Affective Expression and Modulation; (4) Cognitive Coping and Processing; (5) Trauma Narrative; and 6) Enhancing Future Safety.

### **What happens if my agency does not meet the agency credential benchmarks in a reporting period?**

The Coordinating Center will work with you to review the data for your team, identify challenges in meeting the credentialing requirements, and develop a Performance Improvement Plan that will improve your team's progress.

## QI Table: July to December 2017

<b>TF-CBT Quality Improvement Indicators</b> <b>July-December 2017</b>											
Provider Name	a. Penetration Rate	b. # Credentialed Clinicians	c. Percent Above CSQ	d. # of Cases Closed in Period	e. % Engaged	f. % Caregiver Involvement	g. % Cases with 2 Visits/Month	h. % Cases with TN Complete	i. % Cases Successfully Completed	j. % Cases with Assessment Data	k. % Cases with Symptom Improvement
<b>Benchmark</b>	<b>4%</b>	<b>1</b>	<b>70%</b>	<b>n/a</b>	<b>55%</b>	<b>65%</b>	<b>65%</b>	<b>35%</b>	<b>30%</b>	<b>70%</b>	<b>75%</b>
Adebrook, Inc.	N/A	1	100%	1	100%	0%	100%	0%	0%	100%	100%
Boys & Girls Village	41.9%	1	88%	5	100%	100%	100%	100%	100%	100%	80%
Bridges, A Community Support System	19.7%	4	71%	13	100%	54%	77%	62%	31%	62%	88%
Catholic Charities Archdiocese of Hartford	14.6%	3	100%	5	100%	80%	80%	60%	60%	100%	100%
Charlotte Hungerford Hospital	9.6%	6	79%	26	100%	92%	85%	73%	50%	62%	94%
Child and Family Agency of Southeastern Connecticut, Inc	7.8%	6	75%	15	87%	80%	87%	27%	7%	47%	43%
Child Guidance Center of Southern Connecticut, Inc.	5.5%	2	75%	18	94%	61%	83%	44%	33%	56%	80%
Clifford Beers Clinic	5.8%	9	68%	15	93%	53%	80%	33%	27%	87%	100%
Community Child Guidance Clinic, Inc.	6.9%	6	100%	13	85%	69%	77%	15%	8%	69%	78%
Community Health Center, Inc.	3.8%	6	100%	3	67%	33%	0%	0%	0%	0%	0%
Community Health Resources	4.8%	5	36%	25	92%	76%	56%	48%	36%	52%	92%
Community Mental Health Affiliates, Inc.	13.0%	4	53%	20	95%	65%	55%	35%	30%	85%	65%
Connecticut Junior Republic	13.6%	6	80%	13	85%	77%	77%	69%	54%	85%	64%
Cornell Scott Hill Health Center	5.5%	4	73%	13	92%	54%	69%	77%	31%	77%	80%
Day Kimball Healthcare	5.3%	2	100%	4	100%	50%	100%	75%	2%	75%	100%
Family & Children's Aid, Inc.	3.4%	6	91%	21	95%	43%	76%	57%	29%	71%	80%
Family Centers, Inc.	14.1%	4	100%	14	79%	100%	57%	50%	29%	57%	75%
Jewish Family Services	11%	3	83%	2	50%	50%	0%	50%	0%	50%	100%
Kingsberg Family Centers	9.9%	3	60%	11	89%	44%	78%	67%	11%	56%	100%
LifeBridge Community Services	16.2%	7	70%	20	100%	75%	65%	60%	45%	65%	92%
Mid-Fairfield Child Guidance Center, Inc.	9.8%	3	83%	12	100%	100%	92%	50%	33%	75%	89%
Parent Child Resource Center	14.0%	3	73%	8	100%	50%	88%	75%	38%	100%	100%
The Child and Family Guidance Center	7.1%	9	66%	24	96%	75%	92%	50%	29%	67%	100%
The Child Guidance Clinic For Central Connecticut, Inc.	5.6%	2	93%	4	75%	50%	50%	50%	50%	50%	100%
The Village for Families & Children, Inc.	3.7%	8	79%	26	92%	68%	48%	40%	20%	72%	94%
United Community and Family Services	5.8%	11	66%	45	93%	68%	77%	66%	45%	82%	83%
United Services, Inc.	6.8%	6	81%	17	94%	82%	71%	76%	59%	94%	81%
Waterford Country School, Inc.	33.3%	3	100%	4	100%	67%	67%	67%	33%	100%	67%
Wellmore Behavioral Health	5.7%	2	79%	15	93%	67%	67%	33%	33%	73%	82%
Wheeler Clinic	3.8%	5	80%	29	93%	62%	31%	41%	14%	69%	95%
Yale Child Study Center	9.9%	5	48%	10	100%	80%	80%	70%	40%	70%	100%
Yale Child Study Center-West Haven	14.3%	2	100%	3	100%	67%	100%	33%	33%	67%	100%
<b>Total/Average</b>	<b>6.50%</b>	<b>147</b>	<b>80%</b>	<b>454</b>	<b>92%</b>	<b>65%</b>	<b>71%</b>	<b>52%</b>	<b>32%</b>	<b>71%</b>	<b>84%</b>



### TF-CBT QI Table Jan – June 2018

The TF-CBT Coordinating Center located at Child Health and Development Institute. The report summarizes quality indicator performance data during the period January – June 2018 for implementation and sustainment of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) at community based providers in Connecticut. For more information contact: Carol O'Connor, LCSW 860-679-1517/[coconnor@chdi.edu](mailto:coconnor@chdi.edu) Visit our EBP resource page at: <http://www.chdi.org/our-work/mental-health/evidence-based-practices/ebp-provider-resources>.

Provider Name	a. # Credentialed Clinicians	b. Percent Above CSQ	c. # of Cases Closed in Period	d. % Engaged	e. % Caregiver Involvement	f. % Cases with 2 Visits/Month	g. % Cases with TN Complete	h. % Cases Successfully Completed	i. % Cases with Assessment Data	j. % Cases with Symptom Improvement
<b>Benchmark</b>	<b>1</b>	<b>70%</b>	<b>n/a</b>	<b>55%</b>	<b>65%</b>	<b>65%</b>	<b>35%</b>	<b>30%</b>	<b>70%</b>	<b>75%</b>
Addbrook, Inc.	1	75%	3	100%	33%	100%	67%	67%	100%	100%
Boys & Girls Village	1	0%	1	100%	100%	100%	0%	0%	0%	0%
Bridges, A Community Support System	4	59%	23	83%	35%	70%	48%	35%	52%	83%
Catholic Charities Archdiocese of Hartford	3	80%	6	83%	33%	67%	17%	0%	17%	100%
Charlotte Hungerford Hospital	7	77%	28	89%	93%	86%	82%	54%	79%	82%
Child and Family Agency of Southeastern Connecticut, Inc	4	64%	12	100%	50%	75%	33%	8%	67%	63%
Child Guidance Center of Southern Connecticut, Inc	1	75%	9	100%	11%	100%	22%	22%	67%	83%
Clifford Beers Clinic	5	66%	18	94%	61%	83%	61%	22%	78%	79%
Community Child Guidance Clinic, Inc	6	88%	10	90%	70%	50%	20%	20%	80%	75%
Community Health Center, Inc	5	94%	23	80%	60%	65%	45%	25%	55%	73%
Community Health Resources	5	58%	35	88%	62%	79%	47%	24%	62%	76%
Community Mental Health Affiliates, Inc	5	68%	15	100%	67%	60%	27%	13%	87%	77%
Connecticut Junior Republic	4	100%	7	100%	43%	71%	71%	29%	71%	80%
Cornell Scott Hill Health Center	7	79%	20	80%	60%	70%	50%	35%	65%	100%
Day Kimball Healthcare	2	0%	2	100%	0%	100%	50%	50%	50%	100%
Family & Children's Aid, Inc	8	100%	17	75%	31%	63%	63%	31%	50%	88%
Family Centers, Inc	3	91%	10	90%	50%	70%	90%	60%	80%	88%
Jewish Family Services	3	100%	4	100%	50%	100%	100%	100%	100%	100%
Klingberg Family Centers	3	0%	5	100%	80%	100%	20%	20%	60%	33%
LifeBridge Community Services	7	40%	5	80%	100%	40%	20%	20%	60%	100%
Mid-Fairfield Child Guidance Center, Inc	2	59%	9	100%	67%	89%	78%	78%	100%	78%
Parent Child Resource Center	3	69%	8	100%	88%	100%	63%	38%	75%	83%
The Child and Family Guidance Center	8	81%	25	88%	83%	75%	42%	38%	58%	93%
The Child Guidance Clinic For Central Connecticut, Inc	1	90%	10	100%	70%	60%	70%	60%	80%	100%
The Village for Families & Children, Inc	7	69%	18	94%	72%	78%	78%	56%	94%	94%
United Community and Family Services	10	71%	38	90%	63%	82%	53%	34%	71%	74%
United Services, Inc	5	83%	34	97%	71%	68%	71%	41%	79%	70%
Waterford Country School, Inc.	3	100%	12	100%	92%	100%	67%	67%	75%	78%
Wellmore Behavioral Health	3	75%	21	86%	71%	48%	38%	33%	52%	91%
Wheeler Clinic	5	63%	12	83%	42%	50%	42%	8%	50%	50%
Yale Child Study Center	7	74%	18	100%	89%	100%	56%	33%	89%	88%
Yale Child Study Center-West Haven	2	100%	1	100%	100%	100%	0%	0%	100%	0%
<b>Total/Average</b>	<b>141</b>	<b>75%</b>	<b>459</b>	<b>91%</b>	<b>64%</b>	<b>75%</b>	<b>55%</b>	<b>36%</b>	<b>70%</b>	<b>81%</b>

## Appendix E: Using RCI to Measure Improvement?

In FY16, CHDI began using the Reliable Change Index (RCI: Jacobson & Traux, 1991) as a metric for reporting outcomes. The approach uses the properties of an assessment measure to calculate an RCI value; when a change score exceeds that value it is considered to be reliable change and not due to chance. The RCI can be used with a measure's clinical cut-offs to identify both reliable and clinically significant changes (Jacobson NS, Truax P (1991)).<sup>1</sup>

This method places individuals into one of seven separate categories.

1. *Improvement with Clinical Significance* is when there is positive change from intake to discharge that meets or exceeds the RCI value **and** there is a move from the clinical to the non-clinical range
2. *Reliable Improvement* is when there is a positive change from intake to discharge that meets or exceeds the RCI value but there is **no** movement from the clinical to non-clinical range
3. *Partial Improvement* is when there is positive change that is greater in magnitude than half of the RCI value but does not meet the full RCI value
4. *No Change* is when the change, positive or negative, is less than half of the RCI value
5. *Partial Deterioration* is when there is a negative change that greater than half of the RCI values but still less than the full RCI value
6. *Reliable Deterioration* is when there is negative change that meets or exceeds the RCI value but there is **no** movement from outside to inside the clinical range
7. *Deterioration with Clinical Significance* is when there is negative change that meets or exceeds the RCI value **and** the score changes from outside the clinical range to inside the clinical range

These seven categories are used below to demonstrate the outcomes on child PTSD symptoms, child depression symptoms, child problem severity, and child functioning. The RCI values for the Child PTSD Symptom Scale (CPSS) and the Short Mood and Feelings Questionnaire were calculated by CHDI using existing TF-CBT data. The RCI values for the Ohio Problem Severity and Functioning scales were

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<sup>1</sup> Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology* 59, 12-19.

given a previous validation report of the measures (TX DMHMR, 2003). The RCI and partial RCI values used in this report are given in table 3 below.