Connecticut's Evidence Based Treatment Coordinating Center: Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and Conduct Problems (MATCH-ADTC)

FY 2019 Annual Report

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Executive Summary

The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and Conduct problems (MATCH-ADTC) Coordinating Center ("Coordinating Center"), is located at the Child Health and Development Institute (CHDI). Funded by the Connecticut (CT) Department of Children and Families (DCF), the goal of the MATCH-ADTC Coordinating Center is to expand access to high quality, evidence-based outpatient behavioral health treatment for children experiencing anxiety, depression, trauma, and/or conduct problems. Using implementation science and economies of scale, Coordinating Center supports a network of 19 MATCH-ADTC 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 fiscal year 2019 (July 1, 2018 through June 30, 2019).

Highlights of FY 19:

- 820 children received MATCH-ADTC
- 54 new clinical staff were trained to deliver MATCH-ADTC
- Caregivers (~95%) and children (95%) reported high satisfaction with treatment.
- Children completing MATCH-ADTC had positive clinical outcomes with over 60% of children with elevated trauma symptoms reporting remission, and 63% of caregivers reporting remission in children's internalizing/externalizing behaviors.
- This was the sixth year of MATCH-ADTC implementation in CT; cumulative totals reflect the work and commitment on the part of DCF, CHDI, provider agencies, Harvard, and other supporting partners
- A cohort of MATCH-ADTC Train-the-Trainers began and will complete in FY20 to enhance site-based and state-level training capacity across Connecticut.
- All 19 MATCH-ADTC Providers met the QI Engagement benchmark in FY19

Key Recommendations:

- Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity and health equity
- Implement first state-level MATCH-ADTC training with CT-based state-level trainers to enhance statewide implementation efforts in FY20, which will improve access to MATCH-ADTC across the state
- Increased training in assessments so that clinicians have more options and flexibility when measuring symptom reduction while still documenting the positive outcomes
- Add an anxiety measure to the flexible assessment schedule in the PIE-EBP Tracker integrated system.
- Update terminology used in PIE (e.g., sex assigned at birth; Latino) to collect demographic information that complies with current best practices (e.g., gender identity; Latinx)
- Expand collection of zip codes to nine digits in PIE to strengthen opportunities to merge PIE data with external data sources (e.g., Area Deprivation Index) to examine health disparities and inequities

Introduction

The goal of the MATCH-ADTC Coordinating Center is to expand access to high quality, evidence-based outpatient behavioral health treatment for children experiencing anxiety, depression, trauma, and/or conduct problems. Funded by DCF, the Coordinating Center uses economies of scale to create centralized support for the statewide network of 19 MATCH-ADTC 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.

A detailed accounting of these activities during FY19 can be found in Appendix A.

This report summarizes the work of MATCH-ADTC Coordinating Center ("Coordinating Center"), funded by the Connecticut Department of Children and Families (DCF), for state fiscal year 2019 (July 1, 2018 through June 30, 2019). 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 treatment for children experiencing anxiety, depression, trauma, and/or conduct problems through dissemination and sustainment of MATCH-ADTC 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

MATCH-ADTC is an evidence-based treatment designed for children ages 6 - 15. Unlike most treatment approaches that focus on single disorders, MATCH-ADTC is designed to treat four common behavioral health concerns among children, including anxiety, depression, posttraumatic stress, and behavior problems.

MATCH-ADTC is comprised of 33 modules (e.g., praise, rewards, etc.) representing treatment components that are frequently included in cognitive behavioral therapy (CBT) protocols for depression, anxiety (including post-traumatic stress), and behavioral parent training for disruptive behavior. MATCH-ADTC is designed to address broad practitioner caseloads, comorbidity, and changes in treatment needs during episodes of care, creating a foundation for successful outcomes.

CHDI, the Department of Children and Families (DCF) and Harvard University (HU; with Dr. John Weisz) established a partnership in July 2013 to carry out a five-year, $5 million project to implement, replicate and evaluate MATCH-ADTC in Connecticut. By July 2016, a parallel and integrated effort to disseminate and sustain MATCH-ADTC across Connecticut emerged through the "Learning Collaborative" series.

Starting in 2018, the Coordinating Center was expanded to provide additional support for this growing network of MATCH-ADTC providers alongside other EBPs and outpatient providers across Connecticut. This report covers the work of the Coordinating Center for FY 19.

Goals

The primary goals for the Coordinating Center are to:

(1) Provide access to MATCH-ADTC for all Connecticut children experiencing anxiety, depression, trauma, and/or conduct problems

(2) Ensure that high-quality MATCH-ADTC is provided

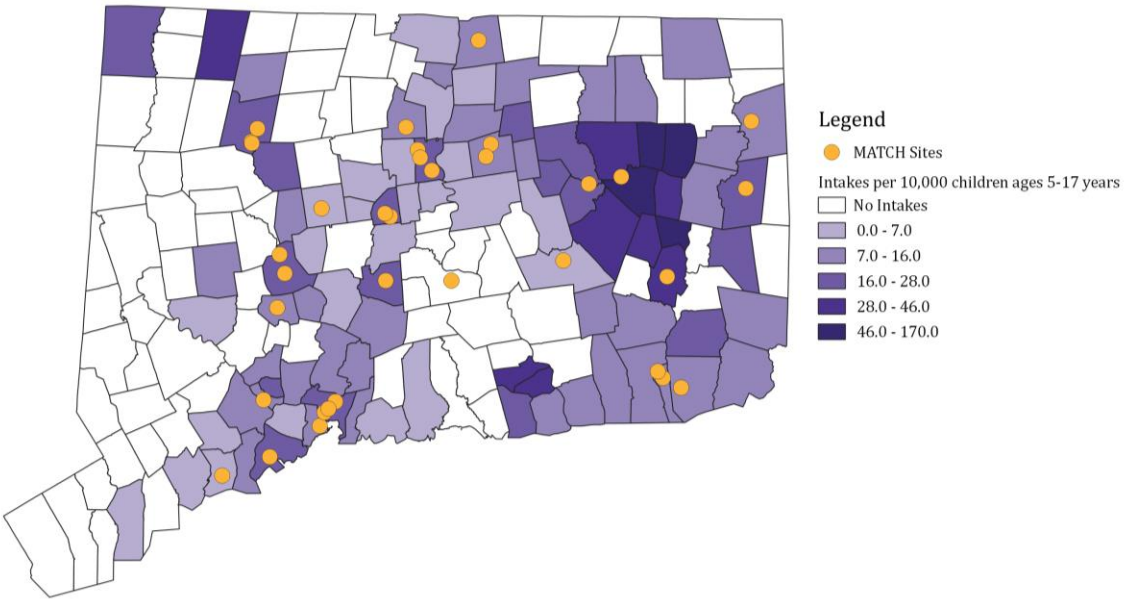
(3) Ensure significant improvements in child outcomes for children receiving MATCH-ADTC

This report is framed around these three primary goals. The first two sections describe progress on ensuring Connecticut children have access to MATCH-ADTC (goal 1). The first section presents information on agency providers, training activities, and workforce development. The second section describes trends in service over time as well as a description of the population of children served in FY19. The third section details the clinical implementation, fidelity monitoring, and quality improvement activities that took place to ensure children received high-quality services (goal 2). The fourth section then describes symptom reduction and functional improvements for children who receive MATCH-ADTC with a careful consideration of demographic characteristics that might influence outcomes (goal 3). The final section provides conclusions and recommendations to guide the work in future years.

Access: Availability of MATCH-ADTC in Connecticut

In FY 19, nineteen agencies offered MATCH-ADTC, with one new provider joining during the year. Figure 1 below shows the location of MATCH-ADTC sites across the state and Table 1 shows the trends in access over the past three years as well as cumulative totals. MATCH-ADTC has had 202 clinicians providing MATCH-ADTC over time. There were 158 clinicians on a MATCH-ADTC team during FY19, and 137 (86.7%) saw at least one MATCH-ADTC case. On average, outpatient providers have 8 clinicians (range 5 – 14) on their MATCH-ADTC clinical teams.

Figure 1. Map of MATCH-ADTC sites and children served



Of the 158 clinicians on a MATCH-ADTC team, 25 (15.8%) left in the fiscal year. To address attrition, 54 new clinical staff were trained in MATCH-ADTC during the year. To support future sustainability of the model, five associate consultants and one CHDI staff began the process of training to become trainers in the model. These train-the-trainer efforts will help ensure there is statewide capacity to continue to train new clinicians at MATCH-ADTC agencies. One train-the-trainer left during the fiscal year. To support high quality delivery of services, 36 clinical staff attended booster training and 20 clinicians were credentialed.

Table 1. Trends in MATCH-ADTC provider network

	FY17	FY18	**FY 19**	Cumulative Since 2014
Providers of MATCH-ADTC	15	20	**19**	21
New MATCH-ADTC Clinicians	48	56	**54**	250
Clinicians Providing MATCH-ADTC	80	113	**137**	202
#Credentialed/Certified	53	14	**20**	93

Demographic characteristics of the 158 clinicians on MATCH-ADTC teams during FY 19 are presented below. MATCH-ADTC clinicians are primarily White (60.8%) and female (90.1%). Aside from English, MATCH-ADTC clinicians also speak Spanish (14.6%), French (1.3%), and French Creole (1.3%).

Many MATCH-ADTC clinicians practiced other EBPs. The most common additional model was Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which was practiced by 42% of MATCH-ADTC clinicians. This is likely of relevance when looking at the protocols used by MATCH-ADTC clinicians and seeing relatively lower rates of the trauma protocol. Attachment, Self-Regulation, and Competency (ARC), a model disseminated in Connecticut with a focus on serving young children, was practiced by 13% of MATCH-ADTC clinicians. Few MATCH-ADTC clinicians also practice Bounce Back or Cognitive Behavioral Intervention for Trauma in Schools (CBITS), likely due those models largely being implemented in school settings.

Table 2. MATCH-ADTC clinician demographics (n=158)

Characteristic	%
Sex (Male)	9.9
Race	
Black or African American	7.0
Hispanic, Latino, or Spanish	16.5
White	60.8
Other Race/Ethnicity	1.9
Languages Spoken	
Spanish	14.6
French	1.3
French Creole	1.3
Other	0.6

Access: Children Receiving MATCH-ADTC

Service Trends Over Time

The number of children receiving MATCH-ADTC has increased each year. In FY 19, 820 children received MATCH-ADTC. The number of children receiving MATCH-ADTC in the state has increased 63.3% from FY17 to FY19. To date, 1,848 children have received MATCH-ADTC since FY14.

Figure 2. Children served by fiscal year

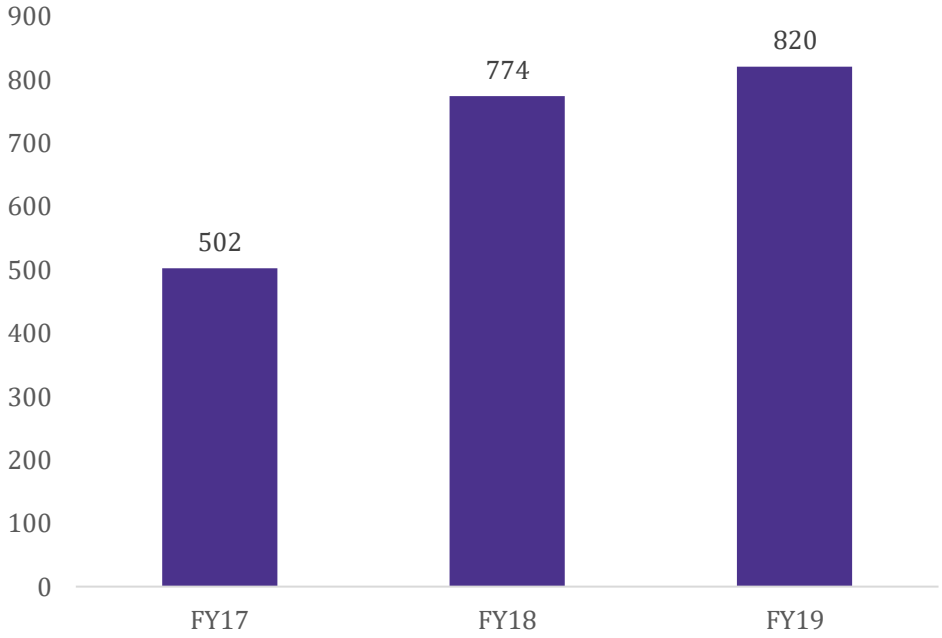


Table 3 on the next page contains demographic statistics on children receiving MATCH-ADTC in FY 19, as well as comparisons to those served in outpatient services (as reported by the Provider Information Exchange [PIE] system) and the general CT population. Children receiving MATCH-ADTC are slightly less likely to be male compared to outpatient and the Connecticut population. They are more likely to be White (Non-Hispanic) compared to outpatient, but less likely compared to the state population. The percentage of children served by outpatient and MATCH-ADTC who are of other race/ethnicity is similar; however, both are lower than the general population. Although caution should be exercised in interpretation due to differences in ways language are collected, children receiving MATCH-ADTC are more likely to have English as a primary language compared to outpatient and the CT population. However, this may be because MATCH-ADTC is only available in Spanish in a limited capacity, and is not available in languages other than English and Spanish. The mean age of children receiving MATCH-ADTC is 11.04 years (SD=3.46); children receiving MATCH-ADTC and those receiving general outpatient services are more likely to be older compared to the Connecticut population.

Table 3. Characteristics of children receiving MATCH-ADTC, with comparisons (n=820)

	MATCH- ADTC		OPCC[1]	CT pop[2]
	N	%	%	%
Sex (Male)	370	45.1	55.0	51.2
Race				
Black or African American	93	11.3	15.2	12.4
Hispanic, Latino, or Spanish[3]	306	37.3	43.3	24.1
White	377	46.0	36.0	54.9
Other Race/Ethnicity (includes multiracial/ethnic)	43	5.2	5.6	16.4
Age (years)				
Under 5 years	20	2.5	6.2	24.5
5-9 years	260	31.9	36.3	26.3
10-14 years	381	46.7	39.0	30.2
15-17 years	155	19.0	18.5	19.0
Child welfare involvement during treatment	109	13.3	18.1	N/A
JJ involvement during treatment	10	2.2	N/A	N/A
Child primary language[4]				
Spanish	31	3.8	12.9	14.2
Neither Spanish nor English	0	0.0	1.3	7.7
Caregiver speaks English(no)	42	5.1	N/A	N/A

Child Clinical Characteristics at Treatment Start

Information on baseline assessments for children receiving MATCH-ADTC is found in Table 4 on the next page. Each assessment was also evaluated to determine if there were demographic factors that influenced reports of trauma exposure or scores on symptom measures at treatment start. Details of the tests can be found in Table B1 to B3 in Appendix B. Most of the measures reflect the child's experience or symptoms.

Trauma Exposure. Children report experiencing an average of 4.81 types of traumatic events; caregivers report their children have experienced 3.93 on average. Older children had higher rates of exposure by both child (β=2.86, p<.001) and caregiver (β=.108, p=.004) report. Compared with females, males (β=-.558, p=.027) had lower trauma exposure for the child report. There were no significant findings by race/ethnicity.

[1] OPCC data comes from DCF's PIE system and includes children that received MATCH-ADTC; therefore differences between MATCH-ADTC and OPCC might actually be of a greater magnitude if we were looking at OPCC excluding those receive MATCH-ADTC

[2] American Community Survey 2017 1 year estimates. Caution should be used with comparison to OPCC and TF-CBT child demographics. Census race categories exclude Hispanic ethnicity only for White children while TF-CBT and OPCC race categories exclude Hispanic regardless of race. Census language is only available by language spoken, not primary language. Age is percentage of children 0-17 years.

[3] We recognize there are alternate terms for describing ethnicity. This report uses "Hispanic" and "Latino" to remain consistent with the way it is reported in the data system, which reflects the terminology in the U.S. Census.

[4] Used Primary Language Inside of Home for child primary language

Baseline Symptoms. Nearly all children (97.7%) receiving MATCH-ADTC in the fiscal year had a measure of baseline symptoms. The highest rates of elevation were on depression symptoms, where 65.2% of caregivers and 55.5% of children reported scores indicating clinical elevation. A relatively low number of children took this optional assessment. The rates of elevation suggest that clinicians were appropriately selecting the measure when they found it was applicable. The most commonly completed assessments were the Ohio Caregiver reports. However, only 36.6% were above the clinical cut-off for Problem Severity and 29.8% were below the cut-off for Functioning.

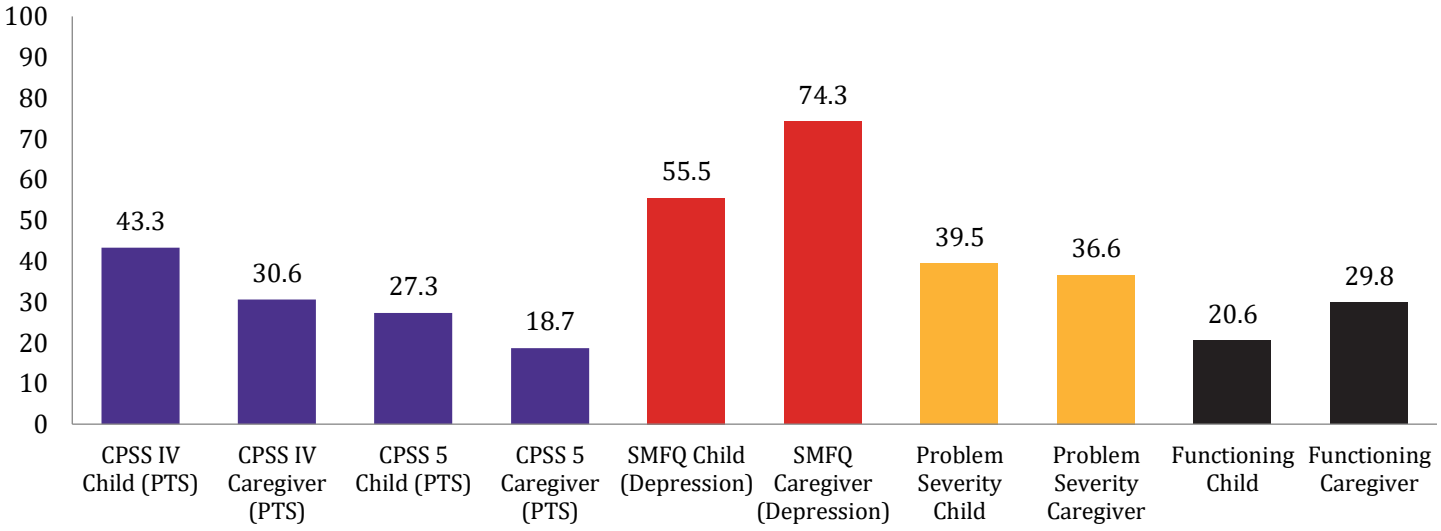
Only caregiver reports of child baseline symptoms were found to have significant findings related to child demographics. Caregivers of males reported significantly lower baseline functioning (β=-5.456, *p*=.010) compared to caregivers of females. Caregivers of children of other race/ethnicity (includes multiracial) reported significantly higher baseline trauma symptoms (β=9.557, *p*=.034) compared to caregivers of White children. No other differences, across reporters or symptom type, were significant. This suggests that children generally begin MATCH-ADTC with similar symptom profiles regardless of age, sex, and race/ethnicity.

Table 4. Intake scores

Measure	Child Report				Caregiver Report			
	N	Mean	SD	Elevated[5] (n, %)	N	Mean	SD	Elevated[5] (n, %)
THS sum	678	4.81	3.22	-	682	3.93	2.75	-
CPSS-IV Total Score	261	14.59	12.03	113, 43.3	271	11.79	10.35	83, 30.6
Re-experiencing Subscore	-	4.00	3.98	-	-	3.24	3.50	-
Avoidance Subscore	-	5.02	5.11	-	-	3.82	4.39	-
Arousal Subscore	-	5.56	4.38	-	-	4.73	3.94	-
CPSS 5 Total Score	330	20.38	16.20	90, 27.3	327	16.48	13.74	61, 18.7
Re-experiencing Subscore	-	4.38	4.32	-	-	3.65	3.82	-
Avoidance Subscore	-	2.47	2.62	-	-	1.75	2.16	-
Cognition & Mood Subscore	-	6.59	6.44	-	-	5.31	5.55	-
Hyperarousal Subscore	-	6.94	5.46	-	-	5.78	5.24	-
SMFQ Total Score	137	9.49	6.24	76, 55.5	115	9.01	5.68	75, 65.2
Ohio Problem Severity	476	22.66	13.99	188, 39.5	733	21.39	12.33	268, 36.6
Internalizing	-	12.41	9.13	-	-	9.63	7.44	-
Externalizing	-	9.68	7.19	-	-	11.17	8.13	-
Ohio Functioning	470	55.00	12.83	97, 20.6	734	50.78	12.89	219, 29.8

[5] Defined as "above clinical cutoff" or "critical impairment". Does not include "high symptoms." Valid percentages reported.

Figure 3. Percentage of children with clinically high score



Note: SMFQ had low response rate; PTS – post-traumatic stress

Quality: Consultation and Clinical Implementation

CHDI staff work closely with agency providers and meet regularly with each agency to provide implementation consultation. The focus of these site visits varies based on the needs of individual agencies but range from identifying children from MATCH-ADTC, ensuring fidelity benchmarks are met, monitoring the quality improvement (QI) indicators are met (detailed below), monitoring client engagement, discharges, and satisfaction. Highlights of these indicators are shared below after a review of the structure of the site-based consultation for MATCH-ADTC.

Implementation Consultation

This year, 63 site visits and 23 formal follow-up consultation calls were completed. The agenda for these meetings is to review the agency the recent monthly dashboards (see Appendix C for example) and QI Report (see Appendix D for overview and examples. The cross-model dashboards provide monthly and cumulative information on clients served. CHDI creates the QI Report twice annually with quarterly updates on progress towards meeting the benchmark for each QI indicator. From this review of data, SMARTER Goals are developed with the agency to address any QI indicator that did not meet the established benchmark.

Data Systems to Support Implementation

Most of the data used in consultation with sites in collected through our secure, web-based system EBP Tracker. To support clinicians and ensure we have timely, accurate, and usable data the Coordinating Center maintains a HelpDesk that has fielded over 900 requests from users since it was opened at the start of FY19. EBP Tracker also provides reports intended

to be used by clinicians and teams to help them monitor and track their progress toward goals in between contacts with CHDI.

In FY19, four new reports were developed in the system based on needs expressed by providers. The Monthly Volume Report made it easier for providers to understand the number of new cases, closing cases, and visits in the month to monitor case flow as well as consistency of care. The Assessments Over Time by Demographic enhanced a prior report to allow breakdowns by demographic groups including by race/ethnicity, sex, and age when looking at change scores on assessments. Additionally, two cross-model reports were developed. The Cross Model Point in Time report shows key data points (intakes, discharges, completed cases) broken out by model for easy comparison across multiple EBPs. The Cross Model Trend report allows agencies to look at trends over a calendar year in number of children served (intakes, discharges, completions), broken out by model. Taken together these reports allow agencies to better monitor both cross-EBP work as well as providing better ways to track service trends and easily monitor outcomes across demographic groups.

Assessment Changes Affecting Implementation

An additional important change in this fiscal year was the introduction and full implementation of the EBP flexible assessment schedule. Changes to the assessments schedules for all EBPs were made to address concerns about the number of required assessments as well as to have a cross-EBP assessment process that allows treatment to be driven based on baseline assessment data. Under this new process, all children evaluated for an EBP completed a core set of assessments. Based on these scores, clinicians selected a primary EBP measure (in addition to the Ohio's) to continue to use to track treatment progress.

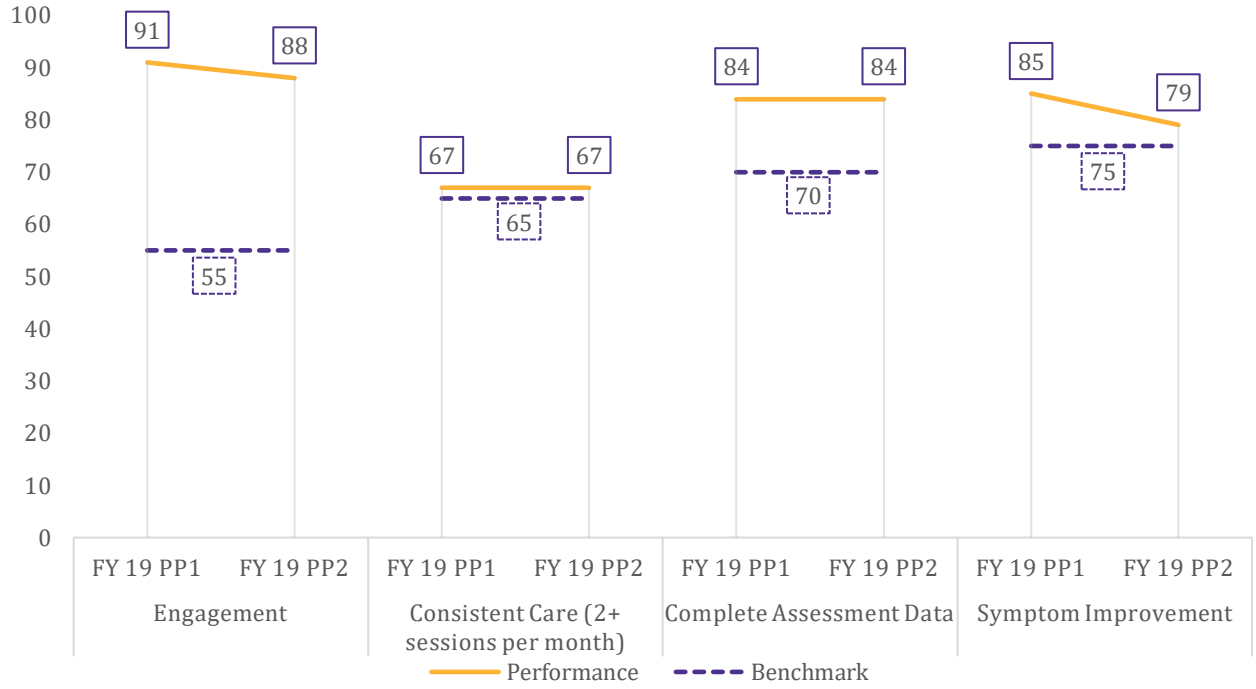
Episode Description

Children completing MATCH_ADTC attended a mean of 16.78 (SD=13.14) sessions within a mean treatment episode length of 6.89 (SD=4.43) months. Out of the 8,313 sessions provided during the fiscal year, 57.6% were completed with children only, 30.0% were child and caregiver together, and 12.4% were caregiver only.

Quality Improvement Indicators

CHDI reports on quality improvement (QI) indicators twice annually. MATCH-ADTC QI indicators started this fiscal year. The definition and explanations of each of the 4 QI indicators and the prepared reports showing each provider's results over the two FY19 performance periods are included in Appendix D. All statewide QI benchmarks were met both performance periods in FY19. A summary of the performance indicators is in Figure 4.

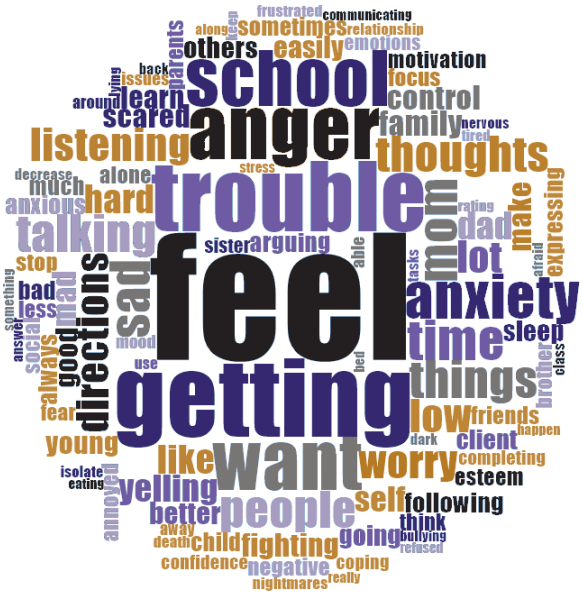
Figure 4. Quality Improvement in FY 19



Top Problem Assessment

Of the 820 MATCH-ADTC treatment episodes open in FY 19 90.6% of caregivers identified at least one top problem to work on during treatment, and 96.3% of children identified at least one top problem. Figures 5 and 6 below show the general topic areas of the top problem areas for children and caregivers.

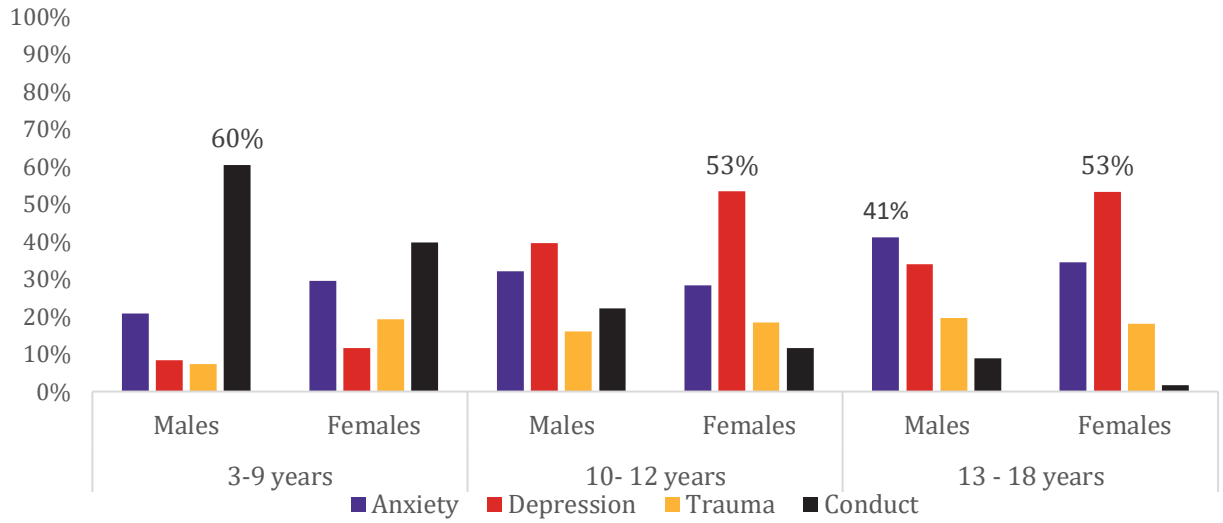
Figures 5 & 6. Child (left) and caregiver (right) reported top problems.



Primary Protocol Area

Children receiving MATCH-ADTC (n=820) in the fiscal year were most likely to be assigned to the Anxiety (250) and Depression (265) protocol areas. Conduct (192) and Trauma (129) were less likely. This trend is consistent with previous years. The Trauma protocol may be least likely to be assigned because clinicians may be opting to provide TF-CBT instead as nearly half (48.9%) of MATCH-ADTC clinicians also practice TF-CBT. Per the developers, the conduct protocol content caters more towards pre-adolescent children with conduct issues, clinicians are encouraged to use another EBP with adolescents (especially older adolescents) with conduct issues. Because 37.1% of children receiving MATCH-ADTC are adolescents this may explain the reduced numbers of children in the conduct protocol.

Figure 7. Primary Protocol Area (PPA) by age and sex (n= 493)



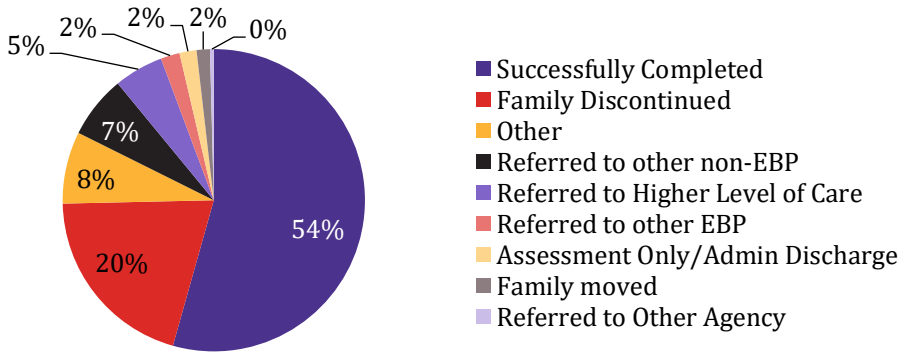
Similar to previous years, young males 3-8 years are most likely to be assigned the conduct protocol. Adolescent and pre-adolescent females are most likely to be assigned the depression protocol area. This year, adolescent males were more likely to be assigned the anxiety protocol area (41% vs. 26%) and less likely to be assigned the depression protocol area (34% vs. 50%). Trauma protocol area was consistently assigned across groups.

A multinomial logistic regression was performed to determine if there were differences in the primary protocol area (PPA) assigned to a child based on age, sex, and race/ethnicity while controlling for child and caregiver reports of trauma exposure, internalizing symptoms, and externalizing symptoms. Few significant differences were found. Children assigned the depression protocol area first were significantly older (β=.135, df=1, p=.023) than children assigned the anxiety PPA. Black non-Hispanic (β=2.358, $p<.001$) and Hispanic (β=1.448, $p<.001$) children were significantly more likely to be assigned the trauma protocol area compared to White children, even after controlling for baseline symptoms, age, and sex. This is a trend that can be shared with providers as part of consultation on how primary problem areas is determined and the degree to which children and caregivers are included. Details of the regression analyses are located in Table B4 in Appendix B.

Discharge Reason

During the fiscal year, 493 children ended their MATCH-ADTC treatment episode. Clinicians rated half of children (54%) ending treatment as "completing all EBP requirements." Children who did not complete all EBP requirements were most likely to not complete due to family discontinuing treatment. A binary logistic regression was performed in order to look at differences in successful discharge across demographic groups (age, sex, race/ethnicity) controlling for trauma exposure. Only race was found to be significant where Black children were less likely to successfully complete (β=-.788, *p*=.038) compared to White children. See Table B5 in Appendix B for regression table.

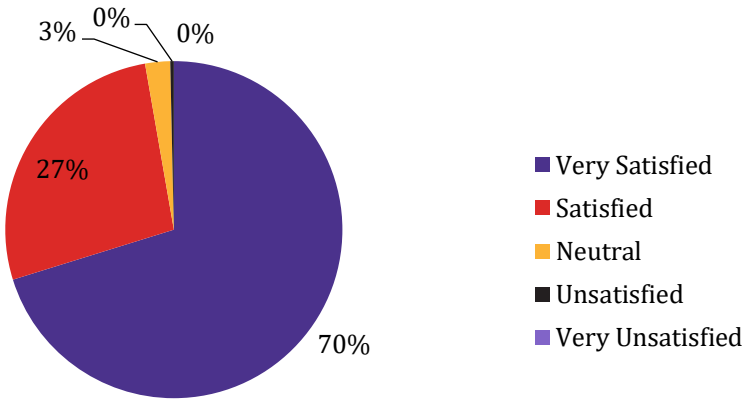
Figure 8. Reasons for discharge in FY 19



Satisfaction

Caregivers report high levels of satisfaction with MATCH-ADTC treatment. In FY 19, there were 210 Youth Services (YSSF) completed, and 82 Ohio Caregiver Satisfaction forms completed, the responses to both measures are illustrated in Figure 9 below with 96% of those completing the YSSF indicating mostly or very satisfied with treatment and 95% of those completing the Ohio Caregiver Satisfaction indicating mostly or very satisfied with treatment. Sixty-three children completed the Ohio Child Satisfaction measure; 95% of these children indicated that they were mostly or very satisfied with treatment.

Figure 9. Satisfaction categories, FY 19



Outcomes: Improvement for Children Receiving MATCH-ADTC

Children receiving MATCH-ADTC 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), a measure of trauma symptoms, and a general behavioral measure appropriate to the age and symptoms of the child.

Each of the measures is listed along with the construct it measures and a summary of intake and discharge scores in Table 6 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.

How is Change Measured in MATCH-ADTC?

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 6 below. Additionally, the Reliable Change Index (RCI) is also used. The RCI assigns a measure-specific point reduction threshold that represents significant change. An overview of the RCI with explanations on how and why it is used as well a table of relevant values by measure is included in Appendix E.

Rates of Outcome Data

Three in four children (76.5%) discharged from MATCH-ADTC in the fiscal year had at least one first and last version of a child symptom assessment (child or caregiver reporter). Only 3.2% had a first and last measure of caregiver symptoms. Children in the trauma (82.3%) and conduct (80.2%) protocols were more likely to have child symptom measures available compared to children in the anxiety (76.8%) and depression (75.5%) protocol areas.

In order to look at differences in rates of outcome data based on child demographics (age, race/ethnicity, sex) a binary logistic regression was performed controlling for trauma exposure and successful discharge. Only successful discharge was found to be significant where children without successful discharge were less likely (β=-2.485, df=1, p<.001 to have outcome data compared to children discharged successfully. Controlling for discharge reason and trauma exposure demographic characteristics did not have any significant effect on whether children had outcome data available. Binary logistic regression analyses are available in Table B6 in appendix B.

Table 5: 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=406)	Exposure to potentially traumatic events	n/a	4.66 (3.18)	n/a	n/a	n/a	n/a
THS Caregiver (n=410)		n/a	3.84 (2.76)	n/a	n/a	n/a	n/a
CPSS IV Child (n=148)	Trauma symptoms	70 (47.3%)	15.38 (12.28)	8.07 (9.05)	-7.31**	9.07	46/76 (65.7%)
CPSS IV Caregiver (n=150)		47 (31.3%)	11.86 (10.84)	6.53 (7.63)	-5.33**	6.84	33/47 (70.2%)
CPSS V Child (n=60)		13 (21.7%)	16.95 (15.76)	10.2 (12.95)	-6.75**	9.91	8/13 (61.5%)
CPSS V Caregiver (n=59)		16 (27.1%)	17.9 (15.58)	9.8 (14.77)	-8.1**	12.18	12/16 (75.0%)
SMFQ Child[6] (n=20)	Depressive symptoms	13 (65.0%)	10.7 (7.04)	6.55 (5.42)	-4.15	-	4/13 (30.8%)
SMFQ Caregiver[6] (n=18)		n/a	9.56 (7.17)	4.5 (4.82)	-5.06	-	n/a
Ohio Problem Severity Child (n=205)	Severity of internalizing/ externalizing behaviors	81 (39.5%)	22.6 (14.5)	15.69 (12.64)	-6.91**	8.57	53/81 (65.4%)
Ohio Problem Severity Caregiver (n=331)		126 (38.1%)	22.18 (13.13)	14.74 (11.38)	-7.44**	8.71	79/126 (62.7%)
Ohio Functioning Child (n=202)	Child's adjustment and functioning	40 (19.8%)	55.6 (12.53)	60.4 (12.63)	4.80**	-3.05	28/40 (70.0%)
Ohio Functioning Caregiver (n= 331)		112 (33.8%)	49.69 (12.31)	55.64 (13.15)	5.95**	-4.75	73/112 (65.2%)

**Indicates significance p< .01

[6] response rate too low for significance testing

Symptom Improvement

Children completing MATCH-ADTC demonstrated significant reductions in post-traumatic stress and problem severity symptoms, and improvements in functioning (see Table 6). Remission rates and reliable change were similar across measures.

Children Improve Across Multiple Domains

Children receiving MATCH-ADTC were assessed on four different assessments of child symptoms across child and caregiver reporter versions. When children were assessed at two or more time points, change scores were calculated and RCI values were used to determine the percentage of children who experienced reliable change.

Children with clinically high symptoms at baseline are more likely to experience reductions in symptoms during treatment.

Children who enter MATCH-ADTC with clinically high symptoms have higher rates of reliable symptom change after treatment. This trend was seen across all symptom categories (PTSD, externalizing/internalizing behaviors, and functioning). Looking at problem severity (externalizing/internalizing) symptom outcome data, 56.8% of those with a caregiver report and 54.6% of those with a children report (54.6%) experienced problem severity symptom reduction. Comparatively, 73.8% of children with elevated caregiver-report at baseline and 81.9% of children with elevated child-report at baseline experienced reliable change in this symptom category. Similar trends were seen for children with elevated PTSD symptoms and functioning. Due to low response rates, we did not look at reliable change by critically high symptoms for depression symptoms. (See Figure 10 for overall reliable change percentages and Figures 11-13 for reliable change by critically high symptom category).

Figure 11. Percent of children with PTSD symptom reduction on the CPSS

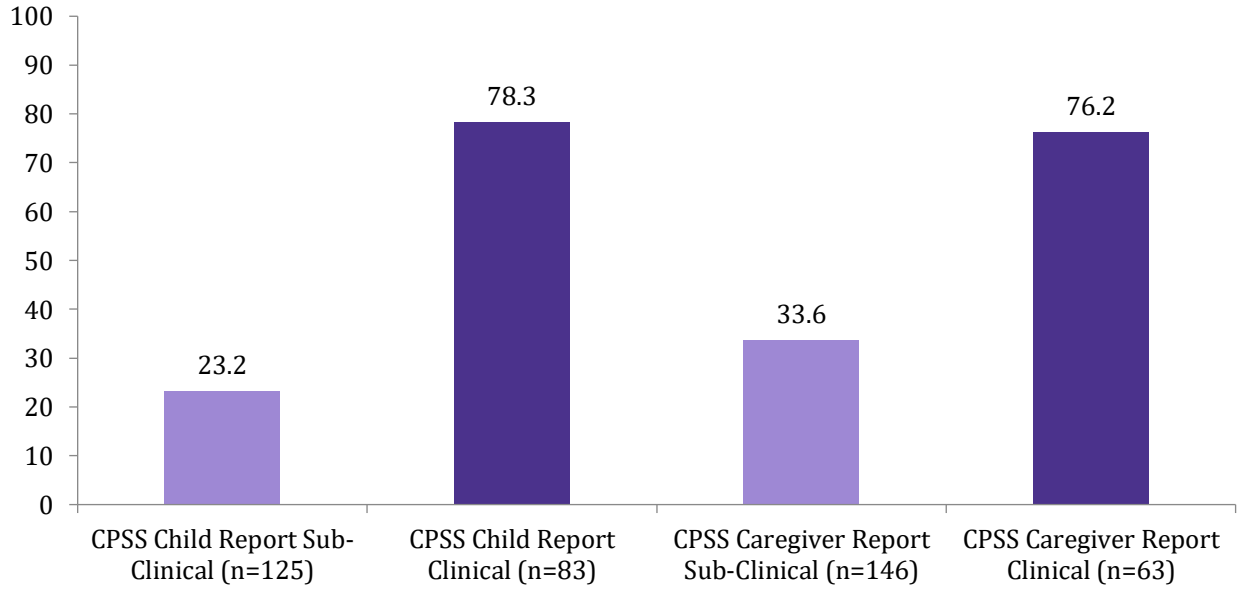


Figure 12. Percent with Ohio Problem Severity reduction

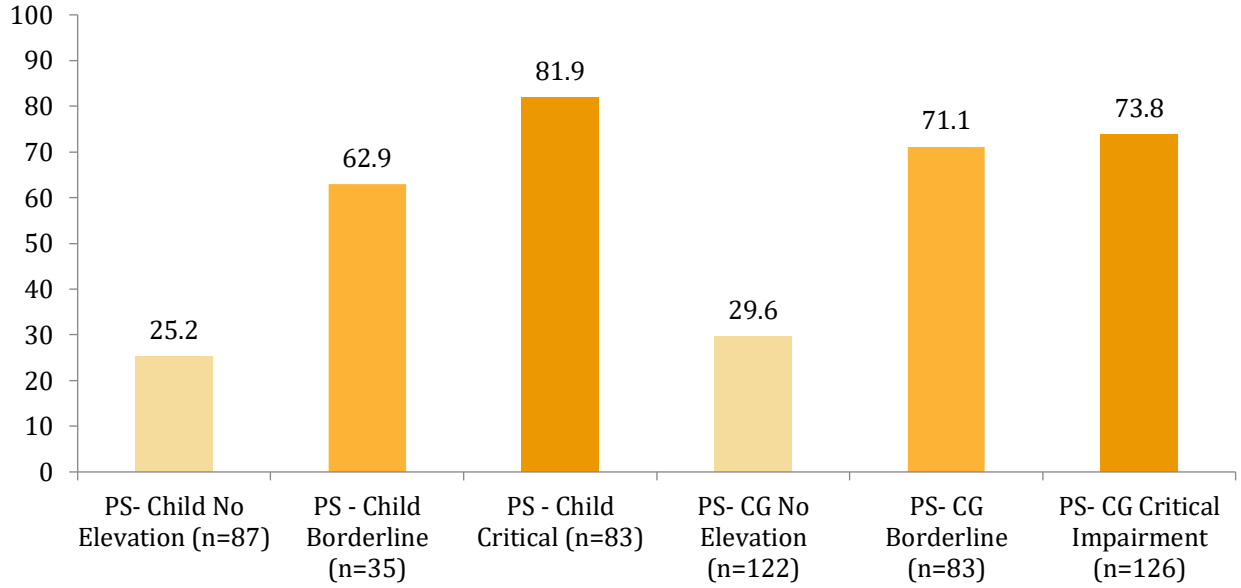
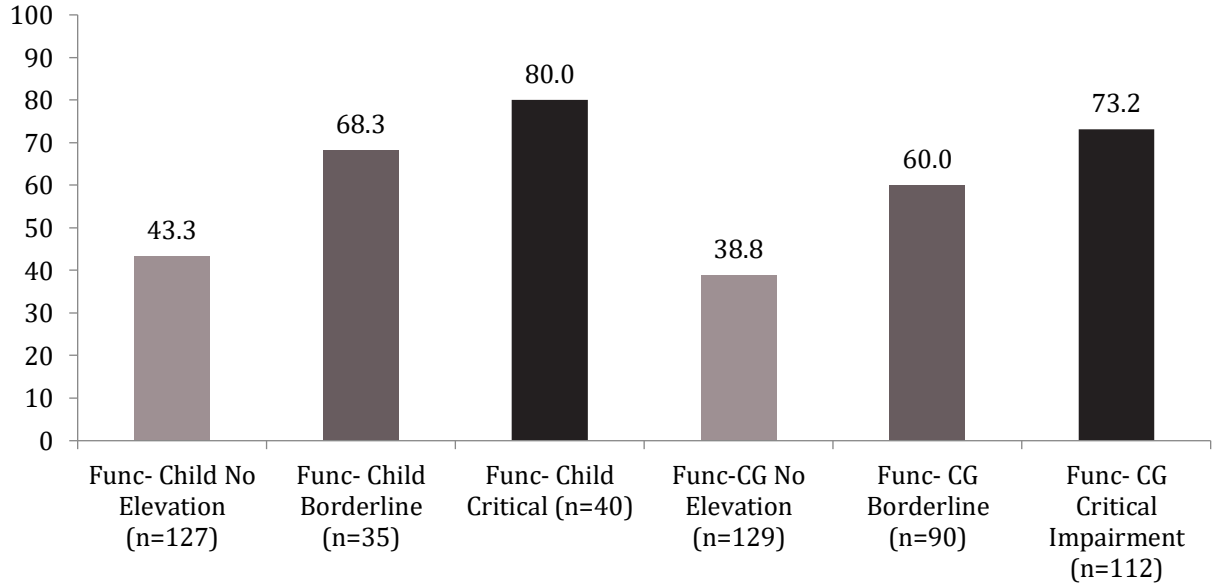


Figure 13. Percent with Ohio Functioning improvement



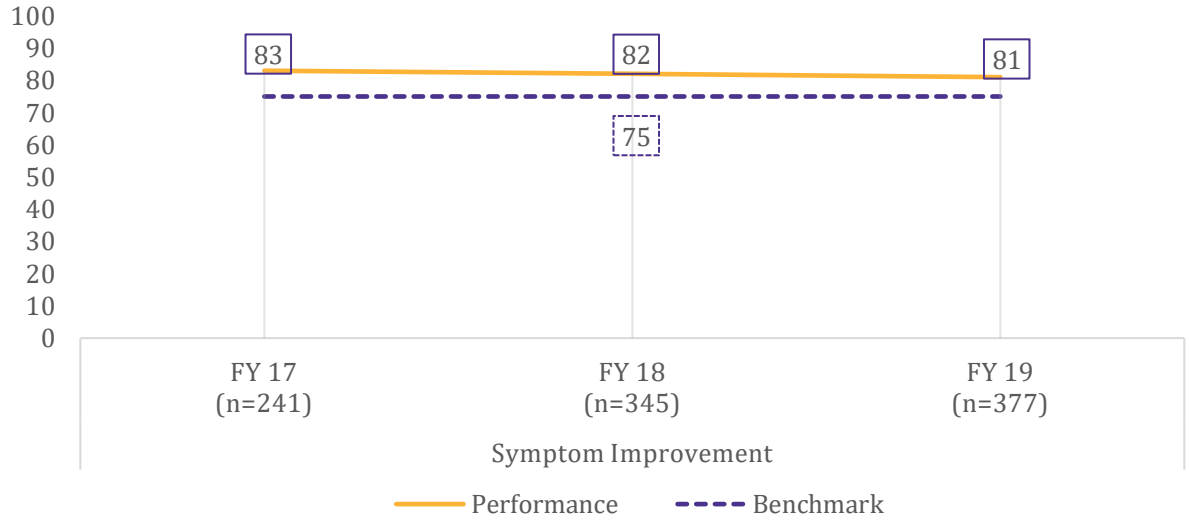
Clinical Improvements Across Groups

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 look at the effect of demographics (age, race/ethnicity, sex) on clinical outcomes controlling for trauma exposure and initial symptom scores. The only demographic variable with significant results was age, and that was only for the Ohio PS Caregiver. This suggests that there may not be significant differences in symptom or functional improvement based on age, sex, or race/ethnicity. Details of the tests are in Tables B7 and B8 of Appendix B.

Trends Over Time in Symptom Improvement

Symptom improvement, as measured by children who experienced reliable change, has remained consistently high over the past three fiscal years. This consistent outcome trend suggests that the quality of care provided over time remains high, which is particularly meaningful given the noteworthy growth and expansion of MATCH-ADTC across Connecticut over the past few years.

Fig 14. Symptom improvement over time



Summary & Conclusions

MATCH-ADTC is available across the state for children suffering from anxiety, depression, trauma, and/or conduct symptoms. Since FY17, the number of children receiving MATCH-ADTC has increased by 63.3%. This suggests that ongoing implementation efforts across Connecticut remain invaluable for future service delivery. Since the first MATCH-ADTC train-the-trainer cohort series will complete in FY20, future efforts in training and consultation will enhance access to MATCH-ADTC, while ensuring effective model delivery.

For children served in FY19, MATCH-ADTC was most commonly employed with 10–14 year olds, which is consistent with the clinical model recommendations. Slightly more than two-thirds of Connecticut children who received MATCH-ADTC had clinically significant baselines scores across at least one symptom area (depression, posttraumatic stress, internalizing/externalizing behaviors, or functioning) with depressive symptoms being the most common. For children younger than 10, the Conduct Primary Protocol Area remained the most prevalent module employed, which parallels the design and utility of the MATCH-ADTC model. Finally, children generally began MATCH-ADTC with similar symptom profiles regardless of age, sex, and race/ethnicity.

MATCH-ADTC has consistently shown more than 80% symptom improvement since FY17. According to the Child PTSD Symptom Scale, children receiving MATCH-ADTC experienced more than 75% symptom reduction for those who fell within clinical ranges. From Ohio Scales Problem Severity, children and caregivers with critical impairment experienced a significant reduction, 81.9% and 73.8% respectively. Child and caregiver with critical impairment in functioning also had similar success with improvements, 80% and 73.2% respectively. Critical impairment is most important to note given the severity and need.

In addition to the baseline and outcome data, quality of service remained high. All statewide QI benchmarks were met in FY 19. Further, client satisfaction remained high - approximately 97% reported either very satisfied or satisfied in their Youth Services Survey for Families. On average, children who completed MATCH-ADTC attended nearly 17 sessions (M=16.78, SD=13.14) within an average of almost seven months of treatment (M=6.89, SD=4.43). This further demonstrates high levels of engagement and continuity in treatment service. Finally, as delineated by the model, most MATCH-ADTC services specifically focused on children (57.6%), some services targeted both children and caregivers (30.0%), and a smaller portion solely targeted caregivers (12.4%).

Recognizing the amount of MATCH-ADTC services currently available in comparison to other EBPs in Connecticut (e.g., TF-CBT), current trends suggest that racial and ethnic data should continue to be monitored for disparities. Increased attention to training clinicians who represent communities of color would also serve as an important protective factor for children and their families of color who may benefit from MATCH-ADTC. Alignment between clinicians and families promotes cultural-sensitivity to a diverse range of experiences. As Connecticut state-level trainings and consultations proceed with CT-based trainers in FY20, our network of providers may further enhance future workforce development that tailors MATCH-ADTC to Connecticut's children and families.

Recommendations

The following recommendations are made for continued support of the MATCH-ADTC 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, with particular focus on training clinicians of color
   - Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity and health equity
   - Assist agencies in their efforts to modify internal data processes with the integration of EBP Tracker and Provider Information Exchange (PIE)
   - The integration of PIE and EBP Tracker allows for MATCH-ADTC information to be linked to a child's full outpatient episode; this data can be used to better understand how and when children receive MATCH-ADTC and its effectiveness compared to other models or treatment as usual
   - Continue to collect relevant financial data and support adequate reimbursement rates for the implementation and sustainability of MATCH-ADTC and other EBPs
   - Develop consultation model that will address QI needs of each agency and will include multiple treatment models
   - Analyze data to better understand demographic factors and other characteristics that might influence engagement, drop out, or differences in symptom reduction
   - Develop data reports that can be used in site-based consultation to help agencies monitor any potential disparities or inequitable trends
   - Continue to convene the group of bilingual clinicians implementing MATCH-ADTC and provide the support and resources
   - Develop agency-based trainers for MATCH-ADTC, which requires implementing funding plans and developing contracting language, to support sustainability of the model in the state

2. **System:**
   - Add Anxiety & Conduct measures to data system. Currently there are narrowband assessments in the data system for the depression (SMFQ) and trauma (CPSS) protocols, however, none exist for the anxiety and conduct protocols. Children receiving MATCH-ADTC (~67%) were less likely to have clinically elevated symptoms compared to children in other models (e.g., TF-CBT). This may be because there are no narrowband assessments addressing two of the four protocol areas.
   - Ensure the functionality for collecting MATCH-ADTC treatment information in Provider Information Exchange (PIE) supports real-time built-in reports, ongoing collection of fidelity information during treatment, and accurate and usable session dosage data

- Provide culturally and linguistically appropriate clinical tools in electronic format (e.g., assessments in Spanish built into PIE).
- Update terminology used in PIE (e.g., sex assigned at birth; Latino) to collect demographic information that complies with current best practices (e.g., sex assigned at birth and gender identity; Latinx)
- Expand collection of zip codes to nine digits in PIE to strengthen opportunities to merge PIE data with external data sources (e.g., Area Deprivation Index) to examine health disparities and inequities
- Provide training and support on in-session use of electronic assessments and concurrent documentation to ensure clinicians can use treatment data actively and share it with families
- Continue funding performance-based sustainment funds to improve capacity, increase access, and ensure quality of care; these incentives are intended to partially offset the increased agency costs of providing an evidence-based practice
- Continue work the Coordinating Center began this year to disseminate, support, and integrate EBPs beyond MATCH-ADTC. This work 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). The lessons learned from the implementation of MATCH-ADTC, which addresses the primary presenting problems seen in outpatient setting, provides a strong foundation for developing a model to improve care for all children in outpatient settings

3. Providers:

- Develop sustainability plans and provide clinical staff the needed
- Modify implementation plans to accommodate changes brought on by the integration of EBP Tracker and PIE
- 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: Activities and Deliverables

The Coordinating Center has worked to support the MATCH-ADTC implementation goals through the following activities carried out in FY19.

1. Training, Consultation, & Credentialing

- Our contracted Harvard University trainers and Connecticut Associate Trainers provided six clinical trainings (36 days) in FY19, with a total of 105 attendees.
- A cohort of six MATCH-ADTC trained individuals commenced the Train-the-trainer series that will be completed in FY20
- Coordinated registration, attendance, and CEUs for New Clinician Training (21 participants) and the consultation call groups (19 completed)
- Maintained a statewide MATCH-ADTC clinician credentialing process and requirements to increase the number of clinicians that complete all training and case requirements; 53 active clinicians were either Connecticut credentialed or nationally certified by the end of FY 19
- Maintained MATCH-ADTC 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 MATCH-ADTC staff, as well as other credentialing requirements for all MATCH-ADTC clinicians; in FY 19 there were 137 active clinicians
- Prepared regular training and case data tables for each provider with updates on individual clinician credentialing status
- Convened tenth annual statewide EBP Conference, an evolution of the original MATCH-ADTC Conference, for 456 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 MATCH-ADTC 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 63 in-person implementation consultation support visits and 13 phone calls with providers to ensure sustainment of high quality services
- Supported 1 new provider that applied to begin implementation of MATCH-ADTC

- Implemented and convened 3 Coordinator meetings focusing on sharing implementation and successful meeting strategies
- Provided updates to all MATCH-ADTC participants through a monthly Data Dashboard
- Distributed additional MATCH-ADTC books, materials, and resources to all MATCH-ADTC 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 MATCH-ADTC providers and the children and families they serve
- Oversaw the first steps in the integration of the PIE and EBP Tracker data systems (scheduled to be completed in FY20). Data migration work was completed at the end of the FY.
- 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 MATCH-ADTC providers through EBP Tracker (tinyurl.com/ebpsearch)
- Monitored, maintained, and provided technical assistance for online data entry for all MATCH-ADTC 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 MATCH-ADTC (See Financial Incentive document in Appendix A for details)
- Developed, executed, and managed contracts with each of the 19 MATCH-ADTC 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 $395,000 in performance-based sustainment funds to agencies (39.5% of total contract funds)

Appendix B: Regression tables

Table B1. Multiple regression analyses of selected demographic variables on child reported baseline scores

	1st Overall Severity, CPSS-IV Child			1st Total Score, Ohio FX Child			1st Total Score, Ohio PS Child		
Predictors	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Intercept	6.431	4.579	(-2.616, 15.479)	65.070	5.842	(53.526, 76.613)	16.466	6.147	(4.319, 28.613)
Hispanic	1.901	1.781	(-1.619, 5.421)	-0.399	2.273	(-4.891, 4.092)	-0.369	2.392	(-5.095, 4.357)
Other Nonhispanic	6.865	4.638	(-2.300, 16.029)	-2.672	5.917	(-14.365, 9.020)	-1.981	6.227	(-14.285, 10.323)
Black Nonhispanic	0.695	2.693	(-4.626, 6.016)	-0.076	3.436	(-6.865, 6.713)	-4.693	3.615	(-11.837, 2.451)
Age at intake	-0.137	0.323	(-0.776, 0.502)	-0.692	0.413	(-1.508, 0.123)	0.354	0.434	(-0.504, 1.212)
Sex	-2.500	1.679	(-5.817, 0.818)	-1.363	2.142	(-5.595, 2.870)	-2.661	2.254	(-7.115, 1.793)
Trauma Exposure- THS, Child	1.872**	0.304	(1.271, 2.473)	-0.157	0.388	(-0.924, 0.610)	0.844*	0.408	(0.037, 1.651)
Trauma Exposure- THS, Caregiver	0.245	0.351	(-0.449, 0.939)	0.025	0.448	(-0.861, 0.910)	-0.124	0.471	(-1.055, 0.808)
R^2	0.350			0.025			0.073		
F	11.478			0.554			1.674		

* p<.05
**p<.01

As compared to White females

Table B2. Multiple regression analyses of selected demographic variables on caregiver reported baseline scores

	1st Overall Severity, CPSS-IV Caregiver			1st Total Score, Ohio FX Caregiver			1st Total Score, Ohio PS Caregiver		
Predictors	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Intercept	2.937	4.420	(-5.795, 11.671)	53.823	5.711	(42.539, 65.108)	21.297	5.481	(10.466, 32.128)
Hispanic	1.760	1.720	(-1.638, 5.158)	1.308	2.222	(-3.082, 5.698)	0.541	2.133	(-3.673, 4.755)
Other Nonhispanic	9.557*	4.477	(0.711, 18.404)	-4.247	5.784	(-15.677, 7.183)	1.070	5.552	(-9.902, 12.041)
Black Nonhispanic	1.790	2.599	(-3.347, 6.926)	2.273	3.359	(-4.364, 8.910)	4.989	3.224	(-1.381, 11.359)
Age at intake	-0.001	0.312	(-0.618, 0.616)	0.018	0.403	(-9.594, -1.318)	-0.280	0.387	(-1.045, 0.485)
Sex	0.332	1.621	(-2.871, 3.534	-5.456*	2.094	(-9.594, -1.318)	1.833	2.010	(-2.139, 5.804)
Trauma Exposure- THS, Child	0.417	0.294	(-0.164, 0.997)	0.219	0.379	(-0.531, 0.968)	-0.590	0.364	(-1.310, 0.129)
Trauma Exposure- THS, Caregiver	1.522**	0.339	(0.853, 2.192)	-0.490	0.438	(-1.356, 0.375)	1.174**	0.420	(0.343. 2.005)
R^2	0.265			0.067			0.080		
F	7.667			1.517			1.844		

* p<.05

**p<.01

As compared to White Females

Table B3. Multiple regression analyses of selected demographic variables on Trauma History Screen

	Trauma Exposure - THS, Child			Trauma Exposure - THS, Caregiver		
Predictors	*B*	*SE*	*95%CI*	*B*	*SE*	*95%CI*
Hispanic	0.398	0.269	(-0.130, 0.925)	0.013	0.246	(-0.470, 0.496)
Other Nonhispanic	0.834	0.618	(-0.379, 2.047)	0.116	0.556	(-0.995, 1.227)
Black Nonhispanic	0.608	0.423	(-0.222, 1.439)	0.220	0.387	(-0.541, 0.980)
Age at intake	2.860**	0.041	(0.206, 0.367)	0.108*	0.037	(0.035, 0.182)
Sex m	-0.558*	0.252	(-1.053, -0.062)	-0.380	0.231	(-0.833, 0.074)
R^2	0.101			0.022		
F	13.374			2.688		

* p<.05 As compared to White Females

**p<.01

Table B4. Multinomial logistic regression predicting child's first primary problem area

	Depression				Trauma				Conduct			
Predictors	*B*	*SE*	*Wald*	e^B *(95% CI)*	*B*	*SE*	*Wald*	e^B *(95% CI)*	*B*	*SE*	*Wald*	e^B *(95% CI)*
Intercept	-2.545	0.89	8.163	- 1.144	-4.408	1.17	12.27	- 0.983	-1.599	1.417	1.273	- 0.921
Age at intake	0.135*	0.06	5.157	(1.019, 1.285)	-0.018	0.08	0.055	(0.848, 1.138)	-0.083	0.093	0.790	(0.767, 1.105)
Trauma Exposure- THS Caregiver	0.013	0.06	0.048	1.013 (0.900, 1.141)	0.300**	0.08	14.12	1.350 (1.154, 1.578)	-0.128	0.116	1.221	0.879 (0.700, 1.105)
Trauma Exposure- THS Child	0.055	0.05	1.06	1.057 (0.951, 1.175)	0.179*	0.07	6.41	1.197 (1.041, 1.375)	0.181	0.100	3.274	1.198 (0.985, 1.457)
Problem Severity, Externalizing, Caregiver	0.029	0.03	1.367	1.029 (0.981, 1.081)	0.020	0.03	0.360	1.020 (0.955, 1.909)	0.136**	0.038	12.450	1.145 (1.062, 1.235)
Problem Severity, Externalizing, Child	0.030	0.03	1.252	1.030 (0.978, 1.085)	0.068*	0.03	3.963	1.070 (1.001, 1.143)	0.042	0.040	1.056	1.042 (0.963, 1.129)
Problem Severity, Internalizing, Caregiver	0.010	0.02	0.247	1.010 (0.971, 1.050)	0.011	0.03	0.156	1.011 (0.958, 1.067)	-0.084	0.044	3.676	0.919 (0.843, 1.002)
Problem Severity, Internalizing, Child	0.002	0.02	0.013	1.002 (0.965, 1.041)	-0.033	0.03	1.438	0.967 (0.916, 1.021)	-0.095*	0.043	4.950	0.909 (0.836, 0.989)
Hispanic	0.535	0.28	3.571	1.708 (0.980, 2.974)	1.448**	0.41	12.72	4.256 (1.920, 9.434)	0.556	0.508	1.200	1.744 (0.645, 4.7190
Other Nonhispanic	0.938	0.61	2.340	2.554 (0.768, 8.493)	0.982	0.96	1.038	2.669 (0.404, 17.637)	0.834	1.265	0.435	2.303 (0.193, 27.488)
Black Nonhispanic	0.795	0.51	2.460	2.214 (0.820, 5.975)	2.358**	0.62	14.72	10.570 (3.168, 35.262)	0.364	0.791	0.212	1.439 (0.305, 6.781)
Sex	-0.423	0.28	2.251	0.655 (0.377, 1.139)	0.158	0.38	0.168	1.171 (0.552, 2.485)	0.491	0.485	1.027	1.635 (0.632, 4.228)

* p<.05 As compared to White Females

**p<.01 As compared to anxiety

Table B5. Logistic regression analyses for predicting child discharged rated as "successful"

Predictors	*N*	β	*SE*	*Wald*	e^B*(95% CI)*
Hispanic	136	0.128	0.231	0.307	1.137 (0.722, 1.789)
Other Nonhispanic	11	0.336	0.648	0.269	1.399 (0.393, 4.980)
Black Nonhispanic	36	-0.788*	0.380	4.310	0.455 (0.216, 0.957)
Sex m	168	-0.013	0.22	0.004	0.987 (0.641, 1.519)
Child age	359	0.003	0.036	0.008	1.003 (0.935, 1.077)
Trauma Exposure-THS Child	359	-0.011	0.045	0.059	0.989 (0.905, 1.081)
Trauma Exposure-THS Caregiver	359	-0.011	0.049	0.825	0.989 (0.899, 1.089)
Constant		0.289	0.460	0.394	1.335

* p<.05
**p<.01

As compared to White Females

Table B6. Logistic regression analyses for predicting measure available for any measure of child or caregiver symptoms

Variable	*N*	β	*SE*	*Wald*	e^B*(95% CI)*
Hispanic	136	0.322	0.326	0.976	1.380 (0.728, 2.615)
Other Nonhispanic	11	18.87	11024.22	0.000	426157769.5 (0, 0)
Black Nonhispanic	36	-0.262	0.439	0.357	0.769 (0.326, 1.818)
Sex	167	0.105	0.31	0.114	1.110 (0.605, 2.040)
Child age	358	0.029	0.051	0.318	1.029 (0.931, 1.138)
Trauma Exposure-THS Child	358	-0.049	0.061	0.633	0.953 (0.845, 1.074)
Trauma Exposure-THS Caregiver	358	0.061	0.066	0.854	1.063 (0.934, 1.210)
Child Discharged "Unsuccessfully"	161	-2.485**	0.366	46.036	0.083 (0.041, 0.171)
Constant		2.415	0.704	11.766	11.191

* p<.05
**p<.01

As compared to White Females

Table B7. Multiple regression analyses of selected demographic variables on child reported outcome scores

	Last Overall Severity, CPSS-IV Child			Last Total Score, Ohio FX Child			Last Total Score, Ohio PS Child		
Predictors	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Trauma Exposure- THS, Child	0.072	0.254	(-0.432, 0.575)	-0.743**	0.26	(-1.256, -0.229)	0.383	0.235	(-0.081, 0.846)
Baseline Score	0.36**	0.064	(0.233, 0.487)	0.437**	0.062	(0.316, 0.559)	0.47**	0.051	(0.370, 0.570)
Discharged Successful	-3.805**	1.279	(-6.334, -1.277)	5.237**	1.579	(2.121, 8.352)	-6.753**	1.388	(-9.492, -4.015)
Hispanic	-2.238	1.389	(-4.986, 0.509)	-2.55	1.686	(-5.876, 0.776)	1.618	1.495	(-1.331, 4.567)
Other Nonhispanic	1.721	3.388	(4.980, 8.423)	-4.647	4.086	(-12.709, 3.415)	-0.857	3.633	(-8.024, 6.311)
Black Nonhispanic	-2.038	2.085	(-6.161, 2.085)	0.216	2.528	(-4.773, 5.204)	-0.239	2.268	(-4.713, 4.235)
Sex m	-0.478	1.316	(-3.082, 2.125)	-0.422	1.595	(-3.570, 2.725)	2.165	1.441	(-5.008, 0.678)
Child age	0.131	0.192	(-0.249, 0.510)	0.061	0.233	(-0.398, 0.521)	-0.125	0.207	(-0.533, 0.678)
Constant	4.394	2.563	(-0.676, 9.464)	37.656	4.576	(28.627, 46.686)	8.918	3.052	(2.895, 41.940)
R^2	0.338			0.332			0.465		
F	8.602			11.165			19.954		

* p<.05
**p<.01

As compared to White females

Table B8. Multiple regression analyses of selected demographic variables on caregiver reported outcome scores

	Last Overall Severity, CPSS-IV Caregiver			Last Total Score, Ohio FX Caregiver			Last Total Score, Ohio PS Caregiver		
Predictors	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Trauma Exposure- THS, Caregiver	0.377	0.221	(-1.044, 7.814)	-0.344	0.213	(-0.764, 0.076)	0.377	0.201	(-0.018, 0.772)
Baseline Score	0.35**	0.060	(0.232, 0.468)	0.595**	0.046	(0.504, 0.685)	0.424**	0.043	(0.339, 0.510)
Discharged Successful	-1.574	1.09	(-0.061, 0.815)	6.142**	1.151	(3.878, 8.407)	-4.421**	1.087	(-6.381, -2.101)
Hispanic	-1.731	1.184	(-3.730, 0.582)	-1.696	1.249	(-4.154, 0.763)	0.316	1.174	(-1.995, 2.627)
Other Nonhispanic	1.031	2.296	(-4.072, 0.611)	-3.996	3.031	(-9.962, 1.969)	-0.122	2.847	(-5.726, 5.481)
Black Nonhispanic	-2.298	1.767	(-4.756, 6.817)	-0.097	1.865	(-3.768, 3.573)	-1.169	1.753	(-4.619, 2.281)
Sex m	1.225	1.114	(-5.794, 1.198)	-0.343	1.206	(-2.717, 2.030)	1.469	1.112	(-0.719, 3.658)
Child age	-0.101	0.158	(-0.977, 3.428)	0.410	0.167	(0.081, 0.739)	-0.436**	0.16	(-0.750, -0.121)
Constant	3.385	2.239	(-0.413, 0.212)	20.382	3.315	(13.857, 26.908)	10.362	2.516	(5.409, 15.314)
R^2	0.332			0.460			0.363		
F	8.248			30.592			20.451		

* p<.05
**p<.01

As compared to White females

Appendix C: June 2019 State Dashboard

Executive Summary

Intakes & Discharges

- 87 new children were enrolled in EBTs June 2019.
- 337 ended evidence-based treatment in the month.
- So far this fiscal year, 41 of the 44 partnering agencies and school systems have enrolled 2,376 new children in EBTs.
- 2,400 children have completed EBTs this fiscal year.

Active Treatment

- In June 2019, 1,035 children actively received EBTs at 38 agencies.
- Agencies provided 2,261 individual clinical sessions and 102 CBITS/BounceBack group sessions in the month.

Monthly Session Forms

- 89% of monthly session forms were completed in June 2019.
- 16 agencies completed all due monthly session forms on time. 20 agencies completed at least 90% of monthly session forms on time.

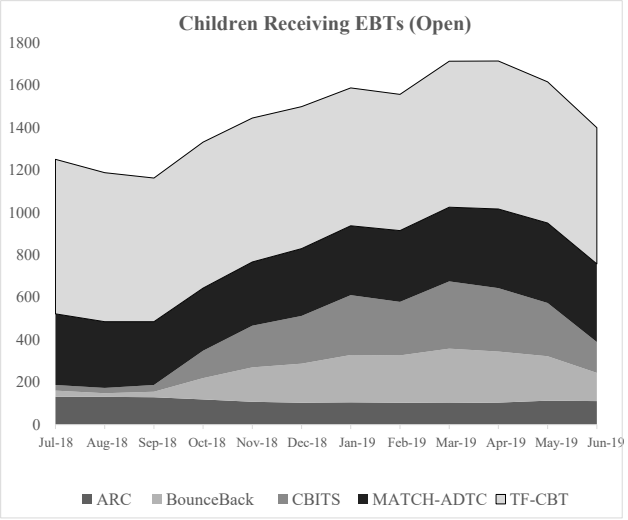
Clinicians & Training

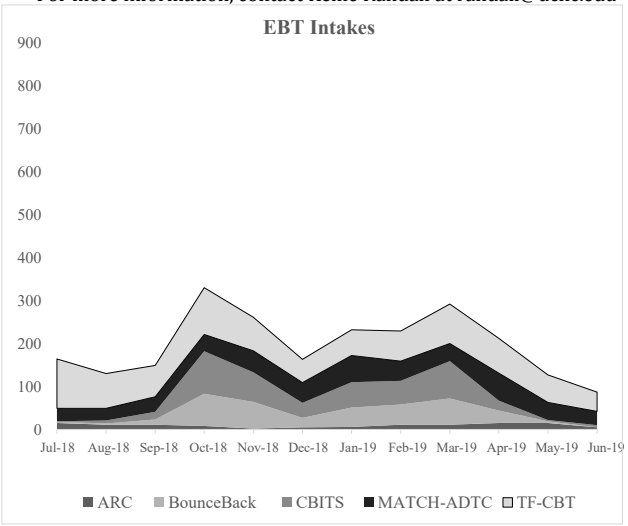
- Individual EBT clinicians were much more likely to have children openly enrolled in TF-CBT (75%), ARC (63%), and MATCH (71%) compared to CBITS (36%) and BounceBack (28%).
- The most recent clinical MATCH training series concluded in May 2019.
- This fiscal year clinicians training in EBT's includes: 26 received ARC training, 59 received Bounce Back training, 51 received CBITS training, 54 received MATCH-ADTC training, and 58 received TF-CBT training.

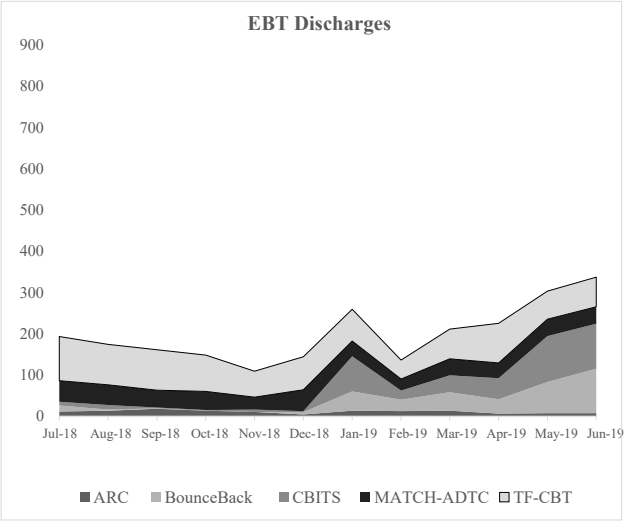
EBT Performance Dashboard: State of Connecticut June 2019

The Coordinating Center is located at Child Health and Development Institute. This report summarizes the monthly performance data for implementation and sustainment of Evidence Based Treatment models (EBTs) including: Attachment, Self-Regulation, and Competency (ARC), BounceBack, Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC), Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

For more information, contact Kellie Randall at randall@uchc.edu





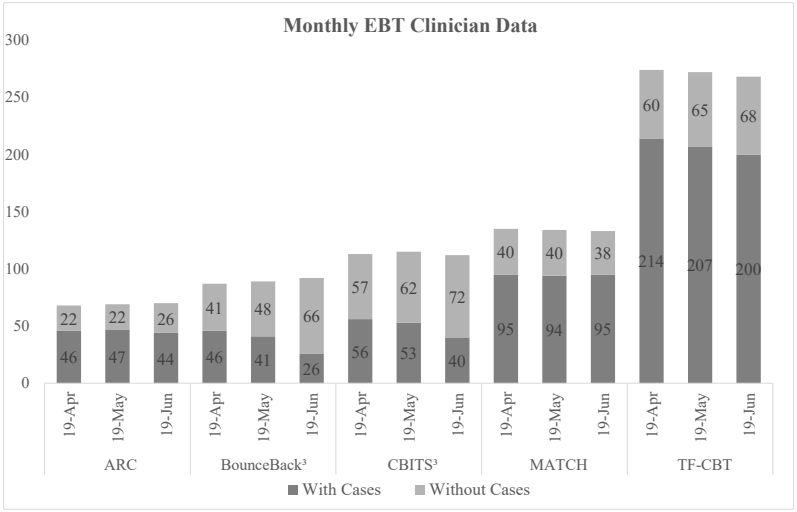


		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	FY19 Total	Yr Total[1]
Open	ARC	131	131	129	119	108	103	105	103	102	104	113	111	231	231
	BounceBack	29	17	26	100	162	184	223	223	256	240	209	133	389	389
	CBITS	27	25	32	129	196	225	282	252	317	299	251	145	487	487
	MATCH-ADTC	335	312	298	295	300	317	327	336	349	373	377	368	820	820
	TF-CBT	728	702	677	688	678	669	649	642	688	697	665	642	1535	1535
Open Total		1250	1187	1162	1331	1444	1498	1586	1556	1712	1713	1615	1399	3462	3462
Intakes	ARC	15	11	11	8	2	5	6	11	11	15	15	5	115	115
	BounceBack	3	3	12	75	62	22	45	47	61	29	4	0	363	363
	CBITS	1	7	18	99	69	35	59	55	87	23	3	5	461	461
	MATCH-ADTC	30	28	35	39	50	47	62	46	41	64	41	32	515	515
	TF-CBT	115	81	73	109	78	54	60	70	92	81	64	45	922	922
Intakes Total		164	130	149	330	261	163	232	229	292	212	127	87	2376	2376
Discharges	ARC	11	13	18	13	10	4	13	12	13	6	7	7	127	127
	BounceBack	15	3	1	0	0	6	47	28	45	35	76	108	364	364
	CBITS	9	11	2	2	6	2	85	22	41	51	111	109	451	451
	MATCH-ADTC	51	49	42	45	30	52	37	28	40	37	41	41	493	493
	TF-CBT	107	98	98	88	63	80	77	46	72	96	68	72	965	965
Discharges Total		193	174	161	148	109	144	259	136	211	225	303	337	2400	2400

[1]Total for the 12 months (year) displayed in table

	Children Served[1] (% of Open)		Children Discharged		
	% June 2019	Average % FY2019	Total Closed FY2019	% Successful June 2019	% Successful FY2019 Avg.
ARC	85%	89%	127	71%	53%
BounceBack	64%	78%	364	96%	95%
CBITS	59%	73%	451	94%	88%
MATCH-ADTC	77%	83%	493	68%	54%
TF-CBT	76%	84%	965	44%	36%
All EBTs	74%	82%	2400	81%	59%

	Monthly Session Forms Completed On Time												
	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Avg. QI Period[2]
ARC	92%	90%	96%	94%	84%	92%	84%	97%	92%	83%	89%	94%	90%
MATCH-ADTC	92%	90%	92%	87%	86%	90%	89%	87%	90%	86%	89%	88%	88%
TF-CBT	89%	85%	87%	86%	86%	94%	86%	92%	90%	90%	88%	89%	89%
All EBTs	90%	87%	89%	87%	86%	93%	86%	91%	91%	88%	89%	89%	89%



Clinicians Trained[4] in EBTs FY2019	
ARC	26
BounceBack	59
CBITS	51
MATCH-ADTC	54
TF-CBT	58

Individual Sessions June 2019 (all models): 2261
Group Sessions June 2019 (BB & CBITS only): 102

No Show June 2019 (ARC, MATCH, TF-CBT): 19%
No Show FY2019 Average (ARC, MATCH, TF-CBT): 16%

[1] One or more visits within the month
[2] QI Period is January 2019 - June 2019
[3] Includes co-facilitators
[4] Includes individuals with a clinical role at time in training. Includes internal agency trainings.

Appendix D: Quality Improvement

QI Overview

The indicators provided in this report cover the period from January-June 2019. Data were pulled from the EBP Tracker database on July 16th, 2019. Child episodes were included in the dataset if they were closed in the QI period, and had at least one clinical session during treatment (entire LOS). Treatment episodes were counted regardless of whether a child received multiple EBTs in the time period.

Although historically QI has applied only to TF-CBT, as of July 2018 indicators have been developed for the following models and are included in this report: ARC, BounceBack!, CBITS, MATCH-ADTC. In order to adhere to common required elements of all models, some indicators have been removed and/or changed as of July 2018. A complete list of the current and past indicators, benchmarks, and definitions is included below.

QI Indicators Prior to July 2018	QI Indicators July 2018 - Present	July 2018 – Present QI Description
Credentialed Clinicians	-	Removed
Percent Above CSQ	-	Removed
Episodes Closed	Episodes Closed	Treatment episodes discharged in QI period with at least one clinical session during entire LOS.
Engaged	Engaged	Percentage of closed episodes with four or more clinical sessions attended.
Caregiver Involvement	-	Removed
Episodes with 2 Visits/ Month	Consistent Care	Percentage of closed and engaged treatment episodes with an average of two or more treatment episodes per month. Calculated by dividing the LOS by number of visits.
Episodes with TN Complete	-	Removed. See 'model completion' description below.
Episodes Successfully Completed	Model Completion	Percentage of closed and engaged treatment episodes that fully complete the model. Model completion definitions are: - BounceBack!: child attends 7 or more group sessions (attended or make-up) - CBITS: child attends 7 or more group sessions (attended or make-up) - TF-CBT: completion of all required child treatment components and 8 or more sessions Indicator does not apply to ARC and MATCH-ADTC treatment models.
Episodes with Assessment Data	Measures	Percentage of closed and engaged treatment episodes with at least one measure available at two different time points for any measure of child or caregiver symptoms.
Episodes with Symptom Improvement	Improved Outcomes	Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change on any measure. Includes any measure of child or caregiver symptoms.

Benchmarks apply to all models. Percentage columns are highlighted green in the report if an agency has met the proposed benchmark for the indicator and model.

Indicator	Benchmark
Engagement	55% of closed episodes
Measurement Based Care	70% of closed and engaged episodes
Improved Outcomes	75% of closed and engaged episodes with measures available
Consistent Care	65% of closed and engaged episodes
Model Completion	30% of closed and engaged episodes

Definitions that Changed After July 2018:

- **Successfully Completed – Model Completion:** Prior QI reports looked at closed episodes with clinician reports of successful completion and completed all required model requirements. Current definition includes closed episodes that were engaged and completed all required model requirements (see table on previous page). Clinician reports of successful completion are not included in the current model completion definition.
- **Episodes with Assessment Data - Measures:** Prior QI reports looked at closed episodes that had at least a CPSS-IV or SMFQ (caregiver or child version) completed at two different time points. Current report looks at closed and engaged treatment episodes with any child or caregiver symptom measure completed at two different time points (see FAQ for a full list of accepted measures).
- **Episodes with Symptom Improvement – Improved Outcomes:** Prior QI reports looked at closed episodes that has at least partial reliable change for trauma (CPSS-IV) or depression (SMFQ) symptoms. Current report looks at closed and engaged treatment episodes with at least data at two different time points that had at least partial reliable change on any child or caregiver symptom measure (see FAQ for a full list of accepted measures).

Additionally, the format of the report has changed, with each indicator on a separate page, to allow comparison across treatment models and agencies. CBITS and Bounce Back QI indicators are reported separately on pages 11 thru 15. QI results for TF-CBT private practices are also reported separately on page 16.

As of July 2018 there is no agency credentialing.

Frequently Asked Questions

Why was agency credentialing removed?
Agency credentialing status has been removed to reduce the number of data points reported. However, agencies are still encouraged to meet all five indicators: engagement, measurement based care, improved outcomes, consistent care, and model completion for every model implemented at the agency. Agencies will continue to receive sustainability funding based on the engagement, measurement based care, and improved outcomes indicators.

Why were the CSQ and caregiver involvement indicators removed? Why was the clinician credentialing requirement removed?
QI indicators have been streamlined to reduce the number of data points reported and adhere to common required elements of all models. Because caregiver involvement is not required for all models, indicators relating to caregiver involvement have been removed. Caregiver involvement will continue to be a credentialing requirement for certain models (see model-specific credentialing documents for more information), and agencies are highly encouraged to have their clinicians credentialed in each model that they received training.

What assessments count towards the measures and improved outcomes indicators?

With the flexible assessment schedule EBP Tracker update in August 2018 the list of accepted measures for these indicators has been expanded. It should be noted that this list of measures only applies to QI indicators, and measurement requirements for credentialing may differ (see model-specific credentialing documents for more information).

The following child symptom assessments count towards the measures and improved outcomes requirements: CPSS-IV (child or caregiver), CPSS-V (child or caregiver), Ohio Functioning Scale (child or caregiver), Ohio Problem Severity Scale (child or caregiver), SMFQ (child or caregiver), UCLA (child or caregiver), Baby Pediatric Symptom Checklist (BPSC), Preschool Pediatric Symptom Checklist (PPSC), or Young Child PTSD (YCPC).

The following caregiver symptom assessments count towards the measures and improved outcomes requirements: CESD-R, Parental Stress Scale (PSS), PTSD Checklist for DSM (PCL-5).

For each individual assessment measure to be considered complete, 90% of the items must be answered. The same assessment needs to be completed at two different time points to meet the measures requirement. To meet the improved outcomes requirement, an episode needs to meet the criteria for at least *partial reliable change*. A full list of reliable change values for each measure can be found in the EBP Tracker Measures Manual.

Why aren't episodes without visits counted in the number of closed episodes for QI indicators?

While these episodes are "closed", they do not meet QI requirements because the child did not receive any evidence-based treatment during the episode. Because indicators are percentage-based, it would not be fair to count these episodes as they did not include any treatment and therefore would not meet the indicator requirements.

What are the required treatment components for TF-CBT?

TF-CBT requires the following child components: (1) Psychoeducation; (2) Relaxation; (3) Affective Expression and Modulation; (4) Cognitive Coping and Processing; (5) Trauma Narrative; and 6) Enhancing Future Safety. Additionally, the model requires the following caregiver components: (1) Parenting Skills; (2) Conjoint Child-Parent Sessions. At minimum, an episode needs to have 8 sessions and complete all child components to count towards the model completion requirement.

What happens if my agency does not meet the proposed benchmarks in a reporting period?

If an agency misses a benchmark, we develop a SMARTER Goal to assist with improving performance in that particular area. If an agency misses multiple benchmarks we generally create a more detailed plan, which may include more frequent in-person and/or telephonic consultation.

Overview - Closed Episodes[1]

July-December 2018

Provider Name	EBT Closed Episodes	ARC	BounceBack!	CBITS	MATCH-ADTC	TF-CBT
Adelbrook, Inc.	5	-	-	-	-	5
Boys & Girls Village	2	-	0	0	-	2
Bridges Healthcare, Inc	39	10	-	-	15	14
Catholic Charities Archdiocese of Hartford	7	-	-	-	-	7
Charlotte Hungerford Hospital	42	2	-	-	13	27
Child and Family Agency of Southeastern Connecticut, Inc	57	3	0	0	25	29
Child Guidance Center of Southern Connecticut, Inc	15	5	-	-	-	10
Clifford Beers Clinic	37	-	3	7	3	24
Community Child Guidance Clinic, Inc	21	4	-	-	6	11
Community Health Center, Inc	23	-	0	4	-	19
Community Health Resources	49	4	-	-	12	33
Community Mental Health Affiliates, Inc	31	-	6	8	7	10
Connecticut Junior Republic	8	-	-	-	2	6
Cornell Scott Hill Health Center	49	-	0	0	28	21
Day Kimball Healthcare	0	-	-	-	-	0
Family & Children's Aid, Inc	26	6	-	-	-	20
Family Centers, Inc	7	-	-	-	-	7
Jewish Family Services	2	-	-	-	-	2
Klingberg Family Centers	4	-	-	-	-	4
LifeBridge Community Services	14	-	-	-	-	14
Mid-Fairfield Child Guidance Center, Inc	11	-	-	-	0	11
Parent Child Resource Center	18	-	-	-	13	5
The Child and Family Guidance Center	16	-	-	-	6	10
The Child Guidance Clinic For Central Connecticut, Inc	30	7	0	0	9	14
The Village for Families & Children, Inc	49	10	0	0	28	11
United Community and Family Services	71	8	0	8	26	29
United Services, Inc	76	-	0	0	36	40
Waterford Country School, Inc.	11	-	-	-	-	11
Wellmore Behavioral Health	47	9	-	-	16	22
Wheeler Clinic	46	-	0	0	10	36
Yale Child Study Center	38	-	-	-	6	32
Yale Child Study Center-West Haven	0	-	-	-	-	0
Average	**27**	**6**	**1**	**2**	**14**	**15**
Total	**851**	**68**	**9**	**27**	**261**	**486**

[1] Closed treatment episodes with at least one clinical session

Engagement[1] July-December 2018

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	55%	-	-	-	-	-	-	5	5	100%	5	5	100%
Boys & Girls Village	55%	-	-	-	-	-	-	2	2	100%	2	2	100%
Bridges, A Community Support System	55%	10	10	100%	15	14	93%	14	14	100%	39	38	97%
Catholic Charities Archdiocese of Hartford	55%	-	-	-	-	-	-	7	7	100%	7	7	100%
Charlotte Hungerford Hospital	55%	2	2	100%	13	12	92%	27	24	89%	42	38	90%
Child and Family Agency of Southeastern Connecticut, Inc	55%	3	3	100%	25	24	96%	29	28	97%	57	55	96%
Child Guidance Center of Southern Connecticut, Inc	55%	5	5	100%	-	-	-	10	8	80%	15	13	87%
Clifford Beers Clinic	55%	-	-	-	3	3	100%	24	19	79%	27	22	81%
Community Child Guidance Clinic, Inc	55%	4	3	75%	6	6	100%	11	8	73%	21	17	81%
Community Health Center, Inc	55%	-	-	-	-	-	-	19	13	68%	19	13	68%
Community Health Resources	55%	4	3	75%	12	11	92%	33	25	76%	49	39	80%
Community Mental Health Affiliates, Inc	55%	-	-	-	7	6	86%	10	9	90%	17	15	88%
Connecticut Junior Republic	55%	-	-	-	2	2	100%	6	5	83%	8	7	88%
Cornell Scott Hill Health Center	55%	-	-	-	28	26	93%	21	21	100%	49	47	96%
Day Kimball Healthcare	55%	-	-	-	-	-	-	0	0	-	0	0	-
Family & Children's Aid, Inc	55%	6	6	100%	-	-	-	20	17	85%	26	23	88%
Family Centers, Inc	55%	-	-	-	-	-	-	7	7	100%	7	7	100%
Jewish Family Services	55%	-	-	-	-	-	-	2	2	100%	2	2	100%
Klingberg Family Centers	55%	-	-	-	-	-	-	4	3	75%	4	3	75%
LifeBridge Community Services	55%	-	-	-	-	-	-	14	11	79%	14	11	79%
Mid-Fairfield Child Guidance Center, Inc	55%	-	-	-	0	0	-	11	11	100%	11	11	100%
Parent Child Resource Center	55%	-	-	-	13	13	100%	5	5	100%	18	18	100%
The Child and Family Guidance Center	55%	-	-	-	6	5	83%	10	9	90%	16	14	88%
The Child Guidance Clinic For Central Connecticut, Inc	55%	7	7	100%	9	8	89%	14	10	71%	30	25	83%
The Village for Families & Children, Inc	55%	10	10	100%	28	24	86%	11	10	91%	49	44	90%
United Community and Family Services	55%	8	7	88%	26	26	100%	29	27	93%	63	60	95%
United Services, Inc	55%	-	-	-	36	29	81%	40	32	80%	76	61	80%
Waterford Country School, Inc.	55%	-	-	-	-	-	-	11	9	82%	11	9	82%
Wellmore Behavioral Health	55%	9	8	89%	16	15	94%	22	15	68%	47	38	81%
Wheeler Clinic	55%	-	-	-	10	8	80%	36	29	81%	46	37	80%
Yale Child Study Center	55%	-	-	-	6	5	83%	32	30	94%	38	35	92%
Yale Child Study Center-West Haven	55%	-	-	-	-	-	-	0	0	-	0	0	-
Average	**-**	**6**	**6**	**-**	**14**	**12**	**-**	**15**	**13**	**-**	**25**	**22**	**-**
Total	**55%**	**68**	**64**	**94%**	**261**	**237**	**91%**	**486**	**415**	**85%**	**815**	**716**	**88%**

[1] Percentage of closed treatment episodes with at least four or more treatment sessions.

Measurement Based Care[1]
July-December 2018

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Engaged	Measures		Engaged	Measures		Engaged	Measures		Engaged	Measures	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	70%	-	-	-	-	-	-	5	5	100%	5	5	100%
Boys & Girls Village	70%	-	-	-	-	-	-	2	1	50%	2	1	50%
Bridges, A Community Support System	70%	10	9	90%	14	14	100%	14	11	79%	38	34	89%
Catholic Charities Archdiocese of Hartford	70%	-	-	-	-	-	-	7	7	100%	7	7	100%
Charlotte Hungerford Hospital	70%	2	2	100%	12	7	58%	24	23	96%	38	32	84%
Child and Family Agency of Southeastern Connecticut, Inc	70%	3	3	100%	24	17	71%	28	22	79%	55	42	76%
Child Guidance Center of Southern Connecticut, Inc	70%	5	4	80%	-	-	-	8	7	88%	13	11	85%
Clifford Beers Clinic	70%	-	-	-	3	1	33%	19	19	100%	22	20	91%
Community Child Guidance Clinic, Inc	70%	3	1	33%	6	5	83%	8	7	88%	17	13	76%
Community Health Center, Inc	70%	-	-	-	-	-	-	13	7	54%	13	7	54%
Community Health Resources	70%	3	3	100%	11	10	91%	25	23	92%	39	36	92%
Community Mental Health Affiliates, Inc	70%	-	-	-	6	6	100%	9	7	78%	15	13	87%
Connecticut Junior Republic	70%	-	-	-	2	2	100%	5	3	60%	7	5	71%
Cornell Scott Hill Health Center	70%	-	-	-	26	22	85%	21	17	81%	47	39	83%
Day Kimball Healthcare	70%	-	-	-	-	-	-	0	0	-	0	0	-
Family & Children's Aid, Inc	70%	6	2	33%	-	-	-	17	10	59%	23	12	52%
Family Centers, Inc	70%	-	-	-	-	-	-	7	3	43%	7	3	43%
Jewish Family Services	70%	-	-	-	-	-	-	2	0	0%	2	0	0%
Klingberg Family Centers	70%	-	-	-	-	-	-	3	1	33%	3	1	33%
LifeBridge Community Services	70%	-	-	-	-	-	-	11	6	55%	11	6	55%
Mid-Fairfield Child Guidance Center, Inc	70%	-	-	-	0	0	-	11	11	100%	11	11	100%
Parent Child Resource Center	70%	-	-	-	13	12	92%	5	5	100%	18	17	94%
The Child and Family Guidance Center	70%	-	-	-	5	4	80%	9	7	78%	14	11	79%
The Child Guidance Clinic For Central Connecticut, Inc	70%	7	7	100%	8	7	88%	10	9	90%	25	23	92%
The Village for Families & Children, Inc	70%	10	2	20%	24	19	79%	10	10	100%	44	31	70%
United Community and Family Services	70%	7	6	86%	26	25	96%	27	22	81%	60	53	88%
United Services, Inc	70%	-	-	-	29	26	90%	32	30	94%	61	56	92%
Waterford Country School, Inc.	70%	-	-	-	-	-	-	9	7	78%	9	7	78%
Wellmore Behavioral Health	70%	8	6	75%	15	12	80%	15	11	73%	38	29	76%
Wheeler Clinic	70%	-	-	-	8	6	75%	29	22	76%	37	28	76%
Yale Child Study Center	70%	-	-	-	5	4	80%	30	19	63%	35	23	66%
Yale Child Study Center-West Haven	70%	-	-	-	-	-	-	0	0	-	0	0	-
Average	**-**	**6**	**4**	**-**	**12**	**10**	**-**	**13**	**10**	**-**	**22**	**18**	**-**
Total	**70%**	**64**	**45**	**70%**	**237**	**199**	**84%**	**415**	**332**	**80%**	**716**	**576**	**80%**

[1] Percentage of closed and engaged treatment epsiodes with least one measure available at two different time points during episode of care.

Improved Outcomes[1]
July-December 2018

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	75%	-	-	-	-	-	-	5	5	100%	5	5	100%
Boys & Girls Village	75%	-	-	-	-	-	-	1	1	100%	1	1	100%
Bridges, A Community Support System	75%	9	2	22%	14	13	93%	11	8	73%	34	23	68%
Catholic Charities Archdiocese of Hartford	75%	-	-	-	-	-	-	7	4	57%	7	4	57%
Charlotte Hungerford Hospital	75%	2	0	0%	7	4	57%	23	17	74%	32	21	66%
Child and Family Agency of Southeastern Connecticut, Inc	75%	3	1	33%	17	16	94%	22	14	64%	42	31	74%
Child Guidance Center of Southern Connecticut, Inc	75%	4	3	75%	-	-	-	7	4	57%	11	7	64%
Clifford Beers Clinic	75%	-	-	-	1	1	100%	19	10	53%	20	11	55%
Community Child Guidance Clinic, Inc	75%	1	0	0%	5	4	80%	7	2	29%	13	6	46%
Community Health Center, Inc	75%	-	-	-	-	-	-	7	6	86%	7	6	86%
Community Health Resources	75%	3	0	0%	10	9	90%	23	19	83%	36	28	78%
Community Mental Health Affiliates, Inc	75%	-	-	-	6	5	83%	7	2	29%	13	7	54%
Connecticut Junior Republic	75%	-	-	-	2	2	100%	3	1	33%	5	3	60%
Cornell Scott Hill Health Center	75%	-	-	-	22	19	86%	17	13	76%	39	32	82%
Day Kimball Healthcare	75%	-	-	-	-	-	-	0	0	-	0	0	-
Family & Children's Aid, Inc	75%	2	0	0%	-	-	-	10	6	60%	12	6	50%
Family Centers, Inc	75%	-	-	-	-	-	-	3	1	33%	3	1	33%
Jewish Family Services	75%	-	-	-	-	-	-	0	0	-	0	0	-
Klingberg Family Centers	75%	-	-	-	-	-	-	1	1	100%	1	1	100%
LifeBridge Community Services	75%	-	-	-	-	-	-	6	3	50%	6	3	50%
Mid-Fairfield Child Guidance Center, Inc	75%	-	-	-	0	0	-	11	8	73%	11	8	73%
Parent Child Resource Center	75%	-	-	-	12	9	75%	5	4	80%	17	13	76%
The Child and Family Guidance Center	75%	-	-	-	4	3	75%	7	2	29%	11	5	45%
The Child Guidance Clinic For Central Connecticut, Inc	75%	7	1	14%	7	7	100%	9	6	67%	23	14	61%
The Village for Families & Children, Inc	75%	2	0	0%	19	17	89%	10	6	60%	31	23	74%
United Community and Family Services	75%	6	2	33%	25	22	88%	22	13	59%	53	37	70%
United Services, Inc	75%	-	-	-	26	20	77%	30	19	63%	56	39	70%
Waterford Country School, Inc.	75%	-	-	-	-	-	-	7	4	57%	7	4	57%
Wellmore Behavioral Health	75%	6	2	33%	12	10	83%	11	9	82%	29	21	72%
Wheeler Clinic	75%	-	-	-	6	5	83%	22	10	45%	28	15	54%
Yale Child Study Center	75%	-	-	-	4	4	100%	19	13	68%	23	17	74%
Yale Child Study Center-West Haven	75%	-	-	-	-	-	-	0	0	-	0	0	-
Average	**-**	**4**	**1**	**-**	**10**	**9**	**-**	**10**	**7**	**-**	**18**	**12**	**-**
Total	**75%**	**45**	**11**	**24%**	**199**	**170**	**85%**	**332**	**211**	**64%**	**576**	**392**	**68%**

[1] Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change on any measure.

Consistent Care[1]
July-December 2018

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Engage	Consistent Care #	Consistent Care %	# Engage	Consistent Care #	Consistent Care %	# Engage	Consistent Care #	Consistent Care %	# Engage	Consistent Care #	Consistent Care %
Adelbrook, Inc.	65%	-	-	-	-	-	-	5	5	100%	5	5	100%
Boys & Girls Village	65%	-	-	-	-	-	-	2	1	50%	2	1	50%
Bridges, A Community Support System	65%	10	9	90%	14	10	71%	14	8	57%	38	27	71%
Catholic Charities Archdiocese of Hartford	65%	-	-	-	-	-	-	7	6	86%	7	6	86%
Charlotte Hungerford Hospital	65%	2	1	50%	12	6	50%	24	21	88%	38	28	74%
Child and Family Agency of Southeastern Connecticut, Inc	65%	3	3	100%	24	22	92%	28	24	86%	55	49	89%
Child Guidance Center of Southern Connecticut, Inc	65%	5	5	100%	-	-	-	8	4	50%	13	9	69%
Clifford Beers Clinic	65%	-	-	-	3	2	67%	19	17	89%	22	19	86%
Community Child Guidance Clinic, Inc	65%	3	3	100%	6	4	67%	8	5	63%	17	12	71%
Community Health Center, Inc	65%	-	-	-	-	-	-	13	6	46%	13	6	46%
Community Health Resources	65%	3	1	33%	11	4	36%	25	17	68%	39	22	56%
Community Mental Health Affiliates, Inc	65%	-	-	-	6	3	50%	9	5	56%	15	8	53%
Connecticut Junior Republic	65%	-	-	-	2	2	100%	5	5	100%	7	7	100%
Cornell Scott Hill Health Center	65%	-	-	-	26	18	69%	21	17	81%	47	35	74%
Day Kimball Healthcare	65%	-	-	-	-	-	-	0	0	-	0	0	-
Family & Children's Aid, Inc	65%	6	4	67%	-	-	-	17	14	82%	23	18	78%
Family Centers, Inc	65%	-	-	-	-	-	-	7	5	71%	7	5	71%
Jewish Family Services	65%	-	-	-	-	-	-	2	1	50%	2	1	50%
Klingberg Family Centers	65%	-	-	-	-	-	-	3	2	67%	3	2	67%
LifeBridge Community Services	65%	-	-	-	-	-	-	11	9	82%	11	9	82%
Mid-Fairfield Child Guidance Center, Inc	65%	-	-	-	0	0	-	11	11	100%	11	11	100%
Parent Child Resource Center	65%	-	-	-	13	12	92%	5	4	80%	18	16	89%
The Child and Family Guidance Center	65%	-	-	-	5	2	40%	9	3	33%	14	5	36%
The Child Guidance Clinic For Central Connecticut, Inc	65%	7	5	71%	8	6	75%	10	6	60%	25	17	68%
The Village for Families & Children, Inc	65%	10	8	80%	24	16	67%	10	4	40%	44	28	64%
United Community and Family Services	65%	7	7	100%	26	21	81%	27	23	85%	60	51	85%
United Services, Inc	65%	-	-	-	29	20	69%	32	16	50%	61	36	59%
Waterford Country School, Inc.	65%	-	-	-	-	-	-	9	7	78%	9	7	78%
Wellmore Behavioral Health	65%	8	1	13%	15	4	27%	15	9	60%	38	14	37%
Wheeler Clinic	65%	-	-	-	8	2	25%	29	16	55%	37	18	49%
Yale Child Study Center	65%	-	-	-	5	4	80%	30	25	83%	35	29	83%
Yale Child Study Center-West Haven	65%	-	-	-	-	-	-	0	0	-	0	0	-
Average	**-**	**6**	**4**	**-**	**12**	**8**	**-**	**13**	**9**	**-**	**22**	**16**	**-**
Total	**65%**	**64**	**47**	**73%**	**237**	**158**	**67%**	**415**	**296**	**71%**	**716**	**501**	**70%**

[1] Percentage of closed and engaged treatment episodes with an average of two or more treatment sessions per month

Overview - Closed Episodes[1]

January - June 2019

Provider Name	EBT Closed Episodes	ARC	BounceBack	CBITS	MATCH-ADTC	TF-CBT
Adelbrook, Inc.	2	-	-	-	-	2
Boys & Girls Village	7	-	4	2	-	1
Bridges Healthcare, Inc	38	12	0	0	10	16
Catholic Charities Archdiocese of Hartford	4	-	-	-	-	4
Charlotte Hungerford Hospital	31	0	-	-	10	21
Child and Family Agency of Southeastern Connecticut, Inc	87	4	35	27	12	9
Child Guidance Center of Southern Connecticut, Inc	23	6	-	-	-	17
Clifford Beers Clinic	105	-	36	29	8	32
Community Child Guidance Clinic, Inc	27	9	-	-	8	10
Community Health Center, Inc	33	-	-	21	-	12
Community Health Resources	52	6	-	-	16	30
Community Mental Health Affiliates, Inc	35	-	2	3	12	18
Connecticut Junior Republic	19	-	-	-	9	10
Cornell Scott Hill Health Center	88	-	35	7	21	25
Family & Children's Aid, Inc	19	5	-	-	-	14
Family Centers, Inc	3	-	-	-	-	3
Jewish Family Services	2	-	-	-	-	2
Klingberg Family Centers	8	-	-	-	-	8
LifeBridge Community Services	10	-	-	-	-	10
Mid-Fairfield Child Guidance Center, Inc	33	-	15	9	1	8
Parent Child Resource Center	11	-	-	-	5	6
The Child and Family Guidance Center	18	-	-	-	6	12
The Child Guidance Clinic For Central Connecticut, Inc	26	1	8	0	6	11
The Village for Families & Children, Inc	47	4	0	0	25	18
United Community and Family Services	69	5	9	11	16	28
United Services, Inc	54	-	0	0	32	22
Waterford Country School, Inc.	15	-	-	-	-	15
Wellmore Behavioral Health	44	6	-	-	20	18
Wheeler Clinic	55	-	14	9	6	26
Yale Child Study Center	14	-	-	-	1	13
Yale - West Haven Clinic	0	-	-	-	-	0
Average	**32**	**5**	**13**	**9**	**12**	**14**
Total	**979**	**58**	**158**	**118**	**224**	**421**

[1] Closed treatment episodes with at least one clinical session

Engagement[1]
January - June 2019

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	55%	-	-	-	-	-	-	2	2	100%	2	2	100%
Boys & Girls Village	55%	-	-	-	-	-	-	1	1	100%	1	1	100%
Bridges Healthcare, Inc	55%	12	12	100%	10	10	100%	16	15	94%	38	37	97%
Catholic Charities Archdiocese of Hartford	55%	-	-	-	-	-	-	4	4	100%	4	4	100%
Charlotte Hungerford Hospital	55%	0	-	-	10	10	100%	21	20	95%	31	30	97%
Child and Family Agency of Southeastern Connecticut, Inc	55%	4	4	100%	12	12	100%	9	9	100%	25	25	100%
Child Guidance Center of Southern Connecticut, Inc	55%	6	6	100%	-	-	-	17	11	65%	23	17	74%
Clifford Beers Clinic	55%	-	-	-	8	8	100%	32	30	94%	40	38	95%
Community Child Guidance Clinic, Inc	55%	9	9	100%	8	6	75%	10	10	100%	27	25	93%
Community Health Center, Inc	55%	-	-	-	-	-	-	12	9	75%	12	9	75%
Community Health Resources	55%	6	5	83%	16	11	69%	30	26	87%	52	42	81%
Community Mental Health Affiliates, Inc	55%	-	-	-	12	10	83%	18	16	89%	30	26	87%
Connecticut Junior Republic	55%	-	-	-	9	8	89%	10	9	90%	19	17	89%
Cornell Scott Hill Health Center	55%	-	-	-	21	19	90%	25	23	92%	46	42	91%
Family & Children's Aid, Inc	55%	5	5	100%	-	-	-	14	13	93%	19	18	95%
Family Centers, Inc	55%	-	-	-	-	-	-	3	3	100%	3	3	100%
Jewish Family Services	55%	-	-	-	-	-	-	2	1	50%	2	1	50%
Klingberg Family Centers	55%	-	-	-	-	-	-	8	8	100%	8	8	100%
LifeBridge Community Services	55%	-	-	-	-	-	-	10	7	70%	10	7	70%
Mid-Fairfield Child Guidance Center, Inc	55%	-	-	-	1	1	100%	8	8	100%	9	9	100%
Parent Child Resource Center	55%	-	-	-	5	5	100%	6	6	100%	11	11	100%
The Child and Family Guidance Center	55%	-	-	-	6	4	67%	12	12	100%	18	16	89%
The Child Guidance Clinic For Central Connecticut, Inc	55%	1	1	100%	6	5	83%	11	11	100%	18	17	94%
The Village for Families & Children, Inc	55%	4	4	100%	25	22	88%	18	14	78%	47	40	85%
United Community and Family Services	55%	5	5	100%	16	14	88%	28	28	100%	49	47	96%
United Services, Inc	55%	-	-	-	32	27	84%	22	19	86%	54	46	85%
Waterford Country School, Inc.	55%	-	-	-	-	-	-	15	14	93%	15	14	93%
Wellmore Behavioral Health	55%	6	3	50%	20	18	90%	18	13	72%	44	34	77%
Wheeler Clinic	55%	-	-	-	6	5	83%	26	24	92%	32	29	91%
Yale Child Study Center	55%	-	-	-	1	1	100%	13	9	69%	14	10	71%
Yale - West Haven Clinic	55%	-	-	-	-	-	-	-	-	-	-	-	-
Average	**-**	**5**	**5**	**-**	**12**	**10**	**-**	**14**	**13**	**-**	**23**	**21**	**-**
Total	**55%**	**58**	**54**	**93%**	**224**	**196**	**88%**	**421**	**375**	**89%**	**703**	**625**	**89%**

[1] Percentage of closed treatment episodes with at least four or more treatment sessions.

Measurement Based Care[1]
January - June 2019

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		#	Measures		#	Measures		#	Measures		#	Measures	
		Engaged	#	%	Engaged	#	%	Engaged	#	%	Engaged	#	%
Adelbrook, Inc.	70%	-	-	-	-	-	-	2	2	100%	2	2	100%
Boys & Girls Village	70%	-	-	-	-	-	-	1	0	0%	1	0	0%
Bridges Healthcare, Inc	70%	12	11	92%	10	10	100%	15	14	93%	37	35	95%
Catholic Charities Archdiocese of Hartford	70%	-	-	-	-	-	-	4	4	100%	4	4	100%
Charlotte Hungerford Hospital	70%	-	-	-	10	4	40%	20	18	90%	30	22	73%
Child and Family Agency of Southeastern Connecticut, Inc	70%	4	3	75%	12	11	92%	9	6	67%	25	20	80%
Child Guidance Center of Southern Connecticut, Inc	70%	6	6	100%	-	-	-	11	7	64%	17	13	76%
Clifford Beers Clinic	70%	-	-	-	8	1	13%	30	25	83%	38	26	68%
Community Child Guidance Clinic, Inc	70%	9	8	89%	6	4	67%	10	10	100%	25	22	88%
Community Health Center, Inc	70%	-	-	-	-	-	-	9	5	56%	9	5	56%
Community Health Resources	70%	5	2	40%	11	8	73%	26	17	65%	42	27	64%
Community Mental Health Affiliates, Inc	70%	-	-	-	10	10	100%	16	16	100%	26	26	100%
Connecticut Junior Republic	70%	-	-	-	8	7	88%	9	6	67%	17	13	76%
Cornell Scott Hill Health Center	70%	-	-	-	19	18	95%	23	16	70%	42	34	81%
Family & Children's Aid, Inc	70%	5	3	60%	-	-	-	13	7	54%	18	10	56%
Family Centers, Inc	70%	-	-	-	-	-	-	3	3	100%	3	3	100%
Jewish Family Services	70%	-	-	-	-	-	-	1	1	100%	1	1	100%
Klingberg Family Centers	70%	-	-	-	-	-	-	8	7	88%	8	7	88%
LifeBridge Community Services	70%	-	-	-	-	-	-	7	7	100%	7	7	100%
Mid-Fairfield Child Guidance Center, Inc	70%	-	-	-	1	0	0%	8	8	100%	9	8	89%
Parent Child Resource Center	70%	-	-	-	5	5	100%	6	6	100%	11	11	100%
The Child and Family Guidance Center	70%	-	-	-	4	4	100%	12	9	75%	16	13	81%
The Child Guidance Clinic For Central Connecticut, Inc	70%	1	1	100%	5	4	80%	11	11	100%	17	16	94%
The Village for Families & Children, Inc	70%	4	3	75%	22	20	91%	14	8	57%	40	31	78%
United Community and Family Services	70%	5	4	80%	14	14	100%	28	26	93%	47	44	94%
United Services, Inc	70%	-	-	-	27	24	89%	19	18	95%	46	42	91%
Waterford Country School, Inc.	70%	-	-	-	-	-	-	14	12	86%	14	12	86%
Wellmore Behavioral Health	70%	3	3	100%	18	15	83%	13	12	92%	34	30	88%
Wheeler Clinic	70%	-	-	-	5	5	100%	24	21	88%	29	26	90%
Yale Child Study Center	70%	-	-	-	1	1	100%	9	6	67%	10	7	70%
Yale - West Haven Clinic	70%	-	-	-	-	-	-	-	-	-	-	-	-
Average	**-**	**5**	**4**	**-**	**10**	**9**	**-**	**13**	**10**	**-**	**21**	**17**	**-**
Total	**70%**	**54**	**44**	**81%**	**196**	**165**	**84%**	**375**	**308**	**82%**	**625**	**517**	**83%**

[1] Percentage of closed and engaged treatment episodes with at least one measure available at two different time points during episode of care.

Improved Outcomes[1]
January - June 2019

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	75%	-	-	-	-	-	-	2	2	100%	2	2	100%
Boys & Girls Village	75%	-	-	-	-	-	-	0	-	-	0	-	-
Bridges Healthcare, Inc	75%	11	3	27%	10	9	90%	14	11	79%	35	23	66%
Catholic Charities Archdiocese of Hartford	75%	-	-	-	-	-	-	4	1	25%	4	1	25%
Charlotte Hungerford Hospital	75%	-	-	-	4	3	75%	18	9	50%	22	12	55%
Child and Family Agency of Southeastern Connecticut, Inc	75%	3	1	33%	11	10	91%	6	3	50%	20	14	70%
Child Guidance Center of Southern Connecticut, Inc	75%	6	2	33%	-	-	-	7	6	86%	13	8	62%
Clifford Beers Clinic	75%	-	-	-	1	1	100%	25	12	48%	26	13	50%
Community Child Guidance Clinic, Inc	75%	8	6	75%	4	2	50%	10	6	60%	22	14	64%
Community Health Center, Inc	75%	-	-	-	-	-	-	5	5	100%	5	5	100%
Community Health Resources	75%	2	0	0%	8	6	75%	17	8	47%	27	14	52%
Community Mental Health Affiliates, Inc	75%	-	-	-	10	9	90%	16	11	69%	26	20	77%
Connecticut Junior Republic	75%	-	-	-	7	6	86%	6	3	50%	13	9	69%
Cornell Scott Hill Health Center	75%	-	-	-	18	11	61%	16	9	56%	34	20	59%
Family & Children's Aid, Inc	75%	3	1	33%	-	-	-	7	6	86%	10	7	70%
Family Centers, Inc	75%	-	-	-	-	-	-	3	2	67%	3	2	67%
Jewish Family Services	75%	-	-	-	-	-	-	1	1	100%	1	1	100%
Klingberg Family Centers	75%	-	-	-	-	-	-	7	3	43%	7	3	43%
LifeBridge Community Services	75%	-	-	-	-	-	-	7	3	43%	7	3	43%
Mid-Fairfield Child Guidance Center, Inc	75%	-	-	-	0	-	-	8	6	75%	8	6	75%
Parent Child Resource Center	75%	-	-	-	5	5	100%	6	3	50%	11	8	73%
The Child and Family Guidance Center	75%	-	-	-	4	3	75%	9	5	56%	13	8	62%
The Child Guidance Clinic For Central Connecticut, Inc	75%	1	0	0%	4	4	100%	11	8	73%	16	12	75%
The Village for Families & Children, Inc	75%	3	1	33%	20	15	75%	8	5	63%	31	21	68%
United Community and Family Services	75%	4	4	100%	14	13	93%	26	21	81%	44	38	86%
United Services, Inc	75%	-	-	-	24	17	71%	18	17	94%	42	34	81%
Waterford Country School, Inc.	75%	-	-	-	-	-	-	12	10	83%	12	10	83%
Wellmore Behavioral Health	75%	3	0	0%	15	13	87%	12	12	100%	30	25	83%
Wheeler Clinic	75%	-	-	-	5	4	80%	21	14	67%	26	18	69%
Yale Child Study Center	75%	-	-	-	1	0	0%	6	3	50%	7	3	43%
Yale - West Haven Clinic	75%	-	-	-	-	-	-	-	-	-	-	-	-
Average	**-**	**4**	**1.8**	**-**	**9**	**7**	**-**	**10**	**7**	**-**	**17**	**12**	**-**
Total	**75%**	**44**	**18**	**41%**	**165**	**131**	**79%**	**308**	**205**	**67%**	**517**	**354**	**68%**

[1] Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change on any measure.

Consistent Care[1]
January - June 2019

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Engaged	Consistent Care		# Engaged	Consistent Care		# Engaged	Consistent Care		# Engaged	Consistent Care	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	65%	-	-	-	-	-	-	2	2	100%	2	2	100%
Boys & Girls Village	65%	-	-	-	-	-	-	1	0	0%	1	0	0%
Bridges Healthcare, Inc	65%	12	9	75%	10	10	100%	15	15	100%	37	34	92%
Catholic Charities Archdiocese of Hartford	65%	-	-	-	-	-	-	4	3	75%	4	3	75%
Charlotte Hungerford Hospital	65%	-	-	-	10	5	50%	20	18	90%	30	23	77%
Child and Family Agency of Southeastern Connecticut, Inc	65%	4	4	100%	12	11	92%	9	8	89%	25	23	92%
Child Guidance Center of Southern Connecticut, Inc	65%	6	5	83%	-	-	-	11	10	91%	17	15	88%
Clifford Beers Clinic	65%	-	-	-	8	8	100%	30	23	77%	38	31	82%
Community Child Guidance Clinic, Inc	65%	9	4	44%	6	4	67%	10	10	100%	25	18	72%
Community Health Center, Inc	65%	-	-	-	-	-	-	9	3	33%	9	3	33%
Community Health Resources	65%	5	2	40%	11	3	27%	26	18	69%	42	23	55%
Community Mental Health Affiliates, Inc	65%	-	-	-	10	6	60%	16	12	75%	26	18	69%
Connecticut Junior Republic	65%	-	-	-	8	6	75%	9	8	89%	17	14	82%
Cornell Scott Hill Health Center	65%	-	-	-	19	15	79%	23	19	83%	42	34	81%
Family & Children's Aid, Inc	65%	5	5	100%	-	-	-	13	11	85%	18	16	89%
Family Centers, Inc	65%	-	-	-	-	-	-	3	2	67%	3	2	67%
Jewish Family Services	65%	-	-	-	-	-	-	1	1	100%	1	1	100%
Klingberg Family Centers	65%	-	-	-	-	-	-	8	8	100%	8	8	100%
LifeBridge Community Services	65%	-	-	-	-	-	-	7	6	86%	7	6	86%
Mid-Fairfield Child Guidance Center, Inc	65%	-	-	-	1	0	0%	8	8	100%	9	8	89%
Parent Child Resource Center	65%	-	-	-	5	5	100%	6	6	100%	11	11	100%
The Child and Family Guidance Center	65%	-	-	-	4	3	75%	12	8	67%	16	11	69%
The Child Guidance Clinic For Central Connecticut, Inc	65%	1	1	100%	5	2	40%	11	10	91%	17	13	76%
The Village for Families & Children, Inc	65%	4	3	75%	22	15	68%	14	9	64%	40	27	68%
United Community and Family Services	65%	5	2	40%	14	14	100%	28	23	82%	47	39	83%
United Services, Inc	65%	-	-	-	27	17	63%	19	13	68%	46	30	65%
Waterford Country School, Inc.	65%	-	-	-	-	-	-	14	11	79%	14	11	79%
Wellmore Behavioral Health	65%	3	0	0%	18	5	28%	13	6	46%	34	11	32%
Wheeler Clinic	65%	-	-	-	5	2	40%	24	15	63%	29	17	59%
Yale Child Study Center	65%	-	-	-	1	0	0%	9	6	67%	10	6	60%
Yale - West Haven Clinic	65%	-	-	-	-	-	-	-	-	-	-	-	-
Average	**-**	**5**	**4**	**-**	**10**	**7**	**-**	**13**	**10**	**-**	**21**	**15**	**-**
Total	**65%**	**54**	**35**	**65%**	**196**	**131**	**67%**	**375**	**292**	**78%**	**625**	**458**	**73%**

[1] Percentage of closed and engaged treatment episodes with an average of two or more treatment sessions per month

Appendix E: Reliable Change Index

Reliable Change Index Value Calculations

Reliable change index (RCI) values were proposed by Jacobson and Traux (1991) as a way to identify when a change in scores is likely not due to chance. The value for a given instrument is calculated based on the standard deviation and reliability of the measure. Change scores are then calculated and when the change exceeds the RCI value, it is considered to be reliable and significant. When values exceed half of the RCI value, but do not meet the RCI value, that is considered partial RCI.

A review of available literature was conducted for the assessments included in this manual, which are used in EBP Tracker. If articles did not include an explicit RCI value, one was calculated using the equation proposed by Jacobson and Traux (1991) with the appropriate values indicated in the research. Values used in the calculation were drawn from literature on the assessment unless noted otherwise. The following table includes a summary of the appropriate RCI values for the assessments.

	Measure	Full RCI	Partial RCI
Child Assessments	CPSS IV	11	6
	CPSS V	15	8
	SMFQ	7	4
	UCLA	16	9
Ohio Scales	Ohio Problem Severity* *(Child, Caregiver, & Worker versions)*	10	5
	Ohio Functioning *(Child, Caregiver, & Worker versions)*	8	4
Caregiver Assessments	CESD-R	9	5
	CPSS IV	10	5
	CPSS V	15	8
	PCL-5	10	5
	PSS	11	6
	SMFQ	6	3
	UCLA	11	6
	YCPC	18	9