

2020



Connecticut's Evidence-Based Treatment Coordination Center

Trauma-Focused Cognitive Behavioral Therapy



Connecticut TF-CBT Coordinating Center

Child Health and Development Institute

270 Farmington Ave, Suite 367
Farmington, CT 06032

www.chdi.org

This report was developed for the Connecticut Department of Children and Families (DCF) by the Child Health and Development Institute of Connecticut (CHDI). For more information, contact Jack Lu at jalu@uchc.edu

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Executive Summary

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for children who experience symptoms related to trauma exposure, including symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety. The Connecticut TF-CBT Coordinating Center (“Coordinating Center”) is located at the Child Health and Development Institute (CHDI). Funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch’s Court Support Services Division (CSSD), the goal of the Coordinating Center is to expand access to high quality, evidence-based outpatient behavioral health treatment for children exposed to trauma. Since 2007, TF-CBT has been disseminated across the state. The Coordinating Center now supports a network of 48 TF-CBT providers throughout Connecticut and 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, highlighting the performance during fiscal year 2020 (July 1, 2019 through June 30, 2020). This year was impacted by global and national events, which included the COVID-19 pandemic and social unrest given a renewed attention to the ongoing injustice that communities of color experience in the United States. Once stay-at-home orders were put in place in mid-March, provider agencies shifted to delivering services through telehealth platforms and trainings shifted to online platforms. National conversations on racial justice and racism came to the forefront during this year, reflected in this report with a continuing focus on disparities and inequities. Even amidst these challenges, TF-CBT demonstrated strong results in quality and outcomes.

FY2020 Highlights

- 1,155 children received TF-CBT
- 54 clinical staff were newly trained to deliver TF-CBT
- Caregivers (99%) and children (96%) reported very high satisfaction with treatment
- Children who completed TF-CBT had excellent outcomes, they reported a high remission rate for post-traumatic stress (>64%) and depressive symptoms (>59%)
- Caregivers reported a 64% remission rate for their own depressive symptoms
- Surpassed four of five Quality Improvement benchmarks
- Exceeded caregiver participation benchmark by 9%
- EBP Tracker database was integrated into the PIE database
- In response to COVID-19, the following additional activities supported TF-CBT implementation in telehealth formats:
 - All TF-CBT clinicians received virtual implementation resources
 - 13 additional weekly agency Coordinator meetings to ensure quality
 - Five additional virtual clinical training sessions were offered
 - Annual EBT trauma conference was held via a virtual platform

Key Recommendations

- Expand access to TF-CBT for children and families by enrolling new providers and expand TF-CBT utilization for existing providers
- Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity, health equity, anti-racism, and TF-CBT with young children

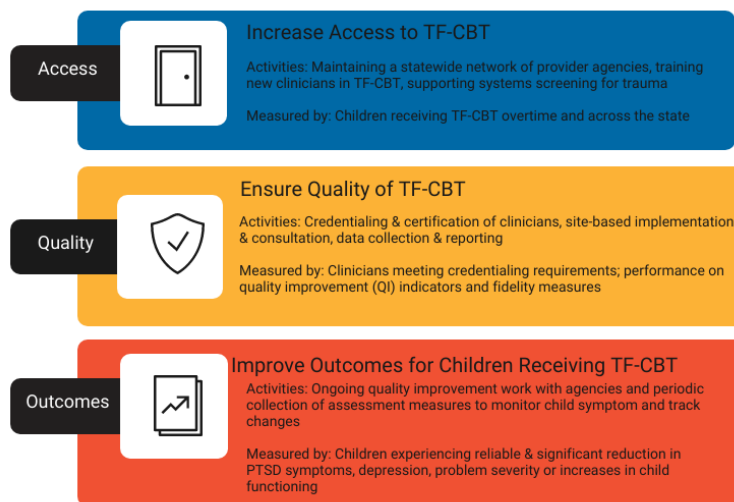
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- Add questions or measures to assess families' experiences of racism and discrimination as part of the overall screening for traumatic experiences, as these experiences can impact symptoms and service outcomes
- Strengthen referral system between external referral partners (e.g., Juvenile Justice) and clinical providers
- Continue to advocate for permanent telehealth session reimbursement through Medicaid and private insurance
- Use virtual platforms for quality improvement strategies and enhancement of TF-CBT clinical skills
- Ensure assessments are available in languages commonly spoken by families in electronic format within the PIE database system

Introduction

TF-CBT is an evidence-based treatment for children aged 3-18 experiencing posttraumatic stress (PTS) symptoms from exposure to violence, abuse, and other forms of trauma. More than 20 empirical studies have shown the success of this short-term, family-centered model.

The Connecticut Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center (“Coordinating Center”) is funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch’s Court Support Services Division (CSSD). Located at the Child Health and Development Institute (CHDI) of Connecticut, the Coordinating Center works to improve access to evidence-based outpatient behavioral health treatment for children experiencing posttraumatic stress (PTS) symptoms from exposure to violence, abuse, and other forms of trauma. Since 2007, the DCF, CSSD, and Coordinating Center advanced TF-CBT and trauma-informed care across the state through a series of Learning Collaboratives and The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) grant, a federally funded effort to improve trauma-informed care for children in the child welfare system. The figure below illustrates the goals and primary activities of the Coordinating Center.¹



This report is framed around these three goals. The first two sections describe progress on ensuring Connecticut children have access to TF-CBT (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 FY20. 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 TF-CBT 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.

¹ A detailed accounting of these activities during FY20 can be found in Appendix A.

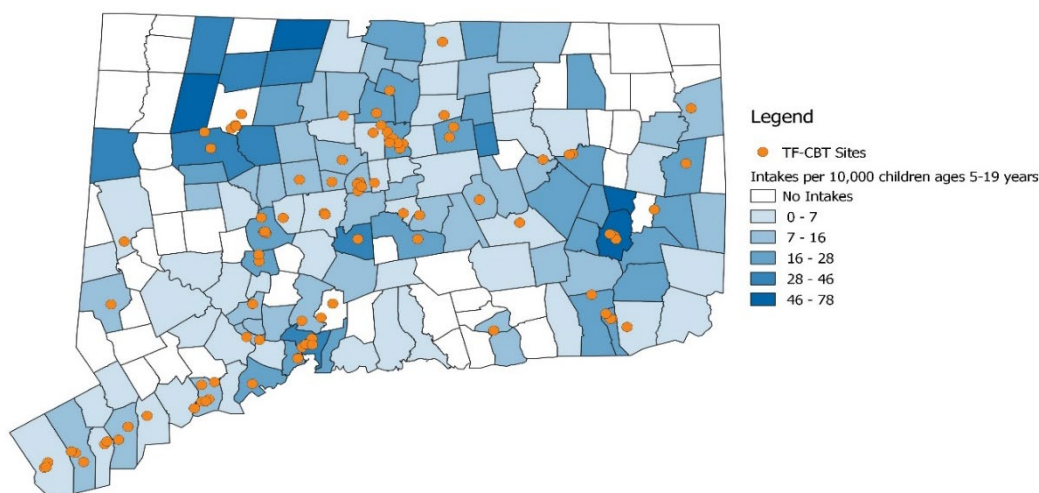
Access to TF-CBT in Connecticut

The first goal of the Coordinating Center and the statewide TF-CBT initiative is to increase access to TF-CBT in Connecticut. This begins with ensuring TF-CBT is available by maintaining a provider network that serves many areas of the state and training new clinicians in the model. The total number of children and families receiving TF-CBT, along with their demographics and characteristics, is a way of monitoring the reach of the model and the state's progress in providing TF-CBT to the children who most need treatment.

Availability Across the State

The number of agencies offering TF-CBT has continued to increase, for a total of 48 providers offering TF-CBT this year. Figure 1 below shows the location of TF-CBT sites across the state and Table 1 shows the trends in access over the past three years as well as cumulative totals. There were 330 clinicians on a TF-CBT team during at least some part of FY20 and 253 (77%) of clinicians saw at least one TF-CBT case. In terms of average team size, outpatient agency teams average 10 clinicians with a range of 1-22 clinicians providing TF-CBT on staff.

Figure 1. Map of TFCBT Providers in CT



Clinician Training and Credentialing

Given DCF's primary interest in supporting TF-CBT in DCF-funded OPCCs and the number of agencies already providing TF-CBT, the primary focus of new clinician training is to address attrition due to staff turnover to maintain implementation capacity across the state. Of the 330 clinicians on a TF-CBT team during FY20, 84 (25.5%) left their TF-CBT teams during the fiscal year. Ongoing training and support to help agencies address attrition resulted in 54 clinicians newly trained in TF-CBT. Additionally, to support high-quality treatment by clinicians who attended the basic TF-CBT training, we continued to facilitate one day TF-CBT Booster training sessions. The booster training is designed to provide newer clinicians supplementary training once they are implementing the model and to further assist any clinician who has not successfully started their TF-CBT practice. Thirty-six clinicians participated in booster training this year. Six clinician consultation call groups were completed this year. Fifty five clinicians attended the 58 clinical consultation calls, and 19 clinicians met the Connecticut TF-CBT Credential criteria in FY20.

Table 1. Trends in TF-CBT provider network

	FY17	FY18	FY 19	FY 20	Cumulative Since 2007
TF-CBT Providers/Agencies	42	43	46	48	54
Newly trained TF-CBT Clinicians	87	48	56	54	875
Clinicians Providing TF-CBT	333	308	294	253	866 ²
# Newly Credentialed/Certified	79	45	22	19	344

Clinician Demographics

The demographic characteristics of the 330 clinicians offering TF-CBT this year are presented in Table 2. TF-CBT clinicians were primarily female (90%) and more than half (62%) were White. In terms of languages spoken, 17.3% spoke Spanish.

Table 2. TF-CBT clinician demographic characteristics (n=330)

Characteristic	%
Sex (Male)	9.4
Race/Ethnicity	
Black or African American	9.1
White	62.1
Other Race/Ethnicity	11.5
Hispanic, Latino, or Spanish (any race)	20.6
Languages Spoken	
Spanish	17.3
Other ³	3.3

Integrating Multiple EBTs

TF-CBT clinicians often are trained in and practicing other evidence-based treatment (EBT) models. In FY20, clinicians were most likely to be trained in MATCH-ADTC with 53 clinicians (47.3%) active in both models. The next most common model TF-CBT clinicians were also implementing was ARC (34 clinicians). Relatively few TF-CBT clinicians additionally practiced CPP (15 clinicians), CBITS (5 clinicians), and Bounce Back (5 clinicians). As both agencies and clinicians provide multiple EBTs, the Coordinating Center has shifted to providing consultation and support recognizing the complexity of managing multiple models with fidelity.

Children Receiving TF-CBT

In FY20, 1,155 children received TF-CBT; this number included 582 children who began TF-CBT during the year. Fewer children received TF-CBT during FY20. The decrease in children served began with the integration of EBP Tracker into the PIE data system (October, 2019) and didn't recover before providers had to cope with COVID-19 in March, 2020. It is likely that some cases did not get transferred to PIE, and were therefore not counted towards the total number of children receiving TF-CBT. To date, 10,121 children have received TF-CBT in Connecticut since 2007. TF-CBT remained the most common EBT used in the outpatient setting.

² Clinicians included from FY16 and prior were included based on training records

³ Other languages include Portuguese, Mandarin, Serbo-Croatian, French, and French Creole.

Child Demographics

Table 3 on the next page provides descriptives for children receiving TF-CBT in FY20, as well as comparisons to those served in outpatient services [as reported in DCF's Provider Information Exchange (PIE) system] and the general CT population. Social and community context is highly related to service receipt and outcomes. Racism is part of that context that research has shown leads to inequities. Recognizing this, special consideration is given in this report to comparisons across racial and ethnic groups. TF-CBT and general outpatient care both served higher rates of Black and Hispanic children and lower rates of White children compared to the overall CT population. Males, accounting for 37% of TF-CBT cases, were relatively underrepresented compared to the outpatient and general CT population.

The mean age of children receiving TF-CBT is 11.91 years (SD=3.69). Children receiving TF-CBT and general outpatient services tend to be older compared to the CT population; this is likely due to later onset of most mental illnesses. While the percentage of children in outpatient care under six was small (18.8%) it was even smaller for those receiving TF-CBT (3.8%). TF-CBT can be used with children as young as three but it is used much less frequently with the youngest children.

While comparisons to the general child population of CT were not available for DCF-involvement, 32.5% of children who received TF-CBT were involved in the child welfare system. This rate is more than double that of children who received general outpatient services and were involved with the child welfare system, 13.3%.

Table 3. Characteristics of children receiving TF-CBT (n=1155) with comparisons

	TF-CBT		OPCC	CT Child pop[2]
	n	%	%	%
Sex (Male)	425	36.8	54.1	50.9
Race				
American Indian or Alaska Native	1	0.1	0.4	0.3
Asian	-	-	0.8	4.6
Black or African American	176	15.2	16.6	12.9
Native Hawaiian or Pacific Islander	5	0.4	0.2	0.1
White	642	55.6	52.6	66.6
Other Race/Ethnicity (includes multiracial/ethnic)	99	8.6	3.0	15.6
Did not disclose/Missing	232	20.1	26.4	-
Hispanic, Latino, or Spanish (any race)	475	41.1	38.6	24.7
Age (years)				
Under 6 years	43	3.8	18.8	29.4
6-11 years	466	41.1	31.9	33.4
12-17 years	624	55.1	46.7	37.2
Child welfare involvement during treatment	368	32.5	13.3	N/A
JJ involvement during treatment	30	2.6	0.8	N/A
Child primary language[4]				
Spanish	49	9.8	13.0	13.4
Neither Spanish nor English	4	0.4	1.3	8.6

Children Involved in the Juvenile Justice System

The Coordinating Center also works to ensure access to TF-CBT for youth involved in the juvenile justice system. Since 2014, CHDI has worked with the Court Support Services Division (CSSD) of the Judicial Branch and the Department of Children and Families (DCF) to improve trauma-informed services for youth involved in Connecticut's justice system by increasing the identification of youth's trauma history and symptoms, and engaging youth evidence-based trauma treatments. One component of this work is the use of the Child Trauma Screen (CTS) which is administered by Juvenile Probation Offices and staff at the Linking Youth to Natural Communities (LYNC) programs; CHDI receives these screens and produces monthly and quarterly reports. Additionally, CHDI provides reports on children who receive TF-CBT and also have involvement with the juvenile justice system.

During FY20, 423 youth were screened for trauma by probation officers and LYNC staff using the CTS. Of those screened, 75% reported exposure to traumatic events, underlining the high rates of trauma exposure among youth in the justice system and the importance of trauma screening for this population. Of those youth with identified trauma exposure, only 20% were referred for treatment services including TF-CBT, MDFT, individual therapy, other mental health services, and LYNC (based on CSSD staff reports). During the fiscal year, 30 youth in the justice system received TF-CBT services, with 41% of discharges successfully completing treatment and 100% reporting satisfaction with treatment. In FY20, youth in the justice system that received TF-CBT 36% reduction in their PTSD symptoms ($n = 11$) and 27% reduction of their Depression symptoms ($n = 6$).

The CTS screening documents the need for trauma-informed services, but relatively few TF-CBT cases have juvenile justice involvement. Unlike children with DCF involvement, which make up ~33% of those receiving TF-CBT, only ~3% are involved with the juvenile justice system. There is more capacity for these youth to receive TF-CBT and CHDI can work with CSSD and DCF to find ways to build partnerships between Juvenile Probation officers and local behavioral health providers to ensure a clear process for screening, referral and treatment.

Child Clinical Characteristics at Treatment Start

Information on baseline assessments for children receiving TF-CBT is found in Table 4. 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. Most of the measures reflect the child's experience or symptoms. The exception is the measure of caregiver depression; 11% of caregivers reported clinically high depression scores at baseline.

Trauma Exposure. Children report experiencing an average of 7.19 types of potentially traumatic events; caregivers report that their children have experienced 5.96 types of potentially traumatic events. Regression analyses were performed to determine if reports of exposure to potentially traumatic events was associated with demographic factors of the child. The full results are report in Table B1 in Appendix B. Additionally, child age was a positive and significant predictor of trauma exposure for both child and caregiver reports. Caregivers in general had lower reports of child trauma exposure compared to their child's own report, a trend that is common in reports of trauma history when collected from both caregiver and child.

The only statistical finding regarding race was that caregivers of Hispanic children reported significantly lower trauma exposure compared to caregivers of White children. Despite this

singularity, a growing body of evidence suggests that racial discrimination have deleterious effects on health, including PTS symptoms⁴. The assessment measures in TF-CBT do not explicitly assess racism or discrimination, so the degree of racism and discrimination experienced by children receiving TF-CBT and the effects on traumatic stress symptoms and treatment are not known.

Baseline Symptoms. Most children (93.1%) receiving TF-CBT in the fiscal year had a measure of baseline symptoms. A summary of intake scores is presented in Table 4. Most children (82.4%) had clinically high symptoms in at least one symptom area (depression, posttraumatic stress, internalizing/externalizing behaviors) or impairments in functioning. Children were more likely to be in the clinical level of depression (60.6 to 63.9%), and trauma symptoms (43.4% to 75.5%), and less likely for problem severity or functioning (21.1% to 42.04%). On average, children were clinically high in 1.72 (SD=1.23) out of the four symptom areas. Multiple regression analyses were used to look for demographic differences in baseline scores. Full results are reported in Tables B2 and B3 in Appendix B. No statistically significant differences were found in baseline scores by race/ethnicity. One statistically significant trend observed was that child reported symptoms of both trauma and depression were lower for males compared to females.

⁴ Williams, D. R., Lawrence, J. A., Davis, B. A., & Vu, C. (2019). Understanding how discrimination can affect health. *Health Services Research*, 54(S2), 1374-1388. doi:10.1111/1475-6773.13222

Table 4. Child and caregiver clinical assessment scores at intake

Measure	Construct	N	Mean	Child Report		N	Caregiver Report		
				SD	Elevated* n (%)		Mean	SD	Elevated* n (%)
THS sum	Exposure to potentially traumatic events	1,075	7.19	3.3	-	947	5.96	2.87	-
CPSS-IV Total Score	Traumatic stress symptoms	135	22.63	9.97	102 (75.5)	129	18.84	11.28	78 (60.4)
Re-experiencing Subscore		-	6.38	3.67	-	-	5.77	4.15	-
Avoidance Subscore		-	8.37	4.91	-	-	6.34	4.94	-
Arousal Subscore		-	7.95	3.82	-	-	6.82	4.09	-
CPSS 5 Total Score	Traumatic stress symptoms	903	34.37	16.68	507 (56.1)	780	28.96	16.13	339 (43.4)
Re-experiencing Subscore		-	8.58	4.96	-	-	7.27	4.82	-
Avoidance Subscore		-	4.66	2.48	-	-	4.0	2.58	-
Cognition & Mood Subscore		-	11.06	6.98	-	-	9.82	6.65	-
Hyperarousal Subscore		-	10.61	5.14	-	-	8.64	5.09	-
SMFQ Total Score	Depressive symptoms	557	10.6	6.48	356 (63.9)	454	9.74	6.29	275 (60.6)
Ohio Problem Severity	Severity of child behaviors	635	23.95	15.05	267 (42.04)	967	23.11	15.04	376 (38.88)
Internalizing		120	13.89	9.98	-	184	11.42	8.57	-
Externalizing		120	10.65	8.06	-	184	11.4	9.2	-
Ohio Functioning	Child's adjustment and functioning	635	53.66	13.24	134 (21.1)	968	50.75	14.39	299 (30.88)
CESD-R	Caregiver's own depressive symptoms	-	-	-	-	313	15.35	13.56	126 (40.3)

Quality: Consultation and Clinical Implementation

CHDI, in collaboration with DCF, works closely with agency providers and meets regularly with each agency to review agency performance data and provide implementation consultation. The focus of these site visits varies based on the needs of individual agencies but generally focus on building internal capacity to sustain TF-CBT and providing strategies to ensure fidelity and outcome benchmarks are met. In addition to site-based consultation, the Coordinating Center helps maintain a database to collect TF-CBT data. To support clinicians and ensure we have timely, accurate, and usable data the Coordinating Center maintains a HelpDesk that has fielded over 1,500 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. The data collected in the system and used in site visits provides information on how teams are performing on Quality Improvement (QI) indicators detailed below.

TF-CBT Data Systems

Most of the data used in consultation with sites is collected through a secure, web-based system. Originally, TF-CBT data were collected in EBP Tracker. In October 2019, EBP Tracker functionality was integrated into DCF's Provider Information Exchange (PIE) system. This integration resulted in two primary changes to EBT data: EBT episodes data can now be linked to the rest of a child's outpatient episode and EBT episodes now include identifying information (such as first and last name) to be entered into the PIE system.

During this period, CHDI worked with DCF, providers, and KJMB (the developers of both EBP Tracker and PIE) to support the transition between systems. The primary focus in the transition was making sure open and active EBT cases were linked to an outpatient episode in PIE, so that at the time the data was transferred it would have a place in the new system. Most episodes (approximately 94%) were successfully transferred. However, any episodes that were not linked to PIE at the time EBP Tracker shut down were automatically closed. **This means there are likely cases that ended prematurely which would affect quality improvement data that is based on assessment outcomes and completion of the model.** Additionally, if a case was re-opened in PIE rather than linked, this could have resulted in duplicated counts. Both of these scenarios likely had some impact on TF-CBT data during FY20.

One additional challenge was linking historic EBT cases that existed in EBP Tracker with the corresponding outpatient case in PIE. Many cases were successfully matched (approximately 83%) but any that were not did not have their information transfer over (though it can be accessed through old data files if needed). Another challenge was supporting agencies that do not receive funding from DCF for their outpatient clinics and therefore never accessed PIE. These agencies needed to gain access to PIE, learn the new system, and develop procedures to collect the new data fields required in PIE that were not previously collected in EBP Tracker. Some of these agencies still have not started using PIE and entering data. CHDI continues to work with these agencies, but it is likely there are some TF-CBT cases that do not appear in the data.

Despite these initial challenges, having EBT data collected in PIE has many advantages. It is now possible to better understand how EBTs contribute to overall outcomes in outpatient care. An EBT episode might only be a small portion of an overall episode; now with the data connected in the system there are opportunities to understand how and when EBTs are used, the dosage of EBT sessions relative to treatment as usual, and examine if there are group-level differences in who receives EBTs and the experiences they have in a particular model relative to treatment as usual.

Implementation Consultation

CHDI Project Coordinators completed 94 in-person or Zoom site meetings, and 42 formal telephone site consultations in FY20. The typical agenda for these site meetings is to review the agency performance on recent reports (e.g., QI report, monthly dashboards). From this review of data, SMARTER (specific, measurable, action-oriented, realistic, timed, evaluated, reviewed) Goals are developed with the agency to address any QI indicator that did not meet the established benchmark.

To further ensure high-quality TF-CBT implementation, CHDI convened regular statewide meetings for agency Coordinators. These meetings focused on strategies related to sustainability and TF-CBT team management. Rather than the specific agency focus of site visits, these were opportunities for sites to co-learn with each other, and bring best practices for TF-CBT and other EBTs back to their agencies.

In response to the COVID-19 pandemic, providers quickly moved to using virtual platforms to conduct TF-CBT sessions. CHDI convened 13 Coordinator meetings to provide additional support to providers with a focus on TF-CBT implementation using these virtual platforms. Every TF-CBT clinician was sent more than 50 additional TF-CBT telehealth implementation resources, and five TF-CBT telehealth implementation training sessions were offered to all clinicians.

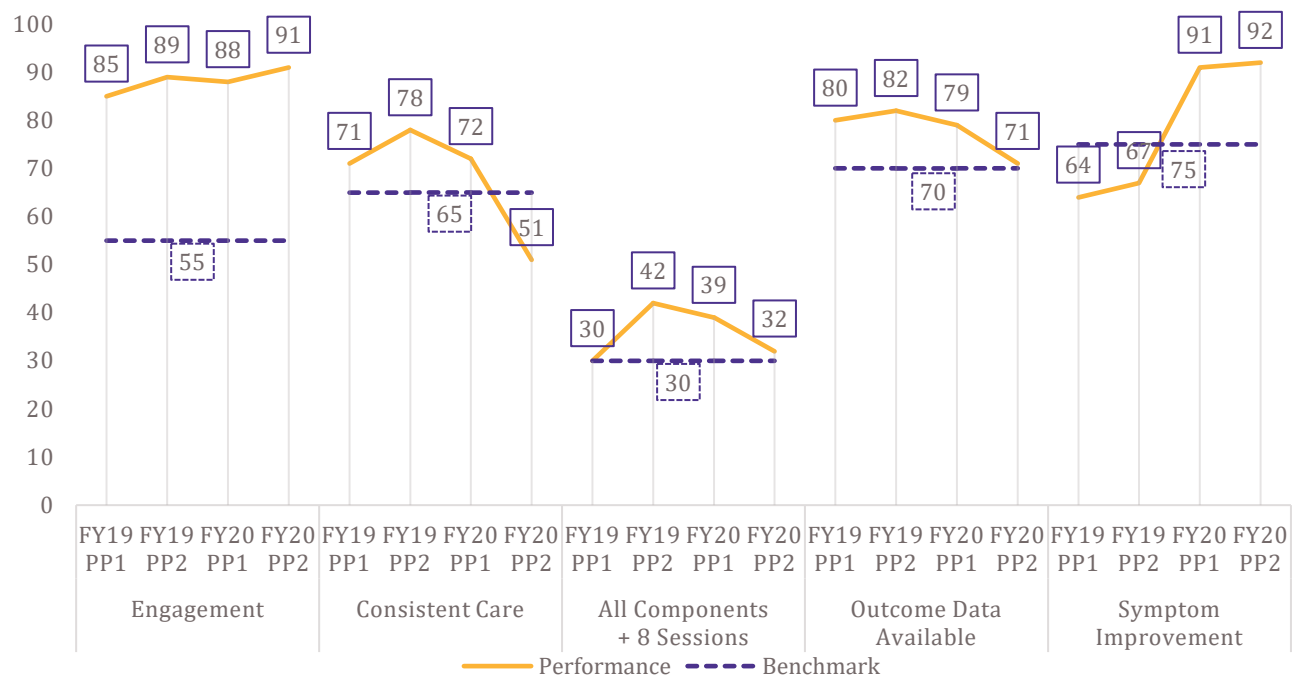
Quality Improvement & Model Implementation

Children completing TF-CBT attended a mean of 17.50 (SD=14.30) sessions with a mean treatment episode length of 8.30 (SD=5.45) months. This is slightly higher than the recommended expectation of completing TF-CBT in 12 to 16 sessions. Newer clinicians often do need additional sessions to complete TF-CBT. In the fiscal year, 61.2% of sessions were completed with the child only, 25.7% were with caregiver and child together, and 13.2% were with caregiver only. TF-CBT stresses the importance of establishing a strong caregiver partnership and involvement in the treatment process. The Coordinating Center has set a benchmark of 33% of session time should be spent with the caregiver (either alone or together with the child). The data reflect that 38.9% of sessions had caregiver involvement, exceeding the benchmark.

Quality Improvement Indicators

CHDI reports on TF-CBT quality improvement (QI) indicators twice annually. These QI indicators guide the work CHDI Project Coordinators do with the sites and are the focus of the SMARTER goals set during consultation visits. The definition and explanations of each of the five QI indicators and the prepared reports showing each provider's results over the two FY20 performance periods are included in Appendix E. Quality improvement indicators have mostly remained consistent across the performance periods, including consistent care (2+ sessions/per month), completing all components, and engagement. CHDI Project Coordinators conducted 94 in person or Zoom site meetings and 42 telephone site consultations in FY20.

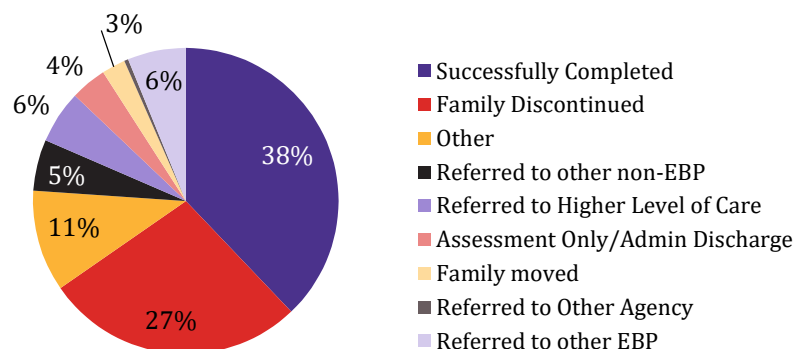
Figure 2. QI indicators in FY20



Discharge Reason

During the fiscal year, 650 children ended their TF-CBT treatment episode. Clinicians rated 38% of children ending treatment as “completing all EBT requirements.” Children who did not complete all EBT requirements were most likely to not complete due to family discontinuation (see Figure 5 below). Binary logistic regression analyses were conducted to determine which factors were associated with successful discharge. Results are reported in Table B4 in Appendix B. Overall, there were no significant differences in successful discharge by race/ethnicity.

Figure 3. Reasons for discharge in FY20

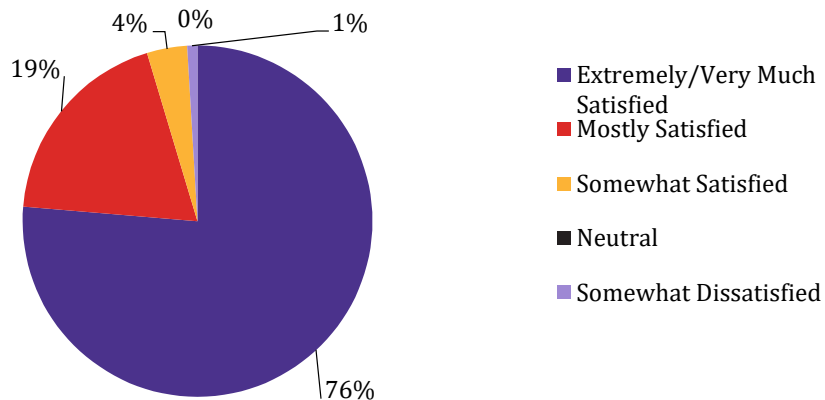


Satisfaction

Caregivers report high levels of satisfaction with TF-CBT treatment. In FY 20, there were 60 Caregiver Satisfaction Questionnaires (CSQ) completed, and 261 Ohio Caregiver Satisfaction

forms completed. The responses to both caregiver measures are illustrated in Figure 7 below with 97% of those completing the CSQ indicating mostly or very satisfied with treatment and 99% of those completing the Ohio Caregiver Satisfaction indicating mostly or very satisfied with treatment. 220 children completed the Ohio Child Satisfaction measure; 96% of these children indicated that they were mostly or very satisfied with treatment.

Figure 4. Caregiver Satisfaction with their child's TF-CBT Treatment



Outcomes: Improvement for Children Receiving TF-CBT

Children receiving TF-CBT are assessed with a variety of measures selected to provide information on trauma history and severity of symptoms at intake and to measure change at discharge. Change cannot be calculated unless there are two data points for an assessment, so the availability of outcome data (having a first and last) is an important indicator in considering outcomes. Of those who do have sufficient data, trends in symptom change both overall and across groups are presented.

Rates of Outcome Data

Of children discharged from TF-CBT in the fiscal year, 68.6% had at least one first and last version of a child symptom assessment (child or caregiver reporter), and 18% had data on caregiver symptoms. Binary logistic regression analyses were conducted to determine which factors were associated with having outcome data. Results are reported in Table B5 in Appendix B. Statistically significant findings show that children were less likely to have assessment outcome data if they were discharged unsuccessfully. No statistically significant differences in rates of outcome data by race/ethnicity were found.

Symptom Improvement

Children experienced significant reductions in trauma, depression, and problem severity symptoms as well as significant gains in functioning (Table B6 in Appendix B). Caregivers received significant reductions in depression symptoms. For children who received TF-CBT, the highest rates of reliable change and remission were in PTS and functioning.

Children Improve Across Multiple Domains

Children receiving TF-CBT were assessed initially on four domains, each with child and caregiver report versions. Caregivers were additionally assessed with a measure of their own depression. Clinicians then selected measures to use periodically; this means not every child was assessed on every measure. 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. Figure 7 through 9 below shows the relative rates of improvement across the measures. **The greatest improvements were in post-traumatic stress symptoms and problem severity.**

Children who entered TF-CBT with clinically high symptoms have higher rates of reliable symptom change after treatment. This trend was seen across all symptom categories (PTSD, depression, externalizing/internalizing behaviors, and functioning). In the full sample of children completing TF-CBT with available PTSD symptom outcome data, according to caregiver report (60%) and children report (64%) experienced trauma symptom reduction. Comparatively, 78% of children with elevated child-report at baseline and 76% of children with elevated caregiver-report at baseline experienced reliable change in this symptom category. Similar trends were seen for children with elevated depressive symptoms, problem severity (externalizing and internalizing) symptoms, and functioning impairments.

Figure 5. Percentage of Children that Show Reliable Change in PTS and Depression Symptoms Based on Baseline Symptom Severity

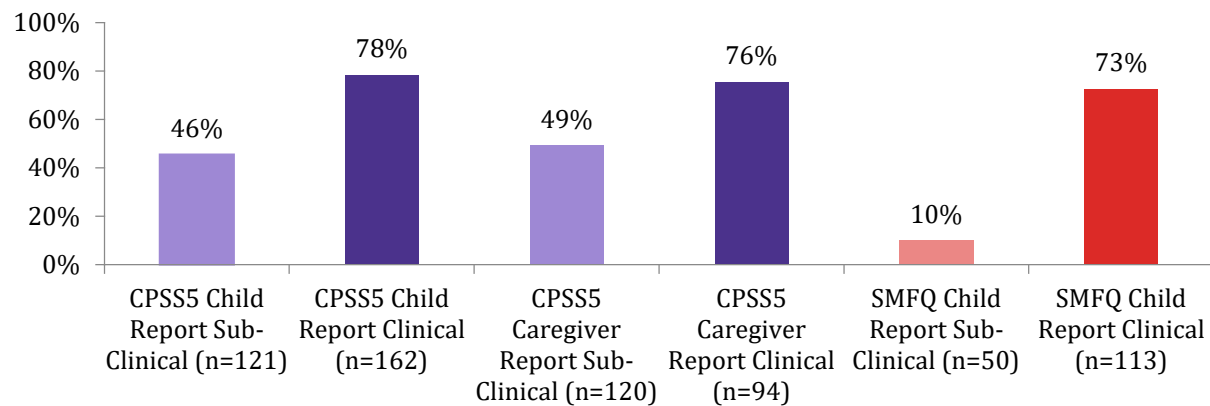


Figure 6. Percentage of Children that Show Reliable Change in Ohio Problem Severity Based on Baseline Symptom Severity

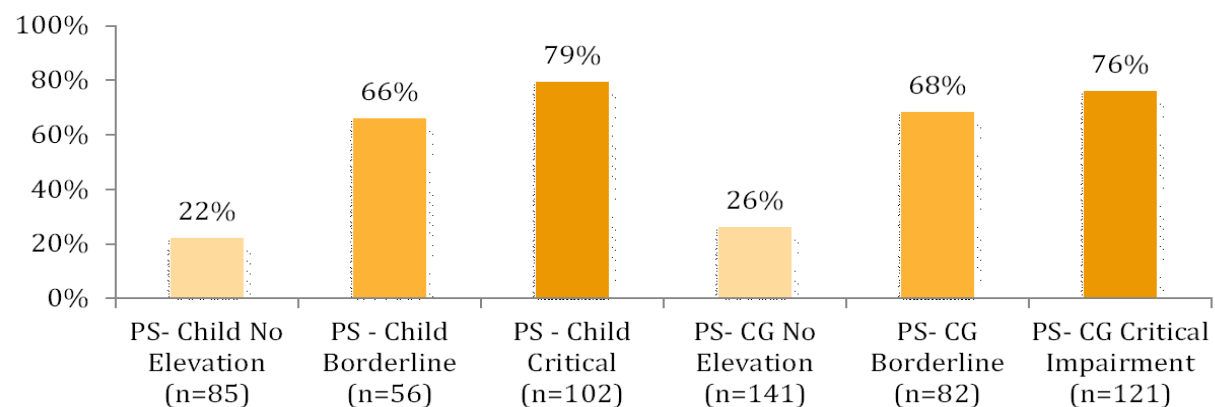
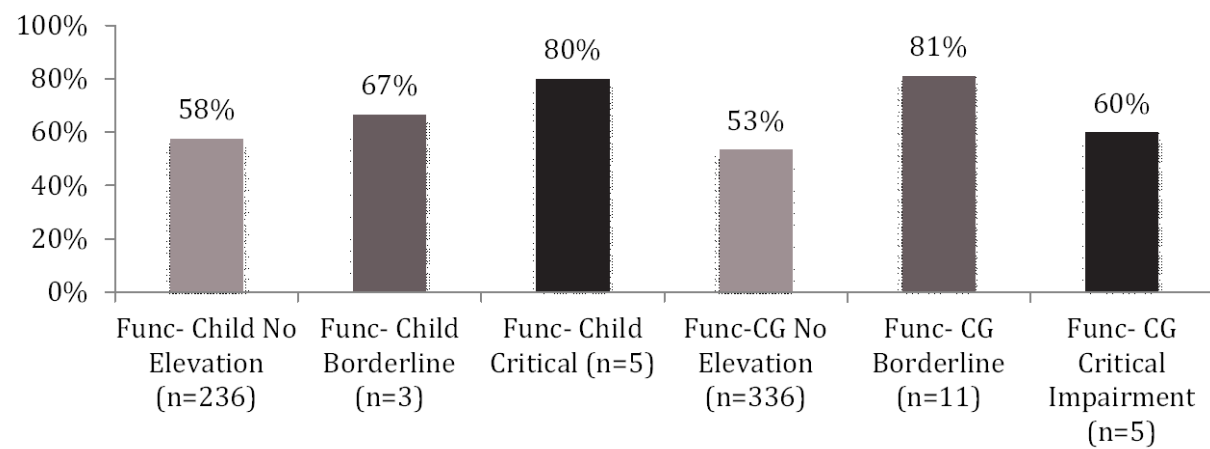


Figure 7. Percentage of Children that Show Reliable Change in Ohio Functioning Based on Baseline Symptom Severity



Clinical Improvements across Groups

In addition to documenting the overall rates of symptom reduction and functional improvement, we examined whether subgroups are experiencing disparate outcomes. Multiple regressions were performed to explore the effect of race categories, age, and sex on discharge scores⁵ (PTS, depression, problem severity, and functioning), controlling for initial scores, successful completion of the model, and trauma exposure.

Details of the tests are in Appendix B (Tables B7 and B8), results are highlighted here. Overall, results show consistent outcomes for children who received TF-CBT. Trauma exposure, successful discharge, and baseline scores were shown to have the largest effect on outcomes. Within the analytic models, some minor statistical differences existed across age, sex, and race/ethnicity for specific outcome measures, which may be expected given the number of outcome assessments. These statistically significant findings included differences in child-reported lower PTS scores at discharge for males, caregiver-reported lower problem severity scores for older children, and child-reported depression scores being higher for Other-non Hispanic children. Most importantly, across reporters and symptom domains, having a successful discharge significantly predicted a decrease in discharge symptom scores.

⁵ The term discharge score is used, but periodic data was used when discharge data was not available.

Summary & Conclusions

TF-CBT is available across the state and continues to be accessed by children suffering from trauma symptoms. While TF-CBT providers demonstrated high quality service, and the children who received TF-CBT exhibited progress over multiple clinical domains, the number of children who received TF-CBT decreased this year. Two important and separate factors contributed to this decrease. Upon review of data trends for the FY20, the number of children served began to decrease in October as EBP Tracker was closed and TF-CBT data was integrated into PIE. This was further impacted in March, 2020 as providers moved to using virtual platforms for all clinical sessions due to COVID-19 stay-at-home orders. Despite these factors, access to TF-CBT remained essential for Connecticut youth and families who are exposed to traumatic events.

Children who began TF-CBT treatment had significant exposure to potentially traumatic events, with an average of 5 to 7 events endorsed by caregiver and child report, respectively. Symptoms are assessed on a number of domains, and 82% of children were above the clinical cut-off on at least one domain, most common were trauma symptoms or problem severity. Children who received TF-CBT are similar to children served in the broader outpatient setting in terms of sex and race/ethnicity; however, they were almost twice as likely to have DCF involvement.

TF-CBT was delivered with fidelity and quality, and was consistently monitored to ensure quality outcomes. Most children who began TF-CBT in FY20 engaged in treatment with 88% to 91% making it to at least four treatment sessions. The average number of sessions was 17.5, though higher than the recommended range (12 to 16 sessions), signaled high engagement with youth and families despite environmental factors, such as COVID-19. Caregivers were involved in approximately 39% of sessions, exceeding the expectation that 33% of session time be spent with the caregiver. A focus over the past two years has been the consistency of visits, and 51% of TF-CBT cases in the most recent reporting period averaged at least two sessions a month during the course of their treatment. This was the only QI indicator to have fallen below the desired benchmark. The percentage of children who made it through all model components and 8 or more sessions have risen over recent reporting periods, and was most recently at 32% (just exceeding the benchmark of 30%). Children and caregivers both reported very high rates of satisfaction with treatment, 96% and 99% respectively. Improvement in symptoms, particularly for traumatic and depressive symptoms, were high for children who receive TF-CBT. Of children who began treatment with clinically elevated trauma symptoms, more than 75% of children and caregivers reported improvement. Reductions in depressive symptoms and problem severity, as well as increases in functioning, were of similar magnitude. These rates underscore the value of TF-CBT, particularly for its intended purpose.

Despite the steady progress on a number of quality indicators, there is room for improvement. In FY20, clinicians reported that 38% of children successfully completed their treatment. Children who left for other reasons most commonly (27%) due to the family discontinuing treatment. In particular, Black children are less likely to have outcome data. In demographic comparison, there were fewer Black, Hispanic, or male clinicians than children who received TF-CBT. In particular, Black children represented 15.2% of the children who received TF-CBT, only 9.1% of TF-CBT clinicians are Black. These trends warrant follow-up on clinician recruitment, training, and retention from communities of color to ensure that all children are receiving TF-CBT services that are sensitive to their background and experience. Separate from these differences, there were no statistically significant racial or ethnic differences found in baseline and outcome scores, rates of outcome data, or successful discharge. This consistent pattern of racial equity is meaningful to address known racial disparities in the behavioral health field.

No pervasive statistical differences in race and ethnicity were found in baseline and outcome functioning, problem severity, and trauma exposure for children who received TF-CBT within both youth and caregiver reports. Further, no racial differences were detected in factors that affect clinically successful discharges. Though these findings may suggest that TF-CBT was equitably effective across diverse racial and ethnic youth, mental health services may still have an important role in confronting institutional racism⁶. Adding measures that detect how racial discrimination may cause and/or affect symptoms of trauma will help further guide TF-CBT services, particularly in addressing how racism affects service delivery⁷.

Very young children, those six and under, were the least likely to receive TF-CBT. These younger children made up a relatively small portion of TF-CBT episodes (3.8%), and it is not certain how many of these children would have trauma exposure and benefit from trauma treatment. In consultation, clinicians often expressed hesitation to start TF-CBT with young children even though the model specifications allow for children as young as three. While there are other EBT models available for young children (ARC as mentioned previously and Child Parent Psychotherapy, which started fall 2019), the TF-CBT network maintained the largest number of participating agencies and trained clinicians. Additional support to TF-CBT clinicians in delivering the model to young children may help ensure children, even at ages six and below, have access to the services they need for future years.

Mid-way through this year, COVID-19 and the resulting stay-at-home orders drastically changed the delivery of outpatient treatment, including TF-CBT. Providers shifted to telehealth and worked to engage children and families under this new format. Assessments were initially hard to administer though providers have worked hard to find ways to successfully collect this information electronically and through video or phone interviews. However, there will likely be an impact on QI indicators and outcomes both in this year and going into the next. Additionally, during this time there was a notable decline in the number of new cases. This suggests that while children already receiving TF-CBT were often able to continue, identifying and engaging new children in the model may have been affected. Significant efforts by participating provider agencies and their clinicians, DCF, and the Coordinating Center were vital to ensure that TF-CBT service access and high quality care remained paramount. Finally, youth and families demonstrated particularly noteworthy commitment to receiving TF-CBT services.

Access to TF-CBT in Connecticut remains a priority, particularly amid any ongoing structural barriers experienced or related trauma exposure due to COVID-19. Initiated in FY20, the transition to telehealth modalities and virtual TF-CBT trainings and consultation ensures the next cadre of TF-CBT providers are best equipped to serve Connecticut's children and families. Despite strong and consistent outcome metrics for all youth served, ongoing model implementation and consultation may focus on identifying and addressing potential racial biases that may exist, and develop strategies that promote ongoing anti-racist service delivery. The TF-CBT network should continue to identify resources and collaboration opportunities to ensure improvements for Connecticut youth and families, particularly those who are Black, Latinx, and/or Indigenous, may be enhanced and remain high for years to come.

⁶ Alang, S. M. (2019). Mental health care among blacks in America: Confronting racism and constructing solutions. *Health Services Research, 54*(2), 346-355. doi: 10.1111/1475-6773.13115

⁷ Williams, M. T., Printz, D. M. B., & DeLapp, R. C. T. (2018). Addressing racial trauma with the Trauma Symptoms of Discrimination Scale. *Psychology of Violence, 8*(6), 735-747. doi: 10.1037/vio0000212

Recommendations

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

Coordinating Center:

- Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity, health equity, anti-racism, and TF-CBT with young children.
- Train new and assist current participating agencies to increase the number of children and families served
- Convene the group of bilingual clinicians implementing TF-CBT and provide the support and resources they recommend; consider having identified Senior Leaders and Coordinators from that group provide feedback and serve as liaisons to the broader EBP Coordinators meeting
- Collect relevant information and continue to advocate for TF-CBT telehealth session reimbursement
- Share findings from this report with the provider network to better understand factors that may influence engagement, drop out, or differences in symptom reduction
- Develop a plan with DCF, CSSD, and providers for ensuring youth involved in the juvenile justice system have access to and utilize TF-CBT treatment in outpatient clinic settings
- Continue to collect relevant financial data and support adequate reimbursement rates for the implementation and sustainability of TF-CBT and other EBTs

Providers:

- Use site meetings to develop sustainability plans that reach established benchmarks
- Hire and retain clinicians who align demographically with the children and families served
- Provide clinical staff the support needed to increase number of children receiving TF-CBT, with particular focus on younger children receiving TF-CBT
- Provide clinical staff the support and resources needed to improve implementation of TF-CBT via telehealth
- Provide clinical staff supervision for implementing multiple evidence-based treatment models
- Participate in trainings on broader topics (beyond the specifics of the model), and develop plans within the teams to implement and use the knowledge from the trainings to improve care for children receiving TF-CBT
- 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 EBTs
- Ensure children and families have the option to receive TF-CBT via telehealth sessions

System:

- Support assessment schedules that allow for clinician discretion in selecting assessment measures to match treatment targets to demonstrate progress while also reducing data entry burdens

- Add questions or assessments on experiences of racism and discrimination as part of the overall screening for traumatic experiences, as these experiences can impact symptoms and service outcomes
- 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 EBP
- Provide education to child welfare staff about the value of evidence-based treatments and TF-CBT for children with behavioral health needs including, what treatments are available in the state, how to determine the type of treatment a child is receiving, and how to advocate for EBTs
- Offer Spanish and Portuguese language versions of assessments in electronic format within the PIE database 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., 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
- Collect information on session format to better understand how telehealth is being used
- Continue the work of the Coordinating Center to disseminate, support, and integrate EBTs beyond TF-CBT. This work includes OPCC quality improvement support, and could have a broader impact on the children's behavioral health system and could test and implement population-based strategies and models through use of standardized assessment measures clinical and organizational strategies that are relevant for all children (e.g., engagement, behavioral rehearsal, use of supervision, self-care).
- Advocate for the continued full reimbursement of providing TF-CBT sessions via telehealth, so that additional children and families have access to TF-CBT services.
- Advocate for the cross-system work of TF-CBT, along with data on utilization and outcomes, within relevant statewide committees and councils, including but not limited to: the Behavioral Health Plan Advisory Board; the Juvenile Justice Policy and Oversight Committee (JJPOC); and the Behavioral Health Partnership Quality Access and Policy Subcommittee.

Appendix A: Activities and Deliverables

The Coordinating Center has worked to support the TF-CBT implementation goals through the following activities carried out in FY20.

1. Training, Consultation, & Credentialing

- Our internal national trainer provided three clinical trainings in August 2019, November 2019, and June 2020. Fifty five new clinicians were trained.
- Two TF-CBT Booster trainings were conducted and attended by 31 previously trained clinicians.
- Completed 6 series of clinical consultation calls (58 total calls) for 55 clinicians.
- Coordinated registration, attendance, and CEUs for New Clinician Training (55 participants) and the consultation call groups (55 registrations)
- Established requirements and maintained a statewide TF-CBT clinician credentialing process to increase the number of clinicians that complete all training and case requirements; 159 (48.2%) of active clinicians were either Connecticut credentialed or nationally certified by the end of FY 20
- Distributed \$2,800 in gift cards to clinicians that met the credentialing requirements
- Maintained a training record database to track training and consultation attendance of all TF-CBT providers as well as the additional credentialing requirements for all TF-CBT clinicians; in FY 20 there were 330 active clinicians
- Convened annual statewide EBP Conference; 365 participants attended nine individual Zoom conference sessions

2. Implementation Support, Quality Improvement, & Technical Assistance

- Produced reports for two QI performance periods based on developed TF-CBT QI Indicators and Benchmarks (Appendix E)
- Produced quarterly QI performance reports that highlighted progress towards the TF-CBT QI indicators and benchmarks
- Utilized a QI process of implementation consultation based on emerging implementation science field and needs of agencies
- Developed agency-specific QI plans using SMARTER Goals focused on agency performance on QI benchmarks and strategies to improve access, quality and service delivery
- Provided 94 in-person or Zoom implementation consultation support visits and 42 phone consultations with providers to ensure sustainment of high quality services
- Nine new providers joined the TF-CBT network
- Convened 15 Coordinator meetings focusing on sharing implementation and successful meeting strategies
- Convened three meetings for bilingual TF-CBT clinicians
- Provided updates to all TF-CBT participants through a monthly Data Dashboard
- Distributed additional TF-CBT books, materials, and resources to all TF-CBT teams including new resources to be used with bi lingual or Spanish speaking children and families and multiple TF-CBT telehealth resources

3. Data Systems

- Continued maintenance of a secure, HIPAA compliant, online database that meets the needs of the increasing number of TF-CBT providers and the children and families they serve

- Oversaw the migration of EBP Tracker to DCF's servers, which reduced hosting costs for the system and brought EBP Tracker onto the same platform as Provider Information Exchange (PIE)
- Maintained a public directory site that provides a searchable, public listing of TF-CBT providers through EBP Tracker (tinyurl.com/ebpsearch)
- Monitored, maintained, and provided technical assistance for online data entry for all TF-CBT providers

4. Agency Sustainment Funds

- Administered performance-based financial incentives to improve capacity, access, and quality care.
- While these financial incentives are intended to partially offset the increased agency costs of providing an evidence-based practice, agency leadership reports that they do not adequately cover the costs of providing TF-CBT
- Developed, executed, and managed contracts with each of the 32 TF-CBT providers eligible for financial incentives to detail implementation expectations, data sharing, and financial incentive details
- Analyzed and reported financial incentives for each agency for two 6-month performance periods.
- Distributed \$478,183.93 in performance-based sustainment funds to agencies (43.3% of total contract funds)

Appendix B: Regression Tables

Table B1. Multiple regression analyses of selected demographic variables on Trauma History Screen, Child, and Trauma History Screen, Caregiver, assessments.

Predictors	Trauma Exposure - THS, Child			Trauma Exposure - THS, Caregiver		
	<i>B</i>	<i>SE</i>	<i>95%CI</i>	<i>B</i>	<i>SE</i>	<i>95%CI</i>
Intercept	3.151	0.452	(2.264, 4.039)	4.967	0.421	(4.140, 5.793)
Hispanic	0.203	0.237	(-0.261, 0.668)	-0.498*	0.220	(-0.931, -0.066)
Other non-Hispanic	0.269	0.530	(-0.771, 1.310)	-0.438	0.494	(-1.407, 0.532)
Black non-Hispanic	0.307	0.357	(0.393, 1.008)	-0.178	0.332	(-0.831, 0.474)
Age at intake	0.314**	0.032	(0.250, 0.337)	0.100**	0.030	(0.041, 0.159)
Sex (male)	-0.164	0.223	(-0.602, 0.273)	0.247	0.208	(-0.161, 0.654)
<i>R</i> ²	0.111			0.023		
<i>F</i>	20.134			3.807		

* $p < .05$

As compared to White Females

** $p < .01$

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

Predictors	1st Total Score, Ohio FX Child			1st Total Score, Ohio PS Child			Overall Severity, CPSS 5 Child			1st Depression Score, SMFQ Child		
	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Intercept	47.619	9.508	(28.802, 66.435)	26.225**	9.744	(6.939, 45.510)	37.878	10.153	(17.784, 57.971)	2.879	4.326	(-5.682, 11.440)
Hispanic	1.196	2.434	(-3.621, 6.041)	-1.834	2.495	(-6.771, 3.103)	-2.359	2.599	(-7.503, 2.785)	-0.225	1.107	(-2.416, 1.967)
Other non-Hispanic	-6.081	5.51	(-16.986, 4.824)	3.151	5.647	(-8.026, 14.328)	7.085	5.884	(-4.559, 18.730)	-0.516	2.507	(-5.477, 4.445)
Black non-Hispanic	-3.337	4.368	(-11.982, 5.308)	3.401	4.477	(-5.46, 12.261)	-4.597	4.664	(-13.828, 4.635)	0.058	1.987	(-3.876, 3.991)
Age at intake	0.637	0.572	(-0.496, 1.769)	-0.873	0.587	(-2.034, 0.288)	-0.595	0.611	(-1.805, 0.615)	0.258	0.26	(-0.258, 0.773)
Sex (male)	3.08	2.434	(-1.737, 7.898)	-5.177*	2.495	(-10.115, -0.240)	-9.002**	2.599	(-14.146, -3.858)	-4.412**	1.107	(-6.604, -2.220)
Trauma Exposure, THS Child	-0.08	0.424	(-0.92, 0.760)	1.216**	0.435	(0.356, 2.077)	1.913**	0.453	(1.016, 2.809)	0.761**	0.193	(0.379, 1.143)
Trauma Exposure, THS Caregiver	-0.505	0.427	(-1.35, 0.341)	0.396	0.438	(-0.47, 1.263)	-0.507	0.456	(-1.41, 0.396)	0.067	0.194	(-0.318, 0.451)
R^2	0.060			0.156			0.232			0.252		
F	1.149			3.304			5.396			6.011		

* $p < .05$

As compared to White females

** $p < .01$

Table B3. Multiple regression analyses of selected demographic variables on caregiver reported baseline scores.

Predictors	1st Total Score, Ohio FX Caregiver			1st Total Score, Ohio PS Caregiver			Overall Severity, CPSS 5 Caregiver			1st Depression Score, SMFQ Caregiver		
	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Intercept	57.603**	10.109	(37.596, 77.611)	17.759	10.619	(-3.257, 38.775)	38.053**	10.363	(17.543, 58.564)	4.323	4.325	(-4.237, 12.882)
Hispanic	-1.492	2.588	(-6.614, 3.630)	-1.415	2.719	(-6.796, 3.965)	4.611	2.653	(-0.64, 9.862)	1.146	1.107	(-1.045, 3.338)
Other non-Hispanic	-6.854	5.859	(-18.449, 4.741)	8.229	6.154	(-3.951, 20.408)	7.886	6.006	(-4.001, 19.772)	4.433	2.506	(-0.528, 9.393)
Black non-Hispanic	-7.814	4.645	(-17.006, 1.378)	7.244	4.879	(-2.411, 16.900)	-4.216	4.761	(-13.639, 5.207)	0.642	1.987	(-3.29, 4.575)
Age at intake	0.057	0.609	(-1.148, 1.261)	-0.388	0.639	(-1.653, 0.878)	-0.651	0.624	(-1.886, 0.584)	0.227	0.26	(-0.289, 0.742)
Sex (male)	-2.198	2.588	(-7.320, 2.925)	2.260	2.719	(-3.121, 7.641)	-1.938	2.653	(-7.189, 3.313)	0.037	1.107	(-2.155, 2.228)
Trauma Exposure, THS Child	0.235	0.451	(-0.658, 1.127)	0.385	0.474	(-0.553, 1.322)	-1.259**	0.462	(-2.174, -0.344)	-0.243	0.193	(-0.625, 0.139)
Trauma Exposure, THS Caregiver	-1.341**	0.454	(-2.240, -0.442)	1.045*	0.477	(0.101, 1.989)	1.616**	0.466	(0.694, 2.537)	0.658**	0.194	(0.273, 1.043)
R^2	0.096			0.1			0.16			0.099		
F	1.892			1.989			3.406			1.972		

* p<.05

As compared to White females

**p<.01

Table B4. Logistic regression analyses for predicting successful clinical discharge from selected background characteristics.

Predictors	<i>N</i>	β	<i>SE</i>	<i>Wald</i>	$e^{\beta}(95\% CI)$
Hispanic	197	-0.2530	0.215	1.38	0.777(0.509, 1.184)
Other non-Hispanic	21	0.145	0.467	0.096	1.156(0.463, 2.886)
Black non-Hispanic	59	-0.153	0.307	0.248	0.858(0.471, 1.556)
Sex (male)	182	-0.267	0.199	1.803	0.766(0.519, 1.130)
Child age	455	-0.004	0.03	0.022	0.996(0.938, 1.057)
Trauma Exposure-THS Child	455	0.02	0.035	0.339	1.02(0.954, 1.092)
Trauma Exposure-THS Caregiver	455	-0.053	0.036	2.107	0.949(0.883, 1.019)
Constant		0.109	0.427	0.065	1.115

* $p < .05$

As compared to White Females

** $p < .01$

Table B5. Logistic regression analyses for predicting first and last measure available for any measure of child or caregiver symptoms except CAGE-AID from selected background characteristics

Variable	<i>N</i>	β	<i>SE</i>	<i>Wald</i>	e^{β} (95% <i>CI</i>)
Hispanic	197	-0.341	0.272	1.579	0.711(0.418, 1.210)
Other non-Hispanic	21	-0.29	0.611	0.225	0.748(0.226, 2.485)
Black non-Hispanic	59	-0.154	0.383	0.162	0.857(0.405, 1.815)
Sex (male)	182	-0.162	0.246	0.434	0.851(0.526, 1.376)
Child age	455	-0.031	0.039	0.642	0.969(0.898, 1.046)
Trauma Exposure-THS Child	455	0.053	0.044	1.479	1.055(0.968, 1.149)
Trauma Exposure-THS Caregiver	455	-0.084	0.046	3.34	0.919(0.840, 1.006)
Child Discharged "Unsuccessful"	266	-3.283*	0.434	57.22	0.038(0.016, 0.088)
Constant		4.173**	0.699	35.681	64.942

* $p < .05$

As compared to White Females

** $p < .01$

Table B6. Descriptives and change scores for all assessment measures

Assessment Name	Construct	Above Cutoff	Intake Mean (S.D.)	Last Mean (S.D.)	Change Score	t-score	Remission
THS Child (n=1,075)	Count of child exposure to potentially traumatic events	n/a	7.19 (3.3)	n/a	n/a	n/a	n/a
THS Caregiver (n=947)		n/a	5.96 (2.87)	n/a	n/a	n/a	n/a
CESD-R (n=104)	Caregiver Depression	33 (31.7%)	12.72 (11.70)	7.97 (8.87)	-4.75**	4.96	21/33 (63.6%)
CPSS IV Child (n=91)	Trauma symptoms	67 (73.6%)	21.68 (9.79)	10.08 (9.46)	-11.60**	9.87	45/67 (67.2%)
CPSS IV Caregiver (n=80)		44 (55.0%)	16.14 (9.05)	7.49 (7.45)	-8.75**	7.953	37/44 (84.1%)
CPSS 5 Child (n=283)		162 (57.2%)	33.85 (16.99)	19.36 (15.91)	-14.49**	14.56	104/162 (64.2%)
CPSS 5 Caregiver (n=214)		94 (43.9%)	28.64 (15.19)	16.71 (14.18)	-11.93**	12.076	57/94 (60.1%)
SMFQ Child (n=163)	Depressive symptoms	113 (69.3%)	10.72 (6.31)	6.15 (5.74)	-4.58**	9.006	67/113 (59.2%)
SMFQ Caregiver (n=436)		n/a	8.51 (6.12)	5.65 (5.50)	-2.87**	5.09	n/a
Ohio Problem Severity Child (n=243)	Severity of internalizing/externalizing behaviors	102 (42.0%)	23.53 (14.79)	16.14 (12.69)	-7.39**	8.35	65/102 (63.7%)
Ohio Problem Severity Caregiver (n=345)		121 (35.1%)	21.57 (14.17)	15.40 (12.97)	-6.13**	8.07	76/121 (62.8%)
Ohio Functioning Child (n=244)	Child's adjustment and functioning	57 (23.4%)	52.77 (14.33)	60.30 (13.55)	7.53**	-7.97	43/57 (75.4%)
Ohio Functioning Caregiver (n= 352)		105 (29.8%)	51.52 (14.15)	56.30 (15.25)	4.78**	-6.76	61/105 (58.1%)

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

Predictors	Last Total Score, Ohio FX Child			Last Total Score, Ohio PS Child			Last Overall Severity, CPSS 5 Child			Last Depression Score, SMFQ Child		
	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Constant	37.378**	4.295	(28.913, 45.843)	9.798**	3.064	(3.759, 15.838)	9.82**	3.283	(3.354, 16.286)	-1.263	1.654	(-4.533, 2.006)
Trauma Exposure-THS, Child	-0.753**	0.249	(-1.244, -0.262)	0.495*	0.237	(0.027, 0.963)	1.24**	0.256	(0.735, 1.745)	0.346**	0.129	(0.091, 0.602)
Baseline Score	0.419**	0.056	(0.309, 0.529)	0.382**	0.049	(0.285, 0.478)	0.328**	0.051	(0.227, 0.429)	0.301**	0.065	(0.174, 0.429)
Child discharged as "successful"	7.734**	1.566	(4.647, 10.821)	-6.399**	1.449	(-9.255, -3.543)	-11.988**	1.549	(-15.038, -8.938)	-3.416**	0.798	(-4.993, -1.839)
Hispanic	0.922	1.737	(-2.501, 4.346)	-1.909	1.605	(-5.072, 1.253)	-2.886	1.705	(-6.243, 0.471)	1.189	0.879	(-0.549, 2.928)
Other non-Hispanic	-4.183	3.665	(-11.406, 3.040)	2.832	3.382	(-3.835, 9.498)	-1.688	3.614	(-8.804, 5.428)	3.883*	1.865	(0.195, 7.570)
Black non-Hispanic	-0.151	2.349	(-4.780, 4.479)	0.537	2.165	(-3.730, 4.804)	-1.411	2.311	(-5.962, 3.140)	1.768	1.192	(-0.589, 4.125)
Sex (male)	-2.507	1.613	(-5.686, 0.672)	-0.741	1.497	(-3.692, 2.210)	-4.182*	1.663	(-7.458, -0.906)	-0.149	0.835	(-1.799, 1.502)
Child age	0.305	0.221	(-0.130, 0.741)	-0.226	0.204	(-0.628, 0.176)	-0.209	0.22	(-0.643, 0.224)	0.185	0.113	(-0.039, 0.409)
R^2	0.317			0.336			0.430			0.360		
F	12.510			13.665			24.022			9.863		

* $p < .05$

As compared to White females

** $p < .01$

Please note: findings significant at the .05 value should be interpreted with caution due to the multiple dependent variables.

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

Predictors	Last Total Score, Ohio FX Caregiver			Last Total Score, Ohio PS Caregiver			Last Overall Severity, CPSS 5 Caregiver			Last Depression Score, SMFQ Caregiver		
	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Constant	28.864**	3.954	(21.085, 36.643)	12.531**	2.818	(6.985, 18.077)	8.008*	3.411	(1.279, 14.737)	1.604	2.012	(-2.385, 5.593)
Trauma Exposure - THS, Caregiver	-0.686**	0.234	(-1.147, -0.225)	0.975**	0.218	(0.546, 1.404)	0.357**	0.051	(0.256, 0.458)	0.394*	0.165	(0.067, 0.721)
Baseline Score	0.573**	0.048	(0.478, 0.668)	0.318**	0.043	(0.234, 0.403)	1.127**	0.278	(0.579, 1.675)	0.281**	0.078	(0.127, 0.435)
Child discharged as "successful"	6.802**	1.365	(4.117, 9.487)	-5.616**	1.272	(-8.119, -3.112)	-10.131**	1.604	(-13.295, -6.967)	-2.274*	0.957	(-4.172, -0.376)
Hispanic	0.355	1.495	(-2.586, 3.296)	-2.188	1.385	(-4.912, 0.537)	0.44	1.762	(-3.036, 3.917)	0.428	1.035	(-1.624, 2.480)
Other non-Hispanic	-0.59	3.159	(-6.805, 5.625)	-1.380	2.926	(-7.138, 4.379)	0.449	3.696	(-6.842, 7.739)	4.053	2.185	(-0.28, 8.386)
Black non-Hispanic	1.73	2.015	(-2.235, 5.694)	-1.956	1.867	(-5.631, 1.718)	-2.711	2.359	(-7.364, 1.942)	1.357	1.398	(-1.414, 4.128)
Sex (male)	-2.178	1.395	(-4.924, 0.568)	0.957	1.285	(-1.572, 3.486)	-2.784	1.622	(-5.984, 0.415)	0.320	0.959	(-1.582, 2.221)
Child age	-0.011	0.180	(-0.365, 0.343)	-0.57	0.167	(-0.899, -0.240)	-0.231	0.212	(-0.65, 0.188)	-0.063	0.125	(-0.311, 0.185)
R^2	0.427			0.332			0.448			0.276		
F	28.781			18.87			19.096			5.053		

* p<.05

As compared to White females

**p<.01

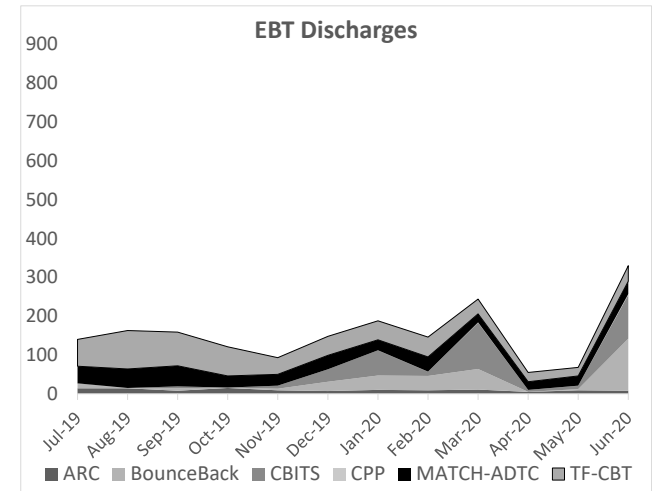
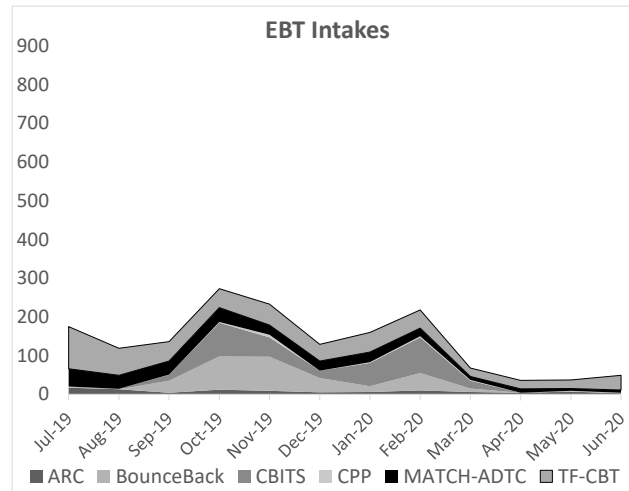
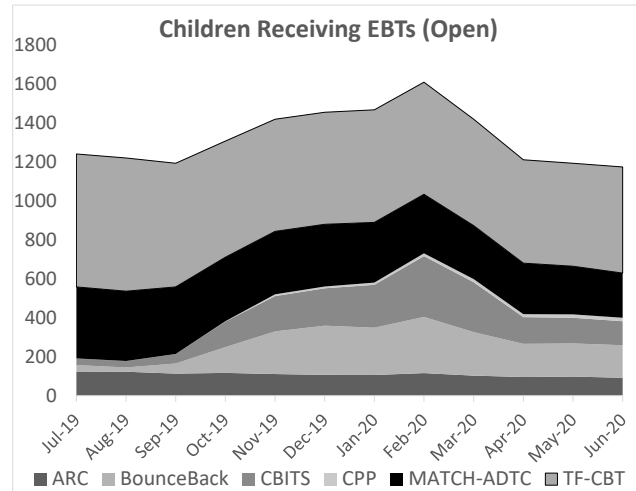
Please note: findings significant at the .05 value should be interpreted with caution due to the multiple dependent variables.

EBT Performance Dashboard: State of Connecticut June 2020

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), Child Parent Psychotherapy (CPP), Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC), Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

Due to COVID-19, CT began stay-at-home orders during March 2020. It is expected that this will affect EBT data and the numbers and trends in this report should be viewed in that context.

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



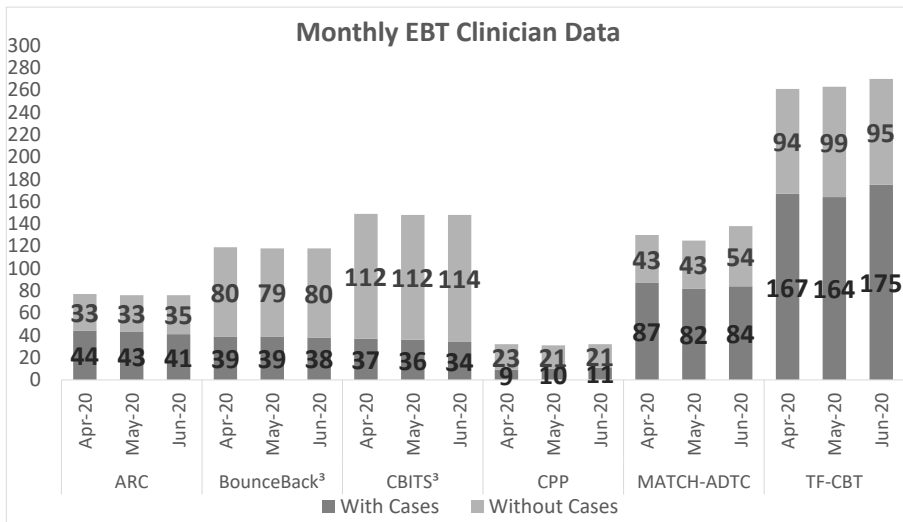
		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	FY20 Total	Yr Total ¹
Open	ARC	124	123	113	117	111	107	106	116	103	96	98	92	203	203
	BounceBack	33	22	52	132	219	252	243	288	223	170	170	167	344	344
	CBITS	34	33	49	131	181	192	220	312	256	137	132	123	379	379
	CPP	0	0	0	2	9	9	11	14	16	15	17	18	19	19
	MATCH-ADTC	367	358	344	328	323	319	309	303	274	262	247	229	603	603
	TF-CBT	682	683	634	596	575	575	577	575	546	530	528	544	1150	1150
Open Total		1240	1219	1192	1306	1418	1454	1466	1608	1418	1210	1192	1173	2698	2698
Intakes	ARC	17	13	4	12	9	5	6	10	6	4	7	3	96	96
	BounceBack	2	0	31	86	88	37	15	45	9	0	0	0	313	313
	CBITS	1	1	16	87	50	19	60	92	20	0	0	0	346	346
	CPP	0	0	0	2	7	0	2	3	2	0	2	1	19	19
	MATCH-ADTC	46	35	35	37	25	25	26	21	9	10	6	7	282	282
	TF-CBT	109	70	50	49	54	43	51	47	22	22	22	38	577	577
Intakes Total		175	119	136	273	233	129	160	218	68	36	37	49	1633	1633
Discharges	ARC	14	14	8	15	9	7	10	9	11	5	9	8	119	119
	BounceBack	11	1	6	1	4	24	37	37	53	0	3	134	311	311
	CBITS	2	0	5	0	8	32	65	11	119	5	9	113	369	369
	CPP	0	0	0	0	0	0	0	0	1	0	0	2	3	3
	MATCH-ADTC	44	49	53	30	29	36	27	38	22	21	25	33	407	407
	TF-CBT	69	99	87	75	43	49	49	51	38	24	22	40	646	646
Discharges Total		140	163	159	121	93	148	188	146	244	55	68	330	1855	1855

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

State of Connecticut: EBT Performance Dashboard cont...

	Children Served ¹ (% of Open)		Children Discharged		
	% June 2020	Average % FY2020	Total Closed FY2020	% Successful June 2020	% Successful FY2020 Avg.
ARC	59%	75%	119	63%	45%
BounceBack	2%	50%	311	0%	35%
CBITS	0%	50%	369	1%	33%
CPP	67%	80%	3	0%	0%
MATCH-ADTC	57%	70%	407	45%	54%
TF-CBT	58%	68%	646	40%	40%
All EBTs	44%	65%	1855	11%	41%

	Monthly Session Forms Completed On Time												
	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Avg. QI Period ²
ARC	94%	92%	89%	82%	83%	75%	74%	71%	64%	68%	70%	67%	69%
CPP				0%	33%	44%	55%	57%	38%	60%	59%	83%	59%
MATCH-ADTC	89%	90%	88%	63%	73%	65%	85%	54%	69%	77%	75%	82%	72%
TF-CBT	81%	81%	80%	57%	66%	67%	76%	57%	66%	65%	69%	79%	68%
All EBTs	85%	85%	83%	61%	70%	67%	78%	57%	66%	69%	70%	78%	69%



Clinicians Trained ⁴ in EBTs FY2020	
ARC	14
BounceBack	56
CBITS	83
CPP	35
MATCH-ADTC	40
TF-CBT	54

CBITS/BB Indicators			
Group Sessions June 2020	Child Sessions June 2020	Caregiver Sessions June 2020	Total Screens FY20
1	6	0	1498

¹ One or more visits within the month

² QI Period is January 2020 - June 2020

³ Includes co-facilitators

⁴ Includes individuals with a clinical role at time in training. Includes internal agency trainings.



Appendix D: QI Reports

A PARTNER IN
NCTSN

The National Child
Traumatic Stress Network

CHDI Child Health and
Development Institute
of Connecticut, Inc.

QI Overview

The indicators provided in this report cover the period from July-December 2019. Data were pulled from the EBP Tracker database on January 23, 2020. Data were pulled from the PIE database on February 10, 2020. (See FAQs for specific information regarding which database episodes were pulled from). 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.

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

QI Indicators	Benchmark	QI Description
Episodes Closed	-	Treatment episodes discharged in QI period with at least one clinical session during entire LOS.
Engaged	55% of closed episodes	Percentage of closed episodes with four or more clinical sessions attended.
Consistent Care	65% of closed and engaged episodes	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.
Model Completion	30% of closed and engaged episodes	Percentage of closed and engaged treatment episodes that fully complete the model. Model completion definitions are: <ul style="list-style-type: none"> - 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.
Measures	70% of closed and engaged episodes	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.
Improved Outcomes	75% of closed and engaged episodes with measures available	Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change (symptom improvement only) on any measure. Includes any measure of child or caregiver symptoms.



Frequently Asked Questions

What determines which database (PIE or EBP Tracker) episodes are pulled from?

All ARC, BounceBack!, and CBITS episodes are housed in and pulled from EBP Tracker regardless of time period.

On October 8, 2019, some (not all) open and closed MATCH-ADTC and TF-CBT episodes were migrated from the EBP Tracker data system to PIE. After that date, all new MATCH-ADTC and TF-CBT data were housed in PIE only. Because integration occurred in the middle of the July-December 2019 QI period, rules were created to determine which database a closed episode was pulled from. These rules were created to increase the number of closed episodes pulled from both systems without duplication.

EBP Tracker - All MATCH & TF-CBT episodes closed in EBP Tracker were included. This includes episodes open on October 7th 2019 that were automatically closed because they were not migrated to PIE. EBP Tracker data were pulled on January 23, 2020.

PIE - MATCH & TF-CBT episodes were included from PIE if 1) the treatment model discharge date was within the QI period and 2) if the system record entry date on the discharge facesheet was after integration (October 8th 2019 or later). PIE data were pulled on February 10, 2020.

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* (symptom improvement only). 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 Episodes¹ July - December 2019

Provider Name	EBT Closed Episodes	ARC	BounceBack!	CBITS	MATCH-ADTC	TF-CBT
Adelbrook, Inc.	0	0	0	0	0	0
Boys & Girls Village	10	-	4	5	-	1
Bridges Healthcare, Inc	25	2	0	0	10	13
Catholic Charities Archdiocese of Hartford	3	-	-	-	-	3
Charlotte Hungerford Hospital	35	1	-	-	3	31
Child and Family Agency of Southeastern Connecticut, Inc	36	4	5	2	17	8
Child Guidance Center of Southern Connecticut, Inc	23	11	-	-	-	12
Clifford Beers Clinic	35	-	0	0	15	20
Community Child Guidance Clinic, Inc	39	11	-	-	14	14
Community Health Center, Inc	13	-	0	2	-	11
Community Health Resources	41	8	-	-	14	19
Community Mental Health Affiliates, Inc	50	-	14	4	17	15
Connecticut Junior Republic	10	-	-	-	3	7
Cornell Scott Hill Health Center	46	-	0	0	14	32
Family & Children's Aid, Inc	17	2	-	-	-	15
Family Centers, Inc	2	-	-	-	-	2
Jewish Family Services	1	-	-	-	-	1
Klingberg Family Centers	6	-	-	-	-	6
LifeBridge Community Services	11	-	-	-	-	11
Mid-Fairfield Child Guidance Center, Inc	7	-	0	0	1	6
Parent Child Resource Center	17	-	-	-	12	5
The Child and Family Guidance Center	20	-	-	-	9	11
The Child Guidance Clinic For Central Connecticut, Inc	42	6	3	0	17	16
The Village for Families & Children, Inc	46	2	0	0	22	22
United Community and Family Services	61	8	0	0	18	35
United Services, Inc	34	-	-	-	18	16
Waterford Country School, Inc.	12	-	-	-	-	12
Wellmore Behavioral Health	61	12	-	-	25	24
Wheeler Clinic	30	-	0	0	4	26
Yale Child Study Center	6	-	-	-	0	6
Yale - West Haven Clinic	2	-	-	-	-	2
Average	24	6	2	1	12	13
Total	741	67	26	13	233	402

¹ Closed treatment episodes with at least one clinical session



Engagement¹ July - December 2019

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	55%	-	-	-	-	-	-	0	-	-	0	-	-
Boys & Girls Village	55%	-	-	-	-	-	-	1	1	100%	1	1	100%
Bridges, A Community Support System	55%	2	2	100%	10	10	100%	13	13	100%	25	25	100%
Catholic Charities Archdiocese of Hartford	55%	-	-	-	-	-	-	3	2	67%	3	2	67%
Charlotte Hungerford Hospital	55%	1	1	100%	3	3	100%	31	28	90%	35	32	91%
Child and Family Agency of Southeastern Connecticut, Inc	55%	4	4	100%	17	15	88%	8	8	100%	29	27	93%
Child Guidance Center of Southern Connecticut, Inc	55%	11	11	100%	-	-	-	12	12	100%	23	23	100%
Clifford Beers Clinic	55%	-	-	-	15	12	80%	20	13	65%	35	25	71%
Community Child Guidance Clinic, Inc	55%	11	11	100%	14	13	93%	14	12	86%	39	36	92%
Community Health Center, Inc	55%	-	-	-	-	-	-	11	9	82%	11	9	82%
Community Health Resources	55%	8	6	75%	14	11	79%	19	17	89%	41	34	83%
Community Mental Health Affiliates, Inc	55%	-	-	-	17	16	94%	15	13	87%	32	29	91%
Connecticut Junior Republic	55%	-	-	-	3	3	100%	7	5	71%	10	8	80%
Cornell Scott Hill Health Center	55%	-	-	-	14	14	100%	32	31	97%	46	45	98%
Family & Children's Aid, Inc	55%	2	2	100%	-	-	-	15	13	87%	17	15	88%
Family Centers, Inc	55%	-	-	-	-	-	-	2	1	50%	2	1	50%
Jewish Family Services	55%	-	-	-	-	-	-	1	1	100%	1	1	100%
Klingberg Family Centers	55%	-	-	-	-	-	-	6	6	100%	6	6	100%
LifeBridge Community Services	55%	-	-	-	-	-	-	11	11	100%	11	11	100%
Mid-Fairfield Child Guidance Center, Inc	55%	-	-	-	1	1	100%	6	5	83%	7	6	86%
Parent Child Resource Center	55%	-	-	-	12	10	83%	5	5	100%	17	15	88%
The Child and Family Guidance Center	55%	-	-	-	9	9	100%	11	10	91%	20	19	95%
The Child Guidance Clinic For Central Connecticut, Inc	55%	6	6	100%	17	17	100%	16	13	81%	39	36	92%
The Village for Families & Children, Inc	55%	2	2	100%	22	20	91%	22	18	82%	46	40	87%
United Community and Family Services	55%	8	8	100%	18	18	100%	35	35	100%	61	61	100%
United Services, Inc	55%	-	-	-	18	14	78%	16	10	63%	34	24	71%
Waterford Country School, Inc.	55%	-	-	-	-	-	-	12	12	100%	12	12	100%
Wellmore Behavioral Health	55%	12	6	50%	25	23	92%	24	20	83%	61	49	80%
Wheeler Clinic	55%	-	-	-	4	4	100%	26	23	88%	30	27	90%
Yale Child Study Center	55%	-	-	-	0	-	-	6	6	100%	6	6	100%
Yale - West Haven Clinic	55%	-	-	-	-	-	-	2	2	100%	2	2	100%
Average	-	6	5	-	12	12	-	13	12	-	23	21	-
Total	55%	67	59	88%	233	213	91%	402	355	88%	702	627	89%

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



Measurement Based Care¹

July - December 2019

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Engaged	Measures		# Engaged	Measures		# Engaged	Measures		# Engaged	Measures	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	70%	-	-	-	-	-	-	-	-	-	-	-	-
Boys & Girls Village	70%	-	-	-	-	-	-	1	1	100%	1	1	100%
Bridges, A Community Support System	70%	2	2	100%	10	5	50%	13	11	85%	25	18	72%
Catholic Charities Archdiocese of Hartford	70%	-	-	-	-	-	-	2	2	100%	2	2	100%
Charlotte Hungerford Hospital	70%	1	1	100%	3	2	67%	28	23	82%	32	26	81%
Child and Family Agency of Southeastern Connecticut, Inc	70%	4	3	75%	15	12	80%	8	8	100%	27	23	85%
Child Guidance Center of Southern Connecticut, Inc	70%	11	7	64%	-	-	-	12	12	100%	23	19	83%
Clifford Beers Clinic	70%	-	-	-	12	8	67%	13	10	77%	25	18	72%
Community Child Guidance Clinic, Inc	70%	11	10	91%	13	12	92%	12	10	83%	36	32	89%
Community Health Center, Inc	70%	-	-	-	-	-	-	9	5	56%	9	5	56%
Community Health Resources	70%	6	3	50%	11	9	82%	17	14	82%	34	26	76%
Community Mental Health Affiliates, Inc	70%	-	-	-	16	16	100%	13	12	92%	29	28	97%
Connecticut Junior Republic	70%	-	-	-	3	1	33%	5	2	40%	8	3	38%
Cornell Scott Hill Health Center	70%	-	-	-	14	11	79%	31	26	84%	45	37	82%
Family & Children's Aid, Inc	70%	2	1	50%	-	-	-	13	8	62%	15	9	60%
Family Centers, Inc	70%	-	-	-	-	-	-	1	1	100%	1	1	100%
Jewish Family Services	70%	-	-	-	-	-	-	1	1	100%	1	1	100%
Klingberg Family Centers	70%	-	-	-	-	-	-	6	3	50%	6	3	50%
LifeBridge Community Services	70%	-	-	-	-	-	-	11	10	91%	11	10	91%
Mid-Fairfield Child Guidance Center, Inc	70%	-	-	-	1	1	100%	5	4	80%	6	5	83%
Parent Child Resource Center	70%	-	-	-	10	9	90%	5	5	100%	15	14	93%
The Child and Family Guidance Center	70%	-	-	-	9	5	56%	10	8	80%	19	13	68%
The Child Guidance Clinic For Central Connecticut, Inc	70%	6	3	50%	17	13	76%	13	11	85%	36	27	75%
The Village for Families & Children, Inc	70%	2	2	100%	20	11	55%	18	14	78%	40	27	68%
United Community and Family Services	70%	8	7	88%	18	18	100%	35	27	77%	61	52	85%
United Services, Inc	70%	-	-	-	14	14	100%	10	9	90%	24	23	96%
Waterford Country School, Inc.	70%	-	-	-	-	-	-	12	10	83%	12	10	83%
Wellmore Behavioral Health	70%	6	5	83%	23	19	83%	20	15	75%	49	39	80%
Wheeler Clinic	70%	-	-	-	4	1	25%	23	18	78%	27	19	70%
Yale Child Study Center	70%	-	-	-	-	-	-	6	1	17%	6	1	17%
Yale - West Haven Clinic	70%	-	-	-	-	-	-	2	1	50%	2	1	50%
Average	-	5	4	-	12	9	-	12	9	-	21	16	-
Total	70%	59	44	75%	213	167	78%	355	282	79%	627	493	79%

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



Improved Outcomes¹ July - December 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%	-	-	-	-	-	-	-	-	-	-	-	-
Boys & Girls Village	75%	-	-	-	-	-	-	1	1	100%	1	1	100%
Bridges, A Community Support System	75%	2	2	100%	5	5	100%	11	11	100%	18	18	100%
Catholic Charities Archdiocese of Hartford	75%	-	-	-	-	-	-	2	2	100%	2	2	100%
Charlotte Hungerford Hospital	75%	1	1	100%	2	2	100%	23	22	96%	26	25	96%
Child and Family Agency of Southeastern Connecticut, Inc	75%	3	3	100%	12	10	83%	8	6	75%	23	19	83%
Child Guidance Center of Southern Connecticut, Inc	75%	7	7	100%	-	-	-	12	12	100%	19	19	100%
Clifford Beers Clinic	75%	-	-	-	8	7	88%	10	7	70%	18	14	78%
Community Child Guidance Clinic, Inc	75%	10	5	50%	12	10	83%	10	10	100%	32	25	78%
Community Health Center, Inc	75%	-	-	-	-	-	-	5	4	80%	5	4	80%
Community Health Resources	75%	3	3	100%	9	4	44%	14	12	86%	26	19	73%
Community Mental Health Affiliates, Inc	75%	-	-	-	16	15	94%	12	12	100%	28	27	96%
Connecticut Junior Republic	75%	-	-	-	1	1	100%	2	2	100%	3	3	100%
Cornell Scott Hill Health Center	75%	-	-	-	11	8	73%	26	21	81%	37	29	78%
Family & Children's Aid, Inc	75%	1	1	100%	-	-	-	8	8	100%	9	9	100%
Family Centers, Inc	75%	-	-	-	-	-	-	1	0	0%	1	0	0%
Jewish Family Services	75%	-	-	-	-	-	-	1	0	0%	1	0	0%
Klingberg Family Centers	75%	-	-	-	-	-	-	3	2	67%	3	2	67%
LifeBridge Community Services	75%	-	-	-	-	-	-	10	10	100%	10	10	100%
Mid-Fairfield Child Guidance Center, Inc	75%	-	-	-	1	1	100%	4	3	75%	5	4	80%
Parent Child Resource Center	75%	-	-	-	9	9	100%	5	5	100%	14	14	100%
The Child and Family Guidance Center	75%	-	-	-	5	4	80%	8	8	100%	13	12	92%
The Child Guidance Clinic For Central Connecticut, Inc	75%	3	2	67%	13	13	100%	11	10	91%	27	25	93%
The Village for Families & Children, Inc	75%	2	2	100%	11	8	73%	14	14	100%	27	24	89%
United Community and Family Services	75%	7	5	71%	18	16	89%	27	25	93%	52	46	88%
United Services, Inc	75%	-	-	-	14	14	100%	9	8	89%	23	22	96%
Waterford Country School, Inc.	75%	-	-	-	-	-	-	10	8	80%	10	8	80%
Wellmore Behavioral Health	75%	5	5	100%	19	18	95%	15	15	100%	39	38	97%
Wheeler Clinic	75%	-	-	-	1	1	100%	18	17	94%	19	18	95%
Yale Child Study Center	75%	-	-	-	-	-	-	1	0	0%	1	0	0%
Yale - West Haven Clinic	75%	-	-	-	-	-	-	1	1	100%	1	1	100%
Average	-	4	3	-	9	8	-	9	9	-	16	15	-
Total	75%	44	36	82%	167	146	87%	282	256	91%	493	438	89%

¹ Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change (symptom improvement only) on any measure.



Consistent Care¹ July - December 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%	-	-	-	-	-	-	-	-	-	-	-	-
Boys & Girls Village	65%	-	-	-	-	-	-	1	1	100%	1	1	100%
Bridges, A Community Support System	65%	2	1	50%	10	5	50%	13	11	85%	25	17	68%
Catholic Charities Archdiocese of Hartford	65%	-	-	-	-	-	-	2	2	100%	2	2	100%
Charlotte Hungerford Hospital	65%	1	1	100%	3	2	67%	28	19	68%	32	22	69%
Child and Family Agency of Southeastern Connecticut, Inc	65%	4	3	75%	15	14	93%	8	8	100%	27	25	93%
Child Guidance Center of Southern Connecticut, Inc	65%	11	11	100%	-	-	-	12	12	100%	23	23	100%
Clifford Beers Clinic	65%	-	-	-	12	7	58%	13	9	69%	25	16	64%
Community Child Guidance Clinic, Inc	65%	11	11	100%	13	8	62%	12	10	83%	36	29	81%
Community Health Center, Inc	65%	-	-	-	-	-	-	9	6	67%	9	6	67%
Community Health Resources	65%	6	3	50%	11	8	73%	17	12	71%	34	23	68%
Community Mental Health Affiliates, Inc	65%	-	-	-	16	11	69%	13	7	54%	29	18	62%
Connecticut Junior Republic	65%	-	-	-	3	2	67%	5	5	100%	8	7	88%
Cornell Scott Hill Health Center	65%	-	-	-	14	9	64%	31	23	74%	45	32	71%
Family & Children's Aid, Inc	65%	2	2	100%	-	-	-	13	11	85%	15	13	87%
Family Centers, Inc	65%	-	-	-	-	-	-	1	1	100%	1	1	100%
Jewish Family Services	65%	-	-	-	-	-	-	1	1	100%	1	1	100%
Klingberg Family Centers	65%	-	-	-	-	-	-	6	4	67%	6	4	67%
LifeBridge Community Services	65%	-	-	-	-	-	-	11	9	82%	11	9	82%
Mid-Fairfield Child Guidance Center, Inc	65%	-	-	-	1	0	0%	5	5	100%	6	5	83%
Parent Child Resource Center	65%	-	-	-	10	8	80%	5	5	100%	15	13	87%
The Child and Family Guidance Center	65%	-	-	-	9	6	67%	10	10	100%	19	16	84%
The Child Guidance Clinic For Central Connecticut, Inc	65%	6	3	50%	17	10	59%	13	4	31%	36	17	47%
The Village for Families & Children, Inc	65%	2	2	100%	20	13	65%	18	9	50%	40	24	60%
United Community and Family Services	65%	8	7	88%	18	13	72%	35	28	80%	61	48	79%
United Services, Inc	65%	-	-	-	14	8	57%	10	7	70%	24	15	63%
Waterford Country School, Inc.	65%	-	-	-	-	-	-	12	11	92%	12	11	92%
Wellmore Behavioral Health	65%	6	2	33%	23	9	39%	20	16	80%	49	27	55%
Wheeler Clinic	65%	-	-	-	4	1	25%	23	7	30%	27	8	30%
Yale Child Study Center	65%	-	-	-	-	-	-	6	3	50%	6	3	50%
Yale - West Haven Clinic	65%	-	-	-	-	-	-	2	1	50%	2	1	50%
Average	-	5	4	-	12	7	-	12	9	-	21	15	-
Total	65%	59	46	78%	213	134	63%	355	257	72%	627	437	70%

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



Overview - Closed Episodes¹ January - June 2020

Provider Name	EBT Closed Episodes	ARC	BounceBack!	CBITS	MATCH-ADTC	TF-CBT
Adelbrook, Inc.	1	-	-	-	-	1
Boys & Girls Village	8	-	4	4	-	0
Bridges Healthcare, Inc	11	0	0	0	6	5
Catholic Charities Archdiocese of Hartford	3	-	-	-	-	3
Center for Family Justice	0	-	-	-	-	0
Charlotte Hungerford Hospital	16	0	-	-	2	14
Child and Family Agency of Southeastern Connecticut, Inc	67	4	38	18	3	4
Child Guidance Center of Southern Connecticut, Inc	17	6	-	-	-	11
Clifford Beers Clinic	67	-	12	26	17	12
Community Child Guidance Clinic, Inc	27	8	-	-	9	10
Community Health Center, Inc	19	-	0	13	-	6
Community Health Resources	44	8	-	-	17	19
Community Mental Health Affiliates, Inc	21	-	4	0	7	10
Connecticut Junior Republic	3	-	-	-	1	2
Cornell Scott Hill Health Center	32	-	7	3	11	11
Family & Children's Aid, Inc	12	0	-	-	-	12
Family Centers, Inc	1	-	-	-	-	1
Jewish Family Services	0	-	-	-	-	0
Klingberg Family Centers	4	-	-	-	-	4
LifeBridge Community Services	0	-	-	-	-	0
Mid-Fairfield Child Guidance Center, Inc	34	-	19	11	0	4
Parent Child Resource Center	11	-	-	-	9	2
The Child and Family Guidance Center	20	-	-	-	7	13
The Child Guidance Clinic For Central Connecticut, Inc	74	1	37	11	14	11
The Village for Families & Children, Inc	27	4	0	0	12	11
United Community and Family Services	46	9	0	0	18	19
United Services, Inc	24	-	-	-	18	6
Waterford Country School, Inc.	5	-	-	-	-	5
Wellmore Behavioral Health	47	12	-	-	18	17
Wheeler Clinic	17	-	0	4	3	10
Yale Child Study Center	0	-	-	-	0	0
Average	21	5	10	8	9	7
Total	658	52	121	90	172	223

¹ Closed treatment episodes with at least one clinical session



Engagement¹ January - June 2020

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged		# Closed	Engaged	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	55%	-	-	-	-	-	-	1	1	100%	1	1	100%
Boys & Girls Village	55%	-	-	-	-	-	-	0	-	-	0	-	-
Bridges, A Community Support System	55%	0	-	-	6	6	100%	5	5	100%	11	11	100%
Catholic Charities Archdiocese of Hartford	55%	-	-	-	-	-	-	3	3	100%	3	3	100%
Center for Family Justice	55%	-	-	-	-	-	-	0	-	-	0	-	-
Charlotte Hungerford Hospital	55%	0	-	-	2	2	100%	14	11	79%	16	13	81%
Child and Family Agency of Southeastern Connecticut, Inc	55%	4	4	100%	3	3	100%	4	4	100%	11	11	100%
Child Guidance Center of Southern Connecticut, Inc	55%	6	6	100%	-	-	-	11	9	82%	17	15	88%
Clifford Beers Clinic	55%	-	-	-	17	15	88%	12	12	100%	29	27	93%
Community Child Guidance Clinic, Inc	55%	8	7	88%	9	8	89%	10	9	90%	27	24	89%
Community Health Center, Inc	55%	-	-	-	-	-	-	6	6	100%	6	6	100%
Community Health Resources	55%	8	8	100%	17	15	88%	19	16	84%	44	39	89%
Community Mental Health Affiliates, Inc	55%	-	-	-	7	7	100%	10	10	100%	17	17	100%
Connecticut Junior Republic	55%	-	-	-	1	1	100%	2	1	50%	3	2	67%
Cornell Scott Hill Health Center	55%	-	-	-	11	10	91%	11	11	100%	22	21	95%
Family & Children's Aid, Inc	55%	0	-	-	-	-	-	12	10	83%	12	10	83%
Family Centers, Inc	55%	-	-	-	-	-	-	1	1	100%	1	1	100%
Jewish Family Services	55%	-	-	-	-	-	-	0	-	-	0	-	-
Klingberg Family Centers	55%	-	-	-	-	-	-	4	4	100%	4	4	100%
LifeBridge Community Services	55%	-	-	-	-	-	-	0	-	-	0	-	-
Mid-Fairfield Child Guidance Center, Inc	55%	-	-	-	0	-	-	4	4	100%	4	4	100%
Parent Child Resource Center	55%	-	-	-	9	9	100%	2	2	100%	11	11	100%
The Child and Family Guidance Center	55%	-	-	-	7	7	100%	13	11	85%	20	18	90%
The Child Guidance Clinic For Central Connecticut, Inc	55%	1	1	100%	14	14	100%	11	11	100%	26	26	100%
The Village for Families & Children, Inc	55%	4	3	75%	12	10	83%	11	11	100%	27	24	89%
United Community and Family Services	55%	9	6	67%	18	18	100%	19	18	95%	46	42	91%
United Services, Inc	55%	-	-	-	18	12	67%	6	4	67%	24	16	67%
Waterford Country School, Inc.	55%	-	-	-	-	-	-	5	5	100%	5	5	100%
Wellmore Behavioral Health	55%	12	11	92%	18	15	83%	17	16	94%	47	42	89%
Wheeler Clinic	55%	-	-	-	3	3	100%	10	8	80%	13	11	85%
Yale Child Study Center	55%	-	-	-	0	-	-	0	-	-	0	-	-
Average	-	5	6	-	9	9	-	7	8	-	14	16	-
Total	55%	52	46	88%	172	155	90%	223	203	91%	447	404	90%

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

Measurement Based Care¹

January - June 2020

Provider Name	Proposed Benchmark	ARC			MATCH-ADTC			TF-CBT			Total EBT		
		# Engaged	Measures Available		# Engaged	Measures Available		# Engaged	Measures Available		# Engaged	Measures Available	
			#	%		#	%		#	%		#	%
Adelbrook, Inc.	70%	-	-	-	-	-	-	1	1	100%	1	1	100%
Boys & Girls Village	70%	-	-	-	-	-	-	-	-	-	-	-	-
Bridges, A Community Support System	70%	-	-	-	6	4	67%	5	4	80%	11	8	73%
Catholic Charities Archdiocese of Hartford	70%	-	-	-	-	-	-	3	3	100%	3	3	100%
Center for Family Justice	70%	-	-	-	-	-	-	-	-	-	-	-	-
Charlotte Hungerford Hospital	70%	-	-	-	2	2	100%	11	9	82%	13	11	85%
Child and Family Agency of Southeastern Connecticut, Inc	70%	4	1	25%	3	2	67%	4	4	100%	11	7	64%
Child Guidance Center of Southern Connecticut, Inc	70%	6	4	67%	-	-	-	9	8	89%	15	12	80%
Clifford Beers Clinic	70%	-	-	-	15	13	87%	12	10	83%	27	23	85%
Community Child Guidance Clinic, Inc	70%	7	7	100%	8	8	100%	9	7	78%	24	22	92%
Community Health Center, Inc	70%	-	-	-	-	-	-	6	5	83%	6	5	83%
Community Health Resources	70%	8	6	75%	15	7	47%	16	8	50%	39	21	54%
Community Mental Health Affiliates, Inc	70%	-	-	-	7	5	71%	10	8	80%	17	13	76%
Connecticut Junior Republic	70%	-	-	-	1	0	0%	1	1	100%	2	1	50%
Cornell Scott Hill Health Center	70%	-	-	-	10	8	80%	11	8	73%	21	16	76%
Family & Children's Aid, Inc	70%	-	-	-	-	-	-	10	8	80%	10	8	80%
Family Centers, Inc	70%	-	-	-	-	-	-	1	0	0%	1	0	0%
Jewish Family Services	70%	-	-	-	-	-	-	-	-	-	-	-	-
Klingberg Family Centers	70%	-	-	-	-	-	-	4	3	75%	4	3	75%
LifeBridge Community Services	70%	-	-	-	-	-	-	-	-	-	-	-	-
Mid-Fairfield Child Guidance Center, Inc	70%	-	-	-	-	-	-	4	1	25%	4	1	25%
Parent Child Resource Center	70%	-	-	-	9	8	89%	2	2	100%	11	10	91%
The Child and Family Guidance Center	70%	-	-	-	7	6	86%	11	7	64%	18	13	72%
The Child Guidance Clinic For Central Connecticut, Inc	70%	1	0	0%	14	14	100%	11	6	55%	26	20	77%
The Village for Families & Children, Inc	70%	3	2	67%	10	5	50%	11	7	64%	24	14	58%
United Community and Family Services	70%	6	3	50%	18	15	83%	18	13	72%	42	31	74%
United Services, Inc	70%	-	-	-	12	9	75%	4	3	75%	16	12	75%
Waterford Country School, Inc.	70%	-	-	-	-	-	-	5	5	100%	5	5	100%
Wellmore Behavioral Health	70%	11	8	73%	15	6	40%	16	9	56%	42	23	55%
Wheeler Clinic	70%	-	-	-	3	2	67%	8	4	50%	11	6	55%
Yale Child Study Center	70%	-	-	-	-	-	-	-	-	-	-	-	-
Average	-	6	4	-	9	7	-	8	6	-	16	11	-
Total	70%	46	31	67%	155	114	74%	203	144	71%	404	289	72%

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



Improved Outcomes¹ January - June 2020

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%	-	-	-	-	-	-	1	1	100%	1	1	100%
Boys & Girls Village	75%	-	-	-	-	-	-	-	-	-	-	-	-
Bridges, A Community Support System	75%	-	-	-	4	4	100%	4	4	100%	8	8	100%
Catholic Charities Archdiocese of Hartford	75%	-	-	-	-	-	-	3	3	100%	3	3	100%
Center for Family Justice	75%	-	-	-	-	-	-	-	-	-	-	-	-
Charlotte Hungerford Hospital	75%	-	-	-	2	2	100%	9	9	100%	11	11	100%
Child and Family Agency of Southeastern Connecticut, Inc	75%	1	1	100%	2	2	100%	4	3	75%	7	6	86%
Child Guidance Center of Southern Connecticut, Inc	75%	4	4	100%	-	-	-	8	8	100%	12	12	100%
Clifford Beers Clinic	75%	-	-	-	13	8	62%	10	7	70%	23	15	65%
Community Child Guidance Clinic, Inc	75%	7	7	100%	8	5	63%	7	6	86%	22	18	82%
Community Health Center, Inc	75%	-	-	-	-	-	-	5	4	80%	5	4	80%
Community Health Resources	75%	6	5	83%	7	6	86%	8	8	100%	21	19	90%
Community Mental Health Affiliates, Inc	75%	-	-	-	5	5	100%	8	7	88%	13	12	92%
Connecticut Junior Republic	75%	-	-	-	0	-	-	1	1	100%	1	1	100%
Cornell Scott Hill Health Center	75%	-	-	-	8	5	63%	8	7	88%	16	12	75%
Family & Children's Aid, Inc	75%	-	-	-	-	-	-	8	7	88%	8	7	88%
Family Centers, Inc	75%	-	-	-	-	-	-	0	-	-	0	-	-
Jewish Family Services	75%	-	-	-	-	-	-	-	-	-	-	-	-
Klingberg Family Centers	75%	-	-	-	-	-	-	3	3	100%	3	3	100%
LifeBridge Community Services	75%	-	-	-	-	-	-	-	-	-	-	-	-
Mid-Fairfield Child Guidance Center, Inc	75%	-	-	-	-	-	-	1	1	100%	1	1	100%
Parent Child Resource Center	75%	-	-	-	8	6	75%	2	2	100%	10	8	80%
The Child and Family Guidance Center	75%	-	-	-	6	6	100%	7	6	86%	13	12	92%
The Child Guidance Clinic For Central Connecticut, Inc	75%	0	-	-	14	12	86%	6	6	100%	20	18	90%
The Village for Families & Children, Inc	75%	2	2	100%	5	4	80%	7	6	86%	14	12	86%
United Community and Family Services	75%	3	3	100%	15	12	80%	13	12	92%	31	27	87%
United Services, Inc	75%	-	-	-	9	7	78%	3	3	100%	12	10	83%
Waterford Country School, Inc.	75%	-	-	-	-	-	-	5	5	100%	5	5	100%
Wellmore Behavioral Health	75%	8	7	88%	6	4	67%	9	9	100%	23	20	87%
Wheeler Clinic	75%	-	-	-	2	0	0%	4	4	100%	6	4	67%
Yale Child Study Center	75%	-	-	-	-	-	-	-	-	-	-	-	-
Average	-	4	4	-	7	6	-	6	5	-	11	10	-
Total	75%	31	29	94%	114	88	77%	144	132	92%	289	249	86%

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



Consistent Care¹ January - June 2020

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%	-	-	-	-	-	-	1	1	100%	1	1	100%
Boys & Girls Village	65%	-	-	-	-	-	-	-	-	-	-	-	-
Bridges, A Community Support System	65%	-	-	-	6	0	0%	5	2	40%	11	2	18%
Catholic Charities Archdiocese of Hartford	65%	-	-	-	-	-	-	3	2	67%	3	2	67%
Center for Family Justice	65%	-	-	-	-	-	-	-	-	-	-	-	-
Charlotte Hungerford Hospital	65%	-	-	-	2	2	100%	11	6	55%	13	8	62%
Child and Family Agency of Southeastern Connecticut, Inc	65%	4	3	75%	3	1	33%	4	3	75%	11	7	64%
Child Guidance Center of Southern Connecticut, Inc	65%	6	5	83%	-	-	-	9	6	67%	15	11	73%
Clifford Beers Clinic	65%	-	-	-	15	8	53%	12	12	100%	27	20	74%
Community Child Guidance Clinic, Inc	65%	7	6	86%	8	5	63%	9	5	56%	24	16	67%
Community Health Center, Inc	65%	-	-	-	-	-	-	6	2	33%	6	2	33%
Community Health Resources	65%	8	6	75%	15	1	7%	16	1	6%	39	8	21%
Community Mental Health Affiliates, Inc	65%	-	-	-	7	4	57%	10	6	60%	17	10	59%
Connecticut Junior Republic	65%	-	-	-	1	1	100%	1	1	100%	2	2	100%
Cornell Scott Hill Health Center	65%	-	-	-	10	1	10%	11	4	36%	21	5	24%
Family & Children's Aid, Inc	65%	-	-	-	-	-	-	10	4	40%	10	4	40%
Family Centers, Inc	65%	-	-	-	-	-	-	1	0	0%	1	0	0%
Jewish Family Services	65%	-	-	-	-	-	-	-	-	-	-	-	-
Klingberg Family Centers	65%	-	-	-	-	-	-	4	4	100%	4	4	100%
LifeBridge Community Services	65%	-	-	-	-	-	-	-	-	-	-	-	-
Mid-Fairfield Child Guidance Center, Inc	65%	-	-	-	-	-	-	4	4	100%	4	4	100%
Parent Child Resource Center	65%	-	-	-	9	7	78%	2	1	50%	11	8	73%
The Child and Family Guidance Center	65%	-	-	-	7	2	29%	11	7	64%	18	9	50%
The Child Guidance Clinic For Central Connecticut, Inc	65%	1	1	100%	14	6	43%	11	3	27%	26	10	38%
The Village for Families & Children, Inc	65%	3	2	67%	10	5	50%	11	7	64%	24	14	58%
United Community and Family Services	65%	6	6	100%	18	12	67%	18	12	67%	42	30	71%
United Services, Inc	65%	-	-	-	12	7	58%	4	1	25%	16	8	50%
Waterford Country School, Inc.	65%	-	-	-	-	-	-	5	4	80%	5	4	80%
Wellmore Behavioral Health	65%	11	2	18%	15	3	20%	16	6	38%	42	11	26%
Wheeler Clinic	65%	-	-	-	3	0	0%	8	0	0%	11	0	0%
Yale Child Study Center	65%	-	-	-	-	-	-	-	-	-	-	-	-
Average	-	6	4	-	9	4	-	8	4	-	16	8	-
Total	65%	46	31	67%	155	65	42%	203	104	51%	404	200	50%

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 (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 (retired)	11	6
	CPSS V	15	8
	PROMIS	6	3
	SMFQ	7	4
	UCLA	16	9
Ohio Scales	Ohio Problem Severity* (<i>Child, Caregiver, & Worker versions</i>)	10	5
	Ohio Functioning (<i>Child, Caregiver, & Worker versions</i>)	8	4
Caregiver Assessments	CESD-R	9	5
	CPSS IV (retired)	10	5
	CPSS V	15	8
	PCL-5	10	5
	PROMIS	6	3
	PSS	11	6
	SMFQ	6	3
	UCLA	11	6
	YCPC	18	9

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Child Health and
Development Institute
of Connecticut, Inc.

270 Farmington Avenue, Suite 367
Farmington, CT 06032
860.679.1519

CHDI.org