

**Connecticut's Evidence Based Treatment  
Coordinating Center:  
Trauma-Focused  
Cognitive Behavioral Therapy (TF-CBT)**

FY 2019 Annual Report



# Report Prepared by:

Kellie G. Randall, Ph.D.  
Carol O'Connor, LCSW  
Ashley Nelson, B.A.  
Jason M. Lang, Ph.D.

Connecticut TF-CBT Coordinating Center  
Child Health and Development Institute  
270 Farmington Ave, Suite 367  
Farmington, CT 06032  
[www.chdi.org](http://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 Kellie G. Randall at [randall@uchc.edu](mailto:randall@uchc.edu)

We wish to acknowledge the following CHDI staff that have worked on the TF-CBT Coordinating Center and this report, including Sharon Bailey, Kyle Barrette, Annabelle Bass, Michelle Delaney, Tiffany Franceschetti, Paulette James, Amanda Kach, Ashley Loser, Jack Lu, Diana Perry, Lori Schon, Carrie Shaw, Heather Solak, Julie Tacinelli, Laurie Valentine, and Jeff Vanderploeg.

## Table of Contents

Executive Summary .....	4
Introduction & Background .....	5
Access: Availability of TF-CBT in Connecticut .....	7
Access: Children Receiving TF-CBT .....	9
Quality: Consultation and Clinical Implementation .....	15
Outcomes: Improvement for Children Receiving TF-CBT .....	19
Summary & Conclusions.....	23
Recommendations.....	25
Appendix A: Activities and Deliverables.....	27
Appendix B: Regression Tables.....	30
Appendix C: Annual Court Support Services Devision RBA .....	37
Appendix D: Statewide Dashboard for June 2019 .....	39
Appendix E: Quality Improvement Indicators FY2019 .....	42
Appendix F: Reliable Change Index.....	60

## **Executive Summary**

The TF-CBT Coordinating Center (“Coordinating Center”), is located at the Child Health and Development Institute (CHDI) and is funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch’s Court Support Services Division (CSSD). The Coordinating Center supports a network of 46 providers throughout CT by providing training, credentialing, implementation support, site-based consultation, data collection and reporting, and ongoing quality improvement. This report summarizes the work of the Coordinating Center for state fiscal year 2019 (July 1, 2018 through June 30, 2019). This was the twelfth year of TF-CBT in CT; cumulative totals reflect over a decade of work and commitment on the part of DCF, CSSD, CHDI, provider agencies, and other partners.

### ***Highlights of FY 19:***

- 1,536 children received TF-CBT. 56 clinical staff were newly trained to deliver TF-CBT.
- Caregivers (~92%) and children (89%) reported high satisfaction with treatment
- Children completing TF-CBT had excellent clinical outcomes with children reporting a ~60% remission rate for post-traumatic stress and depressive symptoms
- Caregivers reported a 61% remission rate for their own depression symptoms
- Implemented a flexible assessment schedule so clinicians could select outcomes measures based on clinical needs while also reducing the overall burden of data entry
- Implemented a one-day booster training to ensure that existing TF-CBT clinicians have the support they need to sustain their implementation of the model
- Revised sustainability funding allocation formulas to support positive outcomes for children and the efforts agencies devote to training and workforce development
- Implemented a consultation plan to provide cross-model and OPCC consultation to each agency to provide a more comprehensive assessment of behavioral health services provided to children and a better understanding of how TF-CBT contributes to positive outcomes

### ***Key Recommendations***

- Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity and health equity, TF-CBT with young children, and use of assessments
- Develop data reports that can be used in site-based consultation to help agencies monitor the progress of clients overall as well as broken out by subgroups that were identified in this report as having specific trends in implementation and outcomes
- Engage in conversations with DCF, CSSD, and providers to develop a plan for ensuring youth involved in the juvenile justice system have access to and utilize TF-CBT treatment in outpatient clinic settings
- Update terminology used in PIE (e.g., sex assigned at birth; Latino) to collect demographic information that complies with current best practices (e.g., gender identity; Latinx)
- Expand collection of zip codes to nine digits in PIE to strengthen opportunities to merge PIE data with external data sources (e.g., Area Deprivation Index) to examine health disparities and inequities

## **Introduction**

The Connecticut Trauma Focused Cognitive Behavioral Therapy (TF-CBT) 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. The Coordinating Center is funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch's Court Support Services Division (CSSD) and is located at the Child Health and Development Institute (CHDI) of Connecticut.

This report summarizes the work of the Coordinating Center for state fiscal year 2019 (July 1, 2019 through June 30, 2019). The Coordinating Center focuses on enhancing the availability and quality of trauma-focused treatment for children through dissemination and sustainment of TF-CBT at Connecticut agencies and private practices. The Coordinating Center integrates knowledge about implementation science, evidence-based practices, childhood trauma, and children's mental health to achieve this goal together through our partnerships with treatment developers, community-based agencies, and state systems.

Using economies of scale to create centralized support for the statewide network of 46 TF-CBT providers, the Coordinating Center serves the following primary functions:

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

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

## **Background**

TF-CBT is an evidence-based, short-term, family-centered behavioral health treatment for children aged 3-18 who experience symptoms related to trauma exposure, including symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety. More than 20 empirical studies have been conducted to evaluate the successful impact of the TF-CBT model.<sup>1</sup>

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

---

<sup>1</sup> For the full list of studies see Cohen, J.A., Mannarino, A.P. & Deblinger, E. (2017). Treating trauma and traumatic grief in children and adolescents, 2<sup>nd</sup> ed.

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

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

In FY14, the Coordinating Center was expanded to provide additional support for this growing network of TF-CBT providers. This expansion included development of a statewide data collection and reporting system, sustainment funding for TF-CBT providers, establishment of best practice criteria and a clinician credentialing process, additional training, and additional implementation support.

Through a contract renewal in FY18, this work continued in FY 19 along with a greater emphasis on integrating TF-CBT with other EBTs.

### **Goals**

The primary goals for the Coordinating Center are to:

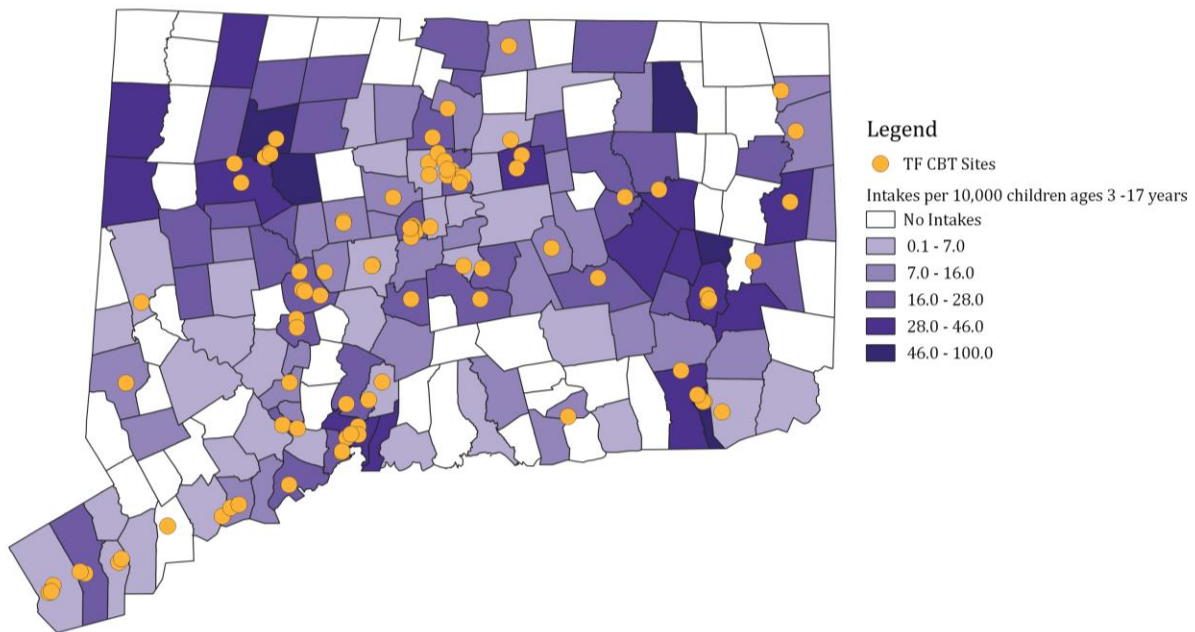
- (1) Provide access to TF-CBT for all Connecticut children recovering from trauma
- (2) Ensure that high-quality TF-CBT is provided
- (3) Ensure significant improvements in child outcomes for children receiving TF-CBT

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 FY19. The third section details the clinical implementation, fidelity monitoring, and quality improvement activities that took place to ensure children received high-quality services (goal 2). The fourth section then describes symptom reduction and functional improvements for children who receive 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.

## Access: Availability of TF-CBT in Connecticut

The number of agencies offering TF-CBT has continued to increase, with three private practice providers starting TF-CBT in FY19 for a total of 46 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 353 clinicians on a TF-CBT team during at least some part of FY19 and 294 (83.3%) clinicians saw at least one TF-CBT case. Although the number of clinicians providing TF-CBT decreased from FY18 by 4.7%, the number of children served increased by 4.4%. In terms of average team size, outpatient agency teams average 10 clinicians with a range of 2-21 clinicians. Private practices average one clinician per provider.

Figure 1. Map of TF-CBT sites and children served



### 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 353 clinicians on a TF-CBT team during FY19, 86 (24.4%) left their TF-CBT teams during the fiscal year. Ongoing training and support to help agencies address attrition resulted in 56 clinicians newly trained in TF-CBT.

Additionally, to support high-quality treatment by clinicians who attended the basic TF-CBT training, we initiated 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. Seventy-four clinicians participated in booster training this year. Advanced TF-CBT training was attended by 20 clinicians.

The advanced training is a one-day training open to any credentialed TF-CBT clinician and provides more in-depth training in specific topics such as using TF-CBT for complex trauma and implementation of the trauma narrative and gradual exposure strategies.

We continued to credential TF-CBT clinicians this year and 22 clinicians met the Connecticut TF-CBT Credential criteria in FY19. The credentialing process recognizes clinicians who complete all training and consultation requirements as well as providing TF-CBT successfully to at least two children.

Table 1. Trends in TF-CBT provider network

	FY17	FY18	<b>FY 19</b>	Cumulative Since 2007
TF-CBT Providers/Agencies	42	43	<b>46</b>	49
Newly trained TF-CBT Clinicians	87	48	<b>56</b>	821
Clinicians Providing TF-CBT	333	308	<b>294</b>	789 <sup>2</sup>
# Newly Credentialed/Certified	79	<b>45</b>	<b>22</b>	306

### Clinician Demographics

The demographic characteristics of the 353 clinicians offering TF-CBT this year are presented in Table 2. TF-CBT clinicians were primarily female (89.9%) and almost half (49.9%) were White. In terms of languages spoken, 19.0% spoke Spanish. In FY19 there were a number of efforts undertaken by CHDI to better support Spanish-speaking TF-CBT clinicians. In June 2019, seven clinicians from CT agencies were able to attend a 2-day TF-CBT clinical training in Spanish and an additional day of training on using assessments to improve family engagement, the administration of CHDI assessments, using assessments for case conceptualization and dealing with secondary traumatic stress. Additionally, they were involved in bringing together a group of bilingual TF-CBT clinicians to provide support and share resources for the implementation of TF-CBT with bilingual families.

Table 2. TF-CBT clinician demographic characteristics (n=353)

Characteristic	%
Sex (Male)	10.1
Race/Ethnicity	
Black or African American	8.5
Hispanic, Latino, or Spanish	21.0
White	49.9
Other Race/Ethnicity	3.1
Languages Spoken	
Spanish	19.0
Other <sup>3</sup>	4.2

<sup>2</sup> Clinicians included from FY16 and prior were included based on training records

<sup>3</sup> Other languages include Armenian, French, French Creole and other



## Integrating Multiple EBTs

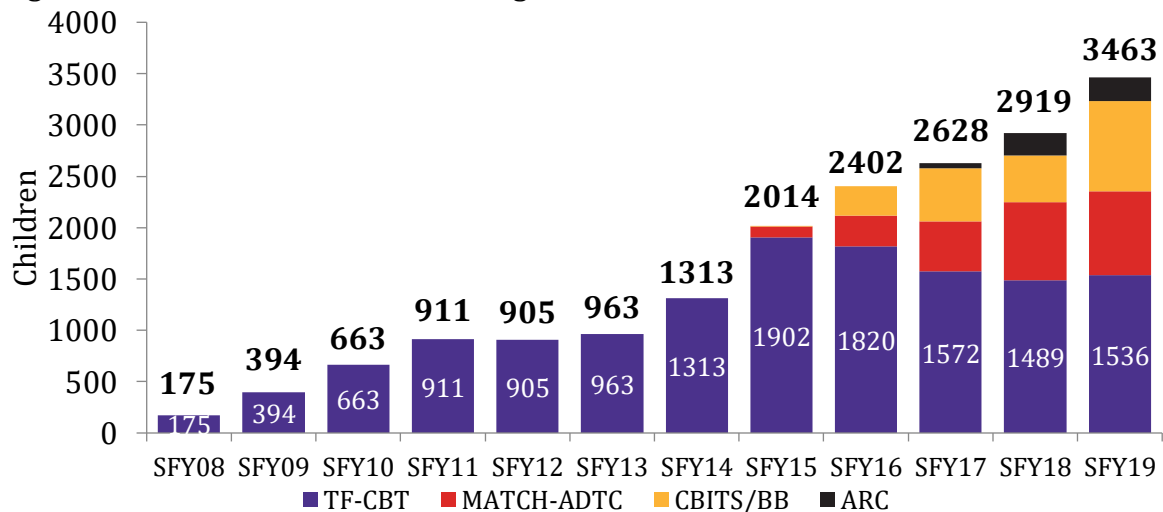
TF-CBT clinicians often are trained in and practicing other evidence-based treatment (EBT) models. In FY19 clinicians were most likely to be trained in MATCH-ADTC with 67 clinicians (22.8%) active in both models. The next most common model TF-CBT clinicians were also implementing was ARC (30 Clinicians). Relatively few TF-CBT clinicians practiced 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 recognizes the complexity of managing multiple models with fidelity. The integration of multiple models has increased the number of children receiving an EBT each year.

## Access: Children Receiving TF-CBT

In FY19, 1,536 children received TF-CBT; this number included 912 children who began TF-CBT during the year. The number of children receiving TF-CBT (and other EBTs) over time is illustrated in Figure 2 below. To date, 9,835 children have received TF-CBT since 2007. The number of children receiving TF-CBT increased 4.4% from FY19. This increase happened even though, as noted previously, the number of active TF-CBT clinicians decreased by 4.7% over the same time period.

As shown in Figure 2, the number of children receiving other EBTs (e.g., MATCH-ADTC, ARC) has increased in the past several years. Further, as noted in the previous section, many TF-CBT clinicians are also trained in these additional models and are able to provide multiple EBTs to the children on their caseloads. Even with the increase in the rates of other EBTs, TF-CBT remained the most common EBT used in the outpatient setting.

Figure 2. Number of children receiving EBTs over time



## Demographics and Characteristics of Children Receiving TF-CBT

Table 3 on the next page provides descriptives for children receiving TF-CBT in FY19, 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.

Males, accounting for almost 40% of TF-CBT cases, were relatively underrepresented compared to the outpatient and general CT population. 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.

The mean age of children receiving TF-CBT is 11.93 years (SD=3.58). 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 five was small (6.2%) it was even smaller for those receiving TF-CBT (1.3%). TF-CBT can be used with children as young as three but it is used much less frequently with the youngest children. The introduction of another trauma-focused EBT applicable to young children, Attachment, Self-Regulation, and Competency (ARC) may have affected the number of younger children receiving TF-CBT. However, it is worth understanding how effective treatments can more frequently be used with children five and under.

While comparisons to the general child population of CT were not available for DCF-involvement, TF-CBT was provided to children involved in the child welfare system (36.0%) at double the rate of overall outpatient treatment (18.1%).

Table 3. Characteristics of children receiving TF-CBT (n=1536) with comparisons

	TF-CBT		OPCC <sup>4</sup>	Child pop <sup>5</sup>
	n	%	%	%
Sex (Male)	609	39.8	55.0	51.2
Race				
Black or African American	252	16.4	15.2	12.4
Hispanic, Latino, or Spanish <sup>6</sup>	632	41.1	43.3	24.1
White	589	38.3	36.0	54.9
Other Race/Ethnicity	63	4.1	5.6	16.4
Age				
Under 5 years	20	1.3	6.2	24.5
5-9 years	401	26.7	36.3	26.3
10-14 years	650	43.2	39.0	30.2
15-17 years	432	28.7	18.5	19.0
Child welfare involvement during treatment	553	36.0	18.1	N/A
JJ involvement during treatment	56	3.6	N/A	N/A
Child primary language				
Spanish	80	5.2	12.9***	14.2
Neither Spanish nor English	10	0.7	1.3	7.7
Caregiver speaks English(no)	104	6.8	N/A	N/A

<sup>4</sup> OPCC data comes from DCF's PIE system and includes children that received TF-CBT; therefore differences between TF-CBT and OPCC may be of a greater magnitude if looking at OPCC excluding those receive TF-CBT.

<sup>5</sup>American Community Survey 2017 1 year estimates. Caution should be used with comparison to OPCC and TF-CBT child demographics. Census race categories exclude Hispanic ethnicity only for White children while TF-CBT and OPCC race categories exclude Hispanic regardless of race. Census language is only available by language spoken, not primary language. Age is percentage of children 0-17 years.

<sup>6</sup> We recognize there are alternate terms for describing ethnicity. This report uses "Hispanic" and "Latino" to remain consistent with the way it is reported in the data system, which reflects the terminology in the U.S. Census.

### **Clinical Characteristics at Treatment Start**

Information on baseline assessments for children receiving TF-CBT is found in Table 5. 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 CESD-R which is a report of caregiver depression. Two in five (41.3%) caregivers report clinically high depression scores at baseline.

**Trauma Exposure.** Children report experiencing an average of 7.25 types of potentially traumatic events; caregivers report that their children have experienced 6.03 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. One trend worth noting is Black non-Hispanic ( $\beta = 0.67, p = .049$ ) and Other non-Hispanic ( $\beta = 1.44, p = .023$ ) children report higher rates of exposure to traumatic events compared to White and Hispanic youth. This trend was seen only on the children report but not the caregiver report. 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. However, the additional discrepancy specifically for these two groups is important for understanding how children engage in treatment. Reports of trauma exposure are associated with baseline symptoms as well as successful completion of the model (analyses detailed later), which ultimately affects outcomes for children. Elevated exposure and potential discrepancies between child and caregivers are indicators that can be noted early on by clinicians and might inform early treatment engagement strategies.

**Baseline Symptoms.** Nearly all children (99.3%) 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 (85.8%) had clinically high symptoms in at least one symptom area (depression, posttraumatic stress, internalizing/externalizing behaviors) or impairments in functioning. Figure 3 shows the rates of elevations graphically by measure and reporter. In general, children were more likely to be in the clinical level of depression (62.1% to 76.9%) and trauma symptoms (42.6% to 67.3%) than on problem severity or functioning (21.5% to 40.0%). This suggests that some measure of trauma symptoms or depression symptoms is useful in guiding TF-CBT treatment. Children experienced clinically high symptoms across multiple areas; on average, children were clinically high in 2.11 ( $SD = 1.3$ ) out of the four symptom areas. This tendency to have elevated scores across domains is what underlies the thorough intake assessment battery that allows for case conceptualization and planning. Once treatment begins, clinicians select a domain to focus on and continue to assess progress with fewer measures.

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.

Caregiver reports of the severity of trauma ( $\beta = -3.880, p = .049$ ) and depression symptoms ( $\beta = -2.90, p = .007$ ) were lower for Black children compared to White non-Hispanic children. This relationship controls for trauma exposure, where it was noted above that caregivers for Black children reported lower rates of exposure compared to child report. Another trend observed was that regardless of race/ethnicity, child-reported symptoms tended to be lower for males than females for both trauma ( $\beta = -2.885, p = .023$ ) and depression symptoms ( $\beta = -2.919, p < .001$ ).

Given the important role of child engagement and caregiver investment in TF-CBT treatment, these findings are important to share with providers and discussed as to how clinicians might modify how assessments are administered and then shared with families. If the child or caregiver does not see the symptoms as significant or do not feel comfortable reporting on sensitive matters, they might be less likely to see the value in continuing with treatment. If clinicians can observe these trends and start to better understand why certain groups have different patterns of reporting, it is possible that there might be modifications to how and when assessments are done, how they are explained to families before administrations as well as how results are shared. Improvements in baseline assessment practices would benefit all children and families starting TF-CBT treatment.

Figure 3. Percentage of children with clinically high score

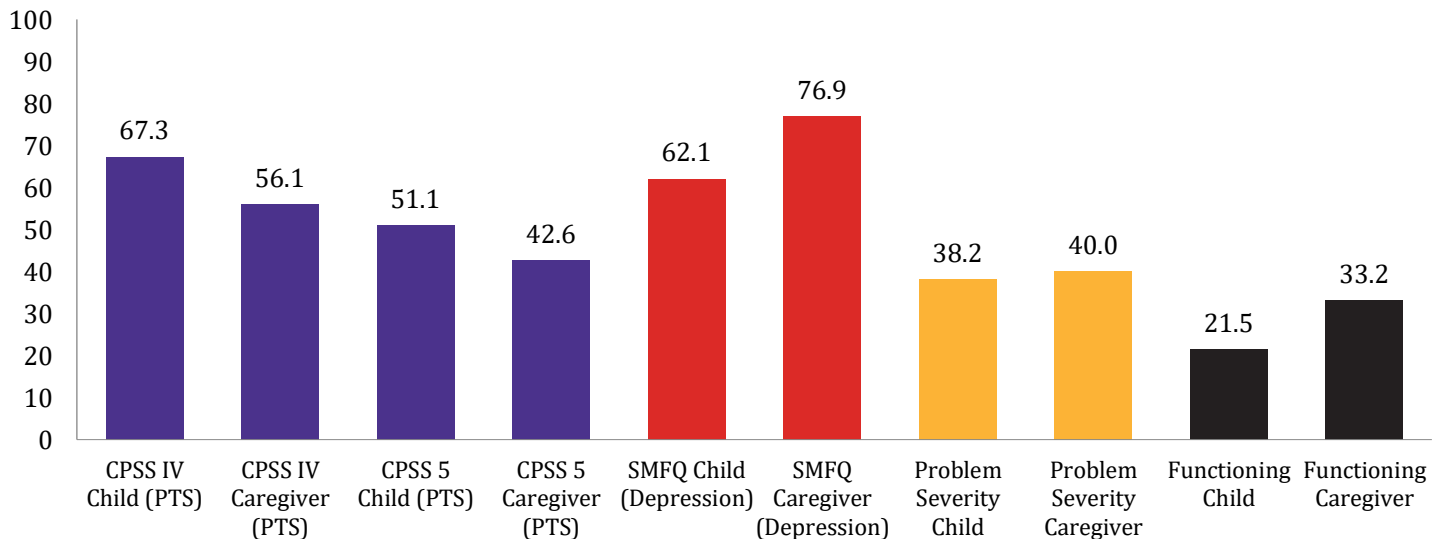


Table 4. Child and caregiver clinical assessment scores at intake

Measure	Construct	n	Child Report			n	Caregiver Report		
			Mean	SD	Elevated* n (%)		Mean	SD	Elevated* n (%)
THS sum	Exposure to potentially traumatic events	1,453	7.25	3.36	-	1,262	6.03	2.86	-
CPSS-IV Total Score	Traumatic stress	776	21.39	10.70	52 (67.3)	718	17.93	10.56	403 (56.1)
Re-experiencing Subscore	symptoms	-	6.06	3.79	-	-	5.17	3.84	-
Avoidance Subscore		-	8	5.09	-	-	6.37	4.89	-
Arousal Subscore		-	7.33	3.85	-	-	6.4	3.80	-
CPSS 5 Total Score	Traumatic stress	660	32.3	16.90	337 (51.1)	538	28.19	16.04	229 (42.6)
Re-experiencing Subscore	symptoms	-	7.73	5.01	-	-	6.63	4.73	-
Avoidance Subscore		-	4.29	2.54	-	-	3.65	2.68	-
Cognition & Mood Subscore		-	10.29	7.20	-	-	9.61	6.75	-
Hyperarousal Subscore		-	9.99	5.34	-	-	8.3	5.15	-
SMFQ Total Score	Depressive symptoms	1086	10.22	6.42	674 (62.1)	930	9.7	6.13	689 (76.9)
Ohio Problem Severity	Severity of child	870	23.18	15.78	332 (38.2)	1224	23.23	15.09	489 (40.0)
Internalizing	behaviors	93	11.92	10.66	-	124	11.65	8.16	-
Externalizing		93	11.11	8.20	-	124	12.05	8.90	-
Ohio Functioning	Child's adjustment and functioning	870	54.02	14.46	187 (21.5)	1224	49.62	14.72	406 (33.2)
CESD-R	Caregiver's own depressive symptoms	-	-	-	-	801	15.6	13.77	331 (41.3)

### **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 justice-involved youth in Connecticut 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 FY19, 613 justice-involved youth were screened for trauma by probation officers and LYNC staff using the CTS. Of those screened, 69% reported exposure to traumatic events, underlining the high rates of trauma exposure among justice-involved youth and the importance of trauma screening for this population. Of those youth with identified trauma exposure, 30% were referred for treatment services including TF-CBT, other mental health services, and in-home services. During the fiscal year, 56 justice-involved youth received TF-CBT services, with 83% partially or successfully completing treatment and 88% reporting satisfaction with treatment. Justice involved youth receiving TF-CBT in FY19 experienced clinically significant reduction in their PTSD and Depression symptoms, with a mean reduction of 10.5 points on PTSD assessments and a mean reduction of 3.7 points on Depression assessments. See Appendix C for more information on the work with CSSD and CTS screening and TF-CBT treatment.

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 36.0% of those receiving TF-CBT, only 3.6% 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.

## **Quality: Consultation and Clinical Implementation**

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

### **Implementation Consultation**

This year, 100 in-person visits and 33 formal follow-up telephone consultations<sup>7</sup> were completed. The typical agenda for these on-site meetings is to review the agency performance on recent reports (e.g., QI report, monthly dashboards). See Appendix D for the June monthly dashboard that shows information from FY19 and Appendix E for QI report. CHDI creates the QI Report twice annually with quarterly updates on progress towards meeting the benchmark for each QI indicator. The cross-model dashboards provide monthly and cumulative information on clients served. From this review of data, SMARTER 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 four 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 share with one another and bring best practices around TF-CBT and other EBTs back to their agencies.

### **Data Systems to Support Implementation**

Most of the data used in consultation with sites is collected through DCF's secure web-based EBP Tracker data system. To support clinicians and ensure we have timely, accurate, and usable data the Coordinating Center maintains a Help Desk that has fielded over 900 requests from users since it was opened at the start of FY19. EBP Tracker also provides reports intended to be used by clinicians and teams to help them monitor and track their progress toward goals in between contacts with CHDI.

In FY19, four new reports were developed in the system based on needs expressed by providers. The Monthly Volume Report made it easier for providers to understand the number of new cases, closing cases, and visits in the month to monitor case flow as well as consistency of care. The Assessments Over Time by Demographic enhanced a prior report to allow breakdowns by demographic groups including by race/ethnicity, sex, and age when looking at change scores on assessments. Additionally, two cross-model reports were developed. The Cross-Model Point in Time report shows key data points (intakes, discharges, completed cases) broken out by model for easy comparison across multiple

---

<sup>7</sup> This does not include additional, unscheduled telephone calls that routinely take place relating to a range of issues such as training, data, system access.

EBTs. The Cross-Model Trend report allows agencies to look at trends over a calendar year in number of children served (intakes, discharges, completions), broken out by model. Together these reports allow agencies to: better monitor cross-EBT work, provide better ways to track service trends, and easily monitor outcomes across demographic groups.

### **Assessment Changes Affecting Implementation**

An additional important change in this fiscal year was the introduction and full implementation of the EBT flexible assessment schedule. Changes to assessment schedules for all EBTs were made to address concerns about the number of required assessments as well as to have a cross-EBT assessment process that allows treatment to be driven based on baseline assessment data. Under this new process, all children evaluated for an EBT completed a core set of assessments. Based on these scores, clinicians selected a primary EBT measure (in addition to the Ohio's) to use to track treatment progress. For TF-CBT, children used to be assessed on PTSD and depressive symptoms, from both child- and caregiver-reports, resulting in four EBT specific assessments every 90 days. Under the new system, they could select one of these, which greatly reduces the assessment burden.

### **Episode Description**

Children completing TF-CBT attended a mean of 18.8 (SD=16.54) sessions with a mean treatment episode length of 6.85 (SD=4.58) months. This is slightly higher than the recommended expectation of completing TF-CBT in 12- 16 sessions. Newer clinicians often do need additional sessions to complete TF-CBT. Of the 18,964 TF-CBT sessions provided in the fiscal year, 62.0% were completed with children only, 24.7% were with caregiver and child together, and 13.3% 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% of sessions had caregiver involvement, exceeding the benchmark by five percentage points.

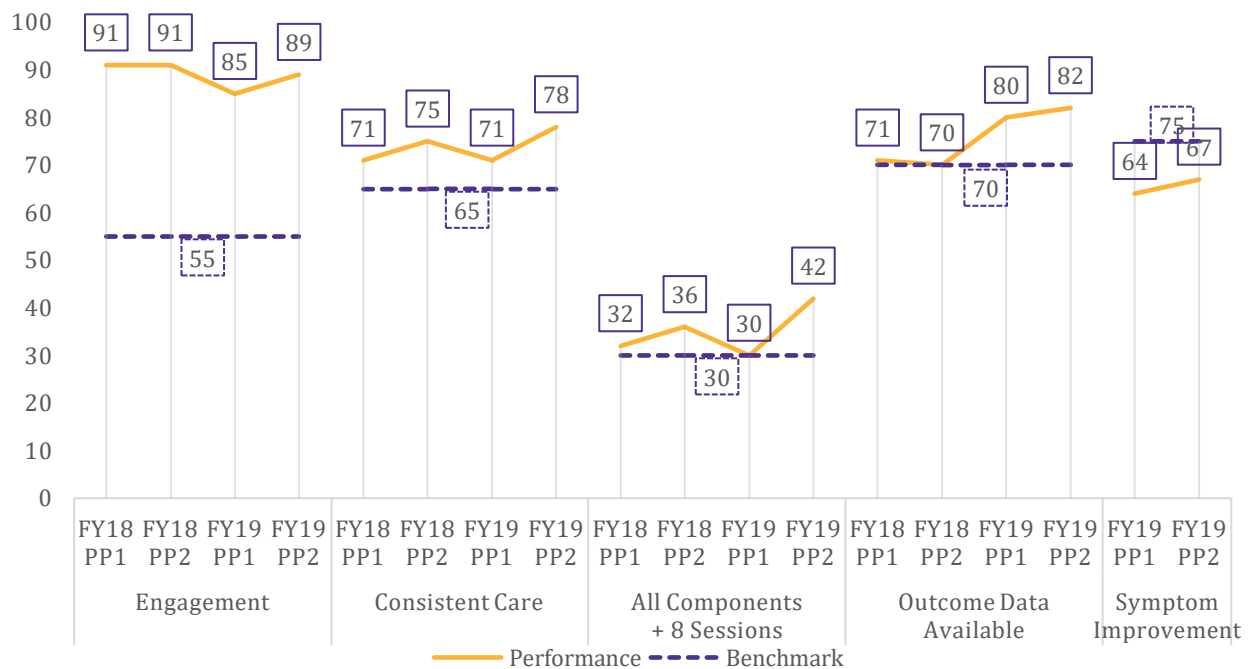
### **Quality Improvement Indicators**

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 often are the focus of the goals set during consultation visits. The definition and explanations of each of the 5 QI indicators and the prepared reports showing each provider's results over the two FY19 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.

Symptom improvement calculations changed in FY19 so it is not comparable to previous years. With the introduction of the flexible assessment schedule, the percentage of children with outcome data has increased. Prior to the flexible assessment schedule, children were assessed on four EBT-specific measures which were explicitly tied to trauma and depression symptoms, which TF-CBT has demonstrated effectiveness in lowering. Under the new assessment rules there are simply fewer chances to improve and only one required measure of trauma or depression symptoms.



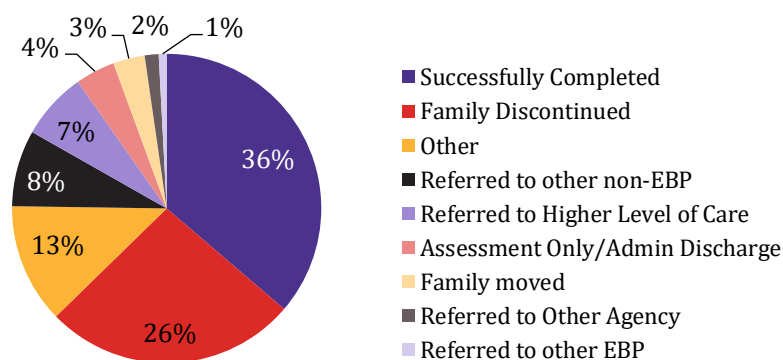
Figure 4. QI indicators in FY 19



### Discharge Reason

During the fiscal year, 965 children ended their TF-CBT treatment episode. Clinicians rated one in three 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 6). Binary logistic regression analyses were conducted to determine which factors were associated with successful discharge. Results are reported in Table B4 in Appendix B. Findings show that Black ( $\beta = -0.855, p < .001$ ) and Hispanic children ( $\beta = -.380, p = .023$ ) were less likely to successfully complete compared to their White peers.

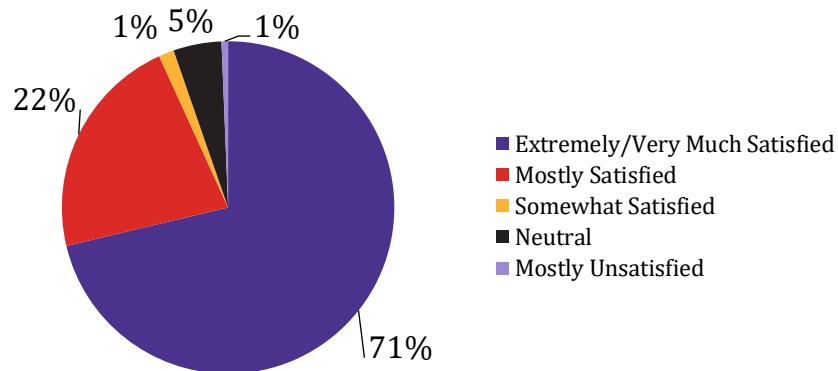
Figure 5. Reasons for discharge in FY19



## Satisfaction

Caregivers report high levels of satisfaction with TF-CBT treatment. In FY 19, there were 364 Caregiver Satisfaction Questionnaires (CSQ) completed, and 108 Ohio Caregiver Satisfaction forms completed. For the CSQ, the responses to both measures are illustrated in Figure 7 below with 93% of those completing the CSQ indicating mostly or very satisfied with treatment and 92% of those completing the Ohio Caregiver Satisfaction indicating mostly or very satisfied with treatment. 82 children completed the Ohio Child Satisfaction measure; 89% of these children indicated that they were mostly or very satisfied with treatment.

Figure 6. Caregiver Satisfaction<sup>8</sup> with Treatment, FY 19



<sup>8</sup> Ohio Caregiver (n=108) does not have a neutral option.

## **Outcomes: Improvement for Children Receiving TF-CBT**

### **Assessments Used, RCI, & Flexible Assessment Schedule**

Children receiving TF-CBT are assessed with a variety of measures selected to provide information on trauma history and severity of symptoms. At intake, children and their caregivers are each asked to complete the Trauma History Screen (THS), a measure of trauma symptoms, and a general behavioral measure appropriate to the age and symptoms of the child.

Each of the measures is listed along with the construct it measures and a summary of intake and discharge scores in Table 7 below. Also indicated in the table, where applicable, are the numbers of children whose score placed them in the clinical or critical range on a particular measure at intake and how many of those had moved out of that range by the last assessment. Change scores are given for each measure broken out by these two groups (those who started in the clinical range and those that did not). This is an important factor in examining change scores because greater change is possible and expected for children who enter with higher scores.

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

Symptom reduction can be assessed for trauma symptoms, depression symptoms, problem severity, or functioning. Each of these dimensions can have both a child and a caregiver report. When presenting symptom reductions, we use two methods to summarize changes. The overall change scores, using t-tests, are presented as a general measure of significant shifts across all children served from intake to discharge. These are represented in the change scores in Table 3 above. Additionally, the Reliable Change Index (RCI) is also used. The RCI assigns a measure-specific point reduction threshold that represents significant change. An overview of the RCI with explanations on how and why it is used as well a table of relevant values by measure is included in Appendix F.

### **Rates of Outcome Data**

Three in four children (72.7%) discharged from TF-CBT in the fiscal year had at least one first and last version of a child symptom assessment (child or caregiver reporter). Two in five (40.5%) 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. Findings show that children were less likely to have assessment outcome data if there were higher child-reported trauma exposure scores ( $\beta = .089, p = .009$ ) at baseline. Black youth were less likely ( $\beta = -0.541, p = .042$ ) to have outcome data compared to their White peers. A better understanding of who is assessed and why some groups are more or less likely to have outcome data is needed.

### **Symptom Improvement**

Children experienced significant reductions in trauma, depression, and problem severity symptoms as well as significant gains in functioning (see table 5). 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 depressive symptoms.

Table 5: 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=913)	Count of child exposure to potentially traumatic events	n/a	7.16 (3.38)	n/a	n/a	n/a	n/a
THS Caregiver (n=804)		n/a	6.10 (2.87)	n/a	n/a	n/a	n/a
CESD-R (n=387)	Caregiver Depression	162 (41.9%)	15.42 (13.57)	9.51 (11.27)	-5.91**	9.31	100/162 (61.7%)
CPSS IV Child (n=474)	Trauma symptoms	311 (65.6%)	20.97 (10.73)	11.69 (10.22)	-9.28**	17.69	186/311 (59.8%)
CPSS IV Caregiver (n=416)		233 (56.0%)	17.8 (10.59)	10.49 (9.14)	-7.31**	13.92	144/233 (61.8%)
CPSS 5 Child (n=118)		51 (43.2%)	28.79 (16.64)	16.92 (14.85)	-11.87**	8.45	36/51 (70.6%)
CPSS 5 Caregiver (n=93)		34 (36.6%)	27.08 (16.74)	16.7 (16.20)	-10.38**	6.52	20/34 (58.8%)
SMFQ Child (n=503)	Depressive symptoms	296 (58.8%)	9.63 (6.19)	5.48 (5.34)	-4.15**	14.73	180/296 (60.8%)
SMFQ Caregiver (n=436)		n/a	9.43 (6.12)	5.87 (5.58)	-3.56**	11.54	n/a
Ohio Problem Severity Child (n=352)	Severity of internalizing/externalizing behaviors	124 (35.2%)	21.51 (14.45)	15.43 (13.64)	-6.08**	9.09	73/124 (58.9%)
Ohio Problem Severity Caregiver (n=503)		187 (37.2%)	22.35 (14.16)	15.67 (13.59)	-6.68**	11.13	104/187 (55.6%)
Ohio Functioning Child (n=352)	Child's adjustment and functioning	64 (18.2%)	55.5 (14.33)	60.11 (12.71)	4.61**	-6.11	42/64 (65.6%)
Ohio Functioning Caregiver (n= 436)		166 (38.1%)	49.98 (14.43)	55.84 (14.19)	5.86**	-8.93	98/166 (59.0%)

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

### Children Improve Across Multiple Domains

Children receiving TF-CBT were assessed initially on four domains, each with child and caregiver report versions. Caregivers were assessed with one measure of their own depression (CESD-R). 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 8 below shows the relative rates of improvement across the measures. The greatest change was in post-traumatic stress symptoms.

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 (59.5%) and children report (61.0%) experienced trauma symptom reduction across CPSS versions IV and 5. Comparatively, 74.6% of children with elevated child-report at baseline and 76.8% 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/internalizing) symptoms, and functioning impairments.

Figure 7. Percent of children with symptom reduction, PTSD and depression

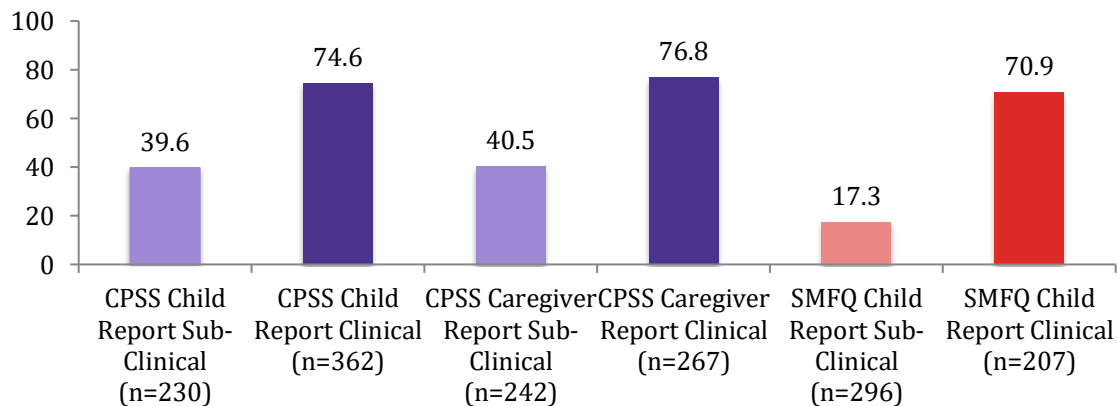


Figure 8. Percent of children with Ohio problem severity reduction

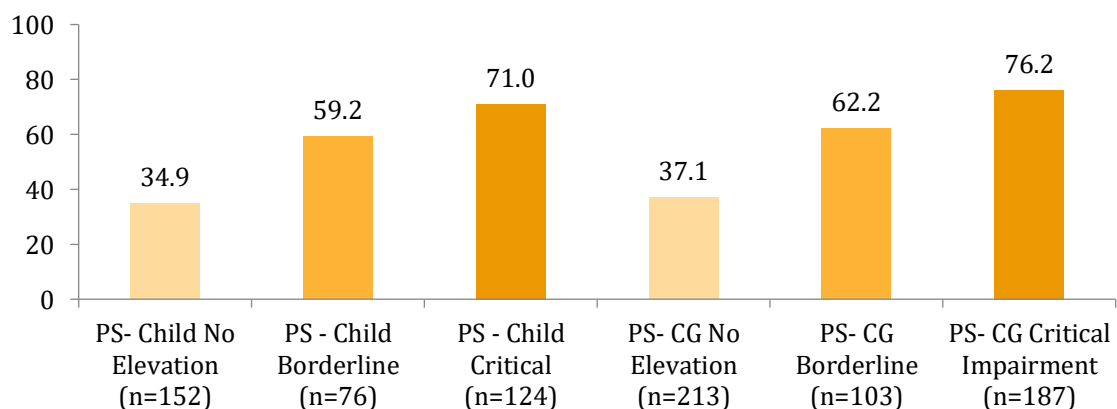
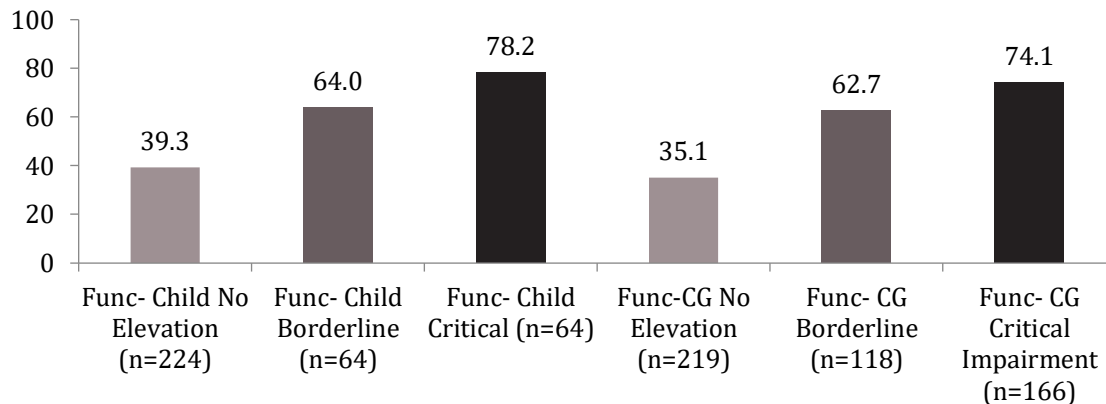


Figure 9. Percent of children with Ohio functioning improvement



### 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 scores<sup>9</sup> (PTS, depression, problem severity, and functioning), controlling for initial scores, successful completion of the model, and trauma exposure. Age, race/ethnicity, and sex were all found to significantly affect child symptom outcomes, although these effects were not consistent across symptom measures. Additionally, trauma exposure, successful discharge, and baseline scores were shown to have an effect on outcomes. Details of the tests are in Appendix B (Tables B6 and B7), significant findings are presented here.

**Age & Sex.** Only discharge functioning scores were found to be significantly related to age or sex where child-reported functioning scores were lower for older children ( $\beta = -0.396, p = .024$ ) and lower for males according to caregiver-report ( $\beta = -3.874, p = .001$ ).

**Race/Ethnicity.** Generally, there were not significant differences and outcome scores were equitable across racial/ethnic groups. Race was associated with discharge scores only in a few instances. Specifically, Black children had better functioning ( $\beta = 4.424, p = .006$ ) and problem severity outcomes ( $\beta = -3.843, p = .012$ ) according to caregiver-reported measures, and better depression outcomes ( $\beta = -1.379, p = .024$ ) according to child measures. However, caution should be used in interpretation because successful discharge also affects outcomes and Black children were less likely to successfully complete TF-CBT compared to their White peers.

<sup>9</sup> 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. The number of children receiving TF-CBT increased this year, after three years of slightly declining numbers. The number of children receiving TF-CBT has remained relatively consistent since FY17, despite growth in the availability of other EBTs such as MATCH-ADTC and ARC. Even as the number of children receiving other models has increased, TF-CBT has remained the most common EBT used in outpatient settings.

Children who begin TF-CBT treatment have significant exposure to potentially traumatic events, with an average of 6 to 7 events endorsed by child and caregiver report, respectively. Symptoms are assessed on a number of domains and 85.8% of children are above the clinical cut-off on at least one domain, most commonly trauma symptoms or depression. Children who receive TF-CBT are similar to children served in the broader outpatient setting in terms of sex and race/ethnicity. Children in TF-CBT are almost twice as likely to have DCF involvement than children receiving general outpatient care.

Very young children, those 5 and under, are the least likely to receive TF-CBT. These younger children make up a relatively small portion of outpatient episodes (6.2%) and it is not certain how many of these children would have trauma exposure and benefit from trauma treatment. However, clinicians often express hesitation to start TF-CBT with young children even though the age range for the model goes down to three. While there are other models available for young children (ARC as mentioned previously and Child Parent Psychotherapy which is starting in Fall 2019), TF-CBT has the largest number of trained clinicians and is at the largest number of agencies. Providing additional support to TF-CBT clinicians in delivering the model to young children would ensure children have access to the services they need even at young ages.

TF-CBT is delivered with fidelity and quality is consistently monitored. Most children who begin TF-CBT initially engage in treatment with 85% to 89% making it to at least four sessions. The average number of sessions is 18.8, which is slightly higher than the recommended 12-16 sessions. Caregivers are involved in 38% of sessions, slightly above the expectation that 33% of session time be spent with the caregiver. A focus over the past two years has been on consistency of visits, and 78% of TF-CBT cases in the most recent reporting period averaged at least 2 sessions a month (at least every other week) during the course of their treatment. The percentage of children who make it through the entire model has risen over recent reporting periods and was most recently at 42% (exceeding the benchmark of 30%). Children and caregivers both report satisfaction with treatment at high rates, 89% and 92% respectively.

Despite the steady progress on a number of quality indicators, there is room for improvement. In FY19, 36% of children ended their episode by successfully completing the model. The others left for other reasons, most commonly the family discontinuing treatment (26%). Further, these rates of premature attrition were associated with race and ethnicity, with both Black and Hispanic youth less likely to complete than their White

counterparts. Similarly, rates of having outcome data are high overall (82% at the last period), but Black children are less likely to have outcome data. In looking at the TF-CBT clinician demographic data, fewer Black, Hispanic, or male clinicians are currently practicing TF-CBT relative to the rates of those demographics among children receiving TF-CBT. While Black children represent 16.4% of the children receiving TF-CBT, only 8.5% of TF-CBT clinicians are Black. These trends warrant follow-up to ensure that all children are receiving the services they need that are sensitive to their background and experience.

Rates of improvement in symptoms is high, with the highest rates of improvement observed on traumatic and depression symptoms. Of children beginning treatment with clinically elevated trauma symptoms, 74.6% improved according to child report and 76.8% improved by caregiver report. Reductions in depression symptoms and problem severity, as well as increases in functioning, were of similar magnitude. These demonstrated improvements are documented even with the introduction of the flexible assessment schedule which reduced the number of EBP-specific measures used on an ongoing basis by 75% (from four to one). When examined for difference across racial/ethnic groups, outcomes were largely similar. The only significant trend was that Black youth actually reported comparatively stronger outcomes, with lower rates of depression by child report, lower rates of problem severity by caregiver report, and higher rates of functioning by caregiver report. While positive, these findings should be interpreted with caution given that this group is less likely to complete treatment or have sufficient data to be included in outcomes. However, it does appear that when Black youth are successfully engaged in treatment they benefit at rates similar to, or even greater than, their White peers.

The bilingual TF-CBT clinician group established this year could be a resource for the network of providers in addressing the trend of Hispanic youth leaving treatment early. This group has already established a resource sharing method with one another. Continuing to support their efforts, and potentially establishing a formal connection from their group to the EBT Coordinator meeting, would use the existing expertise within our provider network to improve practice for all clinicians working with families that speak Spanish or have a Hispanic or Latinx background.

The trends observed in data are areas for development and could be the focus of additional future training opportunities. Information on the patterns across groups, based on demographics but also types of symptom elevations, can help TF-CBT clinicians better use intake assessment and early sessions to match treatment to client needs. As the number of clinicians starting TF-CBT remains consistently high and those trained in past years continue to seek additional training in the model, there are opportunities to address topics within the current training structure. Case conceptualization, using both assessment data and information on the experiences of the individual child and family, has become more of a focus. Cultural-sensitivity has already been a topic increasingly talked about in new clinician training and in consultation calls. This has largely focused on understanding the values and experiences of each individual family to help tailor treatment to their specific family culture. Additional trainings on cultural understanding and sensitivity could be implemented to provide strategies and support to providers to ensure all youth are receiving services that meet their needs.



## **Recommendations**

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

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

- Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity and health equity, TF-CBT with young children, and use of assessments; a series of half-day trainings on these topics could take the place of advanced clinical trainings in FY2020
- Continue to 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
- Develop consultation strategies that help agencies and clinicians document treatment progress while also reducing the number of assessments expected
- Assist agencies in their efforts to modify internal data processes with the integration of EBP Tracker and Provider Information Exchange (PIE)
- The integration of PIE and EBP Tracker allows for TF-CBT information to be linked to a child's full outpatient episode; this data can be used to better understand how and when children receive TF-CBT and its effectiveness compared to other models or treatment as usual
- Share data findings from this report with the provider network to better understand factors that may influence engagement, drop out, or differences in symptom reduction
- Engage in conversations with DCF, CSSD, and providers to develop a plan for ensuring youth involved in the juvenile justice system have access to and utilize TF-CBT treatment in outpatient clinic settings
- Develop data reports that can be used in site-based consultation to help agencies monitor the progress of clients overall as well as broken out by subgroups that were identified in this report as having specific trends in implementation and outcomes (e.g., baseline symptom for males compared to females, early treatment termination for racial/ethnic groups)
- Continue to collect relevant financial data and support adequate reimbursement rates for the implementation and sustainability of TF-CBT and other EBTs

### **2. System:**

- Ensure the functionality for collecting TF-CBT treatment information in Provider Information Exchange (PIE) supports real-time built-in reports, ongoing collection of fidelity information during treatment, and accurate and usable session dosage data
- 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

- Provide culturally and linguistically appropriate clinical tools in electronic format (e.g., assessments in Spanish built into PIE).
- Update terminology used in PIE (e.g., sex assigned at birth; Latino) to collect demographic information that complies with current best practices (e.g., gender identity; Latinx)
- Expand collection of zip codes to nine digits in PIE to strengthen opportunities to merge PIE data with external data sources (e.g., Area Deprivation Index) to examine health disparities and inequities
- Provide training and support on in-session use of electronic assessments and concurrent documentation to ensure clinicians can use treatment data actively and share it with families
- Continue funding performance-based sustainment funds to improve capacity, increase access, and ensure quality of care; these incentives are intended to partially offset the increased agency costs of providing an 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
- Continue work the Coordinating Center began this year to disseminate, support, and integrate EBTs beyond TF-CBT. This work, which now includes OPCC quality improvement support, 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). The lessons learned from over a decade of implementation of TF-CBT strengthens and enables this work.
- Embed the cross-system work of TF-CBT, along with data on utilization and outcomes, within relevant statewide committees and councils, including but not limited to: the Behavioral Health Plan Advisory Board; the Juvenile Justice Policy and Oversight Committee (JJPOC); and the Behavioral Health Partnership Quality Access and Policy Subcommittee.

### **3. Providers:**

- Develop sustainability plans and provide clinical staff the needed consultation for implementation of 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
- Modify implementation plans to accommodate changes brought on by the integration of EBP Tracker and PIE
- Agency Senior Leaders report the inadequacy of provider incentives to cover the cost of providing evidence-based practices, and need to continue to advocate for adequate reimbursement rates to sustain EBTs
- Conduct a further review of the CPSS 5 assessment data and develop a plan to increase the overall rates of the symptom improvement quality indicator

## **Appendix A: Activities and Deliverables**

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

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

- Our internal national trainer provided three clinical trainings in August 2018, November 2018, and March 2019. Fifty-six new clinicians were trained.
- Contracted with a national trainer to provide a 1-day TF-CBT Advanced clinician training attended by 20 credentialed clinicians.
- Initiated one day TF-CBT Booster training for previously trained clinicians. Four Booster training sessions were conducted and attended by 74 clinicians.
- Completed 7 series of clinical consultation calls (84 total calls) for 73 clinicians.
- Two additional call groups for 15 new clinicians began in FY19 and have completed seven of their calls.
- Seven TF-CBT Bilingual clinicians attended Spanish language TF-CBT training through an initiative at Bay State Medical Center.
- Coordinated registration, attendance, and CEUs for New Clinician Training (61 participants) and the consultation call groups (88 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; 192 active clinicians were either Connecticut credentialed or nationally certified by the end of FY 19
- Distributed \$1,600 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 19 there were 353 active clinicians
- Prepared regular training and case data tables for each provider with updates on individual clinician credentialing status
- Convened tenth annual statewide EBP Conference, an evolution of the original TF-CBT Conference, for 456 participants from community providers, DCF, CSSD staff, and other partners in the initiative. Thirty-nine presentations and 38 mini sessions were offered at the conference

### **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
- Performance Improvement Plans were developed with two low-performing agencies
- Provided 100 in-person implementation consultation support visits and 33 phone calls with providers to ensure sustainment of high quality services
  - Supported 2 new private practice providers that applied to begin implementation of TF-CBT
  - One agency provider discontinued TF-CBT services due to staff changes and one private practice discontinued providing services to children to focus on adult clients
- Implemented and convened 4 Coordinator meetings focusing on sharing implementation and successful meeting strategies
- Implemented and convened meeting for bilingual TF-CBT clinicians that was attended by 27 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
- Implemented flexible assessment schedule including the addition of the CPSS-5 in EBP Tracker. The CPSS-5 is the most recent version of this assessment that measures trauma symptoms.
- Distributed Spanish and Portuguese versions of the CPSS-5 to all clinicians
- Additional reports available in EBP Tracker: How Much Do We Do – Monthly Volume Report, Is Anyone Better Off? – Assessments Over Time by Demographic, Cross Model Point in Time, Cross Model Trend, Training Cohort Report, Training Counts Report.

### **3. Data Systems**

- Continued development and maintenance of a secure, HIPAA compliant, online database (EBP Tracker) that meets the needs of the increasing number of TF-CBT providers and the children and families they serve
- Oversaw the migration of EBP Tracker to DCF's servers, which reduced hosting costs for the system and brought EBP Tracker onto the same platform as Provider Information Exchange (PIE)

- Built a “bridge” between PIE & EBP Tracker so that identified data fields can push from PIE to EBP Tracker for matched cases, reducing the burden of duplicate data entry in the two systems
- EBP Tracker provides real-time scoring and reports of individual client assessments and progress, more timely and accurate data for providers and stakeholders, includes CBITS, Bounce Back, ARC, and MATCH-ADTC access and has the capacity for additional EBT models to be included
- Continued improvements to EBP Tracker have been made based upon agency feedback and as possible with available funding
- Maintained a public directory site that provides a searchable, public listing of TF-CBT providers through EBP Tracker ([tinyurl.com/ebpsearch](http://tinyurl.com/ebpsearch))
- Monitored, maintained, and provided technical assistance for online data entry for all TF-CBT providers
- Provided site-based data assistance and reports as requested
- Implemented [ebptrackerhelpdesk](#). Since its creation, the helpdesk completed over 900 requests in FY 2019.

#### **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 \$488,554 in performance-based sustainment funds to agencies (44.4% of total contract funds)

## Appendix B: Regression Tables

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

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	2.883	0.478	(1.945, 3.820)	4.746	0.431	(3.900, 5.592)
Hispanic	-0.004	0.249	(-0.492, 0.484)	-0.102	0.224	(-0.543, 0.338)
Other Nonhispanic	1.442*	0.631	(.203, 2.680)	1.088	0.569	(-0.030, 2.206)
Black Nonhispanic	0.658*	0.334	(0.002, 1.314)	-0.088	0.301	(-0.680, 0.504)
Age at intake	0.335**	0.035	(0.266, 0.403)	0.132**	0.031	(0.070, 0.194)
Sex	-0.195	0.230	(-0.647, 0.257)	-0.347	0.208	(-0.754, 0.061)
<i>R</i> <sup>2</sup>	0.124			0.030		
<i>F</i>	21.417			5.716		

\* 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 4 Child			1st Depression Score, SMFQ Child		
	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>
Intercept	66.789	5.692	(55.585, 77.994)	9.686	5.951	(-2.028, 21.401)	4.640	3.761	(-2.764, 12.043)	4.358	2.242	(-0.056, 8.7772)
Hispanic	-1.148	1.942	(-4.970, 2.674)	-2.263	2.030	(-6.259, 1.733)	-0.437	1.283	(-2.962, 2.088)	-0.034	0.765	(-1.540, 1.471)
Other Nonhispanic	-3.015	5.515	(-13.870, 7.840)	-0.556	5.766	(-11.906, 10.793)	1.930	3.644	(-5.242, 9.103)	3.247	2.712	(-1.029, 7.523)
Black Nonhispanic	-0.028	2.853	(-5.644, 5.589)	4.505	2.983	(-1.367, 10.377)	0.956	1.885	(-2.754, 4.667)	-1.283	1.124	(-3.495, 0.929)
Age at intake	-0.487	0.374	(-1.223, 0.248)	0.613	0.391	(-0.156, 1.382)	0.800**	0.247	(0.314, 1.286)	0.325*	0.147	(0.036, 0.615)
Sex	-0.448	1.904	(-4.196, 3.300)	-4.586*	1.991	(-8.504, -0.667)	-2.885*	1.258	(-5.361, -0.408)	-2.919**	0.750	(-4.395, -1.442)
Trauma Exposure, THS Child	-0.626*	0.303	(-1.223, -0.029)	0.735*	0.317	(0.111, 1.359)	0.914**	0.200	0.520, 1.309)	0.467**	0.120	(0.232, 0.702)
Trauma Exposure, THS Caregiver	0.005	0.355	(-0.693, 0.703)	0.152	0.371	(-1.45, 13.921)	0.203	0.234	(-0.258, 0.664)	-0.088	0.14	(-0.363, 0.187)
$R^2$	0.031			0.083			0.18			0.129		
$F$	1.283			3.66			8.822			7.141		

\* p&lt;.05

As compared to White females

\*\*p&lt;.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 4 Caregiver			1st Depression Score, SMFQ Caregiver		
	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>
Intercept	60.450	5.611	(49.406, 71.495)	21.907	5.436	(11.205, 32.608)	6.218	3.913	(-1.485, 13.921)	4.224	2.146	(-0.001, 8.450)
Hispanic	3.321	1.914	(-0.447, 7.088)	-3.896	1.854*	(-7.546, -0.246)	-1.066	1.335	(-3.693, 1.562)	-0.815	0.732	(-2.256, 0.626)
Other Nonhispanic	4.740	5.436	(-5.960, 15.441)	5.067	5.267	(-5.300, 15.435)	-0.493	3.791	(-7.995, 6.969)	-1.398	2.080	(-5.492, 2.695)
Black Nonhispanic	4.978	2.812	(-0.558, 10.514)	-2.016	2.725	(-7.380, 3.348)	-3.88*	1.961	(-7.741, -0.019)	-2.900**	1.076	(-5.018, -0.783)
Age at intake	-0.648	0.368	(1.373, 0.077)	-0.241	0.357	(-0.944, 0.461)	0.380	0.257	(-0.125, 0.886)	0.292*	0.141	(0.014, 0.569)
Sex	-3.313	1.877	(-7.007, 0.381)	1.307	1.818	(-2.273, 4.886)	1.248	1.309	(-1.328, 3.824)	0.334	0.718	(-1.079, 1.747)
Trauma Exposure, THS Child	0.227	0.299	(-0.362, 0.815)	0.069	0.29	(-0.501, 0.639)	-0.038	0.209	(-0.448, 0.373)	0.044	0.114	(-0.181, 0.270)
Trauma Exposure, THS Caregiver	-0.848*	0.350	(-1.536, -0.160)	0.691	0.339*	(0.024, 1.358)	1.319**	0.244	(0.839, 1.798)	0.348**	0.134	(0.085, 0.611)
$R^2$	0.059			0.045			0.137			0.077		
$F$	2.505			1.91			6.405			3.369		

\* p&lt;.05 As compared to White females

\*\*p&lt;.01



Table B4. Logistic regression analyses for predicting measure available for any measure of child or caregiver symptoms from selected background characteristics

Variable	<i>N</i>	$\beta$	<i>SE</i>	<i>Wald</i>	<i>e<sup>B</sup></i> (95% <i>CI</i> )
Hispanic	304	-0.238	0.214	1.236	0.788 (0.518, 1.199)
Other Nonhispanic	26	-0.128	0.498	0.066	0.880 (0.322, 2.335)
Black Nonhispanic	118	-0.541*	0.266	4.133	0.582 (0.346, 0.981)
Sex m	330	-0.177	0.193	0.370	0.889 (0.609, 1.298)
Child age	765	-0.013	0.031	0.182	0.987 (0.929, 1.049)
Trauma Exposure-THS Child	765	0.089**	0.034	6.785	1.093 (1.022, 1.168)
Trauma Exposure-THS Caregiver	765	-0.041	0.038	1.192	0.960 (0.891, 1.033)
Child Discharged "Unsuccessful"	482	-3.522**	0.463	57.845	0.030 (0.012, 0.073)
Constant		4.085	0.610	44.826	59.446

\* p<.05

As compared to White Females

\*\*p<.01

Table B5. Logistic regression analyses for predicting successful clinical discharge from selected background characteristics

Predictors	<i>N</i>	$\beta$	<i>SE</i>	<i>Wald</i>	$e^B(95\% CI)$
Hispanic	304	-0.380*	0.167	5.175	0.684 (0.493, 0.949)
Other Nonhispanic	26	-0.870	0.484	3.239	0.419 (0.162, 1.081)
Black Nonhispanic	118	-0.855**	0.243	12.349	0.425 (0.264, 0.685)
Sex m	330	0.058	0.157	0.134	1.059 (0.778, 1.441)
Child age	765	-0.039	0.025	2.449	0.961 (0.915, 1.010)
Trauma Exposure-THS Child	765	-0.045	0.029	2.417	0.956 (0.903, 1.012)
Trauma Exposure-THS Caregiver	765	-0.045	0.032	2.041	0.956 (0.898, 1.017)
Constant		0.776	0.352	4.867	2.174

\* p<.05

As compared to White Females

\*\*p<.01

Table B6. 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 4 Child			Last Depression Score, SMFQ Child		
	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>	$\beta$	<i>SE</i>	<i>95%CI</i>
Constant	41.758	3.385	(35.099, 48.471)	5.217	2.551	(0.199, 10.235)	6.732	1.842	(3.112, 10.353)	2.761	0.935	(0.924, 4.598)
Trauma Exposure-THS, Child	-0.041	0.181	(-0.370, 0.342)	0.402*	0.181	(0.047, 0.757)	0.435**	0.134	(0.171, 0.699)	0.183**	0.068	(0.048, 0.317)
Baseline Score Child discharged as "successful"	0.362**	0.039	(0.285, 0.439)	0.463**	0.037	(0.390, 0.536)	0.298**	0.041	(0.217, 0.379)	0.262**	0.035	(0.193, 0.331)
Hispanic	8.219**	1.195	(5.870, 10.569)	-6.496**	1.198	(-8.852, -4.139)	-6.473**	0.860	(-8.162, -4.783)	-2.784**	0.444	(-3.656, -1.913)
Other Nonhispanic	2.189	1.265	(-0.299, 4.677)	-1.371	1.256	(-3.843, -4.139)	-1.572	0.911	(-3.362, 0.218)	-0.907	0.468	(-1.828, 0.013)
Black Nonhispanic	-5.167	3.280	(-11.619, 1.285)	1.645	3.253	(-4.754, 8.044)	0.217	2.367	(-4.435, 4.868)	-1.168	1.216	(-3.557, 1.222)
Sex	0.101	1.661	(-3.166, 3.367)	-2.001	1.647	(-5.240, 1.238)	-1.540	1.195	(-3.889, 0.810)	-1.397*	0.616	(-2.608, -0.187)
Child age	-1.105	1.167	(-3.400, 1.191)	0.000	1.166	(-2.295, 2.294)	-0.846	0.848	(-2.512, 0.820)	-0.586	0.437	(-1.445, 0.273)
<i>R</i> <sup>2</sup>	-0.396*	0.174	(-0.739, -0.053)	0.009	0.173	(-0.331, 0.349)	-0.074	0.127	(-0.323, 0.175)	0.060	0.065	(-0.067, 0.188)
<i>F</i>	0.333			0.430			0.284			0.256		
	21.120			32.011			22.480			20.91		

\*  $p < .05$ 

As compared to White females

\*\* $p < .01$

Table B7. 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 4 Caregiver			Last Depression Score, SMFQ Caregiver		
	$\beta$	SE	95%CI	$\beta$	SE	95%CI	$\beta$	SE	95%CI	$\beta$	SE	95%CI
Constant	39.402	3.269	(32.978, 45.825)	7.635	2.494	(2.733, 12.536)	3.447	1.892	(-0.272, 7.167)	2.413	1.135	(0.181, 4.645)
Trauma Exposure - THS, Caregiver Baseline Score	-0.382	0.199	(-0.773, 0.010)	0.289	0.192	(-0.087, 0.666)	0.222	0.041	(0.246, 0.407)	0.017	0.089	(-0.159, 0.193)
Child discharged as "successful"	0.392**	0.037	(0.319, 0.466)	0.419**	0.036	(0.349, 0.489)	0.326**	0.154	(-0.081, 0.526)	0.337**	0.041	(0.257, 0.418)
Hispanic	7.636**	1.146	(5.383, 9.889)	-5.682**	1.096	(-7.837, -3.528)	-4.239**	0.853	(-5.917, -2.561)	-2.79**	0.511	(-3.795, -1.785)
Other Nonhispanic	1.671	1.220	(-0.727, 4.068)	-1.885	1.157	(-4.160, 0389)	0.424	0.91	(-1.365, 2.213)	-0.422	0.545	(-1.493, 0.649)
Black Nonhispanic	2.931	3.164	(-3.286, 9.147)	-3.119	3.001	(-9.017, 2.779)	-1.731	2.359	(-6.369, 2.908)	-1.199	1.415	(-3.980, 1.581)
Sex	4.424**	1.601	(1.277, 7.570)	-3.843*	1.521	(-6.831, 0.854)	0.640	1.194	(-1.709, 2.988)	-0.657	0.717	(-2.066, 0.752)
Child age	-3.874**	1.130	(-6.094, -1.655)	2.059	1.074	(-0.052, 4.171)	0.425	0.841	(-1.229, 2.079)	0.570	0.504	(-0.420, 1.559)
$R^2$	-0.283	0.160	(-0.597, 0.032)	-0.067	0.153	(-0.367, 0.233)	0.087	0.119	(-0.148, 0.321)	0.106	0.072	(-0.035, 0.246)
$F$	0.320			0.335			0.236			0.221		
	27.263			29.134			15.002			14.541		

\* p<.05

\*\*p<.01

As compared to White females

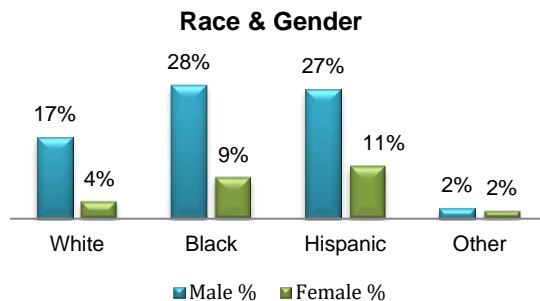
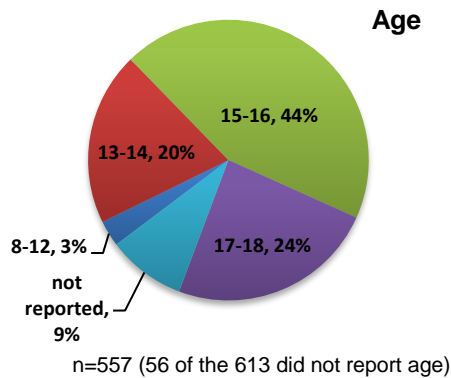
# Appendix C: Annual Court Support Services Devision RBA

## Quarterly Report Card: Improving Trauma-Informed Services for Justice-Involved Youth

Reporting Period: (FY19 July 1<sup>st</sup> 2018 – June 30<sup>th</sup> 2019)

Funded by the Court Support Services Division (CSSD) of the Judicial Branch and the Department of Children and Families (DCF), this initiative aims to improve trauma-informed services for justice-involved youth in Connecticut by increasing the identification of youth's trauma history and symptoms, and engaging youth in trauma evidence-based treatments. To this end, Juvenile Probation Officers and Child Youth Family Support Centers staff use the Child Trauma Screen (CTS) and refer youth to trauma services such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) provided by behavioral health agencies. CHDI collects and analyzes data on the CTS and TF-CBT related to youth involved in the justice system. For more information, contact Heather Solak at solak@uchc.edu.

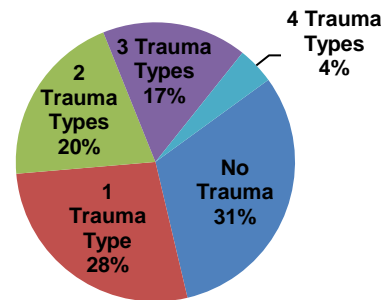
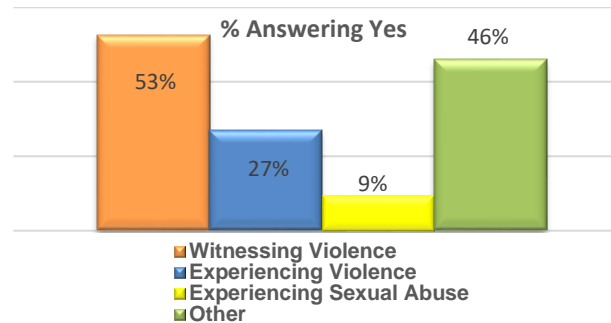
### Justice-Involved Youth Screened for Trauma N=613



n=589 (24 of the 613 did not report race or gender)

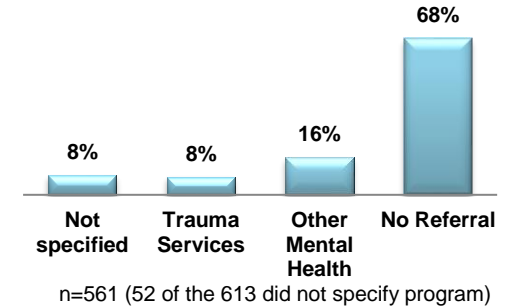
**Story behind:** There were 613 justice-involved youth screened for trauma during FY2019. The majority of the screens were administered by the Juvenile Courts (73%), with 27% administered by LYNC. For the Juvenile Courts, New Britain, New Haven, Waterbury, Hartford, and Bridgeport together administered over three quarters of the screens. For LYNC, Bridgeport, Hartford, and New Haven submitted over half of the screens (59%).

### Justice-Involved Youth Experiencing Trauma N=613

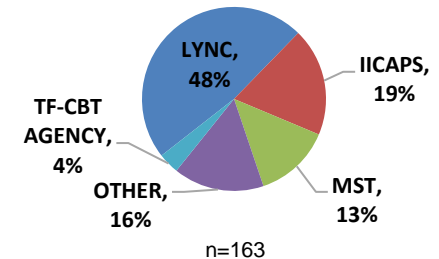


**Story behind:** 417 justice-involved youth (69%) reported exposure to traumatic events. 166 children (28%) experienced one type of trauma and 251 (41%) experienced two or more types of trauma. 130 (21%) of all youth screened scored 6 or higher, indicating a high likelihood of suffering from clinically elevated PTSD symptoms and the need for a more comprehensive trauma assessment.

### Referrals to Services N=613



### Where Referrals Were Made



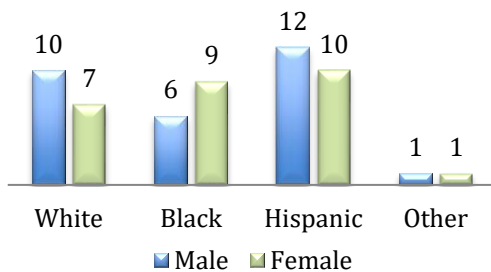
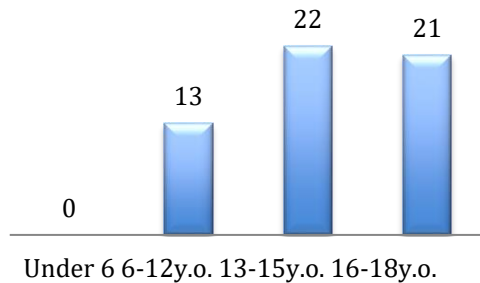
**Story behind:** Of the 613 youth screened, 163 (26%) had referrals where program was specified. For the 163 youth referred, 48% were referred to LYNC, 13% to MST, 19% to IICAPS, 4% to TF-CBT, and 16% were referred to some other service. Among the 613 screened, 130 (21%) scored high for PTSD symptoms (score ≥ 6) and were referred primarily to LYNC (49%). For 59 PTSD youth who were not referred, 34 (58%) were already receiving services; 13 (22%) were referred to a higher level of care, 8 (13%) had higher criminogenic needs, and 4 (7%) had a family who was not interested in services.

# Quarterly Report Card: Improving Trauma-Informed Services for Justice-Involved Youth

Reporting Period: (FY19 July 1<sup>st</sup> 2018 – June 30<sup>th</sup> 2019)

## Who did we serve?

N=56

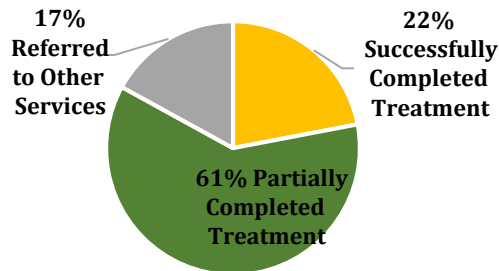


## Story behind:

During FY2019 there were 56 justice-involved youth who were actively receiving TF-CBT services, with 13 of them 6-12y.o. (23%), 22 of them 13-15 y.o (39%), and 21 of them 16-18 y.o (38%). Thirty-nine percent of the children served were Hispanic. Additionally, 27% were Black non-Hispanic, 30% were White non-Hispanic, and 4% were Other non-Hispanic. More males (29) than females (27) were served during the SFY.

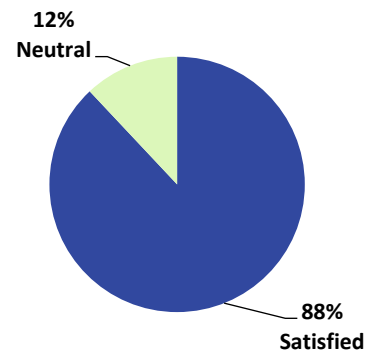
## How well did we serve?

### Discharge Reason



n=41

### Caregiver's Satisfaction Questionnaire Overall Satisfaction with Child's Treatment



n=8

## Story behind:

Successful completion is defined by the clinician's overall assessment of the child's progress at discharge.

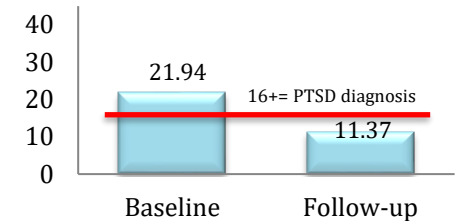
During FY2019, 43 youth concluded their TF-CBT treatment, with 7 youth being referred to other services, 26 partially completing treatment, and 10 successfully completing treatment. Children stayed in treatment an average of 5 months, and the majority of families reported being satisfied with treatment.

## Is anyone better off?

Results based on discharged cases with a baseline and follow up measure.

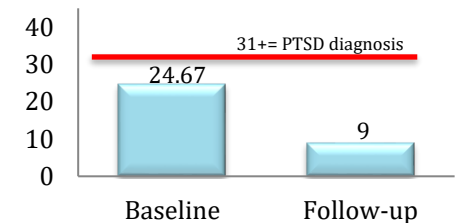
### PTSD Symptom Reduction (CPSS-IV)

n=16



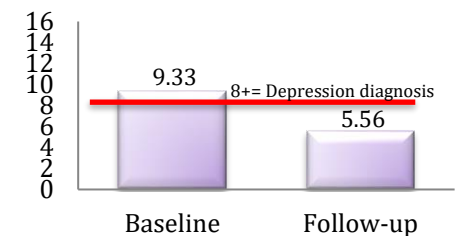
### PTSD Symptom Reduction (CPSS-V)

n=3



### Depression Symptom Reduction

n=18



## Story behind:

Overall, there was a decrease in PTSD symptoms on both the CPSS-IV and CPSS-V from baseline to follow up in the 19 children with outcome data (CPSS IV is currently being phased out)\*. A decrease in depression symptoms was also seen on the SMFQ youth report for 18 children.

\*Note: CPSS-IV scores range from 0-51; CPSS-V scores range from 0-80.

## **Appendix D: June 2019 State Dashboard**

### **Executive Summary**

#### **Intakes & Discharges**

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

#### **Active Treatment**

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

#### **Monthly Session Forms**

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

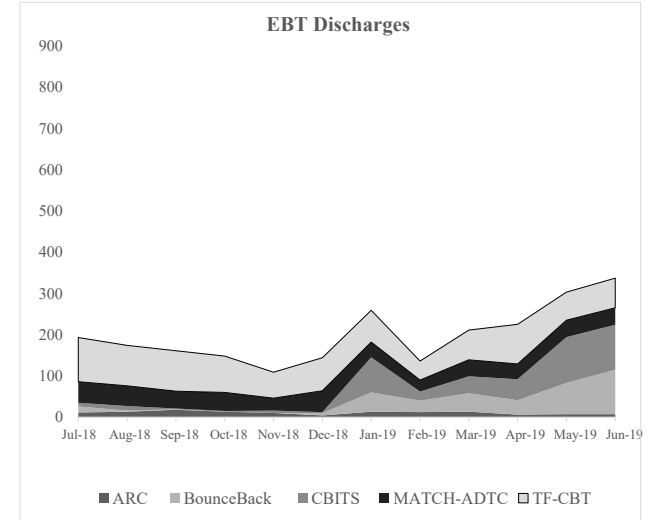
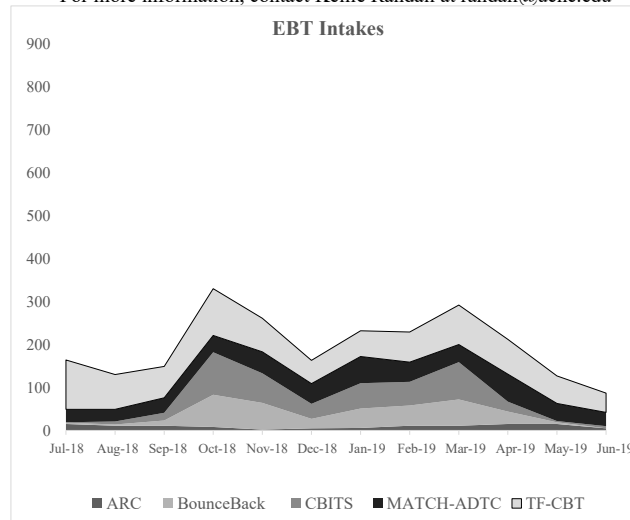
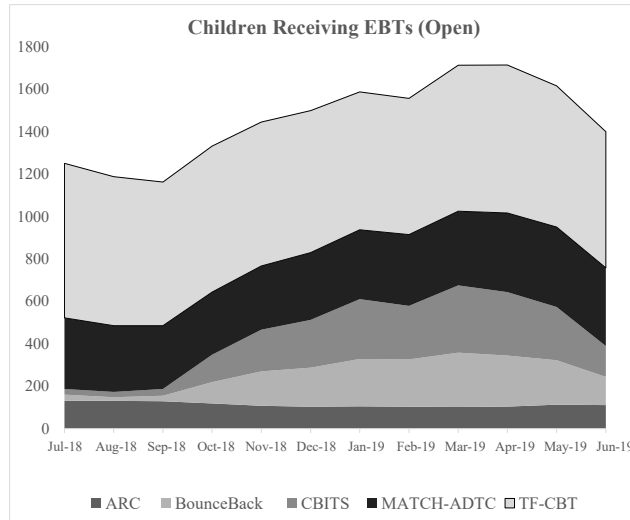
#### **Clinicians & Training**

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

## EBT Performance Dashboard: State of Connecticut June 2019

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

For more information, contact Kellie Randall at [randall@uchc.edu](mailto:randall@uchc.edu)



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

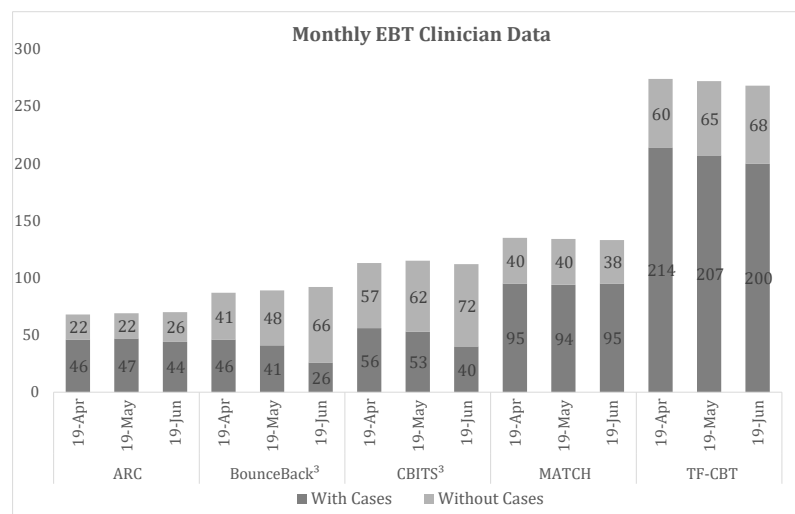
<sup>1</sup>Total for the 12 months (year) displayed in table



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

*State of Connecticut: EBT Performance Dashboard cont...*

	Monthly Session Forms Completed On Time												
	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Avg. Q1 Period <sup>2</sup>
ARC	92%	90%	96%	94%	84%	92%	84%	97%	92%	83%	89%	94%	90%
MATCH-ADTC	92%	90%	92%	87%	86%	90%	89%	87%	90%	86%	89%	88%	88%
TF-CBT	89%	85%	87%	86%	86%	94%	86%	92%	90%	90%	88%	89%	89%
All EBTs	90%	87%	89%	87%	86%	93%	86%	91%	91%	88%	89%	89%	89%



Clinicians Trained <sup>4</sup> in EBTs FY2019	
ARC	26
BounceBack	59
CBITS	51
MATCH-ADTC	54
TF-CBT	58

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

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

<sup>1</sup> One or more visits within the month

<sup>2</sup> Q1 Period is January 2019 - June 2019

<sup>3</sup> Includes co-facilitators

<sup>4</sup> Includes individuals with a clinical role at time in training. Includes internal agency trainings.

## Appendix E: Quality Improvement

### QI Overview

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

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

QI Indicators Prior to July 2018	QI Indicators July 2018 - Present	July 2018 – Present QI Description
Credentialed Clinicians	-	Removed
Percent Above CSQ	-	Removed
Episodes Closed	Episodes Closed	Treatment episodes discharged in QI period with at least one clinical session during entire LOS.
Engaged	Engaged	Percentage of closed episodes with four or more clinical sessions attended.
Caregiver Involvement	-	Removed
Episodes with 2 Visits/Month	Consistent Care	Percentage of closed and engaged treatment episodes with an average of two or more treatment episodes per month. Calculated by dividing the LOS by number of visits.
Episodes with TN Complete	-	Removed. See ‘model completion’ description below.
Episodes Successfully Completed	Model Completion	Percentage of closed and engaged treatment episodes that fully complete the model. Model completion definitions are: <ul style="list-style-type: none"> <li>- BounceBack!: child attends 7 or more group sessions (attended or make-up)</li> <li>- CBITS: child attends 7 or more group sessions (attended or make-up)</li> <li>- TF-CBT: completion of all required child treatment components and 8 or more sessions</li> </ul> Indicator does not apply to ARC and MATCH-ADTC treatment models.
Episodes with Assessment Data	Measures	Percentage of closed and engaged treatment episodes with at least one measure available at two different time points for any measure of child or caregiver symptoms.
Episodes with Symptom Improvement	Improved Outcomes	Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change on any measure. Includes any measure of child or caregiver symptoms.

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

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

#### Definitions that Changed After July 2018:

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

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

**As of July 2018 there is no agency credentialing.**

## Frequently Asked Questions

### **Why was agency credentialing removed?**

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

### **Why were the CSQ and caregiver involvement indicators removed? Why was the clinician credentialing requirement removed?**

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

### **What assessments count towards the measures and improved outcomes indicators?**

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

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

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

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

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

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

**What are the required treatment components for TF-CBT?**

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

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

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



## Overview - Closed Episodes<sup>1</sup>

### July-December 2018

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

<sup>1</sup> Closed treatment episodes with at least one clinical session



## Engagement<sup>1</sup> July- December 2018

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

<sup>1</sup> Percentage of closed treatment episodes with at least four or more treatment sessions.



## Measurement Based Care<sup>1</sup> July-December 2018

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

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





## Improved Outcomes<sup>1</sup> July-December 2018

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

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



## Consistent Care<sup>1</sup> July-December 2018

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

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



## Model Completion<sup>1</sup> TF-CBT July-December 2018

Provider Name	Proposed Benchmark	# Engaged	TF-CBT	
			Model Completion	
			#	%
Adelbrook, Inc.	30%	5	2	40%
Boys & Girls Village	30%	2	0	0%
Bridges, A Community Support System	30%	14	3	21%
Catholic Charities Archdiocese of Hartford	30%	7	6	86%
Charlotte Hungerford Hospital	30%	24	14	58%
Child and Family Agency of Southeastern Connecticut, Inc	30%	28	8	29%
Child Guidance Center of Southern Connecticut, Inc	30%	8	0	0%
Clifford Beers Clinic	30%	19	5	26%
Community Child Guidance Clinic, Inc	30%	8	3	38%
Community Health Center, Inc	30%	13	1	8%
Community Health Resources	30%	25	8	32%
Community Mental Health Affiliates, Inc	30%	9	0	0%
Connecticut Junior Republic	30%	5	3	60%
Cornell Scott Hill Health Center	30%	21	7	33%
Day Kimball Healthcare	30%	0	0	-
Family & Children's Aid, Inc	30%	17	6	35%
Family Centers, Inc	30%	7	2	29%
Jewish Family Services	30%	2	0	0%
Klingberg Family Centers	30%	3	1	33%
LifeBridge Community Services	30%	11	1	9%
Mid-Fairfield Child Guidance Center, Inc	30%	11	6	55%
Parent Child Resource Center	30%	5	1	20%
The Child and Family Guidance Center	30%	9	4	44%
The Child Guidance Clinic For Central Connecticut, Inc	30%	10	5	50%
The Village for Families & Children, Inc	30%	10	1	10%
United Community and Family Services	30%	27	10	37%
United Services, Inc	30%	32	9	28%
Waterford Country School, Inc.	30%	9	3	33%
Wellmore Behavioral Health	30%	15	3	20%
Wheeler Clinic	30%	29	6	21%
Yale Child Study Center	30%	30	8	27%
Yale Child Study Center-West Haven	30%	0	0	-
<b>Average</b>	<b>-</b>	<b>13</b>	<b>4</b>	<b>-</b>
<b>Total</b>	<b>30%</b>	<b>415</b>	<b>126</b>	<b>30%</b>

<sup>1</sup> Percentage of closed and engaged treatment episodes that fully complete the model. TF-CBT defines episode completion as 8 or more treatment sessions and completion of required treatment components.



## TF-CBT Private Practices July-December 2018

Provider Name	Engaged <sup>1</sup> Proposed Benchmark - 55%			Measures <sup>2</sup> Proposed Benchmark -			Outcomes <sup>3</sup> Proposed Benchmark -			Consistent Care <sup>4</sup> Proposed Benchmark -			Model Completion <sup>5</sup> Proposed Benchmark -		
	# Closed	#	%	# Engaged	#	%	# Measures	#	%	# Engaged	#	%	# Engaged	#	%
Elizabeth Domack	1	1	100%	1	1	100%	1	1	100%	1	1	100%	1	0	0%
Helping Hands, Healing Hearts Counseling Services LLC	1	1	100%	1	1	100%	1	0	0%	1	1	100%	1	0	0%
Integrative Behavioral Health, LLC	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
Kettavong Counseling, LLC	1	1	100%	1	1	100%	1	1	100%	1	0	0%	1	0	0%
LaShondra da Cruz	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
Life As It Happens Counseling LLC	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
Lisa Lacen-Romero, LMFT	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
Overcoming Lifes Obstacles, LLC	4	4	100%	4	4	100%	4	2	50%	4	4	100%	4	3	75%
Patrick M. Keenan, NCC, LPC	6	6	100%	6	3	50%	3	0	0%	6	5	83%	6	1	17%
Rachel Collins, LPC	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
Steve Kukolla LMFT	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
Two Rivers Counseling, LLC	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
<b>Average</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>0</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>0</b>	<b>-</b>
<b>Total</b>	<b>13</b>	<b>13</b>	<b>100%</b>	<b>13</b>	<b>10</b>	<b>77%</b>	<b>10</b>	<b>4</b>	<b>40%</b>	<b>13</b>	<b>11</b>	<b>85%</b>	<b>13</b>	<b>4</b>	<b>31%</b>

<sup>1</sup> Percentage of closed treatment episodes with at least four or more treatment sessions.

<sup>2</sup> Percentage of closed and engaged treatment episodes with least one measure available at two different time points during episode of care.

<sup>3</sup> Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change on any measure.

<sup>4</sup> Percentage of closed and engaged treatment episodes with an average of two or more treatment sessions per month

<sup>5</sup> Percentage of closed and engaged treatment episodes that fully complete the model. TF-CBT defines episode completion as 8 or more treatment sessions and completion of required treatment components.



## Overview - Closed Episodes<sup>1</sup>

### January - June 2019

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

<sup>1</sup> Closed treatment episodes with at least one clinical session



## Engagement<sup>1</sup> January - June 2019

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

<sup>1</sup> Percentage of closed treatment episodes with at least four or more treatment sessions.



## Measurement Based Care<sup>1</sup>

### January - June 2019

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

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



## Improved Outcomes<sup>1</sup> January - June 2019

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

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





## Consistent Care<sup>1</sup> January - June 2019

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

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



## Model Completion<sup>1</sup> TF-CBT January - June 2019

Provider Name	Proposed Benchmark	TF-CBT		
		# Engaged	Model Completion	
			#	%
Adelbrook, Inc.	30%	2	2	100%
Boys & Girls Village	30%	1	0	0%
Bridges Healthcare, Inc	30%	15	8	53%
Catholic Charities Archdiocese of Hartford	30%	4	2	50%
Charlotte Hungerford Hospital	30%	20	14	70%
Child and Family Agency of Southeastern Connecticut, Inc	30%	9	0	0%
Child Guidance Center of Southern Connecticut, Inc	30%	11	3	27%
Clifford Beers Clinic	30%	30	8	27%
Community Child Guidance Clinic, Inc	30%	10	8	80%
Community Health Center, Inc	30%	9	1	11%
Community Health Resources	30%	26	12	46%
Community Mental Health Affiliates, Inc	30%	16	5	31%
Connecticut Junior Republic	30%	9	2	22%
Cornell Scott Hill Health Center	30%	23	7	30%
Family & Children's Aid, Inc	30%	13	7	54%
Family Centers, Inc	30%	3	2	67%
Jewish Family Services	30%	1	1	100%
Klingberg Family Centers	30%	8	4	50%
LifeBridge Community Services	30%	7	3	43%
Mid-Fairfield Child Guidance Center, Inc	30%	8	3	38%
Parent Child Resource Center	30%	6	4	67%
The Child and Family Guidance Center	30%	12	2	17%
The Child Guidance Clinic For Central Connecticut, Inc	30%	11	4	36%
The Village for Families & Children, Inc	30%	14	5	36%
United Community and Family Services	30%	28	17	61%
United Services, Inc	30%	19	9	47%
Waterford Country School, Inc.	30%	14	5	36%
Wellmore Behavioral Health	30%	13	5	38%
Wheeler Clinic	30%	24	10	42%
Yale Child Study Center	30%	9	3	33%
Yale - West Haven Clinic	30%	-	-	-
<b>Average</b>	<b>-</b>	<b>13</b>	<b>5</b>	<b>-</b>
<b>Total</b>	<b>30%</b>	<b>375</b>	<b>156</b>	<b>42%</b>

<sup>1</sup> Percentage of closed and engaged treatment episodes that fully complete the model. TF-CBT defines episode completion as 8 or more treatment sessions and completion of required treatment components.



## TF-CBT Private Practices January - June 2019

Provider Name	Engaged <sup>1</sup> Proposed Benchmark - 55%			Measures <sup>2</sup> Proposed Benchmark - 70%			Outcomes <sup>3</sup> Proposed Benchmark - 75%			Consistent Care <sup>4</sup> Proposed Benchmark - 65%			Model Completion <sup>5</sup> Proposed Benchmark - 30%		
	# Closed	#	%	# Engaged	#	%	# Measures	#	%	# Engaged	#	%	# Engaged	#	%
Elizabeth Domack	2	1	50%	1	1	100%	1	1	100%	1	1	100%	1	1	100%
Evolve Behavioral Health	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Helping Hands, Healing Hearts Counseling Services LLC	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Integrative Behavioral Health, LLC	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
LaShondra da Cruz	2	2	100%	2	2	100%	2	2	100%	2	2	100%	2	2	100%
Life As It Happens Counseling LLC	2	2	100%	2	2	100%	2	2	100%	2	2	100%	2	2	100%
Lisa Lacen-Romero, LMFT	1	1	100%	1	1	100%	1	1	100%	1	1	100%	1	1	100%
Overcoming Lifes Obstacles, LLC	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Patrick M. Keenan, NCC, LPC	1	1	100%	1	1	100%	1	1	100%	1	1	100%	1	1	100%
Psychological Health Partners, PLLC	1	1	100%	1	0	0%	0	-	-	1	0	0%	1	0	0%
Rachel Collins, LPC	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Steve Kukolla LMFT	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Two Rivers Counseling, LLC	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>Average</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>-</b>
<b>Total</b>	<b>9</b>	<b>8</b>	<b>89%</b>	<b>8</b>	<b>7</b>	<b>88%</b>	<b>7</b>	<b>7</b>	<b>100%</b>	<b>8</b>	<b>7</b>	<b>88%</b>	<b>8</b>	<b>7</b>	<b>88%</b>

<sup>1</sup> Percentage of closed treatment episodes with at least four or more treatment sessions.

<sup>2</sup> Percentage of closed and engaged treatment episodes with at least one measure available at two different time points during episode of care.

<sup>3</sup> Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change on any measure.

<sup>4</sup> Percentage of closed and engaged treatment episodes with an average of two or more treatment sessions per month

<sup>5</sup> Percentage of closed and engaged treatment episodes that fully complete the model. TF-CBT defines episode completion as 8 or more treatment sessions and completion of required treatment components.

## Appendix F: Reliable Change Index

### Reliable Change Index Value Calculations

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

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

Measure		Full RCI	Partial RCI
Child Assessments	CPSS IV	11	6
	CPSS V	15	8
	SMFQ	7	4
	UCLA	16	9

Ohio Scales	Ohio Problem Severity* ( <i>Child, Caregiver, &amp; Worker versions</i> )	10	5
	Ohio Functioning ( <i>Child, Caregiver, &amp; Worker versions</i> )	8	4

Caregiver Assessments	CESD-R	9	5
	CPSS IV	10	5
	CPSS V	15	8
	PCL-5	10	5
	PSS	11	6
	SMFQ	6	3
	UCLA	11	6
	YCPC	18	9