2020

Child Health and Development Institute of Connecticut, Inc.

Connecticut's Evidenced-Based Treatment Coordination Center

Cognitive Behavioral Intervention for Trauma in Schools

DCF CONNECTICUT

Connecticut CBITS/BB Coordinating Center

Child Health and Development Institute

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

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Executive Summary

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Bounce Back (BB) treatment models are brief, evidence-based, manualized group interventions for young children or youth reporting post-traumatic reactions due to exposure to violence, abuse, and other forms of trauma. The CBITS Initiative Coordinating Center ("Coordinating Center") is located at the Child Health and Development Institute (CHDI). Funded by the Department of Children and Families (DCF), the Initiative represents a partnership between DCF, Sharon Hoover, Ph.D. (National Trainer), Site-Based Trainers (SBT), CHDI, Wheeler Clearinghouse, and participating school-based health centers, schools, school districts, and community providers. The Coordinating Center now supports a network of 26 teams as they developed and executed implementation plans for the provision of CBITS and/or BB.

This report summarizes the work of the Coordinating Center for state fiscal year (FY) 2020 (July 1, 2019 through June 30, 2020). This year was impacted by global and national events, which included the COVID-19 global pandemic and social unrest given the ongoing disproportionate violence that communities of color experience by institutions (e.g., law enforcement) in the United States. CHDI remained connected to each team when implementation efforts in mid-March were halted due to school closures. New demands were placed onto CBITS/BB Initiative teams and the communities they served, and all technical assistance and implementation support refocused to assist teams as they shifted to virtual learning and telehealth. The pandemic and social unrest highlighted longstanding racial inequities, which resulted in a renewed commitment to improving racial justice in critical service areas, such as trauma-focused EBTs.

Highlights of FY20:

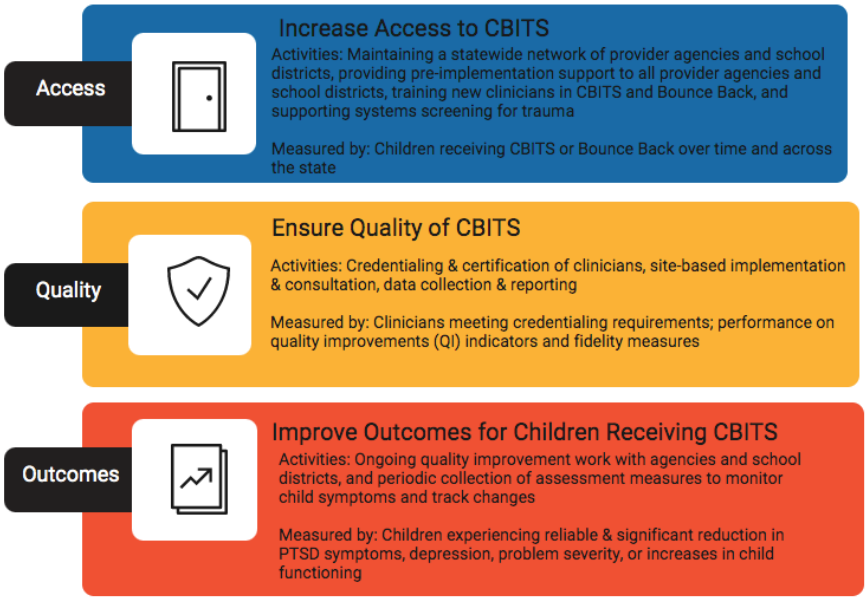
- 723 students received CBITS or BB
- 1807 students were screened for trauma exposure and associated symptom, a 56.6% increase from FY19
- Most CBITS and BB children with clinically significant PTSD symptoms experienced a reliable reduction (67.9% and 75.0%, respectively) and remission (59.5% and 66.1%, respectively) of symptoms
- Children who completed CBITS/BB achieved similar positive outcomes regardless of race or ethnicity
- High satisfaction with CBITS/BB treatment among children (91%) and caregivers (100%)
- Biannual QI reports commenced for CBITS and BB
- Implemented compensation contracts for Site Based Trainers (SBT) to conduct statewide clinical trainings and consultation, these contracts incentivized SBTs and their agency
- 11 hours of additional in-person EBP Tracker Crash Course support to assist team (upon request) with ensuring accurate and timely data entry
- In response to COVID-19 school closures, the following additional activities occurred:
  - All CBITS/BB clinicians, coordinators, and senior leaders received virtual implementation resources
  - Facilitated two Statewide Leadership and six Statewide Clinician Support Calls, along with nine Full Team or Individual Clinician support calls

Key Recommendations:

- Provide virtual clinical trainings and additional resources for partners to conduct CBITS and BB via telehealth and/or in-person while attending to COVID-19 safety requirements
- Develop and test strategies related to screening, consenting, treatment, and data entry protocols to ensure student access during the COVID-19 pandemic
- Strengthen the assessment protocols utilized to collect data related to treatment progress to capture change more adequately over time
- Continue evaluating and refining CBITS and BB QI Indicators via data trends and goal achievement
- Ensure assessments are available in languages commonly spoken by families in electronic format

Introduction

CBITS[1] is a brief, manualized, school-based, trauma-focused group intervention designed for children in grades 5 through 12 that are experiencing post-traumatic reactions due to exposure to violence, abuse, and other forms of trauma. Bounce Back (BB) is an adaptation of CBITS for elementary-aged children[2] in kindergarten through grade 5. Recognizing the need to provide school with resources for supporting students exposed to trauma in 2014, DCF partnered with CHDI to serve as the CBITS Coordinating. By FY20, the network has grown to include 26 partners, each poised to increase access to CBITS/BB. Although our teams worked tirelessly in Q1, Q2, and Q3, the impact of school closures related to COVID-19 resulted in a complete halt to group implementation as they grappled with distance learning and telehealth. Teams worked hard to stay connected to students that were enrolled in CBITS/BB, but teams were unable to provide group services by Q4. The figure below illustrates the goals and primary activities of the Coordinating Center[3].



This report is framed around the three primary goals as it relates to performance during FY2020. The first two sections of this report describe progress on ensuring Connecticut children have access to these EBP's (goal 1). Information on agency providers, training activities, and workforce development is followed by a description of trends in service over time as well as a description of the population of children served. 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 describes symptom reduction and functional improvements for children who receive CBITS/BB (goal 3). The final section provides conclusions and recommendations to guide future work.

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[1] Jaycox, L.H., Langley, A.K., Hoover, S.A. (2018). Cognitive Behavioral Intervention for Trauma in Schools, second edition (revised). Santa Monica, CA: RAND Corporation

[2] Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D. & Jaycox, L. (2015). Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *Journal of Consulting and Clinical Psychology*, *83*(5), 853-865. Doi: 10.1037/ccp0000051.

[3] A detailed accounting of these activities during FY20 can be found in Appendix A

Access to CBITS/BB in Connecticut

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

Availability Across the State

Prior to the impact of COVID-19 on group implementation in FY20, CBITS was available at 47 schools and 6 community-based settings across 22 different providers, and BB was available at 55 schools and 5 community-based settings across 19 different providers. A total of 76 BB and 77 CBITS groups ran in FY20.

Figure 1. Map of CBITS Sites and Children Served

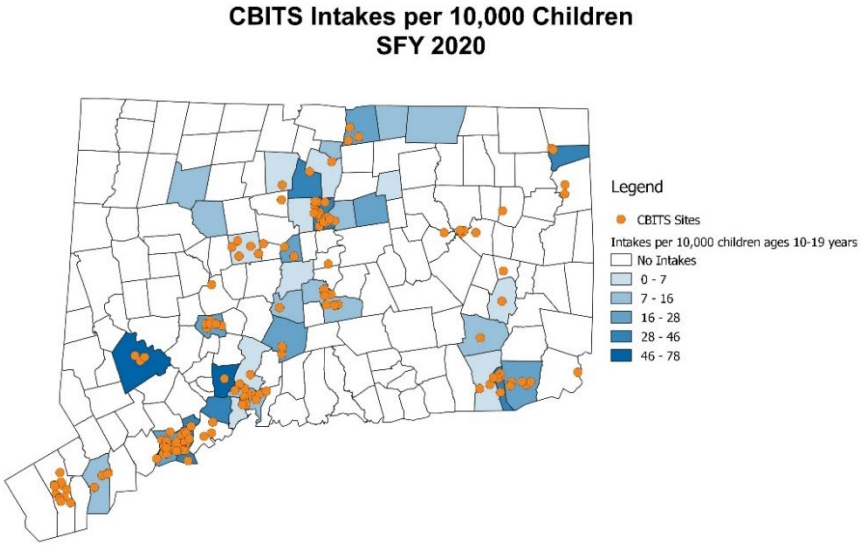
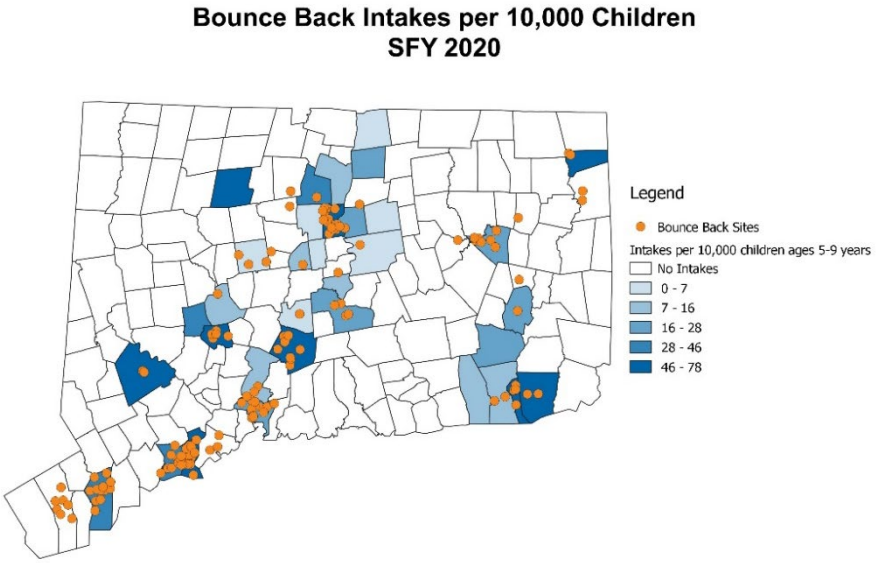


Figure 2. Map of BB Sites and Children Served



Clinician Training and Certification

There were 79 clinicians newly trained in CBITS and 56 clinicians newly trained in BB during the fiscal year. The number of newly trained clinicians is slightly higher than the previous fiscal year due to providing a large-scale training in CBITS/BB for one new, large, district partner. In addition to this training series led by SBTs, three SBT-led internal trainings were offered throughout the fiscal year. Last, CBITS/BB booster training sessions were offered on two occasions. These training spaces provide the opportunity to practice and refine clinical skills; review the use, scoring, and interpretation of clinical assessment measures; streamline data reporting protocols; brainstorm implementation challenges and solutions; and discuss clinician self-care. Two additional booster sessions on the schedule for the second half of FY20 were ultimately cancelled due to COVID-19 closures and the consequent shift in priorities at the provider.

Table 1 below shows details about CBITS and BB teams during FY20. The number of active CBITS clinicians (n = 59) decreased by 14% and the number of active BB clinicians (n = 60) increased by 7% respectively from the previous fiscal year. Figures 1 and 2 above show location of CBITS and BB sites across the state and Table 2 below shows the trends in access over the past three years as well as cumulative totals. In FY20, there were no clinicians that met the Connecticut CBITS or BB certification criteria. Due to COVID-19 school closures, most of our clinicians were unable to make progress toward group-related Certification requirements.

Table 1. FY20 CBITS and BB Teams

	CBITS	BB
# of clinicians on team	185	147
# of clinicians seeing at least one case	59	60
Average team size-school district	6.64 (R 1-16)	2.20 (R 1-15)
Average team size-community based	2.43 (R 1-5)	5.91 (R 1-4)

Table 2. Trends in CBITS/BB provider network

	FY18	FY19	FY20	Cumulative Since 2015
CBITS Schools	34	49	**47**	151*
BB Schools	24	44	**55**	
CBITS School Districts	13	18	**18**	29*
BB School Districts	11	16	**18**	
*CBITS Community-Based Settings***	1	6	**6**	14*
*BB Community-Based Settings***	2	6	**5**	
Newly Trained CBITS Clinicians[1]	66	42	**69**	248*
Newly Trained BB Clinicians[1]	38	49	**47**	
# Newly Certified in CBITS	12	10	**0**	28*
# Newly Certified in BB	4	5	0	
Clinicians Providing CBITS	39	69	**59**	194*
Clinicians Providing BB	27	56	60	

*Unique total (only counted once if trained in/certified in/provided both models, or if site provides both models

**Community based settings include outpatient clinical and extended day treatment settings

[1]Prior to FY19, no distinction was made between clinical and nonclinical participants (administrators, senior leaders, data entry, prospective partners) when assessing training totals

Clinician Demographics

The demographic characteristics of the 185 clinicians providing CBITS and 147 clinicians providing BB this year are presented in Table 3. CBITS and BB clinicians were primarily female and mostly White; 10% of CBITS clinicians and 13% of BB clinicians spoke Spanish.

Table 3. CBITS/BB clinician demographic characteristics (n=185/147)

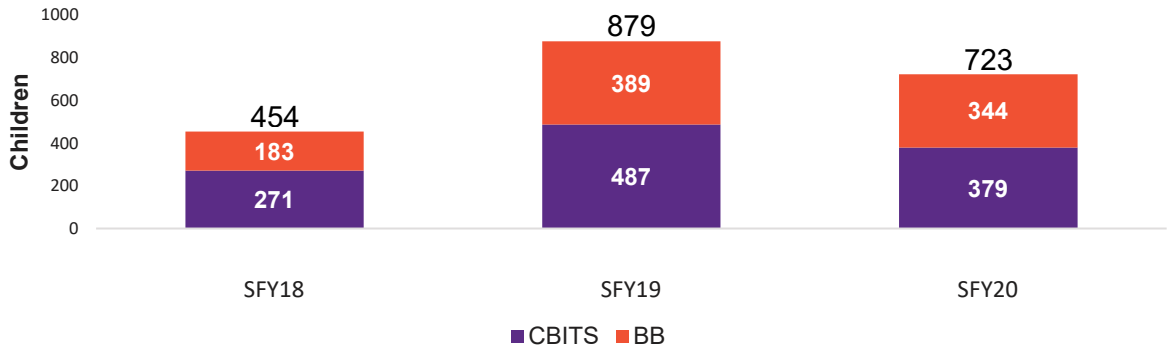
Characteristic	CBITS %	BB %
Sex (Male)	10.3	2.7
Race		
Black or African American	16.8	10.7
Hispanic, Latino, or Spanish	18.2	16.1
White	61.3	69.6
Other Race/Ethnicity	3.6	3.6
Languages Spoken		
Spanish	10.3	13.8
Other[2]	**5.7**	**5.7**

Children Receiving CBITS/BB

In FY20, 1,807 children were screened and 953 were eligible to receive treatment; 379 children received CBITS and 344 children received BB during the year. The number of children receiving CBITS and BB over time is illustrated in Figure 3 below. To date, 1,757 children have received CBITS since 2015 and 1,000 children have received BB since 2017 (2,757 total children served). The number of children served decreased from FY19, with an 11.6% decrease in children receiving BB and a 22.2 % decrease in children receiving CBITS. School closures did prevent some groups from starting that were slated to occur during Q4. Additionally, because of school closures and safety protocols in place throughout the state, some teams were unable to access data that was locked in secure offices. These teams either had children that would have been served in Q4 and/or had not yet completed data entry for children that were being served at the time of the mandated closure. Thus, this number may not accurately represent the total number of children being served at the time that implementation ceased, nor the projected number of children to be served in FY20.

The number of children screened in FY20 increased by 56.6% from last fiscal year, which is related to the increase in clinicians trained to use and score screening measures. Additionally, this increase is a result of a strengthened quality improvement plan implemented to ensure that each partner was able to report screening data in an accurate and timely manner.

Figure 3. Children Served by fiscal year



Child Demographics

Table 4 below provides descriptive statistics for children receiving CBITS and BB in FY20, as well as comparisons to those served in Connecticut schools [as reported on Edsight.gov] and the general CT population. Most children who received CBITS/BB in FY20 were Female (57.8%), White (53.5%) and primarily speak English (92.2%). Forty-seven percent of children were also Hispanic. Higher rates of Hispanic children (any race) and Black children received CBITS/BB as compared to the percentage of Hispanic and Black children in the overall CT school population as well as the general CT population.

The average age of youth who received CBITS is 13.6 years (SD=2.63), and 8.52 years for youth who received BB (SD=1.73). There were higher rates of children age 12-17 years who received CBITS and higher rates of children age 6-11 years who received BB as compared to the CT school population and general CT population, although this is expected based on the appropriate age range specified by the model.

Table 4. Characteristics of children receiving CBITS/BB (n=723) with comparisons

	CBITS		BB		Schools[3]	Child pop[4]
	N	**%**	**N**	**%**	**%**	**%**
Sex (Male)[i]	109	28.8	194	56.4	51.6	50.9
Race						
American Indian or Alaska Native	4	1.1	3	0.9	0.3	0.3
Asian	3	0.8	2	0.6	5.2	4.6
Black or African American	119	31.4	76	22.1	12.7	12.9
Native Hawaiian or Pacific Islander	0	-	0	-	0.1	0.1
White	186	49.1	201	58.4	51.1	66.6
Other Race/Ethnicity	67	17.7	62	18.0	3.8	15.6
Hispanic, Latino, or Spanish (any race)	184	48.5	154	44.8	26.9	24.7
Age (years)						
Under 6 years	5	1.3	21	6.1	N/A	29.4
6-11 years	71	18.7	316	91.9	N/A	33.4
12-17 years	291	76.8	7	2.0	N/A	37.2
Grade						
Elementary	74	19.5	344	100.0	45.6	N/A
Middle	83	21.9	0	-	22.9	N/A
High	222	58.6	0	-	31.5	N/A
Child welfare involvement during treatment	33	8.7	59	17.2	N/A	N/A
JJ involvement during treatment	4	1.1	0	-	N/A	N/A
Child primary language					N/A	
Spanish	21	7.6	18	6.8	N/A	13.4
Neither Spanish nor English	3	1.2	0	-	N/A	8.6
Caregiver speaks English (no)	35	10.6	50	17.2	N/A	N/A

[i]Of those who did not report male, 1.2% reported Other or Intersex
[3]Data obtained from CT Dept. of Education: edsight.ct.gov for 2019-20 school year. Age and language spoken not available
[4]American Community Survey 2018 1 yr. estimates. Caution should be used with comparison to CT schools and CBITS/BB child demographics. Census language is only available by language spoken, not primary language. Age is percentage of children 0-17 years.

Child Clinical Characteristics at Treatment Start

Information on baseline assessments for children receiving CBITS and BB is found in Tables 5 and 6. Youth assessments were also evaluated to determine if there were demographic factors that influenced reports of trauma exposure or scores on symptom measures at treatment start.

Trauma Exposure. Youth who received CBITS reported experiencing an average of 8.05 different types of potentially traumatic events, while those who received BB reported experiencing an average of 5.95 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 reported in Tables B1 and B2 in Appendix B. There was a significant difference in Trauma Exposure Checklist (TEC) scores by race/ethnicity group and sex for children who received CBITS; Hispanic and Black children reported exposure to a greater number of traumatic events compared to White children. Males also reported greater exposure to traumatic events than females. There were also significant differences in TEC scores by age for BB, older youth had higher exposure to trauma. Details of the tests can be found in Tables B1 and B2 in Appendix B.

Baseline Symptoms. A summary of intake scores are presented in Tables 5 and 6. Over half of children who received CBITS/BB reported clinically high trauma symptoms and problem severity (CBITS only), and clinically low functioning scores at the start of treatment. Figure 4 shows the rates of elevations graphically by measure and reporter. In general, children were more likely to be in the clinical level of trauma symptoms for CBITS (71.8% to 76.2%) and BB (53.5% to 77.8%) than on problem severity or functioning (31.9% to 59.0% for CBITS; 25.9% to 45.5% for BB). This suggests that measuring trauma symptoms is useful in guiding CBITS/BB treatment. Those who were not in the clinical range at intake still reported PTSD symptom scores that were high enough to qualify them for CBITS/BB group participation. Scores considered high enough to meet eligibility for invitation to CBITS/BB fall within at least the moderate range of post traumatic symptoms on either the CPSS IV or CPSS-5.

Multiple regression analyses were used to look for demographic differences in baseline scores. Full results are reported in Tables B3 and B4 in Appendix B. Some statistical differences for males and females existed for both CBITS and BB youth. For children who received CBITS, males had statistically lower baseline CPSS-5 scores and Ohio Problem Severity scores compared to females, which reflects lower reported symptoms despite statistically higher scores on the TEC. A similar pattern existed for youth who received BB, males had statistically lower baseline Ohio Functioning baseline scores to females. These findings may suggest that symptom severity is underreported for males despite their level of exposure to traumatic events.

Some age and race-related statistical differences existed for BB youth, but none were detected for CBITS youth. Older children in BB reported statistically lower Problem Severity symptoms compared to their younger counterparts, and Black children reported statistically worse baseline symptoms (Problem Severity and Functioning scores) compared to White children.

Figure 4. Percentage of children with clinically high score

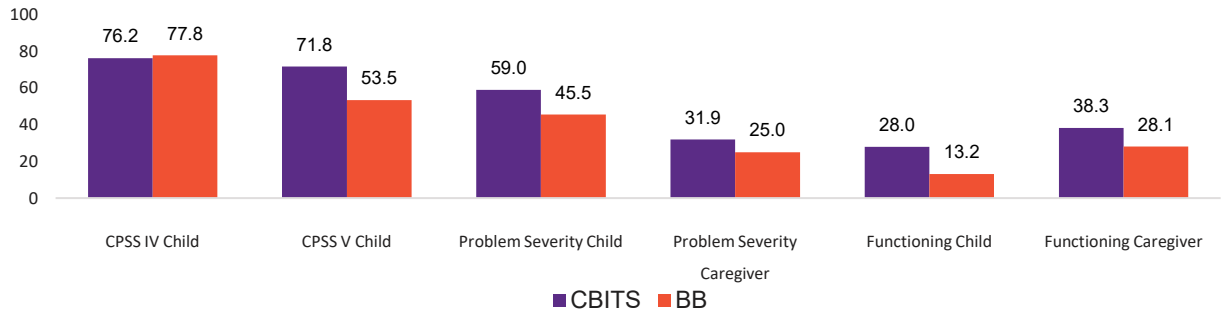


Table 5. Child and caregiver clinical assessment scores at intake [CBITS]

Measure	Child Report				Caregiver Report			
	N	**Mean**	**SD**	**Elevated***	**N**	**Mean**	**SD**	**Elevated***
TEC sum	370	8.05	3.20		-	-	-	-
CPSS-IV Total Score	21	22.52	11.03	16, 76.2	2	21.50	12.02	1, 50.0
Re-experiencing Subscore	-	6.95	3.35		-	8.50	6.36	-
Avoidance Subscore	-	7.86	6.01		-	9.00	2.82	-
Arousal Subscore	-	7.71	3.46		-	4.00	2.82	-
CPSS-5 Total Score	347	40.52	15.10	249, 71.8	1	14.00	-	0, 0.0
Re-experiencing Subscore	-	9.99	4.74		-	2.00	-	-
Avoidance Subscore	-	11.88	2.24		-	0.00	-	-
Arousal Subscore	-	29.67	4.86		-	3.00	-	-
Ohio Problem Severity	329	29.67	15.96	194, 59.0	47	20.34	14.43	15, 31.9
Internalizing	309	15.89	10.14		1	1.00	-	-
Externalizing	309	12.64	7.60	92, 28.0	1	2.00	-	-
Ohio Functioning	329	51.29	12.73		47	50.09	14.80	18, 38.3

Table 6. Child and caregiver clinical assessment scores at intake [BB]

Measure	Child Report				Caregiver Report			
	N	**Mean**	**SD**	**Elevated***	**N**	**Mean**	**SD**	**Elevated***
TEC sum	329	5.95	3.03		-	-	-	-
CPSS-IV Total Score	18	21.28	6.23	14, 77.8	-	-	-	-
Re-experiencing Subscore	-	6.61	3.43		-	-	-	-
Avoidance Subscore	-	6.50	3.51		-	-	-	-
Arousal Subscore	-	8.17	2.95		-	-	-	-
CPSS-5 Total Score	301	32.84	12.98	161, 53.5	29	18.93	12.25	5, 17.2
Re-experiencing Subscore	-	8.45	4.32		-	4.62	3.60	-
Avoidance Subscore	-	4.19	2.49		-	2.24	1.76	-
Arousal Subscore	-	10.72	4.89		-	6.69	4.37	-
Ohio Problem Severity	121	24.99	16.03	55, 45.5	64	19.44	11.61	16, 25.0
Internalizing	118	12.13	9.06		25	6.12	4.48	-
Externalizing	118	11.94	8.60		25	10.64	6.09	-
Ohio Functioning	121	58.51	15.34	16, 13.2	64	50.47	17.67	18, 28.1

Quality: Consultation and Clinical Implementation

CHDI staff work closely with each team and meet quarterly to provide consultation. The focus of site visits varies based on the time of year and the specific needs or barriers faced by each team. In the beginning of the year, consultation mainly focused on streamlining screening, referral, and consenting protocols, brainstorming solutions to anticipated barriers, and developing a staff and caregiver engagement strategy for each site in which a team plans to implement. During the second half of the fiscal year, consultation typically shifts to reviewing performance related to QI benchmarks and other key indicators as teams complete implementation and move toward completing associated discharge documentation. Toward the latter part of Q3 and through the remainder of FY20, problem solving around unanticipated barriers and streamlining discharge data entry protocols related to COVID-19 became the priority. For the remainder of Q3 and the entirety of Q4, CHDI worked with DCF to support the shift to telehealth and distance learning. CHDI also shared resources and recommendations from CBITS/BB model experts, and provided space for interagency collaboration via hosting statewide leadership meetings for senior leaders and coordinators to share resources, and clinician support calls to offer space for clinicians to discuss the impact of COVID-19 on service delivery.

Implementation Consultation

This year, 103 in-person or zoom site visits and 34 formal follow-up telephone consultations were completed. The typical agenda for these on-site meetings is split between discussing any barriers that arose throughout the course of implementation and reviewing team performance on recent dashboards (e.g., QI report, monthly dashboards). Resultant of consultation meetings, SMARTER goals are developed to address any QI indicators that did not meet the established benchmark. These worksheets are also used to assist teams in monitoring pre-implementation tasks that are not monitored through QI reports or other data outputs. For FY20, a total of 101 SMART worksheets were created in collaboration with CBITS/BB Initiative teams. The inclusion of our DCF contract manager in site visits this fiscal year has increased trust and communication between stakeholders, allowing us to focus on accountability to team deliverables via targeted, data-driven goal setting. Next, as COVID-19 introduced itself and shifted the focus for our teams, Project Coordinators offered support to leadership and clinicians every step of the way. In total, 38 resources were created and/or disseminated to the network, and an additional 17 consultation support meetings were held outside of the quarterly site visits noted above.

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 thousands of requests from users since it was created. In addition to this support platform, Project Coordinators created and offered EBP Tracker Crash Courses to support accurate and timely data entry by Initiative teams. A total of nine in-person EBP Tracker support sessions and twenty-three virtual EBP Tracker support sessions were provided. 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.

Episode Description

Of children who completed treatment, CBITS recipients attended a mean of 9.15 (SD=1.21) group sessions and a mean of 1.03 individual sessions (SD=.81), and BB recipients attended a mean of 9.57 group sessions (SD=.67) and a mean of 1.75 individual sessions (SD=1.24). The average length of stay was 4.42 months for

CBITS, and 3.77 months for BB. Altogether, for CBITS, 462 group sessions, 186 child sessions, and 67 caregiver sessions were provided during the year. For BB, 522 group sessions, 252 child sessions, and 182 caregiver sessions were provided during the year. A total of 76 BB and 77 CBITS groups ran this fiscal year.

Quality Improvement Indicators

In FY20, CHDI continued utilizing the CBITS/BB quality improvement (QI) biannual report in site consultations. QI indicators guide CHDI Project Coordinators' work with the sites and often are the focus of the goals set during consultation visits. The definition and explanations of each of the four QI indicators and the prepared reports showing each provider's results over the two FY20 Performance Periods (PP) are included in Appendix D.

Figure 5. QI indicators in FY20 [CBITS]

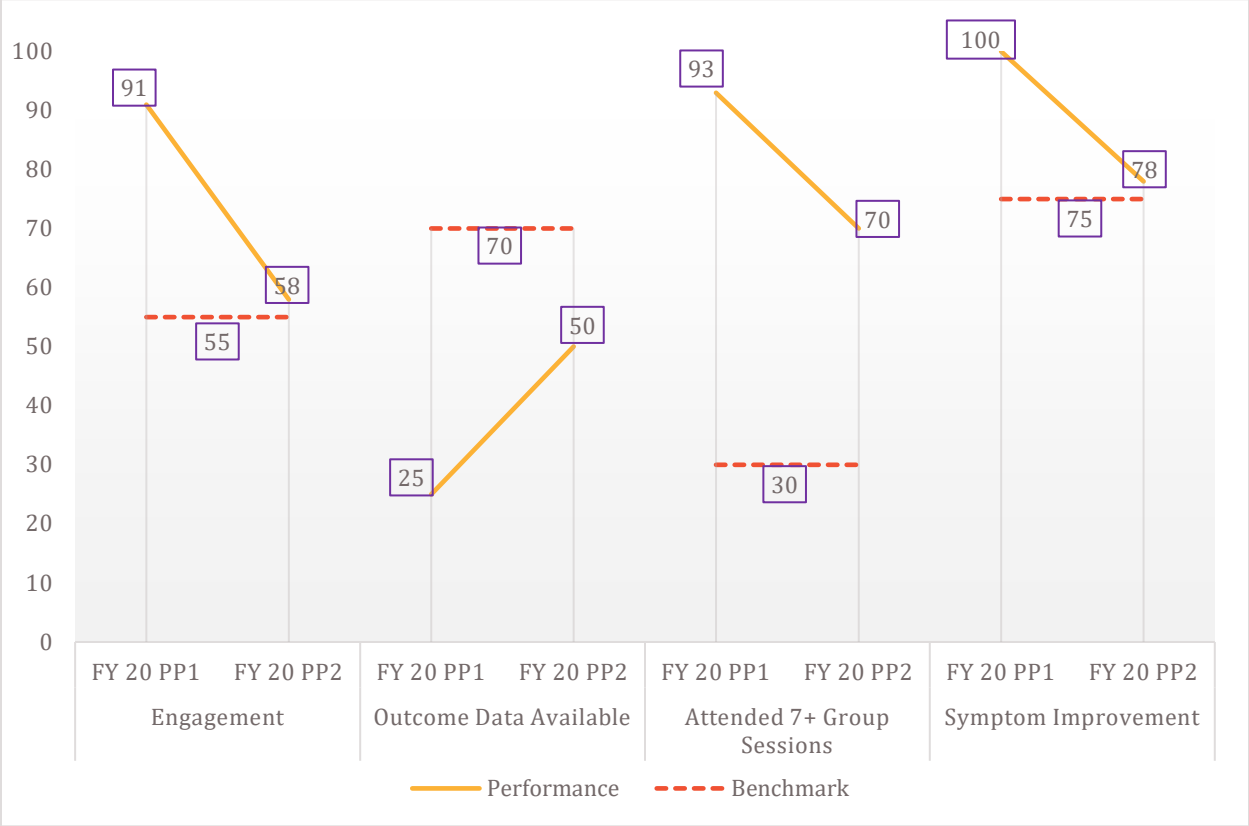
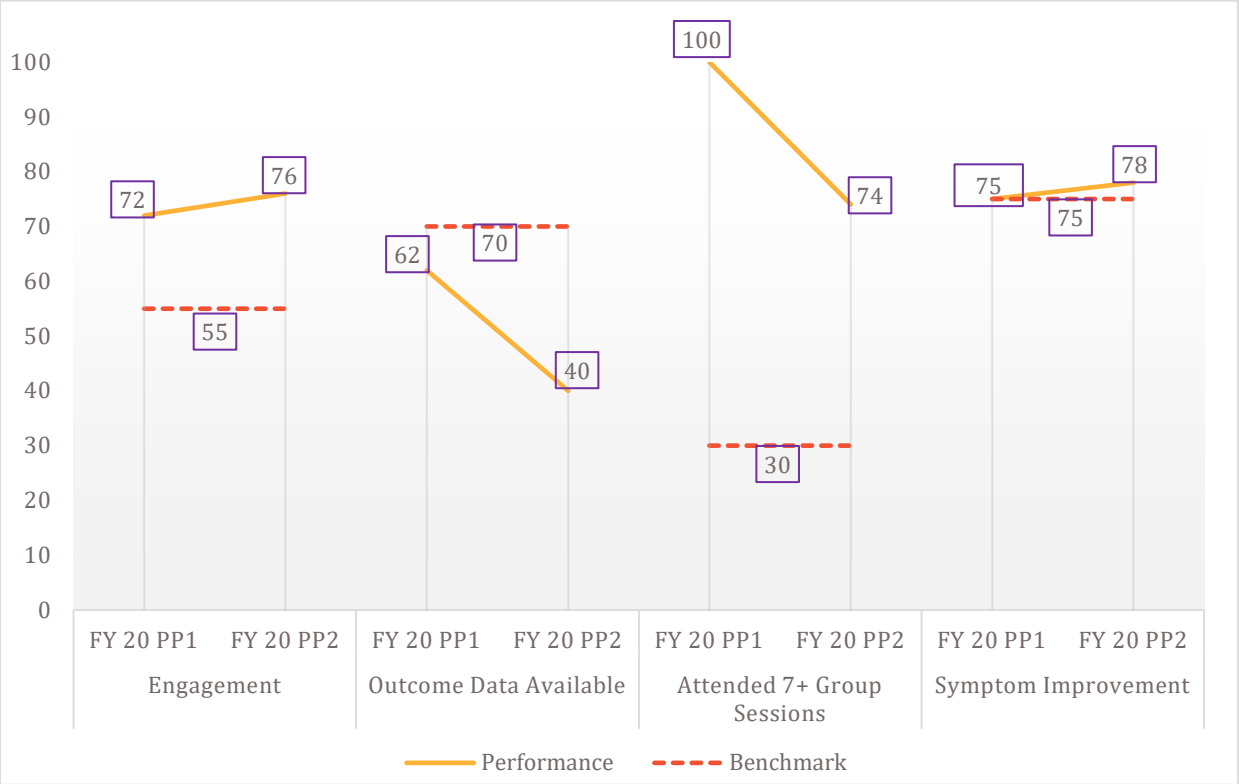


Figure 6. QI indicators in FY20 [BB]



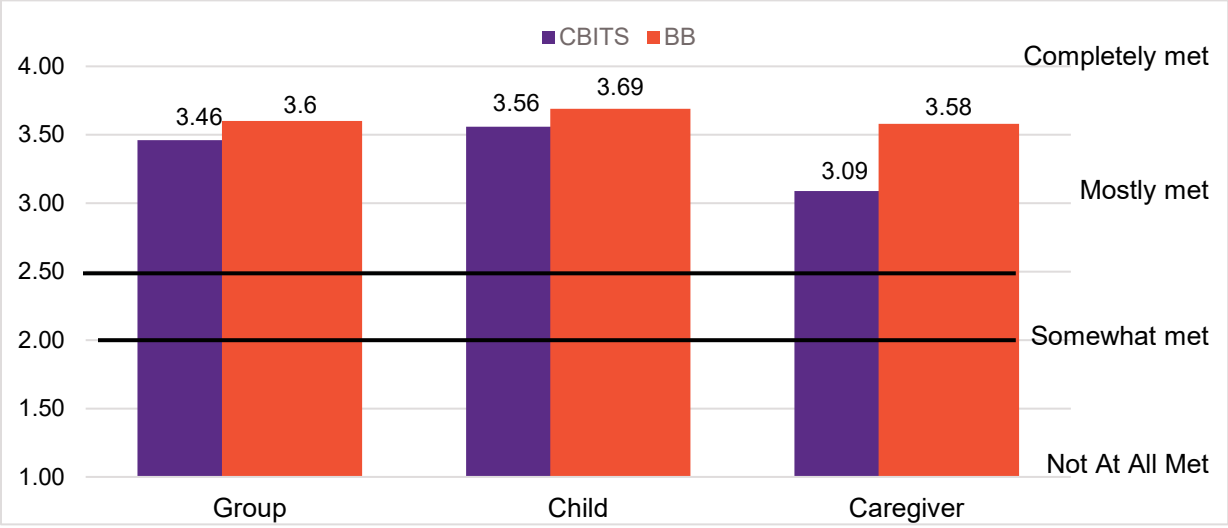
Engagement was moderate in both models, with consistent numbers for Bounce Back (PP1: 72% and PP2: 76%). There was a decrease in engagement from PP1 (91%) to PP2 for CBITS (58%). Both models exceeded the benchmark of 55%. Please note, resultant of statewide school closures and the halt in implementation of CBITS and BB in mid-March, engagement percentages were impacted. Although the majority of our Initiative teams attempted to maintain relationships with students who had been assigned to a group, the inability for groups to be offered resulted in a decrease in engagement as it is defined for the purposes of QI.

On the other QI indicators, CBITS saw a noteworthy improvement in outcome data available (PP1: 25% and PP2: 50%) though both periods were below the benchmark. There were decreases in model completion and symptom improvement, but both exceeded the benchmark. Bounce Back had a similar pattern, meeting the benchmarks model completion, and symptom improvement in both performance periods, but did not meet the benchmark for outcome data available (PP1: 62% AND PP2: 40%). Like other benchmarks, the shift that teams made to distance learning and telehealth resulted in a halt in CBITS/BB implementation, thus no outcomes measures were collected for students that were unable to complete groups.

Session Ratings

Clinicians are asked to indicate how well they are meeting group, child, and caregiver session objectives by rating the objectives on a scale of 1 (not at all met) to 4 (completely met). Overall, clinicians rated group, child, and caregiver session objectives highly for both CBITS and BB, with all session ratings being above the "mostly met" cutoff. See Figure 7 for a breakdown of group, child, and caregiver session objective scores.

Figure 7. Group, Child, and Caregiver Session Objectives-Average Ratings



Discharge Reason

During the fiscal year, 436 children ended their CBITS treatment episode, and 366 children ended their BB treatment episode. A total of 76 BB and 77 CBITS groups ran this fiscal year. The majority of children across both CBITS and BB were discharged for other reasons (43.1%), with 28.8% successfully completing treatment, 21.4% being administratively discharged, and a small number being discharged for the following reasons: family discontinued treatment (2.7%), assessment only (1.1%), referred to other EBP within agency (1.2%), referred to outpatient treatment (0.6%), family moved out of area (0.6%), and referred to higher level of care (0.2%). Binary logistic regression analyses were conducted to determine which factors were associated with successful discharge. Results are reported in Tables B5 and B6 in Appendix B. Black children were more likely to successfully complete treatment compared to White children, and males were less likely to successfully complete treatment compared to females in CBITS. Additionally, older age was associated with lower levels of successful completion of CBITS. There were no significant findings for BB in terms of successful completion. Please note, most children discharged from CBITS and BB during the last two quarters of FY20 indicated "other" as the reason for discharge. In these cases, clinicians overwhelmingly reported COVID-19 school closures.

Figure 8. Reasons for Discharge in FY20 [CBITS]

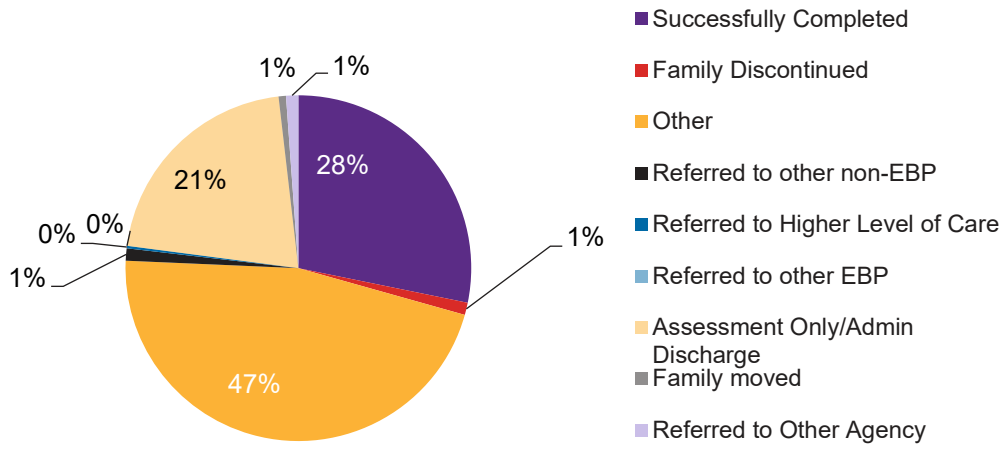
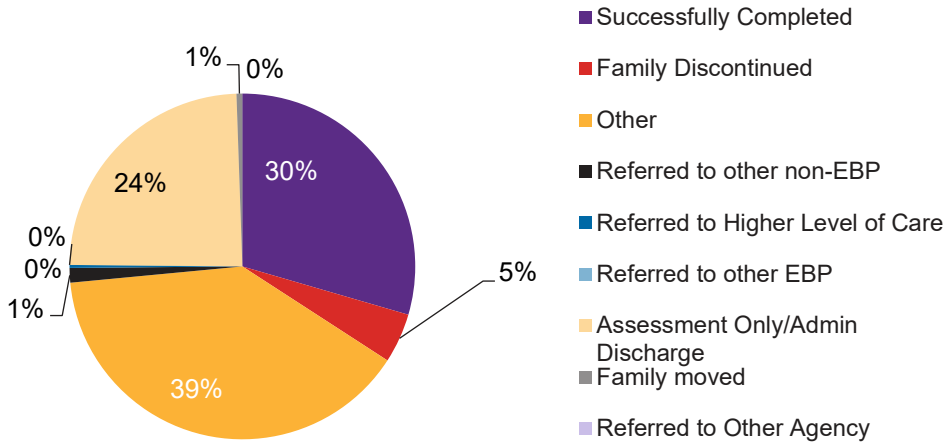
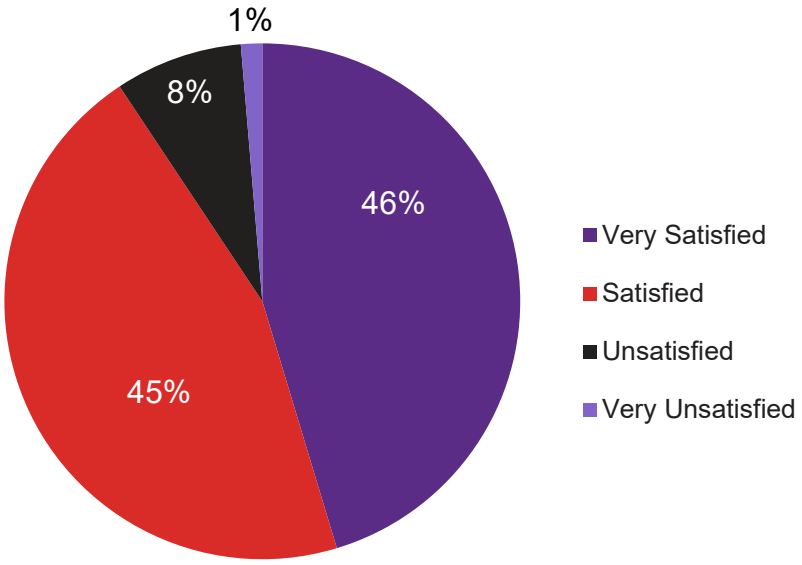


Figure 9. Reasons for Discharge in FY20 [BB]



Children report high levels of satisfaction with their CBITS/BB treatment. In FY20, there were 75 Ohio Child Satisfaction[6] assessments completed. The responses are illustrated in Figure 10 below with 91% of those completing the Ohio Child Satisfaction indicating being mostly or very satisfied with treatment. Six caregivers completed the Ohio Caregiver Satisfaction measure; 100% of these caregivers indicated that they were mostly or very satisfied with treatment.

Figure 10. Satisfaction Categories, FY20 (n=75)



Outcomes: Improvement for Children Receiving CBITS/BB

Children receiving CBITS/BB are assessed with a variety of measures selected to provide information on trauma history, severity of symptoms at intake, and symptom change by discharge. Change cannot be calculated unless there are two data points for an assessment, so the availability of outcome data (having a first and last) is an important indicator in considering outcomes. Of those who do have sufficient data, trends in symptom change are presented for both overall and across groups. For a full description of the measures used and how change is calculated in CBITS/BB, please see Appendix E.

Rates of Outcome Data

A quarter of children (25.2%) discharged from CBITS in the fiscal year had both a first and last trauma symptom measure child report (either version), and 24.8% had both a first and last Ohio Problem Severity and Functioning child report. For BB, 27.3% of children had both a first and last trauma symptom measure child report (either version), and 6.3% had both a first and last Ohio Problem Severity and Functioning child report. Binary logistic regression analyses were conducted to determine which factors were associated with having outcome data. Results are reported in Tables B7 and B8 in Appendix B. The only statistical difference in outcome data availability was for Black youth who received BB; these youth of color had significantly lower rates of outcome data.

Symptom Improvement

Children experienced significant reductions in trauma and Problem Severity symptoms as well as significant gains in functioning (see Tables 7 and 8). For children who received CBITS/BB, the highest rates of reliable change and remission were in post-traumatic stress and Problem Severity symptoms.

Table 7. Descriptives and Change Scores for All Assessment Measures [CBITS]

	Construct Measured	Above Cutoff	Intake Mean (S.D.)	Last Mean (S.D.)	Change Score	t-score	Remission
TEC Child (n=370)	Count of child exposure to potentially traumatic events	n/a	8.05 (3.20)	n/a	n/a	n/a	n/a
CPSS-IV Child (n=5)	Trauma symptoms	5 (100%)	26.20 (11.41)	12.20 (8.07)	-14.0**	3.20	2/5 (60.0%)
CPSS-IV Caregiver (n=1)		1 (100%)	13.00	13.00	0.00	n/a	0/1 (0.00%)
CPSS-5 Child (n=105)		79 (75.2%)	42.31 (15.25)	28.85 (16.04)	-13.46***	9.46	48/79 (39.2%)
CPSS-5 Caregiver (n=0)		n/a	n/a	n/a	n/a	n/a	n/a
Ohio Problem Severity Child (n=108)	Severity of internalizing/externalizing behaviors	69 (63.9%)	31.76 (16.35)	24.28 (16.75)	-7.48***	5.22	38/69 (44.9%)
Ohio Problem Severity Caregiver (n=17)		10 (58.8%)	29.71 (11.65)	24.00 (11.99)	-5.70**	2.84	4/10 (40.0%)
Ohio Functioning Child (n=108)		37 (34.3%)	50.45 (13.68)	53.54 (13.58)	+3.08**	-2.62	17/37 (45.9%)
Ohio Functioning Caregiver (n=17)		12 (70.6%)	39.29 (10.13)	42.06 (11.11)	+2.76	-1.11	4/12 (33.3%)

no caregiver data reported for CPSS-5

****indicates significance p <.05***

*****indicates significance p < .01***

Table 8. Descriptives and Change Scores for All Assessment Measures [BB]

	Construct Measured	Above Cutoff	Intake Mean (S.D.)	Last Mean (S.D.)	Change Score	t-score	Remission
TEC Child (n=348)	Count of child exposure to potentially traumatic events	n/a	5.65 (2.98)	n/a	n/a	n/a	n/a
CPSS-IV Child (n=12)	Trauma symptoms	11 (91.7%)	23.08 (5.72)	20.17 (9.43)	-2.91	1.06	3/11 (27.3%)
CPSS-IV Caregiver (n=0)		n/a	n/a	n/a	n/a	n/a	n/a
CPSS-5 Child (n=88)		45 (51.1%)	33.67 (11.31)	17.82 (11.37)	-15.85***	11.69	34/45 (75.6%)
CPSS-5 Caregiver (n=13)		2 (15.4%)	17.23 (12.09)	11.77 (9.33)	-5.46	1.77	2/2 (100%)
Ohio Problem Severity Child (n=23)	Severity of internalizing/externalizing behaviors	10 (43.5%)	24.04 (15.0)	14.61 (13.32)	-9.43***	4.53	6/10 (60.0%)
Ohio Problem Severity Caregiver (n=17)		5 (29.4%)	18.53 (10.65)	16.24 (13.30)	-2.29	1.21	3/5 (60.0%)
Ohio Functioning Child (n=23)		0 (0.0%)	63.96 (8.19)	67.35 (11.63)	+3.39	-1.42	n/a
Ohio Functioning Caregiver (n=17)		6 (35.3%)	52.29 (14.02)	57.82 (14.72)	+5.52**	-2.51	3/6 (50.0%)

****no caregiver data reported for CPSS-5***
*****indicates significance p <.05***
******indicates significance p < .01***

Children Improve Across Multiple Domains

Children receiving CBITS/BB were assessed on three measures. When children were assessed at two or more time points, change scores were calculated and RCI values were used to see the percentage of children who experienced reliable change. Figure 11, 12, and 13 below show the relative rates of improvement across measures. **The greatest change was in post-traumatic stress symptoms.** It is very important to note that due to the school closures, overall outcome data availability was low; therefore, any findings presented here should recognize the smaller than usual n sizes in Tables 7 and 8 presented above.

Children who entered CBITS/BB with clinically high symptoms have higher rates of reliable symptom change after treatment. This trend was seen across all symptom categories (PTSD, externalizing/internalizing behaviors, and functioning). In the full sample of children completing CBITS with available PTSD symptom outcome data, 65.5% experienced trauma symptom reduction. Comparatively, 67.9% of children with elevated child-report at baseline experienced reliable change in this symptom category. In the full sample of children completing BB with available PTSD symptom outcome data, 72.0% experienced trauma symptom reduction, and 75.0% of children with elevated-child report at baseline experienced reliable change in this symptom category. Similar trends were seen for children with elevated Problem Severity (externalizing/internalizing) symptoms, and Functioning impairments.

Figure 11. Percent of children with symptom reduction, PTSD

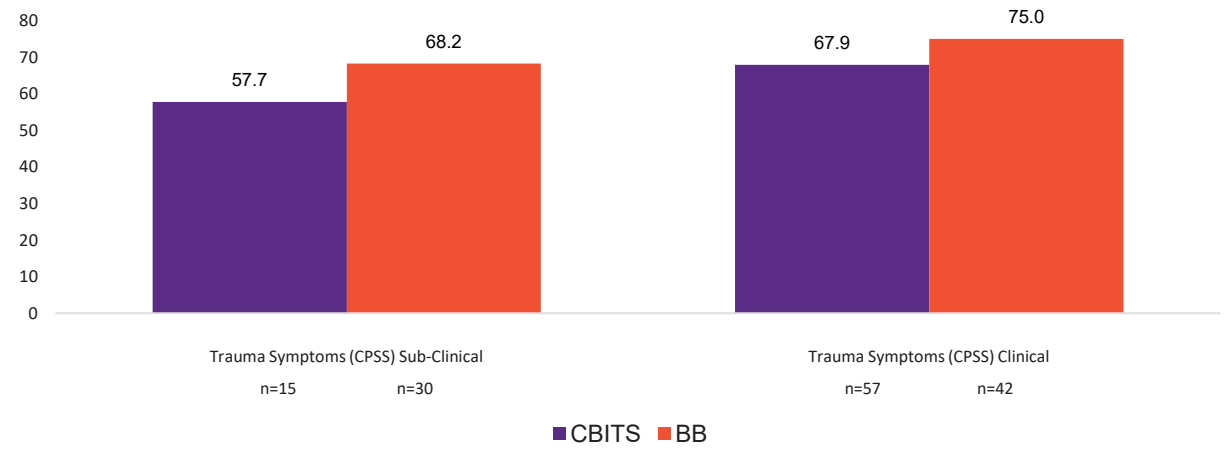


Figure 12. Percent of children with symptom reduction, problem severity (PS)

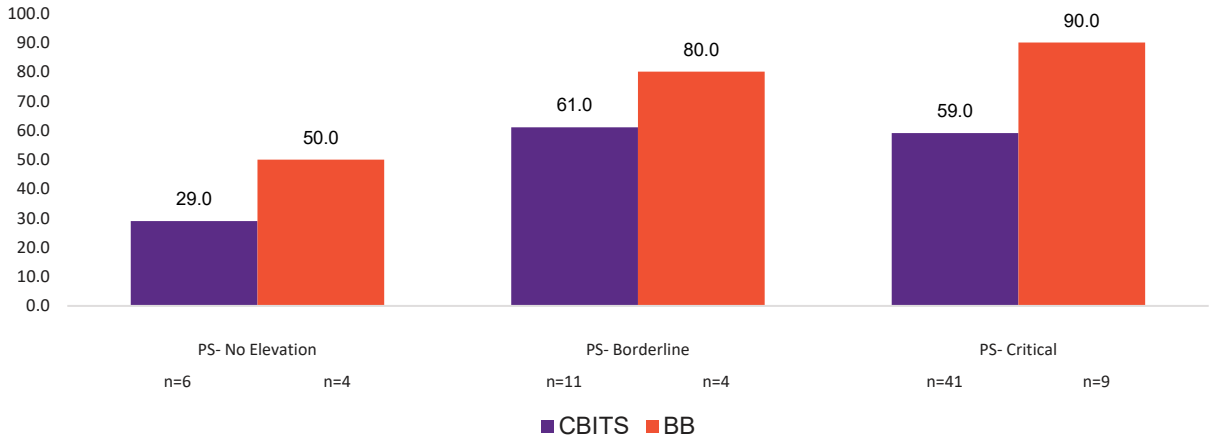
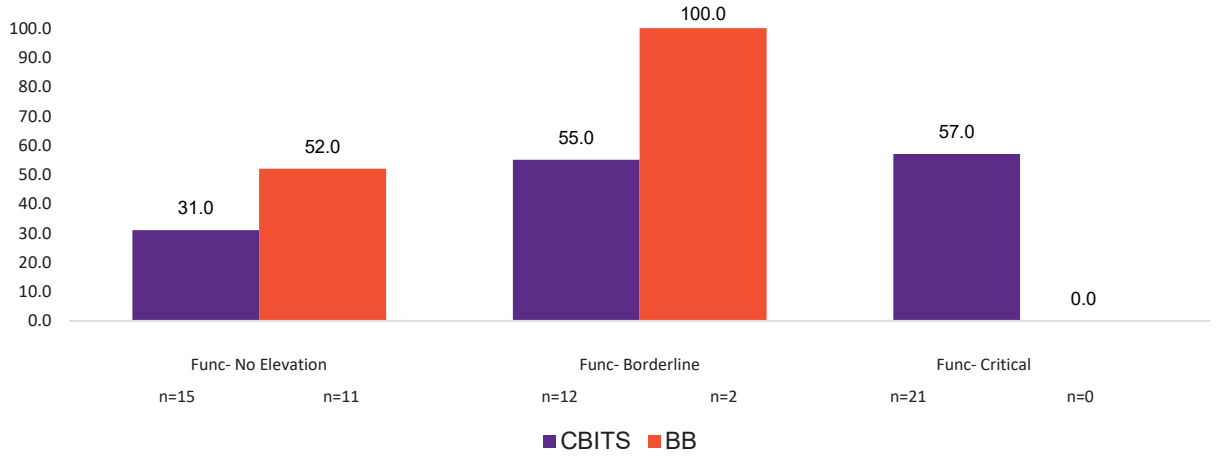


Figure 13. Percent of children with symptom reduction, functioning



Note: There were no children that fell in the critical range for functioning for BB

Clinical Improvements Across Groups

In addition to documenting the overall rates of symptom reduction and functional improvement, we examined whether subgroups experienced disparate outcomes. Due to small n sizes in outcome data, caution should be applied to the interpretation of the findings below.

Multiple regressions were performed to explore the effect of race categories, age, and sex on discharge scores, controlling for initial scores and trauma exposure. No statistical effects were detected for race or ethnicity, which means CBITS/BB may have worked equally well across different racial and ethnic groups. Some findings for Problem Severity suggested statistical differences in sex for CBITS youth and age for BB youth; however, the significance of these findings are unclear given the lack of any other statistically significant effects for age or sex in other symptom measures. In addition to the age and sex differences in Problem Severity, baseline scores had the strongest effect on Problem Severity outcome scores for both CBITS and BB youth. This suggests that youth with higher baseline Problem Severity scores experienced more improvement. More data is needed to determine if any of these above patterns suggest any additional meaningful findings.

Details of the tests can be found in Appendix B (Tables B9 and B10).

Summary & Conclusions

The CBITS and BB Initiative brings vital trauma-informed behavioral health services to Connecticut youth and families by bridging clinical services and the education system. The CBITS/BB Coordinating Center promotes model availability, caregiver and youth accessibility, and enhanced workforce development. The Initiative achieved noteworthy successes in FY20, particularly amid challenges brought on by the COVID-19 pandemic and resulting school closures.

CBITS/BB service delivery was in full swing when Connecticut's executive order to close schools went into effect from March 2020 into FY21. The number of children receiving CBITS and BB in Q3 was higher than any third quarter in previous fiscal years. The network consisted of 53 CBITS and 60 BB sites, and served 723 students, a 17.5% decrease from FY19. Since Q3 and Q4 are the busiest times for the network, the overall drop in students served was a direct result of the school closures. It is also important to recognize that although children were identified for or engaged in CBITS/BB services, the majority ended treatment prematurely due to these closures and schools shifting their resources to distance learning. Despite this tumultuous time, multiple districts and providers maintained their investment in the Initiative, and the state has clearly built an infrastructure that has increased student access CBITS/BB.

Though premature treatment termination impacted data availability, outcomes remained strong in FY20. Most CBITS and BB youth with initial trauma symptom scores above clinical thresholds experienced reliable improvement, 67.9% and 75.0% respectively. More than half of the children who received CBITS (59.5%) and BB (66.1%) also experienced remission of their PTSD symptoms. In terms of Ohio Scale - Problem Severity reductions for CBITS and BB youth scoring in the critical impairment range at baseline, 67.9% and 75.0% respectively reported reliable improvement after receiving group treatment. Alongside these strong clinical outcome improvements, 91% (N=75) of youth and 100% (N=6) of caregivers reported being mostly or very satisfied with CBITS/BB group treatment.

In addition to service delivery, screening is an invaluable, essential tool for trauma-informed networks. For CBITS/BB, over 1,800 students were screened, which is a noteworthy accomplishment in FY20 because it represents a 56% increase from FY19. More than half of these students screened were eligible for services (n = 953), which is also higher than those eligible in last fiscal year (47.8%). The number of traumatic event exposures reported by youths during screens were high, with averages of 8.05 (CBITS) and 5.65 (BB) events. Such high exposure and initial symptomology further support the essential role that CBITS/BB serves in a Multi-Tier System of Supports (MTSS) model[4], a framework that schools use to holistically address behavioral and academic challenges. This is particularly meaningful for CT school districts as reopening strategies are planned for the next academic year.

Prior to COVID-19, approximately 40-60% of children and families dropped out of conventional treatment settings[5] [6]. School settings were historically an ideal place to address some barriers to behavioral health care (e.g., transportation, availability) that disproportionately affect racial, ethnic, and economically underserved

[4] Hoover, S., Bracey, J., Lever, N., Lang, J., & Vanderploeg, J. (2018). *Healthy students and thriving schools: A comprehensive approach for addressing students' trauma and mental health needs.* Child Health and Development Institute. https://www.chdi.org/index.php/publications/reports/impact-reports/health-students-and-thriving-schools

[5] Kazdin, A. E. (1996). Dropping out of child therapy: Issues for research and implications for practice. *Clinical Child Psychology and Psychiatry, 1*, 133–156.

[6] Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, 65, 453–463

youth and families. COVID-19 and the resulting stay-at-home orders drastically changed the feasibility of CBITS/BB delivery, addressing some of these barriers through telehealth service delivery can ensure that CT students continue to have access to these critical interventions.

Recognizing that the pandemic will continue to impact implementation, ongoing consultation efforts should support CBITS and BB teams to incorporate screening and service delivery through telehealth services. Looking ahead, CBITS and BB implementation efforts that ensure telehealth services are available to Connecticut youth and families is paramount in FY21. Serving and engaging marginalized families and youth should also remain a top priority, particularly for any new potential barriers that result from the COVID-19 pandemic (e.g., technology access, physical and emotional wellbeing). Future trainings and consultations should incorporate resources geared for CBITS and BB service provision in virtual platforms. Ongoing collaboration and communication between DCF, CBITS and BB service providers, and the Coordinating Center will ensure that CBITS and BB remain a vital behavioral health service for Connecticut youth and families.

Recommendations

The following recommendations are made for continued support of the network of providers, schools, and districts involved in the CBITS Initiative:

Coordinating Center:

- Provide virtual clinical trainings and additional resources for partners as they navigate CBITS and BB via telehealth and/or in-person while attending to COVID-19 safety requirements.
- DCF, CHDI, and Initiative partners will collaboratively develop and test new strategies related to screening, consenting, treatment, and data entry protocols to support student access during the COVID-19 pandemic.
- Identify implementation resources and strategies to continue scale up of CBITS/BB across the state (e.g., needs assessments, administrator toolkits). Expansion since FY15 has resulted in an increasing number of CBITS/BB provider teams (5 to 26), yet CBITS/BB are still not available to students in most districts and schools in the state.
- Provide training and consultation on topics identified in this report and by network providers as areas for development, including virtual group implementation, caregiver engagement, chronic and/or complex trauma, cultural sensitivity, and health equity.
- Increase training in use of EBP Tracker through reusable documentation and prerecorded videos to increase data entry and self-sufficiency whenever possible. Ongoing live teleconsultation should remain available as needed.
- Provide advanced telehealth resources and implementation support to all teams to ensure high quality service delivery. This will include identification and dissemination of tools that support virtual group implementation with tailored protocols for CBITS or BB as needed.
- Continue to collect relevant financial data and support adequate reimbursement rates for the implementation and sustainability of CBITS/BB and other EBTs.
- Increase training and consultation opportunities for active CBITS/BB Site Based Trainers to enhance their training and consultation capacity in statewide implementation efforts.
- In addition to increasing opportunities for SBT's to provide support, SBT's need guidance in how to effectively train on and consult around particularly difficult intervention components and/or topics.
- Analyze data further to examine demographic factors and other characteristics that may influence access to CBITS/BB treatment, initial engagement, drop out, or differences in symptom reduction. For example, a dearth of Asian youth receiving CBITS or BB remains consistent across fiscal years.
- Continue evaluating and refining CBITS and BB QI Indicators by examining trends that emerge across fiscal years.
- Continue to collaborate with DCF on consultation visits in order to further bridge the gap between DCF and team leadership. Collaboration has thus far enabled a more accurate feedback loop around key issues addressed during site visits and through SMARTER worksheets.

Providers/Districts/State:

- Providers should modify implementation plans to support any accommodations during COVID-19.
- Senior Leaders and Coordinators should provide guidance for clinical team members to conduct screening, intake, and group and individual treatment protocols virtually and/or in-person while managing physical distancing and other COVID-19 safety requirements.
- The state and school districts should consider how to integrate and align CBITS/BB with a broader trauma-informed Multi-Tiered System of Supports. This may include workforce development for all school staff in mental health and trauma, and screening students for mental health/trauma.
- Senior Leaderships should advocate for adequate reimbursement rates to sustain EBTs.

- Schools with technological resources that support students' distance learning should explore using the same resources to enhance CBITS/BB access.
- Schools may strengthen partnerships in the community to ensure students have more access to resources that support both academic needs and telehealth services.
- CBITS/BB network teams should build internal capacity to encourage staff wellness and resilience through trauma-informed supports, such as reflective supervision/consultation groups and Secondary Traumatic Stress prevention efforts.

System:

- DCF, CHDI, model developers, and providers should consider how cultural and social factors, such as poverty, racism, and other forms of discrimination may impact students' experience of CBITS/BB. Use of the *Toolkit for modifying evidence-based practice to increase cultural competence*[7] can support efforts to ensure that CBITS/BB are competently addressing student issues.
- Strengthen the assessment protocols implemented by CBITS/BB teams to develop a more robust measure of treatment progress.
- Alter the Trauma Exposure Checklist so that it allows for experiences of racism, discrimination, and other exposure types to be included during the overall screening for traumatic experiences, as these experiences can impact symptoms and service outcomes.
- Ensure assessments are available in languages commonly spoken by families in electronic format within the EBP Tracker database system.
- Continue funding performance-based sustainment funds to improve capacity, increase access, and ensure quality of care; these incentives partially offset the costs of providing an EBT.
- Collect information on session format to better understand how telehealth is being used.
- Continue discussions with DCF regarding the possibility of updating terminology used in EBP Tracker to collect demographic information that complies with current best practices (e.g., sex versus gender).

[7] Samuels, J., Schudrich, W., & Altschul, D. (2009). *Toolkit for modifying evidence-based practice to increase cultural competence.* Orangeburg, NY: Research Foundation for Mental Health.

Appendix A: Activities and Deliverables

The Coordinating Center has worked to support the CBITS/BB implementation goals through the following activities carried out in FY20.

1. Training, Consultation, & Credentialing

- Coordinated two CBITS and two BB statewide new clinician trainings.
- Developed and implemented a protocol to support Site Based Trainers in offering three internal CBITS new clinician trainings (Clifford Beers Clinic, Hartford Public Schools, Mid-Fairfield) and two internal BB new clinician trainings (Hartford Public Schools, Southwest).
- Trained 105 unduplicated persons in either CBITS/BB or both (79 CBITS and 56 BB persons trained)
- Maintained 59 active CBITS clinicians and 60 active BB clinicians.
- Coordinated two CBITS/BB Booster trainings for 44 clinical staff. A third booster training was replaced with statewide and team-specific consultation via phone/zoom due to COVID-19.
- Coordinated eight CBITS clinical consultation call groups with 65 total calls for 81 clinical staff.
- Coordinated six BB clinical consultation call groups with 48 total calls for 64 clinical staff.
- Held CBITS/BB statewide COVID-19 support calls from March thru June. These calls supported teams in adjusting service delivery and receiving implementation resources during COVID-19:
  - Two statewide Leadership Only
  - 11 statewide Clinician calls
  - One statewide prospective Teams call.
- Developed, executed, and managed contracts for Site Based Trainers (SBT) to conduct statewide training and consultation calls to increase Initiative sustainability.
- Implemented a protocol for internal SBT trainings and consultation support that enabled SBTs, SBT agencies, and CHDI to organize the onboarding of new clinicians in a standardized manner that mirrors statewide training structures.
- Maintained a training and certification record database to track training and consultation attendance of all CBITS/BB providers.
- Implemented a cross-model certification application protocol that enables clinicians to monitor and apply for certification across multiple DCF-funded EBTs in an efficient manner.

2. Implementation Support, Quality Improvement, & Technical Assistance

- Produced reports for two QI performance periods based on developed CBITS/BB QI Indicators and Benchmarks.
- Utilized QI plans and SMARTER goals to enhance pre-group planning, performance on QI benchmarks, and strategies to improve access, quality and service delivery.
- Provided 103 in-person/virtual implementation consultation visits and 34 phone calls with providers to ensure access to quarterly support, and assist teams with sustainment of high quality services.
- Offered an additional 17 virtual consultation support meetings during COVID-19 school closures upon request by CBITS/BB leadership teams and/or clinical providers.
- Onboarded 5 new district-based provider teams; Amity Public Schools, Hartford Public Schools, Middletown Public Schools, Naugatuck Public Schools, and Sprague Public Schools.
- Implemented CBITS/BB Leadership Call Series in response to Senior Leaders and Coordinators requests. Calls focused on Initiative news, fidelity and successful implementation support, and network community-building.
- Disseminated 38 resource materials that support distance learning transitions during the COVID-19 school closures
- Provided updates via monthly Data Dashboards and Quarterly team-specific QI reports
- Disseminated Caregiver Letter Series for CBITS that was adopted by the TSA for international use

3. Data Systems

- Continued development and maintenance of a secure, HIPAA compliant, online database that meets the needs of the increasing number of CBITS/BB providers and the children and families they serve, EBP Tracker.
- Refined the "bridge" between EBP Tracker & PIE databases so that partners have a reduced burden of duplicate and/or inefficient data entry in the two systems for teams that utilize both databases.
- Continued improvements to EBP Tracker have been made based upon agency feedback and as possible with available funding. Key improvements are:
  a. When a new episode starts for existing child, allow certain intake information to copy
  b. Add unique, system-generate identification number for CBITS and BB groups/exports
  c. Add "other" item to Trauma Exposure Checklist
  d. Add a subteam dropdown within intake facesheets
  e. Allow searching by co-facilitator & display co-facilitator in results
  f. Allow child and caregiver individual session to be entered after discharge
  g. Upload preparation and testing.
- Maintained a public directory site that provides a searchable, public listing of CBITS and BB providers through EBP Tracker (**https://ebp.dcf.ct.gov/ebpsearch/**).
- Monitored, maintained, and provided technical assistance for online data entry for all CBITS and BB providers via the use of **ebptrackerhelpdesk@uchc.edu,** which resulted in quicker access to support for users in need of additional assistance.
- Continued data-driven reporting and ad hoc data support requests as needed; added the option for on-site EBP Tracker Crash Courses which resulted in 3 unique requests for on-site team training.
- Disseminated data entry support videos to target top three areas that help was requested for: Setting up a Flexible Assessment Schedule, Performing an Intake for a Child/Group; Discharging a Child/Closing a group.

4. Agency Sustainment Funds

- Analyzed and reported aggregated and team-specific financial incentive reports that detailed the financial incentives received for each of two 6 – month performance periods.
- Administered biannual performance-based sustainability funding to improve capacity, access, and quality care -- incentives are intended to partially offset the increased agency costs of providing an evidence-based practice.
- Developed, executed, and managed contracts with each of the providers eligible for financial incentives to concretize implementation expectations, data sharing, and financial incentive details.
- Developed, executed, and managed contracts with each of the providers that are not eligible for financial incentives to detail implementation expectation and data sharing guidelines.
- Distributed $230,038.17 in performance-based sustainment funds to agencies. 47.7% of our total contract funds were disseminated.

Appendix B: Regression Tables

Table B1. Multiple regression analyses of selected demographic variables on Trauma Exposure Checklist, Child report [CBITS]

Predictors	β	*SE*	*95%CI*
Intercept	6.253	0.951	(4.383, 8.123)
Hispanic	1.302*	0.389	(.536, 2.068)
Other Nonhispanic	-1.037	1.156	(-3.310, 1.236)
Black Nonhispanic	1.358*	0.466	(.441, 2.275)
Age at intake	0.052	0.064	(-.075, .178)
Sex	0.732*	0.363	(.018, 1.445)
R^2	0.051		
F	3.873		

* p<.05 As compared to White females
**p<.001

Table B2. Multiple regression analyses of selected demographic variables on Trauma Exposure Checklist, Child report [BB]

Predictors	β	*SE*	*95%CI*
Intercept	3.182	0.87	(1.469, 4.894)
Hispanic	0.315	0.385	(-.442, 1.071)
Other Nonhispanic	-0.805	0.955	(-2.684, 1.074)
Black Nonhispanic	-0.254	0.48	(-1.199, .691)
Age at intake	0.274*	0.097	(.083, .464)
Sex	0.633	0.339	(-.033, 1.299)
R^2	0.043		
F	2.928		

* p<.05 As compared to White females
**p<.001

Table B3. Multiple regression analyses of selected demographic variables on child reported baseline scores [CBITS]

Predictors	1st Total Score, Ohio PS Child			1st Total Score, Ohio FX Child			Overall Severity, CPSS 5 Child		
	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Intercept	21.14	5.613	(10.096, 32.185)	59.277	4.724	(49.980, 68.574)	21.366	5.012	(11.503, 31.229)
Hispanic	-1.521	2.084	(-5.623, 2.581)	0.011	1.754	(-3.442, 3.463)	-0.513	1.861	(-4.176, 3.150)
Other Nonhispanic	6.067	6.382	(-6.492, 18.626)	-4.055	5.372	(-14.627, 6.516)	5.331	5.699	(-5.884, 16.546)
Black Nonhispanic	0.268	2.457	(-4.566, 5.103)	1.413	2.068	(-2.656, 5.482)	-2.854	2.194	(-7.171, 1.463)
Age at intake	-0.34	0.361	(-1.050, .370)	-0.194	0.304	(-.792, .403)	0.388	0.322	(-.246, 1.021)
Sex	-4.313*	1.932	(-8.114, -.513)	3.262	1.626	(.063, 6.461)	-6.029*	1.725	(-9.423, -2.635)
Trauma Exposure, TEC Child	1.92**	0.279	(1.371, 2.469)	-0.832**	0.235	(-1.294, -.370)	2.03**	0.249	(1.540, 2.520)
R^2	0.145			0.053			0.206		
F	8.582			2.833			13.139		

* p<.05 As compared to White females
**p<.001

Table B4. Multiple regression analyses of selected demographic variables on child reported baseline scores [BB]

Predictors	1st Total Score, Ohio PS Child			1st Total Score, Ohio FX Child			Overall Severity, CPSS 5 Child		
	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Intercept	35.375	8.309	(18.911, 51.839)	63.679	7.686	(48.450, 78.908)	32.316	6.901	(18.643, 45.989)
Hispanic	4.905	3.269	(-1.572, 11.383)	-1.746	3.024	(-7.737, 4.245)	1.081	2.715	(-4.298, 6.460)
Other Nonhispanic	13.256	9.163	(-4.899, 31.411)	-7.119	8.475	(-23.912, 9.674)	12.808	7.609	(-2.269, 27.885)
Black Nonhispanic	12.186*	4.275	(3.716, 20.655)	-11.679*	3.954	(-19.513, -3.844)	4.456	3.550	(-2.578, 11.490)
Age at intake	-2.255*	0.82	(-3.880, -.631)	.578	.758	(-.925, 2.080)	-.817	.681	(-2.166, .532)
Sex	-2.73	2.791	(-8.260, 2.800)	-5.668*	2.582	(-10.783, -.553)	-4.036	2.318	(-8.628, .557)
Trauma Exposure, TEC Child	1.028*	0.452	.132, 1.924)	-.616	.418	(-1.445, 2.13)	1.476**	.376	(.731, 2.220)
R^2	.157			.138			.149		
F	3.468			2.992			3.271		

* p<.05

**p<.001

As compared to White females

Table B5. Logistic regression analyses for predicting successful discharge from selected background characteristics [CBITS]

Variable	*N*	β	*SE*	*Wald*	*eB(95%CI)*
Hispanic	203	0.467	0.29	2.605	1.596 (.905, 2.815)
Other Nonhispanic	9	-0.377	1.106	0.116	.686 (.078, 5.992)
Black Nonhispanic	86	1.020*	0.331	9.497	2.774 (1.450, 5.308)
Sex m	125	-1.036**	0.279	13.786	.355 (.205, .613)
Child age	415	-.138*	0.046	9.264	.871 (.796, .952)
Trauma Exposure-TEC Child	415	0.081*	0.036	4.917	1.084 (1.009, 1.164)
Constant		0.12	0.683	0.031	1.128

* p<.05

**p<.001

As compared to White females

Table B6. Logistic regression analyses for predicting successful discharge from selected background characteristics [BB]

Variable	*N*	β	*SE*	*Wald*	*eB(95%CI)*
Hispanic	160	-0.070	0.269	0.63	.932 (.550, 1.581)
Other Nonhispanic	12	-0.440	0.705	.068	.644 (.162, 2.564)
Black Nonhispanic	56	-0.210	0.365	0.39	.810 (.396, 1.656)
Sex m	194	0.383	0.243	0.333	1.466 (.910, 2.363)
Child age	348	0.001	0.068	2.469	1.001 (.876, 1.143)
Trauma Exposure-TEC Child	348	0.076	0.04	3.631	1.079 (.998, 1.166)
Constant		-1.397	0.621	5.063	0.247

* p<.05

**p<.001

As compared to White females

Table B7. Logistic regression analyses for predicting measure available for any measure of child symptoms from selected background characteristics [CBITS]

Variable	*N*	β	*SE*	*Wald*	*eB(95%CI)*
Hispanic	203	0.629	0.808	0.606	1.876 (.385, 9.140)
Other Nonhispanic	9	0.387	2.513	0.024	1.473 (.011, 202.849)
Black Nonhispanic	86	0.098	0.898	0.012	1.103 (.190, 6.410)
Sex m	125	-0.009	0.728	0	.991 (.238, 4.127)
Child age	415	0.168	0.098	2.919	1.183 (.976, 1.434)
Trauma Exposure-TEC Child	415	0.108	0.103	1.108	1.114 (.911, 1.362)
Child Discharged "Unsuccessful"	294	-7.494**	0.752	99.385	.001 (.000, .002)
Constant		-0.464	1.536	0.094	0.629

* p<.05 As compared to White females
**p<.001

Table B8. Logistic regression analyses for predicting measure available for any measure of child symptoms from selected background characteristics [BB]

Variable	*N*	β	*SE*	*Wald*	*eB(95%CI)*
Hispanic	160	0.125	0.867	0.021	1.133 (.207, 6.196)
Other Nonhispanic	12	-0.195	2.319	0.007	.823 (.009, 77.425)
Black Nonhispanic	56	-2.372*	0.945	6.301	.093 (.015, .594)
Sex m	194	0.296	0.716	0.17	1.344 (.330, 5.472)
Child age	348	-0.297	0.219	1.844	.743 (.484, 1.141)
Trauma Exposure-TEC Child	348	0.111	0.114	0.944	1.118 (.893, 1.398)
Child Discharged "Unsuccessful"	241	-7.856**	0.9	76.276	.000 (.000, .002)
Constant		5.129	2.1	5.968	168.879

* p<.05 As compared to White females
**p<.001

Table B9. Multiple regression analyses of selected demographic variables on child reported outcome scores [CBITS]

	Last Total Score, Ohio PS Child			Last Total Score, Ohio FX Child			Last Overall Severity, CPPS 5 Child		
	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Constant	1.494	8.194	(-14.764, 17.752)	25.132	8.087	(-9.086, 41.178)	11.718	7.72	(-3.604, 27.041)
Trauma Exposure-TEC Child	0.299	0.438	(-.571, 1.168)	-0.540	0.341	(-1.217, .136)	0.44	0.445	(-.444, 1.324)
Baseline Score Child	.609**	0.088	(.435, .783)	0.618	0.086	(.447, .788)	0.533	0.093	(.349, .717)
Hispanic	-1.519	3.184	(-7.836, 4.799)	-0.942	2.561	(-6.023, 4.138)	-5.737	3.058	(-11.807, .332)
Other Nonhispanic	13.854	9.581	(-5.157, 32.865)	2.226	7.711	(-13.075, 17.527)	-15.388	9.233	(-33.713, 2.938)
Black Nonhispanic	0.941	3.927	(-6.850, 8.732)	-3.784	3.161	(-10.057, 2.488)	-4.467	3.741	(-11.891, 2.958)
Sex	-1.921*	2.967	(-7.808, 3.967)	1.594	2.391	(-3.151, 6.338)	-5.843	2.851	(-11.502, -.183)
Child age	0.278	0.511	(-.736, 1.291)	.109	0.411	(-.706, .924)	-0.137	0.487	(-1.103, .830)
R^2	0.381			0.390			0.386		
F	7.603			7.923			8.704		

* p<.05 As compared to White females

**p<.001

[1]No variation in variable, therefore it was deleted from the analysis

Table B10. Multiple regression analyses of selected demographic variables on child reported outcome scores [BB]

	Last Total Score, Ohio PS Child			Last Total Score, Ohio FX Child			Last Overall Severity, CPSS 5 Child		
	β	*SE*	*95%CI*	β	*SE*	*95%CI*	β	*SE*	*95%CI*
Constant	31.824	8.707	(13.367, 50.281)	39.186	15.704	(5.713, 72.659)	11.516	6.55	(-1.521, 24.553)
Trauma Exposure-TEC Child	-0.241	0.504	(-1.310, .828)	0.363	0.775	(-1.289, 2.015)	-0.709	0.421	(-1.547, .129)
Baseline Score Child	0.548**	0.096	(.343, .752)	0.23	0.163	(-.117, .577)	.361	0.091	(.179, .543)
Hispanic	-0.035	3.050	(-6.502, 6.432)	-8.849	5.202	(-19.936, 2.239)	0.745	2.658	(-4.546, 6.036)
Other Nonhispanic	-11.736	8.459	(-29.668, 6.197)	-4.867	13.231	(-33.069, 23.335)	-4.752	6.756	(-18.199, 8.694)
Black Nonhispanic	-	-	-	-15.041	7.186	(-30.357, .275)	1.417	3.547	(-5.644, 8.478)
Sex	-3.584	3.036	(-10.019, 2.852)	2.203	4.800	(-9.155, 11.304)	-1.039	2.38	(-5.776, 3.698)
Child age	-3.238*	0.870	(-5.082, -1.393)	1.309	1.306	(-.581, 4.987)	-0.132	0.668	(-1.462, 1.197)
R^2	0.806			0.432			0.183		
F	11.1			1.631			2.535		

* p<.05 As compared to White females
**p<.001

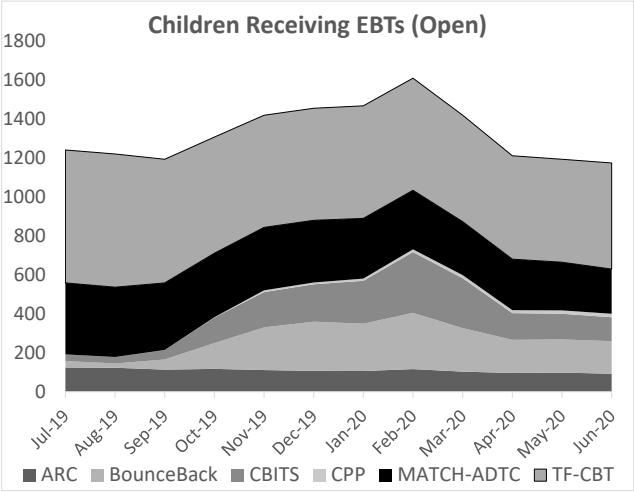
There were no Black Nonhispanic children in dataset for PS analysis

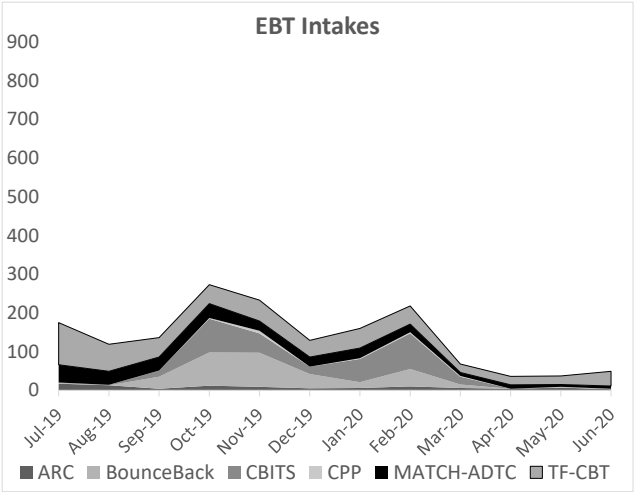
Appendix C: EBT Dashboard

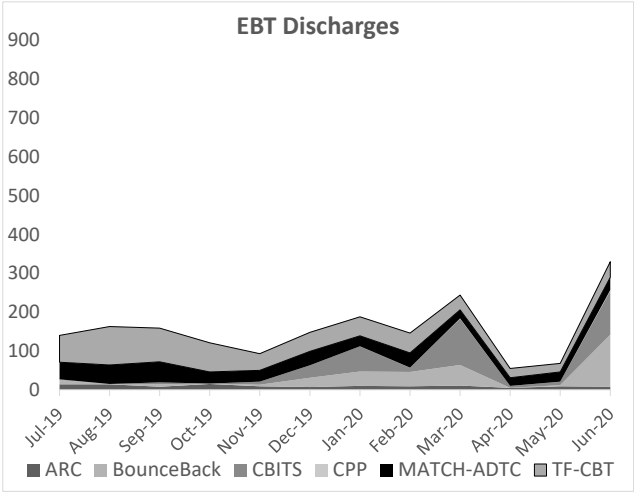
EBT Performance Dashboard: State of Connecticut June 2020

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

Due to COVID-19, CT began stay-at-home orders during March 2020. It is expected that this will affect EBT data and the numbers and trends in this report should be viewed in that context.
For more information, contact Kellie Randall at randall@uchc.edu







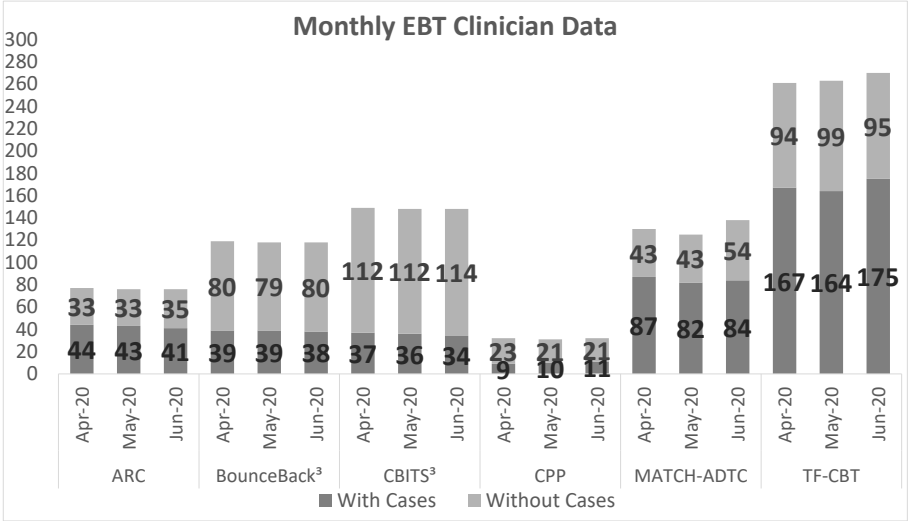
		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	FY20 Total	Yr Total[1]
Open	ARC	124	123	113	117	111	107	106	116	103	96	98	92	203	203
	BounceBack	33	22	52	132	219	252	243	288	223	170	170	167	344	344
	CBITS	34	33	49	131	181	192	220	312	256	137	132	123	379	379
	CPP	0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

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

State of Connecticut: EBT Performance Dashboard cont…

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

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



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

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

[1] One or more visits within the month
[2] QI Period is January 2020 - June 2020
[3] Includes co-facilitators
[4] Includes individuals with a clinical role at time in training. Includes internal agency trainings.

Appendix D: QI Reports

A PARTNER IN NCTSN The National Child Traumatic Stress Network

Child Health and Development Institute of Connecticut, Inc.

QI Overview

The indicators provided in this report cover the period from July-December 2019. Data were pulled from the EBP Tracker database on January 23, 2020. Data were pulled from the PIE database on February 10, 2020. (See FAQs for specific information regarding which database episodes were pulled from). Child episodes were included in the dataset if they were closed in the QI period, and had at least one clinical session during treatment (entire LOS). Treatment episodes were counted regardless of whether a child received multiple EBTs in the time period.

Indicators have been developed for the following models and are included in this report: ARC, BounceBack!, CBITS, MATCH-ADTC, and TF-CBT. In order to adhere to common required elements of all models, some TF-CBT specific indicators have been removed and/or changed as of July 2018. A complete list of the current indicators, benchmarks, and definitions is included below. Benchmarks apply to all models. Percentage columns are highlighted green in the report if an agency has met the proposed benchmark for the indicator and model.

QI Indicators	Benchmark	QI Description
Episodes Closed	-	Treatment episodes discharged in QI period with at least one clinical session during entire LOS.
Engaged	55% of closed episodes	Percentage of closed episodes with four or more clinical sessions attended.
Consistent Care	65% of closed and engaged episodes	Percentage of closed and engaged treatment episodes with an average of two or more treatment episodes per month. Calculated by dividing the LOS by number of visits.
Model Completion	30% of closed and engaged episodes	Percentage of closed and engaged treatment episodes that fully complete the model. Model completion definitions are: - BounceBack!: child attends 7 or more group sessions (attended or make-up) - CBITS: child attends 7 or more group sessions (attended or make-up) - TF-CBT: completion of all required child treatment components and 8 or more sessions Indicator does not apply to ARC and MATCH-ADTC treatment models.
Measures	70% of closed and engaged episodes	Percentage of closed and engaged treatment episodes with at least one measure available at two different time points for any measure of child or caregiver symptoms.
Improved Outcomes	75% of closed and engaged episodes with measures available	Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change (symptom improvement only) on any measure. Includes any measure of child or caregiver symptoms.

Frequently Asked Questions

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

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

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

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

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

What assessments count towards the measures and improved outcomes indicators?

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

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

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

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

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

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

What are the required treatment components for TF-CBT?

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

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

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

Overview - Closed Episodes[1]
July - December 2019

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

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

Overview - Closed Episodes[1]
January - June 2020

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

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

Overview - Closed Episodes - CBITS/BB[1]

July - December 2019

Provider Name	BounceBack!	CBITS	EBT Total
Amity Public Schools	0	0	0
Capitol Region Education Council	0	8	8
Hartford Public Schools	0	0	0
LEARN Regional Education Service Center	0	1	1
Middletown Public Schools	0	0	0
Naugatuck Public Schools	0	0	0
Newtown Public Schools	0	0	0
Optimus Healthcare	0	5	5
Putnam Public Schools	0	2	2
Southwest Community Health Center	0	0	0
Sprague School District	0	0	0
Stamford Public Schools	0	0	0
Stratford Public Schools	9	8	17
Windham Public Schools	1	7	8
Average	**1**	**2**	**3**
Total	**10**	**31**	**41**

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

Overview - Closed Episodes - CBITS/BB[1]

January - June 2020

Provider Name	BounceBack!	CBITS	EBT Total
Amity Public Schools	0	13	13
Capitol Region Education Council	11	86	97
Hartford Public Schools	36	14	50
LEARN Regional Education Service Center	7	11	18
Middletown Public Schools	3	3	6
Naugatuck Public Schools	24	10	34
Newtown Public Schools	11	25	36
Optimus Healthcare	3	22	25
Putnam Public Schools	7	3	10
Southwest Community Health Center	27	11	38
Sprague School District	0	0	0
Stamford Public Schools	0	0	0
Stratford Public Schools	11	13	24
Windham Public Schools	3	21	24
Average	**11**	**17**	**28**
Total	**143**	**219**	**362**

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

Engagement[1] CBITS/BB

July - December 2019

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Closed	Engaged #	Engaged %	# Closed	Engaged #	Engaged %	# Closed	Engaged #	Engaged %
Amity Public Schools	55%	0	-	-	0	-	-	0	-	-
Boys & Girls Village	55%	4	4	100%	5	5	100%	9	9	100%
Bridges Healthcare, Inc	55%	0	-		0	-	-	0	-	-
Capitol Region Education Council	55%	0	-	-	8	8	100%	8	8	100%
Child and Family Agency of Southeastern Connecticut, Inc	55%	5	5	100%	2	2	100%	7	7	100%
Clifford Beers Clinic	55%	0	-	-	0	-	-	0	-	-
Community Health Center, Inc	55%	0	-	-	2	2	100%	2	2	100%
Community Mental Health Affiliates, Inc	55%	14	11	79%	4	0	0%	18	11	61%
Cornell Scott Hill Health Center	55%	0	-	-	0	-	-	0	-	-
Hartford Public Schools	55%	0	-	-	0	-	-	0	-	-
LEARN Regional Education Service Center	55%	0	-	-	1	1	100%	1	1	100%
Mid-Fairfield Child Guidance Center, Inc	55%	0	-	-	0	-	-	0	-	-
Middletown Public Schools	55%	0	-	-	0	-	-	0	-	-
Naugatuck Public Schools	55%	0	-	-	0	-	-	0	-	-
Newtown Public Schools	55%	0	-	-	0	-	-	0	-	-
Optimus Healthcare	55%	0	-	-	5	5	100%	5	5	100%
Putnam Public Schools	55%	0	-	-	2	2	100%	2	2	100%
Southwest Community Health Center	55%	0	-	-	0	-	-	0	-	-
Sprague School District	55%	0	-	-	0	-		0	-	-
Stamford Public Schools	55%	0	-	-	0	-	-	0	-	-
Stratford Public Schools	55%	9	5	56%	8	8	100%	17	13	76%
The Child Guidance Clinic For Central Connecticut, Inc	55%	3	0	0%	0	-	-	3	0	0%
The Village for Families & Children, Inc	55%	0	-	-	0	-	-	0	-	-
United Community and Family Services	55%	0	-	-	0	-	-	0	-	-
Wheeler Clinic	55%	0	-	-	0	-	-	0	-	-
Windham Public Schools	55%	1	1	100%	7	7	100%	8	8	100%
Average	**-**	**1**	**4**	**-**	**2**	**4**	**-**	**3**	**6**	**-**
Total	**55%**	**36**	**26**	**72%**	**44**	**40**	**91%**	**80**	**66**	**83%**

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

Engagement[1] CBITS/BB
January - June 2020

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Closed	Engaged #	Engaged %	# Closed	Engaged #	Engaged %	# Closed	Engaged #	Engaged %
Amity Public Schools	55%	0	-	-	13	13	100%	13	13	100%
Boys & Girls Village	55%	4	4	100%	4	3	75%	8	7	88%
Bridge Healthcare, Inc	55%	0	-	-	0	-	-	0	-	-
Capitol Region Education Council	55%	11	11	100%	86	41	48%	97	52	54%
Child and Family Agency of Southeastern Connecticut, Inc	55%	38	28	74%	18	14	78%	56	42	75%
Clifford Beers Clinic	55%	12	8	67%	26	18	69%	38	26	68%
Community Health Center, Inc	55%	0	-	-	13	4	31%	13	4	31%
Community Mental Health Affiliates, Inc	55%	4	4	100%	0	-	-	4	4	100%
Cornell Scott Hill Health Center	55%	7	6	86%	3	3	100%	10	9	90%
Hartford Public Schools	55%	36	14	39%	14	4	29%	50	18	36%
LEARN Regional Education Service Center	55%	7	7	100%	11	7	64%	18	14	78%
Mid-Fairfield Child Guidance Center, Inc	55%	19	19	100%	11	5	45%	30	24	80%
Middletown Public Schools	55%	3	3	100%	3	0	0%	6	3	50%
Naugatuck Public Schools	55%	24	16	67%	10	0	0%	34	16	47%
Newtown Public Schools	55%	11	0	0%	25	2	8%	36	2	6%
Optimus Healthcare	55%	3	3	100%	22	18	82%	25	21	84%
Putnam Public Schools	55%	7	7	100%	3	3	100%	10	10	100%
Southwest Community Health Center	55%	27	27	100%	11	7	64%	38	34	89%
Sprague School District	55%	0	-	-	0	-	-	0	-	-
Stamford Public Schools	55%	0	-	-	0	-	-	0	-	-
Stratford Public Schools	55%	11	7	64%	13	13	100%	24	20	83%
The Child Guidance Clinic For Central Connecticut, Inc	55%	37	37	100%	11	11	100%	48	48	100%
The Village for Families & Children, Inc	55%	0	-	-	0	-	-	0	-	-
United Community and Family Services	55%	0	-	-	0	-	-	0	-	-
Wheeler Clinic	55%	0	-	-	4	4	100%	4	4	100%
Windham Public Schools	55%	3	0	0%	21	17	81%	24	17	71%
Average	**-**	**11**	**11**	**-**	**12**	**9**	**-**	**23**	**19**	**-**
Total	**55%**	**264**	**201**	**76%**	**322**	**187**	**58%**	**586**	**388**	**66%**

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

Measurement Based Care[1] CBITS/BB
July - December 2019

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Engaged	Measures Available		# Engaged	Available		# Engaged	Available	
			#	%		#	%		#	%
Amity Public Schools	70%	-	-	-	-	-	-	-	-	-
Boys & Girls Village	70%	4	3	75%	5	4	80%	9	7	78%
Bridges Healthcare, Inc	70%	-	-	-	-	-	-	-	-	-
Capitol Region Education Council	70%	-	-	-	8	0	0%	8	0	0%
Child and Family Agency of Southeastern Connecticut, Inc	70%	5	4	80%	2	0	0%	7	4	57%
Clifford Beers Clinic	70%	-	-	-	-	-	-	-	-	-
Community Health Center, Inc	70%	-	-	-	2	0	0%	2	0	0%
Community Mental Health Affiliates, Inc	70%	11	9	82%	0	-	-	11	9	82%
Cornell Scott Hill Health Center	70%	-	-	-	-	-	-	-	-	-
Hartford Public Schools	70%	-	-	-	-	-	-	-	-	-
LEARN Regional Education Service Center	70%	-	-	-	1	1	100%	1	1	100%
Mid-Fairfield Child Guidance Center, Inc	70%	-	-	-	-	-	-	-	-	-
Middletown Public Schools	70%	-	-	-	-	-	-	-	-	-
Naugatuck Public Schools	70%	-	-	-	-	-	-	-	-	-
Newtown Public Schools	70%	-	-	-	-	-	-	-	-	-
Optimus Healthcare	70%	-	-	-	5	0	0%	5	0	0%
Putnam Public Schools	70%	-	-	-	2	0	0%	2	0	0%
Southwest Community Health Center	70%	-	-	-	-	-	-	-	-	-
Sprague School District	70%	-	-		-	-		-	-	-
Stamford Public Schools	70%	-	-	-	-	-	-	-	-	-
Stratford Public Schools	70%	5	0	0%	8	0	0%	13	0	0%
The Child Guidance Clinic For Central Connecticut, Inc	70%	0	-	-	-	-	-	0	-	-
The Village for Families & Children, Inc	70%	-	-	-	-	-	-	-	-	-
United Community and Family Services	70%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	70%	-	-	-	-	-	-	-	-	-
Windham Public Schools	70%	1	0	0%	7	5	71%	8	5	63%
Average	**-**	**4**	**3**	**-**	**4**	**1**	**-**	**6**	**3**	**-**
Total	**70%**	**26**	**16**	**62%**	**40**	**10**	**25%**	**66**	**26**	**39%**

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

Measurement Based Care[1] CBITS/BB
January - June 2020

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Engaged	Measures Available #	Measures Available %	# Engaged	Measures Available #	Measures Available %	# Engaged	Measures Available #	Measures Available %
Amity Public Schools	70%	-	-	-	13	4	31%	13	4	31%
Boys & Girls Village	70%	4	4	100%	3	3	100%	7	7	100%
Bridge Healthcare, Inc	70%	-	-	-	-	-	-	-	-	-
Capitol Region Education Council	70%	11	5	45%	41	40	98%	52	45	87%
Child and Family Agency of Southeastern Connecticut, Inc	70%	28	10	36%	14	3	21%	42	13	31%
Clifford Beers Clinic	70%	8	7	88%	18	10	56%	26	17	65%
Community Health Center, Inc	70%	-	-	-	4	0	0%	4	0	0%
Community Mental Health Affiliates, Inc	70%	4	3	75%	-	-	-	4	3	75%
Cornell Scott Hill Health Center	70%	6	0	0%	3	0	0%	9	0	0%
Hartford Public Schools	70%	14	4	29%	4	0	0%	18	4	22%
LEARN Regional Education Service Center	70%	7	4	57%	7	0	0%	14	4	29%
Mid-Fairfield Child Guidance Center, Inc	70%	19	18	95%	5	0	0%	24	18	75%
Middletown Public Schools	70%	3	0	0%	0	-	-	3	0	0%
Naugatuck Public Schools	70%	16	16	100%	0	-	-	16	16	100%
Newtown Public Schools	70%	0	-	-	2	0	0%	2	0	0%
Optimus Healthcare	70%	3	0	0%	18	8	44%	21	8	38%
Putnam Public Schools	70%	7	4	57%	3	0	0%	10	4	40%
Southwest Community Health Center	70%	27	6	22%	7	7	100%	34	13	38%
Sprague School District	70%	-	-	-	-	-	-	-	-	-
Stamford Public Schools	70%	-	-	-	-	-	-	-	-	-
Stratford Public Schools	70%	7	0	0%	13	4	31%	20	4	20%
The Child Guidance Clinic For Central Connecticut, Inc	70%	37	0	0%	11	0	0%	48	0	0%
The Village for Families & Children, Inc	70%	-	-	-	-	-	-	-	-	-
United Community and Family Services	70%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	70%	-	-	-	4	4	100%	4	4	100%
Windham Public Schools	70%	0	-	-	17	10	59%	17	10	59%
Average	**-**	**11**	**5**	**-**	**9**	**5**	**-**	**18**	**8**	**-**
Total	**70%**	**201**	**81**	**40%**	**187**	**93**	**50%**	**388**	**174**	**45%**

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

Improved Outcomes[1] CBITS/BB
July - December 2019

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Measures Available	Improved Outcomes		# Measures Available	Improved		# Measures Available	Improved	
			#	%		#	%		#	%
Amity Public Schools	75%	-	-	-	-	-	-	-	-	-
Boys & Girls Village	75%	3	3	100%	4	4	100%	7	7	100%
Bridges Healthcare, Inc	75%	-	-	-	-	-		-	-	
Capitol Region Education Council	75%	-	-	-	0	-	-	0	-	-
Child and Family Agency of Southeastern Connecticut, Inc	75%	4	2	50%	0	-	-	4	2	50%
Clifford Beers Clinic	75%	-	-	-	-	-	-	-	-	-
Community Health Center, Inc	75%	-	-	-	0	-	-	0	-	-
Community Mental Health Affiliates, Inc	75%	9	7	78%	-	-	-	9	7	78%
Cornell Scott Hill Health Center	75%	-	-	-	-	-	-	-	-	-
Hartford Public Schools	75%	-	-	-	-	-	-	-	-	-
LEARN Regional Education Service Center	75%	-	-	-	1	1	100%	1	1	100%
Mid-Fairfield Child Guidance Center, Inc	75%	-	-	-	-	-	-	-	-	-
Middletown Public Schools	75%	-	-	-	-	-	-	-	-	-
Naugatuck Public Schools	75%	-	-	-	-	-	-	-	-	-
Newtown Public Schools	75%	-	-	-	-	-	-	-	-	-
Optimus Healthcare	75%	-	-	-	0	-	-	0	-	-
Putnam Public Schools	75%	-	-	-	0	-	-	0	-	-
Southwest Community Health Center	75%	-	-	-	-	-	-	-	-	-
Sprague School District	75%	-	-		-	-		-	-	
Stamford Public Schools	75%	-	-	-	-	-	-	-	-	-
Stratford Public Schools	75%	0	-	-	0	-	-	0	-	-
The Child Guidance Clinic For Central Connecticut, Inc	75%	-	-	-	-	-	-	-	-	-
The Village for Families & Children, Inc	75%	-	-	-	-	-	-	-	-	-
United Community and Family Services	75%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	75%	-	-	-	-	-	-	-	-	-
Windham Public Schools	75%	0	-	-	5	5	100%	5	5	100%
Average	**-**	**3**	**4**	**-**	**1**	**3**	**-**	**3**	**4**	**-**
Total	**75%**	**16**	**12**	**75%**	**10**	**10**	**100%**	**26**	**22**	**85%**

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

Improved Outcomes[1] CBITS/BB
January - June 2020

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes		# Measures Available	Improved Outcomes	
			#	%		#	%		#	%
Amity Public Schools	75%	-	-	-	4	3	75%	4	3	75%
Boys & Girls Village	75%	4	4	100%	3	2	67%	7	6	86%
Bridge Healthcare, Inc	75%	-	-	-	-	-		-	-	-
Capitol Region Education Council	75%	5	3	60%	40	32	80%	45	35	78%
Child and Family Agency of Southeastern Connecticut, Inc	75%	10	9	90%	3	3	100%	13	12	92%
Clifford Beers Clinic	75%	7	2	29%	10	6	60%	17	8	47%
Community Health Center, Inc	75%	-	-	-	0	-	-	0	-	-
Community Mental Health Affiliates, Inc	75%	3	3	100%	-	-	-	3	3	100%
Cornell Scott Hill Health Center	75%	0	-	-	0	-	-	0	-	-
Hartford Public Schools	75%	4	3	75%	0	-	-	4	3	75%
LEARN Regional Education Service Center	75%	4	4	100%	0	-	-	4	4	100%
Mid-Fairfield Child Guidance Center, Inc	75%	18	16	89%	0	-	-	18	16	89%
Middletown Public Schools	75%	0	-	-	-	-	-	0	-	-
Naugatuck Public Schools	75%	16	10	63%	-	-	-	16	10	63%
Newtown Public Schools	75%	-	-	-	0	-	-	0	-	-
Optimus Healthcare	75%	0	-	-	8	8	100%	8	8	100%
Putnam Public Schools	75%	4	3	75%	0	-	-	4	3	75%
Southwest Community Health Center	75%	6	6	100%	7	6	86%	13	12	92%
Sprague School District	75%	-	-	-	-	-	-	-	-	-
Stamford Public Schools	75%	-	-	-	-	-	-	-	-	-
Stratford Public Schools	75%	0	-	-	4	3	75%	4	3	75%
The Child Guidance Clinic For Central Connecticut, Inc	75%	0	-	-	0	-	-	0	-	-
The Village for Families & Children, Inc	75%	-	-	-	-	-	-	-	-	-
United Community and Family Services	75%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	75%	-	-	-	4	3	75%	4	3	75%
Windham Public Schools	75%	-	-	-	10	7	70%	10	7	70%
Average	**-**	**5**	**6**	**-**	**5**	**7**	**-**	**8**	**9**	**-**
Total	**75%**	**81**	**63**	**78%**	**93**	**73**	**78%**	**174**	**136**	**78%**

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

Model Completion[1] CBITS/BB
July - December 2019

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
			Model Completion			Model Completion			Model Completion	
		# Engaged	#	%	# Engaged	#	%	# Engaged	#	%
Amity Public Schools	30%	-	-	-	-	-	-	-	-	-
Boys & Girls Village	30%	4	4	100%	5	4	80%	9	8	89%
Bridges Healthcare, Inc	30%	-	-	-	-	-	-	-	-	-
Capitol Region Education Council	30%	-	-	-	8	7	88%	8	7	88%
Child and Family Agency of Southeastern Connecticut, Inc	30%	5	5	100%	2	2	100%	7	7	100%
Clifford Beers Clinic	30%	-	-	-	-	-	-	-	-	-
Community Health Center, Inc	30%	-	-	-	2	2	100%	2	2	100%
Community Mental Health Affiliates, Inc	30%	11	11	100%	0	-	-	11	11	100%
Cornell Scott Hill Health Center	30%	-	-	-	-	-	-	-	-	-
Hartford Public Schools	30%	-	-	-	-	-	-	-	-	-
LEARN Regional Education Service Center	30%	-	-	-	1	1	100%	1	1	100%
Mid-Fairfield Child Guidance Center, Inc	30%	-	-	-	-	-	-	-	-	-
Middletown Public Schools	30%	-	-	-	-	-	-	-	-	-
Naugatuck Public Schools	30%	-	-	-	-	-	-	-	-	-
Newtown Public Schools	30%	-	-	-	-	-	-	-	-	-
Optimus Healthcare	30%	-	-	-	5	5	100%	5	5	100%
Putnam Public Schools	30%	-	-	-	2	2	100%	2	2	100%
Southwest Community Health Center	30%	-	-	-	-	-	-	-	-	-
Sprague School District	30%	-	-		-	-		-	-	-
Stamford Public Schools	30%	-	-	-	-	-	-	-	-	-
Stratford Public Schools	30%	5	5	100%	8	7	88%	13	12	92%
The Child Guidance Clinic For Central Connecticut, Inc	30%	0	-	-	-	-	-	0	-	-
The Village for Families & Children, Inc	30%	-	-	-	-	-	-	-	-	-
United Community and Family Services	30%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	30%	-	-	-	-	-	-	-	-	-
Windham Public Schools	30%	1	1	100%	7	7	100%	8	8	100%
Average	**-**	**4**	**5**	**-**	**4**	**4**	**-**	**6**	**6**	**-**
Total/Average	**30%**	**26**	**26**	**100%**	**40**	**37**	**93%**	**66**	**63**	**95%**

[1] Percentage of closed and engaged treatment episodes that fully complete the model. CBITS/BB defines episode completion as 7 or more group sessions (attended or make-up).

Model Completion[1] CBITS/BB
January - June 2020

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
			Model Completion			Model Completion			Model Completion	
		# Engaged	#	%	# Engaged	#	%	# Engaged	#	%
Amity Public Schools	30%	-	-	-	13	6	46%	13	6	46%
Boys & Girls Village	30%	4	4	100%	3	3	100%	7	7	100%
Bridge Healthcare, Inc	30%	-	-	-	-	-	-	-	-	-
Capitol Region Education Council	30%	11	11	100%	41	39	95%	52	50	96%
Child and Family Agency of Southeastern Connecticut, Inc	30%	28	20	71%	14	9	64%	42	29	69%
Clifford Beers Clinic	30%	8	8	100%	18	15	83%	26	23	88%
Community Health Center, Inc	30%	-	-	-	4	0	0%	4	0	0%
Community Mental Health Affiliates, Inc	30%	4	4	100%	-	-	-	4	4	100%
Cornell Scott Hill Health Center	30%	6	3	50%	3	0	0%	9	3	33%
Hartford Public Schools	30%	14	5	36%	4	0	0%	18	5	28%
LEARN Regional Education Service Center	30%	7	7	100%	7	3	43%	14	10	71%
Mid-Fairfield Child Guidance Center, Inc	30%	19	19	100%	5	0	0	24	19	79%
Middletown Public Schools	30%	3	0	0%	0	-	-	3	0	0%
Naugatuck Public Schools	30%	16	16	100%	0	-	-	16	16	100%
Newtown Public Schools	30%	0	-	-	2	0	0%	2	0	0%
Optimus Healthcare	30%	3	0	0%	18	17	94%	21	17	81%
Putnam Public Schools	30%	7	7	100%	3	3	100%	10	10	100%
Southwest Community Health Center	30%	27	13	48%	7	7	100%	34	20	59%
Sprague School District	30%	-	-	-	-	-	-	-	-	-
Stamford Public Schools	30%	-	-	-	-	-	-	-	-	-
Stratford Public Schools	30%	7	1	14%	13	8	62%	20	9	45%
The Child Guidance Clinic For Central Connecticut, Inc	30%	37	30	81%	11	4	36%	48	34	71%
The Village for Families & Children, Inc	30%	-	-	-	-	-	-	-	-	-
United Community and Family Services	30%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	30%	-	-	-	4	4	100%	4	4	100%
Windham Public Schools	30%	0	-	-	17	12	71%	17	12	71%
Average	**-**	**11**	**9**	**-**	**9**	**7**	**-**	**18**	**13**	**-**
Total/Average	**30%**	**201**	**148**	**74%**	**187**	**130**	**70%**	**388**	**278**	**72%**

[1] Percentage of closed and engaged treatment episodes that fully complete the model. CBITS/BB defines episode completion as 7 or more group sessions (attended or make-up).

Appendix E: Reliable Change Index

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

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

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

Acknowledgements

We wish to acknowledge the following CHDI staff that have worked on this report: Jason Lang, Jack Lu, Diana Perry, Kellie Randall, and Heather Solak. We also wish to thank others who have contributed to the CBITS/BB Coordinating Center initiative including Sharon Bailey, Lori DiPietro, Tiffany Franceschetti, Amanda Kach, Alice Kraiza, Ashley Loser, Jessica Mahon, Ashley Nelson, Carol O'Connor, Carrie Shaw, and Jeff Vanderploeg.

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