Connecticut's Evidence Based Treatment Coordinating Center: Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Bounce Back

FY 2019 Annual Report

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Executive Summary

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Initiative Coordinating Center ("Coordinating Center"), is located at the Child Health and Development Institute (CHDI). The Coordinating Center is funded by the Department of Children and Families (DCF), and represents a partnership between DCF, Sharon Hoover, Ph.D. (National Trainer), Site-Based Trainers (SBT), the Child Health and Development Institute (CHDI), Wheeler Clearinghouse, and participating school-based health centers, schools, school districts, and community providers. CBITS (designed for students in grades 4-12) and Bounce Back (BB), an adaptation for grades K-5, are brief, evidence-based, manualized group interventions for youth reporting post-traumatic reactions due to exposure to violence, abuse, and other forms of trauma.

The overall goal of the Coordinating Center is to improve access to evidence-based school-based behavioral health treatment for children suffering from exposure to violence, abuse, and other forms of trauma. Using implementation science and economies of scale, the Coordinating Center supports a network of 23 teams offering CBITS and/or BB to students throughout Connecticut. The Coordinating Center provides training, credentialing, implementation support, site-based consultation, data collection and reporting, and ongoing quality improvement. This report summarizes the work of the Coordinating Center for state fiscal year 2019 (July 1, 2018 through June 30, 2019).

Highlights of FY 19:
- A total of 876 students received either CBITS or BB, nearly double the number of children served in FY18.
- Students served were 44% male, and on average 11.2 years old. Participants were racially/ethnically diverse, including 48.1% who identified as Hispanic/Latino, 22.3% as African-American/Black, 25.3% as non-Hispanic Caucasian, and 3.8% identify their race as Other.
- 1154 students were screened for trauma exposure and associated symptoms. Since 2015, more than 3,300 students have been screened, and more than half (54.9%, N=1836) have been found eligible to participate in CBITS or BB due to concerning levels of trauma exposure and traumatic stress symptoms.
- Three CBITS new clinician trainings were held for 51 clinical staff from 18 different provider teams, as well as four BB new clinician trainings for 59 clinical staff from 19 different provider teams; CBITS continued to expand beyond schools to three new community-based sites (e.g. outpatient/EDT).
- Certifications included 10 CBITS and five BB clinicians.
- Children completing CBITS (63.9%) and BB (69.1%) report reliable improvement in PTSD symptoms. For those with pre-treatment PTSD symptoms above the clinical cutoff, 73.4% of children in CBITS and 78.6% of children in BB experienced a reliable reduction in trauma symptoms at discharge. Additionally, for that same subset of children that reported pre-

treatment symptoms above the clinical cutoff, 55.2% of children in CBITS and 68.7% of children in BB experienced symptom remission.

- Children receiving CBITS/BB achieved similar outcomes regardless of race/ethnicity and sex; older children showed slightly less improvement than younger children.
- As defined by the percentage of closed treatment episodes with at least four or more sessions, engagement was extremely high for BB (99.5%) and CBITS (90.5%) participants, and the vast majority of children across CBITS/BB successfully completed treatment (89.4%).
- 98% of caregivers and 81% of children reported they were either "mostly satisfied" or "very satisfied" with CBITS/BB treatment.
- Biannual QI reports commenced for CBITS and BB.
- Significant improvement in three out of four CBITS/BB quality improvement indicators across the state. For the fourth indicator (BB Engagement), there was a minor reduction in engagement from 100% to 99%.
- Enhanced sustainability funding formulas to strengthen performance-based incentives for providers and time devoted to workforce development.
- Created a CBITS Caregiver Letter series to strengthen caregiver engagement, which was adopted by the Treatment and Services Adaptation Center for national and international CBITS model delivery.
- Implemented flexible assessment schedule to support clinicians' application of outcomes measures based on clinical needs.

Key Recommendations:

State/Districts
- State agencies and policymakers communicate about the availability of CBITS/BB and the successful outcomes from CT districts to districts, school-based health centers, and other stakeholders.
- The state and school districts examine best practices for integrating CBITS/BB within a multi-tiered system of supports for trauma-informed school and student mental health.

CHDI Coordinating Center
- Increase clinician training in the use of clinical measures, EBP Tracker data system, special populations, and utilizing school-based infrastructure supports to enhance the CBITS/BB model implementation.
- Identify strategies to strengthen symptom improvement for older children.
- Continue evaluating, and potentially refining, CBITS and BB QI Indicators by examining trends that emerge since FY19.
- Devise and implement new state-level CBITS/BB compensation plan for agencies and their employees who serve as state-level trainers to enhance statewide implementation efforts in FY20.
- Develop a model for evaluating the effect of CBITS/BB on academic performance.

Introduction

The overall goal of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Bounce Back (BB) Coordinating Center is to improve access to evidence-based, school-based behavioral health treatment for children with a history of exposure to abuse, violence, and/or other forms of trauma. Using implementation science and economies of scale, the Coordinating Center supported a network of 23 CBITS/BB teams throughout Connecticut during this fiscal year. The Coordinating Center offers centralized support for the statewide network through the following primary functions:

      1) Training, consultation, and credentialing
      2) Implementation support and quality improvement
      3) Data collection and reporting
      4) Administration of performance-based sustainment funds, and
      5) Expanding access to CBITS and BB training and implementation support throughout the state

This report summarizes the work of The CBITS/BB Coordinating Center for state fiscal year 2019 (July 1, 2018 through June 30, 2019).

Background

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.

In 2014, Connecticut's DCF recognized the need to provide schools with resources for supporting students exposed to trauma. DCF partnered with CHDI to serve as the Coordinating Center for CBITS. In the spring of 2015, CBITS training and dissemination was piloted in Bridgeport, leading to one group being implemented.

During FY16, clinicians serving the Bridgeport, New Haven, New London, and Stamford school districts were trained, resulting in 60 groups being implemented.

In FY17, recognizing the need for even earlier intervention, DCF and CHDI began disseminating BB to assist younger students experiencing traumatic stress. As a result, a total of 101 CBITS/BB groups were held in nine Connecticut communities.

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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.

In FY18, training in both models continued and multiple new districts joined the Initiative. As a result of this expansion, CBITS/BB was implemented in 11 school districts, two Regional Educational Service Center districts, and three additional communities through outpatient or extended day treatment programs.

In FY19, the Coordinating Center expanded to support a growing network of providers. CBITS was available in 49 different schools and 11 community-based settings across 19 different provider teams. BB was available in 44 schools and 10 community-based settings across 18 different provider teams. A total of 94 BB and 105 CBITS groups ran this fiscal year.

Goals

The overarching goals for the Coordinating Center are to:
>   (1) Improve access to CBITS/BB for all Connecticut children who have been exposed to trauma and report post-traumatic stress symptoms.
>   (2) Achieve high quality implementation of CBITS/BB.
>   (3) Demonstrate improved child outcomes for children receiving CBITS/BB.
>   (4) Provide initial clinical training, initial training in the use, scoring, and interpretation of measures, and ongoing booster training opportunities.

Access: Availability of CBITS/BB in Connecticut

Since the Initiative began in 2015, CBITS (and BB once it was first offered in 2017) continues to be disseminated as part of the statewide effort to increase trauma-informed treatment access for children impacted by trauma. Educators, clinical personnel, and community members across the state continue to report interest in bringing CBITS or BB to their districts or schools. As a result, in FY19, CBITS was available at 49 schools and 6 community-based settings across 19 different providers, and BB was available at 44 schools and 6 community-based settings across 18 different providers. . A total of 94 BB and 105 CBITS groups ran in FY19.

Table 1 below shows details about CBITS and BB teams during FY19. The number of active CBITS and BB clinicians grew by 76.9% (N = 69) and 107.4% (N = 56) respectively from the previous fiscal year. Figures 1 and 2 below show location of CBITS and BB sites across the state and Table 2 shows the trends in access over the past three years as well as cumulative totals.

Table 1. FY19 CBITS and BB teams

	CBITS	BB
# of clinicians on team	138	101
# of clinicians seeing at least one case	69	56
Average team size-school district	6.16 (R 1-22)	2.18 (R 1-5)
Average team size-community-based	2.36 (R 1-5)	4.27 (R 1-10)

Figure 1. Map of CBITS Sites and Children Served
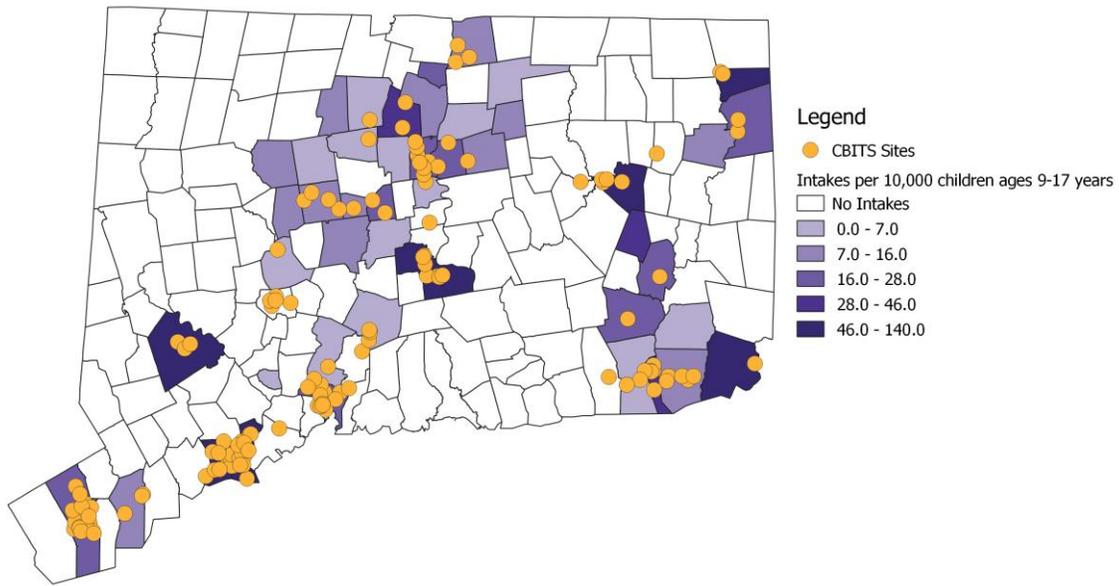
Figure 2. Map of BB Sites and Children Served
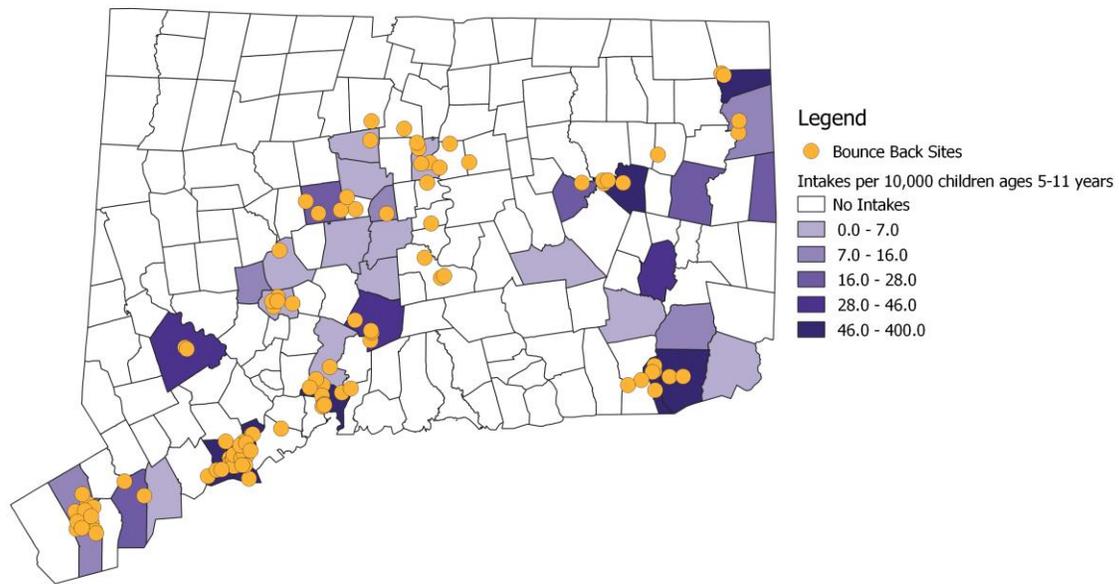
Clinician Training and Credentialing

There were 51 clinicians newly trained in CBITS and 59 clinicians newly trained in BB during the fiscal year. The number of newly trained clinicians is slightly lower than previous years, which is a result of a more intentional process that team leaders (senior leaders and coordinators) have used to build teams. As implementation support increases its focus on quality improvement, team leaders

are more aware of the relationship between training and group deliverable expectations and are interested in managing team composition in order to meet the required expectation. Additionally, full-day CBITS/BB booster training sessions were offered on two occasions this fiscal year. 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, an area that is paramount when working with trauma material. Fifty-one clinicians participated in booster training this year.

We continued to track certification for CBITS and BB clinicians this year and 10 CBITS clinicians and 5 BB clinicians met the Connecticut CBITS or BB certification criteria in FY19. The certification process recognizes clinicians who complete all training and consultation requirements as well as provide CBITS/BB successfully to at least two groups and three children.

Table 2. Trends in CBITS/BB provider network

	FY17	FY18	**FY 19**	Cumulative Since 2015
CBITS Schools	40	34	**49**	
BB Schools	16	24	**44**	110*
CBITS School Districts	9	13	**18**	
BB School Districts	6	11	**16**	24*
CBITS Community-Based Settings**	0	1	**6**	
BB Community-Based Settings**	0	2	**6**	9*
Newly Trained CBITS Clinicians[1]	100	66	**42**	
Newly Trained BB Clinicians[1]	64	38	**49**	277*
Clinicians Providing CBITS	35	39	**69**	
Clinicians Providing BB	15	27	**56**	152*
# Newly Certified in CBITS	-	12	**10**	
# Newly Certified in BB	-	4	**5**	28*

*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 138 clinicians providing CBITS and 101

clinicians providing BB this year are presented in Table 3. CBITS and BB clinicians were primarily female and mostly; 10% of clinicians spoke Spanish.

Table 3. CBITS/BB clinician demographic characteristics (n=138/101)

Characteristic	CBITS %	BB %
Sex (Male)	7.2	1.0
Race		
Black or African American	13.9	3.3
Hispanic, Latino, or Spanish	13.9	13.3
White	69.4	76.7
Other Race/Ethnicity	2.8	6.7
Languages Spoken		
Spanish	10.1	10.0
Other[2]	7.3	3.3

[2]Other languages include American Sign Language, French, French Creole, and Portuguese

Access: Children Receiving CBITS/BB

Service Trends Over Time

CBITS and BB continue to expand throughout the state, with increases each year in the number of children screened, found eligible, and ultimately receiving services. In FY19, 1154 children were screened and 686 were eligible to receive treatment; 487 children received CBITS and 389 children received BB during the year. The number of children receiving CBITS and BB over time is illustrated in Figure 3 below. To date, 1436 children have received CBITS since 2015 and 704 children have received BB since 2017 (2140 total children served). The number of children served increased from FY18 to FY19, with more than double the number of children receiving BB (a 112.6% increase) and a 79.7% increase in children receiving CBITS.

The number of children screened increased by 41.6% from FY18 to FY19, which is related to the increase in clinicians trained to use and score screening measures. Additionally, this increase is a result of a strengthened ability for our network to accurately report screening activities that occur throughout the year. CHDI focused on improving the accuracy of screening data by providing technical assistance, tracking templates, and implementation support focused on building the capacity within each team to report screening data in an accurate and timely manner.

Figure 3. Children served by fiscal year
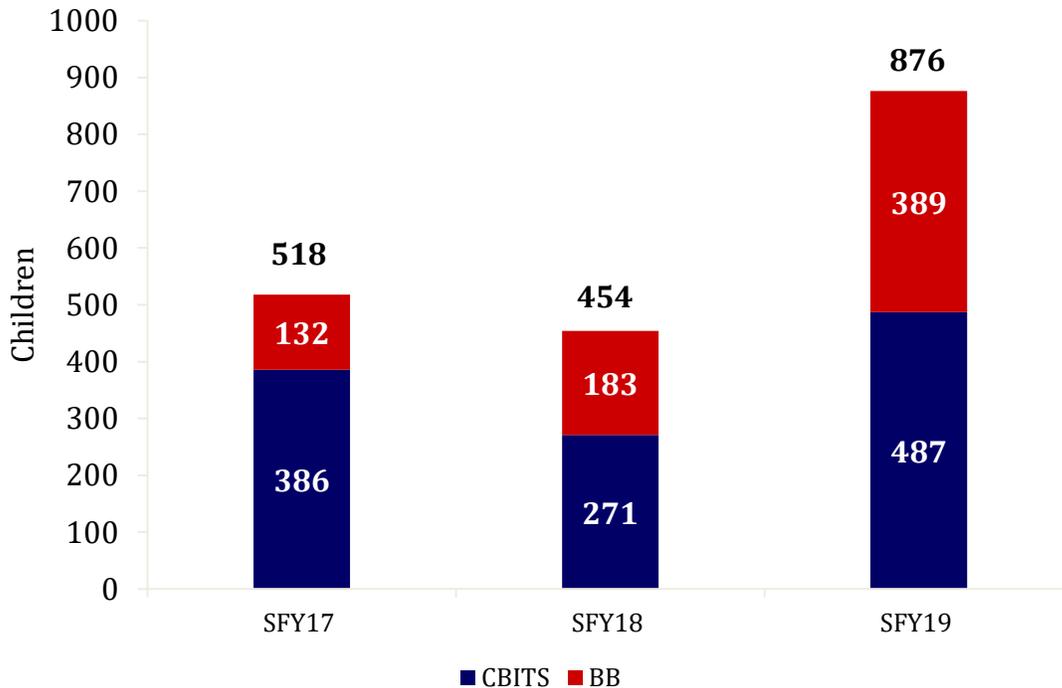
Demographics and Characteristics of Children Receiving CBITS/BB

Table 4 below provides descriptive statistics for children receiving CBITS and BB in FY19, 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 FY19 were Female (55.6%), Hispanic (48.1%), and primarily speak English (94.7%). Higher rates of Hispanic children and lower rates of White children received CBITS/BB as compared to the percentage of Hispanic and White children in the overall CT school population as well as the general CT population.

The average age of youth who received CBITS is 13.3 years (SD=2.38), and 8.38 years for youth who received BB (SD=1.46). There were higher rates of children age 10-14 years and 15-17 years who received CBITS and higher rates of children age 5-9 years who received BB as compared to the CT school population and general CT population, although this is expected based on the age range that the model is appropriate for.

Table 4. Characteristics of children receiving CBITS/BB (n=876) with comparisons

	CBITS		BB		Schools[3]	Child pop[4]
	N	%	N	%	%	%
Sex (Male)[i]	180	37.0	209	53.7	51.6	51.2
Race						
Black or African American	108	22.2	87	22.6	12.8	12.4
Hispanic, Latino, or Spanish	248	50.9	173	44.9	25.8	24.1
White	117	24.0	105	27.3	52.4	54.9
Other Race/Ethnicity	14	2.9	20	5.2	8.8	16.4
Age (years)						
Under 5 years	2	.4	0	-	N/A	24.5
5-9 years	20	4.2	301	77.4	N/A	26.3
10-14 years	319	67.4	88	22.6	N/A	30.2
15-17 years	132	27.9	0	-	N/A	19.0
Grade						
Elementary	56	11.5	376	97.2	45.7	N/A
Middle	207	42.5	11	2.8	22.8	N/A
High	224	46.0	0	-	31.4	N/A
Child welfare involvement during Treatment	57	12.8	52	14.6	N/A	N/A
JJ involvement during treatment	10	2.3	1	.30	N/A	N/A
Child primary language Spanish	17	6.3	28	12.1	N/A	14.2
Neither Spanish nor English	0	0	1	.40	N/A	7.7
Caregiver speaks English (no)	39	11.0	50	17.4	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 2018-19 school year. Hispanic category includes Hispanic/Latino of any race. Age and language spoken not available.
[4]American Community Survey 2017 1 yr. estimates. Caution should be used with comparison to CT Schools and CBITS/BB child demographics. Census race categories exclude Hispanic ethnicity only for White children while CBITS/BB race categories exclude Hispanic regardless of race. Census language is only available by language spoken, not primary language. Age is percentage of children 0-17 years.
[5]We recognize there are alternate terms for describing ethnicity. This report uses "Hispanic" and "Latino" to remain consistent with the way it is reported in the data system, which reflects the terminology in the U.S. Census.

Child 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
8.23 different types of potentially traumatic events, while those who received BB
reported experiencing an average of 5.67 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 Table B1 in Appendix B. There was a significant difference in
TEC scores by race/ethnicity group for children who received CBITS; Hispanic
children (β=1.523, *p*=.000) and Black children (β=1.958, *p*=.000) reported exposure
to a greater number of traumatic events compared to White children. There were
also significant differences in TEC scores by age, but not for sex on baseline TEC
scores for either CBITS or BB. Details of the tests can be found in Tables B1 and B2
in Appendix B.

Baseline Symptoms. A summary of intake scores is presented in Table 6. Over half
of children who received CBITS/BB reported clinically high trauma symptoms and
problem severity, 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 (62.5% to 71.6%) and BB (47.6% to 82.3%) than on problem severity or
functioning (44.8% to 66.4% for CBITS; 47.2% to 57.6% for BB). This suggests that
some measure of 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 participation in a CBITS/BB group. 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. For
children who received CBITS, males had lower baseline CPSS-5 scores (β=-5.304,
p=.001) and Ohio Problem Severity scores (β=-6.537, *p*=.000) compared to females,
reflecting lower symptoms. A similar trend was also found for children who
received BB; baseline scores were lower for both the CPSS-5 (β=-6.103, *p*=.006) and
Ohio Problem Severity (β=-5.736, *p*=.030).

Age was also a significant predictor of baseline CPSS-5 scores for children who
received BB (but was not significant for CBITS). Children had lower PTSD
symptoms for each additional year of age (β=-2.380, *p*=.005).

Figure 4. Percentage of children with clinically high score

15
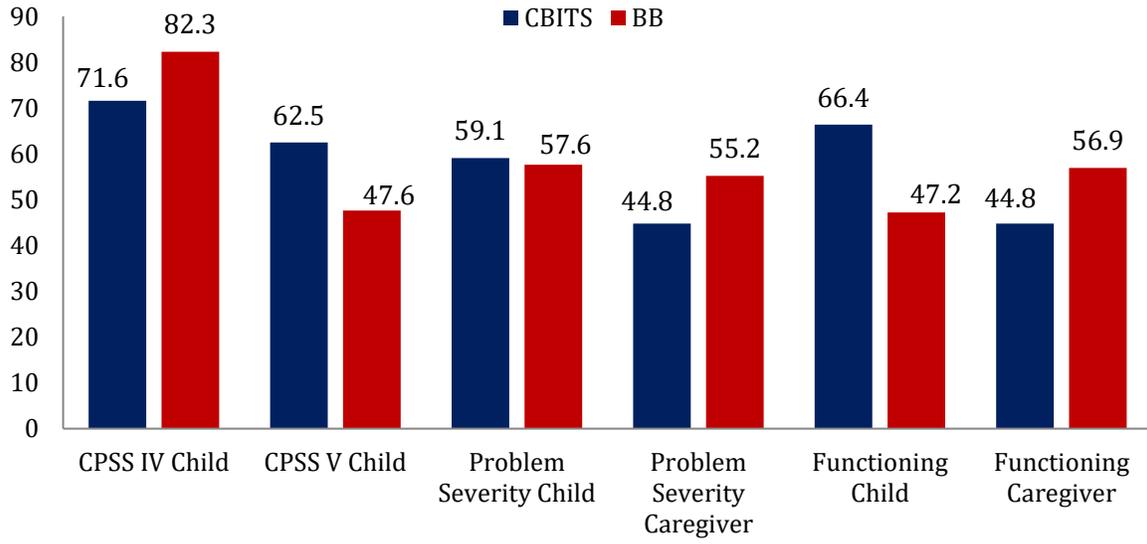
Table 5. Child and caregiver clinical assessment scores at intake [CBITS]

Measure	Child Report				Caregiver Report			
	N	Mean	SD	Elevated* (n, %)	N	Mean	SD	Elevated* (n, %)
TEC sum	478	8.23	3.29		-	-	-	-
CPSS-IV Total Score	109	22.48	10.23	78, 71.6	-	-	-	-
Re-experiencing Subscore	-	6.20	3.78		-	-	-	-
Avoidance Subscore	-	8.46	4.93		-	-	-	-
Arousal Subscore	-	7.82	3.51		-	-	-	-
CPSS-V Total Score	376	37.51	14.82	235, 62.5	-	-	-	-
Re-experiencing Subscore	-	9.28	4.60		-	-	-	-
Avoidance Subscore	-	4.58	2.32		-	-	-	-
Arousal Subscore	-	11.09	4.91		-	-	-	-
Ohio Problem Severity	435	24.10	13.66	191, 43.9	67	20.73	14.91	21, 31.3
Internalizing	347	12.13	8.74		13	4.85	8.17	
Externalizing	347	10.76	6.94		13	9.38	7.33	
Ohio Functioning	435	54.06	11.83	88, 18.1	67	50.57	15.53	22, 32.8

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

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

Measure	Child Report				Caregiver Report*			
	N	Mean	SD	Elevated* (n, %)	N	Mean	SD	Elevated* (n, %)
TEC sum	389	5.67	3.12		-	-	-	-
CPSS-IV Total Score	96	22.75	7.99	79, 82.3	-	-	-	-
Re-experiencing Subscore	-	7.28	2.96		-	-	-	-
Avoidance Subscore	-	7.41	4.34		-	-	-	-
Arousal Subscore	-	8.06	3.35		-	-	-	-
CPSS-V Total Score	288	32.44	13.89	137, 47.6	-	-	-	-
Re-experiencing Subscore	-	8.65	4.45		-	-	-	-
Avoidance Subscore	-	4.08	2.36		-	-	-	-
Arousal Subscore	-	10.41	5.23		-	-	-	-
Ohio Problem Severity	144	25.13	15.67	65, 45.1	58	23.86	14.90	25, 43.1
Internalizing	132	12.55	9.15		10	7.50	7.02	
Externalizing	132	12.52	8.48		10	9.70	7.90	
Ohio Functioning	144	58.22	13.72	28, 19.4	58	49.64	13.99	22, 37.9

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

Quality: Consultation and Clinical Implementation

CHDI staff work closely with agency providers and meet regularly with each agency to provide implementation on consultation. The focus of these 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 focuses on identifying and 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. While these topics come up throughout the year, it is more likely that as the school year progresses, consultation focuses on reviewing performance on recent dashboards (e.g. monthly dashboards, QI report), addressing clinical issues and issues related to vicarious trauma and/or clinician wellness, problem solving around unanticipated barriers, and streamlining discharge data collection and entry protocols.

Implementation Consultation
This year, 93 in-person visits and 74 formal follow-up telephone consultations were completed. The typical agenda for these on-site meetings is split between discussing any barriers that are arising throughout the course of implementation and reviewing team performance on recent dashboards (e.g. QI report, monthly dashboards). See Appendix C for the June monthly dashboard that shows information from FY19 and Appendix D for QI report. CHDI creates the QI report twice annually with quarterly updates on progress towards meeting the benchmark for each QI indicator. The cross-model dashboards provide monthly and cumulative information on clients served. From this review of data, SMARTER goals are developed within the agency to address any QI indicator that did not meet the established benchmark. SMARTER goals are also developed to assist teams in tracking and monitoring pre-implementation tasks that are not monitored through QI reports or other data outputs.

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

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

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

Assessment Changes Affecting Implementation

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

Episode Description

Children completing CBITS attended a mean of 9.21 (SD=1.63) group sessions and a mean of 1.09 individual sessions (SD=.86), while children completing BB attended a mean of 9.51 group sessions (SD=1.45) and a mean of 1.72 individual sessions (SD=1.18). The average length of stay was 3.70 months for CBITS, and 3.83 months for BB. Altogether, for CBITS, 967 group sessions, 449 child sessions, and 185 caregiver sessions were provided during the year. For BB, 875 group sessions, 615 child sessions, and 439 caregiver sessions were provided during the year. A total of 94 BB and 105 CBITS groups ran this fiscal year.

Quality Improvement Indicators

In FY19, CHDI initiated the first CBITS/BB quality improvement (QI) biannual report. These 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 FY19 Performance Periods (PP) are included in Appendix D.

Engagement was high in both models, with consistent numbers for Bounce Back (PP1: 100% and PP2: 99%), and an increase across the two performance periods for CBITS (86% to 95%). Both models exceeded the benchmark of 55%. Due to the short-term nature of these group models, and the fact that CBITS/BB are offered during the school day, some of the barriers often associated with lower engagement (e.g., transportation) are removed, making it much more likely that students will be able to attend weekly group and/or individual sessions.

On the other QI indicators, CBITS specifically saw a great deal of improvement. Only 58% of children had assessment data in PP1 but this number increased to 90% in PP2, exceeding the 70% benchmark. Similarly, with symptom improvement, CBITS went from 43% to 80%, meeting the benchmark of 75% in PP2. Bounce Back met the benchmarks on these indicators in both performance periods, with a notable increase in children with assessment data from PP1 to PP2. Last, in terms of model completion, CBITS and BB most

far exceeded the benchmark of 30% during both PP1 and PP2. Specifically, CBITS went from 71% to 92%, and BB went from 89% to 98%.

Figure 5. QI indicators in FY19 [CBITS]
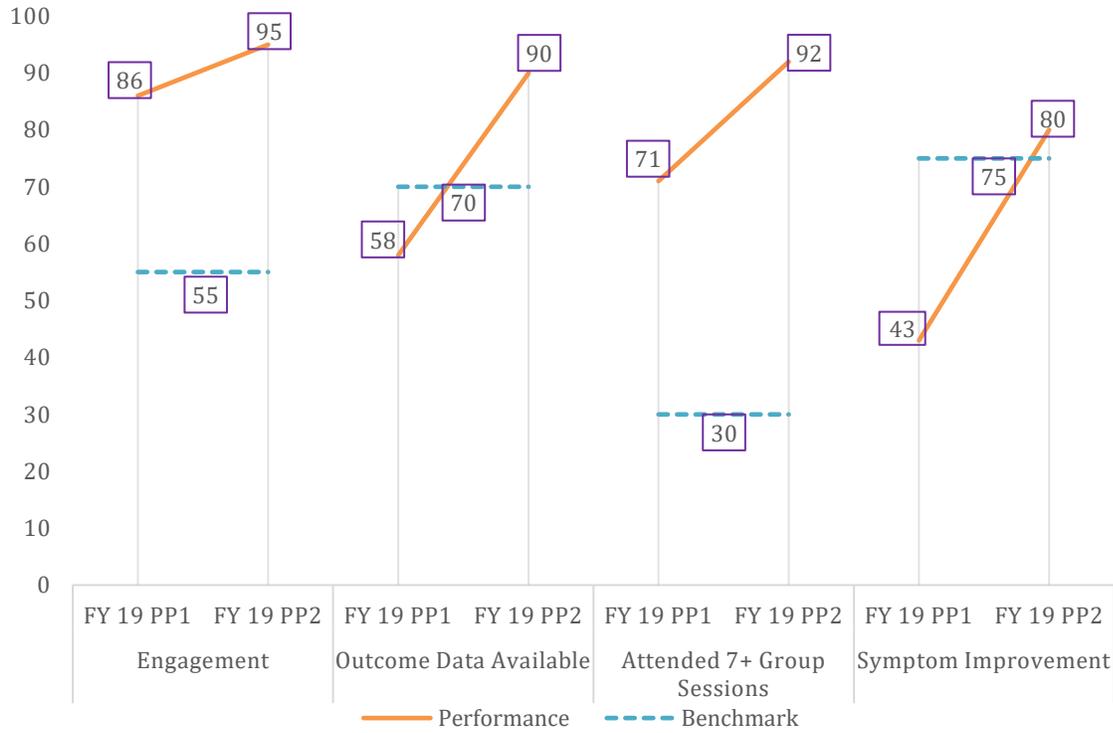
Figure 6. QI indicators in FY19 [BB]

Chart showing Performance and Benchmark across four metrics:

Metric	FY 19 PP1	FY 19 PP2	Benchmark
Engagement	100	99	55
Outcome Data Available	84	93	70
Attended 7+ Group Sessions	89	98	30
Symptom Improvement	7..	76	75
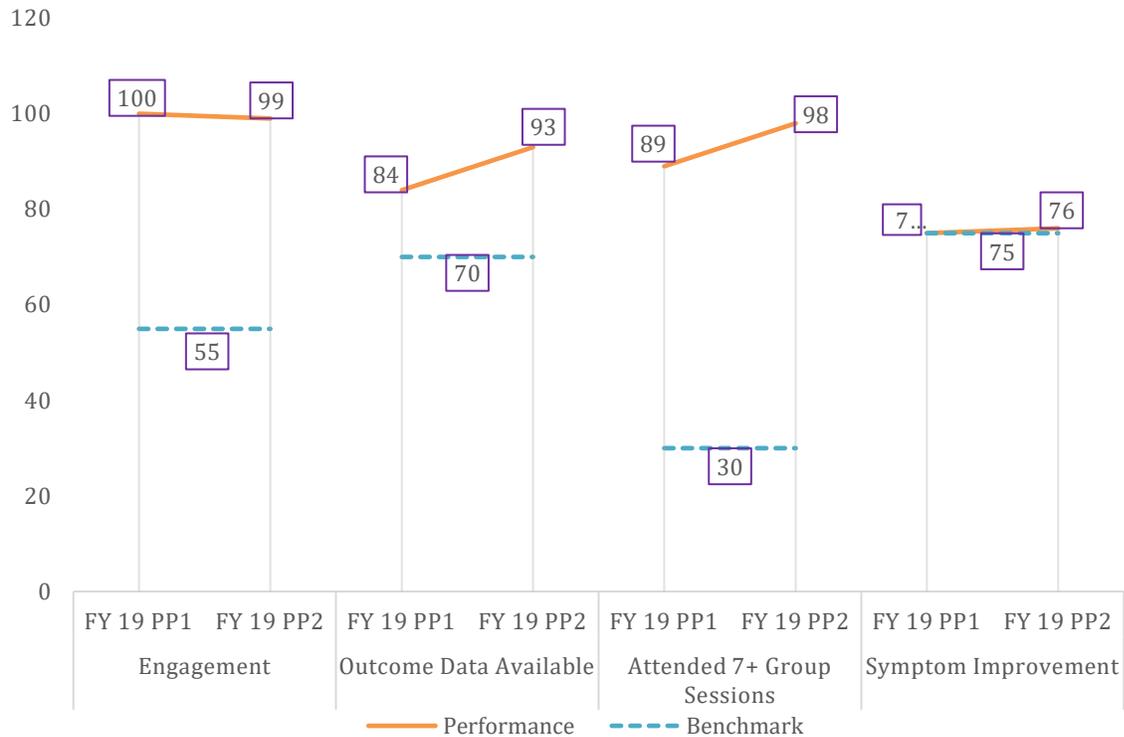
Session Ratings

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, & Caregiver Session Objectives-Average Ratings

Legend: CBITS, BB

Values by category:
- Group: CBITS 3.70, BB 3.69
- Child: CBITS 3.62, BB 3.72
- Caregiver: CBITS 3.70, BB 3.82

Y-axis labels: Completely met (4.00), Mostly met (3.00), Somewhat Met (2.00), Not At All Met (1.00)
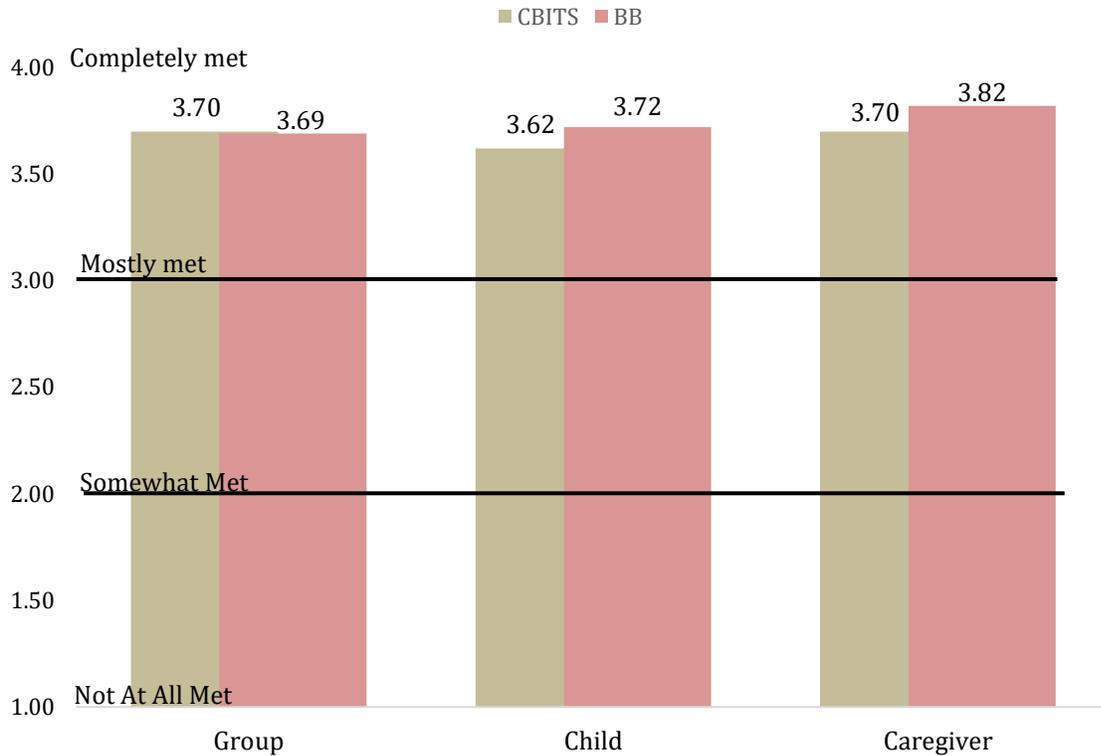
Discharge Reason

During the fiscal year, 468 children ended their CBITS treatment episode, and 373 children ended their BB treatment episode. A total of 94 BB and 105 CBITS groups ran this fiscal year. The majority of children across both CBITS and BB successfully completed treatment (89.4%), while a small number discharged for because the family discontinued treatment (2.0%), they were referred to other services (2.1%), the family moved (2.0%), or some other reason (3.4%). 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. The only significant finding was that older age was associated with lower levels of successful completion of CBITS (β=-.137, p=.027). There were no significant findings for BB in terms of successful completion. This suggests that children successfully complete both models at equivalent rates for males and females as well as across racial/ethnic groups.

Figure 8. Reasons for Discharge in FY19 [CBITS]
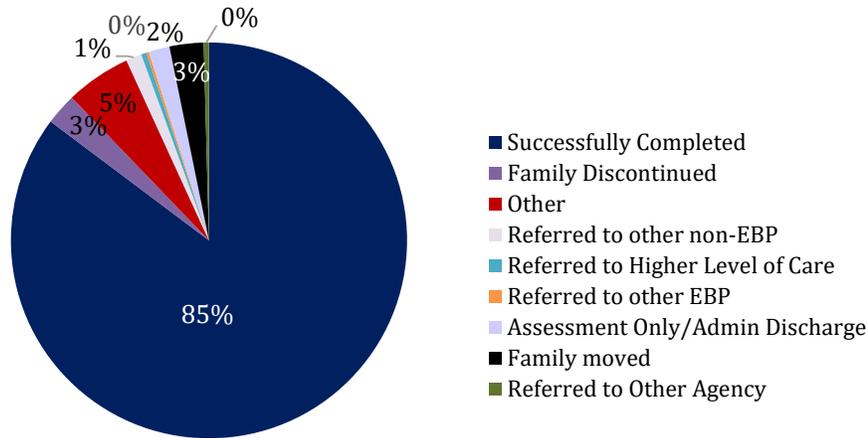
Figure 9. Reasons for Discharge in FY19 [BB]
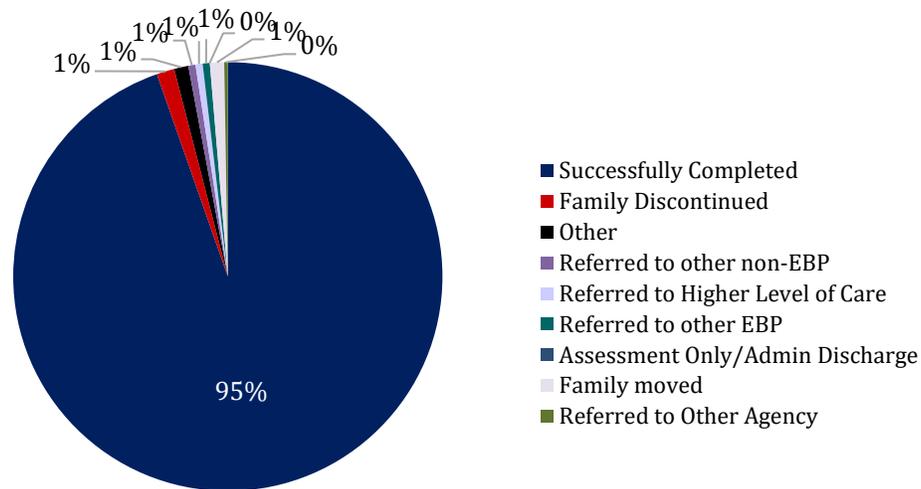
Satisfaction

Caregivers report high levels of satisfaction with CBITS/BB treatment. In FY 19, there were 47 Ohio Caregiver Satisfaction[6] assessments and 5 Youth Services Survey for Families (YSS-F) completed. The responses to both measures are illustrated in Figure 10 below with 100% of those completing the YSS-F indicating being mostly or very satisfied with treatment and 98% of those completing the Ohio Caregiver Satisfaction indicating being mostly or very satisfied with treatment. 262 children completed the Ohio Child Satisfaction measure; 81% of these children indicated that they were mostly or very satisfied with treatment.

Figure 10. Satisfaction Categories, FY19 (n=52)

Legend:
- Very Unsatisfied
- Unsatisfied
- Neutral
- Satisfied
- Very Satisfied

Pie chart values: 2%, 13%, 85%
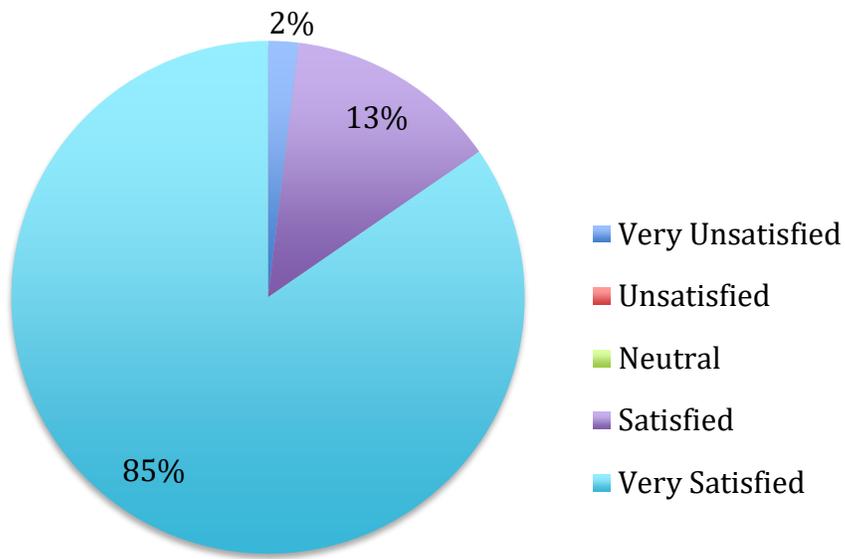
[6]Ohio Caregiver (n=47) does not have a neutral option.

Outcomes: Improvement for Children Receiving CBITS/BB

Assessments Used, RCI, & Flexible Assessment Schedule
Children receiving CBITS/BB are assessed with a variety of measures selected to provide information on trauma history and severity of symptoms. At intake, children are asked to complete the Trauma Exposure Checklist (TEC), the Child PTSD Symptom Scale (CPSS-IV, CPSS-5), and the Ohio Scales for Problem Severity and Functioning. Caregivers are asked to complete the CPSS and Ohio Scales whenever possible. At discharge, each assessment (except the TEC) is re-administered to monitor progress and track symptom change.

Each of the measures is listed along with the construct it measures and a summary of intake and discharge scores in Tables 6 and 7 for CBITS and BB respectively below. Also indicated in the table, where applicable, are the numbers of children whose score placed them in the clinical or critical range on a particular measure at intake and how many of those had moved out of that range by the last assessment. Change scores are given for each measure broken out by these two groups (those who started in the clinical range and those that did not). This is an important factor in examining change scores because greater change is possible and expected for children who enter with higher scores.

How is Change Measured in CBITS/BB?
Symptom reduction can be assessed for trauma symptoms, problem severity, or functioning across child and caregiver reports. We use two methods to summarize changes in symptom reduction. The overall change scores, using t-tests, are presented as a general measure of significant shifts across all children served from intake to discharge. These are represented in the change scores in Tables 7 and 8 below. Additionally, the Reliable Change Index (RCI) is also used. The RCI assigns a measure-specific point reduction threshold that represents significant change. An overview of the RCI with explanations on how and why it is used as well a table of relevant values by measure is included in Appendix E.

Rates of Outcome Data
Three in four children (72.8%) discharged from CBITS in the fiscal year had both a first and last CPSS child report (either version), and 67.6% had both a first and last Ohio Problem Severity and Functioning child report. For BB, 88.7% of children had both a first and last CPSS child report (either version), and 31.1% 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. Findings show that Hispanic youth who received CBITS and BB had higher rates of outcome data, as did Black youth who received BB. Exploration into who are assessed and how much outcome data exists is needed.

Symptom Improvement
Children experienced significant reductions in trauma and problem severity symptoms as well as significant gains in functioning (see Tables 6 and 7). For children who received CBITS/BB, the highest rates of reliable change and remission were in PTS and functioning symptoms.

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

Assessment Name	Construct Measured	Above Cutoff	Intake Mean (S.D).	Last Mean (S.D.)	Change Score	t-score	Remission
TEC Child (n=457)	Count of child exposure to potentially traumatic events	n/a	8.24 (3.29)	n/a	n/a	n/a	n/a
CPSS-IV Child (n=65)	Trauma symptoms	47 (72.3%)	22.83 (10.08)	15.22 (10.50)	-7.61**	4.81	22/47 (46.8%)
CPSS-IV Caregiver* (n=0)		n/a	n/a	n/a	n/a	n/a	n/a
CPSS-V Child (n=293)		183 (62.5%)	37.45 (14.47)	23.42 (15.42)	-14.03**	14.39	105/183 (57.3%)
CPSS-V Caregiver* (n=0)		n/a	n/a	n/a	n/a	n/a	n/a
Ohio Problem Severity Child (n=331)	Severity of internalizing/ externalizing behaviors	136 (41.1%)	23.50 (13.53)	18.08 (13.00)	-5.42**	7.13	69/136 (50.7%)
Ohio Problem Severity Caregiver (n=9)		1 (11.1%)	8.11 (9.22)	8.22 (11.20)	+.11	-.10	0/1 (0%)
Ohio Functioning Child (n=331)	Child's adjustment and functioning	61 (18.4%)	54.21 (11.89)	59.19 (11.99)	+4.98**	-7.13	44/61 (72.1%)
Ohio Functioning Caregiver (n=9)		1 (11.1%)	62.78 (13.53)	64.89 (13.37)	+2.11	-.67	0/1 (0%)

*no caregiver data reported for CPSS IV or CPSS 5
** indicates significance p <.01

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

Assessment Name	Construct Measured	Above Cutoff	Intake Mean (S.D).	Last Mean (S.D.)	Change Score	t-score	Remission
TEC Child (n=373)	Exposure to potentially traumatic events	n/a	5.55 (3.03)	n/a	n/a	n/a	n/a
CPSS-IV Child (n=84)	Trauma symptoms	70 (83.3%)	23.35 (8.10)	12.36 (8.97)	-10.99**	10.84	47/70 (67.1%)
CPSS-IV Caregiver* (n=0)		n/a	n/a	n/a	n/a	n/a	n/a
CPSS-V Child (n=247)		122 (49.4%)	32.34 (13.30)	19.05 (14.55)	-13.29**	14.76	85/122 (69.7%)
CPSS-V Caregiver* (n=0)		n/a	n/a	n/a	n/a	n/a	n/a
Ohio Problem Severity Child (n=116)	Severity of internalizing/ externalizing behaviors	56 (48.3%)	26.03 (14.55)	15.50 (14.36)	-9.80**	4.00	38/56 (67.9%)
Ohio Problem Severity Caregiver (n=21)		9 (42.9%)	21.90 (15.82)	12.10 (10.56)	+.11	-.10	6/9 (66.7%)
Ohio Functioning Child (n=116)	Child's adjustment and functioning	26 (22.4%)	56.47 (13.71)	62.10 (12.78)	+5.63**	-4.82	16/26 (61.5%)
Ohio Functioning Caregiver (n=21)		8 (38.1%)	50.62 (17.85)	55.67 (20.67)	+5.05	-.91	6/8 (75.0%)

*no caregiver data reported for CPSSIV or CPSSV
** 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.

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, 63.9% experienced trauma symptom reduction across CPSS versions IV and 5. Comparatively, 73.4% 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, 69.1% experienced trauma symptom reduction across CPSS versions IV and 5, and 78.6% 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

CBITS   BB

	Trauma Symptoms (CPSS) Sub-Clinical	Trauma Symptoms (CPSS) Clinical
CBITS	46.8	73.4
BB	56.1	78.6

Trauma Symptoms (CPSS) Sub-Clinical
n=169   n=151

Trauma Symptoms (CPSS) Clinical
n=60   n=78
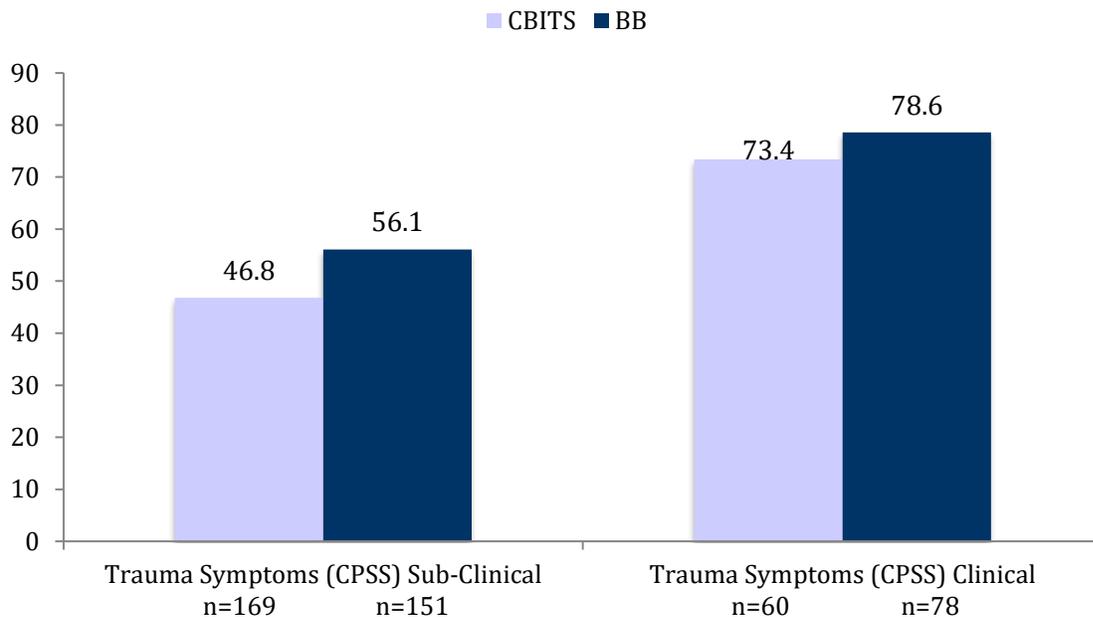
Figure 12. Percent of children with symptom reduction, problem severity

CBITS ■ BB
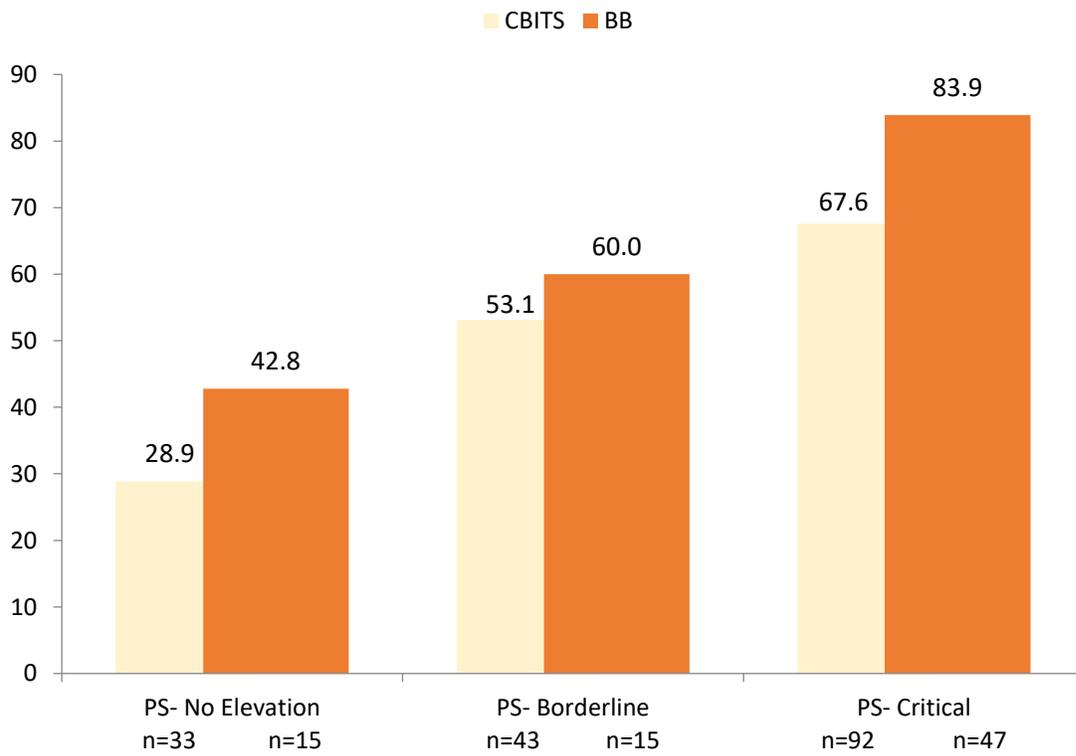
Figure 13. Percent of children with symptom reduction, functioning

CBITS ■ BB
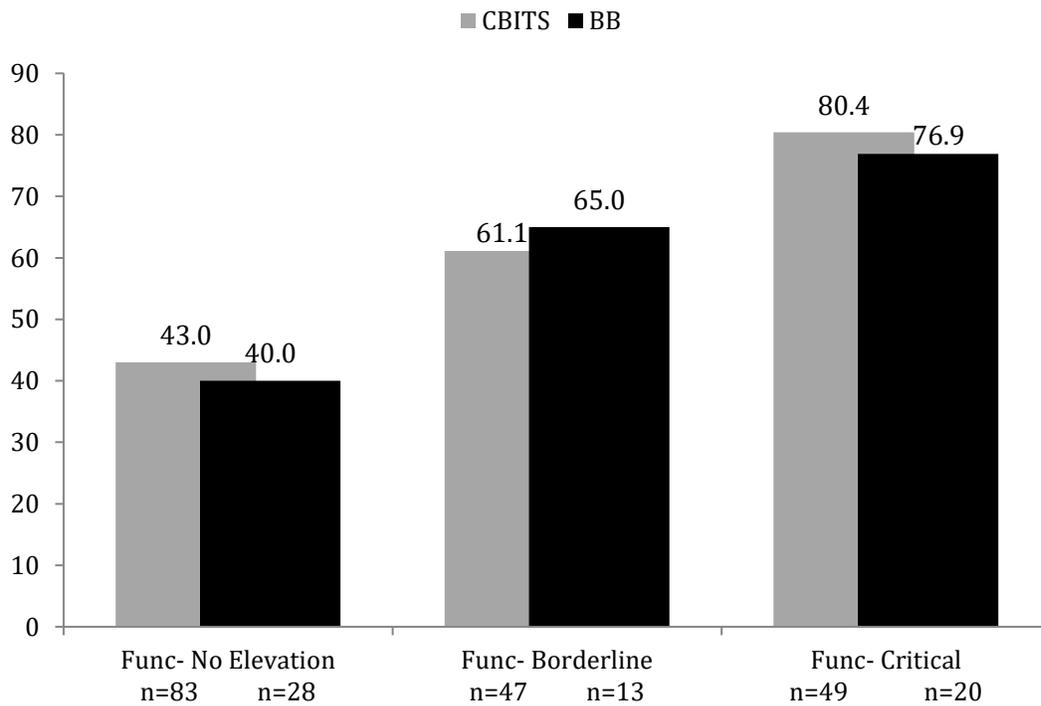
Clinical Improvements Across Groups

In addition to documenting the overall rates of symptom reduction and functional improvement, we examined whether subgroups are experiencing disparate outcomes. Multiple regressions were performed to explore the effect of race categories, age, and sex on discharge scores, controlling for initial scores, successful completion of the model, and trauma exposure. Age and sex were found to significantly affect child symptom outcomes, although these effects were not consistent across symptom measures. Additionally, successful discharge and baseline scores were shown to have an effect on outcomes. Details of the tests can be found in Appendix B (Tables B9 and B10), but the significant findings are presented here.

Age. Youth who received CBITS had slightly higher scores at discharge on the CPSS-5 (β=0.207, p=.000) for each additional year of age, after controlling for baseline score, trauma exposure, and successful discharge. On the Ohio Functioning Scale, youth had a slight decrease in functioning (β=-.107, p=.038) for each additional year of age. There were no significant findings for youth who received BB in regards to age.

Sex. Males who received CBITS were more likely to have lower scores at discharge on Ohio Functioning (β=-.109, p=.033) compared to females. There were no differences on PTSD scores. There were no significant findings for youth who received BB in regards to sex.

Race/Ethnicity. There were no significant differences in outcomes by race/ethnicity**.**

Summary & Conclusions

The Coordinating Center witnessed significant growth in FY19 across several domains: model availability, caregiver and youth accessibility, and enhanced workforce development. The statewide network consists of 55 CBITS and 50 BB sites, which represents a 44% and 83% increase in active sites, respectively. There was an increase in the number of children screened (41.6%) and deemed eligible for group participation (47.8%), as well as an increase in the number of children who received CBITS/BB (92.9%).

Since the inception of the CBITS Initiative in 2015, our teams have screened over 3300 students for trauma exposure and associated post-traumatic stress symptoms. In FY19, screening outcomes related to exposure and associated symptomology are significant, with the number of types of trauma reported by CBITS- and BB-aged students averaging 8.23 and 5.67, respectively. Also, over half of those that received CBITS/BB reported clinically high trauma symptoms and levels of problem severity or impaired levels of functioning. Such high exposure and initial symptomology underscores the critical value of having CBITS and BB available in schools, where youth experience formative development.

Our CBITS and BB network served 876 students, which far exceeded the FY19 goal of 500 children. This resulted in a 112.6% increase in the number of children receiving BB and 79.7% increase in those receiving CBITS. Moreover, engagement was extremely high for BB (99.5%) and CBITS (90.5%) participants, and the vast majority of children across CBITS/BB successfully completed treatment (89.4%). These trends in engagement and completion are unparalleled in traditional outpatient settings, suggesting that these school-based group treatment models eliminate significant barriers to treatment access.

Beyond access, the majority of youth reporting post-traumatic stress symptomology at baseline experienced noteworthy symptom reductions after completing CBITS (63.9%) and BB (69.1%). Moreover, for students who reported initial scores on the CPSS IV or CPSS 5 that crossed the clinical threshold for a likely PTSD diagnosis, 73.4% of children in CBITS and 78.6% of children in BB experienced reliable change in this symptom category. Additionally, 55.2% of children in CBITS and 68.7% of children in BB experienced remission of PTSD symptoms. . In terms of Ohio Scale - Problem Severity reductions for CBITS/BB youth scoring in the critical impairment range at baseline, 67.6% and 83.9% respectively reported reliable improvement after receiving group treatment. In addition to strong clinical outcome improvements, 98% (N=52) of caregivers and 81% (N=262) of youth reported being mostly or very satisfied with CBITS/BB group treatment.

Since approximately 40-60% of children and families drop out of conventional treatment settings[i,ii] school settings are an ideal place to address the barriers to care that disproportionately affect racial, ethnic, and economically underserved youth and families. For FY20, strategic CBITS and BB implementation efforts that serve and engage marginalized families and youth will remain a top priority. Additionally, the Coordinating Center will enhance QI benchmarks and ensure advanced training opportunities to strengthen the CBITS and BB provider network in service delivery.

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

[ii]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.

Recommendations

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

1. **State/District/Provider:**
   - Identify resources and strategies to continue scale up of CBITS/BB across the state. Expansion from FY16 to FY19 has resulted in an increasing number of CBITS/BB provider teams (5 to 23), clinicians trained (24 trained in CBITS in FY16 versus 51 trained in CBITS and 59 trained in BB in FY19), and children served (288 to 876), yet CBITS/BB are still not available to students in most districts and schools in the state.
   - The state should evaluate the impact of CBITS/BB and other school mental health initiatives on academic performance and student health, including potential cost-savings/return on investment, given the strong relationship between trauma and adverse outcomes in these domains and the relationship between trauma and increased health, educational, and social service costs.
   - The state and school districts should consider how to integrate and align CBITS/BB with a broader multi-tiered system of supports that supports trauma-informed school and student mental health. For example, workforce development for all school staff in mental health and trauma, screening students for mental health/trauma, integrating with universal socioemotional development programs, and incorporating into policy are key considerations.
   - State agencies and policymakers should communicate about the availability of CBITS/BB and the successful outcomes from CT districts already implementing the models to districts, school-based health centers, and other stakeholders.

2. **Coordinating Center:**
   - Increase training in the clinical use of measures to enable clinicians more flexibility when measuring symptom reduction, to ensure accurate use and scoring, and to encourage the therapeutic use of assessments with caregiver and/or children.
   - Increase training in the use of EBP Tracker data system to ensure accurate and timely data collection and entry.
   - Target areas to include the CBITS Caregiver Letters to support caregiver engagement, and discussions with model developers and clinicians to identify meaningful CBITS adaptations for older children.
   - Provide resources on topics identified by stakeholders as areas for development, including Intellectual Developmental Disorders, Integrating CBITS/BB into Individualized Educational Plans, and caregiver engagement
   - Collaborate with DCF to evaluate trends related to CBITS/BB QI Indicators that emerge across fiscal years.

- Reallocation of funding for additional project coordination support in order to continue statewide expansion and sustainability efforts.
- Develop a standardized repository of resources that assist with pre-implementation tasks, processes, and protocols.
- Analyze data to better understand demographic factors, symptomology, and other characteristics that may influence access, engagement (caregiver and/or caregiver), or differences in symptom reduction.
- Develop data reports that can be used in site-based consultation to help teams monitor or explore potential disparities related to race, ethnicity, or other key demographic areas.
- Allocate funding to ensure that products available to teams (E.G. caregiver letters, CBITS/BB brochure) are available in Spanish
- Develop and implement funding plan and contracting language for state-level trainers in CBITS/BB to support statewide sustainability of each model.
- Monitor FY20 CBITS/BB initiative expansion, and its impact on current performance-based incentive funding. If FY20 continues to expand in CBITS/BB delivery similar to FY19, then re-examination of adequate incentives through sustainability funding will be necessary.
- Continue evaluating, and potentially refining, CBITS and BB QI Indicators by examining trends that emerge across fiscal years.
- Modify CBITS/BB Certification tracking process so that it enables teams and individual team members to more readily track and monitor progress.
- Continue working with agency providers to evaluate the effect of CBITS/BB on academic performance.
- Collaborate with DCF to devise and implement new state-level CBITS/BB compensation plan for agencies and their employees who serve as state-level trainers to enhance CF20 statewide implementation efforts.
- Collaborate with DCF and/or KJMB to develop strategies for linking or integrating EBP Tracker and PIE to eliminate redundancies. Opportunities to create efficiencies are likely to exist since both systems were developed by the same contractor.
- Collaborate with KJMB to provide culturally and linguistically appropriate clinical tools in electronic format (e.g. assessments translated into Spanish built into EBP Tracker).
- 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).

Appendix A: Activities and Deliverables

The Coordinating Center has worked to support the CBITS/BB implementation goals through the following activities carried out in FY19.

1. **Training, Consultation, & Credentialing**
- Coordinated three CBITS new clinician trainings in July 2018, September 2018, and April 2019 for 51 clinical staff from 18 different provider teams
- Coordinated four Bounce Back (BB) new clinician trainings in July 2018, September 2018 (2 trainings), and April 2019 for 59 clinical staff from 19 different provider teams
- In FY 19 there were 14 newly active CBITS clinicians and 20 newly active BB clinicians out of the total number of unique clinicians that were trained this fiscal year. Please note, 22 trainees from the April CBITS new clinician training and 23 trainees from the April BB new clinician training did not intend to implement the model until the following academic year.
- Coordinated two CBITS/BB booster trainings in December 2018 and January 2019 for 51 clinical staff
- Coordinated three CBITS clinical consultation call groups with 43 total calls, for 29 clinical staff
- Coordinated four BB clinical consultation call groups with 55 total calls for 31 clinical staff
- Based on FY2018 feedback from clinicians, coordinated two Special Topic peer consultation call options. Topics for these drop-in monthly calls were: Implementing with Young Children and Implementing in Alternative Settings. A total of 11 calls were offered for each series (ran August through June)
- Maintained a statewide CBITS/BB clinician certification process and requirements to increase the number of clinicians that complete all training and case requirements; 22 clinicians were Connecticut certified in CBITS and 9 were certified in BB by the end of FY 19
- Conducted one Site Based Trainer (SBT) Booster Session in April 2019 for CT CBITS and BB SBT's. This session was designed to gather feedback on the SBT training program and provide time to practice training components.
- Maintained a training record database to track training and consultation attendance of all CBITS/BB staff, as well as other certification requirements for all CBITS/BB clinicians
- Prepared regular training and case data tables for each provider with updates on individual clinician certification status
- Convened tenth annual statewide EBP Conference, an evolution of the original TF-CBT Conference, for 456 participants from community providers, DCF, CSSD staff, and other partners in the initiative. CBITS and BB – focused breakout sessions continue to increase as our teams begin to build interest in showcasing their successes and implementation plans

2. **Implementation Support, Quality Improvement, & Technical Assistance**
- Produced reports for two QI performance periods based on developed CBITS and BB QI Indicators and Benchmarks
- Utilized a QI process for consultation based on emerging implementation science and individualized needs of agencies, school, and districts
- Developed team-specific QI plans using SMARTER Goals focused on preimplementation planning, performance on QI benchmarks, and strategies to improve access, quality and service delivery
- Provided 93 in-person implementation consultation support visits and 74 phone calls with providers to ensure access to ongoing support and to assist teams with sustainment of high quality services
- Onboarded 3 new provider teams (one community-based; two district) that joined the initiative with the intention of training during SFY19 and implementing group models in FY20
- Collected feedback from Senior Leaders and Coordinators during Q2 and Q3 site visits that will inform the creation of a Leadership Call Series for CBITS/BB teams that will meet quarterly in order to support implementation and build community across the network
- Provided updates to all CBITS/BB teams via monthly Data Dashboard
- Distributed additional clinical books, materials, and resources to all CBITS/BB teams
- Created Caregiver Letter Series for CBITS that was adopted by the TSA for dissemination to all new internationally trained clinicians
- Developed, executed, and managed contracts with each of the providers that are or are not eligible for financial incentives in order to adequately detail implementation expectation and data sharing guidelines

3. **Data Systems**
- Continued development and maintenance of a secure, HIPAA compliant, online database (EBP Tracker) that meets the needs of the increasing number of CBITS/BB providers and the children and families they serve
- Continued to partner in refining the "bridge" between PIE & EBP Tracker so that identified data fields can push from PIE to EBP Tracker for matched cases, reducing the burden of duplicate data entry in the two systems for teams that utilize both databases.
- Continued improvements to EBP Tracker have been made based upon agency feedback and as possible with available funding
- Maintained a public directory site that provides a searchable, public listing of CBITS and BB providers through EBP Tracker (tinyurl.com/ebpsearch)
- Monitored, maintained, and provided technical assistance for online data entry for all CBITS and BB providers. Specifically, CHDI implemented 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 separate requests for on-site team training.
- Created 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**
- 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.
- Analysis and report out regarding financial incentives was done in aggregate form as well as via team-specific reports that detailed the financial incentive received for each of two 6 – month performance periods.
- 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 in order to detail implementation expectation and data sharing guidelines.

Distributed $223,000 in performance-based sustainment funds to agencies. 100% of our total contract funds were disseminated.

Appendix B:Regression Tables

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

Predictors	β	SE	95%CI
Intercept	4.397	.924	(2.580, 6.213)
Hispanic	1.523**	0.366	(.805, 2.242)
Other Nonhispanic	1.11**	0.977	(-.809, 3.029)
Black Nonhispanic	1.958	0.439	(1.097, 2.820)
Age at intake	0.181*	0.062	(.058, .303)
Sex	0.487	0.307	(-.117, 1.092)
R^2	.063		
F	6.310		

* p<.05   As compared to White Females

**p<.001

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

Predictors	β	SE	95%CI
Intercept	.849	.957	(-1.032, 2.731)
Hispanic	0.275	0.375	(-.462, 1.012)
Other Nonhispanic	-0.672	0.741	(-2.128, .785)
Black Nonhispanic	0.801	0.44	(-.064, 1.666)
Age at intake	0.504**	0.106	(.296, .712)
Sex	0.600	0.310	(-.011, 1.210)
R^2	.075		
F	6.162		

* p<.05   Race and Sex 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	14.157	4.417	(5.468, 22.847)	64.706	4.163	(56.516, 72.896)	19.340	4.724	(10.047, 28.632)
Hispanic	-0.243	1.715	(-.142, .887)	0.323	1.616	(-2.856, 3.502)	2.027	1.834	(-1.580, 5.634)
Other Nonhispanic	10.762*	4.977	(.971, 20.553)	3.141	4.691	(-6.086, 12.369)	6.898	5.323	(-3.572, 17.368)
Black Nonhispanic	0.843	2.051	(-3.192, 4.878)	-1.494	1.933	(-5.297, 2.309)	1.787	2.193	(-2.528, 6.102)
Age at intake	0.168	0.294	(-.409, .746)	-0.377	0.277	(-.921, .167)	0.327	0.314	(-.291, .944)
Sex	-6.537**	1.449	(-9.387, -3.687)	2.230	1.366	(-.456, 4.916)	-5.304*	1.550	(-8.352, -2.256)
Trauma Exposure, TEC Child	1.077**	.221	(-1.085, -.266)	-.675	.208	(-1.085, -.266)	1.664**	.236	(1.199, 2.129)
R^2	.127			.053			.175		
F	8.044			3.112			11.747		

* 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	25.644	10.247	(5.370, 45.918)	73.266	9.498	(54.473, 92.058)	42.499	8.520	(25.643, 59.356)
Hispanic	6.024	3.219	(-.344, 12.393)	-0.705	2.983	(-6.608, 5.198)	3.424	2.676	(-1.871, 8.718)
Other Nonhispanic	-0.402	6.56	(-13.381, 12.578)	-0.693	6.081	(-12.724, 11.338)	-0.387	5.455	(-11.179, 10.405)
Black Nonhispanic	0.602	3.924	(-7.161, 8.364)	-1.726	3.637	(-8.922, 5.469)	-0.384	3.262	(-6.839, 6.070)
Age at intake	-1.386	1.006	(-3.377, .604)	-0.932	0.933	(-2.777, .913)	-2.38*	0.837	(-4.035, -.725)
Sex	-5.736*	2.615	(-10.910, -.562)	-1.961	2.424	(-6.757, 2.835)	-6.103*	2.174	(-10.404, -1.801)
Trauma Exposure, TEC Child	2.006	.401	(1.212, 2.801)	-.775	.372	(-1.512, -.039)	2.336	.334	(1.676, 2.997)
R^2	.195			.049			.309		
F	5.213			1.118			9.607		

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

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

Variable	N	β	SE	Wald	e^B(95%CI)
Hispanic	233	0.468	0.334	1.961	1.597 (.829, 3.074)
Other Nonhispanic	12	-1.287	0.661	3.784	0.276 (.076, 1.010)
Black Nonhispanic	97	0.188	0.395	0.226	1.207 (.556, 2.617)
Sex m	166	0.196	0.29	0.458	1.217 (.689, 2.150)
Child age	451	-0.137*	0.062	4.898	0.872 (.772, .984)
Trauma Exposure-TEC Child	451	-0.076	0.043	3.171	0.927 (.852, 1.008)
Constant		3.983	0.964	17.082	53.666

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

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

Variable	N	β	SE	Wald	e^B(95%CI)
Hispanic	166	-0.36	0.552	0.426	0.698 (.236, 2.058)
Other Nonhispanic	20	18.142	8891.692	.000	75674984.44 (.000)
Black Nonhispanic	86	0.480	0.754	0.405	1.616 (.369, 7.077)
Sex m	194	-0.741	0.503	2.168	0.477 (.178, 1.278)
Child age	369	0.098	0.164	0.359	1.103 (.800, 1.523)
Trauma Exposure-TEC Child	369	-0.060	0.075	0.627	0.942 (.813, 1.092)
Constant		2.879	1.439	4.004	17.805

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

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	233	0.924	0.449	4.229	2.52 (1.044, 6.081)
Other Nonhispanic	12	1.528	1.081	1.996	4.608 (.553, 38.374)
Black Nonhispanic	97	0.621	0.537	1.337	1.861 (.649, 5.335)
Sex m	166	-0.348	0.382	0.833	0.706 (.334, 1.491)
Child age	451	-0.061	0.084	0.535	0.941 (.798, 1.108)
Trauma Exposure-TEC Child	451	-0.084	0.058	2.107	0.919 (.820, 1.030)
Child Discharged "Unsuccessful"	67	-4.798**	0.468	105.276	0.008 (.003, .021)
Constant		3.742	1.27	8.679	42.168

* 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	e^B(95%CI)
Hispanic	166	1.252*	0.464	7.27	3.498 (1.408, 8.692)
Other Nonhispanic	20	0.983	1.078	0.832	2.672 (.323, 22.091)
Black Nonhispanic	86	1.543	0.626	6.081	4.68 (1.373, 15.961)
Sex m	194	-0.777	0.435	3.198	0.46 (.196, 1.077)
Child age	369	-0.148	0.145	1.033	0.863 (.649, 1.147)
Trauma Exposure-TEC Child	369	-0.113	0.065	3.013	0.893 (.786, 1.015)
Child Discharged "Unsuccessful"	20	-4.225**	0.648	42.511	0.015 (.004, .052)
Constant		4.165	1.334	9.751	64.376

* 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	0.914	4.900	(-8.728, 10.556)	44.173	5.698	(32.962, 55.385)	-8.607	6.419	(-21.243, 4.029)
Trauma Exposure-TEC Child	0.204	0.209	(-.206, .615)	-0.020	0.19	(-.394, .354)	-0.163	0.279	(-.712, .386)
Baseline Score Child	0.428**	0.050	(.330, .525)	0.437**	0.052	(.335, .538)	0.385**	0.061	(.264, .506)
Child discharged as "successful"	1.731	1.839	(-1.888, 5.350)	-0.824	1.717	(-4.202, 2.554)	0.815	2.39	(-3.889, 5.520)
Hispanic	-2.493	1.625	(-5.690, .704)	1.711	1.517	(-1.273, 4.695)	-0.499	2.121	(-4.674, 3.676)
Other Nonhispanic	3.544	3.949	(-4.225, 11.313)	-2.799	3.688	(-10.056, 4.458)	3.296	5.135	(-6.813, 13.405)
Black Nonhispanic	0.341	1.948	(-3.490, 4.173)	-0.204	1.823	(-3.790, 3.382)	0.267	2.533	(-4.719, 5.253)
Sex	2.411	1.380	(-.304, 5.127)	-2.698*	1.26	(-5.177, -.219)	-1.693	1.779	(-5.196, 1.810)
Child age	0.303	0.292	(-.270, .877)	-0.569*	0.273	(-1.107, -.031)	1.419**	0.378	(.674, 2.164)
R²	0.237			0.220			0.195		
F	12.215			11.045			8.363		

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

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	-15.261	8.729	(-32.565, 2.043)	40.009	8.312	(23.532, 56.487)	-2.544	6.544	(-15.434, 10.347)
Trauma Exposure-TEC Child	-0.200	0.413	(-1.019, .619)	-0.506	0.352	(-1.203, .191)	0.488	0.294	(-.091, 1.068)
Baseline Score Child	0.604**	0.078	(.449, .759)	0.475**	0.073	(.330, .620)	0.483**	0.065	(.355, .612)
Child discharged as "successful"	5.426	4.834	(-4.157, 15.009)	-0.814	4.564	(-9.862, 8.234)	-8.273*	3.560	(-15.286, -1.260)
Hispanic	1.658	2.610	(-3.517, 6.833)	-1.484	2.483	(-6.406, 3.437)	2.939	1.963	(-.928, 6.806)
Other Nonhispanic	1.642	4.990	(-8.250, 11.535)	0.528	4.775	(-8.937, 9.993)	0.47	3.761	(-6.939, 7.878)
Black Nonhispanic	5.064	3.035	(-.954, 11.081)	-2.548	2.901	(-8.299, 3.203)	2.085	2.281	(-2.409, 6.579)
Sex	0.558	2.145	(-3.694, 4.809)	-1.650	2.034	(-5.683, 2.382)	0.731	1.615	(-2.450, 3.912)
Child age	1.02	0.771	(-.508, 2.548)	0.075	0.715	(-1.343, 1.493)	1.046	0.572	(-.080, 2.172)
R^2	0.422			0.333			0.291		
F	9.781			6.674			12.234		

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

Appendix C: June 2019 State Dashboard

Executive Summary

Intakes & Discharges

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

Active Treatment

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

Monthly Session Forms

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

Clinicians & Training

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

EBT Performance Dashboard: State of Connecticut June 2019

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

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

Children Receiving EBTs (Open)

EBT Intakes

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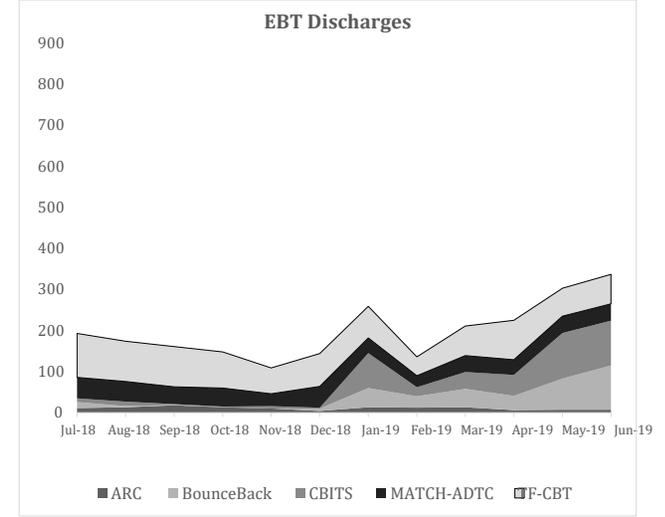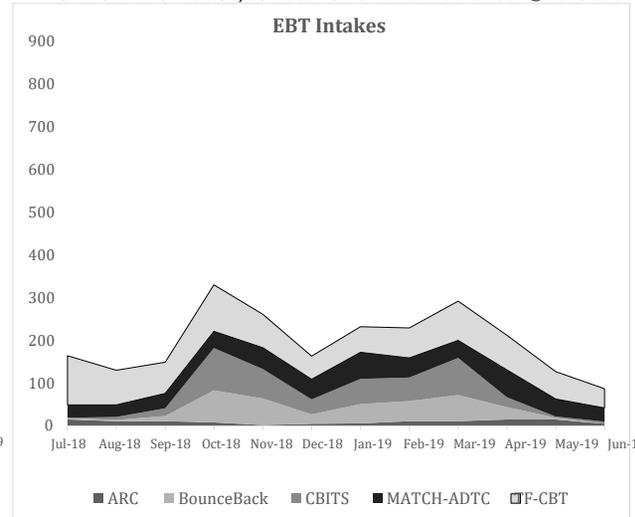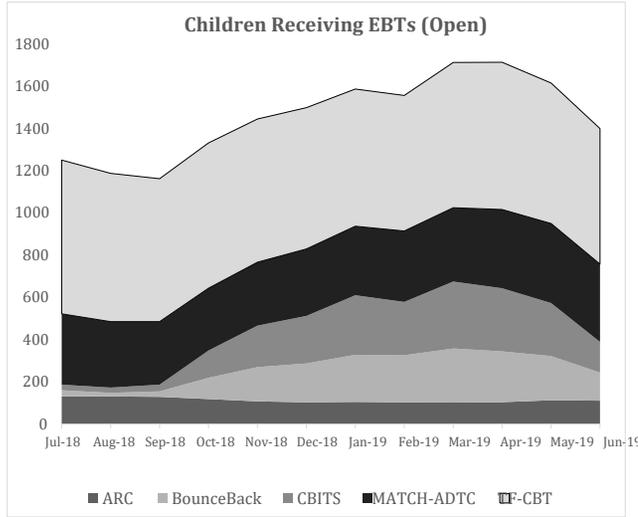
		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	FY19 Total	Yr Total[1]
Open	ARC	131	131	129	119	108	103	105	103	102	104	113	111	231	231
	BounceBack	29	17	26	100	162	184	223	223	256	240	209	133	389	389
	CBITS	27	25	32	129	196	225	282	252	317	299	251	145	487	487
	MATCH-ADTC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

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

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

State of Connecticut: EBT Performance Dashboard cont…

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

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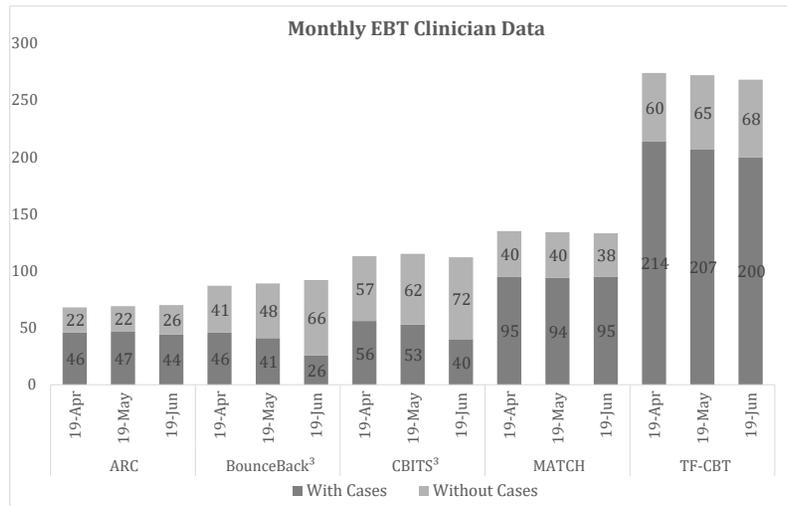
Clinicians Trained[4] in EBTs FY2019	
ARC	26
BounceBack	59
CBITS	51
MATCH-ADTC	54
TF-CBT	58

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

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

[1] One or more visits within the month
[2] QI Period is January 2019 - June 2019
[3] Includes co-facilitators

[4] Includes individuals with a clinical role at time in training. Includes

internal agency

trainings.

Appendix D - Quality Improvement

QI Overview

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

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

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

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

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

Definitions that Changed After July 2018:
- **Successfully Completed – Model Completion:** Prior QI reports looked at closed episodes with clinician reports of successful completion and completed all required model requirements. Current definition includes closed episodes that were engaged and completed all required model requirements (see table on previous page). Clinician reports of successful completion are not included in the current model completion definition.
- **Episodes with Assessment Data - Measures:** Prior QI reports looked at closed episodes that had at least a CPSS-IV or SMFQ (caregiver or child version) completed at two different time points. Current report looks at closed and engaged treatment episodes with any child or caregiver symptom measure completed at two different time points (see FAQ for a full list of accepted measures).
- **Episodes with Symptom Improvement – Improved Outcomes:** Prior QI reports looked at closed episodes that has at least partial reliable change for trauma (CPSS-IV) or depression (SMFQ) symptoms. Current report looks at closed and engaged treatment episodes with at least data at two different time points that had at least partial reliable change on any child or caregiver symptom measure (see FAQ for a full list of accepted measures).

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

As of July 2018 there is no agency credentialing.

Frequently Asked Questions

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

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

What assessments count towards the measures and improved outcomes indicators?

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

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

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

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

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

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

What are the required treatment components for TF-CBT?

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

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

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

Overview - Closed Episodes[1]

July-December

Provider Name	EBT Closed Episodes	2018 ARC	BounceBack!	CBITS	MATCH-ADTC	TF-CBT
Adelbrook, Inc.	5	-	-	-	-	5
Boys & Girls Village	2	-	0	0	-	2
Bridges Healthcare, Inc	39	10	-	-	15	14
Catholic Charities Archdiocese of Hartford	7	-	-	-	-	7
Charlotte Hungerford Hospital	42	2	-	-	13	27
Child and Family Agency of Southeastern Connecticut, Inc	57	3	0	0	25	29
Child Guidance Center of Southern Connecticut, Inc	15	5	-	-	-	10
Clifford Beers Clinic	37	-	3	7	3	24
Community Child Guidance Clinic, Inc	21	4	-	-	6	11
Community Health Center, Inc	23	-	0	4	-	19
Community Health Resources	49	4	-	-	12	33
Community Mental Health Affiliates, Inc	31	-	6	8	7	10
Connecticut Junior Republic	8	-	-	-	2	6
Cornell Scott Hill Health Center	49	-	0	0	28	21
Day Kimball Healthcare	0	-	-	-	-	0
Family & Children's Aid, Inc	26	6	-	-	-	20
Family Centers, Inc	7	-	-	-	-	7
Jewish Family Services	2	-	-	-	-	2
Klingberg Family Centers	4	-	-	-	-	4
LifeBridge Community Services	14	-	-	-	-	14
Mid-Fairfield Child Guidance Center, Inc	11	-	-	-	0	11
Parent Child Resource Center	18	-	-	-	13	5
The Child and Family Guidance Center	16	-	-	-	6	10
The Child Guidance Clinic For Central Connecticut, Inc	30	7	0	0	9	14
The Village for Families & Children, Inc	49	10	0	0	28	11
United Community and Family Services	71	8	0	8	26	29
United Services, Inc	76	-	0	0	36	40
Waterford Country School, Inc.	11	-	-	-	-	11
Wellmore Behavioral Health	47	9	-	-	16	22
Wheeler Clinic	46	-	0	0	10	36
Yale Child Study Center	38	-	-	-	6	32
Yale Child Study Center-West Haven	0	-	-	-	-	0
Average	**27**	**6**	**1**	**2**	**14**	**15**
Total	**851**	**68**	**9**	**27**	**261**	**486**

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

Overview - Closed Episodes[1]
January - June 2019

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

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

Overview - Closed Episodes - CBITS/BB[1]

July-December 2018

Provider Name	BounceBack!	CBITS	EBT Total
Capitol Region Education Council	0	1	1
EASTCONN	0	0	0
LEARN Regional Education Service Center	0	0	0
Manchester Regional Academy	0	0	0
Newtown Public Schools	0	0	0
Optimus Healthcare	0	1	0
Putnam Public Schools	0	0	0
Southwest Community Health Center	10	0	10
Stamford Public Schools	0	0	0
Stratford Public Schools	0	0	0
Windham Public Schools	0	0	0
Average	**1**	**0**	**1**
Total	**10**	**1**	**11**

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

Overview - Closed Episodes - CBITS/BB School Based Providers[1]

January - June 2019

Provider Name	BounceBack!	CBITS	EBT Total
Capitol Region Education Council	8	98	106
EASTCONN	5	5	10
LEARN Regional Education Service Center	4	4	8
Middletown Public Schools	0	0	0
Naugatuck Public Schools	0	0	0
Newtown Public Schools	9	26	35
Optimus Healthcare	28	79	107
Putnam Public Schools	29	11	40
Southwest Community Health Center	44	21	65
Stamford Public Schools	16	23	39
Stratford Public Schools	28	23	51
Windham Public Schools	10	11	21
Average	**15**	**25**	**40**
Total	**181**	**301**	**482**

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

Engagement[1] CBITS/BB

July-December 2018

Provider Name	Proposed Benchmark	BounceBack! # Closed	BounceBack! Engaged #	BounceBack! Engaged %	CBITS # Closed	CBITS Engaged #	CBITS Engaged %	Total EBT # Closed	Total EBT Engaged #	Total EBT Engaged %
Boys & Girls Village	55%	0	0	-	0	0	-	0	0	-
Capitol Region Education Council	55%	0	0	-	0	0	-	0	0	-
Child and Family Agency of Southeastern Connecticut, Inc	55%	0	0	-	0	0	-	0	0	-
Clifford Beers Clinic	55%	3	3	100%	7	6	86%	10	9	90%
Community Health Center, Inc	55%	0	0	-	4	4	100%	4	4	100%
Community Mental Health Affiliates, Inc	55%	6	6	100%	8	6	75%	14	12	86%
Cornell Scott Hill Health Center	55%	0	0	-	0	0	-	0	0	-
EASTCONN	55%	0	0	-	0	0	-	0	0	-
LEARN Regional Education Service Center	55%	0	0	-	0	0	-	0	0	-
Manchester Regional Academy	55%	0	0	-	0	0	-	0	0	-
Mid-Fairfield Child Guidance Center, Inc	55%	0	0	-	0	0	-	0	0	-
Newtown Public Schools	55%	0	0	-	0	0	-	0	0	-
Optimus Healthcare	55%	0	0	-	1	1	100%	1	1	100%
Putnam Public Schools	55%	0	0	-	0	0	-	0	0	-
Southwest Community Health Center	55%	10	10	100%	0	0	-	10	10	100%
Stamford Public Schools	55%	0	0	-	0	0	-	0	0	-
Stratford Public Schools	55%	0	0	-	0	0	-	0	0	-
The Child Guidance Clinic For Central Connecticut, Inc	55%	0	0	-	0	0	-	0	0	-
The Village for Families & Children, Inc	55%	0	0	-	0	0	-	0	0	-
United Community and Family Services	55%	0	0	-	8	7	88%	8	7	88%
United Services, Inc	55%	0	0	-	0	0	-	0	0	-
Wheeler Clinic	55%	0	0	-	0	0	-	0	0	-
Windham Public Schools	55%	0	0	-	0	0	-	0	0	-
Average	-	**1**	**1**	**-**	**1**	**1**	**-**	**2**	**2**	**-**
Total	**55%**	**19**	**19**	**100%**	**28**	**24**	**86%**	**47**	**43**	**91%**

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

Engagement[1] CBITS/BB

January - June 2019

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Closed	Engaged #	Engaged %	# Closed	Engaged #	Engaged %	# Closed	Engaged #	Engaged %
Boys & Girls Village	55%	4	4	100%	2	2	100%	6	6	100%
Capitol Region Education Council	55%	8	8	100%	98	96	98%	106	104	98%
Child and Family Agency of Southeastern Connecticut, Inc	55%	35	35	100%	27	27	100%	62	62	100%
Clifford Beers Clinic	55%	36	35	97%	29	25	86%	65	60	92%
Community Health Center, Inc	55%	-	-	-	21	18	86%	21	18	86%
Community Mental Health Affiliates, Inc	55%	2	2	100%	3	0	0%	5	2	40%
Cornell Scott Hill Health Center	55%	35	34	97%	7	7	100%	42	41	98%
EASTCONN	55%	5	5	100%	5	5	100%	10	10	100%
LEARN Regional Education Service Center	55%	4	4	100%	4	4	100%	8	8	100%
Mid-Fairfield Child Guidance Center, Inc	55%	15	15	100%	9	8	89%	24	23	96%
Middletown Public Schools	55%	0	-	-	0	-	-	0	-	-
Naugatuck Public Schools	55%	0	-	-	0	-	-	0	-	-
Newtown Public Schools	55%	9	9	100%	26	26	100%	35	35	100%
Optimus Healthcare	55%	28	28	100%	79	78	99%	107	106	99%
Putnam Public Schools	55%	29	29	100%	11	11	100%	40	40	100%
Southwest Community Health Center	55%	44	44	100%	21	21	100%	65	65	100%
Stamford Public Schools	55%	16	16	100%	23	23	100%	39	39	100%
Stratford Public Schools	55%	28	27	96%	23	23	100%	51	50	98%
The Child Guidance Clinic For Central Connecticut, Inc	55%	8	8	100%	0	-	-	8	8	100%
The Village for Families & Children, Inc	55%	0	-	-	0	-	-	0	-	-
United Community and Family Services	55%	9	9	100%	11	9	82%	20	18	90%
United Services, Inc	55%	0	-	-	0	-	-	0	-	-
Wheeler Clinic	55%	14	14	100%	9	6	67%	23	20	87%
Windham Public Schools	55%	10	10	100%	11	11	100%	21	21	100%
Average	-	15	14	-	17	17	-	32	31	-
Total	55%	339	336	99%	419	400	95%	758	736	97%

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

Measurement Based Care[1] CBITS/BB

July-December 2018

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		Engage	Measures Available		Engage	Available		Engage	Available	
			#	%		#	%		#	%
Boys & Girls Village	70%	0	0	-	0	0	-	0	0	-
Capitol Region Education Council	70%	0	0	-	0	0	-	0	0	-
Child and Family Agency of Southeastern Connecticut, Inc	70%	0	0	-	0	0	-	0	0	-
Clifford Beers Clinic	70%	3	2	67%	6	6	100%	9	8	89%
Community Health Center, Inc	70%	0	0	-	4	0	0%	4	0	0%
Community Mental Health Affiliates, Inc	70%	6	4	67%	6	3	50%	12	7	58%
Cornell Scott Hill Health Center	70%	0	0	-	0	0	-	0	0	-
EASTCONN	70%	0	0	-	0	0	-	0	0	-
LEARN Regional Education Service Center	70%	0	0	-	0	0	-	0	0	-
Manchester Regional Academy	70%	0	0	-	0	0	-	0	0	-
Mid-Fairfield Child Guidance Center, Inc	70%	0	0	-	0	0	-	0	0	-
Newtown Public Schools	70%	0	0	-	0	0	-	0	0	-
Optimus Healthcare	70%	0	0	-	1	0	0%	1	0	0%
Putnam Public Schools	70%	0	0	-	0	0	-	0	0	-
Southwest Community Health Center	70%	10	10	100%	0	0	-	10	10	100%
Stamford Public Schools	70%	0	0	-	0	0	-	0	0	-
Stratford Public Schools	70%	0	0	-	0	0	-	0	0	-
The Child Guidance Clinic For Central Connecticut, Inc	70%	0	0	-	0	0	-	0	0	-
The Village for Families & Children, Inc	70%	0	0	-	0	0	-	0	0	-
United Community and Family Services	70%	0	0	-	7	5	71%	7	5	71%
United Services, Inc	70%	0	0	-	0	0	-	0	0	-
Wheeler Clinic	70%	0	0	-	0	0	-	0	0	-
Windham Public Schools	70%	0	0	-	0	0	-	0	0	-
Average	-	1	1	-	1	1	-	2	1	-
Total	70%	19	16	84%	24	14	58%	43	30	70%

[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 2019

Provider Name	Proposed Benchmark	BounceBack! # Engaged	Measures Available #	Measures Available %	CBITS # Engaged	Available #	Available %	Total EBT # Engaged	Available #	Available %
Boys & Girls Village	70%	4	4	100%	2	0	0%	6	4	67%
Capitol Region Education Council	70%	8	8	100%	96	91	95%	104	99	95%
Child and Family Agency of Southeastern Connecticut, Inc	70%	35	32	91%	27	27	100%	62	59	95%
Clifford Beers Clinic	70%	35	33	94%	25	23	92%	60	56	93%
Community Health Center, Inc	70%	-	-	-	18	17	94%	18	17	94%
Community Mental Health Affiliates, Inc	70%	2	1	50%	0	-	-	2	1	50%
Cornell Scott Hill Health Center	70%	34	34	100%	7	7	100%	41	41	100%
EASTCONN	70%	5	5	100%	5	4	80%	10	9	90%
LEARN Regional Education Service Center	70%	4	4	100%	4	1	25%	8	5	63%
Mid-Fairfield Child Guidance Center, Inc	70%	15	15	100%	8	8	100%	23	23	100%
Middletown Public Schools	70%	-	-	-	-	-	-	-	-	-
Naugatuck Public Schools	70%	-	-	-	-	-	-	-	-	-
Newtown Public Schools	70%	9	9	100%	26	21	81%	35	30	86%
Optimus Healthcare	70%	28	26	93%	78	74	95%	106	100	94%
Putnam Public Schools	70%	29	29	100%	11	9	82%	40	38	95%
Southwest Community Health Center	70%	44	42	95%	21	21	100%	65	63	97%
Stamford Public Schools	70%	16	16	100%	23	21	91%	39	37	95%
Stratford Public Schools	70%	27	26	96%	23	15	65%	50	41	82%
The Child Guidance Clinic For Central Connecticut, Inc	70%	8	8	100%	-	-	-	8	8	100%
The Village for Families & Children, Inc	70%	-	-	-	-	-	-	-	-	-
United Community and Family Services	70%	9	9	100%	9	8	89%	18	17	94%
United Services, Inc	70%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	70%	14	0	0%	6	3	50%	20	3	15%
Windham Public Schools	70%	10	10	100%	11	11	100%	21	21	100%
Average	**-**	**18**	**16**	**-**	**21**	**20**	**-**	**37**	**34**	**-**
Total	**70%**	**336**	**311**	**93%**	**400**	**361**	**90%**	**736**	**672**	**91%**

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

Improved Outcomes[1] CBITS/BB

July-December 2018

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Measures Available	Improved Outcomes #	%	# Measures Available	Improved #	%	# Measures Available	Improved #	%
Boys & Girls Village	75%	0	0	-	0	0	-	0	0	-
Capitol Region Education Council	75%	0	0	-	0	0	-	0	0	-
Child and Family Agency of Southeastern Connecticut, Inc	75%	0	0	-	0	0	-	0	0	-
Clifford Beers Clinic	75%	2	0	0%	6	3	50%	8	3	38%
Community Health Center, Inc	75%	0	0	-	0	0	-	0	0	-
Community Mental Health Affiliates, Inc	75%	4	3	75%	3	2	67%	7	5	71%
Cornell Scott Hill Health Center	75%	0	0	-	0	0	-	0	0	-
EASTCONN	75%	0	0	-	0	0	-	0	0	-
LEARN Regional Education Service Center	75%	0	0	-	0	0	-	0	0	-
Manchester Regional Academy	75%	0	0	-	0	0	-	0	0	-
Mid-Fairfield Child Guidance Center, Inc	75%	0	0	-	0	0	-	0	0	-
Newtown Public Schools	75%	0	0	-	0	0	-	0	0	-
Optimus Healthcare	75%	0	0	-	0	0	-	0	0	-
Putnam Public Schools	75%	0	0	-	0	0	-	0	0	-
Southwest Community Health Center	75%	10	9	90%	0	0	-	10	9	90%
Stamford Public Schools	75%	0	0	-	0	0	-	0	0	-
Stratford Public Schools	75%	0	0	-	0	0	-	0	0	-
The Child Guidance Clinic For Central Connecticut, Inc	75%	0	0	-	0	0	-	0	0	-
The Village for Families & Children, Inc	75%	0	0	-	0	0	-	0	0	-
United Community and Family Services	75%	0	0	-	5	1	20%	5	1	20%
United Services, Inc	75%	0	0	-	0	0	-	0	0	-
Wheeler Clinic	75%	0	0	-	0	0	-	0	0	-
Windham Public Schools	75%	0	0	-	0	0	-	0	0	-
Average	-	**1**	**1**	-	**1**	**0**	-	**1**	**1**	-
Total	**75%**	**16**	**12**	**75%**	**14**	**6**	**43%**	**30**	**18**	**60%**

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

Improved Outcomes[1] CBITS/BB

January - June 2019

Provider Name	Proposed Benchmark	BounceBack! # Measures Available	Improved #	Outcomes %	CBITS # Measures Available	Improved #	Improved %	Total EBT # Measures Available	Improved #	Improved %
Boys & Girls Village	75%	4	1	25%	0	-	-	4	1	25%
Capitol Region Education Council	75%	8	6	75%	91	71	78%	99	77	78%
Child and Family Agency of Southeastern Connecticut, Inc	75%	32	20	63%	27	16	59%	59	36	61%
Clifford Beers Clinic	75%	33	22	67%	23	12	52%	56	34	61%
Community Health Center, Inc	75%	-	-	-	17	16	94%	17	16	94%
Community Mental Health Affiliates, Inc	75%	1	1	100%	-	-	-	1	1	100%
Cornell Scott Hill Health Center	75%	34	23	68%	7	6	86%	41	29	71%
EASTCONN	75%	5	5	100%	4	4	100%	9	9	100%
LEARN Regional Education Service Center	75%	4	4	100%	1	1	100%	5	5	100%
Mid-Fairfield Child Guidance Center, Inc	75%	15	10	67%	8	8	100%	23	18	78%
Middletown Public Schools	75%	-	-	-	-	-	-	-	-	-
Naugatuck Public Schools	75%	-	-	-	-	-	-	-	-	-
Newtown Public Schools	75%	9	8	89%	21	18	86%	30	26	87%
Optimus Healthcare	75%	26	20	77%	74	66	89%	100	86	86%
Putnam Public Schools	75%	29	26	90%	9	6	67%	38	32	84%
Southwest Community Health Center	75%	42	35	83%	21	19	90%	63	54	86%
Stamford Public Schools	75%	16	15	94%	21	14	67%	37	29	78%
Stratford Public Schools	75%	26	22	85%	15	13	87%	41	35	85%
The Child Guidance Clinic For Central Connecticut, Inc	75%	8	7	88%	-	-	-	8	7	88%
The Village for Families & Children, Inc	75%	-	-	-	-	-	-	-	-	-
United Community and Family Services	75%	9	7	78%	8	7	88%	17	14	82%
United Services, Inc	75%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	75%	0	-	-	3	3	100%	3	3	100%
Windham Public Schools	75%	10	5	50%	11	9	82%	21	14	67%
Average	**-**	**16**	**13**	**-**	**20**	**17**	**-**	**34**	**26**	**-**
Total	**75%**	**311**	**237**	**76%**	**361**	**289**	**80%**	**672**	**526**	**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 2018

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Engaged	Model Completion		# Engaged	Model Completion		# Engaged	Model Completion	
			#	%		#	%		#	%
Boys & Girls Village	30%	0	0	-	0	0	-	0	0	-
Capitol Region Education Council	30%	0	0	-	0	0	-	0	0	-
Child and Family Agency of Southeastern Connecticut, Inc	30%	0	0	-	0	0	-	0	0	-
Clifford Beers Clinic	30%	3	3	100%	6	6	100%	9	9	100%
Community Health Center, Inc	30%	0	0	-	4	1	25%	4	1	25%
Community Mental Health Affiliates, Inc	30%	6	4	67%	6	4	67%	12	8	67%
Cornell Scott Hill Health Center	30%	0	0	-	0	0	-	0	0	-
EASTCONN	30%	0	0	-	0	0	-	0	0	-
LEARN Regional Education Service Center	30%	0	0	-	0	0	-	0	0	-
Manchester Regional Academy	30%	0	0	-	0	0	-	0	0	-
Mid-Fairfield Child Guidance Center, Inc	30%	0	0	-	0	0	-	0	0	-
Newtown Public Schools	30%	0	0	-	0	0	-	0	0	-
Optimus Healthcare	30%	0	0	-	1	0	0%	1	0	0%
Putnam Public Schools	30%	0	0	-	0	0	-	0	0	-
Southwest Community Health Center	30%	10	10	100%	0	0	-	10	10	100%
Stamford Public Schools	30%	0	0	-	0	0	-	0	0	-
Stratford Public Schools	30%	0	0	-	0	0	-	0	0	-
The Child Guidance Clinic For Central Connecticut, Inc	30%	0	0	-	0	0	-	0	0	-
The Village for Families & Children, Inc	30%	0	0	-	0	0	-	0	0	-
United Community and Family Services	30%	0	0	-	7	6	86%	7	6	86%
United Services, Inc	30%	0	0	-	0	0	-	0	0	-
Wheeler Clinic	30%	0	0	-	0	0	-	0	0	-
Windham Public Schools	30%	0	0	-	0	0	-	0	0	-
Average	-	1	1	-	1	1	-	2	1	-
Total/Average	30%	19	17	89%	24	17	71%	43	34	79%

[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 2019

Provider Name	Proposed Benchmark	BounceBack!			CBITS			Total EBT		
		# Engaged	Model Completion		# Engaged	Model Completion		# Engaged	Model Completion	
			#	%		#	%		#	%
Boys & Girls Village	30%	4	4	100%	2	1	50%	6	5	83%
Capitol Region Education Council	30%	8	8	100%	96	84	88%	104	92	88%
Child and Family Agency of Southeastern Connecticut, Inc	30%	35	34	97%	27	27	100%	62	61	98%
Clifford Beers Clinic	30%	35	33	94%	25	25	100%	60	58	97%
Community Health Center, Inc	30%	-	-	-	18	16	89%	18	16	89%
Community Mental Health Affiliates, Inc	30%	2	2	100%	0	-	-	2	2	100%
Cornell Scott Hill Health Center	30%	34	34	100%	7	7	100%	41	41	100%
EASTCONN	30%	5	5	100%	5	4	80%	10	9	90%
LEARN Regional Education Service Center	30%	4	3	75%	4	1	25%	8	4	50%
Mid-Fairfield Child Guidance Center, Inc	30%	15	15	100%	8	8	100%	23	23	100%
Middletown Public Schools	30%	-	-	-	-	-	-	-	-	-
Naugatuck Public Schools	30%	-	-	-	-	-	-	-	-	-
Newtown Public Schools	30%	9	9	100%	26	26	100%	35	35	100%
Optimus Healthcare	30%	28	28	100%	78	76	97%	106	104	98%
Putnam Public Schools	30%	29	29	100%	11	11	100%	40	40	100%
Southwest Community Health Center	30%	44	42	95%	21	21	100%	65	63	97%
Stamford Public Schools	30%	16	16	100%	23	22	96%	39	38	97%
Stratford Public Schools	30%	27	26	96%	23	20	87%	50	46	92%
The Child Guidance Clinic For Central Connecticut, Inc	30%	8	8	100%	-	-	-	8	8	100%
The Village for Families & Children, Inc	30%	-	-	-	-	-	-	-	-	-
United Community and Family Services	30%	9	9	100%	9	9	100%	18	18	100%
United Services, Inc	30%	-	-	-	-	-	-	-	-	-
Wheeler Clinic	30%	14	14	100%	6	0	0%	20	14	70%
Windham Public Schools	30%	10	10	100%	11	11	100%	21	21	100%
Average	**-**	**18**	**17**	**-**	**21**	**21**	**-**	**37**	**35**	**-**
Total/Average	**30%**	**336**	**329**	**98%**	**400**	**369**	**92%**	**736**	**698**	**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).

Appendix E: Reliable Change Index

Reliable Change Index Value Calculations

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

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

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

	Measure	Full RCI	Partial RCI
Ohio Scales	Ohio Problem Severity* *(Child, Caregiver, & Worker versions)*	10	5
	Ohio Functioning *(Child, Caregiver, & Worker versions)*	8	4

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