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Child Health and Development Institute of Connecticut, Inc.

Connecticut's Evidence-Based Treatment Coordination Center

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

DCF CONNECTICUT

Connecticut MATCH-ADTC Coordinating Center

Child Health and Development Institute

270 Farmington Ave, Suite 367
Farmington, CT 06032

www.chdi.org

This report was developed for the Connecticut Department of Children and Families (DCF) by the Child Health and Development Institute of Connecticut (CHDI). For more information, contact Kellie G. Randall at **randall@uchc.edu**

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Executive Summary

The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and Conduct problems (MATCH-ADTC) is an evidence-based treatment for four common behavioral health concerns among children: anxiety, depression, posttraumatic stress, and behavior problems. The MATCH-ADTC Coordinating Center ("Coordinating Center"), is located at the Child Health and Development Institute (CHDI). Funded by the Connecticut (CT) Department of Children and Families (DCF), the goal of the Coordinating Center is to expand access to high quality, evidence-based outpatient behavioral health treatment for children experiencing anxiety, depression, trauma, and/or conduct problems. Beginning in 2013 in a partnership with MATCH-ADTC developers at Harvard University, MATCH-ADTC has been disseminated across the state. The Coordinating Center now supports a network of 23 MATCH-ADTC providers throughout Connecticut and provides training, credentialing, implementation support, site-based consultation, data collection and reporting, and ongoing quality improvement.

This report summarizes the work of the Coordinating Center over the past seven years, highlighting the performance during fiscal year 2020 (July 1, 2019 through June 30, 2020). This year was impacted by COVID-19. Once stay-at-home orders were put in place in mid-March, provider agencies shifted to delivering services through telehealth platforms and trainings shifted to online platforms. National conversations on racial justice and racism came to the forefront during this year, reflected in this report with a continuing focus on disparities and inequities. Even amidst the challenges of COVID-19 and in the context of long-standing disparities in behavioral health treatment and services generally, MATCH-ADTC demonstrated strong results in access, quality, and outcomes.

Highlights of FY 19:

- 610 children received MATCH-ADTC
- 40 new clinical staff were trained to deliver MATCH-ADTC
- Caregivers (94%) and children (91%) reported high satisfaction with treatment
- Children completing MATCH-ADTC had positive clinical outcomes:
    - 74% of children with critical functioning symptoms reported remission
    - 68% of caregivers reported remission in children's internalizing/externalizing behaviors
- A cohort of 4 MATCH-ADTC Train-the-Trainers completed the program, enhancing site-based and state-level training capacity across Connecticut and supporting the sustainability in the state
- Implemented the first state-level MATCH-ADTC virtual training with CT-based state-level trainers

Key Recommendations:

- Add questions to assess families' experiences of racism and discrimination as part of the overall screening for traumatic experiences, as these experiences can impact symptoms and service outcomes
- Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity, health equity, and anti-racism
- Collect information on use of telehealth- when and how it is used in treatment as well as provider experiences- to understand the needs of agencies as they continue delivering services virtually
- Provide resources and support to agencies in implementing best practices when providing telehealth services
- Establish expectations on the number of children trained clinicians should implement MATCH-ADTC with each year, to both ensure they have opportunities to improve their MATCH-ADTC clinical skills and

increase the number of children that are receiving MATCH-ADTC and develop plans and strategies to help teams monitor these targets; this will help increase the number of trained clinicians delivering MATCH-ADTC in the years after training and ensure

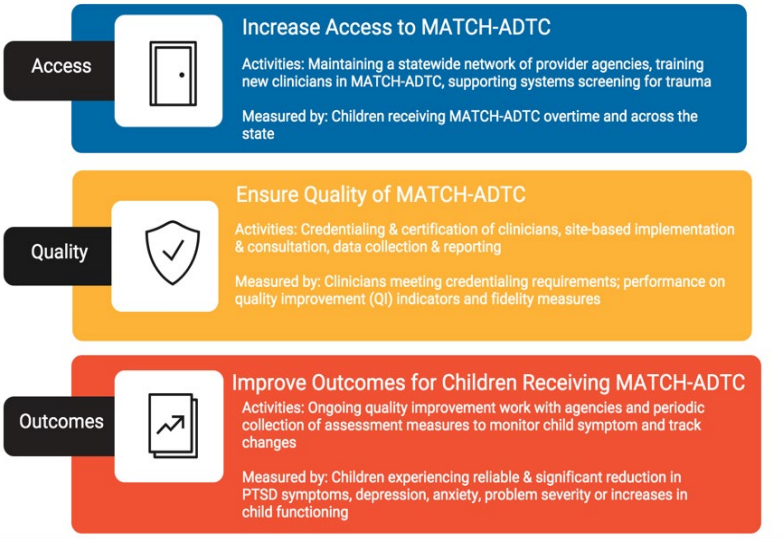
- Examine MATCH-ADTC service rates across racial/ethnic groups compared to outpatient services, which is now possible due to the integration of data systems, to ensure MATCH-ADTC is available
- Use mapping and local data to better understand MATCH-ADTC implementation at the agency and community level, particularly when examining disparities
- Add assessment options to measure conduct and anxiety symptoms in children to support data-driven decision making to determine initial MATCH-ADTC protocol
- Ensure assessments are available in languages commonly spoken by families in electronic format within the PIE database system

Introduction

Children and adolescents seeking treatment often experience a variety of co-occurring problems and the course of treatment may need to change over time. Most treatments address one problem area at a time, although comorbidity and changing clinical needs commonly occur in practice. MATCH-ADTC is an evidence-based treatment to treat four common behavioral health concerns among children, including anxiety, depression, posttraumatic stress, and behavior problems. Appropriate for children 6-15 years of age, MATCH-ADTC is comprised of 33 modules (e.g., praise, rewards, etc.) representing treatment components that are frequently included in cognitive behavioral therapy (CBT) protocols for depression, anxiety (including post-traumatic stress), and behavioral parent training for disruptive behavior. MATCH-ADTC is designed to address broad practitioner caseloads, comorbidity, and changes in treatment needs during episodes of care, creating a foundation for successful outcomes.

The MATCH-ADTC Coordinating Center ("Coordinating Center") is funded by the Connecticut Department of Children and Families (DCF) and located at the Child Health and Development Institute (CHDI) of Connecticut. Beginning in 2013 in a partnership with the model developers at Harvard University, MATCH-ADTC has been disseminated across the state through a series of Learning Collaboratives. The Coordinating Center provides centralized support for the statewide network of 23 MATCH-ADTC providers. The figure below illustrates the goals and primary activities of the Coordinating Center.[1]

Figure 1. Goals and Activities of the Coordinating Center



This report is framed around these three primary goals and the performance during FY2020. Amidst the challenges presented by COVID-19 and the shift to telehealth platforms for services delivery and online trainings for clinicians, there were many successes across the MATCH-ADTC network. The first two sections describe progress on ensuring Connecticut children have access to MATCH-ADTC (goal 1). The first section presents information on agency providers, training activities, and workforce development. The second section describes trends in service over time as well as a description of the population of children served. The third section details the clinical implementation, fidelity monitoring, and quality improvement activities that took place to ensure children received high-quality services (goal 2). The fourth section then describes symptom reduction and functional improvements for children who receive MATCH-ADTC with a careful consideration of demographic characteristics that might influence outcomes (goal 3). The final section provides conclusions and recommendations to guide the work in future years.

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

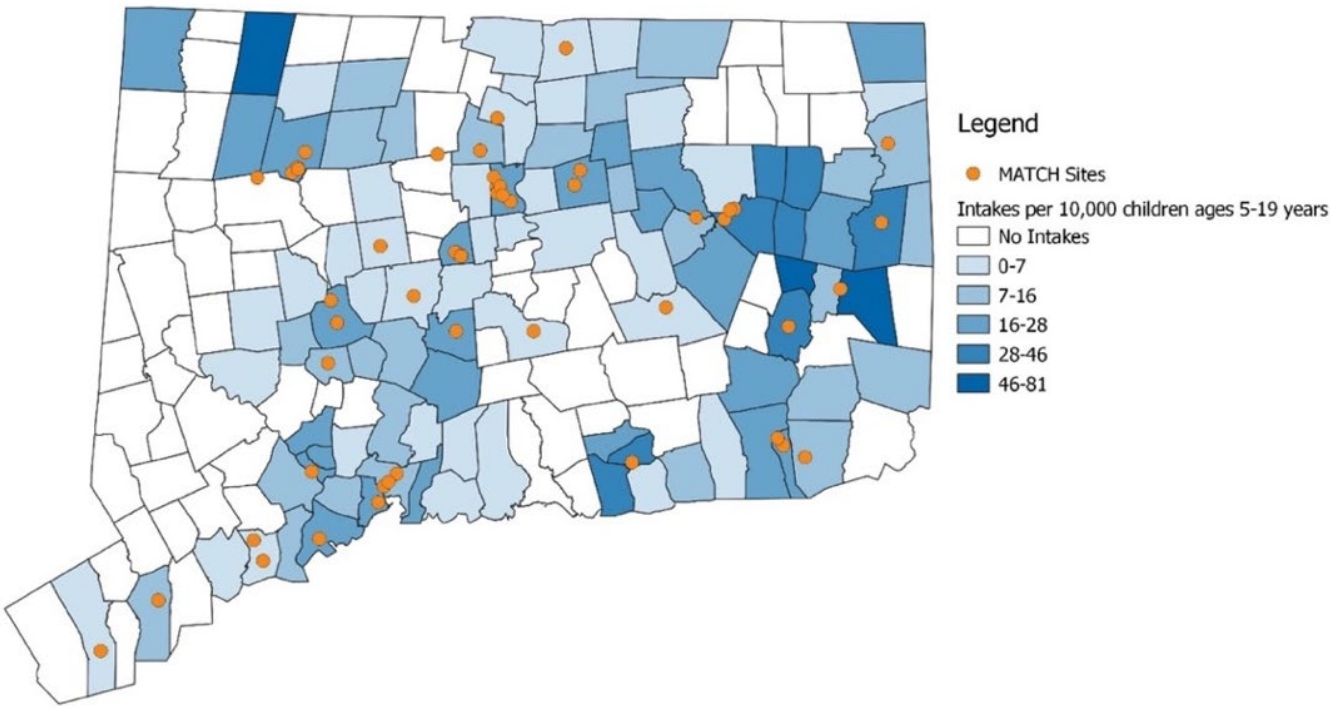
Access to MATCH-ADTC in Connecticut

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

Availability across the State

In FY 20, Connecticut's MATCH-ADTC network consisted of 23 provider agencies. Figure 2 shows the location of MATCH-ADTC sites across the state and Table 1 shows the trends in access over the past three years as well as cumulative totals. Since FY14, there have been 222 clinicians that have provided MATCH-ADTC. There were 169 clinicians on a MATCH-ADTC team during FY19, and 116 (68.6%) saw at least one MATCH-ADTC case. This means there were 53 clinicians that were on teams but did not see any cases. Some of this is due to attrition and clinicians leaving partway through the year, as noted below, but closer monitoring of caseloads and clinician activity can help ensure investments in training are resulting in more children being seen. On average, outpatient providers have 9 clinicians (range 5 – 14) on their MATCH-ADTC clinical teams.

Figure 2. Map of MATCH-ADTC sites and children served



Of the 169 clinicians on a MATCH-ADTC team, 38 (22.4%) left in the fiscal year. To address attrition, 40 new clinical staff were trained in MATCH-ADTC during the year. To support high quality delivery of services, 29 clinical staff attended booster training and 5 clinicians were credentialed. Additionally, four MATCH-ADTC Associate Trainers complete the process to be able to train at the state level, increasing the sustainability of the model in Connecticut.

Table 1. Trends in MATCH-ADTC provider network

	FY18	FY 19	FY20	Cumulative Since 2014
Providers of MATCH-ADTC	20	19	23	24
New MATCH-ADTC Clinicians	56	54	40	288
Clinicians Providing MATCH-ADTC	113	137	116	222
#Credentialed/Certified	14	20	5	98

Table 2. Clinician demographics (n=169)

Race	
Black or African American	**6.5**
Hispanic, Latino, or Spanish	**17.2**
White	**61.5**
Other Race/Ethnicity	**2.4**
Not Reported	**12.4**
Languages Spoken	
Spanish	**13.6**
Other	**2.3**

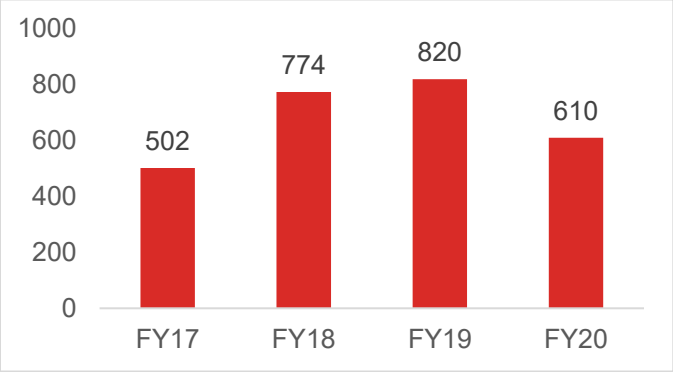
Demographic characteristics of the 169 clinicians on MATCH-ADTC teams during FY 20 are presented in Table 2. MATCH-ADTC clinicians are primarily White (61.5%) and female (88.2%). Aside from English, 13.6% of MATCH-ADTC clinicians also speak Spanish. Other languages reported include Armenian, French, and French Creole.

Many MATCH-ADTC clinicians practiced other EBTs. The most common additional model was Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which was practiced by 45% of MATCH-ADTC clinicians. This is likely of relevance when looking at the modules used by MATCH-ADTC clinicians and seeing relatively lower rates of the trauma module. Attachment, Self-Regulation, and Competency (ARC), a model disseminated in Connecticut with a focus on serving young children, was practiced by 12% of MATCH-ADTC clinicians, and CPP by 7% of clinicians. Few MATCH-ADTC clinicians also practice Bounce Back (4%) or Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (4%), likely due those models largely being implemented in school settings.

Children Receiving MATCH-ADTC

In FY20, 610 children received MATCH-ADTC. This number was a decrease compared to the previous year. This is likely due in large part to stay-at-home orders implemented at the end of Q3 FY20 for the COVID-19 pandemic. During that time, agencies needed to spend time adjusting their procedures to deliver services through a telehealth platform.

Figure 3. Children served by fiscal year



This rapid adoption of telehealth services required technical support and troubleshooting for clinicians and clients resulting in some treatment session delays and impacted agency referrals and intake procedures. CHDI provided implementation support and clinical resources to agencies to support the transition to virtual sessions. To date, 2,185 children have received MATCH-ADTC since FY14.

Child Demographics

Table 3 contains demographic information for children receiving MATCH-ADTC in FY 20, as well as comparisons to those served in outpatient services (as reported by the Provider Information Exchange [PIE] system) and the general CT population. Demographic results are similar to FY 19. Throughout this report, indicators of access, quality, and outcomes are reported by demographic groups. Social and community context is highly related to service receipt and outcomes. Racism is part of that context that research has shown leads to inequities. Recognizing this, special consideration is given in this report to comparisons across racial and ethnic groups.

Table 3. Characteristics of children receiving MATCH-ADTC, with comparisons (n=610)

	MATCH-ADTC		OPCC[2]	CT pop[3]
	N	%	%	%
Sex (Male)	268	43.9	54.1	50.9
Race				
American Indian or Alaska Native	3	0.5	0.4	0.3
Asian	4	0.7	0.8	4.6
Black or African American	69	11.3	16.6	12.9
Native Hawaiian or Pacific Islander	1	0.2	0.2	0.1
White	362	59.3	52.6	66.6
Other Race/Ethnicity (includes multiracial/ethnic)	53	8.7	3.0	15.6
Not Reported	75	12.3	26.4	N/A
Hispanic, Latino, or Spanish (any race)[4]	224	36.7	38.6	24.7
Age (years)				
Under 6 years	33	5.4	18.8	29.4
6-11 years	294	48.4	31.9	33.4
12-17 years	281	46.2	46.7	37.2
Child welfare involvement during treatment	73	12.0	13.3	N/A
JJ involvement during treatment	7	1.1	0.8	N/A
Child's Language[5]				
Spanish	33	7.9	13.0	13.4
Neither Spanish nor English	0	0.0	1.3	8.6
Missing language data	192	31.5	0.0	N/A
Caregiver's Language				
Does not speak English	62	10.1	N/A	N/A

Child Clinical Characteristics at Treatment Start

Information on baseline assessments is found in Table 4. Assessments were evaluated to determine if demographic factors were related to trauma exposure or scores on symptom measures at treatment start. Details of the tests can be found in in Appendix B.

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

[3] American Community Survey 2018 1 year estimates. Caution should be used with comparison to OPCC and MATCH-ADTC child demographics. Census race categories do not exclude Hispanic, therefore OPCC and MATCH racial demographics mirror the Census. Census language is only available by language spoken, not primary language. Age is percentage of children 0-17 years.

[4] 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.

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

Trauma Exposure. Children report experiencing an average of 4.87 types of potentially traumatic events; caregivers report their children having experienced 3.90 on average. Older children had higher rates of exposure by both child and caregiver report. There were no differences found in exposure to potentially traumatic events across sex or race/ethnicity groups. However, there is growing recognition of the impacts of racism and discrimination on behavioral health symptoms. Experiences of discrimination can lead to higher rates of PTS symptoms[6]. The assessment measures in MATCH-ADTC do not explicitly assess racism or discrimination, so the degree of racism and discrimination experienced by children receiving MATCH-ADTC and the effects on traumatic stress symptoms and treatment are not known.

Baseline Symptoms. Nearly all children (96.9%) receiving MATCH-ADTC in the fiscal year had a measure of baseline symptoms. Clinicians have flexibility in selecting the most appropriate symptom measure from a menu of assessment options. The highest rates of elevation were on depression symptoms, where 76.6% of caregivers and 55.9% of children reported scores indicating clinical elevation. The most commonly completed assessments were the Ohio Caregiver reports (88.9%). However, only 34.5% and 27.9% of children had scores suggesting clinical attention was needed on Problem Severity and Functioning scales, respectively.

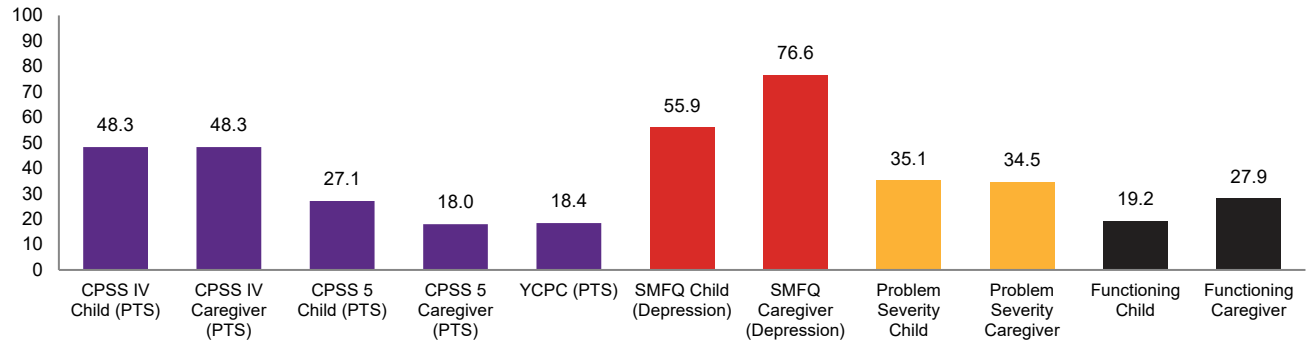
Table 4. Intake scores

Measure	Child Report				Caregiver Report			
	N	Mean	SD	Elevated n,%[7]	N	Mean	SD	Elevated (n, %)
THS sum	479	4.87	3.16	-	496	3.9	2.68	-
CPSS-IV Total Score	29	14.24	12.27	14, 48.3	29	15.52	11.46	14, 48.3
Re-experiencing Subscore	-	4.21	4.24	-	-	4.17	3.2	-
Avoidance Subscore	-	4.97	4.89	-	-	5.07	4.67	-
Arousal Subscore	-	5.21	4.65	-	-	6.28	4.57	-
CPSS 5 Total Score	381	21.64	16.3	108, 27.1	388	17.4	14.35	70, 18.0
Re-experiencing Subscore	-	4.98	4.61	-	-	4.16	4	-
Avoidance Subscore	-	2.73	2.63	-	-	2.03	2.23	-
Cognition & Mood Subscore	-	7.08	6.48	-	-	5.94	5.83	-
Hyperarousal Subscore	-	7.31	5.3	-	-	5.91	5.01	-
YCPC Total Score	-	-	-	-	49	11.96	15.94	9, 18.4
SMFQ Total Score	161	8.94	5.76	90, 55.9	133	9.37	5.5	95, 76.6
Ohio Problem Severity	313	21.81	12.73	110, 35.1	542	20.73	12.43	187, 34.5
Internalizing	-	12.87	8.75	-	-	9.78	7.24	-
Externalizing	-	8.68	6.5	-	-	10.8	8.24	-
Ohio Functioning	313	55.6	12.5	60, 19.2	542	51.56	13.53	151, 27.9

Figure 4. Percentage of children with elevated scores at intake, by measure

[6] Bryant-Davis & Ocampo, 2006; Butts, 2002; Williams et al., 2014

[7] Defined as “above clinical cutoff” or “critical impairment”. Does not include “high symptoms.” Valid percentages reported.



Quality: Consultation and Clinical Implementation

CHDI, in collaboration with DCF, works closely with agency providers and meets regularly with each agency to review agency performance data and provide implementation consultation. The focus of these site visits varies based on the needs of individual agencies but generally focus on building internal capacity to sustain MATCH-ADTC and providing strategies to ensure fidelity and outcome benchmarks are met. In addition to site-based consultation, the Coordinating Center helps maintain a database to collect MATCH-ADTC data. To support clinicians and ensure timely, accurate, and usable data, the Coordinating Center runs a database HelpDesk. The HelpDesk has fielded over 1,500 requests from users since it was opened at the start of FY19. The data collected in the system and used in site visits provides information on how teams are performing on Quality Improvement (QI) indicators (detailed below) as well as other indicators of MATCH-ADTC model implementation including MATCH-ADTC protocol areas used, the top problems identified by children and caregivers, discharge reasons, and family satisfaction with treatment.

MATCH-ADTC Data Systems

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

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

Another challenge was supporting agencies that do not receive funding from DCF for their outpatient clinics and therefore never accessed PIE. These agencies needed to gain access to PIE, learn the new

system, and develop procedures to collect the new data fields required in PIE that were not previously collected in EBP Tracker. Some of these agencies still have not started using PIE and entering data. CHDI continues to work with these agencies, but it is likely there are some MATCH cases that do not appear in the data.

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

Implementation Consultation

This year, 60 consultation meetings were completed with providers. The agenda for these meetings is to review the statewide and provider level data to monitor and analyze the processes of delivering treatment, identifying areas for improvement and track progress towards improvement. The reports reviewed during consultation are the monthly dashboards (see Appendix C for example) and the QI Report (see Appendix D for overview and examples). The cross-model dashboards provide monthly and cumulative information on clients served. CHDI creates the QI Report twice annually while also providing quarterly updates on progress towards meeting the benchmark for each QI indicator. To address areas of concern, SMARTER goals are developed with the agency to identify strategies to improve child and family outcomes.

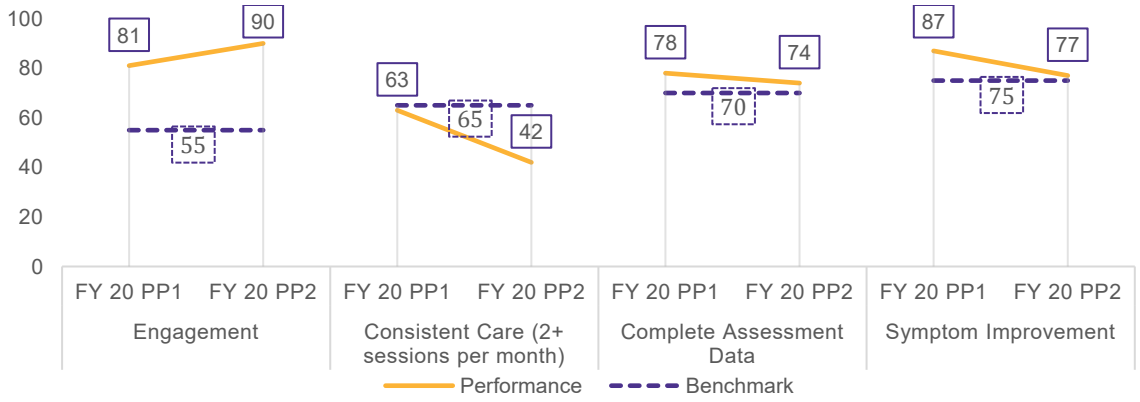
In Q3, CHDI worked with DCF to support agency changes to service delivery to adopt telehealth services due to COVID-19. Guidance was provided on administering assessments through a telehealth platform including instruction on data collection. CHDI shared resources and recommendations from EBT model experts to conduct services virtually. CHDI provided opportunities for cross system collaboration and hosted several statewide meetings for agency coordinators to share resources, tips and considerations for MATCH-ADTC implementation.

Quality Improvement & Model Implementation

Case are reported while they are active and open, but most of the QI reporting and fidelity monitoring is calculated based on children that complete treatment in a given period. In FY20, 413 children had a MATCH-ADTC episode that ended. Children completing MATCH-ADTC attended a mean of 14.04 (SD=12.33) sessions within a mean treatment episode length of 7.15 (SD=6.37) months. For those completing MATCH, on average, clinicians spent 55.74% (SD=30.53%) of time with children alone, 13.72% (SD=19.54%) of time with caregivers alone, and 30.54% (SD=28.61%) of time with children and caregivers together. The following sections detail the QI indicators, use of the MATCH-ADTC model, and clinicians and family perspectives on MATCH-ADTC treatment at episode end.

Quality improvement (QI) indicators are calculated for six-month periods. Explanations of each of the 4 QI indicators and the prepared reports showing each provider's results are included in Appendix D. Three out of four statewide QI benchmarks were met both performance periods in FY20, only the consistent care benchmark was not met. It should be noted that the consistent care benchmark was impacted by changes in service provision due to COVID-19 as well as the changes in the integration of data systems detailed above. A summary of the performance indicators is in Figure 5.

Figure 5. Quality Improvement in FY 20



Top Problem Assessment

Of the 610 MATCH-ADTC treatment episodes open in FY 20, 88.4% of caregivers identified at least one top problem to work on during treatment, and 93.0% of children identified at least one top problem. Figures 6 and 7 below show the general topic areas of the top problem areas for children and caregivers.

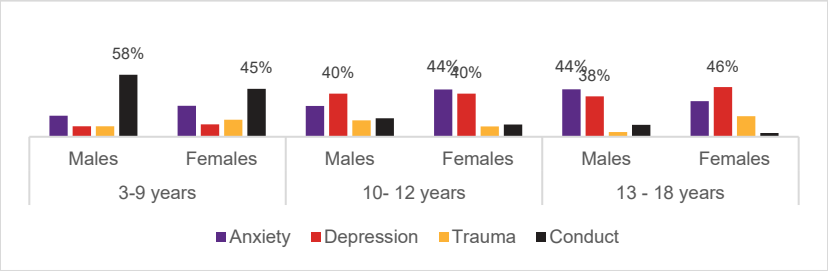
Figure 6. Child reported top problems

Figure 7. Caregiver reported top problems

Primary Protocol Area

Children completing MATCH-ADTC (n=413) in the fiscal year were most often treated with the Anxiety (137), Depression (122), and Conduct (102) protocol areas. Trauma (56) was less common. This trend is consistent with previous years. The Trauma protocol may be least likely to be used because clinicians may be opting to provide TF-CBT instead as nearly half (46.5%) of MATCH-ADTC clinicians also practice TF-CBT. Per the developers, the conduct protocol content caters more towards pre-adolescent children with conduct issues, clinicians are encouraged to use another EBP with adolescents (especially older adolescents) with conduct issues. This may explain why males and females in the 3-9 years age group were most commonly assigned the Conduct primary problem area.

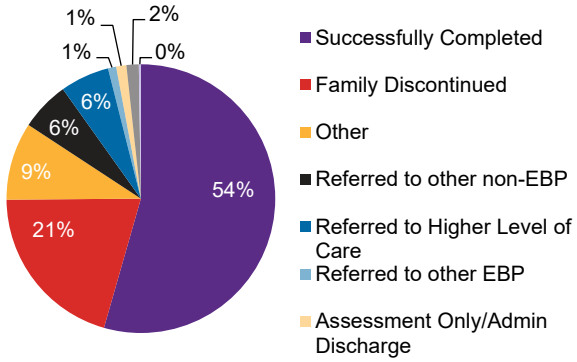
Figure 8. Primary Protocol Area (PPA) by age and sex (n= 413)



Discharge Reason

During the fiscal year, 413 children ended their MATCH-ADTC treatment episode. Clinicians rated half of children (54%) ending treatment as "completing all EBP requirements." Children who did not complete all EBP requirements were most likely to not complete due to family discontinuing treatment. A binary logistic regression was performed in order to look at differences in successful discharge across demographic groups (age, sex, race/ethnicity) controlling for trauma exposure. Hispanic children were less significantly likely to successfully complete compared to White children. No other differences on race or other demographics were found. See Appendix B for regression table.

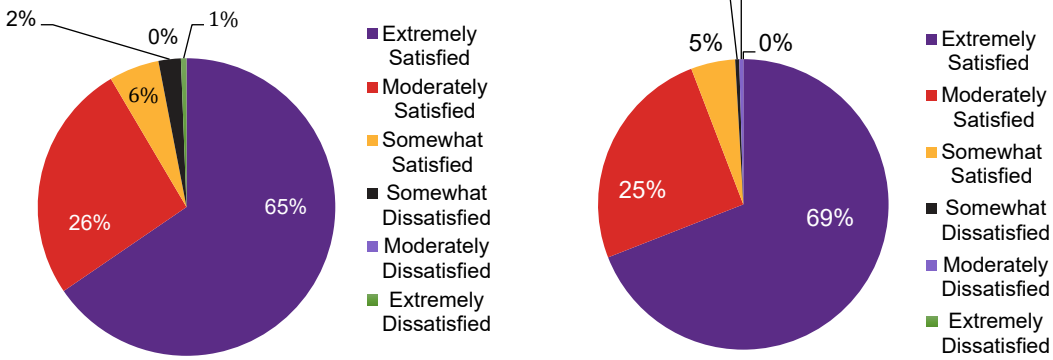
Figure 9. Reasons for discharge in FY 20



Satisfaction

Caregivers report high levels of satisfaction with MATCH-ADTC treatment. In FY 20, there were 165 Ohio Child Satisfaction completed and 223 Ohio Caregiver Satisfaction forms completed. The responses to both measures are illustrated in Figures 10 and 11 below with 91% of children and 94% of caregivers indicating mostly or very satisfied with treatment.

Figures 10 & 11. Satisfaction categories, Child-report (left) Caregiver-report (right)



Outcomes: Improvement for Children Receiving MATCH-ADTC

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

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

Improvement can be assessed for trauma symptoms, depressive symptoms, problem severity, or functioning. Each of these dimensions can have both a child and a caregiver report. When presenting changes in outcomes, we use two methods to summarize changes. The overall change scores, using t-tests, are presented as a general measure of significant shifts across all children served from intake to discharge. These are represented in the change scores in Table 6 below. Additionally, the Reliable Change Index (RCI) is also used. The RCI assigns a measure-specific point reduction threshold that represents significant change. An overview of the RCI with explanations on how and why it is used as well a table of relevant values by measure is included in Appendix E.

Rates of Outcome Data

Three in four children (70.0%) discharged from MATCH-ADTC in the fiscal year had at least one first and last version of a child symptom assessment (child or caregiver reporter). Only 11.4% had a first and last measure of caregiver symptoms. Children receiving the conduct protocol were less likely to have outcome data (63.7%) compared to children receiving the depression (77.1%), trauma (75%), or anxiety (73.7%) protocols.

In order to look at differences in rates of outcome data based on child demographics (age, race/ethnicity, sex) a binary logistic regression was performed controlling for trauma exposure and successful discharge. Only successful discharge was found to be significant where children without successful discharge were less likely (β=-2.496, $p<.001$) to have outcome data compared to children discharged successfully. Controlling for discharge reason and trauma exposure demographic characteristics did not have any significant effect on whether children had outcome data available. Binary logistic regression analyses are available in Appendix B.

Symptom Improvement

Children completing MATCH-ADTC demonstrated significant reductions in post-traumatic stress and problem severity symptoms, and improvements in functioning (see Table 5). Remission rates and reliable change were similar across measures. Children receiving MATCH-ADTC were assessed on four different assessments of child symptoms across child and caregiver reporter versions. When children were assessed at two or more time points, change scores were calculated and RCI values were used to determine the percentage of children who experienced reliable change.

Children with Clinically High Symptoms at Baseline

Children who enter MATCH-ADTC with clinically high symptoms have higher rates of reliable symptom change after treatment. This trend was seen across all symptom categories (PTSD, externalizing/internalizing behaviors, and functioning). Looking at problem severity (externalizing/internalizing) symptom outcome data, 53.7% of those with a caregiver report and 64.4% of those with a child report (54.6%) experienced problem severity symptom reduction. Comparatively, 81.9% of children with elevated caregiver-report at baseline and 73.8% of children with elevated child-report at baseline experienced reliable change in this symptom category. Similar trends were seen for children with elevated PTSD symptoms and functioning. Due to low response rates, we did not look at reliable change by critically high symptoms for depression symptoms. (See Figure 11 for overall reliable change percentages and Figures 12-15 for reliable change by critically high symptom category).

Figure 12. Percent of children with change, by measure

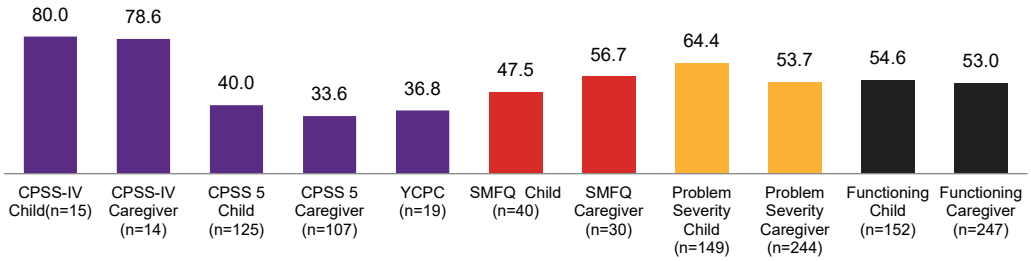


Figure 13. Percent of children with PTSD symptom reduction

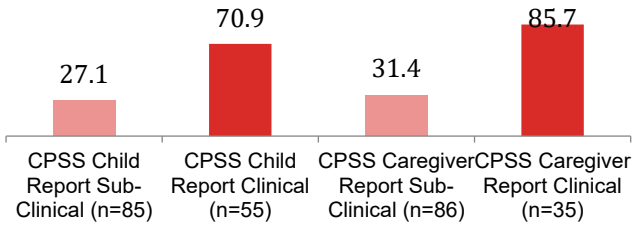


Figure 14. Percent with Ohio Problem Severity reduction

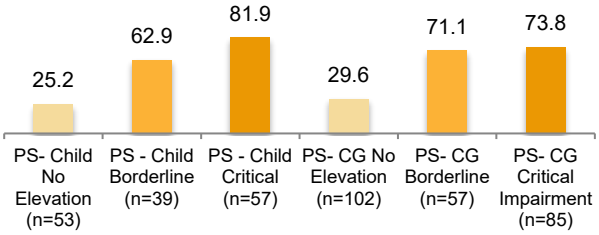


Figure 15. Percent with Ohio Functioning improvement

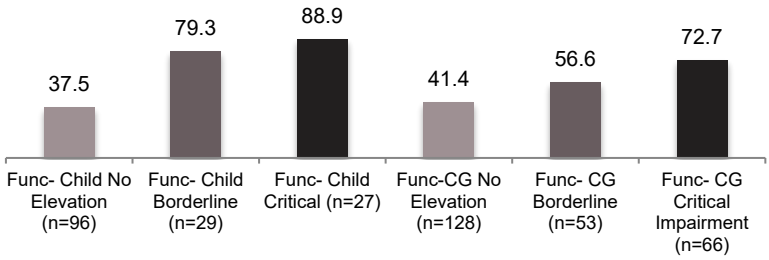


Table 5. Descriptives and Change Scores for all Assessment Measures

Assessment Name[8]	Construct Measured	Above Cutoff	Intake Mean (S.D).	Last Mean (S.D.)	Change Score	t-score	Remission
THS Child (n=323)	Exposure to potentially traumatic events	n/a	4.91 3.22	n/a	n/a	n/a	n/a
THS Caregiver (n=334)		n/a	3.85 2.78	n/a	n/a	n/a	n/a
CPSS IV Child (n=15)	Trauma symptoms	11 73.33%	20.47 6.4	11.55 6.75	-14.07	-	10/11 90.91%
CPSS IV Caregiver (n= 14)		10 71.43%	21.86 8.93	9.05 11.67	-12.93	-	8/10 80.00%
CPSS V Child (n= 125)		44 35.20%	24.37 17.19	16.71 16.42	-7.66**	5.33	25/44 56.82%
CPSS V Caregiver (n=107)		25 23.36%	18.92 14.04	11.76 12.04	-7.16**	5.23	20/25 80.00%
YCPC (n=19)		5 26.32%	13.68 2.74	19.13 3.75	-10.95	-	5/5 100.00%
SMFQ Child (n=40)	Depressive symptoms	25 62.50%	10.3 6.4	6.63 5.85	-3.90	-	12/25 48.00%
SMFQ Caregiver (n=30)		n/a	9.37 6.63	4.76 4.93	-2.73	-	n/a
Ohio Problem Severity Child (n= 149)	Severity of internalizing/ externalizing behaviors	57 38.26%	23.11 13.81	12.66 9.63	-9.30**	9.27	42/57 73.68%
Ohio Problem Severity Caregiver (n = 244)		85 34.84%	20.15 14.34	11.55 10.91	-5.82**	7.91	58/85 68.24%
Ohio Functioning Child (n = 152)	Child's adjustment and functioning	27 17.76%	55.35 61.8	13.16 10.11	6.45**	-6.42	23/27 85.19%
Ohio Functioning Caregiver (n = 247)		66 26.72%	51.97 57.13	12.78 13.55	5.16**	-6.46	43/66 65.15%

[8]**indicates significance Response rates for YCPC, SMFQ, and CPSS-IV too low for significance testing

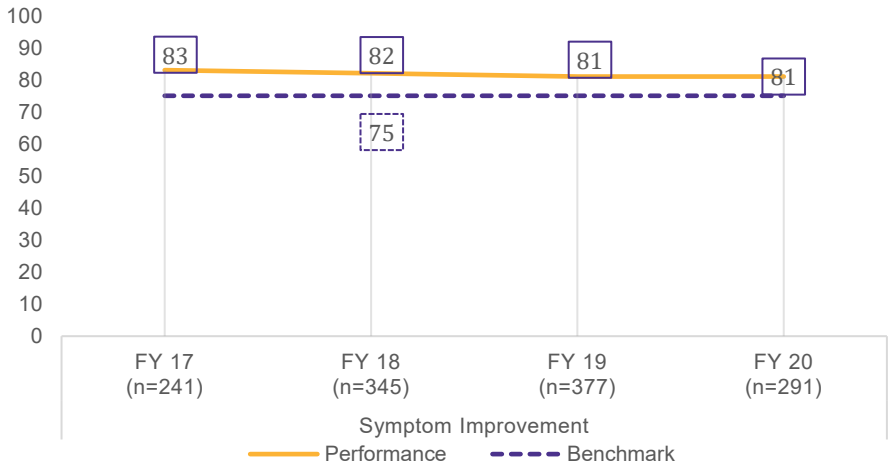
Clinical Improvements Across Groups

In addition to documenting the overall rates of symptom reduction and functional improvement, it is important to monitor if any subgroups are experiencing disproportionate outcomes. Multiple regressions were performed to look at the effect of demographics (age, race/ethnicity, sex) on clinical outcomes controlling for trauma exposure, initial symptom scores, and discharge reason. For child-reported symptoms, only age was found to be significant, and only for problem severity outcomes where older children report lower outcome scores. For caregiver reported symptoms, Black children were found to have higher PTS symptom outcome scores compared to their White counterparts, and males were found to have lower functioning scores compared to females. These findings suggest that there may only be a few significant differences in symptom or functional improvement based on age, sex, or race/ethnicity. Details of the tests are in Appendix B.

Trends Over Time in Symptom Improvement

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

Fig 16. Symptom improvement over time



Summary & Conclusions

MATCH-ADTC is available across the state for children living with anxiety, depression, trauma, and/or conduct symptoms. In FY20, MATCH-ADTC was most commonly employed with 6-17 year olds, which is consistent with the clinical model recommendations. Seventy percent of Connecticut children who received MATCH-ADTC had clinically significant baselines scores across at least one symptom area (depression, posttraumatic stress, internalizing/externalizing behaviors, or functioning) with depressive symptoms being the most common. For children younger than 10, the Conduct Primary Protocol Area remained the most prevalent module employed, which parallels the design and utility of the MATCH-ADTC model. Finally, children generally began MATCH-ADTC with similar symptom profiles regardless of age, sex, and race/ethnicity.

There were 610 children receiving MATCH-ADTC in FY20 across 116 clinicians. This is an average of just over 5 children per clinician, a relatively small percentage of their overall case load. Additionally, there were 169 clinicians on a MATCH-ADTC team at some point in the year though only 116 who saw a case. While there are clinicians who leave the team or are only active part of the year, nearly 1/3 of trained clinicians did not see a child in the model. Clearer expectations on caseloads and guidance on how to balance MATCH-ADTC with other EBT models (nearly half are trained in an additional EBT model) could help ensure both more clinicians are using MATCH-ADTC after training and doing so frequently enough to maintain their clinical skills in the model. This in turn will also support increasing the number of children receiving MATCH-ADTC.

Mid-way through this year, COVID-19 and the resulting stay-at-home orders drastically changed the delivery of outpatient treatment, including MATCH-ADTC. Providers shifted to telehealth and worked to engage children and families under this new format. While many children were able to continue treatment, anecdotally there were children who ended treatment, had long gaps in being seen, or the stressors related to the pandemic changed treatment goals and the content of the sessions. Assessments were initially hard to administer though providers have worked hard to find ways to successfully collect this information electronically and through video or phone interviews. However, there will likely be an impact on QI indicators and outcomes both in this year and going into the next. Additionally, during this time there was a notable decline in the number of new cases. This suggests that while children already receiving MATCH-ADTC were often able to continue, identifying and engaging new children in the model was a struggle, likely due to referrals and volume being down in outpatient generally. Recognizing the number of children receiving MATCH-ADTC decreased partially due to rapid changes in service delivery, further implementation support could benefit our network of providers conducting MATCH-ADTC through telehealth services.

Despite the challenges presented due to the COVID-19 pandemic, MATCH-ADTC demonstrated strong outcomes. According to the Ohio Problem Severity Scales, children with critical impairment experienced a significant reduction, 73.7% and 68.2% respectively. Children with critical impairment in functioning also had similar success with improvements, 85.2% and 65.2% respectively. However, most children that began MATCH-ADTC did not have Ohio Scales scores indicating critical impairment. The relatively low rates of elevated intake scores on the Ohio Scales suggest more targeted assessments, ones that directly measure one of the four protocol areas, might be more appropriate for children starting MATCH-ADTC treatment. Currently there are measures for depression and PTSD symptoms, but there are not options for anxiety or conduct disorder. Even with these limitations in assessment and measurement, MATCH-ADTC has consistently had higher than 80% symptom improvement since FY17 and this year was no exception.

In addition to the baseline and outcome data, quality of service remained high. A majority (3 of 4) statewide QI benchmarks were met in FY 20. Further, client satisfaction remained high; over 90% of children and their caregivers reported either very satisfied or satisfied in on the Ohio Satisfaction. On average, children who completed MATCH-ADTC attended 14 sessions (M=16.78, SD=12.33) within an average of almost seven months of treatment (M=7.15, SD=6.37). This further demonstrates high levels of engagement and continuity in treatment service.

Current trends suggest that racial and ethnic data should continue to be monitored for disparities. While most analyses revealed equitable differences across groups for MATCH-ADTC, there is still a need to give attention to this issue. Rates of improvement were largely comparable across groups, after controlling for successful completion. However, Hispanic children were less likely to successfully complete than their White counterparts. This suggests specific attention to the initial engagement process with these families might improve outcomes. The Coordinating Center supports a group of bilingual EBT clinicians that could review this data and potentially make suggestions. Additionally, assessments are available in hard copy in Spanish but were not built into the electronic database in Spanish. Updating the data systems to have Spanish language versions could support clinicians in administering these assessments in real time and engaging families in this critical process.

Rates of trauma exposure were similar across groups, but the growing recognition of traumas related to racism and discrimination suggests these experiences should be explicitly asked about and addressed. Implementation screening questions about discrimination could provide a more accurate view of a child and family's experience and in turn inform treatment. While outcomes were largely similar across groups, one exception was that Black children tended to end treatment with higher scores on a measure of PTS symptoms compared to their White peers. If during treatment the role of racism and discrimination is not discussed as a part of trauma, it might be that the source of PTS symptoms is not being addressed for some children. This then could result in lower levels of change on PTS symptoms.

Another noted potential disparity is in the rates of groups receiving MATCH-ADTC compared to the population receiving outpatient services. There was a high rate of race and ethnicity not being reported for MATCH-ADTC (12.3%) which makes it difficult to interpret other differences, such as 59.3% of MATCH-ADTC children being White compared to only 52.6% in outpatient. Prior to FY20, the databases for MATCH-ADTC data was separate from the general outpatient system. The system integration that took place in the Fall of 2019 now collects all information on a child's outpatient episode, including EBT treatment and assessment information, together in one place. It is now possible to better understand who receives an EBT and, perhaps more importantly, who does not. Once children begin MATCH-ADTC, most outcomes are comparable across groups, but it is important to consider factors that might influence the opportunity for a child to be identified for and start an EBT. Examining this data, particularly with a lens toward local areas of the state rather than overall statewide numbers, can identify ways agencies and communities can ensure EBTs are being used equitably.

Examining the data by groups is important but it stops short of actively working to ensure there is no biases in treatment and working toward delivering services in a way that is actively anti-racist. This could be the focus of additional training opportunities with a view to ways providers can engage across cultures more equitably and sustainably. Cultural considerations in working with diverse backgrounds using MATCH-ADTC could be explored more with providers and include an awareness of cultural influence in response to anxiety, trauma, depression and conduct problems. The Coordinating Center and DCF, to support the MATCH-ADTC provider community, can identify resources, provide training, and work to partner in myriad ways to ensure improvements for all children and families, specifically for children and families of color, particularly those who are Black, Latinx, and/or Indigenous. A focus on becoming anti-racist and actively addressing disparities in MATCH-ADTC is consistent with the goals of DCF and the provider agencies.

Recommendations

The following recommendations are made for continued support of the MATCH-ADTC statewide network:

Coordinating Center:

- Provide training and consultation on topics identified in this report as areas for development, including cultural sensitivity, health equity, and anti-racism
- Provide resources and continued implementation support to all agencies providing telehealth services to ensure consistency in service delivery to all children receiving behavioral health services
- Provide education to child welfare staff and community providers about the value of evidence-based treatments and MATCH-ADTC for children with behavioral health needs including how to determine the type of treatment a child is receiving, and how to advocate for EBTs
- Establish expectations on the number of children clinicians should use MATCH-ADTC with each year, taking into consideration other EBTs they might be practicing, to both ensure they have opportunities to improve their MATCH-ADTC clinical skills and increase the number of children that are receiving MATCH-ADTC
- Continue to collect relevant financial data and support adequate reimbursement rates for the implementation and sustainability of MATCH-ADTC and other EBPs
- Increased training opportunities in the MATCH-ADTC Train-the-Trainer program to enhance statewide implementation efforts, which will improve access to MATCH-ADTC across the state
- Provide training on cultural considerations with use of MATCH-ADTC and the cultural influence on the response to trauma, depression, and conduct
- Develop consultation model that will address QI needs of each agency and will include multiple treatment models
- Using combined outpatient and MATCH-ADTC data, analyze how symptoms and level of acuity compare between children who receive MATCH-ADTC compared to those who receive treatment as usual (no EBT treatment
- Analyze data to better understand demographic factors and other characteristics that might influence access to MATCH-ADTC treatment, initial engagement, drop out, or differences in symptom reduction
- Use mapping and local data to better understand MATCH-ADTC implementation at the agency and community level, particularly when examining disparities

Providers:

- Identify concrete ways to implement and use the knowledge from trainings on broader topics (beyond the specifics of the model) to improve care for children receiving MATCH-ADTC
- Develop plans to monitor MATCH-ADTC caseloads for clinicians to ensure those trained are maintaining their MATCH-ADTC clinical skills and continuing to deliver the model with children and families
- Modify and discuss implementation plans to accommodate changes brought on by COVID-19
- Agency Senior Leaders report the inadequacy of provider incentives to cover the cost of providing

evidence-based practices, and need to continue to advocate for adequate reimbursement rates to sustain EBTs

System:

- Add questions on experiences of racism and discrimination as part of the overall screening for traumatic experiences, as these experiences can impact symptoms and service outcomes
- Add assessment options to measure conduct and anxiety symptoms in children, which will support data driven decision making to determine initial MATCH-ADTC protocol.
- Offer Spanish and Portuguese language versions of assessments in electronic format within the PIE database system
- Develop the functionality to collect agency led MATCH-ADTC consultation in PIE to support real-time built-in reports that support the MATCH-ADTC certification process for clinicians.
- Update terminology used in PIE (e.g., sex assigned at birth; Latino) to collect demographic information that complies with current best practices (e.g., sex assigned at birth and gender identity; Latinx)
- Expand collection of zip codes to nine digits in PIE to strengthen opportunities to merge PIE data with external data sources (e.g., Area Deprivation Index) to examine health disparities and inequities
- Continue funding performance-based sustainment funds to improve capacity, increase access, and ensure quality of care; these incentives partially offset the increased agency costs of providing an EBT
- Collect information on session format to better understand how telehealth is being used
- Continue to disseminate, support, and integrate EBTs beyond MATCH-ADTC. This work could have a broader impact on the children's behavioral health system and could test and implement population-based strategies and models (e.g. for all children seen in OPCCs) through use of standardized assessment measures (measurement based care) and clinical and organizational strategies that are relevant for all children (e.g. engagement, behavioral rehearsal, use of supervision, self-care). The lessons learned from the implementation of MATCH-ADTC, which addresses the primary presenting problems seen in outpatient setting, provides a strong foundation for developing a model to improve care for all children in outpatient settings

Appendix A: Activities and Deliverables

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

1. Training, Consultation, & Credentialing

- Our contracted Harvard University trainer and Connecticut Associate Trainers provided two MATCH-ADTC trainings (12 days) in FY20 (40 new clinicians trained)
- Initiated one day MATCH-ADTC Booster Training for previously trained clinicians and 29 clinicians attended
- Contracted with Transformative Leadership strategies, LLC to provide 4 virtual trainings to Connecticut Outpatient providers, with a total of 50 attendees.
- In June 2020, The Connecticut Early Psychosis Learning Health Network began a consultation call group with outpatient providers on First Episode Psychosis (FEP); 2 calls were conducted and the call group is scheduled to complete in FY21
- A cohort of four MATCH-ADTC trained individuals successfully completed the Train-the-trainer series.
- The Connecticut Associate Trainers conducted their first MATCH-ADTC training in the Spring of FY20.
- Coordinated registration, attendance, and CEUs for MATCH-ADTC and OPCC Trainings
- Maintained a statewide MATCH-ADTC clinician credentialing process and requirements to increase the number of clinicians that complete all training and case requirements; 50 active clinicians were Connecticut credentialed by the end of FY 20
- Maintained a training record database to track training and consultation attendance of all MATCH-ADTC staff, as well as other credentialing requirements for all MATCH-ADTC clinicians; in FY 20 there were 169 active clinicians
- Convened eleventh annual statewide EBP virtual Conference, an evolution of the original MATCH-ADTC Conference, for 97 participants from community providers, DCF, CSSD staff, and other partners in the initiative.

2. Implementation Support, Quality Improvement, & Technical Assistance

- Produced reports for two QI performance periods based on developed MATCH-ADTC QI Indicators and Benchmarks
- Utilized a QI process of implementation consultation based on emerging implementation science field and needs of agencies
- Developed agency-specific QI plans using SMARTER Goals focused on agency performance on QI benchmarks and strategies to improve access, quality and service delivery
- Provided 60 implementation consultation support meetings with providers to ensure sustainment of high quality services
- Supported 4 new providers that applied to begin implementation of MATCH-ADTC
- Implemented and convened 5 Coordinator meetings focusing on sharing implementation and successful meeting strategies
- Provided updates to all MATCH-ADTC participants through a monthly Data Dashboard
- Distributed additional MATCH-ADTC books, materials, and resources to all MATCH-ADTC teams

3. Data Systems

- The EBP Tracker functionality was integrated into DCF's Provider Information Exchange (PIE) system, continued maintenance of a secure, online database that meets the needs of the increasing number of MATCH-ADTC providers and the children and families they serve
- Provided enrollment assistance to providers when the EBP/PIE integration took place in the FY
- Continued improvements to the PIE system have been made based upon agency feedback and as possible with available funding
- Maintained a public directory site that provides a searchable, public listing of MATCH-ADTC providers through EBP Tracker (tinyurl.com/ebpsearch)
- Maintained a map, public listing of MATCH-ADTC providers on CHDI's website
- Monitored, maintained, and provided technical assistance for online data entry for all MATCH-ADTC providers in PIE
- Provided site-based data assistance and reports as requested

4. Agency Sustainment Funds

- Administered performance-based financial incentives to improve capacity, access and quality care.
- While these financial incentives are intended to partially offset the increased agency costs of providing an evidence-based practice, agency leadership reports that they do not adequately cover the costs of providing MATCH-ADTC (See Financial Incentive document in Appendix A for details)
- Developed, executed, and managed contracts with each of the 20 MATCH-ADTC providers eligible for financial incentives to detail implementation expectations, data sharing, and financial incentive details
- Analyzed and reported financial incentives for each agency for two 6- month performance periods.
- Distributed $461.627.50 in performance-based sustainment funds to agencies (46.1% of total contract funds)

Appendix B: Regression Tables

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

	1st Overall Severity, CPSS5 Child			1st Total Score, Ohio FX Child			1st Total Score, Ohio PS Child		
Predictors	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Intercept	-2.355	7.870	(-17.889, 13.179)	66.954**	7.375	(52.398, 81.510)	26.716	7.13	(12.643, 40.789)
Hispanic	4.962*	2.308	(.405, 9.518)	-4.023	2.163	(-8.293, .247)	-0.210	2.091	(-4.338, 3.917)
Other nonhispanic	2.031	4.990	(-7.819, 11.881	2.393	0.512	(-6.837, 11.623)	0.309	4.521	(-8.614, 9.232)
Black nonhispanic	.468	3.747	(-6.928, 7.864)	-3.715	-1.058	(-10.646, 3.215)	-1.043	3.395	(-7.744, 5.657)
Age at intake	.699	.551	(-.389, 1.786)	-0.570	0.516	(-1.589, .449)	-.737	.499	(-1.722, .248)
Sex m	-6.451**	2.436	(-11.258, -1.643)	-1.685	2.282	(-6.190, 2.820)	-2.853	2.207	(-7.209, 1.502)
Trauma Exposure- THS, Child	2.572**	.421	(1.741, 3.402)	-0.114	0.394	(-.893, .664)	1.323**	.381	(.570, 2.075)
Trauma Exposure- THS, Caregiver	.417	.464	(-.498, 1.332)	-0.254	0.434	(-1.112, .603)	-.186	.420	(-1.015, .643)
R2	0.338			0.04			0.86		
F	12.560			1.026			2.320		

* p<.05

**p<.01

As compared to White females

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

	1st Overall Severity, CPSS5 Caregiver			1st Total Score, Ohio FX Caregiver			1st Total Score, Ohio PS Caregiver		
Predictors	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Intercept	0.436	7.978	(-15.312, 16.183)	43.383**	7.336	(28.903, 57.864)	29.109**	6.947	(15.397, 42.821)
Hispanic	1.191	2.340	(-3.428, 5.810)	1.226	2.152	(-3.021, 5.474)	0.162	2.038	(-3.860, 4.184)
Other nonhispanic	3.122	5.059	(-6.863, 13.107)	-2.468	4.652	(-11.650, 6.713)	2.496	4.405	(-6.199, 11.190)
Black nonhispanic	-3.420	3.798	(-10.917, 4.078)	3.416	3.493	(-3.478, 10.310)	-6.436	3.308	(-12.964, .093)
Age at intake	0.447	0.558	(-.655, 1.549)	0.722	0.513	(-.291, 1.735)	-0.992*	0.486	(-1.951, -.032)
Sex m	1.01	2.469	(-3.863, 5.884)	.215	2.27	(-4.266, 4.697)	1.036	2.15	(-3.208, 5.280)
Trauma Exposure- THS, Child	0.635	0.427	(-.207, 1.477)	0	0.392	(-.744, .775)	-0.104	0.372	(-3.208, 5.280)
Trauma Exposure- THS, Caregiver	1.753**	0.470	(.825, 2.681)	-0.257	0.432	(-1.110, .596)	.810*	0.409	(.002, 1.618)
R2	0.184			0.025			0.084		
F	5.551			0.628			2.259		

* p<.05

**p<.01

Table B3. Multiple regression analyses of selected demographic variables on Trauma History Screen, Child, and Trauma History Screen, Caregiver, assessments, MATCH

	Trauma Exposure - THS, Child			Trauma Exposure - THS, Caregiver		
Predictors	β	SE	95%CI	β	SE	95%CI
Hispanic	0.373	0.312	(-0.24, 0.986)	-2.74	0.293	(-.851, .302)
Other nonhispanic	0.128	0.77	(-1.385, 1.642)	-0.974	0.724	(-2.397, .450)
Black nonhispanic	-0.073	0.528	(-1.111, 0.966)	-0.576	0.497	(-1.552, .401)
Age at intake	0.371***	0.049	(0.276, 0.467)	0.106*	0.046	(.016, .195)
Sex m	0.276	0.303	(-0.320, 0.871)	0.176	0.285	(-.384, .737)
R2	0.135			0.023		
F	12.192			1.797		

* p<.05

**p<.01

As compared to White Females

Table B4. Multinomial logistic regression predicting child's first primary problem areas of Depression, Trauma, or Conduct from selected characteristic variables.

	Depression				Trauma				Conduct			
Predictors	β	SE	Wald	eB (95% CI)	β	SE	Wald	eB (95% CI)	β	SE	Wald	eB (95% CI)
Intercept	-4.047**	1.53	7.036	-	-7.208	2.2	10.75	-	1.593	2.610	0.373	-
Age at intake	0.17	0.1	3.12	1.185 (0.982, 1.431)	0.135**	0.14	0.976	1.145 (0.876, 1.496)	-0.342	0.175	3.808	0.71 (0.504, 1.001)
Trauma Exposure- THS Caregiver	0.013	0.08	0.028	1.014 (0.866, 1.186)	0.291*	0.11	6.59	1.337 (1.071, 1.669)	-0.157	0.189	0.690	0.855 (0.591, 1.238)
Trauma Exposure- THS Child	0.067	0.07	0.848	1.069 (0.927, 1.233)	0.246*	0.11	5.196	1.278 (1.035, 1.579)	0.349*	0.166	4.436	1.417 (1.024, 1.961)
Problem Severity, Externalizing, Caregiver	0.025	0.03	0.559	1.025 (0.961, 1.093)	-0.042	0.05	0.718	0.959 (0.87, 1.057)	0.158**	0.054	8.433	1.171 (1.053, 1.303)
Problem Severity, Externalizing, Child	0.036	0.04	1.011	1.037 (0.966, 1.113)	0.122*	0.05	6.004	1.129 (1.025, 1.245)	0.038	0.066	0.327	1.038 (0.913, 1.181)
Problem Severity, Internalizing, Caregiver	0.024	0.027	0.814	1.024 (0.972, 1.079)	0.104**	0.04	7.467	1.11 (1.03, 1.196)	-0.102	0.061	2.831	0.903 (0.801, 1.017)
Problem Severity, Internalizing, Child	0.02	0.03	0.641	1.02 (0.971, 1.072)	-0.087*	0.04	4.866	0.917 (0.849, 0.99)	-0.133*	0.063	4.411	0.876 (0.774, 0.991)
Hispanic	0.529	0.37	2.013	1.698 (0.817, 3.526)	0.963	0.55	3.105	2.62 (0.898, 7.649)	0.28	0.734	0.146	1.324 (0.314, 5.579)
Other Nonhispanic	-	-	-	-	-	-	-	-	-	-	-	-
Black Nonhispanic	2.008**	0.74	7.284	7.447 (1.733, 32.01)	3.39**	0.95	12.7	29.659 (4.597, 191.338)	0.189	1.373	0.019	1.208 (0.082, 17.797)
Sex	-0.139	0.39	0.128	0.871 (0.408, 1.858)	-0.383	0.58	0.433	0.682 (0.218, 2.133)	-0.137	0.731	0.035	0.872 (0.208, 3.654)

* p<.05

**p<.01

As compared to White Females

As compared to anxiety

Table B5. Logistic regression analyses for predicting child discharged rated as "successful" from selected background characteristics, MATCH

Predictors	N	β	SE	Wald	eB(95% CI)
Hispanic	116	-0.794*	0.271	8.581	.452(.266, .769)
Other Nonhispanic	8	-1.136	0.77	2.178	.321(.071, 1.451)
Black Nonhispanic	20	-0.906	0.492	3.385	.404(.154, 1.061)
Sex m	106	-0.241	0.266	0.817	.786(.466, 1.325)
Child age	165	-0.067	0.046	2.145	.935(.855, 1.023)
Trauma Exposure-THS Child	271	-0.003	0.056	0.002	.997(.893, 1.114)
Trauma Exposure-THS Caregiver	271	0.058	0.057	1.047	1.06(.948, 1.184)
Constant		1.334*	0.587	5.165	3.794

* p<.05

**p<.01

As compared to White Females

Table B6. Logistic regression analyses for predicting first and last measure available for any measure of child/caregiver symptoms except CAGE-AID from selected background characteristics, MATCH

Variable	N	β	SE	Wald	eB(95% CI)
Hispanic	116	-.347	0.351	0.975	.707(.355, 1.407)
Other Nonhispanic	-	-	-	-	-
Black Nonhispanic	20	-.254	0.608	0.174	.776(.236, 2.555)
Sex	106	-.041	0.351	0.014	.960(.483, 1.908)
Child age	271	.008	0.061	0.017	1.008(.894, 1.136)
Trauma Exposure-THS Child	271	-.097	0.072	1.798	.907(.787, 1.046)
Trauma Exposure-THS Caregiver	271	.057	0.073	0.599	1.058(.917, 1.221)
Child Discharged "Unsuccessfully"	120	-2.496**	0.384	42.207	.082(.039, .175)
Constant		2.950**	0.817	13.044	19.111

* p<.05

**p<.01

removed due to small n

As compared to White Females

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

	Last Overall Severity, CPSS5 Child			Last Total Score, Ohio FX Child			Last Total Score, Ohio PS Child		
Predictors	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Trauma Exposure- THS, Child	.588	0.453	(-.310, 1.485)	-.397	0.254	(-.898, .104)	.527*	0.248	(.036, 1.018)
Baseline Score	.448**	0.085	(.279, .617)	.367**	0.06	(.248, .486)	.316**	0.058	(.201, .431)
Discharged Successful	-3.332	2.349	(-7.983, 1.319)	2.341	1.512	(-.646, 5.328)	-2.968*	1.441	(-5.815, -.120)
Hispanic	-2.026	2.513	(-7.001, 2.949)	-1.064	1.636	(-4.296, 2.168)	-1.864	1.541	(-4.910, 1.182)
Other nonhispanic	-3.701	6.31	(-16.193, 8.792)	4.315	4.083	(-3.753, 12.384)	-2.45	3.872	(-10.102, 5.201)
Black nonhispanic	.472	4.004	(-7.455, 8.399)	1.608	2.594	(-3.519, 6.734)	1.197	2.459	(-3.663, 6.057)
Sex m	.980	2.425	(-3.821, 5.781)	-.558	1.549	(-3.618, 2.503)	-.625	1.487	(-3.564, 2.313)
Child age	.172	0.362	(-.544, .888)	.362	1.549	(-3.618, 2.503)	-.476*	0.225	(-.920, -.032)
Constant	4.222	4.85	(-5.379, 13.824)	37.991	4.724	(28.658, 47.325)	12.707	3.229	(6.326, 19.089)
R2	.331			0.496			.256		
F	7.468			6.063			6.269		

* p<.05

**p<.01

As compared to White females

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

	Last Overall Severity, CPSS5 Caregiver			Last Total Score, Ohio FX Caregiver			Last Total Score, Ohio PS Caregiver		
Predictors	β	SE	95%CI	β	SE	95%CI	β	SE	95%CI
Trauma Exposure- THS, Caregiver	0.732	0.42	(-.101, 1.565)	-0.096	0.259	(-.607, .415)	.273	0.234	(-.188, .734)
Baseline Score	0.325**	0.078	(.170, .479)	0.553**	0.051	(.452, .654)	.421**	0.052	(.319, .522)
Discharged Successful	-2.456	2.045	(-6.511, 1.600)	5.928**	1.386	(3.199, 8.658)	-4.457**	1.238	(-6.897, -2.018)
Hispanic	-1.013	2.192	(-5.358, 3.333)	0.031	1.493	(-2.909, 2.971)	-.928	1.328	(-3.544, 1.687)
Other nonhispanic	0.295	5.516	(-10.643, 11.233)	4.429	3.754	(-2.966, 11.823)	1.687	3.341	(-4.894, 8.268)
Black nonhispanic	7.77*	3.508	(.814, 14.726)	-2.626	2.37	(-7.294, 2.042)	-.261	2.135	(-4.466, 3.944)
Sex m	1.794	2.098	(-2.365, 5.954)	-3.709*	1.426	(-6.517, -.901)	2.438	1.271	(-.065, 4.940)
Child age	-0.476	0.297	(-1.065, .114)	-0.146	0.203	(-.545, .254)	-.120	0.185	(-.485, .245)
Constant	10.032*	4.291	(1.524, 18.541)	28.725**	3.904	(21.035, 36.415)	8.425**	2.945	(2.624, 14.225)
R2	0.538			0.624			0.549**		
F	5.284			19.719			13.211		

* p<.05

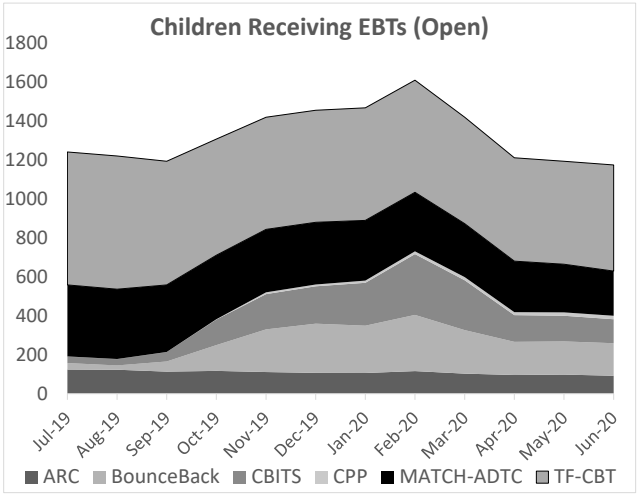
**p<.01

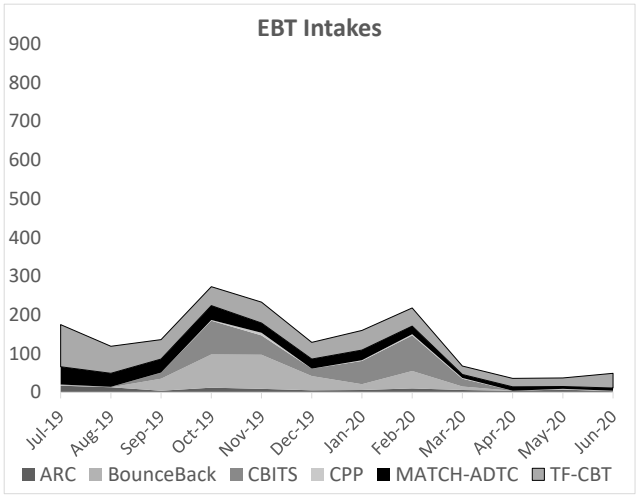
As compared to White females

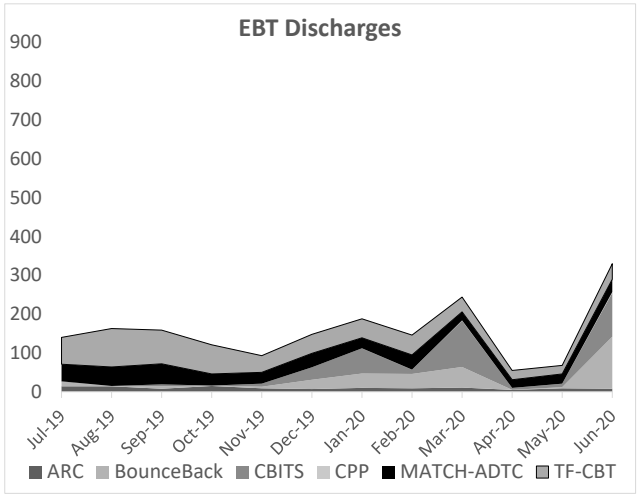
EBT Performance Dashboard: State of Connecticut June 2020

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

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







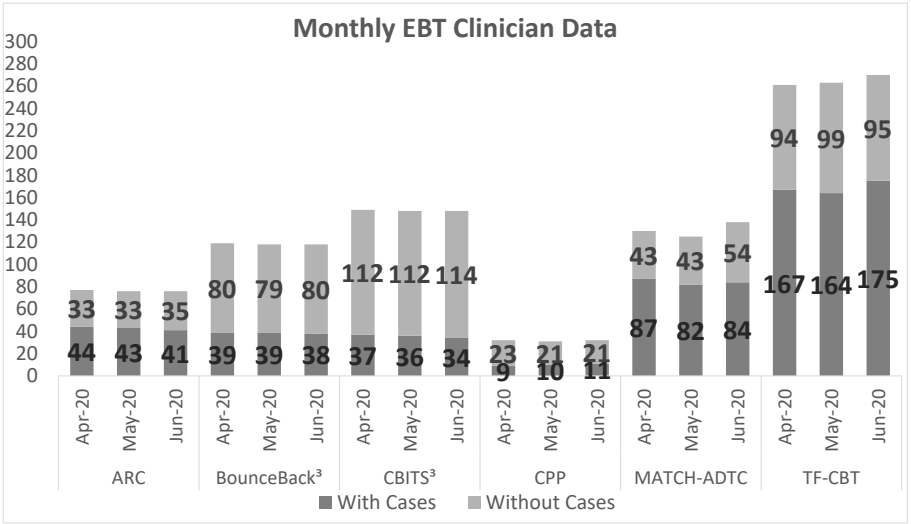
		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	FY20 Total	Yr Total[1]
Open	ARC	124	123	113	117	111	107	106	116	103	96	98	92	203	203
	BounceBack	33	22	52	132	219	252	243	288	223	170	170	167	344	344
	CBITS	34	33	49	131	181	192	220	312	256	137	132	123	379	379
	CPP	0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

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

State of Connecticut: EBT Performance Dashboard cont…

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

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



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

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

[1] One or more visits within the month

[2] QI Period is January 2020 - June 2020

[3] Includes co-facilitators

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

QI Overview

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

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

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

Frequently Asked Questions

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

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

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

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

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

What assessments count towards the measures and improved outcomes indicators?

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

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

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

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

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

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

What are the required treatment components for TF-CBT?

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

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

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

Overview - Closed Episodes[1]
July - December 2019

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

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

Engagement[1]
July - December 2019

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

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

Measurement Based Care[1]

July - December 2019

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

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

Improved Outcomes[1]
July - December 2019

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

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

Consistent Care[1]
July - December 2019

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

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

Overview - Closed Episodes[1]
January - June 2020

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

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

Engagement[1]
January - June 2020

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

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

Measurement Based Care[1]

January - June 2020

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

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

Improved Outcomes[1]
January - June 2020

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

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

Consistent Care[1]
January - June 2020

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

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

Appendix E: Reliable Change Index

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

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

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

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