TCB November Monthly Meeting Minutes

November 19th, 2025
2:00 PM – 4:00 PM
LOB, Zoom
Viewing option YouTube or CTN

Attendance			TYJI Staff
Alice Forrester	Howard Sovronsky	Sinthia Sone-Moyano	Emily Bohmbach
Andrea Goetz	Jeanne Milstein	Susan Hamilton	Erika Nowakowski
Betty Ann MacDonald	Javeed Sukhera	Tammy Exum	Stacey Olea
Boyd Jackson	Kimberly Karanda	Tammy Freeberg	
Claudio Gualtieri	Lorna Thomas Farq.	Toni Walker	
Christina Ghio	Michael Moravecek	Yann Poncin	
Carolyn Grandell	Michael Powers	Yvonne Palloto	
Ceci Maher	Michael Patota		
Cristin McCarthy	Manisha Juthani		
Gerard O'Sullivan	Mickey Kramer		

Welcome and Introductions:
The Meeting was opened with a welcome to all attendees.

Acceptance of TCB October Meeting Minutes:
A motion was introduced to accept the October meeting minutes. The motion carried and was approved.

Administrative Updates:
The TCB Senior Project Manager and the TYJI Executive Director provided updates on upcoming TCB meetings. They highlighted that the December meeting will take place on December 3rd from 2–4 PM and will focus on Crisis Continuum Data, including information from UCCs, Mobile Crisis, Subacute Stabilization, and ED hospital data. Representatives from the three community-based UCCs and United Way will also attend. They also noted that the second half of the CVW Summit will occur in February, with more details forthcoming. In

addition, the TCB will vote on its legislative recommendations during the February meeting. The 2026 legislative session is scheduled to begin on February 4th.

Workgroup Updates:
The TCB Senior Project Manager offered an overview of the current workgroups and introduced the co-chairs for each workgroup.

Community Voices Workgroup:
A representative from the CVW briefed the committee on the workgroup's priorities, which include assessing what is happening in schools, identifying the services and support available to children and families following behavioral health treatment, evaluating youth and family support options across Connecticut, promoting culturally responsive care, distributing resources to the community, and engaging children and families in TCB efforts. The speaker then provided an overview of the CVW's 2025 meetings. In September, the group held its CVW Orientation, where members were introduced to their roles and received background on the TCB's work. In October, the CVW hosted its Summit, facilitated by Health Equity Solutions, which focused on the power of lived experience, navigating power dynamics, and reviewing the CVW workplan and goals. To conclude the update, the CVW committee introduced several representatives attending either virtually or in person. One representative offered their introduction and expressed gratitude for the opportunity to be part of the work. Another described their organizational role and their passion for helping families access the services they need. A third reflected on their lived experiences and how these inform their contributions to the workgroup. Before closing, a representative shared a final reflection for TCB members, emphasizing the obstacles many families face, including language barriers, cultural differences, transportation challenges, emotional burnout, and even limited technology access. She explained that, in her experience, families who qualify for services can still fall through the cracks when no one takes the time to understand their story or build trust. Her role has often involved bridging the gap between families and providers, whether through translation or by helping professionals better understand a family's circumstances. She underscored the importance of the human element, reminding the committee that while data, policies, and expertise are essential, empathy, relationship-building, and lived experience are what truly bring policy to life.

Services:
The workgroup co-chair provided an overview of the group's 2025 priorities and meeting activities. These priorities include strengthening peer-to-peer support, enhancing 211 services, and monitoring TCB recommendations related to the crisis continuum, UCCs, and IICAPS. The workgroup also receives monthly updates on the TCB's Children's Behavioral Health Survey. Throughout 2025, the group hosted a range of presentations and discussions, including sessions on peer-to-peer models, evidence-based practices in children's behavioral health, an overview of Connecticut's substance use services array, and updates on IICAPS. The workgroup is scheduled

to meet again in December, when CHDI will share findings from their Peer-to-Peer Study and UConn Innovations will provide the latest updates on the Children's Behavioral Health Survey.

System Infrastructure:
The Infrastructure Workgroup co-chairs provided an update on their ongoing review of Connecticut's system-of-care framework, originally launched in 1998. They reflected on the significant progress the state has made in developing coordinated behavioral health supports, including the establishment of care management entities and a strong mobile crisis system, elements that have helped Connecticut as a national leader in system-of-care implementation. However, the presenters also acknowledged that the state has recently experienced delays in advancing to the next phase of system development. To illustrate potential growth opportunities, they referenced a presentation from New Jersey's longstanding system-of-care program, which has achieved notable outcomes over the past 25 years, such as reductions in foster care transitions through automatic mobile crisis involvement and large-scale care coordination reaching tens of thousands of children. This comparison highlighted both the strengths of Connecticut's existing foundation and the possibilities for accelerating and expanding its behavioral health infrastructure.

Looking ahead, the Infrastructure Workgroup will shift its focus toward data. With the recent release of a report from the Innovations Institute reviewing statewide behavioral health data sources, the group will begin assessing what information Connecticut currently captures, where gaps remain, and what future data systems will be needed to support effective policy planning and system coordination. This transition reflects a shared understanding that robust data infrastructure is essential for sustaining long-term improvements in children's behavioral health services.

Crisis Continuum and UCC Utilization:
The Behavioral Health Advocate reported on ongoing efforts to strengthen the crisis continuum, with particular focus on the state's Urgent Crisis Centers (UCCs). He explained that the growth and long-term sustainability of UCCs rely on two key factors: establishing a reliable financial structure and increasing utilization. While DSS and DCF continue working to develop appropriate reimbursement rates, a newly formed task group has begun concentrating specifically on utilization. This task group recently convened all UCC providers and DCF representatives for an in-person meeting that participants described as especially productive after years of virtual-only collaboration. Although the conversation began with marketing strategies, such as creating outreach materials, it quickly shifted toward deeper questions about how to reach the families most likely to benefit from UCC services. Members emphasized the need for targeted outreach to primary care offices, schools, faith-based institutions, and parents, rather than relying solely on broad public messaging.

The group also discussed partnering with legislators to support community conversations about behavioral health, suicide prevention, and crisis resources. Such dialogues could help build community understanding while ensuring that policymakers remain connected to local needs. Additionally, the task group acknowledged that UCCs do not operate in isolation; they rely heavily on interconnected systems, including 211, mobile crisis, and the broader crisis continuum. As a result, future meetings will examine how these systems influence UCC utilization and how operational barriers across the continuum can be addressed.

Rural Health Transformation Program Presentation:

The Office of Policy and Management (OPM) and the Department of Social Services (DSS) then provided an in-depth walkthrough of the Rural Health Transformation Program, a new federal initiative under H.R. 1 that allocates $50 billion over five years to improve health outcomes in rural communities nationwide. Although Connecticut is not a predominantly rural state, the presenters emphasized that the federal rules allow for broad system-improvement strategies, enabling Connecticut to submit an application that includes 31 distinct and thoughtfully developed subprojects. They noted that half of the national funding will be distributed equally among all approved states, while the remaining funds will be awarded based on factors such as population health needs and alignment with federal priorities. The application timeline was extremely compressed, the federal notice was released in mid-September, and the deadline fell in early November, requiring rapid coordination among OPM, DSS, and numerous state and community partners. As the presenters outlined the components of the application, they highlighted several major program categories. One focuses on population health and early intervention, including expansions of Access Mental Health and additional school-based mental health supports. Another focuses on strengthening the behavioral health workforce by proposing incentives to attract and retain licensed and unlicensed providers in rural areas, as well as behavioral health residency opportunities and participation in interstate licensure compacts. A third category addresses data and technology expansion, such as upgrades to the Connie health information exchange, enhancements to telehealth capacity for clinicians and patients, and the development of predictive analytics to better identify unmet health needs.

The application also includes a school-based behavioral health initiative aimed at assessing mental health systems in rural schools and implementing scalable interventions, such as on-site support, technical assistance, staff training, and streamlined referral partnerships. All proposed projects were intentionally designed as one-time or infrastructure-focused investments, as ongoing operational programs without sustainable funding were not eligible under federal rules. The presenters emphasized that each initiative builds on successful Connecticut pilots or nationally recognized evidence-supported models.

Q&A Segment:

One committee member asked whether the proposed incentives for both licensed and unlicensed workers would also apply to community health workers and navigators with lived experience,

particularly those serving undocumented and homeless populations. The presenter clarified that the proposal includes salary supplements for credentialed but unlicensed healthcare workers across the state. Rather than providing direct financial incentives, such as loan repayment or housing assistance, the goal is to help providers offer more competitive wages in rural areas, thereby improving their ability to attract and retain staff in a challenging labor market.
Another committee member commended the presenters for their extensive community outreach and engagement efforts, as well as their commitment to keeping the committee informed about upcoming meetings and implementation sessions.
A separate committee member requested additional details regarding interventions for high-acuity students. They asked what supports are being proposed, whether the model would include intensive in-school behavioral health services, and if districts would be allowed to hire board-certified behavior analysts. In response, the presenter explained that the model builds on a recent SDE pilot and will be implemented exclusively in rural areas to ensure access for all 41 rural school districts. They added that the high-acuity school-based mental health programming is specifically designed to support students with the most significant behavioral health needs.
As part of the initiative, program staff will conduct comprehensive evaluations of each district's existing behavioral health supports, identifying service gaps and opportunities to enhance student care. For high-acuity youth, the program uses a push-in approach, bringing clinicians directly into schools to work with students both in classrooms and in private settings on school grounds, providing the highest level of support. The presenter noted that it is still unclear whether districts will be hiring additional clinical staff and is committed to following up with more information.
A tri-chair member then asked, recognizing that an exact figure may not be available, what proportion of the proposed initiatives are already being implemented in some form across the areas reviewed. The presenters responded that although they did not have a precise percentage available, the initiatives draw heavily from evidence-based programs. These programs were selected not only because CMS favors evidence-supported models, but also because the presenters have confidence in their effectiveness and can demonstrate measurable outcomes. Many initiatives build upon successful Connecticut pilots, such as school-based interventions, the Access Mental Health Program, Bridging the Digital Divide for the elderly, and Family Bridge, which provides postpartum maternal and child support, while others are modeled on proven approaches implemented in other states. Overall, the presenters emphasized that most, if not all, of the programmatic initiatives are grounded in strong evidence and have demonstrated success.

FutureThrives Presentation:
The meeting also featured an in-depth presentation from the founder of Futures Thrive, who introduced a modern digital platform designed to screen for and monitor children's mental health needs. The presenter began by sharing the personal experiences that inspired the company's creation, describing a decade-long effort to better understand the challenges of early identification. Citing CDC data estimating an average 11-year delay between the onset of

symptoms and diagnosis, they emphasized the critical need to identify concerns earlier and intervene proactively.

The platform itself is strengths-based and developmentally responsive, offering one version for young children ages five to eight, who interact with guided "helper animals" and another for youth ages nine to sixteen, who respond through typed or clickable inputs. It assesses a wide range of risk and protective factors, including grief, stress, sleep, coping skills, and emotional well-being. The presenter noted that research shows strong alignment with the Pediatric Symptom Checklist, while also capturing additional insights that children often share more openly through a digital format.

They clarified that the tool is never marketed directly to children. Instead, it is implemented through professional clinicians, school staff, and pediatricians to ensure that results lead to meaningful conversations and appropriate follow-up support. The presenter also highlighted the platform's ability to generate a first-of-its-kind longitudinal dataset for Connecticut by tracking 96 different factors across diverse communities and school settings. They concluded by explaining how beginning with small but meaningful topics, such as the loss of a pet, can reduce stigma, build trust with families, and support early intervention before concerns escalate.

Q&A Segment:

A tri-chair of the committee asked for more information about where the program is currently being implemented and the overall scope of the work. They sought clarity on the number of participating sites and the basis for the data referenced earlier, including the mention of 921 children. In response, the presenter explained that the organization has been building relationships across several locations, including private schools in California, a Medicaid provider and rural health project in Texas, and both public and charter schools in New York City—demonstrating a wide range of use cases. The presenter also highlighted a unique partnership with the NYU School of Social Work, which is designed to ensure that social work students are "work-ready" upon graduation by equipping them with practical tools and knowledge specific to in-school social work practices.

The presenter explained that the program is designed to screen children three to four times per year. In therapeutic settings, they noted, therapists sometimes reach a stalemate with clients. Re-administering the screener can bring forward new information about a child's experiences, potentially shifting perspectives and informing next steps. The program also integrates with pediatric well-child visits, embedding mental health screening into routine medical care.

The tri-chair then asked about parents' reactions, particularly regarding the process for obtaining parental consent. The presenter explained that requirements vary by state, and they actively track "mental health-friendly" states to guide implementation. For example, Texas requires parental consent. They shared that parents often respond with comments such as, "I really had no idea what my child was thinking." This feedback, the presenter emphasized, speaks to the tool's ability to give children a meaningful voice and reveals challenges that adults may otherwise misunderstand, such as academic struggles or family changes.

The tri-chair next inquired about the scope of information collected through the screenings. The presenter noted that although the company has only been in the market for a year, and therefore lacks long-term data, they have already gathered substantial information, tracking 96 different risk and protective factors. Early analyses have begun to identify correlations with anxiety and depression, with some confirming known patterns and others offering new insights. In a research study conducted with the National Science Foundation, the tool's data matched 87% of the Pediatric Symptom Checklist. The presenter explained that their assessment captures additional topics, including grief and sleep issues, and emphasized that children often disclose information through the digital platform that they may not share during face-to-face interactions, making the findings particularly valuable.

Another committee member asked about developing a demographic profile of the children using the tool, noting that developmental needs vary significantly across ages. The presenter explained that the younger version of the tool, designed for children ages 5 to 8, does not require reading; instead, children choose a "helper animal" that guides them through the interview. For children ages 9 to 16, the tool involves some typing and clicking, with older youth completing most of the typing, and choices made largely for practical reasons. Overall, the tool is intended to serve as a general-use screener suitable for a wide age range.

Committee members also asked about language accessibility. The presenter confirmed that the tool is currently available in Spanish, with additional translations underway. A follow-up question focused on how the tool will be validated for Latino communities. The presenter responded that they are actively seeking partners to support this process, emphasizing that translation alone is not sufficient and that cultural and linguistic accuracy must also be ensured. Drawing from personal experience, including having majored in Spanish in college and being motivated by a child who struggled, they stressed their commitment to taking the necessary time to get this work right rather than rushing and producing a flawed product.

At the conclusion of the discussion, the tri-chair asked who is permitted to utilize and access the application. The presenter reaffirmed that access is restricted to licensed professionals, such as social workers, therapists, and pediatricians, who can appropriately follow up and engage parents in conversations that ensure the child's safety.

Next TCB Meeting is on December 3rd and will be held in room 1E with a Zoom option