TCB December Monthly Meeting Minutes

December 3rd, 2025
2:00 PM – 4:00 PM
LOB, ZOOM
Viewing Option YouTube or CTN

Attendance				**TYJI Staff**
Alice Forrester	Cristin McCarthy	Lisa Morrisey	Tammy Nuccio	Emily Bohmbach
Andrea Goetz	Edith Boyle	Lorna Thomas-Farq.	Tammy Freeberg	Erika Nowakowski
Angel Quiros	Gerard O' Sullivan	Mickey Kramer	Toni Walker	Stacey Olea
Catherine Foley Geib	Howard Sovronsky	Michael Powers	Yann Poncin	Qurana Guy
Carolyn Grandell	Jeanne Milstein	Nicole Taylor	Yvonne Pallotto	
Carol Bourdon	Jody Bishop	Sean King		
Christina Ghio	Javeed Sukhera	Susan Hamilton		
Ceci Maher	Kai Belton	Tammy Exum		
Claudio Gualtieri	Kimberly Karanda	Tammy Venenga		

Welcome and Introductions:
The Meeting was opened with a welcome to all attendees.
Acceptance of TCB November Meeting Minutes:
A motion to accept the minutes from November meeting was put forward, motion carried and approved.

Administrative Updates:
The Senior Project Manager provided several administrative updates at the beginning of the meeting. It was announced that a collection drive for diapers, winter gear, and toiletries would be held at the January 7th committee meeting, with a flyer to be circulated in advance to raise awareness. The January 7th meeting will also serve as the next committee meeting, taking place from 2:00 to 4:00 PM, with both in-person attendance at the LOB and a Zoom option available. This meeting will focus on potential legislative recommendations for the 2026 session and include a presentation on recommendations related to eating disorders in children. Members were also reminded that the CVW Summit is tentatively scheduled for February 11, immediately

prior to the February TCB meeting, and that the 2026 legislative session will begin on February 4th.

The Senior Project Manager then reviewed upcoming workgroup meetings. The System Infrastructure Workgroup is scheduled to meet on December 16 from 3:00 to 4:30 PM, the Services Workgroup on December 10 from 2:00 to 3:30 PM, and the Prevention Workgroup on December 4 from 3:00 to 4:30 PM. The School-Based Workgroup will not meet this month due to members focusing on legislative tasks assigned through recent legislation. Members interested in attending workgroup meetings or receiving minutes were encouraged to reach out. The Senior Project Manager also highlighted ongoing efforts behind the scenes related to the crisis continuum, noting that subgroups have been meeting regarding the crisis continuum review, and invitations have been sent for the UCC Private Insurance Review meeting, which will commence shortly.

Panel Introduction:
A representative from DCF opened the monthly meeting by introducing themselves and outlining their role to provide context for the discussion, then invited colleagues to highlight work occurring across the crisis continuum. Referring to the opening slide, they noted that the system is commonly described as the Crisis Stabilization Continuum, a term that accurately reflects its purpose. The Crisis Services Continuum is designed to deliver timely resources to children and families during periods of acute need, to help them remain safe in their homes and communities while maintaining connections to appropriate support services. The system seeks to reduce reliance on emergency departments and inpatient hospitalizations by offering a coordinated range of urgent response services. The speaker also referenced SAMHSA's best-practice framework for crisis systems, which is built around three core pillars: someone to contact, someone to respond, and a safe place for help. The speaker emphasized that Connecticut's approach closely aligns with these guidelines.

The presenter noted that under the "someone to contact" pillar, families can reach support 24/7 through either 2-1-1 or, more recently, 988. The presenter further elaborated that there is no wrong door, as both routes connect callers to the Crisis Call Center operated by United Way. Call center staff assess, and triage needs and can immediately connect families by phone to a mobile crisis clinician, available around the clock. Regarding the "someone to respond" pillar, mobile crisis clinicians respond in person to children and families in their homes, schools, or other community settings 24/7. In most cases, the expectation is that responses occur quickly and in person. The statewide mobile crisis network includes providers such as Child and Family Guidance Center, Community Health Resources (with subcontracting through Middlesex Hospital), Clifford Beers, United Community and Family Services (UCFS), Wellmore, and Wheeler Clinic.

The speaker then described the “safe place for help” component of the continuum. Over the past several years, Connecticut has expanded urgent crisis centers where youth and families can receive stabilization, crisis support, and connections to ongoing services when remaining on-site is not sufficient. The presenter added that subacute crisis stabilization centers have been developed for youth needing a higher level of support, allowing youth to stay for up to several weeks to receive intensive services aimed at stabilizing the situation and supporting a return home. Currently, the Village operates one subacute center, and Community Health Resources is in the process of bringing another online.The speaker also noted a developing program at Yale New Haven, which enhances behavioral health emergency services and is expected to come fully online in the future.

The speaker emphasized that Connecticut benefits from strong community partners who have demonstrated significant skill and dedication in supporting youth and families in crisis. They noted that the state is often asked to share its model and is widely regarded as a leader in crisis continuum development. This work, they added, is supported by ongoing leadership and investment from the Governor’s Office and the Legislature.

Crisis Services Data Panel:
The presenters shared that United Way of Connecticut’s mission is to help residents thrive through trusted partnerships and innovative solutions, primarily through operation of the 2-1-1 Contact Center. While United Way is widely known for providing information and referrals related to basic needs, housing, childcare, and other supports, the focus of this presentation was crisis services. United Way serves as a single point of access for multiple crisis lines, including 2-1-1, the 988 Suicide and Crisis Lifeline, Adult Mobile Crisis, and Youth Mobile Crisis.

United Way functions as the entry point and triage hub for crisis calls, listening to callers and determining the appropriate response, which may include emergency services, a mobile crisis response, a non-mobile response, or information and referral. When appropriate, Youth Mobile Crisis teams are deployed immediately through local providers. United Way collects call data in DCF’s shared Provider Exchange system, allowing mobile crisis providers seamless access to information and reducing the need for families to retell their stories. Warm handoffs are also conducted to ensure continuity of care. This shared data system enables the Child Health and Development Institute’s (CHDI) Performance Improvement Center (PIC) to track outcomes from initial contact through aftercare.

The presenters reviewed crisis call volume data, noting a significant increase since the launch of the 988 three-digit dialing code in 2022. Overall crisis volume has increased approximately 67% compared to 2021, with 988 calls increasing nearly two and a half times. CHDI then presented data from the Performance Improvement Center, which serves as the data and quality improvement hub for Mobile Crisis, Urgent Crisis Centers (UCCs), and Subacute Crisis

Stabilization (SACS). Providers enter assessment data into DCF's centralized system, which is shared monthly with CHDI in de-identified form to support reporting, consultation, and data-driven quality improvement.

For Mobile Crisis, data showed a steady increase in utilization over time, peaking in fiscal year 2019, declining during COVID, and stabilizing at approximately 12,000 episodes of care annually over the past four years. The presenter indicated that seasonal trends showed lower volume during summer months and higher volume during the school year, particularly in October and March through May. Calls were most frequent on weekdays and during school-related hours, with nearly every town utilizing Mobile Crisis services annually. Demographic data indicated that Mobile Crisis serves Black and Hispanic youth at higher rates than their proportion of the statewide population, reflecting access for families who may otherwise face barriers to care. The presenter further elaborated that the majority of youth served were between ages 9 and 15, with referrals most commonly coming from schools and families. The most frequently presenting concerns were risk of harm to self and disruptive behavior, followed by depression, anxiety, and family conflict. Performance metrics showed consistently strong outcomes, including high rates of timely in-person response and rapid response times exceeding statewide benchmarks.

A presenter shared a case example of a 14-year-old youth with complex family circumstances who received repeated Mobile Crisis interventions. Ongoing coordination among the family, school staff, clinicians, and community partners helped identify emerging concerns and intervene proactively, illustrating the importance of mobile crisis services and cross-system collaboration in preventing escalation and connecting youth to appropriate care. The presentation then shifted to Urgent Crisis Center (UCC) data. The presenter informed the committee that the UCC utilization increased by 17% from the first to the second year of operation, demonstrating growing awareness and demand. Like Mobile Crisis, UCC utilization followed school-year trends, with peak usage in fall and spring. Families traveled from across the state to access UCC services, though utilization was highest in communities near UCC locations.

Demographic patterns for UCCs largely mirrored statewide trends, with a higher proportion of Hispanic youth served, reflecting the populations of host communities. UCCs served more females than males, with most youth aged 9 to 15. Referral sources included schools, families, community providers, and Mobile Crisis. Presenting concerns mirrored Mobile Crisis data, with risk of harm to self and disruptive behavior most common. Outcome data showed strong performance, with most youth demonstrating clinical improvement and 97–98% able to return home rather than being referred to emergency departments. Approximately half of families reported they would have gone to the emergency department if the UCC had not been available, highlighting the UCCs' role in diversion. UCC providers discussed ongoing challenges, including limited public awareness, the need for stronger integration with EMS transport, and the

importance of ensuring families are informed of all available crisis continuum options when calling 2-1-1. They emphasized continued outreach to schools, pediatricians, and community providers, as well as the need for system-level support to streamline referral pathways. Presenters also discussed sustainability challenges, including reimbursement and billing structures. While progress has been made with Medicaid billing through DSS, UCCs continue to rely on a blended funding approach including Medicaid, commercial insurance, grant funding, and uncompensated care to ensure no family is turned away during a crisis. Ethical considerations were emphasized, noting that financial discussions occur after stabilization, not during moments of acute need.

The presenters highlighted the value of partnership with CHDI, noting that CHDI's longstanding experience in crisis data collection and analysis has strengthened program evaluation and quality improvement. They encouraged continued collaboration, particularly given the legislature's growing focus on crisis services. The presentation concluded with a brief video showing a parent's experience of how the UCC supported her child with autism through a crisis.

Sub-Acute Crisis Stabilization Data Overview:
The next presenters explained that SACS is a short-term residential program designed for children needing a higher level of support than a UCC can provide, but for a limited duration. Services are typically delivered within two weeks, focusing on stabilizing the child and family while working intensively toward treatment goals. Compared to Mobile Crisis and UCCs, SACS is a much smaller and more intensive program, which is important context when reviewing data, as the sample size is limited.

In terms of utilization, data from six quarters showed the program initially served 15–18 youth per quarter. In the third and fourth quarters of fiscal year 2025, that number increased to 25 youth per quarter, reflecting modest growth while still serving a relatively small population. Demographic data indicate that Black and Hispanic youth are served at higher rates than their representation in the Connecticut population, while White youth are served at lower rates. The program serves more females than males, more noticeably than in UCC data, and most youth, approximately 83%, are age 13 or older. Given the small sample size, some differences appear more pronounced than in other services.

The presenter further elaborated that the outcome data from January 2024 through June 2025 showed an average length of stay of 14.9 days. About 28% of episodes exceeded the 14-day benchmark, most often due to logistical delays securing the next appropriate placement. Upon discharge, nearly 90% of youth met treatment goals and completed treatment, rather than being hospitalized or discontinuing services. Overall, the data reflect positive outcomes for the program.

CHA 5-Year Look-Back on ED Utilization and Inpatient Bed Capacity:
The next panelists shared a five-year retrospective analysis conducted by the Connecticut Hospital Association (CHA), focusing on hospital-based services at the highest level of the crisis continuum. To provide context, the presenter described their dual perspective, noting that prior to representing CHA, they spent 17 years at Connecticut Children's Medical Center overseeing social work and care management programs and contributed much of the data used in the analysis. The presenter noted that data collection began in October 2021, following the initial phase of the COVID-19 pandemic, when hospitals began to see dramatic shifts in pediatric behavioral health demand. At Connecticut Children's, which operates an 11-bed psychiatric unit and historically maintained an average daily census of 15 to 20 youth, the census surged to more than 40 youth on many days.
Recognizing that these challenges were not isolated, Connecticut Children's partnered with CHA to assess statewide trends. Hospitals across Connecticut were experiencing similar pressures, and at that time, key components of the crisis continuum, including UCCs and SACS, did not yet exist. Mobile Crisis services were also strained due to workforce shortages, resulting in emergency departments becoming the default access point for families in crisis.

The presenter noted that with CHA's support, a statewide Child and Adolescent Response Team was formed, convening hospital representatives daily to share real-time data, identify capacity constraints, and coordinate patient movement across systems. These discussions revealed that the core challenge was not volume alone, but throughput, as youth became stuck in emergency departments.

To move beyond anecdotal evidence, CHA implemented a standardized data collection process in October 2021. Hospitals submitted daily data detailing the number of youths in emergency departments by age group and the number awaiting inpatient placement. Approximately 60% of youth were ultimately discharged back into the community with wraparound support, underscoring the importance of cross-system coordination. These daily calls fostered unprecedented collaboration among hospitals, with providers sharing capacity information and problem-solving collectively while striving to preserve regional access for families. The child and adolescent response line remains active today, and many of the relationships formed during that period continue.

The data enabled CHA and hospital partners to examine broader trends, including seasonality and system bottlenecks. Consistent with Mobile Crisis and UCC data, emergency department utilization peaked during the school year and declined during summer months and holidays.
The presenter provided an overview of a one-year snapshot from 2024 sharing data collected in response to Public Act 24-4, which showed more than 11,000 behavioral health–related ED visits among youth under 18. Nearly half occurred at children's hospitals, 68% were related to mood or anxiety disorders, and the average length of stay was 26 hours, compared to three hours for

medical-surgical patients. The presenter additionally added that two-thirds of these youth were covered by Medicaid.

Overall, the data demonstrated that youth with behavioral health needs experience significantly longer ED stays, reflecting persistent access and throughput challenges. The findings underscore the importance of strengthening front-end diversion, improving care coordination, addressing reimbursement gaps, and expanding specialized impatience across the continuum.

CT BHP Data Reporting:
The final presenters provided an overview of data from the Connecticut Behavioral Health Partnership, a collaboration among DCF, DMHAS, and DSS, with Carelon serving as the Administrative Services Organization for Medicaid behavioral health services. The partnership's overarching goal is to improve access to and quality of behavioral health care statewide. The presentation focused on Medicaid-specific youth behavioral health utilization in emergency departments, complementing the broader all-payer data previously shared.

The presenters explained that the analysis focused on HUSKY Health youth ages 3 to 17 and excluded individuals with dual coverage. Connecticut Children's Medical Center accounted for the highest volume of Medicaid youth ED visits, followed by Yale New Haven Hospital, a pattern that has remained consistent over time. The data also distinguished between total visits and unique individuals, highlighting that some youth experience multiple ED visits within a year. Further analysis showed that while most youth had a single ED visit, a smaller subset experienced repeated visits. Youth presenting with primary mental health diagnoses were significantly more likely to have multiple ED encounters than those with primary medical concerns. The presenters reviewed connect-to-care outcomes for youth discharged from the ED without inpatient admission. Claims-based data showed that approximately 52% connected to follow-up care within seven days, increasing to about 69% within 30 days. These rates have remained stable over time and compare favorably to national benchmarks, placing Connecticut in the 75th to 90th percentile on related HEDIS measures.

Additional data showed that most youth connected to outpatient behavioral health services following an ED visit, followed by school-based services and IICAPS. Demographic patterns among youth who are connected to care mirrored the overall ED-utilizing population.
The presentation also addressed youth considered "stuck" in emergency departments, defined as remaining in the ED for eight or more hours after medical clearance while awaiting disposition. In 2024, approximately 2,200 such episodes were reported, representing about 1,500 unique youth. The average length of stay was approximately three and a half days, with most patients discharged within three days. Two-thirds were recommended for inpatient care, and most were ultimately admitted.

Finally, presenters highlighted disparities for young people with autism spectrum disorder. Although overall volumes were lower, youth with ASD experienced significantly longer ED stays, averaging eight days compared to three and a half days for other youth. Lengths of stay for this population increased more sharply over time, reinforcing the need for expanded specialized capacity and appropriate placements.

Q&A:
During the discussion, a committee member raised concerns about gaps in the youth crisis continuum, particularly the low number of police referrals to Mobile Crisis services. The member emphasized the need for coordinated responses when 911 is called for a child behavioral health crisis, including simultaneous engagement of 2-1-1 to deploy mobile crisis teams. Legislative and policy barriers were noted, including limitations related to police referral authority and coordination with police accountability frameworks. The member suggested developing public-facing educational materials to clarify when to call 911, 2-1-1, or 9-8-8 and to guide EMS on appropriate transport to Urgent Crisis Centers (UCCs), offering to collaborate with DESP, DCF, and other partners to address these gaps and improve UCC utilization.

A tri-chair requested clarification on CHDI's Mobile Crisis response metrics, specifically the "response within 45 minutes" measure, asking whether the clock begins when a call is placed or when it is answered. Presenters clarified that the clock starts when the call is answered by 2-1-1, which is the time recorded in the system. CHDI does not track call hours, but United Way tracks data for both 2-1-1 and 9-8-8. For context, 9-8-8 currently exceeds the national standard, with approximately 97% of calls answered within five seconds, and Youth Mobile Crisis is performing well below the 180-second benchmark. The tri-chair also requested clarification regarding the CHA-reported shortage of 14 beds, and CHA presenters explained this figure refers specifically to staffed and available beds, meaning beds fully operational and ready for use rather than physical bed capacity alone.

A tri-chair then inquired about CHDI's role and funding status, noting that CHDI is contracted by DCF as the Performance Improvement Center for Mobile Crisis and UCCs, with funding set to expire at the end of 2025. Presenters explained that CHDI's primary contract is for Mobile Crisis, and DCF secured a small federal grant to expand CHDI's role to support initial UCC and Subacute Crisis Stabilization (SACS) implementation and early data collection. The grant supports CHDI through the end of the calendar year, with no replacement funding yet identified.

A committee member asked whether data monitoring and quality metrics could continue through Medicaid now that certain crisis services are recognized as Medicaid services. Presenters explained that CHDI receives data from DCF, which collects it from providers. If CHDI's role ends, responsibility for reporting, particularly for UCCs and SACS, would shift to DCF program

staff. Medicaid may capture some data, but differences in payer mix likely limit its usefulness for fully assessing services.

A committee member also commented on strong UCC outcomes, particularly the high rate of youth returning home, and asked whether the relational and family-centered approach contributes to these results. UCC presenters explained that flexibility in time and pace allows staff to support both child and caregiver during acute distress, noting that helping caregivers regulate anxiety has a powerful impact on stabilization. Relationship-building, commitment to family engagement, and meeting families where they are contributing meaningfully to positive outcomes. Families often report that UCCs are the first setting where caregivers are asked about their well-being, reinforcing a family systems approach. Presenters shared an example of a caregiver returning for broader family support, illustrating the depth of trust built and the difficulty of quantifying such relational work. The committee member emphasized not losing sight of these qualitative factors when evaluating de-escalation, diversion from EDs, and system effectiveness.

A tri-chair highlighted the CHA data showing stark contrasts between behavioral health and medical emergency department lengths of stay, emphasizing the distress experienced by families during prolonged ED stays involving multiple provider handoffs. Clarification was requested regarding how EDs serve as a referral source to Mobile Crisis. A CHA presenter described how Connecticut Children's partnered with Mobile Crisis teams to bridge families from ED discharge to outpatient follow-up, reinforcing safety plans, medications, and next steps. This bridging role mitigates the emotional toll of extended ED stays and helps families retain critical information. The discussion noted regional variability in how Mobile Crisis and UCCs are integrated, suggesting further statewide coordination could be beneficial. Committee members raised the importance of examining perceived versus actual legislative or policy barriers affecting EMS, police, and referral pathways, recommending clearer guidance and involvement from regulatory agencies. A question was raised via chat about EMS reimbursement for UCC transport, with concerns highlighted about equitable access in northeastern Connecticut.

A tri-chair expressed appreciation for the comprehensive presentation and emphasized coordination of care as a key theme. They raised concern regarding hospital follow-up timelines, noting that connection to care within 7- and 30-day windows following ED discharge can feel excessively long for families in crisis. Efforts to improve efficiency and shorten the time to connection were discussed. A presenter acknowledged the concern, explaining that ED utilization often involves repeated visits from some families and varying preferences for care types. The presenter elaborated that hospitals rely on enhanced care clinics and rapid-response outpatient models, but access is uneven, particularly for Medicaid-enrolled youth. Connecticut Children's developed a transitional care clinic to bridge gaps for youth with two- to three-week waits, providing short-term medication management, care coordination, and therapy. Mobile Crisis serves as a short-term bridge, not a long-term follow-up. Similar transitional models could be

explored within UCCs, with tailored approaches to family needs. Additionally, it was noted that Connecticut Children's ranked fourth statewide in 2024 for connect-to-care performance, but even seven or thirty days is too long in crisis situations. The presenter emphasized that children exist within family systems, and caregiver support is essential to prevent repeated crises.

The tri-chair noted UCCs provide a strong example of a whole-family approach, including care plans at discharge, and suggested this approach as a benchmark for collaboration. The tri-chair also inquired about ICAPS and other in-home supports within the crisis continuum and requested updates on Yale's UCC services, including any programmatic or status updates.
A committee member reported that ground has been broken and demolition is underway at Yale's site, though it is not fully operational. Internal progress includes hiring into key positions despite funding not originally allocated for staffing, with ongoing discussions and planning regarding the type of care to be developed. In partnership with DCF, the goal is to create a child-focused version of the adult "empath" model, providing calm, supportive, and restraint-free psychiatric environments. Limited examples exist for children, including a small program in South Carolina and one developing in California. This initiative aligns with the UCC model's mission to provide care outside EDs, and care is already being implemented while the site works toward full operational status.

A committee member emphasized that higher utilization of services by Black and Brown children reflects broader systemic factors and should not be interpreted solely as a racial issue. Behavioral patterns should be understood as communication, and systemic-level analysis is necessary to interpret trends qualitatively alongside quantitative data.

Another committee member reflected on CHA's 14-bed shortage data, describing it as a symptom rather than a solution and emphasizing the need to reimagine crisis services for children. Drawing on personal experience, they noted the trauma of ED stays and observed that many youth previously presenting in EDs now access care at UCCs. They highlighted the importance of family-driven, community-based solutions rather than reliance on hospital beds.

To conclude the monthly meeting, a committee member thanked the panel for sharing the data and highlighted the importance of the snapshot it provides of community services. Behind every statistic, bar graph, and trend line is a child, a parent, and a family seeking support. Numbers alone cannot capture the lived realities of families in crisis, and when 2-1-1 is called, the focus is on receiving help, not data points. Response times reflect parents waiting in fear, volume increases indicate needs outpacing system capacity, successful resolutions show relief for families receiving support, and gaps or missed opportunities reflect parents feeling unheard or re-traumatized. Family voices are central to interpreting data because families live within the numbers. Data should not only inform but drive action, emphasizing that families deserve a seat at the decision-making table as partners. Prevention must be as robust as crisis response, and

follow-up and aftercare should serve as bridges to stability, not endpoints. The call was made for data to strengthen the system, ensure every call counts, and honor families' needs with meaningful, actionable improvements. The presentation concluded with gratitude to the presenters for transparency, courage, and for centering the realities of families on the ground.

The next meeting will be held at the LOB on January 7th, 2026, with hybrid options.