Tow Youth Justice Institute

Making connections. Informing solutions.

Transforming Children's Behavioral Health Policy and Planning Committee

July 15th, 2026

2:00-4:00 PM
Virtual, ZOOM

Tow Youth Justice Institute

About Us: The Tow Youth Justice Institute (TYJI) is a university, state, and private partnership dedicated to transforming the systems that impact youth, young adults up to age 26, and their families. We additionally embrace cross-system collaborations with policymakers, practitioners, service providers, students, researchers, and community members to advance justice that includes public safety, behavioral health, health, housing, and education.

Mission Statement: Rooted in equity and respect, our mission is focused on raising the voices of youth up to age 26, families, and those with lived experience, including those who have experienced victimization, and to promote policies, practices, and programs that reduce harm, build power, and create opportunities for all. Through research, coaching, education, and cross-system collaboration, we strengthen communities and support solutions that are community-informed, evidence-driven, and we focus on wellbeing, dignity, and long-term change.

TCB's Mission Statement

Mission Statement:

The TCB Committee exists to strengthen and align Connecticut's system of care through **legislative recommendations and strategic reforms aimed at improving access to high-quality services and promoting children's behavioral health and well-being through a sustainable continuum of care.**

As a bridgebuilder, TCB will engage **system-wide stakeholders, use data to assess gaps and system inefficiencies, identify cross-system alignment, and make recommendations to address and overcome the root obstacles to promote the well-being and resilience of all children and families.**

We define success as achieving a behavioral health system that is accessible to all children and provides appropriate, affordable, high-quality behavioral health services at the right time and place to ensure the most positive outcomes so that Connecticut's children can thrive well into the future.

Purpose:

The Transforming Children's Behavioral Health Policy and Planning Committee ("TCB") was established in 2023 by Public Act 23-90 and mandated to evaluate the availability and effectiveness of prevention, early intervention, and treatment services for children's behavioral health, substance use disorders, and general well-being of children aged from birth to eighteen. Through targeted recommendations to the General Assembly and executive agencies, the TCB may propose necessary actions to improve:

- **(1) developmental and behavioral health outcomes for children,(2) facilitate transparency and accountability across state agencies, community-based organizations, and institutional providers, and (3) promote policies to advance data sharing and reporting between state agencies and state-funded programs.**

Meeting Facilitation

- **Mute on Zoom**
  - Participants must remain muted on Zoom unless speaking
- **Hand Raising**
  - Virtual attendees should use the Hand Raise feature on Zoom for questions and comments
- **Questions at the End**
  - Hold questions and comments until the presenters have finished speaking
- **TCB only**
  - Only TCB members may ask questions and make comments
- **Recording**
  - This meeting is being recorded

Agenda

Welcoming, Opening Remarks	TCB Tri Chairs: Senator Ceci Maher, Representative Tammy Exum & Claudio Gualtieri, Senior Policy Advisor to the Secretary, OPM
Review and Acceptance of June Minutes	
Administrative Updates	TYJI
Solnit Overview and Update	Dr. Frank Gregory, Administrator of the Children's Behavioral Health Community Service System Division, DCF; Nicole Taylor, MD, Behavioral Health & Wellbeing Chief Administrator; Vincent Russo, Government Relations & Policy Chief Administrator; Susan Hamilton, MSW, JD, Commissioner of DCF Directors at UConn Health; Andrew Agwunobi, MD, MBA, Chief Executive Officer for UConn Health; Caryl Ryan, MS, BSN,RN, Chief Operating Officer at UConn John Dempsey Hospital; Asima A. Zehgeer, MD, Associate Professor of Psychiatry; Deb Abromaitis, Assistant Vice President; Scott R. Allen, MD, Chief Medical Officer; Andrea Keilty, Chief of Staff.
Q&A / Discussion	TCB Members
Integrated Pediatric Behavioral Health Care	Andrea Higani M.D, CEO, Pediatric Healthcare Associates, and Edith Boyle LCSW, President and Chief Executive Officer of LifeBridge Community Services
Q&A / Discussion	TCB Members
Closing Remarks	TCB Tri Chairs: Senator Ceci Maher, Representative Tammy Exum & Claudio Gualtieri, Senior Policy Advisor to the Secretary, OPM

TCB Administrative Updates

Children's Behavioral Health Provider Survey Workshop

The Services Workgroup is partnering with the Innovations Institute. The partnership includes creating and administrating the CT Children's Behavioral Health Provider Survey.

August 4th, 2026, from 10:30 AM -12:30 PM at the State Capital Building, 210 Capitol Ave, Room 310

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Workgroup Upcoming Meeting Dates

Workgroup	Meeting Date
Services	September 9th, 2:00 PM – 3:30 PM
System Infrastructure – Systems of Care Subgroup	September 15th, 3:00 PM – 4:30 PM
Prevention	September 17th, 3:00 PM – 4:30 PM
School-Based	September 7th, 3:00 PM – 4:30 PM on Zoom
CVW	September 21st, 10:00 AM – 11:AM on Zoom

There will be no Workgroup meetings or TCB Meeting in the month of August

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DCF SolNit Overview

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UConn Health SoInit Update

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Q&A

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Please Submit Questions on Solnit

Scan here

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TCB – Solnit Discussion Timeline

Over the next few months, the TCB is committed to diving further into a more comprehensive Solnit discussion/overview. Below is a rough timeline of our projected meeting date topics and focus areas regarding Solnit. This will not be a one meeting discussion -we have received some questions in the last few weeks that will be addressed in upcoming meetings within a working session and fall TCB meetings.

Timeline	Meeting Focus Area
July TCB Meeting	• DCF will provide an overview on history of Solnit, and where Solnit fits within the continuum of care. UConn Health overview of their framework of their new role, and any collaboration efforts with DCF and other State Agencies throughout this process, what UConn hopes to achieve, and how they will measure success. • We will then open the floor for questions. *a QR code will be provided following the q&a to submit questions that will be addressed in future meetings/working group sessions
Working group Workshop to address TCB Questions – Sometime in **August and September**	• Based on Questions received in the past few weeks, and questions asked and submitted at today's TCB meeting, the TCB will convene a working group to discuss and answer and discuss questions brought to the committee. The working group will prepare for an overview of this discussion and provide an update at the September and/or October TCB meeting.
September and/or October TCB Meeting tyji Tow Youth Justice Institute	• An overview of discussions within the working group session, and presentations with responses to said questions for the TCB committee.

Crisis Continuum Report Updates

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Integrated Pediatric Behavioral Health Care

Andrea Higani M.D, CEO, Pediatric Healthcare Associates, and Edith Boyle LCSW, President and Chief Executive Officer of LifeBridge Community Services

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Integrated Pediatric Behavioral Health Care

A Connecticut Solution to Improve Access, Outcomes, and System Efficiency

Presented by

Edith Boyle, LCSW
President & CEO,
LifeBridge Community Services

Andrea Hagani, MD
CEO,
Pediatric Healthcare Associates

Too Many CT Children Reach Care Only in Crisis

11,000+
Youth behavioral health ED visits

1 in 5
Adolescents experienced depression

3.5 Days
Average psychiatric boarding time

1 in 3
return to the ED two or more times in the same year

70%
of ED visits involve treatable conditions

(e.g., anxiety, depression, traumatic stress)

Earlier access prevents later emergencies.

Many Children Are Carrying More Than We See

Children may be coping with:

- Abuse or neglect
- Violence at home or in the community
- Caregiver mental illness or substance use
- Loss of a parent or loved one
- Housing instability and poverty
- Chronic stress and uncertainty

LifeBridge Data:

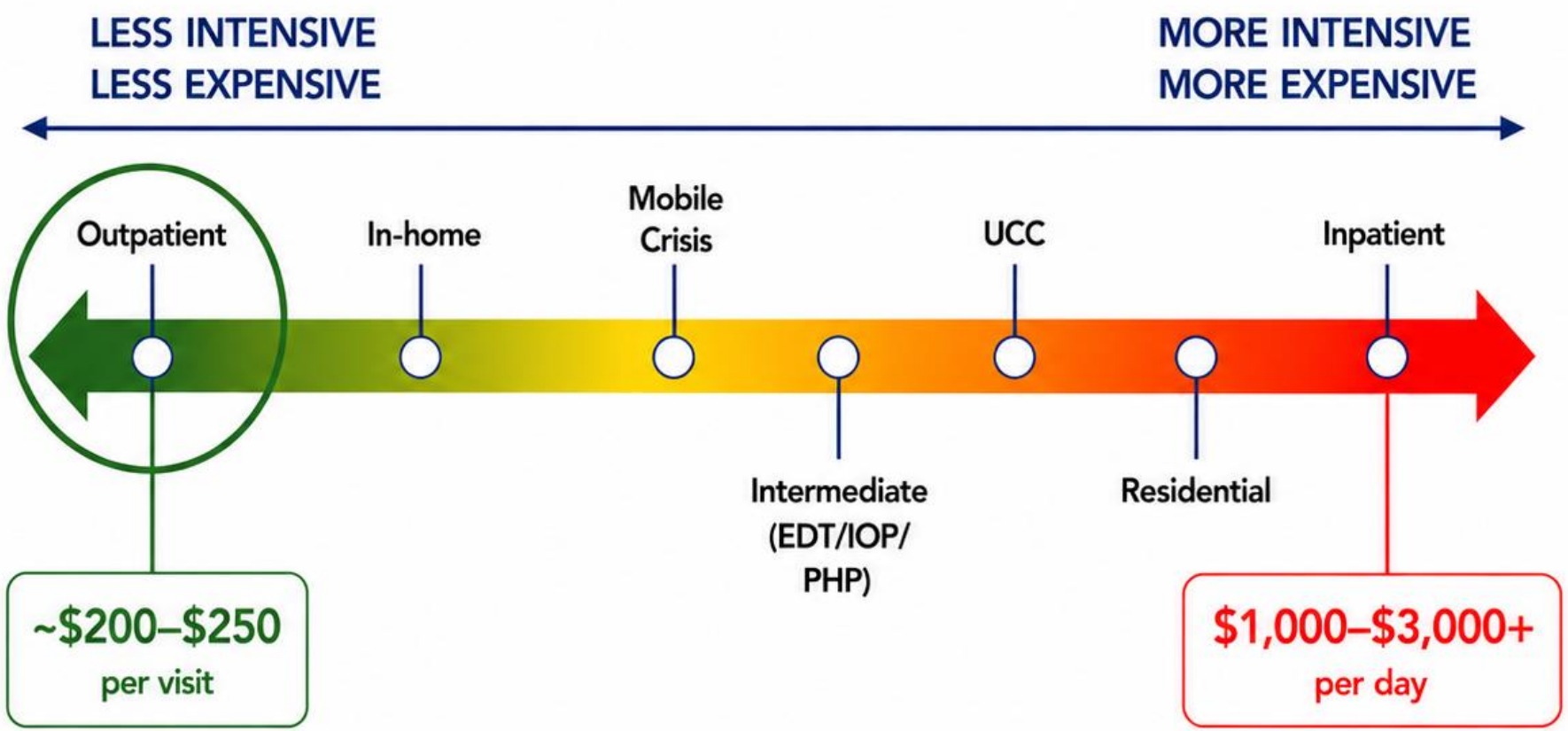
53%

of youth receiving services met the clinical threshold for trauma-related symptoms.

Making Matters Worse:

Bridgeport is a Mental Health Professional Shortage Area.

Earlier Care Prevents Later Crises—and Costs Less



When outpatient care is delayed or unavailable:

- Symptoms worsen
- ↓
- Crises repeat
- ↓
- Emergency department visits increase
- ↓
- Hospitalizations increase
- ↓
- Family stress and disruption increase

Outpatient counseling is not simply one option among many—
it serves the largest number of people and
provides the greatest value to the healthcare system.

Integrated Care Works

Research published in *Pediatrics* and *Health Affairs* shows:

- Improved access to care
- Increased engagement in treatment
- Better clinical outcomes
- Reduced emergency department utilization
- Improved system efficiency and value
- Lower total cost of care

Integrated care is not a theory.
It is an evidence-based model.

LifeBridge Community Services

PHA Pediatric Healthcare Associates

- 30+ years providing community behavioral health care
- Serves Greater Bridgeport families
- Established behavioral health workforce and clinical supervision infrastructure
- Serves many Medicaid-insured children and families
- Member of the National Child Traumatic Stress Network

- 34,000 children served annually
- 60 years serving Fairfield County families
- Four Fairfield County locations (Fairfield, Shelton, Stratford, Trumbull)
- Serves many Medicaid-insured children and families
- Prioritizes youth mental health

Together, these organizations combine pediatric reach with behavioral health expertise to bring integrated care to children who might otherwise go without treatment.

Traditional Referral

Pediatrician provides referral

↓

Weeks or months before treatment begins

↓

Families may never connect with services

- ✗ Multiple handoffs
- ✗ High unkept appt. risk
- ✗ Limited communication between providers

↓

Pediatrician may never know the outcome

LifeBridge-PHA Integrated Care Model

Pediatrician makes direct electronic referral

↓

Access to care within 24 hours

↓

Treatment begins immediately

In a trusted pediatric setting

↓

Pediatrician remains informed and involved throughout treatment

Ongoing communication and care coordination

> *"A child will have the longest relationship with their parents and pediatrician."*
>
> — Anonymous

Pediatric Practice Role

Creates and sustains the integrated-care environment through:

- Screening
- Identification of needs
- Referral coordination
- Shared workflows
- Team communication
- Space and infrastructure
- Multidisciplinary collaboration

Embedded Partnership

LifeBridge clinicians are embedded within:

- PHA Stratford
- PHA Fairfield
- PHA Trumbull

Behavioral Health Provider Role

Brings mental health expertise and provides:

- Clinical assessment
- Therapy
- Care coordination
- Family engagement
- Consultation
- Treatment planning
- Ongoing behavioral health management

MORE THAN HALF THESE ACTIVITIES ARE INELIGIBLE FOR REIMBURSEMENT

Transforming Access to Care

Over the past two and a half years:

393%

increase in youth accessing treatment

More than one-quarter of total access growth was achieved through the integrated-care partnership.

Families are not being handed a list of providers.
They are entering treatment.

Early Results Show Promise

Emotional Regulation *(Self-Control)*

Integrated Care:	48% ↑
Agency Average:	48% ↑

Persistence *(Effort)*

Integrated Care:	51% ↑
Agency Average:	40% ↑

Children accessed care more quickly and received outcomes comparable to, or better than, traditional outpatient services—even during the first 6–8 months of implementation.

Missed Appointment Rates	
Integrated Care Sites	27%
Agency Average	29%
National Medicaid/Community Behavioral Health Benchmark	25–40%

The Economics of Outpatient Mental Health No Longer Work

Actual Cost per Session	**~ $240**
Medicaid Reimbursement	**~ $105**
Unreimbursed Cost	**~ $135**
LifeBridge Annual Loss *(From Unreimbursed Cost)*	**~ $370,000** per year

As workforce costs rise faster than Medicaid reimbursement, the gap continues to grow.

PHA Annual Loss *(Lost Net Revenue)* — **~ $800K** per year

in lost net revenue for PHA from using exam rooms for therapy services instead of pediatric care (3 offices).

Estimate excludes care coordination staff time associated with referrals and follow-up, making the true cost higher.

Connecticut's Own Rate Study Supports Action

Independent Findings

- Behavioral health clinic rates benchmarked 116.9% below target
- Many behavioral health methodologies rely on historical calculations
- Some rates had not been updated in over a decade

Sustainability Findings

- No routine mechanism for annual updates
- Workforce costs rise faster than reimbursement
- Current approaches require repeated legislative intervention

State Recommendations

- Rebase rates
- Establish regular update schedules
- Expand alternative payment models
- Tie investments to access and outcomes

Connecticut has already diagnosed the problem.
The next step is implementing the solution.

Other states reimburse for integrated care to expand access and improve whole-child care. Connecticut can too.

	Massachusetts	Colorado	Connecticut Proposal
Primary Focus	**Sustainable payment** for integrated care	**Embedded behavioral health** in pediatric practices	✓ **Combine both approaches**
Payment Approach	Collaborative Care codes, sub-capitation, and PMPM payments	Traditional reimbursement supplemented by integration initiatives	✓ **Dual reimbursement for integrated pediatric behavioral health partnerships**
Behavioral Health Presence	Behavioral health integrated into primary care teams	Embedded clinicians working within pediatric practices	✓ **Embedded clinicians working within pediatric practices**
Pays for Primary Care Integration Activities	✓ Screening, care coordination, team case review	Limited support through local initiatives	✓ **Enhanced reimbursement for screening, warm handoffs, workflow integration, case review, and infrastructure**
Pays for Behavioral Health Integration Activities	✓ Care management and psychiatric consultation	Limited support for embedded behavioral health	✓ **Enhanced reimbursement for embedded therapy, assessments, care coordination, consultation, and family engagement**
Who Receives Enhanced Payment?	Primarily primary care teams	Varies by initiative	✓ **Both pediatric and behavioral health partners**
Result	Integrated care becomes financially feasible	Behavioral health becomes more accessible	✓ **Sustainable, scalable pediatric–behavioral health partnerships statewide**

Policy Recommendations

TIER 1

1 Partnership Incentive Payments

Incentivize pediatric–behavioral health partnerships statewide through grants, infrastructure payments, technical assistance, and workforce supports.

Children should receive behavioral health services where families already seek care.

2 Integrated Payment Model

Establish an integrated pediatric behavioral health partnership payment model that reimburses both therapy and care coordination.

Integrated care requires two providers doing work beyond the therapy session. A sustainable payment model should reimburse both.

TIER 2

3 Demonstration Waiver

Authorize a Medicaid demonstration waiver to evaluate the effectiveness and cost savings associated with integrated pediatric behavioral health partnerships.

Test and learn what works to improve outcomes and reduce costs.

4 Outpatient Medicaid Rates with COLA Indexing

Increase Medicaid reimbursement rates for outpatient behavioral health to reflect the true cost of care and implement annual Cost-of-Living Adjustments (COLAs).

When workforce costs rise faster than reimbursement, access erodes over time—even after one-time rate increases.

The Cost of Doing Nothing

The cost differences are dramatic.

Level of Care	Typical Cost
Outpatient therapy session	**$200–$250** per visit
Intensive Outpatient Program	**$250–$500** per day
Partial Hospitalization	**$350–$800** per day
Residential treatment	**$500–$1,500+** per day
Psychiatric inpatient hospitalization	**$1,000–$3,000+** per day

These are estimated costs based on typical Medicaid reimbursement rates in Connecticut. Actual costs may vary.

Connecticut is already paying for children's mental health.

The question is whether we pay earlier through prevention—or later through crisis.

One psychiatric hospitalization

can cost as much as months—or even years—of outpatient counseling.

- Connecticut already has the partners.
- Connecticut already has the evidence.
- Connecticut already has the need.

Now Connecticut needs the payment model.

Thank you. | Questions?

Contact Information

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SLIDES 2–5

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SLIDES 9-12

SLIDE	SOURCES
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Slides 13-15

SLIDE	SOURCES
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Next Meeting:

September 2nd, 2026

2:00 – 3:30 PM