TCB October Monthly Meeting Minutes

October 22nd, 2025
2:00 PM – 4:00 PM
LOB, ZOOM
Viewing Option YouTube or CTN

Attendance				**TYJI Staff**
Alice Forrester	Howard Sovronsky	Michael Moravecek	Yann Poncin	Emily Bohmbach
Carol Bourdan	Javeed Sukhera	Michael Patota		Erika Nowakowski
Carolyn Grandell	Jeanne Milstien	Michael Powers		Jacqueline Marks
Catherine Foley-Geib	Jeffrey Vanderpleog	Mickey Kramer		
Catherine McCarthy Vahey	Jody Bishop Pullan	Sinthia Sone Moyano		
Ceci Maher	Kimberly Karanda	Susan Hamilton		
Christina Ghio	Lisa Morrisey	Tammy Exum		
Claudio Gualtieri	Lorna Thomas Farq.	Tammy Venega		
Gerald O'Sullivan				

Welcome and Introductions:
The Meeting was opened with a welcome to all attendees.
Acceptance of TCB September Meeting Minutes:
A motion to accept the minutes from September meeting was put forward, motion carried and approved.
Administrative Updates:
The TCB Senior Project Manager shared upcoming meeting dates for the workgroups and noted that the Services Workgroup meeting date will be changed, with the new date still to be determined. The Senior Project Manager then turned the discussion over to the CVW members, who provided an overview of the in-person CVW Summit held on October 10th. Speakers reflected on how the summit offered valuable insights, opportunities for collaboration, and meaningful exchanges of experience and passion among attendees. They also announced that a

joint CVW/TCB Summit will be rescheduled for January, with further details to be announced. Discussions from the CVW Summit will help inform the CVW workplan, goals, and priorities moving forward.

The TCB Tri-chairs provided a brief overview of the Connecticut Behavioral Health Spotlight, highlighting the Notice of Proposed Medicaid State Plan Amendment issued by DSS regarding UCC billing. The amendment aims to address concerns about billing overlaps and would help UCCs that currently lack access to state-allocated funding, supporting their ability to sustain services in FY26. The Tri-chair also discussed a new initiative launched by Griffin Hospital in Connecticut. The EmPATH unit (Emergency Psychiatric Assessment, Treatment, and Healing) is designed to improve care for individuals experiencing psychiatric distress through a compassionate, dignified, and patient-centered environment. A tentative TCB presentation on this initiative is being planned.
Before concluding, the TCB Senior Project Manager reminded members to regularly check their junk mail folders, as some have reported not receiving emails from TYJI staff.

The Innovations Institute (UConn School of Social Work): National Approaches to Governance for Public Child and Family Serving Systems Comprehensive Fact Sheets Overview:
The presenter began with an introduction and an overview of the purpose of the presentation. She provided a brief explanation of governance and national approaches; the presenter focused on what governance looks like for children and families within the service system. The presenter also referenced a workshop held the previous day with TCB members, during which the Governance Fact Sheet was discussed. She noted key differences between youth and adult systems, emphasizing that they do not share the same level of coordination or support. The presenter highlighted that children often require distinct forms of interagency collaboration, particularly those involved in public systems who have complex behavioral health needs.

The speaker informed members that the primary topics of discussion would include Governance, System Structures, and Accountability in relation to Policy, Financing, and Decision-Making. She then provided an overview of Single Agency System initiatives, explaining that while these efforts tend to be broad and only loosely connected to other community systems, Interagency and Cross-System initiatives engage multiple systems collaboratively. These joint efforts help ensure consistent accountability and shared responsibility for defined groups of children and families, making sure they receive the support they need when they need it.
The speaker emphasized that certain functions must be intentionally structured rather than left to chance, noting that these processes should be regularly evaluated and adjusted as needed over time.

However, what once worked well for the state or community may no longer be effective given the ongoing changes at both the federal and local levels. With these changes come new and evolving challenges each day. The speaker also clarified the distinction between governance and system management. Governance refers to the decision-making authority that determines the allocation of resources and the establishment of policies necessary to build and sustain a system of care or specific initiatives. System management, by contrast, involves day-to-day operational decisions related to managing systems, services, resources, reporting, and outcomes, all of which are accountable to governing bodies, external stakeholders, and oversight
The speaker then highlighted several states. including Maine, Maryland, Massachusetts, New Jersey, New York, and Connecticut and discussed how each is addressing children's behavioral health.

Maine
Maine's governance structure is aligned with the Children's Cabinet, with the DHHS Commissioner serving as chair. Funding for the Cabinet comes from a combination of 50% federal funds and 50% special revenue, with $1 million budgeted annually for the Children's Cabinet Early Childhood Advisory Council. The state focuses on two primary goals: early childhood development and supporting young people transitioning to adulthood. Further clarification is needed regarding specific budget allocations if people are interested. Membership of the Cabinet includes the Commissioners of the Departments of Health and Human Services, Education, Labor, Public Safety, and Corrections.

Maryland
Maryland's governance structure is organized under the Children's Cabinet, chaired by the Special Secretary and the Governor's Office for Children. While funding originally came from state agency budgets, it is now established as a separate line item in the state budget. For fiscal year 2026, approximately $750,000 has been allocated for operations, with an additional $2.5 million designated for personnel costs. Governor Westmore's initiative, Enough, which focuses on ending childhood poverty, is partially supported through this funding; the total $3.6 million allocation is not solely for the Children's Cabinet but also supports initiatives like Enough. Cabinet membership includes the Secretaries of the Departments of Budget and Management, Disabilities, Health, Human Services, Juvenile Services, Higher Education, Labor, Housing & Community Development, and Service and Civic Innovations, as well as the State Superintendent of Schools and the Special Secretary of the Governor's Office for Children.

Massachusetts

Massachusetts has a different governance structure, with children's behavioral health managed through the Children's Behavioral Health Initiative (CBHI), an initiative of the Executive Office of Health and Human Services, which does not have a designated chair. CBHI was established in response to the Rosie D EPSDT lawsuit and operates as a Medicaid initiative that continues to support interagency collaboration within the MassHealth Program. All CBHI services are managed by MassHealth and its contracted vendors. However, according to a personal communication, this structure has resulted in "no well-coordinated or integrated Children's Behavioral Health System."

Minnesota

Minnesota's governance structure is organized under the Children's Cabinet, co-chaired by the Governor and Lieutenant Governor. The Cabinet is supported by the Minnesota Department of Management and Budget and, as of fiscal year 2024, receives approximately $1 million annually for operations and funding. While the Cabinet does not have a published meeting schedule, a public meeting was recently held with full Cabinet participation. Supporting structures include an Advisory Council, a State Advisory Council on Early Childhood Education and Care, and a senior cross-agency leadership team composed of Commissioners. Cabinet membership includes representatives from the Departments of Administration; Children, Youth, and Families; Corrections; Education; Employment and Economic Development; Health; Human Services; Management and Budget; Public Safety; and Transportation, as well as the Minnesota Housing Finance Agency.

New Jersey

New Jersey's governance is organized under the Children's System of Care, a state agency that functions primarily as a systems management structure rather than as a convener of interagency collaboration. The agency utilizes braided funding from multiple federal and state sources, which effectively supports children and families in accessing services. However, the focus remains on how the service array is designed and managed, rather than on broader interagency coordination.

New York

New York's governance is organized by the Council on Children and Families, chaired by the executive director of the Council. There is a mix of funding from federal and states sources with some philanthropic funds. Their membership consists of Commissioners and Directors of the Office of Addiction Services and Supports; Office for the Aging; Office for Children and Family Services; Division of Criminal Justice and Services; State Education Department; Justice Center for the Protection of People with Special Needs; Department of Labor; Office of Mental Health;

Office for people with Developmental Disabilities; Office of Temporary and Disability Assistance; Council on Developmental Disabilities. There is a Cross-System Deputy Commissioners meeting that occurs monthly which is facilitated by the Council. New York DOH and OMH are collaborating on a proposed class action settlement related to access to Medicaid's provision of intensive home and community-based mental health services to Medicaid-eligible children in NY under the age of 21 with a mental or behavioral health condition.

Connecticut

Connecticut's governance structure is organized under the Kids Cabinet, chaired by the Senior Advisor to the Governor. The Cabinet demonstrates a strong commitment to interagency collaboration and cross-system coordination. Membership includes the Departments of Children and Families; Early Childhood; Education; Social Services; Public Health; Developmental Services; Housing; and Mental Health and Addiction Services, as well as the Offices of Health Strategy and Policy and Management. The initiative is supported by existing staff and receives limited philanthropic funding. As of December 24, the Kids Cabinet has prioritized efforts focused on children experiencing homelessness, children involved in the child welfare and juvenile justice systems, and opportunity youth. She also posed several questions for the group to consider, including: *What does and what should governance look like for cross-agency children's services in Connecticut? What lessons can be learned from Connecticut or other states? And what opportunities might be leveraged moving forward?*

Question and Answer Segment:

A Tri-Chair member raised questions regarding Connecticut's representation relative to the other states. The chair noted that the analysis felt incomplete without a full understanding and appreciation of the unique role the Office of Policy and Management (OPM) plays within Connecticut's governance structure, especially when contrasted with states like Maryland and Maine, which are often viewed as gold standards due to their budgetary decision-making processes. Another member agreed with the previous comment, noting that variations in how states are structured often intersect and influence one another. She expressed particular interest in how different states organize and implement Medicaid, how these structures impact children's behavioral health, and the ways in which Medicaid payment systems shape overall governance frameworks.

The presenter responded by emphasizing the importance of identifying the key individuals who hold authority or influence, bringing them together, and ensuring their voices are heard. She highlighted the need to create a space where everyone has an equal voice at the table while also recognizing and engaging those with expertise in children's systems and cross-system collaboration along with clear goals and objectives. Regarding Medicaid, the presenter explained

that a key factor in the success of the Children's Cabinet is its ability to identify specific issues or populations and understand how each agency contributes to and operates within the broader system. She noted that this includes examining access, referrals, service arrays, and payment structures, all of which make Medicaid a critical partner. The presenter highlighted Maryland as an example, where Medicaid actively collaborates with the Maryland Department of Health, the Behavioral Health Administration, the child welfare agency, juvenile justice, and the Department of Budget and Management.

Another member added that OPM plays a significant role not only in managing the budget but also in overseeing the Cabinet itself. However, interest was expressed in better understanding the extent of the Cabinet's power and authority in determining how funds are allocated. In response, the presenter provided an example from Maryland, explaining that while the Maryland Children's Cabinet holds authority over its own operations and agency funds, it does not have control over the budgets of the Department of Human Services or Juvenile Services. The Children's Cabinet has authority over the Children's Cabinet Interagency Fund, all budget requests and approvals still go through the Department of Budget and Management, which must sign off on spending decisions. The Interagency Fund allows the Children's Cabinet to make spending and programmatic decisions, including issuing RFPs and distributing funds to local departments. Over the 15 years, Maryland developed an infrastructure for tiered care coordination and wraparound services aimed at reducing unnecessary residential placements and returning children to their homes. Other agencies collaborated on the Children's Cabinet contracts, contributing funds from their own programs. The Maryland Department of Health also participated whenever Medicaid was involved, particularly through the 1915 Psychiatric Residential Treatment Facility Demonstration Waiver. The Interagency Fund also played a crucial role in supporting children who didn't qualify for other funding streams, ensuring access to needed services through a coordinated, cross-agency model that included every department secretary at the table.

Another member followed up with the information presented, asking what data is available about the shared examples, specifically, who is evaluating their effectiveness and how each initiative connects its work to measurable outcomes for children. The presenter stated that the information is different state by state, Maryland uses result-based accountability in its budgeting and program evaluation, tracking interagency outcomes through annual reports on children's well-being. These reports focus on population-level indicators, rather than direct performance measures, which makes it challenging to assess impact when funding is limited. The effectiveness of such initiatives depends on defining a clear population of focus, such as children with complex behavioral health needs or those experiencing homelessness, which allows for targeted investment, testing changes and evaluating results. Other states, like Minnesota, have created

report cards and progress reports to demonstrate how their structures leverage funding, resources, and policy priorities. The presenter continued by stating that as a service level, evaluation often involves partner collaboration, contracting with entities to monitor outcomes and assess evidence-based practices, as Maryland did through evaluations led by Jill, Connecticut similarly uses organizations like CHDI to track outcomes. The approach combines population-level measures with individual/service-level evaluations. Ensuring the data aligns with the scope of funded initiatives.

Another member asked about the goals the state is establishing, specifically who sets them, which agencies are involved, how they communicate, and who holds ultimate authority. He also questioned how a system like the one depicted in the final slide, with its many moving parts, comes together cohesively, asking who is responsible for assembling it and how that process works. The speaker noted that the Children's Behavioral Health Partnership appears to be the closest existing model in Connecticut to a broader interagency governance structure, through it is narrowly focused by design. Connecticut already has working pieces, with agencies collaborating and exercising real authority, but the question is whether this is more about systems management or governance. The speaker suggested identifying shared policy priorities that genuinely require multiple agencies at the table, rather than initiatives any singly agency can handle alone. Starting with a few targeted priorities, rather than trying to address everything at once, allows the state to leverage existing strengths and improve coordination. The key is to pinpoint areas where progress is hindered due to a lack of regular convening, coordination, implementation planning, or proactive strategy, and use those as starting points for building a more effective, collaborative system.

A member echoed some of the feedback and comments made by their colleagues, emphasizing the importance of conducting a thorough assessment to identify gaps in the current system before considering changes to governance structure. They highlighted the need to determine whether issues are related to governance or other systemic areas and to define how progress will be measured. The presenter highlighted that Connecticut is frequently cited as a model state for work in children's behavioral health, child welfare, and related systems. They emphasized the importance of distinguishing between actual haps or needs and whether perceived issues are truly the state's responsibility. The focus should be on identifying the underlying problem or symptoms and considering whether clarifying or adjusting governance structures will meaningfully help address the issue, rather than assuming structure alone is the solution.

Another member asked the presenter whether any of the states discussed, or any other examples excel at assessing population-level needs, aligning systems to meet those needs, and identifying the children who require services in advance, rather than simply reacting as needs arise. The

speaker advised that while some states have successfully used population-level data to plan and align systems, it often occurs in response to lawsuits, grants, or specific initiatives like statewide system-of-care or Children's Mental Health Transformation Grants. Success depends on having structures in place to intentionally use the data, but consistency is often lacking. Even when statutes exist, outcomes depend on whether agencies actively implement, convene, and review the data. Overall. There are many examples of states doing this well at certain moments, but sustained, consistent use of data remains a challenge.

Another speaker echoed another member's remarks, noting that Connecticut has 25 years of progress in this area and that future efforts should focus on interagency blending of funding and oversight, similar to the Administrative Services Organization (ASO) model, emphasizing that financing and oversight are key areas for continued work. A Tri-Chair member asked about the role of legislators in the states discussed and whether they are actively involved in this work.

The Innovations Institute (UConn School of Social Work): Children's Behavioral Health System of Data Infrastructure and Use of Data for System Improvement Report Presentation:

The presenter began by offering a brief introduction and context for the presentation, outlining the purpose of discussing Connecticut's infrastructure and identifying gaps in services. She described the children's behavioral health system as a network of multiple entities that deliver, coordinate, and fund prevention, early intervention, and treatment services for children, youth, and their families, spanning behavioral health, education, child welfare, juvenile justice, and developmental disabilities. She then reviewed the contents of the report, which includes key terms, core components, model approaches, and an overview of Connecticut's data infrastructure.

The report aims to provide a comprehensive landscape of available resources, highlight system strengths, and offer recommendations for improvement moving forward.

As the presentation progressed, the presenter briefly explained key terms and components, with particular emphasis on data infrastructure. . She discussed the importance of cross-system collaboration and the goal of developing integrated, shared systems as a model for best practice. The presenter also acknowledged the challenges of data integration, noting obstacles such as inconsistent data structures, difficulties in collecting and maintaining data, and limitations in what data can reveal about broader system stories. Finally, she outlined the core elements of the children's behavioral health data infrastructure, which include foundational infrastructure, governance structures, sustainable funding and staffing models, analytic reporting and transparency mechanisms, standardized performance measures and quality improvement frameworks, and the use of innovative technology.

The speaker explained that Connecticut's statewide longitudinal data systems are primarily education-focused and funded by the Department of Education. These systems are designed to link data across the continuum from early childhood through the workforce, to understand long-term outcomes better. The funding also supports the integration of data from related sectors, including the Juvenile Justice and Correctional systems, as well as child welfare services.
In addition, the speaker noted that the All-Payer Claims Database connects healthcare and insurance claims data across both Medicaid and commercial insurers. Health Information Exchanges, on the other hand, are primarily funded to support healthcare coordination and data sharing at the individual level. The speaker noted that many integrated data systems experience time lags, which limit the immediacy of data use; however, there remains significant potential for improved data exchanges. She highlighted several state and local approaches to data infrastructure and integration, including Allegheny County's (PA) DHS Data Warehouse, the South Carolina Integrated Data System (SC IDS), and Massachusetts' Executive Office of Technology Services and Security (EOTSS) in partnership with the Center for Health Information and Analysis (CHIA).

These examples were presented to illustrate successful, long-standing models of data integration. As Connecticut continues to explore solutions to its own data challenges, these states serve as valuable references for best practices and lessons learned.
The speaker proceeded to list out the model approaches and best practices in quality improvement. There isn't a one-size-fits-all, but there is a general strategy that consists of performance measures as a foundation, frameworks for CQI, teams, and collaboratives drive improvement, as well as a dashboard for transparency and accountability. The speaker then briefly discussed Connecticut's data systems and partnerships, noting that additional details can be found on the CHDI website. These systems include the Quality Metrics Reporting and Service Delivery Performance Management and Evaluation system, the Provider Information Exchange and Evidence-Based Practice (EBP) Tracker, the Contractor Data Collection System (CDCS), the All-Payer Claims Database, the P20 WIN (Statewide Longitudinal Data System), and Connie, the state's Health Information Exchange (HIE). The speaker commended Connecticut for the strength of its last three systems, CDCS, P20 WIN, and Connie, highlighting that, when combined with strong expertise, this robust infrastructure and diverse array of data can greatly enhance ongoing efforts across the state.

The presenter briefly touched upon the additional CT partners and resources, such as OPM and the DAPA division, Office of Health Strategy, Children's Behavioral Health Plan Implementation Advisory Board's data integration workgroup, DataHaven, CTData Collaborative, State

Epidemiological Outcomes Workgroup (SEOW) prevention Data portal, and DPH's Connecticut School Health Survey. Overall, there are strengths in terms of a very strong state expertise in data governance, integration, and strong foundational infrastructure. As well as listing out robust data assets across agencies and partners, strong analytic and QI partners, as well as public dashboards. Along with the strengths, she also listed the gaps and opportunities, such as data availability possessing several challenges that limit a understanding of the population being served. Information, such as data on the uninsured, is often missing, and there are delays in accessing data like claims information. In addition, inconsistencies in data definitions and quality, along with incomplete participation from behavioral health providers across Connecticut, further limiting the comprehensiveness of available information. Significant gaps remain, including the lack of data on waitlists and service capacity, which points to areas needing improvement. Reporting dashboards are fragmented, and not all funded services have quality improvement process in place, making it difficult to effectively monitor and enhance service delivery.

Along with what was provided, the presenter also listed recommendations for improvement, such as, establishing a Children's Behavioral Health Data Workgroup that aims to bring together expertise and capacity to plan and support strategies that strengthen the state's behavioral health infrastructure while implementing robust reporting mechanisms to ensure accountability. The workgroup will focus on data infrastructure, quality improvement planning and implementation activities that support a whole-population approach through an equity lens. Its responsibilities include identifying data gaps, advancing consistent performance measures, supporting quality improvement processes, and ensuring that data is both accessible and actionable. The workgroup will be representative of key stakeholders, including members from TCB and CBHPIAB, youth and families with lived experience, state agencies, and relevant organizations, and will collaborate with OPM to support State Data Plan.

The speaker concluded with a series of recommendations, outlining workgroup priority activities within a three- to five-year plan designed to align with the goals of the TCB and broader state priorities. She emphasized the importance of establishing a regular reporting process to ensure ongoing progress and accountability. Initial activities include completing the data mapping process and leveraging existing systems to identify service and data gaps. The speaker also highlighted the need to identify performance measures that align with the TCB's strategic goals and state priorities, while prioritizing efforts to address critical gaps in data collection and strengthen the use of data for quality improvement (QI). For capacity building, she recommended exploring opportunities to leverage P20 WIN, the All-Payer Claims Database (APCD), and Connie for performance measurement, analysis, and evaluation. Additionally, she stressed the importance of developing and disseminating clear guidance on data sharing and consent. The speaker further encouraged promoting the creation of agency-specific dashboards and consolidating online behavioral health data reporting to streamline access and transparency. For long-term enhancements, she recommended developing additional public-facing dashboards, examining relevant laws and guidelines surrounding the use of artificial intelligence (AI) in

Connecticut, identifying ways to reduce administrative burden and improve practices, and maintaining strong accountability and transparency across systems.

In closing, the speaker highlighted several key takeaways for continued improvement. She emphasized that Connecticut has a strong foundation for data governance, integration, and analysis; however, continued effort is needed to strengthen the TCB's and state partners' capacity to use data effectively for decision-making and system improvement. She concluded by noting that the next steps in developing the state's data infrastructure should be guided by the goals and priorities of both the TCB and the State. Establishing a coordinated data workgroup—with broad representation from data experts and key stakeholders—will be essential to aligning efforts and advancing this work collaboratively.

Question and Answer Segment:

One of the members of the Tri-Chair expressed their appreciation for bringing up Connie as one of Connecticut's strengths and wanting to continue the partnership, as well as leveraging the children's behavioral health system. Another Tri-Chair member raised a question regarding Connecticut's partners and resources, asking about the website's engagement, specifically, the number of hits it receives, who is responsible for tracking the data and information, and how the site's connectivity is monitored. In response, the presenter shared insights from her experience working with other states, noting that many have developed dashboards capable of tracking web traffic and user engagement. She emphasized that designing tools tailored to specific tracking and data needs is the most effective way to begin strengthening data monitoring efforts.

A member of the TCB staff followed up by noting ongoing discussions within the Juvenile Justice field about data accessibility and usability. In collaboration with parents, the Office of Policy and Management (OPM), the Judicial Branch Court Support Services Division, and several committee members, a user guide was developed to address this concern. The guiding question behind its creation was: If dashboards are designed to be public and transparent, how effective are they if only a few individuals can understand them? How can we effectively understand these dashboards and make them useful?

Next Steps:

TCB reminded the committee of the schedule change for the November monthly meeting, noting that due to the upcoming special session, the meeting has been rescheduled to November 19th.