**FY 24 Budget Request Summaries & White Papers from the Field**



**Budget Requests**

* Maintain all current levels of FY23 funding
  + $33 million 31a7 (is now 31a6 in FY24 Governor’s Exec Rec)
  + 14.3 million 31n5
* Request for $25 million in one-time funding for infrastructure/technology/security/medical equipment upgrades
  + Included in Governor’s FY24 Exec Rec (Section 12b(1))
  + Requested from field through surveys from SCHA-MI
* Request for $10 million in one-time funding for uniform field data collection
  + Field has repeatedly said the way data is currently collected is an issue – no uniformity and sometimes hand collecting is necessary
* Request for $15 million in ongoing funding for the continued expansion of the CAHC network

**White Papers (Requests from the Field)**

* ***Mobility/Flexibility of Services***
  + **Problem**: The COVID-19 pandemic brought an onslaught of issues surrounding the health care world. Child and Adolescent Health Centers (CAHCs) have seen a multitude of issues unfold as the pandemic continues and as schools begin to return to what will be considered the “new normal”. Once of these issues is the lack of mobility of services that the current Child and Adolescent Health Center Program currently requires. The program was born with the idea that one center should serve the specific student population of the school in which the center is located. While this idea served the students well throughout the years, the health care world is changing its approach to serving patients, and CAHCs need to begin to follow this change.
  + **Request**: We would like the Department to consider allowing centers to be more flexible in seeing students in locations outside the brick-and-mortar building that the center is located. We ask that restrictions are removed on which school district building locations clinicians can provide services in and instead focus on the number of students served within the school district. This allows for more local control and collaborative work with the CAHCs and their school partners.
* ***Data Collection GAS, CRT, Workplans, and Financial Reporting***
  + **Problem**: Many centers are reporting concerns, sharing that the process to collect data for the GAS and primarily the CRT is heavily reliant on manual process to comb medical records to find diagnosis, follow-up, or other information not readily available through their EMR report templates. They also shared that customizing EMR reports is cost-prohibitive or not feasible because of how their systems are set up. A clearer understanding of the time, accuracy and necessity for reporting measures is needed.
  + **Request**: We ask that a Work Group convened that includes health center staff and SCHA-MI staff to explore revising the GAS, CRT, Finance and Work Plans data points to 1) agree as to the data being collected and 2) ensure annual impact data is available and accurately tells the story of the great work being done.
* ***Allowing Telehealth Visits for E3 Models***
  + Problem: Organizations that receive the MDHHS Child and Adolescent Health Center Program E3 Grant- Expanding, Enhancing, Emotional Health grant funding are finding it more and more difficult to meet the needs of their patients and adhere to the E3 requirements. Each E3 provides a full-time or full-time equivalent mental health provider (i.e., 40 hours) in one school building, year-round. Services provided are required to meet the current, recognized scope of mental health practice in Michigan and b) meet the current, recognized standards of care for children and/or adolescents. Services provided by the mental health provider are designed specifically for children and adolescents ages 5 through 21 years and are aimed at achieving the best possible social and emotional health status. During the COVID-19 pandemic, the demand for mental health services in school-aged children has skyrocketed, however, healthcare organizations throughout the nation have experienced various barriers to meeting the demand. This paper will outline the advantages and lessons learned from the pandemic. The conclusion is that all parties involved with the E3 model of service benefit from this approved scope of mental health practice.
  + **Request**: We respectfully request the Department to consider allowing and supporting the mental health providers at E3 locations to continue utilizing virtual care in perpetuity for the patients who prefer it.

* ***Updating User/Visit Definitions***
  + **Problem**: Following the COVID-19 pandemic, many schools are facing decreasing enrollment. Child and Adolescent Health Centers (CAHCs) have traditionally serviced students ages 5-21, with most clients referred from the building or district in which the center is housed. In fact, some districts have elected to offer School Wellness Programs rather than full Clinical models because they only wanted to serve their own students and did not want individuals from outside of their district to visit clinics within their school buildings. CAHCs are tasked with meeting minimum unduplicated user and visit requirements as a contractual obligation. Sponsoring agencies have expressed concerns about meeting these numbers. Decreasing enrollment adds another challenge to barriers CAHC clinics face as they work to meet unduplicated user and visit metrics.
  + **Request**: We would like the Department to consider allowing centers to revise unduplicated user and visit definitions to be more inclusive of the range services provided to students within the districts they serve and to include all student interactions. This will allow CAHCs to serve their partner school districts more fully capture both the scope and number of clients and visits.