Request for Application (RFA): Rural Health Transformation Program Funding Opportunity to Rapid Response to Recovery – CMHC Support

A series of RFAs will be issued over the lifecycle of the Rural Health Transformation Program (RHTP) grant related to Kentucky's five priority programs. During the initial five years of funding for the Rural Health Transformation Plan, Kentucky RHT will utilize procurement methods permitted under Kentucky Revised Statutes Chapter 45A, Finance and Administration Cabinet policies, and approvals from the Centers for Medicare & Medicaid Services. Multiple procurement methods and phases may be used for each initiative. For more information on Kentucky's plan, visit our website: Kentucky Rural Health Transformation.

Applications for this funding opportunity will be considered on a rolling basis. Please submit responses to <Breanna.mcginnis@ky.gov> by June 26, 2026 to be considered for funding available October 1, 2026.

I. Context and Background

The Commonwealth of Kentucky has been awarded funding through the Centers for Medicare & Medicaid Services (CMS) Rural Health Transformation Fund (RHTF). This investment will empower Kentucky to launch and implement its Rural Health Transformation Plan (RHTP), a community-driven strategy to expand access and improve health outcomes for rural residents across the Commonwealth[1].

Our Plan

Kentucky's RHTP launches five interrelated programs designed to build rural health infrastructure and provide sustainable, long-term improvements. This plan directly supports Kentucky's rural counties while advancing statewide impact through innovation, technology-enabled care and strengthened workforce recruitment pipelines for both clinical and non-clinical staff. This strategy will help build a resilient, integrated and technology-forward health system across the Commonwealth.

1. Rural Community Hubs for Chronic Care Innovation: Establishes local "hub-and-spoke" collaboratives focused on obesity and diabetes prevention and management. These hubs will integrate nutrition, physical activity programs, and digital self-management tools.

[1] For more information on this funding opportunity, see Governor's Beshear's press release, the CMS Notice of Funding Opportunity, and federal assistance listing 93.798—Rural Health Transformation Program on Grants.gov.

2. PoWERing Maternal and Infant Health: Expands timely prenatal and postpartum care by deploying telehealth-enabled maternal care teams who will serve maternity-care deserts and high-risk regions, to help mothers and infants receive seamless, high-quality support.
3. Rapid Response to Recovery: Deploys technology-enabled crisis stabilization and mobile behavioral health response teams to connect individuals with community-based treatment and recovery supports.
4. Rooted in Health: Rural Dental Access: Increases access to preventive oral health services through expanded dental hygiene training programs, externships, and investment in Public Health Dental Hygiene (PHDH) teams in Local Health Districts (LHDs).
5. Crisis to Care: Integrated Emergency Medical Services (EMS) Response and Coordination: Enhances pre-hospital capacity and trauma coordination through treat-no-transport protocols, improved data connectivity and workforce training for rural EMS providers.

About the Program

This project is 100% funded by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (HHS) for a total of $212.9 million in budget year 1 with 100% by CMS/HHS. The RHTF grant spans five budget periods aligned with federal fiscal years (FY2026–FY2030). Funding is disbursed annually by CMS based on achievement of performance metrics.

Rapid Response to Recovery (RRR):

Rural Health Transformation has a goal of transforming our rural public health system, resulting in measurable systems change and population health differences. Because of this vision, RHT is approaching this funding opportunity through a series of crisis and prevention service programs under the Rapid Response to Recovery Program:

1) Hospital-based EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing) expansion and enhanced engagement in follow-up services,
2) Community-based crisis response including EMS and paramedicine models, and
3) A telebehavioral health hub with enhanced connection to primary care organizations.

The Rapid Response to Recovery (RRR) program seeks to strengthen the statewide behavioral health crisis continuum by supporting timely stabilization, continuity of care, and recovery following crisis events.

While there are three distinct programs under the Rapid Response to Recovery Program, Rural Health Transformation represents a unique opportunity to strengthen a welcoming and hopeful crisis behavioral health system for those individuals who are the most under-resourced and have the highest acuity-needs.

Overarching goals of the Rapid Response to Recovery Program are:

- Diversion of behavioral health crises from emergency departments and hospital admissions, reducing undue strain on rural hospitals and offering appropriately matched interventions for individuals experiencing crisis

- Increasing follow-up care engagement after individuals have experienced a crisis, keeping them engaged in services to reduce readmissions and crises episodes by creating a well-designed system that welcomes that person into care and eliminates retention barriers
- Improving "front door access" to high quality behavioral health services by meeting individuals where they are, whether that be through at-home or in-the-field care by paramedicine teams or through collaboration with primary care providers
- Welcoming all first responders into a partnership, improving the capacity of rural emergency services and law enforcement to meet community needs by prioritizing collaborative planning and design, specialized training and protocol development, crisis response skills, alternative transportation practices, and connection into the most appropriate level of care

II. Program Objectives

Hospital-based EmPATH expansion and community-based crisis response focus areas of the Rapid Response to Recovery program represent a key opportunity to coordinate a broader system-of-care strategy, enabling CMHCs to tailor RHT-funded work to address unique community needs.

Community Mental Health Centers, as the statewide behavioral health safety net, are uniquely situated to strengthen the behavioral health crisis continuum by: facilitating a process to plan, coordinate, and oversee elements of a crisis system; coordinating with system partners for community assessment and planning; coordination and interconnectedness of services; and data-driven continuous quality improvement.

Rural Health Transformation has a long-term vision of enabling systems change to increase our ability to serve entire populations through enhanced partner collaboration, as opposed to serving individuals as single providers. We encourage applicants to think about the following framework when developing their responses:

- Improving outcomes for the entire crisis system, so that every person receives the right service in the right setting, every time
- Promotion and adoption of enhanced data-sharing technology, agreements, data collection and reporting processes, and real-time information sharing between different system partners as a person moves through the crisis care journey;
- Facilitation of a data-driven quality improvement process, tracking quality outcomes and performance measures and strategizing amongst system partners for improving measures of success, access, and quality;
- Collaboration through shared care planning, policy, protocols, and procedure development; engagement in collaborative structures such as coalitions, committees, workgroups; and moving beyond siloes to ensure people receive the right care at the right time;
- Advancement of clinically effective crisis services across partners, while closing safety net gaps to strengthen prevention, early identification, and access to behavioral, physical, and social supports, primarily through improvements in crisis transitions, continuity of care, and cross-system coordination following crisis events.

The minimum set of system partners to engage in the Rural Health Transformation effort includes law enforcement, EMS, paramedicine teams, mobile crisis response teams, quick response teams, 988, 911, hospitals, behavioral health organizations, community-based organizations, social services, and more. There will be complimentary funding opportunities for hospitals, EMS agencies, and community paramedicine programs.

Applicants should use this framework to inform the specific response prompts and program focus areas outlined below. Responses should remain clearly tied to the allowable uses of funds under the Rapid Response to Recovery Program.

We kindly request that all community partners who are interested in funding work collaboratively on applications. Please consider aligning your design and funding requests as part of a larger community partner effort. Funding requests should be designed to innovatively address gaps in the system, solve barriers to access or quality of care, and ultimately address high-priority population health outcomes in alignment with the Rapid Response to Recovery purpose.

III. Eligible Applicants

- Kentucky's 14 Community Mental Health Centers (CMHCs, Provider Type 30), as the regional boards established pursuant to KRS 210.370-210.480 as the planning authority for behavioral health programs, can apply for grants under this program.
    - **Program 1 Eligibility:** Eligibility for funding to support EmPATH is limited to centers within the counties for which the Board is duly recognized as the Regional Community Mental Health Center of the initial pilot hospitals. For Year 1 funding, these include **Cumberland River Behavioral Health, Kentucky River Community Care, Mountain Comprehensive Care Center, and Pathways.** This will be expanded statewide in later years.
    - **Program 2 Eligibility:** Eligibility for funding to support the Community-Based Crisis Response is **open to all applicants statewide.**

- Applicants must have or must establish a vendor code with the Kentucky Secretary of State if awarded. For more information visit Kentucky Business One Stop.
- Applicants must have or must establish a vendor code from the Finance Cabinet if awarded. For more information visit eProcurement - Finance and Administration Cabinet.

**Please be prepared to provide documentation within ten (10) business days of award notification

IV. Timeline

This funding opportunity will be offered on a **rolling application basis**. Agencies seeking to receive funding in Budget Period 1 (BP1) must submit their application by **Friday, June 26, 2026.**

- June 1, 2026: RFA Released
- June 26, 2026: Deadline for Receipt of Applications
- July 10, 2026: Notification of Award to Grantees
- October 1, 2026: Funding Period Begins*

*Organizations will be required to report on RHTP implementation progress periodically throughout the funding period. Additional reporting guidance will be provided as CMS requirements are further determined.

V. Program Standards

Funded agencies must demonstrate a willingness and commitment to adhere to various regulatory standards:

1. **Program Leadership and Effectiveness:** Programs must demonstrate defined leadership responsibilities, systematic planning, performance monitoring, and alignment with the agency mission and community needs.
2. **Clinical Program Design and Scope of Services:** Programs must define the scope of services to be delivered in alignment with RHT goals and outcomes.
3. **Administration, Staffing, and Training:** Agencies must demonstrate adequate staffing, training, and supervision to support programmatic goals and scope of services.
4. **Patient Safety and Quality Assurance:** Programs must comply with all applicable health, safety, and infection control standards and maintain quality assurance and improvement processes to ensure safe, ethical, and effective patient care.

The standards below describe the expectations against which proposed activities will be assessed. Applicants should address these expectations within the applicable response sections and are not required to submit a separate narrative for each standard.

VI. Allowable Uses of Funds

Applicants must submit a detailed, itemized budget and budget narrative that clearly ties proposed costs to program activities and expected outcomes. All costs must be reasonable, necessary, and allocable to the approved project period.

Allowable budget categories may include:

- Personnel and fringe benefits
- Training and professional development
- Supplies

- Equipment
- Technology and software
- Travel
- Other direct costs

Capital construction is not allowed. Minor, program-related space modifications may be allowable where necessary to support service delivery and must be clearly justified.

Grant funds may not be used to supplant existing funding or replace currently funded services. Funds may be used to expand capacity, enhance service delivery, or support new or augmented activities aligned with RRR goals.

The anticipated budget ceiling for CMHCs in eastern Kentucky supporting all both focus areas is approximately $800,000 - $1,200,000. The anticipated budget ceiling for CMHCs that are only supporting first responder training is approximately $400,000.

Program Focus Area 1: EmPATH

Purpose: Funds may be used to support rapid follow-up, engagement, and continuity of care for individuals discharged from EmPATH, while situating EmPATH follow up within a broader crisis continuum that includes 988, mobile crisis, and other crisis stabilization touchpoints.

Allowable Budget Categories and Examples:

- Personnel
    - Care coordinators, engagement specialists, peer support specialists, community health workers, office managers, or similar roles supporting rapid follow-up care
    - Additional licensed clinicians, including but not limited to social workers, counselors, or psychiatric providers, to expand hours and coverage
    - Proportionate supervisory and administrative support directly tied to the program
- Training
    - Onboarding and required clinical or peer certification training
    - Trauma-informed care, crisis follow-up models, and related workforce development
- Supplies
    - Office and clinical supplies required to support follow-up visits and engagement activities
- Equipment and Technology
    - Connectivity tools to support coordination with hospitals or emergency departments
    - Secure communication systems
    - Scheduling or care coordination tools

- Other Direct Costs
    - Light, program-related space modifications, such as repurposing existing office space to support rapid follow-up visits
    - Security or access-related upgrades needed to support safe service delivery
    - Technology infrastructure upgrades necessary to support connectivity and data sharing
    - Transportation costs directly supporting EmPATH or crisis follow-up engagement (e.g., post-discharge appointments) are allowable and should be coordinated with hospital partners. Transportation related to emergency or large-scale crisis transport may be addressed through separate funding opportunities.

Program Focus Area 2: Crisis Response EMS Training and Care Coordination

Purpose: Funds may be used to support CMHC-led training, coordination, and integration activities for community-based crisis response in partnership with EMS agencies.

Allowable Budget Categories and Examples

- Personnel
    - Training staff and trainers
    - New or expanded roles supporting EMS coordination, such as community health workers or care coordinators
    - Proportionate planning, advisory, and project management staff
- Training and Curriculum Development
    - Train-the-trainer model costs
    - Curriculum development, instructional design, and training materials
    - Delivery of in-person or virtual trainings to all registered EMS agencies during the first project year
- Certification and Continuing Education
    - Costs associated with certifying training through KBEMS
    - Continuing education requirements related to crisis response and integrated care
- Travel
    - Travel necessary to deliver trainings across service areas
    - Travel necessary to participate in train-the-trainer trainings
- Supplies and Materials
    - Training materials, manuals, and participant resources
- Care Coordination and Integration Costs
    - Initial onboarding and integration of new roles into EMS and crisis workflows
    - Tools or workflows supporting referral, handoff, and follow-up activities

VII. Funding Timeline

Applicants may apply for funding to support one or both program focus areas described in this RFA. Award amounts will vary based on the scope, scale, and mix of activities proposed. The funding agency reserves the right to fund proposals in whole or in part and to negotiate final funding amounts and scope of work.

This RFA will prioritize programs that demonstrate high readiness to begin implementation and expend the majority of funds between October 1, 2026 through September 30, 2027. Future funding opportunities with similar scope (expansion of pilot sites, continuation of funding) will be available in future years of the RHTP grant, however those grant opportunities will be tied to future budget periods.

Programs applying for funding available October 1, 2026 should submit budgets and implementation plans aligned to the timeframes outlined below (i.e., indicating what deliverables or milestones in the project plan and budget will be completed by the end of Year 1). **Funds must be used within their assigned funding period and cannot carry over. All funds must be spent by September 30, 2027.**

- **Funding Year 1 Period:** October 1, 2026 (award date) – September 30, 2027
- **Funding Year 2 Period:** October 1, 2027 – September 30, 2028
- **Funding Year 3 Period:** October 1, 2028 – September 30, 2029

Continuation beyond Year 1 is optional and not automatic. Organizations that meet required implementation, performance, training, and reporting requirements may opt in to a second year of funding through a streamlined application, with eligible costs supported at up to 100%. Funding in subsequent years is subject to a phased cost share model and funding availability. Additional funding beyond the five-year RHT period of performance is cost-shareable, subject to CMS funding allocations.

VIII. Funding Limitations

This funding opportunity is subject to restrictions from CMS per federal guidance.[2] If awarded, applicants will be expected to execute the grant agreement in compliance with federal rules, laws, and regulations and specific requirements established by CMS.

- **Funding will be tapered down over time:** Kentucky's intent is that grant dollars help build near-term capacity and operational readiness, then step down as the model stabilizes and partners transition to longer-term financing

[2] For more detail on funding limitations, reference the CMS Notice of Funding Opportunity, CMS Frequently Asked Questions, and CMS Notice of Award.

- **The model is expected to transition toward sustainability:** RHTP is explicitly designed as system transformation and is not intended to fund activities that are unsustainable after the program ends; awardees will be expected to maintain and periodically update a sustainability plan that may include items such as:
    - How core roles/functions will be maintained as grant funding tapers
    - How partner workflows / referral pathways will be embedded into routine operations
    - How the CMHC will coordinate with partners to support longer-term financing
- **Reporting is a condition of award:** Awardees will be required to participate in program monitoring and to submit complete, timely reports in the format and cadence defined in the contract
- **RHTP funding is organized into five budget periods (FY2026–FY2030):** Across RHTP, budget periods are awarded annually and are structured with an extended spending window (i.e., budget periods are awarded annually, with additional time to fully expend funds)
- **There are expectations around expenditure of funds:** It is imperative to maintain clear documentation that funds are supporting transformation work and are not duplicating or replacing other billable clinical services

This RFA is competitive, and all applicants may not be funded. DPH reserves the right to modify or reduce funding based on program performance, progress toward stated objectives, or availability of appropriate staffing support.

IX. Response Scoring

Applications will be scored on a cumulative basis, with total points calculated by summing scores across all applicable sections of the rubric. Applicants will not be penalized for having existing capacity or services in place, provided the application clearly articulates how requested funds will expand, enhance, or better integrate those services to achieve RRR outcomes. Applicants may describe the broader crisis system context for clarity; however, scoring will focus on activities for which funding is requested under this RFA. A detailed overview of the application structure is included below in Section X. Application Instructions.

5 Points Design Layout

- (1 points) Is the application formatted as one Adobe PDF?
- (2 points) Does the application include a cover page with all listed requirements? AND Is the application in Times New Roman 12-point font, single line spacing.
- (2 points) Is the application structured using the same section headers listed in the Application Instructions of this RFA?

10 Points Section A: Executive Summary

- 10 = Provides a clear, concise, and well-organized executive summary that comprehensively addresses all required elements. Proposed activities are clearly described, well aligned with RRR RHT program objectives, and appropriate in scope. Core activities are clearly articulated and integrated. The service area is clearly defined by county or region. Relevant partner organizations are identified, and populations served are clearly described in relation to the proposed activities.
- 5 = Addresses the required elements but with gaps in clarity, specificity, or completeness. Proposed activities or core services may be described at a high level or incompletely. The service area, partner organizations, or populations served may be identified but lack sufficient detail or clear linkage to the proposed use of funds.
- 0 = Executive summary is missing, exceeds length requirements, or does not adequately address the required elements of the section.

15 Points Section B: Project Narrative

- 15 = Provides a clear and well-organized project narrative that explains the purpose and structure of proposed RRR-funded activities. Clearly describes implementation approaches for applicable focus areas, including EmPATH follow-up services and EMS behavioral health training. Demonstrates how services will be delivered at scale, coordinated with community partners, and targeted to address identified gaps in crisis transitions, follow -up care, or behavioral health readiness. Describes how requested funding will complement existing focus areas of the applicant's system.
- 8 = Provides a general project description, but with gaps in clarity, completeness, or integration across focus areas. Implementation approaches, scale, partnerships, or service gaps are described at a high level or unevenly across proposal elements.
- 0 = Does not provide a coherent project description or does not adequately explain proposed activities, implementation approach, or how the project addresses identified service gaps.

10 Points Section C: Service Provisions and Care Coordination

- 10 = Clearly demonstrates how proposed activities advance RRR priorities, including rapid crisis stabilization, reduced unnecessary ED utilization, and improved continuity of care following crisis events. Clearly describes concrete processes for coordinating follow-up care and warm handoffs across EmPATH units, CMHC services, EMS, and mobile crisis. Describes an integrated service approach for addressing co-occurring mental illness and substance use disorders.
- 5 = Addresses service provision and care coordination at a high level, but with gaps in clarity, detail, or cross-system integration. Alignment with RRR goals, continuity of care processes, or integrated behavioral health approach is described but not fully articulated.

- 0 = Does not adequately describe service provision, care coordination, alignment with RRR goals, or the approach to addressing co-occurring mental illness and substance use disorders.

5 Points Section D: Data Collection and Reporting

- 5 = Clearly describes a feasible approach to collecting and reporting data. Demonstrates readiness to track implementation and engagement as applicable, align with shared reporting expectations, and participate in required data sharing or quality improvement efforts. Identifies priority metrics relevant to the proposed activities.
- 3 = Describes data collection and reporting at a high level, but with limited detail, unclear feasibility, or incomplete alignment with shared reporting or quality improvement expectations.
- 0 = Does not adequately describe an approach to data collection or reporting or does not demonstrate readiness to participate in required reporting or quality improvement efforts.

5 Points Section E: Special Populations

- 5 = Clearly describes how proposed activities are tailored to address the needs of special populations, including individuals with high acuity, frequent crisis utilization, or complex social needs. Demonstrates an understanding of barriers faced by these populations and how services will be adapted to support engagement, stabilization, and continuity of care.
- 3 = Acknowledges special populations but provides limited detail on how services will be tailored to meet their specific needs or address identified barriers.
- 0 = Does not adequately address the needs of special populations or does not describe how proposed activities will be adapted for these groups

10 Points Section F: Workforce and Training

- 10 = Clearly describes staff qualifications, licensure, and experience supporting proposed activities, including EmPATH follow-up services and EMS behavioral health training, as applicable. Demonstrates sufficient trainer credentials, realistic train-the-trainer or certification plans, and appropriate staffing models. Describes ongoing staff development, supervision, and support to ensure service quality and sustainability.
- 5 = Describes workforce and training capacity at a high level, but with gaps in detail, role clarity, or readiness. Staff qualifications, training plans, or supervision approaches are described but not fully developed or aligned to proposed activities.
- 0 = Does not adequately describe workforce capacity, staff qualifications, or training approach necessary to support proposed activities.

5 Points Section G: Access and Nondiscrimination

- 5 = Clearly describes how the program will ensure accessible and nondiscriminatory service delivery, including strategies to address language access, disability, and other barriers. Describes use of plain language in client materials and communication and explains how reasonable accommodation and language access services will be coordinated when needed.
- 3 = Describes access and nondiscrimination at a high level, but with limited detail on how barriers will be addressed, how plain language will be used, or how accommodation and language access will be coordinated.
- 0 = Does not adequately describe how the program will ensure access or nondiscriminatory service delivery.

5 Points Section H: Partnerships and Community Engagement

- 5 = Clearly describes how the organization will engage crisis system partners in ongoing collaboration and continuous quality improvement activities. Demonstrates a clear approach to engaging individuals with lived experience in the planning, implementation, and evaluation of RHT programs.
- 3 = Describes partnerships or lived experience engagement at a high level, but with limited detail on role, frequency, or how engagement will inform program improvement.
- 0 = Does not adequately describe partner engagement, continuous quality improvement activities, or engagement of individuals with lived experience.

10 Points Section I: Sustainability Plan

- 10 = Provides strong plan for financial viability post-RHTP, including identification of alternative funding sources or revenue mechanisms to support the program beyond the grant period.
- 5 = Alternative funding resources or revenue mechanisms to support the program beyond the grant period are identified, but do not appear fully sufficient.
- 0 = Plan for financial viability post-RHTP is not adequately demonstrated.

10 Points Section J: Budget and Budget Narrative

- 10 = Budget reflects a sound understanding of program needs and available resources, with costs appropriately scaled to reflect planned programming and staffing.

- 5 = Budget is mostly appropriate but leaves gaps in cost justification, resource alignment, or funding continuity
- 0 = Budget does not demonstrate financial viability, includes unclear or misaligned costs, or fails to meet program requirements.

10 Points Section K: Implementation Timeline

- (5 points) Are milestones detailed enough to be actionable?

    - 5 = Milestones are clearly defined and time-bound, with specific activities, responsible parties, and sequencing that demonstrate readiness for implementation.
    - 3 = Milestones are identified but lack sufficient detail, clarity, or linkage to specific activities or responsible parties.
    - 0 = Milestones are vague, incomplete, or not provided.

- (5 points) What is the feasibility of the proposed timeline?

    - 5 = Timeline is realistic and feasible given staffing plans, infrastructure readiness, and scope of services, and demonstrates the ability to initiate services within the proposed timeframe.
    - 3 = Timeline appears generally feasible but includes assumptions or dependencies that are not fully addressed.
    - 0 = Timeline is not feasible, internally inconsistent, or does not align with program requirements.

X. Application Instructions

Design Layout (5 points)

Applicants should submit the following information as a clearly labeled application packet to Breanna McGinnis Breanna.mcginnis@ky.gov **by June 26, 2026** for funding available October 1, 2026:

1) Application Information:
    a. Name of organization
    b. Name, title, and email address of main point(s) of contact
2) An application narrative **not to exceed ten (10) pages** that responds to the requested information in Sections A – L listed below. If eligible and applying for more than one focus area, the application narrative is **not to exceed 25 pages.**
3) Supporting documentation not included in the ten (10) pages:

a. Letter(s) of support (*strongly encouraged*)
b. Budget for FY27 using the provided budget template ("Attachment A")

SECTION A: Executive Summary (10 points)

Applicants must provide a one-page executive summary describing their proposed use of RRR RHT funding to support behavioral health crisis response and recovery in their service region. Please use Section headers and bolded key components to organize the responses (A, B.1.1,B.2 etc.). Only information included in the section will be considered by reviewers.

The executive summary must include:

1) Program Overview: A brief description of the CMHC's proposed activities under this RFA, including EmPATH follow-up services and behavioral health training for EMS agencies participating in the Community Paramedicine RFA
2) Core Activities: A summary of services to be supported, including EmPATH follow-up care, care coordination, training delivery, technical assistance, and regional coordination
3) Service Area: The geographic area to be served, by county
4) Partner Organizations: Hospitals with EmPATH units, EMS agencies, and other crisis continuum partners involved
5) Populations Served: Individuals stabilized through EmPATH units and EMS personnel receiving behavioral health training

SECTION B: Project Narrative (15 points)

Applicants must provide a clear, organized description of their proposed RRR project.

B.1 Overall Project Description: Describe the purpose, structure, and implementation approach for your RRR funded activities.

1. EmPATH Follow-Up Service Plan: Describe how your organization will:
   - Receive warm handoffs from EmPATH units prior to discharge Where specific workflows are still under development (e.g., EmPATH unit operations), applicants may describe anticipated or proposed approaches and should note assumptions. Final workflows will be refined in coordination with hospital partners.
   - Coordinate follow-up care while the individual is still in the EmPATH unit
   - Reduce duplicative intake and assessment processes
   - Provide short-term stabilization and bridge services for approximately 4–6 weeks post discharge
   - Ensure follow-up contact within 3 days, 7 days, and weekly until longer-term care is established, with a prescriber

2. **EMS Behavioral Health Training Plan:** Describe how your organization will deliver required behavioral health training to EMS agencies, with optional supplemental trainings delivered at the discretion of the CMHC training team based on regional needs and readiness including:
    - Training topics and curriculum approach
    - Staffing and credentials of trainers
    - Scheduling and coordination with EMS agencies
    - Approach to serving both first responders and community paramedicine staff

B.2 Populations and Scale: Describe the anticipated volume of:

- EmPATH discharges supported annually
- EMS personnel trained during the grant period

Community Partnerships: Identify partner hospitals, EMS agencies, and other crisis continuum partners, and describe coordination mechanisms.

Service Gaps Addressed: Identify current gaps in crisis transitions, follow-up care, or overall behavioral health readiness and explain how proposed activities address them.

SECTION C: Service Provision and Care Coordination (10 points)

1) Alignment with RRR Goals: Describe how proposed activities advance RRR priorities:
    - Rapid behavioral health crisis stabilization
    - Reduced unnecessary ED utilization
    - Improved continuity of care following crisis events
2) Continuity of Care and Warm Handoffs: Explain how follow-up care will be coordinated across EmPATH units, CMHC services, EMS, and mobile crisis.
3) Integrated Behavioral Health Approach: Describe how services will address co-occurring mental illness and substance use disorders.

SECTION D: Data Collection and Reporting (5 points)

Applicants must describe their approach to data collection and reporting, including:

1) Tracking EmPATH follow-up engagement and continuity indicators
2) Tracking EMS training delivery and completion

3) Participation in shared data or quality improvement efforts, as required by RHTP and RRR
4) CMHC identified metrics of priority

Specific reporting requirements will be outlined in the award contract.

SECTION E: Special Populations (5 points)

Describe how your program will meet the needs of special populations served through RRR encounters, including individuals with high acuity behavioral health needs, frequent crisis utilization, or complex social needs.

SECTION F: Workforce and Training Capacity (10 points)

Applicants must describe:

1) Staff qualifications and licensure supporting EmPATH follow-up
2) Trainer credentials for EMS behavioral health training
3) Train-the-trainer plans and certification timelines
4) Ongoing staff development and supervision

SECTION G: Access and Nondiscrimination (5 Points)

Applicants must ensure communication access is provided using the method preferred by the client, including the availability of qualified in-person interpreters when requested, as well as telephonic or video interpretation services, consistent with accessibility and nondiscrimination requirements.

Briefly describe how your program will ensure access for all eligible clients and nondiscriminatory service delivery, including: (Limit this section to less than one page.)

1) How clients can obtain services regardless of language, disability, or other barriers.
2) How program materials and communication will use plain language that clients can easily understand.
3) How you will coordinate reasonable accommodation and language access when needed.

SECTION H: Partnerships and Community Engagement (5 Points)

Describe how your organization will engage in the following activities for Rural Health Transformation programing:

1) Engagement of crisis system partners in a continuous quality improvement partnership. Applicants must describe how key partnerships will be formalized or sustained over time (e.g., MOUs, shared protocols, recurring governance structures), particularly as grant funding tapers.

2) Engagement of individuals with lived experience in the planning, implementation, and evaluation of RHT programs

Applicants must include a table of active community partners that identifies each partner's role in the proposed program and the current level of collaboration, using the SAMHSA Levels of Collaboration framework (Networking, Coordinating, Cooperating, Collaborating).

Section I: Sustainability Plan (10 points)

Applicants must describe their approach to sustaining core program activities as RHT funding tapers over time. A fully developed long-term financing model is not required at the application stage.

Applicants must address the following:

1) Approach to sustaining core functions as grant funding tapers, including how key roles or activities will be maintained, adjusted, or transitioned.
2) Integration of funded activities into routine operations or partner workflows to reduce reliance on grant funding over time.
3) Key assumptions or risks affecting sustainability and how the organization plans to monitor and adapt over the course of the program.
4) Commitment to ongoing refinement of a sustainability plan, including annual updates as the RHT program progresses.

SECTION J: Budget and Budget Narrative (10 Points)

Applicants must submit a budget – using a DPH budget form – and narrative describing:

1) Costs related to EmPATH follow-up services
2) Costs related to EMS behavioral health training delivery
3) Allowable travel, materials, and technology expenses

Section K: Implementation Timeline (10 Points)

Applicants must submit a high-level implementation timeline describing:

- High-level implementation timeline that describes anticipated milestones across the proposed period of performance. Milestones should demonstrate readiness to implement proposed activities and alignment with the phased rollout of Rapid Response to Recovery Program.
- Anticipated expenditure of funds by the end of BP1, September 30, 2027.

Thank you for your interest in applying for funding through the Rural Health Transformation Program to support the expansion and modernization of behavioral health services. We value your commitment to expanding care coordination and alternative destination transport in Kentucky.

Please note that applications will be reviewed on a rolling basis, but applications received after the deadline will not be guaranteed consideration for funding available October 1, 2026.

Appendix 1 – EmPATH Follow-Up and Partnership

Overview of EmPATH Units

EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing) units are hospital-based psychiatric care environments designed to provide rapid psychiatric evaluation, treatment, and stabilization for individuals experiencing behavioral health crises. EmPATH units rely on multidisciplinary care teams to emphasize:

- Timely psychiatric assessment and medication management
- A therapeutic, low-stimulation environment
- Initiation of interventions and care such as crisis intervention, individual or group therapy, and peer support services
- Short-duration stays (~23 hours or less) focused on stabilization rather than admission
- Efficient throughput to reduce ED congestion and inpatient admissions
- Enhanced discharge and after-care planning and coordination

EmPATH units are not intended to replace community-based crisis or outpatient services, but rather to function as a specialized stabilization setting within the broader crisis continuum. Added benefits include increased diversion to EmPATH as opposed to emergency departments for crisis partners such as law enforcement and EMS agencies who are typically expected to transport or direct individuals to hospital-based settings. EmPATH units have an open-door policy, accepting individuals who need to go through medical clearance or withdrawal management, individuals with both mental illness and substance use disorder, and individuals with intellectual or developmental disabilities.

In the first year of RHT, the Commonwealth intends to fund EmPATH units in Eastern Kentucky. Eligibility for CMHC funding to support EmPATH is limited to centers within the respective service areas of these hospitals and neighboring regions with satellite ED sites. These include Cumberland River Behavioral Health, Kentucky River Community Care, Mountain Comprehensive Care Center, and Pathways. In subsequent years, the Commonwealth anticipates expanding EmPATH units statewide, with corresponding expansion of CMHC funding eligibility.

EmPATH Follow-Up Model for CMHCs

This appendix describes expectations for CMHC readiness and capacity to support follow-up and care coordination for individuals stabilized through EmPATH units. The focus of this model is intentionally anchored in EmPATH follow-up and strong hospital-based alignment. Applicants are encouraged to apply strategic interventions for improving follow-up and retention rates for EmPATH in coordination with similar activities across other crisis touchpoints (e.g., 988, mobile crisis response, CMHC crisis services). All follow-up engagement strategies should align with the shared goal of reducing avoidable emergency department and inpatient admissions by improving continuity of care as well as offering community bridge care and stabilization through retention and ongoing engagement.

As EmPATH units are phased in over time, CMHCs are expected to establish and strengthen processes for proactive follow-up and care coordination for individuals who utilize crisis services, with initial emphasis on readiness and workflow development in advance of EmPATH unit operations and full integration as units become operational.

Following stabilization in an EmPATH unit, individuals require timely connection to community-based behavioral health services to support recovery and prevent unnecessary return to the emergency department. Follow-up care is intentionally designed to move beyond a traditional referral model toward what clinical leadership describes as a "warm hold-on."

Applicants should propose a follow-up model that moves beyond traditional referrals toward an active, coordinated transition of care. Anticipated elements include:

- Receiving warm handoffs from EmPATH units prior to discharge
- Coordinating follow-up scheduling and engagement while the individual is still in the EmPATH unit
- Utilizing information collected during the EmPATH encounter to reduce duplicative intake and reassessment
- Supporting follow-up touchpoints by a prescriber within 3 days of discharge from an EmPATH unit
- Providing short-term stabilization and bridge services, inclusive of medication management by a prescriber, for 4 to 6 weeks post-discharge or until that individual is able to enter ongoing care
- If the individual chooses to see another provider organization but has a wait time for services, offering bridge-care until that individual enters into treatment with their preferred provider, and conducting seamless transfer coordination to the provider
- Delivering services through outpatient, urgent care, bridge clinic, crisis, care coordination, and peer support
- Addressing barriers that prevent individuals from engaging in follow-up care after EmPATH, ED, or hospital discharge

CMHCs may implement these services through existing outpatient sites, dedicated follow-up spaces, or hybrid in-person models, depending on regional needs and capacity.

Role Expectations

As EmPATH units expand statewide, applicants are expected to function as core partners in the recovery and follow-up phase of crisis care. Anticipated CMHC roles may include:

- Receiving referrals and warm handoffs from EmPATH units following stabilization
- Delivering or coordinating follow-up services, including clinical care, care coordination, peer support, and recovery services across 100% of EmPATH discharges
- Participating in shared care pathways that clarify appropriate routing between CMHC crisis services, mobile crisis, EMS, EDs, and EmPATH units

- Embedding a care coordinator or engagement specialist in the hospital's EmPATH unit or into regional emergency departments connected to EmPATH units
- Participate in EmPATH coordination and learning activities, including regional or statewide consortium efforts
- Monitor follow-up engagement and continuity outcomes to support quality improvement

Support Provided

Funding is intended to build and sustain the behavioral health safety net's capacity to partner with hospitals operating EmPATH units, support timely follow-up, and strengthen coordination across the crisis-to-recovery continuum. Applicants are expected to tailor implementation approaches to regional needs, existing infrastructure, and hospital partnerships.

Allowable support under this RFA may include, but is not limited to:

- Staffing to support EmPATH follow-up, including prescribers, clinicians, care coordinators, engagement specialists, peer support specialists, or other roles necessary to receive warm handoffs and ensure timely connection to community-based services
- Staff time to coordinate follow-up planning while individuals are still receiving care in the EmPATH unit, including scheduling, care transitions, and information transfer to reduce duplicative intake and assessment
- Capacity to provide short-term stabilization and bridge services following EmPATH discharge, including outpatient, urgent care, crisis, peer supports
- Participation in shared care pathway development and refinement with hospitals, EMS agencies, mobile crisis teams, and other crisis continuum partners
- Regional coordination activities, including cross-partner planning, protocol alignment, and problem solving related to crisis transitions and follow-up workflows
- Technology and tools that enable secure information sharing, care coordination, outcomes tracking, and quality improvement across EmPATH and CMHC partners
- Training and onboarding costs for staff supporting EmPATH follow-up, including orientation to EmPATH workflows, hospital coordination processes, and crisis to recovery models
- Travel and related costs associated with onsite coordination with hospitals, partners, or EmPATH units, as appropriate

Applicants are encouraged to describe how funded roles and resources will be integrated into existing service structures, how capacity will be scaled as EmPATH activity increases, and how sustainability will be considered beyond the grant period.

Current RHT planning assumptions anticipate funding to support CMHC EmPATH follow-up readiness and capacity, subject to final funding determinations and program design. Funding may include:

- Onetime costs to support startup or readiness activities, such as space modifications, technology enablement, or workflow development

- Ongoing staffing and operational support to deliver EmPATH follow-up and coordination services over the grant period. Grant allocations will be tapered down over time as CMHCs demonstrate progress towards sustainability plans.

Anticipated Outcomes

While final performance measures will be specified in contract documents, EmPATH-related activities are expected to contribute to broader RHTP and CMS-aligned goals, with sample metrics including:

- Improved rates of timely follow-up after ED or EmPATH discharge
- Rate (%) of individuals treated in EmPATH who receive follow-up care within 3 days, 7 days, 14 days, and 30 days
- Improved retention rates of individuals with follow-up care
- Rate (%) of individuals discharged from EmPATH who receive at least one clinical contact or appointment per week following the crisis episode until regular, ongoing outpatient behavioral health care is established
- Rate (%) of individuals discharged from EmPATH who remain engaged in follow-up care at 3, 6, 9, and 12 months after the crisis episode. Engagement is defined as at least one documented clinical encounter during each specified follow-up period.
- Reduced ED/EmPATH return visits, demonstrating sustained stabilization and community-based supports
- Number (#) and rate (%) of individuals previously treated in the EmPATH unit who return for additional EmPATH or hospital services within specified time intervals following their initial EmPATH encounter, including 30, 90, 120, and 365 days.

Appendix II – Community-Based Crisis Response

EMS and Paramedicine's Role in Behavioral Health Crisis Response

EMS Role Overview:

Emergency Medical Services (EMS) serve as the primary, front-end emergency response during a behavioral health crisis, with crisis clients most often entering the system through a 911 dispatch. In the Kentucky RHT context, EMS is frequently the first responder on scene, particularly in rural areas where alternative crisis infrastructure is limited. EMS focuses on rapid assessment, immediate safety, and medical stabilization, operating under time-limited, incident-based protocols that prioritize resolving the acute emergency. Leadership feedback consistently notes that behavioral health crises often present as medical complaints, placing EMS in the position of recognizing signs of a behavioral health crisis. EMS are often responding to mental health crises, substance-use related calls including overdose, and behavioral health crises for individuals with intellectual or developmental disabilities.

Paramedicine Role Overview:

Community Paramedicine expands 911 response as a necessary complement to EMS to reduce avoidable ED utilization while maintaining safety and accountability. Community Paramedicine enables EMS to stabilize individuals in the field, treat them without transport when appropriate, and coordinate alternatives to unnecessary emergency department transport. The role also extends beyond the moment of crisis to support warm handoffs, follow-up engagement, and connection to community-based services, especially in rural areas where transportation barriers and social needs are persistent challenges. Community paramedicine teams may work closely with hospitals discharging high-risk patients, with behavioral health providers who have individuals at high risk for failing to appear at appointments, or with frequent callers of 911 or 988 to enroll them in a program for home or in-the-field visits. Community paramedicine programs may provide basic services such as physical health assessments, lab withdrawals, and medication reconciliation, and assist individuals in accessing teleservices. Community paramedicine plays a system-integration role, linking EMS, behavioral health providers, and crisis pathways, rather than operating as a standalone service.

Training Requirement Overview

Behavioral health training is a condition of award for EMS agencies funded through the Community Paramedicine RFA and an optional addition in the EMS TNT/TAD RFA. CMHCs will serve as regional training providers, delivering required behavioral health training using appropriately credentialed staff and coordinating directly with participating EMS agencies. Training is intended to establish a consistent baseline of behavioral health response capacity across EMS and community paramedicine programs statewide.

Required Behavioral Health Training

Behavioral health training is a condition of grant award for funded EMS agencies and is intended to establish consistent, baseline behavioral health response capacity statewide.

Training will be led by appropriately credentialed clinical staff and offered at local CMHC sites or EMS agencies at times convenient for participating providers.

Awarded agencies must engage with their regional CMHC or another approved behavioral health provider to support training planning, scheduling, and delivery. Agencies may also assign a primary contact as the "Behavioral Health Champion," who will be responsible for communicating with the CMHC and leading engagement efforts within the EMS agency for behavioral health. Agencies will be required to attest to this engagement as part of the grant application and award process.

At a minimum, CMHCs will be training EMS agencies in the following foundational, cross-cutting skills applicable to all encounters:

- Recognition of behavioral health needs across diverse populations and presentations
- Trauma-informed response and person-centered engagement
- De-escalation techniques and crisis response considerations
- Safety, stabilization, and appropriate referral or escalation

Additional training should continue to be offered as continuing education credits. Specific training programs will be identified in the contract but may include: Crisis Intervention Training, AMSR, and CAMS-CARE.

To allow time for capacity building and workforce development, training will be completed on a rolling basis. By the end of Budget Period 1, CMHC trainers must be certified to deliver all foundational training components. If a CMHC lacks adequate capacity at any point, training opportunities must be coordinated with approved statewide trainers.

Role Expectations

Applicants are expected to fulfill the following responsibilities in partnership with all awarded EMS agencies, inclusive of community paramedicine programs, in their service region:

- Coordinate with EMS agencies in their region to plan, schedule, and deliver required trainings at the location and time most preferred by the EMS agencies
- Ensure trainings are delivered by appropriately credentialed staff
- Pursue and maintain KBEMS approval so trainings qualify for continuing professional education
- Support regional rollout as EMS agencies enter the program on a rolling basis

- Enable Treat-no-Transport, Transport to Alternative Destination, crisis de-escalation, safety management, trauma-informed care, and other strategies that improve the quality of crisis response and care
- Provide technical assistance to participating EMS agencies including, but not limited to, services such as protocol and policy review or development (i.e. diversion policies) and regular case reviews on behavioral health runs
- Be responsible for enabling regional collaboration between all crisis continuum partners, facilitating education and skills building, warm hand-offs, care protocols, data sharing, and outcomes-driven quality improvement for crisis response
- Utilize shared technology designed for crisis care response, enabling real-time data sharing between partners and advanced data analytics for outcomes tracking and system accountability and improvement
- Facilitate local or regional coalitions (i.e 988 regional coalitions, quick response teams) with first responders in attendance to close system gaps

Applicants are expected to fulfill the following responsibilities in partnership with all awarded community paramedicine units in their service region:

- Serve as provider partners in paramedicine programs, establishing agreements with paramedicine teams
- Share and collaborate on client care plans managed by the paramedicine program
- Engage in bidirectional referrals
- Identify criteria for which CMHCs would benefit from participation in the paramedicine program and develop an enrollment process in coordination with paramedicine programs
- Ensure timely follow-up care rates for individuals referred to services by paramedicine programs
- Utilize the paramedicine team as an extension for field-based entry points to care coordination and management for priority populations, as well as for community outreach
- Contribute to practice-level refinement of the community paramedicine model by reviewing protocols, participating in case discussions and learning reviews, and helping translate best practices into workflows.

Support Provided

RHTP funding will support CMHC participation and capacity building, including, but not limited to:

Training Costs

- Supporting a new role, if needed, for a Community-Based Crisis Response Engagement Specialist (credentials include being a clinician to qualify as a trainer for identified curriculum)
- Train-the-trainer costs and required certifications for CMHC staff

- Costs associated with delivering required trainings, including curriculum and materials
- Regional staff travel related to training delivery. Regular travel to EMS agencies and partners is anticipated.
- Enrollment or registration fees for EMS or other first responder participants
- Advisory and planning support, including coordination activities
- Technology to support cross-partner care coordination and outcomes tracking, including tools that enable timely referrals, secure data exchange, shared care plan visibility, and monitoring of training delivery and behavioral health response outcomes across EMS and CMHC partners

Care Coordination Integration Costs:

- Hiring Community Health Workers, peer support specialists, care coordinators, supervisors, or program managers who support paramedicine-initiated referrals and follow-up
- Initial and ongoing training, certification, and continuing education
- Supplies, outreach materials, screening tools, and health education materials
- Integration of technology into CMHC systems that enable referral tracking, case management and reporting connected to community paramedicine activity

Funding for the following is considered elsewhere in the RHT budget and does not need direct funding requests by applicants:

- Funding for EMS agencies (separate RFA is available for EMS agencies and community paramedicine programs)
- Shared technology solutions and data systems for real-time information sharing between partners during a crisis response

Applicants are encouraged to think creatively about how proposed activities and staffing models can advance the goals of community paramedicine within their region. Funding is intended to enable applicants to propose approaches that reflect local needs, existing relationships, and system gaps related to crisis response, follow-up, and care continuity following EMS interactions. Proposals should clearly describe how requested resources would complement community paramedicine activities and contribute to improved system performance.

Transformative strategies designed in partnership with existing training efforts with EMS agencies or paramedicine programs, mobile crisis teams, and law enforcement partnerships is encouraged.

Anticipated Outcomes

While final performance measures will be defined through contract requirements and ongoing program development, behavioral health training supported under this RFA is expected to contribute to system-level improvements, which may include:

- Improved EMS and community paramedicine proficiency in recognizing and responding to behavioral health crises
- Increased use of de-escalation, trauma-informed, and clinically appropriate response strategies during behavioral health encounters

- Improved identification of substance-use disorder, overdose risk, and connection into care for recovery and overdose prevention
- Increased readiness among EMS personnel to manage behavioral health calls without unnecessary emergency department transport, when clinically appropriate
- Improved alignment between EMS response practices and community-based behavioral health services, including clearer referral and handoff pathways
- Reduced variability in behavioral health response practices across regions through consistent baseline training
- Strengthened collaboration between EMS agencies, community paramedicine programs, and behavioral health partners within the crisis continuum
- Improved follow-up and continuity of care following EMS and ED encounters
- Reduction in avoidable emergency department utilization via treatment-in-place and diversion models
- Improved holistically informed response planning to identify and address social determinates of health, including housing instability, transportation barriers, food insecurity, and access to follow-up care
- Increased patient engagement and willingness to connect with services, reducing the amount of clients who “fall through the cracks”
- Strengthened systems learning and accountability through improved documentation, referral tracking, and outcome reporting across hospital, paramedicine, EMS, and behavioral health partners

Benchmarks are intended to support learning, quality improvement, and system accountability and may be refined over time based on program experience and regional readiness.