

Request for Application (RFA): Rural Health Transformation Program Funding Opportunity to Rapid Response to Recovery – Telebehavioral Health 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.mcginis@ky.gov> by July 3, 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 Commonwealth¹.

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

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.

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.
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 RHT 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

These three core focus areas of the Rapid Response to Recovery Program reflect an opportunity to coordinate a larger system of care strategy for tailoring RHT-funded work to address unique community needs

A collaborative, cross-disciplinary network of providers will 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 consider how telebehavioral health capacity, integration, and coordination can support this broader system vision. 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, through telebehavioral health-enabled care coordination and consultation

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, primary care organizations, community-based organizations, social services, and more.

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, with a focus on telebehavioral health capacity, integration, and participation in the statewide hub model.

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.

Please note that there will be complimentary funding opportunities for hospitals, EMS agencies, community paramedicine programs, and for FQHCs and RHCs.

III. Eligible Applicants

- Medicaid enrolled, Eastern Kentucky serving 501(c)(3) nonprofit organizations with a demonstrated focus on behavioral health services
 - FQHCs and RHCs will have an opportunity to participate as PCPs in the model
- 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, July 3, 2026**.

- June 1, 2026: RFA Released
- July 3, 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 applicants supporting the telebehavioral health hub focus area is approximately \$500,000.

Program Focus Area: Telebehavioral Health Capacity and Integration

Purpose: Funds under this focus area may be used to support participation in a statewide telebehavioral health hub designed to expand access to psychiatric consultation, crisis-adjacent behavioral health support, and care coordination. This program focus area emphasizes readiness, integration, and gap-filling rather than the delivery of standalone or duplicative telebehavioral health services.

The statewide telebehavioral health hub is being developed in partnership with academic and statewide entities to provide shared infrastructure for triage, specialty consultation, care coordination, and outcomes tracking. Applicants are expected to function as regional partners and provider spokes within this model, supporting local engagement and continuity while leveraging centralized hub capacity.

Allowable Budget Categories and Examples:

- Personnel
 - Psychiatrists
 - Psychiatric APRNs
 - Licensed Clinical Social workers, Licensed Psychologists, or other licensed clinicians
- Technology and Software
 - Telehealth platforms or secure communication tools necessary to participate in hub-enabled care coordination and consultation
 - Interoperability or EHR integration costs to connect applicants with shared hub infrastructure or reporting requirements

- Licenses required to support care coordination and documentation
- Equipment
- Tablets, laptops, or telebehavioral health carts
- Peripheral equipment necessary to support telehealth encounters
- Training
 - Provider training related to telebehavioral health delivery and workflows
- Other Direct Costs
 - Limited, program-related space modifications to support telehealth delivery
 - Connectivity upgrades necessary to ensure reliable service delivery

VII. Funding Timeline

Applicants may apply for funding to support one or more 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
- **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 applicant 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;

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

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 CoCM telebehavioral health capacity. 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 increase access to behavioral health services through teleservices or technology. Clearly describes concrete processes for coordinating follow-up care and warm handoffs across applicants and primary care. 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 within telebehavioral health, as applicable. 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 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.mcginis@ky.gov **by July 3, 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.
- 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 the telebehavioral health hub. 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 applicants’ proposed activities under this RFA
- 2) Core Activities: A summary of services to be supported, including care coordination, training delivery, technical assistance, and regional coordination
- 3) Service Area: The geographic area to be served by county
- 4) Partner Organizations: FQHCs, RHCs, etc.
- 5) Populations Served: Individuals participating in the CoCM telebehavioral health program

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. **CoCM Telebehavioral Health Plan:** Describe how your organization will build out regional capacity for the telebehavioral health hub, including:
 - Staffing plans that meet the requirements of the CoCM model
 - Supporting crisis protocols and shared community response in primary care settings

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

- Number of patients served through the CoCM telebehavioral health program

Community Partnerships: Identify FQHCs and RHCs; describe coordination mechanisms.

Service Gaps Addressed: Identify current gaps in care 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 increased access to behavioral health services through teleservices and technology enhancements advance RRR priorities.
- 2) **Continuity of Care and Warm Handoffs:** Explain how follow-up care will be coordinated with primary care providers.
- 3) **Integrated Behavioral Health Approach:** Describe how services will address co-occurring mental illness and substance use disorders.
 - Increased access to behavioral health services through teleservices and technology enhancements

SECTION D: Data Collection and Reporting (5 points)

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

- 1) Adoption of a shared reporting approach with primary care teams
- 2) Participation in shared data or quality improvement efforts, as required by RHTP and RRR
- 3) 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 models for the telehub
- 2) 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 the Telebehavioral Health Model
- 2) 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 I – Telebehavioral Health Hub

Overview of the Statewide Telebehavioral Health Hub

The telebehavioral health hub is a statewide infrastructure investment designed to strengthen access to behavioral health expertise across the crisis and non-emergent care continuum. The hub supports timely psychiatric consultation, crisis stabilization, and care coordination by connecting rural primary care providers to shared specialty capacity, standardized workflows, and integrated technology.

The telebehavioral health hub is being developed in partnership with academic and statewide entities to provide centralized infrastructure, including triage protocols, specialty consultation, shared reporting and registry functions, and technology enablement. This approach is intended to reduce administrative and operational burden on participating organizations while improving consistency, coordination, and outcomes across regions and to support participation in the Collaborative Care Model (CoCM) as one pathway for expanding access to psychiatric consultation and care coordination in primary care settings.

Primary care providers across rural Kentucky consistently identify behavioral health needs but face systemic barriers that prevent timely and reliable execution of care. These challenges are not driven by lack of clinical recognition, but by operational breakdowns across the care continuum.

- Providers report limited access to psychiatric consultation or specialty expertise during critical decision points, leading to delays in care or default escalation to emergency departments when timely guidance is unavailable.
- When patients require crisis services, clinics experience difficulty navigating appropriate destinations, coordinating placement, and managing logistics, often resulting in significant staff burden and delayed care transitions.
- Telebehavioral health access is further constrained by rural infrastructure limitations, including unreliable broadband, limited patient access to devices, privacy concerns, and the need for clinic staff to facilitate visits, which can disrupt routine operations during high-demand periods.
- Following referrals or escalation to higher levels of care, primary care providers frequently lack timely access to discharge information, care plans, and confirmation of patient follow-through, resulting in fragmented care and increased risk of poor outcomes.

Collectively, these barriers reflect a fragmented system that limits primary care's ability to deliver coordinated, continuous behavioral health care.

Early planning assumptions reflect a phased approach, beginning with a small cohort of primary care clinics – roughly 5-10 – concentrated in Eastern Kentucky, supported by statewide partners while strengthening regional relationships with local behavioral health providers. This will be scaled to a statewide program in later years.

Hub-and-Spoke Model Design

The telebehavioral health hub will operate using a hub-and-spoke model that clearly delineates responsibilities between centralized hub partners and regional provider partners.

Hub-level functions, operated by academic and statewide partners, may include:

- Centralized triage and routing of telebehavioral health requests
- Specialty psychiatric consultation and clinical oversight where appropriate
- Management of overflow and escalation pathways
- Shared registry and reporting infrastructure to support outcomes tracking, quality improvement, and cross-partner coordination
- Technology platforms and interoperability solutions to facilitate secure information exchange

Spoke-level functions, supported by applicants and other participating providers, focus on:

- Asynchronous or real-time clinical provider consultation or patient teleservices
- Local clinical follow-up, care coordination, and continuity for telebehavioral health encounters
- Integration of telebehavioral health support into existing crisis response and recovery pathways
- Participation in shared workflows, protocols, and quality improvement activities
- Regional relationship-building and coordination with primary care providers and other care system partners

Role of Applicants as Regional Spokes

501(c)(3) nonprofits play a critical role as regional behavioral health partners within the telebehavioral health hub by providing local partnerships, continuity, and integration with community-based services. They are intended to strengthen—not replace—existing behavioral health and primary care relationships within each region.

Anticipated roles may include, but are not limited to:

- **Coordinating with statewide “hub” teams**, including academic partners that will provide technology enhancement, streamlined data reporting, as well as staffing of specialty behavioral health providers, on-demand crisis response with clinician level staff, and care coordination for bed availability and pathway determinations.
- **Operating as “provider spokes” to extend telebehavioral health capacity**, including participating in telepsychiatry coverage and/or shared staffing models that support hub delivery needs as it relates to integration with primary care providers; planning assumptions describe a telehealth team that may include a shared psychiatrist, psychiatric advanced practice nurses, social workers, and/or a care coordinator such as peer support specialist or community health worker

- **Supporting provider-to-provider consultation through collaborative care**, which has been identified as a key service gap in regions where primary care providers report broad adoption of patient-facing telepsychiatry / teletherapy / tele-SUD services
- **Increasing timely access to specialty behavioral health teleservices**, addressing critical service and coordination gaps experienced in rural areas
- **Participating in standardized triage / referral workflows** and strengthening closed-loop handoffs, including improved ability to track referrals and intake metrics as part of a systemwide continuum
- **Coordinating follow-up pathways after stabilization**, including connecting patients to community resources following crisis evaluation, consistent with the hub's objective to improve care continuity and reduce repeat ED utilization

Collaborative Care Model (CoCM)

The hub supports primary care provider (PCP)-based behavioral health integration by enabling Collaborative Care workflows, including standardized screening and structured coordination between the PCP, a Behavioral Health Care Manager (BHCM), and a psychiatric consultant.

- Evidence-based role definitions are defined by the Meadows Mental Health Policy Institute as:
 - Primary Care Provider (PCP): Oversees all aspects of patients' behavioral health care, including facilitating engagement, providing education, and prescribing medications as appropriate
 - Behavioral Health Care Manager (BHCM): Works closely with PCP and psychiatric consultant to manage a caseload of patients, performs validated behavioral health assessments, systematically tracks progress, and provides brief therapeutic interventions. This role will be a licensed clinician. This individual may be employed directly by the primary care organization or could be contracted through the 501(c)(3) nonprofit.
 - Psychiatric Consultant: An employee of the 501(c)(3) nonprofit supports PCP and BHCM by regularly reviewing cases and making treatment recommendations in systematic case reviews.

Support Provided to Applicants

Funding under this RFA is intended to support applicant readiness and participation in a hub-enabled behavioral health continuum.

- Applicant telebehavioral staffing capacity (i.e., tele-BH clinical staff at 501(c)(3) nonprofit as provider spoke) and associated technology enablement costs
- Infrastructure and technology integration with statewide hub management and reporting system (i.e. EHR-specific work)
- Connectivity tools such as tablets to support telehealth between applicants and PCPs

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

- Central hub management and dispatch enablement, including centralized dispatch and care coordination functions housed in a clinical entity
- Training and technical assistance to support Collaborative Care (CoCM) enablement and broader hub workflow adoption, including administrative functions, training, and TA described as necessary for standing up PCP participation
- Infrastructure and technology support needed for effective CoCM and hub operations, including a patient registry approach, enhanced data sharing for shared care plans
- Funding for primary care organizations to participate

Anticipated Outcomes

While final performance measures will be specified in contract documents, telebehavioral health hub related activities are intended to contribute to broader RHTP and CMS-aligned goals, including:

- Expanded capacity to function as a regional “provider spokes” for telebehavioral services
- Stronger provider-to-provider behavioral health consultation support for primary care providers
- Consistent triage, intake, and referral management practices
- Improved close-loop handoffs between applicant and partner settings (PCPs, rural hospitals/EDs, etc.)
- Aligned telebehavioral workflows with hub routing and disposition planning
- Increased access to behavioral health services
- Increased quality of care and behavioral health clinical outcomes