

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



Health Resources & Services Administration

Maternal and Child Health Bureau
Division of Maternal and Child Health Workforce Development

***American Rescue Plan Act - Pediatric Mental Health Care Access –
New Area Expansion***

Funding Opportunity Number: HRSA-21-122
Funding Opportunity Type(s): New
Assistance Listings (CFDA) Number: 93.110

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2021

Application Due Date: July 6, 2021

SAM.gov and Grants.gov administrative flexibilities have been implemented.
Please see [Section IV.3](#) for more information.

Issuance Date: May 19, 2021

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Authority: 42 U.S.C. § 254c-19 (Title III, § 330M of the Public Health Service Act), using funding provided by Section 2712 of the American Rescue Plan Act of 2021 (P.L. 117-2)

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for the fiscal year (FY) 2021 American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion. The purpose of this program is to promote behavioral health integration into pediatric primary care by supporting pediatric mental health care telehealth access programs.

This funding opportunity will expand the Pediatric Mental Health Care Access Program into new states and geographic areas. Newly expanded state or regional networks of pediatric mental health care teams will provide tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat, and refer children with behavioral health conditions. For the purposes of this funding opportunity, telehealth is defined as the use of electronic information and telecommunication technologies to support and promote clinical consultation, patient and professional health-related education, public health, and health administration activities.

Funding Opportunity Title:	American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion
Funding Opportunity Number:	HRSA-21-122
Due Date for Applications:	July 6, 2021
Anticipated Total Annual Available FY 2021 Funding:	Up to \$14,240,000 total per year (Up to \$71,200,000 over 5 years)
Estimated Number and Type of Award(s):	Up to 32 cooperative agreements
Estimated Award Amount:	Up to \$445,000 per year, per award, for the 5-year period of performance
Cost Sharing/Match Required:	Yes: 20 percent (\$89,000) non-federal to federal match in each year from Year 1 to Year 5
Period of Performance:	September 30, 2021 through September 29, 2026 (5 years)
Eligible Applicants:	States, political subdivisions of states, and Indian tribes and tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 450b)) not currently funded under HRSA-18-122 and HRSA-19-096 are eligible to apply (i.e., existing recipients of HRSA PMHCA awards or other entities within funded states are not eligible to apply). Please see Appendix for link to currently-funded PMHCA projects.

	See Section III.1 of this notice of funding opportunity (NOFO) for complete eligibility information.
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Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at <http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf>, except where instructed in this NOFO to do otherwise.

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, May 26, 2021

Time: 2–3:30 p.m. ET

Weblink: <https://hrsa.gov.zoomgov.com/j/1612447695?pwd=R0xzaVYwZzAzTkJTeWIPREJNZGtxQT09>

Meeting ID: 161 244 7695

Weblink Passcode: PMHCA21!

- Computer audio is recommended (make sure computer speakers are “on”)
- Click the link above and select ‘**Join with Computer Audio**’

If you won't have computer access or computer audio, you can use the dial-in information below:

Call-In Number (if you can only participate by telephone): 1-833-568-8864 (US Toll-free); 1-551-285-1373 (US)

Meeting ID: 161 244 7695

Participant Code: 97651244

A recording of this technical assistance webinar will be posted to the PMHCA web page: <https://mchb.hrsa.gov/training/pgm-pmhca.asp>.

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I. Program Funding Opportunity Description

1. Purpose

This notice solicits applications for the American Rescue Plan Act - Pediatric Mental Health Care Access (PMHCA) – New Area Expansion.

The purpose of this program is to promote behavioral health integration into pediatric primary care by supporting pediatric mental health care telehealth access programs. State or regional networks of pediatric mental health care teams will provide tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat, and refer children with behavioral health conditions. Successful recipients will focus on achieving health equity related to racial, ethnic, and geographic disparities in access to care, especially in rural (including frontier and hard-to-reach) and other underserved areas. PMHCA advances HRSA strategic plan goals to improve access to quality health services, foster a health care workforce able to address current and emerging needs, achieve health equity, and enhance population health.

For the purposes of this funding opportunity, telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical consultation, patient and professional health-related education, public health and health administration. Permitted telehealth modalities between providers include (but are not limited to): real-time video, telephonic communications, store-and-forward imaging, and mobile health (mHealth) applications.

For the purposes of this funding opportunity, a pediatric mental health care telehealth access program for which funding may be used, shall—

- A. be a statewide or regional network of pediatric mental health care teams that provide support to pediatric primary care sites as an integrated team;
- B. support and further develop organized state or regional networks of pediatric mental health care teams to provide consultative support to pediatric primary care sites;
- C. conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers' preferred mechanisms for receiving consultation, training, and technical assistance;
- D. develop an online database and communication mechanism, including telehealth, to facilitate consultation support to pediatric primary care practices;
- E. provide rapid statewide or regional clinical telephone or telehealth consultations when requested between the pediatric mental health care teams and pediatric primary care providers;
- F. conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions;
- G. provide information to pediatric providers and assist pediatric providers in accessing pediatric mental health care providers, including child and adolescent psychiatrists, developmental behavioral pediatricians, and licensed mental health

- professionals, such as psychologists, social workers, or mental health counselors and in scheduling and conducting technical assistance;
- H. assist with referrals to specialty care and community or behavioral health resources; and
 - I. establish mechanisms for measuring and monitoring increased access to pediatric mental health care services by pediatric primary care providers and expanded capacity of pediatric primary care providers to identify, treat, and refer children with mental health conditions.

This program will serve as a resource for pediatric primary care providers serving children and adolescents, including, but not limited to, pediatricians, family physicians, nurse practitioners, physician assistants, and care coordinators. The programs are encouraged to broaden the reach to additional providers such as physician specialists (e.g., developmental-behavioral pediatricians, obstetrician-gynecologists, endocrinologists, gastroenterologists), behavioral health clinicians, and social workers.

Enrolled or Participating Provider or Practice

An enrolled or participating provider or practice is defined as a provider or practice who registers to participate in tele-consultation and care coordination services and agrees to provide data to facilitate HRSA-required reporting. The use of the term “enrolled” does not apply to providers or practices where providers participate in training only. Award recipients may require providers or practices to enroll in their program, in order to track usage and outcomes, as well as assure higher quality service to repeat users.

Program Goals

The program goals are to:

- 1) Increase the availability and accessibility of statewide or regional networks of pediatric mental health care teams composed of child and adolescent psychiatrists, licensed mental health professionals, and care coordinators through telehealth consultation and referral to pediatric primary care providers and other providers caring for children and adolescents with behavioral disorders, such as developmental-behavioral pediatricians.
- 2) Conduct training and provide technical assistance to pediatric primary care providers and other providers to enable them to conduct early identification, diagnosis, and treatment for children and adolescents with behavioral health conditions.
- 3) Provide information, and assist pediatric and other providers in accessing pediatric mental health care providers, with the overarching goal of providing timely detection, assessment, treatment, and referral of children and adolescents with behavioral disorders through telehealth, using evidence-based practices and methods such as web-based education and training sessions.
- 4) Improve access through telehealth to treatment and referral services for children and adolescents with identified behavioral disorders, especially those living in rural and other underserved areas.
- 5) Focus on achieving health equity related to racial, ethnic, and geographic disparities in access to behavioral health care, especially in rural and other underserved areas.

- 6) Establish and sustain the use of telehealth technologies, modalities, and care models.

Program Expectations

Recipients are expected to:

- **If there is no HRSA-funded statewide or regional network of pediatric mental health care teams that provide support to pediatric primary care sites as an integrated team**, establish such a network of teams (a team must consist of at least one of each of the following: a care coordinator; a child and adolescent psychiatrist; and a licensed clinical behavioral health professional, such as a psychologist, social worker, or mental health counselor).
- **If one or more statewide or regional networks currently exist, but are not HRSA-funded**, support and improve such teams to begin providing any activities (A–I) outlined under [section I. 1.](#) of the NOFO that are not currently provided and improve the quality and breadth of those activities that are already provided.
- If the state Title V Maternal and Child Health (MCH) Services Block Grant program is not the lead applicant for your proposal, you **must** discuss how you will develop, and/or maintain collaborative relationships between the proposed project and the state Title V MCH Program. You can locate information on how to contact your state Title V MCH Program by visiting the [MCHB](#) web site. In your application, you **must** include a letter of support from the state Title V MCH Program in one attachment under Other Relevant Documents (**Attachments 8–15**).
- Develop and maintain or identify a statewide or regional telehealth referral database, which contains information on community-based mental health and support service providers (including race and ethnicity information about providers, if possible), telehealth capabilities, and other information necessary to support the technical, legal, financial, and clinical aspects of telehealth delivery. Service delivery programs that address social determinants of health (SDOH) (e.g., housing, food insecurity, childcare, etc.) should also be included in the referral database.
- Convene a diverse array of advisory board members comprised of key stakeholders and agencies needed to support a statewide or regional pediatric mental health care access program, which may include mental health, public health, pediatric health and behavioral clinicians, education, human services, and health insurers. HRSA strongly encourages diversity, equity, and inclusion subject matter experts, and families to have an active role on the advisory board.
- Within the first year, initiate a project sustainability plan and enhance it over the remainder of the 5-year period of performance.
- Following the end of the 5-year period of performance, sustain and disseminate key elements of your project that have been effective in improving practices and that have led to improved outcomes for the target population.

HRSA's Maternal and Child Health Bureau (MCHB) Expectations

MCHB also encourages recipients to:

- Develop statewide and/or regional partnerships with a broad range of community-based behavioral clinicians, to increase access through telehealth to behavioral health treatment and referral for children and adolescents and their families. This should include establishing partnerships with entities receiving funding for other HRSA programs, such as Health Centers, MCHB-funded training programs, and the National Health Service Corps. For more information on HRSA-funded grant programs, please visit [the HRSA Data Warehouse](#).
- Establish contacts that may be relevant to the project's goals and objectives, including national and state partners and other HRSA programs. These partnerships can provide linkages to services and resources for your project's target population(s), support actions that address SDOH, support the integration and coordination of health services, and drive initiatives aimed at reducing health disparities in communities. National and state partners may include the following:
 - State and territorial health and human service agencies (e.g., Maternal and Child Health and other Single State Agencies).
 - State Medicaid agencies
 - HRSA Telehealth Resource Centers
 - HRSA Community Health Centers
 - Health care organizations
 - Tribal health organizations
 - Insurers
 - Families who have cared for children and adolescents with behavioral disorders, particularly those who are underserved
 - Organizations that promote family-provider partnerships
 - Child-patient advocates or youth self-advocates
 - Behavioral health disorder support and advocacy organizations
 - Pediatric primary care providers
 - Developmental and behavioral clinicians
 - State chapters of medical and professional associations, such as those representing pediatricians, family physicians, nurse practitioners, and behavioral clinicians
 - Diversity, equity, and inclusion associations or professional organizations
 - Universities and colleges

Collaboration with HRSA Office for the Advancement of Telehealth (OAT) programs and HRSA Telehealth Resource Centers (<https://www.telehealthresourcecenter.org/>), in particular, will provide recipients with up to 10 hours of virtual, high level technical resources to engage in information exchange, share best practices and lessons learned, and receive technical assistance on technology-related challenges. These challenges may relate to both service provision on behavioral disorders and training and education for pediatric primary care providers.

2. Background

This program is authorized by 42 U.S.C. § 254c-19 (Title III, § 330M of the Public Health Service Act, using funding provided by Section 2712 of the American Rescue Plan Act of 2021 (P.L. 117-2)).

Need for the American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion

Within the United States, approximately 22.1 percent of children ages of 3 to 17 have some type of mental, emotional, developmental, or behavioral condition or problem that affects them currently.¹ While need for and receipt of treatment varies by condition, some analyses indicate that children with behavioral/conduct problems are less likely to receive care than those with anxiety problems or depression. Additionally, significant disparities exist in access to behavioral health care. A 2019 study of racial/ethnic disparities in mental health related emergency department visits among children found that Non-Hispanic Black children have more frequent emergency department visits for mental health than Non-Hispanic White children². Compounding this, 34.3 percent of the U.S population lives in a designated Mental Health Professional Shortage Area (HPSAs) and only 27.2 percent of the need for mental health care professionals in these HPSAs has been met.³

The ongoing COVID-19 pandemic has exacerbated pediatric behavioral health care challenges and disparities. According to the Centers for Disease Control and Prevention (CDC), between April and October 2020, hospital emergency departments saw a rise in the proportion of visits among children that were mental-health related.⁴ This may be because the COVID-19 pandemic has created challenges for communities, families, and individuals, leading to a range of emotional and behavioral responses due to uncertainty, social isolation, loss of routines, need for quarantine, and loss of family members or loved ones. Likewise, studies have found higher rates of anxiety, depression, and post-traumatic symptoms among children, especially those facing lower socioeconomic conditions.⁵ One study found significantly higher rates of suicide-related behaviors appear to have corresponded with times when COVID-19 stressors and community responses (e.g., stay-at-home orders and school closures) were heightened, indicating that adolescents experienced elevated distress during these periods.⁶ These studies indicate the increased need for pediatric behavioral health care.

¹ Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2018-2019 National Survey of Children's Health (NSCH) data query. <https://www.childhealthdata.org/browse/survey>. Accessed April 05 2021.

² Abrams, M. Pediatrics August 2019, 144: https://pediatrics.aappublications.org/content/144/2_MeetingAbstract/414

³ Health Resources and Services Administration. Bureau of Health Workforce. Designated Health Professional Shortage Areas Statistics (December 30, 2020). Retrieved 4/2021. <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>

⁴ Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3external_icon

⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7481176/pdf/main.pdf>

⁶ <https://www.aappublications.org/news/2020/12/16/pediatricssuicidestudy121620>

One factor contributing to the gap between children’s behavioral health disorders identification and treatment is the lack of growth in the workforce for child psychiatrists, developmental-behavioral pediatricians, and advanced practice nurses and child psychologists. The United States currently has 9.75 child psychiatrists per 100,000 children aged 0 to 19¹-- a rate which is considerably lower than the recommended 47 child psychiatrists per 100,000 children which the American Academy of Child and Adolescent Psychiatry estimates would be sufficient.^{7,8} The annual rate of increase in child psychiatrists of 2 percent will not meet the need of child psychiatric services over the next decade,⁹ and the COVID-19 pandemic has exacerbated the need. A study recently published online in *JAMA Network Open* finds that large proportions of children with high levels of adverse childhood experiences (ACEs), high distress symptoms, or both, do not receive clinical services.¹⁰ Black children experience ACEs and/or high distress symptoms at higher levels than non-Hispanic White children and have even lower odds of receiving clinical services compared to White children.^{11,12} Often, pediatricians and other pediatric primary care providers (e.g., family physicians, nurse practitioners, and physician assistants), are the first responders in behavioral health disorder identification and service provision. Under-identification of children and adolescents with behavioral disorders occurs because primary care physicians continue to report a lack of training and confidence in treatment of disorders with medication or counseling and addressing behavioral health.¹³

In addition to under-identification, other barriers may limit access to mental health care. Specifically, primary care physicians report more difficulty obtaining mental health services for their patients as compared to other specialty services, limited time during the primary care visit, and a lack of adequate payment mechanisms. Additionally, current primary care pediatric residency programs and rotations typically do not adequately address behavioral health. Both under-identification of behavioral disorders and the lack of access to needed services may lead to conditions severe enough to impair child, adolescent, and family functioning, school performance, and safety.

This PMHCA funding opportunity will address this multi-faceted issue. Since the early 2000s, there has been growth in the formation of statewide or regional networks across the United States that provide consultation, training, technical assistance, and care

⁷ Axelson D. Meeting the Demand for Pediatric Mental Health Care. *Pediatrics*. 2019;44 (6) e20192646; DOI: <https://doi.org/10.1542/peds.2019-2646>

⁸ Axelson D. Meeting the Demand for Pediatric Mental Health Care. *Pediatrics*. 2019;44 (6) e20192646; DOI: <https://doi.org/10.1542/peds.2019-2646>

⁹ Axelson D. Meeting the Demand for Pediatric Mental Health Care. *Pediatrics*. 2019;44 (6) e20192646; DOI: <https://doi.org/10.1542/peds.2019-2646>

¹⁰ Finkelhor D, Turner H, LaSelva D. Receipt of Behavioral Health Services Among US Children and Youth With Adverse Childhood Experiences or Mental Health Symptoms. *JAMA Netw Open*. 2021;4(3):e211435. doi:10.1001/jamanetworkopen.2021.1435

¹¹ Finkelhor D, Turner H, LaSelva D. Receipt of Behavioral Health Services Among US Children and Youth With Adverse Childhood Experiences or Mental Health Symptoms. *JAMA Netw Open*. 2021;4(3):e211435. doi:10.1001/jamanetworkopen.2021.1435

¹² <https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity>

¹³ Horwitz SM, Storfer-Isser A, Kerker BD, et al. Barriers to the Identification and Management of Psychosocial Problems: Changes From 2004 to 2013. *Acad Pediatr*. 2015;15(6):613-620. doi:10.1016/j.acap.2015.08.006

coordination to pediatric primary care sites. Currently, the pediatric primary care providers who serve approximately 26 percent of children and adolescents in the United States have access to networks that provide pediatric behavioral health care through telephone and telehealth consultation.¹⁴ Data suggest that pediatric primary care providers who use these networks continue to use them to care for new and on-going behavioral health concerns in their patient populations. However, funding for these networks is fragmented, creating sustainability challenges and making it difficult to expand these networks. Additionally, large segments of the United States do not have HRSA-funded pediatric mental health access networks, including states in the West and Southwest, the South and Southeast, Appalachia, and the Great Lakes region, U.S. territories, and indigenous communities.

Many states are using pediatric mental health care access models to improve provider access to behavioral clinicians. Specifically, these models connect enrolled pediatric primary care providers with either a child and adolescent psychiatrist or an independently licensed behavioral clinician (e.g., psychologist, social worker, or behavioral health counselor) who is part of a statewide mental health or regional team. These connections are done through tele-consultation programs are encouraged to enroll at the practice level as this appears to have more success with practice/provider participation and utilization of services. A recent RAND study found that 12.3 percent of children in states with HRSA-funded PMHCA programs had received behavioral health services while only 9.5 percent of children in states without such programs received these services.¹⁵ The study's authors concluded that federal investments to expand programs like PMHCA could significantly increase the number of children receiving mental health services.

Providers may seek consultation from PMHCA networks for general questions related to child psychiatry and behavioral health, diagnostic questions, the identification of behavioral health professionals and other resources in communities, medication evaluations, and medication questions. PMHCA networks assist with referral to behavioral health professionals as needed. Existing models also provide pediatric primary care providers with on-site and virtual training on a range of topics, including but not limited to psychiatric disorders and medications, new or updated screening and treatment protocols, and practice transformation processes to improve the integration of primary care and behavioral health. Currently, PMHCA programs are addressing increases in behavioral health concerns among children and adolescents related to the COVID-19 pandemic, including increases in anxiety, depression, and suicidal ideation and attempts. Many PMHCA programs also are supporting resilience strategies among families and enrolled providers. With greater shortages of behavioral clinicians in rural and other underserved areas, targeting these areas to improve pediatric behavioral health care access is especially important. Among 1,253 rural counties with populations of 2,500 to 20,000, nearly three-fourths of these counties lack a psychiatrist, and 95

¹⁴HRSA MCHB-funded Pediatric Mental Health Care Access Program (PMHCA). <https://mchb.hrsa.gov/training/pgm-pmhca.asp>. Calculation of number of children and adolescents 0-18 in HRSA MCHB PMHCA-funded states/total U.S. population of children and adolescents 0-18.

¹⁵ <https://www.rand.org/news/press/2019/07/15.html>

percent lack a child psychiatrist¹⁶. Without intervention, these shortages are expected to continue as more than 90 percent of all psychologists and psychiatrists and 80 percent of professionals with Masters in Social Work practice exclusively in metropolitan areas¹⁷. Currently, 65 percent of residents in rural (including frontier and hard to reach) areas receive behavioral health services from primary care providers¹⁸. Behavioral health challenges in rural and other underserved areas include chronic shortages of behavioral health professionals; lengthy travel distances to find care; lack of public transportation; social stigma of needing or receiving mental health care; and desire to maintain anonymity¹⁹.

The American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion awards will support recipients who demonstrate that they have or can build the needed infrastructure and resources to provide HRSA-funded telehealth (including telephone) consultation and referral services statewide or in regions of a state and provide the resources to enable primary care providers and other providers to utilize these supports.

This funding opportunity may support access to reliable, high-speed broadband technology for pediatric primary care providers and other providers receiving services from the networks. Research indicates that telehealth can improve access to care, reduce health care costs, improve health outcomes, and address workforce shortages in rural and other underserved areas²⁰. The use of web-based technology, including distance-learning modalities, will ensure that pediatric primary care providers and other providers who cannot participate in on-site learning sessions will receive on-going education, training, and peer-to-peer exchange. Adopting principles of adult learning and effective education models utilizing available technologies such as e-learning systems, course management software, web-based conferencing, and social media and social networking tools will further facilitate workforce development.

Current PMHCA recipients achieved the following successes in Fiscal Year 2019:

- Over 4,600 primary care providers (PCPs) in 21 states enrolled in a statewide or regional PMHCA program.
- Approximately 2,500 tele-consultation, technical assistance and training sessions were provided to enrolled PCPs.

¹⁶ Gamm, L., Stone, S., & Pittman, S. (2003). Mental Health and Mental Disorders - A Rural Challenge: A Literature Review, in Rural Healthy People 2010: A companion document to Healthy People 2010. College Station: Southwest Rural Health Research Center

¹⁷ Health Resources and Services Administration. (2011, June). Rural behavioral health programs and promising practices. Retrieved March 2021 from Health Resources and Services Administration: [health/pdf/rural_behavioralmanual05312011.pdf](http://www.hrsa.gov/rural_health/pdf/rural_behavioralmanual05312011.pdf) http://www.hrsa.gov/rural_health/pdf/rural_behavioralmanual05312011.pdf

¹⁸ Rural (including frontier and hard to reach) Health Information Hub. Rural Mental Health (2018). Retrieved 3/2021. healthinfo.org/topics/mental-health.

¹⁹ Rural (including frontier and hard to reach) Health Information Hub. Rural (Mental Health) (2018). Retrieved 3/2021. healthinfo.org/topics/mental-health.

²⁰ The National Academies of Sciences, Engineering, Medicine. The Role of Telehealth in an Evolving Health Care Environment – Workshop Summary (2012). Retrieved 3/2021. <http://www.nationalacademies.org/hmd/Reports/2012/The-Role-of-Telehealth-in-an-Evolving-Health-Care-Environment.aspx>.

- Approximately 2,300 children and adolescents overall were served by pediatric PCPs who contacted the pediatric mental health team.
- Approximately 1,300 children and adolescents living in rural and underserved counties were served by pediatric PCPs who contacted the pediatric mental health team.

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: New

HRSA will provide funding in the form of a cooperative agreement. A cooperative agreement is a financial assistance mechanism where HRSA anticipates substantial involvement with the recipient during performance of the contemplated project.

HRSA program involvement will include:

- Providing the services of experienced HRSA personnel to participate in the planning and development of all phases of this cooperative agreement;
- Participating in appropriate meetings, committees, conference calls, and working groups related to the cooperative agreement and its projects;
- Conducting ongoing review of the establishment and implementation of activities, procedures, measures, and tools for accomplishing the goals and objectives of the cooperative agreement;
- Providing assistance establishing effective collaborative relationships and technical assistance opportunities with federal and state contacts, HRSA-funded programs, and other entities that may be relevant for the successful completion of tasks and activities identified in the approved scope of work;
- Reviewing and providing advisory input on written documents, including information and materials, training materials, screening/assessment/treatment protocols and activities conducted under the auspices of the cooperative agreement;
- Participating with award recipients in peer-to-peer information exchange and the dissemination of project findings, best practices, and lessons learned from the project; and participating in the planning of all-recipient annual meeting and quarterly webinars;
- Conducting a site visit with each recipient during the performance period;
- Disseminating information on the program through conference presentations, journal articles; and
- Facilitating recipient consultation with HRSA evaluation contractor and American Rescue Plan - PMHCA Innovation Center contractor.

The cooperative agreement recipient's responsibilities will include:

- Meeting with the federal project officer at the time of the award to review the current strategies and to ensure the project and goals align with HRSA priorities for this activity;

- Providing ongoing, timely communication and collaboration with the federal project officer, including holding regular check-ins with the federal project officer;
- Providing ongoing, timely communication and collaboration with the HRSA Grants Management Specialist;
- Collaborating with HRSA on ongoing review of activities, procedures and budget items, information/publications prior to dissemination, contracts and interagency agreements;
- Collaborating with HRSA and HRSA evaluation contractor on HRSA's Pediatric Mental Health Care Access Program evaluation, capacity-building and support activities. Award recipient participation may include responding to surveys, which are typically administered in the fall during Years 2, 3, and 4, participating in interviews, providing other reports upon request from HRSA, and participating in ongoing capacity-building webinars. HRSA encourages award recipients to consult with the evaluation contractor carefully on the timeline for HRSA survey administration before administering award recipient-sponsored surveys to reduce burden on enrolled providers;
- Collaborating with HRSA and PMHCA Innovation Center contractor to enhance program capacity to effectively implement models that promote behavioral health integration into pediatric primary care using telehealth. Award recipients will participate in a national network of PMHCA programs and engage with the PMHCA Innovation Center contractor which will provide technical assistance, resources, peer-to-peer learning and support; identify effective and innovative models of training and care; implement program and policy options to strengthen and sustain PMHCA programs. Award recipients will participate in state data collection and analysis efforts; and demonstrate program impact.
- Establishing contacts relevant to the project's mission such as federal and non-federal partners, and other HRSA programs that may be relevant to the project's mission ([see list on p. 4](#));
- Assuring that all recipient administrative data and performance measure reports, as designated by HRSA, will be completed and submitted on time; and
- Providing technical support for the initiation and sustainment of telehealth activities in PMHCA programs to advance tele-consultation, training, technical assistance, and care coordination to enrolled and participating providers.

2. Summary of Funding

HRSA estimates approximately \$71,200,000 to be available to fund up to 32 new recipients over 5 years. You may apply for a ceiling amount of up to \$445,000 total cost (includes both direct and indirect, facilities and administrative costs) per year. The period of performance is September 30, 2021 through September 29, 2026 (5 years). Funding beyond the first year is subject to satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at [45 CFR part 75](#).

III. Eligibility Information

1. Eligible Applicants

States, political subdivisions of states, and Indian tribes and tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 450b)) not currently funded under HRSA-18-122 and HRSA-19-096 are eligible to apply (i.e., existing recipients of HRSA PMHCA awards or other entities within funded states are not eligible to apply). Please see Appendix for link to currently-funded PMHCA projects.

2. Cost Sharing/Matching

Cost sharing/matching is required for this program.

The Secretary may not award a cooperative agreement under the statutory authority for the program unless the state, political subdivision of a state, Indian tribe, or tribal organization involved agrees, with respect to the costs to be incurred by the state, political subdivision of a state, Indian tribe, or tribal organization in carrying out the purpose described in the statutory authority, to make available **non-federal** contributions (**in cash or in-kind**) in each year from years 1–5 toward such costs in an amount that is **not less than 20 percent** of federal funds provided in the cooperative agreement. For example, the match would be \$89,000 for an award in the amount of \$445,000.

3. Other

HRSA will consider any application that exceeds the ceiling amount non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that exceeds the page limit referenced in [Section IV](#) non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in [Section IV.4](#) non-responsive and will not consider it for funding under this notice.

NOTE: Multiple applications from an eligible entity (i.e., an organization) are not allowable.

NOTE: Multiple applications to serve an area that does not currently have a HRSA PMHCA program are allowable if not submitted by the same organization.

HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA **requires** you to apply electronically. HRSA encourages you to apply through [Grants.gov](http://www.grants.gov) using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at <http://www.grants.gov/applicants/apply-for-grants.html>.

The NOFO is also known as “Instructions” on Grants.gov. You must select “Subscribe” and provide your email address for each NOFO you are reviewing or preparing in the workspace application package in order to receive notifications including modifications, clarifications, and/or republications of the NOFO on Grants.gov. You will also receive notifications of documents placed in the RELATED DOCUMENTS tab on Grants.gov that may affect the NOFO and your application. *You are ultimately responsible for reviewing the [For Applicants](#) page for all information relevant to this NOFO.*

2. Content and Form of Application Submission

Section 4 of HRSA’s [SF-424 Application Guide](#) provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, etc. You must submit the information outlined in the Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA’s [SF-424 Application Guide](#) except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files included in the page limit shall not exceed the equivalent of **60 pages** when printed by HRSA. The page limit includes the project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Please note: Effective April 22, 2021, the abstract is no longer an attachment that counts in the page limit. The abstract is the standard form “Project_Abstract Summary.” Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. If you use an OMB-approved form that is not included in the workspace application package for HRSA-21-122, it may count against the page limit. Therefore, we strongly recommend you only use Grants.gov workspace forms associated with this NOFO to avoid exceeding the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **It is therefore important to take appropriate measures to ensure your application does not exceed the specified page limit. Any application exceeding the page limit of 60 will not be read, evaluated, or considered for funding.**

Applications must be complete, within the maximum specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- 1) You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- 2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3321).
- 3) Where you are unable to attest to the statements in this certification, an explanation shall be included in *Attachment 8: Other Relevant Documents*.

See Section 4.1 viii of HRSA's [SF-424 Application Guide](#) for additional information on all certifications.

Temporary Reassignment of State and Local Personnel during a Public Health Emergency

Section 319(e) of the Public Health Service (PHS) Act provides the Secretary of the Department of Health and Human Services (HHS) with discretion upon request by a state or tribal organization to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with § 319(e). Please reference detailed information available on the HHS Office of the Assistant Secretary for Preparedness (ASPR) website via <http://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx>.

Program-Specific Instructions

In addition to application requirements and instructions in Section 4 of HRSA's [SF-424 Application Guide](#) (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), include the following:

i. Project Abstract

Use the Standard OMB-approved Project Abstract Summary Form 2.0 that is included in the workspace application package. Do not upload the abstract as an attachment. For information content required in the Project Abstract Summary Form, see Section 4.1.ix of HRSA's [SF-424 Application Guide](#).

The body of the abstract **must** adhere to the following format:

Problem: Briefly state the principal needs and problems, which are addressed by the project.

Goals and Objectives: Identify the major goal(s) and objectives for the period of performance.

Methodology: Describe the programs and activities used to attain the objectives.

Coordination: Describe the coordination planned with appropriate national, regional, state, and/or local health agencies to implement the proposed project.

Evaluation: Briefly describe the evaluation methods to be used to assess program outcomes and the effectiveness and efficiency of the project in attaining goals and objectives.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and well-organized so that reviewers can understand the proposed project.

Successful applications will contain the information below. Please use the following section headers for the narrative:

- **INTRODUCTION -- Corresponds to Section V's Review Criterion #1 [Need](#)**
 1. Briefly describe the purpose of the proposed project.
 2. Specify and include:
 - a. If this is a new HRSA-funded project for your state or region (in one or more communities), or if you are planning to build on an existing non HRSA-funded statewide or regional pediatric psychiatric consultation, care coordination, and provider training program (e.g., pediatric);
 - b. If HRSA funding for this project will be used to complement, without duplicating, other state or grant funded activities with similar goals and expectations to those stated in this NOFO, list the source of any other funding, the amount from each source, and the years funded.

- **NEEDS ASSESSMENT -- Corresponds to Section V's Review [Criterion 1 Need](#)**
 1. Describe the need to establish a HRSA-funded or build upon an existing non-HRSA-funded statewide or regional psychiatric consultation, care coordination and provider training program that expands pediatric primary care and behavioral clinicians' capacity to screen, treat and refer children and adolescents with behavioral disorders. Include an assessment of need to achieve health equity related to racial and ethnic and geographic disparities in access to care especially in rural and other underserved areas;
 2. Describe (using and citing verifiable demographic and geographic data and trends over time whenever possible) the:
 - a. geographic area(s) to be served (i.e., statewide or regional, based on needs assessment);
 - b. target population(s) to be served, including:
 - i. which types of pediatric primary care and behavioral clinicians (e.g., pediatricians, other pediatric primary care providers such as family physicians, nurse practitioners, and physician assistants,) and other providers (e.g., psychiatrists, behavioral health

- professionals, and care coordinators) you will target for program outreach and engagement, considering methods for delivering outreach and engagement during a public health emergency. Please discuss how you will expand outreach and communication to providers to address health disparities in behavioral health care access.
- ii. population(s) of children and adolescents with behavioral health concerns and their families (e.g., universal/population based, Medicaid only, the size of the population(s) that will be served).
 - c. how proposed activity will meet the unmet needs and health disparities in population(s) being served, especially in rural or other underserved areas; and
 - d. justification for the target area(s) and population(s) being served.
3. Include socio-cultural determinants of health and health disparities that impact the population(s) or communities served.
 4. Discuss any relevant barriers in the service area that the project hopes to overcome and possible solutions.
 5. Assess the current state of telehealth capabilities in networks (technology, training, legal, clinical, etc.) and the gaps that need to be filled for the initiation and sustainment of telehealth activities.

You are encouraged to review the [State Title V MCH Block Grant Program Needs Assessment](#) findings for your state to document need for proposed projects statewide or in the regions of a state that they intend to serve. In these Needs Assessments, states describe the need for preventive and primary care services for pregnant women, mothers, and infants up to age 1; preventive and primary care services for children; and family-centered, community-based coordinated systems of care for children and youth with special health care needs and their families. The Title V MCH Services Block Grant statute requires each state and jurisdiction to conduct a statewide, comprehensive Needs Assessment every 5 years.

You also are encouraged to review the [Title V State Action Plans](#) for your state to document the need for proposed projects. States develop 5-year State Action Plans that document priority needs. In these plans, states take a further step and identify objectives, strategies, and relevant national performance measures to address needs in six population health domains: Women/Maternal Health; Perinatal/Infant Health; Child Health; Children with Special Health Care Needs; Adolescent Health; and Life Course.

- *METHODOLOGY* -- Corresponds to Section V's Review Criteria 2 [Response](#) and 4 [Impact](#)

This section helps reviewers understand *how* you plan to accomplish the goals and expectations of the cooperative agreement.

1. Describe your proposed methods for how you intend to achieve each of the nine program activities (A–I) listed under [Section I. 1. Purpose](#).
 - a. Provide a narrative framework for your proposed project across the 5-year

period of performance.

- b. Describe the model that will be developed and implemented through the proposed project to establish a HRSA-funded or improve a non HRSA-funded statewide or regional pediatric mental health care team that will provide consultation, care coordination, and support services to pediatric primary care providers and other providers. In some instances, direct behavioral/mental care may be provided to children and adolescents as a gap-filling service until a local behavioral clinician is available. Consider the use of both telephone and telehealth consultation in your proposed model.
- c. Demonstrate in the work plan that you will be able to implement the program within the 5-year period of performance.
- d. Describe strategies you will utilize for ongoing staff training, partner and provider outreach, partner collaborations, clear communication between PMHCA team members, and information sharing and dissemination to partners, stakeholders and the general public.
- e. Describe how you will engage child-patient advocates or youth self-advocates and families of children and adolescents with behavioral disorders to ensure services meet their needs.
- f. Describe the evidence-based practices and web-based education and training sessions that mental health care teams will provide to pediatric primary care providers and other providers to increase timely detection, assessment, treatment and referral of children and adolescents with behavioral disorders. This should include relevant content for times of crisis or a public health emergency, where there is an increase in behavioral disorders and an increased need to address family and provider wellness).
- g. Describe the faculty composition of the provider training program and their qualifications, including racial/ethnic demographic information of faculty. Describe how your project will provide training and education on the use of evidence-based, culturally and linguistically appropriate telehealth protocols to support the treatment of children and adolescents with behavioral disorders. Example models or types of training formats include Project Extension for Community Health Care Outcomes (ECHO), and Resource for Advancing Children's Health (REACH). Describe the number of sessions per year, the composition of members (should be representative of the racial, ethnic, and cultural diversity of the target population), the size of sessions, who will moderate, how topics will be selected, how topics will be presented, and provider recruitment and retention plans). Discuss tracking of provider attendance in training sessions and how pre- and post-testing will be incorporated into the training program to assess knowledge change over time. Describe how curriculum incorporates the overarching theme of providing family-centered, culturally/linguistically appropriate, and coordinated care in an interdisciplinary/interprofessional manner.
- h. Describe a plan to convene an advisory committee comprised of key stakeholders and agencies needed to support a statewide or regional pediatric mental health care access program, which may include mental health, public health, pediatric health and behavioral clinicians, human

services, health insurers, education, diversity, equity, and inclusion subject matter experts, and families.

- i. Establish methods to achieve project health equity goals and objectives in pediatric behavioral health.
 - j. Describe your plans for dissemination of project results. Provide a detailed plan describing how you will measure the effectiveness of the project, with respect to both dissemination of project results, and engagement with the population(s) served. Describe the method that will be used to disseminate the project's results and findings in a timely manner and in easily understandable formats to the target population(s), the general public, and other stakeholders who might be interested in using the results of the project. Recipients will be asked to provide information to MCHB in annual progress and performance reports about program activities, products, and lessons learned to facilitate knowledge dissemination.
 - k. Provide assurance that you will participate in an annual all-recipient meeting that will facilitate interchange with other PMHCA Programs, promote cross-recipient interchange, disseminate new information, and assist in the development of collaborative activities.
2. Describe your plan to secure resources (in cash or in-kind) to fulfill the 20 percent non-federal program matching requirement that was discussed in the Section III. 2. Cost Sharing/Matching. The match requirement allows recipients to leverage federal funds as they develop programs, deliver services, and conduct evaluations to test program success. These non-federal resources are important because they increase the capacity of projects during the period of performance. Federal funds complement available non-federal resources to support recipients as they add new components to existing programs and assess the potential for program scalability.
 3. Describe your plan for project sustainability after the period of federal funding ends. You are expected to sustain key elements of the project; those that have been effective in improving practices and those that have led to improved outcomes for the target population. Examples of methods that promote program sustainability include state budgetary support, state Medicaid reimbursement, third party payors, and support from other organizations.
- *WORK PLAN -- Corresponds to Section V's Review Criteria 2 [Response](#) and 4 [Impact](#)*
 1. Describe the activities or steps that you will use to achieve each of the objectives proposed during the entire period of performance in the Methodology section.
 2. Develop a timeline that links each activity to the program expectations, identifies responsible staff, and indicates progress milestones across the full 5-year period of performance.
 3. As appropriate, identify meaningful support, collaboration, and coordination with key stakeholders in planning, designing, and implementation of all activities, including development of the application. Describe the level of readiness of your organization and your expected partners' organizations, to

work together to achieve project goals and expectations. Letters of agreement, memoranda of understanding, and/or description(s) of proposed/existing contracts (project-specific) are required in **Attachment 4**.

4. The work plan must be submitted in table format as **Attachment 1**, and include all of the information detailed in this narrative in outline form.

▪ **RESOLUTION OF CHALLENGES** -- Corresponds to Section V's Review Criterion 2 [Response](#)

1. Discuss challenges that you are likely to encounter in designing and implementing the activities described in the work plan, and approaches that you will use to resolve such challenges.
2. Discuss how you will address the lack of behavioral clinicians for referral services in the target population. Describe your strategies, including the use of telehealth services to provide direct behavioral/mental services to children and adolescents as a gap-filling service until local behavioral clinicians are available.
3. Address how you intend to resolve any challenges related to the level of readiness of your organization and of your expected partner organizations, to work together to achieve project goals and expectations.
4. Discuss any challenges that you may encounter regarding initiation, sustainability, and liability for telehealth services and approaches that you will use to resolve such challenges.
5. Discuss any challenges and potential solutions for the long-term sustainability of the proposed project after the period of federal funding ends.
6. Discuss any challenges and potential solutions for data acquisition, including data agreements.
7. Discuss plans for addressing staff turnover or temporary reassignment of staff.
8. Describe plans to engage providers and practices and promote the program to increase provider participation over time, including plans to engage diverse and rural providers, and providers who serve children covered by Medicaid and CHIP.

▪ **EVALUATION AND TECHNICAL SUPPORT CAPACITY** -- Corresponds to Section V's Review Criteria 3 [Evaluative Measures](#), 4 [Impact](#), and 5 [Resources/Capabilities](#)

Describe and submit a preliminary project evaluation plan that will contribute to continuous quality improvement. Please include the evaluation plan in one attachment under **Attachment 7**). The plan should link the goals and objectives of the project with specific activities, expected outputs and outcomes, and overall impact. The plan should identify the data sources and data collection activities that will be conducted to identify outputs and outcomes. The evaluation plan should include process indicators focused on monitoring the effectiveness of implementation of program activities and ongoing processes to assess progress towards achieving project goals and objectives. Implementation data can be used to inform and improve program performance. Evaluation plans often evolve as a project progresses through a 5-year period of performance. HRSA will ask award recipients to provide updates to their evaluation plans and report findings of the

evaluation in their annual progress reports. An evaluation plan should include the following components:

1. An overall logic model that identifies program inputs, goals, objectives, activities, outputs, and outcomes.
 2. Descriptions of the inputs (e.g., organizational profile, collaborative partners, key personnel, budget, and other resources). Describe current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature.
 3. Data sources (e.g., measurements, performance measures, administrative data, etc.) and a strategy for collecting, analyzing, and tracking data to measure project performance, outcomes, and impact. You should demonstrate an ability to collect patient race and ethnicity data from enrolled providers during tele-consultation. Recipients will be responsible for reporting on the performance measures included at the end of this NOFO section. Describe the systems and processes that will support your organization's performance management requirements through effective tracking of performance outcomes, including a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes.
 4. Description of the activities, outputs, and projected short-, medium-, and long-term outcomes of the project.
 5. Description of the project's anticipated value to increase mental health care access using telephone and telehealth consultations as demonstrated through the evaluation of proposed services (e.g., clinical consultations, technical assistance, and distance learning).
- **ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion 5 Resource and Capabilities**
 1. **Applicant organization**
 - a. Succinctly describe your organization's current mission, structure, history, past experiences, and scope of current activities, provide your organizational chart (**Attachment 5**), and describe how these all contribute to the ability of the organization to conduct the project requirements and meet project expectations. Please also include how the administration and the fiscal management and oversight of the proposed project will be integrated into the current structure. If deficiencies have been noted in the most recent internal/external audit, review or reports on your organization's financial management system and management capacity or its implementation of these systems, policies and procedures, identify the corrective action taken to remedy the deficiencies.
 - b. Discuss expertise of staff who will be assigned to this project, as it relates to the scope of this project, e.g., telephone and telehealth consultation, care coordination, and provider training program. Discuss staff experience in pediatric health and behavioral health, and the health and behavioral health systems and resources serving children, adolescents and their families. At a minimum, as described under the Program Expectations in the Purpose section (Section I. 1.) of this NOFO, pediatric mental health

team members **must** represent the disciplines outlined in this NOFO and should be representative of the target population(s) served. If you would like to propose innovative additions to the staff on the team (e.g., diversity, equity, and inclusion subject matter experts, family leaders, child-patient advocates, youth self-advocates, faith-based leaders, professional organization leaders), discuss how these additional team members will improve the services provided by the project.

- c. Describe the staffing plan (excluding contractor's staff) which identifies positions that will provide personnel for essential programmatic, fiscal and evaluation activities. The Project Director and/or Program Manager from your organization should have adequate qualifications, appropriate experience and reasonable allocated time (%/FTE) to fulfill their proposed responsibilities. Your organization's Project Director and/or Program Manager perform duties such as attend calls with the HRSA Project Officer, meet regularly with project subcontractor, and facilitate collaboration with State Title V and other MCH-related agencies. Position descriptions of Key Personnel for the project should be placed in **Attachment 2**. Biographical sketches and curriculum vitae of Key Personnel for the project should be placed in **Attachment 3**.
- d. Describe organizational experience with the development and support of systems of health and behavioral health care for children and adolescents, including relevant statewide or regional programs.
- e. Demonstrate experience with implementing and sustaining telehealth programs (of applicable modalities and approaches).
- f. Provide information on the organization's resources and capabilities to support provision of and training on culturally and linguistically appropriate and health literate services appropriate for the population to be served.
- g. Describe how the unique needs of target population(s) are routinely assessed and improved.
- h. Discuss how the organization will follow the approved plan, as outlined in the application, properly account for the federal funds, and document all costs so as to avoid audit findings. You are expected to have sound systems, policies, and procedures in place for managing funds, equipment, and personnel to receive cooperative agreement support. All recipients must perform a substantive role in carrying out project activities and not merely serve as a conduit for an award to another party or to provide funds to an ineligible party.
- i. Demonstrate in the application that your organization will be able to fully implement the program within the 5-year period of performance, based on the organization's expertise, experience, resources, and capabilities in developing and supporting systems of health and behavioral health care for children and adolescents.

2. Project partners or partner organizations

- a. If the state Title V MCH program is not the lead applicant for your proposal, describe how you will develop, and/or maintain robust collaborative relationships between the proposed project and the state Title V MCH Program. Report on progress of these collaborative relationships annually in the progress report. State Title V Directors have a strong understanding of children's health needs because they conduct statewide, comprehensive needs assessments. Collaboration with the state Title V MCH Program can include technical assistance with the application and, subsequently, with program implementation. You can locate information on how to contact your state Title V MCH Program by visiting the [MCHB](#) web site.
- b. If the state Title V MCH program is not the lead applicant, a letter of support from the state Title V MCH Program **must** be included in one attachment under **Other Relevant Documents (Attachments 8–15)**.
- c. Describe the administrative and organizational structure within which the project will function, including relationships with other relevant departments, institutions, organizations, agencies, or subrecipients. Overall, organizational capacity may be demonstrated through partnerships with these other entities.
- d. Describe relationships with any organizations or subrecipients with which you intend to partner, collaborate, coordinate efforts or receive assistance from, while conducting project activities.
- e. Describe your planned oversight of, and frequency of communication with any partners or subrecipients. All subrecipients must report to your organization (the award recipient) and are held to the same cooperative agreement requirements.

iii. Budget

The directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions in Section 4.1.iv of HRSA's [SF-424 Application Guide](#) and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if HRSA selects the application for funding, you will have a well-organized plan and, by carefully following the approved plan, may avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) you incur to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by you to satisfy a matching or cost-sharing requirement, as applicable.

[HRSA's Standard Terms](#) apply to this program. Please see Section 4.1 of HRSA's SF-424 Application Guide for additional information. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II. The current Executive Level II salary is \$199,300. See Section 5.1.iv Budget – Salary Limitation of HRSA's [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations may apply in the following fiscal years, as required by law.

iv. Budget Narrative

See Section 4.1.v. of HRSA's [SF-424 Application Guide](#).

In addition, the American Rescue Plan Act - Pediatric Mental Health Care Access - New Area Expansion requires the following:

Awards are subject to adjustment after program and peer review. If this occurs, project components and/or activities will be negotiated to reflect the final award. Reviewers will deduct points from applications for which budgets are not thoroughly justified. The budget and budget narrative correspond to Section V's Review Criterion 6.

Provide the following:

- fully justify your requests by describing and identifying goals, objectives, activities, and outcomes that will be achieved by the proposed project during the period of performance.
- justify costs, as outlined in the budget and required resources sections, as they relate to the scope of work and the technology that will be required to implement the project.
- demonstrate that personnel have adequate time devoted to the project to achieve project objectives.

Budget travel funds and include justification for required PMHCA meetings, including the Pediatric Mental Health Care Access Program all-recipient meeting, which will be held every other year in the Washington, DC area, once routine travel is recommended by the CDC. At least one key program representative from each awarded project must attend. An in-person meeting will be held in Years 1 and 3 of the 5-year period of performance, and virtually in Years 2 and 4.

NARRATIVE GUIDANCE	
To ensure that you fully address the review criteria, this table provides a crosswalk between the narrative language and where each section falls within the review criteria. Any attachments referenced in a narrative section may be considered during the objective review.	
<u>Narrative Section</u>	<u>Review Criteria</u>
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response and (4) Impact
Work Plan	(2) Response and (4) Impact
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures, (4) Impact, and (5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities

Budget and Budget Narrative	(6) Support Requested
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v. Program-Specific Forms

Program-specific forms are not required for application.

vi. Attachments

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Clearly label each attachment.**

Attachment 1: Work Plan

Attach the work plan for the project that includes all information detailed in [Section IV. ii. Project Narrative, Work Plan](#).

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1. of HRSA's [SF-424 Application Guide](#))

Keep each job description to one page in length as much as is possible. It should include the role, responsibilities, and qualifications of proposed project staff. Include a description of your organization's time keeping process to ensure that you will comply with the federal standards related to documenting personnel costs. **NOTE: Key personnel for this project include:**

- Project director (provides overall oversight)
- Program manager (manages the day-to-day operations of the project)
- Fiscal manager (provides routine fiscal/budget tracking and oversight; ensures compliance with all federal fiscal requirements)
- Data manager (handles all data collection, reporting, and evaluation requirements of the project)

Attachment 3: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in **Attachment 2**, not to exceed two pages in length per person. In the event that one of your key personnel has not yet been hired, please include a letter of commitment from that person, along with their biographical sketch.

Attachment 4: Letters of Agreement, Memoranda of Understanding, and/or Description(s) of Proposed/Existing Contracts (project-specific)

Provide any documents that describe working relationships between your organization and other entities, programs, and/or subrecipients cited in the proposal. Documents that confirm actual or pending contractual or other agreements should clearly describe the roles of the contractors and any deliverable. Letters of agreement must be signed and dated.

Attachment 5: Project Organizational Chart

Provide a one-page figure that depicts your organizational structure, and where the American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion project will be managed, and by whom.

Attachment 6: Tables, Charts, etc.

To give further details about the proposal, as applicable (e.g., Gantt or PERT charts, flow charts, etc.).

Attachment 7: Preliminary Project Evaluation Plan

[See Section IV. ii. Evaluation and Technical Support Capacity](#) for more information about this plan.

Attachments 8–15: Other Relevant Documents

Include here any other documents that are relevant to the application and letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.).

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number Transition to the Unique Entity Identifier (UEI) and System for Award Management (SAM)

The requirements for SAM (System of Award Management) registration have temporarily changed due to the federal government's response to the COVID-19 pandemic. To support entities impacted by COVID-19, applicants are not required to have an active SAM registration at the time of submission of the application under this Notice of Funding Opportunity (NOFO). If not registered at time of award, HRSA requires the recipient to obtain a unique entity identifier (i.e., DUNS) and complete SAM registration within 30 days of the Federal award date.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

Currently, the Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (<http://www.dnb.com/duns-number.html>)
- System for Award Management (SAM) (<https://www.sam.gov>)
- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Application Guide](#).

[SAM.GOV](#) ALERT: For your SAM.gov registration, you must submit a [notarized letter](#) appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018.

In accordance with the Federal Government's efforts to reduce reporting burden for recipients of federal financial assistance, the general certification and representation requirements contained in the Standard Form 424B (SF-424B) – Assurances – Non-Construction Programs, and the Standard Form 424D (SF-424D) – Assurances – Construction Programs, have been standardized federal-wide. Effective January 1, 2020, the forms themselves are no longer part of HRSA's application packages and the updated common certification and representation requirements will be stored and

maintained within SAM. Organizations or individuals applying for federal financial assistance as of January 1, 2020, must validate the federally required common certifications and representations annually through SAM located at [SAM.gov](https://sam.gov).

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO is *July 6, 2021 at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA’s [SF-424 Application Guide](#) for additional information.

5. Intergovernmental Review

The American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA’s [SF-424 Application Guide](#) for additional information.

6. Funding Restrictions

You may request funding for a period of performance of up to 5 years, at no more than \$445,000 per year (inclusive of direct **and** indirect costs). Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project’s objectives, and a determination that continued funding would be in the best interest of the Federal Government.

HRSA’s Standard Terms apply to this program. Please see Section 4.1 of HRSA’s SF-424 Application Guide for additional information.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR § 200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the [HRSA Grants Policy Bulletin Number: 2021-01E](#).

All program income generated as a result of awarded funds must be used for approved project-related activities. The program income alternative applied to the award(s) under

the program will be the addition/additive alternative. You can find post-award requirements for program income at [45 CFR § 75.307](#).

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review and to assist you in understanding the standards against which your application will be reviewed. HRSA has critical indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation.

These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review,

Review criteria are used to review and rank applications. The American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion has six review criteria. See the review criteria outlined below with specific detail and scoring points.

Criterion 1: NEED (10 points) – Corresponds to Section IV's [Introduction](#) and [Needs Assessment](#)

1. The strength of the proposed project's purpose and whether it demonstrates an expert understanding of the issues and needs (statewide or regional), goals, and expectations of the project requested in this NOFO.
2. The adequacy of the description and justification of the geographic and target population(s) to be served.
3. The strength of the description of socio-cultural determinants of health and health disparities that impact the population(s) or communities served including unmet needs especially in rural (frontier or hard to reach) or other underserved areas.
4. The strength and effectiveness of how the proposed project will meet the unmet needs, especially in rural or other underserved areas.
5. The adequacy of the discussion of relevant barriers in the service area that the project hopes to overcome and possible solutions.
6. The strength of the description of the current state of telehealth capabilities in networks (technology, training, legal, clinical, etc.) and the gaps that need to be filled for the initiation and sustainment of telehealth activities.

Criterion 2: RESPONSE (25 points) – Corresponds to Section IV's [Methodology](#), [Work Plan](#), and [Resolution of Challenges](#)

Methodology (10 points)

1. The strength of the response to the activities (A–I) outlined under [section I. 1 of the NOFO](#).
2. The strength and reasonableness of the plan to implement the program within the 5-year period of performance.

3. The strength of the evidence-based practices and web-based education and training sessions that mental health care teams will provide to pediatric primary care providers to increase timely detection, assessment, treatment and referral of children and adolescents with behavioral disorders.
4. The strength of the proposed methods to achieve project health equity goals and objectives in pediatric behavioral health.
5. The adequacy of plans to participate in HRSA's technical assistance activities, including sharing best practices, and lessons learned.
6. The effectiveness of the plan to ensure that federal funds secured through this funding opportunity will complement existing non-federal resources to build a new program or build upon, expand, and enhance existing programs that do not currently have HRSA funding and assess the potential for program scalability.

Work Plan (10 points)

1. The strength and feasibility of the proposed framework and methodologies described to meet project goals, expectations, and requirements. The applicant **must** include a work plan in **Attachment 1**.
2. The feasibility of the proposed project based upon the level of readiness and decision-maker support of the applicant and expected partners to work together to achieve project goals, expectations and requirements.
3. The strength of the plan to support an advisory committee consisting of key stakeholders needed to support a pediatric mental health care access program, which may include mental health, public health, pediatric health and behavioral clinicians, human services, health insurers, education, diversity, equity, and inclusion subject matter experts, and families.

Resolution of Challenges (5 points)

The effectiveness of the application in reasonably anticipating project challenges and describing realistic approaches to resolve the challenges, such as lack of behavioral clinicians to refer children and adolescents in rural and other underserved areas.

Criterion 3: EVALUATIVE MEASURES (20 points) – Corresponds to Section IV's [Evaluation and Technical Support Capacity](#)

1. The strength of the proposed methods to monitor and evaluate project performance, outcomes, impact, and sustainability efforts.
2. The capability of the applicant to collect and report on, at a minimum, the required performance and outcome measures in the Evaluation and Technical Support Capacity section of this NOFO.
3. The strength of a plan to participate in HRSA's Pediatric Mental Health Care Access Program evaluation activities.
4. The strength of the program performance evaluation in ensuring continuous quality improvement.
5. The strength of the applicant's description of the:

- a. systems and processes that will support the organization's performance management requirements;
- b. data collection strategy to collect, analyze and track data to measure performance, outcomes, and impact;
- c. potential obstacles to implementing the program performance evaluation, and plans to address those obstacles;
- d. how the evaluation findings will (1) track progress towards the achievement of project goals and objectives throughout implementation of the program; and (2) inform program management and improvement activities, such as revising implementation activities, redirecting program resources to under-performing program components and enhancing data-driven programmatic decision-making.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's [Methodology](#), [Work Plan](#), and [Evaluation and Technical Support Capacity](#)

1. The feasibility and effectiveness of plans for dissemination of project results, and engagement with the population(s) served.
2. The reasonableness of the project's anticipated value to health care using psychiatric telephone and telehealth consultations and care coordination.
3. The reasonableness of plans for securing resources (in cash or in-kind) to fulfill the 20 percent non-federal program matching requirement that is outlined under [Section III., 2., Cost Sharing/Matching](#).
4. The reasonableness of the plan proposed for project sustainability after the period of federal funding ends.

Criterion 5: RESOURCES/CAPABILITIES (25 points) – Corresponds to Section IV's [Evaluation and Technical Support Capacity](#), and [Organizational Information](#)

Applicant Organization (15 points)

The strength, reasonableness, and effectiveness to which:

1. The applicant organization, proposed partners, and project staff are qualified by training, expertise, and/or experience to implement and carry out the project, and applicant organization demonstrates that it will perform a substantive role in carrying out programmatic, administrative and fiduciary responsibilities and will not merely serve as a conduit for an award to another party (subcontractor) or to provide funds to an ineligible party.
2. The applicant organization demonstrates experience in the development and support of systems of health and behavioral health care for children and adolescents, including relevant statewide or regional programs, and experience in pediatric health and behavioral health, and the health and behavioral health systems and resources serving children, adolescents, and their families.
3. The applicant will develop, and/or maintain collaborative relationships between the proposed project and the state Title V MCH Program, if the state Title V MCH program is not the lead applicant for the proposal. If not the lead applicant, the applicant **must** provide a letter of support from the state Title V MCH Program as an attachment under Other Relevant Documents (**Attachments 8–15**).
4. The applicant describes their organization's mission, structure, and scope of

current activities; and whether these components contribute to the organization's ability to conduct the project requirements and meet the project goals and objectives. The applicant **must** include a project organizational chart in **Attachment 5**.

5. The applicant discusses how their organization will be able to fully implement the program within the 5-year period of performance, based on the organization's expertise, experience, resources, and capabilities in developing and supporting systems of health and behavioral health care for children and adolescents.
6. Project personnel, including proposed partners (as listed under Section I. 1, Program Expectations), have sufficient training, qualifications, expertise, and experience to carry out the project, as demonstrated in the application. At a minimum, pediatric mental health care team members **must** represent the disciplines outlined in this NOFO and should be representative of the target population(s) served. If the applicant has proposed innovative additions to the staff on the team (e.g., family leaders, child-patient advocates, youth self-advocates), the extent to which these additional team members will improve the services provided by the project. The applicant **must** include a staffing plan and job descriptions for key personnel in **Attachment 2**. The applicant **must** include biographical sketches in **Attachment 3**.

Project Partners and Partner Organizations (10 points)

The extent to which:

1. The applicant provided a sufficient description of proposed partners, including subrecipients, described relationships to, roles and responsibilities of program implementation, and demonstrates commitments from (e.g., letters of agreement in **Attachment 4**), any organization, entity, or subrecipient that is a critical partner in this project.
2. The applicant fully describes its oversight of and frequency of communication, roles, and responsibilities of partners and subrecipients to provide evidence that the applicant will not merely serve as a conduit for an award to partners and subrecipients.
3. The applicant has sufficient resources and staff with established relationships and/or demonstrated outreach and partnership capability to engage and activate all partners in the state or region, especially pediatric primary care practitioners (pediatricians, family physicians, nurse practitioners, and physician assistants), psychiatrists, behavioral health professionals, and care coordinators.

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV's [Budget](#) and [Budget Narrative](#)

1. The reasonableness of the proposed budget for each year of the period of performance in relation to the objectives, the complexity and timing of the activities, and the anticipated results.
2. The reasonableness of costs, as outlined in the budget and required resources sections, given the scope of work and the technology that will be required to implement the project.
3. The strength of the application in demonstrating key personnel have adequate time devoted to the project to achieve project objectives.

4. The adequacy of the application in discussing how the applicant organization will account for federal funds, and document all costs in order to avoid audit findings.

2. Review and Selection Process

The objective review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below. See Section 5.3 of HRSA's [SF-424 Application Guide](#) for more details.

3. Assessment of Risk

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory, or other requirements ([45 CFR § 75.205](#)).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of your management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will determine whether HRSA can make an award, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

HRSA is required to review and consider any information about your organization that is in the [Federal Awardee Performance and Integrity Information System \(FAPIIS\)](#). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider your comments, in addition to other information in [FAPIIS](#) in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

HRSA will report to FAPIIS a determination that an applicant is not qualified ([45 CFR § 75.212](#)).

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award (NOA) prior to the start date of September 30, 2021. See Section 5.4 of HRSA's [SF-424 Application Guide](#) for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's [SF-424 Application Guide](#).

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

Accessibility Provisions and Non-Discrimination Requirements

Federal funding recipients must comply with applicable federal civil rights laws. HRSA supports its recipients in preventing discrimination, reducing barriers to care, and promoting health equity. For more information on recipient civil rights obligations, visit the HRSA Office of Civil Rights, Diversity, and Inclusion website.

Requirements of Subawards

The terms and conditions in the NOA apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See [45 CFR § 75.101 Applicability](#) for more details.

Data Rights

All publications developed or purchased with funds awarded under this notice must be consistent with the requirements of the program. Pursuant to 45 CFR § 75.322(b), the recipient owns the copyright for materials that it develops under an award issued pursuant to this notice, and HHS reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use those materials for federal purposes, and to authorize others to do so. In addition, pursuant to 45 CFR § 75.322(d), the Federal Government has the right to obtain, reproduce, publish, or otherwise use data produced under this award and has the right to authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes, e.g., to make it available in government-sponsored databases for use by others. If applicable, the specific scope of HRSA rights with respect to a particular grant-supported effort will be addressed in the NOA. Data and copyright-protected works developed by a subrecipient also are subject to the Federal Government's copyright license and data rights.

Human Subjects Protection:

Federal regulations ([45 CFR part 46](#)) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If you anticipate research involving human subjects, you must meet the requirements of the HHS regulations to protect human subjects from research risks.

- Please refer to instructions provided in HRSA's [SF-424 R&R Application Guide](#), Appendix Supplemental Instructions for Preparing the Protection of Human Subjects Section of the Research Plan and Human Subjects Research Policy for specific instructions on preparing the human subjects section of the application.
- Please refer to HRSA's [SF-424 R&R Application Guide](#) to determine if you are required to hold a Federal Wide Assurance (FWA) of compliance from the Office of Human Research Protections (OHRP) prior to award. You must provide your Human Subject Assurance Number (from the FWA) in the application. If you do not have an assurance, you must indicate in the application that you will obtain one from OHRP prior to award.
- In addition, you must meet the requirements of the HHS regulations for the protection of human subjects from research risks, including the following: (1) discuss plans to seek IRB approval or exemption; (2) develop all required documentation for submission of research protocol to IRB; (3) communicate with IRB regarding the research protocol; (4) communicate about IRB's decision and any IRB subsequent issues with HRSA."
- IRB approval is not required at the time of application submission but must be received prior to initiation of any activities involving human subjects. Do not use the protection of human subjects section to circumvent the page limits of the [Methods](#) portion of the Project Narrative section.

3. Reporting

Award recipients must comply with Section 6 of HRSA's [SF-424 Application Guide](#) and the following reporting and review activities:

- 1) **DGIS Performance Reports.** Available through the Electronic Handbooks (EHBs), the Discretionary Grant Information System (DGIS) is where recipients will report annual performance data to HRSA. Award recipients are required to submit a DGIS Performance Report **annually**, by the specified deadline. To prepare successful applicants for their reporting requirements, the listing of administrative forms and performance measures for this program are available at https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/U4C_4.HTML. The type of report required is determined by the project year of the award's period of performance.

Type of Report	Reporting Period	Available Date	Report Due Date
a) New Competing Performance Report	9/30/2021 to 9/29/2022 <i>(administrative data and performance measure projections, as applicable)</i>	Period of performance start date	120 days from the available date
b) Non-Competing Performance Report	9/30/2022 to 9/29/2023 9/30/2023 to 9/29/2024 9/30/2024 to 9/29/2025	Beginning of each budget period (Years 2–4, as applicable)	120 days from the available date
c) Project Period End Performance Report	9/30/2025 to 9/29/2026	Period of performance end date	90 days from the available date

The full OMB-approved reporting package is accessible at <https://mchb.hrsa.gov/data-research-epidemiology/discretionary-grant-data-collection> (OMB Number: 0915-0298 | Expiration Date: 06/30/2022).

- 2) **Progress Report(s)**. The recipient must submit a progress report narrative to HRSA **annually** via the Non-Competing Continuation Renewal in the EHBs, which should address progress against program outcomes (e.g., accomplishments, barriers, significant changes, plans for the upcoming budget year). Submission and HRSA approval of a progress report will trigger the budget period renewal and release of each subsequent year of funding. Further information will be available in the NOA.

In addition to Discretionary Grant Information System (DGIS) reporting in [Section VI.3. Reporting](#), recipients will be expected to collect and report to HRSA in their annual performance, progress reports, or requests for information, the following data:

Performance Measures

Recipients will establish baseline numbers for, and track and report on annually, at a minimum, the following performance measures:

1. Number of trainings held by topic and mechanism used (e.g., in-person, web-based).
2. Number and types of providers trained by training type (e.g., Project ECHO, other distance learning training, in-person training).
3. Number and types of providers enrolled in a statewide or regional pediatric mental health care access program.

4. Percentage of primary care providers enrolled in a statewide or regional pediatric mental health care access program who receive tele-consultation on behavioral health conditions.
5. Reasons for provider contact with the pediatric mental health team (e.g., psychiatric consultation and/or care coordination, and suspected or diagnosed behavioral health conditions such as depression, anxiety, ADHD, Autism Spectrum Disorder).
6. Course of action to be taken by provider as result of contact with the pediatric mental health team and number of times each course of action was recommended (e.g., medication evaluation/change, use of screening tool or instrument, referral to community-based support services or resources, referral to behavioral health provider).
7. Number of consultations and referrals provided to enrolled providers by the pediatric mental health team, by enrolled provider discipline type, and by telehealth mechanism (e.g., telephone, videoconferencing, email).
8. Number of consultations and referrals provided by each discipline type (e.g., psychiatrist, counselor, care coordinator) of the pediatric mental health team.
9. Number and types of community-based mental health and support service and service providers in the telehealth referral database (e.g., childcare, employment/job-seeking training, food programs, housing support, parenting support, school-based services, behavioral health services, inpatient and outpatient treatment programs; inpatient hospitalization or emergency department; all other clinical provider services including medication management; and all other service or service provider types).
10. Types of referrals provided by the pediatric mental health team (e.g., behavioral health services, inpatient and outpatient treatment programs; inpatient hospitalization or emergency department; other clinical provider services including medication management; school-based services; parenting support.)
11. Number of children and adolescents, 0–21 years of age, for whom a provider contacted the pediatric mental health team for consultation or referral during the reporting period.
12. Number of referrals provided to children and adolescents, 0–21 years of age, for whom a primary care provider contacted the pediatric mental health team during the reporting period
13. Number of children and adolescents, 0–21 years of age, for whom a provider contacted the pediatric mental health team, who received at least one screening for a behavioral health condition using a standardized validated tool.
14. Percentage of children and adolescents, 0–21 years of age, for whom providers contacted the pediatric mental health team for consultation or referral during the reporting period, from rural and underserved counties.
15. Number of children and adolescents, 0–21 years of age, for whom a primary care provider contacted the pediatric mental health team during the reporting period, who were recommended for referral to a behavioral clinician or treatment from the primary care provider
16. Number of children and adolescents, 0–21 years of age, for whom a primary care provider contacted the pediatric mental health team during the reporting period, who screened positive for a behavioral health condition using a

validated tool, and who were recommended for referral to a behavioral clinician or treatment from the primary care provider.

A glossary of terms used in PMHCA progress report instructions, performance reports, and Requests for Information is included in the [Appendix](#).

Please note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at [2 CFR § 200.340 - Termination](#) apply to all federal awards effective August 13, 2020.

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Kaleema Ameen | Crystal Howard | Leon Harrison
Grants Management Specialists
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10N104C/10N176D
Rockville, MD 20857
Telephone: (301) 443-7061/3844/9368
Email: kameen@hrsa.gov | choward@hrsa.gov | lharrison@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Madhavi M. Reddy, MSPH | Kelly Dawson Hughes, MPH | Cara de la Cruz, PhD
Public Health Analysts, DMCHWD
Attn: The American Rescue Plan Act - Pediatric Mental Health Care Access – New Area Expansion
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18W52
Rockville, MD 20857
Telephone: (301) 443-0754 | (301) 945-3331 | (301) 443-0764
Email: mreddy@hrsa.gov | kdawson@hrsa.gov | cdelacruz@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: support@grants.gov

Self-Service Knowledge Base: <https://grants-portal.psc.gov/Welcome.aspx?pt=Grants>

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through [HRSA's Electronic Handbooks \(EHBs\)](#). For assistance with submitting information in the EHBs, contact the HRSA Contact Center, Monday–Friday, 8 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: <http://www.hrsa.gov/about/contact/ehbhelp.aspx>

VIII. Other Information

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Wednesday, May 26, 2021

Time: 2–3:30 p.m. ET

Weblink: <https://hrsa.gov.zoomgov.com/j/1612447695?pwd=R0xzaVYwZzAzTkJTeWIPREJNZGtxQT09>

Meeting ID: 161 244 7695

Weblink Passcode: PMHCA21!

- Computer audio is recommended (make sure computer speakers are “on”)
- Click the link above and select ‘**Join with Computer Audio**’

If you won't have computer access or computer audio, you can use the dial-in information below:

Call-In Number (if you can only participate by telephone): 1-833-568-8864 (US Toll-free); 1-551-285-1373 (US)

Meeting ID: 161 244 7695

Participant Code: 97651244

A recording of this technical assistance webinar will be posted to the PMHCA web page: <https://mchb.hrsa.gov/training/pgm-pmhca.asp>.

Tips for Writing a Strong Application

See Section 4.7 of HRSA's [SF-424 Application Guide](#).

508 Compliance Disclaimer

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, please email or call one of the HRSA staff above in [Section VII. Agency Contacts](#).

Appendix: Additional Resources for Applicants

Applicants should view a list of currently funded PMHCA projects to determine whether they are eligible to apply:

<https://mchb.hrsa.gov/training/projects.asp?program=34>

Applicants may wish to consult the following resources as they prepare their applications:

- HRSA MCHB PMHCA program page, including program overview, abstracts, reporting resources: <https://mchb.hrsa.gov/training/pgm-pmhca.asp>
- *HRSA's Telehealth Resource Centers* provide assistance, education, and information to organizations and individuals who provide or are interested in providing health care at a distance, especially for underserved populations. <https://www.telehealthresourcecenter.org/>
- HRSA's *Rural Health Information Hub's Community Health Gateway* is a resource for finding programs and approaches that rural communities can adapt to improve the health of their residents. healthinfo.org/community-health
- *The American Academy of Pediatrics Mental Health Toolkit* outlines strategies to enhance pediatric mental health at both the community level and in individual pediatric practices. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx>
- *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition is a resource that provides health care professionals with updated background and recommendations for pediatric health promotion, health supervision, and anticipatory guidance for 31 age-based visits. The 4th Edition builds upon previous editions with thoroughly revised and updated content that reflects the latest research. It presents a new focus on the social determinants of health and on lifelong physical and mental health. The Bright Futures/AAP Periodicity Schedule presents (in chart form) the screenings, assessments, physical examinations, procedures, and timing of anticipatory guidance recommended for each age-based visit in the *Bright Futures Guidelines*, 4th Edition. <https://brightfutures.aap.org/Pages/default.aspx>
- *American Telemedicine Association*: <http://www.americantelemed.org>
- *Medicaid and Telemedicine*: <https://www.medicare.gov/medicaid/benefits/telemed/index.html>

PMHCA Glossary of Terms

Background:

The terms defined in this document are some of the terms used in PMHCA progress report instructions, performance reports, and Requests for Information. The terms are as follows:

- Assessment
- Care coordination
- Direct Service
- Health Education
- Information Dissemination
- Outreach
- Enrolled or Participating Provider or Practice
- Quality improvement initiatives
- Referral
- Rural
- Screening
- Technical Assistance
- Telehealth
- Training
- Treatment
- Underserved

Definitions:

Assessment

- **Clinical Assessment:** A detailed evaluation within a provider's scope of practice that applies clinical reasoning based on the following types of information: patient history, diagnostic interviewing, physical examination, laboratory evaluation, standardized questionnaires and/or observations from family members, care providers, teachers, or other care team members. (Sources: Adapted from Mosby's Medical Dictionary, 9th edition. © 2009, Elsevier. <https://medical-dictionary.thefreedictionary.com/clinical+assessment> and Bates Guide to Physical Examination and History Taking, 12th North American Ed. 2016)

Care Coordination

- **Care coordination** involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient. (Source: AHRQ, <https://www.ahrq.gov/ncepcr/care/coordination.html>)

- **Pediatric care coordination** is “patient and family centered, assessment driven, team based. Care coordination services facilitate linkage of children and their families with appropriate services and resources that meet their health and social needs to achieve optimal health. This care is to be distinguished from case management which primarily focuses on the children’s medical issues.” (Source: Title V, § 501(b)(3))

Examples of broad care coordination approaches include:

- Interdisciplinary teamwork.
- Care management.
- Medication management.
- Health information technology.
- Patient/family-centered medical home.

Examples of specific care coordination activities include:

- Establishing accountability and agreeing on responsibility.
- Communicating/sharing knowledge.
- Helping with transitions of care.
- Assessing patient needs and goals.
- Creating a proactive care plan.
- Monitoring and follow-up, including responding to changes in patients' needs.
- Supporting patients' self-management goals.
- Linking to community resources.
- Working to align resources with patient and population needs.

Direct Services

- **Direct services are primary, specialty, or preventive clinical services to patients.**

Examples: Preventive, primary or specialty care visits, emergency department visits, inpatient services, outpatient and inpatient mental and behavioral health services, prescribing prescription drugs, occupational and physical therapy, speech therapy, showing how to use durable medical equipment and medical supplies, medical nutrition therapy, dental care, and vision care. (Source: Title V OMB Approved FY 2019_2021 MCH Block Grant Guidance Appendix)

Enrolled or Participating Provider or Practice

Enrolled or participating provider or practice is defined as a provider or practice who registers to participate in tele-consultation and care coordination services and agrees to provide data to facilitate HRSA-required reporting. The use of the term “enrolled” does not apply to providers or practices where providers participate in training only. Award recipients may require providers or practices to enroll in their program, in order to track usage and outcomes, as well as assure higher quality service to repeat users.

Health Education

Health education is a strategy for implementing health promotion and disease prevention programs. Health education provides learning experiences on health topics. Health education strategies are tailored for their target population. Health education presents information to target populations on particular health topics, including the health benefits/threats they face, and provides tools to build capacity and support behavior change in an appropriate setting.

(Source: <https://www.ruralhealthinfo.org/toolkits/health-promotion/2/strategies/health-education>)

Examples:

- Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: Chronic diseases; Injury and violence prevention; Mental illness/behavioral health; Unintended pregnancy; Oral health; Tobacco use; Substance misuse; Nutrition; Physical activity; and Obesity prevention.

Information Dissemination

- The targeted distribution of information and intervention materials to a specific public health or clinical practice audience. The intent is to spread knowledge and the associated evidence-based interventions. (Source: Adapted from AHRQ, Communication and Dissemination Strategies To Facilitate the Use of Health-Related Evidence <https://effectivehealthcare.ahrq.gov/products/medical-evidence-communication/research-protocol/>)

Examples:

- Dissemination of information via listservs, newsblasts, websites, and public service announcements
- Sharing information briefs, fact sheets, infographics, annual reports, and other project-related materials
- Sharing details about upcoming webinars or events, to include those hosted by partner organizations
- Leaving handouts/providing informational materials to professionals/professional organizations about the project

Outreach

- Outreach is an engagement effort by project team members to connect ideas or practices to the efforts of individuals and organizations. Outreach can encompass education, dissemination, and engagement to support recruitment of program participants. (Source: Adapted from Boston University, Community Health Worker Model)

Examples:

- Engaging in the community (e.g., in-person visits, walk-arounds, phone calls, emails) to raise awareness of your program and recruit participants
- Representing the project at community resource fairs
- Giving handouts at conference exhibit booths or during poster sessions

Quality Improvement

- Quality Improvement (QI) consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of individuals in targeted groups.

(Sources: Health Resources and Services Administration, Quality Improvement 2011

<https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf>; Lean Enterprise Institute <https://www.lean.org/WhatsLean/>, <http://www.asq.org>; Institute for Healthcare Improvement <http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>)

Examples:

- PDSA: The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in process by developing a strategy (Plan) to test change, (Do) to carry out the test, (Study) to observe and learn from the test change, and (Act) develop and implement modifications to the test.
- LEAN: Creating more value for customers with fewer resources, a LEAN process improvement plan is usually created within an organization to provide lean production; a systemic method for waste minimization within a system without sacrificing productivity. LEAN also looks at overburden and waste created through workload unevenness.
- Six Sigma: The main focus is on reducing process variation and enhancing process control by utilizing the problem solving approach of define, measure, analyze, improve and control.

Referral

- A process whereby an individual or the individual's family is introduced to additional health resources in the community. (Source: Adapted from <https://medical-dictionary.thefreedictionary.com/referral>)

Rural (including frontier and hard-to-reach)

- HRSA defines rural (including frontier and hard to reach) areas as all non-Metro counties and uses an additional method of determining rurality called the Rural - Urban Commuting Area (RUCA) codes. This rural definition can be accessed [here](#). If the county is not entirely rural or urban, follow the link for “[Health Grants Eligibility by Address](#)” to determine if a specific site qualifies as rural based on its specific census tract within an otherwise urban county.

Screening

- Use of a brief, standardized validated tool (e.g., questionnaire) to identify the possible presence of a problem, which may lead to more detailed assessments when indicated. (Sources: Adapted from the HRSA Screening and Treatment for Maternal Depression and Related Behavioral Disorders notice of funding opportunity; Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series, No. 51. HHS Publication

No. (SMA) 13-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. <https://store.samhsa.gov/system/files/sma15-4426.pdf>)

Technical Assistance (TA)

- The process of providing advice, assistance, and training to recipient(s) by an expert with specific technical/content knowledge to address an identified need and offer solutions (Source: Adapted from Appendix H of the MCH Block Grant - Application/Annual Report Guidance, Appendix of Supporting Documents <https://grants6.tvisdata.hrsa.gov/uploadedfiles/Documents/blockgrantguidanceappendix.pdf>)

Telehealth

- Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. (Source: <https://www.hrsa.gov/rural-health/telehealth/index.html>)

Training

- The process of enrolling an individual in and providing a planned, prepared, and coordinated program, course, or curriculum, in scientific, professional, technical, or other fields, which will improve individual and organizational performance; assist the individual in attaining a required level of knowledge or skill; and assist in achieving the organization's mission and performance goals. (Sources: Adapted from <https://www.law.cornell.edu/uscode/text/5/4101>; <http://www.businessdictionary.com/definition/training.html>)

Treatment

- Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another. (Source: [Uses and Disclosures for Treatment, Payment, and Health Care Operations 45 CFR 164.506](#))

Underserved

- Underserved areas are defined by the following terms: Any Medically Underserved Area/Population (MUA/P); or a Partially MUA/P. MUA/Ps are accessible through <https://data.hrsa.gov/tools/shortage-area/mua-find>. Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population.