

**DHHS**

**Virtual Behavioral Health Services Grant Program**

**Application**

 **NC DHHS Notice of Funding Availability**

Reporting Form



**DHHS Division/Office issuing this notice**: Office of Rural Health

**Date of this notice:** **June 13, 2022**

**Grant Applications will be accepted beginning June 13, 2022**

**Deadline to Receive Applications: July 22,2022**

**Working Title of the funding program:** Virtual Behavioral Services Grant Program

**Purpose: Description of function of the program and reason why it was created:**

The American Rescue Plan Act (ARPA) was enacted on March 11, 2021, to provide relief to address the continued impact of COVID-19 on the economy, public health, state and local governments, individuals, and businesses. A component of ARPA is the State Fiscal Recovery Fund (SFRF) which provides $5.4 billion to North Carolina to help turn the tide on the pandemic, address its economic fallout, and lay the foundation for a strong and equitable recovery. Funds can be used to:

* Support urgent COVID-19 response efforts to continue to decrease spread of the virus and bring the pandemic under control.
* Replace lost revenue for eligible state, local, territorial, and Tribal governments to strengthen support for vital public services and help retain jobs.
* Support immediate economic stabilization for households and businesses.
* Address systemic public health and economic challenges that have contributed to the unequal impact of the pandemic.

The N.C. General Assembly appropriated SFRF in Session Law 2021-180. Under this Session Law, Section 9B.8A.(a) established the creation of the competitive Virtual Behavioral Health Services Grant Program to expand telepsychiatry capacities to respond to the COVID-19 public health emergency by allowing patients being served in primary care settings to access hospital-based virtual psychiatric assessments and consultations from a primary care provider’s office, from home, or from another nonhospital setting.

The N.C. Office of State Budget and Management has determined that the SFRF funding for this grant program is classified as provision of government services within the state’s calculated reduction of revenue due to the COVID-19 public health emergency. This award will be administered and reported under Expenditure Category 6.1 – Revenue Replacement: Provision of Government Services – under the United States Department of the Treasury’s Compliance and Reporting Guidance (updated February 28, 2022).

**RFA Description**

The North Carolina Office of Rural Health (ORH) is accepting applications from hospitals to fund expanded telepsychiatry capabilities as a response to the COVID-19 public health emergency. This initiative will allow patients being served in a primary care setting to access hospital-based virtual psychiatric assessments and consultations. At a minimum, telepsychiatry capabilities must facilitate patient access to hospital-based virtual telepsychiatry services from a primary care provider's office, from home, or from another nonhospital setting. Applicant must demonstrate ability to maintain patient safety and ensure continuity of care. A key component of SFRF is ensuring projects are designed with equity in mind. The projects submitted under this RFA will need to demonstrate equity by indicating which populations are the intended audience (historically underserved, marginalized or adversely affected groups, economically disadvantaged communities, rural and underserved communities, etc.). Applicant must develop and document a realistic and achievable project sustainability plan. For the purposes of this RFA, an originating site is defined as the location of the patient and a distance site is defined as the telehealth site where the provider/ specialist is seeing the patient at a distance.

**Eligibility:**

All North Carolina-based hospitals with behavioral health programs that can be expanded to include virtual services in primary care settings, from home, or from another nonhospital setting are eligible to apply. Only one application per hospital system will be accepted.

**Maximum Award Amount: $1,500,000**

**Funding Period:**

All funds must be used for costs incurred during the period that begins on March 3, 2021 and ends on December 31, 2024. Funds for financial obligations incurred by December 31, 2024 must be expended by December 31, 2026.

**Award Information:**

Funding requests are contingent upon availability of program funding. This funding is not recurring. Highest scoring applicants will receive an award based on scoring criteria established in this RFA. Awards will represent multiple geographic areas of the State.

As a condition of receiving a grant award, successful applicants must:

* Complete contract process by specified due date
* Submit expense reports in a format specified by ORH for reimbursement
* Submit performance reports quarterly or biannually throughout the grant term as specified by ORH
* Connect or have a plan to connect to NC HealthConnex (*To meet the state’s mandate, a provider is “****connected****” when its clinical and demographic information are being sent to NC HealthConnex at least twice daily.” For further information, please see the HIEA website*:  <https://hiea.nc.gov>)
* Develop and document a realistic and achievable project sustainability plan
* Provide letter of collaboration or MOU/MOA signed by primary care offices or non-hospital settings that are not owned, operated or managed by the applicant hospital.
* The Recipient is responsible for adhering to all state and federal requirements on record retention and any changes to state and federal requirements during the contract period. The Recipient shall maintain all pertinent records for a period of five years after all funds have been expended or returned to US Treasury or until all audit exceptions have been resolved, whichever is longer.

**How to Apply:**

Applicants must submit the following documents electronically through the electronic application.

1. Organizational Information and Signature Sheet
2. Organizational Profile
3. Summary of Evaluation Criteria and Baseline Data
4. Grant Narrative
5. Budget
6. Federal Certifications
7. Conflict of Interest Acknowledgement and Related Policy
8. EO224 COVID Vaccination and Testing Certification
9. IRS Tax Exemption Certification
10. State Certification
11. No Overdue Tax Debt Certification
12. FFATA form

**Access to Electronic Application:**

Access to the electronic application is a two-step process:

* **Step One:** Use the ORH application link to submit the hospital name and contact information. The link opens on June 13, 2022 and closes on July 22,2022.

ORH Application Link:

https://ncruralhealth.az1.qualtrics.com/jfe/form/SV\_5w0gyxXnEwjp2C2

* **Step Two:** Upon submitting the required information to the ORH Application Link, an email with a personalized link specific to your hospital will be sent. The link in the email will provide access to the electronic application. The application closes July 22,2022. Please begin the application process in time to ensure completion on or before July 22,2022. No new application links will be sent after July 22,2022.

Applications must be complete, and agencies must respond to all application requirements. Incomplete applications, or applications not completed in accordance with the instructions, will not be reviewed.

All applicants will receive a confirmation notice after an application has been successfully submitted.

**For assistance with the application link contact: Eric Bell at** [**eric.bell@dhhs.nc.gov**](mailto:eric.bell@dhhs.nc.gov)

**How to Obtain Further Information:**

All questions regarding the RFA and/or application should be submitted in writing to [orh\_hit@dhhs.nc.gov](mailto:orh_hit@dhhs.nc.gov).

Funding Agency Contact/Inquiry Information: Eric Bell at[**eric.bell@dhhs.nc.gov**](mailto:eric.bell@dhhs.nc.gov)

**Technical Assistance Webinar:**

**June 22,2022 at 10:00 AM**

<https://www.zoomgov.com/j/1610759137?pwd=dUFlUStvTmhSYXh0UEQ0OHB1OHY5dz09>

Virtual Behavioral Health Services Grant Program.

**ORGANIZATION INFORMATION and SIGNATURE SHEET**

|  |  |
| --- | --- |
| Hospital Name: |  |
| Hospital EIN: |  |
| Hospital NPI  (if applicable): |  |
| DUNS (if applicable): |  |
| Mailing Address: |  |
| Hospital Fiscal Year: |  |

Is your hospital located within North Carolina?

¨ Yes ¨ No

Will your project expand hospital-based telepsychiatry services to patients in primary care provider’s offices, from home, or from another nonhospital setting to respond to COVID-19 public health emergency?

¨ Yes ¨ No

**Summary of Request:** Provide a brief description of how your project will expand hospital-based telepsychiatry services to patients in primary care provider’s offices, from home, or from another nonhospital setting. (800-character limit):

**Total Amount of Grant Request** (cannot exceed $1,500,000):

|  |  |
| --- | --- |
| Grant Contact Name: |  |
| *Grant Contact serves as the primary grant contact for the duration of the grant year.* | |
| Email: |  |
| Phone Number: |  |
| Fax Number: |  |
| Finance Contact Name: |  |
| *Finance Contact is the person responsible for completing Monthly Expense Reports* | |
| Email: |  |
| Phone Number: |  |
| Fax Number: |  |
| Grant Signatory Name: |  |
| *Grant Signatory is the person authorized to sign contracts and other documents on behalf of the organization.* | |
| Title: |  |
| Email: |  |
| Phone Number: |  |

***NOTE: The grant signatory’s signature will be the last item requested in the online application.***

***Overview of Organization*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*10 Poi*nts**

|  |  |
| --- | --- |
| Number of Hospital-Based Telepsychiatry Distance Delivery Site(s) (location): |  |
| Location of Hospital-Based Telepsychiatry Distance Delivery Site(s).  List each location by:   * Hospital Name * Address * County |  |
| Number of Originating Site(s) Primary Care Provider Office (locations): |  |
| Location of Originating Site(s).  Primary Care Provider Office  List each location by:   * Practice Name * Address * County * Indicated if the practice owned or operated by the applicant hospital * Provide letter of collaboration or MOU/MOA signed by primary care offices or non-hospital settings that are not owned, operated or managed by the applicant hospital. * If Originating Sites will not include a primary care office, list Not Applicable. |  |
| Number of Originating Site(s) Patient’s Home: |  |
| If the Originating Site will be from a patient’s home, list the anticipated counties to be served.   * County/Counties * If Originating Sites will not include a patient’s home, list Not Applicable |  |
| Number of Originating Site(s) Non-Hospital Setting: |  |
| If the Originating Site will be from another non-hospital setting list the setting type and list the anticipated counties to be served.   * Site Type * Address or County/Counties * County/Counties * Provide letter of collaboration or MOU/MOA signed by non-hospital settings that are not owned, operated, or managed by the applicant hospital. * If Originating Sites will not include another non-hospital setting, list Not Applicable |  |
| Other Counties Served (if applicable): |  |
| Total Organizational Annual Budget: |  |

1. Provide a brief description of your organization (3,000 character limit).
2. Does your hospital currently provide hospital-based telepsychiatry services?

* Yes
* No

If yes, approximately how many hours per week does your hospital offer these services?

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week

1. What is the telehealth modality your hospital is using? (Check all that apply)

* Live (synchronous) videoconferencing: a two-way audiovisual link between a patient and a care provider
* Store-and-forward (asynchronous) videoconferencing: transmission of a recorded health history to a health practitioner, usually a specialist.
* Remote patient monitoring (RPM): the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time.
* Mobile health (mHealth): health care and public health information provided through mobile devices. The information may include general educational information, targeted texts, and notifications about disease outbreaks.
  1. List the telehealth vendor(s) your hospital is using to provide Telehealth services:

**Provider Documents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*10 points***

Is your organization a government entity (state hospital or county owned hospital)?

Yes

No

Applicant must complete and upload each of the applicable Provider Documents. Links for each document are provide below and located at <https://www.ncdhhs.gov/about/grant-opportunities/rural-health-grant-opportunities>

Documents signed after October 1 of the previous year CAN be used for current calendar year. (i.e., If signed on **10/1/2021**, documents can also be used as 2022 provider documents)

### Required Documents - Non-Governmental Entities

* [**Conflict of Interest Acknowledgement and Policy**](https://www.ncdhhs.gov/media/15081/open)
* [**Conflict of Interest Verification**](https://www.ncdhhs.gov/conflict-interest-verificationdoc/open)
* [**IRS Tax Exemption Form**](https://www.ncdhhs.gov/irs-tax-exemption-form/download?attachment)
* [**State Grant Certification - No Overdue Tax Debts**](https://www.ncdhhs.gov/state-grant-certification-no-overdue-tax-debts/download?attachment)**Note: THIS IS THE ONLY FORM THAT MUST BE NOTARIZED.**
* [**State Certification**](https://www.ncdhhs.gov/state-certificationsdocx/open)
* [**Federal Certifications**](https://www.ncdhhs.gov/federal-certificationsdoc/open)
* [**EO224 COVID Vaccination and Testing**](https://www.ncdhhs.gov/media/15083/open)
* [**Federal Funding Accountability and Transparency Act**](https://ncruralhealth.az1.qualtrics.com/CP/File.php?F=F_5coOZAbLsqLckcu)

### Required Documents – Governmental Entities

* [**State Certification**](https://www.ncdhhs.gov/state-certificationsdocx/open)
* [**Federal Certifications**](https://www.ncdhhs.gov/federal-certificationsdoc/open)
* [**EO224 COVID Vaccination and Testing**](https://www.ncdhhs.gov/media/15083/open)
* [**Federal Funding Accountability and Transparency Act**](https://ncruralhealth.az1.qualtrics.com/CP/File.php?F=F_5coOZAbLsqLckcu)

**Budget \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*15 points***

**Instructions for Submitting Budget and Budget Narrative:**

* + Download the Excel Budget and Budget Narrative provided in the on-line application
  + Complete the Excel document tabs
  + Upload the Excel Budget and Budget Narrative to on-line application

Budget narratives must show the calculations for all budget line items and must clearly justify/explain the need for each budget line item. Calculations should be easy to follow/recreate. Each budgeted line item should explain:

* What is it?
* How many?
* How much?
* For what purpose?

Do not add new line items to the budget. All budget expenses must fit into one of the line items listed in the budget template.

**Funds may be used for both direct and indirect administrative costs. Per 2 C.F.R. 200.403 and US Treasury’s Compliance and Reporting Guidance (updated February 28, 2022), each category of cost should be treated consistently in like circumstances as direct or indirect. The Recipient may not charge the same administrative costs to both direct and indirect cost categories. Unless otherwise agreed between NC DHHS and the Recipient, the Recipient shall use the 10% de minimis indirect cost rate for indirect administrative costs per C.F.R. 200.414(f). Per 2 C.F.R. 200.68, the 10% de minimis indirect cost rate is applied only to the modified total direct cost. Recipients who have a Negotiated Indirect Cost Rate Agreement (NICRA) with the federal government or with NC DHHS shall notify the Contract Administrator to determine whether it may be eligible. If NC DHHS determines the NICRA is eligible, the Recipient must provide the approved indirect cost rate plan. Per S.L. 2021-180 and the requirements of G.S. 143C-6-21 through G.S. 143C-6-23, funds may only be expended for the purpose for which they were awarded and may only be used for nonsectarian, non-religious purposes. Per 2 C.F.R. 200, expenditures must meet reasonable cost requirements.**

***The following is a description of activities and accomplishments to be undertaken by our organization using the provided financial assistance: Recipient is to provide a general description of planned expenditures to serve as a guide for preparing an annual budget related to this award (add or delete categories as needed).***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Expenditure Category** | **Amount of Expenditure** | | | | | |
|  | **SFY 2020-21 (03/03/21-06/30/21)** | **SFY 2021-22 (07/01/21-06/30/22)** | **SFY 2022-23** **(07/01/22-06/30/23)** | **SFY 2023-24** **(07/01/23-06/30/24)** | **SFY 2024-25** **(07/01/24-06/30/25)** | **SFY 2025-26** **(07/01/25-12/31/26)** |
| **Employee Expenses (e.g. program related staffing)** | **$** | **$** | **$** | **$** | **$** | **$** |
| **Services/Contract Expenses**  **(e.g. utilities, telephone, lease related expenses)** | **$** | **$** | **$** | **$** | **$** | **$** |
| **Goods Expenses (e.g. supplies and equipment)** | **$** | **$** | **$** | **$** | **$** | **$** |
| **Administrative Expenses**  **(e.g. overhead and project management)** | **$** | **$** | **$** | **$** | **$** | **$** |
| **Other Expenses (Specify)** | **$** | **$** | **$** | **$** | **$** | **$** |
| **Total Expenses** | **$** | **$** | **$** | **$** | **$** | **$** |

**Note:** All funds must be used for costs incurred during the period that begins on March 3, 2021 and ends on December 31, 2024. Funds for financial obligations incurred by December 31, 2024 must be expended by December 31, 2026.

**Provide a brief budget narrative that explains/justifies the estimated costs listed above by line-item category. Explain how the costs associated with each line-item category relate to the implementation of the project as outlined in the proposed budget. Add extra pages as needed or insert a separate sheet if more room is needed.**

**Project Narrative Section**

**Instructions for Submitting Project Narrative Sections:** The Community Need and Patient Population, Project Description and Improved Access to Care, Collaboration and Community Engagement, and the Project Evaluation and Return on Investment Sections of the on-line application will be submitted by downloading a Word document supplied in the on-line application. Applicants will enter their responses in the Word document and then upload the single document containing all Project Narrative Sections to the on-line application.

Formatting and Page Maximums: Each section must be formatted as follows: Arial, 12-point font, single or double spaced with 1-inch margins.

* Community Need and Patient Population Section – Four Pages
* Project Description and Improved Access to Care Section - Four Pages
* Collaboration and Community Engagement Section – Three Pages
* Project Evaluation and Return on Investment Section – Two Pages (Note: Mandatory Performance Measures will be submitted by direct input into tables/questions provided in the on-line application and should not be included in the Narrative Word Document)

***Community Need and Patient Population \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_15 Points***

**Community Need**

* Describe the population served by this grant proposal. Include the population’s healthcare needs, access to psychiatry and other behavioral health services essential to diagnosis and treatment, gaps in equity, uninsured or medically indigent rates, incidents of behavioral health, Health Professional Shortage Area Mental Health Designation(s) for project area(s), and other pertinent demographic data that supports the necessity for grant funding in the targeted communities.
* Provide information on the impact of COVID-19 in the project area(s).
* Provide citations/reference sources.
* Describe how this project will align with the most recent Community Needs assessment.
* Describe how your hospital plans to achieve the patient population goals with emphasis on creating access to telepsychiatry services for underserved populations.

***Project Description and Improved Access to Care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20 Points***

* Describe how your project will expand telepsychiatry capacity to respond to the COVID-19 public health emergency.
* The project description should describe if the telepsychiatry services will use a consultative model, a direct care model or a combination of consultation and direct care.
* Describe the purpose of the grant proposal and how funds will be used. Description must include:
  + Proposed activities
  + Location of originating and distance sites
  + Timelines to implement activities – Timelines must align to the program funding period
  + Anticipated outcomes (should include the mandatory performance measures)
* The project description should include planning for patient safety, care continuity and patient support.
* The project description should include how the distance delivery site will ensure the originating sites are properly equipped, trained, and staffed to be a successful originating site.
* The project description should directly align with the need and patient population described in the Community Need and Patient Population Section.

***Collaboration and Community Engagement*  \_\_\_\_\_\_ \_\_\_ *15 Points***

* Describe how your hospital currently collaborates with other organizations to address access to telepsychiatry services and respond to the COVID-19 public health emergency. Partners can include other safety net organizations, primary care providers, allied health organizations, health departments, agencies that address social determinants (transportation, food insecurity, personal safety, and/or housing) or other organizations.
  + Describe, *using a specific example*, how your hospital has built collaborative partnerships to address access to telepsychiatry services and respond to COVID-19:
    - Name(s) of each partner organization
    - Purpose of the collaboration
    - Outcome of the collaboration
    - Document the collaborative roles among the partners in your example, specifying the distinct function of each hospital and the designated fiscal contribution.
    - Describe any unique or innovative community partnerships.
    - Detail any barriers to collaboration.
* Describe future plans for your hospital to develop partnerships to address access to telepsychiatry services and respond to COVID-19. Include proposed partners, the purpose of the collaboration, and anticipated outcomes of the partnership. Include any barriers to collaborating with partners and potential ways to address those barriers.
* Describe your organization’s activities and/or plans to address health equity by creating an environment that is welcoming, respectful, inclusive, and is patient-centered to improve health.
* Describe your organization’s plan to provide outreach to create diversity and inclusion in the patient populations engaging in the telepsychiatry services.
* Describe your organization’s plan to reach out to historically marginalized populations in your area.

***Project Evaluation and Return on Investment \_ \_ 15 Points***

* Document your organization’s overall budget and explain why the project is a good use of State funds.
* Complete the mandatory Program Performance Measure Tables.
* Describe how your hospital will reference the program performance measures to monitor and improve program performance.
* Describe is your hospital will create, track and analyze other performance measures (optional)
* Develop and document a realistic and achievable project sustainability plan.

**Evaluation Criteria**

Mandatory performance measures are required for all organizations. These measures will be reported monthly, quarterly, biannually, or annually as indicated.

Optional: Organizations may also create, track, analyze and report on additional performance measures specific to the proposed project and created by the organization. Additional performance measures should be not duplicate established mandatory performance measure and should document reporting frequency, data source, collection process and data limitations.

*For each performance measure, the hospital will include the following information:*

* **Data Source:** Where will the hospital obtain the information reported for each performance measure?
* **Collection Process and Calculation:** What method will the hospital use to collect the information?
* **Data Limitations**: What may prevent the hospital from obtaining data for the performance measures?

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Virtual Behavioral Health Program** |  | **Target to Be Reached**  **by 12/31/2024** |
|  |  | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **Full-Time Equivalents (FTEs)** supported by the Virtual Behavioral Health Program  (Note: FTE will be based on UDS guidelines, which defines FTE based on how each hospital defines full-time and position type. For more information review the [2021 UDS manual](https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2021-uds-manual.pdf), pages 49-50.) |  |  |
| Measure Type |  | Output |
| ORH Required Reporting Frequency |  | Annually (Reported every12 months) |
| Data Source |  |  |
| Collection Process and Calculation |  |  |
| Data Limitations |  |  |

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **unduplicated patients served**. Patients are individuals who have at least one telepsychiatry visit during the reporting period (by site). |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months)  **At the final performance report (12-month report) in addition to number of unduplicated patients served, contractors will also report unduplicated patient information in the following categories: patient age, patient insurance status and patient race/ethnicity as well as patient insurance status is outlined in the tables below.** | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |

**Patients by Race and Ethnicity Table:** Enter the number of unduplicated patients by Race and Latino Ethnicity that received telepsychiatry services. Please use row ‘g’ if race is not reported. Use Column C if race is reported but ethnicity is not.

|  |  |  |  |
| --- | --- | --- | --- |
| Race | Column A  Hispanic/ Latino | Column B  Non-Hispanic/ Latino | Column C  Unreported/ Refused to Report Ethnicity |
| 1. American Indian / Alaska Native |  |  |  |
| 1. Asian |  |  |  |
| 1. Black/African American |  |  |  |
| 1. Native Hawaiian / Other Pacific Islander |  |  |  |
| 1. White |  |  |  |
| 1. More than one race |  |  |  |
| 1. Unreported / Refused to report race |  |  |  |

**Patients by Age Table:** Enter the number of unduplicated patients by Age that received telepsychiatry services.

|  |  |
| --- | --- |
| *If a patient receives multiple telepsychiatry visits during the reporting period, the patient’s age should reflect their age at the initial visit.* | Unduplicated Patients  Served |
| Up to Age 10 |  |
| Age 11 – 15 |  |
| Age 16 – 19 |  |
| Age 20 – 24 |  |
| Age 25 – 29 |  |
| Age 30 – 34 |  |
| Age 35 – 39 |  |
| Age 40 – 44 |  |
| Age 45 – 49 |  |
| Age 50 – 54 |  |
| Age 55 – 59 |  |
| Age 60 – 64 |  |
| Age 65 – 69 |  |
| Age 70 – 74 |  |
| Age 75 – 79 |  |
| Age 80 – 84 |  |
| Age 85 and Above |  |

**Patient Insurance Status Table:** Enter the number of unduplicated patients, by category.

|  |  |
| --- | --- |
|  | Unduplicated Patients  Served |
| 1. No Insurance/Uninsured Patients |  |
| 1. Medicaid |  |
| 1. Children’s Health Insurance Program (CHIP) |  |
| 1. Medicare (including duals) |  |
| 1. Other Public Insurance (e.g. Tricare) |  |
| 1. Private Insurance (e.g., BCBS) |  |
| Total Unduplicated Patients Served (sum of above rows) |  |

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **telepsychiatry visits** during the reporting period. |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months) | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **new patient telepsychiatry visits** during the reporting period |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months) | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **return patient telepsychiatry visits** during the reporting period |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months) | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **Distance Telepsychiatry Sites** activeduring the reporting period. |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months) | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **Originating Primary Care Provider Office Telepsychiatry Sites** active during the reporting period.  If no Originating Telepsychiatry Sties will operate in a primary care office, enter N/A |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months) | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |

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| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **Originating Patient Home Telepsychiatry Sites** active during the reporting period.  If no Originating Telepsychiatry Sties will include the patient’s home, enter N/A |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months) | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |

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| **Evaluation Criteria for Virtual Behavioral Health Program** | **Baseline Values/Measures as of 03/03/2021** | **Target to Be Reached**  **by 12/31/2024** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**  Number of **Originating Non-Hospital Setting Telepsychiatry Sites** active during the reporting period.  If no Originating Telepsychiatry Sties will not operate in another non-hospital setting, enter N/A |  |  |
| Measure Type | Output | |
| ORH Required Reporting Frequency | Quarterly (at 3,6,9 and 12 months) | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Data Limitations |  | |