MEMORANDUM OF UNDERSTANDING FOR THE ESTABLISHMENT OF THE "_____ CONSORTIUM"

This Memorandum of Understanding (MOU) is between the following parties:

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The parties have agreed to apply for grant funding through the US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, Rural Health Care Services Outreach Program (CFDA No. 93-912). The overall purpose of the grant will be to improve care coordination through a strong consortium, to improve population health and demonstrate improved health outcomes and sustainability.

The parties listed above mutually agree to serve as members of the _____ Consortium and agree to the following:

Project Activities: Each consortium member will be actively engaged in the project and will collaborate as partners to carry out the following activities:

1) Develop a Care Coordination Task Force: A multidisciplinary task force will be formed with representation from each of the consortium members as well as patients, providers, and social service organizations to develop processes, protocols, tools, and resources for providers, patients, and family caregivers to ensure safe, consistent and effective transitions of care.

2) Hire Care Coordinators: Local care coordinators will be hired by _____ and _____ to be responsible for developing the care transitions protocols in conjunction with the task force and in collaboration with the _____ staff, _____, and _____. The care coordinators will work together to identify and maximize patient access to current resources already in existence locally, statewide, and through _____.

3) Create and Implement Protocols: Protocols, tools, and resources will be developed and implemented by the consortium members to improve care transitions by consistently providing patients, families, and providers with tools and support to facilitate productive communication during care transitions. The protocols will include processes and guidelines for activities such as:

- Medication management;
- Discharge instructions;
- Follow up care (on site of via Telehealth);
- Health information exchange (HIE);
- Ongoing communication.

4) Training: Once protocols are developed, the consortium members will participate in interdisciplinary training in order to effectively implement consistent processes. Training will be led by members of the consortium as well as outside experts and will be offered in-person and through webinars and videoconferencing. Topics will include, but will not be limited to, communication, medication reconciliation, health information exchange and interoperability, Telehealth, and patient centered care.

Focus Areas: The project will address the highest needs in the region including heart disease, diabetes, cancer, mental health, and ambulatory sensitive care conditions. The primary focus will be on patients needing to access a higher level of care or specialty care services available at other facilities in the _____ or through an urban tertiary facility.

Primary Goals: The consortium members agree that the following are the primary goals of the project:

- Improve communication during care transitions between providers, patients, and family caregivers;
- Establish points of accountability for sending and receiving care, particularly for hospitalists, primary care physicians, and specialists;
- Increase the use of case management, care coordination, and navigation services;
- Develop performance measures to encourage improved transitions of care;
- Maximize health information exchange through electronic health records between all providers across the continuum of care;
- Increase the use of Telehealth for consultation and follow up visits; and
- Consistently incorporate standardized medication reconciliation elements across transitions to prevent medication discrepancies and errors.

Measurable Outcomes: The consortium members agree to contribute to data collection and performance measurement activities related to the following outcomes as well as other measures required by HRSA:

- Reduced readmissions;
- Improved patient satisfaction;
- Reduced ER visits;
- Local primary care providers consistently involved with discharge planning;
- All providers (referring, receiving, PCP) involved with patient care across transitions;
- Each provider receives patient records electronically;
- Medication reconciliation on all transferred patients.

Other Roles and Responsibilities:

- _____ will serve as the grantee, lead applicant organization, and fiscal agent.
- _____will provide an FTE, funded by the grant, to assist with administrative and programmatic functions.
- Each of the consortium members will contribute to the development of a plan for long term sustainability of the project.

This Memorandum of Understanding will be valid from _____ throughout the duration of the Rural Health Care Services Outreach Program Grant, if funded. Revisions or termination may be made at any time with written notice to all parties. Approved and Dated By:

List all parties, organization, names, titles, date signed – all sign one agreement