

Thank you for your interest in enrolling yourself, your loved one, your patient or your client in Project Open Hand!

At Project Open Hand, our **medically tailored meals and groceries** help clients recover from critical illness, get stronger and lead healthier lives.

The Community Supports Program: Alameda County

The Community Supports Program through **Alameda Alliance for Health** provides medically tailored meals and groceries, nutrition education opportunities, and consultation from our Registered Dietitians to critically ill clients. This program currently supports clients diagnosed with:

- **Cancer**
- **Hypertension ($\geq 130/80$, 2 readings, one in the last 30 days)**
- **High cholesterol (≥ 200 , $LDL \geq 130$, $HDL < 40$, non-HDL ≥ 130 , OR TG ≥ 150)**
- **Chronic or End-Stage Kidney Disease ($GFR < 60$)**
- **COPD**
- **Asthma**
- **Congestive Heart Failure**
- **Diabetes ($Hgb A1C \geq 6.5$)**
- **Pre-diabetes ($Hgb A1C \geq 5.6$)**
- **Elevated lead levels ($\geq 3.5\mu g/dL$)**
- **HIV/AIDS**
- **Liver Disease (elevated liver enzymes)**
- **Fatty Liver (confirmed by biopsy or imaging)**
- **Malnutrition (Adults: $BMI < 18.5 kg/m^2$, Child: $BMI < 5th\%$)**
- **Obesity ($BMI > 30.0 kg/m^2$, height and weight measurement in last 30 days)**
- **Stroke (within the last 6 months)**
- **Nutrition-sensitive GI conditions (ie: IBS)**
- **Nutrition sensitive, high-risk perinatal conditions**
- **Disabling mental/behavioral health disorders**
- **Pancreatitis**

Eligibility

1. Provider must fill out referral form (see attached). Please only include an ICD-10 code that is relevant to the nutritionally impacted diagnosis.
2. Provider must include or attach the following to the referral form:
 - a. Labs or documentation proving an eligible, nutrition-sensitive diagnosis (see table on page 3)
 - b. Care plan, minimum one sentence, explaining how the medical nutrition intervention will address the condition (ie. "Patient will eat low-salt diet to manage hypertension.")
 - c. Medications list
 - d. Problems list

Failure to provide any of the above may result in denial of the service request.

Referral process

1. Provider sends referral form with attachments to Alameda Alliance for Health.
2. Alameda Alliance for Health assesses need for service.
3. If eligible, AAH sends approval to Project Open Hand. POH staff processes approval and contacts member for intake. Then services begin!
 - a. If not eligible, AAH will contact POH.

Service duration

Patients who are approved for Community Supports services by Alameda Alliance for Health can receive up to **12 weeks** of medical nutrition intervention services from Project Open Hand.

Don't have one of these diagnoses?

Want to explore more options?

We may have other programs for you!

See our website or call for more details.

www.openhand.org

Questions?

(510) 622-0221; clientservices@openhand.org

Disease	Required Documentation
Cancer	Reports or summary proving diagnosis or operation.
Hypertension	Clinical summary showing $\geq 130/80$ on 2 separate readings, one in the last 30 days.
Hyperlipidemia (High cholesterol)	Labs within last 6 months showing ≥ 200 , LDL ≥ 130 , HDL < 40 , non-HDL ≥ 130 , <u>OR</u> TG ≥ 150 .
Chronic or End-Stage Kidney Disease	Labs within last 6 months showing GFR < 60 , as well as BUN, creatinine, sodium <u>AND</u> potassium levels.
COPD	Proof of diagnosis.
Asthma	Proof of diagnosis.
Congestive Heart Failure	Clinical history, physical exam or diagnostic test results proving diagnosis.
Diabetes	Labs within last 6 months showing Hgb A1C ≥ 6.5 .
Pre-diabetes (Hgb A1C ≥ 5.6)	Labs within last 6 months showing Hgb A1C ≥ 5.6 .
Elevated lead levels	Labs within last 6 months showing $\geq 3.5\mu\text{g/dL}$.
HIV/AIDS	Letter of diagnosis <u>AND</u> proof of symptoms that could be ameliorated with nutritious food.
Liver Disease	Labs within last 6 months showing elevated liver enzymes.
Fatty Liver	Proof of diagnosis.
Malnutrition	Adults: documentation showing BMI < 18.5 Children: BMI $< 5\text{th}\%$.
Obesity	Documentation proving BMI $> 30.0\text{kg/m}^2$, with height measurement in last year, weight in last 30 days .
Stroke	Documentation proving stroke occurred within the last 6 months.
Nutrition-sensitive GI conditions (ie: IBS)	Documentation of diagnostic tests.
Nutrition sensitive, high-risk perinatal conditions	Documentation of maternal conditions that increase risk of perinatal condition in child.
Disabling mental/behavioral health disorders	Documentation proving diagnosis <u>AND</u> how nutrition intervention would treat condition.
Pancreatitis	Labs within last 6 months proving elevated serum lipase or amylase levels.



Food and Nutrition Services Approval Request Form

The Alameda Alliance for Health (Alliance) Food and Nutrition Services Approval Request Form is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may be appropriate for Community Services (CS) medically supportive food and nutrition services, please complete the form below. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Attach a clinical summary and/or supporting documentation (ex. clinic notes, hospital discharge summary, etc.), for medically supportive food and nutrition services.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. **This service is not covered to respond solely to food insecurities.**

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: _____ NPI: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____
Email: _____
Office Contact Name: _____ Date of Request: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____
Date Of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ ☐ Home ☐ Cell

- ☐ Confirmed patient is not receiving duplicative support from other state, local, or federally funded programs, and has been considered first before using Medi-Cal funding.

Is the member currently linked to a case management team?

- ☐ Yes. Please state the case manager or team: _____

Does the member need additional case management services?

- ☐ Yes
- ☐ No
- ☐ No

Does the patient consent to participating in this 12-week, medically-supportive food and nutrition program?

- ☐ Yes
- ☐ No

The patient has access to (please select all that apply):

- ☐ Microwave
- ☐ Refrigerator

Service Request (please select at least one (1)):

- ☐ **Medically-Tailored Meals** – Provided to the patient at home that meets the unique dietary needs of those with chronic diseases. These meals are tailored by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutrition practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

Meal Frequency Request (please select only one (1)):

- ☐ One (1) meal per day
- ☐ Two (2) meals per day

- ☐ **Medically-Supportive Food and Nutrition Services** – Includes medically tailored groceries, healthy food vouchers, and food pharmacies. (please select if the patient would like a grocery box in addition to meals)

- ☐ One (1) grocery box per week

- ☐ **Nutritional Counseling** – Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

☐ **Initial Request**

Patient's Qualifying Condition (please select all that apply, must meet at least one (1) to be eligible):

- ☐ Has chronic condition(s), such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

Associated Diagnostic ICD-10 Code: _____

- ☐ Is being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement.

- ☐ Has intensive care coordination needs.

☐ **Extension Request**

Patient's Medical Necessity (please describe):

(Medical necessity for an extension would be an acute worsening of the patient's condition or the patient is at high-risk for re-developing significant illness.)