Medi-Cal Medically Tailored Meals (MTM) Pilot Program

Referral Packet

The MTM Pilot Program is a statewide endeavor of the California Food is Medicine Coalition and is supported by the California Department of Health Care Services.

Patients with congestive heart failure who are enrolled in this program will receive 12 weeks of medically tailored meals in addition to four Medical Nutrition Therapy sessions with a Registered Dietitian.

Please see eligibility criteria below. If the patient meets the requirements, please fill out the attached application and email it to clientservices@openhand.org or fax it to 415-429-3852.

Program Eligibility Criteria:

1. Participants need to have congestive heart failure and have an emergency department visit, inpatient hospital, or skilled nursing facility stay in the last 12 months.
2. Must be currently enrolled in full-scope, no-cost Medi-Cal for at least 12 continuous months
3. Must have a primary physician or specialist visit within the last 12 months
4. Resident of San Francisco or Oakland
5. 18 or older
6. Speak English or Spanish

Exclusion Criteria:

1. Participants with late/end-stage renal disease
2. Participants with life expectancy of less than a year
3. Participants discharged to a living facility that provides more than seven meals per week
4. Participants receiving more than seven meals per week from another meal provider
5. Participants who don't have food storage or heating capabilities
6. Participants who lack sufficient support or ability to adhere to program

If you have questions regarding the MTM Pilot Program, please contact Serena Ngo at sngo@openhand.org or call 415-447-2462.

For questions regarding the status of a participant's application or service, please contact Client Services at clientservices@openhand.org or call 415-447-2326.

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CALIFORNIA FOOD IS MEDICINE COALITION

No Cost / Medi-Cal Covered Medically Tailored Meals and Medical Nutrition Therapy for Discharged CHF Patients

The Medi-Cal MTM Pilot Program is a medical nutrition intervention for high utilizing Medi-Cal beneficiaries with a diagnosis of congestive heart failure (CHF). The intervention is 12 weeks in duration.

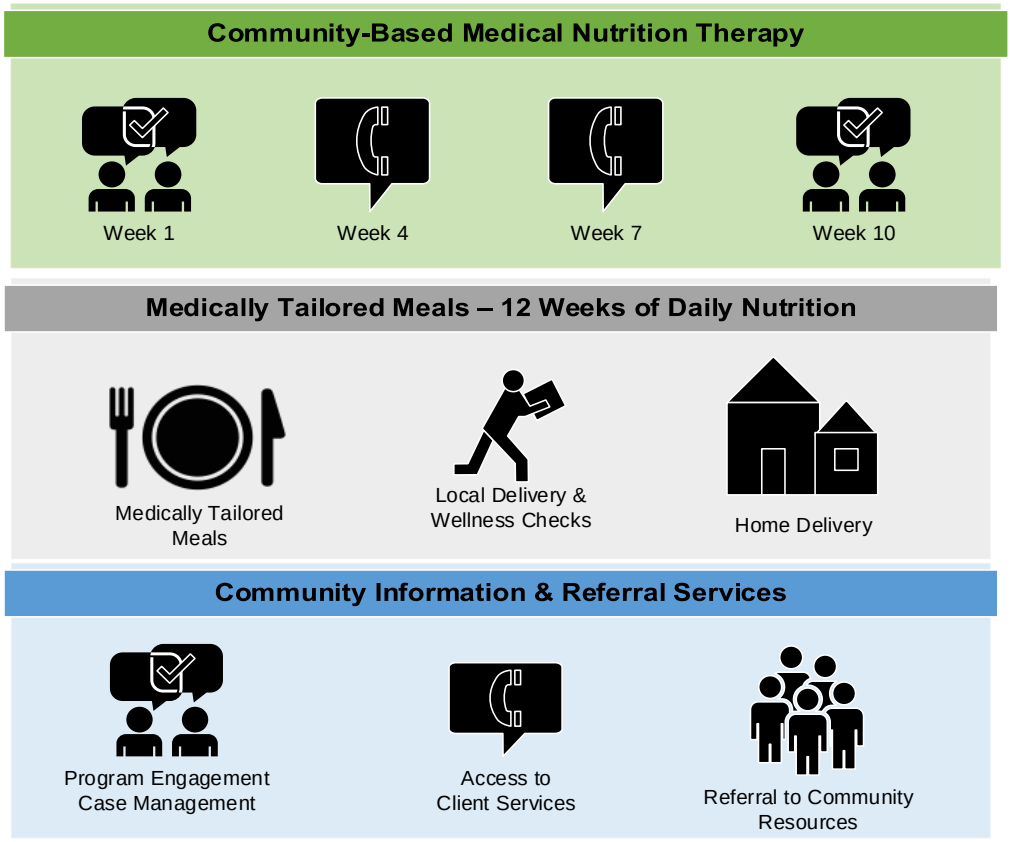
Intervention Goal: Improve health outcomes and reduce preventable healthcare utilization
Who: Medi-Cal patients with congestive heart failure who had an inpatient, skilled nursing facility or emergency department visit within the last 12 months. Patient must have had continuous Medi-Cal in the last 12 months.
Cost: Free for eligible Medi-Cal patients.

Scope of Intervention

Medical Nutrition Therapy
- Community-based
- Four sessions
- Two sessions at home or in community setting

All Meals for 12 Weeks
- Medically tailored meals
- Tailored for CHF patients
- Periodic wellness checks during delivery

Information & Referral Services
- Program engagement case management
- Referral to community-based resources



How to Refer

- A completed referral form is required. A clinician (MD, PA, NP, LCSW, RN, etc.) must make the referral.
- Work with our client services team to ensure patient is eligible.
- Meals can begin as early as 24 to 48 hours after approval.

- **Download the referral form at** https://www.openhand.org/documents/MTMapplication **OR**
- **call Project Open Hand Client Services at 415-447-2326 to refer!**

APPLICATION FOR SERVICES (subject to eligibility)

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PROJECT OPEN HAND

730 Polk Street, San Francisco, CA 94109 **P: 415-447-2326 | F: 415-429-3852**
1921 San Pablo Avenue, Oakland, CA 94612 **P: 510-622-0221 | F: 510-452-1061**

1. PATIENT ONLY: CONSENT TO RELEASE INFORMATION

I authorize my medical providers and referring party to release information about my medical condition to Project Open Hand for purposes of verifying my eligibility. I also authorize Project Open Hand to discuss the terms of my eligibility and/or services with my medical providers and referring party.

Patient Name: _____ **Date of Birth:** _____ **Phone:** _____

Patient Address: _____ **City:** _____ **Zip:** _____

Patient Signature: _____ **Date:** _____

Patient Medi-Cal ID Number (CIN): _____

HEALTHCARE PROVIDER *ONLY* BELOW THIS LINE

2. PHYSICAL DATA (MUST BE CURRENT WITHIN LAST 6 MONTHS)

Height: ____ ft. ____ in. Recent weight: _____ Blood Pressure: _____ / _____ Date: _____

3. PRIMARY DIAGNOSIS AND CLINICAL DATA: *(Check all that apply; data must be current within six months)*

- ☐ **Congestive Heart Failure (REQUIRED)**
- ☐ **Coronary Artery Disease**
- ☐ **Cancer**, active diagnosis
  - Type: _____ Stage: _____
  - Date of most recent diagnosis: _____
  - Active Treatments: *(check those that apply)*
  - ☐Radiation therapy ☐Chemotherapy
  - ☐Hormone therapy ☐Not receiving treatment
- ☐ **Diabetes** *(check one)*
  - ☐Type 1 or ☐Type 2 HbA1c: _____ Date: _____
- ☐ **HIV+/AIDS**
- ☐ **End Stage Renal Disease**
- ☐ **End Stage Liver Disease**
- ☐ **Chronic Obstructive Pulmonary Disease (COPD)**
- ☐ **Autoimmune disease (e.g. Lupus)**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ **Serious Neurologic Condition** (*check all that apply)*
  - ☐Stroke ☐Parkinsons
  - ☐Multiple Sclerosis ☐ALS (Lou Gehrig's disease)

4. CONCOMITANT DIAGNOSES: *(Check any exhibited in the past 30 days)*

- ☐ Opportunistic Infection, inhibiting ability to access and/or prepare meals – Describe: _____
- ☐ Anemia ☐ Hypertension ☐ Hyperlipidemia

5. SYMPTOMS: *(Check any exhibited in the past 30 days)*

- ☐ NO SYMPTOMS
- ☐ Chronic (> 30 days) intractable diarrhea
- ☐ Chronic Nausea
- ☐ Chronic Vomiting
- ☐ Unintentional weight loss of > 5% of baseline body weight
- ☐ Inability to gain weight if underweight (BMI < 18.5)
- ☐ Muscle weakness in hands, arms, or legs
- ☐ Muscle weakness in muscles of speech
- ☐ Muscle weakness with breathing
- ☐ Edema, or other severe swelling in ankles or feet
- ☐ Difficulty swallowing (dysphagia)
- ☐ Fatigue, mild ☐ Fatigue, moderate ☐ Fatigue, severe
- ☐ Shortness of breath, mild ☐ Moderate ☐ Severe
- ☐ Mild diarrhea
- ☐ Mild wasting
- ☐ Severe pain
- ☐ Lymphedema
- ☐ Spasticity
- ☐ Ataxia
- ☐ Slow-healing sores

Patient Name: _____

6. OTHER HEALTH FACTORS

Has had 1 inpatient admission, ER visit or discharged from a skilled nursing facility within the past 12 months?
☐ Yes _____ (date) ☐ No ☐ Unknown

How long has patient been on Medi-Cal?
_____ yrs _____ months ☐ Unknown

Enrolled in health/medical case management or care coordination program?
☐ Yes ☐ No ☐ Unknown

If yes, please provide case manager name and contact:
_____

Palliative Care
☐ Yes ☐ No ☐ Unknown

Hospice
☐ Yes ☐ No ☐ Unknown

7. FOOD

Able to store food?
☐ Yes ☐ No ☐ Unknown

Able to heat food?
☐ Yes ☐ No ☐ Unknown

Needs help to prepare/cook food?
☐ Yes ☐ No ☐ Unknown

Difficulty or not able to feed self?
☐ Yes ☐ No ☐ Unknown

Receives meals elsewhere?
☐ Yes ☐ No ☐ Unknown

Has food allergies?
☐ Yes ☐ No ☐ Unknown
If Yes, please list: _____

8. OTHER FACTORS

☐ **Mental Illness**, describe _____
☐ **Cognitive/developmental disability** _____
☐ **Substance Use** _____

9. LANGUAGE

☐ Check if patient is monolingual in a language other than English. If checked, list language: _____

10. MEDICAL NUTRITION THERAPY

The information requested is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA. Research indicates that Medical Nutrition Therapy is cost-effective as it improves outcomes.

Therapeutic Diet Order: (if available) _____

Past Medical History: _____

Fluid Restriction? ☐ Yes ☐ No If yes, _____ mL/day

Comments: _____

Lab Work (List or Attach)		Medications: (List or Attach)
Glucose	_____mg/dL	
HbA1c	_____%	
T.Chol	_____mg/dL	
HDL	_____mg/dL	
LDL	_____mg/dL	
BUN	_____mg/dL	
Creatinine	_____mg/dL	
Potassium	_____mg/dL	
Sodium	_____mg/dL	
eGFR	_____mL/min	

Signature of Provider	Printed Name of Provider	Office Stamp	Address, Phone, and Fax	Date