Maine Center for Disease Control and Prevention
WIC Nutrition Program

Effective: October 1, 2014 Policy No. NS-6
Revised: October 1, 2018

Medically High-Risk Participants

Authority

7 CFR §246.4(a)(9); §246.11(a)(1-3) and (c)(1, 3-7)

10-144 CMR Chapter 286, §II.O

Policy

1. Participants with a qualifying medically high-risk condition(s) shall be referred to the local agency or consultant registered dietitian/licensed dietitian.
2. Participants with a condition(s) that raises concerns for insufficient intake or inadequate growth/prenatal weight gain shall be referred to the local agency or consultant registered dietitian/licensed dietitian.
3. Participant records that are referred to the RD/LD shall be assessed, and recommendations shall be utilized by local agency counseling staff at follow up contacts.

Procedure

1. Medical Nutrition Therapy (MNT) is not a covered service of WIC and is not routinely provided for participants with medically high-risk conditions.
2. Medically high-risk conditions include but are not limited to:

    2.1 Cancer (RF347)

    2.2 Central nervous system disorders (e.g. cerebral palsy, neural tube defects, spina bifida, epilepsy, Parkinson's disease and multiple sclerosis) (RF348)

    2.3 Diabetes mellitus (RF343)

    2.4 Genetic or congenital disorders (e.g. cystic fibrosis, cleft lip or palate, Down's syndrome, thalassemia major, sickle cell anemia (not sickle cell trait), and muscular dystrophy) (RF349)

    2.5 Inborn errors of metabolism (RF351)

    2.6 Infants or children receiving any formula mixed to $\geq$ 24kcal/ounce (including standard milk or soy-based or exempt infant formulas) or elemental formula

    2.6.1 Children receiving Pediasure do not meet the criteria for RD referral. However, if the child has another medically high-risk condition or the

WIC Counselor identifies another specific concern, a referral shall be made.

2.7 Gestational diabetes (RF302) if not followed by outpatient dietitian or HCP

2.8 Eating disorders (RF 358)

2.9 Failure to thrive (RF134) indicated by significantly slowed growth, drops in major growth chart percentiles channels or low weight-for-length

2.10 Fetal alcohol spectrum disorder (RF382)

2.11 Fetal growth restriction (aka, intrauterine growth restriction) (RF336)

2.12 Gastrointestinal disorders (e.g. small bowel enterocolitis, Crohn's disease, colitis, pancreatitis, or liver disease) (RF342)

2.12.1 Gastro-esophageal reflux does not meet the criteria for RD referral.

2.13 Heart disease or other cardiac abnormalities

2.14 Hyperemesis Gravidarum (RF301)

2.15 Inadequate oral intake requiring tube feeding for nutrition support

2.16 Infant born to a woman with alcohol or drug abuse during most recent pregnancy (woman was not enrolled in substance abuse treatment program during pregnancy)

2.17 Chronic infectious diseases (e.g. hepatitis B, C and D, HIV, AIDS) (RF352)

2.18 Renal disease (RF346)

2.19 Substance abuse (women who are not enrolled in a substance abuse treatment program) (RF372)

2.20 Very low birth weight infants (<1500 grams, or 3 pounds 5 ounces) (RF141)

2.21 Other significant health conditions such as thyroid disorder, heart disease, lupus, cardio-respiratory diseases, or any other conditions, that raise concerns for insufficient food intake or inadequate growth/prenatal weight gain

3. When a participant is identified as meeting medical high-risk criteria, staff shall determine if the local agency/consultant RD/LD or an outpatient RD/LD shall provide the nutrition care plan.

3.1 If a participant identified as medically high-risk is followed by an RD/LD outside of the local WIC agency, staff may request the nutrition care plan from the outpatient registered dietitian instead of requiring documentation from the local agency/consultant RD/LD.

3.1.1 If the nutrition care plan is not received from the outpatient RD/LD in a reasonable amount of time, such as by the next WIC appointment,

the local agency/consultant RD/LD shall review the record and document a nutrition care plan in the record.

3.2 If a participant identified as medically high-risk is not already followed by an RD/LD outside of the local agency, an initial referral to the local agency registered dietitian or consultant dietitian is required at the first appointment when the medical high-risk condition is identified.

4. Staff shall adjust benefit issuance frequency, as necessary, to meet the needs of the client while awaiting nutrition care plan from RD/LD.

5. The local agency or consultant RD/LD shall respond to the referral within 30 days.

   5.1 The local agency or consultant RD/LD shall document the assessment and nutrition care plan in the participant's electronic record.

   5.2 The care plan may include recommendations for more frequent WIC visits, telephone contacts and/or health care provider, if necessary.

   5.3 The care plan shall include recommendations for next RD assessment.

   5.4 If a response is not received within 30 days, the local agency shall submit a second referral or request.

6. If RD/LD assessment indicates medical high-risk condition is resolved or stable, the RD/LD referral may be closed.

7. Follow up referrals to RD/LD shall be made in the following situations:

   7.1 According to RD/LD care plan

   7.2 Prescription changes (formula and/or food)

   7.3 New health concerns such as recent hospitalizations, diagnosis or illnesses

   7.4 Changes in growth or weight gain status

   7.5 Changes in food or formula tolerance

8. The nutrition care plan provided by the RD/LD shall be used by local agency counseling staff to tailor food prescriptions and conduct nutrition education.

9. Medically high-risk participants shall be tracked on a medical high-risk participant log. Refer to Appendix NS-6-A for a sample tracking log.

10. The local agency Nutrition Coordinator shall be responsible for maintenance of the medically high-risk participant log.

11. The local agency Management Evaluation Review (MER), conducted by the state agency, shall include an evaluation of medically high-risk participant files.