Maine Center for Disease Control and Prevention
WIC Nutrition Program

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Nutrition Risk Determination, Documentation, and Priority Assignment

Authority

7 CFR §246.4(a)(11)(i)

7 CFR §246.7(e)

22 MRSA §255 and §1951

10-44 CMR Chapter 286, § II.L and M

WIC Policy Memorandum #2008-4, WIC Nutrition Services Documentation, FNS, July 3, 2008
WIC Policy Memorandum #2011-5, WIC Nutrition Risk Criteria, FNS, May 20, 2011

Policy

1. Local Agency staff shall conduct anthropometric and hematological measurements and/or use anthropometric and hematological measurements from medical referrals.

2. The Local Agency shall document nutrition risk using FNS-approved nutrition risk criteria, as referenced in the most recent Policy Memorandum #2011-5, WIC Nutrition Risk Criteria, published on the FNS PartnerWeb (See Appendix CE-3-A for summary of each nutrition risk code).

3. A nutrition risk priority level shall be assigned to each participant based on his/her nutrition risk in accordance with federal WIC regulations.

4. Each Local Agency nutritionist must ensure that all staff with the responsibility of assigning risk are familiar with cut off thresholds and definitions for assignment of each risk. Periodic Local Agency record audits must include a check of the assigned risk and the appropriateness of the risk criteria used based on the definitions in the manual.

5. Local Agencies are required to perform a complete nutrition assessment for all applicants/participants.

6. A pregnant woman who meets the income eligibility standards may be considered presumptively eligible to participate in the program, and may be certified immediately without an evaluation of nutrition risk for a period of up to sixty (60) days (see CE-1), with a complete assessment of nutrition risk taking place within the sixty (60) days. Only thirty (30) days of benefits may be issued at initial enrollment.

7. With the exception of presumptive eligibility for pregnant women, at least one (1) nutrition risk must be documented at the time of certification in order for an income eligible applicant to receive WIC benefits.

8. The Local Agency shall ensure that hematological assessment data are current and reflect participant status, including blood work periodicity that conforms to the schedule requirements in 7 CFR §246.7(e)(1)(ii)(B); and the procedures listed below.

9. The State Agency requires documentation in the applicant's case file of all nutrition risk criteria used to establish WIC eligibility as described in FNS Policy Memorandum #2008-4, WIC Nutrition Services Documentation.

Procedures

1. Participants are assigned a priority code (see item 3 below). When a Local Agency is at its maximum participation level, participants are enrolled from the waiting list as openings occur according to their assigned priority code.

2. Priority level is assigned based on a participant's current or most recent documented nutrition risk condition, as opposed to any history of the condition, unless otherwise stated in the specific definition of the nutrition risk criterion. All applicable risk conditions must be assessed.

3. The following priority levels shall be assigned based on the specified criteria:

   3.1 Priority 1: Pregnant women, breastfeeding women and infants at nutrition risk as demonstrated by hematological or anthropometric measurements or other documented nutritionally-related medical conditions which demonstrate the need for supplemental foods; pregnant and breastfeeding women who transfer from another state WIC program who have a current VOC which does not specify enrollment risk.

   3.2 Priority 2: Except those infants who qualify for Priority I, infants up to six (6) months of age; Program participants who participated during pregnancy; and infants up to six months of age born of women who were not Program participants during pregnancy, but whose medical records document that they were at nutrition risk during pregnancy due to nutrition conditions detectable by biochemical or anthropometric measurements, or other documented nutritionally related medical conditions which demonstrated the person's need for supplemental foods; infants who transfer from another state WIC program who have a current VOC which does not specify enrollment risk.

   3.3 Priority 3: Children at nutrition risk as demonstrated by hematological or anthropometric measurements or other documented medical conditions which demonstrate the child's need for supplemental foods; children who transfer from another state WIC program who have a current VOC which does not specify enrollment risk.

   3.4 Priority 4: Pregnant women, breastfeeding women, and infants assessed at nutrition risk of inappropriate feeding practices or infants presumed at dietary risk of inappropriate complementary feeding practices.

3.5 Priority 5: Children assessed at nutrition risk because of inappropriate feeding practices, children aged 12-23 months presumed at risk of inappropriate complementary feeding practices, or children aged 24-59 months presumed at risk of failure to meet dietary guidelines.

3.6 Priority 6: Nonbreastfeeding women at nutrition risk; nonbreastfeeding women who transfer from another state WIC program who have a current VOC which does not specify enrollment risk.

3.6.1 High risk nonbreastfeeding women are assigned to a Priority 3 (<18 years of age) or Priority 6 level (≥18 years of age).

3.7 Priority 7: Individuals certified for WIC solely due to homelessness or migrancy and previously certified participants who might regress in nutritional status without continued provisions of supplemental foods 7 CFR §246.7(e)(4)(vii).

4. Participants in the following categories, **who are certified solely due to homelessness/migrant status** are assigned to the following priority:

Pregnant Women	Priority 4
Breastfeeding Women	Priority 4
Nonbreastfeeding Women	Priority 6
Infants	Priority 4
Children	Priority 5

Presumptive Eligibility for Pregnant Women

5. A complete nutrition risk evaluation shall be completed no later than sixty (60) days after a pregnant woman is certified for participation.

6. If no other qualifying risk factor is identified, a hematological test for anemia must be performed or obtained from referral sources before the sixty (60) day period elapses. If a qualifying risk factor is identified, a hematological test for anemia shall be performed within sixty (60) days.

7. A Local Agency may presumptively issue a pregnant woman one month of food benefits and schedule an appointment for a complete certification visit at which time nutrition risk must be assigned. The Local Agency may not issue more than thirty (30) days of benefits to a presumptively eligible pregnant woman. A full nutrition assessment must be completed within 60 days of the initial appointment before additional benefits are issued.

7.1 Presumptively eligible applicants found ineligible to participate in the program shall be advised in writing of the ineligibility, of the reasons for the ineligibility, and of the right to a fair hearing (Appendix OM-16 A. OM-16B)

8. The reasons for the ineligibility shall be properly documented and shall be scanned into the participant electronic record.

9. If the nutrition risk evaluation is not completed within sixty (60) days, the applicant shall be determined ineligible.

Breastfeeding Women and Breastfed Infants

10. Breastfeeding dyads may be assessed to be at nutrition risk based on one another, though the mother-infant dyad risks are not sufficient alone (601, 702).

11. A full nutrition assessment must be completed for both a breastfeeding woman and her infant and other nutrition risk(s) assigned as appropriate. Infants - Other

12. An infant under six (6) months of age may be determined to be at nutrition risk if the infant's mother was a participant during pregnancy or if medical records document that the mother was at nutrition risk during pregnancy because of detrimental or abnormal conditions detectable by biochemical or anthropometric measurements or other documented nutrition- related medical conditions. Hematological Risk Determination

13. Hemoglobin and/or hematocrit data must be collected within ninety (90) days of certification if the participant is determined to have at least one qualifying nutrition risk at the time of certification.

    13.1 Pronto bloodless devices shall be used first to obtain a hemoglobin screening result for women and children twenty-four (24) months of age or older.

        13.1.1 If a reading cannot be obtained with the Pronto device, a capillary blood sample shall be obtained.

    13.2 Hemocue capillary sampling devices shall be used for hemoglobin screening result for children less than twenty-four (24) months of age and/or less than twenty-two (22) pounds.

14. The State shall have procedures to ensure receipt of hematologic data and to assure that hematological assessment data is current and reflects participant status, meaning the test must have been taken for pregnant women during pregnancy and for postpartum or breastfeeding women following termination of pregnancy. The state agency shall monitor the hematological assessment and data collection process at the Management Evaluation Review (MER).

15. A hematological test for anemia, such as hemoglobin or hematocrit, shall be performed and/or documented in the applicant's record at the time of certification, for applicants with no other nutrition risk.

16. If blood work is performed by an outside source within sixty (60) days of certification, the actual date that the test was performed must be entered into the WIC system. Referral data must be reflective of participant status.

17. Refusal of blood work shall only be allowed for medical, sincere religious or philosophical reasons.

17.1 In the case of a medical condition (e.g., hemophilia, osteogenesis imperfecta or a serious skin disease), every effort should be made to obtain a hemoglobin value from the participant's health care provider.

17.1.1 Documentation from a physician of the medical condition must be included in the individual's certification file. If the noted condition is considered to be treatable, such as a serious skin disease, a new statement from the physician would be required for each subsequent certification. If the condition is considered "lifelong", such as hemophilia, a new statement from the physician would NOT be necessary for a subsequent certification(s).

17.2 In the case of a sincere religious or philosophical objection to having blood drawn, the client or authorized representative must be informed that the refusal may mean that the Maine CDC WIC Nutrition Program will not have the information needed to complete a thorough nutrition assessment.

17.3 Refusal to have blood work done must be documented on the Blood Work Refusal Form, (see Appendix CE-3-B) and scanned into the participant's electronic record.

18. Hematological tests for breastfeeding women, who are 6-12 months postpartum, are not required if a test was performed more than four (> 4) weeks after termination of their pregnancy.

19. Hematological testing for infants is not required, but is permitted, for infants less than nine (< 9) months of age.

20. All infants nine months of age and older (≥ 9 months**),** who have not already had a hematological test, shall have a hematological test performed**,** or test results shall be obtained from outside referral sources.

20.1 The hematological test for infants nine months and older does not have to occur within ninety (90) days of the date of certification.

20.2 A reminder can be given to the parent at the infant's six (6) month WIC visit to obtain the hemoglobin test results from the health care provider at the next well baby checkup.

21. The Local Agency staff is responsible for ensuring that the infant's blood work data is obtained according to the anemia screening schedule below and recorded in the participant electronic record. Every effort should be made to obtain the hemoglobin value from the health care provider. However, when this is not possible, the local WIC agency must perform the blood test.

21.1 Children are required to have at least one (1) hematological test between twelve (12) and twenty-four (24) months of age, completed six (6) months after the

infant test, if possible. A blood test, at or after twelve (12) months, will not fulfill the requirement for both the infant and the 12-24 month child screening.

21.2 Blood work shall be obtained annually on children ages 2-5 if prior certification results were normal.

21.3 The participant or parent/guardian shall be informed of the test results when there is a finding of anemia, and notations reflecting the outcome of the tests shall be made in the participant's electronic record.

21.4 Participants with low hemoglobin values shall be referred to their physician for follow-up within the six (6) month certification period per the health care provider's protocol.

21.4.1 If the hemoglobin value for any participant is below 10.0 g/dL or the Local Agency staff member is concerned about the hematological screening value, the participant/authorized representative shall be asked to sign the release statement on the Release Nutrition Assessment form (Appendix CE-3-C) to allowing the local agency staff member to send the hemoglobin information to the health care provider.

21.5 Children with a low hemoglobin value will require a follow-up blood test at 6 month intervals.

22. Nutrition education and referral services related to hematological screening results shall be provided to the participant or parent/guardian, as appropriate.

<u>Lead Screening – Infants and Children</u>

23. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program requires that children receive lead screening at twelve (12) and twenty-four (24) months. WIC staff shall address this at appointments around the ages of twelve (12) and twenty-four (24) months as well as at enrollment for any children older than twenty-four (24) months.

24. Maine CDC WIC Nutrition Program staff shall assess the history of lead testing for every infant and child. The WIC staff shall make a referral to a child's health care provider if the:

24.1 Child has never received a lead test
24.2 Child had an elevated blood lead level twelve (12) months prior and has had no interim follow-up screening
24.3 Child has a sibling or frequent playmate with an elevated blood lead level
24.4 Participant is a recent immigrant, refugee, or foreign adoptee
24.5 Breastfeeding or lactating woman, parent, or child's principal caregiver works professionally or recreationally with lead

24.6 Family has a household member who uses traditional, folk, or ethnic remedies; cosmetics; or who routinely eats unregulated/uninspected food imported from abroad

24.7 Family has been identified at increased risk for lead exposure (http://www.maine.gov/dhhs/mecdc/environmentalhealth/eohp/lead/parents.shtml)

25. If parents indicate that a blood lead test has been done and the results show their child has been exposed to lead, WIC staff is advised to request the blood lead level from the primary care provider. A lead level greater than or equal to (≥) 5 mcg/dl is a nutrition risk that must be verified and documented in the client record. Appropriate nutrition education is required.

Lead Screening - Women

26. Maine CDC WIC Nutrition Program staff shall assess the lead exposure risk and history of testing for pregnant and breastfeeding participants. The WIC staff shall make a referral to a woman's health care provider if the:

26.1 Participant practices pica (consumption of nonnutritive substances for a period of at least one month)

26.2 Participant is a recent immigrant or refugee

26.3 Participant or household member works professionally or recreationally with lead

26.4 Family has a household member who uses traditional, folk, or ethnic remedies; cosmetics; or who routinely eats unregulated/uninspected food imported from abroad

26.5 Family has been identified at increased risk for lead exposure (http://www.maine.gov/dhhs/mecdc/environmentalhealth/eohp/lead/parents.shtml)

27. The following recommendations shall be shared with breastfeeding women who are confirmed to have high lead levels, as needed:

27.1 Mothers with blood lead levels less than (<) 40 µg/dL should breastfeed.

27.2 Mothers with confirmed blood lead levels greater than or equal to (≥) 40 µg/dL should begin breastfeeding when their blood lead levels drop below 40 µg/dL. Until then, they should pump and discard their breast milk.

27.3 Breastfeeding should continue for all infants with blood lead levels below 5 µg/dL.

27.4 Infants born to mothers with blood lead levels greater than or equal to (≥) 5 µg/dL and less than forty (<) 40 µg/dL can continue to breastfeed unless there are indications that the breastmilk is contributing to elevating blood lead levels.

Anthropometric Risk Determination

28. In order to appropriately assess anthropometric risk, equipment must be in good working order. Scales must be calibrated at least annually or whenever there is a suspected issue with accuracy (see Appendix CE-3-D Scale Calibration Instructions).

29. Height/length and weight measurements shall be performed and/or documented in the applicant's electronic record at the time of certification. Height and weight measurements are required at each certification and mid-certification assessment.

30. Referral anthropometric measurements shall be accepted if they were obtained within sixty (60) days prior to the date of the certification and reflective of current participant category.

    30.1 The date entered into the electronic record shall reflect the date the measurement was taken, not the date the measurement was entered into the electronic record.

31. For infants enrolled prior to age six (6) months who are certified until their first birthday, growth must be assessed throughout the certification period, at the following ages:

    31.1 Birth-4 weeks

    31.2 3-5 months

    31.3 6-8 months

    31.4 9-11 months

32. Infants with inadequate growth or rapid growth velocity may require more frequent measurements.

    32.1 If the Local Agency staff member is concerned about the growth patterns of a participant, the participant/authorized representative shall be asked to sign the release statement on the Nutrition Assessment Release form (Appendix CE-3-C) allowing the local agency staff member to send the anthropometric information and nutrition assessment to the health care provider.

33. For infants enrolled after age six (6) months and all children older than twelve (12) months, growth must be assessed at each certification and mid-certification assessment.

34. Growth measurements within a certification period may be done at the discretion of the nutritionist or competent professional authority (CPA), especially for infants or children certified for growth risks (including risk codes 103, 113, 114, or 115).

35. All measurements and dates they are taken must be entered into the WIC SPIRIT application.

36. Electronic Growth Charts- World Health Organization (WHO) and National Center for Health Statistics (NCHS) electronic growth charts shall be used to record the growth of each infant/child participant. There are four variations based on age and sex:

36.1 WHO growth charts: birth-36 months, male and female

36.2 NCHS growth charts: 2-5 years, male and female

37. The WIC SPIRIT application automatically plots growth on these charts using height and weight data that is entered by the Local Agency WIC staff member.

38. Factors that affect the measurement of an infant or child (e.g. uncooperative behavior), should be noted in the client record. Because stature has a strong genetic component, parental stature should be considered when interpreting the measurement of a child with a height/length for age at or below the tenth percentile.

39. For prematurely born infants, it is important to account for gestational age when interpreting growth data, until they are two (2) years old.

    39.1 Subtract the amount of prematurity from the infant's chronological age. Age adjustments for prematurity are based on forty (40) weeks gestational age for full-term infants. For example for an infant/child with a gestational age of twenty-eight0 (28) weeks (twelve [12] weeks premature) subtract three (3) months from the actual age.

    39.2 Assess growth using both the adjusted age and actual age values. Comparing actual and adjusted growth values is important when discussing the premature infant's growth with the parent/guardian. The WIC counseling staff member may use both the electronic WHO growth charts and electronic prematurity growth charts in the SPIRIT application to assess a premature baby's growth velocity.

Prenatal and Postpartum Assessment

40. A woman's height shall be measured at her first clinic visit and her weight at every clinic visit. Height shall be taken without shoes using the appropriate measuring technique. Frequency of measurements may be tailored to the individual, depending on adequacy of weight gain. All measurements and dates obtained must be entered into the participant's electronic record.

41. Anthropometric measurements shall be used to determine the appropriateness of a woman's pre-gravid weight, as well as her pattern of weight gain.

42. The WIC system calculates overweight and underweight using BMI based on the woman's height and prenatal weight entered into the WIC SPIRIT application at certification.

43. Prenatal weight gain shall be plotted by the WIC SPIRIT application from weight data entered by the WIC staff member.

44. Inadequate and excessive weight gain shall be determined by comparing the woman's rate of gain throughout pregnancy with the recommended gain given her prenatal weight status.

44.1 If the Local Agency staff member is concerned about the growth patterns of a participant, the participant/authorized representative shall be asked to sign the release statement on the Nutrition Assessment form (Appendix CE-3-C) to allowing the local agency staff member to send the anthropometric information and nutrition assessment to the health care provider.

45. Postpartum weight status is important for both breastfeeding and non-breastfeeding mothers. Postpartum BMI shall be calculated by the WIC SPIRIT application from the woman's height and postpartum weight entered at certification.

Nutrition Risk Assessment

46. A nutrition risk assessment must be completed for all participants to become certified. All risk assessment information must be documented in the client record.

47. Dietary risk assessment for women and for children older than twenty-four (24) months shall be based on the Dietary Guidelines for Americans and the USDA ChooseMyPlate guidance. Dietary assessment for infants and children 12-24 months is based on the American Academy of Pediatrics (AAP) feeding guidance. (Refer to the Dietary Guidelines for Americans website: http://www.cnpp.usda.gov/dietaryguidelines.html and the ChooseMyPlate Food Guide website: http://www.choosemyplate.gov for more information.)

48. Risk status shall be assessed based on a participant's current or most recent nutrition risk condition, as opposed to any history of the condition, unless otherwise stated in the specific definition of the nutrition risk criterion. All applicable risk conditions must be documented.

49. Women and children over twenty-four (24) months of age who are financially eligible for the Maine CDC WIC Nutrition Program may be enrolled on the basis of failure to meet Dietary Guidelines for Americans (children $\geq$ 24 months, women—risk 401), if no other risk factors are identified.

50. When higher priority risks have not been identified (biochemical, anthropometric, and/or medical), the WIC counselor must interview the participant/authorized representative regarding dietary concerns. Inappropriate nutrition practices to be explored can be found on the Risk Factor Detail Guide in SPIRIT.

51. After the nutrition assessment has been completed, if higher priority risks or an inappropriate nutrition practice has been identified, the counselor may not assign Failure to Meet Dietary Guidelines for Americans (risk 401) for a child aged 2-5 years, or woman of any status.

52. For infants older than four months or children younger than twenty-four (24) months, the counselor may assign Dietary Risk Associated with Complementary Feeding Practices (risk 428) if higher priority risks or Inappropriate Nutrition Practices (risk 411) have not

been identified. Inappropriate nutrition practices to be explored can be found on the Risk Factor Detail Guide in SPIRIT.

Documentation of Nutrition Risk Assessment

53. The applicant's certification record must substantiate the nutrition risk condition(s) used to determine eligibility.

54. All nutrition risk criteria containing a statement requiring a physician's diagnosis must be verified.

55. Documentation of the Nutrition Risk Assessment in the SPIRIT participant record must include the following nutrition services data:

    55.1 Assessment information

    55.2 All risks/needs identified through the assessment process

    55.3 WIC category and priority level

    55.4 Food prescription (to include medical documentation when required and rationale for food prescription tailoring, if applicable)

    55.5 Nutrition education and referral(s) provided (second or subsequent nutrition education contacts during a certification period that are provided to a participant in a group setting must be documented in the participant electronic record)

    55.6 Follow-up activity plans for future visits

    55.7 An individual care plan for medically high risk participants (identified by the WIC staff member)

56. Medical and clinical risks must be documented by a physician or someone acting under the orders of a physician.

57. The applicant/client must give written consent for the WIC staff to obtain documentation of professionally-diagnosed risk conditions. Only the following forms can be used to obtain medical information:

    57.1 Request for Information/Infant/Child (Appendix CE-3-E)

    57.2 Request for Information/Women (Appendix CE-3-F)

    57.3 The Authorization of Release of HIV Status (Appendix CE-3-G) shall be used to request confirmation of HIV diagnosis.

58. A referral diagnosis from a physician or other health care professional documenting an allowed WIC nutrition risk criterion may be assumed to meet the stipulated definition, cut-off or threshold of the applicable criterion. For example, a physician's referral

diagnosis of infant prematurity could be used at face value by WIC staff to certify for nutrition risk, without further review or validation against the definition of prematurity.

59. Self-reported medical diagnoses should prompt the WIC staff member to validate the presence of the condition by asking more pointed questions related to the self-reported diagnosis, such as:

    59.1 Is the condition being managed by a health care provider?

    59.2 What is the name and contact information for the health care provider?

    59.3 Is the condition being controlled by diet or medication?

    59.4 What type of medication has been prescribed?

60. Verification from the Health Care Provider shall be obtained prior to assignment of appropriate nutrition risk(s) related to the self-reported medical diagnosis.