SECTION 5.3

Subject: Nutrition Risk Assessment

References: WIC Policy Memo #98-9, 246.7(e) (1)-(3)

Policy: Local Agency CPAs must conduct a thorough assessment of nutrition risk during the certification process.

Purpose: Nutrition risk assessment is the process of obtaining and synthesizing information about a participant's nutrition and, as appropriate, breastfeeding status in order to provide the most appropriate individualized WIC services. The nutrition assessment is the foundation on which all subsequent nutrition services are based: nutrition education, an individualized food package, and referrals to other health and/or social services providers.

The nutrition risk assessment includes an evaluation of:

- Anthropometric information
- Hematologic information
- Health and medical history
- Dietary information
- Breastfeeding information, as appropriate

Procedures:

The assessment process is meant to be a conversation between the CPA and participant/caregiver. To conduct a WIC nutrition assessment, CPAs must:

1. Accurately collect anthropometric, hematologic, health and dietary information. *Anthropometric* and *hematologic* assessments should be done ***first.*** Identifying any height, weight or blood-iron concerns first, provides a context for assessment information collected in the Information System.
   - Anthropometric and hematologic information should be obtained using standard procedures outlined in the anthropometric and hematologic assessment policies.
   - Health and dietary information must be collected using the questions in the Information System. Probing questions should be used as appropriate to collect relevant, accurate information. This helps the CPA assess a participant's health, nutrition practices, cultural values, preferences and other pertinent areas.
2. Clarify and synthesize the information that has been collected.
3. Identify and assign all applicable risk codes and any other relevant concerns.
4. Document the assessment in the Information System, including all applicable risk codes.
5. Follow up on previous assessments, as appropriate.

6. ***After*** all components of the WIC assessment are completed, provide education based on highest priority risk conditions and participant's interests. *Note:* it is not expected, nor is it recommended, that all nutrition risks be addressed (i.e., counseled/educated on) at the initial certification. See Guidance.

Guidance:

A value-enhanced nutrition assessment (VENA) requires:

- a systematic approach to collecting and evaluating information provided by participants;
- good communication skills and an ability to establish rapport with each participant;
- a knowledge of nutrition and breastfeeding; and
- skill in critical thinking.

1. It is best practice to review previous assessments and relevant notes in the participant's record prior to beginning the new assessment.

2. To enhance the value of the assessment, it is critical the assessment be conducted in space that provides privacy to participants.

3. *Only after* all information has been reviewed and all nutrition risks identified, should education or counseling be provided.
   - Conclusions based on incomplete information might be incorrect.
   - Education based on incorrect conclusions is likely to be inappropriate.

It is important to understand the underlying causes before exploring possible solutions with participants. For example, it would be inappropriate to discuss dietary recommendations for addressing low hemoglobin before completing all aspects of the assessment. Until the nutrition assessment has been completed, the CPA would not know what dietary factors may be related to the low blood iron.

CPAs should prioritize the nutrition issues to be addressed, in collaboration with each participant. Those of greatest importance and/or interest should be addressed first. Other concerns can be addressed at subsequent WIC nutrition visits.

5.3.1 Anthropometric Data

References: 246.7(e)(1)(i)(A and B) and 246.7(e)(1) (ii)

Policy: Local Agency staff must obtain and record accurate anthropometric data reflective of the participant's category at certification, re-certification and mid-certification. The data must have been measured within the previous sixty days.

Purpose: To ensure that accurate applicant/participant anthropometric data is included in the health status assessment so that correct risks are identified, risk codes assigned, and relevant education provided.

Procedures:

1. **Local agency staff must obtain anthropometric data** either by:
   - Measuring height/length and weight using appropriate equipment and following the procedures described in the Minnesota WIC Program Anthropometric Manual, ***or***

   - Obtaining anthropometric data from a medical provider through referral. **See Policy 5.3.1.1 – Use of Referral Weight and Height/Length Data**. Self-reported anthropometric information may not be used.

   Procedures for measuring height/length and weight are described in the *Minnesota WIC Program Anthropometric Manual* (Part II, pages 11 – 36):
   - Measuring recumbent length of infants and young children, see page 11;
   - Weighing children younger than 24 months of age, see page 18;
   - Measuring standing height of older children and adults, see page 24;
   - Weighing older children and adults, see page 29.

2. **Local agency staff must accurately record anthropometric data in the Information System, documenting:**
   - Date measurements were taken; and
   - Whether the length/height was measured in standing or recumbent position.

3. **CPA staff must assess anthropometric data using the appropriate assessment tools.**
   - Infants' and children's anthropometric data will be assessed, and risk codes assigned, using the growth charts displayed in the Information System**.**

     - **For infants and children < 24 months of age**: weigh and measure *recumbent length*. The Information System will plot weight-for-age, length-for-age, and weight-for-length.

     - **For children between 24 and 36 months of age**, either recumbent length ***or*** standing height (preferred) can be measured. Refer to Minnesota WIC Program Anthropometric Manual for information and guidance on selecting appropriate measurement (height or length).
       - If *height* is measured, *standing* must be indicated in the Information System and the system will display and plot BMI-for-age.
       - If *length* is measured, *recumbent* must be indicated in the Information System, and the system will display and plot weight-for-length.

     - **For children > 36 months of age**, weigh and measure *standing height*. The Information System will plot weight-for-age, height-for-age, and BMI-for-age.

       Note: Other growth grids (e.g., for children with Down Syndrome, or for premature infants) may be used for education and assessing the infant/child, **but not for assigning risk codes**.

- **Women's anthropometric data** will be assessed based on the Institute of Medicine's recommendations in Institute of Medicine Weight Gain During Pregnancy: Reexamining the Guidelines
    - The Information System will display the grid appropriate for the woman's weight status (underweight, normal weight, overweight, or obese). Refer to Minnesota WIC Program Anthropometric Manual for information and guidance on using and interpreting pregnancy weight gain charts.
        - For pregnant women and women < 6 months postpartum, *pre-pregnancy* BMI is used to assess weight status.
        - For breastfeeding women > 6 months postpartum, *current* BMI is used to assess weight status.

    - Staff should assess the woman's weight gain during her pregnancy if currently pregnant, and total amount of weight gained if postpartum.

4. Local agencies must have equipment that meets the guidelines in the Minnesota WIC Program Anthropometric Manual

Local agencies must check the accuracy of clinic scales at least twice each year, approximately 6 months apart. See Minnesota WIC Program Anthropometric Manual (pages 18 and 29) for specific instructions and requirements. Results of scale checks must be recorded and the local agency must be able to provide records of scale checks during the local agency's management evaluation. Exhibit 5-K is a form that may be used to record the dates and results of the scale checks.

Guidance:

- All participants, including women, must be measured and weighed. Self-reported height and/or weight may not be used.

- If a woman is ≥20 years of age, staff need measure her height only once (typically at her at her initial certification).

- Each time height/length and weight are measured, a single measurement is adequate when care is taken to assure that *proper measuring techniques are used*. Staff need not measure more than once.

- Whenever there is any doubt about the accuracy of a measurement (including measurements obtained by referral), staff should re-measure. Errors could occur in measuring, reporting, plotting, or entry into the Information System.
    - If an accurate measure is not possible (e.g. child is wearing a cast or is very uncooperative), mark that the measure may not be accurate and select the appropriate reason for the inaccuracy. Document additional information about the suspected inaccuracy in the Notes section.

    - If it is not possible to measure the participant (e.g., because the participant is medically fragile and unable to come to clinic) and no referral data is available, use

the "Unknown ht/wt" button to provide a placeholder for the measurement in the anthropometric tabs of the Information System. Describe the situation more fully in the Notes section, and if possible, obtain these measurements when referral data is available or the condition is resolved.

- **Clothing:** WIC participants must be clothed as specified in the Minnesota WIC Program Anthropometric Manual to ensure accurate weights.
  - Since it is essential that infants be in a ***dry diaper*** for weighing, it is advantageous to have a dedicated diaper-changing area in the *near vicinity* of the weighing area.
  - It is also helpful to have a supply of diapers available.

- **Drapes:** Staff should use drapes on infant scales, recumbent measuring boards, foot beds on scales, and on the headpiece of the height measuring boards.

- Scales must be zero-balanced with the drape prior to each use.

5.3.1.1 Using Referral Weight and Height/Length Data

References: CFR 246.7 (e)(1)(i)(A) and 246.7 (e)(1)(i)(B)

Policy: Referral anthropometric data must meet all the requirements for anthropometric data collected in the clinic.

Purpose: To ensure an accurate assessment of the participant's weight and height/length status using referral data, anthropometric data must reflect the participant's current category, and have been done within the past sixty days for the assessment to be valid.

Procedures:

Weight and height/length data collected by a medical provider other than WIC staff, may be used for certification. Use of referral data does not pre-empt the requirement that the participant be physically present at the certification (see Section 5.2 – 5.2.5 – Physical Presence) .

For referral data to be used, the following conditions must be met:

- The data is provided by a health care provider. The referral data should be provided on letterhead from the source or another form that specifies the Clinic/provider, and include:
  - participant's name
  - date of collection
  - health professional's signature

  The CPA may obtain this information by phone from the health care provider.
- The measurements were taken within sixty days of the certification.
- The participant was in the same categorical status (i.e., pregnant or postpartum) at the time of data collection as at the certification at which the data is used.
- The actual measurement date is entered in the Information System so that plotting is accurate.

- The source of the measurement date is entered in the Information System.

Guidance:
Because infants grow so rapidly, it is best clinical practice to weigh and measure infants at the certification appointment whenever possible. If referral data must be used, it should be as recent as possible, collected no more than 30 days prior to the certification.

5.3.2 Hematologic Assessment

References: Federal Regulation 7 CFR 246.7 (e)(1)(i)(A) and 246.7 (e)(1)(i)(B)

Policy: Local Agency staff must obtain and record accurate hematologic data reflective of the participant's category at certification, re-certification and mid-certification.

Purpose: To ensure that accurate applicant/participant hematologic data is included in the health status assessment so that correct risks are identified, risk codes assigned, and relevant education provided.

It is important to assess iron status as part of a nutritional assessment because individuals eligible to participate in WIC have been shown to be at risk, and the consequences of iron deficiency anemia on development are potentially serious and long-term in nature. WIC has been shown to positively impact iron status through nutrition education, supplemental food and referrals to health care providers.

Procedures:
- Local agency staff must obtain hematologic data either by:
  - Measuring hemoglobin or hematocrit using approved equipment and following the procedures described by the manufacturer, or
  - Obtaining hematologic data from a medical provider through referral. See Policy 5.3.2.2 – Use of Referral Hematologic Data.
- Train all staff having responsibility for bloodwork on correct procedures:
  - Manufacturers of the equipment describe procedures specific to their equipment, including procedures for collecting capillary blood, analyzing the sample, using and handling related equipment (e.g., microcuvettes), and cleaning the equipment.
  - Review hematological procedures as part of the ongoing monitoring and supervision of CPA staff (Section 4.6: CPA Performance and Evaluation).

Local agencies must use the following schedules:

Women:
Hematologic data must be entered for all women certified in WIC.

- Bloodwork must have been done at a time that reflects their current status (i.e., blood work measured during pregnancy if certifying a pregnant woman, or following delivery if certifying a postpartum woman)

- **For women certified for a year:** if blood values obtained at their certification indicated low hemoglobin, blood work must be repeated during the year and recorded in the participant's record.

Infants:

- **Blood work must be done *at or after nine months of age*, generally at the infant's mid-certification appointment.**
- **In the very rare circumstance when the infant's mid-certification occurs *before* the infant is nine months of age, *do not test* the blood at the mid-certification. Instead, do the b**lood work **at the next certification (usually at approximately one year of age).**

Children:

- **For children certified between 12 and 15 months:**
    - Blood work **must be done at certification**, **unless previous blood work was done on or after nine months of age and the hemoglobin value was normal.**
    - **Bloodwork must be done at mid-certification (18 -21 months), *regardless* of the previous hemoglobin status (i.e., even if it was normal).**

- **For children certified between 15 and 24 months:**
    - **Blood work must be done at the certification/re-certification/mid-certification, regardless if the previous hemoglobin value was normal or not.**

- **Children 24 months and older must have blood work done at the certification/re-certification/mid-certification:**
    - **If the most recent blood work indicated low hemoglobin, and/or**
    - **If the most recent blood work was done more than 12 months prior to the current certification appointment.**
    - **If a child aged 20 to 26 months old did not have blood work done between 13 and 24 months, the hemoglobin must be measured.**

Blood Work Schedule for Infants & Children

Child's Age at certification/re-certification or mid-certification	Age at Most Recent Blood Work	Was Hemoglobin Low?	Blood Work Required at certification/re-certification/mid-certification?
0 -- 9 mo.	NA	NA	**No**
9 -- 12 mo.	NA	NA	**YES***
12 --15 mo.	< 9 mo.	Yes or No	**YES**
12--15 mo.	≥ 9 mo.	No	**No**
12 --15 mo.	≥ 9 mo.	Yes	**YES**
15 -- 20 mo.	≥ 9 mo.	Yes or No	**YES**
20 – 24 mo.	< 15 mo.	Yes or No	**YES**
20 -- 24 mo.	≥ 15 mo.	No	**No**
20 -- 24 mo.	≥ 15 mo.	Yes	If last bloodwork < 5 mo. past – **No** If last bloodwork > 5 mo. past – **YES**
24 -- 30 mo.	<15 mo.	Yes or No	**YES**
>24 months	≥ 15 mo.	No	If last bloodwork < 12 mo. past – **No** If last bloodwork ≥ 12 mo. past – **Yes**
>24 months	≥ 15 mo.	Yes	If last bloodwork < 5 mo. past – **No** If last bloodwork > 5 mo. past – **Yes**

*A child/infant first certified on or after nine months old, always needs hemoglobin tested at the first certification.

Guidance:

If the hematologic value at the child's previous certification was near the cut-off point, and the child has risk factors for low hemoglobin (such as late weaning, excessive juice intake and/or excessive milk intake), it is **best practice to repeat blood work** at the next certification/recertification/mid-certification.

The requirement that blood work be done once a year for children over two years of age is intended to mean "approximately one time per year". If the most recent blood work was done more than 10 months ago, while not technically required, it would be best practice to do blood work.

Guidance from the Department of Justice indicates that it would be discriminatory to require HIV-infected applicants to have blood work required for WIC certification done elsewhere if it is the policy of the WIC clinic to perform these tests on site. However, if it is determined, on a case-by-case basis, that the health and safety of others is severely at risk, providing the service by other means may be justified. Applicants cannot be required to obtain such data at their own expense. With rare exception, WIC clinics should be prepared to obtain WIC blood collections from all applicants, following recommended health and safety protocols.

Manufacturers provide training materials, including step by step procedures in both print and video format, demonstrating correct technique. Some manufacturers will provide on-site training and allow staff to practice correct technique. HemoCue has a web-based training module that can be accessed by all staff: http://www.hemocuelearningcenter.com/

5.3.2.1 Exceptions to required Hematological Measurements

There are two exceptions to the hematological testing requirement for WIC certification:

1. Refusal based on religious beliefs;

2. If blood drawing could cause harm to the applicant because of medical conditions documented by a physician (hemophilia, certain skin diseases, etc.)

Procedures:

- When either of these two circumstances apply and blood work is not done in clinic, attempts should be made to obtain referral data from participant's health care provider.

- If referral data is not available, certify the applicant based on other identified risk criteria, and refer to a laboratory that can collect blood from such persons.

- Applicants cannot be required to obtain such data at their own expense.

- If an applicant refuses blood work due to religion or medical condition, the reason blood work was not collected ***must be documented*** in the Notes section of the Information System.

5.3.2.2 Use of Referral Hematological Data

References: CFR 246.7 (e)(1)(i)(A) and 246.7 (e)(1)(i)(B)

Policy: Referral hematologic data must meet the all the requirements for data collected in the WIC clinic.

Purpose: To ensure an accurate assessment of the participant's hematologic status using referral data, hematologic data must reflect the participant's current category, and meet the scheduling requirements described in Section 5.3.2.

Procedures:

- Hematologic data collected by a medical provider other than WIC staff, may be used for certification/recertification/mid-certification provided the following conditions are met:
  - The data is provided by a health care provider.
  - The referral data should be provided on letterhead from the source or another form that specifies the Clinic/provider, and includes:
    - participant's name

        - date of collection

    - The measurements must meet the scheduling requirements described in Section 5.3.2.
        - The participant was in the same categorical status (i.e., pregnant or postpartum) at the time of data collection as at the certification for which the data is used.
        - The *actual measurement date* is entered in the Information System.

- The CPA may obtain this information by phone from the health care provider. Self-reported hematologic data may not be used.

- Use of referral data does not pre-empt the requirement that the participant be physically present at the certification (see Policy 5.2.5).

5.3.2.3 Preventing Blood Borne Pathogen Transmission

All Local agencies employing individuals who may be exposed to blood borne pathogens and other infections agents **must have a written Exposure Control Plan.** Refer to the U.S. Department of Labor - Occupational Safety and Health Administration.

The Exposure Control Plan establishes guidelines, precautions, laboratory rules and standard operating procedures that will limit occupational exposure to blood borne pathogens and other infectious agents.

- All employees must be trained in all aspects of the agency Exposure Control Plan.

Precautions described in the Exposure Control Plan which are intended to prevent transmission of blood borne pathogens are referred to as “Universal Precautions”. All employees must practice “Universal Precautions” at all times when working with blood and body fluids. All individuals/patients are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other blood borne pathogens.

5.3.3 Health and Nutrition Information

References: 246.7(i)(8), 246.7(e)(2)(ii), 246.7(E)(III), WIC Policy Memo #98-9

Policy: Local Agency CPAs must assess a participant's health and nutrition status at certification, recertification and mid-certifications.

Purpose: To ensure all applicants receive a standardized assessment of their medical/health/nutrition status that is based on currently accepted practice and Value Enhanced Nutrition Assessment (*VENA*) guidelines.

Procedures:

1. *Only after* completing an anthropometric and hematologic assessment, assess the participant's medical/health/nutrition status.

2. Collect relevant information about the participant's health (including risk assessment for postpartum/perinatal depression), diet and eating/feeding patterns.

3. Clarify and synthesize information that has been collected.

4. Identify and assign all applicable risk codes.

5. Document the health/medical/nutrition assessment.

6. After all components of the assessment are complete (anthropometric, hematologic, health, diet, and breastfeeding) and all applicable risk codes assigned, provide education based on prioritized needs.

7. Local agencies should coordinate with public health immunization-program staff to ensure infants' and children's immunization status is assessed and appropriate referrals are made.

Guidance:

- Use a participatory, interactive approach when collecting health and diet/breastfeeding information:
    - CPAs may ask the assessment questions in any order.
    - CPAs should "use his/her own voice" when asking the assessment questions, provided the intent of each question is not changed.
    - Actively involve the participant through dialogue, information exchange, listening and feedback.
    - Clarify information by using probing, open-ended questions.
    - Keep discussion at a level appropriate to participants' level of education.
    - Avoid being judgmental.
    - Conduct the assessment with respect and warmth to aid in building rapport.

- Refer to VENA for more information.
- Refer to dietary assessment questions for further information.

- Assess immunization status:
  - At a minimum, CPAs should ask if the child's immunizations are up-to-date with the Child and Adolescent Immunization Schedules for Healthcare Providers.
  - CPA staff should indicate in the Information System if the participant is up-to-date for age by current recommendations or if a referral for services was made.
  - Child and Adolescent Immunization Schedules for Parents may be used for educational purposes.

- Ensure the privacy of each participant when gathering and discussing information.

5.3.4 Nutrition Risk Code and Priority Assignment

References: WIC Policy Memo #98-9, 246.7(e)(1)-(3)

Policy: Local Agency CPAs must assign all applicable risk codes at each certification and recertification.

Purpose: To ensure that all identified risks are documented in the participant's record for determining WIC eligibility and for providing the most appropriate nutrition services. To ensure risk codes are assigned consistently throughout the state.

Procedures:

1. Compare assessment data to the WIC nutrition risk criteria. Refer to Exhibit 5-T and the Allowed WIC Nutrition Risk Criteria.

2. Select all applicable risk codes in the Information System.

3. Provide justification for all assigned risk codes by documenting supporting information in the Information System.

Guidance:

- All applicable risk codes must be assigned and documented, but it is not expected that all nutrition risks conditions be counseled on at the initial certification. WIC staff, in collaboration with the participant, should prioritize the nutrition issues to determine which will be addressed at the certification appointment.

- Begin education or counseling *only after* all information has been reviewed and nutritional risks assessed. Proceeding in this way will provide the CPA with a more comprehensive picture of the participant's nutrition status, so that he/she can counsel accordingly.

- CPAs should be familiar with the federal priority system. Refer to Exhibits 5-U and 5-V for detailed information.