SUBJECT: High-Risk Individual Nutrition Care Plans

References: Federal Regulation: 246.11(e)(5)
Nutrition Service Standards: 3,7,14

Policy: Develop an individual nutrition care plan (INCP) for participants who meet the Minnesota WIC Program High-Risk and Medical Referral Criteria and for any participant requesting one.

Purpose: To ensure that participants with high-risk nutrition related conditions receive appropriate WIC services and referrals.

Goals of High Risk Care: All WIC participants are at nutritional risk, but some health conditions put participants at greater risk for poor health outcomes. Some of the goals of WIC high-risk nutrition education and follow-up are to:

- Reduce fetal deaths and infant mortality.
- Reduce the incidence of infants born at low birth weight.
- Increase the duration of pregnancy.
- Improve growth of nutritionally at-risk infants and children.
- Reduce the incidence of iron-deficiency anemia.
- Assure regular medical care and follow-up.
- Make referrals for health care or for other resources as needed.

Related Policies: Drug and Harmful Substance Abuse Education
Referrals

Procedures:
1. Grantees are responsible for having on staff (or by contract) a credentialed nutrition professional to provide nutrition services to high-risk participants (see first bullet point under Guidance).

2. At a minimum, the Local Agency must use the high-risk criteria defined in High Risk and Medical Referral Criteria, Exhibit 6-A for determining when an INCP is required. Additionally, INCPs should be developed:
   - When the condition or situation warrants an INCP in the CPA’s professional judgment; and
   - when requested by a participant.

3. INCPs must be developed and documented specifically addressing the high-risk condition(s) identified, and must include:
• Assessment of the individual’s overall situation including nutrition status, needs, and any problems;
• Review of health services for the high-risk condition being provided elsewhere;
• Specific goals/recommendations regarding the high-risk condition;
• Referrals to healthcare providers (HCP) and other programs and services as needed; and
• Plans for follow-up visits.

4. **Follow-up** addressing the status of the high-risk condition must be provided at least quarterly until the high-risk condition is resolved or stable.

**Guidance:**

**Staffing**

• **High-risk Care should be provided and/or coordinated by the agency’s credentialed nutrition professional(s) which include** registered dietitians (or registration-eligible), individuals with a bachelor’s or master’s degree in nutrition, or Minnesota Licensed Nutritionist/Dietitians. See policy 4.3.
  o Other CPAs may provide High Risk Care. All staff providing High Risk Care are required to have the specialized skills and knowledge for providing high risk care, including:
    ▪ Knowledge of nutrition in health and disease, and its application to public health practices, and knowledge of the nutrition needs of infants, children, and women during the prenatal, postpartum, and breastfeeding periods.
    ▪ Knowledge of effective counseling and educational concepts and methods.
    ▪ Ability to develop and carry out on-going plans for nutrition education.
  o Agencies with para-professional staff (Locally Trained CPAs) are required to have procedures in place to assure para-professional staff refer high-risk participants to a nutrition professional. See policy 4.3.

**High Risk Criteria**

• **Criteria for INCPs and medical referrals are found in Exhibit 6-A.** If the participant is not receiving medical care for the identified high-risk condition, a written medical referral should be made. Referrals to other programs and services should be made as needed. See Referrals Policy, Section 5.7.

**Develop and Provide Individual Nutrition Care Plan (INCP)**

1. **Assessment of the individual’s overall situation:** The nutrition assessment at certification/recertification identifies any high-risk conditions or issues that need be addressed in an INCP. The assessment should include:
   • Identification of most significant risk factors present;
   • Evaluation of anthropometric and blood-work data;
   • Diet assessment;
   • Instructions or prescriptions (if any) from health care provider(s);
• Participant's/caregiver's knowledge of and attitude toward the condition(s);
• Any relevant concerns expressed by the participant or caregiver.

2. Review of health services for the high-risk condition being provided elsewhere:
• Identify the medical/nutritional support services the participant currently receives, including the frequency and extent of nutrition counseling from other sources;
• Reinforce the medical/nutritional recommendations of other health care providers.

3. Provide specific goals/recommendations regarding the high-risk condition:
• With the participant/caregiver, identify strategies that will be used to alleviate or resolve the condition(s) or issues.
• Individualize the strategies to the circumstances of the participant.

4. Provide referrals to health care providers and other programs and services as needed

5. Determine Plans for follow-up visits: Frequency of follow-up should be based on the health condition and individual’s needs.
• Some participants may need to be seen monthly; others only bi- or tri-monthly.
• For example, it might be prudent to plan monthly follow-up for a pregnant woman with a low rate of weight gain, until expected or desired weight gain is observed.
• At a minimum, follow-up should continue at least quarterly until the condition is resolved or stabilized.

Documentation of INCPs

• Documenting INCPs is essential for providing the best-individualized and responsive services to participants.
  o Documentation must be adequately detailed and comprehensive so that the condition, nutrition intervention, and planned follow-up are clear to others reviewing the record.
  o Documenting in a SOAP (Subjective, Objective, Assessment, Plan) note in the WIC Information System is preferred, but another method may be used if approved in the local agency’s nutrition education plan.

Providing High Risk Follow-up

• Follow-up may include some, or all, of the following:
  o Dietary assessment.
  o Monitoring anthropometric measurements and discussion of growth and weight gain/loss.
  o Monitoring hemoglobin and discussion of blood work results.
  o Discussion of participant's/caregiver's nutrition or health-related concerns.
  o Discussion or reinforcement of instructions given by other health care providers.
  o Assessment of food package needs and/or revision of food package prescription.
  o Individualized nutrition education.
  o Monitoring participants with complex medical problems or serious risks to assure they are receiving adequate care from appropriate health/nutrition professionals.
Referral to other programs and services, as needed.
Follow-up on referral to other programs.
Monitoring/modifying realistic goals established with participant/caregiver.

**Frequency of follow-up** should be based on the health condition and individual’s needs.
- Some participants may need to be seen monthly; others only bi- or tri-monthly.
  
  For example, it might be prudent to plan monthly follow-up for a pregnant woman with a low rate of weight gain, until expected or desired weight gain is observed.
- At a minimum, follow-up should continue *at least quarterly* until the condition is resolved or stabilized.

**Follow-up by phone may be appropriate in some cases.** High-risk follow-up by phone may be appropriate if:
- The participant does not have any anthropometric or hematological high-risk indicators, which require measurement and assessment of current height, weight, and/or hemoglobin before high-risk follow-up, OR
- Current height, weight and/or hemoglobin from a HCP is provided.

Resolving High Risk Care

**Resolve high-risk care** when the CPA determines the participant’s high-risk condition is resolved or stabilized. Document the high-risk condition is resolved or stabilized and select “Resolve High Risk” in the Information System to remove the high-risk indicator.

**Before discontinuing high-risk care,** the CPA should be sure that the condition(s) is resolved or stable, and that further monitoring would either not be necessary or not be beneficial.
- In some cases it may be beneficial to continue care to prevent relapse.
- High-risk status may be discontinued if growth is stable.

Nutrition Support provided by another HCP

- If appropriate nutrition support is provided by another HCP, with expertise in the condition, comprehensive care and follow-up may not be necessary by WIC.
- To indicate that appropriate nutrition care is provided by another HCP, the CPA should document the following:
  - The fact that the participant is receiving nutrition care elsewhere for the Condition.
  - Name, location, and phone number of the provider if available.
  - Expertise of the provider(s), e.g., MD, RD, Certified Diabetes Educator, Occupational Therapist, Physical Therapist, etc.
  - How often the participant is being seen by care provider(s).
  - Time frame for the next WIC nutrition education contact.

- Non-high-risk follow-up could therefore, be provided at the additional education contact. However, it may be beneficial to retain high-risk status for the following reasons:
  - To follow-up on referrals.
  - To answer questions, especially if the condition is newly diagnosed.
  - To assure that the participant is stable and has not relapsed.
  - To assure that the participant continues to receive follow-up from the HCP if needed.
NOTE: “High-risk” is a term used in WIC to designate the need for more advanced nutrition care. When counseling WIC participants determined to have a high-risk condition, you do not need to tell them they are “high-risk”. Consider saying something like “I would like to follow-up with you in one month to see how you are doing.” or “This is an important time for growth and development. I would like to see you (your child) next month to see how you are doing, and to answer questions.”