IDAHO WIC PROGRAM POLICY MANUAL

IDAHO DEPARTMENT OF HEALTH & WELFARE

CHAPTER 1: OVERVIEW AND ORGANIZATION

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

The Idaho WIC Program operates according to WIC program specific Federal Regulations as well as the Department of Health and Welfare operation guidelines. Sections in this chapter describe State Office and local agency responsibilities.

IN THIS CHAPTER

Section	A	State Office Organization
Section	B	Local Agency Organization
Section	C	Applicant Records
Section	D	Supplies and Materials
Section	E	Nutrition Services and Administration

SECTION A: STATE OFFICE ORGANIZATION

Effective: 01/xx/01
Revision: N/A

OVERVIEW

The Idaho WIC Program is organizationally located within the Idaho Department of Health and Welfare. The State Office is organizationally located in the Bureau of Clinical and Preventive Services within the Division of Health.

IN THIS SECTION

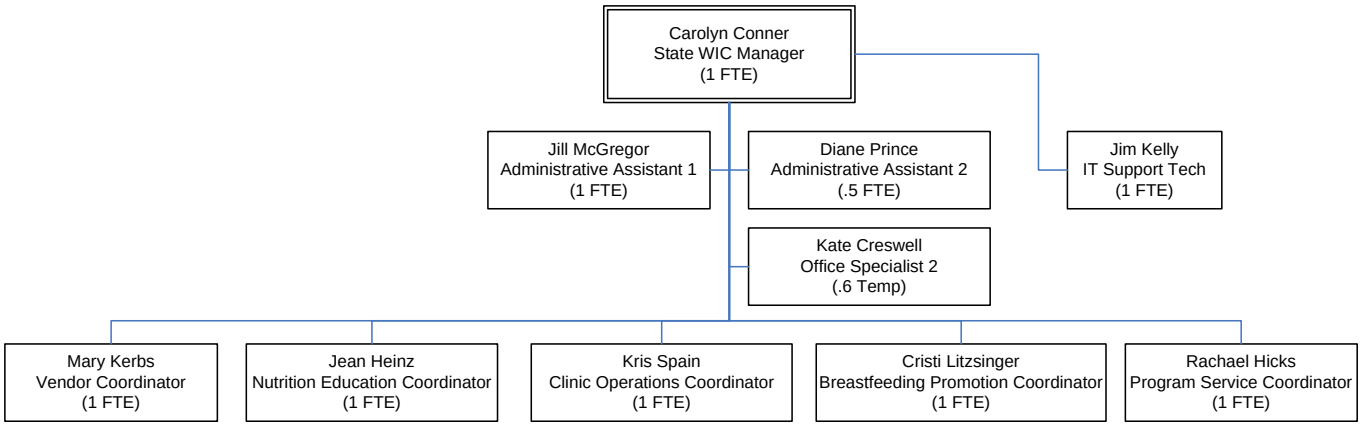
Organizational Chart
State Office Primary Functional Responsibilities

ORGANIZATIONAL CHART

Effective: 12/01/05
Revision: N/A

POLICY

Idaho WIC Program



STATE OFFICE PRIMARY FUNCTIONAL RESPONSIBILITIES

Effective: 01/xx/01
Revision: 01/01/06

STATE OFFICE CONTACT AND MAILING INFORMATION

Idaho WIC Program
Idaho Department of Health and Welfare
Pete T. Cenarrusa Building
450 W. State Street - 4th floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5948 phone
(208) 332-7362 fax

Idaho WIC System Help Desk
Toll free 1-800-942-5811

STAFF MEMBER	PRIMARY RESPONSIBILITIES
Carolyn Conner, RD, LD State WIC Manager TEL: 334-5951 FAX: 332-7362 E-mail: connerc@dhw.idaho.gov	Federal grants management Contracts and budgets Program planning and evaluation Food cost containment WIC program policy Idaho WIC Computer System Caseload management Office Communication Organization Plan Equipment inventory
Kris Spain, MS, RD, LD Nutrition Specialist Clinic Operations Coordinator TEL: 334-5952 FAX: 332-7362 E-mail: spaink@dhw.idaho.gov	Certification and eligibility Complaints/customer service Civil rights – policy, complaints Clinic procedures Monitoring lead/monitoring Policy Manual lead/assigned sections of manual Nutrition Risk Criteria
Jean Heinz, RD, LD Nutrition Specialist Education Coordinator TEL: 334-5953 FAX: 332-7362 E-mail: heinzj@dhw.idaho.gov	Nutrition education Civil rights (training and poster selection) Program evaluation surveillance (PedNSS, PNSS) and program planning monitoring (LAPP, etc.) Policy Manual – assigned sections Training coordination
Cristi Litzsinger, RD, LD, IBCLC Nutrition Specialist Breastfeeding Promotion Coordinator TEL: 334-5919 FAX: 332-7362 E-mail: litzsinc@dhw.idaho.gov	Breastfeeding promotion and support Idaho local breastfeeding councils and coalitions MCH block grant Medicaid/WIC coordination – breastfeeding equipment Program planning and evaluation (LA review and approval) – breastfeeding Policy manual – assigned sections Food authorization - nutrition content RD/IBCLC/LC breastfeeding training (lead) RD/IBCLC/LC breastfeeding referral standards (lead) Standards of care for breastfeeding women Breastfeeding study data Breastfeeding equipment and authorization

STAFF MEMBER	PRIMARY RESPONSIBILITIES
Rachael Hicks, RD, LD Nutrition Specialist Program Service Coordinator TEL: 334-5836 FAX: 332-7362 E-mail: hicksr@dhw.idaho.gov	Infant formula Complaints (formula related) Community partnerships Immunization link WIC outreach Substance abuse Web content Lead screening RD referral standards Standards of care – infants, pregnant women, children Medicaid/WIC coordination – special formulas/feeding products and RD services reimbursement VENA lead
Mary Kerbs Vendor Coordinator TEL: 334-4933 FAX: 332-7362 E-mail: kerbsm@dhw.idaho.gov	Vendor management Vendor training Food delivery Vendor check problems Fraud issues Fair hearing (vendor) Monitoring Compliance buy investigations
Diane Prince Administrative Assistant 2 TEL: 334-5930 FAX: 332-7362 E-mail: princed@dhw.idaho.gov	Secretarial support Formula sample orders (standard/premature) Formula rebate Invoice/receipt processing Travel/education requests Conference call scheduling Conference room scheduling Contracts Vendor returned check processing Assist in form modification

STAFF MEMBER	PRIMARY RESPONSIBILITIES
Jill McGregor Administrative Assistant 1 TEL: 334-5948 FAX: 332-7362 E-mail: mcgregoj@dhw.idaho.gov	Secretarial support Form orders Nutrition education materials Invoice processing Contract Laiaison – hotels, printing, graphic design Website maintenance and coordination Computer supplies - check paper Training manual updates Assist with PowerPoint, laptop, digital camera
Kate Creswell Office Specialist 2 TEL: 334-4998 FAX: 332-7362 E-mail: creswelk@dhw.idaho.gov	Secretarial support Ordering/inventory of breastfeeding supplies Policy Manual updates Breast pump invoice processing State Plan coordination Computer supplies – toner cartridges
Jim Kelly IT Support Technician -WIC Help Desk TEL: 334-4937 FAX: 332-7362 E-mail: kellyj2@dhw.idaho.gov	WIC Help Desk computer and applications support WIC hardware specialist and technical support Computer operations schedule Computer table changes Computer reports; reconciliation, dual participation, unmatched redemptions, bank reports, and report requests Check research Dual participation and check audit research

SECTION B: LOCAL AGENCY ORGANIZATION

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

This section describes general descriptions of the minimum staffing requirements for local agencies. Local agencies may have additional positions.

IN THIS SECTION

Registered Dietitian
Project Dietitian
Breastfeeding Promotion Coordinator
Lactation Educator
Competent Professional Authority
Local Agency Roster
- Panhandle Health District
- North Central District Health Department
- Southwest District Health
- Central District Health Department
- South Central District Health
- Southeastern District Health Department
- Eastern Idaho Public Health District
- Nimiipuu Tribal Health
- Shoshone-Bannock Tribes

REGISTERED DIETITIAN

Effective: 01/xx/01
Revision: N/A

POLICY

At a minimum, the local agency must employ at least one licensed, registered dietitian to manage the program and to provide high risk counseling.

RESPONSIBILITIES

WIC Coordinator
Performs administrative supervisory and professional work necessary to the planning, implementation, and evaluation of local WIC program activities. Many of the duties of this role may be delegated to other staff; however, the ultimate responsibility for clinic operations falls on the WIC Coordinator.

Other Registered Dietitian
Performs professional work necessary for delivery of direct client services, primarily providing counseling and nutrition education for high-risk clients. Participates in supervision of clinic operations and program planning, and evaluation as assigned. Writes/oversees general nutrition education classes for Clinical Assistant.

PROJECT DIETITIAN

Effective: 01/xx/01
Revision: 10/01/07

POLICY

The local agency will appoint a Project Dietitian with a Bachelor's of Science degree in Nutrition who is a Registered Dietitian (RD) and Idaho Licensed Dietitan (LD).

RESPONSIBILITIES

- Oversee nutritional risk certification
- Oversee nutrition education
- Oversee high risk counseling components

REFERENCE

- State policy

BREASTFEEDING PROMOTION COORDINATOR

Effective: 01/xx/01
Revision: N/A

POLICY

Each local agency will appoint a Breastfeeding Promotion Coordinator.
The local agency Breastfeeding Promotion Coordinator is a staff member who serves as a resource person and central contact for the coordination of breastfeeding promotion and support activities in the local agency. The local agency Breastfeeding Promotion Coordinator shall be given support from the local agency to ensure that the resources are available to perform the duties and responsibilities of this position.

RESPONSIBILITIES

Responsibilities are to include but are not limited to the following:

- Lead the implementation of breastfeeding promotion and support plan for the local agency.
- Review breastfeeding data with local agency Coordinator on a regular basis to determine the effectiveness of the plan.
- Maintain current, accurate breastfeeding information resources such as posters, handouts, breastfeeding equipment, resource and referral information, etc. to optimally support breastfeeding in all clinics.
- Work with local agency Coordinator and staff to provide a baby- and breastfeeding-friendly clinic environment for all participants.
- Coordinate the planning and implementation of the breastfeeding promotion and support activities for the local WIC program under the direction of the WIC Coordinator.
- Participate in and conduct or coordinate ongoing training for WIC staff on breastfeeding promotion and support issues and information.
- Provide leadership in the Local Breastfeeding Promotion Council.
- Conduct and/or coordinate World Breastfeeding Week activities annually.
- Monitor breastfeeding classes, counseling, and charting.

REFERENCE

- 246.11 (c)(7) Establish standards for breastfeeding promotion and support

LACTATION EDUCATOR

Effective: 01/xx/01
Revision: N/A

POLICY

The local agency must employ a qualified person to serve as a Lactation Educator.

RESPONSIBILITIES

Provides breastfeeding training for WIC staff and breastfeeding education and support for WIC participants via classes, individual counseling, and telephone support. Assists Breastfeeding Coordinator in the implementation of special projects, performing community breastfeeding/outreach activities, and conducting breastfeeding support services for WIC participants.

COMPETENT PROFESSIONAL AUTHORITY (CPA)

Effective: 01/xx/01
Revision: N/A

DEFINITION

An individual on the local agency staff who is trained and authorized by the Idaho WIC Program as competent to determine nutritional risk, assign priority, and prescribe appropriate food packages

POLICY

Local agencies shall have at least one Competent Professional Authority (CPA) to determine nutritional risk eligibility and prescribe an appropriate food package for each client.

PROFESSIONAL

The following health professionals are qualified as CPAs without completing the minimum paraprofessional competencies

- Registered Dietitian

Registered by the American Dietetic Association as a Registered Dietitian and licensed by the State of Idaho.

- Nutritionist

Bachelor's or Master's degree in Nutritional Sciences, Community Nutrition, Clinical Nutrition, Dietetics, Public Health, or Home Economics with emphasis in Nutrition.

PARAPROFESSIONAL

Paraprofessional competency must be demonstrated after completing the Idaho WIC Program Paraprofessional Staff Training Program. Performance objectives which define specific tasks, skills, knowledge of WIC program policies and procedures, and basic nutrition must be mastered before being designated a CPA by the WIC Coordinator.

NOTE: The signature and title of the CPA are required on each certification and ineligibility document.

AGENCY 100: PANHANDLE HEALTH DISTRICT

Effective: 01/xx/01
Revision: N/A

Shelly Amos, RD, LD
WIC Coordinator
Panhandle Health District
8500 N. Atlas Rd.
Hayden, ID 83835
(208) 415-5130 phone
(208) 415-5131 fax
samos@phd1.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
101	HAYDEN Panhandle Health District 8500 N. Atlas Rd. Hayden, ID 83835 415-5130 phone 415-5131 fax	107	KELLOGG Panhandle Health District 114 W. Riverside Ave. Kellogg ID 83837-2351 786-7474 phone 783-4242 fax
104	SAINT MARIES Panhandle Health District 711 Jefferson Saint Maries, ID 83861-1852 245-4556 phone 245-3692 fax	108	SANDPOINT Panhandle Health District 1020 W. Michigan Ave. Sandpoint, ID 83864-1788 263-5159 phone 263-6963 fax
106	PLUMMER The WIC office is located inside the Tribal Wellness Center in Plummer (use Saint Maries address and phone)	110	BONNERS FERRY Panhandle Health District 7402 Caribou P.O. Box 893 Bonners Ferry, ID 83805-0893 267-5558 phone 267-3795 fax

AGENCY 200: NORTH CENTRAL DISTRICT HEALTH DEPARTMENT

Effective: 01/xx/01
Revision: N/A

Tiffany Muller, MS, RD, LD
WIC Coordinator
North Central District Health Department
215 10th St.
Lewiston, ID 83501-1910
(208) 799-0390 phone
(208) 799-0349 fax
tmuller@phd2.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
201	LEWISTON North Central District Health Dept. 215 10th St. Lewiston, ID 83501-1910 799-0390 phone 799-0349 fax	204	OROFINO North Central District Health Dept. 105 115th St. P.O. Box 1239 Orofino, ID 83544 476-7850 phone 476-7494 fax
202	MOSCOW North Central District Health Dept. 333 E. Palouse River Dr. Moscow, ID 83843-8916 882-7353 phone 882-3494 fax	206	KAMIAH North Central District Health Dept. 132 N. Hill St. P.O. Box 277 Kamiah, ID 83536-0277 935-2124 phone 935-0223 fax
203	GRANGEVILLE North Central District Health Dept. 903 W. Main Grangeville, ID 83530 983-2842 phone 983-2845 fax		

AGENCY 300: SOUTHWEST DISTRICT HEALTH

Effective: 01/xx/01
Revision: N/A

Carol Julius, RD, LD
WIC Coordinator
Southwest District Health
920 Main St.
Caldwell, ID 83605-3700
(208) 455-5330 phone
(208) 454-7722 fax
carol.julius@phd3.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
301	CALDWELL Southwest District Health 920 Main St. Caldwell, ID 83605-3700 455-5330 phone 454-7722 fax	305	NAMPA Southwest District Health 824 S. Diamond St. Nampa, ID 83686 442-2806 phone 465-8437 fax
302	PAYETTE Southwest District Health 1155 3rd Ave. N. Payette, ID 83661 642-9321 phone 642-5098 fax	306	WEISER Southwest District Health 46 W. Court Weiser, ID 83672-1941 549-2370 phone 549-2371 fax
303	COUNCIL Southwest District Health (use Payette address and phone)	308	GRAND VIEW Southwest District Health (use Nampa address and phone)

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
304	EMMETT Southwest District Health 1008 E. Locust St. Emmett, ID 83617-2711 365-6371 phone 365-4729 fax	312	NAMPA TEEN PARENT Southwest District Health (use Nampa address and phone)
311	HOMEDALE Southwest District Health 24 W. Idaho P.O. Box 187 Homedale, ID 83628 337-4931 phone 337-4081 fax	315	FARMWAY VILLAGE Southwest District Health (use Caldwell address and phone)
314	NEW MEADOWS Southwest District Health (use Weiser address and phone)		

AGENCY 400: CENTRAL DISTRICT HEALTH DEPARTMENT

Effective: 01/xx/01
Revision: N/A

Karen Martz, MPH, RD, LD
WIC Coordinator
Central District Health Department
707 N. Armstrong Pl.
Boise, ID 83704
(208) 327-7488 phone
(208) 321-2243 fax
kmartz@cdhd.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
401/405 409/410	BOISE Central District Health Dept. 707 N. Armstrong Pl. Boise, ID 83704 327-7488 phone 321-2243 fax	409	HORSESHOE BEND Central District Health Dept. (use Boise address and phone)
402/411	MOUNTAIN HOME Central District Health Dept. 520 E. 8th St. N. Mountain Home, ID 83647-2199 587-4409 phone 587-3521 fax	410	GARDEN VALLEY Central District Health Dept. (use Boise address and phone)
404/408	MCCALL Central District Health Dept. 703 N. 1st St. P.O. Box 1448 McCall, ID 83638-1448 634-7194 phone 634-2174 fax	411	MOUNTAIN HOME AIR FORCE BASE Central District Health Dept. (use Mountain Home address) 828-3193 phone

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
405	IDAHO CITY (use Boise address and phone)		

AGENCY 500: SOUTH CENTRAL DISTRICT HEALTH

Effective: 01/xx/01
Revision: N/A

Tammy Walters, RD, LD
WIC Coordinator
South Central District Health
2311 Parke Ave., Unit 4, Suite 4
Burley, ID 83318-3412
(208) 678-8608 phone
(208) 678-7465 fax
twalters@phd5.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
501	TWIN FALLS South Central District Health 1020 Washington St. N. Twin Falls, ID 83301-3156 737-5923 phone 734-9502 fax	505	GOODING South Central District Health 202 14th Ave. E. Gooding, ID 83330-0494 934-4477 phone 934-8558 fax
502	BURLEY South Central District Health 2311 Parke Ave., Unit 4, Suite 4 Burley, ID 83318-3412 678-8608 phone 678-7465 fax	506	JEROME South Central District Health 951 H Ave. E. Jerome, ID 83338-3028 324-1323 phone 324-9554 fax
503	SHOSHONE (use Jerome address and phone)	507	BELLEVUE South Central District Health 117 Ash St. BELLEVUE, ID 83313 788-4335 phone 788-0098 fax

AGENCY 600: SOUTHEASTERN DISTRICT HEALTH DEPARTMENT

Effective: 01/xx/01
Revision: N/A

Erin Francfort, MHE, RD, LD
WIC Coordinator
Southeastern District Health Dept.
1901 Alvin Ricken Dr.
Pocatello, ID 83201
(208) 233-5263 phone
(208) 478-9297 fax
efrancfort@phd6.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
601/613	POCATELLO Southeastern District Health Dept. 1901 Alvin Ricken Dr. Pocatello, ID 83201 233-5263 phone 478-9297 fax	606	MALAD Southeastern District Health Dept. 175 S. 300 E. Malad, ID 83252 766-4764 phone 766-2528 fax
602	BLACKFOOT Southeastern District Health Dept. 412 W. Pacific St. Blackfoot, ID 83221-1726 785-2160 phone 785-6372 fax	607	SODA SPRINGS Southeastern District Health Dept. 55 E. 1st S. Soda Springs, ID 83276 547-4375 phone 547-4398 fax
604	PRESTON Southeastern District Health Dept. 42 W. 1st S. Preston, ID 83263-1205 852-0478 phone 852-2346 fax	609	AMERICAN FALLS Southeastern District Health Dept. 590½ Gifford Ave. American Falls, ID 83211-1314 226-5096 phone 226-7145 fax

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
605	MONTPELIER Southeastern District Health Dept. 455 Washington St., Ste. 2 Montpelier, ID 83254-1544 847-3000 phone 847-2538 fax	611	ARCO Southeastern District Health Dept. 178 Sunset P.O. Box 806 Arco, ID 83213-0806 527-3463 phone 527-3972 fax
610	ABERDEEN (use American Falls address) 221-2894 phone	613	TEEN CENTER (use Pocatello address and phone)

AGENCY 700: EASTERN IDAHO PUBLIC HEALTH DISTRICT (FORMERLY DISTRICT VII HEALTH DEPARTMENT)

Effective: 01/xx/01
Revision: N/A

Veena Sohal, MPH, RD, LD
WIC Coordinator
Eastern Idaho Public Health District
254 E St.
Idaho Falls, ID 83402-3597
(208) 522-3823 or (208) 522-0310 phone
(208) 528-0857 fax
vsohal@phd7.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
701	IDAHO FALLS Eastern Idaho Public Health District 254 E St. Idaho Falls, ID 83402-3597 522-3823 or 522-0310 phone 528-0857 fax	705	REXBURG Eastern Idaho Public Health District 314 N. 3rd E. Rexburg, ID 83440-0128 356-9594 or 356-3239 phone 356-4496 fax
702	RIGBY Eastern Idaho Public Health District 380 Community Ave. Rigby, ID 83442 745-0346 phone 745-8151 fax	706	DUBOIS Eastern Idaho Public Health District (use Rigby address) 374-5216 phone 374-5609 fax

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
703	ST ANTHONY Eastern Idaho Public Health District 45 S. 2nd W. St. Anthony, ID 83445-0490 624-7585 phone 624-0954 fax	707	SALMON Eastern Idaho Public Health District 801 Monroe St. Salmon, ID 83467 756-2123 phone 756-6600 fax
704	DRIGGS Eastern Idaho Public Health District 139 Valley Centre Dr. Driggs, ID 83422 354-2220 phone and fax	708	CHALLIS Eastern Idaho Public Health District 1050 N. Clinic Rd. Challis, ID 83226 879-2504 phone 879-5679 fax
709	TERRETON Eastern Idaho Public Health District (use Idaho Falls address) 663-4860 phone		

AGENCY 800: NIMIIPUU TRIBAL HEALTH

Effective: 01/xx/01
Revision: 10/01/07

Julie Keller, MS, RD, LD, CDE
WIC Coordinator
Nimiipuu Tribal Health
111 Bever Grade
P.O. Drawer 367
Lapwai, ID 83540-0365
(208) 843-2271 phone
(208) 843-9406 fax
juliek@nimiipuu.org

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
881	NIMIIPUU TRIBAL HEALTH 111 Bever Grade P.O. Drawer 367 Lapwai, ID 83540-0365 Telephone: 843-9375 FAX: 843-9406	882	KAMIAH (use Lapwai address) 935-0733 phone

AGENCY 900: SHOSHONE-BANNOCK TRIBES

Effective: 01/xx/01
Revision: N/A

Shonni Garbett, RD
WIC Coordinator
Shoshone-Bannock Tribes
Mission Rd.
P.O. Box 306
Fort Hall, ID 83203-0306
(208) 238-5435 phone
(208) 238-6292 fax
garbetts@dhw.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
991	SHOSHONE-BANNOCK TRIBES Mission Rd. P.O. Box 306 Fort Hall, ID 83203-0306 238-5435 phone 238-6292 fax		

SECTION C: APPLICANT RECORDS

Effective: 01/xx/01
Revision: N/A

OVERVIEW

IN THIS SECTION

Confidentiality

CONFIDENTIALITY

Effective: 01/xx/01
Revision: N/A

POLICY

The use or disclosure of information regarding WIC applicants and participants is restricted to:
Persons directly connected with the administration and enforcement of the WIC program.
Representatives of Medicaid or other Dept. of Health and Welfare by the State Office as part of service coordination and adjunctive income information.
Specific vendors approved by the State Office to provide services if the participant or responsible adult signs a release of information, i.e. special formula direct shipment or breast pump related.

SUBPOENA

A subpoena is a request for information issued by a clerk of a court in response to an attorney representing a party. Responding to a subpoena will be according to District legal guidance.

REQUESTS FOR INFORMATION

Participant information must not be released without a signed release of information. This includes telephone requests.

RECORD RETENTION AND REMOVAL

All records pertaining to WIC operations at the State and local agency level must be retained for a minimum of four (4) years per Idaho WIC Program. Records include but are not limited to:

- Financial operations
- Food delivery systems
- Food instrument issuance and redemption
- Equipment inventory and purchases
- Certification
- Nutrition education
- Civil rights
- Fair Hearing proceedings

If any litigation, claim, negotiation, audit, or other action involving the records has been started before the end of the four-year period, the records must be kept until all issues are resolved or until the end of the four-year period, whichever is longer.

In the event that the State or local agency wishes to remove records past the minimum retention requirement, records are to be destroyed per individual agency policy (e.g., shredding, incineration, etc.). Confidentiality of WIC Program records is to be maintained throughou the process.

MAILING

Information containing a client name, identifying information, or medical information sent via mail or fax should be clearly marked as Confidential. This notice must appear on the outer envelope or lead page and is intended for the addressee only.

Electronic Information

Use caution when sending participant information electronically. A disclaimer notice should be attached. Example:
The information contained in this email may be privileged, confidential or otherwise protected from disclosure. All persons are advised that they may face penalties under state and federal law for sharing this information with unauthorized individuals. If you received this email in error, please reply to the sender that you have received this information in error. Also, please delete this email after replying to the sender.

Reference

7 CFR 246.25, *Records and Reports*

SECTION D: SUPPLIES AND MATERIALS

Effective: 01/xx/01
Revision: N/A

OVERVIEW

IN THIS SECTION

Forms and Materials Orders
Ordering WIC Check Supplies

FORMS AND MATERIALS ORDER

Effective: 01/xx/01
Revision: N/A

POLICY

Each central ordering clinic must appoint a Point of Contact (POC) responsible for ordering forms and materials from the State Office. This person will be the contact between the State Office and the local agency if any questions or problems with an order arise.

NOTE: The POC handles all forms/materials orders except check registers, check paper, and MICR toner for the check printers. For procedures on ordering these items, see Ordering WIC Check Supplies.

QUARTERLY ORDERING

The State Office will send an ordering and shipping schedule to each POC prior to the beginning of each federal fiscal year.

The State Office will send and Forms and Materials Order Sheet to the POC in each central ordering clinic every quarter. The POC will inventory the central clinic supply and contact the outlying clinics to identify their needs. The POC may make copies of the sheet for distribution to each clinic and is responsible for compiling all orders and returning the completed local agency order sheet to the State Office. Items must be ordered in quantities noted on the order sheet. Packages will be divided at the local agency to accommodate individual clinic needs. Because forms and brochures are updated on a regular basis, each clinic should keep only a three-month supply in stock.

If a clinic runs out of a nutrition education, breastfeeding, or outreach item, copies may be obtained from a neighboring clinic within the local agency. If a photocopied or two-part or three-part form is needed, the State Office may be contacted for an electronic copy that will be reproduced at the local agency. Changes to State-developed forms are not permitted.

SHIPPING AND RECEIVING

Upon receipt of the full shipment, the POC will:

- Unpack the orders as soon as possible.
- Check to make sure the proper quantity of each item is received.
- Contact the State Office immediately if discrepencies are discovered.
- Divide packets and distribute items as needed to satellite clinics.

Upon receipt of new or revised forms or materials, each clinic will dispose of the outdated item(s).

ORDERING WIC CHECK SUPPLIES

Effective: 01/xx/01
Revision: N/A

POLICY

SUPPLIES

To order:

- Check registers – contact the WIC Help Desk
- Check paper – contact the State Office
- MICR toner – e-mail the retailer at mlarscheid@itgb.com. Use the template provided by the State Office.

SHIPPING

Allow 4-6 weeks for delivery. If an emergency order of check paper is needed, it may be obtained from a neighboring clinic within the agency.

SECTION E: NUTRITION SERVICES AND ADMINISTRATION

Effective: 01/xx/01
Revision: N/A

OVERVIEW

IN THIS SECTION

Participant Survey
Local Agency Program Plan

PARTICIPANT SURVEY

Effective: 01/xx/01
Revision: N/A

POLICY

Annually perform and document evaluations of nutrition education and breastfeeding promotion and support activities. The evaluations shall include an assessment of participants' views concerning the effectiveness of the nutrition education and breastfeeding promotion and support they received.

METHODS

Participants' views on nutrition education, breastfeeding promotion and support, WIC foods, and understanding of core WIC messages will be assessed annually through one or more of the following methods:

- Questionnaire:
  A State-developed questionnaire with instructions for distribution and collection will be sent out to local agencies. Local agencies that are being monitored by the State Office will be exempt that year from distributing the questionnaire.

- Focus Groups (State Office):
  State Office may decide to conduct focus groups in lieu of questionnaires. All local agencies that would be impacted will be notified in advance.

- Focus Groups (Local Agencies):
  Local agencies may conduct focus groups if desired.

RESULTS

Results from the annual assessment of participant views will be made available to all local agencies.

REFERENCE

- 7 CFR *State Agency Responsibilities* 246.11 (c)
- State Policy

LOCAL AGENCY PROGRAM PLAN

Effective: 01/xx/01
Revision: N/A

POLICY

Develop an annual Local Agency Program Plan consistent with the State's nutrition education component of operations and in accordance with guidelines described below.
The State Agency and local agencies have common goals to promote optimal birth outcomes, maintain optimal anthropometry and hematology, promote and support breastfeeding, provide nutrition education to participants and staff, and to manage caseloads.
The local agency Coordinator shall submit the nutrition education plan to the State Office by a date specified by the State Office.

LOCAL AGENCY CHARACTERISTICS

Each local agency has unique characteristics related to the population that it serves. This section at a minimum should include the following:

- The counties served by the local agency
- Population information
- Current economic status of the region served by the local agency
- Social factors
- WIC statistics (number of participants served, education level, marital status, etc.)
- Food insecurity
- Other information as determined by the local agency Coordinator

HEALTH AND NUTRITION INDICATORS

Health and Nutrition Indicators are how the health of the WIC community is measured. Each Health and Nutrition Indicator reflects a major health concern in WIC. The Health and Nutrition Indicators were selected on the basis of their impact on the WIC community, the availability of data to measure progress, and their importance as public health issues.
The Health and Nutrition Indicators are:

- Infants and Children
    - Prevalence of Breastfeeding
    - Low Hematology
    - Underweight
    - Overweight
    - Baby Bottle Tooth Decay
    - Baby Bottle Tooth Decay Risk Behaviors

- Women
    - Low Hematology
    - Underweight
    - Overweight
    - Low Birth Weight
    - Premature Birth
    - Prenatal Weight Gain
    - Time of WIC Enrollment
    - Begin Prenatal Care
    - Self Reported Alcohol Use
    - Self Reported Cigarette Use

- Self Reported Drug Use
- Severe Dental Problems

- Family
  - Food Insecurity

REQUIRED ACTIONS

There are actions required by federal regulations and state contract that must be performed by local agencies. They are:

NUTRITION EDUCATION

Standard 1 – Quality nutrition education and counseling are provided to all participants or, when appropriate, their caregivers or proxies (collectively referred to as "participants").
FR §246.11(c)(6)
Standard 2 – Provision of an individual care plan for low-risk and high-risk participants.
FR §246.11(e)(5)
Standard 3 – Provide appropriate orientation and task-appropriate training on breastfeeding promotion and support.
FR §246.11(c)(7)(iii)
IWPPM, Chapter 9, Section C
Standard 4 - Prepare a Local Agency Program Plan annually.
FR §246.11(d)(2)

BREASTFEEDING

Standard 1 – Implementation and evaluation of specific strategies that promote and support breastfeeding within the population served.
IWPPM, Chapter 9, Section A
Standard 2 – Local WIC agency will appoint a designated Breastfeeding Promotion Coordinator.
FR §246.11(c)(7)(ii)
IWPPM; Chapter 9; Section B
Standard 3 – Provide appropriate orientation and task-appropriate training on breastfeeding promotion and support.
FR §246.11(c)(7)(iii)
IWPPM, Chapter 9, Section C
Standard 4 – Implementation of a policy that encourages a positive clinic environment and that endorses breastfeeding as the preferred and normal way to feed infants.
FR §246.11(c)(7)(i)
IWPPM, Chapter 9, Section D
Standard 5 – Quality breastfeeding education and support shall be offered to all pregnant WIC participants.
FR §246.11(c)(7), FR §246.11(e)(1)
IWPPM, Chapter 9, Sections E and H
Standard 6 – Breastfeeding women will be provided with support, information, and appropriate referrals throughout the postpartum period, particularly at critical times, to successfully establish and maintain breastfeeding for one year or longer if so desired.
FR §246.11(c)(7)(iv)
IWPPM, Chapter 9, Sections F and H
Standard 7 – All eligible women who meet the definition of breastfeeding are certified, to the extent that caseload management permits, and receive a food package consistent with their nutritional needs.
FR §246.11(e)(1), FR §246.10(b)(2)(iii)
IWPPM, Chapter 9, Section G

OUTREACH/TARGETING

Standard 1 – Local agencies will conduct consistent targeted outreach to WIC-eligible populations.
FR §246.4(a)(7)(i)
IWPPM, Chapter 10, Section C

SUBSTANCE ABUSE SCREENING AND REFERRAL

Standard 1 – Local agencies will ensure that quality information and updated referrals on drug and other harmful substance abuse are provided to all participants or, when appropriate, to their caregivers or proxies.
FR §246.11(a)(3), FR §246.7(a)
IWPPM, Chapter 5, Section A

CASELOAD MANAGEMENT

Standard 1 – Maintain a quarterly average caseload level of 96-100% of the authorized participating caseload (including migrant clients) allocated by the State WIC Office. Authorized caseload is defined as the caseload number used to calculate funding and is based on the recent 12-month period's (July-June) actual participation. [WIC Contract Scope of Work, II.D]
Caseload is reviewed on a quarterly basis. If a Contractor is underserving (serving less than 96%) of the authorized participating caseload, a corrective action plan is completed by the agency and the agency is encouraged to increase caseload. If the standard of 96% is not met on average for the year, a reduction in caseload funding is effective beginning the next fiscal year. [WIC Contract Scope of Work, II.E]
On a quarterly basis, if a Contractor is overserving (serving more than 100%) of the authorized participating caseload, the State WIC Office will increase the Contractor's caseload and corresponding funding allocated to serve the caseload. Funding will be increased through the contract amendment process. The increased funding will cover both the quarter in which caseload exceeded 100% and future quarters in order to maintain the higher level caseload. [WIC Contract Scope of Work, II.F]
Standard 2 – Maintain a waiting list to ensure highest risk applicants are served first and within processing timeframes.
IWPPM, Chapter 3, Sections A and C
Standard 3 – Maintain a monthly participation rate of ≥90% (Actual Participation/Enrollment)
FFY 2002 Contract Amendment #1 Memorandum 1/23/02

CHAPTER 2: ADMINISTRATION

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

IN THIS CHAPTER

Section A Customer Service

Section B Civil Rights and Nondiscrimination

Section C Complaints and Incidents

Section D Program Violation

Section E Fair Hearings

Section F Disaster Recovery

Section G Memorandum of Understanding (MOU)

SECTION A: CUSTOMER SERVICE

Effective: 01/xx/01
Revision: N/A

OVERVIEW

The goal of the Idaho WIC Program is to provide WIC services in a positive and helpful manner.

IN THIS SECTION

Clinic Environment
Telephone
Greeting Applicants and Participants
Evaluating Service Quality

CLINIC ENVIRONMENT

Effective: 01/xx/01
Revision: N/A

PRIVATE AND CONFIDENTIAL

Ensure that the clinic atmosphere/environment (including waiting room, bathrooms, counseling offices and reception area) conveys a warm, respectful, and professional atmosphere. The clinic environment should ensure:

- Private areas are available for participant counseling.
- Participants' charts are not identifiable by other participants or persons working outside the program.
- Clinic staff call participants to the front counter when they need to talk with them in the waiting area. Talk softly so other participants do not hear the conversation. Questions should not be called out across the waiting area.

PHYSICAL ARRANGEMENT

The clinic physical arrangement should strive for:

- Comfortable seating for all persons
- Comfortable temperature and appropriate lighting
- Cheerful posters and decorations on the wall
- Furniture arrangement that promotes a cooperative "working together" relationship rather than a dominate/subordinate relationship. When possible:
  - Have participant sit to one side of the desk.
  - Allow participants to sit down while they are signing papers and providing information to staff.
- Signs with positive messages rather than signs which are negative in intent, e.g., controlling signs about being late
- Being organized and non-cluttered

CHILD FRIENDLY

The clinic environment should strive to be child friendly by providing:

- Colorful, clean waiting rooms
- Waiting areas that are inviting places for children
- Toys, coloring books, and/or a child's entertainment center in the waiting area
- Items to amuse children in the counseling offices
- Decorations and distracting toys in the hematocrit/hemoglobin and anthropometric area

PROMPT SERVICE

Serve participants in a timely manner. They should not be kept waiting more than a few minutes. Tell a participant approximately how long the wait will be. If the wait is longer than expected, apologize to the participant and inform him/her how much longer the wait might be. Give participants complete and accurate information. Staff should take time to answer questions completely whether in person or on the phone.

REFERENCE

- State policy

TELEPHONE

Effective: 01/xx/01
Revision: N/A

AVAILABILITY

- Be accessible by telephone.
- Have enough phone lines so callers rarely get a busy signal.
- Keep the use of an answering machine to a minimum.

TECHNIQUE

Good telephone techniques include:

- Ask if you may put the caller on hold and then wait for an answer.
- Telling the caller how long he or she will be on hold. Return to the phone call within that time. The wait should not be more than one minute.
- Take a number and calling the person back if the wait is expected to be more than one minute.
- Thank the person for calling. Do not reprimand a person who calls to cancel, even if it's at the last minute. Let participants know that WIC appreciates the call.

ANSWERING MACHINE

Use the answering machine when the clinic is closed or not in operation due to a staff meeting. Remember to turn the answering machine off as soon as the clinic reopens. The message on the machine should tell the caller:

- Office hours
- When to call back
- To leave a message, especially if calling to cancel an appointment
- If the caller leaves a message, ask the caller to:
  - Give his or her name
  - Indicate the reason for the call
  - Provide a contact phone number

Check messages regularly.
Return calls in a timely manner.
Update the machine message regularly.
Please do not use the answering machine just because the office is busy.

REFERENCE

- State policy

GREETING APPLICANTS AND PARTICIPANTS

Effective: 01/xx/01
Revision: N/A

POLICY

Front office and reception staff should greet and acknowledge participants in a friendly manner. The first staff person to communicate with the participant sets the stage for positive relations. This can be the person who makes the appointment over the phone or the receptionist who interacts with the participant for the first time she comes in. All future interactions will be affected by this first contact. It's important that the first contact be positive. This is the first step in developing a caring, trusting relationship. If this is not established in the beginning, all future communication and teaching may be hindered.

TREAT PARTICIPANTS IN A POSITIVE AND A RESPECTFUL MANNER

Participants should not be rushed through the system. There is a good balance between quick service and taking the time to meet the needs of participants. Greet participants when they arrive and acknowledge their children.

- Listen as well as tell. Listening shows respect.
- Tell participants how long they will be there.
- Tell participants if you are running later and give them the option to reschedule if it involves a significant wait. Apologize sincerely for any delays.
- Offer timely service and respect participants' time.
- Offer flexible appointments.
- Be understanding and don't judge. It's not possible to know what pressures the person may be dealing with, e.g., unemployment, inability to pay bills, divorce, domestic violence, taking care of a child with many medical problems, drug addiction, eviction notices, etc.
- Help participants carry belongings back to counseling rooms.
- Walk beside them and chat with participants while taking them back to get services instead of walking ahead of them.
- Don't interrupt.
- Be sure that behavior and dress are professional.
- Focus on people, not paper or computer.
- Know when to be flexible.

REFERENCE

- State policy

EVALUATING SERVICE QUALITY

Effective: 01/xx/01
Revision: N/A

POLICY

Evaluate services yearly to ensure that clinics offer quality services. Develop a customer service questionnaire or use some other evaluation tool. Examples of questions follow.
Example:
For the most part, are you served within 15 minutes when you arrive on time? Yes No Comments
Have you been able to reach clinic staff by phone easily? Yes No Comments?
I have been treated fairly and kindly by the WIC staff. Yes No Comments Please explain
The WIC clinic uses answering machines: Too much Not enough Just the right amount

DEVELOP CUSTOMER SERVICE GOALS EACH YEAR

Examples:
The average waiting time for a voucher pick up appointment will be reduced to five minutes.
The percentage of clients who say on the questionnaire they have trouble getting through to the clinic by phone will be reduced to 10%.

SELF ASSESSMENT

Have staff check their attitudes by asking themselves which of the following statements reflect their beliefs.

Positive

I do all I can to help.
If I don't know the information needed, I will find out.
I serve participants as quickly as I can because they are important.
I like participants and co-workers.
I know participants and co-workers are trying their best.
I can give information, but participants and co-workers still have choices. I do not hold it against anyone if they don't take my advice.
Participants and co-workers know what is best for them.

Negative

I'm doing participants a favor by waiting on them.
I believe participants should just be thankful they are getting this free.
Participants should follow all our rules without questions.
WIC participants don't have anything to do anyway, so they can spend time at WIC.
I know more than participants and co-workers so I need to tell them what to do.
If we don't have strict rules, WIC participants will take advantage of us.
Participants don't even try.
Participants will never change.
WIC participants just take advantage of the system.
WIC participants are lazy, uneducated, cheaters.

REFERENCE

- State Policy

SECTION B: CIVIL RIGHTS

Effective: 01/xx/01
Revision: 06/01/05

OVERVIEW

The Idaho WIC Program is committed to equal opportunity in the delivery of program services. In accordance with Federal law, U.S. Department of Agriculture, and the Idaho Department of Health and Welfare, the Idaho WIC Program prohibits discrimination on the basis of race, color, national origin, sex, age, or disability.

IN THIS SECTION

Civil Rights and Nondiscrimination
Reasonable Accommodation
Public Notification
Racial/Ethnic Data Collection
Staff Training
Compliance Reviews

CIVIL RIGHTS AND NONDISCRIMINATION

Effective: 10/01/05
Revision: 06/01/05

OVERVIEW

The Idaho WIC Program is committed to equal opportunity in the delivery of program services. In accordance with Federal law, U.S. Department of Agriculture, and the Idaho Department of Health and Welfare, the Idaho WIC Program prohibits discrimination on the basis of race, color, national origin, sex, age, or disability.

POLICY

The Idaho WIC Program is committed to equal opportunity in the delivery of program services. Program benefits are made available to all eligible persons without discrimination based on race, color, national origin, sex, age, or disability.

COMPLAINTS OF DISCRIMINATION

Any person (applicant, potential applicant, or participant) who feels he or she has been excluded from participation in or denied the benefits of services because of discrimination on the basis of race, color, national origin, sex, age or disability may file a complaint within 180 days of the alleged discriminatory action. This person shall have the right to present evidence and/or respond to adverse action.

Examples of Discrimination:

- Exclusion of eligible person(s) from participation in the program on the basis of race, color, national origin, sex, age, or disability
- The inequitable allocation of program benefits to eligible person(s) on the basis of race, color, national origin, sex, age, or disability
- Issuance of program benefits (WIC checks) in a place, time or manner that has the effect of denying or limiting benefits on the basis of race, color, national origin, sex, age, or disability
- Segregation of person(s) in clinic waiting areas or through the appointment system on the basis of race, color, national origin, sex, age, or disability
- Failure to apply the same eligibility criteria to all potential eligible person(s) seeking participation in the WIC program

LIMITED ENGLISH PROFICIENCY (LEP) PERSONS

Local agencies shall ensure meaningful access to WIC as needed to assist in the certification procedure and delivery of any WIC services for persons with Limited English Proficiency (LEP).

- Hiring bilingual or staff interpreters
- Contracting with an outside interpreter service
- Making formal arrangements for the use of voluntary community interpreter services
- Contracting for the use of telephone language interpreter services

Applicants and potential applicants must be informed of the right to request an interpreter at no charge to the applicant/potential applicant. A family member or friend is not considered an acceptable interpreter unless the applicant specifically requests that person be allowed to interpret.

The Participant Rights and Responsibilities should be read in the appropriate language to any applicant/potential applicant who cannot read.

TRANSLATED MATERIALS

Local agency written materials should be provided in languages other than English when needed. The State WIC Office will provide translated certification and nutrition education materials in non-English languages when necessary.
Non-English language materials available from the State WIC Office include: Spanish (all applicant and participant materials).
To determine the obligation to provide the translation of a document in languages other than English, local agencies will consider the following:

- frequency of the language need
- nature of the document
- number of pages in the document
- financial burden to translate
- availability of alternate means of providing information contained in the document to Limited English Proficiency (LEP) participants.

When document translation is not provided, alternate means will be used. This may include oral translation, taped translation, telephone translation, or interpretation.

REFERENCE

- FNS Instruction 113-1 Civil Rights (Nov. 14, 2005)
- 7 CFR 246.8 Nondiscrimination (01/01/03)
- All States Memo 98-90: Nondiscrimination Policy Statement (05/21/98)
- IDHW-Policy Memorandum 04-05 (Replaces 01-1): Procedure for Civil Rights Complaints

REASONABLE ACCOMMODATION

Effective: 10/01/05
Revision: 06/01/05

OVERVIEW

A reasonable accommodation is making adjustments for the disability of an applicant by structuring appointments or policies to enable an individual with a disability to have equal access to services. Reasonable accommodation includes modifying written materials, making facilities accessible, adjusting appointment schedules, providing sign language interpreters, and modifying appointment sites. Reasonable accommodation does not mean a local agency must make costly, disruptive changes or changes which fundamentally alter the nature or operation of WIC.

POLICY

Local WIC agencies must have a procedure for making reasonable accommodations in a timely and cost-effective manner.
Requests for reasonable accommodation should be initiated by the individual needing the accommodation. Determining reasonable accommodation is a case-by-case process and depends on the circumstances of the particular situation. The State WIC Office is available for assistance in this area.

INDIVIDUALS WITH DISABILITIES

An individual with a disability is any person who has a physical or mental impairment that substantially limits one or more of an individual's major life activities, having a record of such impairment, or being regarded as having such impairment (e.g., self-care, performing manual tasks, seeing, hearing, speaking, breathing, and working).
The local agencies will have a written procedure for serving WIC applicants and participants with physical disabilities if a facility is not accessible. Staff working in an office should be aware of the special accommodations available for that office.

REFERENCE

- FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
- 7 CFR 246.8 Nondiscrimination. (01/01/03)

PUBLIC NOTIFICATION

Effective: 10/01/05
Revision: 06/01/05

POLICY

Each local agency will take positive and specific actions to implement a public notification program throughout its jurisdiction which informs participants and applicants, particularly minority populations, of their program rights and responsibilities, their protection against discrimination, and the procedure for filing a complaint. This includes:

- Displaying the nondiscrimination poster, "And Justice For All", in prominent places, such as a waiting room and other areas frequented by participants and applicants.
- Ensuring that appropriate staff, volunteers, or other translation resources are available to serve participants and applicants.
- Making available program regulations and guidelines to the public upon request.
- Providing participants and applicants access to civil rights information. This information includes procedures for filing complaints, program specifics, and Rights and Responsibilities of participants and applicants.

NOTE: An approved nondiscrimination statement must be included on all information printed or distributed with the WIC program listed or described on the material(s).

The nondiscrimination statement is required if the material:

- Describes eligibility requirements of the WIC program
- Identifies the benefits of WIC participation
- Describes participation of the WIC program
- Provides notice of conditions to continue eligibility
- Provides notice of ineligibility or disqualification

USE OF LONG STATEMENT

The complete nondiscrimination statement must appear on all written materials and correspondence that identify or describe the WIC program eligibility and/or ineligibility. The following is the required statement:

> "In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.
>
> To file a complaint of discrimination write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call: (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA (WIC) is an equal opportunity provider and employer."

SHORT STATEMENT

When space is limited, a shorter statement is suitable when written materials are one page or less or are too small to contain the long statement. This statement should be in print size no smaller than the text of the document. The following is the accepted short statement:

> "The USDA (WIC) is an equal opportunity provider."

When providing information for the radio and television public service announcements, the nondiscrimination statement does not have to be read in its entirety. Rather, a statement such as "WIC is an equal opportunity provider" is sufficient to meet the nondiscrimination requirement.

EXCEPTIONS

Nutrition education and breastfeeding promotion and support materials that strictly provide a nutrition message with no mention of WIC operations are not required to contain the nondiscrimination statement. If the nutrition education materials also contain information about WIC operations (e.g., clinic hours, authorized foods, rights and responsibilities), the nondiscrimination statement must be included. Outreach materials that are too small for the statement are exempt from the nondiscrimination statement requirement. Examples of these exceptions are pencils, pens, or small magnets.

POSTER

An approved nondiscrimination poster must be displayed in an obvious, easy to access, and readable location in each WIC office waiting room. More than one nondiscrimination poster may be displayed in the office. Posters are available from the State Office and may be ordered via the Quarterly Forms Order.

REFERENCE

- All States Memorandum 06-21 (Jan. 11, 2006) Nondiscrimination Statement for WIC Materials
- 7 CFR 246.8 Nondiscrimination (01/01/03)
- FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
- All States Memorandum 98-90: Nondiscrimination Policy Statement (05/21/98)

RACIAL/ETHNIC DATA COLLECTION

Effective: 04/01/05
Revision: 06/01/05

OVERVIEW

Federal agencies, not State agencies, are required to compile information on multiple race combinations that represent one percent or more of the population served by the State agency.
Therefore, the State WIC Office will be collecting this data, through local WIC agencies, for statistical reporting purposes only. This information will have no effect on determination of participant eligibility in the WIC program.

POLICY

Racial/ethnic information will be collected by local agencies for each WIC applicant at the time of certification.

PROCEDURE

WIC applicants will be asked to self-identify race and ethnicity on the WIC Application Form. If the applicant does not self-identify race and ethnicity on the WIC Application Form, the WIC staff person must ask the participant to self-identify race and ethnicity, only after it has been explained that the collection of this information is for statistical reporting purposes and to monitor compliance with Federal civil rights laws. Participants should be informed that this information has no effect on the determination of their eligibility to participate in the WIC program.

NOTE: If the applicant declines to self-identify race and ethnicity, WIC staff should visually determine the race and ethnicity and enter the data into the Idaho WIC Computer System. This should be done as discreetly as possible so as not to offend the applicant. A brief notation must be made on the WIC application form that race and/or ethnicity was determined visually.

REFERENCES

- FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
- 7 CFR 246.8 Nondiscrimination (01/01/03)
- All States Memorandum 04-34 (05/21/04) Final Policy on WIC Racial/Ethnic Data Collection

STAFF TRAINING

Effective: 10/01/05
Revision: 06/01/05

POLICY

State and local agencies are required to conduct annual civil rights training for all WIC staff.

TRAINING/DOCUMENTATION

All WIC staff members must complete Civil Rights training yearly.
Documentation of Civil Rights training must be kept on file at the local agency. Documentation will include, but is not limited to:

- Sign-in sheet for attendees
- Date of training for attendees
- Agenda/outline of topic(s) covered in training
  - Specific subject matter must include, but not be limited to:
    - Collection and use of data
    - Effective public notification systems
    - Complaint procedures
    - Compliance review techniques
    - Resolution of noncompliance
    - Requirements for reasonable accommodation of persons with disabilities
    - Conflict resolution and customer service

REFERENCE

- FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
- 7 CFR 246.8 Nondiscrimination (01/01/03)

COMPLIANCE REVIEWS

Effective: 10/01/05
Revision: 06/01/05

PROCEDURE

As part of local agency monitoring, the State WIC Office will conduct a civil rights compliance review. The following items must be determined as a minimum:

- Location of the nondiscrimination poster
- The local agency conducts civil rights training for all staff. The local agency keeps documentation of such training.
- Racial/ethnic data collection occurs according to policy and procedure.
- The nondiscrimination statement is included on all printed materials for the public, per policy.
- All civil rights complaints are handled per policy.
- Review of waiting lists (if applicable) and ineligible applications for civil rights issues.
- The local agency has a policy on how to provide reasonable accommodation.
- The local agency has a policy on how to provide language assistance services for persons with limited English proficiency (LEP).
- The local agency has a policy on how to ensure that program information is available to all applicants/participants (e.g., bilingual staff, interpreter services, written materials in other language(s)).
- Accessibility of physical environment for persons with disabilities.
- Interview staff about civil rights complaint procedures (i.e., how to process a complaint).

REFERENCE

- FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
- 7 CFR 246.8 Nondiscrimination (01/01/03)
- 7 CFR 246.19(b) State Responsibilities (01/01/03)

SECTION C: COMPLAINTS AND INCIDENTS

Effective: 01/xx/01
Revision: N/A

OVERVIEW

Any person has the right to file a complaint if the person feels he or she has been excluded from participation or denied appropriate services. A member of the public has the right to file a complaint if he or she believes a participant is not eligible to receive WIC services. A vendor or local agency staff person has the responsibility to make a formal report if he or she feels a participant has not adhered to WIC regulations or procedures.

Frequently, complaints involve misunderstandings rather than a true denial of participation in WIC or denial of services. The investigation of complaints can assist local agencies in providing better service to applicants and participants.

Complaints are considered one of three types: program, vendor, or civil rights, depending on the nature of the complaint.

IN THIS SECTION

Reporting Complaints and Incidents
Program Complaints and Incidents
Vendor Complaints and Incidents
Civil Rights Complaints
Complaint or Incident Report Form

REPORTING COMPLAINTS AND INCIDENTS

Effective: 01/xx/01
Revision: N/A

POLICY

Program: Any applicant or participant has the right to make a complaint if he/she feels they have been excluded from participation or denied appropriate services. A member of the public has the right to file a complaint if he or she believes a participant is not eligible to receive WIC services.
Vendor: A vendor or local agency staff person has the responsibility to make a formal report if he or she feels a participant has not adhered to the WIC Rights and Responsibilities.
Civil Rights: Any applicant, potential applicant, or participant has the right to file a complaint if they feel they have been excluded from participation or denied services based on race, color, national origin, sex, age, or disability.
No staff person shall intimidate, threaten, retaliate, or discriminate against a person who has made a complaint, testified, assisted, or participated in any manner during a complaint investigation.

TIME FRAME

Complaints filed after the valid complaint period may not be investigated.
Program complaints must be filed within 90 days of the alleged action.
Vendor complaints must be filed within 90 days of the alleged action.
Civil rights complaints must be filed within 180 days of the alleged action.

NOTE: The State Office must be notified immediately if a civil rights complaint is received by the local agency. Refer to a specific topic in this section for details of the types of complaints mentioned above.

WHO CAN FILE

- Applicant or potential applicant
- Participant or responsible adult
- Member of the public
- Vendor
- Local agency staff person on behalf of self
- Representative chosen by the complainant
- Local agency staff person on behalf of the complainant

Complaints may be filed anonymously. The complainant should be encouraged to provide his or her name to aid the investigation, and be reassured that their identity will be kept confidential to the extent possible.

RECEIVING COMPLAINTS

Local agency staff must accept all complaints. Staff should not attempt to determine if the complaint is valid; instead, staff must make sure the complaint is handled according to procedures.
Complaints may be filed in person, by telephone, or in writing. Complainants may write the complaint or request local agency staff to assist in writing the complaint.

- In-person complaints can be made at local agency offices and should be referred to the local agency Coordinator or other person designated by the Coordinator.

- Telephone complaints can be made by contacting the local agency Coordinator (or other designated person) or the State Office at (208)334-5948 or toll free at (866)347-5484.

- Written complaints from applicants, participants, or vendors should be reviewed by the local agency Coordinator and a copy forwarded to the State Office. If a resolution was reached at the local agency, the Coordinator must document this prior to sending a copy of the complaint.

NOTE: All civil rights complaints (whether in person, verbal or written) must be forwarded to the State Office and the State Office must forward the complaint to the USDA.

RESOLUTION

Many times, complaints involve misunderstandings rather than true denial of participation or services.

REFERENCES

- FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
- 246.7(c)(2)(vi) Verification of income. (01/01/03)
- 246.8 Nondiscrimination. (01/01/03)
- State policy

PROGRAM COMPLAINTS AND INCIDENTS

Effective: 01/xx/01
Revision: N/A

POLICY

Any person has the right to make a complaint if they feel they have been excluded from participation or denied appropriate services. A member of the public may file a complaint if he or she believes a WIC participant is not eligible for WIC services. This type of complaint is investigated as potential fraud. It is desirable for program complaints to be handled by the local agency Coordinator. If the Coordinator is not available, the complaint should be referred to the person in charge. The State Office is available for consultation.

TIME FRAME

The program complaint must be filed within 90 days of the alleged action. Complaints filed after the valid complaint period may not be investigated.

WHO CAN FILE

Any applicant, potential applicant, participant, representative chosen by the complainant, or a WIC staff person on behalf of the complainant.
Complaints may be filed anonymously.

HOW TO FILE

Complaints can be made in person, by telephone, or in writing. Complainants may write the complaint or local agency staff should document the complaint if received via telephone or requested to do so by the complainant.
A Complaint or Incident Report Form can be used to file complaints or report incidents. It is not necessary to complete a form for every complaint. Professional judgment should be used to determine if a written complaint form is warranted. If requested by a participant, a written complaint is required. Forward a copy of all written complaints to the State Office. The copy should include any action(s) taken by the local agency.

RESOLUTION PROCEDURES

Many times, complaints involve misunderstandings rather than true denial of participation or services. Complaints will be investigated by the local agency Coordinator and forwarded to the State Office for action, if warranted.
Complaints filed directly with the State Office will be investigated by the State Office. Infant formula complaints are addressed by the Program Service Coordinator. Other program complaints are addressed by the Clinic Operations Coordinator.

DOCUMENTATION

A copy of all complaints and related documentation must be maintained in each local agency.
The State Office recommends the documentation be maintained in a central file. This allows for easier auditing for proper resolution procedures and maintains better confidentiality, possibly reducing the chances of retaliation.

NOTE: The local agency must have a local policy if it prefers to retain a copy in participant files.

REFERENCES

- 246.7(c)(2)(vi) Verification of income. (01/01/03)
- State policy

VENDOR COMPLAINTS AND INCIDENTS

Effective: 01/xx/01
Revision: N/A

POLICY

Any participant has the right to make a complaint if the person feels he or she has been excluded from participation or denied appropriate services while at a vendor location.
Vendors have the right to file an incident report if the vendor feels a participant has not followed correct procedures while cashing WIC checks at the vendor's location.
Local agency staff must accept all incident reports. They should not attempt to determine if the complaint is valid; instead, staff must make sure the complaint is handled according to procedures.
No staff person shall intimidate, threaten, retaliate, or discriminate against a person who has made a complaint, testified, assisted, or participated in any manner during a complaint investigation.

TIME FRAME

A vendor complaint or incident report must be filed within 90 days of the alleged action. Complaints filed after the valid complaint period may not be investigated.

WHO CAN FILE

Any participant or representative chosen by the participant
Any vendor
Local agency staff person on behalf of the participant or vendor

HOW TO FILE

Complaints can be made in person, by telephone, or in writing. Local agency staff should document the complaint if received via telephone or requested to do so by the complainant.
A Complaint or Incident Report Form can be used to file complaints or report incidents. It is not necessary to complete a form for every complaint. Professional judgment should be used to determine if a written complaint form is warranted. If requested by a participant, a written complaint is required. Forward all written vendor complaints to the Vendor Coordinator at the State Office.

RESOLUTION PROCEDURES

Many times, complaints involve misunderstandings rather than true denial of appropriate services. If the complaint or incident report is determined to be valid, the Vendor Coordinator will work with the local agency coordinator and vendor to address and/or resolve the situation.

DOCUMENTATION

A copy of all vendor complaints and related documentation must be maintained in each local agency. The State Office recommends the documentation be maintained in a central file. This allows for easier auditing for proper resolution procedures and maintains better confidentiality, possibly reducing the chances of retaliation.

NOTE: The local agency must have a local policy if it prefers to retain a copy in participant files.

REFERENCES

- State policy

CIVIL RIGHTS COMPLAINTS

Effective: 10/01/05
Revision: 06/01/05

POLICY

Any applicant, potential applicant, or participant alleging discrimination based on race, color, national origin, sex, age, or disability has the right to file a complaint within 180 days of the alleged discriminatory action.

WHO CAN FILE

A civil rights complaint can be filed by the person(s) alleging discrimination on the basis of race, color, national origin, sex, age, or disability, or a representative chosen by the complainant or a local agency staff person on behalf of the complainant.

HOW TO FILE

The complaint may be initiated at a local agency office, State WIC Office, USDA, or IDHW Office of Civil Rights.
All civil rights complaints, verbal or written, shall be accepted by the local agency. If a complaint is verbal, local agency staff will document the complaint using the Idaho WIC Program Complaint or Incident Report Form when the complaint is received by telephone or if requested to do so by the complainant.
Local agency WIC staff and State agency WIC staff must document and report all complaints according to the procedures outlined, regardless of whether or not a complainant requests the reporting or processing of such complaint. These complaints should then be reported as anonymous. Anonymous complaints will be handled as any other complaint.

NOTE: The State WIC Office must be notified immediately if a civil rights complaint is received by the local agency.

Idaho WIC Program
Dept. of Health and Welfare
450 West State Street, 4th Floor
P.O. Box 83720
Boise, ID 83720-0036
Fax: (208) 332-7362

The State WIC Office will forward any civil rights complaint to USDA within 10 days.

Director, Office of Civil Rights
USDA, Western Region Office
550 Kearny Street, Room 400
San Francisco, CA 94108-2518

DOCUMENTATION

To protect the confidentiality of the complainant, documentation related to civil rights complaints will not be kept in a participant's chart. A copy of all civil rights complaints and related documentation must be maintained in a civil rights file in each local agency. A common file for the entire agency or one file per clinic location is acceptable. The State WIC Office will maintain a file documenting all civil rights complaints.

REFERENCES

- FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
- 7 CFR 246.8 Nondiscrimination (01/01/03)
- IDHW - Policy Memorandum 04-05 (replaces no. 01-1) Procedure for Civil rights complaint

COMPLAINT OR INCIDENT REPORT FORM

Effective: 01/xx/01
Revision: N/A

POLICY

A Complaint or Incident Report Form can be used to file complaints or report incidents. A copy of each completed form must be forwarded to the State Office.
The use of professional terminology and objective information is strongly recommended when a staff person completes the form. A confidential copy of the form may be provided to vendors and participants as part of the investigation.

COMPLETING THE FORM:

Front Side

- Date and Time
When did it happen? Identify the date of the alleged action. This is important because there are time limits for filing different types of complaints.

- Location
Describe the clinic or vendor location where the situation or incident occurred. It is virtually impossible to follow up a complaint without knowing where it happened. For example, specify the location of an Albertsons grocery store.

- People Involved
Identify the people involved by full name (best) or describe the person if the name is unknown. It is also helpful to include contact information (if known) to assist the investigator.

- Nature of the Complaint
Describe what happened, including enough information to aid in the investigation and resolution of the complaint. It is also helpful to learn why the complainant feels this situation happened.

- Remedy Sought by Complainant
Describe what the complainant believes would rectify the situation. Investigations will proceed more effectively if the investigator knows the desired outcome at the start.

- Identity of the Complainant
Include as much information as possible so the investigator can contact the person, if necessary. Basic identity includes name, telephone number, mailing address, and relationship to the situation. The complainant relationship is important because it impacts how the complainant can be involved in the resolution.

Back Side

- If actions have been taken to resolve the complaint, describe the actions. This portion may be completed by the person who worked to resolve the complaint or the local agency coordinator.

- It is also acceptable for this portion to be left blank, if local agency staff have not taken action, usually because staff are unaware of the complaint or incident.

ALTERNATE FORM

Complaints can also be taken without using the form. At a minimum, the written complaint should include information described in Completing the Form.

ANONYMITY

Complaints may be filed anonymously. The complainant should be encouraged to provide his or her name to aid the investigation and be reassured that their identity will be kept confidential to the extent possible.

REFERENCES

- State policy

SECTION D: PROGRAM VIOLATION

Effective: 01/xx/01
Revisions: 10/01/07

OVERVIEW

Program violation means any intentional action by a participant, parent, caretaker of an infant or child participant, or proxy that violates Federal or State statutes, regulations, policies or procedures governing the WIC Program.

IN THIS SECTION

Employee Duty Restrictions
Participant and/or Employee Violations
- Reporting of Program Violation
- Participant and/or Employee Sanctions for Program Violations
- Reinstatement Following Suspension/Disqualification

Assessing a Reimbursement Claim
Employee Investigation
Misuse of Program Benefits (WIC Checks)
Definitions

EMPLOYEE DUTY RESTRICTIONS

Effective: 01/xx/01
Revision: 10/01/07

POLICY

Staff duties should be assigned to minimize the potential for fraudulent activities and ensure integrity. Local agency Coordinators may write a local procedure specific to accommodating this requirement.

Employees as Participants
An employee who qualifies for program benefits should not determine eligibility for herself, close friends, or immediate family members, nor should issue checks to herself as a participant or responsible adult of her children. These tasks should be performed by another staff member.

Separation
Local agencies must split benefit issuance between more than one person to the extent possible. This means separating certification procedures, check issuance functions, and check accountability procedures to ensure the entire cycle of issuance does not rest with one person.

Staff must not provide services, such as certifying or issuing checks, to immediate family members, close friends, or to themselves. Immediate family members include parents, siblings, children, and grandchildren. Local agency Coordinators may write a local procedure specific to accommodating this requirement.

In the event that local agencies operate small remote clinics with minimal staff, the local agency must provide the State with a copy of the local agency policy ensuring that separation of duties and program integrity is maintained.

REFERENCES

- All States Memorandum 99-94 (7/8/99) Separation of Duties in WIC Clinic Operations

PARTICIPANT AND/OR EMPLOYEE VIOLATIONS

Effective: 01/xx/01
Revision: 10/01/07

PURPOSE

The WIC Program strives to promote and ensure integrity through the prevention of non-compliance, program fraud and/or misuse. Quality service depends on a partnership between participants, local agency staff, State Office staff, and vendor staff using positive communication techniques.

PARTICIPANT AND/OR EMPLOYEE VIOLATIONS

- Making false or misleading statements or intentionally misrepresenting, concealing or withholding facts to obtain program benefits
- Exchanging food instruments or supplemental foods for cash, credit, non-food items or unauthorized food items
- Exchanging food instruments for more than the specified amount of supplemental foods listed on the food instrument
- Physically harming or threatening to harm WIC clinic staff or vendor staff or property belonging to WIC clinic or vendor
- Participating in more than one WIC clinic or participation in the WIC Program and in Commodities Supplemental Food Program (CSFP) at the same time (dual participation)
- Theft of WIC food instruments
- Redeeming more than the number of food instruments for which the participant is eligible
- Altering the food instrument
- Redeeming food instruments at an unauthorized food vendor
- Misuse of program benefits and/or equipment in direct conflict with policy(s)

REPORTING OF PROGRAM VIOLATION

The local agency shall:

- Document all program non-compliance, fraud and/or misuse in the participant chart, appropriate family member charts, and/or employee personnel file.

- In all cases where non-compliance, fraud and/or misuse are alleged against a participant, provide a copy of all documentation to the State Office.

- Consult with the State Office prior to taking action.

- Provide follow up information to the State Office as requested.

- Investigate all reports of participant non-compliance, fraud, and/or misuse in a timely manner.

- During the investigation, provide any and all additional information and/or statements concerning the issue of non-compliance, fraud, and/or misuse. Intent, knowledge, and circumstances are taken into consideration when determining the need for sanctions.

Possible fraud or misuse of WIC checks is identified in several ways. The State Office monitors computer-generated reports and incident reports filed by participants, vendors, and local agency staff. To prove fraud or misuse of checks, it is critical the incident reports are filed accurately, promptly, and every time an incident occurs.

PARTICIPANT AND/OR EMPLOYEE SANCTIONS FOR PROGRAM VIOLATIONS

Written Warning

The local agency may provide a written *warning* to the participant and/or employee if the WIC Coordinator determines that there are not sufficient facts for a finding that the participant, employee, parent, caretaker of an infant or child participant, or proxy *intentionally* committed a program violation.

At minimum, the written warning must include the following:

- Action(s) which constitute program violation/non-compliance
- Date program violation/non-compliance occurred
- Consequence of subsequent program violation/non-compliance
- Review of Participant Rights and Responsibilities and copy of Participant Rights and Responsibilities, as applicable
- Signature of participant and/or employee acknowledging receipt of written warning. Signature does not constitute admittance of program violation.
- Signature of WIC clinic staff who issued written warning
- Date(s) of signatures

Employee Sanction

Employees found to have committed program fraud or abuse, outside of situations where the employee is a participant, will be held accountable under local agency human resource department rules and regulations.

Employees found to have committed program fraud or abuse as a participant will be treated the same as any other participant committing fraud or abuse of the WIC Program.

Program Suspension

The local agency, in consultation with local agency legal counsel and the State WIC Office, may withhold program benefits for a designated period of three (3) to six (6) months when there is substantiated and documented occurrence of two (2) or more program violations/non-compliance. The program violations/non-compliance must fall within the same or similar category and be within a twelve (12) month period.
Participants suspended from the program due to violation of program rules may continue to participate if the certification period is still valid, or reapply for benefits following the end of the suspension period, or if full restitution is made, or a repayment schedule is agreed upon.
It is the participant's responsibility to contact the local agency for an appointment following the expiration of the suspension period.
The local agency must provide the participant with a written notification of program suspension. The written notification must be sent by certified mail with return receipt requested.
At minimum, the written notification must include:

- Action(s) which constitutes program violation
- Date(s) of program violation
- Length of the pending suspension from program participation (effective begin and end dates)
- Right to fair hearing request and inclusion of Fair Hearing Request Form
- Total amount of reimbursement claims assessed, if applicable
- Identity and contact phone number of WIC staff person the participant must contact to make repayment, if applicable
- Notification that a response is required within thirty (30) days of the request for reimbursement, if applicable

If the participant does not respond to the written request for reimbursement letter within thirty (30) days, the local agency must send a second letter via certified mail notifying the participant that he/she has been suspended from program participation and reason(s) for program suspension (as noted above).

NOTE: In the event that the program violations occurred due to the action(s) of an infant or child participant's parent or caretaker, the responsible adult is the person who is suspended. The infant or child can continue to receive program benefits and participate during the period of suspension if an authorized proxy can be designated. However, if the authorized proxy violates the program rules, the participating infant or child will be suspended for the remainder of the original time period.

Program Disqualification

The local agency, in consultation with the State WIC Office and local agency legal counsel, as applicable, may disqualify a participant for a designated period of time. Disqualification can last up to one (1) year.

Certain serious program violations shall result in disqualification for a period of time not to exceed one (1) year without any written warning if:
There is a documented claim of intentional dual participation
There is documented physical harm to clinic staff or vendor staff or damage to clinic or vendor property

The local agency must provide the participant with a written notification of program disqualification. The written notification must be sent by certified mail with return receipt requested.

At minimum, the written notification must include:

- Action(s) which constitutes program violation
- Date(s) of program violation
- Length of the pending disqualification from program participation (effective begin and end dates)
- Right to fair hearing request and inclusion of Fair Hearing Request Form

NOTE: In the event that the program violations occurred due to the action(s) of an infant or child participant's parent or caretaker, the responsible adult is the person who is suspended. The infant or child can continue to receive program benefits and participate during the period of suspension if an authorized proxy can be designated. However, if the authorized proxy violates the program rules, the participating infant or child will be suspended for the remainder of the original time period.

Referral to Law Enforcement

When appropriate, the local agency and State Office must refer participants who violate program requirements to Federal, State, or local law enforcement authorities for prosecution under applicable statutes.
In the event of physical harm or threat of physical harm to WIC clinic staff or vendor staff or damage to property belonging to the WIC clinic or vendor, the local agency must notify the appropriate law authorities immediately as well as communicate with local agency legal counsel before taking subsequent legal action. The State Office shall be notified of such action immediately.

Penalties

Whoever embezzles, willfully misapplies, steals, or obtains by fraud any funds, assets or property directly or indirectly from the WIC Program, or whoever receives, conceals or retains such funds, assets or property for his or her own interest, knowing such funds, assets or property have been embezzled, willfully misapplied, stolen, or obtained by fraud shall be fined not more than $25,000 or imprisoned not more than five years, or both if the value of funds, assets or property obtained by fraud is $100 or more. If

such funds, assets, or property are of a value of less than $100, shall be fined not more than $1,000 or imprisoned for not more than one year or both.

REINSTATEMENT FOLLOWING SUSPENSION/DISQUALIFICATION

Participants suspended or disqualified from program participation due to a violation of program rules may re-apply for benefits following the end of the suspension or disqualification period, or if full restitution is made, or a repayment schedule is agreed upon.
It is the participant's responsibility to contact the local agency for an appointment following the expiration of the suspension or disqualification period. The participant must re-qualify using the standard eligibility determination criteria.

Local agencies are not required to allow an authorized proxy to continue to participate after the suspension or disqualification period has ended.

REFERENCES

- 7 CFR 246.7 (l) Dual Participation
- 7 CFT 246.7 (j) Notification of Participants Rights and Responsibilities
- 7 CFR 246.9 Fair Hearings
- 7 CFR 246.12 (u) Participant Violations and Sanctions (Referral for Prosecution)
- 7 CFR 246.23 (c) Claims against Participants

Assessing a Reimbursement Claim

Once it has been determined that program non-compliance, fraud, and/or misuse has occurred due to a participant violation, the local agency will assess a claim for the full value of any benefits received fraudulently. The local agency shall issue a written notification requesting repayment and pursue collection until restitution is made or it is determined that collection action is no longer cost effective. The notification must be delivered via certified mail with return receipt requested.

At the time of the claim for repayment, the participant shall be informed that failure to agree to and fully comply with the repayment schedule may result in the participant being disqualified from the WIC Program. If the participant appeals the action within 15 days, the local agency must continue to provide benefits until the participant's certification expires or an appeal decision is made, whichever occurs first.
A claim for reimbursement must be made regardless of the amount if an intentional participant violation occurred.
The local agency coordinator must contact the State Office prior to taking any collection action.

Repayment

All repayment decisions must be determined in consultation with the State Office.

The program may decide not to impose a suspension or a mandatory disqualification if full restitution is made or a repayment schedule is agreed on; or, in the case of a participant who is an infant, child or a woman under the age of 18, approves the designation of a proxy or alternate responsible adult.
At the discretion of the local agency, restitution can be made by performing in-kind services. However, restitution may not include offsetting the claim against future program benefits, even if agreed to by the participant.
The term of the repayment schedule shall be no longer than twelve months and no less than $10.00 per month. Repayment is collected by the local agency and forwarded to the State Office. Repayment must be made via check or money order payable to "Idaho WIC Program." No cash will be accepted.
The local agency must include an explanation with the check or money order that clearly identifies the participant's name, the client ID number, the Family ID number, and the reason for repayment.
If, at any time, the local agency determines that the participant is at least two repayments in arrears, the participant shall be disqualified from the program. The number of months of disqualification shall be determined as a pro-rated portion of the original penalty based on the percentage of months of unpaid restitution. The disqualification shall commence on the date in the notification letter and be subject to the notification requirements as described in Disqualification and Suspension.
The local agency shall be responsible for all documentation of the participant's violation, claim record, and balances due. The local agency must notify the participant when the claim is paid in full. All actions and determinations, including a determination that it is not cost effective to pursue further collection actions, must be documented in the case file.
The State Office may pursue repayment through a state collection agency or another collection agency, including the federal government.

EMPLOYEE INVESTIGATION

Employees who are participants are also subject to participant program violation policies. All employee fraud cases involving benefits are investigated by the local agency, the State Office, law enforcement, and/or the Department of Health and Welfare Fraud Investigation Unit.

Employee program violations include, but are not limited to:

- Disregard for confidentiality of program information
- Physically harming or threatening to harm other WIC clinic staff or vendor staff, or property belonging to other WIC clinic staff or vendor staff
- Falsely obtaining benefits for self or others
- Theft of program supplies/equipment
- Failure to report knowledge of any of the above situations

NOTE: Employee fraud case investigations must be documented and such documentation is kept for a minimum of ten years.

MISUSE OF PROGRAM BENEFITS (WIC CHECKS)

UNAUTHORIZED FOODS

Knowingly purchasing unauthorized foods not specified on a WIC check.
Example:
The participant is informed a food item is not allowed and the participant insists or becomes argumentative with the vendor staff, even after review of the Idaho WIC Authorized Food List.

ALTERATIONS TO A WIC CHECK

The altering of a WIC check includes, but is not limited to: use of correction fluid (e.g., Wite-Out®, Liquid Paper®), blacking out, or writing over dates, names, or food quantities. Participants should not allow anyone to write on a WIC check, as vendor staff will not accept a check that appears altered.

- Example: Participant changes the food quantities in order to receive more food benefits than allowed.
- Example: Participant alters dates on the check to use before or after the dates specified on the check.

SALE OR EXCHANGE OF WIC FOODS

A participant attempts to sell or exchange, or the actual sale of or exchange of a WIC check for cash, credit or other services.

THEFT OF WIC CHECK(S)

A participant steals a check from the clinic or another participant.

GIVING WIC FOODS AWAY

A participant gives WIC foods away to relatives, neighbors, friends, to a food bank, etc.

POST DATED CHECKS

A participant uses a check(s) prior to the “First Day To Use” date printed on the check or insists the vendor allow use prior to the date indicated on the check.

STALE DATED CHECKS

A participant uses a check after the “Last Day To Use” date printed on the check.

EXCESSIVE FOODS

A participant attempts to purchase or does purchase more food than the amount specified on the check. When the error is pointed out, the participant insists that this has been allowed before and demands the vendor staff allow the purchase.

SIGNATURE PROBLEM(S)

Participant fails to sign the check at the time of food purchase.
Participant signs the check prior to checkout.
Unauthorized signature on the check at the time of purchase; signature is different than the one provided on the WIC Identification (ID) Folder.

INVALID VENDOR

A participant uses check(s) at an unauthorized WIC vendor.

EXCESSIVE ISSUANCE

An error occurred when the clinic staff printed checks for the participant, resulting in too many WIC checks being issued. The clinic staff voided and re-issued checks for the participant and mistakenly gave the participant both sets of checks. The participant uses both sets of WIC checks for the same period of time.

DEFINITIONS

ATTEMPT

A participant’s action in violation to program rules that is persistent and/or coercive, whether the intended result is achieved or not.
Example:
A participant tries to purchase a non-authorized cereal by repeatedly trying to talk the store clerk into letting him/her purchase it, stating they always buy this product here, or saying another vendor allows them to purchase the wrong item.

DISQUALIFICATION

The act of removing a participant from the program and prohibiting further participation for specified period of time. The participant must reapply for program benefits at the end of the disqualification. Disqualification can last from one month to one year.

DISRUPTIVE ACTION

Acting in a manner which disturbs other clients at the clinic, WIC or vendor staff, vendor’s customers or disrupting or obstructing clinic or vendor operations.
Example:

Refusing to leave premises when asked to do so, throwing literature in a fit of anger, other actions which cause discomfort or fear

Dual Enrollment

Active participant enrollment in two or more WIC clinics or WIC programs during the same time period. A dually enrolled participant may or may not have more than one set of WIC checks issued for the same benefit month. If the participant redeems only one set of WIC checks, the WIC participant must be terminated from the other WIC clinic/program.

Dual Participation

Participant receiving and cashing WIC checks from one or more WIC clinics/programs for the same time period. This results in excessive food benefits of the federal food allowance for the time period.

Intent

Action carried out or attempted with the purpose to accomplish a result contrary to program rules.

Knowledge

Action carried out when participant has been made aware it is contrary to program rules or has information which would lead a reasonable person in the same situation to believe action is contrary to program rules.

Misuse

Violations of the program rules which could lead to warning, repayment, suspension or disqualification or other sanctions applicable to State or Federal law.

Non-compliance

Failure on the part of the participant to follow program rules. The participant may or may not act with intent or knowledge.

Participant

Participant means the participant, parent, responsible adult (e.g., guardian, caretaker,) proxy, infant, child, pregnant woman, postpartum woman, and/or breastfeeding woman who receive supplemental foods from the WIC program.

Participant violation

Any intentional action or activity by a participant to obtain benefits to which he or she is not entitled and/or to misuse benefits received. These include, but are not limited to, misrepresenting facts used to determine eligibility, exchanging food checks for non-approved items, selling or giving away food obtained with checks, participating at more than one local WIC agency simultaneously, physical contact or threat of physical harm directed toward WIC staff or vendor staff or WIC property.

Physical Abuse

Physical contact or actions with WIC staff, vendor staff, or other participants which cause pain or injury.
Example:
Pushing, shoving, spitting, scratching, and throwing WIC foods or other objects at an intended target or targets.

SANCTION

A penalty for violating WIC program rules, regulations, or policies.

SUBSEQUENT INCIDENT

A second (or more) substantiated and documented occurrence of participant non-compliance and/or program violation.

NOTE: When a subsequent incident occurs and the action falls within the same or similar category, the program response for the subsequent incident is applied. When the action falls in a category different from the first incident (the action is a lesser or a greater violation of program rules), professional judgment is used to determine which response is appropriate.

SUSPENSION

The act of withholding benefits for a designated period of three to six months. The participant will continue on the program without reapplying if still within a current eligibility period at the end of the suspension.

THREATS

Communicating directly or indirectly the intent to cause injury, property damage, or any other act intended to harm the threatened person(s) with respect to their health and safety.
Example:
Raising a fist; making a bomb threat; walking to the back of the counter toward staff in a manner which staff consider intimidating; throwing an object in the vicinity of person; showing weapons or objects which can be used as weapons; and intimidating or threatening with harmful consequences.

VIOLATIONS

Intentionally not following WIC program rules and regulations.

SECTION E: FAIR HEARINGS

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

The purpose of this section is to help clinic staff answer questions from WIC participants about the fair hearing procedure. In Idaho, the WIC program is required to follow the hearing procedures set forth by the Department of Health and Welfare and Federal regulations.

IN THIS SECTION

Notification of Right to Fair Hearing

NOTIFICATION OF RIGHT TO FAIR HEARING

Effective: 01/xx/01
Revision: 10/01/07

POLICY

The following situations require the notification of the right to a fair hearing:

- The participant is denied participation at time of certification
- The participant is suspended/disqualified mid-certification
- The WIC program makes a claim against a WIC participant for repayment of the cash value of improperly issued benefits

Notification is not required at the expiration of a certification period.

NOTICE REQUIREMENTS

At the time of a claim against an individual for improperly issued benefits, participation denial, suspension or disqualification, the local agency must inform the individual in writing of:

- The right to a fair hearing
- The method used to request a hearing
- The fact that positions or arguments on behalf of the individual may be presented personally or by a representative such as a relative, friend, or legal counsel

TIME FRAME

A request for a hearing must be made within 60 days from the date the State WIC office or local agency mailed or gave notice of adverse action to deny or terminate benefits.

The person requesting the fair hearing will receive written notification at least 10 days prior to the conduct of the hearing.

The results of the hearing will be provided within 45 days of the request for fair hearing.

WHO CAN REQUEST

Any applicant or participant aggrieved by any action of the Idaho WIC Program which results in the individual's denial of participation, suspension, disqualification, or termination from the program, may request a hearing.

The right to make such a request will not be interfered with in any way.

The request can be made by the applicant or participant or some other person acting on the applicant or participant's behalf, such as a legal counsel, friend, or household member.

HOW TO REQUEST

A request for a hearing is any clear expression by the individual, individual's parent, caretaker, or other representative that they want to present their case to a higher authority.

The hearing request may be made orally or in writing. If orally, local agency may write the request for the individual.

The Fair Hearing Request Form must be provided to anyone who requests it. A copy of the completed request from should be given to the individual making the request

CONTINUATION OF BENEFITS

Except for participants whose certification period has expired, participants who appeal the termination of benefits within the 15 days of this action shall continue to receive program benefits until the hearing officer reaches a decision or the certification period expires, whichever occurs first.

Participants whose certification period has expired or who have become categorically ineligible during the appeal process will not receive program benefits while awaiting the hearing decision.

Applicants who are denied benefits at initial certification or expiration of their certification may appeal the denial, but will not receive benefits while awaiting the hearing decision.

WIC Program funds may not be used to pay for retroactive benefits.

PROCEDURE

All requests for a fair hearing must be sent to the State WIC Office as soon as a local WIC office receives the request. Attach a copy of the letter of ineligibility or claim for repayment.

The State WIC Office will notify the Department of Health and Welfare, who will maintain responsibility for appointing the Hearing Officer and conducting the hearing according to Department procedures.

DENIAL OR DISMISSAL OF REQUEST

The State WIC Office will not deny or dismiss a request unless the following have occurred and/or upon legal counsel provided by the Department.

- Request is received after the 60-day time limit.
- Request is withdrawn, in writing, by the applicant or authorized representative.
- Appellant or representative fails, without good cause, to appear at the scheduled hearing.
- Appellant has been denied participation by a previous hearing and cannot provide evidence that circumstances relevant to program eligibility have changed.

REFERENCES

- 7 CFR 246.9 Fair hearing procedures for participants
- State of Idaho, Department of Health and Welfare Administrative Rules, 16.05.03 Contested cases and declaratory rulings

SECTION F: DISASTER RECOVERY

Effective: 01/xx/01
Revision: N/A

OVERVIEW

This section describes the division of responsibility for service continuation in the event of a natural disaster, computer system failure, or other emergency situation.

IN THIS SECTION

Local Agency Responsibilities
State Office Responsibilities
Checks Printed by State Office
Contaminated Water

LOCAL AGENCY RESPONSIBILITIES

Effective: 01/xx/01
Revision: N/A

POLICY

The following procedures will vary depending on the circumstances of the disaster or emergency.

1. Clinic staff should notify the local agency Coordinator as soon as possible of the emergency situation.

2. The Coordinator should notify the State WIC Office of the emergency situation.

INFORMATION NEEDED BY STATE OFFICE

- Nature of the disaster or emergency
- Number of clinics affected
- Number of participants involved
- Water supply/safety problems (check with Environmental Health officer)
- The next scheduled clinic day
- Number of potential vendors involved

CHECK ISSUANCE

State Office will work with the local Coordinator regarding printing and issuance of checks.

Options:
1. Checks can be printed at another nearby site.
2. State Office can print checks and mail them to a clinic or to the participant.

Clinics are responsible for check register documentation.

Issue one month of checks only.

PARTICIPANT EDUCATION

Certain areas within the state are at high risk for floods, fire, road problems, snowstorms, etc. Education classes should be provided for participants living in these areas. Information is not limited to, but should include: what to do about inaccessible stores, what to do with checks that aren't cashed, and what to do about contaminated water.

FORMULA

The State WIC Office will work with the local agency Coordinator to determine formula needs (e.g., Ready to Use (RTU) formula).

Formula samples may be mailed, but must be documented in participant chart.

VENDORS

State Vendor Coordinator will determine vendor procedures during the disaster and will work with the vendors as needed.

REFERENCE

- State policy

STATE OFFICE RESPONSIBILITIES

Effective: 01/xx/01
Revision: N/A

POLICY

The following procedure will vary depending on the circumstances of the disaster or emergency.

- State WIC Program Manager will coordinate disaster or emergency response.

The State Office will document all disaster or emergency operations.
Document Information from Clinic

- Nature of the disaster or emergency
- Number of clinics affected
- Number of participants involved
- Water supply problems
- Next scheduled clinic day
- Number of potential vendors involved
- Changes made to assist participant

VENDOR RELATIONS

The State Office will work with vendors during the disaster to accommodate needs of participant and check issues. The Vendor Coordinator will take the lead in this effort.

- Researching alternative stores
- Notifying vendors of procedures
- Sending checks to the State Office instead of the bank
- Issuing credit slips

RED CROSS

If needed, the State Office will contact the Red Cross during a disaster or emergency to deliver formula, supplies, etc.

CHECK ISSUANCE

The State Office will print checks if they cannot be printed in an outlying clinic or closer to participants in need. State Office will work with local Coordinator to determine location of check printing.

FORMULA

The State Office, in conjunction with the local agency Coordinator, will be responsible for:

- Assessing clinic formula needs (type and amount)
- Ordering more formula samples from the company, if needed
- Arranging for mailing/shipment of formula samples
- Working with Vendor Coordinator on vendor supplies
- Working with Coordinator to assess need for RTU formula

- Working with formula companies as needed
- Arranging for shipment of formula, if needed

BREASTFEEDING

The State Breastfeeding Coordinator will work with breastfeeding mother/infant separation concerns and issues involving breast pumps.

REFERENCE

- State policy

CHECKS PRINTED BY STATE OFFICE

Effective: 01/xx/01
Revision: N/A

POLICY

1. Clinic notifies State Office which participants need to have checks printed.
2. Screen print Clinic Appointment screen for participants needing checks.
3. A current food package is set up on CF screen for participants.
4. Checks are printed and mailed to another clinic or to the participant.
5. Copy of Client Appointment Screen sent to Coordinator, with documentation of any changes made.

If no appointments were entered on AC, clinic must fax participant's name, ID #, along with the appointment date and time to State Office. Appointment information will be added to AC screen by State Office and used to print checks.

1. If checks need to be mailed, an address report for labels may be requested.
2. Clinic is responsible for documentation on check register.

REFERENCE

- State policy

CONTAMINATED WATER

Effective: 01/xx/01
Revision: N/A

POLICY

If contaminated water warnings last for several weeks, RTU formulas may need to replace powdered or concentrated formulas.

The State Office should:

1. Find out how many participants and which vendors are involved.
2. Determine if RTU formula is available in other clinics.
3. Contact involved vendors with approximate amount of formula needed.
4. If needed, enter RTU price for vendors on Food Vendor Price Table so check can be printed.

REFERENCE

- State policy

SECTION G: MEMORANDUM OF UNDERSTANDING (MOU)

Effective: 06/01/05
Revision: N/A

OVERVIEW

In general, a Memorandum of Understanding (MOU) is a written document between two or more parties in which they agree to perform certain complementary functions in service of a common goal.

Federal WIC regulations and USDA policy require MOUs or agreements in order to disclose client information, without written consent, to other public health or welfare programs for the purpose of eligibility for program services (State Office function). MOUs may also be developed for other purposes, e.g., delineation of responsibilities or activities to be conducted (local agency function).

IN THIS SECTION

Memorandum of Understanding (MOU)

MEMORANDUM OF UNDERSTANDING (MOU)

Effective: 06/01/05
Revision: N/A

POLICY

State and local WIC agencies must develop MOUs with other agencies/programs to ensure coordination of services and confidentiality.

PROCEDURE

State and local WIC agencies must have MOUs in place with any program (within or outside of the agency) in which services are coordinated and/or participant information is shared. Examples include the immunization program, Head Start, family planning, county extension offices.

State and local WIC agencies must keep MOUs available to be reviewed during site monitoring. Local WIC agencies will be asked to submit a list of current MOUs prior to site monitoring.

NOTE: Participant information may only be shared without written consent as defined by the WIC Application:

"I authorize the release and transfer of medical and social information in the WIC records for myself and my children listed on this form to local, state, and federal WIC sponsors. This information will be used for the purposes of receiving WIC services, evaluating the effectiveness of the program, monitoring, and auditing the program, and referral for other appropriate Department of Health and Welfare services. I release these agencies from any all responsibility and liability concerning the release of the information I have consented to be released."

Sample MOU

CHAPTER 3: CASELOAD MANAGEMENT

Effective: 01/xx/01
Revision: 10/1/07

OVERVIEW

IN THIS CHAPTER

Section A Caseload Management

Section B Waiting Lists

Section C Outreach

SECTION A: CASELOAD MANAGEMENT

Effective: 10/01/05
Revision: 10/01/07

OVERVIEW

The WIC Program is funded by the federal government to serve eligible pregnant, breastfeeding and postpartum women, infants, and children up to age five. In times when funding does not allow for all eligible participants to be served by the WIC Program, the State WIC Office may choose to implement a caseload management policy.

IN THIS SECTION

Caseload Management
Priority System: Sub-Priorities

CASELOAD MANAGEMENT

Effective: 10/01/05
Revision: 10/01/07

OVERVIEW

Caseload management assures that applicants are categorized into appropriate priorities so that benefits can be provided to those in most need and not provided for those in lesser need at times when demand exceeds funding resources.

POLICY

Caseload Management must be made as equitable as possible on a statewide basis to ensure participants have equal access to the WIC Program throughout the state. Therefore, when a state level decision is made to implement caseload management, all local agencies must follow the same procedure for enrolling applicants.

The State WIC Office will determine which priority/sub-priority will receive benefits during caseload management. This decision will be based on current caseload numbers, available funds, and federal guidance.

Local agencies will be notified in writing of the need for caseload management for specific priority/sub-priority groups and the date to implement caseload management.

PRIORITY SYSTEM: SUB-PRIORITIES

Effective: 10/01/05
Revision: 10/01/07

OVERVIEW

The WIC priority/sub-priority system was designed to ensure that persons at the greatest nutritional risk are first to receive program benefits when a state is unable to serve all participants because of limited caseload (statewide caseload management has been implemented at the direction of the State Office).

The order of priorities recognizes the fact that the earlier in a child's development that intervention takes place, the greater the impact on the child's health. For this reason, pregnant women are served first and younger children are served before older children within each priority. The priorities also reflect the importance of serving participants with a current medical nutrition risk before participants with a poor diet who may develop a medical nutrition risk later.

DEFINITION

A sub-priority is any priority other than priority I within a category (for example: pregnant women found to be a Priority IV based on Nutrition Risk Criteria would be a sub-priority of category P). Sub-priority designation shall be used when statewide caseload management is implemented and only a part of a priority can be served.

POLICY

Determining the order of serving participants using the priority and sub-priority system:

- Participants with a valid Verification of Certification (VOC) card will be served first regardless of their priority.
- A Competent Professional Authority (CPA) shall assign the highest priority to each participant based on their category (P, BF, N, I, or C) and nutritional risk.
- All participants in the higher priority shall be served before participants in lower priorities. Sub-priority designation shall be initiated by the State WIC Office. Determination will be based on statewide caseload numbers.
- Participant's who are being recertified have no priority over other applicants during caseload management.
- Federally, there are seven priorities. Priority I is the highest need (highest priority) and VII is the lowest priority. Idaho WIC serves 6 priorities (Priority I is the highest priority need and priority VI is the lowest priority need).

PROCEDURE

In the event that caseload management is initiated by the State WIC Office, all applicants from the date of caseload management implementation must be prescreened to determine priority/sub-priority.

Prescreening takes place when a person first inquires about participation in WIC. Depending on the sub-priority level that has been determined to be used by the State Office, local agencies may need to further prescreen applicants. Local agencies may partially screen to the point where eligibility is determined for the purpose of certification or placement on a waiting list.

Prescreening may involve determining the following:

- Residency of local agency service area

- Applicant category (i.e., pregnant woman, breastfeeding woman <1 year postpartum, postpartum woman, infant, or child under age 5)
- Income eligibility

Probable priorities may be determined with information obtained through interviews with applicants, through referral from a physician, and/or by anthropometric or biochemical data either brought in by applicant (must have been taken within past 60 days and written on prescription from a healthcare provider) or through local agency prescreening for anthropometric and biochemical data.

The six priorities are:

PRIORITY I MEDICAL

Pregnant women, breastfeeding women, and infants with medical nutritional risks based on information gathered during the prescreening assessment.

Sub-prioritized in this order:

1. Pregnant women
2. Breastfeeding women
3. Infants

PRIORITY II INFANT OF WIC MOM

Infants under the age of six months (who are not Priority I) of women who participated in WIC during pregnancy, or who would have been eligible to participate in WIC during pregnancy due to medical or dietary risk. There shall be no sub-priorities. Serve in order of application to the program.

PRIORITY III MEDICAL

Children with medical nutritional risks based on information gathered during the prescreening assessment.

Sub-prioritized in this order:

4. All children with a physician prescription for a WIC-eligible medical food are served first, regardless of age
5. One-year-old children
6. Two-year-old children
7. Three-year-old children
8. Four-year-old children

NOTE: This means children needing WIC-eligible medical foods are served to age 5 years even before younger Priority III children. After Priority I, all other children shall be sub-prioritized by age, with younger children being served first.

PRIORITY IV NUTRITIONAL

Homelessness, migrancy, or pregnant women, breastfeeding women, and infants with nutritional risk based on information gathere during the nutrition assessment.

Sub-prioritized in this order:

9. Pregnant women
10. Breastfeeding women
11. Infants

PRIORITY V NUTRITIONAL

Homelessness, migrancy, and children with nutritional risk based on information gathered during the nutrition assessment.

Sub-prioritized in this order:

12. Sub-prioritized by age, with youngest served first

PRIORITY VI MEDICAL AND NUTRITIONAL

Homelessness, migrancy, and postpartum women (up to six months postpartum) with nutritional risk based on information gathered during the nutrition assessment.

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
Priority I - Medical	Pregnant Women	**Biochemical** 11—Low Hematocrit 12—Low Hemoglobin **Anthropometric** 18—Underweight Woman 17—Overweight Woman 15—Low Maternal Weight Gain 13—Maternal Weight Loss During Pregnancy 14—High Maternal Weight Gain **Medical** 49—Lactose Intolerance 52—Food Allergy 57—Hyperemesis Gravidarum 54—Gestational Diabetes 55—Hx of Gestational Diabetes 68—Hx Low Birth Weight 88—Hx Preterm Delivery (≤ 37 wks) 66—Hx Fetal or Neonatal loss 60—Pregnancy-Young age 63—Closely Spaced Pregnancy 61—Multifetal Gestation 69—Fetal Growth Restriction 70—Hx Birth-Congenital Defect 71—Possibility of Regression 80—Drug Use 81—Maternal Smoking 82—Alcohol Use 86—Hx Birth LGA Infant 90—Nutrition Related Medical Condition 91—Diabetes 93—Inborn Error of Metabolism 95—Dental Problems 96—Eating Disorders
	Breastfeeding Women	**Biochemical** 11—Low Hematocrit 12—Low Hemoglobin **Anthropometric** 14—High Maternal Weight Gain 17—Overweight Woman 18—Underweight Woman **Medical** 49—Suspected Lactose Intolerance 52—Food Allergy 55—Hx Gestational Diabetes 60—Pregnancy-Young Age (< 18 Yr) 61—Multifetal Gestation 63—Closely Spaced Pregnancy 66—Hx Fetal or Neonatal Loss

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
		68—Hx Low Birth Weight 70—Hx Birth-Congenital Defect 80—Drug Use 81—Maternal Smoking 82—Alcohol Use 86—Hx Birth LGA Infant 88—Hx Preterm Delivery (≤ 37 Wk) 90—Nutrition Related Medical Condition 91—Diabetes 93—Inborn Error of Metabolism 95—Dental Problems 96—Eating Disorders 611-BF Mom of Priority I Infant 615-BF Complication - Woman
	Infants	**Biochemical** 11—Low Hematocrit 12—Low Hemoglobin **Anthropometric** 22—Underweight 23—Short Stature 27—Low Birth Weight 30—Inadequate Growth 32—At Risk For Underweight **Medical** 34—Large for Gestational Age 35—Baby Bottle Tooth Decay 37—Prematurity 45—Fetal Alcohol Syndrome 49—Lactose Intolerance 52—Food Allergy 71—Possibility of Regression 90—Nutrition Related Medical Condition 91—Diabetes 93—Inborn Error of Metabolism 620-BF Complication - Infant 621-BF Infant of Priority I Mom
Priority II	Infant of WIC Mom	40—Born To WIC Mom 41—Born To Potential WIC Mom
Priority III - Medical	All children with a physician prescription for a WIC-eligible medical food, regardless of age. All other children sub-prioritized by age; younger children being served first (i.e., 1 year, 2 year, 3 year, 4 year)	100—WIC Eligible Medical Food **Biochemical** 11—Low Hematocrit 12—Low Hematology **Anthropometric** 21—Overweight 22—Underweight

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
		23—Short Stature 27—Low Birth Weight 31—At Risk For Overweight 32—At Risk For Underweight **Medical** 35—Baby Bottle Tooth Decay 45—Fetal Alcohol Syndrome 49—Lactose Intolerance 52—Food Allergy 71—Possibility of Regression 90—Nutrition Related Medical Condition 91—Diabetes 93—Inborn Error of Metabolism
Priority IV - Dietary	Pregnant Women	48—Inappropriate Nutrition Practices - Women 79—Transfer of Certification (VOC)
	Breastfeeding Women	48—Inappropriate Nutrition Practices - Women 79—Transfer of Certification (VOC) 100—WIC Eligible Medical Food 614—BF Mom of Priority IV Infant 701—Homelessness 702—Migrancy 803—Feeding Skills Limitations
	Infants	36—BBTD Risk Behaviors 46—Inappropriate Nutrition Practices - Infant 79—Transfer of Certification (VOC)* 624—BF Infant of Priority IV Mom 701—Homelessness 702—Migrancy 803—Feeding Skills Limitations 804—Foster Care
Priority V - Dietary	Sub-prioritized by age, with youngest children served first	36—BBTD Risk Factors 47—Inappropriate Nutrition Practices - Child 79—Transfer of Certification (VOC) 92—Child with Infant Formula Package 100—WIC Eligible Medical Food 701—Homelessness 702—Migrancy 803—Feeding Skills Limitations 804—Foster Care
Priority VI - Medical and Dietary	No sub-prioritization. Serve in order of application to the program.	**Biochemical** 11—Low Hematocrit 12—Low Hemoglobin **Anthropometric** 14—High Maternal Weight Gain

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
		17—Overweight Woman 18—Underweight Woman **Medical** 48—Inappropriate Nutrition Practices - Women 49—Lactose Intolerance 52—Food Allergy 55—Hx Gestational Diabetes 60—Pregnancy-Young Age 61—Multifetal Gestation 63—Closely Spaced Pregnancy 66—Hx Fetal or Neonatal Loss 68—Hx Low Birth Weight 70—Hx Birth-Congenital Defect 71—Possibility of Regression 79—Transfer of Certification (VOC) 80—Drug Use 82—Alcohol Use 86—Hx Birth LGA Infant 88—Hx Preterm Delivery (≤ 37 Wk) 90—Nutrition Related Medical Condition 91—Diabetes 93—Inborn Error of Metabolism 95—Dental Problems 96—Eating Disorders 100—WIC Eligible Medical Food 701—Homelessness 702—Migrancy 803—Feeding Skills Limitations

SECTION B: WAITING LISTS

Effective: 10/01/05
Revision: N/A

OVERVIEW

IN THIS SECTION

Policy/Procedure for Waiting Lists

POLICY/PROCEDURE FOR WAITING LISTS

Effective: 10/01/05
Revision: N/A

POLICY

The only time a local agency shall have a waiting list is during authorized caseload management per State WIC Office.

When the State WIC Office notifies local agencies for the need to implement caseload management, a waiting list of applicants to be enrolled, including recertifications, must be initiated and maintained. The purpose of the waiting list is to ensure that higher priority applicants are enrolled before lower priorities.

The priority/sub-priority system must be used to schedule certification appointments, to organize the waiting list, to put applicants on the waiting list, or to pull applicants off the waiting list to enroll onto the program during caseload management.

PRIORITIES

Local agencies will maintain a waiting list in accordance with the priority/sub-priority ranking system. Individuals in each priority who the local agency is currently unable to serve, but reasonably expects to serve in the future (6 months), will be placed on a waiting list as well as any other applicant who requests placement on a waiting list. Applicants will be recorded on the waiting list according to their potential priority and in the order in which they apply for services.

CONTENT OF WAITING LISTS

The waiting list will include, at a minimum, the following information:

- Name of applicant
- Mailing address and telephone number of applicant
- Category of applicant (i.e., pregnant woman, breastfeeding woman, postpartum woman, infant, or child)
- Date and notification of placement on the waiting list
- Date and time of appointment for screening (if performed by local agency)
- Potential priority

PROCEDURES FOR MAINTAINING THE WAITING LIST ELIGIBLE TRANSFERS

New Applicant, Certification, Recertification:

- Screen the applicant for residency and income eligibility.
- Depending on the level of caseload management operation as directed by the State Office, screen the applicant for anthropometric, biochemical, and physical/medical status.
- If medical data (height, weight, hemoglobin/hematocrit values, medical condition) are available, the presence of an anthropometric, biochemical or medical risk can be assessed, which would place the applicant in a higher priority than if only a dietary inadequacy were present.
- If the applicant applies for the program without the medical information necessary to determine an anthropometric, biochemical, or medical risk, the local agency must assess through screening.
- Place applicant on a waiting list according to her/his potential priority in chronological order on application.
- Inform the applicant, either verbally or in writing, that he/she has been placed on the waiting list. This must be done within 20 days of the applicant's request for program benefits.

Transferring Participants:

- Participants with a valid Verification of Certification (VOC) card will be served first regardless of their priority.
- In the rare event that a transferring participant with a current VOC card applies for continuing services and the agency is not enrolling additional persons because they are currently operating under a strict caseload management policy directed by the State Office, the participant will be placed on a waiting list and enrolled ahead of all other persons on the waiting list regardless of priority.

If more than one transferring participant with a current VOC card must be placed on a waiting list, she/he will be placed in order of priority.

Enrolling from Waiting List

When an opening occurs, the local agency will contact applicants from the waiting list to schedule a certification appointment.

- Contact applicants by telephone or letter, starting with those individuals on the VOC waiting list. If no applicant has VOC status, contact applicants beginning with the highest priority.
- After all VOC transfers and applicants with the highest priority have been contacted, proceed to the next highest priority.

Example: The local agency would begin contacting anyone on the waiting list with a Priority III status. After all Priority III status applicants have been contacted for a certification appointment, the local agency would precede to the Priority IV applicants, then to Priority V, etc.

- If an applicant fails to keep the scheduled certification appointment, she/he will be removed from the waiting list.

Current Participants Who Come Up For Recertification

A current participant whose priority is lower than applicants on waiting lists will *not* be recertified at the end of the current certification period in order to make space available for higher priority applicants. The participant will then be placed on the waiting list for his/her priority ranking, if the local agency reasonably expects to serve that priority in the future.

Example: Statewide, WIC is only serving Priority V participants up to age 4 years.

Scenario: A four-year-old comes up for recertification. Upon screening, it is determined that this child has low hemoglobin. Therefore, this child is now a Priority III and would be served.

Scenario: A four-year-old comes up for recertification. Upon screening, it is determined that this child has inadequate diet. Therefore, this child is a Priority V and would be placed on the waiting list should the expectation be that WIC would be likely to serve this participant within the next six months.

A current participant whose priority is the same as other applicants on the waiting list will not be recertified ahead of those applicants within the same priority. Rather, at the end of the current certification period, the participant will be served depending on priority or placed on the waiting list at the bottom of the priority category for which he/she is potentially eligible.

References

- Policy Memo 803-2, Revision 1 (1988) WIC Program Certification: Nutritional Risk/Participant Priority System

- Policy Memo 803-6, Revision 1 (1988) WIC Program-Certification: Waiting Lists
- Policy Memo 803-G (1993) Revision Verification of Certification
- Policy Memo 803-S (1993) *Priority Restrictions*

SECTION C: OUTREACH

Effective: 01/xx/01
Revision: N/A

OVERVIEW

Outreach activities are those promotional efforts designed to encourage and/or increase participation in the WIC Program.

The purposes of outreach are to:

1. Improve the health of pregnant women and children.
1. Increase public awareness of the benefits of the WIC Program.
2. Inform potentially eligible persons about the WIC Program in order to encourage and promote their participation in the program.
3. Inform health and social service agencies of the WIC Program's qualifications for participation and encourage referrals.
4. Ensure cooperation between WIC and other related services and programs so that WIC benefits and other related services a participant may be receiving are coordinated to provide more comprehensive service.
5. Promote a positive image of the WIC Program

IN THIS SECTION

General Outreach
Public Notification
Network Building
Benefits Targeting
Outreach Material
Outreach Log

General Outreach

Effective: 01/xx/01
Revision: N/A

Policy

Establish and maintain networks/relationships with agencies and organizations serving potentially eligible persons and publicize the availability of program benefits.

State Responsibilities

Make outreach materials available to local agencies and other relevant programs and organizations on a request basis.

- Outreach materials may be ordered by local WIC agencies quarterly using the Quarterly Order Form
- Supply outreach materials in appropriate languages
- Monitor local agency compliance
- Provide technical assistance to local agencies as needed

PUBLIC NOTIFICATION

Effective: 01/xx/01
Revision: N/A

POLICY

At least once annually, notify the public of WIC services by publishing the availability of program benefits in relevant newspapers.

This may be done by both State Office and local agencies. Local agencies may provide the State Office with a list of local media contacts for assistance in distribution.

PROCEDURE

Develop a news release that includes the following information:

- WIC agency contact information
- A brief description of the WIC program
- A brief description of who is eligible and services provided
- Include the following non-discrimination statement: “The WIC Program is an equal opportunity provider.”

NETWORK BUILDING

Effective: 01/xx/01
Revision: N/A

POLICY

At least annually, local agencies must contact organizations and community groups serving or associated with potentially eligible individuals and provide information about WIC services, income guidelines, and eligibility requirements.

PROCEDURE

At a minimum, contact and inform the following organizations and community groups about WIC:

- Regional Idaho Department of Health & Welfare offices, including Medicaid, Food Stamps, CHIP, TANF (cash assistance), Foster Care, and Child Protective Services
- Migrant farm worker organizations
- Health and medical organizations
- Hospitals and clinics, including migrant health clinics
- Social services agencies and offices
- Homeless facilities and institutions
- Head Start programs

Examples of other organizations that may be contacted include:

- American Indian tribal organizations
- Community action groups
- Neighborhood councils
- Schools and daycares
- Civic organizations
- Churches and religious organizations

Develop and maintain a list of specific agencies and organizations that will be contacted on a regular basis (i.e., at least annually).
Review and update list annually.

- List must include name of organizations and locations and may include contact name, mailing address, and other information relevant to agency.
- List is to be kept on file and will be reviewed by State Office as part of monitoring procedures.

All contacts must be documented on Quarterly Outreach Log and submitted to State Office.

BENEFITS TARGETING

Effective: 01/xx/01
Revision: N/A

POLICY

Each local agency will develop and implement a benefits targeting plan. This plan will be submitted for review and approval by the State WIC Office as part of the Local Agency Program Plan (LAPP).

TARGETING PLAN

The benefits targeting plan must include:

A list or description of strategies the local agency will use to inform each of the following groups about the availability of program benefits:

- Employed families
- Pregnant women in the early months of pregnancy
- Highest-risk (Priorities I-III) individuals and families including:
  - High risk postpartum women (e.g., teenagers)
  - Children in foster care/protective services
  - Priority I infants
  - Incarcerated pregnant women
- Institutionalized persons (see Chapter 4, Section A - Persons Living in a Shelter Home or other Institution)
- Migrant families
- Rural families
- Homeless individuals and families

A description of how the local agency will monitor progress of implementing plan and evaluate impact of plan.

Contacts must be documented on Quarterly Outreach Logs and submitted to State Office.

REFERENCES

- 7 CFR 246.4(a)(5)(i-ii);(6);(7);(18) and (19) Outreach Policies and Procedures
- 7 CFR 246.4(a)(5)(i);(6);(7);(18);(19);(20); and (21) Benefits Targeting

OUTREACH MATERIAL

Effective: 01/xx/01
Revision: N/A

POLICY

The USDA's nondiscrimination statement must be included on all publications, outreach materials, handouts, referral materials, leaflets, and brochures that identify or describe the WIC Program.

If the material is too small to permit the full statement to be included, the material will, at a minimum, include the statement in print size no smaller than the text that, "This institution is an equal opportunity provider."

NONDISCRIMINATION STATEMENT

"In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer."

USE OF STATEMENT ON WRITTEN MATERIALS

- Must be printed on all new materials
- Not required on items such as cups, button, magnets, and pens that identify the WIC Program due space limitations on such items

USE OF STATEMENT FOR RADIO AND TELEVISION

The nondiscrimination does not have to be read in its entirety on these announcements.

PUBLIC SERVICE ANNOUNCEMENTS

It is sufficient to include an abbreviated version of the nondiscrimination statement to meet the nondiscrimination requirement.

"The WIC Program is an equal opportunity provider."

REFERENCE

- All States Memorandum 06-21 (Jan. 11, 2006) Nondiscrimination Statement for WIC Materials

OUTREACH LOG

Effective: 01/xx/01
Revision: N/A

POLICY

A completed Outreach Log must be submitted quarterly to the State Office.

PROCEDURE

Local agency Coordinators may submit this via hard copy or may email the log. A fillable computer document is available upon request.

REFERENCE

- State policy

CHAPTER 4: ELIGIBILITY AND CERTIFICATION

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

IN THIS CHAPTER

Section A Eligibility

Section B Certification

Section C Mid-certification

Section D Ineligible

SECTION A: ELIGIBILITY

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

IN THIS SECTION

Eligibility Criteria
Priority Levels
Adoption and Wet Nurses
Foster Children
Immigrants and Foreign Students
Joint Custody
Migrancy
Persons Living in an Institution
Verification of Certification
- Acceptance of VOC Cards or Documents
- Waiting Lists
- Procedure – Transfer of Certification

Issuing a Verification of Certification Document (VOC)

ELIGIBILITY CRITERIA

Effective: 01/xx/01
Revision: N/A

POLICY

To be certified as eligible to receive WIC program benefits in Idaho, an applicant must be categorically eligible and meet health service area, income, and nutritional risk requirements.

CATEGORICALLY ELIGIBLE

Applicants must be in one of five categories:

- Pregnant woman (P)
- Breastfeeding woman up to one year postpartum (B)
- Postpartum woman not breastfeeding less than six months postpartum (N)
- Infant up to one year of age (I)
- Child 1 to 5 years of age (C)

RESPONSIBLE ADULT

The responsible adult is usually the parent (or caretaker) who makes the initial contact to apply for WIC services and attends the certification appointment to apply for WIC for herself or for children. It is acceptable for either parent to be the responsible adult for infant and child participants.

Generally, the responsible adult should be the parent or caretaker who will most often attend appointments on behalf of the infant or child participant.

It is permissible to designate a proxy to attend appointments for the responsible adult during the certification period if circumstances indicate doing so will lessen participation barriers (e.g., a change in work schedule).

RESIDENCY

All participants must reside within the state where they receive WIC benefits.

Applicants must live within the boundaries of the public health district or tribal services to receive benefits from that program.

Agreements between state agencies may be established for those participants living outside the boundaries of Idaho who use Idaho health care because of long distances to their own state health care services. Contact the State Office.

INCOME ELIGIBLE

An applicant's income must be verified to be within the limits of total household income level/family size as defined in the Income Eligibility Guidelines, or automatically income eligible based on eligibility for Medicaid, TANF, Food Stamps or CHIP.

NUTRITIONAL RISK

Nutrition Risk Criteria are specifically defined per category, and are assessed by a medical assessment (height, weight, hemoglobin or hematocrit, and pertinent medical information) and a nutrient intake evaluation.

ANTHROPOMETRIC SCREENING

Requirements

Measurement of weight and height (or length) is required at certification for assessing nutritional risk.

Measurements from another source (e.g., physician's office) may be used if the measurement was taken within 60 days of the certification and is reflective of the current category.

Exceptions (document in participant file):

- An applicant who has a medical condition or disability which makes obtaining the measurement at certification impossible
- An applicant who has a disability that prevents his/her presence at certification

Measuring Weight

Staff are to perform measurements according to the techniques described in the Paraprofessional Training Manual.

Measurements must be recorded on growth charts or prenatal weight gain charts and in the omputer system.

Measuring Height

Staff are to perform measurements according to the techniques described in the Paraprofessional Training Manual.

Measurements must be recorded on growth charts or prenatal weight gain charts and in the computer system.

INFANTS

Infants are measured without clothing and diaper.
Infants are weighed using an infant scale and measured using a recumbent length board.

CHILDREN

Children are measured in minimal indoor clothing (without coat/hats/boots, in light shirt/pants without shoes).
Child weight is measured using either an infant scale or an adult scale. Which scale to use is determined by the size of the child and up to the discretion of the CPA and responsible adult.
Child length is measured using a recumbent length board if the child is less than 24 months of age.
Child height is measured using a wall stature board if the child is more than 24 months of age, unless the child is too small to use a stature board. If recumbent length is measured, the length must be plotted on the correct growth chart.

WOMEN

Women are measured in minimal indoor clothing (without coat/hats/boots, in light shirt/pants without shoes).
Women are weighed using an adult scale (floor model).
Women are measured using a wall mounted stature board.

CALIBRATION OF EQUIPMENT

Calibration means to standardize a measuring instrument by determining its deviation from a known standard. Each piece of anthropometric equipment should be evaluated at least quarterly to make sure it is calibrated and in working order.

The WIC Coordinator must maintain a written record of equipment calibration and staff training for use of equipment. The Idaho WIC Paraprofessional Training Manual should be used to train staff.

HEMATOLOGICAL SCREENING

A hemoglobin or hematocrit test is required at certification for assessing nutritional risk.

Test results from another source (e.g., physician's office) may be used if the measurement was taken within 60 days of the certification and reflective of the current category.

Exceptions:

- Infants less than nine (9) months of age
- Children two (2) years and older only need one test per year if the test was within normal limits at the previous certification.
- Breastfeeding women only require one postpartum test.

Exceptions (document in participant file):

- An applicant who has a medical condition or disability which makes obtaining the test measurement at certification impossible
- An applicant who has a disability that prevents his/her presence at certification
- An applicant who has cultural, personal, or religious beliefs that conflict with drawing blood

Staff are to perform the hemoglobin/hematocrit test according to the manufacturer's specifications for the machine used and in accordance with CLIA and OSHA recommendations.

REFERENCE

- 7CFR 246.7(e)(1) Determination of Nutritional Risk
- WRO Policy Memorandum 803-AP, Nutrition Risk Criteria (March 30, 2001)
- Nutritional Screening of Children: A Manual for Screening and Follow-up, US Department Health and Human Services Administration, Bureau of Community Health Services, Publication No. HAS 81-5114, 1981
- Lohman, TG et al, editors. Anthropometric Standardization Reference Manual. Human Kinetics Books, 1988, pp.4-8.
- Simko MD et al. Nutrition Assessment: A Comprehensive Guide for Planning Intervention. Aspen Publications, 1984, pp. 72-80.
- All States Memorandum, 803-M, Blood work Protocols, July 27, 1992.

PRIORITY LEVELS

Effective: 01/xx/01
Revision: N/A

CLARIFICATION

According to the category and nutritional risk criteria identified by a Competent Professional Authority, a priority level is assigned to each participant. The priority level establishes the need for WIC services and prioritizes the applicants for WIC services.

- A breastfeeding mother and her breastfed infant must be placed in the same priority level and should be the highest for which either qualifies.

PRIORITY I

- Pregnant women (P), Breastfeeding women (B), or Infants (I) who are at risk based on medical assessment

PRIORITY II

Infants up to six months of age born to a WIC mother, or born to a mother who was at nutritional risk during her pregnancy, but was not enrolled in WIC during the pregnancy

- A Breastfeeding (B) mother of a totally breastfed Priority II infant will also be assigned Priority II.

PRIORITY III

- Children (ages 1 to 5) who are at risk based on medical assessment
- Postpartum women (N) who were less than 16 years old at conception

PRIORITY IV

- Pregnant women (P), Breastfeeding women (B), or Infants (I) who are at risk based on diet evaluation only
- Postpartum, non-breastfeeding women (N) who have two or more nutritional risks based on medical risk only, excluding diet

PRIORITY V

- Children (ages 1 to 5) with diet-related risk only

PRIORITY VI

- Postpartum women (N) who have one nutritional risk, may include diet codes and transfer code (# 79)

ADOPTION AND WET NURSES

Effective: 01/xx/01
Revision: N/A

POLICY

A breastfeeding woman does not have to be the birth mother of the infant to be certified as a breastfeeding woman. Wet nurses and nursing adoptive mothers are eligible if they meet eligibility criteria. However, both the birth mother and adoptive mother of the same infant cannot be certified as breastfeeding women. The birth mother would only qualify as a postpartum woman. This applies if the relationship is known to exist.

ADOPTED CHILD

When a family adopts a child, the family size and income of the entire family is used to determine income eligibility. Typically, the adopted child will have been a foster child in the home for some time prior to adoption.

When a child is adopted, it may be necessary to sever all ties with the previous identity, including issuing a new WIC participant ID and Social Security number. Contact the WIC Help Desk for guidance. The appropriate procedure is determined on a case-by-case basis.

REFERENCE

- FNS Instruction 803-R *WIC Eligibility of Wet Nurses* (6-25-93)
- FNS Instruction 803-AC Non-Birth Mothers Certified as Breastfeeding Women (10-16-95)

FOSTER CHILDREN

Effective: 01/xx/01
Revision: N/A

POLICY

An infant or child in foster care is certified according to standard procedures. A foster child living with a foster family, but remaining the legal responsibility of the Department of Health and Welfare (DHW), is considered a family of one. Children in foster care should have automatic income eligibility because they are enrolled in Medicaid. The payments made by DHW to the foster family caring for the child are the household income for the child. Participant records should be maintained to protect the confidentiality of the parent(s) and the foster family.

PROCEDURE

1. The foster parent should provide documentation that he or she is a foster parent of the child, provide identification, complete an Application and read and sign the Participant Rights and Responsibilities.

2. Establish a Family ID number for each foster child. If a family has more than one foster child, a new Family ID is needed for each child. One Responsible Adult may have multiple Family ID numbers. A child should not be listed as the Responsible Adult. If a foster child moves from one foster family to another foster family, establish a new Family ID number for that child and update the responsible adult data in IWICS. This is currently the only means to keep the IWICS check history accurate

3. The Responsible Adult name is printed on the Verification of Certification screen. If it is necessary to maintain confidentiality of the foster parent, staff may use the following Responsible Adult pseudonym:

   a. Last name = FOSTERPARENT
   b. First name = First Initial Last Name
   Example: FOSTERPARENT, TSMITH

4. Household size = 1, household income = foster care award/grant

5. Indicate child is in foster care on the Client Basic screen

6. Issue a WIC Identification Folder to the foster parent. It is acceptable to issue one folder per foster family with multiple children listed on the folder.

7. At certification, assign nutrition risk criteria 804 if within the preceding six months the child has entered the foster care system, or has moved from one foster family to another.

Local agency Coordinators may develop local procedures as needed (e.g., a procedure for maintaining the participant file).

CHILD IN TEMPORARY CARE

This refers to an infant or child in temporary care of friends or relatives, but not in the legal custody of the Idaho Department of Health and Welfare or other welfare entity (e.g., as in the case of families of military personnel if the absent parent(s) are serving in the military).

PROCEDURE

Staff shall use either of the following options, depending on individual family circumstances.

1. Count the absent parents and children in the household size as would have been the case prior to the parents' departure. Use of this option depends on whether staff is able to reasonably determine income from documentation provided by the friends or relatives who are caring for the children.

2. If the first option is not feasible, consider the children to be part of the temporary caretaker's household.

REFERENCE

- FNS Instruction 803-3, Revision 1 Income Eligibility: Definition of Family and Economic Unit (4-1-88)
- FNS Instruction 800-1 Confidentiality: Release of Information to Applicants and Participants (3-30-90

IMMIGRANTS AND FOREIGN STUDENTS

Effective: 01/xx/01
Revision: N/A

POLICY

U.S. citizenship is not required to receive WIC services in Idaho. Legal and illegal immigrants can apply for and receive WIC services.

Foreign students may participate in WIC without incurring public charge.

The Immigration and Naturalization Service (INS) issued a statement clarifying participation in WIC does not constitute public charge and INS should not request WIC benefits be repaid by a person of alien status.

Confidentiality requirements do not allow WIC staff to report any information about WIC participation to INS, or anyone else, without written consent from the participant.

REFERENCE

- WRO All States Memorandum 98-66 (3/27/98) Impact of Participation in the WIC Population on Alien Status (Immigrants and Foreign Students).

JOINT CUSTODY

Effective: 01/xx/01
Revision: N/A

POLICY

When parents have joint custody and maintain separate households, either parent may apply on behalf of the child, provided the parent has custody of the child at least 50% of the time. The other parent cannot apply for the same child but may apply for other children or for herself if she becomes pregnant.

The benefits for the child will be provided by the local agency to one Responsible Adult, usually the parent who makes the initial contact with the WIC office. It is the responsibility of the two parents to mutually agree on sharing the child's supplemental foods. The other parent can be a proxy if the Responsible Adult requests it.

The child receiving WIC benefits through one parent may be counted in each parent's household size regardless of the custody split.

Joint custody can be complicated, particularly if the parents reside in two separate local agency service areas and custody determination changes.

For example:
Becky's parents have joint custody and each parent has 50% custody. The mother applied for WIC and Becky has been certified eligible. Becky is included when determining household size of the mother and any child support payments the mother receives are counted as income. The two parents must decide how to share the foods.

If Becky's father has remarried, he or his wife may apply for WIC benefits for other children in his new household, but not Becky. He can count Becky as part of his household size. He cannot deduct the child support he pays to Becky's mother when determining income eligibility.

REFERENCE

- FNS Instruction 803-3, Revision 1 Income Eligibility: Definition of Family and Economic Unit (4-1-88)

MIGRANCY

Effective: 01/xx/01
Revision: 10/01/07

POLICY

Categorically eligible women, infants, and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purpose of such employment a temporary abode.

A temporary abode is established when the worker's job location requires him or her to leave the place of regular residence periodically (not permanently) for one or more days. A car, van, or camper may be considered a temporary abode when used for temporary residence.

Agriculture means farming in all its branches, including logging.

This applies to migrant farm worker families in which all members are relocated and families in which only one member is relocated.

INCOME DETERMINATION

- Migrancy income determination is valid for one year.

PROCEDURE

1. Determine if a family meets the definition of migrancy.

- Enter "Y" in Migrant field on Family Basic screen of IWCS system.

2. Ask if the applicant has a VOC document. Review the document (even if expired) to find out when income eligibility was last determined. If it was less than 12 months ago, accept the applicant as income eligible and proceed with the certification as needed. (See Transfer of Certification - VOC)

- Enter "Y" in the VOC field on the Family Basic screen.

- IWCS will generate Nutrition Risk Codes 702 Migrancy and also 79 Transfer of Certification - VOC, if applicable.

3. If no VOC document exists, follow income determination procedures and certification procedure if needed.

- Enter Nutrition Risk Code # 702 to Health Screen.

4. All applicants who are migrant workers must have a VOC card issued at the certification appointment. Refer to Issuing a VOC Document.

REFERENCE

- FNS Instruction 803-14 (1988) WIC Program certification: Eligibility of Special Populations
- WRO Policy Memo 803-X (1994) Loggers as Migrant Farm workers

PERSONS LIVING IN AN INSTITUTION

Effective: 10/01/03
Revision: N/A

POLICY

If an applicant is living in an institution, such as a mother and children temporarily living in a shelter home, she is still eligible to apply for WIC if the following conditions are met:

1. WIC foods given to the participant must not be transferred to the institution's own general inventory. The foods must be available to and used by the WIC participant only.

2. Food purchased with WIC checks cannot be combined and used in group feeding.

3. The institution cannot restrict the use of the supplemental food by the WIC participant or restrict participation in any WIC services.

The family size and income determination does not include the other residents of the institution. The WIC family is considered an independent economic unit from the institution.

ELIGIBILITY OF SHELTER HOMES AND OTHER INSTITUTIONS

To the extent practical, local WIC agencies shall determine whether a homeless facility or institution complies with the conditions listed above. A full certification period may be given to an applicant without establishing the institution's compliance, but food package benefits (except infant formula) are to be suspended in subsequent certification periods if compliance has not been assured.

- Each local agency is encouraged to maintain a master list of eligible institutions so staff may make referrals if an institution is found to be out of compliance.
- Local agencies should periodically contact the institution to ensure continued compliance with the conditions outlined above, as deemed necessary.

REFERENCE

- 7CFR 246.7(n) Certifications of persons in homeless facilities and institutions
- ASM 803-13, WIC Program-Certification Eligibility of Persons Affiliated with Institutions, 11-27-87.

VERIFICATION OF CERTIFICATION

Effective: 10/01/05
Revision: 10/01/07

OVERVIEW

Verification of Certification (VOC) documents are intended to facilitate the transfer of currently eligible WIC participants between states and from those participants who have been participating in the program at another local agency within Idaho who fall under the status of homeless or migrant farm worker. An individual who has a current certification date does not have to go through the certification process until the certification period expires. A VOC document represents proof of nutritional risk.

POLICY

Local agencies shall accept valid Verification of Certification (VOC) information and documentation from out-of-state WIC participants and certification documentation from all persons who have been participating in the WIC program in another local agency within Idaho.

Local agencies shall provide VOC information for each participating family member for whom there is an intention to relocate out-of-state during a certification period. Additionally, local agencies shall provide VOC information to out-of-state WIC agencies who request confirmation of a relocated WIC participant's certification.

DEFINITIONS

In-state Transfer: A participant transferring from one local agency to another local agency within the state of Idaho.

Out-of-state Transfer: A participant transferring into Idaho from another state, and a participant transferring out of Idaho to another state.

ACCEPTANCE OF VOC CARDS OR DOCUMENTS

VOC documents must be accepted as long as they have the minimum required information:

1. Participant name
2. Date the certification expires
3. Name and address of certifying local agency

In the event that the VOC document is missing any of the above required pieces of information, the local agency may contact the previous agency for information missing from the VOC document. *A separate signed release of information is not necessary when one WIC agency contacts another WIC agency.* Information may be taken over the phone, via fax or letter from another state or local agency in order to not create a barrier to service.

Any individual who presents a valid VOC card or document must be served for the length of certification noted on the VOC document, regardless of whether he/she meets Idaho's eligibility criteria. However, the transferring participant must be categorically eligible.

Example: If the transferring participant was last certified as Breastfeeding, but has since stopped breastfeeding and her infant is greater than six months of age, the woman is not eligible as a transfer since she no longer meets the category requirement.

Example: A child whose VOC card indicates a certification period that expires after the end of the month of the child's fifth birthday, is not eligible as a transfer since she/he is no longer categorically eligible.

Example: Individuals who present a VOC card or document with an expired certification date must reapply as new applicants.

WAITING LISTS

In the event that the State of Idaho WIC Program is operating under a strict caseload management policy and is not enrolling any applicants, participants with a current VOC card or document shall be placed on the list ahead of all other waiting applicants, regardless of priority ranking. If more than one transferring participant with a current VOC card or document must be placed on the waiting list, they shall be placed in order of priority rank.

PROCEDURE – TRANSFER OF CERTIFICATION (VOC)

If the participant is transferring from another clinic within the state:

- Transfer the participant into the local agency clinic by using the Transfer [F4] function on the Common Client Directory Screen in the Idaho WIC Computer System.
- Check the certification end date. If the certification has expired, process as a new applicant. If the certification has not expired, provide the next available appointment in order to prevent a break in services.

If the participant is transferring from another state:

- If the certification period has not expired and the VOC card or document contains all of the required information, provide the next available appointment in order to prevent a break in services.
- Check the date the income eligibility was determined. A migrant worker should have income reassessed if the date is more than one year.
- Enter the family and participant information into the Idaho WIC Computer System. Enter "Y" in the VOC field on the Client Basic screen. This generates Nutrition Risk Criteria #79 Transfer of Certification (VOC) on the Client Health Screen. This code is specifically meant to be used for participants lacking sufficient health and nutritional risk information on the VOC document. It allows the computer to certify without health information.
- File the VOC document in the participant's chart.

For all transfers:

- Verify the identity and residence of the participant.
- Have the participant or responsible adult complete an Application and review Participant Rights and Responsibilities.

- Educate the participant/responsible adult about WIC in Idaho. Issue checks and Identification Folder and explain how to use checks, if necessary.
- Provide nutrition education and make referrals as needed.

ISSUING A VERIFICATION OF CERTIFICATION DOCUMENT (VOC)

Effective: 10/01/05
Revision: N/A

VOC ISSUANCE

Verification of Certification (VOC) documents will be issued to:

- A participant who indicates he/she will be moving out of Idaho during the current certification period
- A participant in a family with a migrant farm worker
- A participant in a homeless situation

VOC documents should be issued to migrant and homeless participant(s) at certification, regardless of whether they will be moving or not.

Issue a VOC document by completing Form 116, *Verification of Certification*. The top portion of the form is blank for a screen print of the "Verification of Certification" screen in the Idaho WIC Computer System. Local agency staff should sign the document and complete the information about the clinic site. This information is provided so the clinic where the participant is relocating may be in contact should additional information be needed.

Completed VOC documents shall, at a minimum, include:

- The participant's name
- The date the certification was performed
- The date income eligibility was last determined
- The period for which the last WIC checks were issued
- The nutritional risk(s) of the participant
- The date the certification expires
- The signature and printed or typed name of the certifying local agency staff
- The name and address of the certifying local agency
- Idaho WIC participant ID number

Instruct the responsible adult to:

Call the WIC clinic where he/she is moving and make an appointment. Provide the responsible adult with the name and address of the WIC clinic closest to where he/she is moving, if possible.

Inform the *new* clinic that they have a VOC document from Idaho. The new clinic will either give the participant an appointment to pick up checks or put them at the top of the waiting list, if there are no open appointments for checks.

Instruct the participant *not* to use Idaho WIC checks anywhere other than Idaho. If there are any unspent WIC checks left when they move, the responsible adult should give them to the new WIC clinic.

Update the status to "**CLO**" on the **Client Basic Screen** in the Idaho WIC Computer System. The reason closed is "**(01) Moved from Clinic Area**"

Do not change the status to CLO for migrant or homeless participants. The Idaho WIC Computer System will automatically terminate a participant for failing to pick up checks for two consecutive months.

Mailing of VOC Card

Participants may request a VOC card after they have already moved out of state. Upon receipt of a verbal or written request, the local agency shall forward a completed VOC document to either the participant's new local agency or the participant. The order of preference regarding where VOC cards are to be mailed is as follows:

1. To the participant's new local agency, if known
2. Directly to the participant

If the request to mail a VOC card is received by mail, by fax, or verbally by phone, the local agency shall take reasonable steps to confirm the identity of the individual making the request. The local agency must document in the participant chart the address to which the VOC will be mailed or the agency where the VOC is to be faxed.

Replace the card if needed and make a note in the participant's chart describing the circumstances and solution.

Issuing Duplicate VOC Card

Local agencies shall provide participants with a duplicate VOC document *only* if the original VOC document is returned to the local agency. A comment needs to be written in the participant's chart explaining the reason for a duplicate issuance of the VOC card.

If a participant has lost his/her VOC document and applies for program benefits at a new out-of-state agency as a transfer, the participant's new out-of-state agency may contact the participant's prior local agency to verify the participant's identity and to request certification information. The prior local agency shall accommodate the new local agency's request by printing and forwarding a new VOC document by mail or fax to the new out-of-state agency.

NOTE: A VOC document shall not be printed and mailed to a participant who has lost a VOC which was issued in person or mailed. In the case of a lost VOC, it may only be faxed or mailed to an out-of-state local WIC agency.

References

- FNS Instruction 803-11, Rev. 1 (1988) *Verification of Certification Document*
- FNS Instruction 803-G, Rev. (1993) *Verification of Certification*
- 7 CFR 246.7(k) and 246.25 (a)

SECTION B: CERTIFICATION

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

IN THIS SECTION

Processing Applicants
Certifying Schedule
Certifying Pregnant Women
Certifying Breastfeeding Women up to One Year
Certifying Infants
Certifying Children
Documentation Required at Certification
Required Documentation Not Available
Certification Procedures
Required Referrals
Required Screening

PROCESSING APPLICANTS

Effective: 01/xx/01
Revision: N/A

POLICY

When there are funds available to provide program benefits, the local agency will:

Accept applications
Arrive at eligibility determinations
Notify the applicants of the eligibility status
Provide nutrition education and referral
Issue food checks to eligible applicants

TIMEFRAMES FOR PROCESSING APPLICATIONS

All of the above actions will be accomplished within the following time frames:

Pregnant women and members of migrant workers and their family members who soon plan to leave the service area of the local agency must be notified of their eligibility or ineligibility within 10 working days of the date of the first request for program benefits.

All other applicants shall be notified of their eligibility or ineligibility within 20 working days of the date of the first request for program benefits.

The processing timeframes begin when an applicant visits the local agency to make an oral or written request for program benefits. At the time of the request, instruct the applicant to complete an Application Form. Fill in the date applied for WIC services and the appointment date (upper left-hand corner). When the applicant returns for the certification appointment, the staff person should verify income, residence, identification, and complete the eligibility section on the back page of the Application Form.

Local agencies may have a local policy determining if they will accept telephone requests for application.

RECERTIFICATION

Recertification is treated as a new certification. Participants who are to be recertified have no priority for appointments over those on the waiting list or VOC document holders.

REFERRAL DATA

Certification of nutritional risk may be based on medical data (height, weight, hematocrit or hemoglobin) from another health care provider and which is less than 60 days old. The interval for the return certification will be based on the date when the medical data was taken and entered in IWCS. Pregnant women are exceptions to this rule; their return certification date is calculated six (6) weeks (42 days) beyond the EDC.

APPOINTMENT COORDINATION AND SCHEDULING

When possible, appointments should be scheduled to coincide with other clinic appointments and transportation availability. Appointments should not knowingly require a person to take time off of work.

Pregnant Women Who Miss First Appointment

The local agency shall attempt to contact (by phone call or by mail) each pregnant woman who misses her first appointment to apply for WIC in order to reschedule the appointment. At the time of the initial contact, the local agency shall request an address and telephone number where the pregnant woman may be contacted.

A record of this attempt must be kept.

References

7 CFR 246.7 (f) Processing Standards
7 CFR 246.7 (b)(6) Program Referral and Access

CERTIFYING SCHEDULE

Effective: 06/01/05
Revision: 10/01/05

CERTIFICATION PERIOD LENGTH

- **Pregnant women** are certified for the duration of their pregnancy and for up to six (6) weeks postpartum (after delivery).

- **Breastfeeding women** may be certified up to one year or for six (6) months, whichever is longer, ending with the breastfeeding infant's first (1st) birthday.

- **Postpartum women** are certified for up to six (6) months postpartum (after delivery).

- **Infants (under age 1)** are certified up until age 1 or for six (6) months, period.

- **Children (ages 1 to 5)** are certified at intervals of approximately six (6) months, and ending with the day prior to the child's fifth (5th) birthday

NOTICE OF CERTIFICATION END

Participants shall be advised that the certification is ending at least 15 days before the certification expires.

If the certification is ending because the participant is no longer categorically eligible, the notice must include information about why he or she is no longer eligible and the right to request a fair hearing.

A participant is no longer categorically eligible for the following reasons:

Moved from the clinic area (01)
Reported income too high (03★)
Requests termination from program (11)
Child turns 5 years old (06★)
Woman is categorically ineligible (09★)
Failure to pick up checks for 2 months (07★)

REFERENCE

7 CFR 247.7 (j)(8) Notification of Participant Rights and Responsibilities
7 CFR 246.7 (g) Certification Periods

CERTIFYING PREGNANT WOMEN

Effective: 01/xx/01
Revision: N/A

POLICY

Pregnant women are certified for the duration of their pregnancy and for up to six weeks postpartum (after delivery).

PREGNANT WOMAN WHO DELIVERS OR WHOSE PREGNANCY ENDS

A woman who is certified during pregnancy has a certification period that lasts until six weeks after the pregnancy ends. She can receive WIC checks and services based on the pregnancy certification during that time (up to six weeks after delivery). This is true whether she delivers a baby or has a miscarriage.

To continue receiving WIC more than six weeks after the pregnancy ends, standard postpartum certification eligibility requirements apply.

Breastfeeding women may have their eligibility assessed any time up to one year postpartum.

REFERENCE

- ASM 803-AB, Categorical Eligibility and Postpartum WIC Benefits for Women Whose Pregnancy Terminated, Sept. 21, 1995

CERTIFYING BREASTFEEDING WOMEN UP TO ONE YEAR

Effective: 01/03/06
Revision: N/A

POLICY

- Breastfeeding women may be certified up to one year or for six (6) months, whichever is longer, ending with the breastfeeding infant's first (1st) birthday.
- Breastfeeding women who are less than six (6) months postpartum will be certified up to one year, ending with the breastfeeding infant's first (1st) birthday.
- Breastfeeding women over six (6) months postpartum will be certified for up to six months, also ending with the breastfeeding infant's first (1st) birthday.
- Nutrition/breastfeeding education must be provided to the postpartum woman within three (3) months after the initial certification, at the infant's 5-7 month health screen, and within three (3) months after the infant's health screen. This schedule for providing nutrition/breastfeeding education may vary based on the mother's postpartum certification date.

Local agencies will develop a plan for implementing postpartum breastfeeding education to ensure that nutrition education occurs twice every six months.

PROCEDURE

Breastfeeding woman *less than six* months postpartum
- The computer will automatically set the end date at the breastfeeding infant's first (1st) birthday.

Breastfeeding woman *over six months* postpartum
- The computer will automatically set the end date at the breastfeeding infant's first (1st) birthday.

Breastfeeding woman who stops nursing
- Follow the policy outlined in Chapter 4, Section C.

CERTIFYING INFANTS

Effective: 10/01/05
Revision: 06/01/05

OVERVIEW

An infant under six months of age may be determined to be at nutritional risk if the infant's mother was a WIC program participant during pregnancy. (**ID NRC 40**)

In addition, an infant may be determined to be at nutritional risk if the mother's medical history shows that she was at nutritional risk during pregnancy because of detrimental or abnormal medical conditions detectable by biochemical or anthropometric measurements or other documented nutritionally-related medical conditions. (**ID NRC 41**)

POLICY

Enrollment Certification
Newborn infants may undergo *enrollment certification* using birth weight, birth length, and Nutrition Risk Criteria (ID 40 or 41) through the end of the mother's pregnancy certification period (6 weeks postpartum).

Infants who are less than six months old will be certified up to one year of age. These infants must have a health screening between 5 and 7 months of age and a hemoglobin test done sometime between 9 and 12 months.

Infants over six months of age will be certified for a six-month period.

PROCEDURE

Infants who undergo enrollment certification using ID NRC 40 or 41:
Staff must *manually* enter a certification end date. The infant is only certified through the end of the mother's pregnancy certification, and must have his/her certification completed when the mother is certified postpartum (within 6 weeks of delivery).

In order to support breastfeeding, local agencies are encouraged to assess breastfeeding and make any necessary referrals for the continuation of breastfeeding.

Infants less than six months of age:
The computer will *automatically* set the certification end date at one year from the date of birth. Staff may *manually* shorten this certification end date any time between 9 and 12 months of age.

Deciding when the certification should end depends on the following:

Collecting hemoglobin or hematocrit (between 9 and 12 months of age)
Scheduling to coincide with other family members on WIC

Infants six months of age or older:
The computer will *automatically* set the certification end date six months in the future.

REFERENCES

- 7CFR Subpart C 246.7(e)(1)(ii) Certification of Participants-*Priority II*.

CERTIFYING CHILDREN

Effective: 01/xx/01
Revision: N/A

POLICY

Children (ages 1 to 5) are certified at intervals of approximately six (6) months, and ending with the day prior to the child's fifth (5th) birthday.

DOCUMENTATION REQUIRED AT CERTIFICATION

Effective: 01/xx/01
Revision: N/A

POLICY

Applicants must provide documentation that they meet the eligibility criteria for WIC. Staff must verify that the applicant provided each of these proof documents.

The purpose of this policy is to strengthen the integrity of the WIC certification process, prevent dual participation, and make sure WIC services are provided only to those applicants who are truly eligible.

If the applicant fails to provide this documentation at the certification appointment, a 30-day temporary certification period is available.

Providing documentation should be implemented in a manner that does not constitute a barrier to any applicant, particularly a person who is mobile, such as a homeless person, a person in the military, or a migrant.

CATEGORY

The applicant must provide proof he or she belongs to a category served by the WIC Program. This is determined by identification and proof of pregnancy.

Identification
Acceptable proof of identity includes:

- Social Security card
- Driver's license
- Birth certificate
- Crib card
- Government-issued identification
- Immunization record
- WIC Identification Folder

Visual identification is permissible at subsequent certifications once initial proof of identity has been established.

PROOF OF PREGNANCY

If a woman is not visibly pregnant, she must provide documented proof of her pregnancy. An EDC written on a prescription pad or copy of an ultrasound with an EDC is adequate proof.

RESIDENCE WITHIN HEALTH SERVICE AREA

Applicants must present proof of residence in the health service area. This means establishing the physical location or address where an applicant routinely lives or spends the night.

There is no requirement for length of residency.

Acceptable proof of residency includes:

- Business letter or other postmarked mail addressed to applicant at the physical residence (not a post office box)
- Driver's license or passport
- Paycheck stub with address
- Car registration
- Current utility bill (water, electric, gas, cable TV, sewer, trash)
- Rent or mortgage receipt
- State or local document which is obtained through proof of residency

NOTE: Proof of residency must show the address where the applicant currently lives.

INCOME

Income is defined as ***gross income***, before deductions for income taxes, employee Social Security taxes, insurance premiums, bonds, etc. The determination of the amount of a household's gross income shall not be reduced for any reason (e.g., financial hardship, medical bills, child support).

Use ***net income*** to determine income eligibility for self-employed persons. Net income is determined by subtracting the operating expenses from the gross income.

In order to assess income eligibility:

- Determine household size.
- Assess automatic (adjunct) eligibility on the basis of eligibility to receive Medicaid (MA), Food Stamps (FS), Child Health Insurance Program (CHIP), or Temporary Assistance for Needy Families in Idaho (TANF).

NOTE: Automatic eligibility is determined by verifying participation in or pending status approval for participation in any one of the above-mentioned programs.

- If not automatically income eligible, determine size of household/economic unit and assess total household income.
- If an applicant reports zero income or has no proof of income, the applicant must sign a No Proof Form declaring this.

Income eligibility is determined by comparing the household/economic unit's **gross** income against the Income Eligibility Guidelines. Income guidelines are updated yearly and become effective on July 1. If the household income is *equal to or less than* these guidelines, the applicant is income eligible.

Local agency staff may need to convert the information to monthly income in order to use the Income Eligibility Guidelines chart.

Frequency of Income	To Calculate Monthly Income
Weekly	Multiply by 4.3
Bi-Weekly (every two weeks)	Multiply by 2.15
Semi-Monthly (2 times per month)	Multiply by 2.0
Monthly	Use Actual Value
Quarterly	Divide by 3.0
Annual	Divide by 12.0
Hourly	Rate x hours per week x 4.3
Daily	Rate x 5 or number of days worked per week x 4.3
Lump Sum	Divide by 12.0

HOUSEHOLD/ECONOMIC UNIT SIZE

Staff shall determine the number of persons living in the household/economic unit. A household is an economic unit composed of one person or group of persons, related or non-related, who usually live together and share economic resources and consumption of goods or services to support the household. The term "household," "economic unit," and "family" may be used interchangeably.

It is possible for two households to reside under the same roof. A woman living with another person or group of persons, for example, who pays for her own living expenses can be her own household.

PREGNANT WOMEN

A pregnant woman is counted as a household/economic unit of two (2). A woman expecting a multiple birth (more than one fetus) may be counted as three or more if she provides written confirmation of the number of fetuses from a medical care provider. This option should only be used if the woman is not income eligible when she is counted as two, but would be income eligible if the multiple fetuses were counted. **Exception:** If the applicant indicates that cultural, personal, or religious beliefs conflict with increasing the household size, then do not count the fetus.

RESIDENTS OF AN INSTITUTION

A group of residents of a homeless facility or an institution *shall not* be considered as one (1) household. An individual or group of individuals (e.g., a woman and two children) who reside in a homeless facility or an institution are counted as a separate household.

AUTOMATIC (ADJUNCT) INCOME ELIGIBILITY

By law, persons and/or certain family members certified as eligible for some assistance programs at the time of WIC application are automatically income eligible for WIC. These applicants are not subject to the income guidelines used in Traditional Income Eligibility. Because these programs generally document income, their use for WIC income eligibility determination helps strengthen the integrity of the WIC income eligibility determination process without undue burden to WIC.

An applicant is automatically income eligible for WIC if documentation shows that the individual is one of the following:

- Certified as fully eligible to receive benefits from Medicaid (MA), Food Stamps (FS), Child Health Insurance Program (CHIP) or Temporary Assistance for Needy Families (TANF).
- Determined to be presumptively eligible for the above-mentioned programs pending completion of that program's eligibility process.
- A member of a household containing:
    1. a TANF recipient
    2. a pregnant woman or infant currently on Medicaid

	Medicaid	**TANF**	**Food Stamps**
Pregnant woman	Self and household members	Self and household members	Self
Infant	Self and household members	Self and household members	Self
Child	Self	Self and household members	Self

Proof of automatic income eligibility based on eligibility in Medicaid (MA), Food Stamps (FS), Child Health Insurance Program (CHIP) and/or Temporary Assistance for Needy Families (TANF) *must be confirmed* at the time of application. Self-declaration is not sufficient. Documentation must accurately represent current eligibility for participation in such a program.

Documentation may include:

- Computer system match
- Notice of eligibility letter or card showing current eligibility dates
- Online or telephone access to adjunct programs which indicate current status
- Quest cards by themselves are not adequate because they do not include the period of eligibility. They are acceptable if they can be scanned on a machine to show the eligibility period.

NOTE: WIC staff must obtain a verbal report of income for households where applicants are automatically income eligible. If the verbally reported income exceeds the upper limit for the household size and there is proof the applicant is automatically eligible, enter the household income as the maximum eligible dollar amount.

TRADITIONAL INCOME ELIGIBILITY

If an applicant is not automatically income eligible or staff is unable to substantiate automatic income eligibility with the information provided, Traditional Income Eligibility screening is required. In order to apply the guidelines, household size and total income must be determined.

Income eligibility determination is based on gross income received 30 days prior to application for WIC services.

- Annual income is used if household income fluctuates due to seasonal work, periodic layoffs, or self employment.
- Net income is used for self-employed people.

Local agencies should request that applicants bring income documents which cover the period for the previous 30 days to the certification appointment. The local agency may choose to use income documentation which covers more than 30 days if this better reflects the applicant's income at the time he/she is applying for WIC services (includes periods of unemployment such as layoffs, maternity leave or seasonal work). Do **not** include future income or changes in income that may happen in the future. (Source of Income Chart)

If the applicant does not bring income documents to the certification appointment, a verbal income may be taken and recorded at the time of certification. The applicant has 30 days to provide the income documentation.

Only one income determination is required in a certification period. Once an applicant is certified as "income eligible" he/she remains so for the duration of the certification period. If a participant shares a change in income mid-certification and this information is not solicited by staff, an income reassessment should be made. If at the reassessment of income mid-certification the participant is found to over income, he/she will be ineligible for program participation. Reason for program ineligibility must be documented and must be shared with the participant a minimum of 15 days prior to program termination. Reassessment of income mid-certification is <u>not</u> required if sufficient time does not exist to effect the change. Sufficient time means 90 days prior to the expiration of the certification period.

NOTE: A participant's certification period is to end on December 15. He/she comes to a WIC appointment on September 1 and states he/she may be over income due to a job change. An income reassessment must be done since it is more than 90 days until the certification ends.

Source of Income	Examples of Acceptable Proof of Income
Salary, wages, tips, commissions, bonuses	▪ Current pay stub(s) with information about pay timeframe (e.g., weekly, bi-weekly, monthly) ▪ Signed statement from employer indicating gross cash earnings for a specified period
Net income from self-employment	▪ Income tax return for the most recent calendar year ▪ Accounting records for the self-employed
Regular cash contributions from persons not living in the household	▪ Letter from person contributing resources to the household
Child support payments or alimony	▪ Divorce decree ▪ Award letter ▪ Copy of check received
Cash assistance payment(s)	▪ Decision letter ▪ Quest card
Social Security benefits	▪ Check stub ▪ Award letter from Social Security stating current amount of earnings ▪ Bank statement
Foster care	▪ Foster child placement letter ▪ Foster parent award letter
Student financial assistance, such as grants and scholarships. Certain grants and loans will not be counted as income.	▪ Award letter ▪ Scholarship letter
Unemployment compensation	▪ Unemployment letter or notice
Active military payments	▪ Recent Leave and Earnings Statement ▪ Pay stubs, vouchers, allotments or bank statements confirming the amount of deposit
Net rental income	▪ Income tax return for the most recent calendar year
Dividends or interest on savings or bonds, income from estates, trusts or investments	▪ Income tax return for the most recent calendar year ▪ Bank or account statements
Private pensions or annuities	▪ Income tax return for the most recent calendar year
Government civilian employee or military retirement or pensions or veteran's payments	▪ Annual statement that shows monthly amount of retirement income
Other cash income such as withdrawals from savings, investments, trust accounts and other resources that are readily available to the household	▪ Bank account statements indicating regular draws on the account(s)

INCOME EXCLUSIONS

Income does not include the following:

Child Care: Any child care payments from the following:

- Title IV-A Child Care Program
- Idaho Child Care Program
- At-Risk Child Care Programs
- Child Care Development Block Grant

Compensation

- Payments made under the Disaster Relief Act of 1974, as amended by the Disaster Relief and Emergency Assistance Amendments of 1989
- Payment received due to the Agent Orange Compensation Exclusion Act
- Payment received from Wartime Relocation of Civilians under the Civil Liberties Act of 1988 (Japanese Internment Camps)

Elderly

- Payments received under the Old Age Assistance Claims Settlement Act, except for per capita shares in excess of $2000.00
- Payments received under the Judgment Award Authorization Act

Food Assistance: The value of assistance to children or their families from the following programs:

- School Lunch Program
- Summer Food Service Program
- Child and Adult Care Food Program
- Special Milk Program
- School Breakfast Program
- Food Stamp Program
- Food Distribution Program (e.g., on Indian Reservations)
- Food Bank Programs

Housing

- Reimbursements from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Payments received under the Cranston-Gonzales National Affordable Housing Act, unless the household's income equals or exceeds 80% of the median income of the area
- Payments received under the Housing and Community Development Act of 1987, unless the household's income increases at any time higher than 50% of the median income of the area
- Payments of allowances received from the Home Energy Assistance Act of 1980
- Military housing allowances
- In-kind housing

In-kind Benefits: Such as housing, food, clothing

Job Training: Payments received under the Job Training Partnership Act from the following programs:

- Adult and Youth Training Programs
- Summer Youth Employment and Training Programs
- Dislocated Worker Programs
- Programs for Native Americans
- Migrant Seasonal Farm Workers Programs
- Veterans Employment Programs
- Job Corps

Lump Sum Payments

- Earned Income Credit (EIC), a tax credit for families who work and have children
- Lump sum payments that represent reimbursements including those received from insurance companies for loss or damage of property and payments of medical bills resulting from an accident or injury

Military: Income received by the military individual(s) and all other income received by members of the household should be counted as income.

Income Exclusions:

- Mandatory salary reduction amount for military service personnel which is used to fund the Veteran's Educational Assistance Act of 1984 (G.I. Bill) as amended
- Military housing allowances
- Value of in-kind military housing and other in-kind benefits
- Military off-base housing allowances
- Family Subsistence Supplemental Allowance (FSSA)

NOTE: Military personnel serving overseas or assigned to a military base are considered members of the household even if they are not living with their families at the time of application to the WIC Program.

Native Americans: Payments to the Confederated Tribes and Bands of the following Native American Tribes:

- Yakima Indian Nation
- Apache Tribe of the Mescalero Reservation
- Grand River Bank of Ottawa Indians
- Passamaquoddy Tribe
- Penosbscot Nation
- Sac and Fox Indians (claims agreement)
- Navajo and Hopi Tribes (relocation assistance)
- Turtle Mountain Band of Chippewas (Arizona)
- Blackfeet Tribe (Montana)
- Gros Ventre Tribe (Montana)
- Assiniboine Tribes (Montana)
- Papago Tribe (Arizona)
- Red Lake Bank of Chippewas
- Saginaw Chippewa Indian Tribe (Michigan)
- Chippewas Tribe (Mississippi)

- Payments received under the Alaska Native Claim Settlement Act

- Income derived from certain submarginal land of the United States which is held in trust for certain Native American tribes

Student Financial Assistance: Student loans and grants used for tuition, student fees, the costs for rental or purchase of any required equipment, materials or supplies, books, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis.

Following are examples of student loans and grants that **are not** counted as income:

- Pell Grant
- Supplemental Educational Opportunity Grant
- State Student Incentive Grants
- Stafford Loans
- PLUS
- Supplemental Loans for Students
- College Work Study
- Byrd Honor Scholarships

Short-term, Non-secured Loans: Excludes loans to which the applicant does not have constant or unlimited access to monies.
Vocational Education: Payments received under the Carl D. Perkins Vocational Education Act and the Carl D. Perkins Vocational and Applied Technology Education Act Amendments of 1990

Volunteers

- Any payment to volunteers under Title I (VISTA and others) and Title II (Retired Senior Volunteer Program, foster grandparents, Senior Companions Program, and others)
- Payment to volunteers under Section 8 of the Small Business Act (SCORE and ACE)

CASH INCOME

If an applicant reports cash income payments, he or she should still provide documentation from the employer, if possible.

Request the applicant to have employer provide a written document which acknowledges the employment and rate of pay and number of hours worked. If unable to obtain, ask applicant to write a statement which describes the compensation in terms of hourly rate and number of hours worked.

INCOME CONFIRMATION FROM EMPLOYERS

To confirm income means directly contacting the source of income (i.e., employer) to determine if the documentation provided by the applicant is accurate and complete.

Staff may confirm income reported by applicants or participants when there is reason to suspect the applicant or participant is intentionally misrepresenting income. The reason for making such inquiry must be documented in the applicant/participant file. Reasons may include, but are not limited to:

- Applicant is paid in cash
- Contradictory information is given by applicant or participant
- Complaint made by another individual
- Information WIC staff may have about the financial situation of the applicant or participant

LUMP SUM PAYMENTS

Apply the following guidelines when deciding how to treat lump sum payments for WIC income eligibility:

Reimbursement

Lump sum payments which are reimbursed for lost or damaged property or payments for medical bills resulting from an accident of injury should **not** be counted as income (e.g., an insurance payment for property lost or medical bills).

New Money

Lump sum payments that are new money intended for income such as gifts, inheritances, lottery winnings, workman's compensation for lost income, and severance pay **are to be counted** as income.

Military temporary pay increases due to hazardous duty, combat pay, re-enlistment bonuses, **should be counted** as lump sum payments. Annual income should be used to assess income eligibility.

If the lump sum payment is income:

- Add the lump sum payment to the household's annual income and divide by 12 to calculate monthly income.

Combination of Reimbursement and New Money

If the lump sum payment can not be easily placed into one category (reimbursement or new money), determine what portion of the payment is reimbursement and what portion is considered new income. **Do not** count the reimbursement amount as income. **Do count** the amount which in new money as income.

MIGRANT WORKERS

Migrant workers' income is valid for one year. A migrant worker is an individual whose principle employment is in agriculture on a seasonal basis, who has been employed within the last 24 months, and who establishes, for the purpose of such employment, a temporary abode. Agriculture means farming in all of its branches, including logging.

This applies to migrant worker families in which all members are relocated and families in which only one member is relocated.

SELF-EMPLOYED

Net income is used to make income eligibility determinations for self-employed applicants or household members. Net income is calculated by subtracting the self-employment operating expenses from the gross receipts during the past twelve (12) months.

If the applicant is unable to provide the operating expenses and gross receipts for the past twelve (12) months, net income from the preceding year's Federal income tax return may be used only as a basis for the income determination. In such cases, the applicant is required to adjust the net income from the previous year as necessary to better reflect actual income over the past year. If using an income tax statement, the net income is listed on the 1040 U.S. Individual Income Tax Return under *Farm Income*.

Farm Income: Gross receipts include:

- Value of all products sold
- Rent received from farm land, equipment, or buildings
- Receipts from the sale of items such as wood, sand, gravel, etc.

Operating expenses include:

- Cost of feed, fertilizer, seed and other farming supplies
- Wages paid to farm workers
- Depreciation (must be documented on income tax return)
- Rent paid for farm land, equipment or buildings
- Interest on farm mortgages
- Cost of farm building repairs
- Farm taxes

NOTE: The value of fuel, food, or other farm products which are consumed by the household are **not** considered operating expenses.

Non Farm Income: Gross receipts include, but are not limited to:

- Value of goods sold or services rendered by the business

Operating expenses include:

- Cost of goods purchased
- Salaries and wages paid to employees
- Depreciation (must be documented on most recent tax return)
- Rent and utilities
- Business taxes (not personal income taxes)

NOTE: The value of services and merchandise which are consumed by the household *are not* considered operating expenses. If using an income tax statement, the net income is listed on the 1040 U.S. Individual Income Tax Return under *Business Income or Loss*.

STUDENTS

A student is someone who is attending school at least half time, as determined by the institution. This definition refers to college or a trade school and applies to the applicant or other household members.

Costs associated with attending school are subtracted from the income of students. These subtracted costs include:

- Tuition
- Student fees
- Rental or purchase costs for required equipment
- Materials or supplies
- Cost for books
- Transportation costs to attend school

NOTE: Room, board and dependent care costs *are* **not** excluded from student income.

The following are student loans and grants which **are not** counted as income:

- Pell Grants
- Supplemental Education Opportunity Grants
- State Student Incentive Grants
- Stafford Loans
- PLUS
- Supplemental Loans for Students
- College Work Study income
- Byrd Honor Scholarships

If a student applicant is found to be income eligible using the Traditional Income Eligibility status, continue with the certification. If the student applicant is found to be over income, subtract school-related expenses described above. Calculate the student's income over a semester or quarter and convert to monthly income for determination of eligibility.

TEENAGE APPLICANTS

A teenage applicant is someone who is less than 18 years old at the time of WIC application.

For teenage applicants residing at home with parent(s), determine if the total household income is within income eligibility limits. If the teenage applicant is supported by her parents, the parent's income should

be included in the household income. If it is, consider the teenage applicant income eligible and proceed with the certification.

If the teenage applicant is working to support herself and receiving assistance from her parent(s), she may be considered a separate household. For example, a teenage applicant is living with her parent(s) and has income with which she pays some rent, or she provides a service to cover room and board, such as babysitting or housecleaning, **do not** include the parent's income for eligibility determination.

ZERO INCOME

If an applicant reports zero income, ask additional questions to determine if there is any financial assistance or other support for living expenses.

If there is financial support provided by others, consider this information for income eligibility determination.

If the income is zero, the applicant must complete a No Proof Form which declares that he/she has no income. A copy of this form should be kept with the applicant record.

NOTE: The value of in-kind benefits **is not** counted as income. Providing housing, clothing, or food for someone is an in-kind benefit. Giving money to a person to buy food or to pay for housing is not an in-kind benefit, and this money **should be** counted as income.

REFERENCE

- FNS Instruction 803-3, Revision 1: *WIC Program Certification: Income Eligibility* 05/98.
- FNS Instruction 803-AI [All States Memo 99-54 (1999)]: *Strengthening Integrity in the WIC Certification Process*
- ASM, 00-48, *Publication of New WIC Income Poverty Income Guidelines*, 3/30/00.
- FNS Instruction 803-Q: *Child Care Payments Excluded from Income Consideration in WIC*, 2/19/93.
- 7 CFR 246.7(2)(D) *Verification (of Income) and Exclusions*
- 7 CFR 246.7(h) *Actions affecting participation in mid-certification*
- FNS Instruction 803-L: *Lump Sum Payments as Income*, 1992.
- FNS Instruction 803-14: *WIC Program Certification: Eligibility of Special Populations*, 1988
- FNS Instruction 803-X: *Loggers as Migrant Farm Work*ers, 1994
- FNS Instruction 803-AS, Rev. 2: *Treatment of Family Subsistence Supplemental Allowance in WIC Income Eligibility Determination*

REQUIRED DOCUMENTATION NOT AVAILABLE

Effective: 01/xx/01
Revision: N/A

POLICY

Forgot to Bring Required Written Documentation

If the applicant forgets to bring the required written proof of identity, pregnancy, residence, or income but verbally provides information that appears to make him or her eligible, a temporary, one-month certification may be granted.

The applicant has 30 days to provide the missing documentation. If he or she fails to provide the written proof after 30 days, the certification must be terminated. Refer to Ineligible at Mid-certification in Section D of this chapter.

Cannot Provide Required Documentation

In some situations, the applicant may not be able to provide the required proof for identity, residence or income (for example: homeless, migrant farm workers, military). The applicant must explain why he or she is not able to provide proof and a No Proof Form must be completed.

REFERENCE

Policy Memo 803-AI (1999) Strengthening Integrity in the WIC Certification Process

CERTIFICATION PROCEDURES

Effective: 01/xx/01
Revision: 10/01/07

POLICY

Certification procedures are outlined in greater detail in the *Idaho WIC Program Paraprofessional Training Manual*.

NEW APPLICANT

Give the applicant relevant forms to complete.

- Application for WIC (one per family)
- WIC Participant Rights and Responsibilities (one per family)

PHYSICAL PRESENCE REQUIRED AT CERTIFICATION APPOINTMENT

A local agency shall ensure that WIC applicants and/or participants are physically present at all certification appointments, with limited exemptions. In the case of infants and/or children, a parent or caretaker shall also be present.

Exemptions:

1. Infants under eight (8) weeks of age who cannot be present at certification for a reason determined culturally appropriate by the local agency and for whom all necessary certification information is provided, may be exempt from the physical presence requirement.

Local agency staff shall require the parent(s) and/or caretaker(s) to bring the infant to the next appointment after the infant reaches eight weeks of age unless the infant has been present at the WIC agency or been determined to fall within one of the other exemption reasons as stated below.

2. Participant(s) may be exampt from the physical presence requirement for WIC certification if being physically present would pose an unreasonable barrier to current participation under the following circumstances:

A participant or parent/caretaker of a participant who is a qualified individual with a disability as defined by the Americans with Disabilities Act. Examples are:

- a medical condition that necessitates the use of medical equipment that is not easily transportable
- a medical condition that requires confinement to bed rest
- a serious illness that may be exacerbated by coming into the WIC site
- a serious illness that is highly contagious (e.g., tuberculosis, etc.)

3. The infant or child applicant is under the care of one or more working parents or primary caretakers whose working status presents a barrier to bringing the infant or child into the WIC office. In two-parent/caretaker families, both parents/caretakers must be working and it must present a barrier to participation for the infant/child if neither person were able to leave work and bring the infant/child to the certification appointment.

NOTE: All applicants/participants with disabilities are not automatically exempt from physical presence at certification. Only those persons with a disability that creates a current barrier to the physical presence requirement may have a basis for exemption. All exemptions must be documented by a medical care provider. Documentation must include date, diagnosis, and reason for inability to come into the WIC site.

Determine Eligibility

Determining if applicant is eligible based upon category, residence in health service area, and income is done first. This process does not require using a Competent Professional Authority. It can be done by any trained WIC staff person.

If the applicant does not meet one or more of the above eligibility requirements, give him/her an Ineligible at Certification letter at this time.

If the applicant is eligible, complete the eligibility section of the Application Form and continue with the certification by conducting the health screening and determining nutritional risk.

Eligible Applicant Certification Procedures

An applicant who has met the eligibility requirements (for category, residence, and income to determine the fourth eligibility criteria) may complete the rest of the certification procedure. These steps must be performed by a competent professional authority (CPA).

1. Conduct a health screening by collecting nutrition-related information:

    - Height and weight
    - Blood test
    - Nutrition assessment

2. Determine the nutritional risk of the participant. Document the findings in the chart and computer.
3. If the applicant does not have at least one nutritional risk criteria, give him or her an Ineligible at Certification letter at this time.
4. If the applicant has one or more nutritional risk criteria, print and sign the Certification Record/Care Plan. The person is now eligible for WIC services.
5. Educate the participant about WIC, including a review of Participant Rights and Responsibilities.
6. Issue checks and Identification Folder and explain how to use the checks.
7. Provide nutrition education, make referrals, and schedule follow-up as needed.
8. If migrant or homeless, issue a VOC document.

References

- Consolidated Federal Regulations 7CFR 246.7(p)(1)(2)
- WRO Policy Memorandum 803-BA, Implementation of the Certification and General Administration Provisions of P.L. 108-265

REQUIRED REFERRALS

Effective: 01/xx/01
Revision: 10/01/07

POLICY

WIC benefits include providing applicants and participants with referral information. Required referrals at certification, as applicable, include:

Medicaid/Child Health Insurance Program – CHIP (MA)
Food Stamps (FS)
Immunization (IM)
Temporary Assistance for Needy Families – TANF/TAFI/Cash Assistance (TA)
Drug and Other Harmful Substance Abuse (SA)
Others, as needed

DOCUMENTATION

All referrals should be documented on the Verification of Certification screen and on the Certification/Care Plan form. Each referral type has a two-digit code.

MEDICAID, FOOD STAMPS, CHIP

At certification, each participant or responsible adult must be provided referral information about Medicaid and Food Stamps, and caretakers of children must receive information about CHIP.

IMMUNIZATION

During each certification appointment, review the immunization record of WIC children ages 0-24 months to determine if the child is up to date. At this time, WIC staff members also do the following:

1. Refer any children determined not up to date for immunizations
2. Provide education to parents of newborns about the importance of immunizations

NOTE: WIC offices in district health departments must maintain a copy of the immunization history for each WIC child, as specified in the current WIC/Immunization Linkage contract.

DRUG AND OTHER HARMFUL SUBSTANCE ABUSE

Drug and other harmful substance abuse screening, education, and referral are integrated into the certification process for pregnant women and into nutrition education activities for pregnant, postpartum, and breastfeeding women, and to parents or caretakers of infants and children participating in the program.

REQUIRED SCREENING

Effective: 01/xx/01
Revision: N/A

POLICY

SCREENING AND REFERRAL AT CERTIFICATION

All potentially eligible pregnant women will be screened for drug and other harmful substance abuse at certification by completing the Health and Diet Questionnaire for pregnant women. Screening is completed so that appropriate referrals can be made.

If a potentially eligible pregnant woman has concerns about her drug use or harmful substance abuse or if the Health and Diet Questionnaire identifies a potential problem with drugs or other harmful substance abuse, a referral must be made.

Local agencies must maintain a current list of local substance abuse counseling and treatment services. This must be printed and updated on at least an annual basis. The referral information may be included in a comprehensive written list of important local community resources that is used as a handout for participants.

EDUCATION

Local agencies must provide drug and other harmful substance abuse information to all pregnant, postpartum, and breastfeeding women, and to parents or caretakers of infants and children participating in the program. This information may be provided through handouts or information included in participant newsletters.

State Office will make available materials that can be used to educate WIC participants.

REFERENCE

7CFR 246.7 (a) Integration with health services
7CFR 246.7 (b) Program referral and access
7CFR 246.7 (o) Drug and other harmful substance abuse screening
7CFR 246.11 (a)(3) (General nutrition education)

SECTION C: MID-CERTIFICATION

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

IN THIS SECTION

Notice of Certification End
Category Changes in Women

NOTICE OF CERTIFICATION END

Effective: 01/xx/01
Revision: N/A

POLICY

Participants shall be advised the certification is ending at least 15 days before the certification expires.

If the certification is ending because the participant is no longer categorically eligible, the notice must include information about why he or she is no longer eligible and the right to request a fair hearing.

A participant is no longer categorically eligible for the following reasons

- Moved from the clinic area (01)
- Reported income too high (03★)
- Requests termination from program (11)
- Child turns 5 years old (06★)
- Woman is categorically ineligible (09★)
- Failure to pick up checks for 2 months (07★)

REFERENCE

- 7 CFR 247.7 (j)(8) *Notification of Participant Rights and Responsibilities*
- 7 CFR 246.7 (g) *Certification Periods*

CATEGORY CHANGES IN WOMEN

Effective: 01/xx/01
Revision: 10/01/07

POLICY

PREGNANT WOMAN WITH EDC CHANGE

If the EDC changes by less than two weeks, no changes need to be made to the computer system, the prenatal weight gain grids, or the Certification Record Care Plan Form.

If the EDC changes by two weeks or more staff should adjust the dates on the computer system and prenatal weight gain grids.

PROCEDURE

Paper Chart
Adjust the prenatal weight gain grid to reflect EDC change by drawing a line through the EDC written on the weight gain grids and writing in the revised EDC. The weight gain grid should be re-plotted to reflect the revised EDC. It should be very clear how this was done.

Computer
CERTIFICATION Screen (CR)

1. Press [*F11-Certify with New EDC Dt*] to activate an EDC change.
2. Enter revised EDC date and initials. [R-Ctrl]
3. Computer will assign revised *Cert End Date*

PREGNANT WOMAN WHO DELIVERS OR WHOSE PREGNANCY ENDS

Women who miscarry are treated the same as non-breastfeeding postpartum women.

Non-breastfeeding women who were not on WIC during pregnancy may be certified any time up to six months after the pregnancy end, even if the baby died or is no longer with the mother. There must be written documentation that a pregnancy existed if staff does not have prior knowledge of the pregnancy.

BREASTFEEDING WOMAN WHO NEEDS A BREAST PUMP (MANUAL OR ELECTRIC)

Women and infants who require a breast pump to support breastfeeding must both be certified eligible to participate in WIC to receive a manual pump or rented electric pump.

- If the woman is not enrolled in WIC, she cannot receive a WIC breast pump until she and her infant have been certified.

- If the woman is certified as a pregnant woman and she has recently delivered but has not yet had her postpartum WIC eligibility determined, she may receive a breast pump without being certified as a breastfeeding woman. Her infant must be added with nutrition risk code 40 (infant born to a WIC mom) when the breast pump is distributed. Both mother and baby should be scheduled for certification within six weeks of the delivery.

PROCEDURE

The preferred method is to conduct a complete certification at the first appointment after delivery. However, scheduling conflicts may prevent doing this, so a grace period is allowed and a "full" certification must be completed within six weeks of delivery.

In this situation, the following may be done after delivery to ensure the infant is added to the caseload of the clinic. This procedure is allowed when a breastfeeding infant is still in the hospital. Non-breastfeeding infants must be released from the hospital prior to doing this procedure.

Paper Chart
Document that the baby was added. Can use the calendar page or progress notes. The mother does not have to complete certification forms at this time because she has been on WIC.

Computer

COMMON CLIENT screen (CC)
Add infant following usual procedure

FAMILY BASIC screen (FB)
Update Income Eligible Date by pressing [F4-Income Elig]

Infant's CLIENT BASIC screen (CB)
Enter minimal required information (*Catg, Ethnic, Mom's ID*). [R-Ctrl]

Infant's CLIENT HEALTH screen (CH)
Enter *Birth Weight, Birth Length, Feeding* information and risk code 40 [R-Ctrl]

Infant's CERTIFICATION screen (CR)
Enter initials.
Press [*F4-Certify*] and change *Cert End Date* to six weeks from DOB [R-Ctrl]

BREASTFEEDING WOMEN WHO BECOME PREGNANT

A breastfeeding woman who is exclusively breastfeeding and **receiving an enhanced food package** may remain as category B until she is one year postpartum and no longer categorically eligible as a breastfeeding woman. At that time, she should be certified as a pregnant woman.

A breastfeeding woman who is **not receiving an enhanced food package** should be certified as a pregnant woman. Staff should remember to use nutrition risk criteria 610, Pregnant and Breastfeeding, and other criteria as applicable.

BREASTFEEDING WOMAN WHO STOPS NURSING

A breastfeeding woman who stops breastfeeding is in one of three situations described below.

A. **If she is more than six months postpartum**, she is categorically ineligible. Her participation in WIC must be terminated. See Ineligible at Mid-certification.

B. **If she is less than six months postpartum** and was eligible based solely on her infant (her only risk is a breastfeeding code 611, 612, or 614), she must be <u>certified</u> to establish if she is still eligible to receive WIC benefits.

C. **If she is less than six months postpartum** and qualified because of her own risks (she has other risks in addition to 611, 612, or 614), she may be kept on WIC <u>without a new certification</u>. Any nutrition risk criteria which only applies to breastfeeding women should be removed.

PROCEDURE FOR SITUATION C

Paper Chart
Write the changes on the Certification Record Care Plan by using a single line to cross off outdated information (Catg, Cert End Date, nutrition risk codes). Initial these changes. Update the Care Plan as needed and sign.

Computer
CLIENT BASIC screen (CB)
Press [*F5-Change Category*] to indicate a woman's category change
CLIENT HEALTH screen (CH)
Add new height and weight information, if taken. Otherwise, remove date and information from height and weight fields.
Review the nutritional risk codes and remove those which no longer apply. If there are no longer any applicable risks, do another diet recall and assessment. [R-Ctrl]
FAMILY BASIC screen
Ask if income has changed. Enter new amount if changed and press F4. If no change in income, press F4 to update date on income information.
CERTIFICATION screen (CR)
Enter initials
Press [*F4-Certify*] and computer will assign *Cert End* Date which is six months from ADD
CLIENT FOOD screen (CF)
Issue ONE (1) month or TWO (2) months of checks depending on the client's needs

NON-BREASTFEEDING POSTPARTUM WOMAN WHO RESUMES BREASTFEEDING

A non-breastfeeding woman who notifies staff she has resumed breastfeeding is in one of two situations described below.

A. **If she previously qualified as a breastfeeding woman** and the timeframe is still within that original certification period, she may be kept on WIC without a new certification. Any nutrition risk criteria which only applies to non-breastfeeding postpartum women should be removed.

B. **If she has not previously qualified as a breastfeeding woman**, she must be certified to establish if she is still eligible to receive WIC benefits.

It is acceptable to make the changes when she notifies staff of the change or to make another appointment. It is preferred to do it when she notifies staff, but not always possible.

Paper Chart
Write the changes on the *Certification Record/Care Plan* by using a single line to cross off the outdated information (*Catg, Cert End Date,* nutrition risk codes). Update the care plan as needed and sign.

Computer
CLIENT BASIC screen (CB)
Press [*F5-Change Category*] to indicate a woman's category change.
Change *Catg* to B.
CLIENT HEALTH screen (CH)
Change *BF%* to reflect the current situation.
Review the nutritional risk codes and remove those which no longer apply. Don't forget to add breastfeeding risk codes 611, 612, or 614 (if applicable) so she matches her baby's priority. [R-Ctrl]
CERTIFICATION screen (CR)
Enter initials.
Press [*F4-Certify*] and change the *Cert End Date* to six months from *Cert Begin Date* (instead of six months from ADD). [R-Ctrl]

SECTION D: INELIGIBLE

Effective: 01/xx/01
Revision: N/A

OVERVIEW

IN THIS SECTION

Ineligible at Certification
Ineligible at Mid-Certification

INELIGIBLE AT CERTIFICATION

Effective: 01/xx/01
Revision: N/A

POLICY

An applicant found ineligible at certification must be notified in writing and informed of the right to a Fair Hearing.

REASONS

An applicant will be found ineligible at certification for any of the following reasons:

- Lives outside the health service area
- Income too high
- No nutritional risk
- Lower priority than being served by agency

EXPLANATION

The agency must explain to the applicant why he or she is not eligible.

LETTER

Ask the Responsible Adult to sign a copy of an Ineligible at Certification letter and give him/ her a copy of the letter. File the letter in case a Fair Hearing is requested or a discrimination complaint is filed.

COMPUTER

The Idaho WIC Computer System (IWCS) will generate the ineligible code (INE) in the stat field on the Client Basic screen if over income, or if nutritional risk codes are missing.

DOCUMENTATION

A copy of the Ineligible at Certification letter, the Application, and other certification documentation must be kept in the participant's file for four years. If this is a new applicant, it may be kept in a designated place.

INELIGIBLE AT MID-CERTIFICATION

Effective: 01/xx/01
Revision: N/A

POLICY

A participant who becomes ineligible at any time before the certification period ends **shall be advised in writing at least 15 days before the disqualification.**

REASONS

A participant will be ineligible (closed) mid-certification for the following reasons:

- Moved from the clinic area (01)
- Reported income too high (03★)
- Requests termination from program (11)
- Child turns 5 years old (06★)
- Woman is categorically ineligible (09★)
- Failure to pick up checks for 2 months (07★)

IWCS will automatically put in the reasons 03★, 06★, 09★, 07★ and the stat field CLO for those reasons on the Client Basic Screen. Reasons not computer generated (01, 11) must be manually entered.

EXPLANATION

The agency must explain to the participant why he or she is not eligible.

LETTER

Ask the Responsible Adult to sign a copy of the Ineligible at Mid-Certification letter and give him/her a copy of the letter. File the letter in case a Fair Hearing is requested or a discrimination complaint is filed.

- A letter must be given for reasons (03, 11, 09).
- A termination notice instead of a letter may be given for reasons (09, 06)

DOCUMENTATION

A copy of the completed Ineligible at Mid-Certification letter, the Application, and other certification documentation must be kept in the participant's file for four years.

REFERENCES

- 7CFR, Sub part C, 246.7 *Certification of participants*
- E-mail from Tricia Barnes (06/29/99)
- Policy Memo 803-AC: *Non-Birth Mothers Certified as Breastfeeding Women* (issued as All States Memo 96-06, 10/06/95)
- Policy Memo 803-AB: *Categorical Eligibility and Postpartum WIC Benefits for Women Whose Pregnancy Terminated* (issued as All States Memo 95-148, 09/21/95)
- Policy Memo 803-R: *WIC Eligibility of Wet Nurses* (issued as All States Memo 93-119, 06/25/93)
- All States Memorandum *Participation Reporting, WIC Program* (11/30/88):

CHAPTER 5: NUTRITION EDUCATION

Effective: 02/02/06
Revision: 10/01/07

OVERVIEW

Nutrition education is a benefit available at no cost to all participants. Nutrition education is defined as "individual and group sessions and the provision of materials that are designed to improve health status and achieve positive change in dietary and physical activity habits, and that emphasize the relationship between nutrition, physical activity, and health, all in keeping with the personal and cultural preferences of the individual," as stated in the Child and Nutrition and WIC Reauthorization Act of 2004. Nutrition education should be easily understood and relevant to the participant and integrated into all areas of WIC. Individual care plans shall be developed for participants based on an individual's need for a care plan or for a participant who requests an individual plan.

IN THIS CHAPTER

Section A General Requirements

Section B Delivery of Nutrition Education

Section C Annual Participant Survey

Section D Local Agency Program Plan

Section E Nutrition Education Topic Codes

SECTION A: GENERAL REQUIREMENTS

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

IN THIS SECTION

Availability of Nutrition Education
Low Risk Contact
High Risk Contact
Drugs and Other Harmful Substances
Documentation of Contacts
Refusal of Nutrition Education

AVAILABILITY OF NUTRITION EDUCATION

Effective: 01/xx/01
Revision: N/A

POLICY

Nutrition education must be available to all participants through either individual or group sessions appropriate to the individual participant's nutritional risks and needs. A minimum of two nutrition education contacts must be made available during each six-month certification period for all adult participants, the parents or caretakers of infant and child participants, and the child participants themselves, when possible. Nutrition education shall be thoroughly integrated into participant health care plans, the delivery of supplemental foods, and other program operations.

GOALS

Nutrition education shall be designed to achieve the following broad goals:

- Stress the relationship between proper nutrition and good health with special emphasis on the nutritional needs of pregnant, postpartum, and breastfeeding women, infants, and children under five years of age.

- Assist the individual who is at nutritional risk in achieving a positive change in food habits, resulting in improved nutritional status and in the prevention of nutrition-related problems through optimal use of the WIC supplemental foods and other nutritious foods.

MINIMUM CRITERIA

Nutrition education contacts based on nutritional risks are defined in two categories:

- Low risk nutrition education contacts
- High risk nutrition education contacts

Referral standards for participant risk status are based on Nutritional Risk Criteria and priority level. Roles and qualifications of staff providing nutrition education are identified in the guidelines below.

All contacts must:

- Have a practical relationship to the nutritional risks and needs of the participant.

- Be designed for easy understanding by participants.

- Meet the different cultural, language, educational, economical, and environmental needs of the participant.

- Include information on how to select food for both the participant and the family.

REFERENCE

- 7 CFR 246.11 *Nutrition Education*

LOW RISK CONTACT

Effective: 01/xx/01
Revision: N/A

POLICY

A participant who does not require high risk nutrition education by a registered dietitian can receive nutrition education from a trained paraprofessional. Nutrition education can address participants' nutritional needs specific to category of eligibility.

REFERENCE

- State Policy

HIGH RISK CONTACT

Effective: 01/xx/01
Revision: N/A

POLICY

A high risk participant is one whose health is most in jeopardy due to nutritional status. Every high risk participant must receive at least one contact with the registered dietitian during a six-month certification period. The registered dietitian must develop an individual high risk nutrition care plan.

The purpose of the individual care plan is to give direction and enhance the continuity of care provided by the registered dietitian and support staff. The plan must be realistic and tailored to the individual risks and needs of the participant.

Participants requiring nutrition counseling by a registered dietitian are identified in the Referral Guidelines for Nutrition Counseling.

DOCUMENTATION

Documentation must include a well developed care plan based on an assessment of the participant's risks and needs, the desired changes expected, and the strategies to be used to achieve those changes. Such a plan includes the following components:

- Date of contact
- Assessment including results from nutrition, socioeconomic and cultural assessments, the participant's knowledge and attitude towards nutritional risk.
- Intervention and nutrition education provided, including client goal(s), education materials discussed
- Progress evaluation criteria to determine if problems have been resolved
- Referrals
- Plan for follow-up, including topics to be reviewed and repeat biochemical or anthropological measurements
- Name or initials and credentials of the registered dietitian

REFERENCE

DRUGS AND OTHER HARMFUL SUBSTANCES

Effective: 01/xx/01
Revision: N/A

POLICY

Information on drugs and other harmful substances must be provided to all pregnant, postpartum, and breastfeeding women and to parents or caretakers of infants and children in the WIC Program at certification and as needed.

Health messages related to use of drugs and other harmful substances may be provided through pamphlets, participant newsletters, educational displays in the clinic, and posters or videos in waiting areas.

REFERENCE

7 CFR 246.7(n) Drug and Harmful Substance Abuse Screening

DOCUMENTATION OF CONTACTS

Effective: 01/xx/01
Revision: N/A

POLICY

All nutrition education provided to participants should be entered into the appointment calendar screen of the Idaho WIC Computer System. If this is not possible, documentation must be written in the participant chart. If nutrition education is not provided because a participant refused or was not able to attend, this information should also be entered into the Idaho WIC Computer System or participant chart.

CERTIFICATION CONTACTS

Documentation must include:

- Date of contact or refusal/inability to attend or participate
- Topic of nutrition education provided
- Education materials discussed
- Client goal, if set
- Plans for follow-up, if needed
- Referrals, if given
- Name and title of staff member providing the nutrition education

The above information is captured on the Care Plan portion of the Certification Form.

INDIVIDUAL CONTACTS

Documentation must include:

- Date of contact or refusal/inability to attend or participate
- Topic of nutrition education provided
- Name and title of staff member providing the nutrition education, if written in the chart

GROUP CONTACT

Documentation must include:

- Date of contact or refusal/inability or attend or participate
- Class topic or title
- The average group education length should be 15 to 30 minutes total (including check issuance and appointment scheduling).

BREASTFEEDING CONTACTS

Refer to local agency breastfeeding education and support plan as included annually in the Local Agency Program Plan.

FORMAT OF DOCUMENTATION

Documentation should be accomplished in a manner that is readily understandable by all staff. Narrative notes, Subjective Objective Assessment Plan (SOAP) notes, or a combination of the

two can be used. A description of these methods is found in the Idaho WIC Program Paraprofessional Training Manual, Unit 1 - Basic Skills.
Group education can be documented in several ways:

- Check list
- Progress notes
- Calendar pages
- Card file system

Class outlines, including handouts, must be kept on file along with a schedule of when classes were presented.

REFERENCE

REFUSAL OF NUTRITION EDUCATION

Effective: 01/xx/01
Revision: N/A

POLICY

Documentation is required for participants who refuse or are unable to attend/participate in nutrition education. This documentation is entered into the Idaho WIC Computer System. If this is not possible, refusal or inability should be documented in the participant's chart. The purpose of recording this information is for planning further education efforts and for monitoring of services. Every effort should be made to reschedule participants who were unable to attend /participate in nutrition education.

COMPUTER SYSTEM

All nutrition education and referrals given are required to be entered into the Idaho WIC Computer System unless access to the computer system is not available. Information on how to enter information into the computer system is found in the Paraprofessional Training Manual, Unit I - Basic Skills. Nutrition education topic codes are required to be entered into the computer system.

DOCUMENTATION SUMMARY

Nutrition education is a fundamental benefit to participants of the WIC Program. In order to achieve the two broad goals of nutrition education as defined by federal regulations, nutrition education is entered in the Idaho WIC Computer System. If this cannot be done, the information must be documented in a participant's chart.

REFERENCE

- WRO Policy Memo 803-AW; Participant Orientation (1/31/03)
- State policy

SECTION B: DELIVERY OF NUTRITION EDUCATION

Effective: 01/xx/01
Revision: N/A

OVERVIEW

Nutrition education is any type of learning experience that desires to help an individual adopt dietary behaviors that enhance health and well being. "... nutrition education 'works,' in that it is a significant factor in improving dietary practices when behavioral change is set as the goal and the educational strategies employed are designed with that as a purpose." (Adapted from Volume 27, Number 6, November - December 1995 Journal of Nutrition Education Special Issue *The Effectiveness of Nutrition Education and Implications for Nutrition Education Policy, Programs, and Research: A Review of Research*.)

Education that is both motivational and "how to" is most likely to produce behavioral change. Nutrition education should include communication between local agency staff and participants. Communication is not telling or informing the participant, but recognizing that the participant has an active role in deciding to accept or ignore, misunderstand, or reject the nutrition message. Communication is defined as interaction between WIC staff and participants, such as discussions about nutrition information provided through classes, individual counseling, newsletters, handouts, displays and exhibits, or audiovisuals.

In order to enhance communication with non-English-speaking participants, the FNS regional office recommends the local agency hire at least one bilingual staff person when more than 5% of the caseload or 100 non-English speaking people are served. The local agency should also hire at least one part-time interpreter when over 5% of caseload or 100 people are served in any individual clinic. Interpreter expenses are allowable nutrition education costs.

The three most common strategies for providing nutrition education are:

- Individual counseling
- Group education
- Displays or exhibits

All three strategies are considered acceptable nutrition education contacts when they meet the criteria specified.

IN THIS SECTION

Individual Counseling
Group Education for Adults
Group Education for Children
Other Methods
Learning Environment
Displays and Exhibits
General Visual Aids
Newsletters
Handouts, Booklets and Brochures
Audiovisuals
Evaluation of Nutrition Education

INDIVIDUAL COUNSELING

Effective: 01/xx/01
Revision: N/A

DESCRIPTION

Successful individual counseling is dependent upon establishing a solid relationship with the participant needing help in meeting nutritional needs. The primary role of clinic staff is to help the participant gain knowledge about diet or health behavior, and improve behavior change and decision-making skills through goal setting. In all individual nutrition education sessions, the nutrition education intervention must be tailored to the participant's individual needs and concerns and be relevant to the participant's literacy level and cognitive development as well as be culturally sensitive.

A telephone call is considered an acceptable method of individual counseling in two instances:

- When the call is initiated by the registered dietitian.
- If the participant phones, the call must relate to identified nutritional risks and the appropriate nutrition counselor must respond to the question.

GROUP EDUCATION FOR ADULTS

Effective: 01/xx/01
Revision: N/A

DESCRIPTION

A wide variety of group experiences can be used to provide nutrition education. Group nutrition education can be a very effective education strategy. It brings together participants with similar needs and facilitates learning through idea exchange.

In planning group education sessions, it is essential that class outlines (lesson plans) are developed and used for each class topic. A class outline must include a title, learning objectives including the behavioral change desired, a timeline, a description of activities, an evaluation component, and the date of development. Each class should have an introduction section which includes an icebreaker. This allows the participants to create a sense of camaraderie. All lesson plans should be kept on file and be available for review during monitoring visits. A suggested class size would be eight participants.

Group education proceeds smoothly when taught by trained staff. One option is to present classes to the staff first and clarify all learning objectives prior to having the class presented to participants. A roster of staff who have received training to conduct each class should also be kept on file.

A variety of different types of group nutrition education experiences can be used in the WIC Program. A brief description of such group experiences is provided.

FACILITATED GROUP DISCUSSIONS

Facilitated group discussions are an interactive form of education where participants decide the topic to discuss and share their knowledge and experience with the group. The discussion is facilitated by a trained staff member who encourages, supports, and promotes the group discussion. Discussion should be designed to either help participants with a problem (e.g., shopping on a limited budget) or to introduce a positive health behavior (e.g., delaying the infant's introduction to solid foods). For further information on facilitated group discussion, contact the Nutrition Education Coordinator at the State Office.

DISCUSSION/SUPPORT GROUPS

Discussion groups are similar to facilitated group discussions except the topic is decided ahead of time and a short, five-minute presentation precedes the discussion by the group.

Support groups can usually function as discussion groups as well. Support groups must help participants with nutrition-related problems (e.g., how to relieve engorgement) or introduce positive health behaviors (e.g., combining working and breastfeeding) to be considered a nutrition education contact.

LECTURE CLASSES

Lecture style classes are less effective methods of group nutrition education. Lectures disseminate information from the group leader with little or no time allocated for discussion or interaction. They are not encouraged, but are acceptable occasionally if a guest speaker is sponsored. Even then, discussion is required for the class to be considered a nutrition education contact.

GROUP EDUCATION FOR CHILDREN

Effective: 01/xx/01
Revision: N/A

CHILDREN

Classes designed specifically for the WIC preschooler (3 to 5 years old) have been enthusiastically received by both participants and parents/caretakers. A wide variety of resources is available to use in the planning and development of children's classes.

Some key points to remember when working with this age group are:

- Preschoolers have short attention spans, so class should be 15 minutes or less.
- Lessons should include objects to touch, taste, or smell. Preschoolers learn best from "hands-on" projects.
- Classes should include movement. Preschoolers will not sit for very long.
- Several short projects should be planned rather than one long one.
- Videos, filmstrips, and slide shows should be under 10 minutes long.
- Any visual aids should be large, simple, and easy to identify.

If space permits, children's groups could be scheduled simultaneously with nutrition education for adult participants or the parents/caretakers. The removal of children from adult sessions will help minimize distractions, interruptions, and noise, producing a more conducive atmosphere for adult learning. Ideally, the local agency staff should be assigned to run children's groups. Parents/caretakers may prefer to remain within sight of their children. Participation should be limited to 10 children or less.

OTHER METHODS

Effective: 01/xx/01
Revision: N/A

FOOD DEMONSTRATIONS

Food demonstrations should focus on only one food or theme, using foods and utensils commonly available to participants. Sound principles of proper sanitation, food handling, and storage should be incorporated into the demonstration. Taste testing and recipes should be provided. Food purchases are legitimate nutrition education expenditures.

NUTRITION GAMES

Retention of information improves when individuals are provided with the opportunity to “practice” what they have learned. Using games for providing nutrition education is an effective method for enabling such practice and active participation. Some common, readily identifiable television game shows can be easily adapted to convey nutrition and health-related information. “Game shows” can also be an effective strategy for stimulating greater participant interest in other nutrition education programs provided by the local agency.

PUPPET SHOWS

Both preschoolers and their parents/caretakers can learn nutrition messages from short puppet shows. Puppet shows allow for involvement by more than one staff member, and are less threatening for staff learning to conduct nutrition education classes. Puppet shows should be no longer than 15 minutes and simple enough for the preschooler to understand.

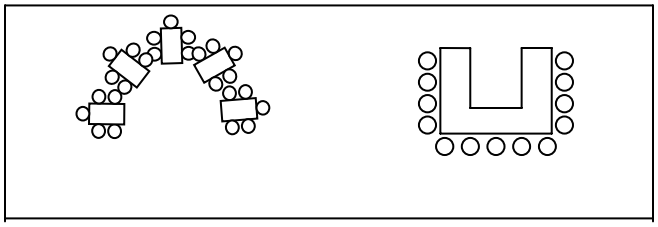
LEARNING ENVIRONMENT

Effective: 01/xx/01
Revision: N/A

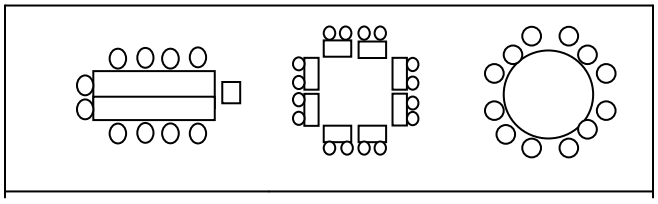
DESCRIPTION

Participants should be seated in a way to encourage greater interaction. If the environment can not be adapted, be assertive in asking participants to sit close together. It is possible in almost any situation to arrange a way to pair up participants in order to have more inactive learning. Look at the following illustrations for ideas on how to set up a learning environment. (From *101 Ways to Make Training Active* Silberman 1995 Jossey-Bass Inc.)

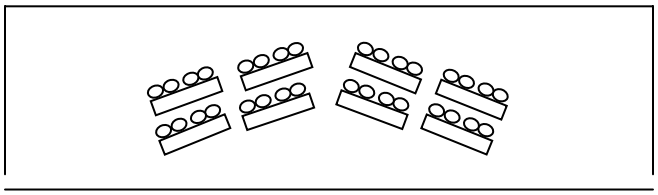
U-SHAPED



CIRCLE



V-SHAPED



LENGTH OF GROUP CONTACT

The average group education length should be 15 to 30 minutes total (including check issuance and appointment scheduling).

DISPLAYS AND EXHIBITS

Effective: 01/xx/01
Revision: N/A

DESCRIPTION

A display is a small amount of visual aid material set up in either the entrance hall or waiting room area of the local agency or satellite clinic. An exhibit is similar to a display, but much more elaborate and on a much larger scale. The main purpose of a display or exhibit is to inform participants of new ideas and information in an understandable and interesting way.

MINIMUM CRITERIA

The following standards should be followed whenever developing and organizing displays or exhibits:

- All displays and exhibits must be carefully planned to meet the needs of the participants who will view the display or exhibit.
- Only one topic should be covered in a display or exhibit. Since the average time spent at an exhibit is 7 minutes (less time for a display), the number of new ideas participants are expected to absorb must be kept to a minimum.
- The display or exhibit should not be crowded with too many visual aids.
- The materials should be arranged in a progressive fashion, with ideas and information becoming more complex as the participant moves along the display or exhibit.
- Simply having participants view a display or exhibit does not constitute a nutrition education contact. Displays and exhibits are appropriate nutrition education contacts if the following requirements are met:
    - Participants must complete a brief written or verbal evaluation after viewing the display or exhibit. The evaluation may be incorporated into the exhibit by using a flip chart or a question-and-answer board.
    - Results of the evaluation must be available to the participants.
    - A staff person must be available at the display or exhibit or immediately after the participant views it to address questions. This can be the person who is issuing food vouchers, as long as the staff person has received training on the contents of the display or exhibit.

NOTE: Displays are a good way of addressing non-nutritional interests such as child development, immunizations, toy safety, etc. However, these can not be counted as a nutrition education contact without an evaluation component and staff interaction. Using displays for non-nutritional topics saves class time for nutrition-specific education.

General Visual Aids

Effective: 01/xx/01
Revision: N/A

Description

Common visual aids used in the WIC Program include handouts, newsletters, posters, flip charts, and audiovisuals. Their use is intended solely to aid in the presentation of information and to facilitate participant learning. Visual aids cannot teach by themselves. Simply giving out a handout, distributing a newsletter, or having participants view a video without discussion does not constitute an acceptable nutrition education contact.

Visual aids are considered appropriate components of nutrition education contacts if used as part of individual counseling, a class, or an exhibit.

NEWSLETTERS

Effective: 01/xx/01
Revision: N/A

DESCRIPTION

Newsletters can help communicate information on clinic schedules, changes in the list of WIC foods, new clinic sites and hours, or changes in local agency WIC staff. Newsletters can also be used to convey nutrition or health information to participants. Simply distributing a newsletter to participants is not an acceptable nutrition education contact.

CRITERIA

To be considered nutrition education, the contents of the newsletter must relate to an individual participant's nutritional risks. It must be reviewed with the participant, and the participant must complete a brief written or verbal evaluation which is then documented into the participant's chart.

PLANNING

The local agency and staff members should meet to plan newsletter themes for the entire year when possible. Themes can be planned around the seasons, holidays, designated health days or months (e.g., National Nutrition Month), or a special nutrition or health topic.

SIZE

In general, newsletters should range from 5" x 8½" to 8½" x 11".

READING LEVEL

The newsletter should be at the sixth grade level or less.

TYPE OF LETTERING

The size of the letters should be easily readable, 12 point font or larger. Key points should be emphasized with underlining or neat free-hand lettering. Do not use all capital letters or italics.

ILLUSTRATIONS

All illustrations should relate to the information presented in the newsletter. A wide variety of clip art books and computer software packages are available for professional looking illustrations. These can be purchased at art supply and computer retail stores, respectively.

REPRODUCTION

Before reproduction, verify that all information is easily understood. If possible, print on bright colored paper or use different colored ink for a more eye-catching product. When distributing the newsletter, make sure it was printed clearly.

TRAINING STAFF

All staff who will be using the newsletter with participants should receive training on the content of the newsletter. It is important to anticipate the types of questions participants may ask and train staff on appropriate answers to questions.

NOTE: All nutrition education information that also provides information about the WIC Program or WIC benefits produced at the state or local level must included the USDA non-discrimination statement as stated in Chapter 2.

HANDOUTS, BOOKLETS AND BROCHURES

Effective: 01/xx/01
Revision: N/A

DESCRIPTION

Handouts and booklets can best assist in promoting attitude and behavior change when used in group or individual counseling sessions. They should be discussed and reviewed with participants. Handouts serve to re-emphasize information or clarify concepts. They can also be an outline or guide during an education session. Ideally, only one (not more than two) handouts should be discussed with a participant in any given education session.

CRITERIA

Handouts should be evaluated prior to use. They should be simple to understand, easy to read, and clear. The reading level of the handout should be sixth grade level or lower. If there are concerns, please contact the Nutrition Education Coordinator at the State Office.

AUDIOVISUALS

Effective: 01/xx/01
Revision: N/A

DESCRIPTION

Video cassettes and DVDs are useful tools for nutrition education. Prior to using any audiovisual product, it is important to preview and evaluate it to make sure its content is appropriate for the social, educational, cultural backgrounds, and nutritional needs of your audience. A list of audiovisual materials should be maintained and updated periodically.

Most audiovisuals are not 100% appropriate and may contain errors, outdated scenes, or confusing or biased information. This does not mean the audiovisual should be discarded. Point out these problems to the group prior to the showing. It is important to check equipment to assure it is in good working order prior to each use.

As with other aids, audiovisuals are not intended to provide the sole educational message. Showing an audiovisual without discussion does not constitute a nutrition education contact. Ideally, the audiovisual should consume less than one-third of the scheduled time, with remaining time devoted to discussion or topic-related activities.

The key points to remember for enhancing the educational experience are:

- Check equipment to assure it is in good working order prior to use.
- Always provide a brief introduction prior to the viewing.
- Use a lead-in or teaser to encourage viewing, for instance, “I noticed one mother in the film has a very creative way to breastfeed in public. See if you can spot this woman.”
- Stay in the room with the group, even if you have seen the audiovisual several times before. This way, it will feel like a shared experience.
- Allow sufficient time for discussion and activities after the showing. Review key points, provide additional information, and address participant questions. You should also try to assess the group’s reaction to the audiovisual.

EVALUATION OF NUTRITION EDUCATION

Effective: 01/xx/01
Revision: N/A

POLICY

Evaluation is critical in the nutrition education process. Evaluation provides information regarding the services participants receive. Whenever possible after a nutritional education contact, consider the following:

- Were only one or two topics discussed?
- If goals were set, was the participant actively involved? Were the goals set by the participant?
- If handouts were used, were the parts that related to the participant emphasized?
- Did the participant have a chance to ask questions?

SECTION C: ANNUAL PARTICIPANT SURVEY

Effective: 01/xx/01
Revision: N/A

OVERVIEW

Policy: Federal Regulation 246.11 (c)(5) Nutrition Education

IN THIS SECTION

Annual Participant Survey

ANNUAL PARTICIPANT SURVEY

Effective: xx/xx/xx
Revision: N/A

POLICY

Annually perform and document evaluations of nutrition education and breastfeeding promotion and support activities. The evaluations shall include an assessment of participants' views concerning the effectiveness of the nutrition education and breastfeeding promotion and support they received.

METHODS

Participants' views on nutrition education, breastfeeding promotion and support, WIC foods, and understanding of core WIC messages will be assessed annually through one or more of the following methods:

Questionnaire
A State-developed questionnaire with instructions for distribution and collection will be sent out to local agencies. Local agencies that are being monitored by the State Office will be exempt that year from distributing the questionnaire.

Focus Groups (State Office)
State Office may decide to conduct focus groups in lieu of a questionnaires. All local agencies that would be impacted will be notified in advance.

Focus Groups (Local Agencies)
Local agencies may conduct focus groups, if desired.

RESULTS

Results from the annual assessment of participant views will be made available to all local agencies.

REFERENCE

- 7 CFR 246.11(c)(5) State Agency Responsibilities

SECTION D: LOCAL AGENCY PROGRAM PLAN

Effective: 01/xx/01
Revision: 10/01/07

POLICY

Develop an annual local agency nutrition education plan consistent with the State's nutrition education component of program operations and in accordance with this part of the Idaho WIC Policy Manual and FCS guidelines.

The local agency shall submit its nutrition education plan to the State Agency by a date specified by the State agency.

IN THIS SECTION

Local Agency Program Plan

LOCAL AGENCY PROGRAM PLAN

Effective: xx/xx/xx
Revision: N/A

METHODS

The State and local agencies have common goals to promote optimal birth outcomes, maintain optimal anthropometry and hematology, promote and support breastfeeding, and provide nutrition education to participants and staff, and to manage caseloads.

LOCAL AGENCY CHARACTERISTICS

Each local agency has unique characteristics related to the population that it serves. This section at a minimum should include the following:

- The counties served by the local agency
- Population information
- Current economic status of the region served by the local agency
- Social factors
- WIC statistics (number of participants served, education level, marital status, etc.)
- Food insecurity
- Other information as determined by the local agency Coordinator

HEALTH AND NUTRITION INDICATORS

Health and Nutrition Indicators are how the health of the WIC community is measured. Each Health and Nutrition Indicator reflects a major health concern in WIC. The Health and Nutrition Indicators were selected on the basis of their impact on the WIC community, the availability of data to measure progress and their importance as public health issues.

The Health and Nutrition Indicators are:

- Infants and Children
  - Prevalence of Breastfeeding
  - Low Hematology
  - Underweight
  - Overweight
  - Baby Bottle Tooth Decay
  - Baby Bottle Tooth Decay Risk Behaviors

- Women
  - Low Hematology
  - Underweight
  - Overweight
  - Low Birth Weight
  - Premature Birth
  - Prenatal Weight Gain
  - Time of WIC Enrollment
  - Begin Prenatal Care
  - Self Reported Alcohol Use
  - Self Reported Cigarette Use
  - Self Reported Drug Use
  - Severe Dental Problems

- Family
  - Food Insecurity

REQUIRED ACTIONS

There are actions required by federal regulations and State contract that must be performed by local agencies. They are:

Nutrition Education

- Standard 1 – Quality nutrition education and counseling are provided to all participants or, when appropriate, to their caregivers or proxies (collectively referred to as "participants"). FR §246.11 (c) (6)
- Standard 2 – Provision of an individual care plan for low-risk and high-risk participants. FR §246.11 (e) (5)
- Standard 3 - Provide appropriate orientations, training and continuing education opportunities for staff.
- Standard 4 - Prepare a local agency program plan annually. FR §246.11 (d) (2)

Breastfeeding

- Standard 1 – Implementation and evaluation of specific strategies that promote and support breastfeeding within the population served. IWPPM; Chapter 9; Section A.
- Standard 2 – Local WIC agency will appoint a designated Breastfeeding Promotion Coordinator. FR §246.11 (c) (7) (ii) IWPPM; Chapter 9; Section B.
- Standard 3 – Provide appropriate orientation and task-appropriate training on breastfeeding promotion and support. FR§246.11(c)(7)(iii) IWPPM; Chapter 9; Section C.
- Standard 4 – Implementation of a policy that encourages a positive clinic environment and that endorses breastfeeding as the preferred and normal way to feed infants. FR§246.11(c)(7)(i) IWPPM; Chapter 9; Section D.
- Standard 5 – Quality breastfeeding education and support shall be offered to all pregnant WIC participants. FR§246.11(c)(7) FR§246.11(e)(1) IWPPM; Chapter 9; Section E and H.
- Standard 6 – Breastfeeding women will be provided with support, information, and appropriate referrals throughout the postpartum period, particularly at critical times, to successfully establish and maintain breastfeeding for one year or longer if so desired. FR§246.11(c)(7)(iv) IWPPM; Chapter 9; Sections F and H.
- Standard 7 - All eligible women who meet the definition of breastfeeding are certified to the extent that caseload management permits and receive a food package consistent with their nutritional needs. FR §246.11 (e) (1) and FR §246.10 (b) (2) (iii) IWPPM; Chapter 9; Section G.

Outreach/Targeting

- Standard 1 – Local agencies conduct consistent targeted outreach to WIC-eligible populations. FR §246.4 (a)(7)(i) IWPPM; Chapter 10; Section C.
- Substance Abuse Screening and Referral
- Standard 1 – Local agencies will ensure that quality information and updated referrals on drug and other harmful substance abuse are provided to all participants or, when appropriate, to their caregivers or proxies. FR §246.11 (a) (3) and FR §246.7 (a) IWPPM; Chapter 5; Section A.

Caseload Management

- The Contractor shall maintain a quarterly average authorized participating caseload level as defined by contract with the State WIC Office. Authorized caseload (including migrant participants) is defined as the caseload number used to calculate funding and is based on the recent past 12-month period (July-June) actual participation.
- Caseload is reviewed on a quarterly basis. Adjustment in funding to local agency Contractors will occur based on review and per contract specification.
- The Contractor must notify the State WIC Office prior to the implementation of a waiting list or priority restriction.

REFERENCES

- State Contract with Local Agency

SECTION E: NUTRITION EDUCATION TOPIC CODES

Effective: 01/xx/01
Revision: N/A

POLICY

The Idaho WIC computer system requires documentation of the nutrition education topic code(s) used.

IN THIS SECTION

Nutrition Education Topic Codes

NUTRITION EDUCATION TOPIC CODES

Nutrition Education Topic Code	Description
100	Welcome to WIC/Individual
110	Welcome to WIC/Class
120	WIC Foods
130	WIC Nutrients
135	Diet
140	B-Breast Infection
150	B-Common Problems
160	B-Engorgement
170	B-Flat Nipples
180	B-Inverted Nipples
190	B-Leaking Nipples
200	B-Nutrition
210	B-Milk Supply
220	B-Plugged Ducts
230	B-Positioning/Attachment
240	B-Sore Nipples
250	B-Return to work/school
260	Budgeting skills/food
270	Budgeting skills-general
280	C-Nutrition
290	Cholesterol Screening
300	Community Resources
310	Constipation
320	Cultural Foods/Meals
330	Dental Health-BBTD
340	Dental Health-General
350	Developmental Milestones
353	Diabetes
355	Diabetes-Gestational
360	Diarrhea
370	Education for Children
380	Fitness
385	Food Allergy
390	Food Safety/Sanitation
400	Gardening
405	Growth Evaluation
410	Health-General
420	HGB/HCT-Low
430	I-Bottle Propping
440	I-Formula Preparation/Storage
445	I-Formula Non Contract
450	I-Infa-Feeders
460	I-Intro to Solids
470	I-Nutrition
480	I-Spitting Up
490	Immunizations
495	Lactose Intolerance
500	LC-Brstfd supply request
510	LC-Brstfd supply follow-up
520	LC-Infant problems

530	LC-Jaundice
540	LC-Multiple Births
550	LC-Special Situations
560	LC-Sucking Problems
570	LC-Thrush
580	Meals
590	N-Nutrition
600	Nutrition-Specific
610	Nutrition-General
620	Nutrition Labeling
630	Overweight
640	P-Common Problem/Change
650	P-Encourage Breastfeeding
660	P-Heartburn
670	P-Nutrition
680	P-Morning Sickness
690	P-Weight Gain Recommended
700	P-Weight Gain Excessive
710	P-Weight Gain Inadequate
720	P-Weight Loss
730	Parenting Skills
740	Picky Eating
750	Preserving Food
760	Recipes
770	RD-Nutr. Supply Request
780	RD-Nutr. Supply Follow-Up
790	Safety/Accident Prevention
800	Shopping Skills-Food
810	Short Stature
820	Smoking Cessation
825	Smoking Cessation Follow-up
830	Snacks
840	Stress Management
850	Substance Abuse
860	Supplements
870	Underweight
880	Wean from bottle
890	Wean from breast
900	Weight Control
990	Other Topic Not Listed

CHAPTER 6: BREASTFEEDING PROMOTION AND SUPPORT

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

Human milk is uniquely superior for infant feeding and is the optimal food for infants from birth to one year and beyond.

"Research documents diverse and compelling advantages to infants, mothers, families, and society from breastfeeding and the use of human milk for infant feeding. These include health, nutritional, immunologic, developmental, psychological, social, economic, and environmental benefits."

American Academy of Pediatrics
Breastfeeding and the Use of Human Milk
December 1997

IN THIS CHAPTER

Section A General Guidelines
Section B Breastfeeding Equipment and Inventory

SECTION A: GENERAL REQUIREMENTS

Effective: 01/xx/01
Revision: N/A

OVERVIEW

The Idaho WIC Program is committed to promoting and supporting breastfeeding. Information and support systems are key to establishing and maintaining breastfeeding for the first year of life and beyond.

IN THIS SECTION

Benefits of Breastfeeding
Breastfeeding Friendly Environment
Prenatal Promotion and Support
Postpartum Support for Women and Infants
Supplemental Formula Use During Breastfeeding
Local Agency Breastfeeding Promotion Coordinator
Peer Counselors
Idaho Peer Counselor Program Manual

BENEFITS OF BREASTFEEDING

Effective: 01/xx/01
Revision: N/A

BACKGROUND

The advantages of breastfeeding range from biochemical, immunological, and endocrinologic to psychosocial, developmental, and economical. Human milk contains the ideal balance of nutrients, enzymes, immunoglobulin, anti-infective agents, anti-allergic substances, hormones, and growth factors. Breastfeeding provides a time of intense maternal-infant interaction and facilitates the physiologic return to the pre-pregnant state. It has numerous possible health benefits for the breastfeeding woman, including improved bone remineralization postpartum with reduction in hip fractures in the postmenopausal period and a reduction in risk of ovarian cancer and premenopausal breast cancer.

AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics supports breastfeeding as the preferred feeding for all infants, with rare exception, for at least the first 12 months of life. The AAP identifies breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as primary in achieving optimal infant and child health, growth, and development. (AAP, 12/97)

NATIONAL WIC ASSOCIATION

Breastfeeding has been shown to have significant advantages for women and infants. As health professionals have a responsibility to provide services designed to optimize the health of their clients, WIC health professionals are committed to encouraging breastfeeding as the preferred method of infant feeding. Therefore, the National Association of WIC Directors (NAWD) calls for all WIC state and local programs to aggressively promote breastfeeding. (NAWD, 1989)

WIC'S ROLE

The Idaho WIC Program breastfeeding promotion and support efforts during the prenatal and postpartum periods include:

- Breastfeeding educational materials
- Individual counseling
- Telephone support
- Nutritious foods
- Peer counselors
- Support groups
- Educational classes
- Referrals to physicians and community support systems

Policies and guidelines included in this chapter provide the foundation for breastfeeding promotion and support in the Idaho WIC Program.

REFERENCE

BREASTFEEDING FRIENDLY ENVIRONMENT

Effective: 01/xx/01
Revision: N/A

POLICY

The local agency will ensure that clinic environments endorse breastfeeding as the preferred method of infant feeding by meeting the criteria listed below.

REQUIRED CRITERIA

- Materials: All print and audio-visual materials, posters, office supplies, equipment, and office furniture will be free of formula product names and pictures.
- Bottle feeding equipment and formula: All formula and bottle feeding equipment will be stored out of view of WIC participants and staff.
- Acceptance of formula by staff: Staff will not accept formula from formula manufacturer representatives for personal use.

RECOMMENDED CRITERIA

Advertise Breastfeeding

- Display or use breastfeeding posters, handouts, bulletin boards, breastfeeding pins, memo pads and pens with breastfeeding messages.
- Have staff wear T-shirts with breastfeeding messages.
- Include positive breastfeeding messages where possible, like WIC newsletters, handouts, recipe cards, calendars, bumper stickers, health department newsletters, etc.
- Put breastfeeding messages in visible and key locations like the receptionist area, waiting area, on scales where pregnant women weigh themselves, and on bathroom doors—anywhere participants are likely to read a message.
- Display signs or exhibits that welcome breastfeeding in the clinic, show breastfeeding women overcoming common barriers to breastfeeding like embarrassment and employment and list the many benefits of breastfeeding.

Supportive Environment

- Discuss breastfeeding early and often with participants.
- Create private areas for breastfeeding women to breastfeed while waiting at the clinic.
- Advertise breastfeeding classes and invite family members and support people to attend.
- Offer advice and encouragement rather than formula when a breastfeeding woman doubts her ability to breastfeed.
- Show breastfeeding videos in waiting areas.

REFERENCE

- 7 CFR 246.11(c)(7)(i) Nutrition Education, State Agency Responsibilities

PRENATAL PROMOTION AND SUPPORT

Effective: 01/xx/01
Revision: N/A

POLICY

The purpose of this policy is to promote the nutritional well-being of infants and to support and encourage women in choosing the most nutritious feeding method for their infants.

All pregnant participants shall be encouraged to breastfeed unless contraindicated for health reasons.

Each local agency must have a written plan ensuring that breastfeeding is encouraged during the prenatal period and breastfeeding education is provided to all pregnant participants (unless it is contraindicated for health reasons).

All local agency staff must be trained on how to support and promote breastfeeding with pregnant participants.

REQUIRED EDUCATION AND SUPPORT

Prenatal breastfeeding education must include all of the following:

- Assisting pregnant participants in identifying any personal barriers to breastfeeding.
- Providing education focused on overcoming barriers of breastfeeding.
- Communicating to participants the benefits of breastfeeding for both infants and their mothers and families.
- Helping women make informed decisions by including information about the risks of using breast milk substitutes (unless breastfeeding is contraindicated for health reasons). Examples of the risks associated with use of breast milk substitutes include:
    - Increased illnesses and infections
    - Increased risk of food allergies
    - Increased risk of diabetes and SIDS
- Providing information on “Getting Started” with breastfeeding. Topics to include at a minimum:
    - Positioning and attachment
    - Signs that baby is getting enough
    - Maintaining milk supply
    - Resources to call for help and/or support
- Offering the following information describing WIC benefits for breastfeeding women:
    - Breastfeeding women are at a higher priority level than non-breastfeeding postpartum women. When local agencies lack funds to serve all qualified individuals, breastfeeding participants are more likely to be served than non-breastfeeding postpartum women.
    - Breastfeeding women may receive WIC benefits for up to one year postpartum, while non-breastfeeding postpartum women are eligible for only six months postpartum.

  - The WIC Program offers a greater variety and quantity of foods to breastfeeding participants than to non-breastfeeding postpartum participants.

- Encouraging and teaching women how to communicate their decision to breastfeed to prenatal care providers; hospital staff; and others involved in the prenatal and postpartum care of women and their infants.

PEER COUNSELORS

Local agencies are encouraged to use Peer Counselors to provide breastfeeding information and support for pregnant participants.

CONTRAINDICATIONS

Contraindications to breastfeeding may exist for the participant. These contraindications will occur in few participants. Breastfeeding is not appropriate and should not be promoted if ANY of the following conditions exist:

- The infant has galactosemia
- The mother is HIV-positive
- Drug abuse (exceptions: use of cigarettes, alcohol)
- Specific medications not compatible with breastfeeding
- The mother or infant is unable to breastfeed because of other physical or medical reasons

DOCUMENTATION

All breastfeeding education and support contacts received by participants must be documented in the participant health record. To facilitate continuity of care, documentation of encouragement to breastfeed should include all aspects of breastfeeding discussed with the participant (e.g., identification of barriers to breastfeeding, plans for overcoming barriers, topics discussed). Local agencies are encouraged to develop a comprehensive flow sheet for documenting breastfeeding education for participants in the prenatal period.

DEFINITIONS

Breast milk substitute/artificial baby milk (ABM): Infant formula.

Contraindication: Any circumstance that makes breastfeeding medically inadvisable.

REFERENCE

- 7 CFR 246.11(c)(7)(iv) Nutrition Education, State Responsibilities
- 7 CFR 246.11(e)(1) Participant Contacts

POSTPARTUM SUPPORT FOR WOMEN AND INFANTS

Effective: 01/xx/01
Revision: N/A

POLICY

All breastfeeding women will be provided with support, information, and appropriate referrals needed to successfully establish and maintain breastfeeding for one year or longer.

PROMOTION AND SUPPORT RESOURCES/ACTIVITIES

Breastfeeding promotion and support are enhanced when breastfeeding support and assistance is provided throughout the postpartum period, particularly at critical times when the mother is most likely to need assistance. Promotion and support resources and activities may include:

- Offering telephone support, home visits, and support groups, Peer Counselors, and referrals.
- Identifying women with special support needs (multiple births, illness, returning to work/school, etc.) and providing education and support needed or making community referrals to appropriate support resources.
- Supplying breastfeeding equipment as needed. See Chapter 6, Section B.
- Providing positive reinforcement for breastfeeding in all postpartum contacts.
- Coordinating breastfeeding support with other programs and groups such as hospitals, health clinics, and La Leche League.

NATIONAL WIC ASSOCIATION POSITION

The National WIC Association position paper, *Guidelines for Breastfeeding Promotion and Support in the WIC Program*, outlines recommendations for breastfeeding promotion.

REFERENCE

- 7 CFR 246.11(c)(7)(iv) Nutrition Education, State Responsibilities

SUPPLEMENTAL FORMULA USE DURING BREASTFEEDING

Effective: 01/xx/01
Revision: N/A

POLICY

Infant food packages will be tailored to encourage continued breastfeeding when mothers choose not to exclusively breastfeed.

DEFINITION

The USDA/FNS definition of breastfeeding is the practice of feeding a mother's breastmilk to her infant(s) on the average of at least once a day.

BACKGROUND

If breastfeeding is not going well, supplemental formula may aggravate the problem. Use of supplemental formula can decrease the amount of milk the mother produces, especially in the first six weeks postpartum.

When supplemental formula is requested, counseling support is required to ensure the continuation of breastfeeding. Ideally, the breastfed infant should require no supplemental formula, especially during the first few months of life.

At about two weeks and again at around six weeks, infants go through growth spurts. They will act as if they want to feed constantly. More frequent nursing during these growth spurts will increase the mother's milk supply. Providing supplemental formula during this first six-week period is generally detrimental to breastfeeding. Therefore, the issuance of supplemental formula to breastfeeding infants younger than four weeks of age is not recommended in most cases.

Refer to the National WIC Association position paper, *The Role of Infant Formula in the WIC Program*.

COUNSELING

Staff must provide counseling before checks for formula are issued to breastfeeding infants.

The appropriate person to provide counseling is a staff member who has completed breastfeeding training. Whenever possible, the counseling shall be provided by an RD, RN, Lactation Educator, Breastfeeding Promotion Coordinator, or health professional who has completed formal breastfeeding training.

Counseling shall include the following steps:

- The first priority is to help the woman successfully breastfeed.
- Inform the breastfeeding woman of the impact of supplementation on breastfeeding (i.e., that milk production will be decreased when a woman breastfeeds less frequently).
- Inform the exclusively breastfeeding woman that her food package will be changed if she accepts any supplemental formula.

- Consider use of a breast pump rather than issuing formula, if appropriate.
- Provide the minimum amount of formula that meets but does not exceed the infant's nutritional needs.

INFANT FOOD PACKAGE

If the decision is to provide supplemental formula, issue an amount consistent with the infant's nutritional needs. It may be necessary to coordinate with the family's health care provider.

Provide powdered formula if available since it can be prepared in small quantities as needed.

If the mother is unsure how many feedings need to be supplemented, start with one can and request that the mother contact the WIC counselor if she feels she needs more.

If the mother is already giving supplemental formula, issue the lowest amount the infant is currently using.

See table, "Supplemental Powdered Formula for Partially Breastfed Infant", for description of amounts.

Only increase supplemental formula based on the infant's nutritional needs.

Follow up on the success of breastfeeding after the introduction of formula. Adjust the formula amount as baby gains weight.

The infant may recieve up to and including a full amount of the infant formula package.

SPECIAL CIRCUMSTANCES

More than half the maximum quantity of formula.

In special circumstances, the Lactation Educator, RD, RN, or other staff member having received intensive breastfeeding training may prescribe more than half a formula package for the infant while the breastfeeding woman also receives the standard breastfeeding food package. In these circumstances, the infant may receive up to and including a full amount of the infant formula package.

REFERENCES

- 246.2 Definitions
- 246.11(c)(7)(iv) State Agency Responsibilities
- WRO Policy Memo 804-H Questions and Answers on the Enhanced Food Package for Breastfeeding Women (Food Package VII) (11-18-94)
- WRO Policy Memo 805-B Breastfeeding Support During Certification and Food Package Issuance (03-31-92)

Table: Supplemental Powdered Formula for Partially Breastfed Infant

Usual Daily Intake of Formula by Infant	Percent Breastfeeding	Number of Cans to Provide per Month	
		Similac Advanced, Similac Sensitive, Isomil Advanced, or Enfamil AR (12.9 oz. can)	Similac Sensitive R.S. (32 oz. RTF)
1 to 4 oz. per day	75%	Check for 1 can powdered formula per month.	3 cans formula per month.
5 to 8 oz. per day	75%	Check for 3 cans powdered formula per month.	7 cans formula per month.
9 to 16 oz. per day	50%	Check for 5 cans powdered formula per month.	13 cans formula per month.
Greater than 16 oz. per day Breastfeeding at least one time per day	25%	Approval from RD, Local Agency Breastfeeding Promotion Coordinator, or Lactation Educator when mother is receiving breastfeeding food package. Document approval in chart	
		Check for 7 or 9 cans powdered formula per month.	19 or 25 cans formula per month.

LOCAL AGENCY BREASTFEEDING PROMOTION COORDINATOR

Effective: 01/xx/01
Revision: N/A

POLICY

Each local agency will appoint a Breastfeeding Promotion Coordinator

OVERVIEW

The local agency Breastfeeding Promotion Coordinator is a staff member who serves as a resource person and central contact for the coordination of breastfeeding promotion and support activities in the local agency. The local agency Breastfeeding Promotion Coordinator shall be given support from the local agency to ensure that the resources are available to perform the duties and responsibilities of this position.

RESPONSIBILITIES

Responsibilities are to include but are not limited to the following:

- Lead the implementation of Breastfeeding Promotion and support plan for the local agency
- Review breastfeeding data with local agency WIC Coordinator on a regular basis to determine the effectiveness of the plan
- Maintain current, accurate breastfeeding information resources such as posters, handouts, breastfeeding equipment, resource and referral information, etc., to optimally support breastfeeding in all clinics
- Work with local agency WIC Coordinator and WIC staff to provide a baby friendly/breastfeeding friendly clinic environment for all WIC participants
- Participate in and conduct or coordinate ongoing training for WIC staff on breastfeeding promotion and support issues and information
- Provide leadership in the local Breastfeeding Promotion Council
- Conduct and/or coordinate World Breastfeeding Week activities annually
- Monitor breastfeeding classes, counseling, and charting

REFERENCE

- 7 CFR 246.11 (c)(7)(ii) State Agency Responsibilities

PEER COUNSELORS

Effective: 01/xx/01
Revision: N/A

POLICY

Local agencies may employ breastfeeding Peer Counselors to assist in breastfeeding promotion and support efforts.

DEFINITION OF BREASTFEEDING PEER COUNSELOR

A breastfeeding Peer Counselor for WIC is a woman who, at a minimum:

- Is familiar with WIC
- Feels she has successfully breastfed at least one child
- Can communicate with strangers
- Is enthusiastic about breastfeeding
- Can organize thoughts and present accurate information
- Can document and keep accurate records

Job descriptions and duties are detailed of the Idaho WIC Peer Counselor Program Implementation Manual. (Section 1).

PROCEDURE

Breastfeeding Peer Counselors will be recruited, trained, and employed under the direction of the local agency Breastfeeding Coordinator.

Breastfeeding Peer Counselors must be recruited and trained in accordance with the State Agency Idaho Peer Counselor Program Manual.

REFERENCE

- 7 CFR 246.11(c)(2) State Agency Responsibilities

IDAHO PEER COUNSELOR MANUAL

Effective: 01/xx/01
Revision: N/A

POLICY

Local agencies must assure that breastfeeding Peer Counselors are qualified, trained, and perform appropriate duties.

Local agencies who chose to use Peer Counselors must use guidelines established in the Idaho WIC Peer Counselor Program Manual.

Section One: Idaho WIC Peer Counselor Program Implementation Manual

Section Two: Idaho WIC Peer Counselor Training Manual

Section Three: Idaho WIC Peer Counselor Student Manual

REFERENCE

- 7 CFR 246.11 (c) (2) *Nutrition Education*
- State Policy

SECTION B: BREASTFEEDING EQUIPMENT AND INVENTORY

Effective: 01/xx/01
Revision: N/A

OVERVIEW

The Idaho WIC Program promotes breastfeeding as the optimal way to feed infants. Breastfeeding support is provided primarily through education, referral, and follow up support. Most women can establish and maintain lactation without the aid of equipment. Careful consideration should be taken when issuing breastfeeding equipment that it does not impede a mother's confidence in her ability to breastfeed and that she understands the commitment needed. Breastfeeding management problems should always be addressed prior to issuing any equipment. For some women, breastfeeding equipment may be helpful in establishing and/or maintaining successful lactation. In such circumstances, equipment may be provided as an adjunct to education and support when determined necessary by authorized staff member.

IN THIS SECTION

Guidelines for Issuance
- Breast Shells
- Manual Pumps
- SNS
- Single User Electric Pumps
- Hospital Grade Rental Pump

Ordering and Inventory Procedure

GUIDELINES FOR ISSUANCE - BREAST SHELLS

BACKGROUND

Often hormonal changes in pregnancy and childbirth cause nipples to protrude naturally. Therefore, breastfeeding experts are not in agreement that breast shells should be used for flat or inverted nipples.

ELIGIBILITY CRITERIA

A person must be an active WIC participant prior to receiving any breastfeeding equipment.

- It is recommended that breast shells be issued in the postpartum period if there is difficulty with latch due to flat or inverted nipples. Studies have found that women given breast shells during pregnancy were less successful at breastfeeding.
- If a mother reports sore nipples she should be referred immediately to the Breastfeeding Coordinator or healthcare provider for further assessment. Once the cause of sore nipples has been addressed, shells can be issued to protect a mother's nipples from her bra or clothing. Caution: Overuse of breast shells can contribute to plugged ducts and nipple soreness.
- Other needs as determined by the local agency Breastfeeding Coordinator or Lactation Consultant.

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or a trained RD is preferred. If the above staff members are unavailable, a Clinical Assistant or Peer Counselor who has had advanced training in issuance of this equipment that is documented in the Breastfeeding Training Log may also provide equipment.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (video, handout)
- Instruction provided with demonstration of assembly
- Care plan for follow up and referrals as necessary
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. She should not sell or give issued equipment away due to health concerns.

GUIDELINES FOR ISSUANCE - MANUAL BREAST PUMP

BACKGROUND

The WIC Program provides pumps that meet quality standards for the most effective pumping session.

ELIGIBILITY CRITERIA

A person must be an active WIC participant prior to receiving any breastfeeding equipment.

Two-handed Manual Pump

- Short term use or infrequent need to pump
- Part time work or school
- Breastfeeding management problem that does not require an electric pump

One-handed Manual Pump

- Carpal Tunnel Syndrome or other condition that might make it difficult to use two-handed pump
- Part time work or school that does not qualify participant for single user double electric pump

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or a trained RD is preferred. If the above staff members are unavailable, a Clinical Assistant or Peer Counselor who has had advanced training in issuance of this equipment that is documented in the Breastfeeding Training Log may also provide equipment.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (video, handout)
- Instruction provided with demonstration of assembly
- Care plan for follow up and referrals as necessary
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. She should not sell or give issued equipment away due to health concerns.

GUIDELINES FOR ISSUANCE - SNS AND DISPOSABLE SNS (INFANT FEEDING TUBE DEVICE)

BACKGROUND

An SNS should not be recommended casually for short term use. Other options should be considered prior to mentioning the SNS because of the dedication it takes.

ELIGIBILITY CRITERIA

A person must be an active WIC participant prior to receiving any breastfeeding equipment.

Disposable SNS

- Helping baby transition from another feeding method
- Inducing lactation/relactation
- Providing extra supplement
- Other reasons as determined by local agency Breastfeeding Coordinator

Non-disposable SNS

For longer term use such as:

- Prematurity
- Down's Syndrome
- Cardiac problems
- Cleft palate
- Failure to thrive
- Neurological impairment
- Weak suck

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or trained RD. Referral and follow up through IBCLC and MD are necessary.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (video, handout)
- Instruction provided with demonstration of assembly
- Care plan for follow-up and referral to IBCLC and MD
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. She should not sell or give issued equipment away due to health concerns.

GUIDELINES FOR ISSUANCE - SINGLE USER DOUBLE ELECTRIC BREAST PUMP

BACKGROUND

The WIC Program provides pumps that meet quality standards for the most effective pumping session.

ELIGIBILITY CRITERIA

A person must be an active WIC participant prior to receiving any breastfeeding equipment.

- Participant exclusively breastfeeding
- Baby 4 weeks old
- Does not meet criteria for hospital rental pump
- No current breastfeeding problems
- Meets criteria for work/school hours set by State Breastfeeding Workgroup
- Pump will assist in maintaining well-established milk supply
- Participant plans to exclusively breastfeed for 4-6 months

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or a trained RD is preferred. If the above staff members are unavailable, a Clinical Assistant or Peer Counselor who has had advanced training in issuance of this equipment that is documented in the Breastfeeding Training Log may also provide equipment.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (video, handout)
- Instruction provided with demonstration of assembly
- Care plan for follow up and referrals as necessary
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. She should not sell or give issued equipment away due to health concerns.

If formula is requested after pump is issued, follow guidelines in the table in Chapter 6, Section A.

GUIDELINES FOR ISSUANCE - HOSPITAL GRADE ELECTRIC RENTAL PUMP

BACKGROUND

Most pumps will only be approved for a one- to two-month period based on prescription and need. If the prescription has no time period specified, it is assumed to be valid for one month. If the prescription has a time period greater than two months, the local agency Breastfeeding Coordinator must provide follow-up after two months to reassess the need for the pump.

ELIGIBILITY CRITERIA

A person must be an active WIC participant prior to receiving any breastfeeding equipment.

- High-risk breastfeeding women and infants to establish or maintain lactation
- Prematurity
- Medical condition that affects ability to suck
- Mother-infant separation for more than 24 hours due to medical condition
- Weight loss greater than 7% of birth weight in first 72 hours of life
- Severe engorgement or soreness
- Other reasons as deemed appropriate by MD, IBCLC, or local agency Breastfeeding Coordinator

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or trained RD. Referral and follow-up through IBCLC and MD are necessary.

REQUIRED DOCUMENTATION

- Prescription required
- Request For Nutritional Supplies: Electric Breast Pump Rental and Attachment Kit form must be completed and faxed or mailed to State Office and breast pump vendor
- Participant must sign “WIC Participant Responsibilities” section of RFNS form if they are present or at their next appointment.
- Instruction provided on collecting and storing breast milk
- Care plan for follow-up and referrals as necessary
- Information on who to contact with question/concerns

IDAHO MEDICAID

For active Idaho Medicaid participants, breast pumps may be covered as durable medical equipment. Please refer to the most current Idaho Medicaid Provider Handbook at www.healthandwelfare.idaho.gov/site/3438/default.aspx.

ORDERING AND INVENTORY PROCEDURE

Staff responsible for inventory should not be the same staff involved in the ordering or issuance of equipment. It is the expectation of the State Office that all equipment is accounted for with each quarterly inventory report. Equipment on hand should not exceed amount issued for a quarter for each agency. Inventory should be issued using first-in, first-out method so that the oldest inventory is issued before newly-ordered inventory.

If procedures are found to be unsatisfactory (e.g., excessive amounts of equipment stored, not completing or submitting quarterly reports, not following above procedures for issuance of specific equipment), a corrective action plan will be implemented with the local agency Breastfeeding Coordinator, local agency WIC Coordinator, State Office Breastfeeding Coordinator, and State Office WIC Manager. The State Office reserves the right to discontinue payment for breastfeeding equipment from a local agency that is practicing unsatisfactory ordering and inventory procedures and does not adhere to corrective action plan measures.

Quarterly Reports
Submit with local agency Coordinator's Quarterly Report. Also submit the Quarterly Distribution Record (lists which participants received what equipment) with your quarterly report.

WSCA Breastfeeding Equipment Order Form
Each agency should order on an as needed basis via phone, fax, or e-mail from the WSCA contract. The equipment that can be ordered on this form includes flanges, manual pumps, and electric breast pumps. It is recommended that you request an order confirmation.

State Office Breastfeeding Equipment Order Form
This is for the local agency Breastfeeding Coordinator to order breastfeeding equipment from the State Office. Local agencies will only be able to order twice per year, on March 31 and September 30. The order can be placed via fax, e-mail, or regular mail. The equipment found on this form includes breast shells and SNS.

Please review these forms with staff who may assist in completing inventory and ordering. Also, please review the WSCA contract for further details.

CHAPTER 7: FOOD DELIVERY

Effective: 05/01/04
Revision: 10/01/07

OVERVIEW

This Chapter describes the different types of supplemental food packages available for issuing to participants. Supplemental Foods are defined as *those foods containing nutrients determined by nutritional research to be lacking in the diets of pregnant, breastfeeding, and postpartum women, infants, and children*, as found in the Child Nutrition and WIC Reauthorization Act of 2004.

IN THIS CHAPTER

Section A Food Packages

Section B Infant Formulas and Medical Foods

Section C Issuing Food Checks

SECTION A: FOOD PACKAGES

Effective: 05/01/04
Revision: 02/08/06

OVERVIEW

The Idaho WIC Program authorizes food packages based on the category and nutritional needs of the participant. WIC participants are grouped into a specific category and multiple food packages are available in each category.

IN THIS SECTION

Approved Foods
Breastfeeding Food Packages
Common Food Packages for Participants by Category
Homeless Food Packages

APPROVED FOODS

Effective: 05/01/04
Revision: 02/08/06

POLICY

Criteria for approving products for inclusion in the Idaho WIC Authorized Food List are based on federal regulations, State Office requirements, cost, nutritional value, and cultural/participant acceptability.

The Idaho WIC Program Food Selection Committee will meet on a regular basis to determine all aspects of the Idaho Authorized Food List per the Food Authorization Procedure and based on the criteria found in this policy.

Food packages are available by category of participant. A participant may be issued a food package tailored to the Recommended Dietary Allowance (RDA) or a food package with the federal maximum quantity allowed. The RDA food packages are typically assigned to participants in Idaho. Tailoring should be based on nutritional need for age and nutrition risk criteria.

- WIC food products shall meet all federal requirements governing the WIC food package to be considered for approval through the Idaho WIC Program.
- WIC food products shall be widely available throughout the state.
- WIC food products shall have been available in retail stores in Idaho for one year prior to request for approval.
- In addition to the criteria specified in this policy, the Idaho WIC Food Selection Committee reserves the right to restrict the number of brands and types of products in order to contain costs and/or minimize confusion on the part of participants and vendors.
- WIC food product composition and marketing approach must be consistent with the promotion of good nutrition and education.

MILK

Federal Standards
Whole milk: pasteurized fluid, evaporated, and dry milk that contains 400 I.U. of Vitamin D per quart are allowed.
Reduced fat, low fat, and skim: pasteurized fluid, evaporated and dry milk that contains 400 I.U. of Vitamin D and 2000 I.U. of Vitamin A per quart are allowed.

State Standards

- Milk is not authorized for infants under any circumstances.
- Reduced fat, low fat, and skim milk are not recommended for children less than 2 years of age.
- All fluid milk products (fat free skim or non-fat milk, low fat ½% and 1%, reduced fat, and whole) must be purchased in half-gallon or gallon size containers unless otherwise stated on the checks.
- Goat's milk, buttermilk, non-fat dry powdered, canned evaporated, acidophilus and lactose free milk is allowed, but must be specified on the check.
- RD approval is required prior to issuing acidophilus, lactose reduced, buttermilk, and goat's milk.
- Soy and rice milk are not approved as they do not meet federal standards.
- Organic, flavored, sweetened condensed, UHT, or powdered goat's milk are not allowed as their nutritional value does not justify the additional cost, and to decrease the confusion for the participant and vendor. Flavored or sweetened milk is not allowed because of the high sugar content.

EGGS

Federal Standards
Eggs or dried egg mix allowed.

State Standards
- One-dozen carton, any size, white eggs are allowed,
- Specialty eggs, Eggland's Best, Nature's Nest, egg substitutes, brown, organic, or dried egg mix are not allowed as the nutritional value does not justify the additional cost, and to decrease confusion of the participant and vendor.

CEREAL

Federal Standards
Adult – Hot or cold cereal that contains a minimum of 28 milligrams of iron per 100 grams of dry cereal and not more than 21.2 grams of sucrose and other sugars per 100 grams of dry cereal (6 grams per ounce) is allowed.
Infant – Dry cereal that contains a minimum of 45 milligrams of iron per 100 grams of cereal is allowed.

State Standards
Adult –
- Only brands and types of cereal that appear on the current Idaho Authorized Food List are allowed.
- WIC reserves the right to determine the number and brands of cereal which include at least one hot cereal and at least one cereal from each grain group. Grain groups are defined as corn, wheat, oat, rice, or multi-grain.
- Cereals that contain greater than or equal to 200 micrograms or 50% Recommended Dietary Intake (RDI) of folic acid, greater than or equal to 2 grams of fiber per serving, contain no partially-hydrogenated fat/trans fat, contain less than 325 milligrams per dry ounce of sodium, contain no artificial dyes or sweeteners, and are made from whole grains will be given preference for their higher nutritional standards.
- Culturally acceptable cereals, cereals targeting specific ethnic groups, or cereals more suitable for children shall be considered.
- The minimum package size allowed is 9 ounces.

Infant

- Only 8- or 16-ounce boxes of infant cereal are allowed.
- Only plain rice, oatmeal, barley, or mixed grain is allowed.
- Organic, added fruit, or jars of cereal are not allowed as the nutritional value does not justify the additional cost, and to avoid confusion of the participant and vendor.
- The Idaho WIC Program encourages the introduction of cereal to infants at 6 months of age; however, a participant may request cereal for their infant at 4 months of age.

JUICE

Federal Standards
Fruit and/or vegetable juice that contains a minimum of 30 milligrams of Vitamin C per 100 milliliters of single strength or reconstituted concentrate is allowed.

State Standards
- Only brands and types of juice that appear on the current Idaho Authorized Food List are allowed.
- RD approval is required prior to issuing individual juices for a child or woman with special circumstances such as homelessness or lack of refrigeration.
- 100% juice that is unsweetened is allowed.
- Juice is allowed in 46-ounce cans or plastic bottles or 11.5-12 ounce frozen cans.

- Country style (extra pulp), pulp free, Calcium fortified, or reduced/low acid orange juice is allowed.
- Fruit drinks, punches, added sugar, blended juices, juice twisters, juice cocktails, or artificially sweetened juices are not allowed due to lower nutritional value, and to decrease participant and vendor confusion.

DRY BEANS AND PEAS

Federal Standards
Dry beans and peas, including but not limited to plain lentils, black, navy, kidney, garbanzo, soy, pinto, and mung beans, crowder, cow, split, and black-eyed peas are allowed.

State Standards
- Only one-pound (16-ounce) package or bulk is allowed.
- Only brands and types of beans that appear on the current Idaho Authorized Food List are allowed.
- Frozen, fresh, soup mix, barley, rice, or flavored beans or peas are not allowed because they do not meet federal standards.
- RD approval is required prior to approval of canned beans for participants who are homeless.

PEANUT BUTTER

Federal Standards
Meets standard of identity for peanut butter.

State Standards
- Peanut butter is not provided for children less than 2 years of age because of the risk of choking.
- RD approval is required in order to substitute peanut butter for eggs on a food package for participants with special circumstances such as homelessness or lack of refrigeration.
- Only 16- or 18-ounce containers or less are allowed. 9-ounce squeezable is not allowed because of the cost.
- All commercially prepared brands of peanut butter, including creamy, crunchy, extra crunchy, and honey roasted, are allowed.
- Peanut butter blends, peanut spreads, and added jelly or candy are not allowed because they do not meet federal standards.
- Fortified, low sodium, gourmet, reduced fat, added honey and low carbohydrate diet peanut butters are not allowed as their nutritional value does not justify the additional cost, and to decrease confusion of the participant and vendor.

CHEESE

Federal Standard
May be substituted for fluid whole milk at the rate of 1 pound per 3 quarts of fluid whole milk. Four (4) pounds is the maximum amount which may be substituted.

State Standard
- Natural, regular, or low fat block cheese, unsliced, vacuum-packed in 16-ounce (1 pound) or 32-ounce (2 pound) packages is approved unless otherwise printed on the check. Only 16-ounce multi-stick bag of mozzarella (string cheese) is allowed.
- Only types of cheese that appear on the current Idaho Authorized Food List are allowed.
- Extra sharp cheddar, shredded, organic, cream, string, grated, imported, flavored, added ingredients, Velveeta, cheese food, spreads, or cheese products are not allowed as the nutritional value does not justify the additional cost, and to decrease the confusion of the participant and vendor.

CARROTS

Federal Standards
Raw, canned (packed in water), and frozen carrots containing only the mature root of the carrot are allowed.

State Standards
- Sliced, fresh, frozen, canned, or baby carrots without added ingredients are allowed.
- Organic, glazed, or julienne carrots are not allowed as their nutritional value does not justify the additional cost, and to decrease confusion of the participant and vendor.

TUNA

Federal Standards
Canned white, light, dark, or blended tuna packed in water or oil including solid pack, chunk, chunk-style flake, or grated are allowed.

State Standards
- Chunk light tuna packed in water or oil is allowed.
- Albacore tuna is allowed.
- Only 6- to 6⅛-ounce cans allowed.
- Low sodium, dietetic, smoked, and tuna pouches are not allowed as the nutritional value does not justify the additional cost, and to decrease confusion of the participant and vendor.

INFANT FORMULA

Federal Standards
Powdered infant formula. Concentrated liquid is an option.

State Standards
- Refer to Section B of this chapter.
- Contract formula approved in a separate contract.

REFERENCES

- Public Law 108-265; WIC Reauthorization Act of 2004
- CFR 246.10
- ASM 99-105
- ASM 99-112

BREASTFEEDING FOOD PACKAGES

Effective: 10/01/05
Revision: N/A

OVERVIEW

Prior to food package VII (Idaho BE and PE), pregnant and breastfeeding women received the same food package. The goal of these food packages is to promote and encourage breastfeeding among participants by providing additional WIC foods.

POLICY

BE Food Package
A breastfeeding woman whose infant(s) *do not receive any infant formula from the WIC Program* will receive an enhanced food package (BE) and may remain as category "B" until she is one year postpartum and no longer eligible as a breastfeeding woman.

PROCEDURE

A breastfeeding woman can be issued a BE food package for 1, 2, or 3 months, depending on the local agency policy and procedure for multi-month check issuance.

WHEN TO CHANGE CATEGORY

A breastfeeding woman is issued a BE food package for 2 or 3 months. A few days (or weeks) later she contacts the local agency requesting formula for her infant(s). **At this time, local agency staff must inform participant to bring in all remaining BE checks before formula checks can be issued.** (There may be some extenuating circumstances, and any questions by the CPA should be referred to the local agency Breastfeeding Coordinator or the local agency Coordinator and in his/her absence, the State Breastfeeding Coordinator.)

1. <u>If participant is no longer breastfeeding</u>: Offer participant breastfeeding support/assistance/ referral in order to encourage the continuation of breastfeeding. Participant must be changed to a "N" category (postpartum woman). Remaining BE checks must be voided in the computer system and infant formula checks may be issued.

NOTE: If participant is changed to a "N" category and the local agency continues to issue a "B" (breastfeeding) food package, this will result in over-issuance of food benefits.

2. <u>If participant wishes to partially breastfeed and receive infant formula from the WIC Program</u>: Offer participant breastfeeding support/assistance/referral in order to encourage the continuation of breastfeeding. Participant must be changed to a "B" category (breastfeeding woman). Participant may keep the currently issued BE food package checks except the bonus check. The bonus check must be collected from the participant and voided in the computer system and then infant formula checks may be issued.

3. If participant chooses scenario 1 or 2 (as above) and arrives at the local agency clinic without the remaining BE food package checks and/or bonus check: Offer participant breastfeeding support/assistance/referral in order to encourage the continuation of breastfeeding. If participant continues to request infant formula, the local agency may choose to issue one month of infant formula checks and inform participant to not use the bonus check(s) or remaining BE checks. The local agency staff should inform the participant that to knowingly use the bonus check or any of the remaining BE checks in this circumstance (if category "N"), will result in over-issuance of food benefits for which the participant will be held liable.

NOTE: Notification of the above should be documented in the participant's progress notes along with staff and the participant signature(s).

POLICY

PE Food Package
A breastfeeding enhanced food package (PE) may be issued for up to 6 weeks postpartum to women who are Category "P" participants if:

- Woman has delivered an infant
- Infant has been added to IWCS (as NRC 40 or NRC 41)
- Infant is not receiving any formula from WIC

PROCEDURE

When a participant contacts the local agency to inform them that she has delivered her baby, efforts should be made to schedule the participant and baby for certification as soon after delivery as possible in order to provide timely referrals for health care and nutrition education.

Certification of the postpartum participant *must* occur within 6 weeks postpartum. The local agency cannot terminate the woman prior to 6 weeks postpartum since she is still eligible to continue to receive a PE package until 6 weeks postpartum.

Scenario 1:
Participant telephones that she has delivered her baby two days ago. She is fully breastfeeding the baby. *Perform an enrollment certification for the infant using NRC 40. Enter the birth height, weight and birth date of the infant into the computer system. The participant remains a category "P" and can continue to receive the PE food package until both participant and baby are certified (within 6 weeks postpartum).*

Scenario 2:
Participant telephones that she has delivered her baby two days ago. She is breastfeeding and would like to receive a partial infant formula package for her baby. Provide breastfeeding support and referral. Reiterate the recommendation that no formula be given to a breastfed infant the first 4 weeks. Participant insists on supplemental formula. *Refer to Chapter 6, Section A, for issuance guidance.* She provides the birth height, weight and birth date of the infant. *Perform an enrollment certification for the infant using NRC 40. Enter the birth height, weight and birth date of the infant into the computer system. Assign appropriate food package for the infant. Participant remains a category "P" until both she and baby are certified (within 6 weeks postpartum).*

FURTHER CLARIFICATION FOR PARTIALLY BREASTFED INFANTS

If a participant is breastfeeding twins (e.g., 50% each) and receiving formula from WIC, offer the participant breastfeeding support/assistance/referral in order to encourage the continuation of breastfeeding. The participant does not qualify for a PE or BE food package since she is receiving formula from WIC. Each infant should be counted as breastfeeding 50% of the time. Local agencies may

not count one infant as 100% breastfeeding and the other infant as 100% formula fed in order to assign a PE or BE food package.

REFERENCES

- All States Memorandum 95-26/WRO Policy Memo 804-H, "*Questions and Answers on the Enhanced Food Package for Breastfeeding Women (Food Package VII)",* Nov. 18, 1994.
- All States Memorandum 98-114/WRO Policy Memo 804-O, *"Food Package VII and Multiple Births"*, July 30, 1998.
- Consolidated Federal Regulations (CFR) 246.10 (7), *Food Package VII-Breastfeeding Women (Enhanced)*.

COMMON FOOD PACKAGES FOR PARTICIPANTS BY CATEGORY

Effective: 05/01/04
Revision: 03/30/06

POLICY

Food packages are available by category of participant. The food packages are designed to be consistent with the current RDIs for the specified category and must meet the state and federal standards. Tailoring options can be found in the paragraph of the corresponding food item at the beginning of this chapter.

Pregnant Food Package

5½ gallons of milk
2 pounds of cheese
2 dozen eggs
36 ounces of iron-fortified cereal
6 cans (46 ounces each) of 100% juice
1 pound of dried beans, peas, or lentils, or 1 18-ounce jar of peanut butter

Postpartum Food Package

4½ gallons of milk
2 pounds of cheese
2 dozen eggs
36 ounces of iron-fortified cereal
4 cans (46 ounces each) of 100% juice

Breastfeeding Food Package

5½ gallons of milk
2 pounds of cheese
2 dozen eggs
36 ounces of iron-fortified cereal
6 cans (46 ounces each) of 100% juice
1 pound of dried beans, peas, or lentils

Bonus check (for mothers who are breastfeeding 100%):
2 pounds of carrots
4 cans (6 ounces) of tuna
1 18-ounce jar of peanut butter
1 pound of cheese
1 can (46 ounces) of 100% juice

Breastfeeding Infant Food Package

A breastfed infant may not receive a food package until 4 months of age and older. At 4 months of age, an infant may receive cereal, however, it is recommended by the American Academy of Pediatrics to wait until 6 months of age before offering cereal.

16 ounces of infant cereal
15 containers of infant juice (63 fluid ounces maximum)

If an infant is partially breastfed or is no longer breastfeeding, refer to Chapter 6 regarding education to be provided to mother and amount of formula to provide.

Non-Breastfeeding Infant Food Package

Birth to 4 months
8 pounds of powdered contract formula

4 months
8 pounds of powdered contract formula
16 ounces of infant cereal (recommended to wait until 6 months of age to offer)

6 months
8 pounds of powdered contract formula
16 ounces of infant cereal
15 containers of infant juice (63 fluid ounces maximum)

Child Food Package

4 gallons of milk
2 pounds of cheese
36 ounces of iron-fortified cereal
4 cans (46 ounces each) of 100% juice
1 pound of dried beans, peas, or lentils *or* 1 18-ounce jar of peanut butter (after 2 years of age to avoid choking risk)

HOMELESS FOOD PACKAGES

Effective: 05/01/04
Revision: N/A

POLICY

Homeless food packages are specifically designed for participants who may not have access to a stove or refrigerator. The homeless food package may not be appropriate for all homeless participants. Tailoring should be based upon the family's individual needs. Often, a standard food package will work fine for a homeless family.

A participant must have a "Y" entered in the Homeless field of the Family Basic screen to receive a homeless food package. Homeless food package checks can be issued for one month.

OPTIONS

Adjustments have been made in the food packages to allow for different circumstances. The food packages generally contain six checks.

A variety of food package options is available for each category. They are on the Food Package screen of the Idaho WIC Computer System. These food package codes begin with H (for example, HBP001).

It may be necessary to contact a local vendor to determine if these unusual WIC foods are stocked by the vendor.

Infants
Alternatives to standard foods include the following:

- 8-ounce bottles of ready-to-use infant formula

Children and Women
Alternatives to standard foods include the following:

- canned beans
- peanut butter substituted for eggs
- individual juices
- evaporated milk or powdered milk

SECTION B: INFANT FORMULAS AND MEDICAL FOODS

Effective: 05/01/04
Revision: 10/01/07

OVERVIEW

Breastfeeding provides a healthy and economical means of feeding an infant. The WIC Program strives to promote and support breastfeeding by providing an enhanced food package to mothers who elect to breastfeed and by tailoring the amount of infant formula provided to partially breastfed infants.

Infant formula and medical foods are the most expensive items in the WIC food package. In 1988, Congress mandated that all WIC state agencies implement some form of infant formula cost containment. In 1989, Congress added the requirement that states use competitive bidding in their cost containment efforts. The Idaho WIC Program is part of the Western States Contracting Alliance to contain the costs of infant formula. The money saved through infant formula rebate contracts is used to serve more participants.

IN THIS SECTION

General Policy and Definitions
Contract Brand Infant Formulas
Issuing Infant Formula Samples
Exempt Formulas and WIC Eligible Medical Foods
Packaging

General Policy And Definitions

Effective: 01/03/06
Revision: N/A

Policy

Local agency staff shall issue infant formula and medical foods according to the following guidelines set forth by the State Office:

- Checks for infant formula and medical foods are issued only to active participants.
- Infant formulas/medical foods may not be provided to participants while they are hospitalized.

Definitions

Contract Brand infant formula is milk-based, soy-based or lactose-free formula intended for healthy, term infants. Contract formulas are routinely provided to infants enrolled in the WIC Program.

Non-Contract standard iron-fortified milk-based, soy-based, and lactose-free formulas that are nutritionally equivalent to contract brand formulas <u>are not provided by WIC and prescriptions for these formulas will not be accepted under any circumstances</u>.

Exempt Formula is intended for use by infants who have inborn errors of metabolism or low birth weight, or who otherwise have an unusual medical or dietary condition.

WIC-eligible Medical Food refers to certain enteral products that are specifically formulated to provide nutritional support for individuals with a diagnosed medical condition where conventional food is precluded, restricted, or inadequate.

References

- Section 412 (h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350a(h))

CONTRACT BRAND INFANT FORMULAS

Effective: 01/03/06
Revision: 10/01/07

POLICY

Contract brand milk-based and soy-based formulas will be issued to all infants unless there is medical documentation for an exempt formula or a WIC-eligible medical food. Non-contract standard infant formulas that are nutritionally equivalent to contract brand formulas will not be issued and prescriptions will not be accepted under any circumstances. For a list of contract brand formulas, refer to formulas provided by the Idaho WIC Program in the Formula Handbook or Idaho WIC Computer System.

Contract brand infant formulas can be issued by certified professional authorities (CPAs).

FORMULAS FOR SPECIAL CONSIDERATION

Added rice formulas cannot be classified as exempt formulas or WIC-eligible medical foods, but are available to participants on the Idaho WIC Program who have a diagnosed medical condition and a current prescription that warrants the use.

The prescription must include:

- Medical diagnosis that warrants the issuance
- Recommended formula
- Recommended length of use
- Feeding instructions, if different from the standard preparation method
- Signature
- Date of request

Added rice formula will be issued for the following conditions:

- GER, GERD, reflux

Prescriptions will need to be renewed every six (6) months.

Local agency RDs must review and approve the request as soon as possible upon receipt of the request.

REFERENCES

- 7CFR 246.10 *Supplemental Foods*
- 7CFR 246.16a *Infant Formula Cost Containment*

Issuing Infant Formula Samples

Effective: 01/03/06
Revision: N/A

Policy

Infant formula samples are provided only to participants for the purpose of challenging exempt formulas and WIC-eligible medical foods with a contract formula.

Inappropriate Issuance

Formula samples cannot be provided when the issued food package does not last the entire month. It is important to help infant caregivers understand that WIC is a supplemental food program and may not provide enough formula for a full month for an older infant. Mothers choosing to formula feed may run out of formula each month and should plan to purchase the balance of what they need for the infant.

Samples must not be distributed after the expiration date stamped on the can.

Procedure

Clinic staff should provide the smallest quantity necessary.

Receiving Formula from Participants

When receiving cans of formula from participants, all formula received must be checked to make sure it is sealed and has not been recalled or expired. Dispose of formula that has been recalled, opened, or is expired per local agency Coordinator.

Contract formula received may be used as samples.

Non-contract formula that is received shall be disposed of or donated to an organization that helps individuals in need. This will be done at the discretion of the local agency Coordinator.

Exempt formulas and WIC-eligible medical foods that were ordered from a medical supply company will be returned to the medical supply company. Exempt formulas and WIC-eligible medical foods that were purchased from a retail grocer may be used as samples or disposed of at the discretion of the local agency Coordinator.

EXEMPT FORMULAS AND WIC-ELIGIBLE MEDICAL FOODS

Effective: 01/03/06
Revision: N/A

POLICY

Exempt formulas and WIC-eligible medical foods are allowed when a physician or other licensed health care professional who is authorized to write medical prescriptions under Idaho state law determines that a participant has a medical condition that restricts the use of contract formula or approved foods. The prescription must include:

- Medical diagnosis that warrants the issuance
- Recommended formula
- Recommended length of use
- Feeding instructions, if different from the standard preparation method
- Signature
- Date of request

Prescriptions will need to be renewed every six (6) months for exempt formulas and every twelve (12) months for WIC-eligible medical foods.

The WIC Program is not required to provide exempt formulas and WIC-eligible medical foods if the diagnosed medical condition does not warrant such formula.

For a complete list of exempt formulas and WIC-eligible medical foods, refer to “Formulas Provided by the Idaho WIC Program” in the WIC Formula Handbook.

Formulas or medical foods may be provided for oral or enteral tube (i.e., nasogastric tube or g-tube) consumption.

NOTE: Formulas and medical foods are not provided to participants while they are hospitalized.

REGISTERED DIETITIAN

Local agency Registered Dietitians must review and approve the request for an exempt formula or WIC-eligible medical food as soon as possible upon receipt of the request. A review of the request must include some type of contact between the Registered Dietitian and responsible adult or caregiver. It is possible the Registered Dietitian may have to contact the health care provider for additional information. The local agency Registered Dietitian must document the recommendations given by the health care provider and when the participant will next be seen by the primary health care provider.

Participants receiving an exempt formula or a WIC-eligible medical food must be seen be a local agency Registered Dietitian at least once during a certification period. Typically, high risk participants would be seen more frequently in clinic depending on their nutritional risk codes. Checks will be issued for one, two, or three months at the discretion of the local agency Registered Dietitian. The local agency Registered Dietitian must also complete the Request for Nutritional Supplies log and submit it monthly to the State Office.

If a formula or medical food is not available at a local vendor, a medical supply company may provide it. In these cases, the responsible adult will receive it. Exceptions allowing the product to be shipped directly

to the participant's home must be approved by the local agency Registered Dietitian on a limited, case-by-case basis.

Exempt formulas and WIC-eligible medical foods can be issued by a CPA after a local agency Registered Dietitian has received a prescription and approved its use.

Challenge with Contract Brand Infant Formula

A challenge with an appropriate contract brand infant formula is made at the discretion of the local agency Registered Dietitian. The plan for and result of a formula challenge is documented in the participant's chart.

References

- 7CFR 246.10 *Supplemental Foods*
- 7CFR 246.16a *Infant Formula Cost Containment*

PACKAGING

Effective: 01/03/06
Revision: N/A

POLICY

The responsible adult may freely choose either powder or concentrate formula.

Ready to use (ready to feed) formula may only be authorized by the local agency Registered Dietitian for the following:

- unsafe water supply
- poor refrigeration
- the person caring for the infant has difficulty diluting concentrate or powder formula correctly
- the participant is homeless

The reason for issuance must be documented in the participant's chart.

If the water supply is deemed unsafe but the caretaker refuses to use ready to use formula for personal reasons, a signed refusal statement should be obtained and kept in the participant’s chart.

EXCEPTION

A formula or medical food which is available only in ready to use form may be issued regardless of the above criteria.

REFERENCE

- 7CFR 246.10 *Supplemental Food*

SECTION C: ISSUING FOOD CHECKS

Effective: 01/xx/01
Revision: 10/01/07

OVERVIEW

IN THIS SECTION

Shopping for Authorized Foods
Check Security
Check Printing
Issuing Checks
Check Register
Proxies
Mailing Checks
Voiding Checks
Unmatched Redemptions
Lost or Stolen Checks
Direct Bill
Check Issuance
Check Issuance Parameter Guidance

SHOPPING FOR AUTHORIZED FOODS

Effective: 01/xx/01
Revision: N/A

AUTHORIZED STORES

WIC participants can only shop at Idaho authorized WIC stores.

FOOD DESCRIPTIONS

Food descriptions are printed on the check. An Idaho WIC Authorized Food List is given to the WIC participant or responsible adult to identify foods/brands allowed.

PAYMENT FOR WIC FOODS

- Participants receive computer printed food checks on a tri-monthly, bi-monthly, or monthly basis.
- WIC foods need to be separated in the shopping cart, not only from non-WIC foods, but also by check if two or more checks are being used at one time.
- When using a WIC check, the WIC participant needs to verify that the dollar amount on each check is for the purchase price of the food items listed on each check prior to signing the check.
- By signing the WIC check(s) after the amount is written in the “Pay Exactly” box, the WIC participant is verifying that the amount on the check is correct.
- The signature on the check must match the signature on the Identification (ID) Folder exactly.

CHECK SECURITY

Effective: 01/xx/01
Revision: N/A

POLICY

All checks must be accounted for, including unused checks (damaged or voided checks). This is accomplished by entering information on the Check Register, data in the Idaho WIC Computer System (IWCS), and/or special notes in the participant's file.

- Voided checks must be either shredded or destroyed so the participant's personal information is not identifiable.

NOTE: Do not leave preprinted checks unattended. Preprinted computer checks must be kept in a locked, controlled area.

CHECK PRINTING

Effective: 01/xx/01
Revision: N/A

ACCESS

Access to WIC checks must be limited to the designated individual on the Idaho WIC Identification (ID) Folder.

To the extent possible, different staff members should print and issue checks. For example, one staff member would certify and print checks for a participant. Another staff member would be responsible for issuing the checks and having the WIC participant sign the Check Register.

PRINTERS

Checks are printed at the clinic upon demand.

The check printers are laser printers that use a higher heat to bond the ink to the check paper. The ink cartridge is a special MICR ink used for bank processing. The alignment of the paper in the printer is important to ensure accurate banking data.

- It is important to monitor the check printer for ink smudges, faded ink, and accurate print positions on the check.
- Poorly printed checks should not be issued.

PRINTING

Checks should not be printed until they are ready to be given to the WIC participant. Remote clinics which receive their checks from the central agency are an exception to this procedure..

PRINTING CHECKS

Time Frame

- Checks can be printed after the client is certified and one day after the “Last Day to Use” date.
- Checks can be printed three days before a participant comes into the clinic, if the certification is current.
- For clinic prints, the checks can be printed four days in advance.

ISSUING CHECKS

Effective: 01/xx/01
Revision: N/A

POLICY

Identification (ID) Folder

A WIC Identification (ID) Folder is issued to a WIC participant or responsible adult/caregiver at the initial certification appointment. Only one ID Folder may be issued on behalf of a participant. If a request is made for an additional ID Folder, the other person may act as a proxy between certification appointments providing the local agency has a signed note from the certifying participant or responsible adult/caregiver on file making such a request and specifying the length of the request. Additional information on issuing an Identification Folder can be found in the Idaho WIC *Paraprofessional Training Manual*.

The following steps are taken when issuing a WIC check:

1. Request the WIC participant's ID Folder.
2. Verify identification by checking the WIC participant's Folder. If the ID Folder is forgotten, another form of identification can be used, such as a photo identification. A visual identification is permissible if the individual is known to you. A new WIC ID Folder must be issued.
3. Print the appropriate checks for the participant.
4. Review the checks for accuracy of name, foods, and dates.
5. Ask the WIC participant or responsible adult to examine the checks for the correct foods.
6. Have the WIC participant or responsible adult sign the Check Register for each participant's series of checks. The signature provides proof that the checks were received by the WIC participant. At the same time, verify the signature on the Check Register with the signature on the WIC ID Folder.
7. Remind the WIC participant/responsible adult that:

    - Checks cannot be redeemed by the vendor if the participant does not present the ID Folder at the beginning of the WIC transaction.
    - Checks cannot be used before "First Day to Use" date or after the "Last Day to Use" date.
    - The signature on the check must match the WIC Identification (ID) Folder exactly.

8. Write the next appointment date and time on the ID Folder. Notify the WIC participant of any return certifications or reasons a participant may no longer be eligible for program participation before the next appointment (e.g., child turning 5 years old).

    - Remind the WIC participant to bring the WIC ID Folder with him/her each and every time they shop with the WIC checks at the store. The store will refuse the use of WIC checks without the WIC ID Folder.
    - Remind WIC participant to bring the WIC ID Folder to all appointments.

CHECK REGISTER

Effective: 01/xx/01
Revision: N/A

DESCRIPTION

The Check Register is an audit trail for printed checks. It shows when checks were given or mailed to a participant (date), for whom the checks were issued (participant ID#), check numbers, and who received the checks (responsible adult's signature). The Registers are pre-numbered with check numbers to make it easier to account for all checks. The following procedures apply for filling out the Check Register.

DATE

The date only needs to be entered once per Check Register page or when the date changes from the original date written on the page. The new date must be written on the Register.

- Each page of the Check Register must have a date.
- The date refers to when the checks were issued to the participant, voided, or mailed. This is not the date the checks were printed.

PARTICIPANT IDENTIFICATION NUMBER

The participant ID number only needs to be written once.

- Write the participant ID number next to the checks that were printed for that participant.
- Local agencies may use ditto marks or arrows down indicating that a group of checks belongs to the previously written participant ID number.

PARTICIPANT SIGNATURE

The client only needs to sign once on each page of the check register next to the appropriate group of checks that the client receives.

- If a client's checks cover two pages, the client needs to sign once on each page.
- Ditto marks, arrows, or other markers can be used to group checks together.
- Blank lines are not acceptable in the signature area on the Check Register.

MAILING CHECKS

Group the checks mailed to each participant with some identifying mark (ditto marks, arrows).

- Since the participant is not available to sign the Register, the staff person responsible for mailing the checks needs to initial or sign his/her name (not the participant's) next to the group of checks and indicate the date the checks were mailed.

VOIDING CHECKS

- Document that the checks are voided. If you can, document why the checks were voided on the Check Register.
- The person responsible for voiding the checks needs to initial or sign his/her name (not the participant's name) next to the group of checks. This shows who took responsibility for voiding the checks.

Correcting the Wrong Signature

Draw one line through the mistake and have the participant sign in the correct place(s).

- Do not use correction fluid or obliterate the previous signature.

PROXIES

Effective: 01/xx/01
Revision: N/A

POLICY

Proxy means any person designated by a woman participant, or by a parent or caretaker of an infant or child participant, to obtain and transact food instruments to obtain supplemental foods on behalf of the participant. Parents or caretakers applying on behalf of a participant are not proxies.

POLICY

To reduce barriers to participation, a responsible adult may designate someone to act on her/his behalf. The responsible adult may authorize a proxy for a specified amount of time, not to exceed the end of the certification period. If no length of time is specified, the proxy authorization is assumed to be for the current appointment only.

A proxy should attend nutrition education appointments. The proxy should be encouraged to share information with the responsible adult.

Due to the confidential information required for eligibility determination, allowing a proxy for certification appointments is discouraged.

The proxy should be over the age of 18 years.

PROCEDURE

All guidelines and policies apply to a proxy the same as if she/he were the responsible adult/caregiver.

The proxy must present written permission from the responsible adult at the time of the appointment unless prior written approval has been documented. If there is a question concerning a valid permission, staff should compare the responsible adult's signatures on the written permission and the participant's chart.

The proxy must provide identification.

The proxy must read and sign the Participant Rights and Responsibilities. A new signature is required for each certification period an individual is a proxy.

Issue a WIC Identification (ID) Folder to the proxy and provide instruction on the section entitled, "Shopping with WIC Checks."

Issue the participant(s) checks to the proxy according to standard check issuance procedures.

At a minimum, the proxy must be informed that she (or he) is responsible for adhering to all check-related procedures and failure to comply with check-related procedures will be considered program misuse and is subject to sanctions. Reference the WIC Identification Folder for detailed information about shopping with WIC checks and rights and responsibilities.

DOCUMENTATION

Retain the written permission note in the participant chart.

Obtain a proxy signature on the Participant Rights and Responsibilities form for each certification period during which an individual is a proxy.

Document instruction of the procedures in the participant's file, including a date and signature or initials of the staff person providing the instructions.

EXCEPTIONS

Exceptions regarding the minimum age and not allowing a proxy for certification appointments are permitted on a case-by-case basis if approved by the local agency Coordinator.

Local agency Coordinators may establish more detailed guidelines or more stringent requirements related to proxies as long as the local policy does not create a barrier to participation. For example:

- Limit check issuance to one month.
- Require a signature on the Participant Rights and Responsibilities for each instance an individual is a proxy within a certification period (i.e., a repeat proxy who is the same person).

REFERENCES

- 7 CFR 246.2 *Definitions*
- 7 CFR 246.12 (r) (1-4) Issuance of food instruments and authorized supplemental foods
- ASM 803-AI Strengthening Integrity in WIC Certification Process (3/10/99)

MAILING CHECKS

Effective: 01/xx/01
Revision: N/A

GUIDELINES

Mailing WIC checks is discouraged as it hinders the delivery of health and nutrition education services. However, some circumstances may require mailing of WIC checks:

- Computer equipment breakdown or malfunction preventing check printing before the WIC participant leaves the clinic.
- Participants added in outlying clinics that do not have computers.
- Extenuating circumstances, such as:
- Illness, medical reason
- Difficulty in accessing the local agency (e.g., snowstorm, natural disaster, etc.)

LIMITATIONS

Mailing checks is limited to one time during a certification period. If checks need to be mailed more than one time per certification, approval by the local agency Coordinator, in consultation with the State WIC Office, is required. Most situations can be resolved by using an alternate (proxy) shopper.

MAILING PROCEDURE

1. Checks must be sent on or before the valid date printed on the check in an envelope sturdy enough to hold several checks.

    - Do not use window envelopes.
    - Check security envelopes which prevent identification of checks are required.
    - The return address on the envelope must be sufficient to ensure the return of undeliverable mail without identifying the local agency or clinic as the sender (i.e., P.O. Box or street address only).
    - “DO NOT FORWARD” must be printed on the envelope to ensure return of undeliverable mail.

2. Enclose a letter with the checks explaining steps the WIC participant is to follow upon receiving checks in the mail:

    - WIC participant must sign and return enclosed self-addressed, stamped postcard by return mail to acknowledge receipt of checks. This postcard will be filed in the participants file for four (4) years for audit documentation.

3. Document the reason for mailing checks in the participant’s file.

4. Sign or initial and note the date checks were mailed on the appropriate line(s) in the Check Register.

CHECKS RETURNED AS UNDELIVERABLE

1. Checks must be stamped “VOID” in the “Pay Exactly” box and coded as voided in the computer.

2. Envelopes marked as undeliverable should be filed in the client’s chart for future reference.

VOIDING CHECKS

Effective: 01/xx/01
Revision: N/A

REASONS

Checks unusable due to the following reasons must be voided:

- (C) computer problems
- (D) damaged checks
- (E) staff errors
- (F) food intolerance
- (I) improper data
- (M) moved
- (U) unused check
- (X) mailed checks not received
- (S) store-food unavailable
- (13) over 90 days old

PROCEDURE

1. Stamp or write “VOID” on the face of the check in the “Pay Exactly” box and in the signature box before you enter the data in the computer. This will prevent a check that was voided from being cashed.

2. Stamp or write the date and “VOID” in the corresponding Check Register signature area. Record the participant ID number on the Register and put the reason the check was voided.

3. Void the checks in the Idaho WIC Computer System.

4. Voided checks should be properly destroyed. If the clinic has a policy to keep these checks for documentation, it is acceptable to keep them.

UNMATCHED REDEMPTIONS

Effective: 01/xx/01
Revision: N/A

DEFINITION

"Unmatched redemptions" refers to checks that have been issued and cashed, but for which no computer records exist to match the checks with the participants. These checks are flagged for research to determine possible fraud.

JUSTIFICATION PROCEDURE

An "unmatched redemptions" report is researched monthly at the state level.

- If there are questions regarding the issuance of WIC checks, a letter is sent to the local agency WIC Coordinator.
- The local agency Coordinator is obligated to research the checks to make sure the participant is a valid WIC participant and that no fraud was committed.
- A justification or clarification of the problem must be sent back to the State Office within 60 days of receipt of request to research. The justification must state what actions are being taken to prevent future incidents or to recover the money.

PREVENTION

To prevent unmatched redemptions:

- Do not give voided computer checks to the client.
- If a check must be voided for food intolerance, fill out a Check Audit Form and send it to the State Office.
- Never void checks in the Idaho WIC Computer System that you do not have in hand.
- Fill out a Check Audit Form for participants who did not receive checks in the mail and for whom more checks are issued. Send the form to the State Office.

LOST OR STOLEN CHECKS

Effective: 01/xx/01
Revision: N/A

POLICY

LARGE AMOUNTS FROM THE CLINIC

If a large amount of preprinted class/clinic checks (30 or more) are lost or stolen from a clinic, contact your local WIC Coordinator immediately. Follow procedure as instructed by the Coordinator.

PROCEDURE

1. The WIC Coordinator may notify the local police.
2. Contact the State Office and give them the missing check numbers. They will research the computer system for the customer names, ID numbers, and store numbers on the checks.
3. Write the date, participant numbers, and your signature on the Check Register. Include a note of the circumstances that surround the checks (i.e., lost or stolen).
4. If the reported checks were improperly redeemed, further steps will be taken by the State Office.

SMALL AMOUNTS FROM THE CLINIC

If a small amount of checks (1-30) are missing from someone's desk, call the State Office and report the missing check numbers. The State Office will research these checks and notify the clinic if there are further questions.

LOST OR STOLEN CHECKS IN THE MAIL

If checks have been mailed to a WIC participant and the participant reports that they have not received the checks:

Review your documentation to see when the checks were mailed. Has there been enough time allowed for the checks to be delivered to the participant?
If so:

1. Void and reissue checks. Do not mail checks again. The participant needs to come in to the clinic to pick them up. This differs from the policy of "not replacing lost or stolen checks" because the participant never received the checks.
2. Fill out a Check Audit Form and send to the State Office.
3. Instruct the participant that if he/she receives the old checks in the mail, they need to destroy them or bring them back to the clinic. The checks are no longer valid. If the participant redeems them, the participant will be responsible for reimbursing the State for the amount of the checks.

LOST OR STOLEN FROM PARTICIPANT

WIC participants are responsible for their checks once they have received them from the WIC clinic. Checks that are lost, misplaced, destroyed, or stolen are not to be replaced unless one of the following situations has occurred:

RECOGNIZABLE CRIMINAL ACT

- Defined as a loss with a minimum value of $500, not including the value of the WIC checks (e.g., burglary or theft). A valid police report must verify claim of loss.

MAJOR CATASTROPHE

- In case of a fire, the client needs to bring in some verification that there was a major fire: a Fire Investigation Report, a Fire Incident Report, or a newspaper clipping. If anyone on the WIC staff personally knows the circumstances of the fire, a verbal verification can be used to document the fire.
- Since the foods from previously redeemed checks will probably be destroyed in a fire or flood, you may need to replace checks that have already been redeemed. If the recipient's next appointment is one or two weeks away, you may not need to replace the full food package.
- Void the appropriate checks and reissue them.
- Fill out a Check Audit Form and send it to the State Office.
- Fill out the Check Register.
- Instruct the WIC participant that you are voiding the previous checks. If she/he happens to find that the checks were not destroyed, instruct the participant not to cash them to avoid having to reimburse the State for the amount of the checks.

DAMAGED OR MUTILATED CHECKS

If a WIC customer can produce the damaged, mutilated, or washed checks, the WIC clinic personnel may choose to replace some or all of the checks.

There are situations where the State Office can approve checks to be replaced, for instance if a mom lost her infant's formula checks and the infant has been diagnosed as failure to thrive, or a homeless person had checks and food stolen. These situations need to be reviewed case by case by the local agency Coordinator in consultation with the State Office.

DIRECT BILL

Effective: 01/xx/01
Revision: 10/01/07

POLICY

A Direct Bill is an alternative to issuing checks that is used in very limited circumstances when formula/medical food cannot be purchased with WIC checks. The form replaces WIC checks and must be filled out completely by a local agency Registered Dietitian.

LIMITED USE

A Direct Bill is primarily used for WIC-eligible medical foods not available on checks. The formula or medical food is usually issued for a very limited time for a specific participant.

- Use of the Direct Bill must be authorized by the State Office.
- Nutrition Risk Criteria 100 – WIC-eligible medical food must be entered on the Client Health Screen.

VENDOR

The vendor must submit the white copy of the Direct Bill with the original invoice to the State Office for payment.

- The formula/medical food does not have to be listed on the vendor's food table, but availability needs to be confirmed.

PARAMETERS

The amount (include number and size of cans) and specific formula/medical food(s) must be itemized in section 3 on the form.

The vendor will only be paid for what is listed.

PROCEDURE

The Direct Bill form must be filled out completely.

1. This section has 3 parts:

   - Clinic Number
   - First Day to Use: It will be the day the client received the Direct Bill from the clinic.
   - Last Day to Use: It is approximately 30 days after the First Day to Use date.

2. This section has 3 parts:

   - Responsible Adult
   - Participant Name
   - WIC participant ID number

3. Fill in the total amount/quantity and nutritional supplement requested (WIC-eligible medical food).
4. The local agency Registered Dietitian must sign the Direct Bill form to authorize its use.

- The pre-arranged vendor's name and address must be listed on the form below the Registered Dietitian's signature.

5. The participant or responsible adult/caregiver signs on the Responsible Adult Signature line at the time they are given the form and then signs on the Responsible Adult countersignature line when they receive the amount of formula/medical food specified.

6. Clinic Staff Signature line is signed only when the formula/medical food is delivered to the clinic office and a clinic staff person signs for the shipment. When the client comes to pick up the shipment, the Responsible Adult signs on both the signature and countersignature lines and completes the data the shipment is received.

REFERENCES

- State Policy

CHECK ISSUANCE

Effective: 09/01/04
Revision: N/A

POLICY

WIC participants are eligible to receive 1-, 2-, or 3-month sets of checks at each visit. Participants have the option to request and receive monthly check issuance, even if the local WIC agency has decided to schedule multi-month check issuance for all appropriate participants.

NOTE: The State WIC Office has the option to direct local agency staff to issue monthly checks to a participant, for example, if the participant is under investigation for non-compliance.

The local WIC agency has the option to limit certain categories of participants to 1- or 2-month check issuance. If the local WIC agency decides to limit certain categories of participants, the local WIC agency will develop a written policy to include:

- A statement authorizing the Competent Professional Authority (CPA, CA) or local agency Registered Dietitian (RD) as the person responsible for determining participant eligibility for 1-, 2- or 3-month checks.
- A list of participant characteristics which would require the participant to receive 1- or 2-month check issuance. Distinction should be made between participants able to receive 2-month versus 1-month checks.
- A statement or notation describing the reason why a participant has been determined to receive 1- or 2-month check issuance.

NOTE: The policy and proposed revisions shall be submitted to the State Office for review prior to implementation. A copy of the policy will be on file at the local WIC agency.

JUSTIFICATION

The choice of 1-, 2-, or 3-month check issuance provides flexibility for participants and for clinic staffing. Multi-month check issuance can enhance clinic resources, participant satisfaction, and nutrition services because each check pick-up is associated with nutrition education.

PROCEDURE

Local WIC agency clinic(s) have on file the policy for 1-, 2-, or 3-month check issuance before implementing 3-month check issuance.

1. Review participant's priority status, care plan and your local agency policy to determine appropriateness of 1-, 2-, or 3-month check issuance.

2. Determine a proposed check pick-up schedule with the participant. It is recommended to schedule all family members according to the same check issuance schedule.

3. Follow procedure for issuing checks. In WIC ID Folder, place first month's checks in first pocket (left side), second month's checks in middle pocket, and third month's checks in last pocket (right side) to avoid participant confusion. Local agency may wish to staple each month's checks in upper left-hand corner to avoid checks from other month(s) inadvertently getting mixed up.

4. Advise participants that if they miss their next scheduled appointment or fail to reschedule, it may be necessary to adjust the check issuance schedule based on certification/re-certification scheduling.

5. Advise participants who call in to change a scheduled appointment to let the receptionist know if they are receiving 1-, 2-, or 3-month checks.

6. Advise participants that if their nutritional status changes, they may need to come in more frequently for WIC to provide better follow-up of care.

7. Advise participants that 2- or 3-month check issuance is on a case-by-case basis decided by each local agency to better serve WIC participants and meet specific local agency requirements. Two- or 3-month check issuance is not one of their rights as a WIC participant.

CHECK ISSUANCE PARAMETER GUIDANCE

Effective: 09/01/04
Revision: 10/01/07

PARAMETERS

Rationale for limiting participant eligibility for multi-month check issuance will vary across the State. In writing the local WIC agency policy regarding 2- or 3-month check issuance, clinic staff may want to consider the following issues:

1. Nutritionally high-risk participants: These participants may require a follow-up nutrition education contact with an RD or breastfeeding consultant more than once during a certification period. The RD may want to determine multi-month check issuance for these participants on a case-by-case basis.

2. Pregnant women: The local WIC agency clinic may partner with another program to provide comprehensive prenatal services. Pregnant women may need to be scheduled monthly to coordinate with these services. Pregnant women who have not seen a health care provider may need to be seen monthly for better monitoring and follow-up of referral needs.

3. Breastfeeding or postpartum women and their infants: Breastfeeding or postpartum women may need to be scheduled more frequently to ensure feeding is well established and supported during the first three to six months.

4. Participants who missed their second nutrition education appointment or infants who missed the six-month health assessment: Reschedule the missed appointment as soon as possible and try to keep the participant on the same issuance schedule. If the appointment must be scheduled for the following month, the participant may need to change to a different issuance schedule (e.g., 1- or 2-month check issuance).

5. Homeless participants

6. Foster children in short term care: It may be beneficial to schedule these participants on a monthly basis.

7. Participants receiving WIC-eligible medical foods: No change to current policy. (Special circumstances per local agency Coordinator and/or RD discretion)

8. Potential difficulty of participant/caregiver to manage multiple sets of checks: An example is the possibility of losing checks or cashing checks out of the valid date. The local agency Registered Dietitian (RD) or CPA may want to determine multi-month issuance for these participants on a case-by-case basis.

9. Mailing checks: Mailing WIC food checks is discouraged as it hinders the delivery of health nutrition education services. Checks may be mailed for one month only issuance.

10. Transfers from one clinic to another or from one state to another: No change to current policy.

11. Changing food packages, formula intolerance, or returning formula: No change to current policy.

12. Proxy check pick-up.

13. Any check violations/sanctions or other issues related to check misuse.

CHAPTER 8: STAFF TRAINING

Effective: 01/xx/01
Revision: N/A

OVERVIEW

Three levels of clinical competency are available to paraprofessional staff employed by the Idaho WIC Program.
The first competency is basic skills, the second is advanced skills and the third is continuing skills. This chapter discusses training and measuring competency.

IN THIS CHAPTER

Section A Training Competency

Section B Continuing Skills Training

SECTION A: TRAINING COMPETENCY

Effective: 01/xx/01
Revision: N/A

OVERVIEW

There are three levels of clinical competency available to paraprofessional staff.

- *Basic skills* (required) include the ability to determine WIC program eligibility, tailor supplemental WIC food packages, and make referrals to other health and social services. Basic skills should be completed within 6 months of hire.
- *Advanced skills* (recommended) include effectively providing accurate, simple, and appropriate nutrition education messages to WIC participants. Advanced skills should be completed within 12 months of hire.
- *Continuing skills* (recommended) includes counseling skills and other job related training related to WIC program services. A minimum of 4 hours should be achieved annually.

IN THIS SECTION

Paraprofessional Training Manual
Competencies for Competent Professional Authorities
Measuring CPA Competency

PARAPROFESSIONAL TRAINING MANUAL

Effective: 01/xx/01
Revision: N/A

POLICY

A competency-based, self-instructional manual is used to teach skills. The manual is available on CD-ROM. Resources were developed by local agency and State Office RDs and staff, and were field tested by staff throughout the State.

The *Idaho WIC Program Paraprofessional Training Manual* combines reading, progress checks, worksheets, viewing of audiovisuals, and other learning activities to convey knowledge. Clinic observation and practice sessions are used to augment learning and enhance clinical skills. The *Idaho WIC Program Paraprofessional Training Manual* is divided into two units: Basic Skills and Advanced Skills.

ORDERING TRAINING MANUALS

Each local agency should have at least one *Idaho WIC Program Paraprofessional Training Manual* at the main clinic site.

Additional manuals are available from the State Office. Orders are placed either by e-mail or telephone to the Nutrition Education Coordinator.

Staff are encouraged to keep the manuals to use as reference after completing the program and during the time of their employment.

TRAINING GOALS

- To improve the consistency and accuracy of services provided to participants.
- To increase nutrition knowledge and improve the counseling skills of staff.
- To increase staff confidence and job satisfaction.
- To organize and standardize staff training.

REFERENCE

State policy

COMPETENCIES FOR COMPETENT PROFESSIONAL AUTHORITIES (CPA)

Effective: 01/xx/01
Revision: N/A

POLICY

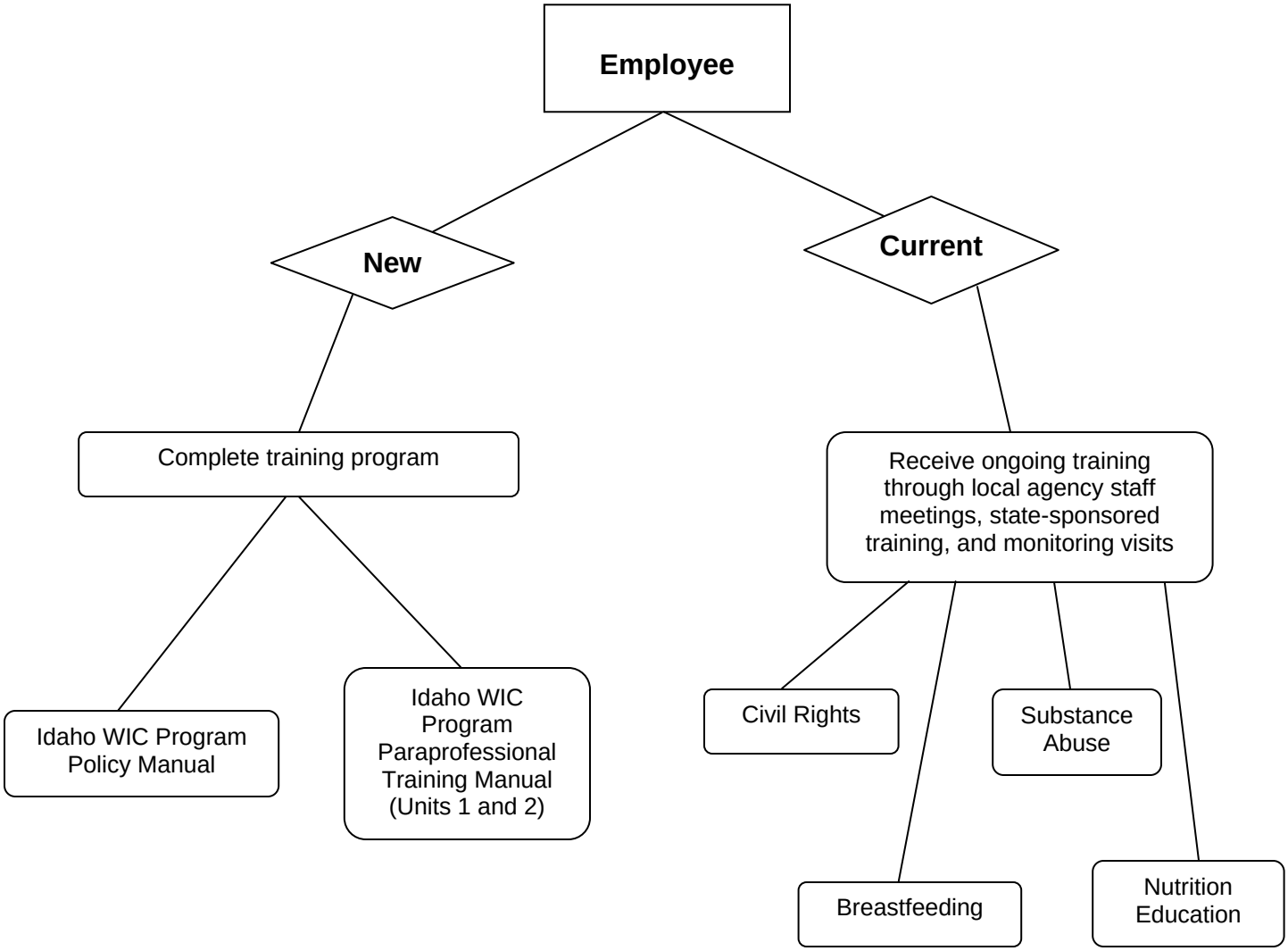
The *Idaho WIC Program Paraprofessional Training Manual* is administered by a local agency appointed trainer (a Registered Dietitian or a trained paraprofessional with at least three years of WIC experience) under whose supervision the trainee will:

- Deliver WIC program services according to established policies and procedures
- Assess the nutritional status of participants by collecting, recording, and comparing to standards the following to determine nutritional risk criteria:
    - Anthropometric Measurements
    - Biochemical Measurements
    - Dietary Data
    - Health
- Demonstrate knowledge of basic nutrition and its application to all WIC participants
- Use appropriate communication techniques during nutrition education contacts
- Plan for the nutritional care of participants based upon assessment findings by:
    - Assisting participants in prioritizing nutrition or health risks
    - Identifying community and agency services that might help resolve risks
    - Tailoring appropriate WIC food packages with participant input
    - Selecting the most practical and relevant nutrition education messages and arranging the most conducive environment in which to communicate them
- Implement nutrition care for participants using planned referral, food delivery, and nutrition education strategies
- Evaluate nutrition care given participants through subsequent assessment of nutritional status, use of WIC foods, and follow-through on nutritional advice and referrals.
- Enter eligibility and education information into the Idaho WIC Computer System.

REFERENCE:

§246.11 (c) (2) Nutrition Education

TRAINING FOR COMPETENT PROFESSIONAL AUTHORITIES (CPA)



MEASURING CPA COMPETENCY

Effective: 01/xx/01
Revision: N/A

POLICY

Each trainee's ability to meet the skills and objectives for each lesson in the *Idaho WIC Program Paraprofessional Training Manual* is rated by the trainer, who supervises progress through the training program. The learning objectives of each section of the manual combine both knowledge and application objectives to support the program competencies. Competency is further assessed through observation, interviewing, quizzes and chart reviews after each section of the manual is completed.

TRAINING PROGRAM EVALUATION

A record of the sections completed by each trainee is kept by local agency Coordinators along with results of observations, interviews, quizzes, and chart reviews. Basic Skills (Unit 1) should be completed within the first six months of employment. Advanced Skills (Unit 2) should be completed within the first year of employment.

The *Idaho WIC Program Paraprofessional Training Manual* is updated and revised periodically based on staff comments and changes in WIC program policies and procedures.

REFERENCE

SECTION B: CONTINUING SKILLS COMPETENCY

Effective: 01/xx/01
Revision: N/A

OVERVIEW

Updates to policies and procedures are typically handled either through training provided by the State Office and/or training materials provided to local agency Coordinators to conduct training for staff.

IN THIS SECTION

Minimum Training Requirements
Breastfeeding Training
Civil Rights Training
Customer Service Training

MINIMUM TRAINING REQUIREMENTS

Effective: 01/xx/01
Revision: N/A

POLICY

Local agencies must provide ongoing training to the staff.

Certain topics must be provided at least annually:

- Breastfeeding
- Civil rights/nondiscrimination
- Customer service training
- Immunizations
- Suspected child abuse reporting (recommended, but not mandatory)

DOCUMENTATION

Agendas with clearly identified training objectives or minutes must be maintained. A roster of staff attending the training or some other means of tracking individual staff must be maintained.

These items will be reviewed during on-site monitoring visits.

REFERENCE

State policy

BREASTFEEDING TRAINING

Effective: 01/xx/01
Revision: N/A

POLICY

Breastfeeding promotion and support training will be included in staff orientation training and offered on an ongoing basis.

SUPPORT STAFF

- Complete "Introduction to WIC" section of the *Paraprofessional Training Manual* within six months of hire.
- Observe at least two different WIC breastfeeding classes.
- Participate in ongoing breastfeeding staff training.

COMPETENT PROFESSIONAL AUTHORITIES

- Complete the breastfeeding section of the *Paraprofessional Training* Manual within six months of hire.
- If available, attend Peer Counselor training.
- Observe at least two different WIC breastfeeding classes.
- Participate in ongoing breastfeeding staff training.
- Attend training seminars as funding permits and state-sponsored training as requested by the State Office.

PROFESSIONAL STAFF

- Complete the breastfeeding section of the *Paraprofessional Training Manual* within 6 months of hire.
- Observe one of each WIC breastfeeding class.
- Attend a 1- to 5-day breastfeeding training within 12 months of hire or document prior attendance at such training in personnel file.
- Participate in and conduct ongoing breastfeeding staff training.
- Attend training seminars as funding permits and state-sponsored training as required by the State Office.

ADVANCED TRAINING

Staff will participate in advanced training opportunities as they are available and funding allows.

REFERENCE

246.11(c)(7)(iii)

CIVIL RIGHTS TRAINING

Effective: 01/01/04
Revision: N/A

POLICY

Local agencies are required to conduct annual civil rights training for WIC staff unless it is provided by the State Office.

TRAINING TOPICS

This training must include, but is not limited to, the following topics:

- Collection and recording of the Race data field on the Client Basic screen.
- Discrimination complaint procedures.
- Reasonable accommodation, including equal assess to program services for the disabled.
- How to provide language assistance services to Limited English Proficiency participants.

DOCUMENTATION

An outline and attendance records for the training should be maintained to document the training occurred.

REFERENCE

7CFR 246.8 Nondiscrimination (01/01/03)
FNS Instruction 113-2, Rev. 1 (06/29/83)
State policy

CUSTOMER SERVICE TRAINING

Effective: 01/xx/01
Revision: N/A

MINIMUM REQUIREMENTS

Include positive customer service as a component of training for all new employees. At a minimum, conduct an annual in-service on quality customer service. Have staff brainstorm ways to improve WIC services on topics such as:

- Nonverbal communication
- Working with difficult participants
- Teamwork
- Preserving participant confidentiality
- Stress management

REFERENCE

State policy

CHAPTER 9: IDAHO WIC COMPUTER SYSTEM

Effective: 01/xx/01
Revision: N/A

OVERVIEW

IN THIS CHAPTER

Section A General Requirements

Section B Reports

SECTION A: GENERAL REQUIREMENTS

Effective: 01/xx/01
Revision: N/A

OVERVIEW

IN THIS SECTION

Help Desk
Data Fields
Security Access
Passwords
Social Security Number
Computer System Down

HELP DESK

Effective: 01/xx/01
Revision: N/A

POLICY

CONTACTS

WIC Help Desk (1-800-942-5811) is available for calls regarding printers, WIC computer applications, software, etc. If not sure of your problem, call the WIC Help Desk.

NOTE: This telephone number is for computer software questions only. Do not use it for other, non-computer system questions.

Information and Technology Service (IT) Help Desk (1-800-399-3503). Use if WIC Help Desk is unavailable.

NOTE: This help desk serves Health and Welfare for the entire State.

Local Agency Systems Technician

1. Hardware problems: call a local agency systems technician. If there is not one, call the IT Help Desk.
2. E-mail problems: call a local agency systems technician or the IT Help Desk

REFERENCE

State policy

DATA FIELDS

Effective: 01/xx/01
Revision: N/A

POLICY

All data fields within the computer system are required except Check Cycle and Cross Reference Number. Several data fields must be reviewed at the time of recertification all others must be checked for current data. New Client Basic (CB) and Client Health (CH) data are required upon certification. The data entered in the computer system impacts the data integrity of the Idaho WIC Program.

DATA INTEGRITY

Correct, valid data must be entered in all computer data fields. Data fields are used to generate reports.

NAME CHANGES

For participants on the Common Client Directory (CCD):

- Print CC screen, mark changes and send to State Office.
- Complete remedy log for changes and send to State Office.
- Call WIC Help Desk.

All copies sent to the State Office will be returned when complete. Checks can be signed with new name before CC is changed, as long as signed the same at the store.

DOB CHANGES

This field impacts the Common Client Directory. Call the WIC Help Desk to make a change to this field.

REFERENCE

State policy

SECURITY ACCESS

Effective: 01/xx/01
Revision: N/A

POLICY

The local agency Coordinator is responsible for his or her agency security access to the host computer. The Coordinator is the only person who can recommend additions, changes or deletions to security access.

The Coordinator must submit the request in writing or e-mail to the WIC Help Desk. Allow one week for a new employee to be added to the security system.

CLINIC LEVEL SECURITY

There are two levels of clinic computer security:

- HWCL - can perform WIC functions and has the ability to transfer clients into own agency.
- HWCR - can perform WIC functions and has the ability to transfer clients into own agency, and print clinic-specific reports and checks for entire clinics.

HARDWARE OR SOFTWARE ACCESS

Protect computers, check printers and confidential information from unknown people wanting to access hardware or software. If staff has a concern regarding strangers in the clinic, follow these procedures until satisfied it is a legitimate computer visit:

- Ask for identification from the person
- Contact the local agency Coordinator or computer support person, to verify
- Call the WIC Help Desk

If staff is still uncomfortable with the person, it is acceptable to refuse entry until receiving proper notification this person is authorized to be in the clinic.

REFERENCE

State policy

PASSWORDS

Effective: 01/xx/01
Revision: N/A

POLICY

Each person is responsible for his or her own password.

- Never share the password with anyone, including computer maintenance people.
- If you think someone may know your password, change it by following the instructions on the controller's CICSPROD computer screen.
- Properly log off the computer every night to prevent someone from using your password.

CHOOSING A PASSWORD

Passwords must be eight characters long and may not include double letters. Mix alpha and numeric characters. Do not use a name that can be associated with you such as your date of birth or address.

REFERENCE

State policy

SOCIAL SECURITY NUMBER

Effective: 01/xx/01
Revision: N/A

POLICY

A Social Security number (SSN) is not required for participation. However, obtaining the SSN is highly recommended.

PREVENTION

The participant's SSN is essential to prevent duplication of records, dual participation between clinics, and to make a match with the Medicaid computer system.

If you suspect that a participant has a fraudulent SSN:

- Double check the SSN card to make sure you read the number correctly
- Serve the participant
- Report the situation to the WIC Help Desk

MEDICAID MATCH

For WIC to make a match with the Medicaid computer system and see if a participant is Medicaid eligible, the following must be the same as Medicaid (EPICS): first five digits of the last name and the SSN.

INVALID SSN

If a SSN is entered incorrectly into the computer system (Common Client Directory screen), contact the WIC Help Desk to have it changed. Do not change it yourself. If you change this data, it can cause major problems for other health programs who also use the Common Client Screen.

REFERENCE

State policy
FNS Policy Memorandum 803-5, *Use of Social Security Numbers*, 10-22-82

COMPUTER SYSTEM DOWN

Effective: 01/xx/01
Revision: N/A

CONTACT	PROBLEM
WIC Help Desk 800-942-5811	Can access the Idaho screen, but can't get anywhere else within the computer system. Problems with hardware and or installations that need tracking Problems with WIC system software WIC security access (expired passwords) Cartridge problems that could cause check problems at the bank Don't know who to call Can't get into the Idaho screen All PCs are "clocking"
IT Help Desk (Information and Technology Services Division) 800-399-3503	WIC Help Desk is unavailable
Local Agency Systems Technician	Hardware issues E-mail problems

SECTION B: REPORTS

Effective: 01/xx/01
Revision: N/A

OVERVIEW

There are five types of reports:

- **Main Menu Reports** are run upon request via the Idaho WIC Computer System
- **State Generated Reports** which are run at the State Office and mailed to the local agency
- **Data Warehouse Reports** run at the State Office upon request
- **Paper Reports** which are forms that are manually filled out by WIC staff
- **Federal Reports**

IN THIS SECTION

Alphabetical Report
Appointment Schedule report
Appointment Summary Future Report
Appointment Summary Past Report
Bank Tape Reconciliation Report
Breastfeeding Report
Dual Participation Report
Enrollment Report
Immunization Tracking Report
Missed Appointments Report
Obligation Status to Date Report
Out-of-State Enrollment Report
Participation Report
Pediatric Nutrition Surveillance System (PedNSS)
Pregnancy Nutrition Surveillance System (PNSS)
Pregnancy Report
Prevalence of Nutritional Risks
Termination Report
Unmatched Redemptions Report

REPORTS

Title	Description	Type	Run Date	Retention
Alphabetical Report	List of active clients within a clinic for a specified date range.	Main Menu	Requested and printed by local agency staff as needed	Not required
Appointment Schedule Report	List of appointments by clinic. Lists date, time, and type of appointments.	Main Menu	Requested and printed by local agency staff as needed	Not required
Appointment Summary Future Report	Summary of appointments scheduled in the future by appointment type and by category. Must request a specific date range.	Main Menu	Requested and printed by local agency staff as needed	Not required
Appointment Summary Past Report	Summary of appointments scheduled in the past, by category. Must request a specific date range.	Main Menu	Requested and printed by local agency staff as needed	Not required
Bank Tape Reconciliation Report	Total of checks and amount of money for redeemed checks	State Generated	Run on the 7th working day of the month	State Office retains for four years
Breastfeeding Report	List of mothers and infants who are breastfeeding. The Mother ID on the infant Client Basic screen is the link between mother and infant records.	Main Menu	Run on the 7th working day of the month. Downloaded to the check printer in the agency main office.	State Office retains for four years; local agency is not required to retain

Title	Description	Type	Run Date	Retention
Dual Participation Report	List of clients with potential dual participation within the state. This report is researched and retained at the State Office. Local agencies are contacted as needed for follow-up.	State Generated	Run on the 7th working day of the month	State Office retains for four years
Enrollment Report	Monthly total of clients enrolled by category, age and priority. Not all enrolled clients receive checks each month.	State Generated	Run on the 7th working day of the month. State Office distributes to local agency Coordinator.	State Office retains for four years; local agency is not required to retain
Immunization Tracking Report	List of enrolled children who are less than two years old	Data Warehouse	Quarterly	Not required
Missed Appointments Report	List of clients who do not have a “Y”or have an “N” in the Attend field in the Client Appointment screen	Main Menu	Requested and printed by local agency staff as needed	Not required
Obligation Status to Date Report	Total of obligated, deobligated, redeemed, and outstanding checks	State Generated	Run the 7th working day of the month	State Office retains for four years
Out-of-State Enrollment Report	List of clients residing outside Idaho. This is researched and retained by the State Office. Local agencies are contacted as needed for follow-up.	State Generated	Run the 7th working day of the month	State Office retains for four years
Participation Report	Monthly total of clients receiving checks by category, priority, and race	State Generated	Run the 7th working day of the month. State Office distributes to local agency Coordinator.	State Office retains for four years; local agency is not required to retain

Title	Description	Type	Run Date	Retention
Pediatric Nutrition Surveillance System (PedNSS)	Idaho submits data to the national surveillance system sponsored by the Centers for Disease Control and Prevention (CDC)	Federal	CDC provides annual reports to contributing states	Not required
Pregnancy Nutrition Surveillance System (PNSS)	Idaho submits data to the national surveillance system sponsored by the Centers for Disease Control and Prevention (CDC)	Federal	CDC provides annual reports to contributing states	Not required
Pregnancy Report	List of enrolled pregnant women and their feeding preferences. Address labels are available from this report.	Data Warehouse	Run the 10th working day of the month	Not required
Prevalence of Nutritional Risks – Children by Age	Report of nutrition risks of participants. Information includes health and demographic data. Highlights are published in the Nutrition Surveillance Report of the Idaho WIC Program.	State Generated	Semi-annually. Reports are distributed annually in conjunction with the Nutrition Surveillance Report of the Idaho WIC Program.	Not required
Prevalence of Nutritional Risks – Children by Ethnicity	Report of nutrition risks of participants. Information includes health and demographic data. Highlights are published in the Nutrition Surveillance Report of the Idaho WIC Program.	State Generated	Semi-annually. Reports are distributed annually in conjunction with the Nutrition Surveillance Report of the Idaho WIC Program.	Not required

Title	Description	Type	Run Date	Retention
Prevalence of Nutritional Risks – Women by Category	Report of nutrition risks of participants. Information includes health and demographic data. Highlights are published in the Nutrition Surveillance Report of the Idaho WIC Program.	State Generated	Semi-annually. Reports are distributed annually in conjunction with the Nutrition Surveillance Report of the Idaho WIC Program.	Not required
Prevalence of Nutritional Risks – Women by Ethnicity	Report of nutrition risks of participants. Information includes health and demographic data. Highlights are published in the Nutrition Surveillance Report of the Idaho WIC Program.	State Generated	Semi-annually. Reports are distributed annually in conjunction with the Nutrition Surveillance Report of the Idaho WIC Program.	Not required
Termination Report	List of clients who terminated during a specific week	Main Menu	Downloaded every two weeks to clinic sites with a check printer	State Office retains for four years; local agency is not required to retain
Unmatched Redemptions Report	A list of checks that were redeemed at the bank but there is no record the checks were issued to a client.	State Generated	Run the 7th working day of the month. State Office distributes to local agency Coordinator.	State Office retains for four years; local agency is not required to retain

CHAPTER 10: VENDOR RELATIONS

Effective: 01/xx/01
Revision: N/A

OVERVIEW

This chapter describes various functions related to vendors contracted to provide foods to participants.

IN THIS CHAPTER

Section A Local Agency Responsibilities

Section B State Office Responsibilities

SECTION A: LOCAL AGENCY RESPONSIBILITIES

Effective: 01/xx/01
Revision: N/A

OVERVIEW

IN THIS SECTION

Local Agency Contract Agreements
Returned Checks
Foods Not Available
Conducting a Preauthorization Visit for New Vendors

LOCAL AGENCY CONTRACT AGREEMENTS

Effective: 01/xx/01
Revision: N/A

POLICY

The local agency is required by contract agreement to:

- Use the State food delivery system
- Address vendor issues per the following:
  - Provide two staff people to assist with compliance investigations two days per year
  - Provide at least one local agency staff person to be present at each vendor training session held within the agency's service area
  - Contact a vendor with customer/vendor concerns

ON-SITE REVIEW

A local agency may be asked to conduct an initial on-site review for a new store using the New Vendor Authorization Visit form.

A local agency may be asked to conduct a store authorization visit using the New Vendor Authorization Visit form for stores who are currently authorized but have changed names.

INCIDENT REPORT

When a local agency receives a Complaint or Incident Report from a participant, the local agency will immediately send the report to the State Office.

CHECKOUT PROCEDURE

A local agency shall discuss checkout procedures with the participant at the first visit and subsequent visits as needed. Checkout procedures should include, but are not limited to, using checks according to the printed dates, choosing the correct foods printed on the check from the Idaho WIC Authorized Food List, signing WIC checks after verifying the correct dollar amount.

PREAUTHORIZATION VISIT

All new authorized vendors are required to have an initial authorization visit conducted by a State Office or local agency employee. Refer to "Conducting a Preauthorization Visit."

RETURNED CHECKS

When the local agency receives a copy of returned checks from the State Office, the local agency will discuss the check return problem(s) and corrective action with the participant.

- The Rights and Responsibilities form will need to be signed again at this time.
- Comments from the participant should be noted in the participant's file and a copy mailed to the State Office.

REFERENCE

State policy

RETURNED CHECKS

Effective: 01/xx/01
Revision: N/A

POLICY

All returned checks require the following actions:

1. WIC staff must re-educate the participant
2. Vendors must return the original check(s) to the State Office immediately for possible reimbursement.
3. Vendors must retrain personnel on proper check cashing procedures found in the WIC Vendor Guide.

The bank returns checks to vendors unpaid for the reasons listed below.

Missing Signature
When the signature is missing from the Authorized Signature box (must be signed at the vendor counter), the check will be returned unpaid to the vendor from the bank.

Invalid Vendor
When a participant uses a WIC check at a vendor other than an Idaho WIC authorized vendor, the bank will return the check unpaid to the vendor as “Invalid Vendor.”

Post Dated
When a check is used prior to the “First Day to Use” date printed on the check, the bank will return the check unpaid to the vendor as “Post Dated.”

Stale Dated (Expired Dates)
When a WIC check is used after the “Last Day to Use” date printed on the check, the bank will return the check unpaid to the vendor as “Stale Dated.”

Alterations
Altered checks are returned to the vendor unpaid. Check alterations consist of, but are not limited to:

- Using correction fluid anywhere on the WIC check
- Crossing out or writing over any printed information on the check
- Dollar amount or signature(s) blacked out, written over, or unreadable
- Changing or writing over the first signature

The clinic will be asked to investigate the reason for the alteration and reply to the Vendor Coordinator.

Excessive Dollar Amount
The bank will return checks stamped “Excessive Dollar Amount” if the amount written in the “Pay Exactly” box exceeds the maximum amount estimated by the computer. Excessive dollar amount checks may be caused by, but are not limited to:

- Vendor provides more food than what is printed on the check, (e.g., 37 oz. of cereal instead of 36 oz., or six 32 oz. cans of Enfamil instead of six 16 oz. cans)
- Dollar amounts transposed or multi-check transactions
- Infant cereal with added fruit is purchased (not allowed on WIC)
- Illegible handwriting appears in the “Pay Exactly” box.

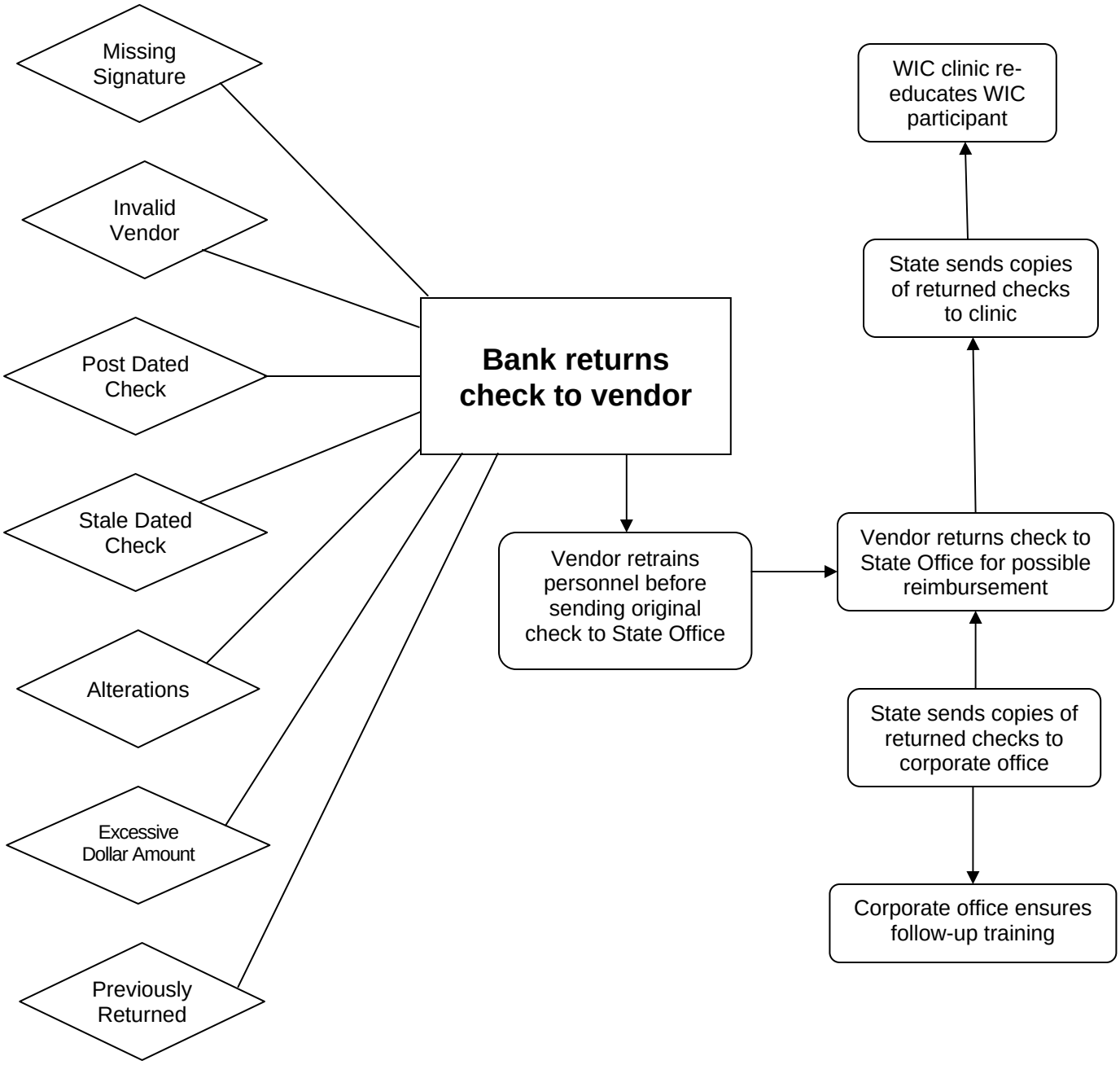
Previously Returned
EVERY returned WIC check is stamped by the bank "VOID. . . DO NOT REDEPOSIT." Checks returned by the bank cannot be redeposited by the vendor.

Vendors should return checks to the State Office immediately for possible reimbursement.

REFERENCE

State policy

BANK RETURNS



FOODS NOT AVAILABLE

Effective: 01/xx/01
Revision: N/A

POLICY

Credit slips or rainchecks are not allowed.

INFANT FORMULA

If there is not enough formula in stock to fill the amount printed on the check there are other options available.

- Preferred option: The participant may shop at another Idaho WIC authorized vendor.
- Alternate option: If the vendor's freight shipment is due in that evening or the next morning, the vendor may ask the participant to come back later that evening or the next day to purchase the infant formula.
- No substitutions are allowed.

OTHER FOODS

The participant may choose to not purchase the food item that is out of stock.

- A participant may come back later that day or the next day to purchase everything on the check.
- If the check will expire before the food item ordered arrives, the participant may choose to purchase similar authorized food items in stock (e.g., 46 oz. Seneca grape juice instead of 46 oz. Welch's grape juice).
- The local agency or State Office may contact the vendor to ensure the minimum stocking requirements are being met.
- The local agency should encourage the participant to use checks before the Last Day to Use.

NOTE: Participants should be encouraged to use the checks before the "Last Day to Use" to avoid the possibility of forfeiting the food items on that check.

REFERENCE

State policy

CONDUCTING A PREAUTHORIZATION VISIT FOR NEW VENDORS

Effective: 01/xx/01
Revision: N/A

POLICY

This visit is conducted by either State Office or local agency staff. The Vendor Coordinator will work with the local agency Coordinator if this responsibility will fall to local staff. The Vendor Coordinator will provide all necessary forms and documentation prior to the visit.

INSTRUCTIONS

1. Staff person must identify herself or himself to the store or manager prior to conducting the preauthorization visit. The staff person may have the store director or manager escort them around the store to answer any questions they may have.

2. The State staff will have conducted training sessions, either prior to or at the time the store is authorized as a WIC store. Staff person must ask if store personnel have any questions regarding the WIC Vendor Guide and Idaho Authorized Food List.

3. Staff person must verify all food prices against a copy of the vendor's price list.

4. Staff person must complete all the questions on the New Vendor Authorization Visit form.

5. Do not fill out the section marked "State Use Only."

6. After food prices on the price lists have been verified and the new vendor form has been completed, the staff person can recommend this store for WIC approval.

VISIT RESULT - APPROVED

If the vendor is approved, the store manager should receive a signed copy of the contract at the time of the visit. The vendor copy is identified by a red "Vendor Copy" stamp. Return all other documentation to the State Office.

VISIT RESULT - DISAPPROVE

If the vendor is not approved, the person who conducted the visit must document the reasons for disapproval and return all documentation to the State Office.

REFERENCE

State policy

SECTION B: STATE OFFICE RESPONSIBILITIES

Effective: 01/xx/01
Revision: N/A

OVERVIEW

This section describes the vendor-related activities which are the responsibility of the State Office.

IN THIS SECTION

Vendor Selection and Authorization
Vendor Closure or Owner Change
Vendor Price Update
Vendor Training
Vendor Monitoring
Vendor Hearing

VENDOR SELECTION AND AUTHORIZATION

Effective: 01/xx/01
Revision: N/A

POLICY

A prospective vendor must complete and submit an Idaho WIC Program Vendor Application and Vendor Contract to the Vendor Coordinator for consideration of possible authorization. See “Idaho WIC Program Vendor Application Selection and Authorization Criteria” for details.

All new authorized vendors are required to have an initial authorization visit and training session conducted by a State staff member or a local agency staff member.

All Idaho Vendor Contracts are for a three-year period unless the vendor is found to be out of compliance, has committed fraud, or has otherwise abused the program.

REFERENCE

State policy

VENDOR CLOSURE OR OWNER CHANGE

Effective: 01/xx/01
Revision: N/A

POLICY

When vendor ownership changes, the existing Vendor Contract is immediately terminated. Vendor Contracts are non-transferable. New owners are required to submit a new Vendor Application and Contract to be considered for authorization.

All vendor owner changes and closures must be reported to the Vendor Coordinator by the owner.

REFERENCE

State policy

VENDOR PRICE UPDATE

Effective: 01/xx/01
Revision: N/A

POLICY

The food and infant formula price updates will occur at least twice a year or more frequently.

REFERENCE

State policy

VENDOR TRAINING

Effective: 01/xx/01
Revision: N/A

POLICY

Vendors are required to receive interactive training annually. Vendors are notified of the training by certified mail and are instructed to send a representative from each store for face-to-face training.

TRAINING TOPICS

During the training, the Vendor Coordinator provides updated information such as:

- WIC Vendor Guide
- Authorized Food Lists
- Training certificate with vendor-specific information such as check volume
- Complaint or Incident Report forms

Vendors are required to provide training to their employees who handle WIC transactions. If a vendor experiences multiple check redemption problems, training is provided by the State WIC Vendor Coordinator.

Vendor bulletins are provided as needed. Bulletins are prepared when program changes occur (e.g., new sole source infant formula rebate contractor selected).

The WIC Vendor Guide is distributed annually. Complaint or Incident Report forms are provided upon request.

INCIDENT REPORTS

Vendors are informed in writing when a Complaint or Incident Report form has been filed against the store for various reasons (e.g., charging sales tax, out of stock of authorized WIC foods).

REFERENCE

State policy

VENDOR MONITORING

Effective: 01/xx/01
Revision: N/A

POLICY

On-site monitoring visits are conducted on a minimum of five (5) percent of all authorized vendors. Follow-up on-site monitoring may be conducted with a new vendor.

- All on-site monitoring visits will be documented and a copy left with the vendor at the time of the visit.
- On-site monitoring visits may be conducted unannounced.

COMPLIANCE INVESTIGATION

All compliance investigations are conducted at an unannounced vendor location. Compliance investigations are documented immediately upon exiting the store.

Criteria have been established by the State Vendor Coordinator to determine if a store warrants a compliance investigation. Compliance investigations are conducted to determine if a vendor requires additional training.

Original checks are obtained from the bank by the State Office to compare with the sales receipt received at the time of the transaction. Vendors are notified in writing by the State Office.

Vendors are instructed and provided with materials to retrain all personnel who handle checks on the proper checkout procedures and authorized food items.

If a vendor has a repeat compliance investigation with negative results, follow-up action will be taken as stated in the Idaho WIC Program Vendor Contract, Appendix A, Sanction Point System.

REFERENCE

State policy

VENDOR HEARING

Effective: 01/xx/01
Revision: N/A

POLICY

All administrative proceedings shall be governed by the provisions of IDAPA 16.05.03.

A vendor may request an administrative hearing under the following circumstances:

- Application for participation is denied
- Vendor disqualified
- Any other adverse action is taken which affects participation in the WIC Program

When a vendor is notified of the decision by the State Office denying participation, a 15-day advance written notice is given. The vendor is advised at that time that a written request for a hearing must be made within 35 days.

FOOD STAMP DISQUALIFICATION

The State Office will disqualify a vendor who has been disqualified from the Food Stamp Program. The disqualification will be for the same length of time as the Food Stamp Program disqualification. The disqualification may begin at a later date than the Food Stamp Program disqualification, and shall not be subject to administrative or judicial review under the WIC Program. Additionally, disqualification of a vendor from the WIC Program may result in a disqualification from the Food Stamp Program. The disqualification shall not be subject to administrative or judicial review under the Food Stamp Program.

PROCEDURE

A hearing will be provided at the State level. Any vendor asking for information about hearings should be referred to the State Vendor Coordinator.

REFERENCES

246.18(a)(1) Vendor appeals
IDAPA 16.05.03 Rules Governing Contested Case Proceedings and Declaratory Rulings

CHAPTER 11: MONITORING

Effective: 01/xx/01
Revision: N/A

OVERVIEW

The State Agency will conduct on-site monitoring reviews of each local agency at least once every two years. This chapter describes the process and what local agencies can do to monitor themselves.

IN THIS CHAPTER

Section A Local Agency Monitoring

SECTION A: LOCAL AGENCY MONITORING

Effective: 01/xx/01
Revision: N/A

OVERVIEW

It is the purpose of this section to ensure that local agencies comprehend and comply with federal and state regulations, policies and procedures.

IN THIS SECTION

Quality Assurance (QA) Local Agency On-Site Monitoring
Quality Assurance (QA) Local Agency Self-Monitoring

QUALITY ASSURANCE (QA) LOCAL AGENCY ON-SITE MONITORING

Effective: 01/xx/01
Revision: N/A

POLICY

Each local agency's clinical operations, fiscal management and food delivery systems shall be monitored for compliance with state and federal regulations, rules, and policies and procedures at least once every two years (biannually). The State Office may conduct additional on-site reviews if it determined to be necessary in the interest of the efficiency and effectiveness of the program.

The reviews will include an on-site visit to a minimum of 20% of the clinics in each local agency or one clinic, whichever is greater.

Monitoring of local agencies must encompass evaluation of the following areas:

- Management
- Certification
- Nutrition education
- Participant services
- Civil rights compliance
- Accountability
- Financial management systems
- Food delivery

PURPOSE

The on-site review assesses:

- How the local agency is providing services to WIC participants
- Whether or not there is confusion about guidance provided by state and federal policies
- Training needs of local agencies
- Information flow
- Questions/discussion related to program service improvement

PROCEDURE

Upon notification by the State Office of an on-site quality assurance (QA) monitoring review, the local agency Coordinator will work with the Clinic Operations Coordinator to determine a mutually agreeable schedule for the on-site review. Once a date for the on-site review has been agreed upon, the Clinic Operations Coordinator will confirm via written correspondence on department letterhead the date of the on-site review, State staff that will be on site, and any additional information needed by the local agency prior to the review.

The local agency Coordinator shall make available requested documentation, including, but not limited to, participant records, staff training logs, equipment inventory, and local agency policies/procedures differing from State for review by State staff while on site.

Local agencies may be asked by the State Office staff to complete monitoring forms prior to the actual on-site review.

Entrance Meeting

Upon arrival at the local agency, the State staff will meet with the local agency Coordinator to review the on-site QA monitoring process and schedule of events.

Exit Meeting

At the completion of the on-site QA monitoring review, the State staff will meet with the local agency Coordinator and any others the Coordinator wishes to have present at the exit meeting. State staff will discuss the results of the on-site review and any areas requiring corrective action on the part of the local agency.

Report(s)

The Clinic Operations Coordinator for the State will compile the results of the on-site QA monitoring review into a formal written report within 60 days on return to the State Office, to be shared with the local agency Coordinator and/or contracting agency contacts.

The local agency must submit a corrective action plan, including implementation timeframes, within 60 days of receipt of the State agency report of the QA monitoring review containing a findings of program non-compliance.

Sample On-site Monitoring Forms

State Monitoring

State Financial Review

State Observation

State Chart Review

QUALITY ASSURANCE (QA): LOCAL AGENCY SELF-MONITORING

POLICY

Each local agency will conduct a QA self-monitoring of each clinic at least every two years (bi-annually). Self-monitoring does not need to be conducted in clinic sites where the State Office performs on-site monitoring. The clinic sites designated for self-monitoring by the local agency Coordinator will be reviewed using the standard Local Agency Self-Monitoring form.

Monitoring of clinic sites must encompass the following areas:

- Management
- Certification
- Nutrition education
- Participant services
- Civil rights compliance
- Accountability
- Financial management systems
- Food delivery

PURPOSE

The clinic review assesses:

- How the clinic is providing services to WIC participants
- Whether or not there is confusion about guidance provided by state and federal policies
- Training needs for clinic staff
- Information flow
- Questions/discussion related to program service improvement

PROCEDURE

Each local agency Coordinator or designated Registered Dietitian (RD) will schedule and conduct an on-site review of each clinic as described above. The WIC Coordinator must use the standard Local Agency Self-Monitoring form. The following table depicts the number of charts to review using the chart review form based on clinic participant number.

Clinic Size	Number of Chart Review(s)
Less than 500	5
501-3000	10
3001+	15

REPORTS

The local agency Coordinator must send a copy of the completed Local Agency Self-Monitoring form along with the chart review forms for each clinic monitored to the Clinic Operations Coordinator at the

State Office. This may be done as the clinic reviews are completed or may be provided to the State Office by September 30 of each year.

SAMPLE SELF-MONITORING FORMS

Local Agency Self-Monitoring

Local Agency Observation

Local Agency Chart Review

REFERENCE

- 7 CFR 246.19(b) *State Agency Responsibilities*
- State of Idaho, Dept. of Health and Welfare Contract with Local Agency-*Scope of Work*

NUTRITION RISK CRITERIA

IDAHO CODE	USDA CODE	NUTRITION RISK CRITERIA
★09	331	PREGNANCY-VERY YOUNG (< 16 YR)
★11	201	LOW HEMATOCRIT
★12	201	LOW HEMOGLOBIN
13	132	MATERNAL WT LOSS IN PREGNANCY
14	133	HIGH MATERNAL WEIGHT GAIN
15	131	LOW MATERNAL WEIGHT GAIN
★17	111	OVERWEIGHT WOMAN
★18	101	UNDERWEIGHT WOMAN
21	113	OVERWEIGHT–CHILDREN (2-5)
22	103	UNDERWEIGHT-INFANTS/CHILDREN
23	121	SHORT STATURE-INFANTS/CHILDREN
★27	141	LOW BIRTH WEIGHT
28	134	FAILURE TO THRIVE
30	135	INADEQUATE GROWTH
31	114	AT RISK FOR OVERWEIGHT
32	103	AT RISK FOR UNDERWEIGHT
★34	153	LARGE FOR GESTATIONAL AGE
35	381	BABY BOTTLE TOOTH DECAY
36	411 & 425	BBTD RISK BEHAVIORS
37	142	PREMATURITY
40	701	BORN TO WIC MOM
41	701	BORN TO POTENTIAL WIC MOM
45	382	FETAL ALCOHOL SYNDROME
46	411	INAPPROPRIATE NUTRITION PRACTICES (INFANTS)
47	425	INAPPROPRIATE NUTRITION PRACTICES (CHILD)
48	427	INAPPROPRIATE NUTRITION PRACTICES (WOMEN)

(★) Computer Generated

NUTRITION RISK CRITERIA

IDAHO CODE	USDA CODE	NUTRITION RISK CRITERIA
49	355	LACTOSE INTOLERANCE
52	353	FOOD ALLERGY
54	302	GESTATIONAL DIABETES
55	303	HX GESTATIONAL DIABETES
57	301	HYPEREMESIS GRAVIDARUM
★60	331	PREGNANCY-YOUNG AGE
61	335	MULTIFETAL GESTATION
★63	332	CLOSELY SPACED PREGNANCY
66	321	HX FETAL OR NEONATAL LOSS
68	312	HX LOW BIRTH WEIGHT
69	336	FETAL GROWTH RESTRICTION
70	339	HX BIRTH-CONGENITAL DEFECT
71	501	POSSIBILITY OF REGRESSION
★79	502	TRANSFER OF CERTIFICATION (VOC)
80	372	DRUG USE
★81	371	MATERNAL SMOKING
82	372	ALCOHOL USE
86	337	HX BIRTH LGA INFANT
88	311	HX PRETERM DELIVERY (≤ 37 WK)
90	340	NUTRITION RELATED MEDICAL COND
91	343	DIABETES MELLITUS
92	N/A	CHILD WITH INFANT FORMULA PACKAGE
93	351	INBORN ERRORS OF METABOLISM
95	381	DENTAL PROBLEMS
96	358	EATING DISORDERS
100	N/A	WIC ELIGIBLE MEDICAL FOOD
401	401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS

(★) Computer Generated

NUTRITION RISK CRITERIA

IDAHO CODE	USDA CODE	NUTRITION RISK CRITERIA
428	428	DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES
610	338	PREGNANT AND BREASTFEEDING
611	601	BF MOM OF PRIORITY 1 INFANT
612	601	BF MOM OF PRIORITY 2 INFANT
614	601	BF MOM OF PRIORITY 4 INFANT
615	602	BF COMPLICATION-WOMAN
620	603	BF COMPLICATION-INFANT
621	702	BF INFANT OF PRIORITY 1 MOM
624	702	BF INFANT OF PRIORITY 4 MOM
★701	801	HOMELESSNESS
★702	802	MIGRANCY
803	902	FEEDING SKILLS LIMITATION
804	903	FOSTER CARE

Nutrition Risk Criteria **09 ★ PREGNANCY AT VERY YOUNG AGE (< 16 YRS)**
USDA CODE 331

Category, Priority and Referral

Category	Priority	Referral
NON-BREASTFEEDING WOMEN	3	RD

Definition

Conception at less than (<) 16 years. This is the only Priority 3 code for non-breastfeeding postpartum women.

Applies to most recent pregnancy.

Required Documentation

EDC
DOB

Justification

Pregnancy before growth is complete, is a nutritional risk because of the potential for competition for nutrients for the pregnancy needs and the woman's growth.

The pregnant teenager is confronted with many special stresses that are superimposed on the nutritional needs associated with continued growth and maturation.

Younger pregnant women of low socioeconomic status tend to consume less than recommended amounts of protein, iron, and calcium, and are more likely to come into pregnancy already underweight. Pregnant teens who participate in WIC have been shown to have an associated increase in mean birth weight and a decrease in LBW outcomes.

Adolescent mothers frequently come into pregnancy underweight, have extra growth related nutritional needs, and because they often have concerns about weight and body image, are in need of realistic, health promoting nutrition advice and support during lactation. Diets of adolescents with low family incomes typically contain less iron, and less vitamin A than are recommended during lactation.

The adolescent mother is also confronted with many special stresses superimposed on the normal nutritional needs associated with continued growth. Nutrition status and risk during the postpartum period follow from the nutritional stresses of the past pregnancy, and in turn have an impact on nutrition related risks in subsequent pregnancies.

Poor weight gain and low intakes of a variety of nutrients are more common in pregnant adolescents. Therefore, participation in the WIC Program should be of substantial benefit.

References

1. Endres J, Dunning S, Poon SW, Welch P, Duncan H. Older pregnant women and adolescents: nutrition data after enrollment in WIC. J.Am.Diet.Assoc. 1987;87:1011-6, 1019.

2. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

3. Kennedy ET, Kotelchuck M. The effect of WIC supplemental feeding on birth weight: a case-control analysis. Am.J.Clin.Nutr. 1984;40:579-85.

4. Story M, editor. Nutrition management of the pregnant adolescent a practical reference guide. Washington, D.C.: National Clearinghouse; 1990. Sponsored by the March of Dimes Birth Defects Foundation, U.S. Department of Health and Human Services, U.S. Department of Agriculture.

Nutrition Risk Criteria **11 ★ LOW HEMATOCRIT**
USDA CODE 201

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD if
BREASTFEEDING WOMEN	1	$\leq$ 31.0 or no rise
NON-BREASTFEEDING WOMEN	6	on recheck
INFANTS	1	
CHILDREN	3	

Definition

Hematocrit value below a baseline for healthy, well nourished individuals of the same age, sex. Adjustments are made for trimester of pregnancy, smoking status, and altitude. The baseline is the 95th confidence interval (0.025th percentile).

Refer to Table 1 HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES for each clinic site.

Required Documentation

ALL: Hematocrit value and date, Clinic Altitude (Tables)
INFANTS/CHILDREN: DOB
PREGNANT: Weeks Gestation
WOMEN: Smoking Status

Justification

Hemoglobin (Hb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hb and Hct reflect the amount of functional iron in the body. Changes in Hb concentration and Hct occur at the late stages of iron deficiency. While neither an Hb or Hct test are direct measures of iron status and do not distinguish among different types of anemia, these tests are useful indicators of iron deficiency anemia.

Iron deficiency is by far the most common cause of anemia in children and women of childbearing age. It may be caused by a diet low in iron, insufficient assimilation of iron from the diet, increased iron requirements due to growth or pregnancy, or blood loss. Anemia can impair energy metabolism, temperature regulation, immune function, and work performance. Anemia during pregnancy may increase the risk of prematurity, poor maternal weight gain, low birth weight, and infant mortality. In infants and children, even mild anemia may delay mental and motor development. The risk increases with the duration and severity of anemia, and early damages are unlikely to be reversed through later therapy.

Clarification

1. **Basis for bloodwork assessment:** For pregnant women being assessed for iron deficiency anemia, bloodwork must be evaluated using trimester values established by CDC. Thus, a pregnant women would be certified, based on the trimester in which her bloodwork was taken.

2. **Definition of Trimester:** CDC defines a trimester as a term of three months in the prenatal gestation period with the specific trimesters defined as follows in weeks:

First Trimester: 0-13 weeks
Second Trimester: 14-26 weeks
Third Trimester: 27-40 weeks.

Further, CDC begins the calculation of weeks starting with the first day of the last menstrual period. If that date is not available, CDC estimates that date from the estimated date of confinement (EDC). This definition is used in interpreting CDC's Prenatal Nutrition Surveillance System data, comprised primarily of data on pregnant women participating in the WIC Program.

3. **Adjustments for smoking:** A State agency may elect to use only one cutoff for all smokers rather than making specific adjustments based on the individual applicant's smoking frequency. If the State chooses to use only one category for this issue, the "up to <1 pack/day" cutoff values category as shown on Tables 201-A and 201-B is the only one that may be used.

References

1. Centers for Disease Control and Prevention. Criteria for anemia in children and childbearing-aged women. MMWR 1998:47:RR-3.

2. Centers for Disease Control and Prevention. Prenatal Nutrition Surveillance System User's Manual. Atlanta: CDC, 1994.

3. Institute of Medicine. Iron deficiency anemia: recommended guidelines for the prevention, detection, and management among U.S. children and women of childbearing age. National Academy Press, Washington, D.C.; 1993.

4. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

5. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **12 ★ LOW HEMOGLOBIN**
USDA CODE 201

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD if
BREASTFEEDING WOMEN	1	≤ 31.0 or no rise
NON-BREASTFEEDING WOMEN	6	on recheck
INFANTS	1	
CHILDREN	3	

Definition

Hemoglobin value below a baseline for healthy, well nourished individuals of the same age, sex. Adjustments are made for trimester of pregnancy, smoking status, and altitude. The baseline is the 95th confidence interval (0.025th percentile).

Refer to Table 1 HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES for each clinic site.

Required Documentation

ALL: Hemgobin value and date, Clinic Altitude (Tables)
INFANTS/CHILDREN: DOB
PREGNANT: Weeks Gestation
WOMEN: Smoking Status

Justification

Hemoglobin (Hb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hb and Hct reflect the amount of functional iron in the body. Changes in Hb concentration and Hct occur at the late stages of iron deficiency. While neither an Hb or Hct test are direct measures of iron status and do not distinguish among different types of anemia, these tests are useful indicators of iron deficiency anemia.

Iron deficiency is by far the most common cause of anemia in children and women of childbearing age. It may be caused by a diet low in iron, insufficient assimilation of iron from the diet, increased iron requirements due to growth or pregnancy, or blood loss. Anemia can impair energy metabolism, temperature regulation, immune function, and work performance. Anemia during pregnancy may increase the risk of prematurity, poor maternal weight gain, low birth weight, and infant mortality. In infants and children, even mild anemia may delay mental and motor development. The risk increases with the duration and severity of anemia, and early damages are unlikely to be reversed through later therapy.

Clarification

3. **Basis for bloodwork assessment:** For pregnant women being assessed for iron deficiency anemia, bloodwork must be evaluated using trimester values established by CDC. Thus, a pregnant women would be certified, based on the trimester in which her bloodwork was taken.

4. **Definition of Trimester:** CDC defines a trimester as a term of three months in the prenatal gestation period with the specific trimesters defined as follows in weeks:

First Trimester: 0-13 weeks
Second Trimester: 14-26 weeks
Third Trimester: 27-40 weeks.

Further, CDC begins the calculation of weeks starting with the first day of the last menstrual period. If that date is not available, CDC estimates that date from the estimated date of confinement (EDC). This definition is used in interpreting CDC's Prenatal Nutrition Surveillance System data, comprised primarily of data on pregnant women participating in the WIC Program.

Adjustments for smoking: A State agency may elect to use only one cutoff for all smokers rather than making specific adjustments based on the individual applicant's smoking frequency. If the State chooses to use only one category for this issue, the "up to <1 pack/day" cutoff values category as shown on Tables 201-A and 201-B is the only one that may be used.

References

6. Centers for Disease Control and Prevention. Criteria for anemia in children and childbearing-aged women. MMWR 1998:47:RR-3.

7. Centers for Disease Control and Prevention. Prenatal Nutrition Surveillance System User's Manual. Atlanta: CDC, 1994.

8. Institute of Medicine. Iron deficiency anemia: recommended guidelines for the prevention, detection, and management among U.S. children and women of childbearing age. National Academy Press, Washington, D.C.; 1993.

9. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

10. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 1: PANHANDLE WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Bonners Ferry Coeur D Alene Kellogg Plummer Post Falls Sandpoint St. Maries	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 1: PANHANDLE WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Bonners Ferry Coeur D Alene Kellogg Plummer Post Falls Sandpoint St. Maries	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 2: NORTH CENTRAL WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lewiston Moscow Orofino	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---
3000-3999 ft. Grangeville	NON-SMOKER	11.2	10.7	11.2	12.0	11.2	11.3
	SMOKER	11.5	11.0	11.5	12.3	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 2: NORTH CENTRAL WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lewiston Moscow Orofino	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---
3000-3999 ft. Grangeville	NON-SMOKER	33.5	32.5	33.5	36.2	33.4	33.5
	SMOKER	34.5	33.5	34.5	37.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 3: SOUTHWEST WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Bruneau Caldwell Cambridge Council Emmett Farmway Village Grandview Homedale Nampa Nampa Teen Payette Weiser	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---
3000-3999 ft. New Meadows	NON-SMOKER	11.2	10.7	11.2	12.0	11.2	11.3
	SMOKER	11.5	11.0	11.5	12.3	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 3: SOUTHWEST WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Bruneau Caldwell Cambridge Council Emmett Farmway Village Grandview Homedale Nampa Nampa Teen Payette Weiser	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---
3000-3999 ft. New Meadows	NON-SMOKER	33.5	32.5	33.5	36.2	33.4	33.5
	SMOKER	34.5	33.5	34.5	37.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 4: CENTRAL WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Boise-Armstrong Horseshoe Bend	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---
3000-3999 ft. Garden Valley Idaho City Mountain Home Mtn Home AFB	NON-SMOKER	11.2	10.7	11.2	12.0	11.2	11.3
	SMOKER	11.5	11.0	11.5	12.3	---	---
4000-4999 ft. Cascade	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. McCall	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 4: CENTRAL WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Boise-Armstrong Horseshoe Bend	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---
3000-3999 ft. Garden Valley Idaho City Mountain Home Mtn Home AFB	NON-SMOKER	33.5	32.5	33.5	36.2	33.4	33.5
	SMOKER	34.5	33.5	34.5	37.2	---	---
4000-4999 ft. Cascade	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. McCall	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 5: SOUTH CENTRAL WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
3000-3999 ft. Gooding Jerome Shoshone Twin Falls	NON-SMOKER	11.2	10.7	11.2	12.0	11.2	11.3
	SMOKER	11.5	11.0	11.5	12.3	---	---
4000-4999 ft. Burley	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. Hailey	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 5: SOUTH CENTRAL WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
3000-3999 ft. Gooding Jerome Shoshone Twin Falls	NON-SMOKER	33.5	32.5	33.5	36.2	33.4	33.5
	SMOKER	34.5	33.5	34.5	37.2	---	---
4000-4999 ft. Burley	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. Hailey	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 6: SOUTHEASTERN WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Aberdeen American Falls Blackfoot Malad Preston Pocatello Roosevelt Teen	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. Arco Montpelier Soda Springs	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 6: SOUTHEASTERN WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Aberdeen American Falls Blackfoot Malad Preston Pocatello Roosevelt Teen	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. Arco Montpelier Soda Springs	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 7 WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Idaho Falls Rexburg Rigby Salmon St. Anthony Terreton	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. Challis Dubois	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---
6000-6999 ft. Driggs	NON-SMOKER	11.7	11.2	11.7	12.5	11.7	11.8
	SMOKER	12.0	11.5	12.0	12.8	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 7 WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Idaho Falls Rexburg Rigby Salmon St. Anthony Terreton	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. Challis Dubois	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---
6000-6999 ft. Driggs	NON-SMOKER	35.0	34.0	35.0	37.7	34.9	35.0
	SMOKER	36.0	35.0	36.0	38.7	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

NEZ PERCE WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lapwai	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

NEZ PERCE WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lapwai	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

SHOSHONE-BANNOCK WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Fort Hall	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

SHOSHONE-BANNOCK WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Fort Hall	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---

Nutrition Risk Criteria **13 MATERNAL WEIGHT LOSS DURING PREGNANCY**
USDA CODE 132

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD

Definition

FIRST TRIMESTER (weeks 1-13) Any weight loss below pre-pregnancy weight.
SECOND TRIMESTER (weeks 14-26) Weight loss of 2 pounds or greater.
THIRD TRIMESTER (weeks 27-40+) Weight loss 2 pounds or greater.

Required Documentation

Self-reported weight loss is acceptable as long as it meets the criteria
Pre-pregnancy
Height
Weeks Gestation
Amount of weight gained to date

Justification

Weight loss during pregnancy may indicate underlying dietary or health practices or health or social conditions associated with poor pregnancy outcomes. These outcomes could be improved by the supplemental food, nutrition education, and referrals provided by the WIC Program.

References

1. Brown JE. Prenatal weight gain considerations for WIC. Final report. Commissioned by the Risk Identification and Selection Collaborative. 1998.

2. Centers for Disease Control and Prevention. Prenatal Nutrition Surveillance System User's Manual. Atlanta: CDC, 1994.

3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

4. Metropolitan Life Insurance Company. New weight standards for men and women. Stat.Bull.Metrop.Life Insur.Co., 1959.

Nutrition Risk Criteria **14 HIGH MATERNAL WEIGHT GAIN**
USDA CODE 133

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant: Greater than or equal to 7 pounds (lbs.)/month *average* weight gain. Applies to all weight groups, all times of pregnancy.

Breastfeeding/Non-Breastfeeding: Weight status is based on pre-pregnancy weight from most recent pregnancy, not current weight.

- Underweight: (BMI≤ 19.7) Greater than (>) 40 lbs. total gain
- Normal Weight: (BMI 19.8 to 26.0) Greater than (>) 25 lbs. total gain
- Overweight: (BMI 26.1 to 29.0) Greater than (>) 25 lbs. total gain
- Obese: (BMI ≥ 29.1) Greater than (>) 15 lbs. total gain

Multi-fetal Pregnancies: There are no nationally recognized recommendations for upper limit for multi-fetal gestations at this time.

Adolescent Pregnancies: Until research supports the use of different BMI cut-offs to determine weight categories for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility.

Required Documentation

Self-reported weight loss is acceptable as long as it meets the criteria.

Pre-pregnancy Weight
Height
Weeks Gestation
Amount of weight gained to date

Justification

Women with large gestational weight gains are at increased risk for delivering high birth weight infants, which can secondarily lead to complications such as: dysfunctional and prolonged labor, midforceps delivery, cesarean delivery, shoulder dystocia, meconium aspiration, clavicular fracture, brachia plexus injury, and asphyxia. Neonatal mortality begins to rise when birth weight is > 4250g. (> 9 ½ lbs). Infants are at higher risk when birth weight is > 4000g. (> 9 lbs).

High gestational weight gains have been associated with pregnancy induced hypertension, preeclampsia and toxemia, although these associations need further study. One goal in the nutritional counseling provided to pregnant women by WIC is to achieve recommended weight gain by emphasizing food choices of high nutritional quality, particularly those foods high in folic acid and which are important in the prevention of neural tube defects.

Breastfeeding and Non-Breastfeeding women with extremely high weight gains during pregnancy may be at increased risk of subsequent obesity leading to other chronic health conditions. The WIC competent professional authority (CPA) is in an excellent position to remind participating women that providing unnecessary calorie rich foods and participating in moderate and appropriate physical activity and exercise play a significant role in minimizing these risks.

The 1998 National, Heart, Lung and Blood Institute (NHLBI) Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults, define weight classifications differently than the Institute of Medicine (IOM) in their 1990 report, Nutrition During Pregnancy. The IOM classifications were validated for pregnancy by Parker and Abrams and by Siega-Riz et al and others. Recommendations for weight gain during pregnancy therefore are based on the 1990 definitions of prepregnancy weight status. If future research shows that prenatal weight gain using the NHLBI definitions of adult weight status is safe for pregnancy and results in similar pregnancy outcomes, the definitions will be revised.

The IOM established prenatal weight gain recommendations based on prepregnancy BMI weight categories (i.e., low, normal, high, obese). As validated by Parker and Abrams, the IOM weight gain recommendations for each weight category are associated with healthy birth outcomes. The decision to use the IOM recommended BMI weight categories for pregnant adolescents as well as for adults is based on three factors.

- There are no established prepregnancy BMI cut-offs to define prepregnancy weight categories (with corresponding recommendations for prenatal weight gain) specific to adolescents.
- There is no research to support using the CDC issued BMI-for-age chart to define prepregnancy BMI weight categories for adolescents.
- It is consistent with the recommendations of the Expert Work Group on Maternal Weight.

It is recognized that both the IOM and the NHLBI BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM and the NHLBI BMI cut-offs will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

An upper limit on weight gain for multifetal pregnancies (twins, triplets, etc.) has not been definitively established. For twin gestations, the recommended range of maternal weight gain is 35-45 pounds with a gain of 1.5 pounds/week during the second and third trimester. Underweight women should gain at the higher end of the range and overweight women should gain at the lower end of the range. Four to six pounds should be gained in the first trimester. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week through out the pregnancy.

For WIC eligibility determinations, multifetal pregnancies are considered a nutrition risk for WIC in and of themselves (Risk #335), aside from the weight gain issue. Education by the WIC nutritionist or paraprofessional should address a steady rate of gain that is higher than that of the singleton pregnancy.

References

1. **Brown JE and Carlson M. Nutrition and multifetal pregnancy. J Am Diet Assoc. 2000;100:343-348.**

2. Carmichael S, Abrams B, Selvin S. The pattern of maternal weight gain in women with good pregnancy outcomes. Am.J.Pub.Hlth. 1997;87;12:1984-1988.

3. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

5. Metropolitan Life Insurance Company. New weight standards for men and women. Stat.Bull.Metrop.Life Insur.Co., 1959.

6. National Heart, Lung, and Blood Institute, National Institute of Diabetes and Digestive and Kidney Diseases.Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults the evidence report. Bethesda, Md.: National Intstitutes of Health, National Heart, Lung and Blood Institute, 1998 No.: 98-4083.

7. Parker JD, Abrams B. Prenatal weight gain advice: an examination of the recent prenatal weight gain recommendations of the Institute of Medicine. Obstet Gynecol 1992; 79:664-9.

8. Suitor CW, editor. Maternal weight gain: A report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

9. Siega-Riz AM, Adair LS, Hobel CJ. Institute of Medicine maternal weight gain recommendations and pregnancy outcomes in a predominately Hispanic population. Obstet Gynecol 1994; 84:565-73.

10. Waller K. Why neural tube defects are increased in obese women. Contemporary OB/GYN 1997; p. 25-32.

Nutrition Risk Criteria **15 LOW MATERNAL WEIGHT GAIN**
USDA CODE 131

Category, Priority and Referral

Category	Priority	Referral
PREGNANT	1	RD

Definition

Use BMI and pre-pregnancy weight to determine which weight status to use. Low weight gain at any point in pregnancy such that a pregnant woman's weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective pre-pregnancy weight category.

Required Documentation

Self-reported weight loss is acceptable as long as it meets the criteria.

Pre-pregnancy Weight
Height
Weeks Gestation
Amount of weight gained to date

Justification

Low maternal weight gain during the 2nd and 3rd trimesters is a determinant of fetal growth, and is associated with smaller average birth weights and an increased risk of delivering an infant with fetal growth restriction. The supplemental foods and nutrition education provided by the WIC Program may improve maternal weight status and infant outcomes.

The 1998 National, Heart, Lung and Blood Institute (NHLBI) Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults, defines weight classifications differently than Institute Of Medicine (IOM) in their 1990 report, Nutrition During Pregnancy. The IOM classifications were subsequently validated for pregnancy by Parker and Abrams and by Siega-Riz et al and others. If future research shows that prenatal weight gain using the NHLBI definitions of adult weight status is safe for pregnancy and results in similar pregnancy outcomes, the definitions will be revised.

The IOM established prenatal weight gain recommendations based on prepregnancy BMI categories (i.e., low, normal, high, obese). As validated by Parker and Abrams, the IOM weight gain recommendations for each weight category are associated with healthy birth outcomes. The decision to use the IOM recommended BMI weight categories for pregnant adolescents as well as for adults is based on three factors.

- There are no established BMI cut-offs to define weight categories (with corresponding recommendations for prenatal weight gain) specific to adolescents.
- There is no research to support using the CDC issued BMI-for-age chart to define prepregnancy BMI weight categories for adolescents.

- It is consistent with the recommendations of the Expert Work Group on Maternal Weight.

It is recognized that both the IOM and the NHLBI BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM and the NHLBI BMI cut-offs will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

For twin gestations, the recommended range of maternal weight gain is 35-45 pounds with a gain of 1.5 pounds per week during the second and third trimesters. Underweight women should gain at the higher end of the range and overweight women should gain at the lower end of the range. Four to six pounds should be gained in the first trimester. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week through out the pregnancy.

For WIC eligibility determinations, multifetal pregnancies are considered a nutrition risk for WIC in and of themselves (Risk #335), aside from the weight gain issue. Education by the WIC nutritionist or paraprofessional should address a steady rate of gain that is higher than that of the singleton pregnancy.

References

1. Centers for Disease Control and Prevention. (1994) *Pregnancy Surveillance System User's Manual*. Atlanta, GA. Pp. 3-8.

2. Institute of Medicine: (1990) *Nutrition During Pregnancy***.** National Academy Press: pp. 12, 97, 107.

3. Institute of Medicine. (1996) *WIC Nutrition Risk Criteria: A Scientific Assessment***.** National. Academy Press: pp. 73-79.

4. Metropolitan Life Insurance Co. (1959) New weight standards for men and women. 40: 1-4.

5. Suitor, CW. (1997) Maternal Weight Gain: A Report of an Expert Work Group. Arlington, VA: National Center for Education in Maternal and Child Health.

Nutrition Risk Criteria **17 ★ OVERWEIGHT WOMAN**
USDA CODE 111

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant: Body Mass Index (BMI) greater than or equal to (≥) 26.1.

- Use pre-pregnancy weight in BMI calculation.

Breastfeeding/Non-Breastfeeding: BMI greater than or equal to (≥) 25.0.

- Use pre-pregnancy weight in BMI calculation for all women who are less than 6 months postpartum.
- Use current weight for breastfeeding women who are equal or greater than 6 months postpartum.

Note: Until research supports the use of different BMI cut-offs for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility.

Required Documentation

Pregnant

- Pre-pregnancy Weight
- Height
- BMI

Breastfeeding/Non-Breastfeeding

- Pre-pregnancy Weight
- Current Weight
- Height
- BMI

Justification

Women who are overweight at conception have increased obstetric risks for diabetes mellitus, hypertension, thromboembolic complications, preterm births, macrosomia, dysfunctional labor, and complications in operative deliveries.

One goal of prenatal nutritional counseling is to achieve recommended weight gain. For the overweight woman, emphasis should be on selecting food choices of high nutritional quality and avoiding calorie rich foods, thereby minimizing further risks associated with increased overweight and obesity.

Although the 1998 National, Heart, Lung and Blood Institute (NHLBI) Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults, define overweight as BMI ≥25; the 1990 Institute Of Medicine (IOM) report, Nutrition During Pregnancy, establishes pre-pregnancy weight classifications that define overweight as BMI ≥26.1. The IOM classifications were subsequently validated for pregnancy by Parker and Abrams and by Siega-Riz et al and others. Recommendations for weight gain during pregnancy therefore are based on the 1990 definitions of pre-pregnancy weight

status. If future research
shows that prenatal weight gain using the NHLBI definitions of adult weight status is safe for pregnancy and results in similar pregnancy outcomes, the definitions will be revised.

The IOM established prenatal weight gain recommendations based on pre-pregnancy BMI weight categories (i.e., low, normal, high, obese). As validated by Parker and Abrams, the IOM weight gain recommendations for each weight category are associated with healthy birth outcomes. The decision to use the IOM recommended BMI weight categories for pregnant adolescents as well as for adults is based on three factors.

- There are no established BMI cut-offs to define pre-pregnancy weight categories (with corresponding recommendations for prenatal weight gain) specific to adolescents.
- There is no research to support using the CDC issued BMI-for-age chart to define pre-pregnancy BMI weight categories for pregnant adolescents.
- It is consistent with recommendations of the Expert Work Group on Maternal Weight.

It is recognized that both the IOM and the NHLBI BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM and the NHLBI BMI cut-offs will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks fluid shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Pre-pregnancy weight, amount of weight
gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the pre-pregnancy weight. In most cases therefore, pre-pregnancy weight is a better indicator of weight status than postpartum weight in the first 6 months after delivery.

The percentage of adolescents who are overweight is increasing rapidly and more than 60% of adults in the U.S. are overweight. Due to the significant impact that overweight and obesity have on morbidity and mortality, it is imperative that every effort be made to identify individuals who are overweight and to assist them in achieving a more healthful weight. The WIC Program is in a position to play an important role in helping to reduce

the prevalence of overweight not only by working with postpartum women on improving their own weight status, but also by helping them to see their role in assisting their children to learn healthful eating and physical activity behaviors.

References

1. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), NIH Publication No. 98-4083. www.nih.gov.

2. Institute of Medicine: Nutrition During Pregnancy; National Academy Press; 1990.

3. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment. National Academy Press, Washington, D.C.; 1996.

4. Naye, R.L.: Maternal body weight and pregnancy outcome. American Journal Clin. Nutr.; 1990; 52:273-279.

5. Parker JD, Abrams B. Prenatal weight gain advice: an examination of the recent prenatal weight gain recommendations of the Institute of Medicine. Obstet Gynecol, 1992; 79:664-9.

6. Siega-Riz AM, Adair LS, Hobel CJ. Institute of Medicine maternal weight gain recommendations and pregnancy outcomes in a predominately Hispanic population. Obstet Gynecol, 1994; 84:565-73.

7. Suitor CW, editor. Maternal weight gain: A report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

8. Weight Changes in the Postpartum Period: A Review of the Literature. D.T. Crowell. Journal of Nurse-Midwifery. Vol. 40, No. 5, September/October 1995; pgs 418-423.

9. Worthington-Roberts, B.S. and S.R. Williams. Nutrition in Pregnancy and Lactation, 6th Edition. McGraw-Hill. 1997.

Nutrition Risk Criteria **18 ★ UNDERWEIGHT WOMAN**
USDA CODE 101

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant: Body Mass Index (BMI) less than or equal to (≤) 19.7.

- Use pre-pregnancy weight in BMI calculation.

Breastfeeding/Non-Breastfeeding: BMI less than or equal to (≤) 18.4.

- Use pre-pregnancy weight in BMI calculation for all women who are less than 6 months postpartum.
- Use current weight for breastfeeding women who are equal or greater than 6 months postpartum.

Note: Until research supports the use of different BMI cut-offs for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility.

Required Documentation

Pregnant

- Pre-pregnancy Weight
- Height
- BMI

Breastfeeding/Non-Breastfeeding

- Pre-pregnancy Weight
- Current Weight
- Height
- BMI

Justification

Underweight women who become pregnant are at a higher risk for delivery of low birth weight (LBW) infants, retarded fetal growth, and perinatal mortality. Pre-pregnancy underweight is also associated with a higher incidence of various pregnancy complications, such as antepartum hemorrhage, premature rupture of membranes, anemia, endometriosis, and cesarean delivery.

The goal in prenatal nutritional counseling provided by WIC is to achieve recommended weight gain by emphasizing food choices of high nutritional quality; and for the underweight woman, by encouraging increased consumption and/or the inclusion of some calorically dense foods.

Although the 1998 National, Heart, Lung and Blood Institute (NHLBI) Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults, define underweight as having a BMI less than 18.5; the 1990 Institute of Medicine (IOM) report, Nutrition During Pregnancy, establishes pre-

pregnancy weight classifications that define underweight as having a BMI <19.8. The IOM classifications were subsequently validated for pregnancy by Parker and Abrams and by Siega-Riz et al and others. Recommendations for weight gain during pregnancy therefore are based on the IOM 1990 definitions of pre-pregnancy weight status.

The IOM established prenatal weight gain recommendations based on pre-pregnancy BMI weight categories (i.e., low, normal, high, obese). As validated by Parker and Abrams, the IOM weight gain recommendations for each weight category are associated with healthy birth outcomes. The decision to use the IOM recommended BMI weight categories for pregnant adolescents as well as for adults is based on three factors.

- There are no established BMI cut-offs to define pre-pregnancy weight categories (with corresponding recommendations for prenatal weight gain) specific to adolescents.
- There is no research to support using the CDC issued BMI-for-age chart to define pre-pregnancy BMI weight categories for pregnant adolescents.
- It is consistent with the recommendations of the Expert Work Group on Maternal Weight.

It is recognized that both the IOM and the NHLBI BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM and the NHLBI BMI cut-off will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks fluid shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Pre-pregnancy weight, amount of weight gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the pre-pregnancy weight. In most cases therefore, pre-pregnancy weight is a better indicator of weight status than
postpartum weight in the first 6 months after delivery. The one exception is the woman with a BMI of <18.5 during the immediate 6 months after delivery. Underweight at this stage may indicate inadequate weight gain during pregnancy, depression, an eating disorder or disease; any of which need to be addressed.

While being on the lean side of normal weight is generally considered healthy, being underweight can be indicative of poor nutritional status, inadequate food consumption, and/or an underlying medical condition. Underweight women who are breastfeeding may be further impacting their own nutritional status. Should she become pregnant again, an underweight woman is at a higher risk for delivery of low birth weight (LBW) infants, retarded fetal growth, and perinatal mortality. The role of the WIC Program is to assist underweight women in the

achievement of a healthy dietary intake and body mass index.

References

1. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), NIH Publication No. 98-4083. www.nih.gov.

2. Institute of Medicine: Nutrition During Pregnancy; National Academy Press; 1990; pg.12.

3. Institute of Medicine. WIC Nutrition Risk Criteria: A Scientific Assessment. National Academy Press, Washington, D.C.; 1996.

4. Parker JD, Abrams B. Prenatal weight gain advice: an examination of the recent prenatal weight gain recommendations of the Institute of Medicine. Obstet Gynecol, 1992; 79:664-9.

5. Siega-Riz AM, Adair LS, Hobel CJ. Institute of Medicine maternal weight gain recommendations and pregnancy outcomes in a predominately Hispanic population. Obstet Gynecol, 1994; 84:565-73.

6. **Suitor CW, editor. Maternal weight gain: A report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.**

7. Weight Changes in the Postpartum Period: A Review of the Literature. D.T. Crowell. Journal of Nurse-Midwifery. Vol. 40, No. 5, September/October 1995; pgs 418-423.

8. Worthington-Roberts, B.S. and S.R. Williams. Nutrition in Pregnancy and Lactation, 6th Edition. McGraw-Hill; 1997.

Nutrition Risk Criteria **21 OVERWEIGHT-CHILDREN (2-5)**
USDA CODE 113

Category, Priority and Referral

Category	Priority	Referral
CHILDREN	3	RD

Definition

Children Age 2 and Older: Body mass index-for-age greater than or equal to (≥) 95th percentile. Based on National Center for Health Statistics/Centers for Disease Control and Prevention (NCHS/CDC) age and sex specific growth charts.

Note: Current data suggests that there is no increased risk of adult obesity based on BMI or weight-for-length during the first two years of life, independent or parental obesity. Therefore, only children 24 months of age or older are included in this criterion.

Required Documentation

DOB
WEIGHT
HEIGHT
BMI
NCHS/CDC growth charts

Justification

Use of the 95th percentile to define overweight identifies those children with a greater likelihood of being overweight as adolescents and adults, with increased risk of obesity-related disease and mortality. It is recommended that an overweight child (≥95th percentile) undergo an in-depth medical assessment and careful evaluation to identify any underlying syndromes or secondary complications. Overweight can result from excessive energy intake, decreased energy expenditure, or impaired regulation of energy metabolism. In addition, overweight in early childhood may signify problematic feeding practices or evolving family behaviors that, if continued, may contribute to health risks in adulthood related to diet and inactivity.

Overweight children and their families often feel embarrassed and ashamed. Therefore, it is extremely important for WIC staff to treat these families with sensitivity, compassion, and a conviction that overweight is an important chronic medical problem that can be treated. The goal in nutritional counseling provided by WIC is to help the child achieve recommended rates of growth and development by emphasizing food choices of high nutritional quality while avoiding unnecessary or excessive amounts of calorie rich foods and beverages.

Also, the importance of reducing inactivity (for example, decreasing sedentary TV viewing) and increasing age appropriate physical activity should be emphasized for children, with information provided to the parent/caretaker. Suggestions for increasing physical activity could include increased outdoor time as well as increased gross motor play (e.g., play-along videos or cassettes that promote physical activity).

Clarification

In addition to nutrition counseling, the referral services WIC provides can greatly assist families in identifying medical providers and other services (if available) that provide the recommended medical assessments and treatment when necessary.

Current data suggests that there is no increased risk of adult obesity based on BMI or weight-for-length during the first two years of life, independent of parental obesity. Therefore, only children ≥24 months of age are included in this criterion. Please refer to risk #114, "At Risk of Becoming Overweight" to assess factors that place infants and children under 2 years of age at risk of becoming overweight.

References

1. Barlow SE, Dietz WH. Obesity Evaluation and Treatment: Expert Committee Recommendations. Pediatrics 1998;102:3.

2. Hamill PV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM. Physical growth: National Center for Health Statistics percentiles. Am.J.Clin.Nutr. 1979;32:607-29.

3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

4. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics. 2000.

5. Whitaker Robert C, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting Obesity in Young Adulthood from Childhood and Parental Obesity. NEJM, September 25, 1997; Vol 337, No 13, pages 869-873.

Nutrition Risk Criteria **22 UNDERWEIGHT-INFANTS/CHILDREN**
USDA CODE 103

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD

Definition

INFANTS AND CHILDREN UNDER AGE 2: Weight-for-length less than or equal to (≤) 5th percentile. Based on National Center Health Statistics/Centers for Disease Control and Prevention (NCHS/CDC) age and sex specific growth charts for infants and children under age 2.

CHILDREN AGE 2 AND OLDER: Body mass index-for-age less than or equal to (≤) 5th percentile. Based on National Center Health Statistics/Centers for Disease Control and Prevention (NCHS/CDC) age and sex specific growth charts for children over age 2.

*Based on National Center for Health Statistics/Centers for Disease Control and Prevention age/sex specific growth charts (2000).

Required Documentation

DOB (CC screen)
Weight (CH screen)
Height (CH screen)
BMI (CH screen)
NCHS/CDC growth charts

Justification

The Centers for Disease Control and Prevention (CDC) uses the cut-off of the 5th percentile to define underweight for purposes of their Pediatric Nutrition Surveillance System. However, CDC does not have a position regarding the cut-off percentile for underweight which should be used to determine nutritional risk.

A survey of articles and texts addressing weight for length or stature cut-off percentiles reveals that: a) many children less than the 5th percentile are in need of nutritional intervention, and b) many authors also view a child at
≤10th percentile as at nutritional risk and in need of preventive nutritional intervention, or at least further evaluation. The 10th percentile is chosen as a cut-off for WIC purposes in accord with the preventive emphasis of this program.

While progress along the 10th percentile may represent normal growth for some children, it may also be an indication of inadequate caloric intake and of an associated inadequate nutrient intake.

A child suffering from chronic malnutrition can have a weight for

length or stature above the 10th percentile, because linear growth has also been stunted. Weight for length or stature ≤10th percentile is most useful for identifying acute undernutrition in which length or stature is less affected.

Mortality rates and morbidity from infections and diarrheal diseases are increased in undernourished children. Child participation in WIC has been associated with improved growth in both weight and height.

References

1. Disbrow DD. The costs and benefits of nutrition services: a literature review. Journal of the American Dietetics Association. 1989; 89: S3-66.

2. Food and Nutrition Information Center, National Agriculture Library. Update of analysis of literature regarding cut-off percentiles for low weight for length in infants. Washington, DC.; February 5, 1991.

3. Metallinos-Katsaras E, Gorman KS. Effects of undernutrition on growth and development. In: Kessler DB, Dawson P, editors. Failure to thrive and pediatric undernutrition: A transdisciplinary approach. Baltimore: Paul H. Brooks Publishing Company, Inc.; 1999. p. 38.

4. Pipes PL, Trahms, CM. Nutrition: Growth and Development. In Pipes PL and Trahms CM, ed. Nutrition in Infancy and Childhood 6th edition; WCB/McGraw-Hill; (1997).

5. Sherry B. Epidemiology of inadequate growth. In: Kessler DB, Dawson P, editors. Failure to thrive and pediatric undernutrition: A transdisciplinary approach. Baltimore: Paul H. Brooks Publishing Company, Inc.; 1999. p. 21.

Nutrition Risk Criteria **23 SHORT STATURE-INFANTS/CHILDREN**
USDA CODE 121

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	-
CHILDREN	3	-

Definition

Short Stature
Birth up to 2 years: Less than or equal (≤) to 5th percentile length-for-age.*
2 to 5 years: Less than or equal (≤) to 5th percentile stature (height)-for-age.*

*Based on National Center for Health Statistics/Centers for Disease Control and Prevention age/sex specific growth charts (2000).

Note: For premature infants and children (with a history of prematurity) up to 2 years of age, assignment of this risk criterion will be based on adjusted gestational age.

Required Documentation

DOB
Height
NCHS growth charts

Justification

Abnormal short stature in infants and children is widely recognized as a response to a limited nutrient supply at the cellular level. The maintenance of basic metabolic functions takes precedence, and resources are diverted from linear growth. Short stature is related to the lack of total dietary energy and to a poor quality of diet, namely, a diet that provided inadequate protein, particularly animal protein, and inadequate amounts of such micronutrients as zinc, vitamin A, iron, copper, iodine, calcium, and phosphorus.

Growth patterns of children of racial groups whose short stature has traditionally been attributed to genetics have been observed to increase in rate and in final height under conditions of improved nutrition.

Short stature may also result from disease conditions such as endocrine disturbances, inborn errors of metabolism, intrinsic bone diseases, chromosomal defects, fetal alcohol syndrome, and chronic systemic diseases.

Participation in WIC has been associated with improved growth in both weight and height in children.

References

1. American Academy of Pediatrics, Committee on Nutrition, Forbes GB, Woodruff CW. Pediatric nutrition handbook. Elk Grove Village, Ill: American Academy of Pediatrics,1985; p. 192 and Appendix A.

2. Disbrow DD. The costs and benefits of nutrition services: a literature review. J.Am.Diet.Assoc. 1989;89:S3-66.

3. Hamill PV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM. Physical growth: National Center for Health Statistics percentiles. Am.J.Clin.Nutr. 1979;32:607-29.

4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

5. Pipes PL. Nutrition in Infancy and Childhood. St. Louis: Times-Mirror/Mosby College Pub, 1989.

Nutrition Risk Criteria **27 ★ LOW BIRTH WEIGHT**
USDA CODE 141

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD

Definition

Low Birth Weight (LBW)
Birth weight defined as less than or equal to (≤) 5 pounds 8 ounces (≤ 2500g) for infants and children less than 24 months.

Required Documentation

DOB
Birth Weight

Justification

Low Birth Weight (LBW) is one of the most important biologic predictors of infant death and deficiencies in physical and mental development during childhood among those babies who survive and continues to be a strong predictor of growth in early childhood. Infants and children born with LBW, particularly if caused by fetal growth restriction, need an optimal nutrient intake to survive, meet the needs of an extended period of relatively rapid postnatal growth, and complete their growth and development.

References

1. Groh-Wargo S, Thompson M, Cox JH, Hartline JV. Nutritional care for high-risk newborns. editors Sharon Groh-Wargo, Melody Thompson, Janice Hovasi Cox ; consulting editor John V. Hartline. Chicago: Precept Press, Inc, 1994.

2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **28 FAILURE TO THRIVE**
USDA CODE 134

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD

Definition

Presence of failure to thrive (FTT) diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Note: For premature infants with a diagnosis of FTT also see: "Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants" (FNS Policy Memorandum 98-9, Revision 7, April 2004).

Required Documentation

N/A

Justification

Failure to thrive (FTT) is a serious growth problem with an often complex etiology. Some of the indicators that a physician might use to diagnose FTT include:

- weight consistently below the 3rd percentile for age;
- weight <80% of ideal weight for height/age;
- progressive fall-off in weight to below the 3rd percentile; or
- a decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile.

FTT may be a mild form of Protein Energy Malnutrition (PEM) that is manifested by a reduction in rate of somatic growth. Regardless of the etiology of FTT, there is inadequate nutrition to support weight gain.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Berkow R, Fletcher AJ. The Merck manual of diagnosis and therapy. Rahway, N.J.: Merck Sharp & Dohme Research Laboratories, 1992.

2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **30 INADEQUATE GROWTH (FORMALLY WEIGHT GAIN)**
USDA CODE 135

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD

Definition

Infants who are age birth to one month with either of these conditions:

- Excessive weight loss after birth (10%) or more
- Not back to birth weight by age two weeks

Age	Average Weight Gain			
Birth - 1 mo	18 gm/day	4 1/2 oz/wk	19 oz/mo	1 lb 3 oz/mo

Examples Using Calculated Expected Minimal Weight

General steps:

1. Determine if time interval between measures is sufficient.
2. Calculate actual weight gain.
3. Calculate expected minimal weight gain using the chart in the definition. *(Note: Due to a variety of reasons, including rounding, different approaches to calculating the expected minimal weight gain may result in slightly different answers.)*
4. Compare the actual weight gain with the calculated expected weight gain to see if person is eligible for WIC using this criterion.

Example #1

Date of Measures	Weight
09/13/98 (birth)	7 pounds 6 oz
9/23/98 (10 days old)	8 pounds 1 oz
10/26/98 (6 weeks & 1 day old)	9 pounds 3 oz

1. interval between birth & 10/26/98 measures = 43 days
2. actual wt gain = 1 pound 13 oz
3. expected minimal weight gain is: (540 gm) + (13 days x 25 gm/day) = 865 gms = 30 oz = 1 pound 15 oz
4. actual weight gain from birth is less than expected minimal weight gain ⇐ eligible for WIC using this criterion

Required Documentation

DOB
WEIGHT
HEIGHT
BMI
NCHS/CDC growth charts

Justification

Weight for age is a sensitive indicator of acute nutritional inadequacy. The rate of gain during infancy, especially early infancy is rapid, and abnormalities in rate of weight gain may often be detected in just a few months. There is little question that decrease in the rate of weight gain during infancy is the earliest indication of nutritional failure. In contrast, children beyond infancy grow rather slowly, and many months of observation may be required to demonstrate that the

rate of weight gain is unusually slow. During the first eighteen months of life, the rate of change in weight fluctuates and then declines rapidly. Because of this deceleration it may be difficult to differentiate normal growth slowing from an abnormal rate. After 18 months weight gain becomes more linear so assessment becomes easier.

Infants and children with abnormally slow growth can benefit from nutrition and health interventions to improve weight and height gain. The diagnosis of slow growth must consider possible causes of growth changes including undereating and disease conditions. Undereating, for any number of reasons, and disease conditions are the main causes of abnormally slow growth. Factors associated with undereating by an infant or child include inadequate sources of nutrient dense foods; lack of social support for the caregiver; an adverse social and psychological environment; a disorganized family; depressed parents or caregivers; and the caregiver's lack of education, health and nutrition knowledge, mental and physical abilities, and responsibility for child care. There is good evidence that through nutrition education, supplemental foods, and referrals to other health and social services, participation in the WIC Program will benefit infants and children with slow growth. In keeping with the preventive nature of the WIC Program, a cut-off point approximating the 10th percentile rate of change in weight for age was chosen.

References

1. Baumgartner RN, Roche AF, Himes JH. Incremental growth tables: Supplementary to previously published charts. Am.J.Clin.Nutr. 1986;43:711-722.

2. Fomon SJ. Nutrition of normal infants. St. Louis: Mosby, 1993.

3. Guo S, Roche AF, Fomon SF, Nelson SE, Chumlea WC, Rogers RR, et al. Reference data on gains in weight and length during the first two years of life. J.Pediatr. 1991; 119:355-362.

4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **31 AT RISK FOR BECOMING OVERWEIGHT**
USDA CODE 114

Category, Priority and Referral

Category	Priority	Referral
CHILDREN	3	-

Definition

Children age 2 and older: Being ≥24 months of age and ≥85th and <95th percentile Body Mass Index (BMI)* or percentile weight-for-stature* (i.e., standing height**)**

*DO NOT USE if NRC 21 OVERWEIGHT applies

Required Documentation

DOB
WEIGHT
HEIGHT
BMI
NCHS/CDC growth charts

Justification

The rise in the prevalence of overweight in children and adolescents in the United States is one of the most important public health issues we face today. National surveys from the mid-1960s to the early 1990s document a significant increase in overweight among children from preschool age through adolescence. These trends parallel a concurrent increase in obesity among adults, suggesting that fundamental shifts are occurring in dietary and/or physical activity behaviors that are having an adverse effect on overall energy balance.

Specific reasons for the rapid rise in obesity in the United States are not well understood. Important contributors include a large and growing abundance of calorically dense foods and an increased sedentary lifestyle for all ages. Evidence from recent scientific studies has shown that obesity tends to run in families, suggesting a genetic predisposition. However, a genetic predisposition does not inevitably result in the development of obesity. Environmental and other factors mediate the relationship.

In any individual, and in the same individual at different times of life, the relative influence of genetics, environment, and development may vary. In other words, individuals with an otherwise genetic predisposition to obesity still may be lean in an environment of food scarcity or high demand for physical activity; while individuals not genetically predisposed may become obese in an environment that encourages over-consumption (especially of calorically dense foods) and includes few inducements to physical activity.

Children 2 years of age or older with a BMI at the 85th-94th percentile are at risk of overweight while those with a BMI at or above the 95th percentile are overweight. Adults with a BMI greater than or equal to 30 are obese while those with a BMI at or greater than 40 are classified as extremely obese.

Increasingly, attention is being focused on the need for comprehensive strategies that focus on preventing overweight/obesity and a sedentary lifestyle for all ages. Scientific evidence suggests that the presence of obesity in a parent greatly increases the risk of overweight in preschoolers, even when no other overt signs of increasing body mass are present.

The WIC Program has the opportunity to become an important player in public health efforts to curb the increasing spread of obesity by actively identifying and enrolling infants and children who may be "at-risk" of becoming overweight in childhood or adolescence, and assisting them and their families in making dietary and lifestyle changes needed to reduce their risks. Appropriate nutrition education emphasizing the importance of prevention (addressing both feeding/eating behaviors and physical activity), food prescriptions, and appropriate referrals provided through WIC would benefit not only the at-risk infants and children, but also their families.

Clarification

For this criterion, the definition of parental obesity (BMI $\geq$30) applies to all parents, regardless of age (teen and adult). Although there are recommended obesity BMI cut-points specific for sex and age for 2 - 18 year olds (see reference #3), there is only a slight difference between these cut-points and the ones used to define obesity for an individual over 18 years of age. Based on the slight differences in cut-points and lack of research suggesting otherwise, RISC elected to use a single definition of parental obesity for ease in applying this criterion.

References

1. American Academy of Pediatrics. The causes and health consequences of obesity in children and adolescents. Pediatrics 1998;101 Suppl 3: part 2 of 2.

2. Barlow SE, Dietz WH. Obesity Evaluation and Treatment: Expert Committee Recommendations. Pediatrics 1998;102:3.

3. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics. 2000.

4. Mokdad AH, Serdula MK, Dietz WH, Bowaman BA, Marks JS, Kaplan JP. The spread of the obesity epidemic in the United States 1991-1998. JAMA 1999;1519-1522.

5. National Heart, Lung, and Blood Institute, National Institute of Diabetes and Digestive and Kidney Diseases. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults the evidence report. Bethesda, Md.: National Intstitutes of Health, National Heart, Lung and Blood Institute, 1998 No.: 98-4083

6. Silverman BL, Rizzo TA, Cho NH, Metzger BE. Long term effects of the intrauterine environment. The Northwestern University Diabetes in Pregnancy Center. Diabetes Care 1998;21;Suppl 2:B142-B149.

7. Whitaker R. At risk for becoming overweight. Report. Commissioned by the Risk Identification and Selection Collaborative. 1999.

8. Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. N.Eng.J.Med. 1997;337;13:869-873.

Nutrition Risk Criteria **32 AT RISK OF BECOMING UNDERWEIGHT**
USDA CODE 103

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	-
CHILDREN	3	-

Definition

At Risk of Underweight
Birth to 2 years: 6th through 10th percentile weight-for-length.*
2 to 5 years: 6th through 10th percentile Body Mass Index (BMI)-for-age.*

*Based on National Center for Health Statistics/Centers for Disease Control and Prevention age/sex specific growth charts (2000).

Do not use code 32 if code 22 UNDERWEIGHT applies.

Required Documentation

DOB
WEIGHT
HEIGHT
BMI
NCHS/CDC growth charts

Justification

CDC uses the cut-off of the 5th percentile weight for length or height to define underweight for purposes of their Pediatric Nutrition Surveillance System. However, the CDC does not have a position regarding the cut-off percentile in weight for length which should be used to determine nutritional risk.

A survey of articles and texts addressing weight for length or height cut-off percentiles reveals that: a) child at or below 5th percentile is universally recognized as underweight and in need of nutritional intervention, and b) many authors also view a child at or below 10th percentile as at nutritional risk and in need of preventive nutritional intervention, or at least further evaluation (FNIC, 1991). The 10th percentile is chosen as a cut-off for WIC purposes in accord with the preventive emphasis of this program.

While progress along the 10th percentile of weight for length or height may represent normal growth for some children, it may also be an indication of inadequate caloric intake and of an associated inadequate nutrient intake.

A child suffering from chronic malnutrition can have a weight for length or height above the 10th percentile, because linear growth has also been stunted. Weight for length or height at or below 10th percentile is most useful for identifying acute undernutrition in which length or height is less affected.

Child participation in WIC has been associated with improved growth in both weight and height.

References

1. Disbrow DD. The costs and benefits of nutrition services: a literature review. J.Am.Diet.Assoc. 1989;89:S3-66.

2. FNIC. Update of Analysis of Literature Regarding Cut-off Percentiles for Low Weight for Length in Infants. Washington, D.C.; 1991.

3. Grand RJ, Sutphen JL, Dietz WH. Pediatric nutrition theory and practice. Boston: Butterworths, 1987.

4. Hamill PV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM. Physical growth: National Center for Health Statistics percentiles. Am.J.Clin.Nutr. 1979;32:607-29.

5. Kempe CH, Current pediatric diagnosis and treatment. Norwalk Conn: Appleton & Lange, 1987.
.

6. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics. 2000.

7. Pipes PL, Trahms CM. Nutrition in Infancy and Childhood. S.I.: WCB/McGraw-Hill, 1997.

8. Wright JA, Ashenburg CA, Whitaker RC. Comparison of methods to categorize undernutrition in children. J.Pediatr. 1994;124: 944-46.

Nutrition Risk Criteria **34 ★ LARGE FOR GESTATIONAL AGE**
USDA CODE 153

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	-

Definition

Large for Gestational Age
Birth weight greater than or equal to (≥) 9 pounds (4000g);

OR

Presence of large for gestational age diagnosed by a physician. If self-reported diagnosis by a physician by the applicant/participant/caregiver, then local agency RD must verify diagnosis with physician or medical care provider and document in progress notes.

Required Documentation

DOB
Birth Weight

Justification

Infant mortality rates are higher among full-term infants who weigh > 4,000 g (> 9 lbs) than for infants weighing between 3,000 and 4,000 g (6.6 and 8.8 lbs). Oversized infants are usually born at term; however, preterm infants with weights high for gestational age also have significantly higher mortality rates than infants with comparable weights born at term. Large for Gestational Age may be a result of maternal diabetes (which may or may not have been diagnosed before or during pregnancy) and may result inobesity in childhood that may extend into adult life.

Very large infants regardless of their gestational age, have a higher incidence of birth injuries and congenital anomalies (especially congenital heart disease) and developmental and intellectual retardation. When large for gestational occurs with pre-term birth, the mortality risk is higher than when either condition exists alone.

Weight should be plotted weekly on an intrauterine or postnatal growth chart and monitored for progress. Intrauterine growth charts have been developed by compiling birth weight, length, and head circumference of infants at varying gestational ages and reflect intrauterine growth, while postnatal growth charts were developed from extrauterine growth data. Both types of growth charts have limitations that should be considered. Choice and use of growth charts are typically facility-specific and determined by the medical team. The Oregon Intrauterine Growth Chart (Babson/Benda), Denver Intrauterine Growth Chart (Lubchenco), and the

Hall/Shaffer and Wright Postnatal Growth Charts are generally available to monitor growth by gestational age. Copies of the Babson/Benda and Lubchenco charts are provided in the Reference Material Section.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Babson SG, Benda GI. Growth graphs for the clinical assessment of infants of varying gestational age. J.Pediatr. 1976;89:814-20.

2. Behrman RE, Kliegman R, Jenson HB. Nelson textbook of pediatrics. Philadelphia: Saunders, 2000.

3. Lubchenco LO, Hansman C, Boyd E. Intrauterine growth in length and head circumference as estimated from live births at gestational ages from 26 to 42 weeks. Pediatrics 1966;37:403-8.

Nutrition Risk Criteria **35 BABY BOTTLE TOOTH DECAY (BBTD)**
***RELATED* USDA CODE 381**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	Dental
CHILDREN	3	Dental

Definition

Presence of nursing or baby bottle caries, smooth surface decay of the maxillary anterior and the primary molars (infants and children);
BBTD is tooth decay affecting two or more of the upper front baby teeth (the primary incisors). It is identified by one or more of the following:

- White or brown areas of decalcification
- Obvious tooth decay (cavities)
- Brownish-black roots (fillings or crowns)
- Missing teeth due to decay
- Presence of restorations (fillings or crowns)
- Parental report of BBTD either diagnosed or treated by a dentist

Required Documentation

NA

Justification

Early childhood caries results from inappropriate feeding practices. Nutrition counseling can prevent primary tooth loss, damage to the permanent teeth, and potential speech problems.

Missing more than 7 teeth in adults seriously affects chewing ability. This leads to eating only certain foods which in turn affects nutritional intake.

Periodontal disease is a significant risk factor for pre-term low birth weight resulting from pre-term labor or premature rupture of the membranes. There is evidence that gingivitis of pregnancy results from “end tissue deficiency” of folic acid and will respond to folic acid supplementation as well as plaque removal.

References

1. Agerberg, G and Carlsson, GE: Chewing ability in relation to dental and general health; Aeta Odontol. Scand.; 1981; 39:147-153.

2. Offenbacher, S. etal.: Periodontal infection as a possible risk factor for pre-term low birth weight; J. Periodontol; October 1996; 67(10 Suppl.):1103-1113.

3. J. Dent. Child29:245.

4. Rugg-Gunn AJ, Hackett AF. Nutrition and dental health. Oxford: Oxford University Press, 1993.

Nutrition Risk Criteria **36 BABY BOTTLE TOOTH DECAY RISK BEHAVIORS**
***RELATED* USDA CODE 411 & 425**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	4	-
CHILDREN	5	-

Definition

Sleeps with Bottle: Allowing the infant/child to fall asleep at naps or bedtime with the bottle.

Bottle as Pacifier: Allowing the infant/child to use the bottle without restriction (i.e. walking around with bottle; or as a pacifier).

Bottle beyond 14 months: Use of a bottle for feeding or drinking beyond 14 months of age.

Bottle with Other Liquids: Routine use of the bottle to feed liquids other than breast milk, formula or water. Includes:

- Fruit juice
- Soda
- Soft drinks
- Gelatin water
- Corn syrup solutions
- Milk
- Other sugar-containing beverages

Required Documentation

Indicate in participant file 'which' behavior exists.

Justification

Fermentation of carbohydrates on surface of the tooth produces organic acids that de-mineralize and destroy enamel, with subsequent tooth decay. Generally, many teeth are involved, decay develops rapidly, and occurs on surfaces normally thought to be at low risk for decay. Maxillary anterior teeth are affected first and most severely because of prolonged repeated exposure, frequently to the extent that extraction of these teeth is required in children as young as 18 months.

If inappropriate use of the bottle persists, child is at risk of toothaches, costly dental treatment, loss of primary teeth, and developmental lags on eating and chewing. If this continues beyond the usual weaning period, there is a risk of decay to permanent teeth.

Propping the bottle deprives infants of vital human contact and nurturing which makes them feel secure. It can cause: ear infections because of fluid entering the middle ear and not draining properly; choking from liquid flowing into the lungs; and tooth decay from prolonged exposure to carbohydrate-containing liquids.

Pediatric dentists recommend that parents be encouraged to have infants drink

from a cup as they approach their first birthday, and that infants are weaned from the bottle at 12-14 months of age.

References

1. American Academy of Pediatrics, Committee on Nutrition, Kleinman RE. Pediatric nutrition handbook. Elk Grove Village, Ill: American Academy of Pediatrics, 1998.

2. American Academy of Pediatric Dentristry. Baby Bottle Tooth Decay. Pediatric Dentistry 1994-95;16;7:26.

3. American Academy of Pediatric Dentistry. Baby Bottle Tooth Decay/Early Childhood Caries. Pediatric Dentistry 1997-98;19:24.

4. Derkson GD, Ponti P. Nursing bottle syndrome; prevalence and etiology in a non-fluoridated city. J.Can.Dent.Assoc. 1982;48:389-93.

5. Dilley GJ, Dilley DH, Machen JB. Prolonged nursing habit: a profile of patients and their families. ASDC J.Dent.Child 1980;47:102-8.

6. Fomon SJ. Nutrition of normal infants. St. Louis: Mosby, 1993.

7. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

8. Pipes PL, Trahms CM, Pipes PL. Nutrition in Infancy and Childhood. St. Louis: Mosby, 1993.

9. Ripa LW. Nursing habits and dental decay in infants: "nursing bottle caries". ASDC J.Dent.Child 1978;45:274-5.

Nutrition Risk Criteria **37 PREMATURITY**
USDA CODE 142

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	-
CHILDREN (less than 24 months of age)	3	-

Definition

Birth at less than or equal to (≤) 37 weeks gestation for **infants and children up to age 24 months (2 years).**

Note: See "Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants" (FNS Policy Memorandum 98-9, Revision 7, April 2004) for more information on the anthropometric assessment and nutritional care of premature infants.

Required Documentation

NA

Justification

Premature infants may have physical problems that have nutritional implications, including immature sucking, swallowing and immature digestion and absorption of carbohydrates and lipids. Premature infants have increased nutrient and caloric needs for rapid growth. Premature infants grow well on breast milk. WIC promotes breastfeeding and provides nutrition education about infant feeding.

References

5. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **40 BORN TO WIC MOM**
***RELATED* USDA CODE 701**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	2	-

Definition

An infant whose mother was a WIC Program participant during pregnancy. Applies up to age 6 months.

Required Documentation

NA

Justification

Federal Regulations designate these conditions for WIC eligibility (3).

WIC participation during pregnancy is associated with improved pregnancy outcomes. An infant whose nutritional status has been adequately maintained through WIC services during gestation and early infancy may decline in nutritional status if without these services and return to a state of elevated risk for nutrition related health problems. Infants whose mother was at medical/nutritional risk during pregnancy, but did not receive those services, may also be thought of as a group at elevated risk for morbidity and mortality in the infant period (1, 2).

WIC participation in infancy is associated with lower infant mortality, decreased anemia for infants and improvements in growth (head circumference, height and weight). Infants on WIC are more likely to consume iron-fortified formula and cereal and less likely to consume cow's milk before one year, thus lowering the risk of developing iron deficiency anemia (1, 2).

References

1. Disbrow DD. The costs and benefits of nutrition services: a literature review. J.Am.Diet.Assoc. 1989;89:S3-66.

2. Ryan AS, Martinez GA, Malec DJ. The effect of the WIC program on nutrient intakes of infants, 1984. Med.Anthropol. 1985;9153-72.

3. WIC Program Regulations; Section 246.7(e)(1)(ii).

Nutrition Risk Criteria **41 BORN TO POTENTIAL WIC MOM**
***RELATED* USDA CODE 701**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	2	-

Definition

An infant whose mother's medical history shows she was at nutritional risk during pregnancy because of detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions. Applies up to age 6 months.

Required Documentation

NA

Justification

Federal Regulations designate these conditions for WIC eligibility (3).

WIC participation during pregnancy is associated with improved pregnancy outcomes. An infant whose nutritional status has been adequately maintained through WIC services during gestation and early infancy may decline in nutritional status if without these services and return to a state of elevated risk for nutrition related health problems. Infants whose mother was at medical/nutritional risk during pregnancy, but did not receive those services, may also be thought of as a group at elevated risk for morbidity and mortality in the infant period (1, 2).

WIC participation in infancy is associated with lower infant mortality, decreased anemia for infants and improvements in growth (head circumference, height and weight). Infants on WIC are more likely to consume iron-fortified formula and cereal and less likely to consume cow's milk before one year, thus lowering the risk of developing iron deficiency anemia (1, 2).

References

4. Disbrow DD. The costs and benefits of nutrition services: a literature review. J.Am.Diet.Assoc. 1989;89:S3-66.

5. Ryan AS, Martinez GA, Malec DJ. The effect of the WIC program on nutrient intakes of infants, 1984. Med.Anthropol. 1985;9153-72.

6. WIC Program Regulations; Section 246.7(e)(1)(ii).

Nutrition Risk Criteria **45 FETAL ALCOHOL SYNDROME**
USDA CODE 382

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD, SA
CHILDREN	3	RD, SA

Definition

Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation.

Presence of FAS diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Copy of physician diagnosis or RD confirmation of self-reported diagnosis must be documented in participant file.

Justification

FAS is a combination of permanent, irreversible birth defects attributable solely to alcohol consumption by the mother during pregnancy. There is no known cure; it can only be prevented. Symptoms of FAS may include failure to thrive, a pattern of poor growth throughout childhood and poor ability to suck (for infants). Babies with FAS are often irritable and have difficulty feeding and sleeping.

Lower levels of alcohol use may produce Fetal Alcohol Effects (FAE) or Alcohol Related Birth Defects (ARBD) that can include mental deficit, behavioral problems, and milder abnormal physiological manifestations. FAE and ARBD are generally less severe than FAS and their effects are widely variable. Therefore, FAE and ARBD in and of themselves are not considered risks, whereas the risk of FAS is unquestionable.

Identification of FAS is an opportunity to anticipate and act upon the nutritional and educational needs of the child. WIC can provide nutritional foods to help counter the continuing poor growth and undifferentiated malabsorption that appears to be present with FAS. WIC can help caregivers acknowledge that children with FAS often grow steadily but slower than their peers. WIC can also educate the caregiver on feeding, increased calorie needs and maintaining optimal nutritional status of the child.

Alcohol abuse is highly concentrated in some families. Drinking, particularly abusive drinking, is often found in families that suffer from a multitude of other social problems. A substantial number of FAS children come from families, either immediate or extended, where alcohol abuse is common, even normative. This frequently results in changes of caregivers or foster placements. New caregivers need to be educated on the special and continuing nutritional needs of the child.

The physical, social, and psychological stresses and the birth of a new baby, particularly one with special needs, places an extra burden upon the recovering woman. This puts the child at risk for poor nutrition and neglect (e.g., the caregiver may forget to prepare food or be unable to adequately provide all the foods necessary for the optimal growth and development of the infant or child.) WIC can provide supplemental foods, nutrition education and referral to medical and social services which can monitor and provide assistance to the family.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Clarren, S.K., and Smith, D.W.: The Fatal Alcohol Syndrome; New England Journal of Medicine; May 11, 1978; 298:1063-1067.

2. Jones, K.L., Smith, D.W., Ulleland, C.N., and Streissguth, A.P.: Pattern of Malformation in Offspring of Chronic Alcoholic Mothers. Lancet; June 9, 1973; 815:1267-1271.

3. Masis B., M.D., May, A: A Comprehensive Local Program for the Prevention of Fetal Alcohol Syndrome, Public Health Reports; September-October 1991; 106: 5; pp. 484-489.

4. Lujan, C.C., BeBruyn, L., May, P.A., and Bird, M.E.: Profile of Abuse and Neglected Indian Children in the Southwest; Child Abuse Negligent; 1989; 34: 449-461.

5. Institute of Medicine: Fetal Alcohol Syndrome, Diagnosis, Epidemiology, Prevention and Treatment; 1996.

6. Weiner, L., Morse, B.A., and Garrido, P.: FAS/FAE Focusing Prevention on Women at Risk; International Journal of the Addictions; 1989; 24:385-395.

Nutrition Risk Criteria **46 INAPPROPRIATE NUTRITION PRACTICES (INFANTS)**
USDA CODE 411

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	INFANTS	4	-

Definition

FORMALLY: QUESTIONABLE INFANT FEEDING

Routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. These practices, with examples, are outlined below. Refer to "Justification and References" for this criterion.

Routinely using a substitute(s) for breast milk or for FDA approved iron-fortified formula as the primary nutrient source during the first year of life.
Examples of substitutes:

- Low iron formula without iron supplementation;
- Cow's milk, goat's milk, or sheep's milk (whole, reduced fat, low-fat, skim), canned evaporated or sweetened condensed milk; and
- Imitation or substitute milks (such as rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."

Routinely using feeding practices that disregard the developmental needs or stage of the infant.
Examples:

- Inability to recognize, insensitivity to, or disregarding the infant's cues for hunger and satiety (e.g., forcing an infant to eat a certain type and/or amount of food or beverage or ignoring an infant's hunger cues).
- Feeding foods of inappropriate consistency, size, or shape that put infants at risk of choking.
- Not supporting an infant's need for growing independence with self-feeding (e.g., solely spoon-feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils).
- Feeding an infant foods with inappropriate textures based on his/her developmental stage (e.g., feeding primarily pureed or liquid foods when the infant is ready and capable of eating mashed, chopped or appropriate finger foods).

Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.
Examples of potentially harmful foods:

- Unpasteurized fruit or vegetable juice;
- Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese;
- Honey (added to liquids or solid foods, used in cooking, as part of processed foods, on a pacifier, etc.);
- Raw or undercooked meat, fish, poultry, or eggs;
- Raw vegetable sprouts (alfalfa, clover, bean, and radish);
- Undercooked or raw tofu; and
- Deli meats, hot dogs, and processed meats (avoid unless heated until

steaming hot).

Routinely feeding inappropriately diluted formula.

- Failure to follow manufacturer's dilution instructions (to include stretching formula for household economic reasons).
- Failure to follow specific instructions accompanying a prescription.

Routinely limiting the frequency of nursing of the exclusively breastfed.

infant when breast milk is the sole source of nutrients.

Examples of inappropriate frequency of nursing:

- Scheduled feedings instead of demand feedings;
- Less than 8 feedings in 24 hours if less than 2 months of age; and

Less than 6 feedings in 24 hours if between 2 and 6 months of age.

Routinely feeding a diet very low in calories and/or essential nutrients.

Examples:

- Vegan diet;
- Macrobiotic diet; and
- Other diets very low in calories and/or essential nutrients.

Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breastmilk.

Examples of inappropriate sanitation:

- Limited or no access to a:
  - Safe water supply (documented by appropriate officials),
  - Heat source for sterilization, and/or
  - Refrigerator or freezer for storage.
- Failure to properly prepare, handle, and store bottles or storage containers of expressed breastmilk or formula.

Feeding dietary supplements with potentially harmful consequences.

Examples of dietary supplements, which when fed in excess of recommended dosage, may be toxic or have harmful consequences:

- Single or multi-vitamins;
- Mineral supplements; and
- Herbal or botanical supplements/remedies/teas.

Routinely not providing dietary supplements recognized as essential by

national public health policy when an infant's diet alone cannot meet nutrient requirements.

- Infants who are 6 months of age or older who are ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride.
- Breastfed infants who are ingesting less than 500 mL (16.9 ounces) per day of vitamin D-fortified formula and are not taking a supplement of 200 IU of vitamin D.

Non-breastfed infants who are ingesting less than 500 mL (16.9 ounces) per day of vitamin-D fortified formula and are not taking a supplement of 200 IU of

vitamin D.

Required Documentation

Document which behaviors are present in the participant file.

Justification

During the first year of life, breastfeeding is the preferred method of infant feeding. The American Academy of Pediatrics (AAP) recommends breast milk for the first 12 months of life because of its acknowledged benefits to infant nutrition, gastrointestinal function, host defense, and psychological well-being (1). For infants fed infant formula, iron-fortified formula is generally recommended as a substitute for breastfeeding (1- 4). Rapid growth and increased physical activity significantly increase the need for iron and utilizes iron stores (1). Body stores are insufficient to meet the increased iron needs making it necessary for the infant to receive a dependable source of iron to prevent iron deficiency anemia (1). Iron deficiency anemia is associated with cognitive and psychomotor impairments that may be irreversible, and with decreased immune function, apathy, short attention span, and irritability (1, 5). Feeding of low-iron infant formula can compromise an infant's iron stores and lead to iron deficiency anemia. Cow's milk has insufficient and inappropriate amounts of nutrients and can cause occult blood loss that can lead to iron deficiency, stress on the kidneys from a high renal solute load, and allergic reactions (1, 3, 5-8). Sweetened condensed milk has an abundance of sugar that displaces other nutrients or causes over consumption of calories (9). Homemade formulas prepared with canned evaporated milk do not contain optimal kinds and amounts of nutrients infants need (1, 5, 8, 9). Goat's milk, sheep's milk, imitation milks, and substitute milks do not contain nutrients in amounts appropriate for infants (1, 3, 5, 10, 11).

Feeding solid foods too early (i.e., before 4-6 months of age) by, for example, adding dilute cereal or other solid foods to bottles deprives infants of the opportunity to learn to feed themselves (3, 10, 20, 22). The major objection to the introduction of beikost before age 4 months of age is based on the possibility that it may interfere with establishing sound eating habits and may contribute to overfeeding (5, 23). Before 4 months of age, the infant possesses an extrusion reflex that enables him/her to swallow only liquid foods (1, 12, 24). The extrusion reflex is toned down at four months (20). Breast milk or iron-fortified infant formula is all the infant needs. Gastric secretions, digestive capacity, renal capacity and enzymatic secretions are low, which makes digestion of solids inefficient and potentially harmful (5, 20, 23, 24). Furthermore, there is the potential for antigens to be developed against solid foods, due to the undigested proteins that may permeate the gut, however, the potential for developing allergic reactions may primarily be in infants with a strong family history of atopy (5, 23). If solid foods are introduced before the infant is developmentally ready, breastmilk or iron-fortified formula necessary for optimum growth is displaced (1, 20, 24). Around 4 months of age, the infant is developmentally ready for solid foods when (1, 5, 20, 23, 24): the infant is better able to express certain feeding cues such as turning head to indicate satiation; oral and gross motor skills begin to develop that help the infant to take solid foods; the

extrusion reflex disappears; and the infant begins to sit upright and maintain balance.

Offering juice before solid foods are introduced into the diet could risk having juice replace breastmilk or infant formula in the diet (14). This can result in reduced intake of protein, fat, vitamins, and minerals such as iron, calcium, and zinc (25). It is prudent to give juice only to infants who can drink from a cup (14).

Infants held to rigid feeding schedules are often underfed or overfed. Caregivers insensitive to signs of hunger and satiety, or who over manage feeding may inappropriately restrict or encourage excessive intake. Findings show that these practices may promote negative or unpleasant associations with eating that may continue into later life, and may also contribute to obesity. Infrequent breastfeeding can result in lactation insufficiency and infant failure-to-thrive. Infants should be fed foods with a texture appropriate to their developmental level. (3, 5, 10, 12, 20, 22)

Only pasteurized juice is safe for infants, children, and adolescents (14). Pasteurized fruit juices are free of microorganisms (14). Unpasteurized juice may contain pathogens, such as Escherichia coli, Salmonella, and Cryptosporidium organisms (14, 26). These organisms can cause serious disease, such as hemolytic-uremic syndrome, and should never be fed to infants and children (14). Unpasteurized juice must contain a warning on the label that the product may contain harmful bacteria (14, 27). Infants or young children should not eat raw or unpasteurized milk or cheeses (1)—unpasteurized dairy products could contain harmful bacteria, such as Brucella species, that could cause young children to contract a dangerous food borne illness. The AAP also recommends that young children should not eat soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese—these foods could contain Listeria bacteria (hard cheeses, processed cheeses, cream cheese, cottage cheese, and yogurt need not be avoided) (1).

Honey has been implicated as the primary food source of *Clostridium botulinum* during infancy. These spores are extremely resistant to heat, including pasteurization, and are not destroyed by present methods of processing honey. Botulism in infancy is caused by ingestion of the spores, which germinate into the toxin in the lumen of the bowel (9, 10, 20, 28, 29).

Infants or young children should not eat raw or undercooked meat or poultry, raw fish or shellfish, including oysters, clams, mussels, and scallops (1)—these foods may contain harmful bacteria or parasites that could cause children to contract a dangerous food borne illness.

According to the AAP, to prevent food-born illness, the foods listed below should not be fed to infants or young children. (1) All of the foods have been implicated in selected outbreaks of food-borne illness, including in children. Background information regarding foods that could be contaminated with harmful microorganisms is also included below:

- Raw vegetable sprouts (alfalfa, clover, bean, and radish)--Sprouts can cause potentially dangerous Salmonella and E. coli O157 infection. Sprouts grown

under clean conditions in the home also present a risk because bacteria may be present in seed. Cook sprouts to significantly reduce the risk of illness (30).

- Undercooked or raw tofu--*Yersinia enterocolitica* bacteria has been found in tofu and causes yersiniosis. It is sensitive to heat and is destroyed by adequate cooking (31).
- Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot) --These foods have been found to be contaminated with *Listeria monocytogenes*; if adequately cooked, this bacteria is destroyed.

Overdilution can result in water intoxication resulting in hyponatremia; irritability; coma; inadequate nutrient intake; failure to thrive; poor growth (1, 3, 5, 10, 20, 32). Underdilution of formula increases calories, protein, and solutes presented to the kidney for excretion, and can result in hypernatremia, tetany, and obesity (3, 5, 10, 20, 32).
Dehydration and metabolic acidosis can occur (3, 5, 10, 32). Powdered formulas vary in density so manufacturer's scoops are formula specific to assure correct dilution (5, 20). One clue for staff to identify incorrect formula preparation is to determine if the parent/caregiver is using the correct manufacturer's scoop to prepare the formula.

Exclusive breastfeeding provides ideal nutrition to an infant and is sufficient to support optimal growth and development in the first 6 months of life (4). Frequent breastfeeding is critical to the establishment and maintenance of an adequate milk supply for the infant (4, 33-37). Inadequate frequency of breastfeeding may lead to lactation failure in the mother and dehydration, poor weight gain, diarrhea, and vomiting, illness, and malnourishment in the infant (4, 35, 38-43). Exclusive breastfeeding protects infants from early exposure to contaminated foods and liquids (41). In addition, infants, who receive breastmilk more than infant formulas, have a lower risk of being overweight in childhood and adolescence (44, 45).

Highly restrictive diets prevent adequate intake of nutrients, interfere with growth and development, and may lead to other adverse physiological effects (3). Infants older than 6 months are potentially at the greatest risk for overt deficiency states related to inappropriate restrictions of the diet, although deficiencies of vitamins B12 and essential fatty acids may appear earlier (1, 46, 47). Infants are particularly vulnerable during the weaning period if fed a macrobiotic diet and may experience psychomotor delay in some instances (1, 48, 49). Well-balanced vegetarian diets with dairy products and eggs are generally associated with good health. However, strict vegan diets may be inadequate in calories, vitamin B12, vitamin D, calcium, iron, protein and essential amino acids needed for growth and development (50). The more limited the diet, the greater the health risk. Given the health and nutrition risks associated with highly restrictive diets, WIC can help the parent to assure that the infant consumes an adequate diet to optimize health during critical periods of growth as well as for the long term.

Infant formula must be properly prepared in a sanitary manner in order to be safe for consumption. Further, prepared infant formula and expressed breastmilk are perishable foods, which must be handled and stored properly in order to be safe

for consumption. (3, 9, 20, 51)

Published guidelines on the handling and storage of infant formula indicate that it is unsafe to feed an infant prepared formula which, for example:

- has been held at room temperate longer than 2 hours or longer than recommended by the manufacturer;
- has been held in the refrigerator longer than 48 hours;
- remains in a bottle one hour after the start of feeding; and/or
- remains in a bottle from an earlier feeding (9, 20).

Lack of sanitation may cause gastrointestinal infection. Most babies who are hospitalized for vomiting and diarrhea are bottle fed. This has often been attributed to the improper handling of formula rather than sensitivities to the formula. Manufacturers' instructions vary in the length of time it is considered to be safe to hold prepared infant formula without refrigeration before bacterial growth accelerates to an extent that the infant is placed at risk (9, 20). Published guidelines on the handling and storage of breastmilk may differ among pediatric nutrition authorities (9, 51-53). However, the following breastmilk feeding, handling, and storage practices, for example, are considered inappropriate and unsafe:

- feeding fresh breastmilk held in the refrigerator for more than 48 hours (51); or held in the freezer for greater than 6 months (1).
- thawing frozen breastmilk in the microwave oven;
- refreezing breastmilk;
- adding freshly expressed unrefrigerated breastmilk to already frozen breastmilk in a storage container**(54, 55);
- feeding previously frozen breastmilk thawed in the refrigerator that has been refrigerated for more than 24 hours (51), and/or
- saving breastmilk from a used bottle for another use at another feeding (51).

** The appropriate and safe practice is to add chilled freshly expressed breastmilk, in an amount that is smaller than the milk that has been frozen for no longer than 24 hours.

Although there are variations in the recommended lengths for breastmilk to be held at room temperate or stored in the refrigerator or freezer, safety is more likely to be assured by using the more conservative guidelines.

The water used to prepare concentrated or powdered infant formula and prepare bottles and nipples must be safe for consumption. Water used for formula preparation which is contaminated with toxic substances (such as nitrate at a concentration above 10 milligrams per liter, lead, or pesticides) poses a hazard to an infant's health and should NOT be used (9).

An infant consuming inappropriate or excessive amounts of single or multivitamin or mineral or herbal remedy not prescribed by a physician is at risk for a variety of adverse effects including harmful nutrient interactions, toxicity, and teratogenicity (1, 56). While some herbal teas may be safe, some have undesirable effects, particularly on infants who are fed herbal teas or who receive breast milk from mothers who have ingested herbal teas (57). Examples

of teas with potentially harmful effects to children include: licorice, comfrey leaves, sassafras, senna, buckhorn bark, cinnamon, wormwood, woodruff, valerian, foxglove, pokeroot or pokeweed, periwinkle, nutmeg, catnip, hydrangea, juniper, Mormon tea, thorn apple, yohimbe bark, lobelia, oleander, Matê, kola nut or gotu cola, and chamomile (57-59). Like drugs, herbal or botanical preparations have chemical and biological activity, may have side effects, and may interact with certain medications--these interactions can cause problems and can even be dangerous (60). Botanical supplements are not necessarily safe because the safety of a botanical depends on many things, such as its chemical makeup, how it works in the body, how it is prepared, and the dose used (60).

Depending on an infant's specific needs and environmental circumstances, certain dietary supplements may be recommended by the infant's health care provider to ensure health. For example, fluoride supplements may be of benefit in reducing dental decay for children living in fluoride-deficient areas (1, 61). Further, to prevent rickets and vitamin D deficiency in healthy infants and children, the AA P recommends a supplement of 200 IU per day for the following (4, 62, 63):

1. All breastfed infants unless they are weaned to at least 500 mL per day of vitamin D-fortified formula or milk.
2. All nonbreastfed infants who are ingesting less than 500 mL per day of vitamin D-fortified formula or milk.

References

1. Committee on Nutrition, American Academy of Pediatrics. Pediatric nutrition handbook. 4th and 5th eds. Elk Grove Village, Ill: American Academy of Pediatrics, 1998 and 2004.

2. American Academy of Pediatrics, Committee on Nutrition: Iron fortification of infant formula. Pediatrics 1999; 104:119-123.

3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

4. American Academy of Pediatrics, Section on Breastfeeding: Breastfeeding and the use of human milk. Pediatrics 2005 Feb;115(2):496-506.

5. Fomon SJ. Nutrition of normal infants. St. Louis: Mosby, 1993.

6. Whitney, EN, Rolfes SR. Understanding nutrition. 9th ed. Wadsworth: Thomson Learning, 2002: p. 541.

7. American Academy of Pediatrics, Committee on Nutrition. The use of whole cow's milk in infancy. Pediatrics 1992;89(6):1105-1109.

8. Friel JK et al. Eighteen-month follow-up of infants fed evaporated milk

formula. Canadian Journal of Public Health. Revue Canadienne de Sante Publique, 90.4 (Jul-Aug 1999): 240-3. Abstract.

9. United States Department of Agriculture, Food and Nutrition Service. Infant nutrition and feeding, a reference handbook for nutrition and health counselors in the WIC and CSF programs. Alexandria, VA: Nutrition and Technical Services Division, 1993. [FNS-288]

10. Trahms CM, Pipes PL, editors. Nutrition in Infancy and Childhood. WCB/McGraw- Hill; 1997.

11. Bellioni-Businco B, Paganelli R, Lucenti P, Giampietro PG, Perborn H, Businco L. Allergenicity of goat's milk in children with cow's milk allergy. J Allergy Clin Immunol 1999;103:1191-1194.

12. Tang J, Altman DS, Robertson D, O'Sullivan DM, Douglass JM, Tinanoff N. Dental caries prevalence and treatment levels in Arizona preschool children. Public Health Rep 1997;112:319-29.

13. Tinanoff N and Palmer CA. Dietary determinants of dental caries and dietary recommendations for preschool children. J Public Health Dent 2000;60(3):197-206.

14. American Academy of Pediatrics Committee on Nutrition: The use and misuse of fruit juice in pediatrics. Pediatrics 2001;107:1210-1213.

15. American Academy of Pediatrics and American Academy of Pedodontics. Juice in ready-to-use bottles and nursing bottle carries. AAP News. 1978;29(1):11.

16. Samour PQ, Helm KK, Lang CE. Handbook of pediatric nutrition. 2nd ed. Gaithersburg, MD: Aspen Publishers, Inc.; 1999.

17. American Academy of Pediatric Dentistry. Baby Bottle Tooth Decay/Early Childhood Caries. Pediatr Dent 2000-2001 (revised May 1996); 2001 Mar-Apr;23(2):18.

18. Fitzsimons D, Dwyer JT, Palmer C, Boyd LD. Nutrition and oral health guidelines for pregnant women, infants, and children. J Am Diet Assoc. Feb 1998;98(2):182-6.

19. Shelov SD. Caring for your baby and young child: birth to age 5. Elk Grove Village, IL: American Academy of Pediatrics; 1998.

20. Satter E. Child of mine: Feeding with love and good sense. Palo Alto (CA): Bull Publishing Company; 2000.

21. Tamborlane, WV, editor. The Yale guide to children's nutrition. Connecticut: Yale University; 1997.

22. Williams, CP, editor. Pediatric manual of clinical dietetics. Chicago:

American Dietetic Association; 1998.

23. Fomon, SJ. Feeding normal infants: rationale for recommendations. J Am Diet Assoc. 2001; 101:1002-1005.

24. Rolfes, DeBruyne, Whitney. Life span nutrition: conception through life; 1990; pp. 231-237.

25. Gibson SA. Non-milk extrinsic sugars in the diets of pre-school children: association with intakes of micronutrients, energy, fat and NSP. Br J Nutr 1997;78:367-378.

26. Parish ME. Public health and nonpasteurized fruit juices. Crit Rev Microbiol. 1997;23:109-119.

27. Food Labeling. Warning and Notice Statement: Labeling of Juice Products; Final Rule. 63 Federal Register 37029-37056 (1998) (codified at 21 CFR §101, 120)

28. Botulism Fact Sheet [electronic file]. Atlanta (GA): Centers for Disease Control and Prevention; 1995.

29. Centers for Disease Control and Prevention (US). Botulism in the United States, 1899-1996. Atlanta (GA): Centers for Disease Control and Prevention; 1998.

30. Food and Drug Administration. Updates: Avoid Raw Sprouts to Reduce Food Poisoning Risk, Agency Advises. FDA Consumer magazine, September-October 1999, see: http://www.fda.gov/fdac/departs/1999/599_upd.html

31. Nebraska Cooperative Extension. NebFacts: *Yersinia enterocolitica* Electronic version issued July 1995 (see: http://ianrpubs.unl.edu/foods/nf161.htm)

32. Fein, SB, Falci, CD. Infant formula preparation, handling, and related practices in the United States. J Am Diet Assoc 1999. 99:1234-1240.

33. Biancuzzo, Marie, Breastfeeding the Newborn, Clinical Strategies for Nurses. St. Louis, MO; Morby, 1999, Pages 103-104.

34. Mochbracher, Nancy and Stock, Julie, The Breastfeeding Answer Book (Revised edition). La Leche League International, 1997, Pages 20-23.

35. Eiger MS, Olds SW. The complete book of breastfeeding. New York: Workman Publishing; 1999, p. 88, 112-114.

36. Rosenthal MS. The breastfeeding sourcebook. Los Angeles: Lowell House; 1996, p. 157.

37. Sears M, Sears W. The breastfeeding book. Boston: Little, Brown and

Company; 2000, p. 108-110.

38. Johnson DB. Nutrition in infancy: Evolving views on recommendations. Nutrition Today 1998; 32: 63-68.

39. Mark DH. Breastfeeding and infant illness: A dose-response relationship. J Amer Med Assoc 1990; 281: 1154.

40. Murtaugh M. Optimal breastfeeding duration. J Am Diet Assoc 1997; 97: 1252-1255.

41. Raisler J, Alexander C, O'Campo P. Breastfeeding and infant illness: A dose-response relationship? Am J Pub Health 1999; 89: 25-30.

42. Scariati PD, Grummer-Strawn LM, Fein SB. A longitudinal analysis of infant mortality and the extent of breastfeeding in the United States. Pediatrics 1997; 99:6.

43. Story M, Hoyt K, Sofka D. Bright Futures in Practice. National Center for Education in Maternal and Child Health. Arlington: Georgetown University; 2000, p. 25.

44. Gillman MW, Rifas-Shiman SL, Camargo CA Jr, Berkey CS, Frazier AL, Rockett HR, Field AE, Colditz GA. Risk of overweight among adolescents who were breastfed as infants. J Amer Med Assoc 2001; 285(19): 2461-7.

45. Von Kries R, Koletzko B, Sauerwald T, von Mutius E, Barnert D, Grunert V, Von Voss H. Breastfeeding and obesity: cross-sectional study. Br Med J 1999; 319(7203):147-50.

46. Sanders TA, Reddy S. Vegetarian diets and children. Am J Clin Nutr. 1994;59(suppl):1176S-1181S.

47. Sanders TA. Essential fatty acid requirements of vegetarians in pregnancy, lactation and infancy. Am J Clin Nutr. 1999;70:555S-559S.

48. Sanders TA. Vegetarian diets and children. Pediatr Clin North Am. 1995;42:955-965.

49. Dagnelie PC, Vergote FJ, van Staveren, WA, et al. High prevalence of rickets in infants on macrobiotic diets. Am J Clin Nutr. 1990;51:202-208.

50. Duyff RL. American Dietetic Association. The American Dietetic Association's complete food and nutrition guide. Minneapolis, MN: Chronimed Pub; 1996.

51. American Academy of Pediatrics: A Woman's Guide to Breastfeeding. 1999, pp. 13-14.

52. United States Department of Agriculture (USDA), Food and Nutrition Service. Breastfeed Babies Welcome Here [Program Aid 1516]. Alexandria, VA: USDA, 1995, pp. 12-15.

53. Lawrence, RA: Breastfeeding: a guide for the medical profession. 5th edition. St. Louis, MO: Mosby, 1999, pp. 677-710.

54. Duke, C.S.: Common Concerns When Storing Human Milk. New Beginnings; July-August 1998; 15 (4), p. 109.

55. Neifert, Marianne: Dr. Mom's Guide to Breastfeeding. 1998; New York, NY: Plume, pp. 305-306.

56. Anderson JV, Van Nierop MR. Basic nutrition facts a nutrition reference. Lansing, MI: Michigan Department of Public Health; 1989.

57. Lawrence, RA. Breastfeeding: a guide for the medical profession. 5th edition. St. Louis, MO: Mosby, 1999, pp. 371-377.

58. Siegel RK. Herbal intoxication: psychoactive effects from herbal cigarettes, tea and capsules. JAMA 236:473, 1976.

59. Ridker PM. Toxic effects of herbal teas. Arch Environ Health 42(3):133-6, 1987.

60. Office of Dietary Supplements, National Institutes of Health (NIH). Botanical Dietary Supplements: Background Information. NIH web page, last updated 7/7/2004, see: http://ods.od.nih.gov/factsheets/BotanicalBackground.asp

61. American Academy of Pediatric Dentistry. Fluoride. Pediatr Dent. 1999;21:40.

62. American Academy of Pediatrics Committee on Nutrition. Prevention of rickets and vitamin D deficiency: new guidelines for vitamin D intake. Pediatrics 2001;111:908-910.

63. Institute of Medicine, Food and Nutrition Board, Standing Committee on the Scientific Evaluation of Dietary Reference Intakes. Vitamin D. In: *Dietary Reference Intakes for Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride.* Washington, DC: National Academy Press; 1997:250-287.

Nutrition Risk Criteria **47 INAPPROPRIATE NUTRITION PRACTICES (CHILD)**
USDA CODE 425

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	CHILDREN	5	-

Definition

FORMALLY QUESTIONABLE CHILD FEEDING

Routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. These practices, with examples, are outlined below. Refer to "Justification and References" for this criterion.

Routinely feeding inappropriate beverages as the primary milk source.
Examples of inappropriate beverages as primary milk source:

- Non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk; and
- Imitation or substitute milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."

Routinely feeding a child any sugar-containing fluids.
Examples of sugar-containing fluids:

- Soda/soft drinks;
- Gelatin water;
- Corn syrup solutions; and
- Sweetened tea.

Routinely using feeding practices that disregard the developmental needs or stages of the child.

- Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's requests for appropriate foods).
- Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking.
- Not supporting a child's need for growing independence with self-feeding (e.g., solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils).
- Feeding a child food with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily pureed or liquid food when the child is ready and capable of eating mashed, chopped or appropriate finger foods).

Feeding foods to a child that could be contaminated with harmful microorganisms.
Examples of potentially harmful foods for a child:

- Unpasteurized fruit or vegetable juice;

- Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese;
- Raw or undercooked meat, fish, poultry, or eggs;
- Raw vegetable sprouts (alfalfa, clover, bean, and radish);
- Undercooked or raw tofu; and
- Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot).

Routinely feeding a diet very low in calories and/or essential nutrients.
Examples:
- Vegan diet;
- Macrobiotic diet; and
- Other diets very low in calories and/or essential nutrients.

Feeding dietary supplements with potentially harmful consequences.
Examples of dietary supplements which when fed in excess of recommended dosage may be toxic or have harmful consequences:
- Single or multi-vitamins;
- Mineral supplements; and
- Herbal or botanical supplements/remedies/teas.

Routinely not providing dietary supplements recognized as essential by

national public health policy when a child's diet alone cannot meet nutrient requirements.
- Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride.
- Providing children 36-60 months of age less than 0.50 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride.

Routine ingestion of nonfood items (pica).
Examples of inappropriate nonfood items:
- Ashes;
- Carpet fibers;
- Cigarettes or cigarette butts;
- Clay;
- Dust;
- Foam rubber;
- Paint chips;
- Soil; and

Starch (laundry and cornstarch).

Required Documentation

Document which of the behavior(s) are present in the participant file.

Justification

Goat's milk, sheep's milk, imitation milks and substitute milks do not contain nutrients in amounts appropriate as a primary milk source for children (1-4).

Non-fat and reduced-fat milks are not recommended for use with children from 1 to 2 years of age because of the lower calorie density compared with whole-fat products (1, 5). The low-calorie, low-fat content of these milks requires that increased volume be consumed to satisfy caloric needs. Infants and children under two using reduced fat milks gain at a slower growth rate, lose body fat as evidenced by skinfold thickness, lose energy reserves, and are at risk of inadequate intake of essential fatty acids.

Abundant epidemiologic evidence from groups who have consumed low quantities of sugar as well as from those who have consumed high quantities shows that sugar—especially sucrose—is the major dietary factor affecting dental caries prevalence and progression (6). Consumption of foods and beverages high in fermentable carbohydrates, such as sucrose, increases the risk of early childhood caries and tooth decay (6,7).

The interactions and communication between a caregiver and child during feeding and eating influence a child's ability to progress in eating skills and consume a nutritionally adequate diet. These interactions comprise the "feeding relationship" (9). A dysfunctional feeding relationship, which could be characterized by a caregiver misinterpreting, ignoring, or overruling a young child's innate capability to regulate food intake based on hunger, appetite and satiety, can result in poor dietary intake and impaired growth (16, 17). Parents who consistently attempt to control their children's food intake may give children few opportunities to learn to control their own food intake (18). This could result in inadequate or excessive food intake, future problems with food regulation, and problems with growth and nutritional status. Instead of using approaches such as bribery, rigid control, struggles, or short-order cooking to manage eating, a healthier approach is for parents to provide nutritious, safe foods at regular meals and snacks, allowing children to decide how much, if any, they eat (1, 17). Young children should be able to eat in a matter-of-fact way sufficient quantities of the foods that are given to them, just as they take care of other daily needs (3). Research indicates that restricting access to foods (i.e., high fat foods) may enhance the interest of 3- to 5-year old children in those foods and increase their desire to obtain and consume those foods. Stringent parental controls on child eating has been found to potentiate children's preference for high-fat energy dense foods, limit children's acceptance of a variety of foods, and disrupt children's regulation of energy intake (19, 20). Forcing a child to clean his or her plate may lead to overeating or development of an aversion to certain foods (7). The toddler and preschooler are striving to be independent (7). Self-feeding is important even though physically they may not be able to handle feeding utensils or have good eye-hand coordination (7). Children should be able to manage the feeding process independently and with dispatch, without either unnecessary dawdling or hurried eating (3, 12). Self-feeding milestones include (1): During infancy, older infants progress from semisolid foods to thicker and lumpier foods to soft pieces to finger-feeding table food (9). By 15 months, children can manage a cup, although not without some spilling. At 16 to 17 months of age, well-defined wrist rotation develops, permitting the transfer of feed from the bowl to the child's mouth with less spilling. The ability to lift the elbow as the spoon is raised and to flex the wrist as the spoon reaches the mouth follows. At 18 to 24 months, they learn to tilt a cup by manipulation with the fingers. Despite these new skills, 2-year-old

children often prefer using their fingers to using the spoon. Preschool children learn to eat a wider variety of textures and kinds of food (3, 7). However, the foods offered should be modified so that the child can chew and swallow the food without difficulty (3).

According to the AAP, to prevent food-borne illness, the foods listed below should not be fed to young children or infants (1). All of the foods have been implicated in selected outbreaks of food-borne illness, including in children. Background information regarding foods that could be contaminated with harmful microorganisms is also included below:

- Unpasteurized fruit or vegetable juice--Only pasteurized juice is safe for infants, children, and adolescents (10). Pasteurized fruit juices are free of microorganisms (10). Unpasteurized juice may contain pathogens, such as Escherichia coli, Salmonella, and Cryptosporidium organisms (10, 21). These organisms can cause serious disease, such as hemolytic-uremic syndrome, and should never be fed to infants and children (10). Unpasteurized juice must contain a warning on the label that the product may contain harmful bacteria (10, 22).
- Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese--Young children or infants should not eat raw or unpasteurized milk or cheeses (1)—unpasteurized dairy products could contain harmful bacteria, such as Brucella species, that could cause young children to contract a dangerous food borne illness. The American Academy of Pediatrics also recommends that young children should not eat soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese—these foods could contain Listeria bacteria (hard cheeses, processed cheeses, cream cheese, cottage cheese, and yogurt need not be avoided) (1).
- Raw or undercooked meat, fish, poultry, or eggs--Young children or infants should not eat raw or undercooked meat or poultry, raw fish or shellfish , including oysters, clams, mussels, and scallops (1)—these foods may contain harmful bacteria or parasites that could cause children to contract a dangerous food borne illness.
- Raw vegetable sprouts (alfalfa, clover, bean, and radish)--Sprouts can cause potentially dangerous Salmonella and E. coli O157 infection. Sprouts grown under clean conditions in the home also present a risk because bacteria may be present in seed. Cook sprouts to significantly reduce the risk of illness (23).
- Undercooked or raw tofu--*Yersinia enterocolitica* bacteria has been found in tofu and causes yersiniosis. It is sensitive to heat and is destroyed by adequate cooking (24).
- Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot)--
  These foods have been found to be contaminated with *Listeria monocytogenes*; if adequately cooked, this bacteria is destroyed.

Highly restrictive diets prevent adequate intake of nutrients, interfere with growth and development, and may lead to other adverse physiological effects (25). Well-balanced vegetarian diets with dairy products and eggs are generally associated with good health. However, strict vegan diets may be inadequate in calories, vitamin B12, vitamin D, calcium, iron, protein and essential amino

acids needed for growth and development (26). The more limited the diet, the greater the health risk. Given the health and nutrition risks associated with highly restrictive diets, WIC can help the parent to assure that the child consumes an adequate diet to optimize health during critical periods of growth as well as for the long term.

A child consuming inappropriate or excessive amounts of single or multivitamin or mineral or herbal remedy not prescribed by a physician is at risk for a variety of adverse effects including harmful nutrient interactions, toxicity, and teratogenicity (1, 27). Like drugs, herbal or botanical preparations have chemical and biological activity, may have side effects, and may interact with certain medications--these interactions can cause problems and can even be dangerous (28). Botanical supplements are not necessarily safe because the safety of a botanical depends on many things, such as its chemical makeup, how it works in the body, how it is prepared, and the dose used (28). While some herbal teas may be safe, some have undesirable effects, particularly on young children who are fed herbal teas or who receive breast milk from mothers who have ingested herbal teas (29). Examples of teas with potentially harmful effects to children include: licorice, comfrey leaves, sassafras, senna, buckhorn bark, cinnamon, wormwood, woodruff, valerian, foxglove, pokeroot or pokeweed, periwinkle, nutmeg, catnip, hydrangea, juniper, Mormon tea, thorn apple, yohimbe bark, lobelia, oleander, Matê, kola nut or gotu cola, and chamomile (29-31).

Depending on a child's specific needs and environmental circumstances, certain dietary supplements may be recommended by the child's health care provider to ensure health. For example, fluoride supplements may be of benefit in reducing dental decay for children living in fluoride-deficient areas (1, 32).

Pica is the compulsive eating of nonnutritive substances and can have serious medical implications (33). Pica is observed most commonly in areas of low socioeconomic status and is more common in women (especially pregnant women) and in children (30). Pica has also been seen in children with obsessive-compulsive disorders, mental retardation, sickle cell disease (33-35). Complications of this disorder include: iron-deficiency anemia, lead poisoning, intestinal obstruction, acute toxicity from soil contaminants, and helminthic infestations (33, 36, 37).

References

1. Committee on Nutrition, American Academy of Pediatrics. Pediatric nutrition handbook. 4th and 5th eds. Elk Grove Village, Ill: American Academy of Pediatrics, 1998 and 2004.

2. American Academy of Pediatrics, Committee on Nutrition: Iron fortification of infant formula. Pediatrics 1999; 104:119-123.

3. Trahms CM, Pipes PL, editors. Nutrition in Infancy and Childhood. WCB/McGraw-Hill; 1997.

4. Bellioni-Businco B, Paganelli R, Lucenti P, Giampietro PG, Perborn H, Businco L. Allergenicity of goat's milk in children with cow's milk allergy.

J Allergy Clin Immunol 1999;103:1191-1194.

5. Tamborlane, WV, editor. The Yale guide to children's nutrition. Connecticut: Yale University; 1997.

6. Tinanoff N, Palmer CA. Dietary determinants of dental caries and dietary recommendations for preschool children. J Public Health Dent 2000;60(3):197-206.

7. Williams, CP, editor. Pediatric manual of clinical dietetics. Chicago: American Dietetic Association; 1998.

8. Tang J, Altman DS, Robertson D, O'Sullivan DM, Douglass JM, Tinanoff N. Dental caries prevalence and treatment levels in Arizona preschool children. Public Health Rep 1997;112:319-29.

9. Satter E. Child of mine: Feeding with love and good sense. Palo Alto (CA): Bull Publishing Company; 2000.

10. American Academy of Pediatrics Committee on Nutrition: The use and misuse of fruit juice in pediatrics. Pediatrics 2001;107:1210-1213.

11. American Academy of Pediatrics and American Academy of Pedodontics. Juice in ready-to-use bottles and nursing bottle carries. AAP News. 1978;29(1):11.

12. Samour PQ, Helm KK, Lang CE. Handbook of pediatric nutrition. 2nd ed. Gaithersburg, MD: Aspen Publishers, Inc.; 1999.

13. Shelov SD. Caring for your baby and young child: birth to age 5. Elk Grove Village, IL: American Academy of Pediatrics; 1998.

14. American Academy of Pediatric Dentistry. Baby Bottle Tooth Decay/Early Childhood Caries. Pediatr Dent 2000-2001 (revised May 1996); 2001 Mar-Apr;23(2):18

15. Fitzsimons D, Dwyer JT, Palmer C, Boyd LD. Nutrition and oral health guidelines for pregnant women, infants, and children. J Am Diet Assoc. Feb 1998;98(2):182-6.

16. Satter, E. Childhood feeding problems. Feelings and Their Medical Significance; Vol. 32, no. 2; Columbus, OH; Ross Laboratories; 1990.

17. Satter EM. The feeding relationship. J.Am.Diet.Assoc. 1986;86:352-6.

18. Johnson SL, Birch LL. Parents' and children's adiposity and eating style. Pediatrics 1994;94:653-61.

19. Olson RE. Is it wise to restrict fat in the diets of children? J Am Diet Assoc 2000 Jan;100(1):28-32.

20. Birch LL, Fisher JO. Development of eating behaviors among children and adolescents. Pediatrics 1998;101:539-549.

21. Parish ME. Public health and nonpasteurized fruit juices. Crit Rev Microbiol. 1997;23:109-119.

22. Food Labeling. Warning and Notice Statement: Labeling of Juice Products; Final Rule. 63 Federal Register 37029-37056 (1998) (codified at 21 CFR §101, 120).

23. Food and Drug Administration. Updates: Avoid Raw Sprouts to Reduce Food Poisoning Risk, Agency Advises. FDA Consumer magazine, September-October 1999 (see: http://www.fda.gov/fdac/departs/1999/599_upd.html)

24. Nebraska Cooperative Extension. NebFacts: *Yersinia enterocolitica* Electronic version issued July 1995 (see: http://ianrpubs.unl.edu/foods/nf161.htm

25. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

26. Duyff RL. American Dietetic Association. The American Dietetic Association's complete food and nutrition guide. Minneapolis, MN: Chronimed Pub; 1996.

27. Anderson JV, Van Nierop MR. Basic nutrition facts a nutrition reference. Lansing, MI: Michigan Department of Public Health; 1989.

28. Office of Dietary Supplements, National Institutes of Health (NIH). Botanical Dietary Supplements: Background Information. NIH web page, last updated 7/7/2004, see: http://ods.od.nih.gov/factsheets/BotanicalBackground.asp

29. Lawrence, RA. Breastfeeding: a guide for the medical profession. 5th edition. St. Louis, MO: Mosby, 1999, pp. 371-377.

30. Siegel RK. Herbal intoxication: psychoactive effects from herbal cigarettes, tea and capsules. JAMA 236:473, 1976.

31. Ridker PM. Toxic effects of herbal teas. Arch Environ Health 42(3):133-6, 1987.

32. American Academy of Pediatric Dentistry. Fluoride. Pediatr Dent. 1999;21:40.

33. Rose EA, Porcerelli JH, Neale AV. Pica: common but commonly missed. J Am Board Fam Pract. 2000;13(5):353-8.

34. LeBlanc LA, Piazza CC, Krug MA. Comparing methods for maintaining the

safety of a child with pica. Res Dev Disabil. 1997; 18(3):215-20.

35. Ivascu NS, et al. Characterization of pica prevalence among patients with sickle cell disease. Arch Pediatr Adoles Med 2001; 155(11):1243-7.

36. Calabrese EJ, et al. Soil ingestion: a concern for acute toxicity in children. Environ Health Perspect. 1997; 105(12):1354-8.

37. Wang PY, Skarsgard ED, Baker RJ. Carpet bezoar obstruction of the small intestine. J Pediatr Surg. 1996; 31(12):1691-3.

Additional Related References:

Food Safety and Inspection Service. Food Safety Focus: Molds On Food: Are They Dangerous? Electronic Consumer Education and Information. April 2002 (see: http://www.nutrition.gov/framesets/search.php3?mw=moldy+food&Submit=Go&url=Select+A+Topic&db=www&mt=all)

Food Safety and Inspection Service. FOCUS ON: Food Product Dating. Electronic Consumer Education and Information. Updated June 2001 (see: http://www.nutrition.gov/framesets/search.php3?mw=moldy+food&Submit=Go&url=Select+A+Topic&db=www&mt=all)

Nutrition Risk Criteria **48 INAPPROPRIATE NUTRITION PRACTICES (WOMEN)**
USDA CODE 427

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-

Definition

FORMALLY QUESTIONABLE DIET FOR WOMEN

Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. These practices with examples are outlined below. Refer to "Justification and References" for this criterion.

Consuming dietary supplements with potentially harmful consequences.
Examples of dietary supplements which when ingested in excess of recommended dosages, may be toxic or have harmful consequences:

- Single or multiple vitamins;
- Mineral supplements; and
- Herbal or botanical supplements/remedies/teas.

Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery.

- Strict vegan diet;
- Low-carbohydrate, high-protein diet;
- Macrobiotic diet; and
- Any other diet restricting calories and/or essential nutrients.

Compulsively ingesting non-food items (pica).

Non-food items:

- Ashes;
- Baking soda;
- Burnt matches;
- Carpet fibers;
- Chalk;
- Cigarettes;
- Clay;
- Dust;
- Large quantities of ice and/or freezer frost;
- Paint chips;
- Soil; and

Starch (laundry and cornstarch

Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.

- Consumption of less than 30 mg of iron as a supplement daily by pregnant woman.
- Consumption of less than 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant woman.

Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms.

Potentially harmful foods:
- Raw fish or shellfish, including oysters, clams, mussels, and scallops;
- Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole;
- Raw or undercooked meat or poultry;
- Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot;
- Refrigerated pâté or meat spreads;
- Unpasteurized milk or foods containing unpasteurized milk;
- Soft cheeses such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as made with pasteurized milk;
- Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog;
- Raw sprouts (alfalfa, clover, and radish); or

Unpasteurized fruit or vegetable juices.

Required Documentation

Document which of the above behavior(s) is present in the participant file.

Justification

Women taking inappropriate or excessive amounts of dietary supplements such as, single or multivitamins or minerals, or botanical (including herbal) remedies or teas, are at risk for adverse effects such as harmful nutrient interactions, toxicity and teratogenicity (1, 2). Pregnant and lactating women are at higher risk secondary to the potential transference of harmful substances to their infant.

Most nutrient toxicities occur through excessive supplementation of particular nutrients, such as, vitamins A, B-6 and niacin, iron and selenium (3). Large doses of vitamin A may be teratogenic (4). Because of this risk, the Institute of Medicine recommends avoiding preformed vitamin A supplementation during the first trimester of pregnancy (4). Besides nutrient toxicities, nutrient-nutrient and drug-nutrient interactions may adversely affect health.

Many herbal and botanical remedies have cultural implications and are related to beliefs about pregnancy and breastfeeding. The incidence of herbal use in pregnancy ranges from 7-55 % with echinacea and ginger being the most common (1). Some botanical (including herbal) teas may be safe; however, others have undesirable effects during pregnancy and breastfeeding. Herbal supplements such as, blue cohash and pennyroyal stimulate uterine contractions, which may increase the risk of miscarriage or premature labor (1, 5). The March of Dimes and the American Academy of Pediatrics recommend cautious use of tea mixtures because of the lack of safety testing in pregnant women (6).

Women consuming highly restrictive diets are at risk for primary nutrient deficiencies, especially during critical developmental periods such as pregnancy. Pregnant women who restrict their diets may increase the risk of birth defects, suboptimal fetal development and chronic health problems in their children. Examples of nutrients associated with negative health outcomes are:

- Low iron intake and maternal anemia and increased risk of preterm birth or low
  birth weight (7, 8).
- Low maternal vitamin D status and depressed infant vitamin D status (9).
- Low folic acid and NTD (10, 11, 12).

Low calorie intake during pregnancy may lead to inadequate prenatal weight gain, which is associated with infant intrauterine growth restriction (IUGR) (13) and birth defects (10, 11, 14). The pregnant adolescent who restricts her diet is of particular concern since her additional growth needs compete with the developing fetus and the physiological changes of pregnancy (14).

Strict vegan diets may be highly restrictive and result in nutrient deficiencies. Nutrients of potential concern that may require supplementation are:

- Riboflavin (15, 16)
- Iron (15)
- Zinc (15, 17)
- Vitamin B12 (15, 16, 18)
- Vitamin D (15, 16, 18)
- Calcium (15, 16, 18, 19,)

- Selenium (16)

The pregnant adolescent who consumes a vegan diet is at even greater risk due to her higher nutritional needs (16, 18). The breastfeeding woman who chooses a vegan or macrobiotic diet increases her risk and her baby's risk for vitamin B12 deficiency (18). Severe vitamin B12 deficiency resulting in neurological damage has been reported in infants of vegetarian mothers (18).

With the epidemic of obesity, treatment by gastric bypass surgery has increased more than 600% in the last ten years and has created nutritional deficiencies not typically seen in obstetric or pediatric medical practices (20). Gastrointestinal surgery promotes weight loss by restricting food intake and, in some operations, interrupting the digestive process. Operations that only reduce stomach size are known as "restrictive operations" because they restrict the amount of food the stomach can hold. Examples of restrictive operations are adjustable gastric banding and vertical banded gastroplasty. These types of operations do not interfere with the normal digestive process (21).

Some operations combine stomach restriction with a partial bypass of the small intestine, these are known as malabsorptive operations. Examples of malabsorptive operations are Roux-en-y gastric bypass (RGB) and Biliopancreatic diversion (BPD). Malabsorptive operations carry a greater risk for nutritional deficiencies because the procedure causes food to bypass the duodenum and jejunum, where most of the iron and calcium are absorbed. Menstruating women may develop anemia because not enough iron and vitamin B12 are absorbed. Decreased absorption of calcium may also contribute to osteoporosis and metabolic bone disease (21). A breastfeeding woman who has had gastric bypass surgery is at risk of vitamin B12 deficiency for herself and her infant (22).

Pica, the compulsive ingestion of non-food substances over a sustained period of time, is linked to lead poisoning and exposure to other toxicants, anemia, excess calories or displacement of nutrients, gastric and small bowel obstruction, as well as, parasitic infection (23). It may also contribute to nutrient deficiencies by either inhibiting absorption or displacing nutrient dense foods in the diet.

Poor pregnancy outcomes associated with pica-induced lead poisoning, include lower maternal hemoglobin level at delivery (24) and a smaller head circumference in the infant (25). Maternal transfer of lead via breastfeeding has been documented in infants and can result in a neuro-developmental insult depending on the blood lead level and the compounded exposure for the infant during pregnancy and breastfeeding (26, 27, 28).

Non-pregnant women of childbearing age who do not consume adequate amounts of folic acid are at greater risk for functional folate deficiency, which has been proven to cause neural tube defects (NTDs), such as, spina bifida and anencephaly (29, 30, 31, 32).

Folic acid consumed from fortified foods and/or a vitamin supplement in addition to folate found naturally in food reduces this risk (12). The terms "folic acid" and "folate" are used interchangeably, yet they have different meanings.

Folic acid is the synthetic form used in vitamin supplements and fortified foods (12, 30, 31). Folate occurs naturally and is found in foods, such as dark green leafy vegetables, strawberries, and orange juice (12).

Studies show that consuming 400 mcg of folic acid daily interconceptionally can prevent 50 percent of neural tube defects (12). Because NTDs develop early in pregnancy (between the 17th and 30th day) and many pregnancies are not planned, it is important to have adequate intakes before pregnancy and throughout the childbearing years (14). NTDs often occur before women know they are pregnant. It is recommended that all women capable of becoming pregnant consume a multivitamin containing 400 mcg of folic acid daily (31, 32, 33). It is important that breastfeeding and non-breastfeeding women participating in the WIC Program know about folic acid and foods that contain folate to encourage preconceptional preventive practices (30).

Food-borne illness is a serious public health problem (34). The causes include pathogenic microorganisms (bacteria, viruses, and parasites) and their toxins and chemical contamination. The symptoms are usually gastrointestinal in nature (vomiting, diarrhea, and abdominal pain), but neurological and "non-specific" symptoms may occur as well. Over the last 20 years, certain foods have been linked to outbreaks of food-borne illness. These foods include: milk (Campylobacter); shellfish (Norwalk-like viruses), unpasteurized apple cider (Escherichia coli O 157:H7); eggs (Salmonella); fish (ciguatera poisoning); raspberries (Cyclospora); strawberries (Hepatitis A virus); and ready-to-eat meats (Listeria monocytogenes).

Listeria monocytogenes can cause an illness called listeriosis. Listeriosis during pregnancy can result in premature delivery, miscarriage, fetal death, and severe illness or death of a newborn from the infection (35). Listeriosis can be transmitted to the fetus through the placenta even if the mother is not showing signs of illness.

Pregnant women are especially at risk for food-borne illness. For this reason, government agencies such as the Centers for Disease Control and Prevention, the USDA Food Safety and Inspection Service, and the Food and Drug Administration advise pregnant women and other high risk individuals not to eat foods as identified in the definition for this criterion (34, 35).

The CDC encourages health care professionals to provide anticipatory guidance, including the "four simple steps to food safety" of the Fight BAC campaign, to help reduce the incidence of food-borne illnesses.

References

1. Tiran D. The use of herbs by pregnant and childbearing women: a risk-benefit assessment. Complementary Therapies in Nursing and Midwifery. November 2003. 9(4):176-181.

2. Position of the American Dietetic Association: Nutrition and lifestyle for a healthy pregnancy outcome. J Am Diet Assoc. 2002 October;102(10):1479-1490.

3. Position of the American Dietetic Association: Food fortification and dietary supplements. J Am Diet Assoc. January 2001.

4. Langkamp-Henken B, Lukowski MJ, Turner RE, Voyles LM. High levels of retinol intake during the first trimester of pregnancy result from use of over-the-counter vitamin/mineral supplements. J Am Diet Assoc. September 2000.

5. March of Dimes (homepage on the Internet). New York: Herbal Supplements: heir Safety, a Concern for Health Care Providers. [cited May 26, 2004] Available from: http://www.marchofdimes.com

6. American Academy of Pediatrics, Committee on Nutrition. Pediatric Nutrition Handbook. 5th ed. Kleinman, Ronald, editor. Washington DC: American Academy of Pediatrics; 2004.

7. Recommendations to prevent and control iron deficiency in the United States. MMWR [serial on the Internet]. 1998 April [cited 2004 March 12]. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/00051880.htm.

8. Rasmussen, K. M. Is there a causal relationship between iron deficiency or iron-deficiency anemia and weight at birth, length of gestation and perinatal mortality? American Society for Nutritional Sciences. 2001;590S-603S.

9. Scanlon KS, editor. Vitamin D expert panel meeting; October 11-12, 2001; Atlanta, Georgia. Available from: http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/Vitamin D Expert Panel Meeting.pdf.

10. Carmichael SL, Shaw GM, Schaffer DM, Selvin S. Diet quality and risk of neural tube defects. Medical Hypotheses. 2003;60(3):351-355.

11. Shaw GM, Todoroff K, Carmichael SL, Schaffer DM, Selvin S. Lowered weight gain during pregnancy and risk of neural tube defects among offspring. Int J Epidemiol. 2001; 30:60-65.

12. American Academy of Pediatrics, Committee on Genetics. Folic acid for the prevention of neural tube defects. Pediatrics.1999; 104(2):325-327.

13. Strauss RS, Dietz WH. Low maternal weight gain in the second and third trimester increases the risk for intrauterine growth retardation. American

Society for Nutritional Sciences. 1999; 988-993.

14. Scholl TO, Hediger ML, Ances IG. Maternal growth during pregnancy and decreased infant birth weight. Am J Clin Nutr. 1990;51:790-793.

15. Position of the American Dietetic Association and Dietitians of Canada: Vegetarian diets. J Am Diet Assoc. 2003; 103(6):748-765.

16. Larsson CL, Johansson GK. Dietary intake and nutritional status of young vegans and omnivores in Sweden. Am J Clin Nutr. 2002; 76:100-106.

17. Bakan R, Birmingham CL, Aeberhardt L, Goldner EM. Dietary zinc intake of vegetarian and nonvegetarian patients with anorexia nervosa. International Journal of Eating Disorders. 1993;13(2):229-233.

18. Specker, Bonny L., Nutritional concerns of lactating women consuming vegetarian diets. Am J Clin Nutr. 1994:59(suppl):1182-1186.

19. Heaney RP, Dowell MS, Rafferty K, Bierman J. Bioavailability of the calcium in fortified soy imitation milk, with some observation on method. Am J Clin Nutr. 2000;71:1166-1169.

20. Steinbrook, R. Surgery for severe obesity. N Engl J Med. 2004; 350(11):1075-9.

21. National Institute of Diabetes and Digestive and Kidney Diseases. Gastrointestinal Surgery for Severe Obesity. [cited August 18, 2004] Available from: http://www.niddk.nih.gov/health/nutrit/pubs/gastric/gastricsurgery.htm

22. Grange DK, Finlay JL. Nutritional vitamin B12 deficiency in a breastfed infant following maternal gastric bypass. Pediatr Hematol Oncol. 1994; 11(3):311-8.

23. Corbett RW, Ryan C, Weinrich SP. Pica in pregnancy: does it affect pregnancy outcomes? American Journal of Maternal and Child Nursing. 2003;28(3):183-189.

24. Rainville AJ. Pica practices of pregnant women are associated with lower maternal hemoglobin level at delivery. J Am Diet Assoc. 1998;98(3): 293-6.

25. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp.270-272.

26. Gulson, Brian L., et. al., Relationships of lead in breast milk to lead in blood, urine, and diet of infant and mother. Environmental Health Perspectives. 1998:106(10): 667-674.

27. Ping-Jian L, Ye-Zhou S, Qian-Ying W, Li-Ya G, Yi-Land W. Transfer of lead via placenta and breast milk in human. Biomedical and Environmental Sciences. 2000; 13:85-89.

28. Canfield, RL, Henderson, C, Cory-Slecha, D, Cox, C, Jusko, T, Lanphear, B. Intellectual impairment in children with blood lead concentrations below 10 mcg per deciliter. N Engl J Med. 2003;348(16):1517-1526.

29. Centers for Disease Control and Prevention, Division of Birth Defects and Developmental Disabilities. Folic acid and the prevention of spina bifida and anencephaly: 10 years after the U.S. Public Health Service recommendation. MMWR 2002;51:(RR-13)1-3.

30. Centers for Disease Control and Prevention. National Center for Environmental Health, Division of Birth Defects and Developmental Disabilities. Preventing neural tube birth defects: a prevention model and resource guide. Atlanta: CDC, 1998.

31. Centers for Disease Control and Prevention. Recommendations for the use of folic acid to reduce the number of cases of spina bifida and other neural tube defects. MMWR 1992;41:RR-14.

32. Evans MI, Llurba E, Landsberger EJ, O'Brien JE, Harrison HH. Impact of folic acid fortification the Untied States: markedly diminish high maternal serum alpha-fetoprotein values. Am Col Obstetr Gynecol. 2004;103(3):447.

33. Chacko MR, Anding R, Kozinetz CA, Grover JL. Neural tube defects: knowledge and preconceptional prevention practices in minority young women. Pediatrics. 2003;112(3):536-542.

34. Centers for Disease Control and Prevention, Diagnosis and Management of Foodborne Illness, A Primer for Physicians. MMWR 2001;50:RR-2.

35. Food Safety and Inspection Service, USDA. Listeriosis and Pregnancy: What is Your Risk? [cited August 11, 2004] Available from: http://www.fsis.usda.gov.

WEBSITES FOR ADDITIONAL INFORMATION:

427.1 References - Supplements/Herbs
http://www.marchofdimes.com
http://www.dietary-supplements.info.nih.gov/
http://www.vm.cfsan.fda.gov/
http://www.herbalgram.org

427.2 References - Highly Restrictive Eating/ Nutrient Malabsorption
http://www.eatright.org
http://www.nimh.nih.gov
http://www.eatright.org/
http://www.llu.edu/llu/vegetarian/
http://www.nal.usda.gov/fnic/pubs/bibs/gen/vegetarian.htm

http://www.gastric-bypass-treatment.com/long-term-weight-loss-surgery-compications.aspx

427.3 References - Non-Food Ingestion
http://www.nieh.nih.gov/
http://www.epa.gov/

427.4 References - Folic Acid
http://www.cdc.gov/
http://www.aap.org/
http://www.iom.edu/

427.5 References - Listeriosis
http://www.cdc.gov/foodsafety
http://www.cdc.gov/ncidod/dbmd/diseaseinfo/listeriosis_g.htm
http://www.cfsan.fda.gov
http://www.foodsafety.gov
http://www.fightbac.org
http://www.ific.org

Nutrition Risk Criteria **49 LACTOSE INTOLERANCE**
USDA CODE 355

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe.

Presence of lactose intolerance diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders; or symptoms must be well documented by the competent professional authority. Documentation should indicate that the ingestion of dairy products causes the above symptoms and the avoidance of such dairy products eliminates them.

Required Documentation

Document in participant file that ingestion of dairy product causes the above symptoms and the avoidance of such dairy products eliminates the symptoms.

Justification

Lactose is found primarily in milk, milk-based formula and other dairy products. Dairy products provide a variety of nutrients essential to the WIC population (calcium, vitamin D, protein). Lactose intolerance varies according to individuals. Some individuals may tolerate up to one cup of milk without discomfort, although many avoid dairy products all together. WIC can provide counseling on how to incorporate small amounts of lactose-containing foods and/or other dietary sources of above nutrients into the client's diet.

References

1. Duyff, Roberta Larson: The American Dietetic Association's Complete Food and Nutrition Guide; Chapter 9 Sensitive About Food; 1996; pp. 189-203.

2. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment, 1996; pp.194-195.

3. American Dietetic Association: Lactose Intolerance Resource Inlcuding Recipes; Chicago; 1985.

Nutrition Risk Criteria **52 FOOD ALLERGY**
USDA CODE 353

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction.

Presence of food allergies diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Documentation in participant file of source of information (i.e. self-report of diagnosis by physician or written documentation by physician).

Justification

The only way to avoid a food allergy reaction is to eliminate the food. This requires the assistance of a nutritionist to help individuals obtain nutrients from other food sources (1).

The goal is to remove from the diet as many potential food allergens as possible while also providing optimal nutrition. Treatment of food allergies by a registered dietitian or competent professional authority not only improves compliance by ensuring strict dietary avoidance through education and appropriate substitution, but also is essential for ensuring the nutritional adequacy of the diet (2).

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Zeman FJ. Clinical nutrition and dietetics. New York: Macmillan Pub. Co, 1991. p.149-185.

2. Queen PM, Helm KK, Lang CE. Handbook of pediatric nutrition. Gaithersburg, Md: Aspen Publishers, 1999.

Nutrition Risk Criteria **54 GESTATIONAL DIABETES**
USDA CODE 302

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD

Definition

Presence of gestational diabetes diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Document in participant file source of information (i.e. self-report of physician diagnosis or physician documentation).

Justification

With gestational diabetes, diabetes is not present before the pregnancy. Abnormal glucose levels appear during pregnancy and then usually return to normal after the pregnancy ends. Ninety percent (90%) of all pregnant diabetics are gestational diabetics. Diabetics are at higher risk for complications of pregnancy and are at increased risk of developing Type II diabetes mellitus later in life. Infants born to women with diabetes are at increased risk of macrosomia, congenital abnormalities, hypoglycemia and neonatal death. The client can benefit from the WIC Program's dietary counseling and supplemental foods.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. American Diabetes Association. Position Statement on Gestational Diabetes. January 1997.

2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **55 HISTORY OF GESTATIONAL DIABETES**
USDA CODE 303

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

History of diagnosed gestational diabetes.

Pregnant Women: any history of gestational diabetes
Breastfeeding/Non-Breastfeeding: most recent pregnancy

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Document in participant file source of information (i.e. self report of diagnosis by physician).

Justification

Diabetes with pregnancy has long been recognized as a serious problem for both the mother and the fetus. A woman with a history of gestational diabetes is at increased risk of developing Type II diabetes mellitus later in life. Infants born of diabetic women are at increased risk of macrosomia, congenital abnormalities, hypoglycemia and neonatal death. The client can benefit from the WIC Program's dietary counseling and supplemental foods.

Clarification

Self-reporting for “History of…”conditions should be treated in the same manner as self-reporting for current conditions requiring a physicians diagnosis, i.e., the applicant may report to the CPA that s/he was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

References

1. American Diabetes Association. Position Statement on Gestational Diabetes. January 1997.

2. Gilbert ES, Harmon JS. Manual of high risk pregnancy & delivery. St. Louis: Mosby, 1993.

3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **57 HYPEREMESIS GRAVIDARUM**
USDA CODE 301

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD

Definition

Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic. Presence of Hyperemesis Gravidarum diagnosed by physician as self reported by applicant/participant/caregiver, or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Document in participant file source of information (i.e. self report of diagnosis by physician; written physician diagnosis).

Justification

Nausea and vomiting are common early in gestation; 50% or more of normal pregnant women experience some vomiting. However, pregnant women with severe vomiting during pregnancy are at risk of weight loss, dehydration, and metabolic imbalances. Nutrition risk is based on chronic conditions, not single episodes.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **60 ★ PREGNANCY AT YOUNG AGE**
USDA CODE 331

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Conception ≤17 years of age.

Pregnant Women: current pregnancy
Breastfeeding/Non-Breastfeeding: most recent pregnancy

Required Documentation

DOB
EDC

Justification

Pregnancy before growth is complete, is a nutritional risk because of the potential for competition for nutrients for the pregnancy needs and the woman's growth.

The pregnant teenager is confronted with many special stresses that are superimposed on the nutritional needs associated with continued growth and maturation.

Younger pregnant women of low socioeconomic status tend to consume less than recommended amounts of protein, iron, and calcium, and are more likely to come into pregnancy already underweight. Pregnant teens who participate in WIC have been shown to have an associated increase in mean birth weight and a decrease in LBW outcomes.

Adolescent mothers frequently come into pregnancy underweight, have extra growth related nutritional needs, and because they often have concerns about weight and body image, are in need of realistic, health promoting nutrition advice and support during lactation. Diets of adolescents with low family incomes typically contain less iron, and less vitamin A than are recommended during lactation.

The adolescent mother is also confronted with many special stresses superimposed on the normal nutritional needs associated with continued growth. Nutrition status and risk during the postpartum period follow from the nutritional stresses of the past pregnancy, and in turn have an impact on nutrition related risks in subsequent pregnancies. Poor weight gain and low intakes of a variety of nutrients are more common in pregnant adolescents. Therefore, participation in the WIC Program should be of substantial benefit.

References

4. Endres J, Dunning S, Poon SW, Welch P, Duncan H. Older pregnant women and adolescents: nutrition data after enrollment in WIC. J.Am.Diet.Assoc. 1987;87:1011-6, 1019.

5. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

6. Kennedy ET, Kotelchuck M. The effect of WIC supplemental feeding on birth weight: a case-control analysis. Am.J.Clin.Nutr. 1984;40:579-85.

4. Story M, editor. Nutrition management of the pregnant adolescent a practical reference guide. Washington, D.C.: National Clearinghouse; 1990. Sponsored by the March of Dimes Birth Defects Foundation, U.S. Department of Health and Human Services, U.S. Department of Agriculture.

Nutrition Risk Criteria **61 MULTIFETAL GESTATION**
USDA CODE 335

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant Women: More than one (>1) fetus in current pregnancy.

Breastfeeding and Non-Breastfeeding Women: most recent pregnancy.

Required Documentation

Document source of information in participant file (self report or physician diagnosis).

Justification

Multifetal gestations are associated with low birth weight, fetal growth restriction, placental and cord abnormalities, preeclampsia, anemia, shorter gestation and an increased risk of infant mortality. Twin births account for 16% of all low birth weight infants. The risk of pregnancy complications is greater in women carrying twins and increases markedly as the number of fetuses increases.

For twin gestations, the recommended range of maternal weight gain is 35-45 pounds with a gain of 1.5 pounds per week during the second and third trimesters. Underweight women should gain at the higher end of the range and overweight women should gain at the lower end of the range. Four to six pounds should be gained in the first trimester. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week through out the pregnancy.

Pregnant or breastfeeding women with twins have greater requirements for all nutrients than women with only one infant. Postpartum, nonbreastfeeding women delivering twins are at greater nutritional risk than similar women delivering only one infant. All three groups of women would benefit greatly from the nutritional supplementation provided by the WIC Program.

References

1. **Brown JE and Carlson M. Nutrition and multifetal pregnancy. J Am Diet Assoc. 2000;100:343-348.**
2. Brown JE, Schloesser PT. Pregnancy weight status, prenatal weight gain, and the outcome of term twin gestation. Am.J.Obstet.Gynecol. 1990;162:182-6.
3. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment.

National Academy Press, Washington, D.C.; 1996.

5. Suitor CW, editor. Maternal weight gain a report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

6. Williams RL, Creasy RK, Cunningham GC, Hawes WE, Norris FD, Tashiro M. Fetal growth and perinatal viability in California. Obstet.Gynecol. 1982;59:624-32.

7. Worthington-Roberts, BS. Weight gain patterns in twin pregnancies with desirable outcomes. Clin.Nutr. 1988;7:191-6.

Nutrition Risk Criteria **63 CLOSELY SPACED PREGNANCIES**
USDA CODE 332

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Conception before 16 months postpartum.

Pregnant Women: current pregnancy
Breastfeeding/Non-Breastfeeding: most recent pregnancy

Required Documentation

EDC
Previous pregnancy end date

Justification

Pregnancy stimulates an adjustment of the mother to a new physiological state which results in rapid depletion of maternal stores of certain nutrients. Mothers with closely spaced pregnancies do not have sufficient time to replenish the nutritional deprivations of the previous pregnancy. Breastfeeding places further nutritional demands on the mother and may increase risks to the pregnancy. After birth, readjustments take place. It is undesirable for another pregnancy to occur before the readjustment is complete since a short interconceptional time period may leave the woman in a compromised nutritional state and at risk for a poor pregnancy outcome. Among low income, inner-city, multiparous women, inter-pregnancy intervals of less than 12 months have been associated with lower folate levels in the postpartum period.

There is a sharply elevated relative risk for low birth weight (LBW) when the interconception interval is less than 6 months. An increased risk persists for inter-pregnancy intervals of up to 18 months and holds when adjusted for potential confounders. The increased risk is for small gestational age term births rather than for LBW due to prematurity.

In one study, postpartum women who received WIC supplements for 5-7 months, delivered higher mean birth weights and lengths and had a lower risk of low birth weight than women who received supplements for two months or less. Women who were supplemented longer had higher mean hemoglobin values and a lower risk of maternal obesity at the subsequent pregnancy. Recognizing the potential problems associated with closely spaced pregnancies, WIC Program Regulations specifically include this condition.

References

1. Caan B, Horgen DM, Margen S, King JC, Jewell NP. Benefits associated with WIC supplemental feeding during the interpregnancy interval. Am.J.Clin.Nutr. 1987;45:29-41.

2. Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. Preventing low birth weight. National Academy Press, Washington, D.C.; 1985.

3. Lang JM, Lieberman E, Ryan KJ, Monson RR. Interpregnancy interval and risk of preterm labor [see comments]. Am.J.Epidemiol. 1990;132:304-9.

4. Lieberman E, Lang JM, Ryan KJ, Monson RR, Schoenbaum SC. The association of inter-pregnancy interval with small for gestational age births. Obstet.Gynecol. 1989;74:1-5.

5. Schall JL, et al. Maternal micronutrient and short interpregnancy interval. In: Society for Epidemiologic Research Annual Meeting 1991 Abstracts; Buffalo, New York; 1991;134;7:770.

6. WIC Program Regulations, Sect. 246.7 (e)(2)(ii).

7. Worthington-Roberts BS, Williams SR. Nutrition During Pregnancy and Lactation. St. Louis: Mosby, 1989.

Nutrition Risk Criteria

66 HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS
USDA CODE 321

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

A spontaneous abortion (SAB) is the spontaneous termination of a gestation at < 20 weeks gestation or < 500 grams
Fetal death is the spontaneous termination of a gestation at ≥ 20 weeks
Neonatal death is the death of an infant within 0-28 days of life.

Pregnant women: any history of fetal or neonatal death or 2 or more spontaneous abortions.
Breastfeeding women: most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living
Non-Breastfeeding: most recent pregnancy

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

NA

Justification

Pregnancy:

Previous fetal and neonatal deaths are strongly associated with preterm low birth weight (LBW) and small for gestational age (SGA) and the risk increases as the number of previous poor fetal outcomes goes up.

Spinnillo et al found that the risk for future small for gestational age outcomes increased two fold if a woman had 2 or more SAB. Adverse outcomes related to history of SAB include recurrent SAB, low birth weight (including preterm and small for gestational age infants), premature rupture of membranes, neural tube defects and major congenital malformations. Nutrients implicated in human and animal studies include energy, protein, folate, zinc, and vitamin A.

Postpartum women:

A SAB has been implicated as an indicator of a possible neural tube defect in a subsequent pregnancy. Women who have just had a SAB or a fetal or neonatal death should be counseled to increase their folic acid intake and

delay a subsequent pregnancy until nutrient stores can be replenished.

The extent to which nutritional interventions (dietary supplementation and counseling) can decrease the risk for repeat poor pregnancy outcomes, depends upon the relative degree to which poor nutrition was implicated in each woman's previous poor pregnancy outcome. WIC Program clients receive foods and services that are relevant and related to ameliorating adverse pregnancy outcomes. Specifically, WIC food packages include good sources of implicated nutrients. Research confirms that dietary intake of nutrients provided by WIC foods improve indicators of nutrient status and/or fetal survival in humans and/or animals.

Clarification

NOTE: A woman who becomes pregnant within 16 months after a SAB (her first) would qualify for risk #332, Closely Spaced Pregnancies.

Self-reporting for "History of…"conditions should be treated in the same manner as self-reporting for current conditions requiring a physicians diagnosis, i.e., the applicant may report to the CPA that s/he was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

References

1. American College of Obstetricians and Gynecologists. Preterm Labor. Technical Bulletin 206. Washington, DC: ACOG, 1995.

2. Carmi R, Gohar J, Meizner I, Katz M. Spontaneous abortion--high risk factor for neural tube defects in subsequent pregnancy [see comments]. Am.J.Med.Genet. 1994;51:93-7.

3. Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. Preventing low birth weight. National Academy Press, Washington, D.C.; 1985.

4. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

5. Kramer MS. Intrauterine growth and gestational duration determinants. Pediatrics 1987;80:502-11.

6. Paz JE, Otano L, Gadow EC, Castilla EE. Previous miscarriage and stillbirth as risk factors for other unfavourable outcomes in the next pregnancy. Br.J.Obstet.Gynecol. 1992;99:808-12.

7. Shapiro S, Ross LF, Levine HS. Relationship of selected prenatal factors to pregnancy outcome and congenital anomalies. Am.J.Public Health 1965;55;2:268-282.

8. Spinillo A, Capuzzo E, Piazzi G, Nicola S, Colonna L, Iasci A. Maternal high-risk factors and severity of growth deficit in small for gestational age

infants. Early Hum.Dev. 1994;38:35-43.

9. Thorn DH. Spontaneous abortion and subsequent adverse birth outcomes. Am.J.Obstet.Gyn. 1992;111-6.

Nutrition Risk Criteria **68 HISTORY OF LOW BIRTH WEIGHT**
USDA CODE 312

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Birth of an infant weighing ≤ 5 lb. 8 oz (≤ 2500 grams)

Pregnant Women: any history of low birth weight
Breastfeeding/Non-Breastfeeding: most recent pregnancy

Required Documentation

NA

Justification

A woman's history of a delivery of a low birth weight (LBW) baby is the most reliable predictor for LBW in her subsequent pregnancy (1). The risk for LBW is 2-5 times higher than average among women who have had previous LBW deliveries and increases with the number of previous LBW deliveries (1). This is true for histories in which the LBW was due to premature birth, fetal growth restriction (FGR) or a combination of these factors. The extent to which nutritional interventions (dietary supplementation and counsel) can decrease risk for repeat LBW, depends upon the relative degree to which poor nutrition was implicated in each woman's previous poor pregnancy outcome. Nutritional deficiencies and excesses have been shown to result in LBW and pregnancy loss. The pregnant woman's weight gain is one of the most important correlates of birth weight and of FGR (2, 3).

References

1. Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. Preventing low birth weight. National Academy Press, Washington, D.C.; 1985.

2. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

3. Kramer MS. Intrauterine growth and gestational duration determinants. Pediatrics 1987;80:502-11.

Nutrition Risk Criteria **69 FETAL GROWTH RESTRICTION**
USDA CODE 336

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	Route Chart

Definition

Fetal Growth Restriction (FGR) (replaces the term Intrauterine Growth Retardation (IUGR)), may be diagnosed by a physician with serial measurements of fundal height, abdominal girth and can be confirmed with ultrasonography. FGR is usually defined as a fetal weight < 10th percentile for gestational age.

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

See above

Justification

Fetal Growth Restriction (FGR) usually leads to low birth weight (LBW) which is the strongest possible indicator of perinatal mortality risk. Severely growth restricted infants are at increased risk of fetal and neonatal death, hypoglycemia, polycythemia, cerebral palsy, anemia, bone disease, birth asphyxia, and long term neurocognitive complications. FGR may also lead to increased risk of ischemic heart disease, hypertension, obstructive lung disease, diabetes mellitus, and death from cardiovascular disease in adulthood. FGR may be caused by conditions affecting the fetus such as infections and chromosomal and congenital anomalies. Restricted growth is also associated with maternal height, prepregnancy weight, birth interval, and maternal smoking. WIC's emphasis on preventive strategies to combat smoking, improve nutrition, and increase birth interval, may provide the guidance needed to improve fetal growth.

References

1. Altman DG, Hytten FE. Intrauterine growth retardation: let's be clear about it. Br.J.Obstet.Gynaecol. 1989;96:1127-32.

2. Barros FC, Huttly SR, Victora CG, Kirkwood BR, Vaughan JP. Comparison of the causes and consequences of prematurity and intrauterine growth retardation: a longitudinal study in southern Brazil. Pediatrics 1992;90:238-44.

3. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

4. Institute of Medicine. Nutrition during pregnancy; part I, weight gain and part II, nutrient supplements. National Academy Press, Washington, D.C. 1990.

5. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

6. Kramer MS, Olivier M, McLean FH, Dougherty GE, Willis DM, Usher RH. Determinants of fetal growth and body proportionality. Pediatrics 1990;86:18-26.

7. Kramer MS, Olivier M, McLean FH, Willis DM, Usher RH. Impact of intrauterine growth retardation and body proportionality on fetal and neonatal outcome. Pediatrics 1990;86:707-13.

8. Stein ZA, Susser M. Intrauterine growth retardation: epidemiological issues and public health significance. Semin.Perinatol. 1984;8:5-14.

9. Williams SR. Nutrition and diet therapy. St. Louis, Missouri: Times Mirror/Mosby College Pub, 1989.

10. Worthington-Roberts BS, Williams SR. Nutrition During Pregnancy and Lactation. St. Louis: Mosby, 1989.

Nutrition Risk Criteria

70 HISTORY OF BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT
USDA CODE 339

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, excess vitamin A.

Pregnant Women: any history of birth with nutrition-related congenital or birth defect
Breastfeeding/Non-Breastfeeding: most recent pregnancy

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

See Above

Justification

The single greatest risk factor for a pregnancy with a neural tube defect is a personal or family history of such a defect. More than 50% of recurrences can be prevented by taking folic acid before conception. Recent studies suggest that intake of folic acid may also be inversely related to the occurrence of cleft lip and palate. The WIC Program provides nutrition education and folic acid-rich foods to women to help prevent future birth defects.

Recurrent birth defects can also be linked to other inappropriate nutritional intake prior to conception or during pregnancy, such as inadequate zinc (LBW) or excess vitamin A (cleft palate or lip). The food package and nutrition education provided to WIC participants help women at risk make food choices that provide appropriate nutrient levels.

Clarification

Self-reporting for “History of…”conditions should be treated in the same manner as self-reporting for current conditions requiring a physicians diagnosis, i.e., the applicant may report to the CPA that s/he was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

References

1. Federal Register, Part III, DHHS, FDA, 21 CFR Part 101, Food Labeling: Health Claims and Label Statements, Folate and Neural Tube Defects. Proposed and Final Rule. March 5, 1996;61;44:8752-8781.

2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **71 POSSIBILITY OF REGRESSION**
***RELATED* USDA CODE 501**

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	1	
NON-BREASTFEEDING WOMEN	6	
INFANTS	1	
CHILDREN	3	

Definition

A participant who has previously been certified eligible for the Program may be considered to be at nutritional risk in the next certification period if the competent professional authority determines there is a possibility of regression in nutritional status without the benefits that the WIC Program provides.

***Possibility of Regression may not be used for consecutive certifications.**

***Use when no other risk can be identified. This code is the only code the participant has when used.**

Required Documentation

Document in participant file what previous risk code qualifies the applicant for regression risk use.

Justification

On occasion, a participant's nutritional status may be improved, to the point that s/he rises slightly above the cutoff of the initial risk condition by the end of the certification period. This occurs most frequently with those conditions that contain specific cutoffs or thresholds, such as anemia or inappropriate growth. Removal of such individuals from the Program can result in a "revolving-door" situation where the individual's recently improved nutritional status deteriorates quickly, so that s/he then re-enters the Program at equal or greater nutrition risk status than before. Therefore, WIC Program regulations permit State agencies to certify previously certified individuals who do not demonstrate a current nutrition risk condition against the possibility of their reverting to the prior existing risk condition if they do not continue to receive WIC benefits. This policy is consistent with the preventive nature of the WIC Program, and enables State and local agencies to ensure that their previous efforts to improve a participant's nutrition status, as well as to provide referrals to other health care, social service, and/or public assistance programs are not wasted.

Competent Professional Authorities and other certifying staff should keep in mind that every nutrition risk condition does not necessarily lead itself to the possibility of regression. For example, gestational diabetes or gingivitis of pregnancy are not conditions to which a new mother could regress, since they are directly associated with pregnancy, and the breastfeeding or non-breastfeeding women cannot regress to being pregnant if she is no longer receiving WIC benefits.

Clarification

After April 1, 1999, any certification for regression must be based on the new set of risk criteria. For example, a person deemed anemic under a State's more inclusive criteria prior to April 1, 1999, may only be certified for regression after

April 1, 1999, if his/her blood values would have met the revised CDC criteria for anemia published in the April 1998 MMWR tables.

Further, regression may only be used as a certifying nutrition risk when it complies with the policies established by the State agency for its use, as set forth in the WIC Nutrition Services Standards issued by FNS in 1988. Such policies must include:

1. A requirement for a nutritional assessment to rule out the existence of another current risk factor before using eligibility on regression.
2. A requirement for written identification of the risk factor to which the participant may regress.
3. A list of risk factors and priority levels for which eligibility based regression may be applied; and
4. A limit on the number of times regression for a given risk factor may be consecutively applied.

References

1. WIC Program Regulations, Sect. 246.7(e)(1)(iii).

Nutrition Risk Criteria **79 ★ TRANSFER OF CERTIFICATION**
USDA CODE 502

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	as needed
BREASTFEEDING WOMEN	4	"
NON-BREASTFEEDING WOMEN	6	"
INFANTS	4	"
CHILDREN	5	"

Definition

Person with current valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants.

This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving State agency.

Required Documentation

VOC document from the certifying WIC clinic*

*See Policy related to VOC transfers for more information

Justification

Local agencies must accept Verification of Certification (VOC) documents from participants. A person with a valid VOC document shall not be denied participation in the receiving State because the person does not meet that State's particular eligibility criteria. Once a WIC participant has been certified by a local agency, the service delivery area into which s/he moves is obligated to honor that commitment.

References

1. FNS Instruction 803-11, Rev.1.
2. WIC Program Regulations; Section 246.7(k).

Nutrition Risk Criteria **80 DRUG USE**
***RELATED* USDA CODE 372**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

For Pregnant Women:

- Any illegal drug use

For Breastfeeding and Non-Breastfeeding Postpartum Women:

- Any illegal drug use

Required Documentation

NA

Justification

Pregnant women who smoke marijuana are frequently at higher risk of still birth, miscarriage, low birth weight babies and fetal abnormalities, especially of the nervous system. Heavy cocaine use has been associated with higher rates of miscarriage, premature onset of labor, IUGR, congenital anomalies, and developmental/behavioral abnormalities in the preschool years. Infants born to cocaine users often exhibit symptoms of cocaine intoxication at birth. Infants of women addicted to heroin, methadone, or other narcotics are more likely to be stillborn or to have low birth weights. These babies frequently must go through withdrawal soon after birth. Increased rates of congenital defects, growth retardation, and preterm delivery, have been observed in infants of women addicted to amphetamines.

Pregnant addicts often forget their own health care, adding to their unborn babies' risk. One study found that substance abusing women had lower hematocrit levels at the time of prenatal care registration, lower pregravid weights and gained less weight during the pregnancy. Since nutritional deficiencies can be expected among drug abusers, diet counseling and other efforts to improve food intake are recommended.

Heroin and cocaine are known to appear in human milk. Marijuana also appears in a poorly absorbed form but in quantities sufficient to cause lethargy, and decreased feeding after prolonged exposure.

References

1. USDA/DHHS Dietary Guidelines; 1995.

2. Lawrence Ruth: Maternal & Child Health Technical Information Bulletin: A Review of Medical Benefits and Contraindications to Breastfeeding in the United States; October 1997.

3. Weiner, L., Morse, B.A., and Garrido, P.: FAS/FAE Focusing Prevention on Women at Risk; International Journal of the Addictions; 1989; 24:385-395.

4. National Clearinghouse for Alcohol and Drug Information; Office for Substance Abuse Prevention; The fact is …alchol and other drugs can harm an unborn baby; Rockville; 1989.

5. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

6. Jones, C. and Lopez, R.: Drug Abuse and Pregnancy; New Perspectives in Prenatal Care; 1990; pp. 273-318.

7. National Household Survey on Drug Abuse, Main Findings 1996; Office of Applied Studies, Substance Abuse and Mental Health services Administration. DHHS.

Nutrition Risk Criteria **81 ★ MATERNAL SMOKING**
USDA CODE 371

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	
BREASTFEEDING WOMEN	1	

Definition

Any daily smoking of tobacco products, i.e., cigarettes, pipes, or cigars.

Required Documentation

Idaho WIC computer system

Justification

Women who smoke are at risk for chronic and degenerative disease. Smokers have lower plasma levels of vitamin C and E. The metabolic turnover of Vitamin C is significantly higher in smokers. Smoking impairs folate status. Smoking is inversely associated with intakes of Vitamin A and C, fiber, folate, and iron among women. The WIC food package supplements the participants intake of these lost nutrients. WIC participation may also include counseling and referral to smoking cessation programs.

References

1. McPhillips, C.E.Eaton, etal.: Dietary Difference in Smokers and Non-Smokers from two Southeastern New England Communities. JADA; March 1994; pp. 287-292.

2. Giraud, D. Martin, J. Driskell: Plasma and Dietary Vitamin C and E Levels of Tobacco Chewers, Smokers and Nonusers, JADA; July 1995; pp. 798-802.

3. Elsie Pamuk' Tim Byers, Ralph Coates, Joidi Vann, Anne Sowell, Elaine Gunter, Deborah Glass: Effect of Smoking on Serum Nutrient Concentrations in African-American Women. Am J Clin Nutr; 1994; 59:891-5.

Nutrition Risk Criteria **82 ALCOHOL USE**
***RELATED* USDA CODE 372**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

For Pregnant Women:

- Any alcohol use

For Breastfeeding and Non-Breastfeeding Postpartum Women:

- Routine current use of ≥ 2 drinks per day (6). A serving or standard sized drink is: 1 can of beer (12 fluid oz.); 5 oz. Wine; and 1 ½ fluid ounces liquor (1 jigger gin, rum, vodka, whiskey (86-proof), vermouth, cordials or liqueurs), or
- Binge Drinking, i.e., drinks 5 or more (≥ 5) drinks on the same occasion on at least one day in the past 30 days; or
- Heavy Drinking, i.e., drinks 5 or more (≥ 5) drinks on the same occasion on five or more days in the previous 30 days; or
- Any illegal drug use

Required Documentation

Justification

Drinking alcoholic beverages during pregnancy can damage the developing fetus. Excessive alcohol consumption may result in low birth weight, reduced growth rate, birth defects, and mental retardation. WIC can provide supplemental foods, nutrition education and referral to medical and social services which can monitor and provide assistance to the family.

"Fetal Alcohol Syndrome" is a name given to a condition sometimes seen in children of mothers who drank heavily during pregnancy. The child has a specific pattern of physical, mental, and behavioral abnormalities. Since there is no cure, prevention is the only answer.

The exact amount of alcoholic beverages pregnant women may drink without risk to the developing fetus is not known as well as the risk from periodic bouts of moderate or heavy drinking. Alcohol has the potential to damage **the fetus** at every stage of the pregnancy. Therefore, the recommendation is not to drink any alcoholic beverages during pregnancy.

Studies show that the more alcoholic beverages the mother drinks, the greater the risks are for her baby. In addition, studies indicate that factors such as cigarette smoking and poor dietary practices may also be involved. Studies show that the reduction of heavy drinking during pregnancy has benefits for both mother and newborns. Pregnancy is a special time in a woman's life and the majority of heavy drinkers will respond to supportive counseling.

Heavy drinkers, themselves, may develop nutritional deficiencies and more serious diseases, such as cirrhosis of the liver and certain types of cancer, particularly if they also smoke cigarettes. WIC can provide education and referral to medical and social services, including addiction treatment, which can help improve pregnancy outcome.

References

8. USDA/DHHS Dietary Guidelines; 1995.

9. Lawrence Ruth: Maternal & Child Health Technical Information Bulletin: A Review of Medical Benefits and Contraindications to Breastfeeding in the United States; October 1997.

10. Weiner, L., Morse, B.A., and Garrido, P.: FAS/FAE Focusing Prevention on Women at Risk; International Journal of the Addictions; 1989; 24:385-395.

11. National Clearinghouse for Alcohol and Drug Information; Office for Substance Abuse Prevention; The fact is …alchol and other drugs can harm an unborn baby; Rockville; 1989.

12. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.

13. Jones, C. and Lopez, R.: Drug Abuse and Pregnancy; New Perspectives in Prenatal Care; 1990; pp. 273-318.

14. National Household Survey on Drug Abuse, Main Findings 1996; Office of Applied Studies, Substance Abuse and Mental Health services Administration. DHHS.

Nutrition Risk Criteria **86 HX LARGE FOR GESTATIONAL AGE (LGA) INFANT USDA CODE 337**

Category, Priority, and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	
BREASTFEEDING WOMEN	1	
NON-BREASTFEEDING WOMEN	6	

Definition

Pregnant Women: **Any** history of giving birth to an infant weighing greater than or equal to (≥) 9 pounds (4000 grams).

BREASTFEEDING/NON-BREASTFEEDING Women: Most recent pregnancy; or history of giving birth to an infant weighing greater than or equal to (≥) 9 pounds (4000 grams).

Required Documentation

Diagnosed by a physician or self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Justification

Women with a previous delivery of an infant weighing more than 9 pounds (4000 gm) are at an increased risk of giving birth to a large for gestational age infant. Macrosomia may be an indicator of maternal diabetes (current or gestational) or a predictor of future diabetes.

The incidence of maternal, fetal, and neonatal complications is high with neonates weighing 9 pounds (4000 gm). Risks for the infant include dystocia, meconium aspiration, clavicular fracture, brachia plexus injury, and asphyxia.

References

Boyd, M.E, et al. (1983) Fetal Macrosomia: Prediction, risks, proposed management. *Obstet. Gynecol*. 1983; 61:715-722.

Institute of Medicine. (1990) *Nutrition During Pregnancy*. National Academy Press. p. 117, 187.

Institute of Medicine. WIC nutrition risk criteria a scientific assessment. Washington (DC): National Academy Press; 1996. p. 117.

Nutrition Risk Criteria **88 HISTORY OF PRETERM DELIVERY**
USDA CODE 311

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

Birth of an infant at ≤ 37 weeks gestation

Pregnant Women: any history of preterm delivery
Breastfeeding/Non-Breastfeeding: most recent pregnancy

Required Documentation

NA

Justification

Preterm birth causes at least 75% of neonatal deaths not due to congenital malformations (1). In most cases of preterm labor, the cause is unknown. Epidemiologic studies have consistently reported low socioeconomic status, nonwhite race, maternal age of ≤ 18 years or ≥ 40 years, and low prepregnancy underweight as risk factors. A history of one previous preterm birth is associated with a recurrent risk of 17-37% (2, 3); the risk increases with the number of prior preterm births and decreases with the number of term deliveries.

References

1. American College of Obstetricians and Gynecologists. Preterm Labor. Technical Bulletin 206. Washington, DC: ACOG, 1995.

2. Hoffman HJ, Bakketeig LS. Risk factors associated with the occurrence of preterm birth. Clin.Obstet.Gynecol. 1984;27:539-52.

3. Keiirse MJNC, Rush RW, Anderson AB, Turnbull AC. Risk of preterm delivery in patients with a previous preterm delivery and/or abortion. Br.J.Obstet.Gynecol. 1978;85:81-85.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
NUTRIENT DEFICIENCY DISEASES
USDA CODE 341

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro and micronutrients. Diseases include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beri Beri, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Cheilosis, Menkes Disease, Xerophthalmia.

Presence of nutrient deficiency diseases diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

The presence of macro- and micro-nutrient deficiencies indicates current nutrition health risks.

Persistent malnutrition may lead to elevated morbidity and mortality rates. Important functional disturbances may occur as a result of single or multiple nutrient deficiencies. Examples include impaired cognitive function, impaired function of the immune system, and impaired function of skeletal muscle. Participation in the WIC Program provides key nutrients and education to help restore nutrition status and promote full rehabilitation of those with an overt nutrient deficiency.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

2. Worthington-Roberts BS, Williams SR. Nutrition throughout the life cycle, 4th edition. Boston: McGraw-Hill, 2001.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
GASTRO-INTESTINAL DISORDER
USDA CODE 342

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Disease(s) or condition(s) that interferes with the intake or absorption of nutrients. The conditions include, but are not limited to:

- stomach or intestinal ulcers
- small bowel enterocolitis and syndrome
- malabsorption syndromes
- inflammatory bowel disease, including ulcerative colitis or Crohn's disease
- liver disease
- pancreatitis
- gallbladder disease
- gastroesophageal reflux (GER)

Presence of gastro-intestinal disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Gastrointestinal disorders increase nutrition risk through a number of ways, including impaired food intake, abnormal deglutition, impaired digestion of food in the intestinal lumen, generalized or specific nutrient malabsorption, or excessive gastrointestinal losses of endogenous fluids and nutrients. Frequent loss of nutrients through vomiting, diarrhea, malabsorption, or infections can result in malnourishment and lowered resistance to disease in individuals with chronic symptoms.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

2. American Dietetic Association, Pediatric Nutrition Practice Group. Pediatric manual of clinical dietetics. Chicago: Pediatric Nutrition Dietetic Practice Group, American Dietetic Association, 1998.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
THYROID DISEASE
USDA CODE 344

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Hypothyroidism (insufficient levels of thyroid hormone produced or defect in receptor) or hyperthyroidism (high levels of thyroid hormone secreted).

Presence of thyroid disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Individuals with hyperthyroidism can benefit from WIC foods and nutrition education due to the increased caloric needs of hypermetabolism. Nutrition education and low-fat WIC food packages can assist individuals with hypothyroidism in weight management and promotion of normal growth and development.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

2. Berkow, et al.: Merck Manual Section 8.87; 1992;16th edition.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
HYPERTENSION (INCLUDES CHRONIC AND PREGNANCY INDUCED)
USDA CODE 345

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Presence of hypertension diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Women with chronic hypertension are at risk for complications of pregnancy such as pre-eclampsia. An estimated 15% of women with hypertension also have renal or cardiac involvement.

Hypertension is the most common medical complication of pregnancy, occurring in 7% of all pregnancies.

Factors associated with these hypertensive disorders include low income, low educational attainment, and poor nutrition. Hypertension during pregnancy may lead to low birth weight, fetal growth restriction, and premature delivery, as well as maternal, fetal, and neonatal morbidity.

Decreased calcium intake in early pregnancy may increase the risk of pregnancy induced hypertension, while increasing calcium intake has been shown to lower blood pressure and may prevent the risk of hypertensive disorders. Zinc deficiency, protein deficiency, excess salt intake, essential fatty acid deficiencies, and magnesium deficiencies have all been associated with increased rates of pregnancy-induced hypertension and preeclampsia. There is evidence that dietary changes aid in the prevention and control of hypertension. The WIC program provides foods and nutrition education compatible with treatment and prevention of hypertension during pregnancy. Children with higher blood pressure are more likely to become adult hypertensives. The definition of hypertension during childhood is age-specific. Blood pressure and overweight status have been suggested as criteria to identify, monitor, and treat hypertensive children. Nutrition-related prevention efforts in high risk children include avoiding overweight, consuming a moderate salt intake, and maintaining an active lifestyle.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine: WIC Nutrition Risk Criteria: A scientific Assessment; 1996; pp. 172-174.

2. Krause's: Food Nutrition and Diet Therapy 8th Edition; 1992; pp.387-388.

3. Institute of Medicine: Nutrition During Pregnancy: Part I, Weight Gain; and Part II, Nutrient Supplements; National Academy Press; 1990.

4. Dekker G.A. and Sibai, Baha, M.: Early detection of preeclampsia; Amer. Journal of Obst. And Gyncol; 1991;165(1):160.

5. **Belizan, JM, Villar J, Gonzalez L, Campodonico L, Bergel E.: Calcium supplementation to prevent hypertensive disorders of pregnancy; New England Journal of Medicine; 1991;325(20):1399.**

6. **O'Brien, WF.: The Prediction of Preeclampsia; Clinical Obstetrics and Gynecology; 1992; 35(2):351.**

7. Henderson P, Little GA.: The detection and prevention of pregnancy-induced hypertension and preeclampsia; New Perspectives on Prenatal Care; 1990;pp. 479-500.

8. **Trahms, CM, and Pipes, P: Nutrition in Infancy and Childhood. 6th Edition; WCB McGraw-Hill, 1997; pp. 238-258.**

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
RENAL DISEASE
USDA CODE 134

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Renal disease can result in growth failure in children and infants. In pregnant women, fetal growth is often limited and there is a high risk of developing a preeclampsia-like syndrome. Women with chronic renal disease often have proteinuria, with risk of azotemia if protein intake becomes too high.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
CANCER
USDA CODE 347

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status.

Presence of cancer diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

An individual's nutritional status at the time of diagnosis of cancer is associated with the outcome of treatment. The type of cancer and stage of disease progression determines the type of medical treatment, and if indicated, nutrition management. Individuals with a diagnosis of cancer are at significant health risk and under specific circumstances may be at increased nutrition risk, depending upon the stage of disease progression or type of ongoing cancer treatment.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION-
CENTRAL NERVOUS SYSTEM DISORDERS
USDA CODE 348

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Conditions which affect energy requirements and may affect the individual's ability to feed self that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to:

- epilepsy
- cerebral palsy (CP) and
- neural tube defects (NTD), such as:
    - spina bifida or
    - myelomeningocele
- Parkinson's disease
- multiple sclerosis (MS)

Presence of central nervous system disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Epileptics are at nutrition risk due to alterations in nutrient status from prolonged anti-convulsant therapy, inadequate growth, and physical injuries from seizures. Poor motor skills in infants and children with CP can cause poor growth, usually from decreased energy and nutrient intake. Limited mobility or paralysis, hydrocephalus, limited feeding skills, and genitourinary problems, put NTDs at increased risk of abnormal growth and development. The participant with Parkinson’s disease will benefit from nutrition education that includes dietary protein modification that ensures adequate nutrition and meets minimum protein requirements. In some cases, protein redistribution diets will be necessary to increase the efficacy of the medication used to treat Parkinson’s disease. MS may cause difficulties with chewing and swallowing that require changes in food texture in order to achieve a nutritionally adequate diet.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-

reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Chang MW, Rosendall B, Finlayson BA. Mathematical modeling of normal pharyngeal bolus transport: a preliminary study. J.Rehabil.Res.Dev. 1998;35:327-34.

2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

3. Nelson JK, Mayo C. Mayo clinic diet manual a handbook of nutrition practices. St. Louis: Mosby, 1994.

4. Sarnoff J, Rector DM. MS information, food for thought: MS and Nutrition; 5/14/99; pp. 1-6.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
GENETIC AND CONGENITAL DISORDERS
USDA CODE 349

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Hereditary or congenital condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. May include, but is not limited to, cleft lip or palate, Down's syndrome, thalassemia major, sickle cell anemia (not sickle cell trait), and muscular dystrophy.

Presence of genetic and congenital disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

For women, infants, and children with these disorders, special attention to nutrition may be required to achieve adequate growth and development and/or to maintain health.

Severe cleft lip and palate anomalies commonly cause difficulty with chewing, sucking and swallowing, even after extensive repair efforts (5). Surgery is required for many gastrointestinal congenital anomalies. (Examples are trachea-esophageal fistula, esophageal atresia, gastroschisis, omphalocele, diaphragmatic hernia, intestinal atresia, and Hirschsprung's Disease.)

Impaired esophageal atresia and trachea-esophageal fistula can lead to feeding problems during infancy. The metabolic consequences of impaired absorption in short bowel-syndrome, depend on the extent and site of the resection or the loss of competence. Clinical manifestations of short bowel syndrome, include diarrhea, dehydration, edema, general malnutrition, anemia, dermatitis, bleeding tendencies, impaired taste, anorexia, and renal calculi. Total parenteral feedings are frequently necessary initially, followed by gradual and individualized transition to oral feedings. After intestinal resection a period of adaptation by the residual intestine begins and may last as long as 12-18 months (3). Even after oral feedings are stabilized, close follow-up and frequent assessment of the nutritional status of infants with repaired congenital gastro-intestinal anomalies is recommended (5).

Sickle-cell anemia is an inherited disorder in which the person inherits a sickle

gene from each parent. Persons with sickle-cell trait carry the sickle gene, but under normal circumstances are completely asymptomatic. Good nutritional status is important to individuals with sickle-cell anemia to help assume adequate growth (which can be compromised) and to help minimize complications of the disease since virtually every organ of the body can be affected by sickle-cell anemia (i.e., liver, kidneys, gall ladder, and immune system). Special attention should be given to assuring adequate caloric, iron, folate, vitamin E and vitamin C intakes as well as adequate hydration.

Muscular dystrophy is a familial disease characterized by progressive atrophy and wasting of muscles. Changes in functionality and mobility can occur rapidly and as a result children may gain weight quickly (up to 20 pounds in a 6 month period). Early nutrition education that focuses on foods to include in a balanced diet, limiting foods high in simple sugars and fat and increasing fiber intake can be effective in minimizing the deleterious effects of the disease.

References

1. American Dietetic Association, Pediatric Nutrition Practice Group. Pediatric manual of clinical dietetics. Chicago: Pediatric Nutrition Dietetic Practice Group, American Dietetic Association, 1998.

2. Ekvall S. Pediatric nutrition in chronic diseases and developmental disorders prevention, assessment, and treatment. New York: Oxford University Press 1993. p. 289-292.

3. Grand RJ, Sutphen JL, Dietz WH. Pediatric nutrition theory and practice. Boston: Butterworths, 1987.

4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

5. Ohio Neonatal Nutritionists. Nutritional care for high risk newborns. Philapelphia, PA: G.F. Stickley Publishers, 1985.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
INFECTIOUS DISEASES
USDA CODE 352

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to:

- tuberculosis
- pneumonia
- meningitis
- parasitic infections
- hepatitis
- bronchiolitis (3 episodes in last 6 months)
- HIV (Human Immunodeficiency Virus infection)*****
- AIDS (Acquired Immunodeficiency Syndrome)*****

The infectious disease must be present within the past 6 months, and diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Chronic, prolonged, or repeated infections adversely affect nutritional status through increased nutrient requirements as well as through decreased ability to take in or utilize nutrients.

Catabolic response to infection increases energy and nutrient requirements and may increase the severity of medical conditions associated with infection. Bronchiolitis is a lower respiratory tract infection that affects young children, usually under 24 months of age. It is often diagnosed in winter and early spring, and is caused by the respiratory syncytial virus (RSV). Recurring episodes of bronchiolitis may affect nutritional status during a critical growth period and lead to the development of asthma and other pulmonary diseases.

HIV is a member of the retrovirus family. HIV enters the cell and causes cell dysfunction or death. Since the virus primarily affects cells of the immune system, immunodeficiency results (AIDS). Recent evidence suggests that monocytes and macrophages may be the most important target cells and indicates that HIV can infect bone marrow stem cells. HIV infection is

associated with the risk of malnutrition at all stages of infection.

Clarification

Developments in the management and prevention of hepatitis have changed the management of infected women during pregnancy and have made breastfeeding safe. The following are guidelines for breastfeeding women with hepatitis, as found in the Technical Information Bulletin (10/97) "A Review of the Medical Benefits and Contraindications to Breastfeeding in the United States":

Hepatitis A: Breastfeeding is permitted as soon as the mother receives

gamma gobulin.

Hepatitis B: Breastfeeding is permitted after the infant receives HBIG (Hepatitis B specific immunoglobin) and the first dose of the series of Hepatitis B vaccine.

Hepatitis C: Breastfeeding is permitted for mothers without co-infection (e.g. HIV).

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp. 184-186.

2. Berkow, et al.: Merck Manual; 1992; 16th Edition.

3. Grand, Stupen, and Dietz: Pediatric Nutrition: Theory and Practice; Butterworths; 1987; pp. 549-570, 571-578, 651-664.

4. Lawrence, Ruth A: Maternal and Child Health Technical Information Bulletin: A Review of Medical Benefits and Contraindications to Breastfeeding in the United States; 1997; pp. 14-17.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
CELIAC DISEASE
USDA CODE 354

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Also known as:

- Celiac Sprue
- Gluten Enteropathy
- Non-tropical Sprue

Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up.

Presence of Celiac Disease diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician or someone working under physician's orders.

Required Documentation

Justification

Individuals need to eliminate all wheat from their diets. Wheat in the diet can cause diarrhea, weight loss, failure to thrive and possibly malabsorption of protein, carbohydrates, and fat (1,2). Nutrition counseling can help individuals meet nutrient needs on a wheat-free diet.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Clinical Nutrition and Dietetics: The intestinal tract and accessory organs. New York; 1991. p. 219-258.

2. Semrod, CE. Celiac disease and gluten sensitivity. Columbia University Division of Gastroenterology. Available at: http://www.cpmcnet.columbia.edu/dept/gi/celiac.html. 1995.

3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.;1996. p. 192-193.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
DRUG NUTRIENT INTERACTIONS
USDA CODE 357

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised.

Required Documentation

Justification

The drug treatment of a disease or medical condition may itself affect nutritional status. Drug induced nutritional deficiencies are usually slow to develop and occur most frequently in long-term drug treatment of chronic disease. Possible nutrition-related side effects of drugs include, but are not limited to, altered taste sensation, gastric irritation, appetite suppression, altered GI motility, and altered nutrient metabolism and function, including enzyme inhibition, vitamin antagonism, and increased urinary loss.

The marketplace of prescribed and over-the-counter drugs is a rapidly changing one. For knowledgeable information on the relationship of an individual's drug use to his/her nutritional status, it is important to refer to a current drug reference such as Physician's Desk Reference (PDR), a text such as Physician's Medication Interactions, drug inserts, or to speak with a pharmacist.

References

1. Allen, M: Food-Medication Interactions; 7th edition; Tempe, Arizona; 1991.

2. Physician's Desk Reference, 51st edition; Montvale, New Jersey; Medical Economics Company, Inc.; 1997.

3. Diet and Drug Interactions. Daphne A. Roe, M.D., F.R.C.P.

4. Handbook on Drug and Nutrient Interactions: A Reference and Study Guide.

5. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp. 217-218.

6. Pronsky, ZM: Powers and Moore's Food Medications Interactions; 10th edition; 1997.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
RECENT MAJOR SURGERY, TRAUMA, BURNS
USDA CODE 359

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status.

Any occurrence:

- within the past two (≤2) months may be self reported
- more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician.

Required Documentation

Justification

The body's response to recent major surgery, trauma or burns may affect nutrient requirements needed for recovery and lead to malnutrition. There is a catabolic response to surgery; severe trauma or burns cause a hypermetabolic state. Injury causes alterations in glucose, protein and fat metabolism.

Metabolic and physiological responses vary according to the individual's age, previous state of health, preexisting disease, previous stress, and specific pathogens. Once individuals are discharged from a medical facility, a continued high nutrient intake may be needed to promote the completion of healing and return to optimal weight and nutrition status.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996. p. 188-9.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
OTHER MEDICAL CONDITIONS
USDA CODE 360

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status.
Includes, but is not limited to:

- juvenile rheumatoid arthritis (JRA)
- lupus erythematosus
- cardiorespiratory diseases
- heart disease
- cystic fibrosis
- persistent asthma (moderate or severe) requiring daily medication

Presence of medical condition(s) diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Juvenile rheumatoid arthritis (JRA) is the most common pediatric rheumatic disease and most common cause of chronic arthritis among children. JRA puts individuals at risk of anorexia, weight loss, failure to grow, and protein energy malnutrition.

Lupus erythematosus is an autoimmune disorder that affects multiple organ systems. Lupus erythematosus increases the risk of infections, malaise, anorexia, and weight loss. In pregnant women, there is increased risk of spontaneous abortion and late pregnancy losses (after 28 weeks gestation).

Cardiorespiratory diseases affect normal physiological processes and can be accompanied by failure to thrive and malnutrition. Cardiorespiratory diseases put individuals at risk for growth failure and malnutrition due to low calorie intake and hypermetabolism.
Cystic fibrosis (CF), a genetic disorder of children, adolescents, and young adults characterized by widespread dysfunction of the exocrine glands, is the most common lethal hereditary disease of the Caucasian race.

Many aspects of the disease of CF stress the nutritional status of the patient directly or indirectly by affecting the patient's appetite and subsequent intake. Gastrointestinal losses occur in spite of pancreatic enzyme replacement therapy. Also, catch-up growth requires additional calories. All of these factors contribute to a chronic energy deficit, which can lead to a marasmic type of malnutrition. The primary goal of nutritional therapy is to overcome this energy deficit.

Studies have shown variable intakes in the CF population, but the intakes are usually less than adequate and are associated with a less than normal growth pattern.

Asthma is a chronic inflammatory disorder of the airways, which can cause recurrent episodes of wheezing, breathlessness, chest tightness, and coughing of variable severity. Persistent asthma requires daily use of medication, preferably inhaled anti-inflammatory agents. Severe forms of asthma may require long-term use of oral corticosteroids which can result in growth suppression in children, poor bone mineralization, high weight gain, and, in pregnancy, decreased birthweight of the infant. High doses of inhaled corticosteroids can result in growth suppression in children and poor bone mineralization. Untreated asthma is also associated with poor growth and bone mineralization and, in pregnant women, adverse birth outcomes such as low birth weight, prematurity, and cerebral palsy. Repeated asthma exacerbations ("attacks") can, in the short-term, interfere with eating, and in the long-term, cause irreversible lung damage that contributes to chronic pulmonary disease. Compliance with prescribed medications is considered to be poor. Elimination of environmental factors that can trigger asthma exacerbations (such as cockroach allergen or environmental tobacco smoke) is a major component of asthma treatment. WIC can help by providing foods high in calcium and vitamin D, in educating participants to consume appropriate foods and to reduce environmental triggers, and in supporting and encouraging compliance with the therapeutic regimen prescribed by the health care provider.

NOTE: This criterion will usually not be applicable to infants for the medical condition of asthma. In infants, asthma-like symptoms are usually diagnosed as bronchiolitis with wheezing which is covered under Criterion #352, Infectious Diseases.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis (“My doctor says that I have/my son or daughter has…”) Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp. 185-187, 190-191

2. Queen, Patricia and Lang, Carol: Handbook of Pediatric Nutrition; 1993; pp. 422-425.

3. National Heart, Lung, and Blood Institute: Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma; 1997; pp. 3, 20, 67-73.

4. National Heart, Lung, and Blood Institute: Management of Asthma During Pregnancy; 1992; pp. 7, 36-37.

5. JAMA: Asthma Information Center: Asthma Medications Misused, Underused in Inner City Residents; 1998, pp.1-2.

Nutrition Risk Criteria

90 NUTRITION RELATED MEDICAL CONDITION
DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH THE ABILITY TO EAT
USDA CODE 362

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Developmental, sensory or motor disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs. Disabilities include but are not limited to:

- minimal brain function
- feeding problems due to a developmental disability such as pervasive development disorder (PDD) which includes autism
- birth injury
- head trauma
- brain damage
- other disabilities

Required Documentation

Justification

Infants and children with developmental disabilities are at increased risk for nutritional problems. Education, referrals, and service coordination with WIC will aid in early intervention of these disabilities. Prenatal, lactating and non-lactating women with developmental, sensory or motor disabilities may: 1) have feeding problems associated with muscle coordination involving chewing or swallowing, thus restricting or limiting the ability to consume food and increasing the potential for malnutrition; or 2) require enteral feedings to supply complete nutritional needs which may potentially increase the risk for specific nutrient deficiencies.

Pervasive Developmental Disorder (PDD) is a category of developmental disorders with autism being the most severe. Young children may initially have a diagnosis of PDD with a more specific diagnosis of autism usually occurring at 2 1/2 to 3 years of age or older. Children with PDD have very selective eating habits that go beyond the usual "picky eating" behavior and that may become increasingly selective over time, i.e., foods they used to eat will be refused. This picky behavior can be related to the color, shape, texture or temperature of a food. Common feeding concerns include:

- difficulty with transition to textures, especially during infancy;
- increased sensory sensitivity; restricted intake due to color, texture, and/or temperature of foods;
- decreased selection of foods over time;
- difficulty accepting new foods; difficulty with administration of multivitamin/mineral supplementation and difficulty with changes in mealtime environment.

Nutrition education, referrals, and service coordination with WIC will assist the participant, parent or caregiver in making dietary changes/adaptations and finding assistance to assure she or her infant or child is consuming a nutritionally adequate diet.

References

1. Quinn, Heidi Puelzl; "Nutrition Concerns for Children With Pervasive Developmental Disorder/Autism" published in Nutrition Focus by the Center on Human Development and Disability; University of Washington, Seattle, Washington; September/October 1995.
2. Paper submitted by Betty Lucas, MPH, RD, CD to the Risk Identification and Selection Collaborative (RISC); November, 1999.
3. Zeman. Frances J.; Clinical Nutrion and Dietetics, 2nd Edition; 1991; pp.713-14, 721-22, 729-730.

Nutrition Risk Criteria **91 DIABETES MELLITUS**
USDA CODE 343

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Presence of diabetes mellitus diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Diabetes mellitus is a metabolic disease characterized by hyperglycemia resulting from defects in insulin secretion, insulin action or both. The chronic hyperglycemia of diabetes is associated with long-term damage, dysfunction, and failure of various organs, especially the eyes, kidneys, nerves, heart and blood vessels.

The two major classifications of diabetes are Type 1 Diabetes (beta-cell destruction, usually leading to absolute insulin deficiency) and Type 2 Diabetes (ranging from predominantly insulin resistance with relative insulin deficiency to predominantly an insulin secretory defect with insulin resistance). The Expert Committee (see reference below), working under the sponsorship of the American Diabetes Association, has identified the following as criteria for the diagnosis of diabetes mellitus.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. American Diabetes Association: Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Diabetes Care; vol. 20, no. 7; p. 1183.

Nutrition Risk Criteria **92 Child with Infant Formula Package**
USDA CODE: None-State assigned

Category, Priority and Referral

Category	Priority	Referral
Children	3	RD

Definition

This nutrition risk code is used when a child needs a food package which contains formula. The local Registered Dietitian must approve the food package before it is assigned.

Exception: Premature infants may continue to receive infant formula without a prescription until the corrected age is one year.

This nutrition risk criteria should never stand alone and is usually found with at least one of the following:

28 Failure to Thrive
37 Prematurity
90 Nutrition Related Medical Condition
93 Inborn Errors of Metabolism

Required Documentation

A copy of the physician or medical care provider prescription must be on file along with a care plan approved by the RD.

Justification

References

Nutrition Risk Criteria	**93 INBORN ERRORS OF METABOLISM** **USDA CODE 351**

Category, Priority and Referral	**Category**	**Priority**	**Referral**

Definition

Presence of inborn error(s) of metabolism diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Generally refers to gene mutations or gene deletions that alter metabolism in the body, including, but not limited to:

- phenylketonuria (PKU)
- maple syrup urine disease
- galactosemia
- hyperlipoproteinemia
- homocystinuria
- tyrosinemia
- histidinemia
- urea cycle disorders
- glutaric aciduria
- methylmalonic acidemia
- glycogen storage disease
- galactokinase deficiency
- fructoaldolase deficiency
- propionic acidemia
- hypermethioninemia.
- medium-chain acyl-CoA dehydrogenase (MCAD)

Required Documentation

Copy of written physician diagnosis in participant file or documentation in notes of self-report of physician diagnosis.

Justification

Appropriate dietary management, which may include the use of special formulas, can minimize the medical risk to individuals with inborn errors of metabolism. If a participant has a physician's diagnosis of a condition not listed in the definition, but included in the table, they may be eligible. If after assessment by a CPA, it is determined that the inborn error of metabolism impacts nutritional health and the condition can be ameliorated by WIC participation, the participant can be certified using this risk code. Such case by case determinations of nutrition risk do not require Federal approval. However, if a specific condition, not listed in the definition, is frequently used as a certifying nutritional risk, than a request for approval to RISC must be submitted by the State agency.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a

medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp. 181-183.

2. Queen, PM and Land, CE: Handbook of Pediatric Nutrition; Aspen Publishers, Inc.; 1993; p. 342.

3. The American Dietetic Association: Pediatric Manual of Clinical Dietetics; Table 2-Metabolic Disorders Amenable to Nutrition Therapy; 1998; p. 288.

Nutrition Risk Criteria **95 DENTAL PROBLEMS**
USDA CODE 381

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD/DENTAL
BREASTFEEDING WOMEN	1	RD/DENTAL
NON-BREASTFEEDING WOMEN	6	RD/DENTAL

Definition

Diagnosis of dental problems by a physician or a health care provider working under the orders of a physician or adequate documentation by the competent professional authority, include, but not limited to:

- Tooth decay, periodontal disease, tooth loss and or ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality (children and all categories of women); and
- Gingivitis of pregnancy (pregnant women).

Required Documentation

Justification

Missing more than 7 teeth in adults seriously affects chewing ability. This leads to eating only certain foods which in turn affects nutritional intake.

Periodontal disease is a significant risk factor for pre-term low birth weight resulting from pre-term labor or premature rupture of the membranes. There is evidence that gingivitis of pregnancy results from "end tissue deficiency" of folic acid and will respond to folic acid supplementation as well as plaque removal.

References

5. Agerberg, G and Carlsson, GE: Chewing ability in relation to dental and general health; Aeta Odontol. Scand.; 1981; 39:147-153.
6. Offenbacher, S. etal.: Periodontal infection as a possible risk factor for pre-term low birth weight; J. Periodontol; October 1996; 67(10 Suppl.):1103-1113.
7. Rugg-Gunn AJ, Hackett AF. Nutrition and dental health. Oxford: Oxford University Press, 1993.

Nutrition Risk Criteria **96 EATING DISORDERS**
USDA CODE 358

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to:

- self-induced vomiting
- purgative abuse
- alternating periods of starvation
- use of drugs such as appetite suppressants, thyroid preparations or diuretics
- self-induced marked weight loss

Presence of eating disorder(s) diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders or evidence of such disorders documented by the CPA.

Required Documentation

Justification

Anorexia nervosa and bulimia are serious eating disorders that affect women in the childbearing years. These disorders result in general malnutrition and may cause life-threatening fluid and electrolyte imbalances. Women with eating disorders may begin pregnancy in a poor nutritional state. They are at risk of developing chemical and nutritional imbalances, deficiencies, or weight gain abnormalities during pregnancy if aberrant eating behaviors are not controlled. These eating disorders can seriously complicate any pregnancy since the nutritional status of the pregnant woman is an important factor in perinatal outcome.

Maternal undernutrition is associated with increased perinatal mortality and an increased risk of congenital malformation. While the majority of pregnant women studied reported a significant reduction in their eating disorder symptoms during pregnancy, a high percentage of these women regressed in the postpartum period. This regression in postpartum women is a serious concern for breastfeeding and non-breastfeeding postpartum women who are extremely preoccupied with rapid weight loss after delivery.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") Should prompt the CPA to validate the presence of the condition by

asking more pointed questions related to that diagnosis.

References

1. Worthington-Roberts, B., and Williams, SR: Nutrition in Pregnancy and Lactation; 5th ed.; Mosby Pub; St. Louis; pp.270-271.

2. Strober, M: International Journal of Eating Disorders; Vol. 8, No. 3; 1986; pp.285-295.

3. Institute of Medicine: Nutrition Services in Perinatal Care; 1992, p. 20.

4. Clinical Issues Perinatal Womens Health Nursing; 1992;3(4); pp. 695-700.

5. Krummel DA, and Kris-Etherton, PM: Nutrition in Women's Health, Aspen Pub; Gaithersburg, MD; pp. 58-102.

Nutrition Risk Criteria **100 WIC Eligible Medical Food**
USDA CODE: None-State assigned

Category, Priority and Referral

Category	Priority	Referral
Pregnant Women	4	RD
Breastfeeding Women	4	RD
Non-Breastfeeding Women	6	RD
Children	5	RD
Infants	4	RD

Definition

A person requiring a WIC Eligible Medical Food needs this code to receive the food package. This nutrition risk should never stand alone and usually is found in conjunction with at least one of the following:

27 Low Birth Weight
28 Failure to Thrive
37 Prematurity
90 Nutrition Related Medical Condition
91 Diabetes Mellitus
93 Inborn Errors of Metabolism

Required Documentation

A copy of the physician or medical care provider prescription must be on file along with a care plan approved by the RD. ***Local agency RD must complete the RFNS log and submit to the State office monthly.**

Justification

References

Nutrition Risk Criteria **401 Failure to Meet *Dietary Guidelines for Americans***
USDA CODE 401

Category, Priority and Referral

Category	Priority	Referral
Pregnant Women	4	-
Breastfeeding Women	4	-
Non-Breastfeeding Women	6	-
Children ≥ 2 years of age	5	-

Definition

Women and children two years of age and older who meet the eligibility requirements of income, categorical, and residency status may be presumed to be at nutrition risk based on *failure to meet Dietary Guidelines for Americans [Dietary Guidelines]* (1). For this criterion, *failure to meet Dietary Guidelines* is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans) based on an individual's estimated energy needs.

This risk may be assigned only to individuals (2 years and older) for whom a complete nutrition assessment (to include an assessment for risk #47, Inappropriate Nutrition Practices for Children, or #48, Inappropriate Nutrition Practices for Women) has been performed and for whom no other risk(s) are identified.

Required Documentation

Complete nutrition assessment

Justification

The 1996 Institute of Medicine (IOM) report, *WIC Nutrition Risk Criteria: A Scientific Assessment* (2) raised questions about the quality of traditional dietary assessment methods (e.g., 24-hour recall and food frequency questionnaires) and recommended further research in the development and validation of diet assessment methodologies. In response to the 1996 IOM report, the Food and Nutrition Service (FNS) commissioned the IOM to review the use of various dietary assessment tools and to make recommendations for assessing inadequate diet or inappropriate dietary patterns, especially in the category of *failure to meet Dietary Guidelines* (3). The review resulted in the publication of the 2002 IOM report, *Dietary Risk Assessment in the WIC Program* (4). The report contains a recommendation (paraphrased in the definition above) and five key findings. The findings of the IOM committee related to dietary risk and a summary of the evidence that supports its recommendation are provided below.

IOM Committee Findings Related to Dietary Risk and Supporting

Research

(Note: The findings related to dietary risk and a summary of the supporting research listed below can be found in the 2002 IOM report: *Dietary Risk Assessment in the WIC Program,* on the pages indicated.)

Findings:

- A dietary risk criterion that uses the WIC applicant's usual intake of the five basic Pyramid food groups as the indicator and the recommended number of servings based on energy needs as the cut-off points is consistent with *failure to meet Dietary Guidelines.* (page 130)
- Nearly all U.S. women and children usually consume fewer than the recommended number of servings specified by the Food Guide Pyramid and, therefore, would be at dietary risk based on the criterion *failure to meet Dietary Guidelines*. (page 130)
- Even research-quality dietary assessment methods are not sufficiently accurate or precise to distinguish an **individual's** eligibility status using criteria based on the Food Guide Pyramid or on nutrient intake. (page 131)

Supporting Research:

- Less than 1 percent of all women meet recommendations for all five Pyramid groups. (page 127)
- Less than 1 percent of children ages 2 to 5 years meet recommendations for all five Pyramid groups. (page 127)
- The percentage of women consuming fruit during 3 days of intake increases with increasing income level. (page 127)

Members of low-income households are less likely to meet recommendations than are more affluent households. (page 127)

- Food-insecure mothers are less likely to meet recommendations for fruit and vegetable intake than are food-secure mothers. (page 127)
- The percentage of children meeting recommendations for fat and saturated fat as a percentage of food energy increases with increasing income level. (page 127)
- Low-income individuals and African Americans have lower mean Healthy Eating Index scores than do other income and racial/ethnic groups. (page 127)
- 24-hour diet recalls and food records are not good measures of an individual's usual intake unless a number of independent days are observed. (page 61)
- On average, 24-hour diet recalls and food records tend to underestimate usual intake–energy intake in particular. (page 61)

- Food Frequency Questionnaires and diet histories tend to overestimate mean energy intakes. (page 61)

IOM Committee Concluding Remark

"In summary, evidence exists to conclude that nearly all low-income women in the childbearing years and children ages 2 to 5 years are at dietary risk, are vulnerable to nutrition insults, and may benefit from WIC's services. Further, due to the complex nature of dietary patterns, it is unlikely that a tool will be developed to fulfill its intended purpose with WIC: to classify individuals accurately with respect to their true dietary risk. Thus, any tools adopted would result in misclassification of the eligibility status of some, potentially many, individuals. By presuming that all who meet the categorical and income eligibility requirements are at dietary risk, WIC retains its potential for preventing and correcting nutrition-related problems while avoiding serious misclassification errors that could lead to denial of services to eligible individuals." (page 135)

Clarification

The recommendation and findings of the IOM Committee were developed using the 2000 *Dietary Guidelines* as the standard for a healthy diet. Subsequent to the 2002 IOM report, the *Dietary Guidelines* have been updated with the release of the 2005 *Dietary Guidelines*. Although the 2005 edition of the *Dietary Guidelines* is different from the 2000 edition, there is no evidence to suggest that the 2002 IOM recommendation and findings are invalid or inaccurate. The fact remains that diet assessment methodologies are insufficiently accurate to determine an individual's eligibility status. In addition, future research will be necessary to determine if there is a change in the IOM finding that nearly all Americans fail to consume the number of servings from the basic food groups as recommended in the *Dietary Guidelines*.

References

1. United States Department of Agriculture and the United States Department of Health and Human Services. Dietary Guidelines for Americans, 6th Edition, 2005. Available from: www.usda.gov/cnpp.

2. Institute of Medicine (IOM); Committee on Scientific Evaluation of WIC Nutrition Risk Criteria. WIC nutrition risk criteria: A scientific assessment. Washington, DC: National Academy Press; 1996.

3. United States Department of Agriculture and the United States Department of Health and Human Services. Dietary Guidelines for Americans, 5th Edition, 2000. Available from: www.usda.gov/cnpp

4. Institute of Medicine (IOM); Committee on Dietary Risk Assessment in the WIC Program. Dietary risk assessment in the WIC program. Washington, DC: National Academy Press; 2002.

Nutrition Risk Criteria

428 Dietary Risk Associated with Complementary Feeding Practices
USDA CODE 428

Category, Priority and Referral

Category	Priority	Referral
Infants 4 to 12 months	4	-
Children 12 through 23 months	5	-

Definition

An infant or child who has begun to or is expected to begin to 1) consume complementary foods and beverages, 2) eat independently, 3) be weaned from breast milk or infant formula, or 4) transition from a diet based on infant/toddler foods to one based on the *Dietary Guidelines for Americans*, is at risk of inappropriate complementary feeding.

A complete nutrition assessment, including for risk #46, Inappropriate Nutrition Practices for Infants, or #47, Inappropriate Nutrition Practices for Children, must be completed prior to assigning this risk.

Required Documentation

Complete Nutrition Assessment

Justification

Overview

Complementary feeding is the gradual addition of foods and beverages to the diet of the infant and young child. (1, 2) The process of adding complementary foods should reflect the physical, intellectual, and behavioral stages as well as the nutrient needs of the infant or child. Inappropriate complementary feeding practices are common and well documented in the literature. Caregivers often do not recognize signs of developmental readiness and, therefore, offer foods and beverages that may be inappropriate in type, amount, consistency, or texture. Furthermore, a lack of nationally accepted feeding guidelines for children under the age of two might lead caregivers to assume that all foods are suitable for this age range.

The 2000 WIC Participant and Program Characteristics study (PC 2000) shows greater percentages of anthropometric and biochemical risk factors in children ages 6 to 24 months than in children 24 to 60 months of age. (3)
These differences could reflect physical manifestations of inappropriate complementary feeding practices. Although PC 2000 shows a lower dietary risk in the 6 to 24 month age group, this risk is probably under-reported due to the high incidence of other higher priority nutrition risks.

AGE	ANTHOPOMETRIC RISK (%)	BIOCHEMICAL RISK (%)	DIETARY RISK (%)
6-11M	40	16	55
1 YEAR	41	14	76
2 YEAR	37	12	80
3 YEAR	32	9	80
4 YEAR	35	7	79

The Institute of Medicine (IOM), in their report, *Summary of Proposed Criteria for Selecting the WIC Food Packages* identified specific nutrients with potential for inadequacy or excess for WIC participants. For breast-ed infants 6 through 11 months, the nutrients of concern for potential inadequacy are iron and zinc while those for children 12 through 23 months are iron, vitamin E, fiber and potassium. The nutrients of concern for excessive intake in children 12 through 23 months are zinc, preformed vitamin A, sodium and energy. (4)

To manage complementary feeding successfully, caregivers must make decisions about what, when, where, and how to offer foods according to the infant's or child's:

- Requirement for energy and nutrients;
- Fine, gross, and oral motor skills;
- Emerging independence and desire to learn to self-feed; and
- Need to learn healthy eating habits through exposure to a vari

  nutritious foods. (1, 2, 5, 6, 7)

How WIC Can Help

The WIC Program plays a key role not only in the prevention of nutrition-related health problems, but also in the promotion of lifelong healthy eating behaviors. The process of introducing complementary foods provides a unique opportunity for WIC staff to assist caregivers in making appropriate feeding decisions for

young children that may have lifelong implications.

Prevention of Nutrition-Related Health Problems

- Zinc deficiency: Zinc is critical for growth and immunity, as well as brain development and function. The concentration of zinc in breast milk declines to a level considered inadequate to meet the needs of infants 7 to 12 months of age. (8, 9) Complementary food sources of zinc, such as meats or zinc-fortified infant cereals, should be introduced to exclusively breastfed infants by 7 months.

Clarification

- Iron deficiency: Hallberg states, "The weaning period in infants is especially critical because of the especially high iron requirements and the importance of adequate iron nutrition during this crucial period of development."(10) According to the Centers for Disease Control and Prevention (CDC), children less than 24 months of age, especially those between 9 and 18 months, have the highest rate of iron deficiency of any age group. (11) In the third National Health and Nutrition Examination Survey (NHANES III), children ages 1 to 2, along with adolescent girls, had the highest rates of overt anemia, while 9 % were iron deficient. (12) Meanwhile, the Pediatric Nutrition Surveillance 2003 Report noted anemia rates of 16.2 % in 6 to 11 month-old infants, 15.0 % in 12 to 17 month-olds, and 13.5 % in 18-23 month old children. (13)

  Picciano et al. reported that the intake of iron decreased from 98% of the recommended amount at 12 months to 76% at 18 months of age. (14) In WIC clinics, Kahn et al. found that the incidence of anemia was significantly more common in 6 to 23 month old children than in 23 to 59 month-olds. The 6 to 23 month-old was also more likely than the older child to develop anemia despite a normal hemoglobin test at WIC certification. (15)

  Feeding practices that may prevent iron deficiency include:
  - Breastfeeding infants exclusively until 4 to 6 months of age;
  - Feeding only iron-fortified infant formula as a substitute for or supplement to breast milk until age 1;
  - Offering a supplemental food source of iron to infants, between 4 to 6 months or when developmentally ready;
  - Avoiding cow's milk until age 12 months; and
  - Limiting milk consumption to no more than 24 ounces per day for children aged 1 to 5 years. (11)

- Obesity: Much of the literature on obesity indicates that learned behaviors and attitudes toward food consumption are major contributing factors. Proskitt states, "The main long term effect of

weaning on nutritional status could be through attitudes toward food and meals learned by infants through the weaning process. This may be a truly critical area for the impact of feeding on later obesity." (16)

Birch and Fisher state, "An enormous amount of learning about food and eating occurs during the transition from the exclusive milk diet of infancy to the omnivore's diet consumed by early childhood." The authors believe that parents have the greatest influence on assuring eating behaviors that help to prevent future overweight and obesity. (17)

The American Academy of Pediatrics (AAP) states, "…prevention of overweight is critical, because long-term outcome data for successful treatment approaches are limited…" and, "Families should be educated and empowered through anticipatory guidance to recognize the impact they have on their children's development through lifelong habits of physical activity and nutritious eating." (1) Parents can be reminded that they are role models and teachers who help their children adopt healthful eating and lifestyle practices.

- Tooth decay: Children under the age of 2 are particularly susceptible to Early Childhood Caries (ECC), a serious public health problem. (18) In some communities, the incidence of ECC can range from 20% to 50%. (19) Children with ECC appear to be more susceptible to caries in permanent teeth at a later age. (1, 20) Dental caries can be caused by many factors, including prolonged use of a bottle and extensive use of sweet and sticky foods. (21) The Avon Longitudinal Study of Pregnancy and Childhood examined 1,026 children aged 18 months and found that baby bottles were used exclusively for drinking by 10 % of the children and for at least one feeding by 64% of the children. Lower income families were found to use the bottle more frequently for carbonated beverages than higher income families. (22)

  Complementary feeding practices that caregivers can use to prevent oral health problems include:
  - Avoiding concentrated sweet foods like lollipops, candy and sweetened cereals.
  - Avoiding sweetened beverages. Introducing fruit juice after 6 months of age (1) and only feeding it in a cup; and limiting fruit juice to 4-6 ounces/day.
  - Weaning from a bottle to a cup by 12 to 14 months. (23)

- Timing of introduction of complementary foods:
  The AAP, Committee on Nutrition (CON) states that, "… complementary foods may be introduced between ages 4 and 6 months…" but cautions that actual timing of introduction of complementary foods for an individual infant may differ from this (population based) recommendation. Furthermore, the AAP-CON acknowledges a difference of opinion with the AAP, Section on Breastfeeding, which recommends exclusive breastfeeding for at least 6 months. (1)

  Early introduction of complementary foods before the infant is developmentally ready (i.e., before 4-6 months of age) is associated with increased respiratory illness, allergy in high-risk infants, and decreased breast milk production (7).

  Infants with a strong family history of food allergy should be breastfed for as long as possible and should not receive complementary foods until 6 months of age. The introduction of the major food allergens such as eggs, milk, wheat, soy, peanuts, tree nuts, fish and shellfish should be delayed until well after the first year of life as guided by the health care provider. (7, 24) Delayed introduction of complementary foods, on the other hand, is also associated with feeding difficulties. Northstone et al found that introduction of textured foods after 10 months of age resulted in more feeding difficulties later on, such as picky eating and/or refusal of many foods. To avoid these and other developmental problems, solid foods should be introduced no later than 7 months, and finger foods between 7 and 9 months of age. (25)

- Choosing Appropriate Complementary Foods and Beverages:
  Complementary foods should supply essential nutrients and be developmentally appropriate. (7) The WIC Infant Feeding Practices Study (WIC-IFPS) found that by 6 months of age, greater than 80% of mothers introduced inappropriate dairy foods (i.e., yogurt, cheese, ice cream and pudding), 60% introduced sweets/snack foods (defined as chips, pretzels, candy, cookies, jam and honey), and 90% introduced high protein foods (beans, eggs and peanut butter) to their infants. This study also found that, among the infants who received supplemental drinks by 5 months of age, three-quarters had never used a cup, concluding that most infants received supplemental drinks from the bottle. By one year of age, almost 90% of WIC infants received sweetened beverages and over 90% received sweet/snack foods. (26)

The Feeding Infants and Toddlers Study (FITS) found that WIC infants and toddlers consumed excess energy but inadequate amounts of fruits and vegetables. In addition, WIC toddlers consumed more sweets, desserts and sweetened beverages than non-WIC toddlers. (27)

Sixty-five percent of all food-related choking deaths occur in children under the age of 2. Children in this age group have not fully developed their oral-motor skills for chewing and swallowing. For this reason, they should be fed foods of an appropriate consistency, size, and shape. Foods commonly implicated in choking include hot dogs, hard, gooey or sticky candy, nuts and seeds, chewing gum, grapes, raisins, popcorn, peanut butter and hard pieces of raw fruits and vegetables and chunks of meat or cheese. (1, 28, 29)

- Introducing a Cup: Teaching an infant to drink from a cup is part of the process of acquiring independent eating skills. A delay in the initiation of cup drinking prolongs the use of the nursing bottle that can lead to excess milk and juice intake and possible Early Childhood Caries (ECC). Weaning from a bottle to a cup should occur by 12 to14 months of age. (23)

- Helping The Child Establish Lifelong Healthy Eating Patterns: Lifelong eating practices may have their roots in the early years. Birch and Fisher state that food exposure and accessibility, the modeling behavior of parents and siblings, and the level of parental control over food consumption influence a child's food preferences. Inappropriate feeding practices may result in under- or over-feeding and may promote negative associations with eating that continue into later life.

  Normal eating behaviors such as spitting out or gagging on unfamiliar food or food with texture are often misinterpreted as dislikes or intolerances leading to a diminished variety of foods offered. Infants have an innate preference for sweet and salty tastes. Without guidance, an infant may develop a lifelong preference for highly sweetened or salty foods rather than for a varied diet. (17)

  A young child gradually moves from the limited infant/toddler diet to daily multiple servings from each of the basic food groups as described in the Dietary Guidelines. (30) The toddler stage (ages 1-2 years) may frustrate caregivers since many toddlers have constantly changing food preferences and erratic appetites. In addition, toddlers become skeptical about new foods and may need

to experience a food 15-20 times before accepting it. (31)

Caregivers can be guided and supported in managing common toddler feeding problems. Feeding practices that caregivers can use to facilitate a successful transition to a food group-based diet include:

- Offering a variety of developmentally appropriate nutritious foods;
- Reducing exposure to foods and beverages containing high levels of salt and sugar;
- Preparing meals that are pleasing to the eye and include a variety of colors and textures;Setting a good example by eating a variety of foods;
- Offering only whole milk from age 1-2; (Lower fat milk can be introduced after that age.)
- Providing structure by scheduling regular meal and snack times;
- Allowing the child to decide how much or whether to eat;
- Allowing the child to develop eating/self-feeding skills; and
- Eating with the child in a pleasant mealtime environment without coercion.

References

5. American Academy of Pediatrics. Committee on Nutrition. Kleinman RE, editor. Pediatric Nutrition Handbook. 5th ed. 2004.

6. Pelto GH, Levitt E, and Thairu L. Improving feeding practices: Current patterns, common constraints, and the design of interventions. Food and Nutrition Bulletin, 2003; 24(1): 45-82.

7. United States Department of Agriculture. Study of WIC participant and program characteristics. 2000.

8. Institute of Medicine. Food and Nutrition Board. Proposed criteria for selecting the WIC food packages. The National Academies Press, Washington DC, 2004.

9. Hervada AR, Hervada-Page M. Infant Nutrition: The first two years. In: Childhood Nutrition. Lifshitz F, editor. CRC Press; 1995.

10. Pipes PL, Trahms CM. Nutrient needs of infants and children. In: PipesPL, Trahms CM editors. Nutrition in infancy and childhood 5th ed. Mosby Publishing Co. 1993.

11. Hendricks KM, Weaning: Pathophysiology, practice and policy. In: Nutrition in Pediatrics, 3rd edition. B.C. Decker Inc, 2003.

12. Institute of Medicine. Food and Nutrition Board. Dietary reference intakes for vitamin A, vitamin K, arsenic, boron, chromium, copper, iodine, iron, manganese, molybdenum, nickel, silicon, vanadium and zinc. National Academies Press, Washington DC, 2001.

13. Clinical Nutrition Services; Warren Grant Magnuson Clinical Center, Office of Dietary Supplements. Facts about dietary supplements: zinc. National Institutes of Health. Bethesda Maryland; 2002.

14. Hallberg L. Perspectives on nutritional iron deficiency. Annu Rev Nutr. 2001; 21:1-21.

15. Centers for Disease Control and Prevention. Recommendations to prevent and control iron deficiency in the United States. MMWR. April 1998:18-21.

16. Looker AC, Dallman PR, Carroll MD, Gunter EW, Johnson CL. Prevalence of iron deficiency in the United States. JAMA. 1997; 277:973-6.

17. Centers for Disease Control and Prevention. Pediatric surveillance system 2003 annual report, Atlanta: U.S. Department of Health and Human Services, Center for Disease Control and Prevention, 2004. Available at http://www.cdc.gov/pednss (accessed 11/04).

18. Picciano MF, Smiciklas-Wright H, Birch LL, Mitchel DC, Murray-Kolb L, McConchy KL. Nutritional guidance is needed during dietary transition in early childhood. Ped. 2000; 106: 109-114.

19. Kahn JL, Binns HJ, Chen T, Tanz RR, Listernick R. Persistence and emergence of anemia in children during participation in the Special Supplemental Nutrition Program for Women, Infants, and Children. Arch Pediatr Adolesc Med. 2002; 156:1028-32.

20. Proskitt EM. Early feeding and obesity. In: Boulton J, Laron Z and Rey J, editors. Long-term consequences of early feeding. Nestle Nutrition Workshops Series; 1996, Nestle Ltd., Vevey/Lippincott-Raven Publishers, Philadelphia; Vol. 36.

21. Birch LL, Fisher JO. Development of eating behaviors among children and adolescents. Ped. 1998; 101:539-549.

22. Bertness J, Holt K, editors. Promoting awareness, preventing pain: Facts on early childhood caries (ECC) 2nd. Ed. [Fact Sheet on the Internet]. Washington (DC); National Maternal & Child Oral Health

Resource Center; 2004. Available from: http://www.mchoralhealth.org.

23. American Academy of Pediatric Dentistry. Baby bottle tooth decay/early childhood caries. Pediatr Dent. 2001 Mar-Apr; 23 (2): 18.

24. al-Shalan TA, Erickson PR, Hardie NA. Primary incisor decay before age 4 as a risk factor for future dental caries. J Pediatr Dent. 1997 Jan-Feb; 9 (1): 37-41.

25. Casamassimo P ed. 1996. Bright futures in practice: oral health. Arlington, VA: National Center for Education in Maternal and Child Health.

26. Northstone K, Rogers I, Emmett P. Drinks consumed by 18-month-old children: Are current recommendations being followed? Eur J Clin Nutr. 2002; 56:236-44.

27. American Academy of Pediatric Dentistry. Policy on early childhood caries (EEC): Classifications, consequences, and prevention strategies. Pediatr Dent; Reference manual 2003-2004: 2004; 25(7):25

28. Butte N, Cobb K, Dwyer J, Graney L, Heird W, Rickard K. The start healthy feeding guidelines for infants and toddlers. J Am Diet Assoc, 2004; 104 (3) 442-454.

29. Northstone, K, Emmett P, Nethersole F. The effect of age of introduction to lumpy solids on foods eaten and reported difficulties at 6 and 15 months. J Hum Nutr Dietet. 2001; 14: 43-54.

30. Baydar N, McCann M, Williams R, Vesper E, McKinney P. WIC infant feeding practices study. USDA Office of Analysis and Evaluation. November 1997.

31. Ponza M, Devaney B, Ziegler P, Reidy K, and Squatrito C. Nutrient intake and food choices of infants and toddlers participating in WIC. J Am Diet Assoc 2004; 104: s71-s79.

32. Harris CS, Baker SP, Smith GA, Harris RM. Childhood asphyxiation by food: A national analysis and overview. JAMA. 1984; 251:2231-5.

33. Lucas B. Normal nutrition from infancy through adolescence. In: Handbook of pediatric nutrition. 2nd ed. Gaithersburg, Maryland: Aspen Publishers, Inc. 1999.

34. United States Department of Agriculture and the United States Department of Health and Human Services. Dietary guidelines for

Americans, 5th ed. 2000. Available from:http://www.usda.gov.cnpp.

35. Story M, Holt K, Sofka D, editors. Bright futures in practice: nutrition. 2nd ed. Arlington, VA: National Center for Education in Maternal and Child Health; 2002.

Nutrition Risk Criteria **610 PREGNANT WOMAN CURRENTLY BREASTFEEDING USDA CODE 338**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD

Definition

Breastfeeding woman now pregnant.

Required Documentation

Justification

Breastfeeding during pregnancy can influence the mother's ability to meet the nutrient needs of her growing fetus and nursing baby. Generally, pregnancy hormones cause the expectant mother's milk supply to drastically decline (until after delivery). If the mother conceived while her nursing baby was still solely or predominantly breastfeeding, the baby could fail to receive adequate nutrition. In addition to changes in milk volume and composition, mothers who breastfeed throughout a pregnancy usually report that their nipples, previously accustomed to nursing, become extremely sensitive (presumably due to pregnancy hormones). When women nurse through a pregnancy it is possible that oxytocin released during breastfeeding could trigger uterine contractions and premature labor. When a mother chooses to nurse through a pregnancy, she needs breastfeeding counseling.

References

1. Mohrbacher N, Stock J, La LL, I. The breastfeeding answer book. Schaumburg, Ill: La Leche League International, 1997.

Nutrition Risk Criteria

611 BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK (PRIORITY 1)
USDA CODE 601

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	1	

---

efinition

A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk.

*DO NOT USE WITH THE FOLLOWING CODES:
612 BF mom of priority 2 infant
614 BF mom of priority 4 infant
621 BF infant of priority 1 mom
624 BF infant of priority 4 mom

Required Documentation

Justification

A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Special attention should therefore be given to the health and nutritional status of the mother (5). Lactation requires an additional approximately 500 Kcal per day as increased protein, calcium, and other vitamins and minerals (3,1). Inadequate maternal nutrition may result in decreased nutrient content of the milk (1).

References

1. Institute of Medicine. Nutrition During Lactation. National Academy Press, Washington, D.C.; 1991.

2. Lawrence RA. Breastfeeding a guide for the medical profession. St. Louis: Mosby, 1994.

3. National Research Council (U.S.), Subcommittee on the Tenth Edition of the RDAs, National Institutes of Health, Committee on Dietary Allowances. Recommended dietary allowances. Washington, D.C.: National Academy Press, 1989.

4. WIC Program Regulations, Sect. 246.7(e)(1)(iii).

Worthington-Roberts BS, Williams SR. Nutrition in Pregnancy and Lactation. St. Louis: Mosby, 1993.

Nutrition Risk Criteria

612 BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK (PRIORITY 2)
***RELATED* USDA CODE 601**

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	2	

Definition

A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk.

*DO NOT USE WITH THE FOLLOWING CODES:
611 BF mom of priority 1 infant
614 BF mom of priority 4 infant
621 BF infant of priority 1 mom
624 BF infant of priority 4 mom

Required Documentation

Justification

A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Special attention should therefore be given to the health and nutritional status of the mother (5). Lactation requires an additional approximately 500 Kcal per day as increased protein, calcium, and other vitamins and minerals (3,1). Inadequate maternal nutrition may result in decreased nutrient content of the milk (1).

References

1. Institute of Medicine. Nutrition During Lactation. National Academy Press, Washington, D.C.; 1991.

2. Lawrence RA. Breastfeeding a guide for the medical profession. St. Louis: Mosby, 1994.

3. National Research Council (U.S.), Subcommittee on the Tenth Edition of the RDAs, National Institutes of Health, Committee on Dietary Allowances. Recommended dietary allowances. Washington, D.C.: National Academy Press, 1989.

4. WIC Program Regulations, Sect. 246.7(e)(1)(iii).

5. Worthington-Roberts BS, Williams SR. Nutrition in Pregnancy and Lactation. St. Louis: Mosby, 1993.

Nutrition Risk Criteria

614 BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK (PRIORITY 4)
***RELATED* USDA CODE 601**

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	4	

Definition

A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk.

*DO NOT USE WITH THE FOLLOWING CODES:
611 BF mom of priority 1 infant
612 BF mom of priority 2 infant
621 BF infant of priority 1 mom
624 BF infant of priority 4 mom

Required Documentation

Justification

A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Special attention should therefore be given to the health and nutritional status of the mother (5). Lactation requires an additional approximately 500 Kcal per day as increased protein, calcium, and other vitamins and minerals (3,1). Inadequate maternal nutrition may result in decreased nutrient content of the milk (1).

References

1. Institute of Medicine. Nutrition During Lactation. National Academy Press, Washington, D.C.; 1991.

2. Lawrence RA. Breastfeeding a guide for the medical profession. St. Louis: Mosby, 1994.

3. National Research Council (U.S.), Subcommittee on the Tenth Edition of the RDAs, National Institutes of Health, Committee on Dietary Allowances. Recommended dietary allowances. Washington, D.C.: National Academy Press, 1989.

4. WIC Program Regulations, Sect. 246.7(e)(1)(iii).

5. Worthington-Roberts BS, Williams SR. Nutrition in Pregnancy and Lactation. St. Louis: Mosby, 1993.

Nutrition Risk Criteria **615 BREASTFEEDING COMPLICATIONS (WOMEN)**
USDA CODE 602

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN		RD/LC

Definition

A breastfeeding woman with any of the following complications or potential complications for breastfeeding:

a. severe breast engorgement
b. recurrent plugged ducts
c. mastitis (fever or flu-like symptoms with localized breast tenderness)
d. flat or inverted nipples
e. cracked, bleeding or severely sore nipples
f. Age ≥ 40 years
g. Failure of milk to come in by 4 days postpartum
h. Tandem nursing (breastfeeding two siblings who are not twins)

Required Documentation

Justification

a. Severe engorgement is often caused by infrequent nursing and/or ineffective removal of milk. This severe breast congestion causes the nipple-areola area to become flattened and tense, making it difficult for the baby to latch-on correctly. The result can be sore, damaged nipples and poor milk transfer during feeding attempts. This ultimately results in diminished milk supply. When the infant is unable to latch-on or nurse effectively, alternative methods of milk expression are necessary, such as using an electric breast pump.
b. A clogged duct is a temporary back-up of milk that occurs when one or more of the lobes of the breast do not drain well. This usually results from incomplete emptying of milk. Counseling on feeding frequency or method or advising against wearing an overly tight bra or clothing can assist.
c. Mastitis is a breast infection that causes a flu-like illness accompanied by an inflamed, painful area of the breast - putting both the health of the mother and successful breastfeeding at risk. The woman should be referred to her health care provider for antibiotic therapy.
d. Infants may have difficulty latching-on correctly to nurse when nipples are flat or inverted. Appropriate interventions can improve nipple protractility and skilled help guiding a baby in proper breastfeeding technique can facilitate proper attachment.

e. Severe nipple pain, discomfort lasting throughout feedings, or pain persisting beyond one week postpartum is atypical and suggests the baby is not positioned correctly at the breast. Improper infant latch-on not only causes sore nipples, but impairs milk flow and leads to diminished milk supply and inadequate infant intake. There are several other causes of

severe or persistent nipple pain, including Candida or staph infection. Referrals for lactation counseling and/or examination by the woman's health care provider are indicated.

f. Older women (over 40) are more likely to experience fertility problems and perinatal risk factors that could impact the initiation of breastfeeding. Because involutional breast changes can begin in the late 30's, older mothers may have fewer functioning milk glands resulting in greater difficulty producing an abundant milk supply.

g. Failure of milk to come in by 4 days postpartum may be a result of maternal illness or perinatal complications. This may place the infant at nutritional and/or medical risk, making temporary supplementation necessary until a normal breast milk supply is established.

h. With tandem nursing the older baby may compete for nursing privileges, and care must be taken to assure that the younger baby has first access to the milk supply. The mother who chooses to tandem nurse will have increased nutritional requirements to assure her adequate milk production.

References

1. Alexander JM, Grant AM, Campbell MJ. Randomised controlled trial of breast shells and Hoffman's exercises for inverted and non-protractile nipples. BMJ 1992;304:1030-2.

2. Akre J. Infant Feeding. The physiological basis. Bull.World Health Organ 1989;67 Suppl:1-108.

3. Amier, L, Garland, SM, Dennerstein, L, et al.: Candida albicans: Is it associated with nipple pain in lactating women? Gynecol Obstetr Invest; 1996; 41:30-34.

4. De Coopman J. Breastfeeding after pituitary resection: support for a theory of autocrine control of milk supply? J.Hum.Lact. 1993;9:35-40.

5. Lawrence RA. Breastfeeding a guide for the medical profession. St. Louis: Mosby, 1994.

6. Livingstone VH, Willis CE, Berkowitz J. Staphylococcus aureus and sore nipples. Can.Fam.Physician 1996;42:654-9.

7. Mohrbacher N, Stock J, La LL, I. The breastfeeding answer book. Schaumburg, Ill: La Leche League International, 1997.

8. Neifert M. Early assessment of the breastfeeding infant. Contemporary Pediatr. 1996 Oct;13:142.

9. Neifert MR. The optimization of breast-feeding in the perinatal period. Clin.Perinatol. 1998;25:303-26.

10. Neifert MR, Seacat JM, Jobe WE. Lactation failure due to insufficient glandular development of the breast. Pediatrics 1985;76:823-8.

11. Riodan J, Auerbach KG. Breastfeeding and human lactation. Boston: Jones and Bartlett Publishers, 1993.
12. The Main Trial Collaborative Group: Preparing for breastfeeding: treatment of inverted and non-protractile nipples in pregnancy; Midwifery; 1994; 10:200.
13. Woolridge MW. Aetiology of sore nipples. Midwifery 1986; 2:172-6.

Nutrition Risk Criteria

621 BREASTFEEDING INFANT OF WOMAN AT NUTRITIONAL RISK (PRIORITY 1 MOM)
USDA CODE 702

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	-

Definition

Breastfeeding infant of a mother who is at nutritional risk with priority 1 codes.

The mother's nutrition risk must be documented on the infant's certification record/plan.

Do not use with the following codes:
611 BF Mom of Priority 1 infant
612 BF Mom of Priority 2 infant
613 BF Mom of Priority 4 infant
624 BF Mom of Priority 4 mom

Required Documentation

Justification

A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Lactation requires the mother to consume an additional 500 Kcal per day (approximately) as well as increased protein, calcium, and other vitamins and minerals (2, 1). Inadequate maternal nutrition may result in decreased nutrient content of the milk (1). Special attention should therefore be given to the health and nutritional status of breastfed infants whose mothers are at nutritional risk (4).

References

1. Institute of Medicine. Nutrition During Lactation. National Academy Press, Washington, D.C.; 1991.

2. National Research Council (U.S.), Subcommittee on the Tenth Edition of the RDAs, National Institutes of Health, Committee on Dietary Allowances. Recommended dietary allowances. Washington, D.C.: National Academy Press, 1989.

3. WIC Program Regulations; Section 246.7(e)(1)(i).

4. Worthington-Roberts BS, Williams SR. Nutrition During Pregnancy and Lactation. St. Louis: Mosby, 1989.

Nutrition Risk Criteria

624 BREASTFEEDING INFANT OF WOMAN AT NUTRITIONAL RISK (PRIORITY 4 MOM)
***RELATED* USDA CODE 702**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	4	-

Definition

Breastfeeding infant of a mother who is at nutritional risk with priority 4 codes.

The mother's nutrition risk must be documented on the infant's certification record/plan.

Do not use with the following codes:
614 BF Mom of Priority 1 infant
615 BF Mom of Priority 2 infant
616 BF Mom of Priority 4 infant
621 BF Mom of Priority 1 mom

Required Documentation

Justification

A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Lactation requires the mother to consume an additional 500 Kcal per day (approximately) as well as increased protein, calcium, and other vitamins and minerals (2, 1). Inadequate maternal nutrition may result in decreased nutrient content of the milk (1). Special attention should therefore be given to the health and nutritional status of breastfed infants whose mothers are at nutritional risk (4).

References

5. Institute of Medicine. Nutrition During Lactation. National Academy Press, Washington, D.C.; 1991.

6. National Research Council (U.S.), Subcommittee on the Tenth Edition of the RDAs, National Institutes of Health, Committee on Dietary Allowances. Recommended dietary allowances. Washington, D.C.: National Academy Press, 1989.

7. WIC Program Regulations; Section 246.7(e)(1)(i).

8. Worthington-Roberts BS, Williams SR. Nutrition During Pregnancy and Lactation. St. Louis: Mosby, 1989.

Nutrition Risk Criteria **701 ★ HOMELESSNESS**
USDA CODE 801

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	RD
BREASTFEEDING WOMEN	4	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	4	RD
CHILDREN	5	RD

Definition

A woman, infant or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:

- a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations;
- an institution that provides a temporary residence for individuals intended to be institutionalized;
- a temporary accommodation of not more than 365 days in the residence of another individual; or
- a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Required Documentation

Justification

Homeless individuals comprise a very vulnerable population with many special needs. WIC Program regulations specify homelessness as a predisposing nutrition risk condition. Today's homeless population contains a sizeable number of women and children – over one-third of the total homeless population in the U.S. Studies show forty-three percent of today's homeless are families, and an increasing number of the "new homeless" include economically-displaced individuals who have lost their jobs, exhausted their resources, and recently entered into the ranks of the homeless and consider their condition to be temporary.

References

WIC Program Regulations; Sect. 246.7(e)(2)(iv).

Nutrition Risk Criteria **702 ★ MIGRANCY**
USDA CODE 802

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	4	-
CHILDREN	5	-

Definition

Categorically eligible women, infants and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

Required Documentation

Justification

Data on the health and/or nutritional status of migrants indicate significantly higher rates or incidence of infant mortality, malnutrition, and parasitic disease (among migrant children) than among the general U.S. population. Therefore, migrancy has long been stipulated as a condition that predisposes persons to inadequate nutritional patterns or nutritionally related medical conditions.

References

WIC Program Regulations; Sect. 246.7(e)(2)(iv).

Nutrition Risk Criteria

803 WOMAN OR INFANT/CHILD OF PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS/PREPARE FOOD
USDA CODE 902

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	4	-
CHILDREN	5	-

Definition

Woman (**pregnant, breastfeeding, or non-breastfeeding**), or infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- ≤ 17 years of age;
- mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist);
- physically disabled to a degree which restricts or limits food preparation abilities; or
- currently using or having a history of abusing alcohol or other drugs.

Required Documentation

Justification

The mother or caregiver ≤ 17 years of age generally has limited exposure and application of skills necessary to care for and feed a total dependent. Cognitive limitation in a parent or primary caregiver has been recognized as a risk factor for failure to thrive, as well as for abuse and neglect. The mentally handicapped caregiver may not exhibit the necessary parenting skills to promote beneficial feeding interactions with the infant. Maternal mental illnesses such as severe depression and maternal chemical dependency are also strongly associated with abuse and neglect. In 22 states, 90% of caregivers reported for child abuse are active substance abusers. Certain physical handicaps such as blindness, para- or quadriplegia, or physical anomalies restrict/limit the caregiver's ability to prepare and offer a variety of foods. Education, referrals and service coordination with WIC will aid the mother/caregiver in developing skills, knowledge and/or assistance to properly care for a total dependent.

References

1. Accardo PJ, Whitman BY. Children of mentally retarded parents. Am.J.Dis.Child 1990;144:69-70.

2. Grand RJ, Sutphen JL, Dietz WH. Pediatric nutrition theory and practice. Boston: Butterworths, 1987.

3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

4. Pollitt E, Wirtz S. Mother-infant feeding interaction and weight gain in the first month of life. J.Am.Diet.Assoc. 1981;78:596-601.

5. WIC Program regulations; Sect. 246.7(e)(2).

Nutrition Risk Criteria **804 FOSTER CARE**
USDA CODE 903

Category, Priority and Referral

Category	Priority	Referral
INFANTS	4	RD
CHILDREN	5	RD

Definition

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.

Required Documentation

Justification

"Foster children are among the most vulnerable individuals in the welfare system. As a group, they are sicker than homeless children and children living in the poorest sections of inner cities." This statement from a 1995 Government Accounting Office report on the health status of foster children confirms research findings that foster children have a high frequency of mental and physical problems, often the result of abuse and neglect suffered prior to entry into the foster care system. When compared to other Medicaid-eligible children, foster care children have higher rates of chronic conditions such as asthma, diabetes and seizure disorders. They are also more likely than children in the general population to have birth defects, inadequate nutrition and growth retardation including short stature.

Studies focusing on the health of foster children often point out the inadequacy of the foster care system in evaluating the health status and providing follow-up care for the children for whom the system is responsible. Because foster care children are wards of a system which lacks a comprehensive health component, the social and medical histories of foster children in transition, either entering the system or moving from one foster care home to another, are frequently unknown to the adults applying for WIC benefits for the children. For example, the adult accompanying a foster child to a WIC clinic for a first-time certification may have no knowledge of the child's eating patterns, special dietary needs, chronic illnesses or other factors which would qualify the child for WIC. Without any anthropometric history, failure to grow, often a problem for foster children, may not be diagnosed even by a single low cutoff percentile.

Since a high proportion of foster care children have suffered from neglect, abuse or abandonment and the health problems associated with these, entry into foster care or moving from one foster care home to another during the previous six months is a nutritional risk for certification in the WIC Program. Certifiers using this risk should be diligent in evaluating and documenting the health and nutritional status of the foster child to identify other risks as well as problems that may require follow-up or referral to other health care programs. This nutritional risk cannot be used for consecutive certifications while the child remains in the same foster home. It should be used as the sole risk criterion only

if careful assessment of the applicant's nutritional status indicates that no other risks based on anthropometric, medical or nutritional risk criteria can be identified.

The nutrition education, referrals and service coordination provided by WIC will support the foster parent in developing the skills and knowledge to ensure that the foster child receives appropriate nutrition and health care. Since a foster parent frequently has inadequate information about a new foster child's health needs, the WIC nutritionist can alert the foster parent to the nutritional risks that many foster care children have and suggest ways to improve the child's nutritional status.

References

1. American Medical News: America's Sickest Children; January 10, 1994; 15-19.

2. Chernoff R, Combs-Orme T, Risley-Curtiss C, Heisler A. Assessing the health status of children entering foster care. Pediatrics 1994;93:594-601.

3. DuRouseau PC, Moquette-Magee E, Disbrow D. Children in foster care: are they at nutritional risk? J.Am.Diet.Assoc. 1991 Jan;91(1):83-85.

4. Government Accounting Office. Foster care health needs of many young children are unknown and unmet: report to the ranking minority member, Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives. Washington D.C.: The Office; 1995 May. Report No.:GA 1.13:HEHS-95-114.

5. Halfon N, Mendonca A, Berkowitz G. Health status of children in foster care. The experience of the Center for the Vulnerable Child. Arch.Pediatr.Adolesc.Med. 1995;149:386-92.

6. Schor EL. The foster care system and health status of foster children. Pediatrics 1982;69:521-8.

7. Takayama JI, Wolfe E, Coulter KP. Relationship between reason for placement and medical findings among children in foster care. Pediatrics 1998;101:201-7.

8. Wyatt DT, Simms MD, Horwitz SM. Widespread growth retardation and variable growth recovery in foster children in the first year after initial placement. Arch.Pediatr.Adolesc.Med. 1997;151:813-6.