**POLICY MANUAL**

5. WIC NUTRITION AND BREASTFEEDING SERVICES.

5.00. Nutrition and Risk Assessment.

A. POLICY OVERVIEW:

PA WIC shall, as part of the nutrition/health assessment, promote and employ a consistent method for collecting hematological and anthropometric measurements, conducting a nutrition assessment and determining nutrition risk.

B. POLICY:

1. Anthropometric Measurements:

a. Each clinic where anthropometric measurements are taken must have the following equipment:

(1) Infant (recumbent) length measurement board.
(2) Child and adult (standing) measurement board.
(3) Infant digital (preferred) or beam balance scale.
(4) Child and adult digital (preferred) or beam balance scale. A measuring rod on an adult scale shall not be used to measure heights.

b. The local agency (LA) shall ensure that equipment is purchased and maintained according to State Agency (SA) guidance.

c. Anthropometric measurements shall be taken at every certification and health evaluation and interpretation of those measurements must be documented in the Management Information System (MIS). When certifying infants and children under 2 years old, birth measurements must be entered into the MIS as well as current measurements. Frequency of measurements within a certification period shall be determined based upon nutritional risk(s) present, except for the following which are required:

(1) Pregnant women shall have their weight entered and interpreted in the MIS at each appointment.
(2) Infants certified for one year shall have their length and weight entered and interpreted in the MIS between 4 and 7 months of age.
(3) Breastfeeding and postpartum women shall have their weight entered and interpreted in the MIS between 4 and 7 months after delivery.

d. Anthropometric measurements from a referring agency or physician must be submitted from a provider and include date of the measurements. Referral data cannot be more than 60 days prior to the date of the participant’s WIC appointment.

e. Anthropometric measurements must be entered accurately into the MIS and documentation shall include circumstances and exceptions which hinder taking accurate measurements and, if applicable, where referral data has been received from.

f. It is best practice to measure the head circumference of infants and children under 2 years old to assess for low head circumference and assignment of the associated risk code. If local agencies measure head circumference or obtain referral head circumference data for infants and children under 2 years old, staff must document the measurement as well as an interpretation of the

measurement in the MIS.

2. Hematological Testing:

a. Hematological data must be collected and documented at or within 90 days of certification appointments for all children and women. If at least one other qualifying risk is present, collection of hematological data does not have to be performed and/or documented at the certification visit but may be deferred for up to 90 days. Deferral must be documented in the MIS.

(1) LAs that choose to implement the option to obtain results within 90 days of certification shall have in place a written procedure to assure that results are received, reviewed with participant, and documented in the MIS within 90 days of certification.
(2) In cases in which a participant fails to provide referral data, despite efforts by the LA to assist the participant in obtaining it, the participant is not to be terminated from the Program. In such cases, the LA must document in the MIS the attempts made to obtain the data and why these attempts failed.
(3) When the deferred hemoglobin results meet the criteria for Low Hemoglobin, the Competent Professional Authority (CPA) or Competent Paraprofessional Authority (CPPA) should document the change in risk status in the MIS in accordance with State guidance.

b. The LA must make arrangements to provide the required hematological testing at no charge to participants. This testing may be performed at the LA, contracted laboratories, or other outside sources. If the LA does not perform the tests, it must maintain records indicating that the cost of the service was paid by the LA. The LA is not responsible for costs incurred by participants who choose to have the test performed by another source when free service is available through the LA.

c. If the participant has had the required hematological testing done for reasons other than WIC certification, either at their own expense or paid by another program (such as Medical Assistance), the LA may secure and use that referral data for certification purposes. The LA is not expected to pay for this information unless the provider charges for transmitting the test information.

d. Hematological test results from a referring agency must be obtained in a verifiable format, include the date of the test, be reflective of a woman applicant's category (P, B, or N), and conform to the anemia screening schedule for infants and children. Referral hemoglobin data must be within 90 days of the participant’s certification or health evaluation appointment.

e. WIC participants must receive hematological testing as follows:

(1) Infants are not required to have a hematological test for anemia performed at initial certification if under 9 months of age. However, a hematological test must be performed on all infants between 9 and 12 months of age. Conducting the hematological test at the 1-year certification appointment is acceptable.
(2) Children must have a hematological test for anemia performed once between 12 and 24 months (preferably between 15 and 18 months) and once a year thereafter if hematological values are within normal limits. If the values are not within normal limits, the test must be repeated in six months.

(3) Blood work obtained on an infant, as described in e.(1) above, may be used to certify a 12-month-old as a child but may not be used to fulfill the blood test required between 12 and 24 months.
(4) Pregnant women must have at least one hematological test for anemia performed during the pregnancy for which they are certified.
(5) Breastfeeding women must have a hematological test performed after delivery (preferably at 4-6 weeks postpartum). It is recommended, but not required, that breastfeeding women who have a positive anemia screening result after delivery receive a follow-up blood test at or before the health evaluation appointment.
a. Women who discontinue breastfeeding within the first six months postpartum are not required to have a hematological test performed at the time they change participant category.
(6) Not Breastfeeding women must have a hematological test performed after delivery (preferably at 4-6 weeks postpartum).

f. The SA shall purchase both finger stick and non-invasive hematological testing equipment for use in all clinic laboratories.

g. Hematological testing performed by the LA shall be conducted according to hematological testing equipment instructions.

h. Both finger stick and non-invasive hemoglobin testing methods must be made available to participants by LAs according to the criteria outlined below.

i. Non-invasive hemoglobin testing must only be used if the applicant meets the following criteria:

(1) Has warm hands or is able to warm hands prior to testing.
(2) Is greater than or equal to 22 pounds.
(3) Is able to sit still for up to 2 minutes.
(4) Is less than 36 weeks gestation, if pregnant.
(5) Is greater than 4 weeks postpartum.
(6) Does not have dark or gel nail polish or fake nails.

j. If the applicant does not qualify for non-invasive hemoglobin testing, either the finger prick testing method must be completed or appropriate referral data must be obtained.

k. Exemptions to finger stick hemoglobin testing include:

(1) Medical conditions in which collecting a blood sample could harm the applicant (e.g. hemophilia, fragile bones, serious skin disorder).
(2) Religious objections.
(3) Participant does not consent.

l. The LA must secure the necessary hematological test results for persons with infectious diseases (e.g. HIV and hepatitis B) in the same manner as it does for other applicants. If performing finger stick testing on-site, follow safety measures outlined in Policy 3.11, Universal Precautions.

3. Nutrition Assessment:

**POLICY MANUAL**

5. WIC NUTRITION AND BREASTFEEDING SERVICES.

5.00. Nutrition and Risk Assessment.

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

(1) Anthropometric information (height/length, weight).
(2) Hematologic information.
(3) Health and medical history.
(4) Nutrition/Dietary information.
(5) Breastfeeding information, as appropriate.

b. Nutrition assessments are an integral part of the WIC Value Enhanced Nutrition Assessment (VENA) model. A thorough nutrition assessment shall be performed by a CPA or CPPA at all certification and health evaluation appointments to identify areas of concern.

c. All nutrition assessments of infants shall include breastfeeding practices as outlined in Policy 5.02, Breastfeeding Promotion and Support.

d. Nutrition assessment data shall be used as a basis for risk determination, planning and providing nutrition education, assisting with the guided goal setting process, tailoring food packages, and determining the need for referrals to other services.

e. Nutrition assessment data must be thoroughly documented in the MIS in accordance with State guidance.

f. Follow-up on information collected during nutrition assessments should be conducted at appointments subsequent to certifications and health evaluations. Updates to the nutrition assessment must be documented in the MIS in accordance with State guidance.

4. Screening and Referrals:

a. LA staff must screen all children for lead testing at approximately one year of age or at initial certifications for any child over 1 year of age. Although it is not required for LA staff to screen women participants for elevated blood lead levels, if an elevated blood lead level is reported, LA staff should document that in the MIS.

(1) If it is determined that a child has been tested for lead, LA staff must document that testing has been completed and enter the child's blood lead level in the MIS.
(2) If a child has a blood lead level within normal limits which is documented in the MIS, no further lead screening by LA staff is required unless a future nutrition assessment yields concern about lead.
(3) If a woman or child has an elevated blood lead level, LA staff must provide appropriate nutrition education and referrals and document each in the MIS. LA staff must re-screen children with elevated blood lead levels at each subsequent

certification and/or health evaluation until a normal blood lead level is reported and documented in the MIS. It is recommended to re-screen women with elevated blood lead levels at future appointments until a normal blood lead level is reported and documented in the MIS.

(4) LA staff must refer children who have not been tested for lead to a local lead testing program, such as those listed in the Community Services Brochure or other State-approved LA referral brochure, or their health care provider. LA staff must follow up at least annually until lead testing has occurred and results within normal limits are documented in the MIS.

b. LA staff must screen all infants and children 24 months of age and under at each certification and health evaluation appointment to ensure they are up-to-date on immunizations. Immunization screening includes, but is not limited to:

(1) Reviewing the immunization record of the child or infant at certification and health evaluation appointments to evaluate for compliance with CDC's most current Child and Adolescent Immunization Schedule. Note: Memory recall by the parent/guardian is not acceptable in place of the written or electronic record originating from the health care provider.
(2) Entering immunization information in the MIS, as appropriate.
(3) Providing a referral for immunization services, ideally to the child or infant's health care provider, should it be determined they are not up-to-date.
(4) Encouraging the parent/guardian to bring the child or infant's immunization record to their next certification or health evaluation appointment to determine compliance with CDC's Child and Adolescent Immunization Schedule.

c. LA staff must screen for substance use/abuse and provide information on the effects of substance use/abuse along with a brief explanation of why it is provided, at each certification and recertification appointment for all women participants and parents or caregivers of infant and child participants. If screening indicates the participant, parent or caregiver is abusing substances, verbal education and referrals to the appropriate treatment and counseling programs must also be provided. Substance use/abuse screening, information provided, verbal education and referrals must be documented in the MIS.

d. LA staff shall utilize the nutrition assessment to determine whether a participant is in need of referral to other resources and community services. When a referral is made, it must be documented in the MIS. LA staff shall follow-up on referrals made and document the follow-up in the MIS at the next appointment.

5. Nutrition Risk:

a. Nutrition risk is defined as:

(1) Detrimental or abnormal nutritional condition detectable by biochemical or anthropometric measurements;
(2) Other documented nutritionally related medical conditions;
(3) Dietary deficiencies or inappropriate dietary practices that impair or endanger health;
(4) Conditions that directly affect the nutritional health of a person, including alcoholism and drug abuse; or
(5) Situations that predispose persons to inadequate nutritional patterns or nutrition-related medical conditions, including, but not limited to

homelessness and migrancy.

b. The State agency shall establish and maintain standard nutrition risk criteria for each category of participants based on the Allowed Nutrition Risk Criteria promulgated by the United States Department of Agriculture.

c. The CPA or CPPA shall be responsible for determining participants' nutrition risk at each certification and assessing for updates to the assigned risks at each health evaluation.

(1) Risk determination shall be based on anthropometric, biochemical, clinical, dietary and environmental information available on the participant.
(2) WIC staff are responsible for accurately entering data into the MIS to facilitate both manual and auto-assignment of all applicable risk codes. Include the required documentation for all the nutrition risks identified in the MIS.

d. Use of the nutritional risk criterion "Prevention of Regression" is limited.

(1) The CPA or CPPA may use the criterion to continue a participant on the Program who is in danger of regressing to the nutrition risk criterion which was applied at the last certification.
(2) The CPA or CPPA may not use this criterion to:
   a. Initially enroll a participant.
   b. Continue a participant on the Program to prevent a condition which was not present or was not used to determine eligibility in the first place.
   c. Prevent a condition that will not occur during the new certification period, such as those specific to participant category or life stage.
(3) Prevention of regression may be used as a primary nutritional risk only. It may not be used if any other risks are present.
(4) Prevention of regression may not be used as the nutritional risk criterion for consecutive certification periods.
(5) Perform a complete nutrition assessment to rule out other risk factors before using "prevention of regression" to continue a participant on the Program. When Prevention of Regression is assigned, the risk factor(s) of which the participant is in danger of regressing must be documented in the MIS.

e. When using the nutritional risk criterion "Breastfeeding mother of an infant at nutritional risk" or "Breastfeeding infant of a mother at nutritional risk," a nutrition assessment for both the mother and infant must be completed to rule out other dietary risks.

(1) If both mother and infant have other identifiable dietary risks, certify each of them based on their own risks. Risk codes "Breastfeeding mother of an infant at nutritional risk" or "Breastfeeding infant of a mother at nutritional risk" may be used for either the mother or the infant when no other risk is present. "Breastfeeding mother of an infant at nutritional risk" and "Breastfeeding infant of a mother at nutritional risk" may not be the only risk code used to certify both mother and infant; the other in the pair must have at least one other risk code assigned.
(2) If the mother stops breastfeeding, reassess her nutritional risk to determine if she may remain on the Program. The infant may continue on the Program without reassessment of nutritional risk.

**POLICY MANUAL**

5. WIC NUTRITION AND BREASTFEEDING SERVICES.

5.00. Nutrition and Risk Assessment.

f. Use of the presumptive risks “Dietary risk associated with Complementary Feeding Practices” (for children 12-23 months old) and “Failure to Meet Dietary Guidelines for Americans” (for women and children 24 months and older) can only occur after a complete nutrition assessment has ruled out all other risks. Specific feeding practices for which the presumptive risks have been assigned must be documented in the MIS.

Reference(s):

1. WIC Regulations: 7 CFR, Part 246.7(e)
2. USDA Memo 92-10 Bloodwork Protocols.
3. FNS Instruction 803-2, Certification: Nutritional Risk/Participant Priority System, April 1, 1988.
4. Final WIC Policy Memo 2011-5, WIC Nutrition Risk Criteria
5. Child Nutrition Act of 1966: WIC Nutrition Risk Criteria | Food and Nutrition Service (usda.gov)
6. Substance Use Prevention: Screening, Education, and Referral Resource Guide for Local Agencies. USDA-FNS, FNS 276

Policy Status:

1. This Policy supersedes Policy Number 3.03 dated April 16, 2018.