



Memorandum

TO: WIC Regional Directors #08-163
WIC Local Agency Directors

FROM: Linda Brumble, Unit Manager (Original Signed)
Nutrition Education/Clinic Services Unit
Nutrition Services Section

DATE: December 12, 2008

SUBJECT: Policy Memo – *Revised Policies: to CS:18.0, Criteria for Nutrition Risk Conditions; CS:17.0, Documentation of a Complete Nutrition Assessment.*

Effective January 1, 2009, Texas WIC will implement the new and revised nutrition risk criteria described in revised policy ***CS:18.0, Criteria for Identifying Nutrition Risk Conditions***. Information on the new and revised risk codes will be presented through Interactive Distance Learning (IDL) classes. Changes to ***Policy CS:17.0, Documentation of a Complete Nutrition Assessment*** will also go into effect.

Summary of Changes

CS:18.0, Criteria for Nutrition Risk Conditions

Risk Code #904, Environmental Tobacco Smoke (ETS) Exposure is a new criterion for all categories.

Risk Code #371, Maternal Smoking – The most significant revision to this criterion is the inclusion of non-breastfeeding women in the category list of this risk.

Risk Code #348, Central Nervous System Disorders: The justification section was revised to include more information about how the diseases listed in the definition impact nutritional status and how WIC can help the participant manage their condition.

CS:17.0 I.B. Criteria for Nutrition Risk Conditions

Deleted: ***Risk Code 422, Inadequate Diet.***

CS:17.0 II.B History (Dietary Recall) Information

Deleted ***History (Dietary Recall) Information*** and replaced with **Utilizing the health history and interview, an assessment of applicants nutritional status shall be conducted.**

CS:17.0 II.C.4.a.i.

Replaced risk codes 419, 422, 424 and 425 with **401, 428 and 470.**

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CS:17.0 II.C.4.a.iv. and v.

May be self reported by applicant/participant/caregiver, or as reported or documented by a physician is replaced by **A written, signed statement by the health care provider, physician is required.**

Attached are the revised policies and beginning January 1, 2009, the policies will be available for download from the WIC website at: http://www.dshs.state.tx.us/wichd/policy/idx_policy.shtm.

Also, attached are the revised *Table of Contents* and risk code pages for the *Clinic Assessment Manual (CAM)*. Please provide copies for all staff and instruct them to remove all outdated risk codes pages from their CAM and to insert copies of the new/revised pages. The new participant forms also reflect the new and revised risk criteria; the implementation of the risk criteria is effective January 1, 2009.

The revised risk codes pages and the *Table of Contents* for the administrative version of the *Texas Risk Code Manual* will also be available on the WIC website January 1, 2009. The administrative version includes a reference section for each risk criteria that the CAM does not have. Please update your copy of the *Administrative Manual* by downloading the new/revised pages at: <http://www.dshs.state.tx.us/wichd/nut/risk-nut.shtm>.

If you have any questions or require additional information, please contact Lisa Rankine, Clinical Nutrition Specialist, Nutrition Education/Clinic Services Unit, at (512) 341-4582 or Lisa.Rankine@dshs.state.tx.us.

Attachments

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102	Underweight (Breastfeeding Women 6 months or more postpartum) (rev.10/02)
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103	Underweight (Infants, Children) (rev. 4/05)
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- 330 *General Obstetrical Risks*
331 Pregnancy at a Young Age (rev. 10/02)
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334 Lack of or Inadequate Prenatal Care (rev. 10/02)
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338 Pregnant Women Currently Breastfeeding (rev. 10/02)
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370 *Substance Abuse (Drugs, Alcohol, Tobacco)*

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- 401 Failure to Meet Dietary Guidelines for Americans (new 10/07)
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901 Recipient of Abuse (rev. 10/02)
902 Woman or Infant/Child of Primary Caregiver with Limited Ability to
Make Feeding Decisions and/or Prepare Food (rev. 5/03)
903 Foster Care (rev. 10/02)
904 Environmental Tobacco Smoke Exposure (rev. 6/07)

revised 12/08

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Effective January 1, 2009

Policy No. CS:17.0

Documentation of a Complete Nutrition Assessment

Purpose

To ensure accurate and thorough determination of eligibility for WIC benefits, and identification of all nutrition risk conditions.

Authority

7 CFR Part 246.7

Policy

Local agency (LA) staff shall perform a complete nutrition assessment on every WIC applicant who is categorically eligible and whose income and residence meet program guidelines. Supporting documentation of the complete nutrition assessment shall be available for audit/review.

Procedures

- I. A nutrition assessment shall be performed by a certifying authority (CA) or a WIC Certification Specialist (WCS). Other trained WIC staff may obtain measurements, blood tests and diet/health histories.
 - A. **Nutrition risk** factors shall be evaluated by a CA or WCS.
 - B. Every health/medical condition of nutrition risk for which a person can qualify shall be evaluated, with the exception of risk code 135, Inadequate Growth (refer to Clarifications/Guidelines, risk code 135 in the Texas Nutrition Risk Manual), risk code 201, Low Hemoglobin/Low Hematocrit (see II.C.4.a. in this policy), or risk code 114, At Risk of Becoming Overweight for Infants and Children (refer to clarification/guidelines for risk code 114 in the Texas Nutrition Risk Manual).

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- II. A nutrition assessment is considered complete when the following indicators of nutritional status have been evaluated:
- A. **Current weight and height/length** – all applicants.
 - 1. The weight and height/length shall be measured and plotted according to the instructions in the Guidelines for Nutrition Assessment.
 - 2. The code “999” for weight and “99 0/8” for length/height shall be entered in the Texas WIC system to indicate that measurements cannot be obtained using standard clinical equipment or from a healthcare provider.
 - 3. Documentation of why measurements were not obtained shall be included in the participant’s chart. Refer to Guidelines for Nutrition Assessment – Weighing and Measuring – Special Considerations.
 - B. **Diet Assessment** – all applicants.

Utilizing the health history and interview, an assessment of applicant’s nutritional status shall be conducted.
 - C. **Hemoglobin or hematocrit**--all applicants age six months of age or older.
 - 1. All infants and children being certified at ages 9 months to 24 months shall have a blood test to screen for iron deficiency:
 - a. Infants shall have a blood test between 9 – 12 months of age and again between 15 – 18 months of age.
 - b. Bloodwork may be performed on infants initially certified between 6 and 9 months of age if any of the following conditions apply. The reason for performing a blood test before the 9-12 month period shall be documented in the client’s chart.
 - i. The certifying authority (CA) determines blood work is required because the infant may be at nutritional risk, or
 - ii. The requirement to return to the clinic for blood work between 9 and 12 months presents a barrier for program participation.

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- c. Premature infants shall not have a blood test before 9 months corrected/ adjusted age.
 - d. All children shall have a blood test performed at least once every 12 months.
 2. Pregnant women shall have a blood test during their pregnancy. Postpartum and breastfeeding women shall have a blood test after the termination of their pregnancy.
 3. Analysis of iron status shall be performed according to the instructions in the Guidelines for Nutrition Assessment.
 4. Waiving the requirement for hemoglobin/hematocrit. The reason for waiving the blood test shall be documented in the client's chart.
 - a. The following exceptions are the only circumstances that would preclude a blood test to screen for iron deficiency.
 - i. Children ages 2 to 5 years of age who, at the previous certification, only qualified for risk code 401 Failure to Meet Dietary Guidelines, 428 Risk Associated with complementary Feeding Practices, or 470 Inappropriate Nutrition Practices, and had a hemoglobin/hematocrit test within the normal range (hemoglobin: 11.1 g/dL or greater, hematocrit: 33.0% or greater). LAs are responsible for ensuring that a blood test is performed on these children at least once every 12 months.
 - ii. Applicants who bring a written result of a hemoglobin/ hematocrit test that was obtained from another agency/program or a private physician's office: Hematological data must not be collected more than 30 days prior to the certification appointment for infants, and more than 60 days for all other applicants.
 - iii. Applicants whose religious beliefs do not allow them to have blood drawn. A statement of refusal to have blood drawn shall be included in the applicant's certification file. Acceptable

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- documentation includes a written, signed statement by the parent/ caretaker or applicant, or written documentation by the WIC staff that is signed by the parent/ caretaker or applicant.
- iv. Applicants with "life long" medical conditions such as hemophilia, fragile bones, or osteogenesis imperfecta. A written, signed statement by the health care provider, physician or someone working under a physician's orders is required.
 - v. Applicants with a treatable skin disease or with a serious skin condition, where the blood collection may cause harm to the applicant. A written, signed statement by the healthcare provider, physician or someone working under a physician's orders is required.
- b. When a blood test is not performed, or waived, a true value for hemoglobin or hematocrit cannot be entered into the computer.
- i. For infants certified at 7 or 8 months of age (exception C.1.b.i through ii), enter the following values in the Texas WIN automated system: 78.0 for hemoglobin or 78 for hematocrit,
 - ii. Exceptions i, iii through v, enter the following values in the Texas WIN automated system: 99.9 for hemoglobin or 99 for hematocrit.
 - iii. Do not use low hemoglobin/hematocrit as a condition of nutrition risk.
- D. **Health History (Medical/Maternal history)** - all applicants.
- 1. Nutrition risk conditions related to medical/maternal history shall be assessed according to the instructions in the Guidelines for Nutrition Assessment. A health history shall be completed for each certification.

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2. For applicants certified as pregnant women, a medical/maternal history shall be completed during the pregnancy, and for applicants certified as postpartum and breastfeeding women, a medical/maternal history shall be collected after the termination of the pregnancy.

III. **Medical/nutrition data** previously obtained in the WIC clinic or from a health care source or a referral may be used to evaluate the applicant's nutritional status.

- A. Medical data for women and children (i.e., weight, height/length measurement, hemoglobin/hematocrit values and diet assessment) may be used for determining nutrition risk for a full certification period, if it is not more than 60 days when eligibility is determined. Medical data for applicants certified as pregnant women shall have been collected during their pregnancy, and data for applicants certified as postpartum and breastfeeding women shall have been collected after the termination of their pregnancies.
- B. Medical data for infants (i.e., weight, height/length measurement, hemoglobin/hematocrit values and diet assessment) may be used for determining nutrition risk for a full certification period if it is not more than 30 days when eligibility is determined, with the exception of birth data.
 1. The birth weight and length of an infant shall not be accepted for certification purposes after the infant is two weeks of age.
 2. When an infant is older than two weeks of age, a current weight and length must be obtained. The birth weight and length shall be plotted in addition to current weight and length.
 3. To certify an infant that is not physically present, obtain and plot the birth weight and length, or more current data, whichever is appropriate based on the age of the infant. To prevent termination of WIC services, the infant shall be presented by six weeks of age to be weighed and

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measured, and the current weight and length shall be plotted. For infants with special health care needs, see section IV. below.

- C. Medical data submitted from a source other than the local WIC agency:
 - 1. Shall be in writing, and include the signature and title of the health professional submitting the data and date measurements were obtained; or
 - 2. If information is obtained via telephone by LA, staff shall document the name of the health care professional, title and date data was obtained.

- IV. When an applicant has **special health care needs**, special accommodations may be made in obtaining medical/nutrition data to evaluate the applicant's nutritional status. Refer to Policy CR:07.0 for the definition of special health care needs and procedures to follow in these circumstances. Refer to Policy CS:04.0 for appropriate waivers, if necessary.

- V. Documentation of a complete nutrition assessment shall be maintained in each income-eligible applicant's record and shall be available for audit/review.

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Criteria For Identifying Nutrition Risk Conditions

Purpose

To provide benefits to meet the special health and nutrition needs of low-income pregnant, breastfeeding and postpartum women, infants, and children. WIC provides supplemental foods and nutrition education to participants at nutrition risk during the critical growth and development periods of pregnancy, infancy, and early childhood.

Authority

7 CFR Part 246.7

Policy

To be eligible for program benefits, all WIC Program applicants shall have a nutrition risk condition identified through the documentation of a complete nutrition assessment.

Procedures

- I. When determining eligibility, compare all data from the applicant's health history, dietary, biomedical, and anthropometric assessment to the risk conditions listed in the Texas Nutrition Risk Manual. The criteria listed in this policy reflect allowable risk conditions. The Texas Nutrition Risk Manual provides the definition, justification, clarifications/guidelines and references about each of the risk conditions.

- II. Every condition of nutrition risk identified shall be marked on the back of the category specific state agency (SA) Participant Form (titled WIC Nutrition Risk Codes). Every risk code marked on the Participant Form shall have supporting documentation, e.g., growth charts, diet and health history forms.

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Guidelines

List of Allowable Nutrition Risk Conditions

The allowable nutrition risk conditions are subsequently listed by category. These risk conditions are in accordance with the national risk conditions identified and required by the United States Department of Agriculture (USDA). See the Texas Nutrition Risk Manual for complete definitions, clarification and justification of each risk criteria.

Pregnant Women

Anthropometric - Priority I

- 101 Underweight
- 111 Overweight
- 131 Low Maternal Weight Gain
- 132 Maternal Weight Loss During Pregnancy
- 133 High Maternal Weight Gain

Biochemical - Priority I

- 201 Low Hematocrit/Low Hemoglobin
- 211 Lead Poisoning

Clinical/Health/Medical - Priority I

Pregnancy-Induced Conditions

- 301 Hyperemesis Gravidarum
- 302 Gestational Diabetes
- 303 History of Gestational Diabetes

Delivery of Low-Birth weight/Premature Infant

- 311 History of Preterm Delivery
- 312 History of Low Birth Weight

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Prior Stillbirth Fetal or Neonatal Death

- 321 History of Spontaneous Abortion (two or more terminations of less than 20 weeks gestation or less than 500 grams), Fetal (20 weeks or greater gestation) or Neonatal Loss (28 days or less of life)

General Obstetrical Risk

- 331 Pregnancy at a Young Age
- 332 Closely Spaced Pregnancies
- 333 High Parity and Young Age
- 334 Lack of or Inadequate Prenatal Care
- 335 Multifetal Gestation
- 336 Fetal Growth Restriction (FGR)
- 337 History of Birth of a Large for Gestational Age Infant
- 338 Pregnant Woman Currently Breastfeeding
- 339 History of Birth with Nutrition Related Congenital or Birth Defect

Nutrition-Related Risk Conditions (Chronic disease, Genetic Disorder, Infection)

- 341 Nutrient Deficiency
- 342 Gastro-Intestinal Disorders
- 343 Diabetes Mellitus
- 344 Thyroid Disorders
- 345 Hypertension
- 346 Renal Disease
- 347 Cancer
- 348 Central Nervous System Disorders
- 349 Genetic and Congenital Disorders
- 351 Inborn Errors of Metabolism
- 352 Infectious Diseases
- 353 Food Allergy
- 354 Celiac Disease
- 355 Lactose Intolerance
- 356 Hypoglycemia
- 357 Drug Nutrient Interactions
- 358 Eating Disorders
- 359 Recent Major Surgery, Trauma, or Burns

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- 360 Other Medical Conditions
- 361 Depression
- 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat

Substance Use (Drugs, Alcohol, Tobacco)

- 371 Maternal Smoking
- 372 Any Alcohol Use in Current Pregnancy
- 373 Any Illegal Drug Use in Current Pregnancy

Other Health Risks

- 381 Dental Problems

Dietary - Priority IV

- 401 Failure to Meet *Dietary Guidelines for Americans*
- 480 Inappropriate Nutrition Practices for Women

Other Risks - Refer to each risk condition for priority level

Regression/Transfer

- 502 Transfer of Certification - No priority

Homelessness/Migrancy

- 801 Homelessness – Priority IV
- 802 Migrancy – Priority IV

Other Nutrition Risks

- 901 Recipient of Abuse (within past six months) – Priority IV
- 902 Woman with Limited Ability to Make Feeding Decisions and/or Prepare Food – Priority IV
- 903 Foster Care – Priority IV
- 904 Environmental Tobacco Smoke Exposure – Priority I

Breastfeeding Women - A woman is considered a breastfeeding woman if she nurses the infant at least once a day.

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Anthropometric - Priority I

- 101 Underweight – less than 6 months postpartum
- 102 Underweight – greater than or equal to 6 months postpartum
- 111 Overweight – less than 6 months postpartum
- 112 Overweight – greater than or equal to 6 months postpartum
- 133 High Gestational Weight Gain in Most Recent Pregnancy

Biochemical- Priority I

- 201 Low Hematocrit/Low Hemoglobin
- 211 Lead Poisoning

Clinical/Health/Medical - Priority I

Pregnancy-Induced Conditions

- 303 Gestational Diabetes

Delivery of Low-Birth weight/Premature Infant

- 311 History of Preterm Delivery
- 312 History of Low Birth Weight

Prior Stillbirth, Fetal or Neonatal Death

- 321 History of Spontaneous Abortion (termination of less than 20 weeks gestation or less than 500 grams), Fetal (20 weeks or greater gestation) or Neonatal Loss (28 days or less of life)

General Obstetrical Risks

- 331 Pregnancy at a Young Age
- 332 Closely Spaced Pregnancies
- 333 High Parity and Young Age
- 335 Multifetal Gestation
- 337 History of Birth of a Large for Gestational Age Infant
- 339 History of Birth with Nutrition Related Congenital or Birth Defect

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Nutrition-Related Risk Conditions (E.g. Chronic Disease, Genetic Disorder, Infection)

- 341 Nutrient Deficiency Diseases
- 342 Gastro-Intestinal Disorders
- 343 Diabetes Mellitus
- 344 Thyroid Disorders
- 345 Hypertension
- 346 Renal Disease
- 347 Cancer
- 348 Central Nervous System Disorders
- 349 Genetic and Congenital Disorders
- 351 Inborn Errors of Metabolism
- 352 Infectious Diseases
- 353 Food Allergy
- 354 Celiac Disease
- 355 Lactose Intolerance
- 356 Hypoglycemia
- 357 Drug Nutrient Interactions
- 358 Eating Disorders
- 359 Recent Major Surgery, Trauma, or Burns
- 360 Other Medical Conditions
- 361 Depression
- 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat

Substance Use (Drugs, Alcohol, Tobacco)

- 371 Maternal Smoking
- 372 Alcohol
- 373 Any Current Illegal Drug Use

Other Health Risks

- 381 Dental Problems

Dietary - Priority IV

- 401 Failure to Meet *Dietary Guidelines for Americans*

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480 Inappropriate Nutrition Practices for Women

Other Risks - Refer to each risk condition for priority level

Regression/Transfer

501 Possibility of Regression - Priority IV

502 Transfer of Certification - No priority

Breastfeeding Mother/Infant Dyad

601 Breastfeeding Mother of Infant at Nutrition Risk - Priority I, II or IV depending on infant's priority. Use only if no other risk condition is identified.

602 Breastfeeding Complications or Potential Complications - Priority I

Homelessness/Migrancy

801 Homelessness - Priority IV

802 Migrancy - Priority IV

Other Nutrition Risks

901 Recipient of Abuse (within past six months) - Priority IV

902 Woman with Limited Ability to Make Feeding Decisions and/or Prepare Food - Priority IV

903 Foster Care - Priority IV

904 Environmental Tobacco Smoke Exposure - Priority I

Postpartum Women

Anthropometric - Refer to each risk condition for priority level

101 Underweight - Priority III

111 Overweight - Priority VI

133 High Gestational Weight Gain in Most Recent Pregnancy (singleton only) - Priority VI

Biochemical - Priority III

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- 201 Low Hematocrit/Low Hemoglobin
- 211 Lead Poisoning

Clinical/Health/Medical - Priority III

Pregnancy-Induced Conditions

- 303 Gestational Diabetes in most recent pregnancy

Delivery of Low-Birth weight/Premature Infant

- 311 History of Preterm Delivery
- 312 History of Low Birth Weight

Prior Stillbirth, Fetal or Neonatal Death

- 321 History of Spontaneous Abortion (termination of less than 20 weeks gestation or less than 500 grams), Fetal (20 weeks or greater gestation) or Neonatal Loss (28 days or less of life)

General Obstetrical Risks

- 331 Pregnancy at a Young Age
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Nutrition-Related Risk Conditions (E.g. Chronic Disease, Genetic Disorder, Infection)

- 341 Nutrient Deficiency Diseases
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 - 345 Hypertension
 - 346 Renal Disease
 - 347 Cancer
 - 348 Central Nervous System Disorders
 - 349 Genetic and Congenital Disorders
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- 351 Inborn Errors of Metabolism
- 352 Infectious Diseases
- 353 Food Allergy
- 354 Celiac Disease
- 355 Lactose Intolerance
- 356 Hypoglycemia
- 357 Drug Nutrient Interactions
- 358 Eating Disorders
- 359 Recent Major Surgery, Trauma, or Burns
- 360 Other Medical Conditions
- 361 Depression
- 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat

Substance Use (Drugs, Alcohol)

- 371 Maternal Smoking
- 372 Alcohol
- 373 Any Current Illegal Drug Use

Other Health Risks

- 381 Dental Problems

Dietary - Priority VI

- 401 Failure to Meet *Dietary Guidelines for Americans*
- 480 Inappropriate Nutrition Practices for Women

Other Risks - Refer to each risk condition for priority level

Regression/Transfer

- 501 Possibility of Regression - Priority VII
- 502 Transfer of Certification- No priority

Homelessness/Migrancy

- 801 Homelessness - Priority VI
 - 802 Migrancy - Priority VI
-

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Other Nutrition Risks

- 901 Recipient of Abuse - Priority VI
- 902 Woman with Limited Ability to Make Feeding Decisions and/or Prepare Food - Priority VI
- 903 Foster Care - Priority VI
- 904 Environmental Tobacco Smoke Exposure – Priority III

Infants

Anthropometric - Priority I

- 103 Infant Underweight
- 104 Infant at Risk of Becoming Underweight
- 114 Infant At Risk of Becoming Overweight
- 121 Short Stature
- 122 Infant at Risk of Short Stature
- 134 Failure to Thrive (FTT)
- 135 Inadequate Growth
- 141 Low Birth Weight
- 142 Prematurity
- 143 Very Low Birth Weight
- 151 Small for Gestational Age
- 152 Low Head Circumference
- 153 Large for Gestational Age

Biochemical - Priority I

- 201 Low Hematocrit/Low Hemoglobin
- 211 Lead Poisoning

Clinical/Health/Medical - Priority I

Nutrition-Related Risk Conditions (E.g., Chronic Disease, Genetic Disorder, Infection)

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- 341 Nutrient Deficiency Diseases
- 342 Gastro-Intestinal Disorders
- 343 Diabetes Mellitus
- 344 Thyroid Disorders
- 345 Hypertension
- 346 Renal Disease
- 347 Cancer
- 348 Central Nervous System Disorders
- 349 Genetic and Congenital Disorders
- 350 Pyloric Stenosis
- 351 Inborn Errors of Metabolism
- 352 Infectious Diseases
- 353 Food Allergy
- 354 Celiac Disease
- 355 Lactose Intolerance
- 356 Hypoglycemia
- 357 Drug Nutrient Interactions
- 359 Recent Major Surgery, Trauma, or Burns
- 360 Other Medical Conditions
- 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat

Other Health Risks

- 381 Dental Problems
- 382 Fetal Alcohol Syndrome (FAS)

Dietary - Priority IV

- 428 Dietary risk Associated with Complementary Feeding Practices (4 to 12 months)
- 460 Inappropriate Nutrition Practices for Infants

Other Risks - Refer to each risk condition for priority level

Regression/Transfer

- 502 Transfer of Certification - No priority
-

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Breastfeeding Mother/Infant Dyad

603 Breastfeeding Complications or Potential Complications - Priority I

Infant of a WIC-Eligible Mother or Mother at Risk During Pregnancy

701 Infant Up to 6 Months Old of WIC Mother - Priority II

702 Breastfeeding Infant of Woman at Nutrition Risk - Priority I, II, or IV depending on woman's priority level. Use only if no other risk condition is identified.

703 Infant Born of Woman with Mental Retardation or Alcohol or Drug Abuse (most recent pregnancy) - Priority I

704 Infant Up to 6 Months of a Woman Who Would Have Been Eligible During Pregnancy.

Priority II

Homelessness/Migrancy

801 Homelessness - Priority IV

802 Migrancy - Priority IV

Other Nutrition Risks

901 Recipient of Abuse (within past six months). Priority IV Abuse in infants refers to abuse and neglect.

902 Infant of Woman or Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food - Priority IV

903 Foster Care - Priority IV

904 Environmental Tobacco Smoke Exposure - Priority I

Children

Anthropometric - Priority III

103 Child Underweight

104 Child At Risk of Becoming Underweight

113 Child Overweight (2-5 Years of Age)

114 Child At Risk of Becoming Overweight

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- | _121 Short Stature
- 122 Child At Risk of Short Stature
- 134 Failure to Thrive (FTT)
- 135 Inadequate Growth
- 141 Low Birth Weight
- 142 Prematurity
- 143 Very Low Birthweight
- 151 Small for Gestational Age

Biochemical - Priority III

- 201 Low Hematocrit/Low Hemoglobin
- 211 Lead Poisoning

Clinical/Health/Medical - Priority III

Nutrition-Related Risk Conditions (E.g., Chronic Disease, Genetic Disorder, Infection)

- 341 Nutrient Deficiency Diseases
 - 342 Gastro-Intestinal Disorders
 - 343 Diabetes Mellitus
 - 344 Thyroid Disorders
 - 345 Hypertension
 - 346 Renal Disease
 - 347 Cancer
 - 348 Central Nervous System Disorders
 - 349 Genetic and Congenital Disorders
 - 351 Inborn Errors of Metabolism
 - 352 Infectious Diseases Within Past Six Months
 - 353 Food Allergy
 - 354 Celiac Disease
 - 355 Lactose Intolerance
 - 356 Hypoglycemia
 - 357 Drug Nutrient Interactions
 - 359 Recent Major Surgery, Trauma, or Burns
 - 360 Other Medical Conditions
-

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- 361 Depression
- 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat

Other Health Risks

- 381 Dental Problems
- 382 Fetal Alcohol Syndrome (FAS)

Dietary - Priority V

- 401 Failure to Meet Dietary Guidelines (2-5 years of age)
- 428 Dietary Risk Associated with Complementary Feeding Practices (12 through 23 months)
- 470 Inappropriate Nutrition Practices for Children

Other Risks - Refer to each risk condition for priority level

Regression/Transfer

- 501 Possibility of Regression - Priority VII
- 502 Transfer of Certification - No priority

Homelessness/Migrancy

- 801 Homelessness - Priority V
- 802 Migrancy - Priority V

Other Nutrition Risks

- 901 Recipient of Child Abuse (within past six months). Priority V. Abuse in children refers to abuse and neglect.
- 902 Child of Woman or Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food - Priority V
- 903 Foster Care - Priority V
- 904 Environmental Tobacco Smoke Exposure - Priority III

Environmental Tobacco Smoke Exposure (also known as passive, secondhand or involuntary smoke) – (P, B, N, I, C)

**Definition/
cut-off value**

Environmental tobacco smoke (ETS) exposure is defined (for WIC eligibility purposes) as exposure to smoke from tobacco products inside the home. *(1,2,3)

* See Clarification for background information.

Justification

ETS is a mixture of the smoke given off by a burning cigarette, pipe, or cigar (sidestream smoke), and the smoke exhaled by smokers (mainstream smoke). ETS is a mixture of about 85% sidestream and 15% mainstream smoke (4) made up of over 4,000 chemicals, including Polycyclic Aromatic Hydrocarbons (PAHs) and carbon monoxide (5). Sidestream smoke has a different chemical make-up than main-stream smoke. Sidestream smoke contains higher levels of virtually all carcinogens, compared to mainstream smoke (6). Mainstream smoke has been more extensively researched than sidestream smoke, but they are both produced by the same fundamental processes.

ETS is qualitatively similar to mainstream smoke inhaled by the smoker. The 1986 Surgeon General's report: *The Health Consequences of Involuntary Smoking. A Report of the Surgeon General* concluded that ETS has a toxic and carcinogenic potential similar to that of the mainstream smoke (7). The more recent 2006 Surgeon General's report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*, reaffirms and strengthens the findings of the 1986 report, and expands the list of diseases and adverse health effects caused by ETS (8).

ETS is a known human carcinogen (2). Women who are exposed to ETS are at risk for lung cancer and cardiovascular diseases (9). Prenatal or postnatal ETS exposure is related to numerous adverse health outcomes among infants and children, including sudden infant death syndrome (SIDS) (10, 11), upper respiratory infections (12), periodontal disease (13), increased severity of asthma/wheezing (12), metabolic syndrome (14), decreased cognitive function (15), lower birth weight and smaller head circumference (16). Infants born to women exposed to ETS during pregnancy have a small decrease in birth weight and a slightly increased risk of intrauterine growth retardation compared to infants of unexposed women (17).

Studies suggest that the health effects of ETS exposure at a young age could last into adulthood. These include cancer (18), specifically lung cancer (19, 20), and cardiovascular diseases (14, 21, 22,). There is strong evidence that ETS exposure to the fetus and/or infant results in permanent lung damage (23, 24, 25, 26).

ETS exposure increases inflammation and oxidative stress (27, 28, 29). Inflammation is associated with asthma (30), cardiovascular diseases (31, 32), cancer (33), chronic obstructive pulmonary disease (34), and metabolic syndrome (14, 35). PAHs are the major class of compounds that contribute to the ETS-related adverse health outcomes. These compounds possess potent carcinogenic and immunotoxic properties that aggravate inflammation.

Oxidative stress is a general term used to describe the steady state of oxidative damage caused by highly reactive molecules known as free radicals. The free radicals can be generated both during the normal metabolic process and from ETS and other environmental pollutants. When free radicals are not neutralized by antioxidants, they can cause oxidative damage to the cells. This damage has been implicated in the cause of certain diseases. ETS provokes oxidant damage similar to that of active smoking (36).

Antioxidants may modulate oxidative stress-induced lung damage among both smokers and non-smokers (22, 27-29, 37-40). Fruits and vegetables are the major food sources of antioxidants that may protect the lung from oxidative stress (1). Research indicates that consuming fruits and vegetables is more beneficial than taking antioxidant supplements (1). This suggests that other components of fruits and vegetables may be more relevant in protecting the lung from oxidative stress. Dietary fiber is also thought to contribute to the beneficial health effects of fruits and vegetables (1).

The Institute of Medicine (IOM) reports that an increased turnover in vitamin C has been observed in nonsmokers who are regularly exposed to tobacco smoke (41). The increased turnover results in lowered vitamin C pools in the body. Although there are insufficient data to estimate a special requirement for non-smokers regularly exposed to ETS, the IOM urges those individuals to ensure that they meet the Recommended Dietary Allowance for vitamin C (36, 41).

The WIC food package supplements the participant intake of vitamin C. In addition, many WIC State Agencies participate in the WIC Farmers' Market Nutrition Program, which provides coupons for participants to purchase fresh fruits and vegetables. WIC Program benefits also include counseling to increase fruit and vegetable consumption, and to promote a healthy lifestyle, such as protecting participants and their children from ETS exposure. WIC staff may also make appropriate referrals to participants, and/or their caregivers, to other health and social services, such as smoking cessation programs.

Clarification

In a comprehensive scientific report, the Surgeon General concluded that there is no risk-free level of exposure to secondhand smoke (8). However, for the purpose of risk identification, the definition used for this risk criterion is based on the Centers for Disease Control and Prevention (CDC) Pediatric Nutrition Surveillance System (PedNSS) and the Pregnancy Nutrition Surveillance System (PNSS) questions to determine Environmental Tobacco Smoke (ETS) exposure:

1. Does anyone living in your household smoke inside the home? (infants, children)
2. Does anyone else living in your household smoke inside the home? (women)

Because the definition used by other Federal agencies for ETS exposure is specific to “inside the home” and has been validated (3), the definition used for WIC eligibility must also be as specific. In addition, FNS encourages the use of the PedNSS and PNSS ETS exposure questions for WIC nutrition assessment.

There are other potential sources of ETS exposure, such as work and day care environments. However, no other validated questions/definitions could be found that were inclusive of other environments and applicable to WIC.

Maternal Smoking – (P, B, N)

**Definition/
cut-off value**

Any smoking of tobacco products, i.e., cigarettes, pipes, or cigars.

Justification

Research has shown that smoking during pregnancy causes health problems and other adverse consequences for the mother, the unborn fetus and the newborn infant such as: pregnancy complications, premature birth, low-birth-weight, stillbirth, infant death, and risk for Sudden Infant Death Syndrome (SIDS) (1). Women who smoke are at risk for chronic and degenerative diseases such as: cancer, cardiovascular disease and chronic obstructive pulmonary disease. They are also at risk for other physiological effects such as loss of bone density (2).

Maternal smoking exposes the infant to nicotine and other compounds, including cyanide and carbon monoxide, in-utero and via breastmilk (3). In-utero exposure to maternal smoking is associated with reduced lung function among infants (4). In addition, maternal smoking exposes infants and children to environmental tobacco smoke (ETS). (See #904, Environmental Tobacco Smoke).

Because smoking increases oxidative stress and metabolic turnover of vitamin C, the requirement for this vitamin is higher for women who smoke (5). The WIC food package provides a good source of vitamin C. Women who participate in WIC may also benefit from counseling and referral to smoking cessation programs.

Central Nervous System Disorders – (P, B, N, I, C)

Definition/ cut-off value

Conditions which affect energy requirements, ability to feed self, or alter nutritional status metabolically, mechanically, or both. These include, but are not limited to:

- epilepsy
- cerebral palsy (CP)
- neural tube defects (NTDs), such as spina bifida
- 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.

Justification

Epileptics are at nutrition risk due to alterations in nutritional status from prolonged anti-convulsion therapy, inadequate growth, and physical injuries from seizures (1). The ketogenic diet has been used for the treatment of refractory epilepsy in children (2). However, children on a ketogenic diet for six months or more have been observed to have slower gain in weight and height (3,4). Growth monitoring and nutrition counseling to increase energy and protein intakes while maintaining the ketogenic status are recommended (4). In some cases, formula specifically prepared for children on a ketogenic diet is necessary. Women on antiepileptic drugs (AEDs) present a special challenge. Most AEDs have been associated with the risk of neural tube defects on the developing fetus. Although it is unclear whether folic acid supplementation protects against the embryotoxic and teratogenic effects of AEDs, folic acid is recommended for women with epilepsy as it is for other women of childbearing age (5-7).

Oral motor dysfunction is associated with infants and children with cerebral palsy (CP). These infants and children often have poor growth due to eating impairment, such as difficulty in spoon feeding, biting, chewing, sucking, drinking from a cup and swallowing.

Rejection of solid foods, choking, coughing, and spillage during eating are common among these children (8,9). Growth monitoring and nutrition counseling to modify food consistency and increase energy and nutrient intakes are recommended. Some children may require tube feeding and referral to feeding clinics, where available.

Limited mobility or paralysis, hydrocephalus, limited feeding skills, and genitourinary problems, put children with neural tube defects (NTDs) at increased risk of abnormal growth and development. Ambulatory disability, atrophy of the lower extremities, and short stature place NTDs affected children at high risk for increased body mass index (10). Growth monitoring and nutrition counseling for appropriate feeding practices are suggested.

In some cases, participants with Parkinson's disease require protein redistribution diets to increase the efficacy of the medication used to treat the disease (11). Participants treated with levodopa-carbidopa may also need to increase the intake of B vitamins (12). Participants with Parkinson's disease will benefit from nutrition education/counseling on dietary protein modification, which emphasizes adequate nutrition and meeting minimum protein requirements. Additionally, since people with Parkinson's often experience unintended weight loss (13), it is important to monitor for adequate maternal weight gain.

Individuals with multiple sclerosis (MS) may experience difficulties with chewing and swallowing that require changes in food texture in order to achieve a nutritionally adequate diet (14). Obesity and malnutrition are frequent nutrition problems observed in individuals with MS. Immobility and the use of steroids and anti-depressants are contributing factors for obesity. Dysphagia, adynamia, and drug therapy potentially contribute to malnutrition. Both obesity and malnutrition have detrimental effects on the course of the disease. Adequate intakes of polyunsaturated fatty acids, vitamin D, vitamin B₁₂ and a diet low in animal fat have been suggested to have beneficial effects in relapsing-remitting MS (15-17). Breastfeeding advice to mothers with MS has been controversial. However, there is no evidence to indicate that breastfeeding has any deleterious effect on women with MS. In fact, breastfeeding should be encouraged for the

health benefits to the infant (18). In addition, mothers who choose to breastfeed should receive the necessary support to enhance breastfeeding duration.

As a public health nutrition program, WIC plays a key role in health promotion and disease prevention. As such, the nutrition intervention for participants with medical conditions should focus on supporting, to the extent possible, the medical treatment and/or medical/nutrition therapy a participant may be receiving. Such support may include: investigating potential drug-nutrient interactions; inquiring about the participant's understanding of a prescribed special diet; encouraging the participant to keep medical appointments; tailoring the food package to accommodate the medical condition; and referring the participant to other health and social services.

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.
