Section 5.3: Nutrition Risk Assessment

12/2023

Nutrition Risk Assessment Overview

References: WIC Policy Memo #98-9, 7 CFR 246.7(e) (1)-(3)

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

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

The nutrition risk assessment includes an evaluation of:

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

Procedures

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

1. Accurately collect anthropometric, hematologic, health and dietary information. *Anthropometric* and *hematologic* assessments should be done ***first*.** Identifying any height, weight, or blood-iron concerns first, provides a context for assessment information collected in the Information System.
    - Anthropometric and hematologic information should be obtained using standard procedures outlined in the anthropometric and hematologic assessment policies.
    - Health and dietary information must be collected using the questions in the Information System. Probing questions should be used as appropriate to collect relevant, accurate information. This helps the CPA assess a participant's health, nutrition practices, cultural values, preferences, and other pertinent areas.

2. Clarify and synthesize the information that has been collected.
3. Identify and assign all applicable risk codes and any other relevant concerns.
4. Document the assessment in the Information System, including all applicable risk codes.
5. Follow up on previous assessments, as appropriate.
6. ***After*** all components of the WIC assessment are completed, provide education based on highest priority risk conditions and participant's interests. *Note:* it is not expected, nor is it recommended, that all nutrition risks be addressed (i.e., counseled/educated on) at the initial certification. See Guidance.

Guidance

A value-enhanced nutrition assessment (VENA) requires:

- A systematic approach to collecting and evaluating information provided by participants
- Good communication skills and an ability to establish rapport with each participant
- Knowledge of nutrition and breastfeeding
- Critical thinking

1. It is best practice to review previous assessments and relevant notes in the participant's record prior to beginning the new assessment.
2. To enhance the value of the assessment, it is critical the assessment be conducted in space that provides privacy to participants.
3. *Only after* all information has been reviewed and all nutrition risks identified, should education or counseling be provided.
    - Conclusions based on incomplete information might be incorrect.
    - Education based on incorrect conclusions is likely to be inappropriate.

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

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

Section 5.3.1: Anthropometric Data

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

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

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

Procedures

1. **Local agency staff must obtain anthropometric data either by:**
   - Measuring height/length and weight using appropriate equipment and following the procedures described in the Minnesota WIC Program Anthropometric Manual ***or***
   - Obtaining anthropometric data from a medical provider through referral. **See** Section 5.3.1.1 below **– Use of Referral Weight and Height/Length Data**. Self-reported anthropometric information may not be used.

   Procedures for measuring height/length and weight are described in the Minnesota WIC Program Anthropometric Manual (Part II, pages 11 – 36):
   - Measuring recumbent length of infants and young children, page 11
   - Weighing children younger than 24 months of age, page 18
   - Measuring standing height of older children and adults, page 24
   - Weighing older children and adults, page 29
2. **Local agency staff must accurately record anthropometric data in the Information System, documenting:**
   - Date measurements were taken and
   - Whether the length/height was measured in standing or recumbent position
3. **CPA staff must assess anthropometric data using the appropriate assessment tools.**
   - Using the growth charts displayed in the Information System, assess anthropometric data for Infants and children and assign risk codes**.**
     - **For infants and children < 24 months of age**: weigh and measure recumbent length. The Information System will plot length-for-age, weight-for-age, and weight-for-length.
     - **For children between 24 and 36 months of age**, either recumbent length ***or*** standing height (preferred) can be measured. Refer to the Minnesota WIC Program Anthropometric Manual for information and guidance on selecting appropriate measurement (height or length).

- If *height* is measured, *standing* must be indicated in the Information System and the system will display and plot BMI-for-age.
- If *length* is measured, *recumbent* must be indicated in the Information System and the system will display and plot weight-for-length.

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

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

- **Women's anthropometric data** will be assessed based on the National Academies of Sciences' recommendations in their report: Weight Gain During Pregnancy: Reexamining the Guidelines.
  - The Information System will display the grid appropriate for the woman's weight status (underweight, normal weight, overweight, or obese). Refer to the Minnesota WIC Program Anthropometric Manual for information and guidance on using and interpreting pregnancy weight gain charts.
    - For pregnant women and women < 6 months postpartum, *pre-pregnancy* BMI is used to assess weight status.
    - For breastfeeding women ≥ 6 months postpartum, *current* BMI is used to assess weight status.
  - Staff should assess the woman's weight gain during her pregnancy if currently pregnant, and total amount of weight gained if Postpartum.

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

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

Guidance

- All participants, including women, must be measured and weighed. **Self-reported height and/or weight may not be used**.
- If a woman is > 20 years of age, staff need measure her height only once (typically at her at her initial certification).

- Each time height/length and weight are measured, a single measurement is adequate when care is taken to assure that proper measuring techniques are used. Staff need not measure more than once.
- Whenever there is any doubt about the accuracy of a measurement (including measurements obtained by referral), staff should re-measure. Errors could occur in measuring, reporting, plotting, or entry into the Information System.
    - If an accurate measure is not possible (e.g., child is wearing a cast or is very uncooperative), mark that the measure may not be accurate and select the appropriate reason for the inaccuracy. Document additional information about the suspected inaccuracy in the Notes section.
    - If it is not possible to measure the participant (e.g., because the participant is medically fragile and unable to come to clinic) and no referral data is available, use the "Unknown ht/wt" button to provide a placeholder for the measurement in the anthropometric tabs of the Information System. Describe the situation more fully in the Notes section, and if possible, obtain these measurements when referral data is available or the condition is resolved.
- **Clothing:** WIC participants must be clothed as specified in the Minnesota WIC Program Anthropometric Manual to ensure accurate weights.
    - Since it is essential that infants be in a **dry diaper** for weighing, it is advantageous to have a dedicated diaper-changing area in the near vicinity of the weighing area.
    - It is also helpful to have a supply of diapers available.
- **Drapes:** Staff should use drapes on infant scales, recumbent measuring boards, foot beds on scales, and on the headpiece of the length measuring board.
- Scales must be zero-balanced with the drape prior to each use.

5.3.1.1: Using Referral Weight and Height/Length Data

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

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

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

Procedures

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

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

- The data is provided by a health care provider.
  - The referral data should be provided on letterhead from the source or another form that specifies the medical clinic/provider, and includes:
  - Participant's name
  - Date of collection
- The referral data may be obtained from the participant's electronic medical record (EMR). The parent must show the WIC staff the value in the EMR.
- The CPA may obtain this information by phone from the medical clinic or health care provider.
- The participant was in the same categorical status (i.e., pregnant or postpartum) at the time of data collection as at the certification at which the data is used.
- The **anthropometric measurements** were taken within sixty days of the certification.
- The *actual measurement date* is entered in the Information System so that plotting is accurate.
- The source of the measurement date is entered in the Information System.
- Self-reported data may not be used.

Guidance

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

Section 5.3.2: Hematologic Assessment

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

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

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

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

Procedures

- Local agency staff must obtain hematologic data either by:
  - Measuring hemoglobin or hematocrit using approved equipment and following the procedures described by the manufacturer, or
  - Obtaining hematologic data from a medical provider through referral. See Section 5.3.2.2 – Using Referral Hematological Data.
- All WIC staff who will be conducting hemoglobin testing must complete training on the equipment they will be using prior to doing tests in clinic. (Section 4.5: Staff Training)
  - Review hematological procedures as part of the ongoing monitoring and supervision of CPA staff (Section 4.6: CPA Performance and Evaluation).

Local agencies must use the following schedules

Blood Work Schedule for Women

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

- Bloodwork must have been done at a time that reflects their current status (e.g., blood work measured during pregnancy if certifying a pregnant woman or following delivery if certifying a postpartum woman).
- **For women certified for a year:** if blood values obtained at their certification indicated low hemoglobin, blood work must be repeated during the year and recorded in the participant's record.

Blood Work Schedule for Infants & Children

Infants

- To meet the scheduling requirement, blood work must be done at or after nine months of age, generally at the infant's mid-certification appointment.
- Infants certified on or after nine months old always need hemoglobin tested at the first certification.

Children

- **For children certified between 12 and 15 months:**
  - Blood work must be done *at 12 month certifications*, ***unless:***
    - Blood work was done on or after nine months of age
    - AND the hemoglobin value was normal.
  - Blood work must be done again at 15-18 months for all children.
- **For children certified between 15 and 24 months:**
  - Blood work must be done *at the certification/re-certification/mid-certification*, regardless if the previous hemoglobin value was normal or not.
  - Blood work must be done *at mid-certification* (18-21 months), *regardless* of the previous hemoglobin status (i.e., even if it was normal).
- **Children 24 months and older must have blood work done *at the certification/re-certification/mid-certification in the following circumstances:***
  - If the most recent blood work indicated low hemoglobin.
  - If the most recent blood work was approximately 12 months prior to the current certification/mid-certification appointment.
  - If a child aged 20 to 26 months old did not have blood work done between 13 and 24 months, the hemoglobin must be measured.

Guidance

- If the hematologic value at the child's previous certification was near the cut-off point, and the child has risk factors for low hemoglobin (such as late weaning, excessive juice intake and/or excessive milk intake), it is **best practice to repeat blood work** at the next certification/ recertification/mid-certification.
- **For children over two years of age and the most recent blood work was done more than 10 months ago, it would be best practice to do blood work.**
- **The blood work schedule outlined above takes priority over Information System requirements. The Information System does not accept blood work done 90 days prior. However, if the test was done within the required timeframes, and the value indicated a normal blood work measure, staff may enter the value in a note rather than the blood work tab.**
- Guidance from the Department of Justice indicates that it would be discriminatory to require HIV-infected applicants to have blood work required for WIC certification done elsewhere if it is the policy of the WIC clinic to perform these tests on site. However, if it is determined, on a case-by-case basis, that the health and safety of others is severely at risk, providing the service by other means may be justified. Applicants cannot be required to obtain such data at their own expense. With rare exception, WIC clinics should be prepared

to obtain WIC blood collections from all applicants, following recommended health and safety protocols.

Machines for hemoglobin testing

- Hemoglobin measuring equipment for obtaining capillary blood samples is used in Minnesota WIC. Equipment manufacturers have created training materials specific to their equipment (available both online and in print).
- Local Agencies must assure that equipment is maintained and cleaned according to manufacturers' instructions.
- Before changing to a new type of hemoglobin measuring equipment, LAs must discuss with their State WIC Consultant to assure it meets WIC requirements.

Lancets should be

- A single use retractable skin puncture device that punctures the skin by either a blade or needle.
- Labeled with length of blade/needle and gauge. Shorter and narrower blades or needles are thought to be less painful. This must be balanced with a need for a puncture deep enough to assure adequate blood for the sample.
- For children: the blade or needle should be about 1.5mm.
- For women: the blade or needle should be less than 2.4 mm.

Collection site

(Collection of Capillary Blood Specimens, Blood Specimens-Specimen Collection): Local Agencies are responsible for training and oversight of hematological testing (See Introduction to Hematological Assessment for more information about technique.)

- The finger or toe may be used for infants nine months of age or older.
- For children over one year and adults, the best site for collecting a capillary sample is the middle or ring finger.
  - The finger used should not have a ring.
  - For children under eight years, the puncture depth should be less than 1.5mm thus the lancet depth should be about 1.5 mm (WHO Guidelines on drawing blood).

  Precaution:

  - When conducting a hemoglobin measurement on young children, be cautious about bandages due to choking risk.

Low Hemoglobin

- **Hemoglobin measures below 10 should be re-tested.**
  - The second sample should be from a different site instead of taking a second sample from the first puncture site.
  - A referral to a health care provider is required when the hemoglobin value meets the high risk criteria (see Exhibit 6-A: High Risk and Medical Referral Criteria)

5.3.2.1: Exceptions to Required Hematological Measurements

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

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

Procedures

- When either of the two exceptions apply and blood work is not done in clinic, attempts should be made to obtain referral data from participant's health care provider.
- If referral data is not available, certify the applicant based on other identified risk criteria, and refer to a laboratory that can collect blood from such persons.
  - Applicants cannot be required to obtain referral data at their own expense.
  - If an applicant refuses blood work due to religion or medical condition, the reason blood work was not collected ***must be documented*** in the Notes section of the Information System.

5.3.2.2: Using Referral Hematological Data

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

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

Purpose: To ensure an accurate assessment of the participant's hematological status using referral data, hematological data must reflect the participant's current category, and have been done within the scheduling requirements to be valid.

Procedures

Hematologic data collected by a medical provider other than WIC staff, may be used for certification/recertification/mid-certification provided the following conditions are met. Use of referral data does not pre-empt the requirement that the participant be physically present at the certification (see Section 5.2.5: Physical Presence).

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

- The data is provided by a health care provider.
  - The referral data should be provided on letterhead from the source or another form that specifies the medical clinic/provider, and includes:
  - Participant's name
  - Date of collection
- The referral data may be obtained from the participant's electronic medical record (EMR). The participant must show the WIC staff the value in the EMR.
- The CPA may obtain this information by phone from the medical clinic or health care provider.
- The participant was in the same categorical status (i.e., pregnant or postpartum) at the time of data collection as at the certification at which the data is used.
- If unable to enter the actual date of the **hematological data** in the Information System, and blood work was done within the timeframes appropriate for WIC Category, the value should be entered in a note. If the blood work value indicates anemia, the date of measurement must be within 30 days (Infants) or 60 days (other Categories).
- Self-reported data may not be used.
- **For hematological data, the blood work schedule outlined in Section 5.3.2 takes priority over Information System requirements. The Information System does not accept blood work done 90 days prior. However, if the test was done within the required time frames, and the value indicated a normal blood work measure, staff may enter the value in a note rather than the blood work tab.**

5.3.2.3: Preventing Blood Borne Pathogen Transmission

All Local Agencies employing individuals who may be exposed to blood borne pathogens and other infections agents **must have a written Exposure Control Plan.** Refer to the Occupational Safety and Health Standards: Bloodborne Pathogens.

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

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

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

5.3.3: Health and Nutrition Information

References: Immunization Screening and Referral in WIC

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

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

Procedures

Follow the Nutrition Assessment Process for a comprehensive screening of the participant's health/medical/nutrition status.

Nutrition Assessment Process

1. *Only after* completing an anthropometric and hematologic assessment, assess the participant's medical/health/nutrition status.
2. Use the appropriate Nutrition Assessment Tool as a guide for collecting and evaluating relevant information about the participant's health and diet and eating/feeding patterns. Collect adequate information to assess for all possible risk codes for the participant's category, including risk assessment for postpartum/perinatal depression.
3. Clarify and synthesize information as needed.
4. Identify and assign all applicable risk codes.
5. Document the health/medical/nutrition assessment.
6. After all components of the assessment are complete (anthropometric, hematologic, health, diet, and breastfeeding) and all applicable risk codes assigned, provide education based on prioritized needs.

Screening and Referral for Immunizations

- Assess immunization status of infants and children. Use the appropriate Nutrition Assessment Tool as a guide:

- At a minimum, ask if the child's immunizations are up-to-date. Refer to Are Your Kids Ready? When to Get Vaccines for the current recommendations.
- Indicate in the Information System when the participant is not up-to-date for age by current recommendations
- If a child's immunization status is not current, refer to immunization program(s). Document the referral in the Information System Referrals or in a note. If the family declines an immunization referral, note that in the participant record.
- Coordinate with public health immunization program staff to ensure infants' and children's immunization status is assessed and appropriate referrals are made.

Screening and Referral for Blood Lead Testing

- Assess blood lead testing status of infants and children. Use the appropriate Nutrition Assessment Tool as a guide:
  - Ask if the child has had a blood lead test. Refer to Minnesota Childhood Blood Lead Screening Guidelines for the current recommendations
  - Indicate in the Information System when the participant **has not had a blood lead test** per current recommendations
  - If a child's blood lead testing is not current, refer to blood lead testing program(s). Document the referral in the Information System Referrals or in a note. If the family declines a blood lead test referral, document that in the participant record.

Guidance

- Use a participatory, interactive approach when collecting health and diet/breastfeeding information:
  - CPAs may ask the assessment questions in any order.
  - CPAs may rephrase questions, provided the intent of each question is not changed.
  - Actively involve the participant through dialogue, information exchange, listening and feedback.
  - Clarify information by using probing, open-ended questions.
  - Keep discussion at a level appropriate to participants' level of education.
  - Avoid judgmental language.
  - Conduct the assessment with respect and warmth to aid in building rapport.
  - Refer to VENA for more information.
  - PCS training materials and tools are available to develop CPA skills.
  - Refer to Nutrition Assessment Tools for further information.

- Ensure the privacy of each participant when gathering and discussing information. See Section 1.7: Data Privacy.

5.3.4: Nutrition Risk Code and Priority Assignment

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

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

Procedures

1. Compare assessment data to the WIC nutrition risk criteria. Refer to Exhibit 5-T: MN WIC Risk Criteria and the allowed WIC Risk Criteria.
2. Select all applicable risk codes in the Information System.
3. Provide justification for all assigned risk codes by documenting supporting information in the Information System.

Guidance

- All applicable risk codes must be assigned and documented at certification and recertification, but it is not expected that all nutrition risk conditions be counseled on or addressed. WIC staff, in collaboration with the participant, should prioritize the nutrition issues to determine which will be addressed at the certification appointment.
- Begin education or counseling only after all information has been reviewed and nutritional risks assessed. Proceeding in this way will provide the CPA with a more comprehensive picture of the participant's nutrition status, so that he/she can counsel accordingly.
- When a complete nutrition assessment has been done and no other dietary risk criteria (400 codes) have been identified, use a presumed dietary risk code:
  - Assign risk code 428, Dietary Risk Associated with Complementary Feeding Practices, for infants 4-12 months or children 12-23 months.
  - Assign risk code 401, Failure to Meet Dietary Guidelines for Americans, for individuals 2 years of age and older.
  - During the certification period, the Information System may assign or delete risk codes based on data added to the participant's record. However, the CPA is not required to assign or delete risk codes during the certification period, e.g., at the Midcertification appointment or Additional Nutrition Education contacts. If a new risk is identified during

the certification period, the CPA should address the risk through counseling as appropriate.

- CPAs should be familiar with the federal priority system. Refer to Exhibit 5-U: Minnesota WIC Participant Priority System and Exhibit 5-V: Nutrition Risk and Priority Assignment Table for detailed information.

Reference – Complete Listing of Hyperlinks

Section 5.3.1

Minnesota WIC Program Anthropometric Manual
(https://www.health.state.mn.us/docs/people/wic/localagency/training/nutrition/nst/anthro.pdf)

Weight Gain During Pregnancy: Reexamining the Guidelines
(http://www.nap.edu/catalog.php?record_id=12584)

Section 5.2.5: Physical Presence
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/chsctns/ch5/sctn5_2_5.pdf)

Exhibit 5-K: Documenting Clinic Scale Testing
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/exhbts/ex5/5k.pdf)

Section 5.3.2

Section 4.5: Staff Training
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/chsctns/ch4/sctn4_5.pdf)

Section 4.6: CPA Performance and Evaluation
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/chsctns/ch4/sctn4_6.pdf)

Collection of Capillary Blood Specimens (https://clsi.org/standards/products/general-laboratory/documents/gp42/)

Blood Specimens-Specimen Collection
(https://www.cdc.gov/dpdx/diagnosticprocedures/blood/specimencoll.html)

Introduction to Hematological Assessment
(https://www.health.state.mn.us/docs/people/wic/localagency/training/nutrition/nst/blood.pdf)

WHO guidelines on drawing blood: best practices in phlebotomy
(https://www.who.int/publications/i/item/9789241599221)

Exhibit 6-A: High Risk and Medical Referral Criteria
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/exhbts/ex6/6a.pdf)

Section 5.2.5: Physical Presence
(https:/www.health.state.mn.us/docs/people/wic/localagency/program/mom/chsctns/ch5/sctn5_2_5.pdf)

Occupational Safety and Health Standards: Bloodborne Pathogens
(https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030)

Section 5.3.3

Immunization Screening and Referral in WIC (https://www.fns.usda.gov/wic/immunization-screening-referral)

Nutrition Assessment Tool
(https://www.health.state.mn.us/people/wic/localagency/training/na.html#NaN)

Are Your Kids Ready? When to Get Vaccines
(https://www.health.state.mn.us/people/immunize/basics/readykidswhento.pdf)

Minnesota Childhood Blood Lead Screening Guidelines
(https://www.health.state.mn.us/communities/environment/lead/docs/reports/leadscreenguide.pdf)

VENA (https://wicworks.fns.usda.gov/resources/value-enhanced-nutrition-assessment-vena-guidance)

PCS training and tools
(https://www.health.state.mn.us/people/wic/localagency/training/pcs/index.html)

Section 1.7: Data Privacy
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/chsctns/ch1/sctn1_7.pdf)

Section 5.3.4

Exhibit 5-T: MN WIC Risk Criteria
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/exhbts/ex5/5t_new.pdf)

WIC Risk Criteria
(https://www.health.state.mn.us/people/wic/localagency/riskcodes/index.html)

Exhibit 5-U: Minnesota WIC Participant Priority System
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/exhbts/ex5/5u.pdf)

Exhibit 5-V: Nutrition Risk and Priority Assignment Table
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/exhbts/ex5/5v_new.pdf)