Section 6.6: High Risk Individual Nutrition Care Plans

10/2024

References: 7CFR 246.11(e)(5) and Nutrition Service Standards: 3, 7, and 14

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

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

Goals of High Risk Care

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

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

Procedures

1. **Grantees are responsible for having on staff** (or by contract) a credentialed nutrition professional to provide nutrition services to high risk participants (see first bullet point under Guidance).
2. **At a minimum, the Local Agency must use the high risk criteria** defined in Exhibit 6-A: High Risk and Medical Referral Criteria, for determining when an INCP is required. Additionally, INCPs should be developed:

- when the condition or situation warrants an INCP in the CPA's professional judgment and
- when requested by a participant.

3. **INCPs must be developed and documented** specifically addressing the high risk condition(s) identified, and must include:
   - Assessment of the individual's overall situation including nutrition status, needs, and any problems.
   - Review of health services for the high risk condition being provided elsewhere.
   - Specific goals/recommendations regarding the high risk condition.
   - Referrals to healthcare providers (HCP) and other programs and services as needed.
   - Plans for follow-up visits.
4. **Follow-up** addressing the status of the high risk condition must be provided at least quarterly until the high risk condition is resolved or stable.

Guidance

Staffing

High risk care should be provided and/or coordinated by the agency's credentialed nutrition professional(s) which include registered dietitians (or registration-eligible), individuals with a bachelor's or master's degree in nutrition, or Minnesota Licensed Nutritionist/Dietitians. See Section 4.3: Competent Professional Authority (CPA) Qualifications and Responsibilities.

- Other CPAs may provide High Risk Care. All non-nutrition credentialed staff providing High Risk Care are required to have or obtain the specialized skills and knowledge before providing High Risk Care, which must include:
  - At minimum, completion of the Nutrition Modules in the New Staff Training Plan is required for non-nutrition credentialed staff. See WIC New Staff Training. Additionally, a strong understanding of nutrition in health and disease, its application to public health practices, and knowledge of the nutrition needs of infants, children, and women during the prenatal, postpartum, and breastfeeding periods.
  - Knowledge of effective counseling and educational concepts and methods. Completion of the High Risk Counseling modules in the New Staff Training Plan is required for all CPAs who will be providing High Risk care. See WIC New Staff Training.
  - Ability to develop and carry out on-going plans for nutrition education.
- Agencies with paraprofessional CPAs (locally trained CPAs) are required to have procedures in place to assure paraprofessional staff refer high risk participants to a nutrition professional. See Section 4.3: Competent Professional Authority (CPA) Qualifications and Responsibilities.

High Risk Criteria

- **Criteria for INCPs and medical referrals are found in Exhibit 6-A: High Risk and Medical Referral Criteria.** If the participant is not receiving medical care for the identified high risk condition, a **written** medical referral should be made. Referrals should be discussed with participants/parents/guardians; they have the right to decline referrals. The CPA should exercise professional discretion in deciding the necessity of sending a referral. See Section 5.7: Referrals and Exhibit 5-Y: Minnesota WIC Program Request for Medical Follow-Up.
- Refer to the procedure for Resolving High Risk Designation below if the participant has been system-assigned as high risk but does not meet the high risk medical and referral criteria.

Develop and Provide Individual Nutrition Care Plan (INCP)

1. **Assessment of the individual's overall situation:** The nutrition assessment at certification/recertification identifies any high risk conditions or issues that need be addressed in an INCP. The assessment should include:
   - Identification of most significant risk factors present
   - Evaluation of anthropometric and blood-work data
   - Diet assessment
   - Instructions or prescriptions (if any) from health care provider(s)
   - Participant's/caregiver's knowledge of and attitude toward the condition(s)
   - Any relevant concerns expressed by the participant or caregiver
2. **Review of health services for the high risk condition being provided elsewhere:**
   - Identify the medical/nutritional support services the participant currently receives, including the frequency and extent of nutrition counseling from other sources.
   - Reinforce the medical/nutritional recommendations of other health care providers.
3. **Provide specific goals/recommendations regarding the high risk condition:**
   - With the participant/caregiver, identify strategies that will be used to alleviate or resolve the condition(s) or issues.
   - Individualize the strategies to the circumstances of the participant.
4. **Provide referrals to health care providers and other programs and services as needed.**
5. **Determine Plans for follow-up visits:** Frequency of follow-up should be based on the health condition and individual's needs.
   - Some participants may need to be seen monthly; others only bi- or tri-monthly.
   - For example, it might be prudent to plan monthly follow-up for a pregnant woman with a low rate of weight gain, until expected or desired weight gain is observed.

- At a minimum, follow-up should continue at least quarterly until the condition is resolved or stabilized.

Documentation of INCPs

Documenting INCPs is essential for providing the best-individualized and responsive services to participants.

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

Providing High Risk Follow-up

The CPA should exercise professional discretion when determining the specific course of high risk follow-up. This includes determining the frequency, type (in-person or remote), and nature of follow-up activities based on the participant's health condition and individual needs.

Frequency and type of follow-up

- At a minimum, follow-up should continue ***at least quarterly*** until the condition is resolved or stabilized. Some participants may need to be seen more frequently (e.g., monthly, or bi-monthly).
- Type of follow-up (in-person versus remote) should be determined based on the participant's needs and the follow-up activities that are of the most importance for managing or resolving the high risk condition.
- High risk follow-up examples:
  - It might be prudent to plan monthly follow-up for a pregnant woman with a low rate of weight gain, until expected or desired weight gain is observed.
  - For a breastfeeding dyad with breastfeeding complications (risk factor 602 or 603), monthly or more frequent follow up may be necessary due to the time sensitive nature of lactation. Frequent follow up allows for support in maintaining milk supply and monitoring for adequate infant growth. In cases where infant's growth is slower than expected, monthly weight checks can prevent more serious issues.
  - For a child assigned risk factor 113 after an initial certification whose assessment reveals no major concerns, it might be fitting to plan a verbal follow-up in three months, with a full re-assessment of height and weight in six months (at the Mid-certification).

Follow-up may include some, or all, of the following:

- Dietary assessment.
- Monitoring anthropometric measurements and discussion of growth and weight gain/loss.

- Monitoring hemoglobin and discussion of blood work results.
- Discussion of participant's/caregiver's nutrition or health-related concerns.
- Discussion or reinforcement of instructions given by other health care providers.
- Assessment of food package needs and/or revision of food package prescription.
- Individualized nutrition education.
- Monitoring participants with complex medical problems or serious risks to assure they are receiving adequate care from appropriate health/nutrition professionals.
- Referral to the Designated Breastfeeding Expert and/or another lactation professional for complex breastfeeding concerns.
- Referral to other programs and services, as needed.
- Follow-up on referral to other programs.
- Monitoring/modifying realistic goals established with participant/caregiver.

Resolving High Risk Designation

The CPA may resolve the system assigned high risk designation after a thorough assessment, and based on their professional discretion, in the following circumstances:

1. Participant does not meet the additional qualifying criteria for the high risk designation per Exhibit 6-A: High Risk and Medical Referral Criteria (e.g., risk codes 101 and 113) and no other high risk conditions are present.
2. High risk condition is beyond the scope of WIC and the participant is receiving appropriate ongoing care from a qualified healthcare provider.
    - See **Nutrition Support provided by another HCP** section below for guidance on appropriate documentation and follow-up in this situation.
    - This situation should be uncommon, as WIC plays a crucial role in helping participants resolve and manage their high risk condition(s).
3. High risk condition has resolved or stabilized, and further monitoring would be unnecessary or not beneficial. This may apply to anthropometric risk codes when growth is stable (e.g., risk codes 103, 131, 133).

- **Always document the reason for resolving the high risk designation with a note in the information system.** This is in addition to the system-generated *High Risk Resolution* note.
- Keep in mind that in some cases, it may be beneficial to continue high risk care to prevent relapse.
- A medical referral is not required if the high risk designation is resolved.

How to resolve the system-assigned high risk designation

To resolve the system-assigned high risk designation in the Information System, the CPA shall:

- Go to: *Risk Factors* screen >> Select: "Assign Risk Factors" >> Check: "Resolve System-assigned High Risk Designations."

Nutrition Support provided by another HCP

- If appropriate nutrition support is provided by another HCP, with expertise in the condition, comprehensive care, and follow-up may not be necessary by WIC.
- To indicate that appropriate nutrition care is provided by another HCP, the CPA should document the following:
- The fact that the participant is receiving nutrition care elsewhere for the Condition.
- Name, location, and phone number of the provider if available.
- Expertise of the provider(s), e.g., MD, RD, Certified Diabetes Educator, Occupational Therapist, Physical Therapist, etc.
- How often the participant is being seen by care provider(s).
- Time frame for the next WIC nutrition education contact.
- Non-high risk follow-up could, therefore, be provided at the additional education contact. However, it may be beneficial to retain high risk status for the following reasons:
- To follow-up on referrals.
- To answer questions, especially if the condition is newly diagnosed.
- To assure that the participant is stable and has not relapsed.
- To assure that the participant continues to receive follow-up from the HCP if needed.

NOTE: "High risk" is a term used in WIC to designate the need for more advanced nutrition care. When counseling WIC participants determined to have a high risk condition, you do not need to tell them they are "high risk". Consider saying something like "*I would like to follow-up with you in one month to see how you are doing*." or "*This is an important time for growth and development. I would like to see you (your child) next month to see how you are doing, and to answer questions*."

Related Policies:

- Section 6.4: Drug and Harmful Substance Abuse Education
- Section 5.7: Referrals

Reference – Complete Listing of Hyperlinks

Nutrition Service Standards
(https://wicworks.fns.usda.gov/sites/default/files/media/document/wic-nutrition-services-standards_0.pdf)

Exhibit 5-Y: MN WIC Program Request for Medical Follow-Up
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/exhbts/ex5/5y.pdf)

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 4.3: Competent Professional Authority (CPA) Qualifications and Responsibilities
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/chsctns/ch4/sctn4_3.pdf)

New Staff Training (https://www.health.state.mn.us/people/wic/localagency/training/nst.html)

Section 5.7: Referrals
(https://www.health.state.mn.us/docs/people/wic/localagency/program/mom/chsctns/ch5/sctn5_7.pdf)

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