

ISSUE DATE: May 22, 2015

TO: WIC Program Coordinators
Other WIC Policy and Procedure Manual owners

FROM: Holly Wilkalis
Oregon WIC Program – Nutrition & Health Screening
OHA Office of Family Health

SUBJECT: **WIC Policy Update 2015-03**



EXPLANATION:

- ◆ **325 – Caseload Management**
 - Updates revised date only – no changes
- ◆ **440 – Staff Training Requirements**
 - Updated to reflect the requirements that all WIC Nutritionists complete the training required for CPAs.
- ◆ **475 – Waiting List**
 - Updates revised date only – no changes
- ◆ **614 – Income Eligibility: Current Income Guidelines**
 - Updated income guidelines for 2015
- ◆ **625 – Risk Assessment**
 - Updates revised date only – no changes
- ◆ **640 – Documentation Requirements for Certification in TWIST**
 - Updates revised date only – no changes
- ◆ **641 – Documentation Requirements for Certification in the Absence of TWIST**
 - Updates list of certification forms in ¶1.1 to note which are available online only
- ◆ **660 – CPA Requirements**
 - Updated to reflect the requirements that all WIC Nutritionists complete the training required for CPAs.
- ◆ **670 – Overview of Risk Criteria and Priorities**
 - Updates revised date only – no changes
- ◆ **675 – Risk Criteria Codes and Descriptions**
 - Added Risk 361 - Depression and renamed Risk 381 - Oral Health Conditions

INSTRUCTIONS FOR UPDATING HARD COPY MANUALS:

Remove page(s)	Insert page(s)	Implementation date	Issue date
325.0 – 325.6	325.0 – 325.5	May 22, 2015	May 22, 2015
440.0 – 440.6	440.0 – 440.6	May 22, 2015	May 22, 2015
475.0 – 475.1	475.0 – 475.1	May 22, 2015	May 22, 2015
614.0 – 614.3	614.0 – 614.3	May 1, 2015	May 22, 2015
625.0 – 625.1	625.0 – 625.1	May 22, 2015	May 22, 2015
640.0 – 640.1	640.0 – 640.1	May 22, 2015	May 22, 2015
641.0 – 641.1	641.0 – 641.2	May 22, 2015	May 22, 2015
660.0 – 660.21	660.0 – 660.21	May 22, 2015	May 22, 2015
670.0 – 670.1	670.0 – 670.1	May 22, 2015	May 22, 2015
675.0 – 675.39	675.0 – 675.39	May 22, 2015	May 22, 2015

NOTE:

- WIC policies can be viewed online at <http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Pages/wicpolicy.aspx>.
- Make sure all hard copies of the WIC Policy and Procedure Manual are updated.
- See the next page for all WIC policy updates for the current year.
- Call the state WIC office at **971-673-0040** if you need additional hard copies of a policy update.

**WIC Policy Updates Issued for 2015
(Year-To-Date)**

Manual Update Number	Policy Number	Policy Title	Manual Page Number(s)	Issue Date
2015-01	485	WIC ID Number and ID Card	485.0 – 485.3	February 9, 2015
2015-01	654	Participant Transfers Within State	654.0 – 654.2	February 9, 2015
2015-01	769	Assigning WIC Food Packages	769.0 – 769.19	February 9, 2015
2015-01	770	WIC Authorized Foods	770.0 – 770.19	February 9, 2015
2015-01	901	TWIST Data System Security	901.0 – 901.1	February 9, 2015
2015-01	145	State Office: Address and Staff	DELETED	February 9, 2015
2015-01	150	Local Program Addresses and State Map	DELETED	February 9, 2015
2015-02	451	Change In Guardianship	451.0 – 451.3	April 13, 2015
2015-02	452	Civil Rights	452.0 – 452.10	April 13, 2015
2015-02	595	Program Integrity: Separation of Duties	595.0 – 595.1	April 13, 2015
2015-02	596	Program Integrity: Acknowledgment of Employee Responsibilities	596.0 – 596.4	April 13, 2015
2015-03	325	Caseload Management	325.0 – 325.5	May 22, 2015
2015-03	440	Staff Training Requirements	440.0 – 440.6	May 22, 2015
2015-03	475	Waiting List	475.0 – 475.1	May 22, 2015
2015-03	614	Income Eligibility: Current Income Guidelines	614.0 – 614.3	May 22, 2015
2015-03	625	Risk Assessment	625.0 – 625.1	May 22, 2015
2015-03	640	Documentation Requirements for Certification in TWIST	640.0 – 640.1	May 22, 2015
2015-03	641	Documentation Requirements for Certification in the Absence of TWIST	641.0 – 641.2	May 22, 2015
2015-03	660	CPA requirements	660.0 – 660.21	May 22, 2015
2015-03	670	Overview of Risk Criteria and Priorities	670.0 – 670.1	May 22, 2015
2015-03	675	Risk Criteria Codes and Descriptions	675.0 – 675.39	May 22, 2015



SECTION: Fiscal
SUBJECT: CASELOAD MANAGEMENT
DATE: May 22, 2015 (*Reviewed*)

325

POLICY: Local WIC programs shall maintain caseload levels that meet their assigned caseload set by the State WIC program.

PURPOSE: To provide WIC services to as many eligible participants as possible by fully utilizing available resources in accordance with the federal priority system.

RELEVANT REGULATIONS: 7 CFR §246.16 ¶(e) 2 Performance Standards
 7 CFR §246.7 ¶(e) 4 Nutritional Risk Priority System

OREGON WIC PPM
 ◆470—Local Program Outreach
 ◆475—Waiting List
 ◆605—Processing Standards

REFERENCES: ◆670—Overview of Risk Criteria and Priorities

DEFINITIONS:

<i>Assigned caseload</i>	Caseload goal set by the State for each local WIC program based on prior performance and available monies.
<i>Certified caseload</i>	The number of participants listed as active in the state computer system.
<i>Priority</i>	The ranking assigned to a participant based on the individual’s category and identified risk factors in accordance with the federal nutritional risk priority system.
<i>Participating caseload</i>	The total number of participants included in the following groups: <ul style="list-style-type: none"> • participants who receive food instruments each month from a local WIC program; • participants who are infants who do not receive food instruments but their breastfeeding mothers receive food instruments each month; • participants who are breastfeeding women who do not receive food instruments but their infants receive food instruments each month.
<i>Participant</i>	An individual who has been determined eligible to receive WIC services appropriate for their category.

CASELOAD MANAGEMENT, *cont.*

PROCEDURE:

- Managing caseload***
- 1.0 Local program staff will develop and enact caseload management policies and procedures to achieve and maintain 97% to 103% of the assigned caseload level set by the State. All caseload management decisions need to account for service to the highest priorities possible based on the federal nutrition risk priority system. See ♦670—Overview of Risk Criteria and Priorities. Gradual changes are recommended as the full impact of adjustments in caseload management policies occur over a period of time.
- 1.1 Review the following caseload reports in TWIST every month to achieve and maintain a participating caseload as close to 100% of assigned as possible.
- a. Certified Caseload-12 Month History
 - b. Participating Caseload-12 Month History
 - c. Percent of Assigned Caseload-12 Month History
 - d. Percentage Not Receiving Food Instruments
- 1.2 Use state staff as a resource for technical assistance in interpreting reports and developing strategies. Talk with experienced coordinators to learn how they have handled caseload changes and to learn more about the art of managing caseload.
- 1.3 Compare caseload levels with trends and patterns from past reports. Maintain and evaluate records that identify caseload fluctuations that occur in response to changes made by the local program.
- 1.4 Determine immediate and long-term monthly caseload levels needed to meet assigned caseload goals, given prior caseload patterns. Incorporate adjustments for any anticipated program changes that might impact future caseload levels such as closing or opening a new clinic site or changes in staffing patterns.
- 1.5 Keep staff and agency managers informed about caseload performance, the implications of current trends and possible impact of changes in caseload management policies. Involve them in making decisions.
- 1.6 Develop strategies to achieve immediate and long-term goals.
- 1.7 Take action. Implement selected strategies.
- 1.8 Maintain ongoing evaluations. Reassess plans as information changes.
- 1.9 Adjust goals and alter strategies as needed.
- Increasing caseload***
- 2.0 Increase caseload levels when caseload is below assigned levels. Options for increasing caseload include, but are not limited to the following:
- Priorities***
- 2.1 Serve all priorities unless instructed differently by the State. If not serving all priorities, adjust priorities served to increase caseload to assigned levels.

CASELOAD MANAGEMENT, *cont.*

(Priorities)

- 2.1.1 Review the WIC Counts by Priority/Category report in TWIST. Look at the number of participants in each priority group to estimate the impact of proposed changes in priorities served on total caseload. Monitor the results of changes made.
- 2.1.2 Adjust priorities served carefully in order to facilitate gradual caseload increases and prevent large swings that are difficult to control.

Outreach activities

- 2.2 Increase outreach activities. See ♦470—Local Program Outreach.
 - 2.2.1 Target populations in need of increased service, such as teen parents, Head Start families, ethnic groups, sight- or hearing-impaired individuals, isolated communities, Native American populations and OHP and SNAP recipients. Utilize census and GIS data to identify growing populations in the local area and develop plans to reach those groups.
 - 2.2.2 Encourage word-of-mouth referrals. Develop “tell a friend” campaigns.
 - 2.2.3 Distribute WIC information to local stores, clinics, agencies. Utilize posters, pamphlets, and fliers printed in languages spoken in the community. Contact the state program for available outreach materials.
 - 2.2.4 Consider promotions via billboards, local newspapers and radio stations. Contact television stations regarding public service announcements.
 - 2.2.5 See the Outreach section of the Oregon WIC website for additional ideas.
 - 2.2.6 Contact the state WIC Outreach Coordinator for additional ideas and technical assistance to develop a local agency outreach plan.

Appointment availability

- 2.3 Increase the number of available appointments.
 - 2.3.1 Add staff time by increasing existing staff hours or by hiring additional or temporary staff. Review staffing patterns and activities. Use volunteers or non-professional staff for support services, routine clerical tasks, and participant weighing and measuring, to increase availability of trained professional staff for certification appointments. Assure that all volunteers receive appropriate training for assigned tasks.
 - 2.3.2 Streamline service to reduce length of time spent per participant so additional appointments can be scheduled. Analyze participant movement through the clinic. Evaluate for logical traffic patterns with efficient flow of participants and staff. Look for duplication of service and grouping of task assignments. Identify problem areas, and plan for

CASELOAD MANAGEMENT, cont.

*(Appointment
availability)*

effective change. Contact the state program for information regarding analysis of clinic flow.

2.3.3 Consider group certifications.

2.3.4 Share staff from other health department programs, local WIC programs, doctors' offices, or other agencies, to assist with certification. Pursue integrated services when possible. Consider training Community Health Nurses to complete certifications and follow up visits in the home during home visits.

*Program
accessibility*

2.4 Increase accessibility to program services. Conduct participant surveys to identify barriers to service and to obtain responses to proposed changes.

2.4.1 Increase ease of phone contact with local program. Examine need for additional phone lines or operators. Consider answering machines to relay information and/or take messages when staff are unavailable or the clinic is closed. Provide adequate staff or volunteers to answer phones and return messages.

2.4.2 Extend clinic hours to include weekend, evening, early mornings, or lunch times.

2.4.3 Check availability of public transportation and free parking near clinic sites.

2.4.4 Assure barrier-free access for individuals with disabilities.

2.4.5 Consider additional clinic sites in under-served or isolated areas.

2.4.6 Have interpreters available for non-English-speaking or hearing-impaired participants.

2.4.7 Make program information available in alternate formats such as large prints, audiotapes, Braille, etc.

2.4.8 Provide adequate waiting room and clinic space to serve the number of participants being seen at each clinic site.

Show rates

2.5 Improve show rates. Review TWIST show rate reports. Evaluate data to identify specific problem areas and strategies for increasing efficiency. Show rates may vary depending on time of month, time of day, or type of appointment.

2.5.1 Identify text or voice mail options for participants in order to utilize the automated ANSWR system for appointment reminder calls prior to their scheduled appointments. Send reminder postcards.

2.5.2 Allow participants to select appointment dates and times that best serve their needs.

2.5.3 Contact participants to reschedule missed appointments.

2.5.4 Adjust appointment schedules to compensate for show rates by over-booking appointments.

CASELOAD MANAGEMENT, cont.

2.5.5 Create an on-call list of participants who are willing and able to come in on short notice to fill appointment slots that became available when participants cancel.

Seasonal workers

2.6 Adjust for caseload fluctuations of seasonal or migrant workers.

2.6.1 Examine past caseload data and make allowances for increased staff and temporary clinic sites needed to provide adequate services in an efficient manner.

Decreasing caseload

3.0 Check with the state WIC program about the need to reduce caseload when caseload is above assigned levels. If so directed, options for reducing include, but are not limited to, the following:

Priorities

3.1 Focus service on the highest priorities. Service to lowest priorities must always be restricted prior to altering the availability of services to higher priorities. For example, service to priority VI women must be discontinued before services to priority V children can be restricted. State must approve any restrictions of priorities served. See ♦670—Overview of Risk Criteria and Priorities.

3.1.1 Use the WIC Counts by Priority/Category report in TWIST for information on the number of participants served at each priority. Use this data to determine the degree of priority restriction needed to achieve assigned caseload levels. Adjust priorities carefully to achieve gradual caseload decreases and avoid excessive reductions that are difficult to control.

EXAMPLE: A coordinator determines that his/her agency is serving 200 priority VI women per month. To determine the estimated number of women who would not be recertified or added per month if he/she stopped serving priority VI participants, divide the total number by 6 months (200 divided by 6 = 33). He/she could estimate that this change in priorities served would decrease caseload by about 33 participants per month.

CASELOAD MANAGEMENT, cont.

(Priorities)

3.1.2 Consider setting priorities within a priority. This approach can be useful when gradual caseload changes are required.

EXAMPLE 1: Discontinue service to priority VI women who only have presumed eligibility as a risk factor.

EXAMPLE 2: When service to all priority VI women has been discontinued, consider serving priority V children only under four years of age. Remember that if any priority V children are served, all participants who are priority I, II, III, or IV must be served.

3.1.3 Restrictions of priorities served will be documented in TWIST. See ♦ 475—Waiting List for additional documentation requirements.

3.1.4 Develop a plan for informing participants, agency personnel, and the community regarding changes in service priorities. A consistent and clear message is important to avoid misinformation and allow for caseload maintenance. All WIC staff need to repeatedly emphasize that as many participants as possible will continue to be served.

EXAMPLE: If a local program is not serving priority VI participants, communicate that services will continue to all pregnant women, all breastfeeding women, all infants, most children, and some post-partum, non-breastfeeding women. Explain that the highest risk participants are served first when funding and caseloads are limited. This is a key message to repeatedly communicate to participants, other health department or agency staff and community partners.

4.0 Maintain current caseload levels by gradually adjusting present caseload management policies when assigned caseload levels are being met.

4.1 When policies for increasing or decreasing caseload have been implemented successfully and caseload levels approach assigned target, gradually adjust policies to allow for caseload to stabilize at assigned levels. Continue to evaluate caseload levels monthly to identify adjustments needed for on-going maintenance of the assigned caseload. ★

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SECTION: Local Program Operations
SUBJECT: Staff Training Requirements
DATE: May 22, 2015 (*revised*)

440

POLICY: Local programs will ensure that staff are appropriately trained to perform their functions according to policy. Local program staff shall complete state training modules or online courses as appropriate for their position. Local program staff must demonstrate an adequate level of competence in performing their tasks.

PURPOSE: To train WIC staff to be Competent Professional Authorities (CPAs) as required by USDA. To ensure a consistent level of competence among all local WIC staff.

RELEVANT REGULATIONS: 7 CFR §246.11 ¶(c)(2)—Provision of training
7 CFR §246.11 ¶(c)(7)(iii)—New staff training
7 CFR §246.7 ¶(e)—Certification of participants: Nutritional risk
7CFR 246.14 ¶(c)(iii) —Allowable Training Costs
USDA WIC Nutrition Services Standards—Standard 3 (A)(1)(a-e)

OREGON WIC PPM REFERENCES: ♦425—Ordering State Produced Materials
♦426—Record Retention
♦452—Civil Rights
♦660—Competent Professional Authority: Requirements
♦710—Breastfeeding: Promotion and Support Standards
♦719—Breastfeeding Peer Counseling: Training
♦850—Nutrition Education Plan

APPENDICES: 440.7 Appendix A WIC Training Module Schedule
440.13 Appendix B WIC Training Supervisor Roles and Responsibilities
440.15 Appendix C Sample Training Calendar for Full Time CPA
440.18 Appendix D Staff Training Tracking Sample
440.20 Appendix E CPA Training Checklist

DEFINITIONS: *Training module* Training modules are self-paced pen and paper instructional modules, produced by the state WIC program to guide training at the local level on topics pertinent to the WIC program.

Online courses Online courses are self-paced training courses produced by the state WIC program, hosted on a central site accessed via the internet, and completed by local agency staff using a computer. Select courses train local staff on topics pertinent to the WIC program.

Local program training supervisor A person designated by the local program to ensure training of local staff is completed in accordance with state policy. Minimum qualifications: must be a health professional as defined in ♦660—Competent Professional Authority: Requirements.

STAFF TRAINING REQUIREMENTS, cont.

<i>Trainee</i>	The local program staff receiving training using the training modules and online courses.
<i>Level 1 Training</i>	Training modules, module chapters or lessons, or online courses that must be completed by all WIC staff.
<i>Level 2 Training</i>	Training modules, module chapters or lessons, or online courses that must be completed by all CPAs.
<i>Level 3 Training</i>	Advanced training, online courses or modules, module chapters or lessons that are completed by staff with previous advanced training in a specific content area.

BACKGROUND: The Oregon WIC program considers well-trained staff an asset to local WIC programs. Local programs employ a variety of staff in WIC with diverse backgrounds and training. Local programs must ensure that all WIC staff are trained and have the basic nutrition knowledge and skills needed to provide WIC services to participants in a participant centered way.

PROCEDURE:

- Training requirements for new WIC staff*
- 1.0 Local program staff working in the WIC program must complete the appropriate training and Oregon WIC Training Modules or online courses for their position within a specified time period. See Appendix A—WIC Training Module Schedule for more information.
 - 1.1 All staff performing WIC functions, including integrated clerical staff, must complete required WIC training regardless of the funding source for the position.
 - 1.2 Staff who are cross trained to perform more than one role (e.g. clerk and CPA) must complete the training requirements for all the positions they are assigned.
- Ordering training materials*
- 2.0 Hard copies of paper and pen WIC training modules, and training supervisor guides are available to order through the state mailroom. See ♦425—Ordering State Produced Materials for more information.
 - 2.1 Modules are also available to download electronically from the state WIC website at <http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Pages/modules.aspx>.
 - 2.2 Online courses are accessed through the state DHS Learning Center. See <http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Pages/modules.aspx> for more information.

STAFF TRAINING REQUIREMENTS, cont.

- Training Supervisors Guides**
- 3.0 There is a training supervisor’s guide for each module or online course.
- 3.1 Most online courses share a single training supervisor’s guide. The “*WIC Participant Centered Education*” online course has its own training supervisors guide.
- Level I training: all WIC staff**
- 4.0 All staff working in WIC in any job classification must at a minimum complete the following training within one month of hire (See Appendix A for details):
- “*Introduction to WIC*” module
 - “*Breastfeeding Level 1*” online course
 - “*Food Package*” module (See 7.1 for exceptions)
 - Civil Rights training as defined in ♦452—Civil Rights
- 4.1 All staff working in WIC in any job classification must complete the following training within 3 months of hire (See Appendix A for details).
- “*PCS – Setting the Stage*” online course
- Level II training: CPAs**
- 5.0 In addition to the modules or courses required for all WIC staff, staff hired as certifiers (Competent Professional Authority/CPAs as defined in ♦660—Competent Professional Authority: Requirements), must complete the following training (see Appendix A for details):
- “*Anthropometrics*” online course (within 1 month of hire and prior to performing these functions)
 - “*Hematology*” online course (within 1 month of hire and prior to performing these functions)
 - “*Dietary Risk*” module (prior to beginning to certify)
 - “*Nutrition Risk*” module (prior to beginning to certify complete the appropriate workbooks for the category of participant to be certified)
 - “*WIC Participant Centered Education*” online course (10 individual modules) (within 3 months of beginning to certify)
 - “*Basic Nutrition*” online course (within 3 months of beginning to certify)
 - “*Prenatal Nutrition*” online course (prior to certifying pregnant women and within 6 months of beginning to certify)
 - “*Child Nutrition*” online course (prior to certifying children and within 6 months of beginning to certify)
 - “*Infant Feeding and Nutrition*” module (prior to certifying infants and within 6 months of beginning to certify)
 - “*Breastfeeding Level 2*” module or “Breastfeeding Level 2” face-to-face training (prior to certifying breastfeeding women and within 6 months of beginning to certify,
 - “*Infant Formula*” module (within 6 months of beginning to certify)

STAFF TRAINING REQUIREMENTS, cont.

- “*Postpartum Nutrition*” online course (prior to certifying non-breastfeeding postpartum women and within 6 months of beginning to certify)
 - “*Baby Behaviors*” online course (with 6 months of beginning to certify)
- 5.1 WIC staff serving in the roles of WIC registered dietitian/nutritionist or training supervisor must complete the training to be a CPA.
- Facilitating groups* 5.2 CPA’s providing group nutrition education must complete the following module prior to facilitating any groups:
- “*Providing Participant Centered Groups*” module
- Staff performing lab functions* 6.0 WIC staff whose jobs are limited to weighing and measuring or drawing blood must complete training appropriate for all staff listed in ¶4.0 plus the “*Anthropometrics*” and “*Hematology*” online courses. (See Appendix A for details.)
- Breastfeeding peer counselors* 7.0 WIC staff whose jobs are limited to breastfeeding peer counseling must complete training appropriate for all staff listed in ¶4.0 and the following modules. (See Appendix A and ♦719—Breastfeeding Peer Counseling: Training for details.)
- “*Breastfeeding Level 2*” module or “*Breastfeeding Level 2*” face-to-face training
 - “*WIC Participant Centered Education*” online course
 - “*Baby Behaviors*” online course
- 7.1 Staff who work 100% of their time as breastfeeding peer counselors are not required to complete the “*Food Package*” module. If they are assigned the role of clerk or CPA in addition to their peer counselor role, they must complete the module.
- Quarterly in-services* 8.0 Certifying staff must, at a minimum, participate in quarterly in-services on topics related to certifier competencies. (See the Certifier Competency Model included as an appendix to ♦660—Competent Professional Authority: Requirements.)
- 8.1 In-service topics must develop staff knowledge, skills or abilities related to CPA competencies identified in the CPA competency model. Examples include: facilitated discussions relating to participant centered services, new WIC mandates or TWIST functionality; attending the WIC statewide meetings; guest speakers on customer service, cultural competence, or nutrition topics; presentations by partner or referral agencies; facilitated discussions about nutrition risks or topics by the WIC nutritionist.

STAFF TRAINING REQUIREMENTS, cont.

- 8.2 It is recommended that selection of quarterly in-service topics either be based on staff training needs identified during local program self-evaluations, or local WIC program needs; or be chosen to further enhance staff skills and job satisfaction.
- Annual civil rights training*
- 8.3 The required annual civil rights training can be considered one of the quarterly in-services (See ♦452—Civil Rights for more information).
- 8.4 Locally mandated trainings that are not related to certifier competencies, such as HIPAA or blood borne pathogens, cannot be counted as meeting the quarterly WIC in-service requirement.
- 8.5 Local program plans for quarterly in-services will be reported as part of the annual nutrition education plan (see ♦850—Nutrition Education Plan) and documentation of in-service topics and attendance kept on file to be reviewed at biennial Local Agency Review.
- 8.6 See Appendix D for a sample training tracking document.
- Selection of training supervisors*
- 9.0 Each local WIC program will identify a training supervisor.
- 9.1 The local WIC coordinator shall select the training supervisor(s) in consultation with the WIC coordinator’s supervisor.
- 9.2 The state WIC program recommends that the training supervisor be a registered dietitian (RD), although at a minimum the training supervisor must be a health professional as defined in ♦660—Competent Professional Authority: Requirements. The goal is to ensure that the training supervisor not only understands the WIC training modules but can also answer questions beyond the scope of the modules. The training supervisor acts as a resource for accurate information to CPA’s in the program.
- 9.3 The title of “training supervisor” indicates oversight of training and does not need to be a person in a supervisory or management position.
- 9.4 The local WIC program may assign more than one person to share this role. Specific duties or responsibilities may be delegated to other staff.
- 9.5 The local WIC coordinator shall submit the name and qualifications of the training supervisor(s) annually in the nutrition education plan (see ♦850—Nutrition Education Plan).
- Training of training supervisors*
- 10.0 The local WIC coordinator shall train the training supervisor to use the training modules. The training supervisor will receive an orientation to the training supervisor’s role and responsibilities from their local WIC coordinator or from the state WIC training coordinator.

STAFF TRAINING REQUIREMENTS, cont.

(Training of training supervisors)

- 10.1 The training supervisor must be a CPA. That means any Level 2 training modules or online course they have not already completed must be completed. This includes:
- reading the module or completing the online courses;
 - working through the practice activities and skill checks in the module or online course;
 - passing the post-test;
 - being observed; and
 - completing the evaluation of the module.
- 10.2 The training supervisor must complete new modules or online courses before training other staff on that module.

Responsibilities of training supervisor

- 11.0 The training supervisor is responsible for ensuring local staff are trained in a timely manner and in compliance with policy. If the training supervisor is not the WIC Coordinator or staff supervisor, they will work closely with the WIC Coordinator or staff supervisor to develop appropriate training plans for staff. The training supervisor can designate another health professional to train another staff member.
- 11.1 See Appendix B for a sample description of the roles and responsibilities of a WIC training supervisor.

Training supervisor tasks

- 12.0 The training supervisor will work with the trainee's supervisor to develop a training plan. See Appendix C for an example of a training time line or plan for a CPA and Appendix E for a CPA training checklist.
- 12.1 The training supervisor shall initiate training by scheduling time for the trainee to complete each module or online course and the activities involved.
- 12.2 The training supervisor will use the training supervisor's guide that accompanies each module or online course for directions on training with that module.
- 12.3 The trainee will read the modules or complete the online courses and complete all activities, practice activities, or skill checks for each module.
- 12.4 The training supervisor shall do the specified observations for all trainees and document them as indicated in the module instructor's manual or training supervisor's guide. Role playing may be used as needed.
- 12.5 The trainee shall complete the post-test. The standard for competency is 90 percent of the questions answered correctly, unless specifically stated as 100 percent in the training supervisor's guide. If the post-test is hand written the training supervisor will grade it. Online courses have post-tests that are graded by the hosting learning management system.

Standard of competency: minimum 90% score on post-test

STAFF TRAINING REQUIREMENTS, cont.

- 12.5.1 If the score is not 90 percent, the training supervisor must take action to ensure that the trainee knows the material. Options include:
- Having the trainee re-read the sections of the module or review the sections of the online course that contain the information missed on the post-test and then retake the missed questions until all are answered correctly.
 - Having the trainee demonstrate to the training supervisor's satisfaction that she/he knows the material.

12.5.2 If a substantial number (approximately one-third or more) of the post-test questions are answered incorrectly, either have the trainee retake the module/course from the beginning, or have the trainee re-read the pertinent sections, complete the necessary progress checks again, and retake the missed questions.

*“Testing out” of
modules*

- 12.6 If the trainee is a health professional or has two or more years of WIC experience, the training supervisor, at his/her discretion, may have the trainee take the post-test without reading the module and doing the module activities, or without completing the online course. If the trainee passes the post-test with 90 percent correct answers, the training supervisor may complete the competency achievement checklist and consider the trainee competent in that module area. If they do not pass with 90 percent correct, the training supervisor shall instruct the trainee as to which sections of the module need to be completed.
- 12.7 The trainee shall complete the “*Module Evaluation Form*” for each module.
- 12.8 File a copy of the graded post-test or a copy of the Certificate from the Learning Center and the “*Competency Achievement Checklist*” in an appropriate place for each trainee after completion of the module.
- 12.9 The training supervisor will enter the module/course completion date into the TWIST data system in the “Operations and Management” module within a month of module or course completion.
- 12.10 The training supervisor may provide the trainee with a certificate of completion. Certificates of completion can be found on the Oregon WIC website. ★

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SECTION: Local Program Operations
SUBJECT: WAITING LIST
DATE: May 22,2015 (*Reviewed*)

475

POLICY: When a local WIC program is serving its maximum assigned caseload, the local program shall maintain a waiting list of individuals who visit the local program to express interest in receiving program benefits and who are likely to be served.

PURPOSE: To indicate when and how to use a waiting list to ensure service to the highest priority participants when local programs cannot serve all applicants.

RELEVANT REGULATIONS: 7 CFR §246.7 ¶(e)(4)—Nutritional Risk Priority System
7 CFR §246.7 ¶(f)(1)—Waiting Lists
FNS Instruction 803-6 Rev. 1

OREGON WIC PPM REFERENCES: ♦652—WIC Transfer Card and WIC Overseas program
♦653—Participant Transfers Into and Out of State
♦654—Participant Transfers Within State
♦670—Overview of Risk Criteria and Priorities

DEFINITIONS: *Waiting list* A list of individuals who have visited the local program expressing interest in receiving benefits and who are likely to be served when caseload slots become available.

PROCEDURES:

- When a waiting list is required*
- 1.0 A waiting list is required when **all** of the following conditions are met:
 - a. The local WIC program is at or above its assigned caseload; **and**
 - b. An individual visits the local program during clinic office hours to request WIC benefits when there are no caseload slots available; **and**
 - c. The applicant is likely to be served in the near future, i.e., their potential priority level and age group are currently being served by the local program; **and**
 - d. The state has been notified and approved the use of the waiting list.
 - 1.1 Any individual who specifically requests to be placed on a waiting list in person must be added to the list, regardless of their qualification status.
 - 1.2 The local program has the option, but is not required to place individuals on the waiting list in response to telephone requests if they meet the conditions in ¶1.0 a. and c.
 - 1.3 Active WIC participants who transfer into the local program from within Oregon or from another state must receive the first available caseload slots, regardless of priority. Place these individuals at the top of the waiting list. Refer to ♦653—Participant Transfers Into and Out of State and ♦654 Participant Transfers Within State.

WAITING LIST, cont.

WIC overseas program

- 1.4 Active WIC participants who transfer in from the WIC Overseas Program must be placed ahead of all other transfers on the waiting list. See ♦652—WIC Transfer Card and WIC Overseas Program.
- 1.5 Participants who fail to keep scheduled WIC appointments may be placed on the waiting list if they contact the local WIC program and request a rescheduled appointment when that local program has no appointments available.
- 1.6 A local program that is below its assigned caseload may **not** use waiting lists.

Equal treatment

- 1.7 Treat all applicants equally. An applicant who has never been on WIC must have the same access to available appointment slots as a participant who is applying for a second or subsequent certification.

Documentation

- 2.0 The waiting list will be maintained in TWIST (see ¶6.0) and must include:
 - The applicant's name
 - Address and/or phone number
 - Applicant status (pregnant, breastfeeding, age of applicant, etc.)
 - The date the applicant was placed on the waiting list.

Ethnic categories on waiting list

- 2.1 Civil rights regulations **do not** allow a request for information on ethnic classification as part of waiting list procedures.

Notification

- 3.0 Notify applicants of their placement on a waiting list within 20 calendar days after their initial visit to the local program to request WIC benefits. This notification date is usually the date of initial contact.
 - 3.1 The 20-day period also applies if the local program is placing applicants on the waiting list in response to telephone requests.
 - 3.2 Notify all applicants of the estimated length of time they will remain on the waiting list before receiving an appointment.
 - 3.3 Encourage all applicants to contact the local program with address changes or new telephone numbers to facilitate future appointment scheduling.
 - 3.4 Inform applicants regarding the need for a waiting list. Explain that the local program will serve highest priority applicants first when funding and caseloads are limited, but WIC services will be extended to as many eligible participants as possible.



SECTION: Certification
SUBJECT: **Income Eligibility: Current Income Guidelines**
DATE: May 1, 2015 (*revised*)

614

POLICY: Local WIC staff will use the current income guidelines when determining income eligibility.

PURPOSE: To ensure that income eligible applicants and participants receive WIC services.

RELEVANT REGULATIONS: §246.7 ¶(d)(1)(ii)—Annual adjustments in the income guideline
 §246.7 ¶(d)(1)(iii)—Implementation of the income guideline annually

OREGON WIC PPM REFERENCES: ◆611—Income Eligibility: Determining Income Eligibility

TWIST TRAINING MANUAL REFERENCES: Chapter 3, Lesson 102, Enrollment

APPENDICES: 614.2 Appendix A Current Income Guidelines
 614.3 Appendix B Calculating Total Household Income Manually

DEFINITIONS: *Annual income guidelines* USDA updates the federal poverty income levels annually. Local programs will implement the new guidelines according to State instructions. The statewide WIC income eligibility standard is 185% of the federal poverty income guidelines.

Household size A person or group of people, related or not, who usually (though not necessarily) live together, and whose income and consumption of goods or services are related and who are not residents of an institution. The key consideration in determining when individuals or groups are a household (or economic unit) is whether they generate the income which sustains them, i.e., room, board and medical care. When determining a household size, count all pregnant women as two, or more, for expected multiple births, unless a woman specifically waives the increase in number.

Income Gross income, including overtime, before deductions for income taxes, employees’ social security taxes, insurance premiums, bonds, etc. The determination of the amount of a household’s gross income shall not be considered reduced for any reason (e.g.; financial hardships, medical bills, child support). Farmers and self-employed use net income. Net income is determined by subtracting the operating expenses from the gross income.

Income Eligibility: Current Income Guidelines, cont.

PROCEDURE:

- Current Guidelines*** 1.0 WIC staff will use the current income guidelines provided by the state WIC program when determining income eligibility.
- 1.1 TWIST automatically calculates income using the current income guidelines. When unsure if printed sources are current, use TWIST or the income guidelines posted on the WIC web page.
 - 1.2 Income guidelines are generally updated once a year, usually in April or May. When new guidelines are provided all printed materials, local web pages, or outreach materials must be updated or replaced with new versions.
 - 1.3 Local agencies will be notified when updates occur or if the annual updates are being delayed for any reason.
- Public information*** 2.0 WIC income guidelines are public information. Local programs must give information about current WIC income guidelines to the public upon request.
- 2.1 The WIC income guidelines are also posted on the WIC web page. Direct the public to <http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Pages/income.aspx> for more information. ★

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OREGON WIC PROGRAM
Income Eligibility Criteria
Effective May 1, 2015



The WIC income standard is 185% of the federal poverty level.

Number of Person(s) In Household	Gross Household Income		
	Annual	Monthly	Weekly
1	\$21,775	\$1,815	\$419
2	\$29,471	\$2,456	\$567
3	\$37,167	\$3,098	\$715
4	\$44,863	\$3,739	\$863
5	\$52,559	\$4,380	\$1,011
6	\$60,255	\$5,022	\$1,159
7	\$67,951	\$5,663	\$1,307
8	\$75,647	\$6,304	\$1,455
Each additional household member add:	+ \$7,696	+ \$642	+ \$148

Household: A person or group of people, related or not, who usually (though not necessarily) live together, and whose income and consumption of goods or services are related and who are not residents of an institution. The key consideration in determining when individuals or groups are a household (or economic unit) is whether they generate the income which sustains them, i.e., room, board and medical care. When determining a household size, count all pregnant women as two, or more, for expected multiple births, unless a woman specifically waives the increase in number.

Income: means gross income, including overtime, before deductions for income taxes, employees' social security taxes, insurance premiums, bonds, etc. The determination of the amount of a household's gross income shall not be considered reduced for any reason (e.g., financial hardships, medical bills, child support).

Calculating Total Household Income Manually

If not using TWIST to calculate income, the following calculations can be used to screen income when it is reported as other than a monthly figure.

Frequency	To Obtain Monthly Income	To Obtain Annual Income
Weekly	Multiply by 4.3	Multiply by 52
Bi-weekly (every 2 weeks)	Multiply by 2.15	Multiply by 26
Semi-monthly (2x a month)	Multiply by 2	Multiply by 24
Monthly	N/A	Multiply by 12
Quarterly	Divide by 3	Multiply by 4
Annual	Divide by 12	N/A
Hourly	Rate x hours per week x 4.3	Rate x hours per week x 52
Daily	Rate x 5 (or number of workdays per week) x 4.3	Rate x 5 (or number of workdays per week) x 52
Lump Sums	Divide by 12	



SECTION: Certification
SUBJECT: RISK ASSESSMENT
DATE: May 22, 2015 (*Reviewed*)

625

POLICY: Local WIC programs shall assess nutrition risk during the certification process to determine eligibility for WIC participation.

PURPOSE: To ensure that all applicants receive accurate and uniform assessment of their nutrition related health needs.

RELEVANT REGULATIONS: 7 CFR §246.7 ¶(e)—Nutritional Risk
All States Memorandum 96-44
WRO Policy Memorandum 803-AO, Attachment B

OREGON WIC PPM REFERENCES: ♦601—Physical Presence at Certification
♦626—Hemoglobin and Hematocrit Screening in WIC
♦640—Documentation Requirements for Certification in TWIST
♦660—Competent Professional Authority: Requirements
♦670—Overview of Risk Criteria and Priorities
♦675—Risk Criteria Codes and Descriptions

DEFINITIONS:

<i>Anthropometric</i>	Pertaining to body size and proportions. In WIC, the term is normally used in reference to measurements of height, length, weight, and head circumference.
<i>Applicant</i>	A person who comes to the WIC clinic requesting WIC services.
<i>Biochemical</i>	Pertaining to blood chemistry.
<i>Certification</i>	The process of identifying eligibility for WIC by using specific procedures and standards.
<i>Competent professional authority (CPA)</i>	An individual on the staff of the local WIC program authorized to determine nutritional risk and prescribe supplemental foods.
<i>Eligibility criteria</i>	Conditions an applicant must meet in order to be enrolled in the WIC program.
<i>Nutrition risk</i>	A health problem, medical condition, diet deficiency or other issue that can compromise the health of a participant and is required for program eligibility.

RISK ASSESSMENT, cont.

PROCEDURE:

- Overview* 1.0 Applicants who meet the WIC program’s category and income eligibility standards must be determined to be at nutrition risk prior to receiving program benefits. Data collection and evaluation must occur during the certification process in order to assess nutrition risk. Completion of a full assessment is recommended prior to providing counseling and education.
- Data collection* 1.1 Accurate and complete anthropometric, biochemical, dietary, and health information must be gathered by staff for evaluation by the competent professional authority (CPA) during the certification process (See ♦660—Competent Professional Authority: Requirements).
- Referral Data* 1.1.1 Participants may be encouraged to bring data from their health care provider to avoid duplication of health procedures. If data is provided by a health care provider, this must be documented in TWIST. See ♦Policy 640-- Documentation Requirements for Certification in TWIST, Appendix B.
- Physical presence* 1.2 Applicants must be physically present at their certification appointments for data collection and evaluation unless an exception is granted and documented (See ♦601—Physical Presence at Certification).
- Refusal of procedures* 1.2.1 An applicant or parent/caretaker has the right to refuse to participate in any of the health procedures, such as blood tests. The person should be made aware that these procedures are assessment tools used to provide information for determining program eligibility, and the applicant may not qualify without them, depending on the presence of other risk criteria. The reason for refusal should be documented in TWIST according to ♦640— Documentation Requirements for Certification in TWIST, Appendix B.
- Using previous data* 1.2.2 Federal regulations allow height or length and weight measurements collected up to 60 days **before** the certification date to be used as data for certification purposes.
- When to obtain data* 1.2.3 Federal regulations allow blood work to be collected within 90 days of the certification date if the applicant has at least one qualifying nutritional risk factor at the time of certification.
- 1.2.4 Data for pregnant women must be obtained during pregnancy; data for postpartum and breastfeeding women must be collected after the pregnancy. Data for infants must be collected during infancy. Data for children is collected while the applicant is a child, although anthropometric data collected at 11 months of age may be used to certify a 12 or 13-month old child.



SECTION: Certification
SUBJECT: DOCUMENTATION REQUIREMENTS FOR CERTIFICATION IN TWIST
DATE: May 22, 2015 (*Reviewed*)

640

POLICY: Required certification information and activities shall be documented on a participant's record in the TWIST system.

PURPOSE: To assure that the required information and activities occurring during certification are documented in the TWIST system.

RELEVANT REGULATIONS: 7 CFR §246.7—Certification of Participants
7 CFR §246.10 ¶(b)(2)(iii)—Supplemental Foods
7 CFR §246.10 ¶(e)—Food Delivery Systems

OREGON WIC PPM REFERENCES: ♦400—Local Program Overview: Responsibilities and Communications
♦530—Food Instrument Register and FI Stub
♦600—Certification Introduction and Overview
♦635—Participant Notification: Eligibility and Rights & Responsibilities
♦636—Participant Notification: Ineligibility and Termination from WIC
♦641—Documentation Requirements for Certification in the Absence of TWIST

APPENDICES: Appendix A 640.2 Documentation Requirements for TWIST Certification
Appendix B 640.6 Additional Documentation Required for Special Circumstances

DEFINITIONS: *Applicant* An individual who comes to the WIC clinic requesting WIC services.
State requirement An action required by the state WIC program due to state and federal requirements, USDA mandates that allow the state office to set local requirements, state grant assurances, and/or requirements from federal management circulars.
USDA requirement An action required by USDA. The requirement is found in the published code of federal regulations (CFR) and/or USDA policy letters and/or all state memorandums (ASM).

BACKGROUND: Certification for WIC eligibility requires that the applicant be in one of the categories being served by WIC, live in the local WIC program's service area, meet the WIC income guidelines, and have a qualifying nutritional risk factor. See ♦600—Certification Introduction and Overview for an overview of the certification process.

PROCEDURE:
Local program requirements 1.0 Local WIC programs will use the TWIST data system for documentation of all information required for WIC certification.

DOCUMENTATION REQUIREMENTS FOR CERTIFICATION IN TWIST, *cont.*

- (Local program requirements)***
- When TWIST is unavailable***
- Local forms***
- TWIST documentation***
- Notification of termination during certification period***
- Other required documentation***
- 1.1 Refer to the TWIST Training Manual for information about a TWIST screen, button or tab that is identified to complete a task.
 - 1.2 If TWIST is unavailable, local programs may use paper certification forms to collect applicant or participant information. See ♦641—Documentation Requirements for Certification in the Absence of TWIST.
 - 1.3 If a local program develops forms for certification purposes, the local program must get approval from the state WIC office before using the forms. State WIC staff will ensure that all required data is included for collection. See ♦400—Local Program Overview: Responsibilities and Communications for more information.
 - 1.3.1 When state certification forms are revised, any similar forms developed by the local program must be revised and approved by the state WIC office within 60 days of the availability of the revised state form.
- 2.0 See Appendix A for a list that shows where specific information must be documented in TWIST. See Appendix B for additional documentation requirements in special circumstances.
- 2.1 When the documentation location is *recommended* rather than *required*, the local program must identify a location where all local staff will document the information to ensure consistency.
- 3.0 A participant who is to be graduated from the WIC program at any time during the certification period shall be notified in writing not less than 15 days before the termination takes effect. Follow procedures for terminating participants during certification as described in ♦636—Participant Notification: Ineligibility and Termination from WIC.
- 4.0 At every certification or recertification visit, participants must sign the paper “*Participant Signature Form*” (form 57-629). This required documentation is not in TWIST and must be obtained and retained according to ♦635—Participant Notification: Eligibility and Rights & Responsibilities.
- 5.0 Participants must sign the food instrument (FI) stub for all vouchers received following completion of the certification process. This required documentation is not in TWIST and must be obtained and retained according to ♦530—Food Instrument Register and FI Stub. ★

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SECTION: Certification
SUBJECT: DOCUMENTATION REQUIREMENTS FOR
CERTIFICATION IN THE ABSENCE OF TWIST
DATE: May 22, 2015 (*revised*)

641

POLICY: Local program staff shall complete the required certification forms in situations where TWIST is unavailable at the time of a certification visit. These situations include home visits, non-computer satellite clinics, and disaster recovery. Local program staff must enter the data into the TWIST system within two working days of the visit to complete the certification and to print vouchers

PURPOSE: To ensure that certification data collected on paper certification forms is properly collected and entered into the TWIST system in a timely manner to complete the certification and issue vouchers.

RELEVANT REGULATIONS: 7 CFR §246.7—Certification of participants

OREGON WIC PPM REFERENCES:

- ◆400—Local Program Overview: Responsibilities and Communications
- ◆600—Introduction & Overview of Certification
- ◆635—Participant Notification: Eligibility and Rights & Responsibilities
- ◆636—Participant Notification: Ineligibility and Termination from WIC
- ◆640—Documentation Requirements for Certification in TWIST

DEFINITIONS:

<i>Required information</i>	Information that must be collected for WIC applicants to be enrolled.
<i>Optional information</i>	Information that may be collected for WIC applicants but is not required.
<i>Initial certification</i>	The first certification for an individual who has never participated in WIC and is applying for enrollment, or has not participated in WIC for 12 months or more and is reapplying for enrollment. .
<i>Subsequent certification (recertification)</i>	Any certification after the initial (first) certification, unless the participant has not received services from the WIC program for more than 12 months.
<i>Disaster recovery</i>	The continuation of WIC services in the event of a disaster.
<i>Non-computer satellite clinics</i>	A non-permanent clinic that certifies participants without a computer system.
<i>Home visits</i>	A certification visit that occurs in a participant’s home without access to TWIST.

DOCUMENTATION REQUIREMENTS FOR CERTIFICATION IN THE ABSENCE OF TWIST, cont.

PROCEDURE:

Initial/subsequent certifications

1.0 For any participant enrolled at an initial or subsequent certification in a situation when TWIST is unavailable, local agency staff must complete the required certification forms. In situations when no computer is available at the time of the certification visit, i.e., home visits, non-computer satellite clinics, and in disaster recovery situations, use the appropriate required certification forms listed in the table below. Some forms are available online only—these can be downloaded from the WIC website as noted in ¶1.1 and printed. Refer to ♦640—Documentation Requirements for Certification in TWIST.

Required certification forms

1.1

Form #		Form Title
57-	Lang.	
Available electronically only		
615	ENGL	Certification Data Entry Document: Women, Infants, Children
617	ENGL	Health Questionnaire: Infants/Children
617	SPAN	Cuestionario de Salud: Infantes y Niños
618	ENGL	Health Questionnaire: Pregnant Women
618	SPAN	Cuestionario de Salud para Mujeres Embarazadas
619	ENGL	Health Questionnaire: Postpartum Women
619	SPAN	Cuestionario de Salud para Mujeres que Han dado a Luz
622	ENGL	Your Baby’s Diet Questions
622	SPAN	Preguntas sobre la dieta de su Bebé
624	ENGL	Your Child’s Diet Questions
624	SPAN	Preguntas sobre la dieta de su Niños
626	ENGL	Your Diet Questions
626	SPAN	Preguntas sobre su Dieta
Available in hard copy or electronically		
629		Participant Signature Form (Available in English, Spanish, Russian, Vietnamese, Chinese, Somali, Arabic)
633	ENGL/ SPAN	No Proof Form for Special Situation and Income Averaging
636	ENGL	Medical Documentation form Word or PDF

Participant rights and responsibilities

1.2 The paper “*Participant Signature Form*” must be completed at every certification or recertification visit regardless of TWIST availability.

1.2.1 Refer to ♦635—Participant Notification: Eligibility and Rights & Responsibilities for guidelines on distribution of the “*My Rights and Responsibilities*” handout (form 57-630) and completion of the “*Participant Signature Form*.”

DOCUMENTATION REQUIREMENTS FOR CERTIFICATION IN THE ABSENCE OF TWIST, cont.

- | | | |
|--|-------|--|
| <i>Required information</i> | 1.3 | Complete all fields on the required paper certification forms in order to subsequently complete the mandatory fields in the TWIST system. |
| <i>Timeframe for data entry</i> | 1.4 | Enter the data into the TWIST system within two working days of certifying an individual using paper certification forms. Contact the state WIC program if TWIST is unavailable within two working days. In emergency situations, another local agency or the state WIC office can assist with data entry and voucher printing. |
| <i>Process for data entry</i> | 1.4.1 | Local programs must ensure that a process is in place for data entry of paper certification forms within the required two working days. |
| <i>CPA review</i> | 1.4.2 | After the required data elements from the health questionnaire have been entered into TWIST, a Certified Professional Authority (CPA) must review the health history questionnaire screen and check the “CPA reviewed” box. |
| <i>FI printing</i> | 1.4.3 | Vouchers can only be printed after all required certification documentation has been entered in TWIST. |
| <i>Disposal of paper certification forms</i> | 1.5 | Once all the required data elements from the paper certification forms are entered into TWIST, local program staff must destroy the forms following the appropriate method for destruction of confidential and sensitive documents. |
| <i>Locally produced paper certification forms</i> | 2.0 | If the local program develops its own paper certification forms, the forms must meet the requirements in this policy. To ensure that all required data is collected, local programs must get approval from the state WIC program prior to using the locally produced forms. See ♦400—Local Program Overview: Responsibilities and Communications. |
| <i>Revisions of required paper certification forms</i> | 2.1 | Whenever state forms are revised, local programs must revise any similar form that they have developed within 60 days of receipt of the revised state form and submit the revised form(s) to the state WIC office for approval before use. |
| <i>Ineligibility</i> | 3.0 | Complete a “ <i>Notice of WIC Ineligibility</i> ” (form 57-607) or “ <i>Change in Your WIC Benefits</i> ” (form 57-608) if an applicant or a participant is found ineligible while completing a certification in the absence of TWIST. Document ineligibility in TWIST within two working days. See ♦636—Participant Notification: Ineligibility and Termination from WIC. ★ |

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POLICY: Each local WIC program shall have a Competent Professional Authority (CPA) on staff to determine nutrition risk eligibility and prescribe an appropriate food package for each participant.

PURPOSE: To assure the quality of nutrition services in the WIC program.

RELEVANT REGULATIONS: 7 CFR §246.2—Definition Competent Professional Authority
7 CFR §246.6(b)(2)—Perform certification procedures
7 CFR §246.7(d)—Determine nutritional risk
7 CFR §246.7(d)(4)—Fill caseload slots
7 CFR §246.7(g)(7)—Sign Certification Form
7 CFR §246.10(a)(2)(iii)—Prescribe supplemental food
7 CFR §246.11(e)(5)—Provide individual care plan
USDA WIC Nutrition Services Standards—Standard 5 (C)

OREGON WIC PPM REFERENCES: ♦215—Local Program Monitoring and Review
♦440—Staff Training Requirements
♦661—Competent Professional Authority: Appropriate Counseling for Risk Levels

APPENDICES: 660.4 Appendix A CPA Competency Model

DEFINITIONS:

<i>Competent Professional Authority (CPA)</i>	An individual on the staff of the local WIC program authorized to assess program eligibility, determine nutritional risk, provide nutrition education and counseling and prescribe supplemental foods.
<i>WIC Nutritionist</i>	A nutrition professional working in WIC who meets one or more of the following qualifications: a Master's Degree in nutrition; a Registered Dietitian (RD) with the Academy of Nutrition and Dietetics, or eligible for RD registration; an Oregon Licensed Dietitian (LD).
<i>Paraprofessional CPA</i>	A person employed to assist or expand the efforts of professional CPAs. A health professional will supervise the paraprofessional's direct contact with WIC participants and their conducting of education programs.
<i>Professional CPA</i>	A person with a bachelor's or master's degree in a health profession, such as nutrition, nursing or health education. Includes physicians, physician assistants, registered nurses, dietitians, or public health educators.

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

<i>Competencies</i>	Skills, actions, or behaviours related to a specific knowledge requirement that a person can be determined to possess based on a specified set of criteria.
<i>CPA competencies</i>	Broad, program-related statements describing tasks or skills to be mastered by a CPA; derived from performance roles and stated in behavioral terms so they can be observed and mastery can be determined.
<i>Training Supervisor</i>	A person designated by the local program to ensure training of local staff is completed in accordance with state policy. Minimum qualifications: must be a health professional as defined in ¶2.0 of this policy.

PROCEDURE:

- 1.0 Only staff designated and trained as a Competent Professional Authority (CPA) may determine nutrition risk eligibility and prescribe or assign food packages.
 - 1.1 Clerical staff, or any staff not trained as a CPA, may not prescribe/assign food packages for participants. All food packages must be approved/assigned by a CPA.
 - 1.2 Non-WIC staff who determine nutrition risk eligibility and/or assign food packages must meet the CPA requirements described in this policy.
- Non-WIC staff*
- Qualifications: professional CPA**
 - 2.0 Health professionals in any of the following categories may be authorized to serve as a professional CPA:
 - 2.1 Registered dietitian/nutritionist or Oregon licensed dietitian
 - 2.2 Bachelor's or master's degree in nutritional sciences
 - 2.3 Bachelor's or master's degree in home economics with emphasis on nutrition
 - 2.4 Bachelor's or master's degree in health education
 - 2.5 Physicians
 - 2.6 Registered nurses
 - 2.7 Physician's assistants
- Qualifications: paraprofessional CPA**
 - 3.0 Individuals may be authorized to serve as paraprofessional CPAs by meeting all of the following requirements:
 - 3.1 Has a high school diploma or GED equivalent.
 - 3.1.1 It is recommended that local programs select individuals with appropriate educational background to meet the functional requirements, for example, language needs.

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

- Qualifications: paraprofessional CPA***
- 3.2 Has received training in specified competency areas by completing WIC training modules or online courses identified in ♦440—Staff Training Requirements.
 - 3.2.1 Initial training should prepare paraprofessionals for duties of the position by teaching them the basic skills needed to function as a CPA.
 - 3.2.2 Competencies attained during the initial training should be further developed through on-the-job training.
- Required quarterly in-services***
- 3.3 Completes quarterly in-services on topics related to the CPA competencies (see ♦440—Staff Training Requirements).
 - 3.4 Has periodic evaluations to assess performance.
 - 3.5 Works under the direct supervision of a health professional who is also responsible for ongoing job training and evaluation.
 - 3.5.1 Paraprofessional CPAs need to consult with the WIC nutritionist on more complex nutrition issues.
 - 3.6 Has training in referring appropriately to the WIC nutritionist.
 - 3.6.1 All paraprofessionals will receive training in the identification of high-risk participants and in how and when to refer high-risk participants. (See ♦661—Competent Professional Authority: Appropriate Counseling for Risk Levels)
 - 3.6.2 Clear referral guidance will be provided to all paraprofessionals.
- Responsibilities***
- 4.0 Responsibilities of the CPA include:
 - 4.1 Perform the certification procedures;
 - 4.2 Determine nutritional risk;
 - 4.3 Prescribe food packages;
 - 4.4 Provide appropriate nutrition education and breastfeeding promotion and support;
 - 4.5 Refer to health care and community services;
 - 4.6 Refer high-risk participants to a WIC nutritionist for follow-up and individual care plans based on the need for such plan (see ♦661—Competent Professional Authority: Appropriate Counseling for Risk Levels).
- CPA competencies***
- 5.0 A complete list of CPA competencies are described in the CPA competency model (see Appendix A). The CPA competency model illustrates the complexity of the tasks expected of a CPA and can be used to guide staff development and training over time. It is not expected that CPAs will meet all the competencies identified in the model after completing the WIC training modules or online courses. The CPA competency model reinforces the need for ongoing support, training and continuing education for CPAs.

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

- CPA competencies***
- 5.1 Minimum CPA competencies are met by completing the WIC training modules or online courses identified in ♦440—Staff Training Requirements.
 - 5.2 Local programs may choose to encourage staff to develop additional competencies to improve the quality of the services they provide to participants.
 - 5.3 Staff development and quarterly in-services may address any of the competencies listed in the CPA competency model.
- Required training for CPA's***
- 6.0 All persons designated as CPAs must demonstrate proficiency in the identified minimum CPA competencies by:
 - 6.1 Completing the appropriate WIC training modules or online courses. See ♦440—Staff Training Requirements for specific training completion guidelines.
 - 6.1.1 The following Oregon WIC training modules must be completed before an individual can begin certifying WIC participants of a particular category:
 - “*Introduction to WIC*” module
 - “*Dietary Risk*” module
 - appropriate sections of the “*Nutrition Risk*” module
 - the module or online course specific to the participant category to be certified
 - 6.1.2 All training modules or online courses must be completed within six months of the time the individual begins certifying WIC participants.
 - 6.1.3 Best practice would be for CPAs working full time to complete all the required training modules and online courses within 2 to 3 months of hire.
- Ongoing competency development***
- 6.2 Once an individual has completed the appropriate WIC training modules or online courses, the local program training supervisor shall document continued competency development by observation, chart reviews, etc. At a minimum, this must be done **yearly** and can be a component of biennial program self-evaluation (see ♦215—Local Program Monitoring and Review).
 - 6.3 WIC staff serving in the roles of WIC registered dietitian/nutritionist or training supervisor must complete the training to be a CPA.
- Documentation***
- 7.0 The local program must maintain a current list of staff members authorized to act as CPAs by completing the “Staff Training” screen in TWIST for each CPA.

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

- 7.1 The local program must document that staff authorized to act as CPAs are appropriately trained and supervised.
- 7.2 Module or course completion forms must be kept on file at the local program. ★

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Competency Model for Oregon WIC Certifiers Competent Professional Authority (CPA)

In this document, competencies are identified for WIC personnel identified as a CPA by their agency (see Policy 660) who complete certification tasks and procedures.

The 11 core areas for WIC certifiers include:

1. Program Integrity;
2. WIC Program overview;
3. Principles of life-cycle nutrition;
4. Nutrition assessment process;
5. Anthropometric and hematologic data collection techniques;
6. Communication;
7. Multicultural awareness;
8. Critical thinking;
9. Technology Literacy;
10. Nutrition Education; and,
11. Community Resources and Referrals

Each competency area is presented in a separate table. The components of the tables and their definitions are listed below:

Core area	A particular area of skill or body of knowledge.
Knowledge required	A specific topic or content area needed to achieve the competency and is the basis for training content.
Competency	Skills, actions, or behaviors related to a specific knowledge requirement.
Training Methods	How staff will become competent – identifies state provided materials, training or support. This does not address training and support provided by the local agency and/or the local agency training supervisor.

Note: Individual local agencies determine prerequisite competencies they expect at hire. This competency model does not include those basic competencies, but rather includes only competencies that are related to the tasks specific to being a certifier/CPA.

Note: Minimum CPA competencies are met by successful completion of the WIC training modules identified in Policy 440.

Note: Competencies may pertain to more than one core area, but are listed only once in the competency model.

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

1. Program Integrity

Competency Area: *Shows personal accountability.*

Knowledge Required	Competency	Training Methods
Personal accountability	<ol style="list-style-type: none"> 1. Balances multiple responsibilities between nutrition assessment, nutrition education, data entry, and voucher issuance (e.g. shopper education). 2. Practices positive work ethics to ensure program integrity (honesty, integrity, reliability, consistency, fairness) 3. Participates actively in staff development/training. 4. Uses technology and program equipment/materials in an appropriate and safe manner for work purposes only. 5. Performs duties within the context of written policies of the agency where employed, Oregon State policy and USDA regulations. 	<p>Local Agency orientation by Training Supervisor</p> <p>Intro to WIC Module</p>
USDA and State agency policies about participant confidentiality	<ol style="list-style-type: none"> 6. Obtains release of information (Participant Signature Form) according to State agency policy before sharing any participant data. 7. Protects participants' confidentiality in all conversations. 8. Maintains confidentiality of all electronic participant records and information. 	<p>Intro to WIC Module</p> <p>TWIST Training Manual</p> <p>TWIST CPA Training</p>
Civil rights	<ol style="list-style-type: none"> 9. Complies with the provisions of Civil Rights laws, regulations and policies. 	<p>Civil Rights In-service</p>

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

2. WIC Program Overview

Competency Area: *Understands and is able to explain the WIC Program.*

Knowledge Required	Competency	Training Methods
WIC Program orientation	<ol style="list-style-type: none">1. Correctly describes the WIC program to potential participants.2. Directs participants through the clinic flow.3. Correctly explains a WIC participant's rights and responsibilities4. Correctly identifies the 4 primary WIC services (Nutritious food, nutrition education, breastfeeding promotion and support, referrals into health and social services)	Intro to WIC Module
WIC eligibility criteria	<ol style="list-style-type: none">5. Correctly screens participants for eligibility.	Intro to WIC Module
Voucher issuance and use	<ol style="list-style-type: none">6. Correctly issues vouchers to participants.7. Educates WIC shoppers on the correct use of WIC vouchers.	Intro to WIC Module

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

3. Principles of Life-Cycle Nutrition

Competency Area: *Understands normal nutrition issues for pregnancy, lactation, the postpartum period, infancy, and early childhood and their impact on the life course.*

Knowledge Required	Competency	Training Methods
Nutrition requirements and dietary recommendations for women, infants, and children served by WIC	<ol style="list-style-type: none"> 1. Understands basic nutrition concepts. 2. Identifies function and food sources of major nutrients. 3. Analyzes health and nutrition histories based on lifecycle stage. 4. Evaluates the impact of the parent/child relationship and feeding dynamics on nutritional status, growth and development. 	Basic Nutrition Online Course Baby Behaviors Online Course Child Nutrition Online Course
Federal nutrition policy guidance and its implications for women, infants and children served by WIC (e.g., <i>Dietary Guidelines for Americans</i> , MyPlate)	<ol style="list-style-type: none"> 5. Interprets and compares dietary practices of WIC participants to federal policy guidance. 6. Differentiates between safe and inappropriate food and nutrition practices. 	Basic Nutrition Online Course Dietary Risk Module
Relevant evidence-based recommendations from the American Academy of Pediatrics, the Academy of Nutrition and Dietetics, the American College of Obstetrics and Gynecology, the International Lactation Consultant Association, and the Institute of Medicine	<ol style="list-style-type: none"> 7. Analyzes and compares dietary practices with published and evidence-based recommendations. 	Dietary Risk Module Food Package Module All lifecycle nutrition courses
Infant Nutrition		
Relevant evidence-based recommendations from the American Academy of Pediatrics, and the Academy of Nutrition and Dietetics	<ol style="list-style-type: none"> 8. Identifies the impact of infant development on feeding. 9. Understands the nutritional needs of infants. 10. Makes correct recommendations regarding infant feeding. 11. Educates participants about nutrition-related problems experienced by infants. 	Breastfeeding Level 1 Online course Breastfeeding Level 2 Module or Breastfeeding Level 2 Training Infant Feeding and Nutrition Module Infant Formula Module Baby Behaviors Online Course

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

Child Nutrition		
Relevant evidence-based recommendations from the American Academy of Pediatrics, and the Academy of Nutrition and Dietetics	<p>12. Understands the nutritional needs of children 1-5 years of age.</p> <p>13. Educates participants about nutrition related problems experienced by children 1-5 years of age.</p> <p>14. Makes correct recommendations to participants on feeding practices for children 1-5 years of age.</p>	Child Nutrition Online Course
Relevant evidence-based recommendations from the American Academy of Pediatrics, and the Academy of Nutrition and Dietetics	<p>15. Recognizes factors that may contribute to childhood obesity.</p> <p>16. Provides appropriate counseling for parents, with the goal of promoting a healthy weight for their child.</p>	Child Nutrition Online Course
Prenatal Nutrition		
Relevant evidence-based recommendations from the Academy of Nutrition and Dietetics, the American College of Obstetrics and Gynecology, and the International Lactation Consultant Association	<p>17. Recognizes factors relating to weight gain in pregnancy.</p> <p>18. Identifies the importance of proper nutrition for a healthy mother and baby.</p> <p>19. Makes recommendations to participant on safe practices and behaviors that impact pregnancy.</p> <p>20. Recognizes the importance of referral and follow-up of women with nutrition-related health problems.</p> <p>21. Able to work with pregnant women from special population groups.</p>	Prenatal Nutrition Online Course
Breastfeeding		
Relevant evidence-based recommendations from the American Academy of Pediatrics, the Academy of Nutrition and Dietetics, the American College of Obstetrics and Gynecology, and the International Lactation Consultant Association	<p>22. Promotes breastfeeding as the biological norm for feeding infants.</p> <p>23. Recognizes potential concerns related to breastfeeding and refers participants appropriately.</p> <p>24. Recognizes health and lifestyle contraindications to breastfeeding.</p> <p>25. Assesses real and perceived barriers to breastfeeding and counsels to assist mothers to overcome these barriers.</p>	<p>Intro to WIC Module</p> <p>Breastfeeding Level 1 Online Course</p> <p>Breastfeeding Level 2 module or Breastfeeding Level 2 Training</p>
The basic physiology of lactation and evidence-based techniques for lactation management	<p>26. Applies knowledge of anatomy and physiology in the assessment of normal breastfeeding and breastfeeding problems.</p> <p>27. Demonstrates and assesses effective practices that support breastfeeding.</p>	<p>Breastfeeding Level 2 Module or Breastfeeding Level 2 Training</p> <p>Baby Behaviors Online Course</p>

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

	<p>28. Completes breastfeeding assessments at critical points in pregnancy and the early postpartum period according to State agency policies.</p> <p>29. Analyzes common breastfeeding problems and identifies solutions using evidence-based information .</p>	
Breast pumps	30. Appropriately issues and explains the use of breast pumps.	<p>Breastfeeding Level 2 Module or Breastfeeding Level 2 Training</p> <p>Breast Pump Handbook</p> <p>TWIST Training Manual</p> <p>TWIST CPA Training</p>
Postpartum Women		
Relevant evidence-based recommendations from the Academy of Nutrition and Dietetics, and the American College of Obstetrics and Gynecology	<p>31. Understands the nutritional needs of postpartum women.</p> <p>32. Makes correct recommendations to postpartum participants regarding healthy weight.</p>	Postpartum Nutrition Online Course

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

4. Nutrition Assessment Process

Competency Area: *Understands the WIC nutrition assessment process including risk assignment and documentation.*

Knowledge Required	Competency	Training Methods
Purpose of nutrition assessment in the WIC Program and how to collect accurate and relevant information	<ol style="list-style-type: none"> 1. Uses nutrition assessment information to determine eligibility, select appropriate food packages, provide appropriate nutrition education, and make appropriate referrals. 2. Provides individualized nutrition assessment for WIC participants. 3. Uses assessment techniques that consider the varied needs of age-specific populations. 4. Obtains relevant assessment data from current and previous WIC visits, including anthropometric, hematologic, clinical, dietary, family and social environment information. 5. Uses standardized data collection tools or procedures according to State agency policies. 	Nutrition Risk Module Dietary Risk Module WIC Participant Centered Education Online Course
WIC nutrition risk criteria	<ol style="list-style-type: none"> 6. Assigns nutrition risks correctly using appropriate cut-off values and definitions. 8. Provides appropriate follow up for assigned risk (i.e. high-risk referrals with the RD or second NE). 	Nutrition Risk Module Dietary Risk Module
Importance of documenting nutrition assessment results	<ol style="list-style-type: none"> 9. Correctly documents nutrition risks according to State agency policies. 10. Maintains appropriate documentation of contacts with participants according to State agency policies. 11. Uses accepted documentation format for nutrition care plans according to State agency policies. 	TWIST CPA Training TWIST Training Manual Nutrition Risk Module Dietary Risk Module

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

5. Anthropometric and Hematologic Data Collection Techniques

Competency Area: *Understands the importance of using appropriate measurement techniques to collect anthropometric and hematologic data.*

Knowledge Required	Competency	Training Methods
Relevance of anthropometric data to health and nutrition status	<ol style="list-style-type: none">1. Demonstrates appropriate anthropometric measurement techniques specific to infants, children ages 2-5, and adults.2. Accurately reads and records, and measures.3. Correctly interprets growth data and prenatal weight gain.	Anthropometric Online Course
Relationship of hematologic parameters to health and nutrition status	<ol style="list-style-type: none">4. Demonstrates appropriate techniques for performing a hemoglobin or hematocrit assessment.5. Evaluates hemoglobin or hematocrit results correctly (e.g., adjusts for smoking and elevation, etc.).	Hematology Online Course

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

6. Communication

Competency Area: *Knows how to develop rapport and foster open communication with participants and caretakers.*

Knowledge Required	Competency	Training Methods
Principles of effective communication	<ol style="list-style-type: none"> 1. Uses appropriate techniques to establish a relationship and begin a conversation. 2. Practices active listening and observation skills. 3. Collects information without interrupting or correcting the applicant. 4. Checks for understanding by paraphrasing or reflecting what was heard. 5. Compares participants' verbal responses to non-verbal behaviors to assess participants' attitude, feelings, and readiness for change. 6. Uses an effective balance of open-ended and closed-ended questions. 7. Affirms participants' feelings, beliefs and efforts. 8. Expresses empathy for the participants' situation. 9. Completes nutrition assessment tasks before providing nutrition counseling. 10. Selects forms for participants to complete that are appropriate for the target population (i.e. language, reading level, length, format) according to State agency policy. 	<p>PCS Setting the Stage Online Course</p> <p>WIC Participant Centered Education Online Course</p> <p>Breastfeeding Level 2 Module or Breastfeeding Level 2 Training</p>
Principles of customer service	<ol style="list-style-type: none"> 11. Provides excellent customer service in person and on the phone to WIC participants, vendors, medical providers, community partners, and referral organizations. 	<p>PCS Setting the Stage Online Course</p>

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

7. Multicultural Awareness

Competency Area: Understands how sociocultural issues (race, ethnicity, religion, group affiliation, socioeconomic status, and world view) affect nutrition and health practices and nutrition-related health problems.

Knowledge Required	Competency	Training Methods
Cultural groups in the target population including their families and communities, values and beliefs, characteristics, and resources	<ol style="list-style-type: none"> 1. Respects different belief systems about issues such as blood work, immunizations, dietary supplements, alternative medicine, and traditional healers. 2. Evaluates cultural practices for their potential to influence the participants' health or nutritional status. 	Intro to WIC WIC Participant Centered Education Online Course Food Package Module
Cultural eating patterns and family traditions such as core foods, traditional celebrations, and fasting	<ol style="list-style-type: none"> 3. Includes a culture's core foods and recognizes their nutrient contributions in any assessment of eating patterns. 4. Evaluates food selection and preparation within a cultural context. 	Food Package Module
Differences in communication styles between groups and how these differences may impact the certification process	<ol style="list-style-type: none"> 5. Uses culturally appropriate communication styles to collect nutrition assessment information and provide participant centered counseling. 6. Uses interpretation and/or translation services appropriately to communicate with participants with limited English proficiency. 7. Uses culturally appropriate strategies to assess breastfeeding and child feeding practices and beliefs. 	WIC Participant Centered Education Online Course Breastfeeding Level 2 Module or Breastfeeding Level 2 Training

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

8. Critical Thinking

Competency Area: *Knows how to synthesize and analyze data to draw appropriate conclusions.*

Knowledge Required	Competency	Training Methods
Principles of critical thinking	<ol style="list-style-type: none"> 1. Collects all information before drawing conclusions and deciding upon the best next steps (course of action). 2. Asks additional questions to clarify information or gather more details. 3. Recognizes superfluous or tangential information and disregards it. 4. Considers the applicant's point of view regarding their needs, concerns, and nutrition and health priorities. 5. Recognizes factors that contribute to the identified nutrition problem(s). 6. Identifies relationships between behaviors/practices and nutritional risk. 7. Checks the accuracy of inconsistent or unusual measurements. 8. Identifies factors that influence the accuracy of anthropometric or hematologic measurements (e.g. uncooperative child or faulty equipment) and documents them. Takes appropriate actions (e.g., rechecks measurements, documents factors that interfere with measurements). 9. Draws conclusions about nutritional status supported by objective data, observations, experience, and reasoning. 10. Prioritizes nutrition concerns to be addressed. 11. Assigns the food package most appropriate to the participants' category, risk, and personal preferences. 	<p>WIC Participant Centered Education Online Course</p> <p>Food Package Module</p> <p>Included as part of all training provided.</p>
Scope of practice	<ol style="list-style-type: none"> 12. Works within the scope of practice for their position and accesses appropriate resources. 	<p>Nutrition Risk Module</p> <p>Breastfeeding Level 2 Module or Breastfeeding Level 2 Training</p>

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

9. Technology Literacy

Competency Area: *Uses technology to record participant data, schedule appointments and produce vouchers.*

Knowledge Required	Competency	Training Methods
Computer use	<ol style="list-style-type: none"> 1. Demonstrates basic computer skills. 	Local Agency Training Supervisor
TWIST data system	<ol style="list-style-type: none"> 2. Records correct participant information in the data system. 3. Uses the data system to document nutrition assessment data including anthropometric measurements,, hemoglobin or hematocrit levels, health history and diet assessment information. 4. Uses the data system to record participant contacts, care plans, and nutrition education provided. 5. Makes appropriate food package selections and correctly records them in the data system. 6. Identifies appropriate food benefits to be issued. 7. Coordinates food benefit issuance with nutrition education. 8. Schedules appropriate appointments for participants. 9. Enters data accurately. 10. Locates and utilizes needed reports. 	TWIST Training Manual TWIST CPA Training TWIST Practice Database

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

10. Nutrition Education

Competency Area: *Provides appropriate targeted Nutrition Education for WIC participants using principles of participant centered education in both individual and group settings.*

Knowledge Required	Competency	Training Methods
Marketing	1. Positively promotes nutrition education to WIC participants.	Intro to WIC Module
Principles of participant centered education Adult Learning Theory Elements of effective nutrition education	2. Uses and demonstrates key educator behaviors of participant-centered education. 3. Understands the factors that influence an individual's food behavior. 4. During a given visit, selects with the participant, a limited number of issues to discuss from all the potential nutrition issues. 5. Uses assessment information to select nutrition education concepts that engage the participant in setting individual, simple and attainable next steps to improve their health outcomes. 6. Provide participants with clear and relevant "how to" actions and ideas to accomplish participant-identified next steps 7. Focuses nutrition education on participant strengths and interests. 8. Provides health-outcome based anticipatory guidance. 9. Uses effective counseling methods or teaching strategies that are relevant to the participants' nutritional risk and interests and are easily understood. 10. When providing nutrition education, assesses the effectiveness of previous interventions on behavior change. 11. Selects research-based education materials based on the participants' language, culture, literacy level and interests and effectively presents the material to the participant. 12. Maintains an environment that promotes good nutrition and health. 13. Uses counseling strategies to build participant self efficacy.	WIC Participant Centered Education Online Course

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

Knowledge Required	Competency	Training Methods
Providing Group Nutrition Education – Only required for CPAs teaching classes		
Adult Learning Theory Facilitation techniques	<ol style="list-style-type: none"> 14. Develops and prepares session guides, activities, and materials based on adult learning theory, participants' needs, interests, age, and abilities. 15. Effectively facilitates group nutrition education sessions. 16. Engages participants in hands-on learning to achieve positive health outcomes. 17. Uses creative facilitation strategies that build on participants learning styles (ways of learning), strengths, prior knowledge, and skills. 18. Creates a respectful learning environment in which participants in a group feel comfortable participating. 19. Provides positive reinforcement in a group setting. 20. Improve group offerings and facilitation skills/techniques using evaluation results. 21. Appropriately uses audiovisual equipment and materials. 22. Organizes and maintains education materials, supplies, and equipment. 	Providing Participant Centered Groups Module

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, cont.

11. Community Resources and Referrals

Competency Area: *Identifies community resources and refers WIC participants for appropriate services.*

Knowledge Required	Competency	Training Methods
Community resources and referral process	<ol style="list-style-type: none">1. Identifies key referral resources available to WIC staff.2. Gives participants appropriate referrals into health care.3. Gives participants appropriate referrals to community resources, including mandatory referrals to OHP, drug and alcohol services.4. Documents referrals appropriately	Intro to WIC Module TWIST Training Module
Immunization schedule	<ol style="list-style-type: none">5. Screens participants' immunization records and refers appropriately.	Screening Immunization Records In WIC packet
Community partnerships	<ol style="list-style-type: none">6. Knows community demographics, resources, needs and issues.	Intro to WIC Module

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

References

Value Enhanced Nutrition Assessment (VENA) in WIC – The First Step in Quality Nutrition Services notebook, USDA - FNS, June 2006, Appendix D: Essential Staff Competency Tables for WIC Nutrition Assessment*

Nutrition Services Standards, USDA – FNS, August 2013

WIC Nutrition Education Guidance, USDA – FNS, All States Memorandum 06-24, January 2006

“Personal Attributes and Job Competencies Needed by EFNEP Paraprofessionals as Perceived by EFNEP Professionals”, Journal of Nutrition Education and Behavior, Volume 35, Number 1

Food Stamp Nutrition Education Paraprofessional Nutrition Educators Core Competencies, Draft presented at the 2006 Society for Nutrition Education Conference

Paraprofessionals in the WIC Program: Guidelines for Developing a Model Training Program, United States Department of Agriculture, Food and Nutrition Service, FNS269, 1993.

Regulations associated with core competency areas

	CPA Core Area	Regulation (CFR)
1.	Program Integrity	246.7(j) 246.8
2.	WIC Program Overview	246.12
3.	Principles of life-cycle nutrition <ul style="list-style-type: none">• Prenatal (maternal)• Breastfeeding• Infant• Child/toddler• BF promotion and Support	246.11(c)(2)
4.	Nutrition Assessment process <ul style="list-style-type: none">• Risk Criteria• Diet Assessment	246.7(e)
5.	Anthropometric and biochemical data collection <ul style="list-style-type: none">• Anthropometric• Biochemical	
6.	Communication <ul style="list-style-type: none">• Customer Service• Counseling	
7.	Multicultural awareness	

COMPETENT PROFESSIONAL AUTHORITY: REQUIREMENTS, *cont.*

	CPA Core Area	Regulation (CFR)
8.	Critical thinking <ul style="list-style-type: none">• Medical/health/economic/social influences• Food package assignment• Individual care plans	246.10(b)(2)(iii) 246.11(e)(5)
9.	Technology Literacy	
10.	Nutrition Education <ul style="list-style-type: none">• Counseling	246.11(c)(2)
11.	Community Resources and Referrals	246.7(b)

Shaded text = competencies identified for VENA



SECTION: Certification 670
SUBJECT: **OVERVIEW OF RISK CRITERIA AND PRIORITY LEVELS**
DATE: May 22, 2015 (*Reviewed*)

POLICY: All participants must be assigned one or more of the medical and/or nutritional risk factors used by the Oregon WIC program to determine nutritional eligibility for WIC participation

PURPOSE: To ensure consistent use of federally-defined risk criteria and priorities among local WIC programs.

RELEVANT REGULATIONS: 7 CFR §246.7(e)—Nutritional risk
 7 CFR §246.7(i)(6-9)—Certification forms

OREGON WIC PPM REFERENCES: ♦325—Caseload Management
 ♦625—Risk Assessment
 ♦640—Documentation Requirements for Certification in TWIST
 ♦653—Participant Transfers Into and Out of State
 ♦654—Participant Transfers Within State
 ♦675—Risk Criteria Codes and Descriptions

DEFINITIONS: *Risk criteria* Health or dietary conditions that indicate a nutrition related problem and is required for program eligibility.

Priority A ranking system used to indicate severity of need when comparing one participant with another and used for caseload management. Priority 1 is highest priority, Priority 7 is lowest priority.

PROCEDURE:

- Minimum risk requirements***
- 1.0 The following must be done at each certification:
 - 1.1 Document all risk criteria applicable to the participant in the participant’s TWIST record. Refer to “*Oregon WIC Training: Nutrition Risk Module*,” “*Oregon WIC Training: Dietary Risk Module*” and ♦625—Risk Assessment for information on risk assessment and assignment.
 - 1.2 All manually assigned risk factors must be supported by documentation in the participant’s record. Refer to “*Oregon WIC Training: Nutrition Risk Module*,” “*Oregon WIC Training: Dietary Risk Module*” and ♦640—Documentation Requirements for Certification in TWIST
 - 1.3 Refer to ♦675—Risk Criteria Codes and Descriptions for the current list of risk criteria for women, infants, and children.
 - 1.4 Document all new risks that develop during a certification period in TWIST. This ensures that the participant’s record accurately reflects their risk and priority status throughout their certification.

List of risk criteria

New risk during a certification period

OVERVIEW OF RISK CRITERIA AND PRIORITIES, *cont.*

- Priority levels** 2.0 A participant's priority level is automatically assigned by TWIST based on the highest priority level that the participant's risk factor(s) allows.
- Priority I Includes pregnant women, breastfeeding women, and infants at nutritional risk for reasons other than dietary risks or presumed eligibility as demonstrated by hematological or anthropometric measurements or nutritionally related medical conditions.
- Priority II Includes infants, except for infants who qualify for Priority I, up to six months of age of WIC program participants who participated during pregnancy and infants up to six months of age born of women who were not program participants during pregnancy but whose medical records indicate that they were at nutritional risk during pregnancy.
- Priority III Includes children at nutritional risk for reasons other than dietary risks or presumed eligibility as demonstrated by hematological or anthropometric measurements or nutrition- related medical conditions.
- Priority IV Includes pregnant women, breastfeeding women, and infants with a dietary risk or presumed eligibility as the only risk factor. It also includes postpartum, non-breastfeeding women at nutritional risk for reasons other than dietary risk or presumed eligibility.
- Priority V Includes children with dietary risks or presumed eligibility.
- Priority VI Includes postpartum, non-breastfeeding women at nutritional risk who do not qualify as a priority IV participant.
- Priority VII Includes participants certified for WIC solely due to homelessness or migrant status or previously certified participants who might regress in nutritional status without WIC supplemental foods.
- 2.1 Regardless of priority level, a participant who is currently enrolled in WIC and transfers from another WIC agency must be enrolled within the guidelines specified in ♦653—Participant Transfers Into and Out of State and ♦654—Participant Transfers Within State.



SECTION: Certification 675
SUBJECT: **RISK CRITERIA CODES AND DESCRIPTIONS**
DATE: May 22, 2015 (*Revised*)

POLICY: The competent professional authority (CPA) shall use this list of risk criteria, codes and descriptions when assigning risk factors to program applicants.

PURPOSE: To specify and define allowable nutrition risk factors used in the Oregon WIC Program. To ensure consistent assessment of applicants for nutritional risk throughout the state.

RELEVANT REGULATIONS: 7 CFR §246.7 ¶(e)—Nutritional Risk
 WIC Policy Memorandum 98-9, (Rev. 7)(Rev. 8)(Rev. 9)(Rev. 10)—WRO Policy Memo 803-AZ

APPENDICES:	Appendix A	675.25	BMI Tables
	Appendix B	675.26	Table for determining BMI without having to perform calculations
	Appendix C	675.27	Metric equivalents for average weight gain (for USDA Code 135)
	Appendix D:	675.30	WIC Hematocrit and Hemoglobin Values (For USDA Code 201)
	Appendix E	675.36	Altitudes of Oregon Cities
	Appendix F	675.39	Drug Nutrient Interaction

DEFINITIONS:	<i>BMI</i>	Body Mass Index
	<i>Gestational age adjust</i>	For the premature infant, adjusting calculation of weight for age and/or length for age based on gestational rather than chronological age.
	<i>Homeless person</i>	A person who lacks a fixed and regular nighttime residence, or whose primary nighttime residence is one of the following: <ol style="list-style-type: none"> a. A temporary accommodation of not more than 365 days in the residence of another individual. b. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (such as cars, park benches, abandoned buildings, or campgrounds). c. A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including a welfare hotel, a congregate shelter or a shelter for victims of domestic violence). d. An institution that provides a temporary residence for individuals intended to be institutionalized.
	<i>Migrant Farm worker</i>	A person whose principal employment is in seasonal agriculture, who has been so employed in the last 24 months, and who establishes, because of that employment, a temporary abode.

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

(DEFINITIONS:) *Migrant, in stream* A migrant farm worker or family member who comes into a clinic service area with the harvest stream and leaves the clinic service area, often mid-certification, for employment in the harvest of other crops or to return to her/his home base.

Nutrition risk

- Detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements;
- Other documented nutritionally related medical conditions;
- Dietary deficiencies that impair or endanger health; or
- Conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions.

BACKGROUND: The purpose of establishing nutrition risk criteria is to identify participants most in need of WIC services. The nutrition education and food supplements WIC provides can help to reduce or eliminate these nutrition risks. Targeting WIC services to those in need improves birth outcomes and the growth and development of infants and young children.

From the time the WIC program began, state agencies have had the responsibility for developing nutrition risk criteria with broad guidance from USDA. In 1989, Congress mandated that USDA complete a study of nutrition risk criteria and priority system to ensure that WIC benefits are targeted towards those most in need of those benefits. In 1993, USDA awarded a grant to the National Academy of Sciences' Institute of Medicine (IOM) to undertake a comprehensive review of most of the nutrition risk criteria used by state agencies.

In 1996, the IOM released its report of this study, *WIC Nutrition Risk Criteria: A Scientific Assessment*. This report contains a detailed literature review and the committee's recommendation for each criterion studied. Using this report, Food and Nutrition Services (FNS) and the National WIC Association (NWA) established a collaborative effort to develop national risk criteria based on sound science and practical application in WIC clinics.

In addition, the NWA/FNS workgroup identified the need for on-going work on unresolved issues and future issues arising out of emergent science. This need led to the formation of the Risk Identification and Selection Collaborative (RISC), which has developed a process for further study and review of nutrition risk criteria.

PROCEDURE: 1.0 This policy outlines the nutrition risk criteria that Oregon has adopted from the national policy. The USDA risk criteria numbering system is used to assign nutrition risks in the TWIST system.

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

Nutrition Risk Criteria Allowed for WIC Program Certification

LEGEND	≤ – is “less than or equal to”	WP – Woman, pregnant
	≥ – is “greater than or equal to”	WE – Woman fully breastfeeding
	I – Infant (IE, IB, IN)	WB – Woman some or mostly breastfeeding
	C – Child	WN – Woman non-breastfeeding

USDA Code	Risk Criterion	Definition and Cutoff *	Participant Category ** & Priorities
100 Series	ANTHROPOMETRIC	Low Weight for Height	
101	Underweight (Women)	<ul style="list-style-type: none"> ◆ Pregnant women — prepregnancy Body Mass Index (BMI) <18.5 ◆ Non-breastfeeding women and breastfeeding women who are < 6 months postpartum — prepregnancy or current BMI <18.5. ◆ Breastfeeding women who are ≥ 6 months postpartum — current BMI <18.5. 	WP I WE, WB I WN, VI
103	Underweight (Infants and Children)	<ul style="list-style-type: none"> ◆ Underweight: <ul style="list-style-type: none"> • Birth to < 24months: ≤2% weight for length • 2-5 years: ≤5% BMI for age ◆ At Risk of Underweight: <ul style="list-style-type: none"> • Birth to < 24months: >2% and ≤ 5% weight for length • 2-5 years: >5% and ≤ 10% BMI for age 	I I C III
100 Series	ANTHROPOMETRIC	High Weight for Height	
111	Overweight (Women)	<ul style="list-style-type: none"> ◆ Pregnant women — prepregnancy BMI ≥ 25.0 ◆ Non-breastfeeding women and breastfeeding women who are < 6 months postpartum — prepregnancy BMI ≥ 25. ◆ Breastfeeding women who are ≥ 6 months postpartum — current BMI ≥ 25. 	WP I WE, WB I WN, VI
113	Overweight (Children 2–5 years of age)	≥ 24 months to 5 years: ≥ 95 % BMI for age	C III
114	At Risk of Overweight (Children 2 -5 years of age)	≥24 months to 5 years : ≥ 85% and < 95 % BMI for age	C III
115	High Weight for Length (Infants and Children < 24 months of age)	Birth to < 24 months: ≥ 98% weight for length	I I C III

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff *	Participant Category ** & Priorities																																	
120 Series ANTHROPOMETRIC Short Stature																																				
121	Short Stature (Infants and Children)	<ul style="list-style-type: none"> ◆ Short Stature: <ul style="list-style-type: none"> • Birth to < 24 months: <2% length for age • 2-5 years : ≤5% height for age At Risk of Short Stature: <ul style="list-style-type: none"> • Birth to < 24 months: >2% and ≤ 5% length for age • 2-5 years: > 5% and ≤ 10 % height for age 	I I C III																																	
130 Series ANTHROPOMETRIC Inappropriate Growth/Weight Gain Pattern																																				
131	Low maternal weight gain	<p>In the 2nd and 3rd trimesters, singleton pregnancies, weight gain:</p> <ul style="list-style-type: none"> ◆ underweight < 1 lbs (16 oz) /week ◆ normal < .8 lbs (12.8 oz) /week ◆ overweight < .5 lbs (8 oz) /week ◆ obese < .4 lbs (6.4 oz) /week <p>In the 2nd or 3rd trimesters, twin pregnancies, weight gain: <1.5 lbs (24 oz) /week In the 1st, 2nd or 3rd trimester, triplet pregnancies, weight gain: <1.5 lbs (24 oz) /week</p> <p>OR</p> <p>Low weight gain at any point in pregnancy, such that a woman’s weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective prepregnancy weight category (underweight, normal, overweight, obese), using IOM-based weight gain grid.</p> <table border="0" style="width: 100%; margin-top: 20px;"> <thead> <tr> <th style="text-align: left;"><u>Prepregnancy Wt Group</u></th> <th style="text-align: center;"><u>BMI</u></th> <th style="text-align: right;"><u>Risk if gain is:</u></th> </tr> </thead> <tbody> <tr> <td colspan="3"><i>Singleton</i></td> </tr> <tr> <td>Underweight</td> <td style="text-align: center;">< 18.5</td> <td style="text-align: right;"><28 lbs</td> </tr> <tr> <td>Normal</td> <td style="text-align: center;">18.5-24.9</td> <td style="text-align: right;"><25 lbs</td> </tr> <tr> <td>Overweight</td> <td style="text-align: center;">25.0-29.9</td> <td style="text-align: right;"><15 lbs</td> </tr> <tr> <td>Obese</td> <td style="text-align: center;">≥ 30.0</td> <td style="text-align: right;"><11 lbs</td> </tr> <tr> <td colspan="3"><i>Twins</i></td> </tr> <tr> <td>Underweight</td> <td style="text-align: center;">< 18.5</td> <td style="text-align: right;"><37 lbs*</td> </tr> <tr> <td>Normal</td> <td style="text-align: center;">18.5-24.9</td> <td style="text-align: right;"><37 lbs</td> </tr> <tr> <td>Overweight</td> <td style="text-align: center;">25.0-29.9</td> <td style="text-align: right;"><31 lbs</td> </tr> <tr> <td>Obese</td> <td style="text-align: center;">≥ 30.0</td> <td style="text-align: right;"><25 lbs</td> </tr> </tbody> </table> <p>*Additional research needed to establish specific range. Use the same assessment for both teens and women.</p>	<u>Prepregnancy Wt Group</u>	<u>BMI</u>	<u>Risk if gain is:</u>	<i>Singleton</i>			Underweight	< 18.5	<28 lbs	Normal	18.5-24.9	<25 lbs	Overweight	25.0-29.9	<15 lbs	Obese	≥ 30.0	<11 lbs	<i>Twins</i>			Underweight	< 18.5	<37 lbs*	Normal	18.5-24.9	<37 lbs	Overweight	25.0-29.9	<31 lbs	Obese	≥ 30.0	<25 lbs	WP I
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RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff *	Participant Category ** & Priorities																																	
130 Series <i>continued</i> ANTHROPOMETRIC Inappropriate Growth/Weight Gain Pattern																																				
132	Maternal weight loss during pregnancy	Any weight loss below pregravid weight during 1st trimester, or Weight loss of ≥ 2 lbs (≥ 1 kg) in the 2nd or 3rd trimesters (14-40 weeks gestation)	WP I																																	
133	High maternal weight gain	<p>In the 2nd and 3rd trimesters, singleton pregnancies, weight gain:</p> <ul style="list-style-type: none"> ◆ underweight >1.3 lbs / week ◆ normal >1 lb /week ◆ overweight >.7 lb /week ◆ obese > .6 lbs /week <p>OR</p> <p>High weight gain at any point in pregnancy, such that a woman’s weight plots at any point above the top line of the appropriate weight gain range for her respective prepregnancy weight category (underweight, normal, overweight, obese), using IOM-based weight gain grid.</p> <p>Breastfeeding or Non-breastfeeding woman, most recent pregnancy total weight gain exceeding:</p> <table border="0" data-bbox="451 747 1665 1136"> <thead> <tr> <th><u>Prepregnancy Wt Group</u></th> <th><u>BMI</u></th> <th><u>Risk if gain is:</u></th> </tr> </thead> <tbody> <tr> <td colspan="3"><i>Singleton</i></td> </tr> <tr> <td>Underweight</td> <td>< 18.5</td> <td>>40 lbs</td> </tr> <tr> <td>Normal</td> <td>18.5-24.9</td> <td>>35 lbs</td> </tr> <tr> <td>Overweight</td> <td>25.0-29.9</td> <td>>25 lbs</td> </tr> <tr> <td>Obese</td> <td>≥ 30.0</td> <td>>20 lbs</td> </tr> <tr> <td colspan="3"><i>Twins</i></td> </tr> <tr> <td>Underweight</td> <td><18.5</td> <td>> 54 lbs*</td> </tr> <tr> <td>Normal</td> <td>18.5-24.9</td> <td>>54 lbs</td> </tr> <tr> <td>Overweight</td> <td>25.0-29.9</td> <td>>50 lbs</td> </tr> <tr> <td>Obese</td> <td>>30</td> <td>>42 lbs</td> </tr> </tbody> </table> <p>* Additional research needed to establish specific range</p>	<u>Prepregnancy Wt Group</u>	<u>BMI</u>	<u>Risk if gain is:</u>	<i>Singleton</i>			Underweight	< 18.5	>40 lbs	Normal	18.5-24.9	>35 lbs	Overweight	25.0-29.9	>25 lbs	Obese	≥ 30.0	>20 lbs	<i>Twins</i>			Underweight	<18.5	> 54 lbs*	Normal	18.5-24.9	>54 lbs	Overweight	25.0-29.9	>50 lbs	Obese	>30	>42 lbs	WP I WE, WB I WN VI
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134	Failure to thrive	Presence of failure to thrive diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician’s orders. Base diagnosis of failure to thrive for premature infants on gestational age adjustment for LBW or VLBW infants.	I I C III																																	

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff*	Participant Category ** & Priorities																																																														
130 Series <i>continued</i> ANTHROPOMETRIC Inappropriate Growth/Weight Gain Pattern																																																																	
135	Slow weight gain	<p>A. INFANTS from Birth to 1 month of age: Excessive weight loss after birth or not back to birth weight by 2 weeks of age.</p> <p>B. INFANTS from Birth to 6 months of age: Based on 2 weights taken at least 1 month apart, the infant’s actual weight gain is less than the calculated expected minimal weight gain based on the table below. See Appendix C for metric equivalents and examples.</p> <table border="1" data-bbox="464 565 1386 776"> <thead> <tr> <th><u>Age</u></th> <th colspan="4"><u>Average Weight Gain</u></th> </tr> </thead> <tbody> <tr> <td>0 – 1 mo.</td> <td>18gm/day</td> <td>4½ oz/wk</td> <td>19 oz/mo</td> <td>1 lb 3 oz/mo</td> </tr> <tr> <td>1 – 2 mo.</td> <td>25gm/day</td> <td>6¼ oz/wk</td> <td>27 oz/mo</td> <td>1 lb 11 oz/mo</td> </tr> <tr> <td>2 – 3 mo.</td> <td>18gm/day</td> <td>4½ oz/wk</td> <td>19 oz/mo</td> <td>1 lb 3 oz/mo</td> </tr> <tr> <td>3 – 4 mo.</td> <td>16gm/day</td> <td>4 oz/wk</td> <td>17 oz/mo</td> <td>1 lb 1 oz/mo</td> </tr> <tr> <td>4 – 5 mo.</td> <td>14gm/day</td> <td>3½ oz/wk</td> <td>15 oz/mo</td> <td></td> </tr> <tr> <td>5 – 6 mo.</td> <td>12gm/day</td> <td>3 oz/wk</td> <td>13 oz/mo</td> <td></td> </tr> </tbody> </table> <p>C. INFANTS AND CHILDREN from 6 months to 59 months of age: Option I: Based on 2 weights taken at least 3 months apart, the infant’s or child’s actual weight is less than the calculated expected weight gain based on the table below. See Appendix –C for metric equivalents and for examples.</p> <table border="1" data-bbox="464 963 1386 1052"> <thead> <tr> <th><u>Age</u></th> <th colspan="4"><u>Average Weight Gain</u></th> </tr> </thead> <tbody> <tr> <td>6 – 12 mo.</td> <td>9gm/day</td> <td>2¼ oz/wk</td> <td>9½ oz/mo</td> <td>3 lbs 10oz/6 mo</td> </tr> <tr> <td>12 – 59 mo.</td> <td>2½gm/day</td> <td>0.6 oz/wk</td> <td>2.7 oz/mo</td> <td>1 lb/6 mo</td> </tr> </tbody> </table> <p>OR</p> <p>Option II: A low rate of weight gain over a six-month period (+ or - 2 weeks) as defined by the following chart. See Attachment 135-B for guidance on using measurements not taken within a 5 to 6 month interval.</p> <table border="1" data-bbox="464 1206 1207 1417"> <thead> <tr> <th><u>Column 1</u></th> <th><u>Column 2</u></th> </tr> </thead> <tbody> <tr> <td>Age in months at end of a 6 month interval</td> <td>Weight gain per 6 month interval in pounds</td> </tr> <tr> <td>6</td> <td>≤ 7</td> </tr> <tr> <td>9</td> <td>≤ 5</td> </tr> <tr> <td>12</td> <td>≤ 3</td> </tr> <tr> <td>18 – 60</td> <td>≤ 1</td> </tr> </tbody> </table> <p>USDA name: Inadequate Growth</p>	<u>Age</u>	<u>Average Weight Gain</u>				0 – 1 mo.	18gm/day	4½ oz/wk	19 oz/mo	1 lb 3 oz/mo	1 – 2 mo.	25gm/day	6¼ oz/wk	27 oz/mo	1 lb 11 oz/mo	2 – 3 mo.	18gm/day	4½ oz/wk	19 oz/mo	1 lb 3 oz/mo	3 – 4 mo.	16gm/day	4 oz/wk	17 oz/mo	1 lb 1 oz/mo	4 – 5 mo.	14gm/day	3½ oz/wk	15 oz/mo		5 – 6 mo.	12gm/day	3 oz/wk	13 oz/mo		<u>Age</u>	<u>Average Weight Gain</u>				6 – 12 mo.	9gm/day	2¼ oz/wk	9½ oz/mo	3 lbs 10oz/6 mo	12 – 59 mo.	2½gm/day	0.6 oz/wk	2.7 oz/mo	1 lb/6 mo	<u>Column 1</u>	<u>Column 2</u>	Age in months at end of a 6 month interval	Weight gain per 6 month interval in pounds	6	≤ 7	9	≤ 5	12	≤ 3	18 – 60	≤ 1	<p>I I C III</p> <p>I I C III</p>
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RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff*	Participant Category ** & Priorities																																				
140 Series ANTHROPOMETRIC Low Birth Weight/Premature Birth																																							
141	Low birth weight	Birth weight ≤ 5 lbs 8 oz (≤ 2500 g). For infants and children <24 months of age.	I I C III (< 24 mo.)																																				
142	Prematurity	Birth at ≤ 37 weeks gestation. For infants and children <24 months of age.	I I C III (< 24 mo.)																																				
150 Series ANTHROPOMETRIC Other Anthropomorphic Risk																																							
151	Small for Gestational Age (SGA)	For infants and children < 24 months of age: Presence as diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders	I I C III (< 24 mo.)																																				
153	Large for Gestational Age (LGA)	Birth weight ≥ 9 lbs (≥ 4000g) Presence as diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	I I																																				
200 Series BIOCHEMICAL Hematocrit or Hemoglobin Below State Criteria																																							
201	Low Hematocrit / Low Hemoglobin	<p>Hemoglobin or Hematocrit concentration that is below the 95% confidence interval (i.e., below the .025th percentile) for healthy, well-nourished individuals of the same age, sex, and stage of pregnancy.</p> <p>Pregnant Women – Nonsmokers</p> <table border="1"> <thead> <tr> <th><u>Altitude</u></th> <th><u>1st Trimester</u></th> <th><u>2nd Trimester</u></th> <th><u>3rd Trimester</u></th> <th><u>PP</u></th> </tr> </thead> <tbody> <tr> <td>0–2,999 ft.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hgb</td> <td>11.0</td> <td>10.5</td> <td>11.0</td> <td>12.0</td> </tr> <tr> <td>Hct</td> <td>33</td> <td>32</td> <td>33</td> <td>36</td> </tr> </tbody> </table> <p>Infants and Children</p> <table border="1"> <thead> <tr> <th><u>Altitude</u></th> <th><u>Infants</u></th> <th><u>Children</u></th> <th><u>Children</u></th> </tr> </thead> <tbody> <tr> <td>0–2,999 ft.</td> <td>6 – 12 mos.</td> <td>1 – 2 yr.</td> <td>2 – 5 yr.</td> </tr> <tr> <td>Hgb</td> <td>11.0</td> <td>11.0</td> <td>11.1</td> </tr> <tr> <td>Hct</td> <td>33</td> <td>33</td> <td>33</td> </tr> </tbody> </table> <p>Cut-off values are included in Appendix D. It includes a table of rounded Hematocrit values adapted from CDC for those WIC agencies that obtain hematocrit only in whole-numeric values. See Appendix E for altitude of Oregon cities.</p>	<u>Altitude</u>	<u>1st Trimester</u>	<u>2nd Trimester</u>	<u>3rd Trimester</u>	<u>PP</u>	0–2,999 ft.					Hgb	11.0	10.5	11.0	12.0	Hct	33	32	33	36	<u>Altitude</u>	<u>Infants</u>	<u>Children</u>	<u>Children</u>	0–2,999 ft.	6 – 12 mos.	1 – 2 yr.	2 – 5 yr.	Hgb	11.0	11.0	11.1	Hct	33	33	33	WP I WE, WB I WN VI I I C III
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Hct	33	33	33																																				
210 Series BIOCHEMICAL Other Biochemical Test Results Which Indicate Nutritional Abnormality																																							
211	Lead poisoning	Blood lead level of ≥ 10 µg/deciliter within the past 12 months. Cut off value is the current published guidance from CDC.	WP I, WE, WB I WN VI I I, C III																																				

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff*	Participant Category ** & Priorities
300 Series CLINICAL/HEALTH/MEDICAL Pregnancy-induced Conditions			
301	Hyperemesis gravidarum	Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic. Presence of hyperemesis gravidarum diagnosed by physician as self reported by applicant/participant/care giver, or as reported or documented by a physician, or someone working under physician's orders.	WP I
302	Gestational diabetes	Presence of gestational diabetes diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I
303	History of Gestational diabetes	History of diagnosed gestational diabetes. May or may not have been insulin dependent. Any pregnancy (WP), most recent pregnancy only (WE, WB), (WN)	WP I WE, WB I WN VI
304	History of Preeclampsia	History of diagnosed preeclampsia in any past pregnancy for any woman (WP, WE, WB, or WN).	WP I WE, WB I WN VI
310 Series CLINICAL/HEALTH/MEDICAL Delivery of Low-Birth Weight/Premature Infant			
311	History of preterm delivery	Birth of an infant at ≤ 37 weeks gestation in any pregnancy (WP) or most recent pregnancy only (WE, WB), (WN)	WP I WE, WB I WN VI
312	History of low birth weight	Birth of an infant weighing ≤ 5 lb 8 oz (≤ 2500 g). Any pregnancy (WP), most recent pregnancy only (WE, WB), (WN)	WP I WE, WB I WN VI
320 Series CLINICAL/HEALTH/MEDICAL History of Poor Pregnancy Outcome			
321	History of fetal or neonatal loss	A fetal death (death at ≥ 20 wks gestation) or a neonatal death (0 – 28 days of life). Pregnant (WP): Any history of fetal or neonatal loss. Non-Breastfeeding (WN): most recent pregnancy. Breastfeeding (WE, WB): most recent pregnancy with one or more infants still living.	WP I WE, WB I WN VI
330 Series CLINICAL/HEALTH/MEDICAL General Obstetrical Risks			
331	Pregnancy at a young age	Conception ≤ 17 years of age. Current pregnancy (WP), most recent pregnancy only (WE, WB), (WN)	WP I WE, WB I WN VI
332	Closely spaced pregnancy	Conception before 16 months postpartum. Current pregnancy (WP), most recent pregnancy only (WE, WB), (WN)	WP I WE, WB I WN VI
333	High parity and young age	Women < 20 yrs old at time of conception who have had ≥ 3 previous pregnancies (> 20 weeks gestation) regardless of birth outcome. Include current pregnancy for WP, most recent pregnancy only for WE, WB and WN	WP I WE, WB I WN VI

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities												
330 Series—Cont. CLINICAL/HEALTH/MEDICAL General Obstetrical Risks															
334	Lack of or inadequate prenatal care	Prenatal care beginning after the 1 st trimester (after 13 th week) or 1 st prenatal visit in the third trimester (7–9 months) or: <table border="0" data-bbox="466 386 1050 565"> <tr> <td><u>Weeks of Gestation</u></td> <td><u>Number of Prenatal Visits</u></td> </tr> <tr> <td>14–21</td> <td>0 or unknown</td> </tr> <tr> <td>22–29</td> <td>1 or less</td> </tr> <tr> <td>30–31</td> <td>2 or less</td> </tr> <tr> <td>32–33</td> <td>3 or less</td> </tr> <tr> <td>34 or more</td> <td>4 or less</td> </tr> </table>	<u>Weeks of Gestation</u>	<u>Number of Prenatal Visits</u>	14–21	0 or unknown	22–29	1 or less	30–31	2 or less	32–33	3 or less	34 or more	4 or less	WP I
<u>Weeks of Gestation</u>	<u>Number of Prenatal Visits</u>														
14–21	0 or unknown														
22–29	1 or less														
30–31	2 or less														
32–33	3 or less														
34 or more	4 or less														
335	Multiple fetus pregnancy	> 1 fetus in a current pregnancy (WP) or the most recent pregnancy (WE, WB and WN) USDA name: Multi fetal Gestation.	WP I WE, WB I WN VI												
336	Fetal growth restriction (FGR)	Fetal Growth Restriction (FGR) (replaces the term Intrauterine Growth Retardation, IUGR), may be diagnosed by a physician with serial measurement of fundal height, abdominal girth and can be confirmed with ultrasonography. FGR is usually defined as a fetal weight below (<) the 10 th percentile for gestational age. Presence diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician or someone working under physician’s orders.	WP I												
337	History of a birth of a large for gestational age infant	History of birth of an infant weighing ≥ 9 lbs (≥ 4000 g) Any pregnancy (WP), most recent pregnancy only (WE, WB and WN).	WP I WE, WB I WN VI												
338	Pregnant woman currently breastfeeding	Breastfeeding woman now pregnant.	WP I												
339	History of birth with nutrition related congenital birth defect	A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, or excess vitamin A. Any pregnancy (WP), most recent pregnancy only (WE, WB and WN)	WP I WE, WB I WN VI												

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
340, 350, 360 Series CLINICAL/HEALTH/MEDICAL Nutritional-related Risk Conditions			
341	Nutrient deficiency diseases	Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro- and micronutrients. Diseases include, but are not limited to: Protein Energy Malnutrition, Scurvy, Rickets, Beriberi, Hypocalcaemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Cheilosis, Menkes Disease, Xerophthalmia, etc. Presence diagnosed by a physician as self reported by applicant/participant/care-giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I WE, WB I WN VI I I C III
342	Gastro-intestinal disorders	Diseases or conditions that interfere with the intake or absorption of nutrients. The conditions include but are not limited to: <ul style="list-style-type: none"> • stomach or intestinal ulcers, • small bowel enterocolitis or short bowel syndrome, • malabsorption syndromes, • inflammatory bowel disease, including: ulcerative colitis or Crohn's disease, • liver disease, • pancreatitis, • biliary tract and gall bladder disease. • gastro esophageal reflux disease (GERD) • post bariatric surgery Presence of gastro-intestinal disorders diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders	WP I WE, WB I WN VI I I C III
343	Diabetes mellitus	Presence of diabetes mellitus diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I WE, WB I WN VI I I C III
344	Thyroid Disorders	Presence of a thyroid disorder diagnosed, documented or reported by a physician or someone working under a physician's orders or as self reported by the applicant/participant/caregiver. Thyroid disorders include but are not limited to the following: <ul style="list-style-type: none"> • Hyperthyroidism • Hypothyroidism • Congenital hyperthyroidism • Congenital hypothyroidism • Postpartum thyroiditis 	WP I WE, WB I WN VI I I C III
345	Hypertension and Prehypertension	Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I WE, WB I WN VI I I C III

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
340, 350, 360 Series cont. CLINICAL/HEALTH/MEDICAL Nutritional-related Risk Conditions			
346	Renal disease	Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I WE, WB I WN VI I I C III
347	Cancer	A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status. Presence of cancer diagnosed by a physician as self reported by applicant/ participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I WE, WB I WN VI I I C III
348	Central nervous system disorders	<p>Conditions that alter nutrition status metabolically and/or mechanically, which affect energy requirements and may affect the individual's ability to feed him/herself. Includes, but is not limited to:</p> <ul style="list-style-type: none"> • epilepsy • cerebral palsy (CP) • neural tube defects (NTD), such as spina bifida or myelomeningocele. <p>Presence of central nervous system disorders diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.</p>	WP I WE, WB I WN VI I I C III
349	Genetic and congenital disorders	<p>Hereditary condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. May include, but is not limited to:</p> <ul style="list-style-type: none"> • cleft lip or palate • Down's syndrome • Thalassemia • sickle cell anemia (not sickle cell trait) <p>Presence of genetic and congenital disorders diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.</p>	WP I WE, WB I WN VI I I C III

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
340, 350, 360 Series—Cont. CLINICAL/HEALTH/MEDICAL Nutritional-related Risk Conditions			
351	Inborn errors of metabolism	<p>Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to:</p> <ul style="list-style-type: none"> • phenylketonuria (PKU) • maple syrup urine disease • galactosemia • hyperlipoproteinuria • homocystinuria • tyrosinemia • histidinemia • urea cycle disorders • glutaric aciduria • methylmalonic acidemia • glycogen storage disease • galactokinase deficiency • fructoaldolase deficiency • propionic acidemia • hypermethioninemia. <p>Presence of inborn error(s) of metabolism diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.</p>	WP I WE, WB I WN VI I I C III
352	Infectious diseases	<p>A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes but is not limited to:</p> <ul style="list-style-type: none"> • tuberculosis • pneumonia • meningitis • parasitic infections • bronchiolitis (3 episodes in last 6 months) • hepatitis* • HIV (Human Immunodeficiency Virus infection) * • AIDS (Acquired Immunodeficiency Syndrome) * <p>*Breastfeeding is contraindicated for women with these conditions. The infectious disease must be present within the past six (6) months, and diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.</p>	WP I WE, WB I WN VI I I C III

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
340, 350, 360 Series—Cont. CLINICAL/HEALTH/MEDICAL Nutritional-related Risk Conditions			
353	Food allergies	An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of food allergy diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I WE, WB I WN VI I I C III
354	Celiac disease	Also known as: Celiac Sprue, Gluten Enteropathy, Non-tropical Sprue Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of Celiac Disease diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician or someone working under physician's orders.	WP I WE, WB I WN VI I I C III
355	Lactose Intolerance	Lactose intolerance occurs when there is insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing the following GI disturbances: nausea, diarrhea, bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of lactose intolerance diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders. Documentation should indicate that the ingestion of dairy products causes the above symptoms and the avoidance of such dairy products eliminates them	WP I WE, WB I WN VI I I C III
356	Hypoglycemia	Presence of hypoglycemia diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.	WP I WE, WB I WN VI I I C III
357	Drug nutrient interactions	Use of prescription drugs that are known to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised. See Appendix F	WP I WE, WB I WN VI I I C III

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
340, 350, 360 Series—Cont. CLINICAL/HEALTH/MEDICAL Nutritional-related Risk Conditions			
358	Eating Disorders	<p>Eating disorders (anorexia nervosa and bulimia) characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to:</p> <ul style="list-style-type: none"> self-induced vomiting purgative abuse alternating periods of starvation use of drugs such as appetite suppressants, thyroid preparations or diuretics self-induced marked weight loss <p>Presence of eating disorders diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.</p>	WP I WE, WB I WN VI
359	Recent major surgery, trauma, burns	<p>Major surgery (includes C-sections), trauma or burns severe enough to compromise nutritional status.</p> <p>Any occurrence: within the past two (≤ 2) months may be self reported; more than two (> 2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician.</p>	WP I WE, WB I WN VI I I C III
360	Other medical conditions	<p>Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but is not limited to:</p> <ul style="list-style-type: none"> • juvenile rheumatoid arthritis (JRA) • lupus erythematosus • cardiorespiratory diseases • heart disease • cystic fibrosis • persistent asthma (moderate or severe) requiring daily medication <p>Presence of other medical condition(s) diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders.</p>	WP I WE, WB I WN VI I I C III
361	Depression	<p>Presence of clinical depression, including postpartum depression, as diagnosed by a physician, clinical psychologist or someone working under a doctor's orders. Condition can be self-reported by a pregnant or postpartum woman or documented by a health care provider.</p>	WP, I WE, WB I WN IV
362	Developmental delays, sensory or motor delays interfering with the ability to eat	<p>Developmental, sensory or motor disabilities that restrict the ability to chew or swallow food or require tube feeding to meet nutritional needs. Includes but not limited to, minimal brain function, feeding problems due to developmental disability such as pervasive development disorder (PDD), which includes autism, birth injury, head trauma, brain damage, and other disabilities.</p>	WP I WE, WB I WN VI I I C III

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
363	Pre-Diabetes	Presence of pre-diabetes diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under physician's orders for a postpartum woman. (WE, WB, WN).	WE, WB I WN VI
370 Series CLINICAL/HEALTH/MEDICAL Substance Abuse			
371	Maternal smoking	Any daily smoking of tobacco products (i.e. cigarettes, pipes or cigars)	WP I WE, WB I WN VI
372	Alcohol and illegal and/or illicit drug use	Pregnancy (WP): Any alcohol use or illegal and/or illicit drug use. Breastfeeding (WE, WB) and Non-Breastfeeding Postpartum Women (WN): Routine current use of ≥ 2 drinks/day (2- 12-oz cans beer, 2- 5-oz glasses wine, 3 fluid oz (2 jiggers) hard liquor Binge drinking, i.e., drinks 5 or more drinks on the same occasion on at least one day in the past 30 days Heavy drinking, i.e., drinks 5 or more drinks on the same occasion on five or more days in the previous 30 days; or Any illegal and/or illicit drug use. Breastfeeding is contraindicated for women with this risk.	WP I WE, WB I WN VI

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
380 Series CLINICAL/HEALTH/MEDICAL Other Health Risk			
381	Oral Health Conditions	Diagnosis of oral health conditions by a physician or a health care provider working under the orders of a physician or adequate documentation by the CPA. Includes, but is not limited to tooth decay, periodontal disease including gingivitis and periodontitis, tooth loss, oral infections and ineffectively replaced teeth.	WP I WE, WB I WN VI I I C III
382	Fetal Alcohol Syndrome (FAS)	FAS is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation. Diagnosed by a physician as self reported by applicant/participant/care giver; or as reported or documented by a physician, or someone working under a physician's orders.	I I C III
400 Series DIETARY Presumed Eligibility			
401	Presumed dietary eligibility for women and children age 2 to 5 years	Women and children age two to five years may be presumed to be at nutrition risk based on inability to meet Dietary Guidelines for Americans as defined by consuming fewer than the recommended number of servings from one or more of the basic food groups. This risk may only be assigned after a complete nutrition assessment has been performed and no other risks have been identified.	WP IV WE, WB IV WN VI C V
411 Series DIETARY Inappropriate Nutrition Practices for Infants			
411.1	Use of substitutes for breast milk or formula	Routinely using substitutes for breast milk or FDA approved iron-fortified formula as the primary nutrient source during the first year of life. Examples of substitutes include but are not limited to: Low iron formula without iron supplementation Cow's milk, goat's milk, sheep's milk, canned evaporated or sweetened condensed milk Imitation or substitute milks such as rice or soy based beverages, non-dairy creamer or other "homemade concoctions"	I IV
411.2	Inappropriate use of bottles or cups	Routinely using nursing bottles or cups improperly. Examples include but are not limited to: <ul style="list-style-type: none"> • Using a bottle to feed juice • Feeding any sugar-containing fluids such as soda, gelatin water, corn syrup solutions, sweetened tea • Allowing the infant to fall asleep or to be put to bed with a bottle at naps or bedtime • Allowing the infant to use a bottle without restriction such as walking around with a bottle or using a bottle as a pacifier • Propping the bottle while feeding • Allowing an infant to carry around and drink throughout the day from a covered training cup Adding any food such as cereal or other solids to the infant's bottle	I IV

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
411 Series—<i>Cont.</i> DIETARY Inappropriate Nutrition Practices for Infants			
411.3	Early introduction of solid foods	Routinely offering complimentary foods (foods or beverages other than breast milk or formula) or other substances that are inappropriate in type or timing. Examples of inappropriate complementary foods include but are not limited to: <ul style="list-style-type: none"> • Offering any food other than breast milk or iron fortified formula before 4 months of age • Adding sweet agents such as sugar, honey or syrup to any beverage including water, or to prepared food, or on a pacifier 	I IV
411.4	Inappropriate feeding practices	Routinely using feeding practices that disregard the developmental needs or stage of the infant. Examples include but are not limited to: <ul style="list-style-type: none"> • Inability to recognize, insensitivity to or disregarding the infant’s cues for hunger or satiety • Feeding foods of inappropriate consistency, size or shape that put infants at risk for choking • Not supporting an infant’s need for growing independence with self-feeding such as solely spoon feeding an infant who is able and ready to finger feed and/or try self-feeding with the appropriate utensils • Feeding an infant foods with inappropriate textures based on his/her developmental stage such as feeding primarily pureed foods when an infant is ready and capable of eating mashed, chopped or finger foods. 	I IV
411.5	Feeding potentially harmful foods	Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins. Examples of potentially harmful foods include but are not limited to: <ul style="list-style-type: none"> • Unpasteurized fruit or vegetable juice • Unpasteurized dairy products or soft cheeses such as feta, brie, camembert, blue-veined and Mexican style cheese • Honey added to liquids or solid foods, used in cooking, as part of processed foods or on a pacifier • Raw or undercooked meat, fish, poultry or eggs • Raw vegetable sprouts such as alfalfa, clover, bean, or radish • Deli meats, hotdogs and processed meats unless heated steaming hot 	I IV
411.6	Incorrect dilution of formula	Routinely feeding inappropriately diluted formula. <ul style="list-style-type: none"> • Failure to follow manufacturer’s dilution instructions including stretching formula for economic reasons • Failure to follow specific instructions accompanying a prescription 	I IV
411.7	Infrequent breastfeeding	Routinely limiting the frequency of nursing of the exclusively breastfed infant when breast milk is the sole source or nutrients. Examples of inappropriate frequency of nursing: <ul style="list-style-type: none"> • Scheduled feedings instead of demand feedings • Less than 8 feedings in 24 hours if less than 2 months of age • Less than 6 feedings in 24 hours if between 2 and 6 months of age 	I IV

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
411 Series—<i>Cont.</i> DIETARY Inappropriate Nutrition Practices for Infants			
411.8	Feeding low calorie or low nutrient diets	Routinely feeding a diet very low in calories and/or essential nutrients. Examples include but are not limited to: <ul style="list-style-type: none"> • Vegan diet • Macrobiotic diet • Other diets very low in calories and/or essential nutrients 	I IV
411.9	Improper handling of expressed breast milk or formula	Routinely using inappropriate sanitation in preparation, handling and storage of expressed breast milk or formulas. Examples of inappropriate sanitation include but are not limited to: <ul style="list-style-type: none"> • Limited or no access to a safe water supply, heat source for sterilization and/or refrigerator or freezer for storage • Failure to properly prepare, handle and store bottles or storage containers of expressed breast milk or formula 	I IV
411.10	Inappropriate use of dietary supplements	Feeding dietary supplements with potentially harmful consequences. Examples of dietary supplements which, if fed in excess of recommended dosage, may be toxic or have harmful consequences include but may not be limited to: <ul style="list-style-type: none"> • Single or multi-vitamins • Mineral supplements • Herbal or botanical supplements/remedies/teas 	I IV
411.11	Inadequate fluoride and Vitamin D supplementation	Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements. Infants who are 6 months of age or older who are ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3ppm fluoride Infants consuming less than one quart of vitamin D fortified formula and not receiving 400 IU Vitamin D supplement	I IV

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
425 Series	DIETARY	Inappropriate Nutrition Practices for Children	
425.1	Use of inappropriate beverages as milk source	Routinely feeding inappropriate beverages as the primary milk source. Examples include but are not limited to: <ul style="list-style-type: none"> • Non-fat or reduced-fat milks between 12 and 24 months of age • Sweetened condensed milk • Imitation or substitute milks such as inadequately or unfortified rice or soy based beverages or other “homemade concoctions” • Non dairy creamer 	C V
425.2	Feeding sweetened beverages	Routinely feeding a child sugar-containing fluids. Examples of sugar-containing beverages include but are not limited to: <ul style="list-style-type: none"> • Soda • Gelatin water • Corn syrup solutions • Sweetened tea 	C V
425.3	Inappropriate use of bottles or cups	Routinely using nursing bottles, cups or pacifiers improperly. Examples include but are not limited to: <ul style="list-style-type: none"> • Using the bottle for feeding or drinking beyond 14 months of age • Using a bottle to feed juice, diluted cereal or other solids • Allowing the child to fall asleep or to be put to bed with a bottle at naps or bedtime • Allowing the child to use a bottle without restriction such as walking around with a bottle or using a bottle as a pacifier • Allowing a child to carry around and drink throughout the day from a covered training cup 	C V
425.4	Inappropriate feeding practices	Routinely using feeding practices that disregard the developmental needs or stage of the child. Examples include but are not limited to: <ul style="list-style-type: none"> • Inability to recognize, insensitivity to or disregarding the child’s cues for hunger or satiety • Feeding foods of inappropriate consistency, size or shape that put children at risk for choking • Not supporting a child’s need for growing independence with self-feeding such as solely spoon feeding a child who is able and ready to finger feed and/or try self-feeding with the appropriate utensils • Feeding a child foods with inappropriate textures based on his/her developmental stage such as feeding primarily pureed or liquid foods when the child is ready and capable of eating mashed, chopped or appropriate finger foods 	C V

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
425 Series	DIETARY	Inappropriate Nutrition Practices for Children	
425.5	Feeding potentially harmful foods	Feeding foods to a child that could be contaminated with harmful microorganisms. Examples of potentially harmful foods for a child include but are not limited to: <ul style="list-style-type: none"> • Unpasteurized fruit or vegetable juice • Unpasteurized dairy products or soft cheeses such as feta, brie, camembert, blue-veined and Mexican style cheese • Raw or undercooked meat, fish, poultry or eggs • Raw vegetable sprouts such as alfalfa, clover, bean, or radish • Deli meats, hotdogs and processed meats unless heated until steaming hot 	C V
425.6	Feeding low calorie or low nutrient diets	Routinely feeding a diet very low in calories and/or essential nutrients. Examples include but are not limited to: <ul style="list-style-type: none"> • Vegan diet • Macrobiotic diet • Other diets very low in calories and/or essential nutrients 	C V
425.7	Inappropriate use of dietary supplements	Feeding dietary supplements with potentially harmful consequences. Examples of dietary supplements which, if fed in excess of recommended dosage, may be toxic or have harmful consequences include but may not be limited to: <ul style="list-style-type: none"> • Single or multi-vitamins • Mineral supplements • Herbal or botanical supplements/remedies/teas 	C V
425.8	Inadequate fluoride and Vitamin D supplementation	Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements. Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride Providing children 36 to 60 months of age less than 0.50 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride Providing children less than 400 IU Vitamin D supplement if drinking less than one quart Vitamin D fortified milk daily	C V
425.9	Pica	Routine ingestion of non-food items. Examples of inappropriate nonfood items include but are not limited to: <ul style="list-style-type: none"> • Ashes • Carpet fibers • Cigarettes or cigarette butts • Chalk • Clay • Dust • Foam rubber • Paint chips • Soil • Starch (laundry or cornstarch) 	C V

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
427 Series	DIETARY	Inappropriate Nutrition Practices for Women	
427.1	Inappropriate use of dietary supplements	Consuming dietary supplements with potentially harmful consequences. Examples of dietary supplements which when ingested in excess of recommended dosages may be toxic or have harmful consequences: <ul style="list-style-type: none"> • Single or multi-vitamins • Mineral supplements • Herbal or botanical supplements/remedies/teas 	WP IV WE, WB IV WN VI
427.2	Consuming very low calorie diets	Consuming a diet very low in calories and/or essential nutrients. Examples include but are not limited to: <ul style="list-style-type: none"> • Strict vegan diet • Low-carbohydrate, high protein diet • Macrobiotic diet • Any other diet restricting calories and/or essential nutrients 	WP IV WE, WB IV WN VI
427.3	Pica	Compulsive ingestion of non-food items. Examples of nonfood items include but are not limited to:: <ul style="list-style-type: none"> • Ashes • Baking soda • Burnt matches • Carpet fibers • Chalk • Cigarettes • Clay • Dust • Large quantities of ice or freezer frost • Paint chips • Soil • Starch (laundry and cornstarch) 	WP IV WE, WB IV WN VI
427.4	Inadequate iron, iodine or folic acid supplementation	Inadequate vitamin-mineral supplementation recognized as essential by national public health policy. Consumption of less than 27 mg of iron as a supplement daily by pregnant women Consumption of less than 150 mcg of supplemental iodine per day by pregnant and breastfeeding women. Consumption of less than 400 mcg of folic acid from fortified foods or supplements daily by non-pregnant women	WP IV WE, WB IV WN VI

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
427 Series--cont. DIETARY Inappropriate Nutrition Practices for Women			
427.5	Eating potentially harmful foods	Pregnant women ingesting foods that could be contaminated with pathogenic microorganisms. Examples of potentially harmful foods include but are not limited to: <ul style="list-style-type: none"> • Raw fish or shellfish • Refrigerated smoked seafood unless it is an ingredient in a cooked dish • Raw or undercooked meat or poultry • Hot dogs, luncheon meat, fermented or dry sausage and other deli style meat or poultry products unless reheated until steaming hot • Refrigerated pate or meat spreads • Unpasteurized milk of foods containing unpasteurized milk • Soft cheeses such as feta, brie, camembert, blue-veined and Mexican style cheese such as queso blanco, queso fresco, or panela unless labeled as made with pasteurized milk • Raw or undercooked eggs or foods containing raw or lightly cooked eggs including salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog • Raw sprouts including alfalfa, clover or bean • Unpasteurized fruit or vegetable juices 	WP IV
400 Series DIETARY Presumed eligibility			
428	Presumed dietary eligibility for infants and children age 4 to 23 months	This risk may only be assigned to infants from 4 to 12 months of age and children 13 to 23 months of age after a complete nutrition assessment has been performed and no other risks have been identified. An infant or child who has begun to consume complementary foods and beverages, to eat independently, to be weaned from breast milk or formula and is transitioning from a diet based on infant/toddler foods to one based on the Dietary Guidelines for Americans is at risk for inappropriate complementary feeding.	I IV C V
500 Series OTHER RISKS Regression/Transfer (Nutrition Risk Unknown)			
501	Preventive Maintenance	A participant who has previously been certified eligible for the Program may be considered to be at nutritional risk in the next certification period if the competent professional authority determines there is a possibility of regression in nutritional status without the benefits that the WIC program provides. Not every nutrition risk criterion leads itself to the possibility of regression. Cannot be used two times in a row.	WE, WB IV WN VI I IV C V
502	Transfer of certification	Person presently with current valid Verification of Certification (VOC) card from another State agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for program benefits. If the receiving local program has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving State agency.	N/A

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
600 Series	OTHER RISKS	Breastfeeding Mother/Infant Dyad	
601	Breastfeeding mother of infant at nutritional risk	A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk.	WE, WB I, II, IV Must be at same priority as at-risk infant
602	Breastfeeding complications or potential complications (woman)	A breastfeeding woman with any of the following complications or potential complications: <ul style="list-style-type: none"> • severe breast engorgement • recurrent plugged ducts • mastitis (fever or flu-like symptoms with localized breast tenderness) • flat or inverted nipples • cracked, bleeding or severely sore nipples • age ≥ 40 years • failure of milk to come in by 4 days postpartum • tandem nursing (breastfeeding two siblings who are not twins). 	WE, WB I
603	Breastfeeding complications or potential complications (infant)	A breastfeeding infant with any of the following complications or potential complications: <ul style="list-style-type: none"> • jaundice • weak or ineffective suck • difficulty latching onto mother's breast • inadequate stooling (for age, as determined by a physician or other health care professional), and/or less than 6 wet diapers per day. 	I I
700 Series	OTHER RISKS	Infant of a WIC-eligible Mother or Mother at Risk During Pregnancy	
701	Infant up to 6 months old of WIC mother or of a woman who would have been eligible during pregnancy	An infant < 6 months of age whose mother was a WIC Program participant during pregnancy or whose mother's medical records document that the woman was at nutritional risk during pregnancy because of detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions.	I II
702	Breastfeeding infant of woman at nutritional risk	Breastfeeding infant of woman at nutritional risk.	I I, II, IV Must be at the same priority as at-risk mother.
703	Infant born of woman with mental retardation or alcohol or drug abuse during most recent pregnancy	Infant born of a woman: diagnosed with mental retardation by a physician or psychologist as self-reported by applicant/participant/care giver; or as reported or documented by a physician, psychologist, or someone working under physician's orders; or documentation or self-report of any use of alcohol or illegal drugs during most recent pregnancy.	I I

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
800 Series OTHER RISKS Homelessness/Migrancy			
801	Homelessness	<p>A woman, infant or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:</p> <ul style="list-style-type: none"> • a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations • an institution that provides a temporary residence for individuals intended to be institutionalized • a temporary accommodation of not more than 365 days in the residence of another individual, or • a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings 	WP IV WE, WB IV WN VI I IV C V
802	Migrancy	<p>Categorically eligible women, infants and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.</p>	WP IV WE, WB IV WN VI I IV C V
900 Series OTHER RISKS Other Nutrition Risks			
901	Recipient of abuse	<p>Battering or child abuse/neglect within past 6 months: as self-reported, or as documented by</p> <ul style="list-style-type: none"> ◆ a social worker ◆ health care provider or ◆ on other appropriate documents, or <p>as reported through consultation with</p> <ul style="list-style-type: none"> ◆ a social worker ◆ health care provider, or ◆ other appropriate personnel. <p>Child abuse/neglect is “any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of an infant or child by a parent or caretaker.”</p> <p>Battering generally refers to violent assaults on women.</p> <p>State law requires the reporting of known or suspected child abuse or neglect, WIC staff must release such information to appropriate State officials. <i>See Violence Prevention Resource Manual, OHD, 1996.</i></p>	WP IV WE, WB IV WN VI I IV C V

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

USDA Code	Risk Criterion	Definition and Cutoff	Participant Category & Priorities
900 Series—<i>Cont.</i> OTHER RISKS Other Nutrition Risks			
902	Pregnant woman, mother or infant or child of primary care giver with limited ability to make feeding decisions and/or prepare food	Woman, (pregnant, breastfeeding, or non-breastfeeding) or infant/child whose primary care giver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are: <ul style="list-style-type: none"> • ≤ 17 years of age • mentally disabled/delayed and/or has a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist) • a physical disability which restricts or limits food preparation abilities • currently using or having a history of alcohol or other drugs. 	WP IV WE, WB IV WN VI I IV C V
903	Foster Care	Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months. Cannot be used two times in a row while the child remains in the same foster home. It should be used as the sole risk criterion only if careful assessment of the applicants status indicates that no other risks based on anthropometric, medical or nutritional risk criteria can be identified.	WP IV WE, WB IV WN VI I IV C V
904	Environmental Tobacco Smoke Exposure	Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home. ETS is also known as passive, secondhand or involuntary smoke.	WP I WE, WB I WN VI I I C III

REFERENCES: WIC Policy Memorandum 98-9, Nutrition Risk Criteria, June 29, 1998
 Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996
 WIC Policy Memorandum 98-9, Revision 6: Nutrition Risk Criteria 2002
 WIC Policy Memorandum 98-9, Revision 7: Nutrition Risk Criteria 2004
 WIC Policy Memorandum 98-9, Revision 8: Nutrition Risk Criteria 2005
 WIC Policy Memorandum 98-9, Revision 9: Nutrition Risk Criteria 2007
 WIC Policy Memorandum 98-9, Revision 10: Nutrition Risk Criteria 2009
 WIC Policy Memorandum 2011-5 WIC Nutrition Risk Criteria
 WIC Policy Memorandum, June 25, 2012, Nutrition Risk Criteria 2013
 WIC Policy Memorandum, November 25, 2013, Nutrition Risk Criteria 2015



**If you need this in large print or an alternate format,
 please call (971) 673-0040.
 WIC is an equal opportunity program and employer.**

RISK CRITERIA CODES AND DESCRIPTIONS, *cont.*

Appendix A

Body Mass Index (BMI) Table for determining weight classification for
Pregnant and Postpartum **Women** ⁽¹⁾

Height (Inches)	Underweight BMI <18.5	Normal Weight BMI 18.5–24.9	Overweight BMI 25.0–29.9	Obese BMI =30.0
58"	<89	89–118	119–142	>142
59"	<92	92–123	124–147	>147
60"	<95	95–127	128–152	>152
61"	<98	98–131	132–157	>157
62"	<101	101–135	136–163	>163
63"	<105	105–140	141–168	>168
64"	<108	108–144	145–173	>173
65"	<111	111–149	150–179	>179
66"	<115	115–154	155–185	>185
67"	<118	118–158	159–190	>190
68"	<122	122–163	164–196	>196
69"	<125	125–168	169–202	>202
70"	<129	129–173	174–208	>208
71"	<133	133–178	179–214	>214
72"	<137	137–183	184–220	>220

⁽¹⁾ Adapted from the Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults. National Heart, Lung and Blood Institute (NHLBI), National Institutes of Health (NIH). NIH Publication No. 98-4083.

Body Mass Index (BMI)

This table allows you to determine your body mass index without having to perform calculations. Locate your height in the left-hand column. Scanning across that row, find the number closest to your weight. At the top of that column is your BMI. If your height or weight isn't listed in the table, here's a shortcut method for calculating BMI: multiply your weight (in pounds) by 703 and then divide this number by your height (in inches) squared (i.e., height × height).

		Body Mass Index													
		19	20	21	22	23	24	25	26	27	28	29	30	35	40
Height	4' 10"	91	96	100	105	110	115	119	124	129	134	138	143	167	191
	4' 11"	94	99	104	109	114	119	124	128	133	138	143	148	173	198
	5' 0"	97	102	107	112	118	123	128	133	138	143	148	153	179	204
	5' 1"	100	106	111	116	122	127	132	137	143	148	153	158	185	211
	5' 2"	104	109	115	120	126	131	136	142	147	153	158	164	191	218
	5' 3"	107	113	118	124	130	135	141	146	152	158	163	169	197	225
	5' 4"	110	116	122	128	134	140	145	151	157	163	169	174	204	232
	5' 5"	114	120	126	132	138	144	150	156	162	168	174	180	210	240
	5' 6"	118	124	130	136	142	148	155	161	167	173	179	186	216	247
	5' 7"	121	127	134	140	146	153	159	166	172	178	185	191	223	255
	5' 8"	125	131	138	144	151	158	164	171	177	184	190	197	230	262
	5' 9"	128	135	142	149	155	162	169	176	182	189	196	203	236	270
	5' 10"	132	139	146	153	160	167	174	181	188	195	202	207	243	278
	5' 11"	136	143	150	157	165	172	179	186	193	200	208	215	250	286
	6' 0"	140	147	154	162	169	177	184	191	199	206	213	221	258	294
	6' 1"	144	151	159	166	174	182	189	197	204	212	219	227	265	302
6' 2"	148	155	163	171	179	186	194	202	210	218	225	233	272	311	
6' 3"	152	160	168	176	184	192	200	208	216	224	232	240	279	319	
6' 4"	156	164	172	180	189	197	205	213	221	230	238	246	287	328	

Overweight

Obese

Weight (lbs)

Source: World Health Organization

Taken from: ADA Complete Food and Nutrition Guide

METRIC EQUIVALENTS FOR AVERAGE WEIGHT GAIN

Infants from birth to 6 months of age
(Need 2 weights taken at least 1 month apart.)

Age	Average Weight Gain (Metric equivalents)		
Birth – 1 mo	18 gm/day	126 gm/wk	0.54 kg/mo
1 – 2 mo	25 gm/day	175 gm/wk	0.75 kg/mo
2 – 3 mo	18 gm/day	126 gm/wk	0.54 kg/mo
3 – 4 mo	16 gm/day	112 gm/wk	0.48 kg/mo
4 – 5 mo	14 gm/day	98 gm/wk	0.42 kg/mo
5 – 6 mo	12 gm/day	84 gm/wk	0.36 kg/mo

Infants & Children from 6 months to 59 months of age
(Need 2 weights taken at least 3 months apart.)

Age	Average Weight Gain (Metric equivalents)			
6 – 12 mo	9 gm/day	63 gm/wk	0.27 kg/mo	1.62 kg/6 mo
12 – 59 mo	2 ½ gm/day	17 ½ gm/wk	0.08 kg/mo	0.45 kg/6 mo

Examples Using Calculated Expected Minimal Weight

General Steps:

1. Determine if time interval between measures is sufficient.

Calculate actual weight gain.

Calculate expected minimal weight gain using the chart in the definition. (*Note: Due to a variety of reasons, including rounding, different approaches to calculating the expected minimal weight gain may result in slightly different answers.*)

Compare the actual weight gain with the calculated expected weight gain to see if person is eligible for WIC using this criterion.

RISK CRITERIA CODES AND DESCRIPTIONS, cont.

(For USDA code 135)

Example #1:

<u>Date of Measures</u>	<u>Weight</u>
09/13/98 (birth)	7 pounds 6 oz
09/23/98 (10 days old)	8 pounds 1 oz
10/26/98 (6 weeks & 1 day old)	9 pounds 3 oz

1. interval between birth and 10/26/98 measures = 43 days
2. actual weight gain = 1 ½ pound 13 oz.
3. expected minimal weight gain is: (540 gm) + (13 days x 25 gm/day) = 865 gm = 30 oz = 1 pound 15 oz
4. actual weight gain from birth is less than expected minimal weight gain → eligible for WIC using this criterion

Example #2:

<u>Date of Measures</u>	<u>Weight</u>
02/27/00 (17 ½ months old)	25pounds
09/13/00 (24 months old)	26 ½ pounds

1. interval between two measures is 6 ½ months
actual weight gain = 1 ½ pound
expected minimal weight gain is (1 pound per 6 months) + (0.5 mo x 2.7 oz/mo) = 1 pound 1.35 oz
actual weight gain is MORE than expected weight gain → NOT eligible for WIC using this criterion.

Metric/English conversion: 1 ounce = 28 gm

**Steps to calculate a low rate of weight gain
when the 2 weight measurements are
NOT within a 5 ½ - 6 ½ month interval**

1. Use the two bullets below to determine if the two measurements were taken within an acceptable time interval for this risk to apply. If they do, proceed to step #2. If they do not, Option II CANNOT be used to determine eligibility for WIC.
 - For Children > 5 months through 17 months of age, the 2 measurements must be taken within a 5–7 month range (*remember, for measurements taken within a 5 ½ – 6 ½ month interval, you do not need to proceed with steps 2–5, just use the chart to determine the applicability of the risk*).
 - For Children 18 months to < 60 months of age, the 2 measurements must be taken within a 4–9 month interval (*remember, for measurements taken within a 5 ½ – 6 ½ month interval, you do not need to proceed with the steps 2–5, just use the chart to determine the applicability of the risk*).
2. Plot both weights on an age and sex specific NCHS growth grid.
3. From the chart, choose the **age** from column 1 that most closely matches the child's age when the second weight was taken and choose the **weight gain** from column 2 that corresponds with this age.
4. Add this weight gain figure to the first of the two weights and plot the sum of the weights on the growth grid at a point exactly 6 months from the date of the first weight.
5. Connect the point for the first weight with the point for the sum of the weights with a straight line (*extend the line if there is a seven month interval between the two weights*). If the point for the second weight is on or below the line then the child's growth is inadequate.

**WIC HEMATOCRIT Values
Adjusted for Altitude and Smoking
1998 CDC Guidelines**

		CATEGORY									
		1 st Trimester	2 nd Trimester	3 rd Trimester	Nonpreg 12 – <15 yrs	Nonpreg 15 – <18 yrs	Nonpreg ≥18 yrs	Infants 0 – <6 mo	Infants 6 – 12 mo	Children 1 – <2 yrs	Children 2 – <5 yrs
		Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <
ALTITUDE	SMOKING										
No altitude adjustment	Nonsmokers	33.0	32.0	33.0	35.7	35.9	35.7		32.9	32.9	33.0
	Up to	34.0	33.0	34.0	36.7	36.9	36.7				
	1–2 packs/day	34.5	33.5	34.5	37.2	37.4	37.2				
	>2 packs/day	35.0	34.0	35.0	37.7	37.9	37.7				
3000–3999 ft	Nonsmokers	33.5	32.5	33.5	36.2	36.4	36.2		33.4	33.4	33.5
	Up to	34.5	33.5	34.5	37.2	37.4	37.2				
	1–2 packs/day	35.0	34.0	35.0	37.7	37.9	37.7				
	>2 packs/day	35.5	34.5	35.5	38.2	38.4	38.2				
4000–4999 ft	Nonsmokers	34.0	33.0	34.0	36.7	36.9	36.7		33.9	33.9	34.0
	Up to	35.0	34.0	35.0	37.7	37.9	37.7				
	1–2 packs/day	35.5	34.5	35.5	38.2	38.4	38.2				
	>2 packs/day	36.0	35.0	36.0	38.7	38.9	38.7				
5000–5999 ft	Nonsmokers	34.5	33.5	34.5	37.2	37.4	37.2		34.4	34.4	34.5
	Up to	35.5	34.5	35.5	38.2	38.4	38.2				
	1–2 packs/day	36.0	35.0	36.0	38.7	38.9	38.7				
	>2 packs/day	36.5	35.5	36.5	39.2	39.4	39.2				
6000–6999 ft	Nonsmokers	35.0	34.0	35.0	37.7	37.9	37.7		34.9	34.9	35.0
	Up to	36.0	35.0	36.0	38.7	38.9	38.7				
	1–2 packs/day	36.5	35.5	36.5	39.2	39.4	39.2				
	>2 packs/day	37.0	36.0	37.0	39.7	39.9	39.7				

**WIC HEMATOCRIT Values
Adjusted for Altitude and Smoking
1998 CDC Guidelines**

		CATEGORY									
		1 st Trimester	2 nd Trimester	3 rd Trimester	Nonpreg 12 – <15 yrs	Nonpreg 15 – <18 yrs	Nonpreg ≥18 yrs	Infants 0 – <6 mo	Infants 6 – 12 mo	Children 1 – <2 yrs	Children 2 – <5 yrs
		Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <
ALTITUDE	SMOKING										
7000–7999 ft	Nonsmokers	36.0	35.0	36.0	38.7	38.9	38.7		35.9	35.9	36.0
	Up to	37.0	36.0	37.0	39.7	39.9	39.7				
	1–2 packs/day	37.5	36.5	37.5	40.2	40.4	40.2				
	>2 packs/day	38.0	37.0	38.0	40.7	40.9	0.7				
8000–8999 ft	Nonsmokers	37.0	36.0	37.0	39.7	39.9	39.7		36.9	36.9	37.0
	Up to	38.0	37.0	38.0	40.7	40.9	40.7				
	1–2 packs/day	38.5	37.5	38.5	41.2	41.4	41.2				
	>2 packs/day	39.0	38.0	39.0	41.7	41.9	41.7				
9000–9999 ft	Nonsmokers	38.0	37.0	38.0	40.7	40.9	40.7		37.9	37.9	38.0
	Up to	39.0	38.0	39.0	41.7	41.9	41.7				
	1–2 packs/day	39.5	38.5	39.5	42.2	42.4	42.2				
	>2 packs/day	40.0	39.0	40.0	42.7	52.9	42.7				
10,000 ft or more	Nonsmokers	39.0	38.0	39.0	41.7	41.9	41.7		38.9	38.9	39.0
	Up to	40.0	39.0	40.0	42.7	42.9	42.7				
	1–2 packs/day	40.5	39.5	40.5	43.2	43.4	43.2				
	>2 packs/day	41.0	40.0	41.0	43.7	43.9	43.7				

**WIC HEMOGLOBIN Values
Adjusted for Altitude and Smoking
1998 CDC Guidelines**

		CATEGORY									
		1 st Trimester	2 nd Trimester	3 rd Trimester	Nonpreg 12 – <15 yrs	Nonpreg 15 – <18 yrs	Nonpreg ≥18 yrs	Infants 0 – <6 mo	Infants 6 – 12 mo	Children 1 – <2 yrs	Children 2 – <5 yrs
		Hgb <	Hgb<	Hgb<	Hgb <	Hgb <	Hgb<	Hgb <	Hgb <	Hgb <	Hgb <
ALTITUDE	SMOKING										
No altitude adjustment	Nonsmokers	11.0	10.5	11.0	11.8	12.0	12.0		11.0	11.0	11.1
	Up to	11.3	10.8	11.3	12.1	12.3	12.3				
	1–2 packs/day	11.5	11.0	11.5	12.3	12.5	12.5				
	>2 packs/day	11.7	11.2	11.7	12.5	12.7	12.7				
3000–3999 ft	Nonsmokers	11.2	10.7	11.2	12.0	12.2	12.2		11.2	11.2	11.3
	Up to	11.5	11.0	11.5	12.3	12.5	12.5				
	1–2 packs/day	11.7	11.2	11.7	12.5	12.7	12.7				
	>2 packs/day	11.9	11.4	11.9	12.7	12.9	12.9				
4000–4999 ft	Nonsmokers	11.3	10.8	11.3	12.1	12.3	12.3		11.3	11.3	11.4
	Up to	11.6	11.1	11.6	12.4	12.6	12.6				
	1–2 packs/day	11.8	11.3	11.8	12.6	12.8	12.8				
	>2 packs/day	12.0	11.5	12.0	12.8	13.0	13.0				
5000–5999 ft	Nonsmokers	11.5	11.0	11.5	12.3	12.5	12.5		11.5	11.5	11.6
	Up to	11.8	11.3	11.8	12.6	12.8	12.8				
	1–2 packs/day	12.0	11.5	12.0	12.8	13.0	13.0				
	>2 packs/day	12.2	11.7	12.2	13.0	13.2	13.2				
6000–6999 ft	Nonsmokers	11.7	11.2	11.7	12.5	12.7	12.7		11.7	11.7	11.8
	Up to	12.0	11.5	12.0	12.8	13.0	13.0				
	1–2 packs/day	12.2	11.7	12.2	13.0	13.2	13.2				
	>2 packs/day	12.4	11.9	12.4	13.2	13.4	13.4				

**WIC HEMOGLOBIN Values
Adjusted for Altitude and Smoking
1998 CDC Guidelines**

		CATEGORY									
		1 st Trimester	2 nd Trimester	3 rd Trimester	Nonpreg 12 – <15 yrs	Nonpreg 15 – <18 yrs	Nonpreg ≥18 yrs	Infants 0 – <6 mo	Infants 6 – 12 mo	Children 1 – <2 yrs	Children 2 – <5 yrs
		Hgb <	Hgb<	Hgb<	Hgb <	Hgb <	Hgb<	Hgb <	Hgb <	Hgb <	Hgb <
ALTITUDE	SMOKING										
7000–7999 ft	Nonsmokers	12.0	11.5	12.0	12.8	13.0	13.0		12.0	12.0	12.1
	Up to	12.3	11.8	12.3	13.1	13.3	13.3				
	1–2 packs/day	12.5	12.0	12.5	13.3	13.5	13.5				
	>2 packs/day	12.7	12.2	12.7	13.5	13.7	13.7				
8000–8999 ft	Nonsmokers	12.3	11.8	12.3	13.1	13.3	13.3		12.3	12.3	12.3
	Up to	12.6	12.1	12.6	13.4	13.6	13.6				
	1–2 packs/day	12.8	12.3	12.8	13.6	13.8	13.8				
	>2 packs/day	13.0	12.5	13.0	13.8	14.0	14.0				
9000–9999 ft	Nonsmokers	12.6	12.1	12.6	13.4	13.6	13.6		12.6	12.6	12.7
	Up to	12.9	12.4	12.9	13.7	13.9	13.9				
	1–2 packs/day	13.1	12.6	13.1	13.9	14.1	14.1				
	>2 packs/day	13.3	12.8	13.3	14.1	14.3	14.3				
10,000 ft or more	Nonsmokers	13.0	12.5	13.0	13.8	14.0	14.0		13.0	13.0	13.1
	Up to	13.3	12.8	13.3	14.1	14.3	14.3				
	1–2 packs/day	13.5	13.0	13.5	14.3	14.5	14.5				
	>2 packs/day	13.7	13.2	13.7	14.5	14.7	14.7				

**ROUNDED WIC HEMATOCRIT Values
Adjusted for Altitude and Smoking
ADAPTED FROM 1998 CDC Guidelines**

		CATEGORY									
		1 st Trimester	2 nd Trimester	3 rd Trimester	Nonpreg 12 – <15 yrs	Nonpreg 15 – <18 yrs	Nonpreg ≥18 yrs	Infants 0 – <6 mo	Infants 6 – 12 mo	Children 1 – <2 yrs	Children 2 – <5 yrs
		Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <
ALTITUDE	SMOKING										
No altitude adjustment	Nonsmokers	33	32	33	36	36	36		33	33	33
	Up to	34	33	34	37	37	37				
	1–2 packs/day	35	34	35	38	38	38				
	>2 packs/day	35	34	35	38	38	38				
3000–3999 ft	Nonsmokers	34	33	34	37	37	37		34	34	34
	Up to	35	34	35	38	38	38				
	1–2 packs/day	35	34	35	38	38	38				
	>2 packs/day	36	35	36	39	39	39				
4000–4999 ft	Nonsmokers	34	33	34	37	37	37		34	34	34
	Up to	35	34	35	38	38	38				
	1–2 packs/day	36	35	36	39	39	39				
	>2 packs/day	36	35	36	39	39	39				
5000–5999 ft	Nonsmokers	35	34	35	38	38	38		34	35	35
	Up to	36	35	36	39	39	39				
	1–2 packs/day	36	35	36	39	39	39				
	>2 packs/day	37	36	37	40	40	40				
6000–6999 ft	Nonsmokers	35	34	35	38	38	38		35	35	35
	Up to	36	35	36	39	39	39				
	1–2 packs/day	37	36	37	40	40	40				
	>2 packs/day	37	36	37	40	40	40				

**ROUNDED WIC HEMATOCRIT Values
Adjusted for Altitude and Smoking
ADAPTED FROM 1998 CDC Guidelines**

		CATEGORY									
		1 st Trimester	2 nd Trimester	3 rd Trimester	Nonpreg 12 – <15 yrs	Nonpreg 15 – <18 yrs	Nonpreg ≥18 yrs	Infants 0 – <6 mo	Infants 6 – 12 mo	Children 1 – <2 yrs	Children 2 – <5 yrs
		Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <	Hct <
ALTITUDE	SMOKING										
7000–7999 ft	Nonsmokers	36	35	36	39	39	39		36	36	36
	Up to	37	36	37	40	40	40				
	1–2 packs/day	38	37	38	41	41	41				
	>2 packs/day	38	37	38	41	41	41				
8000–8999 ft	Nonsmokers	37	36	37	40	40	40		37	37	37
	Up to	38	37	38	41	41	41				
	1–2 packs/day	39	38	39	42	42	42				
	>2 packs/day	39	38	39	42	42	42				
9000–9999 ft	Nonsmokers	38	37	38	41	41	41		38	38	38
	Up to	39	38	39	42	42	42				
	1–2 packs/day	40	39	40	43	43	43				
	>2 packs/day	40	39	40	43	43	43				
10,000 ft or more	Nonsmokers	39	38	39	42	42	42		39	39	39
	Up to	40	39	40	43	43	43				
	1–2 packs/day	41	40	41	44	44	44				
	>2 packs/day	41	40	41	44	44	44				

Altitudes of Oregon Cities

ALTITUDE 1,000 – 2,999		
TOWN	COUNTY	ALTITUDE
Antelope	Wasco	2,631
Condon	Gilliam	2,844
Cove	Union	2,893
Culver	Jefferson	2,633
Dayville	Grant	2,348
Detroit	Marion	1,600
Elgin	Union	2,670
Fossil	Wheeler	2,654
Grass Valley	Sherman	2,269
Heppner	Morrow	1,955
Imbler	Union	2,732
Island City	Union	2,743
La Grande	Union	2,788
Madras	Jefferson	2,242
Metolius	Jefferson	2,530
Mitchell	Wheeler	2,777
Monument	Grant	2,000
Nyssa	Malheur	2,178
Oakridge	Lane	1,209
Ontario	Malheur	2,140
Prineville	Crook	2,868
Rhododendron	Clackamas	1,680
Sandy	Clackamas	1,000
Spray	Tillamook	1,772
Summerville	Union	2,705
Union	Union	2,789
Vale	Malheur	2,243
Wallowa	Wallowa	2,923

Altitudes of Oregon Cities, cont.

ALTITUDE 3,000 – 3,999		
TOWN	COUNTY	ALTITUDE
Baker City	Baker	3,449
Bend	Deschutes	3,623
Canyon City	Grant	3,194
Enterprise	Wallowa	3,757
Government Camp	Clackamas	3,888
Haines	Baker	3,333
Halfway	Baker	3,333
John Day	Grant	3,083
Long Creek	Grant	3,754
Lostine	Wallowa	3,200
North Powder	Union	3,256
Prairie City	Grant	3,539
Redmond	Deschutes	3,007
Shaniko	Wasco	3,340
Sisters	Deschutes	3,182
Ukiah	Umatilla	3,400

Altitudes of Oregon Cities, cont.

ALTITUDE 4,000 – 4,999		
TOWN	COUNTY	ALTITUDE
Beatty	Klamath	4,359
Bly	Klamath	4,360
Bonanza	Klamath	4,200
Burns	Harney	4,148
Chiloquin	Klamath	4,200
Christmas Valley	Lake	4,315
Fort Klamath	Klamath	4,200
Granite	Grant	4,680
Hines	Harney	4,155
Jordan Valley	Malheur	4,389
Joseph	Wallowa	4,191
Klamath Falls	Klamath	4,120
Lakeview	Lake	4,800
LaPine	Deschutes	4,233
Malin	Klamath	4,100
Merrill	Klamath	4,064
Paisley	Lake	4,369
Seneca	Grant	4,666
Silver Lake	Lake	4,345
Sumpter	Baker	4,388
Unity	Baker	4,029

Drug Nutrient Interaction

The drug treatment of a disease or medical condition may itself affect nutritional status. Drug induced nutritional deficiencies are usually slow to develop and occur most frequently in long-term drug treatment of chronic disease. Possible nutrition-related side effects of drugs include, but are not limited to, altered taste sensation, gastric irritation, appetite suppression, altered GI motility, and altered nutrient metabolism and function, including enzyme inhibition, vitamin antagonism, and increased urinary loss.

The marketplace of prescribed and over-the-counter drugs is a rapidly changing one. For knowledgeable information on the relationship of an individual's drug use to his/her nutritional status, it is important to refer to a current drug reference such as Physician's Desk Reference (PDR), a text such as Physician's Medication Interactions, drug inserts, or to speak with a pharmacist.