

WIC CHANGES

WIC CHANGES

This presentation is designed to inform staff of upcoming changes to the WIC.

The following changes will be discussed:

- Six Steps to Achieving Breastfeeding Friendly WIC Clinics
 - Assessing “Ever Breastfed”
 - Assessing “Household Smoking”
 - Revised and New Risk Criteria
 - SOAP Note changes
 - Formula changes
 - Upcoming trainings and changes regarding growth charts
- 

The background consists of several overlapping triangles. A large orange triangle is on the right side, pointing towards the top right. On the left side, there are two blue triangles: a lighter blue one on top and a darker blue one on the bottom, both pointing towards the bottom left. The remaining space is white.

SIX STEPS

SIX STEPS TO ACHIEVE BREASTFEEDING GOALS FOR WIC CLINICS

The National WIC Association (NWA) recognized the ongoing commitment of WIC staff to improve and sustain breastfeeding rates. The Six Steps to Achieve Breastfeeding Goals for WIC Clinics are an integral part of the NWA Breastfeeding Strategic Plan to assist agencies to achieve these goals.

GOALS:

1. To offer practical suggestions to increase exclusive breastfeeding initiation and duration among WIC participants.
2. To promote and create internal and external environments that support exclusive breastfeeding.

STEP 1

Present exclusive breastfeeding as the norm for all mothers and babies.



STEP 1

- Recognize and encourage the use of human milk as the perfect food for all infants
 - Support mothers in setting and reaching their exclusive breastfeeding goals
 - Develop staff training programs to deliver consistent education messages for mothers
 - Encourage breastfeeding at all nutrition contacts, beginning with prenatal enrollment
 - Promote the food package incentives for women who breastfeed exclusively
 - Collaborate with community partners to promote exclusive breastfeeding as the norm
- 

STEP 2

- Become a breastfeeding-friendly WIC clinic by striving to meet the International Code of the Marketing of Breastmilk Substitutes (WHO Code)
 - Train staff in how to assemble, clean and issue breastfeeding equipment appropriately.
 - Provide breastfeeding equipment, as available, following appropriate assessment by trained and qualified staff.
 - Encourage mothers to breastfeed anywhere in the clinic. Provide a private area only upon the mother's request.
 - Facilitate breastfeeding support groups at WIC clinic sites.
 - Provide consistent breastfeeding education, educational materials, and hands-on help—both prenatally and during the postpartum period.
 - Ensure that management fully promotes, encourages, and supports staff in their personal efforts to breastfeed.
- 

STEP 3

Ensure access to competently trained breastfeeding staff at each WIC clinic site.



STEP 3

- Train competent professional authorities (CPAs) to provide thorough assessment and appropriate support of the mother's breastfeeding plans and educational needs throughout the prenatal and postpartum periods
- Encourage and support breastfeeding education and training for staff to pursue advanced credentials in breastfeeding



STEP 4

Develop procedures to accommodate breastfeeding mothers and babies.



STEP 4

- Allow adequate time for assessment, evaluation, and assistance to resolve breastfeeding problems.
 - Address all breastfeeding concerns in a timely manner.
 - Explore collaborative efforts to provide a breastfeeding warm line, with competently trained staff who respond to questions in a timely manner.
 - Support breastfeeding mothers and respond to breastfeeding questions outside of formal nutrition education sessions.
- 

STEP 5

Mentor and train *all* staff to become competent breastfeeding advocates and/or counselors.



STEP 5

- Provide lactation education, including ongoing continuing education
- Allow adequate clinic time for hands-on mentoring
- Train all staff in the necessary skills to assess a breastfeeding dyad

STEP 6

Support exclusive breastfeeding through assessment, evaluation and assistance.



STEP 6

- Provide staff with access to at least one specialist who has received International Board Certified Lactation Consultant (IBCLC) credentials, for referral and mentorship.
 - Maximize utilization of trained Breastfeeding Peer Counselors
 - Ensure that competently trained breastfeeding staff provide breastfeeding classes and /or one-on-one education for all pregnant and breastfeeding women.
- 

WHAT DO YOU NEED TO DO?

- Identify what your clinics are already doing that supports or meets one of the six steps.
 - Identify what your clinics could be doing to meet one of the six steps.
 - Identify practices that clinics should stop doing in order to promote breastfeeding as the norm.
- 

NOTES TO IMPLEMENTATION OF THE SIX STEPS

- Not all steps have to be implemented at once.
- Steps do not have to be implemented in order.



INCENTIVES

New method of distribution of funds for World Breastfeeding Week activities

- Funds will be distributed by clinic
- Those clinics with implemented steps will receive funds
- A higher percentage of funds will be given to clinics with more implemented steps

Plan of expenses must be approved by State Office

- Expenses must support or promote breastfeeding

The new method of fund distribution will begin in 2013. This gives clinics a year to work on implementation of the steps and/or to identify which steps are already being met in order to receive funds.



ASSESSING EVER BREASTFED

ASSESSING “EVER BREASTFED”

- Breastfeeding has recently become one of the major focuses for the health department:
 - to improve support for breastfeeding families
 - to increase breastfeeding rates in the state
 - One way to impact our overall breastfeeding initiation rate is how we ask and interpret the mother’s response to the “Ever Breastfed” question.
 - Using a consistent statement and having a like-minded interpretation in counting “Ever breastfed” can help.
 - This question can be found under the Health Information tab in SPIRIT in the Feeding Information section .
- 

"EVER BREASTFED" QUESTION

File Participant Activities Document Imaging Help

Certification History

Demographics	Immunization	HT/WT/Blood	Food Prescription	Risk Factors	VENA
Health Information	Nutrition Education	Referrals	Income History	Benefits History	Appointments

Birth Information

Unknown Birth Criteria

Birth Weight Lbs Ozs Birth Height In 8ths Premature Birth Gestation Weeks

Birth Facility

Mother's Information

Birth Date On WIC

State WIC Information **Two-Way Link**

ID Name

Feeding Information

Ever Breastfed

Yes No Unknown

Requires Food Package III Breastfeeding Now

Date Food Package III Verified

Date Breastfeeding Verified

Date Breastfeeding Began

Date Breastfeeding Ended

Date Supplemental Feeding Began

Date Solids Were Introduced

Amount of Breastfeeding

Reason(s) Stopped

Medical Conditions

Diabetes Mellitus Hypertension or Prehypertension

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ASSESSING “EVER BREASTFED”

WIC CPA's should use the following statement when asking WIC participants the “Ever Breastfed” question:

“Has your baby EVER been put to the breast and given the opportunity to nurse or EVER received any amount of expressed breastmilk (including donor milk, wet nursing, etc.)?”

- This question only relates to breastmilk that the baby has received, whether from his own mother or another mother.
- Asking the question in this manner captures all possible breastfeeding efforts and puts AR WIC on an equal playing field with how other states are interpreting this information.

ASSESSING HOUSEHOLD SMOKING

HOW TO ASK THE QUESTION TO GET THE CORRECT ANSWER

Household Smoking question in Demographics tab is linked with system-assigned risk factor:

Risk Factor 904:

Environmental Tobacco Smoke Exposure

(also known as passive, secondhand or involuntary smoke)



ISABELLA PEDRO ... MFC ID 88554838 ... LUID 89558188

File Participant Activities Benefit Management Document Imaging Help

Certification History

Health Information	Education	Referrals	Income History	Benefits History	Appointments
Demographics	Immunization	HT/WT/Blood	Food Prescription	Risk Factors	VENA

Household Smoking: No [v] TV/Video Viewing: [v]

Local Use Questions

Currently Unused	[v]

State Use Questions

Currently Unused	[v]

How Heard about WIC: Family Member [v]

Hardship

- Transportation
- Working Authorized Representativ
- Rural Residence
- Chronic Family Illness
- Other
- Childcare Problems

Disability: [v]

Insurance Type: [v]

Type of Medical Home: Private Physician/Clinic [v]

Medical Home: Private Physician [v]

Demographics

AdditionalInfo1

AdditionalInfo2

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Risk Factor 904: *Environmental Tobacco Smoke Exposure* (also known as passive, secondhand or involuntary smoke)

Defined (for WIC eligibility purposes) as

exposure to smoke from tobacco products inside the home



Definition is based on 2 validated questions

Center for Disease Control and Prevention (CCD) Pediatric Nutrition Surveillance System (PedNSS) and *Pregnancy?* Nutrition Surveillance System (PNSS)questions to determine Environmental Tobacco Smoke (ETS) exposure:

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

- Questions are specific to “inside the home” and have been validated.....
- There are other potential sources of ETS exposure - e.g., work and day care environments.....

HOWEVER.... no validated questions/definitions could be found that were inclusive of other environments and applicable to WIC.



ISABELLA A REDD - 4 Months 30 Days - WIC ID:00654030 Household ID:00558109

File Participant Activities Benefit Management Document Imaging Help

Certification History Health Information Nutrition Education Referrals Income History Benefits History Appointments
 Demographics Immunization HIV/TW/Blood Food Prescription Risk Factors VENA

Household Smoking No TV/Video Viewing

Local Use Questions State Use Questions

Currently Unused

How Heard about WIC Family Member

Hardship Transportation Working Authorized Representativ Rural Residence Chronic Family Illness Other Childcare Problems

Disability

Insurance Type

Type of Medical Home Private Physician/Clinic

Medical Home Private Physician

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SO.....

The Household Smoking question in the Demographics tab MUST be asked in this way:

“ Does anyone living in your household smoke inside the home?”

What if.....

- The smoker living in the household only smokes outside.
 - The answer to the question would be... **NO**
- The (pregnant/postpartum) participant is a smoker and only smokes occasionally inside the home.
 - The answer to the question would be... **YES**
- Visitors smoke inside the home during their visit.
 - The answer to the question would be... **NO**

It is important that staff who ask the *“Household Smoking”* question in the Demographics tab be trained in the correct way to ask this question.



**VENA QUESTIONS ON
SMOKING**

VENA QUESTIONS ON SMOKING

INFANT:

#7. What concerns do you have about the safety and health of your baby? (Unsafe or threatening environment [child abuse/neglect within past 6 months], self-reported or from appropriate personnel) (901) Does anyone living in your household smoke? If so, does the smoking occur inside the home? (904)

A: safe environment, no smoking in the home.

DOES this answer give complete information?



DOES this answer give complete information?

NO.....

The answer just says there is no smoking in the home. Does that mean :

a. No one living in the household smokes at all?

OR

b. Someone living in the household does smoke but does not smoke inside the home?



VENA QUESTIONS ON SMOKING

CHILD:

#6. What concerns do you have about the safety and health of your child? (Unsafe or threatening environment [child abuse/neglect within past 6 months], self-reported or from appropriate personnel) (901) Does anyone living in your household smoke? If so, does the smoking occur inside the home? (904)

A: safe environment, no smoking in the home.

DOES this answer give complete information?



DOES this answer give complete information?

NO.....

The answer just says there is no smoking in the home. Does that mean :

a. No one living in the household smokes at all?

OR

b. Someone living in the household does smoke but does not smoke inside the home?



VENA QUESTIONS ABOUT SMOKING

Pregnant/Breastfeeding/Non-breastfeeding:

#6. Tell me about any history of or current use/abuse of alcohol, tobacco, illegal drugs (371-372). Do you or anyone else living in your household smoke? If so, does the smoking occur inside the home? (904)

A: No history of any abuse, no smoking in the home

DOES this answer give complete information?



DOES this answer give complete information?

NO.....

The answer just says there is no smoking in the home. Does that mean :

a. No one living in the household smokes at all?

OR

b. Someone living in the household does smoke but does not smoke inside the home?



What documentation would give a clear and accurate response to:

Does anyone living in your household smoke? If so, does the smoking occur inside the home? (904)

Three possible ways to answer:

- Yes, there is someone who lives in the household that smokes and Yes, the smoking occurs inside the home.
- Yes, there is someone who lives in the household that smokes and No, the smoking does not occur inside the home.
- No, there is no one who lives in the household that smokes.



NUTRITION RISK CRITERIA

REVISED AND NEW

Revised Nutrition Risk Criteria 2012

Risk Criteria (Revised Names)	Applicable Participant Category	Applicable Priority Level(s)	Health Care Provider Diagnosis Required	Risk Factor Code Number
Underweight or At Risk of Underweight	Infants	I	NO	103
	Children	II		
Obese	Children 2 – 5 Years of Age	III	NO	113
Overweight or At Risk of Overweight	Infants	I	NO	114
	Children	III		
*High Weight-for-Length	Infants	I	NO	115
	Children < 24 Months of Age	III		
Short Stature or At Risk of Short Stature	Infants	I	NO	121
	Children	III		
Thyroid Disorders	Pregnant Women	I	YES	344
	Breastfeeding Women	I		
	Non-Breastfeeding Women	III		
	Infants	I		
	Children	III		
Inborn Errors of Metabolism	Pregnant Women	I	YES	351
	Breastfeeding Women	I		
	Non-Breastfeeding Women	III		
	Infants	I		
	Children	III		

*New Criterion

Risk Factors revised due to use of new **World Health Organization** (WHO) growth charts:

- 103 – Underweight or At Risk of Underweight (Infants and Children)
- 121 – Short Stature or At Risk of Short Stature

103 Underweight or At Risk of Underweight (Infants and Children)

Definition/Cut-off Value

Underweight and at risk of underweight are defined as follows:

Weight Classification	Age	Cut-off Value
Underweight	Birth to < 24 months	$\leq 2.3^{\text{rd}}$ percentile weight-for-length as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts (1).*
	2-5 years	$\leq 5^{\text{th}}$ percentile Body Mass Index (BMI)-for-age as plotted on the 2000 CDC age/gender specific growth charts (2).
At Risk of Underweight	Birth to < 24 months	$> 2.3^{\text{rd}}$ percentile and $\leq 5^{\text{th}}$ percentile weight-for-length as plotted on the CDC Birth to 24 months gender specific growth charts (1).*
	2-5 years	$> 5^{\text{th}}$ percentile and $\leq 10^{\text{th}}$ percentile BMI-for-age as plotted on the 2000 CDC age/gender specific growth charts (2).
<p>*Based on 2006 World Health Organization international growth standards (3). For the Birth to < 24 months "underweight" definition, CDC labels the 2.3^{rd} percentile as the 2^{nd} percentile on the Birth to 24 months gender specific growth charts. For more information about the percentile cut-off, please see Clarification.</p> <p>Note: The Birth to 24 months and the 2000 CDC growth charts are available at: www.cdc.gov/growthcharts.</p>		

Participant Category and Priority Level

Category	Priority
Infants	I
Children	III

121 Short Stature or At Risk of Short Stature (Infants and Children)

Definition/Cut-Off Value

Short Stature and at risk of short stature are defined as follows:

Height Classification	Age	Cut-off value
Short Stature	Birth to < 24 months	$\leq 2.3^{\text{rd}}$ percentile length-for-age as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts (1).*
	2 – 5 years	$\leq 5^{\text{th}}$ percentile stature-for-age as plotted on the 2000 CDC age/gender specific growth charts (2).
At Risk of Short Stature	Birth to < 24 months	$> 2.3^{\text{rd}}$ percentile and $\leq 5^{\text{th}}$ percentile length-for-age as plotted on the CDC Birth to 24 months gender specific growth charts (1).*
	2 – 5 years	$> 5^{\text{th}}$ percentile and $\leq 10^{\text{th}}$ percentile stature-for-age as plotted on the 2000 CDC age/gender specific growth charts (2).

*Based on 2006 World Health Organization international growth standards (3). CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts. For more information about the percentile cut-off, please see Clarification.

Notes:

1. The Birth to 24 months and the 2000 CDC growth charts are available at: www.cdc.gov/growthcharts.
2. For premature infants and children (with a history of prematurity) up to 2 years of age, assignment of this risk criterion will be based on adjusted gestational age. For information about adjusting for gestational age see: [Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants](#).

Risk Factors revised due to name change:

- 113 – *Obese (instead of Overweight)-Children 2-5 Years of Age*
- 114 – *Overweight or At Risk of Overweight (instead of At Risk of Becoming Overweight) -Infants and Children*

113 Obese (Children 2-5 Years of Age)

Definition/Cut-off Value

Obesity for children 2-5 years of age is defined as follows:

Age	Cut-Off Value
2-5 years	$\geq 95^{\text{th}}$ percentile Body Mass Index (BMI) or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts (1,2) (available at: www.cdc.gov/growthcharts).*

*The cut off is based on standing height measurements. Therefore, recumbent length measurements may not be used to determine this risk. See Clarification for more information.

Participant Category and Priority Level

Category	Priority
Children (2-5 years of age)	III

Justification

The rapid rise in the prevalence of obesity in children and adolescents is one of the most important public health issues in the United States today. The National Health and Nutrition Examination Survey (NHANES) from the mid-1960s to the early 2000s document a significant increase in obesity among children from preschool age through adolescence. These trends parallel a concurrent increase in obesity among adults, suggesting that fundamental shifts occurring in dietary and/or physical activity behaviors are having an adverse effect on overall energy balance (3).

The causes of increased obesity rates in the United States are complex. Both genetic make-up and environmental factors contribute to the obesity risk. Important contributors include a large and growing abundance of calorically dense foods and an increased sedentary lifestyle for all ages. Although obesity tends to run in families, a genetic predisposition does not inevitably result in obesity. Environmental and behavioral factors can influence the development of obesity in genetically at-risk people (3).

BMI is a measure of body weight adjusted for height. While not a direct measure of body fatness, BMI is a useful screening tool to assess adiposity (3). Children ≥ 2 years of age, with a BMI-for-age $\geq 85^{\text{th}}$ and $< 95^{\text{th}}$ percentile are considered *overweight* and those at or above the 95^{th} percentile, *obese* (4). Research on BMI and body fatness shows that the majority of children with BMI-for-age at or above the 95^{th} percentile have high adiposity and less than one-half of the children in the 85^{th} to $< 95^{\text{th}}$ percentiles have high adiposity (4). Although an imperfect tool, elevated BMI among children most often indicates increased risk for future adverse health outcomes and/or development of diseases (5). BMI should serve as the initial screen and as the starting point for classification of health risks (3).

Use of the 95^{th} percentile to define obesity identifies those children with a greater likelihood of being obese as adolescents and adults, with increased risk of obesity-related disease and mortality. It is recommended

DOES NOT ALLOW
USING RECUMBENT
LENGTH TO ASSIGN
RISK

114 Overweight or At Risk of Overweight (Infants and Children)

Definition/Cut-Off Value

Weight Classification	Age	Definition/Cut-off value
Overweight	2 - 5 years	$\geq 85^{\text{th}}$ and $< 95^{\text{th}}$ percentile Body Mass Index (BMI)-for-age or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts (1,2).*
At Risk of Overweight	< 12 months (infant of obese mother)	Biological mother with a BMI ≥ 30 at the time of conception or at any point in the first trimester of pregnancy.**
	≥ 12 months (child of obese mother)	Biological mother with a BMI ≥ 30 at the time of certification.** (If the mother is pregnant or has had a baby within the past 6 months, use her preconceptional weight to assess for obesity since her current weight will be influenced by pregnancy-related weight gain.)
	Birth to 5 years (infant or child of obese father)	Biological father with a BMI ≥ 30 at the time of certification.**

* The cut off is based on standing height measurements. Therefore, recumbent length measurements may not be used to determine this risk. See Clarification for more information.

** BMI must be based on self-reported weight and height by the parent in attendance (i.e., one parent may not "self report" for the other parent) or weight and height measurements taken by staff at the time of certification.

Note: The 2000 CDC 2 - 20 years growth charts are available at: www.cdc.gov/growthcharts.

Participant Category and Priority Level

Category	Priority
Infants	I
Children	III

DOES NOT ALLOW
USING
RECUMBENT
LENGTH TO
ASSIGN RISK

Risk Factor added as NEW Risk Factor:

- 115 – *High Weight-for-Length -Infants and Children <24 Months of Age*

115 High Weight-for Length (Infants and Children < 24 Months of Age)

Definition/Cut-Off Value

High weight-for-length for infants and children < 24 months of age is defined as follows:

Age	Cut-Off Value
Birth to < 24 months	\geq 97.7 th percentile weight-for-length as plotted on the Centers for Disease Control and Prevention (CDC), Birth to 24 months gender specific growth charts (1) (available at: www.cdc.gov/growthcharts).*

**Based on the 2006 World Health Organization (WHO) international growth standards (2). CDC labels the 97.7th percentile as the 98th percentile on the Birth to 24 months gender specific growth charts. For more information about the percentile cut-off, please see Clarification.*

Participant Category and Priority Level

Category	Priority
Infants	I
Children (< 24 months of age)	III

Justification

In 2006, WHO released international growth standards for infants and children aged 0-59 months (2), similar to the 2000 CDC growth references. Since then, the CDC has developed Birth to 24 months growth charts, based on the WHO growth standards, and recommends their use in the United States (1). For persons 2-20 years, the 2000 CDC growth charts will continue to be used (1).

The WHO and CDC growth charts are similar in that both describe weight-for-age, length (or stature)-for-age, weight-for-length (or stature) and body mass index (BMI) for age. However, they differ in the approach taken to create the growth charts. The WHO growth charts are growth standards that describe how healthy children grow under optimal environmental and health conditions. The 2000 CDC charts are a growth reference, not a standard, and describe how certain children grew in a particular place and time (2).

The WHO growth standards for children < 24 months are based on data collected from 1997-2003 in 6 countries (including the U.S.), from children who were born between 37 and 42 weeks gestation, breastfed for at least 12 months, and introduced to complementary food by at least 6 months but not before 4 months. Infants and children of low-income mothers and/or mothers who smoked were not included in the data sample (2).

The 2000 CDC charts for infants and children < 36 months are based on birth weight (from 1968 to 1980 and from 1985 to 1994) and birth length data (from 1989 to 1994) obtained from U.S. birth certificates; National Health and Nutrition Examination Survey (NHANES) data; and, measurements from infants who had been breastfed and formula fed (approximately 50% ever breastfed and approximately 33% who were

Risk Factors revised due to expanded definition, justification, references and clarification:

- 344 – *Thyroid Disorders*
- 351 – *Inborn Errors of Metabolism*

344 Thyroid Disorders

Definition/Cut-Off Value

Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following:

Thyroid Dysfunction	Definition
Hyperthyroidism	Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter).
Hypothyroidism	Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.
Congenital Hyperthyroidism	Excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation).
Congenital Hypothyroidism	Infants born with an under active thyroid gland and presumed to have had hypothyroidism in-utero.
Postpartum Thyroiditis	Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous.

Presence of condition diagnosed, documented, or reported by a physician or someone working under physician's orders, or as self reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Participant Category and Priority Level

Category	Priority
Pregnant Women	I
Breastfeeding Women	I
Non-Breastfeeding Women	III, IV, V or VI
Infants	I
Children	III

351 Inborn Errors of Metabolism

Definition/Cut-Off Value

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat.

Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body, including but not limited to:

Inborn Errors of Metabolism*	
Amino Acid Disorders	Urea Cycle Disorders
Organic Acid Metabolism Disorders	Carbohydrate Disorders
Fatty Acid Oxidation Disorders	Peroxisomal Disorders
Lysosomal Storage Diseases	Mitochondrial Disorders
<i>*For information about additional IEM, please see Clarification.</i>	

Presence of condition diagnosed, documented, or reported by a physician or someone working under physician's orders, or as self reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Participant Category and Priority Level

Category	Priority
Infants	I
Children	III
Pregnant Women	I
Breastfeeding Women	I
Non-Breastfeeding Women	III, IV, V or VI

Justification

The inheritance of most metabolic disorders is rare. IEM disorders may manifest at any stage of life, from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities for those affected (1).

All States screen newborns for IEM, although the type and number of IEM screened for may vary from State to State. Typically, infants are screened for amino acid disorders, urea cycle disorders, organic acid disorders, and fatty acid oxidation defects. A few States are working toward including lysosomal storage diseases and peroxisomal disorders among their newborn screening panels (2).

SOAP NOTES

SOAP NOTES

- No “S” required, but pertinent information from VENA or participant can be documented.
- Effective August 1, 2012, risk factor 000 must be selected and assigned to all participants during certification.
- Risk factor 000 populates the SOAP note with prompts to better assess the participant’s status, plan, and follow-up.

THE 'A' PROMPT

A: My assessment of this participant's concerns/needs based upon what the participant has told me what I have observed is (be sure to include medical diagnosis or other problems identified, documentation for assignment of risk codes progression towards previously set goal):



THE 'P' PROMPT

P: Plans to address this participant's needs/concerns are education not covered by nutrition education plan or circle charts, breast pump issuance if applicable, any additional referrals such as immunizations, lead screen, 9-12 mo Hgb check, etc., recommended follow-up, and goal if not documented in Goal Tab):

Certification Risk Factors

- Previous Certifications/Risk Factors
 - 03/26/2012 - 08/04/2012
 - S** High Maternal Weight Gain (133)
 - C** Failure to Meet Dietary Guidelines for Ame

Currently Identified Risk Factors

Available

Risk Factor	Description
000	SOAP Default
131	Low Maternal Weight Gain
132	Maternal Weight Loss During Pregnancy
301	Hyperemesis Gravidarum
302	Gestational Diabetes
303	History of Gestational Diabetes
304	History of Preeclampsia

Search ↓ ↑

Selected

Risk Factor	Description
401	Failure to Meet Dietary Guidelines for Americans

High Risk

Risk Factors Details Guide OK Cancel

Certification Risk Factors

- Previous Certifications/Risk Factors
 - 03/26/2012 - 08/04/2012
 - High Maternal Weight Gain (133)
 - Failure to Meet Dietary Guidelines for Americans

Currently Identified Risk Factors

Available

Risk Factor	Description
131	Low Maternal Weight Gain
132	Maternal Weight Loss During Pregnancy
301	Hyperemesis Gravidarum
302	Gestational Diabetes
303	History of Gestational Diabetes
304	History of Preeclampsia
331	Pregnancy at a Young Age

Search

Selected

Risk Factor	Description
000	SOAP Default
401	Failure to Meet Dietary Guidelines for Americans

High Risk

Risk Factors Details [Guide](#)

OK

Cancel

Create SOAP Note

Subject: SOAP

Note Text

S:|

O:

11/29/2011 64 3/8 inches 177 pounds 2 ounces. Height for age percentile: N/A Weight for age percentile: 94.96%
11/29/2011 HGB:13.9 HCT: 0 Lead:0 E.P.:0

Risk Factors Assigned on 11/29/2011

000 SOAP Default

111 Overweight Women

331 Pregnancy at a Young Age

Individual topics discussed on 11/29/2011

Benefits of Nutrition Education

Benefits of WIC Foods

Breastfeeding Promotion

Circle Chart Being Active Feeling Good

Dangers of Substance Abuse

Discussion of WIC Risk Factors

Prenatal Nutrition

Rights & Responsibilities

Use of WIC Checks

A:

MY ASSESMENT OF THIS PARTICIPANT'S CONCERNS/NEEDS BASED ON WHAT THE PARTICIPANT HAS TOLD ME AND WHAT I HAVE OBSERVED IS (BE SURE TO INCLUDE MEDICAL DIAGNOSIS OR OTHER PROBLEMS IDENTIFIED, DOCUMENTATION FOR ASSIGNMENT OF RISK CODES, AND PROGRESSION

Application Area Risk Factors

Protected

OK

Cancel

Create SOAP Note

Subject: SOAP

Note Text

Breastfeeding Promotion
Circle Chart Being Active Feeling Good
Dangers of Substance Abuse
Discussion of WIC Risk Factors
Prenatal Nutrition
Rights & Responsibilities
Use of WIC Checks

A:
MY ASSESMENT OF THIS PARTICIPANT'S CONCERNS/NEEDS BASED ON WHAT THE PARTICIPANT HAS TOLD ME AND WHAT I HAVE OBSERVED IS (BE SURE TO INCLUDE MEDICAL DIAGNOSIS OR OTHER PROBLEMS IDENTIFIED, DOCUMENTATION FOR ASSIGNMENT OF RISK CODES, AND PROGRESSION TOWARDS PREVIOUSLY SET GOAL)

P:
PLANS TO ADDRESS THIS PARTICIPANT'S NEEDS/CONCERNS ARE (BE SURE TO INCLUDE EDUCATION NOT COVERED BY NUTRITION EDUCATION PLAN OR CIRCLE CHARTS, BREAST PUMP ISSUANCE IF APPLICABLE, ANY ADDITIONAL REFERRALS SUCH AS IMMUNIZATIONS, LEAD SCREEN, 9-12 MO HGB CHECK, ETC., RECOMMENDED FOLLOW-UP AND GOAL IF NOT DOCUMENTED IN GOAL TAB).

Referrals Provided on 11/29/2011

ADH - ADH - WIC

Application Area Risk Factors

Protected

OK

Cancel

REMEMBER...

Records that do not indicate risk factor 000 being assigned will be regarded as not following WIC policy and will be sited as so during WIC management evaluations.



FORMULA CHANGES

FORMULA CHANGES

WIC State agencies are required by law to have infant formula rebate contracts with infant formula manufacturers. This means WIC State agencies agree to provide one brand of infant formula and in return the manufacturer gives the State agency a refund for each can of infant formula purchased by WIC participants. By negotiating rebates with formula manufacturers, States are able to use this recovered money to serve more people.



For federal fiscal year 2010, national rebate savings were \$1.7 billion, supporting an average of 1.9 million participants each month, or 20.5 percent of the estimated average monthly caseload. During January 2011-March 2012 Arkansas WIC served an average of 92,983 participants per month. Of those receiving services, 32.28% or 30,024 women, infants, and children per month were able to be served by the funds received by the infant formula rebate.



TRI-STATE INFANT FORMULA CONSORTIUM

Arkansas, New Mexico and North Carolina make up our three state consortium for negotiating and entering into the current infant formula rebates contract.

The total number of infants for the three states affects our ability to negotiate a more favorable contract. Because the three states combined serve over 100,000 infants, federal regulations mandate a contract must be bid and awarded separately for milk-based and soy-based infant formulas.

This could result in having one brand for their milk-based formula and a different brand for their soy-based formula.



Arkansas's current contracts are with Mead Johnson. Each past contract has been for three years, and Mead Johnson has been the contractor for our state for 18 years or for our last 6 contracts. Many WIC employees have never known a time when Enfamil products were not issued.

Arkansas's current contract with Mead Johnson expires on September 30, 2012.

Arkansas, New Mexico and North Carolina began working on a Request for Proposal (RFP) for new formula contracts in May 2011.

The RFP was released in January 2012.

Bids for the contracts were opened April 20, 2012.



INFANT FORMULA REBATE CONTRACT 2013-2015

A letter of intent to award the contract was sent out on May 1, 2012. A two week protest period followed, ending on May 15, 2012. No protests were initiated by the formula companies.

On May 15, 2012, Nestle Gerber officially became the contractor for the Arkansas contracts beginning October 1, 2012. The contracts are for 3 years and will end September 30, 2015.

NEW FORMULAS

Under our new contract we will be issuing:

- Gerber Good Start Gentle
- Gerber Good Start Protect
- Gerber Good Start Soothe
- Gerber Good Start Soy

GOOD START GENTLE



- Primary milk-based formula
- For infants 0-12 months
- 100% Whey Protein
- Contains DHA & ARA
- Contains prebiotics to support digestive health and support immune systems—prebiotic fiber and NUTRIPROTECT (blend of vitamins C & E, zinc and vitamin A)
- Powder, concentrate and RTU

GOOD START PROTECT

- Milk-based formula
- For infants 0-12 months
- 100% Whey Protein
- Contains DHA & ARA
- Contains probiotics to help strengthen a healthy immune system—**IMMUNIPROTECT**—Bifidus BL
- Powder, concentrate and RTU



GOOD START SOOTHE



- Milk-based formula
- For infants 0-12 months
- Contains DHA & ARA
- 30% lactose content
- Contains probiotic L. Reuteri—to reduce crying in colicky infants
- Powder only

GOOD START SOY

- Soy-based infant formula
- For infants 0-12 months
- Contains DHA & ARA
- Milk free & lactose free
- Contains NUTRIPROTECT
- Powder, concentrate and RTU



CONVERSION

Standard Formula Replacements

Old Formula	New Formula
Enfamil Premium Infant	Gerber Good Start Gentle OR Good Start Protect*
Enfamil Gentlease	Gerber Good Start Soothe
Enfamil A.R.	Gerber Good Start Gentle
Enfamil ProSobee	Gerber Good Start Soy

* Participants with infants currently receiving Enfamil Premium Infant will be allowed to choose between Good Start Gentle and Good Start Protect.

SPECIAL FORMULA CHANGES

In order to further impact cost containment efforts, WIC's special formula list has also been revised. The new approved special formula list will also be effective starting October 1, 2012.

Prescriptions still require a documented medical reason/diagnosis and requested amount, and will be re-evaluated every three months by a WIC Nutritionist (Registered Dietitian).

Additional criteria used to evaluate and determine the WIC special formula list are:

- Requests from participants, physicians and hospitals
- product availability, shipping time, etc.,
- if there is already a comparable product being offered.

NEW APPROVED SPECIAL FORMULA LIST

Alimentum

Neocate Infant with DHA & ARA

Neocate Jr. with Prebiotics (unflavored & vanilla)

NeoSure

PediaSure

PediaSure Enteral

PediaSure with Fiber

PediaSure Enteral with Fiber

Phenex I

Phenex II

Portagen

Pregestimil

Similac PM 60/40

Similac Special Care 24 calorie



Special Formula Replacements

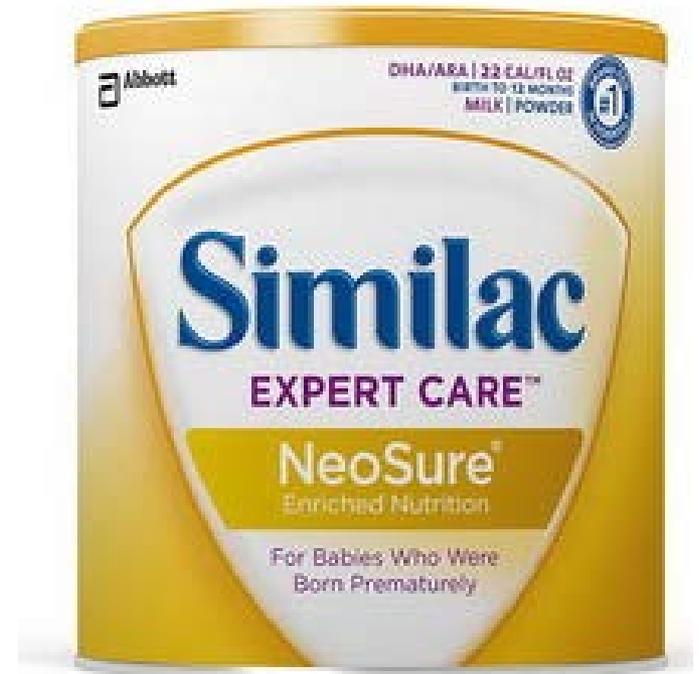
Old Formula	Suggested New Formula
Nutramigen Enflora LGG or Nutramigen LIPIIL	Alimentum
Elecare Infant with DHA & ARA	Neocate Infant DHA & ARA
Elecare Jr. (unflavored or vanilla)	Neocate Jr. with Prebiotics (unflavored or vanilla)
EnfaCare	NeoSure
Enfamil Premature LIPIIL 24 calorie	Similac Special Care 24 with Iron
Phenyl-Free 1	Phenex I
Phenyl-Free 2	Phenex II

The next couple of slides briefly cover the 3 special formulas WIC does not currently authorize.



- Nutritionally complete
- Powdered
- Amino Acid-based medical food
- Children over age one
- Dietary management of cow milk allergy, multiple food protein intolerance (MFPI) and food-allergy-associated conditions; gastroesophageal reflux disease (GERD), eosinophilic esophagitis (EoE), short bowel syndrome (SBS), malabsorption and other GI disorders
- Contains prebiotic fiber to help promote digestive health and extra vitamins and minerals especially helpful for children with GI-related malabsorptive conditions.
- Unflavored or vanilla

- For infants born prematurely
- Can be used for the first year of life
- 25% of the fat blend is medium-chain triglycerides, which are an easily digested and well-absorbed fat source





- Preterm infants
- 24 calories per ounce
- 2 oz nursettes

INFANT FORMULA REBATE CONTRACT 2013-2015

In addition, we are implementing changes to the special formula request (WIC-51).

Although it doesn't really look different, it basically was changed in these four ways:

- Prerequisite formulas not listed
- New 'Request received' signature line
- New 'CPA reviewing request' signature line
- Oral PediaSure changes for diagnosis of FTT

UPDATED SPECIAL FORMULA REQUEST

ARKANSAS DEPARTMENT OF HEALTH
WIC PROGRAM
SPECIAL FORMULA REQUEST

WIC may provide the following formulas with documented medical reason/diagnosis for up to three months. Supplemental foods will only be issued with approval of a physician or advanced practice nurse with prescriptive authority. All prescriptions are reviewed by a WIC Registered Dietitian.

Name of Infant/Child _____ Date of Birth _____

Height/Length _____ Weight _____ Date Taken _____

List history of formulas previously tried and resulting symptoms: _____

Note: Ready-to-Use formula can be issued if the caretaker is physically or mentally unable to prepare formula or if water supply is unsafe

TO REQUEST A SPECIAL FORMULA:

1. Review the descriptions for use.
2. Check selected formula listed below or on back.
3. Write in diagnosis.
4. Circle number of months prescribed.
5. Indicate the amount needed per day.
6. Select supplemental foods to be restricted.
7. Complete date and signature box on back.

Formula	Descriptions for Use	Diagnosis	Duration & Amount
<input type="checkbox"/> Alimentum—Abbott	Allergy to milk and/or soy protein; severe malnutrition; chronic diarrhea, short bowel syndrome; known or suspected corn allergy		1, 2, or 3 month(s) _____oz/day
<input type="checkbox"/> Neocate Infant DHA & ARA*—Nutricia <input type="checkbox"/> Neocate Jr.* with Prebiotics—Nutricia <input type="checkbox"/> Unflavored <input type="checkbox"/> Vanilla	Allergy to intact protein and casein hydrolysates; severe food allergies; short bowel syndrome, malabsorption <i>Neocate Jr. is intended for children over the age of one; standard dilution is 30 calories per ounce</i>		1, 2, or 3 month(s) _____oz/day
<input type="checkbox"/> NeoSure—Abbott	Pretterm infant transitional formula for use between premature formula and term formula; must have minimum weight of 1800 grams or 4 pounds. Not approved for an infant previously on term formula or a term infant for increased calories.		1, 2, or 3 month(s) _____oz/day
<input type="checkbox"/> Portagen*—Mead Johnson	Pancreatic insufficiency, bile acid deficiency or lymphatic anomalies; biliary atresia; liver disease; chylithroax		1, 2, or 3 month(s) _____oz/day
<input type="checkbox"/> Pregestimil—Mead Johnson	Fat malabsorption and sensitivity to intact proteins; cystic fibrosis; short bowel syndrome; intractable diarrhea; severe protein calorie malabsorption		1, 2, or 3 month(s) _____oz/day
Oral Supplements (1-5 years of age) <input type="checkbox"/> PediaSure—Abbott <input type="checkbox"/> PediaSure with Fiber—Abbott	Oral motor feeding disorders, FTT from underlying medical condition that increases calorie requirements beyond what is expected FTT must be indicated by one or more of the following: <ul style="list-style-type: none"> • Weight consistently below the 3rd percentile for age; • Weight less than 80% of ideal weight for height/age; • Progressive fall-off in weight to below the 3rd percentile; or • A decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile 		1, 2, or 3 month(s) _____oz/day

* Indicates formula is available in powder only
WIC-51 (R10/12)

Name of Infant/Child _____ Date of Birth _____

Formula	Descriptions for Use	Diagnosis	Duration & Amount
Tube Feeding (1-5 years of age) Note: may prescribe for 6 months duration. <input type="checkbox"/> PediaSure Enteral—Abbott <input type="checkbox"/> PediaSure Enteral with Fiber—Abbott <input type="checkbox"/> PediaSure—Abbott <input type="checkbox"/> PediaSure with Fiber—Abbott	Tube feedings; oral motor feeding disorders; medical conditions that increase caloric needs Note: Regular PediaSure (not Enteral) can only be prescribed for 6 months duration if infant/child is tube fed.		1, 2, 3, 4, 5, 6 month(s) _____oz/day
<input type="checkbox"/> Phenex I*—Abbott <input type="checkbox"/> Phenex II*—Abbott Note: May prescribe for 6 months duration.	PKU: Hyperphenylalaninemia <i>Phenex I for infants and toddlers</i> <i>Phenex II for children and adults</i>		1, 2, 3, 4, 5, 6 month(s) _____oz/day
<input type="checkbox"/> Similac PM 60/40*—Abbott Note: May prescribe for 6 months duration.	Renal, cardiac or other condition that requires lowered minerals		1, 2, 3, 4, 5, 6 month(s) _____oz/day
<input type="checkbox"/> Similac Special Care 24 with Iron—Abbott	Pretterm, low birthweight infants; not intended for use after a weight of 3600 grams or 8 pounds is reached. Not approved for an infant previously on term formula or a term infant for increased calories		1, 2, or 3 month(s) _____oz/day

* Indicates formula is available in powder only

Supplemental Foods

The participant will receive the supplemental foods listed below, appropriate to their WIC participant category, in addition to the WIC formula. Please indicate any supplemental foods or restrictions not approved due to contraindications with the participant's medical diagnosis.

WIC Participant Category	WIC Supplemental Foods Available	Do Not Give	Restrictions/Comments
Infants (6-12 months)	Infant Cereal		
Children and Women	Infant Vegetables/Fruits		
	Milk		
	Cheese		
	Cereal		
	Juice		
	Eggs		
	Vegetables/Fruits		
	Whole Grains		
	Beans		
	Peanut Butter*		
Canned Fish**			

* Peanut butter will not be issued to children under 2 years of age.

** Exclusively Breastfeeding Women, Partially Breastfeeding Women of Multiples or Pregnant Women with Multiples are the only WIC participant categories eligible to receive canned fish.

Date: _____ Medical Provider (Print): _____ Contact Phone Number: (____) _____

Medical Provider Signature _____ Prescriptive Authority Number: _____
(APN nurses with prescriptive authority only)

LHU/WIC CLINIC USE ONLY:

Request received by: _____ Title: _____ Date: _____

CPA reviewing request: _____ Title: _____ Date: _____

REQUIRED SIGNATURES

Date: _____ Medical Provider (Print): _____ Contact Phone Number: (____) _____

Medical Provider Signature: _____ Prescriptive Authority Number : _____
 (APN nurses with prescriptive authority only)

LHU/WIC CLINIC USE ONLY:

Request received by: _____ Title: _____ Date: _____

CPA reviewing request: _____ Title: _____ Date: _____

Formula	Descriptions for Use	Diagnosis	Duration & Amount
Tube Feeding (1-5 years of age) <i>Note: may prescribe for 6 months duration.</i> <input type="checkbox"/> PediaSure Enteral—Abbott <input type="checkbox"/> PediaSure Enteral with Fiber—Abbott <input type="checkbox"/> PediaSure—Abbott <input type="checkbox"/> PediaSure with Fiber—Abbott <input type="checkbox"/> Pharex F—Abbott <input type="checkbox"/> Pharex F—Abbott <i>Note: May prescribe for 6 months duration.</i>	Tube feedings, oral motor feeding disorders, medical conditions that increase caloric needs <i>Note: Regular PediaSure (not Enteral) can only be prescribed for 6 months duration if infant/child is tube fed.</i>		1, 2, 3, 4, 5, 6 month(s) _____oz/day
<input type="checkbox"/> Similac PM 6040—Abbott <i>Note: May prescribe for 6 months duration.</i>	PKU, Hyperphenylalaninemia		1, 2, 3, 4, 5, 6 month(s) _____oz/day
<input type="checkbox"/> Similac Special Care 24 with Iron—Abbott <i>Note: May prescribe for 6 months duration.</i>	Phenox for infants and toddlers Phenox for children and adults Renal, cardiac or other condition that requires lowered minerals		1, 2, 3, 4, 5, 6 month(s) _____oz/day
<input type="checkbox"/> Similac Special Care 24 with Iron—Abbott	Preterm, low birthweight infants; not intended for use after a weight of 3600 grams or 8 pounds is reached. Not approved for an infant previously on term formula or a term infant for increased calories		1, 2, or 3 month(s) _____oz/day

Supplemental Foods
 The participant will receive the supplemental foods listed below, appropriate to their WIC participant category, in addition to the WIC formula. Please indicate any supplemental foods or restrictions not approved due to contraindications with the participant's medical diagnosis.

WIC Participant Category	WIC Supplemental Foods Available	Do Not Give	Restrictions/Comments
Infants (6-12 months)	Infant Cereal Infant Vegetables/Fruits		
Children and Women	Milk Cheese Cereal Juice Eggs Vegetables/Fruits Whole Grains Beans Peanut Butter** Canned Fish***		

* Peanut butter will not be issued to children under 2 years of age.
 ** Exclusively Breastfeeding Women, Partially Breastfeeding Women of Multiples or Pregnant Women with Multiples are the only WIC participant categories eligible to receive canned fish.

Date: _____ Medical Provider (Print): _____ Contact Phone Number: (____) _____

Medical Provider Signature: _____ Prescriptive Authority Number: _____
 (APN nurses with prescriptive authority only)

LHU/WIC CLINIC USE ONLY:

Request received by: _____ Title: _____ Date: _____
 CPA reviewing request: _____ Title: _____ Date: _____

FTT DIAGNOSIS

<p>Oral Supplements (1-5 years of age)</p> <ul style="list-style-type: none"><input type="checkbox"/> PediaSure—Abbott<input type="checkbox"/> PediaSure with Fiber—Abbott	<p>Oral motor feeding disorders; FTT from underlying medical condition that increases caloric requirements beyond what is expected</p> <p>FTT must be indicated by one or more of the following:</p> <ul style="list-style-type: none">• Weight consistently below the 3rd percentile for age;• Weight less than 80% of ideal weight for height/age;• Progressive fall-off in weight to below the 3rd percentile; or• A decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile		<p>1, 2, or 3 month(s)</p> <p>_____oz/day</p>
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SPECIAL FORMULA APPROVALS

With the formula changes, it is difficult to predict the financial impact to the program. There is always a concern that because these formulas ARE NOT REBATED, and the cost comes from the total food funds allocated to the Program we will be attempting to better monitor approval of these formulas.

To better track if issues arise, special formula will be approved only by:

the Regional Nutrition Coordinator,
their designee(s) , or
State WIC Office Nutritionist/Nutritionist Consultant

This change will become effective October 1, 2012.

This means not every Nutritionist or RD will be allowed to approve special formulas at this time.



NOTIFICATION

Doctor's offices across the state have been notified of the upcoming formula changes.

In addition, Nutrition staff will be visiting local physicians offices to ensure they are aware of the changes and the possible impact to their patients.

A letter to participants has also been prepared and is to be distributed starting July 1, 2012.

A check stuffer and posters for the clinic are also planned as ways to inform our participants about the changes.



HEALTH UNIT GUIDE

This formula conversion sheet has been prepared for use by the local health units to help determine what formula will replace current products or what formula is suggested.

New food prescriptions must be entered manually by a CPA. This chart will help CPAs determine, along with the participant, which formula the infant will be switched to. New food prescriptions can be entered for October starting in July.

Formula Conversions Effective October 1, 2012

Standard Formula Replacements

Old Formula	New Formula
Enfamil Premium Infant	Gerber Good Start Gentle OR Good Start Protect*
Enfamil Gentlease	Gerber Good Start Soothe
Enfamil A.R.	Gerber Good Start Gentle
Enfamil ProSobee	Gerber Good Start Soy

Special Formula Replacements

Old Formula	Suggested New Formula
Alimentum	Alimentum
Nutramigen Enflora LGG or Nutramigen LIPIL	Alimentum
Elecare Infant with DHA & ARA	Neocate Infant DHA & ARA
Elecare Jr. (unflavored or vanilla)	Neocate Jr. with Prebiotics (unflavored or vanilla)
EnfaCare	NeoSure
Enfamil Premature LIPIL 24 calorie	Similac Special Care 24 with Iron
Phenyl-Free 1	Phenex I
Phenyl-Free 2	Phenex II
Phenex I	Phenex I
Phenex II	Phenex II
PediaSure	PediaSure
PediaSure with Fiber	PediaSure with Fiber
PediaSure Enteral	PediaSure Enteral
PediaSure Enteral w/ Fiber	PediaSure Enteral w/ Fiber
Portagen	Portagen
Pregestimil	Pregestimil
Similac PM 60/40	Similac PM 60/40

* Participants receiving Enfamil Premium Infant can choose to change their formula to Good Start Gentle or Good Start Protect.

SPECIAL FORMULA PRESCRIPTIONS

- Prescriptions for special formula products that will be discontinued can only be approved through September 30.
 - New prescriptions will be needed for the new products in order for special formula to be issued in October.
 - Prescriptions for products not changing, will not be affected and can continue to be treated according to policy.
- 

RETURNED FORMULA

- Use it while you can!
- Deplete stock as soon as possible!
- If excess amounts of discontinued formulas remain, the WIC State Office will provide further direction on distribution.

GROWTH CHARTS

WHO AND CDC

WHO IS WHO?

- **World Health Organization (WHO)**
- **Directing and coordinating authority for health within the United Nations system**
- **Core functions:**
 - leadership role on global health matters
 - shaping health research agenda
 - setting norms and standards
 - articulating evidence-based policy options
 - providing technical support to countries
 - monitoring and assessing health trends

WHO IS CDC?

- Centers for Disease Control (CDC)
- Nation's premier health promotion, prevention, and preparedness agency
- Major operating components of the Department of Health and Human Services
- **Focuses on 5 strategic areas:**
 - Supporting state/local health departments
 - Improving global health
 - Implementing measures to decrease leading causes of death
 - Strengthening surveillance and epidemiology
 - Reforming health policies



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

WHO Growth Standards Are Recommended for Use in the U.S. for Infants and Children 0 to 2 Years of Age

The World Health Organization (WHO) released a new international growth standard statistical distribution in 2006, which describes the growth of children ages 0 to 59 months living in environments believed to support what WHO researchers view as optimal growth of children in six countries throughout the world, including the U.S. The distribution shows how infants and young children grow under these conditions, rather than how they do grow in environments that may not support optimal growth.



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

WHO Growth Standards Are Recommended for Use in the U.S. for Infants and Children 0 to 2 Years of Age

Recommendation

CDC recommends that health care providers:

- Use the WHO growth standards to monitor growth for infants and children ages 0 to 2 years of age in the U.S.
- Use the CDC growth charts to monitor growth for children age 2 years and older in the U.S.



**DIFFERENCES BETWEEN
WHO AND CDC**

WHO charts are growth standards

- Describe how children should grow under optimal environmental health conditions – a standard for infants and children 0 to 2 years of age
- Based on predominately breastfed infants and children in 6 sites:
 - Oslo, Norway
 - Muscat, Oman
 - Pelotas, Brazil
 - Accra, Ghana
 - Delhi, India
 - Davis, California

CDC charts are growth references

- Not a standard as WHO but a reference
- Describe growth of children in US during a span of ~ 30 years
- CDC Growth Charts for children 2 to 5 Years of Age



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

Why use WHO growth standards for infants and children ages 0 to 2 years of age in the U.S?

- **The WHO standards establish growth of the breastfed infant as the norm for growth.**

Breastfeeding is the recommended standard for infant feeding. The WHO charts reflect growth patterns among children who were predominantly breastfed for at least 4 months and still breastfeeding at 12 months.



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

Why use WHO growth standards for infants and children ages 0 to 2 years of age in the U.S?

- **The WHO standards provide a better description of physiological growth in infancy.**

Clinicians often use the CDC growth charts as standards on how young children should grow. However the CDC growth charts are references; they identify how typical children in the US did grow during a specific time period. Typical growth patterns may not be ideal growth patterns. The WHO growth charts are standards; they identify how children should grow when provided optimal conditions.



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

Why use WHO growth standards for infants and children ages 0 to 2 years of age in the U.S?

- **The WHO standards are based on a high-quality study designed explicitly for creating growth charts.**

The WHO standards were constructed using longitudinal length and weight data measured at frequent intervals. For the CDC growth charts, weight data were not available between birth and 3 months of age and the sample sizes were small for sex and age groups during the first 6 months of age.

- ADH WIC CPAs will complete required online training that will explain WHO Growth Standards and their rationale.
 - Will register through A-Train
 - Changes in SPIRIT Ht/Wt/Blood tab will be in an upcoming release – date has yet to be announced.
- 



WHO Growth Chart Training

About This Course

Content

The WHO growth standard charts described in this training course apply only to children aged birth to 2 years. There are seven sections in this course:

1. Recommendations and Rationale for Using the WHO Growth Charts in the United States.
2. Creating the WHO Growth Standard for Infants and Young Children.
3. Comparing Methodologies Used to Develop WHO and CDC Growth Charts for Children Birth to 2 Years of Age.
4. Breastfeeding as the Norm for Infant Feeding.
5. Using the WHO Growth Standard Charts.
6. Summary.
7. Case Examples.

Self-assessment questions are included in each section. Supplemental materials are also available, including a course summary and references.

Target Audience

The target audience includes health care providers such as nutritionists, registered nurses, pediatricians, and other providers who measure and assess child growth.

Learning Objectives

At the conclusion of the training, you will be able to

- Discuss recommendations for using the WHO growth charts.
- Describe attributes of a growth reference versus a growth standard.
- Describe the differences between WHO and CDC growth charts for infants and young children aged 0-2 years.
- Discuss the effect of infant feeding on growth.
- Identify issues to consider when interpreting WHO growth charts.

The WHO growth charts are available at http://www.cdc.gov/growthcharts/who_charts.htm.

To move from page to page, click the  next button at the bottom of your screen.

Start Course

[back to top](#)

For questions or concerns about information covered in this presentation, please contact your Regional WIC Coordinator or your Regional WIC Nutrition Coordinator.

