

Nutrition Management Guidelines Toddler

Use the following nutrition management guidelines when certifying child WIC clients between 12 and 24 months old. Elements indicated by an asterisk (*) are useful but not required to assess WIC eligibility. Underlined items indicate WIC risk factors, which should be assigned as identified or autocalculated by the KWIC system. See the Nutrition Risk Factors Manual for a complete definition of each risk factor. In addition, the nutrition management guidelines for specific conditions should be used as determined appropriate.

DEFINITION: A person from the 12 to 24 months old.

RATIONALE: Nutritional status is an important factor affecting growth and development. Nutritional assessment techniques help to identify clients at risk and provide the basis for nutritional management, monitoring and evaluation.

MANAGEMENT.

1.0 **DESIRED HEALTH OUTCOME:** Achieves optimal growth and development in a nurturing environment and begins to acquire dietary and lifestyle habits associated with a lifetime of good health.

2.0 **GUIDELINES:**

- 2.1 The client must be physically present at certification appointment unless a Competent Professional Authority has approved an exception.
- 2.2 Collect demographic information at certification.
- 2.3 Assess income information at certification.
- 2.4 Document the identity of the client at certification.
- 2.5 Document the identity of the caregiver at certification.
- 2.6 The Rights and Responsibilities Statement is read at certification.
- 2.7 Provide the caregiver the opportunity to register to vote at certification.
- 2.8 Assess nutritional risk at certification.
- 2.9 Complete assessment prior to determining topics for counseling.
- 2.10 Provide client centered nutrition counseling at certification.
- 2.11 Help caregiver make goals specific and realistic for lifestyle at certification.
- 2.12 Immunization records are screened at certification.
- 2.13 Appropriate referrals should be made at certification.
- 2.14 Provide the opportunity to attend one additional appropriate nutrition education contact.
- 2.15 WIC checks will be issued at certification, as appropriate.

3.0 **EXPLAIN WIC BENEFITS AND CERTIFICATION PERIODS**

- 3.1 Review the purpose of the WIC Program
 - 3.1.1 Provide nutrition education and strategies for a healthy diet
 - 3.1.2 Provide supplemental foods
 - 3.1.3 Referrals

- 3.2 Clarify the certification period for a child is for 6 months. (CRT 01.02.00)
 - 3.3 Offer the caregiver the opportunity to register to vote. (ADM 06.00.00)
 - 3.3.1 If the caregiver wants to register to vote - provide a Kansas Voter Registration Application.
 - 3.3.2 If the caregiver does not want to register to vote - provide a State of Kansas Agency Declination Form.
 - 3.4 The Rights and Responsibilities Form - The applicant's legal guardian must read, sign and dated the form at the beginning of each certification period. (CRT 03.02.00)
 - 3.5 The nondiscrimination poster, "And Justice for All" and the Fair Hearing poster must be prominently displayed for all WIC clients and applicants to read. (PRI 01.01.00 and PRI 03.00.00)
 - 3.6 Explain that the nutrition assessment process is necessary to identify nutrition needs (e.g., medical conditions, dietary practices) and interests so WIC can provide benefits that are responsive to the client's wants and needs.
- 4.0 COLLECT DEMOGRAPHIC INFORMATION:
- 4.1 Assess client identity.
 - 4.1.1 Name.
 - 4.1.2 Date of birth.
 - 4.1.3 Document proof of identity. (CRT 04.00.00)
 - 4.1.4 * Medicaid Number.
 - 4.2 Ethnicity / Racial Background.
 - 4.3 Assess and document caregiver identity. (CRT 04.00.00)
 - 4.4 Assess residency of the family group.
 - 4.4.1 Telephone information.
 - 4.4.2 Address
 - Street Address.
 - Mailing Address, if different.
 - 4.4.3 Document proof of residency. (CRT 05.00.00)
 - 4.5 Primary language. The primary language spoken in the client's home.
 - 4.6 Need for interpreter.
 - 4.6.1 The caregiver's need for an interpreter.
 - 4.6.2 Need for written communications in Spanish.
 - 4.7 Migrancy status.
 - 4.7.1 A child who is a member of a household in which any member is a migrant farm worker.
 - 4.7.2 A migrant farm worker is an individual whose principal employment is in agriculture, on a seasonal basis, who has been employed within the last 24 months, and who establishes, for the purpose of such employment, a temporary home.

- 4.8 Homelessness. (CRT 05.01.00) A child whose family lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:
- 4.8.1 A supervised publicly or privately operated shelter designed to provide temporary living quarters.
- 4.8.2 An institution that provides a temporary residence for persons intended to be institutionalized.
- 4.8.3 A temporary accommodation at the home of another individual, such as a friend or relative. This temporary accommodation cannot exceed 365 days.
- 4.8.4 A public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.
- 4.9 Assess if the infant has entered into Foster Care or moved from one foster care home to another foster care home during the previous six months.
- 5.0 ASSESS INCOME INFORMATION:
- 5.1 Household composition. (CRT 06.02.00) - A group of related or non-related individuals who are living together as one economic unit .
- 5.2 Assess household income. (CRT 06.02.01)
- 5.2.1 Gross earnings for each household member.
- 5.2.2 Source of income.
- 5.3 Other Assistance. (CRT 06.01.01)
- 5.3.1 Medicaid (MC)
- Client receiving.
 - A pregnant woman in household receiving.
 - An infant in household receiving.
- 5.3.2 Kansas Supplemental Nutrition Assistance Program (FS)
- 5.3.3 Temporary Assistance for Families (TAF).
- 5.3.4 Food Distribution Program on Indian Reservations (FDPIR)
- 5.4 Document proof of income or adjunctive eligibility. (CRT 06.03.00)
- 5.5 Calculate income eligibility.
- 6.0 ASSESS SOCIAL INFORMATION:
- 6.1 Assess potential parenting skills of caregiver.
- 6.1.1 * Educational status of the caregiver(s).
- 6.1.2 * Emotional and psychological attitude toward parenting
- 6.1.3 * Family's nutrition knowledge.
- 6.2 *Medical Provider.
- 6.3 Screen for caregiver substance use. Assess if anyone in the household currently smokes inside the home; assign Tobacco Smoke Exposure in the Home as appropriate.
- 6.4 Average Hours of TV / Video Viewing per Day.
- 7.0 ANTHROPOMETRIC AND LABORATORY ASSESSMENT:
- 7.1 Length of gestation.

- 7.1.1 A child less than 24 months of age who was born at less than or equal to 37 weeks gestation is considered Prematurity.
- 7.1.2 If child is premature, calculate the adjusted gestational age.
 - To calculate an adjusted gestational age:
 - Determine the adjustment for prematurity by subtracting the actual weeks gestational from 40 weeks.
 - Determine the adjusted gestational age by subtracting the adjustment for prematurity from the chronological postnatal age in weeks.
 - The KWIC system calculates the adjusted gestational age.
- 7.2 Obtain self-declared birth length and birth weight status.
 - Birth weight \leq 3 pounds 5 ounces (1500 g) is considered Very Low Birth Weight.
 - Birth weight between 3 pounds 5 ounces (1500 g) and 5 pounds 8 ounces (2500 g) is considered Low Birth Weight.
- 7.3 Obtain recumbent length, without shoes.
- 7.4 Obtain current weight, either nude or in a dry diaper.
- 7.5 * Obtain current head circumference,
 - 7.5.1 * Review the Head Circumference graph.
 - 7.5.2 *Premature children should be assessed using adjusted gestational age.
- 7.6 Review measurements on the appropriate graph.
 - 7.6.1 Review Length/Age graph.
 - Assess premature children using adjusted gestational age.
 - Short Stature, recumbent length \leq 5% length/age
 - At Risk of Short Stature, recumbent length, \geq 6% and \leq 10% length/age .
 - 7.6.2 Review Weight/Length graph.
 - Underweight, weight/length \leq 5% weight/length.
 - At Risk of Becoming Under, weight/length, \geq 6% and \leq 10%.
 - If weight/height is \leq 10th percentile, see the Underweight in Children Nutrition Management Guideline.
 - 7.6.3 * Review the Weight/Age (0-36 mos.) graph. Premature children should be assessed using adjusted gestational age.
- 7.7 *Familial Growth Pattern
 - 7.7.1 *Constitutional short stature.
 - 7.7.2 *Obese biological parents.
 - 7.7.3 * Height pattern of the family as it relates to the growth of the child may be estimated using the following formula.
 - *Add the height (in inches) of the mother and father and divide by two, to find the average height of the parents.
 - *If the child is a boy, add 2 ½ inches.
 - *If the child is a girl, subtract 2 ½ inches.
 - *Estimate percentile by plotting the calculated number on the appropriate stature for age chart for an 18 year old.

- 7.8 Assess hemoglobin / hematocrit.
- 7.8.1 Low Hemoglobin / Hematocrit.
- Hemoglobin < 11.0 g/dl.
 - Hematocrit concentration < 32.9%.
- 7.8.2 *Assess factors that affect hemoglobin/hematocrit. Altitude - Long term residency at altitudes 3,000 - 3,999 feet above sea level will increase hemoglobin by about 0.2 g/dl and hematocrit by approximately 0.5%.
- 7.9 Assess if the child has had a blood lead test within the past 12 months.
- 7.9.1 If no, refer to an appropriate local resource. If the WIC clinic is located at the child's medical home, it is recommended that blood lead screening is provided by the appropriate staff while the infant is still in the clinic.
- 7.9.2 If yes, assess level.
- An Elevated Blood Lead Level is ≥ 10 $\mu\text{g/dl}$.
 - If blood lead level is greater than or equal to 5 $\mu\text{g/dl}$ see the Lead Poisoning Nutrition Management Guideline.

8.0 ASSESS MEDICAL/NUTRITIONAL HISTORY AND RISK FACTORS

- 8.1 Current and usual dietary intake and practices as recorded on the Toddler Diet Questionnaire. Refer to the WIC Staff Guidance Document for the Toddler Diet Questionnaire for information on assessing for Nutrition Risk Factors related to dietary intake and practices.
- 8.2 Food intake including meal and snack pattern
- 8.2.1 Routinely using any of the following Feeding Practices that Disregard Development Needs.
- Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking;
 - Feeding foods with an inappropriate texture for developmental stage.
- 8.2.2 Feeding Foods that Could be Contaminated with harmful microorganisms. Such as:
- Unpasteurized fruit or vegetable juice;
 - Unpasteurized dairy products or soft cheeses;
 - Raw vegetable sprouts (alfalfa, clover, bean, and radish);
 - Unheated deli meats, hot dogs, and processed meats.
- 8.2.3 Routinely using a bottle to feed diluted cereal or any other food is an Inappropriate Use of Bottles, Cups or Pacifiers.
- 8.2.4 Routine ingestion of non-food items or Pica.
- 8.3 Beverage and fluid intake.
- 8.3.1 Routinely using Inappropriate Beverages as Primary Milk Source. Examples include;
- Non-fat or reduced-fat;
 - Sweetened condensed milk; or

- Imitation or substitute milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other “homemade concoctions,”
 - 8.3.2 Routinely Feeding Sugar-Containing Fluids
 - 8.3.3 Inappropriate Use of Bottles, Cups or Pacifiers
 - Using a bottle to feed fruit juice;
 - Using a bottle beyond 14 months of age.
- 8.4 Developmentally appropriate feeding practices
 - 8.4.1 Feeding Practices that Disregard Development Needs
 - Inability to recognize, insensitivity to, or disregarding the child’s cues for hunger and satiety.
 - Not supporting a child’s need for growing independence with self-feeding.
 - 8.4.2 Inappropriate Use of Bottles, Cups or Pacifiers
 - Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime;
 - Allowing the child to use the bottle without restriction or as a pacifier;
 - Using a pacifier dipped in sweet agents such as sugar, honey or syrups.
 - Allowing a child to carry around and drink throughout the day from a cup.
- 8.5 Adequacy of cooking facilities/food resources
- 8.6 Adequacy and safety of water supply
- 8.7 * Household member responsible for purchase and preparation of food.
- 8.8 Cultural, regional, or religious factors affecting food choices.
- 8.9 Food allergies/intolerances.
- 8.10 Any reported diet restrictions or modifications. Assess for a Diet Very Low in Calories and/or Essential Nutrients.
- 8.11 Dental Problems that impair the ability to ingest food in adequate quantity.
- 8.12 Developmental, sensory or motor delays or other Disabilities Interfering with the Ability to Eat.
- 8.13 Clinical manifestations of Nutrient Deficiency Diseases.
- 8.14 Evaluate Vitamin / Mineral usage
 - 8.14.1 Assess if the client is taking supplemental iron.
 - 8.14.2 Assess client’s total fluoride intake from supplements and local water source. Ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride is Inadequate Vitamin/Mineral Supplementation
 - 8.14.3 Assess if the client is taking supplemental Vitamin D. Not taking a daily supplement of 400 IU of vitamin D is Inadequate Vitamin/Mineral Supplementation for children consuming less than a quart of milk a day.

- 8.14.4 Assess for Intake of Dietary Supplements with Potentially Harmful Effects. Routine consumption of inappropriate or excessive amounts of dietary supplements.
- 8.15 Assess use of medications and/or vitamin/mineral supplements, prescribed and/or over-the-counter. Evaluate for Drug Nutrient Interactions.
- 8.16 Medical conditions affecting nutritional status.
 - 8.16.1 Cancer.
 - 8.16.2 Celiac Disease.
 - 8.16.3 Central Nervous System Disorders. If child is diagnosed with Cerebral Palsy, see the Cerebral Palsy Nutrition Management Guideline.
 - 8.16.4 Diabetes Mellitus.
 - 8.16.5 Failure to Thrive.
 - 8.16.6 Fetal Alcohol Syndrome.
 - 8.16.7 Gastrointestinal Disorders.
 - 8.16.8 Genetic and Congenital Disorders. If child is diagnosed with Down Syndrome, see the Down Syndrome Nutrition Management Guideline
 - 8.16.9 Hypertension and Prehypertension.
 - 8.16.10 Inborn Errors of Metabolism.
 - 8.16.11 Infectious Diseases.
 - Bronchiolitis (3 episodes in last 6 months).
 - HIV (human immunodeficiency virus).
 - AIDS (acquired immunodeficiency syndrome)
 - Hepatitis.
 - Tuberculosis.
 - Meningitis.
 - Parasitic infections.
 - Pneumonia.
 - 8.16.12 Other Medical Conditions.
 - Juvenile rheumatoid arthritis.
 - Lupus erythematosus.
 - Cardiorespiratory diseases.
 - Heart disease.
 - Cystic fibrosis. If the infant is diagnosed with cystic fibrosis, see the Cystic Fibrosis Nutrition Management Guidelines.
 - Persistent asthma (moderate or severe) requiring daily medication.
 - 8.16.13 Recent Major Surgery, Trauma, Burns.
 - 8.16.14 Renal Disease
 - 8.16.15 Thyroid Disorders.

9.0 ASSESS WIC NUTRITIONAL RISK ELIGIBILITY

- 9.1 If no priority 3 risk factors are identified, assess the possibility of regression for risk factors assigned in the previous certification.
 - 9.1.1 If “Low Hemoglobin/Hematocrit” assign Possibility of Regression of Hemoglobin/Hematocrit.
 - 9.1.2 If “Underweight” assign Possibility of Regression of Weight.
 - 9.2 If no nutritional risk factors are identified assign the Assumed Risk for Infants and Children between 4 and 24 Months.
- 10.0 ASSESS CAREGIVER’S CONCERNS:
- 10.1 Constipation. If constipation is a concern, see Constipation in Children Nutrition Management Guidelines.
 - 10.2 Dental Health.
 - 10.3 Development.
 - 10.4 Diarrhea
 - 10.5 Allergies.
 - 10.6 Growth.
 - 10.7 Immunizations.
 - 10.8 Ear Infections (Otitis Media).
 - 10.9 Weaning from Breast or Bottle.
 - 10.10 Lead Poisoning.
- 11.0 NUTRITION COUNSELING: (NED 02.01.00)
- 11.1 Solicit questions or concerns regarding diet.
 - 11.2 Work with client to determine counseling topics, by prioritizing client’s concerns, counselor concerns and identified risks.
 - 11.3 Review appropriate concepts or guidelines. Possible topics include:
 - 11.3.1 Feeding responsibilities for parent and child.
 - 11.3.2 Importance of structured meals and snacks at reliable times.
 - 11.3.3 Offer a variety of foods in moderation. Do not label foods as good or bad.
 - 11.3.4 Increasing activity and movement.
 - 11.3.5 Decreasing screen time.
 - 11.3.6 Adequate and appropriate fluid intake.
 - 11.3.7 Normal growth pattern for children.
- 12.0 REVIEW THE POTENTIAL DANGERS OF CAREGIVER SUBSTANCE ABUSE: (CRT 08.03.00)
- 12.1 If the caregiver does not use any alcohol, tobacco or other drugs, praise for not using these substances.
 - 12.2 If anyone routinely smokes around the infant, provide information on the potential dangers of secondhand smoke exposure.
 - 12.3 If the caregiver is smoking cigarettes, provide information on the potential dangers of smoking and refer for smoking cessation.

- 12.4 If the caregiver is using alcohol or other drugs, refer for treatment and review the effects of drugs/alcohol and consequences to the physical and mental health of the mother and infant.

- 13.0 DEVELOP CLIENT'S GOAL
- 13.1 Work with caregiver to choose the area(s) from the items discussed to focus on and write a goal for each area.
 - 13.2 Assist in developing small steps to help the caregiver meet each goal.
 - 13.3 Discuss potential barriers with caregiver and together arrive at a plan that addresses obstacles.
- 14.0 ASSESS IMMUNIZATION STATUS:
- 14.1 Review the current immunization record. If the current immunization record is not available, ask the applicant to bring it to the next WIC appointment.
 - 14.2 Screen the immunization status by using one of the following methods.
 - 14.2.1 Use the WebIZ Recommendations on the KWIC Immunization Window.
 - 14.2.2 Count the number of doses of DTaP (diphtheria and tetanus toxoids and acellular pertussis) vaccine recorded in relation to their age.
 - By 7 months of age the infant should have had 3 or more doses.
 - By 19 months of age the child should have had 4 or more doses.
 - 14.2.3 **OR** Compare the complete immunization record with the current Advisory Committee on Immunization Practices (ACIP) Recommended Childhood Immunization Schedule.
 - 14.3 If the immunizations are not up-to-date.
 - 14.3.1 Provide information to caregiver on the recommended immunization schedule.
 - 14.3.2 Refer to the infant's medical home for completion. If the WIC clinic is located at the infant's medical home, it is recommended that immunizations are provided while the infant is in the clinic.
- 15.0 PROVIDE REFERRALS AS APPROPRIATE.
- 15.1 SRS Programs. (CRT 08.02.00)
 - 15.1.1 Temporary Assistance for Families (TAF).
 - 15.1.2 Supplemental Nutrition Assistance Program (FS).
 - 15.1.3 Medicaid.
 - 15.1.4 Child Support Enforcement.
 - 15.1.5 KAN Be Healthy
 - 15.2 Immunizations.
 - 15.3 Well Child Clinic
 - 15.4 Blood Lead Screening.
 - 15.5 Health Care Provider.
 - 15.6 Healthy Start.
 - 15.7 Early Intervention Services for Infants and Toddlers.
 - 15.8 Early Head Start.

- 16.0 SCHEDULE FOLLOW-UP NUTRITION EDUCATION.
 - 16.1 Low risk clients should be scheduled for a secondary nutrition education contact appropriate for risk factors identified. (NED 02.02.00)
 - 16.2 High-risk clients must be scheduled for an individual high risk contact with the RD. (NED 02.03.00)

- 17.0 ISSUE CHECKS:
 - 17.1 Assign appropriate food package, see the Food Package and Special Formula Policies Training Module for information on assigning food packages.
 - 17.2 Review WIC approved foods to be issued to client
 - 17.2.1 WIC foods are to promote and support her nutritional well-being and should not be shared with other people.
 - 17.2.2 The foods provided by the WIC program are supplemental and are not intended to meet all of her daily food requirements.
 - 17.3 Educate on check usage and WIC Approved Food List. (refer to policy FCI: 04.01.00)
 - 17.3.1 Authorized items for each food category issued.
 - 17.3.2 Definition of least expensive brand and which food categories.
 - 17.3.3 Always take WIC Approved Food List and photo ID to store
 - 17.3.4 Approved WIC vendors.
 - 17.3.5 Shopping with WIC checks.
 - 17.3.6 No substitutions allowed.
 - 17.3.7 Handling WIC checks.

- 18.0 PROGRAM REGULATIONS AND GUIDELINES. Give WIC applicants specific program information that is pertinent to their participation in the program.