



## *The Voldemort Approach*

*Julie Ornelas, RD, LD, CBE*

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The following is excerpted from a March 9, 2009 article in the Australian National University News.

Formula feeding should be clearly named in research showing its potential health risks to babies, according to a new study.

The study, led by Dr. Julie Smith from the Australian Centre for Economics Research on Health at The Australian National University, shows that researchers reporting poorer health among formula-fed children too often shy away from including a mention of formula feeding in their titles or summaries.

“The vast majority of studies do not mention formula feeding in the places that matter most: headlines and abstracts. Rather than naming formula feeding as a significant risk factor, researchers seem to be treating this subject like Voldemort in the Harry Potter novels, as “He Who Shall Not Be Named.” For example, a study showing a higher incidence of a serious condition in formula fed infants was misleadingly named “Breastfeeding and necrotising enterocolitis,” she said.

“How can we expect physicians and other health professionals to be informed and convincing about the importance of breastfeeding if they themselves are not getting the facts on risks of formula feeding presented in a prominent and clear fashion?” Dr. Smith said.

“Adopting the Voldemort approach to describing the risks of formula feeding in published research harms the ability of physicians and other health professionals to support women, and reduces women’s ability to make informed choices. If a mother seeks support and reassurance that continuing breastfeeding is worthwhile, such non committal research reporting means she may get non committal advice from health professionals, even though the evidence is clear that formula feeding disadvantages infant health.”

## *Striving for Healthy People 2010 Breastfeeding Goals*

*Pat Dunavan, MS, RD, LD, CBE*

Healthy People 2010 has a goal that 75 percent of all women should initiate breastfeeding their infants. WIC mothers in particular face a number of barriers to breastfeeding including lack of family support or needing to return to school or work. Therefore, it is important that WIC staff provide not only information regarding the benefits of breastfeeding, but support the woman in her decision to breastfeed her infant.

We want to congratulate the following 27 clinics who have so far in 2009 (January-August 2009) met or exceeded the Healthy People 2010 goal for initiation. Those with a star before their names have an active breastfeeding peer counselor program. They are:

*Chase County	80%	*Olathe-Johnson County	79%
Comanche County	100%	Pawnee County	75.9%
*Douglas County	78.7%	Phillips County	88.2%
Elk County	100%	Rawlins County	80%
Ford County	76.5%	Riley County	79.5%
Gove County	77.8%	Rush County	75%
Graham County	77.8%	Seneca-Nemaha County	80%
Gray County	89.7%	*Shawnee M & I	76.2%
Harvey County	75.2%	Smith County	87.5%
Haskell County	87.5%	St. Marys-Pottawatomie	80%
Kearny County	76.5%	Stafford County	84.2%
Morris County	85.7%	Trego County	80%
Ness County	100%	Woodson County	75%
Norton County	75%		

Each of these clinics will receive a certificate of recognition for their efforts. Additionally, there are another 18 clinics whose initiation rates are between 70-74.9 percent. Keep up the good work! Curious where your clinic falls? Check out the breastfeeding ad hoc reports on KWIC to get your latest statistics.



## Update on Kansas WIC Technology

Darrel Finley, KWIC IT Program Manager

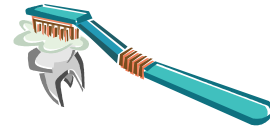


Dave Thomason and I recently attended the National WIC Association (NWA) Technology Conference in November. This conference had been held every other year but as we move forward with getting WIC more computerized, it is becoming apparent to NWA that this conference will be needed annually. It is an exciting time to be in the WIC arena for me as we move towards integrating more technology into our WIC system, such as .Net (a web-based KWIC application) and Electronic Benefit Transfer (EBT). It was stated during the conference that the USDA would like for every WIC program to be EBT compliant by 2020. Kansas is currently in the process of securing ARRA funds to move to a .Net system and implement the use of Electronic Signature Pads. The State WIC office is also currently evaluating whether we should secure funds in 2010 for an EBT feasibility study and then hopefully move towards implementing EBT within the next five years.

The benefits that will be gained by moving to a .Net KWIC system are numerous. The new and improved KWIC system will be more user-friendly by providing helpful hint pop-ups along the way to help you navigate through the various screens, incorporating a more pleasant look and increasing reliability. The goal is to have a new .Net system fully functional by the end of 2011 and some parts will be implemented before then. The Electronic Signature Pads will be bought and installed at clinics hopefully by the end of 2010. As always, local agency input will be solicited and full training will be provided prior to roll-out.

EBT, as you know, will help us move towards a paperless banking system and also will give the client a better feeling about shopping when they can move through the stores and purchase items using cards that look and act like credit cards. This will be a major undertaking by the State and Local Staff and Vendors within the Kansas WIC program and I am sure with your involvement and support we will move into the world of Electronic Benefits Transfer with success.

## Free Dental Health Brochures



We have recently received notice of some new brochures available from the Dept. of Health & Human Services and the National Maternal and Child Oral Health Resource Center. They are written in an easy-to-read style that is appropriate for WIC clients, including those with lower literacy levels, and are available in English and Spanish. The titles available are:

*A Healthy Smile for Your Baby: Tips to Keep Your Baby Healthy*

*A Healthy Smile for Your Young Child: Tips to Keep Your Young Child Healthy*

*Two Healthy Smiles: Tips to Keep You and Your Baby Healthy* (appropriate for pregnant women)

Single or multiple copies are available at no charge and can be ordered online at:

<http://www.mchoralhealth.org/publications.html> Or the brochures are available for download at:

<http://www.mchoralhealth.org/materials/consumerbrochures.html>

## *Risk Factors Based on the Obstetrical History*

*Sandy Perkins, MS, RD, LD, CBE*

When reviewing records as part of the Management Evaluation process, the SA nutritionists are finding that nutritional risk factors based on obstetrical history that must be assigned by the CPA are frequently missed.

Assign the following risk factors based on **any history** of the condition. The risk factors and definitions are as follows:

Risk Factor	Category	Definition
<b>History of Preterm Delivery</b>	PG	an infant born at $\leq 37$ weeks gestation
<b>History of Low Birth Weight</b>	PG	birth of an infant weighing $\leq 5$ pounds 8 ounces (2500 grams)
<b>History of Birth of a Large for Gestational Age Infant</b>	PG	birth of an infant weighing $\geq 9$ pounds (4000 grams)
<b>History of Birth with Nutrition Related Birth Defect</b>	PG	an infant born with a congenital or birth defect linked to inappropriate nutritional intake

The following risk factors should be assigned based on the presence of the condition during the **current pregnancy** for pregnant women or the **pregnancy that just ended** for breastfeeding and postpartum women. The risk factors and definitions are as follows:

Risk Factor	Category	Definition
<b>Hyperemesis Gravidarum</b>	PG	diagnosis by a physician
<b>Multifetal Gestation</b>	PG, BF & PP	two or more fetuses / infants
<b>Preterm Delivery at Last Delivery</b>	BF & PP	an infant born at $\leq 37$ weeks gestation
<b>Low Birth Weight Infant born at Last Delivery</b>	BF & PP	birth of an infant weighing $\leq 5$ pounds 8 ounces (2500 grams)
<b>Large for Gestational Age Infant born at Last Delivery</b>	BF & PP	birth of an infant weighing $\geq 9$ pounds (4000 grams)
<b>Birth with Nutrition Related Birth Defect at Last Delivery</b>	BF & PP	an infant born with a congenital or birth defect linked to inappropriate nutritional intake
<b>Recent Major Surgery, Trauma, Burns</b>	BF & PP	includes a C-Section within the last 2 months


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*Risk Factors Based on the Obstetrical History (continued)*

All of these conditions can be assessed by reviewing questions 14, 15 and 19 on the Prenatal Diet Questionnaire (see figure 1 and 2) or questions 15 and 16 on the Postpartum Diet Questionnaire with the client.

14. Are you expecting twins, triplets, etc? No Yes
15. Are you having any problems/complications with this pregnancy? Heartburn Nausea and vomiting Gestational diabetes  
High blood pressure Constipation Diarrhea Weight loss Other, please describe \_\_\_\_\_

**Figure 1 - Questions 14 & 15 from the Prenatal Diet Questionnaire**

19. Not including this time, how many times have you been pregnant? \_\_\_\_\_ (If this is your first pregnancy stop here) 

- When did your last pregnancy end? \_\_\_\_/\_\_\_\_/\_\_\_\_
- Are you currently breastfeeding a baby/child? No Yes
- Please check any of the following that were true with any of your previous pregnancies.
 

<input type="checkbox"/> My baby was born more than 3 weeks early	<input type="checkbox"/> My baby was born weighing less than 5 pounds 9 ounces
<input type="checkbox"/> My baby was born weighing 9 pounds or more	<input type="checkbox"/> My baby was born with a birth defect
<input type="checkbox"/> My doctor told me I had gestational diabetes	<input type="checkbox"/> I have had no complications
<input type="checkbox"/> Other, please list _____	

10/2007

**Figure 2-Question 19 from the Prenatal Diet Questionnaire**

Since it is such a sensitive subject, the diet questionnaire does not ask the client about fetal or neonatal loss. This needs to be assessed in person and in a delicate manner. The risk factor **History of Fetal or Neonatal Loss** for Pregnant Women is defined as:

- ✦ Two or more spontaneous abortions/miscarriages (the spontaneous termination of a gestation at < 20 weeks of gestation or < 500 grams) ; or
  - ✦ Any history of a fetal death (death ≥ 20 weeks of gestation); or
- Any history of neonatal death (death within 0 - 28 days of life).

For Breastfeeding and Postpartum Women the risk factor **Fetal or Neonatal Loss during Last Pregnancy** is defined as a fetal or neonatal death in the pregnancy that just ended. Obviously if a breastfeeding woman is assigned this risk factor at least one infant must have survived.

A history of multiple pregnancies is a risk factor for young women. This risk factor must be calculated by the CPA. Compare the number of previous pregnancies to the woman’s age at the conception of the current most recent pregnancy. The number of previous pregnancies should not include the current/most recent pregnancy. The risk factor **High Parity at Young Age** – under age 20 at date of conception for the current pregnancy and who have had three or more previous pregnancies that lasted for 20 or more weeks of gestation. Count regardless of whether the infant was alive or dead at birth. Multiple births (twins, etc.) count as one. This risk factor can be assigned for all three client categories (PG, BF & PP) for women.

Risk factors autocalculated by the KWIC system based on the information entered on the Health Interview window in KWIC are not discussed in this article.

## *Report from the 2009 National WIC Association Conference*

Kansas had several attendees at this year's conference held in Nashville, Tenn. The September and November issues of Nutrition and WIC Update included several of their reports. This month the last reports are included.

### **Communicating Effectively Through an Interpreter**

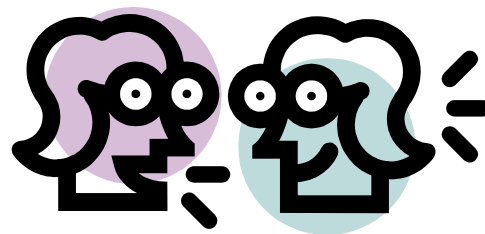
Presenter: Ira SenGupta, MA

*Comments on this session from Nonie Macias, SW Kansas WIC – Finney County*

I was very impressed with the information that Ira SenGupta gave us during her talk. First she explained the difference between an interpreter, who deals with the spoken word, and a translator, who deals with the written word. I had used these words interchangeably not knowing there was a big difference in the two.

She also explained the dangers involved with using family members as interpreters. I understand that in some instances when a family member happens to be in a room with a client, it may seem easier to just use the family member but after the statistics she gave us about information being interpreted wrong by family members, you really think twice about doing that.

She told us her important rule in interpreting. *“Be patient - providing care across a language barrier takes time. However, the time spent up front will be paid back by good rapport and clear communication will help avoid wasted time and dangerous misunderstanding down the line.”* By using this rule, I hope I will become a better interpreter down the road.



*Comments on this session from Jody Hammerschmidt, RD, SW Kansas WIC – Finney County*

This session stressed the differences between using untrained bilingual staff, family members, children, and a professional trained certified interpreter. She made me want to send many of our staff to become certified.

Just because someone is bilingual does not make her or him an interpreter. Many times the connection between client and health professional is lost when using an untrained interpreter.

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*Report from the 2009 National WIC Association Conference (continued)*

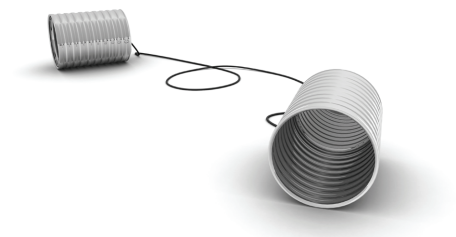
*Comments from Jody Hammerschmidt, continued*

Risks of using an untrained staff member as an interpreter can be:

- Adding material,
- Omitting material,
- Changing the message,
- Giving opinions, and
- Entering into long discussions with the client from which the other is excluded.

Risks of using family can be:

- Editing patient's message heavily,
- Adding his or her own opinion,
- Answering for the patient,
- Impeding development of client-provider relationship,
- Confidentiality issues,
- Rarely trained, and
- Accuracy, completeness, and impartiality highly questionable.



Risks of using children can be:

- Parent disempowerment,
- Role reversal,
- Mistakes due to lack of vocabulary and understanding, and
- Possibly puts the child at risk of neglect if the child is the bearer of bad news.

The best solution for avoiding these risks is by using a professionally trained, certified interpreter. This interpreter normally goes through a certification class and is skilled in the following areas: fluency in two languages, training in interpreting techniques, specialized vocabulary in two languages, knowledge of medical procedures, ability to adjust dialect, ability to process meaning, find equivalency in the second language and express it fluently almost instantaneously, ability to walk in two cultures and make each understandable to someone from the other culture, excellent memory skills and attention to detail.

The role of a good interpreter is that he or she will render the language as exactly what was said in the other with no additions, no omissions, no editing or polishing. This person will adjust words by making word pictures and checks understanding. The interpreter will also provide the necessary cultural framework. If a systemic barrier arises, the interpreter will work as an advocate when the needs of the client are not being met.

## *Making Your Waiting Room Family Friendly*

*Sandi Fry, WIC Vendor Manager*

Your waiting room is the first impression clients will have of your health department and its services. In the layout and design of the waiting room, remember that the child's perception is just as important as the parent's initial observations. Little details that you might not even be aware of will stand out in the minds of children and their parents as they wait for services.

One of the first steps is to walk through the waiting area and look at it with a critical eye. Above all, it should be clean. The basic elements of the waiting room, the floor and the furniture, are important considerations in keeping the area clean. Making sure the toys that are available are easily wiped down and cleaned is also important.

Arrange child-sized furniture for your younger clients, but keep in mind that Mom or Dad will welcome a comfy chair to use. Be sure you have enough seating for your busiest times.

Entertainment is a crucial factor in pediatric waiting rooms. For younger children with unlimited amounts of energy, a play area might be set up.

Franklin County requested WIC funds for a waiting room re-vamp and used chalkboard paint and puzzle furniture pieces to create a Play Area.



Client education can be made available in a variety of ways, the most popular being TVs with DVD players.

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*Making Your Waiting Room Family Friendly continued*

Butler County created different areas in their waiting room by arranging the chairs in half circles, focusing on different things. Parents can sit close while their children play in the area with toys, while other clients can be in the Nutrition Education area reviewing the Interactive Displays. In creating different areas with the chairs and not adding walls or partitions, the room is open and airy while still accommodating all the waiting clients.



The transfer from the waiting room to the exam room should be considered also. Instead of calling the parent's name, summon the next client by using the child's name. Children will be thrilled to hear their own name and will enjoy the personal attention they receive.

Regardless of how you design, furnish and decorate your waiting room and office, you should feel proud of the way it looks. Long after the visit is over, the parents will remember if they were comfortable waiting for their appointment and if their child was occupied.

*January Resolution: Eat Healthier***One Day Menu using Six Small Meals, from Food and Health Communications:**

- Breakfast: 1 cup cooked oatmeal with 1 chopped apple & 1 cup skim milk, herb tea or green tea
- AM Snack: 1 banana and 1 orange
- Lunch: 2 cups large tossed green salad with assorted veggies with 1 tsp oil and 2 Tbsp vinegar, 1 cup low-fat split pea soup, 1 slice toasted 100% whole grain or whole wheat bread
- PM Snack: 1 cup carrots, 2 Tbsp peanut butter on a serving of whole grain low-fat crackers
- Dinner: 2 cups low-fat vegetable stir fry over 1 cup brown rice, 1/2 cup sliced cucumbers
- Late Snack: 1-1/2 cups yogurt/fruit smoothie

Water as needed.

See [www.foodandhealth.com](http://www.foodandhealth.com) for recipes to accompany this menu. (Notice the WIC foods-oatmeal, milk, whole wheat bread, peanut butter, fruits and vegetables.) The menu as listed contains: 1750 calories, 41 g fat, 7 g saturated fat, 41 mg cholesterol, 1500 mg sodium, 274 g carbohydrate, 45 g fiber, 98 g sugars, 80 g protein

## *Local WIC Agency Promotes Healthy Habits*

On October 6, 2009, Teri Vaughn, RN, WIC Coordinator and Janice Steedley, Clerk of SEK Multi-County Health Department participated in the Anderson County Hospital Health Fair. Their booth spread the message of healthy eating habits and promoted a positive image of the WIC program to potential clients and the public. Their creativity made the booth eye-catching and attractive to children of all ages. This was the perfect out-reach opportunity. Thank you to Teri and Janice for their efforts!



## *These Brownies Are Made With What??*

While recently conducting a Management Evaluation, we came across a unique recipe. Janelle VanKooten, Program Assistant for the NW Area K-State Research & Extension Family Nutrition Program provides wonderful food and nutrition information for area WIC clients when she attends their WIC clinic day. She provides the following recipe, which received rave reviews from the lucky WIC staff that tasted these brownies. Janelle states that the brownies tend to crumble when cut, but what a great way to get your fiber and use beans!

### Black Bean Brownies

1 Box Low-fat Brownie Mix

1 can (15 oz) Black Beans

Drain and rinse black beans. Return black beans to their can and fill with water. Blend black beans and water in food processor or blender or mash with fork.

In medium mixing bowl, combine brownie mix and black beans until smooth. Do not add any other ingredients. Bake in a 9 x 13 pan, sprayed with no-stick spray, for amount of time and temperature according to directions on Brownie mix box.

We also loved the pumpkin pudding Janelle made! Check out this and other recipes at: [www.kidsacookin.com](http://www.kidsacookin.com)

## *Local Agency News*

### **We welcome these new WIC employees:**

Barton County, Terra Hull, Breastfeeding Peer Counselor (BFPC)	Johnson County, Marisa Rodriguez, Clerk
Butler County, Susan Shinkle, BFPC	Kiowa County, Kerri Ulrich, Clerk
Crawford County, Stacia Kimrey, BFPC	Lane County, Crystal Hoffman, Clerk
Dickinson County, Gina Anguiano, Clerk	Linn County, Michelle West, RN
Ford County, Natalie Carrillo, RN	Ness County, Lisa Dunbar, Clerk
Ft. Riley, Zoe Rohr, RD	Reno County, Tammy Chesney, RN
Geary County, Erma Patterson, RN	Sedgwick County, Valerie Donelan, RDE
Gray County, Charlotte Harmon, RN	Sedgwick County, Theresa Henry, Clerk
Harvey County, Metrice Calderon, Clerk	Stafford County, Rosie Moody, BFPC
Johnson County, Argelia Woods, Clerk	Wyandotte County, Kellie Horan, BFPC

**Congratulations to:** Kelly Kilgroe Beasley, RD, Butler County, on her marriage November 7, 2009.

**Congratulations to:** Penny Bennett, Clerk, Dickinson County on her retirement.

**Congratulations to:** Danielle Anderes Ast, RD, Saline County, on her marriage November 6, 2009.

### **We say goodbye to these WIC friends:**

Ford County, Carol Heydman, RN	Sedgwick County, Pam Mealiff, RD
Ft. Riley, Lisa Jones, RD	Sedgwick County, Jennifer Zuercher, RD
Johnson County, Rosalba Garcia, Clerk	Trego County, Kami Smith, RN
Kiowa County, Lisa Waters, RN	

## *Iron for Infants*

A recent study in the American Journal of Clinical Nutrition entitled, *Iron Status of Breastfed Infants is Improved Equally by Medicinal Iron and Iron-Fortified Cereal*, found that iron-fortified infant cereal improved an infant's iron status just as well as an iron supplement. This should be a reminder of the importance of feeding infants the Iron-Fortified Infant Cereal that is a part of the Infant food package beginning at six months of age. It is helpful to explain to mothers that their baby is born with some iron stores received from them during pregnancy. But, at about six months of age these iron stores become depleted, so it is important to begin feeding the infant the infant cereal to prevent iron deficiency.



## Nutrition and WIC Services

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**WWW.KANSASWIC.ORG**

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Growing healthy Kansas families

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Our Vision: Healthy Kansans living in safe and sustainable environments

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## Resolve to Eat Healthy...



## All Year Long!