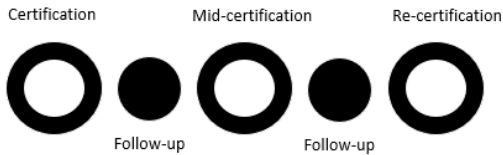



High-Risk (HR) Protocols

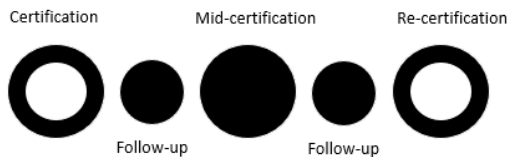
Commented [JP1]: This section moved to its own document from the Nutrition Education P&P document. Track changes show edits (mostly grammatical/minor) that have occurred after transferring to this document. Edits made prior to moving to this document can be seen in the Nutrition Education P&P doc.



- I. High-Risk (HR) Contacts.
 - a. A high-risk participant is defined as a participant who has been assigned any risk factor(s) designated as “high-risk”. Each high-risk participant must have:
 - i. A high-risk Care Plan documented VISION at the time of certification by a CPA or RD. Documented in VISION means going to the Care Plan-Participant screen in the Education and Care section In VISION, select New to create a new Care Plan record date and add relevant information in the SOAP note format ([see ‘Components of the High-Risk Care Plan’ section below for details](#)).
 - ~~ii. SOAP note format for high-risk participants must include an assessment and documented plan for follow up.~~
 - ~~iii.ii.~~ The RD must be responsible for the overall management and coordination of Care Plans for high-risk participants.
 - 1. Each local agency must establish a standardized process that provides consistent tracking and documentation of high-risk participants by an RD.
 - a. Minimum requirements are to have a Care Plan written by an RD or a Care Plan written by a CPA and co-signed by an RD at each follow up visit.



 = care plan written by RD or CPA (no co-sign needed)  = care plan written by RD or CPA and co-signed by RD

- b. Best practice is to have a Care Plan written by an RD or a Care Plan written by a CPA and co-signed by an RD at each follow up and midcertification [appointments visits](#).



 = care plan written by RD or CPA (no co-sign needed)  = care plan written by RD or CPA and co-signed by RD

~~iv-iii.~~ When high-risk nutrition risk factors are assigned to participants, do not use the phrase, "high-risk" when counseling, educating and communicating about scheduling appointments with WIC participants.

1. It is important to not use labels when communicating with participants. Rather than, "your child is ~~high-risk~~~~high-risk~~ for a very low iron value and we want to schedule a ~~high-risk~~~~high-risk~~ visit to check your child's iron again", use customer friendly wording such as "we have a concern about your child's iron value and would like to schedule a follow up visit to check your child's iron again".

b. Registered dietitians who have successfully completed their 6-month probation in the WIC clinics of the Utah WIC Program must change the status of a high-risk designation for a particular risk factor by marking the "HR Resolved" checkbox in the Risk screen when the risk factor is no longer applicable. The reason for changing the status of a high-risk designation must be documented in VISION.

c. IBCLCs who have successfully completed their 6-month probation in the WIC clinics of the Utah WIC Program may change the status of a high-risk designation for breastfeeding risk factors 602 and 603 by marking the "HR Resolved" checkbox in the Risk screen when the risk factor is no longer applicable. If other high risk nutrition risk factors are assigned, in addition to 602 and 603, a registered dietitian needs to be consulted before changing the overall risk status to "HR Resolved".

~~d.~~ If VISION automatically assigns the high-risk designation to a ~~participation~~~~client~~ at the time of certification and the registered dietitian determines the ~~participation~~~~client~~ is not ~~high-risk~~~~high-risk~~, the RD must resolve the high-risk indicator at that certification appointment. A high-risk care plan must still be written and the reason for resolving the high-risk designation needs to be documented in the Care Plan.

~~e.~~

~~e-ii.~~ High-risk follow-up appointments.

i. When a high-risk ~~client~~~~participant~~ comes in for a follow up appointment, the "High Risk Follow Up Appointment" checkbox must be marked in the "Nutrition Education" screen under the "Education and Care" section in VISION.

1. By marking this checkbox, YES will be generated into the High Risk Follow Up column on the "Follow-up Nutrition Risk

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Assessment report”, under “Assessment and Education”, under “Clinic Services Reports” in VISION. It also will show on the AdHoc Report: “All Nutrition Risk Factors” HR Follow-Up column on SharePoint. These reports facilitate monitoring of risk factors and high-risk ~~participants~~clients.

- 4-ii. The follow-up appointment is focused on the specific needs associated with the nutrition risk(s) categorized as “high-risk”. Refer to the participant’s previous appointment’s Care Plan.

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4-III. Components of the High-Risk Care Plan.

a. In the VISION system the SOAP care plan format is used. All high-risk Care Plans must include the “Assessment” and the “Plan” components of the SOAP format. The SOAP format is defined as the following:

- i. **Subjective** data is the information the participant reports. ~~This#~~ includes ~~the perception of risk,~~ reported information on ~~the~~ medical/~~diet~~ history, ~~diet recall/history~~formula history and/or reported symptoms.
- ii. **Objective** data includes ~~physical evidence such as anthropometric and bloodwork~~laboratory data ~~and other measurable data such as,~~ age, ~~last menstrual period~~LMP, number of pregnancies, etc.
- iii. **Assessment** is the CPA’s evaluation of the participant’s nutrition risk.
- iv. **Plan** includes:
 - 1. Brief summary of the nutrition ~~education~~services provided/needed;
 - 2. Goals set to resolve the concern/risk;
 - 3. Any referrals made; (Participant referrals should also be entered ~~in on~~ the “Referrals – Participant” ~~screenpanel~~ under “Family/Intake” ~~in VISION~~).
 - 4. Data that needs to be assessed at the next follow-up visit (e.g., ht., wt., Hgb, Hct., formula tolerance, follow through on referrals, etc.)

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4-IV. High-Risk Phone Contacts.

- a. Phone contacts or telehealth may be substituted for an individual assessment when:
- i. the RD or other appropriate staff cannot be scheduled to meet individually with the participant within the required time frame AND;
 - ii. the exchange of information required during the follow-up appointment is minimal, can be obtained over the phone, and a

physical assessment (e.g., height, weight, hemoglobin/hematocrit, observation of breastfeeding) is available from health care referral data ~~and that~~ has been collected within the 2 weeks prior to the appointment AND;

- iii. the participant has a permanent phone number where he/she can be reached easily and has agreed to participate in a phone counseling session.
- b. All phone contacts must be documented in VISION.
- c. The registered dietitian is still responsible for the overall management of nutrition care for high-risk participants.