Slide 1

Slide 2

- Welcome the trainees to the training and provide a brief overview of CAI and your background/expertise.
- Ask the trainees to introduce themselves by sharing their name, their agency, and how long they have worked with WIC.
- After the last introduction, thank the trainees for sharing.

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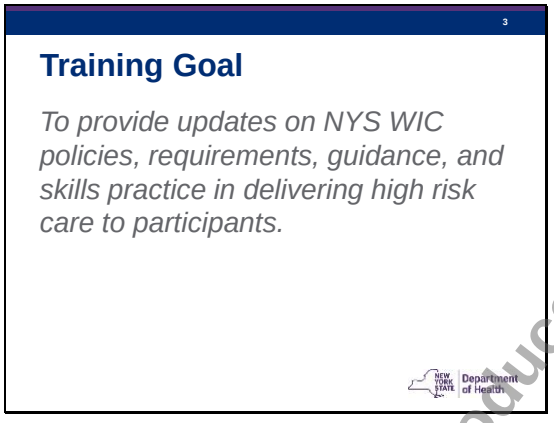
Slide 3



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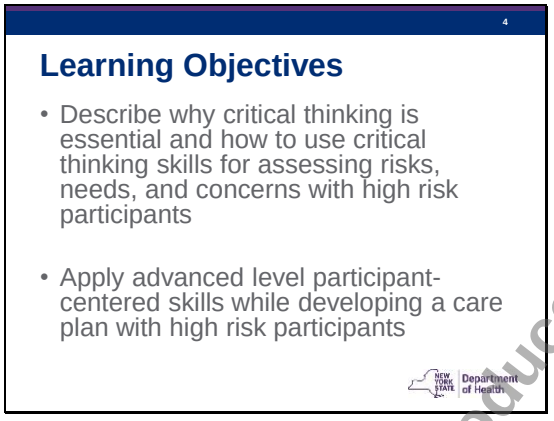

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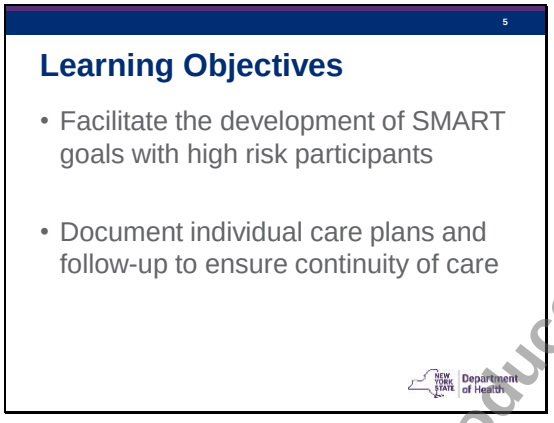

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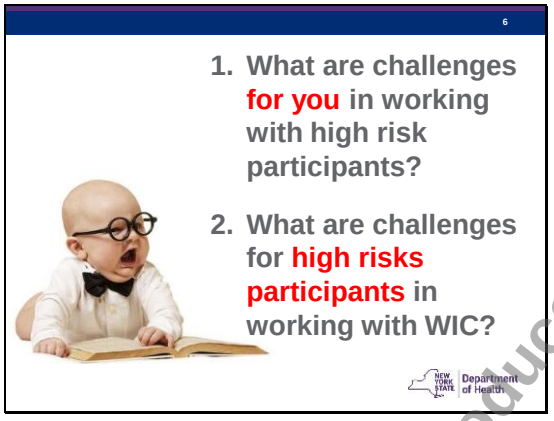
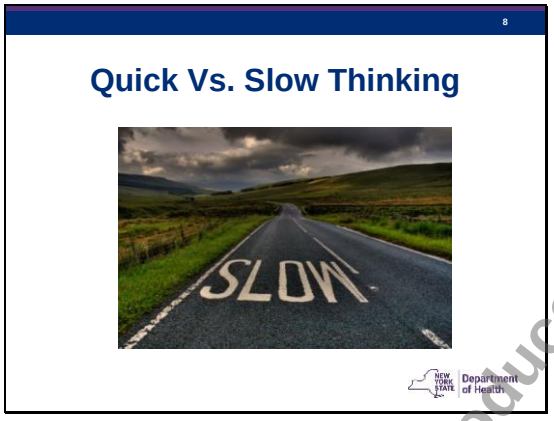


Ask trainees: What are some challenges to working with participants?

Slide 7

Conduct activity

Slide 8

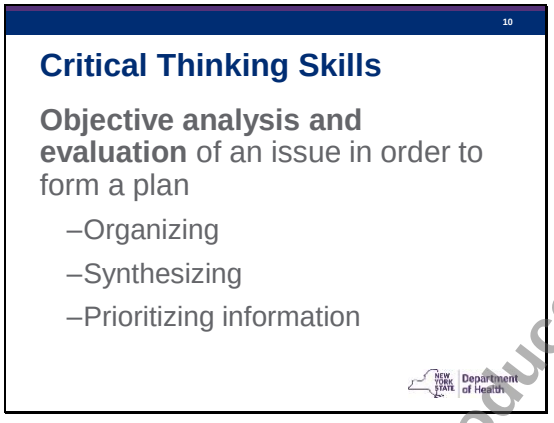


Talking Point: To be effective in the assessment (and therefore improve work with participants), we must slow down our natural tendency to judge, assume, and stereotype.
How do we slow it down?

Slide 9

Conduct critical thinking activity

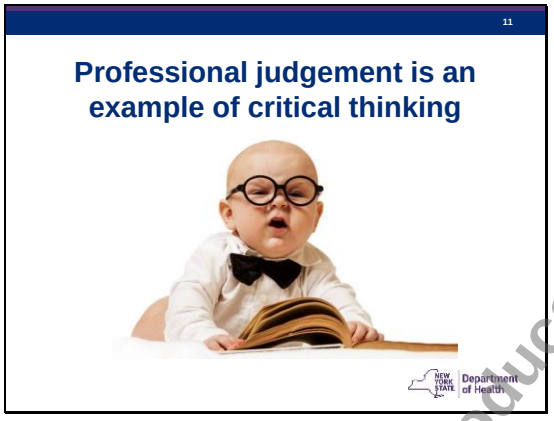
Slide 10



Unlike quick thinking, critical thinking is the objective analysis and evaluation of an issue in order to form a judgment. It is a disciplined process of organizing and synthesizing information to evaluate and to prioritize the information appropriately.

Reference:
Paul, R, Scriven, M. (1987) Defining Critical Thinking. *Critical Thinking as Defined by the National Council for Excellence in critical Thinking, 1987*. Pages 1-4.
https://www.scribd.com/document/69921185/Defining-Critical-Thinking

Slide 11

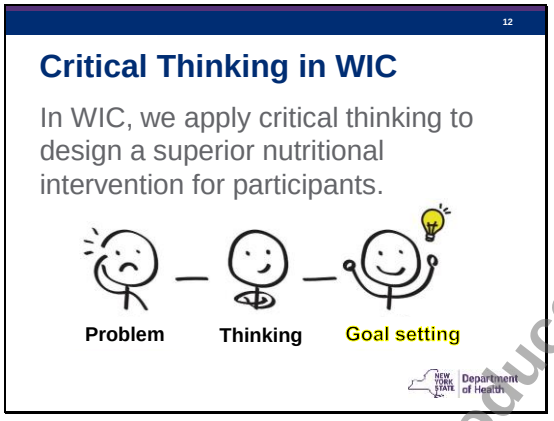


Using professional judgment is an example of critical thinking. Each time you make a decision while working, you, a professional, are using critical thinking to make a judgment as to the best approach, answer, or choice.

Examples include:

- Scheduling the frequency of future appointments
- Contacting the health care provider to clarify information on the participant's condition
- Noting if formula prescribed is inconsistent with the medical condition
- Making phone contact with participant when there is a high level of concern
- Deciding whether or not to close a care plan

Slide 12

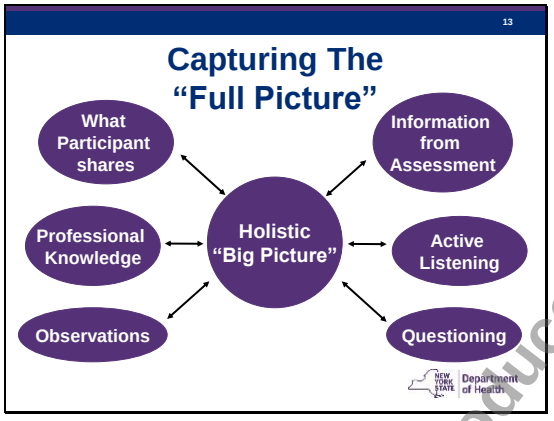


Ask trainees:
What does critical thinking look like when working with a high risk participant?
Why is using critical thinking important with a high risk participant?
Why is critical thinking challenging?

Examples
Who is in the household?
What is the home environment like?

Reference:
Paul, R, Scriven, M. (1987) Defining Critical Thinking. *Critical Thinking as Defined by the National Council for Excellence in critical Thinking, 1987*. Pages 1-4.
https://www.scribd.com/document/69921185/Defining-Critical-Thinking

Slide 13



Information may include observations, experiences, verbal or written expressions, and/or arguments

The critical thinking process provides us with the ability to:

Gather all relevant information including:

- Factors influencing participant's high risk related behavior
- Potential barriers to change
- Participant's perception, concerns, and priorities
- Information from assessment
- Your own expertise and knowledge about the nutritional risk

Critical Thinking must be applied to the goal setting process as we will discover over the course of this training

Reference:

Paul, R, Scriven, M. (1987) Defining Critical Thinking. *Critical Thinking as Defined by the National Council for Excellence in critical Thinking, 1987*. Pages 1-4. https://www.scribd.com/document/69921185/Defining-Critical-Thinking

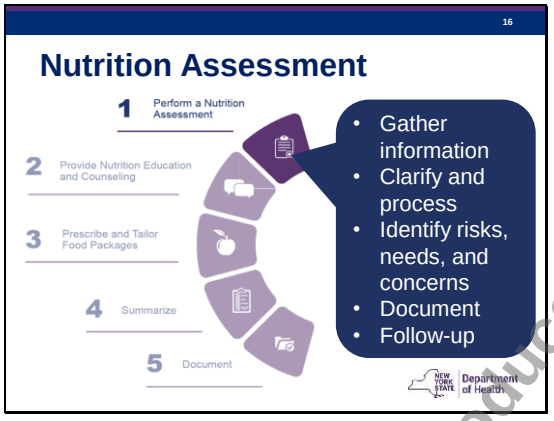
Slide 14

Critical thinking involves a number of steps including gathering information and using your nutrition and WIC knowledge to reach an unbiased conclusion.

Slide 15

Let's look at the steps to provide nutrition services

Slide 16

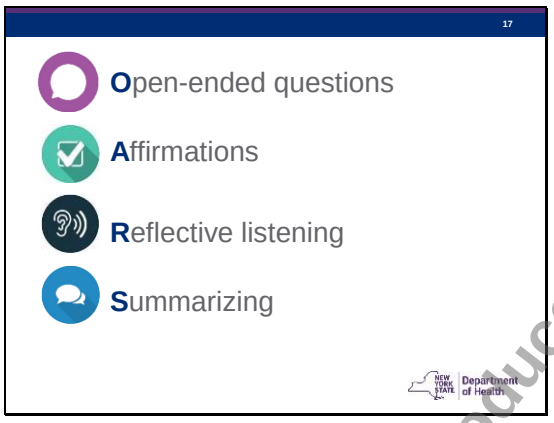


If we take a closer look at the nutrition assessment, we see a process for obtaining and analyzing information in order to identify risks, needs, concerns, and strengths.

Ask: What is the goal of PCNA?
-To create rapport (set the stage to discuss high risks and related behaviors); build trust; allows us to work with the challenges we identified this morning
-Gather information so we can create a full profile of the participant before moving into education and counseling

Point out: Remember the cash register activity when we made decisions about events before having all the information? And then think back to the car activity where you thought through all the information and prioritized

Slide 17



- Motivational interviewing is an effective intervention with people in the early and middle stages of change by helping them resolve their ambivalence and build their commitment to change. It is based on the idea that people have a natural desire for growth and well-being. Motivational interviewing creates a set of conditions that can help participants tap into their own abilities to elicit change.

- The core communication skills of motivational interview are called OARS.
- OARS stands for:
    - Open-ended questions
    - Affirmations
    - Reflective listening, and
    - Summarizing

Open-ended questions

- Cannot be answered with a “yes” or “no” or a specific short answer
- Encourages the participant to lead the conversation while the QN or CPA listens
- Invite the participant to tell their story in their own words
- Promotes trust and a sense of “being heard”
- Do not lead participant in a specific direction
- When asking open-ended questions, one must be ready and willing to listen to the response
- Can help the session feel less like an interview and more like a conversation which in turn, can decrease resistance
- Examples of ways to start open-ended questions (avoid asking “why”):
    - What…
    - When…
    - How..
    - Tell me about…

- Can you explain that?
- Help me understand…

Affirming statements

- Statements of appreciation and understanding that acknowledge and affirm the participant's strengths, efforts, and experiences
- Can normalize behaviors and build confidence for change
- Not about complimenting the participant – Must be genuine and sincere
- Can normalize behavior
    - Normalizing is another participant-centered approach skill
    - Normalizing involves using statements to acknowledged that the participant's questions, thoughts, feelings, and experiences are common and shared by others
    - Examples of normalizing statements: "I hear that from a lot of participants," "A lot of people feel that way."
- Affirming statements should not be mixed with corrective statements (e.g. "That's great ***but*** you really should…")

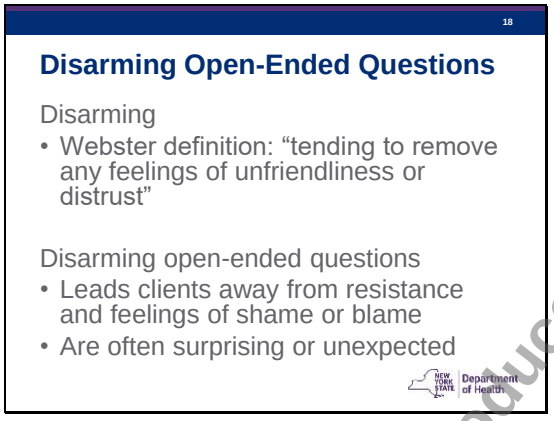
Reflective listening

- Repeating back key messages to the participant by paying close attention to both verbal and non-verbal communication
- Says to the participant that you understand without using the words "I understand"
- Key messages include content but also the participant's emotions, feelings, and meaning
- Simple reflection includes:
    - Repeating – Repeating back the speaker's words
    - Paraphrasing – Stating the message in your own words
    - Identifying emotions – Taking a guess about emotions connected to content based on the verbal and non-verbal communication from the speaker

Summarizing

- Repeating to a participant the key pieces of a conversation or discussion
- Highlights what you want the participant to focus on and take away from the conversation
- Should be thought of as paraphrasing or a longer reflection
- One of the more directive applications of motivational interviewing
- Three purposes of summarizing:
    - Link: Connect what they said to something they said before to point out patterns
    - Collect: Present a summary to help organize and reinforce what has been said and show that you've been listening
    - Transition: Good tool to end one segment and move to the next

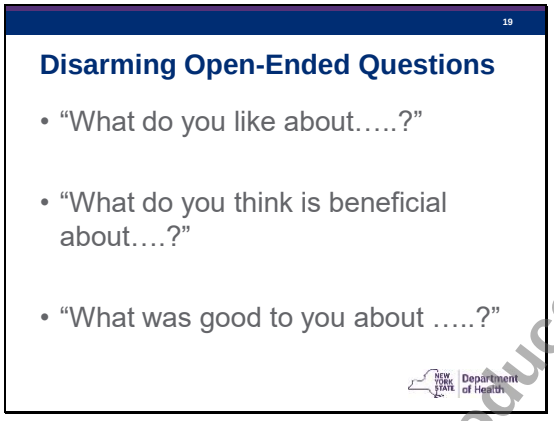
Slide 18



- **Disarming Questions**
  - ✓Leads participants away from resistance and feelings of shame or blame, softens and surprises clients

Example: *“What are three good reasons not to change?”*

Slide 19

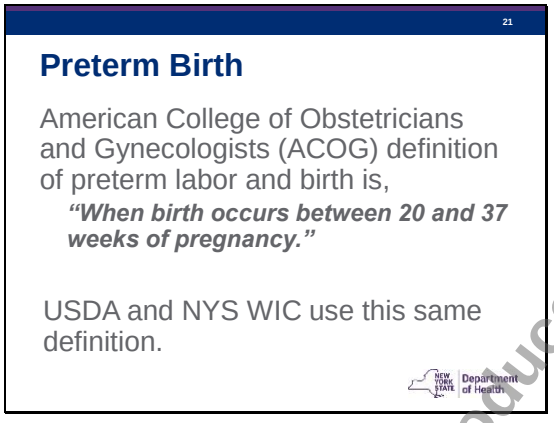


- What do you like about your favorite junk foods?
- What was your best time using drugs
- What is good about eating mcdonalds

Slide 20

PCNA:
Jayla and Demarco

Slide 21



The American College of Obstetricians and Gynecologists (ACOG) definition of preterm labor and birth is, "When birth occurs between 20 and 37 weeks of pregnancy."

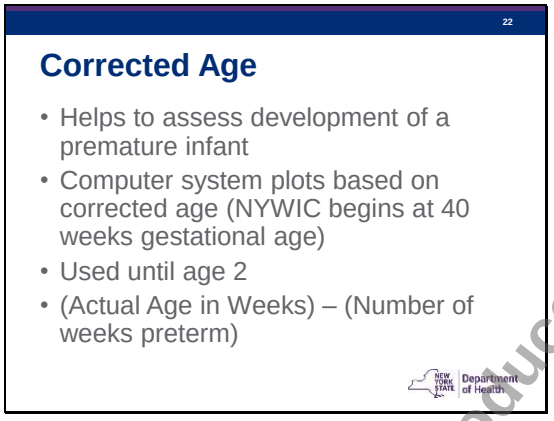
USDA and NYS WIC use this same definition

Resources:

The American College of Obstetricians and Gynecologists (ACOG). Preterm (Premature) Labor and Birth: Resource Overview. *ACOG.org*. Retrieved from https://www.acog.org/Womens-Health/Preterm-Premature-Labor-and-Birth?IsMobileSet=false.

New York State Department of Health. (2019, Oct.). *New York State WIC program manual, section 1136: Nutrition risk criteria & priority system policy supplement*. Albany, New York: New York State Department of Health.

Slide 22



When measuring an infant's development, it is helpful to consider what is appropriate behavior and development for an infant of that particular age. Corrected age helps to determine where he/she should be developmentally.

- When babies are born early, their brain and the rest of their neurological system has not developed or matured to the same degree as a baby born full term. We cannot expect premature infants to behave and be able to achieve developmental milestones in the same way that a full-term infant would.

- To account for this developmental difference, NYWIC calculates corrected age for babies at or less than 36 completed weeks gestation (preterm) and plots the growth chart accordingly. As an example, 36 weeks and 6 days is still considered premature and plotted accordingly on the Fenton Growth Charts.

- Corrected age is used until 2 years of age and is also known as adjusted age.

- Demarco's corrected age:

  Actual age in weeks (number of weeks since DOB) = 9

  Actual age 9 - number of weeks preterm 6 = 3

  Demarco's corrected age is 3 weeks

  Explain to the group that the computer system calculates this and plots the growth chart accordingly. Corrected age is used until 2 years of age.

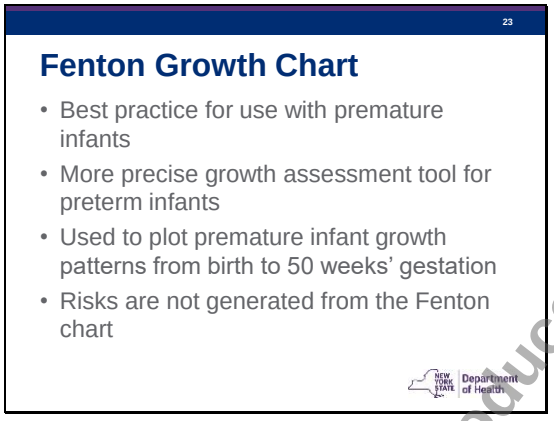
Source:

New York State Department of Health. (2019, Oct.). *New York State WIC program manual, section 1136: Nutrition risk criteria & priority system policy supplement*. Albany, New York: New York State Department of Health.

United States Department of Agriculture. (2017, May). *USDA Nutrition Risk Write Up 142 Preterm or Early Term Delivery*. Albany, New York: New York State Department of Health.

University of Nebraska Medical Center. *Understanding Corrected Age.* Unpublished document available online. https://www.unmc.edu/media/mmi/jackson/TIPS-Intro/Understanding_Corrected_Age.pdf

Slide 23



It is best practice to use the Fenton Growth Chart when working with premature infants.
The Fenton Growth Charts provide a more precise growth assessment for a premature infant by allowing the nutritionist to evaluate growth patterns which more accurately reflect that infant's growth.

- Preterm infants who have not yet reached their due dates will not plot on the WHO charts for weight for age and length for age since their adjusted age is not yet at term
- Increments of time on the horizontal axis are smaller, so it is easier to see how the baby is trending on the chart

The Fenton growth chart is labeled in NYWIC as, "Fenton," previously labeled as, "VLBW".

The, "Fenton," button is enabled anytime the active participant has a value in the, 'Weeks Gestation,' field which is <=36 completed weeks (regardless of the birth weight). Updated with NYWIC Release 1.7

- When entering weeks gestation into NYWIC, users should not round up. For example, 36 6/7 weeks should be entered as 36 weeks because 36 weeks have been completed. The 37th week was not completed.

As with all growth charts, growth screening provides a way to help identify potential medical issues. This is especially crucial for vulnerable preterm infants, who have an increased incidence of complications and mortality roughly proportional to the degree of prematurity.

The Fenton charts can be used until babies are 50 weeks gestation, or 10 weeks past their due dates.
Note that the NYWIC chart goes to 52 weeks.

Most growth charts use chronological/actual age on the horizontal axis, that is they are plotted based on the amount of time since a person's birth. The Fenton chart does not

use chronological age. It ignores the baby's birth. It continues counting in weeks of gestation, just as when the baby was a fetus in utero. The goal is to mimic normal intrauterine growth even though the baby is now in the external environment.

Risks will not be generated from the Fenton chart.

- WHO Growth charts begin at term (NYWIC charts utilize WHO until 2 years of age).

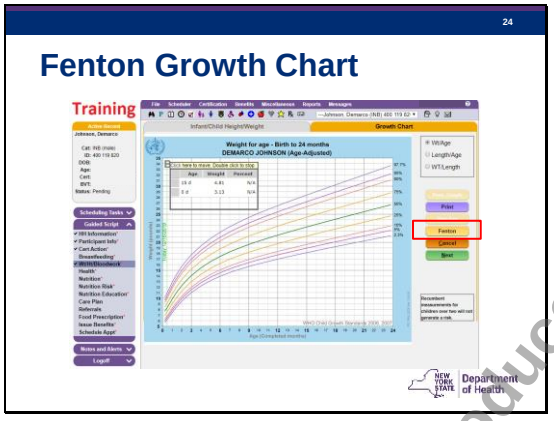
Source:

Tanis. (2013). Welcome to the Fenton Preterm Growth Chart Site. *University of Calgary*. Retrieved from https://www.ucalgary.ca/fenton/2013chart

New York State Department of Health. (2019, Sept.). *NYWIC Release 1.7 Summary*. Unpublished document available in WIC Library.

New York State Department of Health. (2019, Jan.). *WICSIS Wanes and NYWIC Reigns: Policy Changes You Need to Know!, Interim NYWIC Policy PPT*. Unpublished document available in WIC Library.

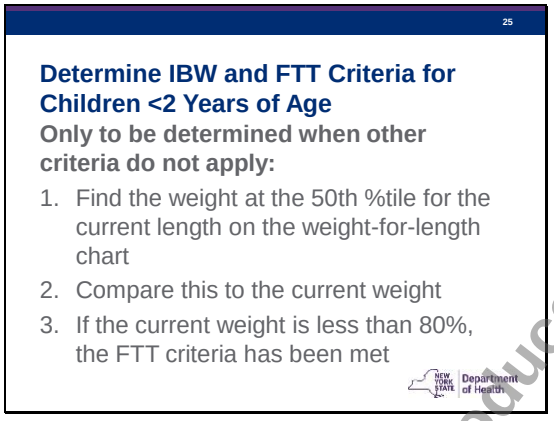
Slide 24



Added to show location of FENTON button in NYWIC program.

Wait for trainees to complete step 4 before moving on to the next slide.

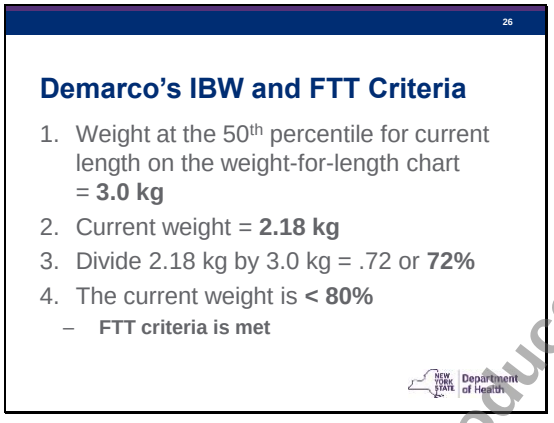
Slide 25



Reference:

New York State Department of Health. (2019, Oct.). *New York State WIC program manual, section 1136: Nutrition risk criteria & priority system policy supplement*. Albany, New York: New York State Department of Health.

Slide 26



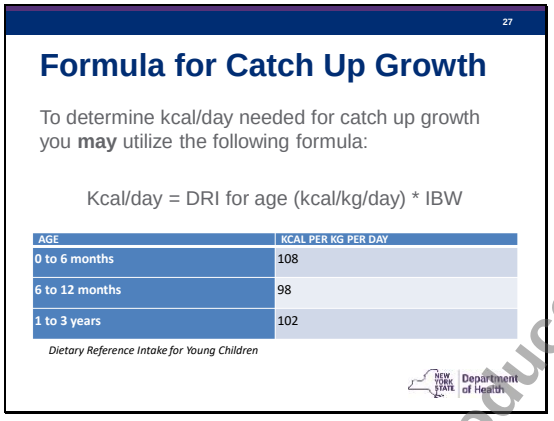
The two formulas to calculate IBW for under two and over two years of age are currently located in Supplement #1136 beginning on page 11 which trainees do not have in their folders today (formula for IBW determination for under two years' old located on PowerPoint for this training).

- Since Demarco meets other criteria, FTT does not have to be assessed in practice but nutritionists should know how to calculate, especially for high risk.
- Comes up most often when MD cites FTT as diagnosis on medical documentation form and other three criteria are not met— nutritionist must then be able to disprove or support that the infant/child's *weight is less than 80% of ideal weight for height/age* to provide appropriate care

Reference:

New York State Department of Health. (2019, Oct.). *New York State WIC program manual, section 1136: Nutrition risk criteria & priority system policy supplement*. Albany, New York: New York State Department of Health.

Slide 27



This formula is adapted from the American Family Physician, "Failure to Thrive, A Practical Guide," e Table B, and is utilized here because Demarco's corrected age can be calculated. Other resources also exist to help you determine calories needed for catch up growth which may be utilized in situations when a preterm infant you are working with has not yet reached 40 weeks gestational age like the Pediatric Nutrition Reference Guide from Texas Children's Hospital—however the likelihood that a preterm infant will be discharged to a WIC clinic prior to achieving gestational age is low

In this case, we can use the following formula to give us an idea of the minimum number of calories needed for catch-up growth so that we can compare this number to the actual calories being provided to Demarco when we get that additional information on day two of the training.

Looking at the DRI chart provided, we can use 108 kcal/kg/day, multiplied by Demarco's IBW to determine minimum calories needed for catch up growth

Slide 28

To calculate the calories and ounces of formula needed for catch up growth, walk trainees through the following example with Demarco:

Formula for catch-up growth:

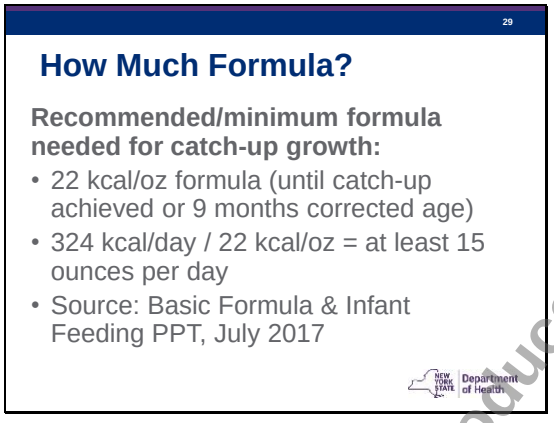
Kcal per day required for catch-up = DRI for age (kcal per kg per day) × ideal weight for height (already reviewed IBW calculation)

Reference:

Homan, G. (2016 Aug.) Failure to Thrive: A Practical Guide. *Am Fam Physician, 15*(94), 295-299. https://www.aafp.org/afp/2016/0815/p295.html

New York State Department of Health. (2017, July.). *Basic Formula & Infant Feeding PPT*. Unpublished document available in WIC library.

Slide 29



Standard formula concentration is 20 kcal/oz. Most HCP will recommend a formula that is 22 kcal/oz to achieve catch-up growth (until catch-up growth achieved or infant reaches 9-12 months corrected age).

- *Per Basic Formula & Infant Feeding July 2017 in the NYWIC Library*
- 324 kcal/day / 22 kcal/oz of formula =15 oz/day at least for catch-up growth
- Trainees will discover an estimate of how many ounces of formula Demarco is receiving on day two of this training.
- Basic Formula & Infant Feeding PPT, July 2017

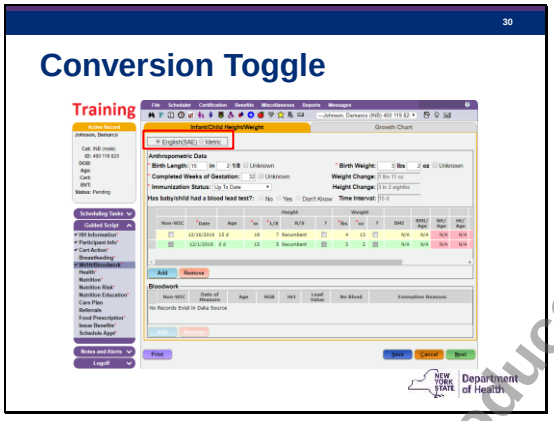
Reference:

Homan, G. (2016 Aug.) Failure to Thrive: A Practical Guide. *Am Fam Physician, 15*(94), 295-299. https://www.aafp.org/afp/2016/0815/p295.html

New York State Department of Health. (2017, July.). *Basic Formula & Infant Feeding PPT*. Unpublished document available in WIC library.

PPT, July 2017

Slide 30

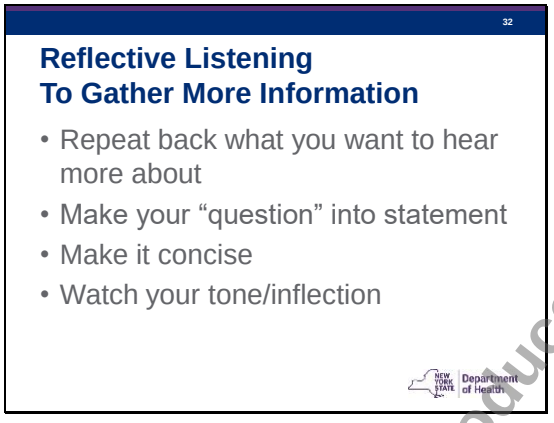


Staff are able to toggle between metric and English measurements in NYWIC. When participant information is provided in metric, enter that information into NYWIC and toggle back to English for the conversion to happen automatically.

Note to trainer: The screen must first be saved in either Metric or English measurement before the toggle button may be used to switch between the two measurement standards.

Slide 31

Slide 32

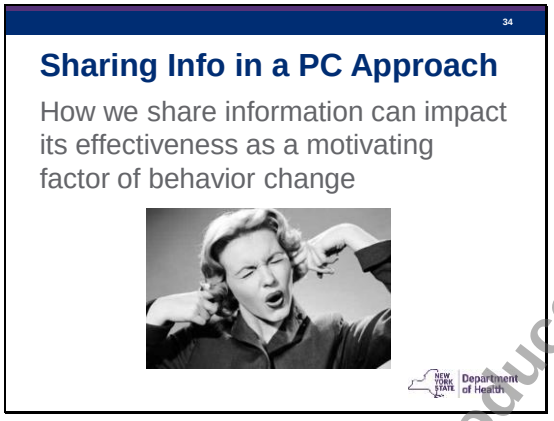


Slide 33

As a professional, you have key information to help the participant make an informed decision about their health.

- While it is important that <u>all</u> participants are aware of nutrition risks which may pose a threat to their (or their child's) health, participants with nutrition risks that place them in the *high risk* category are especially vulnerable.
- As nutrition professionals, we are obligated to inform participants of factors which place them at heightened or even critical health risks.

Slide 34



- While it is important that all participants are aware of nutrition risks which may pose a threat to their (or their child's) health, participants with nutrition risks that place them in the *high risk* category are especially vulnerable.
- As nutrition professionals, we are obligated to inform participants of factors which place them at heightened or even critical health risks.
- How that information is shared with the participant can impact its effectiveness as a motivating factor of behavior change.

Slide 35

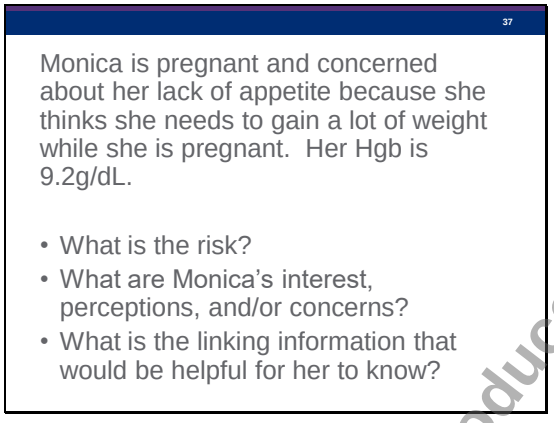
- 2 key steps in providing information about risks.

Slide 36

To discuss risks with participants:

- Use critical thinking skills to:
  - Select the two or three most important pieces of information to bring to the mother's attention.
    - When participants have multiple high risk criteria/risk criteria, there is no need to counsel on every risk.
      - Most severe can be addressed first based on the needs and concerns of the participant.
      - Counseling on every risk can be overwhelming and discouraging to the participant.
  - Think about what the participant has shared as far as their concerns, interests, or needs. What's on *their* mind?
  - How will the risk impact what they have shared as issues of importance? Make the connection between the risk and their interests to highlight the importance.
- Use a participant-centered approach to discuss risks will allow you to provide participants with information so they may make an informed decision.

Slide 37



For example: Monica is pregnant with her first child. She's concerned about her lack of appetite and weight gain. Her hemoglobin (Hgb) is 9.2g/dL.

Identified risks:

Low iron levels (Hgb – 9.2g/dl).

Impact it could have on her pregnancy.

Monica's concern:

Lack of appetite.

Slow weight gain (which she sees as a problem with because she wants to have a healthy pregnancy).

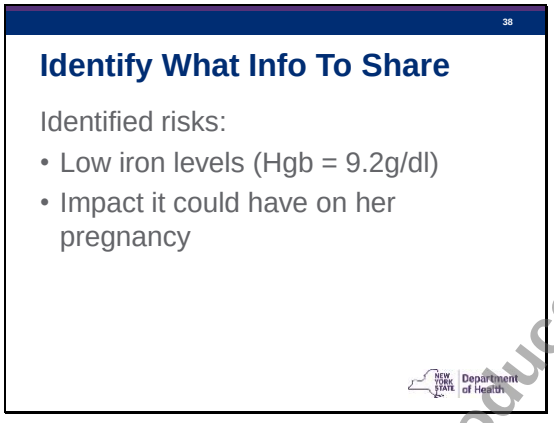
The connection:

If a person does not eat a lot, chances are they are not eating a lot of iron-rich foods.

If a person does not eat iron rich foods, they can have low iron.

Low-iron levels can be a risk for pregnant women.

Slide 38

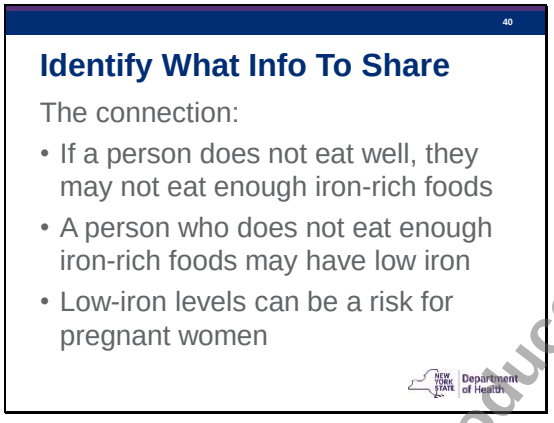


During your assessment, begin to identify what information is going to be important for you to share, in this case you'll want to share with Monic that her iron levels are low and low iron may negatively impact her pregnancy.

Slide 39

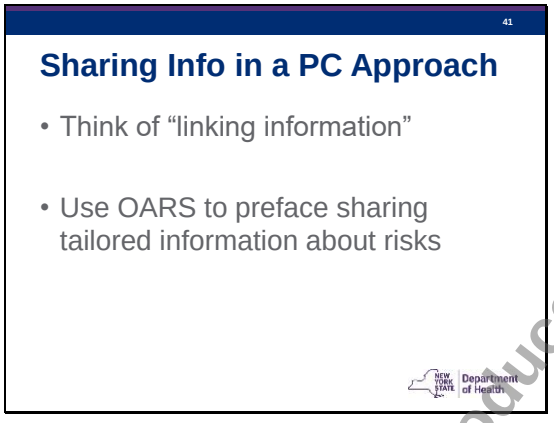
Keep in mind that Monica's concerns are not the same concerns as the nutritionists—but that does not mean there is no connection between the two concerns.

Slide 40



Be ready to overtly state the connection between the nutritionists concerns and the participants concerns—as this connection is critical to a cohesive, individualized care plan between both parties and is NOT as obvious to the participant as it may be to the nutritionist.

Slide 41



Explain how to share information in a participant-centered manner:

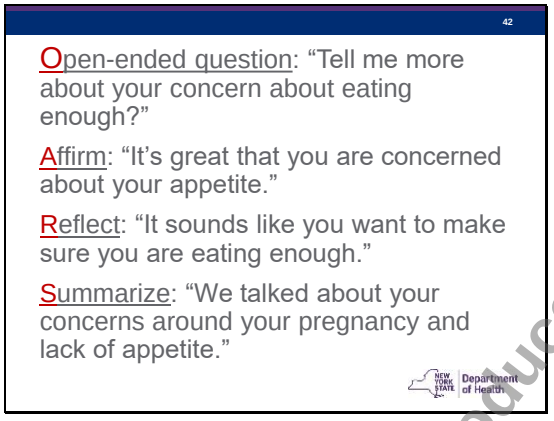
Using the OARS skills, share the information with participant by:

Starting with an OARS statement.

Stating the connection between the participant’s concerns/interest and the identified risks.

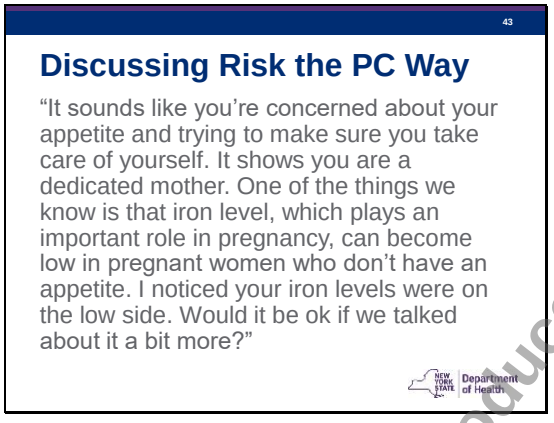
Lead to the discussion.

Slide 42



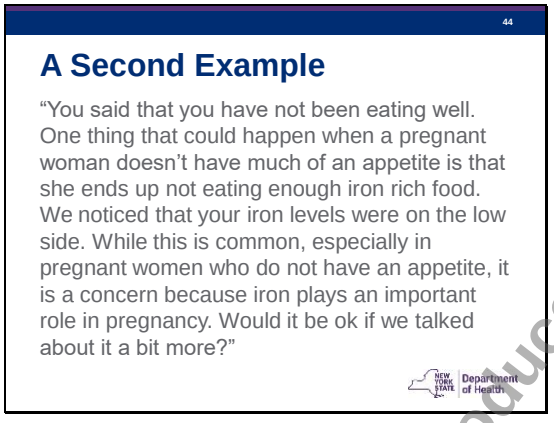
Here are some examples of OARS statement you could use in the case with Monica to initiate sharing the information.

Slide 43



Here is an example of linking information to highlight the relevance to the participant's interests, priorities, and/or concerns.

Slide 44

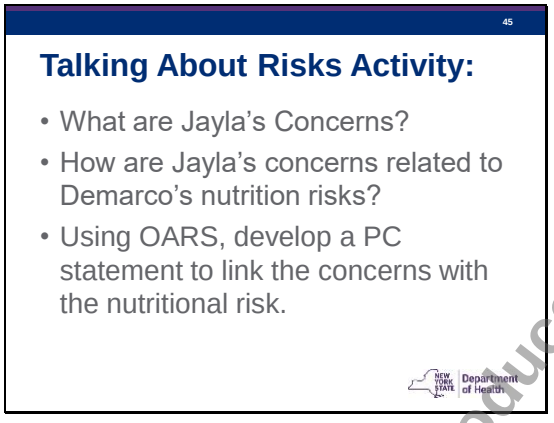


Here is a second example of linking information to highlight the relevance to the participant's interests, priorities, and/or concerns.

Explain and emphasize:

It is important to note that for nutritionist the connection between the participant's concerns and the risks may be obvious and clear. Often, the connection is not clear for a participant who is unaware of their risk. Therefore, it is important to overtly state the connection.

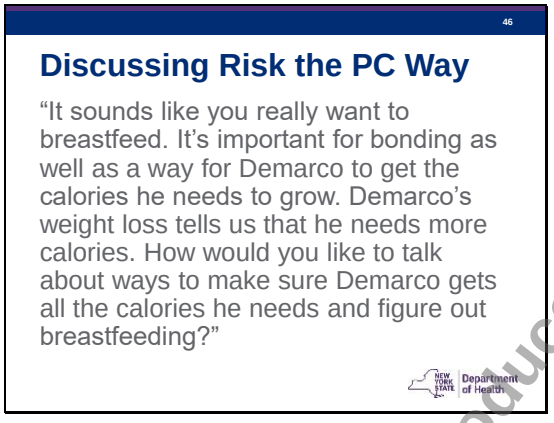
Slide 45



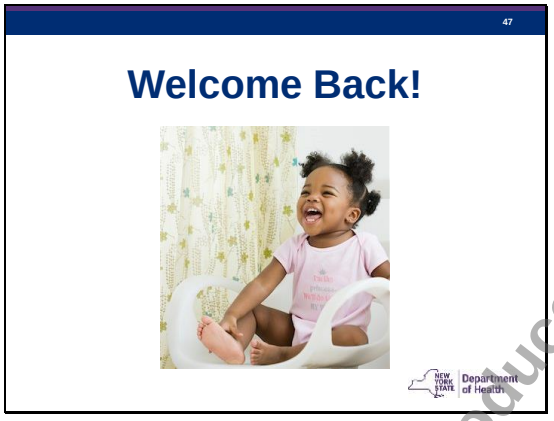
ACTIVITY

- Divide participants into small groups.
- Distribute the *Talking About Risk* worksheet. Provide each group with a newsprint and markers for them to record answers.

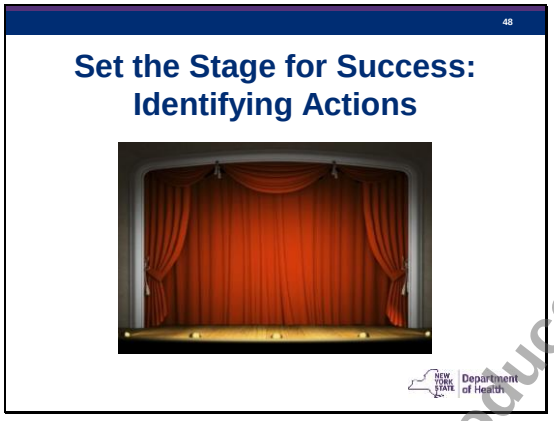
Slide 46



Slide 47



Slide 48



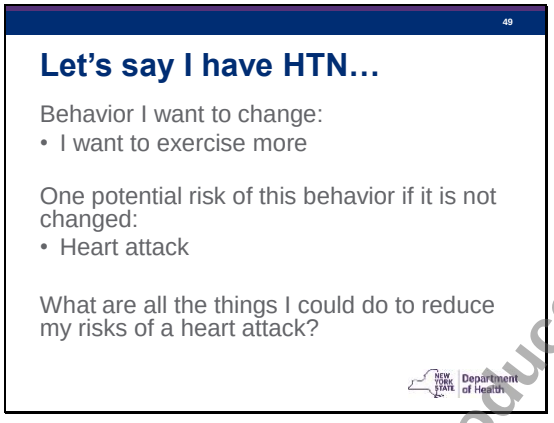
Distribute the *Behavior Change* worksheet.
Explain:

Individually, write the behavior down that you want to change. You can use the one that you spoke about yesterday or feel free to write a different behavior you would like to change (use example on PowerPoint next slide: I want to exercise more).

Next, identify one potential risk if you do not make this behavior change. (use example on PowerPoint: I might have a heart attack).

Instruct trainees to return to the partner they worked with yesterday.

Slide 49

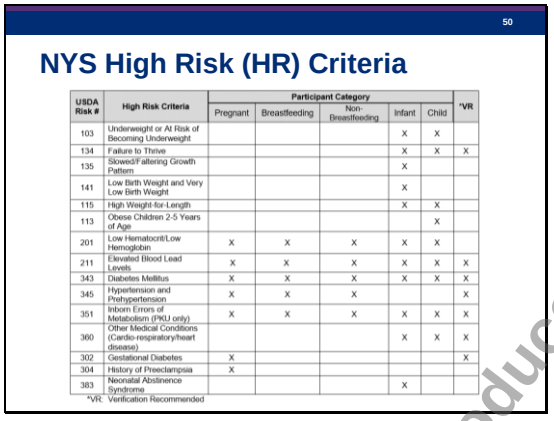


Decide who is person 1 and who is person 2.
Person 1 is the nutritionist first. Person 2 will be the client.
Together, role playing the nutritionist and the client having a conversation, brainstorm a list of possible actions you can take to REDUCE THE RISK of the behavior you identified (use example on PowerPoint: All the things I could do to lessen my risks of having a heart attack).
List all the possible actions you come up with on your worksheet.
Remember:

This is not how to change the behavior but rather ways that you can reduce the risk. You are not trying to help the person find a solution or give advice. The task is to brainstorm a list of possible actions without judgment or discussion regarding how feasible this action is for you as an individual.

We want to think all types of possible actions—even crazy ones (ex. Actions to lose weight = stop eating, walk 5 steps a day, log food, join weight watchers, etc.)

Slide 50



USDA Risk #	High Risk Criteria	Participant Category					*VR
		Pregnant	Breastfeeding	Non-Breastfeeding	Infant	Child	
103	Underweight or At Risk of Becoming Underweight				X	X	
134	Failure to Thrive				X	X	X
135	Slowed/Faltering Growth Pattern				X		
141	Low Birth Weight and Very Low Birth Weight				X		
115	High Weight-for-Length				X	X	
113	Obese Children 2-5 Years of Age					X	
201	Low Hematocrit/Low Hemoglobin	X	X	X	X	X	
211	Elevated Blood Lead Levels	X	X	X	X	X	X
343	Diabetes Mellitus	X	X	X	X	X	X
345	Hypertension and Prehypertension	X	X	X			X
351	Inborn Errors of Metabolism (PKU only)	X	X	X	X	X	X
360	Other Medical Conditions (Cardio-respiratory/heart disease)				X	X	X
302	Gestational Diabetes	X					X
304	History of Preeclampsia	X					
383	Neonatal Abstinence Syndrome				X		

*VR: Verification Recommended

- There is a list of high risk criteria in the trainee folder.

- New York State's High Risk Criteria are designated in WIC Program Manual Section 1136 Nutritional Risk Criteria and Priority System (WPM 1136). Local agencies may establish additional high risk criteria.
    - The policy supplement for WPM 1136 may be found in the WIC library and by clicking the Risk Help button on a participant's Nutrition Risk screen in NYWIC. (Will show visually where this button is on the next slide).

- There are 2 references available to QN/CPAs that contain details on nutrition risks: WPM 1136 policy supplement and the USDA Nutrition Risk Write-Ups

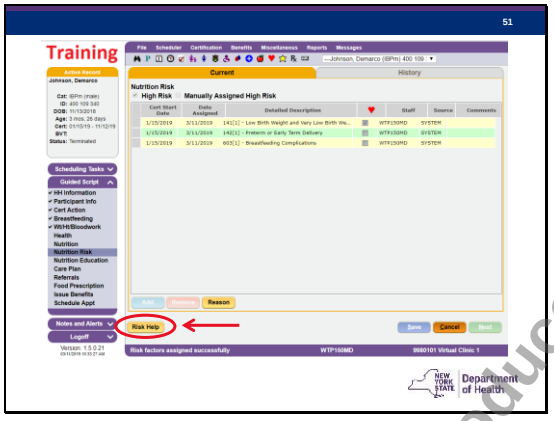
- USDA Nutrition Risk Write-Ups are available in the WIC Library and give more information on all risks (not just HR) (example of USDA risk write up shown in two slides)

- To help a participant limit their risk, you must support any number of small steps a participant is ready and willing to take.

<u>Reference:</u>

New York State Department of Health. (2019, Oct.). *New York State WIC program manual, section 1136: Nutrition risk criteria & priority system policy supplement*. Albany, New York: New York State Department of Health.

Slide 51



The policy supplement for WPM 1136 may be found in the WIC library and by clicking the Risk Help button on a participant's Nutrition Risk screen in NYWIC.

Reference:

New York State Department of Health. (2019, Oct.). *New York State WIC program manual, section 1136: Nutrition risk criteria & priority system policy supplement*. Albany, New York: New York State Department of Health.

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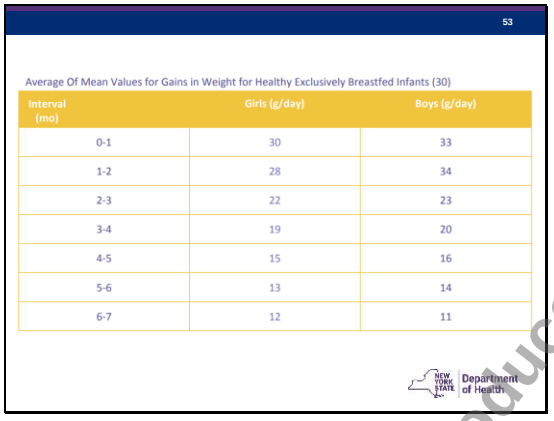
USDA Nutrition Risk Write-Ups are available in the WIC Library and give more information on all risks (not just HR)

Image on the left shows where the USDA Nutrition Risk Write-Ups are located in the WIC Library.

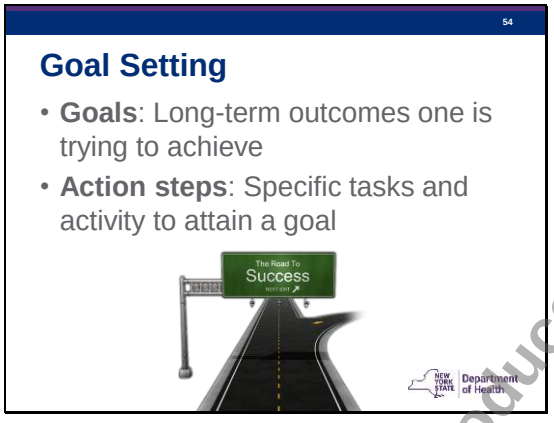
Image on the right is page 1 of 135 Slowed/Faltering Growth Pattern.

Slide 53



USDA risk write ups often have helpful details and/or charts included, such as this chart from p. 3 of 135 Slowed/Faltering Growth Pattern.

Slide 54

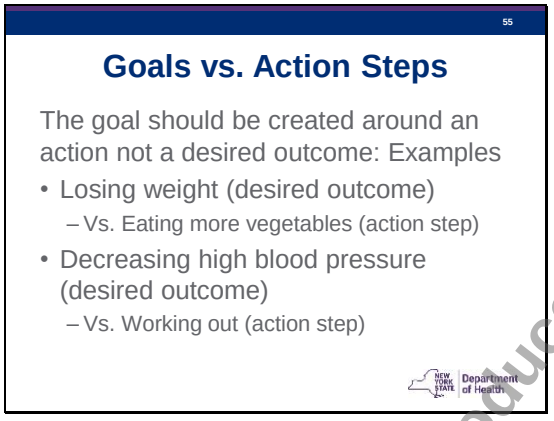


Goals: Are the desired outcome(s) for each nutritional risk (e.g. to achieve an appropriate weight or to decrease high blood pressure).
Action Steps: Are the specific tasks and activities needed/identified to attain a goal. These are the baby steps that contribute to achievement of the desired outcome.

<u>Reference:</u>

New York State Department of Health. (2019, Oct.). *LACASA Guidance Manual*. Unpublished document available in WIC library.
New York State Department of Health. (2019, Aug). *LACASA SMART Goal Evaluation Rubric*. Unpublished document available in WIC library.
New York State Department of Health. (2019, Aug). *NYS WIC Process Goals: Examples for LACASA*. Unpublished document available in WIC library.

Slide 55



Identified goal(s):

As we saw in the previous activity, there are many possible action steps one can take to reduce the negative health outcome(s) of a high risk status/behavior.

The SMART goal should be created around an action not a desired outcome. Examples:

Eating more vegetables (action) vs. losing weight (desired outcome)

Working out (action) vs. decreasing high blood pressure (desired outcome)

Vague goals have a low probability of achievement.

Reference:

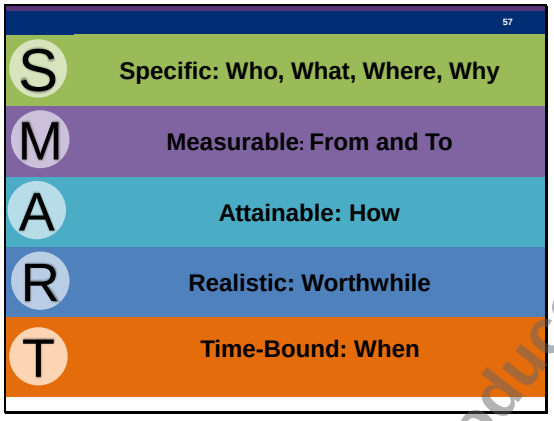
New York State Department of Health. (2019, Oct.). *LACASA Guidance Manual*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *LACASA SMART Goal Evaluation Rubric*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *NYS WIC Process Goals: Examples for LACASA*. Unpublished document available in WIC library.

Slide 56

Slide 57



S: Specific
Who, What, Where, Why
- Is the goal clearly defined or is it vague?
- Who is involved?
- What will be accomplished?
- Where will it be done?
- Why do this?

M: Measurable
- Can you track the progress and measure the outcome?
- Define how you will know when the goal is accomplished by indicating how much or how many
- Spelling out how to achieve the goals and action steps leads to the greatest probability of achievement.

A: Attainable
- Can the goal be accomplished?
- How so?
- Make sure the goal is not out of reach or below standard of performance

R: Realistic
- Is the goal worthwhile and reasonable?
- Is the goal consistent with other roles and responsibilities? Do you have the resources to achieve the goal?

T: Time-Bound

- When will the goal be accomplished?
- Indicate a target date for achieving the goal.

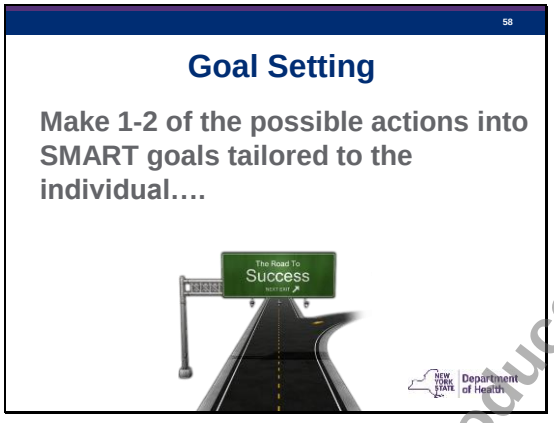
Reference:

New York State Department of Health. (2019, Oct.). *LACASA Guidance Manual*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *LACASA SMART Goal Evaluation Rubric*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *NYS WIC Process Goals: Examples for LACASA*. Unpublished document available in WIC library.

Slide 58



After this training, best practice will be to support the participant in identifying at least 1-2 action steps that may reduce the negative health outcome of a high risk status or behavior in the form of a SMART goal. (It may also be possible to negate the high risk itself through one or two action steps, depending on the high risk—but it is important to remember that behavior change is difficult and often multiple action steps must first be completed to reach the desired outcome).

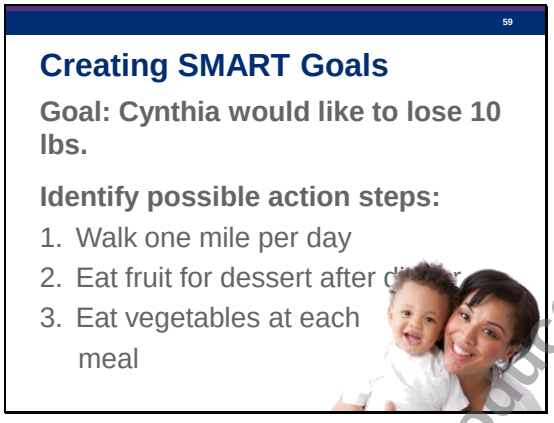
Reference:

New York State Department of Health. (2019, Oct.). *LACASA Guidance Manual*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *LACASA SMART Goal Evaluation Rubric*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *NYS WIC Process Goals: Examples for LACASA*. Unpublished document available in WIC library.

Slide 59



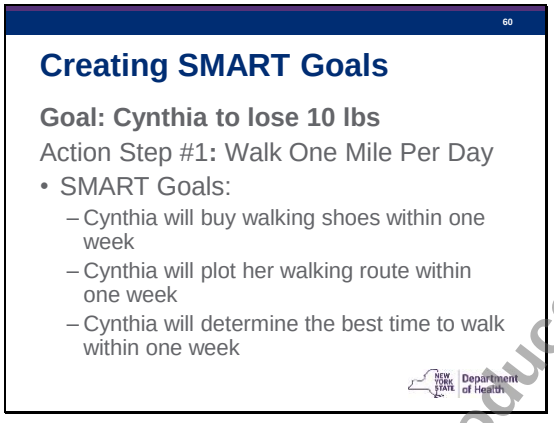
Reference:

New York State Department of Health. (2019, Oct.). *LACASA Guidance Manual*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *LACASA SMART Goal Evaluation Rubric*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *NYS WIC Process Goals: Examples for LACASA*. Unpublished document available in WIC library.

Slide 60



Examples of SMART goals (each statement below represents a separate SMART goal):

SMART goals for walking:

Cynthia will buy walking shoes within one week.

Cynthia will plot her walking route within one week.

Cynthia will determine the best time to walk within one week.

Reference:

New York State Department of Health. (2019, Oct.). *LACASA Guidance Manual*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *LACASA SMART Goal Evaluation Rubric*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *NYS WIC Process Goals: Examples for LACASA*. Unpublished document available in WIC library.

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Review additional example as needed.

Conduct Activity: Practice Creating Effective SMART Goals for Jayla and Demarco: See instructions in design/trainer guide.

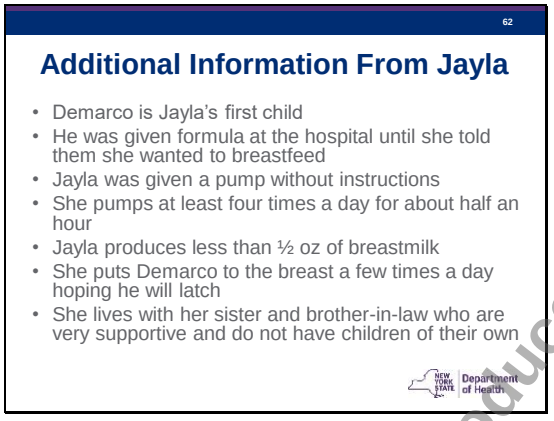
Reference:

New York State Department of Health. (2019, Oct.). *LACASA Guidance Manual*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *LACASA SMART Goal Evaluation Rubric*. Unpublished document available in WIC library.

New York State Department of Health. (2019, Aug). *NYS WIC Process Goals: Examples for LACASA*. Unpublished document available in WIC library.

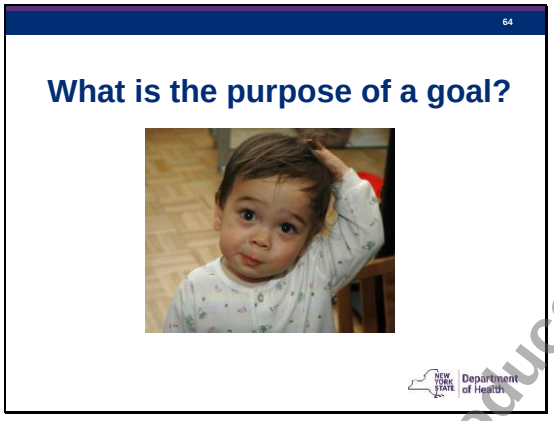
Slide 62



Practice Creating Effective SMART Goals for Jayla and Demarco.

Slide 63

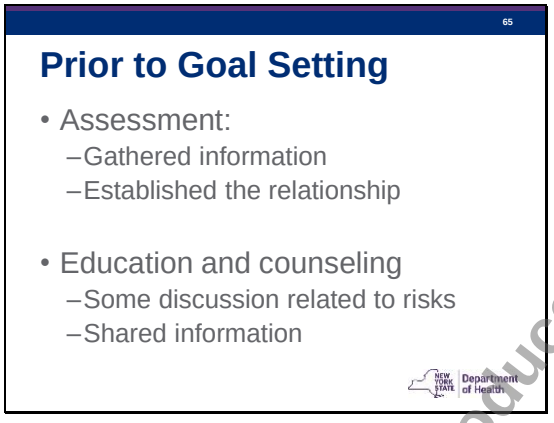
Slide 64



Discuss explaining the concept of goal setting with participants by stating:

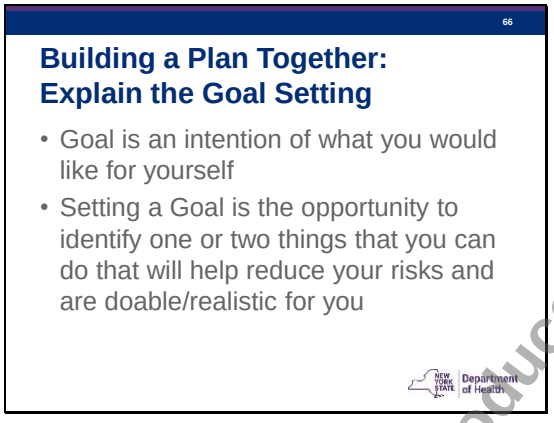
Think about a previous goal you have set for yourself in your lifetime, why do you/did you do it?

Slide 65



Prior to setting a goal with a participant you must first complete the assessment portion of your appointment to gather the appropriate information and begin building rapport and establishing the relationship. You'll also need to complete a portion of the education and counseling piece of the appointment in order to determine where the participant seems most inclined to develop a goal. As we have discussed and reviewed up to this point in the training it is the responsibility of the nutritionist to convey high risk information (no more than one or two at a time, prioritized) **and** overtly state the link between the high risk concern and the participants interest/perceived ability. If a participant states they cannot do anything about their diet at this time they are not ready to set a goal about their diet—perhaps instead they are interested in setting a goal about exercise which may not eliminate the risk but may **reduce** the risk and lay a solid foundation for the next WIC appointment.

Slide 66



Goal setting is something you do for yourself. How you frame goal setting with a participant can influence their level of motivation to set a goal with you rather than to passively "accept" the goal you set for them.

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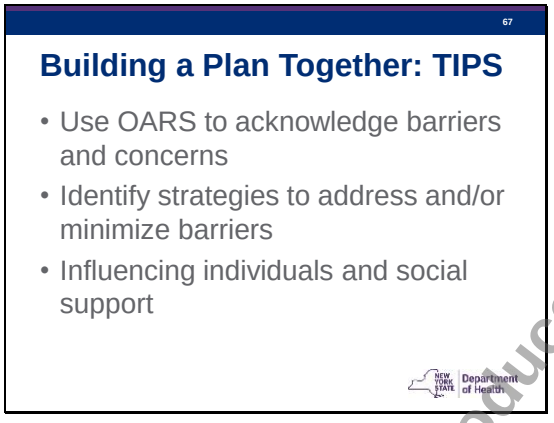

A smart goal must be followed with an effective plan. An effective plan includes steps that can make the goal a reality. Therefore it is important to consider barriers, social support ect…

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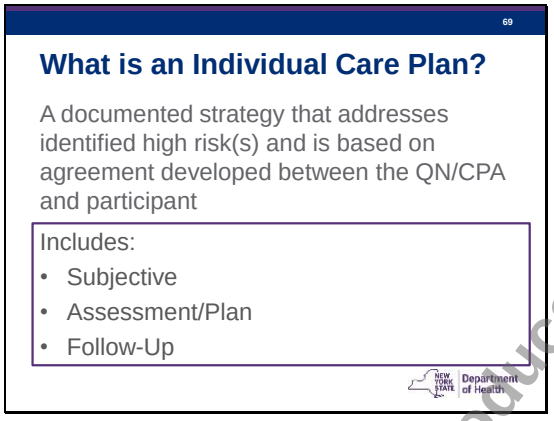
Documenting Individual Care Plans

Slide 69



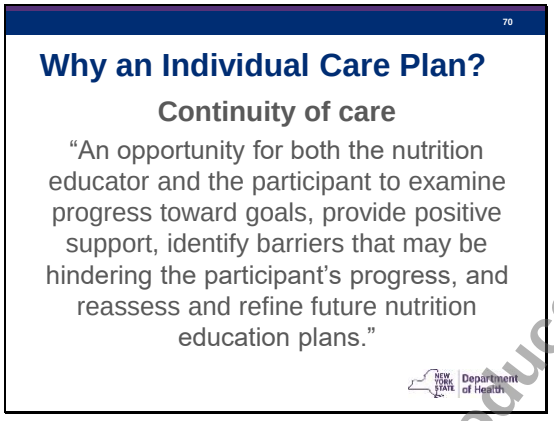
An individual care plan is "a documented strategy that addresses identified high risk criteria and is based on an agreement developed between the QN and the participant."

~~Source: NYSWPM Policy #1011 Acronyms and Definitions~~

Reference:

New York State Department of Health. (2017, Apr.). *New York State WIC program manual, section 1011: Acronyms and Definitions.* Albany, New York: New York State Department of Health.

Slide 70



Ask trainees: Why do we use Individual Care Plans?

The Individual Care Plan allows the current QN/CPA to building on what has already been done with the participant. We refer to this as continuity of care.

The Individual Care Plan allows the QN/CPA to:

- Assess the participant's progress in the set goal
- Evaluate if the interventions were successful or if new interventions are warranted
- Follow-up on previous referrals
- Determine the best plan of action to facilitate the participant in achieving their health goals

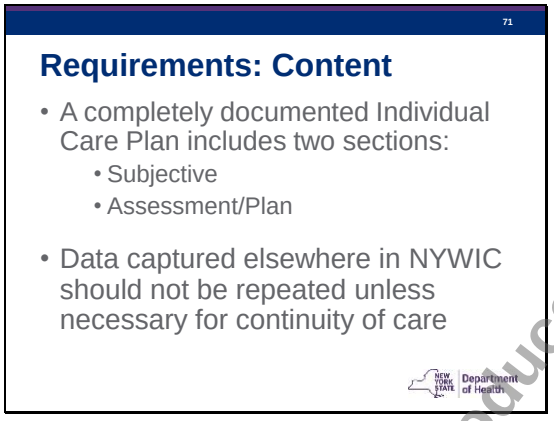
Note: Individual care plans can be created for non-HR participants when desired.

~~Reference: WPM #1011 "Continuity of Care"~~

Reference:

New York State Department of Health. (2017, Apr.). *New York State WIC program manual, section 1011: Acronyms and Definitions*. Albany, New York: New York State Department of Health.

Slide 71



Tell the trainees:

A completely documented Individual Care Plan includes two sections:

Subjective

Includes information and details the participant verbally reports
May include information on previously set goals for recertifying participants

Assessment/Plan

Analysis/interpretation of the subjective and objective data, and conclusions drawn
Participant's stage of change
Information on care from other health care professionals
SMART goals
PES statements may be included

Data captured elsewhere in NYWIC should not be repeated unless necessary for continuity of care

~~Source: Guidance for Documenting Individual Care Plans in NYWIC~~

Reference:

New York State Department of Health. (2019, Oct.). *NYWIC Training Manual*. Albany, New York: New York State Department of Health.

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Explain to the group that once a care plan has been developed, it is important to review it and update it at each participant appointment. Updating the individual care plan includes:

Requirements: Follow-Up

Follow-up should include:

Progress updates on previously identified risks, needs, concerns

Monitoring and modifying progress of SMART goal(s) with the participant/caretaker.

Progress notes in the follow-up section should:

Reflect the content of the follow-up visit.

Maintain a clear picture of the participant's health and nutrition status.

Help QNs/CPAs maintain continuity of care for the participant as long as the Individual Care Plan remains open.

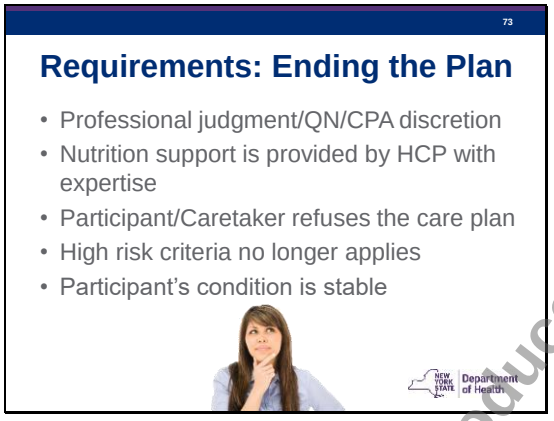
~~Source: WPM Policy #1216 High Risk Care~~

Resource:

New York State Department of Health. (2016, June). *New York State WIC program manual, section 1216: High risk care*. Albany, New York: New York State Department of Health.

New York State Department of Health. (2016, June). *New York State WIC program manual, section 1460: Local agency nutrition staff*. Albany, New York: New York State Department of Health.

Slide 73



QN/CPAs should use professional judgment when making this decision.

Once an Individual Care Plan is determined to no longer be needed/warranted and/or the care plan no longer applies during the certification period, the QN/CPA must document within the Follow-Up section that the Individual Care Plan was ended, including a reason for it ending.

When a CPA is carrying out the Individual Care Plan established by the QN, it is best practice for the QN and the CPA to work together to ensure continuity of care and decide when the plan should be discontinued.

Reasons for ending an Individual Care Plan include:

- Professional judgment or QN/CPA discretion.
- Nutrition support is provided by HCP with expertise.
- Participant/Caretaker refuses the care plan.
- High Risk Criteria no longer applies because:
    - High risk participant subsequently certifies and no High Risk Criteria are generated.
    - In the event that a participant subsequently certifies and continues to have high risk criteria, the best practice is to write a note in the Follow-Up section stating that a new care plan was initiated for the new certification period.
    - High Risk Criteria are generated from birthweight or measurements prior to the certification date and the current measurements are within normal limits.
- Participant's condition is stable (e.g. low hemoglobin has been found to be within normal limits).

There are 2 examples showing what to do if a care plan isn't needed or a participant isn't ready to set a goal included in the Guidance for Documenting Individual Care Plans document (in trainees' folders).

Resource:

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1216: High risk care*****. Albany, New York: New York State Department of Health.**

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1460: Local agency nutrition staff*****. Albany, New York: New York State Department of Health.**

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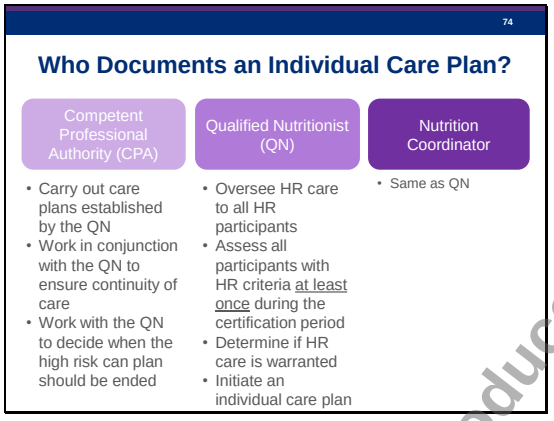

CPA:

- Conducts nutrition and breastfeeding assessments
- Determines nutritional risk
- Prescribes food packages
- Promotes breastfeeding
- Documents nutrition services
- Provides nutrition education

QN:

- Performs all nutrition-related duties at local agency
- Provides and oversees care to high-risk participants
- Offers leadership in preparing, conducting, and evaluating nutrition education services at the local agency

NC:

- Ensures quality nutrition services are provided
- Participates in the development of local agency nutrition education and breastfeeding support plans
- Offers technical assistance and consultation to other local agency staff and health professionals
- Oversees procedures used to fulfill food and formula prescriptions

Resource:

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1216: High risk care*****. Albany, New York: New York State Department of Health.**

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1460: Local agency nutrition staff*****. Albany, New York: New York State Department of Health.**

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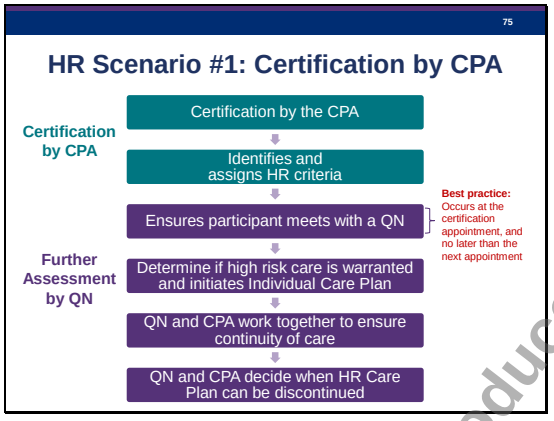

WPM #1216

Scenario #1: Certification by CPA

- Certification is completed by the CPA. The CPA identifies high risk criteria at certification.
- The CPA ensures that the participant will be seen either the same day by a QN, or will be seen no later than at the next appointment by the QN.
- At the time the participant is seen by the QN, a determination is made whether or not the high risk criteria apply. If the participant is not high risk, the Care Plan is ended and an explanation is documented in notes.
- If the high risk criteria applies to the participant, the QN will initiate and appropriately document the individual care plan. Best practice is for the participant to continue to be seen by the QN at subsequent visits.
- After the Individual Care Plan has been opened and established, best practice is for the QN to document and update the Individual Care Plan at each subsequent visit.
- The CPA may carry out the individual care plan that has been established by the QN, and best practice is for the CPA and QN to work together to ensure continuity of care.
- The QN or CPA may decide when the Individual Care Plan may be appropriately discontinued. Best practice is for the QN and CPA to determine the most appropriate time to end the Individual Care Plan.
- CPA duties include provision of participant-centered care, nutrition education and counseling, as well as prescribing appropriate supplemental foods and making appropriate referrals as needed.

Resource:

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1216: High risk care*****. Albany, New York: New York State Department of Health.**

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1460: Local agency nutrition staff*****. Albany, New York: New York State Department of Health.**

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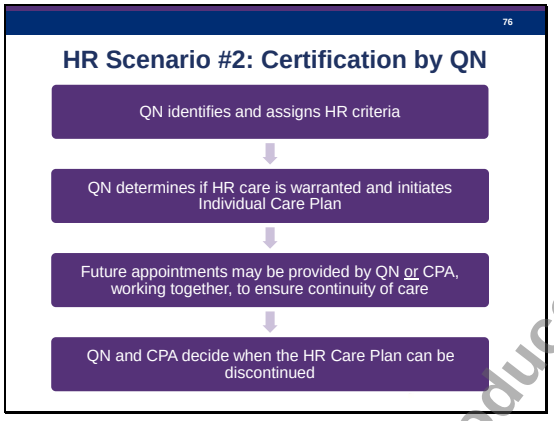

WPM #1216

Scenario #2: Certification by QN

- Certification is completed by the QN, at which time high risk criteria are identified by the QN.
- If the QN determines that the high risk criteria(s) apply, an Individual Care Plan will be initiated and documented.
- All subsequent appointments during the certification period may be provided by either the QN or CPA. The Individual Care Plan should be updated at every visit, by either the QN or CPA, and relevant notes entered to promote continuity of care.
- The CPA may carry out the care plan that has been established by the QN, and best practice is for the CPA and QN to work together to ensure continuity of care. The QN or CPA may decide when the Individual Care Plan may be appropriately ended. Best practice is for the QN and CPA determine the most appropriate time to end the Individual Care Plan.
- The QN provides leadership to local agency staff in the provision of all Participant-Centered Nutrition Education Services as well as provision of supplemental foods and appropriate referrals for participants.

Resource:

New York State Department of Health. (2016, June). *New York State WIC program manual, section 1216: High risk care*. Albany, New York: New York State Department of Health.

New York State Department of Health. (2016, June). *New York State WIC program manual, section 1460: Local agency nutrition staff*. Albany, New York: New York State Department of Health.

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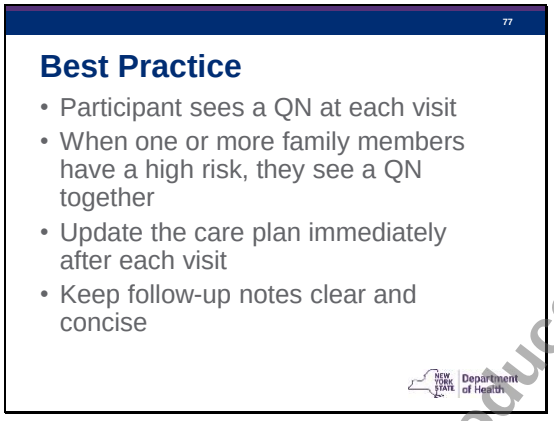

- Ideally, a HR participant would see a QN at each visit
- HR care plans must be updated after each visit. Waiting until later may make it challenging to remember the details of the visit, or to remember to document at all.
- Keep follow-up notes clear and concise including only relevant and pertinent information that cannot be found elsewhere. This may include the rationale for ending or continuing a care plan.

~~Source: WPM Policy #1216 High Risk Care, Guidance for Documenting Individual Care Plans in NYWIC~~

Resource:

New York State Department of Health. (2016, June). *New York State WIC program manual, section 1216: High risk care*. Albany, New York: New York State Department of Health.

New York State Department of Health. (2016, June). *New York State WIC program manual, section 1460: Local agency nutrition staff*. Albany, New York: New York State Department of Health.

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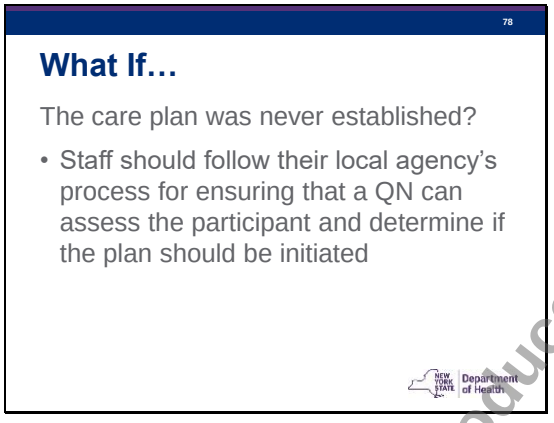

In the event that staff come across a high risk participant without an established care plan, staff should follow their local agency's process for ensuring that a QN can assess the participant and determine if the plan should be initiated.

Example:
- A CPA saw a participant and could not establish a care plan
- A QN saw a participant and forgot to establish a care plan

Resource:

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1216: High risk care*****. Albany, New York: New York State Department of Health.**

New York State Department of Health. (2016, June). ***New York State WIC program manual, section 1460: Local agency nutrition staff*****. Albany, New York: New York State Department of Health.**

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- Distribute Individual Care Plan #1 and the Check-Off List for Individual Care Plan Documentation.
- Explain that we would like them to look at Individual Care Plan #1 and check off the items on the list that have been completed.
- Allow approximately 5 minutes for the group to complete the task.
- Call time and ask them to share what they found on Individual Care Plan #1 that was properly completed.
- Ask the following questions:
    - What was completed well?
    - What was missing?
    - If they opened this care plan in the computer; would they be able to:
        - Understand what happened previously?
        - Know what needs to happen today to continue care?

- Now you'll have the opportunity to practice documenting an individual care plan for Demarco, the case study you've have been working with.
- Distribute *Individual Care Plan 2: Documentation for Jayla and Demarco.*

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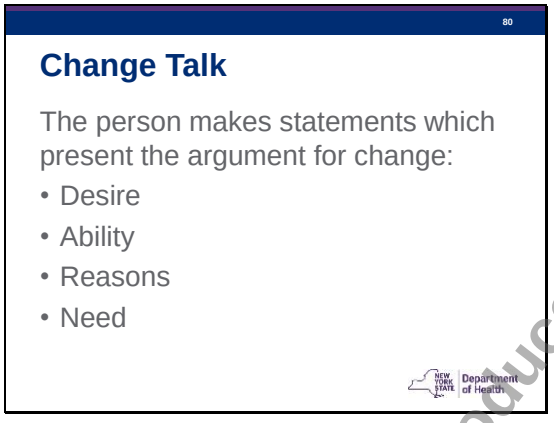

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#1: Can You Hear It?

- **D**esire: “I want…”, “I wish…”
- **A**bility: “I can…”, “I think I could…”
- **R**easons: “I know…”, “I would…”
- **N**eed: “I have to…”, “I should…”

NEW YORK STATE Department of Health

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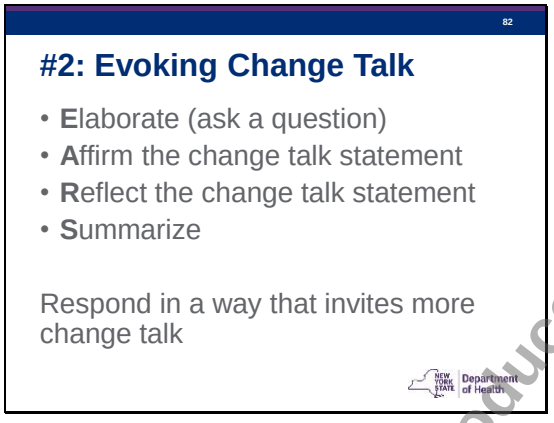

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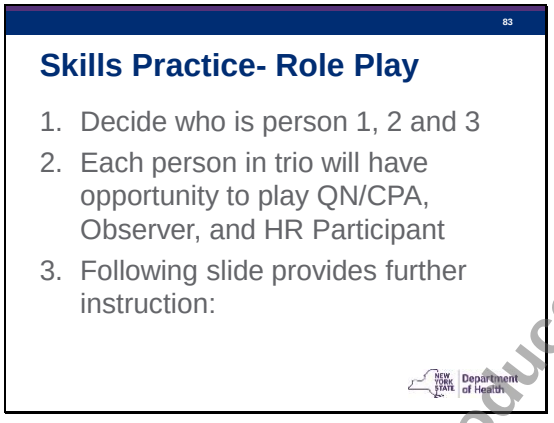

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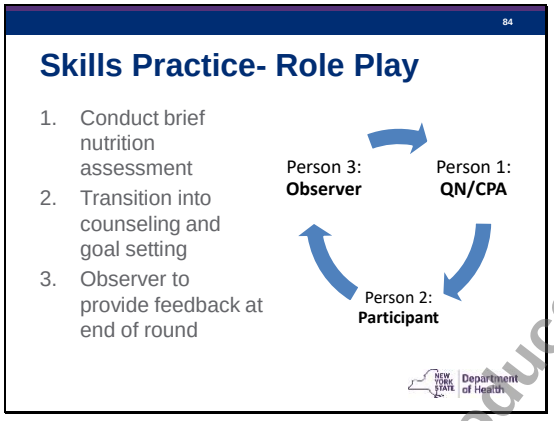

Graphic on right will assist trainees in determining which role begins and which role is next as they move through all three rounds of the role-play skills practice.