

## **Scope of Practice and Clinical Privileging for Dietitians**

### **California Dietetic Association Public Policy Professional Practice Task Force**

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April 24, 2009  
CDA Annual Meeting

## **Scope of Practice and Clinical Privileging for Dietitians**

- ◆ Hot Topics!
  - ◆ Listserv threads
  - ◆ JADA articles
  - ◆ Practice Group (DPG) newsletters/publications
  - ◆ Webinars
  - ◆ State and DPG conference meeting
    - ◆ Public Policy Education Day
    - ◆ CDA Annual Meeting

## **Presentation Outline**

- ◆ Historical Context, Scope of Practice in CA
- ◆ Terminology – definitions, significance
- ◆ Regulations & Laws
- ◆ Scope of Practice Framework – making it personal, “framing” your practice
- ◆ Summary of Questions posed by RDs in California: Answers (for this moment in time)

## **Historical Context: California Dietetic Scope of Practice**

- ◆ **1982:** Dietitian Title Act (Business & Professions Code 2585-2586)
- ◆ **2001-2002:** AB1444: modernize B&P 2585-86 (MNT, verbal and electronic orders, DTR, “protocols”)
  - ◆ Title Act
  - ◆ Practice Act
- ◆ **2007-08:** Rumors and facts about citations in acute care hospitals throughout the state
  - ◆ RDs practicing outside of their scope
  - ◆ Nutrition protocols not written or approved according to the standards/reg

## **Historical Context: California Dietetic Scope of Practice**

- ◆ **June 2008: Professional Practice Task Force formed by CDA Public Policy Coordinator (VP)**
  - ◆ 5 members of the Council with a passion for the clinical issues at stake + representative from California Advocates
  - ◆ Mission – to approach California Dept of Public Health to start a conversation and propose a partnership for clarification of clinical practice do's and don'ts, and recognition of our modernized B&P code.

## **Historical Context: California Dietetic Scope of Practice**

- ◆ Task Force Learning Curve: 9 months, monthly meetings, many emails and conference calls
- ◆ Role of CDPH in hospital surveys: Federal standards vs. State standards
- ◆ Which federal and state regulations are pertinent for evaluations of clinical nutrition policies and practices
- ◆ Terminology Soup:
  - ◆ Scope of Practice
  - ◆ Clinical Privileges
  - ◆ Advanced Practice
  - ◆ Autonomy
  - ◆ Prescriptive Authority
  - ◆ Credentialing
  - ◆ Protocols

## Historical Context: California

- ◆ Our sources of current knowledge
  - ◆ CDPH – Dr. Bonnie Sorensen, MD (Chief Deputy Director of Policy & Programs), Kathleen Billingsley, RN (Deputy Director, Center for Healthcare Quality), Patty Pasquarella, RD (Chief Nutrition Consultant, Licensing and Certification)
  - ◆ ADA – Quality Management and Government Affairs
- ◆ Key regulations:
  - ◆ CMS State Operations Manual (link from ADA website in Advocacy & the Profession – Rules and Regs)
  - ◆ Title 22
  - ◆ CA Business & Professions Codes
- ◆ Valuable references:
  - ◆ California HealthCare Foundation website
  - ◆ Skipper, A – *Advanced Medical Nutrition Therapy Practice*

## Terminology – definitions

- ◆ Terms to understand in the context of Clinical Practice
  - ◆ Scope of Practice
  - ◆ Clinical Privileges
  - ◆ Credentialing
  - ◆ Prescriptive Authority
  - ◆ Advanced Practice
  - ◆ Practice Autonomy
  - ◆ Protocols
  - ◆ Governing Body

## Scope of Dietetics Practice

- ◆ Scope of Practice is NOT:
    - ◆ A list of tasks or job functions that **all** RDs collectively are allowed or not allowed to perform
  - ◆ Scope of Practice IS:
    - ◆ A description of the:
      - ◆ Roles
      - ◆ Functions and Activities
      - ◆ Responsibilities
- that an **individual** RD or DTR is proficient to perform within the boundaries of regulations and practice standards

## Scope of Dietetics Practice

- ◆ Scope of Practice is determined by :
  - ◆ Regulations – define the *legal* scope of practice
    - ◆ Federal laws and regulations (CMS)
    - ◆ State dietetic practice laws (B&P Code 2586)
    - ◆ State Health Care Licensing and Certification regulations (Title 22, Division 5)
  - ◆ Practice Standards
    - ◆ Standards of Practice (ADA)
    - ◆ Standards of Professional Performance (ADA)
  - ◆ Facility/Institutional policies and protocols, approved by the governing body (board of directors)
  - ◆ Training, education, skill, competence and experience of the **individual** RD or DTR

## Clinical Privileging

- ◆ A process defined and mandated by CMS (federal regulation) for licensed healthcare facilities
  - ◆ Holds the Governing Body legally responsible for ensuring that medical and surgical care in the facility are provided by practitioners who are individually evaluated by the Medical Staff.
  - ◆ Requires that categories of practice are described (duties and scope) in the Medical Staff bylaws
  - ◆ Privileges to provide clinical care requires possession of current qualifications (license, certifications) and *demonstrated* competency for each category of practice in review; re-evaluation is every 24 months.
  - ◆ Intent: Patient safety and quality patient care; accountability lies with the one named as responsible for the care of the patient

## Clinical Privileging

- ◆ Examples of categories of nutrition practice, for RDs pursuing clinical privileging:
  - ◆ Therapeutic diet orders
  - ◆ Enteral nutrition ordering/monitoring
  - ◆ Parenteral nutrition ordering/monitoring
  - ◆ Insulin orders for diabetic educators
  - ◆ Vitamin and mineral supplementation
  - ◆ Nutrition-related medications

## Clinical Privileging

- ◆ It is a facility-led process, pursued internally, not transferrable to other institutions/employers
- ◆ Non-physician practitioners may become privileged without becoming members of the Medical Staff
  - ◆ Gov. Body and Med Staff determine per practice category
  - ◆ Privileging would occur on a parallel process, separate from physician privileging, but no less comprehensive
- ◆ Not every practice setting requires non-physician practitioners to seek privileges.
  - ◆ How imp't is it for the RD to independently write orders?
  - ◆ Is the individual RD qualified and able to demonstrate competence for each activity/task?
  - ◆ What about RD coverage (physician/team expectation?)
  - ◆ Return on Investment?

## Credentialing

- ◆ A term sometime used synonymously with *privileging* for health care providers.
- ◆ May mislead – since clinical privileges depend on credentials AND demonstrated ability for every task/activity in review
- ◆ “CMS does not have a preference as to the “term” used to name the hospital's privileging process... the process must comply with CMS hospital Conditions of Participation.”

## Prescriptive Authority

- ◆ Legal recognition that a qualified individual (qualified usually by academic and supervised training specified in the law) is authorized to prescribe certain medical interventions.
- ◆ Can be applied to any treatment that requires an order: pharmaceutical agents/drugs, therapeutic diets, labs, diagnostic exams, etc.
- ◆ By federal and state laws, licensed independent practitioners (MD, DO) have prescriptive authority for patient care within their scope, including therapeutic diets.

## Prescriptive Authority

- ◆ A state practice act that defines prescriptive authority for the RD to write orders for therapeutic diets, labs, specific classes of drugs, etc. is **not sufficient** permission to practice independently or autonomously in a licensed health care facility.
- ◆ Federal regulations trump state practice laws for health professionals working in licensed facilities.
  - ◆ CMS charges the LIP with nutrition care orders.
- ◆ **Conclusion:** RD needs state practice law that specifies prescriptive authority AND need clinical privilege to perform that activity independently.

## Advanced Practice

- ◆ Level of practice assumed by the individual practitioner who possesses expertise, described as “skill and knowledge developed greatly beyond the initial stage; experience-derived”
  - ◆ Role involves complex decision-making
  - ◆ Demonstrate clinical competencies for expanded practice
- ◆ Qualifications support “Practice Autonomy” - in health care, measured by:
  - ◆ MS/PhD level education
  - ◆ Demonstrated ability to diagnose and/or treat a specified set of conditions
  - ◆ Demonstrated ability to prescribe treatments, including drugs
  - ◆ Independence in implementing interventions
  - ◆ Direct reimbursement for services rendered

Advanced Medical Nutrition Therapy Practice, A. Skipper, 2009

## Advanced Practice

- ◆ Not the same as “Specialty Practice”
  - ◆ Specialty level describes the *proficient* provider (vs. *expert* provider)
- ◆ Sophisticated **approach** to practice:
  - ◆ Attitude: broad and balanced; scientific inquiry
  - ◆ Aptitude: advanced degree, credentials
  - ◆ Expertise: pharmacology, pathophysiology, research, counseling, advanced MNT
  - ◆ Context: collaboration, consultation, leadership
- ◆ Nature of Practice:
  - ◆ Case Management / own case load
  - ◆ Advanced health assessment skills, diagnostic-reasoning
  - ◆ Provision of consultant services to other providers
  - ◆ Program planning, implementation, and evaluation

Advanced Medical Nutrition Therapy Practice, A. Skipper, 2009

## Practice Autonomy

- ◆ Levels of independence implementing interventions:
  - ◆ No Autonomy: Recommends initiating, modifying or discontinuing the intervention
  - ◆ Limited Autonomy: Implements within parameters of an approved protocol or algorithm (as legally allowed) addressing the intervention; obtains a co-signature from the licensed independent practitioner managing the care of the patient.
  - ◆ Full Autonomy: Independently implements interventions based on clinical privileges

## Protocols

- ◆ Simple definition: A rule that guides how an activity should be performed.
- ◆ Prevalent in health care due to focus on evidence-based and standardized practice:
  - ◆ Patient Safety
  - ◆ Quality of Care / Outcomes
  - ◆ Cost-containment
- ◆ Facilitate "limited" practice autonomy:
  - ◆ Implementation per guidelines, with co-signature
  - ◆ Protocol must be ordered by MD for the patient, and each needed intervention is co-signed as an order, when implemented

## Protocols

- ◆ Considerations for nutrition care protocols:
  - ◆ Every protocol must be specific to a specialized service, specific intervention, or category of practice
  - ◆ Cannot be all-inclusive of "Medical Nutrition Therapy"
  - ◆ Criteria-based - must indicate how and when the RD will implement the intervention
    - ◆ What condition/signs/symptoms/etiology exist for the patient that dictates the actions of the RD?
  - ◆ Example: Wound Care Nutrition Protocol
    - RD to perform nutrition assessment weekly for patient with wounds/pressure ulcer Stages 2 and higher.
    - For Stage 3 wound, order oral nutritional supplements to meet protein needs. Discontinue supplements as wound heals or assessed protein needs are met.
    - For Stage 4 wound, order oral nutritional supplements as per Stage 3 guideline; order initial prealbumin level; check prealbumin every 4-7 days until stable (>15 mg/dL).

## Regulations & Laws

- ◆ Regulations & Laws: the *legal* scope of practice
  - ◆ Federal laws and regulations (CMS)
  - ◆ State dietetic practice laws (B&P Code 2586)
  - ◆ State Health Care Licensing and Certification regulations (Title 22, Division 5)
- ◆ In California: hospitals surveys for regulatory compliance (federal and state standards) are done by State Dept of Public Health, Licensing and Certification Division
  - ◆ 15 Medical consultants
  - ◆ 20 Pharmacy consultants
  - ◆ 10 Nutrition consultants

## Federal Regulations

- ◆ CMS Conditions of Participation (CoP)
  - ◆ Published in the State Operations Manual
  - ◆ Formatted with Interpretive Guidelines
- ◆ Accreditation organizations (TJC or HFAP) may assume role of determining CMS regulatory compliance, using CMS Interpretive Guidelines
- ◆ State consultants validate accreditation survey reports (validation surveys)

## Pertinent CMS Regulations

- ◆ 482.28, Appendix A, CoP Interpretive Guideline: Food and Dietetic Services
  - (a) Organization Standard
    - ◆ Licensed hospitals must have:
      - ◆ Director of FS
      - ◆ Qualified RD

### **Pertinent CMS Regulations**

- ◆ 482.28, Appendix A, COP Interpretive Guideline: Food and Dietetic Services
- (b) Diet Standard
  - ◆ Hospital menus meet the patients' needs
  - ◆ Nutrition risk screening identifies patients for assessment
  - ◆ Therapeutic diets must be prescribed by the licensed practitioner(s) responsible for the care of the patient
    - ◆ Diets must be ordered in writing, documented in medical record, and evaluated for nutritional adequacy
  - ◆ "In accordance with State law and hospital policy, the dietitian may assess a patient's nutritional needs and provide recommendations or consultations for patients"

### **Pertinent CMS Regulations**

- ◆ 482.28, Appendix A, COP Interpretive Guideline: Food and Dietetic Services
- (b) Diet Standard
  - ◆ Patients' nutritional needs must be met in accordance with recognized dietary practices (RDA, DRI)
  - ◆ Therapeutic Diet Manual required
    - ◆ Approved by the dietitian and the Medical Staff
    - ◆ Readily available to medical, nursing staff & food service
  - ◆ Side-note: does the electronic ADA-Nutrition Care Manual satisfy the requirement?  
Nutrition Care Manual® is consistent with the CMS Interpretive Guidelines for the Hospital Conditions of Participation. NCM also meets the Joint Commission's Hospital Accreditation Standards 2009. Additionally, NCM has been named the preferred diet manual by the Healthcare Facilities Accreditation Program.

### **Pertinent CMS Regulations**

- ◆ 482.23 CoP Interpretive Guideline on Verbal Orders
  - ◆ Should not be common practice
  - ◆ Pose increased risk for miscommunication and error, leading to adverse patient event
  - ◆ Should only be used when it is impossible or impractical for the ordering practitioner to write the order without delaying treatment that affects patient outcomes

### **Pertinent CMS Regulations**

- ◆ Protocols and Standing Orders (CMS memo, **S&C-09-10, October 24, 2008**)
- ◆ Use of written protocols and standing orders must be:
  - ◆ Documented as an order in the patient's medical record
  - ◆ Authenticated (signed) by the responsible practitioner
  - ◆ Timing of documentation "should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances."
  - ◆ ... as soon as possible after implementation of the order

### **Pertinent CMS Regulations**

- ◆ Clinical Privileging (CMS memo, **S&C-05-04, Nov 12, 2004**)
  - ◆ The hospital's Governing Body must ensure that all practitioners who provide a medical level of care and/or conduct surgical procedures in the hospital are individually evaluated by its Medical Staff:
    - ◆ Possess current qualifications
    - ◆ Demonstrate competencies for the privileges granted.
  - ◆ State Survey Agency (SA) surveyors are to determine whether the hospital's privileging process and its implementation of that process comply with the hospital Conditions of Participation (CoPs).

### **Pertinent CMS Regulations**

- ◆ Clinical Privileging (CMS memo, **S&C-05-04, Nov 12, 2004**)
  - ◆ Upon/after appraisal of the individual practitioner, the Medical Staff recommends to the Gov Body:
    - ◆ Grant, deny, continue, discontinue, revise, limit or revoke privileges
    - ◆ Gov Body determines the final action
  - ◆ If Gov Body decides to limit or revoke privileges of an individual practitioner, the hospital must report that action to appropriate authorities: state or federal registries or databases.
    - ◆ Intent: protect the public from practitioner who is not qualified and/or competent

## State Regulations

- ◆ California State dietetic practice law: B&P Code 2585-86
  - ◆ Upon referral, RD may perform MNT, defined as:
    - ◆ Provide nutritional/dietary counseling
    - ◆ Conduct nutritional/dietary assessments
    - ◆ Develop nutritional/dietary treatments, including therapeutic diets
      - ◆ Does not confer privilege or prescriptive authority; develop = plan, recommend
  - ◆ RD may accept and transmit verbal and electronic orders for:
    - ◆ Nutritional/dietary treatments
    - ◆ Nutrition-related medical lab tests

## State Regulations

- ◆ State dietetic practice law: B&P Code 2585-86
  - ◆ "Upon referral"
    - ◆ Referral includes the MD signature, pt diagnosis, objective of dietary treatment (treatment plan or protocol) – the who/what/why
    - ◆ Referral is waived if the medical record reflects the pt diagnosis and a therapeutic diet order is written
  - ◆ Medications/pharmaceutical agents are excluded, since they are not mentioned.
    - ◆ RD cannot order (by protocol or verbal order process)
    - ◆ Vitamins, minerals, insulin/diabetic meds, phosphate binders, parenteral nutrition/agents

## State Regulations

- ◆ State Health Care Licensing and Certification regulations (Title 22, Division 5) - serves to fine-tune the federal regulations
- ◆ Dietetic Service General Requirements (70273)
  - ◆ Food quality/quantity to meet patient needs in accordance with physician order
  - ◆ Policies and procedures need approval of Medical Staff, administration, and Governing Body
  - ◆ Current diet manual must be used as the basis for diet orders and planning modified diets
    - ◆ Approved by the dietitian and Medical Staff
    - ◆ Available at each nursing station

## State Regulations

- ◆ State Health Care Licensing and Certification regulations (Title 22, Division 5)
  - ◆ Dietetic Service General Requirements, cont.
    - ◆ Therapeutic diets are planned, prepared and served as prescribed by an authorized practitioner
    - ◆ Nutritional Care – RD documents in the medical record and in the patient care plan
    - ◆ Food service standards...
  - ◆ Dietetic Service Staff (70725)
  - ◆ Governing Body (70701)

## Scope of Dietetics Practice Framework

- ◆ Definition: A flexible decision-making design or construct to be used by RDs to determine their **individual** scope of practice
- ◆ Developed for the profession to:
  - ◆ Outlines (structure) all components that together describe the FULL RANGE of safe, sanctioned dietetics practice – what we do as RD/DTR
  - ◆ Provide a process to help the RD methodically work with professional tools and resources
  - ◆ JADA, April 2005

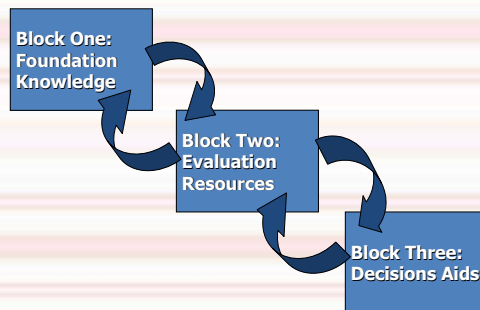
## Scope of Dietetics Practice

- ◆ Assumptions:
  - ◆ Level of education/training, experience, and skills in practice activities *varies among individuals*.
  - ◆ Individual dietetics practitioners may not be competent to practice in all aspects of the field.
  - ◆ Individual practitioners are expected to practice only in areas and at levels in which they are competent.
  - ◆ Practitioners should pursue additional education and experience to expand the scope of *their* dietetics practice.

## Scope of Dietetics Practice Framework

- ◆ Framework is arranged in “Blocks”:
  - ◆ Block 1 = Foundation Knowledge:  
Defines Dietetics as a Profession – outlines the Core *Characteristics* of the RD and DTR
  - ◆ Block 2 = Evaluation Resources:  
Spotlights Core *Standards* that guide the RD and DTR to ensure safe and effective dietetics practice
  - ◆ Block 3 = Decision Aids  
Provides tools to RDs and DTRs to determine whether a specific service or role falls within their individualized scope of practice

## Three SODPF Building Blocks



## Scope of Dietetics Practice Framework

### Block 1 = Foundation Knowledge

- ◆ Lists information and resources all RD and DTRs should know based on formal education/training
- ◆ Outlines the 5 unique characteristics of the RD & DTR:
  - ◆ ADA Code of Ethics
  - ◆ Body of Knowledge (sciences, management, public health, communication)
  - ◆ Education requirements & credentialing by CDR
  - ◆ Autonomy (critical thinking skills, professional development responsibility and accountability)
  - ◆ Service (provision of food/nutrition services; using evidence-based guidelines)

## Scope of Dietetics Practice Framework

### Block 2 = Evaluation Resources:

1. Standards of Practice (SOP)
  2. Standards of Professional Performance (SOPP)
- ◆ Intended for use in conjunction with federal and state regulations and state practice acts
  - ◆ The RD and DTR can use these resources to:
    - ◆ Determine if an activity falls within the RANGE of safe, sanctioned dietetics practice
    - ◆ Conduct performance evaluations
    - ◆ Make hiring decisions
    - ◆ Initiate regulatory reform

## Scope of Dietetics Practice Framework

### Block 2 = Evaluation Resources

- ◆ **ADA Standards of Practice** – Outline responsibilities of the RD or DTR, as related to elements of the Nutrition Care Process
  - ✓ Delineated for different Levels of Practice
    - ◆ Generalist
    - ◆ Specialty
    - ◆ Advanced
  - ✓ General and Area-specific Standards of Practice:
    - ◆ Diabetes Care
    - ◆ Nutrition Support
    - ◆ Behavioral Health
    - ◆ Oncology

## Scope of Dietetics Practice Framework

### Block 2 = Evaluation Resources (continued)

1. **ADA Standards of Professional Performance**
  - ✓ Describe competent level of behaviors that characterize professional roles (RD, DTR)
    - ◆ Provision of Service
    - ◆ Application of Research
    - ◆ Communication and application of Knowledge
    - ◆ Utilization and Management of Resources
    - ◆ Continued Competence
    - ◆ Professional Accountability
  - ✓ Delineated for: Generalist, Specialty, and Advanced Practice RD

## Scope of Dietetics Practice Framework

### Framework Blocks:

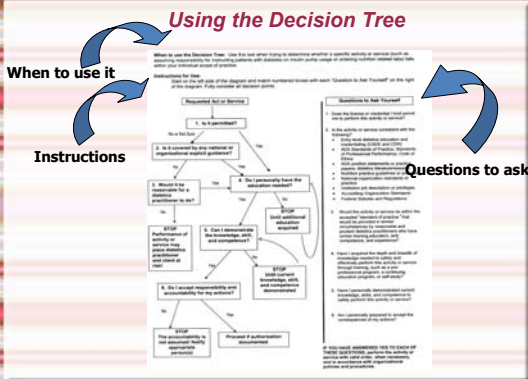
- ◆ Block 3 = Decision Aids
  1. Decision Tree
  2. Decision Analysis Tool
- ◆ Help RDs and DTRs answer whether a role or activity falls within the legal/regulatory and practice boundaries
  - Yes/No Decision Tree: is it legal for me to do this and do I have the training, skill and competence?

## Scope of Dietetics Practice Framework

### Block 3 = Decision Aids

#### Decision Tree (JADA, April 2005 - pg. 640)

- ◆ Is the activity or role permitted by my credential, title, and license (i.e. are there regulatory or legal restrictions)?
- ◆ Is it covered by explicit national or organizational guidance/guideline/policy?
- ◆ Would it be reasonable & safe for an RD/DTR to do?
- ◆ Do I personally have the education needed?
- ◆ Can I demonstrate the knowledge, skill and competence?
- ◆ Do I accept the responsibility and accountability inherent in performing this activity or service?



## Scope of Dietetics Practice Framework

### Block 3 = Decision Aids

#### Decision Analysis Tool (help to build your proposal)

- ◆ General Review (Describe the activity or service and the practice expectations; review SOP and SOPP for individual practice level, check state practice code)
- ◆ Education/Training (Are you competent to do \_\_\_\_?) and Credentialing/Privileging (Does your employer permit you to perform the service?)
- ◆ Existing Documentation (Do national guidelines, the state practice act, SOP, professional position statements, etc. support you to perform the activity or service?)
- ◆ Advisory Opinion (Can you obtain advisement from the hospital governing body or from ADA to perform this service or activity if the above are all uncertain?)

## Scope of Dietetics Practice

### Scope of Dietetics Practice Framework

- ◆ Block 3 = Decision Aids
- ◆ **Supporting Documentation** to use with Decision Aids:
  - ✓ **Credentials:** CDR credentials, Specialty certificates, Advanced Practice certifications, Advanced degrees
  - ✓ **Individual CDR Professional Development Portfolio:** Learning Plan and Learning Activities Log
  - ✓ **Evidence Based Practice:** Existing research and literature, ADA position and practice papers, Ethics opinions, Nationally-developed guidelines, ADA Guides for Practice
  - ✓ **Practice Based Evidence:** Dietetics practice outcomes research
  - ✓ **Organizational Privileging:** Clinical Privilege policies

## Scope of Dietetics Practice

### ◆ Summary:

- ◆ Your Scope of Practice is Determined by:
  - ✓ Federal and state laws & regulations
  - ✓ Standards of Practice and Professional Performance (SOP and SOPP)
- ◆ Your Scope of Practice Impacts:
  - ✓ Institutional policies, protocols, privileging
  - ✓ Individual professional responsibility and accountability
- ◆ Intended to develop and evolve based on YOUR role, YOUR professional education/training & YOUR competence
- ◆ Expected to respond to changes in the health care environment that impact dietetics practice

### **Recent Questions Asked by California RDs**

- ◆ Question: Is it true that anything the RD adds to the patient's diet (oral supplement, milkshake, nourishment, protein-fortified food) goes beyond the diet order and needs an MD order?
- ◆ Answer: Depends on the diet manual.
  - ◆ Diet manual provides the blueprint for the diet order (daily calorie, protein, nutrient provision; foods allowed/not allowed, including specialty food products; nourishment, snack and alternate meal options).
  - ◆ Role of the RD, in delivering nutrition care to the patient, to fulfill the expectations of the diet order, without exceeding or conflicting with the it.
  - ◆ Assumes sufficient monitoring to revise the plan as needed.

### **Recent Questions Asked by California RDs**

- ◆ Question: If the patient requests a different diet (i.e. low salt or mechanical soft) can we send them the menu they request or do we need a new diet order?
- ◆ Answer: If the request is 1-time only, then it falls into "patient rights," honoring their request. If the request is intended for the duration, and it makes sense in the scheme of the nutritional care of the patient, a new diet order is needed. The new order would prompt the correct menu to be sent to the patient daily. It represents a new [treatment] plan.

### **Recent Questions Asked by California RDs**

- ◆ Question: For dietitians pursuing clinical privileges, can the Clinical Nutrition Manager serve as the designated person to evaluate the RD's qualifications and competency for the specific practice activities?
- ◆ Answer: Will be a decision of the Governing Body and Medical Staff at the facility level (risk assessment); CNM would have to be deemed competent to be delegated to evaluate on behalf of the Medical Staff.

### **Recent Questions Asked by California RDs**

- ◆ Question: Since dietitians and doctors are not the only practitioners dealing with patient diet orders (OT, SLP and nurses do also), are the others held to the same standards?
- ◆ Answer: The standards are expected to be the same for all. Many of these non-physician practitioners have not taken the clinical privileging route, but may be operating under approved protocols. Protocols must be criteria-driven, ordered for the specific patient by the practitioner responsible for the patient's care, and any/all resultant orders must be co-signed.

### **Concluding Remarks**

- ◆ The pursuit and development of new practice skills in the field of nutrition and dietetics must occur hand-in-hand with pursuit of knowledge regarding health care-related regulations and professional standards.
  - ◆ Credentials and competence alone are not sufficient to permit advanced level practice.
  - ◆ Approval by your facility administration and/or Medical Staff is not sufficient to permit advanced level practice.
  - ◆ Practice privileges are granted through a process dictated by CMS
  - ◆ If your facility agrees that the value of RD clinical privileging is equal to or outweighs the cost, use the scope of practice framework to lead the way.

### **Concluding Remarks**

- ◆ Use the ADA Standards of Practice and Standards of Professional Performance (general or area-specific) as guides for acceptable practice tasks/activities
  - ◆ Routine activities – no privileging needed, as long as the responsibilities are within legal scope of practice
  - ◆ Form the basis of job description and required competency
- ◆ Use available resources:
  - ◆ CDA Professional Practice Task Force ([www.dietitian.org](http://www.dietitian.org))
  - ◆ ADA Quality Management web page/links (found in the Practice section of [www.eatright.org](http://www.eatright.org))

### ***Concluding Remarks***

- ◆ Quote from California HealthCare Foundation Issue Brief, March 2008:

When healthcare practitioners are not being used to their full capacity in terms of their education, training, and competence, systematic inefficiencies inevitably occur. These inefficiencies may manifest themselves in higher costs, insufficient access to practitioners, and concerns over quality and safety.

### ***Scope of Practice and Clinical Privileging for Dietitians***

Email questions:

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