

Clinical Privileging for Registered Dietitians: A Regulatory Perspective

The Centers for Medicare & Medicaid Services (CMS) and the American Dietetic Association (ADA) are fielding inquiries from concerned registered dietitians (RDs) for information related to the white paper on therapeutic diet orders (1). The federal regulation at issue is 21 CFR §482.28 (b)(1), “Therapeutic diet orders must be prescribed by the practitioner or practitioners responsible for the care of the patient.”

In the white paper, the following phrase is repeated: “a qualified RD acting within their hospital-granted privileges and scope of practice.” The intent of this article is to provide information to assist qualified RDs in seeking clinical privileges in their facilities.

WHO IS THE QUALIFIED RD?

According to the CMS, the qualified RD is a person who:

- is licensed or certified by the state(s) in which they practice;
- meets state hospital licensing requirements for qualified dietitian;
- meets the hospital’s job description requirements for clinical dietitian;
- is working within their individual scope of practice; and
- has training and skills verified and documented, including an evaluation of their competence to perform the task(s) for which they are seeking privileges.

ADA’s Scope of Dietetics Practice Framework is a tool every RD should use to determine if writing therapeutic diet orders or some other medical

or surgical procedure is within their own scope of practice (2). The framework assists RDs in identifying the various factors they should investigate that define and determine their scope. In addition to the Scope of Dietetics Practice Framework, RDs will also need to obtain, read, and know their facility’s state licensing regulations. In some cases, however, the states use the licensing standards in the CMS’ Conditions of Participation published online in the *State Operations Manual* (3).

DO I NEED TO READ FEDERAL AND STATE REGULATIONS IF MY FACILITY IS ACCREDITED?

Hospitals and other facilities will be deemed as meeting Medicare and Medicaid certification requirements if they are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission), the Healthcare Facilities Accreditation Program of the American Osteopathic Association, or other accrediting organizations that have standards that meet the federal Conditions of Participation and that have been granted “deeming” authority by the CMS (4). However, not all states recognize accreditation as meeting their state health care facility licensing regulatory requirements.

To be informed and prepared for discussions with hospital administrators, clinical nutrition managers and RDs should read the applicable CMS Conditions for Participation or Conditions for Payment, state professional practitioner and health care facility licensing regulations, and accreditation standards, as applicable to their employer.

WHY MUST AN RD BE PRIVILEGED TO WRITE DIET ORDERS?

The federal regulations have made diet prescription the physician’s re-

sponsibility. Therefore, it is considered a medical task. Furthermore, the states also assign this responsibility to physicians. However, this should not be surprising since state regulations are harmonious with and ought not to supersede federal regulations.

Some examples of state hospital licensing regulations that explicitly assign the responsibility of diet prescriptions to physicians are shown in the Figure (5-8). Frequently this regulatory requirement is stated in the food and dietary services section of the regulations; other times, it’s included with the physician’s responsibilities. Reading the regulations is the only way to know for certain. In addition, federal and state regulations for health care facilities other than hospitals, such as long-term care institutions, home health, and ambulatory care, also state that the physician must write the diet order, along with orders for medication, physical therapy, occupational therapy, and so forth.

WHAT ARE PRIVILEGES?

In general, “privileges” means the right to provide care to hospital patients in the area in which the practitioner has expertise as a result of education, training, and experience. For physicians to provide care, 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 and that those practitioners possess current qualifications and demonstrated competencies for the privileges granted. Legally, the hospital is responsible for the conduct of the hospital as an institution. Criteria must be developed and in place for determining the privileges that may be granted to individual practitioners, plus procedures for applying the criteria to individual privileges (9).

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State	Regulation	Statement
Arizona (5)	R9-10-227. Dietary Services	9. A medical staff member documents an order for a diet for each patient in the patient's medical record;
Georgia (6)	290-9-7-.23 Food and Dietary Services	(c) 3. Therapeutic diets shall be prescribed by the member of the medical staff responsible for the care of the inpatient.
Wisconsin (7)	HFS 124.16. Dietary services	(5)(b) Therapeutic diets shall be prescribed by the physician in written orders in the medical record.
New York (8)	Section 405.23 - Food and dietetic services	(c)(2) Nutritional needs of patients shall be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients.

Figure. Examples of state hospital licensing regulations that explicitly assign the responsibility of diet prescriptions to physicians.

The medical staff, as an entity, is responsible for the quality of patient care, for establishing bylaws, rules, regulations, policies, and so on for the medical staff and for overseeing the quality of care by all who provide a medical level of care or surgical procedures in the facility. Physicians can be privileged in only those categories within which they have been demonstrated to be competent and provide care in which the hospital supports. For example, a psychiatric hospital cannot privilege physicians to deliver babies if maternity care is not one of its services.

Part of the privileging process is a review of credentials, often referred to as "credentialing." But credentials alone are insufficient for privileging. The CMS advises that it cannot be assumed that a practitioner can perform every task/activity/privilege specified for a particular category. Each practitioner must be assessed to determine their ability to perform specific tasks and activities. Physicians who are privileged are eligible to become members of the medical staff.

According to the CMS, the medical staff must be composed of doctors of medicine or osteopathy and, in accordance with state law, may also be composed of other practitioners appointed by the governing body (9). These other practitioners may include, but are not limited to dentists, podiatrists, chiropractors, advanced practice registered nurses (nurse practitioners and nurse

midwives), certified registered nurse anesthetists, physician assistants, psychologists, licensed clinical social workers, optometrists, etc. The governing body must determine which categories of practitioners (ie, doctors of medicine or osteopathy, nurse practitioners, physician assistants, midwives, etc, who, in accordance with state law, may be granted active, courtesy, emergency, or temporary privileges in the hospital) are eligible for membership to its medical staff, as well as which categories or practitioners are not allowed membership on the medical staff, but are eligible for privileges.

Not all nonphysician practitioners with privileges would necessarily be members of the hospital's medical staff. Furthermore, the privileging process for physician assistants, nurse practitioners, and other allied health mid-level professionals is not required to be exactly the same as for physician practitioners (10). However, the medical staff must conduct appraisals of individual practitioners no less frequently than 24 months or sooner if state laws require more frequent appraisals for continued or revised privileges. Among the competencies appraised is current quality of practice, additional training, patient outcomes, ongoing current credentials, and more. However, credentials alone cannot be used as the only measure on competence for continued or revised privileges.

WHAT SHOULD RDs TAKE INTO ACCOUNT WHEN CONSIDERING CLINICAL PRIVILEGES?

For an RD to be privileged, there are several matters that should be well thought-out. RDs should:

- determine their personal scope of dietetics practice by using the Scope of Dietetics Practice Framework;
- identify current training, credentials, and experiences that are relevant, or need to be obtained to conduct the procedures competently and safely;
- find out what policies and procedures their facility follows for privileging nonphysician professional staff;
- understand the unwritten culture of the facility;
- if the facility is accredited, review the accreditation standards;
- obtain and review a copy of the state licensure rules and regulations for the specific category of facilities (conduct term searches for words such as 'privileging,' 'dieti' [yes, 'dieti,' since it will pull up most any spelling for dietitian or dietician], 'orders,' etc);
- determine the medical services or surgical procedures for which clinical privileges are being sought;
- confirm with your facility which procedures, such as therapeutic diet prescriptions, require privileging to ensure the facility's resources are conserved;
- provide a rationale, supported by data, why granting the privileges would benefit the quality of care and safety of the patients and positively impact resource management;
- arrange for an assessment of competence, including observation and evaluation of specific tasks (if another qualified RD is not available to conduct the appraisal, ask one of the physicians who is held in high regard by the medical staff);
- speak with administrators in charge of risk management, quality management, or regulatory compliance to identify any other local or state requirement for clinical privileging;
- determine what your application packet should contain for medical

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staff review and whether a sponsor is required;

- follow-through with any other facility requirements.

The specific procedures to follow and the final decision rest with the facility, which assumes the risk and has the legal responsibility for safe and quality patient care. With 50 states and other districts and territories, in addition to roughly 5,700 hospitals and 14,800 long-term care facilities, it is impossible to responsibly provide an exact formula for obtaining clinical privileges (11,12).

The more the RD is informed and prepared, the better the impression on the medical staff and administration.

References

1. American Dietetic Association. §482.28 Conditions of Participation: Food and Dietetic Services Interpretive Guidelines for Therapeutic Diet Orders [white paper]. Available at: http://www.eatright.org/ada/files/Therapeutic_Diet_Order_White_Paper_083006.pdf Accessed January 28, 2007.
2. O'Sullivan Maillet J, Skates J, Pritchett E. American Dietetic Association: Scope of Dietetics Practice Framework. *J Am Diet Assoc.* 2005;105:634-640.
3. Centers for Medicare & Medicaid Services. *State Operations Manual*. Available at: <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019027&intNumPerPage=10>. Accessed January 28, 2007.
4. The Joint Commission. Federal deemed status and state recognition. Available at: http://www.jointcommission.org/StateFederal/deemed_status.htm?HTTP___JCSEARCH.JCAHO.ORG_CGI_BIN_MSMFIND.EXE?RESMASK=MssResEN.mskhttp%3A/jcsearch.jcaho.org/cgi-bin/MsmFind.exe%3Fhttp%3A/jcsearch.jcaho.org/cgi-bin/MsmFind.exe%3FRESMASK%3DMssResEN.msk Accessed January 28, 2007.
5. Arizona Secretary of State Web site. Arizona Administrative Code: Title 9. Health Services: Chapter 10. Department Of Health Services

Health Care Institutions: Licensing: Article 2. Hospitals. Available at: http://www.azsos.gov/public_services/Title_09/9-10.htm. Accessed January 28, 2007.

6. Georgia Department of Human Resources, Office of Regulatory Services. Rules of Department of Human Resources Office of Regulatory Services: Chapter 290-9-7: Rules & Regulations for Hospitals. Available at: <http://ors.dhr.georgia.gov/portal/site/DHR-ORS/menuitem.f415af4c87614a608e738510da1010a0/?vgnnextoid=1b490a1681010010VgnVCM100000bf01010aRCRD&vgnnextchannel=ad1687b611a00010VgnVCM100000bf01010aRCRD>. Accessed January 28, 2007.
7. Wisconsin State Legislature Web site. Wisconsin Administrative Code: Health and Family Services: HFS 124.16 Dietary services. Available at: <http://www.legis.state.wi.us/rsb/code/hfs/hfs124.pdf>. Accessed January 28, 2007.
8. New York Code of Rules and Regulations: Title 10, New York State Department of Health. Volume C, Chapter V—Medical Facilities, Subchapter 1, Medical Facilities—Minimum Standards, Article 2. Hospitals. Part 405—Minimum standards. Available at: <http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm>. Accessed January 28, 2007.
9. Hamilton T. Letter to State Survey Agency Directors. Centers for Medicare & Medicaid Services (CMS) Requirements for Hospital Staff Privileging. Ref: S&C-05-04. November 12, 2004.
10. Wallace TE, House S. Credentialing and privileging from the medical staff point of view. Teleconference presented by: Joint Commission Resources. Oak Brook, IL: October 25, 2005.
11. US Census Bureau. *2007 Statistical Abstract*. Table 162. Hospitals—Summary Characteristics: 1980 to 2004. Available at: <http://www.census.gov/compendia/statab/tables/07s0162.xls>. Accessed January 31, 2007.
12. US Census Bureau. *2007 Statistical Abstract*. Table 160. Skilled Nursing Facilities: 2004. Available at: <http://www.census.gov/compendia/statab/tables/07s0160.xls>. Accessed January 31, 2007.