Future Dimensions

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A Message From the Chair

Caroline Steele,
MS, RD, CSP, IBCLC
CNM DPG Chair, 2015-2016

Happy New Year, CNM Members! I want to take this opportunity to personally welcome each of you to the new year for our DPG. While many are still relaxing and enjoying the dog days of summer, the CNM Executive Committee is already hard at work preparing for exciting things to come. The start of the new year is a great time to take stock and remind everyone of the benefits available to CNM members. From the robust discussions on our electronic mailing list to the newsletter, from our informational webinars to the annual symposium—you have tools, resources, and networking opportunities right at your fingertips. Take time to utilize our great resources and consider sharing some of your own!

- CNM DPG website
  Access member's-only information using your Academy log-in and password. Check back often for news and added resources. Find us at www.cnmdpg.org
- Electronic Mailing List (EML)
  A great way to stay connected and reach out to your peers to discuss current challenges and solutions. It's easy to subscribe through the CNM website!
- Future Dimensions Newsletter
  The CNM quarterly electronic newsletter is a great way to stay informed and earn a free CEU. Because our editors are always looking for new and relevant articles, consider being an author and getting your great ideas published!
- Annual CNM Symposium
  Held annually in April, the Symposium is an excellent opportunity to stay current on the latest topics and network with colleagues. We are currently negotiating a contract with the hotel, so stay tuned for details regarding the 2016 Symposium!
- Quality and Process Improvement (QPI) Sub-Unit
  Free to CNM members, this subunit connects those with an interest in quality and process improvement to network, share ideas, and enhance their own knowledge and skills in this arena. This subunit hosts its own EML and supports a quality improvement poster session at the CNM Symposium.

Inside this issue:

Attending FNCE®? Join us for the **CNM Member Reception** Monday, October 5th from 6:00-8:30 at the Omni Hotel!

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Our DPG belongs to our members. If you have suggestions or ideas on how we can better serve our membership, please don't hesitate to contact me. I hope to meet as many of you as possible during the coming year. If you will be attending FNCE®, please join us at the CNM Member Reception on Monday, October 5th from 6:00-8:30 pm (Omni Hotel, Room Cumberland 4).

Be on the lookout for details about our spring Symposium and consider submitting a presentation proposal or a quality improvement poster to share your best practices with our members.
With that, I invite you to join me for the exciting ride ahead with CNM! (And be sure to enjoy a few of those lazy days of summer. Now where did I put that beach chair….)

Caroline Steele, MS, RD, CSP, IBCLC
CNM DPG Chair, 2015-2016

One free CPEU available to CNM DPG members!

1. Read the article titled "Implementation of Order Writing Privileges in Acute Care Hospitals" by Wendy Phillips, Edye Wagner, Jennifer Reiner and Gisele LeBlanc
2. Log on to the CNM DPG website at cnmdpg.org
3. Go to the member's only section and click on the link for the CPE Exam
4. Take the exam; your CPE certificate will be emailed to you within one week

This article has been approved for 1 CPE, Level 2; Learning Needs Codes 1010, 1070, 7100, 7180. The test will remain available for three years after the publication date of this edition of Future Dimensions in Clinical Nutrition Practice (July 31, 2015).

Visit us at the CNM DPG website—cnmdpg.org. Available resources include:

- Searchable member directory
- Resource library
- The DPG's guiding principles and strategic plan
- The Standards of Professional Performance for Dietitians in Clinical Nutrition Management
- Newsletter archives
- CNM annual report to members
- Eblast archives
- Information on the Informatics and Quality and Process Improvement (QPI) subunits
- Sign up for the CNM electronic mailing list (EML)
- Sign up for the QPI EML—in the members only section, click on the Subunits tab, then QPI
- Update your CNM profile—click on Edit Your Profile in the Member Info section

For additional information, contact us at: ClinicalNutritionMgtDPG@gmail.com

Interested in contributing an article to the newsletter? Topics of interest include leadership, management, innovations in clinical practice, research and outcomes, nutrition legislation and public policy, reimbursement and coding, informatics, healthcare reform, and many others. If interested, please contact an editor.

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Implementation of Order Writing Privileges in Acute Care Hospitals

By Wendy Phillips, MS, RD, CNSC, CLE, FAND; Edye Wagner, RD, LDN, CDE; Jennifer Reiner, MS, RD, LD; and Gisele LeBlanc, MS, RD, LDN, CNSC, FAND

In response to President Barack Obama's executive order in January 2011 for federal agencies to reduce unnecessary and burdensome regulations[1], the Centers for Medicare and Medicaid Services (CMS) issued a final rule enabling registered dietitian nutritionists (RDNs) in acute care and critical access hospitals to become privileged to independently order therapeutic diets effective July 11, 2014[2]. For now, this rule change ONLY applies to hospitals and critical access hospitals, not long term care facilities or other care settings as they are governed by a different set of Conditions of Participation (CoP). The Academy of Nutrition and Dietetics is working diligently with CMS to get this privilege expanded to these care settings. For RDNs and nutrition professionals, this privilege enhances our ability to provide timely, cost-effective, and evidence-based nutrition services to our patients by reducing the burden of waiting for physicians to make requested changes in the medical record. It also places additional responsibility and liability on the RDN resulting from independently ordering nutrition care for the patient. Table 1 compares the new wording of the CoP "Food and Dietetic Services § 482.28(b)" with the old wording; the relevant addition is "all patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or other clinically qualified nutrition professional as authorized by the medical staff and in accordance with State law[2]". This new language eliminates the previous requirement that physicians or another licensed independent practitioner (LIP) write all diet orders.

The RDN may also write orders for enteral and parenteral nutrition support as CMS considers "all patient diets to be therapeutic in nature, regardless of the modality used to support the nutritional needs of the patient[2]." The finalized rule does not specifically include privileges for ordering labs or other diagnostic services by nutrition professionals, but does not state that these cannot be ordered by a RDN. As published in the Federal Register on May 12, 2014[2], CMS is now allowing individual hospital governing boards to decide which orders may be written by RDNs in their facilities. The scope of the RDNs' privileges

Table 1. Condition of Participation for Acute Care Hospitals 42 C.F.R. §482.28(b)

Wording for regulation prior to July 11, 2014	**Regulation:** Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the patient. **Interpretive Guidelines:** Therapeutic diets *must* be: Prescribed in writing by *the* practitioner *responsible for the patient's care*; Documented in the patient's medical record (including *documentation* about the patient's tolerance to the therapeutic diet as ordered); and Evaluated for nutritional adequacy. *In accordance with State law and hospital policy, a dietitian may assess a patient's nutritional needs and provide recommendations or consultations for patients but the patient's diet must be prescribed by the practitioner responsible for the patient's care.*
Wording for regulation effective July 11, 2014	**Regulation:** All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or other clinically qualified nutrition professional as authorized by the medical staff and in accordance with State law.

must be delineated by each hospital's privileging policy and only applies to patients admitted to that hospital.

Observation patients in an acute care hospital are treated in accordance to the hospital standards, but are considered outpatients for billing and financial purposes. Laboratory orders generate charges that are tied to the ordering LIP. This may require a provider NPI number or the order input as a telephone/verbal order after discussion with the physician. Work with your patient billing staff to assure the hospital's compliance to billing procedures.

In the comments from the Federal Register[2], CMS outlined the privileging process for qualified dietitians in hospitals. Hospitals will have the flexibility to either grant specific nutrition ordering privileges by appointing RDNs to the medical staff, or to authorize ordering privileges without appointment to the medical staff, all through the hospital's appropriate medical staff rules, regulations, and bylaws. The required and essential medical staff oversight of RDNs and their ordering privileges will be ensured by following either of these processes.

The ability to implement independent nutrition order writing privileges (OWPs) is also dependent on each state's professional licensure regulations and/or the absence of restrictions to this privilege. For example, both Illinois[3] and Virginia[4] have hospital licensing regulations addressing patient diet orders with which hospitals and RDNs must be compliant. State laws governing other healthcare professions must also be considered, such as state pharmacy laws that may affect pharmacies accepting RDN orders for parenteral nutrition support. The Academy of Nutrition and Dietetics (AND) has published a state by state guide of laws and regulations that should be considered in addition to the CMS CoP[5], but this might not be an exhaustive list. Generally, the legal counsel for the hospital can help understand if additional rules, regulations, or laws can affect privileges being requested. Other Academy publications include practice tips for hospital regulations; these resources along with the state by state guide may be accessed on the Advocacy page of the EatrightPro website[6]. Watch for changes in state regulations that relate to this change in CMS rules.

The purpose of this article is to provide guidance for effectively implementing OWPs once all federal and state laws have been reviewed and addressed. Commonly used terminology and definitions are provided to guide this process. The following terms are sometimes used interchangeably but carry slightly different meanings.

Credentialing (Organization)[6]
A defined process within an organization where a practitioner's credentials are reviewed to determine if they possess the required experience or qualifications to obtain admission to the medical staff. Hospitals often include a careful evaluation of professional education, clinical training, licensure, board and other certification, clinical experience, letters of reference, other professional qualifications, and disciplinary actions. The practitioner will be re-evaluated on a regular basis, usually every 1-2 years.

Credentialing (Professional) [6]
A professional agency which establishes standardized criteria and grants formal recognition to practitioners that have met these criteria. For example, the Commission on Dietetic Registration (CDR) is responsible for ensuring that RDNs and DTRs are registered and maintain an acceptable level of continuing education.

Privileging[6]
The practice by which a practitioner has been given permission or "privileges" to engage in specified clinical activities by the credentialing committee.

Clinical Privileges[6]
Authorization that has been granted to a practitioner by the credentialing committee to provide specific care or treatment within well-defined limits, based on the practitioner's license (if applicable), professional scope of practice, education, training, experience, judgment, and demonstrated and documented competence.

Competence[6]
A determination of an individual's capability to perform up to defined expectations. The Academy defines competence as a principle of professional practice, identifying the ability of the provider to adminis-

ter safe and reliable services on a consistent basis. The Academy further states that "a professional that is competent uses up-to-date knowledge and skills; makes sound decisions based on appropriate data and communicates effectively" with others. The clinical nutrition manager should review the Standards of Practice (SOP) and Standards of Professional Performance (SOPP)[7] which establishes the minimum level of competence for RDNs.

Competency[6]

AND defines this term as "a synthesis of knowledge, skills, abilities, behaviors and other characteristics an individual must demonstrate in order to perform their role[7]." Clinical managers are charged with assuring that their dietitians are competent and their skills are in accordance with granted privileges. Competency monitoring should be an ongoing and annual process for all RDNs in the hospital setting, with or without order writing responsibilities.

Several steps that can be planned and implemented concurrently are required to implement OWPs for RDNs in the hospital, the minimum of which are listed in Table 2. Privileges are not granted to a group of RDNs; rather, each individual RDN determines his/her individual competency for writing certain nutrition orders, and then applies for these privileges to the facility's clinical nutrition manager (CNM). Once deemed competent by the CNM using the facility's established process, the CNM recommends privileging of that specific RDN to the hospital's governing board according to the process approved by that board.

Establishing Support for OWPs for RDNs

The federal regulations were originally drafted as a response to promote efficiency, transparency, and burden reduction[1] while allowing hospitals greater flexibility to determine processes that work best in their care settings. Therefore, RDNs should demonstrate the effect of RDN OWPs to meet these goals. Examples of quality assurance and performance improvement (QAPI) projects that may be completed and submitted as evidence of the need for privileges are listed in Table 3. It is important to demonstrate the impact of such activities and results on patient satisfaction and/or quality outcomes.

The clinical nutrition team should seek support from hospital physicians, clinical pharmacy, and nursing prior to requesting privileges from the Credentialing Committee and the hospital governing board (usually referred to as the Medical Executive Committee or Clinical Staff Executive Committee). As the hospital governing board represents the clinicians at the hospital, most members will ask the LIPs who are currently responsible for writing nutrition orders if they support sharing that responsibility with the RDNs. It is helpful to have 1-2 physicians who are additionally willing to champion the proposal by submitting the request along with the CNM. A standardized letter briefly explaining the change in federal regulations and addressing state specific information if relevant can be used to request their signature of support. Information related to logistics of these functions at that hospital should be included. An example of such a letter is shown in Figure 1. Often, the governing board will request guidance

Table 2. Minimum steps required for order writing privilege implementation.

Step	Example activities
Establish support	Share results of quality assurance and performance improvement projects demonstrating need for RDNs to write nutrition orders Meet with the hospital's legal counsel Gain multidisciplinary support Obtain committee approvals
Determine competency assessment program (initial and ongoing)	Knowledge based competencies Practice based competencies
Policy Development	Organizational / facility policy Departmental policy

QAPI Project	Issue Addressed	Description
Efficiency of parenteral nutrition (PN) orders	Efficiency	Track number of phone calls needed by RDN and/or pharmacist to LIP before PN order finalized, and the length of time between RDN determining order and actual order implementation
Compliance with RDN recommendations	Quality of care	Track the number of RDN recommendations ordered by the LIP versus the total number of recommendations made.
Physician contacts made	Burden	Track the number of times the LIPs have to be contacted by the RDN via pager, phone call, or in person to implement nutrition orders.
Timeliness of nutrition intervention	Efficiency	Track the average time between RDN determination of needed nutrition intervention to actual intervention occurring.
Verbal / telephone orders	Efficiency	Track reduction in verbal/telephone orders written by RDNs and/or track reduction in number of verbal/telephone orders which go unsigned
Clarification of diet orders	Efficiency	Track time spent clarifying and/or correcting diet orders that are written inaccurately by providers other than RDNs.
Parenteral nutrition use	Efficiency, stewardship	Track reduction in inappropriate use of parenteral nutrition.

Table 3. Example quality assurance and performance improvement projects to justify RDN OWPs.

from the hospital's legal counsel, so it is recommended that the CNM first meet with them. The text of the Federal Register from May 12, 2014[2] should be shared as well as any state specific regulations. This should be an investigative meeting, in which the CNM asks advice from the legal counsel for any additional state or facility specific regulations that may affect this privileging process. It is wise to meet with key members of the credentialing committee individually to discuss the process and gain support prior to presenting to the entire committee. Often, the chairperson for the committee and the medical director who oversee the credentialing process will be willing to help the CNM and RDNs determine the best way to achieve order writing privileges within the existing framework in the hospital.

Policies

In addition to establishing order writing privileges for individual RDNs based on demonstration of competency, the organization will need a policy to guide the implementation of this privilege. If the organization chooses to add dietitians to the medical staff as LIPs, the scope of practice, the requirements for staff privileges, and other specifications should all be listed in the organizational policy. The policy may look very similar to other practicing LIPs, but the scope of practice will differ. If the organization chooses to grant order writing as part of the dietitians' clinical privileges without appointing them to the medical staff, a policy is also necessary to define the scope of practice and the different levels of privileges. The policy may look similar to those for other hospital mid-level care staff, such as nurse practitioners, but differ in the scope of privileges. The organizational policy should be written in collaboration with the organization's director of professional staff or similar position and/or director of compliance, regulation or accreditation. In addition, the organization's legal counsel should guide and approve the policy. This policy will need to go through the organization's channel for approval which may include any nutrition reporting committee such as Pharmacy and Therapeutics, with final approval granted by the Medical Executive Committee or equivalent. This will differ based on each organizational structure and by-laws.

In addition to an organizational policy outlining dietitian order writing privileges, there must be department specific policies that establish the procedures, define the different levels of privileges including exactly which orders or classes of orders may be written by the RDN, and delineate how competency will be established and monitored. The policy needs to outline the CNM's and the RDNs' responsibilities

Nutrition Order Writing Privileges for Registered Dietitians Nutritionists
Request for Letter of Support

Effective July 11, 2014, registered dietitians nutritionists (RDNs) can write independent nutrition orders in the hospital if authorized by the medical staff at the hospital per CMS Condition of Participation 482.82(b). RDNs need to be credentialed by the hospital to write orders for therapeutic diets, which includes oral, enteral, and parenteral nutrition support. RDNs may also write orders for labs related to the nutrition care of the patient (verify state specific regulations). Hospitals are not required to allow this, but the regulation makes it clear they may do so if they desire.

We are in the process of formally requesting these privileges at _____ (hospital), and are presenting to the Medical Executive Committee (change name of committee if needed) on _____ (date). They have asked for a list of physicians who support RDNs having order writing privileges for nutrition-related orders. It is important to note that privileges are granted to dietitians individually based on demonstrated competence and the physicians can always cancel an order written by the RDN if they would like to change the nutrition care plan.

Please respond to let us know if we may add your name to the list of physicians who support this. If you have any questions before making this commitment please contact _____ (CNM) at _____ (email address and phone number).

Figure 1. Sample Letter of Support request.

in the process. The approved methods for communicating any orders with physicians and healthcare team members must also be included in the policy. The OWP policy guides practices and is a benchmark for performance evaluation for the RDN staff.

Competency Assessment

Competency levels for dietitian order writing should align with the Academy's Scope of Practice, Standards for Professional Practice[7], and the clinician's skill level and certifications. New staff should not be granted order writing privileges at hire. All staff must prove competency, or show that they consistently practice at a specific level before being allowed to place independent orders. That waiting time may vary based on department specific or organizational policy, or the need to go through the hospital application process for privileging. State licensing, if applicable, can also guide requirements for specific levels of practice.

Initial competency assessment should be based on the CNM's evaluation of the RDNs practice, and the clinician's experience, skills, education, and certifications. Competency can be determined through both knowledge and practice based assessments. An example of knowledge based competency assessment would be learning modules created from evidence based research and/or guidelines, with exams that test understanding of the material presented. An example of a practice based assessment would be chart reviews, where actual RDN documentation of patient care is compared against established standards. Another critical component of competency assessment involves observing the RDN's interactions with other healthcare team members as well as patients and their families to ensure accurate information is provided in a collaborative manner. Ongoing review of each RDN's practice to assure they are consistently providing care that meets or exceeds the requirements of their privilege level is required at least annually. If a RDN masters new skills or competencies, they can apply for a higher level of privileges. Specific competencies should be established for high risk, low volume types of patient situations, such as administration of a ketogenic diet plan or caring for a patient with an inborn error of metabolism.

Establishing the ladder of privileges can vary between organizations. Based on the AND's SOPs[7], three levels of competency are recommended. Level One may be considered a "Generalist"; this level of privileges may be appropriate for a dietitian who is consistently staffing a general medical/surgical floor with minimal enteral feedings, and/or a dietitian with less than three years of experience. The years of experience may be less of a determinant than the

practice level demonstrated. This level may allow the dietitian to modify diets, order oral nutrition supplements and basic nutrition related labs. The next level of privileges, Level Two or "Specialist", encompasses all of the level one privileges, plus additional demonstrated abilities such as initiating and modifying enteral feedings. Hospitals and nutrition departments may require different criteria for each level of practice, such as specific board certification or Master's degree. The "Advanced" level of practice, or Level Three, encompasses all of the level one and two privileges, and is for RDNs who consistently demonstrate advanced abilities, such as ordering or modifying parenteral nutrition support or more specific nutrition labs such as vitamin levels. This level of competency may require an advanced degree or board certification. Defining the specific privileges for the different levels of practice will vary between organizations and should be included in the policies that are approved by the medical organization. Table 4 shows sample privileges that may be granted to each of these levels.

Ongoing monitoring and evaluation of OWPs should be part of the chart review process. Specific questions assessing the accuracy of orders written by the RDN can be built in to the scheduled chart reviews, or a separate audit may be used to evaluate the orders on a specified time interval (usually a quarterly or annual basis). Table 5 contains an example audit for OWPs. The patient's response to care provided should be tracked periodically to support OWPs at the facility. If justification for OWPs involved QAPI projects quantifying amount of time or number of contacts required to implement nutrition interventions based on RDN recommendations, follow-up data should be collected and analyzed to determine if efficiency, and therefore stewardship of resources, has increased.

Conclusion

Approval by CMS for OWPs for RDNs in acute care and critical access hospitals will assure the provision of nutrition care in a timely and cost effective manner. Documentation of the provision of safe, quality

Table 4. Example OWPs at different levels. This is meant to provide examples and is not a comprehensive list of privileges that may be requested.

Level	Category of Privilege	Example of Privilege
Level 1 – Generalist	Diet order changes	Change a Regular diet to Heart Healthy diet Downgrade the texture of a diet
	Order oral supplements	Add liquid nutrition supplement for a patient who is not eating well
	Order anthropometric measurements	Daily weights Mid-arm circumference (in children)
	Order basic labs	Hepatic function panel, basic metabolic panel
Level 2 – Specialist	Include all Level 1 privileges	
	Order enteral nutrition (EN) support	Utilize standard order set for EN Make tube feeding rate changes
	Order labs	Serum levels of vitamins and minerals to determine if deficiency exists
	Order specialized infant feedings	Order calorie dense formulas for premature infants
Level 3 – Advanced	Include all Level 1 and 2 privileges	
	Order labs and exams	Fecal fat test, nitrogen balance studies
	Order parenteral nutrition (PN) support	Utilize standard order set for PN Customize macronutrients in PN solution to meet patient's needs
	Order nutrition-related medications	Order vitamins, minerals, and/or probiotics

MRN	Order Date	Order type (EN, PN, Oral, Lab, Med)	Order consistent with policy & privilege?	Is the order appropriate & necessary for the patient?	Did the RDN follow-up on the response to care?	Comments

Table 5. Example audit for OWPs. One form per RDN should be completed and filed in the competency assessment file for that RDN.

care by RDNs using these privileges will enable the expansion of these privileges to other care settings such as long term care facilities and dialysis centers. Clinicians are therefore encouraged to track their efforts using QAPI projects with an emphasis on burden reduction, increased efficiency and transparency, patient safety, and cost effectiveness, while also publishing the results of these QAPI initiatives from which others can emulate best practices.

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Wendy Phillips *recently left her role as the Director of Nutrition Systems at the University of Virginia Health System to take a position as a Corporate Director for Clinical Support for Morrison Healthcare. Wendy can be reached at wendyphillips@iammorrison.com.* ***Edye Wagner*** *is the Assistant Director of Clinical and Patient Services at Northwestern Memorial Healthcare in Chicago, and a Regional CNM with Morrison Healthcare.* ***Jennifer Reiner*** *is the General Manager for Morrison Community Living at Lieberman Center for Health and Rehabilitation near Chicago.* ***Gisele LeBlanc*** *is a Corporate Director of Nutrition & Wellness for Morrison Healthcare.*

The Evolution Of A Department Of Clinical Nutrition

By Beverly J.D. Hernandez, PhD, RD, LD/N

It is possible for a department to transform itself into something more dynamic than it was when it started. Such transformative feats are challenging because they involve deep change, the type that disrupts traditional practices, establishes new norms, and creates more meaningful performance initiatives. In particular, it requires the understanding that as leaders we have the ability to define new realities for others.

Recently, in recognition of the contributions of registered dietitians to the healthcare team and to positive patient outcomes, senior leaders at Tampa General Hospital agreed to form a new department: The Department of Clinical Nutrition Services. With this pivotal change of departmental structure, the director of clinical nutrition now reports to a senior vice president. It is the first time in the history of this 88-year-old nationally recognized hospital that Registered Dietitians were carved out of a traditional food service model to create an independent Department of Clinical Nutrition.

Our hospital leaders were already aware of the skyrocketing costs of preventable diseases and the wounds these can inflict on the financial status of hospital organizations. Therefore, timely, well-supported conversations related to the clinically effective, cost effective strategies of the RDs were embraced by these transformational leaders. The department director took the front line in articulating the success narratives of the clinical team to executive leaders, as well as clearly identifying the vision and role of The Department of Clinical Nutrition within the organization. They highly regarded our uniquely qualified staff of dietitians wh proved capable of deciphering the complexities associated with disease prevention and nutritional management through a history of early screening and prompt, appropriate intervention. Moreover, leadership support of our contemporary staffing structure, coupled with generous employer compensation, sent a clear message regarding the positive value placed on the services of RDs. This level of leader support served to fuel staff productivity and heighten employee engagement.

In our continuous quest for quality service we have learned a few things along the way that helped to position us as a new department:

- **Create knowledge from exploration:** As the pace of technology change sweeps across our hospital, our dietitians investigate and help lead the design/build of platforms and tools that increase our efficiencies. We now have a team of active informatics dietitians. This trend towards the analysis and application of Big Data in dietetic informatics continues the synthesis of new knowledge. This analysis and application of data has enabled us to effectively collaborate in the design and upgrade of our nutrition platform in the EMR, design and upgrade our electronic summary page, create RD notification of TPN orders simultaneously with pharmacy, create multiple smart texts, and ultimately led to IT hiring one of our dietitians who is on our informatics team.

- **“In God we trust, but to everyone else...show the data":** Having undeniable proof of a performance history of timely intervention, physician adoption of RD recommendations, skillful adoption and application of technologies that support interdisciplinary communication, and demonstrated continuity of care are among the performance acts that demonstrated our reliability as a clinical team.

- **Listen to the 'grown-ups' to increase your value:** We continue to determine what's important to the leaders (the grown-ups) in our organization, define our contribution to stated goals, and establish strategies that positively support organizational goals. This requires interactive, sensitive, communicative acts among a variety of disciplines. For example, when our CEO verbalized

the goal of building multiple healthplexes within the community, we supported that effort by creating an outpatient nutrition arm which received administrative support for staffing. We now provide nutrition services to outpatient transplants (liver, kidney, heart, lung, pancreas), to the outpatient cancer/infusion center and the CF clinic, among many other areas.

- **Create meaning and value**: Humans have an inherent desire to attach themselves to meaningful endeavors. We sought to increase staff engagement through purposeful acts. We created an RD communication council. At this council, dietitians continue to document the things that are critical to their practice that require improvement, or have even become obsolete. We collaborated with multiple disciplines and utilized existing technology to: (a) decrease the number of hours patients were NPO (b) more consistently obtain patient weights as ordered (c) ensure supplements were passed to patients and (d) identify and treat malnutrition.

Twenty-first century healthcare is not a gentle environment with its many upheavals and persistent change. Yet it is within this very atmosphere that the greatest opportunities exist for RDs to demonstrate their impact on positive health outcomes through effective and affordable forms of nutrition intervention. As contemporary leaders, we should connect with our hospital leadership culture, use the organizational direction to help guide our focus and define our contributions, and always be ready to tell our story.

Dr. Beverly J.D Hernandez is the Director of the Clinical Nutrition Department at Tampa General. She has been an innovative leader in the healthcare environment for more than 20 years. Her remarkable academic career demonstrates her commitment to healing and caring for ailments that afflict the success of human systems. She can be reached at beverlyhernandez@TGH.org.

CNM DPG Announcements

Quality and Process Improvement Sub-Unit Update

By Sherri Jones, MS, MBA, RDN, LDN, FAND

QPI Award Program:
We are gearing up for our **2nd Annual** Quality/Process Improvement Project Award Program. As you recall, our 1st year was a success with 16 process improvement projects submitted. Begin to think about any quality improvement projects you or members of your staff/team have undertaken. We will be revisiting the project guidelines and submission form for any needed enhancements. Please continue to visit the QPI Sub-Unit website section in the coming months for further details on our 2nd Annual Quality/Process Improvement Project Award Program.

In addition, some posters from our 1st year Top 10 project winners will be posted to the QPI website for your review. Take a look and learn of the quality work your CNM peers have done. It will also give you further examples of sample posters if your project should be selected as a Top 10 winner for next year.

Special QPI EML:
Reminder…The QPI Electronic Mailing List (EML) is still up and running. We currently have a total of 133 QPI EML subscribers with at least 1-3 new subscriber requests per week. If you are not currently subscribed and wish to do so, you can subscribe to this additional EML through the QPI Sub-Unit webpage or enter the following URL directly: http://www.cnmdpg.org/members/page/qpi-sub-unit-member-info
If you are already subscribed, please feel free to post QI related questions, or better yet, share your experience, expertise and resources regarding quality and process improvement. The QPI EML has been much underutilized and not as robust as the main CNM EML. The intent for the QPI EML was to include postings and messages with a sole focus on Quality and Process Improvement. Let's get more activity going on the QPI EML…!!

QPI Resources:
Reminder... If you would like to contribute to the QPI Sub-Unit by submitting sample process improvement projects or additional Quality/Process Improvement resources and forms, feel free to reach out to Sherri and/or Cindy as the QPI Sub-Unit Chair and Vice Chair.

And as always, if you have any questions or suggestions for the QPI Sub-Unit feel free to contact the sub-unit Chair and/or Vice-Chair. The sub-unit is a member benefit, and thus, we want to be sure to meet your needs and expectations. Continue to visit the QPI Sub-Unit section of the website for updates.

Thank you for letting Cindy and I continue to serve as your QPI Sub-Unit Chair and Vice-Chair. We are beginning the 3rd year of the QPI Sub-Unit. Thanks for your continued interest and support!

QPI Sub-Unit Chair: Sherri Jones, MS, MBA, RDN, LDN, FAND jonessl@upmc.edu
QPI Sub-Unit Vice-Chair: Cindy Hamilton, MS, RD, LD hamiltoc@ccf.org

Nominating Committee Update

By Wendy Phillips, MS, RD, CNSC, CLE, FAND

We will be seeking nominations for the upcoming membership year for the following positions:

- Secretary
- Chair-Elect
- Nominating Committee Members (2)
- CNM DPG to the House of Delegates

The call for nominations will be sent on August 1, with candidate submission forms due back on August 30. The ballot will be presented to the membership in November or December prior to the election in February. Currently, all appointed positions are filled, but we are always accepting requests for participation in the following committees:

- Professional Development Committee (plans Symposium)
- Informatics Sub-Unit
- Member Services Committee
- Research Committee
- Quality & Process Improvement Sub-Unit
- Fundraising Committee

If you are interested in participating, please email the corresponding committee or sub-unit chair (contact information on page 21).

Treasurer's Report

By Therese Scollard, MBA, RD, LD, FAND

2014—2015 Fiscal Year

Operating Revenues: $156,770
Expenses: $190,533
Operating Excess / Deficit: - $33,763
Investment Income: $26,370
Net Income / Deficit: - $7,393
Investment Reserves (through June): $308,437

Informatics Sub-Unit Update

By Ann Childers, MS, MHA, RDN, LD
Informatics Sub-Unit Chair

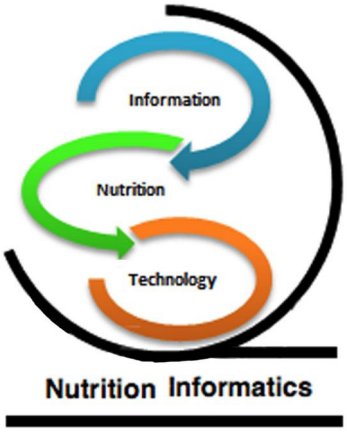
CNM Informatics Sub-unit Committee is starting a new year with the following members of our committee: Krista Clark, MBA, RD, LD, Chair-Elect; Whitney Sanders, MHA, RD, LD, committee member; Deb Hutsler, MS, RD, LD, EML Administrator; and Laurie Szekely, MS, RD, LD, assistant EML Administrator. I am very happy to assume the position of chair for this committee and work with such a great team. I want to thank Janel Welch, MS, RD, LD, our past Informatics Sub-Unit Chair for serving the past two years. Krista Clark and I also serve on the Academy's Nutrition Informatics Committee (NIC) and attended the NIC face-to-face meeting July 10-12 in Washington DC. The following is a recap of some the exciting work of the NIC.

Nutrition Informatics

The Intersection of Information, Nutrition, and Technology

Nutrition Informatics Committee

Including the Consumer Health Informatics Work Group
Interoperability and Standards Committee
Staff Partner, Director of Nutrition Informatics



Informatics Facts

- **Informatics** is used in all areas of practice.
- **Nutrition** practice is changing as U.S. mandates that the "data follows the patient" (Interoperability)
- **Electronic Health Record** (EHR) adoption in U.S. hospitals is at 94%.
- **Data Collection** is being standardized for all – including consumers.
- **Nutrition Data** can be collected once (via health IT) and used twice.
- **Clinical Quality Measures** (CQMs) will be collected in a single way in the future.

Informatics and Policy

Since 2009, the Academy has advocated for nutrition inclusion in health information technology (IT) regulations, standards and terminologies which has occurred as a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act. This progress sets the stage for nutrition inclusion in health IT used across all care settings. For more information, visit www.healthIT.gov www.hl7.org

Join the Nutrition Informatics Community

Over 1100 members discussing informatics
www.adanic.webauthor.com
Stop by the "Genius Zone" at FNCE® 2015!

Nutrition Informatics Blog

The Feed— *a guest blog where nutrition, health, information & technology intersect* moves to FoodandNutrition.org
Sign up to be a **Guest Blogger** on how you use nutrition informatics at:
http://go.osu.edu/nisu

Nutrition Informatics

The Intersection of Information, Nutrition, and Technology

Nutrition Informatics

Serving Size: Daily
Serving: All Areas of Practice

Member	% Practice Area
Clinical	**43%**
EHR/PHR	
Clinical Decision Support	
Outcomes	
Clinical Quality Measures	
BMI/Nutrition Calculation	
Community	**14%**
Electronic Benefits Transfer	
Blogs	
Food & Nutrition Management	**9%**
Inventory	
Menu Management	
Point of Sale	
Allergy Alert/Ingredient ID	
Consultation & Business	**9%**
Social Media	
Nutrient Analysis	
Education	**8%**
Learning Management System	
Research	**3%**
REDCap	
Nutrient Data Systems for Research	
Computer 94% • Mobile Device 63%	
Cont. Edu 84% • E-Journal 82%	
Percent using informatics based on 2014 Nutrition Informatics Member Survey.	
Used in all areas of practice	**100%**

Add Nutrition Informatics to the Program at DPG and Affiliate Meetings

Each year members of the Nutrition Informatics Committee and Interoperability and Standards Committee present at more than a dozen affiliates and DPGs on this topic! If interested, contact Lindsey Hoggle at: lhoggle@eatright.org.

Stop by the "Genius Zone" at FNCE® 2015!

Meet and network with other **"NIRDs"!**
Nutrition Informatics Registered Dietitians
Do you work in informatics? Send us what you do as we update our slideshow of NIRDs for FNCE®!
Inquire at: nutritioninformatics@eatright.org

Around the Bend

***Journal* Publication** on the 2014 Nutrition Informatics Survey
(building on 2008 and 2011 surveys)

Leadership

NIC Chair: Sue Kent, MS, RD, LD
ISC Chair: Donna Quirk, MBA, RD, LD
Staff Partner: Lindsey Hoggle, MS, RD, PMP

Featured Members:
Caroline Steele, MS, RD, CSP, IBCLC
Janel Welch, MS, RD, LD
Sherri L. Jones, MS, MBA, RD, LDN, FAND

This special edition of the Featured Member column highlights leadership. Three members of the CNM Executive Board with diverse leadership and management experiences, both in and outside of the nutrition field, were asked to share their knowledge and advice for being an effective leader.

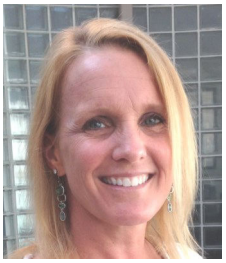
Briefly describe your career as a dietitian.

Caroline Steele,
MS, RD, CSP, IBCLC
CNM DPG Chair

Caroline Steele (CS): I began my career over 22 years ago in Spokane, WA as an inpatient cardiac and thoracic transplant RD at Sacred Heart Medical Center and Children's Hospital (a 600+ bed tertiary hospital). A little over one year later I took my first management position as the manager of two WIC clinics in the Phoenix, AZ area. Approximately one year later, I relocated to Seattle, WA where I spent three years as a Clinical Nutrition Manager in a community hospital and two years as the Director of Nutrition for a large home infusion company. In 2000, I moved back to Spokane, WA where I spent seven years as the NICU dietitian at Sacred Heart Children's Hospital using my skills as a pediatric dietitian and a board certified lactation consultant and two years as a Neonatal Specialist for Mead Johnson Nutrition. Then six years ago, I had the opportunity to move to Orange County, CA to take on a position as Director of Clinical Nutrition and Lactation for Children's Hospital of Orange County (CHOC). In my current role, I supervise 41 staff (25 RDs, 10 DTRs, 5 lactation consultants, and 1 administrative assistant). At CHOC, I also have responsibility for the dietetic interns who complete pediatric rotations at our facility, our twice-yearly pediatric RD residency, and our two-week resident physician nutrition elective, as well as serving as the principal or co-investigator department research studies (at present, six studies).

Janel Welch (JW):
I started my career in dietetics as an acute care dietitian at a 200 bed hospital. I worked for a few years in this setting and felt inspired to be a clinical nutrition manager. My challenge was that as a direct care dietitian, I was told I have no experience in management. So I decided to take a position at another organization as a Food Service Director. I gained the management skills needed to move into a Clinical Nutrition Management position at a large long term care facility. My desire to continue to grow led me down the path of a second master's degree in Public Administration. My knowledge of healthcare grew beyond the profession of food and nutrition. I enjoyed working with the interdisciplinary health care team and felt I had a lot to offer.

I continued my work as a clinical nutrition manager and began to get involved in Lean Six Sigma projects for my department. I enjoyed the work, so completed a yellow belt project, then a green belt certification. Just around that time, there was a position that opened up in the Operational Process Improvement department (OPI). I was asked if I would be interested in applying as I had been very involved with the OPI department. I was selected for the position and decided it was a great opportunity to expand my knowledge in healthcare across the health system. I found out very quickly there was a very large learning curve going into a position outside of dietetics because I had been so comfortable for so long in that space. I enjoyed the challenge and took a college course at Villanova University to complete my Lean Six Sigma Black Belt Certification. This took me about nine months due to the fact that a large process improvement project was required.


Janel Welch, MS, RD, LD

My work continued in the OPI department yet the projects I was assigned started to get more and more focused on a health system merger plan. Our hospital system was merging with the second largest health system in my area. The projects I worked on included areas such as patient care variation, long term care / transitions of care, integration of health system teams, and value analysis opportunities. This was again very interesting, challenging and yet rewarding all at the same time. I felt my expertise in food and nutrition certainly helped teams in various areas of their projects, and at other times, not knowing anything about the subject allowed me to evaluate the situation with fresh eyes. I learned a great deal of project management and change management skills during this time.

Sherri Jones (SJ): Having worked in the dietetics profession for almost 30 years, this question takes me way back to the beginning, when I had such a limited understanding of the broad scope of opportunities my education and training as a dietitian would equip me for. My entry level position as a dietitian was unique in that I did not get to choose my first job. As a part of my dietetic internship program, after completion of internship training, I had to serve one year of obligated service in a Maryland State facility. I was assigned as a Production Dietitian / Patient Services Manager in a maximum security hospital for criminally insane men…Quite an interesting experience to say the least. This was my first experience in management, and boy did I learn by jumping in feet first. Although at that point I had many lessons to learn and would not have selected management as my first entry level position, I look back now and really value that experience and early exposure to management. I believe it set the stage for my ongoing interest in leadership and management.

After serving my year of post internship obligated service, I returned to my home town of Pittsburgh and obtained a clinical dietitian position in a county-owned long term care facility. I worked as a direct care clinical dietitian for almost a year until I pursued a management position that had been vacant at the same facility as a Chief Clinical / Production Manager. I worked in this position for a little over a year and then felt I needed experience in acute care clinical to solidify my clinical skillset.

My next position was a Clinical Dietitian in an acute care urban teaching hospital. This position exposed me to a wide range of experiences including trauma, intensive care, burns, rehabilitation, and pediatrics. I covered a general medical unit, orthopedics, rehab, and pediatrics. I stayed in this position for 6 years and began to feel burned out with frontline clinical care. I wanted once again to have additional responsibility as a manager. So, I obtained a position as the Patient Services Manager for a small contract service company at a large urban children's hospital in Pittsburgh. A part of the contract company takeover and agreement was the rollout of a hostess program, which I led. I soon learned that the staffing I was given was inadequate. And, many times I was called in to work to assist the hostesses. This caused much stress, burnout, and severely impacted my work/life balance. The contract company also began to downsize the management team. At that point I began my search for a better fit.

I was blessed to obtain a position as the Clinical Nutrition Manager at a large urban teaching hospital. The hospital also had its own longstanding Dietetic Internship Program in which my position had responsibility as the Clinical Coordinator. I soon found this position to be very satisfying. It took me out of food service with the unpredictability of service level staffing and back in to clinical nutrition which I preferred. It also provided me with management, precepting, and mentoring responsibilities which I to satisfactorily embraced. I remained as the Clinical Coordinator of the Dietetic Internship for 10 years up to the closing of the program, and as the Clinical Nutrition Manager for 13 years leading up to my current position. During my time as the CNM, I also decided to go back to school to enhance my leadership acumen, and over a span of 8 years, obtained 2 Master's degrees (MS in leadership and MBA). As the CNM, I also developed a strong interest in quality and process improvement. My hospital had a very innovative culture and was constantly conducting tests of change for improvements.

To showcase the great work of the clinical nutrition staff and programs I spearheaded, each and every year my dietitians, dietetic technicians, and I would rally together to submit a project to our hospital's annual quality fair. The clinical nutrition area (and I) soon began to develop a reputation within the hospital of being strong proponents for quality and best practice. Then in 2009, I developed a relationship with the nurse Director of Quality and Innovation through a special project that surfaced in analyzing the clinical staffing. By working on this project with her, I exposed her to the skillset of a dietitian in general, as well as the personal work quality and ethics I practiced. Three years later I found myself speaking with this nurse about a vacant Improvement Specialist position in her quality department.

I was at a point in my career that I wanted to challenge myself and use my leadership and business skills outside of nutrition, but still within healthcare. I thought what a better situation than to stay at my current hospital where I was very comfortable and try a new position. I had many second thoughts, but finally decided to pursue the Improvement Specialist position, and it was subsequently offered to me.

I became an Improvement Specialist in the spring of 2012 very much feeling "like a fish out of water". I was supported by my new boss who sent me to process improvement training and conferences. I am currently pursuing a Six Sigma Green Belt through a program our health system offers. In all honesty, I'm not 100% confident in my skills as an Improvement Specialist as I was as a CNM. But, I have learned so much more about healthcare and have also shown the hospital leadership that dietitians have the skills to succeed in a position outside the food and nutrition department.

I would encourage other dietitians and CNMs to pursue nontraditional positions. I believe it will help to promote the education and value of dietitians in the workforce today. Take a look at some of my current job description responsibilities below…why can't other dietitians interested in leadership and process improvement perform these tasks?

- Effectively coordinate the assessment of new clinical design projects for implementation.
- Conduct yearly assessment of operations / issues and utilize data from other organizational assessments and surveys to contribute to and prioritize the establishment of quality, cost and service goals of the organization.
- Lead or co-facilitate teams created from the annual assessment and organizational goals.
- Create a supportive environment in the department where redesign work is occurring that is sensitive to the issues and needs of that area.
- Ensure that clinical design projects maintain patient care as the center of the work.
- Effectively communicate improvements that are made via verbal or written communication of clinical design activity to work teams, staff, managers and administrators.
- Ensure application of a tracking method to monitor progress toward goals and identify the need for redesign of practice improvements targeted by the clinical design initiative.
- Collect and present accurate, timely data to display the results of process improvement efforts.
- Influence staff acceptance of recommended practice changes by articulating the contribution to clinical improvements established patient care goals.
- Role model appropriate and effective methods for data analysis, problem solving, communication negotiation and persuasion skills.
- Provide mentorship for individuals at the department / unit / team level.
- Communicate clinical design efforts and accomplishments via formal presentations and or publications at local, regional and national forums.
- Consult with essential stakeholders such as administrative and medical staff leaders, department heads and critical committees as appropriate to finalize and advance the project goals.
- Form a partnership with the director of the project area, facilitate work activities and negotiate additional support as needed.

What challenges did you face in your path to becoming a dietitian leader, and how did you overcome these challenges?

CS: Being a leader and being a manager are not the same thing. However, for a leader who also has management responsibilities, there are unique challenges. My biggest challenge in becoming a dietitian manager was the fact that I had only been a dietitian for one year when I took my first management role. As a WIC clinic manager, I had staff who had worked for WIC since I was four years old! I found it very challenging to be in a position of authority so early in my career. In hindsight, there are many things I probably would have done differently! However, I feel that I have been successful in each of my management roles by being open minded and not being too quick to react. Taking time to become familiar with a situation and taking a step back before speaking (or firing off an email!) keeps you from having to backtrack or "undo" something later. I have also found that really understanding the roles and tasks of those people who report to me makes me more comfortable and better able to understand and support my team.

JW: My challenges as a leader trying to venture into new areas that dietitians typically do not work was trying to educate other professionals that RDN's have a place and bring a value to the team. I was often asked "why are you doing this project, it's not nutrition related" or other who would say I was not clinical because I was not a nurse. I did get discouraged many times but I leaned on those who did support me and kept encouraging me to grow.

SJ: I'd say the first challenge was my lack of an advanced degree at the midpoint of my career. Although I had performed as a manager several times in my career, it took me 15 years to go back to school to obtain my Master's degree and formally learn advanced skills. Without advanced credentials I did not feel confident enough pursuing leadership opportunities along my career path, as well as within our professional organization i.e. The Academy of Nutrition and Dietetics and its subgroups. So, I found a program that was the right fit for me and something that would benefit my actual job as a CNM as well. I pursued a Master's degree in Professional Leadership. The knowledge and skills I gained were invaluable. Many universities have such leadership studies and degrees now. I would encourage those who specifically have an interest in management or leadership to pursue programs or training in leadership, organizational development, change management, or even a Master's in Business Administration.

I'd have to say another challenge I faced in becoming a dietitian leader was not having a career mentor or someone to offer guidance and advice along the way. Other than my family and close friends, I did not have someone within the dietetics profession guiding me and looking out for my professional best interest. Sure, I had a few bosses who were registered dietitians, but offering advice on my career path was not something that occurred, nor would it have been appropriate in some circumstances since they were my direct supervisor in my current job. Most of the opportunities I pursued and leadership positions I've held were self-initiated. In my experience, networking and exposure has always been beneficial in opening up further opportunities. By volunteering and getting actively involved in the local, state, and national dietetics groups, I've met lots of people who could potentially serve as mentors or advice givers. Sometimes you just have to ask or take the initiative to reach out.

What advice do you have for dietitians who want to become leaders, not just in dietetics, but in other healthcare positions?

CS: To take on any leadership role or to be an informal leader in your group, it is important to put yourself out there--tackle new challenges, take risks, and don't be afraid to try something new. Volunteer for a special project or task that will expand your skills and showcase your talents. Don't be afraid to make mistakes, but be sure to own up to them and apologize when appropriate. Being a leader means you partake in the glory when things are successful and own your responsibility (and possibly that of the team) when things don't turn out as planned. Finally, be a leader for the right reasons--the greatest win for a leader is a win for the team!

JW: If I was to advise other dietitians about how to go about finding opportunities in non-RDN positions,

I would say, follow your interests, never stop learning, and never stop showing your value as a member of the healthcare team. It can be discouraging at times when you are overlooked because one would not think a dietitian was interested in various opportunities. That is where I had to really show my value.

SJ: First and foremost, I'd have to say you need to become a "lifelong learner". Never stop seeking knowledge or experiences, and keep up on current trends. Along with that, I'd say to continue to challenge yourself and expand your skills. Pursue new positions within and outside your current organization. Volunteer for a professional committee or agree to run on the ballot for an elected position. Don't be afraid to try new things and take advantage of every opportunity. Also, exposure and networking can open many doors and identify opportunities you may wish to pursue. The more you do, the more people will know you and what skills you possess. Learn from other leaders. Find someone you view as a role model and watch what they do. How they present themselves…their verbal and nonverbal skills and begin to mirror their behavior. Also, don't be afraid to ask others for advice. Establish a rapport with someone in a leadership role and "pick their brain". They likely have a wealth of knowledge from their own past experience and can share lessons learned. Or even seek a career mentor if you feel that would be beneficial.

Becoming a leader in other healthcare positions, I feel, starts with exposure. Prove your worth in your current dietetic position by sitting on interdisciplinary or hospital wide committees and actively participate. Speak up. Offer your opinion. Don't just show up and sit there in silence. Also, share your successes with new initiatives or programs you implemented. Ask to be on committee agendas to present this information. Participate in quality fairs. Once you expose yourself and are actively involved, then you need to build relationships and respect. Interact with people in your organization outside your department. Know who the leaders are in other departments. Find out what they are working on. See if there are opportunities to partner on projects.

Always be "on stage". Present yourself in a professional manner, but also be approachable and personable. I came to find out later that other leaders in my hospital initially perceived me to be "stoic" and too "reserved". Basically, I think they found me unapproachable. Since I've been in my Improvement Specialist position and worked on projects with a variety of department leaders, they have come to see me differently. They see that I actually have a personality and a sense of humor and now are more comfortable approaching me. People reach out to me frequently for assistance, not just because part of my job as an Improvement Specialist is project support, but because they personally want me to be a part of the team. By opening up and getting involved, I've been presented with many opportunities in my hospital (including being recommended by a hospital Vice President for the Six Sigma program I am now enrolled in). This is how a leader in other healthcare positions can be discovered!!

2015—2016 CNM DPG Executive Committee

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