COMMENTARY

Nutrition diagnosing and order writing: Value for practitioners, quality for clients

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Although the words have changed today from recognition to value, the issue for our profession continues to be one of respect—and indispensability (1). Recent articles in this *Journal* have addressed the need to increase the value of the profession (1,2). Some have discussed expanding clinical privileges, including nutrition diagnosing and order writing. Similar discussions go back years as part of the general theme of improving professional status and the scope of dietetics practice. In 1988, Koteski and McKinney (3) suggested expanding health-related tasks to increase understanding and respect for the contributions of dietitians.

To be truly valued, and thus indispensable, dietitians must continuously demonstrate that nutrition services are critical to the process and delivery of quality health care. Both Braunschweig and colleagues (4) and Weddle and colleagues (5) demonstrated better patient outcomes, including improved nutritional status, when dietitian recommendations were followed. Yet, nutrition care today too often relies on implementation by other health care providers. Skipper and colleagues (6) showed that physicians implemented only 42% of 865 written dietitian recommendations in Greater Philadelphia area hospitals. Even more concerning, Hagan and colleagues (7) found that, after dietitians wrote recommendations for dietary changes to physician-written nutrition orders in a teaching hospital, physicians revised only 39% of these orders. Thus, at times, current practice fosters barriers to efficacious nutrition care and diminishes professional respect for dietitians. Without nutrition diagnosing and order writing, nothing much will change. Most importantly, patient care will continue to be compromised.

Order-writing privileges in acute-care settings result in better outcomes than written "recommendations" within Subjective/Objective/Assessment/Plan (SOAP) notes. Recently, Moreland and colleagues (8) showed that, after implementing an order-writing system, 75% of patients demonstrated improved nutritional status compared with 55% previously. Dietitians at the University of Massachusetts Medical Center, a 340-bed teaching hospital, facilitate timely effective delivery of nutrition care through order-writing and clinical privileges that are a permanent part of a dietitian's appointment to the Health Professional Staff (9). Thus, we agree with Moreland and colleagues (8) that "conversion of RD recommendations to nutrition orders has been the missing link in the patient care process." We also agree with Kight that nutrition diagnosing is a necessary component to increasing the value of the profession (10). We further suggest that nutrition diagnosing and order writing ensure better continuity of care across health care settings.

THE CONTINUUM OF CARE

A number of position statements of the American Dietetic Association have emphasized the need for comprehensive food and nutrition services in the continuum of care (11-18). In older adults, for example, there has been longstanding recognition of food and nutrition services gaps between medical/health and social services (11). With the dramatic changes in health care delivery from acute to home and community settings—driven by cost containment, shortened hospital stays, and the demographic shift toward an aging America—the need for an "integrated continuum of seamless, coordinated . . . services facilitating . . . movement . . . among community, acute, and long-term care sites is even greater now (12)."

Nutritional problems exist among all populations across the health care continuum. Sixty-one percent of adults are overweight, and 31% are obese (19). Fifteen percent of children and adolescents are overweight or obese, and type 2 diabetes is becoming more common among overweight children and adolescents (19). About 40% of community-dwelling older adults, up to 55% of hospitalized adults, and 35% to 85% of long-term-care residents suffer from protein energy undernutrition (15,16). Six of the 10 leading causes of death are nutrition related (19).

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If dietitians were diagnosing and writing orders routinely, they could be more involved at all levels of care, including discharge planning. Without comprehensive discharge planning, continuity of care suffers, services remain undelivered, and nutrition needs are unmet. For example, malnourished older adults being discharged from a hospital stay may or may not be linked to food and nutrition assistance programs, such as home-delivered meals, depending on whether discharge planners recognize the need for nutrition services and are aware that such community services exist.

Nutrition diagnosing and order writing is not only needed at all levels of care but also in all care settings. More than half of adults receiving formal home health services have chronic diseases treated by dietary interventions (20). Although Ellis and Cowles (21) found that 86.5% of 524 dietitian recommendations were implemented in three long-term-care facilities in San Diego county, protein energy undernutrition and dehydration continue to plague long-term-care residents. Yet, across the health care continuum, nutrition screening, assessment, counseling, treatments, and monitoring are inconsistent because they depend on referrals and the availability and reimbursement of dietetic practitioners (12). Most recently, Kuppersmith and Wheeler (22) showed that the current lack of direct communication between dietitians and physicians promotes inconsistencies in treatment plans and compromises the nutrition care of ambulatory patients. The following provides an example of how similar gaps in care delivery were addressed by obtaining order-writing privileges.

OBTAINING ORDER-WRITING PRIVILEGES: A FIRST PERSON ACCOUNT

In the mid-1990s, after 4 years of informally writing orders based on "Just do it, Heidi" instructions from attending physicians in a university-affiliated, 2,200-bed Medical Center, I decided to pursue a formal procedure to gain hospital-wide, order-writing privileges. I knew, as did my workplace dietetics colleagues, that many of the serious problems we encountered, such as dehydration and electrolyte imbalance, often stemmed from lack of implementation of nutrition recommendations. Conversely, the Medical Center physicians did not perceive such problems to be nutrition related. Like Moreland and colleagues (8), my first step involved reviewing Joint Commission on Accreditation of Healthcare Organizations and American Society for Parenteral and Enteral Nutrition (ASPEN) standards. Because licensure is regulated in Florida, I also communicated with the Florida Department of Professional Regulations to verify that order writing was not excluded from my scope of practice. I next collected data on the percentage of my nutrition recommendations that were followed in each of the medical and surgical units at which I provided patient care. For 6 weeks, I kept a daily log of my recommendations, if and when each recommendation was followed, and the actual or potential adverse clinical outcome for those not followed. I then got on the agenda for each unit's next scheduled medical staff meeting to formally present my data. The attending physicians were shocked to learn that only 57% of my recommendations had been followed. They assumed that all nutrition notes were routinely read and that recommendations were implemented. I provided copies and verbally summarized the findings of Weddle and colleagues (5) showing the benefits of following dietitian recommendations. I also distributed the article by Blackburn and Ahmad (23) that revisited the classic "skeleton in the hospital." I concluded my presentation by asking the physicians to sign a letter of support for order-writing privileges. My final step was to meet with the Medical Center's medical board. At that meeting, I presented my data and a one-page list of the type of orders that I would write. I also distributed copies of the attending physicians' letters of support and the above-mentioned articles. Board members asked questions regarding my training, credentials, and scope of practice. A discussion ensued regarding licensure and liability issues and the types of orders that I would be writing. The Board agreed unanimously to grant order-writing privileges and suggested developing a plan to expand this privilege to other dietitians in the Medical Center.

PRACTICE-WIDE DIAGNOSING AND ORDER-WRITING MODEL

One of the key trends challenging dietitians is competition from other providers of nutrition information and advice (24,25). Development of a standard practice guideline for nutrition diagnosing and obtaining order-writing privileges across nutrition care settings are needed. By assuming advanced responsibilities under an expanded scope of practice, dietitians can help safeguard both patient care and the future of the profession. Dietitians would no longer have to rely on other providers for the delivery of quality nutrition services. By encouraging coordination among systems to reduce discontinuity and fragmentation, patients in all care settings would have access to timely, appropriate, comprehensive, and continuous (ie, efficacious) nutrition care.

We suggest that nutrition diagnosing and order writing be added as necessary and missing components to every Nutrition Care Process model adopted by the Association (10,26,27). Myers and colleagues (28) have advocated for a hierarchical progression of order-writing privileges by type of order with consideration for career level, special credentials, and years of practice. It is assumed that both diagnosing and order writing would be evidenced based (27). To be so, it must be acknowledged that malnutrition still often goes unrecognized and neglected. Many already malnourished patients admitted to hospitals suffer further deterioration in their nutritional status. Because early detection of malnutrition is inadequate, we encourage the Association to include medical nutrition diagnosing, ie, identification of types and degrees of over- and undernutrition, in nutrition-diagnosing privileges.

Success of this extended professional role requires advanced knowledge and skills. Dietetics educators, especially those teaching medical nutrition therapy and clinical nutrition courses, should update their courses to incorporate the knowledge and skills needed for nutrition diagnosing and order writing. The Commission on Accreditation for Dietetics Education should update their quality standards for educational programs to include nutrition diagnosing and order writing as essential competencies. In the 1996 survey, by Mueller and colleagues, of 266 dietitian members of the Dietitians in Nutrition Support practice group and ASPEN, the most valuable preparation for order writing was training under an advanced (nutrition support or specialist) practitioner already experienced in order writing and diagnosing (29). Dietetic internships should include a rotation with nutrition support teams, nutrition support dietitians, and specialists to focus on skill development (30).

The opportunity to expand our role means becoming accountable for meeting the needs of the populations we serve—and increasing our value. It means that appropriate dietary and nutrition recommendations are more likely to be incorporated

into health care provision. It helps bridge the gaps in coordinating care. It means assuming the legal responsibility to protect patients/clients from harm. It will allow dietitians to improve the food security, nutritional status, functionality, health, and quality of life of more Americans. Expanding clinical privileges with nutrition diagnosing and order writing has the potential to revolutionize the practice of our profession.

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