Dietetic Internship

At

Fresno State

Jordan College of Agricultural Sciences and Technology

Internship Program Manual

2018-2019

Food Science & Nutrition Department
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Introduction and Overview
INTRODUCTION

Overview

The demand for Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) is expected to grow by 20% between 2010 and 2020, faster than the average for all occupations according to the Bureau of Labor Statistics. Students who are interested in food, nutrition, and management and have a strong desire to work with the public to promote good health or assist them with disease management are great candidates for the area of study. The RD/RDN professional designation qualifies an individual as the food and nutrition expert to address today’s complex issues surrounding foods and nutrition.

To complete this credential, one must complete all of the steps below:

1. Earn a BS degree from an accredited Didactic Program in Dietetics (DPD) (Certificate in Dietetics at Fresno State) and receive a verification statement,
2. Complete an accredited post-baccalaureate dietetic internship program, and
3. Pass a national board registration examination

The Fresno State Food Science and Nutrition department has an accredited DPD within its undergraduate program. Graduates of the DPD (certificate in dietetics) who meet all of the degree requirements will be eligible to apply for a Dietetic Internship (DI) program. Additional information about the DI and process for earning the RDN credential are included within this document.

About the Program Manual / Handbook
The Dietetic Intern program manual/handbook provides important information to help prospective and current students enrolled in the Fresno State DI, understand the requirements for completion as well as the expectations of student conduct while at Fresno State.

This handbook is subject to revision and interns will be notified of any changes through electronic communications (email and posted on the Fresno State Food Science and Nutrition website). An electronic version of this document is available on the Food Science and Nutrition department website under the Post Graduate section http://www.fresnostate.edu/jcast/fsn/index.html.
Contact Information

The Dietetic Internship (DI) Program in Dietetics is administered by the Food Science and Nutrition Department within the Jordan College of Agricultural Sciences and Technology.

Food Science and Nutrition Department
5300 N. Campus Drive M/S FF17
Fresno, CA
Office phone: 559-278-2164
Fax: 559-278-8424

Dietetic Internship Director (DI)
Erika Ireland, MPH, RD, CDE, CLC
Lecturer and DI Director
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Food Science and Nutrition Administrators and Faculty

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Food Science and Nutrition Staff Assistants

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<tbody>
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Jordan College of Agricultural Sciences and Technology Administration

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<tr>
<td>Witte, Sandra</td>
<td>Dean</td>
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<tr>
<td>Thomas, Michael</td>
<td>Interim Associate Dean</td>
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California State University, Fresno
Mission

The university offers a high-quality educational opportunity to qualified students at the bachelor's and master's levels, as well as in joint doctoral programs in selected professional areas. To carry out this mission, the university provides a General Education program and other opportunities, to expand students' intellectual horizons, foster lifelong learning, prepare them for further professional study and instill within them an appreciation of cultures other than their own. The university offers undergraduate degrees and programs in the liberal arts and sciences as well as in a variety of professional disciplines emphasizing agriculture, business, engineering and technology, health and human services, and education, preparing students for productive careers and responsible world citizenship. Building upon the strength of these undergraduate programs, graduate programs provide opportunities for personal and career enhancement through advanced study, preparing students for positions of leadership in the arts, sciences and professions.

The university encourages and protects free inquiry and expression, ensuring a forum for the generation, discussion and critical examination of ideas. By emphasizing the primacy of quality teaching and the close interaction between faculty and students, the university seeks to stimulate scholarly inquiry and discourse, inspire creative activity, heighten professional and technical competencies, encourage and support research and its dissemination, and recruit and develop outstanding teacher-scholars/artists.

The university fosters an environment in which students learn to live in a culturally diverse and changing society. Within that environment, it strives to develop a community founded upon mutual respect and shared efforts, in which individuals can communicate openly and work together to enrich the lives of all and to further the growth and excellence of the university. The university seeks and encourages historically under-represented students to embark upon and complete a university education.

The university serves the San Joaquin Valley while interacting with the state, nation and world. California State University, Fresno is a center of intellectual, artistic and professional activity. Through applied research, technical assistance, training and other related public service activities, the university anticipates continuing and expanding partnership and linkages with business, education, industry and government.

Jordan College of Agricultural Sciences and Technology

Mission

The Jordan College of Agricultural Sciences and Technology offers high quality undergraduate, graduate and continuing education programs and conducts applied research and public service in selected areas of agriculture, food sciences, industrial technology, and family sciences. Programs combine a science, technology and management focus with experiential learning. The College participates in the general education program of the University and seeks to enhance the ability of students to be successful in their chosen careers and to make positive contributions to the quality of life in their communities.
The Jordan College of Agricultural Sciences and Technology pursues its mission through involvement in: direct instruction and student development; research, scholarly and creative activities; and institutional development.

Direct instruction and student development occurs through on-campus undergraduate and graduate course offerings; continuing education programs to industry; advising of students; and development of student skills outside the classroom through student organizations in the various program areas.

Research, scholarly and creative activities involve faculty, staff and students in projects to improve the educational process, discover new knowledge, find solutions to significant societal and industry problems, communicate findings to industry and society at large, and improve and develop new skills.

Institutional development efforts increase the number of students served; raise funds for scholarship and program support; and enhance alumni relations.

Departments

The Jordan College of Agricultural Sciences and Technology includes seven departments:

- Agricultural Business
- Animal Sciences & Ag Education
- Child, Family & Consumer Sciences
- Food Science & Nutrition
- Industrial Technology
- Plant Science
- Viticulture & Enology

The Food Science and Nutrition Department

Undergraduate Program Vision

The faculty of the Department of Food Science and Nutrition are regionally focused food experts who are committed to student success, scholarly activity, and engagement.

Undergraduate Program Mission

The mission of the faculty of the Department of Food Science and Nutrition is to

- Impart food-related knowledge and skills to our students
- Apply food-related knowledge and skills to research and scholarly activity
- Integrate with industry and students to apply food related knowledge and skills to advance the region.
**Dietetic Program Mission Statement**
Unlocking the potential of future registered dietitian nutritionists (RDNs) through innovative and diverse post graduate practice application with a program concentration on health promotion and disease prevention, while uniquely nourishing cultural competency in a variety of dietetic settings within Fresno County, Fresno Metropolitan and the Central San Joaquin Valley.

**FRESNO STATE UNIVERSITY DIETETIC INTERNSHIP DESCRIPTION**

**Overview**

California State University, Fresno (Fresno State) is part of the California State University. California State University, Fresno, first established as a two-year normal school in 1911, is the sixth oldest of the 23 campuses in the California State University. Fresno is located in the San Joaquin Valley of California which stretches from Sacramento in the north to Bakersfield in the south and is bordered by the Sierra Nevada Mountains. The service area for Fresno State is the San Joaquin Valley which is an estimated population of one million people. The ethnic mix of the area consists of Caucasian, Hispanic, Asian Pacific, African American and Native American. It is ideally located for offering dietetics education programs. The unique food and nutritional needs of the San Joaquin Valley are found in the diversity of the population. The incidence of diabetes mellitus is greater in Hispanic individuals than any other ethnic group, making this a major concern for nutrition care providers. The immigration of Southeast Asians from Vietnam, Cambodia, Thailand and Laos, has made this the home of the largest group of Southeast Asians outside of their native countries. These individuals have unique challenges to nutrition care providers.

Fresno State enrolls more than 22,000 students and offers 64 baccalaureate degree programs and 49 graduate degree programs. The Jordan College of Agricultural Sciences and Technology (JCAST) is one of eight colleges / schools at Fresno State. The Department of Food Science and Nutrition is one of seven departments in JCAST. The University has offered a DPD program since 1940, beginning with the undergraduate degree program. The DPD is administered by the Department of Food Science and Nutrition. The Accreditation Council for Education in Nutrition and Dietetics (ACEND - formerly known as The Commission on Accreditation for Dietetics Education - CADE) has recognized the Didactic Program in Dietetics (DPD) since 1973. In 1999, CADE granted developmental accreditation to the program; this site visit is for the re-accreditation of the DPD. The DPD program was granted accreditation status in 2003. The PAR was approved in 2008.

The department offers two undergraduate academic programs under the Dietetics Option:
- Bachelor of Science in Food and Nutritional Sciences – Certificate in Dietetics
- Bachelor of Science in Food and Nutritional Sciences – Career Specialty

The DPD is under the umbrella of the Bachelor of Science in Food and Nutritional Sciences – Dietetics in Food Administration (Certificate in Dietetics) or the (Career Specialty). The courses
that provide learning experiences for developing the Foundation Knowledge and Skills for the Didactic Component are also the courses necessary to complete the requirements for the Certificate in Dietetics. Most of the students are working towards the Certificate in Dietetics option.

The DPD provides a strong foundation in science, foods, and nutrition with a diverse curriculum to meet the Academy of Nutrition and Dietetics (AND) national accreditation standards set by the ACEND. The course work is includes a science-based curriculum, social science offerings, as well as management courses.

The Bachelor of Science degree in Food and Nutritional Sciences – Option in Dietetics and Food Administration requires completion of 69 semester units in the major and 51 semester units of General Education (120 semester units’ total). The DPD requirements are the same 69 units in the major required for the degree. Students that have already completed a bachelor’s degree are required to complete only the 69 semester units in the major to complete the DPD requirements.

**In order to obtain the RDN credential, graduates of the DPD must successfully complete an accredited pre-professional program in dietetics, known as a dietetic internship program.** Dietetic internship programs include a minimum of 1200 hours of supervised practice experience and can take 10 to 13 months to complete if the student attends full-time. See eatright.org for a full listing of the AND and ACEND accredited internships at Dietetic internship programs charge tuition for the supervised practice experience; tuition costs vary between programs. Additional information on dietetic internship programs can be found on the Food Science and Nutrition Department Dietetic Internship Program at Fresno State [http://www.fresnostate.edu/jcast/fsn/degrees-programs/post-baccalaureate/dietetic-internship.html](http://www.fresnostate.edu/jcast/fsn/degrees-programs/post-baccalaureate/dietetic-internship.html). Graduates of Fresno State University DPD have an acceptance rate into dietetic internship programs that fall within the national average.

In the final step to earn the RD credential, students must successfully meet the requirements of the dietetic internship program and pass the national registration examination. Graduates of the Fresno State DI program have a first time pass rate on the registration examination of 90%. Students who earn their RD credential and want to practice as Dietitians may need to apply for licensure, before they are eligible practice dietetics and provide nutrition counseling in states that require licensure. Licensing statutes include an explicitly defined scope of practice, and performance of the profession is illegal without first obtaining a license from the state. A list of the states that require licensure is available on the Commission on Dietetic Registration website at [http://www.cdrnet.org/certifications/licensure/index.cfm](http://www.cdrnet.org/certifications/licensure/index.cfm).
**DI Program Goals and Objectives:**

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<th>Goal</th>
<th>Data Assessed</th>
<th>Objective/Outcome Measures</th>
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<tr>
<td><strong>1. To provide guidance and leadership for dietetic intern graduates through an ACEND accredited program with a concentration in culturally competent health promotion and disease prevention.</strong></td>
<td>% of enrolled interns completing the program &amp; receiving a verification statement</td>
<td>At least 90% of graduates will complete the program in 53 weeks (150%) of the time planned for completion.</td>
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<td>Alumni/Graduate Surveys</td>
<td>When surveyed 12-18 months after graduation, at least 90% of graduates, who respond to the survey will rate overall satisfaction with their experience as at least 4.0 on a scale of 1-5 (where 5.0 is best and 1.0 is worst). When surveyed 12-18 months after graduation, 25% of graduates who respond to the survey will hold a leadership role within local, state or national affiliation of the Academy of Nutrition &amp; Dietetics (AND).</td>
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<td>5-year average 1st time pass rate and 1-year pass rate</td>
<td>At least 80% of graduates will pass the Registration Examination for Dietitians on the first attempt, measured over 5-year intervals. At least 90% of graduates will pass the Registration Examination for Dietitians at one-year pass rate, aggregate measured over 5-year intervals.</td>
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<td><strong>2. At completion, graduates will be adept for practice as entry-level registered dietitian nutritionists (RDNs) and prepared to actively address the evolving health needs of society and address the unique needs of Fresno County, Fresno metropolitan area and the Central San Joaquin Valley.</strong></td>
<td>- Employer Surveys</td>
<td>- When surveyed, 80% of employers of CSUF DI graduates, who respond to the survey will indicate that program graduates are able to utilize principles of evidence-based practice as at least satisfactory (3.0 or better) on a scale of 1-5 (where 5.0 is best and 1.0 is worst). - When surveyed, 80% of employers of CSUF DI graduates, who respond to the survey will indicate that program graduates professional competence as satisfactory (3.0 or better) on a scale of 1-5 (where 5.0 is best and 1.0 is worst).</td>
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<td>- Alumni/Graduate Surveys</td>
<td>- When surveyed 12-18 months after graduation, at least 70% of graduates, who respond to the survey will indicate they obtained employment in dietetics-related job within one year of graduation. - When surveyed 12-18 months after graduation, at least 10-15% of graduates, who respond to the survey will maintain employment in the Fresno metropolitan area and/or Central San Joaquin Valley. - When surveyed 12-18 months after graduation, at least 60% of graduates, who respond to survey have indicated that they have participated in at minimum of least one (1) event sponsored by a dietetics related professional organization.</td>
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**Program Outcomes Data**

The outcomes data that show how well the DI program is meeting the 5-year pass rate criteria for the Registration Examination for Dietitians are available upon request. Individuals may request this information from the DI director, Erika Ireland, MPH, RD, CDE (eireland@csufresno.edu).
Accreditation Status of the DI at Fresno State University

The dietetic internship program is administered by Department of Food Science and Nutrition. In May, 1998, The Accreditation Council for Education in Nutrition and Dietetics (ACEND - formerly known as CADE) recognized the program for developmental accreditation. The first class of ten students was admitted in August, 1998. The fifth internship class graduated in May, 2003. The internship was simultaneously approved on campus as the Certificate of Advanced Study – Dietetics, a post-baccalaureate, non-degree, certificate program. The Self-Study Application for Initial accreditation was submitted August 2003 and the required PAR 2008 was approved after revisions on October 30, 2009. The university underwent the ACEND Self Study site visit, and continued accreditation application process in Nov 2013. On July 23, 2014, the University received notification that the CSUF Dietetic Internship was granted continued accreditation by the ACEND board through 2021. For more information regarding the site visit or Fresno State University’s DI accreditation, please contact:

ACEND, 120 South Riverside Plaza, Suite 2000, Chicago, Illinois 60606-6995
Phone: 312-899-0040 Ext. 5500.

California State University, Fresno Dietetic Internship Program is accredited by the Accreditation Council for Education in Nutrition and Dietetics of the Academy of Nutrition and Dietetics, 120 South Riverside Plaza, Suite 2000, Chicago, IL 60606-6995, (312) 899-0040 ext 5400. Http://www.eatright.org/ACEND.
Preamble:
When providing services the nutrition and dietetics practitioner adheres to the core values of customer focus, integrity, innovation, social responsibility, and diversity. Science-based decisions, derived from the best available research and evidence, are the underpinnings of ethical conduct and practice.

This Code applies to nutrition and dietetics practitioners who act in a wide variety of capacities, provides general principles and specific ethical standards for situations frequently encountered in daily practice. The primary goal is the protection of the individuals, groups, organizations, communities, or populations with whom the practitioner works and interacts.

The nutrition and dietetics practitioner supports and promotes high standards of professional practice, accepting the obligation to protect clients, the public and the profession; upholds the Academy of Nutrition and Dietetics (Academy) and its credentialing agency the Commission on Dietetic Registration (CDR) Code of Ethics for the Nutrition and Dietetics Profession; and shall report perceived violations of the Code through established processes.

The Academy/CDR Code of Ethics for the Nutrition and Dietetics Profession establishes the principles and ethical standards that underlie the nutrition and dietetics practitioner’s roles and conduct. All individuals to whom the Code applies are referred to as “nutrition and dietetics practitioners”. By accepting membership in the Academy and/or accepting and maintaining CDR credentials, all nutrition and dietetics practitioners agree to abide by the Code.

Principles and Standards:
1. Competence and professional development in practice (Non-maleficence)
   Nutrition and dietetics practitioners shall:
   a. Practice using an evidence-based approach within areas of competence, continuously develop and enhance expertise, and recognize limitations.
   b. Demonstrate in depth scientific knowledge of food, human nutrition and behavior.
   c. Assess the validity and applicability of scientific evidence without personal bias.
   d. Interpret, apply, participate in and/or generate research to enhance practice, innovation, and discovery.
   e. Make evidence-based practice decisions, taking into account the unique values and circumstances of the patient/client and community, in combination with the practitioner’s expertise and judgment.
   f. Recognize and exercise professional judgment within the limits of individual qualifications and collaborate with others, seek counsel, and make referrals as appropriate.
   g. Act in a caring and respectful manner, mindful of individual differences, cultural, and ethnic diversity.
   h. Practice within the limits of their scope and collaborate with the inter-professional team.

2. Integrity in personal and organizational behaviors and practices (Autonomy)
   Nutrition and dietetics practitioners shall:
   a. Disclose any conflicts of interest, including any financial interests in products or services that are recommended. Refrain from accepting gifts or services which potentially influence or which may give the appearance of influencing professional judgment.
   b. Comply with all applicable laws and regulations, including obtaining/maintaining a state license or certification if engaged in practice governed by nutrition and dietetics statutes.
   c. Maintain and appropriately use credentials.
   d. Respect intellectual property rights, including citation and recognition of the ideas and work of others, regardless of the medium (e.g. written, oral, electronic).
   e. Provide accurate and truthful information in all communications.
   f. Report inappropriate behavior or treatment of a patient/client by another nutrition and dietetics practitioner or other professionals.
   g. Document, code and bill to most accurately reflect the character and extent of delivered services.
   h. Respect patient/client’s autonomy. Safeguard patient/client confidentiality according to current regulations and laws.
   i. Implement appropriate measures to protect personal health information using appropriate techniques (e.g., encryption).

3. Professionalism (Beneficence)
   Nutrition and dietetics practitioners shall:
   a. Participate in and contribute to decisions that affect the well-being of patients/clients.
4. Social responsibility for local, regional, national, global nutrition and well-being (Justice)

Nutrition and dietetics practitioners shall:

a. Collaborate with others to reduce health disparities and protect human rights.

b. Promote fairness and objectivity with fair and equitable treatment.

c. Contribute time and expertise to activities that promote respect, integrity, and competence of the profession.

d. Promote the unique role of nutrition and dietetics practitioners.

e. Engage in service that benefits the community and to enhance the public’s trust in the profession.

f. Seek leadership opportunities in professional, community, and service organizations to enhance health and nutritional status while protecting the public.

Glossary of Terms:

Autonomy: ensures a patient, client, or professional has the capacity and self-determination to engage in individual decision-making specific to personal health or practice.¹

Beneficence: encompasses taking positive steps to benefit others, which includes balancing benefit and risk.¹

Competence: a principle of professional practice, identifying the ability of the provider to administer safe and reliable services on a consistent basis.²

Conflict(s) of Interest(s): defined as a personal or financial interest or a duty to another party which may prevent a person from acting in the best interests of the intended beneficiary, including simultaneous membership on boards with potentially conflicting interests related to the profession, members or the public.²

Customer: any client, patient, resident, participant, student, consumer, individual/person, group, population, or organization to which the nutrition and dietetics practitioner provides service.³

Diversity: “The Academy values and respects the diverse viewpoints and individual differences of all people. The Academy’s mission and vision are most effectively realized through the promotion of a diverse membership that reflects cultural, ethnic, gender, racial, religious, sexual orientation, socioeconomic, geographical, political, educational, experiential and philosophical characteristics of the public it serves. The Academy actively identifies and offers opportunities to individuals with varied skills, talents, abilities, ideas, disabilities, backgrounds and practice expertise.”⁴

Evidence-based Practice: Evidence-based practice is an approach to health care wherein health practitioners use the best evidence possible, i.e., the most appropriate information available, to make decisions for individuals, groups and populations. Evidence-based practice values, enhances and builds on clinical expertise, knowledge of disease mechanisms, and pathophysiology. It involves complex and conscientious decision-making based not only on the available evidence but also on client characteristics, situations, and preferences. It recognizes that health care is individualized and ever changing and involves uncertainties and probabilities. Evidence-based practice incorporates successful strategies that improve client outcomes and are derived from various sources of evidence including research, national guidelines, policies, consensus statements, systematic analysis of clinical experience, quality improvement data, specialized knowledge and skills of experts.²

Justice (social justice): supports fair, equitable, and appropriate treatment for individuals¹ and fair allocation of resources.

Non-Maleficence: is the intent to not inflict harm.¹

References:

The Academy of Nutrition and Dietetics (Academy) and its credentialing agency, the Commission on Dietetic Registration (CDR), believe it is in the best interest of the profession and the public it serves to have a Code of Ethics in place that provides guidance to nutrition and dietetics practitioners in their professional practice and conduct. Nutrition and dietetics practitioners have voluntarily adopted this Code of Ethics to reflect the values and ethical principles guiding the profession and to set forth commitments and obligations of the nutrition and dietetics practitioner to the public, clients, the profession, colleagues, and all others to which they provide service. The updated Code of Ethics was approved by the Academy Board of Directors and the Commission on Dietetic Registration, effective June 1, 2018.

**THE CODE OF ETHICS APPLIES TO THE FOLLOWING PRACTITIONERS:**

- All members of the Academy who are credentialed by CDR
- All members of the Academy who are not credentialed by CDR
- All CDR credentialed practitioners whether or not they are members of the Academy

The Code is overseen by a three-person Ethics Committee, with representation from the Board of Directors, Commission on Dietetic Registration and House of Delegates. The term of office is three years.
Code of Ethics

A preamble, 4 principles and 32 standards comprise the code

**PRINCIPLES AND STANDARDS**

1. Competence and professional development in practice (Non-Maleficence)

*Nutrition and dietetics practitioners shall:*

a. Practice using an evidence-based approach within areas of competence, continuously develop and enhance expertise, and recognize limitations.

b. Demonstrate in depth scientific knowledge of food, human nutrition and behavior.

c. Assess the validity and applicability of scientific evidence without personal bias.

d. Interpret, apply, participate in and/or generate research to enhance practice, innovation, and discovery.

e. Make evidence-based practice decisions, taking into account the unique values and circumstances of the patient/client and community, in combination with the practitioner’s expertise and judgment.

f. Recognize and exercise professional judgment within the limits of individual qualifications and collaborate with others, seek counsel, and make referrals as appropriate.

g. Act in a caring and respectful manner, mindful of individual differences, cultural, and ethnic diversity.

h. Practice within the limits of their scope and collaborate with the inter-professional team.

2. Integrity in personal and organizational behaviors and practices (Autonomy)

*Nutrition and dietetics practitioners shall:*

a. Disclose any conflicts of interest, including any financial interests in products or services that are recommended. Refrain from accepting gifts or services which potentially influence or which may give the appearance of influencing professional judgment.

b. Comply with all applicable laws and regulations, including obtaining/maintaining a state license or certification if engaged in practice governed by nutrition and dietetics statutes.

c. Maintain and appropriately use credentials.

d. Respect intellectual property rights, including citation and recognition of the ideas and work of others, regardless of the medium (e.g. written, oral, electronic).

e. Provide accurate and truthful information in all communications.

f. Report inappropriate behavior or treatment of a patient/client by another nutrition and dietetics practitioner or other professionals.

g. Document, code and bill to most accurately reflect the character and extent of delivered services.

**PREAMBLE**

When providing services the nutrition and dietetics practitioner adheres to the core values of customer focus, integrity, innovation, social responsibility, and diversity. Science-based decisions, derived from the best available research and evidence, are the underpinnings of ethical conduct and practice.

This Code applies to nutrition and dietetics practitioners who act in a wide variety of capacities, provides general principles and specific ethical standards for situations frequently encountered in daily practice. The primary goal is the protection of the individuals, groups, organizations, communities, or populations with whom the practitioner works and interacts.

The nutrition and dietetics practitioner supports and promotes high standards of professional practice, accepting the obligation to protect clients, the public and the profession; upholds the Academy of Nutrition and Dietetics (Academy) and its credentialing agency the Commission on Dietetic Registration (CDR) Code of Ethics for the Nutrition and Dietetics Profession; and shall report perceived violations of the Code through established processes.

The Academy/CDR Code of Ethics for the Nutrition and Dietetics Profession establishes the principles and ethical standards that underlie the nutrition and dietetics practitioner’s roles and conduct. All individuals to whom the Code applies are referred to as “nutrition and dietetics practitioners”.

By accepting membership in the Academy and/or accepting and maintaining CDR credentials, all nutrition and dietetics practitioners agree to abide by the Code.
h. Respect patient/client’s autonomy. Safeguard patient/client confidentiality according to current regulations and laws.

i. Implement appropriate measures to protect personal health information using appropriate techniques (e.g., encryption).

3. Professionalism (Beneficence)

Nutrition and dietetics practitioners shall:

a. Participate in and contribute to decisions that affect the well-being of patients/clients.

b. Respect the values, rights, knowledge, and skills of colleagues and other professionals.

c. Demonstrate respect, constructive dialogue, civility and professionalism in all communications, including social media.

d. Refrain from communicating false, fraudulent, deceptive, misleading, disparaging or unfair statements or claims.

e. Uphold professional boundaries and refrain from romantic relationships with any patients/clients, surrogates, supervisees, or students.

f. Refrain from verbal/physical/emotional/sexual harassment.

g. Provide objective evaluations of performance for employees, coworkers, and students and candidates for employment, professional association memberships, awards, or scholarships, making all reasonable efforts to avoid bias in the professional evaluation of others.

h. Communicate at an appropriate level to promote health literacy.

i. Contribute to the advancement and competence of others, including colleagues, students, and the public.

4. Social responsibility for local, regional, national, global nutrition and well-being (Justice)

Nutrition and dietetics practitioners shall:

a. Collaborate with others to reduce health disparities and protect human rights.

b. Promote fairness and objectivity with fair and equitable treatment.

c. Contribute time and expertise to activities that promote respect, integrity, and competence of the profession.

d. Promote the unique role of nutrition and dietetics practitioners.

e. Engage in service that benefits the community and to enhance the public’s trust in the profession.

f. Seek leadership opportunities in professional, community, and service organizations to enhance health and nutritional status while protecting the public.

Glossary of Terms

**Autonomy:** ensures a patient, client, or professional has the capacity and self-determination to engage in individual decision-making specific to personal health or practice.¹

**Beneficence:** encompasses taking positive steps to benefit others, which includes balancing benefit and risk.¹

**Competence:** a principle of professional practice, identifying the ability of the provider to administer safe and reliable services on a consistent basis.²

**Conflict(s) of Interest(s):** defined as a personal or financial interest or a duty to another party which may prevent a person from acting in the best interests of the intended beneficiary, including simultaneous membership on boards with potentially conflicting interests related to the profession, members or the public.²

**Customer:** any client, patient, resident, participant, student, consumer, individual/person, group, population, or organization to which the nutrition and dietetics practitioner provides service.³

**Diversity:** “The Academy values and respects the diverse viewpoints and individual differences of all people. The Academy’s mission and vision are most effectively realized through the promotion of a diverse membership that reflects cultural, ethnic, gender, racial, religious, sexual orientation, socioeconomic, geographical, political, educational, experiential and philosophical characteristics of the public it services. The Academy actively identifies and offers opportunities to individuals with varied skills, talents, abilities, ideas, disabilities, backgrounds and practice expertise.” ⁴

**Evidence-based Practice:** Evidence-based practice is an approach to health care wherein health practitioners use the best evidence possible, i.e., the most appropriate information available, to make decisions for individuals, groups and populations. Evidence-based practice values, enhances and builds on clinical expertise, knowledge of disease mechanisms, and pathophysiology. It involves complex and conscientious decision-making based not only on the available evidence but also on client characteristics, situations, and preferences. It recognizes that health care is individualized and ever changing and involves uncertainties and probabilities. Evidence-based practice incorporates successful strategies that improve client outcomes and are derived from various sources of evidence including research, national guidelines, policies, consensus statements, systematic analysis of clinical experience, quality improvement data, specialized knowledge and skills of experts.²

**Justice (Social Justice):** supports fair, equitable, and appropriate treatment for individuals¹ and fair allocation of resources.

**Non-Maleficence:** is the intent to not inflict harm.¹
**Approach to Ethical Decision-Making**

### STEP 1

**STATE AN ETHICAL DILEMMA**

Identify components of potential ethical dilemma
- Is it an ethical issue, OR a
- Communication problem, OR a
- Practitioner-patient issue, OR a
- Practitioner-supervisor/employer issue, OR a
- Legal matter
- What are the facts of the situation?
- Objectively identify the issue
- Who are key participants
- Identify your perceptions/values
- What further information is needed

### STEP 2

**CONNECT ETHICAL THEORY TO THE DILEMMA IN PRACTICE**

Employ four key principles of ethical theory*
- Autonomy
- Non-Maleficence
- Beneficence
- Justice

### STEP 3

**APPLY THE ACADEMY/CDR CODE TO THE ISSUE AND YOUR ETHICAL DECISION-MAKING**

There are four principles of the current Academy/CDR Code of Ethics:
- Competence and professional development in practice
- Integrity in personal and organizational behaviors and practices
- Professionalism
- Social responsibility for local, regional, national, global nutrition and well-being

### STEP 4

**SELECT THE BEST ALTERNATIVE AND JUSTIFY YOUR DECISION**

Identify possible alternatives to resolve the dilemma, considering:
- Cultural influences affecting your decision-making process
- How alternative solutions track with your values and your institution’s values
- Your confidence in and ability to defend the ultimate decision
- Whether the decision aligns with the Academy/CDR Code of Ethics and/or the SOPs/SOPPs
- How the decision might affect others and whether they will support it
- Make a final decision

### STEP 5

**DEVELOP STRATEGIES TO SUCCESSFULLY IMPLEMENT THE CHOSEN DECISION**

Strategies to successfully implement the chosen resolution
- Seek additional knowledge to clarify or contextualize the situation as needed
- Implement chosen resolution

### STEP 6

**EVALUATE THE OUTCOMES AND HOW TO PREVENT A SIMILAR OCCURRENCE**

- Monitor outcomes, ensuring intended outcome(s) are achieved
- What are the strategies to prevent a similar issue in the future?

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**References**


**INDIVIDUAL – VS – ORGANIZATIONAL ETHICS**

What if my ethics complaint concerns an organization or group, not an individual?

The Code of Ethics for the Nutrition and Dietetics Profession pertains to individual practitioners, not organizations. The Academy is an individual professional membership organization. Thus, the Academy cannot accept ethics complaints that pertain to organizations. If you have an organizational ethics issue:

- Reach out to the governing body or Board of Directors, if your concern involves a for-profit or non-profit organization,
- Consider contacting the American Hospital Association (AHA), if your concern relates to a hospital or healthcare system,
- The America’s Health Insurance Plans (AHIP) may be able to assist, if your complaint involves a health insurer,
- Consider contacting the professional organization that represents that profession or their state department of professional regulation, if your concern relates to a non-CDR credentialed nutrition and dietetics practitioner that is not an Academy member.

**How Do I Know if it is Really an Ethics Issue?**

In the Ethics Committee’s experience, many of the matters brought to them are not ethics matters. Instead, the matters presented are business disputes, employment disputes, or legal matters. What is...

**AN ETHICAL ISSUE?**
The violation of established rules or standards governing the conduct of a person or the members of a profession. An ethical issue is specific to one of the four principles and 32 standards of the Code.

**A LEGAL ISSUE?**
Many state and federal laws apply to our profession. If a state or federal law has been violated, the issue could result in action by the Ethics Committee. However, not every violation of the law is a breach of the Academy/CDR Code of Ethics for the Nutrition and Dietetics Profession.

**A BUSINESS ISSUE?**
An issue may be a business issue, but not an ethical issue, if it arises from a business dispute or breach of a contractual obligation, or a failure to provide products or services of an expected quality. Examples include billing or contract disputes, scheduling problems or other dissatisfaction with services provided. You should not attempt to use the Code to resolve business disputes between practitioners, other health care providers or consumers.

**AN EMPLOYMENT ISSUE?**
Employment issues can be addressed by an employer’s policy or policies or can be resolved in the workplace via the appropriate structure to provide oversight (i.e., Human Resources) or through federal and state laws that protect employees. An employment issue may not be an ethical issue, such as a disagreement with a supervisor or other employee about how to conduct business. Additional examples of an employment issue include: disagreement about time or hours worked; misleading statements to supervisors, co-workers, customers, or vendors; and misusing an employer’s assets.

The focus of the code is:

- **EDUCATION**
- **REMEDICATION**
- **SELF-REGULATION**

The purpose of the code is not policing practitioners.
Preamble:
When providing services the nutrition and dietetics practitioner adheres to the core values of customer focus, integrity, innovation, social responsibility, and diversity. Science-based decisions, derived from the best available research and evidence, are the underpinnings of ethical conduct and practice.

This Code applies to nutrition and dietetics practitioners who act in a wide variety of capacities, provides general principles and specific ethical standards for situations frequently encountered in daily practice. The primary goal is the protection of the individuals, groups, organizations, communities, or populations with whom the practitioner works and interacts.

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Principles and Standards:
1. Competence and professional development in practice (Non-maleficence)
   Nutrition and dietetics practitioners shall:
   a. Practice using an evidence-based approach within areas of competence, continuously develop and enhance expertise, and recognize limitations.
   b. Demonstrate in depth scientific knowledge of food, human nutrition and behavior.
   c. Assess the validity and applicability of scientific evidence without personal bias.
   d. Interpret, apply, participate in and/or generate research to enhance practice, innovation, and discovery.
   e. Make evidence-based practice decisions, taking into account the unique values and circumstances of the patient/client and community, in combination with the practitioner’s expertise and judgment.
   f. Recognize and exercise professional judgment within the limits of individual qualifications and collaborate with others, seek counsel, and make referrals as appropriate.
   g. Act in a caring and respectful manner, mindful of individual differences, cultural, and ethnic diversity.
   h. Practice within the limits of their scope and collaborate with the inter-professional team.

2. Integrity in personal and organizational behaviors and practices (Autonomy)
   Nutrition and dietetics practitioners shall:
   a. Disclose any conflicts of interest, including any financial interests in products or services that are recommended. Refrain from accepting gifts or services which potentially influence or which may give the appearance of influencing professional judgment.
   b. Comply with all applicable laws and regulations, including obtaining/maintaining a state license or certification if engaged in practice governed by nutrition and dietetics statutes.
   c. Maintain and appropriately use credentials.
   d. Respect intellectual property rights, including citation and recognition of the ideas and work of others, regardless of the medium (e.g., written, oral, electronic).
   e. Provide accurate and truthful information in all communications.
   f. Report inappropriate behavior or treatment of a patient/client by another nutrition and dietetics practitioner or other professionals.
   g. Document, code and bill to most accurately reflect the character and extent of delivered services.
   h. Respect patient/client’s autonomy. Safeguard patient/client confidentiality according to current regulations and laws.
   i. Implement appropriate measures to protect personal health information using appropriate techniques (e.g., encryption).

3. Professionalism (Beneficence)
   Nutrition and dietetics practitioners shall:
   a. Participate in and contribute to decisions that affect the well-being of patients/clients.
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d. Refrain from communicating false, fraudulent, deceptive, misleading, disparaging or unfair statements or claims.
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f. Refrain from verbal/physical/emotional/sexual harassment.
g. Provide objective evaluations of performance for employees, coworkers, and students and candidates for employment, professional association memberships, awards, or scholarships, making all reasonable efforts to avoid bias in the professional evaluation of others.
h. Communicate at an appropriate level to promote health literacy.
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4. Social responsibility for local, regional, national, global nutrition and well-being (Justice)
Nutrition and dietetics practitioners shall:
   a. Collaborate with others to reduce health disparities and protect human rights.
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**Autonomy:** ensures a patient, client, or professional has the capacity and self-determination to engage in individual decision-making specific to personal health or practice.¹

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**Non-Maleficence:** is the intent to not inflict harm.¹

References:
Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist

The Academy Quality Management Committee

ABSTRACT
The Academy of Nutrition and Dietetics (Academy) is the world’s largest organization of food and nutrition professionals and the association that represents credentialed nutrition and dietetics practitioners—registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs). RDNs integrate research, professional development, and practice to stimulate innovation and discovery; collaborate to solve the greatest food and nutrition challenges now and in the future; focus on system-wide impact across the food, wellness, and health sectors; have a global impact in eliminating all forms of malnutrition; and amplify the contribution of nutrition and dietetics practitioners and expand workforce capacity and capability. The Revised 2017 Scope of Practice for the RDN reflects the position of the Academy on the essential role of the RDN in the direction and delivery of food and nutrition services. The scope of practice for the RDN is composed of education and credentialing, practice resources, Academy Standards of Practice and Professional Performance, codes of ethics, accreditation standards, state and federal regulations, national guidelines, and organizational policy and procedures. The Revised 2017 Scope of Practice for the RDN is used in conjunction with the Revised 2017 Standards of Practice (SOP) in Nutrition Care and the Standards of Professional Performance (SOPP) for RDNs. The SOP address activities related to direct patient and client care. The SOPP address behaviors related to the professional role of RDNs. These standards reflect the minimum competent level of nutrition and dietetics practice and professional performance for RDNs. A companion document addresses the scope of practice for the NDTR. J Acad Nutr Diet. 2018;118:141-165.

FROM THE ACADEMY

Purpose

Academy is the leader in identifying the abilities of the RDN and linking the RDN’s expertise in food science and nutrition science with how the RDN practices dietetics.

1. Describe the scope of practice for the RDN.
2. Convey the education and credentialing requirements for the RDN in accordance with the Accreditation Council for Education in Nutrition and Dietetics (ACEND) and the Commission on Dietetic Registration (CDR).
3. Educate colleagues in other health care professions, educators, students, prospective students, foodservice providers, health care administrators, regulators, insurers, business owners and managers, legislators, and the public about the RDN’s qualifications, skills, and competence, as well as professional services provided by the RDN.

Approved August 2017 by the Quality Management Committee of the Academy of Nutrition and Dietetics (Academy) and the House of Delegates Leadership Team on behalf of the House of Delegates.

Scheduled review date: June 2023.

Questions regarding the Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist may be addressed to the Academy Quality Management Staff: Dana Buelsing, MS, manager, Quality Standards Operations; and Sharon M. McCauley, MS, MBA, RDN, LDN, FADA, FAND, senior director, Quality Management, at quality@eatright.org.
All registered dietitians are nutritionists—but not all nutritionists are registered dietitians. The Academy’s Board of Directors and Commission on Dietetic Registration have determined that those who hold the credential Registered Dietitian (RD) may optionally use “Registered Dietitian Nutritionist” (RDN). The two credentials have identical meanings. The same determination and option also applies to those who hold the credential Dietetic Technician, Registered (DTR) and Nutrition and Dietetics Technician, Registered (NDTR). The two credentials have identical meanings. In this document, the term RDN is used to refer to both registered dietitians and registered dietitian nutritionists, and the term NDTR is used to refer to both dietetic technicians, registered, and nutrition and dietetics technicians, registered.

4. Describe the relationship between the RDN and the NDTR to illustrate the work of the RDN/NDTR team providing direct patient/client care, and to describe circumstances in which the NDTR works under the supervision of an RDN.2

5. Guide the Academy, ACEND, and CDR in developing and promoting programs and services to advance the practice of nutrition and dietetics and the role of RDNs as leaders in providing quality food and nutrition care and services.

The credential, registered dietitian nutritionist, is a nationally protected title issued by CDR. The Academy’s Revised 2017 Scope of Practice for the RDN applies to all, and only, RDNs. This document does not apply to food and nutrition managers, chefs, or nutritionists with or without credential(s). The Academy publishes a scope of practice for the NDTR. The NDTR credential is also issued and administered by CDR and is a nationally protected title.

WHY WAS THE SCOPE OF PRACTICE FOR THE RDN REVISED?

Academy documents are reviewed and revised every 7 years and reflect the Academy’s expanded and enhanced mission and vision of accelerating improvements in global health and well-being through food and nutrition. Regular reviews are indicated to reflect the RDN’s expanded scope of practice due to changes in health care and other business segments, public health initiatives, new or revised practice guidelines and research, performance measurement, consumer interests, technological advances, and emerging service delivery options and practice environments. Questions and input from credentialed practitioners, federal and state regulations, accreditation standards, and other factors necessitated review and revision of the following 2012 documents which were scheduled for updates in 2017:

- Academy of Nutrition and Dietetics: Scope of Practice for the Registered Dietitian;6
- Academy of Nutrition and Dietetics: Scope of Practice for the Dietetic Technician, Registered;6
- Academy of Nutrition and Dietetics: Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitians;7 and
- Academy of Nutrition and Dietetics: Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Dietetic Technicians, Registered.8

Noteworthy changes since the Scope of Practice for the Registered Dietitian, published in 2012, are the regulation changes in the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Conditions of Participation for Hospitals, Critical Access Hospitals, and Long-Term Care Facilities, which allow a hospital or long-term care facility the option of granting RDNs ordering privileges and/or delegated orders for therapeutic diets and nutrition-related services.9-11

FOUNDATIONAL DOCUMENTS

Academy documents, along with applicable state and federal regulations, state practice acts, accreditation standards, organizational program policies, guidelines and national practice informed standards, serve as guides for ensuring safe, ethical, culturally competent,12 equitable, person-centered, quality nutrition and dietetics practice. Uses may include any of the following: guide career advancement, assist in self-evaluation, develop position descriptions, contribute to hiring decisions, initiate regulatory reform, or determine whether a specific activity aligns with a practitioner’s individual scope of practice, such as ordering privileges. Core documents of the Academy that provide a foundation for the profession of nutrition and dietetics include:

- Academy/CDR Code of Ethics13 (Revised and approved Code of Ethics available in 2018);
- Revised 2017 Scope of Practice for the RDN;
- Revised 2017 Scope of Practice for the Nutrition and Dietetics Technician, Registered14;
- Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists15;
- Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Nutrition and Dietetics Technicians, Registered16; and
- Focus Area Standards of Practice and/or Standards of Professional Performance for RDNs http://www.andjrnl.org/content/credentialing.

SCOPE OF PRACTICE

For the RDN, scope of practice focuses on food, nutrition, and dietetics practice, as well as related services developed, directed, and provided by the RDN to: protect the public, community, and populations; enhance health and well-being of patients/clients and communities; and deliver quality products, programs, and services. The scope of practice in nutrition and dietetics encompasses the range of roles, activities, and regulations within which nutrition and dietetics practitioners perform as outlined in Figure 1.17

The scope of practice for the RDN includes practice components used in nutrition and dietetics. Its depth and breadth begins with education and credentialing; incorporates practice resources; and concentrates on foundational elements of standards of practice and professional performance, codes of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics); accreditation standards, state and federal regulations, national guidelines, organizational policy and procedures, and options and
Figure 1. Nutrition and dietetics practice components for registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs).
Nutrition is defined as the “science of food, the nutrients and other substances therein, their action, interaction, and balance in relation to health and disease, and the process by which the organism ingests, absorbs, transports, utilizes, and excretes food substances.” Dietetics is derived from sciences of food, nutrition, management, communication, and biological sciences—including cell and molecular biology, genetics, pharmacology, chemistry, and biochemistry—and physiological, behavioral, and social sciences. Nutrition and Dietetics reflects the integration of Nutrition—the science of food, nutrients, and other substances contributing to nutritional status and health—with Dietetics—the application of food, nutrition, and associated sciences—to optimize health and the delivery of care and services for individuals and groups. Academy Definition of Terms (www.eatrightpro.org/scope)

resources for practice management and advancement.

EDUCATION AND CREDENTIALING REQUIREMENTS

RDN is the national credential granted to individuals who meet the education and other qualifications established by ACEND and CDR. ACEND is the accrediting agency for dietetics education programs of the Academy and is recognized by the US Department of Education as the accrediting agency for education programs that prepare RDNs. CDR is the credentialing agency of the Academy for all RDNs and NDTRs and is fully accredited by the National Commission for Certifying Agencies, the accrediting arm of the Institute for Credentialing Excellence. Accreditation by the Institute for Credentialing Excellence reflects achievement of the highest standards of professional credentialing.18

Education

All of the following components are required for eligibility for the CDR Registration Examination for the RDN credential:

1. Successful completion of required nutrition and dietetics coursework through an ACEND-accredited didactic program or coordinated program in dietetics and completion of at least a baccalaureate degree granted by a US regionally accredited university or college or foreign equivalent. Coursework typically includes food and nutrition sciences, lifespan nutrition, community nutrition, communications, business, economics, computer science, foodservice management systems, psychology, sociology, anatomy and physiology, pharmacology, genetics, microbiology, organic chemistry, and biochemistry.

2. Completion of supervised practice through a dietetic internship, individualized supervised practice pathway, or a coordinated program in nutrition and dietetics accredited by ACEND. Approximately 50% of RDNs have earned advanced degrees at the master’s or doctorate levels.19 There are international programs in dietetics that have been recognized by ACEND under the Foreign Dietitian Education Standards or International Dietitian Education Standards (http://www.eatrightpro.org/resources/acend/accreditation-programs/international-programs). For more information regarding the academic requirements and supervised practice for RDNs, refer to ACEND’s website: http://www.eatrightpro.org/resources/acend.

Credentialing

Credentialing is maintained through CDR. After completing the degree, nutrition and dietetics coursework, and supervised practice, candidates must successfully pass the required registration examination for dietitians administered by CDR.

CDR currently has reciprocity agreements with foreign regulatory boards or a foreign equivalent. “Reciprocity is extended to individuals who completed all certification requirements (didactic, supervised practice, and examination) in the country with whom CDR has an agreement,”20 including:

- Dietitians of Canada;
- Dutch Association of Dieticians/Ministry of Welfare, Public Health, and Culture;
- Philippine Professional Regulation Commission; and
- Irish Nutrition and Dietetic Institute.

For more information regarding RDN credentialing, refer to CDR’s website (www.cdrnet.org).

Candidates who have not completed supervised practice through a dietetic internship or individualized supervised practice pathway are eligible for the Registration Examination for NDTRs if they have successfully completed coursework in an ACEND-accredited didactic program in dietetics and completed at least a baccalaureate degree at a US regionally accredited college or university (https://www.cdrnet.org/program-director/registration-eligibility-requirements-for-dietetic-technicians-new-pathway-iii).21

COMPETENCE IN PRACTICE

The Academy’s Nutrition and Dietetics Career Development Guide is a cornerstone for practice management and personal advancement in nutrition and dietetics. The Guide uses the Dreyfus model of skill acquisition to illustrate how a practitioner attains increasing levels of knowledge and skill throughout a career.22 Through lifelong learning and professional development, practitioners acquire and develop skills that lead to enhanced competencies and levels of practice. The Academy’s website features a graphic representation and explanation of the Guide (http://www.eatrightpro.org/resource/practice/career-development/career-toolbox/dietetics-career-development-guide).

RDNs are required to maintain registration, including 75 hours of continuing education every 5 years documented in the CDR Professional Development Portfolio.23 In 2015, CDR released the Essential Practice Competencies for CDR Credentialed Nutrition and Dietetics Practitioners24 to provide overarching validated standards for RDNs. Practice competencies define the knowledge, skill, judgment, and attitude requirements throughout a practitioner’s career, across practice, and within focus areas. Competencies provide a structured guide to help identify, develop, and evaluate the behaviors required for continuing competence.24,25

In addition to credentials, CDR, the Academy, accredited education
institutions, and other national organizations offer certificate of training programs for RDNs to gain new skills and develop their practice. Certificates of training assist RDNs in attaining competence in various focus areas of practice and may lead to acquiring advanced degrees and certification credentials. Certificate of training programs provide instruction and training and assess the participant’s knowledge (eg, Certificate of Training in Adult Weight Management).

An example of a credential/certification is the Board Certified Specialist in Pediatric Nutrition. This certification validates competencies and knowledge previously acquired through work experience. In keeping with the Academy/CDR Code of Ethics, RDNs can only practice in areas in which they are qualified and have demonstrated and documented competence to achieve ethical, safe, and quality outcomes in the delivery of food and nutrition services. Competence is an overarching “principle of professional practice, identifying the ability of the provider to administer safe and reliable services on a consistent basis.” Competent practitioners understand and practice within their scope of practice; use up-to-date knowledge, skills, judgment, and best practices; make sound decisions based on appropriate data; communicate effectively with patients, customers, and others; critically evaluate their own practice; identify the limits of their competence; and improve performance based on self-evaluation, applied practice, and feedback from others. In addition, professional competence involves the ability to engage in clinical reasoning that facilitates problem solving and fosters person-centered behaviors and participatory decision making.

Depending on their knowledge, skills, expertise, individual interests, and competence, RDNs can work in multiple practice areas and settings, or may focus on a specific practice area or with a particular population or age group. Integral to the RDN’s commitment to lifelong learning supported by CDR’s Professional Development Portfolio Process is the recognition that additional knowledge, skills, experience, and demonstrated competence are imperative to maintaining currency with advances in practice and to evaluate the nutrition care workflow processes for improving health outcomes.

**INDIVIDUAL SCOPE OF PRACTICE**

Each RDN has an individual scope of practice that is determined by education, training, credentialing, experience, and demonstrated and documented competence to practice. Individual scope of practice is the intersection point of several elements, as illustrated in Figure 2. The RDN reviews the Academy Scope of Practice; state laws (ie, licensure, certification, title protection), if applicable; regulations and interpretive guidelines; CMS conditions of participation and coverage; accreditation standards and measures; organizational policies and procedures; and additional training, credential, and certification options possibly needed to secure advanced levels of practice, emerging opportunities, and employment positions.

**STATE LICENSURE AND PRACTICE ACTS**

State licensure and practice acts guide and govern nutrition and dietetics practice. Some laws are based on protecting the title “dietitian nutritionist”; that is, certification or title protection. These statutory provisions ensure the public has access to professionals that are qualified by education, experience, and examination to provide nutrition care services. As of 2017, 46 states have statutory provisions regarding professional regulations for dietitians and/or nutritionists (http://www.eatrightpro.org/resource/advocacy/legislation/all-legislation/licensure). This document, the Academy’s Revised 2017 Scope of Practice for the RDN, may also be used to guide the development of state practice acts or regulations.

**STATUTORY SCOPE OF PRACTICE**

Statutory scope of practice is typically established within a state-specific practice act and is interpreted and controlled by the agency or board that regulates the practice of the profession. “Legal scopes of practice for the health care professions establish which professionals may provide which health care services, in which settings, and under which guidelines or parameters. With few exceptions, determining scope of practice is a state-based activity. State legislatures consider and pass practice acts, which become state statute or code. State regulatory agencies, such as medical and other health professions’ boards, implement the laws by writing and enforcing rules and regulations detailing the acts.” Requirements for continuing education may also be specified in the practice act.

RDNs operate within the directives of applicable federal and state laws and regulations, policies and procedures established by the organization in which they are employed or provide services, and designated roles and responsibilities. Entities that pay for nutrition services, such as insurance providers, may establish additional regulations that RDNs must follow to receive payment for medical nutrition therapy (MNT) for their beneficiaries. RDNs providing tele-health services where the practitioner and patient are located in different states, the practitioner providing the patient care service must be licensed and/or meet the other applicable standards that are required by state or local laws in both the state where the practitioner is located and the state where the patient is located. To determine whether an activity is within the scope of practice of the RDN, the practitioner evaluates his or her knowledge, skill, and demonstrated and documented competence necessary to perform the service or activity in a safe and ethical manner. The Academy’s Scope of Practice Decision Tool (www.eatrightpro.org/scope), an online, interactive tool, is...
specifically designed to guide practitioners with this process.

NUTRITIONIST QUALIFICATIONS
A nutritionist is a person who studies nutrition and/or provides education or counseling in nutrition principles. This individual may or may not have an academic degree in the study of nutrition, and may or may not actually work in the field of nutrition.17 Some states have enacted licensure laws or other forms of legislation that regulate use of the title “nutritionist” and/or sets specific qualifications for holding the title. Often (but not uniformly), these state laws include an advanced degree in nutrition. According to the Academy’s definition, all RDNs are nutritionists, but not all nutritionists are RDNs.17 Refer to the state licensure board or agency for the state-specific licensing act (http://www.eatrightpro.org/resource/advocacy/quality-health-care/consumer-protection-and-licensure/state-licensure-agency-contact-list).

CREDENTIALS, CERTIFICATES OF TRAINING, AND RECOGNITIONS AVAILABLE FOR RDNs
For RDNs, CDR offers Board Certification in specialty focus areas of practice and advanced practice certification in

Figure 2. Individual scope of practice for registered dietitian nutritionists (RDNs) and nutrition and dietetic technicians, registered (NDTRs).
demonstrated a successful approach to self-growth through a portfolio assessment. The certification period is 5 years. Recertification is required to maintain the advanced practice credential. As of 2017, CDR offers Board Certification as a Specialist in Gerontological Nutrition (CSG); Board Certification as a Specialist in Oncology Nutrition (CSO); Board Certification as a Specialist in Obesity and Weight Management - interdisciplinary certification (CSOWM); Board Certification as a Specialist in Pediatric Nutrition (CSP); Board Certification as a Specialist in Renal Nutrition (CSR); and Board Certification as a Specialist in Sports Dietetics (CSSD).

Until 2002, the Academy offered the Fellow of the American Dietetic Association (FADA) credential. FADA certification demonstrated a successful approach to practice that reflected a global, intuitive, and evolving perspective; creative problem solving; and commitment to self-growth through a portfolio assessment. The FADA credential is still held by some Academy members. In 2013, the Academy began offering the recognition certificate Fellow of the Academy of Nutrition and Dietetics (FAND). FAND recognizes members who have distinguished themselves among their colleagues, as well as in their communities, by their service to the nutrition and dietetics profession and by optimizing the nation’s health through food and nutrition. Additional credentials that may be held by RDNs are listed in Figure 3. Figure 4 outlines health and wellness coaching credentials/certifications that may also be held by RDNs as this is an area of growing interest. This list is not all-inclusive because new programs are emerging and existing programs are being updated. Obtaining additional academic degree(s), and/or certificates of training or credentials/certifications are options that may be desirable or required for specific areas of practice or employment settings. Figure 5 lists certificate of training programs offered by CDR and the corresponding continuing professional education (CPE) units for each program. The programs are intensive training programs that include a self-study module and pretest, on-site program, and a take-home post-test. Certificate of training and certification programs offered by nationally recognized organizations may also be beneficial to RDNs but may not be eligible for CPE units without prior approval. See the Professional Development Portfolio Guide for a list of credentials approved for CPE units (https://www.cdrnet.org/pdp/professional-development-portfolio-guide). The lists are not all-inclusive. The credentials listed are not an endorsement and should be appropriately evaluated by the RDN for benefit in meeting patient/client/group/population/employer needs for delivery of food and nutrition-related services.

The Academy’s Professional Development Department offers distance learning through online teleseminars, webinars, self-study options, and certificates of training on various topics for continuing education. Learn more about CPE options at http://www.eatrightpro.org/resource/career/professional-development/distance-learning/online-learning. For certificates of training CPE opportunities, access the list at http://www.eatrightstore.org/products/cpe-opportunities/certificates-of-training.

NUTRITION CARE PROCESS, WORKFLOW, AND MNT
RDNs whose practice involves nutrition care, MNT, and nutrition-related services use skills, knowledge, evidence-based practice, and clinical judgment to address health promotion and wellness, and prevention, delay, or management of acute or chronic diseases and conditions for individuals and groups. RDNs use various tools and resources, including practice guidelines from federal agencies such as the National Institutes of Health and other professional organizations (eg, American Diabetes Association, National Comprehensive Cancer Network, American Society for Parenteral and Enteral Nutrition, and American Academy of Pediatrics) to guide MNT care practices. Another reference for RDNs is the standardized terminology for the Nutrition Care Process (NCP), published by the Academy as the electronic Nutrition Care Process Terminology (eNCPT) (formerly the International Dietetics & Nutrition Terminology Reference Manual). It is an online comprehensive resource guide for implementing the NCP and documenting care provided using standardized terminology (http://ncpt.webauthor.com).

The NCP is a systematic approach to providing high-quality nutrition care with its application utilized within MNT services provided by the RDN. The NCP consists of four distinct, interrelated steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation. The RDN uses the NCP and other workflow elements to individualize and evaluate care and service processes within organization systems specific to the discipline of nutrition and dietetics. Academy nutrition practice guidelines incorporate the NCP as the standard process for guiding patient/client/population care. MNT protocols provide a plan based on systematically analyzed evidence and clearly define the level, content, and frequency of nutrition care appropriate for diseases and conditions. They are a component of the Academy’s Evidence Analysis Library Evidence-Based Nutrition Practice Guideline Toolkits, which include an MNT Flowchart of Encounters and the MNT Encounter Process.
<table>
<thead>
<tr>
<th>Credentialing agency</th>
<th>Credential</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Professional Coders</td>
<td>Certified Professional Coder (CPC)</td>
</tr>
<tr>
<td>American Association of Diabetes Educators&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Board Certified in Advanced Diabetes Management (BC-ADM)&lt;sup&gt;bc&lt;/sup&gt;</td>
</tr>
<tr>
<td>American Association of Family and Consumer Sciences</td>
<td>Certified in Family and Consumer Sciences (CFCS)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>American College of Healthcare Executives</td>
<td>Board Certified as a Fellow of the American College of Healthcare Executives (FACHE)</td>
</tr>
<tr>
<td>American College of Sports Medicine</td>
<td>ACSM Certified Personal Trainer (CPT)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>American Council on Exercise</td>
<td>ACE-certified Personal Trainer&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>American Culinary Federation - Institute for Credentialing Excellence</td>
<td>Certified Executive Chef (CEC)</td>
</tr>
<tr>
<td>Board of Certification, Inc, for the Athletic Trainer</td>
<td>Athletic Trainer</td>
</tr>
<tr>
<td>Canadian Diabetes Educator Certification Board</td>
<td>Canadian Board Certified Diabetes Educator&lt;sup&gt;bc&lt;/sup&gt;</td>
</tr>
<tr>
<td>Certifying Board of Dietary Managers - Association of Nutrition &amp; Foodservice Professionals</td>
<td>Certified Dietary Manager (CDM); Certified Food Protection Professional (CFPP)</td>
</tr>
<tr>
<td>Commission for Case Manager Certification</td>
<td>Board Certified Case Manager (CCM)</td>
</tr>
<tr>
<td>Healthcare Quality Certification Commission</td>
<td>Certified Professional in Healthcare Quality (CPHQ)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>International Association of Eating Disorders Professionals&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Certified Eating Disorders Registered Dietitian (CEDRD)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>National Academy of Certified Care Managers</td>
<td>Care Manager Certified (CMC)</td>
</tr>
<tr>
<td>National Board of Nutrition Support Certification, Inc, American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Certified Nutrition Support Clinician (CNSC)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>National Certification Board for Diabetes Educators</td>
<td>Certified Diabetes Educator (CDE)&lt;sup&gt;bc&lt;/sup&gt;</td>
</tr>
<tr>
<td>National Commission for Health Education Credentialing, Inc</td>
<td>Certified Health Education Specialist (CHES)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>National Environmental Health Association</td>
<td>Certified Professional-Food Safety (CP-FS) Registered Environmental Health Specialist/Registered Sanitarian (REHS/RS)</td>
</tr>
<tr>
<td>National Strength and Conditioning Association</td>
<td>NSCA-Certified Strength and Conditioning Specialist (CSCS)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Project Management Institute</td>
<td>Certified Associate in Project Management (CAPM) Project Management Professional (PMP)</td>
</tr>
<tr>
<td>School Nutrition Association&lt;sup&gt;a&lt;/sup&gt;</td>
<td>School Nutrition Specialist (SNS)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>The International Board of Lactation Consultant Examiners, Inc</td>
<td>International Board Certified Lactation Consultant (IBCLC)&lt;sup&gt;bc&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Commission on Dietetic Registration accredited provider.<sup>34</sup>

<sup>b</sup>Seventy-five continuing professional education units approved by Commission on Dietetic Registration for completion of certification for consecutive recertification periods.<sup>23</sup>

<sup>c</sup>Seventy-five continuing professional education units approved by Commission on Dietetic Registration for completion of certification for alternate recertification periods.<sup>23</sup>

Figure 3. Credentials that can be held by registered dietitian nutritionists (RDNs) (not all inclusive).
Figure 4. Coach credential or certification options for registered dietitian nutritionists (not all inclusive).

<table>
<thead>
<tr>
<th>Credentialing agency</th>
<th>Credential/certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Council on Exercise</td>
<td>ACE-certified Lifestyle and Weight Management Coach</td>
</tr>
<tr>
<td></td>
<td>ACE-certified Health Coach&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>American Institute of Health Care Professionals</td>
<td>Health Care Life Coach-Certified (HCLC-C)</td>
</tr>
<tr>
<td>International Association for Health Coaches</td>
<td>Certified International Health Coach (CIHC)</td>
</tr>
<tr>
<td>National Society of Health Coaches&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Certified Health Coach (CHC)</td>
</tr>
<tr>
<td>International Consortium for Health &amp; Wellness Coaching</td>
<td>National Board Certified Health &amp; Wellness Coach (NBC-HWC)</td>
</tr>
<tr>
<td>and National Board of Medical Examiners</td>
<td></td>
</tr>
<tr>
<td>Wellcoaches Corporation&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Certified Health &amp; Wellness Coach</td>
</tr>
<tr>
<td></td>
<td>Certified Personal Coach</td>
</tr>
</tbody>
</table>

<sup>a</sup>Seventy-five continuing professional education unit credits approved by Commission on Dietetic Registration for completion of certification for alternate recertification periods.<sup>23</sup>

<sup>b</sup>Commission on Dietetic Registration—accredited provider.<sup>34</sup>

- assess the nutrition-related health needs of patients/clients/populations, considering other factors affecting nutrition and health status (eg, culture, ethnicity, and social determinants of health) and develop priorities, goals, and objectives to establish and implement nutrition care plans;
- provide nutrition counseling and nutrition education to optimize nutritional status, prevent disease, or maintain and/or improve health and well-being;
- make referrals to appropriate resources and programs and act as or collaborate with case managers;
- evaluate, educate, and counsel related to the use of nutrition-related pharmacotherapy plans and over-the-counter medications, dietary supplements, and food—drug and drug—nutrient interactions; and
- document care provided using standardized terminology.

Unique to RDNs is the qualification to provide MNT, a cost-effective, essential component of comprehensive nutrition care.<sup>35-39</sup> Individuals and groups with medically prescribed diets, individualized meal plans, specialized oral feedings, enteral nutrition (tube feedings), and intravenous solutions with adjustments based on the analysis of potential food or nutrient and drug interactions benefit from MNT. MNT involves in-depth nutrition assessment; determination of the nutrition diagnosis; implementation of tailored nutrition interventions for the individual or group; and periodic monitoring, evaluation, reassessment, and revised interventions designed to manage or prevent the disease, injury, or condition.<sup>17</sup> Figure 7 lists examples of medical conditions and diseases for which RDNs provide MNT, as outlined in the Academy Nutrition Care Manual.<sup>40</sup> For a complete list of Nutrition Care Manual medical conditions, including information in the Pediatric Nutrition Care Manual and Sports Nutrition Care Manual, consult the Academy Nutrition Care Manuals.<sup>40</sup> (https://www.nutritioncaremanual.org/ncm-toc).

RDNs in clinical practice:
- Provide MNT in direct care of medical diseases and conditions across the continuum of care (refer to Figure 7).
- Apply the NCP and workflow elements in providing person-centered nutrition care of individuals.<sup>15</sup>
  - Perform assessment of a patient’s/client’s nutrition status via in-person, or facility/practitioner assessment application, or HIPAA compliant video conferencing telehealth platform.
  - Complete a nutrition-focused physical exam through an evaluation of body systems, muscle and subcutaneous fat wasting, feeding ability (suck/swallow/breathe), oral health, skin condition, appetite, and affect. For additional information and education on nutrition focused physical exams, please see http://www.eatrightpro.org/resouce/career/professional-developomn/facetoface-learning/nfpe-workshop and http://www.eatrightstore.org/product/EBB27B14-7C98-40E2-A0EF-6E78AD6FF7D8.
- Order and monitor nutrition-related laboratory tests and waived point-of-care laboratory testing, in cases where an RDN has
Training title & CPEUs
Certificate of Training in Adult Weight Management Program & 35
Level 2 Certificate of Training in Adult Weight Management Program & 50
Certificate of Training in Childhood and Adolescent Weight Management & 32

**Figure 5.** Commission on Dietetic Registration Certificates of Training in Weight Management.

been granted ordering privileges, or received a delegated order from a referring physician.41-43

- Order and monitor nutrition interventions to meet person-centered nutrient and energy needs, including but not limited to prescribed diets, medical foods, dietary supplements, over-the-counter medications, nutrition support therapies such as enteral nutrition (tube feeding) and parenteral nutrition support (specialized intravenous solutions), nasogastric feeding tube placement, and provide feeding therapy (pediatric oral aversion).41-43

- Initiate, implement, and adjust protocol- or physician-order-driven nutrition-related medication orders and pharmacotherapy plans in accordance with established policy or protocols consistent with organizational policy and procedure.41

- Assist in the development, promotion, and adherence to enhanced recovery after surgery protocols, including elimination of preoperative nothing by mouth order, intraoperative nausea/vomiting prophylaxis and goal-directed fluid therapy, and early postoperative nutrition.41

- Provide nutrition counseling; nutrition behavior therapy; lactation counseling; health and wellness coaching; and nutrition, physical activity, lifestyle, and health education and counseling as components of preventive, therapeutic, and restorative health care.41

- Assess and counsel for the treatment of food allergies to prevent consumption of allergens, prevent over-restriction, prevent nutrient deficiencies, and promote optimal growth and/or weight maintenance.44

- Evaluate, educate, and counsel related to nutritional genomics, gene–diet and disease interactions; genetic, environmental, and lifestyle factors; and food–drug–drug–nutrient, and supplement–drug–nutrient interactions.44

- Manage nutrition care, collaborate with other health and nutrition professionals and as members of interprofessional teams, contribute to rounds or care conferences; be part of palliative and hospice care teams; participate in care coordination; and refer to appropriate nutrition resources, programs, or other health professionals.44

- Determine appropriate quality standards in foodservice and nutrition programs.44

- Train nutrition and dietetics personnel and NDTRs and mentor nutrition and dietetics students and interns in the provision of nutrition services.44

- Delegate to and supervise the work of the NDTR or other professional, technical, or support staff who are engaged in direct patient/client nutrition care.44

**Ordering Privileges**

Ordering privileges for RDNs became an option for acute and critical access hospitals to consider with the revisions to the CMS Conditions of Participation, when consistent with state law. **Figure 8** is a listing of regulatory changes published by CMS related to order writing privileges for RDNs or clinically qualified nutrition professionals applicable to hospitals, critical access hospitals, and long-term care facilities in 2017. Further regulatory changes for long-term care facilities allow a physician to delegate diet order writing to an RDN or clinically qualified nutrition professional. CMS will periodically revise conditions for coverage and conditions of participation for various practice settings. Use the guidance link to open each Medicare State Operations Manual Appendix for the specific practice area (e.g., hospital, critical access hospital, end-stage renal disease facilities, or long-term care) at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf). Click on the corresponding letter in the Appendix Letter column to see any available Medicare State Operations Manual file.

The RDN may write, accept, and implement orders based on federal and state laws and regulations and organization policies as well as implement established and approved protocol orders, and make recommendations for nutrition-related modifications. As part of interprofessional teams, the RDN performs health care functions based on clinical privileges or as delegated by the referring practitioner in collaboration with other health care team members, and performs other activities consistent with individual scope of practice, and role(s) and responsibilities in the organization.

**Ethical Billing Practices**

The RDN must have sound business processes and adhere to the elements of ethical billing across the continuum of practice management and the delivery of clinical nutrition care.47 For MNT billing and payment purposes, the RDN should review state licensure laws and payer policies to determine practice criteria for providing MNT services. Under Medicare Part B, MNT services are defined as “nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a Registered Dietitian or nutrition professional ... pursuant to a referral by a physician.”48 For nutrition services payment resources on coverage and reimbursement management and
**PRACTICE AREAS, SERVICES, AND ACTIVITIES**

Nutrition and dietetics as a field is dynamic, diverse, and continuously evolving. The depth and breadth of the RDN’s practice expands with advances in many areas, including nutrition, dietetics, food production, food safety, food systems management, health care, public health, community nutrition, and information and communication technology. The RDN understands how these advances influence health status, disease prevention and treatment, quality of life, agriculture, ecological sustainability, business innovation, and the safety and well-being of the public. The diversity of the population, federal and state legislative actions, health and chronic disease trends, and social and environmental trends influence professional practice and the goals and objectives of those served by the RDN. Quality health and nutrition care and services depend on active participation by patients, clients, families, consumers, groups, and communities in decisions that promote health, well-being, fitness, and performance. Integral to this effort, RDNs play critical roles in leading the public in promoting access to and incorporating healthful food supplies, food choices, and eating behaviors; working physical activity into daily lives; and aiding individuals in making informed choices regarding food and nutrition.

The majority of RDNs are employed in health care settings (e.g., hospitals, accountable care organizations, health care systems, clinics, mental health centers, rehabilitation centers, dialysis centers, bariatric centers, long-term, post-acute, or assisted-living facilities) addressing wellness, prevention, and nutrition management of diseases and medical conditions. Practice settings, services, and activities are discussed using terminology common in each area. Services and activities are not limited to the areas in which they

<table>
<thead>
<tr>
<th>Nutrition Care Process and Workflow element</th>
<th>RDN role</th>
<th>NDTR role</th>
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<tbody>
<tr>
<td>Nutrition Screening</td>
<td>Perform or obtain and review nutrition screening data</td>
<td>Perform or obtain nutrition screening data</td>
</tr>
<tr>
<td>Nutrition Assessment</td>
<td>Perform via in-person, or facility/practitioner assessment application system, or HIPAA compliant video conferencing telehealth platform and document results of assessment</td>
<td>Assist with or initiate data collection as directed by the RDN or per standard operating procedures and begin documenting elements of the nutrition assessment for finalization by the RDN</td>
</tr>
<tr>
<td>Nutrition Diagnosis</td>
<td>Determine nutrition diagnosis(es)</td>
<td>Per RDN-assigned task, communicate and provide input to the RDN</td>
</tr>
<tr>
<td>Nutrition Intervention/Plan of Care</td>
<td>Determine or recommend nutrition prescription and initiate interventions. When applicable, adhere to established and approved disease or condition-specific protocol orders from the referring practitioner</td>
<td>Implement/oversee standard operating procedures; assist with implementation of individualized patient/client/customer interventions and education as assigned by the RDN</td>
</tr>
<tr>
<td>Nutrition Monitoring and Evaluation</td>
<td>Determine and document outcome of interventions reflecting input from all sources to recognize contribution of NDTR/nutrition care team members to patient/client experience and quality outcomes</td>
<td>Implement/oversee (duties performed by other nutrition, foodservice staff) standard operating procedures; complete, document, and report to the RDN and other team members the results and observations of patient/client-specific assigned monitoring activities</td>
</tr>
<tr>
<td>Discharge Planning and Transitions of Care</td>
<td>Coordinate and communicate nutrition plan of care for patient/client discharge and/or transitions of care</td>
<td>Assist with or provide information as assigned by the RDN</td>
</tr>
</tbody>
</table>

*aHIPAA=Health Insurance Portability and Accountability Act.

*bThe RDN or clinically qualified nutrition professional is ultimately responsible and accountable to the patient/client/advocate, employer/organization, consumer/customer, and regulator for nutrition activities assigned to NDTRs and other technical, professional, and support staff.

Figure 6. Nutrition Care Process and Workflow: Roles of registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs).
are described. The RDN has multiple responsibilities and perform services and activities in various settings.

Examples of RDN practice areas, services, and activities include, but are not limited to, the following:

Acute and Ambulatory Outpatient
RDNs participate in, manage, and direct nutrition programs and services. RDNs provide and coordinate food and nutrition services and programs in health care settings such as hospitals, tertiary care centers, critical access hospitals, ambulatory clinics, specialty clinics, primary care medical homes, community health centers, bariatric centers, diabetes prevention and education programs, behavioral health centers, Veterans Affairs and military facilities, and corrections facilities.

RDNs:
- Work within the interprofessional team and with the patient/client and family and/or advocate on nutrition-related aspects of a treatment plan, including risks/burdens of nutrition intervention; participate in interprofessional rounds; provide MNT; and conduct nutrition education, counseling, discharge planning, and care coordination and management to address prevention and treatment of one or more acute or chronic conditions or diseases.
- Supervise NDTRs in the provision of direct patient/client nutrition care. Assignment of tasks takes into consideration components of the NCP and the training and competence of the NDTR and other support staff in performing the assigned functions with a specific patient/client or population. The RDN is ultimately accountable to the patient/client, physicians, regulators, and accrediting organizations for functions assigned to support staff.

Business and Communications
RDNs are employed as consultants, managers, directors, vice presidents, and chief executive officers in business and communications, where they participate, manage, and direct in areas such as news and communications, consumer affairs, public relations, food commodity boards, food and culinary nutrition, retail food business, human resources, nutrition and foodservice computer applications, product development, marketing, sales, product distribution, and consumer education. They are website managers and developers.

RDNs:
- Author books, professional and lay articles, print and electronic publications, newsletters, editorials, columns, social media podcasts, blogs, YouTube videos, and other forms of electronic media. They are also journalists, speakers, commentators, television, internet and radio personalities, and spokespersons.
- Monitor and adhere to ethical and legal guidelines applicable to social media and copyright laws for protection of intellectual property when communicating and sharing content created by other entities.

Coaching
RDNs work as health and wellness coaches in health care facilities, private practices, wellness businesses (eg, in-person or via telehealth), nonprofit organizations, and corporate wellness. RDNs:
- Educate and guide clients to achieve health goals through lifestyle and behavior adjustments.
- Have thorough knowledge and advanced understanding of behavior change, culture, social determinants of health, disease self-management, and evidence-based health education research.
- Empower clients to achieve self-determined goals related to health and wellness.

Community and Public Health
RDNs with public health and community expertise are directors, managers, supervisors, educators, practitioners, consultants, and researchers. They work in a variety of settings from the national to state and local levels, such as government
<table>
<thead>
<tr>
<th>Source</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS hospital guidance</td>
<td>“CMS would make further revisions that would allow for flexibility in this area by requiring that 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. CMS believes that hospitals that choose to grant these specific ordering privileges to RDs may achieve a higher quality of care for their patients by allowing these professionals to fully and efficiently function as important members of the hospital patient care team in the role for which they were trained. CMS stated that they believe hospitals would realize significant cost savings in many of the areas affected by nutritional care.”</td>
</tr>
</tbody>
</table>

The CMS final rule, effective July 11, 2014. The CMS State Operations Manual Conditions of Participation Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals was subsequently revised in sequential order with State Operations Manual updates issued at different times in 2014 and 2015 for implementation.9 $§482.28(b)(2): Condition of Participation: Food and Dietetic Services9 |

Who is a “qualified dietician” and “qualified nutrition professional” per hospital guidelines? $§482.28(b)(2) Condition of Participation: Food and Dietetic Services9 |

“The hospital’s governing body may choose, when permitted under State law and upon recommendation of the medical staff, to grant qualified dietitians or qualified nutrition professionals diet-ordering privileges. In many cases State law determines what criteria an individual must satisfy in order to be a “qualified dietician;” State law may define the term to mean a “registered dietician” registered with a private organization, such as the Commission on Dietetic Registration, or State law may impose different or additional requirements. Terms such as “nutritionists,” “nutrition professionals,” “certified clinical nutritionists,” and “certified nutrition specialists” are also used to refer to individuals who are not dieticians, but who may also be qualified under State law to order patient diets. It is the responsibility of the hospital to ensure that individuals are qualified under State law before appointing them to the medical staff or granting them privileges to order diets.” |

$§482.22(a): Eligibility and Process for Appointment to Medical Staff9 |

“The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at §482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body.” “Non-physician practitioners: Furthermore, the governing body has the authority, in accordance with State law, to grant medical staff privileges and membership to non-physician practitioners. The regulation allows hospitals and their medical staffs to take advantage of the expertise and

(continued on next page)
skills of all types of practitioners who practice at the hospital when making recommendations and decisions concerning medical staff privileges and membership."

“For non-physician practitioners granted privileges only, the hospital’s governing body and its medical staff must exercise oversight, such as through credentialing and competency review, of those non-physician practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff. Practitioners are described in Section 1842(b)(18)(C) of the Act as any of the following: Physician assistant; Nurse practitioner; Clinical nurse specialist; Certified registered nurse anesthetist; Certified nurse-midwife; Clinical social worker; Clinical psychologist; Anesthesiologist’s Assistant; or Registered dietitian or nutrition professional.”

**CMS CAH guidance**

CMS State Operations Manual, Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (revised December 2016). The following policies section includes dietitian privileges as implemented in April 2015

<table>
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| §485.608(d): Licensure, Certification or Registration of Personnel | “Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.”
All staff required by the State to be licensed must possess a current license. The CAH must ensure that these personnel are in compliance with the State’s licensure laws. The laws requiring licensure vary from state to state. Examples of healthcare professionals that a state may require to be licensed could include: nurses, MD/DOs, physician assistants, dieticians, x-ray technologists, dentists, physical therapists, occupational therapists, respiratory technicians and facility administrators. All CAH staff must meet all applicable standards required by State or local law for CAH personnel. This would include at a minimum: Certification requirements; Minimum qualifications; and Training/education requirements.” |
| §485.631(a)(1) 485.631(a): Staffing | “The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.” |
| §485.631(a)(2): Staffing | “Any ancillary personnel are supervised by the professional staff.” Survey Procedures “Use organizational charts and staff interviews to determine how the CAH ensures that the professional staff supervises all ancillary personnel.” |
| §485.631(b)(1)(i): Staffing | “The doctor of medicine or osteopathy (i) Provides medical direction for the CAH’S health care activities and consultation for, and medical supervision of, the health care staff.” |
| §485.635(a): Patient Care Policies Interpretive guidelines: §485.635(a)(2) and (4) | “The CAH’s written policies governing patient care services must be developed with the advice of members of the CAH’S professional healthcare staff. This advisory group must include: At least one MD or DO; |

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**Figure 8.** (continued) Catalog of regulatory changes published by the Centers for Medicare and Medicaid Services (CMS) related to order writing privileges or delegated orders for registered dietitian nutritionists (RDNs) or clinically qualified nutrition professionals in hospitals, critical access hospitals (CAHs), and long-term care facilities. Refer to CMS State Operations Manual for periodic revisions ([https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/som107Appendicestoc.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/som107Appendicestoc.pdf)).
and One or more physician assistants, nurse practitioners, or clinical nurse specialists, at least one of these non-physician practitioners if these professionals are included in the CAH’s healthcare staff, as permitted at §485.631(a)(1). A CAH with no non-physician practitioners on staff is not required to obtain the services of an outside non-physician practitioner to serve on the advisory group.”

“§485.635(a)(3)(vii): Patient Care Policies

Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving post hospital SNF [Skilled Nursing Facility] care.”

“The dietary services must be organized, directed and staffed in such a manner to ensure that the nutritional needs of inpatients are met in accordance with practitioners’ orders and recognized dietary practices. The CAH must designate a qualified individual who is responsible for dietary services. The designated individual must be qualified based on education, experience, specialized training, and, if required by State law, licensed, certified, or registered by the State.”

“All inpatients’ diets, including therapeutic diets, must be provided in accordance with orders from a practitioner responsible for the care of the patient. CAHs may choose, when permitted under State law, to designate qualified dietitians or qualified nutrition professionals as practitioners with diet-ordering privileges. In many cases State law determines what criteria an individual must satisfy in order to be a ‘qualified dietician’; State law may define the term to mean a ‘registered dietician’ registered with a private organization, the Commission on Dietetic Registration, or State law may impose different or additional requirements. Terms such as ‘nutritionists,’ ‘nutrition professionals,’ ‘certified clinical nutritionists,’ and ‘certified nutrition specialists’ are also used to refer to individuals who are not dieticians, but who may also be qualified under State law to order patient diets. It is the responsibility of the hospital to ensure that individuals are qualified under State law before appointing them to the medical staff or granting them privileges to order diets.”

Survey procedures: “Verify that the individual responsible for dietary services is qualified based on education, experience, specialized training, and, if required by State law, is licensed, certified, or registered by the State. Verify that all inpatient diets are prescribed by a practitioner(s) responsible for the care of the patient. If the State and the CAH permit dieticians or other nutrition professionals to order diets, has the CAH verified that they meet any requirements for licensure or certification under State law?”

To increase access and reduce burden, this final rule allows physicians to delegate to a qualified dietician or other clinically qualified nutrition professional the task of prescribing diet, including therapeutic diets, to the extent allowed by state law. CMS does not currently have data to estimate

(continued on next page)

Figure 8. (continued) Catalog of regulatory changes published by the Centers for Medicare and Medicaid Services (CMS) related to order writing privileges or delegated orders for registered dietitian nutritionists (RDNs) or clinically qualified nutrition professionals in hospitals, critical access hospitals (CAHs), and long-term care facilities. Refer to CMS State Operations Manual for periodic revisions (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf).
agencies, community and professional organizations, non-profit organizations, and schools. RDNs participate in federally assisted nutrition programs (eg, Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC], and the Supplemental Nutrition Assistance Program-Education [SNAP-Ed]), community programs (eg, community health centers, Feeding America, Harvesters), and Indian Health Services. RDNs:

- Monitor, educate, and advise the public and populations about nutrition-related issues and concerns.
- Design, implement, evaluate, advocate for, and supervise federally funded nutrition programs and community programs to support individuals with food insecurity and to promote sustainable, resilient, and healthy food and water systems, food safety, health equity, and population-based strategies to promote healthful eating, physical activity, and lifestyle.

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<td>Medicare and Medicaid Programs; Page 68845 of the Final Rule for Reform of Requirements for Long Term Care Facilities</td>
<td>the savings that this will produce in SNFs and NFs [Nursing Facilities], however CMS believes that it will allow for better use of both physician and dietitian time. Likewise, we also allow physicians to delegate to qualified therapists the task of prescribing physical, occupational, speech language, or respiratory therapies, but as with dietitians, we have no empirical evidence with which to quantify a cost savings. Again, however, we believe that this allows better use of both physician and therapist time.”</td>
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| The CMS Final Rule was effective on November 28, 2016. The CMS State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities was subsequently revised for implementation with updates continuing to occur in 2017 and beyond. §483.30: Physician Services §483.30(e)(2) and §483.30(e)(4): Physician Delegation of Tasks in Skilled Nursing Facilities §483.30(f): Performance of Physician Tasks in Nursing Facilities | “A resident’s attending physician may delegate the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who—(i) is acting within the scope of practice as defined by State law; and (ii) is under the supervision of the physician.”
“A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility’s own policies.” |
| §483.60(e)(1): Therapeutic Diets | “Therapeutic diets must be prescribed by the attending physician.” |
| §483.60(e)(2): Therapeutic Diets | “The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident’s diet, including a therapeutic diet, to the extent allowed by State law. Intent: To assure that the residents receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident’s treatment, plan of care in accordance with his her goals and preferences.” |
| Who is a “non-physician practitioner”? Definitions §483.30(a): Physician Services | “Non-physician practitioner (NPP) is a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA).” |
| Guidance §483.30(e)(2)-(3): Physician Services | “Physicians and NPPs may delegate the task of writing orders to qualified dietitians . . . if State practice act allows the delegation of task, and the State practice act for the qualified individual being delegated the task of writing orders permits such performance.”
“Dietary orders written by a qualified dietitian/clinically qualified nutritional professional, or therapy orders written by therapists, do not require physician co-signature, except as required by State law.” |
behaviors. Contribute to emergency preparedness and coordinate food and nutrition services during disasters.  

- Collect, analyze, and report health- and nutrition-related data on specific populations to establish trends, identify benchmarks, and measure effectiveness of nutrition and related interventions.

- Advocate to decrease health disparities (eg, social determinants of health) of specific populations and promote health policies that improve the patient/client experience of care, improve the health of populations, and reduce the per capita cost of health care.

- Provide and coordinate culturally competent nutrition services and programs, including MNT to individuals and groups; collaborate with others to develop nutrition programs and services in accordance with the Public Health Accreditation Board standards and measures; plan and deliver training and education for health personnel; and advocate for sound food and nutrition legislation, policies, and programs at the federal, state, and local levels.

**Culinary and Retail**

RDNs are culinary educators, food writers, cookbook authors, chefs, marketing professionals, public relations executives, supermarket–retail dietitians, food scientists, food and beverage purchasers, consultants, and media reporters. RDNs are executives, directors, managers, researchers, supervisors, and consultants in retail, corporate, agribusiness, and restaurants. RDNs:

- Provide food, nutrition, and culinary expertise in the design, development, and production of food products and menus, including selection of ingredients, methods of preparation, nutrient analysis of recipes and nutrient characteristics; and evaluate cultural appropriateness and customer satisfaction in the production and development of food products, recipes, and menus.

- Educate clients, customers, and the public on food safety.

**Entrepreneurial and Private Practice**

RDNs in private practice are entrepreneurs and innovators in providing nutrition products and services to peers/colleagues, consumers, industry, media, government, for-profit and nonprofit organizations, agribusiness, and businesses. They are chief executive officers, business owners, consultants, professional speakers, writers, journalists, chefs, educators, health and wellness coaches, and spokespersons. They may work under contract or as consultants for organizations and government agencies, such as healthcare or food companies, businesses and corporations, employee wellness programs, public relations, and with the media. Work environments and practice settings are often as varied as the services being provided: clinics, business and government offices, home offices, fitness centers, patient/client homes, online and telehealth, supermarket–retail, and restaurants and food venues. RDNs:

- Provide MNT to individuals and groups in all populations. A promotional source for RDNs to utilize is the Find a Registered Dietitian Nutritionist locator on the Academy website at http://www.eatright.org/find-an-expert.

- Provide comprehensive food and nutrition services to individuals, groups, foodservice and restaurant managers, supermarket–retail and other food vendors and distributors, culinary programs, corporate wellness, athletes, sports teams, and company employees.

- Act as expert witnesses and consultants on legal matters related to food and nutrition services and dietetics practice.

- Design nutrition software, websites, blogs, podcasts, videos, nutrition education tools, and nutrition-related products.

**Foodservice Systems**

RDNs manage and direct or serve as consultants to foodservice operations in health care and other institutions and commercial settings. They are also employed by contract foodservice management companies (eg, in hospitals, schools, colleges and universities, continuing care communities, long-term care hospitals, critical access hospitals, rehabilitation centers, extended care settings, government facilities, retail, and corrections facilities) and commercial settings (eg, restaurants, food distribution and vending, and catering). RDNs:

- Participate in, manage, or direct any or all of the following: menu and recipe management; food, supplies, and equipment purchasing; food receiving, storage, preparation, and service; quality assurance, safety, performance improvement, and customer satisfaction; quality improvement projects; financial management; human resource management; food safety and sanitation programs; waste management, water conservation and composting programs; vending services and catering for special events; foodservice in emergency situations, and kitchen design and redesign.

- Use a wide variety of electronic tools to manage data and may specialize in the development and management of specific technological applications related to foodservice operations.

- Collaborate with the speech language pathologist(s) and the interprofessional team to adopt and use the International Dysphagia Diet Standardization System for texture-modified foods and liquids for individuals with dysphagia.

**Global Health**

RDNs are humanitarians working in foreign countries, following the foreign country’s policies, laws, and regulations, with the objective of influencing food, nutrition, and health. RDNs work internationally in health care; communities; federal and local health departments; schools, colleges, and universities; and private practice. RDNs are authors, educators, activists, researchers, and health care workers. RDNs:

- Educate clients, customers, and the public on global health issues related to nutrition using resources such as the Academy Foundation’s International Resources and Opportunities (http://
Advocate for and influence local and federal health policy in America and foreign countries related to global health issues such as sustainable and healthy agriculture; food and water sanitation and hygiene; malnutrition and nutrition insecurity; potable drinking water; maternal, infant, and child nutrition; and human immunodeficiency virus and acquired immune deficiency syndrome.

Provide assistance and guidance during health and nutritional crises, societal upheaval, and natural disasters.

Demonstrate respect and sensitivity to the local culture.

Conduct research on global health and nutrition to address current and anticipated food and nutrition challenges, influence health policy, and address and eliminate all forms of malnutrition.

Integrative and Functional Medicine
RDNs are skilled in integrative and functional medicine, nutritional genomics, foods, targeted nutrition and dietary supplements and utilizing the NCP in a broad range of holistic and therapeutic modalities. RDNs practice integrative and functional medicine in acute and ambulatory outpatient, coaching, community and public health, private practice, post-acute health care, prevention and wellness care, and research settings. RDNs:

- Promote the integration of conventional and integrative medical and nutrition practices, clinical judgment, and evidence-based alternatives through research, education, and informed practice.
- Lead evidence-based and science-based therapies, including basic concepts of nutritional genomics, gene—diet and disease interactions, holistic health care, and functional nutrition therapies using the Integrative and Functional Medical Nutrition Therapy (IFMNT) Radial (https://integrativerd.org/ifmnt-radial/). The Integrative and Functional Medicine Nutrition Therapy Radial is a model for critical thinking that embraces both the science and art of personalized nutrition care with consideration of multiple conventional or alternative medicine disciplines using five key areas: lifestyle, systems (signs and symptoms), core imbalances, metabolic pathways/networks, and biomarkers.
- Provide training and education to teams ensuring competent nutrition professional and food-service workforce.
- Comply with discharge planning and transitions of care requirements as well as facility policies and procedures to meet patient/client identified post-discharge needs.

Malnutrition
RDNs, as a part of interprofessional teams, manage and direct malnutrition care for patients/clients in health care settings such as acute care hospitals, tertiary care centers, critical access hospitals, ambulatory clinics, specialty clinics, Veterans Affairs and military facilities, children’s hospitals, long-term care hospitals, home health, skilled nursing facilities, memory units, long-term/extended care, continuing care communities, and assisted-living facilities.

Because malnutrition is recognized as a national health and public safety issue, RDNs play a key role in evaluating their nutrition care workflow throughout the continuum of care. (National Blueprint: Achieving Quality Malnutrition Care for Older Adults, http://defeatmalnutrition.today/blueprint/). RDNs:

- Establish malnutrition standards of care and conduct timely screening, assessment, intervention/plan of care to identify appropriate medical malnutrition diagnosis.
- Lead the interprofessional team to identify quality gaps in malnutrition care, evaluate the clinical workflow process, and facilitate quality improvement projects to advance malnutrition care delivery (http://www.eatrightpro.org/malnutrition).

Management and Leadership
RDNs serve in all levels of management (eg, consultant, supervisor, manager, unit manager, director, system director, administrator, vice president, president, chief operations officer, executive officer, and owner). Practice settings for RDNs include health care organizations, schools, colleges and universities, businesses, and corporate settings such as food distribution, group purchasing, health and wellness coaching, nonprofits, association management, population health, and government agencies. Responsibilities range from managing a unit, department, and multidepartments to systemwide operations in multiple facilities.

Management practice areas include health care administration, food and nutrition services, clinical nutrition services, foodservice systems, multidepartment management, and clinical services and care coordination with multiple disciplines (eg, diabetes education center, wound care program, nutrition support team, bariatric center, and medical home management). RDNs are involved in public health agencies, overseeing health promotion and disease prevention, promotion of programs in states and communities, research, community health programs/agencies that serve a specific client population, and corporate wellness and/or consulting services for organizations seeking a specific product or service. RDNs:

- Lead people “to achieve a common goal by setting a direction, aligning people, motivating and inspiring.”
- Provide overall direction for area(s) of responsibility that reflects strategic thinking and planning to align with mission, vision, and principles of the organization to achieve desired outcomes.
- Identify needs and wants of customers to direct the design and
delivery of customer-centered services in line with an organization's mission and expectations.

- Ensure the employee workforce is engaged in the vision for services through training, mentoring, opportunities to give input, and with clear expectations for performance and accountability.

**Military Service**

RDNs serve as active duty and reserve component commissioned officers in the US Armed Forces and work as federal civilian employees alongside active duty and reserve RDNs. RDNs serve as consultants for military readiness, medical education, military training, development of operational meals, Special Operations Forces Human Performance Programs, and overseas Department of Defense school nutrition programs. Practice areas include clinical nutrition and dietetics, health promotion and wellness, community nutrition, and foodservice management. RDNs:

- Educate, counsel, and advise warfighters regarding fueling for operations, recovering from training/missions and injury/illness, such as burns and trauma, achieving and maintaining mission-specific body composition, optimizing mental function, and preparing for arduous environments.
- Manage, develop curriculum, and provide instruction for the US Army dietetic internship.
- Provide nutrition expertise worldwide to active duty and retired service members, their families, and other veterans who are eligible for care in the military health care system.
- Provide nutrition expertise for the Department of Defense, responsible for enhancing human health and performance through policy development, applied nutrition research, comprehensive nutrition assessment, education and intervention, and menu evaluation.

**Nonpracticing**

RDNs who are not working in the nutrition and dietetics workforce, but are maintaining their credential, are ethically obligated to maintain the minimum competent level of practice as outlined in the SOP in nutrition care and/or SOPP15 or an applicable focus area SOP and/or SOPP16 RDNs:

- Identify essential practice competencies for their CDR Professional Development Portfolio and obtain relevant continuing professional education to meet certification and licensure requirement, when applicable.
- Obtain or enhance subject matter knowledge to support information sharing and volunteer activities, particularly where experience as an RDN is a reason for participation or appointment.

**Nutrition Informatics**

Nutrition informatics is the intersection of information, nutrition, and technology and is supported by information standards, processes, and technology.17 RDNs are leaders in the effective retrieval, organization, storage, and optimum use of information, data, and knowledge for food and nutrition-related problem solving and decision making.63,64 RDNs:

- Lead and participate on teams to design or develop criteria for the selection or implementation of software programs, applications, or systems as well as design and implement nutrition software and nutrition education tools.
- Use technology for recipe and menu management, perform or oversee nutrition analysis of product ingredients to comply with state and federal regulations for food labeling and restaurant menu nutrient analysis.
- Utilize the NCP steps, standardized terminology, structured data, and information, such as patient results, to support evidenced-based practice. Participate on interprofessional teams to select optimal technologies and practices to support patient outcomes.
- Use nutrition and health applications (apps)65,66, electronic health records for acute care, outpatient, and post-acute and long-term care settings; and other consumer tools for managing health care data.66 Monitor compliance with Health Insurance Portability and Accountability Act (HIPAA) in the design and use of technologies.
- Educate students and practitioners on informatics and conduct research on informatics tools and processes to enhance practice.

**Post-Acute, Long-Term, Home, and Palliative Care**

RDNs provide and coordinate, or are consultants to food and nutrition services and programs in post-acute care settings (eg, long-term acute care facilities, home health, skilled nursing, memory units, long-term care, continuing care communities, and assisted-living facilities). RDNs are members of interprofessional health care teams that provide palliative and/or end-of-life care (eg, hospice) to adult, pediatric, and neonate patients/clients. RDNs:

- Participate in, manage, and direct nutrition programs and services to identify and evaluate individuals for nutritional risk, provide consultation to the physician and interprofessional health care team on nutrition health care aspects of a treatment plan.
- Participate in care conferences, provide MNT and nutrition education and counseling and care coordination and management to address prevention and treatment of one or more acute or chronic conditions or diseases, and provide support for end-of-life care.
- Are responsible for clinical ethics awareness involving life-sustaining therapies including nutrition interventions, reflecting evidence-based guidelines that evaluate the potential benefits and risks/burdens of therapeutic nutrition support (enteral and intravenous nutrition) in myriad of clinical situations.57,68
- Communicate with the patient/client, family, guardians, and/or advocate15 regarding benefits and risks/burdens of nutrition intervention options.57-70

**Preventive Care, Wellness, and Weight Management**

RDNs are leaders in evidence-based nutrition practices that address
wellness and disease prevention at all stages of life. RDNs recognize that nutrition and physical activity interact to improve the quality of life. National weight management companies, hospital wellness and weight management programs, diet food and supplement producers, and spas employ RDNs at the corporate level. RDNs are employed as developers, consultants, managers, coordinators, health and wellness coaches, and providers of corporate wellness and weight management programs. They are program staff and consultants specializing in health, weight management, and individualized nutrition counseling, and work with wellness programs and fitness programs. RDNs:

- Create nutrition education resources and provide nutrition counseling and guidance for active lifestyles that are consistent with achieving risk reduction from chronic disease, proactive health maintenance, and optimal nutrient intake for healthy lifestyles.
- Address prevention and treatment of overweight and obesity throughout the lifespan.
- Partner with and link the public, scientific organizations, and industry in providing nutrition and weight management services and programs to patients, clients, groups, consumers, and customers.

Quality Management
RDNs work independently and in teams within various health care (acute and post-acute), community and public health, population health, and business settings in the quality and safety area. Quality management professionals oversee the administration of quality, process, and/or business improvement efforts. They typically have authority over a clearly defined area of the organization that may include regulations and industry standards and have a number of direct reports. RDNs:

- Recognize and identify system errors, establish goals, collect qualitative and quantitative data using mixed methodologies, identify trends, and develop and implement strategies.
- Design and implement outcomes-based initiatives in quality assurance and performance improvement, performance measurement, process improvement, and quality improvement to document outcomes of services and compliance with regulations, policies, and procedures, and to monitor and address customer satisfaction.
- Develop, manage, and implement techniques and tools for process improvement; evaluate, document, and communicate quality improvement project outcomes; and interpret data to formulate judgments, conclusions, and reports.
- Report quality measures to CMS; measure or quantify health care processes, outcomes, patient/client perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality care and services.
- Develop, administer, evaluate, and consult regarding food and nutrition policy, including quality standards and performance improvement in foodservice and nutrition programs.

Research
RDNs involved in research are employed in a variety of settings, including general clinical research centers; clinical and translational research centers; academic medical centers; nonprofit research entities; academia; food, dietary supplement, and pharmaceutical companies; and municipal, state, and federal government agencies (eg, National Institutes of Health, the US Department of Agriculture, Food and Drug Administration, the Environmental Protection Agency, Centers for Disease Control and Prevention, and American Indian/Alaska Native Tribal Governments and organizations). RDNs:

- Apply for, direct, and manage grants.
- Design, oversee, and conduct food and nutrition-related research, guide development and implementation of guidelines, and support and develop policy and recommendations for individuals, groups, and special populations.
- Author publications, participate in the peer-review process for grants and manuscripts, and serve on study sections to identify and define priority research areas.
- Interpret, apply, and instruct others on research findings related to food technology, nutrition science, and nutrition and dietetics practice.

School Nutrition
RDNs are employed in early childhood, elementary, and secondary education nutrition programs at the local, state, and national levels to contribute to healthy school environments. They work as educators, agency directors, researchers, and directors of school nutrition programs. RDNs are employed as corporate dietitians supplying products or services to school nutrition operations and as consultants in school nutrition and wellness. RDNs:

- Adhere to Dietary Guidelines for Americans, US Department of Agriculture Food and Nutrition Service (USDA FNS), state agency guidance and regulations, and provide or consult on school-based special diets.
- Provide leadership in a variety of initiatives supported and sponsored by the USDA FNS and various local, state, and national food and nutrition organizations and alliances.
- Promote, advocate for, implement, interpret, and manage federal nutrition program regulations (eg, National School Lunch Program, Child and Adult Care Food Program, and Summer Food Service Program).

Sports Nutrition and Dietetics
RDNs are employed in and/or consult with individual athletes; rehabilitation centers; sports medicine clinics; community and medical fitness centers; amateur, collegiate, and professional sport organizations; the US Olympic Committee; academia; the military; high school, club associations, and sports performance entities; and sports food business and industry. RDNs are members of interprofessional sports
medicine and athletic performance teams in providing nutrition guidance for performance, as well as the prevention and/or management of chronic disease; provide foodservice to athletes and athletic teams and manage related foodservice budgets; and conduct research in sports nutrition and exercise science. RDNs work in prevention of and nutrition interventions for eating disorders, disordered eating, and the relative energy deficiency in sport (RED-S). RDNs develop nutrition programs and counsel the military, first responders, and others whose job requirements include physical performance and/or maintenance of specified levels of physical conditioning or body weight and body composition. 

RDNs:

- Conduct body composition assessment and provide recommendations for change based on sport, position, job requirements, and/or goals.
- Educate and develop nutrition strategies for athletes to support performance, recovery, immune function, and injury prevention or recovery. Sports nutrition strategies are tailored to sport, position, health status and parameters, lifestyle, performance goals, rest/training/competition days, and competition vs off-season.
- Evaluate performance-focused laboratory levels to assess for nutrient deficiency and provide recommendations for improvement in cooperation with the sports medicine team.

Sustainable, Resilient, and Healthy Food and Water Systems

RDNs are leaders and managers in sustainable and accessible food and water systems. RDNs are owners/operators of and/or employed in food banks, food pantries, farms, agribusiness, nongovernment organizations in natural resource conservation and farming groups, local, state, and federal government, private practice consulting, writing and speaking, academia, and foodservice systems management from farm to institution. RDNs serve in leadership capacities on food policy councils, sustainability committees, and food gardening groups. RDNs:

- Promote increased appreciation for and understanding of food security and resiliency, agricultural production, and environmental nutrition issues.
- Promote and establish a culture of food safety in foodservicest, clinical practices, community settings, and in public venues.
- Educate and support policies, systems, and environments that advance sustainable healthy food and water systems related to current and emerging food production, processing, distribution, marketing, retail, and waste management practices.

Telehealth

RDNs use electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. RDNs use interactive electronic communication tools for health promotion and wellness, and for the full range of MNT services that include disease prevention, assessment, nutrition focused physical exam, diagnosis, consultation, therapy, and/or nutrition intervention. For communication of broad-based nutrition information, RDNs use the internet, webinars, video conferencing, e-mail, and other methods of distance communications in various settings such as ambulatory clinics, outpatient clinics, community health centers, private practice, and bariatric centers. RDNs:

- Lead and participate on teams to design or develop criteria for the selection or implementation of software programs, applications, or systems to support long-distance communication or consultation.
- Provide consultations for nutrition management of health conditions using the NCP steps and the appropriate standardized terminology for documentation and payment.
- Conduct real-time HIPAA compliant interactive audio and video telecommunications at the distant site communicating with the patient/client located at one of the authorized originating sites.
- Monitor telehealth technologies for (HIPAA) compliance.

US Public Health Service

RDNs are members of the commissioned corps of the US Public Health Service (USPHS). RDNs work in the US Department of Health and Human Services and in other federal agencies and programs, including the Health Resources and Services Administration, Food and Drug Administration, National Institutes of Health, Centers for Disease Control and Prevention, and CMS. RDNs in the USPHS may be deployed to sites of national emergencies within the United States. RDNs:

- Manage staff and interns; oversee foodservice operations; provide inpatient and outpatient clinical nutrition services; plan, design, and implement research; ensure food and dietary supplement label compliance; inspect food for food safety; and educate the public on nutrition, food labeling, and biologics.

Universities and Other Academic Settings

RDNs are program directors, faculty members, and administrators for academic departments/units, including accredited nutrition and dietetics didactic programs (DP), internship programs (DI), technician programs (DT), and coordinated programs (CP); culinary programs; and hospitality programs in colleges, universities, and academic medical centers. RDNs are program directors, undergraduate- and graduate-level faculty, and preceptors for dietetic internships, supervised practice experiences, and nutrition and dietetics technician programs, and managers and directors of campus foodservicest and student health services, nutrition education, and nutrition awareness programs. RDNs:

- Develop and direct accredited nutrition and dietetics education programs; lead ongoing program and curriculum evaluation and assessment of student learning outcomes; and develop policies and procedures for nutrition and
diabetes education program management and operations.

- Educate, instruct, and mentor nutrition and dietetics students, dietetic interns, health care professionals, medical/nursing/other allied health professional students and residents, and others in food, nutrition, health care, and health-related disciplines as faculty members in academic programs, and/or as preceptors for supervised practice experiences.

- Create opportunities for nutrition and dietetics students and interns to experience a wide variety of career options, including what may be considered nontraditional paths.

- Author textbooks and other education curriculum support and training materials; develop innovative learning strategies, including active learning, simulation, and objective structured clinical examination options to enhance applied learning opportunities.

- Conduct nutrition, food science, food safety, and related basic and applied research.

- Create and manage academic and nonacademic campus-based nutrition and dietetics education programs and promote nutrition awareness, direct and lead campus foodservice departments and campus services in residential living units, retail settings, and catering.

NUTRITION AND DIETETICS VISIONING

The Academy of Nutrition and Dietetics Visioning Report 2017: A Preferred Path Forward for the Nutrition and Dietetics Profession,75 envisioned nutrition and dietetics in the next 10 to 15 years. The Academy is responsible for formalizing an ongoing process to define future nutrition and dietetics practice. The Academy used a visioning process and identified 10 change drivers with associated trends, implications, statements of support, and recommendations.75 RDNs will utilize the change drivers as a guide to enhance the profession of nutrition and dietetics and to maintain relevance in the RDN's nutrition and dietetics practice. The 10 change drivers are:

- aging population dramatically impacts society;
- embracing America’s diversity;
- consumer awareness of food choice ramifications increases;
- tailored health care to fit my genes;
- accountability and outcomes documentation become the norm;
- population health and health promotion become priorities;
- creating collaborative-ready health professionals;
- food becomes medicine in the continuum of health;
- technologic obsolescence is accelerating; and
- simulations stimulate strong skills.

For additional information on the visioning process and findings, refer to http://www.eatrightpro.org/visioning.

FUTURE STEPS FOR NUTRITION AND DIETETICS PRACTITIONERS, EDUCATORS, AND STUDENTS

Effective January 1, 2024, CDR will administer a graduate degree eligibility requirement for the RDN credential. CDR voted to change the entry-level registration eligibility education requirements for RDNs from a baccalaureate degree to a minimum of a graduate degree. This requires that all new RDN exam candidates have a graduate degree in any area along with meeting specified nutrition and dietetics coursework and supervised practice requirements. The diversity of the profession promotes a wide array of degree topics that are seen as related. “Related” is very broadly interpreted to include a variety of business-type degrees such as marketing, human resources, organization development, and labor relations that would support a student’s career goals with the diverse options within nutrition and dietetics. It is anticipated that a graduate-level degree in nutrition and dietetics would be the most efficient means for students to obtain the necessary competence for nutrition and dietetics practice. The graduate degree may be completed at any time before applying for registration eligibility.76

Information on the work of the ACEND Standards Committee is reported monthly and includes updates as well as responses to questions on the 2017 accreditation standards and the proposed future education model. ACEND has recommended changes in the future educational preparation of RDNs. These recommendations have resulted in the release of new accreditation standards. Learn more at http://www.eatrightpro.org/resources/acend/accreditation-standards-fees-and-policies. Materials on the Future Education Model Accreditation Standards for Associate, Bachelor’s, and Graduate Degree Programs and the early adopter demonstration program can be found at www.eatrightpro.org/FutureModel.

SUMMARY

The Revised 2017 Scope of Practice for the RDN describes the Academy’s position on the qualifications; competence expectations; and essential, active, and productive roles and responsibilities for practitioners with the RDN credential. An RDN’s individual scope of practice is developed through entry-level education and supervised practice and is enhanced over time with learning opportunities (eg, advanced degree, continuing professional education, certificates of training, and specialist certifications) and practice experiences. Because RDNs are skilled clinicians and practitioners in varied settings, they contribute to the health and well-being of individuals of all ages and provide quality food- and nutrition-related products and services. The Academy’s future initiatives will offer new and challenging opportunities that will expand the RDN’s nutrition and dietetics practice. This Revised 2017 Scope of Practice for the RDN is a dynamic document; it will continue to be updated with future revisions reflecting changes in health care, public health, education, technology, sustainability, business, and other practice segments impacting RDN practice. Along with the Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for RDNs, it serves as the RDN’s practice resource to support career development, advancement, and ethical and competent practice.
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Academy Scope of Practice: Tools for Determining Competence and Advancing Practice

IN THE PURSUIT OF LIFELONG learning, professional development, and the highest level of scope of practice, the individual registered dietitian (RD) or registered dietitian nutritionist (RDN) and dietetic technician, registered (DTR) must continually self-assess his or her skills, education, training, and knowledge, as well as his or her autonomy, responsibility, and accountability in the practice of nutrition and dietetics. These are the critical components of a profession. How a profession determines its unique role is answered through sources of professional direction. “Professions develop documents or statements about what the members feel is important in order to guide their practice, to establish control over practice, and to influence the quality of that practice.” Examples are social policy statements, scope and standards of practice, code of ethics, and state boards that operate under a practice act detailing regulations to protect the health and safety of the public.

Responding to our members’ requests, the Academy of Nutrition and Dietetics defined professional scope of practice characteristics and metrics through the development of the Comprehensive Scope of Practice Resources for the Registered Dietitian or Registered Dietitian Nutritionist* and the Comprehensive Scope of Practice Resources for the Dietetic Technician, Registered.

The Resources are an all-inclusive set of documents that describe the knowledge and skills the RD or RDN and DTR need to acquire in order to provide quality nutrition and dietetics care. The Resources describe the tasks and services RDs or RDNs and DTRs perform to meet employer, government, customer/client/patient, and other stakeholder requirements and opportunities. The Comprehensive Scope of Practice Resources assist the RD or RDN and DTR in their commitment to improving the nation’s health through food and nutrition.

What is the next step in the process of defining competence in practice? Competence is essential for quality assurance and performance improvement. Competence is “a principle of professional practice, identifying the ability of the provider to administer safe and reliable services on a consistent basis”. According to Principle 14 of the Academy of Nutrition and Dietetics and Commission on Dietetic Registration (CDR) Code of Ethics, “The dietetics practitioner assumes a lifelong responsibility and accountability for personal competence in practice, consistent with accepted professional standards, continually striving to increase professional knowledge and skills and to apply them in practice.”

And according to an Academy/CDR Ethics Opinion, “Professionals who are competent use up-to-date knowledge and skills; make sound decisions based on appropriate data; communicate effectively with patients, customers, and other professionals; critically evaluate their own practice; and improve performance based on self-awareness, applied practice, and feedback from others.” Credentialed nutrition and dietetics practitioners’ effectiveness is gauged through the use of self-assessment competence tools. The Academy provides tools for determining competence and advancing practice via the Comprehensive Resources. They are:

1. Scope of Practice in Nutrition and Dietetics
2. Scope of Practice for the Registered Dietitian
3. Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitians
4. Scope of Practice for the Dietetic Technician, Registered
5. Standards of Practice in Nutrition Care and Standards of Professional Performance for Dietetic Technicians, Registered
6. Definition of Terms List
7. Scope of Practice Decision Tool

SCOPE OF PRACTICE IN NUTRITION AND DIETETICS

The Scope of Practice in Nutrition and Dietetics is an overview of the profession that describes components of the scope of practice in nutrition and dietetics and assists with RD or RDN and DTR scope of practice decision making to provide safe, high-quality food and nutrition services. The article includes a Scope of Practice figure, a visual that outlines the education and credentials required for the RD or RDN and DTR, the references needed for managing and advancing practice, and the available standards and resources from the Academy and quality organizations.

SCOPE OF PRACTICE FOR THE REGISTERED DIETITIAN

The Scope of Practice for the RD describes the roles and activities within which the RD or RDN performs. The RD’s or RDN’s scope of practice expands

*The Academy adopted the registered dietitian nutritionist (RDN) credential on March 13, 2013 (National RD Day), after the electronic publication of the five scope and standards of practice articles collected in this supplement to the Journal. All references to the registered dietitian (RD) in these articles and tools also apply to the RDN.

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with advances in nutrition and food science, health care, and information technology, and is driven by national health quality initiatives and evidence-based research that demonstrates the impact of food and nutrition on health status, disease prevention and treatment, quality of life, and the safety and well-being of the public.

STANDARDS OF PRACTICE IN NUTRITION CARE AND STANDARDS OF PROFESSIONAL PERFORMANCE FOR REGISTERED DIETITIANS

The Revised 2012 Standards of Practice (SOP) in Nutrition Care and Standards of Professional Performance (SOPP) for Registered Dietitians provide a synopsis of the rationale for the RD or RDN standards, details quality indicators, and reviews the role delineation and relationship between the RD or RDN and DTR. The SOP/SOPP is utilized by RDs or RDNs to:

- evaluate practice and performance through self-assessment;
- reflect the minimum competent level of practice and professional performance;
- measure quality and performance improvement through outcomes examples;
- outline quality indicators for practice and performance; and
- guide professional continuum growth and practice development.

The supplementary flowchart on how to use the SOP/SOPP in Figure 3 of the article illustrates the best method for implementing the 2012 SOP for RDs in Nutrition Care and the SOPP for RDs.

SCOPE OF PRACTICE FOR THE DIETETIC TECHNICIAN, REGISTERED

The Scope of Practice for the DTR describes the roles and activities within which the DTR performs. The Scope of Practice for the DTR focuses on food and nutrition and related services provided by the DTR who works under the supervision of an RD or RDN when in direct patient/client nutrition care for the delivery of medical nutrition therapy (MNT). DTRs also work independently in areas such as community/public health, business and industry, research, and management of food and nutrition services in a variety of practice settings.

STANDARDS OF PRACTICE IN NUTRITION CARE AND STANDARDS OF PROFESSIONAL PERFORMANCE FOR DIETETIC TECHNICIANS, REGISTERED

The Revised 2012 Standards of Practice (SOP) in Nutrition Care and Standards of Professional Performance (SOPP) for Dietetic Technicians, Registered, provide a conceptual overview of the rationale for the DTR standards, details quality indicators, and reviews the relationship between the RD or RDN and DTR. The SOP/SOPP is utilized by DTRs to:

- evaluate practice and performance through self-assessment;
- reflect the minimum competent level of practice and professional performance;
- measure quality and performance improvement through outcomes examples;
- outline quality indicators for practice and performance; and
- guide professional continuum growth and practice development.

The supplementary flowchart on how to use the SOP/SOPP in Figure 3 of the article illustrates the best method for implementing the 2012 SOP for DTRs in Nutrition Care and the SOPP for DTRs.

PRACTICE TOOLS

The RD or RDN and DTR use practice tools such as the Definition of Terms, the Scope of Practice Decision Tool, and Quality Management Practice Tips and Case Studies to assist in providing safe, culturally competent, high-quality food and nutrition services. The Definition of Terms is a cumulative anthology of definitions developed by the Academy. The term list is alphabetical and cross-referenced and includes descriptions, key considerations, and references. The definitions are broad based, have implications for use across the nutrition and dietetics profession, and are consistent with the regulatory and legal needs of the profession. The terms are a resource for the RD or RDN, the DTR, and other food and nutrition practitioners. As a reference document, the definitions serve as standardized language with standardized application in various practice settings.

The Scope of Practice Decision Tool is an online, interactive tool that permits an RD or RDN and DTR to answer a series of questions to determine whether a particular activity is within his or her scope of practice. The Tool is designed to allow RDs or RDNs and DTRs to critically evaluate, by using criteria resources, their knowledge, skill, and demonstrated competence. RDs or RDNs and DTRs utilize the Tool to define their individual competence within each separate activity. The Quality Management Practice Tips and Case Studies outline steps for frequently asked questions on quality care and service and review actual scenarios affecting credentialed nutrition and dietetics practitioners.

RD OR RDN AND DTR RESPONSIBILITY

All RDs or RDNs and DTRs are individually responsible for knowledge and understanding of all Scope of Practice and Standards of Practice and Professional Performance resources and practice tools. The resources and tools aid RDs or RDNs and DTRs in assessing their individual scope of practice and, if applicable, statutory scope of practice, and support RDs or RDNs and DTRs in providing safe, high-quality food and nutrition services. The Academy’s Quality Management Committee advises all RDs or RDNs and DTRs to have the most recent copy of the Scope of Practice in Nutrition and Dietetics and its components (as found in this supplement) in their personal libraries. The documents will continue to be reviewed and revised as new trends in the profession of nutrition and dietetics and external influences emerge.

References

The Academy’s Governance and Practice:
Restructuring for the Challenges of the Turn of
the 21st Century

Karen Stein, MFA

At the inaugural meeting of the Academy of Nutrition and Dietetics in October 1917 in Cleveland, OH, Lulu C. Graves, the Academy’s first president, remarked that “The future of dietetics is assured. It is the privilege of those of us who are now in the work to conduct it along such lines that in the not very distant future, it will be a recognized part of the medical profession.”

An untold number of practitioners and volunteer leaders have worked tirelessly over the near-century since to make sure Graves’ forecast proved true and that dietetics practitioners would attain a recognized and respected role in health care. Activities surrounding the governance and practice functions of the profession have played an important role in making this happen.

The early 1990s, a hub of activity to more strongly assert dietetics within the health care professions, represented the start of a series of important changes for the Governance and Practice Units of the Academy of Nutrition and Dietetics. Toward the end of the 1980s, not long after the House of Delegates (HOD) had celebrated its 50th anniversary (1986), the governance arm of the association was focused on generating position papers, integrating dietetic technicians, registered (DTRs) into the Academy; drafting amendments to the bylaws; increasing membership in the National Center for Nutrition and Dietetics; and determining a certification process for functional sub-specialties. But then an explosion of internal and external challenges, among them practice opportunities emerging from an attempt at health care reform during the Clinton Administration and a building interest in restructuring the leadership to dedicate more resources to advocating for the profession, upended the processes and programming of the Academy.

Change within the Academy and the profession was inevitable. Since 1990, major organizations in the medical realm—including government institutions, regulatory bodies, and member associations—have actively attempted to refine what it means to be healthy and to practice health care in the United States. Issues have included recognition of food and nutrition as a therapeutic means for addressing chronic conditions, quality of care, ethics, and reimbursement. The evolution of the systems for delivery of care led to all sectors of the health professions being called on to re-examine how they assert their own roles in health care and how their member organizations assist practitioners in doing so. The Academy’s Governance and Practice Unit is the members’ key link to such essential components of practice.

The Governance and Practice Team encompasses the Board of Directors (BOD), HOD, the Council on Future Practice, the Quality Management Committee, and the Coding and Coverage Committee. Specific areas of concern include strategic planning; Academy position and practice papers; quality management, including Standards of Practice and Professional Performance and scope of practice; and reimbursement of nutrition services.

All of these facets of Governance and Practice have come into play as the US workplace has shifted; health care has evolved to emphasize outcomes-based care; and dietetics as a profession has been compelled to enter discussions related to coding and reimbursement to assert its practitioners as the most qualified to deliver nutrition care. The BOD and the HOD, the governing bodies of the Academy and the profession, respectively, have implemented many timely, strategic changes that were a major departure from operations before 1990 to become a forward-thinking, proactive organization in the 21st century. With strategic planning that capitalized on the forethought of the leadership and an unprecedented adaptability across the membership, the Academy has kept pace with the contemporary reality of what it means to govern a profession.

The BOD and HOD
The BOD and the HOD exist to represent all members of the Academy. Historically, the BOD and HOD have operated mostly as related but separate entities. This approach to operations shifted dramatically after the issuance of a 1999 Governance Task Force white paper that recommended that the HOD and BOD increase collaboration to improve strategic focus and create a more...
flexible, responsible, and forward-thinking organization, while affording the HOD a higher level of responsibility in governing the profession. To facilitate a collaborative approach, internal and external focus groups with consultants, the BOD, and the HOD were called on to weigh in on how the Academy’s leadership could bring the organization into a new era of augmenting the profile and respect of registered dietitians (RDs) and DTRs in the medical and public spheres.6

As a result of this restructuring, the BOD now serves in an executive capacity by establishing and monitoring the Academy’s strategic direction, establishing organizational policy, directing the Academy’s budget and finance activities, and monitoring the chief executive officer’s operational performance. The HOD, on the other hand, serves as a representative of the membership and carries out internal functions related to issues within the dietetics profession.

Marianne Smith Edge, MS, RD, LD, FADA, a past HOD Speaker (2000-2001) and Past-President (2003-2004) who served in Academy leadership in different capacities while these changes were taking place, believes these structural changes allowed for a more fluid and flexible governing body. It also allowed the HOD to focus more on dialogue and deliberation to broaden their perspective on the bigger issues affecting the profession, while allowing the BOD to place its emphasis on the administrative inner workings of the Academy.

How the White Paper Changed the Academy

By the late 1990s, it was evident that transformative changes across the Academy were needed to better serve the membership. Staff restructuring at the Academy headquarters and a switch to strategic planning to set forth attainable goals were major thrusts toward that effort, but, as evidenced by member surveys, governance structure remained a concern. These surveys revealed that members identified the current governance structure, most notably the blurred delineation of BOD and HOD roles, as a barrier to the Academy achieving the vision it had set forth.3

Although the Academy leadership was pioneering several important milestones in preceding years—pursuing Medicare reimbursement for medical nutrition therapy among the most important—the governance structure was not an ideal system. Among the chief concerns were that clarity of purpose was lacking; committees and other groups were duplicating efforts; diversity in demographics and focus areas of practice was largely absent from the leadership composition; and the deliberative processes moved too slowly, as there was more emphasis on sharing information than on solving problems. The Governance Task Force, composed of the BOD and HOD executive committees and facilitated by representatives of the Arthur Andersen consulting group, took the monumental step of interviewing a cross-section of Academy members and leaders, reviewing the bylaws and other governance processes, and benchmarking with other organizations to determine how best to set a new course as the 21st century neared.

The need to modify governance processes at that time was not unique to the Academy. The nonprofit sector in general was in a widespread state of self-reflection and modernization in the 1990s: the American Society of Association Executives (ASAE) reported in 1999 that associations in general were realizing that their governance models were obsolete—not to mention inflexible and sorely lacking collaboration—and encumbered by slow processes that dragged down any progress in an increasingly fast-paced business environment. Furthermore, studies by The Nonprofit Report and ASAE in 1998 and 1999 found that changing the board of directors or reviewing bylaws to streamline organizational requirements had been attempted at 74% and 89%, respectively, of organizations responding to surveys.3 Ann Gallagher, RD, Academy Past-President (1999-2000), made note of this trend in 1999: “Trends among other associations show them moving toward boards that concentrate their energies on setting overall strategy and policy objectives.”

Even the act of issuing a white paper that called for governance restructuring within a professional association was not uncommon at that time. In 2000, the Association of Perioperative Nurses, for example, issued its own paper with a purpose similar to the Academy’s white paper.5

The Governance Task Force sought to create a governance structure that clearly delineated roles and responsibilities and would embrace a commitment to member needs and values, adopt flexibility to enable productive decision making, reflect the diversity of the profession in demographics and practice, be fully cognizant of the Academy’s strengths and weaknesses, maintain a clear vision of organizational success, and periodically self-assess. Most importantly, given the considerable concerns about the previous system of governance, the new structure was expected to lend itself to being proactive—not reactive—and focused when confronting critical issues and challenges.

Clarifying the separation of BOD and HOD responsibilities was the first logical step in setting the strategic course for Academy structure thereafter. BOD

As of 2012, the Academy’s BOD6 holds the following 18 positions:

- President (1-year term)
- President-Elect, elected by the general membership (1-year term)
- Past-President (1-year term)
- Treasurer (2-year term)
- Treasurer-Elect, elected by the general membership (1-year term)
- Three Directors-at-Large, elected by the general membership (3-year term)
- Six HOD Directors, along with the Speaker, Speaker-Elect, and Immediate Past-Speaker, who are elected by the general membership (3-year term)
- Two Public Members, appointed by the BOD (2-year term)
- Academy Foundation Chair, elected by the Foundation
- Chief Executive Officer of the Academy (nonvoting)

Changes in BOD composition that sprang from the white paper were the addition of public members and HOD directors and the retention of the past president (who previously did not serve on the BOD after his or her tenure.
was up). In addition, when the Councils on Practice, Research, and Education were dissolved in 2000, those seats on the BOD naturally were eliminated.

The addition of HOD directors to the BOD was a direct and essential response to the change in governance structure: If the HOD was to lead the profession, it needed to be adequately prepared to handle this responsibility in both procedure and process, and there needed to be sufficient HOD representation in the BOD.

The BOD is tasked with setting and monitoring the Academy’s strategic direction; overseeing fiscal planning; providing leadership for initiatives within the profession; establishing guidelines and policies for various awards, honors, publications, and other business-related concerns; and administering and enforcing the professional Code of Ethics in conjunction with the HOD and the Commission on Dietetic Registration (CDR).

See Appendices 1 and 2 online at www.andjrn.org for a list of all Academy BOD members from 1990 to the present and a list of Past-Presidents from 1990 to the present, respectively.

**HOD**

The HOD, which convened for the first time at the Annual Meeting in Richmond, VA, in 1937, is the deliberative body of the Academy that acts as the voice of its members. Delegates are expected to identify issues important to the profession by communicating with members, identify issues related to the profession that could have an impact on practice, and participate in meetings to communicate these concerns to the HOD leadership.

The HOD develops policy on major professional issues and governs the profession by monitoring and evaluating the trends and mega issues that affect the profession; reviewing, debating, and approving standards of practice as well as professional standards; adopting and revising the Code of Ethics along with the BOD and CDR; providing direction in establishing quality management parameters; leading the development of position and practice papers; and providing oversight to the Academy by-laws.

The HOD uses the knowledge-based strategic governance model it adopted in 2000. This new approach was gaining momentum across not-for-profit organizations at that time, as it revolutionized the governance of association boards by transcending the decision-making process from being rooted in politics to being based on knowledge of the mega issues confronting the organi-
This model requires that decision makers ask the following questions in determining how to confront a challenge or opportunity:

- What is known about stakeholders’ needs, wants, and preferences that is relevant to this decision?
- What is known about the current realities and evolving dynamics of the organization’s environment that is relevant to this decision?
- What is known about the “capacity” and “strategic position” of the organization that is relevant to this decision?
- What are the ethical and legal implications of this issue?

In this approach, a greater emphasis is placed on what must be achieved rather than what has already been done—a major tenet in the Academy’s strategic planning initiatives, which represent one of the major defining moments of the Academy as a respected organization, and a brand, in recent history.

The HOD has approved some major initiatives that were adopted into the Academy’s programming over the past 2 decades. For example, the HOD was involved in establishing a document in 2001 to strengthen members’ understanding and interpretation of research. This effort led to the implementation of practice-based research networks in 2003. The HOD approved the Nutrition Care Process Model that the Academy implemented in 2004 to provide RDs with a decision-making framework for employing efficient and effective patient and client care. The Nutrition Care Process model will be discussed in greater detail in the Research article of this series, but additional HOD initiatives will be discussed throughout this article.

**Issues Management**

The HOD’s issues management system also gives members a voice among Academy leaders and similarly gives leaders a direct line to concerns across the membership. The HOD adopted this issues...
management process in 2001. Using this process, members submit their issues of concern to the Academy's Member Services staff, which solicits response from appropriate organizational units regarding a potential course of action on the issue. Staff tracks these issues, which are reviewed internally.

But the issues of utmost strategic importance to the Academy—mega issues—represent questions that the Academy must ask, answer, and act on within the span of a decade. Delegates identify these challenges that will likely have an impact on future practice in 5 to 10 years and play an important role in multiple goal or outcome areas. (See Figure 1 for recent mega issues the HOD has explored.)

The outcomes of mega-issue discussions result in guidelines, white papers, or toolkits on a given topic, if requested by motion and approved by the HOD. For example, consumer interest in dietary supplements shot up in the 1990s, and clients and patients were flooding RDs with requests for recommendations on these mostly unregulated substances. The HOD flagged this emerging concern as a mega issue and responded by issuing guidelines regarding the professional ethics of selling or recommending supplements, including educational resources and details about the legal status of these supplements, which were published in the Journal in 2002.  

HOD Composition
The HOD Leadership Team is composed of six HOD members that are elected by the membership, including the Speaker, the Speaker-Elect, immediate Past-Speaker, and three HOD Directors.

The change from 156 delegates to 100 delegates occurred in conjunction with the governance restructure in 2000. A composition of 100 delegates was fully in place by 2002. As of 2012, there were 106 delegates serving in the HOD, compared with the range of 140 to 156 delegates in the 1990s, when the number of delegates was tied to membership totals in affiliate groups. The reduction in the number of delegates was also tied to the governance restructuring—many Academy leaders believed that the number of delegates had simply become unwieldy. For example, it was hard to achieve consensus among 156 delegates with varying levels of experience, expertise, education, and professional interests voting on budgets and position papers, recalls Nancy Nevin-Folino, MEd, RD, CSP, LD, FADA, the first Chair of the Council on Future Practice in 2008 and a longtime member of the HOD. Thus, shrinking the HOD was necessary.
Dietetic Practice Group in the HOD

The addition of the dietetic practice group (DPG) Delegates to the HOD was a watershed moment in the HOD’s history. DPG chairs and chairs-elect, along with affiliate presidents, began participating in HOD meetings in the 1980s. However, the DPGs did not have an official seat in the HOD, as Professional Issues Delegates were elected to be the liaison between the HOD and DPGs as a result of governance restructure. But, after a survey of Delegates and interviews with various DPG representatives, the HOD voted to modify the current HOD governance structure. In 2009, the HOD Leadership Team concluded that the incorporation of practice into the HOD would address some key considerations, namely:

- The structure using Professional Issues Delegates as liaisons was less than ideal and needed major improvements.
- The up-and-down flow of communication would be enhanced and more effective.
- The message that DPGs are valuable contributors to the Academy governance needed to be more strongly promoted.

The DPGs then were given the option to elect or appoint one delegate—with this inclusion specifically allowing the HOD to be in line with the Academy’s strategic plan by meeting the goal to have “members and prospective members view the Academy as vital to professional success” and pursuing the strategy to “foster diversity in Academy leadership positions.” The first 12 DPG delegates joined the HOD in June 2010; another 10 DPG delegates joined in 2011, with the remaining six joining the HOD in 2012. DPG delegates did not all join the House at the same time because they were phased into the HOD as the Professional Issues Delegates’ elected terms expired.

Changing Processes in Academy Leadership

Certainly no Academy member in 1987, let alone 1917, could have imagined the impending technological advances of the 1990s and 2000s that would require big changes in the organization’s processes. Gathering of member input for environmental scans via electronic surveys and permitting members to submit online ballots in national Academy elections are features added in the past 10 years that not only simplified processes for the HOD, but kept the Academy current in the ever-changing state of conducting business. The HOD has also adopted advanced technologies for its internal processes; delegates can vote on motions electronically.

But perhaps the most technologically advanced achievement of the Academy was the 2011 Future Connections Summit on Dietetics Practice, Credentialing, and Education. This meeting, celebrating a vision of the future of meeting spaces, hosted more than 200 individuals at multiple locations across the United States hooked up via a web-based video conferencing platform, secure chat rooms, and Twitter; these locations included the Academy headquarters, seven satellite locations, and individuals stationed at their respective offices. Participants communicated via text messages, cell phone calls, Google docs, and e-mail.

To put these tremendous strides in office technologies into context, consider this: the sale of videotapes and audiotapes of selected sessions from the 1987 Annual Meeting in Atlanta, GA, were available for the first time and marked a major technologically advanced offering for members unable to attend the meeting—and not one of the terms used to describe the communication tools used at the Future Summit meeting had yet entered the lexicon.

Strategic Planning

A point of momentous change in its history, the adoption of strategic planning upended the Academy’s previous processes and self-perception and ushered in a new era in operations. In reframing the organizational view of strategic planning as ongoing, evolving process, the Academy shifted from being internally focused on members to being externally focused.

See Appendix 3 online at www.andjrnl.org for a list of the past HOD Speakers from 1990 to the present.
focused on advancing members outside of the organization, including promoting and positioning their expertise as an indispensable part of the health care professions and establishing innovative alliances to do just that.

Early attempts at strategic planning established a mission, vision, philosophy, and values for the organization, but once the Academy's leadership adopted environmental scanning, the process of strategic planning was amplified to include specific goals to further the Academy and its members as well as strategies to attain them.

Environmental Scans
The Academy's interest in environmental scanning first cropped up in 1994, when delegates took an informal look at the trends and issues affecting the practice of dietetics to help shape the HOD agenda. In 1998, building on that foundation, a more formalized process was adopted to involve the HOD, the BOD, affiliates, DPGs, the Council on Professional Issues, and, most importantly, input from members.

Environmental scanning was gaining steam as a useful tool and an integral part of association strategic planning at that time; as stated by Gallagher, “You can't answer the question 'What's in it for me?' without a sense of how the world looks now and, with luck, how it looks a few years from now.”13 No matter which industry was being studied, the trends were similar. At the same time the Academy was conducting its first formal environmental scan, the ASAE had just completed its own scan for the trends that would affect associations in general over the next several years. The themes that emerged from the ASAE scan—namely, responding to the changing needs of members; integrating new technologies into business; building a diverse, qualified workforce; and adapting to the increasing globalization within the profession—were all too familiar to the Academy and its members.13

In 1998, the HOD prioritized 150 recommended actions regarding trends in social, political, technological, economic, clinical, community, and consumer constructs, as well as issues related to food and nutrition management and research, education, and credentialing. A multiphase process (described in detail in articles published in the *Journal of the American Dietetic Association*)—in which trends and issues were identified, discussed, amended, validated, or eliminated as needed, and then distributed to stakeholders—was used to determine actions to recommend to the Academy to address these emerging concerns.

The 1998 scan identified trends within several macro and dietetics-specific constructs that were projected to have a major impact on the future of dietetics practice at that time, including...
social (aging population, consumer access to health care); political (federal reductions in reimbursement and coverage applying to services rather than practitioners); technological (rising use of computers in business and by consumers); economic (lagging increases in salary scales for RDs, declining membership in professional associations); clinical (increasing emphasis on accountability and shifts in the continuum of care); community (media influence on consumer nutrition, rising interest in “health foods”); food and nutrition management (reductions in foodservice costs, outsourcing of foodservice to management companies); research, education, and credentialing (cross-training of allied health professionals, increase in competency-based education); and consumerism (increasing use of nutrition supplements, untrained medical professionals marketing selves as nutrition experts).14,15

A bellwether for the strategic plan, these issues were used to determine how the Academy would tack for a successful future course. Suggestions, which continued to be relevant in all subsequent years, included the following:

- determine what expanded skills or competencies are needed to capitalize on new or expanding markets;
- consider nontraditional employment avenues;
- promote RDs and DTRs within the community—both personal and professional;
- advocate for third-party reimbursement for RDs and DTRs; and
- be a mentor.

Another environmental scan that was performed in 2002, where the HOD reviewed more than 100 trends and identified and validated trends for the profession, included job growth, the need to raise professional status to attract students to the programs, the availability of new professional practice venues (neonatal, medical nutrition therapy, home care, etc), and the emergence of practice creep from non-credentialed practitioners. Again, the trends and issues projected to affect associations overall were raised as concerns within the Academy, including the changing role of leadership and paucity of members confident to assume leadership positions, declining membership, member expectations for greater return on dues investment, responsiveness to the changing needs of members, cultural shift in governance and need for strategic alliances, globalization, and building brand equity for the dietetics profession.16,17

The capture of trends and issues for the 1998 and 2002 environmental scans followed the traditional route of convening meetings (by affiliate boards of directors, affiliate/district members, and DPG executive committees) for group dialogue. With an eye on the contemporary reality of conducting business remotely using advanced digital technologies, the 2006 environmental scan afforded members the opportunity to participate using an online survey site. The 11 themes that encompassed the trends in the 2006 scan were aging; a fast-food, eat-and-run society; growth of obesity; global explosion in communications; growth in diversity across the US population; the maturation of the industrialized food system; the economically fractured society; environmental issues; policy focus on health and wellness; choices in alternative health care; and the revolutionary potential of science and technology. Trends related to changes in associations included using technological advances in conducting meetings and training/credentialing courses, entering into alliances for hosting events, adding nondues revenue via new means, and offering virtual communities where members can interact.17,18

These scans have been so effective in allowing the Academy to set the strategic course for future programming that in 2010 it applied the same methodology to capturing member input on the restaurant menu labeling law written into the Patient Protection and Affordable Care Act (which will be discussed in greater detail in the coverage of Advocacy and Public Policy).

Developing a Plan
Strategic planning was popularized by Jack Welch, who was considered a revolutionary in US business processes in the 1980s.19 In fact, although the Academy’s first formal strategic plan had not been implemented as an operational methodology until 1991, the Academy had set its sights on strategic planning as early as the mid-1980s and approved the model in 1988. According to Mari-anne Smith Edge, who was Academy president when a new iteration of the strategic plan was implemented (2004), perhaps among the greatest benefits of strategic planning for the Academy was that it brought a unified focus to the purpose of the association presidency—
that is, rather than expecting individual presidents to have platforms, ultimately the basis for their leadership was to move the association forward based on the strategic plan.

Welch’s approach focused on competitive advantage and featured the following six rules:

- control your destiny or someone else will;
- face reality as it is, not as you wish it were;
- be candid with everyone;
- do not manage, lead;
- change before you have to; and
- if you do not have a competitive advantage, do not compete.

The Academy’s Strategic Plans: 1990s. Welch’s tenets likely have a familiar ring to RDs and DTRs who were Academy members during that era. The 1991 strategic plan was aptly called “Achieving Competitive Advantage” and, at that time, the profession was confronting two trends that were pushing the practice of dietetics into a new reality: consumers were moving from seeking institutional help to pursuing self-help, and society was moving from an emphasis on industrial to informational. The following priority areas of interest for the Academy were identified when strategic planning was implemented:

- health care reform,
- foodservice, and
- consumer education.

Because the political atmosphere in the early 1990s was steeped in health care reform, the Academy poured the bulk of its 1991 strategic planning into addressing this key area of interest and achieving its goals via legislative bodies. But, of course, the strategic plan was not considered a static blueprint. As broader opportunities for the dietetics profession emerged, the Academy refined its target audience for championing the enormous importance of food and nutrition and the qualifications of RDs to deliver nutrition care and information. Rather than dedicating all efforts and resources toward working with the legislators themselves, the Academy looked to key influencers on public policy and regulations, including those specifically related to at-risk populations—namely, children and older adults—“who [were] particularly vulnerable as a result of proposed legislative changes to certain programs that provide nutrition and other health-related benefits.”

With its updated goals, the Academy sought to ensure a positive, competitive future that affords RDs and DTRs the recognition they deserve. Thus, in 1996, the Academy’s focus had shifted...
to three new primary initiatives—policy, member development, and public education—and an updated strategic plan, “Creating the Future,” was implemented. The 1996 strategic plan was not unrecognizable from the 1991 plan, however, as many of the features of the original framework were incorporated into the update.²³,²⁴

Strategic Planning for the 21st Century. The strategic plan was updated again in 1999 with the help of a health care consulting firm and futurists. Once the HOD and these groups had undertaken the challenge of prioritizing the list of professional trends, new key focus areas were identified for the revision²⁵:

- increased competition to provide nutrition information to the public;
- expansion of food and nutrition services into new areas;
- changes in population demographics;
- advances in medical and health research; and
- changes in the health care environment.

With enhancing the stature of RDs and DTRs in the workplace and adding value to Academy membership at the center of the Academy’s objectives, the quantifiable goals that came with the 1999 strategic planning update included the following⁴:

- be the leader in selected areas of food and nutrition;
- build membership in the Academy;
- influence the policy initiatives of key audiences;
- increase demand for and utilization of services provided by members;
- position members to compete successfully in a rapidly changing environment; and
- set the agenda and facilitate support for food, nutrition, and health services.

It was during the deliberations for a new strategic plan that improving the governance function of the organization, as discussed previously, became a top priority and the Academy clarified the roles and responsibilities of the HOD and the BOD.

Years later, a new strategic plan was submitted by the Strategic Planning Task Force chaired by Martin M. Yadrick, MS, MBA, RD, FADA; it was approved in 2003 and put into place for the period 2004 to 2008, along with a revised mission statement: “Leading the future of dietetics.” (The new mission statement and member values that came with the 2004-2008 strategic plan will be discussed in greater detail later in this article series.)

The goals for 2004-2008, which capitalized on the current health care climate that emphasized outcomes-based, quality care, were as follows²⁶:

- build an aligned, engaged, and diverse membership;
- influence key food, nutrition, and health initiatives;
• affect the research agenda and facilitate research supporting the dietetics profession;
• increase demand for and utilization of members’ services;
• empower members to compete successfully in a rapidly changing environment; and
• proactively focus on emerging areas of food and nutrition.

When the time came to update the 2004-2008 strategic plan, the Strategic Planning Task Force, in conjunction with the BOD, took a hard look at the current trends regarding education, practice, research, and credentialing and noted that additional modifications to the Academy’s vision, mission, values, and goals were in order. At that time, because of the proliferation of untrained nutrition “experts” and practice creep from multiple areas within allied health, enhancing the image of dietetics practitioners as experts was priority one. Connie B. Diekman, MEd, RD, LD, FADA, the Academy’s president in 2007-2008, noted that a common thread among members and stakeholders weighing in on strategic plan updates was that the Academy “needs to be clearer about [its] core purpose and public identity.” This theme has proven to be particularly noteworthy, given the Academy’s tireless efforts to address this concern in the years since, including the name change from American Dietetic Association to Academy of Nutrition and Dietetics implemented in 2012.

For the update in 2008, the task force suggested the following:

• a more active role for the Academy and its members in improving the health of Americans;
• goals that focus on results the Academy wants to achieve; and
• values that are succinct and specific to the organization and to practitioners.

The 2008 update put an emphasis on members’ impact on the health and nutrition knowledge of the American public and delineated customer focus, integrity, innovation, and social responsibility as key values.

The 2008-2012 strategic plan, including mission and values, is presented in Appendix 4 (online at www.andjrnl.org) in a side-by-side comparison with the first official strategic plan that was implemented in 1991.

CODE OF ETHICS

In the earlier decades of the 20th century, as a tenet of business across industries, “ethics” had been an area of only sporadic interest. The establishment of the Society for Business Ethics in 1980 led to an explosion of academic programs, textbooks, societies, and journals dedicated to the topic, and in keeping with this new business reality, the Academy adopted its first Code of Ethics in 1982 (and first implemented it in 1985).28

The Code of Ethics intends to protect the dietetics profession and the RD and DTR credentials; influence policy, both private and public; improve the quality of professional practice; educate practitioners about what it means to make ethical decisions; and meet CDR guidelines. Although a common misconception, the Code of Ethics is not a means for rooting out unqualified RDs and DTRs or punishing infractions via de-credentiaing.29 Fortunately, however, as Yadrick, who was president of the Academy in 2009-2010, has noted, “The majority of [Academy] members and credentialled dietetics practitioners take this Code very seriously and carry out their duties with impeccable ethics.”30

Revisions to the Code of Ethics

A revised Code of Ethics, called the Code of Ethics for the Profession of Dietetics, was adopted in 1999—after HOD approval in 1998—after the Academy and CDR jointly reviewed the first Code. With the assistance of expert consultants, the task force, chaired by Mary Carey, PhD, RD, benchmarked the Academy’s Code with that of other professional associations and collected feedback from members and credentialled practitioners.31,32

The 1999 Code of Ethics—comprising Consideration of Ethics Issues, which included information about the Ethics Committee and information about committee opinions, and delineating the process for ethics complaints—was a departure from the previous iteration in the following ways:

• It emphasized and increased options for educating practitioners about ethical practice, in the interest of resolving problems before there was a need to file a formal complaint.
• It was modernized to encompass current business practices and societal trends—for example, acknowledging the increasingly complicated nature of affiliations, which turned many previously black-and-white ethical situations to shades of gray, by eliminating the wholesale prohibition on conflicts of interest and replacing it with advisement for re-

FROM THE ACADEMY

Julie O’Sullivan Maillet, PhD, RD, FADA (center), past president and past HOD speaker, talks shop at a House of Delegates meeting in 1998, the year that the HOD approved a revised Code of Ethics, with (L) Alice Lenihan, MPH, RD, LDN, and (R) Robert Earl, MPH, RD, past HOD speaker.
FROM THE ACADEMY

vealing potential conflicts of interest.

- It added provisions specifically regarding sexual harassment—a concern that materialized a previously under-recognized and now urgent businesspace concern during the Supreme Court confirmation hearings in 1991—and concerns related to cultural differences, two factors of increasing concern in contemporary conduct of business.

In keeping with the standard process of reviewing and updating the Code every 10 Years, in 2007-2008 the Code of Ethics Task Force (composed of six credentialed practitioners and chaired by Smith Edge) evaluated how the business and practice of dietetics had evolved since the last Code was implemented and determined where amendments were needed. The Code was revised in 2009 after the HOD, BOD, and CDR first reviewed a draft Code and the task force subsequently obtained member input from an online survey and benchmarked against the following external organizations: the American Society of Interior Design, American Physical Therapy Association, American Occupational Therapy Association, American Pharmacist Association, American Nursing Association, American Medical Association, National Society of Professional Engineers, and American Academy of Family Physicians.

The new Code was enforced as of January 1, 2010, rendering the 1999 Code invalid. Among the changes implemented in the 2010 iteration of the Code was division of the Code’s principles into the categories of fundamental principles and responsibilities to the public, to clients, to the profession, and to colleagues and other professionals.

Additional enhancements included reworded principles to clarify their meaning, new principles and combination of existing principles to reflect the current realities of the practice environment, and a direct link between the principles and the Academy’s values delineated in the strategic plan.

The impetus to change the Code often springs from multiple organizational units acknowledging unaddressed issues of substantial concern and bringing them to the Academy’s attention by multiple organizational units; after the Ethics Committee investigates, it determines whether revisions are necessary. In 2012, for example, the use of social media and its associated implications is under consideration as an emerging concern in professional ethics.

To assist members with understanding the Code of Ethics, the Academy has produced materials such as frequent “Ethics in Action” columns in the Journal that explain the ethical implications of practice-related scenarios; Ethics Opinions that explain how provisions in the code apply to specific complaints; and the Ethics Education Toolkit, a facilitator’s guide for presenting the Code of Ethics at DPGs/affiliate meetings and in the classroom.

All these changes to the Code have underscored the transformation of the Academy to an externally focused organization with an emphasis on member values.

NUTRITION SERVICES COVERAGE

The history of the Academy’s pursuit of insurance coverage and reimbursement for nutrition services began in 1966, after the Medicare and Medicaid bill was enacted during President Lyndon Johnson’s administration. As it became evident to the Academy that the lack of coverage for nutrition services was to the detriment of the profession, thus began the organizational efforts toward gaining recognition and reimbursement for nutrition services in legislation and regulation.

Nomenclature for Coverage

In the early 1990s, with health care reform dominating the attention of allied health professions, reimbursement and insurance coverage of nutrition services emerged as an issue of even more critical importance to the Academy and the profession. There was no nationally recognized procedure code for nutrition services, and coding practices were quite variable from state to state. The Academy was fully aware that there was a tremendous opportunity for leveraging RDs into a better bargaining position in obtaining reimbursement and negotiating salaries in managed care organizations. These issues all revolved around the biggest topic in nutrition services coverage at that time: medical nutrition therapy (MNT).

In 1991, the Nutrition Payment Systems Committee, in collaboration with a national group (Morrison’s Hospitality Group) that contracted foodservice and clinical nutrition services, conducted a survey in an attempt to collect empirical and anecdotal data at the state level regarding: (a) the relationship between successful reimbursement and the use of specific diagnostic and procedure codes, and (b) the impact of nutrition therapies on improving outcomes while lowering costs.

Because the Clinton Administration was promoting health care reform, a push that began during his presidential campaign, the Academy needed these data to show insurers that recognition of RDs as health care providers was appropriate and essential.

In fact, in 1992, the Academy coined the term MNT as a means for obtaining buy-in for coverage of nutrition services. “The year that President Clinton was elected, we stepped up our efforts to participate in health care reform and develop a strategy to support reimbursement for nutrition services,” recalls Susan C. Finn, PhD, RD, FADA, who was the Academy’s President at that time (1992-1993). “This was a goal driven not only by the Nutrition Services Payment Systems Committee but from an outcry from members and the BOD. This was an opportunity that we all agreed we needed to seize quickly.”

She adds that the Wexler Group, which contracted with the association for setting its tactical course in attaining its goals, “urged us to be focused and not too broad in our request for reimbursement as well as not to be viewed as self-serving and only supporting dietitians.” Although there were several proposed terms for encapsulating the service to be reimbursed, “MNT” was the overwhelming choice, says Finn. “MNT was a term that the Wexler team believed reflected a serious issue in nutrition care.”

The Path to MNT Recognition

The Academy also launched an effort to petition the American Medical Association (AMA) to assign unique Current Procedural Terminology (CPT) codes—which are mainly used for identification of medical services and procedures provided by physicians and other prac-
titioners within allied health for billing insurance—for nutrition assessment and other services. The AMA published its first set of CPT codes in 1966 in the interest of standardizing the terminology used to describe certain procedures. The Centers for Medicare and Medicaid Services (CMS) (previously called the Health Care Financing Administration) ultimately adopted these CPT standards to be used for reporting services under Medicare Part B (in 1983) and Medicaid services (in 1986). Revising existing codes and creating new ones is a process that starts with medical societies or other interested parties contacting the AMA CPT coding office.

The creation of CPT codes, which was a prerequisite for obtaining Medicare coverage, was crucial, as it permitted claim submissions to the government and private insurance companies. Although the AMA had consistently rebuffed the Academy’s petitions to submit proposals, the effort was not abandoned.

This perseverance paid off in 1999, when MNT was afforded public recognition by the Institute of Medicine (IOM). In its report on the role of nutrition in treating older adults, the IOM acknowledged the evidence that MNT, provided by an RD, improves clinical outcomes while decreasing costs in the treatment of diabetes and recommended that delivery of diabetes care from an RD (with physician referral) be added to the roster of covered Medicare benefits. Also working in the Academy’s favor in 1999 was that the CPT panel, advisory committee, and AMA had received and was sorting through a flurry of proposals to revise the current guidelines for Medicare benefits. These two fortuitous circumstances—a major group promoting MNT and the push toward revising the current CPT structure—ultimately led to the Academy being heard by the AMA.

And when the Academy was invited to join the AMA’s workgroup of nonphysician practitioners, the Health Care Professional Advisory Committee (which is the body that was charged with making recommendations for revisions to the CPT codes), this represented the first time the AMA had invited nonphysician health professionals to participate in its revision process. Jane White, PhD, RD, LDN, FADA, Past-President of the Academy (2000-2001), explains, “We could not formally present codes for approval or have a ‘seat at the table’ until we had obtained Medicare provider status. So the legislation that created the Medicare benefit had to be in place first, before we could participate in the AMA CPT/Relative Value Update Committee panels.”

Doug Henley, MD, a family physician and coding expert for the American Academy of Family Physicians, chaired the AMA CPT Physician Panel at that time; because Jane White had worked with Henley on the Nutrition Screening Initiative, she testified to the CPT panel regarding the need for MNT codes.

The AMA ultimately accepted the Academy’s proposal for seven CPT codes for MNT services (ultimately streamlined into three CPT codes based on feedback from the medical community), which represented a major breakthrough for the Academy. However, the AMA’s proposal involved temporary relative value units (for establishing payment amounts associated with CPT codes) that fell far short of the Academy’s recommendations, which were based on the collected survey data; the Academy took a firm, opposing stance and asked Medicare to reject them. This conflict was ultimately resolved in the summer of 2000 when Congress passed the Medicare Part B MNT provision, effective January 2002, to expand coverage of MNT services; these services were expanded even further with the Medicare Modernization Act of 2003. However, coverage was limited to MNT performed for diabetes or renal patients. The Academy continued its advocacy to extend MNT coverage and reimbursement for cardiovascular diseases (hypertension and dyslipidemia)—something Congress had approved but CMS ultimately rejected.

Sandra J. McNeil, MA, RD, CDN, FADA, DHCF, past chair of the Quality Management Committee (2006-2007), notes that “This era was a huge turning point for RDs to become an integral part of allied health in an unprecedented way.”

Continued Advocacy to Advance MNT
In 2005, the Academy—recognizing that the profession needed to justify its position that MNT is cost effective, improves outcomes, and is most appropriately and effectively performed by RDs—encouraged RDs who provide Medicare MNT to employ evidence-based practice and follow the Nutrition Care Process model. This same year, the Coding and Coverage Committee was established to empower RDs to seek out and receive expanded coverage for delivering quality nutrition care while leading strategic directives in the
development and maintenance of nutrition service codes. Throughout this time, the Academy Positions Committee issued several positions regarding MNT and the profession. Figure 2 presents the major statements from these positions as they relate to the attempts to advocate for coverage and reimbursement for nutrition services.

In 2009, the Coding and Coverage Committee’s sights had been set on getting widespread buy-in by third-party payers that RDs should be eligible for reimbursement for nutrition services. The HOD approved a policy statement, “Registered Dietitians as Preferred Providers for Diabetes Care,” affirming that RDs should be designated as eligible providers of MNT, self-management education, and training interventions in diabetes care, and that third-party payers should not also require that those RDs also possess a certified diabetes educator credential. This pivotal paper was of extreme import to RDs because although Medicare recognized RDs as eligible providers—and some state legislators had enacted laws mandating Medicaid coverage of MNT for diabetes performed by RDs—this was not the case among all payers, especially private insurers. Members affected by this inconsistency in coverage policy benefited from having this support toward their local advocacy efforts.

Beginning in 2010, the Academy launched renewed advocacy efforts for reimbursement as CMS considered expanding Medicare coverage to screening and intensive behavioral counseling for obesity. Reimbursement of RDs for obesity services was not completely unheard of at that time. Some state Medicaid programs and private insurance companies were already covering nutrition counseling for obese children and adults. In addition, since 2009, via the Alliance for a Healthier Generation (a program that aligned pediatric RDs with pediatricians via organizations working together to make sure children had insurance coverage to combat obesity that monitored outcomes), RDs were reimbursed for provision of intensive nutrition counseling over multiple visits to children referred by physicians. However, there were limitations on reimbursement for these services, as only physicians could be reimbursed for the requisite behavioral counseling.

The strategy for gaining CMS buy-in for reimbursing RDs for obesity screening and counseling was developed by Academy staff, the Coding and Coverage Committee, the Legislative and Public Policy Committee, and DPG members. In addition to participating in the public comment period—which CMS noted included the most comprehensive and most evidence-based comments among all submitted—while the issue was being considered, in 2011 representatives from the Academy met with CMS staff and representatives of other groups that joined the Academy in its advocacy efforts (Obesity Society, American Society for Metabolic and Bariatric Surgery, and the Obesity Action Coalition) to present their argument that RDs should be included.

Despite the important achievement that CMS finally recognized obesity as a medical condition that should be granted coverage, the agency limited the eligible providers to primary care physicians or other primary care practitioners in a primary care setting, thus eliminating RDs from eligibility. The CMS stated rationale was that the agency believes it lacks the statutory authority to expand the scope of RDs as MNT providers beyond diabetes and end-stage renal disease, and it believes that primary care providers are the most qualified to deliver comprehensive preventive care.

In response, the Academy submitted a letter to CMS to state its disagreement and advocate for adjustments to the decision. Meanwhile, the Nutrition Services Coverage and Policy Initiatives and Advocacy teams explored strategies and initiatives for a next-steps ap-
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<tr>
<th>Year</th>
<th>Statements published in Academy Position Papers</th>
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<tr>
<td>1992</td>
<td>Quality health care should be available, accessible, and affordable to all Americans. Quality health care is defined to include nutrition services that are integral to meeting the preventive and therapeutic health needs of all segments of the population.a</td>
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<tr>
<td>1993</td>
<td>Cost effectiveness is a major strategy for promoting MNT as one of the solutions to runaway health care expenditures.b Health maintenance organizations and systems of managed care provide nutrition services as an essential component of preventive and therapeutic health care and that these services should be provided by qualified nutrition professionals.b</td>
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<tr>
<td>1995</td>
<td>MNT is effective in treating disease and preventing disease complications, resulting in health benefits and cost savings for the public. Therefore, MNT provided by dietetics professionals is an essential reimbursable component of comprehensive health care services.c</td>
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<tr>
<td>1996</td>
<td>Managed care organizations and integrated delivery systems provide MNT as an essential component of health care and it should be provided by qualified nutrition professionals.d</td>
</tr>
<tr>
<td>1999</td>
<td>MNT and lifestyle counseling are integral components of medical treatment for the management of selected conditions for which pharmacotherapy is indicated. A team approach to care for clients receiving pharmacotherapy and active collaboration among dietetics professionals and other members of the health care team are encouraged.e</td>
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<td>2000</td>
<td>The provision of comprehensive food and nutrition services and the continuation an expansion of research to identify the most effective food and nutrition interventions for older adults over the continuum of care.f</td>
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<tr>
<td>2002</td>
<td>MNT is an essential component of disease management and health care provided by managed care organizations, and such care must be provided by qualified nutrition professionals.g</td>
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<tr>
<td>2004</td>
<td>Nutrition services are essential components of comprehensive care for infants, children, and adults with developmental disabilities and special health care needs. Nutrition services should be provided throughout the life cycle in health care, educational, and vocational programs in a manner that is interdisciplinary, family centered, community based, and culturally competent.h</td>
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the explanation that the provider is not recognized under the definition of a physician as written in the insured individual’s plan. After several discussions, the insurance company reversed course and agreed to reprocess the rejected claims. In a letter to the membership submitted via an e-mail blast, Academy President Sylvia Escott-Stump, MA, RD, LDN (2011-2012), noted that, “This situation represents a vivid example of how membership in the Academy benefits dietetics practitioners, and how the Academy carefully makes use of members’ dues to simultaneously advance the profession, advocate for its members, and protect and improve the nation’s health.”

Despite the disappointments and the battles required even of the victories, these efforts have underscored how the Academy, in its transformation from a longstanding internally focused organization, used evidence-based research to demonstrate that RDs and DTRs do—and should—play a major role in quality health care outcomes.

QUALITY MANAGEMENT

The Academy’s interest in providing members with the necessary tools for ensuring quality care was not a new development in the 1990s or beginning of the 21st century. Susan Finn pointed out in 1993 that standards of care, practice guidelines, and clinical indicators were emphasized increasingly across health care: she stressed that, “The work we do today in developing and implementing standards, practice guidelines, and indicators, and the alliances we create with other health professionals to make them national norms for quality nutrition care will move the profession toward the next era of health care delivery and will position dietetic professionals for competitive advantage.”47 In the several years that followed, the Academy worked diligently on quality management efforts where necessary; for example, a task force worked with the Joint Commission on revising the dietetic service standards for its 1995 hospital accreditation manual and the Quality Management Committee, chaired by Marion Winkler, MS, RD, worked with DPGs to establish SOPs.47 However, it was not until the late 1990s that quality management rose to the significance it has today among all of allied health.

IOM Reports on Quality Care

The IOM launched a national initiative in 1999 that sought to move health care delivery away from fee for service and toward outcomes- and incentives-based quality care. The impetus for this system change came from two studies that had estimated that 44,000 to 98,000 patients die annually as a result of preventable errors borne of poor-quality health care. The IOM’s strategy called on government, health care providers, industry, and consumers to become active participants in the improvement of health care delivery. Most applicable to the Academy, the IOM called on professional groups to raise their respective professional performance standards. After the AMA rapidly adopted the IOM’s recommended strategy, other allied health sectors followed suit.48

This report was quickly followed up by a second report in which the IOM established the following “six pillars of quality,” which identified the core of what quality care must be49:

- **Safe**: Avoiding injuries to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as sex, ethnicity, geographic location, and socioeconomic status.

In a health care system that followed these six pillars, the IOM argued, the patient health care experience would be more responsive to individual needs and more reliable in the provision of preventive care.49

Developing a Quality Care Program at the Academy

Of course, with MNT by then established as a reliable, evidence-based tool for delivering quality care with proven outcomes, the Academy was already at the forefront of quality management efforts at that time. Still, the term quality management itself was a minor departure from the Academy’s early efforts: Once called a “quality assurance” program, it became evident, as the definition of quality evolved, that this was a much more intricate process—one that required practitioners to benchmark their roles; understand their value within hospitals and other types of facilities; improve performance; and meet the standards established by accreditation organizations, such as the Joint Commission and federal and state agencies. Thus, management emerged as the clearly more apt term.

Beyond performing MNT, however, there was still more that could be done, including continuing to educate the medical community about MNT as a means for providing safe, patient-centered care. McNeil recalls that even as recently as December 2004—at a Thought Leaders meeting with the Agency for Healthcare Research and Quality, featuring 12 leaders from across the United States representing various health care environments—there was minimal, if any, understanding among participants as to what the term MNT stood for and what it purported to achieve.

The Quality Management Committee used the IOM’s six aims, as well as Medicare’s new pay-for-performance initiatives, for guidance in laying the groundwork for its action plans and projects, says Kessey Kieselhorst, MPA, RD, CDE, LDN, past chair of the committee (2005-2006). Within a relatively short period of time after these new approaches were widely adopted across health care professions, the committee had published a series of articles about the Nutrition Care Process in 2003 (to be discussed in the coverage of the Research team of the Academy), SOPs and Standards of Professional Performance (SOPs) in 2005, and the scope of dietetics practice framework in 2005. “These ground-
breaking articles provided critical quality management guidance and techniques for dietetics professionals,” Kiesselhorst says.

Enhancing the Quality Program

The Academy’s quality management program really gained steam in the mid-2000s, as it dedicated more and more resources toward adopting the IOM’s overarching pillars and Medicare’s pay for performance in the interest of staying current with the quality management trends in regulatory, competence, and performance measures across allied health. From 2006 to the present, the Academy has compiled an extensive, robust set of tools to help practitioners in adhering to the scope of dietetics practice framework, which was established by the HOD in 2003 to assist practitioners in determining the appropriate level of safe, effective care they are individually qualified to deliver.

Among the enhancements to the quality management program was the issuance of SOPs and SOPPs for focus areas of practice, practice tips, resources, and interactive tools for practitioners to use in the challenging but essential task of assessing their own scope of practice. For example, the Academy’s scope of dietetics practice decision tree (Figure 3) was unveiled in 2005 to lead practitioners through the process of identifying their competencies based on knowledge, skill set, training, and education, and ultimately determining whether specifically requested services or acts fall within their individual scope of practice.

Considering the emphasis on SOPs and standards of competence and accountability throughout the US health care reform efforts in the 1990s and 2000s, these tools signify how dietetics has kept pace in contemporary health care and how members have embraced just how important quality care is. Throughout the years, particularly as the dietetics profession has become more specialized—and, as there is variable, if any, definition in individual states regarding who is qualified to perform work related to nutrition and dietetics—the need for a clearer definition of a scope of practice became apparent. McNeil notes that this emphasis on care has yielded a much different pool of practitioners within the profession. Just as incumbent practitioners have demonstrated the requisite flexibility and patience to unlearn and relearn what they knew about multiple aspects of practice in an environment that looks very different from the one they knew when they first entered the profession, new practitioners are entering the profession with an unprecedented early understanding of practice scope.

In an aggressive and strategic move, the Academy became a member of the National Quality Forum, a not-for-profit organization that endorses the quality measures its member organizations create, in 2010. The National Quality Forum has a stated threefold purpose of:

• building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
• endorsing national consensus standards for measuring and publicly reporting on performance; and
• promoting the attainment of national goals through education and outreach programs.

Quality management has become so integral to the profession and to health care at large that a framework for “quality dietetics practice” was established in 2011 (see Figure 4). The framework focuses on safe, effective, patient-centered, timely, efficient, and...
equitable care, and encompasses the IOM pillars:

- Follows a consistent process and model based on practice knowledge, evidence, research, and science.
- Exists within an individual’s scope of practice, state license, and legal scope of practice, regulations, and standards.
- Employs guides for self-evaluation and used by regulatory agencies to determine competency for credentialed dietetics practitioners.
- Aims for compensated, equitable, and reimbursable services.
- Evaluates and measures patient/client outcomes through data sources.
- Enables lifelong learning with career ladder through credentialing, certification, and advanced practice standards.

The quality management tools and documents are not static, however, and changes in regulatory and legislative language necessitate frequent updates. In 2011, the Academy began an update to the SOPs and SOPPs to address practitioners’ requests that role delineation between RDs and DTRs be further explained. Definitions of competence, quality management, nutritionist, specialist, and expert are also under review for possible revision. Once these updates are vetted and approved by the HOD, they will be released to the membership (likely in early 2013). Figure 5 presents the SOPs and SOPPs issued by the Academy.

**COUNCIL ON FUTURE PRACTICE**

From the 1960s through the 1980s, says Nevin-Folino, the Academy trusted that dietetics would reliably be a constant within the health system simply because hospitals depended on necessary foodservice—and the unintended consequence of this belief system was a limited focus on short-term goals and missed opportunities. “It was all secular thinking, focused on keeping the highest testing standards and meeting immediate needs but not the future. It never occurred to anyone to petition for Medicare coverage,” Nevin-Folino says, noting that the speech therapists and occupational therapists had the foresight to do so. In fact, outpatient physical and occupational therapy services have been reimbursed since 1982, when Medicare Part B coverage was introduced. The Medicare reimbursement for such services is much more generous than that granted to RDs:

- SOP/SOPP for RDs in Disordered Eating and Eating Disorders (August 2011)
- SOP/SOPP for RDs Integrative and Functional Medicine (June 2011)
- SOP/SOPP for RDs in Extended Care Settings (April 2011)
- SOP/SOPP for RDs in Diabetes Care (revised) (January 2011)
- SOP/SOPP for RDs in Oncology Nutrition Care (revised) (February 2010)
- SOP/SOPP for RDs in Nephrology Care (September 2009)
- SOP/SOPP for RDs in Pediatric Nutrition (August 2009)
- SOPP for RDs in Education of Dietetics Practitioners (April 2009)
- SOP/SOPP for RDs in Sports Dietetics (March 2009)
- SOPP for RDs in Management of Food & Nutrition Systems (March 2009)
- SOP in Nutrition Care and SOPP for RDs (September 2008)
- SOP in Nutrition Care and SOPP for DTRs (September 2008)
- SOP/SOPP for RDs in Nutrition Support (October 2007)
- SOP/SOPP for RDs in Behavioral Health Care (April 2006)
with physician referral and if certain criteria are met, Medicare reimburses outpatient therapy services performed by physical therapists, occupational therapists, and speech-language pathologists—and, if permitted by state law, nurse practitioners, clinical nurse specialists, physician assistants, and supervised qualified physical and occupational therapy assistants.

The state of academic preparation across allied health was in flux in the 2000s. The IOM’s National Commission on Allied Health had reported in 1996 that allied health education was not keeping pace with the evolving systems of care delivery. Contributing to this problem were inflexible curricula and traditional scope of practice boundaries across disciplines. Across disciplines, the delivery of care environment put ever-more emphasis on technological advances and accountability, which translated to a growing need to implement changes in practitioner core competencies.

Cognizant of these environmental and technological changes and how they aligned with the Academy’s strategic goal to position the profession at the forefront of health care, the Academy convened the Phase 2 Future Practice and Education Task Force in 2006. The task force’s charge was to first describe what the RD, DTR, and specialty and advanced RD practice roles will be in 2017 and beyond, and then identify how to modify educational preparation and supervised practice to attain those goals.

Based on the task force’s recommendations, presented in May 2008, the Council on Future Practice was established. The genesis of this nine-member committee sprang from the task force identifying that a formalized unit within the HOD—one that could implement, allocate resources to, and monitor the task force’s 11 overarching recommendations regarding education and training for entry-level, specialty, and advance practice—was clearly needed.

The Council on Future Practice’s responsibilities to the Academy is to collaborate with Accreditation Council for Education in Nutrition and Dietetics (ACEND), CDR, the Education Committee, and other Academy organizational units to determine and communicate their recommendations for current and future general, specialist, and advanced practice roles to ensure the viability and relevance of the profession of dietetics.

The Council on Future Practice’s collaboration with ACEND and CDR heralds a monumental shift in the Academy’s persevering work toward furthering the profession: not only can these groups together best identify the future practice, credentialing, and education needs of the profession, but the Council on Future Practice’s second meeting (convened in 2009) marked the first time that CDR and ACEND had come together to seek common goals.

Nevin-Folino notes that the Council on Future Practice was needed to formally do away with the Academy’s historical tendency to focus on what was happening in the current moment—emphasizing “what RDs know” rather than “what RDs need”—and to instead draw on past problems to project what would be needed in the future. She does point out that dietetics is not the only profession confronting the reality that future visioning shapes a profession. Pharmacy and nursing, for example, have encountered similar challenges in establishing a blueprint for their future. The American Association of Colleges of Pharmacy has introduced its own vision for future practice, issuing the “Future Vision for Pharmacy Practice” in 2004 to outline a plan for pharmacists to be considered “the health care professionals responsible for providing patient care that ensures optimal medication therapy outcomes” by 2015.

Establishing constancy in decision-making bodies was another essential goal to be addressed by the Council on Future Practice, notes Nora Nyland, PhD, RD, CD, 2012 Council on Future Practice chair. The determination of future academic needs and state of practice for RDs and DTRs is a judgment so massive that it would be risky to place that burden on ad hoc committees that would hastily convene and dissolve and perhaps have disparate goals. “Instead, the task force wanted one forward-looking, formalized unit with the unified goal of keeping an eye on future practice and educational developments in dietetics,” Nyland says.

The rapid strides in examining where the profession has been and where it is headed would not have been possible in the absence of the collaboration among the Council on Future Practice, ACEND, CDR, and the Education Committee. Charting the Course for the Second Century of the Profession (an unpublished BOD report) was released in 2011 to identify the expected outcomes from the activities springing from this cooperative effort—for example, increasing the number of supervised practice sites (in response to the shortage of dietetics internships, which will be discussed in the article that focuses on ACEND), updating the credentialing examination content outlines (based
on practice audits), and increasing practitioner diversity.

One of the Council on Future Practice’s most important contributions was to bring the issue of, “What is advanced practice?” to the forefront and to break ground on productive dialogue on the topic, says Nyland, adding that, “Historically it has not been an easy task to achieve consensus on how to define advanced practice—with countless ad hoc committees and a membership in the tens of thousands, there has been wide variation in how the term was used to describe various aspects of practice.” In the interim, however, the Council on Future Practice established consensus on how to define “focus area of practice,” “specialist,” and “advanced practice,” delineated in its report on a vision for future practice.

**Future Practice Visioning Report and Future Summit**

Beyond the essential task of providing input on strategic planning and mega issues, the Council on Future Practice has launched many initiatives in the relatively brief time since it first assembled in 2008. The Future Practice Visioning Report and the Future Connections Summit on Dietetics Practice, Credentialing, and Education were among the Council’s most innovative projects.

**Future Practice Visioning Report**

The Future Practice Visioning Report 2011 was created in response to the Phase 2 Future Practice and Education Task Force study. Results from a member visioning survey in 2010 informed a subsequent draft report that the Council on Future Practice presented to CDR’s Dietetics Workforce Demand Study Task Force, the HOD, ACEND, and the Education Committee. Along with the visioning process results, the final report (released in March 2011) yielded the pioneering Dietetics Career Development guide and definitions of levels of practice and focused areas of dietetics practice, including specialist and advanced practice.

Establishing definitions of these areas of practice was a significant achievement, as the profession had a longstanding lack of consensus regarding these designations, as discussed previously. See Figure 6 for details regarding how the Council on Future Practice defined levels of practice.

The dietetics career development guide—which reiterates how the Council on Future Practice and, thus, the Academy, define what is a novice, beginner, competent, proficient, and expert RD, and emphasizes the import of lifelong learning—illustrates how practitioners can enhance their knowledge and skill set throughout their careers—essential components for the quality of care delivery that the Academy emphasizes. The dietetics career development guide (Figure 7) presents a graphic representation of this model.

Future Connections Summit on Dietetics Practice, Credentialing, and Education

At the same time the visioning report was released, the Council on Future Practice—in conjunction with ACEND, CDR, and the Education Committee—convened the March 2011 Future Connections Summit on Dietetics Practice, Credentialing, and Education. The first of its kind at the Academy, this meeting was also an offshoot of the Phase 2 Future Practice and Education Task Force’s recommendations—specifically, that “…adequate resources be allocated by the [Academy] Board of Directors to support the planning and implementation of a Future Practice and Education Summit involving both Dietetic Practice Groups and all types of dietetics education programs.” This recommendation sought to increase communication among educators and practitioners to confront and conquer the challenges and needs within dietetics and to develop innovative mechanisms for bolstering the practice and education for professionals and students at all points along the career trajectory. As noted earlier in this article, the meeting convened virtually in Academy headquarters, in designated sites across seven regions, and in a secure chatroom and via Twitter feed.

The aims of the summit focused on outlining a shared vision for what dietetics practice, credentialing, and education would look like in the future and determining what it would take to adequately prepare the Academy and its members for these projected realities.

Toward that goal, by the summit’s conclusion, the participants had proposed many future-thinking ideas that underscored members’ dedication to continuously moving the profession forward. Pilot programs focused on increasing networking, internship, residency continuing education, and multidisciplinary practice opportunities—essential tenets in keeping dietetics practitioners competitive in the health care sphere.

**Innovations in Dietetics Practice and Education Program**

In keeping with the Academy’s longstanding commitment to recognize creativity, dedication, and ingenuity among its members, the Council on Future Practice launched the Innovations in Dietetics Practice and Educa-

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**Table:**

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<tr>
<th>Level</th>
<th>Description</th>
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<tr>
<td>Novice</td>
<td>Novices are pursuing career education (Associate, Baccalaureate, or advanced degrees) which may include dietetics education via the DTR (dietetic technician program) or RD Pathways (Coordinated Program or Didactic Program in Dietetics).</td>
</tr>
<tr>
<td>Beginner</td>
<td>The beginner is in the learning phase and includes participants in dietetic technician programs, coordinated programs, dietetic internships, or supervised practice.</td>
</tr>
<tr>
<td>Competent</td>
<td>Competent practitioners have just started practice after obtaining their registered status. This is generally the first 3 years of practice.</td>
</tr>
<tr>
<td>Proficient</td>
<td>Proficient practitioners have obtained operational skills and adeptly practiced in a long-term environment. They may begin to acquire Specialist credentials.</td>
</tr>
<tr>
<td>Expert</td>
<td>Experts build and maintain their knowledge, skills, and credentials and may have achieved the “Advanced Practice” level.</td>
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**Figure 6.** Council on Future Practice’s definitions of levels of practice.
tion Program in 2009. As a showcase of the exciting efforts of educators and practitioners in moving the profession forward, each year the Council on Future Practice selects no more than 25 innovators to present at a forum at the Food & Nutrition Conference & Expo.

Academy Positions and Practice Papers

The tremendous amount of respect the Academy has earned across the membership and across external organizations and institutions is partially credited to its position and practice papers. Since the 1970s, these papers—which are based on data available in the research literature and that reflect the Academy’s vision, mission, values, goals, and strategies—have delivered a timely and thoroughly informed stance on the most important nutrition-related issues of the day.

Position Papers

The Academy garners much attention by way of its positions, including endorsements and citations. For example, professional associations—including the American College of Sports Medicine (nutrition for physical fitness and athletic performance) and the New Zealand Dietetic Association (nutrition intervention for eating disorders)—have published endorsements of Academy positions. Furthermore, among the top 10 cited journal articles from 2007 to 2012 are two Academy position papers: the collaborative paper with the Dietitians of Canada regarding dietary fatty acids and the position regarding health implications of dietary fiber.

Position papers have been added and withdrawn during the past 30+ years. Considerations for determining the currency of a given paper include whether peer-reviewed journals are publishing data that do not support the Academy’s position, whether the current scientific data are reflected in the most up-to-date version of the paper, and whether the paper reflects the Academy’s evolving strategic plan. A decision is ultimately made whether to allow the position to expire, to publish an update, or to reframe the position as a practice paper.

With a forward-thinking attention on emerging shifts in the nation’s perception of health care in the late 1990s—notably, the need to support practice with evidence and outcomes and consumers’ increasing interest in seeking information regarding health concerns—the process for developing Academy positions, established in 1984, was updated in 1998. Specifically, the HOD’s interest in revising the protocol was in ensuring the scientific integrity of the positions and the efficiency in messaging.

Although all Academy positions address timely concerns in the dietetics context, some position papers charted new territory for the organization.

- The publication of the original version of the position “Nutrition Intervention and Human Immunodeficiency Virus Infection” in 1994 underscored the profession’s early responsiveness to a global health crisis and marked the first time the Academy jointly issued a position paper with the Dietitians of Canada.
- The position paper “Addressing World Hunger, Malnutrition, and Food Insecurity,” first published in 1995 and then again in 2003, marked the Academy’s first attempt at addressing an issue with implications beyond the Academy.
- “Individual-, Family-, School-, and Community-Based Interventions for Pediatric Over-
weight,” originally published in 2006, represented the Academy’s first use of its evidence analysis process to create an evidence-based position paper—an approach that has been applied to updated versions of all position papers. At the time of publication, this paper was in process of being updated, again using the evidence analysis process in its revisions.

- The Academy’s 2005 position “Liberalization of the Diet Prescription Improves Quality of Life for Older Adults in Long-Term Care” marked a mainstream change in the Academy’s stance that in the face of malnutrition, the importance of feeding superseded the need to follow any prescriptive diet plan. This paper, updated and published in 2010, is now called “Individualized Nutrition Approaches for Older Adults in Health Care Communities” and has an associated practice paper.

See Figure 8 for a list of topics the Academy position papers have explored.

### Practice Papers

In the early 2000s, the Academy Positions Committee recognized that publication of position papers alone was needlessly self limiting. A needs analysis (based on input from position pa-

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**Figure 8.** Topics of position papers published by the Academy of Nutrition and Dietetics. This figure does not include publication dates because position papers are periodically updated and republished. Position papers are accessible at www.eatright.org/positions.

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aJoint position with the School Nutrition Association and Society for Nutrition Education. bJoint position with the Dietitians of Canada. cJoint position with the American Society for Nutrition and the Society for Nutrition Education. dThis topic is also addressed in a practice paper. eJoint position with the Dietitians of Canada and the American College of Sports Medicine.
per authors), results of a member survey (more than 500 respondents), and an audit of the position paper practices of other health care associations led the committee to conclude that a practical applications guide to complement the succinct statements provided in position papers would be a boon to members.

Practice papers57 evaluate and summarize scientific and evidence-based information that address practice-related topics identified by members as worth examining but that do not necessarily have substantial scientific evidence to necessitate that the Academy take a position. Depending on the scientific trajectory of a given topic, practice papers can eventually evolve to position papers. These papers—which include perspectives from content experts, organizations, and businesses, and alliance groups of the Academy—are first evaluated by the Academy Positions Committee, approved by the HOD after a peer-review process, and ultimately published on the Academy’s website. Implications for the Nutrition Care Process, decision trees, benchmark levels, practice definitions, and opposing and emerging science are the hallmark of these papers.

The Academy’s first practice paper was published in 2005. Figure 9 presents the list of current Academy practice papers along with a synopsis of each paper.

## CONCLUSION

The governance of a professional association evolves with the ever-changing times, advances in practice, and member needs. Although the recent history of the governance and practice functions of the Academy delineates a vast sea change, by no means have these units gone static. Perhaps one of the most important takeaways of the period 1990 to present day is that, given the intrepid spirit of members and their leadership, there is no shying away from challenges or from taking risks to assert the profession and the Academy as the premier source for all things related to nutrition and dietetics.
<table>
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<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1991</td>
<td>First formal strategic plan (&quot;Achieving Competitive Advantage&quot;) is implemented.</td>
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<tr>
<td>1992</td>
<td>The Nutrition Services Payment Systems Committee develops the term “medical nutrition therapy” (MNT).</td>
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<tr>
<td>1994</td>
<td>Academy publishes its first joint position paper with the Dietitians of Canada.</td>
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<tr>
<td>1995</td>
<td>The Academy publishes its first position paper (regarding world hunger, malnutrition, and food insecurity) with implications beyond the Academy itself.</td>
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<tr>
<td>1996</td>
<td>Strategic plan is modified somewhat to focus on policy, member development, and public education. The Councils on Practice, Research, and Education are dissolved in favor of establishing a Council on Professional Issues.</td>
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<tr>
<td>1997</td>
<td>The Academy and Commission on Dietetic Registration jointly review the Code of Ethics and draft a revised code, called the Code of Ethics for the Profession of Dietetics.</td>
</tr>
<tr>
<td>1998</td>
<td>The House of Delegates (HOD) adopts a formal approach to projecting future needs of the Academy via its first environmental scan. The HOD updates its process for developing Academy positions to ensure scientific integrity and improve efficiency in messaging.</td>
</tr>
<tr>
<td>1999</td>
<td>Governance is restructured to increase collaboration between the Board of Directors (BOD) and HOD and to give HOD more focus on governing the profession. Strategic plan is updated to promote the value of Academy membership and increase the workplace visibility of registered dietitians (RDs) and dietetic technicians, registered (DTRs). The Institute of Medicine (IOM) acknowledges RD-provided MNT as a means for improving outcomes and reducing costs. Code of Ethics for the Profession of Dietetics is adopted.</td>
</tr>
<tr>
<td>2001</td>
<td>HOD adopts the issues management process for dealing with members’ concerns.</td>
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<td>2002</td>
<td>Medicare Part B for MNT coverage passes.</td>
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<tr>
<td>2003</td>
<td>Weight Management, the newest Dietetic Practice Group (DPG) to assemble, is formed.</td>
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<tr>
<td>2004</td>
<td>Strategic plan is updated to reflect the current health climate and emphasizes outcomes-based, quality care in moving the profession forward.</td>
</tr>
<tr>
<td>2005</td>
<td>Standards of practice (SOP) and standards of professional performance (SOPP) are revised. Academy offers decision analysis tool for determining individual scope of practice. Scope of dietetics practice framework is released. The Academy publishes its first practice paper.</td>
</tr>
<tr>
<td>2006</td>
<td>Phase 2 Future Practice and Education Task Force convenes for the first time. The Academy publishes its first evidence-based position paper.</td>
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<tr>
<td>2007</td>
<td>First official member interest group (LAHIDAN) is recognized by the Academy. DPGs celebrate 30th anniversary.</td>
</tr>
<tr>
<td>2008</td>
<td>Strategic plan is updated to highlight the impact members have on the health and nutrition knowledge of the American public and to highlight customer focus, integrity, innovation, and social responsibility as key values. Council on Future Practice is established by the Phase 2 Future Practice and Education Task Force.</td>
</tr>
<tr>
<td>2009</td>
<td>Council on Future Practice convenes second meeting, which marks the first time Commission on Dietetic Registration (CDR) and the Accreditation Council for Education in Nutrition and Dietetics (ACEND) have come together to address common goals. Council on Future Practice launches Innovations Dietetics Practice and Education program at the Food &amp; Nutrition Conference &amp; Expo (FNCE).</td>
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<tr>
<th>Year</th>
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<tr>
<td>2010</td>
<td>DPG delegates begin serving on the HOD. A new Code of Ethics, wherein categories of principles are established, is implemented (following approval in 2009). Academy launches its efforts to obtain Medicare reimbursement for obesity counseling. Academy becomes member of the National Quality Forum. DPGs enlisted to become more involved when legislative activity affects their respective focus areas of practice.</td>
</tr>
<tr>
<td>2011</td>
<td>Council on Future Practice hosts high-tech 2011 Future Connections Summit on Dietetics Practice, Credentialing, and Education. Council on Future Practice publishes its Visioning Report, which includes the Dietetics Career Development Guide; updated definitions of levels of practice; and revised definitions of level of practice. The Framework for Quality Dietetics Practice, which adheres to the IOM’s six pillars of quality care, is published. Academy initiates the update of the SOP and SOPP to clarify role delineations for RDs and DTRs. The Academy submits a letter to the Centers for Medicare and Medicaid Services to formally disagree with its decision regarding reimbursement for obesity counseling.</td>
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**TIMELINE: Governance and Practice Activities Since 1990**

**References**

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AUTHOR INFORMATION
K. Stein is a freelance writer, a consultant editor for the Nutrition Care Manual, and a former Editor of the Journal, Traverse City, MI.
Appendix 1. Boards of Directors of the Academy, 1990-2012

1990-1991
Mary Abbott Hess, MS, RD, President
Judith L. Dodd, MS, RD, President-Elect
Sara C. Parks, MBA, RD, Secretary/Treasurer
Carol V. Hall, RD, Secretary/Treasurer-Elect
Cheryl A. Bittle, PhD, RD, HOD Speaker
Doris Derelian, MS, RD, HOD Speaker-Elect
Diane R. Kerwin, MS, RD, Council on Practice Chairman
Margaret A. Powers, MPH, RD, Council on Practice Chairman-Elect
Oliveia Bennett Wood, MPH, RD, Council on Education Chairman
Carol W. Shanklin, PhD, RD, Council on Education Chairman-Elect
Sachiko T. St. Jeor, PhD, RD, Council on Research Chairman
Ronni Chernoff, PhD, RD, Council on Research Chairman-Elect
James F. Halling, MS, RD, Director-at-Large
Bettye J. Nowlin, MPH, RD, Director-at-Large
Mary Carey, PhD, RD, Director-at-Large
Judy Ford Stokes, RD, ADA Foundation Representative
Deborah D. Canter, PhD, RD, Commission on Dietetic Registration Representative

1991-1992
Judith L. Dodd, MS, RD, President
Susan C. Finn, PhD, RD, President-Elect
Jean Minskoff Grant, RD, President, ADA Foundation
Carol V. Hall, RD, Secretary/Treasurer
Doris Derelian, MS, RD, HOD Speaker
Jane V. White, PhD, RD, HOD Speaker-Elect
Margaret A. Powers, MS, RD, Council on Practice Chairman
Ann Gallagher, RD, Council on Practice Chairman-Elect
Carol W. Shanklin, PhD, RD, Council on Education Chairman
Margaret Pipkin Garner, MS, Council on Education Chairman-Elect
Ronni Chernoff, PhD, RD, Council on Research Chairman
Janet Mahalko Hunt, Council on Research Chairman-Elect
Bettye J. Nowlin, MPH, RD, Director-at-Large
Mary Carey, PhD, RD, Director-at-Large
Susan T. Borra, RD, Director-at-Large
Deborah D. Canter, PhD, RD, Commission on Dietetic Registration Representative
Beverly Bajus, ADA Chief Operating Officer/Executive Director

1992-1993
Susan C. Finn, PhD, RD, President
Sara C. Parks, MBA, RD, President-Elect
Carol V. Hall, RD, Secretary/Treasurer
Susan S. Kennedy, RD, Secretary/Treasurer-Elect
Jane V. White, PhD, RD, HOD Speaker
Colleen C. Matthys, RD, HOD Speaker-Elect
Mary Carey, PhD, RD, Director-at-Large
Susan T. Borra, RD, Director-at-Large
Cheryl Bittle, PhD, RD, Director-at-Large
Margaret P. Garner, MS, RD, Chairman, Council on Education
Julie O’Sullivan Maillet, PhD, RD, Chairman-Elect, Council on Education
Ann Gallagher, RD, Chairman, Council on Practice
Margaret Tate, MS, RD, Chairman-Elect, Council on Practice

(continued)
FROM THE ACADEMY

Janet R. Hunt, PhD, RD, Chairman, Council on Research
M. Rosita Schiller, RSM, PhD, RD, Chairman-Elect, Council on Research
Ellyn G. Luros, RD, ADAF Representative
Kristin Biskeborn, MPH, RD, Commission on Dietetic Registration (CDR) Representative
Beverly Bajus, Chief Operating Officer

1993-1994
Sara C. Parks, MBA, RD, President
Doris Derelian, PhD, RD, President-Elect
Rita J. Storey (Grandgenett), MS, RD, President, ADA Foundation
Susan S. Kennedy, RD, Secretary/Treasurer
Colleen C. Matthys, RD, HOD Speaker
Judith A. Gilbride, PhD, RD, Speaker-Elect
Susan T. Borra, RD, Director-at-Large
Cheryl A. Bittle, PhD, RD, Director-at-Large
Joyce B. Tower, MS, RD, Director-at-Large
Julie O’Sullivan Maillet, PhD, RD, Chairman, Council on Education
Bernestine B. McGee, PhD, RD, Chairman-Elect, Council on Education
Margaret Tate, MS, RD, Chairman, Council on Practice
Kathy Stone, MBA, RD, Chairman-Elect, Council on Practice
M. Rosita Schiller, RSM, PhD, RD, Chairman, Council on Research
Linda Snetselaar, PhD, RD, Chairman-Elect, Council on Research
Polly A. Fitz, MA, RD, Commission on Dietetic Registration Representative
Beverly Bajus, Chief Operations Officer

1994-1995*
Doris Derelian, PhD, RD, President
Ronni Chernoff, PhD, RD, President-Elect
Audrey C. Wright, MS, RD, President, ADA Foundation
Susan S. Kennedy, RD, Secretary/Treasurer
Susan T. Borra, RD, Secretary/Treasurer-Elect
Judith A. Gilbride, PhD, RD, HOD Speaker
Dawn C. Laine, MPH, RD, HOD Speaker-Elect
Kathy Stone, MS, RD, Chair, Council on Practice
Mary Tonore, MS, RD, Chair-Elect, Council on Practice
Bernestine B. McGee, PhD, RD, Chair, Council on Education
Suzanne Martin, PhD, RD, Chair-Elect, Council on Education
Linda Snetselaar, PhD, RD, Chair, Council on Research
Richard D. Mattes, PhD, RD, Chair-Elect, Council on Research
Cheryl A. Bittle, PhD, RD, Director-at-Large
Joyce Tower, MS, RD, Director-at-Large
Dayle Hayes, MS, RD, Director-at-Large
Polly A. Fitz, MA, RD, Chair, CDR
Beverly Bajus, ADA Chief Operating Officer

[*This was a transition year, in which, because of a structural change in governance created as a result of revisions to the Bylaws, all elected officers of the BOD served an 18-month term (instead of the typical 12-month term). For that reason, there is no separate BOD to list for the 1995-1996 term.]

1996-1997
Ronni Chernoff, PhD, RD, FADA, President
Polly A. Fitz, MA, RD, President-Elect
Carol V. Hall, RD, Chair, ADA Foundation
Susan T. Borra, RD, Secretary-Treasurer
Cheryl A. Bittle, PhD, RD, Secretary/Treasurer-Elect
Dawn C. Laine, MPH, RD, HOD Speaker  
Ann Gallagher, RD, HOD Speaker-Elect  
Joyce B. Tower, MS, RD, Director-at-Large  
Dayle M. Hayes, MS, RD, Director-at-Large  
Suzanne G. Martin, PhD, RD, Director-at-Large  
Richard D. Mattes, PhD, MPH, RD, Director-at-Large  
Mary F. Tonore, MS, RD, FADA, Director-at-Large  
Jane Young Wallace, Public Director-at-Large  
Judith Barr, ScD, Public Director-at-Large  
Erskine B. Smith, PhD, RD, CDR Chair  
Karen M. Fiedler, PhD, RD, Chair, Commission on Accreditation/Approval of Dietetic Education (CADE)  
Beverly Bajus, ADA Chief Operating Officer

**1997-1998**
Polly Fitz, MA, RD, President
Ann M. Coulston, MS, RD, FADA, President-Elect
Susan T. Borra, RD, Chair, ADA Foundation
Cheryl Bittle, PhD, RD, Secretary/Treasurer
Caryl B. Fairfull, MBA, RD, Secretary/Treasurer-Elect
Ann Gallagher, RD, HOD Speaker
Julie O'Sullivan Mailet, PhD, RD, HOD Speaker-Elect
Marianne Smith Edge, MS, RD, FADA, Director-at-Large
Molly Gee, MEd, RD, Director-at-Large
Dayle Hayes, MS, RD, Director-at-Large
Suzanne G. Martin, PhD, RD, Director-at-Large
Mary Tonore, MS, RD, FADA, Director-at-Large
Judith Thompson Barr, ScD, MEd, Public Director-at-Large:
Cornell Scott, MPH, Public Director-at-Large:
Colleen Matthys, RD, CDR Representative
Joyce Mooty, MPH, RD, CADE Representative
Beverly Bajus, ADA Chief Operating Officer

**1998-1999**
Ann Coulston, MS, RD, FADA, President
Ann Gallagher, RD, President-Elect
Susan T. Borra, RD, Chair, ADA Foundation
Caryl B. Fairfull, MBA, RD, Secretary/Treasurer
Margaret H. Tate, MS, RD, Secretary/Treasurer-Elect
Julie O'Sullivan Mailet, PhD, RD, FADA, HOD Speaker
Rebecca S. Reeves, DrPH, RD, FADA, HOD Speaker-Elect
Marianne Smith Edge, MS, RD, FADA, Director-at-Large
Karen M. Fiedler, PhD, RD, Director-at-Large
Molly Gee, MEd, RD, Director-at-Large
Carlene Russell, MS, RD, FADA, Director-at-Large
Elaine G. Williams, PhD, RD, Director-at-Large
Shirley E. Kellie, MD, MSc, Public Director-at-Large
Cornell Scott, MPH, Public Director-at-Large
Kara F. Caldwell-Freeman, DrPH, RD, CADe Representative
Colleen Matthys, RD, CDR Representative

**1999-2000**
Ann Gallagher, RD, President
Jane V. White, PhD, RD, President-Elect
Polly A. Fitz, MA, RD, Chair, ADA Foundation

(continued)
Margaret H. Tate, MS, RD, Secretary/Treasurer
Molly Gee, MEd, RD, Secretary/Treasurer-Elect
Rebecca S. Reeves, DrPH, RD, FADA, HOD Speaker
Marianne Smith Edge, MS, RD, FADA, HOD Speaker-Elect
Karen M. Fiedler, PhD, RD, FADA, Director-at-Large
Barbara Ann Hughes, PhD, RD, FADA, Director-at-Large
Susan H. Laramee, MS, RD, FADA, Director-at-Large
Carlene Russell, MS, RD, FADA, Director-at-Large
Elaine G. Williams, PhD, RD, Director-at-Large
Julie A. Flik, Public Director-at-Large
Shirley E. Kellie, MD, MSc, Public Director-at-Large
Jane K. Ross, PhD, RD, CADE Representative
Kathleen Cobb, MS, RD, CDR Representative
Connie L. Rivera, MBA, ADA Chief Executive Officer

2000-2001
Jane V. White, PhD, RD, President
Susan T. Borra, RD, President-Elect
NylDa Gempel, RD, Chair, ADA Foundation
Molly Gee, MEd, RD, Secretary/Treasurer
Marilyn Laskowski-Sachnow, MA, RD, Secretary/Treasurer-Elect
Marianne Smith Edge, MS, RD, FADA, HOD Speaker
M. Elizabeth (Beth) Kunkel, PhD, RD, FADA, HOD Speaker-Elect
Mary Jo Feeney, MS, RD, FADA, Director-at-Large
Julie A. Flik, Public Director-at-Large
Judith A. Gilbride, PhD, RD, FADA, Director-at-Large
Barbara Ann Hughes, PhD, RD, FADA, Director-at-Large
Gerald C. Keller, MD, FAAFP, Public Director-at-Large
Susan H. Laramee, MS, RD, FADA, Director-at-Large
Margaret H. Tate, MS, RD, Director-at-Large
Denise M. Brown, PhD, RD, CADE Representative
Barbara J. Ivens, MS, RD, CSP, FADA, CADE Representative
Connie L. Rivera, MBA, ADA Chief Executive Officer

2001-2002
Susan T. Borra, RD, President
Julie O’Sullivan Maillet, PhD, RD, FADA, President-Elect
Jane V. White, PhD, RD, FADA, Past President
Kenneth W. Wear, MS, RD, Chair, ADA Foundation
Marilyn Laskowski-Sachnow, MA, RD, Secretary/Treasurer
M. Elizabeth (Beth) Kunkel, PhD, RD, FADA, HOD Speaker
Mary Jo Feeney, MS, RD, FADA, Director-at-Large
Judith A. Gilbride, PhD, RD, FADA, Director-at-Large
Gerald C. Keller, MD, FAAFP, Public Director-at-Large
Margaret H. Tate, MS, RD, Director-at-Large
Cecilia P. Fileti, MS, RD, FADA, HOD Representative
Kathleen Cobb, MS, RD, CDN, HOD Representative
Robert Earl, MPH, RD, HOD Representative
Sylvia Escott-Stump, MA, RD, HOD Representative
Melinda Zook-Weaver, MS, RD, HOD Representative
Gregory Jewell, Public Member
Karen A. Lechowich, MS, MBA, RD, Acting ADA Chief Executive Officer

(continued)
2002-2003
Julie O’Sullivan Mailet, PhD, RD, FADA, President
Marianne Smith Edge, MS, RD, LD, FADA, President-Elect
Susan T. Borra, RD, Past President
Stella Cash, MEd, MS, RD, Chair, ADA Foundation
Marilyn Laskowski-Sachnoff, MA, RD, Treasurer
B. Thomas Malone, MS, RD, LD, Treasurer-Elect
Sylvia Escott-Stump, MA, RD, LDN, HOD Speaker
Robert Earl, MPH, RD, LD, HOD Speaker-Elect
Kathleen Cobb, MS, RD, CDN, Director
Sonja L. Connor, MS, RD, LD, Director
John B. Coombs, MD, Director
Judith A. Gilbride, PhD, RD, CDN, FADA, Director
Gregory Jewell, Director
Rachel K. Johnson, PhD, MPH, RD, Director
Kathleen Niedert, MBA, RD, LA, FADA, Director
Martin M. Yadrick, MS, MBA, RD, FADA, Director
Melinda Zook-Weaver, MS, RD, LD, Director
Ronald S. Moen, ADA Chief Executive Officer

2003-2004
Marianne Smith Edge, MS, RD, LD, FADA, President
Susan H. Laramee, MS, RD, LDN, FADA, President-Elect
Julie O’Sullivan Mailet, PhD, RD, FADA, Past President
Al Cassady, Chair, ADA Foundation
B. Thomas Malone, Jr, MS, RD, LD, Treasurer
Robert Earl, MPH, RD, LD, HOD Speaker
Melinda Zook-Weaver, MS, RD, LD, HOD Speaker-Elect
Ethan A. Bergman, PhD, RD, CD, FADA, Director
Sonja L. Connor, MS, RD, LD, Director
John B. Coombs, MD, Director
Rachel K. Johnson, PhD, MPH, RD, Director
Beth L. Leonberg, MS, RD, CSP, FADA, Director
Kathleen Niedert, MBA, RD, LD, FADA, Director
Nancy P. Siler, MS, RD, LD, CFCS, Director
Martin M. Yadrick, MS, MBA, RD, FADA, Director
Ronald S. Moen, ADA Chief Executive Officer

2004-2005
Susan H. Laramee, MS, RD, LDN, FADA, President
Rebecca S. Reeves, DrPh, RD, FADA, President-Elect
Marianne Smith Edge, MS, RD, LD, FADA, Past President
Margaret Bogle, PhD, RD, LD, ADA Foundation Chair
B. Thomas Malone, Jr, MS, RD, LD, Treasurer
Martin M. Yadrick, MS, MBA, RD, FADA, Treasurer-Elect
Melinda Zook-Weaver, MS, RD, LD, HOD Speaker
Sonja L. Connor, MS, RD, LD, HOD Speaker-Elect
Connie Diekeman, MEd, RD, LD, FADA, Director
Cecilia P. Fileti, MS, RD, FADA, Director
Beth L. Leonberg, MS, RD, CSP, FADA, Director
Kathleen Niedert, MBA, RD, LD, FADA, Director
Monica Phillips Penkilo, MPH, RD, LD, Director
Nancy P. Siler, MS, RD, LD, CFCS, Director

(continued)
FROM THE ACADEMY

Ethan A. Bergman, PhD, RD, CD, FADA, HOD Director
Penny Ralston, Public Member
Chester R. England III, Public Member
Ronald S. Moen, MS, ADA Chief Executive Officer

2005-2006
Rebecca S. Reeves, DrPH, RD, FADA, President
Judith A. Gilbride, PhD, RD, CDN, FADA, President-Elect
Susan H. Laramee, MS, RD, LDN, FADA, Past President
Barbara K. Brandt, Chair, ADA Foundation
Martin (Marty) M. Yadrick, MS, MBA, RD, FADA, Treasurer
Sonja L. Connor, MS, RD, LD, HOD Speaker
Jessie M. Pavlinac, MS, RD, CSR, LD, HOD Speaker-Elect
Connie B. Diekmann, MEd, RD, LD, FADA, Director
Cecilia P. Fileti, MS, RD, FADA, Director
Trisha Fuhrman, MS, RD, LD, FADA, Director
Beth L. Leonberg, MS, RD, CSP, FADA, LDN, Director
Monica A. Penkilo, MPH, RD, LD, CDE, Director
Judith C. Rodriguez, PhD, RD, FADA, HOD Director
Marsha K. Schofield, MS, RD, LD, HOD Director
Penny Ralston, PhD, MEd, Public Member
Diana S. Wynne, MBA, CPA, Public Member
Ronald S. Moen, MS, ADA Chief Executive Officer

2006-2007
Judith A. Gilbride, PhD, RD, FADA, President
Connie B. Diekmann, MEd, RD, FADA, President-Elect
Rebecca S. Reeves, DrPH, RD, FADA, Past President
Neva Hudiburgh Cochran, MS, RD, Chair, ADA Foundation
Martin M. Yadrick, MS, MBA, RD, FADA, Treasurer
Joyce A. Gilbert, PhD, RD, Treasurer-Elect
Jessie M. Pavlinac, MS, RD, CSR, HOD Speaker
Ellen Rosa Shanley, MBA, RD, CDN, HOD Speaker-Elect
Christine M. Palumbo, MBA, RD, Director-at-Large
Cecilia Pozo Fileti, MS, RD, FADA, Director-at-Large
Trisha Fuhrman, MS, RD, FADA, CNSD, Director-at-Large
Yvonne D. Greer, MPH, RD, CD, HOD Director
Judith C. Rodriguez, PhD, RD, FADA, HOD Director
Kathleen M. Rourke, PhD, RD, RN, CHES, HOD Director
Marsha K. Schofield, MS, RD, HOD Director
Michael O. Fleming, MD, FAAFP, Public Member
Diana S. Wynne, MBA, CPA, Public Member
Ronald S. Moen, MS, ADA Chief Executive Officer

2007-2008
Connie B. Diekmann, MEd, RD, LD, FADA, President
Martin M. Yadrick, MS, MBA, RD, FADA, President-Elect
Judith A. Gilbride, PhD, RD, CDN, FADA, Past President
Susan C. Finn, PhD, RD, FADA, Chair, ADA Foundation
Joyce A. Gilbert, PhD, RD, Treasurer
Ellen R. Shanley, MBA, RD, CDN, HOD Speaker
Marsha K. Schofield, MS, RD, HOD Speaker-Elect
Trisha Fuhrman, MS, RD, FADA, Director-at-Large

(continued)
Constance J. Geiger, PhD, RD, CD, Director-at-Large
Christine M. Palumbo, MBA, RD, Director-at-Large
Rita Storey Grandgenett, MS, RD, HOD Director
Yvonne D. Greer, MPH, RD, CD, HOD Director
Kathleen M. Rourke, PhD, RD, RN, CHES, HOD Director
Jody L. Vogelzang, PhD, RD, FADA, HOD Director
Larry K. Ellingson, MBA, RPh, Public Member
Michael O. Fleming, MD, FAAFP, Public Member
Ronald S. Moen, MS, ADA Chief Executive Officer

2008-2009
Martin M. Yadrick, MS, MBA, RD, FADA, President
Jessie M. Pavlinac, MS, RD, CSR, President-Elect
Connie B. Diekman, MEd, RD, LD, FADA, Past President
Susan C. Finn, PhD, RD, FADA, Chair, ADA Foundation
Joyce A. Gilbert, PhD, RD, LD, Treasurer
Kathleen W. McClusky, MS, RD, FADA, Treasurer-Elect
Marsha K. Schofield, MS, RD, LD, HOD Speaker
Ethan A. Bergman, PhD, RD, CD, FADA, HOD Speaker-Elect
Christina K. Biesemeiher, MS, RD, LDN, FADA, Director-at-Large
Christine M. Palumbo, MBA, RD, Director-at-Large
Constance J. Geiger, PhD, RD, CD, Director-at-Large
Evelyn F. Crayton, EdD, RD, LD, HOD Director
Jody L. Vogelzang, PhD, RD, LD, FADA, CHES, HOD Director
Trisha Fuhrman, MS, RD, LD, FADA, CNSD, HOD Director
Rita Storey Grandgenett, MS, RD, HOD Director
Kenneth P. Moritsugu, MD, MPH, FACP, Public Member
Larry K. Ellingson, RPH, Public Member
Ronald S. Moen, MS, ADA Chief Executive Officer

2009-2010
Jessie M. Pavlinac, MS, RD, CSR, LD, President
Judith C. Rodriguez, PhD, RD, FADA, President-Elect
Martin M. Yadrick, MS, MBA, RD, FADA, Past President
Judith L. Dodd, MS, RD, FADA, LDN, Chair, ADA Foundation
Kathleen W. McClusky, MS, RD, FADA, Treasurer
Ethan A. Bergman, PhD, RD, FADA, HOD Speaker
Glenna McCallum-Cloud, DMOL, MPH, RD, HOD Speaker-Elect
Constance J. Geiger, PhD, RD, CD, Director-at-Large
Kathleen M. Zelman, MPH, RD, Director-at-Large
Christina K. Biesemeier, MS, RD, LDN, FADA, Director-at-Large
Mary P. (Trisha) Fuhrman, MS, RD, LD, FADA, CNSD, HOD Director
Mary Pat Raimondi, MS, RD, HOD Director
Pamela J. Charney, PhD, RD, HOD Director
Evelyn F. Crayton, EdD, RD, LD, HOD Director
Jim Lucas, PhD, MA, Public Member
Kenneth P. Moritsugu, MD, MPH, FACP, RADM, USPHS (Ret), Public Member
Christopher Wharton, PhD, Young Member
Patricia M. Babjak, ADA Chief Executive Officer

2010-2011
Judith C. Rodriguez, PhD, RD, LDN, FADA, President
Sylvia Escott-Stumpf, MA, RD, LDN, President-Elect
Jessie M. Pavlinac, MS, RD, CSR, LD, Past President

(continued)
Appendix 2: PAST PRESIDENTS, 1990-2012

1990 Mary Abbott Hess, MS, RD
1991 Judith L. Dodd, MS, RD
1992 Susan C. Finn, PhD, RD, LD, FADA
1993 Sara C. Parks, PhD, MBA, RD
1994 Doris Derelian, PhD, RD
1996 Ronni Chernoff, PhD, RD, FADA
1997 Polly Fitz, MA, RD
1998 Ann Coulston, MS, RD, FADA
1999 Ann Gallagher, RD
2000 Jane V. White, PhD, RD
2001 Susan T. Borra, RD
2002 Julie O’Sullivan Maillet, PhD, RD, FADA
2003 Marianne Smith Edge, MS, RD, LD, FADA
2004 Susan Laramee, MS, RD, LDN, FADA
2005 Rebecca S. Reeves, DrPH, RD, FADA
2006 Judith A. Gilbride, PhD, RD, FADA
Appendix 3: HOD SPEAKERS, 1990-2012

1990 Cheryl A. Bittle
1991 Doris Derelian, PhD, RD
1992 Jane V. White, PhD, RD
1993 Colleen C. Matthys, RD
1994 Judith A. Gilbride, PhD, RD, FADA
1996 Dawn C. Laine, MPH, RD
1997 Ann Gallagher, RD
1998 Julie O’Sullivan Mailet, PhD, RD, FADA
1999 Rebecca S. Reeves, DrPH, RD, FADA
2000 Marianne Smith Edge, MS, RD, LD, FADA
2001 M. Elizabeth (Beth) Kunkel, PhD, RD, FADA
2002 Sylvia Escott-Stump, MA, RD, LDN
2003 Robert Earl, MPH, RD, LD
2004 Melinda Zook-Weaver, MS, RD, LD
2005 Sonja L. Connor, MS, RD, LD
2006 Jessie M. Pavlinac, MS, RD, CSR, LD

Although the groundbreaking strategic plan from 1991 and the updated version in 2008 differ in many ways, perhaps the most significant difference is that by the 21st century, the plan delineated goals and specific action-oriented strategies for achieving those goals. The updated approach to specifically identify actions to meet the Academy's goals reflects the business culture of the time.

1991 Strategic Plan

Mission

The American Dietetic Association is the advocate of the dietetics profession serving the public through the promotion of optimal nutrition, health, and well-being.

Vision

Members of the American Dietetic Association will shape the food choices and impact the nutritional status of the public.

Philosophy

Members of the American Dietetic Association serve the profession best by serving the public first.

Values

- Excellence in the identification, development, and delivery of quality programs, services, and products
- Leadership in significant food, nutrition, and related health issues
- Integrity in all professional and personal actions
- Respect for diverse viewpoints and individual differences
- Communication that is timely and effective
- Collaboration for action on critical issues
- Fiscal responsibility in effectively providing and managing human and financial resources
- Action that is timely and strategic

2008-2012 Strategic Plan*

Mission

Empowering members to be the nation's food and nutrition leaders

Vision

Optimizing the nation's health through food and nutrition

Values

- Customer focus—Meet the needs and exceed the expectations of all customers
- Integrity—Act ethically with accountability for life-long learning and commitment to excellence
- Innovation—Embrace change with creativity and strategic thinking
- Social responsibility—Make decisions with consideration for inclusivity as well as environmental, economic and social implications

(continued)
<table>
<thead>
<tr>
<th>Goals</th>
<th>The public trusts and chooses Registered Dietitians as food and nutrition experts.</th>
<th>Academy members improve the health of Americans.</th>
<th>Members and prospective members view the Academy as vital to professional success.</th>
</tr>
</thead>
</table>
| **Strategy** | 1. Strengthen and differentiate a respected RD brand  
2. Establish value to target audiences through effective programs, services and initiatives offered by registered dietitians  
3. Take proactive science and evidence-based positions on issues related to health  
4. Work collaboratively with local, state, national and international food and nutrition communities  
5. Strategically promote registered dietitians for leadership roles in key influential and visible positions | 1. Engage members to impact food and nutrition policies through participation in the legislative and regulatory processes at local, state and federal levels  
2. Enhance the relevance of public health nutrition within Academy and increase its visibility in the broader public health community  
3. Optimize relationships with key stakeholders and external organizations  
4. Provide support to help members optimize the public’s health through food, nutrition and physical activity  
5. Prepare members to conduct and use research in practice  
6. Strengthen cultural competence of Academy members  
7. Reduce health disparities by promoting improved access to registered dietitian services and nutrition interventions | 1. Empower present and future practitioners to be the leaders in food and nutrition  
2. Provide state-of-the-art professional development for education, competence and career success  
3. Provide relevant and valued products and services for diverse member audiences  
4. Provide research and resources that can be translated into evidenced-based practice  
5. Identify and respond to the needs of a changing diverse group of members  
6. Foster diversity in Academy leadership positions |
Section 2

Program Policy & Procedures
PROSPECTIVE INTERNS

Admission Requirements

Please see the Fresno State University Post Graduate Admissions Office
http://www.fresnostate.edu/studentaffairs/are/graduate/index.html for information regarding the admissions requirements and other details.

Minimum Application Requirements

1. Completed a baccalaureate degree from an accredited institution.
2. Completed an approved DPD within the last 5 years.
3. Earned a minimum cumulative and overall DPD of 3.0 GPA.
4. Earned a minimum score of 138V/136Q (or 300V/300Q on GRE test taken prior to August 1, 2011) on the GRE General Test.
5. Earned a minimum of 550 on TOEFL if native language is not English.
6. Work Experience, paid or volunteer in dietetics
7. Accepted interns must successfully complete background checks, immunization report, CPR certification, and fingerprinting before beginning program.

Application Procedure

Check for updated application procedures using the Dietetic Internship Centralized Application System at: http://www.fresnostate.edu/jcast/fsn

1. The program is using the on-line centralized internship application, DICAS, which may be accessed at https://portal.dicas.org. The on-line application must be completed for our program by 11:59 p.m. Central Time on February 15.
2. Submit Graduate application on line (available at http://www.csumentor.edu). CSU application fee required.
3. Submit to:
   Dietetic Internship Director
   California State University, Fresno
   Department of Food Science and Nutrition
   5300 N. Campus Drive, M/S FF 17
   Fresno, CA 93740-8019
   1. Confirmation page from University Graduate application
   2. Copy of scores from the GRE General Test
4. Submit an application on-line to D & D Digital (for computer match)

Application Deadline
Postmarked no later than February 15

The California State University, Fresno Dietetic Internship is a 9-month schedule with program concentration of Culturally Competent Health Promotion / Disease Prevention (HP/DP). Interns'
complete supervised practice experiences in a variety of facilities in the Central San Joaquin Valley of California, including a veterans’ hospital, a state prison, a school district, two private hospitals, an out-patient diabetes program, and community based health organizations. Eight units of graduate-level course work are required as part of the dietetic internship. The internship is completed in one academic year (two semesters) with an elective rotation completed between the fall and spring semesters. All interns complete all assigned rotations on a rotating basis, with one or two interns in a facility at one time.

Once accepted to the DI program, in order to begin the internship, the following will be required:

- Verification statement from your didactic program
- Original degree posted transcript, when it is available
- Proof of medical and automobile insurance (explained in more depth in this section)
- Completion of a background check with CertifiedBackground.com (required by supervised practice facilities)
- Live Scan Fingerprinting (required by supervised practice facilities)
- Pre-internship physical and immunizations

**Conditions for Program Completion**

**Requirements for Program Completion**

The following requirements must be met for satisfactory completion of the California State University, Fresno Dietetic Internship:

Satisfactory completion of a minimum of 1200 hours of supervised practice.

Satisfactory completion of all rotations assigned by the Dietetic Internship Director.

Satisfactory completion of all assignments in each rotation.

Satisfactory completion of all additional assignments made by the Dietetic Internship Director.

Earn a minimum of 70% (C grade) in all required graduate courses.

Fulfill program requirements to earn Certificate of Advanced Study in Dietetics.

**Criteria for Issuance of Certificate of Advanced Study in Dietetics**

To progress through the Dietetic Internship, the student/intern must:
• Maintain a minimum of 3.0 GPA
• Complete program requirements
• Course requirements include:

<table>
<thead>
<tr>
<th>Course Number</th>
<th>Title</th>
<th>Semester Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>FN 229 (fall)</td>
<td>Graduate Seminar</td>
<td>1</td>
</tr>
<tr>
<td>FN 230 (fall)</td>
<td>Advanced Nutrition Counseling</td>
<td>3</td>
</tr>
<tr>
<td>Nutr 193 (fall)</td>
<td>Supervised Work Experience</td>
<td>4 – Cr/NC</td>
</tr>
<tr>
<td>FN 229 (spring)</td>
<td>Graduate Seminar</td>
<td>1</td>
</tr>
<tr>
<td>FN 250 (spring)</td>
<td>Food &amp; Nutrition Resource Management</td>
<td>3</td>
</tr>
<tr>
<td>FSM 193 (spring)</td>
<td>Supervised Work Experience</td>
<td>4 – Cr/NC</td>
</tr>
</tbody>
</table>

8 units of graduate credit will be granted upon completion of coursework.

Criteria for Issuance of Verification Statement

The following requirements must be met in order for a dietetic intern to successfully complete the dietetic Internship:

Maintain a 3.0 grade point average (GPA) in all required courses and supervised work experience.

Earn a C grade (70%) or better in each required course and all supervised work experience.

Complete evaluation procedures for all supervised practice rotations.

Meet minimum level of competence for each and every core competency and general emphasis competency.

Fulfill program requirements to earn Certificate of Advanced Study in Dietetics.

Program Retention & Remediation

In the event an intern is not able to complete the dietetic internship as indicated (in accordance with university policy) and/or performance and progress is unsatisfactory. As a direct effort for program retention, it is at the discretion of the DI directors to allow remediation. Remediation efforts must be completed in a timely manner and not exceed 150% of the program duration. In the case of CSUF Dietetic Internship:

Calculate the maximum program completion time in weeks or years

36 weeks x 1.5 = 54 weeks

Normal Program Length
Max. Program Completion

Formal Assessment & Student Learning Procedures

Students are expected to complete all requirements for a class by the end of the semester unless an incomplete is permitted by the instructor in accordance with university policy.
All faculty members shall provide students at the beginning of each semester a syllabus or outline stating course goals and objectives including grading methodology, types and number of projects, written assignments, tests, experiments, etc. in accordance with university policy.

Evaluation forms for each rotation in the internship are found on Blackboard. They consist of Part A, which an evaluation of competencies demonstrated, intern’s strengths and objectives for future rotations and Part B which an evaluation of assignments completed.

At the completion of each rotation, the interns will be evaluated by the preceptor and will complete a self-evaluation of the rotation. This evaluation will be discussed with the intern by the preceptor. The intern will give both completed evaluations to the DI director on the Monday following the completion of the rotation.

Evaluations will be maintained by the DI director and secured in a locked file. These will be used to assess interns’ progress which will be discussed with each intern at period progress review sessions.

For further information on university grading policies, consult the general catalog under academic regulations at www.csufresno.edu.

Drug Testing and/or Criminal Background Check(s)

Drug testing and/or criminal background checks may be required by facilities, preceptors, and/or the university. These tests are typically required before the intern begins the internship, however due to fluctuations of preceptors and/or just cause, it is the right of the program to request drug and/or criminal background check at any time during the internship. It is the financial responsibility of the intern to pay for all services unless otherwise specified.

Use of Interns to Replace Employees

The purpose of educational supervised practice is to PREVENT the use of interns to replace employees. In general, interns should not be brought into a workplace if the sole reason is to provide free labor when paid employees are absent. Individuals acting as primary preceptor are expected to take steps to assure that absent employees are replaced by a paid substitute and not to take interns away from scheduled learning activities. However, interns should also recognize that there are expectations (as outlined in the Expectations for Dietetic Interns Agreement) that in some cases one might be expected to give back something in return for the time, attention and resources which the faculty and/or preceptor site have devoted to their educational hands-on learning.
A professional attitude toward work in health care sometimes requires that an intern not get paid for every task performed, or work beyond normal hours, especially if patients are in need of care. In unexpected circumstances, help may be needed and an intern is expected to volunteer as a part of professionalization. If an intern feels the “unexpected circumstances” are being abused by the faculty and/or preceptor, it is the intern’s responsibility to notify the DI director, so the situation can be brought up/resolved to the faculty and/or preceptor site.

**Vacation, Holiday, Sick Leave**

See the current Internship Schedule for the Academic Calendar which lists holidays and class schedule for the current academic year. Internship schedule and holidays correspond with this schedule except as stated. No additional time-off or holidays are allowed in the program.

**Students are expected to attend class and field experience activities and must notify the internship director and preceptors regarding any absences.** It is the responsibility of the intern to contact the preceptor, the moment they know that are ill, but no less than 30 minutes prior to a scheduled shift. It is mandatory for the intern to email and call the preceptor AND the dietetic internship director when an absence will occur. Failure to do this can lead to disciplinary action.

A plan for make-up of missed days of field experience due to illness or other emergency will be developed by the internship director in consultation with the facility preceptor and the student.

Any make-up work or missed assignments remain the responsibility of the student and must be made up to remain eligible for the Academy of Nutrition and Dietetics (AND) verification statement.

Program accreditation is based on completing of all required rotations, assignments and learning experience. All assigned hours must be completed to qualify for program completion. Hours missed will be added to the end of the program.

**Program Calendar and Scheduling Procedures**

The 2018 – 2019 program begins on August 16, 2018 and ends May 20, 2019. The DI program fall semester is from August 24 through December 18, 2018. The DI elective is from January 4 – 22, 2019. The spring semester is from January 25 through May 20, 2019. An intern calendar can be found in the manual in section 3.

Interns will be schedule in medical nutrition therapy, food service management and community nutrition rotations. Interns will be scheduled to rotate through each facility in the program for
the time specified in the summary of rotations (found in section 3 of this manual). Specific assignments will vary to be equal to the number of interns each facility can accommodate.

**Insurance Requirements**

Limited health services are provided by the University Health Center (UHC). A mandatory fee for UHC services are included in the total registration fees for the university. Services are provided by the UHC are listed in the General Catalog. Services are available 8:00am to 5:00pm Monday through Friday.

In addition, dietetic interns are required to have health insurance to cover minimum of the following:
- Hospital benefits
- Medical, surgical and related services for any illness or accident

Students may purchase and insurance plan through an independent company such as, Associated Students Inc.

Students are required to provide the DI director with appropriate documents showing proof of health/medical coverage prior to the start of the internship program calendar.

**Travel Liability of Dietetic Interns**

Dietetic inters are liable for any accident, injury, motor vehicle violation, or moving violation occurring related to travel to an assigned practice site for themselves and any passengers traveling with them.

The State of California requires the following minimum automobile liability coverage:
- $ 15,000 per person / $ 30,000 per accident for bodily injury AND
- $ 5,000 for property damage

If a licensed driver is driving an automobile owned by someone other than themselves, the driver is responsible for assuring that the automobile is covered with the minimum liability coverage.

California State University Fresno and any and its entire faculty, staff, agents and agencies assume **NO** liability for dietetic intern safety in travel to assigned practice sites.

**Illness or Injury in Practice Facility**

Liability for injury incurred associated with an assigned rotation in the DI program is the responsibility of the intern (see the following policies: Health Insurance Requirements for dietetic interns, Professional Liability Insurance Requirements for Dietetic Interns; and Travel liability for Dietetic Interns)
If an injury or illness occurs while a dietetic intern is at the assigned facility, the intern shall follow the policies and/or procedures established by the facility. The supervising dietitian will provide policies and procedures to the dietetic intern on the first day of the rotation.

The dietetic intern is responsible for contacting the supervising dietitian AND the DI director as soon as possible to report the illness or injury.

If the dietetic intern is absent from the rotation due to excused illness or injury, the time will need to be made up at the discretion of the DI director and site preceptors.

Professional Liability

All dietetic interns are covered under CSU provided professional liability insurance while enrolled in supervised practice course (NUTR 193 & FSM 193).

Students will be charged a course fee of approximately $8.00 per semester when they enroll in these courses.

Assess to Personal Files

All student records of the California State University, including California State University, Fresno, are kept in accordance with the provisions of the Family Educational Rights and Privacy Act of 1974. Public law 93-380, section 438 (A)(1)(2), (B)(1)(2).

A student may request access to personal records, must consent to the release of those records (except to those agencies entitled to access under provisions of the act) and may request a copy of records which he/she has requested or consented to be released. Full explanation of this policy is located in the Schedule of Courses.

Particular questions with respect to a student’s prerogative under the Family Educational Rights and Privacy Act of 1974 should be directed to the Vice President for Student Affairs or the Director of Admissions and Records.

Assessment of Prior Learning

All rotations will be completed by all interns despite prior learning or work experience. In the case of significant prior work or learning experience; the intern, preceptor, and DI director will collaborate to design more challenging experiences and assignments. If required graduate classes have been taken prior to the internship, another class of equivalent units will be required. The instructor, intern, and DI director will collaborate to agree on an appropriate class to substitute in the Certificate of Advanced Study plan.

Program Expenses
Tuition and Fees: Information about the tuition rates, housing and other fees associated with Fresno State are available on the Undergraduate Admissions Office website at:
http://www.fresnostate.edu/catoffice/current/fees.html

**Books, materials and supplies:** Required books, software, and printing fees for course materials are estimated to be approximately $400 per semester.

- **Health Service Fee:** $93 (*included in Tuition*)
- **Professional liability insurance:** course fee of $16 (*included in Tuition*)
- **Personal Health Insurance** (*varies*)
- **Background / Fingerprinting** (*varies per preceptor*)
- **Immunizations:** Fees vary
- **Academy of Nutrition and Dietetics membership dues:** $50.00 (due in May) – automatically become a member of the California Dietetic Association
- **Central Valley Dietetic Association:** $15.00 student rate (*but could be subject to change*)

Students are encouraged, but not required, to attend professional meetings in dietetics. Students will be responsible for covering the registration, housing, and travel costs associated with these meetings. These costs will vary depending on the type and location of the meeting.

**Post-baccalaureate Tuition and Fees**
Students who attend a dietetic internship after graduating from the Didactic Program in Dietetics will be expected to pay tuition and fees as part of the program costs. The tuition and fees vary between programs. They can range from $5,000 to $28,000 depending.
The student should be aware that satisfactory completion of the course(s) of the CSUF Dietetic Internship is based on satisfactory performance in all of the Academy of Nutrition and Dietetics Performance Requirements as determined by rotation evaluation by the site preceptors. Evaluations are shared with the student and Internship Director. If either the site preceptor or the student is concerned about a negative performance outcome of the experience, the student, site supervisor and Internship Director will be informed. The degree of discipline applied will be consistent with that necessary to call behavior changes to the interns’ attention rather than to inflict punishment for unsatisfactory behavior. Disciplinary action more serious than a warning must be documented in writing. For the protection of both parties, records of these actions will be stored in a locked filing cabinet in the dietetic internship director’s office. Disciplinary procedures should include the following:

1. Verbal warning with counseling
2. Written reprimand with counseling
3. Dismissal

A meeting will be arranged as soon as possible involving the student site staff member and Internship Director to resolve any difficulties. If the problem is unsatisfactory student performance, the site staff member and Internship Director will set forth activities and performance criteria for the student to meet within a specific timeline for continuance in the Dietetic Internship. Grounds for dismissal will include but are not limited to: mistreatment of patients, clients, preceptors, facility staff, other interns or the public; drug or alcohol use during working hours; excessive absenteeism and tardiness; failure to maintain appropriate or professional standards of dress or hygiene; disclosing confidential information and inability to meet internship requirements. If academic scores fall below 70%, strong efforts will be made to provide additional assistance and individualized experiences to help the intern to succeed. If after a reasonable amount of time (1 month during rotations, or 3 months for academic work) the intern is still not able to achieve an average of 3 (satisfactory) rating in performance evaluation and an average of 70% on academic work, the intern will be removed from the program. If the student’s Internship Director is not available, another faculty member will serve as a substitute at the meeting. Every effort will be made to provide an opportunity for the student to demonstrate satisfactory performance including, if necessary, extending the Dietetic Internship experience, up to the maximum allowable determined by the accredited body. If the student does not perform satisfactorily in the assigned tasks for the specified time period, the student will no longer continue as a Dietetic Internship student and will receive a ‘no credit’ grade in the course.
Expectations for Dietetic Interns

The Dietetic Internship at California State University, Fresno has set high standards for interns in the program. The internship year is a critical observation period during which interns must prove themselves to be competent and suited to the dietetics profession. Interns must “put their best foot forward” at all times during the year, both at work and in situations away from the facility.

1. Interns will conduct themselves as professionals at ALL times. Interns are no longer college students or “kids” and need to conduct themselves as professionals.

2. Interns will behave in an ethical manner at all times.

3. Interns will keep in mind that, to the public, they represent California State University, Fresno, the Dietetic Internship Program, and the sponsoring facilities. Interns will conduct themselves in an appropriate manner so as to reflect positively on the sponsoring entities.

4. Interns will willingly do whatever is asked of them, recognizing that they are expected to give back something in return for the time, attentions and resources which the faculty and/or preceptors have devoted to them. However noting that the educational purpose of supervised practice is to prevent the use of interns to replace employees and must notify the DI director if this occurs.

5. Interns will present a positive attitude at all times when on duty or out in the community.

6. Interns will behave as “team players”, i.e., putting as much priority on the needs of the group, the department or facility as on their own individual needs.

7. Interns are both students and employees, Departmental commitments will, at times; take precedence over homework and academic commitments.

8. Interns will deal with problems and resolve conflicts in an open, direct and assertive (NOT Aggressive) manner.
9. Interns will take the initiative in the learning process, seeking out information and answers, rather than waiting for them to be given.

10. Interns will make their needs known to the faculty, DI Director, preceptors and to each other in an assertive but tactful manner.

11. Interns will follow through on all assigned responsibilities and will complete all tasks on or before the deadline(s).

12. Interns will perform to the best of their abilities in ALL rotations, classes, assignments, presentation or other activities.

13. Interns will give appropriate feedback to faculty and DI director regarding ways in which the program can be improved.

14. Interns will be ON-TIME, appropriately dressed and groomed and prepared to work each time they report for duty.

15. Personal business, personal problems and the like will be attended to during OFF-DUTY hours, insofar as is possible, and should not unduly interfere with performance, work responsibilities or the learning environment. If interns need special consideration or assistance with personal issues, these should be brought to the attention of the DI Director immediately.

16. Interns will NOT fraternize, date or socialize on personal time with non-management, non-professional staff of any of the food service departments in the program. The employees are to be treated with respect and friendliness, but interns are not the “buddy” of the employees.

17. Interns will not date each other, or any member of any facility food service / nutrition department in the program.

I have read the Expectations of Dietetic Interns and understand them. I realize I will be held responsible for fulfilling these expectations, and that failure to do so will result in corrective action, which may include discharge from the program.

Name (print): ___________________________  Signature: ___________________________

Date: ________________
University Policy & Procedure

**Honor Code**

http://www.fresnostate.edu/academics/academicintegrity/reducing/honorcode.html

**Academic Progress**

http://www.fresnostate.edu/studentaffairs/advising/students/probation-disqualification/index.html

**Access to Student Services**

http://www.fresnostate.edu/studentaffairs/

**Assessment of Student Learning**

http://www.fresnostate.edu/academics/oie/assessment/

**Policies and Procedures for Off-Campus Events**

http://www.fresnostate.edu/adminserv/ehsrms/riskmgt/trips/

**Grievance Policy and Procedure**


**Liability Insurance**

http://www.fresnostate.edu/adminserv/ehsrms/riskmgt/insurance/liability.html

**Protection of Privacy of Student Information and Accessing Personal Files**

http://fresnostate.edu/studentaffairs/registrar/student-records/ferpa.html

**Disciplinary Procedures for The California State University**

http://www.fresnostate.edu/studentaffairs/judicialaffairs/exec970.html

http://www.fresnostate.edu/studentaffairs/division/general/policies.html#disc2
Transfer of Credits

http://www.fresnostate.edu/studentaffairs/are/evaluations/transfercredit.html

Withdrawal from Fresno State

http://www.fresnostate.edu/studentaffairs/registrar/registration/withdrawal.html
<table>
<thead>
<tr>
<th>Week</th>
<th>Dates</th>
<th>Activity</th>
<th>Rotation Days*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>August 16-24</td>
<td>Orientation</td>
<td>None</td>
<td>M-F only</td>
</tr>
<tr>
<td>1</td>
<td>August 27-31</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td>Grad Classes begin Monday</td>
</tr>
<tr>
<td>2</td>
<td>September 3-7</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td>No class on Monday, Sept 3 <em>Labor Day</em></td>
</tr>
<tr>
<td>3</td>
<td>September 10-14</td>
<td>Rotations only</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>September 17-21</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>September 24-28</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>October 1-5</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>October 8-12</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>October 15-19</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>October 22-26</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Oct 29-Nov 2</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>November 5-9</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>November 12-16</td>
<td>Rotations only</td>
<td>Tuesday-Friday</td>
<td>No Class on Monday <em>Veterans Day</em> holiday Nov 12</td>
</tr>
<tr>
<td>13</td>
<td>November 19-23</td>
<td>Classes only</td>
<td>None</td>
<td>No rotations / Thanksgiving Break</td>
</tr>
<tr>
<td>14</td>
<td>December 3-7</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>December 10-14</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>December 17-21</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>January 2-21</td>
<td>Elective</td>
<td>None</td>
<td>40-hour rotation weeks</td>
</tr>
<tr>
<td>1</td>
<td>January 22-25</td>
<td>Rotations only</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Jan 28- Feb 1</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td>Classes begin again starting 1/28</td>
</tr>
<tr>
<td>3</td>
<td>February 4-8</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>February 11-15</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>February 18-22</td>
<td>Rotations only</td>
<td>Tuesday-Friday</td>
<td>No class on Monday, Feb 18 <em>Presidents Day</em></td>
</tr>
<tr>
<td>6</td>
<td>February 25-Mar 1</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>March 4-8</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>March 11-15</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>March 18-22</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>March 25-29</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>April 1-5</td>
<td>Rotations only</td>
<td>Tuesday-Friday</td>
<td>No class on Monday, Apr 1 *Cesar Chavez Day</td>
</tr>
<tr>
<td>12</td>
<td>April 8-12</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>April 15-19</td>
<td>Rotations only</td>
<td>Tuesday-Friday</td>
<td><em>Spring Break</em> Still @ Rotation</td>
</tr>
<tr>
<td>14</td>
<td>April 22-26</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Apr 29 - May 3</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>May 6-10</td>
<td>Classes / Rotations</td>
<td>Tuesday-Friday</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>May 13-17</td>
<td>Rotations only</td>
<td>Monday-Thurs</td>
<td>Graduation on Friday, 17th</td>
</tr>
</tbody>
</table>
SECTION 3

Facility Descriptions
# Rotation Summary 2018-2019

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>ROTATION</th>
<th>WEEKS</th>
<th>FACILITIES¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Nutrition Therapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 weeks</td>
<td>Acute Care – Small</td>
<td>3</td>
<td>a) Madera Community Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) Community Medical Center Clovis</td>
</tr>
<tr>
<td></td>
<td>Acute Care MNT- Large</td>
<td>2</td>
<td>VACCHCS or CRMC or SAMC</td>
</tr>
<tr>
<td></td>
<td>Nutrition Support - Large</td>
<td>2</td>
<td>VACCHCS or CRMC or SAMC</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>1</td>
<td>VACCHCS</td>
</tr>
<tr>
<td>448 hours</td>
<td>Out-Patient Counseling</td>
<td>1</td>
<td>VACCHCS</td>
</tr>
<tr>
<td></td>
<td>Rural Health Clinic-Out Pt</td>
<td>1</td>
<td>Family Health Care Network</td>
</tr>
<tr>
<td></td>
<td>CRMC Outpt Specialty</td>
<td>1</td>
<td>Pediatrics or Cancer Center</td>
</tr>
<tr>
<td></td>
<td>Consulting</td>
<td>1</td>
<td>Dietary Directions</td>
</tr>
<tr>
<td></td>
<td>Simulation Study</td>
<td>2</td>
<td>Self-Study and HealthYou Wellness</td>
</tr>
<tr>
<td><strong>Foodservice Systems</strong></td>
<td>Hospital-Large</td>
<td>2</td>
<td>VACCHCS</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 weeks</td>
<td>Hospital-Small</td>
<td>1</td>
<td>Madera Community Hospital</td>
</tr>
<tr>
<td></td>
<td>Community Food Service</td>
<td>1</td>
<td>Fresno-Madera EOC Kitchen</td>
</tr>
<tr>
<td></td>
<td>School Food Service</td>
<td>2</td>
<td>Kings Canyon Unified or Clovis Unified</td>
</tr>
<tr>
<td>320 hours</td>
<td>Skilled/Commissary/Contract FS</td>
<td>2</td>
<td>CRMC – behavior health; rehab; main kitchens</td>
</tr>
<tr>
<td></td>
<td>Prison</td>
<td>2</td>
<td>CSATF at Corcoran State Prison</td>
</tr>
<tr>
<td><strong>Community Nutrition</strong></td>
<td>WIC</td>
<td>2</td>
<td>Fresno County EOC or United Health Cntr</td>
</tr>
<tr>
<td>9 weeks</td>
<td>Health and Wellness</td>
<td>2</td>
<td>University Health and Psychological Services</td>
</tr>
<tr>
<td></td>
<td>Sports Nutrition</td>
<td>1</td>
<td>CSUF Sports RD – Athletics Dept</td>
</tr>
<tr>
<td></td>
<td>Cooperative Extension</td>
<td>2</td>
<td>University of California Cooperative Extension</td>
</tr>
<tr>
<td>288 hours</td>
<td>Community Based Health Org</td>
<td>1</td>
<td>West Fresno Health Care Coalition</td>
</tr>
<tr>
<td></td>
<td>CSUF Student Teaching</td>
<td>1</td>
<td>CSUF Food &amp; Nutrition Department</td>
</tr>
<tr>
<td><strong>Elective</strong></td>
<td>3 weeks of Elective (M-F)</td>
<td>3</td>
<td>Interns Seek/Find their own Elective –</td>
</tr>
<tr>
<td>3 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>120 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

33 weeks of Tue-Friday rotation schedule = 1056 hours  
3 weeks of elective M-F rotation schedule = 120 hours  
Hours of Community Outreach Activity = 40 hours  
Hours of Professional Development = 16 hours  

**TOTAL HOURS: 1,232 SUPERVISED HOURS**

The following courses will provide:  
8 UNITS OF GRADUATE CREDIT

<table>
<thead>
<tr>
<th>Course Number</th>
<th>Title</th>
<th>Semester Units</th>
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</thead>
<tbody>
<tr>
<td>FN 229 (fall)</td>
<td>Graduate Seminar</td>
<td>1</td>
</tr>
<tr>
<td>FN 230 (fall)</td>
<td>Advanced Nutrition Counseling</td>
<td>3</td>
</tr>
<tr>
<td>Nutr 193 (fall)</td>
<td>Supervised Work Experience</td>
<td>4/CR-NC</td>
</tr>
<tr>
<td>FN 229 (spring)</td>
<td>Graduate Seminar</td>
<td>1</td>
</tr>
<tr>
<td>FN 250 (spring)</td>
<td>Food &amp; Nutrition Resource Management</td>
<td>3</td>
</tr>
<tr>
<td>FSM 193 (spring)</td>
<td>Supervised Work Experience</td>
<td>4/CR-NC</td>
</tr>
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</table>

¹ Some rotations use 2-4 facilities, accommodating 5 interns at each facility. The facilities are selected and the experiences are planned to be comparable.
<table>
<thead>
<tr>
<th>Facility</th>
<th>Contact</th>
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</thead>
<tbody>
<tr>
<td>Veterans Affairs Medical Center</td>
<td>Michael Paulissen, MS, RD</td>
</tr>
<tr>
<td>2615 E. Clinton</td>
<td>Manager Nutrition Services</td>
</tr>
<tr>
<td>Fresno, CA 93703</td>
<td>559-225-6100, ext. 4086</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:michael.paulissen@va.gov">michael.paulissen@va.gov</a></td>
</tr>
<tr>
<td>Community Medical Center-Clovis</td>
<td>Carey Davies, MS, RD, CNSD</td>
</tr>
<tr>
<td>2755 E. Clark</td>
<td>Manager, Nutrition Services</td>
</tr>
<tr>
<td>Fresno, CA 93726</td>
<td>559-324-3703</td>
</tr>
<tr>
<td></td>
<td>Cell: 559-241-9274</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:cdavies@csufresno.edu">cdavies@csufresno.edu</a></td>
</tr>
<tr>
<td>Community Regional Medical Center</td>
<td>Jaclyn Looper, RDN</td>
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<tr>
<td>Fresno Community Hospital Campus</td>
<td>Clinical Nutrition Manager</td>
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<tr>
<td>2823 Fresno Street</td>
<td>Office: 559-459-2882</td>
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<tr>
<td>Fresno, CA 93721</td>
<td>Cell: 559-</td>
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<td><a href="mailto:JLooper@communitymedical.org">JLooper@communitymedical.org</a></td>
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<tr>
<td>Community Regional Medical Center</td>
<td>Melinda Bush</td>
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<tr>
<td>Pediatric Specialty Clinics</td>
<td>Office: 559-456-1561</td>
</tr>
<tr>
<td>215 N. Fresno Street, Ste 370</td>
<td><a href="mailto:MBush2@communitymedical.org">MBush2@communitymedical.org</a></td>
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<tr>
<td>Fresno, CA 93701</td>
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<tr>
<td>Community Regional Medical Center</td>
<td>Lauren Nowak, RD</td>
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<tr>
<td>Community Cancer Institute</td>
<td>559-378-1710</td>
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<td><a href="mailto:Inowak2@communitymedical.org">Inowak2@communitymedical.org</a></td>
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<tr>
<td>Community Regional Medical Center</td>
<td>Carrie Der Garabedian, MBA, RD, CFPM</td>
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<tr>
<td>Director of CBHC &amp; CSTCC</td>
<td>559-449-4405</td>
</tr>
<tr>
<td>7171 N. Cedar Ave</td>
<td><a href="mailto:cdergarabedian@communitymedical.org">cdergarabedian@communitymedical.org</a></td>
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<tr>
<td>Fresno, CA 93720</td>
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<tr>
<td>Fresno County EOC</td>
<td>Terri Sores, MS, RD</td>
</tr>
<tr>
<td>1920 Mariposa Mall, Suite 120</td>
<td>WIC Manager</td>
</tr>
<tr>
<td>Fresno, CA 93726</td>
<td>559-263-1158</td>
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<td><a href="mailto:terri.soares@fresnoeoc.org">terri.soares@fresnoeoc.org</a></td>
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<tr>
<td>Clovis Unified School District</td>
<td>Nancy Whalen, RD</td>
</tr>
<tr>
<td>1735 David E Cook Way</td>
<td>Dietitian</td>
</tr>
<tr>
<td>Clovis, CA 93611</td>
<td>559-327-9131</td>
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<tr>
<td></td>
<td><a href="mailto:NancyWhalen@clovisusd.k12.ca.us">NancyWhalen@clovisusd.k12.ca.us</a></td>
</tr>
</tbody>
</table>
California Substance Abuse Treatment Facility and State Prison at Corcoran
900 Quebec Ave. PO Box 7100
Corcoran, CA 93212

Don Perkins
Food Manager
559-992-7100 Ext 5762
Donald.Perkins@cdcr.ca.gov

CSUF Sports Nutrition
Director of Sports Nutrition
1620 E. Bulldog Lane M/S OF87
Fresno, CA 93740

Alisha Parker, MS, RDN
559-278-2020
alishaparker@mail.fresnostate.edu

CSUF Student Teaching
Family Food Science Building
FFS #103 Office number

Lisa Herzig, PhD, RDN, CDE
email do NOT phone
lherzig@csufresno.edu

Dietary Directions
2350 W. Shaw Ave, Ste 112
Fresno, CA 93711

Nikki Andres, RD
Dietitian
C-559-681-6965
0-559-451-0460
nikkiandres11@yahoo.com

Family Health Care Network
400 E. Oak Ave
Visalia, CA 93291

Angela Duran-Isaacs, RD, CLC, CPT
559-741-4519
aisaacs@fhcn.org

Unified Health Centers of San Joaquin Valley
1840 Ashlan Ave
Clovis, CA 93611

Kathleen Harriss, RD, IBCLC
WIC Coordinator
559-638-3948
harrissk@unitedhealthcenters.org

University of California-Cooperative Extension
550 E. Shaw Ave, Ste 210
Fresno, CA 93710

Evelyn Morales
eamorales@ucanr.edu
559-241-7348

Kings Canyon Unified School District
1502 “I” Street
Reedley, CA 93654

Shaun Rodriguez
Director of Nutrition Services
559-305-7056 / Cell: 559-426-0568
rodriguez-s@kcusd.com

St. Agnes Medical Center
1303 E. Herndon
Fresno CA, 93720

Sholeh Shahrokhi, MS, RD
Clinical Dietitian
559-450-3366
Department of Food Science and Nutrition  
Dietetic Internship Affiliations 2018-2019

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>Contact Information</th>
</tr>
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</table>
| Madera Community Hospital                        | Kat Vietti & Kristen Petersen  
| 1250 E. Almond Ave                               | Co-Directors of Nutrition Resources  
| Madera, CA 93638                                 | 559-675-2718  
|                                                 | kvietti@maderahospital.org  
|                                                 | kpetersen@maderahospital.org                              |
| Fresno County EOC Food Preparation Center         | Randy, Moens, RD                                          
| (EOC Kitchen)                                    | Manager                                                  
| 3100 W. Nielsen                                  | 559-266-3663  
| Fresno, CA 93706                                 | Randy.moens@fresnoeoc.org                                 |
| University Health and Psychological Services      | Stephanie Annett, RD                                      
| 5044 N. Barton Avene                             | Health Educator                                          
| Fresno, CA 93740-8012                            | 559-278-6724  
|                                                 | stmorris@csufresno.edu                                    |
Clinical MNT 4-week

Facility: Community Regional Medical Center (CRMC)
2823 Fresno St,
Fresno, CA 93721

Preceptor(s):
Jaclyn Looper
Clinical Nutrition Manager
Office: 559-459-2882
JLooper@communitymedical.org

Carrie Der Garabedian, MBA, RD, CFPM
Director of CBHC & CSTCC
Nutrition & Dining Services
7171 North Cedar Avenue
Fresno, California 93720
Phone # 84405 (559.449.4405)
Fax # 84495 (559.449.4495)
Cell 559.790.6263
CDerGarabedian@communitymedical.org

Out Patient Clinical Rotations:
5 interns go to Pediatric Specialty and 5 will go to Oncology Specialty

Preceptor(s):
Melinda Bush-Pediatrics
Pediatric Specialty Clinics
Office: 559-456-1561
215 N. Fresno Street, Ste. 370
MBush2@communitymedical.org
Fresno, CA 93701

Lauren Nowak-Oncology/Cancer
Lauren Nowak, RD
Community Cancer Institute
Office: 559-378-1710
lnowak2@communitymedical.org

Travel Directions:
For the main hospital (CRMC) –
Located downtown, you can use valet parking.
It’s next to ER at the Rotunda
The outpatient clinics – PEDs clinics are downtown:
215 N. Fresno Street, Ste. 370 and the cancer Institute is in the process of moving out to new facility on the Clovis Community Medical Center Campus: 785 Medical Center Dr. W, Clovis, CA 93611 (ask the preceptors about where to park)

Rotation Information:
When you rotate for FSM – you will be going to at least three locations, CBHC, CSTCC and Main Kitchen at CRMC. For the CSTCC: the parking lot is EXTREMELY small and is hard to find parking - it is in a residential type neighborhood and hard to park on the street near it (but it can be done). The entrance to the facility is technically in the back of the building (which is where the parking is, if you are lucky enough to park there), so if you walk in from the street, remember to go around to the back.

Locations:

Community Subacute & Transitional Care Center
3003 N. Mariposa St.
Fresno, California 93720
(559) 459-1711

Community Behavior Health Center
7171 North Cedar Avenue
Fresno, CA 93720

Instructions:

1. Professional Dress
2. Be prepared as you would for any clinical rotation (calculator, books, etc.)
3. If you are doing FSM, check with Carrie on dress for the day, if she will have you in the kitchen you will need to plan accordingly.

References and assignments:

Clinical Rotation will have assignments posted in Blackboard
Facility:  Section 3-UHPS

University Health and Psychological Services
5044 N. Barton Avenue
Fresno, CA 93740

Preceptor:  Stephanie Annett, RD
Phone: 559-278-6724
Email: stmorris@csufresno.edu

Length of Rotation:  2 Weeks Community

General Instructions:  Business, casual dress, comfortable, close toe shoes. Please contact Stephanie by email, at least one week prior to rotation.

Travel Directions:  Located on the Fresno State Campus (Health Center).
Facility: Department of Food Science and Nutrition
5300 N Campus Drive, M/SFF17
Fresno, CA 93740
P (559) 278-2043

Preceptor: Dr. Lisa Herzig
lherzing@csufresno.edu
*Best to email her ahead of time and you may need to go to her office hours to meet with her at least ONE week ahead of your scheduled week of rotations

Secondary Preceptor: Dr. Shabnam Pooya
shabnampooya@csufresno.edu

Travel Directions: University Campus – Family & Food Science Building

Instructions:
1.) Professional Dress & name tag; 1 hr.
lunch; some evening work is possible if classes are being taught in the evening.
2.) Schedule of courses to be taught will be provided once you have made contact with the preceptor.

Activities and Assignments (subject to change at any time):
To assist in teaching a diverse population of dietetic students; In that all students learn the basic and essential skills at each grade level.

Instructional Process/Responsibilities include:
- Works with the teacher in planning and implementing a program of instruction that adheres to the school’s philosophy, goals and objectives.
- Works with the teacher in making purposeful and appropriate lesson plans that provide for effective teaching strategies and maximize time on task.
- Works with the teacher in planning and implementing a program of study designed to meet individual needs of students.
- Works with the teacher in creating a classroom environment conducive to learning by employing a variety of appropriate teaching strategies.
- Works with the teacher in encouraging student enthusiasm for the learning process and the development of good
study habits.
- Works with the teacher in providing progress through authentic observations.
- Uses effective oral and written expression
- Works with the teacher in recognizing learning problems and makes referrals as appropriate alongside the teacher.

Additional Info may also be in Blackboard and be familiar with the expectations list

Curriculum Development
Keeps current in subject matter knowledge and learning theory and is willing to share this knowledge for continual improvement of the curriculum

Interns in past, say this is a very intense level of the internship – please keep this in mind and give it 100% of your dedication and time. This rotation is ONLY 1 week; however, you are expected to have large assignments that can take many hours. Please plan your schedule accordingly. This rotation also gives you a lot of autonomy and working independently since you are only with the preceptor two days of the week – it is a best practice that you email the lead preceptor daily and give her a summary of your day and what was accomplished.
Facility Section 3-DDI: Dietary Directions

2350 W. Shaw Ave. Suite 112
Fresno, CA 93711

Preceptor: Nikki Andres, RD
P: (559) 835-4011
E: nikkiandres11@yahoo.com

Length of Rotation: 1 Week

General Instructions: Professional Dress,
Check on lunch assignments with each
preceptor as they vary with site

Travel Directions: Travel West on Shaw, located between W.
Avenue and Marks Avenue, just past Van
Ness Blvd. OR meet at location designated
by preceptor.

Reading List: Review prior to rotation
Family Health Care Network
Corporate office:
305 E. Center Ave.
Visalia, CA 93291
P: (559) 737-4700
Website: http://www.fhcn.org

Angela Duran Isac, RD, CLC, CPT
Registered Dietitian,
Certified Lactation Counselor &
Certified Personal Trainer
Family Healthcare Network
400 E. Oak Ave
Visalia, CA 93291
(559)741-4519
aisaacs@fhcn.org
www.fhcn.org

Check with preceptor on locations, you may be working with secondary preceptors at different locations. Go to website and familiarize yourself with their sites. Some preceptors work 4 – 10 hour shifts and you may be asked to do the same. They also occasionally have health fairs and/or weekend work – so please contact preceptor for your exact schedule.

1. Professional Dress, name tag; 1 hr. lunch; some evening work is possible if classes are being taught in evening
2. You will be working with preceptor in an outpatient counseling setting and will see various chronic health diseases.

Please review the company website to get an understanding of Family Health Care Network and the populations they serve (they are considered a Federally Qualiﬁed Health Care Center – if you don’t know that term, look it up ahead of time).

No pre-work at this time.
Facility Section 3-EDC: Fresno County EOC. Kitchen

Preceptor: Randy Moens, RD.
P: (559) 266-3663
E: randy.moens@fresnoeoc.org

Length of Rotation: 1 Week

General Instructions: Pants, short-sleeved shirts, comfortable, non-skid closed toe shoes. No hanging jewelry.

Travel Directions: Travel South on CA-41 to CA-180 W. toward Madera. Exit at Marks Avenue, turn right onto N. Marks. Turn left onto W. Nielson Avenue; destination will be on the right.

Reading List: None prior to the rotation
Facility Section 3-St. Agnes MC:  St. Agnes Medical Center
Nutrition Support
1303 E. Herndon
Fresno, CA 93720

Preceptor:  Sholeh Shahrokhi, MS, RD.
P: (559) 450-3366
E: sholeh.shahrokhi@samc.com

Length of Rotation:  4 Weeks (2 W/ MNT & 2 W/ NS)

General Instructions:  Professional Dress

Travel Directions:  Travel east on Herndon past First St.,
Located on the South side of Herndon and Millbrook.
VA – Out Patient – Monica/Carolyn  
Rotation: VA 1 week of general outpatient  

Preceptors: Monica Kong, MPH, RD and Carolyn Pearce, RD  
Phone: 559-225-6100 ext. 5239  
E-mail: monica.kong@va.gov  
carolyn.pearce@va.gov  

Monica and Carolyn share the intern load.

**General information:** Please contact the preceptor via e-mail one week prior to the rotation, report to the Nutrition Clinic (B1B03) Tuesday, Thursday and Friday 7:30-4pm. Wednesday is an independent project day, will be assigned during the rotation. The structure of this rotation is designed with limited direct supervision and to allow flexibility depending on patient care work-load. You are expected to work independently with minimum supervision and to counsel patients on the first day of the rotation. If needed, please review basic MNT for obesity, HTN, HL, DM, cancer and etc. **PLEASE NOTE:** It is your responsibility to ensure your VA computer codes are functional with the ability to log onto the computer the first day of the rotation. It is **highly recommended that you come to the Nutrition Clinic (B1B03) prior to your rotation to test it out. See Efren Villarama for assistance.**

**Required reading:**

[http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2722407](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2722407)

[https://www.cdc.gov/pcd/issues/2013/12_0325.htm](https://www.cdc.gov/pcd/issues/2013/12_0325.htm)

Rotation: VA  
Preceptors: Carolyn Pearce, RD  
Phone: 559-225-6100 ext. 4132  
E-mail: carolyn.pearce@va.gov  

**General information:** Please contact the preceptor via e-mail one week prior to the rotation, report to the Primary Care (1C03) Tuesday - Friday 8:00-4:15pm. There may be independent project days due to staffing which will be assigned during the rotation. The structure of this rotation is designed with limited direct supervision and to allow flexibility depending on patient care work-load. You are expected to work independently with minimum supervision and to counsel patients on the first day of the rotation. If needed, please review basic MNT for obesity, HTN, HL, DM, cancer and etc.
PLEASE NOTE: It is your responsibility to ensure your VA computer codes are functional with the ability to log onto the computer the first day of the rotation. It is highly recommended that you come to the Nutrition Clinic (B1B03) prior to your rotation to test it out. See Efren Villarama for assistance.

**Required reading:** Provided upon first day or feel free to access via internet.


*Cano, N et al. Intradialytic Parenteral Nutrition Does Not Improve Survival in Malnourished Hemodialysis Patients: A 2-Year Multicenter, Prospective, Randomized Study. JASN J American Society of Nephrology. 2007 September; 18 (9); 2583-2591*


Next Preceptor, CHEN
Please see below for VA – Out Patient – Diabetes Info:
Facility Section 3-VACCHCS Diabetes & Outpatient: VA Central California Health Care System
2165 E. Clinton Avenue
Fresno, CA 93703

Preceptor: C. Chen MS, RD. CDE
P: (559) 225-6100 x 4087
E: chao-yun.chen@va.gov

General Instructions: Please report to the Nutrition Clinic (WB101) Tuesday-Friday 8:00a.m. – 4:30p.m. And contact preceptor 1 week prior to your rotation to clarify any questions you may have.

Reading List: ALL reading assignments must be completed prior to the rotation.

- Ch.13 Medical Nutrition Therapy (pp. 279-291)
- Ch. 16 Combating Clinical Information & Facilitating Engagement (pp. 573-593)
- Ch. 25 Assessment: Gathering Information and Facilitating Engagement
- Ch. 27 Implementation of Diabetes Education (pp. 615-631)
- Ch. 28 Evaluating and Documenting Outcomes (pp. 633-648)
- Ch. 29 Healthy Eating (pp. 652-666)

2.) Conduct counseling and education classes for individual patients in groups as assigned. Be
prepared to sharpen your counseling skills. You will have hands-on experience on your first day of the rotation.

3.) Develop nutrition care plans and document the information in patients’ e-records. Follow the appropriate disease standards of practice for recommendations in planning and providing nutrition care.

4.) Develop on patient education handout each week. Topics will be decided to fit VACCHCS clinic needs. You are encouraged to use your own education handouts in your counseling sessions when appropriate.
Facility Section 2- VACCHCS FSM: VA Central Health Care System
Large Hospital FSM, MNT and Nutrition Support
2615 E. Clinton
Fresno, CA 93704

Preceptor: Food Systems Management
Michael Pauliseen, MS, RD.
P: (559) 225-6100 EXT 5002
E: michael.paulissen@va.gov

Medical Nutrition Therapy and Nutrition Support:
Cris Stilwell, RD. CNSD
P: (559) 225-6100 EXT 5782
E: clarissa.stillwell@va.gov

Geriatric:
Jill Apok, RD.
P: (559) 225-6100 EXT 4084
E: jill.apok@va.gov

Length of Rotation: MNT: You will spend your first week with Jill and then 3 weeks with Cris

General Instructions: Professional dress. Casual work attire (no jeans) may be worn; comfortable enclosed shoes; beige lab coat available which will be provided by the VA. May ear either hairnet or blue disposable cap (available in the kitchen office) during FSM rotation. No meals provided by VA Volunteer Service.

Travel Directions: Located on Clinton Avenue just east of Fresno Street near Highway 41. Clinton is south of Shileds Avenue

Reading List: Check with preceptor prior to rotation to obtain assignments, which may need to be completed prior to rotation. MNT/Nutrition Support Study guides are posted on Blackboard. MNT study guide is due at the beginning of the rotation. Note nutrition support study guide due dates.
Facility: University of California Cooperative Extension

Preceptor: Evelyn Morales | Nutrition Projects Coordinator

Travel Directions: This location is on Shaw Avenue – across from Fashion Fair Mall; cross streets Shaw/Angus

Instructions: Professional Dress, name tag; no jeans. Bring lunch

Activities and Assignments (subject to change at any time):

1. Observation of Adult and/or Youth Expanded Food and Nutrition Education Program (EFNEP) or Food Stamp Nutrition Education Program (FSNEP) teach as the supervisor. Observe for learner-education interaction.
2. Conduct Adult and/or Youth EFNEP/FSNEP teaching experience.
3. Write newsletter or training materials for Nutrition Team staff.
4. Develop and op-ed letter for Fresno Bee or other article, web materials, blog, script, brochure or handout.
5. Write a letter to a local or state leader to provide education about a nutrition-related concern in the Fresno Community.
6. Develop 20-minute in-service structure as a display, activity, or game.
7. Participate and/or conduct evaluation of an event or class.
8. Attend community and departmental meetings and or events as assigned.
9. Integrate experience and personal growth in a reflection summary not to exceed on page.
Facility: West Fresno Family Resource Center
1802 E California Ave
Fresno, CA 93706
(559) 621-2967

Preceptor: JANICE E. MATHURIN, M.A
jmathurinwfhcc@yahoo.com

Travel Directions: This location is on the west side of Fresno. Large landmarks include the 99, (Freeway).

Instructions:

1. Your work hours could vary due to teaching/educations in the community, which could include weekend work, but is not typically. Your weekly schedule will be given to you when you arrive the first day.
2. Professional Dress
3. Janice is very busy, so if you do not get a response to your email, you might try again after a few days.
4. This facility takes many types of FS interns, so you may work alongside Business majors, public health, nursing etc.
5. This rotation is one in which you work independently and need to think for yourself if your preceptor is not always readily available.
6. In the past interns have noted that the Boys and Girls Club is very busy and not much supervision, so sometime you have to manage the class supervision while you are teaching.

References and Assignments: None prior to the rotation
Facility Section 3-CMRC Clovis: Community Medical Centers-Clovis
2755 E. Herndon
Clovis, CA 93611

Preceptor: Carey Davies, MS, RD. CNSD.
P: (559) 324-3703
C: (559) 241-9274
E: cdavies@communitymedical.org

Length of Rotation: 3 Weeks MNT

General Instructions: Business, casual dress, comfortable, closed toe shoes. Please contact Carey by email at least ONE week prior to rotation.

Travel Directions: Take Highway 168 to Temperance exit. Travel south on Temperance then turn left at the stop sign, this should be Herndon. Turn left at the stoplight which marks Hospital entrance. It is easiest if you park in the Parking Garage and enter the Main Hospital Entrance and you will be greeted in the Main Lobby on the first day of rotations. Please see maps on the next pages.
Visiting Hours: General visiting hours for inpatient units are from 10 a.m. to 9 p.m. All visitors arriving after 9 p.m. must check in with security at the main hospital or emergency department information desks.

2755 Herndon Ave., Clovis, CA 93611 | 559.324.4000

Revised November 2016
Facility Section 3-CUSD: Clovis Unified School District
1735 David E. Cook Way
Clovis, CA 93611

Preceptor: Nancy Whalen, RD.
P: (559) 327-9131

Length of Rotation: 2 Weeks

General Instructions: Professional Dress

Travel Directions: East on Herndon, right on Fowler, right on Los Altos, first building on the right. Enter Lobby, Campus Catering office is on the left.

Reading List: Study Guide provided on Blackboard.
Facility Section 3-CSATF: California Substance Abuse and Treatment Facility And State Prison, Corcoran
900 Quebec Avenue
Corcoran, CA 93212
P: (559) 992-7100 EXT 5762

Preceptor: Don Perkins, Food Manager

Length of Rotations: 2 Weeks

Directions: From Fresno State: Head East on Shaw to Highway 168 W. Take 168 to the 99 South. Take Freeway 99 South to Highway to Highway 43. Highway 43 go south to Corcoran. Pass the sign that says Corcoran and Corcoran State Prison. Turn right at the third sign which says: California Substance Abuse and Treatment Center at Corcoran State Prison. Cross the railroad tracks after the right turn. You will pass facility on the right. Enter the parking lot on the right and drive all the way to the end of the Administrative Center. It is at the opposite end from where you enter the parking lot.

General Information: 1.) Your hours of work will vary due to the projects you will be assigned. This is to give you the best/most productive assignments. Your weekly schedule will be given to you when you arrive on your first day. When possible, you will be given the schedule for your two week rotation.
2.) Bring your lunch. We have a refrigerator for the staff. Do not bring glass bottles, dishes or silverware/knives.
3.) Bring your Driver’s License/CA
I.D. each day.
4.) Bring your whistle every day.
5.) You will be given a personal alarm case for use while you are here.
6.) You will always be with a supervisor. Therefore, you must report to work on time.

Dress Code: Follow general dress code guidelines given to you by Erica Ireland. In addition, please:

1.) Wear pants. You will need a belt to wear your alarm. NO blue jeans or pants that have similar appearances.
2.) Do not wear light blue tops/shirts.
3.) All tops must be loose and not tight fitting, covers stomachs/ or back when bending over or raising arms.
4.) Many interns bring a fanny pack to carry personal items and pens/pencils etc.
5.) NO cell phones/pagers allowed
6.) Bring Sunglasses
Facility Section 3: Fresno Economic Opportunities Commission (EOC)- WIC

Preceptor: Terri Soares, MS, RD
E: terri.soares@fresnoeoc.org

Length of Rotation: 2 weeks

General Instructions: Professional Dress; bring lunch; usually 8:30am-5:00pm; Parking for downtown location: park in Executive Parking Plaza parking lot, dial #1150 at callbox, a WIC receptionist will answer, tell them you are a dietetic intern needing to get into The parking lot. You may or may be working at the downtown location, as they have many locations throughout Fresno.

Reading List: Begin reading about WIC before the rotation; some info on Blackboard as well.
Facilities Section 3: Kings Canyon Unified School District

Preceptor: Shaun L. Rodriguez
Director of Food Service, Purchasing and Warehouse
Kings Canyon Unified School District
1502 “I” St.
Reedly, CA 93654
Office: (559) 305-7056
Fax: (559) 637-7136
C: (559) 426-0568
E: rodriguez-s@kcusd.com

Length of Rotation: 2 Weeks

General Instructions: Professional dress; possible work in kitchen/foodservice areas; non-skid close toed shoes; bring hair net; plan for the drive time

Reading List: Study Guides on Blackboard
Facilities Section 3:  

Madera Community Hospital (MCH)

Preceptor:  
Madera Community Hospital  
1250 E. Almond Ave.  
Madera, CA  93638  
(559) 675-5459

FSM & Clinical Leads: Kat Vietti, RD and Kristen Petersen, RD  
E: kvietti@maderahospital.org  
kpetersen@maderahospital.org

Length of Rotation:  
FSM: 1 week; MNT: 3 weeks

General Instructions:  
Professional dress; possible work in kitchen/foodservice areas; non-skid close toed shoes; bring hair net; plan for the drive time; meals provided

Reading List:  
None
Facilities Section 3
United Health Centers of the San Joaquin Valley, Inc. – WIC Program

Preceptor:
Gloria Pecina, MBA, RD
WIC Director
1560 E. Manning Ave.
Reedley, CA 93654

Kathleen Harriss, RDN, IBCLC
United Health Centers WIC
Breastfeeding/Nutrition Education Coordinator
1840 Ashlan Avenue
Clovis, CA 93611
Office: (559) 638-3948
Fax: (559) 294-6517
Email: harrissk@unitedhealthcenters.org

Length of Rotation: 2 weeks

General Instructions: Professional dress; bring lunch; begin reading about WIC BEFORE rotation.

Reading List: Study Guides on Blackboard
General Dress Standards

As a representative of the CSU Fresno Dietetic Internship Program, your appearance reflects on you and the program. For this reason, interns are to dress and groom professionally at all times.

Acceptable Women’s Attire

Professional dresses, suits, coordinated pant outfits and skirts with matching or coordinated tops. Skirts are to be no more than 3 inches above the knee.

Comfortable, closed toed shoes.

Unacceptable Women’s Attire

Bare backs, shoulders or midriff, or low-cut clothing.
See-through or cling clothing.
Halter tops, tube tops, tee-shirts
Sweatshirts, except on casual days.

Shoes - tennis shoes, canvass shoes, except on casual days or specified by rotation.
Thongs.

No bare feet.

Fishnet or lacy hosiery.

Cargo, Stirrup, jeans or leather pants.

Shorts, except on casual days.

Baseball caps.

Acceptable Men’s Attire

Shirts with collar and slacks. Polo shirts are acceptable.


Dress shirt and tie.
Dress shoes and socks required.
Unacceptable Men’s Attire

- Denim pants.
- Tennis shoes, except on casual days. Thongs.
- Shorts, except on casual days.
- Baseball caps.

Casual Dress Days (*Class day only*) – If guest speaker, please be mindful

Acceptable

- Regular business attire is acceptable.
- Shorts, casual or tennis shoes, casual sportswear, stirrup slacks, denim pants.

Unacceptable

- Cutoffs or extremely short shorts.
- Ripped or torn pants or jeans.
- Dirty or torn shoes.
- Exercise apparel

Other requirements

Facilities may have additional requirements. Specific information for each rotation provided in manual.

Have hairnet with you at all times in food service facilities.
CSUF Intern Record of Professional Development

In addition to supervised practice experience, dietetic interns are expected to attend at a minimum of 16 hours of professional education. A copy of the form is available on Blackboard (NUR 193) for Download. It is the responsibility of the intern to keep track of all professional development.

This form should reflect all additional activities that are NOT part of regularly scheduled rotations: professional meetings (*CDA-CVD, CDA, FNCE*), seminars/webinars, and continuing education presentations in the community. This form shall be reviewed with DI Director at each progress review and a completed form will be turned in at the end of the internship in May.

<table>
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<tr>
<th>Activity / Seminar</th>
<th>Sponsor</th>
<th>Date</th>
<th>Hours</th>
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**Total Hours Completed:** _____
CSUF Intern Record of Community Outreach

In addition to supervised practice experience, dietetic interns are expected to participate in a minimum of 40 hours of community outreach. A copy of the form is available on Blackboard (NUR 193) for Download. It is the responsibility of the intern to keep track of all outreach activities.

This form should reflect all additional activities that are NOT part of regularly scheduled rotations. This form shall be reviewed with DI Director at each progress review and a completed form will be turned in at the end of the internship in May.

<table>
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<tr>
<th>Outreach Activity</th>
<th>Target Audience</th>
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Total Hours Completed:_______
SECTION 4

Rotation Evaluation Forms

Use the personal web link provided to you by the Dietetic Internship Director

One web link is for you to give to each preceptor on/or before your last day of rotation. Your preceptor completes the evaluation and you will receive an email copy. Each intern is responsible for providing the preceptors with the proper weblink.

One web link is for each intern to complete about the experience of each internship rotation. These are shared collaboratively and anonymously with the preceptor at the end of the academic year by the internship director.

**Each intern should keep track of these surveys (both one themselves and of each preceptor) as these need to be completed on or before graduation day. Failure to complete these documents, could lead to not processing verification statements and/or full completion of the internship.**
| CRDN 1.1  | Select indicators of program quality and/or customer service and measure achievement of objectives. |
| CRDN 1.2  | Apply evidence-based guidelines, systematic reviews and scientific literature |
| CRDN 1.3  | Justify programs, products, services and care using appropriate evidence or data |
| CRDN 1.4  | Evaluate emerging research for application in dietetics practice |
| CRDN 1.5  | Conduct projects using appropriate research methods, ethical procedures and data analysis |
| CRDN 1.6  | Incorporate critical-thinking skills in overall practice |
| CRDN 2.1  | Practice in compliance with current federal regulations and state statutes and rules, as applicable and in accordance with accreditation standards and the Scope of Dietetics Practice and Code of Ethics for the Profession of Dietetics |
| Core Competencies | Large Acute Care MNT (VA, CRMC, SAMC) | Small Acute Care MNT (MCH or CCRC) | CSUF Sports Nutrition | Family Health Care Network | Renal - Self Study | Nutrition Support (VA, CRMC, or SAMC) | Gerontology, (VA only) | SNF MNT/Consulting - Dietary Directions | Large Hospital FSTM (VA or CRMC) | Small Hospital FSTM (MCH) | Congrate Feeding - EOC-Kitchen | Prison (Corcoran SATF) | FSM - HR / SNF + simulation | WIC (EOC or UHC) | Cooperative Extension (UC Coop Ext) | CSUF Student Teaching | Wellness / HCSUF health Center | Community Health - WFFRC | All Rotations | Course Work | Program Requirement |
|------------------|--------------------------------------|-----------------------------------|-----------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------------------------|-------------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| CRDN 2.12        | Perform self-assessment and develop goals for self-improvement throughout the program | x                                  | x                     |                         |                      |                           |                          | x                                 |                              |                         |                               |                          |                           |                          |                           |                           | x                                 |                          |
| CRDN 2.13        | Prepare a plan for professional development according to Commission on Dietetic Registration guidelines. |                                    |                       |                         |                      |                           |                          | x                                 |                              |                         |                               |                          |                           |                          |                           |                           | x                                 |                          |
| CRDN 2.14        | Demonstrate advocacy on local, state or national legislative and regulatory issues or policies impacting the nutrition and dietetics profession. |                                    |                       |                         |                      | x                         |                          | x                                 | x                             |                         |                               |                          |                           |                          |                           |                           | x                                 |                          |
| CRDN 2.15        | CRDN 2.15 Practice and/or role play mentoring and precepting others. | x                                  | x                     |                         |                      |                           |                          | x                                 | x                             |                         |                               |                          |                           |                          |                           |                           | x                                 |                          |
| CRDN 3.1         | Perform the Nutrition Care Process and use standardized nutrition language for individuals, groups and populations of differing ages and health status, in a variety of settings | x                                      | x                     | x                       | x                     | x                         | x                         | x                                 | x                             | x                       |                               |                          |                           |                          |                           |                           | x                                 |                          |
| CRDN 3.2         | Conduct nutrition focused physical exams | x                                  | x                     |                         |                      |                           |                          | x                                 |                              | x                       |                               |                          |                           |                          |                           |                           | x                                 |                          |
### Core Competencies

<table>
<thead>
<tr>
<th>CRDN 3.3</th>
<th>Demonstrate effective communications skills for clinical and customer services in a variety of formats and settings</th>
<th>x</th>
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<tbody>
<tr>
<td>CRDN 3.4</td>
<td>Design, implement and evaluate presentations to a target audience</td>
<td>x</td>
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<tr>
<td>CRDN 3.5</td>
<td>Develop nutrition education materials that are culturally and age appropriate and designed for the literacy level of the audience</td>
<td>x</td>
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<tr>
<td>CRDN 3.6</td>
<td>Use effective education and counseling skills to facilitate behavior change</td>
<td>x</td>
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<tr>
<td>CRDN 3.7</td>
<td>Develop and deliver products, programs or services that promote consumer health, wellness and lifestyle management</td>
<td>x</td>
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<td>CRDN 3.8</td>
<td>Deliver respectful, science-based answers to client questions concerning emerging trends</td>
<td>x</td>
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<tr>
<td>CRDN 3.9</td>
<td>Coordinate procurement, production, distribution and service of goods and services, demonstrating and promoting responsible use of resources</td>
<td>x</td>
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**Program Requirements:**
- Large Acute Care MNT (VA, CRMC, SAMC)
- Small Acute Care MNT (MCH or CCNC)
- Diabetes/Out-Patient Nutrition (both VA)
- Family Health Care Network Nutrition Support (VA, CRMC, or SAMC)
- Gerontology (VA only)
- Small Hospital FSM (VA or CRMC)
- Large Hospital FSM (MCH)
- SNF MNT/Consulting - EOC-Kitchen
- School (KCUSD or CUSD)
- SNF MNT/Consulting - Dietary Directions
- Large Hospital FSM (VA or CRMC)
- Prison (Corcoran SATF)
- FSM - HR / SNF + simulation
- WIC (EOC or UHC)
- Congrate Feeding - EOC-Kitchen
- Cooperative Extension (UC Coop Ext)
- CSUF Student Teaching
- CSUF Wellness / Health Center
- Community Health - WFFRC
- All Rotations
- Course Work
- Program Requirement
<p>| Core Competencies | Large Acute Care MNT (VA, CRMC, SAMC) | Small Acute Care MNT (MCH or CC模式 | Diabetes/Out-Patient Nutrition | Family Health Care Network | Renal -Self Study | Nutrition Support (VA, CRMC, or SAMC) | Gerontology (VA only) | SNF - MNT/Consulting - Dietary Directions | Large Hospital FSM (VA or CRMC) | Small Hospital FSM (MCH) | Congrate Feeding - EOC-Kitchen | School (KCUSD or CUSD) | Prison (Corcoran SATF) | FSM - HR / SNF + simulation | WIC (EOC or UHC) | Cooperative Extension (UC Coop Ext) | CSUF Student Teaching | CSUF Health - WFFRC | Wellness / HCSUF | All Rotations | Course Work | Program Requirement |
|-------------------|--------------------------------------|--------------------------------------|--------------------------------|-----------------------------|------------------|---------------------------------------|---------------------|--------------------------------------|---------------------------------|----------------------|-----------------------------|----------------------|----------------------|-----------------------------|----------------------|-----------------------------|----------------------|----------------------|------------------|---------------------|-------------------|
| CRDN 3.10         | Develop and evaluate recipes, formulas and menus for acceptability and affordability that accommodate the cultural diversity and health needs of various populations, groups and individuals | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |</p>
<table>
<thead>
<tr>
<th>Core Competencies</th>
<th>Large Acute Care MNT (VA, CRMC, SAMC)</th>
<th>Small Acute Care MNT (MCH or CCMI)</th>
<th>Diabetes/Out-Patient Nutrition</th>
<th>Family Health Care Network</th>
<th>Renal - Self Study</th>
<th>Nutrition Support (VA, CRMC, or SAMC)</th>
<th>Gerontology (VA only)</th>
<th>SNF MNT/Consulting - Dietary Directions</th>
<th>Large Hospital FSM (VA or CRMC)</th>
<th>Small Hospital FSM (MCH)</th>
<th>Congrate Feeding - EOC-Kitchen</th>
<th>Prison (Corcoran SATF)</th>
<th>WIC (EOC or UHC)</th>
<th>Cooperative Extension (UC Coop Ext)</th>
<th>CSUF Student Teaching</th>
<th>Wellness / HCSUF Health Center</th>
<th>Community Health - WFFRC</th>
<th>All Rotations</th>
<th>Course Work</th>
<th>Program Requirement</th>
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<td>CRDN 4.6</td>
<td>Propose and use procedures as appropriate to the practice setting to promote sustainability, reduce waste and protect the environment</td>
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<td>CRDN 4.7</td>
<td>Conduct feasibility studies for products, programs or services with consideration of costs and benefits</td>
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<td>CRDN 4.8</td>
<td>Develop a plan to provide or develop a product, program or service that includes a budget, staffing needs, equipment and supplies</td>
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<td>CRDN 4.9</td>
<td>Explain the process for coding and billing for nutrition and dietetics services to obtain reimbursement from public or private payers, fee-for-service and value-based payment systems</td>
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<td>CRDN 4.10</td>
<td>Analyze risk in nutrition and dietetics practice</td>
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Appendix A: ACEND Procedure for Filing a Complaint against and Accredited DI program.

Programs

The Accreditation Council for Education in Nutrition and Dietetics (ACEND) has established a process for reviewing complaints against accredited programs in order to fulfill its public responsibility for assuring the quality and integrity of the educational programs that it accredits. Any individual, for example, student, faculty, dietetics practitioner and/or member of the public may submit a complaint against any accredited or approved program to ACEND. However, the ACEND board does not intervene on behalf of individuals or act as a court of appeal for individuals in matters of admissions, appointment, promotion or dismissal of faculty or students. It acts only upon a signed allegation that the program may not be in compliance with the accreditation standards or policies. The complaint must be signed by the complainant. Anonymous complaints are not considered. Where a complainant has threatened or filed legal action against the institution involved, ACEND will hold complaints in abeyance pending resolution of the legal issues and the complainant is so advised.

1. ACEND staff forwards all written complaints to the ACEND chair within three weeks of receipt of the complaint.
2. If the ACEND chair determines that the complaint does not relate to the accreditation standards or policies, the complainant is notified in writing within two weeks of the Chair's review that no further action will be taken.
3. If the ACEND chair determines that the complaint may relate to the accreditation standards or policies, the complaint is acknowledged in writing within two weeks of the chair's review and the complainant is provided a copy of the process for handling the complaint.
2. At the same time as the complainant is notified, the complaint is forwarded to the program by express mail second day delivery for tracking purposes. The administrative officers of the institution or organization sponsoring the program, currently on file with ACEND, receive copies of the correspondence by first class mail. At the request of the complainant, the name of the complainant is "blocked out" within the body of the written complaint that is sent to the program.
3. The ACEND chair requests the program to conduct a preliminary investigation and submit a report addressing the relevant accreditation standards or policies postmarked no more than 1. 30 calendar days from receipt of the notification, as documented by the record of second day delivery.
4. The ACEND chair may also request further information or materials relating to the complaint from the complainant, the institution or other sources.
5. The ACEND chair appoints a review committee to consider the complaint, along with all relevant information. The review committee recommends appropriate action to the ACEND board at its next scheduled meeting.
6. In determining the appropriate action, the ACEND board considers the complaint, materials relating to the complaint, the review committee's recommendation, if any, and additional evidence provided by the program, if any.
7. The ACEND board or the ACEND chair may determine that legal counsel is needed to address the complaint. Staff works with the ACEND board and legal counsel to identify a plan to address the complaint.
8. If the complaint is determined to be unsubstantiated or not related to the accreditation standards or policies, no action is taken.
9. If the complaint is substantiated and indicates that the program may not be in compliance with the accreditation standards or policies, appropriate action is taken, which may include, but is not limited to, scheduling an on-site visit of the program. If the complaint is substantiated and the ACEND board determines that the program is not in compliance with the accreditation standards or policies, the ACEND board may place the program on probation or withdraw accreditation or approval.

10. The program director and administration of the sponsoring institution are notified of the ACEND board's decision and action in writing within two weeks of the decision. The complainant is notified of the final decision and action when the reconsideration and appeals process expires.

11. The program has the right to request the ACEND board to reconsider a decision to place the program on probation or to withdraw accreditation or approval.