



**IDENTIFYING AND OVERCOMING BARRIERS TO
COMPETITION IN NUTRITION SERVICES**

**COMMENT SUBMITTED TO THE
FEDERAL TRADE COMMISSION
FOR THE 2014
“EXAMINING HEALTH CARE COMPETITION”
WORKSHOP**

MARCH 10, 2014

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I. Introduction

The Center for Nutrition Advocacy[®] appreciates the opportunity to submit this comment to the Federal Trade Commission for consideration at its public workshop “Examining Health Care Competition” on March 20-21, 2014. The Center for Nutrition Advocacy’s mission is to advance nutrition providers’ pivotal role in healthcare through effective public and private policy. An initiative of the Certification Board for Nutrition Specialists, the Center works toward a healthcare system that promotes science-based nutrition care, supports nutrition providers practicing to the level of their training, and gives consumers access to an array of nutrition practitioners.

Nutrition is increasingly recognized as a central component in human health. Dietary modification has strong supporting evidence for its utility in prevention and management of many chronic diseases. Earlier age of onset and epidemic growth of diseases such as diabetes, obesity and cardiovascular disease underscore the need for expanded nutrition care availability throughout the life cycle. Preventive nutrition education and counseling can avert disease, save employers, governments, and individuals money. It can also improve the health and quality of life for vulnerable and underserved populations. The healthcare system is expanding opportunities for nutrition to play a vital role as a part of our nation’s approach to health.

One private association, the Academy of Nutrition and Dietetics (AND), formerly the American Dietetic Association, has engaged in actions that result in diminished competition in nutrition care services through an interconnected set of public and private sector levers. The result of these activities has been decreased supply, accessibility, quality and innovation in nutrition care services, and increased cost through limitation of supply. This comment documents the variety of barriers to competition that are being erected. This is followed by a discussion of the impact on supply, accessibility, cost, innovation and quality of nutrition services, and, finally, proposed solutions.

A. Background on the Field of Nutrition Services Providers

There are a variety of healthcare professionals that provide nutrition services. One subset is Registered Dietitians[®] (RDs), a private credential associated with the private association, the newly named Academy of Nutrition and Dietetics (AND), formerly American Dietetic Association.

There are several other professional bodies offering private credentials in nutrition. The level of academic preparation, the concentration of areas within academic programs, and patterns of occupational settings between dietitians and credentialed nutritionists training outside of dietetics have some overlap, but also significant variation. There is also innovation in training programs occurring in private institutions that are focused on nutrition-based health promotion, and disease prevention.

B. Overview of Barriers to Competition in Nutrition Services

Despite an urgent need in the U.S. healthcare system for more nutrition therapy and advice, the AND has engaged in actions that result in severely limited competition in nutrition services. These actions include influencing state licensing laws, boards, and regulations; federal statutes and regulations; and using private means, resulting in diminished competition in these important services.

These actions prevent many qualified, non-RD health professionals from providing meaningful nutrition counseling. The crux of the problem is this: unlike the skill set of some health professions, nutrition advice is a toolset effectively used by a wide variety of professionals.

Nutrition advising does not involve controlled substances (such as prescription pharmaceuticals), nor does it involve invasive procedures. Nutrition counseling is the providing of advice with regard to food, a substance available to and consumed by all.

Nutrition affects all systems and functions of the body. Therefore many professionals appropriately serve their patients and clients by incorporating nutrition advice into their professional practice. Those professionals include RDs and clinical nutritionists, whose primary practice is nutrition, as well as medical doctors, nurses, chiropractors, naturopathic physicians, acupuncturists, pharmacists, health coaches, and others. Thus, it is much more problematic to reduce nutrition to a uniform regulatory scheme than it is for a discrete profession, such as nursing.

In a 2011 report, “Market Place Relevance: Regulatory and Competitive Environment of Dietetic Services”, the AND addresses its concerns about rising competition and efforts to counteract such competition:

“This Backgrounder highlights the significant competitive threat Registered Dietitians. . . face in the provision of various dietetic and nutrition services. . . . We must be aware that existing legal and regulatory constraints on practice are unlikely to prevent robust, broad competition in these growth areas.”

“...An array of competitors is already providing would-be clients with personalized health education and nutritional counseling in growth areas such as prevention and wellness and in private practice careers. The required and necessary skill set of RDs competing with these other nutrition professionals may not necessarily be the same as clinical dietitians, but RDs cannot cede this expanding market to others who clearly intend to provide nutrition services.”¹

The Backgrounder enumerates threats from a variety of competitors:

Nurses: “Wellness Nurses’ . . . are more likely to compete with RDs; they largely work in local government, corporate offices, and schools, where they conduct health coaching. . . and other tasks that could otherwise be performed by a community or consultant dietitian.”

Pharmacists: “Research shows that pharmacists are frequently providing information about healthful diets, medical device functions, and numerous other issues raised by customers. The potential for competition from these consultations arises if, after successfully screening a man for diabetes, the pharmacist were to talk with him about changing his diet in light of his diagnosis as diabetic.”

Personal Trainers: “the emphasis on preventive health and wellness care is expected to drive an increase in the number of jobs for fitness professionals,” and “continued competition can be expected. ... [B]ecause of their current practice and expressed intent, trainers should be considered competitors for certain unrestricted preventive and wellness care tasks.”

Chiropractors: “New Jersey legislature radically changed chiropractors’ scope of practice from specifically denying them the authority to recommend nutritional supplements and conduct nutritional counseling to specifically permitting those tasks.”

Naturopaths and Homeopaths: “Alternative practitioners like naturopaths and homeopaths are among the professions most aggressively seeking greater recognition and acceptance by advocating and defeating legislation. It is the group of traditional naturopaths wanting to provide nutritional counseling (and who are closely aligned with holistic medicine and nutrition community) that pose one of the most significant competitive threats to dietitians in the marketplace.”²

The AND’s licensing bills make it illegal to give nutrition advice without a license or exemption. Where enacted, these laws prevent vast numbers of non-RD nutrition practitioners from providing nutrition advice, and artificially limit the number of nutrition practitioners. In states where non-RDs are barred from practicing, citizens are denied access to entire segments of nutrition practitioners—such as clinical nutritionists, naturopathic physicians, and many others. Many potential points of access to qualified nutrition advice are lost.

The sole beneficiaries of the AND’s activities are its RDs, and at great cost to the health and economic welfare of U.S. citizens. RDs are neither the only, nor the most highly qualified nutrition care providers. The RD credential requires a bachelor’s degree, and a bachelors-level examination, while several other nutrition credentials require a master’s or doctoral-level degree, and an advanced-level examination. AND actions form an interconnected web that collectively result in severely limited competition for nutrition services:

1. The AND has been successful at initiating state laws that bar nutrition services by most non-RD providers at a time when their own data show a projected shortage of nutrition professionals relative to the demand³
2. Those state laws install RDs as the dominant force on the Licensing Board.
3. The Licensing Board plays a leading role in determining who can and cannot obtain a license, first by drafting rules that spell out the details of licensure requirements (which mimic AND requirements), and second by serving as the gatekeeper for applicants for licensure.
4. The AND actively encourages RDs to file “anecdotes of potential harm” with the board and to seek out and report unlicensed practice by non-RDs.
5. Hearings and settlements during the course of such prosecutions are often conducted by or in close consultation with the RD-dominated Licensing Board.
6. The AND has attempted to insert language into federal bills and regulations that would create exclusive RD eligibility for benefits and privileges in nutrition services.

7. The AND has taken a number of private actions on its own that appear geared toward consolidating the market for nutrition services under the auspices of its own association.

C. Evolution in Nutrition, Nutrition Training, and Nutrition Care Delivery

When occupational regulation of the nutrition field began in the 1980s, the American Dietetic Association was the largest, but not the only, organized professional association in the food and health arena. Dietetics training was, and still is, largely focused on training professionals for employment in food service management, institutional health care settings, and community programs.⁴

Over the last several decades, nutrition science, nutrition training, and the demand for nutrition care have grown exponentially. Nutrition advice is now accessed through avenues very different than those that existed when regulation of the occupation began almost four decades ago. Nutrition care has shifted from primarily hospital based, acute care, to clinical practice based care which can be delivered independent of a medical facility, and accessed on the initiative of the consumer. There is also increased emphasis on preventive and wellness education delivered through multiple public and private channels such as community non-profits, classes offered by practitioners, after school programs, etc.

The interest in nutrition as a career or as an adjunct to a career is steadily growing. There are currently several other professional associations in addition to the AND that offer more advanced credentials to professionals in nutrition. Universities across the country offer baccalaureate, master's and doctoral degrees in nutrition; these newer and more innovative degrees typically have a more clinical focus than dietetics, though there is some overlap in the area of foundational science and basic assessment and treatment planning skills. For example, an analysis by the Certification Board for Nutrition Specialists compared the knowledge base tested on its Certified Nutrition Specialist[®] (CNS[®]) examination to that required for the RD examination. It shows that 38% of the RD examination is focused on non-clinical areas -- Food Service Systems and Food Management -- while 95% of the CNS examination focuses on clinical nutrition science, assessment, and intervention.⁵

In January 2014, the Bureau of Labor Statistics of the U.S. Department of Labor updated its Occupational Outlook Handbook entry for the occupation of "Dietitians and Nutritionists". The updated entry cites the Certified Nutrition Specialist credential from the Certification Board for Nutrition Specialists as a credential demonstrating an advanced level of knowledge.⁶

The AND has responded to these changing patterns and increased competition by engaging in multi-pronged actions to address what the association defines in their position statements as a competitive threat⁷

II. Barriers to Competition in Nutrition Services

A. State Barriers to Competition in Nutrition Services

The press has widely covered the perceived anti-competitive activity on the part of the AND.⁸ In the 47 states that currently regulate the profession in some fashion, the AND has initiated

legislation and regulations predominantly patterned after the educational, exam, and practice requirements of RDs. In every instance where legislation has been enacted, it has been initiated by the AND. Licensing boards are typically made up of either mostly or entirely RDs. Scope of practice is defined based on the dietetics model, and the definition of scope terms adhere to AND internal terminology.

1. RD Credential as Proxy for State Credential

References to the idea of using the RD credential as the basis for state licensure have been found as early as 1984 in ADA writings:

The active pursuit of licensure by dietitians, as evidenced by the enactment of voluntary licensure in one state and title acts in three states, continues to stimulate questions. First, "can states specify appropriate eligibility requirements to allow applicants who have passed the dietetic registration examination to be eligible for state licensure?" If the answer is yes, the burden and cost to the state to develop and administer an examination could be eliminated. And perhaps the examination for licensure ⁹

Currently, in almost every state that regulates nutrition counseling, there is an automatic waiver into state credentialing for a Registered Dietitian. Only one other private credential, the Certified Nutrition Specialist, is afforded automatic waivers, but in far fewer states than the RD credential.

2. RD-centric Model bill

According to the Dietetic association's "Licensure Backgrounder" report published in 2011,

"The Work Group on Licensure, Scope of Practice And Competition (WGLSC) developed a Model Practice Act to be used to assist affiliates in seeking licensure initiatives. In developing this model act, the work group reviewed an older version used in 1986 which needed updating because of changes in dietetic practice and new terminology adopted by ADA." ¹⁰

The report specifies the following components of model bill language including:

- Definition of key terms such as "medical nutrition therapy" and "non-medical nutrition information"
- Scope of practice language
- Composition of licensure boards
- Connection between boards and affiliates
- Educational requirements
- Essential components
- Reciprocity
- Penalties

Each component of the model bill mimics the RD requirements and serves to severely restrict competition from non-RDs. All the components are crafted such that they result in

near exclusivity of state credentialing for RDs, as the “Essential component’s” section of the model practice act guidance demonstrates:

“The WGLSC decided that terminology for the Model Practice Act must include, at minimum, the following elements: Applicant requirements based on CDR Guidelines (Appendix D), the ADA approved definition of dietetics, ...”¹¹ (emphasis added)

Every bill initiated by AND in recent history has called for “exclusive scope” licensure, that would make it illegal for unlicensed, non-exempted individuals to provide meaningful nutrition advice. In many states, such exclusionary laws have passed. In others, “title protection only” laws have passed. But even though states with “title protection only” regimes don’t prohibit others from practice, fifteen out of the twenty-four “title protection only” states have regimes that only grant state credentials to those who satisfy RD requirements. This effectively excludes non-RDs from any benefits associated with holding such a state credential, such as insurance and marketing benefits.

The effort of AND and its state affiliates for the last three years has been to change title protection states to exclusive scope states, and to introduce exclusive scope laws in states without current statutes.¹² An additional eighteen states have exclusive scope regimes that effectively only license registered dietitians, and prohibit practice by non-dietitian providers¹³, artificially reducing provider supply and access to nutrition services.

3. Redefining Scope to Conform with AND Terminology

Scope language, the model bill guidance states, should include the following:

“Licensed dietitian/nutritionists engage in the nutrition care process, a systematic problem-solving method that dietitians use to critically think and make decisions to address nutrition related problems and provide safe and effective quality nutrition care services and Medical Nutrition Therapy.” (underlining added)

The Licensure Backgrounder describes in detail the steps of the Nutrition Care Process and many other elements of the scope, exactly as defined in the International Dietetics and Nutrition Terminology, a dietetic-specific lexicon developed by ADA beginning in 2003.

“This standardized language or controlled vocabulary is being developed to describe the unique functions of dietetics in nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation”¹⁴

This terminology is increasingly appearing in state regulations and proposed bills.

4. Scope of Practice: Expanding “Medical Nutrition Therapy” for Competitive Advantage

One IDNT term in particular, “Medical Nutrition Therapy” has exerted significant and broadly felt impact on state regulation and on the landscape of nutrition care delivery. In a 2004 Report to Congress on Medical Nutrition Therapy, then Health and Human Services

Secretary Tommy Thompson wrote:

“Medical nutrition therapy (MNT) is comprised of the assessment of nutritional status and the provision of nutritional counseling by a licensed dietitian or nutritional professional.”¹⁵

This report, further defined Medical Nutrition Therapy as those nutrition services delivered to individuals by either a dietitian or a nutrition professional *for the treatment of specific, diagnosed diseases* such as diabetes, kidney disease, or cardiovascular disease. “Therapy”, by definition, is for the purposes of addressing a disorder. Medicare has defined benefits for MNT as of this writing, only for specific services for individuals with Diabetes and Kidney Disease.¹⁶

In statutes and proposed legislation over the last several years, Medical Nutrition Therapy has been increasingly broadly defined by AND to mean virtually any nutrition care service including prevention, education as well as any service rendered to a person with any defined health condition.

5. RD-centric Requirements for Licensure

Education

A majority of the 47 states with regulatory regimes have educational requirements naming a major course of study in human nutrition, nutrition education, foods and nutrition, dietetics, or food systems management, or an equivalent course of study as approved by the board or in some case the department. These are the majors offered in Dietetics programs (although food systems management is no longer offered as a major and remains in laws to grandfather older dietitians who have that major).

In addition to the anticompetitive effects of this model, it is an inflexible system that discourages innovation. Many of today’s non-dietetic nutrition degree programs have developed curricula in response to changing science and changing population needs and are expanding the field. They fall outside these named majors, but because licensing boards are made up primarily of RDs, applicants with nutrition degrees such as Applied Clinical Nutrition, Nutrition and Functional Medicine, or Nutrition and Clinical Psychology are denied licensure in many states. In many cases, they are unable to legally provide nutrition services. In many cases, this has resulted in denial of a state credential or an additional burden including suing for a license.

An increasing number of professionals holding advanced degrees in other health professions have added nutrition training and a professional nutrition credential to integrate nutrition care into their existing health care practice. This hybrid career is desirable from a standpoint of increasing points of access to nutrition counseling and enhanced outcomes. These individuals are likely to have a significant portion of the science, and often nutrition coursework, as part of their primary degree. Current regulatory regimes are constructed based on the dietetics model, and thus fail to assess the totality of an applicant’s academic preparation. The result is that many well-qualified individuals cannot get a

dietetics/nutrition license, and are barred from practicing nutrition, reducing competition in the field.

Examination

Most states allow the RD exam only, despite the existence of other exams including that of the CBNS that are psychometrically valid, more rigorous, and more relevant to clinical nutrition. The CBNS examination is the only other examination widely accepted, yet it is currently only accepted in 13 states. Some state statutes or regulations accept the RD or “another exam approved by the licensing board”, but the licensing boards are typically designed to be dominated by RDs as outlined in the AND model bill.¹⁷

Supervised Experience

Until 2012, most laws required 900 supervised practice hours to fulfill the experience requirement. 900 hours is consistent with the Medicare requirement for an approved dietitian or nutrition professional to provide Medical Nutrition Therapy. However, in 2012 the Commission on Dietetic Registration increased its practice hour requirement to 1200 hours and consequently changed its bill language to specify 1200 hours, further evidence of using state licensure requirements to mimic RD requirements.

6. Questionable Connections Between Licensing Boards and Dietitian Association

Patterns exist in some states calling into question whether functionally the licensing boards function sufficiently separately from the private dietetic association. For example:

- In 2013 the North Carolina Board of Dietetics and Nutrition forwarded an advocacy email of the North Carolina Dietetics Association about an introduced bill to repeal the North Carolina Dietetics Practice Act.¹⁸
- Maryland licenses both dietitians and nutritionists but the board is called the Board of Dietetic Practice.¹⁹
- The Delaware board revoked an already issued license of a non-RD nutritionist based on a complaint by a member of the Delaware Dietetic Association because she didn't feel he was qualified. The person had to reapply, provide additional and extensive²⁰ documentation and was then approved a second time.

B. Federal Barriers to Competition in Nutrition Services

1. Medicare Benefits

Medicare recognizes RDs and “nutrition professionals” as separate entities, although in effect it provides certain advantages to RDs. In states where no licensure or certification exists, a “nutrition professional” qualifies as a provider of MNT services based on a degree in nutrition from an accredited university and 900 supervised practice hours. RDs are automatically granted waivers for those two requirements. However once a state enacts a licensure or certification regime, a person must also possess the state credential in order to qualify as a provider.²¹

Thus, in states where the AND is able to enact licensure mimicking the dietetics model that effectively prevents non-RDs from obtaining a license, it essentially bars non-RDs from Medicare eligibility as well. Would-be non-RD providers and their clients in those states cannot

get Medicare reimbursement for services that would be covered services were it not for discriminatory state law. Private insurers typically follow Medicare's lead in determining provider eligibility, thus economic harm to both client and provider is compounded.

2. Federal Bills

A. Treat and Reduce Obesity Act 2013

Currently the U.S. House of Representatives has a bill before it, the Treat and Reduce Obesity Act of 2013, HR 2415, which, if passed, would add nutrition providers to the eligible providers of the Obesity counseling benefit under Medicare. However, the bill language states that these services would be covered when provided by a registered dietitian, with no mention of nutrition professional. Though the Senate version of the same bill does contain nutrition professional language, and this omission in the House may have been a legislative oversight, the fact remains that the current language of the House version would enshrine members of one private association as the only nutrition provider.

Because PPACA mandates screening and counseling for obesity in the Essential Benefits package, this dietitian-only language would severely limit supply and access to these benefits. Economically disadvantaged and minority communities where obesity is more prevalent would be hardest hit by this artificial limitation.

B. Access to Frontline Healthcare Act of 2013

H.R. 702 would amend the Public Health Service Act to initiate a student loan repayment program for a broad range of interdisciplinary health care providers who commit to two years of service in areas designated as "scarcity areas" which could be geographic areas, populations or facilities in which there is a shortage of frontline healthcare services. However this bill names RDs as providers while excluding nutrition professionals.

These bills and others like them would create exclusive benefits for members of one private association, rather than the full set of qualified providers of these services. This would limit accessibility to care to underserved individuals, precisely those whom it is intended to benefit.

C. Private Barriers to Competition in Nutrition Services

The AND has engaged in actions to gain control over the terms "nutrition" and nutritionist" in ways that would appear to collapse the distinction, and capture both the "dietetics" and the "nutrition" realms for itself.

Association Name Change

In 2012, facing steadily increasing competition from nutrition professionals, the AND changed its name from the American Dietetic Association to "Academy of **Nutrition and Dietetics**". The announcement stated:

"By adding nutrition to our name, we communicate our capacity for translating nutrition science into healthier lifestyles for everyone. Keeping dietetics supports our history as a food and science-based profession. ... registered dietitians are the best-qualified providers. The name change communicates that we are the nutrition experts."²² [emphasis added]

It is inaccurate to assert that RDs are the best-qualified providers, and this conveys the attempt to position RDs as the only nutrition experts, when in fact there is a broad array of such experts.

Credential Name Change

In 2013, the AND announced that RDs had the option to change the name of their credential from “Registered Dietitian” to “Registered Dietitian Nutritionist” (RDN). An unprecedented step, this credential name change expanded the title and perceived capabilities of its credential holders without any increased training or testing to verify additional competence. According to the AND announcement:

RDN Credential: Frequently Asked Questions

What is the new optional RDN credential?

The Academy of Nutrition and Dietetics' Board of Directors and the Commission on Dietetic Registration have approved the optional use of the credential "registered dietitian nutritionist" (RDN) by registered dietitians (RD).

Will the new optional RDN credential have an affect on state licensure of RDs?

No. Legal counsel determined that adding the optional RDN credential will not affect licensure or other regulations. Many state licensure/certification laws already reference the term nutritionist (e.g., LDN or CDN).

Why is the Academy offering the optional Registered Dietitian Nutritionist credential?

*The option was established to further enhance the RD brand and more accurately reflect to consumers who registered dietitians are and what they do. This will differentiate the rigorous credential requirements and highlight that **all registered dietitians are nutritionists but not all nutritionists are registered dietitians**. [emphasis added] ... This option is also consistent with the inclusion of the word "nutrition" in the Academy's new name.*

Will RDs be required to meet separate recertification requirements if they choose to use the optional RDN credential?

No. The current RD recertification requirements apply to the RDN credential.

How does the new optional RDN credential fit into the Academy's ongoing branding and marketing efforts?

The Academy is developing a plan to strengthen and differentiate a respected brand.²³

Note that the term “Registered Dietitian Nutritionist” is markedly similar to the common state credentialing term of “Licensed Dietitian Nutritionist” (LDN), and likely to create consumer confusion.

Nutrition Trademark Activity

In 2011 the AND applied for trademarks for a wide variety of “nutrition” marks, including

- Certified Nutrition Associate
- Certified Nutrition Coach
- Certified Nutrition Educator
- Certified Nutrition Manager
- Certified Nutrition Professional
- Registered Nutrition Associate
- Registered Nutrition Coach
- Registered Nutrition Educator
- Registered Nutrition Manager
- Registered Nutrition Professional
- Nutrition Professional, Registered; and
- the credential acronyms for each of these

The trademark activity, in conjunction with the name and credential changes, suggest that the AND is trying to capture the nutrition market to go along with its dietetics market.

III. Impact of Barriers to Competition in Nutrition Services

A. Impact: Public at Increased Risk of Disease

Protecting the public from harm has been the rationale cited by AND when it urges legislators to enact occupational regulation of dietetics and nutrition. The underlying questions are:

- Are there well-founded concerns based on documented risks associated with dietetics and nutrition care?
- Do the current regulatory regimes have unintended consequences for public harm that outweigh any potential benefits?

To date, publicly available enforcement data shows scant evidence of harm linked to nutrition care delivered by either those with or without state credentials. In contrast there is abundant evidence linking poor nutrition with increased risk for obesity and chronic disease. State regulatory boards predominantly spend time and money pursuing unlicensed practice, not complaints of alleged harm.

The AND has actively conducted a campaign nationally and through its state affiliates to collect “anecdotes of potential harm”, by encouraging RDs to seek out and submit complaints.^{24, 25} Although protecting the public is the AND’s publicly stated reason for initiating highly restrictive barriers to practice, the presentations to AND members are revealing.

A presentation slide by the Massachusetts Dietetic Association asks:

*Why Should Licensure Be a Priority?*²⁶

- “Scope Creep”
- Other Health Groups are Vocal
- Healthcare Reform
- State Budgets Are Limited

A national AND presentation slide warns:

*Why Report?*²⁷

- *Because you are required to*
- *If RDs do not report harm, other groups may gain a competitive advantage*
- *Complacency will allow them to do so*
- *Board actions are your data for protecting your scope of practice!*
- *Competitive environment demands it!*

In the fields of dietetics and nutrition, evidence of harm is scant, despite the effort by AND to encourage its membership to find and report “potential anecdotes of harm” by questioning clients, friends, and relatives about advice obtained from other practitioners.²⁸ Some state licensing boards deploy undercover investigators to pose as potential clients to unlicensed practitioners.²⁹ In Michigan the Dietetic Association ran a contest offering a prize for the dietitian who submitted the most complaints of alleged harm.³⁰

B. Impact: Limitation of Access to and Settings for Nutrition Services

Laws that prohibit most non-RDs from providing nutrition services artificially limit the supply and availability of services. According to the AND, in 2012, individual states ranged from 5 to 55 dietitians per 100,000 population.³¹ Based on this data the average number of RDs per 100,000/state (data includes D.C. and Puerto Rico) is 26.9 with the median being 26.6 and the biggest clusters being in the 25-27 RDs/100,000 range.

Most of these dietitians are accessible to the public only through some type of institutional gateway such as hospital inpatient or outpatient departments or through government programs such as Woman, Infants, Children (WIC). In Dietetics Practice and Future Trends, 2009 data from the American Dietetic Association Compensation and Benefits Survey of the Dietetics Profession, the association’s data shows that only 2% of dietitians are employed in private practice.³² Applied to the average 26.6 dietitians per 100,000 per state, that leaves less than 1 dietitian per 100,000 population to serve individuals in non-institutional venues.

Private and group practices, clinics, faith based and other community organizations and other avenues for delivery of nutrition counseling are being deprived of the ability to employ the services of non-RDs due to the artificial constraints. At a time when the goal is to increase preventive services and decrease the use of the hospital for routine care, or for rurally based populations where health care resources are scarce, these barriers are a threat to the availability and cost effectiveness of health care.

C. Impact: Increased Cost

When regulatory regimes keep non-RDs from practicing or from qualifying for state recognition, effects are many and far-reaching:

- cost of services rise due to limited supply
- availability of less costly provider alternatives are reduced, such as health coaches or

- community based workers that emphasize prevention and education
- reduction in preventive care increases state and federal burden for more costly disease care
- less preventive care increases employer work losses due to avoidable absenteeism
- less preventive care continues the upward spiral in insurance and health care costs
- cost to state for enforcing unlicensed practice increases
- job creation is throttled
- state revenues dwindle as providers and related businesses are forced to close or relocate

D. Impact: Stifled Innovation

The enforcement of a single, narrowly defined path to government recognition in dietetics and nutrition is a strong force against innovation. AND has argued that programmatic accreditation should be the standard applied to academic requirements in regulatory matters. However many both within and outside of AND argue that its programmatically accredited curriculum is outdated and has not kept pace with innovation in the field. Critiques from within AND note that its system of educating dietitians as generalists at an entry level, developed over 85 years ago is not what is needed to keep pace with today's healthcare environment.³³

While programmatic accreditation in a profession can be a tool for standardization, it poses the risk of ossifying the profession. With growth of hybrid careers and use of nutrition integrated into many different kinds of health care practices, rigid requirements tailored to one subset of professionals keep qualified people out rather than raising the standard of care. When a pharmacist with nutrition training, for example, is barred from providing nutrition counseling to patients picking up a prescription, an opportunity is lost. Regulation should not keep other qualified professionals who seek to include nutrition in practice from being legally able to do so.

E. Impact: Loss of Consumer Choice

Overly restrictive regulatory regimes that are tailored to the requirements of one subset of the profession strip the individual consumer of his or her right to seek out the practitioner of their choosing. Many consumers prefer non-RD nutrition service providers for a variety of reasons. They should retain that choice, and also not be penalized by artificial limitations on insurance eligibility for providers.

F. Impact: Diminished Interstate Portability

Regarding licensure reciprocity, many states do not accept the standards of another state. The AND model bill specifies that reciprocity must only be granted in the case where the other state law contains requirements substantially similar to its own. This effectively imposes the RD-centric requirements model across state lines, and severely limits interstate portability of providers and services. Therefore licensure in one state does not guarantee practice rights in all states and the provider must obtain additional states' credentials to practice (if an exclusive scope state) or to bill Medicare or private insurers for services. This creates a problem as telehealth and other modes of remote service delivery are increasingly utilized by employers, insurers, private providers, and others. Virtual work arrangements, as well as it being more common for individuals to work in multiple states are also affected by the limitations of state-based licensing.

Very few states have provisions specifically barring professionals from living in one state in which they are recognized, and providing services remotely to a resident of another state. Yet some states have taken the position that anyone serving a client in their state must be licensed by their state. With the lack of clarity in laws, and the increasing use of technology to deliver services remotely this issue is likely to come to the fore. Both practitioners and consumers appear to be confused.

G. Impact: Diminished Competition in Nutrition Training

The effect of this interconnected set of actions is to force many of those seeking a career in nutrition services through the private association's training, credentialing, and membership system, ultimately accruing members and funds to its own organization. This serves to limit competition and innovation in nutrition training, and ossify long-standing approaches that often no longer keep pace with rapid evolution of the field.

IV. Opportunities for Regulatory Reform to Support Public Health

A. Regulations that Educate Consumers Elevate Standards of Practice of the Profession rather than Elevate the Professional

Consumers have access to a deluge of nutrition information and advice from a myriad of sources of varying quality. And nutrition science like all sciences produces new data on a daily basis often with contradictory implications for dietary behavior. This state of flux is often bemoaned as too confusing for the average person and then used to justify the use of regulations to decide for the consumer whose advice is trustworthy.

Regulations for dietetics and nutrition should allow the consumer to investigate what standards a practitioner has met and a government credential should facilitate that process. The consumer should be able to know what standards entitle the use of a specific title, and the use of the title should set a high but flexible bar. The professional and the professional associations bear the responsibility for making the case that the public is better off buying their model than the competitor's model. This preserves the ability of the consumer to exercise personal beliefs and preferences and it keeps the profession striving for excellence and growth.

B. Regulations that Distinguish Preventive from Therapeutic Practice will Expand Resources and Reduce Costs

Preventive and educational services are the lowest risk, cost less to deliver and have the greatest potential cost-effectiveness to the individual and the public welfare. Teaching people to maximize health through the selection and preparation of food and understanding how nutrition influences the body and health, is based on information already widely and freely available to the public. These are non-medical services that can be delivered competently by trained individuals who do not need the same advanced skills required for therapeutic practice.

Currently twenty-five states have regulations that make the provision of such services illegal by unlicensed individuals.³⁴ Nearly all forty-seven states with existing regulations would preclude insurance coverage (as available) by individuals who don't have trained outside the dietetics model

and thus don't meet the requirements, typically constructed by the dietitian association. This is antithetical to prevention, and creates enormous missed opportunities to improve health, quality of life, and realize individual and public cost-savings.

Regulatory regimes that are consistent with current knowledge and practice could be more effective by recognizing the different skill sets needed for different types and levels of care. This would both allow and encourage more trained individuals to enter the provider workforce increasing points of access, supply, and lowering cost of services that require a lesser degree of training.

C. Regulation that Supports Collaboration, Teamwork and Mentorship Promote Practicing within One's Competencies

When regulation is instituted at the behest of a private association without bringing all stakeholders to the table, the best interests of the public are shortchanged. The current emphasis in health care on team-based care is at odds with attempts by one segment of the profession to block public access to other segments, and thus limit competition.

Regulation should provide a framework that encourages collaborating, referring and mentoring between professionals with different competencies and training. Creating a regulatory framework that encourages professional growth rather than erects barriers to competition would help promote growth of the profession in service of the public.

D. Interstate Portability for all Providers Supports Remote Delivery Technologies and Expand Reach, Competition

With increasing use of technology to deliver services remotely, regulatory regimes that support seamless interstate delivery of services is desirable. By effectively increasing the pool of providers available within a state, remote technologies allow service delivery to many underserved populations -- people with mobility limitations, the elderly and frail, rural communities, and others. This also promotes a diversity of options for consumers.

Cost effective group prevention services, and individual counseling and monitoring can be done remotely. Employers, insurers and independent practitioners already make use of telehealth service delivery. Current regulatory structure however could impose limitations when the employee, insured, or client populations are distributed across states. Because every state law accepts the RD credential, it has portability but no other nutrition professional could seamlessly deliver services, severely diminishing competition and limiting access to a variety of services within the nutrition field.

A national template for regulation would support portability and increase competition but it must be a template that:

- goes beyond the existing dietetics template as the basis for laws and regulations
- is created with all stakeholders on a level playing field
- remains flexible enough to incorporate innovations and advances in the field.

¹ American Dietetic Association Market Place Relevance Regulatory and Competitive Environment of Dietetic Services, House of Delegates Backgrounder February 2011 See attached Exhibit B;

<http://www.forbes.com/sites/michaelellsberg/2012/04/05/american-dietetic-association/>

² *ibid*

³ “The Dietetics Workforce Demand Study projects that demand for dietetics practitioners will exceed supply in the next 10 years” Hooker RS, Williams JH, Papneja J, Sen N, Hogan P. Dietetics supply and demand: 2010-2020. *J Acad Nutr Diet.* 2012; 112 (suppl 1):S75- S91.

⁴ CBNS:CDR Exam Analysis See attached Exhibit A

⁵ *Ibid*

⁶ <http://www.bls.gov/ooh/Healthcare/Dietitians-and-nutritionists.htm#tab-4>

⁷ American Dietetic Association Market Place Relevance Regulatory and Competitive Environment of Dietetic Services, House of Delegates Backgrounder February 2011 See attached Exhibit B

⁸ [Forbes, “American Dietetic Association is Intentionally Using State Legislatures to Block Alternative Nutrition Providers and Restrict Free Speech” July 9, 2012;](#)

[Today’s Dietitian, “RD Licensing Legislation – Is it a Matter of Public Safety or Monopoly” Nov 2012](#)

[Forbes, “Is the American Dietetic Association Attempting to Limit Market Competition in Nutrition Counseling?” April 4, 2012.](#)

⁹ Presidents Page Licensure for dietitians: The issue in context, ADA Reports, vol 84, no 4 April 1985 See attached Exhibit D

¹⁰ American Dietetic Association HOD Licensure Backgrounder 2011, appendix B, p14 See attached Exhibit E

¹¹ *ibid* p16

¹² CA,CO, HA, IN, IL, NE, NJ, NY, VA, W. VA, WI

¹³ State Regulatory Regime Analysis, Certification Board for Nutrition Specialists See attached Exhibit E

¹⁴ Nutrition Care Process Part II: Using the International Dietetics and Nutrition Terminology to Document the Nutrition Care Process, J. of the American Dietetic Association, July 2008 v 108, no 8, p 1287

¹⁵ Report to Congress on Medical Nutrition Therapy, 2004

<https://www.cms.gov/Medicare/Coverage/InfoExchange/Downloads/Report-to-Congress-Medical-Nutrition-Therapy.pdf>

¹⁶ Title 42 <http://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol2/pdf/CFR-2002-title42-vol2-sec410-132.pdf>

¹⁷ American Dietetic Association HOD Licensure Backgrounder 2011 *op.cit.* p.15

¹⁸ Emails from North Carolina Dietetics and Nutrition Licensing Board See attached Exhibit F

¹⁹ <http://dhmh.maryland.gov/dietetic/SitePages/bdmembers.aspx> accessed 2/28/14

²⁰ DE Board of Dietetic Meeting Minutes 2/8/13 See attached Exhibit G

²¹ Medicare Provider Qualifications <http://www.ecfr.gov/cgi-bin/text-idx?SID=82b5cffd54a1801b585250991a4bd50d&node=42:2.0.1.2.10.7.35.3&rgn=div8>

²² Announcement by Sylvia A. Escott-Stump, MA, RD, LDN, ADA President, September 24, 2011

²³ www.eatright.org/rdn

²⁴ “Reporting Harm: Who, What, When, Where, Why, How” power point for State Issues Workshop 4/15/2012 See attached Exhibit H

²⁵ “Dietetic Licensure: What it Means for You and the Profession, power point MA Academy of Nutrition and Dietetics March 2013 cover, p. 27,28,30,43 See attached Exhibit I

²⁶ *Ibid* p28

²⁷ *Op Cit* p4

²⁸ “Dietetic Licensure: What it Means for You and the Profession *op. cit.* p 43

²⁹ Georgia Dietetics Licensing Board meeting minutes, 2_17_12 See attached Exhibit J

³⁰ Michigan Dietetic Association Documentation of Harm Contest See attached Exhibit K

³¹ State-specific ratios of dietetics practitioners per 100,000 population, United States in “Workforce Demand Study, J. of the Academy of Nutrition and Dietetics”, March 2012 Suppl 1 Volume 112 Number 3, p S42-S43

³² American Dietetic Association Compensation and Benefits Survey of the Dietetics Profession 2009 in Winterfeldt, et al, Dietetics Practice and Future Trends, 2011, p.88

³³ Visioning Report: Moving Forward –a Visions for the Continuum of Dietetic Education, Credentialing and Practice, Acad of Nutrition and Dietetics, 9/5/2012, p9

³⁴ State Regulatory Regime Analysis, Certification Board for Nutrition Specialists See attached Exhibit E