



Exhibits to accompany Center for Nutrition Advocacy comments

“Examining Health Care Competition” on March 20-21, 2014

Exhibit A: CBNS:CDR Exam Comparison

- Commission on Dietetic Registration Exam domains
- Certification Board for Nutrition Specialists Exam domains
- CDR sample questions
- CBNS sample questions

CDR Exam Domains

Dietitians		
Domain I	Food and Nutrition Sciences	12%
Domain II	Nutrition Care for Individuals and Groups	50%
Domain III	Management of Food and Nutrition Programs and Services	21%
Domain IV	Foodservice Systems	17%
Domain V		

Q.11	How many questions will be on the Registration Examination for Dietitians?
A	The examination will be variable length. Each examinee will be given, and must receive , a minimum of one hundred and twenty-five questions: one hundred (100) scored questions and twenty-five (25) pretest questions in order for the examination to be scored . The maximum number of questions possible is one hundred and forty-five (145): one hundred and twenty (120) scored questions, and twenty-five (25) un-scored pretest questions.

<http://cdrnet.org/vault/2459/web/files/CBTFactSheet2014.pdf> accessed 2_11_14

REGISTRATION EXAMINATION FOR DIETITIANS TEST SPECIFICATIONS - EFFECTIVE JANUARY 1, 2012

	Percent of Exam
I. Principles of Dietetics	12%
A. Food Science and Nutrient Composition of Foods	
B. Nutrition and Supporting Sciences	
C. Education and Communication	
D. Research	
E. Management Concepts	
II. Nutrition Care for Individuals and Groups	50%
A. Screening and Assessment	
B. Diagnosis	
C. Planning and Intervention	
D. Monitoring and Evaluation	
III. Management of Food and Nutrition Programs and Services	21%
A. Functions of Management	
B. Human Resources	
C. Financial Management	
D. Marketing and Public Relations	
E. Quality Improvement	
IV. Foodservice Systems	17%
A. Menu Development	
B. Procurement, Production, Distribution, and Service	
C. Sanitation and Safety	
D. Equipment and Facility Planning	
E. Sustainability	

<http://cdrnet.org/certifications/registration-examination-for-dietitians-test-specifications-effective-january-1-2012> accessed 2_11_14

CBNS Exam Domains

Certification Exam Content Domains	Percentage of Exam
1. Fundamental Principles of Nutrition <ul style="list-style-type: none"> a. Epidemiology and biostatistics b. Life cycle c. Energy balance and caloric values of foods d. Body composition and regulation of metabolism e. Nutritional biochemistry f. General nutrition-related physiology 	20%
2. Nutrients and Human Health <ul style="list-style-type: none"> a. Metabolism of nutrients b. Digestion, absorption, and transport of nutrients c. Function of nutrients d. Toxicity of nutrients e. Macronutrient sources and nutrient quality f. Micronutrient sources g. Nutrient requirements h. Bioactive components in foods and nutrients i. Insufficiency/deficiency of nutrients 	30%
3. Nutrition Assessment <ul style="list-style-type: none"> a. Health history b. Diet and lifestyle history c. Biochemical and laboratory assessment d. Genetic/genomic factors e. Anthropometrics f. Assessment of diet impact on health status g. Identification of clinical status 	20%
4. Clinical Intervention and Monitoring <ul style="list-style-type: none"> a. Nutrition relationship to disease or system b. Drug-nutrient/ drug-herb interactions c. Interactions between nutrients d. Dietary therapeutics and behavior optimization e. Nutraceutical and supplement therapeutics f. Eating behaviors and eating disorders g. Data comprehension and translation h. Botanical and related therapeutics 	25%
5. Professional Issues <ul style="list-style-type: none"> a. Food quality and safety b. Cultural issues, ethical standards and practice boundaries 	5%

<http://cbns.org/wp-content/uploads/2013/07/CBNS-Exam-Blueprint6-2013-NEW.pdf>
accessed 2_11_14

Examination Content and Format

The CBNS examination contains 200 multiple-choice, single answer questions and will cover the broad spectrum of basic and applied nutritional science. Themes such as fundamental principles on nutrition, nutrients and human health, nutrition assessment, clinical intervention and monitoring, professional issues, epidemiology, biochemistry and integration of these areas are threaded throughout the examination. Detailed information may be found within the published Examination Blueprint. Candidates have 4 hours to complete the examination.

CBNS Candidate Handbook 2013 http://cbns.org/wp-content/uploads/2013/07/2013_CBNS-Candidate-Handbook.pdf accessed 2_18_14

Market Place Relevance

Regulatory and Competitive Environment of Dietetic Services

HOD Backgrounder

House of Delegates

February 2011

The House of Delegates (HOD) list of Mega Issues has included building a positive image of the Registered Dietitian (RD) and Dietetic Technician, Registered (DTR) as perceived by consumers and other related professional groups. The position and perception of the profession of dietetics is important to members of the American Dietetic Association (ADA) and has a long history with the House.

During the Spring 2007 HOD Meeting the topic of the image of the profession of dietetics was discussed. The motion that resulted from the dialogue called for members and credentialed practitioners to take personal responsibility for promoting the value of the RD and DTR in their community and employment settings. The HOD Leadership Team (HLT) has monitored available Association evaluation tools for changes in the perceived image of the professions (Appendix A). The results show that there has been improvement in the available measures. For that reason, HLT felt that the direction of the dialogue needed to address the more critical issue of the market place relevance of the profession.

Mega Issue Question: What will be needed for individual practitioners to establish and retain marketplace relevance in a continuously evolving and competitive environment?

Expected Outcomes:

1. Understand the forces that are coming to bear on the profession and the implications for why Registered Dietitians and Dietetic Technicians, Registered will have to operate differently to maintain relevance.
2. Demonstrate worth/value in all practice areas.
3. Recommendations will be created on how Registered Dietitians and Dietetic Technicians, Registered can create more opportunities and be more nimble and proactive.
4. Individual options and alternatives for personally evolving for the future will be identified.

This backgrounder was prepared for the House of Delegates of the American Dietetic Association by Pepin Andrew Tuma, JD, Tuma Strategies. Input was provided from the House Leadership Team and the ADA Governance Team.

Knowledge-based Strategic Governance is a mechanism for consultative leadership. It recognizes that “strategy” is the necessary and appropriate link in the Board's role to govern the organization, the House's role to govern the profession and the staff's role to manage implementation. To assist you in thinking about the issue to be addressed, four key background areas are presented as standard questions used for each Mega Issue. These questions create an environment of awareness of what we know and what is unknown. A wide range of resources have been used to provide you with what is known.

I. Introduction

This Backgrounder highlights the significant competitive threat Registered Dietitians and Dietetic Technicians, Registered (DTRs) face in the provision of various dietetic and nutrition services. It identifies trends in the current and future competitive environment and assesses legal, regulatory and market impacts on this competition. In short, dynamic changes in the expected demand for nutrition-

related services offer both exceptional opportunities and significant challenges for those willing and able to supply them. We must be aware that existing legal and regulatory constraints on practice are unlikely to prevent robust, broad competition in these growth areas.

II. The Competitive Landscape

A. Broad Trends

Although it is difficult to divine what the American health care system will look like when the next generation of dietitians begins practicing, the constancy and intensity of some trends impel extrapolation in preparing for our future practice. Some of these trends are common to virtually all health care professions; others are more specific to dietetic and nutrition-related practice:

- There continues to be an ongoing shortage of qualified practitioners among nearly every profession across the health care industry.
- A health care profession seeks to expand its scope of practice by appropriating one or more elements from the scope of practice of a competitor profession either above it or next to it on the conceptual prestige/remuneration/education hierarchy of professions.*
- The practitioner selected to provide particular services is largely a function of (a) who is ultimately paying for them, and (b) any legal and regulatory constraints on the selection.
- Many services within a dietitian's scope of practice are increasingly in demand; those increases will cause a corresponding increase in the supply of practitioners—whether Registered Dietitians or not—who are willing and able to meet the demand.
- Competition will be greater for dietitians in emerging and growth practice areas, where fewer regulations and increased funding combine to attract a variety of competitors willing and able to provide services.

Much of the below analysis focuses on competition within the growth areas of community and consulting work in preventive care and wellness. In contrast to the relatively static clinical care competitive environment, the growth areas are expanding without the same regulatory reimbursement framework that assures clinical dietitians an almost exclusive practice in certain facilities and therapies.

* For example, physicians would be atop the conceptual hierarchy with advanced practice nurses chipping away at the scope of practice barrier separating them. Physicians may attempt to avoid outright competition by insisting nurses are not qualified, but for tasks in which there is a desperate need for practitioners, it is likely that (1) nurses or other professionals would demonstrate sufficient competence to perform the task, or (2) the qualifications will be massaged so that artificial barriers to entry fall. The author's research indicates professionals seek to appropriate a task from another profession's scope of practice when performance of the task either (a) compensates them better than other tasks they could perform in the same time, or (b) enhanced individual or professional prestige. This trend is consistent with the understanding that inadequate preventive care in our health care system results from the financial disincentive for practitioners to devote precious time to less well-compensated preventive care tasks.

With fewer legal restrictions and increased available funds in these growth areas, many new types of practitioners envision an enhanced role for themselves.

B. Government Trends

1. Health Care Reform and Emphasis on Preventive Care and Wellness

We live in a country where 45% the population has one or more chronic conditions, including obesity and diabetes and 75% of the nation's aggregate health care spending is on treating patients with chronic disease. The vast majority of these chronic diseases are preventable, and while less than one percent of total health care spending in 2009 went toward prevention,¹ this funding is expected to see sustained increases.² In fact, one element of the Patient Protection and Affordable Care Act of 2010

(PPACA) that appears to most excite the health care and science press is the Act's commitment to a different paradigm for health care that recognizes the centrality of prevention in solving our health care crisis.[†]

New preventive care and wellness efforts will be focused in large part on attacking the growing obesity epidemic, perhaps the most significant health care problem that is affecting every generation and demographic. Although government programs like Medicaid and SCHIP routinely emphasize preventive medicine, less than one half of children or adolescents get the professional guidelines' recommended preventive care, and obesity rates rose in 36 states since the most recent sampling in 2003.³ As detailed below, neither health insurers generally nor the federal government have adopted policies widely incentivizing aggressive intervention for obesity, but there are signs of a likely shift. The PPACA is expected to change this balance, specifically conceiving a broader role for Medical Nutrition Therapy (MNT) that includes preventive services for diet-related chronic diseases beyond renal and diabetes.

2. Reimbursement

The Centers for Medicare and Medicaid Services (CMS) administers Medicare and monitors state Medicaid programs. Among its responsibilities is the promulgation of regulations regarding minimum safety requirements, provider qualifications, and specifying the fee schedule for services. These CMS regulations, particularly related to Medicare, often operate as a benchmark by which private insurers and state insurance regulators set their respective policies, such as Medical Nutrition Therapy (MNT) coverage for diabetes and renal disease.⁴ Covered services include "face-to-face nutritional assessments and interventions in accordance with nationally-accepted dietary or nutritional protocols."⁵ This particular coverage has flowed down to younger individuals not covered by Medicare, and is now included in most private health insurance, offering significant and continuing reimbursable work for clinical dietitians. Reimbursement regulations are hugely influential, but are not dispositive in the choosing of a particular type of practitioner. Some insurance providers offer far more comprehensive coverage options, and individuals paying out of pocket can naturally choose any type of practitioner that provides services in accord with existing laws and regulations.

3. Regulations Restricting Competition

CMS regulations also specify what practitioners are qualified to provide certain covered services, stating that, "For Medicare Part B coverage of MNT, only a Registered dietitian or nutrition professional

[†] For a more comprehensive look at specific provisions in the PPACA, see HOD Backgrounder: Health Reform - Next Steps, August 2010, accessed 5 February 2011 at <http://www.eatright.org/hodmegaissues/>.

may provide the services."[‡] Elsewhere the regulations use the term "qualified dietitian." While the regulation defines "Registered dietitian or nutrition professional" as having minimum educational and experiential requirements mirroring those of Registered Dietitians, there are exceptions that allow non-RDs (such as certified clinical nutritionists (CCNs), described on page 6) to qualify as "nutrition professionals." Other regulations require differently defined "qualified dietitians," where states may specify certain qualifications or duties beyond those detailed in the federal regulations. Regulations thus foreclose some avenues of competition by certain other practitioners, but they may open other avenues for other competitors with skills and training. For example, Alabama's regulations define "qualified dietitian" for renal disease facilities to include not just RDs (or those eligible for registration), but also anyone with a BS in nutrition, food service management, or dietetics who has one year "supervisory experience in the dietetic service of a health care institution and participates annually in continuing dietetic education."⁶

C. Private Insurance Trends

Lacking a state insurance regulator mandate, the trend among health insurers simply has not been to cover substantial obesity-related treatment without present manifestation of a chronic disease

or condition such as diabetes, hyperlipidemia, or hypertension. When states do create these coverage requirements, doctors typically make reimbursable referrals for dietetic services, and dietitians or other nutrition professionals would then generally be able to recover for between one and six sessions of providing nutrition care services, often including those conducted outside of a hospital. Otherwise, insurers' preventive care model is more commonly offering to reduce an employer's insurance costs for implementing employee wellness programs and other outreach strategies.⁷ Many, but not all, private insurers limit referrals for nutritional counseling to Registered Dietitians, although other nutrition professionals potentially could provide the services if they meet the health insurance industry's professional reimbursement requirements, including the necessary professional standards of practice and governing.

D. Demographic Trends

Major demographic changes are creating opportunities for enterprising practitioners and their professional organizations able to anticipate how the population will be most efficiently and effectively served. As the American population has grown, aged, and increased its per capita consumption of health care, the supply of credentialed health care professionals—whether primary care providers (PCPs), nurses, or dietitians—simply has not kept up with demand. Upon implementation of the PPACA, thirty-two million new Americans will enroll in some private or public health plan, driving significant new demand for services.

The Bureau of Labor Statistics (BLS) categorizes the nature of work performed by dietitians and nutritionists into four practices based on the location and type of work performed: clinical dietitians; community dietitians; management dietitians; and consultant dietitians.⁸ Prior to passage of the PPACA, BLS projected a 9% increase in employment opportunities for dietitians and nutritionists in the next decade, roughly mirroring the average growth rate for all occupations, but the paradigmatic shift to prevention is expected to drive that number higher.⁹ Broken down, "dietitian positions in nursing care facilities [are] expected to decline, as these establishments continue to contract with outside agencies for food services. However, employment is expected to grow rapidly in contract providers of food services, in outpatient care centers, and in offices of physicians and other health practitioners."¹⁰

New markets are ripe for culturally competent practitioners who understand differences in growing populations' specific needs and experiences. For example, some ethnic groups are statistically

[†] 42 CFR § 410.134.

more likely to use herbal remedies and non-traditional healers than the population at-large;¹¹ instead of simply ceding the patient to a holistic nutritionist, a dietitian who does not dismiss herbal remedies but instead complements them with science-based care both preserves a client and heals a patient.

E. Institutions and Venues

Schools and community health centers are two institutions primarily charged with providing enhanced preventive care and wellness education to underserved, uninsured populations—particularly children, adolescents, and minorities. In both institutions, multiple practitioner types work together *and* in competition with one another to provide preventive and wellness care. Schools and school districts are expected to hire increased numbers of health educators and dietitians to promote healthy eating, physical activity, and wellness for good reason: studies show that school districts that involve dietitians directly in the formulation of policies to combat childhood and adolescent obesity in schools have better, more comprehensive policies with a greater likelihood of success.¹²

New emphasis on the patient-centered medical home (PCMH) model provides new opportunities for clinical dietitians to work collaboratively with other health care professionals in direct patient-management teams shown to be more effective in fighting patients' chronic conditions.¹³ By using team members within the practice to provide integrated clinical care management, specialized care, and patient self-management services frees up PCP's time, enables staff to work at the highest level their licensure or certification allows, and improves health outcomes for patients.¹⁴

F. Technologies

New technologies, specifically including telehealth, nutritional analysis software and web-based programs that can create nutritional assessment reports,¹⁵ pose a competitive threat to RDs and DTRs, particularly if used by a competitor in a state without practice exclusivity.[§] Yet the dietitian shortage in some areas drives nurses (and other practitioners legally permitted to perform certain dietetics services) towards technologies that can improve care, such as the “Nutrition Analyzer,” a “stand-alone, Web-Independent product, which builds a database of client data that can be manipulated for analysis and research.”¹⁶ Technology like the Nutrition Analyzer poses a potentially significant competitive threat, but this competition necessarily results from supply broadening to meet increased demand. Nutrition technologies also bring advantages to dietitians, often providing a necessary link between health professionals in one location and patients in another. These technology trade-offs will likely persist; vigilant enforcement of dietetic practice acts provides the best remedy for the most common and egregious misuses of nutrition technology by unqualified practitioners.¹⁷

II. Identifying Competitors

A. Government Classification: Dietetics v. Nutrition

The Office of Personnel Management’s (OPM’s) 1980 Position Classification Standard for Dietitian and Nutritionist Series, GS-0630, while dated, remains its most recent professional classification, superseding that issued in 1966.¹⁸ The standard is significant in that it details the types of government positions available for dietitians and nutritionists and specifies the knowledge, skills, and

[§] Without practice exclusivity, unlicensed competitors may engage in nutritional assessments and nutritional counseling without violating the licensing statute, so long as they do not use one of the protected dietetics-related titles[§] to describe themselves.

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abilities required to perform the tasks of each position type. More importantly, it clearly differentiates dietetics^{**} from nutrition^{††}.¹⁹ OPM’s separation of dietitians and nutritionists into two occupations with different roles appears to have had lasting impact both among competitors who see a non-dietitian role for themselves²⁰ as nutritionists and as reflected in the federal and state government’s regulatory frameworks discussed below. Simply put, governments more strictly regulate the work of and qualifications for dietitians than it does for nutritionists, and competitors are explicit about their intention to exploit this dietetics/nutrition distinction. 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 that clinical dietitians, but RDs cannot cede this expanding market to others who clearly intend to provide nutrition services.

B. Holistic Nutrition Professionals

The many certifications, abbreviations, licenses, and education programs for so-called holistic nutrition professionals can be classified into two groups: (1) those focused primarily on holistic nutrition with few academic or credentialing requirements, and (2) those that also have a substantial focus on scientific principles of nutrition. Both groups pose some competitive threat to Registered Dietitians, but the varying educational standards manifested by each credential restrict some from more advanced and regulated clinical and nutrition-related jobs that have minimum education, experience, or licensing requirements.

1. Overview of Nutrition Professional Credentials

Competitor “nutrition professionals” include credentials requiring some substantial educational

qualification, such as “Certified Nutrition Specialists” (CNS) with advanced degrees in an allied health field relevant to nutrition, and “Certified Clinical Nutritionists” (CCN) who complete specific post-graduate courses in nutrition and work as physicians or other credentialed clinical health professionals. There are also Nutrition Consultants (NC) who complete distance learning holistic nutrition coursework prior to attending a culinary school, Certified Nutrition Consultants (CNC) without any credible educational or experience requirements, and Certified Nutritionists (CN) who have either taken six distance learning courses or passed an examination after buying an approved set of expensive study guides. In addition, there are School Nutrition Specialists (SNS) and Certified Dietary Managers (CDM) who are seeking to provide food service/nutrition services, and Certified Health Education Specialists (CHES) who work as health educators after receiving a bachelors or advanced degrees with relevant coursework.

2. Organizing through NANP

The National Association of Nutrition Professionals (NANP) describes itself as “a non-profit

** “Dietetics is an essential component of the health sciences, usually with emphasis on providing patient care services in hospitals or other treatment facilities. The work of the dietitian includes food service management, assessing nutritional needs of individuals or community groups, developing therapeutic diet plans, teaching the effects of nutrition on health, conducting research regarding the use of diet in the treatment of disease, or consulting on or administering a dietetic program.”

†† “Nutrition is the science of food and nutrients, their uses, processes, and balance in relation to health and disease. The work of nutritionists emphasizes the social, economic, cultural, and psychological implications of food usually associated with public health care services or with food assistance and research activities. The work includes directing, promoting, and evaluating nutritional components of programs and projects; developing standards, guides, educational and informational material for use in Federally funded or operated nutrition programs; participating in research activities involving applied or basic research; or providing training and consultation in nutrition.”

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business league of nutrition . . . [that] represents holistically trained nutrition professionals.”²¹ It focuses on two priorities: (1) enhancing the credibility of holistic nutrition and its practitioners and (2) advocating for greater acceptance of holistic nutrition in state law,²² health insurance regulations, and among the general public. NANP is taking the necessary steps to open new and lucrative business opportunities for its members, such as fee-for-service reimbursement from health plans and the preventive care opportunities arising out of health care reform. It recognizes that holistic nutritionists’ professional credibility is hurt in part by the public’s confusion over the many nutrition titles, and it aims to resolve that and other problems by “creating a unified, credible holistic nutrition profession[, which] means creating a professional governing body that sets educational standards, defines our role delineation/scope of practice and creates consistency within the profession on a nation-wide basis.”²³

NANP’s board declared that the first step in creating consistency and credibility for the profession was registration of professionals based on meeting educational standards, specifically requiring proficiency in certain post-secondary subjects clearly within the dietitian’s scope of practice, including nutritional supplementation, nutrition assessment, and nutritional counseling.²⁴ Indeed, in the many states with practice exclusivity, *only* dietitians may legally conduct nutritional assessments and nutritional counseling (unless the non-dietitian practitioner meets the criteria in one of the statutory exemptions). There are presently thirteen educational programs nationwide meeting NANP’s educational standards for nutrition programs^{††}; graduates of qualified programs may obtain registration with NANP and are automatically entitled to sit for the Holistic Nutrition Credentialing Board’s “Board Exam in Holistic Nutrition.”²⁵ The credentialing board will then confer a uniform title/designation on those who pass,⁵⁵ intending to eliminate public confusion arising from the multitude of nutrition credentials.²⁶

The holistic nutrition profession is unifying under a single organizational umbrella because it is in its members’ professional and financial self-interest to do so. The creation of educational standards and a consistent scope of practice will greatly expand professional opportunities for holistic nutritionists, as health insurers’ deem both threshold requirements before qualifying a profession for services reimbursement.²⁷ In short order, NANP has made substantial progress toward its vision of a unified holistic nutrition profession.

3. *Alternative Practitioners*

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. Alternative practitioners’ competitive motivations are predicated on several beliefs about the “role” of dietitians:

- Dietitians seek the status of nutrition counselors without sufficient education in holistic nutrition; . . .

^{††} Graduates of non-preapproved programs may still be eligible for membership if they either (1) complete additional coursework for any deficient subjects or (2) submit sufficient evidence of achievement in a non-preapproved program that nonetheless meets NANP’s standards. Notably, NANP’s educational standards do not require a college degree for registration, but do have a business management component, usually comprised of relevant legal concepts, accounting training, and strategies on growing a successful nutrition practice.

^{§§} In the same way that the Commission on Dietetic Registration (“CDR”) credentials “Registered Dietitians,” NANP seeks to credential “Registered Nutrition Professionals.” See, e.g., *Registration Frequently Asked Questions*, NANP website, available 14 April 2010 at http://www.nanp.org/faq_registration.htm.

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- Dietitians advocate diagnostic care; traditional naturopaths and holistic nutrition counselors emphasize healthy lifestyle choices and wellness care; . . . and
- Licensing dietitians as nutrition counselors will severely limit public access to such personal choices as macrobiotic foods, vegetarianism, organic and whole foods diets, and Ayurvedic nutrition.²⁸

Alternative practitioners have the specific intent to conduct nutritional counseling, and are permitted to do so in those states without practice exclusivity for dietitians. Their efforts to provide preventive and wellness care combines with their history of aggressively opposing legislative priorities of dietitians, to create a force that should be regarded as a resilient and likely growing competitive threat for RDs outside of clinical dietetics.

C. Other Competitors Sampled

1. *Nurses*

Nurses are some of the biggest beneficiaries of the PPACA and are expected to see a broadening of their role in providing primary care. To the extent that this expanded authority comes at the expense of physician’s scope of practice exclusivity, this change is unlikely to affect the competitive landscape with dietitians. However, an increasing number of Licensed Practical Nurses, Vocational Nurses and RNs are becoming “Wellness Nurses.” These practitioners are more likely to compete with RDs; they largely work in local government, corporate offices, and schools, where they conduct health coaching, biometric screenings, online health assessments, and other tasks that could otherwise be performed by a community or consultant dietitian.²⁹

2. *Pharmacists*

At some national pharmacy chains, pharmacists are teaming with nurse practitioners to provide diabetes screening, and consult with participants about nutrition and glucose monitoring.³⁰ Research shows that pharmacists are frequently providing information about healthful diets, medical device functions, and numerous other issues raised by customers.³¹ 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. At the same time, the opportunities for

dietitians to partner with pharmacists to provide similar screenings, assessments, and counseling may be worth considering.

3. Health Educators

Health educators have found significant employment opportunities promoting health and wellness as “Health Coaches” at insurance companies “to assist individuals who have not been diagnosed with a chronic disease, but who want to improve their health status in areas including weight management, *nutrition*, physical activity, tobacco cessation, stress, and back care.”³² A Personal Nurse is assigned to those with a present chronic condition; it is those without conditions who are assigned a CHES or health promotion specialist who use established behavioral models to guide lifestyle modifications.³³ This competition walks a fine legal line as non-credentialed health educators perform certain counseling that dietetic licensure laws may restrict. Assuming no violation of a dietetic practice act, however, a health educator’s training and experience in behavioral change and goal setting add valuable skills that can enhance the likelihood of improving client health.

4. Chiropractors

One of chiropractors’ most recent nutrition-related victories was in January 2010, when the 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.³⁴ In fact, chiropractic groups have long sought to solidify their professional reputation in the field of nutrition, in large part to protect the “almost 90 percent of practicing U.S. doctors of chiropractic [who] offer ‘nutritional counseling, therapy or supplementation’ to their patients.”³⁵ In June 2009, the American Chiropractic Association (ACA) formally created the Chiropractic Board of Clinical Nutrition to “advance clinical nutrition while at the same time enhancing the health of chiropractic patients.”³⁶

Registered Dietitians and DTRs would be well-served to be wary of chiropractic involvement in aspects of nutrition care services, particularly the development of relationships between chiropractors and non-CDR credentialed nutrition professional organizations such as NANP. Lastly, RDs should be vigilant in noting whether a dual-credentialed chiropractor/CCN violates either a state dietetic practice act or state or federal regulations for practicing dietetics without a license and/or without the 900 hours of required supervised dietetics practice.

5. Athletic Trainers

Many athletic and personal trainers have nutrition credentials, and it is fairly common for one or more personal trainers within a health club to be a Registered Dietitian. Trainers remain the profession receiving most complaints in Ohio for the unlicensed practice of dietetics and the improper use of a protected title. In that respect, continued competition can be expected. Further, the emphasis on preventive health and wellness care is expected to drive an increase in the number of jobs for fitness professionals “much faster than the average for all occupations.”³⁷ These fitness workers are necessarily limited in the areas of competition that they pose for dietitians, but because of their current practice and expressed intent, trainers should be considered competitors for certain unrestricted preventive and wellness care tasks.

III. Regulatory Enforcement

A. Role of State Licensure

Most of this above-described competition is perfectly legal, generally either because (1) competitor professions’ scopes of practice often explicitly or implicitly permit those professions to provide the nutrition care services, or (2) states lack the authority to prevent the unlicensed practice of dietetics because the state (often consciously) neglected to include a practice exclusivity clause (providing that only individuals whom the state has properly licensed may engage in activities falling

within the regulated profession's scope of practice) in its dietetics practice act.

States with practice exclusivity generally have multiple legislative exemptions, allowing specific groups (notably members of another licensed profession operating within the scope of their profession) to engage in the otherwise protected practice. A troubling pattern exists when looking at practice exclusivity and title protection in the most populous states, particularly with regard to non-licensed practitioners' use of the title "Nutritionist."³⁸ None of the three states largest in population protect the title "Nutritionist," only one of the three protects the title "Dietitian," and only one has practice exclusivity. Of the ten states largest in population, five provide no protection for the title "Nutritionist," and three provide no protection for the title "Dietitian." There is simply no legal recourse for a significant portion of the U.S. population who encounter unqualified individuals holding themselves out as dietitians or nutritionists. Thus, owing to the proliferation of nutrition credentials and the lack of

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government licensing with practice exclusivity, Registered Dietitians practicing in the most populous states find it more difficult to differentiate themselves in the field of nutrition from aggressive competitors with comparatively little education or training.

B. Importance of Enforcement

A corresponding factor in assessing the strength of a state's regulatory scheme beyond the express letter of the law relates to the effectiveness and aggressiveness of regulatory enforcement. States do not enforce professional regulations in a uniform process, or with similar zeal. Few of the representative states sampled by the author actually receive significant numbers of complaints alleging practice violations; even fewer aggressively pursue the violations they receive. Some states have dietetics-dedicated boards tasked with enforcement; others rely on less specialized boards of health professionals, boards of medicine, departments of professional regulations, or the state attorney general.

States generally require that someone file a complaint before an investigation into a violation can be opened; the complaint process is integral to aggressive enforcement of dietitian licensing acts. Because all too often state dietetic boards receive few (or no) complaints alleging violations, one is led to conclude either that (a) few, if any, violations are occurring in these states or (b) violations are occurring, but are not being reported. If the former scenario is accurate, states may conclude that the licensing of dietitians is wasteful and unnecessary.³⁹ If the latter scenario is accurate, dietitians and others benefitting from licensure must be more vigilant in identifying and reporting violations. In fact, many state dietitian licensure laws *require* that dietitians "report alleged violations of the laws, rules and standards to the state board of dietetics,"⁴⁰ and provide penalties for the failure to comply with that and other standards of professional performance.

Of the eight states selected for detailed research into their respective process and history of enforcement, only one state—Ohio—has demonstrated vigilance.⁴¹ Putting aside the remote possibility that Ohio is a dramatic outlier in the number of individuals both practicing dietetics without a license and using dietetics-related titles without being qualified to do so, it appears that the lack of enforcement in the other selected states directly results from a failure of dietitians and other citizens to file complaints with the state dietetic boards. Given state budgetary constraints and states' expressed willingness to cite the paucity of complaints as a reason to abolish dietitian licensure, it is imperative for dietitians to recognize both our ethical obligation and our professional incentive in aggressively identifying and reporting violations.

IV. Competitive Landscape Summary

As government funding for preventive care and wellness increases and private insurers continue expanding coverage to include visits to nutrition professionals, there will likely be a concomitant growth in the number of health care professionals willing to provide nutritional counseling. A shortage of providers and their desire and willingness to provide health care services formerly provided by physicians means that RDs are more likely to face enhanced competition from so-called "nutrition professionals" with less rigorous academic and experiential credentials.

Although dietitians have been successful at getting legislatures to enact licensing schemes with practice exclusivity, the increasingly competitive relationship between nurse practitioners and physicians shows that strict licensing schemes are insufficient to guarantee exclusivity when there are too few practitioners able to exclusively provide those tasks. Lastly, we must recognize the importance

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of licensure's role as a protective bulwark preventing unqualified competitors from performing nutrition care services, and increase our vigilance in reporting unlicensed competition.

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Appendix A

Results of Association Evaluation Tools

ADA Nutrition Trends Survey - Registered Dietitians: Public Awareness

- ADA conducted its first nationwide consumer nutrition trends survey in 1991, with follow-up surveys in 1993, 1995, 1997, 2000, 2002 and 2008. The aims of each survey have been:
 - To measure people's attitudes, knowledge, beliefs and behaviors regarding food and nutrition.
 - To identify trends and understand how consumers' attitudes and behavior have evolved over time.
- ADA's survey shows 86% of adults have heard of registered dietitians, statistically the same as the 2002 level of awareness.
- Consumers believe by nearly a 3-to-1 margin (74% to 26%) that there is a difference between an RD and a nutritionist.
- Approximately two in five respondents (43%) said they would be interested in a diet and nutrition consultation with a registered dietitian – up from 30% in 2000, the last time the question was asked. That figure increased to 49% when respondents were read a definition of a registered dietitian: "an experienced health professional with a college degree and training in food and nutrition science." And the percentage of consumers interested in a consultation with an RD jumped to 61% if the visit were covered by the person's health insurance.
- Keeping with the survey's findings on the perceived credibility of information sources, younger Americans were much more likely than the average 29% to be "very influenced" by an RD's recommendations on purchasing a brand or product. Another 53% said an RD's recommendation would "somewhat" influence them.

ADA Nutrition Trends Survey - Consumer Awareness of ADA and Web Site

- Awareness of the American Dietetic Association has remained constant from 1999 to 2002 at approximately 50% of respondents having heard of ADA.
- Participants in the survey were asked about their awareness of the American Dietetic Association, and the credibility of ADA and its Web site, eatright.org, as a source of information. According to the survey, 62% of American adults have heard of ADA, which is up substantially from 51% in 2002.
- In 2000, a majority of respondents knew RDs must meet academic requirements to obtain their credential. Thirty-two percent knew that an RD "is certified/has a degree or license." This was not measured in 2002.
- Survey respondents were read a list of sources and asked how credible they believe each one is. At 78% (down from 90% in 2002), registered dietitians were listed as the most credible. RDs were considered especially credible by younger adults and people with the most education. Doctors were named as credible sources by 61% (down from 92% in 2002) and nurses by 57%.
The complete "very credible" listing is:
 - Registered dietitian: 78%
 - Nutritionist: 78%
 - Doctor: 61%
 - Nurse: 57%

- USDA/MyPyramid: 46%
- References/books: 43%
- School: 39%
- Personal trainer: 39%
- Package labels: 35%
- Health club/gym: 29%
- Magazines: 25%
- Internet: 22%
- Newspapers: 21%
- Family/friends: 17%
- TV: 14%
- Radio: 13%
- Grocery store: 11%
- Food manufacturers: 9%

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Impression of Current Status of the Dietetics Profession

- Beginning in 2002, ADA's Scientific Affairs and Research Team surveys a random sample of registered dietitians along with their clients, referrers and employers on a quarterly basis. Respondents are asked questions related to dietetics and the American Dietetic Association.
- Registered dietitians are asked to rate their overall impression of the current status of the dietetics profession on a scale of 1 (very poor) to 11 (excellent).
- Up until 2006 referrers, employers and clients are also surveyed in order to measure perceptions of the dietetics profession. After that time, those categories were removed due to cost.
- The results of this research can shed light on the progress towards ADA's vision that members are the most valued source of food and nutrition services.
- The perception of the status of the dietetics profession had not changed much over the two years. In total, ratings across all groups were either somewhat higher in 2006 than in 2005 or they remained relatively the same (Figure 1).
- Clients, referrers and employers all have a higher perception of the status of the dietetics profession than do registered dietitians of themselves.
- Practitioners were moderately positive in their rating of the current status of the dietetics profession and had improved or unchanged opinions about their own work environment.
- The areas of most concern to practitioners were pay, combating misinformation and lack of respect and recognition.
- Employers' scores increased moderately, specifically their appreciation and respect for registered dietitians and their agreement that dietetic services are a good value for the money.
- Clients were similarly positive in regard to their overall impression of the dietetics profession. They also gave equally high rating of agreement with seven out of the ten statements regarding the service of registered dietitians. These questions were removed from surveys conducted after 2006.
- The status of the dietetics profession did improve since the 2007 dialogue (Figure 1) but varied by area of practice (Table 1).

Figure 1. Overall Impression of Current Status of the Dietetics Profession (1 = very poor to 11 = excellent) by Year

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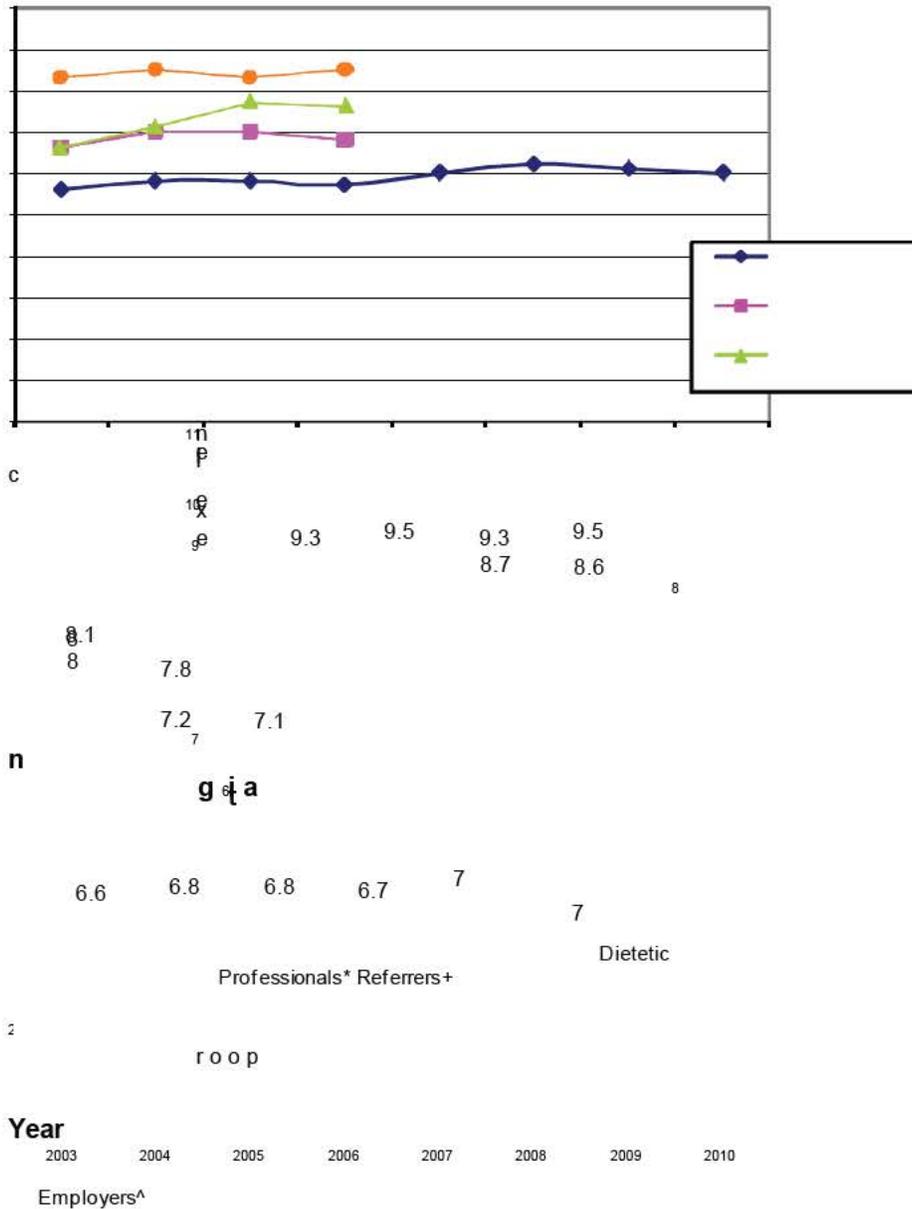


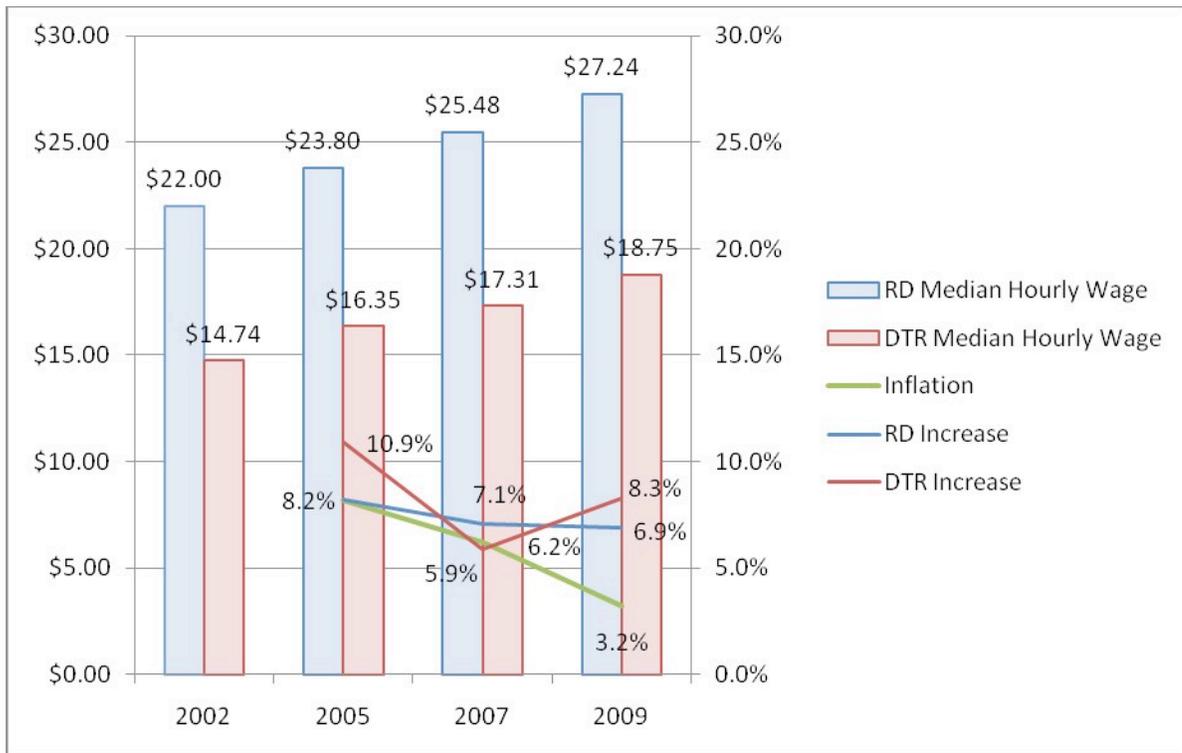
Table 1. Impression of Current Status of the Dietetics Profession 2009 and 2010 Breakdown by Specialty (scale 1 (very poor) to 11 (excellent))

	2009	2010
Food & Nutrition Management	7.9	7.4
Consultation	7.4	6.8
Education	7.4	7.1
Community	7.3	7.2
Clinical Nutrition	6.9	6.9
Research	6.7	6.5

Compensation and Benefits

The other the factor that may indicate the value of the RD is the compensation and benefits. Since 2005, RD and DTR salaries have continued to increase above the rate of inflation with the exception of DTRs between 2005 and 2007. However, since the dialogue session in 2007, if that is to be used as a marker date, there has been significant increases over inflation (Figure 2).

Figure 2. Compensation and Benefits Survey 2002-2009



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¹ See Text of HR 3468 in the 111th Congress, July 31, 2009.

² *Shot in the Arm: Has the U.S. Invested Enough Health Stimulus Money in Prevention?*, Katherine Harmon, *Scientific American*, available 19 February 2010 at <http://www.scientificamerican.com/article.cfm?id=stimulus-health&print=true>. (Reporting that \$87 billion went to established healthcare, like Medicaid reimbursements and physician education, and \$25 billion went to improve health care technology and encourage computerized medical records).

³ "U.S. Childhood Obesity Rate Continues to Rise," *Science News*, 4 May 2010, available at http://www.sciencenews.org/view/generic/id/58867/title/U.S._childhood_obesity_rate_continues_to_rise. (Citing data that will appear in the July issue of *Archives of Pediatrics & Adolescent Medicine*.); "Preventative Care in the United States: Quality and Barriers" (*Annual Review of Public Health*, Apr. 2006).

⁴ 42 C.F.R. 410.130; 42 C.F.R. 410.132.

⁵ 42 C.F.R. 410.132.

⁶ Rules of Alabama State Board of Health 420-5-5-.01.

⁷ *Hispanics Shift Hospital Resources*, Dallas Morning News, 15 September 2007, available http://www.ahiphiwire.org/News/Print.aspx?doc_id=133835.

⁸ *Occupational Outlook Handbook, 2010-11 Edition: Dietitians and Nutritionists*, Bureau of Labor Statistics, modified 7 April 2010 at <http://www.bls.gov/oco/ocos077.htm>.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Hispanics Shift Hospital Resources*, Dallas Morning News, 15 September 2007, available http://www.ahiphiwire.org/News/Print.aspx?doc_id=133835.

¹² See "Arkansas Fights Fat: Translating Research into Policy to Combat Childhood and Adolescent Obesity," Kevin Ryan et al, *Health Affairs*, Volume 24 Number 4 (July/August 2006).

¹³ See, e.g., *Pharmacists Strengthen Medical Home Team*, AHIP Hi-Wire, available 12 February 2010 at

http://www.ahiphewire.org/News/Print.aspx?doc_id=506183.

¹⁴ K. Coleman and K. Phillips, "Providing Underserved Patients with Medical Homes: Assessing the Readiness of Safety-Net Health Centers," *The Commonwealth Fund*, May 2010 at 6, accessed 20 June 2010 at <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/May/Providing-Underserved-Patients-with-Medical-Homes.aspx>.

¹⁵ See, e.g., Food Processor Nutrition Analysis and Fitness Software described at <http://www.nuconnexions.com/Software/FoodProcessor.htm>.

¹⁶ *Nursing's Role in Nutrition*, Henning M.; Nutrition Analyzer available at <http://www.nursing.jmu.edu/msn/nutritionanalyzer.html>.

¹⁷ See, *Telehealth: Opportunities and Pitfalls*, J. Craig Busey and Pam Michael, J. Am. Diet. Assoc., August 2006, available at <http://www.eatright.org/WorkArea/DownloadAsset.aspx?id=11418>. (Providing excellent analysis of telehealth relevant to practice exclusivity and professional competition.)

¹⁸ Available at www.opm.gov/Fedclass/gso630.pdf.

¹⁹ *Id.* at 2.

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²⁰ This continuing attempt to bifurcate the roles and duties of dietitians and nutritionists can be seen, for example, in the video of "What is a Nutritionist" available at <http://sciencestage.com/v/28322/what-is-certified-clinical-nutritionist-or-ccn?-nutrition.html>; in which a CCN dismisses dietitians as working in food services and hospitals, while nutritionists "bridge the gap between the medical paradigm and the alternative paradigm" using dietary supplementation and herbology—things dietitians "are not trained to do."

²¹ National Association of Nutrition Professionals (NANP) website homepage, available 14 April 2010 at <http://www.nanp.org>. The CNS, CCN, CDM CFPP, CHES, and SNS titles discussed below do not fall under NANP's holistic nutrition professional governance umbrella.

²² NANP expressly states that "[s]tate licensing is a long term goal of the NANP." *Id.*

²³ *Registration Frequently Asked Questions*, NANP website, available 14 April 2010 at http://www.nanp.org/faq_registration.htm.

²⁴ *NANP Educational Standards for Professional Membership and Registration*, NANP website, available 22 May 2010 at http://www.nanp.org/NANP_Educational_Standards_2004.pdf.

²⁵ *Recommended Educational Programs*, NANP website, available at 14 April 2010 at http://www.nanp.org/education_train.htm. An individual is eligible to take the exam by (a) meeting NANP's educational standards; (b) maintaining professional membership in NANP; and (c) documentation of 500 hours of professional experience in holistic nutrition, including a minimum of 250 direct contact hours. *Exam Eligibility Requirements*, Holistic Nutrition Credentialing Board website, available 14 April 2010 at http://www.holisticnutritionboard.org/index_files/Page331.htm.

²⁶ *Id.* at Q3. NANP here reiterates that the uniform title/designation will not affect American Health Science University or the Certified Nutritionist (CN) designation.

²⁷ *Id.* at Q2; Q5. ("[T]he insurance industry requires health professions to meet standards of organization and governing, including established educational standards, a system for documenting that you have met professional standards (via exam and/or registration), and defined role delineation or scope of services and a code of ethics.")

²⁸ *Licensing Natural Health is Bad Medicine*, Coalition on Natural Health, available 12 May 2010 at <http://www.naturalhealth.org/agenda/license.asp>.

²⁹ See, e.g., *Employers Recognized by UnitedHealthcare for Outstanding Efforts in Worksite Wellness Programs*, 27 January 2010, available http://ahiphewire.org/News/Print.aspx?doc_id=500273.

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³⁵ *Focusing on Nutrition*, Donald M. Petersen Jr., BS, HCD(hc), FICC(h), *Dynamic Chiropractic*; 21 May 2005, Vol. 23, Issue 11, available at <http://www.dynamicchiropractic.com/mpacms/dc/article.php?id=50222>.

³⁶ http://www.acatoday.org/press_css.cfm?CID=3461

³⁷ *Occupational Outlook Handbook, 2010-11 Edition: Fitness Workers*, modified 17 December 2009, available at <http://www.bls.gov/oco/ocos296.htm>.

³⁸ The top ten states in order of largest population are California, Texas, New York, Florida, Illinois, Pennsylvania, Ohio, Michigan, Georgia, and North Carolina.

³⁹ *See, e.g.*, Colorado Department of Regulatory Agencies Office of Policy and Research, *Dietitians 2001 Sunrise Review*, at 16, available 20 May 2010 at <http://dora.state.co.us/opr/archive/2001.pdf>.

⁴⁰ OAC 4759-6-02(K)(2). *See also*, SCR § 40-11(19) (Code of Ethics) ("The licensed dietitian shall report to the appropriate authorities any incident of which he/she has personal knowledge, of unethical dietetic practice by any individual or organization.") and SCR § 40-10 (Misconduct Defined) ("Misconduct means any one or more of the following . . . violation of any of the principles of dietetic ethics as adopted by the Panel.").

⁴¹ Although the presence of a dedicated investigator attached to the dietetics practice board in Ohio may be a factor in its vigilance, it does not account for the fact that Ohio receives many, many more complaints every year than the other states received over a ten-year timeframe.

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President's Page: Licensure for dietitians: The issue in context

In the 1980s, the issue of licensing health professionals has gained considerable attention in the professions, in government, in business and industry, and in the public sector. The interests of, and therefore the significance of licensure to, those groups are different. In fact, licensure creates conflicting forces. What is beneficial to one group can be disadvantageous to another.

Licensure in America was first instituted in the 19th century to provide a means for distinguishing qualified practitioners from those who were unqualified. Licensure emerged in response to an identified need to protect the public from incompetent or unscrupulous practitioners by preventing unqualified individuals from practicing. In fact, physicians and members of the public alike agreed that practice by unfit physicians, as well as by quacks and charlatans, was undesirable. Yet, early medical societies had no enforcement power to prevent incompetent or unethical physicians from practicing (1).

As illustrated in the classic example of medicine, early licensure laws established the tradition of self-regulation among the professions by vesting regulatory authority in the leaders of the professional group in the form of licensing boards. Members of the profession were generally regarded as the ones best prepared to assure protection of the public. Therefore, although licensing was a form of self-regulation, members of the public viewed it favorably because it was believed to provide valid consumer protection.

Licensing has expanded greatly since 1900, from a handful of licensed occupations to more than 800 licensed occupations and professions in the 1980s (2). The proliferation of new health-related occupations in the last two decades has heightened the interest in licensing among those occupations already established but not licensed.

The purpose of licensure

Certainly, few would doubt that licensure has served a useful purpose for society by providing a means to (a) screen applicants to assure that minimum qualifications for safe practice are met, (b) set standards of practice and codes of conduct for practitioners, (c) investigate charges of incompetence or impropriety against licensees, and (d) take appropriate disciplinary action. The track record of licensure legislation and regulations in fulfilling these



purposes is important to the consideration of the place of licensure in the future.

Studies have shown that licensure boards have been generally effective in screening applications for licensure, although they have been much less rigorous in investigating complaints about the incompetence, negligence, unprofessional conduct, or dishonesty of those already licensed. The

continuing review of licensure activities provides mounting evidence that licensure boards have been lax in checking on those who are licensed. Even though thousands of complaints are filed each year, only a small fraction are reviewed, and even fewer result in disciplinary action. The evaluation of complaints about practitioners is complicated by the lack of agreement and clear definition of what constitutes competent professional practice (1).

Further, the assurance of competence at entry level is certainly not guaranteed, because licensure examinations are generally designed not to measure competence of examinees but to test basic knowledge. It is agreed that the provision for and assurance of continuing competence are complex and difficult. Advances in test technology will soon make possible the measurement of competency by examination. However, the adaptation of this technology for licensure is strongly questioned because of the inflexibility of licensure laws and the structure of licensure boards.

Studies have indicated that licensure of professionals has brought higher standards. Higher incomes for professionals have resulted also, accompanied by an increased cost of services to consumers. At best, the effectiveness of licensure in fulfilling its stated purpose has been less than desired. One thoughtful professional has said: "It is evident that the benefits [of licensure] do not provide substantial protection for the public" (3).

Relevant issues

A central issue regarding licensure is the question of who

really benefits—the public or the professional group. Those in the professions who have examined honestly the true purpose served by licensure have acknowledged quickly that those professional groups which seek licensure are motivated primarily by the anticipated benefit to members of the profession. Yet, the purported purpose of licensing is to protect the public.

Without question, licensing has provided protection not only for the public but also for the licensed group by decreasing competition from newcomers. In reality, some have said that restricting access is the real purpose of licensure and should not be regarded as merely a side effect (4).

The increasing awareness of the need for licensure to demonstrate accountability in meeting its stated purpose has resulted in the passage of sunset legislation in at least 36 states (5). Sunset laws require that licensure boards, as regulatory agencies, be abolished according to a specified timetable unless they demonstrate (a) the continued need for regulation and (b) effective functioning (1).

As health professions face a time of change and conflict, licensing of professionals in the 1980s is beset by numerous contradictions. This is not surprising. The concept of licensing was implemented in an era when one set of assumptions and conditions was applicable, yet the current era is characterized by dramatically different economic, political, social, technological, and legal forces. That is, the assumptions which formed the original basis for licensing are, in many respects, no longer valid. So the question must be asked: "What place does licensing have from now until the 21st century?"

One analyst has said: "The professional scene 10 years from now might bear scant resemblance to that of today" (6). Certainly, the "landscape" of the health professions can be expected to assume a new and different configuration very soon. I assert that the form and the extent of licensure laws among the health professions will have a significant influence.

Pressures for licensure

Examination of the societal pressures reveals that the primary push in favor of licensure has come from practitioners. Although the stated purpose of licensure is to benefit the public, few pleas for licensure have come from the public. Further, rarely has the public's need for licensure been definitively demonstrated. Campaigns for licensure have been orchestrated by practitioners as a way to identify and protect their areas of endeavor. Some professions have experienced intense territorial conflicts because of their efforts to preserve their areas of practice.

Licensing is sought by professionals because it provides legal recognition and thereby is believed to increase professional prestige. Practitioners also observe that licensing increases the potential for third-party payment for professional services and so enhances the availability of services to consumers.

Pressures against licensure

The last decade has brought increasing pressures against licensure. Consumers, for example, have learned that licensing may add to the cost of services while not assuring quality. Some consumers, along with government agencies, legislative policymakers, and leaders in

health care, including hospital administrators, have urged major revisions of professional roles in order to make needed services available at an affordable cost.

A significant stand against licensure was taken by the American Hospital Association in 1970, when it issued a call for a moratorium on licensure and was supported by the American Medical Association and the U.S. Department of Health, Education and Welfare (7). Others also have called for a moratorium on licensing of additional health professionals who provide services in the hospital setting (8). Managers of health care institutions desire to have the flexibility to manage personnel without the constraints imposed by legislative requirements for licensed professional staff and the concomitant higher personnel costs.

Indeed the "pros" and "cons" of licensure have been strongly debated. The arguments clearly represent the interests of the consumer on the one hand and those of professional groups on the other. It is not easy to address licensing and its effects in a dispassionate manner because several interests are involved: concern for the future of the profession, concern for the consumer, and concern for one's own livelihood (3).

The effects of licensure

Notwithstanding the increase in public discussion of occupational licensure, many active professionals do not fully understand how the system works, how it affects consumers, what the critics and defenders are saying, and what might be appropriate solutions for the shortcomings. However, examination of these complex considerations makes it clear that occupational regulation is an important social and political issue which is significant to the professions and deserves their consideration (1).

A brief review of several of the major effects of licensing will provide perspective for planning for the future. First, licensure laws have significant direct and indirect effects on health manpower supply because the law affects not only competence but also geographic distribution and use of personnel (7). Licensure restricts entry and mobility in the health field and has a significant effect on the education of professionals.

The economic impact of licensure has been mentioned. Economists have observed that the exclusionary practices of licensure boards have increased the earnings of professionals and, in turn, the costs to consumers. Certainly, the link between occupational licensing, supply of practitioners, and the cost of goods and services to consumers has been clearly documented.

Charges have emerged from the legal sector that licensure restricts competition and therefore unnecessarily increases costs to consumers. The Federal Trade Commission has made such assertions as a result of the conduct of studies of the prescription drug industry and others. Similar charges have been brought by the Antitrust Division of the U.S. Department of Justice in the form of legal action against a number of professional associations, alleging anti-competitive practices (1).

Licensure for dietitians

Like other professionals, dietitians can justify the enactment of licensure laws because licensing affords the opportunity to protect dietitians from interference in their

field by other practitioners. Licensure also can protect dietitians by limiting the number of practitioners through restrictions imposed by academic, experience, and examination requirements. This protection provides a competitive advantage and therefore is economically beneficial for dietitians.

Licensure can facilitate clarification of the dietitian's responsibilities and scope of practice to those outside the profession, including other health professionals. That can be a strategic step, as encroachment by those who lack professional training in nutrition into what dietitians have considered their area of practice is increasing. Further, the clarification of the dietitian's role to those in the institutional setting is important at a time when hospital management is seeking less costly personnel in the face of looming economic pressures brought on by prospective payment systems.

Of great importance to dietitians is the potential for increased visibility afforded by licensure. Historically, dietitians have had a limited public visibility. That is, dietitians have not enjoyed the recognition of the lay public as experts in the field which dietitians consider to be dietetic practice. Although dietitians have lacked visibility, many other groups with questionable training, or certainly no professional training, have seized the opportunity to provide services to the public—often at a very high price.

Along with increased visibility for dietitians, the availability of nutrition services to consumers can be expected to increase. Licensure provides a recognized base of qualifications to assist consumers in making decisions about nutrition services and nutrition information. As increasing numbers of dietitians become self-employed and engage in private practice, the significance of these influences is apparent.

Considering the future

Indeed, licensing for dietitians can provide significant protection to practitioners in states in which licensure laws are enacted. Yet, consideration of the effect of licensing in the context of its broad impact upon the profession and individual practitioners is essential for making wise decisions about licensure.

One of the most significant questions in this regard is the relationship of individual licensing laws to the established certification program administered by the Commission on Dietetic Registration of The American Dietetic Association. A legally protected professional designation, the "R.D." was established in 1972 for use by registered dietitians. Eligibility requirements for dietetic registration were published and have been reviewed for revision since that time. While dietetic registration has gained considerable acceptance as a recognized professional certification in the health community, it does not provide legal recognition for dietitians or define a scope of practice.

As the future of licensure for dietitians is considered, a clear distinction between licensure and certification is needed. Simply stated, certification limits the use of a professional title or designation, whereas licensing laws regulate the use of the title as well as define the scope of activities that constitute practice. Certification essentially affirms that stated qualifications have been met, while

licensure precludes the provision of services by anyone not legally designated to perform such services (3). Licensure is enacted by law and is not easily changed, while certification is usually administered by a professional association and can be more flexible.

With the recognition that an important purpose of licensure is to assure competence, members of a profession need to consider realistically the relationship of licensing to competency. A licensure law specifies a scope of practice which limits the activities that can be performed by licensees. This scope is both rigid and somewhat narrow and cannot be changed without legal action. The licensure examination for admission to practice is based on the scope of practice and is intended to be a measure of competence.

Changes in societal needs for professional services and influences of technology on practitioner roles suggest that rigid scopes of practice may be problematic. Certainly, legislative changes in scopes of practice are not easily accomplished. Also, experience among the professions suggests that licensure boards cannot act with adequate speed and force to be responsive to rapidly changing needs for practitioner competence. As stated by one authority: "Licensure is threatened by its reliance on outmoded scopes of practice and obsolete educational requirements. Voluntary sector certification may be able to respond to the dynamics of change better than licensure" (6).

On the other hand, the proposed Medicare regulations may or may not include requirements for credentials for health professionals. The trend toward liberalizing federal regulations in order to achieve greater flexibility, and, in turn, lower costs, would suggest less specificity of regulations. Such a direction could give a very different perspective to the question of credentialing for dietitians.

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 could be more consistent among states. Suffice it to say that this question raises a number of other significant political, economic, and legal questions which remain to be completely answered.

Another important related issue is that of reciprocity. Specifically, "will the eligibility requirements in states be sufficiently comparable for dietitians to move between states without losing their license to practice?" While the awareness of the need for reciprocity is keen, this question remains to be answered. Certainly, the problems of other professions regarding reciprocity have been well documented.

Not to be overlooked is the question of the relationship of licensure to certification of dietetic specialties. Although the scope of this article does not allow complete discussion of specialty certification, the issue has been actively debated since 1979 and is important to decisions about licensure and certification for dietitians.

These questions illustrate the complexity of the issue of

licensure. Informed decisions about licensure for dietitians will require careful forethought. Indeed, an essential consideration is that regulation of a profession is appropriate when it protects the public welfare, not the self-interest of the profession.—*Marilyn B. Haschke, R.D.*

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Zinc deficiency retards brain development in rats

Diets mildly deficient in zinc caused memory and learning impairments in the offspring of laboratory rats fed such diets during pregnancy and suckling, according to Edward S. Halas, research psychologist for USDA's Agricultural Research Service. Impaired learning of the animals continued into adulthood.

The zinc-deficiency study was done at the research agency's Grand Forks, ND, Human Nutrition Research Center. A rat maze used to diagnose the impairments was the same kind of maze that researchers at Johns Hopkins University developed to study effects of surgically imposed injuries on the rat brain. University researchers found that injuries to the brain's hippocampus area impaired short- and long-term memory.

In the Grand Forks study, Halas said, "we found that the hippocampus areas were less well developed in zinc-deficient rats with memory and learning impairments than they were in the rats on control diets." In both rats and human beings, the hippocampus normally has high concentrations of zinc, a trace mineral that is essential for formation of nucleic acids and protein.

Whether zinc deficiency occurs in human fetuses and

interferes with the rapidly developing hippocampus during pregnancy and postnatal periods is not known, Halas said. But he suggested that it may be prudent for pregnant women to consume food rich in zinc.

Good sources of zinc include oysters, variety meats such as liver or beef heart, other kinds of beef, dark poultry meat, and crab.

Once the brain has been fully developed in a rat or a child, it is difficult to injure it by nutritional means, Halas said. But if zinc deficiency occurs early in life during the critical period of brain development, normal growth and maturation may be irreversibly impaired.

Can zinc-deficient rats be rehabilitated in other ways?

"Insights for answering that question may depend on whether learning impairments in rats are general or specific in nature," Halas said. "If they're specific, perhaps in other kinds of learning experiments the rats could be rehabilitated to learn through kinds of stimuli that are different from the one involved in our study.

"Knowledge is too limited for us to comment on human beings."

Licensure

HOD Backgrounder

House of Delegates

Fall 2011

The topic of health reform was discussed during the Fall 2009 House of Delegates Meeting and continued through the Fall 2011 meeting. It became clear from the outcomes of these sessions that collaborative efforts with external stakeholders were needed both at the federal and affiliate level in order for the profession of dietetics to be identified as the preferred and qualified provider of nutrition services. Licensure of dietitians protects the public health by establishing minimum educational and experience criteria for those individuals who hold themselves out to be experts in food and nutrition.

For these reasons, as well as its recent identification as a Mega Issue at the Spring 2011 House of Delegates, the House Leadership Team selected the topic of licensure initiatives for discussion at the Fall 2011 House of Delegates Meeting (September 23-24).

Mega Issues Questions:

What is needed to create greater understanding among RDs/DTRs of the value of licensure and the importance of active engagement to the long term future of the profession?

Expected Outcomes:

1. Delegates will develop awareness and understanding of the value of licensure to the future of the profession.
2. Strategies will be identified that individual members can undertake to support the efforts of their states' establishment or maintenance of licensure. Delegates will provide input on messages and resources that can be used by PIA to support state establishment, strengthening and maintenance of licensure.
3. Engage delegates, in creating a plan for working with their affiliate boards and Public Policy Panels to promote licensure to ensure the safety of the public.

Backgrounders for the House of Delegates inform the readers on the mega issue and provide answers to the following questions throughout the document:

1. What do we know about the needs, wants and expectations of members, customers and other stakeholders related to this issue?
2. What do we know about the current realities and evolving dynamics of our members, marketplace, industry, profession, which is relevant to this decision?
3. What do we know about the capacity and strategic position of ADA in terms of its ability to address this issue?
4. What ethical/legal implications, if any, surround the issue?

To prepare the HOD for the discussions on licensure initiatives, this Backgrounder provides information in relation to the four questions throughout the backgrounder and is framed by Licensure Initiative Report prepared by the Policy Initiative and Advocacy Team provided during the ADA Board of Directors Retreat, June 7-9, 2011.

Knowledge-based Strategic Governance is a mechanism for consultative leadership. It recognizes that “strategy” is the necessary and appropriate link in the Board’s role to govern the organization, the House’s role to govern the profession and the staff’s role to manage implementation. To assist you in thinking about the issue to be addressed, four key background areas are presented as standard questions used for each Mega Issue. These questions create an environment of awareness of what we know and what is unknown. A wide range of resources have been used to provide you with what is known.

There is a proliferation of nutrition-related titles and credentials available to individuals seeking a foothold in the field; the academic and experiential requirements for them and the objective value of the credentials vary widely. There are essentially two categories of non-CDR credentialed nutrition practitioners: (1) holistic nutrition practitioners with varying qualifications and education and (2) recipients of Bachelors of Science, professional, or advanced degrees (in fields related to nutrition) who desire nutrition credentialing to work in the field. These “nutrition professionals” are in the process of unifying their credential and academic standards under a new professional organization with the specific purpose of developing new professional opportunities, such as seeking future reimbursements from health insurers and pursuing available preventative care and wellness resources. Many aggressively challenge the notion that dietitians should have practice exclusivity outside of the clinical setting, and they continue pushing legislative initiatives that allow use of the “nutritionist” title and permit them to perform holistic and other nutritional counseling.

Registered dietitians presently face competition for the provision of certain dietetic services from an array of competitors, and should expect broad, varied competition to continue in the future. As government funding for preventative care and wellness increases and private insurers continue expanding clinical coverage to include visits to nutrition professionals, there will likely be a concomitant growth in the number of competitor health care professionals willing to provide some form of nutritional counseling. Competition for RDs may be from professions with fewer academic and experiential requirements, including non-CDR credentialed nutrition professionals. Although dietitians have often been successful in convincing legislatures to enact licensing schemes with practice exclusivity, the increasingly competitive relationship between nurse practitioners and physicians over scopes of practice shows that strict licensing schemes are sometimes insufficient on their own to guarantee exclusivity when there are too few practitioners able to exclusively provide those tasks.

State affiliates have experienced organized opposition to licensure in all states in which current laws have been proposed. Grassroot opposition has been focused on the American Dietetic Association and has included arguments that dietitians lack preparation to deliver wellness and nutrition care outside of the hospital setting, that licensure creates a monopoly and restricts freedom of choice of provider by the public, creates job loss for non-RDs providers (such as WIC and alternative providers) and that licensure requires those who practice to be members of ADA (Appendix A). Rather than respond individually to these media campaigns, ADA can achieve a position of strength by developing and executing an initiative that supports licensure and the dietetics profession while adding member value.

The professional standards set by dietetics licensure are important to the profession and it positions the registered dietitian as recognized providers in state and third-party payer systems. Licensure benefits the public by establishing standards for public awareness on health provider standards and services.

Market Place Relevance Regulatory and Competitive Environment of Dietetic Services

Registered Dietitians and Dietetic Technicians, Registered (DTRs) face a significant competitive threat in the provision of various dietetic and nutrition services. Dynamic changes in the expected demand for

nutrition-related services offer both exceptional opportunities and significant challenges for those willing and able to supply them. RDs and DTRs must be aware that existing legal and regulatory constraints on practice are unlikely to prevent robust, broad competition in these growth areas.

Regulations Restricting Competition

The Center for Medicaid and Medicare Services (CMS) regulations specify that, “For Medicare Part B coverage of MNT, only a Registered Dietitian or nutrition professional may provide [nutrition] services.” Elsewhere the regulations use the term “qualified dietitian.” While the regulation defines “Registered dietitian or nutrition professional” as having minimum educational and experiential requirements mirroring those of Registered Dietitians, there are exceptions that allow non-RDs) to qualify as “nutrition professionals.” Some states may specify certain qualifications or duties beyond those detailed in the federal regulations. Regulations can either close avenues of competition, or open opportunities for competitors with skills and training.

Government Classification: Dietetics vs. Nutrition

The Office of Personnel Management’s (OPM’s) 1980 Position Classification Standard for Dietitian and Nutritionist Series, remains its most recent professional classification. Governments more strictly regulate the work of and qualifications for dietitians than it does for nutritionists. An array of competitors is working to exploit this distinction between dietetics/nutrition and 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.

Competitors Organizing through National Association of Nutrition Professionals

The National Association of Nutrition Professionals (NANP) describes itself as “a non-profit business league of nutrition . . . [that] represents holistically trained nutrition professionals.” It focuses on two priorities: (1) enhancing the credibility of holistic nutrition and its practitioners and (2) advocating for greater acceptance of holistic nutrition in state law, health insurance regulations, and among the general public. NANP’s board declared that the first step in creating consistency and credibility for the profession was registration of professionals based on meeting educational standards, specifically requiring proficiency in certain post-secondary subjects clearly within the dietitian’s scope of practice, including nutritional supplementation, nutrition assessment, and nutritional counseling.

The current status of state regulation is:

- 35 states or territories-- licensure
- 7 states -- certification (4 are seeking licensure)
- 3 states-- title protection
- 3 states -- no statute (2 are seeking licensure)
- 4 states -- pending licensure

Role of State Licensure

Most of this competition is legal, either because (1) competitor professions’ scopes of practice often explicitly or implicitly permit those professions to provide the nutrition care services, or (2) states lack the authority to prevent the unlicensed practice of dietetics because the state (often consciously) neglected to include a practice exclusivity clause (providing that only individuals whom the state has properly licensed may engage in activities falling within the regulated profession’s scope of practice) in its dietetics practice act.

HOD Backgrounder: Licensure

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There are different levels of professional regulation including licensing, certification, and title protection programs.

- Licensing is the most restrictive legislative regulation, other than outright prohibition of professional practice, and usually requires specific educational attainment and passage of a competency examination. Licensing programs often include (1) title protection for licensees, meaning that only those the state has properly licensed may use a particular title or hold themselves out as members of a particular profession, and (2) practice exclusivity, meaning only those the state has properly licensed may engage in activities falling within the regulated profession’s scope of practice. States with practice exclusivity generally have multiple legislative

exemptions, allowing specific groups (notably members of another profession operating within the scope of their profession) to engage in the otherwise protected practice.

- State certification programs provide a lower level of protection for state consumers, and generally require a lower level of educational attainment. Most often, state certification requires that an individual obtain a private credential from a specified non-governmental professional entity, usually includes title protection, and can include practice exclusivity.
- Title protection programs offer one of the lowest levels of regulation, in which there is no practice exclusivity, but in which only those individuals who meet the specified requirements are permitted to use a particular title or hold themselves out as a member of that profession. Unlike licensing and certification programs, title protection programs generally do not provide a mechanism for removing harmful practitioners from practice.

Key elements of dietetics licensure statutes include: title protection, scope of practice, practice exclusivity clause, operations of licensure board, educational standards, and exam standards.

States with practice exclusivity generally have multiple legislative exemptions, allowing specific groups (notably members of another licensed profession operating within the scope of their profession) to engage in the otherwise protected practice. A troubling pattern exists when looking at practice exclusivity and title protection in the most populous states, particularly with regard to non-licensed practitioners' use of the title "Nutritionist." There is simply no legal recourse for a significant portion of the U.S. population who encounter unqualified individuals holding themselves out as dietitians or nutritionists.

State licensing boards provide oversight for the administration of the state licensure laws, including:

- Reviewing qualifications and applications of licensure applicants
- Investigating and implementing discipline for reports of harm (violations to licensure statutes)
- Providing oversight of licensee requirements, including ethical and professional standards

Importance of Enforcement

Registered dietitians have a professional responsibility to report incidents of harm to their state licensing board. If harm is not reported, licensing boards cannot do their job of investigating violations. States do not enforce professional regulations in a uniform process, or with similar zeal. Few of the representative states sampled by the author actually receive significant numbers of complaints alleging practice violations; even fewer aggressively pursue the violations they receive. Some states have dietetics-dedicated boards tasked with enforcement; others rely on less specialized boards of health professionals, boards of medicine, departments of professional regulations, or the state attorney general.

States generally require that someone file a complaint before an investigation into a violation can be opened; the complaint process is integral to aggressive enforcement of dietitian licensing acts. Because all too often state dietetics boards receive few (or no) complaints alleging violations, one is led to conclude either that (a) few, if any, violations are occurring in these states and licensing is not necessary or (b) violations are occurring, but are not being reported. If the latter scenario is accurate, dietitians and others benefitting from licensure must be more vigilant in identifying and reporting violations. In fact, many state dietitian licensure laws *require* that dietitians "report alleged violations" and provide penalties for the failure to comply with that and other standards of professional performance.

Competitive Landscape Summary

As government funding for preventive care and wellness increases and private insurers continue expanding coverage to include visits to nutrition professionals, there will likely be a concomitant growth in the number of health care professionals willing to provide nutritional counseling. A shortage of providers and their desire and willingness to provide health care services formerly provided by

physicians means that RDs are more likely to face enhanced competition from so-called “nutrition professionals” with less rigorous academic and experiential credentials.

The Work Group on Licensure, Scope of Practice and Competition

The Work Group on Licensure, Scope of Practice and Competition (WGLSC) provided a report to the Board of Directors in January 2010. The major focus of the WGLSC was to develop a Model Practice Act (Appendix B) to assist members seeking licensure.

Dietetics Practice Acts are laws designed to protect public health, safety, and welfare enacted in state statute. Their purpose is not to increase reimbursement. They define the scope of dietetics practice and help assure that the public is protected from incompetent, unqualified and unskilled practitioners. State dietetics statutes establish state boards, define the scope of practice, and establish disciplinary procedures to regulate the profession. In most cases, the boards also have the legal authority to write the regulations that implement the law. This, these boards have the responsibility to protect the public by determining who is competent to practice dietetics under the specified statute. The dietetics practice acts are important statutes and must be protected.

The WGLSC decided to put forth a Model Practice Act that could be used by ADA to assist affiliates in their licensure efforts for 2010 and beyond. The Model Practice Act will provide a foundation for affiliates as they seek to lobby for their licensure bills. While the individual licensure bills will continue to vary, the affiliate leadership will be encouraged to work with a bill that is as close as possible to the Model Practice Act. Affiliate licensure leaders will work closely with the ADA Director of State Government Relations to receive training on effective lobbying strategies. They will work together on finalizing an ADA approved bill that will incorporate the guidelines and tenets in the Model Practice Act. Affiliates will be encouraged to begin with a position of strength and compromise on certain elements only if absolutely necessary, in the final phase of negotiations.

Recommendations for essential components in licensure bills:

As ADA state affiliates plan and manage licensure efforts, the Work Group on Licensure, Scope of Practice and Competition considers the following as essential components for licensure bills:

- Commission on Dietetic Registration (CDR) guidelines for licensure.

- Language includes a scope of practice and title protection language similar to the Model Practice Act.
- Language includes the following definition of dietetics.

“Dietetics” is the integration and application of principles derived from the sciences of food, nutrition, management, communication, and biological, physiological, behavioral, and social sciences to achieve and maintain optimal human health.

Managing Competition

Even though the majority of state affiliates already have a practice act, it is important to continue to scan the environment for potential “scope creep”. It is also important that newer members of ADA understand the value and importance of a practice act. To achieve this, the WGLSC recommends to affiliates these approaches for managing competition:

- a. Affiliates need to develop and increase collaborative relationships with state medical associations, hospital associations and other key groups who will advocate for dietitian licensure.
- b. Investigate and know the scope of practice for other professions.
- c. Research and submit case reports on evidence of harm in states without licensure and track incidence of harm in those states with licensure.
- d. Affiliate leaders should work with ADA staff to ensure essential requirements to licensure

statutes are met, including:

- Applicant qualifications consistent with the CDR Guidelines for licensure;
- Statute terminology consistent with the Model Practice Act.

Training of the Practitioners

To assure that members have the knowledge needed, the WGLSC recommends education and training initiatives that would include:

- a. Undergraduate dietetics and dietetic technician education programs should include a basic introduction on licensure and scope of practice and this should be a required component of dietetic internship and coordinated programs.
- b. ADA should develop Webinar presentations on the following topics;
 - Licensure and competition; why licensure is important?
 - Ethics training;
 - Understanding your legal scope of practice;
- c. Develop licensure leader experts to be invited as speakers on ADA Webinars and affiliate annual meetings.
- d. Increase the use of *ADA Times* for education on licensure and scope of practice issues.

Although dietitians have been successful at getting legislatures to enact licensing schemes with practice exclusivity, strict licensing schemes are insufficient to guarantee exclusivity when there are too few practitioners able to exclusively provide those tasks. Lastly, we must recognize the importance of licensure's role as a protective barrier preventing unqualified competitors from performing nutrition care services, and increase our vigilance in reporting unlicensed competition.

States purport to regulate professions to protect their citizens from incompetent practitioners, generally by establishing minimum educational and competency requirements for entry and continued participation in a given profession. The purpose of licensure is to protect the health, safety, and welfare of the public. Because professional regulations act as a barrier to entry and usually provide a mechanism

for removing harmful practitioners from practicing within the state, they effectively restrict the supply of practitioners and often lead to an increase in the cost of services.

Licensure Summary of Statutes to follow

State	Nature of Statute
Alabama	Licensure of dietitian, nutritionist
Alaska	Licensure of dietitian, nutritionist
Arizona	No statute
Arkansas	Licensure of dietitian
California	Title protection for dietitian, RD, and DTR
Colorado	No statute except deceptive advertising
Connecticut	Certification of dietitian
Delaware	Licensure of dietitian, nutritionist
District of Columbia	Licensure of dietitian, nutritionist
Florida	Licensure of dietitian, nutritionist, nutrition counselor
Georgia	Licensure of dietitian
Hawaii	Pending status: Licensure of dietitian approved by state legislature in 1999; regulations and licensure board administration still pending
Idaho	Licensure of dietitian
Illinois	Licensure of dietitian nutritionist
Indiana	Certification of dietitian
Iowa	Licensure of dietitian
Kansas	Licensure of dietitian
Kentucky	Licensure of dietitian; Certification of nutritionist
Louisiana	Licensure of dietitian
Maine	Licensure of dietitian, DTR
Maryland	Licensure of dietitian, nutritionist
Massachusetts	Licensure of dietitian, nutritionist
Michigan	Pending status: Licensure of dietitian, nutritionist approved by state leg., 2008; regulations & licensure board administration still pending
Minnesota	Licensure of dietitian, nutritionist
Mississippi	Licensure of dietitian; Title protection for nutritionist
Missouri	Licensing of dietitian
Montana	Licensure of nutritionist; Title protection for dietitian
Nebraska	Licensure of medical nutrition therapist
Nevada	Title protection for dietitian, LD, and RD
New Hampshire	Licensure of dietitian
New Jersey	None
New Mexico	Licensure of dietitian, nutritionist, nutrition associate
New York	Certification of dietitian, nutritionist
North Carolina	Licensure of dietitian, nutritionist
North Dakota	Licensure of dietitian, nutritionist, RD
Ohio	Licensure of dietitian
Oklahoma	Licensure of dietitian
Oregon	Licensure of dietitian

State	Nature of Statute
Pennsylvania	Licensure of dietitian-nutritionist
Puerto Rico	Licensure of dietitian, nutritionist
Rhode Island	Licensure of dietitian, nutritionist
South Carolina	Licensure of dietitian
South Dakota	Licensure of dietitian, nutritionist
Tennessee	Licensure of dietitian, nutritionist
Texas	Title protection for dietitian
Utah	Certification of dietitian
Vermont	Certification of dietitian
Virginia	Title protection for dietitian, nutritionist
Washington	Certification of dietitian, nutritionist
West Virginia	Licensure of dietitian
Wisconsin	Certification of dietitian
Wyoming	Pending Status: Licensure of dietitian approved by state legislature in 2011, regulations & licensure board administrations pending

Key

Licensure: Yellow

Alabama, Alaska, Arkansas, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, West Virginia

Certification: Green

Connecticut, Indiana, New York, Utah, Vermont, Washington, Wisconsin

Title Protection: Red California, Texas, Virginia

No Statute: Gray

Arizona, Colorado, New Jersey

Pending Status: Pink

Hawaii, Michigan, Wyoming, Nevada

Note: Nevada's licensure bill became law in 2011, but currently their statute includes amendment language that restricts their statute to a Title Protection statute. Plans are underway to work with ADA to gain approval of revised language to be submitted in 2013

State affiliates have experienced organized opposition to licensure in all states in which licensure laws have been proposed. Among the arguments used by those who oppose dietetics licensure are:

- Dietitians lack preparation to deliver wellness and nutrition care outside of the hospital setting
- Licensure creates a monopoly and restricts freedom of choice of provider by the public
- Licensure creates job loss for non-RDs providers (such as alternative providers)
- Licensure requires those who practice to be members of ADA

ADA can achieve a position of strength by developing and executing an initiative that supports licensure and the dietetics profession while adding member value.

Proposed Licensure Initiative Goals:

Goal 1:

- Improve understanding of value of dietetics licensure and the value of the RD for target audiences
 - Target audiences include public, partners/collaborators, members, elected officials,

media

Possible strategies may include:

- Messaging/Communication plan
 - Need specific messaging and tactics for member apathy
- Training

Goal 2:

- **Members take ownership of maintaining the professional standards of dietetics**

Possible strategies may include:

- Mobilize members to report harm (governance/quality management)
- Licensure boards
- Scope creep/ scope of practice

Goal 3:

- **Increase the level of confidence affiliates have in ADA as they face licensure opposition (Appendix J)**

Possible strategies may include:

- Provide dedicated staff
- Integrated quality assurance

Board of Directors:

In considering this initiative, the BOD is asked to review the goals to determine if they are appropriate and comprehensive. The BOD is asked to consider the broad vision of the organization as it relates licensure goals (Appendix C).

Questions:

- *Are there goals that are not identified?*
- *What other strategies help us achieve these goals?*

Overview of Licensure Status

Certification

Indiana's certification board has been proposed for elimination by the governor. A hearing is scheduled for September and the Indiana Dietetic Association and ADA are collaborating on efforts to retain Indiana's certification. The Indiana Dietetic Association plans to submit a licensure bill in January 2012. New York, Washington, and Wisconsin are all seeking licensure.

Title protection

California and Virginia will submit a licensure bill in January 2012. Texas plans to submit a licensure bill in 2013.

HOD Background: Licensure

No Statute

Arizona plans a future licensure effort in 2013 (depending on funding challenges). Colorado will submit a licensure bill in January 2013. New Jersey submitted a licensure bill in 2011 and action was stalled due to the governor's opposition to establishing additional licensing boards. Negotiations are underway with the NJ Department of Consumer Affairs for alternative licensing board/committee status.

Pending

Michigan has developed their rules and regulations which will be considered at a public hearing in 2012. Wyoming has begun the process of developing their rules and regulations. Hawaii's efforts to achieve licensure status have been stalled for ten years, due to administration opposition to administering their statute and finalizing their regulations. Current plans are to connect with their new governor to seek a solution to the agency/board administration questions.

Nevada dietetics licensure became law in 2011, but there are challenges with amendment language. Work has begun on drafting new language to be submitted in the next Nevada legislative session in 2013.

Status of Licensure Efforts with States Seeking Licensure

New York : NYSDA has mobilized their grassroots and have been successful in gaining increased support from state representatives to commit as bill sponsors. This was especially important due to the fact that their Assembly sponsor has indicated that he wants broad support from other potential Assembly sponsors prior to introducing the bill in the assembly. Currently, NYSDA and ADA are working collaboratively to revise the bill language in consideration of both the NY Department of Education standards and Model Practice Act language in coordination with ADA and CDR Guidelines for licensure.

In the meantime, NYSDA has been organizing grassroots systems for increased engagement at the local level. At their annual meeting they held a “Town Hall” meeting on licensure as a way to educate and mobilize their members. ADA staff is providing resources and training on suggested lobbying strategies as they move forward. Next steps include continued efforts to gain the support of outside organizations; with the assistance of ADA staff.

Once bill language is finalized, NYSDA plans to submit their bill in January 2012.

New Jersey: The NJ bill has been stalled in committee due to strong political opposition, particularly from legislators who support the NJ governor’s opposition to increasing regulation and any proposals that potentially increase state budget requests in NJ. The Governor is publicly opposed to any new licensure boards.

The New Jersey Dietetic Association is continuing negotiations with the Department of Consumer Affairs. The DCA proposed an alternative that would provide for certification with oversight by DCA, with no individual certification board. DCA would have the authority to act with duties as a certification board. Currently ADA staff is working with NJ leaders to review this DCA proposal and revised bill language.

Nevada: Nevada’s licensure bill was signed by the governor and became law in 2011. There are significant challenges with the statute language due to a late amendment accepted on the Senate floor. ADA and the Nevada Dietetic Association are collaboratively working to negotiate regulatory language

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and to develop a legislative amendment to their statute to be introduced during the next legislative session in 2013.

Wisconsin: Wisconsin has successfully coordinated extensive structured grassroots support and outside group support. ADA has been working with WI for 3 years on bill language, licensure messaging, Web site development, affiliate testimony, lobbyist negotiations, and key issues regarding bill sponsors.

This year the WI licensure bill was stalled due to the budget battles in the WI legislature. The Wisconsin Dietetic Association continues lobbying and messaging development prior to submitting its bill in January 2012. ADA continues to work closely with WI on lobbying strategies, messaging and gaining support.

California: The California Dietetic Association introduced a licensure bill in February 2011, authored by the Chair of the Assembly Business and Professions Committee. The biggest challenge occurred with opposition of the bill by the CA Nurses Association just prior to the first hearing before that committee. The CA Nurses Association influenced the author to withdraw the bill although the author is still very supportive of CDA’s efforts towards licensure. CDA and the CA Nurses Association plan to convene this

fall to develop revised bill language acceptable to both groups for submission in January 2012.

The affiliate has made progress in mobilizing its grassroots support and the support of outside groups. CDA has worked hard to educate its own membership as well as the CA state legislators by sending monthly nutrition e-mail messages to the legislators and conducting personal visits.

Colorado: The Colorado Dietetic Association plans to submit a licensure bill in January 2013. ADA and the Colorado Dietetic Association are collaboratively working on lobbying strategies and writing the bill for submission in January 2013.

Virginia: The Virginia Dietetic Association plans to submit a bill in January, 2012. ADA staff and VDA worked collaboratively on the lobbyist selection, member surveys and education, and on drafting the bill.

Washington: As Washington prepares for a licensure move in 2012, ADA staff flew to Washington twice for licensure leadership planning meetings and to speak at the annual meeting. At the annual meeting, ADA staff met with the licensure leadership to assist them in writing their bill. Meetings were held on Board unity, timeline strategy, bill sponsors and Sunrise Review application language. ADA is working collaboratively with WSDA in preparation for submitting a licensure bill in January 2013.

Indiana: Since Indiana's certification statute is under review, IDA and ADA's collaborative efforts are focused on retaining Indiana's certification. The governor has posted dietetics certification on a list of boards that may be cancelled due to budget/administrative considerations. A hearing is planned for September to review the status of the certification board. IDA plans to submit a licensure bill in January 2012.

Previous Discussion by the House of Delegates Regarding Market Place Relevance

During the Market Place Relevance Dialogue Session that took place during the Spring 2011 Virtual House of Delegates meeting, recommendations were created on how Registered Dietitians and Dietetic Technicians, Registered could create more opportunities and be more nimble and proactive. Licensure was identified as an opportunity (Appendix D).

Licensure Resources for Affiliates/Members

ADA's Policy Initiatives & Advocacy Team has provided support and resources to affiliates needing support in regards to licensure and members with questions regarding this issue (Appendix E). Many of these resources are available ADA's website or at the request of an affiliate. Resources available by request are provided along with assistance by State Government Relations staff that has experience with licensure across the nation.

Licensure – an ADA Priority

ADA continues to work with affiliate licensure leaders to achieve success in obtaining licensure and in protecting scope of practice for existing licensure statutes. In 2009, ADA convened a Licensure Work Group to provide analysis from members with expertise on licensure issues. The Work Group developed the Model Practice Act, which is currently the model for all licensure bills. ADA has reconvened this licensure work group this year to continue the ADA's licensure goal. The Licensure Work Group Charge is to:

- Provide oversight and review of licensure bill language
- Assist PIA staff in working with affiliates on lobbying strategies
- Make recommendations to the PIA staff and the LPPC regarding licensure strategies and licensure bill language; and
- Make recommendations to the PIA staff and the LPPC regarding ADA positions on licensure related issues and bill language

This year ADA offers a monthly Licensure Forum to add to the opportunity for members' dialogue about current issues facing the states related to licensure efforts and scope of practice protection. Licensure and public policy panel leaders contribute to the discussion and offer examples of success through their best practices used in their state.

ADA staff provides a licensure toolkit to all states seeking licensure and sometimes travels to states seeking licensure to assist with development of bill language, provide guidance on lobbying strategies and develop appropriate messaging. ADA often assists with selection of the lobbyist and provides guidance on how to effectively work with the affiliate lobbyist for licensure success.

Summary

It is important that dietetics licensure acts maximize the registered dietitian's unique skills and expertise in the scope of practice. All registered dietitians and dietetic technicians, registered need to be mindful in these competitive times that other practitioners are seeking expansion of their services, creating "scope creep".

The following is an excerpt from a website claiming that ADA is a "monopoly". The website continues to provide information about multiple states negatively portraying ADA and our members



The American Dietetic Association's Monopoly Continues to Grow—But You Can Stop It Cold!

April 12, 2011

New bills have been introduced in a number of states that will give the ADA a monopoly over the practice of nutritional therapy—these are the people in charge of the wonderful hospital food. Please take action in your state to stop this power grab and ensure consumer choice!

The American Dietetic Association (ADA) has sponsored legislation in over 40 states. These bills lump dietitians and nutritionists into one licensing scheme, and [require nutritionists to complete a dietitian program in order to practice nutritional therapy](#). Even if the nutritionist holds a Masters or a PhD in nutrition, the nutritionist is still required to complete registration through ADA in order to keep practicing. This is the organization that [lists among its corporate sponsors](#) soft drink giants Coca-Cola and PepsiCo, cereal manufacturers General Mills and Kellogg's, candy maker Mars, and Unilever, the multinational corporation that owns many of the world's consumer products brands in foods and beverages.

In some states, individuals are even prohibited from using the words "nutritionist" and "nutritional care." Such legislation impedes an individual's right to access highly qualified nutritional therapists of their choice, and prohibits hundreds of qualified practitioners from providing nutritional therapy.

Nutritionists and dietitians differ in important ways. In general, nutritionists are health practitioners with comprehensive knowledge of how nutrition impacts the whole body focusing on medical nutrition therapy, metabolism and biochemistry, and work primarily in private practice settings conducting one-on-one nutrition counseling. Nutritionists practice an integrative approach to medicine and concentrate on prevention and treatment of chronic disease. Dietitians, in general, are experts in what passes for nutrition science today, much of it often woefully out of date, with training focusing on institutional diets and food service management—developing diets for hospital patients, school food service programs, and nursing homes. Dietitians can provide individualized counseling on diet and disease and there can be an overlap in the type of work each profession practices.

[As we reported previously](#), the Michigan Board of Dietetic and Nutrition voted to make the ADA its sole credentialing arm. We are still watching the rule-making process to see if we can make any changes. We are hoping, at a minimum, to force the board to recognize other credentialing bodies.

And Wyoming recently passed a bill ([SF0093](#)) creating a board and licensure for dietitians. They define "dietetics" as including the nutrition care process and medical nutrition therapy, and specify the ADA as the credentialing organization.

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.

The WGLSC recommends the bill language contain the following components:

Definitions of key terms:

- Dietetics
- Medical nutrition therapy
- Nutrition assessment
- Direct Supervision
- General non-medical nutrition information
- Nutrition care services
- Nutrition counseling
- Nutrition care process
- Nutrition diagnosis
- Nutrition intervention
- Nutrition monitoring and evaluation

Scope of practice language:

The WGLSC agreed that the following definition of dietetics should be included in the scope of practice section of proposed licensure bills:

Dietetics is the integration and application of principles derived from the sciences of food, nutrition, management, communication, and biological, physiological, behavioral, and social sciences to achieve and maintain optimal human health.

Scope language should also 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.

The Nutrition Care Process consists of four distinct, but interrelated and connected steps:

- Nutrition Assessment
- Nutrition Diagnosis
- Nutrition Intervention
- Nutrition Monitoring and Evaluation

- a. Nutrition assessment, development of nutrition-related priorities, goals, and objectives, and establishment and implementation of nutrition care plans;
- b. Provision of nutrition counseling and education as components of preventative, curative and restorative health care;
- c. Provision of medical nutrition therapy;
- d. Evaluation, education and counseling related to food-drug and drug-nutrient interactions.

- e. Development, administration, evaluation, and consultation regarding appropriate nutrition quality standards in food services and nutrition programs;
- f. Conducting independent nutrition research or collaborating in nutrition research intended to demonstrate nutrition outcomes or develop nutrition recommendations for individuals, specific groups, or the general public;
- g. Supervision of dietetic technicians, dietetic students, and dietetic interns in the provision of nutrition care services;
- h. Nutrition case management and referral to appropriate nutrition resources and programs.

Rationale/Guidance:

The scope of practice defines specifically those areas for which there is the greatest potential for public harm and need for regulation and for which the licensed persons are uniquely prepared.

Licensure Boards

Composition of licensure boards:

The majority of board members should be practicing dietitians and there should be at least one public member. The number of dietitians serving on the board should be proportional to the type of licensees.

Connection between boards and affiliates:

The WGLSC agreed that appointing a board liaison may enhance the connection between the affiliate and the licensing board. The WGLSC decided to leave this option up to each affiliate.

Educational requirements:

Affiliates should consider the option of requiring a continuing education course on jurisprudence for licensed practitioners.

Professional memberships:

The WGLSC discussed membership options for dietetic licensing boards, including the Council on Licensure, Enforcement and Regulation (CLEAR) or another association for regulatory agencies. The WGLSC discussed the possible benefits for licensing boards, and there was consensus to leave the choice to the affiliates.

Essential components:

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, a defined scope of practice, and title protection.

Dietitian/nutritionist (LDN):

Discussion included potential consideration of licensing the dietitian/nutritionist (LDN) in order to be inclusive, while maintaining the required standards. The WGLSC also discussed the possibility of licensure statutes that would separately license dietitians and nutritionists within the same statute. The consensus was that this would be confusing to the public.

Reciprocity:

The WGLSC discussion on potential reciprocity language and issues related to telehealth concluded with a consensus that the Model Practice Act should include a reciprocity clause. The WGLSC suggested that reciprocity be provided for licensed dietitians/nutritionists from other states if the applicant is registered with CDR or has successfully completed the CDR exam.

Provisional permits:

The WGLSC had consensus to waive the exam requirement and may grant a provisional license to any applicant who has not taken the CDR dietitian registration exam but is a dietitian registered with CDR or has met the educational requirements of CDR and completed an approved dietitian practice experience.

Penalties:

The WGLSC discussed terminology for penalties and the consensus was that the Model Practice Act includes general provisions for violations of the licensure statute, as well as provisions for discipline of licensees when needed.

Appendix C

Board of Director's May 2011 Discussion on Proposed Licensure Initiative Goals Notes

In considering this initiative, the Board of Directors was asked to review the *Proposed Licensure Initiative Goals* to determine if they are appropriate and comprehensive. The BOD was asked the following questions to direct their discussion in considering the broad vision of the organization as it relates licensure goals.

Questions:

- *Are there goals that are not identified?*
- *What other strategies help us achieve these goals?*

The following notes were collected on flip charts during the BOD's discussions and are in rough format.

Goals:

- Identify unlicensed activity
- Publish malpractice situations
- Need to take ownership –lack of reporting in Code of Ethics
- Launch unlicensed activity, search & reporting campaign
 - during NNM by affiliates.
- Train State Investigators to report unlawful practice
- Develop PSA's and billboards to educate consumers
- Consider changing language to protect licensure as well
- Identify our thresholds or trade offs
- Impact of licensure regulation on practice?
- What is the value of licensure for RDs who don't practice in clinical settings?
- What are the risks of NOT maintaining licensure?
- Should we have a goal that prepares people to be experts in licensure?
- Students are taught/expected to be licensed?
 - Confusion Re: variations from State to State: LD, CD
- Should be considered an ongoing thing
 - Need to update licensure laws as practice changes
- Capture horror stories
- Feel empowered/responsible
- Talking to other Healthcare Professionals @ importance of referring to a licensed professional
- Target training on media/communication skills to high risk States
- Regular reports related to States that are high risk
- Share tactics of what worked
- Teach them how to anticipate/answer opponents' concerns
- ID opportunities to address funding issues for affiliate to pursue/maintain licensure.

- Update disseminate information regarding the implications of telehealth to licensure
- Provide regular updates related to state licensure (both at State and National level)
- Increase the number of licensed RDs to (“X”) in States that have licensure
- To seek licensure for all States

- Clarify why & how

Additional Goals Needed

- Split out reporting harm (So there are set strategies and tactics)
- Training for state investigators
- Add enhance/implement/train affiliates to work/communicate with licensure boards
- Strategic Plan for State to achieve Licensure
- Identify additional organizations to advocate for dietetic licensure
- Develop strategies related to sunset.

Funding Goals:

- Grants from CDR
- Regional contracts for lobbyists
- Allocations from affiliate assets (e.g. Recommended percentage)
- Affiliate fundraising activities
- Develop fact sheets related to costs to pursue/maintain licensure (specific to each State)
- Combine roles: i.e. Exec. Director/lobbyist
- Create ADA wide funds for lobbyist/State licensure support (dues or donations)
- “Protect the Public” fund

Strategies for Goals

- Develop an ADA-wide messaging/communications plan & design for each audience
- Develop & increase training on licensure
- Develop a tactical plan for each target market
- Define (more clearly) the message of competitors
- Become active in Health Care Reform in your State
- Develop more training for members to improve the understanding of protecting licensure
- Extend the objective for a measurable outcome
- To assist affiliates to develop financial resources for licensure efforts
- Develop & communicate best practice to all affiliates

Licensure Comments

- Re: improving understanding (members’) about licensure: FNCE?
- HOD dialog coming
- Suggestion: inviting Board Chairs of licensure group
- Tap into listserv folks offering articulate comments
- Other healthcare groups → How did they get to acceptance of “this is just what we do”

Post Small Groups Discussion/Comments

- Cost of doing business → reciprocity across states (clarification the law follows the patient)
- Targeting specific legislators
- Texas licensure Board not communicating even though they have the money.
- Boards might not be communicating why licensure is important –need follow up, accountability
- Telemedicine & P.H.R.S are here so crossing state lines electronically is important for our Dietitians

Appendix D

Market Place Relevance Threats and Opportunities Consolidation by HLT

Spring 2011 HOD Virtual Meeting – Saturday, April 30

Threats	Opportunities
Competition Other Nutrition Groups Other Professionals Other non-professionals	Ability to Distinguish Our Profession
Characteristics of the Profession Identity Crisis Complacent/Apathy (broadly)	Branding and Intensive Marketing Campaign
Skills Lack Of Business And Entrepreneurial	Transferring Skill Sets to New Opportunities
Technology	Technology
Regulatory Agencies	Getting RD/DTR into Federal Regulations
RD Not Present or Involved in the “decisions” Made Regarding Policy	Public Policy and Advocacy
Licensure Weak Licensure Laws	Build Skills Outside Traditional Training Model
Scope Creep	Bring Food Back into the Profession (RDs Own It)
Health Care Changes	Healthcare reform
Traditional RD Education	Education Optimization – Seamless Process From Student to Practice
Lack of Outcomes	Supporting Growth of Career Levels
EAL Limited Topics	Individual Lobbying
Capacity When RD/DTRs are Valued for Their Services	Public is Interested in Nutrition
	Multidisciplinary Team Involvement; Interdisciplinary Practice; Medical Home

HOD Backgrounder: Licensure

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Appendix E

ADA Website Resources

Dietetics Practitioner State Licensure Provisions

- Link: <http://www.eatright.org/Members/content.aspx?id=8848> > Detailed Chart: State Licensure Provisions
- Pathway: www.eatright.org > Public Policy > State Affairs > Detailed Chart: State Licensure Provisions

Questions and Answers on Professional Regulation

- Link: (<http://www.eatright.org/Members/content.aspx?id=8860>)
- Pathway: www.eatright.org > Public Policy > State Affairs > Why Professional Regulation? > Questions and answers on professional regulation

1. Why should dietitians and nutritionists be licensed?

Licensing of dietitians and nutritionists protects the public health by establishing minimum educational and experience criteria for those individuals who hold themselves out to be experts in food and nutrition. The state has an obligation to protect the health and safety of the public and

licensing of dietitians and nutritionists is consistent with this obligation.

2. Why haven't states licensed dietitians in the past?

Unfortunately, the vital link between nutrition and health has only recently received the attention it deserves. In addition, science has proven that nutrition plays an important part in the prevention and treatment of many serious diseases. Dietitians and nutritionists are now more recognized as healthcare professionals because of their educational background and experience. This is indicated by the fact that since 1984, 41 states and the District of Columbia have passed laws recognizing dietitians and nutritionists as nutrition experts.

3. How has the public been harmed by states not licensing dietitians?

With the explosion of interest in healthy eating and nutrition, consumers have been faced with a dizzying array of products and information. The public deserves to know that the information being given by "experts" is based on science and is being given by individuals with appropriate education and experience. This is especially true of individuals who have medical conditions, which could be adversely affected by improper nutrition counseling. Several states have documented cases of unqualified individuals giving improper nutritional advice, which has harmed patients.

Unfortunately, many cases of healthcare fraud are never reported. A Congressional study on Quackery noted that state offices on aging ranked healthcare fraud (quackery) first as the area of abuse of most concern and with the greatest impact on seniors. The report also acknowledged that the great majority of cases are never reported. (Quackery: A \$10 Billion Scandal; US Government Printing Office Pub. # 98-135; pp.176-178)

4. What are the minimum educational requirements for a dietitian?

In order to be recognized as a dietitian or nutritionist, a person should possess a baccalaureate or higher degree in nutritional sciences, community nutrition, public health nutrition, food and nutrition, dietetics or human nutrition from a regionally accredited college or university and satisfactorily complete a program of supervised clinical experience approved by the Commission on Dietetic Accreditation of the American Dietetic Association.

5. Would licensure prohibit anyone except dietitians from giving nutritional advice?

No. Licensure would not affect anyone that simply describes the nutritional value of products nor would it affect other healthcare professionals. It would, however, provide recourse for victims of unqualified and unscrupulous individuals dispensing improper advice.

6. Aren't too many professions and occupations already licensed by states?

It is the obligation of state legislatures to determine which professions and occupations should be licensed. A compelling case can be made for licensure of dietitians and nutritionists as healthcare professionals.

7. Isn't licensure an attempt to monopolize the nutrition industry?

No. The first obligation of registered dietitians and nutritionists is to serve the public, not sell products or services. Licensure is necessary because the public deserves to know which individuals have the educational background and experience to give nutritional advice. The health food and dietary supplement industry is booming, even in states that have had licensure for many years. The key issue in licensure is accountability. The monopolization argument is a desperate attempt to obscure the real issues of licensure.

8. Will licensing reduce competition or result in costlier services?

No. Once again, licensure is not an attempt to control any market. Licensure allows the public to know which individuals are qualified by education and experience to provide nutritional services. If unqualified individuals disseminate harmful nutrition information, licensure allows the state to take action on behalf of the public against those unqualified individuals. Competition among open and

honest individuals with the public's health and safety foremost in their minds will continue to grow and the public will continue to be well served by it.

9. Isn't it true that if a physician refers me to a dietitian for prevention or treatment of a disease, I am reimbursed for it regardless if the dietitian is licensed?

Many insurance companies require licensure to reimburse healthcare professionals. They require licensure so that unqualified providers dispensing questionable advice are not reimbursed. If a state doesn't license dietitians, services may not be covered regardless of whether a physician orders them.

10. Won't licensure cost the state a lot of money?

No. Fees will provide most of the revenue. Many states have approved legislation or rules to make licensure revenue neutral.

Exhibit E

State Regulatory Regime Analysis

Exclusive Scope RD only or effectively RD only (18)

[AL, FL, GA, IA, KS, LA, ME, MI, MO, MS, MT, NE, NC, ND, OH,, RI, TN, WY]

Exclusive Scope for RD and some Nutritionists (6)

DC, DE, IL, MD, NM, SD,]

Title Protection for RD only (15)

[AR , CA, HI, ID, IN, KY, NH, NV, OK, SC, TX, UT, VT, W. VA, WI]

Title Protection RD and some Nutritionists (9)

[AK, CT, MA, MN, NY, OR, PA, VA, WA]

No regulation (3) [AZ, CO, NJ,]

Center for Nutrition Advocacy 3/8/14

Exhibit F

Emails from NC Dietetic Association via North Carolina Licensing Board

FYI

From: [NC Board of Dietetics and Nutrition](#)
Sent: Thursday, April 11, 2013 4:49 PM
To: noreply@listserv.ncbdn.org
Subject: FW: New Bill Introduced - House Bill 676

Licensees:

As you may or may not be aware, a new bill was filed yesterday proposing to eliminate the Dietetics Practice Act. At present, the North Carolina Dietetic Association (the NCDA) is working with its lobbyist to gain a better understanding of why this new bill was put forth. We did not send out a notice yesterday as we did not know much more than that this bill was filed, and we did not want to invite a panicked response. If you are not an NCDA member, please see the email below that was sent out yesterday by their office.

Once the NCDA has more information/direction to share, we will forward this information to all licensees.

Sincerely,

The North Carolina Board of Dietetics/Nutrition

From: NCDA [<mailto:info@firstpointresources.ccsend.com>] **On Behalf Of** NCDA
Sent: Wednesday, April 10, 2013 11:41 AM
To: info@ncbdn.org
Subject: New Bill Introduced - House Bill 676

House Bill 676

A new bill was filed last night, [House Bill 676](#) "Eliminate Dietetics/Nutrition Board".

Our lobbyists are on top of this. We believe this bill is a matter of misinformation having been provided to these Representatives. We are working on making sure they have the correct facts and do not need members to contact their legislators yet.

The bill currently only has three sponsors. Two of the primary sponsors are in the minority party and the third bill sponsor is chair of the Regulatory Reform Committee.

Please be patient as our lobbyists work to find out what the push behind this bill is and whether Republican leadership plans to put it to rest since they already voted on this issue with SB10. This bill was just filed last night and isn't scheduled yet to be heard for its first reading.

We have time and we need our strategy to be an informed one. Please do not contact your Representatives yet unless you live in the district of one of the three bill sponsors. If you do live in their districts, please refer to the NCDA website page on the [facts about licensure](#) when contacting your legislators.

We will provide you with updates as soon as we have them.

Best Regards,

Anna Lockhart
Executive Director

Clicking the "Refresh" button usually resolves slow uploading of hyperlinks.

1500 Sunday Drive,

[Forward this email](#)

This email was sent to info@ncbdn.org by info@eatrightnc.org | [Update Profile/Email Address](#) | Instant removal with [SafeUnsubscribe™](#) | [Privacy Policy](#).
FirstPoint, Inc. | 225 Commerce Place | Greensboro | NC | 27401

From: NC Board of Dietetics and Nutrition <<mailto:noreply@listserv.ncbdn.org>>

Sent: Tuesday, February 12, 2013 12:07 PM

To: noreply@listserv.ncbdn.org

Subject: Clarification regarding Senate Bill 10

Dear Licensees:

We apologize for the short email last week which only included the bill, SB10, without further information. At the time we sent this to you things were moving quickly, and we did not have more information than what the bill indicated. The North Carolina Board of Dietetics/Nutrition (NCBDN) was shocked to see this bill, which called for the elimination of licensure for NC dietitians/nutritionists. The NCBDN is not permitted by law to lobby, thus under guidance from our legal counsel, we sent out last week's email to inform, rather than to incite action.

Please be aware, if you are not already, that the North Carolina Dietetic Association (NCDA) is very conscious of this bill and its consequences. The NCDA and concerned licensees took significant action last week to ensure the bill did not pass with language

to eliminate licensure for dietitians/nutritionists. However, the most recent amendment to the bill still contains, in the Board's opinion, ill-advised language which would significantly alter the composition and terms of the Board. The bill with the current amendment passed through the Senate and will be read and considered by the House. Should you have specific questions regarding SB 10 and its impact on licensure, we encourage you to contact the North Carolina Dietetic Association at [919-861-4529](tel:919-861-4529) <tel:[919-861-4529](tel:919-861-4529)> or www.eatrightnc.org<<http://www.eatrightnc.org>> .

Again, we apologize for the lack of information last week. Should you have specific questions about your license, please feel free to contact us at info@ncbdn.org or [919-228-6391](tel:919-228-6391) <tel:[919-228-6391](tel:919-228-6391)> .

-The NC Board of Dietetics/Nutrition



Exhibit G (see highlighted section)

Posted:
Ltb

CANNON BUILDING
TELEPHONE: (302) 744-4500

861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE

FAX: (302) 739-2711
WEBSITE:
WWW.DPR.DELAWARE.GOV

DIVISION OF PROFESSIONAL REGULATION

PUBLIC MEETING MINUTES:	Board of Dietetics and Nutrition
MEETING DATE AND TIME:	Friday, February 8, 2013 at 1:30 p.m.
PLACE:	861 Silver Lake Boulevard, Dover, Delaware Conference Room B first floor of the Cannon Building
MINUTES APPROVED:	

MEMBERS PRESENT

Elizabeth Tschiffely, L.D.N., Chair
Maryann Eastep, L.D.N., Secretary
Patricia Hawkins, Public Member
Christy Wright, Public Member

MEMBERS ABSENT

Carol Giesecke, L.D.N., Vice Chair

DIVISION STAFF/DEPUTY ATTORNEY GENERAL PRESENT

Bryan Smith, Deputy Attorney General
Latonya Brown, Administrative Specialist

OTHERS PRESENT

Donna Trader, DDA
Natalie McKenney, DDA
Deanna Rolland, DDA
Leah Palmer, Student
Michell Fullmer, DDA
Duncan Willie Jr, Student
Marianne Carter, DCHP

CALL TO ORDER

Ms. Tschiffely called the meeting to order at 1:36 pm.

REVIEW OF MINUTES

The Board reviewed the minutes from the November 9, 2012, meeting. A motion was made by Ms. Eastep, seconded by Ms. Tsciffely, to approve the minutes, with the amendment of election of the officers motion that was made by Ms. Giesecke, not Ms. Eastep. The motion carried unanimously.

Board of Dietetics and Nutrition
Minutes – February 8, 2013
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UNFINISHED BUSINESS

None

NEW BUSINESS

Ratification of Licensure

A motion was made by Ms. Tsciffely, seconded by Ms. Eastep, to ratify the following CDR applicants who had been granted a license by the Division of Professional Regulation: Lindsey Hickman, Elisabeth Jones, and Crystal Bouchard. The motion carried unanimously.

A motion was made by Ms. Tsciffely, seconded by Ms. Eastep to table the ratification of Scott Schreiber pending further review of his work history and will be looked at during a special meeting on March 8, 2013. The motion carried unanimously.

COMPLAINT STATUS

35-01-12 Open
35-03-12 Open
35-04-12 Open
35-05-12 Open
35-06-12 Open
35-07-12 Open
35-08-12 Open
35-09-12 Referred to AG for Prosecution

REVIEW OF APPLICATIONS

None

CORRESPONDENCE

None

OTHER BUSINESS BEFORE THE BOARD (for discussion only)

Discussion of Governor Markell Executive Order 36 (DAG)

Ms. Brown presented the Board with the Governor Markell signed Executive Order 36 which was elaborated by Mr. Smith. It is requested that all Boards try to streamline and eliminate outdated or unnecessary regulations. Mr. Smith advised that all the Board members read and review the regulations and see if anything is out of date and needs to be streamlined. Mr. Smith also advised that the public comment period ends on March 1, 2013, as of yet no public comments have been received.

Post Renewal Audit

Ms. Ide brought to the Board's attention that when the licensees renewed in 2011, no continuing education audits were conducted. There is a 2013 renewal, we are not going to go back and do the 2011; it will simply be a skipped period. Ms. Tschiffely stated that there was an audit in 2011 because she was one of the licensees that were audited. She also stated that she can provide her CEUs if needed. Ms. Ide advised her that she can submit them. Ms. Ide also advised the Board that they have to consider what percentage to audit. Ms. Tschiffely made a motion to audit 25%. Ms. Eastep made a motion to audit 15%, seconded by Ms. Wright. The motion carried unanimously.

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Scott Schreiber Ratification

Ms. Eastep made a motion, seconded by Ms. Tschiffely, to amend the agenda in order to discuss the ratification of Scott Schreiber's application. The Board and the members of the public discussed concern over Mr. Schreiber's work experience. It was repeatedly stated that his application was tabled at the previous meeting for further review of his detailed nutritional work experience.

Status of Licensures online

Ms. Eastep brought to the Boards attention that when she was looking in the website to check someone's licensures status, she noticed there was a lot of pending statuses. Ms. Eastep questioned how long they will remain in pending status before we remove them. Ms. Ide responded that the rule of thumb is typically one year in house but the application usually states that in 6 months it will be abandoned. She also stated it would have to be an internal file clean up, going through all the paper files and searching each one in order to remove them. Ms. Eastep stated that it was not many but she was concerned because the nursing home administrators that she works with was looking up someone's license and it was in pending status and had been in pending status for a while. She informed us that the administrators will hire someone in a pending status, when they probably shouldn't be hired. Ms. Ide informed Ms. Eastep that she will bring this to the Department's attention.

PUBLIC COMMENT

Donna Trader, Delaware Dietetic Association, provided a copy of the meeting minutes from February 13, 2009, and read them verbatim. She read the License Issuance Authority section under New Business, which sums up the process of approving and issuing licenses through the proper channels. She also stated that a motion was made by Ms. Hawkins, seconded by Ms. Tschiffely to give DPR the authority to approve CDR applicants only. Ms. Trader then stated her concerns for Dr. Schreiber being licensed, and feels that it should not have been approved without going through the proper channels of the board as it is dictated in the Delaware Code. She also stated that she is concerned about the approval process of Dr. Schreiber's application and that it was tabled according to the meeting minutes. She, along with several others from the DDA, questioned his qualifications. Ms. Trader then went on to quote 3804 under section C in the License Law, where she referred to Dr. Carol Giesecke, who has missed several

consecutive meetings according to the past meeting minutes. Including today, Dr. Giesecke had a total of four absences in the last year.

Ms. Tschiffely stated that in the latter part of 2009 (not quoting verbatim) there were three public hearing previously where the public and board got together to discuss the inclusion of CBNS as equivalent to CDR. Ms. Tschiffely stated that the February 2009 meeting pre-dated those public hearings and the time when CBNS was adopted by that board to allow that CBNS certification to be help in equivalence. Marianne Carter, of DCHP, stated that regardless of the exam that's taken you still need to submit proof of 900 hours of supervisory practice. That's the issue; the hours of supervision were not acceptable and were not reviewed by the board. Ms. Carter also stated that as a tax payer and licensee she feels that if DPR erroneously licensed Mr. Schreiber, there

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needs to be a process and he should not be allowed to be practicing as a licensed practitioner. Ms. Carter wanted to know if there was a process of annulment. Mr. Smith, DAG, stated that there is a process and he is entitled to a hearing before the license is annulled. Ms. Tschiffely also stated that she and Ms. Eastep discussed earlier that because the rules and regulations make equivalent to CBNS, we never asked a CDR applicant to prove the 900 hours. Ms. Eastep and Ms. Tschiffely both stated that it is not required from the law. Ms. Tschiffely said that her understanding at the present is that we are "equivalating" CBNS and CDR. Ms. Eastep stated that Dr. Schreiber's CBNS is ok to be accepted because he is applying under examination and that is not the issue. She wants to look more at the accredited college and make sure that he meets all the requirements of the 900 hours, and show verification of the passing exam. The board verification should be sent directly from CBNS and she stated that these are things that she is unclear about. Ms. Tschiffely feels strongly that the DPR's decision to license Mr. Schreiber is justifiable. Catherine Simon offered the Board the option for DPR to contact Dr. Schreiber to have him submit additional documentation to prove he has at least 900 hours of nutrition-specific experience. Ms. Tschiffely made a motion to submit further documents seconded by Ms. Hawkins. Ms. Eastep abstained from the vote; otherwise the motion carried. Michelle Fullmer, DDA, stated that specific detail of hours have to be provided.

NEXT SCHEDULED MEETING

The next meeting will be held on Friday, May 10, 2013 at 1:30 p.m.

ADJOURNMENT

There being no further business, a motion was made by Ms. Tschiffely, seconded by Ms. Eastep to adjourn the meeting. The motion carried unanimously. The meeting adjourned at 3:05pm.

Respectfully submitted,



Latonya Brown

BOARD OF DIETETICS/NUTRITION

4/15/2012

 Academy of Nutrition and Dietetics

Reporting Harm
Who, What, When, Where, Why and How?

Kay Mavko
Chair of Licensure Workgroup
Former Executive Director,
Ohio Board of Dietetics
State Regulatory Specialist, Ohio Dietetic Association

 Academy of Nutrition and Dietetics

Who Should Report Harm?

- Anyone from the public can report violations / harm
- Health professionals who understand dietetic practice and want to protect their scope of practice – the RD
- If you don't report who will?
- Dietetics licensure statutes were written to license you!
- Dietetics licensure statutes exist to protect the public
- You are the professional with the responsibility to report

2

 Academy of Nutrition and Dietetics

What Should be Reported?



3

4/15/2012

 Academy of Nutrition and Dietetics

Thoughts for Consideration

Do you need to totally know your law forward and backward?

No – but a basic awareness of title restrictions and scope of practice is important

Be aware of unlicensed activities in your community

Observe and listen to your instincts!

4

 Academy of Nutrition and Dietetics

Examples of incidents of harm

Person calling herself RD, LD was recommending raw food diets to clients over internet and offering nutritional counseling and medical nutrition therapy to cure specific diseases (DM, heart disease, allergies,)

No nutrition credentials, was a fitness model, self taught raw foodist.

5

 Academy of Nutrition and Dietetics

Examples of incidents of harm

Licensed dietitian (1) loaned over \$2,000 to a patient and reflected the balance of the loan on bills for professional services rendered; and (2) failed to present a patient with a complete accounting of her bills.

6

4/15/2012

 Academy of Nutrition and Dietetics

When Should violations and Harm be Reported?

- Today
- Tomorrow
- And each day that violations or incidents of harm occur
- Licensing Boards need continual incidents to investigate



7

 Academy of Nutrition and Dietetics

When is it too late to report ?

- When your governor has put your licensing board on the elimination list
- When a competing profession decides to expand their scope of practice to include nutrition assessment and counseling
- When your state decides to seek licensure and you are preparing the testimony for the public hearing before your state legislative committee

Don't wait until it is too late



8

 Academy of Nutrition and Dietetics

Where Do You Report?

To Your State Licensing Board



We should not report to

Academy staff

➤

Friends

➤

State Legislator

9

4/15/2012

Why Should You Report ?  Academy of Nutrition and Dietetics

Without reports of violations and harm ...

- No investigations
- No discipline
- Few Board actions
- Value of licensing Board gets questioned
- Board's Existence is diminished!
- Sunset can occur!

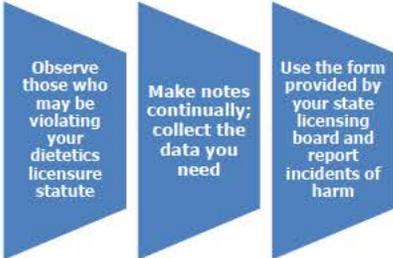


10

Why Report ?  Academy of Nutrition and Dietetics

- Because you are required to
- If RD's 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!

How to Report  Academy of Nutrition and Dietetics



12

Ten benefit categories (per the ACA):

- 1) Ambulatory patient services
- 2) Emergency services
- 3) Hospitalization
- 4) Maternity and newborn care
- 5) Mental health and substance abuse services
- 6) Prescription drugs
- 7) Rehabilitative and habilitative services and devices
- 8) Laboratory services
- 9) Preventive and wellness services and chronic disease management
- 10) Pediatric services, including oral and vision care



Where is nutrition???

4/15/2012

 Academy of Nutrition and Dietetics

HHS  States

7

For More Information and Guidance

Marsha Schofield, MS, RD, LD
Director, Nutrition Services Coverage
mschofield@eatright.org

Juliana Smith
Director, State Government Relations
jsmith@eatright.org

Pepin Tuma, Esq.
Director, Regulatory Affairs
ptuma@eatright.org



Exhibit I



DIETETIC LICENSURE

WHAT IT MEANS FOR YOU
AND THE PROFESSION

MARCH 2013

LEAR

Academy & CDR conference...

Introduced
Liaison to
Licensure
Board Position

Emphasized
Reporting Harm
and Statute
Violations

Often overlooked aspect of protecting our profession

WHY SHOULD LICENSURE BE A PRIORITY?

Our current environment demands it!

"Scope creep"

**Other health
groups are
vocal**

**Healthcare
Reform**

**State budgets
are limited**

**IF WE WERE TARGETED, HOW CAN WE
PROTECT OUR LICENSURE?**

Show Activity of Board!

Prove roll in protecting public

Includes:

**Reports of harm and violations
of statute investigated and
disciplinary action taken
according to the statute**

Stops unlicensed practice

OUR PROFESSION NEEDS YOUR ACTIVE PARTICIPATION!!!

If you are counseling or seeing patients ask, “Have you sought nutrition advice in the past? From whom? Where? Did you feel harmed?”

If they say yes, direct them to the complaint reporting form and help them to complete and submit it

Ask your aunts, uncles, cousins, friends and neighbors the same questions, and to report harm!



Exhibit J

The Georgia Board of Examiners of Licensed Dietitians met on February 17, 2012, via teleconference at the Professional Licensing Boards Division of the Secretary of State located at 237 Coliseum Drive, Macon, Georgia.

MEMBERS PRESENT

Jessie Wright, MS, RD, LD, Chair
Joan Fischer, PhD, RD, LD
Page Love, MS, RD, LD Tracey
Neely, MS, RD, LD
Nancy Walters, MMSC, RD, LD, Cognizant
Frances Cook, MA, RD, LD

MEMBERS ABSENT

Dee Dee Williams, Consumer Member

STAFF PRESENT

James Cleghorn, Executive Director
Wylencia Monroe, JD, Assistant Attorney General

Ms. Wright called the meeting to order at 10:04 a.m. on Friday, February 17, 2012. A quorum to conduct disciplinary matters was determined to exist.

APPROVAL OF BOARD MINUTES

Ms. Walters moved to approve the December 2, 2011 board minutes as corrected. Ms. Fischer seconded the motion and it carried unanimously.

RULES HEARING – 157-2-.01, “DEFINITIONS. AMENDED.”

Ms. Fischer voted to adopt rule 157-2-.01. Ms. Love seconded the motion and it carried unanimously.

157-2-.01 Definitions. Amended.

(1) For purposes of O.C.G.A. 43-11A-9(1) a major course of study shall mean:

(a) A program granted accreditation or approval by the Commission on Accreditation for Dietetic Education (CADE) of the American Dietetic Association (ADA); or

(b) Upper division courses in human nutrition, food and nutrition, dietetics, food systems management, nutrition education or a combination thereof determined by the Board to be greater than or substantially equal to a Commission on Accreditation for Dietetic Education (CADE) accredited or approved program. The earned degree does not need to be in these areas.

(2) For purposes of O.C.G.A. 43-11A-9, “Supervised Experience” component of dietetic practice shall consist of 900 hours of supervised practice/experience under the supervision of a state licensed practitioner or a registered dietitian. The acceptable routes of obtaining this experience include:

(a) A program formerly or currently approved or accredited by the Commission on Accreditation for Dietetic Education (CADE) of the American Dietetic Association (ADA):

1. Dietetic Internship (DI);
2. Coordinated Program (CP);
3. Approved Preprofessional Practice Program (AP4).

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(b) A program formerly approved by the Commission on Accreditation for Dietetic Education (CADE) of the American Dietetic Association (ADA):

1. Six (6) months/900 hours experience;
2. Three (3) years preplanned with B.S. degree.

Authority O.C.G.A. §§ 43-11A-7 and 43-11A-9.

Ms. Walters moved that the formulation and adoption of these rules does not impose excessive regulatory cost on any licensee and any cost to comply with the proposed rules cannot be reduced by a less expensive alternative that fully accomplishes the objectives of the applicable laws as required by O.C.G.A. § 50-13-4. Ms. Fischer seconded the motion and it carried unanimously.

RULES HEARING – 157-4-.03, “LICENSURE BY ENDORSEMENT.”

Ms. Cook voted to adopt rule 157-4-.03. Ms. Walters seconded the motion and it carried unanimously.

157-4-.03 Licensure by Endorsement.

Any applicant holding a valid license as a licensed dietitian issued by another state, political territory, or jurisdiction acceptable to the Board, if, in the Board’s opinion, the requirements are substantially equal to or greater than the requirements of this chapter, 43-11A-8, shall submit:

- (a) The completed application form provided by the Board.
- (b) A photograph of the applicant. Only a passport type (3" × 3") taken within the past twelve months will be accepted.
- (c) The proper fee (see fee schedule).
- (d) A letter under seal from the appropriate state official issuing the license indicating that the license is current and in good standing.
- (e) The Board may request additional verification of any requirements or credentials as it may deem necessary.
- (f) Proof of receipt of a minimum of a baccalaureate or higher degree from a college or university accredited by the Southern Association of Schools and Colleges or any other regional accreditation agency with a major course of study in dietetics, human nutrition, food and nutrition, nutrition education, or food systems management; and
- (g) Proof of satisfactory completion of a documented, supervised experience component in dietetic practice of not less than 900 hours supervised by a licensed dietitian or registered dietitian.

Authority O.C.G.A. §§ 43-11A-7 and 43-11A-8.

Ms. Fischer moved that the formulation and adoption of these rules does not impose excessive regulatory cost on any licensee and any cost to comply with the proposed rules cannot be reduced by a less expensive alternative that fully accomplishes the objectives of the applicable laws as required by O.C.G.A. § 50-13-4. Ms. Love seconded the motion and it carried unanimously.

RENEWAL – CONTINUING EDUCATION REPORT – JOAN FISCHER

Ms. Fischer presented a report regarding continuing education for renewal of licensure. A discussion was held with Board on the information presented.

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SENATE BILL 445 – PROFESSIONAL LICENSURE REGULATION

The Board held a discussion regarding the meeting held with Secretary of State Brian Kemp concerning proposed legislation to modify professional licensure in Georgia

APPLICATIONS APPROVED BY STAFF GUIDELINES

Ms. Walters moved to ratify licenses administratively issued from December 1, 2011 to January 31, 2012. Ms. Neely seconded the motion and it carried unanimously.

NEW POLICY

Ms. Neely moved to accept all consent agreements for unlicensed practice prepared by the Legal Services of the Professional Licensing Boards which have been drafted using the Board's motion with no changes or variations. The Executive Director will sign these orders/agreements with express permission of the Board President and presented to the Division Director for docketing upon receipt. Ms. Walters seconded the motion and it carried unanimously.

EXECUTIVE SESSION

Ms. Neely moved, Ms. Fischer seconded and the Board voted to enter into Executive Session in accordance with O.C.G.A. §§43-1-2(k); 43-1-19(h) and 43-26-5 (c), to deliberate on applications and enforcement matters and to receive information on applications, investigative cases and pending cases. The motion passed unanimously.

At the conclusion of Executive Session on Friday, February 17, 2012, Ms. Wright declared the meeting to be "open" pursuant to the Open and Public Meeting Act O.C.G.A. § 50-14-1 et seq.

ATTORNEY GENERAL'S OFFICE

(DIET=Dietitian Investigative Case Number)

Applicant P.L., #1308284 - Requests Board staff to send a letter to applicant explaining that his application will expire on June 29, 2012.

APPLICATIONS

(DIET=Dietitian Investigative Case Number)

Applicant P.R., #1748484 – Ms. Neely moved to proceed with licensure by examination. Ms. Fischer seconded the motion and it carried unanimously.

Applicant K.U., #1744964 – Ms. Neely moved to proceed with licensure by restoration. Ms. Fischer seconded the motion and it carried with unanimously.

COMPLAINT COMPLIANCE REPORT

(DIET=Dietitian Investigative Case Number)

DIET120009 – Ms. Neely moved to refer to Investigations for further investigations to suggest the investigator poses as having celiac or IBS, request counseling for those issues, retrieve copy of brochure and educational materials provided by the respondent. Also suggest investigator to present as having GI discomfort to see if the respondent attempts to assess the investigator symptoms. Ms. Fischer seconded the motion and it carried unanimously.

DIET120012 – Ms. Neely moved to refer to Georgia Composite State Board of Medical Examiners. Ms. Fischer seconded the motion and it carried unanimously.

DIET110011 – Ms. Neely moved to close the case. Ms. Fischer seconded the motion and it carried unanimously.

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GEORGIA BOARD OF EXAMINERS OF LICENSED DIETITIANS POSITION STATEMENT REGARDING SENATE BILL 445

Ms. Neely moved to approve the following statement:

The purpose of the Georgia Board of Examiners of Licensed Dietitians is to protect the health, safety, and welfare of the public by providing for the licensure and regulation of the activities of persons engaged in dietetic practice.

This Board is dedicated to the continued process improvement of dietitian licensure, investigations, and discipline. We have and will continue to collaborate with the Secretary of State Professional Licensing Boards Division to streamline our processes to better serve the public and our licensees.

We do not believe the best interest of the public would be served by removing this authority from the Georgia Board of Examiners of Licensed Dietitians.

Ms. Fischer seconded the motion and it carried unanimously.

The meeting adjourned 1:21 a.m.

Jessie Wright, **MS, RD, LD, Chair**

James D. Cleghorn, **Executive Director**

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Michigan Dietetic Association “Documentation of Harm” Campaign

Win Free Registration to MDA's 2004 Annual Conference (a \$200+ value)! Generously donated by [REDACTED]

Thank You [REDACTED]
Look for Contest
WINNERS here!!!

Contest Guidelines:

1. Obtain a Documentation of Harm form from the MDA website.
2. Submit one case of Documentation of Potentially Harmful Nutrition Information and/or Products to be eligible to win free registration to the 2004 MDA Annual Conference.
3. Documented incidents must have occurred in Michigan between January 1999 to March 1, 2004.
4. All cases must be sent/postmarked by March 1, 2004 and returned to:



Email (preferred method):

[REDACTED]@madonna.edu Or

Snail mail:

[REDACTED] M.S., R.D.
MDA At Large Director of Legislation
[REDACTED]

Or

Fax:

[REDACTED]

5. Contestant names will be placed in a drawing and one winner will be selected for free registration. For each case of harm submitted, contestant's name will be entered in the drawing (that means you can send in as many as you have!).
6. Please note that the Documentation of Harm forms must be completed thoroughly in order to be eligible for the drawing.

Who is eligible????

All MDA members, includes Board members, Dietetic **Students and Interns** (*must be co-signed by an RD*), and this year non-MDA members are also eligible!

For further information about this contest, please contact:

[REDACTED]@madonna.edu

Documentation of Potentially Harmful Nutrition Information and/or Products

Instruction Sheet

This form is for documenting harm and/or potential harm from unqualified individuals dispensing nutrition advice and/or products. If there are questions regarding whether harm is secondary to the questionable advice and/or product versus the natural progression of the disease state, please cite studies indicating how this information or product can be potentially harmful. With regard to supplements, specifics regarding type of supplement, frequency of usage, approximate cost, ingredients, and dosages are helpful. In clinical settings, laboratory data (trends), weight history and diet history before and after R.D. intervention are helpful too.

This information will help us make a stronger case to our legislators regarding why we need to have State Legal Recognition of the “Registered Dietitian.” These cases will also help to show why the Registered Dietitian is a necessary member of the healthcare team as the most qualified provider of medical nutrition therapy and nutrition services. Please see the suggestions listed below when completing the form.

I. Background Information - Please see form

II. Diagnosis History - Please see form

III. Suspected Nutritional Misinformation/Harm - Please see form

IV. Type of Advice or Product

- Be as specific as possible about the advice the patient received: how much of a supplement was advised, dose, frequency, length of time taken, compliance.
- Collect as much information about changes as possible – weight histories, lab values before and after advice (include dates).
- Dietetics is based on the science of nutrition and food. Please cite references to support why the advice, information or product may have caused harm or could be potentially harmful. Photocopy and include the full article of reference with the pertinent sentences, paragraphs underlined.

V. Type of Harm Incurred

Physical Side Effects/Harm Incurred:

- Include supporting evidence as available (i.e. weight histories, lab values before and after advice- include dates).

Financial Harm Incurred:

(i.e. Consumer spent \$25/week on vitamin/mineral supplements for three months and ended up in the hospital. The estimated cost of the hospitalization was \$6,000)

VI. Quality of Treatment

- What was the R.D.s intervention and how did it affect the outcome? Please include supporting evidence such as weight changes, lab values, changes in eating patterns (i.e. diet history) if available. If a R.D. did not intervene, how could a Registered Dietitian have made a difference in this case.

**Documentation of Potentially Harmful
Nutrition Information and/or Products
(Confidential)**

I. Background Information

Date of Incident: _____ **Date of Report** _____

Identification

Name of Consumer/Patient (optional): _____

Age: _____ Sex: M F (please circle)

City (where occurred): _____

Person Filing the Report

Name and Credentials: _____

Address: _____

Daytime Phone # _____ Evening Phone # _____

II. Diagnosis History

1. Was the consumer/patient diagnosed with any specific disorder by a licensed health professional prior to this interaction with the questionable practitioner/salesperson? YES NO
2. If so, what were the credentials of the individual providing the diagnosis?
3. What was the diagnosis/complaint?

III. Suspected Nutritional Misinformation/Harm

1. Type of Harm: (Check all that apply)
_____ physical _____ emotional _____ financial

2. Source of Nutritional Advice: (Circle all that apply)

Chiropractor	Acupuncturist	Herbalist	Radio/Television
Brochure/Magazine	Newspaper	Naturopathic Doctor	Medical Doctor
Nurse	Pharmacist	Physical Therapist	Health Food Store

Other: _____

3. What credentials were provided to the consumer/patient upon interaction with the questionable nutrition provider/salesperson?
4. Did the questionable practitioner/salesperson obtain:
 - a. a diet record/recall/history? YES NO
 - b. a medical history including past medical problems? YES NO
 - c. a list of current medications the consumer/patient is taking? YES NO