American Dietetic Association

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.

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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.

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[*] 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.

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 themselves[20] 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."

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,[§§] 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.

- 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

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

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

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%

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

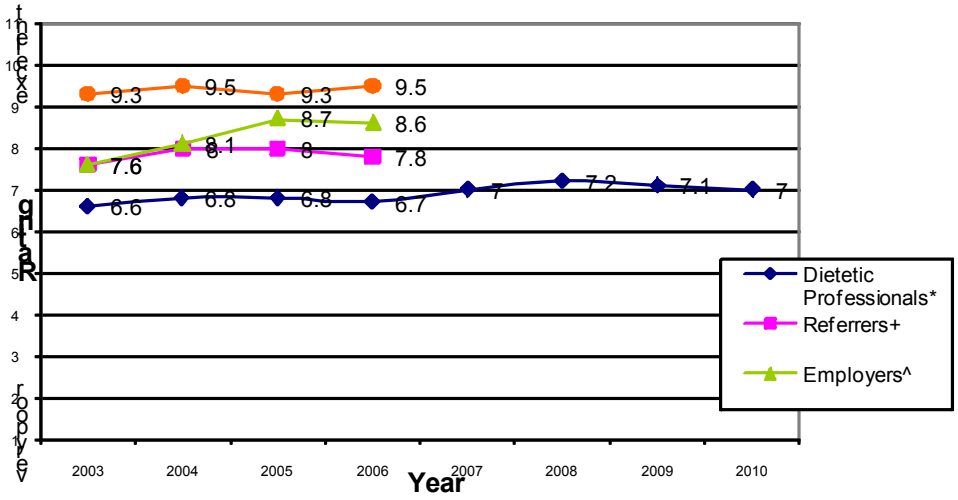


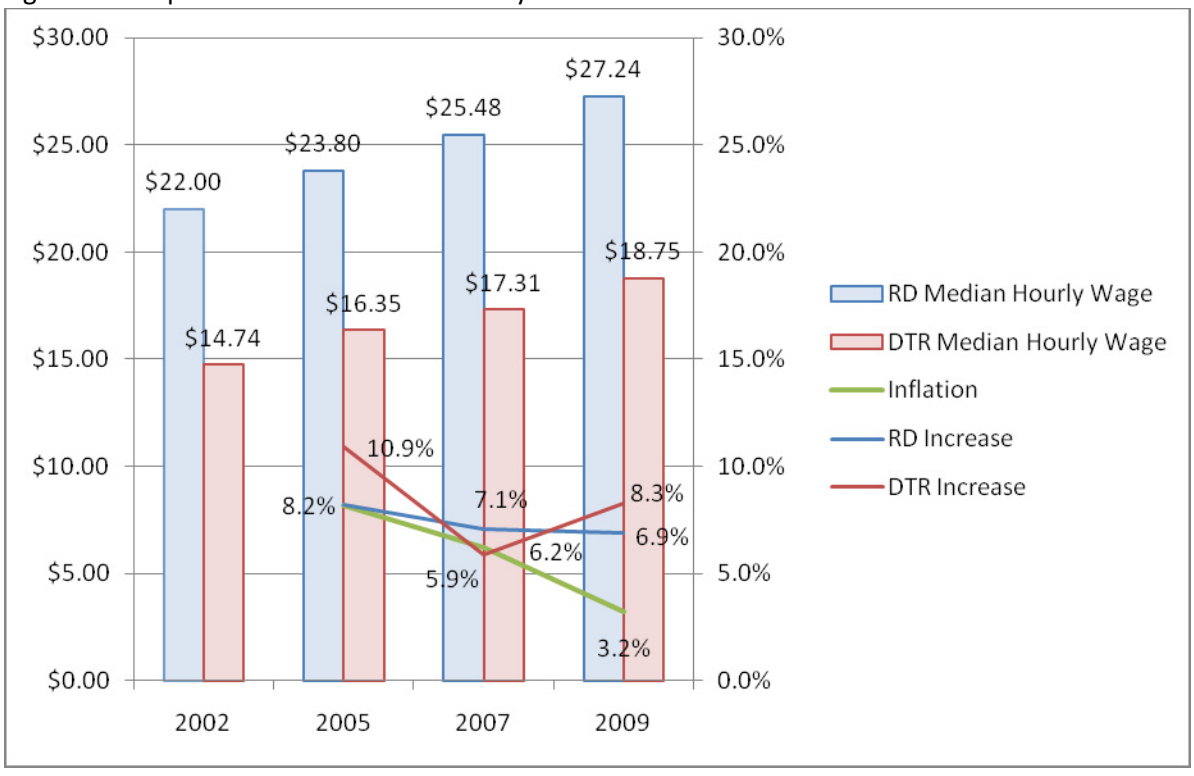
Table 1. Impression of Current Status of the Dietetics Profession 2009 and 2010 Breakdown by Specialty (scale 1 (very poor) to 11 (excellent)

	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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[9] *Id*.

[10] *Id*.

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[13] *See*, *e.g., Pharmacists Strengthen Medical Home Team*, AHIP Hi-Wire, available 12 February 2010 at http://www.ahiphiwire.org/News/Print.aspx?doc_id=506183.

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[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/gs0630.pdf.

[19] *Id*. at 2.

[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.

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[30] "Walgreen to Test Diabetes Services," Timothy W. Martin, *The Wall Street Journal*, 13 January 2010 at D2.

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[33] *Id*.

[34] *Sweeney-Weinberg Bill to Expand Scope of Chiropractic Medicine in NJ Receives Final Legislative Approval*, Jason Butkowski, PolitickerNJ.com, 11 January 2010, available at http://vip.politickernj.com/jbutkowski/35992/sweeney-weinberg-bill-expand-scope-chiropractic-medicine-nj-receives-final-legislat.

[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.