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Application for Credentialing Review

Proposed Revisions to Statutes Relating to Medical Nutrition Therapy Practice Act

Submitted By: Nebraska Academy of Nutrition and Dietetics

August 19, 2020

1) **Provide the following information for the applicant group:**

A) Name, address, telephone number, e-mail address and website of the applicant group in Nebraska and any national parenting organization.

Nebraska Academy of Nutrition and Dietetics
Telephone: (402) 643-2874
Email address: president@eatrightnebraska.org
Website: www.eatrightnebraska.org

Academy of Nutrition and Dietetics
120 South Riverside Plaza
Suite 2190
Chicago, IL 60606-6995
Website: www.eatright.org

B) Composition of the group and approximate number of members in Nebraska.

The Nebraska Academy of Nutrition and Dietetics is the state affiliate of the national Academy of Nutrition and Dietetics and is comprised of more than 770 dietetic professionals, including Registered Dietitians Nutritionists (RDN), Dietetic Technicians Registered (DTR), and Dietetic students.

Members practice in these areas: Clinical, 37%, Community and Public Health, 16%, Consultants, 9%, Education, 7%, Management, 7%, Student, 5%, with the remaining in Business and industry, private practice, nutrition informatics, and other settings.

The Nebraska Academy serves the public by promoting optimal nutrition, health, and well-being. Academy members are the nation's food and nutrition experts, translating the science of nutrition into practical solutions for healthy living. Academy members provide MNT to all age groups who require nutrition medical interventions to prevent or manage acute and chronic diseases and conditions.

C) Relationship of the group to the occupation dealt with in the application.

Over 665 members of The Nebraska Academy of Nutrition and Dietetics are licensed medical nutrition therapists who work in hospitals, rehabilitation, skilled, and long-term care facilities, home health agencies, local and state health departments and governmental agencies, schools, universities and other academic settings, retail, and dialysis centers. Medical nutrition therapists are food and nutrition experts and translate the science of nutrition into practical solutions when delivering highly specialized therapy to help manage disease, or treat or rehabilitate an illness, injury or other condition. Medical nutrition therapists provide medical nutrition therapy (MNT) which involves in-depth individualized nutrition assessments to identify nutrition diagnoses (problems) and select interventions to resolve or minimize those problems resulting in improved health and quality of life. In other states, these professionals may have the title of "licensed Dietitian" or licensed Dietitian/Nutritionist".

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* The Academy approved the optional use of the credential "registered dietitian nutritionist (RDN)" for "registered dietitians (RDs)" to convey more accurately who they are and what they do as the nation's food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

2) Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following:

A) Members of the same occupation or profession as that of the applicant group.
None identified

B) Members of the occupation dealt with in the application.

American Nutrition Association®, Nebraska affiliate
Board for Certification of Nutrition Specialists
211 West Chicago Avenue, Suite 217
Hinsdale, IL 60521
NutritionSpecialists.org
Telephone: (737) 210-1053

C) Employers of the occupation dealt with in the application.

Medical nutrition therapists work in a variety of settings in Nebraska, which include, but are not limited to:

- physician clinics (general practitioner, and specialties of gastrointestinal, bariatric, cardiac, endocrinology, oncology, allergists)
- hospitals
- hospital based ambulatory care
- skilled, rehabilitation, and long-term care
- home health agencies
- renal dialysis centers
- elementary and secondary schools
- professional sports teams
- universities and other academic settings (research and education)
- public health settings (Department of Health and Human Services)
- worksite wellness programs
- community settings (WIC, Health departments, Area Agencies on Aging)

D) Practitioners of the occupations similar to or working closely with members of the occupation dealt with the application.

Nebraska Medical Association
233 S 13th St, Ste 1200
Lincoln, NE 68508
Telephone: (402) 474-4472
www.nebmed.org

Nebraska Nurses Association
c/o Midwest Multi-state Division
3340 American Avenue, Ste F
Jefferson City, MO 65109
Telephone: (888) 885-7025
info@nebraskanurses.org
nebraskanurses.org

Nebraska Academy of Physician Assistants
8700 Executive Woods Dr. #400
Lincoln, NE 68502
Telephone: (402) 476-1528
info@nebraskapa.org
h ttps://nebraskapa.org

Nebraska Nurse Practitioners
4941 S 91st St
Omaha, NE 68127
Telephone: (402)681-6187
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Nebraska Physical Therapy Association
PO Box 24133
Omaha, NE 68124
Telephone: (402) 260-5052
judy@npta.org
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Nebraska Pharmacist Association
6221 S 58th Street, Suite A
Lincoln, NE 68516
Telephone: (402) 420-1500
info@npharm.org
https://www.npharm.org/

Nebraska Speech-Language-Hearing Association
3901 Normal Blvd, Ste 100
Lincoln, NE 68506
Telephone: (402) 476-9573
info@nslha.org
https://www.nslha.org/

E) Educators or trainers of prospective members of the occupation dealt with in the application:

Pre-dietetics requirements can be met by attending any university or college in Nebraska or elsewhere to earn a bachelor's degree. The Accreditation Council for Education in Nutrition and Dietetics is responsible for accreditation of education programs preparing students for careers as registered dietitian nutritionists. The State of Nebraska has two accredited professional education dietetics programs leading to a master's degree and the ability to sit for the Registered Dietitian Nutritionist (RDN) exam.

University of Nebraska Medical Center
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Omaha, Ne 68198
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Telephone: (402) 559-3658
Fax: (402) 559-7420
E-mail: ckhanson@unmc.edu
https://www.unmc.edu/alliedhealth/education/mne/index.html

University of Nebraska Lincoln
Department of Nutrition and Health Sciences
104F Leverton Hall, East Campus
Lincoln, NE 68583-0806
Dr. Heather E Rasmussen
Telephone: (402) 472-1373
Fax: (402) 472-4427
E-mail: hrasmussen2@unl.edu
http://cehs.unl.edu/nhs/internships/dieteticintern.shtml

F) Citizens familiar with or utilizing the services of the occupation dealt with in the application (e.g., advocacy groups, patient right groups, volunteer agencies for particular diseases or conditions, etc.).

None identified.

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G) Any other group that would have an interest in the application.

Nebraska Health Care Association
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Lincoln, NE 68512
nhca@nehca.org
https://www.nehca.org/
Telephone: (402) 435-3551

Nebraska Hospital Association
3255 Salt Creek Cir # 100
Lincoln, NE 68504
info@nebraskahospitals.org
https://www.nebraskahospitals.org/
Telephone: (402) 742-8140

Nebraska Chiropractic Association
13214 Birch Dr
Omaha, NE 68164
Telephone: (402) 943-4744
lbck@ncpa.net
https://nebraskachiropractic.org

3) If the profession is currently credentialed in Nebraska, provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change. This description of the desired scope of practice constitutes the proposal. The application comprises the documentation and other materials that are provided in support of the proposal.

Licensed Medical Nutrition Therapists are currently regulated by Nebraska Statutes Section 38-1801 – 38-1816. This application is requesting a change in those statutes, as attached. It is necessary to modernize the Medical Nutrition Therapy Practice act to ensure Nebraskans have access to the highest level of care they deserve and to protect their safety. The current statute was enacted over 20 years ago and is absent of current standards of practice to enable Nebraskans to receive effective, timely, and efficient nutrition care. These current standards of practice are reflected in the 2017 Standards of Practice in Nutrition Care (Appendix A) and 2017 Scope of Practice (Appendix B). This national standard of practice was used to create the proposed modernization of the Nebraska Licensed Medical Nutrition Therapy Practice Act.

Effective January 1, 2024, CDR will administer a graduate degree eligibility requirement for the RDN credential. Specific details on these professional requirements can be found in question 11. The State of Nebraska Statutes relating to Medical Nutrition Therapy Practice (Appendix C), proposed amended Practice Act (Appendix D), and redline copy (Appendix E) are attached.

The Nebraska Academy of Nutrition and Dietetics requests the following changes to modernize the Medical Nutrition Therapy Practice Act to allow the medical nutrition therapist to provide therapy at the height of the professional scope of practice.

Proposal

1. Advance the scope of practice contained in the Medical Nutrition Therapy Practice Act to the 2017 Scope of Practice to reflect current Standards of Practice in Nutrition Care:
    a. Include Nutrition Care Process as workflow element and as a framework to provide medical nutrition therapy services
    b. Define Nutrition Care Process steps of Assessment, Diagnosis, Intervention, Monitoring and Evaluation

c. Include writing diet, laboratory, and protocol orders in a licensed medical nutrition therapist explicit scope of practice.

2. Require pre-approved supervised practice for all applicants including MS and PhD applicants. In practice, most applicants complete pre-approved supervised practice, but supervised practice is not required by the act for those holding MS and PhD degrees.

3. Add licensure eligibility requirements for individuals who are Board Certified Specialists in Nutrition based on the academic standards and supervised practice requirements currently established for the Registered Dietitian Nutritionist. These individuals currently do not have a clear path to obtain licensure.

4. Update supervised practice experience to 1,000 hours from 1200 hours to align with Accreditation Council of Education for Nutrition and Dietetics requirements.

5. Clarify/add Definitions for practice terms including, but not limited to:
   a. Medical nutrition therapy
   b. Medical weight control
   c. Nutrition
   d. Nutrition care services
   e. Therapeutic diets

6. Clarify exemption language of activities not subject to act.

7. Clarify temporary license for individuals eligible for examination but prior to exam completion and individuals in state on temporary basis for medical emergency.

8. Update membership of the Medical Nutrition Therapy Board to include a Board-Certified Specialist in Nutrition as available.

4) If the profession is not currently credentialed in Nebraska, describe the proposed credential and the proposed scope of practice, and / or the proposed functions and procedures of the group to be reviewed. This description of the desired scope of practice and the proposed credential constitute the core of the proposal. Also, please describe how the proposal would be administered. The application comprises the documentation and other materials that are provided in support of the proposal.

This section is not applicable.

5) Describe in detail the functions typically performed by practitioners of this occupation and identify what if any specific statutory limitations have been placed on these functions. If possible, explain why Legislature created these restrictions.

The following describes in detail the specific functions of the medical nutrition therapists:

- Provide MNT in direct care of medical diseases and conditions across the continuum of care and in all age groups and populations.
- Apply the Nutrition Care Process and workflow elements in providing person-centered nutrition care of individuals.
  - Perform assessment of a patient's/client's nutrition status via in-person, or facility/practitioner assessment application, or HIPAA compliant video.

- Complete a nutrition-focused physical exam through an evaluation of body systems, muscle, and subcutaneous fat wasting, feeding ability (suck/swallow/breathe), oral health, skin condition, appetite, and affect.
- Recommend, perform, and/or interpret test results related to nutrition status: blood pressure, anthropometrics (*e.g.*, height and weight, skinfold thickness, waist circumference, calculation of body mass index with classification for malnutrition and obesity), indirect calorimetry, laboratory tests, and waived point-of-care laboratory testing (e.g., blood glucose and cholesterol).
- Order and monitor nutrition-related laboratory tests and waived point-of-care laboratory testing, in cases where an RDN has been granted ordering privileges or received a delegated order from a referring physician.
- Order and monitor nutrition interventions to meet person-centered nutrient and energy needs, including but not limited to prescribed diets, medical foods, dietary supplements, over-the-counter medications, nutrition support therapies such as enteral nutrition (tube feeding) and parenteral nutrition support (specialized intravenous solutions), nasogastric feeding tube placement, and provide feeding therapy (pediatric oral aversion).
- Initiate, implement, and adjust protocol- or physician-order-driven nutrition-related medication orders and pharmacotherapy plans in accordance with established policy or protocols consistent with organizational policy and procedure.
- Assist in the development, promotion, and adherence to enhanced recovery after surgery protocols, including elimination of preoperative nothing by mouth order, intraoperative nausea/vomiting prophylaxis and goal-directed fluid therapy, and early postoperative nutrition.
- Provide nutrition counseling; nutrition behavior therapy; lactation counseling; health and wellness coaching; and nutrition, physical activity, lifestyle, and health education and counseling as components of preventative, therapeutic, and restorative health care.
- Assess and counsel for the treatment of food allergies to prevent consumption of allergens, prevent over restriction, prevent nutrient deficiencies, and promote optimal growth and/or weight maintenance.
- Evaluate, educate, and counsel related to nutritional genomics, gene–diet and disease interactions; genetic, environmental, and lifestyle factors; and food–drug, drug–nutrient, and supplement—drug–nutrient interactions.
- Manage nutrition care, collaborate with other health and nutrition professionals and as members of interprofessional teams, contribute to rounds or care conferences; be part of palliative and hospice care teams; participate in care coordination; and refer to appropriate nutrition resources, programs, or other health professionals.

- Determine appropriate quality standards in foodservice and nutrition programs.
- Train nutrition and dietetics personnel and Nutrition Dietetic Technician Registered and mentor nutrition and dietetics students and interns in the provision of nutrition services.
- Delegate to and supervise the work of the Nutrition Dietetic Technician Registered or other professional, technical or support staffs who are engaged in direct patient/client nutrition care.

No specific statutory limitations have been placed on these functions. Missing from the statute is explicit language on authority for the writing of laboratory orders and protocol orders to monitor and evaluate interventions. LB1044 (2020) was introduced in response to a proposed regulatory change to clarify the role of medical nutrition therapists in diet order writing. It adds language to 38-1813, "A licensed medical nutrition therapist may order patient diets, including therapeutic diets, in accordance with the provisions of this subsection." This language became law in August 2020 when it was amended into and passed into law as a part of LB1002e.

Medical nutrition therapists are educated and trained to provide these nutrition interventions through didactic coursework and supervised clinical practice experience. Continuing education is required to maintain competency in these interventions.

6) Identify other occupations that perform some of the same functions or similar functions.

Occupations that carry out similar functions are physicians, physician assistants, advance practice nurses.

Same functions performed by these occupations include: order and monitor nutrition related laboratory tests, recommend nutrition interventions to include modified diets, medical foods, dietary supplements, over-the-counter medications, and nutrition support therapies for enteral (tube feeding) and parenteral (specialized intravenous solutions) and adjust protocol- or physician-order-driven nutrition-related medication orders and pharmacotherapy plans in accordance with established policy or protocols consistent with organizational policy and procedure.

Although these professions can provide nutrition and health and wellness coaching as part of preventive, therapeutic and restorative care, they refer these interventions to the licensed medical nutrition therapist, with their unique body of nutrition knowledge, to conduct nutrition assessments, treatment – including writing tube feeding and parenteral nutrition prescriptions, and monitoring for outcomes.

Similar functions provided by registered nurses include initiate, implement, and adjust protocol- or physician-order-driven nutrition-related medication orders and pharmacotherapy plans in accordance with established policy or protocols consistent with organizational policy and procedure.

Although nurses can provide nutrition education and health and wellness coaching, nurses refer these interventions to the licensed medical nutrition therapist with their unique body of nutrition knowledge, to conduct nutrition assessments, treatment – including nutrition education/counseling, and monitoring for outcomes.

Although the before mentioned occupations can legally perform some of the same duties performed by registered dietitians, physicians, physician assistants, advance practice nurses and registered nurses recognize the body of nutrition knowledge unique to registered dietitians and their contribution to the health care teams' care of patients/clients.

7) What functions are unique to this occupation? What distinguishes this occupation from those identified in question 6?

Refer to detailed functions listed in Number 5.

Research demonstrates that MNT provided by individuals with this education and training, as opposed to other health care professionals, can improve health and increased productivity and satisfaction levels through decreased doctor visits, hospitalizations, and reduced prescription

drug coverage.[1] Medical nutrition therapists make decisions about individualized appropriate therapy for specific disease states or condition and individuals with multiple comorbidities. MNT provided by RDNs as part of the health care team results in significant improvements in weight and body mass index, A1c, blood pressure and serum lipids.[1] Physician surveys document their disciplines lack of confidence and competence in providing nutrition guidance, as well as the lack of educational curriculum content to improve that situation.[2] Medical nutrition therapists are experts in specialized nutrition care and are best qualified to apply evidence practice nutrition guidelines to achieve positive patient outcomes.

8) Identify other occupations whose members regularly supervise members of this occupation, as well as other occupations whose members are regularly supervised by this occupation. Describe the nature of the supervision that occurs in each of these practice situations.

Medical nutrition therapists provide nutrition care services independently without supervision as reflected in Standards of Practice (Appendix A). While licensed medical nutrition therapists are not supervised by physicians, they work in consultation with physicians. Current statute (38-1813) says, "The practice of medical nutrition therapy shall be performed under the consultation of a physician licensed pursuant to section 38-2026 or sections 38-2029 to 38-2033." LB1004 (2020) was introduced in response to a proposed regulatory change to clarify the role of licensed medical nutrition therapists in diet order writing. It adds language to 38-1813, "A licensed medical nutrition therapist may order patient diets, including therapeutic diets, in accordance with the provisions of this subsection." This language became law in August 2020 when it was amended into and passed into law as a part of LB1002e.

Medical nutrition therapists directly supervise interns enrolled in an accredited pre-approved supervised practice experience to meet eligibility requirements for Commission on Dietetic Registration national credentialing exam and medical nutrition therapist licensure.

Medical nutrition therapists directly supervise Registered Dietetic Technicians, (Credentialed by the Commission on Dietetic Registration) when providing routine nutrition care services.

9) What actions, judgments, and procedures of this occupation can typically be carried out without supervision or orders? To what extent is this occupation, or portions of its practice, autonomous?

Medical nutrition therapists exercise independent judgment in using the Nutrition Care Process for MNT.

Educational standards and supervised pre-practice experience require a progression of clinical supervision that leads to autonomous practice upon completion of the Commission on Dietetic Registration exam.

The Academy of Nutrition and Dietetics' Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist (Appendix B) specifies, "The RDN may write, accept, and implement orders based on federal and state laws and regulations and organization policies as well as implement established and approved protocol orders, and make recommendations for nutrition-related modifications. As part of interprofessional teams, the RDN performs health care functions based on clinical privileges or as delegated by the referring practitioner in collaboration with other health care team members, and performs other activities consistent with individual scope of practice, and role(s) and responsibilities in the organization."

According to CMS, "RD[N]s are the professionals who are best qualified to assess a patient's nutritional status and to design and implement a nutritional treatment plan in consultation with the patient's interdisciplinary care team.[3] In order for patients to receive timely nutritional care, the

RD[N] must be viewed as an integral member of the hospital interdisciplinary care team, one who, as the team's clinical nutrition expert, is responsible for a patient's nutritional diagnosis and treatment in light of the patient's medical treatment. This frees up time for physicians and other practitioners to care for patients."[3] Thus, CMS specifically anticipated that RDNs should be able to exercise their independent judgment and authorized them to do so. CMS's final rule recognizes both the need and rationale for RDNs' broadly autonomous practice in this regard, if they obtain any requisite privileges from their facility to order therapeutic diets independently.[3]

Although reimbursement of a fraction of RDNs' services may be conditioned upon referral from physicians and other primary care providers, the actual services RDNs provide is unsupervised, recognizing the trust and expertise manifested in their ability to practice autonomously.

10) Approximately how many people are performing the functions of this occupation in Nebraska, or are presenting themselves as members of this occupation? To what extent are these people credentialed in Nebraska?

- As of 6/4/2020, The Academy of Nutrition and Dietetics data reported 771 registered dietitian nutritionists as members of the Nebraska Academy of Nutrition and Dietetics
- As of 7/17/20, the Nebraska Department of Health and Human Services reported 652 licensed medical nutrition therapists

11) Describe the general level of education and training possessed by the practitioners of this occupation, including any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired?

There are currently two routes to becoming a registered dietitian nutritionist. The first route includes earning a bachelor's degree and completing an accredited Didactic Program in Nutrition and Dietetics curriculum, completing an accredited supervised practice program, and then successfully passing the Commission on Dietetic Registration credentialing examination.

1. This route is accredited through demonstrating that the programs meet the Accreditation Council for Education in Nutrition and Dietetics (ACEND) 2017 Accreditation Standards for Nutrition and Dietetics Didactic Programs and 2017 Accreditation Standards for Dietetic Internship Programs found at:
https://www.eatrightpro.org/-/media/eatrightpro-files/acend/about-program-accreditation/accreditation-standards/2017-standardsfordpdprograms.pdf?la=en&hash=18A1A38F32363415418B9E72E055AC98DD0438C0 (Didactic Program in Nutrition and Dietetics)

https://www.eatrightpro.org/-/media/eatrightpro-files/acend/about-program-accreditation/accreditation-standards/2017-standardsfordiprograms.pdf?la=en&hash=B1F08833AABC0FA8A6EBB7B76778A09BE7EDB667 (Dietetic Internship Program)

The Accreditation Standards identify specific knowledge requirements for the Nutrition and Dietetics Didactic component and competency requirements for the supervised practiced component.

2. The second route to becoming a registered dietitian nutritionist is a new route that is comparable to the education and training of other health care professionals. Individuals need to have completed the minimum of a bachelor's degree and meet prerequisites determined by each program. Currently, referred to as the Future Education Model Graduate Program, this accredited program combines both the didactic component with supervised experiential learning and culminates with a graduate degree and meeting the qualifications for sitting for the

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Commission on Dietetic Registration credentialing examination. This route is accredited through demonstrating that the program meets the Future Education Model Accreditation Standards for Graduate Degree Programs found at: https://www.eatrightpro.org/-/media/eatrightpro-files/acend/futureeducationmodel/femgraduatefinal.pdf?la=en&hash=89123715A3E0E426F0A0CA960299FFEA06714FE5.

The curriculum for the Future Education Model Graduate Program includes both competencies and performance indicators. The competency statements are listed below. A complete listing of competencies and performance indicators can be found at: https://www.eatrightpro.org/-/media/eatrightpro-files/acend/futureeducationmodel/competenciesperformanceindicators-graduatedegree.pdf?la=en&hash=7F5F9B57011384AFF72C2B34F79EC2EC717BC835.

University of Nebraska Medical Center
Future Education Model Graduate Program Curriculum
Master of Medical Nutrition
Supervised Experiential Learning Hours (SEL)

Course	Credit Hours	Lecture Hours	SEL Hours
Fall 1			
MNED 720 Interprofessional Learning and Leadership	1	0	50
MNED 710 Nutrition Services Scope	2	0	120
MNED 730 Pediatric Nutrition Care	2	0	90
MNED 732 Nutrition Therapy-Adult & Geriatric Patient Care	3	0	180
MNED 775 Research Methods in Medical Nutrition	3	45	0
MNED 777 Medical Nutrition and Diagnosis Related Care	3	30	60
Spring 1			
MNED 734 Nutrition Therapy-Education and Counseling	2	0	120
MNED 736 Nutrition Therapy Complex Issues and Continuum	2	0	120
of Care	2	0	120
MNED 738 Nutrition Therapy Critical Care & Nutrition Support	2	0	120
BIOS 806 Biostatistics	3	45	0
MNED 787 Medical Nutrition and the Nutrition Care Process	3	30	60
Summer 1			
MNED 773 Clinical Nutrition Management	2	0	100
MNED 779 Nutrition Therapy Practicum	3	0	160
MNED 785 Applied Medical Nutrition Research	3	45	0
MNED 790 Capstone	2	0	0
Fall 2			
MNED 724 Interprofessional Learning & Leadership III	1	0	60
MNED 790 Capstone	4	0	0
EPI 820 Epidemiology in Public Health	3	45	0
MNED 760 Pharmacology, Genetics and Integrative Nutrition	2	0	100
MNED 766 Public Health Nutrition	2	0	200
Program Total	50	240	1560

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To become eligible for licensing as a medical nutrition therapist, candidates must successfully complete **three** fundamental requirements:

- Required nutrition and dietetics coursework through a didactic program or coordinated program in dietetics accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) and completion of at least a baccalaureate degree (master degree requirement beginning 2024) granted by a US regionally accredited university or college or foreign equivalent. Coursework typically includes food and nutrition sciences, lifespan nutrition, community nutrition, communications, business, economics, computer science, foodservice management systems, psychology, sociology, anatomy and physiology, pharmacology, genetics, microbiology, organic chemistry, and biochemistry.

- Supervised practice through a dietetic internship, individualized supervised practice pathway, or a coordinated program in nutrition and dietetics accredited by ACEND of at least 1000 hours in clinical, community nutrition, and food service settings.

- Pass the Commission on Dietetic Registration national credentialing examination for registered dietitian nutritionists and completion of continuing professional education to maintain one's credentials.

For non-RDN route to become eligible for licensure, candidates must successfully complete **three** fundamental requirements:

- Completion of a master's or doctoral nutrition degree granted by a US regionally accredited university of college or foreign equivalent with a major in human nutrition, foods and nutrition, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling , nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or comparable titled major. Required course work includes 15 hours in clinical and life sciences, 15 hours of nutrition and metabolism.

- Supervised practice through a board approved internship or a documented supervised practice experience in nutrition care services and the provision of MNT of not less than 1000 hours involving at least 200 hours of nutrition assessment, 200 hours of nutrition intervention education, counseling, or management, and 200 hours of nutrition monitoring or evaluation under the supervision of a Certified Nutrition Specialist, a Registered Dietitian, a licensed dietitian nutritionist or a licensed nutritionist residing in the state, a state licensed health care provider whose scope of practice includes the provision of nutrition care services for the purpose of treatment or management of disease of medical condition.

- Successful completion of the examination administered by the Board for Certification of Nutrition Specialists: or the applicant has either a valid current certification with the Board for Certification of Nutrition Specialists that gives the applicant the right to use the term "Certified Nutrition Specialist" or "CNS".

12) Identify the work settings typical of this occupation (e.g., hospitals, private physicians' offices, clinics, etc.) and identify any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired?

Typical Work Settings of the Medical Nutrition Therapist		
Hospital, hospital based ambulatory care	Skilled, rehabilitation, long-term care facilities	Home health care organizations
Physician clinics (general practitioner, and specialties of gastrointestinal, bariatric, cardiac, endocrinology, oncology, allergists)	Elementary and secondary schools, universities, and academic settings	Community, public health, and government agencies (WIC, Area Agencies on Aging, NE DHHS)
Professional sports teams	Retail	Private Practice
Worksite wellness programs	Renal dialysis centers	Research settings

Licensed medical nutrition therapists provide specialized nutrition care and support in collaboration with physicians, surgeons, pediatricians, nurses, speech and occupational therapists, and other qualified healthcare professionals.

Required supervised practice experiences are also received in these settings with direct supervision of the licensed medical nutrition therapist or an individual licensed in other states to practice MNT.

Refer to question 11 for how education and training is provided.

13) Do practitioners routinely serve members of the general population: Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)? If so, please specify the type of population served.

MNT is provided to any individual and is received by pregnant and breastfeeding women, infants, children, adolescents, adults, and older adults who require interventions to prevent, or manage acute and chronic medical diseases and conditions.

14) Identify the typical reasons a person would have for using the services of a practitioner. Are there specific illness, conditions, or situations that would be likely to require the services of a practitioner? If so, please specify.

MNT is a widely recognized component of medical guidelines for the prevention and treatment of many chronic diseases, as well as in the reduction of risk factors for these conditions. MNT is a cost-effective disease management strategy that reduces chronic disease risk, delays disease progression, enhances the efficacy of medical/surgical treatment, reduces medication use, and improves patient outcomes including quality of life.**

** Grade 1 data. Academy Evidence Analysis Library, http://andevidencelibrary.com/mnt. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."

Examples of Conditions and Diseases Using Medical Nutrition Therapy in Adult and Pediatric Populations (adapted from 2017 Scope of Practice, Appendix B)		
Anemia	Burns	Alzheimer's disease and dementia
Cardiovascular Disease, Stroke, Heart Failure, Hyperlipidemia	Critical Illness or conditions	COVID-19
Developmental disabilities	Diabetes	Dysphagia
Eating disorders and disordered eating	Food allergies and intolerances	Genetic Disorders- Inborn errors of metabolism, PKU
Gastrointestinal disorders- IBS, Diverticulosis, Crohns, Ulcerative Colitis	Celiac Sprue-Gluten Intolerance	Human immunodeficiency virus/acquired immunodeficiency syndrome
Malnutrition	Mental health disorders	Metabolic syndrome
Musculoskeletal conditions, Osteoporosis, Multiple Sclerosis	Neurological disorders, Parkinson's	Conditions requiring enteral or parenteral nutrition
Organ transplant	Pediatric care- FTT, Obesity	Pulmonology disorders
Renal disorders- renal failure	Sports nutrition	Obesity, weight management
Macronutrient imbalances	Micronutrient deficiencies	Oncology

15) Identify typical referral patterns to and from members of this occupational group. What are the most common reasons for referral.

Members of this occupation refer to another member when the needs of the individual would be best met by another practitioner with specialized experience or expertise beyond that of the referring member or when the patient is transitioning between care settings or relocating or returning to home. Common reasons for referral to another licensed medical nutrition therapist can be for eating disorders, specialized care for pediatric and geriatric patients, individuals with diabetes, advanced stage kidney disease, and inborn errors of metabolism, gluten intolerance, and allergies. Referral patterns also exist to and from other health care practitioners recognizing the need for patient to obtain specialized care, such as psychologists and social workers for patients with eating disorders, etc.

16) Is a prescription or order from a practitioner of another health occupation necessary in order for services to be provided?

Entities that pay for nutrition services, such as insurance providers, may establish policies or requirements that RDNs must follow to receive payment for MNT services. These may include obtaining a referral from a physician. For example, RDNs independently provide MNT under Medicare Part B by physician referral.

Referrals are not necessary for MNT to be provided.

17) How is continuing competence of credentialed practitioners evaluated?

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

Under the current medical nutrition therapist licensure law, Nebraska DHHS requires 30 hours of continuing education per every two-year licensure cycle. Continuing education must be specific to the delivery of MNT services, i.e. assessment, nutrition diagnosis, nutrition intervention and/or monitoring appropriate for a medical or nutritional diagnosis, condition, or disease state.

COMMSISSION ON DIETETIC REGISTRATION

In addition to meeting the 30 hours of continuing education specific to MNT practice, Registered Dietitian Nutritionist (RDN) credentialed practitioners are required to maintain certification through continuous learning to ensure professional knowledge and competence. This is documented through the completion of a minimum of 75 continuing education hours every five years.

To maintain the RDN credential, the Commission on Dietetic Registration constructed the Professional Development Portfolio (PDP) process. The Commission on Dietetic Registration developed the *Essential Practice Competencies for CDR Credentialed Nutrition and Dietetics Practitioners* to provide validated standards for the Registered Dietitian Nutritionist (RDN). Practice competencies define the knowledge, skill, judgment, and attitude requirements throughout a practitioner's career, across practice, and within focus areas. The competencies provide a structured guide for the practitioner to help identify, evaluate, and develop the behaviors required for continuing competence. The portfolio must be submitted every five years to maintain the RDN credential.

HEALTH CARE INSTITUTION POLICY

In addition to the continuing education requirements to maintain the licensed medical nutrition therapist and RDN credentials, hospitals require dietitians performing MNT to demonstrate competency for the tasks that they are expected to perform in the health care setting. The demonstration of competency is an expectation of The Joint Commission *Standard MS.08.01.03 Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.* The process for the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

18) What requirements must the practitioner meet before his or her credentials may be renewed?

Under the current medical nutrition therapy licensure law, Nebraska DHHS requires 30 hours of continuing education per every two-year licensure cycle. Continuing education must be specific to the delivery of MNT services, i.e. assessment, nutrition diagnosis, nutrition intervention and/or monitoring appropriate for a medical or nutritional diagnosis, condition, or disease state.

19) Identify other jurisdictions (states, territories, possessions, or the District of Columbia) wherein this occupation is currently regulated by the government, and the scopes of practice typical for this occupation in these jurisdictions.

According to the Academy of Nutrition and Dietetics, there are currently 46 states, the District of Columbia, and Puerto Rico that regulate the practice of dietetics/nutrition while the states of Arizona, California, Colorado, Virginia either regulate the use of certain titles or specify the ability of members of the profession to perform certain high-level tasks when authorized to do so by medical staff at a state licensed healthcare facility. Following is a list of these states.

Alabama: Regulates "dietetics/nutrition," which "is the integration and application of principles derived from the sciences of nutrition, biochemistry, physiology, food, management, and behavioral and social sciences to achieve and maintain people's health. The primary function of dietetic practice is the provision of nutrition care services which shall include:
(1) Assessing the nutritional needs of individuals and groups and determining resources and constraints in the practice setting.

(2) Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints.
(3) Providing nutrition counseling in health and disease.
(4) Developing, implementing, and managing nutrition care systems.
(5) Evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition services."

Alaska: Regulates "dietetics or nutrition practice," which "means the integration and application of scientific principles of food, nutrition, biochemistry, physiology, food management, and behavioral and social sciences to achieve and maintain human health through the provision of nutrition care services."

Arkansas: Regulates "dietetics practice," which is "the integration and application of the principles derives from the sciences of nutrition, biochemistry, food, physiology, management and behavioral and social sciences to achieve and maintain peoples' health through the provision of nutrition care services."

Connecticut:
Regulates "dietetics or nutrition practice" which is "the integration and application of the principles derived from the sciences of nutrition, biochemistry, food, physiology, and behavioral and social sciences to provide nutrition services that include: (A) Nutrition assessment; (B) the establishment of priorities, goals, and objectives that meet nutrition needs; (C) the provision of nutrition counseling in health and disease; (D) the development, implementation and management of nutrition care plans; and (E) the evaluation and maintenance of appropriate standards of quality in food and nutrition. The term "dietetics or nutrition practice" includes the ordering of oral diets and enteral and parenteral nutrition support and the physical administration of oral diets."

Delaware: Regulates "Dietetic and nutrition therapy" which is "the scope of services utilized in the delivery of preventive nutrition services and/or nutrition therapy. It involves an assessment of the individual's specific nutritional needs and the development and implementation of an intervention plan. The intervention plan can include nutrition education, counseling, administration and monitoring of specialized nutrition support and/or referrals for additional services." Several specific processes and procedures are defined within the Scope of Practice.

District of Columbia: Regulates the "'Practice of dietetics and nutrition' [which] means the application of scientific principles and food management techniques to assess the dietary or nutritional needs of individuals and groups, make recommendations for short-term and long-term dietary or nutritional practices which foster good health, provide diet or nutrition counseling, and develop and manage nutritionally sound dietary plans and nutrition care systems consistent with the available resources of the patient or client."

Florida: Regulates "dietetics and nutrition practice" which includes "assessing nutrition needs and status using appropriate data; recommending appropriate dietary regimens, nutrition support, and nutrient intake; ordering therapeutic diets; improving health status through nutrition research, counseling, and education; and developing, implementing, and managing nutrition care systems, which includes, but is not limited to, evaluating, modifying, and maintaining appropriate standards of high quality in food and nutrition care services." Also regulates "nutrition counseling" which means "advising and assisting individuals or groups on appropriate nutrition intake by integrating information from the nutrition assessment."

Georgia: Regulates "dietetic practice" which is "the integration and application for compensation of principles derived from the sciences of nutrition, biochemistry, food, physiology, management, and behavioral and social sciences to achieve and maintain client health through the provision of nutrition care services, which shall include:

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(A) Assessing the nutritional needs of individuals and groups based upon appropriate biochemical, anthropometric, physical, and dietary data to determine nutrient needs and recommend appropriate intake including enteral and parenteral nutrition.
(B) Establishing priorities, goals, and objectives which meet nutritional needs and are consistent with available resources.
(C) Providing dietetic nutrition counseling by advising and assisting individuals or groups on appropriate nutritional intake by integrating information from the nutritional assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status.
(D) Developing, implementing, and managing nutrition care delivery systems; and
(E) Evaluating, making changes in, and maintaining standards of quality in food and nutrition care services."

Hawaii: Regulates "dietetic practice" which is "the integration and application of scientific principles of nutrition, biochemistry, physiology, food, behavioral, and social sciences, in managing disease, and achieving and maintaining human health throughout the life cycle."

Idaho: Regulates "dietetics" which is "the integration, application and communication of principles derived from food, nutrition, social, business and basic sciences to achieve and maintain optimal nutrition status of individuals through the development, provision and management of effective food and nutrition services in a variety of settings."

Illinois: Regulates "dietetics and nutrition services" which is "the integration and application of principles derived from the sciences of food and nutrition to provide for all aspects of nutrition care for individuals and groups, including, but not limited to:

(1) nutrition counseling; "nutrition counseling" means advising and assisting individuals or groups on appropriate nutrition intake by integrating information from the nutrition assessment.

(2) nutrition assessment; "nutrition assessment" means the evaluation of the nutrition needs of individuals or groups using appropriate data to determine nutrient needs or status and make appropriate nutrition recommendations.

(3) medically prescribed diet; "medically prescribed diet" is one form of medical nutrition therapy and means a diet prescribed when specific food or nutrient levels need to be monitored, altered, or both as a component of a treatment program for an individual whose health status is impaired or at risk due to disease, injury, or surgery and may only be performed as initiated by or in consultation with a physician licensed under the Medical Practice Act of 1987 acting within the scope of his or her practice, except that a medically prescribed diet for a resident of a nursing home shall only be performed as initiated by or in consultation with a physician licensed to practice medicine in all of its branches;

(4) medical nutrition therapy; "medical nutrition therapy" means the component of nutrition care that deals with the systematic use of food and oral supplementation, based on the nutrition assessment and individual health status, and need to manage health conditions.

(5) nutrition services for individuals and groups; "nutrition services for individuals and groups" includes, but is not limited to, all the following:

(A) providing nutrition assessments relative to preventive maintenance or restorative care.
(B) providing nutrition education and nutrition counseling as components of preventive maintenance or restorative care; and
(C) developing and managing systems whose chief function is nutrition care; nutrition services for individuals and groups does not include medical nutrition therapy as defined in this Act; and

(6) restorative; "restorative" means the component of nutrition care that deals with oral dietary needs for individuals and groups; activities shall relate to the metabolism of food and the requirements for nutrients, including dietary supplements for growth, development, maintenance, or attainment of optimal health."

Indiana: Regulates "dietetics" which is the "the integration and application of principles derived from the science of food and nutrition to provide for all aspects of nutrition therapy for individuals and groups, including nutrition therapy services and medical nutrition therapy."

Iowa: Regulates "dietetics" which is the "integration and application of principles derived from the sciences of nutrition, biochemistry, physiology, food management and from behavioral and social sciences to achieve and maintain an individual's health."

Kansas: Regulates "dietetics practice" which is "the integration and application of principles derived from the sciences of nutrition, biochemistry, food, physiology, management and behavioral and social sciences to achieve and maintain the health of people through:
(1) Assessing the nutritional needs of clients.
(2) establishing priorities, goals and objectives that meet nutritional needs of clients; and
(3) advising and assisting individuals or groups on appropriate nutritional intake by integrating information from a nutritional assessment with information on food and other sources of nutrients and meal preparation."

Kentucky: Regulates "the practice of dietetics or nutrition" which is "the integration and application of scientific principles of food, nutrition, biochemistry, physiology, and management, and the behavioral and social sciences in achieving and maintaining the health of people through the life cycle and in the treatment of disease. Methods of practice shall include, but are not limited to, nutrition assessments; development, implementation, management, and evaluation of nutrition care plans; nutrition counseling and education; and the development and administration of nutrition care standards and systems."

Louisiana: Regulates "dietetics/nutrition practice" which is "the integration and application of principles derived from the sciences of nutrition, biochemistry, food, physiology, management, behavioral, and social sciences to achieve and maintain client health through the provision of nutrition care services, which shall include:
(a) Assessing the nutritional needs of individuals and groups based upon appropriate biochemical, anthropometric, physical, and dietary data to determine nutrient needs and recommend to the primary health care provider appropriate nutritional intake including enteral and parenteral nutrition.
(b) Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources.
(c) Providing nutrition counseling by advising and assisting individuals or groups on appropriate nutritional intake by integrating information from the nutritional assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status.
(d) Developing, implementing, and managing nutrition care systems.
(e) Evaluating, making changes in, and maintaining standards of quality in food and nutrition care services.
(f) Within a healthcare facility licensed by the Louisiana Department of Health, ordering appropriate nutritional intake, including enteral and parenteral nutrition, and ordering appropriate laboratory tests to monitor the effectiveness of the dietary plan, subject to the approval of and authorization by the licensed healthcare facility's medical staff or bylaws."

Maine: Regulates "dietetics" which is "the professional discipline of assessing the nutritional needs of an individual, including recognition of the effects of the individual's physical condition and economic circumstances, and the applying of scientific principles of nutrition to prescribing means to ensure the individual's proper nourishment and care."

Maryland: Regulates "dietetics [which] means to apply the principles derived from integrating knowledge of food, biochemistry, physiology, management science, behavioral science, and social science to human nutrition [and] … includes:

(i) Assessing individual and community food practices and nutritional status using anthropometric, biochemical, clinical, dietary, and demographic data, for clinical, research, and program planning purposes.

(ii) Developing, establishing, and evaluating nutritional care plans that establish priorities, goals, and objectives for meeting nutrient needs for individuals or groups.

(iii) Nutrition counseling and education as a part of preventive or restorative health care throughout the life cycle.

(iv) Determining, applying, and evaluating standards for food and nutrition services; and

(v) Applying scientific research to the role of food in the maintenance of health and the treatment of disease."

Massachusetts: Regulates the "field of nutrition and dietetics" which is "the integration and application of scientific principles of food, nutrition, biochemistry, physiology, food management, behavioral and social sciences to achieve and maintain the health of people. The field includes assessing the nutritional needs of individuals and groups of individuals based upon appropriate biochemical, anthropometric, physical, demographic, clinical, and dietary data to determine nutrient needs including enteral and parenteral nutrition; developing, evaluating and monitoring nutrition care plans that establish priorities, goals and objectives for meeting nutrient needs for individuals and groups; and advising and assisting individuals or groups of individuals on appropriate nutritional intake as part of preventive or restorative health care. Dietetics and nutrition also include integrating information from the nutrition assessment with information on food and other sources of nutrient and meal preparation consistent with cultural background and socioeconomic status."

Minnesota: Regulates "dietetics or nutrition practice" which is "the integration and application of scientific principles of food, nutrition, biochemistry, physiology, food management, and behavioral and social sciences to achieve and maintain human health through the provision of nutrition care services."

Mississippi: Regulates "dietetics" which is "the integration and application of principles derived from the sciences of nutrition, biochemistry, physiology, food, management and behavioral and social sciences to achieve and maintain peoples' health. Dietetics practice is the provision of services which include, but are not limited to:

(a) Providing medical nutrition therapy.

(b) Development, administration, evaluation, and consultation regarding nutritional care standards of quality in food services and medical nutrition therapy.

(c) Providing case management services.

(d) Developing, implementing, and managing nutrition care system."

Missouri: Regulates "dietetics practice" which is "the application of principles derived from integrating knowledge of food, nutrition, biochemistry, physiology, management, and behavioral and social science to achieve and maintain the health of people by providing nutrition assessment and nutrition care services. The primary function of dietetic practice is the provision of nutrition care services that shall include, but not be limited to:

(a) Assessing the nutrition needs of individuals and groups and determining resources and constraints in the practice setting.

(b) Establishing priorities, goals, and objectives that meet nutrition needs and are consistent with available resources and constraints.

(c) Providing nutrition counseling or education in health and disease.

(d) Developing, implementing, and managing nutrition care systems.

(e) Evaluating, making changes in, and maintaining appropriate standards of quality and safety in food and in nutrition services.

(f) Engaged in medical nutritional therapy."

Montana: Regulates "dietetics/nutrition practice" or "dietetics-nutrition" which is "the integration and application of principles derived from the sciences of nutrition, biochemistry, physiology, and food management and from the behavioral and social sciences to achieve and maintain health. The

primary function of dietetic-nutrition practice is to provide nutrition assessment and nutrition counseling" .... [and includes]
"(1) assessing the nutrition needs of individuals and groups and determining resources and constraints in the practice setting.
(2) establishing priorities and objectives that meet nutritive needs and are consistent with available resources and constraints.
(3) providing nutrition counseling for any individual.
(4) developing, implementing, and managing nutrition care systems; and
(5) evaluating, adjusting, and maintaining appropriate standards of quality in food and nutrition services."

Nevada: Regulates "the practice of dietetics" which is "the performance of any act in the nutrition care process, including, without limitation, assessment, evaluation, diagnosis, counseling, intervention, monitoring and treatment, of a person which requires substantial specialized judgment and skill based on the knowledge, application and integration of the principles derived from the sciences of food, nutrition, management, communication, biology, behavior, physiology and social science to achieve and maintain proper nourishment and care of the health of the person."

New Hampshire: Regulates dietitians who "shall be authorized to practice applications from food, nutrition, biochemistry, physiology, management, behavioral, and social sciences used in the treatment of illness, injury and other medical conditions, and the maintenance of human health."

New Jersey: Regulates "medical nutrition therapy" which is "the provision of nutrition care services for the intended purpose of treatment or management of a diagnosed disease or medical condition. ... Nutrition care services means the provision of any part or all of the following services within a systematic process: assessing and evaluating the nutritional needs of individuals and groups, and determining resources and constraints in the practice setting, including ordering laboratory tests to check and track nutrition status and monitor effectiveness of dietary plans and orders; establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints; providing nutrition counseling in health and disease; developing, implementing, and managing nutrition care systems; evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition services; and ordering therapeutic diets."

New Mexico: Regulates "nutrition or dietetics practice" which is "the integration and application of principles derived from the sciences of nutrition, biochemistry, physiology, food management and behavioral and social sciences to achieve and maintain human health through the provision of nutrition care services."

New York: Regulates "certified dietitians/nutritionists" which is defined as "one who engages in the integration and application of principles derived from the sciences of nutrition, biochemistry, physiology, food management and behavioral and social sciences to achieve and maintain people's health, and who is certified as such by the department pursuant to section eight thousand four of this article. The primary function of a certified dietitian or certified nutritionist is the provision of nutrition care services that shall include:
A. Assessing nutrition needs and food patterns.
B. Planning for and directing the provision of food appropriate for physical and nutrition needs; and
C. Providing nutrition counseling."

North Carolina: Regulates "medical nutrition therapy" which is "the provision of nutrition care services for the purpose of managing or treating a medical condition. ... Nutrition care services. - Any part or all the following:
a. Assessing and evaluating the nutritional needs of individuals and groups, and determining resources and constraints in the practice setting, including ordering laboratory tests related to the practice of nutrition and dietetics.
b. Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints.

c. Providing nutrition counseling in health and disease.
d. Developing, implementing, and managing nutrition care systems.
e. Evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition services.
f. Ordering therapeutic diets."

North Dakota: Regulates "dietetics" which is "the application of principles derived from integrating knowledge of food, nutrition, biochemistry, physiology, management, and behavioral and social science to achieve and maintain the health of people by providing nutrition assessment and nutrition care services."

Ohio: Regulates "the practice of dietetics" which "means any of the following:
(1) Nutritional assessment to determine nutritional needs and to recommend appropriate nutritional intake, including enteral and parenteral nutrition.
(2) Nutritional counseling or education as components of preventive, curative, and restorative health care.
(3) Development, administration, evaluation, and consultation regarding nutritional care standards."

Oklahoma: Regulates "dietetics" which is "the integration and application of principles derived from the sciences of nutrition, biochemistry, food, physiology, behavioral and social sciences to provide nutrition services that include:
a. nutrition assessment,
b. the establishment of priorities, goals and objectives that meet nutritional needs,
c. the provisions of nutrition counseling in health and disease,
d. the development, implementation, and management of nutrition care plans, and
e. the evaluation and maintenance of appropriate standards of quality in food and nutrition;"

Oregon: Regulates "dietetics practice" which is "the integration and application of principles derived from the sciences of nutrition, biochemistry, food, management, physiology and behavioral and social sciences to achieve and maintain the health of people through:
(a) Assessing the nutritional needs of clients.
(b) Establishing priorities, goals and objectives that meet nutritional needs of clients.
(c) Advising and assisting individuals or groups on appropriate nutritional intake by integrating information from a nutritional assessment with information on food and other sources of nutrients and meal preparation; and
(d) Evaluating and making changes in food, diets and nutrition services, maintaining appropriate standards of nutritional quality in food, and maintaining appropriate standards of nutrition services."

Pennsylvania: Regulates "The 'Practice of dietetics-nutrition' [which] means the integration and application of principles derived from the sciences of food nutrition, biochemistry, physiology, management and behavior to provide for all aspects of nutrition therapy for individuals and groups, including nutrition therapy services and medical nutrition therapy, compatible with dietitian-nutritionist education and professional competence."

Puerto Rico: Regulates "dieticians and nutrition professionals" which include "any professional with an academic background based on a Bachelor of Sciences with a major in nutrition and diets from an academic institution approved by the American Dietetic Association, qualified to interpret and apply scientific nutrition knowledge to the planning, organization, development and direction of programs for the promotion of health and the prevention of debilitating diseases, as well as research, study and solution of nutritional problems of individuals or groups. He/she shall also be qualified to apply this knowledge to the selection and preparation of food, planning of menus and diets, the supervision of the personnel preparing the diets; and qualified to organize and direct nutrition services in institutions such as hospitals, cafeterias, hotels, school lunch rooms, etc., and to select the required equipment. His/her preparation shall further enable him/her to offer consulting and orientation services in preventive and curative dietetics to persons who require or request a specific nourishment plan according to their needs, and to order a nourishment plan when such people are in optimal health

conditions. In all other cases of illness, his/her preparation shall also empower him/her to offer consulting and orientation services to persons who require or request the same, and to prescribe a nourishment plan, provided the patient has been referred by a physician. His/her powers do not include ordering medical tests without previous indication by a physician in cases of illness and in cases of optimal health conditions, he/she may only order the following lab tests: a basic metabolic panel and cholesterol levels."

Rhode Island: Regulates "dietetics" which is "the professional discipline of applying principles derived from the sciences of nutrition, biochemistry, physiology, management, and behavioral and social sciences in the provision of dietetic services."

South Carolina: Regulates "dietetics" which is "the integration and application of dietary principles derived from the science of nutrition, biochemistry, physiology, food, and management and from behavioral and social sciences to achieve and maintain a healthy status. The primary function of dietetic practice is the provision of dietary nutrition care services."

South Dakota: Regulates "the practice of nutrition/ dietetics" which is "the integration and application of scientific principles of food, nutrition, biochemistry, physiology, management, and behavioral and social science to achieve and maintain the health of people. The primary function of a nutrition and dietetic practice is the provision of the following nutrition care services:
(1) Assessing the nutritional needs of individuals and groups.
(2) Establishing priorities, goals, and objectives that meet nutritional needs.
(3) Providing nutrition counseling in health and disease.
(4) Developing, implementing, and managing nutrition care systems; and
(5) Evaluating, making changes in, and maintaining appropriate standards of quality in nutrition care."

Tennessee: Regulates "dietetics/nutrition practice" which is "the integration and application of scientific principles of food, nutrition, biochemistry, physiology, management and behavioral and social sciences in achieving and maintaining health through the life cycle and in the treatment of disease. Methods of practice include, but are not limited to, nutritional assessment, development, implementation and evaluation of nutrition care plans, nutritional counseling and education, and the development and administration of nutrition care standards and systems."

Texas: Regulates "dietetics" which is "the professional discipline of applying and integrating scientific principles of food, nutrition, biochemistry, physiology, management, and behavioral and social sciences under different health, social, cultural, physical, psychological, and economic conditions for the proper nourishment, care, and education of an individual or group throughout the life cycle to achieve and maintain human health. The term includes the development, management, and provision of nutrition services."

Utah: Regulates "dietetics" which is "the integration and application of principles derived from the sciences of food for the development, management, and provision of dietary services for individuals and groups for meeting their health care needs. 'Dietetics' includes:
(a) the evaluation of a person's dietary status.
(b) the advising and education of persons on dietary needs; and
(c) the evaluation of needs, implementation of systems to support needs, and maintenance of appropriate standards of quality in food and dietary service for individuals, groups, or patients in licensed institutional facilities or in private office settings."

Vermont: Regulates "dietetics" which is the "advising and assisting individuals or groups on appropriate dietary intake by integrating information from the individual or group assessment with information of food and other sources of nutrients and meal preparation."

Washington: Regulates "dietetics" which is "the integration and application of scientific principles of food, nutrition, biochemistry, physiology, management, and behavioral and social sciences in

counseling people to achieve and maintain health. Unique functions of dietetics include, but are not limited to:
(a) Assessing individual and community food practices and nutritional status using anthropometric, biochemical, clinical, dietary, and demographic data for clinical, research, and program planning purposes.
(b) Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints.
(c) Providing nutrition counseling and education as components of preventive, curative, and restorative health care.
(d) Developing, implementing, managing, and evaluating nutrition care systems; and
(e) Evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition care services."

West Virginia: Regulates "medical nutrition therapy" [and] "nutrition therapy" [which] "means nutritional diagnostic assessment and nutrition therapy services for the purpose of disease management."

Wisconsin: Regulates "dietetics" which is "the integration and application of principles of nutritional science, biochemistry, food science, physiology, food systems management, behavioral science and social science in order to achieve or maintain the health of an individual or group of individuals. "Dietetics" includes assessing the nutritional needs of an individual or group of individuals and determining available resources and constraints in meeting those nutritional needs; establishing priorities, goals and objectives that meet those nutritional needs and are consistent with available resources and constraints; providing nutrition counseling; or developing, implementing and managing nutritional care systems."

Wyoming: Regulates "dietetics" which 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. "Dietetics" includes the nutrition care process and medical nutrition therapy."

Additional Questions an Applicant Group Must Answer about their Proposal

1) **What is the problem created by not regulating the health professional group under review, or by not changing the scope of practice of the professional group under review?**

   MNT is regulated to identify and provide competent evidence-based nutrition care for Nebraskans to achieve positive outcomes and avoid harm. The proposed scope of practice change mirrors current standards of practice and governmental regulations, including diet order writing. Revision to applicant requirements assures competency for practice.

   Scope of practice advanced

   The current statute has not been modernized since it was passed in 1995; therefore, revision of the current statute is critical to reflect the advancement of MNT as an evidence-based practice, reflect 2017 Professional Standards of Practice for the Registered Dietitian Nutritionist (Appendix A) and federal regulations.

   The most critical need for modernization is to update the advanced practice of the scope for licensed medical nutrition therapist (LMNT). Today, LMNTs scope involves a scientific approach to patient/client nutrition care. Using the scientific approach LMNTs implement a nutrition care process that complements the scientific rationale of medicine, nursing, and other health care professionals by focusing on a diagnostic approach to identifying and solving problems. The knowledge and judgment used identifies the process of nutrition care. The Nutrition Care Process provides a framework for the profession to standardize the approach to MNT, evaluate the effects of an intervention for a specific diagnosis for which it was prescribed and as a basis

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for standardized documentation of MNT. Using the diagnostic approach to practice, LMNTs guide their own body of knowledge into their profession-specific diagnostic codes (Appendix F) to precisely communicate the interventions LMNTs determine for diagnostic judgments. Patient outcomes are derived from nutrition diagnosis and are targeted solutions for patients' nutrition problems. Outcomes are monitored for success of the interventions.

A standardized terminology exists for LMNTs clinical decision making for nutrition assessment, and nutrition interventions to document MNT and outcomes in a standardized manner (Appendix F). Nebraska's Licensed Medical Nutrition Therapy Practice Act does not reflect these realities of practice.

Independent diet order writing privileges for diagnosis-specific nutrition interventions is important so that patients receive timely and effective nutrition therapy and achieve positive outcomes. This practice is in line with the Centers for Medicare and Medicaid (CMS) 2014 proposed rule to allow RDNs to independently order therapeutic diets because "[t]he addition of ordering privileges enhances the ability that RD[N]s already have to provide timely, cost-effective, and evidence-based nutrition services as the recognized nutrition experts on a hospital interdisciplinary team and saves valuable time in the care and treatment of patients, time that is now often wasted as RD[N]s must seek out physicians, [Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs)] to write or co-sign dietary orders".[6] CMS's final rule recognizes both the need and rational for RDNs broadly autonomous practice in this regard, if they obtain any requisite privileges from their facility to order therapeutic diets independently.[3]

Some facts emphasizing the importance of diet order writing privileges are highlighted below.

- Patients' nutrition needs are not always fully addressed upon admission, frequently requiring concomitant changes in diet orders that are often excessively delayed when RDNs must wait for a physician to effectuate the order.
- Timely nutrition interventions and ongoing monitoring of nutrition status by RDNs facilitates earlier discharge, producing substantial cost savings by shortening lengths of stay.[7]
- Patients suffer unnecessary complications and delay in care under the existing rule when RDNs are prevented from independently changing nutritional supplements, liberalizing a diet for better intake, initially assessing appropriate diets for patients with food allergies, or changing diet consistency for patients with dysphagia, an inability to chew food, or at risk of aspiration.
- "Swing bed" patients, who may only see a physician once a week, experience particularly significant delays as their health conditions and nutrition needs change. RDNs authorized to order patient diets are more likely to conform the wording of their diet orders to the formulary, eliminating confusion that has frequently resulted in being served the wrong diet.
- Pediatric patients may be harmed from delays in ordering appropriate infant formula that could be ameliorated if this proposed licensure is enacted.

MNT is a cost-effective disease management strategy that reduces chronic disease risk, delays disease progression, enhances the efficacy of medical/surgical treatment, reduces medication use, and improves patient outcomes including quality of life.[1]

The need for MNT has never been more critical. Half of all U.S. adults – about 117 million people – have a preventable, diet-related chronic disease; two-thirds of Americans have obesity or are overweight. More than 93 million Americans of all ages are affected by obesity, which the Centers for Disease Control and Prevention (CDC) defines as a body mass index greater than 30. Obesity affects every system of the body, and is associated with diabetes, cardiovascular disease, cancers, liver disease and over 240 other serious conditions. MNT is a widely

recognized component of medical guidelines for the prevention and treatment of many chronic diseases and malnutrition, as well as in the reduction of risk factors for these conditions. The COVID-19 pandemic has shown another condition associated with obesity and chronic disease. A report from the CDC reveals that 78 percent of COVID-19 patients requiring admission to an intensive-care unit (ICU) had at least one underlying health condition, many of which were obesity-related diseases.[4]
Data from New York City indicate that people with both COVID-19 and obesity are two times more likely to be admitted to the hospital, and people with severe obesity are 3.6 times more likely to require critical care, such as mechanical ventilation.[5] Most COVID-19 patients on ventilators require enteral or parenteral nutrition, a MNT intervention.

Public confidence in competency of Licensed Medical Nutrition Therapists

Regulation is the mechanism to ensure that a standard of education, supervised practice and exam competency has been met. This standard offers assurance to the public that they can receive care in a safe manner. As our members will attest, Nebraskans engage too often with incompetent, ineffective and dangerous nutrition "care" provided by individuals with spurious credentials and specious promises of success, It is critical to ensure that Nebraskans can identify competent practitioners and obtain timely expert care from qualified professionals. State oversight allows Nebraskans to identify quality practitioners by restricting the misleading use of titles by incompetent or unqualified practitioners and be confident in knowing that state-licensed practitioners are subject to local oversight and compliance with public safety standards.

Pre-planned supervised practice experience is critical to ensuring public safety. This requirement is missing in the current statute for those individuals who have MS and PhD degrees with a board approved competency exam. It is imperative that similar academic standards and supervised practice requirements established for eligibility of registered dietitian nutritionist applies to all MNT applicants.
To address this gap, we propose similar academic standards, supervised practice requirements, and exam competency for all professionals requesting a medical nutrition therapist license. Board Certified Specialists in Nutrition and Diplomates of the American Clinical Board of Nutrition are also eligible for licensure as a licensed nutritionist if they meet similar standards (academic, supervised practice experience, and exam competency) now proposed in the bill. This proposal strengthens the protection of the public as all potential applicants must meet the same minimum standards.

Professional licensure for RDNs and other qualified nutrition professionals protects the public through effective application of objective standards in education, work experience and exams required. These standards ensure competency to provide complex care, such as MNT. Modernizing the statute to be consistent with national standards may increase access to MNT among Nebraskans from providers in other states.

Access

Nebraskans will have access to MNT offered by Certified Nutrition Specialists as the licensure eligibility requirements for this professional are clarified.

2) **If the proposal is for the regulation of a health professional group not previously regulated, all feasible methods of regulation, including those methods listed below, and the impact of such methods on the public, must be considered. For each of the following evaluate the feasibility of applying it to the profession and the extent to which the regulatory method would protect the public.**
    a) **Inspection requirements**
    b) **Injunctive relief**

c) **Regulating the business enterprise rather than individual providers**
d) **Regulating or modifying the regulation of those who supervise the providers under review**
e) **Registering the providers under review**
f) **Certifying the providers under review by the State of Nebraska**
g) **Licensing the providers under review**

Not applicable. Medical nutrition therapists are already a licensed health professional group.

3) **What is the benefit to the public of regulating the health professional group under review or changing the scope of practice of the regulated health profession under review?**

Revising the statute and advancing the scope for MNT as described for question number one, demonstrates that MNT is an evidence-based diagnostic scientific nutrition practice, can reduce health care costs, and provide timely effective nutrition care.

Evidence-based nutrition and positive patient outcomes

The critical benefit to Nebraskans is that the MNT they receive is individualized based upon the nutrition problem/diagnosis determined by the LMNT using the Nutrition Care Process (NCP) and clinical judgment. The LMNT's knowledge and ability to diagnose the nutrition problem (Appendix) that the patient/client is experiencing and order the most beneficial nutrition interventions results in quality and timely care. The identification of a nutrition diagnostic judgment (Appendix) guides the LMNT to select effective nutrition interventions, to achieve positive patient outcomes. Interventions are specific to addressing the problem based on a nutrition diagnosis and not the medical or nursing diagnosis. Therefore, nutrition interventions are individualized to the patient's/client's nutrition problem(s) and effectiveness can be evaluated.

Improved written and oral communication within and among disciplines is realized by entering nutrition diagnostic judgments on the patient/client record in an organized manner using standardized language. A classification of standardized language for nutrition diagnoses, intervention and outcomes (Appendix F) establishes a system suitable for the Electronic Health Record and makes it possible to aggregate & compare nutrition problems, interventions, and outcomes within and across clinical populations and settings and study and identify effective interventions. When nutrition diagnoses are added to the patient/client list of medical, nursing and other health care professionals' problems, all of the patients/client's problems can treated and quality or care and outcomes improved.

The patients/clients benefit from a standard use of the NCP because continuity of care is enhanced. As patients/clients move from one health care setting to another there will be a standardized way to communicate the care plan and the outcomes remaining to be achieved.

Revising scope of practice reduces existing confusion in the implementation of nutrition care services, reduces the burden on physicians in the administration of MNT, and ultimately reduce healthcare costs.

Reduced health care costs

According to the CMS formula, a conservative estimate of nearly **$14.5 million in annual cost savings, can be expected in Nebraska** if RDNs are able to order therapeutic diets consistent with the CMS final rule.[3] CMS published that rule on May 12, 2014 finalizing a proposed rule change in which CMS stated "we believe hospitals would realize significant cost savings in many of the areas affected by nutritional care. As CMS recognized, "Without the proposed regulatory changes allowing hospitals to grant appropriate ordering privileges to RD[N]s, hospitals would not

be able to effectively realize improved patient outcomes and overall cost savings that we believe would be possible with such changes".[3] According to CMS, this "cost reduction estimate includes only [parenteral nutrition or "PN"] solution and pharmacy labor costs, not the savings estimates due to the time needed to administer PN by nurses, time saved by supervising physicians, or many other categories of potential savings. There may, of course, be some minor cost increasing changes, but we know of none that would be consequential . . .". [3] In addition, CMS clarified that, "The savings are based on the impact that RD[N] ordering privileges had on reducing inappropriate PN usage alone and do not include other positive impacts that RD[N] ordering privileges might have on reducing costs to hospitals, such as potential reductions in nursing time needed for dietary administration when patients switch from inappropriate PN to enteral nutrition or a regular hospital diet."[3]

There are particularly significant cost savings when RDNs order and monitor nutrition support. The appropriate selection of route of nutrition support can be associated with decreased complications and mortality rates. The involvement of RDNs in such patient care activities leads to significant cost reduction. One study noted 20% cost savings after allowing RDNs to practice at the highest level of their scope, resulting in a savings of $300,000 over two years for a single hospital.[8]

The studies cited by CMS confirm that providing the revised regulatory authority will produce substantial cost savings, allow RDNs to see and treat more patients, and reduce delays in the ordering of therapeutic diets (including nutritional supplements), particularly PN and EN diet orders, complex infant formula orders, and in the monitoring of associated lab parameters.

The growing number of RDNs with advanced/terminal degrees and specialized credentials is likely to produce even greater benefits as these nutrition experts perform at the height of RDN scope of practice. In January of 2024, an advanced degree will be required for all credentialing of all newly eligible RDNs.

Timely and more effective nutrition therapy

The benefits to the public are not simply financial; Nebraskans will experience improved quality of care and better health outcomes. By modernizing the statute to reflect current standards of practice, LMNTs will be able to more effectively provide timely nutrition therapy to critically ill patients. One study used to inform the current CMS guidelines found "patients whose PN regimens were ordered by RD[N]s have significantly fewer days of hyperglycemia (57 percent versus 23 percent) and electrolyte abnormalities (72 percent versus 39 percent) compared with patients whose PN regimens were ordered by physicians.[9]

One of the conditions that MNT can manage is malnutrition, an issue across all care settings among both adults and children. Malnutrition remains a critical public health issue with exceedingly high impacts on health care costs. A recent study in Barbados showed that adults who had suffered from an episode of moderate to severe malnutrition in the first year of life showed more attention problems and lower social status and standard of living than matched controls, even after 37–43 years.[10.]

In the acute care hospital setting, it is estimated that approximately 20 to 50 percent of admitted patients are malnourished or at-risk of malnutrition [11-15] and nearly 35-50 percent of older residents in long term care facilities are malnourished. Studies show that malnutrition, as a contributing factor to post-hospital syndrome, can increase a patient's risk for a 30-day readmission, often for reasons other than the original diagnosis.[16] For example, 45% of patients who fall in the hospital have malnutrition; costs for falls overall to Medicare totaled $31 billion in 2015.[17-18] Decreased nutrient intake is a major independent risk factor for in-hospital mortality and assistance from across the hospital interdisciplinary team is essential to assuring adequate consumption of nutrients. Studies show in-hospital mortality is highest in the patients in the lowest BMI group (<18.5 kg/m2). Interventions provided by nutrition professionals "decreases

length of stay, episode cost, and 30-day readmission risk in the inpatient population".[19] Food is the bedrock of treatment for malnourished hospital patients, and RDN-provided nutrition care, assessments, and interventions should be assured in a similar manner to other professional services provided as part of an inpatient stay.

Malnourished patients in the hospital are 2 times more likely to develop a pressure ulcer in the hospital,[20] are hospitalized an average of 2 days longer than those screened and treated early[21-22] and have 3 times the risk for surgical site infection.[23] MNT interventions for malnourished patients improves patient quality of care and reduces overall costs by a 25% reduction in pressure ulcer incidence[24], a 28% decrease in avoidable readmissions [25], 14% fewer overall complications [26], and average length of stay reduction by approximately 2 days.[21-22]

4) What is the extent to which the proposed regulation or the proposed change in scope of practice might harm the public?

The potential for harm to the public associated with the proposals is minimal. As depicted throughout this application, substantial benefits will be enhanced for consumers, hospitals, post-acute care centers and patients across the state. LMNTs are uniquely positioned and qualified to provide a diagnostic scientific nutrition practice and the highest quality of nutrition care by virtue of their education from ACEND accredited programs and CDR's registration requirements or similar standards proposed in the bill.

Approximately 50% of LMNTs have advanced graduate degrees. Like other health care professionals RDNs education is advancing and in 2024 a graduate degree will be required for entry level RDNs. With these standards set by national boards and commissions the proposed regulation will neither restrict qualified applicants nor have a negative effect on RDNs migrating from other states.

The profession's code of ethics sets forth commitment and obligations of the practitioner to the public, clients, the profession, colleagues, and other professionals.[27]

5) What standards exist or are proposed to ensure that a practitioner of the health professional group under review would maintain competency?

Under the current medical nutrition therapist licensure law, Nebraska DHHS requires 30 hours of continuing education per every two-year licensure cycle. Continuing education must be specific to the delivery of MNT services, i.e. assessment, nutrition diagnosis, nutrition intervention and/or monitoring appropriate for a medical or nutritional diagnosis, condition, or disease state.

In addition to meeting the 30 hours of continuing education specific to MNT practice, Registered Dietitian Nutritionist (RDN) credentialed practitioners are required to maintain certification through continuous learning to ensure professional knowledge and competence. This is documented through the completion of a minimum of 75 continuing education hours every five years.

To maintain the RDN credential, the Commission on Dietetic Registration constructed the Professional Development Portfolio (PDP) process. The Commission on Dietetic Registration developed the *Essential Practice Competencies for CDR Credentialed Nutrition and Dietetics Practitioners* to provide validated standards for the Registered Dietitian Nutritionist (RDN). Practice competencies define the knowledge, skill, judgment, and attitude requirements throughout a practitioner's career, across practice, and within focus areas. The competencies provide a structured guide for the practitioner to help identify, evaluate, and develop the behaviors required for continuing competence. The portfolio must be submitted every five years to maintain the RDN credential.

In addition to the continuing education requirements to maintain the LMNT and RDN credentials, hospitals require dietitians performing MNT to demonstrate competency for the tasks that they are expected to perform in the health care setting. The demonstration of competency is an expectation of The Joint Commission *Standard MS.08.01.03 Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.* The process for the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

Renewal of the license would require paying applicable renewal fees and maintaining one's credential as an RDN in good standing with CDR and documentation of 30 hours of continuing education over a 2-year period.

6) **What is the current and proposed role and availability of third-party reimbursement for the services provided by the health professional group under review?**

The proposed statute does not include any changes related to third-party reimbursement. Licensure does not mandate third party coverage; it does lend insurers a level of protection by ensuring that those they might cover are qualified practitioners of evidence-based nutrition care.

Insurance providers may establish additional regulations that must be followed for payment of MNT. LMNTs providing telehealth services must be licensed and/or meet other applicable standards that required by state or local laws in both the state where the practitioner is located and the state where the patient is located. MNT provided by RDNs is linked to improved clinical outcomes and reduced health care costs related to physician time, medication use and hospital admissions for people with obesity, diabetes, and other chronic diseases.[1]

7) **What is the experience of other jurisdictions in regulating the practitioners affected by the proposal? Identify appropriate statistics on complaints, describing actions taken, etc., by jurisdictions where the profession is regulated.**

Most of the other states have already determined that there is a substantial risk of significant harm to the public if the practice of MNT is not regulated and the lack of regulation poses a threat to public health and safety. LMNTs are the nutrition experts among health care practitioners and provide complex nutrition care services to Nebraskans in acute, post-acute, ambulatory care, dialysis centers and other venues. Patients diagnosed with many of the leading causes of death—including diabetes, cancers, chronic kidney disease, gastrointestinal disorders, obesity, eating disorders and cardiovascular disease benefit working with a LMNT to effectively treat and manage their disease and medical condition and reduce the risk of adverse outcomes.

Due to the current regulation of medical nutrition therapists in Nebraska, there are few complaints. The DHHS data shows that in the last 5 years, 2 investigations of licensed medical nutrition therapists, occurred. Due to confidentially, outcomes of these complaints are not available.

8) **What are the expected costs of regulating the health professional group under review, including the impact of registration, certification, or licensure on the costs of services to the public? What are the expected costs to the state and to the general public of implementing the proposed legislation?**

Expenses associated with the administrative oversight of licensure are and will be paid for by application fees collected by the DHHS Division of Public Health Licensure Unit. Fees collected from the licensees are sufficient to fund the regulatory regime, with no separate taxpayer funding necessary. The licensure and renewal fees would be established by the MNT Board.

Question # 2 gives detail on the cost savings to Nebraska health care institutions if the proposed language is passed.

9) Is there any additional information that would be useful to the technical committee members in their review of the proposal?

A committee of the Nebraska Academy of Nutrition and Dietetics (NAND), comprised of elected Board members and appointed members comprised of clinicians in various practice settings, and educators, worked jointly on this project. NAND took several steps to ensure its membership had the opportunity to receive information on the proposed changes in this application. Quarterly NAND newsletters (Spring 2019, Fall 2019, Winter 2020, Spring 2020) were sent electronically to members and are archived on the association's member web page.

In person sessions with members were offered at area meetings of the association and a series of virtual meetings in January-February 2020 were conducted for members to ask questions about the proposed bill. A NAND webinar (7.22.20) was offered to update members and answer questions. No revisions to the proposed language were made from information collected at these encounters.

This application is respectfully submitted by:

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Appendixes

Appendix A- Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care

Appendix B- Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice

Appendix C- The State of Nebraska Statutes relating to Medical Nutrition Therapy Practice Act

Appendix D- Proposed amended Medical Nutrition Therapy Practice Act

Appendix E- Redlined changes comparing current practice act to proposed practice act

Appendix F- Academy of Nutrition and Dietetics Nutrition Terminology (eNCPT): Nutrition Diagnostic Terminology, Nutrition Intervention Terminology, Nutrition Assessment and Monitoring and Evaluation Terminology

Appendix A

Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care

Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists

The Academy Quality Management Committee

ABSTRACT

Registered dietitian nutritionists (RDNs) face complex situations every day. Competently addressing the unique needs of each situation and applying standards appropriately are essential to providing safe, timely, patient-/client-/customer-centered, quality nutrition and dietetics care and services. The Academy of Nutrition and Dietetics (Academy) leads the profession by developing standards that can be used by RDNs (who are credentialed by the Commission on Dietetic Registration) for self-evaluation to assess quality of practice and performance. The Standards of Practice reflect the Nutrition Care Process and workflow elements as a method to manage nutrition care activities with patients/clients/populations that include nutrition screening, nutrition assessment, nutrition diagnosis, nutrition intervention/plan of care, nutrition monitoring and evaluation, and discharge planning and transitions of care. The Standards of Professional Performance consist of six domains of professional performance: Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources. Within each standard, specific indicators provide measurable action statements that illustrate how the standard can be applied to practice. The Academy's Revised 2017 Standards of Practice and Standards of Professional Performance for RDNs, along with the Academy's Code of Ethics and the Revised 2017 Scope of Practice for the RDN, provide minimum standards and tools for demonstrating competence and safe practice and are used collectively to gauge and guide an RDN's performance in nutrition and dietetics practice.

J Acad Nutr Diet. 2018;118:132-140.

Editor's note: Figures 2 and 3 that accompany this article are available online at www.jandonline.org.

THE ACADEMY OF NUTRITION and Dietetics (Academy) leads the profession of nutrition and dietetics by developing standards from which the quality of practice and performance of Registered Dietitian Nutritionists (RDNs) can be evaluated. The following Academy foundational documents guide the practice and performance of RDNs in all practice settings: Revised 2017 Standards of Practice (SOP) in Nutrition Care and Standards of Professional Performance (SOPP) for RDNs, along with the Academy/Commission on Dietetic Registration (CDR) Code of Ethics[1] and the Revised 2017 Scope of Practice for the RDN.[2] RDNs are nutrition and dietetics practitioners credentialed by CDR who are specifically trained and qualified to provide nutrition and dietetics services and are accountable and responsible for their competent practice. The SOP in Nutrition Care and SOPP define minimum competent level of practice for RDNs.

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WHAT ARE THE SOP AND SOPP FOR RDNs?

The standards and indicators found within the SOP and SOPP reflect the minimum competent level of nutrition and dietetics practice and professional performance for RDNs. The SOP in Nutrition Care is composed of four standards that apply the Nutrition Care Process and Terminology in the care of patients/clients/populations (see Figure 1).[3] The SOPP for RDNs consist of standards representing six domains of professional performance (see Figure 1).

The SOP and SOPP reflect the education, training, responsibility, and accountability of the RDN. Both sets of standards and indicators (Figures 2 and 3, available at www.jandonline.org) comprehensively depict the minimum expectation for competent care of the patient/client/customer, delivery of services, and professional practice outcomes for the RDN. This article represents the 2017 update of the Academy's SOP in Nutrition Care and SOPP for RDNs.

WHY ARE THE STANDARDS IMPORTANT FOR RDNs?

The standards promote:

- safe, effective, quality, and efficient food, nutrition, and related services, and dietetics practice;

Approved August 2017 by the Quality Management Committee of the Academy of Nutrition and Dietetics (Academy) and the House of Delegates Leadership Team on behalf of the House of Delegates. ***Scheduled review date: June 2023.*** *Questions regarding the Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists may be addressed to the Academy Quality Management Staff: Dana Buelsing, MS, manager, Quality Standards Operations; and Sharon M. McCauley, MS, MBA, RDN, LDN, FADA, FAND, senior director, Quality Management, at quality@eatright.org.*

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All registered dietitians are nutritionists—but not all nutritionists are registered dietitians. The Academy's Board of Directors and Commission on Dietetic Registration have determined that those who hold the credential Registered Dietitian (RD) may optionally use "Registered Dietitian Nutritionist" (RDN). The two credentials have identical meanings. The same determination and option also applies to those who hold the credential Dietetic Technician, Registered (DTR) and Nutrition and Dietetics Technician, Registered (NDTR). The two credentials have identical meanings. In this document, the term *RDN* is used to refer to both registered dietitians and registered dietitian nutritionists, and the term *NDTR* is used to refer to both dietetic technicians, registered and nutrition and dietetics technicians, registered.

CLIENT/PATIENT/RESIDENT/FAMILY/CUSTOMER

Generally, these terms are interchangeable, with a specific term used in a given situation, dependent on the setting and the population receiving care or services. Examples of terms used include, but are not limited to: *patient/client, patient/client/customer, resident, participant, student, consumer,* or any *individual/person, group, population,* or *organization* to which the RDN provides service. In a clinical setting, the term *patient/client* is commonly used. As a universal term, the use of *customer* in the Standards of Professional Performance is intended to encompass all the other terms with the meaning taken by the reader reflecting the context of the situation and setting. Use of *customer* is not intended to imply monetary exchange.

- evidence-based practice and best practices;
- improved nutrition and health-related outcomes and cost-reduction methods;
- efficient management of time, finances, facilities, supplies, technology, and natural and human resources;
- quality assurance, performance improvement, and outcomes reporting;
- ethical and transparent business, billing, and financial management practices[9,10];
- verification of practitioner qualifications and competence because state and federal regulatory agencies, such as health departments and the Centers for Medicare and Medicaid Services (CMS), look to professional organizations to create and maintain standards of practice[7,11,12];
- consistency in practice and performance;
- nutrition and dietetics research, innovation, and practice development; and
- individual professional advancement.

The standards provide:

- minimum competent levels of practice and performance;
- common measurable indicators for self-evaluation;
- a foundation for public and professional accountability in nutrition and dietetics care and services;
- a description of the role of nutrition and dietetics and the unique services that RDNs offer within the health care team and in practice settings outside of health care;
- guidance for policies and procedures, job descriptions, competence assessment tools; and
- academic and supervised practice objectives for education programs.

The SOP in Nutrition Care:

- reflect the Nutrition Care Process and workflow elements as a method to manage nutrition care activities (ie, nutrition screening, nutrition assessment, nutrition diagnosis, nutrition intervention/plan of care, nutrition monitoring and evaluation, and discharge planning and transitions of care); and
- apply to RDNs who provide individualized nutrition assessment, intervention, and discharge planning for patients/clients/populations in acute and post-acute health care, ambulatory care, home-based, public health, and community settings.

The SOPP:

- are formatted according to six domains of professional performance (ie, Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources); and
- apply to all RDNs maintaining the RDN credential:
  - in all practice settings; and
  - not practicing in nutrition and dietetics.

Figure 1. What are the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs)?

HOW DOES THE ACADEMY'S SCOPE OF PRACTICE FOR THE RDN GUIDE THE PRACTICE AND PERFORMANCE OF RDNs IN ALL SETTINGS?

The Revised 2017 Scope of Practice for the RDN is composed of statutory and individual components, including codes of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics), and encompasses the range of roles, activities, and regulations within which RDNs perform. For credentialed practitioners, scope of practice is typically established within the practice act and interpreted and controlled by the agency or board that regulates the practice of the profession in a given state.[2] An RDN's statutory scope of practice can delineate the services an RDN is authorized to perform in a state where a practice act or certification exists. In 2017, 46 states had statutory provisions regarding professional regulations for dietitians and/or nutritionists (http://www.eatrightpro.org/resource/advocacy/legislation/all-legislation/licensure).

The RDN's individual scope of practice is determined by education, training, credentialing, experience, and demonstrating and documenting competence to practice. Individual scope of practice in nutrition and dietetics has flexible boundaries to

capture the depth and breadth of the individual's professional practice. The Scope of Practice Decision Tool (www.eatrightpro.org/scope), an online interactive tool, guides an RDN through a series of questions to determine whether a particular activity is within his or her scope of practice. The tool is designed to allow an RDN to critically evaluate his or her personal knowledge, skill, experience, judgment, and demonstrated competence using criteria resources.

WHY WERE THE STANDARDS REVISED?

Academy documents are reviewed and revised every 7 years and reflect the Academy's expanded and enhanced mission and vision of accelerating improvements in global health and well-being through food and nutrition. Regular reviews are indicated to reflect changes in health care and other business segments, public health initiatives, new or revised practice guidelines and research, performance measurement, consumer interests, technological advances, and emerging service delivery options and practice environments. Questions and input from credentialed practitioners, federal and state regulations, accreditation standards, and other factors necessitated review and revision of the 2012 "core" SOP in Nutrition Care and SOPP for the Registered Dietitian to assure safe, quality, and competent practice.[13] The 2012 core SOP in Nutrition Care and SOPP for Dietetic Technicians, Registered is also under review/revision and will be updated and published in 2018 in this *Journal*.[14]

Examples of significant changes since the published Revised 2012 SOP in Nutrition Care and SOPP for RDs are the updates in the CMS, Department of Health and Human Services Conditions of Participation for Hospitals and Critical Access Hospitals effective July 2014 and Long-Term Care in November 2016, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and the national efforts to address malnutrition.

Acute and Critical Access Hospitals

The CMS Hospital and Critical Access Hospital Conditions of Participation now allow a hospital and its medical staff the option of including RDNs or other qualified nutrition professionals within the category of "non-physician practitioners" eligible for credentialing for appointment to the medical staff or be granted ordering privileges, without appointment to the medical staff, for therapeutic diets and nutrition-related services, if consistent with state law.[5,12]

To comply with regulatory requirements, an RDN's eligibility to be considered for ordering privileges must be approved through the hospital's medical staff rules, regulations, and bylaws, or other facility-specific processes.[6] The actual privileges granted will be based on the RDN's knowledge, skills, experience, specialist certification, if required, and demonstrated and documented competence. RDNs must review state laws, if applicable (eg, licensure, certification, and title protection) and health care regulations to determine whether there are any barriers or state-specific processes to address. For more information, please review the Academy's practice tips that outline the regulations and implementation steps for obtaining ordering privileges (www.eatrightpro.org/dietorders/).

Long-Term Care

The Long-Term Care Final Rule published October 4, 2016 in the *Federal Register* "allows the attending physician to delegate to a qualified dietitian or other clinically qualified nutrition professional the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law" and permitted by the facility's policies. The qualified professional works under the supervision of the physician.[8] The physician's supervision may include, for example, countersigning orders written by the qualified dietitian or clinically qualified nutrition professional, if required by state law.

RDNs who work in long-term care facilities should review the Academy's updates on CMS (www.eatrightpro.org/quality), which outline the regulatory changes to section 483.60 Food and Nutrition Services and considerations for developing the facilities process with medical director and orientation for attending physicians and review revisions to the CMS State Operations Manual, Appendix PP—Guidance to Surveyors for Long-Term Care Facilities.[7]

IMPACT Act—Implications for Hospitals and Post-Acute Care Conditions of Participation

The IMPACT Act of 2014 amends Title XVIII of the Social Security Act by adding a new section—Standardized Post-Acute Care Assessment Data for Quality, Payment, and Discharge Planning. Post-acute care providers include home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. In addition, the legislation includes new survey and medical review requirements for hospice care. The Act requires submission and reporting of specific standardized assessment and quality measure outcomes data with an overarching intent to reform post-acute care payment and reimbursement while ensuring continued beneficiary access to the most appropriate setting for care.

The Act includes quality measure domains that address, at a minimum, functional status, skin integrity, incidence of major falls, hospital readmissions, and the transfer of health information and care preferences when an individual transitions to a different care setting. These quality measure domains provide opportunities for RDNs and Nutrition and Dietetics Technicians, Registered (NDTRs) to help post-acute and long-term health care settings achieve positive clinical outcomes, quality measure improvement, and cost savings, as well as provide an improved quality of life. Obtain IMPACT Act practice resources on the Academy website at www.eatrightpro.org/impact.

In response to provisions of the IMPACT Act, CMS published a proposed rule in November 2015 (final action to be determined by November 2018; https://www.regulations.gov/docket?D=CMS-2015-0120) to revise the discharge planning requirements for hospitals including long-term care hospitals and inpatient rehabilitation facilities, home health agencies, and critical access hospitals. The provisions address discharge planning policies and procedures, applicable

patient types, timing, people involved (includes patient and caregiver), criteria for evaluation of discharge needs, discharge instructions, post-discharge follow-up, transfers (required medical information to the receiving facility), and other hospital requirements (eg, improving focus on behavioral health).[15]

In the proposed rule, CMS expressed concern with the variation in the discharge planning process. CMS is looking to require that all patients, including inpatients, outpatients under observation status, outpatients undergoing surgical procedures, and emergency department patients, receive a discharge plan. Another requirement deals with timing, that is, a copy of the discharge plan and summary must be sent to the practitioners responsible for the patient's follow-up care within 48 hours. The third change is for the hospital to establish a post-discharge follow-up process to check on patients who return home. Discharge planning, Hospital Conditions of Participation section 482.43, is highlighted to assist with limiting readmissions, which has a negative impact on the Medicare program.[16] Check the CMS Regulations and Guidance page regularly, as Hospital Conditions of Participation updates and revisions are released continuously (https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html).

Electronic Clinical Quality Measures for Malnutrition

Malnutrition electronic clinical quality measures were developed as part of the Malnutrition Quality Improvement Initiative when a variety of stakeholder organizations highlighted gaps in existing malnutrition care. The electronic clinical quality measures include screening, assessment, nutrition care plan, and diagnosis for malnutrition, with the goal for inclusion in the CMS federal programs across the continuum of care. In addition, the Malnutrition Quality Improvement Initiative Toolkit was established to evaluate clinical workflow processes and assist with standardizing malnutrition care. Find malnutrition and Malnutrition Quality Improvement Initiative resources at www.eatrightpro.org/malnutrition.

HOW WERE THE STANDARDS REVISED?

The members of the Quality Management Committee and its Scope/Standards of Practice Workgroup utilized collective experience and consensus in reviewing and revising statements, where needed, to support safe, quality practice and desirable outcomes. The review focused on definition of terms, illustrative figures and tables, consideration of services and activities in current practice, and enhancements to support future practice and advancement. The 2017 standards, rationales, and indicators were updated using information from questions received by the Academy's Quality Management Department; discussions with the Academy's Dietetic Practice Groups, Academy's Standing Committees (eg, Consumer Protection and Licensure Subcommittee, Nutrition Informatics Committee), Accreditation Council for Education in Nutrition and Dietetics, CDR; and member comments through focus area SOP and SOPP development.

HOW DO THE SOP IN NUTRITION CARE, THE SOPP, AND FOCUS AREA STANDARDS RELATE TO EACH OTHER?

The Academy's core SOP and SOPP for the RDN serve as blueprints for the development of focus area SOP and SOPP for RDNs. Of note, while the core SOP and SOPP for RDNs reflect the minimum competent level of nutrition and dietetics practice, focus area SOP and SOPP documents contain three levels (competent, proficient, and expert) to convey the continuum of practice as RDNs attain increasing levels of knowledge, skill, experience, and judgment in specific practice areas. The Academy's Nutrition and Dietetics Career Development Guide is a useful tool for practitioners for professional development and lifelong learning (https://www.eatrightpro.org/resource/practice/career-development/career-toolbox/dietetics-career-development-guide).

As of 2017, there are 17 published focus area SOPs and/or SOPPs for RDNs that can be accessed on the *Journal of the Academy of Nutrition and Dietetics* website or through the Academy's website at www.eatrightpro.org/sop:

- Adult Weight Management;
- Clinical Nutrition Management;
- Diabetes Care;
- Disordered Eating and Eating Disorders;
- Education of Dietetics Practitioners;
- Integrative and Functional Medicine;
- Intellectual and Developmental Disabilities;
- Long-Term and Post-Acute Care Nutrition;
- Management of Food and Nutrition Systems;
- Mental Health and Addictions;
- Nephrology Nutrition;
- Nutrition Support;
- Oncology Nutrition;
- Pediatric Nutrition;
- Public Health and Community Nutrition;
- Sports Nutrition and Dietetics; and
- Sustainable, Resilient, and Healthy Food and Water Systems.

WHAT IS THE RELATIONSHIP OF THE RDN AND NDTR IN DELIVERING PERSON-/CLIENT-/POPULATION-CENTERED CARE?

The RDN is responsible for supervising or providing oversight of any patient/client/population care activities assigned to professional, technical, and support staff, including the NDTR, and can be held accountable to the patients/clients/populations and others for services rendered. This description of "supervision" as it relates to the RDN/NDTR team is not synonymous with managerial supervision or clinical supervision used in medicine and mental health fields (eg, peer to peer), supervision of provisional licensees, and/or supervision of dietetics interns and students.[17] Additional information is available regarding the roles and practice of NDTRs in the following resources: Revised 2017 Scope of Practice for the NDTR,[18] Revised 2017 SOP in Nutrition Care and SOPP for NDTRs,[19] Practice Tips: The RDN-NDTR Team-Steps to Preserve,[20] and Practice Tips: What is Meant by "Under the Supervision of the RDN"?[17] (The Revised 2017 Scope of Practice for the NDTR and the Revised 2017 SOP and SOPP for NDTRs will be published in 2018).

In direct patient/client care, the RDN and NDTR work as a team[20] using a systematic process reflecting the Nutrition Care Process[3] and the

organization's manual or electronic documentation system, for example, an electronic health record that uses one of the available standardized terminologies that may incorporate the electronic Nutrition Care Process Terminology (eNCPT).[21] The RDN develops and oversees the system for delivery of nutrition care activities, often with the input of others, including the NDTR. Components of the nutrition care delivery system might include the following: policies and procedures, protocols, standards of care, forms, documentation standards, and roles and responsibilities of professional, technical, and support personnel participating in the care of patients/clients. The RDN is responsible for completing the nutrition assessment; determining the nutrition diagnosis or diagnoses; developing the care plan; implementing the nutrition intervention; evaluating the patient's/client's response; and also supervising the activities of professional, technical, and support personnel assisting with the patient's/client's care.[2,18]

Although NDTRs are not employed in all facilities, when they are available, NDTRs are important members of the care team. The NDTR is often the first staff from the nutrition team that a patient or client meets. The NDTR serves as a conduit of nutrition care information to RDNs and other team members at meetings and care conferences, and contributes to the continuum of care by facilitating communication between nutrition care and nursing staff.

The RDN assigns duties that are consistent with the NDTR's individual scope of practice. For example, the NDTR may initiate standard procedures, such as completing and/or following up on nutrition screening for assigned units/patients, performing routine activities based on diet order and/or policies and procedures, completing the intake process for a new clinic patient/client, and reporting to the RDN when a patient's/client's data suggest the need for an RDN evaluation. The NDTR actively participates in nutrition care by contributing information and observations, guiding patients/clients in menu selections, monitoring meals/snacks/nutritional supplements for compliance to diet order, and providing nutrition education on prescribed diets. The NDTR reports to the RDN on the patient's/client's response, including documenting outcomes or providing evidence signifying the need to adjust the nutrition intervention/plan of care.

HOW ARE THE STANDARDS STRUCTURED?

Each of the standards is presented with a brief description of the competent level of practice. The rationale statement describes the intent, purpose, and importance of the standard. Indicators provide measurable action statements that illustrate applications of the standard and examples of outcomes depict measureable results that relate the indicators to practice. Each standard is equal in relevance and importance (see Figures 2 and 3, available at www.jandonline.org).

HOW CAN I USE THE STANDARDS TO EVALUATE AND ADVANCE MY PRACTICE AND PERFORMANCE?

RDNs should review the SOP in Nutrition Care and the SOPP at determined intervals. Regular self-evaluation is important because it helps identify opportunities to improve and enhance practice and professional performance. RDNs are encouraged to pursue additional training and experience, regardless of practice setting, to maintain currency and to expand individual scope of practice within the limitations of the legal scope of practice, as defined in state law, if applicable, and federal and state regulations. Refer to Figure 4 for a flow chart that outlines how an RDN can apply the SOP and SOPP to their practice.

The standards can also be used as part of CDR's Professional Development Portfolio process[22] to develop goals and focus continuing education efforts. The Professional Development Portfolio process encourages CDR-credentialed nutrition and dietetics practitioners to incorporate self-reflection and learning needs assessment for development of a learning plan for improvement and commitment to lifelong learning. CDR's updated system implemented with the 5-year recertification cycle that began in 2015 incorporates the use of essential practice competencies for determining professional development needs.[23] In the 3-step process, the credentialed practitioner accesses an online Goal Wizard (step 1), which uses a decision algorithm to identify essential practice competency goals and performance indicators relevant to the RDN's area(s) of practice (essential practice competencies and performance indicators replace the learning need codes of the previous process). The Activity Log (step 2) is used to log and document continuing professional education over a 5-year period. The Professional Development Evaluation (step 3) guides self-reflection and assessment of learning and how it is applied. The outcome is a completed evaluation of the effectiveness of the practitioner's learning plan and continuing professional education. The self-assessment/self-evaluation information can then be used in developing the plan for the practitioner's next 5-year recertification cycle. (For more information, see https://www.cdrnet.org/competencies-for-practitioners.)

RDNs use the SOP and SOPP as a self-evaluation tool to support and demonstrate quality practice and competence. RDNs can:

- apply every indicator and achieve the outcomes in line with roles and responsibilities all at once, or identify areas to strengthen and accomplish;
- identify additional indicators and examples of outcomes (ie, outcomes measurement is a way to demonstrate value and competence) that reflect their individual practice/setting;
- apply only applicable indicators based on diversity of practice roles, activities, organization performance expectations, and work or volunteer practice settings; and
- refer to focus area SOPs and SOPPs to identify competence outcomes, demonstrate competence, and document learning in specific areas of practice.

The standards are written in broad terms to allow for an individual practitioner's handling of nonroutine situations. The standards are geared toward typical situations for practitioners with the RDN credential. Figure 5 provides role examples illustrating how RDNs can use the standards in a variety of settings. Strictly adhering to standards does not, in and of itself, constitute best care and service. It is the responsibility of individual practitioners to recognize and interpret situations and to know what standards apply and in what ways they apply.[24]

Academy Scope of Practice for the Registered Dietitian Nutritionist (RDN)
Academy Scope of Practice for the Nutrition and Dietetics Technician, Registered (NDTR)

Scope of practice in nutrition and dietetics encompasses the range of roles, activities, and regulations within which nutrition and dietetics practitioners perform.

Identify your individual scope of practice[2]:

An RDN's and NDTR's individual scope of practice is determined by education, training, credentialing, and demonstrated competence, as well as state statutory scope of practice, if applicable. Establishment of statutory scope of practice is the authority of the state(s) in which the RDN or NDTR practices. See Academy of Nutrition and Dietetics (Academy) Definition of Terms for differences between licensure, statutory certification, and title protection.

- Review federal and state regulations and organizational policies and procedures.
- Utilize Academy resources: Revised 2017 Scope of Practice for the RDN; Revised 2017 Scope of Practice for the NDTR; Current Academy/Commission on Dietetic Registration (CDR) Code of Ethics, Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for RDNs, Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for NDTRs, Scope of Practice Decision Tool, and the Academy Definition of Terms.

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Academy Standards of Practice in Nutrition Care and Standards of Professional Performance

The four standards of practice in nutrition care and six standards of professional performance describe a minimum competent level of nutrition and dietetics practice and professional performance. Standards of practice and standards of professional performance are self-evaluation tools. Standards of practice in nutrition care apply to practitioners who provide care to patients/clients/populations.

- Read the standards and rationale statements to determine how each relates to your practice. For NDTRs, identify direct patient/client care situations or activities that require working under the supervision of an RDN.

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Indicators

Indicators are action statements that identify a minimum competent level of practice, demonstrate how each standard relates to practice, and link standards to outcomes.

- Identify indicators that apply to your practice. Depending on your setting and work responsibilities, some indicators may not apply. Re-evaluate routinely and as responsibilities change.

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Examples of Outcomes for Each Standard

The outcome statements illustrate examples of measurable actions that result from demonstrating competence in practice.

- Review the outcome examples.
- Evaluate measurable evidence of your performance to evaluate competence. Examples include documentation of outcomes from peer interactions, patient/client/customer/population interventions, customer service reports, and job responsibility deliverables.
- Comply regularly with standards and indicators utilizing organizational policies, procedures, and protocols.

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How do I demonstrate competence in my practice? Take a continuous quality improvement approach to implementing the standards and achieving desirable outcomes. Re-evaluate on a regular basis.

What do I need to do to enhance my practice? Use the standards to develop your Professional Development Portfolio. The CDR professional development recertification process provides a framework for the RDN and the NDTR to develop specific goals, identify essential practice competencies and performance indicators, and pursue continuing education opportunities. Incorporate your goals and essential practice competencies, practice illustrations and actions into your annual performance review and learning development process.

Figure 4. Flow chart on how to use the Academy of Nutrition and Dietetics Standards of Practice and Standards of Professional Performance.

SUMMARY

RDNs face complex situations every day. Competently addressing the unique needs of each situation and applying standards appropriately is essential to providing safe, timely, person-/client-/population-centered, quality care and service. All RDNs are advised to conduct their practice based on the most recent edition of the Academy/CDR Code of Ethics[1] and the Revised 2017 Scope of Practice for the RDN,[2] the Revised 2017 SOP in Nutrition Care and SOPP for RDNs, and any applicable focus area SOP and SOPP for RDNs. These resources provide minimum standards and tools for demonstrating competence and safe practice and are used collectively to gauge and guide an RDN's performance in nutrition and dietetics practice. The SOP and SOPP for the RDN are self-evaluation tools that promote quality assurance, performance improvement, and outcomes management.[25] Self-assessment provides opportunities to identify areas for enhancement, new learning, and skill development, and to encourage progression of career growth.

To ensure that RDNs always have access to the most current materials,

Role	Examples of use of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) documents by RDNs in different practice roles
Clinical practitioner, inpatient or outpatient care	A hospital-based RDN in general clinical practice has accepted a new coverage assignment that includes patients with gastrointestinal (GI) disorders. The RDN notes the types of GI disorders and reviews medical nutrition therapy resources and published practice guidelines to identify areas for enhancing knowledge and skills with continuing education and mentoring from a more experienced practitioner. Because the available focus area SOP and SOPP do not specifically address GI disorders, the RDN uses the SOP and SOPP for RDNs as the primary guide for self-evaluation. The RDN recognizes that this self-evaluation and review of GI-related resources will assist with revising their professional development plan to incorporate new competencies, if necessary, and to identify relevant continuing education activities.
Sales representative, national food distributor	An RDN with a management role in hospital foodservice has accepted a sales representative position with a national foodservice distributor. In reviewing resources for the new role, the RDN identifies knowledge and skill areas to strengthen for quality practice. The RDN reviewed the Academy of Nutrition and Dietetics (Academy)/Commission on Dietetic Registration (CDR) Code of Ethics,[1] the Academy's ethics resources, and the SOPP for RDNs to be reminded of areas to consider when in a business practice role. This self-evaluation process identifies knowledge/skill areas for continuing education and mentoring by more experienced RDN colleagues and others with expertise in business and sales. The RDN updates professional development plan to incorporate new practice competencies applicable to the new role in sales.
Quality improvement specialist, multi-hospital system	An RDN with experience as a clinical nutrition manager and as a clinical practitioner in oncology is recruited for an open position in the quality improvement/compliance monitoring department for the hospital system. In evaluating the position description and role expectations, the RDN identifies some knowledge and skill areas for development/enhancement. The RDN uses the SOP and SOPP for RDNs for self-evaluation reflecting on the standards and indicators with the perspective of the quality improvement role. The RDN identifies specific continuing-education activities, updates professional development plan with new essential competencies, and sets a goal to qualify for one of the quality credentials or certifications.
RDN practitioner in a rural community	An RDN who lives in a rural community works professionally in multiple settings (critical access hospital, clinic at the county health department, and the community's senior meal program) as a part-time employee or contractor. Because of varying professional roles, the RDN uses the SOP and SOPP for RDNs as the guiding self-evaluation resource with each role. This allows the RDN to direct attention to, and reflect on, any new/enhanced knowledge or skills needed for quality and competent practice. Applicable focus area SOP and SOPPs are reviewed as well, to inform this process and to identify any additional resources for investigation (eg, regulations, practice guidelines, professional organizations, websites, and literature citations). With each role, the RDN evaluates the need for any new essential practice competencies and updates professional development plan as needed.

(continued on next page)

Figure 5. Examples of use of the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) for self-evaluation and the promotion of competent practice.

Role	Examples of use of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) documents by RDNs in different practice roles
Telehealth practitioner, nutrition and wellness	An RDN accepts a new position with a national company that provides telehealth wellness information and coaching to enrollees of private insurance providers. The RDN, who has more than 5 years of general clinical practice, including staffing a hospital's wellness center, investigates the requirements for providing telehealth services within the state. The RDN also explores limitations related to licensure and regulations for callers who live in other states. The RDN reviews the SOP and SOPP for RDNs as a self-evaluation tool, accesses the telehealth resources on the Academy's website, and participates in the company's training webinars that incorporate review of policies and procedures to assure legal and competent practice as a licensed practitioner. The RDN updates professional development plan and identifies continuing education opportunities to enhance coaching skills to ultimately qualify for one of the accredited coaching certifications.
RDN, nonpracticing	An RDN takes a leave of absence from the nutrition and dietetics workforce. Because the RDN is maintaining his or her credential, sustaining professional performance is an expectation. The RDN maintains and establishes networking and professional relationships. The RDN participates in and volunteers for the local and national nutrition and dietetics association. The RDN volunteers within the community to promote healthy lifestyles and responds to public policy calls to action by contacting representatives via social media, correspondence, and personal visits. The RDN obtains continuing professional education units for CDR certification requirement and licensure. The RDN recognizes the need to maintain skills at least at the minimally competent level identified within the SOP in Nutrition Care and SOPP for RDNs.

Figure 5. *(continued)* Examples of use of the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) for self-evaluation and the promotion of competent practice.

The standards have been formulated for use by individuals in self-evaluation, practice advancement, and for indicators of quality. These standards do not constitute medical or other professional advice, and should not be taken as such. The information presented in the standards is not a substitute for the exercise of professional judgment by the nutrition and dietetics practitioner. The standards are not intended for disciplinary actions, or determinations of negligence or misconduct. The use of the standards for any other purpose than that for which they were formulated must be undertaken with the sole authority and discretion of the user.

each resource is maintained on, or accessed through, the Academy website. The documents are reviewed and updated as new trends in the profession of nutrition and dietetics, health care, public health, food science, and other external influences emerge.

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Standards of Practice for Registered Dietitian Nutritionists
Standard 1: Nutrition Assessment
The registered dietitian nutritionist (RDN) uses accurate and relevant data and information to identify nutrition-related problems.
Rationale:
Nutrition screening is the preliminary step to identify individuals who require a nutrition assessment performed by an RDN. Nutrition assessment is a systematic process of obtaining and interpreting data in order to make decisions about the nature and cause of nutrition-related problems and provides the foundation for nutrition diagnosis. It is an ongoing, dynamic process that involves not only initial data collection, but also reassessment and analysis of patient/client or population/community needs. Nutrition assessment is conducted using validated tools based in evidence, the five domains of nutrition assessment, and comparative standards. Nutrition assessment may be performed via in-person, or facility/practitioner assessment application, or Health Insurance Portability and Accountability Act (HIPAA)-compliant video conferencing telehealth platform.

Indicators for Standard 1: Nutrition Assessment		
Each RDN:		
1.1	Patient/client/population history: Assesses current and past information related to personal, medical, family, and psychosocial/social history	
1.2	Anthropometric assessment: Assesses anthropometric indicators (eg, height, weight, body mass index [BMI], waist circumference, arm circumference), comparison to reference data (eg, percentile ranks/*z*-scores), and individual patterns and history	
1.3	Biochemical data, medical tests, and procedure assessment: Assesses laboratory profiles (eg, acid–base balance, renal function, endocrine function, inflammatory response, vitamin/mineral profile, lipid profile), and medical tests and procedures (eg, gastrointestinal study, metabolic rate)	
1.4	Nutrition-focused physical examination (NFPE) may include visual and physical examination: Obtains and assesses findings from NFPE (eg, indicators of vitamin/mineral deficiency/toxicity, edema, muscle wasting, subcutaneous fat loss, altered body composition, oral health, feeding ability [suck/swallow/breathe], appetite, and affect)	
1.5	Food and nutrition-related history assessment (ie, dietary assessment): Evaluates:	
	1.5A	Food and nutrient intake, including composition and adequacy, meal and snack patterns, and appropriateness related to food allergies and intolerances
	1.5B	Food and nutrient administration, including current and previous diets and diet prescriptions and food modifications, eating environment, and enteral and parenteral nutrition administration
	1.5C	Medication and dietary supplement use, including prescription and over-the-counter medications, and integrative and functional medicine products
	1.5D	Knowledge, beliefs, and attitudes (eg, understanding of nutrition-related concepts, emotions about food/nutrition/health, body image, preoccupation with food and/or weight, readiness to change nutrition- or health-related behaviors, and activities and actions influencing achievement of nutrition-related goals)
	1.5E	Food security defined as factors affecting access to a sufficient quantity of safe, healthful food and water, as well as food/nutrition-related supplies

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Figure 2. Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Indicators for Standard 1: Nutrition Assessment		
	1.5F	Physical activity, cognitive and physical ability to engage in developmentally appropriate nutrition-related tasks (eg, self-feeding and other activities of daily living), instrumental activities of daily living (eg, shopping, food preparation), and breastfeeding
	1.5G	Other factors affecting intake and nutrition and health status (eg, cultural, ethnic, religious, lifestyle influencers, psychosocial, and social determinants of health)
1.6	Comparative standards: Uses reference data and standards to estimate nutrient needs and recommended body weight, body mass index, and desired growth patterns	
	1.6A	Identifies the most appropriate reference data and/or standards (eg, international, national, state, institutional, and regulatory) based on practice setting and patient-/client-specific factors (eg, age and disease state)
1.7	Physical activity habits and restrictions: Assesses physical activity, history of physical activity, and physical activity training	
1.8	Collects data and reviews data collected and/or documented by the nutrition and dietetics technician, registered (NDTR), other health care practitioner(s), patient/client, or staff for factors that affect nutrition and health status	
1.9	Uses collected data to identify possible problem areas for determining nutrition diagnoses	
1.10	Documents and communicates:	
	1.10A	Date and time of assessment
	1.10B	Pertinent data (eg, medical, social, behavioral)
	1.10C	Comparison to appropriate standards
	1.10D	Patient/client/population perceptions, values, and motivation related to presenting problems
	1.10E	Changes in patient/client/population perceptions, values, and motivation related to presenting problems
	1.10F	Reason for discharge/discontinuation or referral, if appropriate

Examples of Outcomes for Standard 1: Nutrition Assessment

- Appropriate assessment tools and procedures are used in valid and reliable ways
- Appropriate and pertinent data are collected
- Effective interviewing methods are used
- Data are organized and categorized in a meaningful framework that relates to nutrition problems
- Use of assessment data leads to the determination that a nutrition diagnosis/problem does or does not exist
- Problems that require consultation with or referral to another provider are recognized
- Documentation and communication of assessment are complete, relevant, accurate, and timely

Standard 2: Nutrition Diagnosis

The registered dietitian nutritionist (RDN) identifies and labels specific nutrition problem(s)/diagnosis(es) that the RDN is responsible for treating.

Rationale:

Analysis of the assessment data leads to identification of nutrition problems and a nutrition diagnosis(es), if present. The nutrition diagnosis(es) is the basis for determining outcome goals, selecting appropriate interventions, and monitoring progress. Diagnosing nutrition problems is the responsibility of the RDN.

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Indicators for Standard 2: Nutrition Diagnosis	
Each RDN:	
2.1	Diagnoses nutrition problems based on evaluation of assessment data and identifies supporting concepts (ie, etiology, signs, and symptoms)
2.2	Prioritizes the nutrition problem(s)/diagnosis(es) based on severity, safety, patient/client needs and preferences, ethical considerations, likelihood that nutrition intervention/plan of care will influence the problem, discharge/transitions of care needs, and patient/client/advocate[a] perception of importance
2.3	Communicates the nutrition diagnosis(es) to patients/clients/advocates, community, family members or other health care professionals when possible and appropriate
2.4	Documents the nutrition diagnosis(es) using standardized terminology and clear, concise written statement(s) (eg, using Problem [P], Etiology [E], and Signs and Symptoms [S] [PES statement(s)] or Assessment [A], Diagnosis [D], Intervention [I], Monitoring [M], and Evaluation [E] [ADIME statement(s)])
2.5	Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available

Examples of Outcomes for Standard 2: Nutrition Diagnosis

- Nutrition diagnostic statements that accurately describe the nutrition problem of the patient/client and/or community in a clear and concise way
- Documentation of nutrition diagnosis(es) is relevant, accurate, and timely
- Documentation of nutrition diagnosis(es) is revised as additional assessment data become available

Standard 3: Nutrition Intervention/Plan of Care

The registered dietitian nutritionist (RDN) identifies and implements appropriate, person-centered interventions designed to address nutrition-related problems, behaviors, risk factors, environmental conditions, or aspects of health status for an individual, target group, or the community at large.

Rationale:

Nutrition intervention consists of two interrelated components—planning and implementation.

- Planning involves prioritizing the nutrition diagnoses, conferring with the patient/client and others, reviewing practice guidelines, protocols and policies, setting goals, and defining the specific nutrition intervention strategy.
- Implementation is the action phase that includes carrying out and communicating the intervention/plan of care, continuing data collection, and revising the nutrition intervention/plan of care strategy, as warranted, based on change in condition and/or the patient/client/population response.

An RDN implements the interventions or assigns components of the nutrition intervention/plan of care to professional, technical, and support staff in accordance with knowledge/skills/judgment, applicable laws and regulations, and organization policies. The RDN collaborates with or refers to other health care professionals and resources. The nutrition intervention/plan of care is ultimately the responsibility of the RDN.

Indicators for Standard 3: Nutrition Intervention/Plan of Care	
Each RDN:	
Plans the Nutrition Intervention/Plan of Care:	
3.1	Addresses the nutrition diagnosis(es) by determining and prioritizing appropriate interventions for the plan of care
3.2	Bases intervention/plan of care on best available research/evidence and information, evidence-based guidelines, and best practices

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Indicators for Standard 3: Nutrition Intervention/Plan of Care			
3.3	Refers to policies and procedures, protocols and program standards		
3.4	Collaborates with patient/client/advocate/population, caregivers, interprofessional[b] team, and other health care professionals		
3.5	Works with patient/client/advocate/population and caregivers to identify goals, preferences, discharge/transitions of care needs, plan of care and expected outcomes		
3.6	Develops the nutrition prescription and establishes measurable patient-/client-focused goals to be accomplished		
3.7	Defines time and frequency of care including intensity, duration, and follow-up		
3.8	Uses standardized terminology for describing interventions		
3.9	Identifies resources and referrals needed		
Implements the Nutrition Intervention/Plan of Care:			
3.10	Collaborates with colleagues, interprofessional team, and other health care professionals		
3.11	Communicates and coordinates the nutrition intervention/plan of care		
3.12	Initiates the nutrition intervention/plan of care		
	3.12A	Uses approved clinical privileges, physician/non-physician practitioner[c]—driven orders (ie, delegated orders), protocols, or other facility-specific processes for order writing or for provision of nutrition-related services consistent with applicable specialized training, competence, medical staff, and/or organizational policy	
		3.12A1	Implements, initiates, or modifies orders for therapeutic diet, nutrition-related pharmacotherapy management, or nutrition-related services (eg, medical foods/nutrition/dietary supplements, food texture modifications, enteral and parenteral nutrition, intravenous fluid infusions, laboratory tests, medications, and education and counseling)
		3.12A2	Manages nutrition support therapies (eg, formula selection, rate adjustments, addition of designated medications and vitamin/mineral supplements to parenteral nutrition solutions or supplemental water for enteral nutrition)
		3.12A3	Initiates and performs nutrition-related services (eg, bedside swallow screenings, inserting and monitoring nasoenteric feeding tubes, and indirect calorimetry measurements, or other permitted services)
3.13	Assigns activities to NDTR and other professional, technical, and support personnel in accordance with qualifications, organizational policies/protocols, and applicable laws and regulations		
	3.13A	Supervises professional, technical, and support personnel	
3.14	Continues data collection		
3.15	Documents:		
	3.15A	Date and time	
	3.15B	Specific and measurable treatment goals and expected outcomes	
	3.15C	Recommended interventions	
	3.15D	Patient/client/advocate/caregiver/community receptiveness	
	3.15E	Referrals made and resources used	
	3.15F	Patient/client/advocate/caregiver/community comprehension	
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Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Indicators for Standard 3: Nutrition Intervention/Plan of Care		
	3.15G	Barriers to change
	3.15H	Other information relevant to providing care and monitoring progress over time
	3.15I	Plans for follow up and frequency of care
	3.15J	Rationale for discharge or referral if applicable

Examples of Outcomes for Standard 3: Nutrition Intervention/Plan of Care

- Goals and expected outcomes are appropriate and prioritized
- Patient/client/advocate/population, caregivers, and interprofessional teams collaborate and are involved in developing nutrition intervention/plan of care
- Appropriate individualized patient-/client-centered nutrition intervention/plan of care, including nutrition prescription, is developed
- Nutrition intervention/plan of care is delivered and actions are carried out as intended
- Discharge planning/transitions of care needs are identified and addressed
- Documentation of nutrition intervention/plan of care is:
  - Specific
  - Measurable
  - Attainable
  - Relevant
  - Timely
  - Comprehensive
  - Accurate
  - Dated and timed

Standard 4: Nutrition Monitoring and Evaluation

The registered dietitian nutritionist (RDN) monitors and evaluates indicators and outcomes data directly related to the nutrition diagnosis, goals, preferences, and intervention strategies to determine the progress made in achieving desired results of nutrition care and whether planned interventions should be continued or revised.

Rationale:

Nutrition monitoring and evaluation are essential components of an outcomes management system in order to assure quality, patient-/client-/population-centered care, and to promote uniformity within the profession in evaluating the efficacy of nutrition interventions. Through monitoring and evaluation, the RDN identifies important measures of change or patient/client/population outcomes relevant to the nutrition diagnosis and nutrition intervention/plan of care; describes how best to measure these outcomes; and intervenes when intervention/plan of care requires revision.

Indicators for Standard 4: Nutrition Monitoring and Evaluation		
Each RDN:		
4.1	Monitors progress:	
	4.1A	Assesses patient/client/advocate/population understanding and compliance with nutrition intervention/plan of care
	4.1B	Determines whether the nutrition intervention/plan of care is being implemented as prescribed

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Indicators for Standard 4: Nutrition Monitoring and Evaluation		
4.2	Measures outcomes:	
	4.2A	Selects the standardized nutrition care measurable outcome indicator(s)
	4.2B	Identifies positive or negative outcomes, including impact on potential needs for discharge/transitions of care
4.3	Evaluates outcomes:	
	4.3A	Compares monitoring data with nutrition prescription and established goals or reference standard
	4.3B	Evaluates impact of the sum of all interventions on overall patient/client/population health outcomes and goals
	4.3C	Evaluates progress or reasons for lack of progress related to problems and interventions
	4.3D	Evaluates evidence that the nutrition intervention/plan of care is maintaining or influencing a desirable change in the patient/client/population behavior or status
	4.3E	Supports conclusions with evidence
4.4	Adjusts nutrition intervention/plan of care strategies, if needed, in collaboration with patient/client/population/advocate/caregiver and interprofessional team	
	4.4A	Improves or adjusts intervention/plan of care strategies based upon outcomes data, trends, best practices, and comparative standards
4.5	Documents:	
	4.5A	Date and time
	4.5B	Indicators measured, results, and the method for obtaining measurement
	4.5C	Criteria to which the indicator is compared (eg, nutrition prescription/goal or a reference standard)
	4.5D	Factors facilitating or hampering progress
	4.5E	Other positive or negative outcomes
	4.5F	Adjustments to the nutrition intervention/plan of care, if indicated
	4.5G	Future plans for nutrition care, nutrition monitoring and evaluation, follow-up, referral, or discharge

Examples of Outcomes for Standard 4: Nutrition Monitoring and Evaluation

- The patient/client/community outcome(s) directly relate to the nutrition diagnosis and the goals established in the nutrition intervention/plan of care. Examples include, but are not limited to:
  - Nutrition outcomes (eg, change in knowledge, behavior, food, or nutrient intake)
  - Clinical and health status outcomes (eg, change in laboratory values, body weight, blood pressure, risk factors, signs and symptoms, clinical status, infections, complications, morbidity, and mortality)
  - Patient-/client-/population-centered outcomes (eg, quality of life, satisfaction, self-efficacy, self-management, functional ability)
  - Health care utilization and cost-effectiveness outcomes (eg, change in medication, special procedures, planned/unplanned clinic visits, preventable hospital admissions, length of hospitalizations, prevented or delayed nursing home admissions, morbidity, and mortality)

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- Nutrition intervention/plan of care and documentation is revised, if indicated
- Documentation of nutrition monitoring and evaluation is:
  - Specific
  - Measurable
  - Attainable
  - Relevant
  - Timely
  - Comprehensive
  - Accurate
  - Dated and timed

[a]**Advocate:** An *advocate* is a person who provides support and/or represents the rights and interests at the request of the patient/client. The person may be a family member or an individual not related to the patient/client who is asked to support the patient/client with activities of daily living or is legally designated to act on behalf of the patient/client, particularly when the patient/client has lost decision-making capacity. (Adapted from definitions within The Joint Commission Glossary of Terms[4] and the Centers for Medicare and Medicaid Services, Hospital Conditions of Participation[5]).

[b]**Interprofessional:** The term *interprofessional* is used in this evaluation resource as a universal term. It includes a diverse group of team members (eg, physicians, nurses, dietitian nutritionists, pharmacists, psychologists, social workers, and occupational and physical therapists), depending on the needs of the patient/client. Interprofessional could also mean interdisciplinary or multidisciplinary.

[c]**Non-physician practitioner:** A *non-physician practitioner* may include a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, qualified dietitian, or nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[5,6] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services long-term care (LTC) regulations. With publication of the Final Rule revising the Conditions of Participation for LTC facilities effective November 2016, post-acute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutrition supplements, or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law, and organization policies.[7,8]

Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Standards of Professional Performance for Registered Dietitian Nutritionists
Standard 1: Quality in Practice
The registered dietitian nutritionist (RDN) provides quality services using a systematic process with identified ethics, leadership, accountability, and dedicated resources.
Rationale:
Quality practice in nutrition and dietetics is built on a solid foundation of education and supervised practice, credentialing, evidence-based practice, demonstrated competence, and adherence to established professional standards. Quality practice requires systematic measurement of outcomes, regular performance evaluations, and continuous improvement.

Indicators for Standard 1: Quality in Practice		
Each RDN:		
1.1	Complies with applicable laws and regulations as related to his/her area(s) of practice	
1.2	Performs within individual and statutory scope of practice and applicable laws and regulations	
1.3	Adheres to sound business and ethical billing practices applicable to the role and setting	
1.4	Uses national quality and safety data (eg, National Academies of Sciences, Engineering, and Medicine: Health and Medicine Division, National Quality Forum, Institute for Healthcare Improvement) to improve the quality of services provided and to enhance customer-centered services	
1.5	Uses a systematic performance improvement model that is based on practice knowledge, evidence, research, and science for delivery of the highest quality services	
1.6	Participates in or designs an outcomes-based management system to evaluate safety, effectiveness, quality, person-centeredness, equity, timeliness, and efficiency of practice	
	1.6A	Involves colleagues and others, as applicable, in systematic outcomes management
	1.6B	Defines expected outcomes
	1.6C	Uses indicators that are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)
	1.6D	Measures quality of services in terms of structure, process, and outcomes
	1.6E	Incorporates electronic clinical quality measures to evaluate and improve care of patients/clients at risk for malnutrition or with malnutrition (www.eatrightpro.org/emeasures)
	1.6F	Documents outcomes and patient reported outcomes (eg, PROMIS[a])
	1.6G	Participates in, coordinates, or leads program participation in local, regional, or national registries and data warehouses used for tracking, benchmarking, and reporting service outcomes
1.7	Identifies and addresses potential and actual errors and hazards in provision of services or brings to attention of supervisors and team members as appropriate	
1.8	Compares actual performance to performance goals (ie, Gap Analysis, SWOT Analysis [strengths, weaknesses, opportunities, and threats], PDCA Cycle [plan, do, check, act], DMAIC [define, measure, analyze, improve, control])	
	1.8A	Reports and documents action plan to address identified gaps in care and/or service performance
1.9	Evaluates interventions and workflow process(es) and identifies service and delivery improvements	
1.10	Improves or enhances patient/client/population care and/or services working with others based on measured outcomes and established goals	

Examples of Outcomes for Standard 1: Quality in Practice
- Actions are within scope of practice and applicable laws and regulations
- National quality standards and best practices are evident in customer-centered services

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Figure 3. Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

- Performance improvement program specific to program(s)/service(s) is established and updated as needed; is evaluated for effectiveness in providing desired outcomes data and striving for excellence in collaboration with other team members
- Performance indicators are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)
- Aggregate outcomes results meet pre-established criteria
- Quality improvement results direct refinement and advancement of practice

Standard 2: Competence and Accountability
The registered dietitian nutritionist (RDN) demonstrates competence in and accepts accountability and responsibility for ensuring safe, quality practice and services.
Rationale:
Competence and accountability in practice includes continuous acquisition of knowledge, skills, experience, and judgment in the provision of safe, quality customer-centered service.

Indicators for Standard 2: Competence and Accountability		
Each RDN:		
2.1	Adheres to the code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics)	
2.2	Integrates the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) into practice, self-evaluation, and professional development	
	2.2A	Integrates applicable focus area(s) SOP SOPP into practice (www.eatrightpro.org/sop)
2.3	Demonstrates and documents competence in practice and delivery of customer-centered service(s)	
2.4	Assumes accountability and responsibility for actions and behaviors	
	2.4A	Identifies, acknowledges, and corrects errors
2.5	Conducts self-evaluation at regular intervals	
	2.5A	Identifies needs for professional development
2.6	Designs and implements plans for professional development	
	2.6A	Develops plan and documents professional development activities in career portfolio (eg, organizational policies and procedures, credentialing agency[ies])
2.7	Engages in evidence-based practice and uses best practices	
2.8	Participates in peer review of others as applicable to role and responsibilities	
2.9	Mentors and/or precepts others	
2.10	Pursues opportunities (education, training, credentials, certifications) to advance practice in accordance with laws and regulations, and requirements of practice setting	

Examples of Outcomes for Standard 2: Competence and Accountability
- Practice reflects:
  - Code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics)
  - Scope of Practice, Standards of Practice, and Standards of Professional Performance
  - Evidence-based practice and best practices
  - Commission on Dietetic Registration Essential Practice Competencies and Performance Indicators

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

- Practice incorporates successful strategies for interactions with individuals/groups from diverse cultures and backgrounds
- Competence is demonstrated and documented
- Services provided are safe and customer-centered
- Self-evaluations are conducted regularly to reflect commitment to lifelong learning and professional development and engagement
- Professional development needs are identified and pursued
- Directed learning is demonstrated
- Relevant opportunities (education, training, credentials, certifications) are pursued to advance practice
- Commission on Dietetic Registration recertification requirements are met

Standard 3: Provision of Services
The registered dietitian nutritionist (RDN) provides safe, quality service based on customer expectations and needs, and the mission, vision, principles, and values of the organization/business.
Rationale:
Quality programs and services are designed, executed, and promoted based on the RDN's knowledge, skills, experience, judgment, and competence in addressing the needs and expectations of the organization/business and its customers.

Indicators for Standard 3: Provision of Services		
Each RDN:		
3.1	Contributes to or leads in development and maintenance of programs/services that address needs of the customer or target population(s)	
	3.1A	Aligns program/service development with the mission, vision, principles, values, and service expectations and outputs of the organization/business
	3.1B	Uses the needs, expectations, and desired outcomes of the customers/populations (eg, patients/clients, families, community, decision makers, administrators, client organization[s]) in program/service development
	3.1C	Makes decisions and recommendations that reflect stewardship of time, talent, finances, and environment
	3.1D	Proposes programs and services that are customer-centered, culturally appropriate, and minimize disparities
3.2	Promotes public access and referral to credentialed nutrition and dietetics practitioners for quality food and nutrition programs and services	
	3.2A	Contributes to or designs referral systems that promote access to qualified, credentialed nutrition and dietetics practitioners
	3.2B	Refers customers to appropriate providers when requested services or identified needs exceed the RDN's individual scope of practice
	3.2C	Monitors effectiveness of referral systems and modifies as needed to achieve desirable outcomes
3.3	Contributes to or designs customer-centered services	
	3.3A	Assesses needs, beliefs/values, goals, resources of the customer, and social determinants of health
	3.3B	Uses knowledge of the customer's/target population's health conditions, cultural beliefs, and business objectives/services to guide design and delivery of customer-centered services
	3.3C	Communicates principles of disease prevention and behavioral change appropriate to the customer or target population

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Indicators for Standard 3: Provision of Services			
	3.3D	Collaborates with the customers to set priorities, establish goals, and create customer-centered action plans to achieve desirable outcomes	
	3.3E	Involves customers in decision making	
3.4	Executes programs/services in an organized, collaborative, cost effective, and customer-centered manner		
	3.4A	Collaborates and coordinates with peers, colleagues, stakeholders, and within interprofessional[b] teams	
	3.4B	Uses and participates in, or leads in the selection, design, execution, and evaluation of customer programs and services (eg, nutrition screening system, medical and retail foodservice, electronic health records, interprofessional programs, community education, grant management)	
	3.4C	Uses and develops or contributes to selection, design and maintenance of policies, procedures (eg, discharge planning/transitions of care), protocols, standards of care, technology resources (eg, Health Insurance Portability and Accountability Act [HIPAA]-compliant telehealth platforms), and training materials that reflect evidence-based practice in accordance with applicable laws and regulations	
	3.4D	Uses and participates in or develops processes for order writing and other nutrition-related privileges, in collaboration with the medical staff[c] or medical director (eg, post-acute care settings, dialysis center, public health, community, free-standing clinic settings), consistent with state practice acts; federal and state regulations; organization policies; and medical staff rules, regulations, and bylaws	
		3.4D1	Uses and participates in or leads development of processes for privileges or other facility-specific processes related to (but not limited to) implementing physician/non-physician practitioner[d]–driven delegated orders or protocols, initiating or modifying orders for therapeutic diets, medical foods/nutrition supplements, dietary supplements, enteral and parenteral nutrition, laboratory tests, medications, and adjustments to fluid therapies or electrolyte replacements
		3.4D2	Uses and participates in or leads development of processes for privileging for provision of nutrition-related services, including (but not limited to) initiating and performing bedside swallow screenings, inserting and monitoring nasoenteric feeding tubes, providing home enteral nutrition or infusion management services (eg, ordering formula and supplies) and indirect calorimetry measurements
	3.4E	Complies with established billing regulations, organization policies, grant funder guidelines, if applicable to role and setting, and adheres to ethical and transparent financial management and billing practices	
	3.4F	Communicates with the interprofessional team and referring party consistent with the HIPAA rules for use and disclosure of customer's personal health information	
3.5	Uses professional, technical, and support personnel appropriately in the delivery of customer-centered care or services in accordance with laws, regulations, and organization policies and procedures		
	3.5A	Assigns activities, including direct care to patients/clients, consistent with the qualifications, experience, and competence of professional, technical, and support personnel	
	3.5B	Supervises professional, technical, and support personnel	
3.6	Designs and implements food delivery systems to meet the needs of customers		
	3.6A	Collaborates in or leads the design of food delivery systems to address health care needs and outcomes (including nutrition status), ecological sustainability, and to meet the culture and related needs and preferences of target populations (ie, health care patients/clients, employee groups, visitors to retail venues, schools, child and adult day-care centers, community feeding sites, farm to institution initiatives, local food banks)	
	3.6B	Participates in, consults/collaborates with, or leads the development of menus to address health, nutritional, and cultural needs of target population(s) consistent with federal, state or funding source regulations or guidelines	

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services		
	3.6C	Participates in, consults/collaborates with, or leads interprofessional process for determining medical foods/nutritional supplements, dietary supplements, enteral and parenteral nutrition formularies, and delivery systems for target population(s)
3.7	Maintains records of services provided	
	3.7A	Documents according to organization policies, procedures, standards, and systems including electronic health records
	3.7B	Implements data management systems to support interoperable data collection, maintenance, and utilization
	3.7C	Uses data to document outcomes of services (ie, staff productivity, cost/benefit, budget compliance, outcomes, quality of services) and provide justification for maintenance or expansion of services
	3.7D	Uses data to demonstrate program/service achievements and compliance with accreditation standards, laws, and regulations
3.8	Advocates for provision of quality food and nutrition services as part of public policy	
	3.8A	Communicates with policy makers regarding the benefit/cost of quality food and nutrition services
	3.8B	Advocates in support of food and nutrition programs and services for populations with special needs and chronic conditions
	3.8C	Advocates for protection of the public through multiple avenues of engagement (eg, legislative action, establishing effective relationships with elected leaders and regulatory officials, participation in various Academy committees, workgroups and task forces, Dietetic Practice Groups, Member Interest Groups, and State Affiliates)

Examples of Outcomes for Standard 3: Provision of Services

- Program/service design and systems reflect organization/business mission, vision, principles, values, and customer needs and expectations
- Customers participate in establishing program/service goals and customer-focused action plans and/or nutrition interventions (eg, in-person or via telehealth)
- Customer-centered needs and preferences are met
- Customers are satisfied with services and products
- Customers have access to food assistance
- Customers have access to food and nutrition services
- Foodservice system incorporates sustainability practices addressing energy and water use and waste management
- Menus reflect the cultural, health and/or nutritional needs of target population(s) and consideration of ecological sustainability
- Evaluations reflect expected outcomes and established goals
- Effective screening and referral services are established or implemented as designed
- Professional, technical, and support personnel are supervised when providing nutrition care to customers
- Ethical and transparent financial management and billing practices are used per role and setting

Standard 4: Application of Research

The registered dietitian nutritionist (RDN) applies, participates in, and/or generates research to enhance practice. Evidence-based practice incorporates the best available research/evidence and information in the delivery of nutrition and dietetics services.

Rationale:

Application, participation, and generation of research promote improved safety and quality of nutrition and dietetics practice and services.

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 4: Application of Research		
Each RDN:		
4.1	Reviews best available research/evidence and information for application to practice	
	4.1A	Understands basic research design and methodology
4.2	Uses best available research/evidence and information as the foundation for evidence-based practice	
4.3	Integrates best available research/evidence and information with best practices, clinical and managerial expertise, and customer values	
4.4	Contributes to the development of new knowledge and research in nutrition and dietetics	
4.5	Promotes application of research in practice through alliances or collaboration with food and nutrition and other professionals and organizations	

Examples of Outcomes for Standard 4: Application of Research

- Evidence-based practice, best practices, clinical and managerial expertise, and customer values are integrated in the delivery of nutrition and dietetics services
- Customers receive appropriate services based on the effective application of best available research/evidence and information
- Best available research/evidence and information is used as the foundation of evidence-based practice

Standard 5: Communication and Application of Knowledge

The registered dietitian nutritionist (RDN) effectively applies knowledge and expertise in communications.

Rationale:

The RDN works with others to achieve common goals by effectively sharing and applying unique knowledge, skills, and expertise in food, nutrition, dietetics, and management services.

Indicators for Standard 5: Communication and Application of Knowledge		
Each RDN:		
5.1	Communicates and applies current knowledge and information based on evidence	
	5.1A	Demonstrates critical thinking and problem-solving skills when communicating with others
5.2	Selects appropriate information and the most effective communication method or format that considers customer-centered care and the needs of the individual/group/population	
	5.2A	Uses communication methods (ie, oral, print, one-on-one, group, visual, electronic, and social media) targeted to various audiences
	5.2B	Uses information technology to communicate, disseminate, manage knowledge, and support decision making
5.3	Integrates knowledge of food and nutrition with knowledge of health, culture, social sciences, communication, informatics, sustainability, and management	
5.4	Shares current, evidence-based knowledge, and information with various audiences	
	5.4A	Guides customers, families, students, and interns in the application of knowledge and skills
	5.4B	Assists individuals and groups to identify and secure appropriate and available educational and other resources and services

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 5: Communication and Application of Knowledge		
	5.4C	Uses professional writing and verbal skills in all types of communications
	5.4D	Reflects knowledge of population characteristics in communication methods
5.5	Establishes credibility and contributes as a food and nutrition resource within the interprofessional health care and management team, organization, and community	
5.6	Communicates performance improvement and research results through publications and presentations	
5.7	Seeks opportunities to participate in and assume leadership roles with local, state, and national professional and community-based organizations (eg, government-appointed advisory boards, community coalitions, schools, foundations or nonprofit organizations serving the food insecure) providing food and nutrition expertise	

Examples of Outcomes for Standard 5: Communication and Application of Knowledge

- Expertise in food, nutrition, dietetics, and management is demonstrated and shared
- Interoperable information technology is used to support practice
- Effective and efficient communications occur through appropriate and professional use of e-mail, texting, and social media tools
- Individuals, groups, and stakeholders:
  - Receive current and appropriate information and customer-centered service
  - Demonstrate understanding of information and behavioral strategies received
  - Know how to obtain additional guidance from the RDN or other RDN-recommended resources
- Leadership is demonstrated through active professional and community involvement

Standard 6: Utilization and Management of Resources

The registered dietitian nutritionist (RDN) uses resources effectively and efficiently.

Rationale:

The RDN demonstrates leadership through strategic management of time, finances, facilities, supplies, technology, natural and human resources.

Indicators for Standard 6: Utilization and Management of Resources		
Each RDN:		
6.1	Uses a systematic approach to manage resources and improve outcomes	
6.2	Evaluates management of resources with the use of standardized performance measures and benchmarking as applicable	
	6.2A	Uses the Standards of Excellence Metric Tool to self-assess quality in leadership, organization, practice, and outcomes for an organization (www.eatrightpro.org/excellencetool)
6.3	Evaluates safety, effectiveness, efficiency, productivity, sustainability practices, and value while planning and delivering services and products	
6.4	Participates in quality assurance and performance improvement and documents outcomes and best practices relative to resource management	
6.5	Measures and tracks trends regarding internal and external customer outcomes (eg, satisfaction, key performance indicators)	

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Examples of Outcomes for Standard 6: Utilization and Management of Resources

- Resources are effectively and efficiently managed
- Documentation of resource use is consistent with operational and sustainability goals
- Data are used to promote, improve, and validate services, organization practices, and public policy
- Desired outcomes are achieved, documented, and disseminated
- Identifies and tracks key performance indicators in alignment with organizational mission, vision, principles, and values

[a]**PROMIS:** The Patient-Reported Outcomes Measurement Information System (*PROMIS*) (https://commonfund.nih.gov/promis/index) is a reliable, precise measure of patient-reported health status for physical, mental, and social well-being. *PROMIS* is a web-based resource and is publicly available.

[b]**Interprofessional:** The term *interprofessional* is used in this evaluation resource as a universal term. It includes a diverse group of team members (eg, physicians, nurses, dietitian nutritionists, pharmacists, psychologists, social workers, and occupational and physical therapists), depending on the needs of the customer. Interprofessional could also mean interdisciplinary or multidisciplinary.

[c]**Medical staff:** *Medical staff* is composed of doctors of medicine or osteopathy and can, in accordance with state law, including scope of practice laws, include other categories of physicians, and non-physician practitioners who are determined to be eligible for appointment by the governing body.[5]

[d]**Non-physician practitioner:** A *non-physician practitioner* may include a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, qualified dietitian, or nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[5,6] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services long-term care (LTC) regulations. With publication of the Final Rule revising the Conditions of Participation for LTC facilities effective November 2016, post-acute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutrition supplements or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law, and organization policies.[7,8]

Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Appendix B

Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice

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

The Academy Quality Management Committee

ABSTRACT

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

J Acad Nutr Diet. 2018;118:141-165.

THE ACADEMY OF NUTRITION and Dietetics (Academy) is the world's largest organization of food and nutrition professionals and the association that represents credentialed nutrition and dietetics practitioners—registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs). The Academy's mission is to accelerate improvements in global health and well-being through food and nutrition. The RDN integrates research, professional development, and practice to stimulate innovation and discovery; collaborates to solve the greatest food and nutrition challenges now and in the future; focuses on system-wide impact across the food, wellness, and health sectors; has a global impact in eliminating all forms of malnutrition; and amplifies the contribution of nutrition and dietetics practitioners and expands workforce capacity and capability.[1] The Academy is the leader in identifying the abilities of the RDN and linking the RDN's expertise in food science and nutrition science with how the RDN practices dietetics.

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Available online 22 November 2017

PURPOSE

This document describes the scope of practice for the RDN. The RDN is educated and trained in food and nutrition science and dietetics practice. RDNs are integral members and leaders of interprofessional teams in health care, foodservice management, education, research, and other practice environments. They provide services in varied settings, including health care; business and industry; community and public health systems; schools, colleges, and universities; the military; government; research; wellness and fitness centers; agribusiness; private practice; and communications. The purposes of this document are to:

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

Approved August 2017 by the Quality Management Committee of the Academy of Nutrition and Dietetics (Academy) and the House of Delegates Leadership Team on behalf of the House of Delegates. ***Scheduled review date: June 2023.*** *Questions regarding the Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist may be addressed to the Academy Quality Management Staff: Dana Buelsing, MS, manager, Quality Standards Operations; and Sharon M. McCauley, MS, MBA, RDN, LDN, FADA, FAND, senior director, Quality Management, at quality@eatright.org.*

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All registered dietitians are nutritionists—but not all nutritionists are registered dietitians. The Academy's Board of Directors and Commission on Dietetic Registration have determined that those who hold the credential Registered Dietitian (RD) may optionally use "Registered Dietitian Nutritionist" (RDN). The two credentials have identical meanings. The same determination and option also applies to those who hold the credential Dietetic Technician, Registered (DTR) and Nutrition and Dietetics Technician, Registered (NDTR). The two credentials have identical meanings. In this document, the term *RDN* is used to refer to both registered dietitians and registered dietitian nutritionists, and the term *NDTR* is used to refer to both dietetic technicians, registered, and nutrition and dietetics technicians, registered.

4. Describe the relationship between the RDN and the NDTR to illustrate the work of the RDN/NDTR team providing direct patient/client care, and to describe circumstances in which the NDTR works under the supervision of an RDN.[2-4]
5. Guide the Academy, ACEND, and CDR in developing and promoting programs and services to advance the practice of nutrition and dietetics and the role of RDNs as leaders in providing quality food and nutrition care and services.

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

WHY WAS THE SCOPE OF PRACTICE FOR THE RDN REVISED?

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

- Academy of Nutrition and Dietetics: Scope of Practice for the Registered Dietitian[5];
- Academy of Nutrition and Dietetics: Scope of Practice for the Dietetic Technician, Registered[6];
- Academy of Nutrition and Dietetics: Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitians[7]; and
- Academy of Nutrition and Dietetics: Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Dietetic Technicians, Registered.[8]

Noteworthy changes since the Scope of Practice for the Registered Dietitian,[5] published in 2012, are the regulation changes in the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Conditions of Participation for Hospitals, Critical Access Hospitals, and Long-Term Care Facilities, which allow a hospital or long-term care facility the option of granting RDNs ordering privileges and/or delegated orders for therapeutic diets and nutrition-related services.[9-11]

FOUNDATIONAL DOCUMENTS

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

- Academy/CDR Code of Ethics[13] (Revised and approved Code of Ethics available in 2018);
- Revised 2017 Scope of Practice for the RDN;
- Revised 2017 Scope of Practice for the Nutrition and Dietetics Technician, Registered[14];
- Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists[15];
- Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Nutrition and Dietetics Technicians, Registered[16]; and
- Focus Area Standards of Practice and/or Standards of Professional Performance for RDNs http://www.andjrnl.org/content/focus and http://www.andjrnl.org/content/credentialed.

SCOPE OF PRACTICE

For the RDN, scope of practice focuses on food, nutrition, and dietetics practice, as well as related services developed, directed, and provided by the RDN to: protect the public, community, and populations; enhance health and well-being of patients/clients and communities; and deliver quality products, programs, and services. The scope of practice in nutrition and dietetics encompasses the range of roles, activities, and regulations within which nutrition and dietetics practitioners perform as outlined in Figure 1.[17]

The scope of practice for the RDN includes practice components used in nutrition and dietetics. Its depth and breadth begins with education and credentialing; incorporates practice resources; and concentrates on foundation elements of standards of practice and professional performance, codes of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics), accreditation standards, state and federal regulations, national guidelines, organizational policy and procedures, and options and

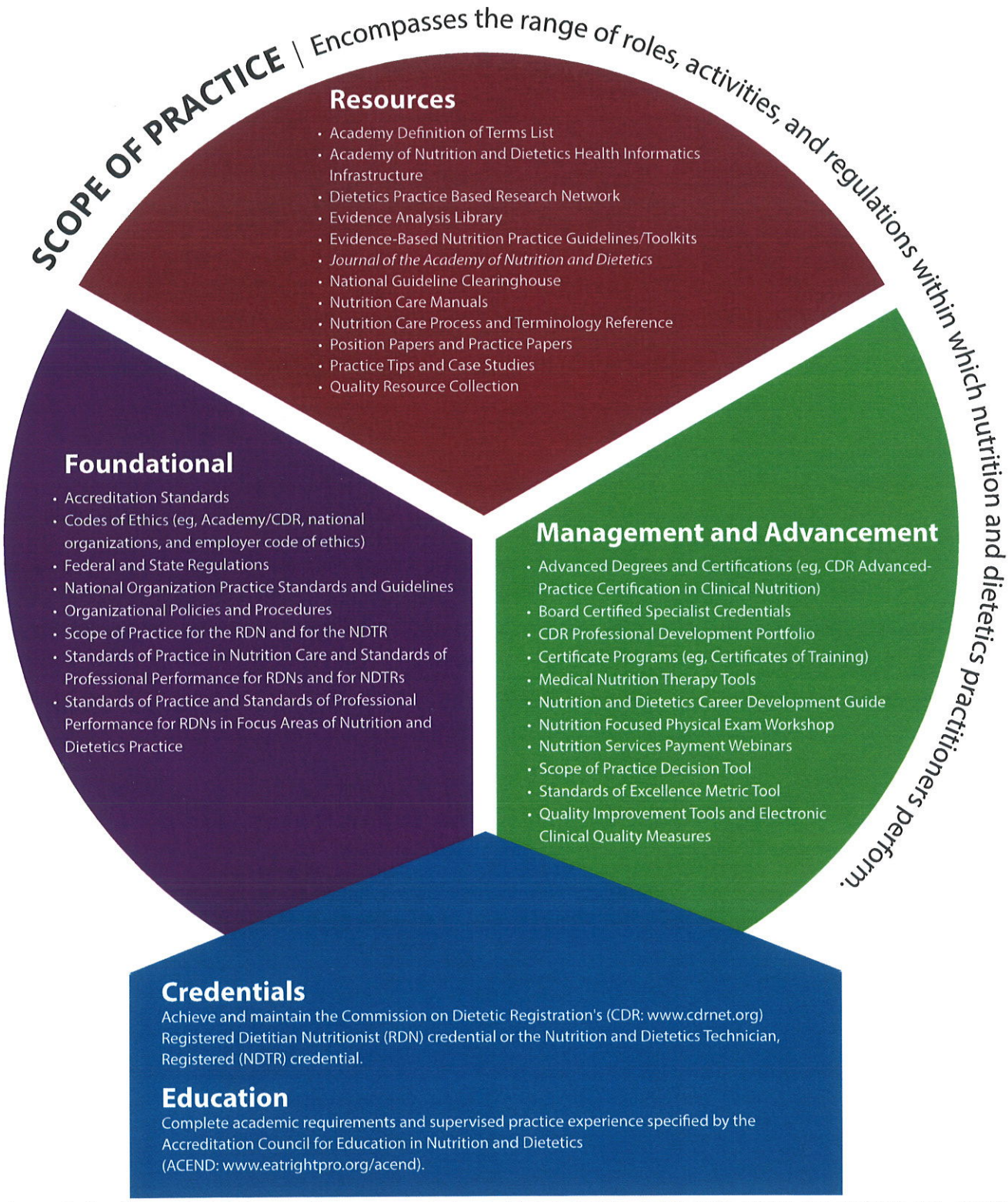

Figure 1. Nutrition and dietetics practice components for registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs).

Nutrition is defined as the "science of food, the nutrients and other substances therein, their action, interaction, and balance in relation to health and disease, and the process by which the organism ingests, absorbs, transports, utilizes, and excretes food substances."
Dietetics is derived from sciences of food, nutrition, management, communication, and biological sciences—including cell and molecular biology, genetics, pharmacology, chemistry, and biochemistry—and physiological, behavioral, and social sciences.
Nutrition and Dietetics reflects the integration of Nutrition—the science of food, nutrients, and other substances contributing to nutritional status and health—with Dietetics—the application of food, nutrition, and associated sciences—to optimize health and the delivery of care and services for individuals and groups.
Academy Definition of Terms (www.eatrightpro.org/scope)

resources for practice management and advancement.

EDUCATION AND CREDENTIALING REQUIREMENTS

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

Education

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

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

Approximately 50% of RDNs have earned advanced degrees at the master's or doctorate levels.[19] There are international programs in dietetics that have been recognized by ACEND under the Foreign Dietitian Education Standards or International Dietitian Education Standards (http://www.eatrightpro.org/resources/acend/accredited-programs/international-programs). For more information regarding the academic requirements and supervised practice for RDNs, refer to ACEND's website: http://www.eatrightpro.org/resources/acend.

Credentialing

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

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

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

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

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

COMPETENCE IN PRACTICE

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

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

In addition to credentials, CDR, the Academy, accredited education

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

An example of a credential/certification is the Board Certified Specialist in Pediatric Nutrition. This certification validates competencies and knowledge previously acquired through work experience. In keeping with the Academy/CDR Code of Ethics, RDNs can only practice in areas in which they are qualified and have demonstrated and documented competence to achieve ethical, safe, and quality outcomes in the delivery of food and nutrition services.[13] Competence is an overarching "principle of professional practice, identifying the ability of the provider to administer safe and reliable services on a consistent basis."[26] Competent practitioners understand and practice within their scope of practice; use up-to-date knowledge, skills, judgment, and best practices; make sound decisions based on appropriate data; communicate effectively with patients, customers, and others; critically evaluate their own practice; identify the limits of their competence; and improve performance based on self-evaluation, applied practice, and feedback from others.[27] In addition, professional competence involves the ability to engage in clinical reasoning that facilitates problem solving and fosters person-centered behaviors and participatory decision making.[28]

Depending on their knowledge, skills, expertise, individual interests, and competence, RDNs can work in multiple practice areas and settings, or may focus on a specific practice area or with a particular population or age group. Integral to the RDN's commitment to lifelong learning supported by CDR's Professional Development Portfolio Process is the recognition that additional knowledge, skills, experience, and demonstrated competence are imperative to maintaining currency with advances in practice and to evaluate the nutrition care workflow processes for improving health outcomes.[25]

As of 2017, there are 17 focus area Standards of Practice (SOP) and/or Standards of Professional Performance (SOPP) for registered dietitian nutritionists (RDNs).[15] Because RDNs are accountable for their own competence, focus area SOPs and SOPPs are available to assist RDNs in self-evaluation, determining learning needs, and identifying opportunities for advancement. The *Journal of the Academy Nutrition and Dietetics* houses collections of the SOPs and SOPPs: http://jandonline.org/content/focus and http://jandonline.org/content/credentialed.

INDIVIDUAL SCOPE OF PRACTICE

Each RDN has an individual scope of practice that is determined by education, training, credentialing, experience, and demonstrated and documented competence to practice.[13,17] Individual scope of practice is the intersection point of several elements, as illustrated in Figure 2. The RDN reviews the Academy Scope of Practice; state laws (ie, licensure, certification, title protection), if applicable; regulations and interpretive guidelines; CMS conditions of participation and coverage; accreditation standards and measures; organizational policies and procedures; and additional training, credential, and certification options possibly needed to secure advanced levels of practice, emerging opportunities, and employment positions.

STATE LICENSURE AND PRACTICE ACTS

State licensure and practice acts guide and govern nutrition and dietetics practice. Some laws are based on protecting the title "dietitian nutritionist"; that is, certification or title protection. These statutory provisions ensure the public has access to professionals that are qualified by education, experience, and examination to provide nutrition care services.[17] As of 2017, 46 states have statutory provisions regarding professional regulations for dietitians and/or nutritionists (http://www.eatrightpro.org/resource/advocacy/legislation/all-legislation/licensure). This document, the Academy's Revised 2017 Scope of Practice for the RDN, may also be used to guide the development of state practice acts or regulations.

STATUTORY SCOPE OF PRACTICE

Statutory scope of practice is typically established within a state-specific practice act and is interpreted and controlled by the agency or board that regulates the practice of the profession. "Legal scopes of practice for the health care professions establish which professionals may provide which health care services, in which settings, and under which guidelines or parameters. With few exceptions, determining scope of practice is a state-based activity. State legislatures consider and pass practice acts, which become state statute or code. State regulatory agencies, such as medical and other health professions' boards, implement the laws by writing and enforcing rules and regulations detailing the acts."[29] Requirements for continuing education may also be specified in the practice act.

RDNs operate within the directives of applicable federal and state laws and regulations, policies and procedures established by the organization in which they are employed or provide services, and designated roles and responsibilities. Entities that pay for nutrition services, such as insurance providers, may establish additional regulations that RDNs must follow to receive payment for medical nutrition therapy (MNT) for their beneficiaries. RDNs providing telehealth services where the practitioner and patient are located in different states, the practitioner providing the patient care service must be licensed and/or meet the other applicable standards that are required by state or local laws in both the state where the practitioner is located and the state where the patient is located.[9,30] To determine whether an activity is within the scope of practice of the RDN, the practitioner evaluates his or her knowledge, skill, and demonstrated and documented competence necessary to perform the service or activity in a safe and ethical manner. The Academy's Scope of Practice Decision Tool (www.eatrightpro.org/scope), an online, interactive tool, is

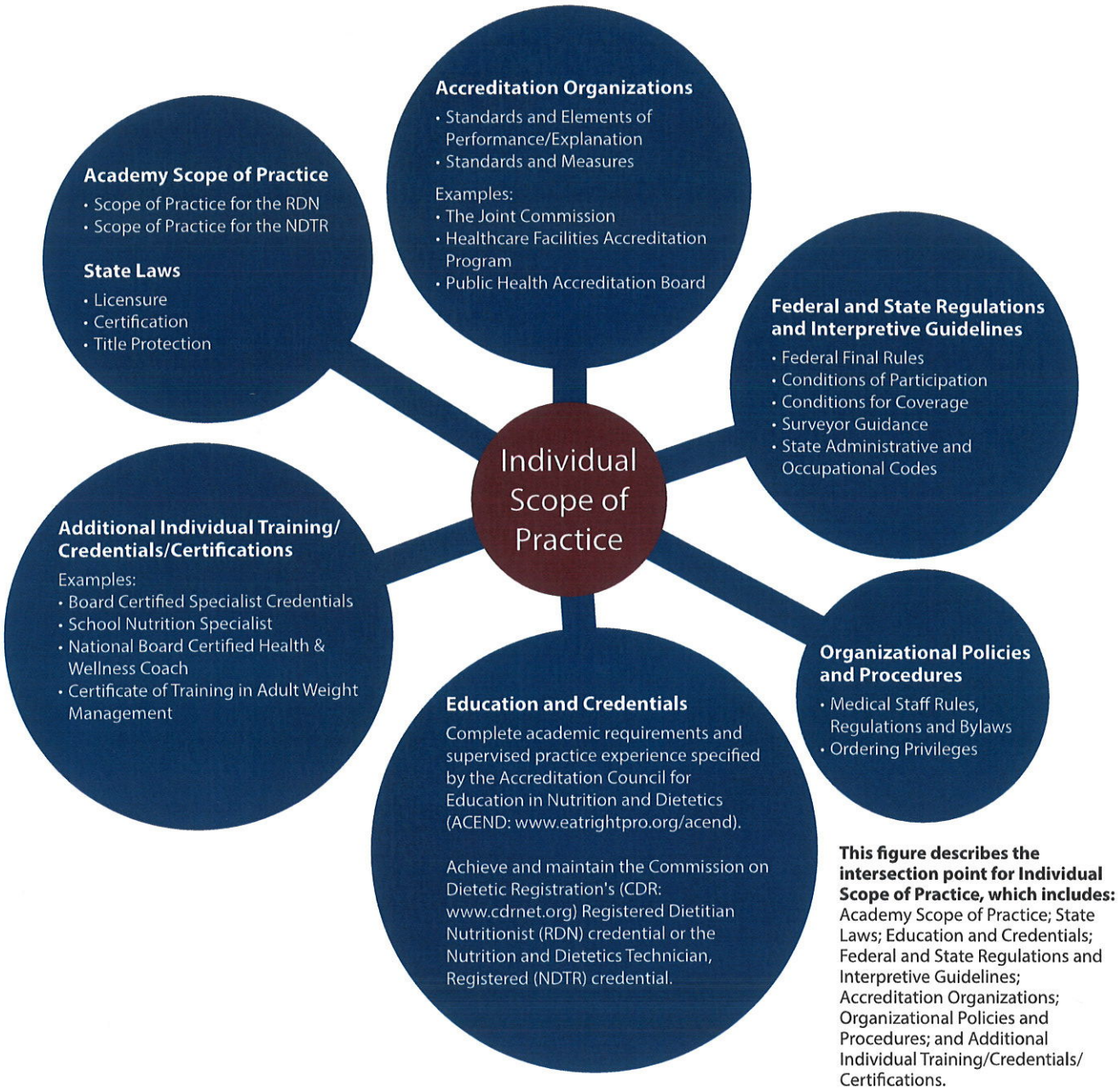

Figure 2. Individual scope of practice for registered dietitian nutritionists (RDNs) and nutrition and dietetic technicians, registered (NDTRs).

specifically designed to guide practitioners with this process.

NUTRITIONIST QUALIFICATIONS

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

CREDENTIALS, CERTIFICATES OF TRAINING, AND RECOGNITIONS AVAILABLE FOR RDNs

For RDNs, CDR offers Board Certification in specialty focus areas of practice and advanced practice certification in

This document, the Revised 2017 Scope of Practice for the RDN, does not supersede state practice acts (ie, licensure, certification, or title protection laws). However, when state law does not define scope of practice for the RDN, the information within this document may assist with identifying activities that may be permitted within an RDN's individual scope of practice based on qualifications (ie, education, training, certifications, organization policies, referring physician-directed protocols or delegated orders, demonstrated and documented competence, and clinical privileges).

clinical nutrition (RD-AP or RDN-AP) for those RDNs who document 8,000 hours of clinical nutrition practice within the past 15 years (800 hours of which must be within the past 2 years). Both require recognition of documented practice experience and successful completion of an examination. The certification period is 5 years. Recertification is required to maintain the advanced practice and specialist credentials.[31,32] As of 2017, CDR offers Board Certification in the following specialty areas:

- Board Certification as a Specialist in Gerontological Nutrition (CSG);
- Board Certification as a Specialist in Oncology Nutrition (CSO);
- Board Certification as a Specialist in Obesity and Weight Management - interdisciplinary certification (CSOWM);
- Board Certification as a Specialist in Pediatric Nutrition (CSP);
- Board Certification as a Specialist in Renal Nutrition (CSR); and
- Board Certification as a Specialist in Sports Dietetics (CSSD).

Until 2002, the Academy offered the Fellow of the American Dietetic Association (FADA) credential. FADA certification demonstrated a successful approach to practice that reflected a global, intuitive, and evolving perspective; creative problem solving; and commitment to self-growth through a portfolio assessment.[17] The FADA credential is still held by some Academy members. In 2013, the Academy began offering the recognition certificate Fellow of the Academy of Nutrition and Dietetics (FAND). FAND recognizes members who have distinguished themselves among their colleagues, as well as in their communities, by their service to the nutrition and dietetics profession and by optimizing the nation's health through food and nutrition.[33]

Additional credentials that may be held by RDNs are listed in Figure 3. Figure 4 outlines health and wellness coaching credentials/certifications[17] that may also be held by RDNs as this is an area of growing interest. This list is not all-inclusive because new programs are emerging and existing programs are being updated. Obtaining additional academic degree(s), and/or certificates of training or credentials/certifications are options that may be desirable or required for specific areas of practice or employment settings. Figure 5 lists certificate of training programs offered by CDR and the corresponding continuing professional education (CPE) units for each program. The programs are intensive training programs that include a self-study module and pretest, on-site program, and a take-home post-test. Certificate of training and certification programs offered by nationally recognized organizations may also be beneficial to RDNs but may not be eligible for CPE units without prior approval. See the Professional Development Portfolio Guide for a list of credentials approved for CPE units (https://www.cdrnet.org/pdp/professional-development-portfolio-guide). The lists are not all-inclusive. The credentials listed are not an endorsement and should be appropriately evaluated by the RDN for benefit in meeting patient/client/group/population/employer needs for delivery of food and nutrition-related services.

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

NUTRITION CARE PROCESS, WORKFLOW, AND MNT

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

The NCP is a systematic approach to providing high-quality nutrition care with its application utilized within MNT services provided by the RDN. The NCP consists of four distinct, interrelated steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation.[17] The RDN uses the NCP and other workflow elements to individualize and evaluate care and service processes within organization systems specific to the discipline of nutrition and dietetics. Academy nutrition practice guidelines incorporate the NCP as the standard process for guiding patient/client/population care. MNT protocols provide a plan based on systematically analyzed evidence and clearly define the level, content, and frequency of nutrition care appropriate for diseases and conditions. They are a component of the Academy's Evidence Analysis Library Evidence-Based Nutrition Practice Guideline Toolkits, which include an MNT Flowchart of Encounters and the MNT Encounter Process.[17]

The RDN uses the NCP and its standardized terminology as described in Figure 6 to:

Credentialing agency	Credential
American Academy of Professional Coders	Certified Professional Coder (CPC)
American Association of Diabetes Educators[a]	Board Certified in Advanced Diabetes Management (BC-ADM)[bc]
American Association of Family and Consumer Sciences	Certified in Family and Consumer Sciences (CFCS)[c]
American College of Healthcare Executives	Board Certified as a Fellow of the American College of Healthcare Executives (FACHE)
American College of Sports Medicine	ACSM Certified Personal Trainer (CPT)[c] ACSM Certified Health/Fitness Specialist (HFS)[c]
American Council on Exercise	ACE-certified Personal Trainer[c] ACE-certified Group Fitness Instructor[c] ACE-certified Advanced Health & Fitness Specialist[c]
American Culinary Federation - Institute for Credentialing Excellence	Certified Executive Chef (CEC) Certified Culinary Educator (CCE)
Board of Certification, Inc, for the Athletic Trainer	Athletic Trainer
Canadian Diabetes Educator Certification Board	Canadian Board Certified Diabetes Educator[bc]
Certifying Board of Dietary Managers - Association of Nutrition & Foodservice Professionals	Certified Dietary Manager (CDM); Certified Food Protection Professional (CFPP)
Commission for Case Manager Certification	Board Certified Case Manager (CCM)
Healthcare Quality Certification Commission	Certified Professional in Healthcare Quality (CPHQ)[c]
International Association of Eating Disorders Professionals[a]	Certified Eating Disorders Registered Dietitian (CEDRD)[c]
National Academy of Certified Care Managers	Care Manager Certified (CMC)
National Board of Nutrition Support Certification, Inc, American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.)[a]	Certified Nutrition Support Clinician (CNSC)[b]
National Certification Board for Diabetes Educators	Certified Diabetes Educator (CDE)[bc]
National Commission for Health Education Credentialing, Inc	Certified Health Education Specialist (CHES)[c]
National Environmental Health Association	Certified Professional-Food Safety (CP-FS) Registered Environmental Health Specialist/Registered Sanitarian (REHS/RS)
National Strength and Conditioning Association	NSCA-Certified Strength and Conditioning Specialist (CSCS)[c] NSCA-Certified Personal Trainer (NSCA-CPT)[c]
Project Management Institute	Certified Associate in Project Management (CAPM) Project Management Professional (PMP)
School Nutrition Association[a]	School Nutrition Specialist (SNS)[c]
The International Board of Lactation Consultant Examiners, Inc	International Board Certified Lactation Consultant (IBCLC)[bc]

[a]Commission on Dietetic Registration accredited provider.[34]

[b]Seventy-five continuing professional education units approved by Commission on Dietetic Registration for completion of certification for consecutive recertification periods.[23]

[c]Seventy-five continuing professional education units approved by Commission on Dietetic Registration for completion of certification for alternate recertification periods.[23]

Figure 3. Credentials that can be held by registered dietitian nutritionists (RDNs) (not all inclusive).

Credentialing agency	Credential/certification
American Council on Exercise	ACE-certified Lifestyle and Weight Management Coach ACE-certified Health Coach[a]
American Institute of Health Care Professionals	Health Care Life Coach-Certified (HCLC-C)
International Association for Health Coaches	Certified International Health Coach (CIHC)
National Society of Health Coaches[b]	Certified Health Coach (CHC)
International Consortium for Health & Wellness Coaching and National Board of Medical Examiners	National Board Certified Health & Wellness Coach (NBC-HWC)
Wellcoaches Corporation[b]	Certified Health & Wellness Coach Certified Personal Coach

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

[b]Commission on Dietetic Registration—accredited provider.[34]

Figure 4. Coach credential or certification options for registered dietitian nutritionists (not all inclusive).

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

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

RDNs in clinical practice:

- Provide MNT in direct care of medical diseases and conditions across the continuum of care (refer to Figure 7).
- Apply the NCP and workflow elements in providing person-centered nutrition care of individuals.[15]
  - Perform assessment of a patient's/client's nutrition status via in-person, or facility/practitioner assessment application, or HIPAA compliant video conferencing telehealth platform.
  - Complete a nutrition-focused physical exam through an evaluation of body systems, muscle and subcutaneous fat wasting, feeding ability (suck/swallow/breathe), oral health, skin condition, appetite, and affect. For additional information and education on nutrition focused physical exams, please see http://www.eatrightpro.org/resource/career/professional-development/face-to-face-learning/nfpe-workshop and http://www.eatrightstore.org/product/EBB27B14-7C98-40E2-A0EF-6E78AD6FF7D8.
  - Recommend, perform, and/or interpret test results related to nutrition status: blood pressure, anthropometrics (eg, height and weight, skinfold thickness, waist circumference, calculation of body mass index with classification for malnutrition and obesity), indirect calorimetry, laboratory tests, and waived point-of-care laboratory testing (eg, blood glucose and cholesterol) (http://wwwn.cdc.gov/dls/waivedtests/ and http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/waivetbl.pdf).
  - Order and monitor nutrition-related laboratory tests and waived point-of-care laboratory testing, in cases where an RDN has

Training title	CPEUs
Certificate of Training in Adult Weight Management Program	35
Level 2 Certificate of Training in Adult Weight Management Program	50
Certificate of Training in Childhood and Adolescent Weight Management	32

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

been granted ordering privileges, or received a delegated order from a referring physician.[41-43]
  - Order and monitor nutrition interventions to meet person-centered nutrient and energy needs, including but not limited to prescribed diets, medical foods, dietary supplements, over-the-counter medications, nutrition support therapies such as enteral nutrition (tube feeding) and parenteral nutrition support (specialized intravenous solutions), nasogastric feeding tube placement, and provide feeding therapy (pediatric oral aversion).[41-43]
  - Initiate, implement, and adjust protocol- or physician-order-driven nutrition-related medication orders and pharmacotherapy plans in accordance with established policy or protocols consistent with organizational policy and procedure.[41]
  - Assist in the development, promotion, and adherence to enhanced recovery after surgery protocols, including elimination of preoperative nothing by mouth order, intraoperative nausea/vomiting prophylaxis and goal-directed fluid therapy, and early postoperative nutrition.
  - Provide nutrition counseling; nutrition behavior therapy; lactation counseling; health and wellness coaching; and nutrition, physical activity, lifestyle, and health education and counseling as components of preventative, therapeutic, and restorative health care.
  - Assess and counsel for the treatment of food allergies to prevent consumption of allergens, prevent over-restriction, prevent nutrient deficiencies, and promote optimal growth and/or weight maintenance.[44]
  - Evaluate, educate, and counsel related to nutritional genomics, gene–diet and disease interactions; genetic, environmental, and lifestyle factors; and food–drug, drug–nutrient, and supplement–drug–nutrient interactions.
  - Manage nutrition care, collaborate with other health and nutrition professionals and as members of interprofessional teams, contribute to rounds or care conferences; be part of palliative and hospice care teams; participate in care coordination; and refer to appropriate nutrition resources, programs, or other health professionals.
- Determine appropriate quality standards in foodservice and nutrition programs.
- Train nutrition and dietetics personnel and NDTRs and mentor nutrition and dietetics students and interns in the provision of nutrition services.
- Delegate to and supervise the work of the NDTR or other professional, technical, or support staff who are engaged in direct patient/client nutrition care.

Ordering Privileges

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

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

Ethical Billing Practices

The RDN must have sound business processes and adhere to the elements of ethical billing across the continuum of practice management and the delivery of clinical nutrition care.[13,47] For MNT billing and payment purposes, the RDN should review state licensure laws and payer policies to determine practice criteria for providing MNT services. Under Medicare Part B, MNT services are defined as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a Registered Dietitian or nutrition professional … pursuant to a referral by a physician."[48] For nutrition services payment resources on coverage and reimbursement management and

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

[a]HIPAA=Health Insurance Portability and Accountability Act.

[b]The RDN or clinically qualified nutrition professional[11] is ultimately responsible and accountable to the patient/client/advocate, employer/organization, consumer/customer, and regulator for nutrition activities assigned to NDTRs and other technical, professional, and support staff.

Figure 6. Nutrition Care Process and Workflow: Roles of registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs).

best practices for MNT services, see http://www.eatrightpro.org/resources/practice/getting-paid.

PRACTICE AREAS, SERVICES, AND ACTIVITIES

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

The majority of RDNs are employed in health care settings (eg, hospitals, accountable care organizations, health care systems, clinics, mental health centers, rehabilitation centers, dialysis centers, bariatric centers, long-term, post-acute, or assisted-living facilities)[19] addressing wellness, prevention, and nutrition management of diseases and medical conditions. Practice settings, services, and activities are discussed using terminology common in each area. Services and activities are not limited to the areas in which they

Examples of Conditions and Diseases Using Medical Nutrition Therapy in Adult and Pediatric Populations		
Anemia	Addictions	Alzheimer disease and dementia
Burns	Cardiovascular disease	Critical illness or conditions
Developmental disabilities	Diabetes	Dysphagia
Eating disorders and disordered eating	Food allergies and intolerances	Genetic disorders
Gastrointestinal disorders	Human immunodeficiency virus/acquired immunodeficiency syndrome	Malnutrition
Mental health disorders	Metabolic syndrome	Musculoskeletal conditions
Neurological disorders	Oncology	Organ transplant
Pediatric care	Pulmonary disorders	Renal disorders
Reproduction	Sports nutrition and performance	Weight management

Figure 7. Examples of conditions and diseases in which registered dietitian nutritionists perform medical nutrition therapy in adult and pediatric populations.

are described. The RDN has multiple responsibilities and perform services and activities in various settings.

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

Acute and Ambulatory Outpatient

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

- Work within the interprofessional team and with the patient/client and family and/or advocate on nutrition-related aspects of a treatment plan, including risks/burdens of nutrition intervention; participate in interprofessional rounds; provide MNT; and conduct nutrition education, counseling, discharge planning, and care coordination and management to address prevention and treatment of one or more acute or chronic conditions or diseases.
- Supervise NDTRs in the provision of direct patient/client nutrition care. Assignment of tasks takes into consideration components of the NCP and the training and competence of the NDTR and other support staff in performing the assigned functions with a specific patient/client or population. The RDN is ultimately accountable to the patient/client, physicians, regulators, and accrediting organizations for functions assigned to support staff.[3]

Business and Communications

RDNs are employed as consultants, managers, directors, vice presidents, and chief executive officers in business and communications, where they participate, manage, and direct in areas such as news and communications, consumer affairs, public relations, food commodity boards, food and culinary nutrition, retail food business, human resources, nutrition and foodservice computer applications, product development, marketing, sales, product distribution, and consumer education. They are website managers and developers.[49] RDNs:

- Author books, professional and lay articles, print and electronic publications, newsletters, editorials, columns, social media podcasts, blogs, YouTube videos, and other forms of electronic media. They are also journalists, speakers, commentators, television, internet and radio personalities, and spokespersons.
- Monitor and adhere to ethical and legal guidelines applicable to social media and copyright laws for protection of intellectual property when communicating and sharing content created by other entities.[50]

Coaching

RDNs work as health and wellness coaches in health care facilities, private practices, wellness businesses (eg, in-person or via telehealth), nonprofit organizations, and corporate wellness. RDNs:

- Educate and guide clients to achieve health goals through lifestyle and behavior adjustments.[17]
- Have thorough knowledge and advanced understanding of behavior change, culture, social determinants of health, disease self-management, and evidence-based health education research.[17]
- Empower clients to achieve self-determined goals related to health and wellness.[17]

Community and Public Health

RDNs with public health and community expertise are directors, managers, supervisors, educators, practitioners, consultants, and researchers. They work in a variety of settings from the national to state and local levels, such as government

Source	Information
CMS hospital guidance	
Federal Register / Vol. 79, No. 91 / Monday, May 12, 2014 / Rules and Regulations; pages 27117-27118 of the Final Rule for Regulatory Reforms Impacting Hospital Conditions of Participation (CoPs) Agency: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS)[45]	"CMS would make further revisions that would allow for flexibility in this area by requiring that all patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or other clinically qualified nutrition professional as authorized by the medical staff and in accordance with State law. CMS believes that hospitals that choose to grant these specific ordering privileges to RDs may achieve a higher quality of care for their patients by allowing these professionals to fully and efficiently function as important members of the hospital patient care team in the role for which they were trained. CMS stated that they believe hospitals would realize significant cost savings in many of the areas affected by nutritional care."
The CMS final rule, effective July 11, 2014. The CMS State Operations Manual Conditions of Participation Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals was subsequently revised in sequential order with State Operations Manual updates issued at different times in 2014 and 2015 for implementation.[9] §482.28(b)(2): Condition of Participation: Food and Dietetic Services[9]	"All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals."
Who is a "qualified dietician" and "qualified nutrition professional" per hospital guidelines? §482.28(b)(2) Condition of Participation: Food and Dietetic Services[9]	"The hospital's governing body may choose, when permitted under State law and upon recommendation of the medical staff, to grant qualified dietitians or qualified nutrition professionals diet-ordering privileges. In many cases State law determines what criteria an individual must satisfy in order to be a "qualified dietician;" State law may define the term to mean a "registered dietician" registered with a private organization, such as the Commission on Dietetic Registration, or State law may impose different or additional requirements. Terms such as "nutritionists," "nutrition professionals," "certified clinical nutritionists," and "certified nutrition specialists" are also used to refer to individuals who are not dieticians, but who may also be qualified under State law to order patient diets. It is the responsibility of the hospital to ensure that individuals are qualified under State law before appointing them to the medical staff or granting them privileges to order diets."
§482.22(a): Eligibility and Process for Appointment to Medical Staff[9]	"The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at §482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body." "Non-physician practitioners: Furthermore, the governing body has the authority, in accordance with State law, to grant medical staff privileges and membership to non-physician practitioners. The regulation allows hospitals and their medical staffs to take advantage of the expertise and

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Figure 8. Catalog of regulatory changes published by the Centers for Medicare and Medicaid Services (CMS) related to order writing privileges or delegated orders for registered dietitian nutritionists (RDNs) or clinically qualified nutrition professionals in hospitals, critical access hospitals (CAHs), and long-term care facilities. Refer to CMS State Operations Manual for periodic revisions (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf).

Source	Information
	skills of all types of practitioners who practice at the hospital when making recommendations and decisions concerning medical staff privileges and membership." "For non-physician practitioners granted privileges only, the hospital's governing body and its medical staff must exercise oversight, such as through credentialing and competency review, of those non-physician practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff. Practitioners are described in Section 1842(b)(18)(C) of the Act as any of the following: Physician assistant; Nurse practitioner; Clinical nurse specialist; Certified registered nurse anesthetist; Certified nurse-midwife; Clinical social worker; Clinical psychologist; Anesthesiologist's Assistant; or Registered dietician or nutrition professional."
CMS CAH guidance CMS State Operations Manual, Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (revised December 2016). The following policies section includes dietitian privileges as implemented in April 2015[10]	
§485.608(d): Licensure, Certification or Registration of Personnel[10]	"Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations." "All staff required by the State to be licensed must possess a current license. The CAH must ensure that these personnel are in compliance with the State's licensure laws. The laws requiring licensure vary from state to state. Examples of healthcare professionals that a state may require to be licensed could include: nurses, MD/DOs, physician assistants, dieticians, x-ray technologists, dentists, physical therapists, occupational therapists, respiratory technicians and facility administrators. All CAH staff must meet all applicable standards required by State or local law for CAH personnel. This would include at a minimum: Certification requirements; Minimum qualifications; and Training/education requirements."
§485.631(a)(1) 485.631(a): Staffing[10]	"The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists."
§485.631(a)(2): Staffing[10]	"Any ancillary personnel are supervised by the professional staff." Survey Procedures "Use organizational charts and staff interviews to determine how the CAH ensures that the professional staff supervises all ancillary personnel."
§485.631(b)(1)(i): Staffing[10]	"The doctor of medicine or osteopathy (i) Provides medical direction for the CAH'S health care activities and consultation for, and medical supervision of, the health care staff."
§485.635(a): Patient Care Policies Interpretive guidelines: §485.635(a)(2) and (4)[10]	"The CAH's written policies governing patient care services must be developed with the advice of members of the CAH's professional healthcare staff. This advisory group must include: At least one MD or DO;

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Figure 8. *(continued)* Catalog of regulatory changes published by the Centers for Medicare and Medicaid Services (CMS) related to order writing privileges or delegated orders for registered dietitian nutritionists (RDNs) or clinically qualified nutrition professionals in hospitals, critical access hospitals (CAHs), and long-term care facilities. Refer to CMS State Operations Manual for periodic revisions (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf).

Source	Information
	and One or more physician assistants, nurse practitioners, or clinical nurse specialists, at least one of these non-physician practitioners if these professionals are included in the CAH's healthcare staff, as permitted at §485.631(a)(1). A CAH with no non-physician practitioners on staff is not required to obtain the services of an outside non-physician practitioner to serve on the advisory group."
"§485.635(a)(3)(vii): Patient Care Policies[10]	"Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving post hospital SNF [Skilled Nursing Facility] care." "The dietary services must be organized, directed and staffed in such a manner to ensure that the nutritional needs of inpatients are met in accordance with practitioners' orders and recognized dietary practices. The CAH must designate a qualified individual who is responsible for dietary services. The designated individual must be qualified based on education, experience, specialized training, and, if required by State law, licensed, certified, or registered by the State." "All inpatients' diets, including therapeutic diets, must be provided in accordance with orders from a practitioner responsible for the care of the patient. CAHs may choose, when permitted under State law, to designate qualified dietitians or qualified nutrition professionals as practitioners with diet-ordering privileges. In many cases State law determines what criteria an individual must satisfy in order to be a 'qualified dietician'; State law may define the term to mean a 'registered dietician' registered with a private organization, the Commission on Dietetic Registration, or State law may impose different or additional requirements. Terms such as 'nutritionists,' 'nutrition professionals,' 'certified clinical nutritionists,' and 'certified nutrition specialists' are also used to refer to individuals who are not dieticians, but who may also be qualified under State law to order patient diets. It is the responsibility of the hospital to ensure that individuals are qualified under State law before appointing them to the medical staff or granting them privileges to order diets."
§485.635(a)(3)(vii): Patient Care Policies[10]	Survey procedures: "Verify that the individual responsible for dietary services is qualified based on education, experience, specialized training, and, if required by State law, is licensed, certified, or registered by the State. Verify that all inpatient diets are prescribed by a practitioner(s) responsible for the care of the patient. If the State and the CAH permit dieticians or other nutrition professionals to order diets, has the CAH verified that they meet any requirements for licensure or certification under State law?"
CMS long-term care guidance	
Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations; Department of Health and Human Services, Centers for Medicare & Medicaid Services,	"To increase access and reduce burden, this final rule allows physicians to delegate to a qualified dietitian or other clinically qualified nutrition professional the task of prescribing diet, including therapeutic diets, to the extent allowed by state law. CMS does not currently have data to estimate

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Figure 8. *(continued)* Catalog of regulatory changes published by the Centers for Medicare and Medicaid Services (CMS) related to order writing privileges or delegated orders for registered dietitian nutritionists (RDNs) or clinically qualified nutrition professionals in hospitals, critical access hospitals (CAHs), and long-term care facilities. Refer to CMS State Operations Manual for periodic revisions (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf).

Source	Information
Medicare and Medicaid Programs; Page 68845 of the Final Rule for Reform of Requirements for Long Term Care Facilities[46]	the savings that this will produce in SNFs and NFs [Nursing Facilities], however CMS believes that it will allow for better use of both physician and dietitian time. Likewise, we also allow physicians to delegate to qualified therapists the task of prescribing physical, occupational, speech language, or respiratory therapies, but as with dietitians, we have no empirical evidence with which to quantify a cost savings. Again, however, we believe that this allows better use of both physician and therapist time."
The CMS Final Rule was effective on November 28, 2016.The CMS State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities was subsequently revised for implementation with updates continuing to occur in 2017 and beyond. §483.30: Physician Services §483.30(e)(2) and §483.30(e)(4): Physician Delegation of Tasks in Skilled Nursing Facilities §483.30(f): Performance of Physician Tasks in Nursing Facilities[11]	"A resident's attending physician may delegate the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who— (i) Is acting within the scope of practice as defined by State law; and (ii) Is under the supervision of the physician." "A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies."
§483.60(e)(1): Therapeutic Diets[11]	"Therapeutic diets must be prescribed by the attending physician."
§483.60(e)(2): Therapeutic Diets[11]	"The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. Intent: To assure that the residents receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident's treatment, plan of care in accordance with his her goals and preferences."
Who is a "non-physician practitioner"? Definitions §483.30(a): Physician Services[11]	"'Non-physician practitioner (NPP)' is a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)."
Guidance §483.30(e)(2)-(3): Physician Services[11]	"Physicians and NPPs may delegate the task of writing orders to qualified dietitians . . .*if State practice act allows the delegation of task, and the State practice act for the qualified individual being delegated the task of writing orders permits such performance.*" "Dietary orders written by a qualified dietitian/clinically qualified nutritional professional, or therapy orders written by therapists, do not require physician co-signature, except as required by State law."

Figure 8. *(continued)* Catalog of regulatory changes published by the Centers for Medicare and Medicaid Services (CMS) related to order writing privileges or delegated orders for registered dietitian nutritionists (RDNs) or clinically qualified nutrition professionals in hospitals, critical access hospitals (CAHs), and long-term care facilities. Refer to CMS State Operations Manual for periodic revisions (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf).

agencies, community and professional organizations, nonprofit organizations, and schools.[51] RDNs participate in federally assisted nutrition programs (eg, Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC], and the Supplemental Nutrition Assistance Program-Education [SNAP-Ed]), community programs (eg, community health centers, Feeding America, Harvesters), and Indian Health Services. RDNs:

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

behaviors. Contribute to emergency preparedness and coordinate food and nutrition services during disasters.[52]

- Collect, analyze, and report health- and nutrition-related data on specific populations to establish trends, identify benchmarks, and measure effectiveness of nutrition and related interventions.
- Advocate to decrease health disparities (eg, social determinants of health) of specific populations and promote health policies that improve the patient/client experience of care, improve the health of populations, and reduce the per capita cost of health care.[53]
- Provide and coordinate culturally competent nutrition services and programs, including MNT to individuals and groups; collaborate with others to develop nutrition programs and services in accordance with the Public Health Accreditation Board standards and measures; plan and deliver training and education for health personnel; and advocate for sound food and nutrition legislation, policies, and programs at the federal, state, and local levels.

Culinary and Retail

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

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

Entrepreneurial and Private Practice

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

- Provide MNT to individuals and groups in all populations. A promotional source for RDNs to utilize is the Find a Registered Dietitian Nutritionist locator on the Academy website at http://www.eatright.org/find-an-expert.
- Provide comprehensive food and nutrition services to individuals, groups, foodservice and restaurant managers, supermarket-retail and other food vendors and distributors, culinary programs, corporate wellness, athletes, sports teams, and company employees.
- Act as expert witnesses and consultants on legal matters related to food and nutrition services and dietetics practice.
- Design nutrition software, websites, blogs, podcasts, videos, nutrition education tools, and nutrition-related products.

Foodservice Systems

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

- Participate in, manage, or direct any or all of the following: menu and recipe management; food, supplies, and equipment purchasing; food receiving, storage, preparation, and service; quality assurance, safety, performance improvement, and customer satisfaction; quality improvement projects; financial management; human resource management; food safety and sanitation programs; waste management, water conservation and composting programs; vending services and catering for special events; foodservice in emergency situations, and kitchen design and redesign.[54]
- Use a wide variety of electronic tools to manage data and may specialize in the development and management of specific technological applications related to foodservice operations.[54]
- Collaborate with the speech language pathologist(s) and the interprofessional team to adopt and use the International Dysphagia Diet Standardization System for texture-modified foods and liquids for individuals with dysphagia.[55,56]

Global Health

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

- Educate clients, customers, and the public on global health issues related to nutrition using resources such as the Academy Foundation's International Resources and Opportunities (http://

eatrightfoundation.org/international-resources-and-opportunities), the Academy's Global Food and Nutrition Resource Hub (http://www.eatrightpro.org/resources/practice/practice-resources/international-nutrition-pilot-project), and the International Confederation of Dietetic Associations (http://www.internationaldietetics.org).

- Advocate for and influence local and federal health policy in America and foreign countries related to global health issues such as sustainable and healthy agriculture; food and water sanitation and hygiene; malnutrition and nutrition insecurity; potable drinking water; maternal, infant, and child nutrition; and human immunodeficiency virus and acquired immune deficiency syndrome.
- Provide assistance and guidance during health and nutritional crises, societal upheaval, and natural disasters.
- Demonstrate respect and sensitivity to the local culture.
- Conduct research on global health and nutrition to address current and anticipated food and nutrition challenges, influence health policy, and address and eliminate all forms of malnutrition.

Integrative and Functional Medicine

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

- Promote the integration of conventional and integrative medical and nutrition practices, clinical judgment, and evidence-based alternatives through research, education, and informed practice.
- Lead evidence-based and science-based therapies, including basic concepts of nutritional genomics, gene–diet and disease interactions, holistic health care, and functional nutrition therapies using the Integrative and Functional Medical Nutrition Therapy (IFMNT) Radial (https://integrativerd.org/ifmnt-radial/). The Integrative and Functional Medicine Nutrition Therapy Radial is a model for critical thinking that embraces both the science and art of personalized nutrition care with consideration of multiple conventional or alternative medicine disciplines using five key areas: lifestyle, systems (signs and symptoms), core imbalances, metabolic pathways/networks, and biomarkers.[57]

Malnutrition

RDNs, as a part of interprofessional teams, manage and direct malnutrition care for patients/clients in health care settings such as acute care hospitals, tertiary care centers, critical access hospitals, ambulatory clinics, specialty clinics, Veterans Affairs and military facilities, children's hospitals, long-term care hospitals, home health, skilled nursing facilities, memory units, long-term/extended care, continuing care communities, and assisted-living facilities.[58] Because malnutrition is recognized as a national health and public safety issue, RDNs play a key role in evaluating their nutrition care workflow throughout the continuum of care. (National Blueprint: Achieving Quality Malnutrition Care for Older Adults, http://defeatmalnutrition.today/blueprint/). RDNs:

- Establish malnutrition standards of care and conduct timely screening, assessment, intervention/plan of care to identify appropriate medical malnutrition diagnosis.
- Lead the interprofessional team to identify quality gaps in malnutrition care, evaluate the clinical workflow process, and facilitate quality improvement projects to advance malnutrition care delivery (http://www.eatrightpro.org/malnutrition).
- Provide training and education to teams ensuring competent nutrition professional and foodservice workforce.
- Comply with discharge planning and transitions of care requirements as well as facility policies and procedures to meet patient/client identified post-discharge needs.[59,60]

Management and Leadership

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

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

- Lead people "to achieve a common goal by setting a direction, aligning people, motivating and inspiring."[61]
- Provide overall direction for area(s) of responsibility that reflects strategic thinking and planning to align with mission, vision, and principles of the organization to achieve desired outcomes.
- Identify needs and wants of customers to direct the design and

delivery of customer-centered services in line with an organization's mission and expectations.
- Ensure the employee workforce is engaged in the vision for services through training, mentoring, opportunities to give input, and with clear expectations for performance and accountability.

Military Service

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

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

Nonpracticing

RDNs who are not working in the nutrition and dietetics workforce, but are maintaining their credential, are ethically obligated to maintain the minimum competent level of practice as outlined in the SOP in nutrition care and/or SOPP[15] or an applicable focus area SOP and/or SOPP.[62] RDNs:

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

Nutrition Informatics

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

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

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

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

- Participate in, manage, and direct nutrition programs and services to identify and evaluate individuals for nutritional risk, provide consultation to the physician and interprofessional health care team on nutrition aspects of a treatment plan.
- Participate in care conferences, provide MNT and nutrition education and counseling and care coordination and management to address prevention and treatment of one or more acute or chronic conditions or diseases, and provide support for end-of-life care.
- Are responsible for clinical ethics awareness involving life-sustaining therapies including nutrition interventions, reflecting evidence-based guidelines that evaluate the potential benefits and risks/burdens of therapeutic nutrition support (enteral and intravenous nutrition) in myriad of clinical situations.[67,68]
- Communicate with the patient/client, family, guardians, and/or advocate[15] regarding benefits and risks/burdens of nutrition intervention options.[67-70]

Preventive Care, Wellness, and Weight Management

RDNs are leaders in evidence-based nutrition practices that address

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

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

Quality Management

RDNs work independently and in teams within various health care (acute and post-acute), community and public health, population health, and business settings in the quality and safety area. Quality management professionals oversee the administration of quality, process, and/or business improvement efforts. They typically have authority over a clearly defined area of the organization that may include regulations and industry standards and have a number of direct reports.[71] RDNs:

- Recognize and identify system errors, establish goals, collect qualitative and quantitative data using mixed methodologies, identify trends, and develop and implement strategies.
- Design and implement outcomes-based initiatives in quality assurance and performance improvement, performance measurement, process improvement, and quality improvement[17] to document outcomes of services and compliance with regulations, policies, and procedures, and to monitor and address customer satisfaction.
- Develop, manage, and implement techniques and tools for process improvement; evaluate, document, and communicate quality improvement project outcomes; and interpret data to formulate judgments, conclusions, and reports.
- Report quality measures to CMS; measure or quantify health care processes, outcomes, patient/client perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality care and services.
- Develop, administer, evaluate, and consult regarding food and nutrition policy, including quality standards and performance improvement in foodservice and nutrition programs.

Research

RDNs involved in research are employed in a variety of settings, including general clinical research centers; clinical and translational research centers; academic medical centers; nonprofit research entities; academia; food, dietary supplement,[17] and pharmaceutical companies; and municipal, state, and federal government agencies (eg, National Institutes of Health, the US Department of Agriculture, Food and Drug Administration, the Environmental Protection Agency, Centers for Disease Control and Prevention, and American Indian/Alaska Native Tribal Governments and organizations). RDNs:

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

School Nutrition

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

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

Sports Nutrition and Dietetics

RDNs are employed in and/or consult with individual athletes; rehabilitation centers; sports medicine clinics; community and medical fitness centers; amateur, collegiate, and professional sport organizations; the US Olympic Committee; academia; the military; high school, club associations, and sports performance entities; and sports food business and industry. RDNs are members of interprofessional sports

medicine and athletic performance teams in providing nutrition guidance for performance, as well as the prevention and/or management of chronic disease; provide foodservice to athletes and athletic teams and manage related foodservice budgets; and conduct research in sports nutrition and exercise science. RDNs work in prevention of and nutrition interventions for eating disorders, disordered eating, and the relative energy deficiency in sport (RED-S). RDNs develop nutrition programs and counsel the military, first responders, and others whose job requirements include physical performance and/or maintenance of specified levels of physical conditioning or body weight and body composition.[72] RDNs:

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

Sustainable, Resilient, and Healthy Food and Water Systems

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

- Promote increased appreciation for and understanding of food security and resiliency, agricultural production, and environmental nutrition issues.
- Promote and establish a culture of food safety in foodservice settings, clinical practices, community settings, and in public venues.
- Educate and support policies, systems, and environments that advance sustainable healthy food and water systems related to current and emerging food production, processing, distribution, marketing, retail, and waste management practices.[73,74]

Telehealth

RDNs use electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.[17] RDNs use interactive electronic communication tools for health promotion and wellness, and for the full range of MNT services that include disease prevention, assessment, nutrition focused physical exam, diagnosis, consultation, therapy, and/or nutrition intervention. For communication of broad-based nutrition information, RDNs use the internet, webinars, video conferencing, e-mail, and other methods of distance communications in various settings such as ambulatory clinics, outpatient clinics, community health centers, private practice, and bariatric centers. RDNs:

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

US Public Health Service

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

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

Universities and Other Academic Settings

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

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

dietetics education program management and operations.

- Educate, instruct, and mentor nutrition and dietetics students, dietetic interns, health care professionals, medical/nursing/other allied health professional students and residents, and others in food, nutrition, health care, and health-related disciplines as faculty members in academic programs, and/or as preceptors for supervised practice experiences.
- Create opportunities for nutrition and dietetics students and interns to experience a wide variety of career options, including what may be considered nontraditional paths.
- Author textbooks and other education curriculum support and training materials; develop innovative learning strategies, including active learning, simulation, and objective structured clinical examination options to enhance applied learning opportunities.
- Conduct nutrition, food science, food safety, and related basic and applied research.
- Create and manage academic and nonacademic campus-based nutrition and dietetics education programs and promote nutrition awareness, direct and lead campus foodservice departments and campus services in residential living units, retail settings, and catering.

NUTRITION AND DIETETICS VISIONING

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

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

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

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

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

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

SUMMARY

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

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All members contributed material, reviewed the manuscript, and approved the final product.

Appendix C

The State of Nebraska Statutes relating to Medical Nutrition Therapy Practice Act

2017

STATE OF NEBRASKA

STATUTES RELATING TO MEDICAL NUTRITION THERAPY PRACTICE ACT

Department of Health and Human Services
Division of Public Health
Licensure Unit

301 Centennial Mall South, Third Floor
PO Box 94986
Lincoln, NE 68509-4986

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71-1,290. Repealed. Laws 2007, LB 463, § 1319.
71-1,291. Repealed. Laws 2007, LB 463, § 1319.
71-1,291.01. Repealed. Laws 2007, LB 463, § 1319. 71-
1,292. Repealed. Laws 2007, LB 463, § 1319. 71-1,293.
Transferred to section 38-1816.
71-1,294. Repealed. Laws 2007, LB 463, § 1319.

STATUTES PERTAINING TO MEDICAL NUTRITION THERAPY PRACTICE ACT

38-1801. Act, how cited.

Sections 38-1801 to 38-1816 shall be known and may be cited as the Medical Nutrition Therapy Practice Act. **Source:** Laws 2007, LB463, § 623.

38-1802. Legislative findings.

(1) The Legislature finds that:

(a) The unregulated practice of medical nutrition therapy can clearly harm or endanger the health, safety, and welfare of the public;

(b) The public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and

(c) The public cannot be effectively protected by a less cost-effective means than state regulation of the practice of medical nutrition therapy. The Legislature also finds that medical nutrition therapists must exercise independent judgment and that professional education, training, and experience are required to make such judgment.

(2) The Legislature further finds that the practice of medical nutrition therapy in the State of Nebraska is not sufficiently regulated for the protection of the health, safety, and welfare of the public. It declares that this is a matter of statewide concern and it shall be the policy of the State of Nebraska to promote high standards of professional performance by those persons representing themselves as licensed medical nutrition therapists. **Source:** Laws 1988, LB 557, § 1; Laws 1995, LB 406, § 20; R.S.1943, (2003), § 71-1,285; Laws 2007, LB463, § 624.

38-1803. Definitions, where found.

For purposes of the Medical Nutrition Therapy Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definitions found in sections 38-1804 to 38-1810 apply. **Source:** Laws 1988, LB 557, § 2; Laws 1995, LB 406, § 21; Laws 1999, LB 828, § 146; R.S.1943, (2003), § 711,286; Laws 2007, LB463, § 625.

38-1804. Assessment, defined.

Assessment means the process of evaluating the nutritional status of patients. The assessment includes review and analysis of medical and diet histories, biochemical lab values, and anthropometric measurements to determine nutritional status and appropriate nutritional treatment. **Source:** Laws 2007, LB463, § 626.

38-1805. Board, defined.

Board means the Board of Medical Nutrition Therapy. **Source:** Laws 2007, LB463, § 627.

38-1806. Consultation, defined.

Consultation means conferring with a physician regarding the activities of the licensed medical nutrition therapist. **Source:** Laws 2007, LB463, § 628.

38-1807. General nutrition services.

General nutrition services includes, but is not limited to:

(1) Identifying the nutritional needs of individuals and groups in relation to normal nutritional requirements; and

(2) Planning, implementing, and evaluating nutrition education programs for individuals and groups in the selection of food to meet normal nutritional needs throughout the life cycle. **Source:** Laws 2007, LB463, § 629.

38-1808. Licensed medical nutrition therapist, defined.

Licensed medical nutrition therapist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Credentialing Act and who holds a current license issued by the department pursuant to the Medical Nutrition Therapy Practice Act. **Source:** Laws 2007, LB463, § 630.

38-1809. Medical nutrition therapy, defined.

Medical nutrition therapy means the assessment of the nutritional status of patients. Medical nutrition therapy involves the assessment of patient nutritional status followed by treatment, ranging from diet modification to specialized nutrition support, such as determining nutrient needs for enteral and parenteral nutrition, and monitoring to evaluate patient response to such treatment. **Source:** Laws 2007, LB463, § 631.

38-1810. Patient, defined.

Patient means a person with a disease, illness, injury, or medical condition for which nutritional interventions are an essential component of standard care. **Source:** Laws 2007, LB463, § 632.

38-1811. Board; membership; qualifications.

a. The board shall consist of three professional members, one physician, and one public member appointed pursuant to section 38-158. The members shall meet the requirements of sections 38-164 and 38-165. **Source:** Laws 2007, LB463, § 633.

38-1812. License required; activities not subject to act.

No person shall practice medical nutrition therapy unless he or she is licensed for such purpose pursuant to the Uniform Credentialing Act. The practice of medical nutrition therapy shall not include:

(1) Any person credentialed in this state pursuant to the Uniform Credentialing Act and engaging in such profession or occupation for which he or she is credentialed;

(2) Any student engaged in an academic program under the supervision of a licensed medical nutrition therapist as part of a major course of study in human nutrition, food and nutrition, or dietetics, or an equivalent major course of study approved by the board, and who is designated with a title which clearly indicates the person's status as a student or trainee;

(3) Persons practicing medical nutrition therapy who serve in the armed forces of the United States or the United States Public Health Service or who are employed by the United States Department of Veterans Affairs or other federal agencies, if their practice is limited to that service or employment;

(4) Persons practicing medical nutrition therapy who are licensed in another state, United States possession, or country, or have received at least a baccalaureate degree, and are in this state for the purpose of:

(a) Consultation if the practice in this state is limited to consultation; or

(b) Conducting a teaching clinical demonstration in connection with a program of basic clinical education, graduate education, or postgraduate education which is sponsored by a dietetic education program or a major course of study in human nutrition, food and nutrition, or dietetics, or an equivalent major course of study approved by the board;

(5) Persons performing general nutrition services incidental to the practice of the profession insofar as it does not exceed the scope of their education and training;

(6) Persons who market or distribute food, food materials, or dietary supplements, including persons employed in health food stores, or persons engaged in the advising of the use of those products, or the preparation of those products, or the counseling of individuals or groups in the selection of products to meet general nutrition needs;

(7) Persons conducting classes or disseminating information related to general nutrition services;

(8) Persons who care for the sick in accordance with the tenets and practices of any bona fide church or religious denomination;

(9) Persons who provide information and instructions regarding food intake or exercise as a part of a weight control program; and

(10)Persons with advanced postgraduate degrees involved in academic teaching or research.

Source: Laws 1988, LB 557, § 3; Laws 1995, LB 406, § 22; R.S.1943, (2003), § 71-1,287; Laws 2007, LB463, § 634.

38-1813. Licensed medical nutrition therapist; qualifications.

A person shall be qualified to be a licensed medical nutrition therapist if such person furnishes evidence that he or she:

(1) Has met the requirements for and is a registered dietitian by the American Dietetic Association or an equivalent entity recognized by the board;

(2)(a) Has satisfactorily passed an examination approved by the board;

(b) Has received a baccalaureate degree from an accredited college or university with a major course of study in human nutrition, food and nutrition, dietetics, or an equivalent major course of study approved by the board; and (c) Has satisfactorily completed a program of supervised clinical experience approved by the department. Such clinical experience shall consist of not less than nine hundred hours of a planned continuous experience in human nutrition, food and nutrition, or dietetics under the supervision of an individual meeting the qualifications of this section; or

(3)(a) Has satisfactorily passed an examination approved by the board; and

(b)(i) Has received a master's or doctorate degree from an accredited college or university in human nutrition, nutrition education, food and nutrition, or public health nutrition or in an equivalent major course of study approved by the board; or

(ii) Has received a master's or doctorate degree from an accredited college or university which includes a major course of study in clinical nutrition. Such course of study shall consist of not less than a combined two hundred hours of biochemistry and physiology and not less than seventy-five hours in human nutrition.

For purposes of this section, accredited college or university means an institution currently listed with the United States Secretary of Education as accredited. Applicants who have obtained their education outside of the United States and its territories shall have their academic degrees validated as equivalent to a baccalaureate or master's degree conferred by a United States regionally accredited college or university.

The practice of medical nutrition therapy shall be performed under the consultation of a physician licensed pursuant to section 38-2026 or sections 38-2029 to 38-2033.

Source: Laws 1988, LB 557, § 5; Laws 1995, LB 406, § 24; R.S.1943, (2003), § 71-1,289; Laws 2007, LB463, § 635.

38-1814. Reciprocity; military spouse; temporary license.

The department, with the recommendation of the board, may issue a license based on licensure in another jurisdiction to an individual who meets the requirements of the Medical Nutrition Therapy Practice Act or substantially equivalent requirements as determined by the department, with the recommendation of the board. An applicant for a license to practice under the act who is a military spouse may apply for a temporary license as provided in section 38-129.01. **Source:** Laws 2007, LB463, § 636; Laws 2017, LB88, § 59.

Operative Date: April 26, 2017

38-1815. Fees.

The department shall establish and collect fees for credentialing under the Medical Nutrition Therapy Practice Act as provided in sections 38-151 to 38-157. **Source:** Laws 2007, LB463, § 637.

38-1816. Act, how construed.

Nothing in the Medical Nutrition Therapy Practice Act shall be construed to permit a licensed medical nutrition therapist to practice any other profession regulated under the Uniform Credentialing Act.

Source: Laws 1988, LB 557, § 9; Laws 1994, LB 853, § 1; Laws 1995, LB 406, § 29; R.S.1943, (2003), § 711,293; Laws 2007, LB463, § 638.

71-1,285. Transferred to section 38-1802.
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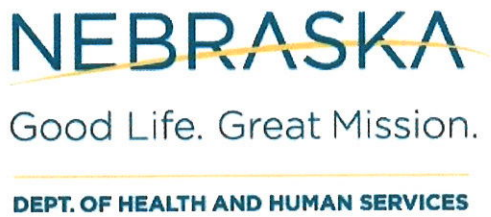
Appendix D

Proposed amended Medical Nutrition Therapy Practice Act

2017

STATE OF NEBRASKA

STATUTES RELATING TO MEDICAL NUTRITION THERAPY PRACTICE ACT



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INDEX is not marked for proposed changes

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38-1812. License required; activities not subject to act.
38-1813. Licensed medical nutrition therapist; qualifications.
38-1814. Reciprocity; military spouse; temporary license.
38-1815. Fees.
38-1816. Act, how construed.

71-1,285. Transferred to section 38-1802.
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STATUTES PERTAINING TO MEDICAL NUTRITION THERAPY PRACTICE ACT

38-1801. Act, how cited.

Sections 38-1801 to 38-1816 shall be known and may be cited as the Medical Nutrition Therapy Practice Act. **Source:** Laws 2007, LB463, § 623.

38-1802. Legislative findings.

(1) The Legislature finds that:

(a) The unregulated practice of medical nutrition therapy can clearly harm or endanger the health, safety, and welfare of the public;

(b) The public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and

(c) The public cannot be effectively protected by a less cost-effective means than state regulation of the practice of medical nutrition therapy. The Legislature also finds that medical nutrition therapists must exercise independent judgment and that professional education, training, and experience are required to make such judgment.

(2) The Legislature further finds that the practice of medical nutrition therapy in the State of Nebraska is not sufficiently regulated for the protection of the health, safety, and welfare of the public. It declares that this is a matter of statewide concern and it shall be the policy of the State of Nebraska to promote high standards of professional performance by those persons representing themselves as licensed medical nutrition therapists. **Source:** Laws 1988, LB 557, § 1; Laws 1995, LB 406, § 20; R.S.1943, (2003), § 71-1,285; Laws 2007, LB463, § 624.

38-1803. Definitions, where found.

For purposes of the Medical Nutrition Therapy Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definitions found in sections 38-1804 to 38-1810 apply. **Source:** Laws 1988, LB 557, § 2; Laws 1995, LB 406, § 21; Laws 1999, LB 828, § 146; R.S.1943, (2003), § 711,286; Laws 2007, LB463, § 625.

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Board means the Board of Medical Nutrition Therapy. **Source:** Laws 2007, LB463, § 627.

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Commission on Dietetic Registration (CDR) means the credentialing agency for the Academy of Nutrition and Dietetics.

General nonmedical nutrition information, defined

General nonmedical nutrition information means information on any of the following

(1) Principles of good nutrition and food preparation

(2) Food that should be included in the normal diet
(3) The essential nutrients needed by the human body
(4)The recommended amounts of essential nutrients in the human body
(5) The actions of nutrients in the human body
(6) Food and supplements that are good sources of essential nutrients in the human body

.

38-1808. Licensed medical nutrition therapist, defined.

Licensed medical nutrition therapist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Credentialing Act and who holds a current license issued by the department pursuant to the Medical Nutrition Therapy Practice Act. **Source:** Laws 2007, LB463, § 630.

Licensed nutritionist, defined

Licensed nutritionist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Credentialing Act and who holds a current license issued by the department pursuant to the provisions of _____.

38-1809. Medical nutrition therapy, defined.

Medical nutrition therapy means assessment of nutrition problems/diagnosis and their cause, establish nutrition diagnosis-specific goals, determine and implement a nutrition care intervention plan to resolve or minimize the problem and monitor and evaluate effectiveness of the interventions and progress toward goals/outcomes; medical nutrition therapy is furnished as part of the treatment or management of a diagnosed disease or medical condition and provided by a licensed medical nutrition therapist or licensed nutritionist. The term includes the provision of all of the following services:

(1) Interpreting anthropometric, biochemical, clinical and dietary data in acute and chronic disease states and recommending or ordering nutrient needs based on the data, including but not limited to, tube feedings and parenteral nutrition
(2) Food and nutrition counseling regarding prescription drug interactions.
(3) Developing and managing systems operations with the primary focus of nutrition care or recommending or ordering therapeutic diets.
(4) Medical weight control.

.

Medical weight control, defined

Medical weight control means medical nutrition therapy for the purpose of reducing, maintaining, or gaining weight for individuals having a diagnosed disease or medical condition

Nutrition, defined.

Nutrition means the biochemical and physiological aspects of human nutrition. It interprets the nutrients and other bio-substances in food in relation to growth, maintenance, reproduction, health, and disease of an organism. It includes food (via oral, enteral or parenteral route) absorption, distribution, metabolism/metabolic pathway
and excretion.

Nutrition Assessment, defined.

Nutrition assessment means the systematic process of obtaining, verifying, and interpreting biochemical, anthropometric, drugs, clinical, physical and dietary data during the nutrition history or patient interview, patient record review, and nutrition focused physical examination in order to make decisions about the nature and cause of nutrition related problems. It is an ongoing, dynamic process that involves initial data collections and reassessment and analysis of client or community needs and provides the foundation for nutrition diagnosis and nutrition recommendations including enteral and parenteral nutrition.

Nutrition Diagnosis, defined.
Nutrition diagnosis means identifying and labeling nutritional problems that a licensed medical nutrition therapist or licensed nutritionist is responsible for treating independently.

Nutrition Intervention, defined.
Nutrition intervention means the purposefully planned actions intended to positively change a nutrition-related behavior, risk factor, environmental condition, or aspect of health care status for an individual (and his/her family or caregivers), target groups, or community at large.

Nutrition Monitoring and Evaluation, defined.
Nutrition monitoring and evaluation means identifying patient/client outcomes relevant to the nutrition diagnosis and intervention plans and goals and comparing those outcomes with previous status, intervention goals or a reference standard to determine the progress made in achieving desired outcomes of nutrition care and if planned interventions should be continued or revised is identify

Nutrition care services, defined.
Nutrition care services means the provision of any part or all of the following services within a systematic process: medical nutrition therapy, general nonmedical nutrition information, assessing and evaluating the nonmedical nutritional needs of individuals and groups and determining resources and constraints in the practice setting: establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints: providing nutrition counseling in health: evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition services.

38-1810.

Registered dietitian or Registered dietitian nutritionist, defined
Registered dietitian or Registered dietitian nutritionist means an individual registered as such with the Commission on Dietetic Registration that gives the individual the right to use the term "registered dietitian nutritionist," "registered dietitian," or "RDN," or "RD."

Therapeutic diets, defined.
Therapeutic diets means a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or diagnosed clinical conditions to modify, eliminate, decrease, or increase identified micro-nutrients and macro-nutrients in the diet.

38-1811. Board; membership; qualifications.

a. The board shall consist of five members. Two members shall be medical nutrition therapists licensed under this act, one member shall be a licensed nutritionist or medical nutrition

therapist licensed under this act, one member shall be a physician, and one member shall be a public member appointed pursuant to section 38-158. The members shall meet the requirements of sections 38-164 and 38-165. **Source:** Laws 2007, LB463, § 633.

38-1812. License required; activities not subject to act.

No person shall practice medical nutrition therapy unless he or she is licensed for such purpose pursuant to the Uniform Credentialing Act. The practice of medical nutrition therapy shall not include:

(1) An individual licensed to practice medical nutrition therapy from engaging in the practice or teaching of dietetics and nutrition within the scope of the individual's license

(2) A student enrolled in an accredited course on dietetics and nutrition recognized by the board from performing any action necessary to complete the student's course of study or engaging in the practice of dietetics and nutrition under a supervisor in accordance with section _____for a time period of no more than five years after the student completes the course of study. The board, in its discretion, may grant a limited extension to the time period specified under this paragraph in the event of extraordinary circumstances to allow an individual to satisfy the qualifications for licensure under section _____. Extraordinary circumstances may include a circumstance when an individual who legally provides medical nutrition therapy in another state has not met the qualifications for licensure under section ____ within the time period specified under this paragraph

(3) An individual from medical nutrition therapy within the scope of the individual's official duties when employed by the Federal Government, serving in the United States Armed Forces or employed by any State agency of entity

(4) An individual who does not hold himself or herself out to be a medical nutrition therapist or licensed nutritionist from furnishing or explaining general nonmedical nutrition information regarding the use of food, food materials or dietary supplements

(5) An individual from presenting a general program of instruction for medical weight control if the program has been approved in writing by any of the following:

(i) a licensed medical nutrition therapist or licensed nutritionist

(ii) a licensed dietitian nutritionist or licensed nutritionist in another state that has requirements equivalent to the licensure requirements under this act

(iii) a dietitian registered by the Commission on Dietetic Registration

(iv) a nutritionist certified by the Board for Certification of Nutrition Specialists

(v) a licensed physician as part of a plan of care

(6) A nutrition and dietetic technician from providing medical nutrition therapy services under the supervision of a medical nutrition therapist or licensed nutritionist.

(7) An individual from providing nutrition information, guidance, encouragement, individualized nutrition recommendations, behavior change management, coaching, assessments, or weight control services that do not constitute medical nutrition therapy on the condition that the individual does not hold himself or herself out as licensed to practice medical nutrition therapy or as a licensed dietitian nutritionist, licensed nutritionist, nutritionist, dietitian or dietician.

(8) An individual trained, licensed or certified under any other law of this state from engaging in a practice within the scope of the individual's license or certification.

Nothing in this act shall be construed to authorize the board to regulate practitioners licensed or certified by other licensing boards.

38-1813. Licensed medical nutrition therapist, licensed nutritionist; qualifications.

A. To be eligible to be licensed as a medical nutrition therapist, an applicant shall be at least 18 years of age; be of good moral character; and submit a completed application as required by the board, and submit any fees as required by the board. The applicant shall meet one of the following criteria: provide evidence of current, valid registration as a registered dietitian nutritionist with the Commission on Dietetic Registration; or submit proof of completion for all of the following educational, supervised practice experience, and examination requirements:

(1) the applicant has received a baccalaureate, master's or doctoral degree with a major course of study in human nutrition, foods and nutrition, dietetics, food systems management, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study from:

(a) a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the federal Department of Education and that, as approved by the Board, meets the competency requirements of an Accreditation Council for Education in Nutrition and Dietetics accredited didactic program in dietetics; or

(b) has an academic degree from a foreign country that has been validated as equivalent to the baccalaureate or post-baccalaureate degree conferred by a regionally accredited college or university in the United States by a credential evaluation agency recognized by the federal Department of Education and that, as approved by the board, meets the competency requirements of an Accreditation Council for Education in Nutrition and Dietetics accredited didactic program in dietetics;

(2) the applicant has successfully completed a planned clinical program in an approved practice of dietetics and nutrition that, as approved by the board, meets the competency requirements of an Accreditation Council for Education in Nutrition and Dietetics accredited supervised practice experience of not less than 1000 hours under the supervision of a dietitian nutritionist licensed in this State or licensed, registered, or certified in any other state having requirements for licensure, registration, or certification substantially similar to licensure requirements in this State, as approved by the board; or a registered dietitian nutritionist registered with the Commission on Dietetic Registration. Supervisors who obtained their doctoral degree outside the United States and its territories must have their degrees validated as equivalent to the doctoral degree conferred by a United States regionally accredited college or university by a credential evaluation agency recognized by the federal Department of Education; and

(3) the applicant has passed the registration examination for dietitian nutritionists administered by the Commission on Dietetic Registration, which shall be held by the board at least twice a year and may be administered by a national testing service, as determined by the board.

B. To be eligible to be licensed as a nutritionist, an applicant shall be at least 18 years of age; be of good moral character; submit a completed application as required by the board, submit any fees as required by the board, and submit proof of completion of the following educational, supervised practice experience, and examination requirements:

(1) the applicant has received a master's or doctoral nutrition degree or, has an academic degree, from a foreign country, that has been validated as equivalent to the masters or doctoral degree conferred by a regionally accredited college or university in the United States by a credential evaluation agency recognized by the federal Department of Education, with a major in human nutrition, foods and nutrition, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or a comparable titled major, or master's or doctoral degree or validated foreign equivalent, in a field of clinical health care from a college or university accredited at the time of graduation from the appropriate regional

accrediting agency recognized by the Council on Higher Education Accreditation and the United States Department of Education, and has completed coursework leading to competence in medical nutrition therapy, which includes, but may not be limited to, the following content areas:

(a) 15 semester hours of clinical or life sciences, at least three semester hours must be in human anatomy and physiology or the equivalent;

(b) 15 semester hours of nutrition and metabolism, at least six semester hours must be in biochemistry;

(2) the applicant must have completed a board approved internship or a documented, supervised practice experience in nutrition care services and the provision of medical nutrition therapy of not less than 1000 hours involving at least 200 hours of nutrition assessment, 200 hours of nutrition intervention, education, counseling or management, and 200 hours of nutrition monitoring or evaluation under the supervision of a Certified Nutrition Specialist, a Registered Dietitian Nutritionist, a licensed medical nutrition therapist, or a licensed nutritionist in this State, a State licensed health care provider whose scope of practice includes the provision of nutrition care services for the purpose of treatment or management of disease or medical condition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in this section. For purposes of this subparagraph, a supervisor shall be licensed in this State if supervising an applicant providing medical nutrition therapy to an individual located in this State. Supervisors who obtained their doctoral degree outside the United States and its territories must have their degrees validated as equivalent to the doctoral degree conferred by a regionally accredited college or university in the United States by a credential evaluation agency recognized by the federal Department of Education. The applicant shall complete this documented, supervised practice experience within five years of completing the academic requirements specified in this section, but the board, in its discretion, may grant a limited extension to this time frame in the event of extraordinary circumstances, which may include consideration for individuals who have been legally providing medical nutrition therapy in another jurisdiction; and

(3) The applicant meets one of the following examination criteria:
the applicant has successfully passed the examination administered by the Board for Certification of Nutrition Specialists; or the applicant has a valid current certification with the Board for Certification of Nutrition Specialists that gives the applicant the right to use the term "Certified Nutrition Specialist" or "CNS" "

New section- No person, business entity or its employees, agents, or representatives shall use the titles, "dietitian nutritionist," "nutritionist," "dietitian," "dietician," "nutrition counselor," "nutrition specialist," "LDN," "LD," "LN," "nutritional therapy practitioner," "nutritional therapy consultant," "certified nutrition therapy practitioner," "master nutrition therapist," "licensed dietitian nutritionist," "licensed nutritionist" or any other title, designation, words, letters, abbreviations, or insignia indicating one as a provider of medical nutrition therapy or as licensed under P.L. (pending before the Legislature as this bill unless licensed to practice dietetics and nutrition under the provisions of P.L. (pending before the Legislature as this bill). A dietitian registered by the Commission on Dietetic Registration may use the title registered dietitian or registered dietitian nutritionist and the designation RD or RDN, and a nutritionist certified by the Board for Certification of Nutrition Specialists may use the title Certified Nutrition Specialist and the designation CNS, and an individual may use any lawfully earned federally trademarked title.

Licensing

The board shall issue a license to any applicant who, in the opinion of the board, has satisfactorily met the requirements specified in PL_____. Except in the case of a temporary license issued pursuant to _____, all licenses shall be issued for a two-year period upon the payment of the licensure fee prescribed by the board, and shall be renewed upon filing of a renewal application, the payment of a licensure fee, and presentation of satisfactory evidence that the renewal applicant has successfully completed the continuing education requirements prescribed by the board by regulation.

38-1814. Reciprocity; military spouse; temporary license.

The department, with the recommendation of the board, may issue a license based on licensure in another jurisdiction to an individual who meets the requirements of the Medical Nutrition Therapy Practice Act or substantially equivalent requirements as determined by the department, with the recommendation of the board. An applicant for a license to practice under the act who is a military spouse may apply for a temporary license as provided in section 38-129.01. **Source:** Laws 2007, LB463, § 636; Laws 2017, LB88, § 59.

Operative Date: April 26, 2017

Temporary license

Upon payment to the board of a fee and the submission of a written application on forms provided by it, the board shall issue a temporary license to

a. a person who has applied for licensure pursuant to P.L. , c. (C.) (pending before the Legislature as this bill) and who, in the judgment of the board, is eligible for examination. A temporary license shall be available to an applicant with the applicant's initial application for examination and the applicant may practice only under the supervision of a supervisor specified in ------ of P.L. , c. (C.) (pending before the Legislature as this bill), consistent with State law. A temporary license shall expire automatically upon failure of the licensure examination but may be renewed until the date of the next examination at which time it shall automatically expire and be surrendered to the board.

b. a person who has applied for licensure pursuant to ------, and without exam, and to hold oneself out as a medical nutrition therapist or nutritionist in this State who provides evidence that the person is in the State on a temporary basis to assist in a medical emergency or engage in a special project or teaching assignment relating to the practice of medical nutrition therapy. A temporary license shall expire one year from its date of issuance but may be renewed by the board for an additional one-year period. This temporary license shall be surrendered to the board upon its expiration.

Scope of Medical Nutrition Therapy Practice

Licensed medical nutrition therapists and licensed nutritionists provide medical nutrition therapy using evidence-based practice and the Nutrition Care Process for patients and clients in clinical and community settings for the purpose of treatment or management of a diagnosed medical disease or medical condition. The Nutrition Care Process is application of the scientific method to medical nutrition therapy and consists of four distinct, but interrelated steps of nutrition assessment: nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation. Specialized knowledge and skills are used to apply the systematic problem-solving method to make diagnostic judgements when providing medical nutrition therapy for safe, effective, and high-quality care. Critical thinking is used to collect relevant data, determine nutrition diagnosis, based upon interpreted data, establish patient/client goals, determine a nutrition plan and interventions to solve the problem and evaluate effectiveness of interventions and progress toward goals/outcomes.

a. A licensed medical nutrition therapist or licensed nutritionist may accept or transmit oral, verbal, delegated, or electronically transmitted orders from the referring provider consistent with applicable laws and rules in conjunction with protocols established to implement medical nutrition therapy.

b. A licensed medical nutrition therapist or licensed nutritionist may order patient diets, including therapeutic diets, oral nutrition supplements, and dietary supplements, in accordance with the provisions of P.L. , c. (C.) (pending before the Legislature as this bill). Therapeutic diets may include oral, enteral, or parenteral nutrition therapy. Enteral and parenteral nutrition therapy consist of specialized enteral or intravenous solutions and shall only be ordered by an individual licensed under P.L. , (C.) (pending before the Legislature as this bill) who also meets one of the following criteria:

(i) the individual is a registered dietitian nutritionist registered with the Commission on Dietetic Registration;

(ii) the individual is a Certified Nutrition Support Clinician certified by the National Board of Nutrition Support Certification; or

(iii) the individual meets other requirements demonstrating competency at the novice level in evaluating and ordering enteral and parenteral therapy and administering enteral therapy, as published in the Revised 2017 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists.

c. A medical nutrition therapist may order medical or laboratory tests related to nutritional therapeutic treatments consistent with state law.

d. A medical nutrition therapist may implement a protocol that does not reference a specific patient and results in a prescription of a legend drug that has been predetermined and delegated by a licensed practitioner as defined in section_____ when caring for a patient whose condition falls within the protocol and the protocol specifies the circumstances under which the drug is to be prescribed or administered."

Nothing in this section shall be construed to limit the ability of any other licensed health care provider in this State to order therapeutic diets, so long as the order of therapeutic diets falls within the scope of the license held by the health care provider.

38-1815. Fees.

The department shall establish and collect fees for credentialing under the Medical Nutrition Therapy Practice Act as provided in sections 38-151 to 38-157. **Source:** Laws 2007, LB463, § 637.

38-1816. Act, how construed.

Nothing in the Medical Nutrition Therapy Practice Act shall be construed to permit a licensed medical nutrition therapist to practice any other profession regulated under the Uniform Credentialing Act.

Source: Laws 1988, LB 557, § 9; Laws 1994, LB 853, § 1; Laws 1995, LB 406, § 29; R.S.1943, (2003), § 711,293; Laws 2007, LB463, § 638.

71-1,285. Transferred to section 38-1802.
71-1,286. Transferred to section 38-1803.
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Transferred to section 38-1816.
71-1,294. Repealed. Laws 2007, LB 463, § 1319.

Appendix E

Proposed amended Medical Nutrition Therapy Practice Act with proposed changes marked

2017

STATE OF NEBRASKA

STATUTES RELATING TO MEDICAL NUTRITION THERAPY PRACTICE ACT

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Division of Public Health
Licensure Unit

301 Centennial Mall South, Third Floor
PO Box 94986
Lincoln, NE 68509-4986

~~INDEX~~ **INDEX is not marked for proposed changes**

MEDICAL NUTRITION THERAPY PRACTICE ACT

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Sections 38-1801 to 38-1816 shall be known and may be cited as the Medical Nutrition Therapy Practice Act. **Source:** Laws 2007, LB463, § 623.

38-1802. Legislative findings.

(1) The Legislature finds that:

(a) The unregulated practice of medical nutrition therapy can clearly harm or endanger the health, safety, and welfare of the public;

(b) The public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and

(c) The public cannot be effectively protected by a less cost-effective means than state regulation of the practice of medical nutrition therapy. The Legislature also finds that medical nutrition therapists must exercise independent judgment and that professional education, training, and experience are required to make such judgment.

(2) The Legislature further finds that the practice of medical nutrition therapy in the State of Nebraska is not sufficiently regulated for the protection of the health, safety, and welfare of the public. It declares that this is a matter of statewide concern and it shall be the policy of the State of Nebraska to promote high standards of professional performance by those persons representing themselves as licensed medical nutrition therapists. **Source:** Laws 1988, LB 557, § 1; Laws 1995, LB 406, § 20; R.S.1943, (2003), § 71-1,285; Laws 2007, LB463, § 624.

38-1803. Definitions, where found.

For purposes of the Medical Nutrition Therapy Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definitions found in sections 38-1804 to 38-1810 apply. **Source:** Laws 1988, LB 557, § 2; Laws 1995, LB 406, § 21; Laws 1999, LB 828, § 146; R.S.1943, (2003), § 711,286; Laws 2007, LB463, § 625.

~~**38-1804. Assessment, defined.**~~

~~Assessment means the process of evaluating the nutritional status of patients. The assessment includes review and analysis of medical and diet histories, biochemical lab values, and anthropometric measurements to determine nutritional status and appropriate nutritional treatment. **Source:** Laws 2007, LB463, § 626.~~

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Board means the Board of Medical Nutrition Therapy. **Source:** Laws 2007, LB463, § 627.

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Commission on Dietetic Registration (CDR) means the credentialing agency for the Academy of Nutrition and Dietetics.

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~~**38-1806. Consultation, defined.**~~

~~Consultation means conferring with a physician regarding the activities of the licensed medical nutrition therapist.~~ ~~**Source:** Laws 2007, LB463, § 628.~~

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General nonmedical nutrition information, defined

General nonmedical nutrition information means information on any of the following

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(1) Principles of good nutrition and food preparation
(2) Food that should be included in the normal diet
(3) The essential nutrients needed by the human body
(4)The recommended amounts of essential nutrients in the human body
(5) The actions of nutrients in the human body
(6) Food and supplements that are good sources of essential nutrients in the human body

~~**38-1807. General nutrition services.**~~
~~General nutrition services includes, but is not limited to:~~
~~(3) Identifying the nutritional needs of individuals and groups in relation to normal nutritional requirements; and~~
~~(4) Planning, implementing, and evaluating nutrition education programs for individuals and groups in the selection of food to meet normal nutritional needs throughout the life cycle. **Source:** Laws 2007, LB463, § 629.~~

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38-1808. Licensed medical nutrition therapist, defined.

Licensed medical nutrition therapist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Credentialing Act and who holds a current license issued by the department pursuant to the Medical Nutrition Therapy Practice Act. **Source:** Laws 2007, LB463, § 630.

Licensed nutritionist, defined

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Licensed nutritionist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Credentialing Act and who holds a current license issued by the department pursuant -to the provisions of _____.

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38-1809. Medical nutrition therapy, defined.

Medical nutrition therapy means assessment of nutrition problems/diagnosis and their cause, establish nutrition diagnosis-specific goals, determine and implement a nutrition care intervention plan to resolve or minimize the problem and monitor and evaluate effectiveness of the interventions and progress toward goals/outcomes; medical nutrition therapy is furnished as part of the treatment or management of a diagnosed disease or medical condition and provided by a licensed medical nutrition therapist or licensed nutritionist. The term includes the provision of all of the following services:

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(1) Interpreting anthropometric, biochemical, clinical and dietary data in acute and chronic disease states and recommending or ordering nutrient needs based on the data, including but not limited to, tube feedings and parenteral nutrition
(2) Food and nutrition counseling regarding prescription drug interactions.
(3) Developing and managing systems operations with the primary focus of nutrition care or recommending or ordering therapeutic diets.
(4) Medical weight control.

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~~Medical nutrition therapy means the assessment of the nutritional status of patients. Medical nutrition therapy involves the assessment of patient nutritional status followed by treatment, ranging from diet modification to~~

~~specialized nutrition support, such as determining nutrient needs for enteral and parenteral nutrition, and monitoring to evaluate patient response to such treatment. **Source:** Laws 2007, LB463, § 631.~~

Medical weight control, defined

Medical weight control means medical nutrition therapy for the purpose of reducing, maintaining, or gaining weight for individuals having a diagnosed disease or medical condition

Nutrition, defined.

Nutrition means the biochemical and physiological aspects of human nutrition. It interprets the nutrients and other bio-substances in food in relation to growth, maintenance, reproduction, health, and disease of an organism. It includes food (via oral, enteral or parenteral route) absorption, distribution, metabolism/metabolic pathway
and excretion.

Nutrition Assessment, defined.

Nutrition assessment means the systematic process of obtaining, verifying, and interpreting biochemical, anthropometric, drugs, clinical, physical and dietary data during the nutrition history or patient interview, patient record review, and nutrition focused physical examination in order to make decisions about the nature and cause of nutrition related problems. It is an ongoing, dynamic process that involves initial data collections and reassessment and analysis of client or community needs and provides the foundation for nutrition diagnosis and nutrition recommendations including enteral and parenteral nutrition.

Nutrition Diagnosis, defined.

Nutrition diagnosis means identifying and labeling nutritional problems that a licensed medical nutrition therapist or licensed nutritionist is responsible for treating independently.

Nutrition Intervention, defined.

Nutrition intervention means the purposefully planned actions intended to positively change a nutrition-related behavior, risk factor, environmental condition, or aspect of health care status for an individual (and his/her family or caregivers), target groups, or community at large.

Nutrition Monitoring and Evaluation, defined.

Nutrition monitoring and evaluation means identifying patient/client outcomes relevant to the nutrition diagnosis and intervention plans and goals and comparing those outcomes with previous status, intervention goals or a reference standard to determine the progress made in achieving desired outcomes of nutrition care and if planned interventions should be continued or revised is identify

Nutrition care services, defined.

Nutrition care services means the provision of any part or all of the following services within a systematic process: medical nutrition therapy, general nonmedical nutrition information, assessing and evaluating the nonmedical nutritional needs of individuals and groups and determining resources and constraints in the practice setting: establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints: providing nutrition counseling in health: evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition services.

~~**38-1811. Patient, defined.**~~

~~**38-1810.** Patient means a person with a disease, illness, injury, or medical condition for which nutritional interventions are an essential component of standard care. **Source:** Laws 2007, LB463, § 632~~

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Registered dietitian or Registered dietitian nutritionist, defined

Registered dietitian or Registered dietitian nutritionist means an individual registered as such with the Commission on Dietetic Registration that gives the individual the right to use the term "registered dietitian nutritionist," "registered dietitian," or "RDN," or "RD."

Therapeutic diets, defined,

Therapeutic diets means a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or diagnosed clinical conditions to modify, eliminate, decrease, or increase identified micro-nutrients and macro-nutrients in the diet.

~~38-1812.~~38-1811. Board; membership; qualifications.

a. The board shall consist of five ~~three professional~~ members. Two members shall be medical nutrition therapists licensed under this act, one member shall be a licensed nutritionist or medical nutrition therapist licensed under this act, one member shall be a ~~, one~~ physician, and one member shall be a public member appointed pursuant to section 38-158. The members shall meet the requirements of sections 38-164 and 38-165. **Source:** Laws 2007, LB463, § 633.

~~38-1813.~~38-1812. License required; activities not subject to act.

No person shall practice medical nutrition therapy unless he or she is licensed for such purpose pursuant to the Uniform Credentialing Act. The practice of medical nutrition therapy shall not include:

~~(1) Any person credentialed in this state pursuant to the Uniform Credentialing Act and engaging in such profession or occupation for which he or she is credentialed;~~

~~(2) Any student engaged in an academic program under the supervision of a licensed medical nutrition therapist as part of a major course of study in human nutrition, food and nutrition, or dietetics, or an equivalent major course of study approved by the board, and who is designated with a title which clearly indicates the person's status as a student or trainee;~~

~~(3) Persons practicing medical nutrition therapy who serve in the armed forces of the United States or the United States Public Health Service or who are employed by the United States Department of Veterans Affairs or other federal agencies, if their practice is limited to that service or employment;~~

~~(4) Persons practicing medical nutrition therapy who are licensed in another state, United States possession, or country, or have received at least a baccalaureate degree, and are in this state for the purpose of:~~

~~(a) Consultation if the practice in this state is limited to consultation; or~~

~~(b) Conducting a teaching clinical demonstration in connection with a program of basic clinical education, graduate education, or postgraduate education which is sponsored by a dietetic education program or a major course of study in human nutrition, food and nutrition, or dietetics, or an equivalent major course of study approved by the board;~~

~~(5) Persons performing general nutrition services incidental to the practice of the profession insofar as it does not exceed the scope of their education and training;~~

~~(6) Persons who market or distribute food, food materials, or dietary supplements, including persons employed in health food stores, or persons engaged in the advising of the use of those products, or the preparation of those products, or the counseling of individuals or groups in the selection of products to meet general nutrition needs;~~

~~(7) Persons conducting classes or disseminating information related to general nutrition services;~~

~~(8) Persons who care for the sick in accordance with the tenets and practices of any bona fide church or religious denomination;~~

~~(9) Persons who provide information and instructions regarding food intake or exercise as a part of a weight control program; and~~

~~(10) Persons with advanced postgraduate degrees involved in academic teaching or research.~~

~~**Source:** Laws 1988, LB 557, § 3; Laws 1995, LB 406, § 22; R.S.1943, (2003), § 71-1,287; Laws 2007, LB463, §~~

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(5) ~~634.~~

(1) An individual licensed to practice medical nutrition therapy from engaging in the practice or teaching of dietetics and nutrition within the scope of the individual's license

(2) A student enrolled in an accredited course on dietetics and nutrition recognized by the board from performing any action necessary to complete the student's course of study or engaging in the practice of dietetics and nutrition under a supervisor in accordance with section _____ for a time period of no more than five years after the student completes the course of study. The board, in its discretion, may grant a limited extension to the time period specified under this paragraph in the event of extraordinary circumstances to allow an individual to satisfy the qualifications for licensure under section _____. Extraordinary circumstances may include a circumstance when an individual who legally provides medical nutrition therapy in another state has not met the qualifications for licensure under section _____ within the time period specified under this paragraph

(3) An individual from medical nutrition therapy within the scope of the individual's official duties when employed by the Federal Government, serving in the United States Armed Forces or employed by any State agency of entity

(4) An individual who does not hold himself or herself out to be a medical nutrition therapist or licensed nutritionist from furnishing or explaining general nonmedical nutrition information regarding the use of food, food materials or dietary supplements

(5) An individual from presenting a general program of instruction for medical weight control if the program has been approved in writing by any of the following:

(i) a licensed medical nutrition therapist or licensed nutritionist

(ii) a licensed dietitian nutritionist or licensed nutritionist in another state that has requirements equivalent to the licensure requirements under this act

(iii) a dietitian registered by the Commission on Dietetic Registration

(iv) a nutritionist certified by the Board for Certification of Nutrition Specialists

(v) a licensed physician as part of a plan of care

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(6) A nutrition and dietetic technician from providing medical nutrition therapy services under the supervision of a medical nutrition therapist or licensed nutritionist.

(7) An individual from providing nutrition information, guidance, encouragement, individualized nutrition recommendations, behavior change management, coaching, assessments, or weight control services that do not constitute medical nutrition therapy on the condition that the individual does not hold himself or herself out as licensed to practice medical nutrition therapy or as a licensed dietitian nutritionist, licensed nutritionist, nutritionist, dietitian or dietician.

(8) An individual trained, licensed or certified under any other law of this state from engaging in a practice within the scope of the individual's license or certification.

Nothing in this act shall be construed to authorize the board to regulate practitioners licensed or certified by other licensing boards.

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38-1813. Licensed medical nutrition therapist, licensed nutritionis; qualifications.

~~A person shall be qualified to be a licensed medical nutrition therapist if such person furnishes evidence that he or she:~~

~~(1) Has met the requirements for and is a registered dietitian by the American Dietetic Association or an equivalent entity recognized by the board;~~

~~(2)(a) Has satisfactorily passed an examination approved by the board;~~

~~(b) Has received a baccalaureate degree from an accredited college or university with a major course of study in human nutrition, food and nutrition, dietetics, or an equivalent major course of study approved by the board; and (c) Has satisfactorily completed a program of supervised clinical experience approved by the department. Such clinical experience shall consist of not less than nine hundred hours of a planned continuous experience in human nutrition, food and nutrition, or dietetics under the supervision of an individual meeting the qualifications of this section; or~~

~~(3)(a) Has satisfactorily passed an examination approved by the board; and~~

~~(b)(i) Has received a master's or doctorate degree from an accredited college or university in human nutrition, nutrition education, food and nutrition, or public health nutrition or in an equivalent major course of study approved by the board; or~~

~~(ii) Has received a master's or doctorate degree from an accredited college or university which includes a major course of study in clinical nutrition. Such course of study shall consist of not less than a combined two hundred hours of biochemistry and physiology and not less than seventy-five hours in human nutrition.~~

~~For purposes of this section, accredited college or university means an institution currently listed with the United States Secretary of Education as accredited. Applicants who have obtained their education outside of the United States and its territories shall have their academic degrees validated as equivalent to a baccalaureate or master's degree conferred by a United States regionally accredited college or university.~~

~~The practice of medical nutrition therapy shall be performed under the consultation of a physician licensed pursuant to section 38-2026 or sections 38-2029 to 38-2033.~~

~~**Source:** Laws 1988, LB 557, § 5; Laws 1995, LB 406, § 24; R.S.1943, (2003), § 71-1,289; Laws 2007, LB463, § 635.~~

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A. To be eligible to be licensed as a medical nutrition therapist, an applicant shall be at least 18 years of age; be of good moral character; and submit a completed application as required by the board, and submit any fees as required by the board. The applicant shall meet one of the following criteria: provide evidence of current, valid registration as a registered dietitian nutritionist with the Commission on Dietetic Registration; or submit proof of completion for all of the following educational, supervised practice experience, and examination requirements:

(1) the applicant has received a baccalaureate, master's or doctoral degree with a major course of study in human nutrition, foods and nutrition, dietetics, food systems management, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study from:

(a) a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the federal Department of Education and that, as approved by the Board, meets the competency requirements of an Accreditation Council for Education in Nutrition and Dietetics accredited didactic program in dietetics; or

(b) has an academic degree from a foreign country that has been validated as equivalent to the baccalaureate or post-baccalaureate degree conferred by a regionally accredited college or university in the United States by a credential evaluation agency recognized by the federal Department of Education and that, as approved by the board, meets the competency requirements of an Accreditation Council for Education in Nutrition and Dietetics accredited didactic program in dietetics;

(2) the applicant has successfully completed a planned clinical program in an approved practice of dietetics and nutrition that, as approved by the board, meets the competency requirements of an Accreditation Council for Education in Nutrition and Dietetics accredited supervised practice experience of not less than 1000 hours under the supervision of a dietitian nutritionist licensed in this State or licensed, registered, or certified in any other state having requirements for licensure, registration, or certification substantially similar to licensure requirements in this State, as approved

by the board; or a registered dietitian nutritionist registered with the Commission on Dietetic Registration. Supervisors who obtained their doctoral degree outside the United States and its territories must have their degrees validated as equivalent to the doctoral degree conferred by a United States regionally accredited college or university by a credential evaluation agency recognized by the federal Department of Education; and

(3) the applicant has passed the registration examination for dietitian nutritionists administered by the Commission on Dietetic Registration, which shall be held by the board at least twice a year and may be administered by a national testing service, as determined by the board.

B. To be eligible to be licensed as a nutritionist, an applicant shall be at least 18 years of age; be of good moral character; submit a completed application as required by the board, submit any fees as required by the board, and submit proof of completion of the following educational, supervised practice experience, and examination requirements:

(1) the applicant has received a master's or doctoral nutrition degree or, has an academic degree, from a foreign country, that has been validated as equivalent to the masters or doctoral degree conferred by a regionally accredited college or university in the United States by a credential evaluation agency recognized by the federal Department of Education, with a major in human nutrition, foods and nutrition, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or a comparable titled major, or master's or doctoral degree or validated foreign equivalent, in a field of clinical health care from a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the United States Department of Education, and has completed coursework leading to competence in medical nutrition therapy, which includes, but may not be limited to, the following content areas:

(a) 15 semester hours of clinical or life sciences, at least three semester hours must be in human anatomy and physiology or the equivalent;

(b) 15 semester hours of nutrition and metabolism, at least six semester hours must be in biochemistry;

(2) the applicant must have completed a board approved internship or a documented, supervised practice experience in nutrition care services and the provision of medical nutrition therapy of not less than 1000 hours involving at least 200 hours of nutrition assessment, 200 hours of nutrition intervention, education, counseling or management, and 200 hours of nutrition monitoring or evaluation under the supervision of a Certified Nutrition Specialist, a Registered Dietitian Nutritionist, a licensed medical nutrition therapist or a licensed nutritionist in this State, a State licensed health care provider whose scope of practice includes the provision of nutrition care services for the purpose of treatment or management of disease or medical condition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in this section. For purposes of this subparagraph, a supervisor shall be licensed in this State if supervising an applicant providing medical nutrition therapy to an individual located in this State. Supervisors who obtained their doctoral degree outside the United States and its territories must have their degrees validated as equivalent to the doctoral degree conferred by a regionally accredited college or university in the United States by a credential evaluation agency recognized by the federal Department of Education. The applicant shall complete this documented, supervised practice experience within five years of completing the academic requirements specified in this section, but the board, in its discretion, may grant a limited extension to this time frame in the event of extraordinary

circumstances, which may include consideration for individuals who have been legally providing medical nutrition therapy in another jurisdiction; and

(3) The applicant meets one of the following examination criteria:

the applicant has successfully passed the examination administered by the Board for Certification of Nutrition Specialists; or the applicant has a valid current certification with the Board for Certification of Nutrition Specialists that gives the applicant the right to use the term "Certified Nutrition Specialist" or "CNS".

New Section No person, business entity or its employees, agents, or representatives shall use the titles, "dietitian nutritionist," "nutritionist," "dietitian," "dietician," "nutrition counselor," "nutrition specialist," "LDN," "LD," "LN," "nutritional therapy practitioner," "nutritional therapy consultant," "certified nutrition therapy practitioner," "master nutrition therapist," "licensed dietitian nutritionist," "licensed nutritionist" or any other title, designation, words, letters, abbreviations, or insignia indicating one as a provider of medical nutrition therapy or as licensed under P.L. (pending before the Legislature as this bill unless licensed to practice dietetics and nutrition under the provisions of P.L. (pending before the Legislature as this bill). A dietitian registered by the Commission on Dietetic Registration may use the title registered dietitian or registered dietitian nutritionist and the designation RD or RDN, and a nutritionist certified by the Board for Certification of Nutrition Specialists may use the title Certified Nutrition Specialist and the designation CNS, and an individual may use any lawfully earned federally trademarked title.

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Licensing

The board shall issue a license to any applicant who, in the opinion of the board, has satisfactorily met the requirements specified in PL . Except in the case of a temporary license issued pursuant to , all licenses shall be issued for a two-year period upon the payment of the licensure fee prescribed by the board, and shall be renewed upon filing of a renewal application, the payment of a licensure fee, and presentation of satisfactory evidence that the renewal applicant has successfully completed the continuing education requirements prescribed by the board by regulation.

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38-1814. Reciprocity; military spouse; temporary license.

The department, with the recommendation of the board, may issue a license based on licensure in another jurisdiction to an individual who meets the requirements of the Medical Nutrition Therapy Practice Act or substantially equivalent requirements as determined by the department, with the recommendation of the board. An applicant for a license to practice under the act who is a military spouse may apply for a temporary license as provided in section 38-129.01. **Source:** Laws 2007, LB463, § 636; Laws 2017, LB88, § 59.

Operative Date: April 26, 2017

Temporary license

Upon payment to the board of a fee and the submission of a written application on forms provided by it, the board shall issue a temporary license to

a. a person who has applied for licensure pursuant to P.L. , c. (C.) (pending before the Legislature as this bill) and who, in the judgment of the board, is eligible for examination. A temporary license shall be available to an applicant with the applicant's initial application for examination and the applicant may practice only under the supervision of a supervisor specified in ------ of P.L. , c. (C.) (pending before the Legislature as this bill), consistent with State law. A temporary license shall expire automatically upon failure of the licensure examination but may be

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renewed until the date of the next examination at which time it shall automatically expire and be surrendered to the board.

b. a person who has applied for licensure pursuant to ------, and without exam, and to hold oneself out as a medical nutrition therapist or nutritionist in this State who provides evidence that the person is in the State on a temporary basis to assist in a medical emergency or engage in a special project or teaching assignment relating to the practice of medical nutrition therapy. A temporary license shall expire one year from its date of issuance but may be renewed by the board for an additional one-year period. This temporary license shall be surrendered to the board upon its expiration.

Scope of Medical Nutrition Therapy Practice

Licensed medical nutrition therapists and licensed nutritionists provide medical nutrition therapy using evidence-based practice and the Nutrition Care Process for patients and clients in clinical and community settings for the purpose of treatment or management of a diagnosed medical disease or medical condition. The Nutrition Care Process is application of the scientific method to medical nutrition therapy and consists of four distinct, but interrelated steps of nutrition assessment: nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation. Specialized knowledge and skills are used to apply the systematic problem-solving method to make diagnostic judgements when providing medical nutrition therapy for safe, effective, and high-quality care. Critical thinking is used to collect relevant data, determine nutrition diagnosis, based upon interpreted data, establish patient/client goals, determine a nutrition plan and interventions to solve the problem and evaluate effectiveness of interventions and progress toward goals/outcomes.

a. A licensed medical nutrition therapist or licensed nutritionist may accept or transmit oral, verbal, delegated, or electronically transmitted orders from the referring provider consistent with applicable laws and rules in conjunction with protocols established to implement medical nutrition therapy.

b. A licensed medical nutrition therapist or licensed nutritionist may order patient diets, including therapeutic diets, oral nutrition supplements, and dietary supplements, in accordance with the provisions of P.L. , c. (C.) (pending before the Legislature as this bill). Therapeutic diets may include oral, enteral, or parenteral nutrition therapy. Enteral and parenteral nutrition therapy consist of specialized enteral or intravenous solutions and shall only be ordered by an individual licensed under P.L. , (C.) (pending before the Legislature as this bill) who also meets one of the following criteria:

(i) the individual is a registered dietitian nutritionist registered with the Commission on Dietetic Registration;

(ii) the individual is a Certified Nutrition Support Clinician certified by the National Board of Nutrition Support Certification; or

(iii) the individual meets other requirements demonstrating competency at the novice level in evaluating and ordering enteral and parenteral therapy and administering enteral therapy, as published in the Revised 2017 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists.

c. A medical nutrition therapist may order medical or laboratory tests related to nutritional therapeutic treatments consistent with state law.

d. A medical nutrition therapist may implement a protocol that does not reference a specific patient and results in a prescription of a legend drug that has been predetermined and delegated by a licensed practitioner as defined in section _____ when caring for a patient whose condition falls

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within the protocol and the protocol specifies the circumstances under which the drug is to be prescribed or administered."

Nothing in this section shall be construed to limit the ability of any other licensed health care provider in this State to order therapeutic diets, so long as the order of therapeutic diets falls within the scope of the license held by the health care provider.

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38-1815. Fees.

The department shall establish and collect fees for credentialing under the Medical Nutrition Therapy Practice Act as provided in sections 38-151 to 38-157. **Source:** Laws 2007, LB463, § 637.

38-1816. Act, how construed.

Nothing in the Medical Nutrition Therapy Practice Act shall be construed to permit a licensed medical nutrition therapist to practice any other profession regulated under the Uniform Credentialing Act.

Source: Laws 1988, LB 557, § 9; Laws 1994, LB 853, § 1; Laws 1995, LB 406, § 29; R.S.1943, (2003), § 711,293; Laws 2007, LB463, § 638.

71-1,285. Transferred to section 38-1802.
71-1,286. Transferred to section 38-1803.
71-1,287. Transferred to section 38-1812.
71-1,288. Repealed. Laws 2003, LB 242, s. 154.
71-1,289. Transferred to section 38-1813.
71-1,290. Repealed. Laws 2007, LB 463, § 1319.
71-1,291. Repealed. Laws 2007, LB 463, § 1319.
71-1,291.01. Repealed. Laws 2007, LB 463, § 1319.
71-1,292. Repealed. Laws 2007, LB 463, § 1319. 71-1,293.
Transferred to section 38-1816.
71-1,294. Repealed. Laws 2007, LB 463, § 1319.

Appendix F

Academy of Nutrition and Dietetics Nutrition Terminology (eNCPT): Nutrition Diagnostic Terminology, Nutrition Intervention Terminology, Nutrition Assessment and Monitoring and Evaluation Terminology

Nutrition Diagnostic Terminology

Each term is designated with an alpha-numeric NCPT hierarchical code, followed by a five-digit (e.g., 99999) Academy SNOMED CT/LOINC unique identifier (ANDUID). Neither should be used in nutrition documentation. The ANDUID is for data tracking purposes in electronic health records.

INTAKE (NI)

Actual problems related to intake of energy, nutrients, fluids, bioactive substances through oral diet or nutrition support

Energy Balance (1)

Actual or estimated changes in energy (calorie/kcal/kJ) balance

	NCPT Code	ANDUID
❑ Increased energy expenditure	NI-1.1	10633
❑ Inadequate energy intake	NI-1.2	10634
❑ Excessive energy intake	NI-1.3	10635
❑ Predicted inadequate energy intake	NI-1.4	10636
❑ Predicted excessive energy intake	NI-1.5	10637

Oral or Nutrition Support Intake (2)

Actual or estimated food and beverage intake from oral diet or nutrition support compared with client goal

	NCPT Code	ANDUID
❑ Inadequate oral intake	NI-2.1	10639
❑ Excessive oral intake	NI-2.2	10640
❑ Inadequate enteral nutrition infusion	NI-2.3	10641
❑ Excessive enteral nutrition infusion	NI-2.4	10642
❑ Enteral nutrition composition inconsistent with needs	NI-2.5	11142
❑ Enteral nutrition administration inconsistent with needs	NI-2.6	11143
❑ Inadequate parenteral nutrition infusion	NI-2.7	10644
❑ Excessive parenteral nutrition infusion	NI-2.8	10645
❑ Parenteral nutrition composition inconsistent with needs	NI-2.9	11144
❑ Parenteral nutrition administration inconsistent with needs	NI-2.10	11145
❑ Limited food acceptance	NI-2.11	10647

Fluid Intake (3)

Actual or estimated fluid intake compared with client goal

	NCPT Code	ANDUID
❑ Inadequate fluid intake	NI-3.1	10649
❑ Excessive fluid intake	NI-3.2	10650

Bioactive Substances (4)

Actual or estimated intake of bioactive substances, including single or multiple functional food components, ingredients, dietary supplements, alcohol

	NCPT Code	ANDUID
❑ Inadequate bioactive substance intake	NI-4.1	10859
❑ Inadequate plant stanol ester intake	NI-4.1.1	11077
❑ Inadequate plant sterol ester intake	NI-4.1.2	11078
❑ Inadequate soy protein intake	NI-4.1.3	11080
❑ Inadequate psyllium intake	NI-4.1.4	11079
❑ Inadequate beta glucan intake	NI-4.1.5	11076
❑ Excessive bioactive substance intake	NI-4.2	10653
❑ Excessive plant stanol ester intake	NI-4.2.1	11084
❑ Excessive plant sterol ester intake	NI-4.2.2	11085
❑ Excessive soy protein intake	NI-4.2.3	11087
❑ Excessive psyllium intake	NI-4.2.4	11086
❑ Excessive beta glucan intake	NI-4.2.5	11081
❑ Excessive food additive intake	NI-4.2.6	11083
❑ Excessive caffeine intake	NI-4.2.7	11082
❑ Excessive alcohol intake	NI-4.3	10654

Nutrient (5)

Actual or estimated intake of specific nutrient groups or single nutrients as compared with desired levels

	NCPT Code	ANDUID
❑ Increased nutrient needs (specify) _____	NI-5.1	10656
❑ Inadequate protein energy intake	NI-5.2	10658
❑ Decreased nutrient needs (specify) _____	NI-5.3	10659
❑ Imbalance of nutrients	NI-5.4	10660

Fat and Cholesterol (5.5)

	NCPT Code	ANDUID
❑ Inadequate fat intake	NI-5.5.1	10662
❑ Excessive fat intake	NI-5.5.2	10663
❑ Intake of types of fats inconsistent with needs (specify) _____	NI-5.5.3	10854

Protein (5.6)

	NCPT Code	ANDUID
❑ Inadequate protein intake	NI-5.6.1	10666
❑ Excessive protein intake	NI-5.6.2	10667
❑ Intake of types of proteins inconsistent with needs (specify) _____	NI-5.6.3	10855

Amino Acid (5.7)

	NCPT Code	ANDUID
❑ Intake of types of amino acids inconsistent with needs (specify) _____	NI-5.7.1	12007

Carbohydrate and Fiber (5.8)

	NCPT Code	ANDUID
❑ Inadequate carbohydrate intake	NI-5.8.1	10670
❑ Excessive carbohydrate intake	NI-5.8.2	10671
❑ Intake of types of carbohydrate inconsistent with needs (specify) _____	NI-5.8.3	10856
❑ Inconsistent carbohydrate intake	NI-5.8.4	10673
❑ Inadequate fiber intake	NI-5.8.5	10675
❑ Excessive fiber intake	NI-5.8.6	10676

Vitamin (5.9)

	NCPT Code	ANDUID
❑ Inadequate vitamin intake (specify)	NI-5.9.1	10678
❑ A (1)		10679
❑ C (2)		10680
❑ D (3)		10681
❑ E (4)		10682
❑ K (5)		10683
❑ Thiamin (6)		10684
❑ Riboflavin (7)		10685
❑ Niacin (8)		10686
❑ Folate (9)		10687
❑ B6 (10)		10688
❑ B12 (11)		10689
❑ Pantothenic acid (12)		10690
❑ Biotin (13)		10691
❑ Excessive vitamin intake (specify)	NI-5.9.2	10693
❑ A (1)		10694
❑ C (2)		10695
❑ D (3)		10696
❑ E (4)		10697
❑ K (5)		10698
❑ Thiamin (6)		10699
❑ Riboflavin (7)		10700
❑ Niacin (8)		10701
❑ Folate (9)		10702
❑ B6 (10)		10703
❑ B12 (11)		10704
❑ Pantothenic acid (12)		10705
❑ Biotin (13)		10706

Mineral (5.10)

	NCPT Code	ANDUID
❑ Inadequate mineral intake (specify)	NI-5.10.1	10709
❑ Calcium (1)		10710
❑ Chloride (2)		10711
❑ Iron (3)		10712
❑ Magnesium (4)		10713
❑ Potassium (5)		10714
❑ Phosphorus (6)		10715
❑ Sodium (7)		10716
❑ Zinc (8)		10717
❑ Sulfate (9)		10718
❑ Fluoride (10)		10719

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	NCPT Code	ANDUID
❑ Copper (11)		10720
❑ Iodine (12)		10721
❑ Selenium (13)		10722
❑ Manganese (14)		10723
❑ Chromium (15)		10724
❑ Molybdenum (16)		10725
❑ Boron (17)		10726
❑ Cobalt (18)		10727
❑ Excessive mineral intake (specify)	NI-5.10.2	10729
❑ Calcium (1)		10730
❑ Chloride (2)		10731
❑ Iron (3)		10732
❑ Magnesium (4)		10733
❑ Potassium (5)		10734
❑ Phosphorus (6)		10735
❑ Sodium (7)		10736
❑ Zinc (8)		10737
❑ Sulfate (9)		10738
❑ Fluoride (10)		10739
❑ Copper (11)		10740
❑ Iodine (12)		10741
❑ Selenium (13)		10742
❑ Manganese (14)		10743
❑ Chromium (15)		10744
❑ Molybdenum (16)		10745
❑ Boron (17)		10746
❑ Cobalt (18)		10747

Multinutrient (5.11)

❑ Predicted inadequate nutrient intake (specify) _____	NI-5.11.1	10750
❑ Predicted excessive nutrient intake (specify) _____	NI-5.11.2	10751

CLINICAL (NC)

Nutritional findings/problems identified that relate to medical or physical conditions

Functional (1)

Change in physical or mechanical functioning that interferes with or prevents desired nutritional consequences

❑ Swallowing difficulty	NC-1.1	10754
❑ Biting/Chewing (masticatory) difficulty	NC-1.2	10755
❑ Breastfeeding difficulty	NC-1.3	10756
❑ Altered GI function	NC-1.4	10757
❑ Predicted breastfeeding difficulty	NC-1.5	11146

Biochemical (2)

Change in capacity to metabolize nutrients as a result of medications, surgery, or as indicated by altered laboratory values

❑ Impaired nutrient utilization	NC-2.1	10759
❑ Altered nutrition related laboratory values (specify) _____	NC-2.2	10760
❑ Food medication interaction (specify) _____	NC-2.3	10761
❑ Predicted food medication interaction (specify) _____	NC-2.4	10762

Weight (3)

Chronic weight or changed weight status when compared with usual or desired body weight

❑ Underweight	NC-3.1	10764
❑ Unintended weight loss	NC-3.2	10765
❑ Overweight/obesity	NC-3.3	10766
❑ Overweight, adult or pediatric	NC-3.3.1	10767
❑ Obese, pediatric	NC-3.3.2	10768
❑ Obese, Class I	NC-3.3.3	10769
❑ Obese, Class II	NC-3.3.4	10818
❑ Obese, Class III	NC-3.3.5	10819
❑ Unintended weight gain	NC-3.4	10770
❑ Growth rate below expected	NC-3.5	10802
❑ Excessive growth rate	NC-3.6	10803

Malnutrition Disorders (4)

Health consequences resulting from insufficient or excessive energy and/or nutrient intake compared to physiologic needs and/or utilization

❑ Malnutrition (undernutrition)	NC-4.1	10657
❑ Starvation related malnutrition	NC-4.1.1	11130
❑ Moderate starvation related malnutrition	NC-4.1.1.1	13210
❑ Severe starvation related malnutrition	NC-4.1.1.2	13211
❑ Chronic disease or condition related malnutrition	NC-4.1.2	11131
❑ Moderate chronic disease or condition related malnutrition	NC-4.1.2.1	13212
❑ Severe chronic disease or condition related malnutrition	NC-4.1.2.2	13213
❑ Acute disease or injury related malnutrition	NC-4.1.3	11132
❑ Moderate acute disease or injury related malnutrition	NC-4.1.3.1	13214
❑ Severe acute disease or injury related malnutrition	NC-4.1.3.2	13215
❑ Non illness related pediatric malnutrition	NC-4.1.4	13017
❑ Mild non illness related pediatric malnutrition	NC-4.1.4.1	13216
❑ Moderate non illness related pediatric malnutrition	NC-4.1.4.2	13217
❑ Severe non illness related pediatric malnutrition	NC-4.1.4.3	13218
❑ Illness related pediatric malnutrition	NC-4.1.5	13018
❑ Mild illness related pediatric malnutrition	NC-4.1.5.1	13219
❑ Moderate illness related pediatric malnutrition	NC-4.1.5.2	13220
❑ Severe illness related pediatric malnutrition	NC-4.41.5.3	13221

BEHAVIORAL-ENVIRONMENTAL (NB)

Nutritional findings/problems identified that relate to knowledge, attitudes/beliefs, physical environment, access to food, or food safety

Knowledge and Beliefs (1)

Actual knowledge and beliefs as related, observed, or documented

❑ Food and nutrition related knowledge deficit	NB-1.1	10773
❑ Unsupported beliefs/attitudes about food or nutrition related topics (use with caution)	NB-1.2	10857
❑ Not ready for diet/lifestyle change	NB-1.3	10775
❑ Self monitoring deficit	NB-1.4	10776
❑ Disordered eating pattern	NB-1.5	10777
❑ Limited adherence to nutrition related recommendations	NB-1.6	10778
❑ Undesirable food choices	NB-1.7	10779

Physical Activity and Function (2)

Actual physical activity, self care, and quality of life problems as reported, observed, or documented

❑ Physical inactivity	NB-2.1	10782
❑ Excessive physical activity	NB-2.2	10783
❑ Inability to manage self care	NB-2.3	10780
❑ Impaired ability to prepare foods/meals	NB-2.4	10785
❑ Poor nutrition quality of life	NB-2.5	10786
❑ Self feeding difficulty	NB-2.6	10787

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	NCPT Code	ANDUID
Food Safety and Access (3)		
Actual problems with food safety or access to food, water, or nutrition related supplies		
❑ Intake of unsafe food	NB-3.1	10789
❑ Limited access to food	NB-3.2	12009
❑ Limited access to nutrition related supplies	NB-3.3	10791
❑ Limited access to potable water	NB-3.4	12010

	NCPT Code	ANDUID
Other (NO)		
Nutrition findings that are not classified as intake, clinical or behavioral-environmental problems.		
Other (1)		
❑ No nutrition diagnosis at this time	NO-1.1	10795

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Nutrition Intervention Terminology

Each term is designated with an alpha-numeric NCPT hierarchical code, followed by a five-digit (e.g., 99999) Academy SNOMED CT/LOINC unique identifier (ANDUID). Neither should be used in nutrition documentation. The ANDUID is for data tracking purposes in electronic health records.

Nutrition Prescription (NP)

The client's tailored recommended intake of energy and/or selected foods or nutrients based on current reference standards and evidenced based practice nutrition guidelines and related to the client's health and nutrition diagnosis (specify).

	NCPT Code	ANDUID
❑ Nutrition Prescription	NP-1.1	10794

FOOD AND/OR NUTRIENT DELIVERY (ND)

Individualized approach for food /nutrient provision.

Meals and Snacks (1)

Regular eating episode (meal); food served between regular meals (snack)

	NCPT Code	ANDUID
❑ General healthful diet	ND-1.1	10489
❑ Modify composition of meals/snacks	ND-1.2	10828
❑ Texture modified diet (1)	ND-1.2.1	10829
❑ Easy to chew diet	ND-1.2.1.1	10914
❑ Mechanically altered diet	ND-1.2.1.2	10915
❑ Pureed diet	ND-1.2.1.3	10916
❑ Liquid consistency thin liquids	ND-1.2.1.4	10865
❑ Liquid consistency nectar thick liquids	ND-1.2.1.5	10866
❑ Liquid consistency honey thick liquids	ND-1.2.1.6	10867
❑ Liquid consistency spoon thick liquids	ND-1.2.1.7	10868
❑ Soft bite sized food Level six Blue	ND-1.2.1.8	12216
❑ Minced moist food Level five Orange	ND-1.2.1.9	12217
❑ Pureed food Level four Green	ND-1.2.1.10	12218
❑ Extremely thick liquid Level four Green	ND-1.2.1.11	12219
❑ Liquidized food Level three Yellow	ND-1.2.1.12	12220
❑ Moderately thick liquid Level three Yellow	ND-1.2.1.13	12221
❑ Mildly thick liquid Level two Pink	ND-1.2.1.14	12222
❑ Slightly thick liquid Level one Grey	ND-1.2.1.15	12223
❑ Energy modified diet (2)	ND-1.2.2	10830
❑ Increased energy diet	ND-1.2.2.1	10935
❑ Decreased energy diet	ND-1.2.2.2	10936
❑ Protein modified diet (3)	ND-1.2.3	10831
❑ Consistent protein diet	ND-1.2.3.1	10896
❑ Increased protein diet	ND-1.2.3.2	10972
❑ Decreased protein diet	ND-1.2.3.3	10973
❑ Decreased casein diet	ND-1.2.3.4	10999
❑ Decreased gluten diet	ND-1.2.3.5	11000
❑ Gluten free diet	ND-1.2.3.5.1	11027
❑ Amino acid modified diet	ND-1.2.3.6	10897
❑ Arginine modified diet	ND-1.2.3.6.1	10898
❑ Increased arginine diet	ND-1.2.3.6.1.1	10974
❑ Decreased arginine diet	ND-1.2.3.6.1.2	10975
❑ Glutamine modified diet	ND-1.2.3.6.2	10899
❑ Increased glutamine diet	ND-1.2.3.6.2.1	10976
❑ Decreased glutamine diet	ND-1.2.3.6.2.2	10977
❑ Histidine modified diet	ND-1.2.3.6.3	10900
❑ Increased histidine diet	ND-1.2.3.6.3.1	10978
❑ Decreased histidine diet	ND-1.2.3.6.3.2	10979
❑ Increased homocysteine diet	ND-1.2.3.6.4	10980
❑ Isoleucine modified diet	ND-1.2.3.6.5	10902
❑ Increased isoleucine diet	ND-1.2.3.6.5.1	10981
❑ Decreased isoleucine diet	ND-1.2.3.6.5.2	10982
❑ Leucine modified diet	ND-1.2.3.6.6	10903
❑ Increased leucine diet	ND-1.2.3.6.6.1	10983
❑ Decreased leucine diet	ND-1.2.3.6.6.2	10984
❑ Lysine modified diet	ND-1.2.3.6.7	10904
❑ Increased lysine diet	ND-1.2.3.6.7.1	10985
❑ Decreased lysine diet	ND-1.2.3.6.7.2	10986
❑ Methionine modified diet	ND-1.2.3.6.8	10905
❑ Increased methionine diet	ND-1.2.3.6.8.1	10987
❑ Decreased methionine diet	ND-1.2.3.6.8.2	10988
❑ Phenylalanine modified diet	ND-1.2.3.6.9	10906
❑ Increased phenylalanine diet	ND-1.2.3.6.9.1	11971
❑ Decreased phenylalanine diet	ND-1.2.3.6.9.2	10989
❑ Threonine modified diet	ND-1.2.3.6.10	10907
❑ Increased threonine diet	ND-1.2.3.6.10.1	10990
❑ Decreased threonine diet	ND-1.2.3.6.10.2	10991
❑ Tryptophan modified diet	ND-1.2.3.6.11	10908
❑ Increased tryptophan diet	ND-1.2.3.6.11.1	10992
❑ Decreased tryptophan diet	ND-1.2.3.6.11.2	10993
❑ Decreased tyramine diet	ND-1.2.3.6.12	10994
❑ Tyrosine modified diet	ND-1.2.3.6.13	10910
❑ Increased tyrosine diet	ND-1.2.3.6.13.1	10995
❑ Decreased tyrosine diet	ND-1.2.3.6.13.2	10996
❑ Valine modified diet	ND-1.2.3.6.14	10911
❑ Increased valine diet	ND-1.2.3.6.14.1	10997
❑ Decreased valine diet	ND-1.2.3.6.14.2	10998
❑ Carbohydrate modified diet (4)	ND-1.2.4	10832
❑ Consistent carbohydrate diet	ND-1.2.4.1	10860
❑ Increased carbohydrate diet	ND-1.2.4.2	10930
❑ Increased complex carbohydrate diet	ND-1.2.4.2.1	11972
❑ Increased simple carbohydrate diet	ND-1.2.4.2.2	11973
❑ Decreased carbohydrate diet	ND-1.2.4.3	10931
❑ Decreased complex carbohydrate diet	ND-1.2.4.3.1	11974
❑ Decreased simple carbohydrate diet	ND-1.2.4.3.2	11975
❑ Galactose modified diet	ND-1.2.4.4	10861
❑ Increased galactose diet	ND-1.2.4.4.1	11976
❑ Decreased galactose diet	ND-1.2.4.4.2	10932
❑ Lactose modified diet	ND-1.2.4.5	10862
❑ Increased lactose diet	ND-1.2.4.5.1	11977
❑ Decreased lactose diet	ND-1.2.4.5.2	10933
❑ Fructose modified diet	ND-1.2.4.6	11978
❑ Increased fructose diet	ND-1.2.4.6.1	11979
❑ Decreased fructose diet	ND-1.2.4.6.2	11980
❑ Fat modified diet (5)	ND-1.2.5	10833
❑ Increased fat diet	ND-1.2.5.1	10937
❑ Decreased fat diet	ND-1.2.5.2	10938
❑ Monounsaturated fat modified diet	ND-1.2.5.3	10869
❑ Increased monounsaturated fat diet	ND-1.2.5.3.1	10939
❑ Decreased monounsaturated fat diet	ND-1.2.5.3.2	10940
❑ Polyunsaturated fat modified diet	ND-1.2.5.4	10870

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	NCPT Code	ANDUID
❑ Increased polyunsaturated fat diet	ND-1.2.5.4.1	10941
❑ Increased linoleic acid diet	ND-1.2.5.4.1.1	11981
❑ Decreased polyunsaturated fat diet	ND-1.2.5.4.2	10942
❑ Decreased linoleic acid diet	ND-1.2.5.4.2.1	11982
❑ Saturated fat modified diet	ND-1.2.5.5	10871
❑ Decreased saturated fat diet	ND-1.2.5.5.1	10943
❑ Trans fat modified diet	ND-1.2.5.6	10872
❑ Decreased trans fat modified diet	ND-1.2.5.6.1	10944
❑ Omega 3 fatty acid modified diet	ND-1.2.5.7	11983
❑ Increased omega 3 fatty acid diet	ND-1.2.5.7.1	11984
❑ Increased alpha linolenic acid diet	ND-1.2.5.7.1.1	11985
❑ Increased eicosapentaenoic acid diet	ND-1.2.5.7.1.2	11986
❑ Increased docosahexaenoic acid	ND-1.2.5.7.1.3	11987
❑ Decreased omega 3 fatty acid diet	ND-1.2.5.7.2	11988
❑ Decreased alpha linolenic acid diet	ND-1.2.5.7.2.1	11989
❑ Decreased eicosapentaenoic acid diet	ND-1.2.5.7.2.2	11990
❑ Decreased docosahexaenoic acid diet	ND-1.2.5.7.2.3	11991
❑ Medium chain triglyceride modified diet	ND-1.2.5.8	11992
❑ Increased medium chain triglyceride diet	ND-1.2.5.8.1	11993
❑ Decreased medium chain triglyceride diet	ND-1.2.5.8.2	11994
❑ Cholesterol modified diet (6)	ND-1.2.6	10863
❑ Decreased cholesterol diet	ND-1.2.6.1	10934
❑ Fiber modified diet (7)	ND-1.2.7	10834
❑ Increased fiber diet	ND-1.2.7.1	10945
❑ Decreased fiber diet	ND-1.2.7.2	10946
❑ Soluble fiber modified diet	ND-1.2.7.3	10947
❑ Increased soluble fiber diet	ND-1.2.7.3.1	10948
❑ Decreased soluble fiber diet	ND-1.2.7.3.2	10949
❑ Insoluble fiber modified diet	ND-1.2.7.4	10950
❑ Increased insoluble fiber diet	ND-1.2.7.4.1	10951
❑ Decreased insoluble fiber diet	ND-1.2.7.4.2	10952
❑ Fluid modified diet (8)	ND-1.2.8	10835
❑ Increased fluid diet	ND-1.2.8.1	10874
❑ Fluid restricted diet	ND-1.2.8.2	10873
❑ Clear liquid diet	ND-1.2.8.3	10876
❑ Full liquid diet	ND-1.2.8.4	10877
❑ Diets modified for specific foods or ingredients (9)	ND-1.2.9	10836
❑ Vitamin modified diet (10)	ND-1.2.10	10837
❑ Vitamin A modified diet	ND-1.2.10.1	10923
❑ Increased vitamin A diet	ND-1.2.10.1.1	11013
❑ Decreased vitamin A diet	ND-1.2.10.1.2	11014
❑ Vitamin C modified diet	ND-1.2.10.2	10926
❑ Increased vitamin C diet	ND-1.2.10.2.1	11019
❑ Decreased vitamin C diet	ND-1.2.10.2.2	11020
❑ Vitamin D modified diet	ND-1.2.10.3	10927
❑ Increased vitamin D diet	ND-1.2.10.3.1	11021
❑ Decreased vitamin D diet	ND-1.2.10.3.2	11022
❑ Vitamin E modified diet	ND-1.2.10.4	10928
❑ Increased vitamin E diet	ND-1.2.10.4.1	11023
❑ Decreased vitamin E diet	ND-1.2.10.4.2	11024
❑ Vitamin K modified diet	ND-1.2.10.5	10929
❑ Increased vitamin K diet	ND-1.2.10.5.1	11025
❑ Decreased vitamin K diet	ND-1.2.10.5.2	11026
❑ Thiamine modified diet	ND-1.2.10.6	10922
❑ Increased thiamine diet	ND-1.2.10.6.1	11011
❑ Decreased thiamine diet	ND-1.2.10.6.2	11012
❑ Riboflavin modified diet	ND-1.2.10.7	10921
❑ Increased riboflavin diet	ND-1.2.10.7.1	11009
❑ Decreased riboflavin diet	ND-1.2.10.7.2	11010
❑ Niacin modified diet	ND-1.2.10.8	10919
❑ Increased niacin diet	ND-1.2.10.8.1	11005
❑ Decreased niacin diet	ND-1.2.10.8.2	11006
❑ Folic acid modified diet	ND-1.2.10.9	10918
❑ Increased folic acid diet	ND-1.2.10.9.1	11003
❑ Decreased folic acid diet	ND-1.2.10.9.2	11004
❑ Vitamin B6 modified diet	ND-1.2.10.10	10924
❑ Increased vitamin B6 diet	ND-1.2.10.10.1	11015
❑ Decreased vitamin B6 diet	ND-1.2.10.10.2	11016
❑ Vitamin B12 modified diet	ND-1.2.10.11	10925
❑ Increased vitamin B12 diet	ND-1.2.10.11.1	11017
❑ Decreased vitamin B12 diet	ND-1.2.10.11.2	11018
❑ Pantothenic acid modified diet	ND-1.2.10.12	10920
❑ Increased pantothenic acid diet	ND-1.2.10.12.1	11007
❑ Decreased pantothenic acid diet	ND-1.2.10.12.2	11008
❑ Biotin modified diet	ND-1.2.10.13	10917
❑ Increased biotin diet	ND-1.2.10.13.1	11001
❑ Decreased biotin diet	ND-1.2.10.13.2	11002
❑ Mineral modified diet (11)	ND-1.2.11	10838
❑ Calcium modified diet	ND-1.2.11.1	10879
❑ Increased calcium diet	ND-1.2.11.1.1	10953
❑ Decreased calcium diet	ND-1.2.11.1.2	10954
❑ Chloride modified diet	ND-1.2.11.2	10880
❑ Iron modified diet	ND-1.2.11.3	10886
❑ Increased iron diet	ND-1.2.11.3.1	10960
❑ Decreased iron diet	ND-1.2.11.3.2	10961
❑ Magnesium modified diet	ND-1.2.11.4	10887
❑ Increased magnesium diet	ND-1.2.11.4.1	10962
❑ Decreased magnesium diet	ND-1.2.11.4.2	10963
❑ Potassium modified diet	ND-1.2.11.5	10891
❑ Increased potassium diet	ND-1.2.11.5.1	10966
❑ Decreased potassium diet	ND-1.2.11.5.2	10967
❑ Phosphorus modified diet	ND-1.2.11.6	10890
❑ Increased phosphorus diet	ND-1.2.11.6.1	10964
❑ Decreased phosphorus diet	ND-1.2.11.6.2	10965
❑ Sodium modified diet	ND-1.2.11.7	10893
❑ Increased sodium diet	ND-1.2.11.7.1	10968
❑ Decreased sodium diet	ND-1.2.11.7.2	10969
❑ Zinc modified diet	ND-1.2.11.8	10895
❑ Increased zinc diet	ND-1.2.11.8.1	10970
❑ Decreased zinc diet	ND-1.2.11.8.2	10971

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	NCPT Code	ANDUID
❑ Sulfur modified diet	ND-1.2.11.9	10894
❑ Fluoride modified diet	ND-1.2.11.10	10884
❑ Copper modified diet	ND-1.2.11.11	10883
❑ Increased copper diet	ND-1.2.11.11.1	10956
❑ Decreased copper diet	ND-1.2.11.11.2	10957
❑ Iodine modified diet	ND-1.2.11.12	10885
❑ Increased iodine diet	ND-1.2.11.12.1	10958
❑ Decreased iodine diet	ND-1.2.11.12.2	10959
❑ Selenium modified diet	ND-1.2.11.13	10892
❑ Manganese modified diet	ND-1.2.11.14	10888
❑ Chromium modified diet	ND-1.2.11.15	10881
❑ Increased chromium diet	ND-1.2.11.15.1	10955
❑ Molybdenum modified diet	ND-1.2.11.16	10889
❑ Boron modified diet	ND-1.2.11.17	10878
❑ Cobalt modified diet	ND-1.2.11.18	10882
❑ Modify schedule of food/fluids	ND-1.3	10815
❑ Modify schedule of intake to limit fasting	ND-1.3.1	11995
❑ Specific foods/beverages or groups	ND-1.4	10492
❑ Fruit modified diet	ND-1.4.1	11996
❑ Vegetable modified diet	ND-1.4.2	11997
❑ Starchy vegetable modified diet	ND-1.4.2.1	11998
❑ Bean and pea modified diet	ND-1.4.2.2	11999
❑ Grain modified diet	ND-1.4.3	12000
❑ Diet modified for uncooked food starch	ND-1.4.3.1	12001
❑ Protein food modified diet	ND-1.4.4	12002
❑ Diet with foods modified to be low in protein	ND-1.4.4.1	12003
❑ Diet modified for egg	ND-1.4.4.2	12004
❑ Raw egg free diet	ND-1.4.4.2.1	12005
❑ Other	ND-1.5	10493

(specify) _____

Enteral and Parenteral Nutrition (2)

Nutrition provided through the GI tract via tube, catheter, or stoma (enteral) or intravenously, centrally or peripherally (parenteral)

Enteral Nutrition (2.1)

Nutrition provided through the GI tract

❑ Modify composition of enteral nutrition	ND-2.1.1	10503
❑ Modify concentration of enteral nutrition	ND-2.1.2	10502
❑ Modify rate of enteral nutrition	ND-2.1.3	10500
❑ Modify volume of enteral nutrition	ND-2.1.4	10501
❑ Modify schedule of enteral nutrition	ND-2.1.5	10504
❑ Modify route of enteral nutrition	ND-2.1.6	10792
❑ Insert enteral feeding tube	ND-2.1.7	10497
❑ Enteral nutrition site care	ND-2.1.8	10498
❑ Feeding tube flush	ND-2.1.9	10499

Parenteral Nutrition/IV Fluids (2.2)

Nutrition and fluids provided intravenously

❑ Modify composition of parenteral nutrition	ND-2.2.1	10511
❑ Modify concentration of parenteral nutrition	ND-2.2.2	10510
❑ Modify rate of parenteral nutrition	ND-2.2.3	10509
❑ Modify volume of parenteral nutrition	ND-2.2.4	11141
❑ Modify schedule of parenteral nutrition	ND-2.2.5	10512
❑ Modify route of parenteral nutrition	ND-2.2.6	10793
❑ Parenteral nutrition site care	ND-2.2.7	10507
❑ IV fluid delivery	ND-2.2.8	10508

Nutrition Supplement Therapy (3)

Foods or nutrients that are not intended as a sole (only) item or a meal or diet, but that are intended to provide additional nutrients

Medical Food Supplement Therapy (3.1)

Commercial or prepared foods or beverages intended to supplement energy, protein, carbohydrate, fiber, and/or fat intake

❑ Commercial beverage medical food supplement therapy	ND-3.1.1	10515
❑ Commercial food medical food supplement therapy	ND-3.1.2	10516
❑ Modified beverage medical food supplement therapy	ND-3.1.3	10517
❑ Modified food medical food supplement therapy	ND-3.1.4	10518
❑ Purpose of medical food supplement therapy	ND-3.1.5	10519

Vitamin and Mineral Supplement Therapy (3.2)

Supplemental vitamins or minerals

❑ Multivitamin mineral supplement therapy	ND-3.2.1	10521
❑ Multitrace element supplement therapy	ND-3.2.2	10522
❑ Vitamin supplement therapy	ND-3.2.3	10523
❑ A (1)		10524
❑ C (2)		10525
❑ D (3)		10526
❑ E (4)		10527
❑ K (5)		10528
❑ Thiamin (6)		10529
❑ Riboflavin (7)		10530
❑ Niacin (8)		10531
❑ Folate (9)		10532
❑ B6 (10)		10533
❑ B12 (11)		10534
❑ Pantothenic acid (12)		10535
❑ Biotin (13)		10536
❑ Mineral supplement therapy	ND-3.2.4	10538
❑ Calcium (1)		10539
❑ Chloride (2)		10540
❑ Iron (3)		10541
❑ Magnesium (4)		10542
❑ Potassium (5)		10543
❑ Phosphorus (6)		10544
❑ Sodium (7)		10545
❑ Zinc (8)		10546
❑ Sulfate (9)		10547
❑ Fluoride (10)		10548
❑ Copper (11)		10549
❑ Iodine (12)		10550
❑ Selenium (13)		10551
❑ Manganese (14)		10552
❑ Chromium (15)		10553
❑ Molybdenum (16)		10554
❑ Boron (17)		10555
❑ Cobalt (18)		10556

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	NCPT Code	ANDUID
Bioactive Substance Management (3.3)		
Addition or change in provision of bioactive substances		
❑ Plant stanol esters management	ND-3.3.1	10559
❑ Plant sterol esters management	ND-3.3.2	10816
❑ Soy protein management	ND-3.3.3	10561
❑ Psyllium management	ND-3.3.4	10817
❑ Beta glucan management	ND-3.3.5	10563
❑ Food additives management	ND-3.3.6	10564
❑ Alcohol management	ND-3.3.7	10565
❑ Caffeine management	ND-3.3.8	10566
Feeding Assistance Management (4)		
Accommodation or assistance in eating		
❑ Adaptive eating device management	ND-4.1	10808
❑ Feeding position management	ND-4.2	10570
❑ Meal set up management	ND-4.3	10571
❑ Mouth care management	ND-4.4	10572
❑ Menu selection assistance	ND-4.5	10809
Manage Feeding Environment (5)		
Adjustment of the factors where food is served that impact food consumption		
❑ Feeding environment lighting management	ND-5.1	10575
❑ Feeding environment odor management	ND-5.2	10576
❑ Feeding environment distraction management	ND-5.3	10577
❑ Feeding environment table height management	ND-5.4	10578
❑ Feeding environment table service management	ND-5.5	10849
❑ Feeding environment room temperature management	ND-5.6	10580
❑ Feeding environment meal service management	ND-5.7	10810
❑ Feeding environment meal location management	ND-5.8	10811
Nutrition Related Medication Management (6)		
Modification of a medication or complementary/alternative medicine to optimize client nutritional or health status		
❑ Management of nutrition related prescription medication	ND-6.1	10839
❑ Management of nutrition related over the counter (OTC) medication	ND-6.2	10584
❑ Management of nutrition related complementary and alternative medicine	ND-6.3	10799
Infant Feeding Management (7)		
Actions to manage breastfeeding and/or infant formula feeding		
❑ Breastmilk feeding modification	ND-7.1	14143
❑ Modify concentration of breastmilk	ND-7.1.1	14144
❑ Modify human milk fortifier additive in breastmilk	ND-7.1.1.1	14145
❑ Modify carbohydrate additive in breastmilk	ND-7.1.1.2	14146
❑ Modify fat additive in breastmilk	ND-7.1.1.3	14147
❑ Modify protein additive in breastmilk	ND-7.1.1.4	14148
❑ Modify fiber additive in breastmilk	ND-7.1.1.5	14149
❑ Modify added infant formula in breastmilk	ND-7.1.1.6	14150
❑ Modify breastfeeding attempts	ND-7.1.2	14151
❑ Modify volume of breastmilk	ND-7.1.3	14152
❑ Evaluation of breastfeeding plan	ND-7.1.4	14153
❑ Evaluation of breastfeeding	ND-7.1.5	14154
❑ Evaluation of breastfeeding behavior	ND-7.1.6	14155
❑ Promotion of exclusive breastfeeding	ND-7.1.7	14156
❑ Promotion of predominant breastfeeding	ND-7.1.8	14157
❑ Promotion of partial breastfeeding	ND-7.1.9	14158
❑ Infant formula modification	ND-7.2	14159
❑ Modify composition of infant formula	ND-7.2.1	14160
❑ Modify concentration of infant formula	ND-7.2.2	14161
❑ Modify human milk fortifier additive in infant formula	ND-7.2.2.1	14162
❑ Modify carbohydrate additive in infant formula	ND-7.2.2.2	14163
❑ Modify fat additive in infant formula	ND-7.2.2.3	14164
❑ Modify protein additive in infant formula	ND-7.2.2.4	14165
❑ Modify fiber additive in infant formula	ND-7.2.2.5	14166
❑ Modify infant formula feeding attempts	ND-7.2.3	14167
❑ Modify volume of infant formula	ND-7.2.4	14168
❑ Evaluation of infant formula feeding plan	ND-7.2.5	14169
❑ Evaluation of infant formula feeding	ND-7.2.6	14170
❑ Evaluation of infant formula feeding behavior	ND-7.2.7	14171

NUTRITION EDUCATION (E)

Formal process to instruct or train clients in a skill or to impart knowledge to help clients voluntarily manage or modify food, nutrition and physical activity choices and behavior to maintain or improve health

Nutrition Education Content (1)		
Instruction or training intended to lead to nutrition related knowledge		
❑ Content related nutrition education	E-1.1	13223
❑ Education on nutrition's influence on health	E-1.2	10591
❑ Physical activity guidance	E-1.3	12012
Nutrition Education Application (2)		
Instruction or training leading to nutrition related result interpretation or skills		
❑ Nutrition related laboratory result interpretation education	E-2.1	10596
❑ Nutrition related skill education	E-2.2	10597
❑ Technical nutrition education	E-2.3	13222

NUTRITION COUNSELING (C)

A supportive process characterized by a collaborative counselor–client relationship to establish food, nutrition, and physical activity priorities, goals, and individualized action plans that acknowledge and foster responsibility for self-care to treat an existing condition and promote health

Theoretical Basis/Approach (1)		
The theories or models used to design and implement an intervention		
❑ Nutrition counseling based on cognitive behavioral theory approach	C-1.1	10601
❑ Nutrition counseling based on health belief model	C-1.2	10602
❑ Nutrition counseling based on social learning theory approach	C-1.3	10603
❑ Nutrition counseling based on transtheoretical model stages of change approach	C-1.4	10604
❑ Other	C-1.5	10605
Strategies (2)		
Selectively applied evidence-based methods or plans of action designed to achieve a particular goal		

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	NCPT Code	ANDUID
❑ Nutrition counseling based on motivational interviewing strategy	C-2.1	10607
❑ Nutrition counseling based on goal setting strategy	C-2.2	10608
❑ Nutrition counseling based on self monitoring strategy	C-2.3	10609
❑ Nutrition counseling based on problem solving strategy	C-2.4	10610
❑ Nutrition counseling based on social support strategy	C-2.5	10611
❑ Nutrition counseling based on stress management strategy	C-2.6	10612
❑ Nutrition counseling based on stimulus control strategy	C-2.7	10613
❑ Nutrition counseling based on cognitive restructuring strategy	C-2.8	10614
❑ Nutrition counseling based on relapse prevention strategy	C-2.9	10615
❑ Nutrition counseling based on rewards and contingency management strategy	C-2.10	10616
❑ Other	C-2.11	10617

COORDINATION OF NUTRITION CARE BY A NUTRITION PROFESSIONAL (RC)

Consultation with, referral to, or coordination of nutrition care with other providers, institutions, or agencies that can assist in treating or managing nutrition-related problems

Collaboration and Referral of Nutrition Care (1)

Facilitating services with other professionals, institutions, or agencies during nutrition care

❑ Team meeting involving nutrition professional	RC-1.1	10620
❑ Referral by nutrition professional to another nutrition professional with different expertise	RC-1.2	10621
❑ Collaboration by nutrition professional with other nutrition professionals	RC-1.3	10622
❑ Collaboration by nutrition professional with other providers	RC-1.4	10812
❑ Referral by nutrition professional to other providers	RC-1.5	10624
❑ Referral by nutrition professional to community agencies and programs	RC-1.6	10625

Discharge and Transfer of Nutrition Care to New Setting or Provider (2)

Discharge planning and transfer of nutrition care from one level or location of care to another.

❑ Discharge and transfer of nutrition care to other providers	RC-2.1	10813
❑ Discharge and transfer of nutrition care to community agencies and programs	RC-2.2	10814
❑ Discharge and transfer of nutrition care from nutrition professional to another nutrition professional	RC-2.3	10627

POPULATION BASED NUTRITION ACTION (P)

Interventions designed to improve the nutritional well-being of a population

Population Theoretical Frameworks (1)

Theories, models, and approaches used to design, implement, and evaluate nutrition interventions at the population level

	NCPT Code	ANDUID
❑ Social ecological model	P-1.1	12154
❑ Community organizing	P-1.2	12155
❑ Diffusion of innovations	P-1.3	12156
❑ Social marketing	P-1.4	12157
❑ Organizational change theory	P-1.5	12158
❑ Mass communications	P-1.6	12159
❑ Political action	P-1.7	12160

Population Strategies (2)

Plans of action that target environmental change, organizational change, and public policy change

❑ Environmental change	P-2.1	12162
❑ Food environment change	P-2.1.1	12163
❑ Built environment change	P-2.1.2	12164
❑ Social norm change	P-2.1.3	12165
❑ Organizational change	P-2.2	12166
❑ Public policy change	P-2.3	12167

Population Settings (3)

Locations where the population based nutrition intervention is implemented

❑ Residential settings	P-3.1	12169
❑ School settings	P-3.2	12170
❑ Worksite settings	P-3.3	12171
❑ Recreation and sports settings	P-3.4	12172
❑ Food production and provision settings	P-3.5	12173
❑ Service settings	P-3.6	12174
❑ Government settings	P-3.7	12175
❑ Community at large settings	P-3.8	12176

Population Sectors (4)

Public, private, and nonprofit entities integral to the development and implementation of interventions that impact determinants of the nutritional well-being of the population

❑ Agriculture sector	P-4.1	12178
❑ Education sector	P-4.2	12179
❑ Government sector	P-4.3	12180
❑ Healthcare sector	P-4.4	12181
❑ Food and beverage sector	P-4.5	12182
❑ Business and industry sector	P-4.6	12183
❑ Social welfare sector	P-4.7	12184
❑ Nonprofit sector	P-4.8	12185
❑ Communities, neighborhoods, families sector	P-4.9	12186

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Nutrition Assessment and Monitoring and Evaluation Terminology

This is a combined list of Nutrition Assessment and Monitoring and Evaluation terms. All terms can be used for Nutrition Assessment. Client History terms are used for Nutrition Assessment, but not for Nutrition and Monitoring and Evaluation. Each term is designated with an alpha numeric NCPT hierarchical code, followed by a five-digit (eg, 99999) Academy SNOMED CT/LOINC unique identifier (ANDUID). Neither should be used in nutrition documentation. The ANDUID is for data-tracking purposes in electronic health records.

	NCPT Code	ANDUID
FOOD/NUTRITION-RELATED HISTORY (FH)		
Food and nutrient intake, food and nutrient administration, medication and complementary/alternative medicine use, knowledge/beliefs/attitudes, behavior, food and supply availability, physical activity and function, nutrition-related client-centered measures.		
Food and Nutrient Intake (1)		
Composition and adequacy of food and nutrient intake, meal and snack patterns, current and previous diets and/or food modifications, and eating environment.		
Energy Intake (1.1)		
Total energy intake from all sources including, food, beverages, breastmilk/formula, supplements, and via enteral and parenteral routes.		
Estimated energy intake (1.1.1)		
❑ Total energy estimated intake in 24 hours	FH-1.1.1.1	11383
❑ Total energy estimated intake per kg in 24 hours	FH-1.1.1.2	14001
❑ Total energy estimated intake from oral nutrition in 24 hours	FH-1.1.1.3	14002
❑ Total energy estimated intake from enteral nutrition in 24 hours	FH-1.1.1.4	14003
❑ Total energy estimated intake from parenteral nutrition in 24 hours	FH-1.1.1.5	14004
❑ Total energy estimated intake from intravenous fluids in 24 hours	FH-1.1.1.6	14005
Measured energy intake (1.1.2)		
❑ Total energy measured intake in 24 hours	FH-1.1.2.1	10005
❑ Total energy measured intake per kg in 24 hours	FH-1.1.2.2	14006
❑ Total energy measured intake from oral nutrition in 24 hours	FH-1.1.2.3	14007
❑ Total energy measured intake from enteral nutrition in 24 hours	FH-1.1.2.4	14008
❑ Total energy measured intake from parenteral nutrition in 24 hours	FH-1.1.2.5	14009
❑ Total energy measured intake from intravenous fluids in 24 hours	FH-1.1.2.6	14010
Food and Beverage Intake (1.2)		
Type, amount, and pattern of intake of foods and food groups, indices of diet quality, intake of fluids, breastmilk and infant formula		
Fluid intake (1.2.1)		
❑ Estimated fluid intake	FH-1.2.1.1	14011
❑ Total fluid estimated intake in 24 hours	FH-1.2.1.1.1	14012
❑ Fluid estimated intake from oral nutrition in 24 hours	FH-1.2.1.1.1.1	11386
❑ Water estimated oral intake in 24 hours	FH-1.2.1.1.1.2	14013
❑ Sugar sweetened beverage estimated oral intake in 24 hours	FH-1.2.1.1.1.3	14014
❑ Beverage with high intensity sweetener estimated oral intake in 24 hours	FH-1.2.1.1.1.4	14015
❑ 100 percent fruit juice estimated oral intake in 24 hours	FH-1.2.1.1.1.5	14016
❑ Liquid dairy product estimated oral intake in 24 hours	FH-1.2.1.1.1.6	14017
❑ Caffeinated beverage estimated oral intake in 24 hours	FH-1.2.1.1.1.7	14018
❑ Nutritionally complete liquid supplement estimated oral intake in 24 hours	FH-1.2.1.1.1.8	14019
❑ Liquid meal replacement estimated oral intake in 24 hours	FH-1.2.1.1.1.9	14020
❑ Total fluid estimated intake per kg in 24 hours	FH-1.2.1.1.2	14021
❑ Total fluid estimated intake from food	FH-1.2.1.1.3	10009
❑ Total free water estimated intake in 24 hours	FH-1.2.1.1.4	14022
❑ Total free water estimated intake from breastmilk in 24 hours	FH-1.2.1.1.4.1	14023
❑ Total free water estimated intake from infant formula in 24 hours	FH-1.2.1.1.4.2	14024
❑ Total free water estimated intake from enteral nutrition in 24 hours	FH-1.2.1.1.4.3	14025
❑ Total free water estimated intake from parenteral nutrition in 24 hours	FH-1.2.1.1.4.4	14026
❑ Total free water estimated intake from intravenous fluids in 24 hours	FH-1.2.1.1.4.5	14027
❑ Measured fluid intake	FH-1.2.1.2	14028
❑ Total fluid measured intake in 24 hours	FH-1.2.1.2.1	14029
❑ Fluid measured intake from oral nutrition in 24 hours	FH-1.2.1.2.1.1	10008
❑ Water measured oral intake in 24 hours	FH-1.2.1.2.1.2	14030
❑ Sugar sweetened beverage measured oral intake in 24 hours	FH-1.2.1.2.1.3	14031
❑ Beverage with high intensity sweetener measured oral intake in 24 hours	FH-1.2.1.2.1.4	14032
❑ 100 percent fruit juice measured oral intake in 24 hours	FH-1.2.1.2.1.5	14033
❑ Liquid dairy product measured oral intake in 24 hours	FH-1.2.1.2.1.6	14034
❑ Caffeinated beverage measured oral intake in 24 hours	FH-1.2.1.2.1.7	14035
❑ Nutritionally complete liquid supplement measured oral intake in 24 hours	FH-1.2.1.2.1.8	14036
❑ Liquid meal replacement measured oral intake in 24 hours	FH-1.2.1.2.1.9	14037
❑ Total fluid measured intake from food	FH-1.2.1.2.2	14038
❑ Total fluid measured intake per kg in 24 hours	FH-1.2.1.2.3	14039
❑ Total free water measured intake in 24 hours	FH-1.2.1.2.4	14040
❑ Total free water measured intake from breastmilk in 24 hours	FH-1.2.1.2.4.1	14041
❑ Total free water measured intake from infant formula in 24 hours	FH-1.2.1.2.4.2	14042
❑ Total free water measured intake from enteral nutrition in 24 hours	FH-1.2.1.2.4.3	14043
❑ Total free water measured intake from parenteral nutrition in 24 hours	FH-1.2.1.2.4.4	14044
❑ Total free water measured intake from intravenous fluids in 24 hours	FH-1.2.1.2.4.5	14045

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	NCPT Code	ANDUID
Food intake (1.2.2)		
❑ Amount of food	FH-1.2.2.1	10012
❑ Estimated amount of food	FH-1.2.2.1.1	13125
❑ Grain servings estimated in 24 hours	FH-1.2.2.1.1.1	11387
❑ Fruit servings estimated in 24 hours	FH-1.2.2.1.1.2	11389
❑ Vegetable servings estimated in 24 hours	FH-1.2.2.1.1.3	11391
❑ Milk product servings estimated in 24 hours	FH-1.2.2.1.1.4	11393
❑ Protein food servings estimated in 24 hours	FH-1.2.2.1.1.5	11395
❑ Fat servings estimated in 24 hours	FH-1.2.2.1.1.6	11397
❑ Empty energy servings estimated in 24 hours	FH-1.2.2.1.1.7	11399
❑ Estimated percent of meals eaten in 24 hours	FH-1.2.2.1.1.8	14046
❑ Measured amount of food	FH-1.2.2.1.2	13126
❑ Grain servings measured in 24 hours	FH-1.2.2.1.2.1	11388
❑ Fruit servings measured in 24 hours	FH-1.2.2.1.2.2	11390
❑ Vegetable servings measured in 24 hours	FH-1.2.2.1.2.3	11392
❑ Milk product servings measured in 24 hours	FH-1.2.2.1.2.4	11394
❑ Protein food servings measured in 24 hours	FH-1.2.2.1.2.5	11396
❑ Fat servings measured in 24 hours	FH-1.2.2.1.2.6	11398
❑ Empty energy servings measured in 24 hours	FH-1.2.2.1.2.7	11400
❑ Measured percent of meals eaten in 24 hours	FH-1.2.2.1.2.8	14047
❑ Types of food	FH-1.2.2.2	10013
❑ Fortified food intake	FH-1.2.2.2.1	14048
❑ Enriched food intake	FH-1.2.2.2.2	14049
❑ Special dietary food intake	FH-1.2.2.2.3	14050
❑ Medical food intake	FH-1.2.2.2.4	14051
❑ Processed food intake	FH-1.2.2.2.5	14052
❑ Quick service food intake	FH-1.2.2.2.6	14053
❑ Self prepared food intake	FH-1.2.2.2.7	14054
❑ Prepared food intake	FH-1.2.2.2.8	14210
❑ Meal/snack pattern	FH-1.2.2.3	10014
❑ Estimated meal and snack pattern	FH-1.2.2.3.1	13127
❑ Number of meals estimated in 24 hours	FH-1.2.2.3.1.1	11404
❑ Number of snacks estimated in 24 hours	FH-1.2.2.3.1.2	11402
❑ Measured meal and snack pattern	FH-1.2.2.3.2	13128
❑ Number of meals measured in 24 hours	FH-1.2.2.3.2.1	11405
❑ Number of snacks measured in 24 hours	FH-1.2.2.3.2.2	11403
❑ Diet quality index	FH-1.2.2.4	10015
❑ Healthy eating index (HEI) 2015 score	FH-1.2.2.4.1	14055
❑ Food variety	FH-1.2.2.5	10016
Breastmilk/infant formula intake (1.2.3)		
❑ Breastmilk intake	FH-1.2.3.1	10018
❑ Breastmilk feeding attempts in 24 hours	FH-1.2.3.1.1	11406
❑ Adequacy of breastmilk intake	FH-1.2.3.1.2	11409
❑ Donor breastmilk intake	FH-1.2.3.1.3	14056
❑ Mother's expressed breastmilk intake	FH-1.2.3.1.4	14057
❑ Estimated breastmilk intake	FH-1.2.3.1.5	14058
❑ Breastmilk intake estimated volume in 24 hours	FH-1.2.3.1.5.1	11407
❑ Breastmilk intake estimated volume per kg in 24 hours	FH-1.2.3.1.5.2	14059
❑ Measured breastmilk intake	FH-1.2.3.1.6	14060
❑ Breastmilk intake measured volume in 24 hours	FH-1.2.3.1.6.1	11408
❑ Breastmilk intake measured volume per kg in 24 hours	FH-1.2.3.1.6.2	14061
❑ Infant formula intake	FH-1.2.3.2	10019
❑ Infant formula feedings in 24 hours	FH-1.2.3.2.1	11412
❑ Adequacy of infant formula intake	FH-1.2.3.2.2	11413
❑ Infant formula intake composition	FH-1.2.3.2.3	14211
❑ Infant formula intake concentration	FH-1.2.3.2.4	14062
❑ Estimated infant formula intake	FH-1.2.3.2.5	14063
❑ Infant formula intake estimated volume in 24 hours	FH-1.2.3.2.5.1	11410
❑ Infant formula intake estimated volume per kg in 24 hours	FH-1.2.3.2.5.2	14064
❑ Measured infant formula intake	FH-1.2.3.2.6	14065
❑ Infant formula intake measured volume in 24 hours	FH-1.2.3.2.6.1	11411
❑ Infant formula intake measured volume per kg in 24 hours	FH-1.2.3.2.6.2	14066
Enteral and Parenteral Nutrition Intake (1.3)		
Specialized nutrition support intake from all sources, eg, enteral and parenteral routes.		
Enteral nutrition intake (1.3.1)		
❑ Enteral nutrition formula/solution	FH-1.3.1.1	10022
❑ Enteral nutrition formula composition	FH-1.3.1.1.1	11414
❑ Enteral nutrition formula concentration	FH-1.3.1.1.2	11415
❑ Enteral nutrition formula estimated volume in 24 hours	FH-1.3.1.1.3	11416
❑ Enteral nutrition formula measured volume in 24 hours	FH-1.3.1.1.4	13227
❑ Enteral tube feeding flush estimated volume in 24 hours	FH-1.3.1.2	10023
❑ Enteral tube feeding flush measured volume in 24 hours	FH-1.3.1.3	13228
Parenteral nutrition intake (1.3.2)		
❑ Parenteral nutrition formula/solution	FH-1.3.2.1	10025
❑ IV fluids	FH-1.3.2.2	10026
Bioactive Substance Intake (1.4)		
Alcohol, plant stanol and sterol esters, soy protein, psyllium and beta glucan, and caffeine intake from all sources, eg, food, beverages, supplements, and via enteral and parenteral routes.		
Alcohol intake (1.4.1)		
❑ Alcohol intake in one week	FH-1.4.1.1	14172
❑ Alcohol intake in 24 hours	FH-1.4.1.2	14173
❑ Beer intake in 24 hours	FH-1.4.1.2.1	14174
❑ Distilled alcohol intake in 24 hours	FH-1.4.1.2.2	14175
❑ Wine intake in 24 hours	FH-1.4.1.2.3	14176
❑ Hard cider intake in 24 hours	FH-1.4.1.2.4	14177
❑ Days per week alcoholic drinks consumed	FH-1.4.1.3	14188
❑ Alcohol intake pattern on drinking days	FH-1.4.1.4	10031
Bioactive substance intake (1.4.2)		
❑ Estimated bioactive substance intake	FH-1.4.2.1	13129
❑ Plant stanol ester estimated intake in 24 hours	FH-1.4.2.1.1	11422
❑ Plant sterol ester estimated intake in 24 hours	FH-1.4.2.1.2	11424

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❑ Soy protein estimated intake in 24 hours	FH-1.4.2.1.3	11426
❑ Psyllium estimated intake in 24 hours	FH-1.4.2.1.4	11428
❑ Beta glucan estimated intake in 24 hours	FH-1.4.2.1.5	11430
❑ Measured bioactive substance intake	FH-1.4.2.2	13130
❑ Plant stanol ester measured intake in 24 hours	FH-1.4.2.2.1	11423
❑ Plant sterol ester measured intake in 24 hours	FH-1.4.2.2.2	11425
❑ Soy protein measured intake in 24 hours	FH-1.4.2.2.3	11427
❑ Psyllium measured intake in 24 hours	FH-1.4.2.2.4	11429
❑ Beta glucan measured intake in 24 hours	FH-1.4.2.2.5	11431
❑ Food additive intake (specify)	FH-1.4.2.3	10038
❑ High intensity sweetener additive intake	FH-1.4.2.3.1	14067
❑ Excessive high intensity sweetener additive intake	FH-1.4.2.3.1.1	14068
Caffeine intake (1.4.3)		
❑ Total caffeine estimated intake in 24 hours	FH-1.4.3.1	11432
❑ Total caffeine measured intake in 24 hours	FH-1.4.3.2	10041
Macronutrient Intake (1.5)		
Fat and cholesterol, protein, carbohydrate, and fiber intake from all sources including food, beverages, supplements, and via enteral and parenteral routes.		
Fat intake (1.5.1)		
❑ Estimated fat intake	FH-1.5.1.1	13131
❑ Total fat estimated intake in 24 hours	FH-1.5.1.1.1	11433
❑ Saturated fat estimated intake in 24 hours	FH-1.5.1.1.2	11435
❑ Trans fatty acid estimated intake in 24 hours	FH-1.5.1.1.3	11437
❑ Polyunsaturated fat estimated intake in 24 hours	FH-1.5.1.1.4	11439
❑ Linoleic acid estimated intake in 24 hours	FH-1.5.1.1.4.1	11602
❑ Monounsaturated fat estimated intake in 24 hours	FH-1.5.1.1.5	11441
❑ Omega 3 fatty acid estimated intake in 24 hours	FH-1.5.1.1.6	11443
❑ Alpha linolenic acid estimated intake in 24 hours	FH-1.5.1.1.6.1	11445
❑ Eicosapentaenoic acid estimated intake in 24 hours	FH-1.5.1.1.6.2	11447
❑ Docosahexaenoic acid estimated intake in 24 hours	FH-1.5.1.1.6.3	11449
❑ Essential fatty acid estimated intake in 24 hours	FH-1.5.1.1.7	11451
❑ Medium chain triglyceride estimated intake in 24 hours	FH-1.5.1.1.8	11453
❑ Total fat estimated intake in one meal	FH-1.5.1.1.9	14069
❑ Percent saturated fat estimated intake in 24 hours	FH-1.5.1.1.10	14070
❑ Total fat estimated intake from oral nutrition in 24 hours	FH-1.5.1.1.11	13000
❑ Total fat estimated intake from enteral nutrition in 24 hours	FH-1.5.1.1.12	12014
❑ Total fat estimated intake from parenteral nutrition in 24 hours	FH-1.5.1.1.13	13001
❑ Total fat estimated intake from intravenous fluids in 24 hours	FH-1.5.1.1.14	13002
❑ Fat additive estimated intake in 24 hours	FH-1.5.1.1.15	14071
❑ Percent fat estimated intake in 24 hours	FH-1.5.1.1.16	14216
❑ Measured fat intake	FH-1.5.1.2	13132
❑ Total fat measured intake in 24 hours	FH-1.5.1.2.1	11434
❑ Saturated fat measured intake in 24 hours	FH-1.5.1.2.2	11436
❑ Trans fatty acid measured intake in 24 hours	FH-1.5.1.2.3	11438
❑ Polyunsaturated fat measured intake in 24 hours	FH-1.5.1.2.4	11440
❑ Linoleic acid measured intake in 24 hours	FH-1.5.1.2.4.1	13225
❑ Monounsaturated fat measured intake in 24 hours	FH-1.5.1.2.5	11442
❑ Omega 3 fatty acid measured intake in 24 hours	FH-1.5.1.2.6	11444
❑ Alpha linolenic acid measured intake in 24 hours	FH-1.5.1.2.6.1	11446
❑ Eicosapentaenoic acid measured intake in 24 hours	FH-1.5.1.2.6.2	11448
❑ Docosahexaenoic acid measured intake in 24 hours	FH-1.5.1.2.6.3	11450
❑ Essential fatty acid measured intake in 24 hours	FH-1.5.1.2.7	11452
❑ Medium chain triglyceride measured intake in 24 hours	FH-1.5.1.2.8	11454
❑ Total fat measured intake in one meal	FH-1.5.1.2.9	14072
❑ Percent saturated fat measured intake in 24 hours	FH-1.5.1.2.10	14073
❑ Total fat measured intake from oral nutrition in 24 hours	FH-1.5.1.2.11	14074
❑ Total fat measured intake from enteral nutrition in 24 hours	FH-1.5.1.2.12	14075
❑ Total fat measured intake from parenteral nutrition in 24 hours	FH-1.5.1.2.13	14076
❑ Total fat measured intake from intravenous fluids in 24 hours	FH-1.5.1.2.14	14077
❑ Fat additive measured intake in 24 hours	FH-1.5.1.2.15	14078
❑ Percent fat measured intake in 24 hours	FH-1.5.1.2.16	14217
Cholesterol intake (1.5.2)		
❑ Cholesterol estimated intake in 24 hours	FH-1.5.2.1	11455
❑ Cholesterol measured intake in 24 hours	FH-1.5.2.2	11456
Protein intake (1.5.3)		
❑ Estimated protein intake	FH-1.5.3.1	13133
❑ Total protein estimated intake in 24 hours	FH-1.5.3.1.1	11457
❑ High biological value protein estimated intake in 24 hours	FH-1.5.3.1.2	11459
❑ Casein estimated intake in 24 hours	FH-1.5.3.1.3	11461
❑ Whey estimated intake in 24 hours	FH-1.5.3.1.4	11463
❑ Gluten estimated intake in 24 hours	FH-1.5.3.1.5	11465
❑ Total protein estimated intake per kg in 24 hours	FH-1.5.3.1.6	11467
❑ Natural protein estimated intake in 24 hours	FH-1.5.3.1.7	11610
❑ Total protein estimated intake in one meal	FH-1.5.3.1.8	14079
❑ Percent protein estimated intake in 24 hours	FH-1.5.3.1.9	14080
❑ Total protein estimated intake from oral nutrition in 24 hours	FH-1.5.3.1.10	13003
❑ Total protein estimated intake from enteral nutrition in 24 hours	FH-1.5.3.1.11	13004
❑ Protein additive estimated intake in 24 hours	FH-1.5.3.1.12	14081
❑ Measured protein intake	FH-1.5.3.2	13134
❑ Total protein measured intake in 24 hours	FH-1.5.3.2.1	11458
❑ High biological value protein measured intake in 24 hours	FH-1.5.3.2.2	11460
❑ Casein measured intake in 24 hours	FH-1.5.3.2.3	11462
❑ Whey measured intake in 24 hours	FH-1.5.3.2.4	11464
❑ Gluten measured intake in 24 hours	FH-1.5.3.2.5	11466

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❑ Total protein measured intake per kg in 24 hours	FH-1.5.3.2.6	11468
❑ Natural protein measured intake in 24 hours	FH-1.5.3.2.7	14082
❑ Total protein measured intake in one meal	FH-1.5.3.2.8	14083
❑ Percent protein measured intake in 24 hours	FH-1.5.3.2.9	14212
❑ Total protein measured intake from oral nutrition in 24 hours	FH-1.5.3.2.10	14084
❑ Total protein measured intake from enteral nutrition in 24 hours	FH-1.5.3.2.11	14085
❑ Protein additive measured intake in 24 hours	FH-1.5.3.2.12	14087
Amino acid intake (1.5.4)		
❑ Estimated amino acid intake	FH-1.5.4.1	13135
❑ Total amino acid estimated intake in 24 hours	FH-1.5.4.1.1	10057
❑ Essential amino acid estimated intake in 24 hours	FH-1.5.4.1.2	10058
❑ Histidine estimated intake in 24 hours	FH-1.5.4.1.2.1	11612
❑ Methionine estimated intake in 24 hours	FH-1.5.4.1.2.2	11613
❑ Isoleucine estimated intake in 24 hours	FH-1.5.4.1.2.3	11614
❑ Leucine estimated intake in 24 hours	FH-1.5.4.1.2.4	11615
❑ Lysine estimated intake in 24 hours	FH-1.5.4.1.2.5	11616
❑ Threonine estimated intake in 24 hours	FH-1.5.4.1.2.6	11617
❑ Tryptophan estimated intake in 24 hours	FH-1.5.4.1.2.7	11618
❑ Phenylalanine estimated intake in 24 hours	FH-1.5.4.1.2.8	11619
❑ Valine estimated intake in 24 hours	FH-1.5.4.1.2.9	11620
❑ Nonessential amino acid estimated intake in 24 hours	FH-1.5.4.1.3	11621
❑ Arginine estimated intake in 24 hours	FH-1.5.4.1.3.1	11622
❑ Glutamine estimated intake in 24 hours	FH-1.5.4.1.3.2	11623
❑ Homocysteine estimated intake in 24 hours	FH-1.5.4.1.3.3	11624
❑ Tyramine estimated intake in 24 hours	FH-1.5.4.1.3.4	11625
❑ Tyrosine estimated intake in 24 hours	FH-1.5.4.1.3.5	11626
❑ Measured amino acid intake	FH-1.5.4.2	13226
❑ Total amino acid measured intake in 24 hours	FH-1.5.4.2.1	13137
❑ Essential amino acid measured intake in 24 hours	FH-1.5.4.2.2	13138
❑ Histidine measured intake in 24 hours	FH-1.5.4.2.2.1	13139
❑ Methionine measured intake in 24 hours	FH-1.5.4.2.2.2	13140
❑ Isoleucine measured intake in 24 hours	FH-1.5.4.2.2.3	13141
❑ Leucine measured intake in 24 hours	FH-1.5.4.2.2.4	13142
❑ Lysine measured intake in 24 hours	FH-1.5.4.2.2.5	13143
❑ Threonine measured intake in 24 hours	FH-1.5.4.2.2.6	13144
❑ Tryptophan measured intake in 24 hours	FH-1.5.4.2.2.7	13145
❑ Phenylalanine measured intake in 24 hours	FH-1.5.4.2.2.8	13146
❑ Valine measured intake in 24 hours	FH-1.5.4.2.2.9	13147
❑ Nonessential amino acid measured intake in 24 hours	FH-1.5.4.2.3	13148
❑ Arginine measured intake in 24 hours	FH-1.5.4.2.3.1	13136
❑ Glutamine measured intake in 24 hours	FH-1.5.4.2.3.2	13149
❑ Homocysteine measured intake in 24 hours	FH-1.5.4.2.3.3	13150
❑ Tyramine measured intake in 24 hours	FH-1.5.4.2.3.4	13151
❑ Tyrosine measured intake in 24 hours	FH-1.5.4.2.3.5	13152
❑ Total amino acids from enteral nutrition	FH-1.5.4.2.4	13005
❑ Total amino acids from parenteral nutrition	FH-1.5.4.2.5	13006
❑ Total amino acids from intravenous fluids	FH-1.5.4.2.6	13007

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Carbohydrate intake (1.5.5)		
❑ Estimated carbohydrate intake	FH-1.5.5.1	13153
❑ Total carbohydrate estimated intake in 24 hours	FH-1.5.5.1.1	10060
❑ Complex carbohydrate estimated intake in 24 hours	FH-1.5.5.1.2	11627
❑ Simple carbohydrate estimated intake in 24 hours	FH-1.5.5.1.3	11628
❑ Galactose estimated intake in 24 hours	FH-1.5.5.1.4	11629
❑ Lactose estimated intake in 24 hours	FH-1.5.5.1.5	11630
❑ Fructose estimated intake in 24 hours	FH-1.5.5.1.6	11631
❑ Total carbohydrate estimated intake per kg in 24 hours	FH-1.5.5.1.7	14088
❑ Total carbohydrate estimated intake in one meal	FH-1.5.5.1.8	14089
❑ Percent carbohydrate estimated intake in 24 hours	FH-1.5.5.1.9	14090
❑ Total carbohydrate estimated intake from oral nutrition in 24 hours	FH-1.5.5.1.10	12143
❑ Total carbohydrate estimated intake from enteral nutrition in 24 hours	FH-1.5.5.1.11	12011
❑ Total carbohydrate estimated intake from parenteral nutrition in 24 hours	FH-1.5.5.1.12	11180
❑ Total carbohydrate estimated intake from intravenous fluids in 24 hours	FH-1.5.5.1.13	11240
❑ Carbohydrate additive estimated intake in 24 hours	FH-1.5.5.1.14	14091
❑ Estimated total daily glycemic index value	FH-1.5.5.2	12013
❑ Estimated total daily glycemic load	FH-1.5.5.3	12142
❑ Insulin to carbohydrate ratio	FH-1.5.5.4	10066
❑ Measured carbohydrate intake	FH-1.5.5.5	13154
❑ Total carbohydrate measured intake in 24 hours	FH-1.5.5.5.1	13155
❑ Complex carbohydrate measured intake in 24 hours	FH-1.5.5.5.2	13156
❑ Simple carbohydrate measured intake in 24 hours	FH-1.5.5.5.3	13157
❑ Galactose measured intake in 24 hours	FH-1.5.5.5.4	13158
❑ Lactose measured intake in 24 hours	FH-1.5.5.5.5	13159
❑ Fructose measured intake in 24 hours	FH-1.5.5.5.6	13160
❑ Total carbohydrate measured intake per kg in 24 hours	FH-1.5.5.5.7	14092
❑ Total carbohydrate measured intake in one meal	FH-1.5.5.5.8	14093
❑ Percent carbohydrate measured intake in 24 hours	FH-1.5.5.5.9	14094
❑ Total carbohydrate measured intake from oral nutrition in 24 hours	FH-1.5.5.5.10	14095
❑ Total carbohydrate measured intake from enteral nutrition in 24 hours	FH-1.5.5.5.11	14096
❑ Total carbohydrate measured intake from parenteral nutrition in 24 hours	FH-1.5.5.5.12	14097
❑ Total carbohydrate measured intake from intravenous fluids in 24 hours	FH-1.5.5.5.13	14098
❑ Carbohydrate additive measured intake in 24 hours	FH-1.5.5.5.14	14099
Fiber intake (1.5.6)		
❑ Estimated fiber intake	FH-1.5.6.1	13161
❑ Total fiber estimated intake in 24 hours	FH-1.5.6.1.1	10068
❑ Soluble fiber estimated intake in 24 hours	FH-1.5.6.1.2	10069

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❑ Insoluble fiber estimated intake in 24 hours	FH-1.5.6.1.3	10070
❑ Total fiber estimated intake from oral nutrition in 24 hours	FH-1.5.6.1.4	14213
❑ Total fiber estimated intake from enteral nutrition in 24 hours	FH-1.5.6.1.5	14100
❑ Fiber additive estimated intake in 24 hours	FH-1.5.6.1.6	14214
❑ Measured fiber intake	FH-1.5.6.2	11519
❑ Total fiber measured intake in 24 hours	FH-1.5.6.2.1	13162
❑ Soluble fiber measured intake in 24 hours	FH-1.5.6.2.2	13163
❑ Insoluble fiber measured intake in 24 hours	FH-1.5.6.2.3	13164
❑ Total fiber measured intake from oral nutrition in 24 hours	FH-1.5.6.2.4	14101
❑ Total fiber measured intake from enteral nutrition in 24 hours	FH-1.5.6.2.5	14102
❑ Fiber additive measured intake in 24 hours	FH-1.5.6.1.6	14103
Micronutrient Intake (1.6)		
Vitamin and mineral intake from all sources, including food, beverages, supplements, and via enteral and parenteral routes.		
Vitamin intake (1.6.1)		
❑ Estimated vitamin intake	FH-1.6.1.1	13165
❑ Vitamin A estimated intake in 24 hours (1)		10073
❑ Vitamin C estimated intake in 24 hours (2)		10074
❑ Vitamin D estimated intake in 24 hours (3)		10075
❑ Vitamin E estimated intake in 24 hours (4)		10076
❑ Vitamin K estimated intake in 24 hours (5)		10077
❑ Thiamin estimated intake in 24 hours (6)		10078
❑ Riboflavin estimated intake in 24 hours (7)		10079
❑ Niacin estimated intake in 24 hours (8)		10080
❑ Folate estimated intake in 24 hours (9)		10081
❑ Vitamin B6 estimated intake in 24 hours (10)		10082
❑ Vitamin B12 estimated intake in 24 hours (11)		10083
❑ Pantothenic acid estimated intake in 24 hours (12)		10084
❑ Biotin estimated intake in 24 hours (13)		10085
❑ Multivitamin estimated intake in 24 hours (14)		10086
❑ Measured vitamin intake	FH-1.6.1.2	13167
❑ Vitamin A measured intake in 24 hours (1)		13168
❑ Vitamin C measured intake in 24 hours (2)		13169
❑ Vitamin D measured intake in 24 hours (3)		13170
❑ Vitamin E measured intake in 24 hours (4)		13171
❑ Vitamin K measured intake in 24 hours (5)		13172
❑ Thiamin measured intake in 24 hours (6)		13173
❑ Riboflavin measured intake in 24 hours (7)		13174
❑ Niacin measured intake in 24 hours (8)		13175
❑ Folate measured intake in 24 hours (9)		13176
❑ Vitamin B6 measured intake in 24 hours (10)		13177
❑ Vitamin B12 measured intake in 24 hours (11)		13178
❑ Pantothenic acid measured intake in 24 hours (12)		13179
❑ Biotin measured intake in 24 hours (13)		13180
❑ Multivitamin measured intake in 24 hours (14)		13181
Mineral/element intake (1.6.2)		
❑ Estimated mineral intake	FH-1.6.2.1	13182
❑ Calcium estimated intake in 24 hours (1)		10089
❑ Chloride estimated intake in 24 hours (2)		10090
❑ Iron estimated intake in 24 hours (3)		10091
❑ Magnesium estimated intake in 24 hours (4)		10092
❑ Potassium estimated intake in 24 hours (5)		10093
❑ Phosphorus estimated intake in 24 hours (6)		10094
❑ Sodium estimated intake in 24 hours (7)		10095
❑ Zinc estimated intake in 24 hours (8)		10096
❑ Sulfate estimated intake in 24 hours (9)		10097
❑ Fluoride estimated intake in 24 hours (10)		10098
❑ Copper estimated intake in 24 hours (11)		10099
❑ Iodine estimated intake in 24 hours (12)		10100
❑ Selenium estimated intake in 24 hours (13)		10101
❑ Manganese estimated intake in 24 hours (14)		10102
❑ Chromium estimated intake in 24 hours (15)		10103
❑ Molybdenum estimated intake in 24 hours (16)		10104
❑ Boron estimated intake in 24 hours (17)		10105
❑ Cobalt estimated intake in 24 hours (18)		10106
❑ Multimineral estimated intake in 24 hours (19)		10107
❑ Multitrace element estimated intake in 24 hours (20)		10108
❑ Measured mineral intake	FH-1.6.2.2	13183
❑ Calcium measured intake in 24 hours (1)		13184
❑ Chloride measured intake in 24 hours (2)		13185
❑ Iron measured intake in 24 hours (3)		13186
❑ Magnesium measured intake in 24 hours (4)		13187
❑ Potassium measured intake in 24 hours (5)		13188
❑ Phosphorus measured intake in 24 hours (6)		13189
❑ Sodium measured intake in 24 hours (7)		13190
❑ Zinc measured intake in 24 hours (8)		13191
❑ Sulfate measured intake in 24 hours (9)		13192
❑ Fluoride measured intake in 24 hours (10)		13193
❑ Copper measured intake in 24 hours (11)		13194
❑ Iodine measured intake in 24 hours (12)		13195
❑ Selenium measured intake in 24 hours (13)		13196
❑ Manganese measured intake in 24 hours (14)		13197
❑ Chromium measured intake in 24 hours (15)		13198
❑ Molybdenum measured intake in 24 hours (16)		13199
❑ Boron measured intake in 24 hours (17)		13200
❑ Cobalt measured intake in 24 hours (18)		13201
❑ Multimineral measured intake in 24 hours (19)		13202
❑ Multitrace element measured intake in 24 hours (20)		13203
Food and Nutrition Component Intake (1.7)		
Intake of substances for modifying the composition of oral or enteral nutrition intake.		
Consistency modifier intake (1.7.1)		
❑ Estimated consistency modifier intake	FH-1.7.1.1	14104
❑ Thickener additive estimated intake in 24 hours	FH-1.7.1.1.1	14105
❑ Measured consistency modifier intake	FH-1.7.1.2	14106

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❑ Thickener additive measured intake in 24 hours	FH-1.7.1.2.1	14107
Food and Nutrient Administration (2)		
Current and previous diets and/or food modifications, eating environment, and enteral and parenteral nutrition administration.		
Diet History (2.1)		
Description of food and drink regularly provided or consumed, past diets followed or prescribed and counseling received, and the eating environment.		
Diet order (2.1.1)		
❑ General, healthful diet order	FH-2.1.1.1	10113
❑ Modified diet order	FH-2.1.1.2	10114
❑ Enteral nutrition order	FH-2.1.1.3	10115
❑ Parenteral nutrition order	FH-2.1.1.4	10116
Diet experience (2.1.2)		
❑ Previously prescribed diets	FH-2.1.2.1	10118
❑ Previous diet/nutrition education/counseling	FH-2.1.2.2	10119
❑ Self selected diet/s followed	FH-2.1.2.3	10120
❑ Dieting attempts	FH-2.1.2.4	10121
❑ Food allergies	FH-2.1.2.5	10805
❑ Food intolerance	FH-2.1.2.6	10806
Eating environment (2.1.3)		
❑ Location	FH-2.1.3.1	10123
❑ Atmosphere	FH-2.1.3.2	10124
❑ Caregiver/companion	FH-2.1.3.3	10125
❑ Appropriate breastfeeding accommodations/facility	FH-2.1.3.4	10126
❑ Eats alone	FH-2.1.3.5	10127
Enteral and parenteral nutrition administration (2.1.4)		
❑ Enteral access	FH-2.1.4.1	10129
❑ Parenteral access	FH-2.1.4.2	10130
❑ Body position, EN	FH-2.1.4.3	10804
Fasting (2.1.5)		
❑ Fasting pattern in one calendar day, reported	FH-2.1.5.1	11633
❑ Fasting pattern in one calendar week, reported	FH-2.1.5.2	11634
❑ Fasting pattern in one calendar month, reported	FH-2.1.5.3	11635
❑ Fasting pattern in one calendar year, reported	FH-2.1.5.4	11636
❑ Fasting tolerance, reported	FH-2.1.5.5	11637
Medication and Complementary/Alternative Medicine Use (3)		
Prescription and over the counter medications, including herbal preparations and complementary/alternative medicine products used.		
Medications (3.1)		
❑ Prescription medication use	FH-3.1.1	10820
❑ Insulin sensitivity factor	FH-3.1.1.1	11241
❑ Over the counter (OTC) medication use	FH-3.1.2	10134
❑ Misuse of medication	FH-3.1.3	10135
Complementary/Alternative Medicine (3.2)		
❑ Nutrition related complementary/alternative medicine use	FH-3.2.1	10137
Knowledge/Beliefs/Attitudes (4)		
Understanding of nutrition-related concepts and conviction of the truth and feelings/emotions toward some nutrition-related statement or phenomenon, along with readiness to change nutrition-related behaviors.		
Food and nutrition knowledge(4.1)		
❑ Nutrition knowledge of community	FH-4.1.1	13204
❑ Nutrition knowledge of supportive individuals	FH-4.1.2	13205
❑ Nutrition knowledge of individual client	FH-4.1.3	13206
Food and nutrition skill (4.2)		
❑ Nutrition skill of the community	FH-4.2.1	13207
❑ Nutrition skill of supportive individuals	FH-4.2.2	13208
❑ Nutrition skill of individual client	FH-4.2.3	13209
Beliefs and attitudes (4.3)		
❑ Conflict with personal/family value system	FH-4.3.1	10145
❑ Distorted body image	FH-4.3.2	10146
❑ End of life decisions	FH-4.3.3	10147
❑ Motivation	FH-4.3.4	10148
❑ Preoccupation with food/nutrients	FH-4.3.5	10149
❑ Preoccupation with weight	FH-4.3.6	10150
❑ Readiness to change nutrition-related behaviors	FH-4.3.7	10151
❑ Self efficacy	FH-4.3.8	10152
❑ Self talk/cognitions	FH-4.3.9	10153
❑ Unrealistic nutrition related goals	FH-4.3.10	10154
❑ Unscientific beliefs/attitudes	FH-4.3.11	10155
❑ Food preferences	FH-4.3.12	10156
❑ Emotions	FH-4.3.13	10157
Behavior (5)		
Client activities and actions, which influence achievement of nutrition related goals.		
Adherence (5.1)		
❑ Self reported nutrition adherence score	FH-5.1.1	10160
❑ Nutrition encounter ratio	FH-5.1.2	14215
❑ Ability to recall nutrition goals	FH-5.1.3	10162
❑ Nutrition self monitoring at agreed upon rate	FH-5.1.4	10163
❑ Nutrition self management as agreed upon	FH-5.1.5	10164
Avoidance behavior (5.2)		
❑ Avoidance	FH-5.2.1	10166
❑ Restrictive eating	FH-5.2.2	10167
❑ Cause of avoidance behavior	FH-5.2.3	10168
Bingeing and purging behavior (5.3)		
❑ Binge eating behavior	FH-5.3.1	10170
❑ Purging behavior	FH-5.3.2	10171
Mealtime behavior (5.4)		
❑ Meal duration	FH-5.4.1	10173
❑ Percent of meal time spent eating	FH-5.4.2	10174
❑ Preference to drink rather than eat	FH-5.4.3	10175
❑ Refusal to eat/chew	FH-5.4.4	10176
❑ Spitting food out	FH-5.4.5	10177
❑ Rumination	FH-5.4.6	10178
❑ Patient/client/caregiver fatigue during feeding process resulting in inadequate intake	FH-5.4.7	10179
❑ Willingness to try new foods	FH-5.4.8	10180
❑ Limited number of accepted foods	FH-5.4.9	10181
❑ Rigid sensory preferences	FH-5.4.10	10182

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	NCPT Code	ANDUID
Social network (5.5)		
❑ Ability to build and utilize social network	FH-5.5.1	10184
Factors Affecting Access to Food and Food/Nutrition-Related Supplies (6)		
Factors that affect intake and availability of a sufficient quantity of safe, healthful food as well as food/nutrition-related supplies.		
Food/nutrition program participation (6.1)		
❑ Eligibility for government programs	FH-6.1.1	10187
❑ Participation in government programs	FH-6.1.2	10188
❑ Eligibility for community programs	FH-6.1.3	10189
❑ Participation in community programs	FH-6.1.4	10190
Safe food/meal availability (6.2)		
❑ Availability of shopping facilities	FH-6.2.1	10192
❑ Procurement of safe food	FH-6.2.2	10800
❑ Appropriate meal preparation facilities	FH-6.2.3	10194
❑ Availability of safe food storage	FH-6.2.4	10195
❑ Appropriate storage technique	FH-6.2.5	10196
❑ Identification of safe food	FH-6.2.6	10801
Safe water availability (6.3)		
❑ Availability of potable water	FH-6.3.1	10198
❑ Appropriate water decontamination	FH-6.3.2	10199
Food and nutrition related supplies availability (6.4)		
❑ Access to food and nutrition related supplies	FH-6.4.1	10201
❑ Access to assistive eating devices	FH-6.4.2	10202
❑ Access to assistive food preparation devices	FH-6.4.3	10203
Physical Activity and Function (7)		
Physical activity, cognitive and physical ability to engage in specific tasks, eg, breastfeeding and self-feeding.		
Breastfeeding Assessment (7.1)		
❑ Initiation of breastfeeding	FH-7.1.1	10206
❑ Start breastfeeding	FH-7.1.1.1	14108
❑ Stop breastfeeding	FH-7.1.1.2	14109
❑ Breastfeeding approach	FH-7.1.2	14110
❑ Exclusive breastfeeding	FH-7.1.2.1	10208
❑ Predominant breastfeeding	FH-7.1.2.2	14111
❑ Partial breastfeeding	FH-7.1.2.3	14112
❑		
❑ Breastfeeding problems	FH-7.1.3	10209
❑ Infant able to latch on to breast for feeding	FH-7.1.3.1	14113
❑ Infant unable to latch on to breast for feeding	FH-7.1.3.2	14114
❑ Difficulty latching onto breast for feeding	FH-7.1.3.3	14115
❑ Abscess of breast associated with lactation	FH-7.1.3.4	14116
❑ Cracked nipple associated with lactation	FH-7.1.3.5	14117
❑ Infection of nipple associated with lactation	FH-7.1.3.6	14118
❑ Non purulent mastitis associated with lactation	FH-7.1.3.7	14119
❑ Retracted nipple associated with lactation	FH-7.1.3.8	14120
❑ Inversion of nipple associated with lactation	FH-7.1.3.9	14121
❑ Breast engorgement associated with lactation	FH-7.1.3.10	14122
❑ Previous breast surgery associated with lactation	FH-7.1.3.11	14123
❑ Breast abnormality associated with lactation	FH-7.1.3.12	14124
❑ Inadequate flow of breastmilk	FH-7.1.3.13	14125
❑ Finding related to infant's ability to suck	FH-7.1.4	14126
❑ Infant able to suck	FH-7.1.4.1	14127
❑ Infant unable to suck	FH-7.1.4.2	14128
❑ Difficulty sucking	FH-7.1.4.3	14129
Nutrition related ADLs and IADLs (7.2)		
❑ Physical ability to complete tasks for meal preparation	FH-7.2.1	10211
❑ Physical ability to self feed	FH-7.2.2	10212
❑ Ability to position self in relation to plate	FH-7.2.3	10213
❑ Receives assistance with intake	FH-7.2.4	10214
❑ Ability to use adaptive eating devices	FH-7.2.5	10215
❑ Cognitive ability to complete tasks for meal preparation	FH-7.2.6	10216
❑ Remembers to eat	FH-7.2.7	10139
❑ Recalls eating	FH-7.2.8	10218
❑ Mini mental state examination score	FH-7.2.9	10219
❑ Nutrition related activities of daily living (ADL) score	FH-7.2.10	10220
❑ Nutrition related instrumental activities of daily living (IADL) score	FH-7.2.11	10221
Physical activity (7.3)		
❑ Physical activity history	FH-7.3.1	10223
❑ Consistency	FH-7.3.2	10224
❑ Frequency	FH-7.3.3	10225
❑ Duration	FH-7.3.4	10226
❑ Intensity	FH-7.3.5	10227
❑ Type of physical activity	FH-7.3.6	10228
❑ Strength	FH-7.3.7	10229
❑ Handgrip strength	FH-7.3.7.1	11680
❑ TV/screen time	FH-7.3.8	10230
❑ Other sedentary activity time	FH-7.3.9	10231
❑ Involuntary physical movement	FH-7.3.10	10232
❑ Non exercise activity thermogenesis	FH-7.3.11	10233
Factors affecting access to physical activity (7.4)		
❑ Neighborhood safety	FH-7.4.1	10822
❑ Walkability of neighborhood	FH-7.4.2	10823
❑ Proximity to parks/green space	FH-7.4.3	10824
❑ Access to physical activity facilities/programs	FH-7.4.4	10825
Nutrition Related Patient/Client Centered Measures (8)		
Patient/client's perception of his or her nutrition intervention and its impact on life.		
Nutrition quality of life (8.1)		
❑ Nutrition quality of life responses	FH-8.1.1	10236
ANTHROPOMETRIC MEASUREMENTS (AD)		

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Height, weight, body mass index (BMI), growth pattern indices/percentile ranks, and weight history.

Body composition/growth/weight history (1.1)

	NCPT Code	ANDUID
❑ Height	AD-1.1.1	10239
❑ Measured height	AD-1.1.1.1	11377
❑ Measured length	AD-1.1.1.2	12015
❑ Birth length	AD-1.1.1.3	12016
❑ Preamputation measured height	AD-1.1.1.4	12017
❑ Preamputation estimated height	AD-1.1.1.5	12018
❑ Estimated height	AD-1.1.1.6	12019
❑ Stated height	AD-1.1.1.7	12020
❑ Measured peak adult height	AD-1.1.1.8	12021
❑ Stated peak adult height	AD-1.1.1.9	12022
❑ Knee height	AD-1.1.1.10	12023
❑ Tibia length	AD-1.1.1.11	12024
❑ Arm span	AD-1.1.1.12	12025
❑ Arm demispan	AD-1.1.1.13	12026
❑ Arm halfspan	AD-1.1.1.14	12027
❑ Height measurement device	AD-1.1.1.15	12028
❑ Weight	AD-1.1.2	10240
❑ Measured weight	AD-1.1.2.1	12029
❑ Stated weight	AD-1.1.2.2	12030
❑ Stated peak weight	AD-1.1.2.3	12031
❑ Measured peak weight	AD-1.1.2.4	12032
❑ Usual stated body weight (UBW)	AD-1.1.2.5	12033
❑ UBW percentage	AD-1.1.2.6	12034
❑ Birth weight	AD-1.1.2.7	12035
❑ Stated prepregnancy weight	AD-1.1.2.8	12036
❑ Dosing weight	AD-1.1.2.9	12037
❑ Estimated dry weight	AD-1.1.2.10	12038
❑ Preamputation measured weight	AD-1.1.2.11	12039
❑ Preamputation estimated weight	AD-1.1.2.12	12040
❑ Postamputation measured weight	AD-1.1.2.13	12041
❑ Postamputation estimated weight	AD-1.1.2.14	12042
❑ Predialysis weight	AD-1.1.2.15	12043
❑ Postdialysis weight	AD-1.1.2.16	12044
❑ Frame	AD-1.1.3	10241
❑ Frame size	AD-1.1.3.1	12045
❑ Wrist circumference	AD-1.1.3.2	12046
❑ Weight change	AD-1.1.4	10242
❑ Weight gain	AD-1.1.4.1	12047
❑ Weight loss	AD-1.1.4.2	12048
❑ Weight change percentage	AD-1.1.4.3	12049
❑ Measured interdialytic weight gain	AD-1.1.4.4	12050
❑ Measured interdialytic weight loss	AD-1.1.4.5	12051
❑ Measured gestational weight gain	AD-1.1.4.6	12052
❑ Measured gestational weight loss	AD-1.1.4.7	12053
❑ Weight change intent	AD-1.1.4.8	12054
❑ Body mass	AD-1.1.5	10243
❑ Body mass index (BMI)	AD-1.1.5.1	12055
❑ Body mass index prime ratio (BMI prime)	AD-1.1.5.2	12056
❑ Growth pattern indices	AD-1.1.6	10244
❑ BMI for age percentile	AD-1.1.6.1	12057
❑ BMI for age z score	AD-1.1.6.2	12058
❑ Head circumference	AD-1.1.6.3	12059
❑ Birth head circumference	AD-1.1.6.4	12060
❑ Head circumference for age percentile	AD-1.1.6.5	12061
❑ Head circumference for age z score	AD-1.1.6.6	12062
❑ Length for age percentile	AD-1.1.6.7	12063
❑ Length for age z score	AD-1.1.6.8	12064
❑ Stature for age percentile	AD-1.1.6.9	12065
❑ Stature for age z score	AD-1.1.6.10	12066
❑ Weight for length percentile	AD-1.1.6.11	12067
❑ Weight for length z score	AD-1.1.6.12	12068
❑ Weight for age percentile	AD-1.1.6.13	12069
❑ Weight for age z score	AD-1.1.6.14	12070
❑ Weight for stature percentile	AD-1.1.6.15	12071
❑ Weight for stature z score	AD-1.1.6.16	12072
❑ Mid parental height comparator	AD-1.1.6.17	12073
❑ Body compartment estimates	AD-1.1.7	10245
❑ Body fat percentage	AD-1.1.7.1	12074
❑ Body fat percentage technique	AD-1.1.7.2	12075
❑ Body surface area	AD-1.1.7.3	12076
❑ Calculated body surface area	AD-1.1.7.4	12077
❑ Bone age	AD-1.1.7.5	12078
❑ Bone mineral density t score	AD-1.1.7.6	12079
❑ Bone mineral density z score	AD-1.1.7.7	12080
❑ Bone mineral density technique	AD-1.1.7.8	12081
❑ Mid arm muscle circumference	AD-1.1.7.9	12082
❑ Mid arm muscle circumference percentile	AD-1.1.7.10	12083
❑ Triceps skinfold thickness	AD-1.1.7.11	12084
❑ Triceps skinfold percentile	AD-1.1.7.12	12085
❑ Triceps skinfold z score	AD-1.1.7.13	12086
❑ Waist circumference	AD-1.1.7.14	12087
❑ Waist circumference narrowest point	AD-1.1.7.15	12088
❑ Waist circumference iliac crest	AD-1.1.7.16	12089
❑ Hip circumference	AD-1.1.7.17	12090
❑ Waist to hip ratio	AD-1.1.7.18	12091
❑ Mid upper arm circumference	AD-1.1.7.19	12092
❑ Mid upper arm circumference left arm	AD-1.1.7.20	12093
❑ Mid upper arm circumference z score	AD-1.1.7.21	12094

BIOCHEMICAL DATA, MEDICAL TESTS, AND PROCEDURES (BD)

Laboratory data, (eg, electrolytes, glucose, and lipid panel) and tests (eg, gastric emptying time, resting metabolic rate).

Acid base balance (1.1)

	NCPT Code	ANDUID
❑ Arterial pH	BD-1.1.1	10248
❑ Arterial bicarbonate	BD-1.1.2	10249
❑ Partial pressure of carbon dioxide in arterial blood (PaCO2)	BD-1.1.3	10250
❑ Partial pressure of oxygen in arterial blood (PaO2)	BD-1.1.4	10251
❑ Venous pH	BD-1.1.5	10252
❑ Venous bicarbonate	BD-1.1.6	10253

Electrolyte and renal profile (1.2)

	NCPT Code	ANDUID
❑ BUN	BD-1.2.1	10255
❑ Creatinine	BD-1.2.2	10256
❑ BUN:creatinine ratio	BD-1.2.3	10257
❑ Glomerular filtration rate	BD-1.2.4	10258
❑ Sodium	BD-1.2.5	10259

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	NCPT Code	ANDUID
❑ Chloride	BD-1.2.6	10260
❑ Potassium	BD-1.2.7	10261
❑ Magnesium	BD-1.2.8	10262
❑ Calcium, serum	BD-1.2.9	10263
❑ Calcium, ionized	BD-1.2.10	10264
❑ Phosphorus	BD-1.2.11	10265
❑ Serum osmolality	BD-1.2.12	10266
❑ Parathyroid hormone	BD-1.2.13	10267
Essential fatty acid profile (1.3)		
❑ Triene:tetraene ratio	BD-1.3.1	10269
Gastrointestinal profile (1.4)		
❑ Alkaline phosphatase	BD-1.4.1	10271
❑ Alanine aminotransferase (ALT)	BD-1.4.2	10272
❑ Aspartate aminotransferase (AST)	BD-1.4.3	10273
❑ Gamma glutamyl transferase (GGT)	BD-1.4.4	10274
❑ Gastric residual volume	BD-1.4.5	10275
❑ Bilirubin, total	BD-1.4.6	10276
❑ Ammonia, serum	BD-1.4.7	10277
❑ Toxicology report, including alcohol	BD-1.4.8	10278
❑ Prothrombin time (PT)	BD-1.4.9	10279
❑ Partial thromboplastin time (PTT)	BD-1.4.10	10280
❑ INR ratio	BD-1.4.11	10281
❑ Amylase	BD-1.4.12	10283
❑ Lipase	BD-1.4.13	10284
❑ Fecal fat, 24 hour	BD-1.4.14	11242
❑ Fecal fat, 72 hour	BD-1.4.15	11243
❑ Fecal fat, qualitative	BD-1.4.16	11244
❑ Fecal calprotectin	BD-1.4.17	11245
❑ Fecal lactoferrin	BD-1.4.18	11246
❑ Pancreatic elastase	BD-1.4.19	11150
❑ 5'nucleotidase	BD-1.4.20	11247
❑ D xylose	BD-1.4.21	10286
❑ Lactulose hydrogen breath test	BD-1.4.22	11248
❑ Lactose hydrogen breath test	BD-1.4.23	11249
❑ Fructose hydrogen breath test	BD-1.4.24	11250
❑ Glucose hydrogen breath test	BD-1.4.25	11251
❑ Urea hydrogen breath test	BD-1.4.26	11252
❑ Intestinal biopsy	BD-1.4.27	10288
❑ Stool culture	BD-1.4.28	10289
❑ Gastric emptying time	BD-1.4.29	10290
❑ Small bowel transit time	BD-1.4.30	10291
❑ Abdominal X-ray	BD-1.4.31	11253
❑ Abdominal CT (computed tomography)	BD-1.4.32	11254
❑ Abdominal ultrasound	BD-1.4.33	11255
❑ Endoscopic ultrasound	BD-1.4.34	11256
❑ Pelvic CT (computed tomography)	BD-1.4.35	11257
❑ Modified barium swallow	BD-1.4.36	11258
❑ Barium swallow	BD-1.4.37	11259
❑ Esophagogastroduodenoscopy	BD-1.4.38	11260
❑ Endoscopic retrograde cholangiopancreatography (ERCP)	BD-1.4.39	11261
❑ Capsule endoscopy	BD-1.4.40	11262
❑ Esophageal manometry	BD-1.4.41	11263
❑ Esophageal pH test	BD-1.4.42	11264
❑ Gastroesophageal reflux monitoring	BD-1.4.43	11265
❑ Gastrointestinal sphincter monitoring	BD-1.4.44	11266
❑ Urate	BD-1.4.45	11638
Glucose/endocrine profile (1.5)		
❑ Glucose, fasting	BD-1.5.1	10295
❑ Glucose, casual	BD-1.5.2	10296
❑ Hemoglobin A1c (HgbA1c)	BD-1.5.3	10297
❑ Preprandial capillary plasma glucose	BD-1.5.4	10298
❑ Peak postprandial capillary plasma glucose	BD-1.5.5	10299
❑ Glucose tolerance test	BD-1.5.6	10300
❑ Cortisol level	BD-1.5.7	10301
❑ IGF binding protein	BD-1.5.8	10302
❑ Thyroid stimulating hormone	BD-1.5.9	11639
❑ Thyroxine test	BD-1.5.10	11640
❑ Triiodothyronine	BD-1.5.11	11641
❑ Adrenocorticotropic hormone	BD-1.5.12	11642
❑ Follicle stimulating hormone	BD-1.5.13	11643
❑ Growth hormone	BD-1.5.14	11644
❑ Luteinizing hormone	BD-1.5.15	11645
Inflammatory profile (1.6)		
❑ C reactive protein	BD-1.6.1	10305
Lipid profile (1.7)		
❑ Cholesterol, serum	BD-1.7.1	10307
❑ Cholesterol, HDL	BD-1.7.2	10308
❑ Cholesterol, LDL	BD-1.7.3	10309
❑ Cholesterol, non HDL	BD-1.7.4	10310
❑ Total cholesterol:HDL cholesterol ratio	BD-1.7.5	10311
❑ LDL:HDL ratio	BD-1.7.6	10312
❑ Triglycerides, serum	BD-1.7.7	10313
Metabolic rate profile (1.8)		
❑ Resting metabolic rate, measured	BD-1.8.1	10315
❑ Respiratory quotient, measured	BD-1.8.2	10316
Mineral profile (1.9)		
❑ Copper, serum or plasma	BD-1.9.1	10318
❑ Iodine, urinary excretion	BD-1.9.2	10319
❑ Zinc, serum or plasma	BD-1.9.3	10320
❑ Boron, serum or plasma	BD-1.9.4	10841
❑ Chromium, serum or urinary	BD-1.9.5	10842
❑ Fluoride, plasma	BD-1.9.6	10843
❑ Manganese, urinary, blood, plasma	BD-1.9.7	10844
❑ Molybdenum, serum	BD-1.9.8	10845
❑ Selenium, serum or urinary	BD-1.9.9	10846
Nutritional anemia profile (1.10)		
❑ Hemoglobin	BD-1.10.1	10323
❑ Hematocrit	BD-1.10.2	10324
❑ Mean corpuscular volume	BD-1.10.3	10325
❑ Red blood cell folate	BD-1.10.4	10326
❑ Red cell distribution width	BD-1.10.5	10327
❑ B12, serum	BD-1.10.6	10328
❑ Methylmalonic acid, serum	BD-1.10.7	10329
❑ Folate, serum	BD-1.10.8	10330
❑ Homocysteine, serum	BD-1.10.9	10331
❑ Ferritin, serum	BD-1.10.10	10332
❑ Iron, serum	BD-1.10.11	10333
❑ Total iron binding capacity	BD-1.10.12	10334
❑ Transferrin saturation	BD-1.10.13	10335
Protein profile (1.11)		
❑ Albumin	BD-1.11.1	10337

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	NCPT Code	ANDUID
❑ Prealbumin	BD-1.11.2	10338
❑ Transferrin	BD-1.11.3	10339
❑ Phenylalanine, plasma	BD-1.11.4	10340
❑ Tyrosine, plasma	BD-1.11.5	10341
❑ Amino acid panel	BD-1.11.6	10342
❑ Phenylalanine, dried blood spot	BD-1.11.7	11151
❑ Tyrosine, dried blood spot	BD-1.11.8	11152
❑ Phenylalanine:tyrosine ratio	BD-1.11.9	11153
❑ Hydroxyproline	BD-1.11.10	11154
❑ Threonine	BD-1.11.11	11155
❑ Serine	BD-1.11.12	11156
❑ Asparagine	BD-1.11.13	11157
❑ Glutamate	BD-1.11.14	11158
❑ Glutamine	BD-1.11.15	11159
❑ Proline	BD-1.11.16	11160
❑ Glycine	BD-1.11.17	11161
❑ Alanine	BD-1.11.18	11162
❑ Citrulline	BD-1.11.19	11163
❑ Valine	BD-1.11.20	11164
❑ Cysteine	BD-1.11.21	11165
❑ Methionine	BD-1.11.22	11166
❑ Isoleucine	BD-1.11.23	11167
❑ Leucine	BD-1.11.24	11168
❑ Ornithine	BD-1.11.25	11169
❑ Lysine	BD-1.11.26	11170
❑ Histidine	BD-1.11.27	11171
❑ Arginine	BD-1.11.28	11172
❑ Lysine:arginine ratio	BD-1.11.29	11173
❑ Tryptophan	BD-1.11.30	11174
❑ Plasma organic acid panel	BD-1.11.31	11175
❑ Organic acids/creatinine	BD-1.11.32	11176
❑ 3 hydroxybutyrate	BD-1.11.33	11181
❑ 3 hydroxyisovalerate	BD-1.11.34	11182
❑ Acetoacetate	BD-1.11.35	11183
❑ Ethylmalonate	BD-1.11.36	11184
❑ Succinate	BD-1.11.37	11185
❑ Fumarate	BD-1.11.38	11186
❑ Glutarate	BD-1.11.39	11187
❑ 3 methylglutarate	BD-1.11.40	11188
❑ Adipate	BD-1.11.41	11189
❑ 2 hydroxyglutarate	BD-1.11.42	11190
❑ 3 hydroxyphenylacetate	BD-1.11.43	11191
❑ 2 ketoglutarate	BD-1.11.44	11192
❑ Citrate	BD-1.11.45	11193
❑ Propionate	BD-1.11.46	11194
❑ Methylcitrate	BD-1.11.47	11195
❑ 3 hydroxy propionate	BD-1.11.48	11196
❑ Beta hydroxy butyrate	BD-1.11.49	11197
❑ Creatine kinase	BD-1.11.50	11198
❑ Troponin I. cardiac	BD-1.11.51	11199
❑ Troponin T. cardiac	BD-1.11.52	11200
❑ B type natriuretic peptide	BD-1.11.53	11201
❑ Succinylacetone	BD-1.11.54	11202
❑ Total serum immunoglobulin A	BD-1.11.55	11267
❑ Tissue transglutaminase antibodies (IgA)	BD-1.11.56	11268
❑ Tissue transglutaminase antibodies (IgG)	BD-1.11.57	11269
❑ Deamidated gliadin peptide antibodies (IgG)	BD-1.11.58	11270
❑ Endomysial antibodies	BD-1.11.59	11271
❑ Carbohydrate deficient transferrin	BD-1.11.60	10847
Urine profile (1.12)		
❑ Urine color	BD-1.12.1	10345
❑ Urine osmolality	BD-1.12.2	10346
❑ Urine specific gravity	BD-1.12.3	10347
❑ Urine volume	BD-1.12.4	10349
❑ Urine calcium, 24 hour	BD-1.12.5	11272
❑ Urine d xylose	BD-1.12.6	11273
❑ Urine glucose	BD-1.12.7	11203
❑ Urine ketones	BD-1.12.8	11204
❑ Urine sodium	BD-1.12.9	11205
❑ Urine microalbumin	BD-1.12.10	11206
❑ Urine protein, random	BD-1.12.11	11207
❑ Urine protein, 24 hour	BD-1.12.12	11208
❑ Urine uric acid, random	BD-1.12.13	11209
❑ Urine uric acid, 24 hour	BD-1.12.14	11210
❑ Urine organic acid panel	BD-1.12.15	11211
❑ Urine glutarate	BD-1.12.16	11212
❑ Urine methylmalonate	BD-1.12.17	11213
❑ Urine acylglycines/creatinine	BD-1.12.18	11214
❑ Urine argininosuccinate	BD-1.12.19	11215
❑ Urine succinylacetone/creatinine	BD-1.12.20	11216
❑ Urine orotate	BD-1.12.21	11217
❑ Urine orotate/creatinine	BD-1.12.22	11218
❑ Urine 2 hydroxyisovalerate	BD-1.12.23	11219
❑ Urine 2 oxoisovalerate	BD-1.12.24	11220
❑ Urine galactitol	BD-1.12.25	11221
❑ Urine reducing substances	BD-1.12.26	11222
❑ Urine porphyrins	BD-1.12.27	11274
❑ Urine creatinine, 24 hour	BD-1.12.28	14189
❑ Urine citrate, 24 hours	BD-1.12.29	14190
❑ Urine phosphorus, 24 hour	BD-1.12.30	14191
❑ Urine pH, random	BD-1.12.31	14192
❑ Urine pH, 24 hour	BD-1.12.32	14193
❑ Urine sodium, 24 hour	BD-1.12.33	14194
❑ Urine urea nitrogen, 24 hour	BD-1.12.34	14195
❑ Urine oxalate, 24 hour	BD-1.12.35	14196
❑ Urine chloride, 24 hour	BD-1.12.36	14197
❑ Urine ammonium, 24 hour	BD-1.12.37	14198
❑ Urine magnesium, 24 hour	BD-1.12.38	14199
❑ Urine potassium, 24 hour	BD-1.12.39	14200
❑ Urine sulfate, 24 hour	BD-1.12.40	14201
❑ Urine cystine, 24 hour	BD-1.12.41	14202
❑ Calcium oxalate supersaturation in 24 hour urine	BD-1.12.42	14203
❑ Calcium phosphate supersaturation in 24 hour urine	BD-1.12.43	14204
❑ Brushite supersaturation in 24 hour urine	BD-1.12.44	14205
❑ Uric acid supersaturation in 24 hour urine	BD-1.12.45	14218
Vitamin profile (1.13)		
❑ Vitamin A, serum or plasma retinol	BD-1.13.1	10351
❑ Vitamin C, plasma or serum	BD-1.13.2	10352
❑ Vitamin D, 25 hydroxy	BD-1.13.3	10353
❑ Vitamin E, plasma alpha-tocopherol	BD-1.13.4	10354

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	NCPT Code	ANDUID
❑ Thiamin, activity coefficient for erythrocyte transketolase activity	BD-1.13.5	10355
❑ Riboflavin, activity coefficient for erythrocyte glutathione reductase activity	BD-1.13.6	10356
❑ Niacin, urinary N'methyl-nicotinamide concentration	BD-1.13.7	10357
❑ Vitamin B6, plasma or serum pyridoxal 5'phosphate concentration	BD-1.13.8	10358
❑ Pantothenic acid, urinary pantothenate excretion, plasma	BD-1.13.9	10850
❑ Biotin, urinary 3 hydroxyisovaleric acid excretion	BD-1.13.10	11275
❑ Biotin, lymphocyte propionyl CoA carboxylase in pregnancy, serum	BD-1.13.11	11276
❑ Biotinidase	BD-1.13.12	11223
❑ Protein induced by vitamin K absence or antagonist II	BD-1.13.13	11224
Carbohydrate metabolism profile (1.14)		
❑ Galactose 1 phosphate in red blood cell	BD-1.14.1	11226
❑ Galactose 1 phosphate uridyl transferase	BD-1.14.2	11227
❑ Fructose	BD-1.14.3	11228
❑ Lactate	BD-1.14.4	11177
❑ Pyruvate	BD-1.14.5	11178
❑ Lactate:pyruvate ratio	BD-1.14.6	11179
Fatty acid profile (1.15)		
❑ Acylcarnitine panel	BD-1.15.1	11230
❑ Acylcarnitine, plasma	BD-1.15.2	11231
❑ Free carnitine	BD-1.15.3	11232
❑ Total carnitine	BD-1.15.4	11233
❑ Free carnitine:total carnitine	BD-1.15.5	11234
❑ Fatty acid panel mitochondrial C8 to C18	BD-1.15.6	11235
❑ Fatty acid panel essential C12 to C22	BD-1.15.7	11236
❑ Fatty acid panel peroxisomal C22 to C26	BD-1.15.8	11237
❑ MCAD enzyme assay in fibroblasts or other tissues	BD-1.15.9	11238
❑ Fatty acid beta oxidation in fibroblasts	BD-1.15.10	11239

NUTRITION-FOCUSED PHYSICAL FINDINGS (PD)

Findings from a nutrition-focused physical exam, interview, or the medical record including muscle and subcutaneous fat, oral health, suck/swallow/breathe ability, appetite, and affect.

Nutrition-focused physical findings (1.1)

	NCPT Code	ANDUID
❑ Overall findings (1)		
❑ Asthenia	PD-1.1.1.1	11646
❑ Buffalo hump	PD-1.1.1.2	11647
❑ Cachexia	PD-1.1.1.3	11648
❑ Cushingoid appearance	PD-1.1.1.4	11649
❑ Ectomorph	PD-1.1.1.5	11650
❑ Endomorph	PD-1.1.1.6	11651
❑ Lethargic	PD-1.1.1.7	11652
❑ Mesomorph	PD-1.1.1.8	11653
❑ Neglect of personal hygiene	PD-1.1.1.9	11654
❑ Obese	PD-1.1.1.10	11655
❑ Short stature for age	PD-1.1.1.11	11656
❑ Tall stature	PD-1.1.1.12	11657
❑ Adipose (2)		
❑ Atrophy of orbital fat	PD-1.1.2.1	11659
❑ Excess subcutaneous fat	PD-1.1.2.2	11660
❑ Loss of subcutaneous fat	PD-1.1.2.3	11661
❑ Central adiposity	PD-1.1.2.4	11662
❑ Loss of subcutaneous triceps fat	PD-1.1.2.5	12095
❑ Loss of subcutaneous biceps fat	PD-1.1.2.6	12096
❑ Loss of subcutaneous fat overlying the ribs	PD-1.1.2.7	12097
❑ Bones (3)		
❑ Bow legs	PD-1.1.3.1	11664
❑ Frontal bossing	PD-1.1.3.2	11665
❑ Harrison's sulcus	PD-1.1.3.3	11666
❑ Rachitic rosary	PD-1.1.3.4	11667
❑ Rickets	PD-1.1.3.5	11668
❑ Scoliosis	PD-1.1.3.6	11669
❑ Acromion abnormal prominence	PD-1.1.3.7	12098
❑ Bone widening at ends	PD-1.1.3.8	12099
❑ Clavicle abnormal prominence	PD-1.1.3.9	12100
❑ Rib abnormal prominence	PD-1.1.3.10	12101
❑ Scapula abnormal prominence	PD-1.1.3.11	12102
❑ Spine abnormal prominence	PD-1.1.3.12	12103
❑ Iliac crest abnormal prominence	PD-1.1.3.13	12104
❑ Patella abnormal prominence	PD-1.1.3.14	12105
❑ Cardiovascular-pulmonary system (4)		
❑ Absent breath sounds	PD-1.1.4.1	11670
❑ Bradycardia	PD-1.1.4.2	11671
❑ Bradypnea	PD-1.1.4.3	11672
❑ Decreased breath sounds	PD-1.1.4.4	11673
❑ Dyspnea	PD-1.1.4.5	11674
❑ Increased breath sounds	PD-1.1.4.6	11675
❑ Normal breath sounds	PD-1.1.4.7	11676
❑ Tachypnea	PD-1.1.4.8	11677
❑ Tachycardia	PD-1.1.4.9	11678
❑ Respiratory crackles	PD-1.1.4.10	11679
❑ Digestive system (5)		
❑ Abdominal bloating	PD-1.1.5.1	11684
❑ Abdominal cramping	PD-1.1.5.2	11685
❑ Abdominal distension	PD-1.1.5.3	11686
❑ Abdominal pain	PD-1.1.5.4	11687
❑ Absence of bowel sounds	PD-1.1.5.5	11688
❑ Anorexia	PD-1.1.5.6	11689
❑ Ascites	PD-1.1.5.7	11690
❑ Bulky stool	PD-1.1.5.8	11691
❑ Constipation	PD-1.1.5.9	11692
❑ Decrease in appetite	PD-1.1.5.10	11693
❑ Diarrhea	PD-1.1.5.11	11694
❑ Early satiety	PD-1.1.5.12	11695
❑ Epigastric pain	PD-1.1.5.13	11696
❑ Excessive appetite	PD-1.1.5.14	11697
❑ Excessive belching	PD-1.1.5.15	11698
❑ Excessive flatus	PD-1.1.5.16	11699
❑ Fatty stool	PD-1.1.5.17	11700
❑ Heartburn	PD-1.1.5.18	11701
❑ Hyperactive bowel sounds	PD-1.1.5.19	11702
❑ Hypoactive bowel sounds	PD-1.1.5.20	11703
❑ Increased appetite	PD-1.1.5.21	11704
❑ Liquid stool	PD-1.1.5.22	11705
❑ Loose stool	PD-1.1.5.23	11706

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	NCPT Code	ANDUID
❑ Nausea	PD-1.1.5.24	11707
❑ Normal bowel sounds	PD-1.1.5.25	11708
❑ Retching	PD-1.1.5.26	11709
❑ Vomiting	PD-1.1.5.27	11710
❑ Gastrointestinal drainage volume	PD-1.1.5.28	12106
❑ Gastric drainage volume	PD-1.1.5.29	12107
❑ Bile duct drainage volume	PD-1.1.5.30	12108
❑ Pancreatic drainage volume	PD-1.1.5.31	12109
❑ Chylous drainage volume	PD-1.1.5.32	12110
❑ Wound drainage volume	PD-1.1.5.33	12111
❑ Intestinal fistula output volume	PD-1.1.5.34	12112
❑ Edema (6)		
❑ +1 pitting edema	PD-1.1.6.1	11712
❑ +2 pitting edema	PD-1.1.6.2	11713
❑ +3 pitting edema	PD-1.1.6.3	11714
❑ +4 pitting edema	PD-1.1.6.4	11715
❑ Anasarca	PD-1.1.6.5	11716
❑ Ankle edema	PD-1.1.6.6	11717
❑ Edema of calf	PD-1.1.6.7	11718
❑ Edema of eyelid	PD-1.1.6.8	11719
❑ Edema of foot	PD-1.1.6.9	11720
❑ Edema of hand	PD-1.1.6.10	11721
❑ Edema of scrotum	PD-1.1.6.11	11722
❑ Edema of thigh	PD-1.1.6.12	11723
❑ Edema of vulva	PD-1.1.6.13	11724
❑ Mucosal edema	PD-1.1.6.14	11725
❑ Sacral edema	PD-1.1.6.15	11726
❑ Extremities (7)		
❑ Amputated foot	PD-1.1.7.1	11728
❑ Amputated hand	PD-1.1.7.2	11729
❑ Amputated leg	PD-1.1.7.3	11730
❑ Athetoid movement	PD-1.1.7.4	11731
❑ Decreased range of ankle movement	PD-1.1.7.5	11732
❑ Decreased range of cervical spine movement	PD-1.1.7.6	11733
❑ Decreased range of elbow movement	PD-1.1.7.7	11734
❑ Decreased range of finger movement	PD-1.1.7.8	11735
❑ Decreased range of foot movement	PD-1.1.7.9	11736
❑ Decreased range of hip movement	PD-1.1.7.10	11737
❑ Decreased range of knee movement	PD-1.1.7.11	11738
❑ Decreased range of lumbar spine movement	PD-1.1.7.12	11739
❑ Decreased range of shoulder movement	PD-1.1.7.13	11740
❑ Decreased range of subtalar movement	PD-1.1.7.14	11741
❑ Decreased range of thumb movement	PD-1.1.7.15	11742
❑ Decreased range of toe movement	PD-1.1.7.16	11743
❑ Decreased range of thoracic spine movement	PD-1.1.7.17	11744
❑ Decreased range of wrist movement	PD-1.1.7.18	11745
❑ Hypertonia	PD-1.1.7.19	11746
❑ Hypotonia	PD-1.1.7.20	11747
❑ Joint arthralgia	PD-1.1.7.21	11748
❑ Lower limb spasticity	PD-1.1.7.22	11749
❑ Peripheral cyanosis	PD-1.1.7.23	11750
❑ Spasticity	PD-1.1.7.24	11751
❑ Tetany	PD-1.1.7.25	11752
❑ Upper limb spasticity	PD-1.1.7.26	11753
❑ Eyes (8)		
❑ Abnormal vision	PD-1.1.8.1	11755
❑ Angular blepharitis	PD-1.1.8.2	11756
❑ Bitot's spots	PD-1.1.8.3	11757
❑ Circles under eyes	PD-1.1.8.4	11758
❑ Corneal arcus	PD-1.1.8.5	11759
❑ Conjunctival discoloration	PD-1.1.8.6	11760
❑ Conjunctival hemorrhage	PD-1.1.8.7	11761
❑ Conjunctival keratinization	PD-1.1.8.8	11762
❑ Excessive tear production	PD-1.1.8.9	11763
❑ Keratomalacia	PD-1.1.8.10	11764
❑ Jaundiced sclera	PD-1.1.8.11	11765
❑ Night blindness	PD-1.1.8.12	11766
❑ Ophthalmoplegia	PD-1.1.8.13	11767
❑ Sunken eyes	PD-1.1.8.14	11768
❑ Xerophthalmia	PD-1.1.8.15	11769
❑ Xanthelasma	PD-1.1.8.16	11770
❑ Pale conjunctiva	PD-1.1.8.17	12113
❑ Genitourinary system (9)		
❑ Amenorrhea	PD-1.1.9.1	11772
❑ Anuria	PD-1.1.9.2	11773
❑ Delay in sexual development and/or puberty	PD-1.1.9.3	11774
❑ Menorrhagia	PD-1.1.9.4	11775
❑ Oliguria	PD-1.1.9.5	11776
❑ Polyuria	PD-1.1.9.6	11777
❑ Hair (10)		
❑ Abnormal keratinization of hair follicle	PD-1.1.10.1	11779
❑ Alopecia	PD-1.1.10.2	11780
❑ Brittle hair	PD-1.1.10.3	11781
❑ Corkscrew hairs	PD-1.1.10.4	11782
❑ Dry hair	PD-1.1.10.5	11783
❑ Fine hair	PD-1.1.10.6	11784
❑ Follicular hyperkeratosis	PD-1.1.10.7	11785
❑ Hair changes due to malnutrition	PD-1.1.10.8	11786
❑ Hair lacks luster	PD-1.1.10.9	11787
❑ Hypertrichosis	PD-1.1.10.10	11788
❑ Increased loss of hair	PD-1.1.10.11	11789
❑ Nutritional hair color change	PD-1.1.10.12	11790
❑ White hair	PD-1.1.10.13	11791
❑ Easily pluckable hair	PD-1.1.10.14	12114
❑ Lanugo hair formation	PD-1.1.10.15	12115
❑ Head (11)		
❑ Altered olfactory sense	PD-1.1.11.1	11793
❑ Anosmia	PD-1.1.11.2	11794
❑ Bulging fontanelle	PD-1.1.11.3	11795
❑ Epistaxis	PD-1.1.11.4	11796
❑ Headache	PD-1.1.11.5	11797
❑ Hyposmia	PD-1.1.11.6	11798
❑ Macrocephaly	PD-1.1.11.7	11799
❑ Microcephaly	PD-1.1.11.8	11800
❑ Nasal mucosa dry	PD-1.1.11.9	11801
❑ Sunken fontanelle	PD-1.1.11.10	11802
❑ Hand and nails (12)		
❑ Beau's lines	PD-1.1.12.1	11804
❑ Clubbing of nail	PD-1.1.12.2	11805
❑ Flaking of nails	PD-1.1.12.3	11806
❑ Koilonychia	PD-1.1.12.4	11807
❑ Leukonychia	PD-1.1.12.5	11808

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	NCPT Code	ANDUID
❑ Longitudinal grooving of nails	PD-1.1.12.6	11809
❑ Muehrcke's lines	PD-1.1.12.7	11810
❑ Nail changes	PD-1.1.12.8	11811
❑ Palmar erythema	PD-1.1.12.9	11812
❑ Ridged nails	PD-1.1.12.10	11813
❑ Splits in nails	PD-1.1.12.11	11814
❑ Thin nails	PD-1.1.12.12	11815
❑ Trachyonychia	PD-1.1.12.13	11816
❑ Splinter hemorrhage under nail	PD-1.1.12.14	11817
❑ White flecks in nails	PD-1.1.12.15	11818
❑ Blue nail bed	PD-1.1.12.16	12116
❑ Pale nail bed	PD-1.1.12.17	12117
❑ Russell's sign	PD-1.1.12.18	12118
❑ Mouth (13)		
❑ Ageusia	PD-1.1.13.1	11820
❑ Angular stomatitis	PD-1.1.13.2	11821
❑ Aphthous ulcer of mouth	PD-1.1.13.3	11822
❑ Aptyalism	PD-1.1.13.4	11823
❑ Blue lips	PD-1.1.13.5	11824
❑ Blue line on gingiva	PD-1.1.13.6	11825
❑ Candidiasis of the mouth	PD-1.1.13.7	11826
❑ Cheilosis	PD-1.1.13.8	11827
❑ Cheilitis	PD-1.1.13.9	11828
❑ Cleft palate	PD-1.1.13.10	11829
❑ Cracked lips	PD-1.1.13.11	11830
❑ Drooling	PD-1.1.13.12	11831
❑ Dry mucous membranes	PD-1.1.13.13	11832
❑ Dysgeusia	PD-1.1.13.14	11833
❑ Excessive salivation	PD-1.1.13.15	11834
❑ Excessive thirst	PD-1.1.13.16	11835
❑ Gingival hypertrophy	PD-1.1.13.17	11836
❑ Gingivitis	PD-1.1.13.18	11837
❑ Halitosis	PD-1.1.13.19	11838
❑ Hemorrhagic gingivitis	PD-1.1.13.20	11839
❑ Hypogeusia	PD-1.1.13.21	11840
❑ Ketotic breath	PD-1.1.13.22	11841
❑ Micrognathia	PD-1.1.13.23	11842
❑ Swollen gums	PD-1.1.13.24	11843
❑ Oral candidiasis	PD-1.1.13.25	11844
❑ Oral lesion	PD-1.1.13.26	11845
❑ Parotid swelling	PD-1.1.13.27	11846
❑ Poor oral hygiene	PD-1.1.13.28	11847
❑ Retains food in mouth	PD-1.1.13.29	11848
❑ Stomatitis	PD-1.1.13.30	11849
❑ Uremic breath	PD-1.1.13.31	11850
❑ Pale gums	PD-1.1.13.32	12119
❑ Muscles (14)		
❑ Muscle atrophy	PD-1.1.14.1	11852
❑ Muscle contracture	PD-1.1.14.2	11853
❑ Muscle cramp	PD-1.1.14.3	11854
❑ Muscle pain	PD-1.1.14.4	11855
❑ Muscle weakness	PD-1.1.14.5	11856
❑ Quadriceps muscle atrophy	PD-1.1.14.6	11857
❑ Deltoid muscle atrophy	PD-1.1.14.7	12120
❑ Gastrocnemius muscle atrophy	PD-1.1.14.8	12121
❑ Gluteal muscle atrophy	PD-1.1.14.9	12122
❑ Interosseous hand muscle atrophy	PD-1.1.14.10	12123
❑ Pectoral muscle atrophy	PD-1.1.14.11	12124
❑ Temporalis muscle atrophy	PD-1.1.14.12	12125
❑ Trapezius muscle atrophy	PD-1.1.14.13	12126
❑ Latissimus dorsi muscle atrophy	PD-1.1.14.14	12150
❑ Neck (15)		
❑ Goiter	PD-1.1.15.1	11859
❑ Nerves, cognition, and feelings (16)		
❑ Abnormal gait	PD-1.1.16.1	11860
❑ Absent reflex	PD-1.1.16.2	11861
❑ Asterixis	PD-1.1.16.3	11862
❑ Ataxia	PD-1.1.16.4	11863
❑ Clouded consciousness	PD-1.1.16.5	11864
❑ Cranial nerve finding	PD-1.1.16.6	11865
❑ Decreased vibratory sense	PD-1.1.16.7	11866
❑ Delirious	PD-1.1.16.8	11867
❑ Dementia	PD-1.1.16.9	11868
❑ Depressed mood	PD-1.1.16.10	11869
❑ Disoriented	PD-1.1.16.11	11870
❑ Dizziness	PD-1.1.16.12	11871
❑ Feels cold	PD-1.1.16.13	11872
❑ Flat affect	PD-1.1.16.14	11873
❑ Hyperreflexia	PD-1.1.16.15	11874
❑ Hyporeflexia	PD-1.1.16.16	11875
❑ Inappropriate affect	PD-1.1.16.17	11876
❑ Many seizures a day	PD-1.1.16.18	11877
❑ Numbness of foot	PD-1.1.16.19	11878
❑ Numbness of hand	PD-1.1.16.20	11879
❑ Peripheral nerve disease	PD-1.1.16.21	11880
❑ Tremor of outstretched hand	PD-1.1.16.22	11881
❑ Tingling of foot	PD-1.1.16.23	11882
❑ Tingling of hand	PD-1.1.16.24	11883
❑ Skin (17)		
❑ Acanthosis nigricans	PD-1.1.17.1	11884
❑ Calcinosis	PD-1.1.17.2	11885
❑ Carotenemia	PD-1.1.17.3	11886
❑ Cutaneous xanthoma	PD-1.1.17.4	11887
❑ Decreased skin turgor	PD-1.1.17.5	11888
❑ Dermatitis	PD-1.1.17.6	11889
❑ Diaper rash	PD-1.1.17.7	11890
❑ Dry skin	PD-1.1.17.8	11891
❑ Ecchymosis	PD-1.1.17.9	11892
❑ Erythema	PD-1.1.17.10	11893
❑ Eczema	PD-1.1.17.11	11894
❑ Flushing	PD-1.1.17.12	11895
❑ Hirsutism	PD-1.1.17.13	11896
❑ Hyperpigmentation of skin	PD-1.1.17.14	11897
❑ Impaired skin integrity	PD-1.1.17.15	11898
❑ Jaundice	PD-1.1.17.16	11899
❑ Keratinization of skin	PD-1.1.17.17	11900
❑ Pale complexion	PD-1.1.17.18	11901
❑ Peeling skin	PD-1.1.17.19	11902
❑ Petechiae	PD-1.1.17.20	11903
❑ Impaired wound healing	PD-1.1.17.21	11904
❑ Pressure injury of ankles	PD-1.1.17.22	11905
❑ Pressure injury of back	PD-1.1.17.23	11906

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❑ Pressure injury of breast	PD-1.1.17.24	11907
❑ Pressure injury of buttock	PD-1.1.17.25	11908
❑ Pressure injury of dorsum of foot	PD-1.1.17.26	11909
❑ Pressure injury of elbow	PD-1.1.17.27	11910
❑ Pressure injury of head	PD-1.1.17.28	11911
❑ Pressure injury of heel	PD-1.1.17.29	11912
❑ Pressure injury of hip	PD-1.1.17.30	11913
❑ Pressure injury of knee	PD-1.1.17.31	11914
❑ Pressure injury of natal cleft	PD-1.1.17.32	11915
❑ Pressure injury of shoulder	PD-1.1.17.33	11916
❑ Pressure injury stage 1	PD-1.1.17.34	11917
❑ Pressure injury stage 2	PD-1.1.17.35	11918
❑ Pressure injury stage 3	PD-1.1.17.36	11919
❑ Pressure injury stage 4	PD-1.1.17.37	11920
❑ Pruritus of the skin	PD-1.1.17.38	11921
❑ Psoriasis	PD-1.1.17.39	11922
❑ Scaling skin	PD-1.1.17.40	11923
❑ Seborrheic dermatitis	PD-1.1.17.41	11924
❑ Skin rash	PD-1.1.17.42	11925
❑ Stasis ulcer	PD-1.1.17.43	11926
❑ Yellow skin	PD-1.1.17.44	11927
❑ Perifollicular hemorrhages	PD-1.1.17.45	12127
❑ Pressure injury of the coccyx	PD-1.1.17.46	12128
❑ Pressure injury of the sacrum	PD-1.1.17.47	12129
❑ Vesiculobullous rash	PD-1.1.17.48	12130
❑ Teeth (18)		
❑ Baby bottle tooth decay	PD-1.1.18.1	11929
❑ Broken denture	PD-1.1.18.2	11930
❑ Broken teeth	PD-1.1.18.3	11931
❑ Dental caries	PD-1.1.18.4	11932
❑ Dental fluorosis	PD-1.1.18.5	11933
❑ Dental plaque	PD-1.1.18.6	11934
❑ Denture loose	PD-1.1.18.7	11935
❑ Denture lost	PD-1.1.18.8	11936
❑ Denture present	PD-1.1.18.9	11937
❑ Edentulous	PD-1.1.18.10	11938
❑ Erosion of teeth	PD-1.1.18.11	11939
❑ Impaired dentition	PD-1.1.18.12	11940
❑ Ill fitting denture	PD-1.1.18.13	11941
❑ Mottling of enamel	PD-1.1.18.14	11942
❑ Partially edentulous mandible	PD-1.1.18.15	11943
❑ Partially edentulous maxilla	PD-1.1.18.16	11944
❑ Rampant dental caries	PD-1.1.18.17	11945
❑ Throat and swallowing (19)		
❑ Choking during swallowing	PD-1.1.19.1	11947
❑ Cough	PD-1.1.19.2	11948
❑ Dysphagia	PD-1.1.19.3	11949
❑ Esophageal lesion	PD-1.1.19.4	11950
❑ Food sticks on swallowing	PD-1.1.19.5	11951
❑ Gagging	PD-1.1.19.6	11952
❑ Hoarse voice	PD-1.1.19.7	11953
❑ Hypoactive gag reflex	PD-1.1.19.8	11954
❑ Odynophagia	PD-1.1.19.9	11955
❑ Swallow impairment	PD-1.1.19.10	11956
❑ Suck, swallow, breath incoordination	PD-1.1.19.11	11957
❑ Tongue (20)		

	NCPT Code	ANDUID
❑ Atrophy of tongue papillae	PD-1.1.20.1	11959
❑ Beefy red tongue	PD-1.1.20.2	11960
❑ Difficulty moving tongue	PD-1.1.20.3	11961
❑ Dry tongue	PD-1.1.20.4	11962
❑ Glossitis	PD-1.1.20.5	11963
❑ Glossodynia	PD-1.1.20.6	11964
❑ Hypertrophy of tongue papillae	PD-1.1.20.7	11965
❑ Lesion of the tongue	PD-1.1.20.8	11966
❑ Strawberry tongue	PD-1.1.20.9	11967
❑ Macroglossia	PD-1.1.20.10	11968
❑ Short frenulum of tongue	PD-1.1.20.11	11969
❑ Split frenulum of tongue	PD-1.1.20.12	11970
❑ Blue tongue	PD-1.1.20.13	12131
❑ Cracked tongue	PD-1.1.20.14	12132
❑ Magenta tongue	PD-1.1.20.15	12133
❑ Pale tongue	PD-1.1.20.16	12134
❑ Vital signs	PD-1.1.21	10370
❑ Blood pressure, systolic	PD-1.1.21.1	14206
❑ Blood pressure, diastolic	PD-1.1.21.2	14207
❑ Blood pressure, systolic, reported	PD-1.1.21.3	14208
❑ Blood pressure, diastolic, reported	PD-1.1.21.4	14209
❑ Heart rate	PD-1.1.21.5	12139
❑ Jugular venous pressure	PD-1.1.21.6	12140
❑ Mean arterial pressure	PD-1.1.21.7	12138
❑ Pulse rate	PD-1.1.21.8	12141
❑ Respiratory rate	PD-1.1.21.9	12137
❑ Temperature	PD-1.1.21.10	12136

CLIENT HISTORY (CH)

Current and past information related to personal, medical, family, and social history.

Personal History (1)

General /client information such as age, gender, sex, race, ethnicity, language, education, and role in family.

Personal data (1.1)

❑ Age	CH-1.1.1	10374
❑ Gender	CH-1.1.2	10375
❑ Sex	CH-1.1.3	11138
❑ Race	CH-1.1.4	11139
❑ Ethnicity	CH-1.1.5	11140
❑ Language	CH-1.1.6	10377
❑ Literacy factors	CH-1.1.7	10378
❑ Education	CH-1.1.8	10379
❑ Role in family	CH-1.1.9	10380
❑ Tobacco use	CH-1.1.10	10381
❑ Physical disability	CH-1.1.11	10382
❑ Mobility	CH-1.1.12	10383

Patient/Client/Family Medical/Health History (2)

Patient/client or family disease states, conditions, and illnesses that may have nutritional impact.

Patient/client OR family nutrition-oriented medical/health history (2.1)

Specify issue(s) and whether it is patient/client history (P) or family history (F)

❑ Patient/client chief nutrition complaint	CH-2.1.1	10386

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	NCPT Code	ANDUID
(specify) _____ P or F		
❑ Cardiovascular	CH-2.1.2	10387
(specify) _____ P or F		
❑ Endocrine/metabolism	CH-2.1.3	10388
(specify) _____ P or F		
❑ Excretory	CH-2.1.4	10389
(specify) _____ P or F		
❑ Gastrointestinal	CH-2.1.5	10390
(specify) _____ P or F		
❑ Gynecological	CH-2.1.6	10391
(specify) _____ P or F		
❑ Hematology/oncology	CH-2.1.7	10392
(specify) _____ P or F		
❑ Immune (eg, food allergies)	CH-2.1.8	10393
(specify) _____ P or F		
❑ Integumentary	CH-2.1.9	10394
(specify) _____ P or F		
❑ Musculoskeletal	CH-2.1.10	10395
(specify) _____ P or F		
❑ Neurological	CH-2.1.11	10396
(specify) _____ P or F		
❑ Psychological	CH-2.1.12	10397
(specify) _____ P or F		
❑ Respiratory	CH-2.1.13	10398
(specify) _____ P or F		
❑ Other	CH-2.1.14	10399
(specify) _____ P or F		
Treatments/therapy (2.2)		
Documented medical or surgical treatments that may impact nutritional status of the client		
❑ Medical treatment/therapy	CH-2.2.1	10401
(specify) _____		
❑ Surgical treatment	CH-2.2.2	10402
(specify) _____		
❑ Palliative/end of life care	CH-2.2.3	10404
(specify) _____		
Social History (3)		
Client socioeconomic status, housing situation, medical support, and involvement in social groups.		
Social history (3.1)		
❑ Socioeconomic factors	CH-3.1.1	10407
(specify) _____		
❑ Living/housing situation	CH-3.1.2	10408
(specify) _____		
❑ Domestic issues	CH-3.1.3	10409
(specify) _____		
❑ Social and medical support	CH-3.1.4	10410
(specify) _____		
❑ Geographic location of home	CH-3.1.5	10411
(specify) _____		
❑ Occupation	CH-3.1.6	10412
(specify) _____		
❑ Religion	CH-3.1.7	10413
(specify) _____		
❑ History of recent crisis	CH-3.1.8	10414
(specify) _____		

	NCPT Code	ANDUID
❑ Daily stress level	CH-3.1.9	10415
(specify) _____		
ASSESSMENT, MONITORING AND EVALUATION TOOLS (AT)		
Tools used for health or disease status or risk assessment, reassessment, and monitoring and evaluation.		
Nutrition assessment, monitoring and evaluation tool ratings (1)		
❑ Subjective global assessment (SGA) rating	AT-1.1	14132
❑ Patient generated subjective global assessment (PG-SGA) rating	AT-1.2	14133
❑ Patient generated subjective global assessment (PG-SGA) score	AT-1.3	14134
❑ Mini nutritional assessment long form (MNA-LF) rating	AT-1.4	14135
Household food security assessment tool scores (2)		
❑ US household food security module: six item short form raw score	AT-2.1	14137
❑ US household food security module: six item short form scale score	AT-2.2	14138
❑ Food insecurity experience scale (FIES) raw score	AT-2.3	14139
Food variety assessment tool scores (3)		
❑ Minimum dietary diversity for women (MDD-W) indicator score	AT-3.1	14141
COMPARATIVE STANDARDS (CS)		
Energy Needs (1)		
Estimated energy needs (1.1)		
❑ Total energy estimated needs in 24 hours	CS-1.1.1	12205
❑ Method for estimating total energy needs	CS-1.1.2	10420
❑ Total energy estimated needs per kg of body weight	CS-1.1.3	13008
Macronutrient Needs (2)		
Estimated fat needs (2.1)		
❑ Total fat estimated needs in 24 hours	CS-2.1.1	12206
❑ Total fat estimated needs per kg of body weight	CS-2.1.2	13010
❑ Method for estimating total fat needs	CS-2.1.3	10425
❑ Proportion of energy needs from fat in 24 hours	CS-2.1.4	13009
Estimated protein needs (2.2)		
❑ Total protein estimated needs in 24 hours	CS-2.2.1	12207
❑ Total protein estimated needs per kg of body weight	CS-2.2.2	13011
❑ Method for estimating total protein needs	CS-2.2.3	10429
❑ Proportion of energy needs from protein in 24 hours	CS-2.2.4	13012
Estimated carbohydrate needs (2.3)		
❑ Total carbohydrate estimated needs in 24 hours	CS-2.3.1	12008
❑ Total carbohydrate estimated needs per kg of body weight	CS-2.3.2	13013
❑ Method for estimating total carbohydrate needs	CS-2.3.3	10433
❑ Proportion of energy needs from carbohydrate in 24 hours	CS-2.3.4	13014
Estimated fiber needs (2.4)		
❑ Total fiber estimated needs in 24 hours	CS-2.4.1	12209

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	NCPT Code	ANDUID
❑ Method for estimating total fiber needs	CS-2.4.2	10437
Fluid Needs (3)		
Estimated fluid needs (3.1)		
❑ Total fluid estimated needs	CS-3.1.1	10440
❑ Method for estimating needs	CS-3.1.2	10441
Micronutrient Needs (4)		
Estimated vitamin needs (4.1)		
❑ A (1)		10444
❑ C (2)		10445
❑ D (3)		10446
❑ E (4)		10447
❑ K (5)		10448
❑ Thiamin (6)		10449
❑ Riboflavin (7)		10450
❑ Niacin (8)		10451
❑ Folate (9)		10452
❑ B6 (10)		10453
❑ B12 (11)		10454
❑ Pantothenic acid (12)		10455
❑ Biotin (13)		10456
❑ Method for estimating needs (14)		10458
Estimated mineral needs (4.2)		
❑ Calcium (1)		10460
❑ Chloride (2)		10461
❑ Iron (3)		10462
❑ Magnesium (4)		10463
❑ Potassium (5)		10464
❑ Phosphorus (6)		10465
❑ Sodium (7)		10466
❑ Zinc (8)		10467
❑ Sulfate (9)		10469
❑ Fluoride (10)		10470
❑ Copper (11)		10471
❑ Iodine (12)		10473
❑ Selenium (13)		10474
❑ Manganese (14)		10475
❑ Chromium (15)		10476
❑ Molybdenum (16)		10477
❑ Boron (17)		10478
❑ Cobalt (18)		10479
❑ Method for estimating needs (19)		10480
Weight and Growth Recommendation (5)		
Recommended body weight/body mass index/growth (5.1)		
❑ Ideal/reference body weight (IBW)	CS-5.1.1	10483
❑ Recommended body mass index (BMI)	CS-5.1.2	10484
❑ Goal weight	CS-5.1.3	12144
❑ Goal weight gain/day	CS-5.1.4	12145
❑ Goal weight for length z score	CS-5.1.5	12146
❑ Goal mid upper arm circumference z score	CS-5.1.6	12147
❑ Goal BMI for age z score	CS-5.1.7	12148
❑ Percent median BMI	CS-5.1.8	12149

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