Academy of Nutrition and Dietetics

Championing Nutrition and Dietetics Practitioners in Roles of Leadership in Public Health
HOD Backgrounder

House of Delegates *Fall 2017*

Introduction
Nutrition and dietetics practitioners must be well-equipped to pursue higher level positions and lead organizations to create a culture of health promotion and disease prevention in the public health arena. The mega issue of Public Health was discussed during the fall 2012 HOD meeting. Dialogues during the fall 2003, spring 2010, and fall 2014 HOD meetings focused on applying leadership and management skills in all areas of practice. In addition, the attributes of leadership and management have been identified as fundamental skills and areas of improvement in almost every mega issue discussion. The Academy and its organizational units over the years have created resources and learning opportunities for nutrition and dietetics practitioners to hone in on these skills. This backgrounder is not intended to review past mega issue discussions, but to set the stage for the conversation moving forward.

In order to promote health and disease prevention and meet public health practice needs in the next 3-5 years, nutrition and dietetic practitioners must be in leadership positions to sustain national policy efforts. Now is the time to move beyond the leadership conversation to capitalize on the opportunities to serve in and advocate for influential positions. While elected local, state, and federal legislators are public health influencers, the current dialogue will focus on other roles in organizations, institutions, and government.

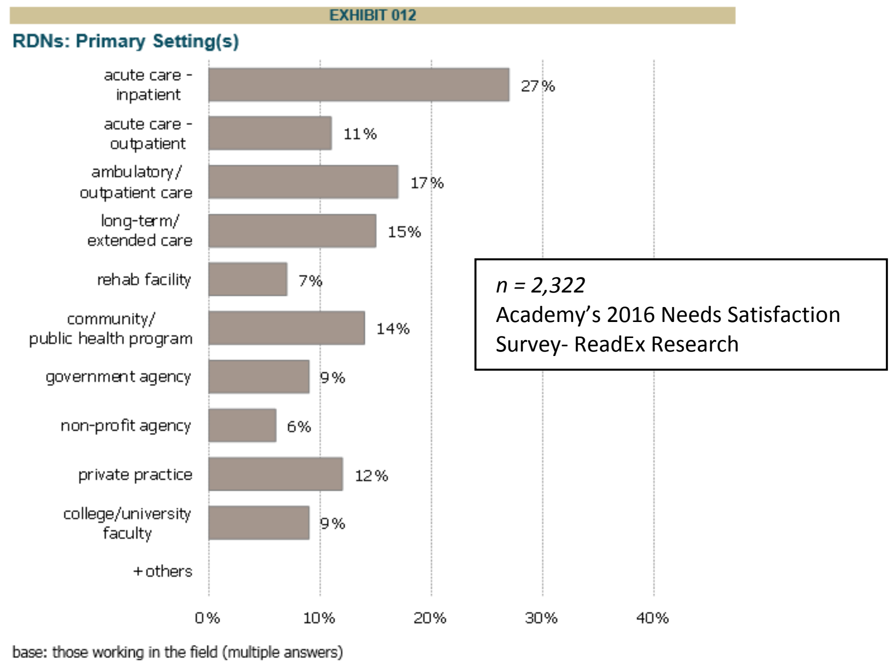
Public Health Nutrition
Public health nutrition is the application of nutrition and public health principles to design programs, systems, policies, and environments that aim to improve or maintain the optimal health of populations and targeted groups.

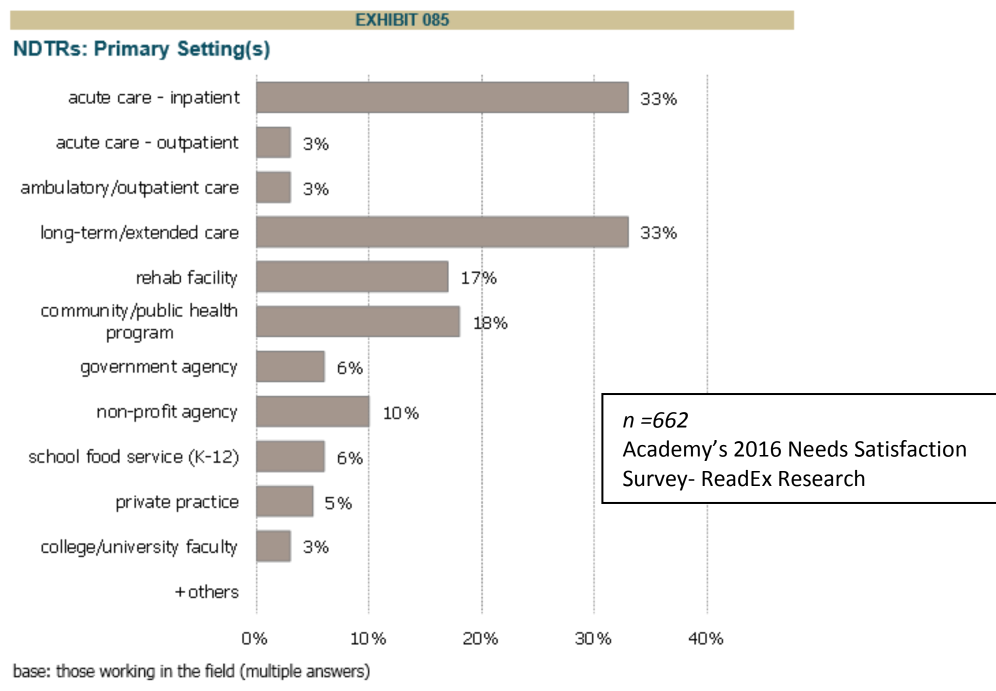
Mega Issue Question:
How can nutrition and dietetics practitioners secure influential public health positions in institutions, organizations, and government bodies?

Meeting Objectives:
Participants will be able to:
1. Understand the relevance of public health leadership roles to the profession.
2. Recognize themes or significant trends among leaders that facilitated their rise to public health leadership.
3. Stimulate discussions on what systems, structures, and collaborations must be in place to help nutrition and dietetics practitioners pursue this high level of leadership.
4. Identify key action steps nutrition and dietetics practitioners can take to:
   a. prepare for and pursue public health leadership positions
   b. advocate for current and future opportunities.

Question #1:
What do we know about the current realities and evolving dynamics of our members, marketplace, industry, and the profession that is relevant to this decision?

According to the *Academy's 2016 Needs Satisfaction Survey* (1), when asked to indicate all of the practice areas in which RDNs and NDTRs spend at least 20% of their time, the results were as follows [Exhibits 012 and 085]:





Who are Dietetics Practitioners?

Demographics from the *2015 Compensation and Benefits Survey* (2).

- **Sex:** 95% of practitioners are female.
- **Age:** Median age is 49 years; 35% are 55 or older, and 21% are under 35.
- **Race:** 4% indicated they are of Hispanic heritage; 9% indicated a race other than White (4% Asian, 4% Black/African American, and 1% other).
- **Education:** 48% of practicing RDNs hold master's degrees, and 4% doctoral degrees, as their highest level of attainment. Among practicing NDTRs, 43% hold a bachelor's degree or higher.

Work Setting-Community/Public Health Focus

From the responses of the *Academy's 2016 Needs Satisfaction Survey* (1) and *the 2015 Compensation and Benefits Survey* (2), between 7-14% of RDNs and 10-18% of NDTRs note they work in community and public health. However, nutrition and dietetics practitioners in other work settings could be working in public health areas.

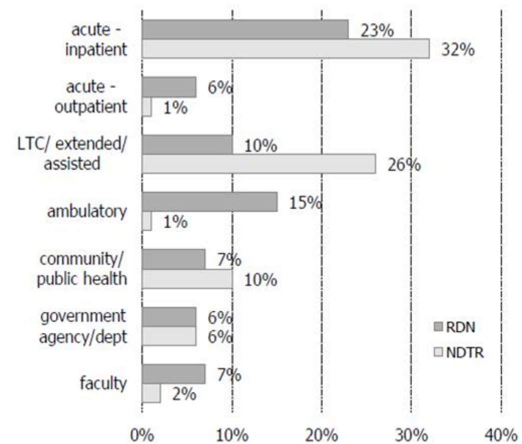
- 83 of the 119 public health respondents noted working in the government sector.

What Responsibilities Do Dietetics Practitioners Have?

According to the *2015 Compensation and Benefits Survey* (2):

- 24% percent of RDNs and 18% of NDTRs hold executive, director, or management positions
    - 2% RDNs are at the executive level
- 17% of RDNs and 21% of NDTRs are supervisors or coordinators.

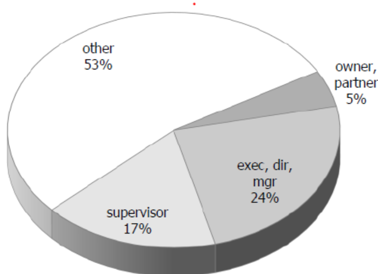
Exhibit 2.8
Work Setting - Top Mentions



base: 4,555 practicing RDNs, 636 practicing NDTRs

2015 Compensation and Benefits Survey

Exhibit 2.13
Responsibility Level



base: 5,229 practitioners
See Exhibit 7.22 for supporting data

Both graphics from the 2015 Compensation and Benefits Survey

Exhibit 7.22
Responsibility Level
What is this position's responsibility level?

	ALL RESPONDENTS	REGISTRATION STATUS			PRACTITIONERS	REGISTRATION STATUS			not currently in dietetics
	total	RDN	NDTR	not	total	RDN	NDTR	not	
base: practitioners*	5229 100%	4555 100%	636 100%	38 100%	5229 100%	4555 100%	636 100%	38 100%	
owner or partner	260 5%	245 5%	11 2%	4 11%	260 5%	245 5%	11 2%	4 11%	
executive	79 2%	77 2%	1 0%	1 3%	79 2%	77 2%	1 0%	1 3%	
director or manager	1138 22%	1010 22%	117 18%	11 29%	1138 22%	1010 22%	117 18%	11 29%	
supervisor or coordinator	911 17%	771 17%	132 21%	8 21%	911 17%	771 17%	132 21%	8 21%	
other	2772 53%	2394 53%	365 57%	13 34%	2772 53%	2394 53%	365 57%	13 34%	
no answer	69 1%	58 1%	10 2%	1 3%	69 1%	58 1%	10 2%	1 3%	

* "practitioners" excludes those not currently in dietetics

Public Health Responsibilities

- 23 of the 119 (19%) respondents reported responsibilities as a director, manager, or higher.
- 92 of 119 (77%) respondents reported responsibilities as a supervisor, coordinator, or staff.

Years of Experience

The typical (median) RDN practitioner has 19 years of work experience in dietetics/nutrition (excluding time taken off to return to school, raise a family, or work in other areas); the typical NDTR practitioner has 18 years of experience.

- When looking at public health as a practice area, 59 of the 119 respondents (50%) have been in the field 20+ years and 54 of the respondents reported being in their position for 10+ years (2).

Compensation

As in past surveys, factors showing the strongest association with compensation levels include number of years of experience, level of supervisory responsibility, budget responsibility, and practice area: clinical and community positions tend to pay less, whereas business, management, education, and research positions pay more (2).

Trends in the Profession and Workforce

Data from the *2015 Compensation and Benefits Survey* indicated over one-third of respondents were 55 or older (2) and based upon historical workforce data, the anticipated attrition rate of 2% to 5% will impact the future supply of nutrition and dietetics practitioners (3).

- The *Workforce Demand Study* also noted the demand for nutrition and dietetics services is predicted to increase due to health care reform and the expansion of health care services to an additional 30 million people (3).
- Without an adequate supply of credentialed nutrition and dietetics practitioners, the competitive space for RDNs and NDTRs may be challenged (4).
- Leadership positions, particularly those within government and government-sponsored organizations, are being threatened through position elimination or the hiring of non-nutrition professionals related to cultural competence, aging workforce, health care, and personnel costs (5).
- Furthermore, current discussions within the national political arena around changes to the Affordable Care Act (ACA) may impact these previous projections in ways we cannot yet anticipate.

The Council on Future Practice's (CFP) *Visioning Report 2017: A Preferred Path Forward for the Nutrition and Dietetics Profession* (6) identified change drivers recognizing opportunities for the dietetics practitioner now and in the future. The recommendations within the report are not meant to be all-inclusive, but rather specific, actionable items that can be pursued in the next 10-15 years to advance the profession. The table below lists the change drivers that have leadership and public health components. The full list can be found in **Appendix A**.

Select Change Drivers from the CFP *Visioning Report 2017: A Preferred Path Forward for the Nutrition and Dietetics Profession* (6)	
Change Drivers	**Associated Trends**
Aging Population Dramatically Impacts Society	• Increasing rates of obesity and chronic diseases among older adults dramatically impact the health care system and the economic burden of disease. • Demand for health care services is increasing dramatically although fewer funds are available to cover the cost. • Disease prevention and health maintenance for the aging population are increasingly the focus to improve quality of life and care and contain costs. • An aging workforce impacts the economy, businesses, families, and health professions.
Embracing America's Diversity	• Community health workers and other lay educators will continue to be used to reduce health disparities and as a solution to the lack of diversity in the health care workforce. • As the U.S. population grows more diverse, stark differences between what health providers intend to convey in written and oral communications and what patients understand may increase and further exacerbate health disparities. • Health equity is an increasingly important public health priority because of evolving U.S. racial and ethnic demographics.
Consumer Awareness of Food Choice Ramifications Increases	• Agricultural challenges and rapidly changing technology present entrepreneurial opportunities as food companies seek innovative ways to meet consumer demand for healthy foods and demonstrate their social responsibility. • Siloed approaches to agriculture, health, sustainability, and economics are being abandoned for transdisciplinary solutions to reduce hunger, poverty, disease, and environmental destruction. • There is a growing interdependence of countries around the world in sustaining the planet's national resources. • Consumers demand increasing levels of food transparency to meet their health, social justice, and environmental stewardship aspirations.
Population Health and Health Promotion Become Priorities	• Evidence-based and multifactorial interventions that access levels of influence at the policy, systems, and environmental level of the social ecological framework are essential to address population health priorities. • Institutions, organizations, and governments are increasingly striving for policy changes that are informed by research, help create a culture of health, and make healthy choices the easy choices. • The ACA paves the way for tremendous growth and unprecedented opportunities in workplace health promotion and disease prevention interventions. • Hospitals redefine their roles in the continuum of health care services and become immersed in the daily culture of the communities they serve.

Creating Collaborative-Ready Health Professionals	• Transdisciplinary professionalism is becoming an essential ideology for a 21st century health care system. • Interprofessional education (IPE) is an increasingly essential strategy for preparing the health care workforce for a patient-centered, coordinated, and effective health care system. • A resurgence of interest in IPE has occurred with the goal of team-based care becoming the norm in health care. • Many difficulties and challenges exist to the successful implementation of IPE, but innovative approaches can help overcome some of the challenges.
Food Becomes Medicine in the Continuum of Health	• Innovations by food and nutrition-related industries are capitalizing on consumer's growing passion for nutrition and health. • Unprecedented opportunities to lead preventive aspects of health arise from health care reform and emerging models of health care. • Nutrition and MNT are poised for primetime with the high prevalence of obesity and its related diseases.

Public Health Employment Trends

A 2012 systematic review suggested that the U.S. public health workforce is facing several urgent priorities (7):

- developing an ethnically/racially diverse workforce for a diverse nation
- recruiting and retaining highly trained, well-prepared employees, as well as succession planning
- building public health workforce infrastructure while also recognizing the continued shortage of public health workers
- ensuring job satisfaction including competitive salaries, career advancement, and strong organizational cultures.

Public health promotes and protects the health of people and the communities where they live, learn, work, and play--American Public Health Association

Studies have identified that balancing workforce management, and recruitment and retention initiatives, against anticipated retirements in public health may present challenges (5). A 2009 study found retirement rates for nutrition and dietetics practitioners in public health may be similar to the overall public health workforce (8). With a societal shift toward health promotion and disease prevention, and an aging workforce, nutrition and dietetics practitioners need to be positioned to qualify for these leadership roles.

Question #2:
What do we know about the needs, wants, and expectations of members, customers, and other stakeholders related to this issue?

Expectations of RDNs and NDTRs

The themes most frequently tallied regarding major challenges to the profession from the *Academy's 2016 Needs Satisfaction Survey* (1) are familiar ones from prior surveys: gaining respect from the medical profession and from the public; competition from "nutritionists" and other non-credentialed people; information found on the Internet or in the media; compensation; and getting reimbursement.

Expectations of Stakeholders

The Accreditation Council for Education in Nutrition and Dietetics (ACEND) interviewed stakeholders representing healthcare administration (pharmacy, nursing), deans of allied health colleges, employers of less traditional roles (communications, marketing, and management), physicians, educators in allied health graduate programs, and researchers regarding their needs with employment of current and future practitioners (9). There is an increased focus on disease prevention and integrative healthcare; and the need for more knowledge in emerging areas such as genomics, telehealth, behavioral counseling, diet order writing, and informatics.

Below are the themes, several of which are also vital to the role of the RDN and NDTR in public health (9):

- Health care professionals will work more interprofessionally.
- Employers indicated the need for improved communication skills in nutrition and dietetics practitioners and an improved ability to understand the patient's community and cultural ecosystem.
- Practitioners need to be able to read and apply scientific knowledge and interpret this knowledge for the public. Employers also expressed a desire for stronger organizational leadership, project management, communication, patient assessment, and practice skills.
- Many of the stakeholders identified gaps in current competencies in areas of research, communication, leadership/management skills, cultural care, interprofessional work, basic food and culinary preparation, and sustainability.
- Employers indicated that more time might be needed in the preparation of future nutrition and dietetics practitioners to assure application of knowledge and demonstration of skills needed for effective practice.
- Stakeholders identified the importance of associate and bachelor's level prepared graduates for roles in community health, wellness, and management.
- Employers identified the need for preparing undergraduates with transferable skills in leadership, business, and management; and they expressed the need for faculty prepared at the doctoral level.

Integration of Public Health and Primary Care

An effort has been made to integrate public health and clinical care. The Health Resources and Services Administration's (HRSA's) top priorities match many of the trends identified through the profession's environmental scans (10).

- Health Equity
- Public Health and Primary Care
- Research, Evaluation, and Data
- Workforce
- Collaboration

Allied health professions have worked to integrate public health and primary care. A 2015 position statement from the American Academy of Family Physicians encouraged members to become informed about the importance, the value, and the movement for integration of primary care and public health (11). Additionally, the call urged all national, state, federal, and private sector institutions to partner with primary care and public health partners to ensure a more integrated delivery system is provided to improve population health (11). Current and future nutrition and dietetics practitioners not only need to be aware of the areas of integration, but must be willing to expand skills and boundaries to meet the needs of society and the profession.

Question #3:
What do we know about the capacity and strategic position of the Academy in terms of its ability to address this issue?

Academy Vision (12)
A world where all people thrive through the transformative power of food and nutrition
Academy Mission (12)
Accelerate improvements in global health and well-being through food and nutrition

Principle Directly Related to the Current Mega Issue and Workforce Capacity and Capability
***Amplify** the contribution of nutrition practitioners and **expand** workforce capacity and capability.*

Strategic Planning

- The Academy Board of Directors is finalizing a new Strategic Plan that includes three areas where the Academy will focus efforts to accelerate progress towards achieving the vision and mission:
  - Prevention and Well-being
  - Health Care and Health Systems
  - Food and Nutrition Safety and Security

  **The new strategic plan will be unveiled during the 2017 Food & Nutrition Conference & Expo™ (FNCE®).*

As the mission and vision align closely with public health goals, so will the programs and projects that drive the work of the Academy in the future.

Alliances
The Academy of Nutrition and Dietetics forms alliances with other organizations for special projects and to participate in coalitions with shared goals and objectives. A list of current Academy alliances can be viewed on the Academy's website at: http://www.eatrightpro.org/resources/about-us/alliances-and-collaborations/other-academy-alliances. In addition, the Dietetic Practice Groups (DPGs), the Policy Initiatives and Advocacy team, the Quality Management team, and other Academy teams also have formal relationships with external organizations and workgroups. As the new strategic plan advances, the Academy will continue to expand these relationships to meet our shared goals.

Advocacy and Public Policy Efforts
Advocacy within the Academy involves member leaders on the Legislative and Public Policy Committee and the Academy of Nutrition and Dietetics Political Action Committee; Affiliates, Dietetic Practice Groups and Member Interest Groups; and thousands of grassroots members. Academy members work on a broad range of issues, improving America's nutrition and health status. The health of our nation is influenced by public health policies and by policies in many other sectors (13). Public policy decisions impact resources, and affect every area of the profession from funding of programs to reimbursement of services and beyond.

The Academy has identified the following evidence-based priority areas in public policy (14):

- **Disease prevention and treatment,** including cancer, cardiovascular health, diabetes and pre-diabetes, HIV/AIDS, obesity and weight, and access to healthcare.
- **Lifecycle nutrition,** including prenatal and maternal health, early childhood nutrition, and nutrition for school-age students as well as older adults.
- **Healthy food systems and access**, including food security, supply and management of food systems, food safety, dietary supplements and food fortification, food and menu labeling, and nutrition education.
- **Quality healthcare,** including healthcare equity, consumer protection and licensure, workforce demand, research and monitoring, lowering healthcare costs, and quality measures.

The Committee for Public Health/Community Nutrition

The Committee for Public Health/Community Nutrition (CPHCN) promotes public health and community nutrition to internal and external partners, the public, the profession, and the Academy (15). While early efforts have been focused on food security, the committee is also tasked with:

- keeping members aware of public health and community nutrition's accomplishments, relevance, and impact
- providing a formal mechanism to integrate a public health and community nutrition perspective in all Academy initiatives and activities
- representing the Academy's interests in public health and community nutrition when working with external partners.

The committee's work and resources can be found at: http://www.eatrightpro.org/resource/leadership/volunteering/committees-and-task-forces/public-health-community-nutrition-committee

The Public Health/Community Nutrition Practice Group

The Public Health/Community Nutrition Practice Group (PHCNPG) offers networking, continuing professional education, resources, and volunteer opportunities. Their members work in partnership with health professionals, community leaders, and other key stakeholders to serve the public through the promotion of optimal nutrition, health, and well-being.

- **Vision:** *Optimizing the population's health through the application of public health nutrition and community nutrition principles and interventions*
- **Mission:** *Empowering members to be leaders in the practice of public health nutrition and community*

PHCNPG's work and resources can be found at: http://www.phcnpg.org/page/resources.

Continuing Professional Education

As a result of the spring 2010 HOD Mega Issue dialogue on Management and Leadership across Practice, the *Center for Lifelong Learning* created three online certificate of training programs:

- Developing Your Role as a Leader (Level 1)
- Advancing Your Role as a Leader (Level 2)
- Executive Management (Level 2)

These resources can be found at: http://www.eatrightpro.org/resource/career/professional-development/distance-learning/online-learning. In addition, a new Level 3 Advanced Practice track in Leadership will be held as a part of FNCE® 2017 to provide additional high-level leadership training.

New Online Certificate of Training Program: Public Health Nutrition
The newly launched Level 2 program consists of five modules covering the foundations of public health nutrition, including developing, implementing, and evaluating a public health nutrition plan, and more. The program was developed by the Academy's Center for Lifelong Learning and planned with the Association of State Public Health Nutritionists, Committee for Public Health/Community Nutrition, and the Public Health and Community Nutrition Dietetic Practice Group. The program can be found at: http://www.eatrightstore.org/collections/public-health-nutrition.

Academy Foundation Public Health Activities

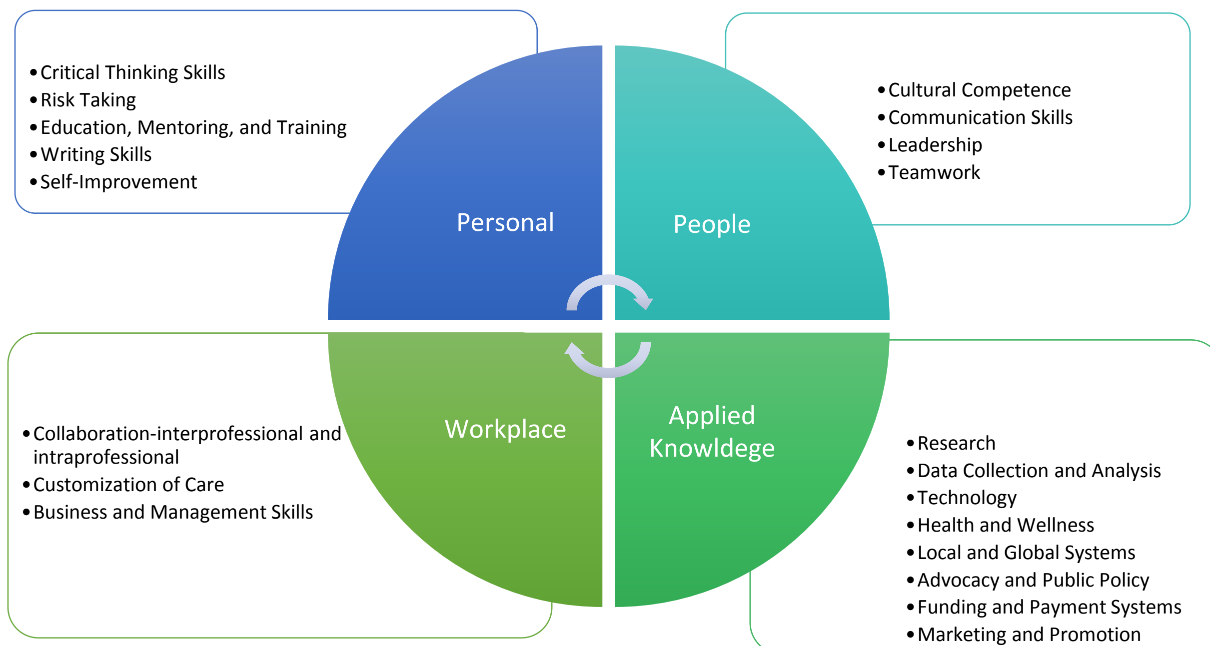
- *Kids Eat Right*
  A consumer website, www.kidseatright.org, which is filled with age-appropriate, Academy-approved tips, articles, recipes, and videos to help families shop smart, cook healthy and eat right.
- *Feeding America*
  The Foundation has completed several collaborative projects with Feeding America since 2012. The Foundation is entering its third year of evaluating the Healthy Cities program, which aims to deliver four critical services for children facing food insecurity (nutritious food, nutrition education, health screenings, and safe places to play) to create opportunities for optimal physical and cognitive development. The 2015-2016 program was implemented through food banks with community partners in Cleveland, Houston and New Orleans.
- *Meet the Challenge*
  Since 2012, the Foundation and the Iowa Department of Education have collaborated on the Meet the Challenge program to implement RD Coach expertise to over 100 schools in Iowa to assist in applying for USDA's HealthierUS School Challenge awards.
- *Hunger Free Communities*
  Through support from the General Mills Foundation, a fellow was selected who collaborated with food security, nutrition, and health economics experts from around the world to develop and validate:
  - a food and nutrition security community assessment facilitator guide tailored for existing data and community characteristics
  - a decision process that allows communities to consider financial, impact, and uncertainty criteria to rank a list of potential food and nutrition interventions
  - food and nutrition security assessment tool recommendations
  - an infrastructure assessment for communities to collect data and evaluate impact with the Academy of Nutrition and Dietetics' Health Informatics Infrastructure (ANDHII) platform.
- *Gardens for Health International Fellowship*
  Gardens for Health International (GFHI) is a non-profit organization whose innovative approach works to bridge the gap between health and agriculture. Based in Rwanda with an office in Boston, their core program works to integrate agricultural support and comprehensive health education into the clinical treatment of malnutrition. GFHI works in partnership with 18 health centers in two districts of Rwanda.
  - Through the support of the Foundation Nutrition Education for the Public and Research Endowment funds, a fellow was tasked with developing and overseeing the implementation of a unique antenatal care program (ANC) to improve nutritional outcomes for women and infants in a targeted village in Rwanda.

Future Practice

The mega issue for spring 2017 was Future Practice. As a result of the dialogue, an All-Member Call to Action for Future Practice (16) was released to help members capitalize on skills needed to advance future practice. Many of these are the same areas that are needed to advance public health.

All-Member Call to Action for Future Practice

The House of Delegates challenges all existing and new credentialed nutrition and dietetics practitioners, in all areas of practice, to take action to elevate and expand their competencies in the following areas to achieve the desired vision of future practice.



All credentialed nutrition and dietetics practitioners will develop strategies to create and achieve a future vision that will better meet the needs of clients, customers, the profession, and society of the future by (16):

i. Using the Second Century Initiative and the Council on Future Practice's *Visioning Report 2017: Preferred Path Forward for the Nutrition and Dietetics Profession* to imagine and create the future of nutrition and dietetics.

ii. Expanding leadership skills, collaborative skills, and communication skills by utilizing current programs; and by creating new educational opportunities through collaboration with Academy groups (such as Affiliates, DPGs, MIGs) and external stakeholders.

iii. Taking personal action to gain new skills, knowledge, and education as life-long learners.

iv. Being assertive and visionary leaders of the profession of nutrition and dietetics by having the strength, confidence, and courage to be risk-takers.

Other Resources

- A dedicated page to public health resources on the Academy's website at: http://www.eatrightpro.org/resources/practice/practice-resources/public-health-and-community.
- For additional information on public health, leadership, or management, review past HOD backgrounders at: https://www.eatrightpro.org/resource/leadership/house-of-delegates/mega-issues-and-backgrounders/archived-mega-issue-backgrounders.

Standards of Practice and Standards of Professional Performance for the RDN in Public Health and Community Nutrition

The Public Health/Community Nutrition Dietetic Practice Group of the Academy of Nutrition and Dietetics, under the guidance of the Academy Quality Management Committee, has developed Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition (17). The individuals that would be creating and/or filling higher level roles in the public health arena would be at the expert level, but it is vital that nutrition and dietetics practitioners advance along the continuum (18) so they are prepared to step into these roles.

The expert practitioner exhibits a set of characteristics that include **leadership and vision, and demonstrates effectiveness in planning, achieving, evaluating, and communicating targeted outcomes.** An expert practitioner may have an expanded or specialist role or both, and may possess an advanced credential, if available, in a focus area of practice (17). Generally, the practice is more complex and the practitioner has a high degree of professional autonomy and responsibility.

Review Appendix B-Academy of Nutrition and Dietetics: Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Public Health and Community Nutrition

Figures 1 and 2 relates to levels of practice and career progression in Public Health and Community Nutrition
http://jandonline.org/article/S2212-2672(15)01108-9/fulltext

Review Appendix C- Nutrition and Dietetics Career Development Guide
https://www.eatrightpro.org/resource/career/career-development/career-toolbox/dietetics-career-development-guide

Below are examples of ways in which practitioners are using the Academy of Nutrition and Dietetics: Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Public Health and Community Nutrition across different practice areas (17).

Role	***Examples of use of the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) documents by registered dietitian nutritionists (RDNs) in different practice roles***
Clinical practitioner	An RDN with responsibility for the nutrition component of the hospital's community education program uses the SOP and SOPP for RDNs in Public Health and Community Nutrition (PHCN) as a resource for personal development to improve competence in providing services to individuals participating in classes for the community and outreach activities. This RDN networks with a community and public health RDN for mentoring on preventative program content, leads to continuing education programs, and resources.
Clinical nutrition manager	A hospital's clinical nutrition manager (CNM) represents the hospital on a community coalition workgroup addressing access to healthy food. The CNM meets with public health RDNs to increase knowledge in PHCN, nutrition surveillance for the community, food assistance programs, food access, and best practices in policies, systems, and environmental change interventions. In reviewing the PHCN SOP SOPP, the CNM notes the use of logic models to plan nutrition programs and interventions that may have application in the hospital and seeks additional training.
Food and nutrition services manger	A food and nutrition manager obtains a contract to provide congregate and home delivered meals to a local senior center. The contract includes having staff RDNs oversee menu planning, complying with regulations, and providing nutrition education at the meal site. The PHCN SOP SOPP were reviewed to evaluate competency level on topics, such as cultural competency, senior feeding programs, engagement of the target population in the planning and delivery of services, and additional funding for programming.
Retail RDN	An RDN working for a grocery chain in the community reports receiving more requests to participate in community initiatives to increase healthy food access, such as working with sustainable, local agriculture,[26] in community gardens, and improving the healthfulness of foods donated to food banks. The RDN reviews the SOP and SOPP to identify ways to gain more knowledge and skills to increase effectiveness in responding to these requests. The retail RDN partners with PHCN RDNs to identify sources of continuing education and resources to help with addressing needs of target populations.
Public health practitioner, community nutrition practitioner	An RDN working in public health and community nutrition programs or in policy, system, and environmental approaches develops and designs population approaches in alignment with the SOP and SOPP to standardize quality improvement methods and maximize public health and community nutrition program and policy outcomes. The RDN wants to become more active in advocating for changes in regulations related to nutrition and uses the SOP and SOPP to create a professional development plan to address gaps in competencies.
Researcher	A research RDN works with a state education department to assess changes in student food intake as a result of new federal meal guidelines. The RDN uses the SOP and SOPP as a resource in designing the research protocol and evaluation methodology using current evidence-based knowledge tools as it relates to school foodservice and disparities in food intake across grade and free/reduced-price lunch status. The SOP and SOPP may also be used for identifying the need for staff development and/or collaboration with a colleague more experienced in public health and community nutrition school nutrition research.
Nutrition educator	An RDN working in nutrition education with a food bank reviews the SOP and SOPP for ideas on expanding knowledge and skills to qualify for leadership roles with nonprofit organizations serving individuals with food insecurity. Using the indicators in the SOP SOPP, the RDN identifies knowledge and skills to develop, revises professional development plan, and seeks mentorship to advance his or her career

Figure 7. Case examples of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Public Health and Community Nutrition.

The change drivers from the CFP *Visioning Report 2017: A Preferred Path Forward for the Nutrition and Dietetics Profession,* along with the All-Member Call to Action for Future Practice, and the Academy's mission and vision pave a path for practitioners to capitalize on the opportunities and serve in influential positions in public health. In addition the SOP/SOPPs can provide insights for nutrition and dietetics practitioners on what they need to do to practice at the expert level in public health nutrition.

Question #4:
What ethical/legal implications, if any, surround this issue?

The Academy of Nutrition and Dietetics/Commission on Dietetic Registration Code of Ethics (19) guides RDNs and NDTRs in their professional practice and conduct.

Legal Implications
The RDN or NDTR must operate within the directives of applicable federal and state laws and regulations, as well as policies and procedures established by the organization in which they are employed (20, 21).
The RDN or NDTR manager must be aware of and understand all potential legal risks associated with:

- contract negotiations
- human resource management
- business communications
- marketing and promotion
- confidentiality requirements
- compliance with regulations and standards
- survey readiness
- quality assurance and performance improvement
- customer service and customer satisfaction.

The RDN or NDTR manager is accountable for ensuring their area or department meets all regulations and standards and is responsible for the actions of his or her subordinates.

Conclusion
The Academy and its members have laid the foundation to help nutrition and dietetics practitioners meet the needs of a changing society to create and fill influential public health positions. Nutrition and dietetics practitioners are strategically positioned to positively influence the existence of career ladders and high-level opportunities for RDNs and NDTRs in public health. Once again, it is time to move beyond the leadership conversation to capitalize on the opportunities to serve in and advocate for influential positions.

Reference List

1. Academy of Nutrition and Dietetics 2016 Needs Satisfaction Survey. *ReadEx Research.*
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CFP *Visioning Report 2017: A Preferred Path Forward for the Nutrition and Dietetics Profession Change Drivers*	
Change Drivers	**Associated Trends**
Aging Population Dramatically Impacts Society	• Increasing rates of obesity and chronic diseases among older adults dramatically impact the health care system and the economic burden of disease. • Demand for health care services is increasing dramatically although fewer funds are available to cover the cost. • Disease prevention and health maintenance for the aging population are increasingly the focus to improve quality of life and care and contain costs. • An aging workforce impacts the economy, businesses, families, and health professions.
Embracing America's Diversity	• Community health workers and other lay educators will continue to be used to reduce health disparities and as a solution to the lack of diversity in the health care workforce. • As the U.S. population grows more diverse, stark differences between what health providers intend to convey in written and oral communications and what patients understand may increase and further exacerbate health disparities. • Health equity is an increasingly important public health priority because of evolving U.S. racial and ethnic demographics.
Consumer Awareness of Food Choice Ramifications Increases	• Agricultural challenges and rapidly changing technology present entrepreneurial opportunities as food companies seek innovative ways to meet consumer demand for healthy foods and demonstrate their social responsibility. • Siloed approaches to agriculture, health, sustainability, and economics are being abandoned for transdisciplinary solutions to reduce hunger, poverty, disease, and environmental destruction. • There is a growing interdependence of countries around the world in sustaining the planet's national resources. • Consumers demand increasing levels of food transparency to meet their health, social justice, and environmental stewardship aspirations.
Tailored Healthcare to Fit my Genes	• Advances in research and increased demand for personalized health and nutrition result in increased availability and decreased costs of genetic testing. • Health professionals increasingly manage patient care using genetic profiles but the science of genetics must continue to advance to inform practice.
Population Health and Health Promotion Become Priorities	• Evidence-based and multifactorial interventions that access levels of influence at the policy, systems and environmental level of the social ecological framework are essential to address population health priorities. • Institutions, organizations and governments are increasingly striving for policy changes that are informed by research, help create a culture of health, and make healthy choices the easy choices. • The ACA paves the way for tremendous growth and unprecedented opportunities in workplace health promotion and disease prevention interventions. • Hospitals redefine their roles in the continuum of health care services and become immersed in the daily culture of the communities they serve.

Creating Collaborative-Ready Health Professionals	• Transdisciplinary professionalism is becoming an essential ideology for a 21st century health care system. • Interprofessional education (IPE) is an increasingly essential strategy for preparing the health care workforce for a patient-centered, coordinated and effective health care system. • A resurgence of interest in IPE has occurred with the goal of team-based care becoming the norm in health care. • Many difficulties and challenges exist to the successful implementation of IPE but innovative approaches can help overcome some of the challenges.
Food Becomes Medicine in the Continuum of Health	• Innovations by food and nutrition-related industries are capitalizing on consumer's growing passion for nutrition and health. • Unprecedented opportunities to lead preventive aspects of health arise from health care reform and emerging models of health care. • Nutrition and MNT are poised for primetime with the high prevalence of obesity and its related diseases.
Technological Obsolescence is Accelerating	• Innovative digital technologies personalize, revolutionize and increase access to health care. • Technological applications, economics and student demands disrupt traditional educational institutions. • Technological advances impact work settings and change how, when and where people work. • The digital age is transforming next generation food systems.
Simulations Stimulate Strong Skills	• Simulations help address increased complexity of health care, higher patient acuity levels and patient safety. • Accountability of care, pay for performance and financial penalties for provider errors spur interest in simulations. • The use of simulations increases in response to cost-cutting in higher education and reduction in the availability of clinical placements for students. • The desire to improve critical thinking skills of learners drives the development and use of simulations.

Figure 2. Ten priority change drivers and their associated trends for the Council on Future Practice's 2014-2017 Visioning Cycle.

Source: CFP *Visioning Report 2017: A Preferred Path Forward for the Nutrition and Dietetics Profession*

The full paper can be found at: http://jandonline.org/article/S2212-2672(16)31194-7/fulltext

Academy of Nutrition and Dietetics: Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Public Health and Community Nutrition

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ABSTRACT

The need and demand for population-level disease prevention has increased, especially with the passage of the Affordable Care Act, a worldwide increase in obesity and chronic disease, and a global emphasis on preventative health care that includes behavioral, environmental, and policy interventions. In response to these evolving needs, the Public Health and Community Nutrition Dietetic Practice Group, with guidance from the Academy of Nutrition and Dietetics Quality Management Committee, has developed Standards of Practice and Standards of Professional Performance as tools for registered dietitian nutritionists (RDNs) currently in practice or interested in working in public health and community nutrition, to assess their current skill levels and to identify areas for professional development. The Standards of Practice address the four steps of the Nutrition Care Process for community and public health RDNs, which are assessment, diagnosis, intervention, and evaluation/monitoring. The Standards of Professional Performance consist of the following six domains of professional performance for community and public health RDNs: 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 the ways in which RDNs can address client and population nutrition and health. The indicators describe three skill levels (competent, proficient, and expert) for RDNs. These tools highlight the unique scope of expertise that RDNs provide to the field of public health and community nutrition.
J Acad Nutr Diet. 2015;115:1699-1709.

Editor's note: Figures 1 and 2 that accompany this article are available online at www.andjrnl.org.

THE PUBLIC HEALTH AND Community Nutrition Dietetic Practice Group of the Academy of Nutrition and Dietetics (Academy), under the guidance of the Academy Quality Management Committee, has developed Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. These documents build on the Academy of Nutrition and Dietetics Revised 2012 SOP in Nutrition Care and SOPP for RDs.[1] The Academy of Nutrition and Dietetics/Commission on Dietetic Registration's (CDR) Code of Ethics[2] and the Academy of Nutrition and Dietetics Revised 2012 SOP in Nutrition Care and SOPP for RDs[1] are tools within the Scope of Practice in Nutrition and Dietetics[3] and Scope of Practice for the RD[4] that guide the practice and performance of RDNs in all settings.

The scope of practice in nutrition and dietetics is composed of statutory and individual components, includes the 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

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http://dx.doi.org/10.1016/j.jand.2015.06.374
Available online 11 August 2015

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) instead. The two credentials have identical meanings. In this document, the expert working group has chosen to use the term RDN to refer to both registered dietitians and registered dietitian nutritionists.

Approved May 2015 by the Quality Management Committee of the Academy of Nutrition and Dietetics (Academy) and the Executive Committee of the Public Health and Community Dietetic Practice Group of the Academy. ***Scheduled review date: October 2019.*** *Questions regarding the Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists in Public Health and Community Nutrition may be addressed to Academy quality management staff: Sharon McCauley, MS, MBA, RDN, LDN, FADA, FAND, director, Quality Management, at quality@eatright.org.*

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the practice act and interpreted and controlled by the agency or board that regulates the practice of the profession in a given state.[3] An RDN's statutory scope of practice may delineate the services an RDN is authorized to perform in a state where a practice act or certification exists.

The RDN's individual scope of practice is determined by education, training, credentialing, and demonstrated and documented competence to practice. Individual scope of practice in nutrition and dietetics has flexible boundaries to capture the breadth of the individual's professional practice. The Scope of Practice Decision Tool, which is an online, interactive tool, permits an RDN to answer a series of questions to determine whether a particular activity is within his or her scope of practice. The tool is designed to assist an RDN in critically evaluating personal knowledge, skill, and demonstrated competence with criteria resources.[5]

With the passage of the Affordable Care Act, a worldwide increase in obesity and chronic disease, and a global emphasis on preventative health care that includes behavioral, environmental, and policy interventions, the demand for registered dietitian nutritionists (RDNs) with unique expertise in public health and community nutrition (PHCN) is increasing.[6-10] Public health and community RDNs work collaboratively across all sectors, including health, education, government, nonprofits, and industry, to understand the complex factors that impact population and individual health and to promote health equity and disease prevention for the populations with whom they work. They work in a variety of interdisciplinary settings to provide essential public health services,[11] such as assessment and diagnosis of population health problems, grant writing, creation, management and evaluation of intervention programs, generation of policy and research, and administration of nutrition education, counseling, and training to groups and individuals at all stages of prevention and across all stages of the life course.

About 11% of RDNs currently report that their primary practice area is community nutrition, but the demand for RDNs with expertise in PHCN is expected to dramatically increase in the near future.[12,13] To meet the recommended staffing ratio of one public health nutritionist per 50,000 people, there is an immediate need for a 113% increase in the workforce.[14-16] RDNs who focus on prevention and wellness are able to reduce health care expenditures, as prevention is often significantly less costly than treatment.[17]

OVERVIEW OF ACADEMY QUALITY AND PRACTICE RESOURCES

The Academy's Revised 2012 SOP in Nutrition Care and SOPP for RDs[1] reflect the minimum competent level of nutrition and dietetics practice and professional performance for RDNs. These standards serve as blueprints for the development of focus area SOP and SOPP for RDNs in competent, proficient, and expert levels of practice. The SOP in Nutrition Care is composed of four standards representing the four steps of the Nutrition Care Process (NCP) as applied to the care of patients/clients.[18] In PHCN, the NCP is used for interventions targeted to individual clients as well as to population groups. The SOPP consist of standards representing 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. The SOP and SOPP for RDNs are designed to promote the provision of safe, effective, and efficient food and nutrition services; facilitate evidence-based practice; and serve as a professional evaluation resource.

These focus area standards for RDNs in PHCN provide a guide for self-evaluation and expanding practice, a means of identifying areas for professional development, and a tool for demonstrating competence in delivering PHCN and dietetics services. They are used by RDNs to assess their current level of practice and to determine the education and training required to maintain currency in their focus area and advancement to a higher level of practice. In addition, the standards can be used to assist RDNs in transitioning their knowledge and skills to a new focus area of practice. Like the SOP in Nutrition Care and SOPP for RDs,[1] the indicators (ie, measureable action statements that illustrate how each standard can be applied in practice) (see Figures 1 and 2; available online at www.andjrnl.org) for the SOP and SOPP for RDNs in PHCN were developed with input and consensus of content experts representing diverse practice and geographic perspectives. The SOP and SOPP for RDNs in PHCN were reviewed and approved by the Executive Committee of the PHCN Dietetic Practice Group and the Academy Quality Management Committee.

THREE LEVELS OF PRACTICE

The Dreyfus model[19] identifies levels of proficiency (novice, advanced beginner, competent, proficient, and expert) (refer to Figure 3) during the acquisition and development of knowledge and skills. The first two levels are components of the required didactic education (novice) and supervised practice experience (advanced beginner) that precede credentialing for nutrition and dietetics practitioners. Upon successfully attaining the RDN, a practitioner enters professional practice at the competent level and manages his or her professional development to obtain individual professional goals. This model is helpful in understanding the levels of practice described in the SOP and SOPP for RDNs in Public Health and Community Nutrition. In Academy focus areas, the levels are represented as competent, proficient, and expert practice levels.

Competent Practitioner

In nutrition and dietetics, a competent practitioner is an RDN who is either just starting practice after having obtained RDN registration by CDR or an experienced RDN who has recently assumed responsibility to provide nutrition and dietetics services in a new focus area. A focus area is defined as an area of nutrition and dietetics practice that requires focused knowledge, skills, and experience.[20] A competent practitioner who has obtained RDN status and is starting in professional employment acquires additional on-the-job skills and engages in tailored continuing education to further enhance knowledge and skills obtained with formal education. An RDN starts with technical training and professional interaction for advancement and expanding breadth of competence. A general practice RDN

Standards of Practice are authoritative statements that describe practice demonstrated through nutrition assessment, nutrition diagnosis (problem identification), nutrition intervention (planning, implementation), and outcomes monitoring and evaluation (four separate standards) and the responsibilities for which registered dietitian nutritionists (RDNs) are accountable. The Standards of Practice for RDNs in Public Health and Community Nutrition presuppose that the RDN uses critical thinking skills; analytical abilities; theories; best-available research findings; current accepted nutrition, dietetics, and medical knowledge; and the systematic holistic approach of the nutrition care process as they relate to the application of the standards. Standards of Professional Performance for RDNs in Public Health and Community Nutrition are authoritative statements that describe behavior in the professional role, including activities related to Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources (six separate standards).

Standards of Practice and Standards of Professional Performance are evaluation resources with complementary sets of standards—both serve to describe the practice and professional performance of RDNs. All indicators may not be applicable to all RDNs' practice or to all practice settings and situations. RDNs operate within the directives of applicable federal and state laws and regulations, as well as policies and procedures established by the organization in which they are employed. To determine whether an activity is within the scope of practice of the RDN, the practitioner compares his or her knowledge, skill, and competence with the criteria necessary to perform the activity safely, ethically, legally, and appropriately. The Academy's Scope of Practice Decision Tool, which is an online, interactive tool, is specifically designed to assist practitioners with this process.

The term client/population *is used in the Standards of Practice as a universal term, as these Standards relate to direct provision of nutrition care and services provided to individual clients across the life course, as well as population groups.* Client/population *could also mean client/patient, resident, participant, consumer, student, stakeholder or any individual or group who receives public health and community nutrition care and services.* Client/population *is also used in the Standards of Professional Performance as a universal term. In public health and community nutrition, we also refer to populations and communities that we serve. Populations are groups of people found regionally, within states, nationally, or internationally. It is recognized that the family and caregiver(s) and community stakeholders of individual and populations of all ages, including individuals with special health care needs, play critical roles in overall health and are important members of the team throughout the assessment and intervention process. The term* appropriate *is used in the standards to mean: Selecting from a range of best practice or evidence-based possibilities, one or more of which would give an acceptable result in the circumstances.*

Each standard is equal in relevance and importance and includes a definition, a rationale statement, indicators, and examples of desired outcomes. A standard is a collection of specific outcome-focused statements against which a practitioner's performance can be assessed. The rationale statement describes the intent of the standard and defines its purpose and importance in greater detail. Indicators are measurable action statements that illustrate how each specific standard can be applied in practice. Indicators serve to identify the level of performance of competent practitioners and to encourage and recognize professional growth.

Standard definitions, rationale statements, core indicators, and examples of outcomes found in the Academy of Nutrition and Dietetics Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for RDs have been adapted to reflect three levels of practice (Competent, Proficient and Expert) for RDNs in Public Health and Community Nutrition (see figure below). In addition, the core indicators have been expanded to reflect the unique competence expectations for the RDN providing public health and community nutrition services.

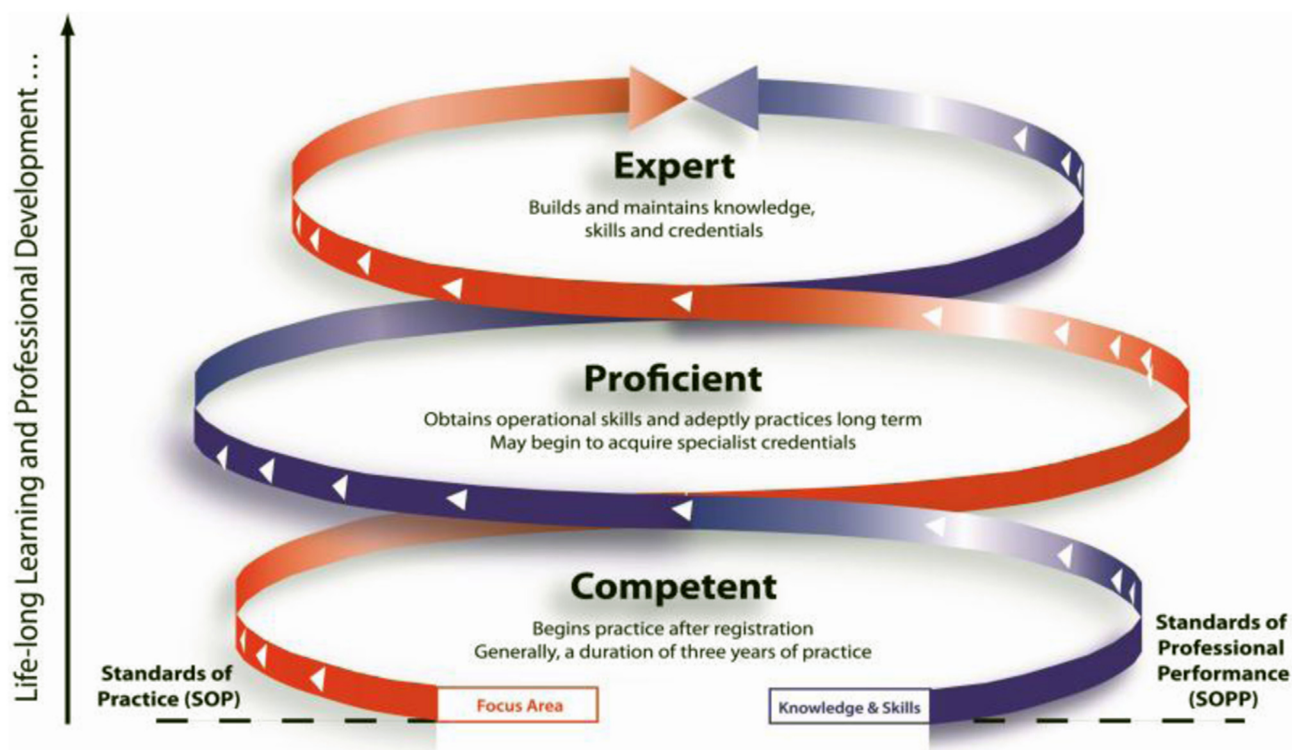

Figure 3. Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Public Health and Community Nutrition.

can include responsibilities across several areas of practice, including, but not limited to, community, clinical, consultation and business, research, education, and food and nutrition management.[20]

Proficient Practitioner

A proficient practitioner is an RDN who is generally 3 or more years beyond entry into the profession, who has obtained operational job performance skills, and is successful in the RDN's chosen focus area of practice.[20] The proficient practitioner demonstrates additional knowledge, skills, and experience in a focus area of nutrition and dietetics practice. An RDN may acquire specialist credentials, if available, to demonstrate proficiency in a focus area of practice.

Expert Practitioner

An expert practitioner is an RDN who is recognized within the profession and has mastered the highest degree of skill in, or knowledge of, a certain focus or generalized area of nutrition and dietetics through additional knowledge, experience, or training.[20] An expert practitioner exhibits a set of characteristics that include leadership and vision and demonstrates effectiveness in planning, achieving, evaluating, and communicating targeted outcomes. An expert practitioner may have an expanded or specialist role or both, and may possess an advanced credential, if available, in a focus area of practice. Generally, the practice is more complex and the practitioner has a high degree of professional autonomy and responsibility. The expert practitioner in PHCN tends to target population-level health.

These Standards, along with the Academy/CDR Code of Ethics,[2] answer the following questions: Why is an RDN uniquely qualified to provide PHCN services? What knowledge, skills, and competencies does an RDN need to demonstrate for the provision of safe, effective, and quality PHCN care and service at the competent, proficient, and expert levels?

OVERVIEW

PHCN is a diverse area of practice. Both public health and community RDNs improve nutritional health through culturally sensitive applications of health behavior theory across the lifespan, with a focus on reducing the prevalence of nutrition-related diseases and their complications through primary, secondary, and tertiary prevention interventions. As highlighted in the 2012 Academy House of Delegates Backgrounder,[16] public health RDNs combine expertise in nutrition and public health to focus on population assessment, program development and evaluation, policy generation, and systems and environmental change. Public health RDNs often need skills in biostatistics, epidemiology, program management, and policy development, in addition to classic nutrition expertise. Community RDNs provide counseling, education, and training to enhance the nutritional knowledge, attitudes, behaviors, and skills of individuals and groups in community-based settings.

Foundational models and health behavior theories for PHCN practice include the Socio-ecological Model, the Social Determinants of Health, Life Course Theory, and Community-Based Participatory Research approaches (Figure 4).

Public health RDNs work with partners across all sectors to accomplish identified priorities, as this is an important strategy to ensure that programs are effective and sustained when priorities shift or resources become more limited. They use participatory models, such as Community-Based Participatory Research (Figure 4), to engage stakeholders in making a sustainable and meaningful nutrition and health impact at every step of the NCP and across multiple socio-ecological levels as well as stages of the life course. It would not be unusual for a public health RDN to attend a city council meeting to provide nutrition and health justification for code improvements to create community gardens or for the strategic placement of grocery stores to improve food access. For example, public health RDNs and countless other stakeholders worked with Blue Cross Blue Shield, the Centers for Disease Control and Prevention, and the Minnesota Department of Health to create the Minnesota Food Charter (http://mnfoodcharter.com/), a statewide roadmap to provide access to safe, affordable, and healthy food.

Public health RDNs are also adept evaluators, as there is a constant need to demonstrate impact and outcomes in order to justify funding for the programs that they administer. Working at the population level is inherently different from individual-based programming. To illustrate how a public health RDN might adapt classic individual-based strategies for assessment, a sample Problem (P), Etiology (E), Signs/Symptoms (S) statement can be found in Figure 5.

Often, population-level public health nutrition programs are funded by the federal government and administered through state agencies, such as universities and departments of health, education, and/or aging. Descriptions of key federally funded programs can be found elsewhere, such as in *Mapping the World of Nutrition: An Overview of Federal Funding for Nutrition Programs*.[23] In addition, public health RDNs may receive funding support from, and work with, chronic disease prevention associations (eg, American Diabetes Association, American Heart Association, and American Cancer Society), insurance companies, private businesses, and nonprofit foundations to implement programs and interventions.

Community nutrition RDN practice involves working directly with individuals and families, while contributing to larger public health efforts to prevent and intervene upon nutrition-related problems. Community-based RDNs often use individual participant-centered counseling methods (eg, motivational interviewing) or broad approaches, such as social marketing, to promote and enhance changes in knowledge, attitudes, behavior, and health outcomes, while being sensitive to the systems and environments in which clients live. Community nutrition RDNs work with populations across the lifespan and have expertise in counseling, nutrition education, program development and administration, and management. Much like public health RDNs, community nutrition RDNs work across sectors to ensure care for their clients, often working closely with social service agencies and community health workers (promotoras) to support the delivery of services. For example, a community RDN may provide cooking classes in a senior center, or may train community health workers to implement the classes.

Model/theory	Brief description	Resources
Socio-ecological Model	Developed by McLeroy and colleagues, the Socio-ecological Model posits that there are interacting spheres of influence that impact a person's health behaviors and health. Those spheres include individual factors (eg, knowledge, beliefs, attitudes, skills, preferences); intrapersonal factors (eg, family and friends); institutional factors (eg, schools, churches workplaces); community/environmental factors (eg, neighborhoods); and societal factors (eg, laws, policy, social norms).[10,21]	Addressing Obesity Disparities: Social Ecological Model: http://www.cdc.gov/obesity/health_equity/addressingtheissue.html
Social Determinants of Health	An explanation of the social conditions (ie, economic stability, education, neighborhood, and built environment, health and health care, social and community context) and related underlying factors that influence people's disease.	Healthy People 2020: http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health World Health Organization: http://www.who.int/social_determinants/en/ Centers for Disease Control and Prevention: http://www.cdc.gov/socialdeterminants/
Life Course Theory	A framework that describes how health outcomes in each life stage are influenced by the long-term effects of exposures during critical periods (eg, pregnancy, infancy), by long-term health habits across the life course, and through the interaction of biological, behavioral, psychological, social, economic, environmental, and equity factors.	Maternal Child Health Bureau: Life Course Resource Guide http://mchb.hrsa.gov/lifecourse/ World Health Organization: A Life Course Approach to Health http://www.who.int/ageing/publications/lifecourse/alc_lifecourse_training_en.pdf Life Course Nutrition-Maternal and Child Health Strategies in Public Health: http://www.mchnutritionpartners.ucla.edu/life-course/module-life-course-nutrition-maternal-and-child-health-strategies-public-health
Community-Based Participatory Research and Participatory Action Research	Community-based participatory research involves long-term, equitable, co-learning relationships between academic institutions and community partners that focus on community-selected issues and aim to improve community health and eliminate health disparities by generating action for social change.[22]	National Institutes of Health: http://obssr.od.nih.gov/scientific_areas/methodology/community_based_participatory_research/ University of Washington: https://depts.washington.edu/ccph/cbpr/index.php Association of Asian Pacific Community Health Organizations/National Association of Community Health Centers: CBPR toolkit http://www.aapcho.org/resources_db/cbpr-toolkit/

Figure 4. Foundational models and theories for public health and community nutrition.

ACADEMY STANDARDS OF PRACTICE AND STANDARDS OF PROFESSIONAL PERFORMANCE FOR REGISTERED DIETITIAN NUTRITIONISTS (COMPETENT, PROFICIENT, AND EXPERT) IN PUBLIC HEALTH AND COMMUNITY NUTRITION

An RDN can use the Academy SOP and SOPP for RDNs (Competent, Proficient, and Expert) in PHCN (see the website-exclusive Figures 1 and 2; available online at www.andjrnl.org, and Figure 3) to:

- identify the competencies needed to provide PHCN care and services;
- self-assess whether he or she has the appropriate knowledge base and skills to provide safe and effective PHCN care and service for their level of practice;
- identify the areas in which additional knowledge and skills are needed to practice at the competent, proficient, or expert level of PHCN practice;
- provide a foundation for public and professional accountability in PHCN care and service;
- support efforts for strategic planning and assist management

P-Problem: Excessive energy intake in a population of pregnant women
related to:
E-Etiology/Determinants of problem: Food- and nutrition-related knowledge/skill deficit, undesirable food choices, and physical inactivity,
as evidenced by:
S-Signs/Symptoms: Population-level data reports indicating an increase in prevalence of excessive gestational weight gain among US pregnant women from 35% in 2005 to 45% in 2012.

Figure 5. Example Problem (P), Etiology (E), Signs/Symptoms (S) statement for public health registered dietitian nutritionists.

in the planning of PHCN services and resources;
- enhance professional identity and communicate the nature of PHCN care and services;
- guide the development of PHCN and dietetics-related education and continuing education programs, job descriptions, and career pathways; and
- assist educators and preceptors in teaching students and interns the knowledge, skills, and competencies needed to work in PHCN and dietetics, and the understanding of the full scope of this focus area of practice.

Application to Practice

All RDNs, even those with significant experience in other practice areas, must begin at the competent level when practicing in a new setting or new focus area of practice. At the competent level, an RDN in public health and community nutrition is learning the principles that underpin this focus area and is developing skills for safe and effective public health and community nutrition practice. This RDN, who may be an experienced RDN or may be new to the profession, has a breadth of knowledge in nutrition and dietetics and may have proficient or expert knowledge/practice in another focus area. However, the RDN new to the focus area of public health and community nutrition may experience a steep learning curve while becoming familiar with the body of knowledge and available

How to Use the *Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Public Health and Community Nutrition* as part of the *Professional Development Portfolio* Process[a]	
1. Reflect	Assess your current level of practice and whether your goals are to expand your practice or maintain your current level of practice. Review the SOP and SOPP for RDNs in Public Health and Community Nutrition document to determine what you want your future practice to be, and assess your strengths and areas for improvement. These documents can help you set short- and long-term professional goals.
2. Conduct learning needs assessment	Once you have identified your future practice goals, you can review the SOP and SOPP for RDNs in Public Health and Community Nutrition document to assess your current knowledge, skills, behaviors, and define what continuing professional education is required to achieve the desired level of practice.
3. Develop learning plan	Based on your review of the SOP and SOPP for RDNs in Public Health and Community Nutrition, you can develop a plan to address your learning needs as they relate to your desired level of practice.
4. Implement learning plan	As you implement your learning plan, keep reviewing the SOP and SOPP for RDNs in Public Health and Community Nutrition document to reassess knowledge, skills, and behaviors and your desired level of practice.
5. Evaluate learning plan process	Once you achieve your goals and reach or maintain your desired level of practice, it is important to continue to review the SOP and SOPP for RDNs in Public Health and Community Nutrition document to reassess knowledge, skills, and behaviors and your desired level of practice.

[a]The Commission on Dietetic Registration *Professional Development Portfolio* process is divided into five interdependent steps that build sequentially upon the previous step during each 5-year recertification cycle and succeeding cycles.

Figure 6. Application of the Commission on Dietetic Registration *Professional Development Portfolio* Process.

Role	*Examples of use of the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) documents by registered dietitian nutritionists (RDNs) in different practice roles*
Clinical practitioner	An RDN with responsibility for the nutrition component of the hospital's community education program uses the SOP and SOPP for RDNs in Public Health and Community Nutrition (PHCN) as a resource for personal development to improve competence in providing services to individuals participating in classes for the community and outreach activities. This RDN networks with a community and public health RDN for mentoring on preventative program content, leads to continuing education programs, and resources.
Clinical nutrition manager	A hospital's clinical nutrition manager (CNM) represents the hospital on a community coalition workgroup addressing access to healthy food. The CNM meets with public health RDNs to increase knowledge in PHCN, nutrition surveillance for the community, food assistance programs, food access, and best practices in policies, systems, and environmental change interventions. In reviewing the PHCN SOP SOPP, the CNM notes the use of logic models to plan nutrition programs and interventions that may have application in the hospital and seeks additional training.
Food and nutrition services manager	A food and nutrition manager obtains a contract to provide congregate and home delivered meals to a local senior center. The contract includes having staff RDNs oversee menu planning, complying with regulations, and providing nutrition education at the meal site. The PHCN SOP SOPP were reviewed to evaluate competency level on topics, such as cultural competency, senior feeding programs, engagement of the target population in the planning and delivery of services, and additional funding for programming.
Retail RDN	An RDN working for a grocery chain in the community reports receiving more requests to participate in community initiatives to increase healthy food access, such as working with sustainable, local agriculture,[26] in community gardens, and improving the healthfulness of foods donated to food banks. The RDN reviews the SOP and SOPP to identify ways to gain more knowledge and skills to increase effectiveness in responding to these requests. The retail RDN partners with PHCN RDNs to identify sources of continuing education and resources to help with addressing needs of target populations.
Public health practitioner, community nutrition practitioner	An RDN working in public health and community nutrition programs or in policy, system, and environmental approaches develops and designs population approaches in alignment with the SOP and SOPP to standardize quality improvement methods and maximize public health and community nutrition program and policy outcomes. The RDN wants to become more active in advocating for changes in regulations related to nutrition and uses the SOP and SOPP to create a professional development plan to address gaps in competencies.
Researcher	A research RDN works with a state education department to assess changes in student food intake as a result of new federal meal guidelines. The RDN uses the SOP and SOPP as a resource in designing the research protocol and evaluation methodology using current evidence-based knowledge tools as it relates to school foodservice and disparities in food intake across grade and free/reduced-price lunch status. The SOP and SOPP may also be used for identifying the need for staff development and/or collaboration with a colleague more experienced in public health and community nutrition school nutrition research.
Nutrition educator	An RDN working in nutrition education with a food bank reviews the SOP and SOPP for ideas on expanding knowledge and skills to qualify for leadership roles with nonprofit organizations serving individuals with food insecurity. Using the indicators in the SOP SOPP, the RDN identifies knowledge and skills to develop, revises professional development plan, and seeks mentorship to advance his or her career.

Figure 7. Case examples of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Public Health and Community Nutrition.

resources to support public health and community-related nutrition and dietetics practice. RDNs at the competent level tend to focus more on community nutrition as compared to public health nutrition practice.

At the proficient level, an RDN has developed a deeper understanding of PHCN practice and is better equipped to adapt and apply evidence-based guidelines and best practices than at the competent level. This RDN is able

to modify practice according to unique situations (eg, develop policies enhancing safe and affordable access to healthy foods and creating national or state surveillance systems to monitor population-level nutritional health).

At the expert level, the RDN thinks critically about PHCN and dietetics; demonstrates a more intuitive understanding of PHCN and dietetics care and service; displays a range of highly developed skills; and formulates judgments acquired through a combination of education, experience, and critical thinking. Essentially, practice at the expert level requires the application of composite nutrition, dietetics, and public health knowledge, with practitioners drawing on not only their practical experience, but also the experience of the public health and community RDNs in various disciplines and practice settings. Expert RDNs, with their extensive experience and ability to see the significance and meaning of PHCN and dietetics within a contextual whole, are fluid and flexible and have considerable autonomy in practice. They not only implement PHCN and dietetics services, they also manage, drive, and direct programs and policies; conduct and collaborate in research and advocacy; accept organization leadership roles; engage in scholarly work; guide interdisciplinary teams; and lead the advancement of PHCN and dietetics practice.

Indicators for the SOP (Figure 1; available online at www.andjrnl.org) and SOPP (Figure 2; available online at www.andjrnl.org) for RDNs in PHCN are measurable action statements that illustrate how each standard can be applied in practice. Within the SOP and SOPP for RDNs in PHCN, an "X" in the competent column indicates that an RDN who is working with clients/populations is expected to complete this activity and/or seek assistance to learn how to perform at the level of the standard. A competent RDN in PHCN could be an RDN starting practice after registration or an experienced RDN who has recently assumed responsibility to provide PHCN services and programs for clients/populations (eg, Special Supplemental Nutrition Program for Women, Infants, and Children participants, Supplemental Nutrition Assistance Program Education recipients, and Meals on Wheels recipients).

An "X" in the proficient column indicates that an RDN who performs at this level has a deeper understanding of PHCN and dietetics and has the ability to shape programs and interventions to meet the needs of clients/populations in various situations (eg, creating statewide programs and policies to promote healthy

Academy Public Health and Community Nutrition Resources

1. **House of Delegates Fall 2012 Backgrounder: Public health nutrition: It's every member's business**: Provides in-depth overview of public health and community registered dietitian nutritionists (RDNs), including educational requirements, examples of practice areas, scope of activities, and data demonstrating increasing need for more RDNs in this area of practice.[16] http://www.eatrightpro.org/~/media/eatrightpro%20files/leadership/hod/mega%20issues/backgrounders/09%20public%20health%20nutrition%20backgrounder.ashx
2. **Guidelines for Community Nutrition Supervised Experiences**: Provides guidelines for supervised experiences in community nutrition programs that promote the health and well-being of individuals, families, and communities. These guidelines are the essential starting point for personnel working in community nutrition programs who seek to enhance their level of practice. The 3rd edition, "Guidelines for Public Health and Community Nutrition Practice," expected to be published fall 2015. http://www.phcnpg.org/docs/Resources/GuideCommunityNutrSuperExp.pdf (2nd edition)
3. **Public Health/Community Nutrition – Nutrition Care Process Toolkit**: Provides a guide for practitioners working in public health and community nutrition to utilize the NCP and adapt it as needed whether they are working directly with individuals, populations, families, caregivers, programs, and grants or at the administration level with regulations, policies, or performance/quality improvement measures. Available for purchase at: http://www.eatrightstore.org/products/practitioner-tools/toolkits?p=3

Competency Assessment Tools for Public Health and Community Nutrition Practitioners

1. **University of Minnesota Self-Assessment Tool for Public Health/Community Nutritionists**: Four free online modules that provide PHCN practitioners, students, and others with an opportunity to systematically identify strengths and weaknesses in specific areas of PHCN practice. http://www.epi.umn.edu/let/assessment/index.shtm
2. **Core Competencies for Public Health Professionals:** A consensus set of skills for the broad practice of public health, as defined by the 10 Essential Public Health Services,[11] reflecting foundational skills desirable for professionals engaging in the practice, education, and research of public health. http://www.phf.org/resourcestools/pages/core_public_health_competencies.aspx
3. **Competency Assessments for Public Health Professionals**: General self-assessment (using self-scoring PDFs) for all public health practitioners that assess knowledge and skill with respect to each of the domains that comprise the Core Competencies, separated by three tiers of experience. Developed by the Public Health Foundation. http://www.phf.org/resourcestools/Pages/Competency_Assessments_For_Public_Health_Professionals.aspx

Figure 8. Additional Public Health and Community Nutrition (PHCN) practitioner resources.

eating and physical activity in early child care settings). An "X" in the expert column indicates that the RDN who performs at this level possesses a comprehensive understanding of PHCN and dietetics and a highly developed range of skills and judgments acquired through a combination of experience and education. The expert RDN builds and maintains the highest level of knowledge, skills, and behaviors including leadership, vision, and credentials.

Standards and indicators presented in Figures 1 and Figure 2 (available online at www.andjrnl.org) in boldface type originate from the Academy's Revised 2012 SOP in Nutrition Care and SOPP for RDs[1] and should apply to RDNs in all three levels. Several indicators developed for this focus area not in boldface type are identified as applicable to all levels of practice. Where an "X" is placed in all three levels of practice, it is understood that all RDNs in PHCN are accountable for practice within each of these indicators. However, the depth with which an RDN performs each activity will increase as the individual moves beyond the competent level. Several levels of practice are considered in this document; thus, taking a holistic view of the SOP and SOPP for RDNs in PHCN is warranted. It is the totality of individual practice that defines the level of practice and not any one indicator or standard.

RDNs should review the SOP and SOPP in PHCN at regular intervals to evaluate their individual focus area knowledge, skill, and competence. Regular self-evaluation is important because it helps identify opportunities to improve and/or enhance practice and professional performance. This self-appraisal also enables public health and community RDNs to better utilize these Standards in CDR's *Professional Development Portfolio* process and each of its five steps for reflection, self-assessment, planning, improvement, and commitment to lifelong learning[24] (see Figure 6). RDNs are encouraged to pursue additional training, 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 by State law. RDNs are expected to practice only at the level at which they are competent, and this will vary depending on education, training, and experience.[25] RDNs are encouraged to pursue additional knowledge and skill training, and collaboration with other RDNs in PHCN to promote consistency in practice and performance and continuous quality improvement. See Figure 7 for case examples of how RDNs in different roles, at different levels of practice, may use the SOP and SOPP for RDNs in Public Health and Community Nutrition.

In some instances, components of the SOP and SOPP for RDNs in PHCN do not specifically differentiate between proficient-level and expert-level practice. In these areas, it was the consensus of the content experts that the distinctions are subtle, captured in the knowledge, experience, and intuition demonstrated in the context of practice at the expert level, which combines dimensions of understanding, performance, and value as an integrated whole.[27] A wealth of knowledge is embedded in the experience, discernment, and practice of expert-level RDN practitioners. The knowledge and skills acquired through practice will continually expand and mature. The indicators will be refined as expert-level RDNs systematically record and document their experience using the concept of exemplars. Exemplars include a brief description of the need for action and the process used to change the outcome. The experienced practitioner observes events, analyzes them to make new connections between events and ideas, and produces a synthesized whole. Exemplars provide outstanding models of the actions of individual public health and community RDNs in public health settings and the professional activities that have enhanced client and community/population health.[28]

The SOP/SOPP indicators for each practice level should be considered in conjunction with other Academy publications that support the work of public health and community nutrition RDNs (Figure 8).

Future Directions

There is a need for expertise in preventive and public health nutrition; RDNs in this area of practice would benefit from specialist or advanced practice certification. The SOP and SOPP for RDNs in PHCN are innovative and dynamic documents. Future revisions will reflect changes and advances in practice, dietetics education programs, and outcomes of practice audits and coordination with the Academy resources in Figure 8. The authors acknowledge that the three practice levels may require more clarity and differentiation in content and role delineation, and that competency statements that better characterize differences among the practice levels are needed. Creation of this clarity, differentiation, and definition are the challenges of today's public health and community RDNs to better serve tomorrow's practitioners and their patients, clients, and communities/populations.

CONCLUSIONS

RDNs face complex situations every day. Addressing the unique needs of each situation and applying standards appropriately are essential to providing safe, timely, population- or person-centered quality care and service. All RDNs are advised to conduct their practice based on the most recent edition of the Code of Ethics, the Scope of Practice in Nutrition and Dietetics, the Scope of Practice for RDs, and the SOP in Nutrition Care and SOPP for RDs. The SOP and SOPP for RDNs in PHCN are complementary documents and are key resources for RDNs at all knowledge and performance levels. These standards can and should be used by public health and community RDNs in daily practice to consistently improve and appropriately demonstrate competency and value as providers of safe and effective nutrition and dietetics care and services. These standards also serve as a professional resource for self-evaluation and professional development for RDNs specializing in PHCN practice. Just as a professional's self-evaluation and continuing education process is an ongoing cycle, these standards are also a work in progress, and will be reviewed and updated every 5 years. Current and future initiatives of the Academy as well as advances in PHCN care and services will provide information to use in these updates and in further clarifying and documenting the specific roles

These standards have been formulated to be used for individual self-evaluation and the development of practice guidelines and specialist credentials, but not for disciplinary actions or determinations of negligence or misconduct. These standards do not constitute medical or other professional advice, and should not be taken as such. The information presented in these standards is not a substitute for the exercise of professional judgment by the health care professional. The use of the standards for any other purpose than that for which they were formulated must be undertaken within the sole authority and discretion of the user.

and responsibilities of RDNs at each level of practice. As a quality initiative of the Academy and the PHCN Dietetic Practice Group, these standards are an application of continuous quality improvement and represent an important collaborative endeavor.

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STATEMENT OF POTENTIAL CONFLICT OF INTEREST

No potential conflict of interest was reported by the authors.

FUNDING/SUPPORT

There is no funding to disclose.

ACKNOWLEDGEMENTS

We would like to acknowledge the input and efforts by Margaret Tate, MS, RD, and Jamie Stang, PhD, MPH, RD, to the indicators. We would also like to thank the following people for their careful review and suggestions to the document: Jamie Stang, PhD, MPH, RD; Marsha Spence, PhD, MS-MPH, RD; Marion Taylor Baer, PhD, RD; Samia Hayden, MPH, RD; and Kay Sisk, MS, RD, LD. Finally, we would like to thank the Academy staff, in particular, Carol Gilmore, MS, RD, LD, FADA, FAND, and Sharon McCauley, MS, MBA, RDN, LDN, FADA, FAND, who supported and facilitated the development of these SOP and SOPPs.

Standard 1: Nutrition Assessment
The registered dietitian nutritionist (RDN) uses accurate and relevant data and information to identify nutrition-related problems.

Rationale:
Nutrition assessment is the first of four steps of the Nutrition Care Process. Nutrition assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and screening of individuals or groups for nutrition risk factors.

Nutrition assessment is conducted using validated tools, the five domains of nutrition assessment and comparative standards as documented in the Nutrition Care Process Terminology (eNCPT). eNCPT is available as an online resource (formerly the *International Dietetics & Nutrition Terminology Reference Manual* [IDNT]). Nutrition assessment is an ongoing, dynamic process that involves not only initial data collection, but also reassessment and analysis of client or community needs. In public health and community nutrition, assessments are completed with clients and other stakeholders, including community members and health practitioners. Process assessments are also involved. Assessments provide the foundation for nutrition diagnosis, the second step of the Nutrition Care Process.

Refer to eNCPT online.

Indicators for Standard 1: Nutrition Assessment					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
1.1	**Anthropometric assessment: Assesses anthropometric measures that may include: height, weight, body mass index (BMI), waist circumference, growth pattern indices/percentile ranks/z scores and weight history**		**X**	**X**	**X**
	1.1A	Utilizes culturally appropriate methods for anthropometric assessments	X	X	X
	1.1B	Monitors individual and population-based measures	X	X	X
	1.1C	Participates in collecting measures for population-based programs (eg, WIC[a] database, BRFSS[b])	X	X	X
	1.1D	Initiates collecting measures for population-based programs (eg, SNAP-Ed[c])		X	X
	1.1E	Manages systems for anthropometric assessment (ie, provides training, quality assessment, updating, monitoring)		X	X
	1.1F	Designs and contributes to improvements of systems for anthropometric data collection across populations			X
1.2	**Biochemical data, medical tests, and procedure assessment: Assesses laboratory profiles, medical tests, and procedures, which may include: acid–base balance, electrolyte, renal, essential fatty acid, gastrointestinal, glucose/endocrine, inflammatory, lipid, metabolic rate, mineral, nutritional anemia, protein, urine, and vitamin/mineral profiles**		**X**	**X**	**X**
	1.2A	Interprets and applies diagnosis-related data from medical providers (eg, anemia, cancer, diabetes) in assessments	X	X	X
	1.2B	Initiates and participates in collection of biochemical data (eg, nutritional anemia profile, oral glucose tolerance test to screen for gestational diabetes, elevated blood lead or mercury levels, population-based laboratory data from health surveillance systems, electronic health record data)	X	X	X

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Figure 1. Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 1: Nutrition Assessment					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	1.2C	Designs protocols and systems for nutritional biochemical assessment at population levels		X	X
	1.2D	Applies quantitative skills to evaluate diet and disease relationships in epidemiologic studies		X	X
1.3	**Nutrition-focused physical findings assessment (often referred to as clinical assessment): Assesses findings from evaluation of body systems, muscle and subcutaneous fat wasting, oral health, hair, skin and nails, signs of edema, suck/swallow/breathe ability, appetite, and affect**		**X**	**X**	**X**
	1.3A	Participates in collection of self-reported and other sources of data	X	X	X
	1.3B	Trains staff on applying physical findings into health care (including direct client care and with other health care providers)	X	X	X
1.4	**Food and nutrition-related history assessment (often referred to as dietary assessment): Assesses**		**X**	**X**	**X**
	1.4A	**Food and nutrient intake including the composition and adequacy of food and nutrient intake, meal and snack patterns, and food allergies and intolerances**	**X**	**X**	**X**
		1.4A1 Applies and participates in multiple individual and population group assessment methods (eg, interviews, surveys, nutrient analysis software, nutrition surveillance systems)	X	X	X
		1.4A2 Initiates data collection using multiple individual and population group assessment methods (eg, interviews, surveys, nutrient analysis software, meal patterns in food programs, nutrition surveillance systems)		X	X
		1.4A3 Designs systems and tools for multiple individual and population group assessment methods (eg, interviews, surveys, questionnaires, nutrient analysis, meal patterns in food programs, nutrition surveillance systems)			X
	1.4B	**Food and nutrient administration, including current and previous diets and diet prescriptions and food modifications, eating environment, and enteral and parenteral nutrition administration**	**X**	**X**	**X**
		1.4B1 Accommodates and tailors approach for participants with special needs participating in federal nutrition assistance programs (eg, NSLP[d], WIC, special formulas, congregate and home delivered meals)	X	X	X
	1.4C	**Medication and dietary and herbal supplement use, including prescription and over-the-counter medications, herbal preparations, and complementary medicine products used**	**X**	**X**	**X**
		1.4C1 Considers potential diet interactions with medications, as well as dietary and herbal supplement use across the life course on individual and population levels (eg, interactions with human milk)	X	X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 1: Nutrition Assessment						
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		1.4C2	Addresses any potential toxicities on individual and population levels (eg, human milk fortifier)	X	X	X
		1.4C3	Assesses illegal substance effects on individual and population levels	X	X	X
		1.4C4	Considers client/population use of and need for dietary and herbal supplementation	X	X	X
	1.4D	**Knowledge, beliefs, and attitudes including understanding of nutrition-related concepts, conviction of the truth and feelings/ emotions toward some nutrition-related statement or phenomenon, body image and preoccupation with food and weight, and readiness to change nutrition-related behaviors**		**X**	**X**	**X**
	1.4E	**Behavior including client/population activities and actions, which influence achievement of nutrition-related goals**		**X**	**X**	**X**
		1.4E1	Assesses behavioral and environmental influences using the socio-ecological approach or other health behavior theory	X	X	X
	1.4F	**Factors affecting access to food that influences intake and availability of a sufficient quantity of safe, healthful food and water, as well as food/nutrition-related supplies**		**X**	**X**	**X**
		1.4F1	Evaluates access to food at individual and population level (eg, availability and use of federal feeding programs such as NSLP, congregate and home-delivered meals, and presence of food deserts)	X	X	X
			1.4F1i Determines influence of policy/systems and other environmental factors on food access		X	X
	1.4G	**Physical activity, cognitive and physical ability to engage in specific tasks such as self-feeding, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and breastfeeding**		**X**	**X**	**X**
	1.4H	**Nutrition-related client/population-centered measures, including nutrition quality of life, and client/population perception of nutrition intervention, cultural, ethnic, religious, and lifestyle factors and their impact on life**		**X**	**X**	**X**
		1.4H1	Collaborates with promotoras/peer/community health workers in assisting with assessments	X	X	X
		1.4H2	Trains and mentors promotoras/peer/community health workers on proper assessment techniques		X	X
1.5	**Client/population history: Assesses current and past information related to personal, medical, family, and social history**			**X**	**X**	**X**
	1.5A	Assesses target population health status in relation to community health		X	X	X

(continued on next page)

Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 1: Nutrition Assessment					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	1.5B	Uses population-based data to inform history and assessment	X	X	X
	1.5C	Tracks changes in personal history (community RDNs) and population-based health (public health RDNs)	X	X	X
	1.5D	Leads interdisciplinary team in identifying plan and tools for assessing target populations initially and over time		X	X
1.6	**Comparative standards: Identifies and uses comparative standards to estimate energy, fat, protein, carbohydrate, fiber, fluid, vitamin, and mineral needs, as well as recommended body weight, BMI, and desired growth patterns**		**X**	**X**	**X**
	1.6A	**Identifies the most appropriate reference standards (ie, national, state, institutional, and regulatory) based on practice setting, client age, and disease/injury state and compares nutrition assessment data to appropriate criteria, relevant norms, population-based surveys, and standards**	**X**	**X**	**X**
	1.6B	Utilizes reference standards for guidance (eg, food safety, IOM[e] and US Preventative Services Taskforce recommendations, DGA[f], CDC[g], and WHO[h] [infant growth charts] guidelines)	X	X	X
1.7	**Physical activity habits and restrictions: Assesses physical activity, history of physical activity and exercise training**		**X**	**X**	**X**
	1.7A	Analyzes factors of accessibility, adequacy, and safety of the physical environment for both individuals and populations	X	X	X
	1.7B	Applies Physical Activity Guidelines for Americans, NASPE[i], and CDC guidelines in assessments	X	X	X
	1.7C	Consults with exercise scientists, kinesiologists, and physical therapists as appropriate	X	X	X
1.8	**Reviews collected data for factors that affect nutrition and health status**		**X**	**X**	**X**
	1.8A	**Utilizes nutrition assessment data documented by the nutrition and dietetics technician, registered (NDTR) or dietetic technician, registered (DTR) or other health care practitioner**	**X**	**X**	**X**
	1.8B	Utilizes nationally available nutrition assessment data (eg, NHANES[j], BRFSS/YRBSS[k], Profiles, SHIPs[l], Safety Performance Standards)	X	X	X
	1.8C	Integrates knowledge of human nutrition with principles of epidemiology		X	X
	1.8D	Uses biostatistical skills to assess relationships between nutrition-related factors and behaviors/outcomes		X	X
	1.8E	Oversees methods and instruments to ensure ongoing collection of valid and reliable quantitative and qualitative assessment data which may include electronic devices or web-based tools			X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 1: Nutrition Assessment					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
1.9	**Organizes and clusters nutrition risk factors, complications, and assessment data to identify possible problem areas for determining nutrition diagnoses**		**X**	**X**	**X**
	1.9A	Uses health theories to cluster nutrition risk factors	X	X	X
	1.9B	Gains deep understanding of epidemiological principles to interpret the magnitude and directionality of nutrition-related risk factors		X	X
1.10	**Documents and communicates:**		**X**	**X**	**X**
	1.10A	**Date and time of assessment**	**X**	**X**	**X**
	1.10B	**Pertinent data (eg, medical, social, behavioral)**	**X**	**X**	**X**
	1.10C	**Comparison to appropriate standards**	**X**	**X**	**X**
	1.10D	**Client/population perceptions, values, and motivation related to presenting problems**	**X**	**X**	**X**
	1.10E	**Changes in client/population perceptions, values, and motivation related to presenting problems**	**X**	**X**	**X**
	1.10F	**Reason for discharge/discontinuation or referral if appropriate**	**X**	**X**	**X**
	1.10G	Communicates and disseminates assessment findings via a brief or report with the community and stakeholders	X	X	X
	1.10H	Integrates feedback from stakeholders in documenting program justifications and in planning program design		X	X

Examples of Outcomes for Standard 1: Nutrition Assessment

- Appropriate assessment tools and procedures (matching assessment method to situation) are implemented (eg, focus groups to assess population-level barriers to accessing early prenatal care or federal nutrition programs).
- Appropriate and pertinent data are collected (eg, demographic data such as age, sex, race, ethnicity, income, migrant status, or health indicator data such as low birth weight, prematurity, anemia, overweight, obesity, special needs, and food security).
- Effective interviewing methods are utilized (eg, USDA[m] Participant Centered Value Enhanced Nutrition Assessment [VENA]).
- Use of population-level assessment data leads to the determination that a nutrition diagnosis/problem does or does not exist (eg, prenatal weight gain data from a subpopulation of Hispanic women of child-bearing age, indicates a risk factor of excessive maternal weight gain due to cultural norms with food intake).
- Consultation with or refer to another health practitioner (eg, assessment of prenatal smoking in a maternal population requiring referral to community smoking cessation programs).
- Documentation and communication of assessments are complete, relevant, accurate, and timely (eg, individual care plans and/or population-level executive summary reports).

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

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:
Nutrition diagnosis is the second of four steps of the Nutrition Care Process. At the end of the nutrition assessment step, data are clustered, analyzed, and synthesized. This will reveal a nutrition diagnosis category from which to formulate a specific nutrition diagnosis statement.

The nutrition diagnosis demonstrates a link to determining goals for outcomes, selecting appropriate interventions, and tracking progress in attaining expected outcomes. Diagnosing nutrition problems is the responsibility of the RDN in collaboration with the client (community nutrition) and community (public health nutrition).

Refer to the eNCPT online.

Indicators for Standard 2: Nutrition Diagnosis						
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
2.1	**Derives the nutrition diagnosis(es) from the assessment data**			**X**	**X**	**X**
	2.1A	**Identifies and labels the problem**		**X**	**X**	**X**
		2.1A1	Relates problems/diagnoses to demographics and characteristics of targeted population groups; consults with more experienced practitioners as needed	X	X	X
	2.1B	**Determines etiology (cause/contributing risk factors)**		**X**	**X**	**X**
		2.1B1	Identifies and labels individual, social, environmental, community or policy conditions that are influencing the problem(s) using health behavior theory, such as the Socio-ecological Model; consults with more experienced practitioners as needed	X	X	X
		2.1B2	Relates risk factors to broad community health indicators (eg, cultural child feeding practices in relation to nutrition/health risk factors)	X	X	X
		2.1B3	Uses epidemiological data to evaluate the personal and social determinants that impact the nutrition diagnosis(es)		X	X
	2.1C	**Clusters signs and symptoms (defining characteristics)**		**X**	**X**	**X**
		2.1C1	Applies epidemiological methodologies (ie, surveys) and other qualitative methods (ie, focus groups and interviews) to determine the incidence and prevalence of common signs, symptoms, and risk factors among population groups, including trends in chronic disease risk and health disparities		X	X
		2.1C2	Designs nutrition epidemiology studies to understand clustering of signs and symptoms			X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 2: Nutrition Diagnosis					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
2.2	**Prioritizes and classifies the nutrition diagnosis(es)**		**X**	**X**	**X**
	2.2A	Relates the client's/population's diagnosis(es) to food and environmental problems in the community	X	X	X
	2.2B	Prioritizes individual, social, environmental, community, or policy conditions that can be addressed to mitigate the nutrition diagnosis(es)		X	X
2.3	**Validates the nutrition diagnosis(es) with clients/community, family members or other health care professionals when possible and appropriate; corroborates right client/population to right diagnosis**		**X**	**X**	**X**
	2.3A	Consults with other community and public health practitioners and community leaders	X	X	X
	2.3B	Validates nutrition diagnosis(es) with nutrition surveillance data, population-based research, and community feedback		X	X
2.4	**Documents the nutrition diagnosis(es) using standardized language and written statement(s) that include Problem (P), Etiology (E), and Signs and Symptoms (S) (PES statement[s])**		**X**	**X**	**X**
	2.4A	Assesses prevalence and incidence of nutrition diagnoses at a population level		X	X
	2.4B	Frames and communicates diagnoses within the context of logic models, health behavior theories, and/or population outcomes data		X	X
2.5	**Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available**		**X**	**X**	**X**
	2.5A	Applies timely and relevant standards, program evaluation, and research-based evidence to population groups	X	X	X
	2.5B	Tracks changes and trends in diagnoses	X	X	X
	2.5C	Confers with biostatisticians to discuss methodologies		X	X

Examples of Outcomes for Standard 2: Nutrition Diagnosis

- Nutrition Diagnostic Statements are: 1) clear and concise; 2) specific client or community-centered; 3) science-based; 4) based on reliable and accurate assessment data; and 5) includes date and time. Examples:
  - *Inadequate physical activity related to limited outside recess after school lunch as evidenced by children returning immediately to class after school lunch.*
  - *Percent of low-income schools implementing policies for recess before lunch or at least 30 minutes of daily outside recess.*
  - *Increase in community breastfeeding initiation rates with implementation of social media texting program targeting prenatal women who are in the third trimester.*
- Documentation of nutrition diagnosis(es) is relevant, accurate, and timely (eg, applicable population-level data reports on public health problems [obesity, anemia, neural tube defects] are generated and retained within a standardized computer database system using a consistent procedure at regular intervals).
- Documentation of nutrition diagnosis(es) is revised and updated as additional assessment data become available (eg, as maternal weight gain data become available for a population of pregnant women, the data are entered into a computer database system and analyzed on a periodic basis. The determination of prevalence will occur at regular intervals with documentation of any increase or decrease in excessive maternal weight gain over time).

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Standard 3: Nutrition Intervention
The registered dietitian nutritionist (RDN) identifies and implements appropriate, purposefully planned interventions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition or aspect of health status for an individual, target group, or the community at large.

Rationale:
Nutrition intervention is the third of four steps of the Nutrition Care Process. It consists of two interrelated components—planning and implementation. Planning involves prioritizing the nutrition diagnoses, conferring with the client and others, reviewing practice guidelines and policies, and setting goals and defining the specific nutrition intervention strategy.

Implementation of the nutrition intervention/plan of care 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 the client/population response. An RDN implements the interventions or assigns components of nutrition intervention/plan of care to support staff in accordance with applicable laws and regulations. Nutrition intervention/plan of care is ultimately the responsibility of the RDN.

Refer to the eNCPT online.

Indicators for Standard 3: Nutrition Intervention					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
Plans the Nutrition Intervention/Plan of Care:					
3.1	**Prioritizes the nutrition diagnosis(es) based on problem severity, safety, client/population needs, likelihood that nutrition intervention/plan of care will influence problem and client/population perception of importance which involves community input and includes policy initiatives and the community environment**		**X**	**X**	**X**
3.2	**Bases intervention/plan of care on best available research/evidence, evidence-based guidelines, and best practices**		**X**	**X**	**X**
	3.2A	Creates interventions based on funding requirements, including as appropriate state and federal guidelines	X	X	X
	3.2B	Considers health behavior theory (eg, Socio-ecological Model) in developing interventions	X	X	X
	3.2C	Collaborates with epidemiologists and/or biostatisticians to refine project goals, available resources, and measures		X	X
	3.2D	Leads the development of intervention guidelines and outcome measures for local, state, and/or national nutrition services			X
3.3	**Refers to policies and program standards**		**X**	**X**	**X**
	3.3A	Uses community/population-based national standards and guidelines/standards such as DGA, MyPlate, community health indicators, in planning the intervention	X	X	X
	3.3B	Develops policy and environmental change/systems approaches, aligning messages across programs, collaborating with partners in order to strengthen messaging and leverage funding, and maximize reach to target populations			X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 3: Nutrition Intervention						
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
3.4	**Confers with client, caregivers, interdisciplinary team, community stakeholders, other health care and community professionals (eg, city planners, educators, and policy makers)**			**X**	**X**	**X**
	3.4A	Communicates priorities and community needs to policy and other decision makers to support nutritional health of the population		X	X	X
	3.4B	Raises awareness on policy-related issues with stakeholders and policy makers that can impact environmental conditions contributing to problems (eg, federal nutrition programs and food regulations)			X	X
	3.4C	Convenes and collaborates with multisector public and private community coalitions and partners (eg, urban planners, NGOs[n], nonprofits, breastfeeding coalitions, advocacy organizations) to develop and implement policy and environmental changes				X
3.5	**Determines client/population-centered plan, goals, and expected outcomes**			**X**	**X**	**X**
	3.5A	Uses logic model for planning and implementation of interventions, considering target population, as well as the broader community according to assessment of needs		X	X	X
	3.5B	Creates goals that are inclusive of cultural sensitivity, geographic diversity, socioeconomic diversity, practical implementation		X	X	X
	3.5C	Incorporates the concepts of the social determinants of health into programs and services that promote health equity and minimize/eliminate health disparities		X	X	X
		3.5C1	Focuses interventions on prevention approaches	X	X	X
3.6	**Develops the nutrition prescription**			**X**	**X**	**X**
	3.6A	Identifies, selects, and/or develops evidence-based or evidence-informed practices, programs, and science-based nutrition education materials based on nutritional needs of the target population; consults with more experienced practitioners as needed		X	X	X
	3.6B	Implements health promotion and disease prevention activities that are based on population's nutritional status		X	X	X
	3.6C	Intervenes and coordinates on all levels of the Socio-ecological Model to promote population health			X	X
3.7	**Defines time and frequency of care including intensity, duration, and follow-up**			**X**	**X**	**X**
	3.7A	Develops short-, intermediate-, and long-term interventions using logic models and needs assessment data		X	X	X
	3.7B	Utilizes realistic and appropriate time frames to measure outcomes, with the understanding that some interventions can take many years to see change		X	X	X
		3.7B1	Describes specific time frames for each level of intervention, with intrapersonal and interpersonal components generally taking shorter periods of time, and community, systems interventions taking years	X	X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 3: Nutrition Intervention						
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		3.7B2	Defines measures specific to intervention outcomes, which could take months, years, or decades for each measure		X	X
		3.7B3	Develops guidelines for timing of interventions and follow-up based on research and best practices			X
3.8	**Utilizes standardized terminology for describing interventions**			**X**	**X**	**X**
	3.8A	Incorporates standard terminology from the fields of nutrition and public health, systems/environmental approaches, including the Public Health Community Nutrition Care Process Toolkit		X	X	X
	3.8B	Frames intervention-related communication to targeted stakeholders (eg, community partners, policy makers, businesses)			X	X
3.9	**Identifies resources and referrals needed**			**X**	**X**	**X**
	3.9A	Applies factors that impact accessibility, adequacy, and safety of food supply to community health		X	X	X
		3.9A1	Connects population groups to services for food/water supplies and systems (via agriculture, business, retail, safety net programs, public institutions, hospitals)	X	X	X
		3.9A2	Uses information about nutrients and contaminants in the food and water supply in planning the intervention		X	X
	3.9B	Links individuals/populations to food and nutrition services to assure optimal nutritional status (eg, food pantries, home delivered meals programs, SNAP-Ed, free and reduced-price school meals, Summer Food Service Program, Child and Adult Care Food Program, WIC) and assists them with determining program eligibility and enrollment options		X	X	X
	3.9C	Utilizes an interdisciplinary approach to leverage resources across systems			X	X
	3.9D	Establishes and maintains interagency networks based on client/population intervention needs; links nutrition and other services				X
Implements the Nutrition Intervention/Plan of Care:						
3.10	**Collaborates with colleagues, interdisciplinary team, and other health and community professionals**			**X**	**X**	**X**
	3.10A	Identifies key stakeholders and collaborators		X	X	X
	3.10B	Collaborates within and across agencies and organizations, including other governmental sectors, nonprofits, community partners, business/insurance companies, industry and coalitions that work on addressing population health issues (eg, disparities in access to food, nutritional intake)			X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 3: Nutrition Intervention					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			The "X" signifies the indicators for the level of practice		
Each RDN:			Competent	Proficient	Expert
	3.10C	Advocates for evidence-based approaches to addressing nutrition-related population health issues with policy makers, elected officials, and other influential leaders		X	X
	3.10D	Mobilizes stakeholders, including food policy councils while building community leadership capacity for change to create health promoting environments and practices		X	X
3.11	**Communicates and coordinates the nutrition intervention/plan of care**		**X**	**X**	**X**
	3.11A	Partners with primary health care providers to ensure community nutrition services complies with clients' plans of care	X	X	X
	3.11B	Participates in boards, organizations, task forces, committees, coalitions, and partnerships to support nutrition interventions		X	X
	3.11C	Disseminates intervention plans and outcomes with key community partners and stakeholders in a transparent manner		X	X
	3.11D	Convenes boards, organizations, task forces, committees, coalitions, and partnerships to support nutrition interventions			X
3.12	**Initiates and individualizes the nutrition intervention/plan of care**		**X**	**X**	**X**
	3.12A	**Utilizes physician/referring practitioner-driven protocols or other facility-specific processes to implement, initiate, or modify orders for diet or nutrition-related services (eg, nutrition supplements, dietary supplements, food-texture modifications for dentition or individual preferences, enteral and parenteral nutrition, nutrition-related laboratory tests and medications, and nutrition education and counseling); services are consistent with specialized training where required, competence, approved clinical privileges for order writing and organization policy**	**X**	**X**	**X**
	3.12B	**Utilizes physician/referring practitioner-driven protocols or other facility-specific processes to manage nutrition support therapies (eg, formula selection, rate adjustments based on energy needs or laboratory results, addition of designated medications and vitamin/mineral supplements to parenteral nutrition solutions or supplemental water for enteral nutrition); services are consistent with specialized training where required, competence, approved clinical privileges for order writing, and organization policy**	**X**	**X**	**X**
	3.12C	Ensures availability of quality nutrition services to target populations, including screening, assessment, education, counseling, and referral to food assistance programs	X	X	X
	3.12D	Considers social/ethnic disparities, culture, food access, and socioeconomic status in developing the nutrition intervention	X	X	X
	3.12E	Employs a variety of strategies (eg, social media, billboards, flyers, public service announcements, radio ads) to reach/educate target population		X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 3: Nutrition Intervention						
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
3.13	**Assigns activities to NDTR or DTR and other administrative support and technical personnel in accordance with qualifications, organization policies, and applicable laws and regulations**			**X**	**X**	**X**
	3.13A	**Supervises support personnel**		**X**	**X**	**X**
		3.13A1	Engages community volunteers		X	X
		3.13A2	Collaborates with and oversees community health workers (ie, paraprofessionals, lay health workers, promotoras)		X	X
		3.13A3	Mobilizes cross-disciplinary staff in program interventions (eg, school and school foodservice staff, government professionals, public university employees, city planners, and community advocates)			X
3.14	**Continues data collection**			**X**	**X**	**X**
	3.14A	Tracks progress toward achieving short-, intermediate-, and long-term outcomes according to intervention plans often using logic models		X	X	X
	3.14B	Obtains and utilizes client and community input and feedback in asset mapping, needs assessment, gap analysis, program outputs, and outcomes			X	X
	3.14C	Trains staff on data collection protocols and methods			X	X
3.15	**Follows up and verifies that nutrition intervention/plan of care is occurring**			**X**	**X**	**X**
	3.15A	Monitors intervention for achievement of expected outcomes		X	X	X
	3.15B	Conducts process evaluations and fidelity assessments to ensure that programs are being implemented according to standards/plans and for potential efficiencies			X	X
3.16	**Adjusts nutrition intervention/plan of care strategies, if needed, as response occurs**			**X**	**X**	**X**
	3.16A	Uses population-level data to inform and adjust program and objectives			X	X
	3.16B	Uses formative research and focus group testing for ongoing program/intervention planning and adjustments for optimal outcomes			X	X
	3.16C	Mentors and guides process and planning in unpredictable and dynamic situations (eg, emergency preparedness and response)				X
3.17	**Documents:**					
	3.17A	**Date and time**		**X**	**X**	**X**
	3.17B	**Specific intervention goals and expected outcomes**		**X**	**X**	**X**
	3.17C	**Recommended interventions**		**X**	**X**	**X**
	3.17D	**Adjustments to the plan and justification**		**X**	**X**	**X**
	3.17E	**Client/community receptivity**		**X**	**X**	**X**
	3.17F	**Referrals made and resources used**		**X**	**X**	**X**
	3.17G	**Client/population comprehension**		**X**	**X**	**X**

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 3: Nutrition Intervention					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	3.17H	Knowledge, skill, and behavior change of client/populations	X	X	X
	3.17I	**Barriers to change**	**X**	**X**	**X**
	3.17J	**Other information relevant to intervention and monitoring progress over time**	**X**	**X**	**X**
	3.17K	**Plans for follow up and frequency of care**	**X**	**X**	**X**
	3.17L	**Rationale for discharge or referral, if applicable**	**X**	**X**	**X**
	3.17M	Reports to funders, policy makers, and other stakeholders	X	X	X

Examples of Outcomes for Standard 3: Nutrition Intervention

- Documentation of nutrition intervention/plan of care is: 1) comprehensive (eg, revisions and updates to WIC and hospital lactation policies, education and practices); 2) specific (eg, no artificial nipples or ABM[o] provided to WIC mothers in the hospital after delivery); 3) accurate (eg, correctly identifies factors, eg, artificial nipples and ABM, that are barriers to breastfeeding initiation and success); 4) relevant (eg, eliminate nipple confusion and ABM administration leading to breastfeeding preference); 5) timely (eg, early preference for breastfeeding success = increase in imitation rate in population); and 6) dated and timed (eg, documentation in hospital medical records and WIC records).
- Documentation of nutrition intervention/plan of care is revised and updated as needed and determined by epidemiological/tracking data.
- Food insecurity is considered as a nutrition diagnosis and refers clients to nutritional services and food assistance programs.
- Convening of stakeholders (school officials, teachers, foodservice directors, elected officials) to present plan for increasing school breakfast program offering within a county school system to address high levels of childhood food insecurity.
- Appropriate prioritizing and setting of goals/expected outcomes.
- Client/population, caregivers, and interdisciplinary team, as appropriate, are involved in developing nutrition intervention/plan of care.
- Appropriate individualized client/population-centered nutrition intervention/plan of care, including nutrition prescription, is developed (eg, schedule intervention team meeting to plan intervention, including review of policies and practices, setting goals to increase participation in congregate meals).
- Interdisciplinary collaborations are utilized (eg, food bank RDNs collaborate with business owners and farmers to increase availability of fresh produce to clients/populations).
- Logic model as a dynamic tool is used to document intervention/plan of care.

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, and intervention strategies to determine the progress made in achieving desired outcomes of nutrition care and whether planned interventions should be continued or revised.

Rationale:

Nutrition monitoring and evaluation is the fourth step in the Nutrition Care Process. Through monitoring and evaluation, the RDN identifies important measures of change or client/population outcomes relevant to the nutrition diagnosis and nutrition intervention/plan of care and describes how best to measure these outcomes.

Nutrition monitoring and evaluation are essential components of an outcomes management system. The aim is to promote uniformity within the profession in evaluating the efficacy of nutrition interventions/plans of care.

Refer to the eNCPT online.

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 4: Nutrition Monitoring and Evaluation						
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
4.1	**Monitors progress:**			**X**	**X**	**X**
	4.1A	**Assesses client/population understanding and compliance with nutrition intervention/plan of care**		**X**	**X**	**X**
		4.1A1	Tracks nutrition-related trends at a population level	X	X	X
			4.1A1i Uses principles of epidemiology and basic biostatistics to track trends		X	X
		4.1A2	Applies a range of evaluative measures (eg, qualitative, quantitative, impact, and process information)		X	X
		4.1A3	Determines evaluation measures and systems for use with client/population interventions			X
	4.1B	**Determines whether the nutrition intervention/plan of care is being implemented as prescribed**		**X**	**X**	**X**
		4.1B1	Adjusts intervention based on evaluation data		X	X
		4.1B2	Determines if measures are capturing desired outcomes (ie, reliability and validity of measures)		X	X
	4.1C	**Evaluates progress or reasons for lack of progress related to problems and interventions**		**X**	**X**	**X**
		4.1C1	Assesses program/intervention assessment tools for reliability and validity		X	X
		4.1C2	Engages target population and other stakeholders to understand evaluation outcomes (eg, satisfaction surveys, focus groups)		X	X
		4.1C3	Communicates barriers and progress to stakeholders		X	X
		4.1C4	Mobilizes stakeholders in analysis and troubleshooting		X	X
	4.1D	**Evaluates evidence that the nutrition intervention/plan of care is influencing a desirable change in the client/population behavior or status**		**X**	**X**	**X**
		4.1D1	Evaluates behavior change through knowledge, application of social, behavioral, and educational theories	X	X	X
		4.1D2	Evaluates impact of health status of populations receiving public health nutrition services		X	X
		4.1D3	Identifies complex underlying problems beyond the scope of nutrition that are interfering with the intervention and recommends appropriate intervention, partnering with stakeholders			X
	4.1E	**Identifies positive or negative outcomes**		**X**	**X**	**X**
		4.1E1	Documents effectiveness, accessibility, and quality of population-based services		X	X
		4.1E2	Identifies unintended consequences and outcomes, adjusts intervention based on findings (especially at policy and system level)			X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Indicators for Standard 4: Nutrition Monitoring and Evaluation							
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators					The "X" signifies the indicators for the level of practice		
Each RDN:					Competent	Proficient	Expert
	4.1F	**Supports conclusions with evidence**			**X**	**X**	**X**
	4.1G	Evaluates impact of policy on health status of a population group.					X
4.2	**Measures outcomes:**				**X**	**X**	**X**
	4.2A	**Selects the nutrition care/intervention outcome indicator(s) to measure**			**X**	**X**	**X**
	4.2B	**Uses standardized nutrition care outcome indicator(s)**			**X**	**X**	**X**
4.3	**Evaluates outcomes:**				**X**	**X**	**X**
	4.3A	**Compares monitoring data with nutrition goals/prescription or reference standard**			**X**	**X**	**X**
		4.3A1	Benchmarks datasets from program participants to national, state, and local public health datasets (eg, Healthy People National Health Objectives, Healthcare Effectiveness Data and Information Set)				X
	4.3B	**Evaluates impact of the sum of all interventions on overall client/ population health outcomes**			**X**	**X**	**X**
		4.3B1	Participates in the evaluation of interventions		X	X	X
		4.3B2	Leads evaluation of the efficacy and effectiveness of interventions on overall client/population health outcomes in partnership with stakeholders and the community			X	X
		4.3B3	Analyzes legislative impact on health programs, federal food assistance programs, policies, and interventions				X
	4.3C	Applies surveillance systems to monitor population health over time				X	X
4.4	**Documents**				**X**	**X**	**X**
	4.4A	**Date and time**			**X**	**X**	**X**
	4.4B	**Indicators measured, results, and the method for obtaining measurement**			**X**	**X**	**X**
	4.4C	**Criteria to which the indicator is compared (eg, nutrition goal/ prescription or a reference standard)**			**X**	**X**	**X**
	4.4D	**Factors facilitating or hampering progress**			**X**	**X**	**X**
	4.4E	**Other positive or negative outcomes**			**X**	**X**	**X**
	4.4F	**Future plans for nutrition care, nutrition monitoring, and evaluation, follow up, referral or discharge**			**X**	**X**	**X**
	4.4G	Uses the logic model as a dynamic tool to document revisions/ updates to the plan of care, especially in population-based interventions			X	X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Examples of Outcomes for Standard 4: Nutrition Monitoring and Evaluation

- The client/population 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)
  - Client-centered outcomes (eg, quality of life, satisfaction, self-efficacy, self-management, functional ability)
  - Community-centered outcomes (eg, access to fruits/vegetables, changes in prevalence of overweight/obesity, increase in rate of breastfeeding duration, consumption of fruits and vegetables, increased access to federal nutrition programs and improved food systems)
  - Health care utilization and cost effectiveness outcomes (eg, special procedures, decreased admissions for preventable nutrition-related problems, prevented or delayed morbidity and mortality)
- Documentation of nutrition monitoring and evaluation is comprehensive, specific, accurate, relevant, timely, dated, and timed

[a]WIC=Special Supplemental Nutrition Program for Women Infants and Children (United States) (http://www.fns.usda.gov/wic/women-infants-and-children-wic).
[b]BRFSS=Behavioral Risk Factor Surveillance System (http://www.cdc.gov/brfss/index.htm).
[c]SNAP-Ed=Supplemental Nutrition Assistance Program Education (http://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-education-snap-ed).
[d]NSLP=National School Lunch Program (http://www.fns.usda.gov/nslp/national-school-lunch-program-nslp).
[e]IOM=Institute of Medicine (United States) (http://www.iom.edu/).
[f]DGA=Dietary Guidelines for Americans (http://www.cnpp.usda.gov/dietaryguidelines).
[g]CDC=Centers for Disease Control and Prevention (United States) (http://www.cdc.gov).
[h]WHO=World Health Organization (http://www.who.int/en/).
[i]NASPE=National Standards for Physical Education (http://www.shapeamerica.org/standards/pe/).
[j]NHANES=National Health and Nutrition Examination Survey (United States) (http://www.cdc.gov/nchs/nhanes.htm).
[k]YRBSS=Youth Risk Behavior Surveillance System (http://www.cdc.gov/HealthyYouth/yrbs/index.htm).
[l]SHIPs=State Health Improvement Plans (http://www.astho.org/WorkArea/DownloadAsset.aspx?id=6597).
[m]USDA=US Department of Agriculture (http://www.usda.gov/wps/portal/usda/usdahome).
[n]NGOs=nongovernmental organizations.
[o]ABM=artificial breast milk.

Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition.

Standard 1: Quality in Practice
The registered dietitian nutritionist (RDN) provides quality services using a systematic process with identified leadership, accountability, and dedicated resources.

Rationale:
Quality practice in nutrition and dietetics is built on a solid foundation of education, 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					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
1.1	**Complies with applicable laws and regulations as related to his/her area(s) of practice**		**X**	**X**	**X**
	1.1A	Complies with local, regional, state, and federal government regulations and guidance (eg, nutrition education should be based off of MyPlate and/or DGA[a], ethics boards) and/or funders	X	X	X
1.2	**Performs within individual and statutory scope of practice**		**X**	**X**	**X**
	1.2A	Incorporates the Public Health Core Functions and 10 Essential Services (http://www.cdc.gov/nphpsp/essentialservices.html) in practice	X	X	X
	1.2B	Follows any additional scope of practice requirements related to additional credentialing or position (eg, Certified Health Education Specialist, Certified Diabetes Educator)	X	X	X
1.3	**Adheres to sound business and ethical billing practices applicable to the setting**		**X**	**X**	**X**
	1.3A	Provides accurate and timely financial reports to funders (eg, government grants and contracts, foundations, and nonprofits)		X	X
1.4	**Utilizes national and global quality and safety data (eg, Institute of Medicine, National Quality Forum, Institute for Healthcare Improvement, Healthy People 2020, Millennium Development Goals, NGO[b]/foundation benchmarks [eg, Kids Count, US Preventive Task Force]) to improve the quality of services provided and to enhance client/population-centered service**		**X**	**X**	**X**
	1.4A	Contributes to interdisciplinary team to promote understanding an adoption of recommended evidence-based practices		X	X
	1.4B	Leads local, state, national, and/or international quality initiative efforts to support public health and community nutrition goals and best practices			X
1.5	**Utilizes a systematic performance improvement model (eg, community health improvement plans) that is based on practice knowledge, evidence, research, and science for delivery of the highest quality services**		**X**	**X**	**X**
	1.5A	Incorporates health behavior theory, logic models, and/or other appropriate models to plan and implement programs and services; consults with more experienced practitioners as needed	X	X	X

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Figure 2. Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 1: Quality in Practice				
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators		**The "X" signifies the indicators for the level of practice**		
Each RDN:		**Competent**	**Proficient**	**Expert**
1.6	**Participates in or designs an outcomes-based management system to evaluate safety, effectiveness, and efficiency of practice**	**X**	**X**	**X**
1.6A	**Involves colleagues and others, as applicable, in systematic outcomes management**	**X**	**X**	**X**
1.6A1	Engages community members, funders, and multidisciplinary stakeholders in developing and monitoring outcomes-based management systems		X	X
1.6B	**Utilizes indicators that are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)**	**X**	**X**	**X**
1.6C	**Defines expected outcomes**	**X**	**X**	**X**
1.6C1	Includes process, impact, and outcome indicators	X	X	X
1.6C2	Relates program outcomes to multilevel outcomes (eg, agency, program, individual outcomes/needs)		X	X
1.6D	**Measures quality of services in terms of process and outcome**	**X**	**X**	**X**
1.6D1	Considers short-, medium-, and long-term outcomes, collaborating across agencies and partners, including cost-effectiveness		X	X
1.6E	**Documents outcomes**	**X**	**X**	**X**
1.6E1	Engages multidisciplinary partners, including the community, in documenting outcomes and impact		X	X
1.7	**Identifies and addresses potential and actual errors and hazards in provision of services**	**X**	**X**	**X**
1.7A	Applies food safety and sanitation protocols within food distribution programs	X	X	X
1.7B	Refers clients to appropriate services when hazard is outside of practitioner's scope of practice		X	X
1.7C	Works closely with federal, state, and local regulatory bodies to inform the public on food recalls and environmental hazards based on epidemiological surveillance data		X	X
1.7D	Applies Health Impact Assessments and/or biostatistical assessments to address unintended consequences		X	X
1.7E	Leads in collaboration with stakeholders development of processes to identify, addresses, and prevent errors or hazards (eg, state food safety protocols)			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 1: Quality in Practice					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
1.8	**Compares actual performance to performance goals (eg, Gap Analysis, SWOT Analysis [Strengths, Weaknesses, Opportunities, and Threats], PDCA Cycle [Plan-Do-Check-Act], Logic Models)**		**X**	**X**	**X**
	1.8A	**Reports and documents action plan to address identified gaps in performance**	**X**	**X**	**X**
1.9	**Evaluates interventions to improve processes and services**		**X**	**X**	**X**
	1.9A	Participates in dissemination and collection of intervention evaluations	X	X	X
	1.9B	Engages community members and stakeholders in intervention evaluations (eg, satisfaction surveys, alignment with cultural norms, process and outcome evaluations)		X	X
	1.9C	Designs systems and processes for obtaining community and stakeholder participation in intervention evaluations			X
1.10	**Improves or enhances services based on measured outcomes**		**X**	**X**	**X**
	1.10A	Uses culturally competent group engagement processes to improve and enhance services	X	X	X
	1.10B	Oversees, monitors, ensures consistency, and revises process and outcome evaluation efforts to improve services		X	X
	1.10C	Leads the development of performance improvement activities; designs and implements evaluation protocols, analyzes data, and implements improvements			X

Examples of Outcomes for Standard 1: Quality in Practice

- Actions are within scope of practice and applicable laws and regulations (eg, in providing MNT[c]; counsels, refers, and guides clients based on state rules around WIC-approved foods and current food package rules).
- National quality standards and best practices are evident in client/population-centered services (eg, organizes, participates in training on, and demonstrates effective application of Value Enhanced Nutrition Assessment).
- Performance indicators are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.) (eg, ensures program objectives align with and evaluation tools are valid and reliable in measuring intended outcomes).
- Aggregate outcomes meet pre-established criteria (eg, application of safe food-handling guidelines results in lowered risk/incidence of foodborne illness in food rescue program).
- Results of quality-improvement activities direct refinement and advancement of practice (eg, focus groups and client feedback forms are used to measure satisfaction with program participation and areas for improved delivery).

Standard 2: Competence and Accountability
The registered dietitian nutritionist (RDN) demonstrates competence in and accepts accountability and responsibility for ensuring safety and quality in the services provided.

Rationale:
Competence and accountability in practice includes continuous acquisition of knowledge, skills, and experience in the provision of safe, quality, client/population-centered service.

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 2: Competence and Accountability					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
2.1	**Adheres to the Academy Code of Ethics and Code of Ethics for Public Health**		**X**	**X**	**X**
	2.1A	Applies Public Health Code of Ethics (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447186/pdf/0921057.pdf) and the principal of interdependence of people and the health of the community	X	X	X
	2.1B	Applies Academy and Public Health Codes of Ethics within the context of federal, state, local, and agency guidelines (eg, advocacy guidelines)	X	X	X
2.2	**Integrates the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) into practice, self-assessment, and professional development**		**X**	**X**	**X**
	2.2A	Integrates applicable focus area SOPs and SOPPs into practice according to populations served (eg, Sustainable, Resilient, and Healthy Food and Water Systems, Diabetes Care, Pediatric Nutrition)	X	X	X
	2.2B	Incorporates the Public Health and Community Nutrition SOP and SOPP into human resources systems (eg, job descriptions and performance plans)		X	X
2.3	**Demonstrates and documents competence in practice and delivery of client/population-centered service**		**X**	**X**	**X**
	2.3A	Documents the engagement of the community and stakeholders in the delivery of services	X	X	X
2.4	**Assumes accountability and responsibility for actions and behaviors**		**X**	**X**	**X**
	2.4A	**Acknowledges and corrects errors**	**X**	**X**	**X**
		2.4A1 Reports errors and problems to funding agencies and ethical review boards		X	X
	2.4B	Utilizes lessons learned from previous projects		X	X
	2.4C	Ensures that all staff (including paraprofessionals or colleagues in other disciplines) have adequate training to deliver appropriate services; seeks consultation if needed		X	X
	2.4D	Directs and develops policies that assure accountability as applicable to a management role			X
2.5	**Conducts self-assessment at regular intervals**		**X**	**X**	**X**
	2.5A	**Identifies needs for professional development**	**X**	**X**	**X**
	2.5B	Uses self-assessment tools, such as those incorporated in the Guidelines for Community Nutrition Supervised Experiences (self-assessment tool for public health nutritionists to be republished in 2015/2016 as *Guidelines for Public Health and Community Nutrition Practice*, 3rd ed)	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 2: Competence and Accountability					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
2.6	**Designs and implements plans for professional development**		**X**	**X**	**X**
	2.6A	**Documents professional development activities in career portfolio**	**X**	**X**	**X**
		2.6A1 Includes professional development goals around key dimensions of public health practice (Analytical/Assessment, Policy Development/Program Planning, Communication, Cultural Competency, Community Dimensions of Practice, Public Health Sciences, Financial Planning and Management, Leadership, and Systems Thinking)	X	X	X
	2.6B	**Documents professional development activities as per organization guidelines**	**X**	**X**	**X**
2.7	**Engages in evidence-based practice and utilizes best practices**		**X**	**X**	**X**
	2.7A	Incorporates best practices for addressing the health needs of clients and population groups	X	X	X
	2.7B	Collaborates with key partners and allied professionals (eg, urban planners, social workers) to ensure incorporation of evidence-based and best practices from their field in program planning and implementation	X	X	X
	2.7C	Utilizes health behavior theories as the framework for best practices	X	X	X
	2.7D	Participates in councils, committees, and taskforces that shape evidence-based guidelines and practices supported by policy		X	X
	2.7E	Integrates research findings and evidence into peer-reviewed publications and recommendations for practice			X
2.8	**Participates in peer review of self and others**		**X**	**X**	**X**
	2.8A	Addresses public health domains in evaluation of self-performance and peer or employee evaluations	X	X	X
2.9	**Mentors others**		**X**	**X**	**X**
	2.9A	Guides the professional development and training of paraprofessionals, volunteers, community health workers, and promotoras working in the community	X	X	X
	2.9B	Participates in mentoring entry-level RDNs and RDNs interested in public health and community nutrition		X	X
	2.9C	Provides expertise and council to educational institutions related to mentoring and training of community and public health nutrition professionals			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 2: Competence and Accountability					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
2.10	**Pursues opportunities (education, training, credentials) to advance practice in accordance with laws and regulations and requirements of practice setting**		**X**	**X**	**X**
	2.10A	Remains informed on nutrition practice-related laws and public policy	X	X	X
	2.10B	Participates in training to ensure that programs are fair and equitable	X	X	X
	2.10C	Provides leadership to colleagues (RDNs, community members, and other public health professionals) on nutrition and public policy		X	X
	2.10D	Monitors public health nutrition program integrity and gains professional development as it relates to program regulations and nutrition standards (eg, FNS[d] programming: WIC[e], CACFP[f], NSLP[g])		X	X
	2.10E	Takes leadership roles in local, state and national advisory groups related to public health nutrition laws and regulations			X

Examples of Outcomes for Standard 2: Competence and Accountability

- Practice reflects the code of ethics and adheres to ethical principles relevant to public health issues (eg, Skills for the Ethical Practice of Public Health, James Thomas, PhD, MPH, University of North Carolina—Public Health Leadership Society, 2004)
- Practice reflects the SOP/SOPP as a basis for all interactions with organizations, communities, populations, and individuals
- Competence is demonstrated and documented (Core Competencies for Public Health Professionals, Council on Linkages between Academia and Public Health Practice, 2010: http://www.phf.org/programs/corecompetencies)
- Safe, quality client/population service is provided, which is client/population-centered recognizing community linkages and relationships among multiple factors/determinants (eg, uses the Socio-ecological Model)
- Practice incorporates successful strategies for interactions with individuals/groups from diverse backgrounds (cultural, socioeconomic, educational, racial, sex, age, ethnic, sexual orientation, religious, mental/physical capabilities)
- Self-assessments are conducted regularly using this SOP/SOPP or the University of Minnesota's Self-Assessment Tool for Public Health/Community Nutritionists (http://www.epi.umn.edu/let/assessment/index.shtm)
- Professional Development needs are identified and incorporate assessment of skills for Public Health Professionals (eg, Competency Assessment, Public Health Foundation)
- Practice reflects evidenced-based practice and best practices
- Partnerships are developed with other public health and community professionals to build the scientific base
- Commission on Dietetic Registration recertification requirements are met

Standard 3: Provision of Services

The registered dietitian nutritionist (RDN) provides safe, quality service based on client/population expectations and needs, and the mission and vision of the organization/business.

Rationale:

Quality programs and services are designed, executed, and promoted based on the RDN's knowledge, experience, and competence in addressing the needs and expectations of the organization/business and its clients/populations.

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
3.1	**Contributes to or leads the development and maintenance of programs/services that address needs of the clients/target population(s)**			**X**	**X**	**X**
	3.1A	**Aligns program/service development with the mission, vision, and service expectations and outputs of the organization/business**		**X**	**X**	**X**
		3.1A1	Utilizes the logic model in order to meet the health outcomes of clients/populations	X	X	X
		3.1A2	Develops programs with short-, medium- and long-term goals with a shared vision of health across all levels of the Socio-ecological Model in order to maximize the reach and effectiveness of programs			X
	3.1B	**Utilizes the needs, expectations, and desired outcomes of the client/population (eg, administrator, client organization[s]) in program/service development**		**X**	**X**	**X**
		3.1B1	Includes the community, policy makers, and other stakeholders in the development of programs	X	X	X
		3.1B2	Integrates population-based/formative assessments findings into service delivery		X	X
	3.1C	**Makes decisions and recommendations that reflect stewardship of time, talent, finances, and environment**		**X**	**X**	**X**
		3.1C1	Shapes, modifies, and adapts program and service delivery in alignment with funding requirements and priorities		X	X
		3.1C2	Emphasizes the transformation of community environments through population-level programs			X
	3.1D	**Proposes programs and services that are client/population-centered, culturally appropriate, and minimize health disparities**		**X**	**X**	**X**
		3.1D1	Follows federal guidance (eg, USDA[h], FNS, and CDC[i]) to ensure that programming incorporates inclusivity, equality and equity	X	X	X
		3.1D2	Engages community stakeholders in the development, adaptation, and sustainability of programs	X	X	X
		3.1D3	Uses and collects data to track changes in health disparities and ensure inclusivity, equality, and equity		X	X
		3.1D4	Creates messages and opportunities to address social justice and social equity		X	X
		3.1D5	Develops recommendations related to policy, systems, and environmental support			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 3: Provision of Services					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
3.2	**Promotes public access and referral to credentialed nutrition and dietetics practitioners for quality food and nutrition programs and services**		**X**	**X**	**X**
	3.2A	**Contributes to or designs referral systems that promote access to qualified, credentialed nutrition and dietetics practitioners**	**X**	**X**	**X**
	3.2A1	Ensures that RDNs are part of a multidisciplinary approach across collaborative programs and efforts	X	X	X
	3.2B	**Refers clients/populations to appropriate providers when requested services or identified needs exceed the RDN's individual scope of practice**	**X**	**X**	**X**
	3.2B1	Implements established agreements and referral systems for social and health-related services (eg, dental, family planning, community action agencies)	X	X	X
	3.2B2	Creates policies and practices that support a strong safety net for clients and populations		X	X
	3.2B3	Establishes agreements and referral systems with health and community partners			X
	3.2B4	Supports referral sources with curriculum and training regarding needs of client/population			X
	3.2C	**Monitors effectiveness of referral systems and modifies as needed to achieve desirable outcomes**	**X**	**X**	**X**
	3.2C1	Collects and uses data to track effectiveness of referral systems (eg, WIC information systems) for targeted outcomes	X	X	X
	3.2C2	Shares aggregate referral data and related outcomes of the referral with external partners (eg, reports on smoking rates)	X	X	X
	3.2C3	Completes process and outcome evaluation of referral system and reports back to stakeholders and/or funders		X	X
	3.2C4	Modifies referral system in collaboration with external partners to improve effectiveness			X
3.3	**Contributes to or designs client/population-centered services**		**X**	**X**	**X**
	3.3A	**Assesses needs, beliefs/values, goals, and resources of the client/population**	**X**	**X**	**X**
	3.3A1	Conducts needs assessments (eg, community health assessments) in partnership with individuals and community stakeholders; consults with more experienced practitioners as needed	X	X	X
	3.3A2	Develops targeted, tailored, and/or personalized services based on needs assessments and cultural norms	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				The "X" signifies the indicators for the level of practice		
Each RDN:				Competent	Proficient	Expert
		3.3A3	Conducts formative assessments/research in developing services			X
	3.3B	**Utilizes knowledge of the client's/target population's health conditions, cultural beliefs, and business objectives/services to guide design and delivery of client/population-centered services**		**X**	**X**	**X**
		3.3B1	Collaborates with community stakeholders to ensure comprehensive services	X	X	X
		3.3B2	Tailors interventions based on health behavior theory (eg, Stages of Change, Socio-ecological Model, Social Cognitive Theory)	X	X	X
		3.3B3	Utilizes common terminology with community stakeholders to promote community nutrition initiatives/services	X	X	X
		3.3B4	Creates programs tailored to populations' needs based on nutrition-related factors identified in assessments		X	X
		3.3B5	Leads in utilizing, evaluating, and communicating the effectiveness of different theoretical frameworks for interventions (eg, Health Belief Model, Social Cognitive Theory)			X
	3.3C	**Communicates principles of disease prevention and behavioral change appropriate to the client or target population**		**X**	**X**	**X**
		3.3C1	Communicates the relationships among food, environment/ systems, and disease prevention as the foundation for nutrition education, programs, and prevention approaches	X	X	X
		3.3C2	Connects food and the environment/systems using the Socio-ecological Model for clients, populations, and stakeholders		X	X
	3.3D	**Collaborates with the clients and target populations to set priorities, establish goals, and create client/population-centered action plans to achieve desirable outcomes**		**X**	**X**	**X**
		3.3D1	Uses a participatory process to engage clients and populations	X	X	X
	3.3E	**Involves clients and target population in decision making**		**X**	**X**	**X**
3.4	**Executes programs/services in an organized, collaborative, and client/ population-centered manner**			**X**	**X**	**X**
	3.4A	**Collaborates and coordinates with peers, colleagues, stakeholders, and within interdisciplinary teams**		**X**	**X**	**X**
		3.4A1	Consults and provides expertise with partners to ensure evidence-based nutrition services	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				The "X" signifies the indicators for the level of practice		
Each RDN:				Competent	Proficient	Expert
		3.4A2	Shares initiatives and health outcomes of services with all levels of stakeholders and policy makers (eg, evaluations shared with government and legislature, policy makers, school communities); consults with more experienced practitioners as needed		X	X
		3.4A3	Ensures that public health nutrition is integrated in multidisciplinary programs across the lifespan (eg, child care, schools, senior programs)		X	X
		3.4A4	Leads interdisciplinary and/or interagency teams addressing community and public health nutrition priorities			X
	3.4B	**Participates in or leads in the design, execution, and evaluation of programs and services (eg, nutrition screening system, medical and retail foodservice, electronic health records, interdisciplinary programs, community education, grant management) for clients and target populations**		**X**	**X**	**X**
		3.4B1	Comments on state and federal rules to actively shape nutrition programs (eg, MCHB[j] block grant and federal nutrition assistance programs)	X	X	X
		3.4B2	Incorporates social determinants of health into evaluation		X	X
		3.4B3	Communicates feasibility and fiscal implications of services with funders, policy makers, and stakeholders			X
		3.4B4	Justifies public dollars and ROI[k] based on services			X
		3.4B5	Writes and reviews guidelines and statutes for local, state, and federal programs			X
	3.4C	**Develops or contributes to design and maintenance of policies, procedures, protocols, standards of care, technology resources, and training materials that reflect evidence-based practice in accordance with applicable laws and regulations**		**X**	**X**	**X**
		3.4C1	Conducts reviews to ensure that policies and procedures are followed		X	X
		3.4C2	Demonstrates effectiveness of staff training in compliance with policies and procedures		X	X
		3.4C3	Ensures that program staff have the appropriate technology, infrastructure, and tools to implement programs/services according to policies and procedures		X	X
		3.4C4	Documents that policies and practices are being implemented appropriately to provide a data-driven practice		X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		3.4C5	Interprets federal regulations for state and local policy implementation			X
		3.4C6	Conducts feasibility analyses to ensure alignment with expected outcomes and sustainability			X
		3.4C7	Forecasts financing and mechanisms for funding nutrition services			X
	3.4D	**Participates in or develops process for clinical privileges required for enhanced activities and expanded roles consistent with state practice acts, federal and state regulations, organization policies, and medical staff rules, regulations and bylaws; enhanced activities include but not limited to implementing physician-driven protocols or other facility-specific processes, initiating or modify orders for therapeutic diets, nutrition supplements, dietary supplements, enteral and parenteral nutrition, nutrition-related laboratory tests and medications, and adjustments to fluid therapies or electrolyte replacements; expanded roles and nutrition-related services include but not limited to initiating and performing bedside swallow screenings, insertion and monitoring of nasogastric and nasoenteric feeding tubes, and indirect calorimetry measurements**		**X**	**X**	**X**
		3.4D1	Complies with federal and state regulations to administer client nutrition services (eg, special WIC formulas and special diets in schools)	X	X	X
	3.4E	**Complies with established billing regulations and adheres to ethical billing practices**		**X**	**X**	**X**
		3.4E1	Collects data to support funding and program costs	X	X	X
		3.4E2	Manages financial operations in accordance with grant/ funding requirements and guidelines		X	X
		3.4E3	Oversees braid funding (mixing and intertwining) to ensure rules are being followed (eg, state money with foundation funds)			X
		3.4E4	Maximizes population impact by leveraging funding and institutes policies and practices to prevent supplanting of funds			X
	3.4F	**Communicates with the interdisciplinary team and referring party consistent with the Health Insurance Portability and Accountability Act (HIPAA) rules for use and disclosure of client's personal health information**		**X**	**X**	**X**
		3.4F1	Operates in accordance with state guidance on disclosure/ protection of personal identifying information	X	X	X

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Indicators for Standard 3: Provision of Services					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
3.5		**Utilizes support personnel appropriately in the delivery of client/population-centered care in accordance with laws, regulations, and organization policies**	**X**	**X**	**X**
	3.5A	**Assigns activities, including direct care to clients/populations, consistent with the qualifications, experience and competence of support personnel**	**X**	**X**	**X**
	3.5A1	Designs procedures to appropriately assign client referrals based on nutrition risk and competence level of health professionals (eg, support personnel, such as paraprofessionals providing nutrition education in WIC)		X	X
	3.5A2	Creates and provides continuing education for staff at all levels and partnering agencies		X	X
	3.5B	**Supervises technical and support personnel (eg, promotoras and community health workers, volunteers, and cultural brokers)**	**X**	**X**	**X**
3.6		**Designs and implements food delivery systems to meet the needs of clients/target populations**	**X**	**X**	**X**
	3.6A	**Collaborates on or designs food delivery systems to address nutrition status, health care needs and outcomes, and to satisfy the cultural preferences and desires of target populations (eg, health care patients/clients, employee groups, visitors to retail venues, schools, senior centers, community clinics, farmers markets, grocery stores, community feeding sites, food banks)**	**X**	**X**	**X**
	3.6A1	Tailors food availability within federal programs (eg, WIC food packages) to populations' and clients' needs	X	X	X
	3.6A2	Supports and leverages increased healthy food access across food assistance programs (eg, food banks and food assistance programs)	X	X	X
	3.6A3	Collaborates with interdisciplinary partners to create and improve access to healthy food systems (eg, farmers markets, healthy food financing, food policy councils, community supported agriculture initiatives)	X	X	X
	3.6A4	Participates in outreach and/or referrals to ensure those who are eligible participate in federal food assistance programs	X	X	X
	3.6B	**Participates in, consults with others or leads in developing menus to address health and nutritional needs of target population(s) in accordance with guidance (eg, federal food assistance programs such as CACFP, School Meal Programs)**	**X**	**X**	**X**
	3.6C	**Participates in, consults, or leads interdisciplinary process for determining nutritional supplements, dietary supplements, enteral and parenteral nutrition formularies and delivery systems for target population(s)**	**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				The "X" signifies the indicators for the level of practice		
Each RDN:				Competent	Proficient	Expert
3.7	**Maintains records of services provided**			**X**	**X**	**X**
	3.7A	**Documents according to organization policy, standards, and system including electronic health records**		**X**	**X**	**X**
		3.7A1	Creates reports as required by state and federal program regulations and/or grant requirements		X	X
	3.7B	**Implements data management systems to support data collection, maintenance, and utilization**		**X**	**X**	**X**
		3.7B1	Transfers local and state data to federal agencies (eg, USDA Participant Characteristics Report)	X	X	X
		3.7B2	Participates in nutrition surveillance systems	X	X	X
		3.7B3	Aligns measures with state and federal recommendations		X	X
		3.7B4	Creates data management systems for local and state nutrition surveillance		X	X
	3.7C	**Uses data to document outcomes of services (eg, health outcomes, staff productivity, cost/benefit, budget compliance, quality of services) and provide justification for maintenance or expansion of services**		**X**	**X**	**X**
		3.7C1	Monitors and documents short-, medium-, and long-term outcomes	X	X	X
		3.7C2	Shares program outcomes and impact with the program participants and public	X	X	X
		3.7C3	Provide structure and systems for staff to create reports to identify program outcomes and gaps		X	X
	3.7D	**Uses data to demonstrate compliance with accreditation standards, laws, and regulations**		**X**	**X**	**X**
		3.7D1	Conducts (eg, through management evaluations) reviews to ensure compliance with state policies and federal regulations		X	X
3.8	**Advocates for provision of quality food and nutrition services as part of public policy**			**X**	**X**	**X**
	3.8A	**Communicates with policy makers regarding the benefit/cost of quality food and nutrition services**		**X**	**X**	**X**
		3.8A1	Identifies policies and proposed legislation at local, state, federal, and international levels that impact public health nutrition	X	X	X
		3.8A2	Considers organizational policies related to advocacy	X	X	X

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Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		3.8A3	Promotes policy change in support of public health and community nutrition services		X	X
		3.8A4	Collaborates with groups working on public health nutrition policies and legislation at local, state, federal, and international levels		X	X
		3.8A5	Organizes dynamic grassroots campaigns to educate and engage the community on benefit/cost of quality public health and community nutrition services		X	X
		3.8A6	Facilitates forums about proposed legislation, rules, or codes that impact the delivery of quality public health and community nutrition services		X	X
		3.8A7	Develops draft legislation or policies in cooperation with policy makers that advance public health and community nutrition services			X
		3.8A8	Performs public health and community nutrition policy analysis, identifies gaps and opportunities in current public policies and adjusts strategies as needed			X
		3.8A9	Develops and implements a communication plan to educate policy makers about benefit/cost of quality public health and community nutrition services			X
	3.8B	**Advocates in support of food and nutrition programs and services for populations with special needs**		**X**	**X**	**X**
		3.8B1	Advances access to healthy food/water and food assistance programs for underserved populations including underserved groups (eg, individuals living on reservations)	X	X	X
	3.8C	Serves on local, state, federal, or international committees that support policies and initiatives that improve the delivery of public health and community nutrition as appropriate to experience and skill level		X	X	X

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Examples of Outcomes for Standard 3: Provision of Services

- Program/service design and systems aligns with organization/agencies mission and is centered around client/population needs and impact.
- Population and targeted communities participate in establishing goals and client/population-focused action plans.
- Population/community needs are met and feel that public health and community nutrition programs are responsive to public concerns about nutrition and health.
- The public is actively engaged in improving the health of themselves and their larger community.
- Evaluations reflect expected outcomes, including efficiency, effectiveness, and ability to achieve equity among populations.
- Effective screening and referral services are established.
- Clients have access to food assistance.
- Clients have access to food and nutrition services at the federal, state, and local levels.
- Support personnel are supervised when applying nutrition care standards in programs and policies.
- Ethical and transparent funding practices are utilized in all aspects of grant management.

Public Health Nutrition Provision of Service Example: The Value Enhanced Nutrition Assessment (VENA) process in WIC includes participant-centered standards for nutrition assessment centered around personalizing WIC nutrition education, providing more relevant community referrals, and tailoring the food package based on needs and cultural preferences. This participant-centered approach in WIC has strengthened the effectiveness of nutrition services and optimized the nutrition status of the larger population as a whole.

Standard 4: Application of Research
The registered dietitian nutritionist (RDN) applies, participates in, or generates research to enhance practice. Evidence-based practice incorporates the best available research/evidence 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.

Indicators for Standard 4: Application of Research						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
4.1	**Accesses and reviews best available research/evidence for application to practice**			**X**	**X**	**X**
	4.1A	Identifies science-based information from multiple reputable disciplines and sources (eg, government, national/international nongovernment organization publications)		X	X	X
	4.1B	Demonstrates understanding of research design and methodology, data collection, interpretation of results, and application within client and population groups			X	X
		4.1B1	Critically evaluates the integrity of science-based information for limitations and potential bias		X	X
	4.1C	Demonstrates the experience and critical thinking skills required to review original research and evidence-based guidelines relevant to public health and community nutrition			X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 4: Application of Research					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
4.2	**Utilizes best available research/evidence as the foundation for evidence-based practice**		**X**	**X**	**X**
	4.2A	Follows evidence-based practice guidelines and recommendations (eg, Academy EAL[l], APHA[m], IOM[n], CDC, WHO[o], HRSA[p], USDA, MCHB, USPSTF[q], HHS[r], AAP[s]) to provide quality service for populations and communities	X	X	X
	4.2B	Interprets current research in public health and community nutrition and related areas and applies to professional practice as appropriate	X	X	X
	4.2C	Utilizes the Academy EAL as a resource in writing or reviewing research papers	X	X	X
	4.2D	Incorporates latest evidence to support delivery of public health programs in grant proposals		X	X
	4.2E	Applies an evidence-based approach to develop and/or evaluate proposals in relationship to existing public health nutrition research, laws/regulations, and recommendations			X
4.3	**Integrates best available research/evidence with best practices, clinical and managerial expertise, and client/population values**		**X**	**X**	**X**
	4.3A	Creates opportunities for community engagement to address target population needs in public health and community nutrition research and evaluation	X	X	X
	4.3B	Evaluates and responds to the unintended consequences and externalities of public health and community nutrition practice		X	X
	4.3C	Mentors others in identifying and applying best available research/evidence and best practices to integrate into practice			X
4.4	**Contributes to the development of new knowledge and research in nutrition and dietetics**		**X**	**X**	**X**
	4.4A	Uses evidence-based guidelines, best practices, and clinical experience to generate new knowledge and develop guidelines, programs, and policies in public health and community nutrition	X	X	X
	4.4B	Participates in interdisciplinary research teams to address public health and community nutrition issues	X	X	X
	4.4C	Initiates research with specific population groups to address public health and community nutrition needs in collaboration with others (eg, biostatistician, epidemiologist)		X	X
	4.4D	Evaluates impacts of public health and community nutrition services on environmental, economic, social, and health outcomes		X	X
	4.4E	Contributes to the development of evidence-based practice guidelines and position papers related to public health and community nutrition		X	X

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Indicators for Standard 4: Application of Research					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			The "X" signifies the indicators for the level of practice		
Each RDN:			Competent	Proficient	Expert
	4.4F	Functions as an author or major contributor or reviewer of research and organization position papers, and other scholarly work			X
	4.4G	Serves as advisor, mentor, preceptor, and/or committee member for graduate-level research			X
4.5	**Promotes research through alliances and collaboration with food and nutrition and other professionals and organizations**		**X**	**X**	**X**
	4.5A	Participates as a member/consultant to collaborative teams addressing public health and community nutrition issues by providing science-based expertise as appropriate for skill level	X	X	X
	4.5B	Disseminates the results and emphasizes the significance and value of public health and community nutrition research findings	X	X	X
	4.5C	Identifies key stakeholder groups and their public health and community nutrition priorities for further research collaborations		X	X
	4.5D	Advocates to stakeholder organizations for prioritizing and funding of public health and community nutrition research projects			X
	4.5E	Serves as a primary or senior investigator in collaborative research and evaluation teams that examines relationships among environmental, economic, social, and health outcomes			X

Examples of Outcomes for Standard 4: Application of Research

- Evidence-based practice, best practices, clinical and managerial expertise, client/population values, and public health and community nutrition principles are integrated in the delivery of nutrition and dietetics services
- Innovations in nutrition services are provided based on the effective application of best available research/evidence
- Improvements to federal and state nutrition guidelines and/or programs are made based on trends and data from public health and community nutrition programs and studies

Standard 5: Communication and Application of Knowledge
The registered dietitian nutritionist (RDN) effectively applies knowledge and expertise in communications.

Rationale:
The RDN works with and through others to achieve common goals by effective sharing and application of their unique knowledge, skills and expertise in food, nutrition, dietetics, and management services.

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Indicators for Standard 5: Communication and Application of Knowledge					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
5.1	**Communicates current, evidence-based knowledge related to a particular aspect of the profession of nutrition and dietetics**		**X**	**X**	**X**
	5.1A	Disseminates nutrition recommendations and tailors communications to population groups	X	X	X
	5.1B	Incorporates appropriate communication strategies to meet the needs of internal and external partners	X	X	X
	5.1C	Translates evidence-based research (eg, epidemiological trends, program outcomes) and policy to practical application in communications with diverse stakeholders and the general public		X	X
	5.1D	Serves as an expert in public health and community nutrition with diverse stakeholders		X	X
5.2	**Communicates and applies best available research/evidence**		**X**	**X**	**X**
	5.2A	**Demonstrates critical thinking and problem-solving skills when communicating with others**	**X**	**X**	**X**
		5.2A1 Evaluates and addresses environmental, economic, social, and health variables in communications with diverse stakeholders		X	X
	5.2B	Addresses potential bias (eg, funding, motivation, values) and the importance of transparency in public health and community nutrition-related science	X	X	X
	5.2C	Models critical thinking skills and provides open and inclusive environments for discussions		X	X
5.3	**Selects appropriate information and most effective method or format when communicating information and conducting nutrition education and counseling**		**X**	**X**	**X**
	5.3A	**Utilizes communication methods (ie, oral, print, one-on-one, group, visual, electronic, and social media) targeted to the audience**	**X**	**X**	**X**
		5.3A1 Communicates public health and community nutrition information and trends through social media networks	X	X	X
	5.3B	**Uses information technology to communicate, manage knowledge, and support decision making**	**X**	**X**	**X**
		5.3B1 Implements systems including health/management information systems in order to facilitate, communicate and collaborate with partners to deliver services (eg, Utah WIC electronic prescription system)			X

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Indicators for Standard 5: Communication and Application of Knowledge						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	5.3C	Incorporates health literacy, cultural competence, and developmental appropriateness in communications and educational materials		X	X	X
		5.3C1	Evaluates materials for health literacy, cultural competence, developmental appropriateness (eg, CDC's Simply Put, Academy DANEH[t], HECAT[u])	X	X	X
		5.3C2	Advises others as a subject matter expert on health literacy, cultural competence, developmental appropriateness			X
5.4	**Integrates knowledge of food and nutrition with knowledge of health, social sciences, communication, and management in new and varied contexts**			**X**	**X**	**X**
	5.4A	Networks with multilevel partners and stakeholders that impact federal, state, and local public health and community nutrition programs		X	X	X
		5.4A1	Addresses the environment, policy, and systems with regards to food access and community needs		X	X
		5.4A2	Leads activities that engage multilevel partners and stakeholders in collaborations around local, state, national, and/or international public health and community nutrition programs			X
5.5	**Shares current, evidence-based knowledge, information with clients/populations, colleagues, and the public**			**X**	**X**	**X**
	5.5A	**Guides clients/populations, students, and interns in the application of knowledge and skills**		**X**	**X**	**X**
		5.5A1	Mentors or serves as a preceptor for community nutrition students and dietetic interns, as well as novice public health students considering specialties in nutrition and food systems	X	X	X
		5.5A2	Provides multidisciplinary education and experiential learning opportunities		X	X
		5.5A3	Contributes to the education and professional development of RDNs, public health, and/or health care professionals through formal and informal mentor/teaching		X	X
		5.5A4	Expands course curricula, site-specific learning activities and research projects to include public health and community nutrition principles and application			X
	5.5B	**Assists individuals and groups to identify and secure appropriate and available resources and services**		**X**	**X**	**X**
		5.5B1	Promotes and supports programs, businesses, policies, and resources that incorporate public health and community nutrition principles	X	X	X

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Indicators for Standard 5: Communication and Application of Knowledge					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			The "X" signifies the indicators for the level of practice		
Each RDN:			Competent	Proficient	Expert
	5.5C	**Utilizes professional writing and verbal skills in communications**	**X**	**X**	**X**
	5.5C1	Sharpens written and oral communication skills with the ability to translate complex scientific and policy information to the general public	X	X	X
	5.5C2	Disseminates public health and community nutrition lessons learned and best practices	X	X	X
	5.5C3	Develops grants and white papers, delivers presentations, and authors books and articles that incorporate public health and community nutrition for peers, consumers, health professionals, community groups, policy makers, and food systems leaders		X	X
	5.5C4	Functions as an expert or media spokesperson on public health and community nutrition (eg, interviews, guest commentary, editorials)			X
5.6	**Establishes credibility and contributes as a resource within interdisciplinary professional teams and communities to promote food and nutrition strategies that enhance health and quality of life outcomes for target populations**		**X**	**X**	**X**
	5.6A	Conducts activities and provides resources to educate members of the interdisciplinary team about public health and community nutrition, its applications and impacts on human, environmental, economic, and social health	X	X	X
	5.6B	Participates in multidisciplinary or interdisciplinary collaborations at a systems level (eg, community advisory boards, food policy councils, licensure boards)		X	X
	5.6C	Contributes nutrition-related expertise to high-level national projects and professional organizations (eg, USDA food assistance programs, Let's Move!, Healthy People, IOM)			X
5.7	**Communicates performance improvement and research results through publications and presentations**		**X**	**X**	**X**
	5.7A	Presents evidence-based public health and community nutrition research and information to community groups and colleagues	X	X	X
	5.7B	Interprets demographics, statistical, epidemiological, programmatic, and scientific information		X	X
	5.7C	Serves in a leadership role for public health and community nutrition-related scholarly work (eg, reviewer, editor, editorial advisory board) and in program planning for conferences (eg, local, regional, national, and international)			X
	5.7D	Directs collation of research data (eg, position papers, practice papers, meta-analysis, review articles) into publications and presentations			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 5: Communication and Application of Knowledge					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			The "X" signifies the indicators for the level of practice		
Each RDN:			Competent	Proficient	Expert
	5.7E	Translates research findings for incorporation into development of policies, procedures, and guidelines for professional and lay audiences			X
5.8	**Seeks opportunities to participate in and assume leadership roles in local, state, and national professional and community-based organizations**		**X**	**X**	**X**
	5.8A	Functions as a public health and community nutrition resource as an active member of local/state/national organizations	X	X	X
	5.8B	Serves as a subject matter expert in public health and community nutrition with local, state, national, and international organizations			X
	5.8C	Manages and directs the integration of public health and community nutrition principles within larger systems			X

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

- Expertise in food, nutrition, and management is demonstrated and shared (eg, document and communicate expertise through policy briefs, articles, position statements, and proposals).
- Information technology is used to support practice (eg, support the daily practice/work, enhance efficiency, productivity, and effectiveness through the utilization of shared networks and applications, such as SharePoint).
- Effective and efficient communications occur through appropriate and professional use of e-mail, texting, and social media tools such as Facebook and Twitter. Clients/populations and stakeholders:
  - Receive current and appropriate information and client/population-centered service;
  - Demonstrate understanding of information received; and
  - Know how to obtain additional guidance from the RDN.
- Leadership is demonstrated through active professional and community involvement (eg, participate on committees, boards, and work groups for organizations such as March of Dimes, State Public Health Associations and Health Coalitions, American Heart Association and American Diabetes Association, Academy of Nutrition and Dietetics)

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, and human resources.

Indicators for Standard 6: Utilization and Management of Resources					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			The "X" signifies the indicators for the level of practice		
Each RDN:			Competent	Proficient	Expert
6.1	**Uses a systematic approach to manage resources and improve operational outcomes**		**X**	**X**	**X**
	6.1A	Uses logic model or other appropriate models to guide the planning, implementation, and evaluation of services	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 6: Utilization and Management of Resources					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	6.1B	Manages and implements information management systems to disseminate resources, policies, and trainings while maximizing staff resources		X	X
	6.1C	Implements programs with long-term sustainability plans, leveraging diverse resources and funding streams		X	X
	6.1D	Oversees the responsible and accurate management of sub-grants in order to achieve comprehensive outcomes			X
6.2	**Quantifies management of resources in the provision of nutrition and dietetic services with the use of standardized performance measures and benchmarking as applicable**		**X**	**X**	**X**
	6.2A	Participates in operational planning of food and nutrition programs and services (eg, grant writing, management of deliverables, collecting program evaluation data, budgeting staff and resources in accordance with grant allocation and expected outcomes)	X	X	X
	6.2B	Manages effective delivery of nutrition programs and services (eg, business and marketing planning, cost−benefit analysis, program administration, delivery of education programs, materials development, program evaluation) related to public health and community nutrition programs		X	X
	6.2C	Directs or manages business and strategic planning for the design and delivery of nutrition services in public health and community nutrition for international, federal, state, and/or local settings			X
6.3	**Evaluates safety, effectiveness, productivity, and value while planning and delivering services and products**		**X**	**X**	**X**
	6.3A	Incorporates formative evaluations through a participatory approach including diverse stakeholders and community members	X	X	X
	6.3B	Assesses and communicates short-, medium-, and long-term program effectiveness given the use of public funds to deliver services		X	X
	6.3C	Ensures organizational practices are in concert with changes in the public health and community nutrition system and the larger social, political, and economic environment			X
6.4	**Participates in quality assurance and performance improvement and documents outcomes and best practices relative to resource management**		**X**	**X**	**X**
	6.4A	Engages the community and stakeholders in continuous quality-improvement processes		X	X
	6.4B	Anticipates outcomes and consequences of different approaches and makes necessary modifications to achieve desired outcomes (eg, health impact assessment process) in context of resources		X	X
	6.4C	Directs the development and management of continuous quality-improvement systems (eg, fiscal, personnel, services, materials, data)			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Public Health and Community Nutrition. Note: The term *client/population* is used in this evaluation resource as a universal term. Client/population could also mean client/patient, resident, participant, consumer, student, or any individual, group, organization or stakeholder to which the RDN provides services.

Indicators for Standard 6: Utilization and Management of Resources					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	6.4D	Reports outcomes of delivery of services against goals and performance targets			X
	6.4E	Partners with health economists to assess ROI of services and programs			X
6.5	**Measures and tracks trends regarding patient/client/population, employee and stakeholder satisfaction in the delivery of products and services**		**X**	**X**	**X**
	6.5A	Conducts regular surveys with participants and stakeholders to assess client/population satisfaction	X	X	X
	6.5B	Communicates the need for change based on collected data		X	X
	6.5C	Resolves internal and external problems that may affect the delivery of essential public health and community nutrition services			X

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

- Resources are effectively and efficiently managed to promote client/population health.
- Documentation of resource use is consistent with requirements of funding and oversight agencies.
- Data are used to promote, improve, and validate interventions, organizational practice, and public policy.
- Desired outcomes are achieved, documented, and disseminated to stakeholders.

[a]DGA=Dietary Guidelines for Americans (http://www.cnpp.usda.gov/dietaryguidelines).
[b]NGO=nongovernmental organization.
[c]MNT=medical nutrition therapy.
[d]FNS=US Department of Agriculture Food and Nutrition Service (http://www.fns.usda.gov/).
[e]WIC=Special Supplemental Nutrition Program for Women Infants and Children (United States) (http://www.fns.usda.gov/wic/women-infants-and-children-wic).
[f]CACFP=Child and Adult Care Food Program (United States) (http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program).
[g]NSLP=National School Lunch Program (http://www.fns.usda.gov/nslp/national-school-lunch-program-nslp).
[h]USDA=US Department of Agriculture (http://www.usda.gov/wps/portal/usda/usdahome).
[i]CDC=Centers for Disease Control and Prevention (United States) (http://www.cdc.gov).
[j]MCHB=Maternal and Child Health Bureau (http://mchb.hrsa.gov/).
[k]ROI=return on investment.
[l]EAL=Academy of Nutrition and Dietetics Evidence Analysis Library (http://andeal.org).
[m]APHA=American Public Health Association (http://www.apha.org).
[n]IOM=Institute of Medicine (United States) (http://www.iom.edu/).
[o]WHO=World Health Organization (http://www.who.int/en/).
[p]HRSA=Health Resources and Services Administration (http://www.hrsa.gov/index.html).
[q]USPSTF=US Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/).
[r]HHS=US Department of Health and Human Services (http://www.hhs.gov/).
[s]AAP=American Academy of Pediatrics (https://www.aap.org/en-us/Pages/Default.aspx).
[t]DANEH=Developing and Assessing Nutrition Education Handouts (http://healthyfoodbankhub.feedingamerica.or/wp-content/uploads/2013/12/Nutrition-Education-Handout-Checklist-rev-10-17-13.pdf).
[u]HECAT=Health Education Curriculum Analysis Tool (http://www.cdc.gov/healthyyouth/HECAT/).

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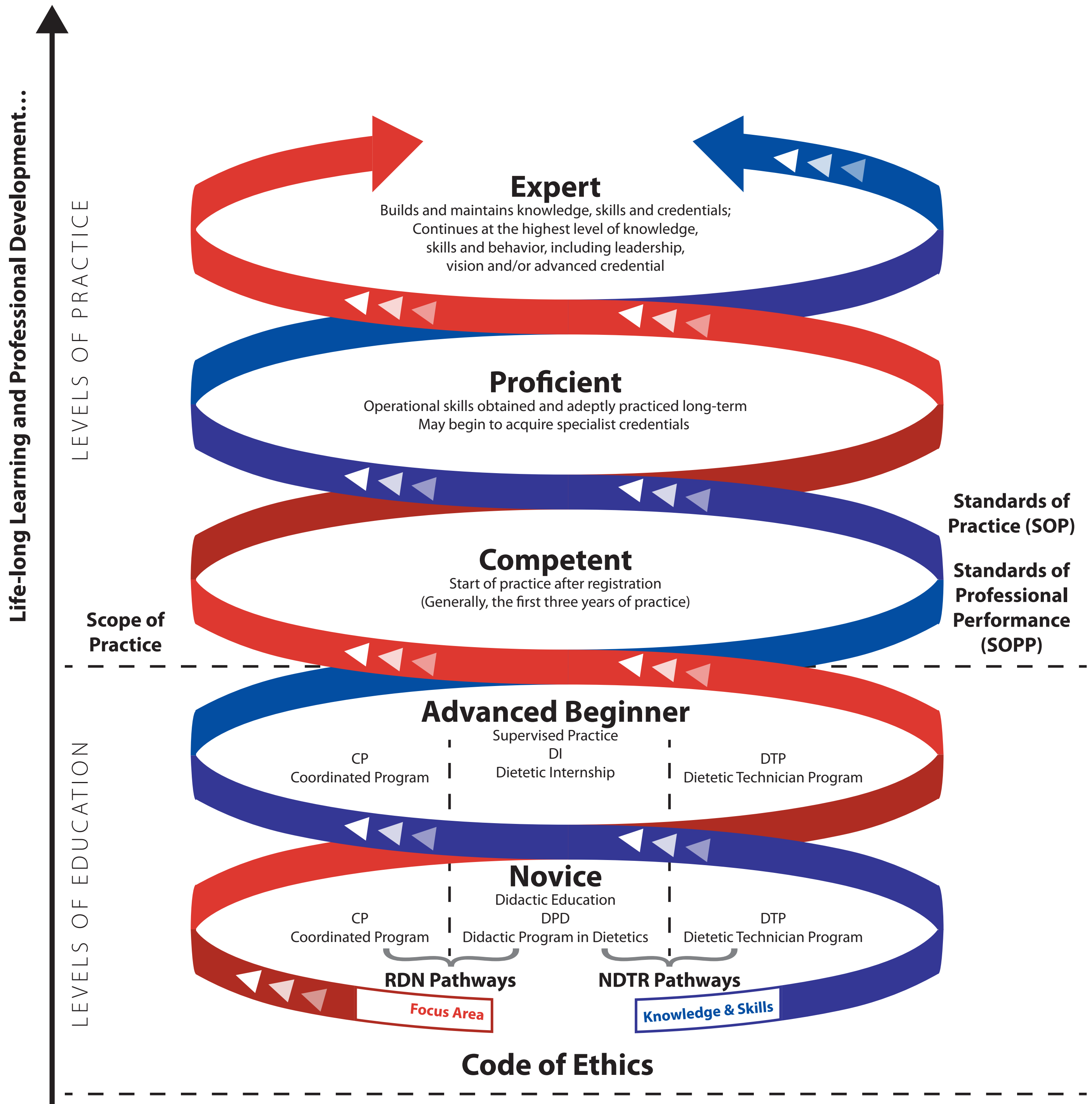
Nutrition and Dietetics Career Development Guide



Education for Entry into Career

Associate, Baccalaureate or Advanced Degree

Definition of Nutrition and Dietetics: Nutrition and Dietetics reflects the integration of Nutrition—which encompasses the science of food, nutrients and other substances contributing to nutrition status and health, with Dietetics—which is the application of food, nutrition and associated sciences, to optimize health and the delivery of care and services for individuals and groups.

Approved: 9/29/10; 10/11/10
Modified: 2/3/2014; 4/27/2015; 7/2/2015; 6/13/2016; 6/20/2016; 8/4/2017