# Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Diabetes Care

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**ABSTRACT**

There are 30.3 million people with diabetes and 86 million with prediabetes in the United States, underscoring the growing need for comprehensive diabetes care and nutrition for the management of diabetes and diabetes-related conditions. Management of diabetes is also critical for the prevention of diabetes-related complications such as cardiovascular and renal disease. The Diabetes Care and Education Dietetic Practice Group along with the Academy of Nutrition and Dietetics Quality Management Committee have updated the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The SOP and SOPP for RDNs in Diabetes Care provide indicators that describe three levels of practice: competent, proficient, and expert. The SOP utilizes the Nutrition Care Process and clinical workflow elements for care and management of those with diabetes and prediabetes. The SOPP describes six domains that focus on professionalism: Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources. Specific indicators outlined in the SOP and SOPP depict how these standards apply to practice. The SOP and SOPP are complementary resources for RDNs caring for individuals with diabetes or specializing in diabetes care or practicing in other diabetes-related areas, including research. The SOP and SOPP are intended to be used for RDN self-evaluation for ensuring competent practice and for determining potential education and training needs for advancement to a higher practice level in a variety of settings.

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

THE DIABETES CARE AND EDUcation Dietetic Practice Group (DCE DPG) of the Academy of Nutrition and Dietetics (Academy), under the guidance of the Academy Quality Management Committee, has revised the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitians (RDs) in Diabetes Care published in 2011.[1] The revised documents, Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Diabetes Care, reflect advances in diabetes practice during the past 6 years and replace the 2011 Standards. These documents build on the Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for RDNs.[2] The Academy/Commission on Dietetic Registration's (CDR) Code of Ethics[3] (revised and approved Code of Ethics available in 2018) along with the Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for RDNs[2] and Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist,[4] guide the practice and performance of RDNs in all settings.

Scope of practice in nutrition and dietetics is composed of statutory and individual components, including codes of ethics (eg, Academy or other national organizations and/or employer code of ethics), and encompasses the range of roles, activities, practice guidelines, and regulations related to RDN performance. For credentialed practitioners, scope of practice is typically established within the practice act and interpreted and controlled by the agency or board that regulates the practice of the profession in a given state.[4] An RDN's statutory scope of practice can delineate the services an RDN is authorized to perform in a state where a practice act or certification exists. For more information see www.cdrnet.org/state/licensure-agency-list.

An RDN's individual scope of practice is determined by education, training,


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*Approved December 2017, by the Quality Management Committee of the Academy and the Executive Committee of DCE DPG.* ***Scheduled review date: May 2024****. Questions regarding the Revised 2017 SOP and SOPP for RDNs (Competent, Proficient, and Expert) in Diabetes Care may be addressed to Academy Quality Management Staff: Dana Buelsing, MS, manager, quality standards operations, and Sharon McCauley, MS, MBA, RDN, LDN, FADA, FAND, senior director, quality management, at quality@eatright.org.*

All registered dietitians are nutritionists—but not all nutritionists are registered dietitians. The Academy's Board of Directors and Commission on Dietetic Registration have determined that those who hold the credential Registered Dietitian (RD) may optionally use "Registered Dietitian Nutritionist" (RDN). The two credentials have identical meanings. In this document, the authors have chosen to use *RDN* to refer to both RDs and RDNs.

credentialing, experience, organizational policies and procedures, and demonstrating and documenting competence to practice. Individual scope of practice in nutrition and dietetics has flexible boundaries to capture the breadth of an individual's professional practice. Professional advancement beyond the core education and supervised practice to qualify for the CDR RDN credential provides RDNs practice opportunities such as expanded roles within an organization based on specified training and certifications, if required; or additional credentials (eg, focus area CDR specialist certification, if applicable, or Advanced Practice Certification in Clinical Nutrition [RDN-AP], Certified Diabetes Educator [CDE], Board Certified-Advanced Diabetes Management [BC-ADM], Certified Case Manager [CCM], or Certified Professional in Health Care Quality [CPHQ]). The Scope of Practice Decision Tool (www.eatrightpro.org/scope), an online interactive tool, guides an RDN through a series of questions to determine whether a particular activity is within his or her scope of practice. This tool is designed to allow an RDN to critically evaluate his or her personal knowledge, skill, experience, judgment, and demonstrated competence using criteria resources.[5]

The Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, Hospital[6] and Critical Access Hospital[7] Conditions of Participation now allows a hospital and its medical staff the option of including RDNs or other qualified nutrition professionals within the category of "non-physician practitioners" eligible for ordering privileges for therapeutic diets and nutrition-related services when it is consistent with state law and health care regulations. RDNs in hospital settings interested in obtaining ordering privileges must review state laws (eg, licensure, certification, and title protection) if applicable and health care regulations to determine whether there are any barriers or state-specific processes that must be addressed. For more information, review the Academy's practice tips that outline the regulations and implementation steps for obtaining ordering privileges (www.eatrightpro.org/dietorders). For assistance, refer questions to the Academy's State Affiliate organization.

Medical staff oversight of an RDN(s) occurs in one of two ways. A hospital has the regulatory flexibility to appoint an RDN(s) to the medical staff and grant the RDN(s) specific nutrition ordering privileges, or can authorize the ordering privileges without appointment to the medical staff. To comply with regulatory requirements, an RDN's eligibility to be considered for ordering privileges must be through the hospital's medical staff rules, regulations, and bylaws, or other facility-specific process.[8] The actual privileges granted will be based on an RDN's knowledge, skills, experience, and specialist certification, if required, and demonstrated and documented competence.

The Long-Term Care Final Rule published October 4, 2016, in the *Federal Register* "allows the attending physician to delegate to a qualified dietitian or other clinically qualified nutrition professional the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law" and permitted by the facility's policies.[9] The qualified professional must be acting within the scope of practice as defined by state law and is under the supervision of the physician that may include, for example, countersigning the orders written by the qualified dietitian or clinically qualified nutrition professional. RDNs who work in long-term care facilities should review the Academy's updates on CMS that outline the regulatory changes to §483.60 Food and Nutrition Services (www.eatrightpro.org/quality). Review his or her state's long-term care regulations to identify potential barriers to implementation and identify considerations for developing the facility's process with the medical director and for orientation of attending physicians. The CMS State Operations Manual, Appendix PP–Guidance for Surveyors for Long-Term Care Facilities[10] contains the revised regulatory language (new revisions are italicized and in red color[10]). CMS periodically revises the State Operations Manual Conditions of Participation; obtain the current information at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf.

## ACADEMY QUALITY AND PRACTICE RESOURCES

The Academy's Revised 2017 SOP in Nutrition Care and SOPP for RDNs[2] reflect the minimum competent level of nutrition and dietetics practice and performance. The core 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 consistent with the Nutrition Care Process and clinical workflow elements as applied to the care of patients/clients/populations in all settings.[11] 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, efficient, and quality food and nutrition care and services; facilitate evidence-based practice; and serve as a professional evaluation resource.

These focus area standards for RDNs in diabetes care 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 diabetes care and dietetic 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

**Nutrition and Dietetics Diabetes Care and Services (for the purpose of the SOP and SOPP in Diabetes Care)** encompasses medical nutrition therapy, counseling, both patient and professional education, support, research, and other diabetes nutrition-related services (eg, utilizing the Nutrition Care Process in nutrition planning, food preparation and modification, and lifestyle education).

Standards of Practice (SOP) are authoritative statements that describe practice demonstrated through nutrition assessment, nutrition diagnosis (problem identification), nutrition intervention (planning and implementation), and outcomes monitoring and evaluation (four separate standards) and the responsibilities for which Registered Dietitian Nutritionists (RDNs) are accountable. The SOP for RDNs in Diabetes Care 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. The Standards of Professional Performance (SOPP) for RDNs in Diabetes Care 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 use and management of resources (six separate standards).

SOP and SOPP are complementary standards and serve as evaluation resources. 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 by which they are employed. To determine whether an activity is within the scope of practice of an RDN, the practitioner compares his or her knowledge, skill, experience, judgment, and demonstrated competence with the criteria necessary to perform the activity safely, ethically, legally, and appropriately. The Academy of Nutrition and Dietetics Scope of Practice Decision Tool, which is an online interactive tool, is specifically designed to assist practitioners with this process.

*The term* patient/client *is used in the SOP as a universal term because these Standards relate to direct provision of nutrition care and services. Patient/client could also mean client/patient, resident, participant, consumer, or any individual or group who receives diabetes care, education, and support services.* Customer *is used in the SOPP as a universal term. Customer could also mean client/patient, client/patient/customer, participant, consumer, or any individual, group, or organization to which the RDN provides services. These services are provided to individuals of all ages. These SOP and SOPP are not limited to the clinical setting. In addition, it is recognized that the family and caregiver(s) of patient/clients 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 2017 SOP in Nutrition Care and SOPP for RDNs have been adapted to reflect three levels of practice (competent, proficient and expert) for RDNs in diabetes care (see image below). In addition, the core indicators have been expanded to reflect the unique competence expectations for an RDN providing diabetes care, education, and support services.

Standards described as proficient level of practice in this document are not equivalent to the National Certification Board for Diabetes Educators certification, Certified Diabetes Educator (CDE). Rather, the designation recognizes the skill level of an RDN who has developed and demonstrated through successful completion of the certification examination, diabetes nutrition knowledge and application beyond the competent practitioner and demonstrates, at a minimum, proficient-level skills. An RDN with a CDE designation is an example of an RDN who has demonstrated additional knowledge, skills, and experience in diabetes nutrition by the attainment of a specialist credential and compliance with recertification requirements. Standards described as expert level of practice in this document are not equivalent to the American Association of Diabetes Educators certification, Board Certified-Advanced Diabetes Management (BC-ADM). Rather, the designation recognizes the skill level of an RDN who has developed additional diabetes nutrition knowledge and application beyond the proficient-level practitioner. An RDN with a BC-ADM designation is an example of an RDN who has demonstrated, at a minimum, expert level skills as presented in this document.

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**Figure 3.** Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Diabetes Care.

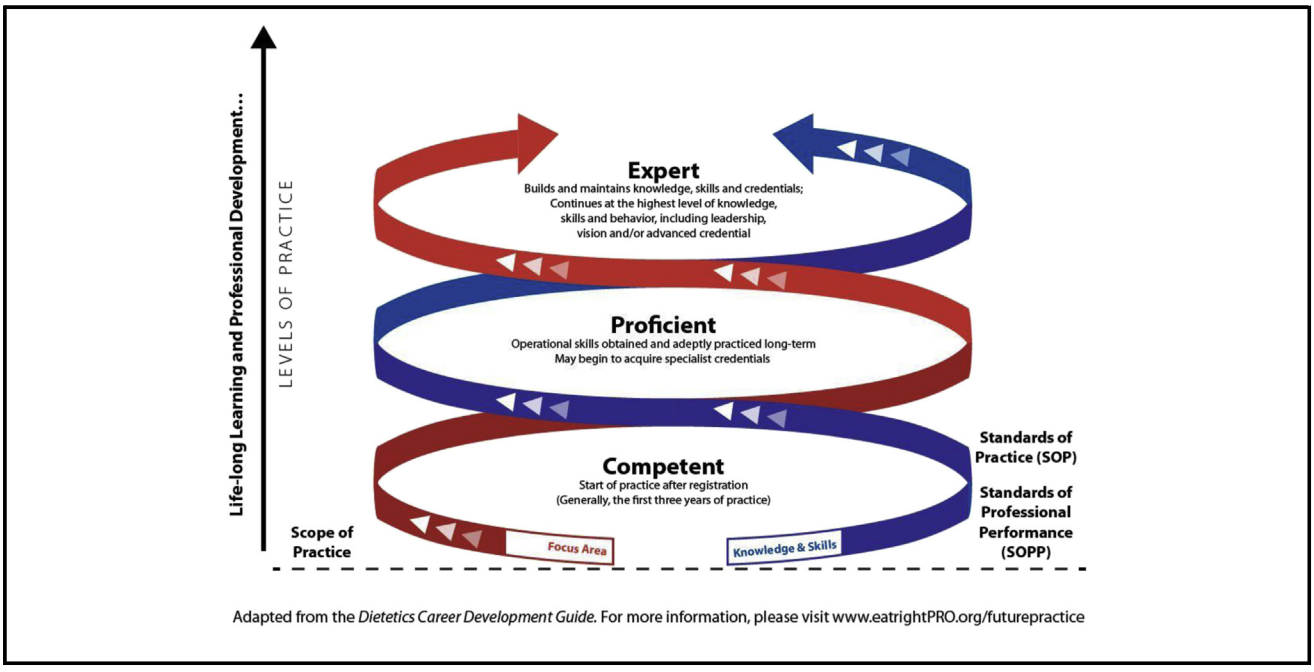


**Figure 3.** *(continued)* Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Diabetes Care.

focus area and advancement to a higher level of practice. In addition, the standards can be used to assist RDNs in general clinical practice with maintaining minimum competence in the focus area and by RDNs transitioning their knowledge and skills to a new focus area of practice. Like the Academy's core SOP in Nutrition Care and SOPP for RDNs,[2] the indicators (ie, measurable action statements that illustrate how each standard can be applied in practice) (see Figures 1 and 2, available at www.jandonline.org) for the SOP and SOPP for RDNs in Diabetes Care were revised with input and consensus of content experts representing diverse practice and geographic perspectives. The SOP and SOPP for RDNs in Diabetes Care were reviewed and approved by the Executive Committee of the Diabetes Care and Education Dietetic Practice Group and the Academy Quality Management Committee.

## THREE LEVELS OF PRACTICE

The Dreyfus model[13] identifies levels of proficiency (novice, advanced beginner, competent, proficient, and expert) (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 credential, a practitioner enters professional practice at the competent level and manages his or her professional development to achieve individual professional goals. This model is helpful in understanding the levels of practice described in the SOP and SOPP for RDNs in Diabetes Care. In Academy focus areas, the three levels of practice are represented as competent, proficient, and expert.

### 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 recently transitioning his or her practice to a new focus area of nutrition and dietetics. A focus area of nutrition and dietetics practice is a defined area of practice that requires focused knowledge, skills, and experience that applies to all levels of practice.[14] A competent practitioner who has achieved credentialing as an RDN and is starting in professional employment consistently provides safe and reliable services by employing appropriate knowledge, skills, behavior, and values in accordance with accepted standards of the profession; acquires additional on-the-job skills; and engages in tailored continuing education to further enhance knowledge, skills, and judgment obtained in formal education.[14] A general practice RDN can include responsibilities across several areas of practice, including but not limited to community, clinical, consultation and business, management, research, education, and food and nutrition systems. Because of the prevalence of prediabetes and/or diabetes in the population, nutrition care, as part of an interprofessional team for the management of individuals with diabetes along with other medical conditions, is an integral component of educational preparation and clinical practice for RDNs. To enhance competence in managing the care of individuals with a variety of medical diagnoses where diabetes is a comorbid condition, strengthening understanding of the disease process and treatment options, including medical nutrition therapy (MNT), will contribute to safe and quality care. Refer to the Academy's Evidence Analysis Library practice guidelines for diabetes (www.andeal.org), and the American Diabetes Association's Standards of Medical Care in Diabetes.[15]

| Resource | Address | Description |
|---|---|---|
| Academy[a] Cultural Competency for Nutrition Professionals | www.eatrightstore.org/product/E2EBE1F2-A38E-49AB-B5B6-D1D432585F17 | This online publication provides an overview of various cultures and food practices with the goal of supporting care and services for diverse populations. |
| Academy Diabetes Care and Education Dietetics Practice Group | www.dce.org/ | This Academy practice group strives to empower its members to be leaders in food, nutrition, and diabetes care and prevention. |
| Academy Diabetes Mellitus Toolkit | www.eatrightstore.org/product/10BFB22D-2301-428C-8446-CA38C10D832D | The toolkit is designed to assist RDNs[b] in applying the Academy Diabetes Mellitus Management Evidence-Based Nutrition Practice Guidelines. |
| Academy EAL[c] Diabetes Mellitus Types 1 and 2 Systematic Review and Guideline | www.andeal.org/topic.cfm?menu=5305 | The focus of the EAL guideline is on MNT[d] for adults with type 1 and type 2 diabetes. |
| Academy EAL Gestational Diabetes Mellitus Guideline and Supporting Systematic Review | www.andeal.org/topic.cfm?menu=5288 | This resource focuses on the treatment of women with gestational diabetes and provides evidence-based MNT recommendations for management of gestational diabetes mellitus. |
| Academy EAL Prevention of Type 2 Diabetes Project | www.andeal.org/topic.cfm?menu=5344 | This EAL resource focuses on MNT for individuals who are at high risk for type 2 diabetes, such as individuals with prediabetes. |
| Academy Gestational Diabetes Toolkit | www.eatrightstore.org/product/70EC4F6C-A75D-40F0-85F6-9E0ACEA47FE7 | The toolkit is designed to assist an RDN in applying the Academy Gestational Diabetes Evidence-Based Nutrition Practice Guidelines. |
| Academy Making Choices Meal Planning for Diabetes and Chronic Kidney Disease | www.eatrightstore.org/product/87A0732F-B41D-4A58-9D15-2105C0CF397B | This resource is designed to help health care professionals counsel patients/clients with both diabetes (type 1 or type 2) and chronic kidney disease stage 3 or 4. |
| Academy Pocket Guide to Lipid Disorders, Hypertension, Diabetes, and Weight Management | www.eatrightstore.org/product/65068CB9-A25C-497F-BF73-302CA684A0CB | This resource integrates evidence-based nutrition practice guidelines into nutrition care for patients/clients who have one or more medical diagnoses. |
| Academy Pocket Guide to Pediatric Weight Management, 2nd edition | www.eatrightstore.org/product/DDCCA4CB-DADE-445F-A09C-3F620BF3B6C9 | This pocket guide describes interventions that will help reduce the risk of health complications in children and adolescents with overweight and obesity issues. |
| American Association of Clinical Endocrinologists | www.aace.com | A health care association that specializes in endocrinology, diabetes, and metabolism which provides individuals with resources such as guidelines and algorithms for diabetes care. |
| American Association of Diabetes Educators | www.diabeteseducator.org/home | A professional membership organization with the goal of improving diabetes care through education, management, and support. The organization also offers the Board Certified-Advanced Diabetes Management (BC-ADM) credential, which is its certification for advanced-level practitioners. |

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**Figure 4.** Diabetes nutrition resources (not all inclusive).

| Resource | Address | Description |
|---|---|---|
| American College of Obstetricians and Gynecologists | www.acog.org | A nonprofit organization that produces practice guidelines and other educational material for the American Congress of Obstetricians and Gynecologists. |
| American Diabetes Association Guide to Nutrition Therapy for Diabetes, 3rd edition | www.ada.org | A comprehensive compilation of evidence-based information for providing medical nutrition therapy and nutrition interventions for the spectrum of diabetes care. |
| American Diabetes Association's Standards of Medical Care in Diabetes | professional.diabetes.org/content-page/standards-medical-care-diabetes | These standards, updated annually, are aimed at providing individuals with the components of diabetes care, general treatment goals, and tools to evaluate quality care for all populations and a variety of settings. |
| Centers for Disease Control and Prevention | www.cdc.gov/diabetes | A place for resources such as data and statistics, programs and initiatives, research, and publications on diabetes. |
| Diabetes Self-Management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics | www.eatrightpro.org/resource/practice/position-and-practice-papers/position-papers/academy-position-papers-index | This joint position statement focuses on the position that all individuals with diabetes receive diabetes self-management education and support. |
| Guiding Principles for the Care of People with or at Risk for Diabetes | www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/guiding-principles-care-people-risk-diabetes | Principles that aim to help guide primary care providers and health care teams deliver quality diabetes care to adults with or at risk for diabetes. |
| National Certification Board for Diabetes Educators | www.ncbde.org/ | An organization with a mission to promote quality diabetes education by developing and maintaining certification and credentialing process for Certified Diabetes Educators (CDEs). |
| National Standards for Diabetes Self-Management Education and Support | www.diabeteseducator.org/practice/practice-documents/national-standards-for-dsmes | Guidelines for operating a diabetes self-management education and support program that are updated every 5 years. |

[a]Academy=Academy of Nutrition and Dietetics.

[b]RDN=registered dietitian nutritionist.

[c]EAL=Evidence Analysis Library.

[d]MNT=medical nutrition therapy.

**Figure 4.** *(continued)* Diabetes nutrition resources (not all inclusive).

## Proficient Practitioner

A proficient practitioner is an RDN who is generally 3 or more years beyond credentialing and entry into the profession and consistently provides safe and reliable service; has obtained operational job performance skills, and is successful in an RDN's chosen focus area of practice. The proficient practitioner demonstrates additional knowledge, skills, judgment, 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.[14] A proficient-level practitioner in diabetes care has gained additional knowledge in diabetes care and management; work experience in delivering diabetes MNT counseling, education, and care; and may have obtained the CDE credential (www.ncbde.org). In 2017, the National Certification Board for Diabetes Educators reports that 41% of CDEs are RDNs, 50% are nurses, 7% are pharmacists, and 2% are from other disciplines (www.ncbde.org).

### Expert Practitioner

An expert practitioner is an RDN who is recognized within the profession and has mastered the highest degree of skill in, and knowledge of, nutrition and dietetics. Expert level achievement is acquired through ongoing critical evaluation of practice and feedback from others. The individual at this level strives for additional knowledge, experience, and training. An expert has the ability to quickly identify "what" is happening and "how" to approach the situation. Experts easily use nutrition and dietetics skills to become successful through demonstrating quality practice and leadership, and to consider new opportunities that build upon nutrition and dietetics.[14] An expert practitioner may have an expanded or specialist role or both, and may possess an advanced credential(s). Generally, the practice is more complex and the practitioner has a high degree of professional autonomy and responsibility. An expert-level RDN in diabetes care and management has extensive knowledge and practice experiences in the care and management of individuals with prediabetes and diabetes and may have one or more certifications such as the CDE and/or BC-ADM credential (www.diabeteseducator.org/education-career/certification). These RDNs are recognized by others for their practice and professional contributions to further quality diabetes care, education, and research.

These Standards, along with the Academy/CDR Code of Ethics,[3] answer the questions: Why is an RDN uniquely qualified to provide diabetes care and related nutrition and dietetics services? What knowledge, skills, and competencies does an RDN need to demonstrate for the provision of safe, effective, and quality diabetes care and service at the competent, proficient, and expert levels?

## OVERVIEW

According to the Centers for Disease Control and Prevention, in 2017 there were 86 million people with prediabetes and 30.3 million (9.4% of the United States population) with diabetes.[16] Approximately 50% of adults older than age 65 years have prediabetes. Due to the increasing numbers of people experiencing prediabetes and diabetes (type 1, type 2, gestational, and stress/or medication induced), diabetes care has become a specialized field for RDNs. Responding to the increasing demand for the screening, prevention, treatment, and management of persons with both prediabetes and diabetes is crucial throughout the life cycle (eg, children, adolescents, and adults). Due to the chronic nature of diabetes, the treatment approach has evolved from that of acute hospital/facility-based care to outpatient/ambulatory care settings using a patient-centered collaborative–integrative medical home model.[17] Under this model, individuals adopt a more proactive and participatory role in providing the needed care for themselves and their loved ones. According to the American Diabetes Association's Standards of Medical Care in Diabetes, management for the person with diabetes should consist of a physician coordinated team, including a nurse, dietitian, physician assistant, pharmacist, and/or mental health professional.[15] The Standards emphasize that MNT should be provided to all individuals with diabetes, with preference that this be provided by an RDN with the skill set and knowledge specific to diabetes care.

Diabetes, like other chronic diseases, requires a multifaceted treatment approach. This includes lifestyle management (individualized eating and physical activity plan), considering a medication plan when applicable, as well as educational and behavioral support. Knowledge in the areas of actual and recommended health practices and outcomes is an essential component for patient/client involvement in the management of diabetes. There is strong evidence that type 2 diabetes can be delayed or prevented by altering lifestyle factors, specifically dietary pattern and physical activity.[18-20] MNT provided by an RDN has been shown to enhance weight loss and improve clinical parameters, such as fasting and 2-hour postprandial blood glucose level, and waist circumference associated with development of type 2 diabetes.[18] Along with MNT, weight loss of 5% to 7% has repeatedly been shown to be a strong predictor for reducing the risk of developing type 2 diabetes. For every 1 kg of weight loss, there is a 16% reduction in risk.[21] According to the Academy, MNT provided by an RDN should be included in an integrated collaborative health care program for improving metabolic outcomes such as glycated hemoglobin (hemoglobin A1c) level as well as preventing the progression or delay from prediabetes to diabetes and complications associated with diabetes.[18,22-25]

The RDN is positioned to empower patients/clients and provide nutrition counseling, education, and support. RDNs provide diabetes MNT and services in a variety of settings, including but not limited to outpatient collaborative care clinics, inpatient and outpatient health care facilities, diabetes education centers, and community health centers (eg, diabetes prevention program and diabetes self-management education and support [DSMES][26] services). Medicare defines MNT as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a Registered Dietitian . . ." supporting that RDNs have the clinical skills, training, and education for providing diabetes-related nutrition services.[27]

DSMES services have become an integral component and foundation for the development of an individual's plan for diabetes care and national standards guide their provision. More importantly, these care plans should be individualized and consist of collaboration between the individual and the physician as well as other members of the diabetes care team, including the RDN providing MNT[18,28] in any care setting. There have been a number of studies underscoring the importance of educating patients/clients in diabetes self-care, now known as DSMES, for improving metabolic control, and in turn, decreasing the incidence and progression of many of the diabetes-associated complications.[29-32] The goals of DSMES services, using a patient-centered collaborative/integrated medical home, are to:

empower the patient/client with diabetes to obtain the knowledge on what to do; attain the skills to do it; gain confidence and the desire to perform the self-care behaviors; and cultivate problem-solving and coping skills for dealing with the barriers of self-care behaviors for obtaining metabolic goals.

Technology advances such as continuous glucose monitoring (CGM) share capabilities through the cloud, mobile applications, and crowdsourcing, provide timely feedback in the care of a person with diabetes and has been shown to enhance diabetes self-management skills and patient satisfaction.[32-35] However, there are a multitude of factors influencing metabolic outcomes, including the patient's knowledge, cultural background, psychosocial and social factors, treatment team, and medication regimens.[36] Endocrine Society Practice Guidelines underscore the role of the experienced RDN as part of the care team for providing individualized MNT diabetes care plans for those receiving continuous sustained insulin infusion (CSII) and CGM.[37]

Research demonstrates that there is a need to improve and maintain patient engagement in self-care and DSMES.[38] Computer-based interactive tools, social media, and telehealth technologies can help improve self-care practices and patient engagement.[35,39] It is important for nutrition and dietetics practitioners in any setting providing diabetes and nutrition education to be aware of and skilled at using the available diabetes technology resources for ensuring that evidenced-based care is being provided. Due to health disparities and barriers to DSMES, telehealth is being used increasingly as an alternative for providing education.[40,41]

The Joint Position Statement of the American Diabetes Association, American Association of Diabetes Educators (AADE) and the Academy emphasizes the importance of DSMES at four critical times. This position paper provides DSMES algorithms to be initiated and implemented by collaborative health care teams, with RDNs being the preferred providers of MNT for people with diabetes.[20,42,43] The four critical points include at the time of a new diagnosis, annually, with treatment changes or complicating conditions (eg, hospitalization), and in transitions of care to assess and provide DSMES. The SOP and SOPP include resources for expanding knowledge and encourages RDNs providing care to individuals with diabetes and other comorbid conditions to continuously assess their skills for providing care and advancing practice (eg, competent, proficient, and expert levels of practice) (Figure 4). The education algorithm included in the Joint Position Statement along with the SOP and SOPP in Diabetes Care can be used by an RDN and the interprofessional team for gauging how, what, and when to deliver diabetes education and nutrition services (Figure 5). RDNs whose professional practice focuses in diabetes who are not working in direct care settings such as in academia, research, federal or state agencies, or in positions of professional organizations (eg, American Diabetes Association and AADE) should regularly reference the SOP and SOPP for assessing their skills, advancing practice, and application in their work settings.

In specific instances, the practice of some RDNs has evolved to include care beyond diabetes MNT. In accordance with demonstrated competence and organization-approved protocols, some RDNs now provide instruction for self-monitoring blood glucose, insulin administration, adjusting diabetes medication, as well as provide training on CSII and CGM devices. It is important to note that neither the CDE nor BC-ADM credential authorizes an individual to perform tasks outside of his or her professional scope of practice, but an RDN, after competency is demonstrated, can teach a patient/client to self-administer his or her own insulin injections or perform an invasive procedure and adjust medications when using provider or organization-approved protocols.

The Academy supports a variety of DPGs such as the DCE DPG. The DCE DPG is for those interested in diabetes information, networking, and for those working in the diabetes focus area. Membership has maintained a steady growth with more than 5,400 members. The mission of the DCE DPG further emphasizes the role of RDNs in diabetes care by empowering its members "to be leaders in food, nutrition, diabetes care, and prevention" with the vision of "optimizing the health of people impacted by diabetes using food, nutrition and self-management education."[44] The DCE DPG provides numerous opportunities for professional growth by promoting clinical/educational research, offering continuing education through its newsletter and webinars, collaborations with diabetes organizations and industry, proactively advocating for diabetes legislation, and providing diabetes educational tools and publications for both professional use and for people with diabetes available through the DPG's website at www.dce.org/.

## ACADEMY REVISED 2017 SOP AND SOPP FOR RDNs (COMPETENT, PROFICIENT, AND EXPERT) IN DIABETES CARE

An RDN can use the Academy Revised 2017 SOP and SOPP for RDNs (Competent, Proficient, and Expert) in Diabetes Care (see Figures 1 and 2, available at www.jandonline.org, and Figure 3) to:

- identify the competencies needed to provide diabetes nutrition and dietetics care and services;
- self-evaluate whether he or she has the appropriate knowledge, skills, and judgment to provide safe and effective diabetes care, and other nutrition and dietetics diabetes-related services for their level of practice;
- identify the areas in which additional knowledge, skills, and experience are needed to practice at the competent, proficient, or expert level of diabetes nutrition and dietetics practice;
- provide a foundation for public and professional accountability in diabetes nutrition and dietetics care and services;
- support efforts for strategic planning, performance improvement, outcomes reporting, and assist management in the planning and communicating of diabetes nutrition care, dietetics services, research, and resources;
- enhance professional identity and skill in communicating the nature of diabetes nutrition and dietetics care and services;
- guide the development of diabetes nutrition and dietetics-related education and continuing

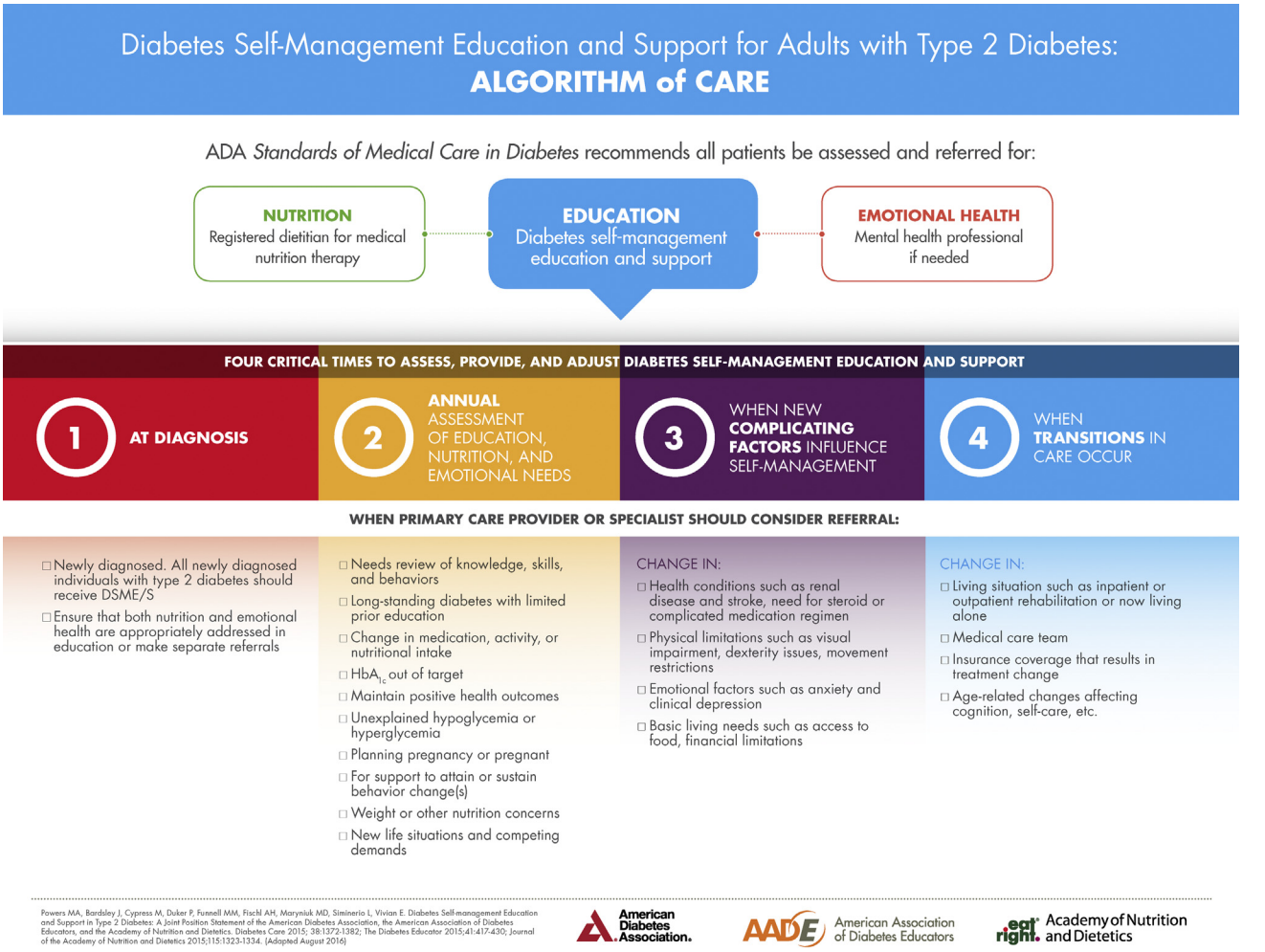


**Figure 5.** Diabetes self-management education and support for adults with type 2 diabetes: Algorithm of care.[42]

education programs, job descriptions, practice guidelines, competence evaluation tools, and career pathways; and

- assist educators and preceptors in teaching students and interns the knowledge, skills, and competencies needed to work and specialize in diabetes nutrition 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 diabetes care is learning the principles that underpin this focus area and is developing knowledge and skills, and judgment for safe and effective diabetes nutrition and dietetics practice. This RDN, who may be new to the profession or may be an experienced RDN, has a breadth of knowledge in nutrition and dietetics and may have proficient or expert knowledge/practice in another focus area. However, an RDN new to the focus area of diabetes care must accept the challenge of becoming familiar with the body of knowledge, practice guidelines, and available resources to support and ensure quality diabetes-related nutrition and dietetics practice.

At the proficient level, an RDN has progressed to a more in-depth understanding of diabetes practice, and is more skilled at adapting and applying evidence-based guidelines and best practices than at the competent level. This RDN is able to modify practice to meet individualized needs (eg, integrating care of multiple comorbid diabetes-related conditions, cultural and population health factors, and psychosocial concerns). In addition, an RDN at this level understands the interrelationship of MNT, blood glucose monitoring, physical activity, and medication adjustments in the overall treatment plan for the individual with diabetes. RDNs at the proficient level may possess a CDE or other specialist credential(s). Indicators described as proficient level of practice in this document are not equivalent to the CDE or other specialist credential(s). Rather, the CDE or other specialist credential(s) refer to an RDN who has developed and demonstrated, through successful completion of the certification examination and compliance with recertification requirements, diabetes nutrition, care and management knowledge, skill, and application beyond the

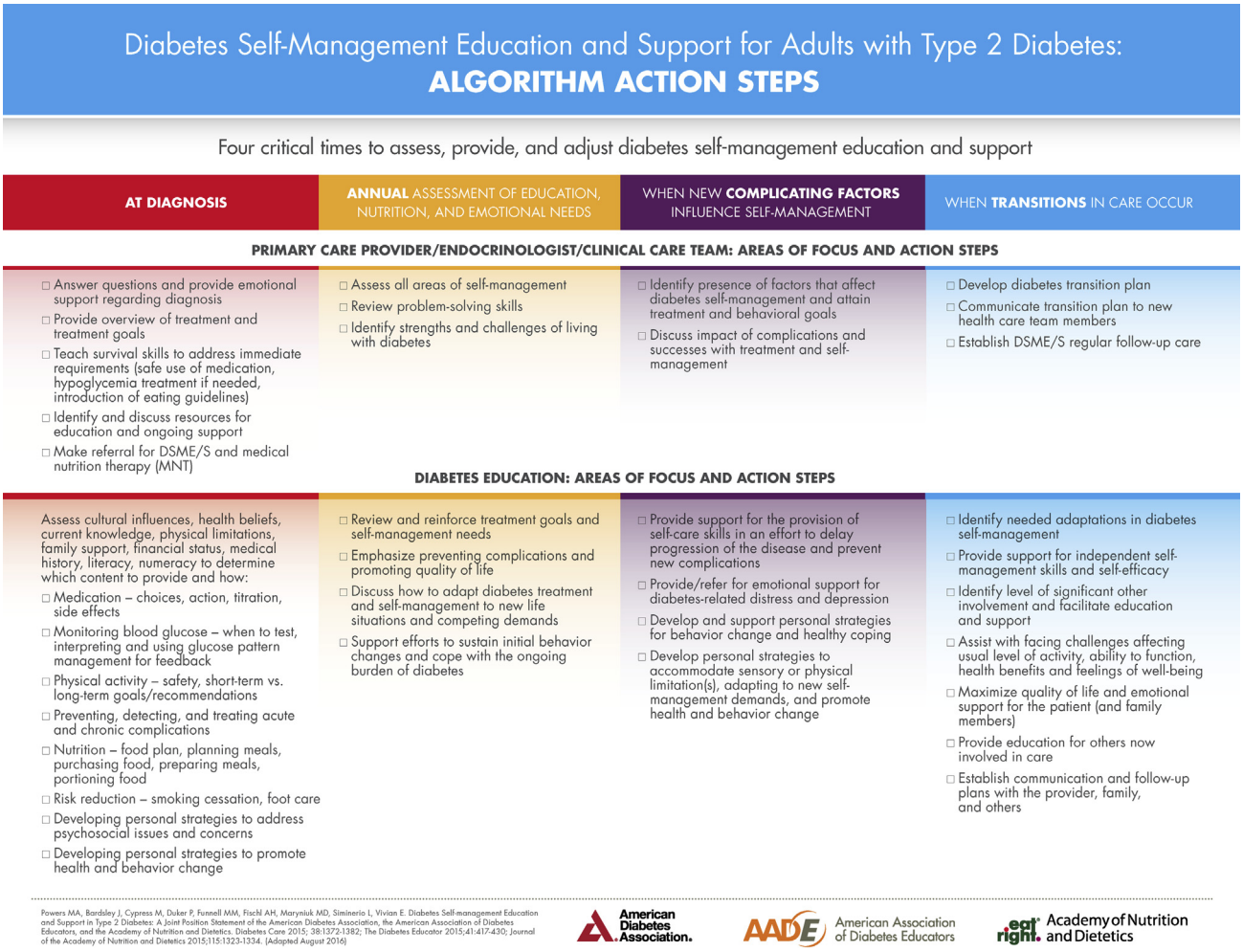


**Figure 5.** (*continued*) Diabetes self-management education and support for adults with type 2 diabetes: Algorithm of care.[42]

competent practitioner. An RDN practicing at this level may obtain certification to provide education and training on the use of diabetes technology (eg, CSII, CSII integrated with continuous glucose monitoring, hybrid-closed loop CSII, or stand-alone CGM).

At the expert level, RDNs think even more critically about diabetes nutrition and dietetics care and services, demonstrate a more intuitive understanding of diabetes care and service, display a range of highly developed clinical knowledge and technical skills, and formulate judgments acquired through a combination of education, experience, and critical thinking. Essentially, practice at the expert level requires the application of advanced nutrition and diabetes care knowledge, with practitioners drawing not only on their practice experience, but also on the experience of RDNs providing diabetes care and services in various disciplines and practice settings. Expert RDNs, with their extensive experience and ability to see the significance and meaning of diabetes nutrition and diabetes within a contextual whole, are flexible and have considerable autonomy in practice. In addition, they may hold a specialist credential such as BC-ADM or CDE. They not only develop and implement diabetes nutrition and diabetes care services, but they also manage, drive, and direct clinical care; conduct and collaborate in research and advocacy; accept organization leadership roles; engage in scholarly work; guide interprofessional teams; and lead the advancement of diabetes nutrition and dietetics practice. An RDN practicing at this level may assist with the development of organization-approved protocols for making adjustments to diabetes-related medications based on analysis of the nutrition assessment and biochemical parameters or research pertaining to diabetes care and management.

Indicators for the SOP and SOPP for RDNs in Diabetes Care are measurable action statements that illustrate how each standard can be applied in practice (Figures 1 and 2, available at www.jandonline.org). Within the SOP and SOPP for RDNs in Diabetes Care, an "X" in the competent column indicates that an RDN who is caring for patients/clients is expected to complete this activity and/or seek assistance to learn how to perform at the level of the standard. For example, a competent RDN in diabetes care could be an RDN starting practice after registration or an experienced RDN who cares for patients with a wide variety of medical diagnoses, including diabetes, who collaborates with RDN experienced

| Role | Examples of use of SOP and SOPP documents by RDNs in different practice roles |
|---|---|
| Clinical practitioner—inpatient care | A community hospital recently employed a newly credentialed Registered Dietitian Nutritionist (RDN) for the adult general medicine units. The RDN observes that diabetes is a common medical diagnosis. To strengthen knowledge and skills in diabetes management and education, the RDN reviews the SOP and SOPP in Diabetes Care to evaluate skills and competencies for providing care to individuals with diabetes and sets professional goals to improve competency in this area of practice. The RDN meets with the RDN in the Diabetes Education Center to learn about the program and referral process, and obtain advice on continuing education options for inclusion in a professional development plan. The RDN uses other staff RDNs as mentors and consults when patients have complex management needs beyond the RDN's experience/level of competence. |
| Clinical practitioner—ambulatory care | An experienced RDN working in a primary care clinic routinely provides medical nutrition therapy counseling and education for patients with diabetes (or comorbid condition) because there is not a community diabetes education program. The RDN would like to qualify for the Certified Diabetes Educator (CDE) credential. The RDN uses the SOP and SOPP for Diabetes Care, the Academy Evidence Analysis Library guidelines and resources from diabetes organizations to demonstrate best practices in diabetes self-management education and support activities. The RDN uses the SOP and SOPP for self-evaluation of current level of practice in determining areas to strengthen with the goal of achieving the proficient practice level. The RDN reviews the criteria for the CDE certification examination to update professional development plan for successful CDE credential attainment. |
| Clinical practitioner—diabetes education program | An RDN who is a CDE practicing in a diabetes education program, is trained in quality improvement, and is eligible for the quality coordinator position. The role would entail leading the interprofessional diabetes care team to develop and manage the program's quality improvement processes for data collection, analysis, presentation of results, and adjusting services to achieve quality outcomes. Resources to assist with accomplishing the role tasks are the SOP and SOPP for RDNs in Diabetes Care and other disciplines' standards. The RDN reviews current professional development plan and updates essential practice competencies to add continuing education activities in Lean/Six Sigma, quality improvement-related training and quality management outcomes measures development process. |
| Clinical nutrition manager | A clinical nutrition manager who manages inpatient and outpatient nutrition services, and the accredited diabetes education center refers to the focus area SOP and SOPP as support tools for developing position descriptions, competence standards, and assessment tools. The RDN also uses the SOP and SOPP as a resource to help guide self-evaluation and professional development activities with RDN staff. The clinical nutrition manager refers to the SOP and SOPP for RDNs in Diabetes Care, standards of practice for the diabetes nurse educator, and diabetes organization standards of care (eg, American Diabetes Association Standards of Medical Care in Diabetes,[15] and diabetes self-management education and support Algorithm of Care[42]) as key resources for ensuring a quality program and compliance with accreditation program standards. |
| Long-term care/skilled nursing practitioner | An RDN working in a skilled nursing and long-term care facility observes increases in the number of new residents having more complex diabetes-related management requirements. The RDN refers to the SOP and SOPP in Diabetes Care for reviewing knowledge and skills needed to provide quality diabetes care and identifies areas for continuing education. The RDN makes the case for why an RDN, CDE consultation would be beneficial for individualized resident care to the facility's administrator, medical director, and/or director of nursing. The RDN uses the information and resources in discussions with the interprofessional team for care plan development and diet order and/or meal plan adjustments. |

*(continued on next page)*

**Figure 6.** Role examples of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Diabetes Care.

| Role | Examples of use of SOP and SOPP documents by RDNs in different practice roles |
|---|---|
| Telehealth practitioner | An RDN in a hospital offers telehealth services providing nutrition consultations to patients/clients with diabetes. The RDN considers the SOP and SOPP in Diabetes Care when determining expertise needed. The RDN routinely monitors all relevant state laws and regulations, the Academy of Nutrition and Dietetics telehealth resources, and organization policies regarding the practice of telehealth specifically considering requirements in the case that a patient/client lives in another state. The RDN uses the SOP SOPP in Diabetes Care to evaluate level of competence and identify areas for additional knowledge and/or skills in diabetes self-management education and support. The review assists the RDN recognizing when a referral is needed including, but not limited to, an RDN, CDE with more extensive diabetes management experience in dealing with complex medical and diabetes issues. |

**Figure 6.** *(continued)* Role examples of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Diabetes Care.

with care of individuals with diabetes and/or CDE in ambulatory care to provide care for inpatients requiring intensified diabetes treatment such as CSII and/or CGM after discharge.

An "X" in the proficient column indicates that an RDN who performs at this level has a deeper understanding of diabetes care and related services and has the ability to modify or guide therapy to meet the needs of patients/clients in various situations (eg, caring for clients with multiple diabetes-related comorbidities and acute/complex issues such as trauma/injury/illness, or serves as outpatient diabetes educator, or coordinator of a diabetes self-management education and support program).

An "X" in the expert column indicates that the RDN who performs at this level possesses a comprehensive understanding of diabetes care and related services, or role and responsibilities in the diabetes focus area (eg, research); and a highly developed range of skills and judgments acquired through a combination of experience and education (eg, provides MNT for clients referred for counseling, making medical recommendations to providers, education on adjusting for meals, physical activity, illness, other complex situations or utilizing diabetes technology, and/or developing organizational policies related to diabetes care). The expert RDN builds and maintains the highest level of knowledge, skills, and behaviors, including leadership, vision, and credentials.

Standards and indicators presented in Figure 1 and Figure 2 (available at www.jandonline.org) in boldface type originate from the Academy's Revised 2017 SOP in Nutrition Care and SOPP for RDNs[2] and should apply to RDNs in all three levels. Additional indicators not in boldface type developed for this focus area 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 diabetes care 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 Diabetes Care is warranted. It is the totality of individual practice that defines a practitioner's level of practice and not any one indicator or standard.

RDNs should review the SOP and SOPP in Diabetes Care at determined intervals to evaluate their individual focus area knowledge, skill, and competence. Consistent self-evaluation is important because it helps identify opportunities to improve and enhance practice and professional performance, and set goals for professional development. This self-appraisal also enables RDNs providing diabetes care, nutrition counseling and education to better utilize these Standards as part of the *Professional Development Portfolio* recertification process,[45] which encourages CDR-credentialed nutrition and dietetics practitioners to incorporate self-reflection and learning needs assessment for development of a learning plan for improvement, and commitment to lifelong learning. CDR's updated system implemented with the 5-year recertification cycle that began in 2015 incorporates the use of essential practice competencies for determining professional development needs.[46] In the new three-step process, a credentialed practitioner accesses an online Goal Wizard (step 1), which uses a decision algorithm to identify essential practice competency goals and performance indicators relevant to an RDN's area(s) of practice (essential practice competencies and performance indicators replace the learning need codes of the previous process). The Activity Log (step 2) is used to log and document continuing professional education over the 5-year period. The Professional Development Evaluation (step 3) guides self-reflection and assessment of learning and how it is applied. The outcome is a completed evaluation of the effectiveness of the practitioner's learning plan and continuing professional education. The self-assessment information can then be used in developing the plan for the practitioner's next 5-year recertification cycle. For more information, see www.cdrnet.org/competencies-for-practitioners.

RDNs are encouraged to pursue additional knowledge, skills, and 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.[47] RDNs should collaborate with other RDNs in

diabetes care as learning opportunities and to promote consistency in practice, performance, and continuous quality improvement. See Figure 6 for role examples of how RDNs in different roles and at different levels of practice may use the SOP and SOPP in Diabetes Care.

In some instances, components of the SOP and SOPP for RDNs in Diabetes Care do not specifically differentiate between proficient-level and expert-level practice. In these areas, it remains 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.[48] A wealth of knowledge is embedded in the experience, discernment, and practice of expert-level RDN practitioners. An experienced practitioner observes events, analyzes them to make new connections between events and ideas, and produces a synthesized whole. The knowledge and skills acquired through practice will continually expand and mature. The SOP and SOPP indicators are updated with each review of these standards, and includes input from expert-level RDNs who systematically record and document their experiences, often through use of exemplars. Exemplary actions of individual RDNs in diabetes care in practice settings and professional activities that enhance patient/client care and/or services can be used to illustrate outstanding practice models and serve as benchmarks for practitioners who aspire to advance their professional skills to the expert level. One such example is the leadership role that RDNs took to guide the development of the DSMES Algorithm of Care and the AADE7 Self-Care Behaviors system.[19,41,42]

## FUTURE DIRECTIONS

The SOP and SOPP for RDNs in Diabetes Care are innovative and dynamic documents. Future revisions will reflect changes and advances in practice, changes to dietetics education standards, regulatory changes, outcomes of practice audits, and the refinement of the expectation of entry-level vs advanced practice in an integrative collaborative health care environment. Continued clarity and differentiation of the three practice levels in support of safe, effective, and quality practice in diabetes care remains an expectation of each revision to serve tomorrow's practitioners and their patients, clients, and customers.

## SUMMARY

RDNs face complex situations every day. Addressing the unique needs of each situation and applying standards appropriately is essential to providing safe, timely, 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 for RDNs, and the SOP in Nutrition Care and SOPP for RDNs, along with applicable federal and state regulations and facility/program accreditation standards. The SOP and SOPP for RDNs in Diabetes Care are complementary documents and are key resources for RDNs and others, including regulators and accrediting organizations. These standards can and should be used by RDNs in daily practice who provide care to individuals with diabetes to consistently improve and appropriately demonstrate competence and value as providers of safe, effective, and quality nutrition and dietetics care and services. These standards also serve as a professional resource for self-evaluation and professional development for RDNs specializing in diabetes care 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 7 years. Current and future initiatives of the Academy as well as advances in diabetes care and services will provide information to use in future updates and in further clarifying and documenting the specific roles and responsibilities of RDNs at each level of practice. As a quality initiative of the Academy and the DCE DPG, these standards are an application of continuous quality improvement and represent an important collaborative endeavor.



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### AUTHOR CONTRIBUTIONS

Each author contributed to editing the components of the article and reviewed all drafts of the manuscript.

**Standards of Practice for Registered Dietitian Nutritionists in Diabetes Care**

**Standard 1: Nutrition Assessment**

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

**Rationale:**

Nutrition screening is the preliminary step to identify individuals who require a nutrition assessment performed by an RDN. Nutrition assessment is a systematic process of obtaining and interpreting data to make decisions about the nature and cause of nutrition-related problems and provides the foundation for nutrition diagnosis. It is an ongoing, dynamic process that involves not only initial data collection, but also reassessment and analysis of patient/client or community needs. Nutrition assessment is conducted using validated tools based in evidence, the five domains of nutrition assessment and comparative standards. Nutrition assessment may be performed via in-person, or facility/practitioner assessment application, or Health Insurance Portability and Accountability Act-compliant video conferencing telehealth platform.

| **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** | ***Patient/client/population history*: Assesses current and past information related to personal, medical, family, and psychosocial/social history** | | | **X** | **X** | **X** |
| | 1.1A | Evaluates diabetes history, including assessment of diabetes education, support, skills, and behaviors considering EAL[a] diabetes-related guidelines and AADE7[b] and DSMES[c] guidelines | | X | X | X |
| | | 1.1A1 | Evaluates diabetes, nutrition history, and intensity of diabetes management (eg, DSMES, CSII,[d] and/or use of CGM[e]) | | X | X |
| | 1.1B | Evaluates medical history of health, disease conditions, and other comorbidities (eg, CVD[f], lipid disorders, hypertension, overweight/obesity, kidney disease, cancer, metabolic/bariatric surgery, stroke, chronic obstructive pulmonary disease, and heart failure) | | X | X | X |
| | | 1.1B1 | Assesses history of past and recurrent sleep disturbances, insomnia (eg, night eating, hormonal changes, and blood glucose variability) | | X | X |
| | | 1.1B2 | Assesses history of problems with ingestion, digestion, absorption, and metabolism of macronutrients and micronutrients potentially impacted as a consequence of diabetes or other comorbidities | | X | X |
| | 1.1C | Evaluates family history (eg, diabetes, CVD, lipid disorders, hypertension, overweight/obesity, kidney disease, cancer, peripheral vascular disease, and stroke) | | X | X | X |
| | 1.1D | Evaluates associated autoimmune comorbidities (eg, thyroid conditions, Addison's disease, celiac disease, cystic fibrosis-related diabetes, pernicious anemia) | | X | X | X |
| | 1.1E | Determines history of tobacco (eg, cigarettes, e-cigarettes, or smokeless tobacco), alcohol, illicit drug use | | X | X | X |
| | 1.1F | Evaluates psychosocial factors or issues, including family and significant others and social support, cognitive impairment support, diabetes distress/depression/anxiety, disordered eating, or eating disorder | | X | X | X |
| | | 1.1F1 | Assesses nutrition-related patient/client-centered measures, including nutrition quality of life and activities of daily living | X | X | X |
| | | 1.1F2 | Assesses perception of his or her nutrition and diabetes care (eg, cultural, ethnic, religious, and lifestyle factors) | X | X | X |

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**Figure 1.** Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

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| | | 1.1F3 | Screens for signs/symptoms of diabetes distress | | X | X |
| | | 1.1F4 | Assesses history of past and current impacts of trauma/stress on dietary intake and diabetes management (eg, mental health technology phobia, fear of SMBG[g], fear of hypoglycemia, and health anxiety) | | | X |
| | | 1.1F5 | Assesses history of or signs/symptoms for depression | | | X |
| | 1.1G | | Evaluates preventive care strategies and behaviors (eg, lifestyle prevention practices and screening family members for diabetes risk) | X | X | X |
| **1.2** | ***Anthropometric assessment:* Assesses anthropometric indicators (eg, height, weight, body mass index, waist circumference, and arm circumference), comparison to reference data (eg, percentile ranks/*z* scores), and individual patterns and history** | | | **X** | **X** | **X** |
| | 1.2A | | Identifies appropriate adult and pediatric reference standards for comparison | X | X | X |
| | | 1.2A1 | Estimates and modifies anthropometric measurements, as appropriate (eg, amputations and pregnancy) | X | X | X |
| | | 1.2A2 | Identifies and interprets trends in anthropometric indexes (eg, for suboptimal growth and development or overweight/obesity in children, adolescents, and teens) | | X | X |
| **1.3** | ***Biochemical data, medical tests, and procedure assessment:* Assesses laboratory profiles (eg, acid-base balance, renal function, endocrine function, inflammatory response, vitamin/mineral profile, lipid profile), and medical tests and procedures (eg, gastrointestinal study and metabolic rate)** | | | **X** | **X** | **X** |
| | 1.3A | | Evaluates nutrition implications of diagnostic tests:<br>• diagnosis of diabetes, pre-diabetes, or gestational diabetes<br>• laboratory data for diabetes-related complications such as lipids, glucose, renal function, and other nutrition-related biochemical parameters<br>• blood pressure and carotid ultrasound<br>• neuropathy or retinopathy | X | X | X |
| | | 1.3A1 | Evaluates and interprets other diabetes nutrition-related biochemical parameters (eg, long-term metformin use and vitamin B 12, or celiac disease) and lab tests associated with definitive diagnosis of diabetes type (eg, c-peptide, insulin antibodies) | | | X |
| | 1.3B | | Evaluates patient's/client's food records, SMBG data, and/or medication regimen for pattern management | X | X | X |
| | | 1.3B1 | Applies decision making to interpret food intake, labs (eg, HbA1c[h]), and glucose monitoring data (eg, SMBG, CGM, device settings, and/or electronically generated data reports) for pattern management evaluation | | X | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

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| *Each RDN:* | | | | **Competent** | **Proficient** | **Expert** |
| | | 1.3B2 | Evaluates and interprets food intake, glucose monitoring (eg, SMBG, CGM, device settings, and/or electronically generated data reports) and procedures (eg, in/outpatient surgery, MRI[i] or CT[j]) for more complex decisions in pattern management and medication adjustments | | | X |
| **1.4** | ***Nutrition-focused physical examination (NFPE) may include visual and physical examination*: Obtains and assesses findings from NFPE (eg, indicators of vitamin/mineral deficiency/toxicity, edema, muscle wasting, subcutaneous fat loss, altered body composition, oral health, feeding ability [suck/swallow/breathe], appetite, and affect)** | | | **X** | **X** | **X** |
| | 1.4A | | Reviews screening data or screens for nutrition risk (eg, malnutrition, food security) using evidence-based screening tools for the setting and/or population (adult or pediatric) | X | X | X |
| | 1.4B | | Performs NFPE that includes, but is not limited to the inspection of injection, CSII and sensor sites; oral health; monofilament foot exams; body areas or skin for signs of irritation or dry or cracked at risk of ulcer; conditions related to diabetes (eg, nonhealing wound, acanthosis nigricans, foot exams, or vitiligo) | | X | X |
| | 1.4C | | Utilizes evidence-based recommendations for guiding the NFPE and evaluating the physical or clinical findings (eg, AMA—PQRI[k] Measures and ADA[l] Standards of Medical Care in Diabetes [www.diabetes.org]) | | | X |
| | 1.4D | | Assess clinical signs of malnutrition, undernutrition, disordered eating, or eating disorder (eg, muscle wasting, dry, brittle, or thinning hair and nails, sarcopenia, and cachexia) to identify a nutrition diagnosis and developing a plan of care/intervention | | | X |
| **1.5** | ***Food and nutrition-related history assessment (ie, dietary assessment):* Evaluates:** | | | **X** | **X** | **X** |
| | **1.5A** | | **Food and nutrient intake, including the composition and adequacy, meal and snack patterns, and appropriateness related to food allergies and intolerances** | **X** | **X** | **X** |
| | | 1.5A1 | Assesses fluid intake, appetite, and dietary pattern changes (eg, oral issues-chewing and swallowing, gastrointestinal problems, or comorbid conditions), and any changes for potential impact on diabetes management; seeks guidance as needed | X | X | X |
| | | 1.5A2 | Assesses changes in appetite or usual intake resulting from illness, sports, travel, medical conditions, and/or psychological issues (eg, stress, trauma, depression, or disordered eating) for impact on diabetes management | | X | X |
| | | 1.5A3 | Assesses daily fluid needs for health, physical activity, fitness level, and environmental conditions, and comorbid conditions (eg, renal or heart failure) | | X | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

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| *Each RDN:* | | | | | **Competent** | **Proficient** | **Expert** |
| | | 1.5A4 | | Assess food and nutrient intake considering the following:<br>• type and distribution of macronutrient intake (eg, carbohydrate, protein, and fat), and fiber<br>• micro- and macronutrient intake using appropriate tools, and comparing with evidence-based nutrition recommendations for individuals with diabetes across the life cycle (eg, vitamins and minerals)<br>• adequacy of nutrition intake to maintain energy balance under various conditions throughout the life cycle (eg, physical activity or comorbid conditions)<br>• history of food allergies/intolerances (eg, gluten sensitivity or intolerance, lactose intolerance)<br>• understanding of dietary modifications superimposed with comorbidities (eg, heart failure, renal, CVD) | | X | X |
| | **1.5B** | **Food and nutrient administration, including current and previous diets and diet prescriptions and food modifications, eating environment, and enteral and parenteral nutrition administration** | | | **X** | **X** | **X** |
| | | 1.5B1 | | Evaluates diet experience and current meal planning approach (eg, carbohydrate counting, calorie counting, plate method, carbohydrate controlled, previous diabetes/nutrition education/ counseling, or weight management attempts) | X | X | X |
| | | 1.5B2 | | Evaluates eating environment, access, and cultural influences or differences (eg, location, atmosphere, family/caregiver/ companion, eats alone, and types/preparation of cuisine) | | X | X |
| | | 1.5B3 | | Considers complex issues (eg, recovery from surgery/ trauma/injury/illness) or changes in severity of comorbid conditions (eg, steroid- or chemically-induced diabetes) related to food intake and clinical complications; seeks assistance from experienced practitioner, if needed | | | X |
| | | 1.5B4 | | Considers complex diabetes management issues (eg, recovery from major surgery/trauma/injury/illness, nutrition support) related to food intake, changes in comorbid conditions, and medication management | | | X |
| | **1.5C** | **Medication and dietary supplement use including prescription and OTC[m] medications, and integrative and functional medicine products** | | | **X** | **X** | **X** |
| | | 1.5C1 | | Evaluates prescriptions and adherence to oral diabetes medications, other injectables, and/or insulin (eg, type, dosage, effect, and duration); seeks assistance if needed | | X | X |
| | | | 1.5C1i | Assesses current and coordinates regimen of all medications, including diabetes-related (injectables and/ or oral), comorbid conditions (eg, hypertension, CVD, and renal), and other disease-related medications (eg, thyroid, Addison's disease, posttransplant, cancer) in relation to food intake and timing of administration (eg, insulin to carbohydrate ratios, ISF[n], exercise, and antibiotics) | | | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

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| | | | 1.5C1ii | Assesses overall medication management in the context of integrated disease state management (eg, end-stage renal disease or heart failure) | | | X |
| | | 1.5C2 | | Assesses safety and efficacy of OTC medications and dietary supplements, including herbals | X | X | X |
| | | 1.5C3 | | Reviews relationships between prescription, OTC, and dietary supplements, including herbals and medicinal spices used and their potential influence on blood glucose levels | | X | X |
| | | 1.5C4 | | Observes and evaluates administration technique of insulin, other injectable or medication delivery systems, and their appropriateness and use (eg, CSII, syringe, or pen); glucagon administration technique; and urine and blood ketone testing when appropriate | | X | X |
| | | 1.5C5 | | Evaluates blood glucose monitoring equipment selection, use, techniques, and reports either self-reported or electronically generated (eg, SMBG or CGM) | | | X |
| | **1.5D** | **Knowledge, beliefs, and attitudes (eg, understanding of nutrition-related concepts, emotions about food/nutrition/health, body image, preoccupation with food and/or weight, readiness to change nutrition- or health-related behaviors, and activities and actions influencing achievement of nutrition-related goals)** | | | **X** | **X** | **X** |
| | | 1.5D1 | | Assesses behavioral mediators (or antecedents) related to living with diabetes/chronic disease and dietary intake (eg, attitudes, self-efficacy, knowledge, intentions, readiness and willingness to change, and perceived social support) | X | X | X |
| | | 1.5D2 | | Evaluates nutrition and self-care skills, behaviors, health care knowledge/beliefs/attitudes from the patient's/client's/caregiver's perspective (eg, experience self-adjusting the treatment plan and culture) | X | X | X |
| | | 1.5D3 | | Evaluates lifestyle behaviors related to diabetes, its complications and congruency with patient-centered management goals (eg, self-reported adherence, appointments, recall of nutrition or diabetes-related goals, self-monitoring, and self-management as agreed upon) | | X | X |
| | | 1.5D4 | | Evaluates various influences (eg, language, physical activity, social networks, culture, ethnicity, and religion) that relate to the potential impact on behavior change | | X | X |
| | | 1.5D5 | | Determines readiness of patient/client for intensifying glycemic control to prevent or reduce the progression of chronic complications and/or comorbidities | | | X |

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| | | 1.5D6 | Assesses risk/history of eating disorders and/or disordered eating pattern or factors (eg, medication adjustments/omissions, food issues, and physical activity) such as:<br>• bingeing and purging eating behavior and antecedents (eg, goes into bathroom immediately after eating or exercises or misses medication doses)<br>• abnormal mealtime behaviors (eg, drinking in place of eating, spitting out food, or restrictive behaviors such as limiting carbohydrates)<br>• insulin omissions for weight control (eg, teens)<br>• avoidance behavior (eg, eats alone, avoids social situations)<br>• obsessive behaviors regarding meal composition | | | X |
| | **1.5E** | **Food security defined as factors impacting access to a sufficient quantity of safe, healthful food and water, as well as food/nutrition-related supplies** | | **X** | **X** | **X** |
| | | 1.5E1 | Assesses food and water safety, access, and availability of healthy food/meals:<br>• for appropriate food preparation resources (eg, financial, food markets/grocery stores, and equipment for cooking, serving, and safe food storage),<br>• food environment or access (eg, use of food pantry, meal programs, homeless shelter), and<br>• plans for emergency situations/disaster events (eg, food and water availability and supply of medications) | X | X | X |
| | **1.5F** | **Physical activity, cognitive and physical ability to engage in developmentally appropriate nutrition-related tasks (eg, mobility, self-feeding, and other ADLs°), instrumental ADLs (eg, shopping and food preparation), and breastfeeding** | | **X** | **X** | **X** |
| | | 1.5F1 | Assesses health literacy and numeracy (eg, ability to read, write, and perform calculations) | X | X | X |
| | | 1.5F2 | Identifies and uses evidenced-based quality-of-life surveys for performing ADLs related to nutrition interventions | | X | X |
| | **1.5G** | **Other factors affecting intake and nutrition and health status (eg, cultural, ethnic, religious, lifestyle influencers, psychosocial, and social determinants of health)** | | **X** | **X** | **X** |
| | | 1.5G1 | Assesses patient's/client's/family's/caregiver's understanding of health condition(s) and nutrition-related effects and implications as it relates to cultural, ethnic, and religious beliefs and traditions | X | X | X |
| | | 1.5G2 | Identifies and evaluates other influences (eg, nonmedical friend/family advice, commercial influences such as the Internet/media) that relate to diabetes management or nutrition therapy | | X | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

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| **1.6** | **Comparative standards: Uses reference data and standards to estimate nutrient needs and recommended body weight, body mass index, and desired growth patterns** | | | **X** | **X** | **X** |
| | **1.6A** | **Identifies the most appropriate reference data and/or standards (eg, international, national, state, institutional, and regulatory) based on practice setting, and patient-/client-specific factors (eg, age and disease state)** | | **X** | **X** | **X** |
| | | 1.6A1 | Compares nutrition assessment data to appropriate criteria, relevant norms, population-based surveys, standards (eg, Academy[p], Dietitians of Canada, ADA, IDF[q], The National Academies of Sciences, Engineering, and Medicine: Health and Medicine Division) positions for determining nutrition- and diabetes-related recommendations:<br>• energy needs/balance<br>• macronutrient and micronutrient needs<br>• fluid and electrolyte balance | | X | X |
| | 1.6B | Evaluates implications of data, reference standards, and practice guidelines for determining diabetes care and management approach through the life cycle | | | | X |
| **1.7** | **Physical activity habits and restrictions: Assesses physical activity, history of physical activity, and physical activity training** | | | **X** | **X** | **X** |
| | 1.7A | Evaluates current diabetes treatment plan for appropriate physical activity prescription according to current guidelines | | X | X | X |
| | 1.7B | Assess physical activity limitations (eg, vision, mobility, dexterity, and medication contraindications) and physical inactivity (eg, television/screen and other sedentary activity time) | | X | X | X |
| | 1.7C | Assesses factors influencing access to physical activity (eg, environmental safety [eg, physical and climatic], walkability of neighborhood, proximity to parks/green space, access to physical activity facilities/programs) | | X | X | X |
| | 1.7D | Assesses ability to perform physical activity in the presence of suboptimal blood glucose control (eg, hypo- or hyperglycemia) and specific long-term complications of diabetes (eg, retinopathy and neuropathy) in accordance with the current ADA Standards of Medical Care in Diabetes recommendations | | | X | X |
| **1.8** | **Collects data and reviews collected and/or documented data by the nutrition and dietetics technician, registered (NDTR), other health care practitioners(s), patient/client, or staff for factors that influence nutrition and health status** | | | **X** | **X** | **X** |
| | 1.8A | Assesses risk of developing acute complications (eg, hypoglycemia and fall risk, hyperglycemia, DKA[r]) | | X | X | X |

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| *Each RDN:* | | | **Competent** | **Proficient** | **Expert** |
| | 1.8B | Reviews collected data from all sources to identify factors that impact nutrition and health status and diabetes care and management:<br>• frequency, severity, and consequences of hypoglycemia/hyperglycemia, and prevention/treatment<br>• patient/client/advocate[s] understanding of the most common precipitants of DKA and behaviors leading to DKA and hypoglycemia<br>• results of preventive screenings for diabetes lifestyle prevention practices and diabetes complications (eg, immunizations, eye, foot, circulation, kidney function-microalbumin, HbA1c, lipid levels, and blood pressure)<br>• actual risk of developing chronic macrovascular CVD and microvascular complications (eg, neuropathy, diabetic kidney disease, or retinopathy)<br>• preventive care behaviors (eg, foot care, annual influenza immunization, pneumococcal immunization, annual dilated eye, and dental exams) based on the recommendations of the ADA Standards of Medical Care in Diabetes | | X | X |
| | 1.8C | Directs nutrition management of long-term complications of diabetes within the context of interprofessional[t] care and referrals | | | X |
| **1.9** | **Uses collected data to identify possible problem areas for determining nutrition diagnoses** | | **X** | **X** | **X** |
| | 1.9A | Assesses and prioritizes nutrition-related problems (eg, intake, behavior change, and weight change) for factors that influence nutrition and health status | X | X | X |
| | 1.9B | Assesses more complex issues related to food intake and clinical complications (eg, presence of nutrition risk factors and multiple complications) for prioritizing nutrition diagnoses | | X | X |
| | 1.9C | Assesses complex food-related issues, clinical complications, and current or anticipated treatment options (eg, surgery or medical management adjustments) in prioritizing nutrition problems in collaboration with the interprofessional team | | | 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, and behavioral)** | **X** | **X** | **X** |
| | **1.10C** | **Comparison to appropriate standards** | **X** | **X** | **X** |
| | **1.10D** | **Patient/client/population perceptions, values, and motivation related to presenting nutrition and diabetes management-related problems** | **X** | **X** | **X** |
| | **1.10E** | **Changes in patient/client/population perceptions, values and motivation related to presenting nutrition and diabetes management-related problems** | **X** | **X** | **X** |
| | **1.10F** | **Reason for discharge/discontinuation or referral, if appropriate** | **X** | **X** | **X** |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

**Examples of Outcomes for Standard 1: Nutrition Assessment**

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

**Standard 2: Nutrition Diagnosis**

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

**Rationale:**

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

| **Indicators for Standard 2: Nutrition Diagnosis** | | | | | |
|---|---|---|---|---|---|
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| *Each RDN:* | | | **Competent** | **Proficient** | **Expert** |
| **2.1** | **Diagnoses nutrition problems based on evaluation of assessment data and identifies supporting concepts (ie, etiology, signs, and symptoms)** | | **X** | **X** | **X** |
| | 2.1A | Uses evidence-based guidelines and protocols to organize and group data consisting of intake, clinical, physical function, behavioral, environmental, and other assessments | X | X | X |
| | 2.1B | Considers complex information related to food intake and clinical factors (eg, metabolic/bariatric surgery, gestational diabetes/high-risk pregnancy, hyperlipidemia, hypertension, disordered eating or eating disorder, developmental disability, or psychiatric illness) when deriving the nutrition diagnosis(es) | | X | X |
| | 2.1C | Integrates complex information related to food intake, biochemical data, therapeutic procedures, and clinical complications and their management within an interprofessional environment (eg, uncontrolled diabetes, diabetic kidney disease, and neuropathy) when formulating a nutrition diagnosis(es) | | | X |
| **2.2** | **Prioritizes the nutrition problems(s)/diagnosis(es) based on severity, safety, patient/client needs and preferences, ethical considerations, likelihood that nutrition intervention/plan of care will influence the problem, discharge/transitions of care needs, and patient/client/advocate perception of importance** | | **X** | **X** | **X** |
| | 2.2A | Prioritizes nutrition diagnoses in order of importance or urgency using evidence-based protocols and guidelines for diabetes care | X | X | X |
| | 2.2B | Prioritizes nutrition diagnoses based on diabetes disease states and/or status (eg, at diagnosis, illness, or transition of care), complications, protocols, and guidelines for diabetes care | | X | X |
| | 2.2C | Prioritizes nutrition diagnoses using advanced clinical reasoning and judgment for diabetes and other-related complications | | | X |

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| Indicators for Standard 2: Nutrition Diagnosis | | | | | |
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| *Each RDN:* | | | **Competent** | **Proficient** | **Expert** |
| **2.3** | **Communicates, providing evidence as necessary, and confirms the nutrition diagnosis(es) to patients/clients/advocates, community, family members, or other health care professionals when possible and appropriate** | | **X** | **X** | **X** |
| | 2.3A | Communicates and confirms the diagnosis(es) using clinical judgment skills (eg, consideration of the prevention of micro- and macrovascular complications) | | X | X |
| | 2.3B | Communicates and confirms the diagnosis(es) using advanced clinical reasoning and judgment as part of an interprofessional team (ie, addressing diabetes as a complex metabolic disorder) | | | X |
| **2.4** | **Documents the nutrition diagnosis(es) using standardized terminology and clear, concise written statement(s) (eg, using Problem [P], Etiology [E], and Signs and Symptoms [S] [PES statement(s)] or Assessment [A], Diagnosis [D], Intervention [I], Monitoring [M], and Evaluation [E] [ADIME statements(s)])** | | **X** | **X** | **X** |
| **2.5** | **Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available** | | **X** | **X** | **X** |

**Examples of Outcomes for Standard 2: Nutrition Diagnosis**

- Nutrition Diagnostic Statements that are:
  - Clear, concise, accurate, and prioritized
  - Specific to patient/client (eg, community and/or culturally centered)
  - Based on reliable and accurate assessment data
- Documentation of nutrition diagnosis(es) is relevant, accurate, and timely
- Documentation of nutrition diagnosis(es) is revised as additional assessment data become available

**Standard 3: Nutrition Intervention/Plan of Care**

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

**Rationale:**

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

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

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

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| Indicators for Standard 3: Nutrition Intervention/Plan of Care | | | | | |
|---|---|---|---|---|---|
| **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** | **Addresses the nutrition diagnosis(es) by determining and prioritizing appropriate interventions for the plan of care** | | **X** | **X** | **X** |
| | 3.1A | Prioritizes considering one or more of the following based on type of diabetes, ie, gestational diabetes, prediabetes, type 1 diabetes, or type 2 diabetes:<br>• survival skills (eg, meal timing and composition, physical activity, SBGM, action and timing of medication[s], and prevention and treatment of hypo-/hyperglycemia)<br>• DSMES/DSMT[U] needs (eg, National DSMES Standards and Algorithm of Care, AADE7 Self-Care Behaviors, and ADA Standards of Medical Care in Diabetes)<br>• patient's/client's ability or willingness to implement and adhere to the nutrition plan<br>• presence of comorbid diseases or conditions (eg, CVD, gastrointestinal disorders, renal function, and altered weight/growth status) | X | X | X |
| | 3.1B | Considers medical issues, treatment goals, patient/client/advocate goals including quality of life in determining appropriateness for intensive glycemic control to prevent or reduce progression of comorbidities, including need for hospitalizations and/or surgery | | X | X |
| **3.2** | **Bases intervention/plan of care on best available research/evidence and information, evidence-based guidelines, and best practices** | | **X** | **X** | **X** |
| | 3.2A | Uses EAL diabetes-related guidelines (eg, type 1 diabetes, type 2 diabetes, gestational diabetes, and prevention type 2) and ADA Nutrition recommendations[43] | X | X | X |
| | 3.2B | Adjusts application of the diabetes education guidelines/protocols (National Standards for DSMES, AADE-7 Behaviors) based on the individual needs of the person with diabetes and progress of intervention in collaboration with the interprofessional team | | X | X |
| | 3.2C | Recognizes when it is appropriate to utilize adjusted intervention guidelines (eg, intellectual or developmental disabilities, hypoglycemic unawareness, cognitive changes, or emotional factors such as anxiety, clinical depression, or medications influencing glucose management) | | | X |
| **3.3** | **Refers to policies and procedures, protocols, and program standards** | | **X** | **X** | **X** |
| **3.4** | **Collaborates with patient/client/advocate/population, caregivers, interprofessional team, and other health care professionals** | | **X** | **X** | **X** |
| | 3.4A | Organizes and leads communication with patient/client, caregiver, family, or designee, and acts as case manager to coordinate and organize care in collaboration with interprofessional team | | X | X |
| **3.5** | **Works with patient/client/advocate/population and caregivers to identify goals, preferences, discharge/transitions of care needs, plan of care, and expected outcomes** | | **X** | **X** | **X** |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| Indicators for Standard 3: Nutrition Intervention/Plan of Care | | | | | |
|---|---|---|---|---|---|
| **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** |
| | 3.5A | Develops goals and outcomes with patient/client participation using clear, concise, and measurable terms | X | X | X |
| | 3.5B | Identifies, evaluates, and addresses readiness to change and barriers to successful implementation of patient-/client-centered goals and outcomes (eg, adherence, food availability and preparation issues, social support, readiness to change, financial considerations, realistic expectations, food knowledge and duration of treatment, commitment to process) | X | X | X |
| | 3.5C | Develops and implements strategies to address lapses in self-care management or behaviors and identifies recovery strategies | | X | X |
| | 3.5D | Directs nutrition management of long-term complications within the context of integrated care (eg, pregnancy, renal disease, heart failure, and surgery) | | | X |
| **3.6** | **Develops the nutrition prescription and established measurable patient-/client-focused goals to be accomplished** | | **X** | **X** | **X** |
| | 3.6A | Develops or adjusts the nutrition prescription and diabetes self-management plan, as appropriate, considering:<br>• medical conditions, including food restrictions and intolerances and treatment goals<br>• nutrition diagnosis(es)—priority<br>• physical activity and work schedule, if applicable<br>• medication plan, if applicable<br>• educational needs, including health literacy and numeracy<br>• cultural, religious, and other influences and/or beliefs<br>• food access and preparation skills<br>• psychological and behavioral factors influencing diabetes management and support | X | X | X |
| | 3.6B | Reviews and determines need for initiation and/or adjustment of pharmacotherapy, considering nutrition, physical activity, growth, medication, blood glucose and/or CGM data, and physical exam (eg, intensification of medication management [adjusting dose/timing], discontinuation of medications based on progression of the disease or macronutrient impact), as part of an interprofessional team | | X | X |
| **3.7** | **Defines time and frequency of care, including intensity, duration, and follow-up** | | **X** | **X** | **X** |
| | 3.7A | Uses guidelines established for medical nutrition therapy (eg, EAL diabetes-related guidelines [eg, type 1 diabetes and type 2 diabetes, gestational diabetes, and prevention type 2]), and DSMES (eg, DSMES Algorithm of Care) to determine duration and follow-up | X | X | X |
| **3.8** | **Uses standardized terminology for describing interventions** | | **X** | **X** | **X** |
| **3.9** | **Identifies resources and referrals needed** | | **X** | **X** | **X** |
| | 3.9A | Identifies resources and tools to assist patient/client with managing food intake and glucose management (eg, food guides, mobile apps, portion guides, community support groups, fitness facilities, or other outpatient programs) to support behavior change goals | X | X | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| Indicators for Standard 3: Nutrition Intervention/Plan of Care | | | | | | |
|---|---|---|---|---|---|---|
| **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** |
| | 3.9B | Identifies referrals to programs and/or providers (eg, behavioral health, ophthalmologist, podiatrist, physical therapist, personal trainer, and dentist) as appropriate and based on individual patient/client needs | | X | X | X |
| | 3.9C | Identifies resources/initiates referrals for complex needs (eg, behavioral, communication ability, digestive changes, skills training for care providers/ family, food security, transportation, and access) | | | X | X |
| *Implements the Nutrition Intervention/Plan of Care:* | | | | | | |
| **3.10** | **Collaborates with colleagues, interprofessional team, and other health care professionals** | | | **X** | **X** | **X** |
| | 3.10A | Provides ongoing follow-up documentation to referring physician or midlevel providers (eg, physician assistants and advance practice nurses) and collaborates with interprofessional teams outside the immediate diabetes care team (eg, CVD, renal disease, obstetrics, cystic fibrosis, or posttransplant) for potential changes to plan of care (eg, medications) | | X | X | X |
| | 3.10B | Recommends to health care provider when medication adjustment is warranted (eg, based on glucose monitoring data or availability of payer coverage) | | | X | X |
| | 3.10C | Partners or collaborates within an interprofessional diabetes team and other providers to recommend changes to the diabetes protocols consistent with facility policies to manage nutrition-related conditions and support therapies | | | X | X |
| | 3.10D | Initiates and/or leads planning and discussion of nutrition components of DSMES with the interprofessional team and other stakeholders | | | | X |
| **3.11** | **Communicates and coordinates the nutrition intervention/plan of care** | | | **X** | **X** | **X** |
| | 3.11A | Communicates plan of care to health care professionals involved in implementation of the plan | | X | X | X |
| | | 3.11A1 | Communicates, coordinates, and confirms understanding of care plan components with members of the health care team (eg, physician, pharmacist, nurse, nurse educator, mental/behavioral health practitioner, or bariatric coordinator) | | X | X |
| | 3.11B | Verifies patient/client and, if applicable, family/significant others/caregivers, understand and can articulate goals and other relevant plan of care aspects | | | X | X |
| **3.12** | **Initiates the nutrition intervention/plan of care** | | | **X** | **X** | **X** |
| | **3.12A** | **Uses approved clinical privileges, physician/non-physician practitioner[v]-driven orders (ie, delegated orders), protocols, or other facility-specific processes for order writing or for provision of nutrition-related services consistent with applicable specialized training, competence, medical staff, and/or organizational policy** | | **X** | **X** | **X** |
| | | **3.12A1** | **Implements, initiates, or modifies orders for therapeutic diets, pharmacotherapy management, or nutrition-related services (eg, medical foods/nutrition/dietary supplements, food texture modifications, enteral and parenteral nutrition, intravenous fluid infusions, laboratory tests, medications, and education and counseling)** | **X** | **X** | **X** |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| Indicators for Standard 3: Nutrition Intervention/Plan of Care | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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** |
| | | **3.12A2** | **Manages nutrition support therapies (eg, formula selection, rate adjustments, addition of designated medications and vitamin/mineral supplements to parenteral nutrition solutions or supplemental water for enteral nutrition)** | | **X** | **X** | **X** |
| | | | 3.12A2i | Manages enteral/parenteral nutrition and specialized nutrition support therapy, including formula selection and adjustment based on patient/client laboratory results, using provider-approved protocols, clinical privileges for order writing, or similar documents consistent with organization policies (eg, adjusting insulin dosage or pump settings) | | X | X |
| | | **3.12A3** | **Initiates and performs nutrition-related services (eg, beside swallow screenings, inserting and monitoring nasoenteric feeding tubes, and indirect calorimetry measurements, or other permitted services)** | | **X** | **X** | **X** |
| | | | 3.12A3i | Plans and reviews selection and initiation of glucose monitoring equipment (eg, blood glucose meters, CGM systems, and sensor-augmented pumps) | | X | X |
| | | | 3.12A3ii | Provides education and training with required CSII and CGM certification according to institution or organization protocol or approved clinical privileges | | X | X |
| | 3.12B | Utilizes appropriate behavior change theories (eg, motivational interviewing, behavior modification, and modeling) to facilitate individualized self-management self-care strategies and nutrition prescription and meal plan based on:<br>• meal and pharmacotherapy interventions<br>• physical activity and work schedules, if applicable<br>• acute and chronic complications<br>• sick days<br>• SMBG frequency<br>• growth and development | | | X | X | X |
| | 3.12C | Educates patient/client on glucose regulation to support setting realistic self-management goals (eg, age, stress, or pregnancy) | | | | X | X |
| | 3.12D | Educates using multiple intervention approaches as appropriate to guide decision making for patient/client in complicated, unpredictable, and dynamic situations (eg, trauma, acute diabetes-related complications) considering cultural and psychosocial factors | | | | X | X |
| | 3.12E | Educates using experiential and current body of advanced knowledge of patient/client population to individualize the treatment strategy for complex interventions (eg, culture, psychosocial, belief structure, and practices) | | | | | X |
| | *Provides DSMES for the following topics in 3.12F-3.12J as applicable to patient/client/advocate needs:* | | | | | | |
| | 3.12F | Discusses medication plan, if applicable | | | X | X | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| Indicators for Standard 3: Nutrition Intervention/Plan of Care | | | | | | |
|---|---|---|---|---|---|---|
| **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** |
| | | 3.12F1 | Reviews actions, duration, and side effects of medications commonly used in diabetes management (eg, oral, injectable, inhaled, and patches) | | X | X |
| | | 3.12F2 | Provides instruction on medication delivery systems (eg, syringes, pens, CSII, or patch), use and storage, reducing risk of bloodborne pathogens, and sharps disposal | | X | X |
| | | 3.12F3 | Uses advanced judgment and reasoning, including laboratory monitoring, to adjust and implement pharmacotherapy plan following provider and/or facility approved protocols and policies | | | X |
| | | 3.12F4 | Discusses integrative and functional medicine strategies when medically appropriate, including potential interactions | | | X |
| | 3.12G | Discusses acute complications such as treatment of hyper- and hypoglycemia | | X | X | X |
| | | 3.12G1 | Reviews basic information and provides instruction on prevention and treatment for hyper- and hypoglycemia | X | X | X |
| | | 3.12G2 | Provides instruction on treatment of severe hypoglycemia, including glucagon administration | | X | X |
| | 3.12H | Discusses sick day guidelines (eg, food and liquid intake) | | X | X | X |
| | | 3.12H1 | Provides information for sick day guidelines beyond food intake (eg, medication adjustment, urine or blood ketone testing, and adequate hydration) | | X | X |
| | 3.12I | Reviews glucose monitoring data (eg, CGM or home) for pattern related to physical activity and food intake following adjustment algorithms or protocols | | | X | X |
| | | 3.12I1 | Provides instruction for adjusting the food, physical activity, and/or diabetes medication plan based on glucose data (eg, calculation and explanation of ICR[w] and ISF) | | | X |
| | | 3.12I2 | Provides instruction on trending of glucose, use of personal data management tools (eg, monitoring and health apps), and interpreting glucose patterns at home | | | X |
| | 3.12J | Discusses reducing risk of chronic complications (eg, foot care, monitoring blood pressure; annual eye, dental, and lipid level evaluations) addressing the "ABCs of Diabetes Care" (http://www.diabetes.org/living-with-diabetes/complications/heart-disease/healthy-abcs.html) | | X | X | X |
| | | 3.12J1 | Reviews components of NFPE (eg, foot/wound care, skin/nail care, dental, and neurological) for prevention and when to contact medical provider | | X | X |
| **3.13** | **Assigns activities to nutrition and dietetics technician, registered (NDTR), and other professional, technical, and support personnel in accordance with qualifications, organization policies/protocols, and applicable laws and regulations** | | | **X** | **X** | **X** |
| | **3.13A** | **Supervises professional, technical, and support personnel** | | **X** | **X** | **X** |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| Indicators for Standard 3: Nutrition Intervention/Plan of Care | | | | | |
|---|---|---|---|---|---|
| **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** |
| | 3.13B | Provides support personnel with information and guidance needed to complete assigned activities | X | X | X |
| **3.14** | **Continues data collection** | | **X** | **X** | **X** |
| | 3.14A | Identifies and records specific data collection for patient/client, including weight change, biochemical, behavioral, and lifestyle factors using prescribed/standardized format | X | X | X |
| | 3.14B | Analyzes data trends to modify plan, if indicated; consults with more experienced practitioner or interprofessional team as needed | X | X | X |
| **3.15** | **Documents:** | | | | |
| | **3.15A** | **Date and time** | **X** | **X** | **X** |
| | **3.15B** | **Specific and measurable treatment goals and expected outcomes** | **X** | **X** | **X** |
| | **3.15C** | **Recommended interventions** | **X** | **X** | **X** |
| | **3.15D** | **Patient/client/advocate/caregiver/community receptiveness** | **X** | **X** | **X** |
| | **3.15E** | **Referrals made and resources used** | **X** | **X** | **X** |
| | **3.15F** | **Patient/client/advocate/caregiver/community comprehension** | **X** | **X** | **X** |
| | **3.15G** | **Barriers to change** | **X** | **X** | **X** |
| | **3.15H** | **Other information relevant to providing care and monitoring progress over time** | **X** | **X** | **X** |
| | **3.15I** | **Plans for follow up and frequency of care** | **X** | **X** | **X** |
| | **3.15J** | **Rationale for discharge or referral if applicable** | **X** | **X** | **X** |

**Examples of Outcomes for Standard 3: Nutrition Intervention**

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

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

**Standard 4: Nutrition Monitoring and Evaluation**

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

**Rationale:**

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

| **Indicators for Standard 4: Nutrition Monitoring and Evaluation** | | | | | | |
|---|---|---|---|---|---|---|
| **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 patient/client/advocate/population understanding and compliance with nutrition intervention/plan of care** | | **X** | **X** | **X** |
| | | 4.1A1 | Evaluates congruency of nutrition intervention/diabetes management plan (eg, eating plan and portion and/or calorie controlled) to diabetes/nutrition prescription | X | X | X |
| | | 4.1A2 | Evaluates nutrition intervention that includes patient-/client-centered S.M.A.R.T.[x] goals | X | X | X |
| | | 4.1A3 | Reassesses patient's/client's stage of behavior change and learning style to evaluate need to revise nutrition intervention | | X | X |
| | **4.1B** | **Determines whether the nutrition intervention/plan of care is being implemented as prescribed** | | **X** | **X** | **X** |
| | | 4.1B1 | Evaluates nutrition intervention/plan of care to identify and address barriers to diabetes management and nutrition intervention | X | X | X |
| | | 4.1B2 | Evaluates nutrition intervention in the face of complex clinical situations (eg, pre- and postmetabolic/bariatric surgery; managing weight with complex conditions such as comorbid conditions, multiple medications, food allergies and intolerances, and cultural factors) | | X | X |
| | | 4.1B3 | Tailors tools and methods to ensure desired outcomes reflect the patient's/client's social, physical, environmental factors, and diabetes nutrition goals | | | X |
| **4.2** | **Measures outcomes:** | | | **X** | **X** | **X** |
| | **4.2A** | **Selects the standardized nutrition care measurable outcome indicator(s):** | | **X** | **X** | **X** |
| | | 4.2A1 | Anthropometric measures (eg, weight, body mass index, waist circumference, rate of weight change, growth, and development) | X | X | X |
| | | 4.2A2 | Body composition measures (eg, fat mass and lean) | X | X | X |
| | | 4.2A3 | Laboratory measures (eg, HbA1c, lipid panel, comprehensive metabolic panel, and renal panel) | X | X | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| 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** |
| | | 4.2A4 | Behavioral measures (eg, activity level, eating behaviors, cognitive functioning, and goal attainment) | | X | X | X |
| | | | 4.2A4i | Treatment outcomes (eg, possible barriers, mood and cognitive function changes, treatment delays, signs of relapse, and need for more advanced/involved treatment options) | | X | X |
| | | 4.2A5 | Quality of life measures (eg, activity and daily living) | | X | X | X |
| | | 4.2A6 | Health care utilization for achieving nutrition and diabetes management outcomes (eg, consistent, adequate delivery or access to care; incidence of infections and hospitalizations; and resource utilization) | | | | X |
| | **4.2B** | **Identifies positive or negative outcomes, including impact on potential needs for discharge/transitions of care** | | | **X** | **X** | **X** |
| | | 4.2B1 | Documents progress in meeting desired goals (eg, eating patterns, weight loss/maintenance, blood pressure, blood lipids, and blood glucose [ie, HbA1c goal]; and improved physical capabilities, such as activity level and sleep patterns) | | X | X | X |
| | | 4.2B2 | Identifies unintended consequences (eg, excessive rate of weight loss or extreme blood glucose variability), or the use of inappropriate methods of achieving goals (eg, insulin omission or self-imposed dietary restrictions and personal beliefs) | | | X | X |
| | | 4.2B3 | Addresses underlying factors interfering with meeting the diabetes and nutrition intervention goals (eg, access to resources, lack of insurance, cost of medications) | | | X | X |
| **4.3** | **Evaluates outcomes:** | | | | **X** | **X** | **X** |
| | **4.3A** | **Compares monitoring data with nutrition prescription and established goals or reference standard (eg, EAL for diabetes-related guidelines [eg, type 1 diabetes and type 2 diabetes, gestational diabetes, and prevention type 2], ADA Nutrition Recommendations[41])** | | | **X** | **X** | **X** |
| | **4.3B** | **Evaluates impact of sum of all interventions on overall patient/client/population health outcomes and goals** | | | **X** | **X** | **X** |
| | | 4.3B1 | Completes comprehensive analysis of indicators for each identified problem compared with protocols and reference standards for impact on patient/client health outcomes and goals | | | X | X |
| | | 4.3B2 | Completes a detailed trending analysis of the indicators and how they correlate with each other, to determine and evaluate the complexity of problems and influence on patient/client/population health outcomes and goals | | | | X |
| | **4.3C** | **Evaluates progress or reasons for lack of progress related to problems and interventions** | | | **X** | **X** | **X** |
| | | 4.3C1 | Determine whether outcomes meet expectations | | X | X | X |

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**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| 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** |
| | | 4.3C2 | Elicits feedback from patient/client/advocate about success with behavior change (eg, food and physical activity and health outcome goals) | | X | X | X |
| | | | 4.3C2i | Elicits feedback from patient/client/advocate about challenges/barriers with behavior change (eg, monitoring, taking medications, problem solving, healthy coping, and reducing risks) | | X | X |
| | | 4.3C3 | Adjusts plan with patient/client/caregiver to overcome obstacles to change and achieving goals | | X | X | X |
| | | 4.3C4 | Modifies nutrition intervention based on patient/client tolerance, response, environmental limitations (eg, food security and economic status), and outcome measures | | | X | X |
| | **4.3D** | **Evaluates evidence that nutrition intervention/plan of care is maintaining or influencing a desirable change in patient/ client/population behavior or status** | | | **X** | **X** | **X** |
| | | 4.3D1 | Evaluates patient/client outcomes in relation to nutrition plan and goals (eg, laboratory data; physical, social, cognitive, environmental factors, ADLs, and growth and development) | | X | X | X |
| | | 4.3D2 | Evaluates and analyzes underlying factors interfering with intervention outcomes and access to services (eg, prognosis, psychological factors, or use/lack of resources) for impact on health outcomes, nutrition plan, and goals | | | X | X |
| | | 4.3D3 | Reassesses, modifies, and coordinates, if applicable, action plan in complex cases based on effects of all interventions on patient's/client's complications, comorbid conditions, and overall health outcomes | | | | X |
| | **4.3E** | **Supports conclusions with evidence (eg anthropometric, biochemical, clinical, SMBG, and dietary data)** | | | **X** | **X** | **X** |
| | | 4.3E1 | Clearly documents outcomes and processes | | X | X | X |
| **4.4** | **Adjusts nutrition intervention/plan of care strategies, if needed, in collaboration with patient/client/population/advocate/caregiver and interprofessional team** | | | | **X** | **X** | **X** |
| | **4.4A** | **Improves or adjusts intervention/plan of care strategies based on outcomes data, trends, best practices, and comparative standards** | | | **X** | **X** | **X** |
| | 4.4B | Modifies intervention strategies as needed (eg, culture, psychosocial, change in living/care situation, progress/change in goal, change in health status); seeks assistance as needed | | | X | X | X |
| | 4.4C | Modifies intervention strategies as appropriate to address patient/client needs and complex situations (comorbidities and complications [eg, gastroparesis or steroid-induced diabetes]) | | | | X | X |
| | 4.4D | Arranges for additional resources and support services (eg, training of direct care providers, collaboration with health care professionals) for implementing nutrition intervention/plan of care in patients/clients balancing multiple situations (eg, emergency situations, and/or clinical complications) | | | | X | X |

*(continued on next page)*

**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

| 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** |
| | 4.4E | Adjusts in complicated situations (eg, glycemic variability or comorbidities) and when combining multiple intervention approaches | | | X |
| | 4.4F | Adjusts in complicated situations by drawing on practice experience, knowledge, clinical judgment, and evidence-based practice about the patient/client population in complicated, unpredictable, and dynamic situations (eg, critical care, wound management, and factors related to comorbid conditions/ complications) | | | X |
| **4.5** | **Documents:** | | **X** | **X** | **X** |
| | **4.5A** | **Date and time** | **X** | **X** | **X** |
| | **4.5B** | **Indicators measured, results, and method for obtaining measurement (eg, HbA1c, lipid levels, height, weight, vitamin B 12 level, and vitamin D level)** | **X** | **X** | **X** |
| | **4.5C** | **Criteria to which indicator is compared (eg, nutrition prescription/goal or a reference standard)** | **X** | **X** | **X** |
| | **4.5D** | **Factors facilitating or hampering progress** | **X** | **X** | **X** |
| | **4.5E** | **Other positive or negative outcomes** | **X** | **X** | **X** |
| | **4.5F** | **Adjustments to the nutrition intervention/plan of care, if indicated** | **X** | **X** | **X** |
| | **4.5G** | **Future plans for nutrition care, nutrition monitoring and evaluation, follow-up, referral, or discharge** | **X** | **X** | **X** |

**Examples of outcomes for Standard 4: Nutrition Monitoring and Evaluation**

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

*(continued on next page)*

**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

[a]EAL=Academy of Nutrition and Dietetics Evidence Analysis Library. *Review EAL list of guidelines as there are multiple guidelines that relate to diabetes (Gestational, Type 1 and Type 2 in Adults, Prevention Type 2), and comorbidities (eg, Chronic Kidney Disease; Hypertension; Obesity/Overweight, Adult and Childhood)*.

[b]AADE7=American Association of Diabetes Educators 7 Self Care Behaviors (www.diabeteseducator.org).

[c]DSMES=diabetes self-management education and support (https://professional.diabetes.org/content-page/standards-medical-care-diabetes).

[d]CSII=continuous sustained insulin infusion (ie, insulin pump).

[e]CGM=continuous glucose monitoring.

[f]CVD=cardiovascular disease.

[g]SMBG=self-monitoring blood glucose.

[h]HbA1c=glycated hemoglobin.

[i]MRI=magnetic resonance imaging.

[j]CT=computed tomography scan.

[k]AMA-PQRI=American Medical Association-Physician Quality Reporting Initiative (https://assets.ama-assn.org/resources/doc/cqi-templates/pqri-sort.shtml).

[l]ADA=American Diabetes Association (www.diabetes.org).

[m]OTC=over the counter.

[n]ISF=insulin sensitivity factor.

[o]ADL=activities of daily living.

[p]Academy=Academy of Nutrition and Dietetics (www.eatrightpro.org).

[q]IDF=International Diabetes Federation (www.idf.org).

[r]DKA=diabetic ketoacidosis.

[s]**Advocate:** An *advocate* is a person who provides support and/or represents the rights and interests at the request of the patient/client. The person may be a family member or an individual not related to the patient/client who is asked to support the patient/client with activities of daily living or is legally designated to act on behalf of the patient/client, particularly when the patient/client has lost decision making capacity. (Adapted from definitions within The Joint Commission Glossary of Terms[12] and the Centers for Medicare and Medicaid Services, Hospital Conditions of Participation[6]).

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

[u]DSMT=diabetes self-management training (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/DSMT-Accreditation-Program.html).

[v]**Non-physician practitioner:** A *non-physician practitioner* may include a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, qualified dietitian, or nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[6,7] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services Long-Term Care Regulations. With publication of the Final Rule revising the Conditions of Participation for Long Term Care Facilities effective November 2016, post-acute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutritional supplements, or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law and organization policies.[9,10]

[w]ICR=insulin to carbohydrate ratio.

[x]S.M.A.R.T.=specific, measurable, attainable, realistic, and timely goals.

**Figure 1.** *(continued)* Standards of Practice (SOP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. The terms *patient*, *client*, *customer*, *individual*, *person*, *group*, or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services.

**Standards of Professional Performance for Registered Dietitian Nutritionists in Diabetes Care**

**Standard 1: Quality in Practice**

The registered dietitian nutritionist (RDN) provides quality services using a systematic process with identified ethics, leadership, accountability, and dedicated resources.

**Rationale:**

Quality practice in nutrition and dietetics is built on a solid foundation of education and supervised practice, credentialing, evidence-based practice, demonstrated competence, and adherence to established professional standards. Quality practice requires systematic measurement of outcomes, regular performance evaluations, and continuous improvement.

| **Indicators for Standard 1: Quality in Practice** | | | | | |
|---|---|---|---|---|---|
| **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 (eg, HIPAA[a], sharps disposal, and food safety)** | | **X** | **X** | **X** |
| | 1.1A | Complies with state licensure or certification laws and regulations, if applicable, including telehealth and continuing education requirements | X | X | X |
| | 1.1B | Complies with relevant regulatory, accreditation standards, and reimbursement policies for providers and institutions | X | X | X |
| **1.2** | **Performs within individual and statutory scope of practice and applicable laws and regulations** | | **X** | **X** | **X** |
| | 1.2A | Reflects scope of practice as defined by state and federal rules and regulations, accreditation, or other applicable standards in diabetes practice | X | X | X |
| | 1.2B | Follows any scope of practice requirements related to additional credentialing or position (eg, CDE[b], BC-ADM[c], or certified diabetes technology clinician) | X | X | X |
| | 1.2C | Reviews and ensures that job description complies with defined scope of practice and assigned duties and professional responsibilities | X | X | X |
| | 1.2D | Adheres to provider or organization-approved protocols and/or privileges for including in scope of work: interpreting and adjusting treatment (eg, adjusting medication doses, evaluating electronic blood glucose or CGM[d] records, and obtaining insulin pump training, and making pump adjustments) | | X | X |
| | 1.2E | Adheres to provider or organization-approved protocols (eg, to initiate/titrate medications for management of diabetes and basic cardiovascular disease preventive medical regimen and associated lab orders) | | | X |
| **1.3** | **Adheres to sound business and ethical billing practices applicable to the role and setting** | | **X** | **X** | **X** |
| | 1.3A | Ensures ethical and accurate reporting of diabetes nutrition services (eg, billing codes for payer; ie, group or individual visit) | X | X | X |

*(continued on next page)*

**Figure 2.** Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | 1.3B | Develops/presents training for staff and team members on ethics and best practices for billing procedures | | X | X |
| | 1.3C | Collaborates with billing services and establishes protocols/ algorithms to guide decision making to ensure professional/ethical billing practices | | | X |
| **1.4** | **Uses national quality and safety data (eg, National Academies of Sciences, Engineering, and Medicine: Health and Medicine Division, National Quality Forum, Institute for Healthcare Improvement, American Diabetes Association (ADA), American Association of Clinical Endocrinologists, and American College of Obstetricians and Gynecologists) to improve the quality of services provided and to enhance customer-centered services** | | **X** | **X** | **X** |
| | 1.4A | Participates and/or leads organization, and local/state/national quality initiatives to identify need for changes related to diabetes nutrition management (eg, monitoring and medication protocols) | | X | X |
| | 1.4B | Anticipates changes to local, state, and national quality initiatives and leads performance improvement initiatives in the organization to support diabetes care and related services to facilitate improved outcomes | | | X |
| **1.5** | **Uses a systematic performance improvement model that is based on practice knowledge, evidence, research, and science for delivery of the highest quality services** | | **X** | **X** | **X** |
| | 1.5A | Identifies and participates in using an appropriate organization-approved performance improvement model(s)/process(es) (eg, Six Sigma and LEAN Thinking) | X | X | X |
| | 1.5B | Identifies performance improvement criteria to monitor effectiveness of services | X | X | X |
| | 1.5C | Obtains training and mentors members of the interprofessional[e] team on the organization performance improvement model(s) and leads performance improvement initiatives | | X | X |
| | 1.5D | Develops implementation strategies for quality improvement activities (eg, identification/adaptions of evidence-based practice guidelines/protocols, skills training/reinforcement, and organizational support/incentives) | | | X |
| | 1.5E | Leads interprofessional performance improvement initiatives across the organization or system | | | X |
| **1.6** | **Participates in or designs an outcomes-based management system to evaluate safety, effectiveness, quality, person-centeredness, equity, timeliness, and efficiency of practice** | | **X** | **X** | **X** |
| | **1.6A** | **Involves colleagues and others, as applicable, in systematic outcomes management** | **X** | **X** | **X** |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | | 1.6A1 | Collaborates with the interprofessional team to define the role of various team members | X | X | X |
| | **1.6B** | **Defines expected outcomes** | | **X** | **X** | **X** |
| | | 1.6B1 | Identifies quality outcomes to measure (eg, CMS[f], National Quality Forum, ADA, American Association of Clinical Endocrinologists, and American College of Obstetricians and Gynecologists, NCQA[g], or institution-specific measures) | | X | X |
| | **1.6C** | **Uses indicators that are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)** | | **X** | **X** | **X** |
| | | 1.6C1 | Selects criteria for data collection, and advocates for and participates in the development of data collection tools (eg, clinical, operational, and financial) | | X | X |
| | | 1.6C2 | Serves in leadership role to evaluate benchmarks of diabetes care based on public health and population-based indicators (eg, HEDIS[h] and national diabetes quality improvement measure sets) to improve outcomes | | | X |
| | **1.6D** | **Measures quality of services in terms of structure, process, and outcomes** | | **X** | **X** | **X** |
| | | 1.6D1 | Uses and/or develops systematic quality improvement approach to collect and organize data to measure performance against desired outcomes using data from multiple sources | X | X | X |
| | | 1.6D2 | Routinely assesses current services using culturally competent engagement processes and in accordance with established performance criteria to change practice for improving diabetes nutrition care | | X | X |
| | | 1.6D3 | Develops and/or uses systematic processes to monitor and analyze diabetes-related pooled data/aggregate data against expected outcomes | | | X |
| | **1.6E** | **Incorporates electronic clinical quality measures to evaluate and improve care of patients/clients at risk for malnutrition or with malnutrition (www.eatrightpro.org/emeasures)** | | **X** | **X** | **X** |
| | **1.6F** | **Documents outcomes and patient reported outcomes (eg, PROMIS[i])** | | **X** | **X** | **X** |
| | | 1.6F1 | Documents outcomes per selected protocol and participates in evaluation and reporting | X | X | X |
| | | 1.6F2 | Evaluates patient/client and service outcomes using identified metrics to reinforce current practices or implement changes in program/services | | X | X |

*(continued on next page)*

**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | | 1.6F3 | Synthesizes and publishes effectiveness outcomes on programs and services | | | X |
| | **1.6G** | | **Participates in, coordinates, or leads program participation in local, regional, or national registries and data warehouses used for tracking, benchmarking, and reporting service outcomes** | **X** | **X** | **X** |
| | | 1.6G1 | Actively promotes the inclusion of RDN-provided MNT[j] and DSMES[k] service components in local, regional, and/or national diabetes data registries | | X | X |
| | | 1.6G2 | Analyzes and uses information for long range strategic planning (eg, program and service efficacy) | | | X |
| **1.7** | | | **Identifies and addresses potential and actual errors and hazards in provision of services or brings to attention of supervisors and team members as appropriate** | **X** | **X** | **X** |
| | 1.7A | | Evaluates and ensures safe diabetes care; seeks assistance as needed | X | X | X |
| | | 1.7A1 | Identifies and educates patients/clients/families and other health care professionals regarding potential drug-food/nutrient interactions | X | X | X |
| | | 1.7A2 | Refers patients/clients to appropriate services when error/hazard is outside of practitioner's scope of practice | X | X | X |
| | 1.7B | | Collaborates with provider and other members of the diabetes team (eg, pharmacist) to recognize potential drug to drug (prescribed and over the counter) nutrient and drug—dietary supplement (eg, vitamin, mineral, or herbal) interactions | | X | X |
| | 1.7C | | Maintains awareness of problematic product names (eg, insulin products, oral diabetes medications, other injectables) and error prevention recommendations provided by Institute for Safe Medication Practices (www.ismp.org), Food and Drug Administration (www.fda.gov), and US Pharmacopeial (www.usp.org) | | X | X |
| | 1.7D | | Contributes to developing systems to problem solve and prevent errors (eg, medication, sharps disposal, bloodborne pathogens and infection control, and hyper- and hypoglycemia) in collaboration with other health care providers | | | X |
| | 1.7E | | Implements and evaluates a reporting mechanism to capture, report, and intervene in sentinel events and near misses (eg, incorrect medication administration such as inpatient insulin dosing and subsequent hypoglycemia) | | | X |
| **1.8** | | | **Compares actual performance to performance goals (ie, Gap Analysis, SWOT Analysis [strength, weaknesses, opportunities, and threats], PDCA Cycle [plan, do, check, act], DMAIC [define, measure, analyze, improve, control])** | **X** | **X** | **X** |
| | **1.8A** | | **Reports and documents action plan to address identified gaps in care and/or service performance** | **X** | **X** | **X** |

*(continued on next page)*

**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | 1.8B | Compares and evaluates individual and departmental/organizational performance with nutrition and diabetes-related care and services to goals and expected outcomes; prepares and reports action plan to address identified gaps | | | X |
| | 1.8C | Benchmarks departmental/organizational performance with national programs and standards | | | X |
| **1.9** | **Evaluates interventions and workflow process(es) and identifies service and delivery improvements** | | **X** | **X** | **X** |
| | 1.9A | Analyzes data and success of action plans in reaching patient/client and program outcome goals | | X | X |
| | 1.9B | Synthesizes results and communicates to key stakeholders | | | X |
| | 1.9C | Guides the development, testing, and redesign of program evaluation systems | | | X |
| **1.10** | **Improves or enhances patient/client/population care and/or services working with others based on measured outcomes and established goals** | | **X** | **X** | **X** |
| | 1.10A | Uses data and outcomes to implement changes in processes and/or practices or seeks assistance as needed | | X | X |
| | 1.10B | Leads in creating and evaluating systems, processes, and programs that support institutional nutrition and diabetes-related core values and evidence-based guidelines for safe, quality care | | | X |
| | 1.10C | Develops or investigates and shares systems, processes, and programs that support best practices in diabetes nutrition care and services; publishes outcomes and best practices | | | X |

**Examples of outcomes for Standard 1: Quality in Practice**

- Actions are within scope of practice and applicable laws and regulations
- National quality standards and best practices are evident in customer-centered services
- Performance improvement program specific to program(s)/service(s) is established and updated as needed; is evaluated for effectiveness in providing desired outcomes data and striving for excellence in collaboration with other team members
- Performance indicators are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)
- Aggregate outcomes results meet pre-established criteria
- Quality improvement results direct refinement and advancement of practice

**Standard 2: Competence and Accountability**

The registered dietitian nutritionist (RDN) demonstrates competence in and accepts accountability and responsibility for ensuring safe, quality practice and services.

**Rationale:**

Competence and accountability in practice includes continuous acquisition of knowledge, skills, experience, and judgment in the provision of safe, quality customer-centered service.

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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 code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics)** | | **X** | **X** | **X** |
| **2.2** | **Integrates the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) into practice, self-evaluation, and professional development** | | **X** | **X** | **X** |
| | **2.2A** | **Integrates applicable focus area SOP and SOPP into practice** (www.eatrightpro.org/sop) | **X** | **X** | **X** |
| | 2.2B | Uses the current SOP and SOPP for RDNs in Diabetes Care to assess performance at the appropriate level of practice and for developing a professional development plan, advancing skills, and practice (competent, proficient, or expert) | X | X | X |
| | 2.2C | Develops corporate/institutional policies, guidelines, human resource materials (eg, job descriptions, job-related competencies, career ladders, acceptable performance level) using the SOP and SOPP for RDNs in Diabetes Care as a guide when in a management role | | X | X |
| | 2.2D | Uses advanced practice experience and knowledge to define specific actions for levels of practice (competent, proficient, or expert) reflecting the SOP and SOPP for RDNs in Diabetes Care | | | X |
| **2.3** | **Demonstrates and documents competence in practice and delivery of customer-centered service(s)** | | **X** | **X** | **X** |
| | 2.3A | Documents examples of expanded professional responsibility reflective of a proficient practice role (eg, evaluates the delivery of customer-centered services provided and recommends changes) | | X | X |
| | 2.3B | Documents examples of expanded professional responsibility reflective of an expert practice role (eg, evaluates and develops practice and delivery models for customer-centered services) | | | X |
| **2.4** | **Assumes accountability and responsibility for actions and behaviors** | | **X** | **X** | **X** |
| | **2.4A** | **Identifies, acknowledges, and corrects errors** | **X** | **X** | **X** |
| | 2.4B | Exhibits professionalism and strives for improvement in practice (eg, manages change effectively; demonstrates assertiveness, listening, and conflict resolution skills; and demonstrates ability to build coalitions) | X | X | X |
| | 2.4C | Develops and directs diabetes nutrition-related policies and procedures that ensure staff accountability and responsibility when serving in a management role | | X | X |
| | 2.4D | Is active in promoting the specialty of nutrition and diabetes care | | X | X |
| | 2.4E | Leads by example; exemplifies professional integrity as a leader in diabetes care | | | X |

*(continued on next page)*

**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| **2.5** | **Conducts self-evaluation at regular intervals** | | | **X** | **X** | **X** |
| | **2.5A** | **Identifies needs for professional development** | | **X** | **X** | **X** |
| | 2.5B | Compares individual performance to self-directed goals and for consistency with best practices in diabetes care to identify areas for professional development | | X | X | X |
| **2.6** | **Designs and implements plans for professional development** | | | **X** | **X** | **X** |
| | **2.6A** | **Develops plan and documents professional development activities in career portfolio (eg, organizational policies and procedures, credentialing agency[ies])** | | **X** | **X** | **X** |
| | | 2.6A1 | Engages in continuing education opportunities in nutrition and diabetes management and related areas according to his/her professional development plan and career goals | X | X | X |
| | | 2.6A2 | Develops and implements plan for professional growth in proficient practice areas of diabetes care (eg, participates in scholarly review of professional articles or serves as a reviewer or editorial board associate, including but not limited to, diabetes professional articles, chapters, or books) | | X | X |
| | | 2.6A3 | Develops and implements plan for professional growth for expert practice areas (eg, leading an editorial board for scholarly review) | | | X |
| **2.7** | **Engages in evidence-based practice and uses best practices** | | | **X** | **X** | **X** |
| | 2.7A | Recognizes and uses major diabetes nutrition-related peer reviewed publications and continuing education opportunities | | X | X | X |
| | 2.7B | Integrates evidence-based practice and research evidence in delivering quality care (eg, Academy[l] and EAL[m]; ADA Standards of Medical Care in Diabetes[15]; National Standards for DSMES[36]; ADA, AADE[n], Academy Joint Position Statement[42]; and organization position papers) | | X | X | X |
| | 2.7C | Participates in research activities and publication of results to advance evidence and best practices | | | X | X |
| | 2.7D | Integrates research findings and evidence into peer-reviewed publications and recommendations for practice | | | | X |
| **2.8** | **Participates in peer review of others as applicable to role and responsibilities** | | | **X** | **X** | **X** |
| | 2.8A | Engages in peer review activities consistent with setting and patient/client population (eg, peer evaluation, peer supervision, clinical chart review, and performance evaluations) | | X | X | X |

*(continued on next page)*

**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| **2.9** | **Mentors and/or precepts others** | | **X** | **X** | **X** |
| | 2.9A | Participates in mentoring entry-level and competent level RDNs in diabetes care, and serves as a preceptor for dietetic students/interns; seeks guidance as needed | X | X | X |
| | 2.9B | Develops and directs mentoring or practicum opportunities for RDNs in diabetes practice to support achieving proficient level practice and/or specialist certification | | X | X |
| | 2.9C | Precepts and mentors RDNs and non-nutrition professionals (eg, medical students/residents, advanced practice nurses, pharmacists, or behavioral health staff) | | | X |
| **2.10** | **Pursues opportunities (education, training, credentials, or certifications) to advance practice in accordance with laws and regulations and requirements of practice setting** | | **X** | **X** | **X** |
| | 2.10A | Obtains and maintains specialty certification in diabetes (eg, CDE or BC-ADM) | | X | X |
| | 2.10B | Develops programs, tools, and resources in support of assisting RDNs to obtain specialty certification in diabetes care and education (eg, CDE or certified diabetes technology clinician) | | X | X |
| | 2.10C | Develops programs, tools, and resources in support of assisting RDNs to obtain advanced practice certification in diabetes care, education, and management (eg, BC-ADM) | | | X |

**Examples of Outcomes for Standard 2: Competence and Accountability**

- Practice reflects:
  - Code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics)
  - Scope of Practice, Standards of Practice, and Standards of Professional Performance
  - Evidence-based practice and best practices (eg, EAL, ADA Standards of Medical Care in Diabetes)
  - Commission on Dietetic Registration Essential Practice Competencies and Performance Indicators
- Practice incorporates successful strategies for interactions with individuals/groups from diverse cultures and backgrounds
- Competence is demonstrated and documented
- Services provided are safe and customer-centered
- Self-evaluations are conducted regularly to reflect commitment to lifelong learning and professional development and engagement
- Professional development needs are identified and pursued
- Directed learning is demonstrated
- Relevant opportunities (education, training, credentials, and certifications) are pursued to advance practice
- Commission on Dietetic Registration recertification requirements are met

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

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

| **Indicators for Standard 3: Provision of Services** | | | | | | |
|---|---|---|---|---|---|---|
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| *Each RDN:* | | | | **Competent** | **Proficient** | **Expert** |
| **3.1** | **Contributes to or leads in development and maintenance of programs/ services that address needs of the customer or target population(s)** | | | **X** | **X** | **X** |
| | **3.1A** | **Aligns program/service development with the mission, vision, principles, values, and service expectations and outputs of the organization/business** | | **X** | **X** | **X** |
| | | 3.1A1 | Participates in operational planning of diabetes nutrition-related programs and services | X | X | X |
| | | 3.1A2 | Participates in strategic and operational planning for the acquisition and utilization of internal and external resources for the organization; and, for collaboration with local and regional programs that support and optimize provision of diabetes services (eg, networks and volunteer organizations) | | X | X |
| | | 3.1A3 | Develops and manages DSMES and diabetes prevention programs in compliance with evidence-based guidelines and national standards (eg, ADA and AADE) | | X | X |
| | | 3.1A4 | Seeks executive and/or medical staff commitment to new services that will meet organizational goals for diabetes care | | | X |
| | **3.1B** | **Uses the needs, expectations, and desired outcomes of customers/ populations (eg, patients/clients, families, community, decision makers, administrators, and client organization[s]) in program/ service development** | | **X** | **X** | **X** |
| | | 3.1B1 | Conducts ongoing needs assessment of the diabetes environment to identify opportunities to deliver additional diabetes education, screening, and prevention services (eg, DSMES and prevention programs) | | X | X |
| | **3.1C** | **Makes decisions and recommendations that reflect stewardship of time, talent, finances, and environment** | | **X** | **X** | **X** |
| | | 3.1C1 | Advocates for staffing which supports patient/client population, census, program services/goals | | X | X |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| Indicators for Standard 3: Provision of Services | | | | | | |
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| *Each RDN:* | | | | **Competent** | **Proficient** | **Expert** |
| | **3.1D** | **Proposes programs and services that are customer-centered, culturally appropriate, and minimize disparities** | | **X** | **X** | **X** |
| | | 3.1D1 | Adapts practices to minimize or eliminate health disparities associated with culture, race, gender, socioeconomic status, age, and other factors | X | X | X |
| | 3.1E | Uses an evaluation plan for examining the program effectiveness | | X | X | X |
| **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 | Participates in or designs processes to receive or make referrals to other providers that address the needs of patient/client population (eg, pharmacist, mental/behavioral health professional, social worker, ophthalmologist, or podiatrist) | | X | X |
| | | 3.2A2 | Directs and manages referral processes and systems | | | X |
| | **3.2B** | **Refers customers to appropriate providers when requested services or identified needs exceed the RDN's individual scope of practice** | | **X** | **X** | **X** |
| | | 3.2B1 | Builds relationships with health care practitioners for collaboration and to assist with referrals when patient/client need(s) is outside RDN's scope of practice (eg, mental/behavioral health professional, exercise physiologist, podiatrist, pharmacist, ophthalmologist, or dentist) | X | X | X |
| | | 3.2B2 | Establishes and maintains networks to support the overall care of the patients/clients with diabetes | | X | X |
| | | 3.2B3 | Uses facility electronic health record and population health tools to identify patients/clients with diabetes or at risk of diabetes for referral for MNT and/or DSMES according to organization policy | | X | X |
| | | 3.2B4 | Supports referral resources with curriculum and training regarding the complex needs of patients/clients with diabetes | | | X |
| | **3.2C** | **Monitors effectiveness of referral systems and modifies as needed to achieve desirable outcomes** | | **X** | **X** | **X** |
| | | 3.2C1 | Tracks data to evaluate the effectiveness of nutrition and diabetes referral process and systems | | X | X |
| | | 3.2C2 | Audits, evaluates, and revises nutrition and diabetes referral processes for efficiency and effectiveness | | | X |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

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| **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** |
| **3.3** | **Contributes to or designs customer-centered services** | | | **X** | **X** | **X** |
| | **3.3A** | **Assesses needs, beliefs/values, goals, resources of the customer, and social determinants of health** | | **X** | **X** | **X** |
| | | 3.3A1 | Applies goal setting and behavior change strategies and techniques (eg, stages of change, TTM[o], or motivational interviewing technique) in gathering information to reflect in design of customer-centered services | X | X | X |
| | **3.3B** | **Uses knowledge of the customer's/target population's health conditions, cultural beliefs, and business objectives/services to guide design and delivery of customer-centered services** | | **X** | **X** | **X** |
| | | 3.3B1 | Adapts practice and participates in design and maintenance of program/services to meet the needs of culturally-diverse (race, ethnicity, age) populations | X | X | X |
| | | 3.3B2 | Pursues and uses resources to positively influence health-related decision making within patients'/clients' specific ethnic/cultural community | | X | X |
| | | 3.3B3 | Develops, manages, and updates processes to identify, track, and monitor use of patient/client/population resources within the specific ethnic/cultural community, and collaborates as appropriate | | | X |
| | **3.3C** | **Communicates principles of disease prevention and behavioral change appropriate to the customer or target population** | | **X** | **X** | **X** |
| | | 3.3C1 | Recognizes patient/client/population cultural beliefs regarding chronic disease such as diabetes in relationship to health | X | X | X |
| | | 3.3C2 | Advises on and uses systems or tools for communicating disease prevention and behavioral change with specific populations | | X | X |
| | | 3.3C3 | Develops systems or tools to communicate disease prevention and behavioral change with specific populations | | | X |
| | **3.3D** | **Collaborates with the customers to set priorities, establish goals, and create customer-centered action plans to achieve desirable outcomes** | | **X** | **X** | **X** |
| | | 3.3D1 | Collaborates with patients/clients/caregivers, health care providers, and other support resources to create person-centered action plans that reflect the patients'/clients' needs, wishes, desired outcomes, and program/service objectives | X | X | X |
| | **3.3E** | **Involves customers in decision making (eg designing MNT and DSMES program/services, and networking)** | | **X** | **X** | **X** |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

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| *Each RDN:* | | | | **Competent** | **Proficient** | **Expert** |
| **3.4** | **Executes programs/services in an organized, collaborative, cost effective, and customer-centered manner** | | | **X** | **X** | **X** |
| | **3.4A** | **Collaborates and coordinates with peers, colleagues, stakeholders, and within interprofessional teams** | | **X** | **X** | **X** |
| | | 3.4A1 | Collaborates, as part of an interprofessional team, with organization and community programming, resources, services, and referrals as needed | X | X | X |
| | | 3.4A2 | Facilitates and fosters active communication, learning partnerships, and collaboration within an interprofessional diabetes team and with other providers as needed | | X | X |
| | | 3.4A3 | Serves in consultant role for medical nutrition management of diabetes and comorbidities | | X | X |
| | | 3.4A4 | Directs efforts to improve collaboration between patients/clients and other health care providers | | | X |
| | **3.4B** | **Uses and participates in, or leads in the selection, design, execution, and evaluation of customer programs and services (eg, nutrition screening system, medical and retail foodservice, electronic health records, interprofessional programs, community education, and grant management)** | | **X** | **X** | **X** |
| | | 3.4B1 | Incorporates standards for nutrition and diabetes nutrition care based on evidence-based guidelines and recommendations in design of programs and services; seeks assistance as needed | X | X | X |
| | | 3.4B2 | Identifies and uses population-specific nutrition and diabetes screening tools | X | X | X |
| | | 3.4B3 | Implements and manages diabetes nutrition and diabetes education and community prevention programs consistent with national standards for DSMES (ie, ADA Education Recognition Program and/or AADE Diabetes Education Accreditation Program), and diabetes prevention programs (eg, CDC DPP[P]) in compliance with CMS and state Medicaid regulations | | X | X |
| | | 3.4B4 | Guides the development, implementation, and evaluation of diabetes care, programs, screening initiatives, and services (eg, MNT, DSMES, CDC DPP) inclusive of those at risk of diabetes, suboptimal and optimal control using electronic health record/population health tools | | | X |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

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| *Each RDN:* | | | | **Competent** | **Proficient** | **Expert** |
| | **3.4C** | **Uses and develops or contributes to selection, design and maintenance of policies, procedures (eg, discharge planning/ transitions of care), protocols, standards of care, technology resources (eg, HIPAA-compliant telehealth platforms), and training materials that reflect evidence-based practice (eg, EAL, ADA, and AADE) in accordance with applicable laws and regulations** | | **X** | **X** | **X** |
| | | 3.4C1 | Participates in the development and updating of policies, procedures, and evidence-based practice tools for diabetes nutrition-related services for populations served by practice setting(s) (eg, pediatric and/or adult type 1 diabetes and type 2 diabetes, prediabetes, and gestational diabetes) | X | X | X |
| | | 3.4C2 | Develops and/or maintains diabetes nutrition programs, protocols, and policies based on research and evidence-based guidelines, best practices, trends, and national and international guidelines for practice setting | | X | X |
| | | 3.4C3 | Leads interprofessional process of monitoring, evaluating, revising, and implementing protocols, guidelines, and diabetes practice tools/process as needed | | | X |
| | | 3.4C4 | Leads the development of policies for data analysis according to program or organization diabetes practice needs | | | X |
| | **3.4D** | **Uses and participates in or develops processes for order writing and other nutrition-related privileges, in collaboration with the medical staff[q] or medical director (eg, post-acute care settings, dialysis center, public health, community, and free-standing clinic settings), consistent with state practice acts, federal and state regulations, organization policies, and medical staff rules, regulations, and bylaws** | | **X** | **X** | **X** |
| | | **3.4D1** | **Uses and participates in or leads development of processes for privileges or other facility-specific processes related to (but not limited to) implementing physician/non-physician practitioner[r]-driven delegated orders or protocols, initiating or modifying orders for therapeutic diets, medical foods/nutrition supplements, dietary supplements, enteral and parenteral nutrition, laboratory tests, medications, and adjustments to fluid therapies or electrolyte replacements** | **X** | **X** | **X** |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

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| *Each RDN:* | | | | | **Competent** | **Proficient** | **Expert** |
| | | | 3.4D1i | Contributes to the development of privilege options for RDNs with CDE and/or BC-ADM advanced practice credentials (eg, training and management of patients/clients using CSII[s] and CGM; adjusting medication order per provider or organization-approved protocol based on evaluation of SMBG[t], CSII, and/or CGM data reports) | | X | X |
| | | | 3.4D1ii | Participates and/or leads in the development of provider or organization-approved pharmacotherapy protocols (eg, to initiate/titrate medications for management of diabetes, basic cardiovascular disease preventive medical regimen, and associated lab orders) | | | X |
| | | | 3.4D1iii | Negotiates and/or establishes nutrition privileges at a systems level for new advances in practice | | | X |
| | | **3.4D2** | **Uses and participates in or leads development of processes for privileging for provision of nutrition-related services, including (but not limited to) initiating and performing bedside swallow screenings, inserting and monitoring nasoenteric feeding tubes, providing home enteral nutrition or infusion management services (eg, ordering formula and supplies), and indirect calorimetry measurements** | | **X** | **X** | **X** |
| | | | 3.4D2i | Recommends adjustments to diabetes nutrition plan consistent with medication plans, and/or referral to diabetes team or credentialed diabetes practitioner based on nutrition assessment, SMBG data reports, medical data, and/or patient/client/caregiver information/ request; seeks assistance as needed | X | X | X |
| | | | 3.4D2ii | Ensures adjustments to CSII and CGM device settings are based on nutrition assessment, medical data, device data reports, and/or patient/client/caregiver information and according to provider or organization-approved protocols | | X | X |
| | | | 3.4D2iii | Collaborates in the development of physician-driven protocols for managing individuals using CGM and/or CSII devices for use by credentialed practitioners with diabetes management privileges | | | X |

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| *Each RDN:* | | | | **Competent** | **Proficient** | **Expert** |
| | **3.4E** | | **Complies with established billing regulations, organization policies, grant funder guidelines, if applicable to role and setting, and adheres to ethical and transparent financial management and billing practices** | **X** | **X** | **X** |
| | | 3.4E1 | Develops tools to monitor ethical billing practice and adherence to billing regulations | | X | X |
| | **3.4F** | | **Communicates with interprofessional team and referring party consistent with HIPAA rules for use and disclosure of customer's personal health information** | **X** | **X** | **X** |
| | | 3.4F1 | Develops process and tools to monitor adherence to HIPAA rules and/or address breaches in personal health information protection and use of electronic medical record | | X | X |
| **3.5** | **Uses professional, technical, and support personnel appropriately in delivery of customer-centered care or services in accordance with laws, regulations, and organization policies and procedures** | | | **X** | **X** | **X** |
| | **3.5A** | | **Assigns activities, including direct care to patients/clients, consistent with qualifications, experience, and competence of professional, technical, and support personnel** | **X** | **X** | **X** |
| | | 3.5A1 | Assesses and determines capabilities/expertise of support staff in working with patients/clients with diabetes to determine tasks that may be delegated | | X | X |
| | **3.5B** | | **Supervises professional, technical, and support personnel** | **X** | **X** | **X** |
| | | 3.5B1 | Trains professional, technical, and support personnel and evaluates their competence | | X | X |
| **3.6** | **Designs and implements food delivery systems to meet the needs of customers** | | | **X** | **X** | **X** |
| | **3.6A** | | **Collaborates in or leads design of food delivery systems to address health care needs and outcomes (including nutrition status), ecological sustainability, and to meet the culture and related needs and preferences of target populations (ie, health care patients/clients, employee groups, visitors to retail venues, schools, child and adult day care centers, community feeding sites, farm to institution initiatives, and local food banks)** | **X** | **X** | **X** |
| | | 3.6A1 | Collects data and provides feedback on current food delivery systems serving individuals with diabetes in health care and community settings (eg, inpatient and ambulatory care settings, long-term care settings, senior meal sites, and home delivery) | X | X | X |

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| *Each RDN:* | | | | **Competent** | **Proficient** | **Expert** |
| | | 3.6A2 | Evaluates foodservice planning and delivery for individuals with diabetes to identify areas for improvement applicable to setting and role | | X | X |
| | | 3.6A3 | Consults on design, evaluation, and/or revision of food delivery systems and nutrition-related services (eg, for nonselect, selective, and/or room service menu systems) in health care and community settings | | | X |
| | **3.6B** | **Participates in, consults/collaborates with, or leads the development of menus to address health, nutritional, and cultural needs of target population(s) consistent with federal, state, or funding source regulations or guidelines** | | **X** | **X** | **X** |
| | | 3.6B1 | Participates in development or provides consultation on menu system to meet needs of individuals with diabetes across the lifespan | | X | X |
| | | 3.6B2 | Develops nutrition and diabetes-related guidelines reflecting national standards (eg, ADA Standards of Medical Care in Diabetes, EAL,) and applicable federal or state regulations (eg, menu-related regulations and food assistance programs) to guide foodservice program according population served by the setting | | | X |
| | **3.6C** | **Participates in, consults/collaborates with, or leads interprofessional process for determining medical foods/nutritional supplements, dietary supplements, enteral and parenteral nutrition formularies, and delivery systems for target population(s)** | | **X** | **X** | **X** |
| | | 3.6C1 | Provides guidance regarding medical food/nutritional supplements, enteral and parenteral nutrition, in accordance with best practice for diabetes care (eg, ADA Standards for Medical Care in Diabetes and ASPEN[u]) | | X | X |
| | | 3.6C2 | Designs or consults on organizational protocols to provide guidance for nutrition support best practices for individuals with diabetes | | | X |
| **3.7** | **Maintains records of services provided** | | | **X** | **X** | **X** |
| | **3.7A** | **Documents according to organization policies, procedures, standards, and systems, including electronic health records** | | **X** | **X** | **X** |
| | | 3.7A1 | Uses and/or participates in design/revision of electronic health records | | X | X |
| | **3.7B** | **Implements data management systems to support interoperable data collection, maintenance, and utilization** | | **X** | **X** | **X** |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

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| **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** |
| | | 3.7B1 | Contributes to design of electronic health record system to capture data needed to document care and monitor outcomes for patients/clients with diabetes | | X | X |
| | | 3.7B2 | Seeks opportunities to contribute expertise to national bioinformatics/medical informatics projects as applicable/ requested | | | X |
| | **3.7C** | **Uses data to document outcomes of services (ie, staff productivity, cost/benefit, budget compliance, outcomes, quality of services), and provide justification for maintenance or expansion of services** | | **X** | **X** | **X** |
| | | 3.7C1 | Analyzes and uses data to communicate value of nutrition services in relation to patient/client and organization outcomes/goals | | X | X |
| | **3.7D** | **Uses data to demonstrate program/service achievements and compliance with accreditation standards, laws, and regulations** | | **X** | **X** | **X** |
| | | 3.7D1 | Prepares and presents reports for organization and accrediting bodies, if applicable (eg, ADA Education Recognition Program or AADE Diabetes Education Accreditation Program) | | 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 benefit/cost of quality food and nutrition services** | | **X** | **X** | **X** |
| | | 3.8A1 | Advocates with state and federal legislative representatives regarding benefit of MNT/diabetes management and prevention services on health care costs (eg, responds to Academy Action Alerts and other calls to action) | X | X | X |
| | | 3.8A2 | Initiates and coordinates advocacy activities/issues (eg, article development, presentations, and networking events) | | X | X |
| | | 3.8A3 | Interacts and serves as a resource with legislators, payers, and policy makers to contribute and influence diabetes care and services (eg, providing testimony at legislative and regulatory hearings and meetings) | | X | X |
| | | 3.8A4 | Develops and revises policy and statutes and contributes to development/review/comments on administrative rules and regulations | | | X |
| | **3.8B** | **Advocates in support of food and nutrition programs and services for populations with special needs and chronic conditions** | | **X** | **X** | **X** |
| | | 3.8B1 | Participates in patient/client diabetes advocacy activities (eg, community diabetes screenings, local ADA and JDRF[v] events, NDEP[w]) | X | X | X |

*(continued on next page)*

**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | | 3.8B2 | Assesses patient/client population for situations where diabetes advocacy is needed and participates in efforts to address issue(s) (eg, local, state, and national diabetes coalitions or collaborations) | | X | X |
| | **3.8C** | **Advocates for protection of the public through multiple avenues of engagement (eg, legislative action, establishing effective relationships with elected leaders and regulatory officials, participation in various Academy committees, workgroups, and task forces, Dietetic Practice Groups, Member Interest Groups, and State Affiliates)** | | **X** | **X** | **X** |

**Examples of Outcomes for Standard 3: Provision of Services**

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

**Standard 4: Application of Research**

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

**Rationale:**

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

| 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** | **Reviews best available research/evidence and information for application to practice** | **X** | **X** | **X** |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | **4.1A** | **Understands basic research design and methodology** | **X** | **X** | **X** |
| | 4.1B | Reads primary peer-reviewed publications for diabetes self-management care and support; uses evidenced-based practice guidelines and algorithms and related resources (eg, EAL, ADA Standards of Medical Care in Diabetes) to guide clinical practice | X | X | X |
| | 4.1C | Mentors RDNs and other health care professionals to develop skills in accessing and critically analyzing research for application to practice | | X | X |
| | 4.1D | Identifies and addresses diabetes management-related questions and uses a systematic approach for applying research and evidence-based guidelines (eg, EAL); guides others in making informed decisions for diabetes care | | | X |
| | 4.1E | Functions as a primary or senior author of research, academic and/or organization position and practice papers, or other scholarly work | | | X |
| **4.2** | **Uses best available research/evidence and information as the foundation for evidence-based practice** | | **X** | **X** | **X** |
| | 4.2A | Applies evidence-based practice guidelines (eg, EAL, AHA[x], AACE[y], and ADA) to provide consistent, safe, effective quality care for individuals with diabetes; consults with more experienced practitioner for guidance as needed | | X | X |
| | 4.2B | Critically evaluates and applies available scientific literature in situations where evidence-based practice guidelines for diabetes are not established (eg, complex disease processes) | | | X |
| | 4.2C | Uses advanced training, available research, and emerging theories to manage complex cases (eg, uncontrolled type 1 diabetes and type 2 diabetes, multiple comorbidities, and complications) in target populations | | | X |
| **4.3** | **Integrates best available research/evidence and information with best practices, clinical and managerial expertise, and customer values** | | **X** | **X** | **X** |
| | 4.3A | Manages the integration of evidence-based guidelines into policies, procedures, and protocols for diabetes self-management education and MNT practice | | X | X |
| **4.4** | **Contributes to the development of new knowledge and research in nutrition and dietetics** | | **X** | **X** | **X** |
| | 4.4A | Participates in efforts to extend research to practice through journal clubs, professional supervision, and the Academy's DPBRN[z] | X | X | X |
| | 4.4B | Participates in practice-based research networks (ie, Academy's DPBRN or EAL workgroup) and the development and/or implementation of practice-based research | | X | X |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | 4.4C | Identifies and initiates research relevant to diabetes practice; acts as principal or co-investigator as part of collaborative research or with health care teams examining nutrition and diabetes care | | | X |
| | 4.4D | Serves as advisor, preceptor, and/or committee member for graduate level research | | | X |
| **4.5** | **Promotes application of research in practice through alliances or collaboration with food and nutrition and other professionals and organizations** | | **X** | **X** | **X** |
| | 4.5A | Identifies research questions and facilitates or participates in studies related to diabetes care | X | X | X |
| | 4.5B | Collaborates with interprofessional and/or interorganizational teams to perform and disseminate nutrition and diabetes research | | X | X |
| | 4.5C | Leads interprofessional and/or interorganizational research activities and integration of research data into publications and presentations related to diabetes care | | | X |

**Examples of Outcomes for Standard 4: Application of Research**

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

**Standard 5: Communication and Application of Knowledge**

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

**Rationale:**

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

| Indicators for Standard 5: Communication and Application of Knowledge | | | | | | |
|---|---|---|---|---|---|---|
| **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 and applies current knowledge and information based on evidence** | | | **X** | **X** | **X** |
| | **5.1A** | **Demonstrates critical thinking and problem-solving skills when communicating with others** | | **X** | **X** | **X** |
| | | 5.1A1 | Demonstrates ability to review and apply evidence-based guidelines when communicating and disseminating information | | X | X |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | | 5.1A2 | Demonstrates ability to convey complex concepts to other health care practitioners, patients/clients, and the public when communicating and disseminating information | | | X |
| | 5.1B | | Identifies and reviews relevant diabetes-related nutrition and education publications, resources, and public health trends (eg, prevalence, prevention, and treatment) and applies to practice | X | X | X |
| | 5.1C | | Evaluates and translates public health trends, epidemiologic reports, regulatory, accreditation, reimbursement programs, and standards specific to diabetes prevention, care, and education (eg, CMS, The Joint Commission, NCQA, and ADA) and applies to practice | | X | X |
| | 5.1D | | Consults as an expert on complex diabetes service issues with other health care professionals, organizations, and community | | | X |
| **5.2** | **Selects appropriate information and most effective communication method or format that considers customer-centered care and needs of the individual/group/population** | | | **X** | **X** | **X** |
| | **5.2A** | | **Uses communication methods (ie, oral, print, one-on-one, group, visual, electronic, and social media) targeted to various audiences** | **X** | **X** | **X** |
| | **5.2B** | | **Uses information technology to communicate, disseminate, manage knowledge, and support decision making** | **X** | **X** | **X** |
| | | 5.2B1 | Identifies and uses web-based/electronic diabetes tools/ resources (eg, lifestyle apps) and electronic health records within the worksite as appropriate | X | X | X |
| | | 5.2B2 | Develops and updates web-based/electronic diabetes nutrition tools/resources (eg, lifestyle apps) | | X | X |
| | | 5.2B3 | Leads technology/informatics advancement in diabetes management | | | X |
| | | 5.2B4 | Contributes diabetes and nutrition-related expertise to national informatics projects (eg, national databases) | | | X |
| | 5.2C | | Participates in, uses, and/or leads electronic professional networking groups to stay current in diabetes nutrition practice (eg, Academy's Diabetes Care and Education Dietetic Practice Group listserv or My AADE Network) | X | X | X |
| **5.3** | **Integrates knowledge of food and nutrition with knowledge of health, culture, social sciences, communication, informatics, sustainability, and management** | | | **X** | **X** | **X** |
| | 5.3A | | Integrates current and emerging scientific knowledge of diabetes care and nutrition when considering an individual's health status, behavior barriers, communication skills; seeks collaborative guidance as needed | | X | X |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | 5.3B | | Leads the integration of scientific knowledge and experience in diabetes management into practice for complex problems or in new research methodologies | | | X |
| **5.4** | **Shares current, evidence-based knowledge, and information with various audiences** | | | **X** | **X** | **X** |
| | **5.4A** | | **Guides customers, families, students, and interns in the application of knowledge and skills** | **X** | **X** | **X** |
| | | 5.4A1 | Contributes to educational and professional development of RDNs, students, and health care professionals in other fields, through formal and informal teaching activities, preceptorship, and mentorship | | X | X |
| | | 5.4A2 | Builds and maintains collaboration between researchers, faculty, and/or decision makers to facilitate effective knowledge transfer for health professionals' education programs (eg, fellowships) | | | X |
| | **5.4B** | | **Assists individuals and groups to identify and secure appropriate and available educational and other resources and services** | **X** | **X** | **X** |
| | | 5.4B1 | Recommends current, evidence-based diabetes management educational resources (eg, Academy, US Department of Agriculture Choose My Plate at www.choosemyplate.gov, NHLBI[aa], Diabetes Care and Education Dietetic Practice Group website at www.DCE.org) | X | X | X |
| | | 5.4B2 | Provides programs/services that deliver cost-effective care and education with improved metabolic outcomes (eg, diabetes prevention, reduction of diabetes complications, and improved quality of life) | X | X | X |
| | | 5.4B3 | Establishes systematic process and provides guidance to consumers regarding participation in diabetes-related clinical research studies | | X | X |
| | | 5.4B4 | Directs and manages systematic processes to identify, track, and monitor use of patient/client resources | | | X |
| | **5.4C** | | **Uses professional writing and verbal skills in all types of communications** | **X** | **X** | **X** |
| | | 5.4C1 | Sharpens written and oral communication skills to address communication needs of various audiences | X | X | X |
| | **5.4D** | | **Reflects knowledge of population characteristics in communication methods** | **X** | **X** | **X** |

*(continued on next page)*

**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | | 5.4D1 | Reflects knowledge of population characteristics in communication methods used with patient/client population (eg, literacy and numeracy levels, need for translation of written materials and/or a translator, and communication skills) | X | X | X |
| **5.5** | **Establishes credibility and contributes as a food and nutrition resource within the interprofessional health care and management teams, organization, and community** | | | **X** | **X** | **X** |
| | 5.5A | | Communicates with providers and other allied health care professionals (eg, nurses, pharmacists, diabetes educators, physical therapists, social workers, and psychologists) to promote the use of evidence-based guidelines and the EAL to integrate food and nutrition with diabetes care and management | X | X | X |
| | 5.5B | | Participates in interprofessional collaborations at a systems level promoting the use of evidence-based guidelines integrating food and nutrition and RDNs in diabetes care and management to state, regional, and national professional organizations | | X | X |
| | 5.5C | | Leads interprofessional collaborations at an organization or systems level | | | X |
| **5.6** | **Communicates performance improvement and research results through publications and presentations** | | | **X** | **X** | **X** |
| | 5.6A | | Presents information on evidence-based diabetes guidelines and research at the local level (eg, community groups and colleagues) | X | X | X |
| | | 5.6A1 | Presents evidence-based diabetes management research and information at professional meetings and conferences (eg, local, regional, national, and international) | | X | X |
| | 5.6B | | Serves in leadership role for local and national organizations, publications (ie, editor or editorial advisory board) and program planning committees | | X | X |
| | 5.6C | | Directs collation of research data into publications (eg, systematic reviews and position papers) and presentations | | | X |
| | 5.6D | | Communicates information about evolving roles of advanced level practitioner (eg, initiating/titrating medications based on provider-approved protocols) | | | X |
| **5.7** | **Seeks opportunities to participate in and assume leadership roles with local, state, and national professional and community-based organizations (eg, government-appointed advisory boards, community coalitions, schools, foundations, or nonprofit organizations serving the food insecure) providing food and nutrition expertise** | | | **X** | **X** | **X** |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| | 5.7A | Functions as diabetes nutrition resource as an active member of local/state organizations, coalitions and industry task forces, committees, or advisory boards | X | X | X |
| | 5.7B | Serves as subject matter expert on regional and national diabetes organizations/coalitions/task forces/advisory boards for health professionals and industry | | X | X |
| | 5.7C | Proactively seeks opportunities to integrate diabetes practices and programs at local, regional, national, and international level | | X | X |
| | 5.7D | Pursues leadership development opportunities to be identified as a recognized expert in diabetes care | | X | X |
| | 5.7E | Leads development, testing, implementation, review, and revision of innovative approaches to complex diabetes practice issues | | | X |
| | 5.7F | Proactively seeks opportunities for leadership positions to be identified as an expert on diabetes nutrition-related issues and educational needs of consumers and health care professionals (eg, consultant to business, industry, national diabetes organizations, and/or media spokesperson) | | | X |

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

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

**Standard 6: Utilization and Management of Resources**

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

**Rationale:**

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

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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 outcomes** | | **X** | **X** | **X** |
| | 6.1A | Recognizes and uses existing resources (eg, educational/training tools and materials and staff time) as needed in the provision of diabetes nutrition services | X | X | X |
| | 6.1B | Manages effective delivery of diabetes nutrition programs and services (eg, business and marketing plan, staffing, budget and billing processes, program administration, education programs, materials development, and supplies) | | X | X |
| | 6.1C | Evaluates and monitors current diabetes practices at the systems level considering business best practices, expected revenue, and formulates revisions based on data | | | X |
| | 6.1D | Directs or manages design and delivery of diabetes nutrition services in various settings | | | X |
| **6.2** | **Evaluates management of resources with the use of standardized performance measures and benchmarking as applicable** | | **X** | **X** | **X** |
| | **6.2A** | **Uses the Standards of Excellence Metric Tool to self-assess quality in leadership, organization, practice, and outcomes for an organization** (www.eatrightpro.org/excellencetool) | **X** | **X** | **X** |
| | 6.2B | Leads and participates in data collection regarding the population served, services provided, and outcomes (eg, demographic characteristics, staffing benchmarking, and reimbursement/revenue) | | X | X |
| | 6.2C | Evaluates the provision of diabetes care, including staff to patient/client ratio, reimbursement/revenue data, and customer satisfaction survey results | | | X |
| **6.3** | **Evaluates safety, effectiveness, efficiency, productivity, sustainability practices, and value while planning and delivering services and products** | | **X** | **X** | **X** |
| | 6.3A | Demonstrates understanding of and complies with The Joint Commission standards (www.jointcommission.org), the National Standards for DSMES and the ADA Standards of Medical Care in Diabetes, and those of other accreditation bodies | X | X | X |
| | 6.3B | Participates in evaluation, selection, and implementation (when applicable) of new products, equipment, and services to ensure safe, optimal, and cost-effective delivery of diabetes nutrition care and services | X | X | X |
| | 6.3C | Manages evaluation of products, equipment, and services (eg, blood glucose meters and medical food/nutrition supplements) | | X | X |
| | 6.3D | Evaluates at the systems level, safety, effectiveness, and budget; and planning and delivery of DSMES and nutrition care, services, and products | | | X |

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

| 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** |
| **6.4** | **Participates in QAPI[bb] and documents outcomes and best practices relative to resource management** | | **X** | **X** | **X** |
| | 6.4A | Participates actively in QAPI, including collecting, documenting, and analyzing relevant data to ensure continued assessment of resource use (eg, personnel, services, fiscal, materials, and supplies) | X | X | X |
| | 6.4B | Recognizes best practices in similar diabetes settings and collaborates with interprofessional team for application | X | X | X |
| | 6.4C | Proactively and systematically recognizes needs; anticipates outcomes and consequences of various approaches; and modifies resource management and/or delivery of services for improvement in achieving desired outcomes | | X | X |
| **6.5** | **Measures and tracks trends regarding internal and external customer outcomes (eg, satisfaction and key performance indicators)** | | **X** | **X** | **X** |
| | 6.5A | Gathers and assesses data regarding patient/client satisfaction related to diabetes care, education, and related services; seeks assistance as need | X | X | X |
| | 6.5B | Analyzes data related to program services and customer satisfaction; communicates results and recommendations for change(s) | | X | X |
| | 6.5C | Implements, monitors, and evaluates changes based on data collection and analysis | | | X |

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

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

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

[b]CDE=Certified Diabetes Educator (www.ncbde.org).

[c]BC-ADM=Board Certified-Advanced Diabetes Management (www.diabeteseducator.org).

[d]CGM=continuous glucose monitoring.

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

[f]CMS=Centers for Medicare and Medicaid Services (www.cms.gov).

[g]NCQA=National Committee for Quality Assurance.

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**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.

[h]HEDIS=Healthcare Effectiveness Data and Information Set.

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

[j]MNT=medical nutrition therapy (www.eatrightpro.org/scope > Definition of terms).

[k]DSMES=diabetes self-management education and support (https://professional.diabetes.org/content-page/standards-medical-care-diabetes).

[l]Academy=Academy of Nutrition and Dietetics (www.eatrightpro.org).

[m]EAL=Academy of Nutrition and Dietetics Evidence Analysis Library (www.andeal.org).

[n]AADE=American Association of Diabetes Educators (www.diabeteseducator.org).

[o]TTM=transtheoretical model (www.prochange.com/transtheoretical-model-of-behavior-change).

[p]CDC DPP=Centers for Disease Control and Prevention-Diabetes Prevention Program (www.cdc.gov/diabetes/prevention/index.html).

[q]**Medical staff:** *Medical staff* is composed of doctors of medicine or osteopathy and, may in accordance with state law, including scope of practice laws, include other categories of physicians, and nonphysician practitioners who are determined to be eligible for appointment by the governing body.[6]

[r]**Non-physician practitioner:** A *non-physician practitioner* may include a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, registered dietitian, or nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[6,7] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services Long-Term Care Regulations. With publication of the Final Rule revising the Conditions of Participation for Long-Term Care facilities effective November 2016, postacute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutrition supplements, or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law, and organization policies.[9,10]

[s]CSII=continuous sustained insulin infusion (ie, insulin pump).

[t]SMBG=self-monitoring blood glucose.

[u]ASPEN=American Society for Parenteral and Enteral Nutrition (www.nutritioncare.org).

[v]JDRF=Juvenile Diabetes Research Foundation (www.jrdf.org).

[w]NDEP=National Diabetes Education Program (www.cdc.gov/diabetes/ndep/index.html).

[x]AHA=American Heart Association (www.heart.org).

[y]AACE=American Association of Clinical Endocrinologist (www.aace.org).

[z]DPBRN=Dietetics Practice-Based Research Network (www.eatrightpro.org/resources/research/projects-tools-and-initiatives/dpbrn).

[aa]NHLBI=National Heart, Lung, and Blood Institute (www.nhlbi.nih.gov).

[bb]QAPI=quality assurance and performance improvement.

**Figure 2.** *(continued)* Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) in Diabetes Care. *Customer* is used in this evaluation resource as a universal term. *Customer* could also mean client/patient, client/patient/customer, family, participant, consumer, or any individual, group, or organization to which an RDN provides service.