ARIZONA ACADEMY
OF NUTRITION & DIETETICS

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October 31, 2019

Russell Bowers, Speaker
Arizona House of Representatives
1700 W. Washington, H223
Phoenix, AZ 85007

Dear Speaker Bowers,

It is our honor and privilege to submit this Sunrise Application, "To Provide Licensure for Registered Dietitians/Registered Dietitian Nutritionists," from the Arizona Academy of Nutrition and Dietetics.

We look forward to working with you and Senator Pace on this important legislation.

Sincerely,

Michelle Berman, MS, RDN, CDE, FAND
Advocacy Director, Arizona Academy of Nutrition and Dietetics

Catherine Trier, PhD., RDN
President, Arizona Academy of Nutrition and Dietetics

SUNRISE APPLICATION
November 1, 2019

To Provide Licensure for Registered Dietitians/Registered Dietitian Nutritionists

Arizona Academy of Nutrition and Dietetics (AzAND)

I. A DEFINITION OF THE PROBLEM AND WHY REGULATION IS NECESSARY INCLUDING THE NATURE OF THE POTENTIAL HARM TO THE PUBLIC IF THE HEALTH PROFESSION IS NOT REGULATED AND THE EXTENT TO WHICH CONSUMERS NEED AND WILL BENEFIT FROM REGULATION THAT PROTECTS AND PROMOTES PUBLIC HEALTH AND SAFETY

The Arizona Academy of Nutrition and Dietetics (AzAND) respectfully submits this sunrise application, seeking permission and direction, pursuant to A.R.S. §32-3105, to safeguard public health, safety, and welfare by providing for the licensure of persons engaged in the practice of dietetics or nutrition, the provision of Medical Nutrition Therapy, and the ordering of therapeutic diets[1] under a grant of authority and subject to regulation.

A. Nature of Request for Professional Regulation and Potential Harm Without It

The need for qualified nutrition and dietetics providers has never been more critical. Half of all U.S. adults – about 117 million people – have a preventable, diet-related chronic disease; two-thirds of Americans have obesity or are overweight. Medical Nutrition Therapy (MNT) provided by qualified Registered Dietitian Nutritionists (RDNs) is a widely recognized component of medical guidelines for the prevention and treatment of many chronic diseases, as well as in the reduction of risk factors for these conditions. As primary prevention, strong evidence supports optimal nutritional status as a cost-effective cornerstone in the maintenance of health, well-being, and functionality. As secondary and tertiary prevention, MNT is a cost-effective disease management strategy that reduces chronic disease risk, delays disease progression, enhances the efficacy of medical/surgical treatment, reduces medication use, and improves patient outcomes including quality of life.[2]

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[1] The Academy of Nutrition and Dietetics (the "Academy")--of which the Arizona Academy of Nutrition and Dietetics is an affiliate—defines therapeutic diets similarly to the Centers for Medicare and Medicaid Services: "A therapeutic diet is a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or clinical conditions to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet."

[2] Grade 1 data. Academy Evidence Analysis Library, http://andevidencelibrary.com/mnt. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about

Among the conditions that MNT can manage includes malnutrition, which among both adults and children remains a critical public health issue with exceedingly high impacts on health care costs. Malnutrition is unfortunately a common issue across all care settings. In the acute care hospital setting, it is estimated that approximately 20 to 50 percent of admitted patients are malnourished or at-risk of malnutrition.[3 4 5 6 7] According to the National Resource Center on Nutrition and Aging, nearly 35-50 percent of older residents in long term care facilities are malnourished. Studies show that malnutrition, as a contributing factor to post-hospital syndrome, can increase a patient's risk for a 30-day readmission, often for reasons other than the original diagnosis.[8] For example, 45% of patients who fall in the hospital have malnutrition; costs for falls overall to Medicare totaled $31 billion in 2015.[9 10]

According to a recent review, "Many studies have compared school-age children who had suffered from an episode of severe acute malnutrition in the first few years of life to matched controls or siblings who had not. These studies generally showed that those

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generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."

[3] Barker LA, Gout BS, Crowe TC. Hospital malnutrition: Prevalence, identification and impact on patients and the healthcare system. Int J Environ Res Public Health. 2011; 8(2):514-527.

[4] Bistrian BR, Blackburn GL, Hallowell E, Heddle R. Protein status of general surgical patients. JAMA. 1974;230(6):858-860.

[5] Christensen KS, Gstundtner KM. Hospital-wide screening improves basis for nutrition intervention. J Am Diet Assoc.1985;85(6):704-706.

[6] Lim SL, Ong KC, Chan YH, et al. Malnutrition and its impact on cost of hospitalization, length of stay, readmission and 3-year mortality. Clin Nutr. 2012;31(3)345-350.

[7] Somanchi M, Tao X, Mullin GE. The facilitated early enteral and dietary management effectiveness trial in hospitalized patients with malnutrition. JPEN J Parenter Enteral Nutr. 2011;35(2):209-216.

[8] Krumholz HM. Post-hospital syndrome – An acquired, transient condition of generalized risk. N Engl J Med. 2013; 368(2):100-102.

[9] Bauer JD, et al. Nutritional status of patients who have fallen in an acute care setting. J Hum Nutr Diet. 2007;20:558-564.

[10] Burns EB, Stevens JA, Lee RL. The direct costs of fatal and non-fatal falls among older adults—United States. J Safety Res 2016:58.

who had suffered from early malnutrition had poorer IQ levels, cognitive function, and school achievement, as well as greater behavioral problems. A recent study in Barbados showed that adults who had suffered from an episode of moderate to severe malnutrition in the first year of life showed more attention problems and lower social status and standard of living than matched controls, even after 37–43 years."[11]

As of 2019, Arizona remains one of three states that has yet to enact legislation regulating either the practice of dietetics for Registered Dietitians ("RDs") or Registered Dietitian Nutritionists ("RDNs") or the use of associated titles.[12] The RD/RDN credential[13] (hereinafter, RDN) is a legally protected title that can only be used by practitioners who are credentialed as such by the Commission on Dietetic Registration (CDR), the credentialing agency of the Academy of Nutrition and Dietetics. However, for RDNs in Arizona, national registration without state regulation is (1) insufficient to protect the health and safety of Arizonans seeking complex nutrition care to treat chronic diseases and medical conditions and (2) insufficient to ensure that RDNs are able to practice at the height of their scope of practice to provide highly cost-effective and clinically-effective nutrition care services or ordering therapeutic diets pursuant to AZ Rev Stat § 36-416 (2017). Licensure will be limited to individuals who have obtained the required education, practice experience, and competencies (*see* Sections IV(C)(5); VI; and VI, *infra*); the ability to order therapeutic diets will be restricted to those deemed qualified by both the Centers for Medicare and Medicaid Services (CMS) and

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[11] Elizabeth L Prado, Kathryn G Dewey, Nutrition and brain development in early life, Nutrition Reviews, Volume 72, Issue 4, 1 April 2014, Pages 267–284, https://doi.org/10.1111/nure.12102 (internal citations omitted).

[12] New Jersey and Michigan are the other two states that presently do not regulate the title or practice of dietitian nutritionists, although the New Jersey Assembly passed a mandatory licensure bill (NJ A1582) in June 2019 that crossed over to the state senate for an imminent vote, and we anticipate the introduction of similar, soon-to-be-finalized legislation in Michigan in the coming year.

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

the state of Arizona working in licensed health care institutions consistent with statute and rules adopted by the proposed Arizona Board of Dietetics and Nutrition.

"RDNs integrate research, professional development, and practice to stimulate innovation and discovery; collaborate to solve the greatest food and nutrition challenges now and in the future; focus on systems-wide impact across the food, wellness, and health sectors; have a global impact in eliminating all forms of malnutrition; and amplify the contribution of nutrition and dietetics practitioners and expand workforce capacity and capability."[14] This recommended proposal for licensure would allow a licensed RDN to:

1. Order therapeutic diets;
2. Order specific laboratory tests to monitor nutritional interventions and then modify those interventions in accordance with facility policies and protocols; and
3. Provide Medical Nutrition Therapy and other nutrition care services at the height of RDNs' professional scope of practice.

As the vast majority of other states have already determined, there is a substantial risk of significant harm to the public if the practice of dietetics and nutrition is not regulated and the lack of regulation poses a threat to public health and safety.[15] RDNs are the

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[14] Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. J Acad Nutr Diet. 2018;118(1):141-165.

[15] *See, e.g.,* New Mexico (N.M. Stat. § 61-7A-2: "The legislature finds that the application of scientific knowledge relating to food plays an important part in the treatment of disease and in the attainment and maintenance of health. The legislature further finds that the rendering of dietetics services in institutions and other settings requires trained and competent professionals. . . . The purpose of the Nutrition and Dietetics Practice Act is to safeguard life and health and to promote the public welfare by providing for the licensure and regulation of the persons engaged in the practice of nutrition and dietetics in the state and by providing the consumer a means of identifying those qualified to practice nutrition or dietetics."); Nevada (Nev. Rev. Stat. § 640E.010 (2011) "The Legislature hereby declares that the practice of dietetics is a learned profession affecting the safety, health and welfare of the public and is subject to regulation to protect the public from the practice of dietetics by unqualified and unlicensed persons and from unprofessional conduct by persons licensed to practice dietetics."); North Carolina (N.C. Gen. Stat. § 90-351 (July 1, 2018): "It is the purpose of this Article to safeguard the public health, safety and welfare and to protect the public from being harmed by unqualified persons by providing for the

nutrition experts among health care practitioners and provide complex nutrition care services in hospitals, long-term care facilities, private practice, dialysis centers, and other venues. Patients diagnosed with many of the leading causes of death--including diabetes, cancers, chronic kidney disease, gastrointestinal disorders, obesity, eating disorders, and cardiovascular disease—rely upon RDNs to save their lives by effectively treating and managing their diseases and medical conditions.

As our members will attest, Arizona's patients and vulnerable citizens engage all too often with incompetent, ineffective, and dangerous nutrition "care" provided by individuals with spurious credentials and specious promises of success. It is critical to ensure that Arizonans can identify competent practitioners and obtain timely, expert care from qualified nutrition professionals in hospitals and other facilities consistent with federal regulations; at present, our state is denying Arizonans access to timely, cost-effective and clinically effective nutrition care services care provided by qualified RDNs.

B. Arizonans' Will Benefit from Professional Regulation That Effectuates CMS' Therapeutic Diet Order Rule and Identifies Competent Practitioners

At present, Arizona RDNs are not able to provide patients in hospitals or long-term care facilities with the timely, effective parenteral (PN) and enteral nutrition (EN) care services that RDNs in other states across the country are able to provide. The Centers of Medicare and Medicaid Services (CMS) pre-published a final rule[16] on May 7, 2014 finalizing a proposed rule change[17] in which CMS "stated[,]. . . we believe hospitals would realize significant cost savings in many of the areas affected by nutritional

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licensure and regulation of persons engaged in the practice of dietetics or nutrition and by the establishment of educational standards for those persons.").

[16] Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II, 79 Fed. Reg. 27105 (May 12, 2014) (codified at 42 CFR 482.28) (hereinafter, "CMS TDO Final Rule").

[17] Medicare and Medicaid Programs; Part II-Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 78 Fed. Reg. 9215 (February 7, 2013) (hereinafter, "CMS TDO Proposed Rule").

care."[18] According to CMS's formula, the cost savings for Arizona can be conservatively estimated at $9.7 million.[19] As CMS recognized, "Without the proposed regulatory changes allowing hospitals to grant appropriate ordering privileges to RD[N]s, hospitals would not be able to effectively realize improved patient outcomes and overall cost savings that we believe would be possible with such changes."[20]

There are particularly significant cost savings when RDNs order and monitor PN usage. The appropriate selection of route of nutrition support (*i.e.*, EN versus PN) can be associated with decreased complications and mortality rates. It also decreases costs; CMS references the Peterson *et al* study noting a 50% reduction in inappropriate PN usage during pre-and post-ordering privilege periods produces a 20% cost savings in PN usage totaling $300,000 over two years for a single hospital.[21]

Winchester (VA) Medical Center, where RDNs have been approving PN and writing the orders as "verbal per physician request" since Dec 2010, has seen similar cost savings by significantly reducing its inappropriate PN usage. Active engagement and autonomy of RDNs resulted in an annual savings of $841,282.00 (2012 usage compared to 2009 usage) for this single hospital. Cost savings (assuming at least a five day course of

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[18] CMS TDO Final Rule

[19] CMS TDO Final Rule ("In order to estimate the reduced costs that our changes to § 482.28 might bring to hospitals, we based our calculations on this study and its finding of $135,233 savings for a single hospital that granted ordering privileges to RDs. The study presented its figures in 2003 dollars, and to adjust to a comparable figure in 2014 dollars we used the increase in the Gross Domestic Product deflator over this period. Since that index will be up about 25 percent, our savings estimate, rounded, is $169,000. We note that Peterson et al.'s cost reduction estimate includes only PN solution and pharmacy labor costs, not the savings estimates due to the time needed to administer PN by nurses, time saved by supervising physicians, or many other categories of potential savings. There may, of course, be some minor cost increasing changes, but we know of none that would be consequential (for example, the marginal cost of a day or two eating a regular hospital diet rather than parenteral feeding would at most be a few dollars per patient, and likely close to zero). Importantly, the Peterson et al study found that inappropriate use of PN decreased only to 27 percent of patients when using nutrition support teams. Other studies have found greater reduction. We use the Peterson et al estimates of dietary changes and add some, but not all, of the other likely savings to our overall estimate of savings.").

[20] CMS TDO Final Rule

[21] Peterson SJ, Chen Y, Sullivan CA, et al. Assessing the influence of registered dietician order---writing privileges on parenteral nutrition use. J AM Diet Assoc. 2010; 110; 1702–1711.

therapy) are realized from reductions in multiple areas: lab monitoring, central line and supplies, RDN/RN/IV therapy and pharmacy labor, and PN bag/tubing/additives. When RDNs are able to enter the therapeutic diet order, nutrition delays are reduced and fewer burdens are placed on providers.

The studies cited by CMS confirm that providing the revised regulatory authority will produce substantial cost savings, allow RDNs to see and treat more patients, and reduce delays in the ordering of therapeutic diets (including nutritional supplements), particularly PN and EN diet orders, complex infant formula orders, and in the monitoring of associated lab parameters. The growing number of RDNs with advanced/terminal degrees and specialized credentials is likely to produce even greater benefits as these dietetics experts perform at the height of RDN scope of practice. In January of 2024, an advanced degree will be required for the credentialing of all newly-eligible RDNs.

C. Extent to Which RDNs Exercise Independent Judgment and the Extent of Skill or Expertise Required in Making the Independent Judgment

CMS finalized its proposed rule that would "[s]ave hospitals significant resources by permitting registered dietitians to *order patient diets independently, which they are trained to do, without requiring the supervision or approval of a physician or other practitioner*. This frees up time for physicians and other practitioners to care for patients."[22] Thus, CMS specifically anticipated that RDNs should be able to exercise their independent judgment and authorized them to do so. CMS's final rule recognizes both the need and rationale for RDNs' broadly autonomous practice in this regard, if

[22] CMS TDO Proposed Rule (emphasis added).

they obtain any requisite privileges from their facility to order therapeutic diets independently.[23]

In finalizing the proposed rule, CMS recognized RDNs as the "recognized nutrition experts on a hospital interdisciplinary team" and authorized a practical and accountable mechanism for efficaciously ordering patient diets in hospitals.[24] RDNs' training and education best qualifies them to order patient diets both initially upon admission and after a nutrition assessment that considers the connection between patients' complex medical problems, nutrition status, and actual nutrition risk. In its final rule, CMS emphasized that, "We believe that hospitals that choose to grant these specific ordering privileges to RD[N]s may achieve a higher quality of care for their patients by allowing these professionals to fully and efficiently function as important members of the hospital patient care team in the role *for which they were trained*. [25]

CMS's authorization comports with the Academy of Nutrition and Dietetics' Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist, which specifies, "The RDN may write, accept, and implement orders based on federal and state laws and regulations and organization policies as well as implement established and approved protocol orders, and make recommendations for nutrition-related modifications. As part of interprofessional teams, the RDN performs health care functions based on clinical privileges or as delegated by the referring practitioner in collaboration with other health care team members, and performs other activities consistent with individual scope of practice, and role(s) and responsibilities in the organization."[26]

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[23] *See*, CMS TDO Final Rule ("Therefore, we are revising our proposed regulatory language in this final rule to now require that all patient diets, 'including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals.'").

[24] CMS TDO Proposed Rule.

[25] CMS TDO Final Rule (emphasis added).

[26] Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. J Acad Nutr Diet. 2018;118(1):141-165.

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

According to CMS, "RD[N]s are the professionals who are best qualified to assess a patient's nutritional status and to design and implement a nutritional treatment plan in consultation with the patient's interdisciplinary care team. In order for patients to receive timely nutritional care, the RD[N] must be viewed as an integral member of the hospital interdisciplinary care team, one who, as the team's clinical nutrition expert, is responsible for a patient's nutritional diagnosis and treatment in light of the patient's medical diagnosis."[27]

CMS made clear the benefits conferred by the final rule: "The addition of ordering privileges enhances the ability that RDNs already have to provide timely, cost-effective, and evidence-based nutrition services as the recognized nutrition experts on a hospital interdisciplinary team." However, CMS specifically highlighted "that this requirement does not require hospitals and medical staff to grant or authorize specific privileges to specific practitioners, but only allows them the flexibility to do so if they choose, and only if State law allows for it."[28]

II. THE EFFORTS MADE TO ADDRESS THE PROBLEM

However, despite successful efforts to pass AZ Rev Stat § 36-416 (2017) allowing hospitals to privilege RDNs "to order diets, enteral feeding, nutritional supplementation or parenteral nutrition if authorized by medical staff pursuant to 42 Code of Federal

[27] CMS TDO Final Rule.

[28] CMS TDO Final Rule.

Regulations section 482.28(b)," Although CMS did provide significant flexibility and authority for states to allow RDNs to order therapeutic diets and other medical nutrition therapies, it tacitly recognized the potential need for states to enact relevant legislation or regulations to effectuate its final rule in allowing RDNs' ordering of therapeutic diets "as long as each qualified dietitian or clinically qualified nutrition professional meets the requirements of his or her respective State laws, regulations, or other appropriate professional standards."[29]

As CMS specified, "Additionally, we believe that it is best left to individual States to determine the regulatory processes by which these professions are governed and that hospitals, through their medical staff privileging processes, should be allowed the flexibility to determine the credentials and qualifications for dietitians and nutrition professionals, in accordance with their respective State laws if and when they choose to grant ordering privileges to these professionals."[30] In this sunrise review, AzAND respectfully requests that the Arizona legislature facilitate sufficient regulation of the RDN profession to provide sufficient state oversight necessary for hospitals and other facilities to allow RDNs to order therapeutic diets in accordance with federal law and regulations.

III. THE ALTERNATIVES CONSIDERED

AzAND has steadfastly considered and pursued all available alternatives before submitting this sunrise review application. Regulations to business or employers is not considered to be a viable solution due to the potential administrative and financial burden this could place on business, especially with respect to small businesses. Moreover, regulated facilities are seeking the state's oversight and regulation of the

[29] CMS TDO Final Rule.

[30] CMS TDO Final Rule.

profession before effectuating the CMS therapeutic diet order rule. Regulation on nutrition services does not serve as an option to take action on individuals who may potentially pose harm to the public. Licensure with an exclusive scope of practice for dietitian nutritionists exists in many states to protect the public, but is a more restrictive form of regulation than that proposed in this sunrise application. National registration of practitioners currently exists for RDNs; licensure would leverage the foundation set in registration while also improving local control of practice and will address the current challenges limiting scope of practice by not having state regulation in place. Our self-regulation has been effective in setting a code of ethics and regulating ethical practice, but the lack of state regulation means there is no body in Arizona able to report substandard or incompetent practice or ensure standards sufficient to enable hospitals to privilege RDNs to order therapeutic diets. In summary, any proposed alternatives to regulation continue to present a threat to Arizonans by limiting the scope of practice for RDNs, negatively impacting the quality of care of Arizona patients and residents, and continuing to place Arizonans at harm by not instituting state oversight. Licensure of RDNs would protect the public interest by expanding access and scope for nutrition care services, provide, state oversight for the reporting of harm and complaints for lack of compliance, and enable health care facilities to fully utilize RDNs to reduce costs, reduce patient length of stay, and improve patient care.

IV. THE BENEFIT TO THE PUBLIC IF REGULATION IS GRANTED:

A. Reduction in Incidence of Specific Problems Present

RDNs have been hired by large medical centers, small community hospitals, and a variety of other community-based settings throughout the state. Licensure will reduce existing confusion in the implementation of nutrition care services, reduce the burden on physicians in the administration of medical nutrition therapy that should otherwise have RDN oversight, and ultimately reduce healthcare costs. State oversight will better allow Arizonans to identify quality practitioners by restricting the misleading use of titles

by incompetent or unqualified practitioners and be confident in knowing that state-licensed practitioners are subject to local oversight and compliance with public safety standards. Licensure defines a necessary set of qualifications and competencies for dietetics practitioners, thereby providing greater consumer protection. In cases where serious underlying medical conditions exist, there is real potential for adverse patient impacts if practitioners without specialized expertise inappropriately dispense non-evidence-based "nutrition" advice and treatment. In addition to protecting the public with a defined scope of practice and state oversight, reimbursement issues can be more clearly defined and prescribed for licensed professionals. While licensure does not mandate third party coverage, it does lend insurers a level of protection by ensuring that those they might cover are qualified practitioners of evidenced based nutrition care with proven and measured outcomes.

CMS sought to allow RDNs to independently order therapeutic diets because "[t]he addition of ordering privileges enhances the ability that RD[N]s already have to provide timely, cost-effective, and evidence-based nutrition services as the recognized nutrition experts on a hospital interdisciplinary team and saves valuable time in the care and treatment of patients, time that is now often wasted as RD[N]s must seek out physicians, [Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs)] to write or co-sign dietary orders."[31] AzAND notes that the $9.7 million in annual cost savings Arizona can expect if RDNs are able to order therapeutic diets consistent with the CMS final rule is a highly conservative estimate. According to CMS, its "cost reduction estimate includes only [parenteral nutrition or "PN"] solution and pharmacy labor costs, not the savings estimates due to the time needed to administer PN by nurses, time saved by supervising physicians, or many other categories of potential savings. There may, of course, be some minor cost increasing changes, but we know of

[31] CMS TDO Proposed Rule.

none that would be consequential . . ."[32] In addition, CMS clarified that, "The savings are based on the impact that RD[N] ordering privileges had on reducing inappropriate PN usage alone and do not include other positive impacts that RD[N] ordering privileges might have on reducing costs to hospitals, such as potential reductions in nursing time needed for dietary administration when patients switch from inappropriate PN to enteral nutrition or a regular hospital diet."[33]

The benefits to the public if the regulation is granted are not simply financial; Arizonans will experience improved quality of care and better health outcomes. CMS relied upon "[o]ne 2008 study indicat[ing] that patients whose PN regimens were ordered by RD[N]s have significantly fewer days of hyperglycemia (57 percent versus 23 percent) and electrolyte abnormalities (72 percent versus 39 percent) compared with patients whose PN regimens were ordered by physicians. [CMS a]lso, [cited] a recent literature review conclude[ing] that for at least general surgery and trauma patients, starting enteral feeding as soon as possible reduces infectious complications. This will most likely translate into decreased length of stays for these patients as well as quicker recovery times and reduced incidents of readmissions after discharge from the hospital."[34]

Because RDNs have a limited time to improve a patient's status during hospitalization, the Academy welcomes the proposed rule change that will facilitate RDNs' abilities to influence critical patient outcomes. Malnutrition is prevalent among hospital patients,

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[32] CMS TDO Final Rule.

[33] CMS TDO Final Rule.

[34] CMS TDO Final Rule, citing Duffy JK, Gray RL, Roberts S, Glanzer SR, Longoria SL. Independent nutrition order writing by registered dieticians reduces complications associated with nutrition support [abstract]. J Am Diet Assoc. 2008; 108 (suppl 1):A9; Caitlin S. Curtis et al, "Enteral Feedings in Hospitalized Patients: Early versus Delayed Enteral Nutrition," Practical Gastroenterology, October 2009, pp. 22-30.

with studies showing between 20%-50% of patients may be malnourished.[35] [36] Decreased nutrient intake is a major independent risk factor for in-hospital mortality and assistance from across the hospital interdisciplinary team is essential to assuring adequate consumption of nutrients. Studies show in-hospital mortality is highest in the patients "in the lowest BMI group (<18.5 kg/m2), increasing further when the proportion of plated food eaten was reduced and [again] increasing further when no snacks were taken."[37] Use of oral nutrition supplements as snacks and substitutions "decreases length of stay, episode cost, and 30-day readmission risk in the inpatient population.[38] Food is the bedrock of treatment for malnourished hospital patients, and RDN-provided nutrition care, assessments, and interventions should be assured in a similar manner to other professional services provided as part of an inpatient stay.[39]

The Academy has surveyed members about their experiences practicing pursuant to existing restrictive regulation (such as that in Arizona) that precludes RDNs from independently ordering patient diets and identified several recurrent themes:

- Patients' nutrition needs are not always fully addressed upon admission, frequently requiring concomitant changes in diet orders that are often excessively delayed when RDNs must wait for a physician to effectuate the order.
- Timely nutrition interventions and ongoing monitoring of nutrition status by RDNs facilitates earlier discharge, producing substantial cost savings by shortening lengths of stay.[40]

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[35] Barker LA, Gout BS, Crowe TC. Hospital malnutrition: prevalence, identification and impact on patients and the healthcare system. Int J Environ Res Public Health. 2011; 8(2); 514–527.
[36] Fessler T, "Malnutrition: a Serious Concern for Hospitalized Patients". Today's Dietitian; July 2008.
[37] Elia M. Nutrition, hospital food and in-—hospital mortality. *Clin Nutr.* 2009;28:481–483.
[38] Philipson T, et al. "Impact of Oral Nutritional Supplementation on Hospital Outcomes". Am J Manag Care. 2013;19(2): 121-—128 (Enhancing care practices with nutritional interventions yielded a 6.7% decrease probability in 30 day hospital readmissions and a 21% decrease in length of stay.).
[39] *Ibid.*
[40] Cawood AL, Elia M, Stratton RJ. Systematic review and meta-—analysis of the effects of high protein oral nutritional supplements. Ageing Res Rev. 2012;11(2):278-—96.

- Patients suffer unnecessary complications and delay in care under the existing rule when RDNs are prevented from independently changing nutritional supplements, liberalizing a diet for better intake, initially assessing appropriate diets for patients with food allergies, or changing diet consistency for patients with dysphagia, an inability to chew food, or at risk of aspiration.
- "Swingbed" patients, who may only see a physician once a week, experience particularly significant delays as their health conditions and nutrition needs change.
- RDNs authorized to order patient diets are more likely to conform the wording of their diet orders to the formulary, eliminating confusion that has frequently resulted in food service workers serving the wrong diet.
- Pediatric patients may be harmed from delays in ordering appropriate infant formula that could be ameliorated if this proposed licensure is enacted.

B. The Public Can Be Confident that Qualified RDN Practitioners Are Competent

1. Proposed Regulatory Entity

Under this request for regulation, AzAND is seeking to establish a regulatory board of dietetics and nutrition to (1) provide oversight at the state level using licensure of qualifications and (2) exercise the authority to investigate complaints concerning compliance with requisite qualifications, standards of practice, and a code of ethics in order to adequately protect the public. The board would have the authority to issue, revoke, and renew licenses, adopt rules and a canon of ethics, and collect fees from RDNs seeking to become licensed. We note that across the country, fees collected by licensees or certificants are sufficient to fund the regulatory regime, with no separate taxpayer funding necessary. In fact, in some states, there is sufficient funding through

fees to enable significant cuts thereto without negatively impacting the effectiveness of the state dietetics and nutrition board.[41]

A sunrise application is necessary to ensure the appropriate enactment of regulation for the licensure of dietetics and nutrition practice to safeguard and enhance the health of Arizonans. As is typical elsewhere in the country, a majority of the proposed board would be composed of members of the profession, with other board members potentially including another licensed health care practitioner (such as a physician) and/or a member of the public.

2. *Proposed Standards for Licensure*

The proposed standards for licensure largely mirror those in other jurisdictions across the country. In several of the states that restrict the practice of dietetics and nutrition only to those with an active license, however, one need not actually be an RDN credentialed in good standing by the Commission on Dietetic Registration to become licensed although the standards to qualify for a license largely mirror the academic and experiential requirements making one eligible to be an RDN. Nearly all jurisdictions have reciprocity or licensure by endorsement provisions that the proposed regulatory entity could use to allow Arizona RDNs to become licensed or certified elsewhere. There would be no need to enact a grandfather clause given that all RDNs would be eligible for licensure and there is presently no state oversight of the profession.

[41] *See, e.g.*, Minutes of the Board of Dietitian/Nutritionist Examiners of Tennessee. August 31, 2018. Available at https://www.tn.gov/content/dam/tn/health/healthprofboards/minutes/dietitians-nutritionist/DN-Board-Minutes-08.31.2018.pdf. Accessed October 17, 2019 ("From the expenditure/revenue comparison it shows that in the last five years the board's income was significant compared to its expenses, which prompted the fee reduction conversation at the last year end meeting per the Health Related Boards policy 106.05. The board's cumulative carryover balance exceeds twice the three year average of operating expenditures. The board voted at the last meeting to have a fee reduction for the renewals.").

3. *Nature and Duration of Training and Experience Requirements*

To become eligible for credentialing as an RDN, candidates must successfully complete three fundamental requirements:

- Required nutrition and dietetics coursework through a didactic program or coordinated program in dietetics accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) and completion of at least a baccalaureate degree granted by a US regionally accredited university or college or foreign equivalent. Coursework typically includes food and nutrition sciences, lifespan nutrition, community nutrition, communications, business, economics, computer science, foodservice management systems, psychology, sociology, anatomy and physiology, pharmacology, genetics, microbiology, organic chemistry, and biochemistry.
- Supervised practice through a dietetic internship, individualized supervised practice pathway, or a coordinated program in nutrition and dietetics accredited by ACEND of at least 1200 hours in clinical, community nutrition, and food service settings.
- Pass the national Commission on Dietetic Registration examination for registered dietitian nutritionists and completion of continuing professional education to maintain one's credentials.

There are three ACEND-accredited academic programs currently operating in Arizona, at Arizona State University, Northern Arizona University, and the University of Arizona. AzAND proposes that renewal of the license would require paying applicable renewal fees and maintaining one's credential as an RDN in good standing with Commission on Dietetic Registration, which requires completion of continuing education of 75 hours over a 5-year period.

V. THE EXTENT TO WHICH REGULATION MIGHT HARM THE PUBLIC:

Not only does AzAND anticipate no potential for harm to the public associated with the proposed regulation, but as noted throughout this sunrise application, substantial benefits will accrue to consumers, hospitals, and patients across the state. RDNs are uniquely positioned and prepared to provide the highest quality of nutrition care by virtue of their education from ACEND accredited programs and Commission on Dietetic Registration's registration requirements. With these standards set by national boards and commissions and the ability of individuals who are not RDNs to practice within their respective scopes of practice, the proposed regulation will neither restrict entry into the profession nor have a negative effect on RDNs migrating from other states. In fact, licensure will more clearly identify and articulate the necessary requirements for a qualified, competent Arizona practitioner in the field of nutrition and dietetics.

We note that a small number of states presently license or certify certain individuals as qualified practitioners of certain specified nutrition care services. The examination conducted by the Board for Certification of Nutrition Specialists is sufficient in a small number of states to demonstrate competency in certain aspects of nutrition care when combined with specified academic and supervised practice requirements. However, it is critical to underscore that one can obtain the Certified Nutrition Specialist (CNS) credential without having attended an accredited academic program or an accredited preprofessional experience. Moreover, unlike RDNs, there is no assurance that a CNS's competencies include the education or training necessary to prepare one for qualification to order therapeutic diets consistent with CMS's rules. This sunrise application for licensure would not interfere with or foreclose the ability of any of the small number of CNSs who may be living in Arizona to continue practicing within their scope of practice, nor would it restrict their currently permitted type of practice.

VI. THE MAINTENANCE OF STANDARDS AND A DESCRIPTION OF THE GROUP PROPOSED FOR REGULATION

A. Existing Code of Ethics

The primary goal of the *Academy of Nutrition and Dietetics (Academy) and its credentialing agency the Commission on Dietetic Registration Code of Ethics for the Nutrition and Dietetics Profession* "is the protection of the individuals, groups, organizations, communities, or populations with whom the practitioner works and interacts."[42] Further, "[t]he nutrition and dietetics practitioner supports and promotes high standards of professional practice, accepting the obligation to protect clients, the public and the profession; upholds the Academy of Nutrition and Dietetics and its credentialing agency the Commission on Dietetic Registration Code of Ethics for the Nutrition and Dietetics Profession; and shall report perceived violations of the Code through established processes." While this national code of ethics exists, there is not a local system in place to help resolve disputes between nutrition practitioners and consumers, nor is there a mechanism to ensure there is Arizona oversight to protect the public and meet the needs of nutrition and dietetics practitioners, employers and consumers to address violations and compliance. Licensure will provide this valuable service.

B. Introduction to Registered Dietitian Nutritionists (RDNs)

RDNs are the nationally recognized food and nutrition experts uniquely skilled at translating the science of nutrition into practical solutions for healthy living. The National Academies of Science, Engineering, and Medicine (formerly the Institute of Medicine) recognizes that "the registered dietitian [nutritionist] is currently the single identifiable group of health-care professionals with standardized education, clinical

[42] Academy of Nutrition and Dietetics (Academy) and its credentialing agency the Commission on Dietetic Registration (CDR) Code of Ethics for the Nutrition and Dietetics Profession. Academy of Nutrition and Dietetics website. June 1, 2018. Available at https://www.eatrightpro.org/-/media/eatrightpro-files/career/code-of-ethics/coeforthenutritionanddieteticsprofession.pdf?la=en&hash=0C9D1622C51782F12A0D6004A28CDAC0CE99A032. Accessed September 26, 2019.

training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."[43] Medical Nutrition Therapy (MNT) is at the core of the RDN's scope of practice and involves in-depth individualized nutrition assessments, diagnosis and interventions designed to meet a person's nutritional needs and goals for prevention, wellness and disease management. RDN-provided MNT is linked to improved clinical outcomes and reduced health costs.[44]

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

An RDN has earned a minimum of a bachelor's degree[45] with a major course of study in nutrition from a U.S. accredited college or university including course work approved by the ACEND; completed an accredited dietetics program including 1200+ hours of supervised practice in clinical, community nutrition, and food service settings; passed the Commission on Dietetic Registration's registration examination for dietitians and are

[43] Committee on Nutrition Services for Medicare Beneficiaries. "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population." Washington, DC: Food and Nutrition Board, Institute of Medicine; January 1, 2000 (published).

[44] Academy of Nutrition and Dietetics Evidence Analysis Library. MNT: Cost effectiveness, cost-benefit, or economic savings of MNT (2009). Accessed September 10, 2019.

[45] As of January 1, 2024, a masters or other graduate-level degree will be required of any individual seeking to become newly eligible for credentialing as an RDN.

required to complete continuing professional education to maintain their credentials. In addition to the didactic and clinical education RDNs receive in obtaining a bachelor's degree and qualifying as a professional registered dietitian nutritionist, graduate programs provide training that prepares them for the specialized practice of their role. Approximately 50% of Arizona RDNs hold advanced degrees; most frequently including a Master's of Science degree in Nutrition, Health Education, Public Health, MBA, or Ph.D in Nutrition. Many Arizona RDNs also hold additional certifications in specialized areas of practice, such as pediatric or renal nutrition, nutrition support, sports dietetics, weight management and diabetes education.

RDNs first established the credential in 1917 and have been providing nutrition care and services in Arizona almost continuously since we were granted statehood. In rural Arizona areas that are considered medical professional shortage areas, RDNs are recognized as critical clinicians in the delivery of preventive care and treatment, enabling physicians and rural healthcare facilities in underserved areas to provide more timely and quality care to Arizonans, often through the use of telehealth. RDNs provide nutrition care and support in collaboration with physicians, surgeons, pediatricians, nurses, speech and occupational therapists, and other qualified healthcare professionals. In addition to hospitals, long term care facilities, dialysis centers and other traditional healthcare settings, RDNs work in education settings, private practice, community settings, foodbanks, public health, with sports teams, and in foodservice.

C. Nutrition Care Process and RDNs' Scope of Practice

The Nutrition Care Process (NCP) is a systematic approach to providing high-quality nutrition care with its application utilized within MNT services provided by the RDN. The NCP consists of four distinct, interrelated steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation. The RDN uses the NCP and other workflow elements to individualize and evaluate care and service processes within organization systems specific to the discipline of nutrition and

dietetics. Academy nutrition practice guidelines incorporate the NCP as the standard process for guiding patient/client/population care. MNT protocols provide a plan based on systematically analyzed evidence and clearly define the level, content, and frequency of nutrition care appropriate for diseases and conditions. They are a component of the Academy's Evidence Analysis Library Evidence-Based Nutrition Practice Guideline Toolkits, which include an MNT Flowchart of Encounters and the MNT Encounter Process.

The RDN uses the NCP and its standardized terminology to:

- assess the nutrition-related health needs of patients/clients/populations, considering other factors affecting nutrition and health status (e.g., culture, ethnicity, and social determinants of health) and develop priorities, goals, and objectives to establish and implement nutrition care plans;
- provide nutrition counseling and nutrition education to optimize nutritional status, prevent disease, or maintain and/or improve health and well-being;
- make referrals to appropriate resources and programs and act as or collaborate with case managers;
- evaluate, educate, and counsel related to the use of nutrition-related pharmacotherapy plans and over-the-counter medications, dietary supplements, and food–drug and drug–nutrient interactions; and
- document care provided using standardized terminology.[46]

RDNs in clinical practice:

- Provide MNT in direct care of medical diseases and conditions across the continuum of care.

[46] Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. J Acad Nutr Diet. 2018;118(1):141-165.

- Apply the NCP and workflow elements in providing person-centered nutrition care of individuals.
    - Perform assessment of a patient's/client's nutrition status via in-person, or facility/practitioner assessment application, or HIPAA compliant video conferencing telehealth platform.
    - Complete a nutrition-focused physical exam through an evaluation of body systems, muscle and subcutaneous fat wasting, feeding ability (suck/swallow/breathe), oral health, skin condition, appetite, and affect.
    - Recommend, perform, and/or interpret test results related to nutrition status: blood pressure, anthropometrics (*e.g.*, height and weight, skinfold thickness, waist circumference, calculation of body mass index with classification for malnutrition and obesity), indirect calorimetry, laboratory tests, and waived point-of-care laboratory testing (*e.g.*, blood glucose and cholesterol).
    - Order and monitor nutrition-related laboratory tests and waived point-of-care laboratory testing, in cases where an RDN has been granted ordering privileges, or received a delegated order from a referring physician.
    - Order and monitor nutrition interventions to meet person-centered nutrient and energy needs, including but not limited to prescribed diets, medical foods, dietary supplements, over-the-counter medications, nutrition support therapies such as enteral nutrition (tube feeding) and parenteral nutrition support (specialized intravenous solutions), nasogastric feeding tube placement, and provide feeding therapy (pediatric oral aversion).
    - Initiate, implement, and adjust protocol- or physician-order-driven nutrition-related medication orders and pharmacotherapy plans in accordance with established policy or protocols consistent with organizational policy and procedure.
    - Assist in the development, promotion, and adherence to enhanced recovery after surgery protocols, including elimination of preoperative nothing by mouth

order, intraoperative nausea/vomiting prophylaxis and goal-directed fluid therapy, and early postoperative nutrition.

- Provide nutrition counseling; nutrition behavior therapy; lactation counseling; health and wellness coaching; and nutrition, physical activity, lifestyle, and health education and counseling as components of preventative, therapeutic, and restorative health care.
- Assess and counsel for the treatment of food allergies to prevent consumption of allergens, prevent over-restriction, prevent nutrient deficiencies, and promote optimal growth and/or weight maintenance.
- Evaluate, educate, and counsel related to nutritional genomics, gene–diet and disease interactions; genetic, environmental, and lifestyle factors; and food–drug, drug–nutrient, and supplement—drug–nutrient interactions.
- Manage nutrition care, collaborate with other health and nutrition professionals and as members of interprofessional teams, contribute to rounds or care conferences; be part of palliative and hospice care teams; participate in care coordination; and refer to appropriate nutrition resources, programs, or other health professionals.

- Determine appropriate quality standards in foodservice and nutrition programs.
- Train nutrition and dietetics personnel and NDTRs and mentor nutrition and dietetics students and interns in the provision of nutrition services.
- Delegate to and supervise the work of the NDTR or other professional, technical, or support staff who are engaged in direct patient/client nutrition care.[47]

RDNs operate within the directives of applicable federal and state laws and regulations, policies and procedures established by the organization in which they are employed or provide services, and designated roles and responsibilities. Entities that pay for

[47] Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. J Acad Nutr Diet. 2018;118(1):141-165.

nutrition services, such as insurance providers, may establish additional regulations that RDNs must follow to receive payment for Medical Nutrition Therapy for their beneficiaries. RDNs providing telehealth services where the practitioner and patient are located in different states, the practitioner providing the patient care service must be licensed and/or meet the other applicable standards that are required by state or local laws in both the state where the practitioner is located and the state where the patient is located.[48] This sunrise application seeks to enact dietetics licensure to support the work of RDNs as a valuable component of the healthcare delivery system allowing RDNs to practice within their full scope, which is currently limited by not having state oversight through licensure in place and thus precludes the ordering of therapeutic diets. MNT provided through RDNs is linked to improved clinical outcomes and reduced health costs related to physician time, medication use and hospital admissions for people with obesity, diabetes and other chronic diseases.[49] Not having regulation in place poses harm to Arizonans by limiting access to RDNs and the quality nutrition care services they provide. Moreover, it prevents healthcare institutions from enacting quality care practices that permit RDNs to work at the height of their scope of practice for RDNs ultimately impacting care to patients. Furthermore, Arizonans will benefit from licensure in knowing that there is localized state oversight of nutrition practice that will be more responsive to the unique needs of Arizonans. Licensure will allow Arizonans to be confident that practitioners are competent, qualified, and practicing ethically.

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[48] Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. J Acad Nutr Diet. 2018;118(1):141-165, citing US Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Operations Manual. Appendix A Survey protocol, regulations and interpretive guidelines for hospitals (rev. 151, 11-20-15); §482. 28 Food and Dietetic Services. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Accessed September 10, 2019.

[49] *See*, RDNs and PCPs: A Healthy Partnership for Primary Care. Availab le at https://www.eatrightpro.org/~/media/eatrightpro%20files/practice/patient%20care/why_adding_rd_to_yourpractice%20team_is_good_medicinehandout.ashx. Accessed September 26, 2019. (Internal citations omitted.)

Establishing a licensure regime that identifies the profession's scope, education, and training and mirrors the federally recognized national standard will ensure the health and safety of Arizonans seeking complex nutrition care services. We propose that quality assurance, enforcement rules, and code of ethics be adopted to reflect Arizona's unique needs as identified through a public process. We also propose that the board be authorized to suspend or revoke one's license if any of the following conduct occurs: employment fraud, deceit, or misrepresentation in obtaining a license; committing an act of malpractice, gross negligence, or incompetence in the practice of dietetics or nutrition; practicing as a licensed RDN without a current license; holding oneself out as a dietitian without a license, engaging in conduct that could result in harm or injury to the public; conviction of or a plea of guilty or nolo contendere to any crime involving moral turpitude; adjudication of insanity or incompetence; and/or, engaging in any act or practice in violation of any provisions of the regulation. By creating a state board to provide oversight of RDNs, Arizona could be assured that a revocation of a license could be communicated to the Commission on Dietetic Registration for appropriate action, and individuals who practiced unethically or incompetently in Arizona could be deemed ineligible for a license.

VII. DESCRIPTION OF GROUP PROPOSED FOR REGULATION:

There are currently 1,857 RDNs in the state of Arizona. RDNs are food and nutrition experts, translating the science of nutrition into practical solutions for healthy living. RDNs provide Medical Nutrition Therapy which involves in-depth individualized nutrition assessments, diagnosis and interventions designed to meet a person's nutritional needs and goals for prevention, wellness and disease management.

It is expected that all applicants seeking a license will adhere to all standards set forth by the Academy of Nutrition and Dietetics and its credentialing agency, the Commission on Dietetic Registration including: to become a RDN, candidates must earn a bachelor's degree in nutrition from a U.S. accredited college or university including course work

approved by the ACEND; completed an accredited dietetics program including 1200+ hours of supervised practice in clinical, community nutrition, and food service settings; passed the National Commission on Dietetic Registration exam and are required to complete continuing professional education to maintain their credentials.

RDNs integrate highly-specialized Medical Nutrition Therapy services to help manage disease or treat or rehabilitate an illness, injury, or other condition. RDNs in healthcare settings interpret dietary data and recommend nutrient needs for therapeutic diets, including ordering tube feedings, specialized intravenous solutions, and specialized oral feedings; provide guidance on food and drug interactions that could do serious harm to patients with various medical conditions; and, develop and manage food services operations in hospitals, skilled nursing facilities, long term care, dialysis centers, and other settings in which patients require therapeutic diets.[50]

VIII. THE EXPECTED COSTS OF REGULATION:

There is no anticipated financial impact to the state or the public. Expenses associated with the administrative oversight of licensure will be paid for through reasonable application fees administered by the Board or agency that is assigned oversight. As noted above, across the country, fees collected by licensees or certificants are sufficient to fund the regulatory regime, with no separate taxpayer funding necessary. In fact, in some states, such as Tennessee, there was more than sufficient funding through fees to enable approximately a 50% cut thereto without negatively impacting the effectiveness of the state dietetics and nutrition board.[51]

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[50] The Academy defines a therapeutic diet—which has been adopted by CMS for various settings--as "a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or clinical conditions to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet." Definition of Terms List. Academy of Nutrition and Dietetics website. Available at https://www.eatrightpro.org/-/media/eatrightpro-files/practice/scope-standards-of-practice/20190910-academy-definition-of-terms-list.pdf?la=en&hash=1DB6495E0B94CB5FA3E7443B1E8436A32E50B8B8. Accessed October 30, 2019.

[51] *See, e.g.*, Minutes of the Board of Dietitian/Nutritionist Examiners of Tennessee. August 31, 2018. Available at https://www.tn.gov/content/dam/tn/health/healthprofboards/minutes/dietitians-nutritionist/DN-Board-Minutes-

The relevant licensure and renewal fees proposed would be established by the Board. AzAND does not foresee establishment of fee structures and amounts that pose any potential for costs incurred by Arizona or any Arizonan other than those eligible and seeking a license by the proposed Board.

08.31.2018.pdf. Accessed October 17, 2019 ("From the expenditure/revenue comparison it shows that in the last five years the board's income was significant compared to its expenses, which prompted the fee reduction conversation at the last year end meeting per the Health Related Boards policy 106.05. The board's cumulative carryover balance exceeds twice the three year average of operating expenditures. The board voted at the last meeting to have a fee reduction for the renewals.").