

Public Policy Priority Areas

Executive Summary

The Academy of Nutrition and Dietetics is committed to improving the nation's health and advancing the profession through research, education, and advocacy. Public policy and advocacy are core functions of the Academy and are critical to achieving the mission, vision, goals and strategies outlined in the Strategic Plan Roadmap. Public policy significantly influences and forms the public image of the Academy and that of the dietetics profession.

The 2012-2014 priorities areas are divided into two areas that align with the Academy's Strategic Road Map and are targeted to enhance our members' value in policy initiatives and to improve the nutritional health of Americans. For the first time, the evidence that supports the Academy's positions and policy efforts has been included. Adding an area that addresses professional issues helps to assure that the Academy considers competition, friendly or not, as well as scope creep with regard to licensure and practice.

The following priority areas and issues were identified:

Consumer and Community Issues

1. Prevention and treatment of chronic disease, including health care equity
2. Meeting nutrition needs through the life cycle: Maternal and child nutrition to healthy aging
3. Quality food and nutrition through education, production, access and delivery
4. Nutrition monitoring and research

Professional Issues

1. Licensure: Protection of the Public
2. Workforce demand: Assuring the Public has access to nutrition services delivered by qualified practioners
3. Outcome driven nutrition services in changing health systems

Process

Each of these priorities areas includes the relevance to specific Dietetic Practice Groups (DPGs) and Member Interest Groups (MIGs) to provide a pathway for members' ownership in these issues. The description of each of the priorities also includes the major pieces of legislation connected to these areas to help plan for what is ahead on the legislative calendar. The federal agencies with jurisdiction over these areas are also included to help members be aware of the interaction between these agencies and the funding and regulations for nutrition programs and initiatives. The supportive research is identified, which includes current position papers and topics addressed in the Evidence Analysis Library (EAL). These positions provide the evidence needed to take the Academy's messages and requests to policy makers. It is also important that the Legislative and Public Policy Committee be comprised of

members from all areas of practice. The LPPC members with expertise in each priority area are noted and will be considered as leadership works to identify appointments for each year's class of LPPC members. It is the intent to review this document at least annually in order to reflect the dynamic and current state of public policy. It will be used as the guiding document for LPPC and PIA staff to achieve the public policy goals of the Academy.

Academy of Nutrition and Dietetics Public Policy Priority Areas

The Academy of Nutrition and Dietetics is committed to improving the nation's health and advancing the profession through research, education, and advocacy. Public policy and advocacy are core functions of the Academy and are critical to achieving the mission, vision, goals and strategies outlined in the Strategic Plan Roadmap. Public policy significantly influences and forms the public image of the Association and that of the dietetics profession.

Advocacy within the Academy involves member leader committees of LPPC and ADAPAC, affiliate and Dietetic Practice Groups (DPGs) and Member Interest Groups (MIGs) and thousands of grassroots members to achieve advocacy goals. Members of the Academy of Nutrition and Dietetics work on a broad range of issues to improve the nutritional and health status of Americans. Our members are recognized for their contributions and influence in food, nutrition and health policy. To help focus and guide our policy efforts, the following priority areas and issues have been identified:

Consumer and Community Issues

1. Prevention and treatment of chronic disease, including health care equity
2. Meeting nutrition needs through the life cycle: Maternal and child nutrition to healthy aging
3. Quality nutrition and food through education, production, access and delivery
4. Nutrition monitoring and research

Professional Issues

1. Licensure: Protection of the Public
2. Workforce demand: Assuring the Public has access to nutrition services delivered by qualified practitioners
3. Outcome driven nutrition services in changing health systems

A. Consumer and Community Issues

1. Prevention and Treatment of Chronic Disease

According to the CDC, chronic diseases are the leading causes of death and disability in the U.S: "Chronic diseases – such as heart disease, stroke, cancer, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the U.S." (1). Poor nutrition is one of the four modifiable health risk behaviors that is responsible for chronic disease development and severity of its outcomes (1).

- 7 out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer and stroke account for more than 50% of all deaths each year (1). Additionally, diabetes is the seventh leading cause of death in the U.S. (2).
- In 2005, 133 million Americans – almost 1 out of every 2 adults – had at least one chronic illness, and about one-fourth of people with chronic conditions have one or more daily activity limitations (1).
- Obesity has become a major health concern. 1 in every 3 adults is obese, and almost 1 in 5 youth between the ages of 6 and 19 is obese (BMI $\geq$ 95th percentile of the CDC growth chart) (1).
- Arthritis is the most common cause of disability, with nearly 19 million Americans reporting activity limitations resulting in costs of \$128 billion annually and continuing to be the most

common cause of disability. The number of states in which more than 30% of adults with arthritis were obese increased from 38 (including D.C.) in 2003 to 48 in 2009 (3).

- Diabetes continues to be the leading cause of kidney failure, nontraumatic lower-extremity amputations, and blindness among adults, aged 20-74 (1). Adults with diabetes have heart disease and stroke death rates 2 – 4 times higher than adults without diabetes.

Prevention is the most effective, affordable course of action for reducing risk for and severity of chronic disease. Recently The National Prevention and Health Promotion Strategy was released based on four pillars of prevention – building healthy and safe communities, expanding quality preventive services in both clinical and community settings, empowering people to make healthy choices and eliminating health disparities (4). Our members are leaders in delivering preventive services, as evidenced most recently in the Community Transformation Grants. Many of these grant awards were for nutrition and environmental changes (5).

As secondary and tertiary prevention, medical nutrition therapy is an effective disease management strategy that lessens risks from chronic diseases, slows disease progression and reduces symptoms. The application of medical nutrition therapy (MNT) and lifestyle counseling as a part of the Nutrition Care Process is an integral component of the medical treatment for management of specific disease states and conditions and should be the initial step in the management of these situations. MNT helps reduce chronic disease and the costs associated with it. Cost-effective interventions that produce a change in personal health practices are likely to lead to substantial reductions in the incidence and severity of the leading causes of disease in the US.

Academy members are committed to improving the health of racial and ethnic populations through effective nutrition policies and programs that eliminate health disparities. The United States spends more on health care than any other nation, yet not all Americans have equal access to quality health care, nutrition services and healthy safe food. Racial and ethnic minorities are in poorer health, suffer worse health outcomes, and have higher morbidity and mortality rates. Through Academy members' research, teaching, and community outreach to provide nutrition services, the disparity margin can be narrowed.

DPG Alignment

Behavioral Health Nutrition	Medical Nutrition Practice Group
Clinical Nutrition Management	Nutrition Education for the Public
Diabetes Care and Education	Nutrition Educators of Health Professionals
Dietetic Educators of Practitioners	Nutrition Entrepreneurs
Dietetic Technicians in Practice	Oncology Nutrition
Dietetics in Health Care Communities	Pediatric Nutrition
Dietitians in Business and Communications	Public Health/Community Nutrition
Dietitians in Integrative and Functional Medicine	Renal Dietitians
Dietitians in Nutrition Support	Research
Food & Culinary Professionals	School Nutrition Services
Healthy Aging	Sports, Cardiovascular and Wellness Nutrition
Hunger and Environmental Nutrition	Vegetarian Nutrition
Infectious Diseases Nutrition	Weight Management

MIG Alignment

Chinese Americans in Dietetics and Nutrition (CADN)
Filipino Americans in Dietetics and Nutrition (FADAN)
Latinos and Hispanics in Dietetics and Nutrition (LAHIDAN)
Muslims in Dietetics and Nutrition (MIDAN)
National Organization of Blacks in Dietetics and Nutrition (NOBIDAN)
National Organization of Men in Nutrition (NOMIN)

Major Legislation

Affordable Care Act
Farm Bill
Ryan White Care Act
Social Security Act of 1965 (Medicare, MNT and Medicaid)

Federal Agencies with Authority for Programs in This Area

Health and Human Services (HHS)
Centers for Disease and Prevention (CDC)
Centers for Medicare and Medicaid Services (CMS)
Food and Drug Administration (FDA)
Health Resources and Services Administration (HRSA)
United States Department of Agriculture (USDA)

Academy Position Papers

Dietary Fatty Acids
Ethical and Legal Issues in Nutrition, Hydration and Feeding
Food Insecurity in the United States
Functional Foods
Health Implications of Dietary Fiber
Impact of Fluoride on Health
Individual-, Family-, School- and Community-Based Interventions for Pediatric Overweight
Integration of Medical Nutrition Therapy and Pharmacotherapy
Nutrient Supplementation
Nutrition Intervention and Human Immunodeficiency Virus Infection
Nutrition Intervention in the Treatment of Eating Disorders
Obesity, Reproduction and Pregnancy Outcomes
Oral Health and Nutrition
Prevention (currently being updated)
Providing Nutrition Services for People with Developmental Disabilities and Special Health Care Needs
The Roles of Registered Dietitians and Dietetic Technicians, Registered in Health Promotion and Disease Weight Management

Evidence Analysis Library Topics

Adult Weight Management
Bariatric Surgery, Nutrition Care
Celiac Disease
Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease

Critical Illness
 Diabetes 1 and 2
 Disorders of Lipid Metabolism
 Gestational Diabetes
 Heart Failure
 HIV/AIDS
 Hydration
 Hypertension
 Oncology
 Pediatric Overweight – Interventions to treat pediatric overweight
 Prediabetes
 Spinal Cord Injury
 Wound Care
 Screening and Referral System
 [Nutrition Assessment]
 Nutrition Assessment – Energy Expenditure
 Nutrition Assessment – Health Disparities evidence analysis project
 [Nutrition Diagnosis]
 [Nutrition Intervention]
 Nutrition Intervention – Nutrition Counseling
 [Nutrition Monitoring and Evaluation]
 Medical Nutrition Therapy
 Comparative Effectiveness of MNT Services
 [MNT Cost-effectiveness – MNT cost effectiveness, cost-benefit, or economic savings]
 Effectiveness of MNT for Hypertension
 Effectiveness of MNT for Obesity
 [MNT Effectiveness and other EAL Topics – Chronic Kidney Disease, Diabetes, Disorders of Lipid Metabolism, Gestational Diabetes, Heart Failure, HIV, Oncology, Spinal Cord Injury, Unintended Weight Loss, Cost Effectiveness and Critical Illness]
 Outcomes Management System – Telenutrition evidence analysis project

LPPC Representatives

- Karen Bellesky
- Karen Ehrens
- Susan Foerster
- Irma Gutierrez
- Kathleen Niedert
- Martha Peppones
- Dianne K. Polly
- Lisa Eaton Wright

2. Nutrition Needs through the Life Cycle

Maternal and Child Nutrition

In 1969, the White House Conference on Food, Nutrition, and Health was convened with the intention of focusing national attention and resources on the problem of malnutrition and hunger due to poverty. Among the recommendations stated in the conference report was that special attention be given to the

nutritional needs of low-income pregnant women and preschool children. As a result of this conference and the efforts of supporters, the WIC Program was established in 1976. Outcome data with its high rates of return for its investment has provided WIC strong Congressional support. Academy members are key to the success of WIC, providing effective nutrition education and MNT. WIC is not an entitlement program; it is a Federal grant program for which Congress authorizes a specific amount of funding each year for program operations. Consequently, the Academy advocates annually for needed funding based on the evidence of the program's success.

The WIC program was not the first program targeted at mothers and children. With the passing of the Social Security Act in 1935, the Federal Government, through Title V, pledged its support of State efforts to extend health and welfare services for mothers and children. This landmark legislation resulted in the establishment of State departments of health or public welfare in some States and facilitated the efforts of existing agencies in others. Over the years, the achievements of Title V-supported projects have been integrated into the public health systems for families. Some projects include guidelines for nutrition care during pregnancy and lactation, standards for prenatal care, and strategies for the prevention of childhood injuries. Food and nutrition programs create a safety net that ensures that children and adolescents at risk for poor nutritional intakes have access to a safe, adequate, and nutritious food supply and nutrition screening, assessment and intervention.

Congress first passed The National School Lunch Act in 1948. Based on the Act's provisions, USDA provides States with cash assistance and donations of commodity foods to help schools serve children nutritious lunches. These lunches must meet specific nutritional requirements to receive reimbursements. In 1966 the Child Nutrition Act expanded to include breakfast, and in 1968 the Act extended the breakfast program and authorized funds for some summer programs. In 1993 legislation required that schools that have 25% or more of their enrollment eligible for free or reduced-price meals offer the breakfast program. Amendments to the National School Lunch Act and the Child Nutrition Act in 1970 provided special assistance to States based on family income. In 1975 the National School Lunch Act extended eligibility to include residential childcare institutions. Additional programs, such as the Special Milk Program have been enacted to enhance nutrition programs by providing reimbursement for free and reduced cost provision of nutritious foods to children in schools and camps. In 2010, the Healthy Hunger Free Kids Act was passed which provides significant changes in school meals. This historical piece of legislation has several key highlights including:

- Enhancing the nutritional quality of food served in school-based and preschool settings
- Expanding the Afterschool Meal Program to all 50 states
- Supporting improvements to direct certification for school meals to reduce red tape
- Making "competitive foods" offered or sold in schools more nutritious

DPG Alignment

Behavioral Health Nutrition	Public Health/Community Nutrition
Diabetes Care and Education	School Nutrition Services
Hunger and Environmental Nutrition	Women's Health
Management in Food and Nutrition Systems	Nutrition Education for the Public
Pediatric Nutrition	Weight Management

MIG Alignment

Latinos and Hispanics in Dietetics and Nutrition (LAHIDAN)
National Organization of Blacks in Dietetics and Nutrition (NOBIDAN)

Major Legislation

Annual Agricultural and Health Appropriation Bills
Child Nutrition Reauthorization-Healthy Hunger Free Kids Act
Farm Bill
Title V Social Security Act of 1935

Federal Agencies with Authority for Programs in This Area

United States Department of Agriculture (USDA)
Centers for Disease and Prevention (CDC)
Center for Medicare and Medicaid Services (CMS)
Food and Drug Administration (FDA)
Health Resources and Services Administration (HRSA)

Academy Position Papers

Benchmarks for Nutrition Programs in Child Care Settings
Child and Adolescent Nutrition Assistance Programs
Comprehensive School Nutrition Services
Individual-, Family-, School- and Community-Based Interventions for Pediatric Overweight
Local Support for Nutrition Integrity in Schools
Nutrition and Lifestyle for a Healthy Pregnancy Outcome
Nutrition Guidance for Healthy Children Aged 2 to 11 Years
Obesity, Reproduction and Pregnancy Outcomes
Promoting and Supporting Breastfeeding

Evidence Analysis Library Topics

Breastfeeding and Dietary Factors
Artificial Nipple and Duration of Breastfeeding
Infant Nutrition and Breastfeeding
Infant Nutrition and Food Security
Child Nutrition and Fluoride
Child Nutrition and Food Security
Child Nutrition and Nutritive and Non-nutritive Sweeteners (Aspartame, Non-Nutritive Sweeteners, Sucralose)
Child Nutrition and Obesity/Overweight
Child Nutrition and Sodium
Child Nutrition and Vegetarian Nutrition
Nutrition Guidance for Healthy Children (2 – 11 years) Project
School-based Programs and Interventions
Adolescent Nutrition
 Adolescent Nutrition and Obesity
 Adolescent Nutrition and Vegetarian Nutrition
Pregnancy and Nutrition – Vegetarian Nutrition
Pregnancy and Nutrition – Gestational Diabetes
Pregnancy and Nutrition – Gluten-Free Diet
Pregnancy and Nutrition – Non-nutritive Sweeteners
Gestational Diabetes
Pediatric Overweight

LPPC Representatives

- Karen Ehrens
- Susan Foerster
- Irma Gutierrez

Healthy Aging

Growing older generally increases nutritional risk. As primary prevention, nutrition helps promote health and functionality and affects the quality of life in older adults. Although many older adults are enjoying longer and more healthful lives in their own homes, others, especially those with health disparities and poor nutritional status, would benefit from greater access to food and nutrition programs and services. Given the federal cost-containment policy to rebalance long-term care away from nursing homes to home- and community-based services, it is the position of the Academy that all older adults should have access to food and nutrition programs and services that ensure the availability of safe, adequate food to promote optimal nutritional status and the services of a registered dietitian. Appropriate food and nutrition programs include adequately funded food assistance and meal programs, nutrition education, screening, assessment, counseling, therapy, monitoring, evaluation, and outcomes documentation to ensure more healthful aging. For those older adults who require long-term residential services, the Academy is committed to the requirement that this population be under the care of a nutrition professional who will assure adequate intake of safe and nutritious food that meets the medical and social needs of the individual.

DPG Alignment

Behavioral Health Nutrition
Diabetes Care and Education
Dietitians in Functional Medicine
Dietetics in Health Care Communities
Healthy Aging
Hunger and Environmental Nutrition
Weight Management

Major Legislation

Affordable Care Act
Farm Bill
Older Americans Act
Social Security Act of 1965 (Medicare, MNT and Medicaid)

Federal Agencies with Authority for Programs in This Area

Administration on Aging (AoA)
Centers for Medicare and Medicaid (CMS)
Food and Drug Administration (FDA)

Academy Position Papers

Food and Nutrition Programs for Community-Residing Older Adults
Individualized Nutrition Approaches for Older Adults in Health Care Communities
Interdisciplinary Team Training in Geriatrics: An Essential Component of Quality Healthcare for Older Adults
Nutrition Across the Spectrum of Aging

Evidence Analysis Library Topics

Older Adults & Nutrition

- Bone Density
- Cognition
- Energy Measurements
- Nutrition Programs
- Obesity/Overweight
- Osteoporosis
- Vitamins & Antioxidants
- Weight Gain

Food and Nutrition for Older Adults Promoting Health and Wellness

Unintended Weight Loss in Older Adults

LPPC Representatives

- Mildred Cody
- Susan Foerster
- Kathleen Niedert
- Martha Peppones
- Dianne K. Polly
- Lisa Eaton Wright

3. Quality nutrition and food through education, production, access and delivery

Academy members work to assure that all Americans have access to a healthy, safe food supply by leading efforts to reduce food deserts, increasing participation in nutrition programs and working with industry to help develop nutritious food products. Sustainable food systems for health means being capable of being maintained over the long term in order to meet the needs of the present without jeopardizing the ability of future generations to meet their needs. The Academy has identified sustainable food systems as a priority in their commitment to helping individuals enjoy healthy lives. Our members are positioned to provide nutrition education and food/water safety education in community, clinical settings, and foodservice operations and food industries. We recognize that many of the populations that served are vulnerable to food insecurity and to food- and waterborne illness and that counseling and other services require inclusion of these topics to be effective. Academy members use a variety of engaging and effective nutrition education interventions that include social marketing initiatives to empower consumers to make safe, healthy food choices, as directed in the National Prevention and Health Promotion Strategy (3). It is important that consumers be given accurate and easy to understand information to make these food choices.

DPG Alignment

Dietitians in Business and Communications
Food & Culinary Professionals
Hunger and Environmental Nutrition
Infectious Diseases Nutrition
Management in Food and Nutrition Systems

Nutrition Education for the Public
Nutrition Entrepreneurs
Public Health/Community Nutrition
School Nutrition Services
Weight Management

MIG Alignment

Latinos and Hispanics in Dietetics and Nutrition (LAHIDAN)

National Organization of Blacks in Dietetics and Nutrition (NOBIDAN)

Major Legislation

Dietary Supplement Health and Education Act of 1994 (DSHEA)

Farm Bill

Federal Food, Drug, and Cosmetic Act

Food Safety Modernization Act

Nutrition Labeling and Education Act of 1990

Federal Agencies Having Authority for Programs in This Area

Food and Drug Administration (FDA)

United States Department of Agriculture (USDA): Food and Nutrition Service (FNS), Food Safety & Inspection Service (FSIS)

Position Papers

Addressing World Hunger, Malnutrition and Food Insecurity

Agricultural and Food Biotechnology (under revision)

Ecological Sustainability

Food and Nutrition Misinformation

Food and Water Safety

Food Insecurity in the United States

Food and Nutrition Professionals Can Implement Practices to Conserve Natural Resources and Support

Nutrient Supplementation

Total Diet Approach to Communicating Food and Nutrition Information

Vegetarian Diets

Evidence Analysis Library Topics

Advanced Food Productions and Sustainable Agriculture

Vegetarian Nutrition

Health Disparities Evidence Analysis Project: Nutrition Assessment

Availability and Access to Healthcare

Cross-Cultural Communication

Food Security – Nutrition Assessment Health Disparities

LPPC Representatives

- Karen Bellesky
- Mildred Cody
- Karen Ehrens
- Susan Foerster
- Irma Gutierrez
- Kathleen Niedert
- Martha Peppones
- Dianne K. Polly

- Lisa Eaton Wright

4. Nutrition Monitoring and Research

Knowing what Americans eat and how their diets directly affect their health provides valuable information to guide policies on food safety, food labeling, food assistance, military rations and dietary guidance. Nutrition monitoring is necessary for evaluating public health strategies, the effectiveness of food and nutrition programs, and making the connection between diet and health. Tools that allow analysis of food, such as nutrient databases, are integral to tracking individual and population nutrient consumption and should be updated to reflect foods in the current marketplace. It is crucial that the Academy has the research to support the value of our services and provide outcome measures. This research is used as the basis for the need for services provided by our members in legislation and policy.

DPG Alignment

Behavioral Health Nutrition	Medical Nutrition Practice Group
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Diabetes Care and Education	Nutrition Educators of Health Professionals
Dietetic Educators of Practitioners	Nutrition Entrepreneurs
Dietetic Technicians in Practice	Oncology Nutrition
Dietetics in Health Care Communities	Pediatric Nutrition
Dietitians in Business and Communications	Public Health/Community Nutrition
Dietitians in Integrative and Functional Medicine	Renal Dietitians
Dietitians in Nutrition Support	Research
Food & Culinary Professionals	School Nutrition Services
Healthy Aging	Sports, Cardiovascular and Wellness Nutrition
Hunger and Environmental Nutrition	Vegetarian Nutrition
Infectious Diseases Nutrition	Weight Management

MIG Alignment

Chinese Americans in Dietetics and Nutrition (CADN)
 Filipino Americans in Dietetics and Nutrition (FADAN)
 Fifty Plus in Nutrition and Dietetics
 Latinos and Hispanics in Dietetics and Nutrition (LAHIDAN)
 Muslims in Dietetics and Nutrition (MIDAN)
 National Organization of Blacks in Dietetics and Nutrition (NOBIDAN)
 National Organization of Men in Nutrition (NOMIN)

Major Legislation

National Nutrition Monitoring and Related Research Act of 1990
 Farm Bill

Federal Agencies with Authority for Programs in This Area

Health and Human Services (HHS)-National Institutes of Health (NIH)
 United States Department of Agriculture (USDA): Agricultural Research Service (ARS), National Institute of Food and Agriculture (NIFA)

Position Papers

LPPC Representatives

- Karen Bellesky
- Susan Foerster

B. Professional Issues

1. Licensure: Protection of the Public

Overview and status

Forty-six (46) states currently have statutory provisions regarding professional regulation of dietitians and/or nutritionists. The rationale for legislatures acting to protect these titles is that the public deserves access to professionals that are qualified by education, experience and examination to provide nutrition care services. Enacting licensure laws in states without current regulations and protecting current licensure remains a high priority of the Academy.

Impact on Profession

Licensure provides the public, health insurance companies, and state and federal governments with the assurance that practitioners meet standards of professional competence in order to be reimbursed for providing nutrition care services. In states without licensure, “nutrition professionals” may be reimbursed despite meeting only some of the qualifications required to become a registered dietitian.

Key issues

- Scope creep is the provision of dietetic/nutrition services by professionals licensed for other healthcare professions who do not have the specialized training of RDs and who are not working under the supervision of or in collaboration with RDs.
- Unqualified practitioners are individuals who do not have the education, experience and examination to demonstrate their competency in the field of nutrition and dietetics.

LPPC Representatives

- Dianne K. Polly
- Lisa Eaton Wright

Committees, workgroups, and staff liaisons

LPPC Licensure subcommittee

2. Workforce Demand: Assuring The Public Has Access To Nutrition Services Delivered By Qualified Practitioners

Overview and status

Meeting the future demands for nutrition services and intervention delivered by qualified persons is a very important issue for the Academy. The Dietetics Workforce Demand Study Task Force (DWDSTF), appointed by the Commission on Dietetic Registration, has completed a comprehensive review and future projections based on its best understanding of the profession in 2011. Understanding the workforce allows the Academy to better align our strategy and resources to adequately support the

practicing professional and the development of new practitioners to achieve our goals and position the profession to meet future demands. The results of the task force review will be included in the supplement to the March 2012 issue of the *Journal of the Academy of Nutrition and Dietetics*.

Impact on profession

Unless there are sufficient numbers of qualified practitioners to perform services, these practitioners may not be designated as service providers by third party payers, making it unlikely that many members of the Public will have access to qualified practitioners. In addition to direct service, nutrition interventions and other prevention efforts that are found to save healthcare costs need to be led by qualified staff.

Key issues

To reach the task force's vision of the future, we are challenged to meet three major goals: increase entrants into the profession; learn to work effectively, proactively and, when appropriate, in partnership with our competitors; and support dietetic professionals in the development and advancement of career skills and competencies that meet the demands of society and the workplace. In addition, there are many new innovative programs and models that will influence not only workforce demands but also practice. These include the focus on prevention and consumer knowledge, medical homes, changes in health care systems, Accountable Care Organizations (ACO) and the expansion of health information technology. Nutrition informatics will continue to be an important issue for the Academy as the implementation of the electronic health record expands and the way to use this information to demonstrate return on investment for nutrition services. Telenutrition programs may also expand to meet targeted needs. Legislation might help meet these goals and provide the necessary return on investment as evidenced by the Affordable Care Act.

LPPC Representatives

- Karen Bellesky
- Mildred Cody
- Karen Ehrens
- Susan Foerster
- Irma Gutierrez
- Kathleen Niedert
- Martha Peppones
- Dianne K. Polly
- Lisa Eaton Wright

3. Outcome driven nutrition services in changing health systems

The application of medical nutrition therapy (MNT) and lifestyle counseling as a part of the Nutrition Care Process is an integral component of the medical treatment for prevention and management of specific disease states and conditions and should be the initial step in the management of these situations. Cost-effective interventions that produce a change in personal health practices are likely to lead to substantial reductions in the incidence and severity of the leading causes of disease in the US. It is very important that nutrition services are covered and provided by a qualified practitioner.

Overview and status

- Current Medicare coverage for MNT: Part B coverage for diabetes and non-dialysis renal disease. RDs are recognized providers and can direct bill; co-pay/deductible waived as a result of the ACA
 - RDs paid at 85% of physicians per Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule. Changes up or down impact RDs (i.e., The Medicare Sustainable Growth Rate (SGR) decisions – Band-Aids vs. permanent fixes). Also, how CMS calculates rates impacts RDs. Other issues addressed in this rule (annually) potentially impact RDs in terms of things like quality measures.
 - Need RDs to become Medicare providers (even if current coverage is limited) to demonstrate to CMS that there is a supply available that could deal with an increased demand
- RDs can be providers under the Diabetes Self-Management Training (DSMT) benefit but CMS does not allow both DSMT and MNT to be provided on the same day of service. This guideline creates a barrier to access due to transportation issues. CMS does recognize the services as distinct and complementary services
- ACA's recognition of U.S. Preventive Services Task Force (USPSTF) recommendations has resulted in many private insurance companies expanding MNT/nutrition counseling coverage to include obesity (adults and children) and risk factors for cardiovascular disease. Policies recognize RDs as providers, but not exclusively
- HHS has been directed to develop the Essential Health Benefits (EHB) package as created in the ACA. The EHB is to provide benefits similar to small employer health plans. The EHB will set a national minimum "bar" for health insurance coverage for non-ERISA (self-insured) plans. HHS has proposed policies that would defer design of the EHB to the individual states with the option of using 1 of 4 potential benchmarks. If these policies are enacted, advocacy efforts will shift from the national to the state level.
- Pre-diabetes legislation introduced to expand current Medicare Part B benefit
- For Medicare Part A, nutrition services are included in bundled payment
- CMS is promoting primary care driven, bundled payment models vs. traditional fee-for-service
 - Models include incentive payments and penalties related to quality outcomes
- Physician Quality Reporting System (PQRS) – RDs can submit quality measures and need to do so to earn incentives and to avoid (future) penalties. CMS has also introduced an initial core set of health care quality measures for Medicaid-eligible adults for voluntary use by states and providers of services under Medicaid programs.
- CMS has authority via The Medicare Improvements for Patients and Providers Act (MIPPA) to expand preventive services covered by Medicare through NCD process, although recently they have indicated they do not feel they have the statutory authority to expand the MNT benefit/allow RDs to direct bill for anything beyond diabetes and renal disease
- Two recent decision memos issued by CMS on Intensive Behavioral Counseling for CVD and IBC for Obesity. Neither allows RDs to direct bill for services. Allows "incident to" billing, which has significant limitations due to "immediately accessible" and "on site" requirements for physician supervision
 - Other new opportunities for RDs to be involved include partnering with physicians to provide parts of the Medicare Annual Wellness Visit (initial and subsequent)
- ADA has prepared a NCD to submit to CMS (final submission was pending CVD and Obesity decisions at the recommendation of CMS)

Impact on profession

- Coverage creates opportunities in terms of revenue, recognition and jobs, which ties to workforce supply issues
- Recognition of RDs as providers ensures public can access RDs and establishes RDs as the nutrition experts
- We are better positioned to document outcomes and demonstrate effectiveness if services are reimbursed (often services are not provided by RDs if there is no payment for their services)

Key issues

The Academy is working on several issues to enhance reimbursement for members. These are:

- Medicare Physician Fee Schedule: The Academy submits comments on an annual basis. We are monitoring notices for any proposed long term fixes and will evaluate their potential impact on RDs and respond appropriately.
- Essential Health Benefits package: The Academy has submitted comments to various agencies through available venues on the national level. We continue to educate members and PPPs on the topic and provide tools to support state advocacy efforts. We continue to monitor HHS recommended policies and comment as needed as the package(s) may evolve over time.
- CMS National Coverage Determination(s): The Academy is finalizing its legislative and regulatory strategies in an effort to get CMS to recognize RDs as providers who can direct bill for preventive nutrition services beyond diabetes and renal disease.
- Same day services for DSMT and MNT: The Academy, in collaboration with other professional associations, continues to communicate with CMS in an effort to get them to revise their current guidelines so as to allow DSMT and MNT services on the same day.
- Pre-diabetes legislation: The Academy worked with Congresswoman DeGette's' office on the language of this piece of legislation and is working on securing additional sponsors and support for the bill.

ADA committees, workgroups, and staff liaisons

Coding and Coverage Committee

LPPC, CMS workgroup

Nutrition Care Process/Standardized Language Committee

Nutrition Informatics Committee

Quality Management Committee

Research Committee

DPG and Affiliate Reimbursement Representatives

Federal Agencies Having Authority for Programs in This Area

Health and Human Services (HHS)

Centers for Medicare and Medicaid Services (CMS)

Office of the National Coordinator for Health Information Technology

LPPC Representatives

- Karen Bellesky
- Kathleen Niedert
- Martha Peppones
- Dianne K. Polly

Gap Analysis

The Academy of Nutrition and Dietetics has identified the core priority areas for public policy initiatives efforts. To be successful in the efforts, a gap analysis was conducted to identify areas for improvement to help assure success and proper allocation of resources. The goals of our priority areas are to help improve the health of Americans and to ensure that the public trusts and chooses Registered Dietitians as food and nutrition experts. Public policy can help create our value by passing effective legislation and issuing regulations that support our roles in medical nutrition therapy, public health, food systems and access, and food/nutrition education. The role of research is crucial in providing the evidence needed for providing the rationale to include our services in legislation and public policy.

Academy Position Gaps – Consumer Issues

Reviewing the information to create this document, it is evident that there are several areas that need to be addressed, including position statements and topics in the Evidence Analysis Library. In the area of “Prevention and Treatment of Chronic Disease,” it is important that we have positions that clearly identify best practices and our role in delivering clinically-effective and cost-effective outcomes. This is an area of growth for our members and our leadership. Reviewing the current position papers, the analysis revealed the following gaps:

1. Need for expanded positions for the major diseases and the effectiveness of RD services.
The Roles of Registered Dietitians and Dietetic Technicians, Registered in Health Promotion and Disease Prevention is currently being revised. It would be helpful if this paper were expanded to give more evidence on the importance of nutrition interventions. In addition, it would be helpful to have three expanded separate positions that include best practices (clinical-effectiveness and cost-effectiveness) and RD’s role in each of the major diseases – cardiovascular, cancer and diabetes. These positions would be useful for presenting our position to policy makers and regulators in a clear, concise document.
2. Need for position on disease prevention and environmental nutrition interventions.
Both individual and community interventions are driving positive behavior change. It would be helpful to have a position on the effectiveness of “Policy, Systems, and Environmental Change” that is being used to develop healthy communities. This position would address the need to focus on the population as well as on the individual and would stress the roles of RDs in public health.

Academy Position Gaps – Professional Issues

This area protects our members’ area of practice and, importantly, the public. As the health care delivery model changes, it is important that we have current information and position statements for members. Gaps identified:

1. Need to have a position on the value of RDs in new health models and health care systems that include medical homes, affordable care organizations and national health system.
2. Need to have a position on healthcare informational technology including the need for nutrition information to be interfaced for other providers. The importance of nutrition informatics should be included.
3. Need to have a position statement on telenutrition to complement the EAL topic.

4. Need to have a position on licensure and protection of the public. Realizing the importance and weight a position carries, it will be important that this one address the need for public protection and not for improving reimbursement for nutrition services.
5. Need to have documentation on the effectiveness of the Nutrition Care Process and the role of the RD in the process. While the process makes conceptual sense, the components do not seem well documented. This is crucial in part because our model licensure bill assigns these responsibilities to RDs.

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