Revised 2025 Scope and Standards of Practice for Registered Dietitian Nutritionists in Diabetes Care

A complementary document to the Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist

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APPROVAL

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This document uses the term RDN to refer to both registered dietitians (RD) and registered dietitian nutritionists (RDN) and the term NDTR to refer to both dietetic technicians, registered (DTR) and nutrition and dietetics technicians, registered (NDTR).

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INTRODUCTION

The Diabetes Dietetic Practice Group (DDPG) of the Academy of Nutrition and Dietetics (Academy) under the guidance of the Commission on Dietetic Registration (CDR) Practice Competence Committee, has revised the Scope and Standards of Practice for Registered Dietitian Nutritionists in Diabetes Care (Scope and Standards in Diabetes Care), previously titled Revised 2017 Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Diabetes Care.[1] A focus area of nutrition and dietetics is a defined area of practice that requires focused knowledge, skills, and experience that applies to all levels of practice.[2] This document, along with the Code of Ethics[3] and 2024 Scope and Standards of Practice for Registered Dietitian Nutritionists (RDNs)[4] can be used by RDNs to guide their practice and performance. These foundational documents describe how RDNs practicing in diabetes care:

- are uniquely qualified to provide nutrition and dietetics care and services;
- demonstrate the knowledge, skills, and competencies for the provision of safe, effective, and quality care and services at the competent, proficient, and expert levels of practice; and
- use a systematic approach to benchmarking levels of proficiency and determining paths for knowledge and skill development for personal and professional advancement.

SCOPE OF PRACTICE

The scope of practice for RDNs in Diabetes Care encompasses a range of roles, activities, practice guidelines, regulations, and the code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer[s] code of ethics) within which RDNs practice. Each RDN has a unique scope of practice with flexible boundaries to capture the breadth of the individual's professional practice, which is determined by initial and ongoing continuing education, training, credentialing, and experience.[2] Scope of practice may change throughout the RDN's career with professional advancement, expanded or revised roles within an organization, and additional training, certifications, and/or credentials such as, Certified Diabetes Care and Education Specialist (CDCES), Board Certified-Advanced Diabetes Management (BC-ADM), and/or another related focus area CDR specialist certification, if applicable such as Board Certified Specialist in Renal Nutrition (CSR), or Board Certified Specialist in Obesity and Weight Management (CSOWM). The Scope of Practice Decision Algorithm (www.cdrnet.org/scope) guides credentialed nutrition and dietetics practitioners through a series of questions to determine whether a particular activity is within their scope of practice.[5]

STANDARDS OF PRACTICE

The 2024 Scope and Standards of Practice for the RDN serves as a blueprint for the development of the focus area scope and standards of practice for RDNs. As of 2025, there are 17 published focus area standards (based on the Scope and Standards of Practice for the RDN) that can be accessed through CDR's website at www.cdrnet.org/focus. With publication of the Revised 2024 Scope and Standards of Practice for RDNs, the focus area scope and standards are updated to the new format as part of their next 7-year review.

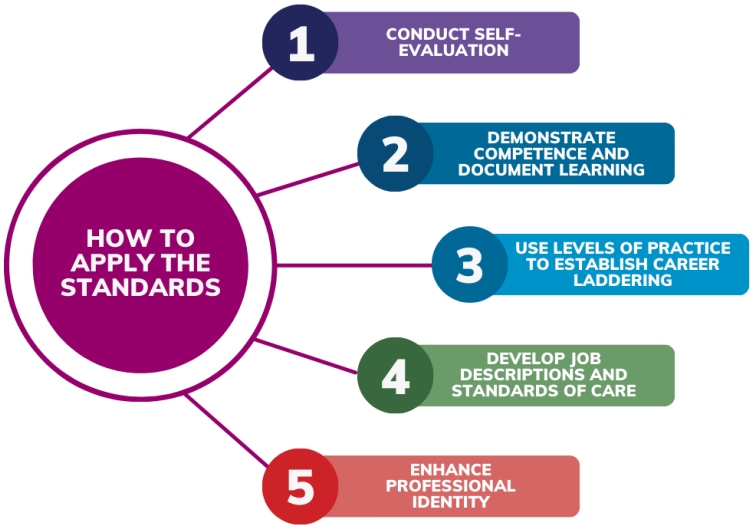
The Revised 2024 Scope and Standards of Practice for the RDN serves as the foundation for the development of focus area scope and standards of practice for RDNs in competent, proficient, and expert levels of practice. While this document addresses the diabetes care focus area, it is with the expectation that RDNs using the focus area scope and standards are meeting the minimum competent level of practice outlined in the Revised 2024 Scope and Standards of Practice for all RDNs.[4] Thus, the minimum competent level indicators are not repeated in this document unless they have been edited extensively to highlight their application within diabetes care.

The 2 scope and standards documents are intended to be used together.

The focus area Scope and Standards in Diabetes Care provides:

- a guide for self-evaluation, change management, and expanding practice;
- a means of identifying areas for professional development;
- a tool for demonstrating competence in delivering nutrition and diabetes-cardiometabolic care and services; and
- a resource to determine the education, training, and experience required to maintain currency in the focus area and for advancement to a higher level of practice.

Figure 2: How to Apply the Standards



The indicators are measurable action statements that illustrate how each standard can be applied in practice. Figure 1 has detailed indicator descriptions and Figure 2 describes how to apply them. The Scope and Standards in Diabetes Care was revised with input from, and consensus of, content experts representing diverse practice and geographic perspectives, and was reviewed and approved by the Executive Committee of the Diabetes Dietetic Practice Group and the CDR Practice Competence Committee.

The 2024 Scope and Standards of Practice for the RDN, along with focus area scope and standards do not supersede state practice acts (eg, licensure, certification, or title protection laws). However, when state law does not define scope of practice for the RDN, the information within these documents may assist with identifying activities that may be permitted within an RDN's individual scope of practice based on qualifications (eg, education, training, certifications, organization policies, clinical privileges, referring physician-directed protocols or delegated orders, and demonstrated and documented competence).

SCOPE AND STANDARDS OF PRACTICE IN DIABETES CARE OVERVIEW

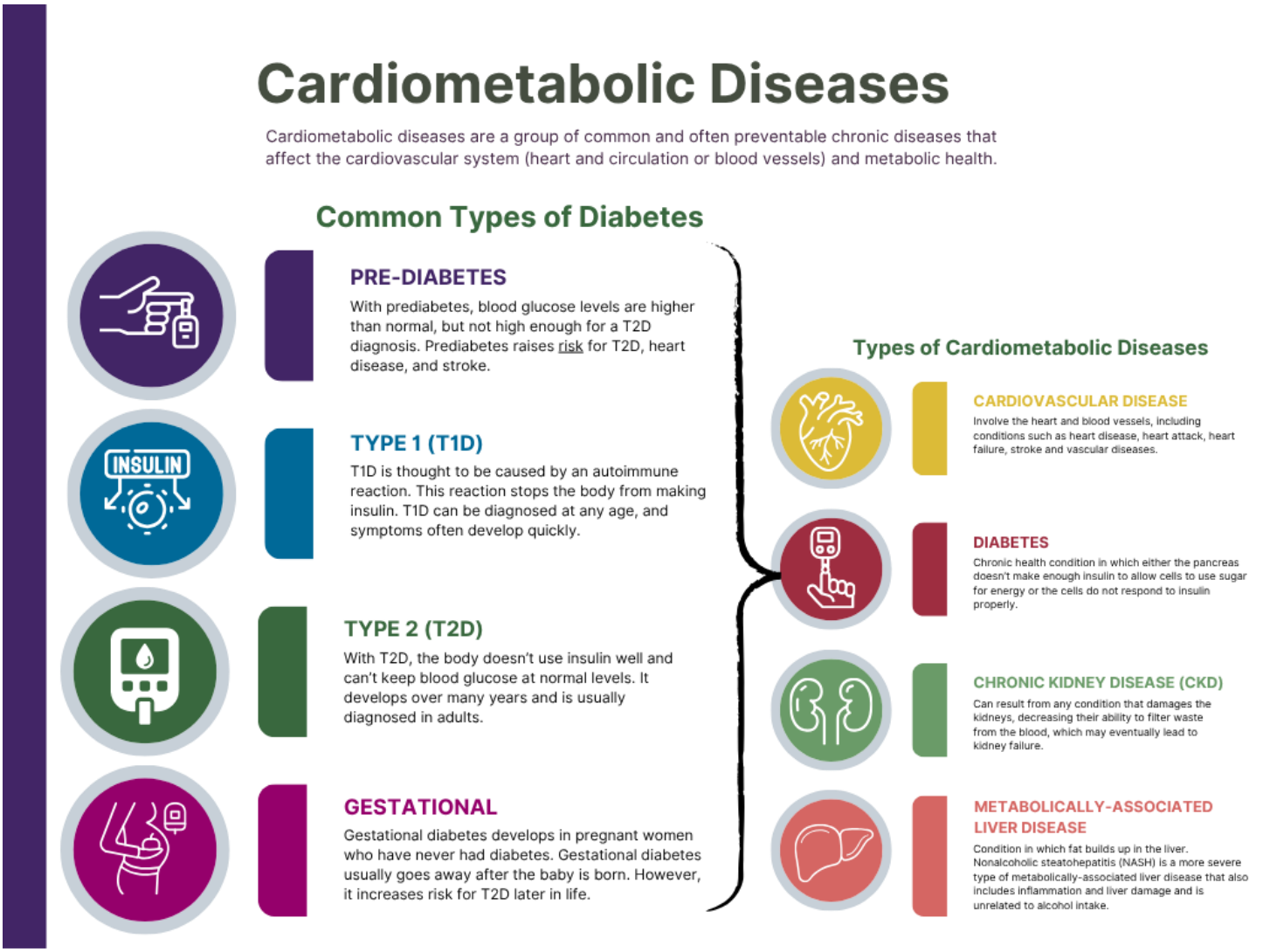
The RDN is fundamental to meeting the increasing demand for the screening, prevention, treatment, and management of persons with both prediabetes and diabetes throughout the life cycle (eg, children, adolescents, adults, gestational and older adults). There are 97.6 million (38% United States [US] adults) people with prediabetes, 38.4 million (11.6% US adults) with diabetes and nearly half of adults aged 65 and over have prediabetes.[6] A multidisciplinary consensus report[7] emphasizes medical nutrition therapy (MNT) and diabetes self-management education and support (DSMES) provided by a collaborative health care team at 4 critical times (at diagnosis, annually or more often as needed, when complicating factors develop, and when transition in life occur) improves diabetes-related quality of life, health outcomes and decreases cost (Diabetes Self-

"Cardiometabolic diseases are a group of symptoms that encompass cardiovascular, renal, metabolic, prothrombotic, and inflammatory abnormalities. These symptoms are usually characterized by insulin resistance, impaired glucose tolerance, dyslipidemia, hypertension, and central adiposity." [73] In this document, PWD encompasses people living with diabetes-cardiometabolic conditions (see Figure 3).

Management Education & Support [DSMES]). The RDN, as the provider of MNT, has an opportunity to lead team-based interprofessional care embracing technologic advances to address the imbalance of people with chronic diseases and access to health care.

The American Diabetes Association (ADA) Standards of Care in Diabetes highlights that people with diabetes (PWD) benefit from care provided by an interprofessional coordinated team which includes the RDN.[8] Team-based care may reduce therapeutic inertia by promoting shared decision making and timely care plan adjustments (eg, behavioral, nutrition, medications). Both the Academy and the ADA emphasize that MNT should be provided by an RDN with the skill set and knowledge specific to diabetes care.[9] Diabetes-cardiometabolic diseases (see box for definition of cardiometabolic and Figure 3[10–12]) require a multifaceted treatment approach including MNT and DSMES incorporating ADCES7 Self-Care Behaviors by the Association of Diabetes Care and Education Specialist [ADCES].[13] RDNs consult with practitioners specializing in a variety of cardiometabolic conditions (eg, renal, cardiac, hepatic). There is strong evidence that MNT and promoting lifestyle behavior changes such as physical activity and eating pattern can delay, prevent, or remit type 2 diabetes (T2D).[8] MNT provided by an RDN is shown to enhance weight loss and improve metabolic parameters associated with the development of T2D.[8] Weight loss of at least 5% is a strong predictor for reducing T2D.[8] The RDN, using the Nutrition Care Process (NCP),[14] provides nutrition counseling, education, and support that is coordinated and aligned with the medication plan, technology use, food preferences, and psychosocial needs. RDNs provide individualized MNT in a variety of settings, including inpatient, outpatient, specialty clinics, primary care, and community-based settings (delivered either virtually or in person).

Figure 3: Cardiometabolic Diseases[10–12]



Person-Centered Nutrition and Diabetes Care

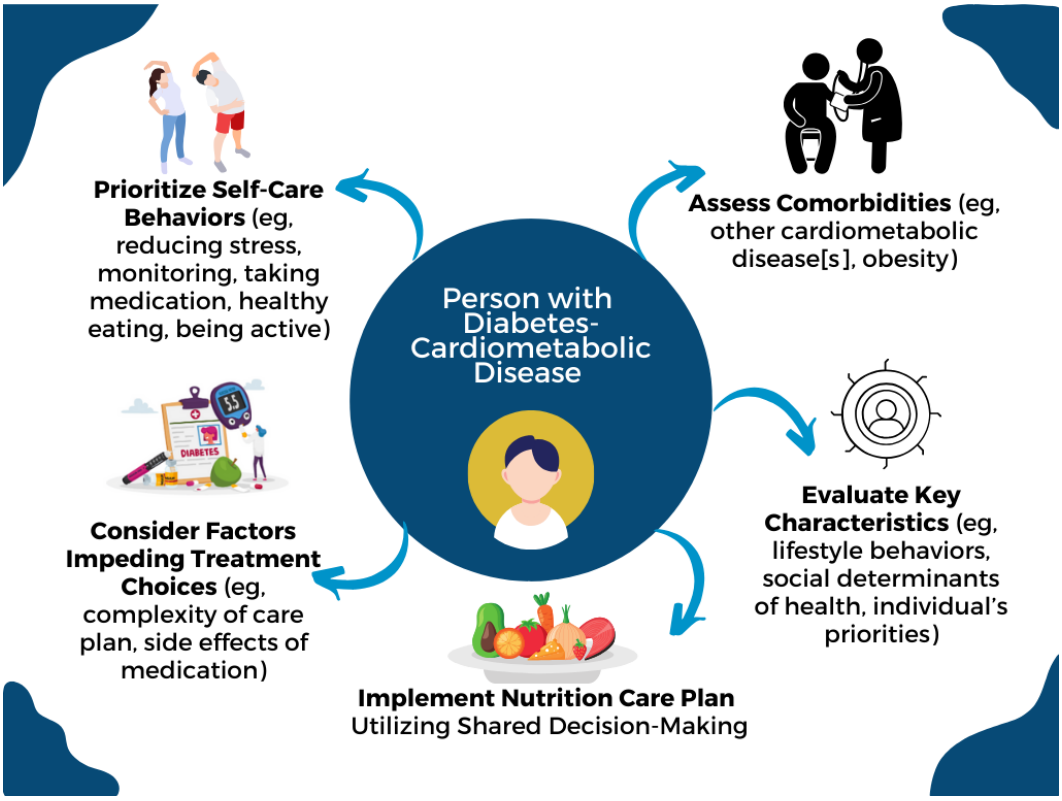
Endocrine Society Practice Guidelines[15] and the ADA Standards of Care in Diabetes[8] underscore the role of the experienced RDN as part of the care team. The RDN provides individualized MNT using person-first language[16] and aligned with the diabetes-cardiometabolic care plans including shared decision making, whole-person care, technology support, and medications.[8]

Whole-Person Care

Whole-person care is inclusive of cultural preferences, traditions and social determinants of health (SDOH). Providing person-centered care (PCC) is one of the DSMES 6 National Standards[17] and is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions".[18] There is a continuous growth in racial and ethnic diversity in the

US.[19] Racial/ethnic minorities and those with lower socioeconomic status are disproportionately affected by diabetes, its complications and have a higher undiagnosed rate.[7,20,21] Providing PCC includes considering a person's cultural preferences, traditions, beliefs, and SDOH (Figure 4). Despite research demonstrating the value of MNT and DSMES in lowering A1c and the associated metabolic markers, these RDN-provided services are underutilized.[7] A major barrier is the limited availability of services that meet the cultural, language, economic, and social needs of the person/population.[7] Upstream systemic issues must be addressed to narrow the disparity gap. RDNs can help by developing cultural competency and humility[21,22] to provide more inclusive nutrition recommendations and interventions to PWD to improve diabetes outcomes.[23] Understanding the impact of SDOH on diabetes-cardiometabolic diseases, RDNs assess social and financial situations and then personalize interventions to be relevant to individual circumstances, such as access to community resources and services.[24] In addition, it's recommended that RDNs assess language proficiency, health literacy, and numeracy skills of PWDs to tailor education to individual learning preferences and needs using plain language.[22,25] Additional considerations include: physical limitations (eg, vision, hearing, mobility), cognitive capacity (eg, learning, neurodiversity), psychosocial, trauma (eg, adverse childhood events [ACEs]), and sexual orientation and/or gender identity.[25] Considering the whole persons' needs, RDNs can help PWDs identify and configure the appropriate diabetes therapies, including technologies, for empowering diabetes-cardiometabolic care and self-management.[26] (See Social Determinants of Health - Healthy People 2030 | odphp.health.gov) [27]

Figure 4: Person-Centered Care



Medication Considerations and the RDN

When providing MNT, utilizing the NCP, RDNs have the tools to provide a comprehensive nutrition assessment and care interventions including an in-depth medication plan evaluation. The evaluation includes medication taking habits, drug to drug and nutrient interactions, side-effects, and quality of life.[28] The RDN's role includes care beyond diabetes MNT. RDNs with demonstrated competence and organization-approved protocols provide instruction for glucose monitoring, medication administration (injectable and oral) as well as recommending and adjusting diabetes-cardiometabolic and weight management-related medications, including incretin-based therapies (eg, glucagon-like peptide-1 [GLP-1] and glucose-dependent insulinotropic peptide [GIP]). Numerous additional agents are in various stages of development; therefore, it is incumbent on the RDN to remain current in this rapidly evolving field.[29–31] It is important to note that obtaining diabetes-related credentials such as the CDCES or BC-ADM do not circumvent the RDN professional scope of practice. An RDN must demonstrate competence and follow protocols to teach an individual to self-administer injectable medications or use devices (eg, continuous glucose monitoring [CGM] or automated insulin delivery [AID]). Using person-generated data from technologies (eg, CGM, health and medication tracking apps), the RDN can make real-time and personalized medication changes and adjustments if utilizing organization approved

protocols. (See DDPG Technology page for additional information: https://www.diabetesdpg.org/diabetes-technology/tech-resources)

Diabetes-Related Technology

RDNs who provide diabetes and nutrition care should continually advance their skills to utilize diabetes technology and support data-driven individualized care. Technology, coupled with ongoing education and clinical support, has led to improvements in self-management engagement, quality of life, and positive health outcomes for those living with diabetes.[32] Technologies to gather data, including medication delivery, health and wellness behaviors, and food intake present an opportunity to build a data-informed approach to diabetes-cardiometabolic care.[33–35] The Identify-Configure-Collaborate (ICC) framework[35] is a standardized method for integrating technology into clinical practice. For current information, education and training regarding available diabetes technologies, see DDPG Technology page https://www.diabetesdpg.org/diabetes-technology/tech-resources and the ADCES diabetes technology danatech website (https://www.adces.org/education/danatech/home). Technology advances enable the RDN to pivot from time-bound, reactive, episodic care to continuous and proactive care. Telehealth, remote physiological monitoring,[34] and virtual care-education clinics coordinated and led by RDNs, may use protocols to make care plan adjustments, guided by the prescribing clinician.[26,36] Artificial intelligence (AI) is a tool making available data actionable to the PWD and their care team for timely care plan adjustments.[37] RDNs with demonstrated and documented competence provide instruction and training on diabetes technologies including smart insulin pens and pen caps, insulin pumps, AID, and CGMs.[35] RDNs have the opportunity to leverage technology, including AI, to transform health care, connecting people living with or at-risk for diabetes with a diabetes-focused RDN. The RDN needs to continuously build AI acumen as AI capability advances and the role of the RDN in diabetes-cardiometabolic care evolves.[36]

Value of the Scope and Standards in Diabetes Care

This Scope and Standards in Diabetes Care document includes resources for expanding knowledge and encourages RDNs providing care to PWD and other related conditions to continuously assess their skills for delivering care and advancing practice (eg, competent, proficient, and expert levels of practice). (Figure 1) The education algorithm included in the multidisciplinary consensus report[7] along with the Scope and Standards in Diabetes Care can be used by an RDN and the interprofessional team for gauging how, what, and when to deliver diabetes education and nutrition services. RDNs whose professional practice focuses on diabetes and in work settings such as in academia, research, federal or state agencies, or in positions of professional organizations (eg, ADA, ADCES) should regularly reference the Scope and Standards in Diabetes Care to

assess skills, advance practice, and apply in their work settings. The Academy's Diabetes Dietetic Practice Group provides valuable resources to the RDN in providing diabetes care (https://www.diabetesdpg.org/).

QUALITY PRACTICE

Quality services are a foundation of the Academy's/CDR's Code of Ethics and the 2024 Scope and Standards of Practice for RDNs. RDNs in all areas of practice are expected to provide quality services that are routinely measured and evaluated to ensure quality outcomes. Importantly, consumers, third party payers, and regulatory agencies also expect quality, evidence-based nutrition care and services, and to have access to data that report quality measures by facility and compare facilities' services to one another. Quality nutrition and dietetics services that demonstrate measurable outcomes and are incorporated into health care standards of care and provider practice settings also elevate the unique contribution of RDNs.

Code of Ethics

The Code of Ethics reflects the values and ethical principles guiding the nutrition and dietetics profession, and serve as commitments and obligations of the practitioner to the public, clients, the profession, colleagues, and other professionals.[3,38] As the profession of nutrition and dietetics, and more specifically the practices in the diabetes care focus area evolve, new ethical situations may arise that require focus area knowledge, practice experience, and perhaps consultation with a knowledgeable professional colleague or legal counsel/risk management. When questioning the ethical implications of a situation, personal self-reflection is required to determine what information and/or resources are needed to act safely, appropriately, and to the benefit of the individual(s) or programs involved.[39] Examples may include use of social media,[40] contributing to or publishing blogs, use of online business platforms, delivering telehealth services,[41] adherence to HIPAA regulations,[42] when advocating on behalf of an individual, and/or developing materials that require proper citation of intellectual property,[3,43] health equity,[44,45] or conflicts of interest.[46] The RDN should refer to the Academy/CDR Code of Ethics to ensure transparency in the use of personal health information when using online technology and AI platforms (see ethics resources at www.cdrnet.org/codeofethics and https://www.cbdce.org/canons-of-ethical-conduct). [35,47,48]

Principle 1 in the Code of Ethics states the following: "Recognize and exercise professional judgement within the limits of individual qualifications and collaborate with others, seek counsel, and make referrals as appropriate".[3] The Scope and Standards in Diabetes Care are written in broad terms to allow for an individual practitioner's handling of non-routine situations. The standards are geared toward typical situations for practitioners with the RDN credential. Strictly adhering to standards does not always constitute the best care and service. It is the responsibility of individual practitioners to recognize and interpret situations and to know which standards apply and in what ways they apply.

Competence

In keeping with the Code of Ethics,[3] RDNs can only practice in areas in which they are qualified and have demonstrated and documented competence to achieve ethical, safe, equitable, and quality outcomes.[49] Competence is an overarching "principle of professional practice, identifying the ability of the provider to administer safe and reliable services on a consistent basis".[50] Lifelong learning and professional development enables practitioners to acquire and develop skills enhancing their competencies and levels of practice. RDNs should recognize that diabetes is a cardiometabolic disease and provide a holistic approach when making diabetes-cardiometabolic care recommendations (Figure 3). Aligning with the ADA, American Heart Association (AHA), and ADCES, RDNs should approach diabetes care with a cardiometabolic lens.[51] Competent practitioners at all levels of practice in diabetes-cardiometabolic care:

- understand and practice within their individual scope of practice[2,4];
- use up-to-date knowledge, practice skills, critical thinking, judgement, and best practices;
- make sound decisions based on appropriate data;
- communicate effectively with patients, clients, customers, and others;
- critically evaluate and strengthen their own practice;
- identify the limits of their competence; and
- improve performance based on self-evaluation, applied practice, and feedback from others.

Professional competence involves the ability to engage in clinical or practice-specific reasoning that facilitates problem solving and fosters person-/client-/customer-centered behaviors and participatory decision making.

Evidence-Based Practice

A competent RDN searches literature and applicable practice guidelines (eg, Academy Evidence Analysis Library, ADA, AHA, ADCES, American Association of Clinical Endocrinology [AACE], Endocrine Society) and assesses the level of evidence to select the best available research/evidence to inform recommendations. With high-quality, evidence-based practice and safety[2,52] as guiding factors when working with patients, clients, customers, and/or populations, the RDN identifies the level of evidence, clearly states research limitations, provides safety information from reputable sources, and describes the risk of the intervention(s), when applicable. RDNs must evaluate and understand the best available evidence to be able to converse with the interprofessional team and other decision makers/stakeholders authoritatively with transparency and accuracy involving the patient/client/population and caregivers in shared decision making (Figure 5 is a list of resources).

LAWS AND REGULATIONS SHAPING RDN PRACTICE IN DIABETES CARE

Laws and regulations specific to an RDN's area(s) of nutrition and dietetics practice may impact roles and/or responsibilities. RDNs are responsible for adhering to and implementing all applicable laws, regulations, and standards related to their specific practice area(s) and responsibilities, department, organization, and other programs within their area of responsibility. If a task is delegated, the RDN is responsible for ensuring the task is completed by a legally appropriate, trained, and competent individual. The laws, regulations, and accreditation standards applicable to diabetes-cardiometabolic care include but are not limited to:

- Local, state, and federal laws (eg, state licensure*[41,53])
- Organization accreditation standards (eg, The Joint Commission [TJC], Diabetes Education Accreditation Program [DEAP],[54] ADA Education Recognition Program [ERP]),[55] and Public Health Accreditation Board (PHAB)[56]
- Federal health care facility regulations (eg, Centers for Medicare and Medicaid Services State Operations Manuals [eg, Appendix A-Hospitals, Appendix PP Long-Term Care]) https://www.cms.gov/files/document/som107appendicestoc.pdf
- Federally Qualified Health Centers (https://www.cms.gov/files/document/mln006397-federally-qualified-health-center.pdf) and U.S. Department of Veterans Affairs (https://www.healthquality.va.gov/)
- Federal or state/territory, local, and/or tribal laws and regulations related to RDN order writing privileges/credentialing*
- US Department of Agriculture Food and Nutrition Service Nutrition Standards for School Meals[57,58]
- Health Insurance Portability and Accountability Act (HIPAA)[42,59]

CDR's Practice Tips and Case Studies are helpful resources that credentialed nutrition and dietetics practitioners can use to guide their professional practice. Topics covered in this document with corresponding Practice Tips or Case Studies are marked with an asterisk (*). These resources can be found at https://www.cdrnet.org/tips.

FRAMEWORK TO ADVANCE PRACTICE FROM COMPETENT TO EXPERT

The Dreyfus model[60] identifies levels of proficiency (novice, advanced beginner, competent, proficient, and expert) during the acquisition and development of knowledge and skills. In nutrition and dietetics, the first 2 levels are components of the required didactic education (novice) and supervised practice experience (advanced beginner) that precedes credentialing for nutrition and dietetics practitioners. Upon successfully attaining the RDN credential, a practitioner enters professional practice at the competent level and manages their professional development to achieve individual professional goals. This model can be used by RDNs to better understand the levels of practice described in focus area standards (competent, proficient, and expert).

Competent-Level Practitioner

In nutrition and dietetics, a competent practitioner is an RDN who is either just starting practice in a professional setting after becoming credentialed through CDR or an experienced RDN recently transitioning their practice to a new focus area of nutrition and dietetics. A competent practitioner consistently provides safe and reliable services by employing appropriate knowledge, skills, behaviors, and values in accordance with accepted standards of the profession; acquires additional on-the-job skills; and engages in tailored continuing education to further enhance knowledge, skills, and judgement obtained in formal education.[2]

All RDNs, even those with significant experience in other practice areas, must begin at the competent level when transitioning to a new setting or new focus area of practice. At the competent level, an RDN in diabetes-cardiometabolic care is learning the principles that underpin this focus area and is gaining experience and developing knowledge, skills, and judgement, to practice safely and effectively in diabetes practice settings. This RDN, who may be new to the profession or an experienced RDN, has a breadth of knowledge in nutrition and dietetics and may have proficient or expert knowledge/practice in another focus area. For example, an experienced RDN might have broad-based clinical practice expertise or have responsibilities across multiple and diverse areas such as clinical, community nutrition, consultation and business, education and food and nutrition management. (Figure 6a is an example with full description in Appendix 1) However, the RDN new to the focus area of diabetes care must critically evaluate their current level of knowledge, skills, and experience against those required to practice in this focus area, and when needed, seek assistance from more experienced practitioners. The type of assistance required will depend on the practitioner's task-specific competence and may include activities such as mentorship, discussion, resource review, or hands-on training and competency assurance. It is incumbent upon the practitioner to ensure competence for tasks performed. Useful resources for self-evaluation include position descriptions, the Scope and Standards in Diabetes Care and other related focus area scope and standards, applicable practice guidelines, and other focus area resources. (Figure 5 Resource List)

Figure 6a. Competent Practice

Description of Competent Practice	Examples of use of the Scope and Standards of Practice in Diabetes Care
The RDN consistently provides safe and reliable services by employing appropriate knowledge, skills, behaviors and values in accordance with accepted standards for the profession.[2]	JD is an experienced RDN working in a primary care clinic where they routinely provide MNT counseling and education for individuals with diabetes (and related cardiometabolic conditions) because there is no diabetes education program in the community. JD identifies a professional goal of qualifying for the Certified Diabetes Care and Education Specialist (CDCES) credential. The RDN performs regular self-evaluation of current level of practice using the Scope and Standards in Diabetes Care to determine areas to strengthen with the goal of achieving the proficient practice level. The RDN reviews the criteria for the CDCES certification examination to update professional development plan for successful CDCES credential attainment. JD decides to join local diabetes-related professional organizations and begins developing evidence-based educational materials.

Review Appendix 1 Using the Scope and Standards to Advance Practice in Diabetes Care following the references to identify actions to advance practice from competent to proficient.

Proficient-Level Practitioner

A proficient-level practitioner is an RDN who has obtained operational job performance knowledge, skills, and practice experience in a focus area, and consistently provides safe and reliable services.[2] This RDN is more skilled at adapting and applying evidence-based guidelines and best practices and can modify practice according to unique situations (eg, assist the PWD to identify technology tools to support their daily self-care; provide training; and configure technology tools to match care plan preferences) (Figure 6b is an example with full description in Appendix 1). The RDN may possess or be working toward acquiring a specialist credential, if available, to demonstrate proficiency in a focus area.

Proficient-level indicators within the Standards in this document are consistent with, but not equivalent to, Certified Diabetes Care and Education Specialist (CDCES) credential. Rather, the CDCES designation recognizes the skill level of an RDN who has developed and demonstrated, through successful completion of the certification examination, diabetes-cardiometabolic care knowledge and application beyond the competent practitioner and demonstrates, at a minimum, proficient-level skills. An RDN with a CDCES designation is an example of an RDN who has demonstrated additional knowledge, skills, and experience in diabetes nutrition by the attainment of a specialist credential. For additional information on the CDCES credential, please visit https://www.cbdce.org/.

Figure 6b. Proficient Practice

Description of Proficient Practice	Examples of use of the Scope and Standards of Practice in Diabetes Care
The RDN has obtained operational job performance knowledge and skills, and consistently provides safe and reliable services.[2]	JD has obtained the CDCES credential and is now a clinical nutrition manager overseeing inpatient and outpatient nutrition services. JD wants to develop an accredited diabetes self-management education and support (DSMES) service. JD refers to the Scope and Standards of Practice in Diabetes Care as a tool for developing position descriptions, competence standards, and assessment tools; guiding self-evaluation and professional development activities with RDN staff; and ensuring a quality program and compliance with accreditation program standards. JD's professional goal is to reach expert level. To achieve this, JD volunteers on local and national diabetes-related organizations and begins developing guidelines for operating at the top of RDN scope of practice in therapy adjustments and recommendations (eg, medications and technology).

Review Appendix 1 Using the Scope and Standards to Advance Practice in Diabetes Care following the references to identify actions to advance practice from proficient to expert.

Expert-Level Practitioner

Expert-level achievement is acquired through critical evaluation of practice, and feedback from others with additional knowledge, experience, and training.[2] Expert-level RDNs in diabetes-cardiometabolic care are recognized within the profession as they are able to combine dimensions of highly developed focus area knowledge and skills, critical thinking, performance, and professional values as an integrated whole to formulate effective and appropriate judgements that reflect their advanced practice.[61]

An expert can quickly identify "what" is happening and "how" to approach the situation, and easily uses practice skills to demonstrate quality practice and leadership.[2] They not only develop and implement diabetes-related nutrition and dietetics services, they also lead, manage, drive, and direct clinical care; mentor colleagues and/or precept students/interns; engage in advocacy; conduct and collaborate in research and scholarly work; accept organization leadership roles; guide interprofessional teams; and lead the advancement of diabetes-cardiometabolic nutrition and dietetics practice. They model shared-decision making regarding diabetes-cardiometabolic medications and technology, obesity management strategies, and self-management plans. An expert practitioner may have an expanded and/or specialist role and may possess an advanced credential(s), such as the CDR Advanced Practitioner Certification in Clinical Nutrition (RDN-AP) and/or BC-ADM credential (for additional information on the BC-ADM credential, please visit https://www.cbdce.org/). Generally, the RDN's practice is more complex and has a high degree of professional autonomy and responsibility (Figure 6c is an example with full description in Appendix 1)

Figure 6c. Expert Practitioner

Description of Expert Practice	Examples of use of the Scope and Standards of Practice in Diabetes Care
The RDN is recognized within the profession as an expert and has mastered the highest degree of skill in and knowledge of nutrition and dietetics.[2]	JD recognizes the rapidly evolving diabetes medications, technology, and clinical practice standards and decides to pursue the Board Certified-Advanced Diabetes Management (BC-ADM) credential. Through quality assurance and performance improvement (QAPI) projects, JD identifies a need for access to diabetes care and education services beyond the local community. JD works with the interprofessional team to create virtual care and digital health solutions. JD volunteers to participate in the Academy workgroup to review and update the EAL in the topic of diabetes.

Review Appendix 1 Using the Scope and Standards to Advance Practice in Diabetes Care following the references to identify actions for expert practice and to seek out opportunities to build upon expertise.

Figure 5: Resource List

Professional Organizations/Government

- Academy of Nutrition and Dietetics (Academy) Diabetes Dietetic Practice Group
  - https://www.diabetesdpg.org/diabetes-technology/tech-resources
- American Association of Clinical Endocrinologists
- Association of Diabetes Care and Education Specialist
  - Diabetes Technology Education for Healthcare Professionals | danatech
- American College of Obstetricians and Gynecologists
- Certification Board for Diabetes Care and Education
- Centers for Disease Control and Prevention

Guidelines/Consensus

- Academy Evidence Analysis Library
- American Diabetes Association Guide to Nutrition Therapy for Diabetes, 3rd edition (4th Edition in process)
- American Diabetes Association's Standards of Care in Diabetes (updated annually)
- Diabetes Self-management Education and Support in Adults With Type 2 Diabetes: A Consensus Report of the American Diabetes Association, the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association
- Guiding Principles for the Care of People with or at Risk for Diabetes
- National Standards for Diabetes Self-Management Education and Support
- ADCES7 Self-Care Behaviors

Education/Certifications

- Academy Diabetes Certificate of Training
- Commission on Dietetic Registration Certificate of Training in Obesity for Pediatrics and Adults
- Certification Board for Diabetes Care and Education (CBDCE)
- Board Certified in Advanced Diabetes Management (BC-ADM)

Books and Other Resources

- Culture, Foodways and Counseling: A Guide to Culturally Sensitive Nutrition Care in the United States, 2nd Ed.
- Academy Health Professional's Guide to Nutrition, Diabetes, and Pregnancy
- Cultural and Linguistic Competence Health Practitioner Assessment (CLCHPA)
- Harvard University's Implicit Association Test (IAT)
- Pocket Guide to Chronic Kidney Disease and Nutrition Care Process

HOW ARE THE STANDARDS STRUCTURED?

Each of the 7 standards is presented with a brief description of the competent level of practice[2] and a rationale statement explaining the intent, purpose, and importance of the standard. Indicators provide measurable action statements that illustrate applications of the standard. The standards are equal in relevance and importance and are not limited to the clinical setting (Figure 1 has detailed indicator descriptions). The term *appropriate* is used in the standards to mean: selecting from a range of best practice or evidence-based possibilities, one or more of which would give an acceptable result in the circumstances.

HOW CAN I USE THE STANDARDS IN DIABETES CARE TO ELEVATE AND ADVANCE MY PRACTICE AND PERFORMANCE?

While the focus area standards in diabetes care are based on and complement the Standards in the 2024 Scope and Standards for RDNs, they provide additional guidance by providing focus area indicators for 3 levels of practice (competent, proficient, and expert) that are specific to RDNs practicing in diabetes-cardiometabolic care. The 7 standards and subsection titles presented in Figure 1 are from the 2024 Scope and Standards for the RDN, while the indicators for competent, proficient, and expert levels are specific to practice in diabetes care. Some competent-level indicators from the 2024 Scope and Standards for the RDN may also be included if they were adapted to apply to diabetes care and practice (www.cdrnet.org/scope).

The indicators are measurable action statements that illustrate how each standard can be applied in practice. An "X" appears in the Level of Practice columns to indicate level of practice for each indicator. The depth with which an RDN performs each activity will increase as the individual moves beyond the competent level. Several levels of practice are considered in this document; thus, taking a holistic view of the diabetes care Standards is warranted. It is the totality of individual practice that defines a practitioner's level of practice and not any one indicator or standard.

As practitioners progress through the levels of competence from competent to proficient and proficient to expert, their ability to perform the activities described in the indicators becomes more nuanced. For example, an indicator marked "proficient" would be applicable to both proficient- and expert-level practitioners. The expert, because of more extensive knowledge and experience, can more readily adjust their approach based on the specific context of the situation, such as the individual's goals, previous experience with similar situation(s), and knowledge of available resources. This approach is a hallmark of true expertise, showcasing the adaptability and depth of understanding that experts possess (see Scope and Standards of Practice Learning Module for Case Study examples). The indicators are refined with each review of these Standards as expert-level RDNs systematically record and document their experiences, often through use of exemplars.

The Revised 2025 Scope and Standards for RDNs in Diabetes Care (Figure 1) should be used as a self-evaluation tool to support and demonstrate quality practice and competence.[49] More specifically, RDNs can use this document to:

- identify the competencies needed to provide safe, effective, equitable, and quality diabetes-cardiometabolic care and/or services;
- self-evaluate whether they have the appropriate knowledge, skills, experience, and judgement to provide diabetes-cardiometabolic care and/or services for their current or desired level of practice;
- develop a continuing education plan where additional knowledge, skills, and experience are needed;
- demonstrate competence and document learning;
- apply applicable indicators and achieve the outcomes in line with work/volunteer roles, responsibilities, and desired outcomes;
- demonstrate value and competence by identifying additional indicators and examples of outcomes that reflect individual areas of practice/setting(s);
- enhance professional identity and provide a foundation for public and professional accountability as an RDN practicing in the diabetes care focus area;
- support efforts for strategic planning and change management, performance improvement or quality improvement projects, outcomes reporting, and assist management in planning and communicating the nature of diabetes-cardiometabolic care nutrition and dietetics services and resources;
- guide the development of diabetes-cardiometabolic care nutrition and dietetics-related education and continuing education programs, career ladders*, job descriptions, standards of care and services, best practices, protocols, clinical models, competency evaluation tools, career pathways; and advocacy; and
- assist educators and preceptors in teaching students and interns the knowledge, skills, and competencies needed to work in diabetes-focused nutrition and dietetics, lead effectively in interprofessional teams/efforts, and grasp the full scope of this focus area of practice.

RDNs should review the Scope and Standards in Diabetes Care at determined intervals, as regular self-evaluation is important for identifying opportunities to improve and enhance practice and professional performance. RDNs are expected to practice only at the level at which they have demonstrated and documented competence, which will vary depending on education, training, and experience.[49] RDNs are encouraged to pursue opportunities to collaborate and/or additional training and experience in order to maintain currency and expand individual scope of practice[2] within the limitations of their statutory scope of practice.[2] See Appendix 1 to review suggested actions for advancing practice along with a role example that illustrates use of the Scope and Standards in Diabetes Care.

The Scope and Standards in Diabetes Care can also be used as part of CDR's *Professional Development Portfolio* (PDP) recertification process,[62,63]* to develop goals and focus continuing education efforts. CDR's PDP encourages RDNs to use the essential practice competencies to determine professional development needs, develop a learning plan for their 5-year recertification cycle, report completed continuing education, and report application of outcome(s) of self-reflection and learning.[62,64] For information about PDP policy updates and announcements, visit https://www.cdrnet.org/commission-on-dietetic-registration-policy-updates-announcements.

EMERGING ISSUES

The Scope and Standards in Diabetes Care is an innovative and dynamic document. Each new iteration reflects changes and advances in practice (eg, cardiometabolic disease aspects, assessing beyond a patient's A1c, outcome measures, medication, inclusive care), changes to dietetics education standards, regulatory changes, advances in technology, and outcomes of practice audits. The evolving treatment strategies in diabetes and obesity management (eg, Nutrient-Stimulating Hormone-Based Therapies for Obesity or incretin-based therapies) have provided an opportunity for the RDN to advance their role.[29–31,65–68] The RDN in diabetes-cardiometabolic care and services has an essential role as the team member who can lead and coordinate a multidisciplinary/interprofessional team of diabetes and health care professionals. By utilizing the NCP, RDNs have the tools for providing person-centered care that integrates technology, behavioral strategies, medication regimens, and dietary needs congruent with the person's lifestyle. Patient-reported outcome measures (PROMs)[69] on perceived physical, mental and social health are gaining importance, in addition to traditional clinical measurements (eg, A1c, hospital readmission rate). Through a person-centered approach that addresses an individual's physical and psychosocial needs, RDNs have an important role in improving the PROMs of PWDs. They can also help to identify barriers and optimize the use of diabetes technology for PWDs using the ICC framework.[35] Digital health (the convergence of health care and technology) has considerable potential to address key health care challenges in diabetes. Issues such as person and provider burden, therapeutic inertia, access to care and treatment, and costs may be minimized through technological advances. Digital health enables more seamless collection and interpretation of data, thus driving better outcomes at lower cost in less time. Digital technology provides the critical platform for access, reach and efficiency to help accomplish the Quintuple Aims (Figure 7 The Institute for Healthcare Improvement Quintuple Aim).[70,71]

Figure 7: The Institute for Healthcare Improvement Quintuple Aims

Advances in automated insulin delivery systems and algorithms are shifting the focus of RDN support for individuals with type 1 diabetes (T1D) using these devices. Advanced carbohydrate counting is most effective for traditional pump therapy. Algorithms incorporated in automated insulin delivery (AID) systems consider sensor glucose, sensor trend, rate of glucose change, and active insulin to continuously adjust insulin delivery; versus working with less accurate carbohydrate entry or simple qualitative meal announcements. The RDN shifts from teaching advanced carbohydrate counting and math skills to person-centered conversations focusing on overall health and can lead in the expansion of technology access to a broader population. A reduced focus on carbohydrate counting could also potentially lessen the risk of eating disorders.[72]

Diabetes-focused RDNs have the opportunity to lead in harnessing the expanding AI-powered digital health capability. An AI-powered digital health capability can provide a way to build a continuous, data-informed, virtual care model linking people with diabetes-cardiometabolic conditions to expert care on-demand, 24/7. This is the diabetes-focused RDN's opportunity to lead in leveraging technology to transform health care.[36]

Continued clarity and differentiation of the 3 practice levels in support of safe, effective, equitable, and quality practice in diabetes-cardiometabolic care remains an expectation of each revision to serve tomorrow's practitioners and their patients/clients/populations/customers. A continued focus on health equity, cultural humility, improving access to nutrition services for underrepresented groups, and addressing health disparities is critical to diabetes-cardiometabolic care and practice.

SUMMARY

RDNs face complex situations every day. Addressing the unique needs of each situation and applying scope and standards appropriately is essential to providing safe, timely, effective, efficient, equitable, person-centered, quality care and service. All RDNs are advised to conduct their practice based on the most recent editions of the Code of Ethics for the Nutrition and Dietetics Profession, the 2024 Scope and Standards of Practice for RDNs, and applicable federal, tribal, state, and local regulations and facility accreditation standards. The Scope and Standards in Diabetes Care is a complementary document and a key resource for RDNs at all knowledge and

performance levels. These standards can and should be used by RDNs who provide care and/or services to individuals with or at-risk for diabetes to consistently improve and appropriately demonstrate competence and value, and as a professional resource for self-evaluation and professional development. Just as a professional's self-evaluation and continuing education process is an ongoing cycle, these standards are also a work in progress and will be reviewed and updated every 7 years.

Current and future initiatives of CDR and the Academy, as well as advances in diabetes-cardiometabolic care and services, will guide future updates by clarifying and documenting the specific roles and responsibilities of RDNs at each level of practice. As a quality initiative of CDR and the Academy Diabetes Dietetic Practice Group, these standards are an application of continuous quality improvement and represent an important collaborative endeavor.

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

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Figure 1. Standards of Practice

The 2025 Scope and Standards of Practice in Diabetes Care (Scope and Standards in Diabetes Care) provides focus area-specific indicators intended to guide and expand practice for RDNs working in diabetes settings. However, because many standards are not unique to a particular setting or focus area, RDNs using this document are also expected to review the primary indicators in the 2024 Scope and Standards of Practice for RDNs.

Unlike the 2024 Scope and Standards of Practice, which includes only competent-level indicators, this document provides indicators for multiple levels of practice (competent, proficient, and expert) indicated by the columns titled C, P, and E. Consider role(s) and responsibilities in job or volunteer activities to identify applicable indicators. Refer to the information below when determining which indicators are relevant to your specific level of practice:

- X in the "C" column: applies to competent, proficient and expert levels
- X in the "P" column: applies to proficient and expert levels
- X in the "E" column: applies to the expert level

Note: Terms such as patient, client, individual, and population are interchangeable in this resource depending on the indicator wording. A term could also mean patient, client, individual, family, caregiver, advocate*, participant, consumer, customer, or any individual, group, or organization to which an RDN provides care or service.

*See alphabetical Glossary and Acronym List following Standard 7

STANDARD 1. DEMONSTRATING ETHICS AND COMPETENCE IN PRACTICE

Standard

The registered dietitian nutritionist (RDN) demonstrates competence, accountability, and responsibility for ensuring safe, ethical, and quality person-centered care and services through regular self-evaluation, and timely continuing professional education to maintain and enhance knowledge, skills, and experiences.

Standard Rationale

Professionalism in nutrition and dietetics practice is demonstrated through:

- evidence-based practice;
- continuous acquisition of knowledge, skills, experience, judgement, demonstrated competence; and
- adherence to established ethics and professional standards.

Locate additional competent-level indicators for all RDNs in the Revised 2024 Scope and Standards of Practice.

Each RDN in Diabetes Care:		**C**	**P**	**E**
1.1 Adheres to code of ethics				
1.1.1	Adheres to all the applicable code(s) of ethics (eg, Academy and CDR, other national organizations [eg, CBDCE], and/or employer code of ethics)	X		
1.1.2	Performs duties within their individual scope of practice; obtains supervision and refers when appropriate; collaborates with colleagues; adheres to applicable code(s) of ethics (eg, self-disclosure of actual or potential conflicts of interest or fiscal relationships)	X		

Each RDN in Diabetes Care:		C	P	E
1.1.3	Adheres to or develops diabetes nutrition-related policies and procedures to ensure staff adheres to all applicable code(s) of ethics		X	
1.1.4	Evaluates diabetes nutrition-related policies and procedures for expanding responsibilities with consideration for maintaining the RDN's scope of practice		X	
1.1.5	Performs work duties that exemplify the highest scope of practice, supervision, collaboration (eg, sitting on and/or leading ethics committees and/or writing/presenting on diabetes-related ethical issues) and all applicable code(s) of ethics			X
1.2 Ensures competence in practice				
1.2.1	Assesses current performance using focus area standards (eg, Scope and Standards for RDNs in Diabetes Care, Weight Management, Nephrology Nutrition, and other applicable focus areas) and creates a learning plan to advance skills	X		
1.2.2	Uses diabetes nutrition-related evidence-based practice guidelines (eg, EAL, ADA Standards of Care in Diabetes) and participates in continuing education opportunities to inform practice	X		
1.2.3	Evaluates need for continuing education and/or mentoring to strengthen the delivery of person-centered care and services	X		
1.2.4	Trains staff and team members on ethics and best practices for billing procedures		X	
1.2.5	Develops and/or contributes to organization policies, protocols, and guidelines (eg, job descriptions, job-related competencies, career ladders, acceptable performance level) using applicable focus area standards (eg, Diabetes Care, Nephrology Nutrition, Pediatric Nutrition)		X	
1.2.6	Demonstrates through actions, communications, and mentoring the integration of evidence-based practice and research evidence in delivering quality diabetes care and services		X	
1.2.7	Provides mentoring and skill development opportunities to support colleagues and staff in advancing practice to achieve their highest scope of practice		X	
1.2.8	Develops organization policies and protocols to enable practitioners to perform at their highest scope of practice			X
1.3 Adheres to laws and regulations				
1.3.1	Performs duties within statutory scope of practice (ie, state licensure, licensure compact when applicable), certifications (eg, RDN, CDCES, CSR), and other applicable requirements (eg, provider credentialing and billing/reimbursement requirements, ie, National Provider Identifier [NPI] number)	X		
1.3.2	Adheres to federal, state, and local laws and regulations and organization/program policies applicable for diverse practice settings (eg, telehealth, inpatient, private practice) and populations	X		
1.3.3	Complies with HIPAA and organization's policies and standards regarding sharing of protected health information and personally identifiable information.	X		
1.3.4	Identifies regulations, risks, and benefits of using technology resources (eg, EHR, telehealth, artificial intelligence [AI]) such as privacy, confidentiality,		X	

Each RDN in Diabetes Care:		C	P	E
	safety, and effectiveness in achieving outcomes for individuals/clients and organization			
1.3.5	Performs quality improvement processes for ensuring compliance with HIPAA, other federal/state regulations, organization policies and protocols		X	
1.4 Completes self-evaluation to identify needs for continuing education				
1.4.1	Compares individual performance to self-directed goals and for consistency with best practices in diabetes care to identify areas for professional development	X		
1.4.2	Evaluates personal level of practice in diabetes care to identify areas for professional development to expand responsibilities (eg, nutrition focused physical exam and/or CDR Certificate of Training in Obesity for Pediatrics and Adults) or position: • uses self-assessment tools to evaluate knowledge, skills, and practice consistent with best practices and research findings for care of individuals with diabetes according to level of practice (eg, CDR Scope of Practice Decision Algorithm) • seeks formal/informal feedback from colleagues, members of the interprofessional* team, and supervisor(s) • explores new or increased responsibilities for advancing practice (eg, Certification in Diabetes Care and Education Specialist [CDCES])	X		
1.5 Pursues continuing education				
1.5.1	Completes and documents professional development activities related to evidence-based practice in diabetes care in career portfolio (eg, department and/or personnel records; credentialing agency[ies] reporting tool)	X		
1.5.2	Implements plan for professional growth in proficient practice areas of diabetes care including working toward specialty certifications (eg, CDCES) and/or contributing to scholarly work in diabetes-cardiometabolic care		X	
1.5.3	Evaluates programs, tools, and resources supporting RDNs advancing practice in diabetes-cardiometabolic care		X	
1.5.4	Implements plan for professional growth for expert practice areas including specialty certifications (eg, BC-ADM) and/or leading scholarly contributions in diabetes-cardiometabolic care			X
1.5.5	Identifies or develops programs, tools, and resources supporting RDNs to advance practice in diabetes-cardiometabolic care			X

STANDARD 2. STRIVING FOR HEALTH EQUITY

Standard

The registered dietitian nutritionist (RDN) approach to practice reflects the value the profession places on health equity in all forms of interaction when delivering care and/or services to colleagues, customers, students/interns, and when interacting with stakeholders.

Standard Rationale

Health equity is at the core of nutrition and dietetics practice where:

- all individuals have the same opportunity and access to healthy food and nutrition;
- RDNs advocate for a world where all people thrive through the transformative power of food and nutrition; and
- RDNs work to accelerate improvements in health and well-being through food and nutrition.

Locate additional competent-level indicators for all RDNs in the Revised 2024 Scope and Standards of Practice.

Each RDN in Diabetes Care:		**C**	**P**	**E**
2.1 Addresses social determinants of health, nutrition security, food insecurity, malnutrition				
2.1.1	Assesses an individual's access to safe food and water by evaluating: • availability of appropriate food preparation resources (eg, financial, food markets/grocery stores, and equipment for cooking, serving, and safe food storage) • food environment or access (eg, use of food pantry, meal programs, homeless shelter) • plans for emergency situations/disaster events (eg, food and water availability and supply of medications) • risk of health disparity, specific social determinants of health (SDOH), and food security	X		
2.1.2	Incorporates the concepts of the SDOH into programs and services that promote health equity and minimize/eliminate health disparities		X	
2.1.3	Participates in or conducts a needs assessment considering SDOH in collaboration with the interprofessional team and community stakeholders		X	
2.1.4	Develops a process to identify, track, and monitor the population's needs based on: • SDOH (eg, health literacy, socioeconomic status; access to health care services and associated resources) • culture • race • gender • age			X
2.1.5	Collaborates with experts (eg, consultants of diverse background) in the process of providing care or services that minimizes or eliminates disparities (see list in 2.1.4)			X
2.2 Promotes sustainability practices (eg, food systems, food/ingredient/supply choices)				
2.2.1	Considers population with or at-risk for diabetes in the context of sustainability of food, water, packaging, utility usage, and waste management applicable to role and responsibilities (eg, evaluates types of	X		

Each RDN in Diabetes Care:		C	P	E
	foods available at community meal site or at food pantry for meeting the needs of the population served)			
2.2.2	Recognizes potential environmental health issues in foods, food and medication packaging, supply chain, and preparation methods		X	
2.2.3	Examines access to and infrastructure for food and water when coordinating efforts for individuals with or at risk for diabetes in: • responding to disasters and public health emergencies • assisting populations as they adjust for environmental changes • food and medication recalls and shortages • transitioning relocating population		X	
2.2.4	Collaborates with community partners to create or lead diabetes programs and services that promote sustainability practices applicable to the community			X
2.3 Maintains awareness of public health and community nutrition/population health				
2.3.1	Identifies culturally sensitive programs and services with resources for individuals with diabetes, such as: • food banks, food pantries, congregate meal programs • meal delivery services (eg, medically tailored meals, home delivered meals) • diabetes prevention program (CDC DPP) • diabetes self-management education and support (DSMES) • community health workers support • social services • technologies (eg, CGM, food tracking and analysis apps) • drug prescription programs	X		
2.3.2	Collaborates with individuals and the community with or at risk for diabetes having challenges with meeting medication needs and plan (eg, support individuals in the homeless community who have diabetes)	X		
2.3.3	Performs need assessments to identify gaps in community programs and services to support the population with diabetes being served		X	
2.3.4	Contributes to or creates programs for improving access to culturally sensitive programs in collaboration with interprofessional and community partners		X	
2.3.5	Conducts population health research on gaps and needs for community services and programs serving individuals with diabetes			X
2.4 Recognizes the effects of global food and nutrition				
2.4.1	Uses a culturally sensitive approach to consider SDOH that influence an individual's food practices when developing diabetes and nutrition self-care plan	X		
2.4.2	Identifies and/or develops tools and programs for assessing factors that influence food practices, such as: • migration history • dietary patterns • life cycle and gender transitions • food security • financial impacts		X	

Each RDN in Diabetes Care:		C	P	E
2.4.3	Leads research efforts for assessing and addressing factors influencing cultural food practices of individuals with diabetes to personalize and advance diabetes and nutrition care			X

STANDARD 3. ILLUSTRATING QUALITY IN PRACTICE

Standard
The registered dietitian nutritionist (RDN) provides quality services effectively and efficiently using systematic processes with identified ethics, leadership, accountability, and dedicated resources.

Standard Rationale
Delivery of quality nutrition and dietetics care and/or services reflects:

- application of knowledge, skills, experience, and judgement;
- demonstration of evidence-based practice, adherence to established professional standards, and competence in practice; and
- systematic measurement of outcomes, regular performance evaluations, and continuous improvement to illustrate quality practice.

Locate additional competent-level indicators for all RDNs in the Revised 2024 Scope and Standards of Practice.

Each RDN in Diabetes Care:		**C**	**P**	**E**
3.1 Incorporates quality assurance and performance improvement (QAPI) processes				
3.1.1	Participates actively in QAPI, including collecting and documenting relevant data for assessing resource use (eg, personnel, services, fiscal, materials, supplies)	X		
3.1.2	Contributes to quality improvement (QI) projects to address identified gaps in care and service performance: • uses a systematic performance improvement model and national quality and safety data to identify performance improvement criteria (eg, sharps disposal, addressing hypo/hyperglycemia risk) • provides performance improvement results through methods applicable to role and setting (eg, reports, presentations) • documents action plan		X	
3.1.3	Modifies resource management and/or delivery of services for ongoing improvement in achieving individual/client desired outcomes, such as: • metabolic outcomes • quality of life • health care utilization		X	
3.1.4	Collaborates with organization and/or local quality initiatives to identify the need for changes related to diabetes nutrition management (eg, monitoring and medication protocols)		X	
3.1.5	Collaborates with interprofessional team on QAPI initiatives through training and mentoring on the organization's performance improvement model(s)		X	
3.1.6	Analyzes data and success of action plans in reaching individual/client and program outcome goals		X	
3.1.7	Develops implementation strategies for quality improvement activities (eg, identification/adaption of evidence-based practice guidelines/protocols, skills training/reinforcement, and organization support/incentives)			X
3.1.8	Develops systematic processes to monitor and analyze diabetes-related pooled/aggregate data against expected outcomes			X

Each RDN in Diabetes Care:		C	P	E
3.1.9	Directs collation of data from performance improvement projects into publications and presentations			X
3.1.10	Leads state and/or national quality initiatives to identify need for changes related to diabetes nutrition management (eg, technology integration, guidelines, and medication protocols)			X
3.1.11	Leads interprofessional performance quality improvement initiatives across the organization or system for: • guiding the development, testing, and redesign of program evaluation systems • synthesizing and communicating results to stakeholders			X
3.2 Identifies and uses tools for determining/conducting quality improvement (QI)				
3.2.1	Collects data regarding individuals' satisfaction related to diabetes care, education, and related services using validated surveys	X		
3.2.2	Collects data on diabetes and nutrition-related services and performance such as: • population demographics • staffing (client to staff ratio) • cost effectiveness	X		
3.2.3	Evaluates diabetes and nutrition-related services and performance at the individual/department/organization level using recognized quality improvement tools (eg, SWOT Analysis [strengths, weaknesses, opportunities, and threats], PDSA Cycle [plan, do, study, act]), and/or credentialing organizations standards (ADA, ADCES) to summarize, implement, and communicate changes		X	
3.2.4	Analyzes survey data related to program services, customer satisfaction and related services to summarize, implement, and communicate changes		X	
3.2.5	Coordinates and/or leads data collection initiative(s) related to program services and customer satisfaction (eg, ADCES Diabetes Education Accreditation Program [DEAP], ADA Education Recognition Program, [ERP]) using validated and organization-approved tools			X
3.2.6	Establishes department/organization performance benchmarks using national programs and standards and the analysis of data from quality improvement analysis initiatives.			X
3.3 Identifies measures and outcomes				
3.3.1	Participates in care and service evaluations examining program effectiveness by: • using selected protocol(s) or surveys • evaluating and documenting outcomes and collaborating with interprofessional diabetes team as needed	X		
3.3.2	Advocates for the inclusion of RDN-provided MNT and DSMES service components in local, regional, and/or national diabetes data registries	X		
3.3.3	Identifies criteria for data collection (eg, clinical, operational, financial, person-related outcomes)		X	
3.3.4	Evaluates individual/client and service outcomes using identified metrics (eg, Malnutrition Composite Score, eCQM, CMS, National Quality Forum,		X	

Each RDN in Diabetes Care:		C	P	E
	ADA, NCQA, or institution-specific measures) for tracking, benchmarking, and reporting to inform current practices			
3.3.5	Develops long-range strategic plan based on a comparison of quality improvement project data to local/regional/national benchmarks (eg, NCQA, national registries)			X
3.4 Monitors and addresses customer safety				
3.4.1	Follows organization policies and procedures or protocols to ensure safe diabetes care such as: • recommended technology uses (eg, establishing CGM alerts and targets) • potential interactions (eg, medications, foods, nutrients, and dietary supplement[s]) • potential and actual errors and/or hazards (ie, medication and insulin administration, insulin pump/pen set-up)	X		
3.4.2	Applies current safety-related findings impacting care and services for individuals with diabetes including: • dietary supplements (eg, Natural Medicine Database [https://naturalmedicines.therapeuticresearch.com/], MedWatch, Nutrition.gov: Dietary Supplements) • food safety • food and medication recalls and shortages	X		
3.4.3	Develops organization/program protocol in collaboration with the diabetes team for educating individuals/families/other health care professionals regarding: • potential interactions (eg, medications, foods, nutrients, and dietary supplement[s]) • hyperglycemia and hypoglycemia management • safe sharps disposal • bloodborne pathogens and infection control practices • potential incorrect medication administration		X	
3.4.4	Implements error prevention recommendations and provides education based on: • Institute for Safe Medication Practices (www.ismp.org) • Food and Drug Administration (www.fda.gov) • US Pharmacopeia (www.usp.org)		X	
3.4.5	Leads protocol development and reporting process for diabetes care and service safety concerns (eg, incorrect medication administration, drug supply shortages impacting recommended dosages, improper sharps disposal practices)			X

STANDARD 4. DEMONSTRATING LEADERSHIP, INTERPROFESSIONAL COLLABORATION, AND MANAGEMENT OF PROGRAMS, SERVICES AND RESOURCES

Standard

The registered dietitian nutritionist (RDN) provides safe, quality service based on customer expectations and needs; the mission, vision, principles, and values of the organization/business; and integration of interprofessional collaboration.

Standard Rationale

Quality programs and services are designed, executed, and promoted reflecting:

- RDN's knowledge, skills, experience, and judgement;
- knowledge of organization/practice setting operations, culture, and the needs and wants of its customers; and
- competence in addressing the current and future needs and expectations of the organization/business and its customers.

Locate additional competent-level indicators for all RDNs in the Revised 2024 Scope and Standards of Practice.

Each RDN in Diabetes Care:		C	P	E
4.1 Engages in collaborative ready practice				
4.1.1	Collaborates with the interprofessional team as the qualified member to provide evidence-based MNT in diverse practice settings	X		
4.1.2	Develops tools and resources for the interprofessional team to facilitate consistent use of evidence-based nutrition guidelines including: • organization programs • community programs • resources • referrals • HIPAA regulations		X	
4.1.3	Leads interprofessional team collaboration at the organization or systems level to ensure adherence to HIPAA rules in using electronic health record and/or technology			X
4.1.4	Evaluates collaboration efforts between individuals and the interprofessional team to identify gaps in services (ie, organization programs, community programs, resources, referrals) for the population being served			X
4.2 Facilitates referrals				
4.2.1	Utilizes organization protocol or screening tools to identify individual/population need for referral for care or services (eg, behavioral health, social determinants, co-morbid conditions)	X		
4.2.2	Collects data to evaluate the effectiveness of diabetes and nutrition referral process and systems	X		
4.2.3	Establishes network and process for referral to support the overall care of the individual including services deemed outside RDN's scope of practice		X	
4.2.4	Establishes organization referral criteria and process utilizing EHR and population health tools for auto referral (eg, 4 Critical Times)		X	

Each RDN in Diabetes Care:		C	P	E
4.2.5	Evaluates the effectiveness of diabetes and nutrition referral process and systems		X	
4.2.6	Directs referral processes and systems providing training and resources to address individual and population needs			X
4.2.7	Revises diabetes and nutrition referral processes for addressing and removing gaps and barriers to timely services			X
4.3 Manages programs and services				
4.3.1	Collects outcomes data on delivery of diabetes- and nutrition-related programs and services	X		
4.3.2	Identifies existing resources (eg, educational/training tools and materials and staff time for mentoring and scheduling) as needed in the provision of diabetes nutrition services	X		
4.3.3	Collects data for the development/revision of policies, procedures and evidence-based practice tools for diabetes- and nutrition-related services such as therapies, diabetes-related technologies, and as methods of health care and education delivery evolve	X		
4.3.4	Uses established protocols for recommending adjustments (eg, nutrition, medication, referrals) to diabetes-related care plan	X		
4.3.5	Assesses current services provided based on established criteria to ensure culturally relevant practice (eg, EAL, ADA Standards of Care in Diabetes and Academy of Nutrition and Dietetics Guidelines and Positions)	X		
4.3.6	Follows established billing procedures for ensuring ethical and accurate reporting of diabetes nutrition and related services (eg, billing codes such as remote patient monitoring, individual and group encounters)	X		
4.3.7	Complies with accreditation standards (eg, The Joint Commission [www.jointcommission.org]), the National Standards for DSMES, and the ADA Standards of Care in Diabetes	X		
4.3.8	Uses the EHR based on organization policies, system, procedures	X		
4.3.9	Manages delivery of diabetes nutrition-related programs and services by: • conducting ongoing needs assessment of the diabetes community and resources • identifying diabetes education, screening, and prevention services opportunities (eg, DSMES and prevention programs) • identifying local and regional programs that support and optimize provision of diabetes services (eg, networks and volunteer organizations)		X	
4.3.10	Evaluates products, equipment, policies, procedures, and evidence-based practice tools for diabetes nutrition-related services (eg, blood glucose meters and medical food/nutrition supplements) to ensure safe, optimal, and cost-effective delivery of care and services		X	
4.3.11	Develops/revises diabetes nutrition-related programs, protocols, policies, resources and tools based on research and evidence-based guidelines, best practices, trends, and national and international guidelines for practice setting (eg, HIPAA) considering: • psychosocial conditions • cultural background • learning abilities		X	

Each RDN in Diabetes Care:		C	P	E
	• literacy and numeracy			
4.3.12	Manages diabetes education and community prevention programs consistent with national standards for DSMES (ie, ADA Education Recognition Program and/or ADCES Diabetes Education Accreditation Program), and diabetes prevention programs (eg, CDC DPP) in compliance with CMS and state Medicaid regulations		X	
4.3.13	Develops, revises, and maintains the organization or physician-approved pharmacotherapy protocols based on RDN's individual scope of practice for initiating and titrating medications (eg, diabetes-cardiometabolic-related injectables and oral drugs) and associated monitoring (ie, lab orders)		X	
4.3.14	Develops performance criteria for ensuring culturally relevant practice (see Resource List, Figure 5)		X	
4.3.15	Develops tools to monitor ethical and accurate reporting of diabetes and nutrition-related services (eg, billing codes such as remote patient monitoring, individual and group encounters)		X	
4.3.16	Collaborates in designing the EHR system to support interoperable data collection, maintenance, utilization, and automated services (eg, triggers for nutrition services, other referrals, and lab orders)		X	
4.3.17	Reports data demonstrating the value of nutrition services provided in alignment with the organization mission and vision		X	
4.3.18	Prepares reports for organization and accrediting bodies (eg, ADA Education Recognition Program or ADCES Diabetes Education Accreditation Program).		X	
4.3.19	Develops programs using evidence-based guidelines and national standards (eg, ADA and ADCES)			X
4.3.20	Orchestrates the design and delivery of diabetes nutrition-related services in various settings by advocating for: • staffing • program services/goals • budget • program recognition or accreditation (ADCES or ADA or CDC)			X
4.3.21	Leads the interprofessional process of monitoring, evaluating, developing, revising, and implementing programs, protocols, policies, guidelines, and diabetes-related practice tools			X
4.3.22	Guides the development, implementation, and evaluation (eg, accreditation, monitoring utilization, and expanding access) of diabetes care, programs, screening initiatives, and services (eg, MNT, DSMES, CDC DPP) inclusive of those at risk of diabetes, suboptimal and optimal cardiometabolic management			X
4.3.23	Develops practice and delivery models (eg, telehealth, private practice, group classes, and grand rounds) for person-centered diabetes care and services reflecting the Scope and Standards in Diabetes Care			X
4.3.24	Advocates for the development of organization- or physician-approved pharmacotherapy protocols based on level of practice for initiating and titrating medications (eg, diabetes-cardiometabolic-related injectables and oral drugs [eg, incretin-based therapies]) and associated monitoring (ie, lab orders)			X

Each RDN in Diabetes Care:		C	P	E
4.3.25	Advocates for advanced practice activities for the RDN at a systems level based on emerging evidence (eg, creation and promotion of standards of care, consensus recommendations, and new research)			X
4.4 Contributes to, manages, and/or designs food/nutrition delivery systems				
4.4.1	Collects data and provides feedback on current food delivery systems serving individuals with diabetes in health care and community settings to address client needs (eg, cultural, health status, social, economic), outcomes (eg, clinical and psychosocial), and sustainability practices	X		
4.4.2	Reviews and/or collaborates in developing menus (meals and snacks) that address health/nutrition needs throughout the lifespan (eg, infancy, childhood, adolescence, adults) in all practice settings for individuals with diabetes	X		
4.4.3	Participates in the interprofessional process for identifying food and nutrition systems and formularies (eg, medical foods/nutrition supplements, dietary supplements, enteral and parenteral nutrition formularies, and delivery systems) for target population(s)	X		
4.4.4	Evaluates current food delivery systems to identify areas for improvement applicable to setting, role of the RDN, population needs, outcomes, and sustainability practices		X	
4.4.5	Collaborates with an interprofessional team to determine medical food/nutrition supplements, enteral and parenteral nutrition products, in accordance with best practice for diabetes care (eg, Academy Nutrition Care Manual [NCM], ADA Standards of Care in Diabetes, and ASPEN) in all practice settings		X	
4.4.6	Develops diabetes- and nutrition-related guidelines reflecting national standards (eg, ADA Standards of Care in Diabetes, EAL, NCM), applicable federal or state regulations (eg, menu-related regulations and food assistance programs), and approved diet manual to guide foodservice program for the population served and practice setting			X
4.4.7	Designs organization protocols to provide guidance for nutrition care best practices for individuals with diabetes for all practice settings (eg, complex disease states, oral health, GI disorders) and emergency events (eg, utility outages, crisis, natural disasters, pandemics)			X
4.5 Precepts, supervises, and engages in career laddering				
4.5.1	Participates in peer review activities consistent with setting and populations served (eg, peer evaluation, peer supervision, clinical chart review, and performance evaluations)	X		
4.5.2	Mentors and/or precepts dietetics and nutrition students/interns in diabetes and nutrition-related care	X		
4.5.3	Provides mentoring for entry-level and competent-level RDNs in diabetes care and services to support achieving proficient level practice and/or specialist certification		X	
4.5.4	Develops mentoring program opportunities for RDNs in diabetes care and services for advancing practice		X	
4.5.5	Trains professional, technical, and support personnel and evaluates their competence when applicable to role and responsibilities		X	

Each RDN in Diabetes Care:		C	P	E
4.5.6	Provides diabetes nutrition expertise and counsel to education programs related to food and nutrition care and services, industry standards, practice guidelines, and practice roles for nutrition and dietetics practitioners		X	
4.5.7	Mentors interprofessional team members (eg, RDNs, medical students/residents, advanced practice nurses, pharmacists, or behavioral health staff) for achieving proficient-level practice and/or diabetes specialist certification			X
4.5.8	Serves as advisor, preceptor, and/or committee member for graduate-level research			X
4.6 Contributes to a healthy work environment (eg, safety, incident reporting, anti-bullying, personal protective equipment)				
4.6.1	Follows organization guidelines to ensure all team members and individuals are treated fairly, without stigma or bias, held equally accountable regardless of age, size, medical condition(s), ethnicity, race, culture, religion, sexual orientation, and/or gender identity (eg, Pledge of Professional Civility)	X		
4.6.2	Models professional and collaborative behaviors that support clear rules of conduct in the provision of timely, effective care	X		
4.6.3	Orients all team members on the organization's/program's safety requirements for their role(s); and arranges for appropriate training and protective equipment to perform role and tasks		X	
4.6.4	Creates an environment of transparency and respect that encourages incident and close call reporting that leads to improved workplace and customer safety		X	

STANDARD 5. APPLYING RESEARCH AND GUIDELINES

Standard

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

Standard Rationale

Application, participation, and generation of research promotes:

- maintenance and enhanced familiarity with the peer-reviewed literature applicable to nutrition and dietetics and for specific populations and area(s) of practice to support evidence-based practice; and
- improved safety and quality of nutrition and dietetics practice and services.

Locate additional competent-level indicators for all RDNs in the Revised 2024 Scope and Standards of Practice.

Each RDN in Diabetes Care:		**C**	**P**	**E**
5.1 Engages in scholarly inquiry (ie, identifies and uses evidence-based publications and practice guidelines applicable to practice area; and contributes to process of research)				
5.1.1	Applies basic research design, methodology, and research findings by evaluating the: • strength and limitations of original research and evidence-based guidelines • potential bias • reliability • potential practice applications	X		
5.1.2	Collaborates with peers and interprofessional team to share best practices and evidence-based resources	X		
5.1.3	Participates in research activities including: • developing research activities (eg, quality improvement initiatives, person-generated health data collection and evaluation, literature review) • identifying research gaps that may lead to potential research questions • mentoring RDNs and other health care professionals for developing research skills in practice • integrating research findings and evidence into peer-reviewed publications and recommendations for practice		X	
5.1.4	Develops research, academic and/or organization position and practice papers, or other scholarly work as the primary or senior author			X
5.1.5	Facilitates research relevant to diabetes practice as the principal or co-investigator examining diabetes and nutrition care as part of the interprofessional team			X
5.2 Applies critical thinking and judgement for evidence-based practice				
5.2.1	Uses critical thinking to guide practice by: • reading primary peer-reviewed publications (eg, randomized/nonrandomized clinical trials, prospective cohort studies) in diabetes-related care and services • participating in journal clubs and/or professional discussion groups	X		

Each RDN in Diabetes Care:		C	P	E
	• participating in the Academy's Nutrition Research Network • participating in professional networking groups (eg, Academy's Diabetes Dietetic Practice Group (DDPG) or ADCES Connect and Communities of Interest) • using evidenced-based practice guidelines and algorithms and related resources (eg, EAL, ADA Standards of Care in Diabetes)			
5.2.2	Integrates most current evidence-based publications, guidelines, and standards (eg, EAL, AHA, AACE, and ADA) into policies, procedures, and protocols for diabetes-related care and MNT		X	
5.2.3	Contributes to or develops practice-based research by collaborating in research networks and workgroups (ie, Academy's Nutrition Research Network or EAL)		X	
5.2.4	Collaborates with interprofessional and/or interorganizational teams to conduct and disseminate diabetes and nutrition research		X	
5.2.5	Applies advanced training, current research, and emerging practice (eg, type 1 diabetes screening and person-generated data) to manage complex cases (eg, multiple comorbidities and complications)			X
5.2.6	Leads interprofessional and/or interorganizational practice-based research activities including developing publications and presentations for diabetes-related care and services			X
5.2.7	Leads technology integration into clinical practice to expand diabetes technology access and adoption and enable data-informed care including use of person- and population-level data			X

STANDARD 6. PROVIDING EFFECTIVE COMMUNICATIONS AND ADVOCACY

Standard

The registered dietitian nutritionist (RDN) effectively applies knowledge and expertise in communications with customers and the public, and in public policy advocacy efforts.

Standard Rationale

The RDN works with others to achieve common goals by effectively sharing and applying unique knowledge, skills, and expertise in food, nutrition, dietetics, and management services; and in contributing to public policy efforts by advocating for nutrition and dietetics programs and services that benefit patient/clients, individuals, customers, and the public.

The RDN works with others to:

- achieve common goals by effectively sharing and applying unique knowledge, skills, and expertise in food, nutrition, dietetics, and management services; and
- contribute to public policy efforts by advocating for nutrition and dietetics programs and services that benefit patients/clients, and individuals, customers, and the public.

Locate additional competent-level indicators for all RDNs in the Revised 2024 Scope and Standards of Practice.

Each RDN in Diabetes Care:		**C**	**P**	**E**
6.1 Engages in information dissemination through conversations, presentations, publications, media, social media with various audiences				
6.1.1	Identifies relevant diabetes-related nutrition and education publications, resources, and public health trends (eg, diabetes prevalence, prevention, and treatment) when communicating and disseminating information to individuals and health care team	X		
6.1.2	Considers SDOH (eg, food security, access to health care and health information, community environment) when addressing and providing nutrition services	X		
6.1.3	Applies communication styles (ie, verbal and written) to match the target audience considering their background (eg, culture, literacy, numeracy, language)	X		
6.1.4	Recommends current, evidence-based diabetes management educational resources and programs/services (eg, Academy, US Department of Agriculture Choose My Plate at www.choosemyplate.gov , NHLBI, Diabetes DPG website at www.dce.org/home, CDC DPP)	X		
6.1.5	Selects from appropriate recommended web-based/electronic diabetes tools/resources (eg, lifestyle apps; connected diabetes-related technologies, population data platforms for remote monitoring) for meeting the needs of the individual/group/population or target audience	X		
6.1.6	Identifies web-based/electronic diabetes tools/resources (eg, lifestyle apps; connected diabetes-related technologies, population data platforms for remote monitoring) to be used to meet the needs of the individual/group/population or target audience		X	
6.1.7	Evaluates and/or translates resources (eg, public health trends, epidemiological reports, regulatory, accreditation, payment programs, and standards) and applies to practice when disseminating information professionally and publicly		X	

Each RDN in Diabetes Care:		C	P	E
6.1.8	Disseminates evidence-based best practice updates to RDNs and health care professionals in other fields, through formal and informal teaching activities		X	
6.1.9	Manages systematic processes to identify, track, and monitor the use of individual/client resources		X	
6.1.10	Demonstrates the ability to convey complex concepts to match the target audience (eg, organization leadership, other health care practitioners, individuals, and the public)			X
6.1.11	Orchestrates programs and collaborations among researchers, faculty, and/or other stakeholders for advancing health professionals' knowledge and skills (eg, fellowships, research, grand rounds, certificate programs, grant funding)			X
6.2 Participates in advocacy and public policy engagement and outreach				
6.2.1	Functions as diabetes nutrition resource as an active member of local/state organizations, coalitions and industry task forces, committees, or advisory boards (eg, workgroups and task forces, dietetic practice groups)	X		
6.2.2	Participates in diabetes advocacy activities (eg, community diabetes screenings, local ADA and Breakthrough T1D [formerly JDRF] events, NDEP)	X		
6.2.3	Advocates with state and federal legislative representatives regarding benefit of MNT/diabetes management and prevention services on health care costs (eg, responds to Academy Action Alerts and other calls to action)	X		
6.2.4	Assesses individual/client population for situations where diabetes advocacy is needed and participates in efforts to address issue(s) (eg, local, state, and national diabetes coalitions or collaborations)		X	
6.2.5	Coordinates advocacy activities/issues (eg, article development, letters, presentations, and networking events) transparently and in a nonpartisan manner when updating legislators and the community on recent CMS or state laws/regulation changes		X	
6.2.6	Serves as a resource with legislators, payers, and policy makers to communicate the cost and benefits of diabetes care and nutrition services (eg, providing testimony at legislative and regulatory hearings and meetings)		X	
6.2.7	Participates in regional and national diabetes organizations/coalitions/ task forces/advisory boards for health professionals and industry as a recognized subject matter expert		X	
6.2.8	Contributes to the development of comments/recommendations on policy, statutes, administrative rules and regulations			X
6.2.9	Advises at the regional and national level on diabetes nutrition-related issues and education needs of individuals, health care professionals, and organizations as a recognized subject matter expert (eg, consultant to business, industry, national diabetes organizations, and/or media spokesperson)			X

STANDARD 7. PROVIDING PERSON-/POPULATION-CENTERED NUTRITION CARE

Standard

The registered dietitian nutritionist (RDN) provides medical nutrition therapy using the nutrition care process and workflow elements to identify and address nutrition-related problems which a RDN is responsible for treating incorporating the following elements:

- Reviews or obtains nutrition screening data to identify malnutrition or risk of malnutrition
- Obtains and evaluates medical, nutrition, and food-related information for relevance and accuracy
- Identifies and labels nutrition problem(s)/diagnosis(es)
- Develops plan and implements culturally appropriate person-/population-centered nutrition interventions
- Monitors and evaluates person-/intervention-specific indicators and outcomes data to determine whether planned interventions should be continued or revised
- Documents and communicates results with interprofessional team and patients/clients/caregivers

Standards Rationale

Quality nutrition and dietetics patient/client/population care reflects the Nutrition Care Process and workflow elements:

- Nutrition screening -- the preliminary step to identifying individuals who require a nutrition assessment performed by an RDN
- Nutrition assessment -- a systematic process of obtaining and interpreting data in order to make decisions about the nature and cause of nutrition-related problems and provides the foundation for identifying a nutrition diagnosis; an ongoing, dynamic process that involves conferring with patient/client and others, initial data collection, and analysis of patient/client or population needs
- Nutrition diagnosis -- the basis for determining goals and interventions
- Nutrition intervention/plan of care -- consists of two interrelated components- planning with patient/client/caregivers, interprofessional team, and others; and implementation.
- Nutrition monitoring and evaluation -- provides an outcomes management system to assure quality care and to determine whether reassessment and revision of interventions/plan of care is required
- Discharge planning and transitions of care – process with patient/client/caregiver and interprofessional team for facilitating transfer of nutrition care plan and nutrition-related data between care settings

Locate additional competent-level indicators for all RDNs in the Revised 2024 Scope and Standards of Practice.

Each RDN in Diabetes Care:		**C**	**P**	**E**
7.1 Reviews or completes nutrition screening				
7.1.1	Reviews nutrition risk screening data or screens for nutrition and cardiometabolic risk (eg, malnutrition, food security, disordered eating, hypo/hyperglycemia, ASCVD risk estimator/index) using evidence-based screening tools specific to the setting and/or population for informing an individualized intervention plan including referral, if needed	X		
7.1.2	Identifies population-specific nutrition and diabetes-cardiometabolic screening tools (eg, malnutrition, food security, disordered eating, hypo/hyperglycemia)		X	

Each RDN in Diabetes Care:		C	P	E
7.2 Conducts nutrition assessment				
7.2.1	Performs nutrition assessment, including the nutrition focused physical exam (NFPE), consistent with level of practice following organization-approved policies, procedures and standards of care (EAL diabetes-related guidelines, ADCES7 and DSME standards) impacting nutrition and health status in diabetes-cardiometabolic care by evaluating: • adequacy of nutrition intake (eg, micro/macronutrient intake, energy balance, fiber, hydration status/electrolyte balance) considering lifecycle stage, physical activity, appetite, gastrointestinal and comorbid conditions • risk of chronic and acute complications • anthropometric, biochemical data (eg, lipids and glucose data) and vital signs using appropriate population- specific comparison standards • current medication plan for drug-drug, drug-nutrient interactions and side effects • family and individual's health history (eg, risk of chronic conditions and acute complication, food allergies, intolerances, gluten sensitivity or intolerance, lactose intolerance) • psychosocial factors (eg, SDOH, tobacco, alcohol, substance use, sleep patterns, and mental/behavioral health) • individual's and/or caregiver's knowledge, attitudes, and health beliefs (eg, cultural, ethnic, religious, body image, and lifestyle factors) • health literacy and numeracy (eg, ability to read, write, and perform calculations) • current diabetes knowledge (Survey Instruments | Elizabeth Weiser Caswell Diabetes Institute (umich.edu) • individual's and their caregiver's understanding of diabetes-cardiometabolic conditions and its implications as it relates to cultural, ethnic, religious beliefs and traditions	X		
7.2.2	Engages with individual/caregiver to identify personal preferences, current quality of life, and goals for nutrition interventions in support of person-centered care	X		
7.2.3	Assess administration technique of insulin, other injectable or medication delivery systems, (eg, CSII, syringe, or pen); glucagon administration technique; and urine and blood ketone checking	X		
7.2.4	Documents and communicates assessment findings in accordance with organization policies, protocols, and regulations	X		
7.2.5	Interprets assessment data collected from all sources impacting nutrition and health status in diabetes-cardiometabolic care using shared-decision making such as: • dietary modifications associated with comorbidities (eg, heart failure, renal, CVD) • trends in anthropometric indexes (eg, growth and development, weight changes, body composition) • frequency, severity, and consequences of hypo/hyperglycemia (eg, safety, DKA, Hyperosmolar Hyperglycemic State)		X	

Each RDN in Diabetes Care:		C	P	E
	• trends in labs and person-generated data (eg, CGM, vital signs, medication dosing, insulin delivery technology) • medication management in the context of integrated disease state management (eg, end-stage renal disease or heart failure) • preventive care screenings and diagnostic tests • treatment and/or care of individuals with diabetes in accordance with the ADA Standards of Care in Diabetes for delaying micro/macrovascular complications and co-morbidities (eg, immunizations, neuropathy, kidney, liver, autoimmune diseases, and eye/oral health) • nutrition needs for various types of diabetes (eg, cystic fibrosis-related diabetes, post-transplant-diabetes, type 1 and 2 diabetes, gestational diabetes) • patient-reported outcomes (eg, PHQ2 or PHQ9, Diabetes Distress Scale, Problem Areas In Diabetes [PAID] Scale)			
7.2.6	Performs diabetes-focused NFPE such as: • body composition shifts • inspection of sites for injections, CSII, glucose monitoring (eg, sensor or fingertip) • foot inspection and monofilament test • signs of irritation or dry or cracked skin assessing for risk of ulcer, non-healing wounds		X	
7.2.7	Evaluates history of past and current impacts of trauma/stress on dietary intake and diabetes management (eg, mental health, technology resistance, fear of needles, fear of hypo/hyperglycemia, disordered eating, health anxiety)		X	

7.2.8	Develops organization protocols incorporating evidence-based recommendations (eg, ADA Standards of Care in Diabetes [www.diabetes.org]) for integrating individual's health data (eg, person-generated blood glucose, food intake, physical activity, sleep patterns, results from procedures, labs, surgeries, vitals) to:
	• guide more complex decision making, pattern interpretation, and therapy adjustments
	• interpret other diabetes nutrition-related biochemical parameters (eg, metformin and vitamin B 12 deficiency, nutrient deficiencies in celiac disease, anemia) and lab tests associated with definitive diagnosis of diabetes type (eg, c-peptide, T1D risk screening using insulin antibodies)
	• facilitate NFPE for evaluating the physical or clinical findings for signs of:
	  ○ malnutrition (eg, muscle wasting, dry, brittle, or thinning hair and nails)
	  ○ undernutrition
	  ○ disordered eating or eating disorder
	  ○ sarcopenia
	  ○ cachexia
				X

Each RDN in Diabetes Care:		C	P	E
7.2.9	Develops organization protocols for assessing medication plan including evaluating for: • weight loss and body composition shifts associated with changes in food and fluid intake and/or induced by medication action • side effects, tolerances, and appropriateness of medications • appropriate administration technique for injectables (eg, insulin and incretins) including injection site rotation, timing of insulin dose relative to eating, priming, recommended storage, and supply rotation • unexplained hyper/hypoglycemia (eg, physical palpation of insulin injection sites, injection technique, hypoglycemia unawareness, medication dose adjustment, need for glucagon) • current insulin dose, target glucose, insulin-to-carbohydrate ratios or meal doses and insulin sensitivity factor (correction factor) to match individual's needs • insulin delivery methods • optimal blood glucose monitoring schedule compatible with prescribed insulin/medication plan and lifestyle or work schedule			X
7.3 Identifies nutrition diagnosis				
7.3.1	Identifies nutrition problems based on evaluation of assessment data; consistent with level of practice, seeks assistance if needed	X		
7.3.2	Documents nutrition diagnosis(es) incorporating the etiology, signs, and symptoms using standardized terminology (https://www.cdrnet.org/nutrition-care-process-and-terminology) and written statement(s) that are clear and concise; seeks assistance if needed	X		
7.3.3	Prioritize nutrition diagnoses for developing a plan of care/intervention based on severity, safety, needs and preferences	X		
7.3.4	Uses person-first language when communicating the nutrition diagnosis(es) to an individual and/or caregiver, interprofessional team in all settings	X		
7.3.5	Re-evaluates and revises nutrition diagnosis(es) as the individual's condition or status changes (ie, improves, declines, transitions)	X		
7.3.6	Confirms the nutrition diagnosis(es) using advanced clinical reasoning and judgement as part of an interprofessional team by: • integrating information from multiple sources (eg. food intake, biochemical data, therapies, and co-morbid conditions/ complications) • considering complex diabetes-related management issues such as recovery from major surgery/trauma/injury/illness • considering medication adjustment with status changes in diabetes and/or co-morbid conditions/complications (eg, heart failure, weight loss, kidney disease, gastroparesis)		X	
7.4 Develops nutrition intervention/plan of care				
7.4.1	Participates in DSMES services for individuals and groups consistent with level of practice in the following areas: • nutrition and meal planning • medication plan including types, actions, side-effects, appropriate administration (delivery methods - inhaled, oral, injectable), and storage	X		

Each RDN in Diabetes Care:		C	P	E
	• risk for acute complications, prevention and treatment (eg, hyper/hypoglycemia, sick day, glucagon administration) • reducing risk of chronic complications (eg, foot care, blood pressure monitoring, annual eye exam, dental care, cardiometabolic screenings) • blood glucose monitoring			
7.4.2	Prioritizes diabetes-related education and/or counseling based on evidence-based recommendations and nutrition diagnosis considering: • survival skills (eg, meal timing and composition, physical activity, BGM, action and timing of medication[s], and prevention and treatment of hypo-/hyperglycemia) • DSMES/DSMT needs (eg, National DSMES Standards and Algorithm of Care, ADCES7 Self-Care Behaviors, and ADA Standards of Care in Diabetes) • individual's ability or willingness to implement the nutrition plan, and prevention and management of acute and chronic complications • medication plan (eg, when and how to take medications, side effects, injection techniques, and safe disposal of sharps) • sick day guidelines (eg, food and fluid intake) • routine check-up plan (eg, eye and dental visits, lipids, foot examination, and blood pressure evaluation)	X		
7.4.3	Utilizes appropriate behavior change theories (eg, motivational interviewing, behavior modification, and modeling) and shared decision making to facilitate individualized self-care strategies and nutrition prescription	X		
7.4.4	Develops clear and concise S.M.A.R.T. (specific, measurable, attainable, realistic, and timely) goals based on desired outcomes with the individual and/or caregiver considering: • personal preference and needs • readiness to change • SDOH (eg, food security and availability, ability to prepare food, social support, financial considerations) • realistic expectations • food knowledge and literacy • quality of life • health conditions (age, presence of comorbidities, presence of severe hypoglycemia, disordered eating, gastroparesis) • psychosocial factors	X		
7.4.5	Identifies resources and tools to support behavior change goals, such as: • food and portion guides • mobile apps • community organizations and support groups • fitness facilities • other outpatient programs and specialists for referral	X		
7.4.6	Develops nutrition prescription (eg, 2 gram sodium, carbohydrate consistent, gluten free, vitamin/mineral supplementation) using established evidence-based guidelines considering: • medical conditions and treatment goals • food restrictions and intolerances	X		

Each RDN in Diabetes Care:		C	P	E
	• nutrition diagnosis(es)-priority • lifestyle and physical activity • medication plan			
7.4.7	Applies person-first language when communicating the nutrition intervention/plan to an individual and/or caregiver and interprofessional team in all settings	X		
7.4.8	Collaborates with the interprofessional team to develop care and service protocol at 4 critical times: • diagnosis • annually or more often if metabolic outcomes are not met • when complicating condition(s) develop • transition in life occurs (eg, using new technology, lifecycle stage, medication changes)		X	
7.4.9	Determines the need for initiation and/or adjustment of pharmacotherapy using established protocol considering: • nutrition • physical activity • growth and development • medications • blood glucose and/or CGM data • diabetes progression • comorbidities		X	
7.4.10	Consults on and/or manages enteral/parenteral nutrition and specialized nutrition support therapy, including formula selection and adjustment based on individual's laboratory results using approved protocols		X	
7.4.11	Educates individuals on decision-making skills to manage glucose, with considerations of cultural and psychosocial factors, and in various dynamic situations, (eg, trauma, acute diabetes-related complications, stress, and life-stage transitions)		X	
7.4.12	Provides education and training to individuals/caregivers on diabetes-related technologies (eg, glucose meter, CGMs, insulin pumps)		X	
7.4.13	Collaborates with interprofessional team in developing infrastructure (eg, electronic health record system) for facilitating referrals at 4 critical times: • diagnosis • annually or more often if metabolic outcomes are not met • when complicating condition(s) develops • transition in life occurs (eg, using new technology, lifecycle stage, medication changes)			X
7.4.14	Directs person-centered interventions and education using shared decision making, clinical judgement/experience, evidence-based practice and current body of advanced knowledge regarding the individuals and/or populations being served (eg, culture, psychosocial, belief structure, and practices)			X
7.5 Implements nutrition monitoring and evaluation				
7.5.1	Assesses individual's/caregiver's ability to follow the nutrition intervention/plan of care by:	X		

Each RDN in Diabetes Care:		C	P	E
	• determining if nutrition intervention/plan of care has been implemented as recommended • evaluating if nutrition diagnosis is still active, is resolved, or can be discontinued • performing a nutrition reassessment for potential new nutrition diagnosis(es) (assessment details listed in indicator 7.2.1) • identifying barriers to following diabetes-cardiometabolic care plan • evaluating Quality of Life measures (eg, DQOL) • evaluating intervention plan based on standardized nutrition care measurable outcome indicator(s) • modifying intervention strategies as needed (eg, culture, psychosocial, change in living/care situation, progress/change in goal, change in health status)			
7.5.2	Reassesses individual's need for a revised nutrition intervention by: • evaluating behavior change stage and learning style • assessing factors interfering with intervention outcomes and access to services • conducting diabetes-focused NFPE (refer to indicator 7.2.3) • evaluating treatment barriers including mood and cognitive function changes, treatment delays, and signs of relapse for providing more advanced treatment options (transition of care or referral)		X	
7.5.3	Assesses individuals with complicated and dynamic situation (eg, critical care, wound management, and for factors related to comorbid conditions/complications) to adjust the intervention plan and protocols by drawing on practice experience, clinical judgement, and evidence-based practice			X
7.6 Participates in coordination and transitions of care				
7.6.1	Contributes to, develops, documents, and communicates, diabetes-cardiometabolic care-related nutrition care and education plan, and provides appropriate education materials, counseling, and resources (eg, arranging for home delivered meals) to support person-centered care: • as individual returns home or transitions to another care setting (eg, acute rehab or assisted living) • to communicate the plan of care to referring provider and associated interprofessional team members • to refer for follow-up with an RDN specializing in diabetes and/or referral to DSMES services	X		

Advocate: An *advocate* is a person who provides support and/or represents the rights and interests at the request of the patient/client. The person may be a family member, or an individual not related to the patient/client who is asked to support the patient/client with activities of daily living or is legally designated to act on behalf of the patient/client, particularly when the patient/client has lost decision-making capacity.

(Adapted from definitions within The Joint Commission Glossary of Terms and the Centers for Medicare and Medicaid Services, Hospital Conditions of Participation)

Interprofessional: The term *interprofessional* is used in this evaluation resource as a universal term. It includes a diverse group of team members that work collaboratively, depending on the setting and needs of the individual/patient/client.

Social Determinants of Health (SDOH): Based on the Centers for Disease Control and Prevention definition, *social determinants of health* are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. These conditions include economic stability, education, social and community context, health/healthcare, and built environment. Specific to the nutrition and dietetics field, poverty limits access to healthy foods and safe neighborhoods; more than education is a predictor of better health.

Acronyms

- AACE: American Association of Clinical Endocrinology https://pro.aace.com/clinical-guidance/diabetes
- AADE7: ADCES7 Self-Care Behaviors https://www.adces.org/diabetes-education-dsmes/adces7-self-care-behaviors
- Academy: Academy of Nutrition and Dietetics https://www.eatrightpro.org
- ADA: American Diabetes Association https://diabetes.org/
- ADCES: Association of Diabetes Care and Education Specialists https://www.adces.org/
- AHA: American Heart Association https://www.heart.org/
- ASPEN: American Society for Parenteral and Enteral Nutrition https://www.nutritioncare.org
- BC-ADM: Board Certified Advanced Diabetes Management https://www.adces.org/dces-career/bc-adm-credential
- BGM: Blood glucose monitor
- CBDCE: Certifying Boards for Diabetes Care and Education https://www.cbdce.org/
- CDC DPP: Centers for Disease Control and Prevention Diabetes Prevention Program -- https://www.cdc.gov/diabetes-prevention/index.html
- CDCES: Certified Diabetes Care and Education Specialist https://www.cbdce.org/
- CDR: Commission on Dietetic Registration https://www.cdrnet.org
- CGM: Continuous Glucose Monitor https://diabetes.org/advocacy/cgm-continuous-glucose-monitors

- CMS: Centers for Medicare & Medicaid Services Quality Measures https://www.cms.gov/medicare/quality/measures
- CSII: Continuous subcutaneous insulin infusion pump
- CSR: Board Certification as a Specialist in Renal Nutrition https://www.cdrnet.org/board-certification-as-a-specialist-in-renal-nutrition
- CVD: Cardiovascular disease
- DKA: Diabetic Ketoacidosis
- DQOL: Diabetes Quality of Life measures https://diabetesjournals.org/spectrum/article/17/1/41/1784/Development-and-Validation-of-the-Diabetes-Quality
- DSMES: Diabetes Self-Management Education and Support https://www.cdc.gov/diabetes/education-support-programs/index.html
- DSMT: Diabetes Self-Management Training https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/diabetic-self-management-training-dsmt-accreditation-program
- EAL: Evidence Analysis Library (membership or subscription required) https://www.andeal.org/
- eCQM: electronic Clinical Quality Measure https://www.cdrnet.org/GMCS
- HIPAA: Health Insurance Portability and Accountability Act https://www.cdc.gov/phlp/php/resources/health-insurance-portability-and-accountability-act-of-1996-hipaa.html
- MNT: Medical Nutrition Therapy
- NCQA: National Committee for Quality Assurance https://www.ncqa.org/
- NHLBI: National Heart, Lung and Blood Institute https://www.nhlbi.nih.gov/
- PHQ2: Patient Health Questionnaire-2 https://cde.nida.nih.gov/instruments
- PHQ9: Patient Health Questionnaire 9 https://cde.nida.nih.gov/instruments
- T1D: Type 1 Diabetes

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Appendix 1: Using the Scope and Standards to Advance Practice in Diabetes Care

Competent practitioners critically evaluate their own practice; improve performance based on self-awareness, applied science, and feedback from others; and engage in continuing education to enhance skills, proficiency, and knowledge. Self-evaluation is particularly important when shifting roles throughout the practitioner's career. (CDR Definition of Terms; see Competence Section for Levels of Practice)

When performing a self-evaluation, the RDN:

- uses the Scope and Standards in Diabetes Care and other applicable focus area standards (eg, Renal Nutrition, Weight Management, Nutrition Support) to self-evaluate level of practice and to determine areas to strengthen;
- applies evidence-based research and resources including nutrition-related guidelines from professional organizations (eg, American Diabetes Association [ADA], American Heart Association [AHA], National Kidney Foundation [NKF], American Society for Parenteral and Enteral Nutrition [ASPEN]) and Academy of Nutrition and Dietetics (Academy) Evidence Analysis Library (EAL) Projects for information and to implement appropriate interventions;
- updates their professional development plan to include applicable essential practice competencies for diabetes care and service; and considers working toward (competent level) or applying for/maintaining the Certified Diabetes Care and Education Specialist (CDCES) or Board-Certified in Advanced Diabetes Management (BC-ADM) credential(s) (proficient or expert levels).

Determine your actionable goals based on your self-assessment and career priorities.

Competent	Proficient	Expert
Description		
The RDN consistently provides safe and reliable services by employing appropriate knowledge, skills, behaviors and values in accordance with accepted standards for the profession.[2]	The RDN has obtained operational job performance knowledge and skills, and consistently provides safe and reliable service.[2]	The RDN is recognized within the profession as an expert and has mastered the highest degree of skill in and knowledge of nutrition and dietetics.[2]
Responsibilities and Approaches		
• Implements MNT, including evidence-based nutrition and diabetes management care plans considering: ✓ Impact of culture and psychosocial environment ✓ Pathophysiology of diabetes-cardiometabolic conditions ✓ ADCES7 Self-Care Behaviors	In addition to competent-level approaches: • Provides person-centered MNT care and services considering: ✓ Current clinical practice guidelines and evolving science ✓ Pharmacology- appropriateness of medication plans and make recommendations for adjustments (eg, using organization-approved protocols)	In addition to competent and proficient-level approaches: • Fosters a person-centered care culture by promoting and educating on: ✓ Current clinical practice guidelines and evolving science ✓ Cultural humility and addressing psychosocial environment ✓ Pharmacology options

Competent	Proficient	Expert
✓ Shared decision making regarding various options for diabetes management therapy ✓ ADCES Identify-Configure-Collaborate (ICC) Technology Framework • Accesses resources/clinical guidelines for diabetes care (Resource Figure 5) • Recognizes when to make a referral to other providers (eg, activity exceeds individual scope of practice) or local resources (eg, food banks) • Obtains diabetes-focused continuing education • Demonstrates the ability to teach the use of: ✓ Glucose monitoring devices ✓ Insulin and injectables • Participates in local diabetes-related organizations • Identifies evidence-based educational materials to support people with diabetes (PWD) • Participates in quality improvement (QI) projects (eg, collecting and evaluating data) • Obtains greater than 1000 hours of supervised diabetes clinical-focused care with a qualified RDN/CDCES to become eligible to apply to take the CDCES examination	✓ Current technologies (eg, Automated Insulin Delivery [AID], activity and food trackers and analysis, glucose monitoring devices) ✓ ADCES ICC Technology Framework (eg, onboarding and configuring the device settings for a person with diabetes [PWD], ongoing collaboration with PWD in interpreting and using glucose and other health data) ✓ Assess appropriateness of pharmacotherapy plans and make recommendations for adjustments (eg, using organization-approved protocols) • Guides PWD to initiate diabetes technology and medications • Participates in national diabetes-related organizations • Adapts or creates peer-reviewed educational materials • Recognizes QI needs in practice setting and proposes QI projects and research questions	✓ Shared decision making regarding various options for diabetes management therapy ✓ Person-centered technology (eg, AID, activity and food trackers and analysis, glucose monitoring devices) • Translates emerging research findings and evidence-based guidelines into personal clinical practice • Develops or revises protocols, policies, clinical workflows and guidelines, including organization-approved protocols for medication/insulin adjustment • Trains staff on use of protocols; creates workflows that define roles and responsibilities • Leads or contributes to organization integrating diabetes technology; performs QI projects to collect data and effect on clinical practice; expands diabetes technology access and adoption; and enables data-informed care models • Leads organization in developing population management strategies • Mentors and leads RDNs and other members of the diabetes-cardiometabolic care team • Obtains leadership role in national diabetes-related organizations

Competent	Proficient	Expert
		• Trains and teaches colleagues on the interprofessional team on diabetes care and clinical practice guidelines • Supervises and guides the identification and/or creation of educational materials to meet the needs of the population served by setting • Designs, initiates, and executes or collaborates and participates in research projects including QI studies
Actionable Goals to Advance Practice		
• Complete the Diabetes Certificate of Training offered by the Academy of Nutrition and Dietetics and/or the CDR Certificate of Training in Obesity for Pediatrics and Adults • Review resources on the Diabetes Dietetic Practice Group website • Acquire continuing professional education (CPE) related to pharmacology to advance knowledge in latest medications for people with diabetes • Attend educational programs on the American Diabetes Association Standards of Care (https://professional.diabetes.org/) • Identify a diabetes RDN mentor(s) • Determine who would be qualified to evaluate competence in performing desired activities such as teaching how to use diabetes monitoring	• Obtain advanced diabetes-related certification, eg, Certified Diabetes Care and Education Specialist (CDCES), Certified Specialist in Obesity and Weight Management (CSOWM) • Become a Fellow of the Academy of Nutrition and Dietetics (FAND) • Attend the Diabetes Technology conference (https://www.adces.org/conferences/conferences) • Participate in a seminar on health equity (eg, seminar related to health equity or focused to needs of a specific population [eg, culture, food insecurity]) • Attend the CORE Concepts training by ADCES	• Attend the Academy Leadership Institute • Become a Fellow of the Association of Diabetes Care and Education Specialists (FADCES) • Volunteer for national organizations (eg, writing or contributing to practice papers and serving on a committee) • Obtain Board-Certified in Advanced Diabetes Management (BC-ADM) or another certification related to population being served, eg, Board Certified Specialist in Renal Nutrition (CSR)

Competent	Proficient	Expert
devices and the interpretation of results		
Examples of use of the Scope and Standards of Practice in Diabetes Care *(see introduction for foundational self-evaluation resources)*		
JD is an experienced RDN working in a primary care clinic where they routinely provide MNT counseling and education for individuals with diabetes (and related cardiometabolic conditions) because there is no diabetes education program in the community. JD identifies a professional goal of qualifying for the CDCES credential. The RDN performs regular self-evaluation of current level of practice using the Scope and Standards in Diabetes Care to determine areas to strengthen with the goal of achieving the proficient practice level. The RDN reviews the criteria for the CDCES certification examination to update professional development plan for successful CDCES credential attainment. JD decides to join local diabetes-related professional organizations and begins developing evidence-based educational materials.	JD has obtained the CDCES credential and is now a clinical nutrition manager overseeing inpatient and outpatient nutrition services. JD wants to develop an accredited DSMES service. JD refers to the Scope and Standards of Practice in Diabetes Care as a tool for developing position descriptions, competence standards, and assessment tools; guiding self-evaluation and professional development activities with RDN staff; and ensuring a quality program and compliance with accreditation program standards. JD's professional goal is to reach expert level. To achieve this, JD volunteers on local and national diabetes-related organizations and begins developing guidelines for operating at the top of RDN scope of practice in therapy adjustments and recommendations (eg, medications and technology).	JD recognizes the rapidly evolving diabetes medications, technology, and clinical practice standards and decides to pursue the BC-ADM credential. Through quality assurance and performance improvement (QAPI) projects, JD identifies a need for access to diabetes care and education services beyond the local community. JD works with the interprofessional team to create virtual care and digital health solutions. JD volunteers to participate in the Academy workgroup to review and update the EAL in the topic of diabetes.

Roles and responsibilities vary across diabetes practice settings. Outcome indicators in the Scope and Standards in Diabetes Care may not apply at a point in time. Select approaches described in this Appendix that would support current or desired role and responsibilities and enhance knowledge and skills with the goal of advancing practice and achieving career goals.

For questions, please email quality@eatright.org