Commission on Dietetic Registration
the credentialing agency for the Academy of Nutrition and Dietetics

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Dietetics Workforce Capacity and Demand: 2025-2035 Projections

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Executive Summary

The Commission on Dietetic Registration (CDR) commissioned this project to develop an updated framework for projecting the future supply and demand of Registered Dietitians (RDs) and Dietetic Technicians, Registered (DTRs). Since the previous national workforce study was completed in 2012, the dietetics profession has evolved considerably, with changes in workforce participation, practice settings, healthcare delivery, telehealth, and the availability of workforce data. This report presents a new workforce projection framework that independently estimates workforce supply and demand across nine practice areas using updated registry, survey, and demand-driver data. The framework is accompanied by an interactive dashboard that enables users to explore baseline projections, evaluate alternative scenarios, and assess the effects of key modeling assumptions.

Under the baseline assumptions, the national RD workforce is projected to experience a relatively stable workforce shortage over the 2025–2035 projection period, while both workforce supply and demand for DTRs are projected to decline. Although the national projections remain relatively stable, they mask substantial differences across practice areas. Clinical – Inpatient is projected to transition from a workforce shortage to a modest surplus, whereas Clinical – Long-Term Care, Clinical – Telehealth, and Food & Nutrition Management experience widening workforce shortages. These findings demonstrate that workforce challenges are likely to be concentrated within specific practice areas rather than uniformly distributed across the profession. By combining updated data, practice-area-specific projections, scenario analysis, and an interactive dashboard, the framework provides CDR with a practical tool for supporting workforce planning in an evolving healthcare environment.

I. Introduction

A. Background

1. Evolution of the Dietetics Profession

The role of dietetics professionals has evolved substantially over the past several decades in response to changes in healthcare delivery, advances in nutrition science, and increasing recognition of the importance of nutrition in disease prevention and management (Academy of Nutrition and Dietetics, 2024a and 2024b). Registered Dietitians (RDs) and Dietetic Technicians, Registered (DTRs) provide nutrition-related services across a wide range of clinical and nonclinical settings, including hospitals, outpatient clinics, long-term care facilities, community nutrition programs, education and research, business and consultation, food and nutrition management, and, increasingly, telehealth. As the profession has expanded, the distribution of practitioners across these practice areas has continued to evolve in response to changing healthcare needs, technological innovation, and broader economic and policy trends.

2. Importance of Workforce Planning

Effective workforce planning requires understanding both the current workforce and the factors that are likely to influence future workforce supply and demand. Reliable workforce projections support educational planning, workforce development, strategic investment, and policy decisions by identifying practice areas where workforce shortages or surpluses may emerge (World Health Organization, 2010). Because the factors influencing workforce demand differ substantially across practice settings, projections at the overall profession level may mask important variation within individual practice areas. Consequently, workforce planning benefits from a framework that separately considers the diverse environments in which dietetics professionals practice.

3. Motivation for Updating the 2012 Study

In 2012, the Commission on Dietetic Registration (CDR) sponsored the development of a national workforce projection model to estimate the future supply and demand for dietetics professionals. The model projected workforce supply and demand separately across multiple practice areas using the best data and assumptions available at the time (Hooker et. al., 2012).

Since that study was completed, the profession has continued to evolve. Workforce participation has changed, practice area distributions have shifted, telehealth has emerged as an important practice setting, and new data sources have become available for estimating workforce supply and demand. In addition, changes in healthcare delivery, technology, reimbursement, and public policy have created new sources of uncertainty that were not reflected in the original projection framework.

These developments motivated the creation of an updated workforce projection model. Building on the foundation established by the 2012 study, the current framework incorporates updated data sources, revised practice area definitions, independent models for workforce supply and demand, and an interactive dashboard that enables users to evaluate alternative assumptions and future scenarios. Together, these enhancements provide a more flexible and transparent framework for workforce planning.

B. Objectives

The objective of this project was to develop an updated workforce projection framework capable of estimating the current and future supply and demand for RDs and DTRs across nine practice areas. Specifically, the project sought to:

1. Estimate the current and future workforce supply for RDs and DTRs using recent registry data, survey data, and historical workforce trends.
2. Estimate the current and future workforce demand using practice-area-specific demand drivers that reflect changes in healthcare utilization, demographics, economic conditions, and other external factors.
3. Identify potential workforce shortages and surpluses at both the overall profession level and within individual practice areas.
4. Evaluate the potential effects of alternative future conditions through predefined scenario analyses and an interactive dashboard that enables users to explore the sensitivity of the projections to key modeling assumptions.

The resulting framework is intended to support workforce planning by providing a flexible, transparent, and data-driven approach for evaluating future workforce supply and demand under a range of plausible assumptions.

II. Conceptual Framework

A. Overview

This study projects the future supply and demand for Commission on Dietetic Registration (CDR)-credentialed practitioners through 2035, separately for RDs and DTRs. The model is designed to provide a transparent, flexible framework for evaluating how changes in workforce supply, healthcare utilization, population demographics, educational pipelines, and other external factors may affect the future dietetics workforce.

The model consists of two complementary components: a supply model and a demand model. The supply model projects the future availability of CDR-credentialed practitioners, while the demand model projects the future need for dietetics services across nine practice areas. These components are developed independently and then compared to identify potential workforce shortages or surpluses over the projection period.

B. Workforce Structure

The model estimates workforce supply and demand separately for the two CDR credentials:

- **Registered Dietitians** are food and nutrition experts who complete accredited education and supervised practice requirements, pass a national credentialing examination, and maintain continuing professional education. They practice dietetics, provide medical nutrition therapy, nutrition assessment, counseling, and nutrition management across a wide range of clinical and community settings.
- **Dietetic Technicians, Registered** work under varying levels of supervision by Registered Dietitians or other healthcare professionals to support nutrition care and foodservice operations. They complete accredited education, pass a national credentialing examination, and maintain continuing professional education. They assist with nutrition screening, patient education, quality improvement, and food and nutrition management in clinical and community settings.

The projection framework estimates workforce supply and demand for the following nine practice areas:

1. **Clinical – Inpatient.** Practitioners provide nutrition assessment, medical nutrition therapy, and related clinical nutrition services to hospitalized patients during inpatient admissions.
2. **Clinical – Hospital Outpatient.** Practitioners provide nutrition services within hospital-based outpatient settings, including emergency departments, outpatient specialty clinics, infusion centers, and other hospital-operated ambulatory services.
3. **Clinical – Office-Based.** Practitioners provide nutrition services in physician offices, private practices, community clinics, and other non-hospital outpatient settings, including nutrition counseling, chronic disease management, preventive care, and medical nutrition therapy.
4. **Clinical – Long-Term Care.** Practitioners provide nutrition services for residents of skilled nursing facilities, nursing homes, assisted living facilities, and other residential care settings.

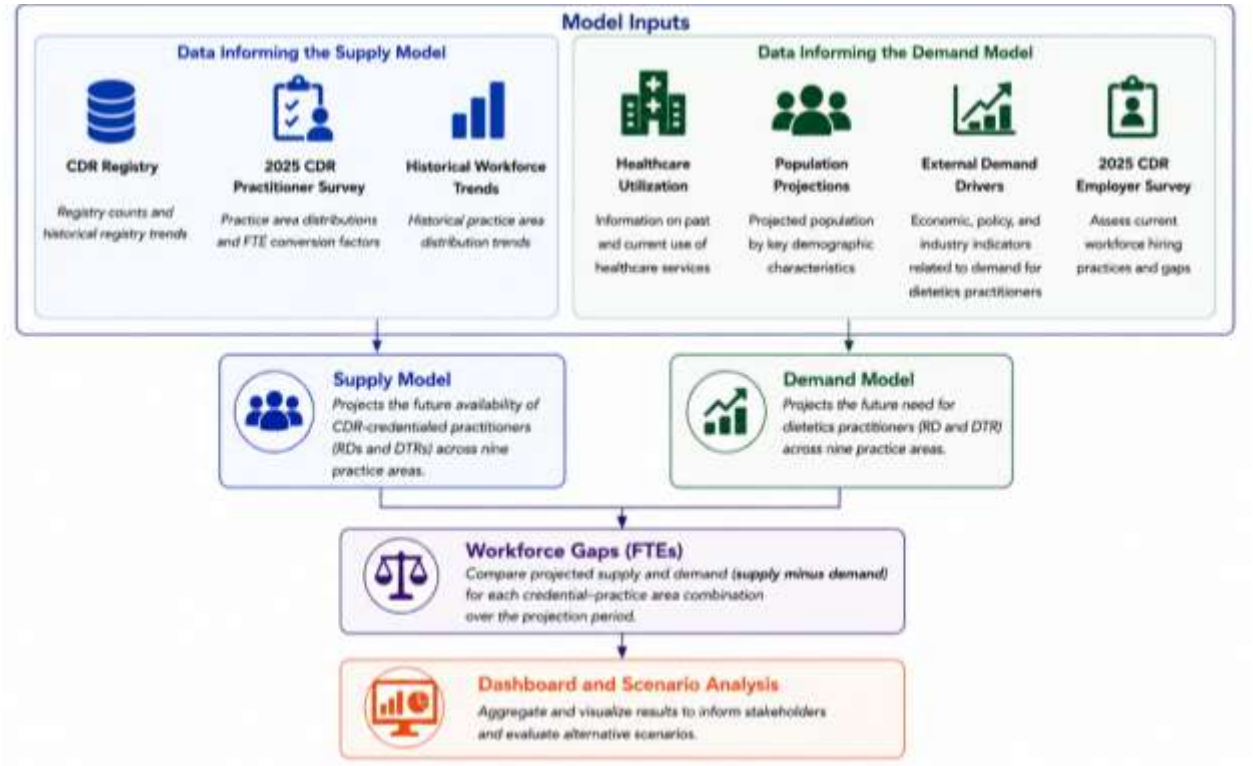
5. **Clinical – Telehealth.** Practitioners deliver nutrition services remotely using telecommunication technologies, including medical nutrition therapy, nutrition counseling, patient education, and follow-up care.
6. **Community Nutrition.** Practitioners develop, implement, and evaluate nutrition programs designed to improve the health of communities and populations through public health agencies, community organizations, schools, and food assistance programs.
7. **Education and Research.** Practitioners educate future dietetics professionals and advance the science of nutrition through teaching and research activities.
8. **Business and Consultation.** Practitioners apply nutrition expertise in business, consulting, communications, industry, regulatory, entrepreneurial, and other nontraditional practice settings.
9. **Food and Nutrition Management.** Practitioners manage foodservice operations in healthcare, education, government, and commercial settings, including responsibilities related to menu planning, food safety, budgeting, procurement, personnel management, and regulatory compliance.

Workforce supply is measured in full-time equivalents (FTEs), rather than headcount, to account for differences in workforce participation and hours worked across credentials and practice areas.

C. Modeling Approach

The model combines information from multiple national data sources to estimate historical workforce supply and demand and project both quantities through 2035. Figure 2.1 provides an overview of our modeling approach.

Figure 2.1. High-level overview of the supply and demand modeling framework.



The supply model uses historical CDR registry data to project the future number of credentialed practitioners. Projected practitioners are allocated across practice areas using survey-derived practice distributions and converted to effective workforce supply using practice area-specific FTE conversion factors. The demand model estimates workforce demand independently for each practice area using one or more practice area-specific demand drivers. For three clinical practice areas (Inpatient, Outpatient, and Office-Based), demand is estimated from national healthcare utilization data by identifying nutrition-sensitive healthcare encounters and projecting age- and sex-specific encounter rates using national population projections. For the remaining practice areas, demand is projected using external indicators selected to represent the primary drivers of workforce need within each setting, including federal nutrition assistance programs, educational activity, research funding, employment statistics, foodservice activity, and other publicly available data sources.

By modeling supply and demand independently, the framework provides a transparent basis for evaluating future workforce gaps while allowing each component of the model to evolve according to its own underlying drivers.

D. Model Assumptions and Scenario Analysis

1. Baseline Scenario

The base model incorporates two types of parameters. The first consists of **data-driven parameters**, which are estimated directly from historical data sources and generally remain fixed unless updated data become available. Examples include historical registry trends, practice area distributions, age-specific healthcare utilization rates, historical demand driver growth rates, and population projections.

The second consists of **assumption-based parameters**, which represent quantities that cannot be estimated directly from available data and therefore require assumptions informed by literature review, subject matter experts, and stakeholder input. Examples include workforce participation assumptions, baseline workforce equilibrium assumptions, and other model parameters for which multiple plausible values exist. The model includes recommended default values for all assumption-based parameters, which define the baseline projection.

2. “What If?” Scenarios

In addition to the baseline projection, the model supports a series of predefined **"What If?" scenarios** that represent coherent alternative futures. Each scenario simultaneously modifies multiple assumption-based parameters to evaluate the potential effects of changes such as workforce participation, educational capacity, reimbursement policy, healthcare delivery, technological adoption, or other emerging trends. By modifying groups of related assumptions together, these scenarios provide more realistic assessments of how alternative future conditions could influence workforce supply, demand, and shortages.

3. Dashboard

To facilitate future updates and scenario analyses, the model has been implemented as an interactive dashboard application. The dashboard allows users to modify assumption-based parameters, evaluate predefined "What If?" scenarios, and visualize projected workforce supply, demand, and workforce gaps

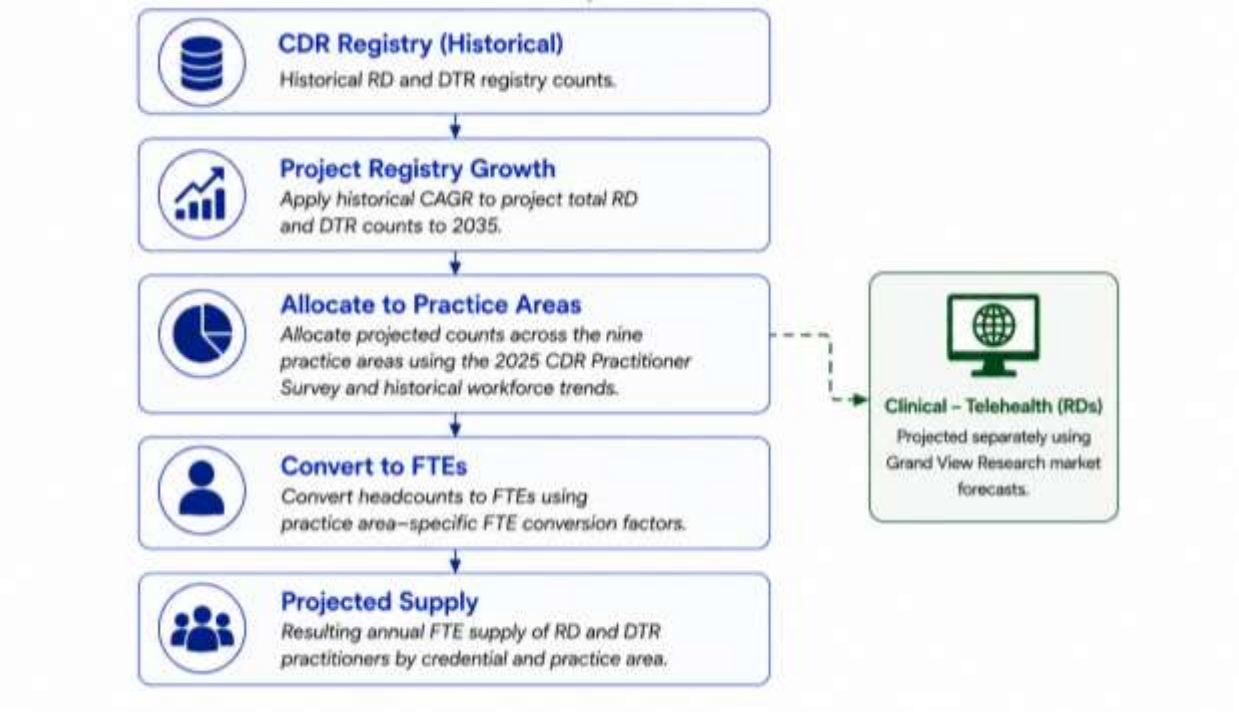
across credentials, practice areas, and projection years. This framework provides a flexible tool for evaluating future workforce planning questions.

III. Supply Model

A. Overview

The supply model estimates the number of CDR-credentialed practitioners (in terms of FTEs) available in each year of the projection period, separately for RDs and DTRs and for each of the nine practice areas. The model first establishes baseline supply in 2025 and then projects changes in supply through 2035. Figure 3.1 provides an overview of the supply modeling process, illustrating how historical registry data are projected forward, allocated across practice areas, converted to FTEs, and combined to estimate projected workforce supply.

Figure 3.1. Supply model workflow for projecting future availability of RD and DTR practitioners across nine practice areas.



Supply is estimated through a series of sequential calculations. The model first projects the total number of credentialed practitioners for each credential using historical registry trends. These projected practitioners are then allocated across practice areas using survey-based practice area distributions and historical workforce trends, after which practitioner headcounts are converted to full-time equivalent (FTE) workforce estimates using credential- and practice area-specific conversion factors. The resulting FTE estimates represent projected workforce supply for each credential, practice area, and year. The same general calculation is used to estimate both baseline and projected supply:

$$S_{cpt} = R_{ct} \times \pi_{cpt} \times q_{cp}$$

where:

- S_{cpt} is the estimated FTE supply for credential c, practice area p, and year t;

- R_{ct} is the number of practitioners in the CDR registry with credential c in year t;
- π_{cpt} is the proportion of practitioners with credential c allocated to practice area p in year t; and
- q_{cp} is the FTE conversion factor for credential c and practice area p.

For the baseline year, registry counts, practice area distributions, and FTE conversion factors are derived from the most recent available CDR registry and the 2025 CDR Dietetics Workforce Capacity and Demand Project Practitioner Survey (2025 CDR Practitioner Survey). For subsequent years, total registry counts and practice area distributions are projected forward, while the baseline FTE conversion factors are held constant.

Conceptually, changes in the registry reflect the combined effects of practitioners entering and leaving the credentialed population. Because the available registry data do not identify individual entrants and exits, the model does not estimate these flows separately. Instead, it projects the overall registry directly from observed historical trends, thereby capturing their combined net effect. Sections 3.2 and 3.3 describe, respectively, how the baseline values and changes over time are estimated for each component of the supply model.

B. Baseline Supply

1. Baseline Registry

The starting point for the supply model is the 2025 CDR registry, which provides annual counts of credentialed practitioners separately for RDs and DTRs. Registry counts for the baseline year represent the total number of credentialed practitioners available for allocation across the nine practice areas.

2. Baseline Practice Area Distribution

Baseline practitioner counts are allocated across the nine practice areas using responses from the 2025 CDR Practitioner Survey. These survey results provide the estimated distribution of practitioners across practice areas separately for each credential and represent the best available estimate of the composition of the workforce during the baseline year. To improve representativeness, responses from the 2025 CDR Practitioner Survey were weighted so that the age distribution of survey respondents matched the age distribution of credentialed practitioners in the 2025 CDR registry. These weights were used in estimating the baseline practice area distribution and FTE conversion factors.

3. Baseline Full-Time Equivalent Supply

Because practitioners differ in workforce participation and hours worked, workforce supply is measured in FTEs rather than headcount. Practice area- and credential-specific FTE conversion factors are estimated from the 2025 CDR Practitioner Survey.

For the purposes of this study, practitioners working between 30 and 50 hours per week are considered to contribute one FTE. Practitioners working fewer than 30 hours or more than 50 hours contribute proportionally fewer or greater FTEs based on a linear scaling approach. Applying these conversion factors to the projected practitioner counts yields the estimated baseline FTE supply for each credential and practice area.

C. Changes in Supply Over Time

1. Projecting the Credentialed Workforce

Historical CDR registry counts from 2020 through 2025 are used to project the future number of credentialed practitioners separately for RDs and DTRs. Annual registry counts are projected using the historical compound annual growth rate (CAGR) observed over this period.

Conceptually, workforce supply evolves through practitioners entering and leaving the profession. Because longitudinal information on individual registry entries and exits is not available, the implemented model projects the overall size of the credentialed workforce directly using historical registry trends. As a result, projected registry counts implicitly reflect the combined effects of workforce entrants, retirements, mortality, and other factors affecting the size of the credentialed workforce.

2. Changes in Practice Area Distribution

The distribution of practitioners across practice areas is allowed to evolve over time to reflect long-term changes in professional practice.

The baseline practice area distribution is estimated from the 2025 CDR Practitioner Survey. We then use results from the Compensation and Benefits Surveys of the Dietetics Profession from 2011 through 2024 to estimate long-term growth trends for each practice area. These historical trends are applied to the baseline practice area distribution to estimate updated distributions for each subsequent projection year. Practice area shares are normalized annually so that the distributions sum to 100 percent within each credential.

The Compensation and Benefits Surveys of the Dietetics Profession report a single Ambulatory Care category that combines hospital outpatient and office-based practice, and do not report telehealth separately. Accordingly, historical trends for Ambulatory Care were applied to both Clinical – Hospital Outpatient and Clinical – Office-Based in the projection model. Telehealth is modeled independently from the other practice areas. For RDs, projected Telehealth supply is based on an external market forecast prepared by Grand View Research (Grand View Research, 2025), which projects approximately 7.0 percent annual growth in the supply of digital dietitians (those who provide virtual nutrition services) between 2025 and 2035. This projection reflects increasing adoption of telehealth practice among dietitians, expansion of digital health platforms, improvements in technology infrastructure, broader reimbursement for tele-nutrition services, and continued growth of hybrid care delivery models. Because telehealth practice is considered outside the scope of DTRs in this model, projected DTR supply within the Telehealth practice area is assumed to remain zero throughout the projection period.

3. Changes in Full-Time Equivalent Supply

The baseline FTE conversion factors estimated from the 2025 CDR Practitioner Survey are applied throughout the projection period to convert projected practitioner counts into effective workforce supply. These conversion factors account for systematic differences in workforce participation and average hours worked across credentials and practice areas.

The resulting projections represent the estimated annual FTE supply available within each credential and practice area.

D. Supply Scenarios

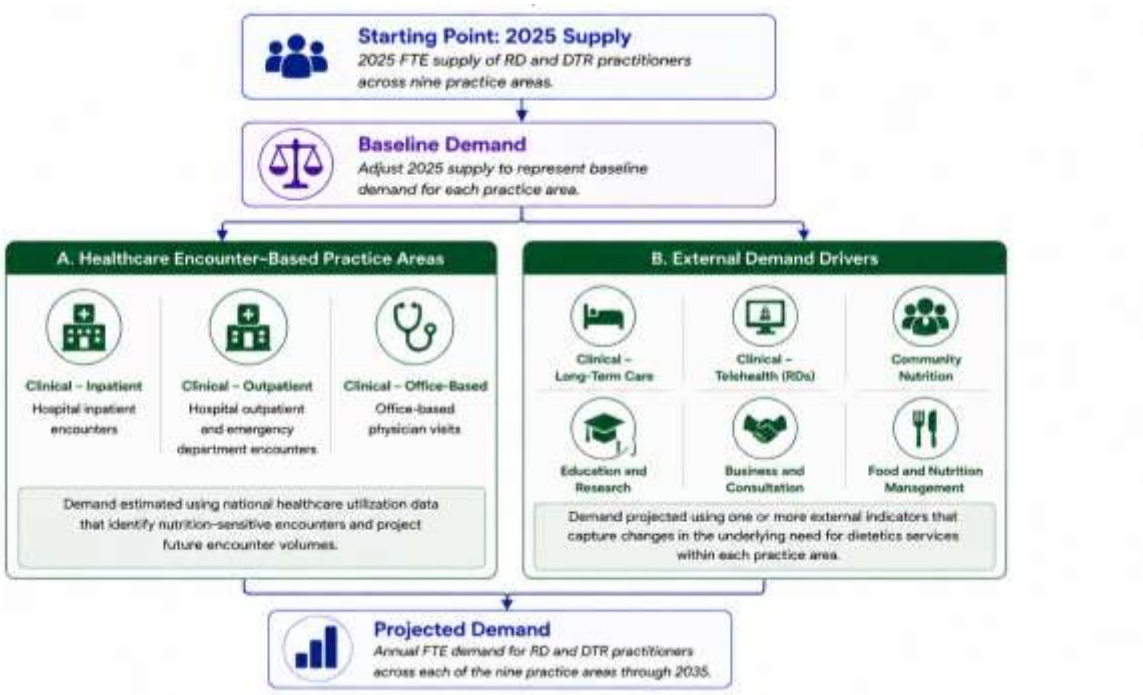
The baseline supply projection reflects historical registry growth, observed practice area distributions, historical practice area trends, and workforce participation patterns estimated from the available data. The modeling framework also supports evaluation of alternative supply assumptions through the interactive dashboard application. Users may modify assumed growth rates for each practice area to evaluate how alternative assumptions affect projected workforce supply. Alternative supply assumptions are also explored in the "What If?" scenarios described in Chapter 5.

IV. Demand Model

A. Overview

The demand model estimates the number of CDR-credentialed practitioners as FTEs needed in each year of the projection period, separately for RDs and DTRs and for each of the nine practice areas. The model first establishes baseline demand in 2025 and then projects changes in demand through 2035. Figure 4.1 provides an overview of the demand modeling process, illustrating how baseline demand is established and subsequently projected using healthcare encounter data or practice area-specific external demand drivers.

Figure 4.1. Demand model workflow for projecting future need for dietetics practitioners (RD and DTR) across nine practice areas.



Baseline demand is anchored to estimated 2025 workforce supply and adjusted, where applicable, to reflect assumptions regarding the relationship between supply and demand in the baseline year. Changes in demand after 2025 are projected using practice area-specific demand drivers selected to represent changes in the underlying need for nutrition and dietetics services. Because the factors affecting workforce demand differ substantially across practice areas, the model does not apply a single projection method to all areas. Clinical demand is projected using nutrition-sensitive healthcare encounters and national population projections, whereas demand in the remaining practice areas is generally projected using historical growth in one or more external indicators.

The demand model includes both data-driven parameters and assumption-based parameters. Data-driven parameters are derived from observed utilization, demographic, program, employment, and expenditure data. Assumption-based parameters are used where the available evidence does not directly identify the

quantity needed for the model. Default values for these parameters are informed by literature review, subject matter expert input, and consultation with CDR.

B. Baseline Demand

1. Baseline demand by credential and practice area

Direct national estimates of employer demand for RD and DTR FTEs are not available across all nine practice areas. Baseline demand is therefore anchored to estimated 2025 FTE supply and adjusted using an assumed baseline demand gap.

For credential c and practice area p, baseline demand is calculated as:

$$D_{c,p,2025} = S_{c,p,2025}(1 + \delta)$$

where:

- $D_{c,p,2025}$ is the baseline demand in FTEs;
- $S_{c,p,2025}$ is the estimated baseline supply in FTEs (from the supply model); and
- δ is the assumed proportional difference between baseline demand and supply.

A value of $\delta = 0$ indicates that supply and demand are assumed to be in equilibrium in 2025[1]. A positive value indicates that demand exceeds supply, while a negative value would indicate that supply exceeds demand. The default baseline scenario assumes that $\delta = 0.1$, indicating that at baseline, demand exceeds supply by 10%. This value was informed primarily by results of the 2025 CDR Dietetics Workforce Capacity and Demand Project Employer Survey (2025 CDR Employer Survey), which indicated widespread difficulty recruiting and retaining RDs, including a large majority of employers reporting positions they were unable to fill, prolonged time-to-fill for open positions, and relatively few qualified applicants for many vacancies. Because the survey does not directly estimate the magnitude of the national workforce shortage, the 10 percent assumption represents a reasonable baseline informed by these findings and consultation with CDR. Dashboard users may modify this assumption.

For DTR Telehealth, both baseline supply and baseline demand are fixed at zero because telehealth practice is considered outside the scope of the DTR credential in this model.

2. Baseline distribution of demand

Baseline demand is estimated separately for each credential and practice area. Except where a practice area-specific baseline adjustment is applied, the initial distribution of demand follows the 2025 distribution of FTE supply. These baseline values provide the starting point from which subsequent changes in demand are projected.

[1] The 2012 workforce model assumed that supply and demand were in equilibrium in the baseline year. The current model relaxes this assumption by introducing the parameter δ, which allows baseline demand to exceed or fall below baseline supply.

C. Demand Drivers

Demand drivers are indicators intended to represent changes in the underlying need for nutrition and dietetics services within each practice area. Because the factors affecting workforce demand differ substantially across healthcare, public-sector, educational, business, and foodservice settings, the model uses different projection methods for different groups of practice areas. Three clinical practice areas are projected using healthcare encounter data, while the remaining practice areas are projected using historical trends in one or more external demand indicators.

1. Demand drivers for healthcare encounter settings

Demand for the Clinical – Inpatient, Clinical – Hospital Outpatient, and Clinical – Office-Based practice areas is based on national healthcare encounter data (Table 4.1). Specifically, the model uses the Healthcare Cost and Utilization Project National Inpatient Sample (NIS), the Healthcare Cost and Utilization Project Nationwide Emergency Department Sample (NEDS), and the National Ambulatory Medical Care Survey (NAMCS), respectively.

Table 4.1. Data sources for the demand drivers for healthcare encounter settings

Practice Area	Data Source	Available Years
Clinical – Inpatient	Healthcare Cost and Utilization Project National Inpatient Sample (NIS)	2018, 2019, 2022, 2023
Clinical – Hospital Outpatient	Healthcare Cost and Utilization Project Nationwide Emergency Department Sample (NEDS)	2018, 2019, 2022, 2023
Clinical – Office-based	National Ambulatory Medical Care Survey (NAMCS)	2016, 2018, 2019

In consultation with clinical subject matter experts, the study team identified diagnosis codes representing nutrition-sensitive conditions. Each diagnosis was assigned an intensity weight reflecting both the likelihood that dietetics services would be involved when the diagnosis occurs and the expected time and complexity of that involvement. When multiple nutrition-sensitive diagnoses are present for a single encounter, each diagnosis contributes independently to the estimated nutrition workload.

Within each dataset, weighted nutrition demand is estimated separately by age group, sex, and year. Each qualifying diagnosis contributes the product of the dataset's encounter weight and the clinician-assigned diagnosis intensity weight. These values are summed across encounters to obtain the total weighted nutrition demand for the age group, sex, and year. The primary analysis considers nutrition-sensitive diagnoses appearing anywhere on the claim (as opposed to limiting to the primary diagnosis) because conditions relevant to dietetics services frequently appear as secondary diagnoses rather than as the principal reason for the encounter.

Let $W^{p}_{a,g,t}$ denote the total weighted nutrition demand for practice area p, age group a, sex g, and year t, and let $P_{a,g,t}$ denote the corresponding national population. The annual weighted demand rate is calculated as

$$r^{p}_{a,g,t} = \frac{W^{p}_{a,g,t}}{P_{a,g,t}}.$$

To reduce year-to-year variability, baseline rates are pooled across the selected baseline years. Rather than averaging annual rates, the model pools the numerators and denominators:

$$\bar{r}_{a,g}^{p} = \frac{\sum_{t \in B} W_{a,g,t}^{p}}{\sum_{t \in B} P_{a,g,t}},$$

where B denotes the set of baseline years. Projected demand indicators are then obtained by applying the pooled rates to future population projections:

$$X_{t}^{p} = \sum_{a,g} \bar{r}_{a,g}^{p} P_{a,g,t}$$

where X_{t}^{p} is the projected weighted nutrition demand in year t for the practice area p.

This approach captures changes in demand resulting from both overall population growth and changes in the age and sex composition of the population. Under the baseline projection, the pooled age- and sex-specific demand rates remain constant over time.

2. Demand drivers for the remaining practice areas

The remaining practice areas—Clinical – Long-Term Care, Clinical – Telehealth, Community Nutrition, Education and Research, Business and Consultation, and Food and Nutrition Management—are projected using external indicators selected to represent changes in the underlying demand for dietetics services. Unlike the three healthcare encounter-based practice areas described in Section 4.3.2, these practice areas do not have national encounter datasets that can be used to directly estimate nutrition workload. Instead, demand is projected using one or more external indicators that are expected to track changes in the need for dietetics services within each setting. Table 4.2 summarizes the demand driver(s) used for each practice area and the primary data source from which each driver is obtained.

Table 4.2. Demand drivers for practice areas in non-healthcare encounter settings

Practice Area	Demand Driver(s)	Weight	Data Source
Clinical– Long-Term Care	Average number of residents per day	100%	CMS Care Compare - Nursing Home Data
Clinical – Telehealth	Digital dietetics market growth	100%	Grand View Research (2025) report
Community Nutrition	Supplemental Nutrition Assistance Program (SNAP) participation	20%	USDA/FNS SNAP National Level Annual Survey
	Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation	35%	USDA/FNS WIC National Level Annual Survey
	National School Lunch Program participation	15%	USDA/FNS NSLP Annual Participation and Meals Served Tables
	Total federal and state inmates	10%	Bureau of Justice Statistics National Prisoner Statistics
	Head Start enrollment	10%	Head Start Program Facts and Program Information

Practice Area	Demand Driver(s)	Weight	Data Source
	Food banks and pantries	10%	USDA ERS Food Security Interactive Charts and Highlights
Education and Research	DT, CP, DPD, and DI programs and enrollment	60%	AND Accredited Programs Directory
	Federal grants	40%	NIH Research, Condition, and Disease Categorization
Business and Consultation	Total employees under OCC Code 29-1031 (Registered Dietitians)	100%	Census Bureau Economic Census sectors 54 and 55; Bureau of Labor Statistics Occupational Employment and Wage Statistics (OEWS)
Food and Nutrition Management	Total US food-away-from-home expenditures	100%	USDA Economic Research Service National Food Expenditures

For a demand driver with value $X_{t_0}^p$ in the first historical year and $X_{t_1}^p$ in the final historical year, the CAGR is calculated as

$$g_p = \left(\frac{X_{t_1}^p}{X_{t_0}^p}\right)^{1/(t_1 - t_0)} - 1,$$

where g_p is the estimated annual growth rate for practice area p.

When multiple demand drivers are used for a practice area, a separate CAGR is calculated for each driver. The overall growth rate for the practice area is then calculated as the weighted average of the individual growth rates:

$$g_p = \sum_{k=1}^{K_p} w_{k,p}\, g_{k,p},$$

where $g_{k,p}$ is the CAGR for demand driver k, $w_{k,p}$ is the weight assigned to that driver, and the weights sum to one within each practice area. Weights were selected in consultation with a subject matter expert and are intended to reflect the relative contribution of each demand driver to projected changes in demand for dietetics professionals within the practice area.

For Clinical–Telehealth, growth rates came directly from Grand View Research's U.S. Digital Dietitian Market report (Grand View Research, 2025). The projected market growth reflects increasing demand for virtual nutrition services associated with rising chronic disease prevalence, expanded telehealth adoption, broader insurance reimbursement, employer wellness programs, AI-enabled nutrition technologies, and increasing consumer preference for remote care.

The resulting annual growth rates are used to project future demand for each practice area, as described in the next section.

3. Changes in Demand Over Time

a. Projecting RD demand

For RDs, demand generally follows the projected change in the relevant practice area-specific demand driver. For the three clinical practice areas, the annual demand index is derived from the projected weighted nutrition demand described in Section 4.3.2. For the remaining practice areas, demand is projected using the CAGR described in Section 4.3.3.

For the Clinical – Inpatient, Clinical – Hospital Outpatient, and Clinical – Office-based practice areas, projected RD demand is calculated by applying the change in the clinical demand driver relative to 2025:

$$D_{p,t}^{RD} = D_{p,2025}^{RD}\left(\frac{X_{p,t}}{X_{p,2025}}\right),$$

where $X_{p,t}$is the projected weighted nutrition demand for practice area $p$in year t.

For all other practice areas, projected RD demand is calculated by applying the corresponding annual demand growth rate g_p to the baseline demand over the corresponding timeframe:

$$D_{p,t}^{RD} = D_{p,2025}^{RD}\left(1+g_p\right)^{t-2025}.$$

b. Projecting DTR demand

The available data do not support estimating separate external demand drivers for RDs and DTRs within each practice area. Initially applying the RD growth rates directly to DTR demand produced rapidly widening projected DTR shortages because the registered DTR population has been declining while most external demand drivers have been increasing.

In consultation with CDR, the baseline model therefore assumes that total DTR demand changes at the same annual rate as total DTR supply. Under the baseline supply projection, total DTR supply declines by 7.9 percent annually. The model preserves the relative differences in growth across practice areas implied by the RD demand drivers while recentering the DTR growth rates so that their 2025-demand-weighted average equals negative 7.9 percent.

For each practice area other than Telehealth:

$$g_p^{DTR} = g_p^{RD} + \theta,$$

where:

- g_p^{RD} is the annual RD demand growth rate for practice area p;
- g_p^{DTR} is the corresponding DTR demand growth rate; and
- θ is a common offset applied across DTR practice areas.

The value of θ is selected to satisfy:

$$\frac{\sum_p D_{p,2025}^{DTR} g_p^{DTR}}{\sum_p D_{p,2025}^{DTR}} = -0.079.$$

The sums exclude Telehealth because DTR Telehealth demand is fixed at zero. Projected DTR demand is then calculated as:

$$D_{p,t}^{DTR} = D_{p,2025}^{DTR}\left(1+g_p^{DTR}\right)^{t-2025}.$$

This approach preserves the relative pattern of stronger and weaker demand growth across practice areas while aligning the overall DTR demand trajectory with the baseline projected change in DTR supply. The assumption does not imply that declining DTR supply directly causes declining need for dietetics services. Rather, it reflects consultation with CDR regarding the likely evolution of employer demand for the DTR credential in the context of a contracting DTR workforce and potential redistribution of work to RDs or other staff.

The assumed overall DTR demand growth rate is user-modifiable in the dashboard. Alternative values can therefore be used to examine how different assumptions about the future role of DTRs affect projected workforce gaps.

D. Demand Assumptions and Scenarios

The baseline demand projection incorporates both data-driven and assumption-based parameters. Data-driven parameters include observed healthcare encounter rates, national population projections, and historical growth in external demand drivers. Assumption-based parameters include the relationship between baseline supply and demand, weights used to combine multiple demand drivers, clinician-assigned diagnosis intensity weights, the relationship between RD and DTR demand growth, and other quantities that cannot be estimated directly from available data.

Recommended default values for many of the assumption-based parameters are informed by literature review, subject matter expert input, and consultation with CDR. These default values form part of the base scenario and may be modified by dashboard users to evaluate alternative assumptions. The “What If?” scenarios in the next chapter also explore alternative demand assumptions.

V. "What If?" Scenarios

In addition to the baseline projection, the dashboard includes three predefined "What If?" scenarios that allow users to explore how alternative future conditions could affect the dietetics workforce. Each scenario represents a plausible future that may differ from the assumptions used in the baseline projection. The scenarios are intended to support planning and discussion rather than to predict future conditions.

Each scenario modifies a selected set of assumption-based model parameters while leaving the overall supply and demand modeling framework unchanged. Users may activate any scenario either individually or in combination and specify the magnitude of their effect using the dashboard controls. Unless otherwise specified, the recommended default values were developed in consultation with CDR and subject matter experts and are intended to represent plausible, rather than expected, changes.

A. Artificial Intelligence and Technological Change

Advances in artificial intelligence (AI), digital health technologies, and other innovations have the potential to change both the demand for dietetics services and the settings in which those services are delivered. Some routine or lower-complexity activities may increasingly be supported or replaced by AI-based tools, while technological advances may also expand access to virtual nutrition services.

The AI and Technological Change scenario modifies projected demand growth rates for selected practice areas to reflect these potential changes. Specifically, the scenario:

- decreases projected demand growth for Clinical – Hospital Outpatient, Clinical – Office-Based, and Business and Consultation;
- applies smaller decreases to Community Nutrition, Education and Research, and Food and Nutrition Management; and
- increases projected demand growth for Clinical – Telehealth.

The magnitude of these adjustments is specified by the dashboard user. Larger values produce correspondingly larger increases or decreases in projected demand growth. The scenario does not affect Clinical – Inpatient or Clinical – Long-Term Care, reflecting the expectation that these practice areas will continue to require substantial direct patient interaction.

B. Workforce and Job Alignment

Preferences for work environment, schedule flexibility, and job intensity may influence where dietetics professionals choose to practice. Future changes in these preferences could alter the distribution of the workforce across practice areas even if the total number of credentialed practitioners remains unchanged.

The Workforce and Job Alignment scenario assumes that an increasing proportion of practitioners shift from relatively high-intensity practice areas toward lower-intensity practice areas over time. Under this scenario, a user-specified percentage of the workforce is reallocated each year from Clinical – Inpatient, Clinical – Hospital Outpatient, Clinical – Long-Term Care, and Food and Nutrition Management, with a smaller shift from Clinical – Office-Based. The reallocated practitioners are redistributed among Clinical –

Telehealth, Community Nutrition, Education and Research, and Business and Consultation in proportion to the projected size of those practice areas.

This scenario affects only the distribution of workforce supply across practice areas. The total projected supply of practitioners and the projected demand for services remain unchanged.

C. Federal Policy Changes

Recent changes in federal policy have the potential to affect demand for dietetics professionals through reductions in funding for nutrition assistance programs, research, and other federally supported activities. Because the historical data used to estimate the baseline demand drivers end before many of these policy changes occurred, the baseline projection does not directly capture their potential effects.

The Federal Policy Changes scenario allows users to examine the implications of reduced federal support for selected programs. The scenario decreases baseline demand for Community Nutrition to reflect reductions in participation in major federal nutrition assistance programs, including the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the National School Lunch Program (NSLP). It also decreases baseline demand for Education and Research to reflect reductions in federally supported nutrition research.

The magnitude of these reductions is controlled by the dashboard user. The reduction applied to each practice area is proportional to the contribution of the affected programs or funding sources to that practice area's demand model.

Recognizing that future federal policies are uncertain, the dashboard provides three alternative assumptions regarding the restoration of funding following the current presidential administration:

- **No rebound:** Reduced funding levels persist throughout the projection period.
- **Immediate rebound:** Funding returns immediately in 2029, restoring the full reduction in demand.
- **Gradual rebound:** Funding is restored incrementally between 2029 and 2032, with one-quarter of the removed demand restored in each year.

These rebound options restore the amount of demand removed by the initial policy change while allowing demand to continue evolving according to the underlying demand growth assumptions. As a result, the projected demand trajectory following a rebound does not necessarily return to the baseline projection, but instead reflects both the restoration of funding and the ongoing growth in demand over time.

VI. Results

A. Current Workforce

Before presenting the projected supply and demand for dietetics professionals, this section summarizes the characteristics of the workforce at the beginning of the projection period. These results provide context for interpreting the projections presented in the following sections and describe the baseline workforce used to initialize the supply and demand models.

1. Registry size and recent trends

As of 2025, the Commission on Dietetic Registration (CDR) registry included **112,867 RDs** and **3,260 DTRs**. These registry counts serve as the baseline workforce from which future supply projections are developed.

Table 6.1 presents annual registry counts for both credentials from 2020 through 2025. Over this period, the RD registry increased steadily, corresponding to a compound annual growth rate of **1.3 percent per year**, while the DTR registry declined substantially, with a compound annual decline of **7.9 percent per year**. These historical growth rates provide the basis for the baseline registry projections described in Chapter 3.

Table 6.1. CDR Registry Counts, 2020–2025

Credential	2020	2021	2022	2023	2024	2025	Growth Rate
RD	105,870	107,893	109,812	111,530	112,513	112,867	1.3%
DTR	4,916	4,554	4,223	3,876	3,606	3,260	-7.9%

2. Practice area distribution and recent trends

The 2025 CDR Practitioner Survey was used to estimate the distribution of practitioners across the nine practice areas included in the projection model. Table 6.2 presents the estimated practice area distributions separately for RDs and DTRs.

Table 6.2. Estimated 2025 Practice Area Distribution

Practice Area	Registered Dietitians	Dietetic Technicians, Registered
Clinical - Inpatient	18.6%	12.9%
Clinical - Hospital Outpatient	9.3%	2.4%
Clinical - Office-based	10.1%	4.5%
Clinical - Long-Term Care	5.6%	13.9%
Clinical - Telehealth	2.5%	0.0%[a]
Community Nutrition	12.3%	23.0%
Education and Research	13.1%	7.0%
Business and Consultation	18.1%	23.1%
Food and Nutrition Management	10.3%	13.3%

[a] The distribution of DTRs in Clinical – Telehealth was fixed at 0%, and the remaining distributions were rescaled to sum to 100%.

The distribution of practitioners differs substantially between the two credentials. RDs are more heavily concentrated in clinical practice settings, particularly Clinical – Inpatient, Clinical – Hospital Outpatient, and Clinical – Office-Based, and have a larger presence in Education and Research. In contrast, DTRs are more concentrated in Community Nutrition, Business and Consultation, Food and Nutrition Management, and Clinical – Long-Term Care. Clinical – Telehealth represents a small but growing area of practice for RDs, whereas the projected distribution of DTRs in this practice area was assumed to be zero. These differences highlight the distinct roles that RDs and DTRs play across the dietetics workforce and underscore the importance of modeling workforce supply separately for the two credentials.

To project future changes in the distribution of practitioners across practice areas, the model incorporates historical information from the Compensation and Benefits Surveys of the Dietetics Profession conducted between 2011 and 2024. Table 6.3 summarizes the 2011 and 2024 practice area distributions for each credential together with the compound annual growth rates used in the projection model. Although the growth rates are calculated using only the 2011 and 2024 values, the intermediate survey years exhibited generally smooth trends, suggesting that the estimated growth rates provide a reasonable summary of long-term changes in the distribution of practitioners across practice areas. These growth rates provide the basis for projecting future changes in the distribution of practitioners across practice areas, while the historical distributions provide context for understanding the long-term evolution of the workforce.

Table 6.3. Historical Practice Area Distribution and Growth Rates, 2011–2024

	Registered Dietitians			Dietetic Technicians, Registered		
Practice Area	2011 Distribution	2024 Distribution	Growth Rate	2011 Distribution	2024 Distribution	Growth Rate
Clinical - Inpatient	30%	42%	2.6%	43%	42%	-0.2%
Clinical - Ambulatory	17%	17%	0.0%	1%	1%	5.5%
Clinical - Long-Term Care	9%	5%	-4.4%	15%	8%	-4.7%
Community Nutrition	11%	7%	-3.4%	12%	21%	4.4%
Food and Nutrition Management	12%	10%	-1.4%	18%	14%	-1.9%
Business and Consultation	8%	8%	0.0%	2%	3%	3.2%
Education and Research	7%	5%	-2.6%	2%	1%	-5.2%

Source: Compensation and Benefits Surveys of the Dietetics Profession, 2011 and 2024.

Note: The survey reports a single Ambulatory Care category combining hospital outpatient and office-based practice. In the projection model, the estimated growth rate for Ambulatory Care is applied to both Clinical – Hospital Outpatient and Clinical – Office-Based. Telehealth is projected independently using external assumptions.

Among RDs, the largest increase in the share of practitioners occurred in Clinical – Inpatient, while Clinical – Long-Term Care and Community Nutrition experienced the largest declines. The proportion of RDs working in Clinical – Ambulatory and Business and Consultation remained relatively stable over the period. Among DTRs, Clinical – Ambulatory and Community Nutrition experienced the largest increases, whereas Education and Research and Clinical – Long-Term Care experienced the largest declines. These historical trends form the basis for projecting future changes in the distribution of practitioners across practice areas.

3. Full-time equivalent conversion

Because many practitioners work part-time, the projection model estimates workforce supply in terms of FTEs rather than headcount. FTE conversion factors were estimated separately for each credential and practice area using the 2025 CDR Practitioner Survey. Table 6.4 presents the estimated FTE conversion factors used throughout the projection model.

Table 6.4. FTE Conversion Factors by Credential and Practice Area

Practice Area	Registered Dietitians	Dietetic Technicians, Registered
Clinical - Inpatient	0.951	0.973
Clinical - Hospital Outpatient	0.952	0.887
Clinical - Office-based	0.934	0.892
Clinical - Long-Term Care	0.923	0.948
Clinical - Telehealth	0.815	--
Community Nutrition	0.937	0.912
Education and Research	0.936	0.862
Business and Consultation	0.884	0.926
Food and Nutrition Management	0.981	0.988

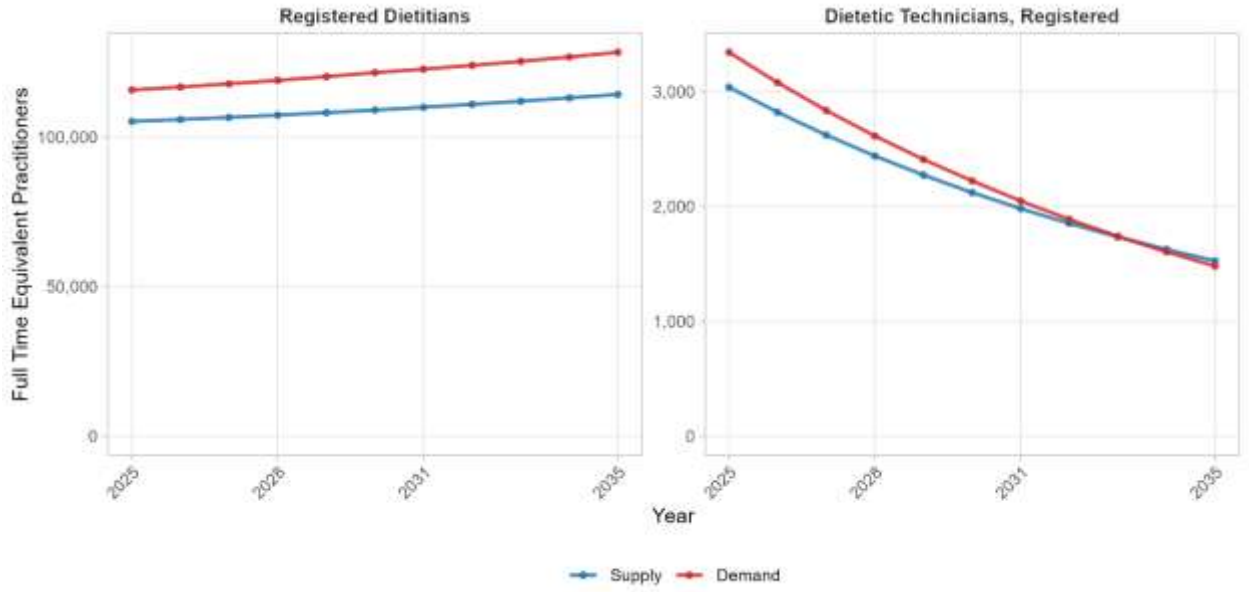
FTE conversion factors were generally high across practice areas, indicating that most practitioners work close to full time. For RDs, the lowest conversion factor was observed in Clinical – Telehealth (0.815), suggesting a greater prevalence of part-time work in this setting, while Food and Nutrition Management had the highest conversion factor (0.981). Among DTRs, conversion factors were similarly high, ranging from 0.862 in Education and Research to 0.988 in Food and Nutrition Management. These factors were applied to convert projected practitioner counts into full-time equivalent (FTE) workforce estimates.

B. Baseline Workforce Projections

1. Overall projections

Figure 6.1 presents the baseline projections of workforce supply and demand for RDs and DTRs under the default model assumptions.

Figure 6.1. Baseline Workforce Supply and Demand Projections by Credential



For **RDs**, both projected supply and projected demand increase steadily throughout the projection period. The two trajectories are nearly parallel, indicating that under the baseline assumptions, the overall workforce gap remains relatively stable over time. The projected demand exceeds projected supply throughout the projection period, reflecting the baseline assumption that demand exceeds supply by 10 percent in 2025. Because projected supply and demand grow at similar rates, this initial gap persists rather than widening or narrowing substantially. The aggregate projections mask important differences across practice areas.

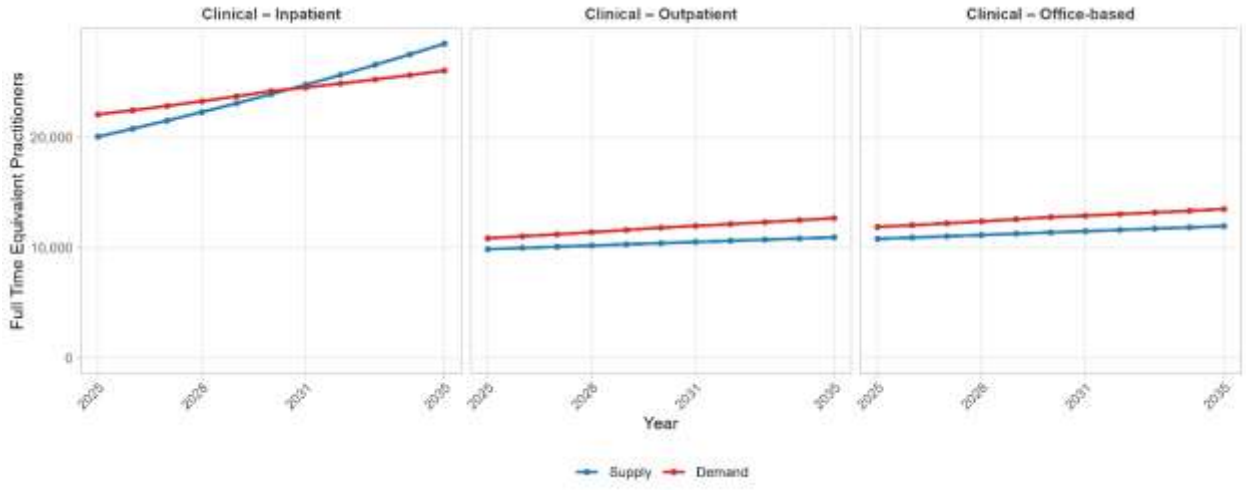
For **DTRs**, both projected supply and projected demand decline substantially over the projection period, reflecting recent declines in the credentialed DTR workforce. Unlike the RD projections, the workforce gap narrows gradually over time, as projected demand declines slightly faster than projected supply. By the end of the projection period, projected supply and demand are nearly equal. As with the RD workforce, however, the aggregate projections conceal meaningful variation across practice areas.

Although the aggregate projections suggest relatively stable workforce conditions for both credentials, they mask substantial differences across practice areas. As shown in the following sections, individual practice areas exhibit markedly different supply and demand trajectories, resulting in projected shortages or surpluses that vary considerably across practice settings.

2. Encounter-based clinical practice areas

Figure 6.2 presents the projected workforce supply and demand (combining RDs and DTRs) for the three clinical practice areas whose demand is estimated from healthcare encounter data: Clinical – Inpatient, Clinical – Hospital Outpatient, and Clinical – Office-Based.

Figure 6.2. Baseline Supply and Demand Projections (RD+DTR) for Encounter-Based Clinical Practice Areas



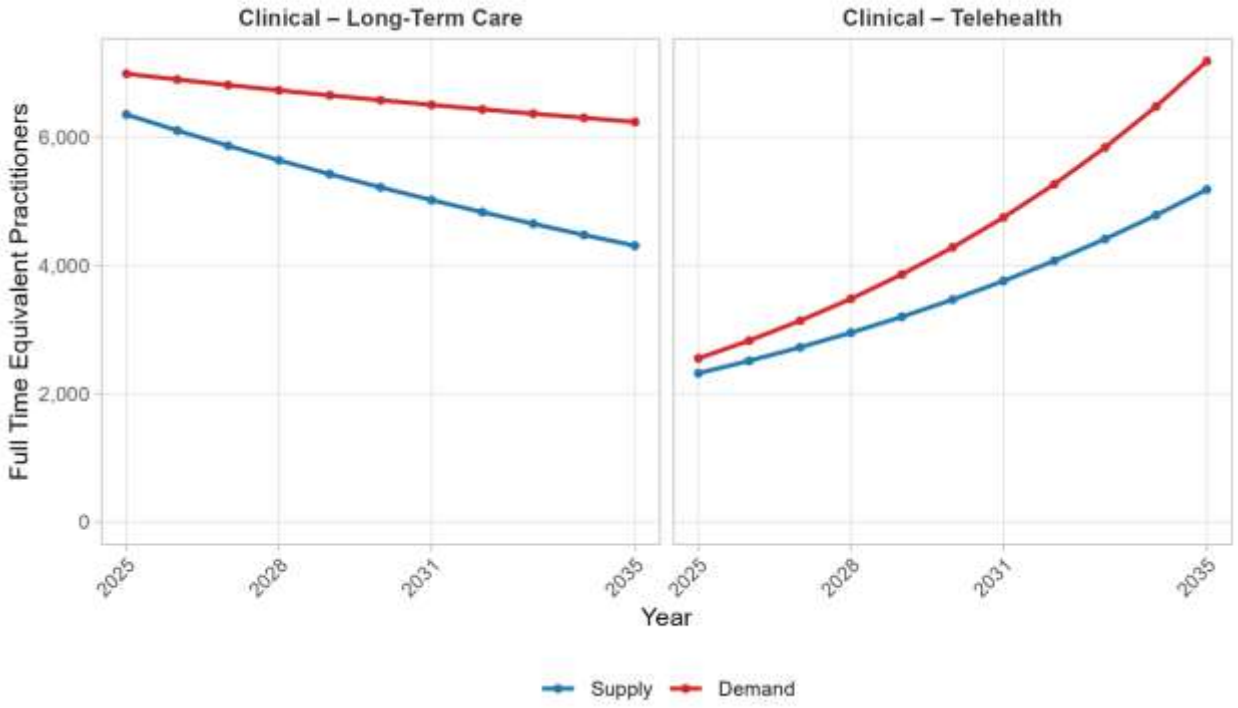
The projected trajectories differ substantially across the three practice areas, illustrating how changes in practice area distribution and healthcare utilization interact to influence projected workforce gaps. Among the encounter-based practice areas, **Clinical – Inpatient** exhibits the largest increase in projected workforce supply. Although projected demand initially exceeds supply, the gap narrows steadily over the projection period. By approximately 2031, projected supply exceeds projected demand, resulting in a modest projected surplus by the end of the projection period. In contrast, **Clinical – Hospital Outpatient** exhibits relatively slow growth in both supply and demand. The two trajectories remain nearly parallel throughout the projection period, resulting in a persistent but relatively stable workforce shortage. **Clinical – Office-Based** displays a similar pattern, with projected demand consistently exceeding projected supply and little change in the magnitude of the projected workforce gap over time.

These differences reflect both projected changes in the distribution of practitioners across practice areas and differences in the underlying demand drivers. Inpatient demand is driven primarily by projected changes in nutrition-sensitive inpatient encounters, whereas demand for Hospital Outpatient and Office-Based practice is based on projected trends in emergency department and physician office encounters, respectively. At the same time, projected supply reflects historical changes in the distribution of practitioners across practice areas observed in the Compensation and Benefits Surveys of the Dietetics Profession.

3. Other clinical practice areas

Figure 6.3 presents the baseline workforce projections (combining RDs and DTRs) for the remaining two clinical practice areas: Clinical – Long-Term Care and Clinical – Telehealth. Unlike the encounter-based clinical practice areas presented in Section 6.2.2, demand for these practice areas is projected using external demand drivers rather than healthcare encounter data.

Figure 6.3. Baseline Supply and Demand Projections (RD+DTR) for Other Clinical Practice Areas



The projected trajectories for Clinical – Long-Term Care and Clinical – Telehealth differ substantially from one another, reflecting differences in both projected workforce supply and the underlying demand drivers.

For **Clinical – Long-Term Care**, both projected supply and projected demand decline over the projection period. However, projected supply declines more rapidly than projected demand, resulting in a steadily widening workforce shortage. This pattern reflects the projected shift of practitioners away from long-term care over time, combined with a more gradual decline in demand for long-term care nutrition services. **Clinical – Telehealth** exhibits the opposite pattern. Both projected supply and projected demand increase substantially throughout the projection period, reflecting continued expansion of telehealth services. However, projected demand grows more rapidly than projected supply, resulting in an increasing workforce shortage over time. The projected increase in demand reflects broad expansion of virtual nutrition services driven by chronic disease management, telehealth adoption, payer reimbursement, employer wellness programs, and digital health technologies, while projected supply reflects continued growth in the number of dietitians practicing through digital care models. Under the baseline assumptions, telehealth represents one of the fastest-growing practice areas in both workforce supply and demand.

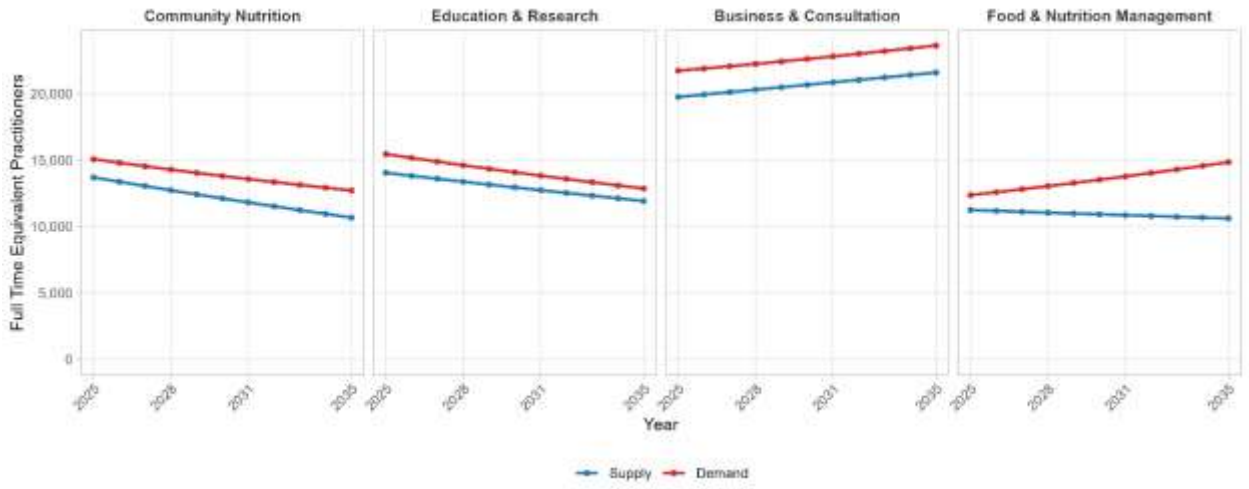
Although the projected trends for these two practice areas differ markedly, both are characterized by increasing gaps between projected supply and demand. In Long-Term Care, the widening shortage results from declining workforce supply outpacing the decline in demand, whereas in Telehealth it results from demand growing more rapidly than supply. These findings illustrate that workforce shortages may arise

through different mechanisms depending on the characteristics of the practice area and its underlying demand drivers.

4. Nonclinical practice areas

Figure 6.4 presents the baseline workforce projections combining RDs and DTRs for the four nonclinical practice areas: Community Nutrition, Education & Research, Business & Consultation, and Food & Nutrition Management. As with the other practice areas, projected supply and demand vary considerably across settings, reflecting differences in the underlying demand drivers and projected changes in workforce participation.

Figure 6.4. Baseline Supply and Demand Projections (RD+DTR) for Nonclinical Practice Areas



Among the nonclinical practice areas, **Community Nutrition** and **Education and Research** exhibit similar projected trajectories. In both practice areas, projected supply and projected demand decline throughout the projection period. However, projected supply declines more rapidly than projected demand, resulting in gradually widening workforce shortages over time. **Business and Consultation** exhibits the opposite pattern. Both projected supply and projected demand increase steadily throughout the projection period, reflecting continued growth in this practice area. Although workforce supply also increases, projected demand grows at a slightly faster rate, resulting in a modest increase in the projected workforce shortage. **Food and Nutrition Management** displays the greatest divergence between projected supply and demand among the nonclinical practice areas. Projected demand increases steadily over the projection period, while projected supply declines slightly. As a result, the workforce shortage widens substantially, producing the largest projected increase in the supply-demand gap among the four nonclinical practice areas.

Overall, the nonclinical practice areas demonstrate that similar workforce shortages may arise through different combinations of supply and demand dynamics. Community Nutrition and Education & Research experience declining supply and demand, with supply declining more rapidly. Business & Consultation experiences concurrent growth in both supply and demand, with demand increasing slightly faster than supply. In contrast, Food & Nutrition Management combines increasing demand with declining supply,

resulting in the most pronounced increase in projected workforce shortage among the nonclinical practice areas.

5. Comparison across practice areas

Although the overall workforce projections presented in Section 6.2.1 suggest relatively stable national supply-demand dynamics, the practice area analyses reveal substantial heterogeneity in projected workforce trends. Table 6.5 summarizes the projected direction of change in workforce supply, workforce demand, and the resulting workforce outlook for each practice area under the baseline scenario.

Table 6.5. Summary of Baseline Workforce Projections (RD+DTR) by Practice Area

Practice Area	Supply Trend	Demand Trend	Workforce Outlook
Clinical – Inpatient	↑↑	↑	Transitions from a shortage to a modest surplus
Clinical – Hospital Outpatient	↑	↑	Stable workforce shortage
Clinical – Office-Based	↑	↑	Stable workforce shortage
Clinical – Long-Term Care	↓↓	↓	Widening workforce shortage
Clinical – Telehealth	↑↑	↑↑↑	Widening workforce shortage
Community Nutrition	↓↓	↓	Widening workforce shortage
Education and Research	↓	↓	Widening workforce shortage
Business and Consultation	↑	↑↑	Slightly widening workforce shortage
Food and Nutrition Management	↓	↑	Largest projected increase in workforce shortage

Note: Arrows indicate the relative direction and magnitude of projected change over the 2025–2035 projection period. They are intended to facilitate qualitative comparisons across practice areas and do not represent quantitative thresholds.

Table 6.4 highlights several broad patterns. Clinical – Inpatient is the only practice area projected to transition from a workforce shortage to a modest surplus by the end of the projection period. Clinical – Hospital Outpatient and Clinical – Office-Based maintain relatively stable shortages, while Clinical – Long-Term Care and Clinical – Telehealth both experience widening workforce shortages, although their underlying supply and demand trajectories differ substantially.

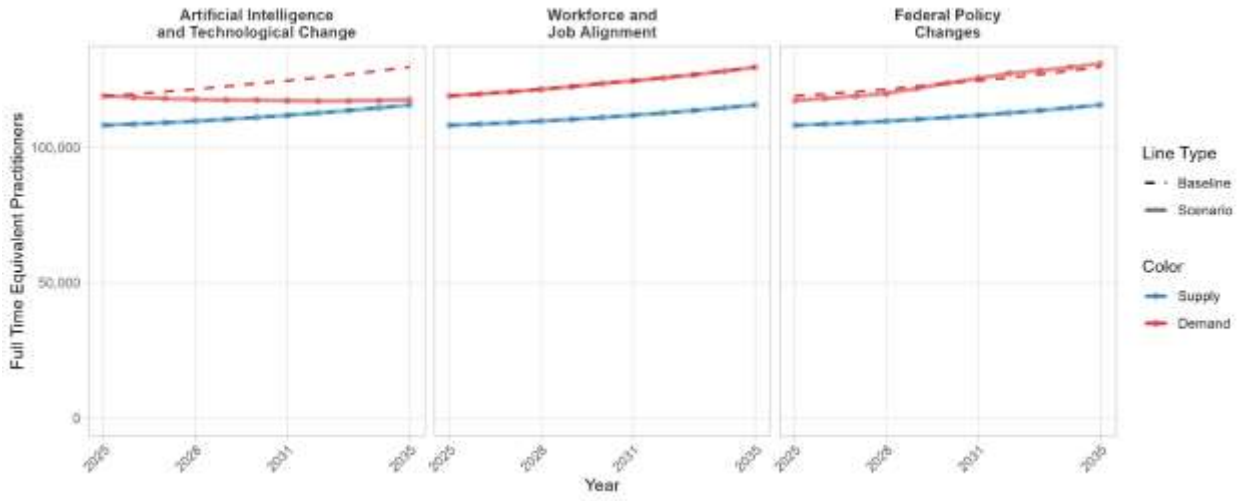
Among the nonclinical practice areas, Community Nutrition and Education and Research are characterized by declining workforce supply and demand, with supply declining more rapidly than demand. Business & Consultation experiences continued growth in both workforce supply and demand, with demand increasing slightly faster than supply. In contrast, Food and Nutrition Management combines increasing demand with declining supply, resulting in the largest projected increase in workforce shortage among the nine practice areas.

Overall, these findings demonstrate that the relatively stable national workforce projections mask substantial differences across practice areas. The baseline projections suggest that future workforce challenges are likely to be concentrated in specific practice settings rather than uniformly distributed across the profession.

C. Scenario Analysis

The dashboard includes three predefined "What If?" scenarios that allow users to examine how alternative future conditions may affect projected workforce supply and demand. Figure 6.5 compares the baseline projections with the projections obtained by applying each scenario individually using the recommended default parameter values. In each comparison, only a single scenario is activated while all other model assumptions remain unchanged.

Figure 6.5. Comparison of Baseline and Scenario Projections (RD+DTR)



Under the default assumptions, the **Artificial Intelligence and Technological Change** scenario produces the largest change in the overall workforce projections. By reducing projected demand growth for several practice areas while increasing demand growth for Clinical – Telehealth, the scenario slows overall demand growth relative to the baseline projection. Because projected workforce supply is unchanged, the overall workforce gap narrows steadily over the projection period.

The **Workforce and Job Alignment** scenario has little effect on the aggregate workforce projections. This is expected because the scenario redistributes practitioners across practice areas without changing the total projected workforce supply or demand. Consequently, its primary effects occur within individual practice areas rather than at the national level.

The **Federal Policy Changes** scenario produces a modest reduction in overall projected demand relative to the baseline scenario. Under the default assumptions, reductions in demand associated with federally supported nutrition programs are followed by a gradual restoration between 2029 and 2032. As a result, the scenario diverges modestly from the baseline projection before gradually converging toward it over the remainder of the projection period.

Overall, the scenario analysis demonstrates that the predefined "What If?" scenarios affect the projected workforce in different ways. The Artificial Intelligence and Technological Change scenario primarily alters the overall balance between workforce supply and demand, whereas the Workforce and Job Alignment and Federal Policy Changes scenarios primarily influence the distribution of workforce supply and demand

across practice areas. The dashboard allows users to further explore these scenarios by modifying the scenario parameters and examining their effects on individual practice areas and credentials.

VII. Discussion

A. Major Drivers

Several factors drive the projected changes in workforce supply and demand presented in this report. On the supply side, projections are influenced primarily by historical trends in the size of the RD and DTR registries and by changes in the distribution of practitioners across practice areas. Historical registry growth indicates continued expansion of the RD workforce but a substantial decline in the DTR workforce. These trends, combined with projected changes in practice area distribution and workforce participation, form the basis for the projected supply estimates.

On the demand side, the projections reflect the diverse settings in which dietetics professionals practice. For the encounter-based clinical practice areas, projected demand is driven by expected changes in healthcare utilization associated with nutrition-sensitive conditions. For the remaining practice areas, demand is based on external indicators selected to represent changes in the underlying need for dietetics services, including participation in nutrition assistance programs, educational enrollment, research funding, employment, and foodservice expenditures.

One of the most notable findings is the substantial variation in projected workforce trends across practice areas. Although the overall RD workforce is projected to remain relatively stable, individual practice areas experience markedly different trajectories. Clinical – Inpatient is projected to transition from a workforce shortage to a modest surplus, whereas Clinical – Long-Term Care, Clinical – Telehealth, and Food and Nutrition Management experience widening workforce shortages. These findings illustrate that workforce shortages may arise through different mechanisms. In some practice areas, shortages result from workforce supply changing more rapidly than demand, whereas in others they result from demand outpacing workforce supply.

Clinical – Telehealth represents a particularly distinct case. Unlike the other clinical practice areas, projected demand is based on external forecasts of the digital dietitian market rather than healthcare encounter data. Consequently, demand reflects anticipated expansion of virtual nutrition services associated with increasing telehealth adoption, digital health technologies, insurance reimbursement, employer wellness programs, and consumer preference for remote care. Supply, in contrast, reflects the projected growth in the number of dietitians practicing through digital care models. Together, these assumptions produce the most rapid projected growth in demand among the nine practice areas.

The scenario analysis further illustrates the importance of the underlying modeling assumptions. The Artificial Intelligence and Technological Change scenario primarily affects projected demand, while the Workforce and Job Alignment scenario redistributes workforce supply across practice areas without materially changing the overall workforce. The Federal Policy Changes scenario demonstrates how changes in public funding may influence selected practice areas while having relatively modest effects on the overall workforce. Together, these scenarios demonstrate the flexibility of the projection framework and highlight the importance of considering alternative future conditions when planning for the dietetics workforce.

B. Implications

The projections presented in this report suggest that national workforce estimates alone provide an incomplete picture of future workforce needs. Although the baseline projections indicate relatively stable overall workforce supply and demand for both RDs and DTRs, these aggregate trends mask substantial differences across practice areas. Workforce planning efforts may therefore benefit from focusing on individual practice settings in addition to the profession as a whole.

A second implication is the value of independently modeling workforce supply and demand. Unlike previous projection models that assumed supply and demand were in equilibrium at the beginning of the projection period, the current framework allows baseline workforce shortages or surpluses to be incorporated explicitly. This approach provides a more transparent representation of workforce dynamics and enables the model to distinguish between shortages that arise from changes in workforce supply, changes in workforce demand, or both.

Finally, the interactive dashboard extends the usefulness of the projection model beyond the results presented in this report. Rather than providing a single deterministic forecast, the dashboard enables users to evaluate alternative assumptions, explore predefined "What If?" scenarios, and examine projected workforce supply and demand for individual practice areas. This flexibility allows the model to support workforce planning under uncertainty while accommodating evolving healthcare, economic, and policy conditions.

C. Comparison with the 2012 Study

The projection framework developed in this report builds upon the 2012 Dietetics Supply and Demand model while introducing several important methodological enhancements. Like the 2012 model, the current framework projects workforce supply and demand separately for multiple practice areas and incorporates practice-area-specific demand drivers. Both models also recognize that different sectors of the profession are influenced by different demographic, healthcare, and economic factors.

The most important conceptual difference is that the current framework no longer assumes that workforce supply and demand are in equilibrium at the beginning of the projection period. The 2012 model explicitly assumed baseline equilibrium and projected future shortages from that starting point. The current framework relaxes this assumption by independently estimating baseline workforce supply and demand, allowing the model to represent existing workforce shortages or surpluses before projecting future trends.

The current framework also incorporates several structural enhancements. Clinical practice has been divided into five practice areas rather than three, distinguishing Hospital Outpatient, Office-Based, Long-Term Care, and Telehealth settings. Demand models have been updated to incorporate contemporary data sources and practice-area-specific demand drivers, including external forecasts for Clinical – Telehealth. The supply model incorporates updated registry data, recent survey data, and historical changes in practice area distributions. In addition, the projection framework is accompanied by an interactive dashboard that allows users to explore alternative assumptions and predefined scenarios without modifying the underlying model.

Taken together, these enhancements provide a more flexible and transparent framework for workforce planning while preserving the practice-area structure that formed the foundation of the 2012 model.

D. Limitations

As with any projection model, the results presented in this report depend on the quality of the available data and the assumptions used to project future workforce supply and demand. Although historical data provide an empirical basis for many model components, future workforce conditions may differ if healthcare delivery, technology, reimbursement, workforce participation, or public policy evolve differently than assumed.

Several model parameters are necessarily assumption-based rather than empirically estimated. These include the baseline workforce gap, selected demand-driver weights, and the parameters underlying the predefined scenario analyses. Although these assumptions were developed in consultation with CDR and subject matter experts, they remain uncertain. The interactive dashboard was designed to allow users to evaluate the sensitivity of the projections to these assumptions by modifying parameter values and examining alternative scenarios.

The projection framework also simplifies several aspects of workforce dynamics. Practitioners are assigned to a single primary practice area, interactions among practice areas are not modeled explicitly, and changes in the distribution of practitioners across practice areas are projected using historical trends rather than modeling individual career transitions. In addition, demand drivers are intended to serve as proxies for underlying workforce demand and cannot fully capture all factors that influence employment within a given practice area.

Finally, the projections should be viewed as planning tools rather than precise forecasts. Their primary value lies in identifying the relative direction and magnitude of future workforce trends under a consistent set of assumptions and in providing a flexible framework for evaluating how alternative assumptions may influence those projections.

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