NDBODP
NORTH DAKOTA BOARD OF DIETETIC PRACTICE

# Board Meeting Minutes – 11.20.2020
# ZOOM Meeting
# 9 a.m. (CDT)

**Mission Statement:** To protect the public and ensure compliance with the ND Century Code Chapter 43-44.

Present – Board Members: Linda Schloer, Brooke Fredrickson, Wendy Mankie, and Nancy Overson.
Absent – Shaundra Ziemann-Bolinske
Also present - Pat Anderson, NDBODP Executive Secretary and Allyson Hicks (joined at 9:42 a.m.), Assistant Attorney General

## I. Call to Order

Chair, Brooke Fredrickson called the meeting to order at 9:05 a.m.

## II. Procedure for Guests

Guests present included Sandra Horob, Mark Rifkin, and Bri Srnsky
Brooke Fredrickson welcomed guests present and asked that guests do not speak unless called upon. She announced that we would leave time towards the end of the meeting for public comment for guests to ask questions or make comments.

## III. Legislative Planning

Brooke gave an update on our Monday morning meeting. Pat and I reached out to Senator Kristin Roers and she is interested in meeting with us and we have that planned for this afternoon; she is very excited about it. Pat said the board needs to decide how we are going to proceed. Are we going to file this as an agency bill with a primary sponsor or to have legislators have the bill and put it forth? Pat talked to an executive director at another agency whereby they put forth bills quite often and he said that if it is not a controversial bill he will file it as an agency bill and if he expects some controversy with the legislation and there may be some pushback, he recommended that you put it into the hands of a legislator. So, the board needs to decide what you would like to do. Since we have a Senator that is potentially excited to do this for us and I think we could potentially get some other legislators to co-sponsor, I would recommend to the board that we pursue that avenue. The other reason for that is that with a Senator as a primary sponsor then we could get the bill directed to the Senate first. Brooke said that filing it as an agency with a legislator is not common and looking at what other agencies have done in other years it is usually filed fully sponsored. Linda Schloer moved that we ask Senator Kristin Roers to sponsor the bill and file it as a sponsored bill; Wendy Mankie seconded the motion. Roll Call Vote: Yeas – Nancy, Wendy, Brooke and Linda. Nays – None. Passed.

Pat brought forth the proposed changes to the statute since the last meeting and the following discussion was held:

a. For the definition of general supervision – we did not change the definition and the intent of general supervision is for the supervision of non-MNT related functions.

b. Pat provided a revision to the last statement of the nonmedical weight control definition to remove the word, in order. The revised statement would say: It includes weight control services for healthy population groups ~~in order~~ to achieve or maintain a healthy weight.

c. The onsite supervision definition is the same and is for the purpose of supervision of the individual providing MNT. Brooke said we had a lot of discussion about this and we do believe it is necessary for the supervision of MNT when someone is in their internship. We might get some pushback on it but I am not sure we compromise it anymore without lowering the standard.

d. The qualified supervisor definition; the part about the supervisor under this subdivision by the state, I need to ask Allyson what the correct legal terminology should be, whether it is subdivision or subsection. Letter d. would actually fall under this whole subsection or subdivision.
We also had an equivalent course of study and I'm not sure how equivalent course of study would be interpreted so I did add, as approved by the board.

e. Telehealth definition; we had a long discussion the last time and Allyson advised that basically this is a tool kit that is in front of you and it is the means to provide services that you practice. Pat shared a reference to an Oct. 2020 document put out by the Academy and telehealth is defined as the use of electronic information and telecommunications technologies to provide services under this chapter to support clinical health care, patient and professional health-related education, public health and health administration. A variety of nutritional care and health promotion activities may be provided through teledietetics communication, including interventions (such as education, advice and reminders) and monitoring of interventions. Pat has contacted the Academy to get permission to use the definition because it is copyrighted and share the proposed language for the definition in no. 30. The definition is very broad. Last time we talked about whether phone is allowable because the ND insurance statute doesn't allow it, but Allyson said we could incorporate it into our language. Pat proposed the revised definition that is listed under no. 30 because it mirrors the Academy's definition. Pat stated she didn't get too specific on what types of interventions in the telehealth definition and section 43-44-21 adds language that telehealth complies with applicable telehealth regulations and laws, personal health information is protected and documentation of nutrition care services are included in the medical records of patients. Brooke said she is okay with those changes and Wendy said she printed off that same document. Mark Rifkin asked if we wanted to include informed consent somewhere in this?
Pat said that would fall under the applicable laws and regulations part.

f. All meetings are open to the public except that the board may have closed meetings to review patient medical records, patient testimony and for other reasons as referenced in section 44-04-19.2. Allyson recommended at the last meeting that we have spelled out substantially clear that we can review patient records and patient testimony.

g. Pat added under the courses required that we include the equivalent of biochemistry as approved by the board which we talked about at the last meeting.

Additional language was added for the LN supervised practice requirement and Pat proposed the following information:

h. The applicant must have completed a board approved internship or a documented, supervised practice experience demonstrating competency in nutrition care services and the provision of medical nutrition therapy of not less than 1000 hours including at least 200 hours of nutrition assessment, 200 hours of nutrition intervention, education, counseling or management, and 200 hours of nutrition monitoring or evaluation. A minimum of 700 hours of the supervised practice experience is required in professional work settings and no more than 300 hours can be in alternate supervised experiences such as observational client/practitioner interactions, simulation, case studies, and role playing. This experience shall be under the supervision of a qualified supervisor with the requisite education, training, and license or certification required pursuant to section 43-44-01. Qualified supervisors must provide onsite supervision of an applicant's supervised practice experience in the provision of medical nutrition therapy and provide general supervision of an applicant's provision of other nutrition care services that do not constitute medical nutrition therapy.

Pat said that applicants as an LN must have completed a board approved internship, or a supervised practice experience and she added, demonstrating competency, in the first sentence and that she will explain that a little later.

Pat said that Brittany had brought forth concerns that our statute language was problematic for them because we are requiring the onsite supervision for MNT. Pat said she really tried to think broadly and also try to assess where the dietetics field is going. She had sent to the board some of the research information that she had pulled together. ACEND is transitioning to a new model for dietetics and so she was looking at what that looks like. She talked with Doris Wang at UND on where things are going and obtained her perspective on that. Doris had explained to Pat that during Covid the supervised hours for the students have decreased from 1200 hours to 1000 hours for the supervised experience. She said that 600 hours is comprised of actually going to the sites to do real work and the student is assigned to a qualified supervisor and 400 hours is alternative learning in simulation or virtual experience. I asked her about the future model for training and she said they are going to get away from the exact no. of hours and they are going to look at performance and assessing a student reaching competencies. She said there is not a specification of hours for the experience.

Pat said she wondered what this future model is going to look like as far as virtual and she said the new models are being tested now, testing started back in 2017, and ACEND will look at what is producing the best outcomes. Pat said she looked at one of the future models that is being offered that meets the new ACEND models and all of the supervised practice component is onsite. The student can take a good portion of their courses online and then the student has to go to the professional worksites in their health centers and the university person told me that this is 6 – 9 months onsite. I don't know if the variance in time is based on how soon a student completes the competencies. I think this is so important of that onsite requirement. I also looked at the student handbook from UND and something that really stuck out to me is in that handbook pertained to the responsibilities of the preceptor. The handbook said, teach as you work. Observation is an important part of the students' learning experience. Simply allowing the student to observe you as you go about your job teaches them more than you might realize. However, it is important to "think out loud" to give them the advantage of understanding how you make decisions and what is important in certain situations and why. It is also critical for them to observe how and when you interact with others in the organization. These interactions form a framework in the student's mind for

professional relationships. A survey of students found two learning experiences to be the most valuable: observing preceptors communicating with colleagues and hearing preceptors think aloud to arrive at care plans.

Pat said she is really trying to understand from Brittany's perspective of where she is coming from and also understand the future model for training of dietitians. The key messages that she took away from ACEND's analysis is that we are moving towards a more progressed academic preparation, you all know the Masters' degree will be required in 2024. There are more competencies and indicators in the future and it is expected for more higher level competencies. The future education model is to be determined based on the piloting of programs that started in 2017 and the future education will be assessing the competency aspect. Demonstrating of competence must be integrated into the coursework and supervised experiential experiences built into the program and these must include a variety of educational approaches for the delivery of content to meet learning needs and facilitate learning objectives. If any portion of the program is offered through distance learning the program assures regular and substantive interactions between students and instructors.

Pat explained that is why she put in language in the statue of demonstrating competency. Her hope is that the board, through the administrative rules, could outline what they would expect to see from someone who would be applying through this avenue. Pat said that she has been in contact with another state who is working through this process more and more and she thinks there is a lot that could be learned from them. This is a whole other journey; she doesn't think we could spell out this in the next few weeks but if we have authority for it in the statute, we could build what that would look like.

Pat said that one of the reasons we want to include CNSs in the statute is that we don't want to be overly restrictive if someone meets the standards and is competent to practice MNT. The other reason we are moving forward with statute changes is that we don't want to be overly restrictive in that we are not allowing individuals to provide nonmedical general nutrition information. So, in looking at what we are trying to accomplish, trying to bring someone into the practice of nutrition and dietetics I think we need to have high standards. Pat said we have certain expectations and frankly based on her research with the CNS, and she said, I am not going to say this across the board, because there are some well qualified individuals, but I do have concerns with the fact that from what Brittany said, 50% of the CNS candidates participate in some form of virtual supervised practice experiences. Some of these candidates work with either clients that are through their supervisors or they get their own clients. This raises a question for me because this client professional relationship appears for some of the candidates to be started on their own. I had asked Brittany; how do they get candidates? Brittany emailed and said that candidates may work with either their own clients, obtained through marketing and networking efforts as they develop a private practice or through other work settings, or they may work with their supervisors' clients. Pat said she has a concern with this, because if you are getting your own clients, you are doing this virtually, your supervisor is doing regular virtual supervision which was explained as: Virtual supervision includes a combination of regular email communication to review clients and treatment planning, ask questions, and get feedback; review written client case studies; case presentation and discussion; telephone conversations and video conferencing it appears that this is more of a mentorship. I did not get any confirmation that supervisors are always

signing off on the medical record notes. It appears that it could be more of a mentorship for some of these individuals where they are building a practice, they are getting clients, they are doing a lot of things on their own.

Pat reported that the actual BCNS supervision requirements require that CNS candidates meet with their supervisor (either in person or virtually) for a minimum of 1 hour per every 40 hours worked with clients to review and discuss case studies. Pat noted that the 40 hours is inclusive of all activities working with clients, including research etc., not just direct client contact. She noted that Brittany said most supervisees have more frequent contact with their supervisor. Pat said that she has concerns that it doesn't appear that all are having their chart notes signed off. She also said that she thinks their SPE model was established to allow for candidates to get their own supervised practice and supervisors and some flexibility on how they are going to meet that supervised practice experience. Pat said that in her opinion some of those supervised practice experiences are not going to be a means of where you can assess competency. Pat said she would like to recommend to the board what ACEND has put forth in their 2022 draft standards for internships. In that the program you must document that interns complete at least 1000 hours of supervised practice experience with a minimum of 700 hours in professional work settings and a maximum of 300 hours in alternate supervised experiences such as simulation, case studies, and role playing. The program must document the number of hours in professional work settings and in alterative supervised experiences and I think that is something we could include in the rules potentially. A question Pat brought up is, do we need to define professional work settings? Because if it is virtual, someone could say, that is a professional work setting, I want to avoid that as potentially being misunderstood. I did include in the 300 hours of alternate supervised experiences to include observational client/practitioner interactions, simulation, role playing and case studies. I was trying to think of Brittany's point that telehealth is happening and more of that with Covid, so would observational client/practitioner interactions be appropriate where there is a telehealth situation and there is the ability to have your supervisor actually observe or if the actual candidate would observe the practitioner so it is in real time. Maybe that needs to somehow be spelled out better and I may need to visit with Allyson on this. I really think we have to have some stringent language in here. Pat mentioned that Brittany had put forth in her comments that other states that have brought them in haven't included some of this language such as the qualified supervisor and the onsite supervision but I think it is because there was a certain amount of trust that these are professionals, they have their Masters degree, they have a board that is overseeing. Pat said that it is of concern that the supervision can be all remotely and the supervision requirements are minimal. Pat said she did ask Brittany on how many CNSs they have and they have 1142 active CNSs across the country. They are an evolving profession. I think the potential for ND would probably be through telehealth and we have to look at the role of the board and it is to protect the public against harm. Pat said she thinks we have to have a high standard that we establish for bringing these folks on. She also said that we are trying to establish how their model works and we don't want to lower the standards for what is required to practice MNT. Pat recommended to the board that we really think about how we want to approach this whole thing and that she thinks it is important that we include language in the statute that upholds standards and protects the public.

Brooke said that I think we are going to have opposition from the CNSs because of this language but I don't think we can water down the requirements for them while holding dietitians to a higher standard and still license them to practice MNT.

Brookes says I do agree that we do have to have specific standards and if they want to practice in the state of North Dakota as a CNS or a LN, then they can apply for licensure. If they do want to practice non-MNT in ND they can do that but if our purpose is to protect the public then we don't want to license them without meeting the standards. Brooke said she thinks the competency piece is very important because one of the other states is finding that their supervised practice, they are running their own private practice, as an unlicensed practitioner, but checking in with their supervisor every now and then and considering that their supervised practice. Brooke also said that some of them are only doing weight loss or one specific thing so they aren't getting or proving competency in all the different disease states than encompass MNT and therefore we are licensing them to do diabetes, renal, GI issues and all they are doing is weight loss and they are not able to prove that they are competent on those things. Brooke said she agrees if we can lay all of that out in the rules that that would be a good way to assure that they are getting all those MNT components.

Allyson joined the meeting. Pat explained that we have been having quite a lengthy discussion about the CNS requirements and the variances in their supervised practice and how that is occurring. Brittany has told us that a lot of these candidates are doing virtual experiences and their supervision is done basically through email communications, reviewing client and treatment plans through regular email, asking questions and getting feedback, review of client case studies, case presentation and discussion, telephone conversations and video conferencing. Brittany has further told us that the requirements for supervision are a minimum of 1 hour per every 40 hours worked with clients to review and discuss case studies. This also includes activities involved with clients, including research, not just direct patient contact and most supervisees have more frequent contact with their supervisors. Brittany has told us that many of the candidates are experienced professionals in nutrition. When asking Brittany, how do these individuals get their clients if they are doing their practice virtually and she said, candidates may work with either their own clients, obtained through marketing efforts as they develop a private practice or through other work settings, or they may work with their supervisors clients. When Brittany was asked about charging for services, Brittany said that some may charge a fee to clients directly, and others are able to earn their hours in a work environment for which they get paid. Pat expressed that in her opinion, that some of these seem more like a mentorship set up where you are getting your own clients, you are having some communications with your supervisor and Pat did not get an answer on whether the medical records are always signed off. Pat expressed that she has some concerns with this and shared that on the dietetics end for the accreditation standards for supervised practices from the internship standards, there is the requirement for a minimum of 700 hours of the supervised practice requirements in professional work settings and no more than 300 hours in alternate supervised experiences such as simulation, case studies, and role playing and I added client/practitioner interactions which would be that telehealth component. Could we have something in the statute that specifies demonstrating competency and then the board would have to outline that in the rules what that would like out? Pat said she thinks there needs to be some provision of how these supervised practices were done. Allyson said, I tend to agree and something I have talked to other boards about is the pandemic and the reliance on virtual stuff for everything is somewhat in a vacuum. A some point we are going to go back to normal so I would discourage the board from adopting something just because of the unavailability of in person experiences at this time because now is not normal and whatever you put in your statute you are stuck with for at least two years. Allyson thinks having some hesitancy about doing everything by email, virtually, that kind of stuff, is appropriate and I am fine with it. Just like Pat said, you are going to have to parse out what competency is in the rules so you are not moving the goal post if one person does something and that is showing competency and the other person does the same thing and it does not. You are setting yourself up for a substantial administrative rules' hearing on that, but I am fine with the language that is proposed. It gives another alternative of

300 hours and giving people some leeway. I do think demonstrating competency gives the board some wiggle room that in the future if something would come up that you can adapt the administrative rules a lot easier than changing the statute.

Pat asked if we need to define professional work settings, especially that someone may define that telehealth, is a virtual work setting. Allyson said, it we define telehealth as part of the profession now, calls from your office could be a professional work setting so we would likely flush this entire section out in the administrative rules. I would put that definition in the rules and as your profession continues to evolve that might be something that could more easily be changed and you give yourself more flexibility to modify in shorter timeframes than in the two year legislative sessions.

Allyson is fine with the updated telehealth definition and because it is adopted by the Academy it is an industry standard so that is much easier for people that are trying to work interstate to comply with. Pat said that when she got permission to use the definition the Academy requested that we cite the source and I said I am not sure how that is done in a statute, I have never seen it in a statute. She did make reference that it would be used in a statute and mentioned that this isn't something she has seen in a statute. Allyson said she can ask legislative council if they would allow that but honestly she has never seen it and thinks it is kind of bizarre that they copyrighted it, why wouldn't you encourage people to use it? Allyson said even if we took a portion of the definition it still would be copyrighted. Honestly, we should use their definition it to promote continuity amongst the states. Allyson said she will figure this out.

Mark Rifkin agreed with Alyson that we don't want to rubberstamp the Academy, imply or indicate that this is from the Academy. He is curious what Pepin would say about this; does it need to say copyrighted or could it be slightly reworded to avoid the copyright obligation? Mark said he can check with Pepin. Pat asked if he could check with the Academy and see if we could avoid having to cite the definition? Mark will check with Pepin or perhaps other folks.

Pat said we checked with the Board of Pharmacy to see if they had any issues with the language, we added under no. 6 in section 43-44-11:
A licensed registered dietitian or licensed nutritionist may implement prescription drug dose adjustments for specific disease treatment protocols within the limits of their knowledge, skills, judgment, and current evidence-informed clinical practice guidelines as indicated in a facility approved protocol and as approved and delegated by the licensed prescriber. This does not allow licensees to prescribe or initiate drug treatment. Licensed registered dietitians and licensed nutritionists may be authorized to prescribe vitamin and mineral supplements or discontinue unnecessary vitamins and minerals.

This is language that Brooke researched and came up with and we have been in communication with Dr. Mark Hardy from the Board of Pharmacy and he doesn't have any concerns with this language. Allyson said that if Mark is fine with it, she is fine with it.

Brooke asked if Wendy had any input on this? Wendy didn't have any issues with it as it basically is what we do. Brooke said she also called a renal dietitian that works at Sanford in Fargo to just ask how this works in a renal setting because it was brought up that some renal dietitians make some prescriptive type supplements during dialysis and she said vitamin D analogs and writing

prescriptions out for renal vitamins that you can't buy over the counter and she thought this would be very helpful to have in our statute. Allyson said that the only question she would have is, would there ever be a time when a vitamin or mineral prescribed by a dietitian or a nutritionist would have a negative interaction with a drug that a dietitian or a nutritionist would not be aware of it. Brooke indicated that it could, but this is part of our job to understand nutrient drug interactions.

Wendy said that typically in a hospital setting RDs are not allowed to make an order right now unless we specifically have order writing privileges for that facility. Right now, in Grand Forks we don't have that yet, we are going through it and right now we can only ask the practitioner to make that order. So, we will need to prove our competency that we can and are qualified and competent to make those orders. Brooke said it does say in here in a facility approved protocol and as approved and delegated by the licensed prescriber. It is within our scope of practice, but we still need to obtain authority from the facility that we are working in.

Mark Rifkin said that some vitamin D formulations, I don't know that they would be classified as a drug or a vitamin. Brooke said, but they require a prescription. Mark said yes, my concern being that it doesn't allow licensees to prescribe a drug treatment and I don't know; for example because vitamin D requires a function of the kidney; any vitamin D supplement provided to a kidney patient may be downstream from the metabolic function, they call it calcitriol, I don't know if that would be classified as a drug. Therefore, I am wondering if that would come into conflict and it wouldn't allow a licensee to prescribe. I don't want to see a RDN not subject to be able to prescribe calcitriol for a renal patient. Allyson asked, would it be beneficial to add a definition of vitamin and mineral supplements? Mark said he could also put us in touch with a renal DPG contact. Brooke said that the renal dietitian she talked to in ND isn't allowed to act in this way because it is not in ND law but in Minnesota some are. Wendy said that she can look to see what they have at Altru. Brooke asked if we need to add competency to the definition or does knowledge, skills and judgement cover this. Allyson said that she thinks the language we have does include competency and if you add competency than it is more of a board decision. Brooke said that when she talked to the board of pharmacy that it was clear that we cannot prescribe a drug so that is why we added that in there that it does not allow licensees to prescribe or initiate a drug treatment. If we do insulin adjustments and carbohydrate counting, we do adjustments in the insulin we are sending that back to the doctor and the doctor updates the prescription. That is one thing the board of pharmacy wanted clear, are you actually writing a prescription or not? If we can get clarification on whether any vitamins or minerals are considered drugs that would be the only thing, we need to clarify on this one. Wendy and Brooke will follow up on this and if Mark could get us in touch with a renal dietitian.

Pat shared the language that Allyson sent for exemption no. 3:

Any individual aiding the practice of medical nutrition therapy, if the individual works under the general supervision of a registered dietitian licensed by this board; licensed nutritionist licensed by this board; or other health care practitioner licensed by the appropriate North Dakota board whose licensed scope of practice includes the practice of dietetics or nutrition.

Pat said that for exemption no. 11 as far as keeping with the language in exemption no. 1 we would add to the definition, consistent with the accepted standards of their profession.

(i) as part of a plan of care overseen by a North Dakota licensed health care practitioner who is acting within the scope of the individual's licensed profession, consistent with the accepted standards of their profession to provide nutrition care services for the purpose of treatment or management of a disease or medical condition.

43-44-21. Telehealth
Allyson recommended that we remove under sub 3, telehealth. Otherwise she is fine with it and thinks they are all good notations to make.

43-44-22 – Limited practice without a license
Allyson said to make an edit to reference to 43-51-05.

43-44-23 – Criminal history record checks
Allyson stated that with this inclusion there will also need to be made a change in the BCI statute that includes background checks for applications or renewals through Chapter 43-44. Allyson will take care of that paperwork and send it to us. It will have to be included with the part of the bill draft when filing because it affects another statute. Basically your statute gives you the ability to order it and the BCI statute gives them the authority to give it to you.

Pat informed Allyson that Senator Kristin Roers is willing to sponsor the bill and that the board decided to file as a nonagency bill and have Senator Kristin Roers to champion it and there is the potential to get other sponsors on the bill. Allyson said we should make sure she is comfortable with the entire text of the bill and then we can go ahead and put it in bill draft format and give it to her so it is packaged up and legislative council won't have to fuss with it too much. Once you hand it to Roers it is out of your hands. Obviously, you will testify to it but it isn't like you have to do anything with legislative council. It would all be on Representative Roers. And as far as the deadline for her filing, Allyson said the filing date is Jan. 25. Allyson recommended that she still try to get it in somewhat early. Allyson is going to put this into bill draft form and then the board needs to officially approve it. We still need to get the pharmacy language worked out.

**IV. Public Comment**

Brooke invited public comment.

Brittany McAllister stated that she was asked by Pat to provide some information about our supervised practice experience and I am sorry that I wasn't able to join the meeting earlier. I was wondering what decisions were made in regard to the pathway for our recipients in regard to supervised practice etc. Just so you know the supervision of onsite MNT is something that is not required for all CNSs and for my understanding is not done for all registered dietitians. There are some registered dietitians that receive supervision that is not onsite so I just want to state for the record that if the point of the bill is to expand licensure for the pathway of CNSs this does not do that and we continue to find this a problem and we continue to wonder what the reasoning is behind it is if the goal is to regulate the profession in the least restrictive means necessary which is the lens that many legislators will look at this through. Requiring onsite supervision is pretty much irrelevant and is not necessary for the level of harm that someone may do with virtual nutrition counseling.

The definition of onsite supervision was brought up for review: “Onsite supervision” means the qualified supervisor is onsite and present in the department or facility where nutrition care services are provided, is immediately available to the individual being supervised, and maintains continual involvement in the appropriate aspects of patient care, and has primary responsibility for all nutrition care services rendered by an individual.

Brittany stated that if the change includes immediately available that is different than physical, but am I correct in that the intention of this it is to include both the physical presence and immediately available in either or? Brooke stated that this would be in the definition of general because we have either or in the definition of general supervision. Brittany said so it appears the bill would require that medical nutrition therapy supervision would be for only licensed nutritionists not licensed registered dietitians to have onsite supervision even if the interaction is virtually with the client. So, I could be seeing a client virtually over ZOOM or face time and my supervisor would have to drive to my office and physically sit next to me. This could be a supervisor across the State, so we find that unnecessary and unfair and anti-competitive in nature.

Brooke said, so you feel that we are putting more restrictions on the licensed nutritionists that aren’t on registered dietitians? Yes, it is my understanding that not 100% of dietitians, RDs, would have onsite supervision for medical nutrition therapy if they are working let’s say in private practice, especially now. There is the aspect of Covid which has allowed us to do telehealth and Covid has also taught us that things that we thought were necessary to do in person are not and so regardless of that though, it is my understanding that not every dietitian has not given every hour of MNT with supervision and that would require those unlicensed nutritionists to give every hour of that supervised. Wendy asked, could you give me an example of someone that would not be supervised? Brittany said that the supervisor may be over video chat or over whatever we are doing right now. Wendy said that right now as a practicing RD and as a preceptor supervisor for my students I don’t know of any case where I am not aware of any of my students being supervised virtually, we are not doing anything virtually. Brittany said I think many of your dietitians, about 2/3 of them, work in inpatient settings or hospitals and facilities where there is going to be someone onsite but conversely 75% of our CNSs work in private practice outpatient settings where you are not having that, you are not touching the patient. You are not providing enteral, parenteral tube feeding, you are not going to the hospital setting, the patient is laying in a bed. We are really doing more counseling than touching and so the nature and the amounts of practice and the areas where we work are different. So I think that is significant and when you think of onsite supervision I agree with you that facilities usually set that requirement but setting that requirement on someone who works in a private practice doing virtual nutrition counseling is definitely something different than work requiring for it to be in a hospital.

Brooke said, so Brittany my thing comes back to, as a supervised practice, aka, internship, this person should not be working with clients independently and doing MNT without direct supervision because technically they are doing something they are not licensed to do. And so, even as dietitians whether we were doing it via telehealth or in a hospital or in an outpatient setting we would still have someone there who is signing off on all the notes because we are technically seeing their patients.

We are not allowed to see our own patients as an unlicensed person. And that's across the board for dietitians.

Brittany said, so when you are seeing someone virtually, you are saying that 100% of dietitians are having a supervisor physically present. Let's say with Covid right now, for example, those people are probably working from home, like many of us, so you would have your supervisor drive to your home while you saw a client virtually and be sitting next to you? Brooke said, I can't attest to that and asked Pat how the students are doing it now. Pat said that during Covid, 600 hours is going to sites to do real work and the student is assigned to a supervisor. 400 hours is alternate supervised experiences such as simulation or virtual experiences and a lot of that is for providing in services, teaching education and there is the ability for the supervisor to be part of that. Pat said in the language we included for alternate learning experiences that would allow for observational client/practitioner and the supervisor could be part of that and involved in that.

Allyson said I think the point she is trying to make is that when you are on the same virtual platform it is not the same as being onsite. Onsite indicates that you are in the same physical location doing things together, not in the same virtual platform. Do we need to specify that if you are providing services on a virtual platform that joint or simultaneous use of the virtual platform with the client would suffice, opposed to being physically onsite at the location with the supervisee? I know it gets really wordy and language heavy but I think that is the point she is trying to make so that nobody is arguing about the fact that whether you are both at the hospital, you can both be onsite but what if you are meeting with a client via ZOOM and that person is on the same ZOOM call but from their own home?

Brooke said in the onsite definition I think, present, is important and I think we could add virtual or in person. Brittany asked if onsite implies a physical nature, does that mean physically? Brooke said we could change it back to direct supervision because that is what we had before. Allyson said onsite in the definition means the qualified supervisor is present in the department or facility and could you add, or virtual platform? Allyson said we can continue to call it onsite supervision but add, or virtual platform, and delete the second, onsite, in the definition. Allyson said, does that address everyone's concerns? Brittany said, she thinks that is a step in the right direction as far as maintaining telehealth services through all of this. This requires a level of continuous availability above what a level of CE is but this is a huge step in the right direction. I am wondering how this affects the supervised practice for the sake of qualifying for licensure so for individuals who may have done their supervised practices previously, lets say they did it in MN and they want to move to ND and become licensed, there are different requirements in MN, would they have to have some of these hours or is the board contemplating some sort of grandfathering clause that would allow supervised practices already completed to count? Pat said that we talked about demonstrating competency for the LNs. Brooke said that I don't know that we are going to have reciprocity for LNs because it specifically states that individuals are going to have to meet or exceed our standards and that we are not going to accept someone with standards lower than ours. This would have to be looked at on an individual basis and we are not going to accept reciprocity. Brittany said I didn't mean to say reciprocity in that if you had a license in MN you could actually get one in ND, I mean specifically for someone. Say there is someone from California and there is no license available to them but they are a CNS and they did 1000 hours of SPE and they moved to ND and you are requiring them to be on ZOOM 100% of the time and their supervisor was on ZOOM 50% of the time, how carefully would you review that? How

would you look at that sort of situation? Brittany said that Pepin and him have been talking about this in different states and the grandfathering in. Particularly in states where there is not a licensure in place now. Brooke said that where we have it laid out under item no. b, you know 700 hours in a professional situation and 300 hours in alternate settings, I think we would be asking for that.

Brooke asked if there were any more questions. Brittany stated that she thinks we have answered the big ones and she appreciates this conversation very much so we can come to a mutual understanding of each other. I also am wondering what the process or the requirements around the board will be for communicating with stakeholders? This is your bill so I am not going to try to push my luck here but are you sharing after each draft with stakeholders and is there any consideration as to what is shared with AND? Pat mentioned that we planned to share with licensees. Allyson asked if once we make all the changes, could the bill be posted on the web site? In that way you wouldn't have to send to all licensees. Brooke and Pat answered yes.

Brooke asked for any further public comments. None were received.

Allyson said that since the grand majority of changes have been made, I will have my legislative assistant put it in bill draft form and by early next week I should have a draft. Allyson suggested that as we continue to talk about this instead of changing it in the document that we have been changing we will just change it directly in the bill draft. In that way no matter what, it is ready to go. Allyson will have Vanessa start on this right away today and then as soon as she has a draft she will send it to Pat, she can circulate it around to everyone, post it on the website, whatever you guys want to do. All we would wait on is the updated vitamin and mineral language. I think that is all that is really left.

Allyson says she thinks the draft could be sent to her by next, Tuesday.

**V. Next Meeting Date**

The next meeting will be Monday, November 30 at 3 p.m. with the plan to review the draft.

**VI. Adjournment of the Meeting**

Brooke asked for a motion to adjourn. Wendy moved to adjourn the meeting; Linda seconded the motion. The meeting was adjourned at 10:41 a.m.

**Respectfully Submitted,**

Pat Anderson

**Pat Anderson, NDBODP Executive Secretary**