Future Dimensions

In Clinical Nutrition Practice

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Spring 2021 Special Edition: Diversity, Equity and Inclusion

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"…the proposition that all…are created equal…" is the introduction of the most famous and often quoted speech by President Lincoln; the Gettysburg Address. Centuries later there has been tremendous progress—most recently the election of the first multi-racial female Vice President of the United States, and the most diverse presidential cabinet in US history—however, the events of the past year proved that there are still significant and monumental changes that are needed to bring truth to the words of President Lincoln.

The events in 2020 shed light on the systemic lack of diversity, equity and inclusion. Unfortunately our profession was not exempt from being under the microscope.

In building on this foundation and in the achievement of cultural competence, this special edition on Diversity was published. All members are invited to utilize its contents as well as share it. Let's fulfill the Academy's Vision…"membership will be comprised of richly diverse, culturally proficient nutrition and dietetic practitioners…"

Ensuring Success for RDNs and Interns with Disabilities: Clinical Managers Can Make it Work

By Suzanne Domel Baxter, PhD, RD, LD, FADA, FAND and Neva Cochran, MS, RDN, LD, FAND

Diversity, inclusion and cultural competence have taken center stage in the United States (U.S.) this year and the Academy of Nutrition and Dietetics (the Academy) is among the many organizations placing additional emphasis on this issue for its members and the people they serve. The mission of the Academy's Diversity Strategic Plan[1] is to "enhance the diversity of nutrition and dietetics providers so that they more closely resemble the communities they serve; providing all practitioners with vital tools to practice culturally proficient care." Practitioners from underrepresented groups generally have more insight and understanding of the group's cultural and food traditions and health challenges. They are often better equipped to gain their patients' trust to facilitate positive changes that may result in better outcomes from nutrition therapy.

Healthcare practitioners are among a significant proportion of individuals who are either born with or develop a disability over the course of their lives.[2] Healthcare professionals with disabilities—both in training and in practice—face a myriad of obstacles that can inhibit them from providing patient care. Registered Dietitian Nutritionists (RDNs) with disabilities have long been an overlooked diverse group within the nutrition and dietetics profession. The authors of this article have worked together for four years to change this through a variety of initiatives to create more awareness of the need to increase the number of RDNs and Academy members with disabilities. From the patients' perspective, more healthcare professionals with disabilities have the potential to improve outcomes and clinical experiences.[2]

Recruiting, hiring, retaining, and advancing workers with disabilities is good for business.[3] People with disabilities represent the third largest market segment in the U.S. Individuals with disabilities can offer employers a competitive advantage by strengthening workplaces through varied perspectives on how to confront challenges and get the job done. Individuals with disabilities bring creativity, innovation, problem solving, and commitment to the workplace. Employees with disabilities stay at jobs longer, thus reducing the time and cost involved in retraining and replacing personnel. Other benefits provided by employees with disabilities include increased productivity and morale, and more workplace diversity.[3]

A 2020 article, "Enhancing Diversity and the Role of Individuals with Disabilities in the Dietetics Profession,"[4] provides information on the prevalence of individuals with disabilities in the U.S., healthcare professions and the dietetics profession; disability rights laws; accommodation recommendations for individuals with disabilities in various settings; online resources for etiquette strategies to interact with individuals with disabilities; professional health science associations for individuals with disabilities; and future research and inclusion needs.

Specifically, this article provides information on

- Disability prevalence in the dietetics profession,
- Descriptions of organizations working toward disability inclusion and the disability equality index,
- Success stories of individuals with disabilities working in settings similar to those of clinical RDNs and dietetic interns,
- Etiquette strategies for interacting with clinical RDNs and dietetic interns with disabilities, and
- Perspectives from clinical nutrition managers (CNMs) of, and clinical RDNs with disabilities.

This article's goals are to equip CNMs with strategies to recruit, hire, accommodate and support clinical RDNs and dietetic interns with disabilities to be as successful as possible.

Disability Prevalence in the Dietetics Profession

There is minimal data on disability prevalence in the dietetics profession. For the first time, the *2019 Compensation and Benefits Surveys of the Dietetics Profession*[5] included disability status questions. Of 8,765 respondents (7,966 RDNs, 799 nutrition dietetics technicians, registered [NDTRs]), 1,350 (16%) reported non-employment in dietetics; Table 1 shows that 37 (3%) reported disability/health problems as the reason for non-employment in dietetics.

Table 2 provides responses concerning long-lasting conditions by three groups—"all" respondents (n=8,765), "employed-in-dietetics" subset (n=7,415), and "not-employed-in-dietetics" subset (n=1,350).

Table 3 provides responses concerning difficulties due to a personal condition lasting 6 months or more by the same three groups. In Tables 2 and 3, the percentage of respondents with disabilities was small but similar for the employed and not employed in dietetics subsets. For example, in Table 2, "blindness, deafness..." was indicated by 1% of those employed and by 1% of those not employed in dietetics. In Table 3, "(difficulty) learning, remembering, or concentrating" was identified by 2% of those employed in dietetics and by 3% of those not employed in dietetics. Thus, although 3% were not employed in dietetics due to disabilities, 1–2% of individuals with disabilities were employed in dietetics. The 2019 survey also showed that 60% of employed RDNs had clinical nutrition as their primary position's practice area, but did not specify practice areas of RDNs with disabilities employed in dietetics.[5] However, because 60% of employed RDNs practiced in the clinical setting, it is logical to assume that employed RDNs with disabilities practiced in the clinical setting, too. Results from the 2019 survey are crucial to building a database on disability prevalence among RDNs.

Continuing to include disability status questions on future surveys will allow the prevalence of disabilities among RDNs to be assessed on a regular basis in efforts to increase diversity in the profession. However, data on disability rates among dietetic students/interns are still needed.

If not currently employed or self-employed in a nutrition/dietetics-related position, your reason(s)?	**Respondents Not Employed in Dietetics**		
	RDN	*NDTR*	*Total*
Tabulated responses	1122	228	1350
Weighted base: not currently working in the field	1269	119	1388
Found higher-paying job outside nutrition/dietetics	222 18%	24 20%	246 18%
Changed career/profession	219 17%	15 12%	234 17%
Could not find nutrition / dietetics employment	90 7%	40 34%	130 9%
Relocated or in the process of relocating	93 7%	8 7%	101 7%
Promoted into a non-dietetics related position	82 6%	5 4%	86 6%
Retired	337 27%	151 13%	352 25%
At home raising a family	328 26%	15 12%	343 25%
Currently a student	29 2%	19 16%	48 3%
Disability/health problems	33 3%	4 4%	37 3%
Other	120 9%	16 14%	136 10%
No answer	18 1%	1 <1%	19 1%

Table 1. Reason(s) for Non-Employment in Nutrition/Dietetics.* All respondents listed multiple reasons.
*Adapted from Exhibit 7.03 in the *Compensation & Benefits Survey of the Dietetics Profession 2019*.[5]

Organizations Working Toward Disability Inclusion and the Disability Equality Index

The *Job Accommodation Network* (JAN)[6] is the main source of free, expert, and comprehensive guidance on workplace accommodations. JAN helps employers enhance the workplace by capitalizing on the value of individuals with disabilities, and helps individuals with disabilities improve their employability. JAN offers one-on-one guidance by telephone and online regarding reasonable accommodations as defined by the Americans with Disabilities Act (ADAct), as well as guidance on locating and purchasing specific prod-

Which of the following long-lasting conditions do you have?	All Respondents	Respondents Employed in Dietetics	Respondents Not Employed in Dietetics
Tabulated responses	8765	7415	1350
Weighted base: all respondents	8765	7377	1388
Condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying	88 1%	58 1%	30 2%
Blindness, deafness, or a severe vision or hearing impairment	51 1%	41 1%	9 1%
Indicated at least one	137 2%	98 1%	39 3%
Neither	8427 96%	7098 96%	1329 96%
No answer	200 2%	180 2%	20 1%

Table 2. Long-Lasting Conditions Held Reported by Respondents from the Compensation & Benefits Survey of the Dietetics Profession 2019.*
*Adapted from Exhibit 7.07 in the *Compensation & Benefits Survey of the Dietetics Profession 2019*.[5]

Due to a physical, mental, or emotional condition lasting 6 months or more, which of the following have you had any difficulty doing?	All Respondents	Respondents Employed in Dietetics	Respondents Not Employed in Dietetics
Tabulated responses	8765	7415	1350
Weighted base: all respondents	8765	7377	1388
Learning, remembering, or concentrating	173 2%	136 2%	37 3%
Working at a job or business	83 1%	55 1%	27 2%
Going outside the home alone to shop or visit a doctor's office	28 0%	17 0%	11 1%
Dressing, bathing, or getting around inside the home	12 0%	9 0%	3 0%
Indicated at least one	223 3%	165 2%	58 4%
None of these	8431 96%	7120 97%	1311 94%
No answer	112 1%	92 1%	19 1%

Table 3. Difficulties Due to a Personal Condition Reported by Respondents from the Compensation & Benefits Survey of the Dietetics Profession 2019.*
*Adapted from Exhibit 7.08 in the *Compensation & Benefits Survey of the Dietetics Profession 2019*.[5]

ucts and equipment to make facilities accessible. JAN's data suggest that more than half of all accommodations cost nothing. Their user-friendly website (askjan.org) has an "*ADA Library*" tab linked to ADAct accessibility guidelines and "*A to Z Lists*" tabs for users to search by disability, limitation, work-related function, topic, or accommodation. The "*Accommodation Search*" tab allows users to search for information about various accommodation options. The "*Publications & Articles*" tab provides links to publications by group ("Accommodation and Compliance Series" [disability, topic, Consultant's articles, case studies]) and to articles by group (newsletter issues, newsletter articles, Blog, Effective Accommodation Practice Series, guides/other publications). JAN is funded by the U.S. Department of Labor's Office of Disability Employment Policy (ODEP).[6]

The *Employer Assistance and Resource Network on Disability Inclusion* (EARN)[7] supports employers to recruit, hire, retain, and advance qualified individuals with disabilities. EARN's website (askearn.org) is a centralized source of employer-focused tools, resources, and publications on disability inclusion with easy-to-navigate information on a variety of topics from recruiting qualified job candidates to tax incentives for hiring people with disabilities. EARN provides a gateway to free training on the latest disability inclusion topics. Its interactive Training Center is a one-stop resource for comprehensive, curated multimedia training on strategies, policies, and practices for enhancing the inclusion of people with disabilities in the workplace. EARN provides the latest disability employment news and information on its e-newsletter, e-blasts, homepage, and social media. EARN researches disability inclusion issues and gathers exemplary policies and practices from employers and businesses that are getting it right.[7] An Institute on Employment and Disability at Cornell University works collaboratively with numerous partners (including JAN and PEAT) to manage EARN's activities.[8]

The *Partnership on Employment & Accessible Technology* (PEAT: www.peatworks.org)[9] is a multifaceted initiative to promote the employment, retention, and career advancement of people with disabilities through the development, adoption, and promotion of accessible technology. PEAT has toolkits for workplace accessibility specifically for staff training (accessibility skills and awareness resources), talent (accessible e-recruiting for employers), buying (guide for purchasing accessible technology), and policy matters (accessible information and communications technology). PEAT also offers podcasts and a newsletter.[9] Accessibility, according to PEAT,[10] means that everyone can use the exact same technology as anyone else for everything (e.g. emails, PDFs, documents, images, presentations, social media, multimedia, website, staff training resources, virtual digital interviews), regardless of whether they can manipulate a mouse, have limited vision, see fewer colors, have hearing difficulties, or process information differently. PEAT is funded by the U.S. Department of Labor's ODEP.[9]

Disability:IN (www.disabilityin.org)[11] is the leading nonprofit resource for business disability inclusion worldwide. Its network of over 220 corporations expands opportunities for individuals with disabilities across enterprises. Its central office and 27 affiliates raise a collective voice of positive change for individuals with disabilities in business. Disability:IN collaborates to promote the full inclusion of individuals with disabilities, to inspire accessible innovation for all, and to foster cultures of inclusion.[11]

The *Disability Equality Index* (DEI)[12] is a joint initiative between Disability:IN and the *American Association of People with Disabilities*. The DEI is a prominent benchmarking tool for Fortune 1000 and America's top 200 revenue grossing law firms to gauge their level of disability workplace inclusion against competitors. Now in its sixth official year, the DEI continues to see an increase in year-over-year participation, with the number of companies increasing from 48 in 2014 to 247 in 2020, with a total workforce of 11 million people. Furthermore, the number of top-scoring companies quadrupled from 43 in 2015 to 205 in 2020. For the 2020 DEI, on average, 5.5% of current employees had a disability, and 3.5% of new hires had a disability. The 2020 DEI measured six components—culture and leadership, enterprise-wide access, employment practices (benefits, recruitment, employment, education, retention and advancement, accommodations), community engage-

ment, supplier diversity, and non-US operations (non-weighted). For the 2020 DEI, 22 of the 247 participating companies were healthcare.[12] Figure 1 shows areas where companies excelled, Figure 2 shows areas where companies demonstrated marked improvement, and Figure 3 shows areas where companies have opportunities to improve. Top-scoring DEI companies who earn a score of 80 or above receive the recognition Best Places to Work for Disability Inclusion™.[12] A score of 100 does not convey "perfection" because there is no single best way to practice inclusion, and some practices may be more effective for some companies or industries than others. A DEI score of 100 means that a company adhered to many of the numerous leading disability inclusion practices feature din the DEI, although there's still room for improvement. For a full listing of top-scoring companies (that scored 100, 90 or 80% on the 2020 DEI), please visit https://disabilityin.org/what-we-do/disability-equality-index/2020companies/.

SUCCESS STORIES

Actual cases and accommodation success stories from JAN[6] are available online at askjan.org/a-to-z.cfm; click on a specific disability (e.g., Deafness), scroll down to "*Situations and Solutions*," and click on "*Read more*" and the right-pointing arrows. This section provides four success stories applicable to RDNs with various disabilities. At the time this newsletter article was written, this article's authors were unable to identify any success stories about RDNs in JAN; perhaps CNMs and RDNs with disabilities can contact JAN about success stories for future reference.

- A deaf phlebotomist received a text-to-speech device to communicate with patients, and vibrating pager with visual display so he could be contacted in the hospital.[13]
- A healthcare worker with lupus had low vision and difficulty viewing her computer screen and paper copies; she was accommodated with a large monitor, screen magnification software, hand/stand magnifier for paper copies, and closed circuit television system.[14]
- A healthcare facility educator had no vision and wanted to bring her service dog to work for mobility assistance; her employer allowed her to do so.[15]
- A speech therapist with quadriplegia could not access the workstation provided; the employer accommodated with an adjustable workstation that elevated to permit the wheelchair to fit underneath.[16]

Etiquette for Interacting With RDNs and Dietetic Interns with Disabilities

Etiquette strategies foster the inclusion and integration of RDNs and dietetic interns with disabilities into worksites and organizations.

Culture	Leadership	Enterprise-Wide Access
Of **97%** of businesses with a company-wide written statement of commitment to Diversity and Inclusion, **85%** specifically mentioned disability.	**88%** of businesses with a Diversity Council have a member who is openly public about his/her disability and/or is an ally/supporter for individuals with disabilities.	**70%** of businesses have an accessibility expert who can resolve accessibility or compatibility issues needed for individuals with disabilities to use technology systems.
Employment Practices: Recruitment	**Employment Practices: Accommodations**	**Community Engagement**
89% of businesses have external recruitment efforts in place that are specifically geared toward hiring individuals with disabilities.	**94%** of businesses have a written disability accommodation procedure available to employees, which explains the process to use to request a disability accommodation.	**95%** of businesses have provided philanthropic support to an external disability-related event or organization.

Figure 1. 2020 Disability Equality Index (DEI): Areas Where Companies Excelled *

* Figure revised from page 11 of DEI Disability Equality Index Report.[12]

Enterprise-Wide Access	Employment Practices: Benefits	Employment Practices: Accommodations
For the 2020 DEI, **64%** of businesses have a company-wide commitment to digital accessibility, an increase from **59%** for the 2019 DEI.	For the 2020 DEI, **69%** of businesses have mental health benefits above and beyond that required by the Federal mental health parity bill and any other relevant laws, an increase from **62%** for the 2019 DEI.	For the 2020 DEI, **60%** of businesses are tracking accommodation metrics, an increase from **53%** for the 2019 DEI.
Employment Practices: Employment, Education, Retention & Advancement	**Supplier Diversity**	**Non-US Operations**
For the 2020 DEI, **72%** of businesses with employee retention and advancement programs have programs focused on employees with disabilities versus **33%** for the 2019 DEI.	For the 2020 DEI, **64%** of businesses with public websites listing preferred 3rd party certification or verification orgs included at least one that verified disability-owned businesses versus **54%** for the 2019 DEI.	For the 2020 DEI, **75%** of DEI companies had operations outside of the US. Of those multinational companies, **75%** reported operations outside of the US had disability inclusive standards of non-discrimination in the workplace that applied to all employees compared to **69%** for the 2019 DEI.

Figure 2. 2020 Disability Equality Index (DEI): Areas Where Companies Demonstrated Marked Improvement *
* Figure revised from page 12 of DEI Disability Equality Index Report.[12]

General Etiquette

The U.S. Department of Labor's ODEP offers the following disability etiquette strategies concerning general interaction and conversations.[17]

- Refrain from asking personal questions about an individual's disability; limit inquiries to information necessary to provide accommodations.
- Realize that many individuals have disabilities that are not visible but do exist.
- Do offer to shake hands; individuals with limited hand use or artificial limbs usually shake hands.
- Some individuals with disabilities require extra time to complete certain tasks, so be considerate of the extra time.
- Respect all assistive devices (e.g., canes, crutches, communication boards, service dogs, wheelchairs, scooters) as personal property; do not touch, move, play with, or use assistive devices unless you are given permission, and do not pet a service or companion dog while it is working.
- Before you help an individual with a disability, ask whether assistance is needed; if the offer is accepted, ask for, and listen to, instructions about how to help.
- Always direct communication to the individual with a disability, not to a personal assistant or sign language interpreter, if they have one.
- Host work-related social and training events at accessible locations with appropriate accommodations for individuals with disabilities with activities to include all employees.
- Avoid excessively praising individuals with disabilities when they accomplish normal tasks, and avoid using terms that imply that individuals with disabilities are overly special, brave, courageous, or superhuman.
- The use of common expressions (e.g., "See you later," "Let's run to...," or "Have you heard about...?") is fine even if these phrases are at odds with an individual's disability; individuals with disabilities use these phrases often. Anyone can make mistakes; apologize if you forget a courtesy, relax and keep a sense of humor.[17]
- Display common courtesy by opening doors for individuals with disabilities who use mobility devices and are attempting to enter or exit buildings or rooms without automatic door openers.
- In public restrooms, avoid using stalls designed and/or designated for wheelchair access.
- Avoid placing trash cans directly below up/down buttons for elevators.

Culture	Leadership	Enterprise-Wide Access
95% of businesses utilized a company-wide employee engagement survey, but only **38%** reviewed the aggregate survey results for employees with a disability.	**88%** of business had a Diversity Council, but just **65%** had one with a mission statement that specifically included disability inclusion as an area of focus.	**60%** of businesses had a web accessibility policy that required coding to AA Level of Conformance of the W3C WCAG2.1** and only **56%** of them were auditing their internal sites.
Employment Practices: Recruitment	**Community Engagement**	**Supplier Diversity**
Only **45%** of businesses asked all candidates during the interview scheduling process if they needed a reasonable accommodation.	**62%** of businesses had a smart phone app available for use by the public, but only **46%** of them had audited the app for accessibility under the W3C Content Accessibility Guidelines.**	Only **25%** of businesses had company-wide disability-focused goals in place for supplier diversity and inclusion.

Figure 3. 2020 Disability Equality Index (DEI): Areas Where Companies Have Opportunities to Improve *
* Figure revised from page 13 of DEI Disability Equality Index Report.[12]
** W3C (World Wide Web Consortium) includes strategies, standards, and supporting resources to make the Web accessible to individuals with disabilities by developing international standards for the Web: HTML, CSS, and many more (https://www.w3.org/WAI/).

Recruitment Etiquette

Individuals with disabilities continue to be the most unemployed and underemployed U.S. population and are an untapped labor pool with valuable skills, qualifications, and assets for employers.[18] JAN offers these strategies to increase an organization's access to potential applicants.[18]

- Post job openings with local disability organizations and career centers at colleges and universities; advertise vacancies in disability-related publications, websites, and job fairs.
- In postings, detail the job location and highlight the location's accessible features. Specify availability of flexible working conditions, including telecommuting or flexible scheduling. Only include qualifications that are actually required for positions, and require equal qualifications of all job applicants, regardless of disability. Include that the organization is an equal opportunity employer.
- Establish internship and mentoring programs targeted towards students with disabilities.[18]

Interview and New Employee Etiquette

JAN offers the following interview and new employee etiquette strategies.[18]

Scheduling Interviews[18]

- Inform applicants that accommodations can be provided upon request and who to contact for information.
- Schedule interviews at an accessible location.
- Be familiar with travel directions to the interview location, including the accessible travel path into the building. Provide descriptive directions that do not require reliance on visual references. Note if Braille signage is posted on walls and doors.
- Inform applicants of the names of all interview participants.
- Provide applicants with an estimate of the interview's duration and expected end time.[18]

Greeting Interviewees[18]

- Be prepared to provide information concerning the interview location's accessible features including restrooms, drinking fountains, and telephones.
- When welcoming the interviewee, use a normal tone of voice; raise your voice upon request only.
- Introduce yourself and other interview participants.[18]

Interviewing[18]

- Ask similar questions of all interviewees, regardless of disability. Emphasize abilities, achievements, and interviewee qualities.
- Treat all interviewees with the same respect and courtesy.[18]

New Employees[18]

- Make adjustments in the work environment if any potential barriers exist for new employees with disabilities,
- Include training and orientation to disability-specific issues as an overall disability awareness initiative for supervisors and co-workers to prepare for new employees with disabilities; do not use it to single-out individuals with disabilities.
- Include employees with disabilities in emergency evacuation planning and procedures.[18]

Mobility and Sensory Disabilities

JAN also provides etiquette tips for situations involving employees or applicants with motor, mobility, or sensory disabilities.[18] For more comprehensive information about disability etiquette, see the resources at www.askjan.org.

Mobility Disabilities[18]

- Do not make assumptions about limitations. Individuals who use mobility aids (e.g., canes, walkers, wheelchairs, scooters) have different limitations and may use a mobility aid regularly or only as required by their limitations. Also, individuals who appear mobile may require accommodations such as accessible parking because they are unable to walk long distances due to a medical condition (e.g., asthma).
- When hiring an individual with an obvious mobility disability, offer to provide a tour and evaluate the worksite for accessibility.
- Make workplace accessibility changes according to the specific work-related needs of the employee (e.g., workspace modifications, clear paths, position items at appropriate reach heights).
- When speaking for more than a few minutes with an individual in a wheelchair or scooter, sit down so you are at eye level.[18]

Vision Disabilities[18]

- Greet them by saying your name and where you are in proximity to them; use a verbal greeting when entering or leaving a room, or say good bye when ending a conversation, and do not just walk away when talking with them.
- Offer your arm instead of taking the individual's arm when guiding them; as you walk, tell the individual when you are turning right or left, approaching inclines or steps, and alert him/her to opening doors or other obstacles.
- Give new employees a guided tour of the workplace.
- Walk on the side opposite the animal when walking along-side someone who is using a service dog.
- Offer to read written information during an interview or on the job, when appropriate.
- Inform them of structural changes or hazards in the event of new construction or workplace modifications.
- Provide work-related materials, such as employee handbooks or benefits information, in an accessible format (e.g., large print, Braille, accessible web page accessed with screen reader).[18]

Deaf or Hard of Hearing[18]

- Individuals with hearing disabilities communicate in various ways; pay attention to cues such as whether the individual uses sign language or reads lips.
- Do not be afraid to say that you do not understand; it is better to find another way to communicate, such as through writing notes, than to pretend to understand.
- When communicating with someone who reads lips, do not put your hands or other objects in front of your mouth, do not put food or other items in your mouth, and do not turn your head or walk away while talking.
- When masks are worn in the workplace, consider the communication needs of workers who read lips. It may be necessary to use a clear mask or face shield, video chat from a different room without a mask, or use other methods of communication such as texting or using a portable text communication device.

- When possible, speak in a well-lit room free of background noise.
- Speak calmly, slowly, and directly with a normal speaking tone and style; if an individual needs you to speak in a louder voice, they will ask you to do so.
- During meetings, take turns when talking so the individual with the hearing disability can read lips if they are able to do so.
- Before you start speaking, get the person's attention by waving your hand, tapping on the shoulder, or some other appropriate gesture.
- Talk with the individual about their preferred method of communication for job training or complex work-related situations; when appropriate, provide a qualified sign-language interpreter, communication access real-time translation [CART] service, or training videos with captions.
- Include employees with hearing disabilities in casual conversation and social events; provide a sign-language interpreter for employer-sponsored social events, when appropriate.[18]

Speech Disabilities[18]

- Listen to, and be patient with these individuals; do not complete their words or sentences but relax and communicate as you would normally.
- If you do not understand, ask the individual to repeat and listen carefully, repeat what you heard to verify, or, ask the individual to write it down.
- Maintain conversational eye contact and focus on the content of communication rather than the delivery.
- Provide interview questions in advance, if possible, to allow the individual time to prepare and deliver responses effectively.
- Offer a personal interview as an alternative to a phone interview for people who stutter, be patient and listen, and do not complete words or sentences for people who stutter.[18]

Perspectives From CNMs of, and From RDNs With Disabilities

Accommodating RDNs and Dietetic Interns with Disabilities in Work Settings

Clinical managers play an important role in hiring and accommodating RDNs with disabilities. According to Erica Gonzales, RDN, LD, CDE, Clinical Nutrition Manager at Driscoll Children's Hospital in Corpus Christi, Texas, hiring a dietitian with a disability has nothing to do with the disability but whether the RDN has the qualifications for the position. When speaking about Jordan Griffing, MS, RD, LD, CNSC, a neonatal intensive care unit (NICU) dietitian she hired whose disability requires she use a wheelchair, Gonzales says, "Making accommodations is not a challenge or hardship because it is just part of making it work for the team. For example, when updating our on-call/back up coverage schedules, I moved a few around so that the units Jordan backed up were not physically far from her office."

Jordan Griffing, MS, RD, LD, CNSC

Griffing agrees that Gonzales has been very proactive in making the few accommodations she has needed as well as securing any equipment she requested like a special computer keyboard. She believes Gonzales has done everything correctly stating, "My disability isn't some challenge or hardship to overcome, it's just a tiny part of my work life that sometimes needs to be brought up. It's not what she sees first or a diversity box she can check off. I'm here because I have the qualifications and earned my right to be here. I just happen to also have a disability."

Wendy Wittenbrook, MA, RD, CSP, LD

Both Kim MacFarlane Oberman, RD, LD, Director of Dietary and Janice Scott MS, RD, CSP, LD, Clinical Nutrition Manager at Texas Scottish Rite Hospital for Children in Dallas, Texas, have taken steps to ensure an office environment that helps Wendy Wittenbrook, MA, RD, CSP, LD be successful in her job. A 20-year clinical dietitian at the hospital, Wittenbrook has a profound hearing loss, which requires she wear hearing aids. The telephone in the RDN's office was adapted to read messages and connect to her cell phone and, in the shared office space, sound-absorbing cubicles

were added, floors carpeted and white noise installed to help minimize ventilation noise.

Janice Scott, MS, RD, CSP, LD

In working with an employee with a hearing impairment, Scott makes sure important conversations take place in a quiet environment with few distractions, tries to be face-to-face to allow Wittenbrook to lip-read and see her facial expressions, and checks in with her by pausing and letting her process, then asks some clarifying questions. "Wendy and I have worked well together for 20 years and if some problem comes between us, we know we need to sit together and sort out what was miscommunicated," Scott notes.

According to Whittenbrook, "The technology advances over the past 40 years have been amazing. With my iPhone, I can stream phone calls, Zoom meetings, music, and YouTube videos, through both of my hearing aids so that I can have bilateral hearing. When I was growing up, we did not have the Americans with Disabilities Act (ADA), individualized education programs (IEP) or formal plans to give children with disabilities the support they need in school (504 plans) that provide support and remove barriers for students with disabilities. I am thrilled that we have progressed throughout the years to make it easier for a person with disabilities to pursue their dreams."

Scott has also worked as a preceptor to a dietetic intern with severe dyslexia who was extremely intelligent and hid her disability well. She explains, "In a clinic setting with no time to spare, I discovered she couldn't retrieve information from the paper chart on the fly. From that point on, I made sure to allow a few extra minutes for work that required information retrieval from written resources." Scott said it was easy to accommodate her by setting up a learning process of talking through items and allowing her to read details later, adding "She's currently practicing as a dietitian and clinic supervisor and I couldn't be prouder of her success."

Jackie Henderson, RD, LD is the Spinal Cord Injury Dietitian at the VA Medical Center in St. Louis. At the age of 15, a car accident completely severed her spine so she uses a manual wheelchair for all of her mobility but has full use of her upper body. "I have not had to have any major accommodations to be able to function in my current or past roles," she says. "There have been issues that needed addressing, however, to make a more universal, accessible environment. Even in an entire ward serving spinal cord injured patients, these details can get neglected like having personal protective equipment within reach and access to waste containers that do not require a foot to open."

Jackie Henderson, RD, LD

Benefits of Employing RDNs or Precepting Dietetic Interns with Disabilities

Scottish Rite's Oberman says, "Qualified RDs should not be overlooked due to a disability. We are a pediatric hospital serving children with many different disabilities so our RD is a great example of being able to do what you desire. It's also beneficial for the interns to work with and observe a coworker with a disability and what that involves."

Her CNM, Janice Scott, agrees that a professional with a disability provides an example of what might be possible for a child with a physical difference. She adds, "Working with RDNs or interns with disabilities challenges me to step out of my 'box' and consider the needs of others. Frequently, the person with a disability has gifts that have come from pushing through difficult situations."

Jordan Griffing quickly achieved her goal of becoming a NICU dietitian, which she has pursued since she was an undergraduate first delving into the world of nutrition. "I believe any medical professional with disabilities is a huge resource in any setting, but particularly clinical. I have a personal perspective and understanding of the patient's situation and feelings more so than healthier counterparts because

they've never literally shared the experience," she explains. With a literal lifetime of hospitals and doctors' offices she knows how she's been treated and how things look on the other side. With her insight she can make a patient's experience less scary and can meet them on their level.

Working with people with new disabilities and outwardly demonstrating the ability to overcome a disability herself is what Jackie Henderson describes as her greatest success as an RDN. She started her career in the mental health unit at the VA, followed by a longer stint in outpatient nutrition counseling. During that time she began considering the position of Spinal Cord Injury Dietitian. But she states, "I was so hesitant to join the spinal cord injury team because I wanted to be recognized as the dietitian and not just the token spinal cord injured employee! Once I got there, however, I spent less time explaining my injury to clients and there was this unspoken mutual understanding about what I have been through and how I have to live my life. I truly believe that regardless of what the disability is, having our coworkers or clients exposed to a certain physical limitation does strengthen that relationship and lowers their defenses." Henderson is most fulfilled and proud of her cooking groups with the veterans. These groups, taught alongside an occupational therapist, teach healthy eating and adaptive ways of cooking.

Wendy Wittenbrook was awarded the Excellence in Practice for Intellectual and Developmental Disabilities by the Behavioral Health Nutrition DPG in 2017. She says, "Working with children that have disabilities and their families over the past 20 years has been meaningful and rewarding."

Creating a Work Environment to Promote Success of RDNs or Dietetic Interns with Disabilities

Both the clinical RDNs and their managers agree that an open and honest discussion about the dietitian's needs is critical to creating a successful work environment. Wittenbrook encourages managers to trust and listen to their staff with disabilities when accommodations are requested as they are the experts on our disabilities. Henderson concurs, "The best start is to have an open conversation about barriers that exist and a willingness to work together to overcome those barriers. Many times these barriers go unspoken by the employee for fear of appearing needy or becoming a burden, thus developing unwanted attitudes or judgments toward the person with the disability. In general, most people with a disability are not looking for 'extra perks' but ways to perform at the same level as their colleagues." Scott recommends bringing up the physical or mental difference from the start, even if it is observable. "Let it be a conversation starter in the interview that allows you to turn it into a strength. Teach us from your learned experience what accommodations might help you be successful."

Oberman also advises RDNs with disabilities to be up front with managers about what they need to help them do their jobs well. She suggests that a dietitian who is not comfortable speaking to the manager due to the personal nature of the disability should contact the Human Resources Department to seek changes rather than remaining frustrated.

Finally, Gonzales says that at Driscoll Children's Hospital the RDNs are a team and consider each other family. "We want to be personal with each other and get to know each other, but for those with a disability it has to be a little more 'personal' because a disability can sometimes affect the RDN's work." There is a fine line between what the "family/team" needs to know if the dietitian requires help vs. that individual's right to keep medical information private.

Conclusion

This article's information provides CNMs with strategies to recruit, hire, accommodate and support clinical RDNs and dietetic interns with disabilities to be as successful as possible. Doing so will improve the dietetics profession at large, and more importantly, will improve the well-being of the patients and clients served by the dietetics profession. CNMs can contact organizations like JAN to inquire about specific accommodations for clinical RDNs with disabilities as well as submit success stories concerning RDNs with disabilities for the JAN website. CNMs can encourage the healthcare facilities where they work to partici-

pate in the DEI and strive for recognition as one of the Best Places to Work for Disability Inclusion™.[12] Data collection needs to continue on RDNs and dietetic interns with disabilities, not only in the *Compensation and Benefits Surveys of the Dietetics Profession* (which included disability questions for the first time for the 2019 survey), as well as in other surveys and reports collected by the Academy and Commission on Dietetic Registration (CDR) and ACEND. The Academy's Diversity and Inclusion Statement[19] identifies differences in "ability" as an underrepresented group.

In 2021, one author of this article (SDB) established an endowed fund through the Academy Foundation in memory of her parents (LaVerne and Edwin Domel) to create a scholarship for diverse students pursuing an education in nutrition and dietetics, with primary reference to applicants with long-term physical or sensory disabilities, and secondary preference to applicants from underrepresented racial/ethnic groups. Consideration will also be given to applicants from South Carolina, Texas and Georgia, the states where the author worked during her career as an RDN. The author of this article (SBD) worked with Academy Foundation staff to add optional questions concerning disabilities to the Foundation Scholarship application for applicants to disclose this information. The Academy, along with the authors of this article, continue to strategize on how best to serve its members with disabilities.

Proactively hiring RDNs and precepting interns with disabilities requires colleagues who support their contributions and a work and social environment that accommodates them. The inclusion of students, interns, and RDNs with disabilities in the dietetics profession can provide valuable insight and understanding to research and practice that is unique from that of their peers.

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Caring for Transgender and Gender Diverse Patients: Considerations for the Clinical Nutrition Manager

By Whitney Linsenmeyer, PhD, RD, LD and Rabia Rahman, PhD, RD, LD

An estimated 0.6% of the adult population in the United States identifies as transgender, a figure that has doubled in the past decade.[1] Given the marked rates of human immunodeficiency virus (HIV), certain cancers, and mental health disorders affecting the transgender population, the National Institutes of Health formally designated sexual and gender minorities as a health disparate population.[2,3] Health disparities are compounded by discrimination and bias throughout the healthcare system.[3] Though social awareness and medical research is growing, very little is known about the diet and nutrition-related considerations for transgender patients.

Questions from clinical dietitians persist: How are the dietary needs of a transgender patient unique? What types of medical interventions may a transgender patient be undergoing that could affect nutritional status? How can dietitians communicate effectively with their transgender patients?

At this point, there are more questions than answers related to nutrition care for the transgender population. Nonetheless, clinical dietitians play a unique role in the health of their transgender patients and can provide gender-affirming healthcare, or healthcare that honors and supports a patient's gender identity. Clinical nutrition managers (CNMs) may be uniquely positioned to establish screening protocols, promote an inclusive culture, and advance dietetic practice for their transgender patients.[4]

Key Terms

Familiarity with key terms is often the first step when working with the transgender community. Note that the vocabulary does evolve and certain key terms that were once used often are now considered outdated (i.e. the term *queer* was once considered derogatory, but now has been reclaimed by the LGBTQ community). Therefore, it is advised that organizations continue to familiarize themselves with the most current terms by referring to leading transgender health and advocacy groups. The key terms presented here were published by the American Psychological Association in 2018.[5]

- ***Cisgender***: Used to describe an individual whose gender identity and gender expression align with the sex assigned at birth.
- ***Gender binary*****:** The classification of gender into two discrete categories of male and female.
- ***Gender dysphoria*****:** Discomfort or distress related to incongruence between an individual's gender identity and the gender assigned at birth.
- ***Gender expression*****:** Clothing, physical appearance and other external presentations and behaviors that express aspects of gender identity or role.
- ***Gender identity*****:** An internal sense of being male, female or something else, which may or may not correspond to an individual's sex assigned at birth or sex characteristics.
- ***Gender nonconforming*****:** Describes an individual whose gender identity or gender expression differs from the gender norms associated with the sex they were assigned at birth.
- ***Genderqueer*****:** Describes an individual whose gender identity doesn't align with a binary understanding of gender, including those who think of themselves as both male and female, neither, moving between genders, a third gender or outside of gender altogether.
- ***Trans-affirmative*****:** Being aware of, respectful and supportive of the needs of transgender and gender-nonconforming individuals.
- ***Transgender*****:** An umbrella term encompassing those whose gender identities or gender roles differ from those typically associated with the sex they were assigned at birth.
- ***Transition*****:** The process of shifting toward a gender role different from that assigned at birth, which can include social transition, such as new names, pronouns and clothing, and medical transition, such as hormone therapy or surgery.

Two helpful tools in conceptualizing several of these key terms are "The Gender Unicorn" and "The GenderBread Person" (Figures 1 & 2), which illustrate gender identity, gender expression, sex assigned at birth, physical attraction and emotional attraction. These tools may be utilized to educate other healthcare professionals on key terms, as well as serve as a visual indicator of gender inclusiveness if displayed in a clinical setting.[6,7]

Standards of Care for Transgender and Gender Diverse Patients

Two leading organizations have published standards of care or guidelines for the care of transgender patients. The World Professional Association for Transgender Health (WPATH) is now in its seventh version of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.[8] The Center of Excellence for Transgender Health through the University of California, San Francisco has published its second edition of the Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.[9]

These guidelines do not provide explicit information regarding nutrition. However, CNMs may make inferences where diet-related issues are addressed. For example, the Guidelines for the Primary and Gender Affirming Care of Transgender and Gender Nonbinary People address relevant topics including cardiovascular disease, diabetes mellitus, and bone health and osteoporosis. CNMs may refer to these sections for a synopsis on the most relevant research and recommendations regarding their intersection with transgender health.

Dietary Considerations for Transgender Patients and the Role of Dietitians

Transgender patients may pursue medical interventions to physically transition towards a more masculine or feminine gender expression. These include hormonal therapy in the form of testosterone, estro-

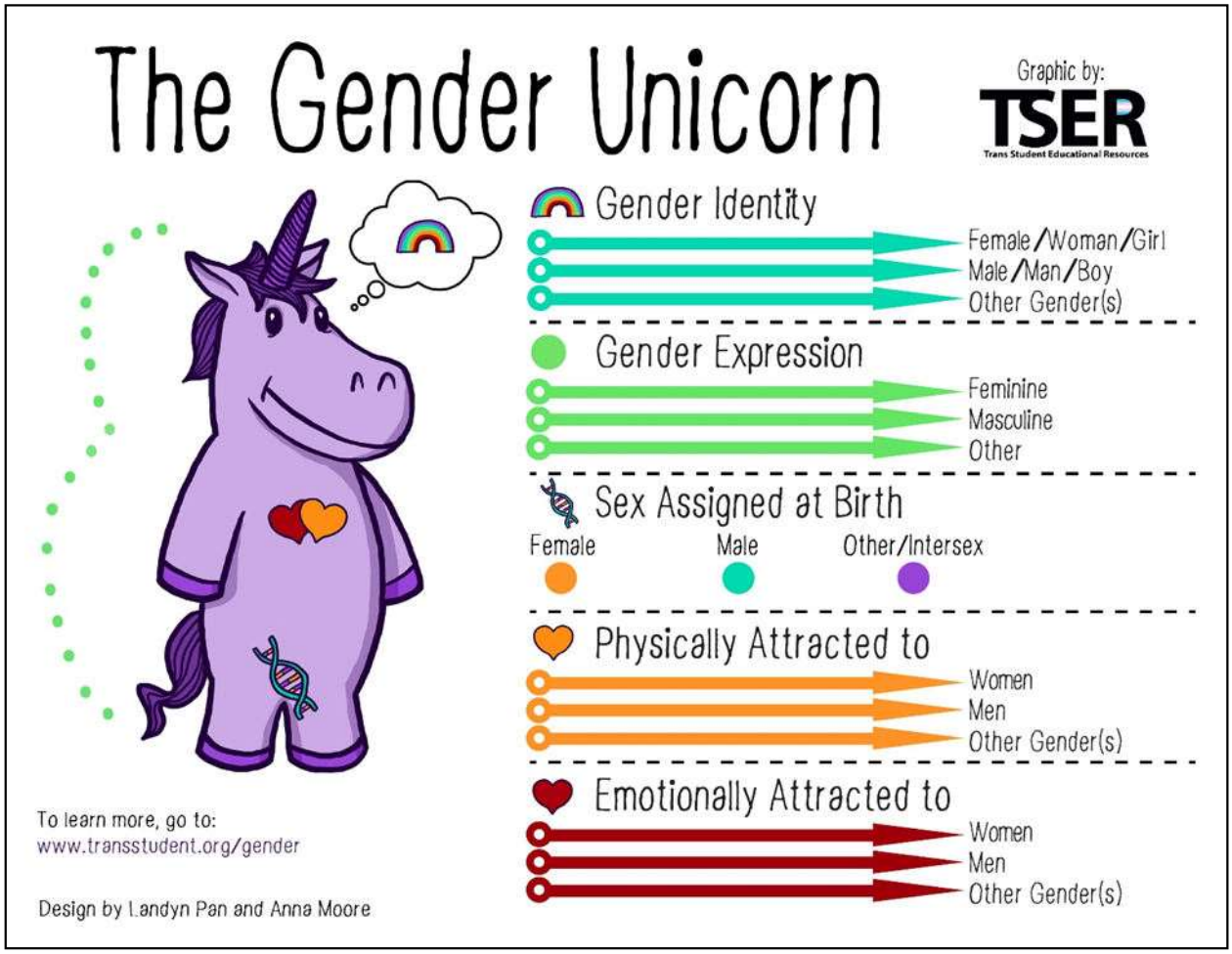

Figure 1. The Gender Unicorn

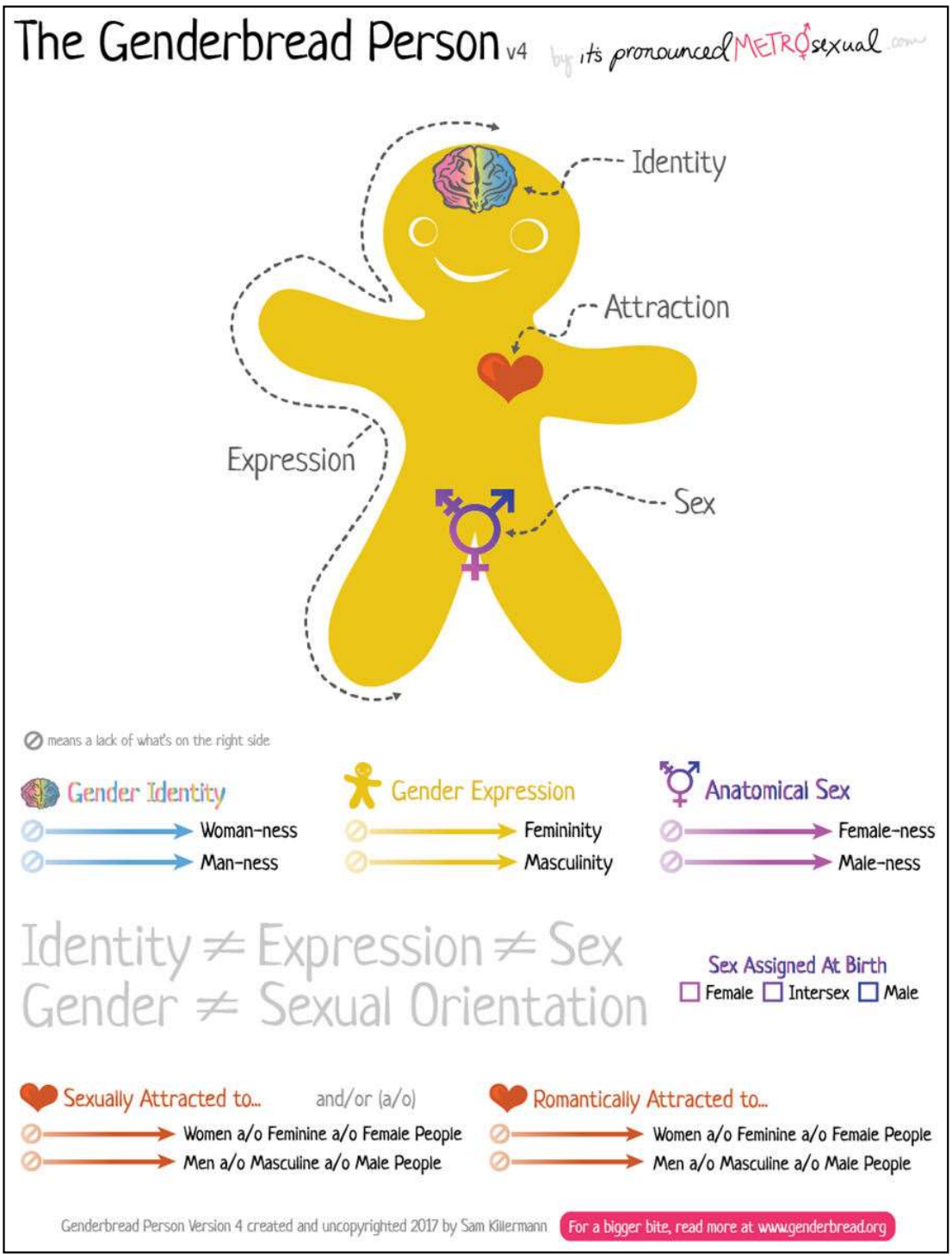

Figure 2. The GenderBread Person

gen, or antiandrogens, as well as gender-affirming surgeries such as a masculinizing chest surgery ("top" surgery), hysterectomy and/or oophorectomy, or feminizing vaginoplasty. However, it is notable that not all people that identify as transgender will necessarily undergo hormonal therapy or surgery.

Known side effects of hormone therapy may be well within the scope of clinical dietitians (Table 1). Transgender men (or female-to-male, "FtM") on testosterone therapy may experience weight gain, increased lean body mass, decreased fat mass, increased LDL-cholesterol, or decreased HDL-cholesterol levels. Transgender women (or male-to-female, "MtF") on estrogen therapy may experience changes in both LDL-cholesterol and HDL-cholesterol depending on the route of administration, changes in blood pressure, and increased bone mineral density.[10-15]

Though energy needs may change second to changes in body weight and composition, no guidelines exist to accurately estimate energy needs for transgender patients. Dietitians have anecdotally reported a range of different approaches. The authors suggested estimating energy needs using a range of values and individualizing the patient's care. For example, using the Estimated Energy Requirement (EER) equation, the estimated energy needs for a 25 year-old, 5'5" patient weighing 140 lbs and classified as "low active" are: 2,334 kcals/day for a female and 2,536 kcals/day for a male. Thus, the energy needs for a transgender female or transgender male patient of the same height, weight, and activity level differ by only 200 kcals and may be expressed as a range of 2,330-

Biochemical Maker	Expected Impact of HRT	
	FtM	MtF
LDL-C	Increase	Variable
HDL-C	Decrease	Variable
Triglycerides	Variable	Increase
Total Cholesterol	Variable	Variable
Hemoglobin A1C	Variable	Variable
Bone Mineral Density	Decrease	Increase
Blood Pressure	Variable	Increase

Table 1. Expected changes in nutrition-relevant parameters in transgender patients using HRT.

2,530 kcals/day.
Diet-related considerations are also psychosocial in nature. Research indicates elevated rates of disordered eating, self-reported eating disorders, unhealthy weight control behaviors, and use of compensatory behaviors among the transgender population.[16-20] The relationship between a patient's body image, gender identity, and gender expression is highly complex. CNMs may ensure active participation of dietitians among a patient's healthcare team in order to address any concerns of disordered eating. Food insecurity has also been suggested as a concern for the transgender in one community, though the prevalence has not yet been quantified; clinical dietitians can collaborate with social workers to connect their patients to community resources.

Though much of transgender health research is centered on disease risk and progression, clinical dietitians may have the opportunity to work with transgender patients in using diet to support their physical transition. The decision to transition may coincide with elevated motivation to make healthy diet and lifestyle changes.[21] Clinical dietitians may emphasize the importance of nutrition to overall health, self-care, and wellbeing.

Recommendations for Nutrition Screening
Currently there are no nutrition-related screening tools that have been specifically validated for the transgender population. However, clinical dietitians may screen for psychosocial, biochemical and medical conditions that are either more common among transgender individuals or for known side effects of hormone therapy.

Cardiovascular Disease. Determining true cardiovascular risk among transgender individuals is a challenge, primarily due to inconsistent evidence. However, some research suggests that hormone therapy in conjunction with lifestyle factors such as higher tobacco use, diabetes, obesity, dyslipidemia and reduced physical activity increases the risk of cardiovascular disease risk in transgender patients.[9] Therefore, clinical dietitians should assess a patient's lipid panel, usual diet, and ask questions about smoking, alcohol and exercise.

Bone Health. Though there are no validated osteoporosis screening protocols for transgender individuals, preliminary evidence suggests that hormone therapy may affect bone mineral density. As such, clinical dietitians should evaluate a patient's diet for adequate calcium and Vitamin D intake and encourage weight bearing exercise and smoking cessation.[9]

Diabetes. Current screening recommendations for Diabetes Mellitus among transgender individuals are consistent with current national guidelines. Clinical dietitians are encouraged to identify risk factors for diabetes such as obesity, metabolic syndrome, and impaired glucose tolerance.[9]

Eating Disorders or Disordered Eating Patterns.
With a significant body of evidence suggesting an increased prevalence of eating disorders, disordered eating patterns, compensatory behaviors and unhealthy weight management strategies, it is vital that clinical dietitians assess for these behaviors.[16-20] Some of the validated and frequently used screening tools may include:

- EAT-26
- SCOFF Questionnaire
- Eating Disorder Inventory-3
- Eating Disorder Examination

Establishing an Inclusive Culture
Although societal understanding and acceptance of

transgender individuals has increased, troubling gaps exist in the provision of culturally competent, gender-affirming care.[22,23]

Discrimination against the transgender population by healthcare providers has been implicated as a primary contributor to suboptimal healthcare. Discrimination, both overt and subtle, appears to be strongly influenced by sexual and social stigma and often results in poor healthcare access and utilization by the transgender community.[23]

CNMs, as leaders in the healthcare setting, can play an important role in creating a culture of inclusion and acceptance. While lack of access remains the biggest obstacle to receiving appropriate and equitable healthcare, there are significant social, structural and economic impediments that prevent transgender individuals from seeking and receiving care. These barriers, identified in Table 2, are important considerations when aiming to achieve inclusivity in the healthcare setting.[24] Not all of these can be addressed by CNMs; however, awareness is a critical first step in mitigating or eliminating these factors entirely.

While these barriers persist, health care institutions and individual providers can take concrete measures to strengthen inclusivity. Table 3 includes strategies that can be implemented specifically by CNMs to promote patient-centered and gender affirming care for the LGBTQ community. These strategies have been previously outlined by the Joint Commission, and The Center of Excellence for Transgender Health through the University of California, San Francisco as best practices designed to foster the equitable provision of care for transgender individuals.[9,25,26]

Barriers to Healthcare Access and Utilization
Discrimination by healthcare providers and staff
Lack of cultural competence among health care providers
Lack of provider knowledge on transgender health and identity issues
Denial of services
Poor communication
Financial constraints and insurance limitations
Inappropriate/incorrect electronic records or forms
Incorrect reference points for biochemical measures
Unwelcoming physical facilities
Lack of transportation and/or housing
Mental health issues

Table 2. Barriers to healthcare access and utilization

Next Steps: Practical Applications to Supporting an Inclusive Clinical Environment

CNMs may feel overwhelmed by unfamiliar terminology or clinical considerations when working with transgender patients. The following are simple next steps that CNMs can take towards supporting a more inclusive clinical environment.

- Revise patient intake forms to utilize the two-step method (Table 4).[9] Review all parts of patient intake forms to ensure consistent language.
- List personal pronouns on nametags or email signatures. When clinicians initiate this practice, patients may feel more comfortable in sharing their preferred pronouns. For example:

  Carmen Rogers, MS, RDN
  Staff Dietitian
  Pronouns: she, her, hers
- Seek further education for yourself and your colleagues. For example The Safe Zone Project provides LGBTQ-inclusive training, online courses, and workshops.

Additional Resources

- CNMs seeking further education on transgender health may utilize the following resources:
- Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version published by the World Professional Association for Transgender Health.
- Guidelines for the Primary and Gender-Affirming Care of Transgender People, 2nd edition published by the Center of Excellence for Transgender Health through the University of California, San Francisco.
- Caring for Transgender Patients and Clients: Nutrition-Related Clinical and Psychosocial Considerations by Rabia Rahman and Whitney Linsenmeyer in the *Journal of Nutrition and Dietetics*.
- Affirmative Counseling and Psychological Practice

Strategies to Promote Inclusivity and Gender-Affirming Care	
Strategy	**Application**
Create a safe, inclusive and culturally-cued physical environment	Include clues of acceptance in the patient waiting room and other areas, such as transgender-pertinent posters, brochures, magazines, and LGBT-friendly flags Display the facility's non-discrimination policy or patient bill of rights where it can be easily viewed Have staff wear LGBT-friendly flag pins Have staff display their preferred pronouns on their name badges, email signatures and business cards Designate a gender-neutral restroom with clear signage and easy access and communicate to patients that they may choose a gendered restroom based on their preference
Ensure that **all** staff are trained in the provision of culturally-competent, gender-affirming care	Provide training to all staff involved in patient care that focuses on the provision of gender-affirming care Encourage staff to seek webinars specifically aimed at increasing transgender cultural competence
Foster an environment in which gender identity data is collected in a safe, supportive and gender-affirming manner	Evaluate all health forms and electronic health records to ensure that gender-neutral, inclusive language is used Ask about patient's chosen name and pronouns
Promote effective communication	Ensure that all staff are familiar with basic terminology used by the transgender community Use gender neutral and inclusive language when interacting with all patients In the event that staff is unsure of a person's gender identity, ask gender-neutral questions such as "what is your preferred name?" Ensure confidentiality and use discretion, not all patients will be ready to disclose their gender identity to family members
Become an advocate	Ensure that the facility has a non-discrimination policy that specifically references sexual orientation and gender identity. If this does not exist, work with leadership to develop and distribute this policy. Work with facility leadership to ensure physical spaces are transgender friendly Become familiar with available resources for the transgender community and ensure that all staff are aware of these resources Provide patients with appropriate referrals and assist them in finding clinicians who are comfortable with working with transgender individuals

Table 3. Strategies for clinical nutrition managers to promote gender-affirming care for transgender and gender diverse populations.[8,24,25,28,29]

with Transgender and Gender Nonconforming Clients by Anneliese A. Singh, PhD and lore m. dickey, PhD is published by the American Psychological Association. Clinical dietitians in an outpatient setting may particularly benefit from this resource.

- National Transgender Health Summit through the Center of Excellence for Transgender Health through the University of California, San Francisco.

Conclusion

Though transgender health research is advancing steadily, important questions persist regarding the diet and nutrition considerations for transgender patients in a clinical setting. CNMs can play an active role in providing gender-affirming healthcare by making tangible changes to their workplaces, assessing for the known diet-related effects of hormone therapy, and seeking resources for further education and training.

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What is your sex or current gender? (Check all that apply)
Male
Female
TransMale/Transman
TransFemale/Transwoman
Genderqueer
Additional Category (Please Specify):
Decline to state
What sex were you assigned at birth?
Male
Female
Decline to State

Table 4. Gender-affirming screening questions

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Know Your Role: Strategies for CNMs to Stop Weight Stigma

By Nina Crowley, PhD, RDN, LD & Angie Hasemann Bayliss, MS, RDN, CSP

With a vision to positively influence health care through nutrition leadership, the Clinical Nutrition Management Dietetic Practice Group (CNM DPG) has set the bar high in providing resources to facilitate making a difference in the intersection of nutrition and health care. The multi-faceted role of Clinical Nutrition Managers (CNMs) requires and polishes a broad set of skills. CNMs have countless opportunities to take the lead and model the mission to empower and support leaders to advance nutrition practices in health care. With this in mind, this article delineates the role CNM DPG members can take to address weight bias and stigma.

Reducing weight stigma in clinical care is a shared responsibility of health care providers as well as the health care systems and organizations that have the power to implement intervention strategies broadly. Many of the strategies discussed here can be implemented by individual providers but could have a wider influence if embedded in the culture of the health care organization. CNMs have the unique opportunity to influence a wide-ranging group of nutrition professionals, both current and future Registered Dietitian Nutritionists (RDNs), as well as the multidisciplinary teams they work on, and thereby, set the stage for further growth in this area by providing a platform for awareness and discussion of methods to address stigma.

Obesity and Weight Stigma Paradox

The majority of Americans have obesity or excess weight and and are at risk for development of weight -related health problems like type 2 diabetes and cardiovascular disease, among others.[1] While obesity has been associated with morbidity, mortality, and psychosocial implications, our society has yet to systematically address prevention or treatment. The paradox of a majority of people living with a condition which has received minimal attention or commitment to prevention, treatment, policy, or protection is both perplexing and unacceptable.

It is uniquely disconcerting that the same people who internalize weight bias also harbor biased attitudes toward others with the same condition, but it does provide a possible explanation for the lack of progress made towards addressing both obesity and the stigma that is associated with it. Bias can be considered explicit or implicit; explicit attitudes are consciously accessible evaluations of a person that could be readily reported and controlled, while implicit attitudes are considered beyond conscious awareness and control, and less amenable to responding in socially desirable ways.[2]

Some postulate that stigma about obesity is based in the assumption that one's weight can be simply and personally controlled, therefore those who are affected by obesity are responsible for their condition.[3] This view may stem from traditional conservative American values of self-determinism and individualism where people 'get what they deserve' and are responsible for their life situation.[4] A theoretical framework, attribution theory, suggests that negative attributes can be explained by the influence of causal beliefs and responsibility.[5] The more a disease is perceived as under volitional control, the more an emotional response such as stigmatized attitudes and behavioral consequences such as discrimination can result.[6]

When biological, genetic, and environmental causes of obesity are ignored, blame is increased on those who are affected, resulting in negative attitudes toward people with obesity.[7] When examining bias in a group of RDNs, Hellbardt and colleagues found that RDNs assessed individuals as being responsible for their obesity ('lack of physical activity', 'overeating', and 'lack of willpower') whereas genetic or illness factors like metabolic disorders were seen as contributing less to one's weight, confirming their opinion that weight was simply under the person's control.[8]

To understand weight bias and stigma, it is beneficial to review the methods used to assess and measure weight bias. Table 1 provides names and links to many of the validated measures available to assess weight bias. Many of the measures utilize adjective check lists with a rating scale for characteristics attributed to people with 'thin' or 'fat' body size. Implicit Associations Tests (IAT) are available to measure your own weight bias.[2] IAT are timed word association tests where you are given words that fit into one of four categories. People find it easier to categorize words faster when the pair matches their attitude than when it is mismatched, thereby finishing the tasks faster. People with greater levels of bias pair more words in the time allotted when 'fat people' is paired with negative characteristics (slow, lazy, sluggish) than positive characteristics (determined, motivated, eager).

Consequences of Weight Bias

While weight bias and stigma have negative consequences in families, workplaces, education, and the media, its prevalence in health care providers seems to be the most alarming given our role in helping people improve their health. Negative attitudes held by health care providers influence the way they connect with their patients and have serious consequences for the clinical treatment of people with obesity. Health care providers have been found to spend less time with people with obesity, discuss treatment options less often, and limit communication about obesity, as well as view their patients as unwilling to engage in weight management.[9] People who experience weight bias are more vulnerable to experience depression, low self-esteem, anxiety, social isolation, perceived stress, substance abuse, and suicide.[10] When a person experiences stigma during a health care interaction, they are more likely to avoid future episodes of preventive health care, further exacerbating health problems associated with obesity.[10] Tomiyama suggests that stigma leads to weight gain through a feedback loop model where weight stigma is a stressor leading to increased cortisol levels and increased food intake, unhealthy eating and weight-control behaviors, binge eating, emotional eating, and further weight gain, which provokes further stigma.[11,12]

Fat Phobia Scale (FPS)[32]
Anti-fat Attitudes Questionnaire (AFA)[33]
Anti-fat Attitudes Test (AFAT)[34]
Anti-fat Attitudes Scale (AFAS)[35]
Obese Persons Traits Survey (OPTS)[19]
Universal Measure of Bias–Fat[36]
Attitudes Toward Obese Persons and Beliefs About Obese Persons scales (ATOP and BAOP)[37]
Weight Bias Internalization Scale (WBIS)[38]

Table 1. Validated measures to assess weight bias[19,32-38]

Weight Bias in RDNs

Despite training and a focus or passion for helping people achieve healthier lifestyles, RDNs are not immune from exhibiting weight bias and causing unintended negative consequences on the patients we serve. A systematic review examined weight bias among exercise and nutrition professionals in 31 studies, 11 of which were in nutrition professionals, including students/trainees.[13] Three of the four studies with RDNs saw a high prevalence of weight bias.[8,14,15] RDNs described individuals with obesity as having greed, unattractiveness, ungainliness, lack of willpower, and laziness.[14] Seventy six percent reported a moderate to strong preference for thin people compared with those with overweight, while similar studies in the general population show this preference in 52% of respondents.[15]

CNMs may wonder how weight bias shows up in an inpatient setting. A qualitative study from Australia examined clinical leaders and managers' perceptions of inpatients with obesity.[16] Leaders described taking care of patients with obesity as problematic and they focused on their personal and professional perception of greater risk of complications. Even when someone is hospitalized for other health conditions, obesity tends to become the central focus during the admission and can overshadow a patient's other concerns. Classifying the patient as being 'obese' reduces their identity to a single condition, and their multiple, complex, and intersecting needs as a whole person are often missed or downplayed.[16] This study highlights the discrepancy between one's intentions

and their actions. Seeing this paradox may provide some motivation to CNMs for addressing bias and working to align actions with intentions for providing optimal patient care.

Actionable Steps to Reduce Bias/Stigma

It is undeniable that weight bias compromises quality of care and can promote weight gain, outcomes that contrast with the care we intend to provide for patients who seek counsel from RDNs.[11] After becoming aware of this problem, there are many ways for individuals, organizations, and health systems to take improvement steps. If weight bias can negatively impact those who receive education or counseling from providers like RDNs, then it becomes our professional responsibility to train those in other health care positions, to reduce further harm associated with weight bias and stigma.[17] Consider the driving force for entering the field of nutrition and health care; we have a common goal to support the health and well-being of all individuals, not just those who we decide 'deserve' our best care.[12]

Recently, a multidisciplinary expert panel convened to publish the "Joint international consensus statement for ending stigma of obesity", with specific calls to action - a must-read for all current and future health care providers.[18] Table 2 describes other resources to help recognize weight bias and take action to address stigma.

Alter Perceived Norms

Social norms are informal rules that govern the behavior of groups. They can powerfully shape attitudes and behavior, and alteration of social norms has been tested to explore obesity stigma. Providing participants with 'phony' feedback about their peers' view of people with obesity as being more positive than their own resulted in more assignment of positive traits to people with obesity.[19] Clarifying and/or setting expectations for social norms can have a constructive application in how people may endorse or condemn expression of weight bias. In a clinical setting, this could be accomplished by creating a zero-tolerance policy for comments or humor/jokes about stereotypes or statements about weight.[20]

Regulate Emotions

Fostering positive affect through techniques that providers can practice to regulate emotions (i.e. meditation, deep breathing) can help reduce the impairment in judgment that results from pressure on time.[21] Providers who feel that their 'difficult' or 'complex' patients 'did it to themselves' or who are

Resource	Weblink
ASMBS Position Statement on Weight Bias and Stigma[39]	https://link.springer.com/article/10.1007/s11695-020-04525-0
Joint international consensus statement for ending stigma of obesity[18]	https://www.soard.org/article/S1550-7289(19)30168-6/fulltext
Obesity Action Coalition (OAC) Weight Bias Resources	https://www.obesityaction.org/action-through-advocacy/weight-bias/weight-bias-resources/
Guidelines for Media Portrayals of Individuals Affected by Obesity	https://www.obesityaction.org/action-through-advocacy/weight-bias/media-guidelines-for-obesity/
Obesity Action Coalition Image Library	https://www.obesityaction.org/get-educated/public-resources/oac-image-gallery/
Rudd Center Library Images/Media Gallery	https://uconnruddcenter.org/media-gallery/#
Strategies to Overcome and Prevent (STOP) Obesity Alliance: Why Weight Guide	http://whyweightguide.org/
Provider Competencies for the Prevention and Management of Obesity	https://www.obesitycompetencies.gwu.edu/competencies
Examine explicit and implicit bias with IAT	http://www.implicit.harvard.edu

Table 2. Weight Bias/Obesity Stigma Resources

harming their own health through poor decision making may feel strong negative emotions. Prejudice reduction strategies like meditation and deep breathing can help overcome negative emotions and improve compassion.[22,23]

Educate On Complex Nature of Obesity

Health care providers need to be reminded consistently that there are genetic, environmental, biological, psychological, and social contributors to weight gain and loss. Understanding the complex web of causality can contribute to having a more positive attitude about people with obesity. Patients who hear a message of 'obesity is complex' feel more positively about taking action than when they hear the cliché 'eat less, move more' or 'calories in, calories out'. Interventions based on changing attitudes about the 'controllability' of weight by highlighting the causes of obesity that cannot be modified or controlled have had some success.[24,25]

Provide Welcoming and Less Threatening Environment

Creating physical environments where people with obesity feel accepted and not threatened is a step that all health care providers can work toward to provide optimal care for people of all sizes.[26] A psychological concept called 'stereotype threat response' occurs when someone feels that their actions are perceived in a way that confirms the negative stereotypes associated with the stigmatized group and experience disrupted performance afterwards due to the physiological stress response and negative emotions and thoughts that result.[27] Stereotype threat response can be activated in situations that remind people of those negative stereotypes, such as the clinic and hospital environment where equipment and furniture reminds patients how 'unusual' or 'odd' they are. Providers and CNMs can ensure that the clinical environment is welcoming to patients of all sizes by requiring that larger sized chairs, medical equipment, gowns, scales, blood pressure cuffs, and instruments are available and not difficult or cumbersome to use.[17]

Use Appropriate Imagery

The media is known to be a pervasive source of weight stigma reinforcing bias through inaccurate framing of obesity with images, language, and terminology. Health care providers have the opportunity to minimize weight bias by using positive and non-stereotypical images of people with obesity in marketing materials, signage, pamphlets, artwork, and on websites and social media.[17] Table 2 lists resources to find appropriate images.

Provide Patient-Centered Care

RDNs should have training in motivational interviewing strategies to facilitate behavior change with their clients, which is associated with both better adherence and positive outcomes.[28] Weight bias can also be reduced when providers move focus away from body weight and turn to the health conditions for which obesity is a risk factor and can be targeted. RDNs should work with patients to improve health and wellbeing through cultivation of sustainable practices that can be maintained. Creating interactive education materials in collaboration with people who have had the lived experience of obesity can help to reduce stigma.[29] Additionally, it is advised to utilize real patients whenever possible to accurately capture the patient experience and provide feedback to providers about how patients experience provider bias.

Consider Viewing Brief Educational Films

A recent study indicates that brief educational films may provide a feasible method of improving trainee health care professionals' beliefs about and attitudes toward people with obesity, with this effect continuing for some time after viewing them.[17] Short films might offer a novel way of tackling negative attitudes; however, the intervention did not significantly improve implicit anti-fat bias. Use of guided discussions and summative assessments, or guided self-reflections can provide a framework for processing and understanding the information. Interventions combining multiple attitude-change strategies may be needed to tackle the complexities of obesity stigma and translate it into less biased behavior.

Self-Reflect Through Journaling

An innovative approach to mitigate weight bias involved journaling as a modality for self-reflection by nursing students who periodically wrote about their experiences with weight bias as they cared for patients with obesity.[30] This introspective self-reflection

as part of a weight sensitivity training curriculum could lead to improved patient care and a suspected reduction of weight bias in future practice.[31] As teams of health care professionals are learning about their impact on the care of patients of all sizes, this strategy may help providers process and integrate knowledge they are learning as part of continuing education.

Approach From a Population Level

While individual-level approaches are often the first step in addressing assumptions and reducing stigma, Alberga and colleagues argue for an upstream, population-level approach.[25] Suggestions include: legislation to prohibit weight discrimination, mandatory curriculum to train health care professionals, employment and health care policies, financial incentives for avoiding bias and stigma, stringent media guidelines, and modifying the built environment to accommodate people of all sizes.[25] This comprehensive approach offers a map toward a future where weight bias is both unacceptable and not tolerated.

Actionable Resources for CNM Leaders

CNM leaders know that evidence-based practice requires combining research with provider experience and putting patient values at the center. Table 3 lists suggestions for CNM leaders to implement with their teams. Utilizing diversity and inclusion trainings and response frameworks for addressing weight bias can provide further resources, as illustrated below.

Include resources on internal website, staff portals, and agendas for staff meetings for both inpatient and outpatient RDNs.
Provide RDNs with access to tools/resources to assess their own weight bias as part of onboarding and regular staff meetings.
Support attendance at national and regional conferences both financially and by coordinating coverage for time away.
Include patient perspective by involving them in development and evaluation of education materials; invite patients to share their first-hand experience with weight bias in the health care setting.
Commit to creating an internal policy to use 'people first' language in the office, at meetings, and in written materials. For example, instead of an 'obese patient', say 'a person with obesity'.
Create a culture to check in on each other and learn tolerance together. Discuss and practice how to address concerning language.
Include size diversity whenever diversity is being discussed. Recommend RDN involvement on team in charge of system-wide education and competencies.
Integrate regular training opportunities on weight bias/stigma into onboarding toolkits for staff in hospital.
Coordinate with metabolic and bariatric surgical and medical management programs (if available), who likely have developed training materials.
Facilitate discussion and training with hospital diet office and nursing staff about how liberalized vs. restrictive diets may send unintended messages that may be perceived as stigmatizing (include patient perspective).
Advocate for appropriate equipment and supplies for patients of all sizes in inpatient and outpatient settings, including consideration of patient transport and mobility. Have the equipment and supplies already available and visible, so that it is not obvious when these need to be obtained for a particular person.
Consider input from and diversity in practice approaches from RDNs practicing in weight management, metabolic and bariatric surgery, eating disorders, non-diet, and initiative eating.
Involve RDNs in teaching curriculum to medical professionals about nutrition, obesity, and weight bias/stigma in both non-traditional and traditional pathways.
Include dietetic interns in similar pathways as RDNs. Include assessment and discussion of providers' interactions with patients at several time points during internship.
Consider ways in which bias/stigma may affect patient satisfaction such as diet office staff/patient interactions, diet orders, and interactions across the continuum of care.

Table 3. Actionable Items for CNM Leaders to Address Weight Bias/Obesity Stigma

Examples in Action from the University of Virginia (UVA) Health, Charlottesville, VA

Team Training to Respond to Discriminatory Behavior

UVA Health developed a training for team members to provide a framework for responding to situations where they experience or witness discriminatory behavior. To support the framework, the clinical nutrition management team set up four training sessions to allow their team of RDNs and interns to join in a raw discussion about discrimination. Unsurprisingly, weight-based discrimination was brought up as an example that RDNs had witnessed.

Highlights of the training included clarifying that we have a duty to act when we see disrespect or bias and the best tool to prepare us to act is practice or develop muscle memory. Instructors shared the strategy that if you've said it once, you may be more comfortable in saying it again.

The BEGIN framework for responding to discrimination was also provided. See Table 4.

The training team also provided potential responses to acts of discrimination, including questioning or interrupting ("I'm sorry, could you repeat that? I'm not sure I understood you"), disagreeing ("I don't think that issue is related to her weight"), or expressing emotions ("I'm really uncomfortable, disappointed, surprised by that comment"). Consistent, repeated training provided many opportunities to practice the new skills and were effective in equipping team members to respond to any act of bias or discrimination, including those around weight.

Breath	Take a breath, take a step back, pause
Empathy	Enter for opening up conversation
Goals	Recognize mutual goals
Inquiry	"Help me understand how I can help you today"
e**N**gage	Bring patient/team member into making plan for how to move forward

Table 4. The BEGIN framework for responding to discrimination

Mandatory Language in all Course Syllabi

Another resource used by the UVA School of Nursing is the language in Figure 1 that is present in all course syllabi. The language establishes a culture of respect and provides a framework for addressing tough conversations, including those around bias.

Conclusion

CNMs have a tremendous responsibility to develop and support diverse teams of RDNs, diet techs, students, interns, and other health care providers. Weight stigma is a pervasive problem that interferes with optimal patient care and contrasts with our goals to help people enjoy a healthier life. CNMs must understand the dire need for training and resources to address weight-based discrimination. We are called to do better. We must recognize and address bias in ourselves and others in order to fulfill our mission to empower and support leaders to advance nutrition practices in health care. CNMs equipped with tools, resources, and strategies can use their unique role to work to stop weight stigma.

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Engagement as a Community of Scholars

We in this UVA School of Nursing community represent many diverse characteristics, perspectives, beliefs, values, and experiences. We recognize and value this rich diversity and aspire to offer an equitable, inclusive, welcoming, secure, responsive, and affirming environment that fosters mutual respect, empathy and trust. This is our shared responsibility.

At times, issues or comments may surface in class that can cause offense or be hurtful to someone. Such comments may be made by either students or faculty, or sometimes raised in reading assignments. It is important that we all commit to addressing issues as they arise, in a respectful manner.

Please let me know if you are concerned about anything said in class or raised in the readings.

One process we may use to facilitate discussions is ***HEALS***©, a process developed by the Diversity in Action Committee (DIVA) at the University of California, San Francisco School of Nursing.[40]

HEALS Model

- **Halt** the discussion
  - Pause to consider the comment.
  - Ask for clarification.
  - Express appreciation for raising the issue.
  - Focus on the idea.
  - Deconstruct the comment without placing the individual on the defensive.
- **Engage** with the issue
  - Self-check, check the room/virtual room, look for body language, listen for tone. How are others responding?
  - Discuss the issue in a non-judgmental, respectful manner.
- **Allow** exchange of opinions, stories, perspective, and reactions
  - Let others express their thoughts, beliefs, feelings, and opinions.
- **Learn** – Listen deeply to one another
  - What can we learn from one another's experiences or observations?
  - Even with conflict, there can be a positive take-away like gaining a perspective and understanding for views and beliefs that challenge our own.
- **Synthesize the discussion** – Why does this discussion matter?
  - Think about why does this discussion matter?
  - Can you relate the conversation back to health equity, quality of care, and/or respect?

Figure 1. UVA School of Nursing Syllabi Language

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Hiring With Diversity in Mind

By Lorna Fuller, MS, RDN, LD, Patricia Moore, RD, LD, PHR, SHRM-CP and Cordialis Msora-Kasago, MA, RDN

Hiring with Diversity in Mind

A Business Insider article[1] told the heartbreaking story of Jose Zamora, a job seeker who, in an attempt to get a callback, decided to alter his name from "Jose" to "Joe" on his resume. The tactic worked. After a few months of applying to over fifty jobs each day without any response, Jose received a flood of interview requests after he changed his name to Joe. Similarly, an article published in the New York Times shared the experience of Yvonne Orr, a job seeker who "whitened" her resume also to get an interview.[2]

Orr:

- Removed her bachelor's degree from Hampton University, a historically black college.
- Only listed her master's degree from Spertus Institute, a Jewish school.
- Omitted a position she once held at an African American nonprofit organization; and
- Rearranged her references so the first people listed were not black.

The article further reported that minority job seekers sometimes choose to "whiten" their resumes by hiding racial markers. These alterations were not merely to get an interview but also a means of making sure they appear palatable to hiring managers once the race was revealed.[2]

Activism in black organizations and even majoring in African American studies can be signals of race to employers. Removing such details, as illustrated in the examples, was all part of what Orr described as "calming down on the blackness."

Jose and Orr's experiences are not isolated. Research from the Natural Bureau of Economic Research shows that despite laws against discrimination, résumés containing minority racial cues, such as distinctively African American or Asian names, lead to 30% to 50% fewer callbacks from potential employers than those applicants with otherwise equivalent résumés without such cues.[3]

Diversity, Equity and Inclusion Matter

In a world full of people from different walks of life, ensuring diversity, equity and inclusion is simply the right thing to do. According to Lucille Beseler, Past President of the Academy of Nutrition and Dietetics: "A health profession must look like the public it serves to remain strong, trusted and aware of the challenges and needs of a diverse population."[4]

The US Department of Health and Human Services (HHS) concurs and indicates that a diversified workforce provides "greater access to care for underserved populations and better interactions between patients and health professionals."[5] This notion is supported by research that indicates that workforce diversity not only improves access to high-quality healthcare services but also advances cultural competency and the ability to recruit a wider pool of participants for research initiatives while ensuring optimal management of healthcare systems.[6]

Health disparities exist along racial and ethnic lines. For instance, the National Academies of Sciences, Engineering and Medicine reports that in 2010, African Americans were 30 percent more likely than whites to die prematurely from heart disease.[7] Given this disproportionate impact of disease, increasing the diversity of nutrition providers is critical for improved and sustained outcomes.

Diversity, Equity and Inclusion – What's the Difference?

Longtime Diversity, Equity and Inclusion (DE &I) educator Verna Myers said it best: "Diversity is being asked to the party. Inclusion is being asked to dance."[8]

DE&I often considers a person's race, color, ethnicity, gender, age, socioeconomic status, religion, sexual orientation, national origin, education, marital status, language(s) spoken, mission-relevant age, veteran status, gender expression, gender identity, and mental or physical appearance/ability, genetic information and learning styles.[5,9]

Diversity accepts the differences in people, encompasses the various characteristics that make an individual or group unique and places value on those qualities. Beyond geography and race, it embraces all the things that make us, as individuals, organizations and societies unique. It is about perspective, representation, challenging conversations, and support.

Alone, diversity is not enough. We must be inclusive, giving dissimilar voices a seat at the table. People must feel included, welcomed, respected, supported, and valued as they participate. By giving everyone an opportunity to actively contribute and participate, inclusion embraces differences and offers respect in words, actions, and deeds for all people.

Equity can be described as fairness and is an approach that ensures everyone access to the same opportunities. It recognizes that advantages and barriers exist, and that as a result, we all do not start at or come at from the same place.

Equity flourishes in an environment built upon respect and dignity and acknowledges that there are people who face numerous barriers that limit their ability to reach their full potential.

The Role of Bias

Patricia Moore, Clinical Recruiter for Sodexo and co-author of this article advises that one must be sure that unconscious bias does not influence the hiring decision.

Unconscious bias is everywhere, developed throughout life span and retained at the subconscious level. Each day, our brains receive, process, and store trillions of pieces of data– unconsciously categorizing and formatting that data into familiar patterns.[10]

From the neighborhoods that we choose, the friends we engage, to the people we date and even co-workers we sit with during lunch, there is bias in our daily interactions. The key is not whether we hold bias but in recognizing and correcting the biases as they occur.

Biases that favor information based upon personal belief include:

- Confirmation Bias – forming conclusions based on information that confirms our personal views, perceptions or beliefs.[11]
- Contrast Effect – evaluating the performance of one person to another. A candidate must be assessed individually and not compared to another.
- Affinity Bias – gravitating toward candidates or people who are like us.
- Weight Bias – judging a person negatively because of body size.
- Anchoring – focusing on one trait or piece of information to make a decision.
- Halo/Horn Effect – negative feeling, impression or perception. May include stereotypes such as race, gender, ethnicity or placing someone on a pedestal after learning something impressive.

Self-awareness tools such as the Implicit Association Test[12] and the Intercultural Development Inventory[13] can be as a step in assessing personal bias. In addition, formal and informal trainings such as webinars, books, and videos can aid in self-discovery.

Throughout the hiring process, it is important to remember that social media is personal and not professional. Judging a candidate's profile to assess if they are a good fit for your company culture is like judging a book by its cover. Never allow preconceptions to overrule ethical and personal recruitment processes.

Building Diverse Teams

According to the Standards of Professional Performance for Registered Dietitian Nutritionists in Clinical Nutrition Management, dietitians must guide, design and deliver customer-centered services.[14] As leaders, clinical nutrition managers play an integral

role in ensuring everyone is represented and patients can see themselves reflected in the care and recommendations provided.

DE&I must be a priority, and leaders should strike a balance between ensuring that they have the right balance of talent on their teams.

To create a diverse team:

- **Create a diverse network** by interacting with dietitians in settings outside of your usual network. Participate in the local dietetic association or join a dietetic practice group (DPG) or member interest group (MIG) that emphasizes an area or population with which you are not familiar.
- **Develop the hiring strategy** by understanding the demographics and characteristics of the population that you serve and evaluating your workforce to ensure that the team is representative of the community served and has the skills necessary to address the need. Hire to fill the gaps in your identified needs.
- **Create a diverse slate of candidates** and conduct an interview with a diverse peer panel. This gives the team the opportunity to select their co-worker and the applicant an opportunity to interface with the team. After all, the candidate is also interviewing you while you interview them.
- **Ask the same questions** of all candidates.
- **Be a preceptor/mentor/coach**. We can only diversify dietetics if we attract and usher new people into the profession and build up the ones already in the profession. Offer an internship, speak at a career fair, volunteer to mentor and help a dietitian navigate to their next role.
- **Never stop learning**. DE& I is an iterative process. Reach out to your network, organizations, ask questions, be transparent and open to learning every day.

Suggested Resources

- Implicit Association Test from Harvard University
- Resources from the Academy of Nutrition and Dietetics.
- Academy of Nutrition and Dietetics Member Interest Groups (MIGs)
- Diversify Dietetics

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