Improved demographic data are needed for more accurate assessment of race/ethnic and gender diversity in the nutrition and dietetics profession.

Suzanne Domel Baxter, PhD, RD, LD, FADA, FAND (corresponding & reprint author); Matthew J. Landry, PhD, RDN, LDN; Judith Rodriguez, PhD, RD, FADA; Neva Cochran, MS, RDN, LD, FAND; Sharon S. Sweat, BS, MS, RDN, LD; and Levin Genciano Dotimas, MS, RD, CD

Abstract

A diverse workforce is vitally important to ensure that our nation has quality, affordable, and accessible health care. Diversity, equity, and inclusion are crucial to the nutrition/dietetics profession. As the Academy of Nutrition and Dietetics (Academy) strives to increase and better target efforts in these areas, assessment will be required to measure progress. Evaluation of progress hinges on the cooperation of individual nutrition/dietetics practitioners — registered dietitians (RDs) or registered dietitian nutritionists (RDNs) and dietetic technicians registered (DTRs) and nutrition dietetics technicians, registered (NDTRs) to self-report race/ethnicity and gender to the Academy and/or the Commission on Dietetic Registration (CDR). Furthermore, accurate assessment and reporting of demographics of the profession relies on the Academy and/or the CDR to use the full de-identified database of practitioners rather than smaller surveys. This article 1) summarizes data collection standards issued by the U.S. government on race/ethnicity, 2) summarizes reports on practitioners in health occupations by race/ethnicity and gender from the CDR, U.S. government, and other professional organizations, 3) provides a recommended action step to encourage nutrition/dietetics practitioners to self-report race/ethnicity and gender to the Academy and/or the CDR, and 4) provides recommended action steps to encourage the Academy and/or the CDR to use the full de-identified database of nutrition/dietetics practitioners rather than smaller surveys to report demographics of RDs/RDNs and DTRs/NDTRs by Academy groups, and to make several revisions to the CDR Registry Statistics and surveys to enhance future race/ethnic and gender diversity and more accurate assessment of race/ethnic and gender diversity in the profession.

INTRODUCTION

Diversity is defined as the presence of differences within a given setting; these differences include race/ethnicity, religion, color, gender, national origin, disability, sexual orientation, age, size, education, geographic origin, and skill characteristics, among others (Academy of Nutrition and Dietetics [Academy], 2021a). Diversity refers to the composition of a group of people from any number of demographic backgrounds, identities (innate and selected), and the collective strength of their experiences, beliefs, values, skills, and perspectives (Academy, 2021a).

A diverse workforce is vitally important to ensure that our nation has quality, affordable, and accessible health care (U.S. Department of Health and Human Services [USDHHS], 2015). Diversity, equity, and inclusion are crucial to the nutrition/dietetics profession. The Academy (2020) summarized its numerous efforts concerning diversity, equity, and inclusion in an online letter on 12/16/2020. The Academy has added an Inclusion, Diversity, Equity and Access (IDEA) professional Resource Hub to its website where one can read the latest updates from organizational units

at the Academy, meet the IDEA Committee, learn about the Academy's IDEA grants and scholarships, view the Academy's Strategic Plan, review a list of IDEA definitions, and read spotlights of IDEA projects and initiatives of Dietetic Practice Groups (DPGs), Member Interest Groups (MIGs), Affiliates, and the Academy (Academy, 2021b).

Lund et al. (2021) recently provided action steps such as suggesting continuing professional education on bias awareness and cultural humility. They also recommended examples to increase the understanding of racial inequity in power and privilege in dietetic training for some of the Academy's units including the Accreditation Council for Education in Nutrition and Dietetics (ACEND), the Commission on Dietetic Registration (CDR), the Academy's Committee for Professional Development, the Nutrition and Dietetics Advocacy Summit, the Leadership Institutes, and the annual Food & Nutrition Conference & Expo (Lund et al., 2021).

As the Academy strives to increase and better target its IDEA efforts, assessment will be required to measure progress, especially concerning race/ethnicity and gender which are key aspects of IDEA. Evaluation of progress hinges on the cooperation of individual nutrition/dietetics practitioners—registered dietitians (RDs) or registered dietitian nutritionists (RDNs) and dietetic technicians registered (DTRs) or nutrition dietetics technicians, registered (NDTRs) to self-report their demographics. However, accurate assessment of race/ethnic and gender diversity in the profession cannot currently occur due to nutrition/dietetics practitioners who do not self-report race/ethnicity and gender to the Academy or to the CDR. Furthermore, accurate assessment and reporting of demographics of the profession rely on the Academy and/or the CDR to use the full de-identified database of practitioners rather than smaller surveys. The full de-identified database of nutrition/dietetics practitioners would not provide information for cells with less than 5 individuals, to help protect privacy.

This article has four purposes. The first purpose is to summarize data collection standards issued by the U.S. government for race and ethnicity. The second purpose is to summarize reports on practitioners in health occupations by race/ethnicity and gender from the CDR, U.S. government, and other professional organizations. The third purpose is to provide a recommended action step to encourage nutrition/dietetics practitioners to self-report race/ethnicity and gender to the Academy

and the CDR. The fourth purpose is to provide several recommended action steps to encourage the Academy and/or the CDR to use the full de-identified database of nutrition/dietetics practitioners rather than smaller surveys to report demographics of RD/RDNs and DTR/NDTRs by Academy groups, as well as to make several revisions to the CDR *Registry Statistics* and surveys to enhance future race/ethnic and gender diversity and more accurate assessment of race/ethnic and gender diversity in the profession.

This article concerns self-reporting of race/ethnicity and gender by and for nutrition/dietetic practitioners — RD/RDNs and DTR/NDTRs; it was beyond this article's scope to include students/interns, too. However, the ACEND (2020) provides demographic enrollment trends for 1998-2020 with the number of students/interns by race/ethnicity, and by gender, enrolled in all program types; race/ethnicity includes annual numbers for "not able to report ethnic origin."

The six authors of this article represent diverse groups as their collective Academy/Affiliate service includes two current IDEA Liaisons (Affiliate; MIG), two members of the recent Advisory Group to the Academy's IDEA Committee, an Academy MIG current Chair, an Academy MIG current Chair-Elect, an Academy Past-President, a past member of the Academy's IDEA Leaders Program, two Affiliate Past-Presidents, an Academy past Delegate, and three past members of numerous Academy Committees (including IDEA). Demographics of this article's six authors include a Latinx member, an Asian member, a member of color, a member with a disability, two males, one member under age 30 years, and three members over age 60 years.

Data Collection Standards for Race and Ethnicity from the U.S. Government

The U.S. government has long collected data on race and ethnicity through censuses, surveys, and administrative records to examine change in disparities and social, demographic, health, and economic characteristics. This section summarizes data collection standards for race and ethnicity issued by the U.S. government over a time span of 39 years.

Beginning in 1977 on May 12, the Office of Management and Budget (OMB) issued Statistical Policy Directive No. 15 titled *Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (OMB, 1977). This OMB Directive (1977) provided standard classifications

for record keeping, collection, and presentation of data on race and ethnicity in Federal program administrative reporting and statistical activities. The five basic racial and ethnic categories were defined as American Indian or Alaskan Native, Asian or Pacific Islander, Black, Hispanic, and White. Separate data collection was preferred on race and ethnicity with minimum designations for race as American Indian or Alaskan Native, Asian or Pacific Islander, Black, and White; and for ethnicity as Hispanic origin and not of Hispanic origin. The minimum standard collection categories were to be utilized for civil rights reporting, general program administrative and grant reporting, and statistical reporting. This OMB Directive (1977) stated, "The designation 'nonwhite' is not acceptable for use in the presentation of Federal Government data. It is not to be used in any publication of compliance or statistical data or in the text of any compliance or statistical report" (Section 4. Presentation of Race/Ethnic Data).

Twenty years later, in 1997 on July 9, the OMB issued a Notice titled *Recommendations from the Interagency Committee for the Review of the Racial and Ethnic Standards to the Office of Management and Budget Concerning Changes to the Standards for the Classification of Federal Data on Race and Ethnicity* (Federal Register, 1997a). This Notice (Federal Register, 1997a) made available for comment the Interagency Committee's recommendations for how OMB should revise Directive No. 15.

That same year, in 1997 on October 30, the OMB issued a Notice titled *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* (Federal Register, 1997b). This Notice (Federal Register, 1997b) presented revised standards for the classification of Federal data on race and ethnicity to replace and supersede Statistical Policy Directive No. 15. The revised standards separated the Asian or Pacific Islander category into two categories — "Asian" and "Native Hawaiian or Other Pacific Islander" — and changed the term "Hispanic" to "Hispanic or Latino." Thus, the revised standards had five minimum categories for data on race — American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White; there were two categories for data on ethnicity — "Hispanic or Latino" and "Not Hispanic or Latino." The new standards were to be used by the Bureau of the Census in the 2000 decennial census and by other Federal programs in household surveys, administrative forms and records, and other data collections (Federal Register, 1997b).

Nineteen years later, in 2016 on September 30, the OMB issued a Notice titled *Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity* (Federal Register, 2016). This Notice (Federal Register, 2016) was a review and possible limited revision of the 1997 standards in four specific areas concerning the 1) use of separate questions measuring race and ethnicity and question phrasing; 2) classification of a Middle Eastern and North African group and reporting category; 3) description of the intended use of minimum reporting categories; and 4) terminology used for race and ethnicity classifications. This Notice (Federal Register, 2016) stated, "The standard not only guides information collected and presented from the decennial census and numerous other statistical collections, but also is used by Federal agencies for civil rights enforcement and for program administrative reporting" (Supplementary Information, Federal Uses of Race and Ethnicity Data) with examples provided including enforcing requirements of the Voting Rights Act; revising State congressional redistricting plans; collecting and presenting data on population characteristics, labor force, education, and vital and health statistics; establishing and evaluating Federal affirmative action plans and evaluating affirmative action and discrimination in employment in the private sector; monitoring access of minorities to home mortgage loans under the Home Mortgage Disclosure Act; enforcing the Equal Credit Opportunity Act; monitoring and enforcing desegregation plans in public schools; assisting minority businesses under the minority business development programs; and monitoring and enforcing the Fair Housing Act. This Notice (Federal Register, 2016) stated principles to consider including that "the racial and ethnic categories set forth in the standard should not be interpreted as being scientific or anthropological in nature;" and "while Federal data needs for racial and ethnic data are of primary importance, consideration should also be given to needs at the State and local government levels...as well as to general societal needs for these data" (Supplementary Information, General Principles for Review of the Racial and Ethnic Data Categories).

These data collection standards issued by the U.S. government over the last 39 years — since 1977 — illustrate the importance it places on documenting and reporting race and ethnicity to evaluate these aspects of diversity and inclusion in a wide range of government-funded programs. The nutrition/dietetics profession could similarly benefit by collecting and reporting more complete demographic data of its practitioners.

Reports On Practitioners in Health Occupations by Race/Ethnicity and Gender from the CDR, U.S. Government, and Other Professional Organizations

Reports from the CDR Registry Statistics

The first author obtained an Academy-funded IDEA mini grant for her Affiliate for the 2020-2021 fiscal year. One part of the mini-grant's project was to conduct an anonymous email survey of the Affiliate's membership to obtain demographics. However, the Affiliate's annual membership survey that summer had a low response rate of around 10%. A demographic survey with a low response rate of around 10% would not provide useful information. Thus, the first author emailed the CDR on December 14, 2020 and requested either a de-identified excel file or the number of RD/RDNs by gender and by race/ethnicity in her Affiliate. She received a reply with a link for the demographic information that CDR gathers (Johnson-Freeman, personal communication, December 15, 2020). Specifically, on the CDR *Registry Statistics* page (2021a; 2021b), the subheadings REGISTERED DIETITIAN (RD) AND REGISTERED DIETITIAN NUTRITIONIST (RDN) and NUTRITION DIETETICS TECHNICIAN, REGISTERED NDTR) AND DIETETIC TECHNICIAN REGISTERED (DTR) opened pages with demographic information (numbers and percentages by gender and by race/ethnicity) for RD/RDNs and DTR/NDTRs, respectively, both for the Academy overall and for each Affiliate. Information from these pages was downloaded as screenshots by the authors on January 18, 2021 and compiled into tables for RD/RDNs and DTR/NDTRs for race/ethnicity and for gender, and then used for this article. The CDR data is for all credentialed RD/RDNs and credentialed DTR/NDTRs irrespective of Academy membership.

RD/RDN practitioners. On January 18, 2021, the CDR *Registry Statistics* (2021a) had 105,828 RD/RDNs with 83.8% female, 3.8% male, and 12.4% who did not report gender, and 0.5% American Indian/Alaskan Native, 3.8% Asian, 2.4% Black/African American, 3.6% Hispanic/Latino, 0.8% Native Hawaiian Pacific Islander, 1.1% other, 0.8% two or more races, 71.3% White, 13.8% who did not report race/ethnicity, and 2.0% who responded, "prefer not to disclose" race/ethnicity. For gender, response options were male and female whereas for race/ethnicity, there was a response option for "prefer not to disclose." Thus, race/ethnicity was missing for

15.8% total or 16,763 RD/RDNs. By summing numbers and percentages for RD/RDNs in the six categories of color — American Indian/Alaskan Native, Asian, Black/African American, Hispanic/Latino, Native Hawaiian Pacific Islander, other — to create a single category, there were 12,856 RD/RDNs of color or 12.1% total. Out of the 105,828 RD/RDNs overall, 15.8% for whom race/ethnicity was missing accounted for more RD/RDNs than 12.1% for all RD/RDNs of color (CDR *Registry Statistics*, 2021a).

Before writing this article, the first author made comments verbally and in the chat boxes on two separate occasions during WebEx calls to Academy staff and practitioners to highlight that the summed percentage of not-reported plus prefer-not-to-disclose categories on the CDR *Registry Statistics* was greater than the summed percentage across all race/ethnicities for RD/RDNs of color. One occasion was when she audited the Academy's House of Delegates Fall Meeting on October 15-16, 2020. The other occasion was when she met with a breakout session group on February 9, 2021 for the Advisory Group to the IDEA Committee of the Academy.

DTR/NDTR practitioners. On January 18, 2021, the CDR *Registry Statistics* (2021b) had 4,908 DTR/NDTRs with 66.0% female, 29.5% male, and 4.5% who did not report gender, and 0.5% American Indian/Alaskan Native, 3.0% Asian, 3.7% Black/African American, 4.4% Hispanic/Latino, 0.5% Native Hawaiian Pacific Islander, 0.9% other, 1.3% two or more races, 52.1% White, 31.7% did not report race/ethnicity, and 1.9% who responded, "prefer not to disclose" race/ethnicity. For gender, response options were male and female whereas for race/ethnicity, there was a response option for "prefer not to disclose." Thus, race/ethnicity was missing for 33.5% total or 1,645 DTR/NDTRs. By summing numbers and percentages for DTR/NDTRs in the six categories of color to create a single category, there were 637 DTR/NDTRs of color or 13.0% total. Out of the 4,908 DTR/NDTRs overall, 33.5% for whom race/ethnicity was missing accounts for many more DTR/NDTRs than 13.0% for all DTR/NDTRs of color (CDR *Registry Statistics*, 2021b).

Not self-reporting race/ethnicity and gender by RD/RDNs and DTR/NDTRs by Affiliate. Accurate assessment of the status of race/ethnic and gender diversity of RD/RDNs and DTR/NDTRs cannot be achieved with such data gaps due to not self-reporting race/ethnicity and

gender, or preferring not to self-report race/ethnicity. Table 1 and Table 2 compile the number and percent of RD/RDNs (Panels A) and DTR/NDTRs (Panels B) from the *CDR Registry Statistics* (2021a; 2021b) on January 18, 2021 by Affiliate for race/ethnicity and gender, respectively, to highlight the extent to which this information was not self-reported by respective practitioners. These tables' panels are useful resources because each provides a snapshot of race/ethnicity or gender data compiled across all 59 Affiliates — listed in alphabetical order — for a single date in early 2021.

A pattern was identified concerning RD/RDNs by Affiliate who did not self-report race/ethnicity and gender. The 10 Affiliates with the largest percentages of RD/RDNs not self-reporting gender (Table 2 [Panel A]) shared a common subset of eight of the 10 Affiliates with the largest percentages of RD/RDNs who did not self-report race/ethnicity (Table 1 [Panel A]). This common subset was comprised of Puerto Rico, Utah, Alaska, New York, New Jersey, Massachusetts, California, and Washington.

A similar but slightly different pattern was identified concerning DTR/NDTRs by Affiliate who did not self-report race/ethnicity and gender. The 10 Affiliates with the largest percentages of DTR/NDTRs not self-reporting gender (Table 2 [Panel B]) shared a common subset of nine of the 10 Affiliates with the largest percentages of DTR/NDTRs who did not self-report race/ethnicity (Table 1 [Panel B]). This common subset was comprised of North Dakota, Delaware, Vermont, Arizona, Hawaii, Rhode Island, Colorado, California, and Iowa.

It is important to note that the *CDR Registry Statistics* provide data by groups and not by individual nutrition/dietetics practitioners. Thus, the authors do not know whether the same practitioners who did not self-report gender also did not self-report race/ethnicity and vice versa.

Changes in CDR Registry Statistics. The *CDR Registry Statistics* (2021a,b) in mid-April 2021 removed race/ethnicity and gender results by Affiliate to instead provide a list of the number of RD/RDNs and DTR/NDTRs by Affiliate. For demographics, the *CDR Registry Statistics* (2021a; 2021b) changed to state that the most current and accurate demographic data is offered by research, and to list two citations for such research — *the Compensation and Benefits Survey*

2019 (Griswold & Rogers, 2020) hereafter referred to as the “2019 survey” and *the Report on the Academy/CDR 2020 Needs Satisfaction Survey* (Rogers, 2021) hereafter referred to as the “2020 survey” — and to provide one table and three figures from the 2020 survey (Rogers, 2021). *The Compensation and Benefits Surveys* are conducted across probability samples drawn from the population of domestic Academy members plus domestic nonmembers who maintain current registration as an RD/RDN or DTR/NDTR (Griswold & Rogers, 2020). *The Needs Satisfaction Surveys* are conducted across stratified samples drawn from the population of four groups: RD/RDNs (whether current Academy members or not), DTR/NDTRs (whether current Academy members or not), uncredentialed persons (currently nonregistered Academy active and retired category members plus currently nonregistered nonmembers who at some point were eligible to take the RD/RDN and/or DTR/NDTR examinations and may or may not have been registered at one time since 2011), and students (current nonregistered student members of the Academy plus nonregistered student members whose Academy memberships lapsed in the previous 2 years) (Rogers, 2021).

The table on the *CDR Registry Statistics* (2021a; 2021b) from the 2020 survey (Rogers, 2021) included one column for students and another column for professionals but the current article summarizes only the results for professionals. That table showed 119,249 professionals comprised of 92% female, 80% white, 6% Hispanic/Latino, 3% Black/African American, 5% Asian, 2% other, and 3% who provided no answer, but did not include the percentage who marked “prefer not to disclose;” furthermore, neither the *CDR Registry Statistics* website page nor table specified that the 2020 survey had only 5,752 usable responses for a 10% response rate (Rogers, D. 2021) and neither defined “usable responses.” The 2020 survey's results were weighted to reflect true population proportions (Rogers, 2021), but population proportions were not provided for those who marked, “prefer not to disclose.” The 2019 survey (Griswold & Rogers, 2020) had 8,765 usable responses for a 23% response rate (but “usable responses” were undefined), and results which were weighted to reflect true population proportions showed that practitioners were 95% women with 6% Hispanic/Latino, 5% Asian, 3% Black/African American, and 2% other. However, in the full 2019 Survey (Academy, 2019), Exhibit 7.04 – Gender indicated that 25 respondents (0.3%) marked

Table I (Panel A). Registered Dietitians (RDs) and Registered Dietitian Nutritionists (RDNs) — Number and Percentage by Affiliate and Race/Ethnicity using Data from the Commission on Dietetic Registration (CDR) Registry Statistics on January 18, 2021 (CDR, 2021a)

AFFILIATE (STATE, TERRITORY)*	TOTAL n: DTRs & NDTRs	RACE/ETHNICITY values shown within each cell are number (%)														Not reported + prefer not to disclose*
		American Indian/ Alaskan Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian /Pacific Islander	Other	Two or more races	White	Of Color**	Not Reported	Prefer not to disclose				
Alabama	1,413	8 (0.6)	13 (0.9)	80 (5.7)	5 (0.4)	1 (0.1)	7 (0.5)	5 (0.4)	1,112 (78.7)	114 (8.2)	168 (11.9)	14 (1.0)	182 (12.9)			
Alaska	245	8 (3.3)	8 (3.3)		6 (2.4)	3 (1.2)	3 (1.2)	1 (0.4)	170 (69.4)	28 (11.4)	41 (16.7)	5 (2.0)	46 (18.8)			
Arizona	1,960	28 (1.4)	51 (2.6)	27 (1.4)	126 (6.4)	7 (0.4)	29 (1.5)	21 (1.1)	1,342 (68.5)	268 (13.7)	277 (14.1)	50 (2.6)	327 (16.7)			
Arkansas	865	4 (0.5)	5 (0.6)	24 (2.8)	7 (0.8)		2 (0.2)	3 (0.3)	705 (81.5)	42 (4.9)	107 (12.4)	8 (0.9)	115 (13.3)			
California	11,269	41 (0.4)	1,461 (13.0)	191 (1.7)	746 (6.6)	332 (2.9)	278 (2.5)	200 (1.8)	5,951 (52.8)	3,049 (27.1)	1,703 (15.1)	364 (3.2)	2,067 (18.3)			
Colorado	2,569	8 (0.3)	34 (1.3)	9 (0.4)	76 (3.0)	8 (0.3)	18 (0.7)	22 (0.9)	1,967 (76.6)	153 (6.0)	370 (14.4)	57 (2.2)	427 (16.6)			
Connecticut	1,493	7 (0.5)	39 (2.6)	17 (1.1)	22 (1.5)	11 (0.7)	9 (0.6)	9 (0.6)	1,146 (76.8)	105 (7.0)	212 (14.2)	20 (1.3)	232 (15.5)			
Delaware	317	1 (0.3)	8 (2.5)	12 (3.8)	6 (1.9)	2 (0.6)	2 (0.6)		243 (76.7)	31 (9.7)	39 (12.3)	4 (1.3)	43 (13.6)			
Florida	5,407	18 (0.3)	125 (2.3)	210 (3.9)	594 (11.0)	27 (0.5)	72 (1.3)	40 (0.7)	3,445 (63.7)	1,046 (19.3)	764 (14.1)	110 (2.0)	874 (16.2)			
Georgia	2,533	7 (0.3)	77 (3.0)	243 (9.6)	54 (2.1)	7 (0.3)	25 (1.0)	24 (0.9)	1,706 (67.4)	413 (16.3)	329 (13.0)	60 (2.4)	389 (15.4)			
Hawaii	417	1 (0.2)	150 (36.0)	1 (0.2)	7 (1.7)	33 (7.9)	4 (1.0)	12 (2.9)	143 (34.3)	196 (47.0)	48 (11.5)	18 (4.3)	66 (15.8)			
Idaho	679	7 (1.0)	4 (0.6)		13 (1.9)	2 (0.3)	4 (0.6)	2 (0.3)	556 (81.9)	30 (4.4)	80 (11.8)	11 (1.6)	91 (13.4)			
Illinois	4,259	11 (0.3)	157 (3.7)	87 (2.0)	111 (2.6)	34 (0.8)	32 (0.8)	34 (0.8)	3,145 (73.8)	432 (10.2)	571 (13.4)	77 (1.8)	648 (15.2)			
Indiana	2,116	6 (0.3)	19 (0.9)	31 (1.5)	17 (0.8)	8 (0.4)	10 (0.5)	10 (0.5)	1,725 (81.5)	91 (4.4)	254 (12.0)	36 (1.7)	290 (13.7)			
Iowa	1,098	4 (0.4)	6 (0.5)	1 (0.1)	5 (0.5)	1 (0.1)	6 (0.5)	3 (0.3)	932 (84.9)	23 (2.1)	128 (11.7)	12 (1.1)	140 (12.8)			
Kansas	1,004	6 (0.6)	11 (1.1)	10 (1.0)	10 (1.0)	6 (0.6)	8 (0.8)	6 (0.6)	835 (83.2)	51 (5.1)	103 (10.3)	9 (0.9)	112 (11.2)			
Kentucky	1,370	3 (0.2)	8 (0.6)	18 (1.3)	10 (0.7)	2 (0.1)	14 (1.0)	6 (0.4)	1,139 (83.1)	55 (3.9)	157 (11.5)	13 (0.9)	170 (12.4)			
Louisiana	1,405	6 (0.4)	8 (0.6)	107 (7.6)	14 (1.0)	2 (0.1)	15 (1.1)	6 (0.4)	1,079 (76.8)	152 (10.8)	143 (10.2)	25 (1.8)	168 (12.0)			
Maine	450	1 (0.2)	5 (1.1)	1 (0.2)	2 (0.4)		7 (1.6)	1 (0.2)	367 (81.6)	16 (3.5)	57 (12.7)	9 (2.0)	66 (14.7)			
Maryland	1,934	7 (0.4)	80 (4.1)	181 (9.4)	35 (1.8)	20 (1.0)	31 (1.6)	11 (0.6)	1,261 (65.2)	354 (18.3)	259 (13.4)	49 (2.5)	308 (15.9)			
Massachusetts	2,985	9 (0.3)	90 (3.0)	20 (0.7)	33 (1.1)	13 (0.4)	22 (0.7)	19 (0.6)	2,228 (74.6)	187 (6.2)	477 (16.0)	73 (2.4)	550 (18.4)			
Michigan	3,510	15 (0.4)	82 (2.3)	75 (2.1)	42 (1.2)	21 (0.6)	33 (0.9)	17 (0.5)	2,687 (76.6)	268 (7.5)	462 (13.2)	74 (2.1)	536 (15.3)			
Minnesota	2,513	6 (0.2)	40 (1.6)	9 (0.4)	22 (0.9)	7 (0.3)	4 (0.2)	8 (0.3)	2,038 (81.1)	88 (3.6)	349 (13.9)	29 (1.2)	378 (15.0)			
Mississippi	825	4 (0.5)	5 (0.6)	54 (6.5)	6 (0.7)	2 (0.2)	1 (0.1)	4 (0.5)	664 (80.5)	72 (8.6)	75 (9.1)	10 (1.2)	85 (10.3)			
Missouri	2,060	6 (0.3)	27 (1.3)	27 (1.3)	23 (1.1)	3 (0.1)	15 (0.7)	9 (0.4)	1,661 (80.6)	101 (4.8)	263 (12.8)	26 (1.3)	289 (14.0)			
Montana	433	7 (1.6)	4 (0.9)		6 (1.4)	2 (0.5)		5 (1.2)	342 (79.0)	19 (4.4)	53 (12.2)	14 (3.2)	67 (15.5)			
Nebraska	765	2 (0.3)	6 (0.8)	6 (0.8)	10 (1.3)		2 (0.3)	2 (0.3)	660 (86.3)	26 (3.5)	68 (8.9)	9 (1.2)	77 (10.1)			
Nevada	660	8 (1.2)	51 (7.7)	10 (1.5)	21 (3.2)	10 (1.5)	6 (0.9)	17 (2.6)	434 (65.8)	106 (16.0)	91 (13.8)	12 (1.8)	103 (15.6)			
New Hampshire	618	3 (0.5)	6 (1.0)	1 (0.2)	6 (1.0)	2 (0.3)	4 (0.6)	3 (0.5)	518 (83.8)	22 (3.6)	64 (10.4)	11 (1.8)	75 (12.1)			
New Jersey	3,249	12 (0.4)	204 (6.3)	77 (2.4)	78 (2.4)	41 (1.3)	50 (1.5)	8 (0.2)	2,168 (66.7)	462 (14.3)	525 (16.2)	86 (2.6)	611 (18.8)			
New Mexico	470	7 (1.5)	9 (1.9)	4 (0.9)	56 (11.9)	1 (0.2)	7 (1.5)	7 (1.5)	309 (65.7)	84 (17.9)	62 (13.2)	8 (1.7)	70 (14.9)			
New York	7,135	23 (0.3)	366 (5.1)	211 (3.0)	186 (2.6)	62 (0.9)	104 (1.5)	36 (0.5)	4,771 (66.9)	952 (13.4)	1,201 (16.8)	173 (2.4)	1,374 (19.3)			
North Carolina	3,542	15 (0.4)	54 (1.5)	135 (3.8)	47 (1.3)	14 (0.4)	26 (0.7)	21 (0.6)	2,668 (75.3)	291 (8.1)	500 (14.1)	61 (1.7)	561 (15.8)			
North Dakota	399	6 (1.5)	2 (0.5)	1 (0.3)	2 (0.5)		2 (0.5)	1 (0.3)	345 (86.5)	13 (3.3)	38 (9.5)	2 (0.5)	40 (10.0)			
Ohio	4,640	9 (0.2)	60 (1.3)	61 (1.3)	30 (0.6)	13 (0.3)	21 (0.5)	19 (0.4)	3,716 (80.1)	194 (4.2)	641 (13.8)	70 (1.5)	711 (15.3)			
Oklahoma	1,134	64 (5.6)	26 (2.3)	17 (1.5)	12 (1.1)	1 (0.1)	10 (0.9)	22 (1.9)	840 (74.1)	130 (11.5)	127 (11.2)	15 (1.3)	142 (12.5)			
Oregon	1,283	10 (0.8)	34 (2.7)	2 (0.2)	21 (1.6)	9 (0.7)	12 (0.9)	10 (0.8)	969 (75.5)	88 (6.9)	184 (14.3)	32 (2.5)	216 (16.8)			
Pennsylvania	4,893	15 (0.3)	62 (1.3)	49 (1.0)	37 (0.8)	12 (0.2)	26 (0.5)	18 (0.4)	3,971 (81.2)	201 (4.1)	637 (13.0)	66 (1.3)	703 (14.4)			
Rhode Island	439		6 (1.4)	3 (0.7)	3 (0.7)		2 (0.5)	2 (0.5)	352 (80.2)	14 (3.3)	65 (14.8)	6 (1.4)	71 (16.2)			
South Carolina	1,332	6 (0.5)	15 (1.1)	60 (4.5)	18 (1.4)	4 (0.3)	11 (0.8)	5 (0.4)	1,035 (77.7)	114 (8.6)	159 (11.9)	19 (1.4)	178 (13.4)			
South Dakota	318	5 (1.6)		1 (0.3)	1 (0.3)			3 (0.9)	269 (84.6)	7 (2.2)	37 (11.6)	2 (0.6)	39 (12.3)			
Tennessee	2,193	7 (0.3)	19 (0.9)	67 (3.1)	29 (1.3)	6 (0.3)	13 (0.6)	13 (0.6)	1,761 (80.3)	141 (6.5)	244 (11.1)	34 (1.6)	278 (12.7)			
Texas	7,449	37 (0.5)	313 (4.2)	255 (3.4)	860 (11.5)	58 (0.8)	99 (1.3)	69 (0.9)	4,552 (61.1)	1,622 (21.7)	1,053 (14.1)	151 (2.0)	1,204 (16.2)			
Utah	1,134	5 (0.4)	16 (1.4)		12 (1.1)	1 (0.1)	3 (0.3)	11 (1.0)	881 (77.7)	37 (3.3)	189 (16.7)	16 (1.4)	205 (18.1)			
Vermont	266		3 (1.1)	1 (0.4)	3 (1.1)			1 (0.4)	219 (82.3)	7 (2.6)	35 (13.2)	4 (1.5)	39 (14.7)			
Virginia	2,203	7 (0.3)	97 (3.8)	106 (4.2)	58 (2.3)	26 (1.0)	23 (0.9)	15 (0.6)	1,857 (73.6)	317 (12.5)	282 (11.2)	51 (2.0)	333 (15.1)			
Washington	2,701	18 (0.7)	115 (4.3)	11 (0.4)	56 (2.1)	20 (0.7)	25 (0.9)	39 (1.4)	1,939 (71.8)	245 (9.1)	408 (15.1)	70 (2.6)	478 (17.7)			
West Virginia	380	3 (0.8)	3 (0.8)	4 (1.1)	3 (0.8)	1 (0.3)	1 (0.3)	3 (0.8)	302 (79.5)	15 (4.1)	53 (13.9)	7 (1.8)	60 (15.8)			
Wisconsin	2,316	11 (0.5)	18 (0.8)	10 (0.4)	22 (0.9)	4 (0.2)	7 (0.3)	4 (0.2)	1,901 (82.1)	72 (3.1)	306 (13.2)	33 (1.4)	339 (14.6)			
Wyoming	174	1 (0.6)	2 (1.1)		1 (0.6)	1 (0.6)			139 (79.9)	5 (2.9)	28 (16.1)	2 (1.1)	30 (17.2)			
American Samoa	1								1 (100)			0	0 (0)			
Armed Forces	61		2 (3.3)		1 (1.6)				52 (85.2)	3 (4.9)	4 (6.6)	2 (3.3)	6 (9.8)			
Armed Forces Americas (except Canada)	8		1 (12.5)						7 (87.5)	1 (12.5)			0			
Armed Forces Pacific	31		1 (3.2)		3 (9.7)		2 (6.5)		18 (58.1)	6 (19.4)	6 (19.4)	1 (3.2)	7 (22.6)			
District of Columbia	243	2 (0.8)	12 (4.9)	30 (12.3)	9 (3.7)		5 (2.1)	2 (0.8)	135 (55.6)	58 (23.8)	38 (15.6)	10 (4.1)	48 (19.8)			
Guam	26		9 (34.6)		2 (7.7)	5 (19.2)			6 (23.1)	16 (61.5)	3 (11.5)	1 (3.8)	4 (15.4)			
Northern Mariana Islands	4		1 (25.0)			1 (25.0)	1 (25.0)		1 (25.0)	3 (75.0)			0			
Puerto Rico	305			1 (0.3)	214 (70.2)		1 (0.3)	2 (0.7)	20 (6.6)	216 (70.8)	62 (20.3)	5 (1.6)	67 (22.0)			
Virgin Islands	8			3 (37.5)			1 (12.5)		3 (37.5)	4 (50.0)	1 (12.5)		1 (12.5)			
TOTAL	105,828	505 (0.5)	4,030 (3.8)	2,561 (2.4)	3,799 (3.6)	846 (0.8)	1,115 (1.1)	811 (0.8)	75,408 (71.3)	12,856 (12.1)	14,600 (13.8)	2,136 (2.0)	16,736 (15.8)			

Empty cells have no data.

*Red font indicates 10 Affiliates with the greatest percentages in the not-reported plus prefer-not-to-disclose race/ethnicity categories. These 10 Affiliates were the Armed Forces Pacific (22.6%), Puerto Rico (22.0%), District of Columbia (19.8%), New York (19.3%), Alaska and New Jersey (each 18.8%), Massachusetts (18.4%), California (18.3%), Utah (18.1%), and Washington (17.7%); they accounted for 5,453 of the 16,763 RD/RDNs for whom race/ethnicity was missing.

** Of Color = sum of n or % for American Indian or Alaskan Native + Asian + Black or African American + Hispanic or Latino + Native Hawaiian Pacific Islander + Other.

Table I (Panel B). Dietetic Technicians Registered (DTRs) and Nutrition Dietetics Technicians, Registered (NDTRs) — Number and Percentage by Affiliate and Race/Ethnicity using Data from the Commission on Dietetic Registration (CDR) Registry Statistics on January 18, 2021 (CDR, 2021b)

AFFILIATE (STATE, TERRITORY)*	TOTAL n: DTRs & NDTRs	RACE/ETHNICITY values shown within each cell are number (%)												
		American Indian/ Alaskan Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian /Pacific Islander	Other	Two or more races	White	Of Color**	Not Reported	Prefer not to disclose	Not reported + prefer not to disclose*	
Alabama	17				1 (5.9)				14 (82.4)	1 (5.9)	2 (11.8)		2 (11.8)	
Alaska	3								2 (66.7)	0 (0%)	1 (33.3)		1 (33.3)	
Arizona	300	4 (1.3)	6 (2.0)	2 (0.7)	23 (7.7)	1 (0.3)	3 (1.0)	6 (2.0)	107 (35.7)	39 (13.0)	142 (47.3)	6 (2.0)	148 (49.3)	
Arkansas	36	1 (2.8)		4 (11.1)	1 (2.8)				19 (52.8)	6 (16.7)	11 (30.6)		11 (30.6)	
California	708	1 (0.1)	72 (10.2)	17 (2.4)	68 (9.6)	15 (2.1)	7 (1.0)	16 (2.3)	193 (27.3)	180 (25.4)	308 (43.5)	11 (1.6)	319 (45.1)	
Colorado	95	1 (1.1)	1 (1.1)	2 (2.1)	3 (3.2)		1 (1.1)	3 (3.2)	40 (42.1)	8 (8.4)	43 (45.3)	1 (1.1)	44 (46.3)	
Connecticut	125	1 (0.8)	3 (2.4)	3 (2.4)	5 (4.0)	1 (0.8)			70 (56.0)	13 (10.4)	37 (29.6)	5 (4.0)	42 (33.6)	
Delaware	10	1 (10.0)		2 (20.0)					2 (20.0)	3 (30.0)	5 (50.0)		5 (50.0)	
Florida	271	1 (0.4)	4 (1.5)	21 (7.7)	27 (10.0)	1 (0.4)	9 (3.3)	2 (0.7)	141 (52.0)	63 (23.2)	60 (22.1)	5 (1.8)	65 (24.0)	
Georgia	41			7 (17.1)			3 (7.3)	1 (2.4)	16 (39.0)	10 (24.4)	14 (34.1)		14 (34.1)	
Hawaii	7	1 (14.3)	1 (14.3)						2 (28.6)	2 (28.6)	3 (42.9)		3 (42.9)	
Idaho	18								13 (72.2)	0 (0)	4 (22.2)	1 (5.6)	5 (27.8)	
Illinois	142	1 (0.7)	5 (3.5)	8 (5.6)	7 (4.9)	2 (1.4)			67 (47.2)	23 (16.2)	51 (35.9)	1 (0.7)	52 (36.6)	
Indiana	67			2 (3.0)					51 (76.1)	2 (3.0)	14 (20.9)		14 (20.9)	
Iowa	15			2 (13.3)					7 (46.7)	2 (13.3)	6 (40.0)		6 (40.0)	
Kansas	11			1 (9.1)					6 (54.5)	1 (9.1)	4 (36.4)		4 (36.4)	
Kentucky	19				1 (5.3)				12 (63.2)	1 (5.3)	6 (31.6)		6 (31.6)	
Louisiana	42		2 (4.8)	2 (4.8)	4 (9.5)			2 (4.8)	16 (38.1)	8 (19.0)	16 (38.1)		16 (38.1)	
Maine	60								44 (73.3)	0 (0)	15 (25.0)	1 (1.7)	16 (26.7)	
Maryland	47			11 (23.4)	2 (4.3)		1 (2.1)		20 (42.6)	14 (29.8)	10 (21.3)	3 (6.4)	13 (27.7)	
Massachusetts	58	1 (1.7)	1 (1.7)	1 (1.7)	1 (1.7)		1 (1.7)		39 (67.2)	5 (8.6)	13 (22.4)	1 (1.7)	14 (24.1)	
Michigan	63		1 (1.6)	10 (15.9)				1 (1.6)	29 (46.0)	11 (17.5)	19 (30.2)	2 (3.2)	21 (33.3)	
Minnesota	174		8 (4.6)	1 (0.6)		1 (0.6)	1 (0.6)	7 (4.0)	112 (64.4)	11 (6.3)	43 (24.7)	1 (0.6)	44 (25.3)	
Mississippi	5			2 (40.0)					2 (40.0)	2 (40.0)	1 (20.0)		1 (20.0)	
Missouri	60			1 (1.7)	3 (5.0)			1 (1.7)	43 (71.7)	4 (6.7)	11 (18.3)	1 (1.7)	12 (20.0)	
Montana	10								8 (80.0)	0 (0)	2 (20.0)		2 (20.0)	
Nebraska	22								20 (90.9)	0 (0)	1 (4.5)	1 (4.5)	2 (9.1)	
Nevada	46			2 (4.3)	2 (4.3)	1 (2.2)	1 (2.2)	2 (4.3)	20 (43.5)	6 (13.0)	17 (37.0)	1 (2.2)	18 (39.1)	
New Hampshire	26				1 (3.8)				15 (57.7)	1 (3.8)	10 (38.5)		10 (38.5)	
New Jersey	136		4 (2.9)	5 (3.7)	2 (1.5)		1 (0.7)	2 (1.5)	85 (62.5)	12 (8.8)	33 (24.3)	4 (2.9)	37 (27.2)	
New Mexico	6								5 (83.3)	0 (0)	1 (16.7)		1 (16.7)	
New York	505	2 (0.4)	14 (2.8)	20 (4.0)	19 (3.8)		2 (0.4)	7 (1.4)	282 (55.8)	57 (11.3)	144 (28.5)	15 (3.0)	159 (31.5)	
North Carolina	110			5 (4.5)	5 (4.5)		1 (0.9)	1 (0.9)	54 (49.1)	11 (10.0)	43 (39.1)	1 (0.9)	44 (40.0)	
North Dakota	5								1 (20.0)	0 (0)	4 (80.0)		4 (80.0)	
Ohio	704	3 (0.4)	3 (0.4)	16 (2.3)	8 (1.1)	2 (0.3)	5 (0.7)	6 (0.9)	436 (61.9)	37 (5.3)	209 (29.7)	16 (2.3)	225 (32.0)	
Oklahoma	26	1 (3.8)	1 (3.8)		1 (3.8)			2 (7.7)	11 (42.3)	3 (11.5)	10 (38.5)		10 (38.5)	
Oregon	35	2 (5.7)	1 (2.9)						21 (60.0)	3 (8.6)	10 (28.6)	1 (2.9)	11 (31.4)	
Pennsylvania	227	1 (0.4)	5 (2.2)	7 (3.1)	1 (0.4)		3 (1.3)	1 (0.4)	150 (66.1)	17 (7.5)	57 (25.1)	2 (0.9)	59 (26.0)	
Rhode Island	7								4 (57.1)	0 (0)	3 (42.9)		3 (42.9)	
South Carolina	32			3 (9.4)	1 (3.1)				19 (59.4)	4 (12.5)	9 (28.1)		9 (28.1)	
South Dakota	4								3 (75.0)	0 (0)	1 (25.0)		1 (25.0)	
Tennessee	60		1 (1.7)	3 (5.0)				1 (1.7)	35 (58.3)	4 (6.7)	19 (31.7)	1 (1.7)	20 (33.3)	
Texas	182	1 (0.5)	9 (4.9)	9 (4.9)	28 (15.4)		3 (1.6)		71 (39.0)	50 (27.5)	59 (32.4)	2 (1.1)	61 (33.5)	
Utah	9								7 (77.8)	0 (0)	2 (22.2)		2 (22.2)	
Vermont	10								4 (40.0)	0 (0)	6 (60.0)		6 (60.0)	
Virginia	63		1 (1.6)	6 (9.5)				1 (1.6)	39 (61.9)	7 (11.1)	15 (23.8)	1 (1.6)	16 (25.4)	
Washington	81		2 (2.5)	2 (2.5)	3 (3.7)			3 (3.7)	42 (51.9)	7 (8.6)	27 (33.3)	2 (2.5)	29 (35.8)	
West Virginia	13								11 (84.6)	0 (0)	2 (15.4)		2 (15.4)	
Wisconsin	190	2 (1.1)	3 (1.6)	2 (1.1)		1 (0.5)		1 (0.5)	146 (76.8)	8 (4.2)	30 (15.8)	5 (2.6)	35 (18.4)	
Wyoming	3								2 (66.7)	0 (0)	1 (33.3)		1 (33.3)	
District of Columbia	1								1 (100)	0 (0)				
Guam	1		1 (100)							1 (100)				
TOTAL	4,908	25 (0.5)	149 (3.0)	180 (3.7)	216 (4.4)	25 (0.5)	42 (0.9)	66 (1.3)	2,559 (52.1)	637 (13.0)	1,554 (31.7)	91 (1.9)	1,645 (33.5)	

Empty cells have no data. Table I (Panel B) excludes 7 Affiliates — American Samoa; Armed Forces Africa, Canada, Europe and Middle East; Armed Forces Americas (except Canada); Armed Forces Pacific; Northern Mariana Islands; Puerto Rico; Virgin Islands — for which the number of DTR/NDTRs was zero in CDR's Registry Statistics on 1/18/2021.

*Red font indicates 10 Affiliates with the greatest percentages in the not-reported plus prefer-not-to-disclose race/ethnicity categories. These 10 Affiliates were North Dakota (80.0%), Vermont (60.0%), Delaware (50.0%), Arizona (49.3%), Colorado (46.3%), California (45.1), Hawaii and Rhode Island (each 42.9%), and Iowa and North Carolina (each 40.0%). These 10 Affiliates accounted for 582 of the 1,645 DTR/NDTRs for whom race/ethnicity was missing.

** Of Color = sum of n or % for American Indian or Alaskan Native + Asian + Black or African American + Hispanic or Latino + Native Hawaiian Pacific Islander + Other.

Table 2 (Panel A). Registered Dietitians (RDs) and Registered Dietitian Nutritionists (RDNs) — Number and Percentage by Affiliate and Gender using Data from the Commission on Dietetic Registration (CDR) Registry Statistics on January 18, 2021 (CDR, 2021a)

AFFILIATE (STATE, TERRITORY)*	TOTAL n: RDs & RDNs	Female		Male		Not Reported	
		n	%	n	%	n	%
Alabama	1,413	1,219	86.3%	37	2.6%	157	11.1%
Alaska	245	200	81.6%	8	3.3%	37	15.1%
Arizona	1,960	1,603	81.8%	97	4.9%	260	13.3%
Arkansas	865	750	86.7%	21	2.4%	94	10.9%
California	11,269	9,299	82.5%	455	4.0%	1,515	13.4%
Colorado	2,569	2,125	82.7%	99	3.9%	345	13.4%
Connecticut	1,493	1,241	83.1%	58	3.9%	194	13.0%
Delaware	317	267	84.2%	12	3.8%	38	12.0%
Florida	5,407	4,438	82.1%	277	5.1%	692	12.8%
Georgia	2,533	2,140	84.5%	100	3.9%	293	11.6%
Hawaii	417	351	84.2%	26	6.2%	40	9.6%
Idaho	679	586	86.3%	20	2.9%	73	10.8%
Illinois	4,259	3,600	84.5%	137	3.2%	522	12.3%
Indiana	2,116	1,800	85.1%	78	3.7%	238	11.2%
Iowa	1,098	966	88.0%	21	1.9%	111	10.1%
Kansas	1,004	876	87.3%	36	3.6%	92	9.2%
Kentucky	1,370	1,170	85.4%	55	4.0%	145	10.6%
Louisiana	1,405	1,234	87.8%	46	3.3%	125	8.9%
Maine	450	385	85.6%	17	3.8%	48	10.7%
Maryland	1,934	1,638	84.7%	64	3.3%	232	12.0%
Massachusetts	2,985	2,480	83.1%	87	2.9%	418	14.0%
Michigan	3,510	2,966	84.5%	129	3.7%	415	11.8%
Minnesota	2,513	2,134	84.9%	70	2.8%	309	12.3%
Mississippi	825	715	86.7%	40	4.8%	70	8.5%
Missouri	2,060	1,755	85.2%	76	3.7%	229	11.1%
Montana	433	371	85.7%	17	3.9%	45	10.4%
Nebraska	765	675	88.2%	28	3.7%	62	8.1%
Nevada	660	529	80.2%	47	7.1%	84	12.7%
New Hampshire	618	554	89.6%	13	2.1%	51	8.3%
New Jersey	3,249	2,691	82.8%	100	3.1%	458	14.1%
New Mexico	470	381	81.1%	35	7.4%	54	11.5%
New York	7,135	5,768	80.8%	294	4.1%	1,073	15.0%
North Carolina	3,542	2,938	82.9%	154	4.3%	450	12.7%
North Dakota	399	355	89.0%	9	2.3%	35	8.8%
Ohio	4,640	3,861	83.2%	184	4.0%	595	12.8%
Oklahoma	1,134	972	85.7%	47	4.1%	115	10.1%
Oregon	1,283	1,078	84.0%	45	3.5%	160	12.5%
Pennsylvania	4,893	4,142	84.7%	170	3.5%	581	11.9%
Rhode Island	439	370	84.3%	12	2.7%	57	13.0%
South Carolina	1,332	1,145	86.0%	49	3.7%	138	10.4%
South Dakota	318	269	84.6%	11	3.5%	38	11.9%
Tennessee	2,193	1,912	87.2%	67	3.1%	214	9.8%
Texas	7,449	6,204	83.3%	310	4.2%	935	12.6%
Utah	1,134	917	80.9%	34	3.0%	183	16.1%
Vermont	266	227	85.3%	10	3.8%	29	10.9%
Virginia	2,522	2,203	87.4%	67	2.7%	252	10.0%
Washington	2,701	2,248	83.2%	94	3.5%	359	13.3%
West Virginia	380	312	82.1%	21	5.5%	47	12.4%
Wisconsin	2,316	1,981	85.5%	64	2.8%	271	11.7%
Wyoming	174	140	80.5%	11	6.3%	23	13.2%
American Samoa	1			1	100.0%	0	0.0%
Armed Forces Africa, Canada, Europe & Middle East	61	56	91.8%	2	3.3%	3	4.9%
Armed Forces Americas (except Canada)	8	8	100.0%	0	0.0%	0	0.0%
Armed Forces Pacific	31	26	83.9%	1	3.2%	4	12.9%
District of Columbia	243	197	81.1%	15	6.2%	31	12.8%
Guam	26	20	76.9%	3	11.5%	3	11.5%
Puerto Rico	305	234	76.7%	14	4.6%	57	18.7%
Virgin Islands	8	7	87.5%	0	0.0%	1	12.5%
TOTAL	105,828	88,566	83.7%	3,976	3.8%	13,049	12.3%

*Red font indicates 10 Affiliates with the greatest percentages for not reporting gender. These 10 Affiliates were Puerto Rico (18.7%), Utah (16.1%), Alaska (15.1%), New York (15.0%), New Jersey (14.1%), Massachusetts (14.0%), California and Colorado (each 13.4%), and Washington and Arizona (each 13.3%); they accounted for 4,705 of the 13,049 RD/RDNs for whom gender was missing.

Table 2 (Panel B). Dietetic Technicians Registered (DTRs) and Nutrition Dietetics Technicians, Registered (NDTRs)
— Number and Percentage by Affiliate and Gender using Data from the Commission on Dietetic Registration Registry
Statistics on January 18, 2021 (CDR, 2021b)

AFFILIATE (STATE, TERRITORY)*	TOTAL n: RDs & RDNs	Female		Male		Not Reported	
		n	%	n	%	n	%
Alabama	17	14	82.40%	1	5.90%	2	11.80%
Alaska	3	2	66.70%			1	33.30%
Arizona	300	158	52.70%	8	2.70%	134	44.70%
Arkansas	36	22	61.10%	3	8.30%	11	30.60%
California	708	373	52.70%	45	6.40%	290	41.00%
Colorado	95	50	52.60%	6	6.30%	39	41.10%
Connecticut	125	81	64.80%	7	5.60%	37	29.60%
Delaware	10	4	40.00%	1	10.00%	5	50.00%
Florida	271	196	72.30%	16	5.90%	59	21.80%
Georgia	41	25	61.00%	2	4.90%	14	34.10%
Hawaii	7	4	57.10%			3	42.90%
Idaho	18	15	83.30%			3	16.70%
Illinois	142	95	66.90%	3	2.10%	44	31.00%
Indiana	67	55	82.10%			12	17.90%
Iowa	15	8	53.30%	1	6.70%	6	40.00%
Kansas	11	8	72.70%			3	27.30%
Kentucky	19	14	73.70%			5	26.30%
Louisiana	42	25	59.50%	2	4.80%	15	35.70%
Maine	60	44	73.30%	2	3.30%	14	23.30%
Maryland	47	37	78.70%	1	2.10%	9	19.10%
Massachusetts	58	40	69.00%	5	8.60%	13	22.40%
Michigan	63	44	69.80%			19	30.20%
Minnesota	174	132	75.90%	5	2.90%	37	21.30%
Mississippi	5	4	80.00%			1	20.00%
Missouri	60	46	76.70%	3	5.00%	11	18.30%
Montana	10	9	90.00%			1	10.00%
Nebraska	22	20	90.90%	1	4.50%	1	4.50%
Nevada	46	28	60.90%	2	4.30%	16	34.80%
New Hampshire	26	18	69.20%			8	30.80%
New Jersey	136	100	73.50%	5	3.70%	31	22.80%
New Mexico	6	5	83.30%			1	16.70%
New York	505	354	70.10%	20	4.00%	131	25.90%
North Carolina	110	67	60.90%	6	5.50%	37	33.60%
North Dakota	5	2	40.00%			3	60.00%
Ohio	704	477	67.80%	33	4.70%	194	27.60%
Oklahoma	26	13	50.00%	3	11.50%	10	38.50%
Oregon	35	23	65.70%	1	2.90%	11	31.40%
Pennsylvania	227	161	70.90%	13	5.70%	53	23.30%
Rhode Island	7	4	57.10%			3	42.90%
South Carolina	32	24	75.00%			8	25.00%
South Dakota	4	3	75.00%			1	25.00%
Tennessee	60	37	61.70%	5	8.30%	18	30.00%
Texas	182	124	68.10%	5	2.70%	53	29.10%
Utah	9	7	77.80%			2	22.20%
Vermont	10	4	40.00%	1	10.00%	5	50.00%
Virginia	63	45	71.40%	3	4.80%	15	23.80%
Washington	81	48	59.30%	6	7.40%	27	33.30%
West Virginia	13	11	84.60%	1	7.70%	1	7.70%
Wisconsin	190	155	81.60%	5	2.60%	30	15.80%
Wyoming	3	2	66.70%			1	33.30%
District of Columbia	1	1	100.00%				
Guam	1	1	100.00%				
TOTAL	4,908	3,239	66.00%	221	4.50%	1,448	29.50%

Empty cells have no data. Table 2 (Panel B) excludes 7 Affiliates — American Samoa; Armed Forces Africa, Canada, Europe and Middle East; Armed Forces Americas (except Canada); Armed Forces Pacific; Northern Mariana Islands; Puerto Rico; Virgin Islands — for which the number of DTR/NDTRs was zero in CDR's Registry Statistics on 1/18/2021.

*Red font indicates 10 Affiliates with the greatest percentages for not reporting gender. These 10 Affiliates were North Dakota (60.0%), Delaware and Vermont (each 50.0%), Arizona (44.7%), Hawaii and Rhode Island (each 42.9%), Colorado (41.1%), California (41.0%), Iowa (40.0%), and Oklahoma (38.5%); they accounted for 498 of the 1,448 DTR/NDTRs for whom gender was missing.

“prefer not to disclose” and 15 (0.2%) gave no answer, and Exhibit 7.06 – Heritage/Race indicated that 7,377 respondents (84%) were White, 19 (0.2%) American Indian/Alaska Native, 14 (0.2%) Native Hawaiian/Pacific Islander, 171 (2.0%) some other race, and 78 (0.9%) gave no answer. Not-reporting race/ethnicity and gender was less in the 2019 survey (Griswold & Rogers, 2020) and 2020 survey (Rogers, 2021) than in the *CDR Registry Statistics* (2021a; 2021b) on January 18, 2021, but response rates were low and thus final samples were small for the surveys compared to the *CDR Registry Statistics* (2021a; 2021b) on January 18, 2021. Also, the *CDR Registry Statistics* (2021a; 2021b) on January 18, 2021 provided demographic results including non-reporting, by Affiliate, whereas none of the 2019 survey (Griswold & Rogers, 2020), full 2019 survey (Academy, 2019), or 2020 survey (Rogers, 2021) did.

Government Reports on Demographics of U.S. Health Occupations

Three government reports provide data on demographics of U.S. health occupations including RD/RDNs and DTR/NDTRs (USDHHS, 2015; USDHHS, 2017; U.S. Bureau of Labor Statistics [USBLS], 2021). Although all three reports considered RD/RDNs as a single occupation, none considered DTR/NDTRs as a single occupation. Reports for 2010–2012 (USDHHS, 2015) and 2011–2015 (USDHHS, 2017) considered DTR/NDTRs in a group of technologists from six areas total consisting of dietary, pharmacy, psychiatry, respiratory therapy, surgery, and veterinary. The year 2020 report (USBLS, 2021) considered DTR/NDTRs with ophthalmic medical technicians, and provided data only for Women, White, Black/African American, Asian and Hispanic/Latino.

Tables 3, 4, and 5 show U.S. health occupations by sex and race/ethnicity from government reports for 2010–2012 (USDHHS, 2015), 2011–2015 (USDHHS, 2017), and 2020 (USBLS, 2021), respectively. The USDHHS (2015) reference used data from the 2010-2012 American Community Survey (described in the legend of Table 3). The USDHHS (2017) reference used data from the 2011-2014 American Community Survey. The USBLS (2021) reference used data from the Current Population Survey (described in the legend of Table 5). Compared to the *CDR Registry Statistics* (2021a) on January 18, 2021, the government reports showed fewer RD/RDNs for one report (USDHHS, 2015) but similar numbers for two reports (USDHHS, 2017;

USBLS, 2021). However, compared to the *CDR Registry Statistics* (2021a) on January 18, 2021, the government reports showed greater percentages of RD/RDNs for two reports for males (USDHHS, 2015; USDHHS, 2017) and Asians (USDHHS, 2015; USBLS, 2021), and for three reports for Hispanics (USDHHS, 2015; USDHHS, 2017; USBLS, 2021) and Blacks (USDHHS, 2015; USDHHS, 2017; USBLS 2021). For differences between the *CDR Registry Statistics* (2021a) on January 18, 2021 and the government reports, the role of not self-reporting gender and race/ethnicity by RD/RDNs in the *CDR Registry Statistics* is unknown. There may be more RD/RDNs of diverse groups than are reflected in the *CDR Registry Statistics* (2021a) on January 18, 2021 due to not self-reporting and preferring not to disclose race/ethnicity and/or gender. Comparisons for DTR/NDTRs between the three government reports and the *CDR Registry Statistics* (2021b) on January 18, 2021 were not made because the three government reports did not count DTR/NDTRs as a single occupation.

Reports on Demographics from Other Professional Organizations

A 2019 report by the Association of American Medical Colleges provided self-identified demographic data on the U.S. physician workforce (Association of American Medical Colleges [AAMC], 2019a). As of July 1, 2019, there were 918,547 active physicians; by race/ethnicity, there were 0.3% American Indian/Alaska Native, 17.1% Asian, 5.0% Black/African American, 5.8% Hispanic, 0.1% Native Hawaiian/Other Pacific Islander, 1.0% Multiple race Non-Hispanic, 0.8% Other, 56.2% White, and 13.7% unknown (i.e., not reported) (AAMC, 2019b). By sex, physicians were 35.8% female, 64.1% male, and 0.2% unknown (AAMC, 2019c).

The *2019 National Pharmacist Workforce Study* (Doucette et al., 2020) provided self-identified demographic data on a random sample of 96,100 U.S. licensed pharmacists from an email survey conducted during late May through mid-July 2019. The response rate was 5.8% (5,467 usable responses). Usable responses were defined as “responses which contained responses (i.e., no missing data) for each of five key variables – work status, gender, age, hours worked weekly and practice setting” which is the same usable response definition used in previous national surveys. By gender, pharmacists were 61.8% female, 38.0% male, and 0.2% non-binary. By race/ethnicity, pharmacists were 78.2% White, 11.1% Asian, 4.9% Black, and 5.8% “Other” (defined as American

Table 3. Health Occupations in the U.S. by Number, Sex, and Race/Ethnicity, 2010–2012

Occupation	Total (n)	Sex (%)		Hispanic or Latino (%)	Non-Hispanic or Latino (%)					
		Male	Female		White	Black/ African American	Asian	American Indian and Alaska Native	Native Hawaiian and Other Pacific Islander	Multiple/ Other Race
Dietitians and Nutritionists	79,159	10	89.7	9.1	76.0	15.4	6.6	0.6	NR	1.2
Health Practitioner Support Technologists and Technicians (including Dietary)*	493,953	21.9	78.1	8.4	75.8	14.3	7.2	0.7	0.1	1.9
Advanced Practice Registered Nurses**	118,846	15	85	4	89.5	5	4.0	-0.2	NR	1.1
Chiropractors	54,444	73	27.3	3.4	89.4	2.5	56.6	0.1	NR	1.2
Dentists	157,395	75	25.5	6.1	80.5	3.3	14.5	-0.1	NR	1.5
Optometrists	33,202	60.2	39.8	4.9	82.0	2.8	13.0	NR	NP	1.8
Pharmacists	261,128	46	53.7	4	73.7	5.9	18.0	0.2	NR	1.8
Physicians	835,723	65	34.9	6	72.2	5.3	20.0	0.2	0.03	2.2
Physician Assistants	106,419	32.6	67.4	10.8	81.6	8	7.2	0.3	NR	2.9
Occupational Therapists	90,483	10.2	89.8	4.3	87.2	5	6.3	-0.2	NP	1.2
Physical Therapists	198,400	31	69.5	4.2	82.8	4.2	11.4	0.2	NR	1.2
Respiratory Therapists	98,495	34	65.6	7.5	77.5	13.5	6.7	0.3	-0.1	1.8
Speech-Language Pathologists	118,209	4.1	95.9	5.8	92.0	4.6	2.1	0.2	NR	1.1
Registered Nurses	2,682,262	9.2	90.8	5.4	78.6	10.7	8.8	0.4	0.1	1.4

Source: Abstracted from the American Community Survey Public Use Microdata Sample (ACS PUMS), 2010–2012 (USDHHS, 2015).

The ACS, conducted by the U.S. Census Bureau, surveys approximately 1% of U.S. households annually and obtains self-reported information on individuals' occupations and location (USDHHS, 2015).

*From six areas total consisting of dietary (i.e., DTR/NDTRs), pharmacy, psychiatry, respiratory therapy, surgery, and veterinary.

**Includes Nurse Anesthetists, Midwives, and Nurse Practitioners.

Not all totals equal 100 percent due to rounding. Numbers in parenthesis represent estimates with relative standard errors (RSE) > 20% and should be used with caution.

NR – Data are not reported because RSE > 30%; estimate does not meet standards of reliability.

NP – There are no data present in the 2010-2012 ACS PUMS for this subgroup.

Table 4. Health Occupations in the U.S. by Number, Sex and Race/Ethnicity, 2011–2015

Occupation	Year 2010					
	Total employed	Percent of total employed				
		Women	White	Black or African American	Asian	Hispanic or Latino
Dietitians and Nutritionists	105,575	10.6	89.4	8.5	68.7	15.0
Health Practitioner Support Technologists and Technicians (including Dietary)*	674,868	21.7	78.3	12.3	65.5	12.8
Advanced Practice Registered Nurses**	152,629	14.9	85.1	4.5	84.0	5.7
Chiropractors	59,525	71.8	28.2	3.7	86.7	1.9
Dentists	182,012	72.6	27.4	6.1	74.8	3.0
Optometrists	38,233	59.9	40.1	3.9	78.4	1.8
Pharmacists	316,183	45.5	54.5	3.7	70.4	5.9
Physicians	961,098	65.1	34.9	6.3	67.0	4.8
Physician Assistants	125,771	32.2	67.8	10.0	72.7	7.1
Occupational Therapists	108,412	9.7	90.3	4.0	83.8	4.4
Physical Therapists	235,238	29.2	70.8	4.8	77.8	4.4
Respiratory Therapists	118,675	35.4	64.6	7.9	70.1	12.8
Speech-Language Pathologists	156,512	4.0	96.0	6.2	86.1	4.1
Registered Nurses	3,327,165	9.6	90.4	5.7	73.5	10.4

Source: Table abstracted from USDHHS, 2017.

*From six areas total consisting of dietary (ie, DTR/NDTRs), pharmacy, psychiatry, respiratory therapy, surgery, and veterinary.

**Includes Nurse Anesthetists, Midwives, and Nurse Practitioners.

NR: Data not reported because relative standard errors (RSE) ≥30; estimate does not meet standards of reliability or data not present. Numbers in parenthesis represent estimates with RSE ≥20 percent and should be interpreted with caution. Not all totals equal to 100 percent due to rounding.

Table 5. Selected Employed Health Occupations in the U.S. by Number, Sex, Race, and Ethnicity, 2020

Occupation	Year 2020					
	Total employed	Percent of total employed				
		Women	White	Black or African American	Asian	Hispanic or Latino
Dietitians and Nutritionists	106,000	91.4	74.7	15.5	8.2	9.9
Dietetic Technicians and Ophthalmic Medical Technicians	66,000	73.5	68.5	27.6	2.1	5.3
Chiropractors	66,000	22.2	90.7	2.4	5.1	6.1
Dentists	173,000	28.7	78.8	1.4	16.6	5.5
Optometrists	42,000	-			-	-
Pharmacists	327,000	61.6	67.9	8.3	20.0	3.4
Physicians	929,000	40.6	67.0	8.5	22.0	8.8
Physician Assistants	141,000	65.5	79.9	6.3	12.3	7.9
Occupational Therapists	124,000	86.3	87.6	4.0	7.4	6.5
Physical Therapists	281,000	67.2	77.8	5.2	15.0	4.4
Respiratory Therapists	122,000	72.4	75.0	18.5	2.3	7.0
Speech-Language Pathologists	195,000	94.4	89.7	6.6	3.6	8.5
Registered Nurses	3,256,000	87.4	75.3	13.4	8.7	7.9
Nurse Practitioners	218,000	88.0	86.2	9.1	3.2	6.3

Source: Table abstracted from USBLS, 2021 which uses data from the Current Population Survey (a monthly survey of households conducted by the Bureau of Census for the Bureau of Labor Statistics; this Survey provides a comprehensive body of data on the labor force, employment, unemployment, persons not in the labor force, hours of work, earnings, and other demographic and labor force characteristics).

Table footnote:

The year 2020 report (USBLS, 2021) considered DTR/NDTRs along with ophthalmic medical technicians, and provided data only for Women, White, Black/African American, Asian and Hispanic/Latino. Estimates for the race groups (White, Black or African American, and Asian) do not sum to totals because data are not presented for all races. Persons whose ethnicity is identified as Hispanic or Latino may be of any race. Updated population controls are introduced annually with the release of January data. Effective with January 2020 data, occupations reflect the introduction of the 2018 Census occupational classification system, derived from the 2018 Standard Occupational Classification (SOC). No historical data have been revised. Data for 2020 are not strictly comparable with earlier years. Dash indicates no data or data that do not meet publication criteria (values not shown where base is less than 50,000).

Indian, Hispanic/Latino and Other). Responders had a higher percentage of females overall, but race/ethnicity was not assessed for non-response bias (Doucette et al., 2020).

The 2020 *National Nursing Workforce Survey* (Smiley et al., 2021) provided self-identified demographic data on 42,021 RNs from a national, randomized survey of the U.S. nursing workforce conducted in 2020 between February and June. By race/ethnicity, there were 0.5% American Indian/Alaska Native, 7.2% Asian, 6.7% Black/African American, 5.6% Hispanic, 0.4% Native Hawaiian/other Pacific Islander, 0.2% Middle Eastern/North African, 80.6% White/Caucasian, 2.3% Other, and 2.1% two or more races. By gender, RNs were 90.5% female, 9.4% male, and 0.1% other. Published appendices provided insight concerning survey nonresponse. The response rate for RNs was 27.3%, women were more likely to complete the survey than men (28.5% vs 20.3%; $p < 0.001$), and Pacific Islanders (29.6%) were most likely to respond followed by Whites (28.0%) with African

Americans (19.0%) the least likely to respond ($p < 0.001$) (Smiley et al., 2021).

In summary, the workforces for pharmacists in 2019 (Doucette et al., 2020) and RNs in 2020 (Smiley et al., 2021) were majority women, like the nutrition/dietetics workforce (USDHHS, 2015; CDR Registry Statistics, 2021a; USDHHS, 2017; USBLS, 2021). Of the U.S. workforce reports for physicians (AAMC, 2019a; AAMC, 2019b; AAMC, 2019c), nurses (Smiley et al., 2021) and pharmacists (Doucette et al., 2020) only the reports for physicians (AAMC, 2019b; AAMC, 2019c) specified the percentages of unknown for not self-reporting gender and race/ethnicity. Like the nutrition/dietetics profession, reports on workforce demographics in the physician, nursing, and pharmacist professions suggest that improvements in the race/ethnic and gender diversity of health-care professionals are needed to better reflect the U.S. general population which in 2020 was 50.8% female with 60.1% White, 13.4% Black/African American, 1.3% American Indian/Alaska Native, 5.9% Asian, 0.2% Native Hawaiian/Pacific Islander, and 18.5% Hispanic (U.S. Census Bureau, 2020).

Recommended Action Step for Practitioners: Report Race/Ethnicity and Gender to The Academy and/or The CDR

This article's second purpose is to propose a recommended action step for practitioners. This recommended action step respectfully requests RD/RDNs and DTR/NDTRs to self-report race/ethnicity and gender to the Academy and/or the CDR. At the authors' request, it is now possible for Academy members, non-members, credentialed practitioners, and non-credentialed practitioners to check and/or edit that their race/ethnicity and gender are self-reported correctly. To do so:

- 1) Go to Academy website (<https://www.eatrightpro.org/>).
- 2) Log in with username and password.
- 3) Click on "My Academy".
- 4) Scroll to "Demographics".
- 5) Click "Edit".
- 6) Two gender response options (female, male).
- 7) Nine ethnicity response options (American Indian or Alaskan Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian Pacific Islander, Other, Prefer not to disclose, Two or more races, White).
- 8) Click "Save" to save edited responses
(Johnson-Freeman, personal communication, March 24, 2021).

Underlying factors may deter self-reporting of race/ethnicity and gender by nutrition/dietetics practitioners, other health professionals, and patients. Although it is recommended that health systems routinely collect patient sociodemographic data as a key step in providing equitable person-centered care, collection of this information has the potential to cause harm, especially for vulnerable or potentially disadvantaged patients (Petkovic et al., 2019).

A study by Baker et al. (2007) used a telephone survey with 563 Californians (35.3% Hispanic, 22.9% Asian, 18.7% white, 17.2% black, 5.9% multiracial) to determine attitudes towards collection of race/ethnicity by health care providers (HCPs). Most (87.8%) participants somewhat or strongly agreed that HCPs should collect race/ethnicity information and 73.6% supported state

legislation to require it; however, 17.2% of participants were uncomfortable (score of 1-4 on a 10-point scale) with reporting their own race/ethnicity, and 46.3% were somewhat or very worried that providing information could be used to discriminate against them. All statements explaining the rationale for data collection modestly increased participants' comfort level; the statement that this would be used for staff training increased comfort the most. The authors concluded that although most participants believed that HCPs should collect information about race/ethnicity, many felt uncomfortable giving this information and worried it could be misused, and that statements explaining the rationale for collecting data assuaged some concerns, but community engagement and legislation to prevent misuse are needed to gain more widespread trust and comfort (Baker et al., 2007).

A study by Kandula et al. (2009) used a telephone survey with 480 Californians (36.0% Hispanic, 20.4% Asian, 21.0% white, 17.1% black, 5.4% multiracial) to determine whether perceived experiences of discrimination (both in general and in medical care) were associated with comfort providing race/ethnicity information, and conversely, to worry about providing the information. Compared to whites, Hispanics and Asians reported significantly less comfort giving HCPs information about their race/ethnicity, while blacks, Hispanics, and multiracial individuals were significantly more worried that race/ethnicity information could be used to discriminate against them. Adjusting for perceived experiences of discrimination in general and in medical care partially explained the higher discomfort and worry among minorities. The authors concluded that perceived experiences of discrimination are associated with greater discomfort and worry about providing race/ethnicity data, and that health care institutions should consider how they can address the public's concerns about possible misuses of data (Kandula et al, 2009).

Petkovic et al. (2019) searched the literature through January 2018 for studies that reported harms of collecting sociodemographic information in health-care settings. Of 18 studies identified, 13 provided patient perceptions or experiences with the collection of these data, 7 studies reported on provider perceptions, and 5 reported on patient recommendations for collecting sociodemographic information. Patients and providers reported similar potential harms which were grouped into 6 themes — altered behavior (which may affect

care-seeking), discomfort, discrimination, data misuse or privacy concerns, offense or negative reactions, and quality of care. Discomfort followed by discrimination were the most frequently reported harms by patients. Patients suggested that sociodemographic information be collected face to face by a physician. The authors concluded that overall, patients support the collection of sociodemographic information, but harms are possible, especially for some population subgroups, and that harms may be mitigated by providing a rationale for the collection of this information (Petkovic et al., 2019).

More complete demographic data on race/ethnicity and gender for nutrition/dietetics practitioners will 1) provide insight concerning the professional needs of practitioners of different racial/ethnic and gender groups, 2) increase the likelihood of effective actions to address and monitor disparities among practitioners, and 3) help ensure that individuals from all racial/ethnic and gender groups have the opportunity to join and flourish in the profession. Research is needed to explore barriers to self-reporting race/ethnicity and gender by nutrition/dietetics practitioners, and to identify ways to address and overcome such barriers.

Recommended Action Steps for The Academy and/or The CDR: Use Full De-identified Practitioner Database to Report Demographics on Academy Groups

This article's third purpose is to propose recommended action steps for the Academy and/or the CDR. One recommended action step respectfully requests the Academy and/or the CDR to use the full de-identified database of nutrition/dietetics practitioners rather than small surveys to report official demographics of RD/RDNs and DTR/NDTRs overall. The Academy's *Commitment to Transparency* (Academy, 2021c) states, "...ensuring Academy members have regular and timely access to information and a firm understanding of the Academy's...ongoing strategic direction" is a high priority. The Academy's Council on Research and the Academy's Board of Directors approved six "Scientific Integrity Principles" (Tappenden, 2015) in January 2015 and March 2015, respectively, to ensure that scientific activities conducted and/or funded by the Academy are conducted in a transparent manner that is objective and of high quality to ensure the trust of members, other professionals, and the public. The conduct of research,

both generating new data and/or aggregating existing data, is a scientific activity (Tappenden, 2015), and science is the basis of the nutrition/dietetics profession. The Academy's Strategic Plan (Academy, 2021d) includes research as a Principle, and Diversity and Inclusion is a Focus Area. It is recommended that when reporting official demographics of RD/RDNs and DTR/NDTRs overall, the Academy and the CDR not use surveys with low response rates that yield small samples of practitioners, especially when the full de-identified database of nutrition/dietetics practitioners exists. Small surveys conceal the issue of not self-reporting and "prefer-not-to-disclose" responses concerning race/ethnicity and gender which the CDR *Registry Statistics* (2021a; 2021b) on January 18, 2021 documented and which this article highlights as problematic to accurate assessment of race/ethnic and gender diversity in the nutrition/dietetics profession.

Two additional recommended action steps concern revisions to the CDR *Registry Statistics* to enhance future reporting of demographics in the nutrition/dietetics profession. One recommended action step is for the CDR *Registry Statistics* to again archive group demographic data for RD/RDNs and DTR/NDTRs online separately by Affiliate as it was before mid-April 2021; this useful revision would help IDEA Liaisons for Affiliates as well as facilitate IDEA research by practitioners. Another recommended action step is for the CDR *Registry Statistics* to also provide group demographic data for RD/RDNs and DTR/NDTRs online for other Academy groups, specifically DPGs and MIGs; this practical revision would help IDEA Liaisons for DPGs and MIGs.

A recommended action step concerning gender identity is for the Academy and/or the CDR to revise response options to better reflect diversity and inclusion. For example, response options for gender identity in addition to male and female might also include transgender, gender neutral, non-binary, agender, pangender, genderqueer, two-spirit, third gender, and other. At the very least, the authors encourage the Academy and/or the CDR to include a response option for other. The authors note that in addition to response options for male and female, the 2019 *National Pharmacist Workforce Study* included a response option for non-binary (Doucette et al., 2020) and the 2020 *National Nursing Workforce Survey* included a response option for other (Smiley et al., 2021).

A final recommended action step to encourage individual RD/RDNs and DTR/NDTRs to self-report race/ethnicity and gender is for the Academy and/or the CDR to include a statement on each survey about the use of data. Such a statement could read something like, *Reporting race/ethnicity and gender is optional. However, the Academy and the CDR encourage practitioners to report this information so that race/ethnic and gender diversity of the profession overall and by group (eg, Affiliate, DPG, MIG) can be assessed accurately. The Academy and the CDR keep personally identifiable information confidential, and use only de-identified data at the group level for analyses (like U.S. Census data).*

Concluding Remarks

Accurate assessment of race/ethnic and gender diversity in the profession is hindered by individual nutrition/dietetic practitioners who do not self-report race/ethnicity and/or gender to the Academy and/or the CDR, and when the Academy and/or the CDR use small surveys rather than the full de-identified database of practitioners to report official demographics for RD/RDNs and DTR/NDTRs overall. As the Academy and the CDR continue to actively pursue IDEA initiatives, more accurate demographic data will enable them to better target these initiatives. Every RD/RDN and DTR/NDTR needs to do their part by self-reporting race/ethnicity and gender to the Academy and/or the CDR. Likewise, the Academy and the CDR need to do their part when assessing and reporting official demographics for RD/RDNs and DTR/NDTRs overall by using the full de-identified database of practitioners rather than small surveys, and by archiving this de-identified information online for Academy groups. It will be impossible to target IDEA initiatives and to accurately assess IDEA progress if RD/RDNs and DTR/NDTRs do not self-report their race/ethnicity and gender, and if the Academy and/or the CDR use small surveys (with low response rates which yield small samples of practitioners) which conceal the problematic issue of not self-reporting and “prefer-not-to-disclose” responses concerning race/ethnicity and gender. The U.S. government places importance on collecting and reporting race and ethnicity to evaluate race/ethnic and gender diversity in numerous government-funded program as illustrated by the data collection standards it has issued over a 39-year time span. The nutrition/dietetics profession could similarly benefit by collecting and reporting more complete demographic data of its practitioners.

Author Bios

Suzanne Domel Baxter, PhD, RD, LD, FADA, FAND (corresponding & reprint author; baxtersuzi957@gmail.com; ORCID ID 0000-0002-9031-9087) is an Affiliate Research Professor in the College of Social Work at the University of South Carolina in Columbia, South Carolina. She completed a bachelor's degree and Coordinated Undergraduate Program at Texas Christian University, MS and PhD from Texas Woman's University, and Post-Doctoral Fellowship at the Medical College of Georgia. As Principal Investigator on numerous research grants funded mainly by the National Institutes of Health, her primary research concerned the accuracy of dietary recalls by children. Dr. Baxter resigned her Research Professor position in late 2016 due to an acquired disability which impacts her mobility. She is an active Academy member as her current positions include the Inclusion, Diversity, Equity and Access (IDEA) Liaison of the South Carolina Affiliate, Membership Chair of the Cultures of Gender and Age (COGA) MIG, member and mentor of the National Organization of Blacks in Dietetics and Nutrition (NOBIDAN) MIG, multi-year member of the Editorial Board for the Journal of the Academy of Nutrition and Dietetics, and member of the Evidence Analysis Library Adult Weight Management Workgroup. She is also a member and Dietetic Internship Application Program Volunteer of Diversify Dietetics. Her past Academy positions include member of the Diversity Leaders Program 2017–2019, President and Foundation Fundraising Liaison for the South Carolina Affiliate, member of the Advisory Group to the IDEA Committee member, and member and Chair of the Foundation Scholarship Committee. In 2017, she won the 14th Annual Elaine R. Monsen Award for Outstanding Research Literature from the Academy of Nutrition and Dietetics Foundation.

Matthew J. Landry, PhD, RDN, LDN (ORCID ID 0000-0003-2285-7702) is a nutrition and health promotion postdoctoral fellow and registered dietitian at the Stanford Prevention Research Center at Stanford University. He received a bachelor's degree from Louisiana State University and a doctorate degree from The University of Texas at Austin where he completed a dietetic internship through the Coordinated Program in Dietetics. His current research is focused on identifying the optimal diet (or diets) for chronic disease prevention and addressing the challenges of designing, implementing, and reporting clinical trials that test dietary patterns. Additionally, he is a passionate advocator for policies

that address nutrition-related health inequalities related to food insecurity and structural disparities. As an active member of the Academy of Nutrition and Dietetics, he has volunteered on numerous Academy Committees. He is currently Chair of the Academy's Cultures of Gender and Age Member Interest Group (COGA MIG).

Judith Rodriguez, PhD, RDN, LD/N, FAND (ORCID ID 0000-0003-2892-9836) is Professor and Chair Emeritus of the Department of Nutrition and Dietetics at the University of North Florida. She received a BS in Nutrition and Dietetics and an MA in Nutrition and Higher Education from New York University, and a PhD in Anthropology from Rutgers University. She completed a Dietetic Internship at Deaconess/Beth Israel Hospital. Her major areas of interest include nutrition education, underserved and at-risk populations, food and culture, cultural proficiency, and diversity. She is Vice-Chair of the Academy's IDEA Committee, an Academy past President and the Academy's only Latinx President to date. She serves on the Board of Directors of the International Confederation of Dietetic Associations, on a Science Advisory Council for FoodMinds, on a Mayo Jacksonville Women's Advisory Council, and on the Rutgers Department of Clinical and Preventive Nutrition Sciences Program Advisory Committee.

Neva Cochran, MS, RDN, LD, FAND is a Nutrition Communications Consultant based in Dallas, TX. She received a BS in nutrition and dietetics from the University of Oklahoma, a master's in nutrition from the Texas Woman's University and completed her dietetic internship at Texas Health Resources Presbyterian Hospital in Dallas. She serves as a nutrition communications consultant to a variety of food and nutrition organizations. She is passionate about promoting fact-based food and nutrition information to help people eat beyond the headlines and enjoy a variety of nutrient-rich foods. An active member of the Academy at the district, state and national level throughout her career, she is a member of numerous Academy DPGs and MIGs, a past President for the Texas Affiliate, past Academy Delegate, past Academy Foundation Chair, and past member of numerous Academy Committees including the IDEA Committee. She was a 2012 recipient of the Academy's Medallion Award and the 2016 Texas Academy's Outstanding Preceptor Award.

Sharon S. Sweat, BS, MS, RDN, LD received her first bachelor's degree in Health Promotion at Coastal Carolina University in 2012, and her second bachelor's

degree in Dietetics at the University of Northern Colorado in 2017. She received a master's degree in Dietetics combined with a dietetic internship at the University of Northern Colorado in August 2021, and passed the RD Exam in December 2021. She was one of 11 winners of the South Carolina Affiliate IDEA Mini-Grant 2020–2021 Program funded by the Academy. Sharon is active member of color in her local dietetic district as well as in NOBIDAN. In 2022, she became one of three RD Exam Coordinators for the NOBIDAN RD Exam Study Group.

Levin Genciano Dotimas, MS, RD, CD is a Patient Services Manager at Utah Valley Hospital in Provo, UT. He received a bachelor's degree from Brigham Young University and a master's degree at Oklahoma State University where he completed a dietetic internship. Levin was born and raised in Manila, Philippines. He is Chair-Elect of the Academy's Asian Americans and Pacific Islanders MIG and also the IDEA Liaison for the Academy's COGA MIG. He is a past member of the recent Advisory Group to the Academy's IDEA Committee, and a past member of numerous Academy Committees including the Academy's IDEA Committee.

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