ORIGINAL ARTICLE

Clinical ladders are positively associated with job satisfaction and career advancement for registered dietitians in clinical nutrition management

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ABSTRACT

Background: Following a change in reporting structure, Registered Dietitian Nutritionists (RDNs) in a Virginia hospital system provided patients with better care, cost savings, and almost doubled clinical nutrition staff from 2008 to 2013. **Objective:** The study was conducted to determine if the administrative alignment of RDNs in their place of employment 1) allows them to perform to their greatest scope of practice and 2) influences job perceptions.
Methods: A survey was developed and distributed nationally to Clinical Nutrition Managements (CNMs) and their coworkers.
Statistical analyses: Using SPSS 24, univariate descriptive statistics and bivariate analyses were conducted. Contingency tables were generated and Pearson Chi-square tests and as appropriate Fisher's exact tests were used to draw statistical inferences.
Results: Respondents (n = 508) represented four regions of the US with various job titles. Some reported to vice presidents of support services (34%) and others reported to vice presidents overseeing both clinical and support services (26%). Respondents, regardless of alignment, were either "satisfied" (47%) or "very satisfied" (36%) with their current positions. Most (74%) were in a nutrition department separate from food service. There was no difference in education ($p = .87$) or pay ($p = .62$) dependent on reporting structure. However, when RDNs reported to a clinical nutrition department, separate from food service, it was more likely that there was a clinical ladder for RDNs and there were more levels on the clinical ladder.
Conclusion: This survey suggests alignment of a clinical nutrition department is associated with a higher likelihood that RDNs will have a clinical ladder to promote career advancement.

Key Words: Clinical ladder, Job satisfaction, Administrative alignment, Clinical nutrition services, Support services

1. INTRODUCTION

In 2011, the Registered Dietitian Nutritionists (RDNs) at Valley Health separated from the nutrition services department to create their own clinical department, Nutrition Therapy. Valley Health is based in Winchester, Virginia, and is a not-for-profit health system serving a population of more than 500,000 in northwest Virginia, West Virginia's eastern panhandle, and Western Maryland. The name Nutrition Therapy was chosen to further align the RDNs with other clinical health care professionals, i.e., respiratory therapy, physical therapy, etc. Following this change in administrative reporting structure, RDNs documented improvements in patient care and sustained remarkable cost savings of approximately $700,000 annually which resulted in an increase in staffing for RDNs from 2008 to 2013.

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RDNs at Valley Health credit these successes to a change in their administrative alignment which provided RDNs with greater autonomy and responsibility for patient care. These experiences led to an interest in understanding how RDNs nationwide are administratively aligned within other facilities. A survey of the Clinical Nutrition Management (CNM) Dietetic Practice Group (DPG) of the Academy of Nutrition and Dietetics (AND) was conducted to solicit responses and characterize employment situations, reporting structures, and Academy member perceptions about their career opportunities within their current organizations.

As reported in the 2016 Needs Satisfaction Survey, the profession of RDNs is expanding and their role on the healthcare team shifts with continually evolving responsibilities.[1] As our profession's educational requirements increase, students are being asked to pay more for their education. With advanced degrees, our young professionals should expect to perform at a higher level, be capable of more responsibilities and have the opportunity to advance professionally.[2–6]

Communication to administration can facilitate RDNs alignment, within the organizational structure, to be the most effective in caring for patients. The expanding roles of RDNs in the DPG for CNMs have been studied by many. In 1995, Witte and Messersmith reported that the responsibilities of CNMs included 46 named job duties. Recently, Howells et al.[5] named 84 job activities for hospital CNMs, 40 identified as managerial. While CNM job duties have expanded and evolved, their primary job continues to be administering clinical nutrition services to hospitalized patients.

The role of the CNMS has been well characterized. CNMs possess valuable knowledge and skills to improve patient care, cut hospital costs, advance research, mentor young professionals, and add value to interdisciplinary teams.[3, 7, 8] With careful documentation, the Valley Health RDNs demonstrated their expertise and value. They provided patients with better care, documented tremendous cost savings and almost doubled the clinical nutrition staff from 2008 to 2013. RDNs efficiently provide Medical Nutrition Therapy (MNT) in the Valley Health System. The system's RDNs raised their scope of practice and elevated their role on the healthcare team, cut hospital costs, and as a result were able to increase RDN staffing by 172%. The cost savings to the hospital system were a result of careful RDN management and documentation of adult malnutrition and performance improvement activities over eight years. The financial savings to the hospital system with reduced malnutrition expenses provided the revenue to hire more RDNs, thus increasing their RDN staff full-time equivalents (FTEs) from 5.5 to 9.5 in their largest system hospital licensed for 455 acute care beds.

The study was conducted to determine if the administrative alignment of RDNs in their place of employment 1) allows them to perform to their greatest scope of practice and 2) influences job perceptions.

2. METHODS

The study was approved by the Valley Health Institution Review Board, Winchester Medical Center in collaboration with the Edward Via College of Osteopathic Medicine-Virginia Campus. The CNM DPG is a practice group of the Academy of Nutrition and Dietetics. The CNM DPG has a membership of approximately 1,960 members. The survey instrument was designed to obtain demographic and perception information relevant to the administrative alignment of RDNs in their workplaces. An on-line survey was designed using Survey Monkey® and distributed to CNM members who were then encouraged to forward the link to their colleagues and front line clinical RDN staff. Demographic information included geographic region of employment, educational attainment, years of employment as an RDN, and specialist certifications. Information about their place of employment included the number of licensed, acute-care hospital beds, the role of contracted food service companies, the number of RDNs employed, and the rates of turnover among facility RDNs. Respondents were asked about their current positions including how long they have worked in their current job, salaries, job responsibilities, job satisfaction and their alignment within the organization's management structure. Open-ended responses were sought regarding whether or not food service and clinical nutrition departments should be separate or combined.

Statistical analysis was conducted using SPSS 24. Descriptive statistics for demographic data and survey question responses were reported in frequency tables and bar charts. Bivariate analyses were used to explore the relationship between two questions. Contingency tables were displayed, and Pearson Chi-square tests and as needed Fisher's exact tests were used to draw statistical inferences. Significance level, α was set to be 0.05.

3. RESULTS

Respondents (n = 508) were asked to identify their current positions and select all that applied; 39% were CNMs, 8% were Clinical Nutrition Directors, 4% were Food Service Directors, 45% were staff clinical RDNs, and 11% specified other varied positions. The greatest representation of RDNs reported they worked in the South (31%) followed by those working in the Northeast (29%), Midwest (25%) and the West (15%). No responses were received from Alaska or Hawaii (see Figure 1).

Table 1. Demographic characteristics of registered dietitian nutritionists (RNDs) reported as the number and valid percent of responses (Clinical Nutrition Managers Survey)

Variable	Results		Variable	Results	
a. Region in United States	**n**	**%**	**h. RDN 5-yr turnover rate at facility**	**n**	**%**
South	157	31	0%	47	10
Northeast	146	29	1%-25%	241	49
Midwest	127	25	26%-50%	54	11
West	78	15	51%-75%	23	5
Total	508	100	76%-100%	20	4
b. Highest degree received	**n**	**%**	Unsure	110	22
Registered Dietary Technologist	1	0.2	Total	495	
Bachelor's degree	216	43	**i. Length of employment in current position**	**n**	**%**
Master's degree	272	54	<1 year	32	11
Doctoral degree	11	2	1-3 years	80	29
Other	9	2	4-5 years	33	12
Total	508	100	6-10 years	49	18
c. Years as RDN	**n**	**%**	>10 years	86	31
<1 year	33	7	Total	280	
1-3 years	52	10	**j. Average tenure of RDNs in your facility**	**n**	**%**
4-5 years	34	7	<1 year	2	1
6-10 years	63	12	1-3 years	35	16
>10 years	326	64	4-5 years	65	30
Total	508		6-10 years	92	42
d. Specialist certifications	**n**	**%**	>10 years	63	22
No	339	67	Unsure	23	11
Yes	169	33	Total	280	
Total	508		**k. Job satisfaction with current position**	**n**	**%**
e. Size of employment facility, number of beds	**n**	**%**	Very dissatisfied	5	2
0-50	22	4	Dissatisfied	18	6
51-100	46	9	Not satisfied or dissatisfied	23	8
101-250	150	30	Satisfied	132	47
251-400	128	25	Very satisfied	102	36
>400	162	32	Total	280	
Total	508		**l. Approximate annual compensation**	**n**	**%**
f. RDNs in department	**n**	**%**	$43,000 - $50,200	5	2
1 FTE	37	8	$50,200 - $61,000	28	10
2 FTE	50	10	$61,000 - $75,000	71	25
3 FTE	65	13	$75,000 - $92,700	113	40
4 FTE	44	9	$92,700	49	18
5 FTE	44	9	No reply	12	4
6-10 FTE	100	20	Unsure	2	1
>10 FTE	145	29	Total	280	
Unsure	10	2			
Total	495				
g. RDN 1-yr turnover rate at facility	**n**	**%**			
0%	133	27			
1%-25%	235	48			
26%-50%	36	7			
51%-75%	9	2			
76%-100%	5	1			
Unsure	77	16			
Total	495				

Additional responses providing descriptive information from survey participants are reported in Table 1. Table 1 provides the number and percent of valid responses to additional questions obtained from the surveys returned All respondents replied to questions inquiring demographic data, i.e., location, educational attainment, specialist certifications, length of time on the job, etc. When asked "What is the highest degree you have received?" the greatest number of responders replied a master's degree (54%) followed by those with a bachelor's degree (43%), a doctoral degree (2%) or other

degree or were nutrition and dietetic technicians registered (NDTR) (2%). Two-thirds (67%) of those surveyed replied "no" to having at least one specialist certification, such as Certified Nutrition Support Clinician (CNSC), Certified Diabetes Educator (CDE), Board Certified Specialist in Oncology Nutrition (CSO), etc. Almost two-thirds (64%) of those surveyed had been working for more than 10 years with the remainder of RDNs working for less than ten years. The majority of RDNs (87%) were working in a facility with more than 100 licensed, acute-care hospital beds.

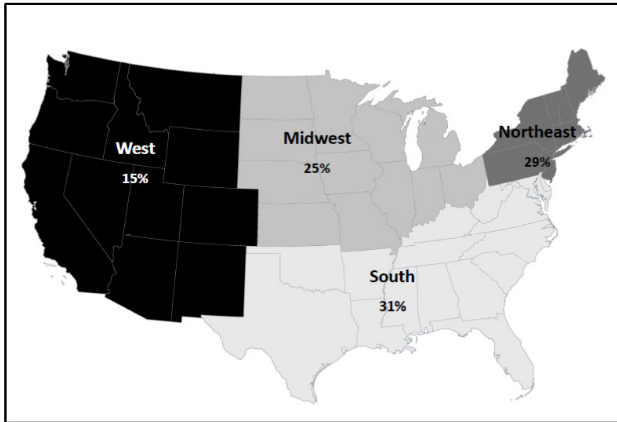

Figure 1. Regional representation of registered dietitian nutritionists (RDN) responding to the on-line survey distributed to Clinical Nutrition Managers (CNM)

Almost half of the RDNs (49%) who responded worked in a facility that employed more than 6 RDN full time equivalents (FTEs). Almost half of all respondents reported turnover rates, yearly (48%) and 5-year (49%), to be 25% or less. The response rate to FTEs and turnover rates was 97% (see Table 1).

A number of questions solicited responses from directors and managers only, thus the response rates of 55%, reflected results without the participation of RDN staff. RDNs were asked how long they had been in their current positions and the greatest number (31%) indicated having been in their job longer than 10 years. Most survey respondents (42%) reported the average tenure of all RDNs in their facility was 6 to 10 years. Those indicating how satisfied they were with their current position reported being either "satisfied" (47%) or "very satisfied" (36%) with their jobs as RDNs. When respondents were asked "What is your approximate pay?" over half (58%) indicated earning annual salaries over $75,000 (see Table 1).

Table 2 provides information regarding the administrative alignment of RDNs in hospitals. There were fewer (26%) RDNs in nutrition departments separate from the food service or combined departments (74%). Survey respondents were asked if the vice president in their department chain of command was responsible for the oversight of clinical services or support services or both. Of those responding most (34%) reported their vice president was responsible for support services and 26% reported their vice president was responsible for both clinical and support services and 15% reported their supervisor reported to clinical services. With a total response rate of 88%, one quarter of respondents were unsure of their vice president's responsibilities related to clinical nutrition or food service.

Table 2. Characteristics of the administrative alignment of registered dietitian nutritionists (RDNS) in their facilities (Clinical Nutrition Managers Survey)

Variables	n	%
a. Is the clinical nutrition department separate from food service department?		
Yes	123	26
No	358	74
Total	481	
b. Vice President Role		
Clinical services	65	15
Support services	151	34
Clinical and support services	117	26
Unsure	113	25
Total	446	
c. Director of Food Service		
Is a Registered Dietitian	309	64
Is not a Registered Dietitian	172	36
d. Clinical ladder for Registered Dietitians		
n	%	
Yes	203	42
No	278	58
Total	481	
e. Levels on clinical ladder		
1 level	9	2
2 levels	45	10
3 levels	100	23
4 levels	31	7
5 levels or greater	12	3
N/A No clinical ladder (included)	248	56
Total	447	
f. Satisfaction if in separate department from food service?		
Very dissatisfied	1	1
Dissatisfied	1	1
Not satisfied or dissatisfied	11	9
Satisfied	34	28
Very satisfied	74	61
Total	121	
g. Satisfaction if clinical nutrition and food service departments are together		
Very dissatisfied	22	6
Dissatisfied	62	18
Not satisfied or dissatisfied	82	23
Satisfied	123	35
Very satisfied	66	19
Total	355	

Of responders in a department separate from food service,

81% percent replied clinical nutrition was a stand-alone department. Others reported to departments of nursing, pharmacy, surgery, or ancillary services, i.e., speech or physical therapy.

Survey respondents were asked to select job responsibilities performed by RDNs at their facility. When asked to select all that applied from a list of 14 responsibilities, including tasks such as performing indirect calorimetry and documenting malnutrition, there were no differences in the number of responsibilities identified by RDNs when their administrator was overseeing clinical services, support services or both (data not shown).

Of those returning surveys (95%) responded when asked if a clinical ladder, a path for career advancement, for RDNs was currently available, i.e., a path for progression from entry level positions to positions of more responsibilities, knowledge, skills and authority. More than half (58%) of RDNs indicated that they did not have a clinical ladder in their current position and two thirds (67%) were in departments that were not separated by clinical and food service responsibilities. If the departments were separate, the greatest number (46%) had three levels, with 12% reporting two levels and 11% reporting four levels in a clinical ladder. If the departments were not separate, 15% of RDNs had three levels on their clinical ladder, 10% had two levels and 6% had four levels (see Table 2).

There were no statistically significant differences in educational attainment if the clinical nutrition and food service departments were together or separate. Pearson Chi-square test (test statistic = 0.88, df = 3, p = .83) and Fisher's Exact test (test statistic = 0.88, p = .87) were conducted.

Likewise, being in a separate nutrition department from food service is not associated with differences in pay. Forty percent of those responding reported their approximate annual salary to range from $75,000 to $92,700. Others (25%) reported incomes of $61,000 to $75,000 and another 15% reported an annual salary above $92,700. Results from Pearson Chi-square test (test statistic = 3.10, df = 5, p = .68) and Fisher's Exact test (test statistic = 3.42, p = .62) showed that there were no statistically significant differences in approximate annual compensation if the clinical nutrition and food service departments were together or separate.

The availability of a clinical ladder was reported by less than half of those responding, 42% (203 of 481). While fewer RDNs were in separate nutrition departments they were more likely to have a clinical ladder. Those in a clinical nutrition department separate from food service represented 73% (90 of 123) of those in an employment situation with a structured path to advance, i.e., a clinical ladder.

There were statistically significant differences in the availability of a clinical ladder between RDNs employed in clinical nutrition departments separate from food service departments. Pearson Chi-square test statistic was 64.97 with df = 1 and $p < .0001$ (see Figure 2).

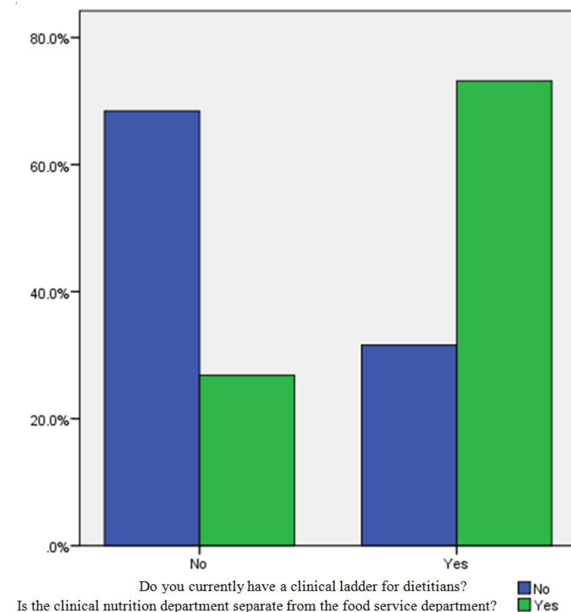

Figure 2. Percent of respondents indicating the availability of a clinical ladder if employed in clinical nutrition departments separate from food service departments.
Pearson Chi-square test has a test statistic = 64.97, df = 1 and p < .0001

Bivariate analysis identified significant differences among responders when asked how many clinical ladders were available if in a clinical nutrition department separate from the food service department. There were more levels on the clinical ladder for RDNs when clinical nutrition departments were separated from food service departments (see Figure 3). Analysis using Pearson Chi-Square provided a test statistic of 71.07 with df = 5 and $p < .0001$. Fisher's exact test resulted in the same conclusion (test statistic = 71.15 and $p < .0001$).

There were no statistically significant differences when respondents rated satisfaction with their current job while in a clinical nutrition department that was separate or combined with food service. However, when rating satisfaction with being administratively aligned in a separate department from food service about 9 out of 10 responded being either "satisfied" (28%) or "very satisfied" (61%). Of those who rated their satisfaction with being in a combined department with food service, about hall were either "satisfied" (34%) or were 'very satisfied' (18%) (see Table 2g). Bivariate analysis con-

firmed a statistically significant difference in respondents' satisfaction with a preference for their reporting structure to be aligned with separate clinical and food service departments via Pearson Chi-square test (test statistic = 90.09, df = 4, $p < .001$) (see Figure 4).

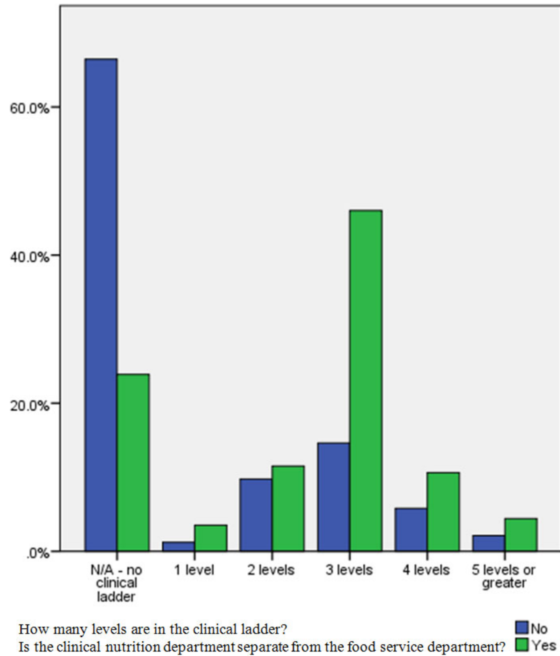

Figure 3. Percent of respondents identifying the levels on a clinical ladder in their facility if the clinical nutrition department was separate from the food service department.
Pearson Chi-Square test statistic 71.07, df = 5 and p < .0001

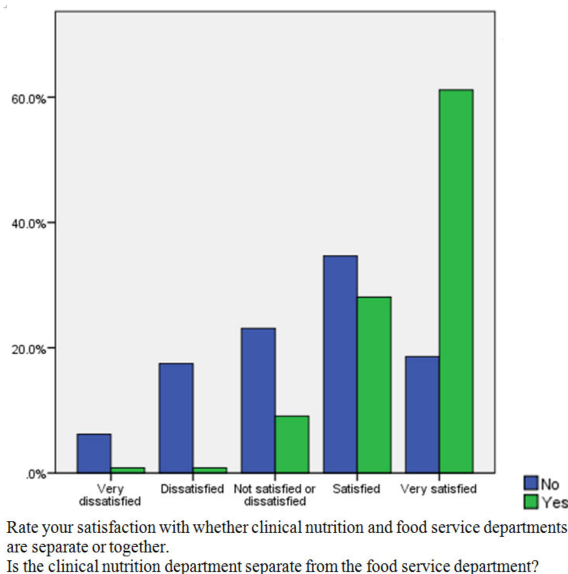

Figure 4. Percent of respondents rating their satisfaction with administrative alignment if in a clinical nutrition department separate from the food service department.
Pearson Chi-square test statistic = 90.09, df = 4, p < .001

Bivariate analysis was used to examine differences between RDNs reporting to departments of clinical nutrition and food servcie that are separate or combined and dependent on the food service director being a RDN. Only 35% of respondents had a RDN food service director. When the food service director was not a RDN, 70% of respondents said that clinical nutrition and food service departments should be separated. Pearson Chi-square test statistic = 5.40, df = 1 and $p = .01$, 1-sided) (see Figure 5).

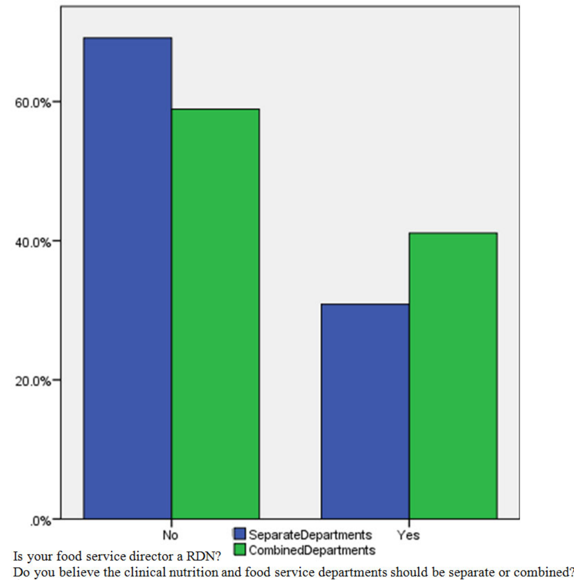

Figure 5. Percent of respondents that believe clinical nutrition and food service departments should be separate or combined if their food service director is a RDN?
Pearson Chi-square test statistic = 5.40, df = 1, p = .01 (1-sided)

4. DISCUSSION

This study is the first to highlight that a clinical ladder was more likely to be available to RDNs aligned with clinical services rather than support or food services departments. Also, there were more steps on the clinical ladder if the clinical nutrition department was separate from the food service. RDN satisfaction with their administrative reporting structure was also associated with the separate departments. Likewise, RDN respondents expressed interest in separating departments when the director was a RDN. An organizational structure that rewards career advancement will allow more RDNs to perform at the top of their skill level. As the profession grows and responsibilities expand more advanced nutrition services can ensure better patient care and efficient and safe cost-cutting measures as demonstrated at Valley Health in Virginia.

Our findings in the current study were representative of the CNM DPG nationally. The characteristics of the sample

of respondents reflected profiles similar to those presented in previous surveys of the CNM DPG and of the Academy at large. The current survey distributed to CNMs and colleagues represented participants from four major regions of the country. Most respondents (85%) reported working in a facility with more than 100 licensed, acute-care hospital beds. A 2015 survey sent to CNM DPG members reflected a similar primary practice area with 82% responding that they worked in acute care.[4] The AND annual benefits survey indicated that acute-inpatient and facilities for long term care comprised the largest places of employment for RDNs.[1] The benefits survey indicated most (35%) of RDNs were 55 years of age or older.[2] Howells survey of CNMs also reported that 31% of respondents had been working for more than 10 years, the same as the 31% reporting a long tenure status in the current survey.[4,5]

The level of educational attainment by respondents in the current study reflects levels reported for the RDN profession nationally, more than half had obtained a master's degree and very few had an advanced doctoral degree. The most recent AND survey reported 48% of all RDNs had a master's degree and 4% a doctoral degree. In the current survey almost two-thirds of those responding did not have a specialist certification. Also, in the current study regardless of the administrative alignment, CNM and staff RDNs were performing similar important roles. Thus, on the basis of location, job tenure, education, compensation and job duties the respondents overall profile reflected that of the most recent profiles reported by AND.[1]

In our study one quarter of RDN survey respondents reported through a clinical chain of command while three fourths reported to an administrator that oversees support services or oversees both clinical and support services. The RDNs reporting clinically had a greater likelihood of a clinical ladder. When a clinical ladder was available, there was a greater likelihood of having more opportunities for advancement when RDNs reported to a clinical administrator compared to those reporting to food service. Notably, respondents were more satisfied with their job alignment in a clinical realm and when in facilities with a pathway for advancement. The Academy reported in 2014 on standards of excellence for organizations to support dietitians in their workplaces and practice settings. An organizational self-assessment tool was developed to assess how an organization identified and distinguished the RDN as professionals. The tool addressed the "importance of increased autonomy, supportive management, respect within peers and community, opportunities for professional development, support for further education and compensation for the RDN". Organizations that demonstrated leadership quality included those valuing RDN's education, skills and knowledge, promoting RDNs to positions of importance, and evidence of career ladders to promote and manage advancement of the RDN within the organization.[9]

The quantitative responses in the current study provide insight into RDNs' workplace environments. Our study, in addition to providing quantitative responses also solicited write in comments. RDNs were given the opportunity to provide additional thoughts on whether or not clinical nutrition and food service departments should be either separate or combined, some provided the following comments:

Those in support of separate food service and clinical nutrition departments stated:

- "Our offices are right next to one another and we communicate daily. While it is important to know what one another are doing, I do feel RDNs should be more with the clinical division to be linked with the patient care team verses nutrition services."
- "While there certainly needs to be a partnership between RDNs and food service, dietitians would be perceived as more of a clinical entity if the departments were separate."
- "RDNs are clinicians and should be more closely aligned with other clinicians."
- "I have worked in both types of settings and feel there is no need for them to be together. They can work synergistically while remaining separate."
- "I think we should be separate because the RDNs would then be classified as a 'clinical' service vs a 'support' service. Currently, all the clinical departments report to our CNO except for the RDNs because we are part of Food Service and report to VP of Ancillary and Support Services."
- "Our food service manager is the immediate supervisor of the clinical RD's. There is a disconnect and the RDNs do not feel well supported."
- "Although we will always need a partnership and association to the food department, the daily focus is quite different."
- "RDNs are commonly referred to as 'dietary' and not as members of the clinical team. Patients/other staff members sometimes assume we are there to take meal orders vs. providing MNT. Although being combined with foodservice has some benefits, overall, I feel limited in how far I can move in my job and salary. I often feel underappreciated by other members of the clinical team."

Those in support of combined food service and clinical nutrition departments stated:

- "When services are combined, it provides continuity of services and care."
- "I think these departments should be combined as they are very related and I strongly feel they should be integrated. This can impact the food quality, nutritionals and affect patient satisfaction scores. I also believe it helps to make dietitians well rounded when they are better versed with the food service aspects of our field."
- "You can't improve the nutritional care of the patient without good food! RDNs need to have the ability to impact the food service side to do their job."

While these comments reflect varying points of view regarding RDN alignment it should be noted that in our current study CNMs, regardless of alignment, performed the same number and types of job duties. Also, RDNs have management training. RDNs are often promoted to director's positions over their health care peers due to their management training in food service management. The educational curriculum for dietitians includes courses, i.e., accounting, economics and business and personnel management not required in other clinical health care programs. This knowledge gives RDNs an advantage and more opportunities for career advancement. Food service managers are among the highest paid RDNs.[1]

Career advancements generally come with increased responsibilities for personnel management, budget management, etc. Career advancement is often associated with more leadership potential. RDNs in administrative positions are also recognized as leaders within the profession and among other professionals, coworkers on health care teams and in administrative circles. The dietetics profession has addressed the roles and responsibilities of advanced practice RDNs through the years. Some of the early reports reflecting on these professional challenges and changes appeared in the 1980s.[10–12] As the conversations evolved Mandel and Garey (1993) examined behaviors relevant to the organizational environment and recommended empowering RDNs with information, education and accomplishments. They suggested strategies to overcome limits to achieving professional accomplishments; "negotiation, compromise, and coalitions", concepts that should continue to be stressed and incorporated in today's dietetics education.

This survey was prompted by the alignment change that took place at Valley Health placing clinical nutritionists in an autonomous department. Valley Health dietitians were able to achieve professional accomplishments through realignment within their hospital system. Through clinical nutrition services malnutrition costs were greatly reduced, primarily by reducing unnecessary enteral and parenteral feedings. Valley Health dietitians were also strategic in documenting services provided, patient outcomes and costs savings. These steps were key to demonstrating the impact that clinical nutrition services can make to improve efficiency, safety and patient outcomes.

Unfortunately, the problem of malnutrition in hospitalized adult patients persists today in the United States.[7, 13–16] Adult hospital malnutrition, often overlooked, has been estimated to occur in 20% to 50% of admitted patients.[17] Left untreated, malnutrition leads to increased morbidity, mortality and health care costs, over $15.5 billion nationally.[18, 19] Hospital malnutrition continues to be a burden and recent reports have stressed the importance of understanding the nutrition care process and plan execution that is dependent on an interdisciplinary team.[20]

The improvements demonstrated in this one hospital system illustrated how management of malnutrition could positively affect patients, hospital operations and elevate the role of the dietitian. If applied on a national scale the cost savings of keeping patients on oral feedings would highlight the profession and confirm the importance of both clinical nutrition services and food services in patient care.

Looking forward, as our profession increases educational requirements for new RDNs, and our young professionals invest more in their education it is important that they see a future in which they can aspire to professional positions that allow them to perform to their fullest and promote quality health care. An organizational clinical ladder should reassure young professionals of career advancement opportunities and appropriate compensation that reflects the level of responsibilities and rewards effective performance.

4.1 Limitations and solutions (Leadership, Education)

There were limitations to the current study. The survey was distributed to the CNM DPG and CNMs were encouraged to forward the survey to their staff RDNs. The survey was also distributed to members of the Virginia Academy of Nutrition and Dietetics via email and posted on several conversation boards on LinkedIn. It is recommended that a future study be distributed to the Academy membership with the ability to determine response rates from clinical nutrition and food service managers, clinical nutritionists and survey organizational leaders.

4.2 Summary

To summarize, the key finding of this study highlights the importance of a career ladder to provide opportunities for RDNs to advance in their careers and perform at their highest capacity. The availability of a clinical ladder and alignment

within a clinical nutrition department has afforded RDNs with the ability to "see and be seen" as leaders and strongly affect change in patient care, hospital costs and elevate their greatest scope of clinical practice. Career ladders and organizational alignment were highlighted as important to job satisfaction and job performance. Additionally, it is important to acknowledge the comments supporting integration of clinical and food services, continuity of care and cooperation among all RDNs within an organization. Regardless of alignment RDNs will benefit from a united front and retain a stronger professional position within an organization.

5. Conclusion

This study identified a tangible "way forward" for the profession. The importance of a clinical ladder and the growing trend of RDNs aligned to a clinical reporting administrator can help CNMs as well as all RDNs keep pace with changing trends in healthcare systems with the overall goal of elevating the role of the RDN when providing better quality care at lower costs with improved safety for patients.

Conflicts of Interest Disclosure

The authors declare no conflicts of interest.

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