
# Q&A

## "Developing a Culture of Nutrition at a Community Cancer Center" Webinar

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**Q:** Define "proactive" -- i.e. , which diagnoses do you target?

**A:** Proactive means appropriately triaging and providing intervention at the earliest indication or sign of interference to adequate nutrition for all diagnoses. Early nutrition intervention is most effective, least time consuming, and most likely to protect patient quality of life. If there is inadequate nutrition time to provide these services, you may need to limit your interventions for the high-risk diagnoses. An example: Breast cancer patient in chemotherapy with a 1 kg weight loss over the week. C/o nausea. When RN/Pharmacist processes the patient report that she lost weight because she didn't take her nausea medication, they instruct "take your nausea medication." When the RD interacts and reviews all the digestive tract symptoms, the patient reports, "I don't take the nausea medication because it constipates me," it leads to an "easy fix" of bowel regimen instruction. True story. Time for intervention: 15 minutes.

**Q:** A number of patients will state their concern about eating sugar. They have a fear that consumed sugar will "drive their cancer to grow." Please set the record straight. What is the best advice to give a patient who has this concern?

**A:** Click Here to View the ACS website for common questions. Cancer cells eat more glucose than healthy cells because they are growing faster. The most effective methods to slow or kill cancer cells are surgery, chemotherapy and radiation cancer treatment. Nutrition modifications do not treat cancer. Adequate calories and adequate protein support the healthy body to heal and repair from effective cancer treatments. Patients in active treatment who experience side effects of cancer or treatment may be challenged to take in adequate calories and protein. Avoid limiting enjoyable foods that offer calories and protein.

**Q:** Do you have a reference for the decrease in efficacy of radiation treatment for a one-day delay?

**A:** The resource is:
Russo G, Haddad R, Posner M, Machtay M. Radiation treatment breaks and ulcerative mucositis in head and neck cancer. *Oncologist.* 2008; 13:886-898. doi: 10.1634/theoncologist. 2008-0024

The risk is reported that each day radiation is held, it increases risk of recurrence in head and neck tx by 1%.

# Establishing and Improving Cancer Nutrition Programs in the Community Cancer Setting

An Education Program from ACCC's Center for Provider Education

**Q:** How much does depression due to diagnosis play into loss of appetite and therefore, weight loss and side effects from weight loss?

**A:** I don't have specific data, however, my experiences would indicate that depression and stressors play a huge role in decreased appetite and ability to take action in self care. It is helpful to encourage patients to utilize social services, chaplains, as well as integrative medicine practices to help alleviate some of the impact. Physicians may be able to offer medications to assist, as some medications address depression and also increase appetite (i.e. , Remeron).

**Q:** Do you have any data on incidence of negative protein balance in pediatric oncology?

**A:** I am not a pediatric oncology dietitian, but was able to find the following references for needs:
Seattle Cancer Care Alliance for BMT Peds use:
Birth-6 years: 2.5-3 g/kg/day
7-10 years: 2.4 g/kg/day
11-14 years: 2 g/kg/day
15-18 years: 1.8 g/kg/day

Seattle Children's Hospital for Peds oncology use:
Infants birth to 6 months: 3 g/kg/day
6-12 months: 2.5-3 g/kg/day
Children: 2-2.5 g/kg/day
Adolescents: 1.5-1.8 g/kg/day

For PN from a PNPG article for Peds oncology use:
Infants: 2.2 g/kg, no more than 3.5 g/kg
Children greater than one year: 2-3 g/kg
"Based on DRI for age, with an additional factor given for the inflammatory state"

**Q:** How do you handle patient billing? Are they billed directly for nutrition services or is it incorporated into other costs? I find that insurance not covering many of the nutrition services is prohibitive for the MD, NP, and RN referrals and for patients wanting to set up appointments.

**A:** At my cancer centers oncology nutrition is offered to all patients at no additional cost. There are some parts of the clinic that they charge for our education time when seeing patients with the NP. Previously our clinic had the same issue where the cost was prohibitive to many patients. Heidi Ganzer published an article as well as Nagi Kumar regarding working with their local insurance providers to increase reimbursement for patient care.

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**Q:** How often do you recommend ongoing screening when patients just on EBRT?

**A:** I recommend all patients have some form of malnutrition screening throughout their treatment. So with EBRT in prostate patients, they are likely seeing the Rad Onc at least weekly, which would mean this patient would be screened weekly. If you use the MST it is two data points: weight loss combined with decrease in appetite resulting in a trigger to nutrition. These patients do well, and would rarely screen for nutrition intervention in XRT.

**Q:** Are community hospital nutritionists also working with patients who gain weight (i.e. , breast cancer patients on hormonal therapy) to discuss diet and exercise programs? Many of our patients are requesting these services. Also, who discusses food supplements and interactions with chemotherapy?

**A:** Many oncology nutrition / registered dietitians are seeing breast cancer patients (and other diagnoses) for survivorship nutrition issues (like weight control). A barrier to meeting the needs of breast patients are the sheer numbers of survivors. I have addressed this at my clinics by providing survivorship classes or materials and resources prepared for these patients (as it is impossible for me to see them all individually). I also offer an "annual nutrition update" evening presentation for breast, prostate and general cancer survivors. The Registered Dietitian and RN discuss the use of food supplements, as well as other vitamin/mineral/antioxidant supplements with patients prior to start of chemo or XRT in a class setting. I also provide the NCI "Eating Hints" booklet for each patient to address these concerns.

**Q:** What screening tool are you are using?

**A:** We have chosen the Malnutrition Screening Tool (MST) which is only 2 data points: weight loss and decrease in appetite. It is valid but not specific and leads to many "false positives." We follow each with at least a nutrition chart review, and will contact the patient or schedule them to be seen if there is a trend, if the change is significant, or if we anticipate further decline due to treatment regimen or diagnosis, etc.

**Q:** To implement a nutrition screening process, where in the patient encounters with staff is the best place to complete the PG-SGA? Reception, medical assistant, nursing, physician?

**A:** The PG SGA is intended to be implemented in the waiting room where the patient answers the first self assessment questions, then usually the medical assistant fills in some (weight, etc. ), and finally nursing or the physician completes the rest (evaluation for edema or wasting , etc. ) The Malnutrition Screening Tool (MST) is completed at the medical assistant step as when the patient is being weighed, they ask "have you had a decrease in your appetite." It seems a natural discussion to the patient, yet fulfills the 7th Vital Sign as the malnutrition screening step.

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**Q:** Is there data available on how many cancer centers do not directly charge the patient for MNT services? We charge by appointment and it is by far our greatest limitation in accessing patients because Medicare, Medicaid, and many other providers does cover nutrition counseling.

**A:** I do not have any direct data on how many cancer centers charge/don't charge. However, my perception is that most do not charge due to the concern about limiting access to patients in need of services. Nutrition service may be more appropriately compared to provision of social workers. Many centers have charged in the past and stopped due to the costs of billing vs. actual revenue received. Another way to view nutrition services are the revenue generating aspects of cancer center marketing. Nutrition has been found to be one of the most desired and sought after service by cancer patients. Availability of an oncology registered dietitian has been demonstrated to influence patient satisfaction with overall treatment, and can be a driver when choosing a center for treatment. Lastly, cost savings are found when RN, MD, NP time is not utilized to address nutrition issues.

**Q:** Do you bill for each patient that you see? How good is the reimbursement?

**A:** At my cancer centers oncology nutrition is offered to all patients at no additional cost. There are some parts of the clinic that they charge for our education time when seeing patients with the NP. Previously our clinic had the same issue where the cost was prohibitive to many patients. Heidi Ganzer published an article as well as Nagi Kumar regarding working with their local insurance providers to increase reimbursement for patient care.

**Q:** Do most facilities charge for nutrition services in radiation centers?

**A:** I do not have any direct data on how many cancer centers charge/don't charge. However, my perception is that most do not charge due to limiting access to patients in need of services. Many centers have charged in the past and gave up due to the costs of billing vs. actual revenue received.

**Q:** I find the chemo clinic, which is a private practice is not interested in the cost savings of MNT services (because it does not actually save them any money) or quality of life.

**A:** This is an opportunity to use your nutrition expertise to lead the clinic to develop a "culture of nutrition." Using your knowledge of what motivates these folks (new programs, advertising to potential patients, driving business to choose their clinic, patient satisfaction, perhaps good outcomes, etc.) you can gradually shift their interest to include good nutritional practices. Most clinicians are interested in patient well-being and quality of life. I suspect that the old paradigm of “no one is asking about challenges with nutrition” exists in the clinic.

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**Q:** I work in a small rural hospital with a clinic and small cancer outpatient center attached. Our RDs would like to begin to be involved in this unit as we are not at all currently - any ideas on where to start?

**A:** The best way to "get your foot in the door" is to start a discussion with your hospital leadership (supervisor and up). Target radiation therapy head and neck patients as highest risk and in need of initial and ongoing nutrition intervention. Many of these patients may have a feeding tube. Then look at adding the other high-risk diagnoses such as pancreas, lung, etc. If you can, offer a day per week or every other week to be available to as many of the radiation patients as possible. I try to be in the rural clinic the same day as the radiation oncologist to coordinate the best care for these patients. The next step would be focusing on implementing some kind of screening tool to capture the malnutrition that occurs across all diagnoses and all treatment types.