Setting Standards, Saving Lives

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Over the 30 years of my practice career, the treatment of oncologic patients has progressed from the inpatient to the outpatient setting. Delivery of the increasing number of therapies and supportive medications requires attention to detail and a broad knowledge base, and the nurses and pharmacists that support this endeavor are ever more skilled. Yet, until recently, no one had critically evaluated the process of delivering these therapies and codified standards that would ensure a safe experience for the patients in our offices. In 2009, ASCO and the Oncology Nursing Society (ONS), collaborated and published such a set of standards.¹

In this issue, Gilmore et al outline revisions to the ASCO/ONS chemotherapy standards. The revisions extend the scope of the standards to any setting in which anticancer therapeutics are given, whether inpatient or outpatient. This is important, given the fact that in many practices significant numbers of patients are being transitioned back to institutional settings for therapy. Pharmacoeconomics, poor Medicare/Medicaid reimbursement, a growing population of uninsured, and practice alignment with hospital systems are some of the reasons for this shift.

Yet the transition is not without risks for patients. Institutions are designed to treat the breadth of human illness. Specific understanding and structural support for delivery of onco-therapeutics are often not present. Oncology drugs are mixed in the general oncology pharmacy, often by pharmacists with limited oncology training. Electronic health records (EHRs) in institutions are often not designed to accommodate the specific needs for ordering oncology medications, nor do they do a good job of tracking patients' course through therapy. Institutions often create a record around one clinical visit. This is a "billable event" with its own documentation, separated from the next clinical encounter. These systems make it difficult to see or track an oncologic course of therapy over time. Oncologists often complain that they do not have standing within the institution to gain administrative support to change the EHR and pharmacy systems, as institutions are reluctant to deviate from universal systems that are designed to serve general needs throughout the institution.

Transitions between the inpatient and outpatient systems are also risky for patients. The revised standards emphasize the need for seamless documentation and communication between the settings of care. Jacobson and Mulvey have penned a companion perspective to the Gilmore paper that will appear in an upcoming issue of *Journal of Clinical Oncology*.² Using a patient vignette that will be familiar to practicing oncologists, they dramatically illustrate the growing gaps in care of patients who are receive therapy in more than one setting. The vignette underlines the applicability of the new standards.

It is hoped that these standards will provide oncologists with an authoritative resource to advocate for appropriate personnel

and systems changes to support safe delivery of therapy. The standards are challenging. In this issue of *JOP*, Weingart et al evaluate the implementation of the 2009 standards among chemotherapy practices at National Cancer Institute–designated cancer centers. As these authors reveal, only four of the 44 responding centers had implemented all 31 of the standards.

We all chafe at being told what to do. Physicians feel the increasing burden of rules and regulations with each patient encounter. As we make rounds, there are more signs on each patient room door spelling out the requirements of gowning, masks, or strict hand washing before we ever reach the patient. Charting and documentation standards grow ever more complex, and even participation with the medical staff brings requirements for meetings and various trainings. Yet there is growing appreciation that as the complexity of our interactions increase, standardization of care improves outcomes and increases safety. Taking a cue from industry, where dramatically reduced error rates in flying airplanes and building cars have been accomplished by standardizing processes and strict use of checklists, incorporating more standards in medical care will reduce error and save lives. All oncologists should be aware of these standards and should push our offices and institutions to implement them.

A note to authors and readers: over the past few months, *JOP* has shifted to a fully implemented publish ahead of print system. This means that as accepted manuscripts complete their transition to a *JOP*-produced format, they are formally published online. The date of online publication is the date of record, and the article is citable and searchable at that point. This allows authors to see and cite their work without waiting for the print issue. *JOP* print issues will continue to be produced six times a year, yet readers will find ongoing new and refreshed content at our Web site regularly. As always, we encourage feedback at editorsdesk@jop.asco.org. The editors and staff wish you good reading.

Accepted for publication on November 21, 2011.

DOI: 10.1200/JOP.2011.000508

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