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Commentary

Improving Goal Concordant Care Among 10 Leading Academic U.S. Cancer Hospitals: A Collaboration of the Alliance of Dedicated Cancer Centers

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Patients with cancer in the U.S. benefit from a health care system that fosters innovation and discovery. The 10 free-standing, academic cancer hospitals (Table 1) led by the authors play a crucial role in advancing the science to assure excellence in treatment modalities; for example, our centers participated in 75% of the phase I studies for U.S. Food and Drug Administration–approved cancer drugs between 2009 and 2015. Our perspective on cancer care spans the continuum, from bench science to supportive end-of-life care; this broad view allows us to identify opportunities for innovation. A critical area for investment across our centers—and throughout the U.S. health care system overall [1]—is designing care environments in which patient values and goals are reliably elicited and honored.

In reality, the goals and priorities of the health care system are not always aligned with those of the patients we serve [2, 3]. Even when caring for patients with a serious illness, physicians do not consistently speak with their patients about their prognosis, preferences, or goals of care [4–7].

Goals of care have been defined as the overarching aims of medical care for a patient that are informed by patients' underlying values and priorities, established within the existing clinical context, and used to guide decisions about medical interventions [8]. Understanding a patient's goals of care during significant time points of cancer treatment is essential in tailoring a goal concordant recommendation. When faced with advanced cancer and a life-limiting prognosis, patients may prioritize aggressive care, living independently at home, attending a major life event (e.g., a child's wedding), or transition to hospice care. Preferences may shift over time along with changes in factors such as disease status, prognosis, function, and home and support environments; thus, ongoing conversations are required to continue to provide goal concordant care [7, 9].

Research shows that goals of care discussions with patients with advanced cancers begin too late (about 1 month before death) and usually occur in inpatient settings with providers who are not their primary oncologists [5]. Not surprisingly, studies indicate a gap between the goals of patients with cancer and of their families and the care patients actually receive [10, 11]. When we fail to provide care in accordance with our patients' unique priorities, we are committing a medical error [1].

On the other hand, when goals of care discussions do happen, they are associated with better patient and family outcomes and less intensive care toward the end of life [12–15]. Diverse national organizations that define quality have recognized goal concordant care as one of the most important outcomes for our patients with serious illness [7, 16–18].

Why, then, don't these discussions to elicit patient goals of care occur more often and earlier? First, oncologists lack the training necessary to assure effective and efficient goals of care discussions [19]. Although palliative care specialists may be uniquely qualified to conduct goals of care discussions, there are not enough of these specialists to meet the demand

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Table 1. Member cancer hospitals of the Alliance of Dedicated Cancer Centers

Member	Location
City of Hope Cancer Center	Duarte, CA
Dana-Farber Cancer Institute	Boston, MA
Fox Chase Cancer Center	Philadelphia, PA
The James Comprehensive Cancer Center	Columbus, OH
Moffitt Cancer Center	Tampa, FL
The University of Texas MD Anderson Cancer Center	Houston, TX
Memorial Sloan Kettering Cancer Center	New York, NY
Roswell Park Cancer Institute	Buffalo, NY
Seattle Cancer Care Alliance	Seattle, WA
USC Norris Comprehensive Cancer Center	Los Angeles, CA

for their services [18]. Furthermore, the established patient-provider relationship (a foundation of trust for these discussions) is typically with the oncologist. Finally, the cancer care system is fraught with barriers to reliable goals of care discussions, including competing demands and priorities for oncologists, challenges in documenting these discussions in electronic health records in a way that can be easily retrieved when needed, and few systematic methods to identify patients in the ambulatory setting who would most benefit from these discussions.

These barriers persist in our cancer centers, and it is our responsibility to find effective ways to address them. Enhancing goal concordant cancer care is one of the most critical improvements we can make, and our hospitals have already started the hard work of implementing the practice and cultural changes required. One option would be to proceed cautiously and independently. A more compelling option—and the one our centers have chosen—is to use a collaborative learning approach to accelerate the learning possible at any individual center.

The collaborative project is the Improving Goal Concordant Care (IGCC) Initiative, convened by the Alliance of Dedicated Cancer Centers. Collectively, our cancer hospitals have embraced the vision that *all patients with cancer and their families should receive care that aligns with their values and unique priorities*. To realize this vision, we believe that primary oncology teams must take responsibility for timely initiation and ongoing conversations regarding goals of care with their patients. However, we recognize that oncologists need enhanced training and an enabling practice infrastructure to achieve reliable, effective, and efficient goals of care conversations.

The IGCC is a 3-year (September 2020 to September 2023) initiative designed to address system gaps across our centers and to establish new expectations for when and how goals of care conversations occur. The IGCC's conceptual development was led by palliative care and oncology experts across our 10 cancer centers, with guidance from patient and family advisors. The clinical experts were

Table 2. The core components of the ADCC's IGCC Initiative

Component	Description
Implement a formal communications skills training program	Training is made available to all oncologists and APPs at each center, with a goal that the majority have completed training by September 2023. The training program is interactive, with skills observation and feedback; is conducted by proficient, certified trainers; includes, at a minimum, assessment of patient prognostic awareness, sharing of prognostic information with patients, elicitation of goals and values, response to emotions, and goal concordant recommendations; and is sustainable, including new provider and refresher training.
Create structured GOC documentation in electronic health records	Oncologists and APPs document goals of care discussions in electronic health records. As GOC discussions often occur over time, documentation may be iterated over multiple encounters. Electronic records must allow for the following GOC content to be documented, at minimum: intent of the current treatment, physician's estimated prognosis, prognosis disclosed/discussed with patient (and others, if relevant), patient prognostic awareness, patient goals, and recommendations.
Establish expectations regarding goals of care communications	The IGCC initiative focuses on patients with advanced cancer. Each center is developing an actionable definition of advanced cancer, e.g., metastatic, locally advanced, or recurrent solid tumors and relapsed hematologic malignancies, including those receiving transplant or CAR T-cell therapy. Centers are creating systems and workflows to identify priority patients and trigger conversations. Timing for the completion of the GOC discussions among priority patients is determined by each center.
Implement a measurement framework	The ADCC is leading a process evaluation to collect information describing the progress of each center in implementing these core components, share the results across the collaborative, and encourage collaborative learning and best practices sharing. Quality measures assessing provider training, goals discussions and documentation, end-of-life utilization, and patient outcomes are being specified, tested, implemented, and reported.

Abbreviations: ADCC, Alliance of Dedicated Cancer Centers; APP, advanced practice provider; CAR, chimeric antigen receptor; IGCC, Improving Goal Concordant Care; GOC, goals of care.

convened in a series of structured consensus building sessions in 2019 and 2020. Modified Delphi processes—including literature review, brainstorming, voting, and refinement—were employed in developing the IGCC core components. Patient and family advisors were convened via focus group, and the themes were derived and disseminated. As further described in Table 2, the IGCC core components are the following:

- a formal communications skills training program for hematologists/oncologists and collaborating advanced practice professionals,
- structured goals of care documentation in electronic health records,
- expectations regarding the patients who are prioritized to receive goals of care discussions and timing for communication, and
- an evaluation and measurement framework.

As our hospitals began to implement these far-reaching changes, we also faced the unprecedented challenges of the COVID-19 pandemic. For our patients and their families, the pandemic has brought a renewed awareness of the importance of advanced care planning. Instead of detracting from our commitment, the pandemic has only reinforced the need to understand and honor our patients' goals of care. At all times, goal concordant care is the best patient care we can provide for our patients.

The IGCC will be a critical lever for our centers to test care delivery innovation. We believe that accomplishing this initiative will represent a substantive advance in the experience of patients with cancer throughout the centers, allow sensitivity to diverse populations and cultures, enhance satisfaction of oncology providers, and provide a national exemplar for other cancer care providers. The qualitative and quantitative evaluation across our cancer centers will generate pragmatic learning that we will disseminate and publish. As the leaders of our cancer centers, we are each prepared to provide the guidance, resources, and ongoing support required to implement the IGCC core components. We anticipate that the collaborative commitment of our cancer centers greatly increases the likelihood that our findings will then translate to widespread practice change and improve goal concordant care for patients nationally and internationally.

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For Further Reading:
Inge Henselmans, Hanneke W.M. van Laarhoven, Pomme van Maarschalkerweerd et al. Effect of a Skills Training for Oncologists and a Patient Communication Aid on Shared Decision Making About Palliative Systemic Treatment: A Randomized Clinical Trial. ***The Oncologist*** 2020;25:e578–e588.

Implications for Practice:
Treatment for advanced cancer offers uncertain and often small benefits, and the burden can be high. Hence, treatment decisions require shared decision making (SDM). SDM is increasingly advocated for ethical reasons and for its beneficial effect on patient outcomes. Few initiatives to stimulate SDM are evaluated in robust designs. This randomized controlled trial shows that training medical oncologists improves both observed and patient-reported SDM in clinical encounters ($n = 194$). A preconsultation communication aid for patients did not add to the effect of training oncologists. SDM training effectively changes oncologists' practice and should be implemented in (continuing) educational programs.