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 for care.
from these discussions. When needed, and few systematic methods to identify electronic health records in a way that can be easily retrieved. Challenges in documenting these discussions, including competing demands and priorities for oncologists, 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

| 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          | Houston, TX    |
| MD Anderson Cancer Center        |                |
| Memorial Sloan Kettering Center  | New York, NY   |
| Roswell Park Cancer Institute    | Buffalo, NY    |
| Seattle Cancer Care Alliance     | Seattle, WA    |
| USC Norris Comprehensive Cancer Center | Los Angeles, CA |

| 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. |

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 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          | Houston, TX    |
| MD Anderson Cancer Center        |                |
| Memorial Sloan Kettering Center  | New York, NY   |
| Roswell Park Cancer Institute    | Buffalo, NY    |
| Seattle Cancer Care Alliance     | Seattle, WA    |
| USC Norris Comprehensive Cancer Center | Los Angeles, CA |

| 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 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.

ACKNOWLEDGMENTS

The authors would like to acknowledge the contributions of the following Alliance of Dedicated Cancer Centers committee members in the conceptual development of, and planning for, the IGCC implementation: Eduardo Bruera, M.D., MD Anderson Cancer Center; Amy Case, M.D., Roswell Park Comprehensive Cancer Center; Marcin Chwistek, M.D., Fox Chase Cancer Center; William Dale, M.D., City of Hope National Medical Center; Jullian Gustin, M.D., Arthur G. James Cancer Hospital; Joseph Jacobson, M.D., Dana-Farber Cancer Institute; Shirley Johnson, Roswell Park Comprehensive Cancer Center; Elizabeth Loggers, M.D., Seattle Cancer Care Alliance; Judith Nelson, M.D., Memorial Sloan Kettering Cancer Center; Diane Portman, M.D., Moffit Cancer Center; Sunita Puri, M.D., USC Norris Cancer Center; James Tulsky, M.D., Dana-Farber Cancer Institute; and Jeff Walker, Roswell Park Comprehensive Cancer Center. Funding for the IGCC Collaborative is provided by the Alliance of Dedicated Cancer Centers and its member institutions.

DISCLOSURES

Richard I. Fisher: Bayer US, BeiGene (C/A); Laurie H. Glimcher: Bristol-Myers Squibb, Waters Corporation (E—former), GlaxoSmithKline Pharmaceuticals, Analog Devices, Inc. (E, OI), Repare Therapeutics, Abpro Therapeutics, Kaleido Therapeutics (SAB); Patrick Hwu: Immunx, Dragonfly (SAB); Craig B. Thompson: Agios Pharmaceuticals (SAB). The other authors indicated no financial relationships.

(C/A) Consulting/advisory relationship; (RF) Research funding; (E) Employment; (ET) Expert testimony; (H) Honoraria received; (OI) Ownership interests; (IP) Intellectual property rights/ inventor/patient holder; (SAB) Scientific advisory board

REFERENCES

1. Sanders JI, Curtis JR, Tulsky JA. Achieving goal-concordant care: A conceptual model and approach to measuring serious illness communication and its impact. J Palliat Med 2018;21 (suppl 2):517–527.
2. Blinderman CD, Krakauer EL, Solomon MZ. Time to revise the approach to determining cardiopulmonary resuscitation status. JAMA 2012; 307:917–918.
3. Alesi GL, Halpern SD. Choice architecture in code status discussions with terminally ill patients and their families. Intensive Care Med 2016;42:1065–1067.
4. Mack JW, Cain A, Taback N et al. End-of-life care discussions among patients with advanced cancer: A cohort study. Ann Intern Med 2012; 156:204–210.
5. Yung VY, Walling AM, Min L et al. Documentation of advance care planning for community-dwelling elders. J Palliat Med 2010;13:861–867.
6. Heyland DK, Allan DE, Rocker G et al. Discussing prognosis with patients and their families near the end of life: Impact on satisfaction with end-of-life care. Open Med 2009;3(2):e101–e110.
7. Bernacki RE, Block SD; American College of Physicians High Value Care Task Force. Communication about serious illness care goals: A review and synthesis of best practices. JAMA Intern Med 2014;174:1994–2003.
8. Secunda K, Wirpsa MJ, Neely KJ et al. Use and meaning of “goals of care” in the healthcare literature: A systematic review and qualitative discourse analysis. J Gen Intern Med 2020;35: 1559–1566.
9. Sanders JI, Miller K, Desai M et al. Measuring goal-concordant care: Results and reflections from secondary analysis of a trial to improve serious illness communication. J Pain Symptom Manage 2020;60:889–897.e2.
10. Wright AA, Keating NL, Ayanian JZ et al. Family perspectives on aggressive cancer care near the end of life. JAMA 2016;315:284–292.
11. Wright AA, Keating NL, Balboni TA et al. Place of death: Correlations with quality of life of patients with cancer and predictors of bereaved caregivers’ mental health. J Clin Oncol 2010;28:4457–4464.
12. Wright AA, Zhang B, Ray A et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA 2008; 300:1665–1673.
13. Zhang B, Wright AA, Huskamp HA et al. Health care costs in the last week of life: Associations with end-of-life conversations. Arch Intern Med 2009;169:480–488.
14. Cheung MC, Earle CC, Rangrej J et al. Impact of aggressive management and palliative care on cancer costs in the final month of life. Cancer 2015;121:3307–3315.
15. Temel JS, Greer JA, Muzikansky A et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 2010;363:733–742.
16. Dy SM, Kiley KB, Ast K et al. Measuring what matters: Top-ranked quality indicators for hospice and palliative care from the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association. J Pain Symptom Manage 2015;49:773–781.

17. Tulsky JA, Beach MC, Butow PN et al. A research agenda for communication between health care professionals and patients living with serious illness. JAMA Intern Med 2017;177:1361–1366.

18. Bickel KE, McNiff K, Buss MK, et al. Defining high-quality palliative care in oncology practice: An American Society of Clinical Oncology/American Academy of Hospice and Palliative Medicine guidance statement. J Oncol Pract 2016;12:e828–e838.

19. Fulmer T, Escobedo M, Berman A et al. Physicians’ views on advance care planning and end-of-life care conversations. J Am Geriatr Soc 2018;66:1201–1205.

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.