



PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor

**PCHQR Program: Documentation of Goals of Care Discussions
Among Cancer Patients (PCH-42) Measure Overview
Presentation Transcript**

Speakers

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February 22, 2024

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Lisa Vinson: Good afternoon and thank you for joining today's PPS-Exempt Cancer Hospital Quality Reporting Program educational event entitled, *Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42) Measure Overview*. My name is Lisa Vinson, and I am the PCHQR Program Lead for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program with the Inpatient Value, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. I will be one of the speakers for today's event. As the title indicates, today's presentation will focus on the Documentation of Goals of Care Discussions Among Cancer Patients, or Goals of Care, measure that was finalized for inclusion in the fiscal year 2024 Inpatient Prospective Payment System/Long-term Care Hospital Prospective Payment System final rule, effective for the fiscal year 2026 program year. This is a process measure that focuses on the essential process of documenting goals of care conversations in the electronic health record, or EHR, by assessing the presence of this documentation in the medical record. Furthermore, today's topic and information will be beneficial to PCHQR Program participants as they prepare to collect data for the Goals of Care measure this year and report these data next summer. Additionally, I would like to emphasize that the specific content for today's webinar is only applicable to the participants in the PCHQR Program related to participation and reporting in CMS Quality Reporting Programs.

If you have a question as we go along through today's presentation, please type your question in the chat window. At the end of this event, we will have a moderated question-and-answer session. For our speaker to best answer your question, we ask that at the beginning of your question, please reference the slide number along with your question in the chat window. Questions that are not addressed during this question-and-answer session will be posted to the [QualityNet](#) and [Quality Reporting Center](#) websites at a later date. We look forward to addressing as many of your questions related to this webinar topic as time allows. Any questions received that are not related to the topic of the webinar will not be answered in the chat tool during the question-and-answer session.

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To obtain answers to questions that are not specific to the content of this webinar, we recommend that you go to the QualityNet Q&A tool. You can access the Q&A tool from the QualityNet home page. There, you can search for questions unrelated to the current webinar topic. If you do not find your question there, then you can submit your question via the tool. Lastly, the slides for today's event were posted on QualityReportingCenter.com prior to the event. The transcript and recording of today's event will be posted on the same website, QualityNet, in the near future as well.

Today's materials were created in collaboration with Kristen McNiff Landrum, a consultant to the Alliance of Dedicated Cancer Centers, also known as the ADCC. Kris is the president of KM Healthcare Consulting, LLC. We are happy that she joined us today to lend her expertise on today's topic.

As a reminder, we do not recognize the raised hand feature in the chat tool during webinars. Instead, you can submit any questions pertinent to the webinar topic to us via the chat tool. All questions received via the chat tool during this webinar that pertain to this topic will be reviewed and a question-and-answer summary document will be made available at a later date. To maximize the usefulness of the question-and-answer summary document, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. These questions will be addressed in a question-and-answer summary document, to be published at a later date. Again, as stated earlier, any questions received that are not related to the topic of the webinar will not be answered in the chat tool nor in the question-and-answer summary document. To obtain answers to questions that are not specific to the content of this educational event, again, we recommend that you go to the [QualityNet Question and Answer Tool](#). You can access this tool by using the hyperlink on this slide. There, you can search for questions unrelated to the current webinar topic. If you do not find your question there, again, you can submit your question to us via the question-and-answer tool, which you can access at the link on this slide.

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Here is a list of acronyms you may hear today during today's presentation, some of which are familiar to participants in the program and regular attendees of our events. Acronyms you may hear and see include E-H-R for electronic health record; F-Y for fiscal year; G-O-C for Goals of Care, which will use as a short name for this measure throughout today's event; and Q for quarter

The purpose of today's event is to provide an overview of the Documentation of Goals of Care Discussions Among Cancer Patients measure for the PCHQR Program.

At the culmination of today's event, we hope that you understand how the Goals of Care measure was developed based on the measure specifications, and we hope that you are able to answer questions related to the measure specifications and submission requirements.

Before we delve into today's topic, I would first like to provide background information as it relates to the Goals of Care measure and the PCHQR Program.

As I mentioned in my introductory remarks, the Goals of Care measure was finalized for inclusion in the PCHQR Program in the fiscal year 2024 final rule for the fiscal year 2026 program year. If you would like to review the information on this measure, you can click the final rule hyperlink on this slide and direct your attention to pages 59222 through 59224. The measure information in the final rule provides background information; an overview of the measure, which include the measure population; denominator and numerator statements; and how to calculate the performance score. There is also information about the public display requirements, as outlined on this slide as well. The Goals of Care data submission is web-based; therefore, you will be required to log in to the Hospital Quality Reporting System and utilize a data form to submit your data. This will be an annual submission due in August. For fiscal year 2026, which is when this measure is effective, calendar year 2024 data will be submitted in August 2025.

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Lastly, CMS anticipates that public display of this measure will begin in July 2026. As a reminder, all PCHQR Program data are located on the data catalog on data.cms.gov. For your convenience, you can access this site by selecting the hyperlink on this slide titled data.cms.gov.

I would now like to turn the floor over to Kristen. She will discuss the Goals of Care measure for the PCHQR program in detail. Kristen, the floor is yours!

Kristen

McNiff Landrum: Good afternoon. Thank you, Lisa. As Lisa mentioned, I'm Kristen McNiff Landrum, and I'm presenting today on behalf of the Alliance of Dedicated Cancer Centers.

We'll start with the conceptual themes that underpin this measure. First, goal concordant care has been widely recognized by a variety of clinical and quality leaders in the nation as a critical outcome for those with serious illness. Measuring documentation of goals of care discussions then is a key step toward achieving that outcome of goal concordant care, which is difficult to achieve in healthcare settings and is very difficult to measure. Even though goals of care discussions are best accomplished by a team, in the cancer setting we believe that medical oncologists and hematologic oncologists have the responsibility for ensuring that these discussions occur and that they are documented among their patients who are seriously ill. Further, documentation of goals in structured fields within the electronic record promotes good discussion. So, it prompts them and promotes them. It enhances their quality and efficiency, and it promotes accessibility and retrieval of those goals of care, documentation data, downstream in the clinical setting and for secondary use. Finally, those goals of care discussions should predominantly be occurring in the ambulatory setting and outpatient interactions, for instance in visits, and, as much as possible, we want them to occur early in the care process for those with serious illness. We recognize that goals of care discussions often should occur over multiple encounters as goals should be re-assessed and updated throughout the journey of our patients with serious illness.

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At a very high level, this measure assesses goals of care documentation among patients with cancer who die while receiving care at the reporting hospital. I do just really want to pause and comment on that call out. So, it's important to note that we have created this measure, really thinking about feasibility and reliability. That is why the denominator is looking at a patient population, limited to those who die while receiving care at the reporting hospital. We are using this patient population despite recognizing, again, as I previously discussed, that we really want these discussions to be happening early and in an ambulatory setting. Again, this is really identified for that measure feasibility and reliability purposes. This is a process measure, as Lisa indicated, reporting annually. Hospitals report the percent of patients who died during the reporting period who had goals of care documentation prior to death.

Very briefly, the rationale for this measure is that clinicians lack serious illness communication training. Thus, it's perhaps not surprising that too few goals of care conversations occur. We know from the literature that almost all clinicians believe that serious illness conversations are important, but only about a third report having had any training about having those discussions. Then, when we speak to patients themselves and we talk to those who have serious illness, we hear that only about one in ten reports those conversations happening. Almost all Americans, and thus Medicare beneficiaries, say that they would be comfortable having these discussions with their clinicians.

Further research indicates that, when goals of care discussions do occur, they are often conducted in the inpatient setting and close to death. Among serious ill patients who prefer comfort care, less than a half report care that is consistent with their wishes. So, we know from the literature as well, that when care is consistent with patient preferences toward the end of life or among those with serious illness, they do have higher quality of care, as well as lower utilization and medical costs. For all of these reasons, we see these reflected in guidelines as well. For instance, the American Society of Clinical Oncology, or ASCO, recommends that clinicians be trained in these communication skills.

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Specifically, it recommends discussing goals of care with their patients. That includes prognosis, treatment selection, end of life care, and facilitating family involvement in care.

For these reasons, the Alliance of Dedicated Cancer Centers determined that this was an important area for measurement, specifically to round out the existing claims-based End of Life measures that are reported in this CMS reporting program. These claims-based measures provide, we believe, an important and actionable set of data, but they really don't present the full story as we can't tell whether this utilization near the end of life is consistent with patient preferences and wishes or not. So, those really, we think, provide a very important set of data, we wanted to try to promote a measure that could look at whether care was goal-focused as well. So, the ADCC convened an expert committee of national oncology and palliative care thought leaders and clinical leaders and engaged them in a structured consensus process. During that process, the group determined that oncologists, and that means medical oncologists and hematologic oncologists, should oversee documentation of goals of care discussions in the EHR. Although, as I previously mentioned, other team members may contribute to those discussions and their documentation. Second, goals of care documentation is beyond and different from what we talk about when we talk about advanced care planning. Goals of care documentation is that which reflects a patient's values, preferences, and wishes. To drill down more, that documentation captures things like the intent of the patient's treatment, the physician's estimated prognosis for that patient, whether this prognosis was discussed with the patient and caregivers as appropriate, what patient goals are, and recommendations related to those goals for the patient's care. So, these are the concepts, and these are the concepts which we're promoting to be captured in the electronic health record. Yet, I do want to note that these are no particular words for which there may be synonyms used in the capture in the electronic health record. Finally, the committee recommended that goals of care documentation should be structured to ease entry and to facilitate retrieval and reporting.

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So, we'll dive into specifications for this measure. First is the patient population. As I mentioned, the population is the number of patients who die in the measurement period. Again, that really is not because that's the only group of patients for whom these discussions should occur. In fact, we do want them to be happening earlier in the disease trajectory for those with serious illness, but this is for feasibility and reliability of measurement. So, we're looking for those who died at the reporting hospital and had a diagnosis of cancer and those who had at least two eligible contacts in the six months prior to the date of death. Here are the eligible contacts. We're really trying to identify those touches with the medical or hematologic oncologist. So, we're looking for either inpatient admissions or ambulatory visits. You can see the codes that go along with that definition that I just read, including the diagnosis of cancer that might be included or that are recommended from ICD-10 and the definition for those eligible contacts.

Thus, the denominator is the patients who meet those inclusion criteria that I was just reviewing in the reporting period. The numerator then is the number of those individual deceased patients for whom a goals of care conversation was documented in a structured field within the electronic health record. To repeat some of the definitional items previously reviewed, goals of care documentation is that which reflects a patient's own values, preferences, and wishes. It includes fields, which I previously reviewed, like the intent of current treatment, physician estimated prognosis, whether that prognosis was discussed with patient, patient's own goals, and recommendations in accordance with those goals. The measure requires documentation within the fields in the EHR. I do want to clarify the use of the term "structured fields." So, here, we're really trying to avoid documentation that is pure text within, for instance, physician progress notes, which then are very difficult to find for future clinical care and for our secondary use. So, we're really looking for fields which have been structured in the electronic health record, and that could happen in a variety of different ways. It could be in a template or any other way that you can really prompt and capture that discussion and facilitate that retrieval.

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This does not mean that the response always has to be done in a drop-down or selection box. The actual responses that the clinician is entering during the point of care may include some free text, and that would still count. So, if you have a template, for instance, that's capturing goals of care, and you have a field that is looking for some of the detail about the patient's own goals of care, and that includes free text, that is fine, That would count as a measure. Yet, having just free texts within a physician's progress note, for instance, would not count toward the measure. So, we're looking for that structure to be there. Then further, the documentation can originate from any visit type or any provider. Again, we really think that and believe, based on our expert input, that these discussions fall under the responsibility of the oncologist, but it might be that other members of the care team are empowered to have those discussions and to do some of that data entry within an individual provider site. That would count toward this measure.

The measure calculation then is straightforward. We're looking at the proportion or percentage, who is calculated by looking at the denominator and the numerator. So, dividing the numerator by the denominator and multiplying by 100, a higher score is better for this measure. Due to the nature of this measure, it's not risk adjusted or stratified.

Let's speak a little bit about implementation experience with this measure throughout the, you know, conceptualization and development process. So, what we learned in doing this work through the Alliance of Dedicated Cancer Centers is that there was a lack of really structured capture within oncology setting that we worked with for these goals of care notes. Notably, the advanced care planning aspects of the electronic health record did not fully capture patient goals, as I mentioned before. So, this really does go beyond the previous kind of concept of advanced care planning documentation to expand that to be focused on those patient's own values, preferences, and wishes. This required additional thought at each of our sites to think about how to really capture those well within the EHR. That said, there is a growing recognition among electronic health record vendors.

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There's an interest in capturing these goals of care fields specifically. There are some like Epic that are working to create those, so that they don't have to be individually developed by each of the reporting sites. So, we have found over time that all of the centers were able to create structured capture of goals of care notes that were acceptable and useable by their clinicians, and many were able to create reports based on those. It's also really critical that, as I went through in the background, this is more than just, you know, creating fields in an electronic health record. This is really about changing expectations for oncologists and others on the clinical team to have these discussions with their patients. As we noted in reviewing the literature, the majority of oncologists say that they have not received that training. So, certainly, an implementation best practice, which we have been exploring, is for cancer programs to really invest in those training programs with their oncologists and potentially others on the team, so that they're ready to have effective and efficient goals of care conversations with their patients. That goes along with this structure capture. Finally, I'll mention from our implementation experience that we were able to engage a patient family advisory group, a committee that really had a broad representation of patients and family members to comment on and to really help drive this work. They reinforced repeatedly, you know, in our interactions with them, the importance of that dual focus of having that training, so that providers really were better equipped to have these conversations and to have them efficiently and effectively and to have this way to do this structured capture of patient preferences and wishes. They said they reflected on a few areas. One being an option, and that's an option in our numerator, is that patients may say that they don't want to have these conversations. They may want to be able to opt out. If they do that, they want that to be documented and documented in a way that they're not going to be asked repeatedly the same questions which may not be something that's consistent with what they want to have in their communication with their providers. So, they want to have that documentation be retrievable. Then, secondarily, these conversations, you know, are high emotion. They are usually very welcomed by patients, but they are high emotion. The patients didn't want to have them repeated if they had just had that conversation.

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So, that's another, you know, kind of support that we heard from patients for having these in structured ways that are easy to find. Then, that next clinical encounter, maybe with another physician, they wanted any future conversations about goals of care to reflect the knowledge that that had already happened, and the knowledge of what the patient preferences were already had been documented. Don't keep asking us, you know, the same questions over and over without an acknowledgment of what we have already told you. So, we heard that from patients as well in strong support for, you know, this work, and ultimately, for this measure. Certainly, we heard from patients that when there comes a time that feels like a crisis, for instance acute admission, that patients wanted that information especially to be readily available and for their care team to have that knowledge and to be interacting with them with that background knowledge, again, supporting our concept of a structured, easily retrievable, well-organized documentation of patient preferences in the electronic health record. With that, I will turn back over to Lisa.

Lisa Vinson:

Thank you so much, Kristen. Now, we will take a brief moment to review measure resources and key program reminders before we begin our question-and-answer session.

Around this time of year, we begin to review and update resources and tools along with the related QualityNet and Quality Reporting Center web pages. On the QualityNet site, there are many valuable program-related resources readily available at your disposal. As it relates to the question-and-answer tool, if you have questions about the Goals of Care measure, you can submit your inquiry under the program of PCH – Cancer Hospital Quality Reporting. The topic would be Patient Engagement/Experience of Care Measure. There are also QualityNet web pages that will be undergoing updates, such as the PCHQR Measures and Data Collection pages. These pages house measure-specific information. Most importantly, please be sure that you are signed up to receive PCHQR Program notifications. You can select the hyperlink on this slide under Subscribe to PCHQR Program Email Updates which will take you directly to the sign-up page.

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Lastly, the CMS Measures Inventory Tool, or CMIT, houses all of the PCHQR Program and other quality reporting program measure specifications. By selecting the hyperlink on this slide, you will be taken directly to the Documentation of Goals of Care Discussions Among Cancer Patients page, which also houses measure-specific information.

Now, I would like to review a few key program reminders. First, the next upcoming data submission deadline is April 3. The PCHs will be submitting Quarter 3 2023 [correction: Quarter 4 2023] HCAHPS Survey data. Next, the April 2024 preview period closes today, February 22. Please take some time to review your preview report to ensure that the information contained within is accurate. As outlined on this slide, the following data will be publicly displayed in April: Quarter 3 2022 through Quarter 2 2023 HCAHPS Survey data; Quarter 3 2022 through Quarter 2 2023 HAI measure data; and, lastly, Quarter 2 2023 COVID-19 HCP. Third, I wanted to highlight the claims-based measure report releases for fiscal year 2025 that are on the horizon this summer. These include Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measures, PCH-30 and PCH-31. The data collection period is July 1, 2022, through June 30, 2023. The four End of Life measures are PCH-32, -33, -34, and -35. These measures are being publicly reported for the first time this summer, and the data collection period is also July 1, 2022, through June 30, 2023. Lastly, Surgical Treatment Complications for Localized Prostate Cancer, PCH-37, is also being publicly reported for the first time, and the data collection period for this measure is July 1, 2021, through June 30, 2022. As a reminder, these claims-based measure reports will be available via the Hospital Quality Reporting System, and there will be a Listserve communication distributed announcing their availability. So, again, please be sure you are signed up to received PCHQR Program notifications via the sign-up link on the QualityNet home page, or you can refer to previous slide which has the hyperlink to take you directly to that page.

Now, we will begin our question-and-answer session.

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We will now take this time to begin addressing questions received in the chat box. As I mentioned, at the start of our event, we will address as many questions as time allows. If we are not able to address your question during this time, the question-and-answer summary document will be posted at a later date on both QualityNet and Quality Reporting Center websites. So, now we will get started.

Our first question reads: I am looking to confirm how cancer diagnosis is defined. Also, is there a time limitation on the conversation with the provider? In other words, the patient died this month, but goals of care conversations may have taken place a year ago. Is it OK, as long as any conversation is documented, regardless of when it occurs?

Kristen

McNiff Landrum: Thank you, Lisa. I'll respond to those. In terms of the definition of cancer diagnosis, if you refer back to the slide showing the denominator, you'll see the codes that are pretty broadly encompassing codes, ICD-10 codes for cancer diagnoses. So, please, refer to those. Again, it's a broad definition of cancer. Second, in terms of timing, there is not a specific timing definition. We've found in working with experts that the cadence of these discussions is really dependent on a patient's own clinical progression or their journey. Certainly, some centers may want to create minimum time expectations that they'll use locally. Yet, there really isn't, at this point, evidence or a knowledge base to use as a rationale for measurement purposes. So, no explicit timing is in the measure at this point.

Lisa Vinson:

Thank you, Kristen. For the second question, I will address this one. That question states: Is the measure only approved for fiscal year 2026 or 2026 and beyond? So, per the fiscal year 2024 final rule, the Goals of Care measure begins with the fiscal year 2026 program year. Any changes to the data submission or reporting requirement for this measure will be specified in a future final rule publication. So, for right now, it is fiscal year 2026 program year, which is for calendar year 2024 data, which will be reported in the summer of 2025. OK. We do have another question here. It states: What if the patient was being treated at the cancer center, but he died through another circumstance, an accident, for example?

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Kristen

McNiff Landrum: Yes. Thank you, and I can take that question. For the denominator here, we're really looking for patients who did have that cancer diagnosis and who died at the reporting cancer center. So, we should not be capturing individuals who were admitted to the PCH during that admission. We do recognize that a broader definition, even within a deceased patient population, would be anyone who was treated at the hospital and then died. We found in doing this work that there was a variety of completeness across our centers in being able to identify patients who they treated but who died elsewhere. So, whether he died at home or in hospice or in another inpatient setting, that's not the recording PCH. Some of our centers really are still working. The centers that we worked with were working to really have full, valid, reliable captures. So, for those reasons, again, our denominator is very pragmatic. It's really looking at a population that will maximize that the reliability of measurement. So, for that purpose, these are individuals who died as inpatients at the reporting center.

Lisa Vinson:

Thank you, Kristen. That looks like that's all the questions that we've received thus far in the chat box. So, we will go ahead and conclude our question-and-answer session at this time. We do thank you for submitting your inquiries, and we hope that the answers provided gave you a better understanding about the Goals of Care measure and reporting requirements for the PCHQR Program. So, again, if you do have any additional questions, please feel free to submit those via the question-and-answer tool on the QualityNet home page. Also, the question-and-answer summary document for the questions that we received during the event will be available at a later date on both QualityNet and Quality Reporting Center websites. So, again, we do thank you for your time and attention during today's presentation. Also, a special thank you goes to Kristen for her expertise and participation today. We hope that the information provided was beneficial to you as a PCHQR Program participant. Thank you and enjoy the remainder of your day.