

## Peer Review File

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### Reviewer A

- 1. The focus on equitable implementation is valuable. It would be helpful to add a rationale for limiting equity considerations to racial/ethnic groups. That is, additional equity-deserving groups in cancer care include older and younger adults, individuals in rural settings, Indigenous patients and those who identify as LGBTQ2S+. Might these groups be considered by the authors or is their intent to focus on the needs of those identifying with under-served racial and ethnic groups?**

We thank the reviewer for this interesting and important consideration. We agree that the manuscript, as it stands, is primarily focused on ensuring equitable implementation of stepped palliative care among under-served racial and ethnic groups, and we wholeheartedly agree that equity considerations must be extended to other marginalized groups, such as older and younger adults, individuals in rural settings, Indigenous patients, and those who identify as LGBTQ+. However, we believe that equity considerations are nuanced for different marginalized groups to the extent that a singular editorial commentary would not be able to cover them all adequately or appropriately. Our intent is to address the specific barriers and disparities faced by racial and ethnic groups within the scope of this manuscript. We recognize the importance of expanding this discussion to include other equity-deserving groups in future work and appreciate the reviewer's suggestion to acknowledge these broader considerations. We have added the following sentence to emphasize that we are primarily focusing on under-served racial/ethnic groups in this editorial commentary:

*“In this editorial commentary, we propose equitable considerations for palliative care delivery to under-served racial/ethnic groups, while recognizing the importance of equitable implementation for other marginalized groups based on age, residence location and sexual orientation and/or gender identification, emphasizing the promise of stepped palliative care in achieving this goal in under-served racial/ethnic groups.”*

## Reviewer B

- 1. This is a well written and interesting editorial commentary. 1) However, I noted some errors with the description of the Temel JAMA 2024 study (Lines 44-58) which need correction. I have also suggested some areas for clarification of the JAMA study description for the readers' understanding, as below. Line 47: Suggest use the JAMA authors' terminology "intensive palliative care exposure" (or similar wording) rather than 'more intensive care' which could be mistaken by the reader for care in the ICU.**

We thank the reviewer for their praise of our manuscript and for pointing these errors out. We have edited the sentence appropriately:

*"Stepped palliative care, a resource-efficient approach, is emerging as a promising delivery method that Temel et al. recently reported in JAMA to be noninferior to traditional early palliative care approaches.<sup>12</sup> Stepped palliative care involves minimal initial clinician contact, escalating to intensive palliative care exposure if needed based on systematic monitoring."*

- 2. Line 48: The Temel study was not 'controlled'. The study should be described as a "randomized non-blinded clinical trial".**

We have edited the sentence appropriately:

*"In this large randomized non-blinded clinical trial of 507 adult patients with advanced lung cancer (ECOG performance status of 0 to 2) across three hospitals across three states in the United States, Temel et al. compared patient-reported quality of life through the Functional Assessment of Cancer Therapy – Lung (FACT-L) questionnaire as the primary outcome."*

- 3. Line 48: The Temel study had "507 patients", not 510. Perhaps say "507 adult patients"?**

We have amended the sentence appropriately, as seen in the quotation to the previous suggestion.

- 4. Line 48: In order to better describe the patient population, suggest clarifying that the "advanced lung cancer" had been diagnosed within the previous 12 weeks. I think it is also important to add that the patients had ECOG performance status of 0 to 2.**

We have amended the sentence appropriately, as seen in the quotation to the previous suggestion.

- 5. Line 49: Suggest clarifying that the "three states" were in the United States.**

We have amended the sentence appropriately, as seen in the quotation to the previous suggestion.

- 6. Line 52: Suggest clarifying that it was "patient-reported communication" about end-of-life "care" preferences (as it was not healthcare provider reported).**

We have amended the sentence appropriately:

*“Secondary endpoints included palliative care utilization (measured through number of visits), patient-reported communication about end-of-life care preferences, and length of hospice stay.”*

- 7. Lines 57-58: Suggest adding description of what ‘early palliative care’ was for the purposes of the Temel study. E.g., Notably, stepped palliative care reduced the number of palliative care visits by half compared to early palliative care, where patients were scheduled for palliative care visits every 4 weeks, independent of a patient’s needs.**

We have amended the sentence appropriately:

*“Notably, stepped palliative care reduced the number of palliative care visits by half compared to early palliative care, where patients were scheduled for palliative care visits every 4 weeks, independent of a patient’s needs.”*

- 8. 2) Of note, the patient population in the Temel study was ~85% white (84.6%), predominantly Christian and 65.7% were married or partnered. Is this worth a comment in this editorial with its focus on equitable implementation?**

This is a very important observation, and we wholeheartedly agree that the patient population in the Temel et al. study does not adequately represent the diversity of many communities. As such, we have added the following consideration:

*“However, the current stepped palliative care approach will need to continue to evolve in directions that emphasize equitable care delivery. Notably, the patient population in Temel et al. consisted predominantly of patients who were white, Christian, or married or partnered. As such, further research investigating the impacts of stepped palliative care in diverse racial/ethnic and minority communities is warranted.”*

- 9. 3) I completely agree with the authors that are limitations with relying on QOL metrics to assess palliative care needs, and the need for physical/ psychological/ existential distress screening tools. Another area that should be assessed, but was not included in this editorial commentary, is assessing for family caregiver needs for support. As per the WHO definition and line 19, the family is part of the circle of care.**

The reviewer brings forth an important consideration in family and caregiver needs for support. We have added this into our criteria proposals:

*“Defining and acting upon actionable metrics — such as patient-reported pain levels, emotional or psychological needs, spiritual and existential concerns, physical symptoms, and family and caregiver needs for support — can identify patients who may require more intensive, issue-specific palliative care sessions.<sup>14</sup>”*

**10. 4) I was thinking that citations should be included for FACT-L, PHQ-9 and Brief-COPE, but then saw that these instruments were not cited in the original paper!**

As the reviewer noted, we agree that the citation may not be necessary given that the assessment frameworks were not cited in the original paper.

**11. 5) Line 66: Delete ‘or’, so reads “early palliative care for patients”.**

The original sentence may have been phrased ambiguously. We meant to propose two different scenarios in which the implementation of stepped palliative care may prove more beneficial than the use of early palliative care approaches: 1) hospitals with a limited capacity to ubiquitously implement early palliative care, and 2) patients with a terminal prognosis but extended expected survival. We have amended the wording to clarify this:

*“Especially for hospitals with limited capacity to ubiquitously implement early palliative care or for patients with a terminal prognosis but extended expected survival, integration of stepped palliative care can optimize resource use and maintain high standards of patient care, making it a viable and effective option in diverse healthcare settings.”*

## **Reviewer C**

- 1. This is an excellent piece of work that should be published. The argument is well formulated and referenced appropriately. Highlighting the importance of culturally appropriate care cannot be emphasized enough. How to measure culturally appropriate care in a context with multiple cultures need to become part of the research agenda in palliative care.**

We thank the reviewer for their praise of our manuscript.

## Reviewer D

- 1. This is an excellent and timely Editorial which highlights to readers another 'landmark' paper from Temel that it is important for all palliative care clinicians to be aware of, particularly given its high profile. The authors raise important points with regards to the study's findings that are worth consideration by our field. My only suggestion is that I feel that any paper appearing in APM ought to read well as a stand-alone piece, therefore, could the authors please clarify whether the Temel study involved pen-and-paper or tablet administration of the FACT-L or was it embedded within a clinical consultation? I am assuming the later, since they advocate that cultural training for staff would improve the rate of identification of unmet needs. If the former, perhaps they could comment on the limitations of this and whether any literature exists on the rate of identification of unmet needs for the more vulnerable and under-served groups they discuss.**

We thank the reviewer for their praise of our manuscript and for indicating this important consideration. However, upon further investigation, it seems that Temel et al. does not specify whether the FACT-L assessment was administered as a standalone written assessment or embedded in a clinical consultation. We agree that these are important considerations, so we added a paragraph to emphasize the benefits of administering the questionnaire as part of a clinical consultation to prevent the exacerbation of health disparities.

*“Second, the method of QOL questionnaire delivery must be carefully honed to prevent the exacerbation of health disparities. Studies have shown that certain social determinants of health may affect differential survey completion rates. One study found that women, younger adults, Hispanic and Black adults, and people with less formal education were less likely to answer open-ended survey questions, which may translate to differential non-response rates when administering FACT-L questionnaires for stepped palliative care. As such, it may be beneficial to administer FACT-L questionnaires or other such surveys of assessment metrics directly within a clinical consultation to avoid exacerbating health disparities associated with differential rates of non-response, especially as stepped palliative care is upscaled to communities with higher proportions of under-served populations.”*

## **Reviewer E**

- 1. As highlighted, the reliance on deterioration in QOL to step up to higher intensity palliative care is limited by the completion of the QOL PROM questionnaires. Furthermore, lower completion rate of PROMs may be found in groups with lower education levels and poorer socioeconomic status, thereby exacerbating the health disparities. Along with other suggested iterations to the model, would the authors consider non-completion of QOL PROMs to be a trigger to initiate a triage assessment by a care coordinator or patient navigator or other healthcare professional. This could go some way to ensuring that the upscaling of palliative care is equitable.**

We thank the reviewer for this suggestion. The reviewer presents another important consideration for equity for our piece, and we agree that non-completion of QOL PROMS may be indicative of systemic barriers that have the potential to exacerbate health disparities. However, similarly to the point raised by Reviewer D, we are uncertain whether the administration of the questionnaire was conducted via a traditional pen-and-paper/tablet assessment or embedded within clinical consultations. We believe that embedding the survey within clinical consultations may be a more straightforward way to alleviate this issue, as opposed to initiating a triage assessment for all instances of non-completion. As such, we have added the above paragraph quoted in the previous response to address the reviewer's concern.