

Peer Review File

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Reviewer A

The paper is easy to follow and does have a logical flow. It is well written and focuses on an interesting topic that is relevant in the optimal care of patients living with advanced diseases. The title and abstract cover the main aspects of the work.

I agree with the authors that integration of Palliative Care occurs often late in disease progression of patients with terminal illnesses. Therefore, this fact should be examined critically.

Nevertheless, I would like to address some minor concerns to help to improve the quality of the manuscript.

Line 111: Maybe you could explain this more deeply. Were all patients or all included data part of the the HZV? Outside of Germany HZV is not known, you could give some more information on this model of care.

Reply: I tried to explain this model of care.

Line 125: Please consider including the definition of the codes 01425 and 01426.

Reply: I did.

Line 182: I think a limitation of the study is that we do not know if patients were seeing palliative care doctors or specially trained oncologists during hospital stays or outpatient service in hospitals as it is quite common in some regions for example (I do not know for Baden Württemberg though). You mentioned this already in the limitations section. In addition, some General Practitioners might have had special training in palliative care which would also not be visible in this insurance data.

In my region, SOPC is only referred to if patients are unable to leave the house for example and show symptom burden, which might have been the case for only some of the patients in your study. Others might have also visited palliative care doctors in an outpatient setting. In my opinion, this is a blind spot of this research design and should be stated more clearly as well as further studies should be recommended.

Reply: Yes I agree and I tried to pronounce this point again more clear.

Aim of the study was, to find out whether the general practitioner were able, to send the patients with needs of palliative care early to the palliative care team for advice. This is often a good chance to get in contact with the PC-Team. This can help the patients and their relatives.

Fig 1: I would rather use “Persons with AOK health insurance” and “Patients in a Palliative Setting” or “..with advanced/life-limiting/serious disease” as “palliative patients” sounds rather german.

Furthermore, please make sure to include a figure without the red underlining.

Reply: done

Good luck to the authors in revising the manuscript!

Reviewer B

- I think the title is misleading. I would expect the manuscript to describe a program that provides early, integrated palliative care to patients in a general practice clinic, but that's not what this manuscript is about. – **we have changed**
 - Mind the capitalization in the title. **corrected**
 - Do not begin sentences with a numeral. **corrected**
 - On line 35 there is a typo with the word "where" used instead of "were". **corrected**
 - I don't agree with the conclusion that referring to palliative care more than 12 weeks after a diagnosis of metastatic cancer is "very late". In fact, I think having 45% of patients referred to palliative care on the same day of diagnosis is quite a remarkably high rate of early referrals.
 - Instead, I might focus the discussion/conclusions on the fact that only 17% of patients with adv cancer and palliative care needs were referred to palliative care. This seems like the more significant quality gap in need of improvement. **We took the Temel definition for early integration now and emphasized now, that only about one quart of all patients had an referral to a pc-specialist. We hope its now very clear.**
 - Please standardize whether you're using periods or commas to indicate decimal places in number.
 - Comment on lines 82 & 83 that "this tendency is astonishing and self-defeating" is opinion, which should be reserved for the discussion. Not appropriate in the intro. **changed**
 - Some metastatic cancer (e.g. oligometastatic colon cancer) can be curable, so I would not claim that all of these patients have incurable disease. **Of course are there some people with metastatic cancer, who are cured. But we think, that advice from a palliative care specialist can help to improve the quality of life. This is shown in many studies and therefore a chance for the patients. Very often these patients have many needs for palliative care and the general practitioner can help them to get in contact."**
- As written in the conclusions "It seems to be important that all colleagues realise that palliative care means much more than end-of-life care during the last few days, or at most weeks, of the patients' lives".**
- I don't agree that only referrals made in the first 4 weeks after diagnosis are "early". Instead, I think including in this group all referrals made up to ~12 weeks after diagnosis would be more appropriate.
 - It needs to be described better what the designations of "palliative care necessary" or "palliative patient" by GPs means. Are there definitions for these categorizations? At a minimum, you need to describe these designations in the methods. If it's not entirely clear how GPs use these categories then you need to acknowledge that limitation very clearly and state your findings humbly, for instance as hypothesis-generating and warranting further exploration. **We took the WHO definition for palliative medicine. This definition shows the difficulties to define the "palliative patients". We see these difficulties in many parts of palliative medicine. Patients with COPD or heart failure have no sharp threshold between chronic disease and palliative needs. We know there are some patients with cancer and metastasis, who are in a good condition. But we think, these patients have palliative needs. That's a fundamental problem for research in this subject.**
- We tried to explain the definition of palliative care in the methods.**