Pallium Canada

Quality Improvement
Condensed (QUIC)

Identify patients with palliative care needs and develop a practice palliative care register

pallium.ca

How to use this toolkit

AIM OF TOOLKIT

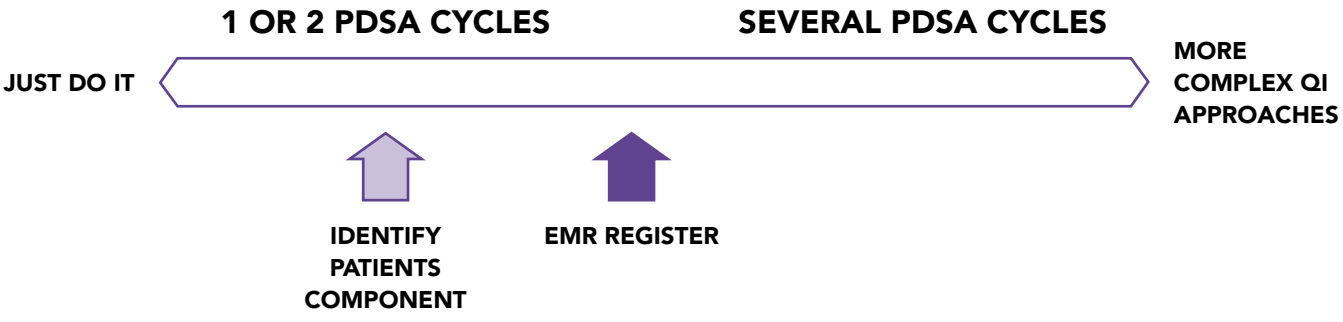
To help you identify patients who could benefit from a palliative care approach **and develop a palliative care register (list) for your practice.**

- The toolkit is a condensed step-by-step approach to undertaking quality improvement (QI) in your practice as it relates to palliative care. It draws on, and provides links to excellent existing resources.
- This QUIC goes hand-in-hand with QUIC Activating a palliative care approach (forthcoming).
- First, review the entire document to understand the big picture. Then follow the steps and refer to the Resources section and useful links at the end of the toolkit as you go along.
- QI is a team activity, so involve all those who will be affected or involved. Consider including a patient or family member in your team.
- This toolkit uses the Model for Improvement (MFI) of the Institute for Healthcare Improvement (IHI). It consists of three key questions and Plan-Do-Study-Act (PDSA) cycles. You may use other approaches that you may feel more acquainted with or feel would be more appropriate.
- Don't forget to celebrate successes! If there are shortfalls or failures, try a different approach. That is the advantage of using a QI approach — small ongoing steps.

EASE OF IMPLEMENTATION SCALE (VARIABLE)

Some QI efforts are straightforward and quite easy. We call these "just do its." Others require several cycles (PDSA cycles), each one making small adjustments and improvements. A few require complex approaches.

This QUIC, especially the 'identifying patients' part of it, falls toward the "just do it" spectrum, as showcased in this diagram. Developing a registry for your practice may require some PDSA cycles, especially if you need to embed it in your electronic medical record (EMR)—but it is worth it!



This QUIC applies to: Clinic settings

WHY DOES THIS QUIC MATTER?

- Palliative care, including a palliative care approach, is often activated only at the very end-of-life (EOL), in the last days or weeks. This results in unnecessary suffering.
- Research shows that earlier palliative care, whether it is a cancer or a non-cancer diagnosis, has significant benefits for patients, families and the health care system.[1–4] Patients report better symptom control, improved quality of life, and reduced psychological distress. There is less use of inappropriate treatments, tests, and resources.
- A palliative care approach can be activated alongside treatments to control the disease.[5,6] See Resource 1 for a summary of this approach and some useful links. The approach can be delivered by the primary care team. Palliative care colleagues or teams can be consulted for complex cases.
- There are different methods to identify patients who could benefit. See Resources 2 and 3 for tools to help you with this.
- Practice registers (lists) of patients who require palliative care have been found to help practices pro-actively organize and optimize care for patients.[7,8]

QUADRUPLE AIMS AND QUALITY DIMENSIONS ADDRESSED BY THIS QUIC

Timely, Equitable, Patient-Centred

IMPROVED PATIENT EXPERIENCE

IMPROVED PATIENT OUTCOMES

QUADRUPLE AIM

LOWER COST OF CARE

IMPROVED PROVIDER EXPERIENCE

QUIC Steps

STEP 1: GET STARTED

Ask: Is this for my patients or for the whole clinic?

- Sometimes you may need to start first with your own patients and then use your example to convince your colleagues.

Ask: Who can help me with this?

- This may be one or two colleagues. Can be from different professions and/or administrative team.

Get one or two colleagues and staff on board.

- Get them to view the short Pallium video **Better Early Than Late** and discuss. Think of a specific patient in your practice where earlier palliative care could have helped them.

Coffee chat (in-person or virtual)

- Explore this QUIC together to start thinking about how to implement this improvement in your practice.
- Reflect briefly on the following questions:
  - Does this make sense for our practice?
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change(s) can we make to accomplish this improvement?

STEP 2: DOES THIS APPLY TO US?

Consider one or two of the following:

- Rapid chart audit (See Resources 4 & 5)
- A check sheet (See Resource 5)
- Case reflections (See Resource 5)
- If this confirms an improvement opportunity, use this information and the "Make the Case" slide deck to engage the whole team (Currently in development).

STEP 3: A DEEPER DIVE

The following questions can help to understand the opportunity better:

1. What are the root causes of the problem in our practice? (See Resource 6)
2. Are we ready for the change?
3. What should we do to prepare for the change?
4. What would make most sense in our practice?
5. What can help us get there?
6. What could block us?
7. Who need to be involved?
8. Who do we need to speak to (folks who could help or could have other important views)?
9. What resources or tools will help us?

STEP 4: PREPARE FOR THE CHANGE

WHAT ARE WE TRYING TO ACCOMPLISH?

HOW WILL WE KNOW IT IS AN IMPROVEMENT?

WHAT CHANGES CAN WE MAKE?

What are we trying to accomplish?

Summarise your problem

- In my/our practice, we activate a palliative care approach too late in the illness journey, often only in the last days or weeks of life. We also don't have a good idea of who the patients are in our practice who would benefit from a palliative care approach. This makes it difficult to be pro-active in organizing their care.

Develop an AIM STATEMENT

- **Example:** Within [x] months [or by date], [select doable % e.g. 80%] of all patients in my/our practice with advanced [name disease] that meet the "Surprise Question" and SPICT criteria, will be flagged in their charts as requiring a palliative care approach and included in a practice Palliative Care Register
- **Note:** The register can be done simultaneously with early clinical identification (preferred) or can follow work on first making clinical identification part of everyday practice.
- **Note:** Creating a register would require incorporating a unique flag or code in your electronic medical record (EMR) to help with searches or an indicator in your paper records that identifies patients with palliative care needs. You may need help from your EMR support team.
  - The Surprise Question (See Resource 2)
  - The SPICT Tool (See Resource 3)

TIPS

- There are many cancer and non-cancer diseases. You may consider, as a test/pilot, starting with one disease group. Learn from that, fine-tune, celebrate success, and then extend to other diseases.
- Seek input from all team/clinic members that will be involved in this change. Engage them in co-developing the AIM statements, measures and changes being implemented.

How will we know it is an improvement?

Usually, 3 types of measures are used in a QI project
(outcomes, process, balance — Resources 7a and 7b).

The following are examples of Process Measure(s)
(These are examples only, develop ones that best suit your practice)

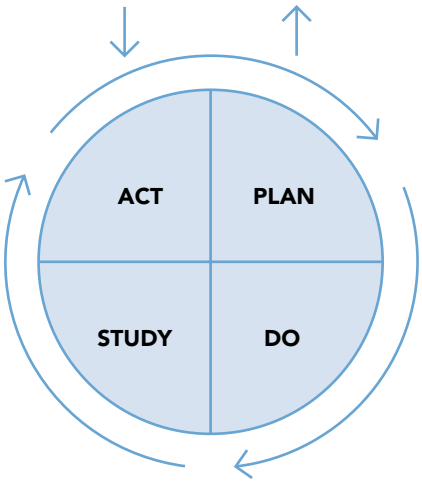
- **Clinical identification**
  - Patients who meet the Surprise Question and SPICT criteria are a) identified and b) a palliative care approach is activated.
- **Register**
  - A unique code that identifies patients with palliative care needs is embedded into the EMR (See Resources 7a and b for examples of the other important group of measures, namely Outcomes and Balance Measure).

What changes can we make?

- At minimum, use the Surprise Question in daily practice. Ideally, use Surprise Question complemented by a tool such as SPICT.
- Develop a practice Palliative Care Register (a list of all the patients who could benefit from a palliative care approach).
- Incorporate these tools in your charting and/or EMR.
- Implement visual cues as reminders: Sticker on desk/computer that says Surprise Question and SPICT sheet on desk/computer.
- Activate a palliative care approach once a patient has been identified (See Resource 1). This requires setting up an appointment for a practice physician or nurse to conduct a comprehensive assessment.

STEP 5: PLAN (P)

- This will depend on the scope of your intended improvement idea (e.g., clinical identification only or clinical identification alongside register).
- Engage the whole team and involve them in the work.
- See tables on P. 6 and 7 for planning considerations.



Clinical Identification

(See Resources 2 and 3)

Questions to answer	Possible "answers" or solutions (modify to your practice realities and context)
What? (what will be done?)	• Use the Surprise Question and SPICT tool in daily practice. • If a register has been established, review the list and practice charts to identify patients to be added (may require appointments to see some). Or create list "on the fly", as you see the patients or receive reports from other specialists.
Who?	Clinic doc(s), nurses, admin staff. Identify responsible person(s) for each task above.
When?	Practice co-decides timelines and milestones for each of the tasks.
Where?	Practice decides: One clinician starts, or group (e.g. team), or whole practice.
What should we anticipate?	Pushback from colleagues, and/or patients. Identify strategies to mitigate (e.g. palliative care training such as LEAP courses or LEAP Online modules) (See Resource 8)
Enablers & barriers?	Who and what? Team identifies. Identify strategies to harness or mitigate.

Practice Palliative Care Register

(See Resource 9)

Questions to answer	Possible "answers" or solutions (modify to your practice realities and context)
What? (what will be done?)	• Review the SPICT criteria and identify codes/words in your EMR (or words in your paper charts) that will identify these patients and create a list that you can review and maintain. (See Resource 9; eHealth Centre of Excellence Tool). • Develop the Register, and populate it to help you identify patients who would benefit from a palliative care approach. • Once identified, activate a palliative care approach (See Resource 1).
Who?	• Clinic doc(s), nurses and EMR manager, admin staff. • Identify someone responsible for each of the tasks listed above.
When?	Team decides timelines and milestones for each of the tasks. Ensure input from practice.
Where?	Practice decides: One clinician starts, or group (e.g. team), or whole practice.
What should we anticipate?	Predictions. E.g. Some challenges, depending on the EMR (or paper-based filing), incorporating a code or flagging mechanism. May need additional IT help and resources.
Enablers & barriers?	Who and what? Team identifies. Identify strategies to harness or mitigate.

Data collection

(See Resource 10)

Answer the same questions as above (see Resource 10 for ideas).

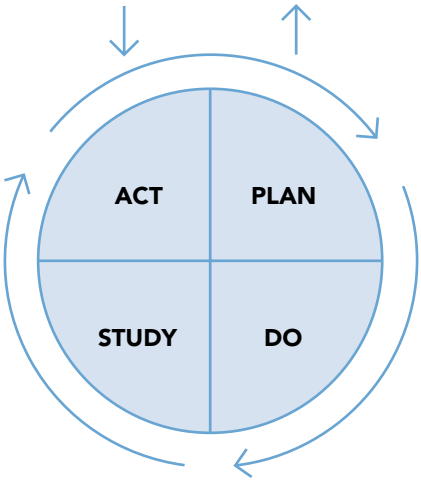
Develop a Project Charter

(See Resource 11)

WHAT ARE WE TRYING TO ACCOMPLISH?

HOW WILL WE KNOW IT IS AN IMPROVEMENT?

WHAT CHANGES CAN WE MAKE?



IF ADAPT, REPEAT PDSA CYCLE

IF ADOPT, PROCEED TO STEP 9 ON NEXT PAGE

TIPS

- Sometimes more than one PDSA cycles are needed.
- Make small changes and tweaks after each cycle and test.

STEP 6: DO (D)

- Implement your plan, pilot the change.
- Observe and keep notes.
- Collect data (keep it simple, this is not research).
- Bring to regular QI huddles of team (10–15 minutes minutes to discuss progress and problem solve).
- Start analyzing.

STEP 7: STUDY (S)

- Complete the analysis.
- Compare the data to predictions.
- Summarize what you learned.
- Keep the whole team informed with periodic reporting of the results as they come in.

STEP 8: ACT (A)

- **ADOPT**, **ADAPT** or **ABANDON**.
- **ADOPT**: Proceed to Step 9.
- **ADAPT**: Make a small tweak or a big change and repeat the PDSA cycle.
- **ABANDON**: Do not proceed further with implementing this change idea. Determine learning from attempting to implement it.
- Let the team know the results of the PDSA cycle.
- Highlight the first wins.

STEP 9: CELEBRATE

STEP 10: SUSTAIN

- Plan for sustainability from the outset.
  - Strategies include forced functions like using your EMR for periodic monitoring and reporting of performance (e.g. periodic audit charts).
- What will help sustainability:
  - Periodic reminders (email or mention at team meetings monthly or quarterly).
  - Mentions at QI huddles.
  - Periodic monitoring (quick audit or check sheet).
  - Periodic reporting.
- **CELEBRATE** the Improvement's birthday every year!

TIPS

- Sustainability is achieved when new ways of working and improved outcomes become the norm ... and stay the norm!
- But we are only human and slippage can occur … so keep working at it.

SHARE YOUR QI LEARNINGS (SUCCESSES OR FAILURES)

- When an improvement has successfully been made, **CELEBRATE**.
- Find a fun way to announce the achievement and to celebrate it. Thank all involved, and pat yourselves and on the back.

Share your story and learning with others

- The lessons we learned are important, whether one succeeds, fails, or continues to try.
- Share your QI work with Pallium and consider joining the **Palliative Care Quality Improvement Community of Practice**.

GET CME CREDITS

- Physicians can submit their QI work to the College of Family Physicians of Canada (Linking Learning to Practice) for credits.

Resources for this QUIC

RESOURCE 1: A PALLIATIVE CARE APPROACH

- The palliative care approach refers to palliative care provided by non-palliative care specialists like family physicians and other primary care providers.[5,6] It requires some core competencies that can be acquired with education programs such as Pallium's **LEAP courses**.
- A palliative care approach consists of the following tasks:
  - **Identify**
    - Identify patients early who may benefit from palliative care
  - **Assess**
    - Their understanding of the illness and information needs
    - Symptoms
    - Psychosocial and spiritual needs
    - Quality of life
    - Values, wishes, preferences
  - **Plan**
    - Advance care planning (even when people are well)
    - Goals of care and care plans
    - Treatment plans
    - Link to resources and other care providers
    - Review treatments and medications
    - Prepare for emergencies
  - **Manage**
    - Symptoms
    - Psychosocial and spiritual needs
    - Essential discussions
    - Refer for assistance as needed
    - It requires competency and compassionate care
    - Review current treatment medications to ensure patient receives optimal care
    - Consider referral to specialist palliative care team if needs are complex and difficult to manage
  - See **OPCN's Palliative Care Toolkit**
  - See **BC Palliative Care Centre's Palliative Care Symptom Kits**

RESOURCE 2: THE SURPRISE QUESTION

- For any patient with a serious illness, ask "Would I be surprised if this patient died within the next 6–12 months?" If the answer to the question is "No", then a palliative care approach should be activated if it has not yet been activated.
- Lynn and colleagues in the USA introduced this simple question to promote initiating a palliative care approach early.[9] It was designed simply to challenge us to think of it early. It was never designed to be used as a prognostic tool.
- It recognizes that prognostication is not accurate, but it does value the clinical indicators that serve to provide warnings that a person's life expectancy may be shorter than a year (or even shorter). Use a tool like the Supportive and Palliative Care Indicators Tool (SPICT) to help with prognostication. (See Resource 3).
- Studies have shown it to be useful across cancer and non-cancer diagnoses.[10,11]
- The Gold Standards Framework (GSF) in the United Kingdom, and the World Health Organization demonstration centre in Catalonia (NECPAL tool), have adopted the Surprise Question.[8]
- Some argue that the Surprise Question is not useful in cancer and non-cancer populations.[12] However, these studies assessed the Surprise Question on its ability to prognosticate. This is much like asking "How effective is an airplane as a submarine?". An airplane was never designed to be a submarine. Similarly, the Surprise Question was never designed to a prognostic tool per se. It is simply a tool that requires us to think differently about palliative care and not solely for the last weeks or days of life. Furthermore, palliative care is not limited to the last year of life. Many patients benefit from it much earlier.
- It should not be used as a referral tool for specialist palliative care. Many patients do not require the services of a specialist team, but simply a palliative care approach.
- The Surprise Question should not be used in isolation. Its use requires broader clinical assessment. The Surprise Question can be supplemented with clinical criteria that help with prognostication such as the Supportive and Palliative Care Indicators Tool (SPICT). (See Resource 3)

RESOURCE 3: TOOLS TO IDENTIFY PATIENTS WITH PALLIATIVE CARE NEEDS

Prognostication Tools

- There are many prognostication tools that try to inform estimations of life expectancy (See the **Pallium Palliative Pocketbook** for a summary of these and the **OPCN tools to support earlier identification for palliative care**).
- All tools have their respective pros, cons, and limitations. In this QUIC, we are promoting the use of the SPICT. Some of the others are summarized here as an FYI.

SPICT (Recommended): Supportive and Palliative Care Indicators Tool

- Derived from the Gold Standards Framework (GSF) prognostication tool (UK).
- Consists of a single page that includes general (i.e. weight loss, hospital admissions, etc.) and broad specific disease indicators (i.e. breathlessness at rest for heart and respiratory disease).
- Includes an assessment approach.
- Can be applied across all care settings.
- Not disease specific.
- There is **website** that supports its use.

HOMR: Hospital One-year Mortality Risk

- The goal is to predict 12-month mortality.
- It is an automated tool that uses administrative data (i.e. admitting service, arrival by ambulance, readmission, Charlson Comorbidity index score, etc.) to calculate mortality risk at 12-months after an acute admission, and sends a notification for all patients whose risk exceeds a preset threshold.
- Applicable only in acute care settings (so not applicable for this QUIC).
- Not disease specific.

RESPECT: Risk Evaluation for Support: Predictions for Elder-life in the Community Tool

- A newly developed electronic prognostic algorithm.
- Currently in process of research validation and community-based evaluation in Ontario.
- The aim is to improve identification of individuals who are frail (i.e., need long-term support) but are not necessarily in the last year of life.
- It uses a wider range of predictors — routinely collected in the home care setting — to determine the survival of low-risk and high-risk community-based individuals.
- It can be used to support clinical judgement and care planning.
- Since it uses data routinely collected in home care, it can be used to identify all individuals within home care populations who are at risk of clinical decline and may benefit from palliative care.
- It is a web-based tool that asks questions that can be readily self-reported by individuals.
- It can be used either by the patients themselves or supported by clinicians.
- **See Project Big Life Elder Care Calculator here.**

NECPAL: NECesidades PALiativas Centro Colaborador de la Organización Mundial de la Salud

- Developed in Spain and being used increasingly across Europe.
- The aim is to identify patients with limited life prognosis (less than 1 year) who may benefit from palliative care.
- It is a 1– to 2–page checklist that starts with the surprise question and uses yes/no questions (patient or family request or need for PC; general clinical indicators of severity and progression, including co-morbidity, resource use; and disease-specific indicators).
- It may require some data that may not be readily available in all settings.
- It is generally applicable across care settings.
- **See the checklist version of the NECPAL tool**.

RESOURCE 4: CONFIRMING THE NEED

Chart Audit

If you have an EMR

- Use codes or key words that are searchable in your EMR related to the Surprise Question and SPICT criteria. Retrieve 10 charts to review.
- Look for evidence that the patient has been formally flagged as "palliative" or requires a palliative care approach.
- Look for evidence that a palliative care approach has been activated (See Resource Section).
- Use the results to confirm or exclude an improvement opportunity.

If you do not have an EMR (cross sectional approach)

- Think of patients whom you know in your practice who may meet the Surprise Question and SPICT criteria. Retrieve up to 10 such charts (Relationship approach).
- Count how many of these have been formally flagged as "palliative" and for how many have you activated a palliative care approach. (See Resource Section).
- Use the results to confirm or exclude an improvement opportunity.

Check Sheet (prospective)

- Prepare a simple check sheet (paper-based, word document or excel document).
- Include the following columns: 1) file #, 2) Diagnosis, 3) Meets Surprise or SPICT criteria (YES/NO), 4) Already identified as "Palliative" in chart (YES/NO), 5) GoC documented (YES/NO). Ensure you chart that you have had ACP discussions, including SDM identified.
- For every patient with a serious and/or advanced illness that you see over the next one or two months (determine a time frame that is most realistic), add them to the list and complete the columns.
- Use the results to confirm or exclude an improvement opportunity.

Case Reflections

- Reflect on a case, or some cases, of patient(s) in your practice with serious illnesses whose end-of-life care could have been better.
- Using a patient safety approach, review the cases and reflect if early palliative care would have made a difference. Use these cases to inform the improvement opportunity.

RESOURCE 5: CHART AUDIT

Example

- Select a disease group (e.g., **advanced heart disease**).
- **See the SPICT indicators for this group:**
  - General indicators (2 or more):
    - Poor performance status and deteriorating (needs help with personal care, in bed or chair for 50% or more of the time).
    - 2 or more unplanned hospital admissions in the past 6 months.
    - Weight loss (5–10%) over past 3–6 months.
    - Persistent troublesome symptoms.
  - Specific indicators:
    - NYHA Class III/IV heart failure or extensive, untreatable coronary artery disease.
- **If you have an EMR:** Identify codes or words that will help you identify patients that meet these criteria (See eHealth Centre of Excellence Toolkit resource below. Consider adopting their tool and approaches.)

RESOURCE 6: ROOT CAUSE ANALYSIS

- When undertaking QI work, one must understand what the improvement opportunity is, including the root causes of the problem at hand.
- A number of simple tools are available to help diagnose and understand the problem(s) and its contributing factors better. These include:
  - Fishbone diagrams
  - The 5 Whys
  - Process Mapping

RESOURCE 7A: WHAT ARE THE ELEMENTS OF A GOOD AIM STATEMENT?

SMART

- **S**pecific
- **M**easurable
- **A**ctionable
- **R**elevant
- **T**imebound

RESOURCE 7B: MEASURES TO TRACK (IDEAS)

Measures

(Examples. Develop further to best suit your practice)

- **Outcomes Measures** (So what?):
  - Patients feel informed and aware of care choices
  - Patients feel they are receiving whole person care
  - Patients' symptoms are managed
- **Process Measures**
  (Are we doing the right thing?)
  - Use of Surprise Question plus a tools such as SPICT in all patients with serious illnesses.
  - Every patient that meets the Surprise and/or SPICT criteria is flagged as "palliative" or "Supportive Care").
  - Advance care planning and goals of care discussions occur and charted.
  - Symptoms are assessed (e.g., ESAS) and charted. (See QUIC ESAS).
- **Balance Measures (Are there unintended consequences?)**
  - Patients distressed about receiving "palliative care" or "Support Care" or "Supportive and Palliative Care."
  - Provider distress about starting palliative care.
  - Identifying patients in EMR adds considerable effort and work.
  - The Palliative Care Register is being used.

RESOURCE 8: WHAT SHOULD WE ANTICIPATE?

- Pushback about using the Surprise Question. (See "Toolbox" for response.)
- Pushback about using the SPICT tool (See "Toolbox" for response).
- Concerns that initiating a palliative care approach early will cause patient distress. Responses are:
  - Research shows the contrary.
  - We don't have to say "we are starting palliative care". We can initiate a palliative care approach, without having to say it, because it is just good competent and compassionate care.
  - In a UK program, the term "anticipatory care" was used.[7] However, when it is very clear that the main focus of care is palliative care, then the term "palliative" should be used, accompanied by an explanation of it. A similar project in primary care practices in Scotland found that physicians preferred to allocate patients into 4 "categories":
    a) "Definitely not palliative"
    b) "early palliative care which they preferred to refer to as "Anticipatory Care"
    c) "Would benefit from palliative care but I can't intervene"
    d) "Definitely palliative".[7]
- Pushback because once identified, all patients need to be referred to a specialist palliative care physician, nurse or team. Responses are:
  - Not all identified patients have to be referred to a palliative care specialist or team. With core competencies, all health care professionals can initiate a palliative care approach (e.g. LEAP course training). Refer only when complex or if you need advice.
- Pushback because staff don't know what to do once a patient is identified (don't have the skills or have not usually provided palliative care). Responses are:
  - We can initiate a palliative care approach ourselves. If we feel we don't have the skills, we could do a LEAP course for the whole team, or LEAP Online modules.
  - If complex case, we could consult a palliative care team for advice.

RESOURCE 9: EHEALTH CENTRE OF EXCELLENCE TOOLKIT

The eHealth Centre of Excellence has developed approaches and algorithms to help you **identify patients requiring a palliative care approach using a practice's EMR**.

RESOURCE 10: HOW WILL WE COLLECT AND REPORT THE DATA

- There are different ways to collect, monitor and report the data. This includes, among others, run charts, check sheets and graphs.
- See the following Guides for examples:
- HQO Quality Improvement Guide
- TOP Alberta QI Guide
- IHI QI Essentials Toolkit
- BC Patient Safety and Quality Council EPIQ Resources

RESOURCE 11: PROJECT CHARTERS AND PDSA FORMS: TEMPLATES

- HQO Quality Improvement Guide Project Charter
- IHI QI Project Charter Template
- TOP Alberta Project Charter

USEFUL CLINICAL PALLIATIVE CARE RESOURCES RELATED TO THIS QUIC

- Ontario Palliative Care Network (OPCN); Tools to support earlier identification for palliative care
- Ontario Palliative Care Network (OPCN); OPCN Palliative Care Toolkit (including the palliative care approach)

PALLIATIVE CARE-SPECIFIC QUALITY IMPROVEMENT (QI) RESOURCES

- OPCN and Ontario Health Quality Improvement COP
- IHI QI resources

GENERAL QUALITY IMPROVEMENT RESOURCES

- HQO Quality Improvement
- Quality Improvement Plan Guidance
- IHI QI Essentials Toolkit
- TOP Alberta Quality Improvement Guide
- BC Patient Safety and Quality Council Sharpen Your Skills
- Engaging People in Quality — EPIQ

REFERENCES

1. Davis MP, Temel JS, Balboni T, Glare P. A review of the trials which examine early integration of outpatient and home palliative care for patients with serious illnesses. **Ann Palliat Med** 2015;4(3):99-121. doi: 10.3978/j.issn.2224-5820.2015.04.04
2. 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;363:733-42.
3. Greer JA, Pirl WF, Jackson VA, et al. Effect of early palliative care on chemotherapy use and end-of-life care in patients with metastatic non-small-cell lung cancer. **J Clin Oncol** 2012;30:394-400.
4. Pirl WF, Greer JA, Traeger L, et al. Depression and survival in metastatic non-small-cell lung cancer: effects of early palliative care. **J Clin Oncol** 2012;30:1310-
5. Shadd JD, Burge F, Stajduhar KI, Cohen SR, Kelley M Lou, Pesut B. Defining and measuring a palliative approach in primary care. **Canadian Family Physician**. 2013 ;59(11):1149–50
6. Sawatzky R, Porterfield P, Lee J, Dixon D, Lounsbury K, Pesut B, et al. Conceptual foundations of a palliative approach: a knowledge synthesis. **BMC Palliative Care**. 2016 Dec 15; 15(1):5.
7. Mason B, et al. Computer screening for palliative care needs in primary care: A mixed-methods Study. **Br J Gen Pract** 2018;3361 DOI: https://doi.org/10.3399/bjgp18X695729
8. Dale et al. **Qual Saf Health Care** 2009,18:174-180
9. Lynn J, et al. Quality improvements in end-of-life care: Insights from two collaboratives. **Joint Commission Journal on Quality and Patient Safety** 2000; 26(5):254-267
10. Moroni M, et al. The 'surprise' question in advanced cancer patients: A prospective study among general practitioners. **Palliat Med** 2014; 28(7):959-964]
11. Murray SA, Boyd K. Using the "surprise question" can identify people with advanced heart failure and COPD who would benefit from a palliative care approach. **Pall Med** 2011;25(4):382]
12. Downar J, Goldman R, Pinto, R, et al. The "surprise question" for predicting death in seriously ill patients: a systematic review and met-analysis. **CMAJ**. 2017 Apr 3;189(13):E484-E493. doi: 10.1503/cmaj.160775.

FUNDING

Health Canada Santé Canada

Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.