undermine their impact. Consideration of systemic drivers of high-intensity care should be incorporated into palliative care interventions.

Effect of a Collaborative Palliative Care Intervention vs Usual Care on Quality of Life of Patients with Symptomatic Heart and Lung Diseases: A Randomized Clinical Trial (CO202A)

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Outcomes.

1. Propose a primary palliative care approach to improve quality of life in chronic obstructive pulmonary disease and chronic heart failure

2. Compare quality of life outcomes from a randomized clinical trial of a primary palliative care intervention

Importance. Patients with heart failure (HF), chronic obstructive pulmonary disease (COPD), and interstitial lung disease (ILD) endure poor quality of life (QOL) despite conventional therapy.

Objective(s). Determine whether a collaborative palliative care intervention improves QOL in outpatients with HF, COPD, or ILD compared to usual care.

Method(s). We conducted a single-blind, 2-arm, multisite randomized clinical trial within 2 VA health care systems. We included outpatients with HF, COPD, and ILD at high risk of hospitalization or death who reported poor QOL. The intervention included symptom care provided by a nurse and psychosocial care provided by a social worker. The nurse and social worker met weekly with a study primary care and palliative care physician, pulmonologist, and cardiologist. The primary outcome was difference in change in QOL from baseline to 6 months between intervention and usual care (FACT-G score, range 0-100, higher score better, clinically meaningful change ~4-6 points). Analysis used the intent-to-treat approach and mixed models.

Results. A total of 306 patients were enrolled (154 intervention, 152 usual care). Participants were generally male (90.2%), White (80.1%), with a mean age of 68.9 (SD 7.7) years; 57.8% had COPD, 21.9% HF, 16% both COPD/HF, 4.2% ILD. Baseline FACT-G scores were similar (intervention, 52.9; usual care, 52.7). FACT-G completion was 76% at 6 months for both intervention and usual care groups. In the intervention arm, 112/154 (73%) patients completed the planned intervention. At 6 months, mean FACT-G score improved by 6.0 points in the intervention arm and 1.4 points in the usual care arm (difference, 4.6; 95% CI 1.8, 7.4; $p = 0.001$; standardized effect size [ES], 0.41). This effect was observed at all time points (4-month ES 0.30, $p = 0.02$; 12-month ES 0.36, $p = 0.007$).

Conclusion(s). A collaborative palliative care intervention demonstrated early, persistent, clinically meaningful improvements in QOL for high-risk outpatients with heart and lung diseases.

Impact. A team primary palliative care approach increased the reach of palliative care for common, serious noncancer illnesses.

Racial Disparities in Advance Care Planning and Palliative Care Consultation in Kidney Transplant Candidates and Recipients (CO202B)

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Outcomes.

1. Discuss the state of the science on advance care planning and palliative care consultation in kidney transplant candidates and recipients

2. Describe the prevalence and racial and ethnic disparities of advance care planning and palliative care consultation in kidney transplant candidates and recipients

3. Propose solutions and interventions for the racial disparities and low prevalence of advance care planning and palliative care consultation among kidney transplant candidates and recipients

Importance. Among patients listed for kidney transplant (KT), 27% die or are removed from the waitlist. Many KT recipients will need another transplant in their lifetime; therefore, both candidates and recipients experience high mortality and symptom burden. These patients could benefit from palliative care (PC) and advance care planning (ACP), but it is unclear how many and which patients receive ACP and PC.

Objective. To estimate prevalence of ACP and PC by age and race among adult KT candidates and recipients.