Kaiser Permanente Research

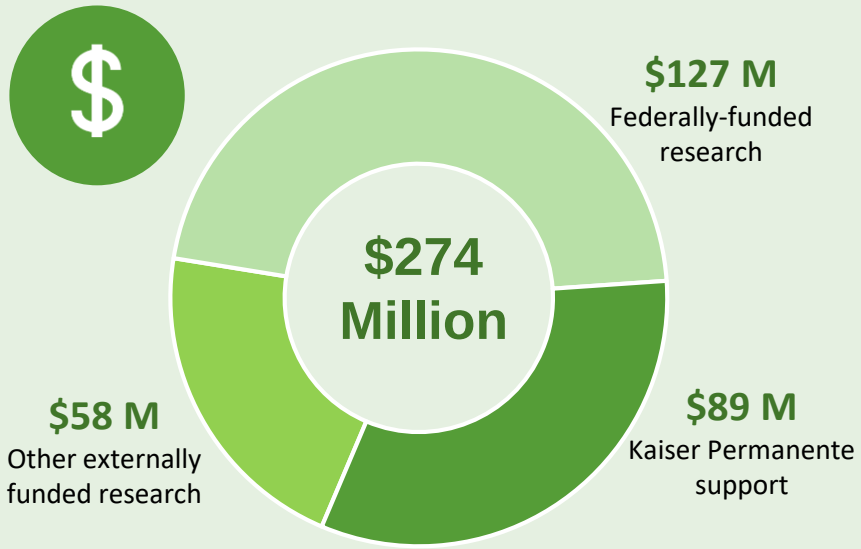
Kaiser Permanente Research During COVID

Elizabeth A. McGlynn, PhD
Vice President, Kaiser Permanente Research
Interim Senior Associate Dean for Research & Scholarship
Kaiser Permanente Bernard J. Tyson School of Medicine

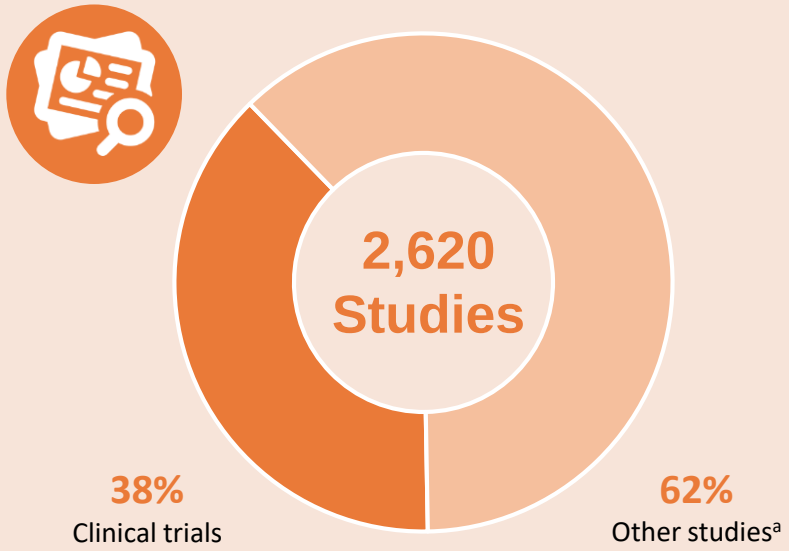
Kaiser Permanente International
Fireside Chat — September 22, 2020

Kaiser Permanente Research Fast Facts, 2019

Funding in 2019[a]



Research Studies Underway in 2019



Research Personnel[a]

80 Full-time research leaders **&** **1,670** Research support staff

Research Publications

1,890 Journal articles published in 2019 **&** **19,020** Articles total since 2000[b]

[a]Refers to the 8 regional research centers
[b]Refers to total count of articles in the Kaiser Permanente Publications Library available at https://kpresearchpublications.kp.org/

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Kaiser Permanente is Engaged in Research on SARS-CoV-2, COVID

Existing research teams and infrastructure enabled rapid engagement

- Clinical trials
  - Vaccine candidates
  - New or repurposed treatments
- Operational input
  - Surge planning
  - Changes in telehealth use
  - Tracking disparities, outcomes
- Observational studies
  - Understanding risk factors for COVID
  - Examining changes in care for other conditions

Clinical Trials Undertaken in Vaccines & Treatments

KP has been engaged in multiple vaccine and treatment trials

Vaccine Trials

- NIAID/Moderna
  - Phase 1 trial started March 16, 2020 at KPWA
    - Preliminary report in *NEJM* on July 14, 2020 found vaccine was well tolerated and generated an immune response
  - Phase 1 trial extended to older adults starting April 16, 2020
  - Phase 3 trial started in July 2020
- Pfizer/BioNTech
  - Phase 3 trial started in August 2020
  - 3 regions engaged: KPNC, KPSC, KPNW
- Ongoing discussions around other potential vaccine trials

Treatment Trials (selected)

- NIAID/Gilead/Remdesivir
  - Phase 3 trial started on March 22, 2020 in KPSC for patients with moderate or severe disease
  - KPNC joined the trial later; other regions participated through contract hospitals
- NIAID ACTT2 (Remdesivir + Baricitinib)
  - Started June 22 in KPNW
  - Inhibit cytokine inflammatory response
- Selinexor
  - KPNC trial; testing anti-inflammatory response in patients hospitalized with moderate to severe COVID-19
- MITIGATE COVID-19
  - KPNC patients with atherosclerotic cardiovascular disease with no prior history of COVID-19; studying effect on rate of moderate to severe upper respiratory tract infection

We've Published on a Variety of COVID-Related Topics (A Sampler)

RESEARCH

OPEN ACCESS

Check for updates

FAST TRACK

Incidence, clinical outcomes, and transmission dynamics of severe coronavirus disease 2019 in California and Washington: prospective cohort study

Joseph A Lewnard,[1,2,3] Vincent X Liu,[4] Michael L Jackson,[5] Mark A Schmidt,[6] Britta L Jewell,[7,8] Jean P Flores,[9] Chris Jentz,[9] Graham R Northrup,[3] Ayesha Mahmud,[10] Arthur L Reingold,[1] Maya Petersen,[1] Nicholas P Jewell,[1,11] Scott Young,[9,12] Jim Bellows[9]

For numbered affiliations see

ABSTRACT

100 000 cohort members in northern California, 23.3

Morbidity and Mortality Weekly Report

Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020

Jeanne M. Santoli, MD[1]; Megan C. Lindley, MPH[1]; Malini B. DeSilva, MD[2]; Elyse O. Kharbanda, MD[2]; Matthew F. Daley, MD[3]; Lisa Galloway[1]; Julianne Gee, MPH[4]; Mick Glover[5]; Ben Herring[6]; Yoonjae Kang, MPH[1]; Paul Lucas, MS[1]; Cameron Noblit, MPH[1]; Jeanne Tropper, MPH, MS, MBA[1]; Tara Vogt, PhD[1]; Eric Weintraub, MPH[4]

THE ORTHOPAEDIC FORUM

Orthopaedic Systems Response to and Return from the COVID-19 Pandemic

Lessons for Future Crisis Management

Ronald A. Navarro, MD, Nithin C. Reddy, MD, Jennifer M. Weiss, MD, Adolph J. Yates Jr., MD, Freddie H. Fu, MD, Michael McKee, MD, FRCS(C), and Evan S. Lederman, MD

editorials

Telehealth in Oncology During the COVID-19 Outbreak: Bringing the House Call Back Virtually

Raymond Liu, MD[1]; Tilak Sundaresan, MD[1]; Mary E. Reed, DrPH[2]; Julia R. Trosman, PhD[3,4]; Christine B. Weldon, MBA[3,4]; and Tatjana Kolevska, MD[5]

San Diego, Kaiser Permanente ia; the University of Arizona

alth-care issue of this epartments enacted a ems' response to the care systems.

Introduction

The coronavirus disease 2019 (COVID-19) pandemic is disproportionately affecting patients with cancer and is threatening the health and availability of the oncology workforce.[1] Social distancing is required to reduce the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2),[2] and telehealth is a key strategy to continue delivery of life-saving cancer care while protecting vulnerable oncology patients and providers alike.[3] Telehealth uses digital and telecommunications tools—including telephone, secure messages, and video technology—to manage patient care, health-related education, public health, and health administration.[4] Recent changes in reimbursement have removed some traditional changes in oncology care delivery, entrenching telehealth as an integral component of cancer care.

Deploying Patient-Provider Telehealth Along the Oncology Care Continuum

When preparing to rapidly implement or expand oncology telehealth, two aspects should be considered along the oncology care continuum: (1) which key points of the patient-provider interaction can be transitioned to a virtual setting, and (2) which key services could be delivered virtually. Table 1 summarizes key patient encounters and services conducive to telehealth, and here we describe them in the context of the cancer care continuum.

Annals of Internal Medicine

ORIGINAL RESEARCH

Obesity and Mortality Among Patients Diagnosed With COVID-19: Results From an Integrated Health Care Organization

Sara Y. Tartof, PhD, MPH; Lei Qian, PhD, MS; Vennis Hong, MPH; Rong Wei, MA; Ron F. Nadjafi, MD, MS; Heidi Fischer, PhD, MS; Zhuoxin Li, MS; Sally F. Shaw, DrPH, MPH; Susan L. Caparosa, MA; Claudia L. Nau, PhD, MA; Tanmai Saxena, MD, PhD; Gunter K. Rieg, MD; Bradley K. Ackerson, MD; Adam L. Sharp, MD, MSc; Jacek Skarbinski, MD; Tej K. Naik, MD; and Sameer B. Murali, MD

Background: Obesity, race/ethnicity, and other correlated characteristics have emerged as high-profile risk factors for adverse coronavirus disease 2019 (COVID-19)-associated outcomes, yet studies have not adequately disentangled their effects.

Objective: To determine the adjusted effect of body mass index (BMI), associated comorbidities, time, neighborhood-level sociodemographic factors, and other factors on risk for death due to COVID-19.

Design: Retrospective cohort study.

patients with a BMI of 18.5 to 24 kg/m^2, those with BMIs of 40 to 44 kg/m^2 and greater than 45 kg/m^2 had relative risks of 2.68 (95% CI, 1.43 to 5.04) and 4.18 (CI, 2.12 to 8.26), respectively. This risk was most striking among those aged 60 years or younger and men. Increased risk for death associated with Black or Latino race/ethnicity or other sociodemographic characteristics was not detected.

Limitation: Deaths occurring outside a health care setting and not captured in membership files may have been missed.

VIEWPOINT

From Containment to Mitigation of COVID-19 in the US

Stephen M. Parodi, MD
The Permanente Medical Group, Kaiser Permanente, Oakland, California; and The Permanente Federation, Oakland, California.

Coronavirus disease 2019 (COVID-19) is a respiratory illness that results from severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection.[1] Following initial reports of disease outbreak in China, COVID-19 has spread worldwide with cases identified in at least 67 countries across 6 continents.[2] On March 2, California Governor Gavin Newsom announced $20 million in

cal care or evaluation.[1,5] Eighty percent of patients infected with SARS-CoV-2 have minimal or mild symptoms.[2] Combining these characteristics and the emergence of community transmission, it is likely that silent spread has already occurred in multiple US locales. As a result, COVID-19 containment is no longer realistic and further emphasis on containment strategies may have the unintended consequence of hampering effective health care y for patients infected with COVID-19 and others equire general hospital care. At Kaiser Permaemergency management and preparedness teams used on developing a COVID-19 mitigation protable) based on good clinical practice, available evi- and past experience. Whether this program will efly achieve mitigation remains unknown.
ithin acute care settings, the focus will be on mini- disease transmission. Because SARS-CoV-2 is itted primarily by droplets, the proposed plan will n ensuring that reliable droplet precautions are Personal protective equipment will include the

CORRESPONDENCE

The Covid-19 Pandemic and the Incidence of Acute Myocardial Infarction

International Journal of Infectious Diseases 99 (2020) xxx–xxx

Contents lists available at ScienceDirect

International Journal of Infectious Diseases

journal homepage: www.elsevier.com/locate/ijid

ELSEVIER

INTERNATIONAL SOCIETY FOR INFECTIOUS DISEASES

Early identification of COVID-19 cytokine storm and treatment with anakinra or tocilizumab

Check for updates

Annette Langer-Gould[a,*], Jessica B. Smith[b], Edlin G. Gonzales[b], Rhina D. Castillo[c], Judith Garza Figueroa[d], Anusha Ramanathan[e], Bonnie H. Li[b], Michael K. Gould[b,f]

[a] Los Angeles Medical Center, Department of Neurology, Southern California Permanente Medical Group, 1505 N Edgemont, 5thFloor, Los Angeles, CA 90027, USA
[b] Department of Research & Evaluation, Southern California Permanente Medical Group, 100 S Los Robles Avenue, Pasadena, CA 91101, USA
[c] Orange County Medical Center, Department of Pediatric Rheumatology, Southern California Permanente Medical Group, 2521 Michelle Drive, Tustin, CA 92780, USA
[d] Los Angeles Medical Center, Department of Pediatric Rheumatology, Southern California Permanente Medical Group, 4700 W Sunset Blvd, Los Angeles, CA 90027, USA
[e] Downey Medical Center, Department of Pediatric Rheumatology, Southern California Permanente Medical Group, 9449 E Imperial Hwy, Downey, CA 90242, USA
[f] Kaiser Permanente Bernard J. Tyson School of Medicine, 98 S Los Robles Avenue, Pasadena, CA 91101, USA

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Kaiser Permanente Colorado Region CARING Conversations

Innovation during COVID-19

Meri Nomi
Care Management Institute

September 22, 2020

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CARING Conversations | Proactive Outreach to Elderly and Seriously Ill Patients

Proactive outreach goals of care conversations by Primary Care Physicians, Physician Assistants, RNs, LCSWs, & others with just-in-time training

Target outreach population includes > age 70 with a significant burden of underlying chronic disease, & other high-risk patients as appropriate

Support includes assistance with Advance Care Planning (ACP), social non-medical needs, behavioral health, pharmacy, and Supportive (Palliative) Care services

C	**C**heck In
A	**A**ssess need for information or support
R	**R**eview prior ACP / identify decision maker
I	**I**dentify what matters most and preferences for care
N	**N**ote recommendations and decisions in problem list
G	**G**ive thanks and reaffirm your commitment to their care

CARING Conversations | Data, Member and Provider Experience

6000+ CARING Conversations completed from April 8, 2020 through May 31, 2020

96% of CARING Conversations resulted in verbal designation of decision maker

Insights from Member and Provider Interviews

Members were thinking about their goals and values and were grateful for the conversation.

Having a caring, welcoming, thoughtful demeanor was important for the connection to be made and the conversation to be successful.

Providers managed their anxiety and found these goals of care conversations to be some of the most rewarding work of their medical careers.

To do this well, providers need dedicated time in their schedules and an easy process to have these conversations.

Providers understand the effort to know, respect and guide patients is an important part of honoring patient wishes.

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CARING Conversations | Success Factors

CARING Conversations required minimal investment for training and are an excellent example of sustainable quality, experience & service.

Document in consistent place in the EMR and write the order

Provide time in the workflow for conversations

Heads up to member that provider is going to call
- Schedule the call with member

Have a **separate conversation** just **focused on goals of care** and periodically update and **continue** the conversation

Telephone calls make it easy for provider to read from script

Use an **App** - number recognizable as KP

Have a **simple process** to make it easy
- Generate outreach list
- Technology in place – concentrate on conversation
- Script provides framework for conversations

Team up with others to **exchange ideas**
- What went well, what didn't go so well
- How to handle awkward moments

Kaiser Permanente Equitable Care Initiatives
A presentation to KP International

Nicole Barnett, DHSc, MBA, RN, CNL

Regional Director Nursing and Clinical Practice

Living in a “Dual Pandemic”

- Systemic Racism
- Covid-19

We were founded on delivering equitable care and inclusion for all

- In the 1940s, Sidney Garfield, MD and Henry Kaiser committed to building a unique health care system that would deliver the highest standard of care and be accessible to everyone without discrimination.
- This was a bold approach at a time of rampant racial segregation and gender inequities in America.

California ranks the most diverse state in 2019 on the factors of socio-economic diversity, cultural diversity, economic diversity, household diversity, religious and political diversity.

We care for a significant portion of all Northern California residents

PATIENTS

Making sure that the care that we deliver is culturally informed and promotes health equity

PEOPLE

Creating work environments that respect the unique backgrounds and experiences of our staff and physicians

COMMUNITY

Structuring community relationships and engagement opportunities that are data informed and address areas of inequity

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An educational subsidiary for global impact

#KPIHE2020