**Multicenter Perioperative Outcomes Group (MPOG)**
**PCRC Meeting Notes – Monday, March 9, 2015**

**Attendees: P=Present; A=Absent; X=Expected Absence**

| **Active PIs** | | **In Progress PIs Continued** | |
|---|---|---|---|
| **P** | Arbi 'Ben' Abdallah – Wash U | **A** | Brian Bateman, MD - MGH |
| **P** | Michael Avidan, MD - Wash U | **A** | Matthias Eikermann, MD - MGH |
| **A** | Michael Aziz, MD - OHSU | **A** | Bassam Kadry, MD - Stanford |
| **A** | Mitchell Berman, MD - Columbia | **A** | Fabian Kooij, MD – AMC Amsterdam |
| **P** | Daniel Biggs, MD – Oklahoma | **P** | Warren Levy, MD – Pennsylvania |
| **A** | Randal Blank, MD - Virginia | **A** | Philip Lirk, MD – AMC Amsterdam |
| **A** | Robert Craft, MD –Tennessee | **A** | Marco Navetta, MD – Santa Barbara Cottage |
| **A** | Douglas Colquhoun, MD –Virginia | **P** | Jonathan Pablate, CRNA – Florida Jacksonville |
| **A** | Jurgen de Graaff MD – Utrecht | **A** | David Robinowitz, MD - UCSF |
| **A** | Karen Domino, MD, MPH – U of Washington | **P** | Leif Saager, MD – Cleveland Clinic |
| **A** | Marcel Durieux, MD, PhD- Virginia | **P** | Robert Schonberger, MD - Yale |
| **A** | Jerry Epps, MD - Tennessee | **P** | Anshuman Sharma, MD – Wash U |
| **P** | Jesse Ehrenfeld, MD - Vanderbilt | **A** | Scott Springman, MD – Wisconsin |
| **A** | Ana Fernandez-Bustamente, MD - Colorado | **Chairs** | |
| **A** | Peter Fleishut, MD – Weill-Cornell | **A** | David C. Adams, MD - Vermont |
| **A** | Alexander Friend, MD –Vermont | **A** | Jerry Epps, MD – Tennessee |
| **A** | Daniel Helsten, MD – Wash U | **A** | Timothy Morey, MD - Florida |
| **P** | Leslie Jameson, MD - Colorado | **P** | Kevin Tremper, PhD, MD - Michigan |
| **P** | Sachin Kheterpal, MD - Michigan | **A** | Warren Sandberg, MD, PhD – Vanderbilt |
| **P** | Kai Kuck, MD - Utah | **A** | Wilton van Klei, MD – Utrecht |
| **A** | Karen Nanji, MD - MGH | **MPOG** | |
| **A** | Bala Nair, PhD – U of Washington | **X** | Mark Dehring |
| **P** | Nathan Pace, MD – Utah | **P** | Genevieve Bell |
| **A** | William Paganelli, MD – Vermont | **P** | Shelley Housey, MS |
| **P** | W. Pasma - Utrecht | **P** | Tory Lacca, MBA |
| **A** | Kelley Smith, MD – Utah | **P** | Nirav Shah, MD |
| **A** | Wilton van Klei, MD – Utrecht | **P** | Amy Shanks, MS, PhDc |
| **A** | Jonathan Wanderer, MD - Vanderbilt | **P** | Tyler Tremper |
| **A** | Kevin Wethington, MD - Utah | **P** | John Vandervest |

**Ground Rules for PCRC:**

1. Each protocol must have specific testable hypothesis with data available in MPOG data structure
2. People requesting specific data elements must also supply that data type to MPOG. If you don't submit that data type currently, then you can't get that type of data type out. However, if you have a co-investigator from another site that does supply that data, then you can ask for that type of data. The reason is so someone on the research team understands the limitations of each data element being requested and used
3. To ensure that there is not a lack of clarity about what the status of the proposal is, each proposal will get the following overall decision at the end of each presentation and discussion
    a. Accept with minimal or no changes required

            i. E-mail revision to PCRC
   b. Accept with moderate changes required
      i. Represent at a future PCRC
      ii. E-mail Revisions to PCRC
   c. Revise and reconsider at future meeting
   d. Reject
4. Meeting will be recorded to be shared later with members of MPOG via the MPOG website. There were no objections to this via the members that were on the call.

**Welcome to our two new Active MPOG members and thank you for your hard work**

1. Cleveland Clinic
2. Yale

**Updates on Sponsored Projects**

1. BD revised proposal in progress. BD will give us money for each site to get the data required. They are currently taking it through their contract progress but nothing has been signed yet. Each site that gives the data (medication error and costs for the patients that had error vs those that did not) will receive $15,000. There is only funding for 8 sites. University of Michigan will not receive money for this project. When the revised proposal is sent out, please respond back to us and let us know if you are interested. Please note a new IRB will be needed by each site for participation. The total budget is $400,000 and $175,000 is data access fees that will go into MPOG funds.
2. Merck – Merck is interested in neuromuscular blockade and are interested in doing a project in neuromuscular blockade monitoring and variation across centers. We have data from Aspire measures. Sachin will present this at an upcoming PCRC in the next couple months. There are no additional data pulls required for this project.

**Updates on Aspire**

1. In-person meeting March 16th in Ann Arbor.
   a. Morning session: Drs. Leslie Jameson and Greta Krapohl from MSQC to present
2. We have become a QCDR and will calculate measures based on what the quality committee agrees upon. Please contact Nirav and Tory if you want to use the QDCR for 2015.

**ASA – 2015**

1. Oct 23 – MPOG Retreat (CME credits offered).
2. Executive board decided to make the retreat break even with funding. This cost is $100 for each person to attend.
3. General discussion in the morning and two breakout afternoon sessions:
   a. Quality Improvement
   b. Peer reviewed research

**Presentation**

**Title:** Intraoperative Transitions of Anesthesia Care and Postoperative Adverse Outcomes

**Proposed Authors:** Sachin Kheterpal, Daniel Sessler, Andrea Kurz, Edward Mascha, Jing You

**Primary Institution:** Cleveland Clinic

**Presented by:** Leif Saager, MD

**Discussion Points:**

- Look at attendings that do not work with a resident as a sub-analysis. Yale, Colorado, and Cleveland clinic all have hospitals that run more like a private practice hospital
- This project is important because we need to do more research from the primary article to see if the effect is still seen across institutions. We need to validate this and also look to see if we need to manage our hand-overs better or do fewer handovers.
- From some institutions: A lot of handovers will be relieved from lunch and the person comes back and that the sign-in's don't actually happen.
    - Previously Leif excluded the people who left for lunch and then came back to finish the case
- At the end of the workday, there are a lot of turn-overs to look at where you look at the number of attendings and the number of CRNA's.
- How do we communicate misclassification error or lunch breaks that aren't documented? Does anybody else have criteria that they do not use signouts for lunch?
    - Colorado – The only way to know is to actually measure it for 6 months. They suspect but don't know that quite a few breaks occur without signout. CRNA/AA normally don't signin/signout for lunches. If passing on care, and not returning that data is very accurate.
    - Utah – Breaks may not be documented
    - We need to put this into the proposal as a limitation about breaks that are not documented that will error us towards the null hypothesis. Perhaps we do a sensitivity analysis to exclude centers that suspect they don't document breaks.
- A lunch break will be about 40 minutes and making sure that the same person signs back in.
- Hand-overs at the end of the case: If the person signs out 20 minutes before the end of the case, that will be a hand-over? Yes
- Will center (institution) be a fixed effect?
    - We will use it as an interaction effect first between hand-overs on primary outcomes across institutions. If it's different, we won't do the overall assessment. If there is no interaction, we will use an overall assessment.
- We have different hand-over practices. At UM we tried to use a check-list with variable use. Do other centers have similar efforts? Do you want to include that as a "good" or "bad" hand-over?
    - PI thinks this would be very interesting to contribute to the analysis. Ask each center if they have a structured process.

    - Jacksonville – Structured s-bar attendings hand-over is completed. This is on every script
    - Oklahoma – They have a statement for structured hand-over
    - Colorado – In Epic the nursing staff records it but not Anesthesia.
    - Include in the proposal an intake instrument for how each hospital handles hand-overs and if they have a private practice group as well and how they are documented within MPOG.
- Does anybody have a system where there is a hand-over and a page is generated if no documented is found?
    - No
- Start date for contribution?
    - Will take all the data.

| Institution | Vote |
|---|---|
| Columbia | **Not on call** |
| Oregon Health Science University | **Not on call** |
| University Medical Center of Utrecht | **No vote** |
| University of Colorado | **Revise – Electronic** |
| University of Florida | **Revise – Electronic** |
| University of Michigan | **Revise – Electronic** |
| University of Oklahoma | **Revise – Electronic** |
| University of Tennessee | **Not on call** |
| University of Utah | **Revise – Electronic** |
| University of Vermont | **Not on call** |
| University of Virginia | **Not on call** |
| University of Washington | **Not on call** |
| Vanderbilt | **Revise – Electronic** |
| Washington University , St. Louis | **Revise – Electronic** |
| Weill-Cornell Medical Center – New York Presbyterian | **Not on call** |
| Yale | **Revise – Electronic** |

**Final Decision: Revise with minor electronic revisions**