Multicenter Perioperative Outcomes Group (MPOG)
PCRC Meeting Notes – Monday, March 13, 2017

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

P	Mike Aziz (Oregon)	**P**	Fabian Kooij (AMC)
P	Michael Avidan (Wash U)	**P**	Kai Kuck (Utah)
P	Mitch Berman (Columbia)	**P**	Tory Lacca (Michigan)
P	Joshua Berris (Beaumont)	**P**	Lance Lichtor (Yale)
P	Dan Biggs (Oklahoma)	**P**	Michael Mathis (Michigan)
P	Randall Blank (Virginia)	**P**	Bhiken Naik (Virginia)
P	Ruth Cassidy (Michigan)	**P**	Nathan Pace (Utah)
P	Douglas Colquhoun (Michigan)	**P**	Leif Saager (Michigan)
P	Germaine Cuff (NYU Langone)	**P**	Robert Schoenberger (Yale)
P	Ken Cummings (Cleveland Clinic)	**P**	Nirav Shah (Michigan)
P	Marcel Durieaux (Virginia)	**P**	Allie Thompson (Michigan)
P	Alex Evers (Wash U)	**P**	Kevin Tremper (Michigan)
P	Shelley Housey (Michigan)	**P**	John Vandervest (Michigan)
P	Sachin Kheterpal (Michigan)		

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 no changes
    b. Accept with minor changes send revision electronically
    c. Accept with major changes and represent at PCRC
    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.

General Meeting Notes

- Please send quick email if you are planning on submitting an ASA abstract using MPOG data
- EOS updates - data collection will be electronic

Presentations

PCRC 0038 - "A retrospective analysis of anesthetic management and outcomes for pyloromytomy"

Principle Investigator: J. Lance Lichtor
Institution: Yale

General comments

- Q: How will you calculate length of stay?
  - For some hospitals, it's the time of surgery end to time out of OR/extubation/etc.
  - For hospitals providing discharge ICD-9 data, we use the admit and discharge dates to calculate hospital LOS (in days).
  - Depending on missingness (how many sites have accurate ICD-9 admit/discharge dates), this outcome may be removed. All of the active sites are giving it well – but this may be limited in how many of these hospitals are doing pediatric cases. Sample size analysis needed.
- Comment: Need to be sure we are calculating postoperative length of stay – patients may enter the hospital a day prior.
- Q: Most of these patients will go home postop day 1 or day 2 – perhaps "hours" should be used instead of "days"?
  - A: Will not have good data for "hours".
  - A: Consider coming up with binary concept for prolonged length of stay (< or > 3 days).
- Q: Naloxone administration may be given intraoperatively or on the floor. Could this be used as an outcome measure? How reliable is naloxone documented?
  - A: Could be an outcome of interest.
  - A: More importantly could be length of time in the operating room – specifically, surgery end to time leaving the OR. Consider timeframes including end of surgery, out of OR, and anesthesia end
- Q: Define missingness and where process of care data are amenable to hypothesis driven analysis. Move forward with the descriptive analysis – hypothesis driven analysis may be influenced by this.
  - A: Before we start pulling the outcomes, we need a finalized list of outcomes. Revision of proposal to have list of candidate outcome measures (a priori defined with multiple definitions if necessary).
- Q: Target journal
  - A: Anesthesiology

FINAL DECISION: ACCEPTED

Institution	Vote
Academic Medical Center (AMC) Amsterdam	**Accept**
Beaumont	**N/A**
Bronson	**N/A**
Cleveland Clinic	**Electronic revisions**
Holland	**N/A**
St. Joseph/Trinity	**N/A**

NY Langone	**Accept**
Oregon Health Science University	**N/A**
Sparrow	**N/A**
Stanford	**N/A**
University Medical Center of Utrecht	**N/A**
University of Colorado	**N/A**
University of Michigan	**Accept**
University of Pennsylvania	**N/A**
University of Oklahoma	**Accept**
University of Tennessee	**N/A**
University of Utah	**N/A**
University of Vermont	**N/A**
University of Virginia	**Accept**
University of Washington	**N/A**
Vanderbilt	**N/A**
Washington University, St. Louis	**Accept**
Weill-Cornell Medical Center – New York Presbyterian	**N/A**
Yale	**Abstain (Presenting institution)**
Columbia	**Electronic revisions**

PCRC 0039 - "Management of one lung ventilation during thoracic surgery – impact on clinical outcomes"

Principle Investigator: Randall Blank
Institution: University of Virginia

General comments

- Q: Where is plateau pressure measured? Are most MPOG sites contributing?
  - A: DataDirect/Concept browser show 9 institutions with plateau pressure – only 3 are STS contributing.
  - A: Backup plan is currently estimating driving pressure as (P inspired minus PEEP), however this should probably become the primary analysis and the new backup plan should be plateau pressure.
- Q: Does collaborating with STS require any payment?
  - A: No, it does not.
- Q: What was the random effect?
  - A: Institution
  - A: If only a limited set of institutions, a random effect may not by meaningful.
  - A: Targeting 6 institutions
- Q: Topic well-suited for propensity scoring analysis – is this being considered?
  - A: Will discuss adding to the proposal.

    - A: Outcome of regression would be yes/no received protective ventilation.
    - A: Include risk adjustment and selection bias variables in the propensity model (all things related to treatment or outcome bias).
    - A: Include all variables that may influence treatment and outcome.
    - A: Consider inverse probability weighting.
- Q: Do all the outcomes need to come from the STS database?
    - A: Yes, all the outcomes are from STS.
- Q: Is there a statistical way to combine two continuous outcomes into a summary continuous outcome (instead of turning it into a binary outcome).
    - A: Propensity scores cannot be created for more than 2 categories.
- Comment: Suggested revisions to include updated statistical plan and vent modes.

FINAL DECISION: TIE (ELECTRONIC REVISIONS and ACCEPT)
PI will send an electronic revision to PCRC for review

Institution	Vote
Academic Medical Center (AMC) Amsterdam	**Electronic revisions**
Beaumont	**N/A**
Bronson	**N/A**
Cleveland Clinic	**Electronic revisions**
Holland	**N/A**
St. Joseph/Trinity	**N/A**
NY Langone	**N/A**
Oregon Health Science University	**N/A**
Sparrow	**N/A**
Stanford	**N/A**
University Medical Center of Utrecht	**N/A**
University of Colorado	**N/A**
University of Michigan	**Accept**
University of Pennsylvania	**N/A**
University of Oklahoma	**Abstain**
University of Tennessee	**N/A**
University of Utah	**N/A**
University of Vermont	**N/A**
University of Virginia	**Abstain (Presenting institution)**
University of Washington	**N/A**
Vanderbilt	**N/A**
Washington University , St. Louis	**Accept**

Weill-Cornell Medical Center – New York Presbyterian	**N/A**
Yale	**Accept**
Columbia	**Electronic revisions**