Multicenter Perioperative Outcomes Group (MPOG)
PCRC Meeting Notes – Monday, April 10, 2017

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

P	AnneMarie Akkermans (Utrecht)	**P**	Sachin Kheterpal (Michigan)
P	Mitch Berman (Columbia)	**P**	Kai Kuck (Utah)
P	Joshua Berris (Beaumont)	**P**	Tory Lacca (Michigan)
P	Dan Biggs (Oklahoma)	**P**	Patrick McCormick (Memorial Sloan Kettering)
P	Randall Blank (Virginia)	**P**	Bhiken Naik (Virginia)
P	Ruth Cassidy (Michigan)	**P**	Mark Neuman (Pennsylvania)
P	Robert Craft (Tennessee)	**P**	Nathan Pace (Utah)
P	Germaine Cuff (NYU Langone)	**P**	William Paganelli (Vermont)
P	William DePasquale (NY Langone	**P**	Wietze Pasma (AMC)
P	Karen Domino (U of Washington)	**P**	Leif Saager (Michigan)
P	Robert Freundlich (Vanderbilt)	**P**	Robert Schoenberger (Yale)
P	Hugh Hemmings (Weill Cornell)	**P**	Nirav Shah (Michigan)
P	Shelley Housey (Michigan)	**P**	Eric Sun (Stanford)

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.

Enhanced Observational Study Updates

General Comments

- Currently working on case report form, IRB applications and recruitment of participating MPOG members
- Provisional target date for initial recruitment ~May 2017
- Next steps: informational webinar, commitment, administrative IRB and local waiver of consent documentation, training of data collectors and pilot enrollments
- Discussed the time commitment for each MPOG site – local PI and data collectors (will circulate powerpoint slide)

Discussion/Questions

- Timeline: ideally would like to start the study towards the end of May; alternative would be September
- Participation: invitations were sent out
- Q: Will all sites be conducting data collection during the same 2-week window?
    - A: Yes, but with May deadline, it may be difficult for all sites to collect on the same day. Perhaps we could identify a specific 4-week period, and then each site can pick a 2-week period during that.
- Q: Is it possible to send out the matrix for data collection/time commitment?
    - A: Yes, we will send that out.

ASA 2017 Announcements

General Comments

- MPOG/ASPIRE Retreat on Friday, October 20, 2017 from 7am-3pm
- Lectures will be combined group
- Afternoon breakouts for Research and Quality
- MPOG abstracts submitted to ASA

PCRC 0032 Addendum- "An observational study of end-tidal CO2 trends in general anesthesia: A report from the Multicenter Perioperative Outcomes Group"

Principle Investigator: Annemarie Akkermans, MD

Institution: Utrecht

General comments

- Initial proposal was focused on descriptive pattern and change over time; currently propose to extend the previously presented proposal to include
    - Postoperative pulmonary complications, length of stay, mortality at discharge
    - Patient associated, procedure associated, and anesthesia related confounders
    - Stratified sub-groups for analysis
    - Methods for dealing with missing data
- Q: Has data already been collected or is this to start the data collection now?
    - Patient data has already been collected (cohort identified); initial descriptive analysis is complete
    - Data was pulled and described the trend (per the approved protocol); proposal was to add an outcome piece to extend existing work; skeptical about adding confounders and other pieces that would change the already approved analysis; less comfortable changing the initial analysis
- Q: Spec sheet addendum on page 13 – is this what you are looking to capture now?
    - Yes, these are the new variables to be collected
    - Consider including a marker for prone positioning

- Q: How many patients are in the cohort right now?
    - ~320,000 patients
- Previous proposal was for descriptive analysis only – this could be problematic since we saw the initial results and changed the analysis. One way to move forward is keeping the same analysis, but only adding in outcomes (this does not change the initial analytic plan). Other way to move forward is analyzing the same data in a different way (but perhaps this should be a different proposal/study/etc.).
- Q: Is the descriptive portion able to be published on its own and then publish the outcomes as a separate publication? Or do we need both components (descriptive and outcomes) for publication? Do we publish descriptive portion of paper in lower impact journal, but sooner? Or, do we propose a new project that includes both descriptive and outcomes portion in a higher level journal article that may take longer.
    - PI is supportive of finishing initial descriptive manuscript (including provider variation) and a subsequent project with outcomes/confounders included as a separate project
- Q: Why aren't we looking at variation across providers (anesthesiologists) in addition to variation across institution?
    - We will be completing this analysis later this week.
    - Q: Would you turn this information into a high vs. low end CO2 provider user?
        - Yes, if you find there is inter-provider variability.
- Q: If we are capturing outcomes/confounders can we capture recruitment measures?
- **FINAL DECISION** is to leave the original proposal unchanged (write a manuscript); use what we learned from this initial project as foundation for a new proposal including outcomes and confounders – represent the confounders/outcome proposal at a later date

PCRC 0035 - "Concurrent surgery and perioperative outcomes: Evidence from the Multicenter Perioperative Outcomes Group"

Principle Investigator: Eric Sun, MD, PhD

Institution: Stanford

General comments

- Comment: We will not have identified surgeon IDs (only deidentified system IDs) so we don't know the specific surgeon
- Comment: group needs to discuss whether pathway forward is interacting with surgeons at each site, so that they are part of this research project. Local surgeon at UM suggested that we work peer-to-peer with engaged/open-minded local surgeons – these collaborators can then help policy change, if necessary.
- Q: Overlapping procedures may be vastly different – are we accounting for this in any way? Also what if more than one surgeon is involved – is the data quality able to capture this (especially if schedule only lists one)?
    - Model adjusts for procedure (procedure fixed effects)
    - Data quality on how to sites record surgeons (multiple surgeons in a case varies and will need to be accounted for in model
        - We may restrict data to only sites where we see multiple surgeons in data

- Q: Have you considered restricting to "typical" procedures that are done concurrently as the primary focus group?
    - Good point – empirically look at which ones are done concurrently
    - Will consider focusing the analysis on top 50-100 procedure types that are done concurrently
- Comment: Reliable data on anesthesia CPT codes, but limited data on surgical CPT codes
    - PI preference is for surgical CPT codes, even if it limits number of institutions
    - Can use DataDirect to see how much data drops out if we use surgical CPT codes
- Q: With the model run on Stanford data – were there estimation difficulties on surgeon fixed effects?
    - No because for a given surgeon, they had to have a certain percentage of cases as concurrent to be included
    - Is this scalable across multiple MPOG surgeons – yes, only really affected by each surgeon having a large enough sample size (not so much based on larger number of surgeons)
- Q: Power is largely a function of within-surgeon variation – how do we increase power by adding more MPOG surgeons?
    - One dimension of power is number of surgeons; another dimension is how much variation within a surgeon
    - Using MPOG data also allows for conclusions regarding generalizability and external validity (compared to what is already in the literature)
- Comment: No age exclusion criteria for calculating concurrency measure
    - 18-90 for analytic database

FINAL DECISION: ACCEPT

Institution	Vote
Academic Medical Center (AMC) Amsterdam	**N/A**
Beaumont	**N/A**
Bronson	**N/A**
Cleveland Clinic	**N/A**
Columbia	**Accept**
Holland	**N/A**
NY Langone	**Accept**
Oregon Health Science University	**N/A**
St. Joseph/Trinity	**N/A**
Sparrow	**N/A**
Stanford	**Abstain**
University Medical Center of Utrecht	**Accept**
University of Colorado	**N/A**

University of Michigan	**Electronic revisions**
University of Oklahoma	**Accept**
University of Pennsylvania	**N/A**
University of Tennessee	**Accept**
University of Utah	**Accept**
University of Vermont	**N/A**
University of Virginia	**Accept**
University of Washington	**Electronic revisions**
Vanderbilt	**N/A**
Wake Forest	**N/A**
Washington University, St. Louis	**N/A**
Weill-Cornell Medical Center – New York Presbyterian	**N/A**
Yale	**Electronic revisions**