Multicenter Perioperative Outcomes Group (MPOG)
PCRC Meeting Notes – Monday, September 12, 2016

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

P	Michael Aziz, MD - OHSU	**P**	Bhiken Naik – U of Virginia
A	Joshua Berris, DO - Beaumont	**P**	Bala Nair, PhD – U of Washington
P	Daniel Biggs, MD – Oklahoma	**P**	Nathan Pace, MD – Utah
P	Greg Giambrone, MS – Weill Cornell	**P**	W. Pasma - Utrecht
P	Shelley Housey, MPH – U Michigan	**P**	Nirav Shah, MD – U Michigan
P	Sachin Kheterpal, MD – U Michigan	**P**	Amy Shanks, PhD – U Michigan (MPOG)
A	Kai Kuck, MD - Utah	**A**	Zachary Turnbill, MD – Weill-Cornell
P	Tory Lacca, MBA – U Michigan (MPOG)	**P**	John Vandervest – U of Michigan
P	Leif Saager, MD – U Michigan	**P**	Ken Cummings, MD – Cleveland Clinic
P	Jurgen de Graaff, MD, PhD	**P**	Michael Mathis, MD – U of Michigan
P	Leslie Jameson, MD – U of Colorado	**P**	William Paganellli, MD, PhD – U of Vermont
P	Robert Craft, MD, PhD – U of Tennessee	**P**	Kevin K. Tremper, PhD, MD – U of MIchigan
P	Zack Turnbull, MD – Weill Cornell		

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.

Meeting Minutes

- Jurgen de Graaf – Published ahead of print
- ASA annual retreat is coming up. Everyone is welcome. Please forward to anyone in your department that is interested.

Presentation: "Variation in management of neuromuscular blocking agents, monitoring, reversal and the risk of pulmonary complications and resource utilization after major surgery"

Presenter: Sachin Kheterpal, MD, MBA

Institution: University of Michigan

Comments:

- New IRB needed for this study at the coordinating center since this is a sponsored project
- One co-investigator from Merck. After this is completed, it will go through a Merck review process.
- Could we get comparative cost data to neostigamine as that may be a primary driver of when sugammadex is used? Look at how much the center has to pay to use sugammadex.
    - The PI thinks that should be included in the survey if the hospital will release the information. Perhaps put brackets and ranges?
    - Are you requiring a single dose or multi-dose usage in the survey
    - U of Colorado determined they save about $2 a patient using sugammadex. The perception that it's more expensive may not be accurate.
        - The differential of how much more do you spend versus how much less than you spend should be investigated
    - Another hospital has determined they are about $2 higher per patient using sugammadex.
- What is the value of the descriptive part of sugammadex use?
    - The value of the descriptive paper is limited due to timing. So if we get this out early 2017 then there is value there since some centers do not use it currently.
- What's the role of Merck as a co-investigator and what value do they add?
    - Merck is helping it make it worth our effort. What funds we make will go into the MPOG reserve funds.
- Do we restrict the patients that get roc only? Or do we look at both patients that received vec and roc?
    - No one has any issues including both
- Do we have 3 groups, neo only, sugammadex only, or no reversal? Or just two groups with neo and sugammadex?
    - No objections to look at 3 groups
- Should propensity score derivation be done within each center since we are matching on centers?
    - Another approach is to use inverse probability weighting
        - Each observation is inversely used on the propensity score. Look at Austin papers
    - Do we put in the protocol that we are going to do it both ways?
        - The protocol is that we are data mining to keep on going until we get something that we like. This is a difficult question that needs to be explored.
        - We will discuss offline how to manage this problem. Plan for standard differences less than 10.
- There are other ways to calculate propensity scores that should be explored.
    - Classification trees, etc
- There isn't much value doing 1:many versus 1:1 matching. Any strong opinions on doing 1:1 or 1:many?
    - The PI will assume 1:1 unless we hear feedback
- We don't see enough site of monitoring data in the database. Therefore we are not going to include location of monitoring and it will just be a limitation to the study. Does anyone have any objections?
    - None stated
- Do we leave the provider out of the analysis?
    - Dr. Jameson suggested to just leave it neutral

    - Dr. Craft agrees it's not significant to identify in-room provider
    - Unless we hear otherwise, we will not include provider in this analysis
- It would be tough for Merck to pay for a study to describe all the ways that sugammadex is getting used when it's not supposed to be used. The PI feels this is an important paper but Merck will not pay for this part of the project.
    - Are people comfortable doing a separate "off-label" manuscript even though Merck will not be funding it?
        - No objections
- In the descriptive study, a non-parsimonious logistic regression, there are a lot of variables in that. You may want to consider a parsimonious or semi-parsimonious model.
    - Perhaps come up with a "clinically meaningful adjusted odds ratio" to report the data
- Can you describe the role of the PI at each site?
    - PI role – Describe systematic policy at your site
    - Reviewing the final protocol
    - Reviewing the final manuscript and offering feedback on it

Institution	**Vote**
Academic Medical Center (AMC) Amsterdam	*
Beaumont	*
Bronson	*
Cleveland Clinic	**Accept – Electronic Revisions**
Holland	*
Mercy Health System	*
New York University	*
Oregon Health Science University	**Accept – Electronic Revisions**
Sparrow	*
University Medical Center of Utrecht	**Accept – Electronic Revisions**
University of Colorado	**Accept**
University of Michigan	**Abstain**
University of Pennsylvania	*
University of Oklahoma	**Accept**
University of Tennessee	**Accept**
University of Utah	**Accept**
University of Vermont	*
University of Virginia	**Accept – Electronic Revisions**
University of Washington	**Accept**
Vanderbilt	*
Washington University , St. Louis	*
Weill-Cornell Medical Center – New York Presbyterian	**Accept**

Yale	*

*Not on call

Final Decision: Accept