October 23, 2013

Dear SAGES Research Committee:

Please accept this grant proposal entitled: “Choledocholithiasis Management in America: Do Rural Surgeons Need Different Skills than Urban Surgeons?” for review. As the responsible Co-PI for the proposed study, I agree to assume full responsibility for the grant should the Candidate Member leave Vanderbilt University Medical Center and be unable to transfer the grant in the event of a move.

We did submit similar proposals to SAGES in 2010 and 2012. Since the initial proposal, we have made significant changes. We have modified the survey extensively after multiple expert reviews and have performed a pilot study in the Nashville community testing the usability of the survey. In addition, we have performed a much more robust power and sample size calculation. The application process this year allows us to submit the survey instrument as an appendix to the application. Our team hopes these changes will result in a successful application. We are also excited to resubmit this proposal at a time when SAGES has renewed its focus on the management of common bile duct stones.

Sincerely,

Benjamin K. Poulose, MD, MPH
Statement of Funds
We currently do not have funds for this study. We have not submitted this proposal for other funding mechanisms.

Summary
Choledocholithiasis (CDL) management remains challenging even in the age of advanced laparoscopy and interventional endoscopy. Often, management is dictated by locally available resources and expertise rather than recognized best practices. Our previous work has identified a strikingly consistent variation pattern in CDL management: more operations and less endoscopic interventions are performed in rural communities. In urban areas however, less operations and more endoscopic interventions are performed. The main goal of this proposal is to ascertain why this variation exists and to target potential opportunities for improving access to less invasive techniques of CDL management.

We will evaluate why surgeons choose to manage preoperatively discovered CDL either by open common bile duct exploration (OCBDE), laparoscopic common bile duct exploration (LCBDE), or endoscopic retrograde cholangiopancreatography (ERCP). We will evaluate similar responses for CDL discovered incidentally at the time of cholecystectomy. The results of this research can help determine if surgeons in rural communities should strive to obtain additional training in laparoendoscopic techniques to manage CDL. In addition, these results may help policymakers target interventional endoscopic services to rural areas of the country.

We hypothesize that surgeons in rural communities are more likely to perform operative interventions than their urban counterparts for CDL. In order to test this hypothesis, a 22 item, web-based survey tool will be administered to general surgeons in the AMA Physician Masterfile. Surgeons will be contacted via email and the survey will be completed using Vanderbilt University’s REDCap Survey system. Respondents will be classified into one of six NCHS urban-rural classes based on the location of their primary practice. These classes will be collapsed into 3 groups for analysis: metropolitan areas (NCHS 1-4), micropolitan areas (NCHS 5), and rural areas (NCHS 6). Exploratory analysis will be performed amongst the collected variables to assess consolidation of responses for simplification of analysis. Descriptive statistics and frequencies will be reported. Chi-square statistics and tests of correlation will be performed as appropriate.
Background

Current Problems in the Management of CDL and Significance

Choledocholithiasis (CDL) management remains a challenging problem given the different methods available for treatment, accessibility to these interventions, and costs involved for unnecessary or inefficient care.\(^2\) The precise role of common bile duct exploration (CBDE) in the age of ERCP still remains to be defined. Usually, patients obtain care near home for benign gallstone pathology, as cholecystectomy remains one of the most common procedures performed by general surgeons in the United States. Rural surgeons are often called upon to manage complex CDL patients with limited resources and training specific to this disease process.\(^3,4\) In addition, interventional endoscopic care may not be readily available to these surgeons unlike their urban counterparts. As such, identifying CDL management differences and the reasons for these differences could help target interventions to reduce this variation and improve care.

Prior Studies Evaluating Urban-Rural Influence on Management of CDL

To date, only a single study has attempted to address the issue of rural influences on the management of CDL. Bingener et al. administered a survey to 207 rural surgeons in Texas with a 33% response rate.\(^5\) The preferred approach to manage suspected CDL was reported as ERCP (73%), followed by LCBDE (22%) and OCBDE (5%) with a very similar distribution for unsuspected stones. The two most popular reasons for not performing LCBDE were the time-consuming nature and lack of available equipment. The sole factor predictive of increased performance of LCBDE was a high volume (>50 per year) of laparoscopic cholecystectomy.

Although this study does provide a glimpse into how CDL is managed in rural areas, its inferential validity and generalizability is limited. Given such a small sample in south Texas, it is impossible to generalize results to all rural surgeons. No comparison group of urban surgeons was surveyed, greatly limiting the conclusions. Finally, no information from the non-respondent group was obtained. This would be important to determine if the respondents themselves were somehow biased to complete the survey. This study still leaves a sizable knowledge gap to be addressed.

Preliminary Studies/Progress Report

Our group has performed an initial evaluation of access to surgical and endoscopic care for CDL in the United States.\(^6\) Patients undergoing inpatient management of CDL in 2007 were identified from the Healthcare Cost and Utilization Project inpatient database. Hospital characteristics, including availability of ERCP, were determined from the 2007 American Hospital Association survey. The proportion of ERCP or CBDE interventions for CDL was determined and compared across U.S. census regions and NCHS urban-rural classes.

Of approximately 111,000 hospitalizations for CDL, 67% had an intervention performed with similar frequencies across census regions. Comparisons across NCHS classes revealed higher proportions of ERCP in metropolitan areas (NCHS 1-4) while a higher proportion of CBDE was seen in micropolitan and rural areas (NCHS 5 and 6, Figure 1). ERCP availability was higher in metropolitan areas (available in 35%-44% of NCHS 1-4 hospitals) than in micropolitan and rural areas (25% of NCHS 5 and 5% of
NCHS 6 hospitals). Percutaneous management was similar. From this study, we concluded that rural hospitals and communities need surgeons trained in CBDE techniques, where ERCP may not be readily available. More importantly, this study raised several questions: Why do rural surgeons perform CBDE more often than urban surgeons? How does performance of LCBDE impact this difference? Should more effort be spent in targeting interventional endoscopy in rural areas? Answers to these questions may have an impact on the goals of surgical training. This proposal directly hopes to address these critical questions.

**Figure 1** – Proportion of patients undergoing ERCP and CBDE for CDL in 2007 Healthcare Cost and Utilization Project inpatient database. In rural areas (NCHS 1) a significantly reduced proportion of endoscopic interventions were performed for CDL compared to urban areas (NCHS 6).

**Pilot Study**

We have performed a pilot study testing the usability of the survey locally. Clinical faculty in the general surgery departments at Vanderbilt University Medical Center, Nashville VA Medical Center, Williamson Medical Center, and St. Thomas Hospital were surveyed in an initial effort to quantify practice patterns in the greater Nashville area. Eight-two individuals were contacted by email and 17 completed the survey (20.7%). Respondents ranged in age from 31 to 64 years old and have been in practice for an average of 13 years. Fifteen respondents were male and 2 were female.

As expected, the majority of respondents prefer to manage CDL by referral for pre- or postoperative ERCP. Of note, a high percentage of respondents (29.4%) identified LCBDE as the preferred method for managing incidentally discovered CDL despite 100% ERCP availability at their home institution. Respondents overwhelmingly identified lack of comfort with performing the procedure as a limiting factor in performing LCBDE when indicated (70.6%). Additionally, lack of appropriate equipment (35.3%), time constraints (23.5%), lack of support staff (11.8%), insufficient reimbursement (5.9%), increased morbidity (5.9%), and size of stone (5.9%) were influential. Fear of losing referrals for not referring out for ERCP was not influential. These results may reflect the highly academic nature of the sample population since all individuals surveyed practice in a university hospital or university-affiliated community hospital.
Hypothesis

We hypothesize that surgeons in rural communities are more likely to perform operative interventions for CDL than their urban counterparts, and that this is due to resource availability. Two specific aims are derived from this hypothesis:

Specific Aim 1: Using a national web-based survey, determine whether a difference exists between urban and rural management of CDL.

Specific Aim 2: Determine factors that influence the preference of CDL management of practicing general surgeons.

Methods

Design Summary

A 22 item, web-based survey tool will be administered to general surgeons in the AMA Physician Masterfile. Surgeons will be contacted via email and the survey will be completed using Vanderbilt University’s REDCap Survey system. Respondents will be classified into one of six NCHS urban-rural classes based on the location of their primary practice. These classes will be collapsed into 3 groups for analysis: metropolitan areas (NCHS 1-4), micropolitan areas (NCHS 5), and rural areas (NCHS 6). Descriptive statistics and frequencies will be reported. Chi-square statistics and tests of correlation will be performed as appropriate.

Survey Inception and Design

Given the lack of a standardized centralized database that could provide reliable information to address the specific aims of this project, a national survey was chosen as the methodology for implementation. Administrative datasets, although rich in information, do not reflect the reasons why certain management options were chosen. As such, a survey design was chosen with prospective collection of data. To this end, iterative focus groups were conducted at our institution over a 6 month period with participation from our minimally invasive General Surgery faculty, senior surgical residents, and medical students to help formulate survey items to address the hypothesis and specific aims. After 6 rounds of refinement, a 22 item survey was developed addressing items of surgical experience, endoscopic experience, resources available, technical factors, training, and demographics (see survey instrument). All 22 survey items are required for completion with an optional prompt for the respondent’s email address and entry into a raffle. One question (survey item 7) uses branching logic that will enable a follow-up question (survey item 7b) depending upon the original response.

Targeted Population

The population of interest to complete this survey will be practicing surgeons designated as either ‘General Surgeons’ or ‘Abdominal Surgeons’ in the AMA Physician Masterfile. Access to the AMA Physician Masterfile is facilitated by Direct Medical Data, which acts as the clearinghouse for AMA data. Surgeons in all 50 states and territories of the United States and the District of Columbia will be invited to participate. Currently 24,694 surgeons have valid email addresses within the Masterfile; this represents 76.3% of ‘General’ or ‘Abdominal’ surgeons.
*Survey Procedures and Data Collection*

Direct Medical Data (DMD) will be sent the text of the introductory email (see survey instrument). The introductory email will be sent as an initial email blast by DMD to surgeons with valid email addresses. The email will contain a link which will send participants to the Vanderbilt REDCap web-based survey system where survey responses will be managed. REDCap is a secure, web-based application designed to support data capture for research studies, providing: 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources. Participants will complete the 3-5 minute survey and will then be presented an option to enter a raffle for a $500 Visa gift card as an incentive for participation. Participation in the raffle is optional and the winner will be selected at random.

Two weeks after the initial email blast, a second email blast will be sent to those who did not click on the link sent in the first email blast. Participants who did complete the survey will not be sent a second email. After an additional two weeks, response rates will be assessed and if greater than 20%, the survey will be closed. If less than 20% response still remains, another 2 weeks will be allowed for survey completion.

*Potential Limitations and Possible Solutions*

Several potential limitations will be taken into consideration with this study. First, the study design itself (i.e. administered survey) does not produce inferential validity similar to randomized controlled trials or well-designed cohort studies. However, the methods used in this study are felt to be the only feasible way of obtaining information from such a wide range of general surgeons in a reasonable period of time. In addition, the survey method allows investigation of reasons behind decisions made by caregivers. This would be very difficult, if not impossible, to achieve with traditional study methods. Self-reporting of procedural volumes can overestimate or underestimate the true numbers of a particular procedure performed. We anticipate a higher chance of overestimation with this particular group surveyed, however we do not expect these differences to vary between urban and rural surgeons. As such, the relative differences between the two groups should still be maintained. In addition, the survey is designed to force the choice between ranges of procedural volumes which should minimize misreporting to some degree.

Given the electronic nature of the survey administration, the respondents may be a group more biased toward high technology applications and services. The AMA Masterfile has 76.3% of email addresses for ‘Abdominal’ or ‘General’ surgeons. It is within reason that this group of individuals would be more likely to perform “higher technology operations” (i.e. laparoscopic common bile duct exploration) than those surgeons who do not routinely use email or other technology intensive services. We recognize this as an essentially unavoidable bias as the alternative would be a paper and mail administered survey. The latter would likely have a much lower response rate and data integrity would be difficult to ensure. As such, we accept this bias with the assumption that both rural and urban surgeons have similar access to email. We do feel that contacting 76.3% of general surgeons will produce a reliable sample. At the time of
study initiation, it is expected that an even higher proportion of email addresses will be obtained.

Although we expect at least a 20% response rate, there is a chance that a smaller percentage would be achieved. Assuming a ‘worst case’ scenario of 10% response rate, we would still achieve 2,469 estimated responses. We will have ZIP code information on the non-respondents as well and can characterize differential non-response by NCHS classes to help determine if there was a response bias from urban or rural surgeons.

**Study Timeline**

Step 1 involves finalization of the survey tool, webhosting, and two email blasts to general surgeons (1.5 months). In step 2, data synthesis will incorporate data gathered from specific aims and classification of respondents by NCHS class (9 months). Step 3 proceeds with descriptive statistics, analysis of proportions, and correlations (3 months). Reports and manuscript preparation will be performed in Step 4 (4.5 months).

**Sample Size Justification and Statistical Analysis Plan**

To correctly assign NCHS class for each completed survey, individual ZIP codes collected from survey data (survey item 14) will be mapped to county-level Federal Information Processing Standard (FIPS) codes. This will be accomplished using software from CD Light LLC at [www.zipinfo.com](http://www.zipinfo.com). The county level FIPS codes will then, in turn, be categorized into NCHS classes 1 (most urban) through 6 (most rural) using public access data files from the Center for Disease Control and Prevention NCHS website [http://www.cdc.gov/nchs/data_access/urban_rural.htm#resources](http://www.cdc.gov/nchs/data_access/urban_rural.htm#resources). At the conclusion of this data processing step, a fully analyzable file of all completed surveys will result. These classes will be collapsed into 3 groups for analysis: metropolitan areas (NCHS 1-4), micropolitan areas (NCHS 5), and rural areas (NCHS 6).

We will begin with an exploratory analysis of survey item responses to determine if multiple response items can be condensed into simpler groupings. For example, items 1-6 include 5 ordinal responses; if this many responses are not needed, the data will be collapsed into a smaller group of responses while maintaining the ordinal nature of the item. Data analyses will include descriptive statistics (proportion of respondents by response options) for demographic characteristics, ZIP code (of primary practice), training, and practice-related questions (e.g. items 1 – 8). Potential differences in the clinical management of common bile duct stones: item 9 (5 discrete response options) and item 10 (4 discrete response options) will be tested using the chi-square statistic. Tests of correlation will be performed as appropriate.

In terms of the original hypothesis and specific aims of this study, rural surgeons will be compared to urban counterparts based on NCHS classification. The responses to survey items 9 and 10 serve as the crucial outcomes pertinent to specific aims 1 and 2, respectively. These items ask surgeons about their preferred method of managing CDL either preoperatively or incidentally discovered at the time of cholecystectomy. All other items essentially serve as covariates to help determine the influence of surgical experience, endoscopic experience, resources available, technical factors, training, and demographics on these outcome measures.
Power Calculation

To estimate power for this study, we assume a total response rate of at least 20% of our targeted population (n=24,694) based on prior surveys administered to surgeons. These prior surveys had response rates ranging from 23-72%. King et al. reported that surgeons in a typical U.S. population area included 71.1% practicing in metropolitan areas (NCHS 1-4), 21.1% in micropolitan areas (NCHS 5), and 7.7% in rural areas (NCHS 6). We assume that the smallest overall response will be from rural surgeons and base our power calculation on this group. Based on the anticipated minimum response rate of 20%, published data that indicate about 8% of likely respondents will come from rural areas, and expected patterns of clinical management preferences by practice setting (see attached power calculations), this sample will provide adequate power (>95% at the 0.05 alpha level) to detect an effect size of 0.12 – 0.27, i.e. a small to medium effect.
SAGES RESEARCH GRANT APPLICATION
BUDGET SHEET

Detailed budget for 12 month period from 7/1/2014 through 6/30/2015.

Dollar amount requested (Omit cents) $29,500

Total for the grant request may not exceed $30,000.

* Salary funds should be used for staff required to execute the study, but should not be used for salary support for the primary investigator. If salary support exceeds 50% of the project budget, then specific justification is required.

**Funds requests for travel for the presentation of a SAGES funded study should be limited to $1,000.

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<td>2. Irene Feurer, PhD</td>
<td>Co-Investigator</td>
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<td>3. Rebeccah B. Baucom, MD</td>
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CONSULTANT COSTS

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TRAVEL**

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PATIENT CARE COSTS

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CONSORTIUM/CONTRACTUAL COSTS

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TOTAL DIRECT COSTS

$29,128.92
References


November 19, 2010

Benjamin K. Poulose, M.D., MPH
General Surgery - Medicine
D-5203 MCN 37232-2637

William J. Lee, MS
Nashville, TN

RE: IRB# 101468 "Choledocholithiasis Management Variation in America: Do Rural Surgeons Need Different Skills than Urban Surgeons?"

Dear Benjamin K. Poulose, M.D., MPH:

A designee of the Institutional Review Board reviewed the Request for Exemption application identified above. It was determined the study poses minimal risk to participants. This study meets 45 CFR 46.101 (b) category (2) for Exempt Review. Approval is extended for the Request for Exemption application dated 11/4/2010.

Any changes to this proposal that may alter its exempt status should be presented to the IRB for approval prior to implementation of the changes. In accordance with IRB Policy III.C, amendments will be accepted up to one year from the date of approval. If such changes are requested beyond this time frame, submission of a new proposal is required.

DATE OF IRB APPROVAL: 11/19/2010

Sincerely,

Erin L Hutchins
Behavioral Sciences Committee

ELH/elh
Electronic Signature: Erin L Hutchins/VUMC/Vanderbilt: (806F9C80B5EFE3CF281478F3A1615582)
Signed On: 11/19/2010 10:32:51 AM CST
Available Resources

Key Study Personnel:

Benjamin K. Poulose, MD, MPH (Principle Investigator) is an MD graduate of the Johns Hopkins University School of Medicine who also holds a Master of Public Health degree from Vanderbilt University. He is an active, fellowship-trained General Surgeon at Vanderbilt University Medical Center with specialty interest in abdominal wall reconstruction and hernia repair. Dr. Poulose has a robust clinical practice in General Surgery, and his research efforts focus on Health Services Research in General Surgery with an emphasis on quality improvement, cost-effectiveness analysis, and comparative effectiveness. Dr. Poulose is the founder and director of the Vanderbilt Procedural Outcomes Database that serves to integrate administrative data, patient-centered data, cost data, and health utility/quality of life data using an Enterprise Data Warehouse approach. As PI on the proposed project, he will have responsibility for the overall direction and administration of the project, coordinating its various phases, and orchestrating the efforts of all personnel involved.

Rebeccah B. Baucom, MD (Research Fellow) is an MD graduate of the University of Texas Southwestern Medical School at Dallas where she finished near the top of her class. She has completed three years of General Surgery at Vanderbilt University Medical Center and one year of dedicated research. She has already demonstrated great clinical intuition, as well as a strong interest in research and academic medicine. During her time at UT Southwestern, she participated in basic science research. As she has spent more time in patient care, her interests have grown in the area of health services research. For the proposed project, she will serve as the study contact, and she will be responsible for survey distribution, data collection, analysis and publications. She will have 100% protected time to devote to her research, and the Department of Surgery is committed to providing any additional support that is necessary for the completion of this project.

Irene Feurer, PhD (Research Professor of Surgery) is a graduate of the University of Pennsylvania where she received her Masters in Health Professions Education and completed a PhD in Measurement, Evaluation, and Techniques of Experimental Research. She joined the faculty at Vanderbilt in 1997 and has been a Research Professor of Surgery since 2003. She currently serves as the Director of Quantitative Services and Outcomes Research and is an active member of the Center for Surgical Quality and Outcomes Research at Vanderbilt University. She independently collaborates as a member of research teams, and assists with design, implementation, analysis, and publication of research. She will provide statistical expertise for this project, and was instrumental in development of the survey tool for the pilot study. She will participate in data verification as well as intensive analysis for the project.
Biographical Sketch

Provide the following information for the key personnel and other significant contributors in the order listed on Form Page 2. Follow this format for each person. DO NOT EXCEED FOUR PAGES.

NAME
Benjamin K. Poulose, MD, MPH

POSITION TITLE
Assistant Professor, Vanderbilt University Medical Center, Department of Surgery

eRA COMMONS USER NAME
POULOSBK

EDUCATION/TRAINING (Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)

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<td>B.S.</td>
<td>1994</td>
<td>Biology</td>
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<tr>
<td>Johns Hopkins University School of Medicine, Baltimore, MD</td>
<td>M.D.</td>
<td>1999</td>
<td>Doctor of Medicine</td>
</tr>
<tr>
<td>Vanderbilt University School of Medicine, Nashville, TN</td>
<td>M.P.H.</td>
<td>2005</td>
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A. Personal Statement

I am an active general surgeon and health services researcher. I work in a busy surgical practice in an academic setting that is committed to excellence in patient care, research, and teaching. I see patients every week with abdominal wall hernia, foregut, and biliary disease. My research has focused heavily on health services research and epidemiology in efforts to help improve the real-world care of surgical patients. My practice and my Department are committed to our efforts within the Vanderbilt Surgical Health Services Research group. We have successfully mentored both medical students and surgical residents pursuing academic careers. As a successful clinician-researcher, I have developed several relationships that lend itself well to clinical research as it is easy for me to access colleagues who are stakeholders for patient advocacy, health care providers, insurance companies, hospital administrators, industry, and professional societies. Most importantly, I am very fortunate to work in a collegial and innovative research environment with so many talented people who are experts in their respective fields of stakeholder engagement, epidemiology, bioinformatics, biostatistics, and qualitative methods.

B. Positions and Honors

Positions and Employment

1993-1994  Cancer Education Fellow, University of North Carolina at Chapel Hill, Chapel Hill, NC
1997-1998  Predoctoral Research Fellow, Johns Hopkins University School of Medicine, Baltimore, MD
1999-2000  Internship in General Surgery, Vanderbilt University Medical Center, Nashville, TN
2002-2005  Fellowship in Surgical Research, Vanderbilt University Medical Center, Nashville, TN
2003-2005  Health Services Research Fellowship, Vanderbilt University School of Medicine
2001-2007  Residency in General Surgery, Vanderbilt University Medical Center, Nashville, TN
2007-2008  Fellowship in Minimally Invasive Surgery and Surgical Endoscopy, University Hospitals Case Medical Center, Cleveland, OH
2008-  Assistant Professor, Department of Surgery, Vanderbilt University Medical Center, Nashville, TN

Other Experience and Professional Memberships

1992-1994  Undergraduate Research in Cancer Biology, University of North Carolina at Chapel Hill, Chapel Hill, NC
1995  Predoctoral Research in Microbiology, Christian Medical College and Hospital, Vellore, Tamil Nadu, India
2008-present  Active Member, Society of American Gastrointestinal Endoscopic Surgeons
2008-present  Associate Fellow, American College of Surgeons
2008-present  Fellow, Southeastern Surgical Congress
Honors

1990        Phi Eta Sigma Freshman Honor Society
1990-1994   Dean’s List, University of North Carolina at Chapel Hill, Chapel Hill, NC
1993        Phi Beta Kappa
1994        Bachelor of Science (Biology) with Highest Distinction and Highest Honors, University of North Carolina at Chapel Hill, Chapel Hill, NC
2002        H. William Scott, Jr. Research Scholarship in Surgery, Vanderbilt University School of Medicine, Nashville, TN
2007        Alfred Blalock Surgical Resident Award, Vanderbilt University School of Medicine, Nashville, TN

C. Selected peer-reviewed publications (in chronological order)


2008


2009


2010


2011


2012


D. Research Support

Completed Research Support

Health Services Research Fellowship, T32, HS 13833-01
Vanderbilt University School of Medicine, Nashville, TN
Role: Health Services Research Fellow
Principal Investigator: Marie R. Griffin, M.D., M.P.H.

Natural Orifice Surgery Consortium for Assessment and Research
Cost Effectiveness Analysis of Transgastric Cholecystectomy, Transvaginal Cholecystectomy, and Laparoscopic Cholecystectomy: Projected Long Term Outcomes and Complications Evaluation
University Hospitals Case Medical Center, Department of Surgery, Cleveland, OH
Vanderbilt University School of Medicine, Nashville, TN
Role: Principal Investigator
$20,000

Current Research Support

Karl Storz, U.S.A.
Barriers to Microlaparoscopy
Vanderbilt University School of Medicine, Nashville, TN
Role: Principal Investigator
$48,000

American Hernia Society
Prospective Randomized Trial of Biologic Mesh versus Synthetic Mesh for the Repair of Complex Ventral Hernias
University Hospitals Case Medical Center, Cleveland, OH and Vanderbilt University School of Medicine, Nashville, TN, Departments of Surgery
Role: Co-Investigator (Principal Investigator Michael Rosen, M.D.)
$25,000

Vanderbilt Initiative in Surgery and Engineering
Towards an Image Guided Classification System for Ventral Abdominal Wall Hernia
Vanderbilt University School of Medicine, Department of Surgery, Nashville, TN
Role: Principal Investigator; (Co-Investigator Bennett Landman, Ph.D, Department of Biomedical Engineering)
$35,000
BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors in the order listed on Form Page 2. Follow this format for each person. DO NOT EXCEED FOUR PAGES.

NAME
Baucom, Rebecca B.

POSITION TITLE
General Surgery Research Fellow

eRA COMMONS USER NAME (credential, e.g., agency login)
BAUCOMR

EDUCATION/TRAINING
(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)

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<td>Medicine</td>
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</tbody>
</table>

A. Personal Statement

The proposed research project aims to determine whether a difference exists between urban versus rural management of choledocholithiasis. I am fortunate to be a surgery resident at an academic institution committed to excellence in clinical training as well as patient care. Additionally, I have the support of the General Surgery Department at Vanderbilt University Medical Center to have two years of 100% devoted research time. My qualifications demonstrate that I have the motivation and aptitude to complete the proposed project. While in my junior clinical years as a General Surgery resident, I successfully published a review article on the surgical management of Hereditary Nonpolyposis Colorectal Cancer (HNPCC). As a research fellow at UT Southwestern I participated in research involving corneal transplantation in mice. This required meticulous attention to detail, as well as dedication to develop the initial protocol for the project. I have demonstrated that I have the qualifications necessary to complete the proposed project, including clinical aptitude, attention to detail, dedicated research time, and motivation.

B. Positions and Honors

Positions and Employment
2006  Medical Student Research Fellow, UT Southwestern Medical Center
2008-09  Tutor, Human Anatomy and Medical Physiology, UT Southwestern Medical Center
2009-  General Surgery Resident, Vanderbilt University Medical Center
2012-  General Surgery Research Fellow, Vanderbilt University Medical Center

Professional Memberships
2005-  Member, Phi Beta Kappa
2009-  Member, Alpha Omega Alpha
2009-  Member, American Medical Association
2009-  Resident Member, American College of Surgeons
2012-  Candidate Member, Society of American Gastrointestinal and Endoscopic Surgeons
2013-  Candidate Member, American Society of Colon and Rectal Surgeons

Awards and Honors
2005-07  Southwestern Medical Foundation Scholarship
2011-12  Lester F. Williams, Jr. Research Scholarship
C. Selected Peer-reviewed Publications

Publications


D. Research Support

No current or previous research support.
BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors in the order listed on Form Page 2. Follow this format for each person. DO NOT EXCEED FOUR PAGES.

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feurer, Irene Debra</td>
<td>Research Professor of Surgery and Biostatistics</td>
</tr>
</tbody>
</table>

**eRA COMMONS USER NAME** (credential, e.g., agency login)
FEURERID

**EDUCATION/TRAINING** (Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)

<table>
<thead>
<tr>
<th>INSTITUTION AND LOCATION</th>
<th>DEGREE</th>
<th>MM/YY</th>
<th>FIELD OF STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ursinus College, Collegeville, PA</td>
<td>B.S.</td>
<td>06/76</td>
<td>Biological Sciences</td>
</tr>
<tr>
<td>University of Pennsylvania, Philadelphia, PA</td>
<td>M.S.Ed.</td>
<td>05/83</td>
<td>Health Professions Education</td>
</tr>
<tr>
<td>University of Pennsylvania, Philadelphia, PA</td>
<td>Ph.D.</td>
<td>05/97</td>
<td>Measurement, Evaluation, and Statistical Methods</td>
</tr>
</tbody>
</table>

**A. Personal Statement**

The primary aim of this proposal is to ascertain variables associated with variations in the management of choledocholithiasis, particularly factors contributing to differences in the use of operative and endoscopic methods. I have broad experience in research design, statistical methods, and person-reported outcomes research. Additionally, I collaborated with Dr. Poulose in the early development of the proposed study and would be pleased to participate in this project.

**B. Positions and Honors**

**Positions and Employment**

1976-79 Upper school instructor in mathematics and science, The Stevens School, Philadelphia, PA
1979-85 Coordinator, Metabolic Testing Services, Clinical Nutrition Center, Hospital of the University of Pennsylvania, Philadelphia, PA
1985-88 Education Specialist, Clinical Nutrition Center, Hospital of the University of Pennsylvania
1988-90 Associate Director, Graduate Medical Education Division, Department of Surgery, University of Pennsylvania
1990-92 Research Coordinator for Practice Guidelines, American Psychiatric Association, Washington, DC
1995-2000 Statistician, John F. Kennedy Center for Research on Human Development (NICHD-funded Mental Retardation Research Center), Vanderbilt University, Nashville, TN
1997-2000 Research Assistant Professor of Psychiatry, Vanderbilt University School of Medicine
2000- Research Associate Professor of Surgery, Vanderbilt Transplant Center
2000-03 Research Associate Professor of Surgery, Vanderbilt University School of Medicine
2001-03 Research Associate Professor of Preventive Medicine, Division of Biostatistics, Vanderbilt University School of Medicine, Nashville, TN
2003- Research Professor of Surgery, Vanderbilt University School of Medicine, Nashville, TN
2003-06 Research Professor of Preventive Medicine, Vanderbilt University School of Medicine
2004- Research Professor of Biostatistics, Vanderbilt University School of Medicine, Nashville, TN
2004- Faculty Statistician, Vanderbilt-Ingram Cancer Center, Nashville, TN
2008- Adjunct Professor of Nursing (Research), Vanderbilt University School of Nursing, Nashville, TN
Other Experience and Current Professional Memberships

1993- Member, American Psychological Association
2001- Member, American Statistical Association (Secretary, 2002 and President, 2003, Middle Tennessee Chapter)
2001- Member, Americas Hepato-Pancreato-Biliary Association
2005- Member, ad hoc expert panel on quality of life measurement, Division of Diabetes, Endocrinology and Metabolic Diseases, NIDDK
2005- Member, clinical study planning and oversight committee, “Islet Transplantation in Type 1 Diabetic Kidney Allograft Recipients: Efficacy of Islet after Kidney Transplantation”, NIDDK, NIAID, and Juvenile Diabetes Research Foundation
2009- Member, International Hepato-Pancreato-Biliary Association
2009- Member, Vanderbilt Center for Surgical Quality and Outcomes research, Nashville, TN
2011- Invited faculty member, Vanderbilt Center for Quantitative Sciences, Nashville, TN

C. Selected Peer-Reviewed Publications (Selected from 112 peer-reviewed publications)


D. Research Support

Ongoing Research Support

1R01 DK091748-01A1 Abumrad (PI) 09/01/11 – 08/30/16
RYGB Improves Metabolism by Interrupting the Gastric Adipose Tissue Axis
This study addresses the mechanisms associated with metabolic improvements immediately following bariatric surgery.
Role: Co-Investigator

5R01 NR011477-04 Fowke (PI) 07/01/09 – 04/30/14
A New Instrument to Comprehensively Assess Sedentary Behaviors
The major goal of this project is to develop a questionnaire of manageable length that comprehensively assesses major sedentary behaviors in the population.
Role: Co-Investigator

3P30 CA068485-15S1 Pietenpol (PD) 09/10/10 – 08/31/15
Cancer Center Support Grant
The goal of this project is to conduct, coordinate and integrate Vanderbilt University’s cancer-related activities.
Role: Co-Investigator

Completed Research Support and Research Training Sponsorship

R01 DK70860-01 Abumrad (PI) 04/01/05 – 03/31/11
Role of the Omentum in the Treatment of Morbid Obesity
This grant supported a clinical study assessing the impact of omentectomy during bariatric surgery on metabolic and molecular markers of inflammation in morbid obesity.
Role: Co-Investigator

IAF-06-085 Department of Veterans Affairs (HSR&D) Weinger (PI) 01/2008 – 09/2011
Operating Room Workload and Quality of Care
The study evaluated multi-discipline clinician perceptions of workload in the operating room and models relationships among perceived workload and intraoperative quality of care.
Role: Co-Investigator

F32 DK077482-02 Russell (post-doctoral fellow) 09/15/06 – 06/2008
Evaluating Cognitive Function, Cost Utility, and Outcomes after Liver Transplantation
This individual fellowship award supported the stipend and MPH program tuition costs of Dr. Robert Russell’s
post-doctoral research training program in transplant outcomes research.
Role: Faculty Sponsor

1-R03 HS13036   Feurer (PI)  09/2002 – 08/2004
Measuring Quality of Life in Organ Transplant Patients
The goal was to evaluate the reliability, validity, and responsiveness of measures of patient satisfaction and health-related quality of life in organ transplant candidates and recipients.
Role: Principal Investigator
Participation in SAGES
Dr. Baucom is a newly elected candidate member of SAGES. She attended the 2013 meeting, and was an author of the poster, “Prospective Evaluation of Barriers to Microlaparoscopy.”

Dr. Poulose has participated in SAGES since 1998 and has continued to be actively involved on multiple levels throughout his career. He has participated on multiple committees within SAGES including Resident Education, Flexible Endoscopy, and Fundamentals of Endoscopic Surgery. Dr. Poulose has presented at the SAGES annual meeting on multiple occasions and has mentored several medical students, residents, and fellows who have also participated in SAGES. Dr. Poulose has taken an active role in SAGES participating as faculty for post-graduate courses, resident and fellow courses. He has served as the SAGES Annual Meeting Poster Session Co-Chair for 2012 and 2013.
Choledocholithiasis Management Survey - Final Copy

Dear Surgeon:

We are investigating practice patterns regarding the management of choledocholithiasis and how these may be affected by local resources. In light of changes to national healthcare policy, access to care and physician availability have recently moved into the spotlight. We have created a simple survey to address these issues that we hope you will invest 3-5 minutes to complete.

Please know that although we do ask for demographic information, all information will be de-identified. Data will be kept strictly confidential and will only be presented in its aggregate form.

We are grateful for you taking the time to complete this survey. As a token of our appreciation, you will have the option of entering a raffle for a $500 Visa gift card upon completion of the survey!

Best Regards,

Rebeccah Baucom, M.D.

Benjamin Poulse M.D., M.P.H., Assistant Professor of Surgery

Michael Holzman M.D., M.P.H., Lester and Sara Jayne Williams Chair in Academic Surgery

The following questions address some basic information about you, your surgical practice, and how you address the management of choledocholithiasis. Please read each item carefully and answer according to your practice habits.

1. On average, I perform laparoscopic cholecystectomy:
   - □ Never
   - □ < once per month
   - □ 1-5 times per month
   - □ 6-10 times per month
   - □ > 10 times per month
2. On average, I perform upper GI endoscopy:
   - ☐ Never
   - ☐ < once per month
   - ☐ 1-5 times per month
   - ☐ 6-10 times per month
   - ☐ > 10 times per month

3. On average, I perform colonoscopy:
   - ☐ Never
   - ☐ < once per month
   - ☐ 1-5 times per month
   - ☐ 6-10 times per month
   - ☐ > 10 times per month

4. On average, I perform open common bile duct exploration:
   - ☐ Never
   - ☐ < once per month
   - ☐ 1-5 times per month
   - ☐ 6-10 times per month
   - ☐ > 10 times per month

5. On average, I perform laparoscopic common bile duct exploration:
   - ☐ Never
   - ☐ < once per month
   - ☐ 1-5 times per month
   - ☐ 6-10 times per month
   - ☐ > 10 times per month

6. On average, I perform ERCP:
   - ☐ Never
   - ☐ < once per month
   - ☐ 1-5 times per month
   - ☐ 6-10 times per month
   - ☐ > 10 times per month

7. I routinely perform intraoperative cholangiography (IOC) during cholecystectomy:
   - ☐ Yes
   - ☐ No

   7b. If you use IOC selectively, what are your typical indications? (check all that apply)
   - ☐ History of gallstone pancreatitis
   - ☐ History of jaundice
   - ☐ Elevated bilirubin or alkaline phosphatase
   - ☐ Common bile duct dilation
   - ☐ Cystic duct dilation
   - ☐ Anatomic concerns
   - ☐ Suspected common bile duct stones

8. The closest proceduralist who performs ERCP:
   - ☐ Is affiliated with one or all of the hospitals in which I practice
   - ☐ Requires a referral to another hospital

9. My preferred method for managing common bile duct stones discovered preoperatively:
   - ☐ Laparoscopic common bile duct exploration
   - ☐ Open common bile duct exploration
   - ☐ Preoperative ERCP
   - ☐ Intraoperative ERCP
   - ☐ Postoperative ERCP

10. My preferred method for managing common bile duct stones discovered during cholecystectomy:
    - ☐ Laparoscopic common bile duct exploration
    - ☐ Open common bile duct exploration
    - ☐ Intraoperative ERCP
    - ☐ Postoperative ERCP

11. What limitations, if any, prevent you from performing laparoscopic common bile duct exploration when indicated? (check all that apply)
    - ☐ Time constraints
    - ☐ Lack of appropriate equipment
    - ☐ Lack of support staff
    - ☐ A reliable ERCP proceduralist is available
    - ☐ Lack of appropriate reimbursement
    - ☐ Increased morbidity
    - ☐ Fear of losing referrals if I don’t refer out for ERCP
    - ☐ Size of stone
    - ☐ Lack of comfort with performing the procedure

12. My age (in years) is: ______________________________________

13. My current practice is best described as:
    - ☐ University hospital/VA
    - ☐ Community hospital
    - ☐ Community hospital, university affiliated
    - ☐ Military
14. Enter 5 digit zip code in which your primary practice is located. The results of this response will be kept strictly confidential and used for demographic groupings only.

15. Since completing my training, I have been in practice for ____ years.

16. My residency program would be best described as:
- University hospital/VA
- Community hospital
- Community hospital, university affiliated
- Military

17. I received the majority of my laparoscopic training:
- In residency
- In fellowship
- Other (e.g. postgraduate course, mini-fellowship, preceptorship, on the job)
- Did not receive laparoscopic training

18. I received the majority of my endoscopic training:
- In residency
- In fellowship
- Other (e.g. postgraduate course, mini-fellowship, preceptorship, on the job)
- Did not receive endoscopic training

19. I consider myself a general surgeon:
- Yes
- No

20. Including myself, there is(are) ____ general surgeon(s) in my practice.

21. Please select your gender:
- Male
- Female
- Transgender

22. Please enter your ethnicity and race: (check all that apply)
- Hispanic, Latino/a, or of Spanish origin
- White
- Black
- American Indian or Alaska Native
- Asian or Pacific Islander
- Prefer not to respond

OPTIONAL: Enter email address if you wish to be entered into a raffle for a $500 Visa gift card. Your email address will be kept strictly confidential and only used to contact you should you be selected as the winner.