documented disparities in the use of breast reconstruction by patient race, insurance type, and age, mostly in cross-sectional studies. This study aimed to estimate disparities over time in the use of breast reconstruction by race/ethnicity, insurance type, and age.

METHODS: We analyzed data from our institution’s prospectively collected National Cancer Institute-Designated Comprehensive Cancer Center Tumor Registry. We used the Chi-squared test and multivariable logistic regression to estimate associations between race/ethnicity, insurance type, age, and breast reconstruction rate. Likelihood-ratio tests assessed the interaction between these associations and period of surgery.

RESULTS: From 2000 to 2014, 2,599 women underwent mastectomy for breast cancer. Of these, 1,052 (40.5%) underwent mastectomy only and 1,547 (59.5%) also underwent breast reconstruction. Most reconstructions were autologous (65.1%), followed by implant-based (26.8%), and mixed (8.1%). A multivariable logistic regression model showed that higher cancer stage (p<0.001), being older (p<0.001), smoking status (p<0.007), African-American (p<0.001) or Asian (p<0.001) race, having Medicare (p<0.001) or Medicaid (p=0.044) coverage, and being uninsured (p=0.019) were significant and independent risk factors for not receiving breast reconstruction after mastectomy. We found no evidence that disparities based on age, race/ethnicity, or insurance type changed over the study period (p>0.050). Cancer stage, age, race/ethnicity, or insurance type were not significant predictors for type of reconstruction (p>0.050).

CONCLUSION: Despite being a tertiary and quaternary clinical center with a comprehensive approach to breast cancer care, our findings demonstrate disparities in use of breast reconstruction according to women’s age, race/ethnicity, and insurance type. Furthermore, these disparities did not change significantly over the study period. Given the recent and anticipated changes associated with the Affordable Care Act, it is more important than ever to identify the reasons behind these differences and continue to evaluate barriers in access to breast reconstruction.

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PURPOSE: With the implementation of the Hospital Value-Based Purchasing Program as a part of the Affordable Care Act, standardized metrics for evaluating healthcare quality at the provider level have become a cornerstone for guiding the reformation of healthcare policy and reimbursement models in the United States. For many surgical procedures, adverse perioperative outcomes and hospital readmissions have consequently been increasingly utilized as indicators of provider quality and determinants of reimbursement. While numerous studies have explored the underlying factors associated with outcome disparities following surgery, there is limited data in the literature that evaluates the relative impact of patient insurance status on perioperative outcomes. Given its high annual incidence and significant healthcare burden, ventral hernia repair (VHR) was considered an appropriate model for conducting our investigation. In this study, we used an all-payer data reporting system to characterize the association between patient insurance status and surgical outcomes following VHR.

METHODS: Following IRB approval, the New York Statewide Planning and Research Cooperative System (SPARCS) database was queried to identify the records of all patients who underwent open or laparoscopic primary VHR in the state of New York between 2009 and 2013. Patients were stratified by their insurance status into one of four categories—commercial coverage, Medicare, Medicaid, or self-pay/uninsured. Primary outcomes evaluated were perioperative complications, emergency department (ED) visits, and hospital readmissions up to one year following surgery. Data analysis also included patient characteristics and demographic information. Multivariate logistic regression was used to control for confounding differences among groups.

RESULTS: 71,409 patients underwent primary VHR in New York between 2009 and 2013. 74.2% of patients had commercial coverage, 18.3% had Medicare, 6.3% had Medicaid, and 1.3% of patients were uninsured. When individually compared to patients with other types of insurance coverage, patients with Medicare and Medicaid coverage were more likely to visit the ED within 30 days of surgery (odds ratio [OR] 1.56 and 2.03 respectively, p<0.0001) and between 31 and 90 days following surgery (OR 1.65
and 1.98 respectively, \(p<0.0001\). Patients with Medicaid had an independently increased comparative likelihood of wound infection during their perioperative course (OR 1.96, \(p<0.0001\)). An evaluation of hospital readmission rates demonstrated that compared to patients with other types of insurance coverage, patients with Medicare and Medicaid were also more than twice as likely to experience readmission within one year of surgery (OR: 2.33 and 2.38 respectively, \(p<0.0001\)). However, there was no significant difference in the likelihood of readmission within 30 days or between 31 and 90 days for any of the insurance status groups.

CONCLUSION: In this study of a statewide patient sample, we identify significant discrepancies when evaluating risk-adjusted outcomes following VHR for patients with Medicare or Medicaid coverage and patients who are commercially insured. Despite controlling for confounding differences between patient characteristics and demographic information, our data suggest the influence of additional factors that may impact accessibility to quality care for patients with government-funded health insurance. Further studies are indicated in order to better understand the underlying factors that drive this disparity.

How Big is Our Piece of the Pie? Perceived Plastic Surgery Scope of Practice Among Physicians and Patients

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PURPOSE: Plastic and reconstructive surgery (PRS) has evolved into a broad field, encompassing reconstructive and aesthetic procedures of the head/neck, breast, and body. Such diversity in scope of practice may be confusing for patients and referring providers, who may not be aware of the breadth or depth of our discipline. Further contributing to the confusion are other specialties with overlapping clinical expertise: neurosurgery (N), ENT, oral maxillofacial surgery (OMFS), general surgery (GS), orthopedic surgery (O), OB/GYN, and dermatology (D). While current studies of medicine residents and emergency room patients’ perceptions of plastic surgeons’ scope of practice exist, there has never been a study of referring surgeons in a tertiary hospital and their perceptions of plastic surgeons’ scope of practice. Furthermore, none have used crowdsourcing to survey patients on their perception of surgical expertise. Our study purpose is to compare physician and patient perceptions towards the procedures commonly performed by plastic surgeons.

METHODS: An anonymous, Web-based survey was sent to faculty from all surgical specialties. Respondents were asked to choose which specialist they would consult for various reconstructive and aesthetic problems. Age, gender, specialty, years in practice, and training location was elicited. A simplified survey was sent to an Internet crowdsourcing service, representing potential patients without medical training.

RESULTS: Of 228 faculty, 68 responded (29.8%). The majority were OB/GYN (26.5%), followed by general surgery (GS) (20.6%), then dermatology (D) (13.2%). Most did not receive any part of their training at our institution. Referring surgeons considered plastic surgeons experts in 16/35 (45.7%) reconstructive problems, with the exception of head/neck cancer defects (ENT), myelomeningocele (N), skin cancer (D), hand fractures (O), upper extremity tendon lacerations (O), tissue biopsies (GS), hernia repair (GS), perineal defects (GS), lower extremity traumatic injuries (O), acute burns (O), and chronic lower extremity wounds (GS). To address aesthetic problems, most referring surgeons chose plastic surgeons with the exception of correction of deviated septum (ENT, 73.5% vs. PRS 35.3%). In contrast, 78 patients recruited via crowdsourcing considered plastic surgeons experts for only 3/32 (9.4%) reconstructive problems (correction of large breasts, breast reconstruction, and burn scar contracture). For aesthetic problems, patients chose plastic surgeons, except for deviated septum correction (ENT, 43% vs. PRS 20.5%).

CONCLUSIONS: Referring surgeons and patients clearly choose plastic surgeons for aesthetic concerns. For hand fractures, upper extremity lacerations, head and neck cancer defects, tissue biopsies, abdominal surgery, lower extremity soft tissue defects, and chronic lower extremity wounds, referring surgeons and patients choose orthopedic, ENT, and general surgeons more often than plastic surgeons. In an era of increasing surgical specialization, plastic surgeons risk losing these important reconstructive fields to other subspecialties. Increased physician and patient outreach and education of plastic and reconstructive surgeon’s breadth of practice may increase referrals in these areas.