that required debridement. Overall, 290 patients (85%) were satisfied with their nipple-areolar reconstruction.

CONCLUSION: This is the largest series of patients undergoing NAC reconstruction in the current literature that we are aware of. We use a variety of techniques that may lead to a natural outcome and a greater satisfaction rate following NAC reconstruction. Our approach includes performing NAC reconstruction with local anesthetic in an office-based setting with immediate post-flap tattooing. A pre-mastectomy color evaluation of the NAC for all mastectomy patients has proven to be highly beneficial for those undergoing bilateral mastectomies. Encouraging patient participation in pre-operative NAC site markings may make patients feel more involved in their care and further enhance satisfaction rate. Selecting the type of local flap performed based on the patient’s individual scar pattern may lead to better aesthetic outcomes. These are practical modifications that can be easily implemented to augment nipple-areolar reconstructions.

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Plastic Surgery Tool-Kit to Build a Culture of Patient Safety, Quality, and Service

Michele A. Manahan, MD; Jeffrey W. Aston, BS; Ricardo J. Bello, MD, MPH; Carisa M. Cooney, MPH; Gedge D. Rosson, MD

BACKGROUND: Despite the increasing importance of quality assessment and improvement initiatives in health care, national quality measures and patient safety practice guidelines remain difficult to define in plastic surgery. As a quality of life specialty, plastic surgery may require heavier reliance upon unique patient-reported outcomes and different clinical indicators of quality. Comprehensive departmental frameworks for patient safety, quality, and service have yet to be described in the plastic surgery literature. These conditions present us with opportunities to standardize and improve the quality of care. We describe a dynamic model for quality improvement used successfully for the past three years in the Department of Plastic Surgery at Johns Hopkins and provide a tool-kit for implementation across various practice environments and hospital infrastructures.

METHODS: Drawing from three years of experience using a Comprehensive Unit-Based Safety Program, formal quality improvement committee structure, literature review, and work from The Johns Hopkins Armstrong Institute for Patient Safety and Quality, we devised a framework specific to and exportable for the field of plastic surgery.

RESULTS: Our departmental structure provides channels to facilitate the input and output of naturally trending and recorded data. Monthly Patient Safety, Quality, and Service Committee meetings are a transparent way to address important topics and expeditiously make appropriate changes. Meetings are attended by departmental administration, physicians, physician extenders, clinical support staff, clerical support staff, and trainees, and are structured in a bottom-up fashion to encourage participation from all levels. Four key domains are addressed: (1) safety, (2) external measures, (3) patient experience, and (4) value. Examples of indicators we use from these domains include hand washing, pain management, rate of postoperative hematoma, readmission rates, the Breast-Q Reconstruction Survey, and auto-scheduling (pre-scheduling) of postoperative clinic appointments. The core team identifies opportunities and needs; develops, implements, and tracks improvement plans; and celebrates and advertises accomplishments to colleagues, the institution, and the public.

CONCLUSION: We anticipate that formal departmental quality improvement structure will promote excellence and national leadership on externally reported measures of patient safety, quality, and service. We provide other plastic surgery departments and divisions with a potential framework that can be adapted to different settings. This work becomes increasingly relevant as value-based reimbursement and pay-for-performance initiatives are implemented with the expectation to drive improvements in healthcare.

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Trainee Selection and the Correlation between Cognitive and Technical Skill Evaluation

Mark V. Schaverien, MD, MSc, MEd; Charles E. Butler, MD; Jun Liu, MD, PhD; Jesse C. Selber, MD, MPH

INTRODUCTION: The selection process for surgical trainees aims to identify those who will perform best during training and have the greatest potential as future surgeons. Better understanding the predictive relationship between interview performance, level of technical skill, and performance during training will allow optimization of the interview and evaluation process to identify the best candidates.1–3

MATERIALS AND METHODS: Three annual cohorts of Reconstructive Microsurgery fellows at the Department of Plastic Surgery at the University of Texas MD Anderson Cancer Center, comprising 20 trainees, were included in the study. At interview, subjects were rated using seven criteria, as well as given a score for overall impression. At the start and end of the fellowship, microsurgical technical skill was assessed both in the OR and laboratory using a validated tool. At the end of the fellowship there was a final evaluation of performance using criteria adapted from the six Accreditation Council for Graduate Medical Education (ACGME) core competencies. Scores at interview, technical skill assessment, and final evaluation scores were all compared in multiple ways to determine associations and predictive factors.

RESULTS: Microsurgical skill assessment in the OR at the start of training correlated with all domains evaluated at interview, most closely with Plastic Surgery Training Experience. Microsurgical skill assessment in the OR at the end of training also correlated with scores on the majority of final assessment criteria based on ACGME core competencies, with the highest correlations with Patient Care and Medical Knowledge. Assessment of microsurgical skill in the laboratory at the start of the fellowship did not improve the predictive relationship between interview scores and ACGME core competency evaluations.

CONCLUSION: Microsurgical technical skill in the OR tracked with all domains evaluated at interview, and also with the majority of ACGME core competency evaluations. These results validate the use of the current selection process in choosing candidates with the highest level of both cognitive and technical skill, and also support the effectiveness of the one-year microsurgical fellowship at improving microsurgical skill in all trainees.

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A New Modified Closed-Open Approach as Part of a Graduated and Integrative Approach to Rhinoplasty

Jonas Röjdmark, MD, PhD; Mouchammed Agko, MD

BACKGROUND: Open versus closed approach in rhinoplasty is a frequently debated topic in aesthetic plastic surgery.1–3 Although good results can often be achieved with either technique, both have unique advantages and disadvantages. We present a new modified closed-open approach employed in selected cases that encompasses features of both.

METHODS: The surgical approach is described in detail followed by clinical examples. Indications and limitations are discussed. The procedure begins as a closed approach through an intracartilaginous incision allowing cephalic trimming of the lateral crura and dorsal rasping and/or excision. Patients requiring extensive nasal tip maneuvers are dealt with exposure of the alar cartilage framework through a transcolumellar/limited marginal incision to provide adequate exposure of the alar cartilages as well as easy access to the septum. In our hands this approach is easy and expeditious. It requires less tip dissection, and therefore avoids the prolonged postoperative edema associated with open or extended closed tip delivery approaches.

CONCLUSION: The modified closed-open technique circumvents the limitations of the closed approach by providing good exposure of the tip and septum without incurring...