RESULTS: Fifty-five participants (31 patients and 24 parents) completed all questionnaires, 98.2% preferred active involvement in therapeutic decision-making. The SDM-Q-9 scores, assessed by patients and physicians, were acceptable (mean 68 out of 100). However, the independently assessed OPTION-5 scores were significantly lower (mean 31 out of 100). In the consultations, physicians rarely asked for patient preferences regarding involvement. In addition, the patient's freedom of choice and pros and cons of treatment options were inadequately explained. The degree of patient involvement from the patient's perspective (CollaboRATE) was significantly correlated with patient satisfaction (ρ 0.35, $p<0.01$).

CONCLUSION: In this cohort, almost all patients and parents preferred involvement in therapeutic decision-making. If they felt involved, they were more likely to score higher on the satisfaction scale. However, SDM was not adequately performed in this cohort. An explanation for this could be that both patients and parents are relatively unfamiliar with SDM. To enhance and facilitate SDM practice, physician and patient targeted interventions (such as trainings and digital decision aids) are essential.

DISCLOSURE/FINANCIAL SUPPORT: *The authors have no relevant financial relationships to disclose.*

The Economic Impact of Skin Cancer

Jenny Chen, MD; Steve Kempton, MD; Venkat Rao, MD, MBA

BACKGROUND: The incidence and cost of non melanoma skin cancers (NMSC) is skyrocketing. Five million cases cost $8.1 billion in 2011. The average cost of treatment per patient increased from $1000 in 2006 to $1600 per patient by 2011. We present a study of the economics and costs of skin cancer management in Medicare patients.

METHODS: We studied data released by the Centers for Medicare and Medicaid Services in 2014. Treatment modalities for the management of skin cancer were reviewed and costs of treatment were quantified for a sample of 880,000 providers.

RESULTS: Review of Medicare payment records related to the management of skin cancer yielded data from over 880,000 health care providers who received $77 billion in Medicare payments in 2012. From 1992–2009, the rate of Mohs Micrographic Surgery (MMS) has increased by 700% and these procedures typically have Medicare payments 120–370% more than surgical excision, even when including pathology fees. From 1992–2009, MMS increased by 700% whereas surgical excisions increased by only 20%. In 2009, 1800 providers billed Medicare for MMS; in 2012 that number increased to 3209. On average, 1 in 4 cases of skin cancer is treated with MMS.

CONCLUSION: Mohs excision is more expensive than surgical excision in an office setting. Procedures requiring the operating room are much more expensive than office procedures. In an era of high deductible health plans, patients' financial burden is much less with simple excisions of skin cancers done in a clinic setting when compared to Mohs surgery or operative procedures.

The Proliferation of Accredited Plastic Surgery Subspecialty Fellowship Programs

Jason Silvestre, BS; Jesse A. Taylor, MD; L. Scott Levin, MD; Joseph M. Serletti, MD; Benjamin Chang, MD

BACKGROUND: There is an increasing trend toward subspecialty training in the U.S. healthcare workforce. This study determines the percentage of surgical chief residents seeking fellowship training. Additionally, trends in Accreditation Council for Graduate Medical Education (ACGME) accreditation of plastic surgery subspecialty fellowships are determined.

METHODS: Program directors of U.S. surgical residency programs were surveyed on career intentions of chief residents for 2013. The percentage of residents pursuing fellowship training were determined for integrated and independent plastic surgery residents and compared with statistics from other surgical specialties. Temporal trends in ACGME accreditation of craniofacial, hand, and microsurgery fellowship programs were assessed via chi square goodness of fit tests. The percentage of ACGME accredited programs were compared between subspecialty areas with Subspecialty Certification (hand surgery) relative to areas without Subspecialty Certification (craniofacial surgery and microsurgery).

RESULTS: The majority of integrated and independent plastic surgery chief residents pursued fellowship training (62.0% vs 55.6%, $p = 0.554$). Significant differences were seen compared with chief residents in other surgical specialties from a high in orthopaedics (91.0%) to a low in colon

& rectal surgery (6.2%). Regarding ACGME accreditation, the percentage of ACGME accredited craniofacial fellowship programs was stable from 2005 to 2015 ($p = 0.386$). In hand surgery, the percentage of ACGME accredited plastic surgery ($p = 0.755$) and orthopaedic ($p = 0.253$) fellowships remained stable while general surgery decreased ($p = 0.010$). There was greater ACGME accreditation in subspecialty areas with Subspecialty Certification (100%) relative to areas without Subspecialty Certification (19.2%, $p < 0.001$).

CONCLUSIONS: There is an increasing trend toward subspecialty training in plastic surgery with no significant differences between integrated and independent residents. ACGME accreditation of fellowship programs varies across plastic surgery disciplines and remains highest in areas with the option for Subspecialty Certification. Future studies should assess educational outcomes of ACGME accredited fellowship programs.

DISCLOSURES: *None*

Resident Performance on the Plastic Surgery In-Service Exam Varies By Training Year and Pathway

Jason Silvestre, BS; L. Scott Levin, MD; Joseph M Serletti, MD; Benjamin Chang, MD

BACKGROUND: Few studies in surgery have addressed medical knowledge competency training as defined by the American Council of Graduate Medical Education (ACGME). As in-training exams are ubiquitous educational tools for surgical residents in the U.S, insights into exam performance may help fill this void. The purpose of this study was to determine the relationship between in-service exam performance and training profile in plastic surgery.

METHODS: This retrospective cohort study reviewed performance data for the Plastic Surgery In-Service Training Exam (PSITE) for years 2012–2015. Comparisons were made both within and between training pathways via non-parametric tests.

RESULTS: Data were available for 1367 independent (37.9%) and 2240 integrated (62.1%) residents. Among integrated residents, performance increased with additional years of training ($p < 0.001$), but no difference existed between PGY-5 and PGY-6 residents ($p > 0.05$). Similarly, independent resident exam performance increased by year of training ($p < 0.001$) with no difference between PGY-2 and PGY-3 years ($p > 0.05$). At each level of training (PGY 4–6), integrated residents outperformed their independent resident colleagues (PGY 1–3) ($p < 0.001$).

CONCLUSIONS: Performance on the PSITE increases during residency with integrated residents outperforming independent residents. These findings may have implications on medical knowledge competency training as defined by the ACGME.

DISCLOSURES: *None*

Trends in Racial, Ethnic and Gender Diversity in Integrated Versus Independent Plastic Surgery Residencies

Jonathan T. Unkart, MD, Christopher M. Reid, MD, Michael G. Brandel, BA, Anne M. Wallace, MD

INTRODUCTION: No prior studies have examined the differences between integrated and independent programs with regard to race, ethnic and gender composition, or whether there are trends in their respective demographic compositions.

METHODS: JAMA Graduate Medical Education annual reports of integrated versus independent residencies were reviewed for the 2009–2015 academic years. Data recorded included academic year, race, ethnicity and gender. An analysis of 3 specific sub-groups was performed: Blacks, Hispanics and females. The Cochran-Armitage test was used to assess trends among the subgroups.

RESULTS: From the 2009 to 2015 academic years, active residents in integrated programs rose from 189 to 573 residents (+203.2%). During the same period, the number of independent residents declined from 508 to 372 (-26.7%). Blacks saw a statistically significant trend decline in representation in integrated programs from 2009 (4.8%) to 2015 (2.1%), $p = 0.026$, but no statistically significant difference in the independent pathway from 2009 (4.5%) to 2015 (5.6%), $p= 0.19$. Hispanic ethnicity saw an increase, but not statistically significant trend in representation in the integrated and independent programs from 2009 to 2015, 4.8% to 7.0%, $p= 0.64$ and 7.7% to 9.4%, $p=0.71$, respectively. Females saw a statistically significant trend increase in representation in integrated programs from 2009 (21.7%) to 2015 (38.0%), $p < 0.01$. For the independent programs, no