

surgical site infection occurred in 9% (n=46) of cases. The readmission rate was 4.3% (n=21). Several preoperative factors had higher odds of readmission: BMI (aOR 9.81, CI 1.77-22.13, p=0.005), higher ASA class (aOR 3.23, CI 1.23-9.03, p=0.003), diabetes (aOR 5.39, CI 1.42-20.45, p=0.006), and hypertension (aOR 3.63, CI 1.26-10.47, p=0.01). The reoperation rate was 4.7% (n=23), with no significant patient factors associated with this complication. Of the reoperations, 68.2% of cases were due to wound problems, vaginal bleeding, or hematoma.

CONCLUSION: In transgender women undergoing vaginoplasty for gender affirmation, severe postoperative complications are rare, occurring in 5.5% of patients. The majority of patients experience minor or no complications following surgery.

Table 1. Operative Characteristics and Postoperative Complications

Variable	All Vaginoplasties (N = 488)
Operative Time, median (IQR), min	271 (214-344)
Hospital stay (IQR), days	4 (3-6)
Postop transfusion, number (%)	1.8 (9)
Superficial surgical site infection	1.8 (9)
Deep surgical site infection	0.6 (3)
Sepsis (No cases of septic shock)	0.6 (3)
Wound dehiscence	6.9 (34)
Pulmonary Embolism or DVT	0.2 (1)
UTI	2.0 (10)
Return to OR	4.7 (23)
Wound problem	31.8 (7)
Vaginal bleeding	18.2 (4)
Hematoma	18.2 (4)
Fistula	9.1 (2)
Graft problem	4.5 (1)
Other	18.2 (4)
Readmission in 30 days	4.3 (21)
Bleeding	23.8 (5)
Wound disruption	19.0 (4)
Incisional infection	9.5 (2)
Sepsis	9.5 (2)
Vein thrombosis	4.8 (1)
Cholelithiasis	4.8 (1)
Surgery related other	28.6 (6)

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Kavita Mishra: Nothing to disclose; Cecile Ferrando: Nothing to disclose.

09 The impact of subspecialty training on outcomes following surgery for pelvic organ prolapse – a NSQIP-based study



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OBJECTIVES: To describe the impact of subspecialty training on outcomes following surgery for pelvic organ prolapse (POP).

MATERIALS AND METHODS: Using the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) database, we identified women undergoing POP surgery between 2014 and 2018 using Common Procedural Terminology codes. Patient and

procedural characteristics, 30-day readmission, reoperation, and postoperative complications (POC) were collected. Patients whose surgery was performed by “Urogynecologists” (FPMRS) or “Obstetrician-Gynecologists” (OBG) were included in the study. The primary outcome was the presence or absence of a 30-day POC. Descriptive statistics were used to characterize the cohort, and pairwise analyses were performed to describe differences between cases performed by FPMRS vs OBG. Multivariable logistic regression was used to determine the impact of FPMRS training on 30-day POC while controlling for potential confounders.

RESULTS: 3,358 women underwent POP surgery—68% by FPMRS and 32% by OBG. Significant intergroup differences were noted across all surgical procedures. The 30-day POC rate was higher in the OBG group compared with FPMRS (7.0% vs 10.7%, P < 0.001). No differences were noted in readmissions (2.1% vs 2.0%, P=1.0); however, reoperations were higher in the OBG group (1.0% vs 1.8%, P=0.04). In a multivariable logistic regression model controlling for age, BMI, ASA class, smoking and types of surgeries, FPMRS training remained associated with a nearly 40% lower odds of any 30-day POC (aOR 0.62, 95% CI 0.48–0.80).

CONCLUSION: FPMRS training was associated with lower odds of any 30-day POC following surgery for POP.

Table 1. Complications

Complications	Overall N = 3558	FPMRS N = 2432 (68.4)	OBG N = 1126 (31.6)	P value
Any Complication	291 (8.2)	170 (7.0)	121 (10.7)	<0.001
Major	73 (2.1)	44 (1.8)	29 (2.6)	0.17
Minor	230 (6.5)	125 (5.6)	95 (8.4)	0.001
Ureteral obstruction	5 (0.1)	3 (0.1)	2 (0.2)	1.0
Ureteral fistula	1 (0)	1 (0)	0 (0)	1.0
Bladder fistula	0 (0)	0 (0)	0 (0)	NA
Prolonged urinary retention	25 (0.7)	15 (0.6)	10 (0.9)	0.49
Readmissions	74 (2.1)	51 (2.1)	23 (2.0)	1.0
Reoperations	44 (1.2)	24 (1.0)	20 (1.8)	0.04

Table 2. Univariable and Multivariable Logistic regression Models evaluating the association of subspecialty training and 30-day postoperative complications

	Odds Ratio (95% Confidence Interval)	Adjusted Odds Ratio (95% Confidence Interval)
Subspecialty training	--	--
OBG	--	--
FPMRS	0.62 (0.49-0.80)	0.62 (0.48 - 0.80)
Age	1.01 (0.99-1.02)	1.01 (0.99 - 1.01)
BMI	1.02 (0.99-1.04)	1.01 (0.99 - 1.03)
ASA Class	--	--
1	--	--
2	1.66 (1.05 - 2.80)	1.54 (0.95 - 2.62)
3	2.03 (1.24 - 3.47)	1.81 (1.06 - 3.23)
Smoking	1.65 (1.11 - 2.38)	1.56 (1.03 - 2.29)
Hysterectomy	--	--
None	--	--
LAVH	1.26 (0.65 - 2.49)	1.23 (0.52 - 2.58)
TLH	0.42 (0.07 - 1.35)	0.46 (0.07 - 1.56)
TVH	0.93 (0.68 - 1.24)	0.82 (0.59 - 1.13)
Apical Procedure	--	--
None	--	--
Uterosacral	1.10 (0.76 - 1.55)	1.30 (0.88 - 1.90)
Sacrospinous	1.66 (1.26 - 2.17)	1.64 (1.23 - 2.18)
Sacrococcygeal	0.45 (0.07 - 1.47)	0.40 (0.06 - 1.45)
Other procedures	--	--
None	--	--
Anterior repair	0.89 (0.43 - 1.72)	0.97 (0.46 - 1.91)
Posterior repair	0.81 (0.43 - 1.47)	0.91 (0.47 - 1.66)
Combined APR	1.09 (0.77 - 1.56)	1.32 (0.92 - 1.94)
Mesh	0.62 (0.26 - 1.28)	0.93 (0.39 - 2.0)
Obliterative procedure	0.37 (0.06 - 1.19)	0.39 (0.06 - 1.30)
Sling	1.23 (0.93 - 1.61)	1.29 (0.97 - 1.70)

Figure 1. Patient and surgical characteristics of cohort

	Overall N = 3558	FPMRS N = 2432 (68.4)	OBG N = 1126 (31.6)	P value
Age (years) ^a	62.4 (11.8)	62.5 (12.0)	62.4 (11.5)	0.85
Race ^b				0.07
White	1693 (90.0)	1232 (91.0)	461 (87.5)	
Black	112 (6.0)	74 (5.5)	38 (7.2)	
Other	76 (4.0)	48 (3.5)	28 (5.3)	
BMI (kg/m ²) ^a	28.3 (15.2, 32.2)	29.0 (5.6)	29.2 (5.6)	0.26
ASA Class ^b				<0.001
1	378 (10.6)	232 (9.5)	146 (13.0)	
2	2261 (63.5)	1530 (62.9)	731 (64.9)	
3	919 (25.8)	670 (27.5)	249 (22.1)	
Smoker ^b	277 (7.8)	181 (7.4)	96 (8.5)	0.29
Hysterectomy ^b				<0.001
None	2677 (75.2)	1889 (77.7)	788 (70.0)	
LAVH	78 (2.2)	23 (0.9)	55 (4.9)	
TLH	55 (1.5)	25 (1.0)	30 (2.7)	
TVH	748 (21.0)	495 (20.4)	253 (22.5)	
Apical procedures ^b				<0.001
None	2120 (59.6)	1451 (59.7)	669 (59.4)	
Uterosacral	550 (15.5)	441 (18.1)	109 (9.7)	
Sacrospinous	829 (23.3)	514 (21.1)	315 (28.0)	
Sacrocolpopexy	59 (1.7)	26 (1.1)	33 (2.9)	
Other procedures ^b				<0.001
None	500 (14.1)	333 (13.7)	167 (14.9)	
Anterior	153 (4.3)	127 (5.2)	26 (2.3)	
Posterior	227 (6.4)	183 (7.5)	44 (3.9)	
Combined APR	2515 (70.8)	1638 (67.4)	877 (78.1)	
Mesh	157 (4.4)	148 (6.1)	9 (0.8)	
Obliterative ^b procedure	62 (1.7)	55 (2.3)	7 (0.6)	<0.001
Sling ^b	806 (22.7)	624 (25.7)	182 (16.2)	<0.001
Operative time (minutes) ^a	105.0 (65.3-154.0)	110.0 (68.0, 157.0)	93.5 (64.0-149.0)	<0.001
Length of stay (days) ^a	1 (1, 1)	1 (0, 1)	1 (1, 2)	<0.001

BMI, Body Mass Index; ASA, American Society of Anesthesiologists Classification; LAVH, Laparoscopic Assisted Vaginal Hysterectomy; TLH, Total Laparoscopic Hysterectomy; TVH, Total Vaginal Hysterectomy; APR, Anterior-Posterior Repair.

a. Mean ± Standard deviation
b. N (%)
c. Median (interquartile range)

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10 Improving the identification of equity-related adverse events in gynecology

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OBJECTIVES: The practical tools to detect and understand systemic racism and pervasive bias have not been well-delineated. For gynecologic patients, bias and racism—systemic and individual—may affect the quality of care in several ways: delays in care, cognitive bias in a clinician's decision making, care coordination, access, and other effects of social determinants of health (SDOH). Currently, there is no described equity-focused process or framework to evaluate the role of SDOH, bias and racism in adverse events. The aim of this project was to establish a sustainable and trackable process to delineate the role of SDOH, bias, and racism in adverse gynecologic events.

MATERIALS AND METHODS: The existing process entails monthly reviews of adverse events based on standard criteria established by the Yale Gynecologic Quality and Safety Committee. Each case is assessed for preventability, harm, and care standards.

The equity-focused process consisted of:

1. Creation of a standardized checklist of SDOH based on the World Health Organization framework.
2. Application of the standardized checklist to each gynecologic adverse event beginning September 1, 2020 [Figure 1].
3. Collection of event review data in a secure central digital repository at the time of review.
4. Review of the cases to understand apparent causes of the event by the committee.

5. Exploration of areas for improvement utilizing process improvement and SDOH checklists.

6. Identification of specific change ideas.

RESULTS: Within 12 months, 33 cases were identified by standard criteria. Twelve of the cases were deemed preventable. Of those twelve, there were 5 cases in which SDOH and/or bias were identified to play a role. From this sample, important themes emerged including: the role of patient trauma and previous microaggressions affecting trust in the medical system; mismatched understanding between patient and provider in the shared decision-making paradigm; cognitive bias affecting provider's understanding of pain in certain populations; a need for consistent access to language services; and gaps in care coordination for certain populations.

[Figure 2]

CONCLUSION: These initial findings have been leveraged to encourage inclusion of the discussion of bias and racism in gynecology and, by doing so, normalizing this conversation. We have included these cases in departmental Morbidity and Mortality Conferences. This work represents an initial exploration and serves as a needs assessment. Within our department this information has identified units that may need directed bias training. There are now plans to utilize this checklist in perioperative services and other surgical services. As we continue to gather data and share stories, we hope to further normalize conversations about bias and racism, integrate equity into quality and safety efforts, and identify opportunities for improvement.

Which patient characteristics or social determinants of health may have precipitated or affected the outcome?

Access to healthcare

- Resources for transportation
- Resources for childcare
- Work/school schedule
- Housing instability
- Financial insecurity (paying for meds, competing life stressors)
- Insurance
- Incarceration
- Social support network
- Immigration status
- Unemployment, under employment
- Technology for telehealth

Communication

- Language barrier
- Cultural differences
- Language literacy
- Health literacy

Psychosocial

- Mental health condition
- Substance abuse
- Situational Fear/Anxiety
- Domestic violence or intimate partner violence

Bias

- Did bias or discrimination of patient characteristics play a role in the outcome?
- What was the bias? _____
- How did it play a role? _____

Patient experienced mistrust of the healthcare process and/or system

Other _____

None

FIGURE 1

Figure 1: Social determinants of health and bias checklist

THE EQUITY CHECKLIST: Results Workflow

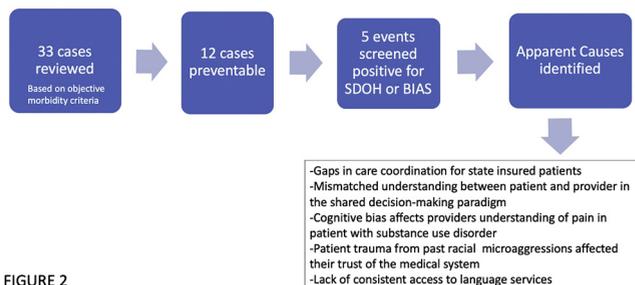


FIGURE 2

Figure 2: Using the checklist in a standardized results workflow

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