



Cohort- and cancer site-specific analyses identified isolated significant estimates without consistent directional patterns.

**CONCLUSIONS:** Implementation of PARHM was not associated with changes in short-term postoperative outcomes among rural residents undergoing cancer surgery. These results suggest that Pennsylvania's global budget model did not measurably influence surgical oncology outcomes during the demonstration period.

Table 2. Difference-in-Differences Estimates of the Association Between PARHM Implementation and Postoperative Outcomes

Outcome <sup>c</sup>	Cohort, mean (SD)						Estimated effect of PARHM <sup>b</sup> (95% CI)	p-value
	Before PARHM			After PARHM				
	PARHM	Non-PARHM	Average	PARHM	Non-PARHM	Average		
30-Day Mortality	0.043 (0.203)	0.041 (0.198)	0.041 (0.198)	0.043 (0.204)	0.036 (0.187)	0.036 (0.187)	0.010 (-0.014 to 0.034)	0.391
30-Day Readmission	0.167 (0.373)	0.159 (0.366)	0.160 (0.366)	0.136 (0.343)	0.141 (0.348)	0.138 (0.345)	-0.007 (-0.045 to 0.030)	0.695
30-Day Composite <sup>a</sup>	0.196 (0.397)	0.188 (0.390)	0.188 (0.391)	0.168 (0.374)	0.166 (0.372)	0.167 (0.373)	0.003 (-0.038 to 0.044)	0.875
90-Day Mortality	0.078 (0.269)	0.073 (0.260)	0.074 (0.261)	0.081 (0.272)	0.087 (0.251)	0.084 (0.261)	0.011 (-0.018 to 0.039)	0.460
90-Day Readmission	0.252 (0.434)	0.239 (0.427)	0.240 (0.427)	0.209 (0.407)	0.215 (0.411)	0.212 (0.409)	-0.016 (-0.058 to 0.027)	0.465
90-Day Composite <sup>a</sup>	0.289 (0.453)	0.276 (0.447)	0.277 (0.447)	0.252 (0.434)	0.249 (0.432)	0.251 (0.433)	-0.002 (-0.044 to 0.039)	0.906

<sup>a</sup> Composite outcomes include death or readmission.

<sup>b</sup> Models adjusted for patient- and area-level covariates and included hospital service area and year fixed effects. Propensity score weights were applied, and SEs were clustered at the hospital service area level.

<sup>c</sup> Outcomes are expressed as the proportion (0-1) of surgical admissions experiencing each event. Estimated effects represent the differential change in this proportion associated with PARHM implementation

**Source of Funding:** This research was supported by the National Cancer Institute (R01CA244189).

**PD04-11  
UNPLANNED HEALTHCARE UTILIZATION AFTER BENIGN PROSTATE INTERVENTION IN MICHIGAN**

John Michael Di Bianco, Gainesville, FL; Michael Uy, Ann Arbor, MI; Sabry Mansour, Lapeer, MI; Stephanie Daignault-Newton, Naji Ayyash, Mahin Mirza, Ann Arbor, MI; Jay Lonsway, Holland, MI; Mark Bradshaw, Kushbu Narendar Singh, Khurshid Ghani, Casey Dauw, Wilson Sui for the Michigan Urological Surgery Improvement Collaborative, Ann Arbor, MI

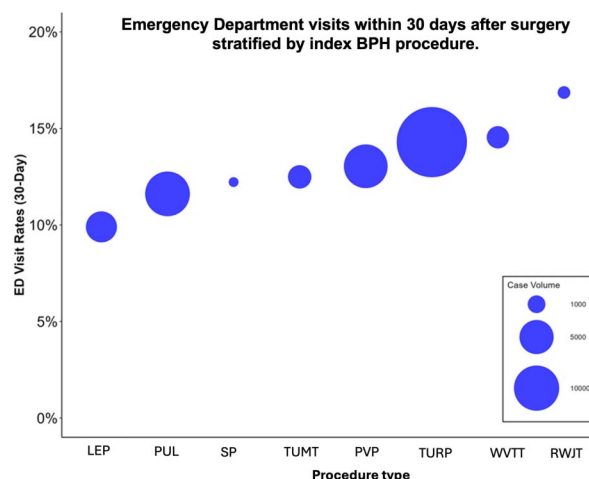
**INTRODUCTION AND OBJECTIVES:** Randomized controlled trials have demonstrated the safety and efficacy of therapies for benign prostatic hyperplasia (BPH). These common procedures are performed in a wide variety of patient populations and perioperative contexts in routine clinical practice. However, real-world data on perioperative outcomes are limited. Therefore, we sought to understand the incidence and predictors of emergency department (ED) visits after BPH procedures in a contemporary, real-world cohort.

**METHODS:** Using Michigan statewide claims data, patients who underwent a BPH procedure between 2015 and 2023 were identified. Procedures included: water vapor thermal therapy (WVTT), transurethral resection of prostate (TURP), prostatic urethral lift (PUL), transurethral microwave thermotherapy (TUMT), laser photovaporization (PVP), simple prostatectomy (SP), robotic waterjet therapy (RWJT) and laser enucleation of prostate (LEP). ED visit rates were assessed within 30 days of index procedure and categorized by the primary ICD-9/10 diagnosis code. Multivariable logistic regression models were used to identify predictors of 30-day ED visits.

**RESULTS:** A total of 55,693 procedures were identified. ED visit rates ranged from 10% to 17% by procedure (Figure 1) with an overall rate of 13.3%. The most common urologic reasons for ED visits were: urinary retention (39%), hematuria (29%), UTI/infection (21%), and catheter-related complications (17%). Patients experiencing an ED visit were older and more comorbid. On multivariable analysis, predictors of ED visits included: higher age (OR 1.01, 1.00-1.02), preoperative catheter use (OR 1.47, 1.29-1.67), and preoperative anticoagulation (OR 1.38, 1.22-1.55). Compared to TURP, patients undergoing RWJT had a higher risk of ED visits (OR 1.56, 1.12-2.17) and LEP a lower risk (OR 0.63, 0.51-0.78).

**CONCLUSIONS:** Emergency department visits are common after BPH intervention particularly amongst older patients who are on anti-coagulation and are catheter dependent preoperatively. The most common causes of ED visits included hematuria, urinary retention,

UTI and catheter-related complications. Further, the risk of unplanned ED visits differs by procedure with RWJT being the highest and LEP the lowest. Future work should develop strategies to reduce these visits.



Laser enucleation of the prostate (LEP); simple prostatectomy (SP); robotic waterjet therapy (RWJT); laser photovaporization (PVP); transurethral resection of the prostate (TURP); water vapor thermal therapy (WVTT); prostatic urethral lift (PUL); and transurethral microwave therapy (TUMT).

**Source of Funding:** Data was provided by the Michigan Value Collaborative which is funded by Blue Cross Blue Shield of Michigan.

**PD04-12  
BOTH OVER-PRESCRIPTION AND UNDER-PRESCRIPTION OF OPIOIDS AFTER INPATIENT UROLOGIC SURGERY INCREASES ODDS OF POSTSURGICAL OPIOID REFILLS**

Walter R. Hsiang, Benjamin X. Guan, Patrick Hoang, Zhonghui Guan, Michelle Van Kuiken, San Francisco, CA

**INTRODUCTION AND OBJECTIVES:** To assess the impact of mismatched (over-prescription and under-prescription) discharge opioid prescriptions on opioid refills up to 90 days after inpatient urologic surgery.

**METHODS:** A retrospective single institutional cohort study examined 7,381 adult opioid-naïve and non-opioid-naïve patients discharged after inpatient urologic surgery between 2017 and 2024. Each patient's daily dose of discharge opioid prescription was compared to their last inpatient daily opioid consumption before discharge. Discharge opioid prescriptions were categorized as matched, over-, and under-prescribed, defined as prescribed daily dose within 7.5 oral morphine equivalents [OME], ≥7.5 OME above, and ≤7.5 OME below of inpatient daily dose, respectively. Fisher's test and multiple logistic regression analyses were used.

**RESULTS:** 38.3% of patients were discharged with matched opioid prescriptions while 38.0% were over-prescribed and 23.7% were under-prescribed. Compared to the patients with matched prescriptions, patients with either over-prescription or under-prescription had higher opioid refill rates at 1-30, 31-60, and 61-90 days (Figure 1). Multiple logistic regression analyses revealed that when controlling for opioid-naïve status, type of surgical procedure, and other factors such as age, gender, and length of stay, opioid over-prescription independently increased the odds of refills at 1-30, 31-60, and 61-90 days after discharge by 85%, 49%, and 85%, respectively, while opioid under-prescription increased odds refills at 1-30 and 61-90 days by 47% and 33%, respectively (Figure 2). In contrast, the total dose of opioid prescriptions had minimal contribution to opioid refills.

**CONCLUSIONS:** Both over-prescribing and under-prescribing of opioids, rather than the total dose of opioid prescriptions, independently contribute to increased odds of refills. Patient-centered, individualized discharge opioid dosing based on inpatient