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– FOCUS ISSUE – AUA ADVOCACY

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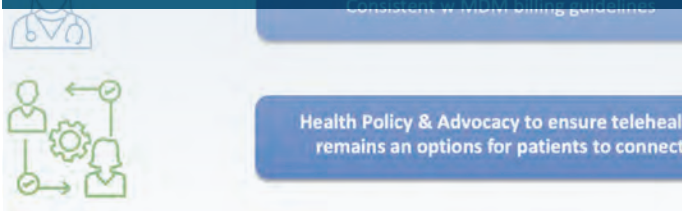
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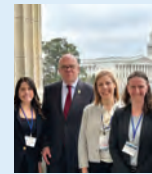


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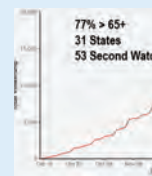
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AUA ADVOCACY

The Value of Advocating for Urology Research at the 2024 AUA Summit Meeting

Toby C. Chai, MD

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The health care delivery system in the US is highly complex, regulated, and labyrinthine. Delivering quality urology care is becoming increasingly difficult. Ultimately, our patients will be the ones who suffer the adverse consequences that arise out of this environment. To ensure this does not happen, the sixth annual AUA Summit was held February 26-28, 2024, in Washington, DC, to advocate for our specialty of urology and for our patients. This meeting was attended by undergraduates, medical students, urology residents and fellows, patients, patient advocates, practicing urologists (community based, employed, academic, urban, rural), and urologic researchers. Topics for advocacy that were discussed included workforce shortages, patient access to urologic care, telehealth, decreased reimbursement, and urologic research. While advocating for policies that deliver effective, efficient, high-quality urologic care and for policies that ensure

“Delivering quality urology care is becoming increasingly difficult. Ultimately, our patients will be the ones who suffer the adverse consequences that arise out of this environment.”

a pipeline capable of delivering enough future urologists are easily understood, advocating for policies related to increasing urologic research can be more difficult to grasp. This is because, typically, the impact of research is not felt immediately in clinical practice. However, a shortsighted view of research is detrimental to urology and our patients. Advances in diagnosis, treatment, and prevention of urologic conditions and diseases come only with research. Research achievements create value and hope that are irreplaceable.

I, as a current member and prior chair of the AUA Research Appropriations Committee (currently chaired by Joshua Stern, MD), along with other committee members (Figure), met with legislative aides of US House of Representative appropriators with a specific advocacy “ask” to introduce language into the Congressionally Directed Medical Research Program (CDMRP) appropriations bill designating an \$8-million line item specifically just for bladder cancer research. CDMRP currently has line item amounts for prostate cancer (\$110 million, FY23) and kidney cancer (\$50 million, FY23). The growth of CDMRP funding in prostate and kidney cancers resulted in improvements in diagnosis and care of patients afflicted with these cancers. It is expected that over time, a similar impact will occur in bladder cancer if this line item ask is successful.

To further amplify this specific ask, the AUA Summit included a panel session, which I moderated, discussing the impact of research in bladder cancer. Dr Daniel Petrylak, professor of medicine and urology at Yale University and division chief of genitourinary cancer at Smilow Cancer Center, presented a talk entitled “Bladder



Figure. From left to right: Drs Rajat Jain (University of Rochester), Naveen Kachroo (Henry Ford Health), Daniel Petrylak (Yale University), Toby Chai (Boston University).

“We must continue to advocate with one voice to continue to help our patients in a time of complex, regulated, and labyrinthine health care delivery.”

Cancer Treatment: An Evolution in Progress.” Dr Petrylak showed that results from the randomized controlled trial in advanced bladder cancer demonstrated that enfortumab vedotin and pembrolizumab, compared to standard platinum chemotherapy, doubled median overall survival to 32 months from 16 months.¹ This result gives new hope to patients with metastatic bladder cancer. Carlos Glender, a US Navy veteran and a bladder

cancer survivor, spoke about his experience with bladder cancer and the outstanding care he received at Atrium Health Levine Cancer in Charlotte, North Carolina. This panel session was also intended to motivate and exhort those attending the AUA Summit to communicate with their congressional representatives to support the \$8-million line item for bladder cancer research in the CDMRP appropriations bill.

Urology is a vital specialty that has improved and saved the lives of many individuals. We must continue to advocate with one voice to continue to help our patients in a time of complex, regulated, and labyrinthine health care delivery. You can help by attending future AUA Summit meetings and donating to the AUA Political Action Committee at <https://myauapac.org>. ■

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AUA ADVOCACY

The FUTURE in Urology at the 2024 Advocacy Summit Affirms Vital Role of Mentorship

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When I said, “Urology is the best field, ever!” speaking up at the 2024 AUA Advocacy Summit, the audience erupted in hoots and applause. Despite the challenges we face, it’s clear we love our specialty, patients, colleagues, and trainees. As urologists we all strive to improve health outcomes and patients’ satisfaction, and there is a growing body of evidence that demonstrates a diverse workforce improves health outcomes and drives organizational excellence.¹ The AUA Census illustrates that there is room for improvement in increasing representation in our workforce.² As I reflect on my own medical school experience, I recall a desire to become a surgeon, but my mentor was a pivotal magnetic figure that pulled me toward urology.

Undeniably, mentorship plays a role in attracting students to our specialty.³ Specifically, mentorship of students who are underrepresented in medicine (URiM) and from historically disadvantaged backgrounds may be an avenue to increase recruitment of diverse applicants.⁴

When I took my seat as the inaugural chief diversity officer and Diversity, Equity & Inclusion (DEI) Committee chair, I noted,

“When I said, “Urology is the best field, ever!” speaking up at the 2024 AUA Advocacy Summit, the audience erupted in hoots and applause.”



Figure. Mentees and mentors visit Senator Richard Durbin’s office on Capitol Hill. From left to right, Rasheed Thompson, Bebe Eke, Alexandra Lopez Chaim, Dr Larissa Bresler, Dr Asafu-Adjei, Richard Durbin’s Health Policy Adviser, and Samuel Tate III.

“Persistent advocacy and activism, rather than persistent complaining, lead to positive changes,” in my very first *AUANews* Voices interview.⁵ Our committee’s unwavering collaboration with the AUA Public Policy Council illustrates that.

The FUTURE (Future Urology Talent from Underrepresented Entities) in Urology Mentorship event at the 2024 Advocacy Summit was a resounding success. This novel and inaugural effort engaged preclinical and clinical medical students in advocacy and provided exceptional opportunities to network with their peers, urologists, lawmakers, and AUA leadership. Each student was paired with a mentor to guide them through the conference and Capitol Hill visits and to help them with their career planning (Figure). Many mentors and mentees attending the Summit were immigrants from countries where it’s not safe to use their voices with lawmakers. As one of these individuals, I especially valued this unique opportunity to participate in the AUA advocacy efforts. FUTURE students embraced this opportunity as well and were not

shy to speak up, especially in addressing our workforce issues. It was truly an honor walking Capitol Hill with the FUTURE students advocating for our patients, colleagues, and trainees.

The AUA’s FUTURE in Urology Program is a comprehensive incubator platform aiming to augment the urology pipeline by equipping URiM, URiU (underrepresented in urology), and other students from historically disadvantaged backgrounds with tools to achieve their career aspirations, including effective mentorship, networking, and skills development. We are bridging the gap between aspiring urologists and experienced professionals and fostering a vibrant ecosystem of learning, collaboration, and growth. The platform is not restricted to students; it also fosters mentorship and individual growth opportunities for all AUA members who join. We welcome urologists to join as mentors (virtually and/or in person) and mentees. For instance, I currently serve as a mentor for our young and aspiring urologists, but as the program expands, I’ll also seek mentorship for my own professional growth.

“This novel and inaugural effort engaged preclinical and clinical medical students in advocacy and provided exceptional opportunities to network with their peers, urologists, lawmakers, and AUA leadership.”

“The platform is not restricted to students; it also fosters mentorship and individual growth opportunities for all AUA members who join. We welcome urologists to join as mentors (virtually and/or in person) and mentees.”

Mentorship is a key part in fostering AUA pipeline efforts and augmenting leadership opportunities for our members. The FUTURE Summit event mentors’ feedback was encouraging, indicating that the program was meaningful and that they were inspired by our URiM/URiU students’ enthusiasm flexing their “advocacy muscle.” Our committee is grateful to the AUA Public Policy team for their support of the FUTURE in Urology program at the 2024 Advocacy Summit and hope that we can continue this meaningful collaboration at many future Summits to come. ■

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AUA ADVOCACY

Advocacy for Environmental Sustainability in Urologic Operating Rooms: Implications for Environmental and Human Well-Being

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In the US, health systems generate 6 million tons of medical waste,¹ 1 million tons of noninfectious plastic,² and a startling 8.5% of the nation's total greenhouse gas emissions each year.³ Operating rooms and labor and delivery suites are 3 to 6 times more energy intensive than clinical areas⁴ and generate 60% of total hospital regulated medical waste.⁵ Because regulated biohazardous waste requires specific costly and environmentally harmful processes for safe elimination, proper separation of medical waste into regulated medical waste (RMW) and nonregulated municipal waste is integral to minimizing the cost and carbon footprint associated with waste disposal.

In an analysis of waste generated from 31 urologic cases performed at a single institution during a 3-month period, an average of 11.11 kg in waste was generated per case: RMW represented 31% of the total waste, while non-RMW represented 53% of total waste weight. Improper disposal of non-RMW items was identified in all cases, highlighting the importance of cautious separation of medical waste to reduce the financial and environmental burden of its disposal.⁶ Noting that 80% of packaging waste is generated before a patient enters the operating room, precautions focused on separating this large proportion of nonbiohazardous waste before exposure to bodily fluids could be beneficial in reducing the cost of waste disposal (Figure).⁷

It is essential that urologists take action to streamline waste disposal in operative rooms, revise operative trays and preference cards to minimize the inclusion of extraneous instruments,⁸ reduce the amount of printed resources utilized in exchange for virtual information, and raise awareness at their institution about environmental sustainability in operative settings. Urologists, especially those practicing in academic settings, can utilize their role as educators in promoting change towards a culture of sustainability in current and future generations of trainees. Moreover, as the global urology device market is worth over \$35 billion and expected to grow significantly in the next decade,⁹ urologists can collaborate with device manufacturers to create more efficient and sustainable packaging and reduce their carbon footprint. These efforts can be further supported in collaboration with sustainability committees within health care groups, across other surgical subspecialties, through advocacy groups within the AUA, and even with larger organizations such as the American Medical Association.

Environmental emissions associated with waste disposal pose

“In the US, health systems generate 6 million tons of medical waste,¹ 1 million tons of noninfectious plastic,² and a startling 8.5% of the nation's total greenhouse gas emissions each year.³”

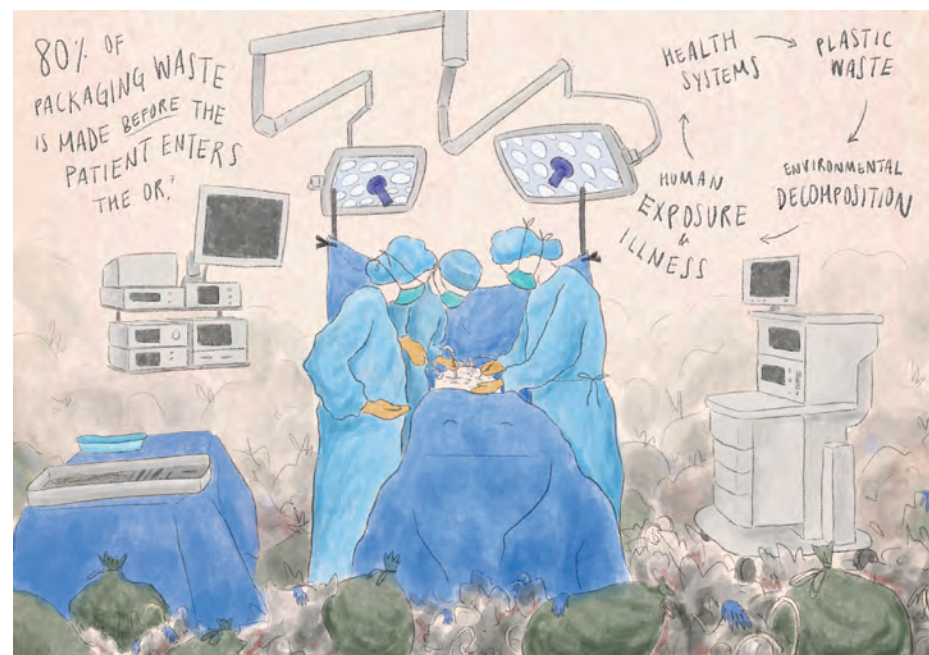


Figure. The intersection of health systems, environmental waste, and human illness in the operating room. Used with permission of Oscar Li.

a significant threat to medical well-being. In fact, by-product components of plastics including bisphenol A (BPA) have been shown to accumulate in a dose-dependent fashion in human tissue and act as carcinogens and endocrine disruptors.¹⁰ In the US, 90% of the population is exposed to BPAs, which have been linked to breast cancer and hepatocellular carcinoma.¹⁰ Moreover, it has been demonstrated in animal models that BPA activates the androgen receptor, suggestive of a link between BPA and the development of prostate cancer.¹¹ Follow-up analyses of patients with prostate cancers identified higher levels of urinary BPA concentration in patients with prostate cancer.¹² Additional studies indicate that BPA can also adversely affect the efficacy of androgen deprivation therapy, which is the mainstay of treatment for prostate cancer,¹¹ cause kidney toxicity via direct glomerular injury,¹³ and alter mitochondrial metabolism, promoting the progression of bladder cancer.¹⁴ Plastic by-products may also be associated with tumor progression and with attenuating the

efficacy of cancer treatment.¹⁵

Considering the significant impact of waste generation and its by-products on environmental and human well-being, environmental sustainability in operating rooms is integral to protecting our planet and its inhabitants. To this end, advocacy efforts are underway to effect change in operative environmental sustainability. On Earth Day 2022, the White House/US Health and Human Services put forward the Health Sector Climate Pledge, asking health care institutions to commit to reducing health care-related environmental emissions by half by 2030, and to achieving carbon neutrality by 2050.¹⁶ As of November 16, 2023, the petition has been signed by 133 organizations representing 900 hospitals.¹⁶ Within hospitals, waste audits have effectively identified and addressed potential sources of preventable waste in operation rooms.^{17–19}

US health care represents 18% of the nation's economy, and 10% of the global economy.²⁰ As such, changes towards environmental

ADVOCACY FOR ENVIRONMENTAL SUSTAINABILITY IN UROLOGIC OPERATING ROOMS

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sustainability in operating rooms, which are the most prominent source of revenue for health systems, would have a significant impact on environmental and human well-being. Hospitals contributing to the 2019 Environmental Excellence Awards saved \$68 million on sustainability initiatives in 2018, reduced 309 million kBtus of energy, and avoided the production of 146,750 tons of waste and 182,370 metric tons of carbon emissions. This equated to a median savings of \$100,000 across 327 hospitals.²¹ Importantly, surgeons are ready to make a change. Of surgeons interviewed at 2 major academic centers in the United States, 95% of survey respondents demonstrated willingness to reduce operative room waste and promote environmental sustainability,²² suggesting that urologists today have a responsibility and willingness to change to protect their environ-

ment, their communities, and their future patients. ■

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AUA ADVOCACY

Establishing Telehealth's Permanent Place in Health Care: What's Left to Accomplish?

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As one of the 3 key legislative asks for the annual AUA Advocacy Summit, telehealth remains top of mind for urologists and all physicians and providers. During the COVID-19 pandemic, there was a massive uptake in telehealth as a result of regulatory flexibilities and improved regulatory landscape allowing patients to seek out new patient evaluations.¹ Patients, physicians, and providers have become accustomed to using tele-

health as a substitute for in-person care.² Because of the Consolidated Appropriations Act signed by President Biden, many of the telehealth flexibilities at the federal level have been extended until December 31, 2024. Without congressional action, telehealth regulation and reimbursement could return to pre-pandemic levels—severely restricted, without allowing new patient evaluations, and not reimbursing physicians for the medical decision-making they are providing for patients.

Dr Helen Bernie kicked off the session by highlighting one of the existing pieces of legislation, the Connect for Health Act, and how the language in this bill would support the many flexibilities that patients and providers alike have become used to. Most critically, it would permanently remove all geographic restrictions on telehealth

Health policy landscape

Consolidated Appropriations Act: extension of flexibilities until 12/31/24

Medicare

- Waiver of **originating site requirement** (ie pt can use from home)
- **Payment parity** for telehealth vs in-person
- **Audio only** paying at same rate as established patients
- **Direct supervision** includes virtual supervision (originally ending 2023, extended thanks to provider feedback)
- **Licensure across states** – terminated

Figure 1. Summary of key telehealth flexibilities that remain in place until end of 2024.

and allow patients to do telehealth visits from home and other nonclinical sites for Medicare beneficiaries. She also shared her own personal

experience with telehealth for sexual medicine and male infertility.

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ESTABLISHING TELEHEALTH'S PERMANENT PLACE IN HEALTH CARE

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Figure 2. AUA Summit 2024: call to action.

As she is a key specialist in a large state, many of her patients travel to her from all over Indiana. Telehealth has allowed her to provide high-quality care while removing geographic and financial barriers to patients—until an in-person exam or a surgical intervention is needed.

Next, Bryan Lewis as a kidney cancer survivor and president of KidneyCAN shared the patient perspective. He shared his own story and that of many other kidney cancer patients. Telehealth is allowing patients to seek out expert opinions at centers of excellence, removing geographic barriers. During the public health emergency, some of this even took place across state lines, though this flexibility is no longer available ex-

cept for in specific circumstances (ie, Veterans Affairs health system, specific state laws, or physician licensed in multiple states).

To build on these patient testimonials, Dr Juan Andino provided an overview of the newest data that emerged during the pandemic as a result of public health emergency flexibilities. For the first time, new patient consultations were studied, and these showed even greater cost and time savings, highlighting the ability to eliminate previous barriers to accessing specialty care, especially with known workforce shortage issues. Additionally, physician satisfaction and positive perception of telehealth has skyrocketed. The data shown, with many of the studies included

in a recent *mHealth* publication,³ highlighted the positive impact of telehealth in providing the same level of quality care.

Finally, Martin Gewirtz, a prostate cancer patient, certified advocate, and board director of Active Surveillance Patients International, closed out the session by sharing additional patient testimonials on the role telehealth has played in managing cancer and health, such as allowing specialists to review laboratory results and imaging obtained locally to determine an appropriate course of action.

As part of an educational curriculum to prepare AUA Summit attendees to meet with the offices of lawmakers, this session provided a comprehensive overview of telehealth: where we were prior to 2020; the regulatory and reimbursement changes that have allowed for appropriate expansion of telehealth services; and the real-world, day-to-day impact that connecting patient and physician or provider through telehealth can have on facilitating care.

At the time of this submission, the future of telehealth remains in limbo. While there is bipartisan support for ensuring telehealth remains a tool for connecting with patients, an election year and myriad other political battles make it difficult to understand when and

“Patients, physicians, and providers have become accustomed to using telehealth as a substitute for in-person care.”²

how Congress will tackle this issue of telehealth. Thankfully, the AUA in partnerships with patient and provider organizations continues to advocate for continued use of telehealth and reimbursing providers for the care delivered. But we need all your help—as the year comes to a close, keep an eye out for opportunities to communicate with your local representatives to ensure that congressional action is taken to allow us to deliver and receive care in a modern medical system. ■

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AUA ADVOCACY

Policy Solutions to Address an Impending Urologist Workforce Shortage

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The impending urologic workforce shortage has been a key focus of the AUA and a priority issue when we meet with congressional leaders at the annual AUA Advocacy Summit in Washington,

DC (Figures 1 and 2). Several factors have led to the physician workforce shortage where the current supply of urologists is unable to meet the demands of a growing and aging population. The supply of urologists is impacted by limited Medicare funded residency positions, a long pipeline to replace urologists, a preference for practicing in metropolitan

locations, prevalent burnout among urologists, and an aging workforce where 40% of urologists will reach retirement age (65 years or older) in the next decade. This comes at a time when the US population is growing and aging with an estimated 11,500 individuals turning 65 each day. Those over 65 years old utilize urological services at a rate 3 times that

of the general population.

Our work used the AUA Census, the Accreditation Council for Graduate Medical Education Data Resource Book, and US Census data to anticipate the timing and degree of the urologist shortage through 2060.^{1,3} Our models begin with the current urologist workforce

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POLICY SOLUTIONS TO ADDRESS AN IMPENDING UROLOGIST WORKFORCE SHORTAGE

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Figure 1. The Michigan delegation on Capitol Hill. Left to right: Lindsey Herrel, Benjamin Pockros, Rebecca Howland, Kassem Faraj.

and account for both incoming urologists, those graduating residency or fellowship and joining the workforce, and urologists exiting the workforce through retirement. These models show that without growth in urology residency positions, we will have a continued decline in the number of urologists per capita. This decline can be offset by increasing the number of urology residency positions to increase the supply of urologists, but it would

take more than 20 years to see the impact of this growth.

An inadequate supply of the urologic workforce will result in limited access to urological care for patients. There will be delays in care

“Several factors have led to the physician workforce shortage where the current supply of urologists is unable to meet the demands of a growing and aging population.”

“Increasing demand from a growing and aging population and an increased rate of retirees exiting the workforce are nonmodifiable factors affecting the physician workforce.”

that may result in more advanced disease and prolonged suffering for patients. As the workforce contracts, rural and underserved communities will be disproportionately impacted, with longer travel times to receive care. Currently, only 38% of US counties have a practicing urologist.

Increasing demand from a growing and aging population and an increased rate of retirees exiting the workforce are nonmodifiable factors affecting the physician workforce. However, there are modifiable factors that can be addressed to create and maintain a robust and resilient urologic workforce. Among these are increasing

urologic residency positions, reducing burnout, reducing administrative and regulatory burdens on urologists, and enhancing support of the entire care team to aid in the seamless delivery of high-quality patient care.

Some policy solutions to address the impending urologist shortage have bipartisan support. Recent legislative successes include policies that reduce administrative burdens in prior authorization and health care documentation, and policies that improve access to care and treatments (eg, Inflation Reduction Act). During our time at the AUA Advocacy Summit in Washington, DC this year, we brought legislative asks to members of the House and Senate. Members of the AUA met with members of Congress to garner support for the Resident Physician Shortage Act, the Conrad State 30 and Physician Access Reauthorization Act, and the Specialty Physicians Advancing Rural Care Act, all of which strive to increase and retain urologists in the workforce. We also discussed the CONNECT for Health Act, which will provide permanent support for telehealth access and reimbursement. Finally, we asked for support of the Preserving Seniors’ Access to Physicians Act of 2023, which aims to increase Medicare physician reimbursement.

The AUA Advocacy Summit brings together urologists across the training spectrum, from those who have been in practice for many years to those who are in medical school and considering a career in urology. We highly encourage you to attend the 2025 AUA Advocacy Summit next spring so that you can be a part of ongoing work to support patient care and the future of urology through policy and advocacy. ■



Figure 2. The Michigan delegation on Capitol Hill. Left to right: Wendy Martino, Rebecca Howland, Benjamin Pockros, Victoria Houston (legislative correspondent for Senator Peters), Lindsey Herrel, Kassem Faraj.

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AUA ADVOCACY

Future Directions and Goals for AUA Policy and Advocacy Efforts

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Chair, AUA Public Policy Council*

Resilience. It was the theme of our recent and best-yet AUA Summit in Washington, DC. Our specialty faces so many challenges today. It feels like there's "incoming" from all sides, all the time. Workforce concerns have surpassed our still-formidable administrative burden concerns, both in surveys and in our personal communications with colleagues.

Over the past 23 years, adjusting for inflation, our Medicare payments have gone down almost 30% while inflation continues to increase the cost of providing care. We physicians are the only group in health care paid by the federal government whose payments are not inflation adjusted. The Consolidated Appropriations Act of 2024 made this year's Medicare cut less deep, but we're still bleeding. One of the leading advocates for Medicare payment reform in the US House of Representatives is the AUA's own Dr Greg Murphy (R, North Carolina). Our other colleague currently serving in Congress, Dr Neil Dunn (R, Florida), has also done tremendous work in this area. A group of senators have recently formed a work group to study and propose reforms to Medicare physician payment: Catherine

"Over the past 23 years, adjusting for inflation, our Medicare payments have gone down almost 30% while inflation continues to increase the cost of providing care."

Cortez Masto (D, Nevada), Marsha Blackburn (R, Tennessee), John Thune (R, South Dakota), John Barrasso (R, Wyoming; an orthopedic surgeon), Debbie Stabenow

(D, Michigan), and Mark Warner (D, Virginia). I, like most of you, still get deep satisfaction from the practice of urology and feeling like I'm making a difference in

my patients' lives. External forces, however, continue to make it harder and harder to provide that care,

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FUTURE DIRECTIONS AND GOALS FOR AUA POLICY AND ADVOCACY EFFORTS

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“Those of us practicing in rural areas, in particular, are starting to see excess morbidity and even mortality from lack of availability of urological expertise.”

and that’s why the third pillar of the AUA’s mission statement is “the formulation of health care policy.” That’s the work of the public policy council in our role as advisers to the AUA Board of Directors. Our work is about resilience in the face of persistent forces acting to reduce our ability to deliver the urologic care that Americans need.

Our state and federal legislative priorities are assessed by alternating biennial surveys of the membership on their state and federal pain points. Those data are evaluated by our State Advocacy Committee under the expert

leadership of Dr Brian Duty, and our Legislative Affairs Committee under the sage guidance of Dr Robert Bass. Those committees formulate the suggested priorities and submit them to the AUA Public Policy Council, which approves and submits to the AUA board for approval. Our current state and federal priorities are shown in Figures 1 and 2. The lists do not imply a rank order of importance. The bulleted items serve as a signal to staff as to the issues on which we are willing to spend our limited time and resources.

Workforce. It has assumed a prominent place in our federal and state legislative agenda. I have tremendous admiration and gratitude for Dr Andy Harris and the members of the Urology Workforce Task Force, which has studied the problem from all angles and has published on several aspects of our workforce challenges. The task force has couched the problem as a supply-demand mismatch, which I think is a very effective way to attack the problem. There are not enough practicing urologists in the country. According to AUA Census data, 60% of US counties don’t have a urologist. And the problem is only getting worse. Those of us

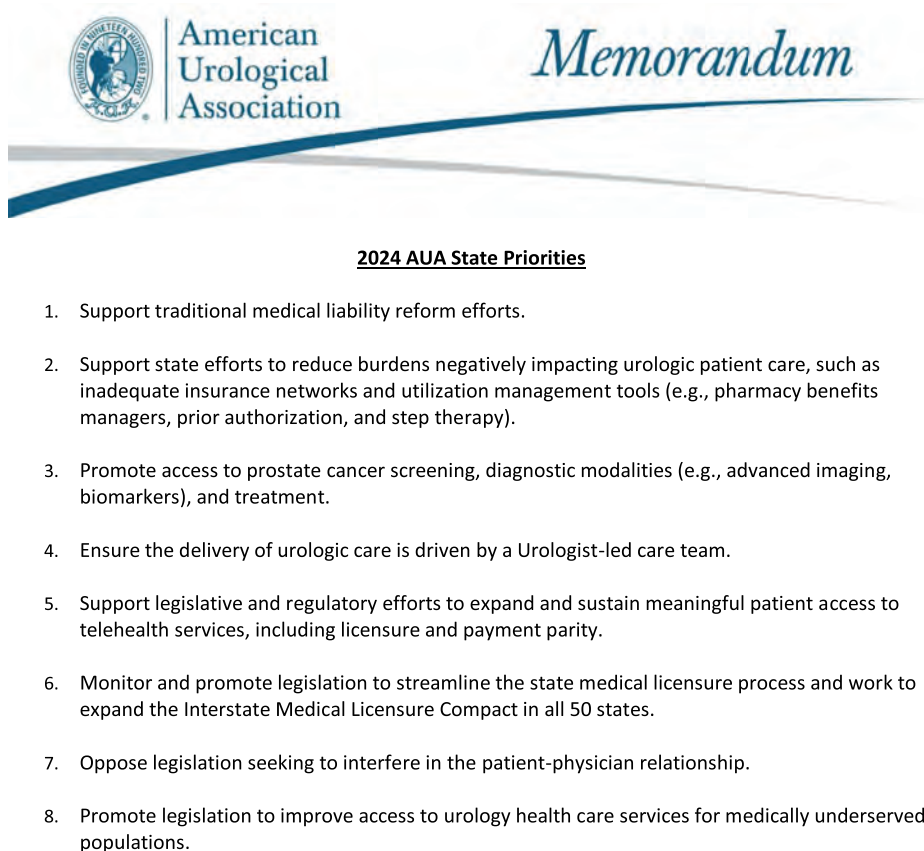


Figure 1. 2024 AUA state priorities.



Figure 2. 2024 AUA federal priorities.

practicing in rural areas, in particular, are starting to see excess morbidity and even mortality from lack of availability of urological expertise. Possible solutions include making it less onerous for foreign-trained urologists to achieve American Board of Urology certification, increasing GME slots, and appropriate expansion of Advanced Practice Providers’ scope of practice to include select urologic procedures under the supervision of a physician as part of a physician-led team.

We can attack the demand side as well; for example, educating our primary care colleagues and other referral sources as to the basic initial management of certain urological conditions to avoid referrals too early in a disease process.

AUA Political Action Committee (AUAPAC). We don’t have a voice or brand recognition on Capitol Hill without a strong PAC. It’s the necessary facilitator of long-term congressional relationships. The PAC’s founding

leadership has brought it very successfully from infancy to adolescence, and it’s now time that we make a strong adult out of this thing with some name recognition on Capitol Hill. PAC leadership will be working in the near term to reach out to different AUA constituencies with a targeted value proposition. With the diversity of our membership and practice types, the answer to the question



Figure 3. QR code for AUA Political Action Committee contributions.

FUTURE DIRECTIONS AND GOALS FOR AUA POLICY AND ADVOCACY EFFORTS

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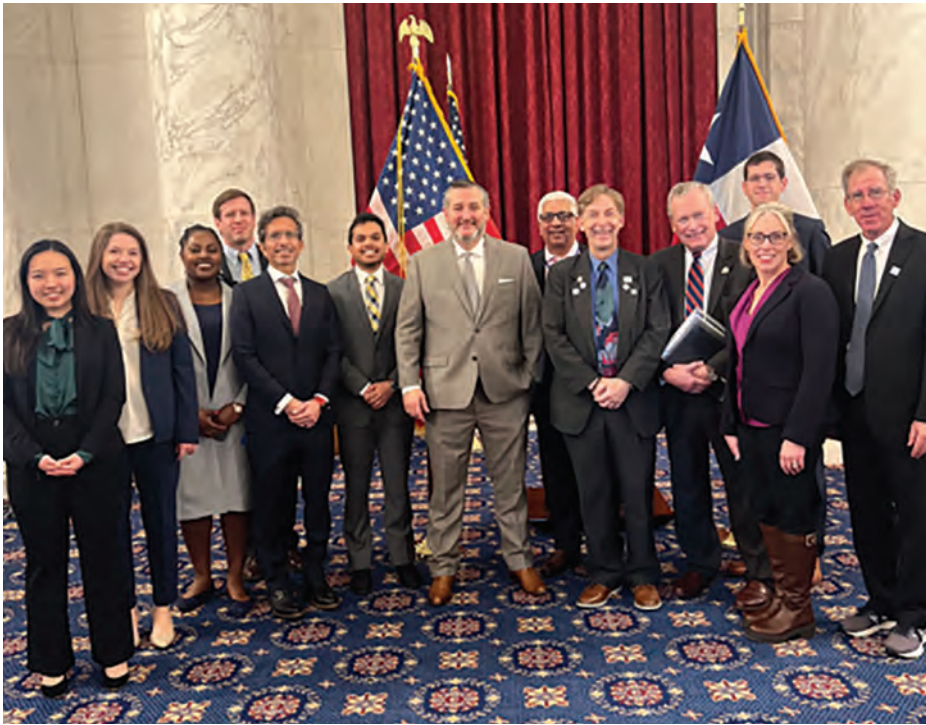


Figure 4. Texas delegation with Sen. Cruz.



Figure 7. Minnesota delegates.



Figure 5. Louisiana delegates meeting with Sen. Cassidy.



Figure 8. Tennessee delegates with patient advocates.



Figure 6. Massachusetts urologists with Rep. McGovern.



Figure 9. Massachusetts coalition with Sen. Markey.

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FUTURE DIRECTIONS AND GOALS FOR AUA POLICY AND ADVOCACY EFFORTS

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“why should I give” is different for each. But a strong answer exists for each, and we are going to deliver that proposition to you in the near future. For residents, please start right now—today—to get in the habit of making an annual contribution to the AUAPAC. Use the QR code in Figure 3 to make a contribution.

I’m leading by example. I recently became the third Platinum member in AUAPAC’s history. The dollar amount is not important. Ten or twenty dollars helps. The act of making this a yearly habit is critical. We’ve got to create a culture in urology

that the lawyers created years ago—which is why they are a \$4M PAC.¹ We need to consider an annual PAC contribution a cost of doing business. It should be part of our annual professional checklist, like renewing our license and getting our CME done.

If you love this advocacy stuff like I do, please join us in Washington, DC, March 2-5, 2025, for the next AUA Advocacy Summit (Figures 4 through 9). If your heart is with us but you just can’t or don’t want to make the trip to DC, no problem. Please contribute to the PAC. (Scan the QR code right now!) It is the single best thing you can do to sup-

port AUA’s efforts toward improving the practice environment for every one of us.

We’ve got work to do! Let’s get to it! ■

AUAPAC is a “separate segregated” fund (SSF) established by the American Urological Association, Inc. Contributions to AUAPAC, which is a multicandidate committee, are not deductible as charitable contributions for Federal Income Tax purposes. Further, contributions by one person in the name of another person are prohibited. PAC contributions are also not reimbursable by an employer or any other entity. The FEC requires that certain information on each donor (who contributes \$200 or more per year) such as the

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1. PAC Profile: American Assn for Justice. Open Secrets. Accessed March 17, 2024. <https://www.opensecrets.org/political-action-committees-pacs/american-assn-for-justice/C00024521/summary/2024>

AUA ADVOCACY

Improving Care Delivery for NMIBC Patients: In-Home Intravesical Therapy

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Nonmuscle-invasive bladder cancer (NMIBC) accounts for approximately 75% of the over 83,000 new bladder cancer cases diagnosed annually, and there are over 700,000 individuals living with bladder cancer in the United States.¹ Progression of NMIBC is associated with significant morbidity and mortality and more than doubles health care costs.² The mainstay of therapy to help reduce the risks of recurrence and progression is intravesical therapy, either bacillus Calmette-Guérin (BCG) or chemotherapy.

Yet despite known efficacy and guideline support for using intravesical therapy in NMIBC, use rates remain lower than desired. In the United States, less than two-thirds of patients receive adequate induction BCG, and only one-quarter receive maintenance BCG.³ Even in clinical trial settings, intravesical ther-

apy is discontinued at rates higher than expected from adverse events alone.⁴ Although reasons for this are multifactorial, there is evidence that the time toxicity of intravesical therapy is a meaningful barrier for some NMIBC patients in receiving guideline-concordant care.

Time toxicity is defined as the time spent both coordinating and receiving cancer treatment in a health care facility, including time for travel, wait times, seeking unscheduled care for side effects, and time for follow-up tests.⁵ For some patients, time toxicity may be substantial enough to offset potential therapeutic gains. This may be particularly true among patients with NMIBC, who are often elderly with multiple comorbidities and are asked to make up to 19 urology visits in the first year after diagnosis for treatment and surveillance.

We recently performed a survey among bladder cancer survivors to characterize the treatment burden they experienced in receiving intravesical therapy.⁶ Over half of respondents reported a one-way travel time exceeding 30 minutes, and one-third spent over \$25 out

of pocket per trip, not adjusting for inflation, which can add up quickly for patients on a fixed income (Figure 1).⁶ Additionally, more than half of patients reported that a single treatment lasted over 2 hours, and one-third missed work for each treatment. Lost wages are known to contribute significantly to the financial toxicity of NMIBC and can result in delays in care.⁷ The cumulative effect is a substantial burden of treatment for patients undergoing intravesical therapy, and the expectation that our patients will travel to a medical facility for

every treatment not only overlooks the time toxicity of therapy but may also exacerbate existing health disparities among those in rural geography or with lower incomes and among racial/ethnic minorities.⁸

In-home delivery of intravesical therapy is one potential solution that may help reduce time toxicity and improve the patient experience of NMIBC care. We believe that the postpandemic paradigm shift toward increasing telehealth and remote care in urology presents a

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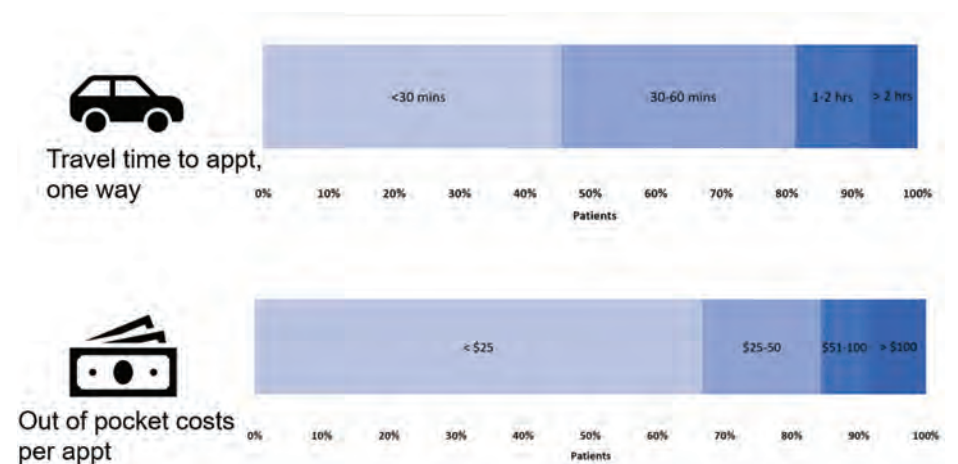


Figure 1. One-way travel times and out-of-pocket costs per treatment reported by NMIBC patients to receive intravesical therapy (N = 233).

IMPROVING CARE DELIVERY FOR NMIBC PATIENTS

→ Continued from page 12

prime opportunity to rethink the process of care delivery for intravesical therapy, which remains effectively the same as when intravesical BCG was introduced in 1976.⁹ In our aforementioned survey study, 72% of respondents reported openness to receiving in-home intravesical therapy, and many patients cited potential benefits, including reduced anxiety around receiving treatments, supporting the development of such an approach.⁶

To evaluate this hypothesis, we are conducting the phase 2, single-arm, In-Home Intravesical Therapy (INVITE) trial, which will enroll patients receiving intravesical therapy for NMIBC to receive treatments delivered in their homes through a network of contracted home care nurses (Figure 2). Patients receiving induction therapy with either BCG or intravesical chemotherapy will receive their first treatment in the brick-and-mortar clinic to ensure safety and tolerability, with doses 2 to 6 delivered in their home, and patients receiving maintenance therapy will receive all 3 scheduled doses at home. The primary outcome is the feasibility of delivering in-home intravesical therapy, with a key secondary outcome of patient satisfaction and likelihood to recommend in-home therapy. Additional secondary outcomes include patient safety, health-related quality of life, number of home days without physical health care

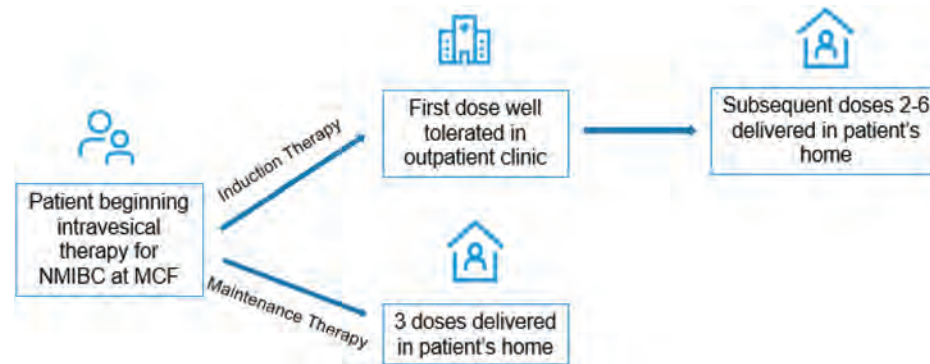


Figure 2. Schema for INVITE trial. Used with permission from Timothy D. Lyon, MD.

system contact during the study period, and number of unscheduled interactions with the urology care team during treatment.

Several operational challenges need to be overcome to implement in-home intravesical therapy successfully.¹⁰ Reconstituted BCG should be refrigerated and used within 2 hours, which impedes transport outside of a pharmacy. However, closed-system transfer devices can safely transport BCG prior to reconstitution, with subsequent reconstitution within a sterile system while in the patient's home, effectively overcoming this barrier.¹¹ Widespread implementation beyond the trial setting will require an adequate infrastructure of resource pharmacies and home care delivery providers to help reach patients where they are. Thankfully, several existing companies market their services to interested health care systems to help navigate the logis-

tics of in-home treatment delivery, and more entrants to this market are expected in the near future. Reimbursement models for in-home treatment that ensure the financial viability of this approach will also need to be negotiated. Patient cost-sharing could be considered; notably, in our survey, one-quarter of respondents reported willingness to pay an additional out-of-pocket fee beyond their traditional copays for the added convenience of receiving treatment in the home.⁶

In conclusion, in-home intravesical therapy has the potential to decrease time toxicity of therapy and improve patient satisfaction and compliance with treatment, and we look forward to generating data to inform the feasibility of this approach. We owe it to our patients to develop and test innovative care delivery methods to help improve the patient experience of bladder cancer care. ■

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AUA ADVOCACY

Bridging the Gap Between Health Policy Research and Dissemination

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The traditional path of research in academia typically involves a presentation at a conference, production of a manuscript, and publication in a journal. Although this framework serves our academic

community well through its rigor and peer-review process, it can also be restrictive. In the case of health policy research, for example, patients and policymakers are some of the key stakeholders that would benefit from accessing research, but they are not the targeted audience in the traditional path of research. This “dissemination gap” (Figure) presents a significant obstacle to

achieving the ultimate goal of informing legislators and empowering advocates to guide political change that may influence clinical practice.

Narrowing the dissemination gap in health policy research is critical. Improving the access and distribution of research can help policymakers make informed decisions about policies that are grounded in scientific rigor and empirical ev-

idence. Urologists interested in taking more creative and innovative approaches to maximize the impact of their research can consider a few strategic approaches.

1. Collaborate with a diverse team, including health care economists, health services researchers,

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BRIDGING THE GAP BETWEEN HEALTH POLICY RESEARCH AND DISSEMINATION

→ Continued from page 13

public health experts, and policy analysts. Interdisciplinary collaborations can facilitate a comprehensive understanding of complex health care issues. Partner with patient advocacy groups, disease-specific foundations, and nonprofit organizations to disseminate research findings. These organizations may share enthusiasm about the research and help broaden the distribution to interested parties. Likewise, researchers can learn from these organizations about issues most affecting their members, and organically develop future research questions that better address their needs.

- Utilize digital platforms such as social media, blogs, podcasts, and webinars to broaden your audience. Urologists can use these platforms to disseminate research findings, engage with diverse audiences, and discuss key policy issues. The Backtable Urology podcast is a popular option for urologists. These sources of media may also be more accessible for patients, particularly compared to academic journals that require institutional subscriptions. Twitter/X is another option to provide patients access to reliable in-

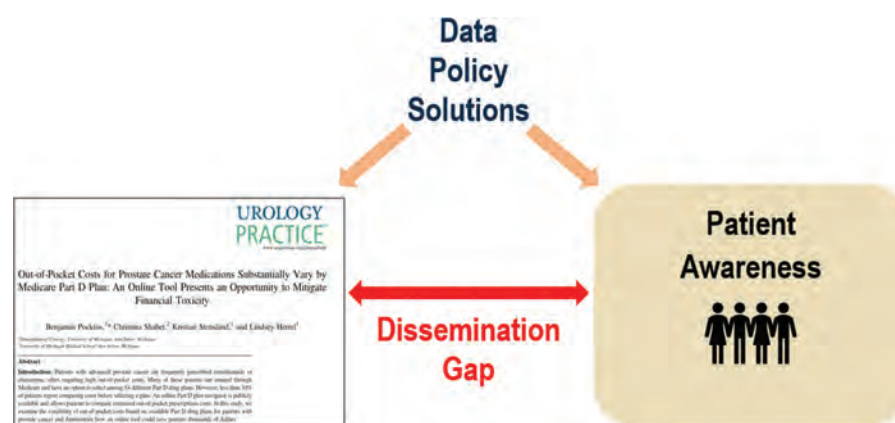


Figure. The dissemination gap between key stakeholders and the traditional research framework. This article identifies multiple strategies to bridge the gap.

formation, resources, and links to reputable sources for further reading and exploration of topics discussed in research studies. A third example, specifically designed for patients, is well-prept.com, a website founded by Dr David Canes, a urologist at Lahey Hospital, which offers customizable information that urologists can send to patients so they can arrive at the clinic informed.

- Tailor your language to your intended audience. Urologists should prioritize plain language summaries, infographics, and multimedia presentations to make research findings accessible to patients. Medical journals

such as the *The Journal of Urology*[®] and *Urology Practice*[®] now emphasize these efforts by routinely including visual abstracts and single-page takeaway summaries. Advances in artificial intelligence may ease this process in their ability to edit and tailor manuscripts according to instructed reading levels.

There are several examples of urologists who have utilized these dissemination strategies to increase the outreach and impact of their research. Dr Chad Ellimoottil, a urologist at the University of Michigan, is an expert in telemedicine who testified before the Senate Finance Committee in November 2023 to help

advocate for the adoption of continued telehealth availability. Dr Ruchika Talwar, a urologist at Vanderbilt University Medical Center, investigated the potential cost savings of Medicare prescription medication by analyzing the Mark Cuban Cost Plus Drugs company. In addition to publishing in an academic journal, she highlighted this work by hosting a live video interview with Mark Cuban, which attracted over 4600 views on YouTube.

To encourage more dissemination efforts from urologists, academic institutions should consider increasing the value placed on this work. Currently, traditional models of promotion at academic universities rely most heavily on grant funding, publications in journals, and lecturing events with mainly medical audiences. However, these platforms are not broadly accessible for patients and may be limited in their scope of reach or impact. Departments should begin to include alternative criteria for promotion, including dissemination efforts and outreach, to help incentivize more unique dissemination efforts. Tackling the dissemination gap could significantly improve a health care system aimed at optimizing clinical practice for providers and patients. ■

AUA ADVOCACY

The Next Generation of Policy Leaders: Summary of the Summit's Debut Public Policy Forum

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Vanderbilt University, Nashville, Tennessee

This year's annual Advocacy Summit included a brand new session designed to highlight urology trainees' advocacy work. The Public Policy Forum on the

second morning of the Summit was created by the Policy & Advocacy Resident/Recruitment Work Group as a route to increase trainee engagement. Of the approximately 120 trainees in attendance at the Summit—an exponential increase from years prior—13 had projects selected for presentation, 6 of which were presented as “winning selections” on stage during the Forum. Summaries of a sample of these projects are below. Virtual posters for each project can be found on the

Summit website: aumasummit.org/virtual-advocacy-posters.

If you or a trainee you know has a policy-related project that could be presented at the Public Policy Forum next year, keep an eye out for applications in the fall! The AUA fully funds attendance of the Summit for all trainees with winning selections.

Overutilization of Transfer for Testicular Torsion: An Opportunity

for Multilevel Policy Intervention

Emily Clennon, PGY4

Transfer of pediatric and adolescent patients for testicular torsion has gradually increased and doubles both time to surgical intervention and cost of care for patients in Oregon. Drivers of transfer include institutional policies preventing

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THE NEXT GENERATION OF POLICY LEADERS

→ Continued from page 14

emergent surgical care of patients < 18 years old, lack of local urology coverage, and lack of availability or willingness among local urologists. There are routes to intervene on the growing trend of transfer of these patients at multiple levels in the health system as outlined in Figure 1.

Dissemination of an Informational Video to Reduce Out-of-Pocket Spending for Prescription Medications

Benjamin Pockros, PGY2

Medicare Part D drug plans have highly variable out-of-pocket costs. Unfortunately, less than a third of patients compare drug plan pricing prior to selecting a new plan each year. We designed a patient-centered instructional video about the use and importance of the online Medicare Part D plan comparison tool and tested dissemination strategies to maximize viewership. Over a 6-week period, targeted advertising on YouTube led to 22,844 views. Clinicians and health care organizations interested in disseminating important policy or public health information to patients can utilize new affordable and accessible online technologies to quickly build

“Transfer of pediatric and adolescent patients for testicular torsion has gradually increased and doubles both time to surgical intervention and cost of care for patients in Oregon.”



Figure 1. Examples of policy changes or multi-institutional collaborations at different levels of the health system to promote local care of pediatric testicular torsion patients.

videos and increase viewership (Figure 2).

Geographic Changes in Rural Access to Urological Care in the United States

Kelly Lehner, PGY3

Kelly Lehner presented on recent trends in rural access to urologic care. Using AUA Census data (2014-2022), she found that despite increased political attention and policy programs aimed at growing the rural physician workforce over the 8-year study period, less than 10% of US urologists work in rural areas, and this number has remained stagnant. The percentage of counties with no practicing urologist has also remained stable around 60%. Some regional varia-

tions were observed, with states in the Mountain West and South losing rural urology providers at a higher rate. The findings overall suggest that redoubling multipronged efforts to implement pipeline training programs and legislative policy solutions is imperative to begin to bridge the rural care divide.

National Cancer Drug Shortages: Policy Response and Potential Solutions

Taryn Ellis, PGY4

In the United States, there has been an ongoing issue with supplying the demand for generic prescription drugs. The COVID-19 pandemic further exacerbated these issues as a result of supply chain-

“The findings overall suggest that redoubling multipronged efforts to implement pipeline training programs and legislative policy solutions is imperative to begin to bridge the rural care divide.”

related difficulties, as many factories were shut down during this time. There was a 30% increase in new drug shortages between 2021 and 2022 and a 10-year high in the number of active drug shortages at the end of 2023.¹ Low-cost generic drugs are more susceptible to shortages when the suppliers shut down, and many chemotherapy agents commonly used when treating urologic conditions fall into this category. Currently there has been a severe shortage of 2 important chemotherapy drugs—carboplatin and cisplatin—both of which are commonly used when treating multiple urologic malignancies. The National Cancer Comprehensive Network reported that 93% of surveyed cancer centers reported a shortage of carboplatin and cisplatin.² We identified proposed legislative and federal agency policy changes to address and prevent these shortages and worked to bring these matters to the attention of the urologic community as targets for future advocacy efforts. ■

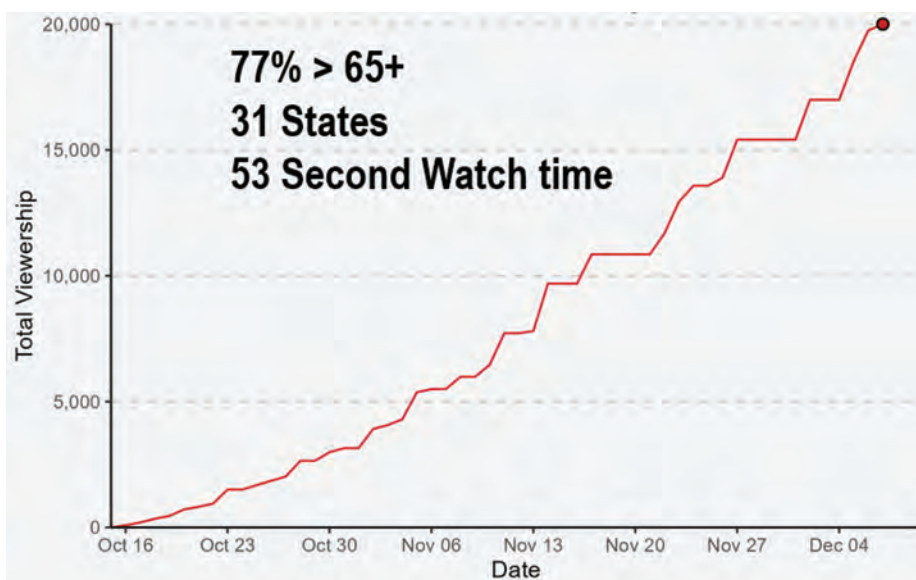


Figure 2. Total viewership of Part D navigator video based on YouTube search engine optimization.

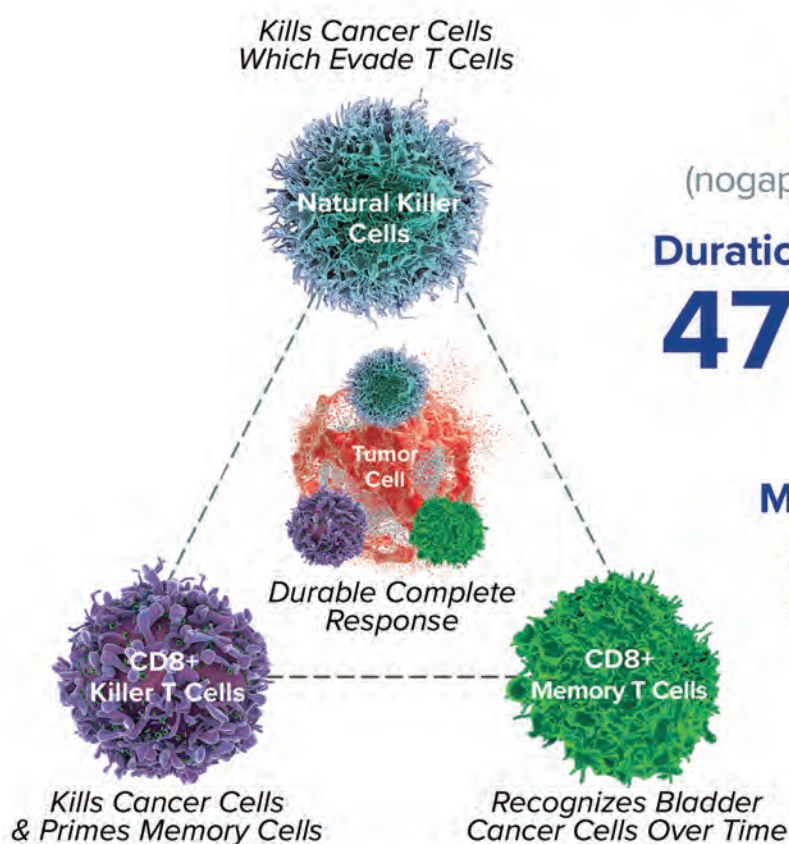
1. Schondelmeyer SW. A resilient U.S. drug supply: current & emerging vulnerabilities. Statement before the United States House Committee on Ways and Means Hearing on Chronic Drug Shortages in the United States; February 6, 2024. <https://democrats-waysandmeans.house.gov/sites/evo-subsites/democrats-waysandmeans.house.gov/files/evo-media-document/Schondelmeyer%20Testimony%20House%20Ways%20Means%20Shortages%202024-02-06%20v2.pdf>

2. NCCN Best Practices Committee. Drug shortage follow-up survey results. October 5, 2023. Accessed April 13, 2024. www.nccn.org/docs/default-source/oncology-policy-program/NCCN-Drug-Shortages-Survey-Update.pdf

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¹. ANKTIVA Package insert. ImmunityBio, Inc.; 2024. ². Chamie K, et al. IL-15 Superagonist NAI in BCG-Unresponsive Non-Muscle-Invasive Bladder Cancer. NEJM Evid. 2023 Jan;2(1): EVIDoa2200167. doi: 10.1056/EVIDoa2200167. ³. One death reported due to a cardiac arrest that was unrelated to N-803 + BCG.