

Statistical analysis included chi-squared and ANOVA where appropriate. Significance was set to $p < 0.05$.

RESULTS: 13,657 men met inclusion criteria, equating to 60 million men. There were minimal significant differences in age, average income, and education level, but no differences in race between the groups. Results of the multivariable analysis are presented in the table. Men who identified as gay were more likely to be asked about number of sexual partners, condom use, and types of sexual practices. They were also more often tested and treated for STIs.

CONCLUSIONS: This is the first nationally representative, controlled assessment of the influence of sexual orientation on physician discussions surrounding sexual health. Men who identified as gay or bisexual had significantly different interactions with providers, but contrary to published data, sexual health counseling and discussion were more common in this population, even after controlling for baseline sexual health risk.

	Heterosexual/Straight (%)	Homosexual/Gay (%)	Bisexual (%)	P-Value
Asked About Number of Sexual Partners	13.4	33.2	20	<0.001
OR*	Reference	2.26 (1.62-3.16)	1.33 (0.92-1.93)	
Asked About Sexual Orientation or Sex of Partners	14.9	35.6	20.8	<0.001
OR	Reference	2.31 (1.69-3.16)	1.24 (0.84-1.83)	
Asked About Condom Use	15.8	39.2	25.9	<0.001
OR	Reference	2.37 (1.71-3.28)	1.52 (1.06-2.19)	
Asked About Type of Sexual Practices	8.5	32.8	14.7	<0.001
OR	Reference	3.65 (2.60-5.13)	1.43 (0.95-2.16)	
Asked if Sexually Active	38	59.4	55.9	<0.001
OR	Reference	1.85 (1.22-2.80)	1.73 (1.23-2.43)	
Discussed Emergency Contraception	4.8	8	6.7	0.336
OR	Reference	1.53 (0.91-2.56)	1.13 (0.56-2.28)	
Discussed Condom Use with Female Contraception	10	15	14.5	0.141
OR	Reference	1.34 (0.81-2.22)	1.15 (0.73-1.81)	
Tested for STI in Past Year	14.4	44.8	24.1	<0.001
OR	Reference	3.86 (2.75-5.42)	1.69 (1.17-2.42)	
Had Pharyngeal or Rectal STI Test in Past Year	30.3	57.3	44.2	<0.001
OR	Reference	2.77 (1.75-4.37)	1.60 (0.86-2.94)	
Treated for STI in Past Year	2.1	12.1	5.3	<0.001
OR	Reference	3.70 (2.05-6.66)	1.85 (0.81-4.24)	

*OR = Odds Ratio

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MP19-19
GUIDELINE-DRIVEN CHANGES IN SURGICAL MANAGEMENT OF URETHRAL STRICTURE IN MEDICARE PATIENTS

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INTRODUCTION AND OBJECTIVE: Urethral stricture disease is traditionally managed surgically, either endoscopically by procedures such as urethral dilation or direct visual internal urethrotomy or by urethroplasty. In 2016, the AUA released guidelines recommending urethroplasty over repeated endoscopic procedures, such as dilation or direct visual internal urethrotomy (DVIU) for recurrent strictures. We investigated changes in Medicare practice patterns for urethral strictures from 2010 to 2018.

METHODS: The Centers for Medicare and Medicaid Services (CMS) database was queried for reimbursement and provider-level data related to urethral stricture from 2010 to 2018. Monetary data was adjusted for inflation to 2020 US dollars (USD). Average annual and total number of providers and procedures were calculated for all included procedures. An unpaired student's t-test was used to compare variables.

RESULTS: On average, endoscopic procedures were billed 14,923 times by 1110 providers annually. Urethroplasty was billed an average of 209 times annually by 127 providers. Significantly more endoscopies were performed annually than urethroplasties (9.3 vs. 1.6, $p = .02$). Average urethroplasty reimbursement was \$777 versus \$214

for endoscopy (\$103 dilation; \$326 DVIU). Overall, providers were reimbursed \$1893 annually for endoscopies (\$1614 dilation; \$2172 DVIU) compared with \$1310 for urethroplasties. Total endoscopies per year decreased 35% (-44% dilation and -27% DVIU), while total urethroplasties increased 36% (Figure 1).

CONCLUSIONS: Providers performed significantly more endoscopic procedures for urethral strictures than urethroplasties under Medicare from 2010 to 2018. Although reimbursement is higher for urethroplasty than endoscopy, providers received greater annual reimbursement for endoscopic management after accounting for procedural volume. Regardless total endoscopic procedures decreased over time. These findings suggest that although Medicare might incentivize repeated endoscopic management over definitive urethroplasty, urologists are nonetheless responding to urethral stricture guidelines.

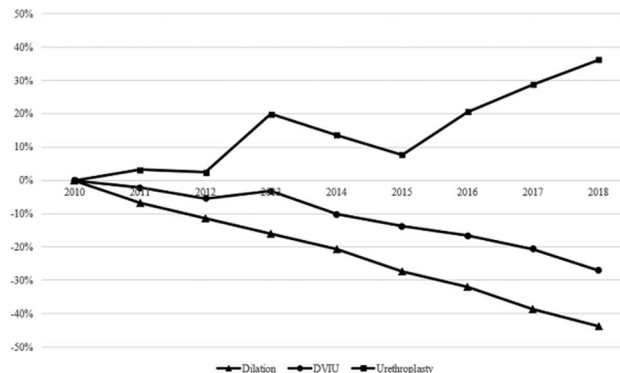


Figure 1. Annual percent change in total dilation, DVIU, and urethroplasty procedures performed from 2010 to 2018.

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MP19-20
RISK PREDICTION TOOLS IN AN INTUITION-BASED WORLD: A MIXED METHODS STUDY OF UROLOGIC SURGEONS

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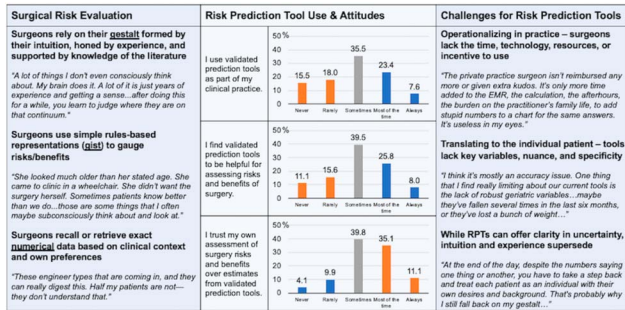
INTRODUCTION AND OBJECTIVE: A plethora of risk prediction tools (RPTs) have been developed to support surgical decision-making. However, past studies indicate both limited uptake and minimal impact on actual decisions. To promote the design of impactful tools, we sought to understand the current role of RPTs and prevailing attitudes among urologists.

METHODS: We conducted a national mixed methods study using a sequential explanatory design. Via the 2019 AUA Census, we surveyed urologists on RPT use, perceived helpfulness, and relative trust and identified associated characteristics through bivariable and multivariable analyses. We then interviewed 25 respondents on their surgical decision-making, risk evaluation, and RPTs. Coding-based thematic analysis was applied and integrated with survey findings.

RESULTS: Among a weighted sample of 12,366 practicing urologists, 30.4% (28.2–32.6%) routinely used RPTs and 34.3% (31.9–36.6%) found them to be helpful while 47.0% (44.6–49.5%) more often trusted their own assessment over RPT-generated estimates. On multivariable analysis, more years in practice were negatively associated with RPT use, perceived helpfulness, and relative trust ($p < 0.001$) whereas oncologists reported greater use and more positive attitudes ($p < 0.001$). As illustrated in the joint display, almost all interviewed urologists described relying on their intuition/gestalt to assess surgical risks and benefits. Most employed gis-

based approximations and less actively retrieved numerical information, which is where RPTs reside. Challenges to greater RPT use appear both methodological (e.g., translating group statistics to an individual, missing variables) and operational (e.g., ease of use at the point-of-care). In the current state, interviewed urologists found more value in RPTs as a communication aid for patients rather than decision support for their own surgical decision-making.

CONCLUSIONS: Despite their wide availability, RPTs are used infrequently and have limited perceived utility among urologists. This likely reflects both the intuitive nature of surgical decision-making and implementation challenges. For RPTs to be used more broadly and affect decision-making, both types of barriers will need to be addressed.



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