for endoscopy ($103 dilation; $326 DVIU). Overall, providers were reimbursed $1893 annually for endoscopies ($1614 dilation; $2172 DVIU) compared with $1310 for urethroplasies. 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 urethroplasies 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.

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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 impact of 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%) reported greater use and oncologists reported more often trusted their own assessment over RPT-generated estimates. On multivariable analysis, more years in practice was 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 gist-
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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