4TH Edition

AUA Young Urologists Committee

Transitioning from Residency to Practice Manual

What's New:

Women in Urology

Working with Advanced Practice Providers

2019 CPT® Codes

American Urological Association, Inc.

Advancing Urology™

PREFACE:
TRANSITIONING FROM RESIDENCY TO PRACTICE

Are you a young urologist navigating your new career path? Do you have questions about transitioning into practice?

The American Urological Association's (AUA) Young Urologists Committee (YUC) has prepared this manual to guide residents and young urologists, such as yourself, as you embark on your transition to practice. One of the goals of this manual is to answer questions like, "which type of practice should I enter? Academic, private, or hospital-based?" These are questions we don't usually think to ask our faculty members when we are going through residency/fellowship training. This manual will not only guide you in determining what type of practice you should enter, but will also help you decide where you would like to practice, information on the application process, contract negotiation, and physician compensation models. Most importantly, it will offer you wellness tools, as residents and young urologists are at a higher risk of burnout.

This year, we have two important additions to our manual. The first addresses challenges that women in urology face. Dr Julie Riley has prepared an excellent section on this topic and provides tips on how to overcome these unique challenges. Her advice is relevant to both women and men who practice urology. The second important addition is the section on Advanced Practice Providers (APP), which includes Physician Assistants and Advanced Practice Nurses. This section explains how Advanced Practice Providers can assist urologists in meeting the increased demands of urologic practice. To demonstrate the importance of APPs to urologic practice and improve collaboration, the YUC has collaborated with the APP Membership Committee by creating a liaison a positon that serves on both Committees.

I would like to thank the rest of the YUC members, especially Chair-Elect Dr. Steven Hudak and Vice-Chair Elect Dr Kyle Richards, for their hard work and commitment to the AUA. I would like to specially thank Ms. Adriene Williams, the YUC staff liaison, for her tireless work in making this manual possible.

I wish you success and happiness in your career. Please feel free to email your comments, questions and feedback to youngurologists@AUAnet.org. We would like to update this manual annually and we rely on your input to make it better next year.

Sero Andonian, MD, MSc, FRCSC, FACS

Young Urologists Committee Chair (2018-2019)
AUA Leadership Class (2018-2019)

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AUA Young Urologists Committee

Transitioning from Residency to Practice

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Acknowledgement: This guidebook has been adapted from the original AUA Young Urologists Guide, "Transitioning from Residency to Practice."

1. DECIDING WHERE TO SETTLE

Research the geographic areas that you are considering.
Is there a high density of urologists?
Are the competitive markets already saturated with urologists?
Are there less competitive areas with fewer urologists?
What are the typical payer mixes for these regions?
What types of insurance do the patients have?

We posed these questions in the Young Urologists Online Community and here are some of the responses that we have received. We are re-publishing their recommendations with their permissions. The opinions are their own and do not reflect those of the American Urological Association (AUA).

DR. RUSSEL WILLIAMS – HOUSTON, TX:

I remember this stage well and I have had years to observe large group practice, hospital-based practice, solo traditional practice and now I am in solo (soon to be small group) entrepreneur Urology practice.

I have practiced in a large city all my career but I did a locum rotation in a small rural hospital/ medical community. I have many close friends being urologists in the academic setting so I know somewhat their life. I have seen many different scenarios!

For me the strongest consideration (aside from practicing in an ideal city) is who will be those people around me with the greatest influence/control on me. Will it be that hospital administrator? Will I be placed in a political role needing to manage relationships? Will I be asked to be on committees?

Will I be responding to large group administrator wanting me "to be in non-ideal clinical duties"? Will I be covering call for multiple physicians with in-house patients with prolonged weekend rounds? Keep these things in mind!

Quality of life, good family life and longevity of practice requires you to find a practice setting where you can minimize stress and be excited about being a physician.

I agree with the comment that hanging your shingle and opening up practice is difficult. Not that you "do not have the skills" but rather the insurance contracts can be very poor, starting a new practice as a solo doctor.

Best- (and the AUA data shows this) is a small group practice that is established with like-minded considerate physicians who seem to control their business environment.

I now practice in a non-hospital based, patient to patient referral, community outreach referral ambulatory Urology practice. Yes, this still exists and if you are interested in "how", you can reach out to me.

Think about education opportunities for the children, if you have or expect a family. I have seen many physicians leave their practice, move cities and start over because they had educational concerns for their children in their first practice location.

Ending on a good note- You are in demand and thus have choices! Godspeed!

DR. TODD LEHRFELD, EGG HARBOR TOWNSHIP, NJ:

What I usually tell residents/applicants, first settle on location:

When applicable, the first factor should be, "where will my spouse be happy?" If he or she NEEDS to be in a particular city, then you need to take a job there, period.

If you are lucky enough where that is not an issue, choose a place that you would be happy in but weigh in the cost of living.

Urologists (and doctors) have the advantage of location arbitrage; often times, better-paying jobs are in lower cost of living cities- quite different than our tech and law colleagues. Unless you feel you MUST live in a high-cost-of-living area, choose a nice (livable) area, and visit the NYC type places with the extra money you will make/save.

After you know the general area you wish to live, find a practice:

*NOTE: If you're going into academics, you probably will know by now. Your mentor will send you on interviews and tell you where to go. Go where you are told!

Everyone else: you need to decide your level of entrepreneurial acumen; this is quite difficult to do prior to entering the "real world". You'll need to decide between private practice or hospital employment.

Hospital Employment

I know I am biased, but realize that the hospitals are NOT your friends; you are a commodity to them, and they will do everything they can to disempower you. The trend is moving toward hospital-owned doctors; realize that any offer made likely has an expiration date, at which point your pay will likely suffer and you may even lose your job (which I've seen happen all too often.) If you are lured in by a hospital, I recommend splurging for the best health care contract lawyer you can find; make sure you are PROTECTED.

I wholeheartedly agree that practicing without a hospital (or at least minimizing its impact on your practice) is ideal for many/most urologists. Hospitals are incredibly inefficient; the moment you walk into one, your productivity drops at best by 75%, and your liability and agitation skyrocket compared to that of your office.

Hospitals NEED us, but we have very little need for THEM.

In the past, it was considered "an honor and a privilege" to be on staff at a hospital; older doctors even took call for free! The times have indeed changed, and our generation is so very different than the urologists of yesteryear. We are now starting to wise up enough to see the economic impact of being an extremely high-demand, low-supply specialty. Hospital administrators are now learning that the free ride is over. If they feel it is important for them to have access to urologists 24/7, they will have to reimburse us at a level that is congruent with "27 years of schooling plus being in the top 1% of your med school class" to convince us to walk into their facilities.

If you do practice at a hospital, payment should be at least equal to the amount of productivity you are projected to lose plus a factor to account for the agitation of dealing with their bureaucracy, plus a factor to account for your time and possible loss of the next day's productivity if you are taking call.

The one confounding factor is that many surgical centers require active hospital privileges. There may be some creative ways around this, such as the use of urologic hospitalists or having other groups cover your portion of call. (Or just negotiating with the hospital CEO to a fair enough reimbursement/ salary for you to take some call and have the next day off with pay.)

Private Practice

It's very difficult to hang a shingle and start your own practice; I recommend finding a "like-minded" group of other urologists you can join.

Feel out the groups and their leadership, and find out if they have similar interests as you; factors I deem crucial:

1. **Age of members- you are young.** You will have far more in common with other young urologists. What percentage of the group is over 50 years old? If it's high, that may be a red flag. Older urologists have very different goals than you will. In general, find young, like-minded people to work with.
2. **Quality of life: I believe this is the most important factor;** determine what type of lifestyle you wish to live. You've gone through hell and back- maybe you like living like that, but you will probably want to have a "normal family life" at some point. Does the group you are looking at stress quality of life?

   How many days per week do the partners work? A group that works more than 4 days a week would be a red flag to me.

   Does the group force its partners to take call? If so, how much, how busy is it, and how much do the hospitals pay you for coverage?

   If you do take call at multiple hospitals, how far apart are they? How much driving is involved? (I've seen large groups whose members drive over 90 minutes for night call! Another red flag.) Do they give you the following day off?
3. **Economics: How does the group do financially vs MGMA average?** Are there ownership opportunities? More specifically- Are there ownership opportunities for ME? (I've seen large groups that only offer things to the older partners (see: "Age of Partners" above). If you are truly considering the group, have them spell out ownership of various items such as surgery centers, radiation machines, ESWL, etc... in the contract.

   And again, pay to have a GOOD health care contract lawyer review anything before you consider signing. It will pay for itself many times over.

Quick version of my recs:

Find the right area to live for you, then find a group with young, business savvy urologists who believe in a great quality of life with minimal (well paid) hospital-based call.

DR. NATHAN GRUNEWALD, PRAIRIE DU SAC, WI:

Here is what I usually tell folks when they ask. This assumes private practice.

1. Take a few minutes to make a list of what you and your partner want in life. Family, Career (work/life balance), Pleasure.
2. Look ahead using a long term focus. Your life has been dominated by school friends forever. You'll still have those, but the circle you keep will likely change. Kids, new money, real job responsibilities, debt, free time.
3. Prioritize these items. Write it down. Save it. Look back on it as you seriously consider contract options.
4. It is a job seeker's market right now. Urologists are in MAJOR demand and will be for the foreseeable future. Your pay should reflect that, i.e. don't sell yourself short. Plenty of data out there regarding reasonable pay expectations.
    a. Be careful as you inquire. Self interests. People will be upset if you don't choose them/their group. Express appreciation, but leave options open it until the contract is signed. Thank them afterwards. Know your friends.
5. Evaluating a Urology job in general terms:
    a. Call requirements. How often, what are you covering (how many locations, hospitals), who are you covering (# partners, what are you and them doing case wise), triage available (when does a patient actually get you), volume (trauma too?)
    b. # partners, cases
    c. hospital beds covered
    d. community, travel times
    e. clinic and support staff assistance
    f. OR access (block time option), Ancillary access (IR, imaging, hospitalists)
    g. Pay (guarantee vs. production basis, sign on, production bonus)
    h. Contract term (many don't stay in their first job)
    i. Competition restrictions
    j. Payer Mix

I personally am hospital employed in a solo setting of a small (35 bed) rural hospital with a superb surgeon base and hospitalists. This is a new service line for the hospital, so I had to start from scratch for them. If that interests you, feel free to message me and I'll explain how I set it up and how I created work/life balance.

Good luck!

2. DETERMINING WHAT KIND OF PRACTICE TO ENTER (Salaried Employment vs. Private Practice)

Academics? Large group? Small group? Hospital-based? Rural? Suburban? Urban? Decide what fits best for you.

The practice locations that you will have to decide on are divided into two broad categories – hospital-based and private practice.

2.1 Salaried Employment

The decision to become a salaried physician can be seen as one way to escape increasing administrative burdens or achieve a more satisfactory lifestyle especially in a health care environment that is in flux. There are several advantages to working in this type of setting that include a guaranteed salary typically with an incentivized plan, often a built-in retirement plan, and lack of administrative issues (ie. human resources, billing and collecting, rent and overhead, and daily operations). Some disadvantages include not being in charge, being told who you will see, possibility that compensation can be changed, and/or being judged by certain metrics (ie. quality and patient satisfaction measures) that may be part of the overall compensation plan. However, you may be able to climb the career ladder and manage multiple practices or become a leader within the organization.

Hospitals may be a stand-alone or part of a hospital network, such as Kaiser Permanente, Mayo Clinic, Cleveland Clinic, Veterans Affairs, an HCA (Hospital Corporation of America) Affiliate, etc. These are all based on an employed salary model. It will be helpful to you to become familiar with

the location's track record of treating hospital-based physicians. One way to do this is by contacting other hospital-contracted physicians in the hospital. This will give you a better understanding of their satisfaction level with their current contracts. It also provides you with an opportunity to ask questions and to discuss any suggestions that may help you in your negotiations with the hospital.

2.2 Private Practice

Private practices can be organized in a corporate model where the physicians are shareholders, or where one or more physicians own the practice and employ other physicians or providers. Physician practices are usually organized into corporations for the tax benefits as well as protecting the owners from liability. The owners typically take a salary draw, split any receipts after all expenses are paid, and generally distribute receipts monthly or quarterly, and is often an "eat what you kill" model. These can include a solo practice, small or large single-specialty group, or multi-specialty group.

Private practice often gives one more control over how one individually practices. This includes control over the physical set up, the electronic health record (EHR)/health informatics system, employees, which patients are seen and how they are treated. You are generally free to make decisions based on your interests and not those of an entire health care system. You will have to work with your partners and learn to compromise, but that process is maybe easier than working with an employer who has many other concerns. Some other challenges in private practice include nurturing referral sources and partnering with hospitals for mutually beneficial outcomes.

2.3 Military Practice

Opportunities for practicing urology within the military exist as well. Practice can range from a solo shop overseas to an academic group practice at a major Military Treatment Facility (MTF). Most of these positions will be filled by individuals who attended medical school on a military scholarship program and who subsequently trained at a MTF or a civilian program in urology. However, opportunities for direct accession to the military, upon completion of training, as an independent urologist may be available depending on each branch of service's specific needs. These opportunities can exist for full active duty positions or in the military reserve. Interested individuals should contact a recruiter (Army, Navy, Air Force) and should be sure to specifically speak with a one who is well versed in physician recruitment. Be sure you know what you are signing if you go this route.

Residents and fellows currently training in an active duty status are likely up to speed on their short-term career planning. It is critical to communicate with the respective urology leads for your respective branch of service. In the Navy, this is the individual known as the Specialty Leader; in the Army and Air Force, this person is known as the Consultant. They are a part of the team that will ultimately deliver your orders/assignment. It is important to convey special considerations (such as individual or family member health considerations or other extenuating circumstances) so that these can be factored into the decision regarding where you will go. Always maintain a respectful tone, as these are some of the most senior members of your military urology community. Additionally, you should do what you can to stay flexible. As the Marines say, "Semper Gumby."

Some transitioning residents/fellows may have been in a "deferred" status during training. For these individuals the transition can be more challenging in some situations. However, contacting the Specialty Leader/Consultant, as described above, is an imperative first step in determining what your first practice will look like within the military.

Practicing urology while serving your country within the military offers a breadth of rewarding practice opportunities, as well as chances to go places and do things you would not otherwise have had the opportunity to do. Military urology represents another great career path option.

2.4 Career Resources

- **AUA JobFinder**
  www.AUAnet.org/Jobfinder
- **Elsevier eHealth Careers Updated URL**
  www.myhealthtalent.com/

American Urological Association

AUA JobFinder

THE ONLINE SOURCE FOR CAREERS IN UROLOGY

The AUA JobFinder is free for all job seekers! We offer a variety of features and resources to help make your job search easy:

- **APPLY ONLINE**
  Search and apply for job openings directly from the site and use the confidential option to mantain your privacy.
- **CAREER PROFILE BUILDER**
  An enhanced career profile builder that allows you to upload a copy of your Curriculum Vitae or Resumé or recruiters to find you.
- **JOB SEARCH AGENT**
  Create an email tool that allows you to have jobs that match your preference emailed directly to your email inbox.

FIND YOUR PERFECT OPPORTUNITY TODAY!

Visit AUA JobFinder at **AUAnet.org/JobFinder** for more details

3. APPLYING FOR THE POSITION

3.1 How To Find Jobs

Knowing someone with a group through a family member, attending, or friend with a close contact is a good way to put you in contact with a job opportunity. Often groups looking to hire will contact program directors in search of residents or fellows that will be graduating. However, there are alternate ways to find the job that best suits you and positions you to interact with multiple potential employers. A career fair is a good way to start looking for a job as this can introduce you to many employers in a relatively short period of time. One can meet face-to- face with recruiters (internal and external) and select groups at a career fair. A good recruiter will consider your needs and match you accordingly to the best fit of employers. In addition, the AUA JobFinder and classified advertisements in the back of medical journals or publications, such as *JAMA*, *The Journal of Urology®* or *Urology Times*, will have job postings. Lastly, social media is your friend. Doximity, LinkedIn, Twitter, and Facebook gives you an opportunity to network while being mobile.

Obtaining personal recommendations by networking is considered one of the best ways to start off your job search. Use your attendings, advisers, or program director to help with finding a job that may fit your goals. If they don't know of anyone that may be hiring, they may be able to direct you to someone who can help you. Once you have prepared your CV and have references, the next step is to decide if you will use an external recruiter right away or look for internal recruiters and specific jobs.

3.2 The CV

Doctors use a curriculum vitae (CV) to apply for employment. The CV is typically longer than a resumé and provides more detailed, relevant information to those who are seeking more knowledge about you and your achievements as a doctor. A CV is more common than a resumé in the academic world and within international medical communities. In order to make it effective, a doctor's CV must be up-to-date and flexible enough to speak to any opportunity for which you are applying. Write a CV by listing your achievements, experience, skills, education, special research and publication credits.

There's a formula you might use when crafting your CV. [www.wikihow.com/Write-a-Doctor's-Curriculum-Vitae]

1. Begin with contact information. On the top of your first page, put your full name, address, phone numbers, pager number, fax number and email address(es).
2. Write a brief objective or career statement. This should be a one sentence summary of your current position and your professional goals. Example: I have completed a fellowship in minimally invasive surgery and have extensive experience in robotic surgery and wish to continue in the private practice environment as a urologic cancer surgeon.
3. List any board certifications, including the dates of national examinations that were taken and passed. Include a list of states where you are licensed.
4. List your educational history and your professional experience. Share your educational credentials by starting with the most recent institution you attended, and list the schools, degrees and years of attendance. Include any relevant activities you participated in while a student/resident/fellow. List all awards and honors you have received.
5. Include a section on special professional successes. You can list any research you have conducted, publications you have written, the American Urological Association teaching you have done, and awards you have received.
6. List the names and contact information of three or four professional references. It is very important that you ask your references if they can be included on your CV and provide them with a copy of your CV in case they are contacted.
7. Include memberships of any professional organizations or associations, and any leadership roles that you may have within them.
8. If you have any gaps in your education or training, it is recommended that you explain the breaks as it may come up in your interview. It is better for you to take control of the gap than to leave it without an explanation.
9. For first time job seekers, it is suggested that you include information about your residency and any relevant volunteer experience.

10. Share all languages that you speak, including your level of fluency.

3.3 The Cover Letter

This is probably the most important part of the resumé. If the cover letter does not attract the attention of the person reading it, the letter, resumé, and/or CV will get tossed and no interview will take place. Some tips for successful cover letters include the following:

1. Address the cover letter to a specific person, i.e. the person doing the hiring.
2. Use bullet points to differentiate yourself as someone who knows what the job consists of and what you can and will do in the position. Clearly define yourself and your unique skills so that the decision maker will want to meet you and, ultimately, offer you a position. Example: As an experienced male infertility and erectile dysfunction expert, I can:
    - Perform microscopic vasal anastomoses
    - Perform penile prosthesis surgery
    - Treat Peyronie's disease with synthetic and auto grafts
    - Work with a reproductive endocrinologist for assisted fertility cases
    - Market and promote Andrology to the community and to potential referring physicians
    - Share with you multiple publications that I have written in peer-reviewed literature on these topics
3. Underscore your commitment to seeking the position by including that you will be calling the hiring manager at a specific time, usually within a week of him/her receiving the letter.
4. In your signature block, along with your name, include the following:
    - Phone number
    - Email address
    - LinkedIn profile link
5. Include a "P.S." Market research has shown that eight out of ten people who open a direct mail piece will read the "P.S." first before reading anything else in the letter. Be creative but relevant with your P.S. For example, P.S. I am also an amateur magician which brings smiles to my patients.
6. Send the letter to the decision maker by certified mail so that you know that the right person receives it, and in a timely manner.

3.4 Site Visit

During the site visit, the candidate will meet primarily with the physician recruiter if this is a salaried position. The recruiter will be your liaison during this process. He or she will be walking you through the many steps needed to complete the visit and the negotiations process.

You may also visit with the CEO, COO, CFO, CNO, OR supervisor, OR specialist (urologist) or members of the marketing department. You should be prepared for each of these interactions.

When interviewing for hospital-based opportunities, it is important that you do your homework on the practice opportunity. Is this hospital in an urban or rural setting? This is important because the reimbursements that hospitals receive in rural designations are generally higher than urban locations. Remember that the hospital can bill and collect for the technical component of the urologists' practice and also for the professional portion.

3.5 The Interview Process

In today's medical job market, urologists are in high demand. A tightening workforce in urology, combined with a need for hospitals to attract urologic care physicians (versus losing out to other centers in their geographic area), has caused the demand for well-trained urologists to skyrocket. A graduating urologist might get 9-12 job offers prior to selecting a particular location to practice. To find a practice location, graduating residents in urology should begin the interview process as early as possible. It is also important to always have an updated CV published and accessible online.

The interview process is still considered crucial because it gives the two parties the unique opportunity to not only meet face-to-face but also to figure out if the proposed relationship is a good match for both sides. One of the classic teachings when buying real estate is that the three most important things are location, location, location. Similarly, when interviewing, the three most important things are preparation, preparation, preparation. Nothing will influence the interview more in a positive or negative way than the preparation or lack thereof of the interviewee. When interviewing, you should know some of the history of the institution and be familiar with the

individuals already in the practice and their area of interest or specialization. Most of this information can be easily found online.

Anticipate what questions might be asked during the interview. For example, "What can you or your skill set bring to the practice that we don't already have?" or "Why do you think this practice would be beneficial to you"? These are questions that you should have already considered and be prepared to answer. Many times, the most helpful thing is to have three or four talking points on each of these responses rather than a complete or memorized answer so that the response will not seem rehearsed.

Try to connect with the person with whom you are interviewing on some level. This could be something having to do with the job or a particular interest in the medical practice. It could be on a personal level such as children, family, hobbies, or time spent outside of work. You could share the region of the country that you come from, places visited, or sports enjoyed. The bottom line is that a personal connection will make you stand out more in the interviewer's mind. It will also show your sincere interest in the position and that you have done your homework in preparing for the interview.

This may be obvious, but you should certainly arrive early to the interview, never show up late, and dress appropriately. If there is a question about the dress, it is better to overdress than appear to be too casual. At times, there may be some factor in a candidate's background that is not entirely positive. For example, a DUI citation or arrest may come up. It is important to be truthful and upfront about such incidents. Nearly every practice will do a background check on you and you will not be able to conceal problems, issues or gaps in your training or work experience. It is far better for you to prepare a true explanation and give it a positive spin in your direction (what have you learned from it?).

One cardinal rule in the interview process is never to say anything negative about your former institution, colleagues, residents, or students. If you are negative about places you have been in the past, then it is likely that you will continue to be negative about your new institution.

One of the most important things that hiring institutions look for is evidence that a candidate is a team player. Positive examples of this would be participation in team sports, clubs or societies. Any leadership positions held in any of these activities are certainly worth emphasizing.

Smile. Sit up and lean slightly forward and act interested. Be enthusiastic but avoid being too flamboyant. It is desirable to be remembered, but you want to be remembered in a positive light, so don't go over the top in trying to impress or make a statement.

It is a good idea to practice the interview process before you "go live." Try scheduling mock interviews with your colleagues who are in the same position. If you currently work at a hospital, you can ask the human resources department to practice with you for an interview. Most departments will be happy to accommodate you and help you with interview preparation.

Finally, once the interview is over ask for a contact method (business card) in order to give a follow up by sending a "Thank You" or "Follow-up" letter to each individual that interviewed you. You can do this either with a hand-written note that is mailed or through email. Be sure to include some specific information that was brought up during the interview, such as an anecdote or family connection.

If the practice or group likes you they will send an employment agreement for you to read over and tell them if you want the job. Contracts are further discussed in greater detail in Section 5.

3.6 Factors to Consider

One of the key decisions for residents is to choose a geographic location that is also acceptable to your spouse/significant other and family. Other considerations such as the partner's employment opportunities and satisfaction with the location, is a critical decision that should be made together.

Location

Finding a city or a practice location where you will be happy is very important. Today's physicians are concerned not only with coding and reimbursement matters but also lifestyle issues. A harmonious work-life balance is critical to your success. You should be well versed with the social opportunities in the vicinity. Dining, night/family life, educational system for children and other social activities play a significant role in choosing a place to practice.

After you have narrowed down your choices for practice locations, there will be an exchange of data and practice information, including your residency experience. The interview process has

changed significantly over the past few years, and this initial process has become more of a "getting-familiar" event rather than something that would be a deal breaker.

It is important that you visit the sites on more than one occasion. The first visit should be planned to get familiar with the area and to meet the appropriate hospital or future practice managers. A second visit, that includes ones' partner and family, is also important. Scouting and being familiar with the neighborhoods, decisions on renting versus purchasing a home, dining and social activities need to be addressed during these visits. After all, this will be your new home.

Compensation

Most of the time one can get a pretty good idea of the salary and benefits from publicly available documents. The benefits package for most universities will be clearly delineated and, likely, non-negotiable. In public institutions, salaries are a matter of public record, and you can get a good approximation of salaries of those already there. This may be a little more difficult to ascertain in a private institution where the data is not necessarily made public, but you can compare salaries at some nearby public institutions to get an idea of the salary range. Although salary and benefits are important, you do not want to spend the bulk of your time dwelling on these particular issues. In addition, do not bring up salary as the first question you have about the practice. An employer will expect to answer this question but don't make it your first question or concern.

A Word about Malpractice

Malpractice insurance for doctors comes with tail or without tail. Tail is coverage that takes effect once you leave the place that you were employed and practicing. This insurance covers any lawsuit that is submitted to the court from the time of you leaving this job till the statute of limitation runs out for a lawsuit to be submitted to the court. This type of coverage can get quite expensive depending on the state so make sure you know who is expected to cover this.

Locum Tenens

If you are still not finding success or direction with your job search, another option is to consider working as a locum tenens physician for a while. Locum tenens will provide the opportunity to experience a range of practice conditions and locations, and this may help you determine what your best job actually is. Other advantages include good pay, lodging is usually provided, and some locum tenens jobs include the option for permanent placement if the "fit" is good.

3.7 Resources

The following links will bring you to samples and more information about preparing a CV and cover letter, obtaining references and recommendations, and preparing for the interview.

- How to create a CV, plus samples of CVs and cover letters **http://jobsearch.about.com/od/resumes/u/resumesandletters.htm**
- Samples of CVs and cover letters, and ways to request references and recommendations **http://jobsearch.about.com/od/curriculumvitae/a/curriculumvitae.htm**
- Interviewing tips **https://www.thebalancecareers.com/job-interviews-4161912**

Job Search Timeline for Residents and Fellows

Figure 1: It is extremely important to follow this timeline so that you do not have to scramble for a job with limited options as graduation approaches, thus weakening your ability to negotiate effectively

4. NEGOTIATING CONTRACTS

After you have visited the potential practice location more than once and you have evaluated

your practice locations, now is the time to focus on the contract negotiations. Remember, any contract you sign is a legal document. Thus, it is important to have your own legal counsel (or two) review the contract, in detail, so your interests are protected. Many new physicians recommend hiring a lawyer to assist in contract negotiations.

4.1 Needs/Requests

1. **List Equipment Needs**
    - Office-based equipment needs
    - Hospital-based equipment requirements
    - Special equipment, such as robot, intra-op ultrasound equipment, lasers
2. **List Personnel Requirements**
    - In your office: adequate nursing and ancillary staff members
    - In the hospital: Will they provide you with appropriate trained personnel for surgical procedures? It's especially important for procedures such as robotic surgery to be staffed with a qualified first assistant or bedside surgeon.

4.2 Understand Compensation

Usually the hospital will guarantee your salary for one to two years. The suggested length of your initial contract should be negotiated for three years, with frequent evaluations and/or meetings to ensure that you are staying focused and close to target expectations and projections. Your interview process should clearly define your remuneration methodology.

Key questions to consider include:

1. Will you be evaluated on a quarterly basis?
2. What if there is overage?
3. Will you be paid additionally on a quarterly basis?
4. Will you be reimbursed based on your work Relative Value Units (RVUs)?
    - Though contracts will vary, the RVUs are based on national guidelines with an average RVU production of 9,000-10,000 per year. Academic positions usually have a lower RVU requirement to facilitate research activity.
5. If you exceed expectations, then how will you be compensated?
    - One suggestion is that you be paid 75% of any overage of professional fees collected and that the hospital will keep 25%.
6. Caution: It is important that you are aware of the billing and collections process, since the hospital may have several other physicians in different subspecialties on their payroll. Therefore, you should be mindful of the following:
    - Make sure that your billing and collections are handled promptly and appeals to third-party payers and are processed in a timely fashion.
    - Review and audit your own surgical case logs and RVUs.

4.3 Contract Renewal

Review the hospital's policy for continuing your contract. Contracts can be terminated based on factors such as performance, professionalism or surgical outcomes. It is important to have a 90-120 day notice so that you will have enough time to relocate and move to a new practice location, if necessary. Contracts usually suggest a 30-60 day window; this may be inadequate.

4.4 Vacation/Time off

Contracts usually give you 20 vacation days and national holidays as part of your time-off package. Make sure this is included in your contract. Emergency room coverage and in-home consult expectations need to be clearly defined. You should know if these duties will be shared with other urologists on the staff or if you are expected to be constantly on call. Some hospitals do not force urologists to be on call once they have reached 60 years of age. How will this impact your call schedules?

4.5 Credentialing Process

Begin the credentialing process for the hospital as soon as possible. Credentialing can take up to six months to complete. Be aware that each insurance carrier has its own credentialing process. You should be fully credentialed by the time you start your practice so that you can immediately treat patients. Be aware of additional state or medical board requirements including fluorosocpy or jurisprudence certification.

4.6 Malpractice Coverage

The hospital should be providing you with insurance coverage as per state or regional guidelines. Make sure that there is tail coverage to ensure you are protected, should you have to leave the practice.

5. PHYSICIAN COMPENSATION MODELS

Most providers are reimbursed for services through several "payers," including federal and state government programs (e.g., Medicare, Medicaid) and insurance programs offered through employment and individual plans. Prior to the implementation of these programs, providers were paid directly "out-of-pocket" by patients themselves.

Reimbursement often involves a payment as a percentage of the total bill received and is often impacted by standards set by Centers for Medicare and Medicaid Services (CMS) as well as on negotiations between the provider and regional insurance companies that the provider is contracted with. A co-payment is a small percentage of the bill paid directly by the insured patient. A premium is a monthly charge to the patient in order to stay covered. Various payment structures are described below:

There are two basic compensation models with variations: pure productivity and base plus bonus. Guaranteed total salary is not common, but several healthcare systems (e.g., Kaiser Permanente), government positions (e.g., Veterans administration), and/or academic positions will offer this.

5.1 Fee-for-Service

The fee-for-service model compensates physicians based on the amount of services provided to a patient and is a common payment structure seen in both private and public practices. This varies from other payment structures such as the concept of capitation, which involves paying a provider a fixed amount of money per patient over a pre-specified period of time. Potential issues that arise with each of these payment methods relate to the possibility of incentivizing providers to "over-treat" or "under-treat" patients. New kinds of payment models are currently being tested and pay for performance has been a method that ties bonus payments to the quality of care of each patient rather than to how much or how little services are provided.

5.2 Relative Value Units

There are many models currently based on Relative Value Units (RVUs). This is a pay for performance model where the physician's training, skillset and time expended to provide a given service are taken into account when establishing compensation. Compensation based on RVUs provides a model that focuses on value-based healthcare, more so than the fee-for-service volume-based model attached to the number of patients a provider sees or the amount of revenue the provider bills for or collects.

RVUs are part of the system Medicare uses to decide how much it will reimburse physicians for each of the services and procedures covered under its Physician Fee Schedule, and which are assigned current procedural terminology (CPT) code numbers. The dollar amount for each service is determined by three components:

1. Provider's work effort
2. Practice expenses associated with producing the service
3. Professional liability insurance expense

Each of these three components is assigned an RVU and to account for variations in living and business costs across the country, each of the three components is multiplied by a factor known as the Geographic Practice Cost Index, or GPCI. The three components are added together, and the resulting sum is then multiplied by a dollar amount known as the conversion factor set by CMS on an annual basis to arrive at the reimbursement dollar figure.

RVUs are determined as part of the Resource-based Relative Value Scale (RBRVS), which is a system for describing, quantifying, and reimbursing physician services relative to one another. The values in the RBRVS scale are reviewed periodically by a panel of physicians, known as the Relative Value Scale Update Committee (RUC), representing every sector of medicine.

The basic premise of work RVU compensation models is to align the provider's compensation to the productivity (as measured by work RVU). This is completed with the use of independent compensation surveys and analyzing expected productivity. The most commonly used "government endorsed" surveys to accomplish this task are:

1. American Medical Group Association (AMGA) Medical Group

Compensation and Financial Survey

2. Medical Group Management Association (MGMA) Physician Compensation and Production Survey
3. Sullivan Cotter and Associates, Inc. (Sullivan Cotter) Physician Compensation and Productivity Survey

The most common methods of clinical compensation arrangements utilizing work RVU are:

1. Compensation per work RVU: Also known as an "eat what you kill" model. Providers are paid a set dollar conversion rate for each work RVU generated.

Example 1.

Work RVU	$/Work RVU	Compensation
8,000	$50,00	$400,000

2. Graduated scale: Under this model, providers are paid dollar conversion rates per work RVU based on a graduated scale.

Example 2.

Work RVU Scale	Work RVU	$/Work RVU	Compensation
0 - 2,666	2,666	$45.00	$119,970
2,667 - 5,333	2,666	$50.00	$133,300
5,334+	2,666	$55.00	$146,630

APPROXIMATE TOTAL: $400,000

3. Base guarantee plus productivity bonus: Under this model, providers are paid a base guarantee and will receive incentive/productivity compensation for every work RVU generated above a pre-determined threshold..

Example 3.

Base Salary	Threshold	Work RVU	$/ Work RVU	Bonus	Compen-sation
$266,650	5,333	8,000	$50.00	$133,350	$400,000

5.3 Bundled Payments

The Bundled Payments for Care Improvement (BPCI) initiative was developed by the Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care for beneficiaries. Provider and hospital expenses are linked to make a single payment for an episode of care with bundled payments models. There are four bundled payments models – Retrospective Acute Care Hospital Stay Only, Retrospective Acute Care Hospital Stay plus Post-Acute Care, Retrospective Post-Acute Care Only and Acute Care Hospital Stay Only.

5.4 Resources

- https://www.amga.org
- https://www.sullivancotter.com
- https://www.cms.gov

6. FINANCIAL MANAGEMENT

The financial information in this section was partly contributed by MEDIQUS Asset Advisors, Inc. Please note that this does not constitute an endorsement of this firm by the AUA.

Congratulations! You have completed your training and have started your career practicing medicine. This is an exciting time in your life! Whether you come from meager or modest beginnings, it's likely you are making more money than you ever have in your life. You struggled financially through medical school, residency, and fellowships and you may still be struggling through payment of your student loans. Before you start treating yourself and upgrading many aspects of your life, consider creating a detailed financial plan to ensure you are making financial decisions that are in your long- term best interest. There are some important financial planning tips to ensure you are beginning your career on a smart financial path.

6.1 Beware of Lifestyle Creep

It's called "lifestyle creep" because it's sneaky and happens to just about everyone whose earnings have increased significantly. It begins innocently enough - you survey your surroundings and decide it's time to upgrade your home, your car, your furniture, your cuisine and so on and so on. Then instead of your usual bottom shelf bargain wine, you move up to a more expensive Cabernet

Sauvignon. Soon items that used to be a luxury become routine purchases. You're spending more because you can, not because it's truly necessary. You gradually make a complete shift with regard to what's "normal," and over time things that used to lie quietly in the want category call loudly from the need category. You hardly notice the lifestyle creep because it's happened so slowly, like the tortoise catching up with the hare.

Unfortunately, physicians slide into full blown creep mode far too often. They worry about money on a monthly basis despite earning $300,000 or more per year because they aren't fully prepared for the higher standard of living they've embraced. Consider the long-term financial impact of your purchasing choices. Do you need to buy a brand new home with a hefty mortgage, or can you live comfortably in a more modest condo that you'll pay off in few years?

You may be asking yourself, "Why work hard to get ahead if I can't enjoy my money?" You absolutely can and should! However, you should do it in a deliberate manner that fits your overall financial plan. Upgrade your life in such a way that you don't wind up earning two, three, or even four times as much money only to find that finances are tighter than ever. You need to control the creep. Start by being truly honest with yourself about which aspects of your lifestyle are most important to you. Then construct a financial plan that will keep you focused on the goals you deem to be a priority and force you to be accountable to yourself and your family. Wealth can come in many forms, but the more committed you are to your financial plan, the greater chance you have of becoming truly financially independent.

6.2 Pick a Strategy for Paying Your Student Loan Debt

In the current landscape there are many repayment options available to student loan borrowers. The government offers multiple repayment programs, and private loan refinancing is also an option. When speaking with early career physicians who have significant student loan debt, the majority fall into one of two categories; those who practice medicine at a non-profit hospital and those who practice medicine at a private practice.

For physicians practicing at a non-profit hospital, Public Service Loan Forgiveness (PSLF) is a great option to consider. Under this program, if you work for a PSLF qualified organization and make regular monthly loan payments for 10 years under an income-based plan offered through the government, any remaining balance at the conclusion of the 10 years is forgiven tax free. For physicians with significant loan balances, this is an option worth exploring.

For physicians practicing at a for-profit organization where PSLF is not available, refinancing may be a good route to investigate. Many private loan refinancing companies offer significantly lower interest rates than those on government loans. Refinancing at a lower interest rate allows borrowers to save significantly over the duration of the loan. These savings can be directed to other financial goals like buying a home or saving for retirement.

A common question is "Should I pay extra towards my student loans to pay them off as quickly as possible, or should I save the extra money in investment and retirement accounts". The answer is "it depends". The general rule of thumb is if an individual believes they can earn a higher after-tax rate of return in their investment account than the interest rate being charged on the loan, then it makes sense to invest. If they do not believe they will earn as high of a return on their investment account as the interest rate on the loan, it is better to pay down the loan. Refinancing can often times bring the loan interest rate down enough that an individual can feel confident saving in an investment account rather than paying down the loan. This strategy only works, though, if income that would otherwise be used for loan repayment truly is redirected to investing. If it's accidentally used to fund lifestyle creep, you'd have been better off with the forced savings of paying off loans.

6.3 Create a Budget and Stick to It

This simple tool is far too underutilized. Physicians who create a budget and are disciplined about sticking to it have a much greater chance of staying on track to reach their financial goals. A budget can help an individual better understand their monthly cash flows as well as identify areas where spending is too high and funds can be reallocated toward more important goals.

Creating a budget is relatively straight forward; determine your monthly take-home income (post-tax), subtract all your necessary monthly expenses (i.e rent/ mortgage payments, utilities, insurance premiums, loan payments, etc.), from the remainder, subtract your required savings for

retirement and/or a home purchase down-payment. The money that remains is called discretionary income and can be used as you wish, however, this is only the money left over after all other spending and saving needs have been met. There are many free or inexpensive budgeting tools available online, or you can create one in a spreadsheet program such as Excel and use it as a living-breathing document that you adjust each month.

6.4 Start Saving For Retirement Early

Even if you cannot save a lot, starting to save as soon as possible will have a big impact on when you can retire and the level of income you can expect. In addition to the tax benefits you can receive by contributing to retirement accounts, contributing sooner rather than later to these accounts allows you to take advantage of compounding interest for longer. Albert Einstein once said of compounding interest, "[It] is the eighth wonder of the world. He who understands it, earns it ... he who doesn't ... pays it. Compound interest is the most powerful force in the universe." Compounding interest can be thought of as interest on interest and it can help your investments grow at a faster rate. How does it work? If you have an investment that is supposed to pay you interest or a cash dividend, and instead of taking that payment as cash and putting it in your pocket, you instead reinvest it back into the same investment. The next time that investment is supposed to pay out interest or a dividend, it is doing so not only on your initial investment but also the reinvested amount. This causes a snowball effect and over time your investments grow in value. For example, assume you invest $100. That $100 is expected to return an 8% annual dividend. If you reinvest the dividend you now have $108 ($100 x 1.08= $108). The following year when the dividend is paid out, your account balance is now $116.64 ($108 x 1.08= $116.64). If this continues for 30 years, your $100 will turn into $1,006.27. This is the beauty and power of compounding interest, afforded to those who can start saving and investing for their retirement as early as possible. As you can imagine, if you also contribute additional funds into the account over this 30-year period, the funds available at retirement may be considerable. Start this process early, waiting even 5 or 10 years could be a difference of hundreds of thousands of dollars at retirement age.

Consider working with a financial professional who can assist you with investment decisions. If you do this, be cognizant of the substantial and oftentimes surprising effect that management fees have on returns over time. Returning to the example of $100 growing at 8% annually over 30 years, an identical investment with even a 1% annual fee will grow to just $744, or 25% less. Urologists who educate themselves on investing may thus stand to save hundreds of thousands of dollars or more over the course of their careers. Consider reviewing an internet-based or print resource that teaches investing basics, some of which are written specifically with physician audiences in mind.

Finally, proper planning should be done to ensure you are contributing sufficient amounts every month/year. Those who properly plan and take advantage of compounding interest as soon as possible will have the luxury of retiring at the age they want and with the level of income necessary to sustain their desired standard of living throughout their retirement.

6.5 Disability Insurance is a Necessary Added Expense

A physician's most valuable asset is their ability to work and earn income in their specialty field for an extended period of time. Physicians can generate millions of dollars of income throughout their working lives, and it is important to protect this earning potential in the event of something physically catastrophic. Without the income generated from practicing medicine, a physician may need to forfeit many of their financial goals such as purchasing a new home, paying for their children's college educations, or even retiring comfortably. Long-term disability insurance can ensure that many of these goals are reached even in the event of a sickness or disability.

How does long-term disability insurance work? Typically, a disability insurance company is willing to insure up to 60-70% of a physician's pre-disability income. In the event of a disability, the policy will pay out a monthly benefit amount. These funds can be used to pay for necessary expenses and save for financial goals such as retirement.

Insurance can sometimes be viewed as an annoyance and something rarely used. Yet most of us have car insurance and health insurance. Why? To protect ourselves from a severe financial loss in the event something unexpected happens. Disability insurance works the same way except it protects your MOST valuable asset–your ability to practice medicine and earn income in your specialty field.

Many employers now provide disability insurance as part of their benefit package but policy limits may still leave physicians underinsured. Work with an insurance professional to determine an appropriate amount of coverage.

6.6 Life Insurance is Necessary for Some but Not All

Life insurance can be an important wealth management tool for some physicians. What would happen if you were to die prematurely? Would your family still be able to afford the mortgage you just took without your physician salary? What would the impact of your lost salary be? Would your family be forced to sell the house and move into a less desirable home? Would your family still be able to maintain the standard of living you hoped to provide with your physician salary? Would your family still be able to afford to pay for your children's college education?

Life insurance is a great tool that can answer many of these questions. However, it is not necessary for everyone. If you are an individual who does not have others financially dependent on you, are without debt, and have no organizations you hope to leave a considerable sum of money to at your death, life insurance may not be an important part of your financial plan.

There are many types of life insurance available to purchase. For a low-cost option that provides significant coverage amounts, explore Term Life insurance policies. They are typically designed to be in-force only for your working years, and they do not have an internal cash value account. If you pass away within the term, the policy pays out the death benefit to your beneficiaries. If you outlive the term, the policy can be terminated and coverage will end. For these reasons, premiums are often significantly lower than other types of coverage.

Choosing the right life insurance policy can be difficult. Work with an experienced life insurance professional to determine which type of policy fits your unique needs best. Be cautious about complex "whole life" policies that are advertised as a mix of insurance and investing, as these are rarely the best option for young physicians.

Conclusion

While there are many important financial topics for physicians, the ones discussed here are a great place to start. Remember, being financially proactive takes a little work but pays huge dividends later in life. Start planning today so that you can pave your pathway to financial success. Our 30 years of experience advising physicians has taught us that not everyone is financially successful, but everyone who is has common characteristics. They:

- Have clearly defined goals.
- Know what they make, need to save, & have to spend each month.
- Know basic financial concepts.
  - Know it is not enough to have, you must protect.
- Have a reasonable sense of urgency.

7. DEFINING YOURSELF

As a junior member of your practice/department, it is important that you establish yourself as a capable and hardworking urologist to your new colleagues, while also building a rapport with your patients and local community. Relationships are vital. Get to know your referring physicians. Introduce yourself to colleagues. Volunteer to speak at local health advocacy groups. Join hospital committees. Identify senior colleagues who you trust to act as mentors.

Below are a few questions to ask yourself as you begin to establish these important associations.

7.1 Examine Yourself

1. What is your niche?
   - Is there a unique clinical area that you would like to commit a large amount of time and effort to?
2. What can you provide that is lacking in your new practice?
   - What skills do you bring to your group that can fulfill potential voids?
3. Did you do a fellowship – if so, where did you train and is there something that your fellowship program does which you can bring to your new group? It helps you harness the good reputation of your previous program to your new job.
4. How can you support your group in non-clinical ways (leadership, business acumen, research, etc.)?
5. What untapped revenue streams exist in your community?
6. Are you willing and able to take on complex

and difficult cases that others may not wish to tackle.

7.2 Develop A Referral Base

- Take exceptional care of your patients. There is no substitute for high quality, safe medical and surgical care delivered in a patient centered, well-communicated manner.
- Face-to-face introductions with key leaders within the local medical group (usually facilitated by the practice manager).
- There is nothing better than face-to-face interaction. Hospitalists often take care of inpatients and very few primary care doctors round on patients during the day. As such the "esprit de corps" has changed in the hospital and it has become harder to meet our medical colleagues. Some hospitals have "liaisons" to assist in these introductions. However, setting up a list for yourself and going out to meet referring doctors on your own will be well received. Offering email and cell phone contact information demonstrates that you are serious about addressing any patient concerns swiftly.
- Be kind to everyone. Remember, everyone talks. One bad interaction will spread much further than several good interactions. Your reputation is like gold and can be impacted by early negative interactions. Be careful when posting on social media, especially when posting both personal and professional items.
- Let the operating room staff know what your specific set of expertise is and set up lectures for the operating staff so they see what you are all about. Those referrals will grow quickly!

7.3 Staff Selection

Everything that happens to your patient while under your care reflects back on you, which is why you should surround yourself with a high quality support staff.

- Advanced Practice Providers (Physician Assistants, Advanced Practice Registered Nurses)
- Nurses (RNs, LVNs)
- Medical office assistants
- Administrative Assistants

7.4 Publicity

- Your highest degree of visibility will come from patients talking about you to their friends, family and their other doctors. However, when building a practice, one can further define themselves with publicity. Either the hospital or your group can advertise your arrival with mailings to the community, patients and affiliated physicians.
- Other ways to successfully introduce yourself can be established through scheduled lectures (i.e. "grand rounds") at your hospital(s). Some larger medical groups have their own lunchtime talks which can often be a great introduction to referring physicians.
- Talking to local advocacy groups, patient support groups and even the local high school can also assist in getting your name out there.
- Hospital announcements
- There are public relations staff at all hospitals and most practices have advertised in the past, so they will have a vehicle for you to get noticed.
- If you're headed into academics, certainly presenting abstracts and developing a niche that one publishes on can give you and the hospital a reason to publicize your work. Free press!
- Patients support groups (i.e. Us TOO)
- Colleges – participate in research projects or mentorships
- Lecture in the community
- Academics (can elevate your status locally as well as nationally)
- Abstracts
- Courses
- Interviews and review articles in magazines and journals

7.5 Leadership and Mentorship Opportunities

There are numerous leadership opportunities available for one to get involved. These include various hospital communities (credentials and privileges, safety and quality, medical executive,

etc.) as well as local, state and national medical or urology-specific organizations.

AUA Leadership Program

In 2004, the AUA and its Sections launched the AUA Leadership Program to identify urologists who have demonstrated effective leadership skills within organized medicine or the community. This program seeks applicants who are driven to tackle future roles of responsibility within the AUA. This is a call for younger AUA members to polish their leadership skills, take advantage of networking opportunities and become better acquainted with AUA programs and services. All early career urologists with an interest in AUA involvement should strongly consider applying for this important program.

Every two years, there is a selection process for the next incoming class of program participants. To qualify, you must be an American Board of Urology (ABU) (or equivalent) certified urologist, and 15 years or less out of training and have demonstrated leadership skills. You must have an interest in developing these skills to serve your Section and the AUA as a future volunteer leader. You must also be an Active member of the AUA and the AUA Section where you live and practice.

Benefits of the Leadership Program

- Develop your leadership skills
- Expand your network and accelerate your professional growth
- Learn about the AUA's operations and sphere of influence
- Earn the recognition and prestige that comes with being an AUA Leadership Program graduate
- Be mentored by highly respected AUA Leaders
- Learn about the legislative process and advocate on behalf of the specialty
- Make significant contributions through a group project
- Be prepared to serve as a future leader in urology

In addition to the AUA Leadership Program, the AUA offers several other important programs for you to consider joining. Each one offers unique opportunities and benefits to its members.

Gallagher Health Policy Scholar Program

The Gallagher Health Policy Scholar, established by the AUA Board of Directors in 2006 to train the next generation of AUA health policy leaders, serves as a non-voting consultant for the Public Policy Council for one year (Jan-Dec) to learn the committee structure and health policy's role within the AUA.

Science and Quality Scholar Program

The AUA launched the Science and Quality Scholars Program in 2015. This unique program is designed to advance the fields of guidelines, quality and data. This program will help residents and fellows develop insight into how the AUA develops and promotes the advancement of evidence-based science.

H. Logan Holtgrewe Legislative Fellowship Program

The Holtgrewe Fellow, established by the AUA Board of Directors in 2014 to train the next generation of AUA health policy leaders, serves as a non-voting consultant for the Public Policy Council for one year (May-April) to prepare and educate urology residents and fellows in the legislative aspect of health policy.

AUA Academic Exchange Program

The AUA's Academic Exchange Programs provide junior faculty and residents an opportunity to interact with and learn from colleagues in different regions of the world. These funded fellowship programs encourage the interchange of urological skills, expertise and knowledge, which are critical to the continued success of urology worldwide.

In addition to a unique educational and cultural experience, academic exchange programs offer scholars the opportunity to interface directly with the leadership of the AUA and other international urological associations, which can lead to professional opportunities in the future. As technology continues to advance at a rapid pace, the exchange of knowledge will continue to increase resulting in a higher quality of care to our patients. However, Academic Exchanges provide face-to-face interaction and the ability to network, which remain critically important to the advancement of urology.

8. WORKING WITH ADVANCED PRACTICE PROVIDERS (APPs)

Advanced practice providers (APPs)—specifically advanced practice nurses and physician assistants—play an essential role in providing quality urologic care and augmenting and extending the services provided by practicing urologists. Juxtaposing the current projections, which estimate a decrease of almost 30% in the number of urologists in the United States from 2009 to 2025, against estimates showing an expanding cohort of Americans aged 65 years and older, it is clear that the urologic community needs to develop strategies to ensure that urologic care remains abundantly available in the coming years. Solidifying physician-APP teams is an essential component in maintaining access to urologic services. Integration of APPs is part of the solution to the declining urologist workforce, highlighting their value in both community-based and academic urology practices.

8.1 Advanced Practice Registered Nurses (APRNs)

APRNs—also commonly referred to as advanced practice nurses (APNs)—are qualified, competent healthcare providers who work within the fabric of the healthcare team and are an integral part of the collaborative team supervised by the urologist. After being licensed as registered nurses, APRNs receive additional postgraduate education at a master's or doctoral level. Advanced coursework includes pathophysiology, pharmacology, and physical assessment, coupled with extensive clinical training. APRNs are licensed by each state's board of nursing. National board certification is required for APRNs to practice, and certification in caring for specific populations, as well as specialty certification, may also be obtained. APRNs in urology include clinical nurse specialists and nurse practitioners. APRNs can write prescriptions; order and interpret full range of laboratory and radiographic studies; authorize ancillary health services, such as physical and occupational therapy; and coordinate home health care.

8.2 Physician Assistants (PAs)

PA training is modeled on the medical school curriculum, combining classroom and clinical instruction. Most PA program graduates are awarded a master's degree. PA education includes instruction in the core sciences, pharmacology, physical diagnosis, pathophysiology, and behavioral science. Didactic instruction is coupled with extensive clinical training in a range of medical specialties. PAs graduate proficient in primary care and general surgery, and additional training can be obtained through residencies or postgraduate fellowships. National board certification is required for PAs to practice. Although PAs can see patients independently, they consult with their supervising physician whenever a clinical issue arises that exceeds the PA's expertise or when physician involvement is necessary for care. PAs can write prescriptions; order and interpret full range of laboratory and radiographic studies; authorize ancillary health services, such as physical and occupational therapy; and coordinate home health care. The PA and physician together define the PA's role in the practice.

8.3 APPs in Urology Practice

Physician-APP teams benefit both patients and practices, expanding the scope and access to urologic care, while adding to a practice's revenue. With the ability to undertake both general and specialized aspects of urologic practice, APPs are extremely flexible and APPs, along with their physician partners decide where APP services are most needed. Models of team-based integrative care are based on the needs of the particular practice. Examples can include: assisting in surgery, seeing postoperative patients, hospital consults, emergency room consults, and overflow office patients. This allows the physician to see more complex urologic patients. Outreach clinics can also be staffed by experienced APPs. Preoperative and postoperative educational classes that can be conducted by APPs can increase patient satisfaction and patient retention. In the hospital setting, consultations, history and physical examinations, and difficult bladder catheterizations also can be performed by APPs. In the clinic setting, certain procedures such as prostate ultrasound, urodynamics, cystoscopy, vasectomy, and stent removal have been performed by APPs; however this remains an area of controversy that requires further study. Factors such as APP education level, APP proficiency with procedures, state scope of practice laws, and the level of comfort for the supervisory/collaborative physician must be considered in order to maintain the highest quality and patient safety for urologic care.

State laws governing APP supervision can have subtle differences between states. States that have restrictive language regarding the physician's delegating authority are challenged and modified

regularly. The purpose of these challenges is to improve the physician's ability to extend access to care through physician-APP teams. More and more states use language that defines supervision more broadly and look to repeal laws that requires physicians to be present at their practices for a set number of hours. The most effective physician-APP team practices provide optimum patient care by designing a practice model in which the skills and abilities of each team member are used most efficiently. Ideally, physicians are not involved in care best provided by APPs and similarly, APPs do not undertake tasks best provided by physicians. Studies consistently find enhanced quality of care in settings that fully integrate physician-APP practice.

APPs help urology practices meet the following goals:

- Increase patient access to quality urologic care
- Ease/shift physician workload
- Increase patient satisfaction and compliance
- Create specialty niches within the urology practice
- Increase revenue

APPs are uniquely equipped to assist the urologist in meeting the ever-increasing demands of a busy urology practice. The team-oriented and patient-centered approach of APPs provide patients with a high-level evidenced-based quality urologic care, ensuring the health and wellbeing of all patients presenting with urologic conditions. Urologists wishing to expand the reach of their practice should strongly consider recruiting APPs to their urologic team.

8.4 Resources

For additional information on the use of APPs, please refer to the following resources:

- AUA Consensus Statement on Advanced Practice Providers (www.AUAnet.org)
- American Academy of Physician Assistants (www.AAPA.org)
- American Association of Nurse Practitioners (www.AANP.org)
- Society of Urologic Nurses and Associates (www.SUNA.org)
- Urological Association of Physician Assistants (www.UAPAnet.org)

9. WOMEN IN UROLOGY: UNIQUE CHALLENGES TO WOMEN IN THEIR EARLY CAREERS

This section was written by Dr. Julie Riley, Assistant Professor of Urology & Stones at The University of New Mexico. Dr. Riley is also a member of the AUA Young Urologists Committee, a graduate of the AUA Leadership Program, and a wonderful colleague!

Equality for women is steadily improving in the US and has recently gotten a lot of attention. However, it is important to remember that women in the field of urology is relatively new. The first woman to be board certified in urology was in 1962. Currently, just less than 9% (1,106) of practicing urologists are women and most are younger. For practicing urologists less than 45 years old, 20% are women and a quarter of urology residents are women.1 Clearly the number is rising but it is important to note that presently there are equal number male and female medical student admissions. Furthermore, in the 2019 urology match, there was a record high match rate for women at 83% but this in comparison to 86% match rate for men.2

9.1 Practice Patterns

Often times entering a practice, women can get pigeon-holed into seeing the female patients even if this isn't necessarily the desire of the physician. While this may be a much needed role to fill within the practice, it is important to consider that often these are non-operative conditions and could potentially lead to decreased earnings. Suggestions to help with practice patterns:

1. Prior to joining, discuss with partners your targeted patient population and prior to joining and consider adding clauses to contracts to note this.
2. Market to your target population.
3. If your targeted population is female patients, ensure that your compensation reflects the work you do given the RVUs and operative case potential may not compare to other subspecialties.
4. Ensure that those that schedule for you, know the desired patient population. The front staff can have significant influence on the patients scheduled into clinic. Some schedulers may ask patients if they mind seeing a woman. While there is a non-malicious intent, it is a very

subtle way in which your practice can be dramatically affected. You may need to be involved in scripting the language used by schedulers, front staff and even advanced practice providers within your practice who may refer patients.

9.2 Work Life Balance

Once we realize this is a myth, this will become easier. There is no magical harmonious balance between work and life. There are moments when outside life becomes the priority and other moments when work takes that role. Women tend to feel guilty in both arenas and this distracts from productivity and satisfaction. Be present in what is happening and realize it is a give and take. No one is perfect nor will be but stop feeling guilty about it. Prioritize events and stick to it. Some suggestions that have been utilized by women previously (that men can easily use as well):

1. Have a unified calendar for work and personal life (this could include school schedules, spouse schedules, important life events like birthdays, anniversaries, etc.)
2. Choose events that are important well in advance like family commitments or work events and put them on the calendar.
3. Set time limits on activities and do not do anything else (like check email, take phone calls, etc.) and when the time is up, move to the next activity.
4. Ask for help when you need it. If you don't have the support staff you need, ask for it (particularly if you male counterparts have this help). Use house cleaning and/or laundry services if it will help.
5. Take 20 minutes periodically for yourself (and schedule it). A happier doctor is a more productive doctor. Remember you would never miss a day in the operating room because there just wasn't enough time in the day.

One other issue more prevalent in women is the inability to say no and/or the strong desire to please everyone. It is important when you say yes to something it is meaningful and you do what you say you will do. It is important to say yes to some things (particularly those things you are passionate about) otherwise the opportunities will begin to dwindle. On the other hand taking on too much is counterproductive and likely will lead to decreased satisfaction and quality overall. Consider having two or three close friends to vet out a new offer. If the offer is not desirable, practice a professional way to say no. Make sure whenever you do say yes, do it and take credit for it.

9.3 Burnout

Women are disproportionately affected by burnout. In 2017, Medscape reported that 70% of women urologists suffer from burnout compared to 49% of men.3 These numbers have been increasing as well over several years. Women usually experience burnout differently than their male counterparts. The first stage for women is emotional exhaustion. The belief is that women tend to support others in their lives and there is only so much emotional support to go around. The second stage for women is depersonalization and cynicism. This is a way to detach from the stress and overwhelming nature of medicine. It is usually short lived for women and often leads to the third stage of reduced accomplishment or a sense that one's work doesn't matter. Men more often start with depersonalization followed by emotional exhaustion. Rarely do men reach the third stage of a feeling like they are a bad doctor. Because the genders typically experience burnout different, the presentation is also different. Women tend to first feel a lack of energy and unable to recover even with time off followed by cynicism and blaming patients leading to subsequent feelings of inadequacy. Men on the other hand present first with blaming patients and cynicism followed by exhaustion. It should be noted that younger physicians are more likely to suffer from burnout. This makes early career women urologists particularly susceptible to burnout.

Unfortunately, burnout can lead to depression and worse suicide. Male physicians have about a 1.41 relative risk of suicide to the general population. Compare this to female physicians who have about a 2.5 relative risk to the general population. In addition, women physicians have a suicide completion rate comparable to their male counterparts which is in contrast to the general population where completion rates are lower for women.4 This has not been specifically studied in urologist.

One of the best treatments for burnout is social support. This has been shown more effective than even counseling or therapy. Reach out when feeling even the first signs of burnout and reach out to others when it is recognized in colleagues and friends. Other suggestions to decrease burnout

are exercise, meditation, mindfulness, setting boundaries, getting more sleep and even just simply pausing and taking a deep breath. See the wellness section within this handbook for further resources

9.4 Gender pay gap

Within the US, there is a gender pay gap. As of 2015, women were payed 20% less than men for equivalent work. This is significantly improved since the passage of the Equal Pay Act in 1963 when women earned 31% less than men. At this rate, it will take until the year 2152 to finally erase the gender pay gap.5 Urology has not been spared from this gender pay gap. In fact in 2017, urology had the 3rd largest gender pay gap among all medical specialties and the widest gap among surgical specialties. Women urologists on average were found to make 20% less than male counterparts. This equated to $84,799 less per year.6 If this is maintained over the course of her career, this gives a nearly $3 million loss to women. There have been many reasons given for this pay gap such as less hours worked, more part time work, maternity leave and others. However when controlling for variables that would affect take home pay, women urologists were still found to make approximately $76,000 less than men.7

9.5 Maternity Leave

There simply is no standard parental leave for men or women. It is important to research potential or current employers on the policy for maternity leave as well as FMLA, paid sick leave, unpaid sick leave and vacation (all of which may be required for sufficient time with a new child). Ask for the maximum allowed time off, you can always choose to return early or have the occasional urgent patient visit if necessary. Learn what paternity leave consists of to understand what your male counterparts are receiving. It would be recommended prior to starting leave to discuss call coverage. Be sure to tell your institution early (not just clinic or OR schedulers) as this can help to ensure that all necessary paperwork is completed prior to leave. While some women may hide their pregnancy, it would be recommended to be upfront about your needs and plans, often more is offered when your group/institution/partners have time to accommodate. If you are in private practice, you will likely need to continue to pay overheard so consider saving money for this. In addition, understand how maternity leave affects partnership, equipment buy in, etc. For academia or employed practice models, know what effect this leave has on promotion and incentives and have everything in writing. There are options of prorating RVU requirements if you ask for this. Consider this in negotiating with a potential employer if this may be a concern in the future but unfortunately there may be unavoidable discrimination related to maternity leave.

Coming back from maternity leave can also be stressful and problematic. Consider lighter loads in clinic and block off time to pump (if necessary) several times throughout the day. Hospitals are legally required to have lactation rooms so do your research to ensure there is adequate space for this. After a break of possibly up to 3 months, many surgeons will be rusty on surgical skills. This is a good time to schedule less complicated, shorter cases while readjusting. If doing longer/larger cases, consider having a senior partner back up in case a break is needed for pumping or simply to take a little stress off.

Maternity leave has been done by many female surgeons throughout their career, reach out to those that have done this before and take advice. There are many groups on social media and on-line if your particular practice hasn't had experience with maternity leave previously. This discussion was directed more at the young urologist dealing with pregnancy, but consider many of the same issues if adoption is chosen.

9.6 Negotiating

There is a body of evidence to suggest that women do not negotiate as often as men. Recently stated was 68% of women accepted the salary they were offered and did not negotiate, compared with 52% of men.8 While a sensitive subject, more and more, physicians are willing to share salaries. Be sure to ask or research potential partners and compensation in a desired location. The first step is to know what fair compensation within the market is.

Negotiating is more than just salary, everything is negotiable. Consider support staff, office space, time off, professional funds, titles, administrative time, equipment etc. Consider that negotiating for ease of practice may be more meaningful at the end of the day than simply a base salary, particularly if you can't directly reinvest the money into your practice (academia, hospital based practice).

9.7 Imposter Syndrome

There is a phenomenon of a feeling of not belonging and are not qualified to be there. While this can lead to high achievements and serve to motivate, it also can lead to anxiety, stress and prevent someone from advancing in one's career. It is more commonly seen in minorities within professional fields, particularly women. There are many reason female physicians are susceptible to this. Staff and patients refer to women by first name but male counterparts as doctor. Patients will ask after finishing a consultation who the doctor is that will operate on them or worse when the doctor will be seeing them. So many subtle ways predispose women physicians to feel inadequate. The imposter syndrome causes doctors to feel that success is from an external force or luck rather than internal forces like hard work, diligence and intelligence. The long term effects are burnout, depression, decreased productivity, career sabotage and less likely to ask for promotion or leadership roles.

Suggestions to overcome the imposter syndrome is to write down accomplishments and refer to it often until these are internalized. Use support systems to remind yourself how qualified you are to be in your role. Name the imposter syndrome and recognize when one is suffering from anxiety related to this. Take credit for the work you do and try hard to not self-depreciate those accomplishments. Get rid of the word just in your vocabulary ("I am just a general urologist", "I just do slings and manage incontinence", etc.).

9.8 Mentors

Mentorship can be invaluable to women (and men) when starting into practice (and throughout one's career). It is encouraged to seek multiple mentors but for women there is utility in having female mentors. Many of the struggles that can be unique or approached differently as a woman, can be navigated easier with a female mentor. However, it is not a necessity to have a female mentor as it may be challenging to find one. The important thing is to have someone supportive who listens to individual needs and is honest and approachable. Seek people who are knowledgeable in the area in which guidance is needed such as research, leadership, practice management, etc. Mentorship relationships can be short lived or over a career, don't be afraid to move on if the advice is no longer relevant.

It should be noted that this is difficult to find mentorship particularly for women. In fact, 1/3 of female urologists were dissatisfied with their lack of mentoring and 25% of women that left academia stated it was due to lack of mentorship.9 There is little formal training for mentors and few advanced career women within urology.

9.9 Leadership/Promotion

On the academic side, women have been shown to have decreased publications and decreased rates of promotion.9 As of 2017, only 11% of women in academia advance to full professor compared to 33% of men who advance. In addition there are 3 female chairs (1.3% of female urologists) in contrast to 441 male chairs (26% of male urologists).10 14.6% of program directors are women and while better than the overall percentage of women in urology, this falls short of the representation of current female residents in urology. This is certainly multifactorial but there remains a difference between genders.

Within leadership of the AUA, there has been increasing numbers of women but as of 2017, 75% of committees had at least 1 woman but of those women only 75% were urologists (relative to 95% of men on AUA committees).11 In 2019, there is one woman on the AUA board of directors and two women trustees on the American Board of Urology, which is representative of the AUA and practicing urologists as a whole (approximately 8% of the board). The AUA is making a conscious effort to increase women in leadership positions. For example, the 2018-2019 AUA Leadership Class is composed of 50% of women urologists.

9.10 Resources

Society of Women in Urology

The Secret Thoughts of Successful Women: Why Capable People Suffer from the Imposter Syndrome and How to thrive in Spite of It by Valerie Young

Women in Surgery Committee of American College of Surgeons

Association of Women Surgeons

Being a Woman Surgeon: Sixty Women Share Their Stories by Preeti R John

Ask For It: How Women Can Use the Power of Negotiation to Get What They Really Want by Linda Babcock and Sara Laschever

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10. WELLNESS FOR UROLOGISTS

The amount of time physicians spend delivering direct patient care has diminished due to increasing administrative responsibilities from greater regulatory pressures and evolving payment and care delivery models. Increasing responsibilities and stress can lead to physician burnout, which plagues more than half of the U.S. physician work force. Furthermore, urology has the distinction of being one of the most burned-out specialties in medicine today. Data gathered by the AUA via its member survey disputes this claim, but the topic of burnout in urology deserves attention nonetheless. Increasing rates of suicides, depression and burnout and decreasing personal and professional satisfaction among physicians emphasize the importance of creating a wellness culture within the health care profession and its organizations. Wellness consists of multi-dimensional aspects that in combination lead to optimal levels of health and emotional and social functioning. Increasing wellness and resiliency amongst physicians will lead to less stress and better engagement with their patients and provide higher quality care.

10.1 Specialty Related Stressors

Some reasons why urology has become one of the most stressed specialties:

- Drive for relative value units (RVUs), resulting in physicians' being pushed to see significantly more patients in significantly less time
- Urologists are getting busier as the population ages and people are becoming more demanding
- Rising patient and public expectations and intolerance of complications and/or unsatisfactory outcomes
- Fear of litigation, investigation by medical boards or, worse, prosecution for "gross negligence manslaughter"
- Busy after-hours call
- Added clerical burden associated with electronic medical records
- General practitioners are unhappy and it is difficult to recruit, so urologists are managing overflow office-based urologic conditions and impacting access
- Nation-wide shortage of urologists
- Decreased reimbursement
- Outcomes based pay and government regulatory outcome reporting and mandates
- Gender based pay discrepancy

10.2 Effects of Burnout

Stressful work conditions and burnout can lead to:

- Increased clinician errors
- Reduced empathy for patients
- Reduced patient satisfaction

- Decreased patient adherence to treatment recommendations
- Increased physician intent to leave the practice
- Increased malpractice claims
- Poor physician mental health: depression, anxiety, relationship stress, substance abuse, suicide

10.3 Assessment

- Maslach-Burnout Inventory
- Mayo Well Being Index
- Mini Z Survey

10.4 Mayo Clinic's 5-Pillar Anti-Burnout Remedy

- **Control over your life:** partner with leaders and work with those who offer you a say in the organization's direction
- **Leadership:** satisfaction increases when leaders communicate transparently, show appreciation, and are interested in ideas and career development
- **'Pebbles':** determine the pebbles in your shoes and work to remove them through policy changes or quality improvement
- **Camaraderie:** meet with colleagues over a meal and talk about some positive aspects of your career and professional issues
- **Healthy habits:** maintain habits involving diet, exercise, laughter, gratitude, forgiveness, meditation, and sleep

10.5 Wellness Activities

Suggested activities and workshops to help establish a culture of wellness:

- Sleep
- Exercise, such as running, yoga classes, etc.
- Movie nights or dinners
- Holiday potlucks
- Ballroom dancing classes that include spouses and significant others
- Charity work (e.g., volunteer at a soup kitchen)
- Mindfulness and meditation classes to promote stress reduction
- Sporting events (e.g., playing in a recreational league, watching a televised match or attending a university game)
- Painting or pottery classes
- Exploring the local culture

Workshop topics:

- Finding balance in personal and professional goals/life
- Understanding personality with the Myers-Briggs Type Indicator®
- The dark side of medicine: exploring the emotions of caring for sick and dying patients (e.g., Schwartz Rounds)
- Navigating interpersonal dynamics with "difficult" patients or colleagues
- Overcoming burnout and fatigue
- Violence in the workplace
- Leadership skills
- Mitigating conflict in a care team
- Perfectionism
- Difficult conversations: how to speak to a grieving family and write a condolence note

Resources

- Stanford Medicine WellMD Center (first of its kind) http://wellmd.stanford.edu/healthy/stress.html
- STEPSForward.org (American Medical Association)
- www.jeffsmithmd.com
- www.TheHappyMD.com
- scpmgphysicianwellness.kaiserpermanente.org

11. ADVANCING RESEARCH

The field of urology prides itself on being a champion of medical progress. Urologists have received two Nobel Prizes and have made numerous advances in the understanding of diseases and applications of novel technologies. In fact, contemporary urologic research takes on many forms. Pure basic science, translational science, clinical research, and health sciences/comparative effectiveness research are just some areas of scientific investigation that urologic clinicians pursue.

11.1 Rewards and Challenges

Participating in research is central to the job satisfaction of many physicians. The opportunity to advance medicine, to live on the cutting-edge of clinical care and to be immersed in the world of

ideas clearly satisfies some of the intrinsic rewards that many physicians sought when entering medicine. Furthermore, success in research also affords opportunities for leadership roles within one's institution and professional groups, and often offers a seat at the table with policy makers and industry leaders. Importantly, clinician researchers continue to remain leaders in training the next generation of practitioners. Participation in research clearly has its well-known challenges, such as dwindling funding, significantly fewer like-minded peers, "publish or perish" pressures and a lack of successful role models and mentors. In addition, the research community is increasing outside of urology and, in some instances, the opportunity costs of foregoing income from clinical activities. As such, individuals motivated to establish a dynamic research career must be well informed and well prepared for the challenges ahead.

11.2 Research as a Job Function

After completing residency/fellowship, the new practicing urologist interested in pursuing research is faced with a new challenge–how to efficiently and productively manage both a clinical practice and a research program and how one can best assure long term success.

Two major goals of a clinical practice are to make sure one can provide effective, safe care and to be available to patients and their families. One of the major objectives of the research program is to pursue discovery that will impact the current knowledge, and contribute to the future well-being of patients. Nonetheless, both areas have to be financially viable and sustainable long-term.

When considering a career with a significant research component, junior faculty members need to have a clear understanding of several factors that are critical to success:

- Finding a mentor is the first and, probably, the most important step. He/she is someone who has "been there and done that" and can provide crucial career and research guidance to you.
- Know exactly what type of institutional support/commitment each potential job is willing to provide (i.e., startup funds, cost-sharing of salary short falls).
- Assess the types of resources that are available. For example, will you have to start your own tumor bank or can you draw on an existing one? Is there a database already established or will you need to build one on your own?
- Survey potential collaborations available institutionally or regionally (i.e., other institutes, industry) is key. The strength of each must be weighed against the type of research you want to pursue and your ultimate career goals.

11.3 Obtaining Funding

Numerous public and private sources support scientific studies and young researchers. These include the U.S. Department of Defense Research Program, U.S. Department of Veterans Affairs, foundation support for investigator-initiated grant awards, as well as the National Institutes of Health (NIH), which is the nation's largest funder of academic research.

In addition to the federal and private foundation sources, there are local research grants (your own academic institution, local charities and organizations, health insurance companies/payers), industry (pharmaceutical and medical device) and private donors (endowments, gifts, etc.) as well as crowdsourcing platforms.

The AUA is committed to supporting urologic research through funding, advocacy and scholarly exchange. Through Research Scholars Program and other internal and external funding awards, the AUA and Urology Care Foundation have been providing support to young urology researchers for 40 years! Please find more information at: www.AUAnet.org/research/funding-opportunities.cfm.

The NIH Guide (grants.nih.gov) is a comprehensive resource for funding opportunities and materials to guide researchers through the process. The Research Project Grant (R01) is the original and, historically, oldest grant mechanism used by NIH. The R01 provides support for health-related research and development based on the mission of the NIH. R01s can be investigator-initiated or can be in response to a program announcement or request for application.

The following NIH research awards are also available for beginning investigators:

- Mentored Research Scientist Development Award (K01)
- Independent Scientist Award (K02)
- Mentored Clinical Scientist Development Award (K08)
- Clinical Scientist Institutional Career Development Program Award (K12)

- Career Transition Award (K22)
- Clinical Scientist Institutional Career Development Program Award (K23)
- Small Grant (R03)
- Academic Research Enhancement Award (R15)
- Exploratory/Developmental Grant (R21)
- Clinical Trial Planning Grant (R34)
- Research Program Project (P01)

Grant applications are peer-reviewed by standing or ad hoc review groups and scored based on significance, investigator credentials, innovation and research approach and environment. Funding decisions are determined by the score, the "fit" with the mission of the institute and approval of the institute's External Advisory Council.

11.4 Clinical Trials

Clinical trials to evaluate new drugs, tests and devices have traditionally been carried out in academic institutions, but private medical practices or healthcare organizations with little or no academic affiliation are also getting involved.

Dedicated staff is needed to provide support for the activities that will be performed. It is also necessary to have certain equipment and space, both of which vary depending on the nature of the clinical trial. The requirements for management of data, regulatory and institutional review board concerns, marketing, patient recruitment and documentation of clinical visits are different for clinical trials compared with clinical care.

12. CONTINUING EDUCATION & PRACTICE MANAGEMENT

12.1 Maintenance of Certification (MOC)

Beginning in 2007, the American Board of Urology joined the 23 other member boards of the American Board of Medical Specialties (ABMS) in implementing Maintenance of Certification. The MOC process will extend over a 10-year period, with some requirements in the process to be completed every two years. Find out more information about MOC. Visit www.abu.org/maintenanceofcertification.aspx

There are a number of excellent resources to remain current with the practice of urology. AUAUniversity, a tool that provides access to all of your educational needs in one place, offers a robust educational program with numerous resources.

- AUA Clinical Guidelines
- NCCN Guidelines
- Coding Resources
- Patient Education
- AUA University

12.2 Medical Coding and Billing

It is important to stay current on key coding issues. We highly recommend having your practices up to date with yearly changes from Current Procedural Terminology (CPT®). Using outdated books can lead to unnecessary denials or may result in delayed reimbursement. See the new codes for 2019 below*. This will be updated again in November for January 2020.

Current Procedural Terminology (CPT®) has been revised to standardize coding placement under more appropriate headings in an effort to better categorize CPT® procedures. New, revised or deleted CPT® codes are listed below. Code revisions are noted in italics and new codes/additions are noted in bold.

Current Procedural Terminology (CPT®) has been revised to standardize coding placement under more appropriate headings in an effort to better categorize CPT® procedures. New, revised or deleted CPT® codes are listed below. Code revisions are noted in green and new codes/additions are noted in bold.

New Codes: Evaluation and Management

Digitally Stored Data Services/Remote Physiologic Monitoring

99453 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

(**Do not report** 99453 more than once per episode of care)

(**Do not report** 99453 for monitoring of less than 16 days)

99454 device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

(For physiologic monitoring treatment management services, use 99457)

(Do not report 99454 for monitoring of less than 16 days)

(Do not report 99453, 99454 in conjunction with

codes for more specific physiologic parameters (eg, 93296, 94760)

Rationale

A new subsection (digitally Stored Data Services/ Remote Physiologic Monitoring) and guidelines have been added to the Evaluation and Management services section. With the addition of this new subsection, two new codes have been added.

Code **99453** has been added to report the remote monitoring of physiologic parameter(s) initial set-up and patient education, specifically on the use of the device. This code should be reported once for each episode of care, as defined in the new guidelines. Code 99454 has been established to report the device supply for daily recordings or programmed alert transmissions for 30-day periods.

Remote Physiologic Monitoring Treatment Management Services

99457 Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/ caregiver during the month

(Report 99457 once each 30 days, regardless of the number of parameters monitored)

(Do not report 99457 in conjunction with 99091)

Rationale

A new subsection (Remote Physiologic Monitoring Treatment Management Services) and guidelines have been added to the Evaluation and Management services section. In addition, a new code (99457) has been established to report remote physiologic monitoring treatment management services for 20 minutes or more in a calendar month. Code 99457 requires interactive communication with the patient/caregiver during the month. As indicated in the guidelines, it is important to note the at the device used to provide these services must be a medical device defined by the FDA, and it must be ordered by a physician/ QHP.

Surgery Guidelines (Revision)

Imaging Guidance

When imaging guidance or imaging supervision and interpretation is included in a surgical procedure, guidelines for image documentation and report, included in the guidelines for Radiology (Including Nuclear Medicine and Diagnostic Ultrasound), will apply. Imaging guidance should not be reported for use of a non-imaging-guided tracking or localizing system (eg, radar signals, electromagnetic signals). Imaging guidance should only be reported when an imaging modality (eg, radiography, fluoroscopy, ultrasonography, magnetic resonance imaging, computed tomography, or nuclear medicine) is used and is appropriately documented.

Rationale

Guidelines in the Surgery/Imaging Guidance subsection have been revised to clarify reporting for nonimaging guidance. Imaging guidance should not be reported when a non-imaging-guided modality (eg, radar signals, electromagnetic signals) is used. Instead, it should only be reported when an imaging modality (eg, radiography, fluoroscopy, ultrasonography, magnetic resonance imaging, computed tomography, or nuclear medicine) is used and is appropriately documented.

Fine Needle Aspiration (FNA) Biopsy (Revision)

10021 **(revised)** Fine needle aspiration biopsy, without imaging guidance; first lesion

(10022 has been deleted. To report, see 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012)

10004 each additional lesion (List separately in addition to code for primary procedure)

(Use 10004 in conjunction with 10021)

(Do not report 10004, 10021, in conjunction with 10005, 10006, 10007, 10008, 10009, 10011, 10012 for the same lesion)

(For evaluation of fine needle aspirate, see 88172, 88173, 88177)

10005 Fine needle aspiration biopsy, including ultrasound guidance; first lesion

10006 each additional lesion (List separately in addition to code for primary procedure)

(Use 10006 in conjunction with 10005)

(Do not report 10005, 10006 in conjunction with 76942)

(For evaluation of fine needle aspirate, see 88172, 88173, 88177)

10007 Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion

10008 each additional lesion (List separately in addition to code for primary procedure)

(Use 10008 in conjunction with 10007)

(Do not report 10007, 10008 in conjunction with 77002)

(For evaluation of fine needle aspirate, see 88172, 88173, 88177)

10009 Fine needle aspiration biopsy, including CT guidance; first lesion

10010 each additional lesion (List separately in addition to code for primary procedure)

(Use 10010 in conjunction with 10009)

(Do not report 10009, 10010 in conjunction with 77012)

(For evaluation of fine needle aspirate, see 88172, 88173, 88177)

10011 Fine needle aspiration biopsy, including MR guidance; first lesion

10012 each additional lesion (List separately in addition to code for primary procedure)

(Use 10012 in conjunction with 10011)

(Do not report 10011, 10012 in conjunction with 77021)

(For evaluation of fine needle aspirate, see 88172, 88173, 88177)

(For percutaneous needle biopsy other than fine needle aspiration, see 49180 for abdominal or retroperitoneal mass, 50200 for kidney, 54500 for testis, 54800 for epididymis)

(For percutaneous image-guided fluid collection drainage by catheter of soft tissue [eg, extremity, abdominal wall, neck], use 10030)

Rationale

Rather significant changes have been made to the codes for fine needle aspiration (FNA) biopsy procedures, which now include imaging guidance as part of the procedure; in addition, new guidelines have been added to the new subsection and a number of parenthetical notes have been added and/or revised throughout the CPT code set to accommodate these changes.

(*Revision to parenthetical notes)

Kidney

Incision

50080 Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm

50081 over 2 cm

*(For establishment of nephrostomy without nephrostolithotomy, see 50040, 50432, 50433, 50434)

*(For fluoroscopic guidance use 76000)

*(Do not report 50080, 50081 in conjunction with 50436, 50437, when performed by the same physician or other qualified health care professional)

Excision

50020 Renal biopsy; percutaneous, by trocar or needle

(For radiological supervision and interpretation, see 76942, 77002, 77012,77021)

*(For fine needle aspiration biopsy, see 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012)

(For evaluation of fine needle aspirate, see 88172, 88173)

50205 by surgical exposure of kidney

Renal Pelvis Catheter Procedures

Introduction

50384 Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation

(For bilateral procedure, use modifier 50)

*(Do not report 50382, 50384 in conjunction with 50436, 50437)

Other Introduction (Injection/Change/Removal) Procedures

New

50436 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed

50437 including new access into the renal collecting system

(For nephrostolithotomy, see 50080, 50081)

(For retrograde percutaneous nephrostomy, use 52334)

(For endoscopic surgery, see 50551-50561)

*(Do not report 50436, 50437 in conjunction with 50080, 50081, 50382, 50384, 50430, 50431, 50432, 50433, 52334, 74485)

Transurethral Surgery (*Revision to parenthetical notes)

Ureter and Pelvis

52334 Cystourethroscopy with insertion of

ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde

*(For percutaneous nephrostolithotomy, see 50080, 50081; for establishment of percutaneous nephrostomy, see 50432,50433)

*(Do not report 52334 in conjunction with 50437, 52000, 52351)

Deleted Codes

50395 Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous

Urethra (New)

53854 (Rezum) Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy

Rationale

Code 53854 has been established to report water vapor thermotherapy for the destruction of prostate tissue.

Code 53854 includes indirect application of RF energy to create thermotherapy in the form of water vapor or steam applied to the prostate tissue to cause tissue destruction.

Male Genital System (*Revision to parenthetical notes)

Testis/Excision

54500 Biopsy of testis, needle (separate procedure)

(*For fine needle aspiration biopsy, see 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, 10021)

Epididymis/Excision

54800 Biopsy of epididymis, needle

(*For fine needle aspiration biopsy, see 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, 10021)

Prostate/Incision

55700 Biopsy, prostate; needle or punch, single or multiple, any approach

(*For fine needle aspiration biopsy, see 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, 10021)

Female Genital System

Vulva, Perineum, and Introitus (*Revision to parenthetical notes)

56630 Vulvectomy, radical, partial;

(* For partial radical vulvectomy with inguinofemoral lymph node biopsy without complete inguinofermoral lymphadenectomy, use 56630 in conjunction with 38531)

56633 Vulvectomhy, radical, complete;

(* For complete radical vulvectomy with inguinofemoral lymph node biopsy without complete inguinofemoral lymphadenectomy, use 56633 in conjunction with 38531

Modifier Revision

Modifier 63 Procedure Performed on Infants less than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20100-69990 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.

Administrative Codes for Multianalyte Assays with Algorithmic Analyses (MAAA)

New Codes

NeoLAB™ Prostate Liquid Biopsy, NeoGenomics Laboratories

0011M Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk

Cxbladder™ Detect, Pacific Edge Diagnostics USA, Ltd

0012M Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2, [CDK1] IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma

Cxbladder™ Monitor, Pacific Edge Diagnostics USA, Ltd

0013M Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2, [CDK1] IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma

Oncotype DX Genomic Prostate Score, Genomic Health, Inc, Genomic Health, Inc

0047U Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score

Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2, [CDK1] IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma

Prostate Cancer Risk Panel, Mayo Clinic, Laboratory Developed Test

0053U Oncology (prostate cancer, FISH analysis of 4 genes (ASAP1, HDAC9, CHD1, and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade

If you have any questions you may contact the AUA Coding Hotline at 1-866-746-4282 Opt 3 or via email at codinghotline@auanet.org.

13.UNDERSTANDING PUBLIC POLICY AND GOVERNMENT ADVOCACY

Health policy can be a very complex area for young urologists. However, the Public Policy Council of the AUA is comprised of several committees and workgroups that essentially protect the interest of urology health care professionals. It is run by urologists for urologists. Learn more about the many urological resources that are available to assist you in understanding health policy and government advocacy by visiting www.AUAnet.org/advocacy/get-involved.

The AUA is a leading advocate for the specialty of urology and maintains a consistent presence in Washington, DC, working with lawmakers and regulators to promote and preserve the interests of urologists. The AUA has a long history of promoting legislation and regulation that positively impacts a urologists' ability to provide quality patient care. The AUA's advocacy efforts are varied to ensure that the interests of members are made known to a wide array of decision makers. Whether AUA is contacting lawmakers on Capitol Hill or federal officials in government agencies, the AUA is supporting and defending the practice of urology. In addition to independent advocacy activities, the AUA often joins with other like-minded organizations and specialty societies, collaborating on issues of mutual interest and concern. These efforts are especially important in both legislative and regulatory matters. Member involvement is critical to advocacy.

Component committees of the AUA Public Policy Council include, but are not limited to the:

- Coding and Reimbursement Committee (serves as urology's representative in the area of coding, terminology development and reimbursement as well as seeks new and updated codes to ensure accurate identification of urologic diseases and procedures).
- Legislative Affairs Committee (provides feedback on the continual refinement of the federal legislative agenda and its execution, provides advice and guidance regarding new opportunities for urology's involvement, and represents the AUA to the federal government).
- State Advocacy Committee (provides feedback on the continual refinement of the state legislative agenda and its execution, provides advice and guidance regarding new opportunities for urology's involvement, and represents the AUA within state capitals).
- Practice Management Committee (evaluates, investigates and advises on initiatives designed to improve the overall business operations of the urology practice).
- Research Advocacy Committee (advocates for public, private and philanthropic support of urologic research, engages with urology stakeholders including patient advocates to ensure funding for urologic research is protected, communicates with federal and non-federal agencies to ensure urology is represented on advisory boards and strategic planning initiatives).

Below is a list of terms and resources that may be helpful in understanding this area as it relates to both your professional and personal life.

13.1 Health Policy Terms

APM – Alternative Payment Models developed by the Centers for Medicare & Medicaid Services to replace current payment system.

ICD-10-CM – International Classification of Diseases – 10th Version – Clinical Modifications – Listing of diagnostic and procedure codes developed by the World Health Organization and modified for use in the United States medical community.

RUC – relative value scale update committee (AMA)

MAC – Medicare administrative contractor (local Medicare carrier)

MedPAC – Medicare Payment Advisory Commission

ACO – accountable care organization

Medicare part A – hospital, SNF, hospice coverage

Medicare part B – physician services, lab, imaging services, and office medications

Medicare part C – proper ties to Medicare advantage plans (HMO)

Medicare part D – drug coverage

MIPS – Merit-based Incentive Payment Program

QPP – Quality Payment Program

13.2 Additional Resources (available at www.AUAnet.org)

- Gallagher Health Policy Scholarship
- Public Policy & Council Committees
- Policy and Advocacy News Briefs
- Centers for Medicare & Medicaid Services
- Department of Health and Human Services
- American Medical Association (AMA)

Urology Care FOUNDATION™
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Urological
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