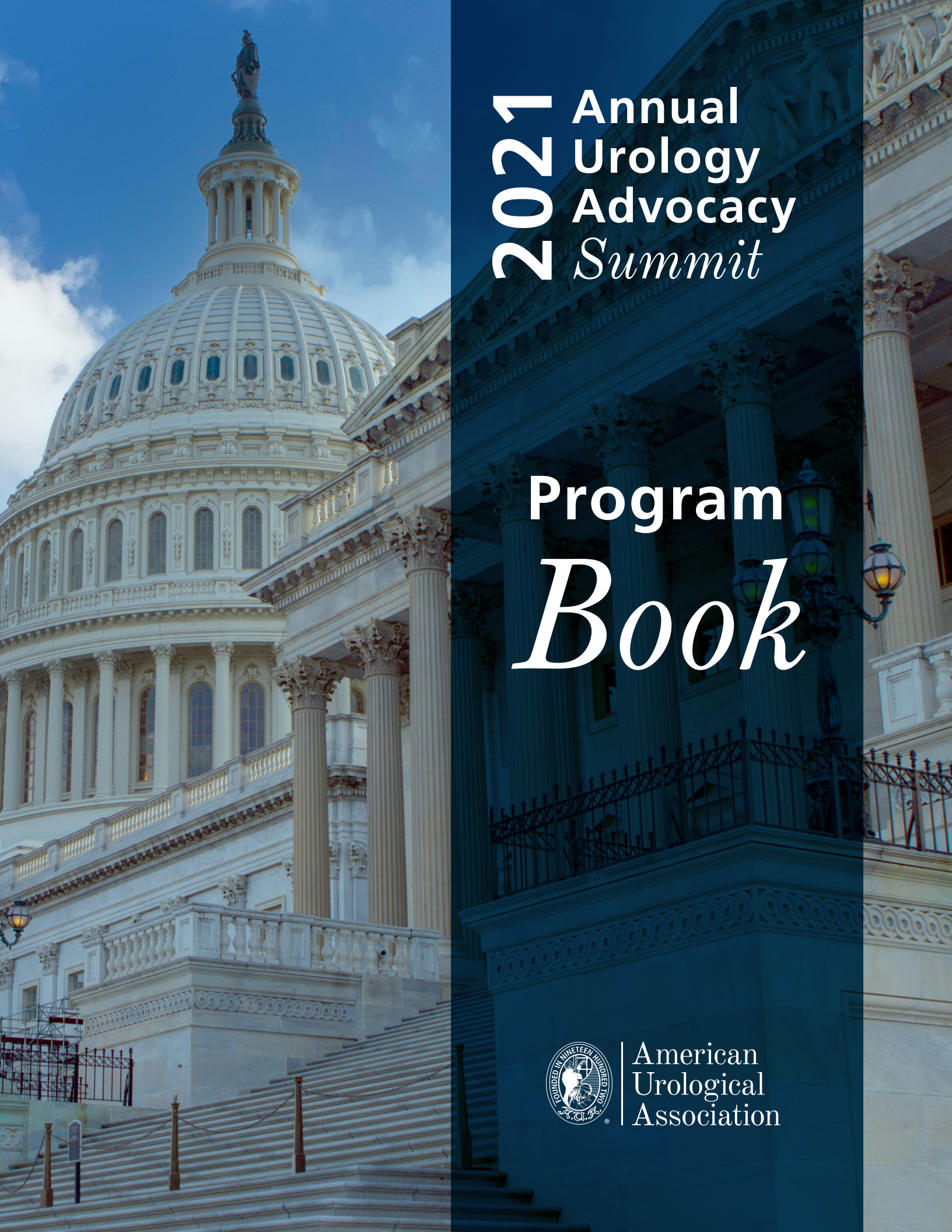


2021 Annual Urology Advocacy *Summit*

Program *Book*

American Urological Association

American Urological Association

2021 Annual Urology Advocacy *Summit*

July 16, 2021

Thank you for participating in the 4th Annual Urology Advocacy (AUA) Summit! We are deeply grateful and honored that you have joined us virtually for the important work ahead. We strive to make this event exciting and unique by empowering each of you as the strongest advocate for urology and our profession.

This summit is both visionary and bittersweet as our communities, states, and nation traverse a most challenging landscape populated by a pandemic, inequities, political division, and economic uncertainties. Unsurprisingly, AUA members and other urologic stakeholders have continued to serve communities to the best of their abilities even within these, at times, insurmountable odds. Yet, there is much to be done as we begin to emerge from the COVID-19 pandemic. The public health emergency has profoundly affected our specialty and made clear the importance of articulating with policymakers the shared mission and goals of the American Urological Association.

The AUA Summit represents all facets of the urological community – including physicians, patient advocates, researchers, and advanced practice providers. The event is founded upon a mission to expand, strengthen, and unify the voice of urology on matters that affect our practices and the patients we serve. This year, we have more than 225 total registrants. We are particularly proud that new voices will be heard, with 75 medical students, residents, or fellows having signed up to participate.

This year's event offers a great taste of what our profession has to share, with the entire month of July being "Advocacy Action Month". As a result, the AUA has already sponsored a specific session for patient advocacy groups and AUAPAC held a unique fundraiser complete with cocktails and a virtual tour experience featuring Abe Lincoln. In addition, on Monday night, we are planning a unique networking event for urology trainees hoping to serve as future advocates.

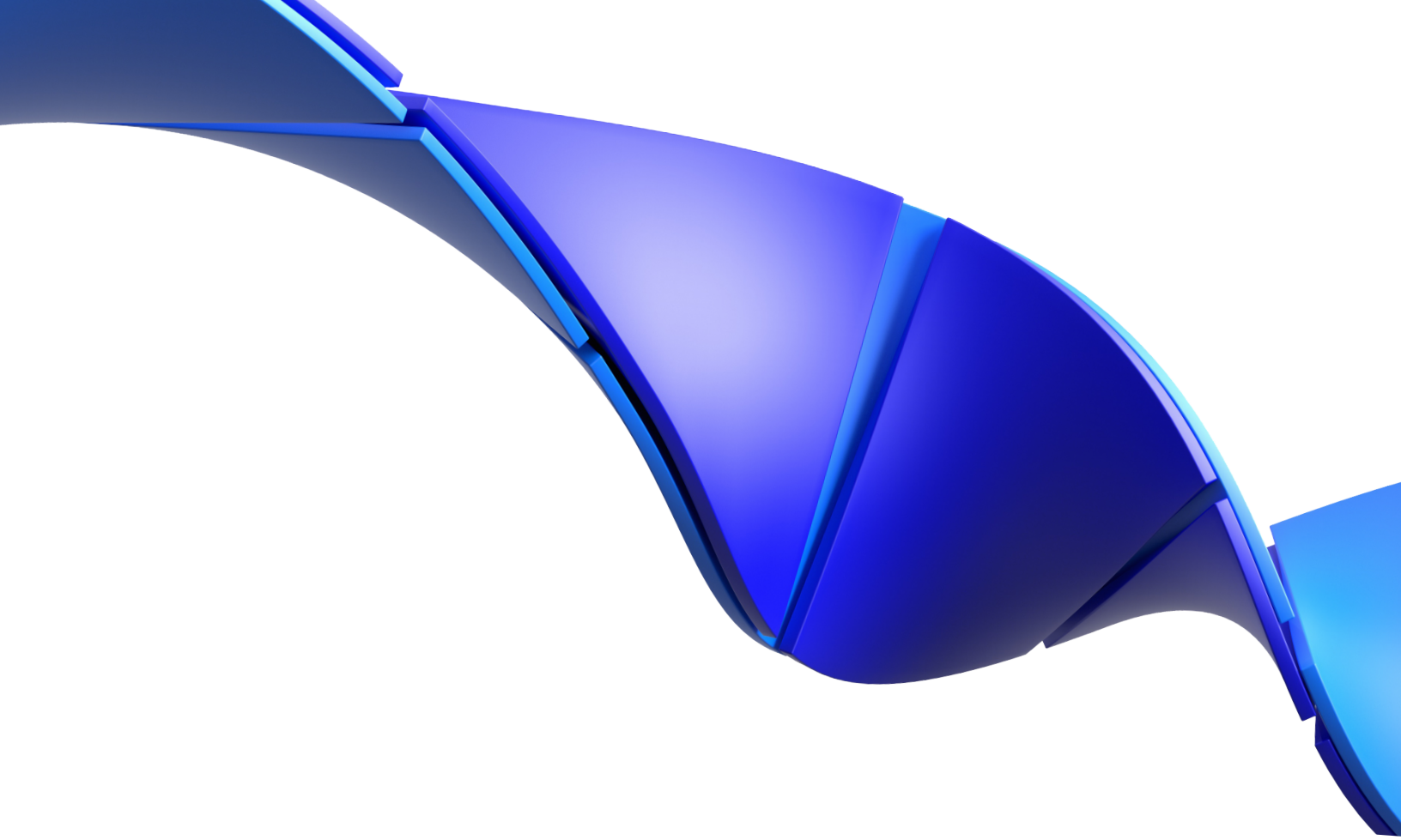
Looking forward, the AUA is now enlisting summit registrants to convey our positions and priorities to Congress and federal agencies alike, including various centers within the National Institutes of Health, the Centers for Medicare & Medicaid Services, and the Agency for Healthcare Research and Quality. On July 20, we invite all of those interested to join us for an in-depth educational session detailing our congressional asks. On July 21, we will have the opportunity to discuss these priorities directly with lawmakers and congressional staff during Virtual Capitol Hill Day. Registrants also will be able to hear from Dr. Ashish Jha, Dean of Brown University's School of Public Health and a world authority on the COVID-19 pandemic.

The AUA is committed to bringing you resources that serve your practices, academic institutions, and the patient community. Topics featured this month are essential as we seek to unite the urologic community and work to inform and educate the government on how urology is an integral part of our healthcare delivery system.

We are excited you could join us to advocate for our specialty, and we hope to see you next year!

Scott K. Swanson, MD, FACS
President, AUA

Eugene Rhee, MD, MBA
Chair, AUA Public Policy Council



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American Urological Association

2021 Annual Urology Advocacy Summit

Tuesday, July 20

6:00 p.m. Welcome/The Importance of Urologic Advocacy

- *Eugene Rhee, MD, MBA, Chair, AUA Public Policy Council*

6:10 p.m. Issue 1: Telehealth Expansion

Moderator: Aaron Spitz, MD, Chair, AUA Urology Telehealth Task Force

- Sexual Medicine Society of North America
  - *Speaker: Mohit Khera, MD, MBA, MPH, President-Elect*
- Prostate Cancer Foundation
  - *Speaker: Rebecca Levine, Vice President Government Affairs*

6:30 p.m. Issue 2: Workforce Shortages

Moderator: Amanda North, MD, Chair, AUA Workforce Work Group

- AUA Workforce Work Group
  - *Speaker: Andrew Harris, MD*
- AUA Patient Advocacy Liaison (PAL)
  - *Speaker: Jacqueline Zarro, PhD, AUA Patient Advocacy Liaison*

6:50 p.m. Issue 3: Veterans' Prostate Cancer Care

- Urological Society for American Veterans
  - *Speaker: Jeffrey Jones, MD, President*
- ZERO – The End of Prostate Cancer
  - *Speaker: Michael Crosby, MS*

7:10 p.m. Issue 4: Research Funding

Moderator: Toby Chai, MD, Immediate Past Chair, AUA Research Advocacy Committee

- Society of Women in Urology

- *Speaker: Priya Padmanabhan, MD, MPH, FACS*

- KidneyCan
  - *Speaker: Bryan Lewis, President & Founder*

7:30 p.m. Capitol Hill Schedules and Logistics: An Overview
- Soapbox Consulting
  - *Speaker: Christopher Kush, MPP, CEO*

7:45 p.m. Virtual Capitol Hill Meeting Practice Session
- Go To Meeting Virtual Room found at the top of registrants' Hill schedule in the orange box

Wednesday, July 21

12:00 p.m. Welcome Remarks
- *Scott Swanson, MD, FACS, President, AUA*

12:05 p.m. Keynote Speaker
- *Ashish Jha, MD, MPH, Dean, Brown University School of Public Health*

1:00 – 5:00 p.m. Hill Meetings
- Videoconferences with lawmakers and congressional staff

AUA Summit Planning Committee

- **Robert Bass, MD, MBA**
  Legislative Affairs Committee and AUAPAC Chair
- **Quardricos B. Driskell, MPP**
  Legislative & Political Affairs Manager
- **Eugene Rhee, MD, MBA**
  Public Policy Council Chair
- **Brad Stine**
  Legislative & Political Affairs Director
- **Kathy Shanley, PhD, CAE**
  Public Policy & Advocacy Executive Vice President
- **Ruchika Talwar, MD**
  Policy & Advocacy Resident Work Group Member
- **Arthur Tarantino, MD**
  State Advocacy Committee Chair
- **Ray Wezik, JD**
  Policy & Advocacy Director

AUA Summit Staff Liaisons

- **Adina Lasser**
  Advocacy Coordinator
- **Juliana Nicolini**
  Public Policy & Advocacy Coordinator
- **Kimberly Serota, MSW**
  Policy & Advocacy Manager

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Attendee Roster (as of July 15)

A. Lenore Ackerman, MD
Aaron Spitz, MD
Abdul Qadar
Adam Berry
Adam Schneider
Aileen Arevalo
Aimee Cloutier
Akhil Muthigi, MD
Alba Kuqi, MD
Aleksandar Popovic
Alex Shteynshlyuger, MD
Alexandria C. Lynch, MD
Ali Kasraeian, MD
Alisa Marie Driscoll Berger, MD
Amanda C. North, MD
Amanda Hall
Amanda Lokke
Amelia Aynaz Khoei
Amit Gupta, MD
Anders Olsen
Andrea K. Balthazar, MD
Andrew Harris, MD
Andrew J. Park, MD
Andrew McIntosh, MD
Andrew Rabley, MD
Andrew Zebrak
Anirban Mitra, MD
Ann Decker
Anthony Y. Smith, MD
Anurag Kumar Das, MD
Aravind Chandrashekar, MD
Arthur Edgar Tarantino, MD
Arthur Louis Burnett, II, MD
Arvind M. Patel, MD
Asher George
Avi Assidon, MD
B. Mayer Grob, MD
Barry A. Kogan, MD
Belinda Li, MD
Benjamin Pockros
Brett Jacob Friedman
Brian D. Duty, MD
Brian Keith McNeil, MD
Brooke Namboodri Spratte
Bryan Lewis
Caleb Harold Bercu
Candace F. Granberg, MD
Carleen Tortello Bensen, MD
Charles Douglas Scales Jr., MD
Christopher Warren
Daniel A. Igel, MD
Danielle Velez, MD
D'Anna Holmes
David Andrew Taub, MD
David Duchene, MD
David F. Green, MD
David Mois Albala, MD
Denise A. Asafu-Adjei, MD
Dolores Jean Lamb, PhD
Dominique Waldman
E. Ann Gormley, MD
E. Michael D. Scott
Edward M. Messing, MD
Ellen Ivey
Elmore James Becker, MD
Emilie K. Johnson, MD
Emily Clennon
Emma Bethel
Eric D. Biewenga, MD
Eric J. Zeidman, MD
Eric L. Walton, MD
Erin Bruce
Eudoxie C. Bataba
Eugene Young Rhee, MD
Fernando J. W. Kim, MD
Frederick Okoye, III
Gabrielle Difiore
Gail S. Prins, PhD
Gary W. Chien, MD
Gaurang Shah, MD
Geolani W. Dy, MD
Grace S. Hyun, MD
Grant S. Chavin, MD
Hans C. Arora, MD

Industry Representative

Haritha Pavuluri
Hassan Razvi, MD
Helal A. Syed, MD
Hersh Trivedi
Hiten D. Patel, MD
Hyung Lae Kim, MD
Iha Kaul
Irene Mary McAleer, MD
Jacob Zipkin
Jacqueline Welch, MD
Jacqueline Zarro, PhD
James C. Ulchaker, MD
James Herbert Gilbaugh, III, MD
James M. Cummings, MD
James R. Wendelken, MD
Jason J. Jameson, MD
Jay Simhan, MD
Jeffrey Jones, MD
Jeffrey Lewis Evans, MD
Jen Mihalo
Jennifer K. Yates, MD
Jennifer Nguyen
Jeremy D. Lai, MD
Jeremy S. Archer, MD
Jocelyne Fletcher
Jodi Maranchie, MD
Joel T. Nowak
John Christopher Lyne, MD
John D. Denstedt, MD
John H. Lynch, MD
John M. Dibianco, MD
John Stephen Lam, MD
Jonathan H. Berger, MD
Joseph Charles Presti Jr., MD
Joshua Paul Langston, MD
Juan J. Andino, MD
Julie M. Riley, MD
Junghwan Choi, MD
Kaleigh Trainer
Karny Jacoby, MD
Kathy Huen, MD
Kelly A. Swords, MD
Kelly Davies
Kelvin Paul Davies, PhD
Kevin Koo, MD
Kira Golub
Kiritkumar M. Pandya, MD
Kripa Kavasseri, MD
Kristen Wachsmuth, PhD
Kuemin Hwang
Kurt Anthony McCammon, MD
Lane Stuart Palmer, MD
Leslie Fox
Lillian Y Lai, MD
Lindsey A. Kerr, MD
Lindsey Allison Herrel, MD
Liv Gagne
Logan Galansky, MD
Lori Ann Hergan, MD
Lorie G. Fleck, MD
Lucia Diaz, NP
Maria J. D'Amico, MD
Mark Barry Irwin, MD
Mark Gibbons
Martin A. Koyle, MD
Martin K. Dineen, MD
Matthew A. Uhlman, MD
Matthew Edward Nielsen, MD
Matthew Pollard, MD
Mayra Lucas
Megan Bing, MD
Mei Nicole E. Tuong, MD
Melinda Fu
Michael Ernst, MD
Michael Hsieh, MD
Michael Sazon Gomez, MD
Micheal F. Darson, MD
Michel Arthur Pontari, MD
Mike Crosby
Miyad Movassaghi, MD
Mohit Khera, MD
Nancy Quintanilla
Nathan Grunewald, MD
Naveen Kachroo, MD
Nityam Rathi
Omer Raheem, MD
Patricia Peggy Vidal, MD
Paul Yong Gweon, MD
Petar Bajic, MD
Peter N. Bretan, MD

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Piyush N. Joshi, MD
Polina Reyblat, MD
Priya Padmanabhan, MD
Quentin Clemens, MD
Rabun H. Jones, MD
Raevti Bole, MD
Raj Anirudh Kumar
Raju Thomas, MD
Rebecca Howland
Rebecca Levine
Rebekah Russell
Rena D. Malik, MD
Reza Ghavamian, MD
Richard K. Babayan, MD
Rick Davis
Rishi Robert Sekar, MD
Robert Andrews Bass, MD
Robert Edward Weiss, MD
Robert Lurvey, MD
Robert M. Coward, MD
Ruchika Talwar, MD
Russell Becker, MD
Sam Stokes, III, MD
Samuel Gold, MD
Sanjay Kumar Das
Sayani Bhattacharjee
Scott K. Swanson, MD
Seth A. Cohen, MD
Siobhan Hartigan, MD
Sivaprasad D. Madduri, MD
Steven Abraham Kaplan, MD
Subodh G. Patel
Sudhir Isharwal, MD
Susan Diane Glover, MD
Susan Hensley
Susan Kasper, PhD
Susana Elena Berrios
Tatum Williamson
Terrence Robert Grimm, MD
Thomas F. Stringer, MD
Thomas L. Osinski, MD
Thomas Schroeder
Timothy David Averch, MD
Toby C. Chai, MD
Tracey A. Hessert, NP
Tyrone McClain
Valentina Grajales, MD
Vanessa Anne Lukas
Vannita Simma-Chiang, MD
Vernon M. Pais Jr., MD
Veronica Triaca, MD
William C. Reha, MD
William H. Annesley, Jr., MD
William R. Clark, MD
Yale Shulman, MD
Yash Khandwala, MD
Yehuda Sugarman
Yooni Yi, MD

Industry Representative

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I am a urologist. I am a patient.

"When my BPH symptoms became unbearable I really didn't want to undergo invasive surgery and I'm not a personal fan of BPH medications. Relief can be inadequate and temporary and they have a whole host of side effects.[1]"

Peter J. Walter, M.D., F.A.C.S.* *Western New York Urology Associates* and UROLIFT® SYSTEM PATIENT

Enlarged Prostate (BPH) affects over 40 million men in the United States. Symptoms may include interrupted sleep and urinary problems as well as loss of productivity, depression and decreased quality of life.[2]

If your patients have symptoms of an enlarged prostate, introduce them to the UroLift® System.
Here's why I chose UroLift System and recommend it to my patients.

- **Proven**, minimally invasive approach to treating enlarged prostate that provides rapid symptom relief and recovery[3,4]
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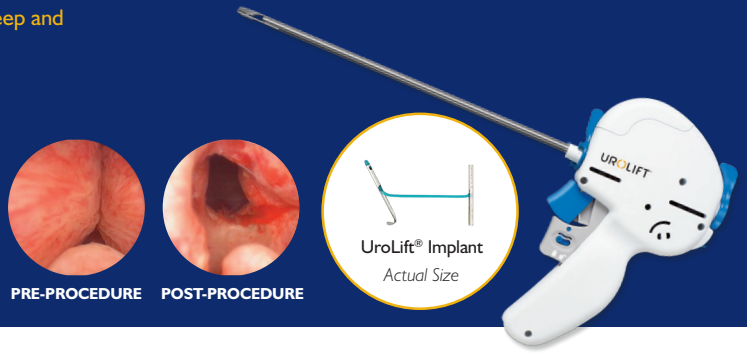
- **Durability** through 5 years[6]
- **Over 175,000**** men have been treated with the UroLift System worldwide
- The procedure is **covered by Medicare** and all major private insurers when medical criteria are met.

Learn more and check out the data at **UroLift.com/info**



The UroLift System procedure is FDA-cleared for the treatment of symptoms due to urinary outflow obstruction secondary to BPH, including lateral and median lobe hyperplasia, in men 45 years of age or older. Results and patient experience may vary. Clinical data from a pivotal 206-patient randomized controlled study showed that most common adverse events reported include hematuria, dysuria, micturition urgency, pelvic pain, and urge incontinence. Most symptoms were mild to moderate in severity and resolved within 2 to 4 weeks after the procedure.

*Dr. Walter is UroLift System faculty and a paid consultant for NeoTract|Teleflex **Management estimate based on product sales and average units per procedure

1. AUA Guidelines 2003, 2010; 2. Speakman et al. 2014 BJUI International; 3. Roehrborn J Urol 2013 L.I.F.T. Study;
4: Shore, Can J Urol 2014 Local Study; 5. AUA BPH Guidelines 2003; 6. Roehrborn et al. Can J Urol 2017

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INTERVENTIONAL UROLOGY

SUPPORT H.R. 2903/S. 1512
TO PERMANENTLY EXPAND TELEHEALTH SERVICES

Since the start of the pandemic, there has been more than a 70 percent adoption of telehealth services in urology, and our specialty leads all other surgical specialties in usage rate during that time. American Urological Association (AUA) members have reported that telehealth allows physicians to meet the needs of many of their patients, including those with non-routine issues like kidney stones and prostate disorders. Unfortunately, many of the regulations intended to encourage telehealth use are set to expire once the COVID-19 public health emergency concludes.

REQUEST – The AUA urges legislators to cosponsor the CONNECT for Health Act (H.R. 2903 and S. 1512). If you are already a cosponsor, the AUA urges members of Congress to request a hearing on the legislation.

BACKGROUND – The CONNECT for Health Act is a bipartisan bill introduced by Representative Mike Thompson (D-CA-05) and Senator Brian Schatz (D-HI). The CONNECT for Health Act takes a comprehensive approach to improving the availability and equity of telehealth services to help more patients and providers access necessary care.

Providers and patients have benefited greatly from the flexibilities in care granted during the COVID-19 pandemic. The use of telehealth services reduces the burden on patients that are required to travel significant distances to see a urologist and may be forced to forgo necessary medical care. It also allows patients to receive care that does not require a face-to-face visit or exam in a location that is more convenient to them, potentially increasing patient compliance with medical recommendations and improving outcomes.

RATIONALE – The bill eliminates geographic restrictions for patients and expands originating sites to include the home. These changes are necessary for equitable telehealth access for the following reasons:

- Clinicians and patients are best able to determine which setting is appropriate;
- Telehealth reduces exposure risk for communicable diseases (even without a pandemic);
- Patients with spinal cord injuries and other neurogenic conditions (ex: spina bifida), patients in a facility, or patients in rural areas or with a long-distance commute may struggle to get to predetermined sites to receive care.

Telehealth is more advantageous for those patients who do not have the time, transportation, mobility, mental faculty, or independence to appear for an in-person visit without difficulty (originating site mitigates these benefits).

CONTACT – For more information or to be added as a cosponsor, please contact Crozer Connor with Rep. Mike Thompson at 5-3311 or crozer.connor@mail.house.gov or Meghan O'Toole with Sen. Schatz at 4-3934 or meghan_o'toole@schatz.senate.gov.

American Urological Association

2021 Annual Urology Advocacy *Summit*

TELEHEALTH USE IN UROLOGY

Data from **23 diverse practices** in the state of Michigan reported the following:

*Percentage of respondents who used video visits **before COVID:***

8% NEW PATIENTS

21% EXISTING PATIENTS

*Percentage of respondents who used video visits **after COVID:***

87% NEW PATIENTS

94% EXISTING PATIENTS

87% say they will use video visits after the pandemic

According to data available from Kaiser Permanente for urological visits in southern California,

Face-to-face visits between 2019 and 2020 dropped **below 10% of average** at the onset of the pandemic and **leveled around 50%** of the 2019 average for the remainder of 2020.

On the other hand, monthly urologic **telehealth video visits** trended up from less than 50 monthly visits in 2019 to **nearly 4,000 monthly visits** by December 2020.

American Urological Association · 1000 Corporate Boulevard · Linthicum, MD 21090
202.687.3700 · LegislativeAffairs@AUAnet.org

SUPPORT H.R. 944 TO ADDRESS SPECIALTY MEDICINE PHYSICIAN SHORTAGES IN RURAL AREAS

The American Urological Association (AUA) has actively worked with members of Congress on legislation to address the urological workforce shortage that jeopardizes patient access to care. The shortage of urologists and other specialists is most acute in the rural areas of the United States.

REQUEST – The AUA urges House members to cosponsor H.R. 944, a bill that would encourage urologists and other specialty medicine physicians to practice in rural communities by creating a student loan forgiveness program for these important providers.

While there currently is no Senate companion bill, the AUA encourages any offices interested in sponsoring a Senate version to please contact the AUA's Legislative & Political Affairs Department.

BACKGROUND – The United States is facing an overall shortage of physicians. Projections have shown that at least half of the shortage is among specialty medicine physicians such as urologists**.** In fact, only 38 percent of all U.S. counties have a practicing urologist, there have been significant declines in the number of urologists per capita, and the average age of a practicing urologist makes the specialty one of the oldest in the medical profession. While the number of specialty medicine physicians, such as urologists, is decreasing and the average age is increasing, 53.8 percent of urology residents have more than $150,000 in student loan debt, and for 26.8 percent of them, the figure is $250,000 or more.

The bill authorizes the U.S. Department of Health and Human Services (HHS) to provide urologists and other qualified specialty medicine physicians the opportunity to have a portion of their eligible student loans repaid by the federal government in exchange for practicing in a rural community experiencing a shortage of specialty medicine physicians.

The required period of service is six years of full-time employment with no more than one year passing between any two-year period of employment. The loan repayment for each year of service would be 1/6 of the principal and interest on each eligible loan (which is outstanding on the date the service started). The remaining principal and interest on any loans is paid upon completion of the sixth and final year of service. The total amount of repayments cannot be more than $250,000.

The bill defines a specialty medicine physician as a physician whose specialty has a baseline projected demand that exceeds its projected supply, as identified in the Health Resources and Services Administration's report on the physician workforce, **"**The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand".

CONTACT – For more information or to be added as a cosponsor, please contact Kirsten Wing with Rep. David McKinley (R-WV-01) at 5-4172 or Kirsten.Wing@mail.house.gov or Gabie Camozzi with Rep. Peter Welch (D-VT-AL) at 5-4115 or Gabie.Camozzi@mail.house.gov.

SUPPORT LEGISLATION TO DEVELOP A NATIONAL PROSTATE CANCER CLINICAL PATHWAY FOR VETERANS

The American Urological Association (AUA) has a steadfast commitment to America's veterans and supports legislative and regulatory policies to ensure that those who served our country in uniform receive the best care possible. Unfortunately, despite the high incidence rate of prostate cancer within our veteran population, the Veterans Health Administration (VHA) does not yet have a comprehensive national effort to combat this critical public health issue. The AUA believes that VHA is uniquely situated to deliver the highest quality prostate cancer care in the country and lead the rapid generation of new research into the disease and optimal delivery method.

REQUEST – The AUA urges House members to become an original cosponsor of the Veteran's Prostate Cancer Treatment and Research Act, which is set to be reintroduced in the coming days. It directs the Secretary of Veterans Affairs (VA) to establish a national clinical pathway for prostate cancer within the National Surgery Office at the VA for all stages of prostate cancer. The Secretary also would be required to develop a plan on the challenges around creating a real-time prostate cancer registry.

While there currently is no Senate companion bill, the AUA encourages any offices interested in sponsoring a Senate version to please contact the AUA's Legislative & Political Affairs Department.

BACKGROUND – Prostate cancer is the number one cancer diagnosed in the VHA, with nearly 489,000 patients currently being treated. Statistics also show that men diagnosed with prostate cancer at the VA are nearly twice as likely to have more advanced disease verses men diagnosed outside the VA. It is critical for veterans who may be at high-risk for prostate cancer to seek preventative clinical services for early detection and successful treatment. This bill presents an opportunity for the VA to provide a substantial improvement to the research and evidence-based treatments for veterans suffering from or remain at high-risk of developing prostate cancer.

RATIONALE – A clinical pathway is a tool based on multidisciplinary evidence that guides healthcare best practices for a specific condition or disease. It aims to streamline and improve both the quality and delivery of care for patients, resulting in improved outcomes for those patients. The main tenets of the Veteran's Prostate Cancer Treatment and Research Act include the following:

1) **Create a national prostate cancer clinical pathway within one year.** The pathway will cover the disease from early detection to end-of-life care. The pathway should reflect relevant prostate cancer care guidelines and will be updated as needed. The pathway should be multi-disciplinary and consider transformative innovations in the field of prostate cancer treatment and diagnostics as well as clinical data. The clinical pathway shall be consulted with, and incorporate feedback from, veterans who have received prostate cancer care at department medical facilities as well as experts in multi-disciplinary cancer care and clinical research.

2) **Develop a national prostate cancer care implementation program.** This would be administered by the undersecretary of health in the VA, who would coordinate efforts across

relevant VA entities, measure prostate cancer care quality and costs, and create a national prostate cancer education plan aimed at administrators, providers, and patients. VA facilities, as well as community-based providers and research centers, may be utilized.

3) **Design a plan to create a Prostate Cancer Registry and Research Program.** The aim of the program is to provide a complete evaluation on all aspects, barriers, and challenges of establishing a patient registry and disease continuum from screening to end-of-life care, including optimal ways of implementing recommended guidelines, coordinating care, discovering new insights into the treatment of the disease, and evaluating the comparative effectiveness of existing treatments.

CONTACT – For more information or to be added as an original cosponsor, please contact Sarah Gilbert with Rep. Neal Dunn, MD (R-FL-02) at 5-5235 or sarah.gilbert@mail.house.gov.

SUPPORT FEDERAL FUNDING FOR UROLOGICAL RESEARCH

The American Urological Association (AUA) has a long-standing commitment to supporting federal funding for urologic biomedical research. The following outlines why advocating to protect and secure urologic funding for federally funded research programs is critical to improving patient outcomes and quality of life. Research study outcomes delivered through the Department of Defense (DoD) Congressionally Directed Medical Research Programs (CDMRP) and National Institutes of Health (NIH) provide life-changing data that address treatment disparities for a variety of urological diseases and conditions.

Department of Defense – Congressionally Directed Medical Research Programs

REQUEST – The AUA urges Congress to support robust funding in Fiscal Year (FY) 2022 for the DoD CDMRP. This includes funding a new Bladder Cancer Research Program at $10 million (if not, continued inclusion of bladder cancer in the Peer Reviewed Cancer Research Program, or PRCRP), an increase of $10 million for the Prostate Cancer Research Program to total $120 million, and sustained funding of $50 million for the Kidney Cancer Research Program.

BACKGROUND – The CDMRP was established in 1992 through a Congressional appropriation with the directive to develop new approaches to basic, translational, and clinical research and fill gaps in research not being explored by other federal agencies. The CDMRP is funded through the annual DoD Appropriations bill, but the program is not included in the multi-year DoD budget request sent to Congress in the form of the President's budget.

Since 1992, the CDMRP has funded 18,663 research grants and projects totaling $17.8 billion in funding. Numerous urologic conditions benefit each year from CDMRP funding; however, bladder cancer is one condition that would benefit from the establishment of its own funding line in the program. Therefore, the urologic community is requesting a $10 million line item in the CDMRP for a new bladder cancer research in FY 2022. Since 2016, bladder cancer has resided within the PRCRP that entails sharing a pot of funding with multiple disease areas. Having a designated line item for bladder cancer, the 6th most common cancer in the United States and the 4th most common cancer in the veteran population, will ensure that this underfunded and understudied cancer receives progress toward minimizing research gaps in patient treatment and care. Further, with a dedicated line of funding, researchers can begin investigating alternative therapies to bladder cancer treatments, examining environmental factors linked to bladder cancer, improving survivorship quality of life, and more. To date, bladder cancer has received funding through the PRCRP in response to the critical need to better address the needs of patients; we respectfully request this continue should Congress decide not to create a new funding line for this research.

Prostate cancer is the most recognizable and longstanding urologic research topic area supported by the CDMRP. In FY 2021, the CDMRP prostate cancer line item received $110 million in funding from Congress. Kidney cancer is another urologic disease that benefits from military medical research. In FY 2021, Congress provided $50 million for kidney cancer in the CDMRP.

National Institutes of Health

REQUEST – The AUA supports the biomedical research community's FY 2022 funding recommendation of $46.1 billion for the National Institutes of Health (NIH), a $3.2 billion increase over the agency's FY 2021 level. We also respectfully request that Congress provide an increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the home for urologic research, which is at least proportional to that for NIH.

BACKGROUND – The NIH is at the forefront of funding, conducting, and supporting health and medical research in the United States. Many important discoveries have been made through the NIH, and many drugs and treatments have been developed out of NIH-supported activities.

NIH funding already has improved the lives of Americans with urologic diseases, including those with benign prostatic hyperplasia (BPH). BPH is a non-cancerous enlargement of the prostate gland, commonly found in men over the age of 50 and causing numerous office visits, symptoms such as pain and urinary dysfunction, and significant economic burden.

In addition, NIH research has shed light on potential healthcare savings with better treatment options for urinary incontinence. Urinary incontinence is a highly prevalent condition and costs more than $7.5 billion annually to evaluate and treat. Through a large collaborative research effort involving urology, gynecology, epidemiologists, physical therapy, geriatrics, and biostatistics, NIH-funded researchers discovered that certain bladder testing before surgery was unnecessary, and the application of these findings will save tens of millions of dollars by preventing unnecessary testing. NIDDK-funded researchers played an important role in these advances making it critical that Congress ensure this institute receive a proportional increase in funding to ensure work in this area continues.

INTUITIVE

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* Based on internal Intuitive data.

Important Safety Information
For Important Safety Information, indications for use, risks, full cautions and warnings, please refer to www.intuitive.com/safety.

Da Vinci SP
The safety and effectiveness of this device for use in the performance of general laparoscopic surgery procedures have not been established. This device is only intended to be used for single port urological procedures and for transoral otolaryngology surgical procedures in the oropharynx for benign tumors and malignant tumors classified as T1 and T2 with the da Vinci EndoWrist SP Instruments and the da Vinci SP surgical system (SP1098).

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