

TApT Collaborative Webinar

November 13, 2026

Agenda

- Welcome
- TApT Data Update
- PDSA Report Outs
- Addressing IVC pre pathology
- Final Logistics
- Q and A

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Housekeeping

- Please mute yourself
- Slides and recording will be posted to the project website
- Collaborative Call will also be available in 5-7 days
- Bookmark this website for most up-to-date information throughout the project
  - https://www.facs.org/quality-programs/cancer-programs/cancer-qi-programs/tapt-nationalquality-improvement-project/

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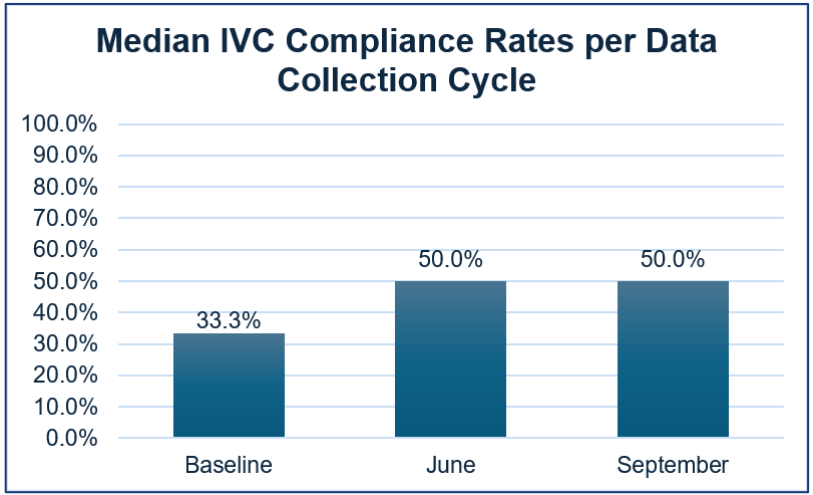


TApT Data Update

Dhruv Patel, MD

September Data Collection

- Included TURBT performed after June 1, 2026
- 2938 patients submitted from 179 programs
  - 1518 patients met TApT eligibility
- Median compliance: 50.0% (IQR: 22.1%, 77.8%)



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September Data Collection

- 90 programs (out of 170) [52.9%] achieved either target compliance (≥75%) OR 20% absolute increase from baseline
  - This is up from 78 (out of 171) [45.6%] in June

- 51 programs (out of 170) [30.0%] achieved target compliance
  - This is up from 46 (out of 171) [26.9%] in June.

- Median change in compliance from baseline was 11.1%

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Data Reminders

- Please double check all IVC administration and TURBT procedure dates

- Please continue to log dates along with the “hours” variable and check for concordance

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TApT PDSA Discussion

Most Common PDSA Themes Mentioned

124 *66.7%*	**Education & training**	**84** *45.2%*	**Eligibility & contraindication clarification**
115 *61.8%*	**Workflow/process standardization**	**77** *41.4%*	**Pharmacy & medication logistics**
95 *51.1%*	**Audit, monitoring, and provider feedback**	**92** *49.5%*	**EHR/EMR support**
87 *46.8%*	**Multidisciplinary communication & coordination**	**11** *6.0%*	**Staffing, capacity, and location constraints**

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Common Issues Based on Setting & Location Mentioned

Ambulatory / outpatient	Coordinating treatment after discharge, nursing competencies, patient education, and outpatient scheduling.	**74** *39.8%*
PACU / recovery	Limited recovery space, patient holding time, nursing capacity, and medication administration immediately after TURBT.	**21** *11.3%*
Infusion centers	Medication availability referral processes, scheduling, and coordination with surgical teams.	**4** *2.2%*
Inpatient / outpatient coordination	Differences in protocols, staff responsibilities, and communication between departments.	**12** *6.5%*
Operating room / preoperative	Advance orders, surgical scheduling, pharmacy notification, handoffs, and treatment eligibility.	**99** *53.2%*
Multiple facilities	Inconsistent workflows, resources, documentation, and responsibilities across locations.	**7** *3.8%*

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Diana Jackson MSN RN, OCN

Kentucky Region Oncology Director
Deaconess Health System

Addressing IVC Before Pathology

M. Minhaj Siddiqui, MD, FACS

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Why instill before pathology?

A thoughtful question from a participating program, and one many of us share

1. **Suspected LG Ta isn't always LG Ta**
   At TURBT we judge by appearance; final pathology may be benign, high grade, or invasive.

2. **Is chemo unnecessary for some?**
   Patients whose pathology is benign may receive an instillation they did not need.

3. **Why not wait for pathology?**
   Or limit the measure to patients with a known history of LG Ta disease?

4. **What does it mean for compliance?**
   How are contraindicated patients and benign cases counted?

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Same uncertainty in SWOG S0337

Patients were enrolled on cystoscopic appearance alone, without pre-TURBT biopsy

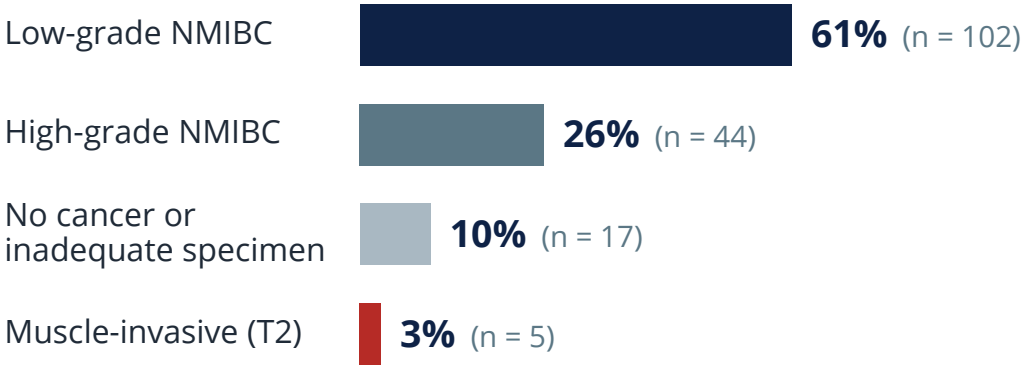
406 eligible patients randomized (gemcitabine vs saline)

201 randomized to gemcitabine

168 received gemcitabine after TURBT

33 did not receive drug: 11 never had TURBT; 22 had instillation withheld (17 medical reasons, 5 refused or logistical)

Final pathology in the 168 who received gemcitabine



39% did not have the suspected diagnosis, yet the trial's benefit was measured with that misclassification built in.

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Benefit despite the uncertainty

The intention-to-treat analysis included every misclassified patient

EFFICACY

0.66

Hazard ratio for recurrence, all randomized patients (ITT)

35% vs 47% at 4 years: about one-third lower risk

EFFICACY

0.53

Hazard ratio for recurrence, confirmed LG NMIBC that received drug

34% vs 54% at 4 years

SAFETY

0

Grade 4–5 adverse events in either arm

Grade 3: 2.4% gemcitabine vs 3.4% saline (P = .29); grade 1–2 events similar

Across the whole suspected-low-grade population: fewer recurrences, with toxicity no different from saline

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Why not wait for pathology?

The benefit depends on instilling before pathology can be known



TURBT
Hour 0

Instillation
Within hours (≤3 h in SWOG S0337)

Final pathology
Days later

Timing drives the benefit

Immediate instillation is thought to prevent implantation of tumor cells released during resection. Waiting days for pathology gives up that window.

Requiring prior LG Ta excludes first tumors

63% of SWOG S0337 patients had a first occurrence, and benefit did not differ for new vs recurrent tumors (interaction P = .25).

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Guidelines recommend it on suspicion

Both AUA/SUO and NCCN apply the recommendation before pathology is known

AUA/SUO NMIBC Guideline

2026 amendment, Statement 17

"suspected or known low- or intermediate-risk bladder cancer"

- One instillation (e.g., gemcitabine, mitomycin C) within 24 h of TURBT
- 2026: "should consider" became "should administer" (Moderate; Grade B)
- Not with suspected perforation or extensive resection

NCCN Bladder Cancer

Version 1.2026

Recommended "if non–muscle invasive disease is suspected"

- Gemcitabine (preferred) or mitomycin, both category 1, within 24 h
- Sits at the TURBT step; later care follows the TURBT pathology
- Not with extensive TURBT or concern for perforation

Sources: AUA/SUO NMIBC Guideline, 2026 amendment; NCCN Guidelines, Bladder Cancer v1.2026 (JNCCN 2026;24:186–203)

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How the measures handle it

Surgeon judgment is built into how compliance is measured

Document contraindications

A valid contraindication noted in the op report (e.g., suspected high-risk disease, concern for perforation) removes the patient from the TApT denominator.

Use the synoptic op-note templates

Pre-built synoptic templates are in the QI packet and are easy to set up as an Epic dot phrase.

Benign pathology isn't counted

For CoC measure BLCT1, a cancer diagnosis triggers case capture, so patients with benign pathology never enter the data.

Bottom line: treating on clinical suspicion is how the benefit was proven: about a third fewer recurrences, with safety comparable to saline

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Questions

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Final Logistics

Accreditation Reminders

- Earn credit for CoC Standard 7.2 and 7.3 for 2026
- Must document in meeting minutes at least twice over the course of the year
- Good practice to complete 7.2 and 7.3 template but not required
- Must submit all data and meaningfully participate

Meaningfully Participate

- Forming a QI team and meeting on a regular cadence
- Complete a current state process map and identify at least 1 root cause for intervention
- Submit 4 cycles of data and 3 surveys
- Attend collaborative calls or listen after
- Programs will be sent an attestation form to complete by January 2027

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Reminders

Important Dates

- December 31: eligible patients September 1- November 30, 2026
  - Final “survey” (see next slide)
  - The link will be sent out December 1
- Attestations will be send mid January
- Final results of the collaborative- coming March/April 2027

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Final Survey

Readiness Assessment:

Drug Availability:
Does your institution have at least one intravesical chemotherapy agent (e.g., gemcitabine) on formulary and physically available for post-TURBT use within 24 hours. If chemotherapy is made in an oncology pharmacy separate from the OR pharmacy, a process is in place by which drug can be ordered, requested and transferred to the perioperative environment for patient treatment. Please confirm you have identified the process for drug ordering, production, transportation and availability for patients at your center.

Either reply "CONFIRMED" or state the reason why this is not confirmed:

* must provide value

CONFIRMED

Expand

Institutional Process:
Does your site have an established process that supports giving immediate post-TURBT intravesical chemotherapy for eligible patients as well as a basic protocol for delivery. Coordination amongst the urologist, OR staff, pharmacy team, and PACU staff has occurred to coordinate a plan for delivery of IVC post-TURBT. Please confirm you have established an institutional process. Please fill in the process map outlined separately in the QI project support materials associated with this project.

Either reply "CONFIRMED" or state the reason why this is not confirmed:

* must provide value

CONFIRMED

Expand

Chemotherapy Handling Equipment:
Chemotherapy disposal and spill/clean-up supplies, with appropriate PPE are reliably available in the locations where intravesical chemotherapy is administered (OR/PACU/clinic). Have you confirmed at least one location where this is established?

Either reply "CONFIRMED" or state the reason why this is not confirmed:

* must provide value

CONFIRMED

Expand

Patient Consent:
There is a readily available consent for post-TURBT intravesical chemotherapy (either as part of the TURBT consent or as a separate consent), and this is consistently obtained for eligible patients. What is your consent process for IVC?

* must provide value

- (●) Consent within TURBT consent
- ( ) Separate IVC Consent
- ( ) Other consent process (please explain)

Process Standardization:

Case Posting:
Eligible TURBTs are routinely scheduled with IVC to allow for OR and PACU planning related to post-TURBT IVC administration. Does your institution coordinate TURBT case posting and identification of potential candidates for post-TURBT IVC administration?

* must provide value

- (●) Already performed prior to QI initiative
- ( ) Not performed prior, but protocol implemented as part of QI project
- ( ) Not performed prior to or during QI project

Patient identification:
Our site has clearly defined clinical eligibility criteria for immediate post-TURBT intravesical chemotherapy (e.g., stage/grade, tumor size, completeness of resection) that is agreed upon by providers. Does your institution have standardized institutional eligibility criteria for both consideration and ultimate delivery of post-TURBT IVC?

* must provide value

- (●) Already available prior to QI initiative
- ( ) Not established prior, but standard criteria implemented as part of QI project
- ( ) Not performed prior to or during QI project

Pool of qualified providers for IVC facilitation:
There are identified individuals (house staff, PACU nurses) beyond the attending surgeon who may administer intravesical chemotherapy and has received specific training in IVC handling, instillation technique, drainage, monitoring, disposal, and spill management. Who are individuals available to facilitate IVC administration at your institution? Select all that apply

* must provide value

- [x] Attending surgeon
- [ ] Anesthesia team
- [ ] Residents
- [ ] Nurses
- [ ] Pharmacists
- [ ] Other

EHR order set:
There is an Electronic Health Record (EHR) order set or standardized order for ordering post-TURBT intravesical chemotherapy (including drug, dose, dwell time, and nursing instructions). Please select your institutional status for EHR integration, or other source of standardization and integration of this order-set, for post-TURBT IVC. Please include the details included in the order information in the response.

- [ ] Already integrated in EHR prior to QI initiative
- [ ] Not available in EHR, but available as paper form
- [ ] Not established prior to QI project, but standard order implemented as part of QI project
- [x] Not performed prior to or during QI project

Practice Optimization:

Synoptic reporting for TURBT/IVC:
Operating reports utilizes a synoptic reporting format that accurately captures IVC eligibility, contraindications, administration, and reasons for non-use in discrete fields. This is utilized in both patients who underwent IVC, and those who were potentially eligible but for whom IVC was actively decided against due to some contraindication. Please identify if synoptic reporting has been integrated into the practice at your facility. An example Synoptic Reporting template is included in the QI packet for your convenience (see project website).

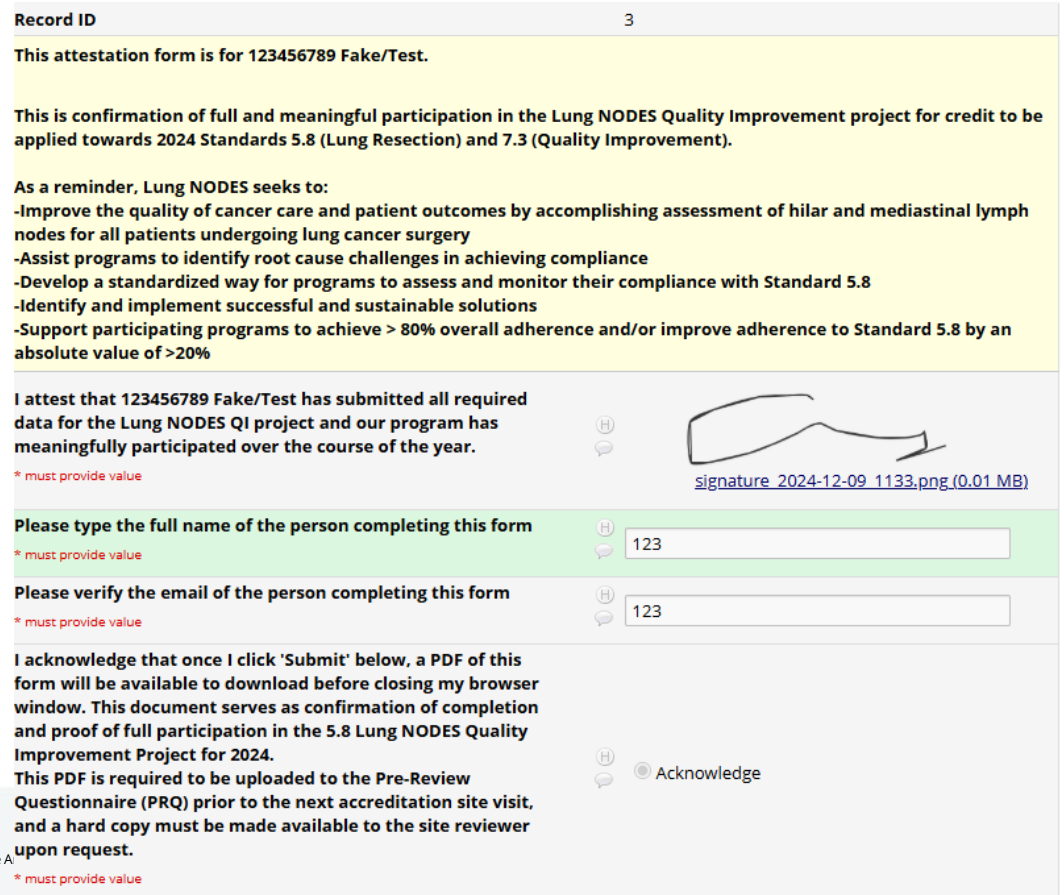
- ( ) Already available prior to QI initiative
- ( ) Not established prior, but synoptic reporting implemented as part of QI project
- (●) Not performed prior to or during QI project

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Attestation: mid January 2027

- Sign and save a downloaded copy
- This is what you upload to your PRQ
- If you need this before mid January, please reach out to cancerqi@facs.org



Record ID	3
This attestation form is for 123456789 Fake/Test. **This is confirmation of full and meaningful participation in the Lung NODES Quality Improvement project for credit to be applied towards 2024 Standards 5.8 (Lung Resection) and 7.3 (Quality Improvement).** **As a reminder, Lung NODES seeks to:** **-Improve the quality of cancer care and patient outcomes by accomplishing assessment of hilar and mediastinal lymph nodes for all patients undergoing lung cancer surgery** **-Assist programs to identify root cause challenges in achieving compliance** **-Develop a standardized way for programs to assess and monitor their compliance with Standard 5.8** **-Identify and implement successful and sustainable solutions** **-Support participating programs to achieve > 80% overall adherence and/or improve adherence to Standard 5.8 by an absolute value of >20%**	
I attest that 123456789 Fake/Test has submitted all required data for the Lung NODES QI project and our program has meaningfully participated over the course of the year. * must provide value	signature_2024-12-09_1133.png (0.01 MB)
Please type the full name of the person completing this form * must provide value	123
Please verify the email of the person completing this form * must provide value	123
I acknowledge that once I click 'Submit' below, a PDF of this form will be available to download before closing my browser window. This document serves as confirmation of completion and proof of full participation in the 5.8 Lung NODES Quality Improvement Project for 2024. **This PDF is required to be uploaded to the Pre-Review Questionnaire (PRQ) prior to the next accreditation site visit, and a hard copy must be made available to the site reviewer upon request.** * must provide value	Acknowledge

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Q & A

Education and QI Reminders

- 2027 QI Projects
- Cancer Webinars
- 2027 NAPBC Standards 101



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