

TApT Frequently Asked Questions

This information is to help provide additional clarification about this project. If you still need clarification, please contact us at cancerqi@facs.org

General

Who can participate?

Any CoC accredited program that is interested in participating in this project is encouraged to do so. The “Intent to participate survey” can be found on the [project website](#) and is due by February 15th. Completion of the survey link ensures your participation.

Please be aware of some participation requirements:

- Must have completed >10 TURBT procedures in calendar year 2024
- Must have pharmacy on site OR access and ability to provide intravesical chemotherapy instillation with gemcitabine or mitomycin within 24 hours of procedure
- Current BLCT1 measure ≤90%
- Must have support of cancer committee and pharmacy (if available)

We are 90% compliant with BLCT1. Should we still participate?

We do not recommend participation for programs that are at or above 90% compliance with BLCT1. This would leave very little room for improvement and the amount of time and effort spent for this project may not result in much progress for your program. However, if you want to share your best practices or tips for how your program is achieving such success, please reach out to cancerqi@facs.org.

We do not have a pharmacy on site or ability to administer IVC within 24 hours of TURBT. Can we still participate?

If your program does not have a pharmacy on site, and you do not have a partnership or ability to obtain pharmacy services within 24 hours of the procedure, this project is not a good fit. If you'd like to discuss this further, please reach out to cancerqi@facs.org

Are all QI team members required to attend the cohort calls?

At least 1 member from each team is required to attend or listen to the recording after the call. While it is not a requirement that all QI team members attend every call, it is encouraged.

Data

What data will be collected? This project collects data on all patients with Ta or T1, high or low grade bladder cancer undergoing TURBT within a defined time period. Please see the TApT toolkit for specific data collection tools.

We will also collect a brief pre, mid, and post survey to better understand implementation strategies, barriers, and successes. We will also ask your team to complete a current state process map, root cause analysis, and future state workflow over the course of the project.

How many patients do I need to submit?

You should submit all patients with Ta or T1 bladder cancer (high or low grade), or up to 20 for larger volume programs, within the specified time frame that underwent a TURBT.

What if we are not abstracting data concurrently?

You do not need to abstract data concurrently, but you will need to conduct a retrospective chart review or pull data via a specific report to ensure inclusion of patients. Non-PHI will be entered into REDCap via a web link sent to the primary contact

What is REDCap?

REDCap is a data collection tool that can be accessed online to complete your data.

Do I have to download software or purchase a subscription?

No. The software is accessed through a link on the project web page and completed online. This secure database is unique to the American College of Surgeons and does not require any downloads or IT interface with your systems. You will not need IT permissions or admin rights to access the program.

Does more than one person need to complete the surveys in REDCap?

No, though it is strongly encouraged that the team discuss the qualitative points in the questionnaire prior to completing. A primary contact is required, and the email associated with this primary contact will be the one used to communicate about the project and access subsequent questionnaires. If this individual leave or need to be changed, you will need to contact cancerqi@facs.org to change the primary contact in the REDCap for your program.

Will each patient need to sign a participation agreement?

No. Patients will not sign a participation agreement or a consent. We are not gathering any patient identifying data

Data: Patient Level Collection Questions:

Our urologists perform procedures at multiple facilities, including hospitals and ambulatory surgical centers, some of which are not owned or operated by our organization. Should our quality improvement (QI) initiative focus exclusively on patients who underwent surgery or intravesical chemotherapy (IVC) within our own facilities, or should it include all patients treated by our providers, regardless of location?

In general, if any component of care is delivered within your facility where processes, staffing, or systems can be guided or improved the patient may be appropriate for inclusion. Conversely, if there is no operational control or influence over key aspects of care (e.g., nursing, pharmacy, or treatment delivery), the patient should not be included.

If a patient receives BCG following surgery, should this be categorized as “Other”? We understand that BCG is not traditionally considered chemotherapy; however, should it be included under this option?

Administration of BCG immediately following surgery is uncommon. In most cases, BCG represents a planned postoperative treatment regimen, typically initiated one week or more after TURBT. This scenario falls outside the scope of the QI project and would not be included.

Can total tumor size on the pathology report be taken from the gross description of aggregate size?

The aggregate size is appropriate to include.

If a qualifying procedure performed for a known malignancy results in no tumor identified on the final pathology specimen, should the case still be considered eligible for intravesical chemotherapy (IVC) instillation?

Yes, the case should still be considered. At the time of the procedure, and within the 24-hour window for IVC administration, final pathology results are typically not yet available. Therefore, IVC would generally still be considered. If the surgeon determines that IVC is not appropriate based on clinical judgment, this decision and its rationale should be documented in the synoptic report. In such cases, omission of IVC would not be counted against performance, as it reflects appropriate clinical decision-making.

For noninvasive low-grade (LG) papillary urothelial carcinoma, I have classified the case as low-grade. Since “papillary urothelial” is not listed as a histologic subtype, should I also select “Other Variant Histology”?

No, “papillary urothelial carcinoma” is considered part of the standard low-grade urothelial carcinoma classification and should not be categorized as a variant histology. Variant histologies refer to the subtypes of squamous cell, sarcomatoid, plasmacytoid, adenocarcinoma, micropapillary, and neuroendocrine / small cell carcinoma. Therefore “Other Variant Histology” should not be selected in this case.

When would “within 24 hours” time start post TURBT?

This would typically be after a patient leaves the OR, or once they arrive in recovery. It may depend what is documented.

Documentation Questions

What do we need to submit to let the CoC know we are participating? Where is it submitted?

You do not need to let the CoC know ahead of time if you are participating in this QI project. Documentation indicating your participation will be given to you by the end of the year and you will upload an attestation form certifying your full participation by December 2026. You will need to provide status updates/documentation in meeting minutes programs progress to the cancer committee. It is encouraged that you complete the 7.3 reporting template, but is not required.

What happens if we begin participation but leave the project early?

If you leave the project before all data cycles have been submitted and all cohort calls have been conducted, you will need to identify a different QI project for the year and will not receive credit for participation. You will need to follow all requirements of the 7.3 QI standard.

Accreditation Credit for Participation

Is this project available for programs undergoing initial accreditation?

Yes, we encourage participation by programs working toward their first accreditation as long the application for accreditation has been submitted and an ID number has been issued. This will be a Facility Identification Number (FIN). This Identification Number is a required field in the initial Intent to Participate.

May participation be used to satisfy deficiency resolution?

Yes, participation in this project and completing requirements may be counted toward a deficiency resolution for standard 7.3. It may not be applied to an unrelated standard.

Do we need to complete the template for Standard 7.3?

No. You simply need to upload the attestation form at the end of the calendar year. This form is sent out by cancerqi@facs.org following receipt of all data cycles. It is strongly encouraged you also save copies of the data you submitted and any other QI worksheets, RCA documents, or correspondence from the project. These will need to be uploaded to demonstrate your 2026 compliance in your Pre-Review Questionnaire (PRQ) during the year of your next site visit. Although sites do not need to complete the template, they may find it beneficial for summarizing the project and tracking the updates to the cancer committee

For network (INCP/NCIN) programs, is this project done at the network parent level? Or must it be done at each of the children?

For Network Accreditations (INCP/NCIN) this project is done at the child level only. A second QI project including all sites would need to be done.

