Timely Administration post TURBT (TApT)

2026 Cancer Programs National QI project

Agenda

- Welcome
- Project Overview and Goals
- Project Process
- Process Map and Other QI Packet Components
- Data Collection Strategies
- Final Logistics
- Q and A

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Housekeeping:

- Please mute yourself

- We will email slides to all who registered
  - Slides and recording will be posted to the project website
  - Video 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-national-quality-improvement-project/
  - Google “TApT QI”

Project Overview and Goals

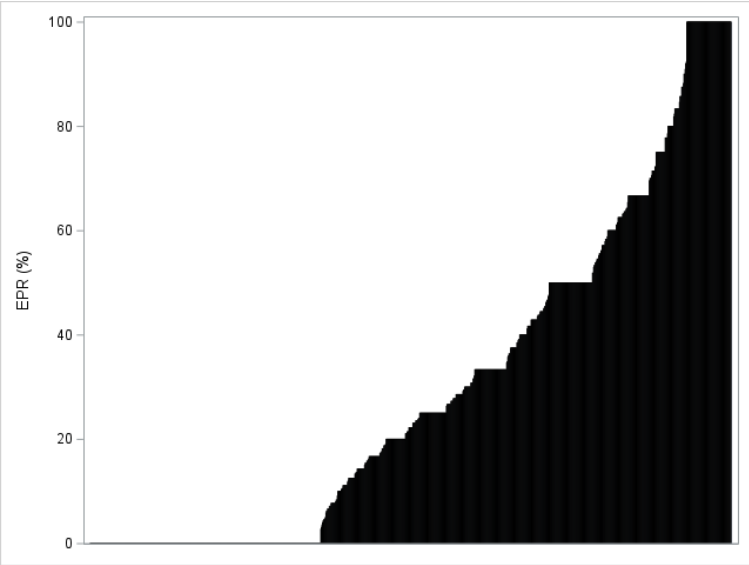
- Bladder cancer is the sixth most commonly diagnosed cancer in the US
- Most patients have non-muscle invasive blader cancer (NMIBC)
  - Characterized by:
    - High recurrence rates
    - High surveillance burden
    - Risk for progression

1.DeGeorge KC, Holt HR, Hodges SC. Bladder Cancer: Diagnosis and Treatment. *American family physician*. 2017;96(8):507-514.

- Multiple RCTs have shown decreased recurrence with single dose intravesical chemotherapy (IVC) immediately after TURBT for Low-Grade NMIBC
  - Thought to kill circulating tumor cells after resection
  - Main Agents:
    - Gemcitabine
    - Mitomycin
- American Urological Association (AUA), Society of Urologic Oncology (SUO), and NCCN guidelines all recommend single dose chemo post TURBT for low grade disease
- IVC post TURBT decreases recurrence by 33% in all NMIBC, and by 47% in Low Grade Ta NMIBC

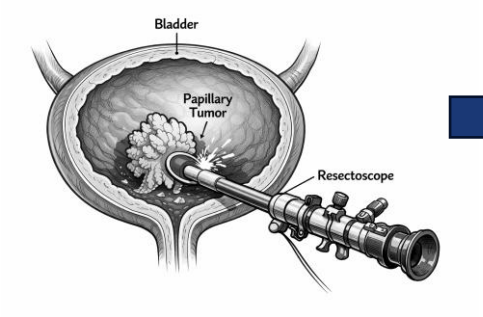
Measure	Measure Abbreviation
For patients with low grade Ta bladder cancer undergoing transurethral resection of bladder tumor, intravesical chemotherapy* is initiated within 24 hours of the procedure, or recommended. *chemotherapy within 24 hours of the transurethral resection assumed to be intravesical however the NCDB does not differentiate this from systemic chemotherapy	BLCT1

Compliance	#/% of hospitals
1-10%	9 (2.79%)
11-25%	86 (26.63%)
26-50%	103 (31.89%)
51-75%	34 (10.53%)
76-90%	12 (3.72%)
91-100%	79 (24.46%)



Why is the eligibility criteria different than BLCT1?

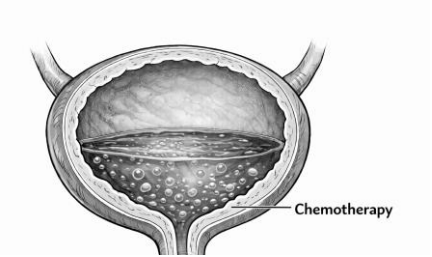
Answer is within the treatment journey



TURBT

Criteria for intravesical chemo

1. No perforation or excessive bleeding
2. Non-invasive ***appearing*** tumor
3. Visually complete resection
4. No history of invasive high-grade tumors



Intravesical Chemotherapy

Pathology is not available until after the treatment decisions are made…

Eligibility Criteria: <u>At least one of the following:</u>

- Primary bladder tumor
- Recurrent tumor, prior history Ta urothelial cell carcinoma
- Limited tumor burden amenable to complete resection
- No strong suspicion for muscle invasion

Project Goals

Programs will achieve a >20% increase of individual baseline, or at least 75% compliance with intravesical chemotherapy after TURBT for eligible patients

- Improve the quality of cancer care and patient outcomes by accomplishing delivery of intravesical chemotherapy within 24 hours of the procedure.
- Assist programs to identify root cause challenges in achieving compliance.
- Develop a standardized way for programs to assess and monitor their compliance.
- Identify and implement successful and sustainable solutions.
- Support participating programs to achieve greater than 20% increase of individual baseline or reach 75% compliance

Project Process

Timeline

Date	Event
November 14, 2025 11am CT	Informational webinar, Intent to participate survey opens (via project website)
Feb 15, 2026	Intent to participate survey support due (HERE)
March 13, 2026 11am CT	Collaborative call Overview of project QI and process mapping, root cause case study
April 30	Baseline Collection data due (eligible patients March 1-May 31, 2024) Pre-Survey due (sent via REDCap to primary contact) Letter of Support DUE with first REDCap Survey; template on project website Data submission examples and case study videos released
March-May	Programs complete process map, identify root causes
June 30	Collection 2 data due (eligible patients March 1- May 31 2026) Current state process map DUE (details on submission forthcoming)
June-August	Programs develop interventions based on root cause; develop a future state map
August 14, 2026 11am CT	Collaborative call 2
August 31	Mid Year survey due (sent via REDCap to primary contact)
September 30	Collection 3 data due (eligible patients June 1-August 31, 2026)
September-November	Programs implement interventions
November 13, 2026	Collaborative Call 3
December 31	Collection 4 data due (eligible patients Sept 1-Nov 30, 2026) Final Survey Due

TApT QI Packet

- **TApT Instructions** – Your guiding document for the project
- **TApT Questionnaire** – please fill this in over the course of the 3 phases of the QI project
- **Process Map Overview** – example of global process map for IVC administration post TURBT
- **Process Map Worksheet** – Worksheet to be filled in in review of process map
- **PACU Process Map** – reference of sample process map for IVC administration in the PACU
- **Synoptic reporting template (TURBT)** – sample synoptic report template for operative report documentation of TURBT procedures
- **ACS TApT Fast Facts** – useful information for raising awareness associated to benefits of IVC after TURBT, and BLCT1 specifically

TApT Questionnaire – Do this ASAP (but by April 30)

Tier 1: Readiness Assessment

These questions assess elements that our experts consider ***essential*** for delivering post-TURBT IVC

Tier 2: Process Standardization

These steps are ***recommended*** for successful and high compliance in administration of post-TURBT IVC

Tier 3: Process Optimization

This section focuses on ***suggested*** processes to consider that enhance efficiency and documentation.

TApT Questionnaire – Example

- **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.
    - Confirmed
    - Unable to confirm: Reason: _____

- **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.
    - Confirmed
    - Unable to complete: Reason: _____

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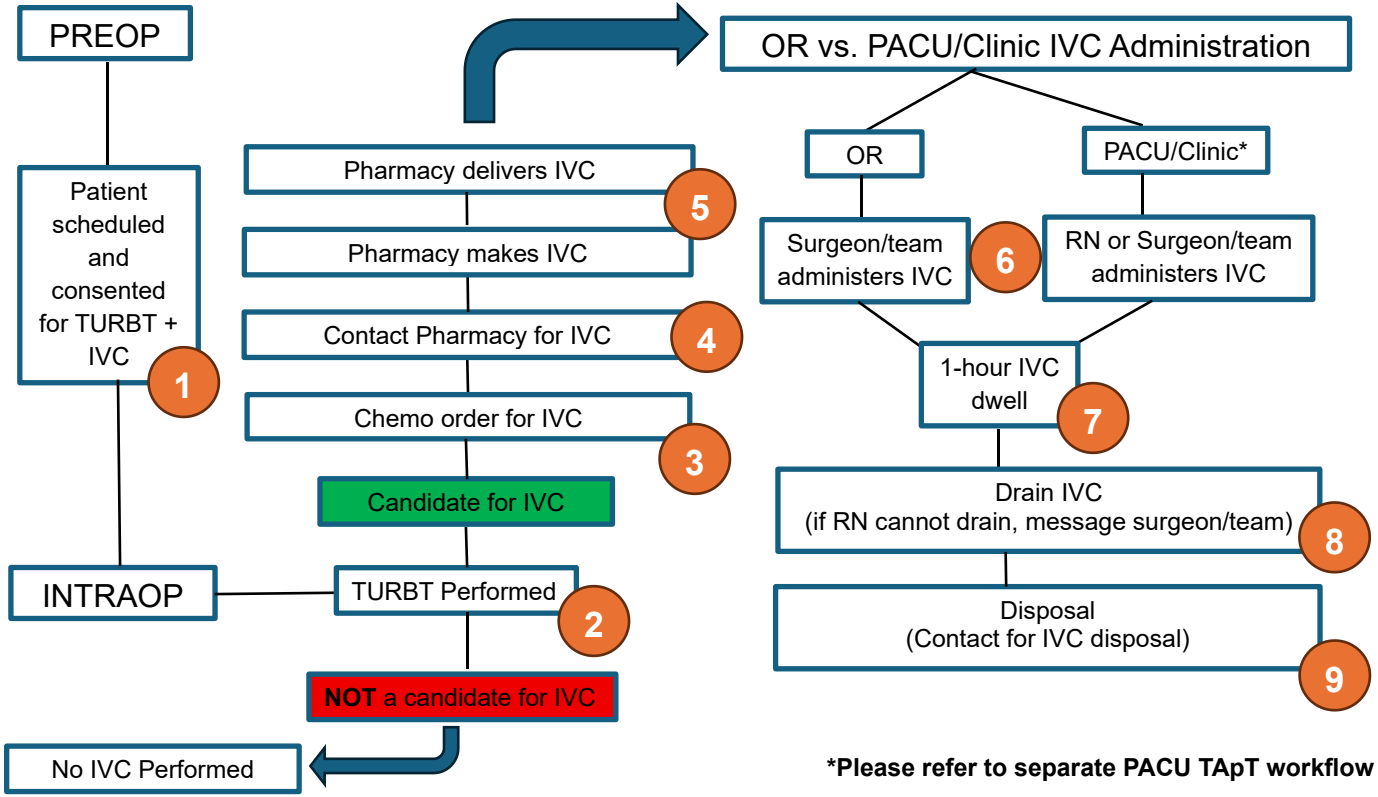
Process Map and Other QI Packet Components

TApT (Timely Administration post-TURBT) Process Map – Streamlining Administration of Intravesical Chemotherapy (IVC)



***Please refer to separate PACU TApT workflow**

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Process Step 1

Patient Scheduling and Consent

What Occurs

- Patient scheduled for TURBT.
- Anticipated need for postoperative intravesical chemotherapy discussed.
- Informed consent obtained for:
  - TURBT
  - Intravesical chemotherapy administration
- Documentation completed prior to surgery when feasible.

Potential Locations

- Urology clinic
- Preoperative clinic
- Surgical scheduling office
- Preop area

Potential Responsible Individuals

- Urologist
- Resident
- Advanced Practice Provider (APP)
- Clinic nurse
- Surgical scheduler

Site Task Considerations:

- When chemotherapy consent occurs (clinic vs day of surgery)
- How eligibility anticipation is communicated to OR/postoperative teams.

Process Step 2	Evaluation for Intravesical Chemotherapy Candidacy

What Occurs

- Assessment of eligibility based on:
  - Suspected NMIBC
  - Tumor characteristics
  - Patient clinical status
- Intraoperative reassessment after TURBT:
  - Completeness of resection
  - Absence of perforation
  - Hemostasis

Potential Location

- Operating room (Hospital, ASC)
- Post-anesthesia care unit (PACU)

Potential Responsible Individuals

- Operating surgeon
- Surgical team
- Recovery nurse (verification)

Site Task Considerations:

- Who makes the final eligibility decision.
- Whether candidacy is standardized or surgeon dependent.

TApT (Timely Administration post-TURBT) – Task List and Contacts for Key Personnel

Process Map Worksheet

Process Step		Location of Action	Responsible Roles/Individuals	Facilitators and Barriers
1	Patient Scheduling and consent			
2	Evaluation for IVC candidacy			
3	Ordering of IVC			
4	Chemotherapy Preparation			
5	Chemotherapy Delivery			

TApT – PACU Intravesical Chemotherapy (IVC) Workflow

Patient received in PACU

Document urine color

Message surgeon/team picture of urine if Grade III or higher

Urine NOT appropriate for IVC

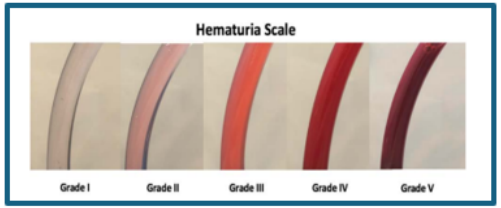
Contact pharmacy to cancel IVC

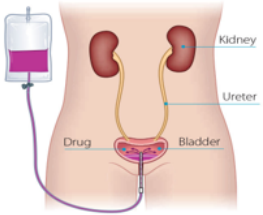
Urine appropriate for IVC

Don chemotherapy PPE

1) If CBI running, stop CBI
2) Instill IVC
3) Clamp catheter

Plan for 1-hour instillation (or different duration if otherwise indicated)





Remove Foley and discard appropriately

Change Foley bag and resume CBI, if necessary

NO

YES

Is patient discharging with Foley?

Document post-drainage urine color

Refer to general process map for RN vs. surgeon drainage and IVC disposal

Message surgeon if:

- Pain
- Abdominal cramping
- Allergic reaction
- Failure of drainage after completion

Synoptic Op report

Synoptic Reporting:

Findings:

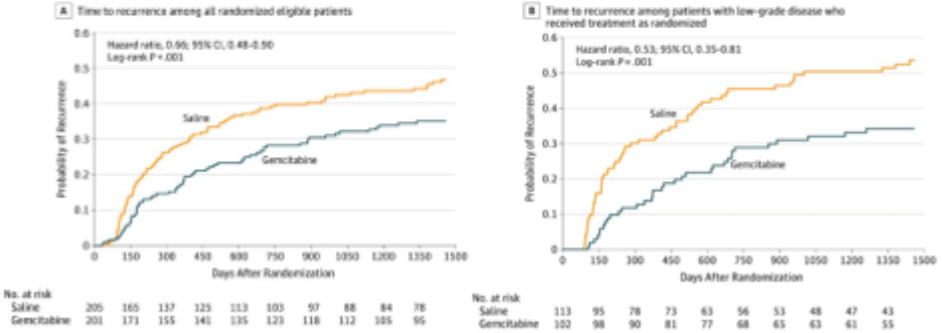
1. Location of main tumor:
   - ☐ Anterior
   - ☐ Posterior
   - ☐ Trigone
   - ☐ Lateral
   - ☐ Left
   - ☐ Right
2. Prostate or urethra involved?
   - ☐ Yes – urethra
   - ☐ Yes – prostate
   - ☐ No
3. Total tumor volume:
   - ☐ <0.5cm
   - ☐ 0.5cm – 2cm
   - ☐ 2cm – 5 cm
   - ☐ > 5 cm
4. Multifocal:
   - ☐ Yes
   - ☐ No
5. Ureteral orifice involved/resected:
   - ☐ No
   - ☐ Yes – left
   - ☐ Yes – Right
   - ☐ Stent placed
6. Entirety of grossly visible tumor resected:
   - ☐ Yes
   - ☐ No
   - ☐ Likely but recommend repeat TURBT
7. Concerning for likely Muscle Invasive disease
   - ☐ Yes
   - ☐ No
8. Erythema suspicious for CIS present?
   - ☐ Yes
   - ☐ No
9. Muscle included in specimen
   - ☐ Yes
   - ☐ No
10. Concern for deep resection
    - ☐ No
    - ☐ Yes
11. Intravesical chemotherapy to be given
    - ☐ Yes
    - ☐ No due to following reason:
      - ☐ IVC not available
      - ☐ Patient refusal
      - ☐ Physician preference
      - ☐ Concern for deep resection
      - ☐ Concern for muscle invasive disease
      - ☐ Prior history or concern for CIS or high-grade disease
      - ☐ Need for further resection
      - ☐ Significant hematuria
      - ☐ Allergy or other patient contraindication
      - ☐ Other: _____
12. Highest prior pathology:
    - ☐ First time TURBT, no prior pathology
    - ☐ Prior pathology not available
    - ☐ LG
    - ☐ HG
    - ☐ CIS
    - ☐ Ta
    - ☐ T1
    - ☐ T2+
    - ☐ Variant histology

ACS Fast Facts Informational Sheet

FAST FACTS: Intravesical Chemotherapy After TURBT & BLCT1 Quality Measure

Why Intravesical Chemotherapy Matters After TURBT

- Bladder cancer is the 6th most commonly diagnosed cancer in the United States, and most patients present with non-muscle invasive bladder cancer (NMIBC).
- NMIBC is characterized by high recurrence rates, significant surveillance burden, and risk of progression.
- Multiple randomized clinical trials demonstrate that a single postoperative dose of intravesical chemotherapy reduces tumor recurrence, most notably the RCT SWOG S0337 showed a **34% decrease in recurrence** in all patient who received gemcitabine vs saline, **and 47% decrease in recurrence** for low-grade disease (see figures from referenced paper)
- Guidelines from the AUA, SUO, and NCCN recommend a single perioperative dose (within 24 hours) for eligible low-grade NMIBC patients.
- Common agents include gemcitabine and mitomycin.



What is the BLCT1 Measure?

- BLCT1 is a Commission on Cancer (CoC) quality measure evaluating delivery of intravesical

Data collection

Changes to Data Collection Strategy

- Collecting data via REDCap instead of cancer registry software via RCRS
- Ta or T1
- NO changes to BLCT1- Submit via Cancer Registry Software to RCRS as always

	Eligible Patients	Data Due
Baseline	March 1-May 31 2024	~~March 31~~ **April 30**
Collection 2	March 1-May 31, 2026	June 30
Collection 3	June 1-August 31, 2026	Sept 30
Collection 4	Sept 1-Nov 2026	Dec 31

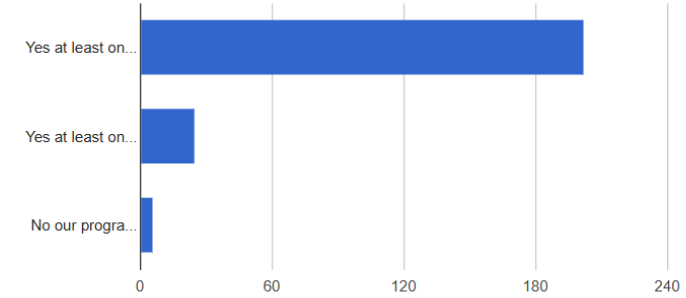
Final logistics

Who is participating?

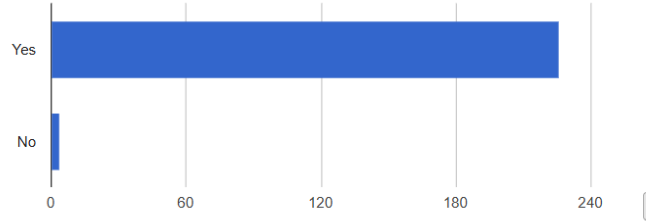
N=232

- Program location
  - South- 79
  - Midwest- 57
  - Northeast-55
  - West- 41
- Program Type
  - CCCP- 79
  - INCP-57
  - ACAD-44
  - Others: 52

Does your program have a urologist on staff?



Does your program have an on-site pharmacy



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

Q and A

Final Reminders

- Data Collection will be sent to the primary contact on Monday, March 16
  - Due April 30
- Email Letters of Support to cancerqi@facs.org by April 30th (Template on project website)
- Begin current state process maps

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