Timely Administration post-TURBT (TApT)
National Quality Improvement Project

Sponsored by the ACS Cancer Programs

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Introduction

Thank you for your participation in the 2026 American College of Surgeons National Quality Improvement Project! The Timely Administration post-TURBT (TApT) National Quality Improvement Project is a national collaborative sponsored by the American College of Surgeons (ACS) Cancer Programs designed to improve delivery of postoperative intravesical chemotherapy (IVC) following transurethral resection of bladder tumor (TURBT). TApT focuses on improving performance on the Commission on Cancer (CoC) quality measure **BLCT1**, which evaluates:

"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."

This evidence-based intervention has been shown to reduce tumor recurrence in non–muscle invasive bladder cancer, yet national utilization remains low despite strong guideline support and inclusion as a national quality metric. **However, it is important to emphasize that while the TApT QI Project is designed to improve BLCT1 performance, the inclusion criteria for this initiative is not limited to only LG Ta disease as that is information only available post-intervention when pathology returns. Specifically, the eligibility criteria is as follows:**

Eligibility Criteria: **At least one of the following:**

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

Your hospitals will engage in a structured, year-long quality improvement collaborative aimed at identifying local barriers to timely chemotherapy administration and implementing sustainable workflow solutions. The project emphasizes practical implementation rather than education alone, recognizing that gaps in performance often arise from system-level challenges such as OR workflow, pharmacy coordination, postoperative care processes, and communication among multidisciplinary teams.

Through participation in TApT, hospitals will:

- Analyze institutional performance related to BLCT1
- Identify root causes limiting compliance
- Develop and test workflow improvements
- Monitor progress using standardized national reporting

Participating programs will receive guidance from ACS Cancer Programs and national clinical experts while collaborating with peer institutions facing similar operational challenges. The overall goal is for each participating site to achieve a **≥20% improvement from baseline performance or sustained high compliance**, resulting in improved quality of bladder cancer care and reduced recurrence risk for patients nationwide.

Process Mapping Instructions

The purpose of this project is to help participating sites systematically evaluate and optimize the delivery of post-TURBT intravesical chemotherapy (IVC) by mapping the complete clinical workflow required for safe and reliable administration. As a general guide, we have divided the process into nine suggested steps, although your institution may customize as necessary.

Each site should analyze its institutional process across the nine steps outlined below, identifying:

- What occurs at each step
- Where the step occurs
- Who is responsible at this step
- Barriers or delays affecting delivery

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.

Please review and edit the **Process Map Overview** document to reflect the workflow at your institution and then fill in the **Process Map Worksheet**. Each site should analyze its institutional process across the nine or so steps outlined below.

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.

Process Step 3

Ordering of Intravesical Chemotherapy

What Occurs

- Chemotherapy order entered into EMR or paper order processed
- Drug selection, dose, and timing specified.
- Pharmacy notification triggered.

Potential Location

- Operating room
- PACU
- Preoperative in clinic

Potential Responsible Individuals

- Surgeon
- Resident
- OR circulating nurse (verification)
- PACU nurse (order confirmation)

Site Task Considerations:

- When the order is placed.
- Whether standardized order sets exist.
- Backup process if order is delayed.

Process Step 4

Chemotherapy Preparation

What Occurs
- Pharmacy receives order.
- Medication compounded under hazardous drug protocols.
- Drug labeled and transported safely.

Potential Location
- Pharmacy sterile compounding area
- Hazardous drug preparation facility

Potential Responsible Individuals
- Oncology pharmacist
- Pharmacy technician

Site Task Considerations:
- Average preparation time.
- Process for 2-way communications if issues / changes in plan

Process Step 5

Chemotherapy Delivery to Clinical Area

What Occurs
- Prepared chemotherapy transported to administration site.
- Chain-of-custody maintained.
- Medication receipt confirmed.

Potential Location
- OR
- PACU
- Same-day surgery unit

Potential Responsible Individuals
- Pharmacy courier
- Receiving nurse
- Charge nurse

Site Task Considerations:
- Medication handoff process.
- Storage procedures pending administration.

Process Step 6

Administration to Patient

What Occurs
- Foley catheter confirmed or placed.
- Bladder drained.
- Intravesical chemotherapy instilled via catheter.
- Catheter clamped or removed per protocol.

Potential Location
- Operating room
- PACU
- Ambulatory recovery area

Potential Responsible Individuals
- Urologist
- PACU nurse
- Trained chemotherapy-certified nurse

Site Task Considerations:
- Who administers chemotherapy: Required staff certification or training.

Process Step 7

Management During IVC Dwell Time

What Occurs
- Medication retained in bladder (typically 60–90 minutes).
- Patient monitored for:
  - Leakage
  - Discomfort
  - Vital sign instability
- Patient repositioning if required.

Potential Location
- PACU
- Recovery unit
- Ambulatory surgery area

Potential Responsible Individuals
- PACU nurse
- Recovery nursing staff

Site Task Considerations:
- Monitoring protocol.
- Responsibility for dwell-time tracking.

Process Step 8

Drainage of Intravesical Chemotherapy

What Occurs
- Catheter unclamped or bladder drained.
- Chemotherapy evacuated safely.
- Exposure precautions followed.

Potential Location
- PACU
- Recovery unit restroom or drainage system

Potential Responsible Individuals
- Surgeon
- Resident
- Chemotherapy-trained nurse
- Recovery staff

Site Task Considerations:
- Drainage method.
- Personal protective equipment (PPE) requirements.

Process Step 9

Disposal of Chemotherapy

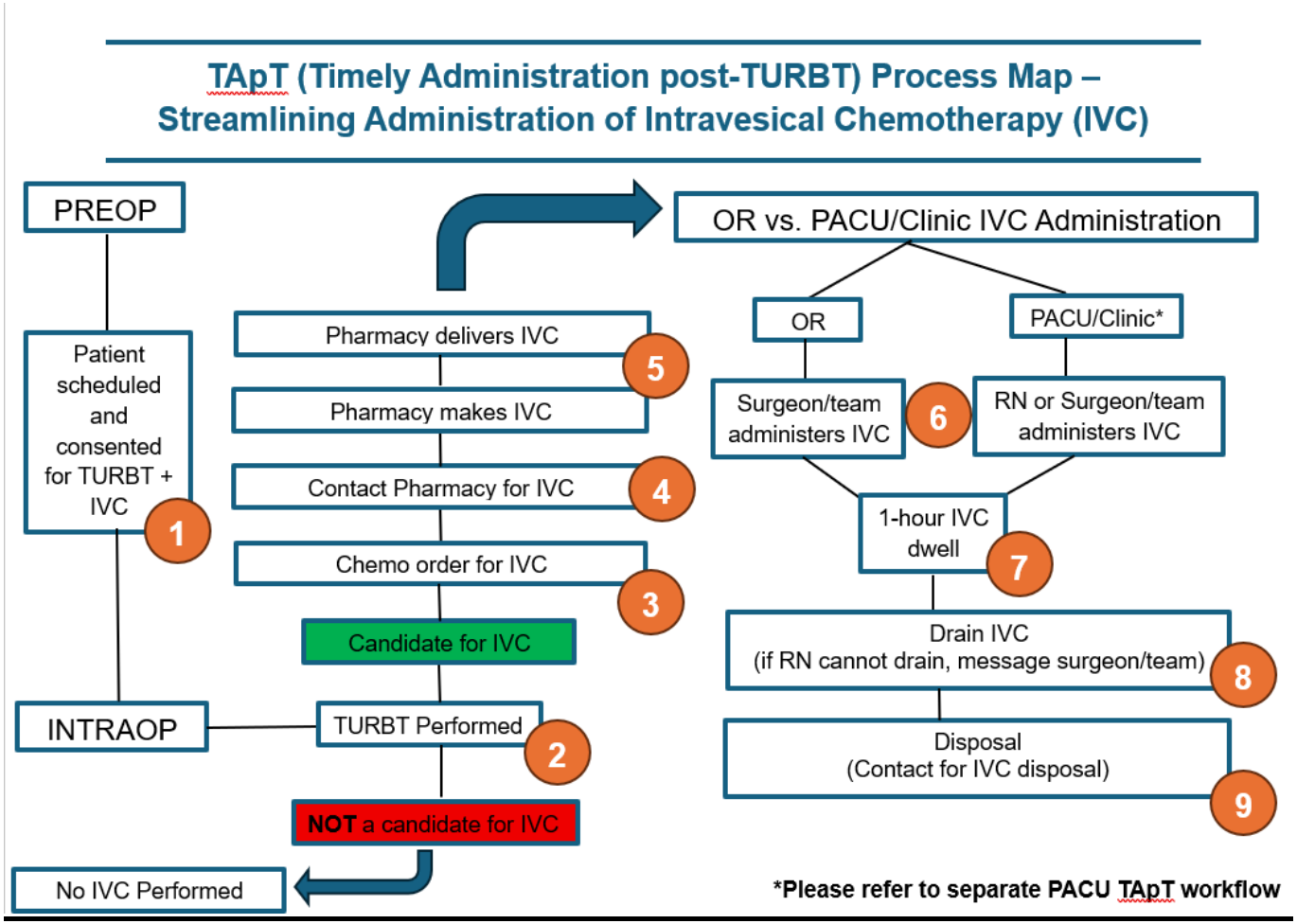
What Occurs
- Hazardous waste disposal per institutional policy.
- PPE discarded appropriately.
- Documentation completed.

Potential Location
- Hazardous waste disposal area
- Patient care unit

Potential Responsible Individuals
- Nursing staff
- Environmental services
- Pharmacy oversight (policy level)

Site Task Considerations:
- Waste handling procedures.
- Compliance with hazardous drug regulations.

Process Map Overview



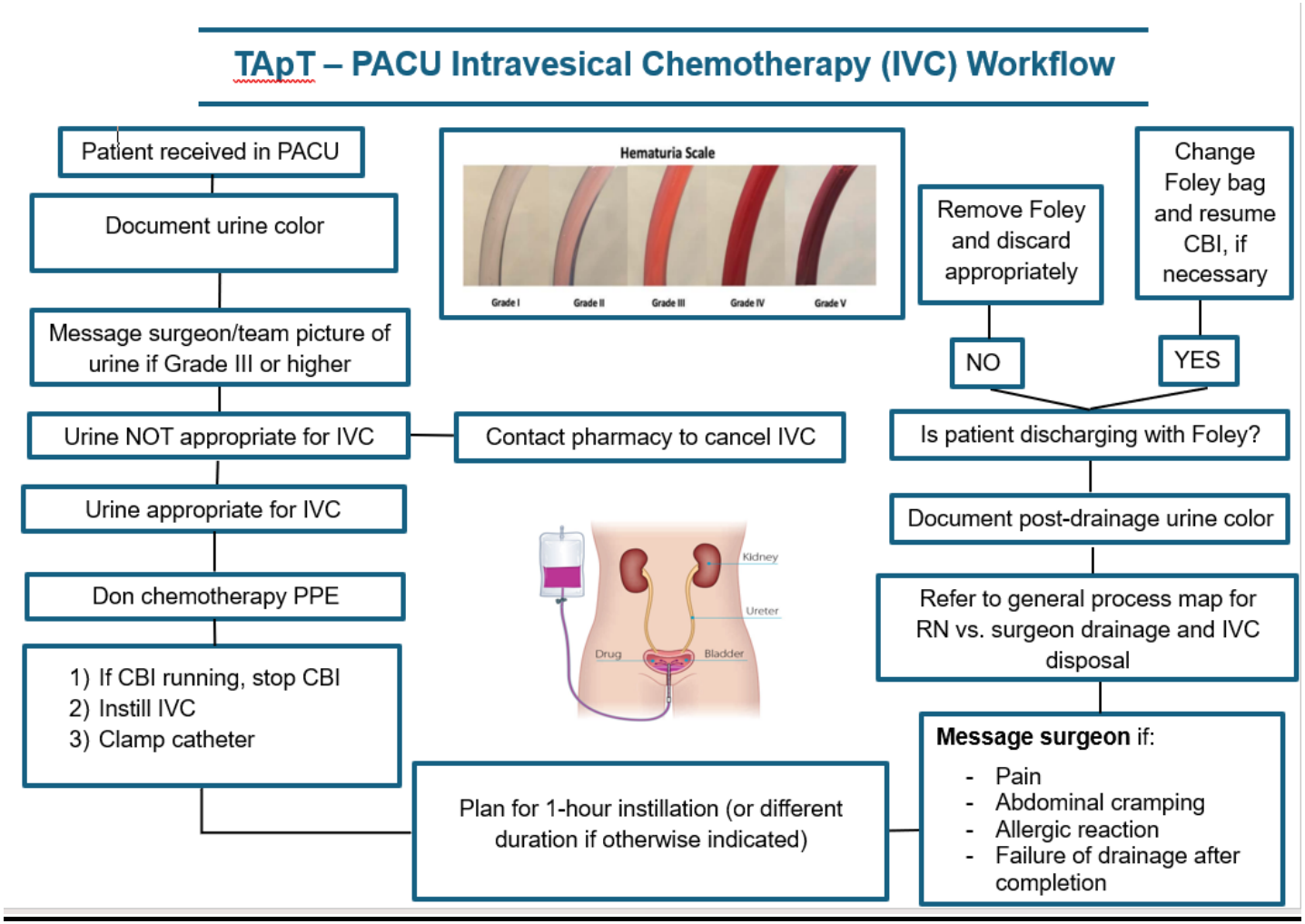
Process Map Worksheet - Example

Process Step		Location of Action	Responsible Roles/Individuals	Facilitators and Barriers
1	Patient Scheduling and consent	Clinic	Urologist – Dr. Smith Physician Assistant – PA Smith Secretary – Sam Smith	F: Pt is consented preop B: Paper consent sometimes gets lost
2	Evaluation for IVC candidacy	OR	Urologist – Dr. Smith	B: No standardized criteria agreed upon by team
3	Ordering of IVC	OR	Urologist or Resident – Dr. Smith or Anderson	B: Order form not always easy to find
4	Chemotherapy Preparation	Chemo Pharmacy	Pharmacy contact: 555-867-5309	F: Gemcitabine can be preordered B: Chemo hood not always immediately available
5	Chemotherapy Delivery	Chemo Pharmacy to PACU	Pharmacy courier: Paging contact	B: Courier unpredictably available
6	Administration to patient	PACU	Some PACU Nurses Resident: Paging contact	F: XYZ Nurse is trained and can administer B: Resident has to be paged when XYZ not available
7	Management of patient during IVC dwell	PACU	PACU Nursing: PACU Nurse Manager Smith	F: Education of management has been disseminated to whole PACU team
8	Drainage of IVC	PACU	Resident: Paging contact	B: Resident often busy when IVC needs to be drained
9	Disposal of chemotherapy	PACU	PACU Nursing Environmental Services	F: Fairly established already

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			
6	Administration to patient			
7	Management of patient during IVC dwell			
8	Drainage of IVC			
9	Disposal of chemotherapy			

PACU Process Map



Process readiness and optimization questionnaire instructions

This TApT questionnaire document is intended to help identify potential quality improvement targets for post-TURBT intravesical chemotherapy (IVC). It is not exhaustive; your institution may have additional barriers that are not captured here. The items below highlight core features of an efficient, guideline-concordant IVC program. You will complete these questions once at the beginning of the QI initiative, and again at the conclusion of the QI initiative to understand where your program has made growth or changes.

Tier 1: Readiness Assessment

These questions assess elements that our experts consider ***essential*** for delivering post-TURBT IVC and will be required to participate in this study, with an emphasis on the structural components required for chemotherapy delivery. If your institution answers **"No"** to any Tier 1 item, focus improvement efforts there before moving on to Tier 2. These steps are required for successful administration of post-TURBT IVC.

Tier 2: Process standardization

This section addresses key processes that support consistent and efficient post-TURBT IVC delivery. Addressing these items should help ensure that most eligible patients receive IVC. If your institution answers **"No"** to any Tier 2 item, prioritize these before proceeding to Tier 3, when feasible. The goal will be to optimize these components ideally with some lessons learned from the baseline and Collection 2 rounds of data collection. These steps are ***recommended*** for successful and high compliance in administration of post-TURBT IVC.

Tier 3: Practice optimization

This section focuses on ***suggested*** processes to consider that enhance efficiency and documentation. These items are not strictly required for IVC delivery but can further streamline care and improve record-keeping. The decision to implement and optimize these areas will be institution specific. The goal will be to optimize this component by the end of data collection round 3 so that impact on data collection round 4 can be observed. While optional, these steps are supportive of high-achieving programs in post-TURBT administration of IVC.

Process Readiness and Optimization Questions

Tier 1: Readiness assessment

1. **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: _____

2. **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: _____

3. **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?
   - Confirmed
   - Unable to complete: Reason: _____

4. **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?
   - Consent within TURBT consent
   - Separate IVC consent
   - Other consent process: _____

5. **Team Education**
   Members of the healthcare team that are involved with decision-making and facilitation of intravesical chemotherapy after TURBT are aware of the disease-specific benefits to eligible patients of this intervention. Has your site discussed the rationale and benefits of this intervention with participants? Consider distribution of the **ACS TApT Fast Facts** document on this topic.
   - Confirmed
   - Unable to complete: Reason: _____

Tier 2: Process standardization

6. **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?
   - 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

7. **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?
   - 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

8. **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
   - Attending surgeon
   - Anesthesia team
   - Residents
   - Nurses
   - Pharmacists
   - Other: _____

9. **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
   - Not performed prior to or during QI project

Tier 3: Practice optimization

10. **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.
    - 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

11. **Nurse-directed PACU administration policy**
    There is a PACU nurse-directed administration protocol (standing orders from the MD and a process algorithm) that allows nurses to proceed with IVC when a template order was placed by the MD preoperatively and predefined criteria are met, without needing new individual orders each time.
    - Already available prior to QI initiative
    - Not established prior, but nurse-directed IVC administration implemented as part of QI project
    - Not performed prior to or during QI project

12. **Pre-ordering of IVC**
    For IVC-eligible patients, intravesical chemotherapy is routinely pre-ordered (e.g., at the pre-op visit or before the case) so that drug preparation and delivery are not delayed after TURBT. Has your institution started pre-ordering or streamlining order placement for IVC-eligible patients undergoing TURBT
    - Already available prior to QI initiative
    - Not established prior, but pre-ordering protocols implemented as part of QI project
    - Not performed prior to or during QI project

13. **After hours drug delivery**
    There is a process in place for delivering intravesical chemotherapy for after-hours or weekend TURBT cases (or a clearly defined plan for how these cases are handled).
    - Already available prior to QI initiative
    - Not established prior, but after-hours drug availability implemented as part of QI project
    - Not performed prior to or during QI project

14. **Data capture**
    Training has been provided to billers and institutional oncology data specialists to reliably capture IVC delivery.
    - Already available prior to QI initiative
    - Not established prior, but implemented as part of QI project
    - Not performed prior to or during QI project

Ongoing Data Collection- Sample

Check the below box if you have no cases to enter for this time period	◯ No cases to enter
Patient Accession Number, if available; If unavailable, leave blank)	_____
Patient birthdate (Year only)	_____
Race	☐ White ☐ Black ☐ American Indian, Aleutian, or Eskimo ☐ Chinese ☐ Japanese ☐ Filipino ☐ Hawaiian ☐ Korean ☐ Vietnamese ☐ Laotian ☐ Hmong ☐ Kampuchean (including Khmer and Cambodian) ☐ Thai ☐ Asian Indian or Pakistani, NOS (formerly code 09) ☐ Asian ☐ Indian ☐ Pakistani ☐ Micronesian, NOS ☐ Chamorran ☐ Guamanian, NOS ☐ Polynesian, NOS ☐ Tahitian ☐ Samoan ☐ Tongan ☐ Melanesian, NOS ☐ Fiji Islander ☐ New Guinean ☐ Other Asian, including Asian, NOS and Oriental, NOS ☐ Pacific Islander, NOS ☐ Other ☐ Unknown
Sex	◯ Female ◯ Male
Occurrence	◯ Primary ◯ Recurrent tumor

Highest prior pathology (select all that apply)	☐ First time TURBT, no prior pathology ☐ Prior pathology not available ☐ LG ☐ HG ☐ CIS ☐ Ta ☐ T1 ☐ T2+ ☐ Variant histology
Date-Intravesical chemotherapy administered (D-M-Y) (skip if not administered)	_____
Location intravesical chemotherapy administered	◯ Hospital ◯ Ambulatory care setting ◯ Other (please specify) ◯ Unknown ◯ Not administered
Other: Please specify	_____
Postoperative intravesical chemotherapy used	◯ None ◯ Gemcitabine ◯ Mitomycin ◯ Other ◯ Unknown
If not administered, why wasn't ICV administered within 24 hours of procedure?	☐ Insurance issues ☐ Patient refused ☐ Patient complications (perforation, bleeding) ☐ Physician preference ☐ Not indicated due to disease extent (prior CIS or high grade, concern for muscle invasive disease, incomplete resection) ☐ Chart note incomplete; unable to confirm it was received ☐ No documented reason for non-administration of IVC ☐ Chemotherapy not available ☐ Other (please specify)
Other: Please specify	

The below data items are most likely found in the operative note	
Date- Transurethral resection performed (D-M-Y)	_____
Location Transurethral resection performed	◯ Hospital ◯ Ambulatory Care Setting ◯ Other (please specify) ◯ Unknown
Other: Please specify	_____
Total tumor size on op report	◯ < 0.5cm ◯ 0.5cm - 2cm ◯ 2cm - 5 cm ◯ > 5 cm ◯ Unknown
Multifocal	◯ Yes ◯ No ◯ Unknown
Involvement of urethra or prostate:	◯ Yes ◯ No ◯ Unknown
Entirety of grossly visible tumor resected:	◯ Yes ◯ No ◯ Unknown
Ureteral orifice involved/resected:	◯ Yes ◯ No ◯ Unknown
If yes, was a stent placed?	◯ Yes ◯ No
Concern for possible muscle invasive disease	◯ Yes ◯ No ◯ Unknown
Documentation of any concern for perforation or deep resection	◯ Yes ◯ No

The below data items are most likely found in the pathology report	
Muscle included in a specimen	◯ Yes ◯ No
Final pathology from TURBT (select all that apply)	☐ No tumor seen ☐ Pathology not available ☐ LG ☐ HG ☐ CIS (carcinoma in-situ) ☐ Ta ☐ T1 ☐ T2 ☐ T3 ☐ T4 ☐ "Invasive" ☐ Sarcomatoid ☐ Micropapillary ☐ Squamous ☐ Small cell / Neuroendocrine ☐ Other variant histology
Total tumor size on path report	◯ < 0.5cm ◯ 0.5cm - 2cm ◯ 2cm - 5 cm ◯ > 5 cm ◯ Unknown

Synoptic Reporting:

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

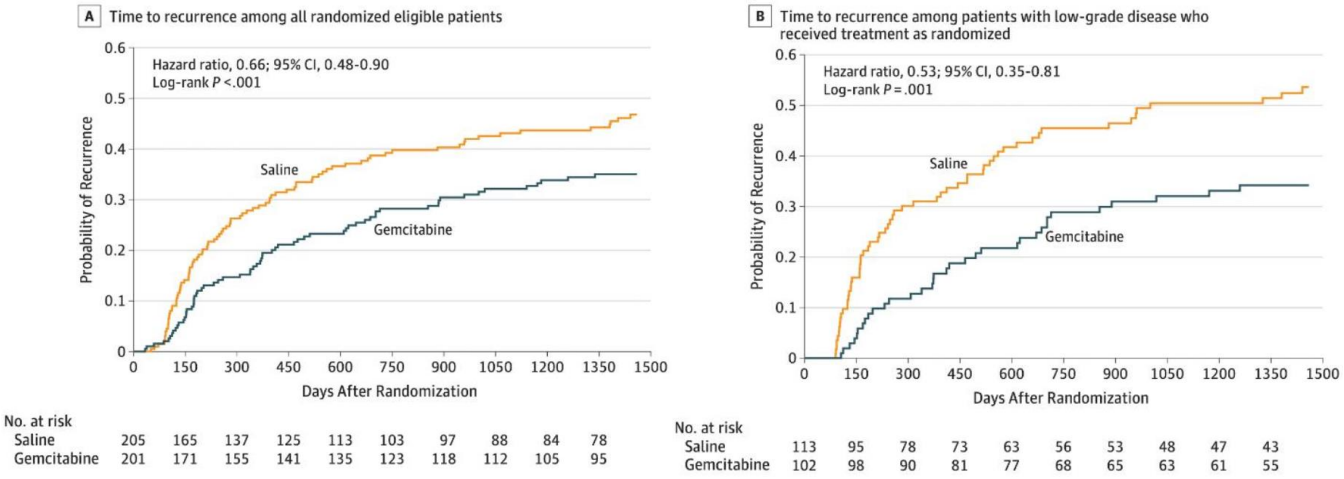
11. Intravesical chemotherapy to be given
    ☐ Yes
    ☐ No due to following reason:
        ☐ IVC not available
        ☐ Patient refusal
        ☐ Physician preference
        ☐ Concern for deep resection
        ☐ Concern for muscle invasive disease
        ☐ Prior history or concern for CIS or high-grade 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 TApT Fast Facts

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 chemotherapy within 24 hours of TURBT.
- Despite Level 1 evidence and guideline endorsement, BLCT1 performance remains among the lowest of all CoC cancer quality measures.
- National estimated performance rates have remained low: ~25–30% compliance between 2019–2023.
- In 2023, 87.5% of CoC hospitals had <75% compliance, and 57% reported 0% delivery rates.

Messing EM, Tangen CM, Lerner SP, et al. Effect of Intravesical Instillation of Gemcitabine vs Saline Immediately Following Resection of Suspected Low-Grade Non– Muscle-Invasive Bladder Cancer on Tumor Recurrence: SWOG S0337 Randomized Clinical Trial. *JAMA : the journal of the American Medical Association*. 2018;319(18):1880-1888. doi:10.1001/jama.2018.4657

TApT Important Dates Checklist

Date	Event	Completed
March 13, 2026 11am CT	**Attend Collaborative Call**	
April 30	• Complete Pre-survey Questionnaire and Baseline data collection via REDCap (link emailed to primary contact April 1 or earlier) • Letter of Support DUE (email to cancerqi@facs.org)	
June 30	• Complete data collection 2 (link emailed to primary contact June 1 or earlier) • Current state process map DUE (details on submission forthcoming)	
August 14, 2026 11am CT	**Attend Collaborative Call**	
August 31	Complete mid project survey (sent via REDCap to primary contact Aug 1 or earlier)	
September 30	Complete data collection 3 (link emailed to primary contact Sept 1 or earlier)	
November 13, 2026	**Attend Collaborative Call**	
December 31	Complete final questionnaire and data collection 4 via REDCap (link emailed to primary contact Dec 1 or earlier)	

- If you need to change the name of the primary contact, please email cancerqi@facs.org
- PDF copies of data collection tools can be found on the project website