Transplant Administrative Survey

1. Provide the name and address of the institution or corporation responsible for the provision of transplant services.

Legal Name: _____

Name as appears on CIBMTR Center Specific Outcomes Report (if different):

_____

Street Address: _____

City: _____

State: _____ **Zip**: _____

Hospital Tax ID Number: _____

Program Clinical Director Email:

Program Administrative Director Email:

2. Are there transplant-associated clinical services being provided at locations other than the one named above? Yes ☐ No ☐

If yes, please explain:

3. Clinical programs available (mark all that apply):

Therapy Type	Adult	Pediatric
Allogeneic Matched Related		
Allogeneic Haplo Related		
Allogeneic Unrelated - PBSC		
Allogeneic Unrelated - Marrow		
Allogeneic Unrelated - Cord blood		
Autologous - Marrow		
Autologous - PBSC		
Autologous/Autologous Tandem		
Autologous/Allogeneic Tandem		

If services are provided to both adult and pediatric patients, indicate program type:

☐ Separate programs ☐ Combined program

4. Does your institution have the following facilities and services available either directly or via contract/referred services:

Special Inpatient and Outpatient Facilities:	**Yes**	**No**	**# Beds**
BMT Unit	☐	☐	
Medical Intensive Care Unit	☐	☐	
Surgical Intensive Care Unit	☐	☐	
Pediatric Intensive Care Unit	☐	☐	
Neurological Intensive Care Unit	☐	☐	
General Pediatric Unit	☐	☐	
BMT Clinic	☐	☐	
Home Health Transplant Nursing Specialists	☐	☐	
Are the following available 24 hours/day, 7 days/week at your institution?	**Yes**	**No**	
Anesthesiology	☐	☐	
Pathology	☐	☐	
Blood banking	☐	☐	
Renal dialysis	☐	☐	
Operating rooms	☐	☐	
Emergency clinical care	☐	☐	

If "no" to any of the above, please explain:

5. Are housing accommodations available for patient(s)/companion(s) throughout the treatment process? Yes ☐ No ☐

If yes, list and provide information:

Part A: General Information

A-1. Accreditation / certification*

	Current Accreditation	Effective Date		Applied for	Date
FACT – Clinical Program					
Adult Autologous	Yes ☐ No ☐	_____	or	Yes ☐ No ☐	_____
Adult Allogeneic	Yes ☐ No ☐	_____	or	Yes ☐ No ☐	_____
Pediatric Autologous	Yes ☐ No ☐	_____	or	Yes ☐ No ☐	_____
Pediatric Allogeneic	Yes ☐ No ☐	_____	or	Yes ☐ No ☐	_____
FACT – Collection Program	Yes ☐ No ☐	_____	or	Yes ☐ No ☐	_____
FACT – Cell Processing Program	Yes ☐ No ☐	_____	or	Yes ☐ No ☐	_____
FACT – Immune Effector Cell Program	Yes ☐ No ☐	_____	or	Yes ☐ No ☐	_____

NMDP	Approved	Date
Apheresis Donor Center	Yes ☐ No ☐	_____
Marrow Donor Center	Yes ☐ No ☐	_____
Transplant Center	Yes ☐ No ☐	_____

Cell Therapy Laboratory	Approved	Date
CAP	Yes ☐ No ☐	_____
CLIA	Yes ☐ No ☐	_____
AABB	Yes ☐ No ☐	_____

Medicare Provider	Yes ☐ No ☐
State-Sponsored Provider	Yes ☐ No ☐

***NOTE:** ASTCT does not warrant, guarantee, or endorse every accreditation/certification program listed above, and transplant and cell therapy centers need not obtain accreditation/certification from every program listed. Payers individually establish requirements for the inclusion of transplant centers in their networks.

A-2. Has the Autologous <u>Adult</u> Program been closed or suspended for any reason during the past 36 months?

Yes ☐ No ☐ Not applicable ☐

If yes, provide dates and explain:

Has the Autologous <u>Pediatric</u> Program been closed or suspended for any reason during the past 36 months?

Yes ☐ No ☐ Not applicable ☐

If yes, provide dates and explain:

Has the Allogeneic Adult Program been closed or suspended for any reason during the past 36 months?

Yes ☐ No ☐ Not applicable ☐

If yes, provide dates and explain:

Has the Allogeneic Pediatric Program been closed or suspended for any reason during the past 36 months?

Yes ☐ No ☐ Not applicable ☐

If yes, provide dates and explain:

A-3. How does the Program provide the following transplant-related services?

Mobilization therapy	☐ inpatient	☐ outpatient	☐ both
Marrow Harvest	☐ inpatient	☐ outpatient	☐ both
PBSC Apheresis	☐ inpatient	☐ outpatient	☐ both
Conditioning Regimens	☐ inpatient	☐ outpatient	☐ both
Marrow/Stem Cell Infusion	☐ inpatient	☐ outpatient	☐ both
Recovery	☐ inpatient	☐ outpatient	☐ both

A-4. Does the Program perform the following?

Donor leukocyte infusions	Yes ☐	No ☐
Cell purging	Yes ☐	No ☐
Photopheresis	Yes ☐	No ☐
T-cell depletion	Yes ☐	No ☐
Double cord blood transplants (cord blood units infused separately)?	Yes ☐	No ☐
Pooled cord blood transplants (cord blood units combined for infusion)?	Yes ☐	No ☐

Does the Program have any protocols that involve planned tandem/multiple cycles of high dose chemotherapy followed by hematopoietic stem cell infusion:

Autologous / Autologous	Yes ☐	No ☐
Autologous / Allogeneic (ablative or non-myeloablative)	Yes ☐	No ☐
Other planned multiple sequential infusions of autologous stem cells	Yes ☐	No ☐

A-5. Number of Patients Receiving Planned Tandem/Sequential Transplants

Tandem transplant is defined as receiving two cycles of chemotherapy (high dose or immunosuppressive) with progenitor cell support. The second course of therapy and stem cell infusion is planned in advance, at the time of planning for the first course of therapy and stem cell infusion. Report the patient in the year in which the **first** transplant was performed.

Autologous Transplant followed by Autologous Transplant(s), including Tandem/Sequential:

Disease	Number of patients receiving tandem/sequential transplants			
	2021	2022	2023	2024

Autologous Transplant followed by Allogeneic Transplant:

Disease	Number of patients receiving tandem transplants			
	2021	2022	2023	2024

A-6. Number of Transplant Procedures Performed

Record the total number of transplant procedures performed in the years indicated. Categories are mutually exclusive. Do not include DLIs or stem cell boosts. Antigens to be used are Class I + DRB1 (the denominator is 8 antigens). Patients with multiple transplants will be counted more than once.

Adult (greater than or equal to 18 years of age):

Transplant Type	2021	2022	2023	2024
Autologous				
Allogeneic Myeloablative Related Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Non-myeloablative Related Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Myeloablative Unrelated Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Non-myeloablative Unrelated Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Cord Blood				
Total				

Pediatric (less than 18 years of age):

Transplant Type	2021	2022	2023	2024
Autologous				
Allogeneic Myeloablative Related Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Non-myeloablative Related Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Myeloablative Unrelated Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Non-myeloablative Unrelated Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Cord Blood				
Total				

A-7. Number of Patients Transplanted by Age

Performed from 1/1 through 12/31 of the most recent calendar year only. Antigens to be used are Class I + DRB1 (the denominator is 8 antigens). Do not include DLIs or stem cell boosts.

Transplant Type	0-10	11-17	18-64	65+
Autologous				
Allogeneic Myeloablative Related Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Non-myeloablative Related Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Myeloablative Unrelated Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Non-myeloablative Unrelated Donor:				
0 Antigen Mismatch				
1 Antigen Mismatch				
> 1 Antigen Mismatch				
Cord Blood				
Total				

A-8. Number of Patients Receiving Retransplantation

A retransplant is defined as a second transplant occurring within 365 days of the first transplant for the same indication for which the first transplant was performed. The retransplant is performed due to graft failure or due to disease progression within 365 days of the first transplant. Report the patient in the year in which the **second** transplant was performed.

Retransplantation	Due to graft failure				Due to disease progression			
	2021	2022	2023	2024	2021	2022	2023	2024
Number of patients								

Part B: Protocols

B-1. Patient Selection

a) Describe the patient selection processes utilized by the Program (patient selection committee, frequency with which it meets, who attends, are minutes taken, etc).

Describe protocols for patient selection, including indications and contraindications for adult and pediatric autologous and allogeneic transplantation. Include the match criteria for allogeneic transplants.

b) Are all patients managed under a protocol (either research or institutional standard of care)?

Yes ☐ No ☐

If treatments are performed "off protocol," how is the decision made?

B-2. Describe patient and family support services provided throughout the transplant process.

B-3. Describe patient education provided throughout the transplant process.

B-4. Is a patient satisfaction survey used by the Program? Yes ☐ No ☐

B-5. Is the Program affiliated with the NCI and/or other cooperative clinical research groups? Yes ☐ No ☐

If yes, please list which groups.

B-6. Data Reporting to the CIBMTR

Does the Program report its allogeneic transplant data? Yes ☐ No ☐
Does the Program report its autologous transplant data? Yes ☐ No ☐

B-7 Provide a list of research and treatment protocols in which transplant patients may be enrolled. Include protocol title, inclusion criteria and exclusion criteria, objectives, type of protocol (e.g. multi-center, pharmaceutical, institutional), and if not included in the title, induction agents and the protocol Phase. You may include the protocol's executive summary.

(continues on next page)

Part C: Program Teams

C-1. Adult Transplant Team Composition

Name	Board Certification / Specialty	Years of experience actively managing transplant patients		Became a member of this team
		Allo	Auto	Month / Year
Program Clinical Director:				
Program Administrative Director:				
Transplant Physician(s):				
Transplant Clinical Coordinator(s)				
Social Service:				
Financial Coordinator:				
Data Coordinator(s):				
Clinical PharmD and/or Pharmacist(s):				
Other				

Have there been any changes in medical leadership of the Adult Program in the past 12 months?

Yes ☐ No ☐

If yes, provide date(s) and explain.

C-2. Pediatric Transplant Team Composition

Name	Board Certification / Specialty	Years of experience actively managing transplant patients		Became a member of this team Month / Year
		Allo	Auto	
Program Clinical Director:				
Program Administrative Director:				
Transplant Physician(s):				
Transplant Clinical Coordinator(s):				
Social Service:				
Child Life:				
Financial Coordinator:				
Data Coordinator:				
Clinical PharmD and/or Pharmacist(s):				
Other:				

Have there been any changes in medical leadership of the Pediatric Program in the past 12 months? Yes ☐ No ☐

If yes, provide date(s) and explain:

Part D: Quality

D-1. Attach your most recent FACT Quality Management Program Description (e.g. metrics monitored). Detailed plans with actual variances are not requested.

Part E: Summary Information

E-1. Describe the Program's unique qualities.

E-2. Provide any additional information that you feel is important regarding the Program.

Part F: Outcomes Data

Report outcomes data using the RFI-associated excel spreadsheets. Please review the Definitions tab of the spreadsheet prior to completion of the outcome data tables.

I have investigated and certify that the information contained in this survey and all attachments is accurate, complete, and true.

I understand that submission of this survey does not automatically result in participation or continued participation.

Name _____ Signature _____

Title Program Administrative Director Date _____

Name _____ Signature _____

Title Program Clinical Director Date _____