# Part A: General Information

**Transplant Center Name:**

**A-1. Accreditation / certification\***

Current Accreditation 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

NMDP Approved Date

Apheresis Donor Center Yes  No

Marrow Donor Center Yes  No

Transplant Center Yes  No

Laboratory Approved Date

CAP Yes  No

CLIA Yes  No

AABB Yes  No

Medicare Provider Yes  No

State Sponsored Provider Yes  No

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

Indicate the patient populations to which your facility provides transplant services:

Adult only  Pediatric only  Adult and pediatric

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

Separate programs  Combined program

**A-2. Number of patients transplanted.**

**Inception is the date the first transplant of each type was performed; from inception = patients transplanted from this date through 12/31 of the most recent calendar year. Categories are mutually exclusive. (Do not include DLIs or stem cell boosts.) If a patient received a 2nd transplant < 365 days from the 1st transplant, report only in the category of the 1st transplant. If a patient received a 2nd transplant > 365 days from the 1st transplant, report both transplants in the appropriate years and categories. Antigens to be used are Class I + DRB1 (the denominator is 8 antigens). See the Multiple Transplant Grid**

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

| **Transplant Type** | **Inception Date** | **From inception** | **2017** | **2018** | **2019** | **2020** |
| --- | --- | --- | --- | --- | --- | --- |
| Autologous |  |  |  |  |  |  |
| Allogeneic Myeloablative Related Donor: | | | | | | |
| 0 Antigen Mismatch |  |  |  |  |  |  |
| ≥ 1 Antigen Mismatch |  |  |  |  |  |  |
| Non-myeloablative Related Donor | | | | | | |
| 0 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** | **Inception Date** | **From inception** | **2017** | **2018** | **2019** | **2020** |
| Autologous |  |  |  |  |  |  |
| Allogeneic Myeloablative Related Donor: | | | | | | |
| 0 Antigen Mismatch |  |  |  |  |  |  |
| ≥ 1 Antigen Mismatch |  |  |  |  |  |  |
| Non-myeloablative Related Donor | | | | | | |
| 0 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 |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient’s Age at Time of Transplant | **From inception** | **2017** | **2018** | **2019** | **2020** |
| 0-10 |  |  |  |  |  |
| 11 - 17 |  |  |  |  |  |

**A-3. Has your Autologous Program been closed or suspended for any reasons during**

**the past 36 months?**

Yes  No  Not applicable

If yes, provide dates and explain:

**Has your Allogeneic Program been closed or suspended for any reason during**

**the past 36 months?**

Yes  No  Not applicable

If yes, provide dates and explain:

**A-4. Number of patients transplanted by age.**

**Performed from Program inception through 12/31 of the most recent calendar year. (Do not include DLIs or stem cell boosts. Please follow guidelines stated in A-2 with regard to reporting multiple transplants). Antigens to be used are Class I + DRB1 (the denominator is 8 antigens).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Transplant Type** | **0 – 10** | **11 – 17** | **18 – 45** | **46 – 64** | **65 +** |
| Autologous |  |  |  |  |  |
| Allogeneic Myeloablative Related Donor | | | | | |
| 0 Antigen Mismatch |  |  |  |  |  |
| ≥ 1 Antigen Mismatch |  |  |  |  |  |
| Non-myeloablative Related Donor | | | | | |
| 0 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-5. How does your Program provide the following transplant-related services?**

Mobilization therapy  inpatient  outpatient  both

Harvesting/Apheresis  inpatient  outpatient  both

Conditioning Regimens  inpatient  outpatient  both

Marrow/Stem Cell Reinfusion  inpatient  outpatient  both

Recovery  inpatient  outpatient  both

**A-6. Does your Program perform the following?**

Donor leukocyte infusions Yes  No

Cell purging Yes  No

Photophoresis Yes  No

T-cell depletion Yes  No

Genetic manipulation Yes  No

Does your 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

Multiple, sequential infusion of stem cells Yes  No

#### A-7. Number of Patients Receiving Tandem 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**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Disease | Number of patients receiving tandem transplants | | | |
| **2017** | **2018** | **2019** | **2020** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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**Autologous Transplant followed by Allogeneic Transplant**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Disease | Number of patients receiving tandem transplants | | | |
| **2017** | **2018** | **2019** | **2020** |
|  |  |  |  |  |
|  |  |  |  |  |
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#### 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** | | | |
| **2017** | **2018** | **2019** | **2020** | **2017** | **2018** | **2019** | **2020** |
| Number of patients |  |  |  |  |  |  |  |  |

**A-9. Does your Program perform:**

**Double cord blood transplants (cord blood units infused separately)?** Yes  No

**Pooled cord blood transplants (cord blood units combined for infusion)?** Yes  No

If yes, are all of these performed on IRB approved research protocols?  Yes  No

**A-10. Complete the data table below for all ADULT patients who underwent stem cell transplantation (marrow or pbsc) from January 1, 2017 through December 31, 2020.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Transplant Type | **2017** | | **2018** | | **2019** | | **2020** | |
| # Pts | % of 2017 total | # Pts | % of 2018 total | # Pts | % of 2019 total | # Pts | % of 2020 total |
| **Allogeneic** | | | | | | | | |
| Patients who expired after the start of conditioning therapy (Myeloablative regimen) but prior to re-infusion of stem cells (transplant) |  |  |  |  |  |  |  |  |
| **Autologous** | | | | | | | | |
| Patients who expired after the start of conditioning therapy (Myeloablative regimen) but prior to re-infusion of stem cells (transplant) |  |  |  |  |  |  |  |  |

**A-11 Complete the data table below for all PEDIATRIC patients who underwent stem cell transplantation (marrow or pbsc) from January 1, 2017 through December 31, 2020.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Transplant Type | **2017** | | **2018** | | **2019** | | **2020** | |
| # Pts | % of 2017 total | # Pts | % of 2018 total | # Pts | % of 2019  total | # Pts | % of 2020  total |
| **Allogeneic** | | | | | | | | |
| Patients who expired after the start of conditioning therapy (Myeloablative regimen) but prior to re-infusion of stem cells (transplant) |  |  |  |  |  |  |  |  |
| **Autologous** | | | | | | | | |
| Patients who expired after the start of conditioning therapy (Myeloablative regimen) but prior to re-infusion of stem cells (transplant) |  |  |  |  |  |  |  |  |

**A-12 Number of Transplant Procedures Performed.**

**Record the total number of transplant procedures performed in the years indicated. Inception is the date the first transplant of each type was performed; from inception = transplant procedures from this date through 12/31 of the most recent calendar year. 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** | **Inception Date** | **From inception** | **2017** | **2018** | **2019** | **2020** |
| --- | --- | --- | --- | --- | --- | --- |
| Autologous |  |  |  |  |  |  |
| Allogeneic Myeloablative Related Donor: | | | | | | |
| 0 Antigen Mismatch |  |  |  |  |  |  |
| ≥ 1 Antigen Mismatch |  |  |  |  |  |  |
| Non-myeloablative Related Donor | | | | | | |
| 0 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** | **Inception Date** | **From inception** | **2017** | **2018** | **2019** | **2020** |
| Autologous |  |  |  |  |  |  |
| Allogeneic Myeloablative Related Donor: | | | | | | |
| 0 Antigen Mismatch |  |  |  |  |  |  |
| ≥ 1 Antigen Mismatch |  |  |  |  |  |  |
| Non-myeloablative Related Donor | | | | | | |
| 0 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 |  |  |  |  |  |  |

# Part B: Outcomes Data

Report outcomes data using excel spreadsheets. Please review the definitions tab and the FAQ prior to completion of the outcome data tables.

**Part C: Protocols**

**C-1. Patient Selection**

**a) Describe the patient selection process (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 transplants are performed “off protocol”, how is the decision made?**

**C-2. Describe pre and post transplant patient and family support services.**

**C-3. Describe pre and post transplant patient education.**

**C-4. Is a patient satisfaction survey used by the Program?** Yes  No

**C-5. Is the Program affiliated with the NCI and/or other** Yes  No

**cooperative clinical research groups?**

If yes, please list which groups.

**C-6.** **Does the Program report its data to the CIBMTR?** Yes  No

**C-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.)**

**Part D: Transplant Team**

**D-1. Adult Transplant Team Composition**

| **Name** | **Board Certification / Specialty** | **Years of experience actively managing transplant patients**  **Allo Auto** | | **Became a Member of this team**  **Month / Year** | **% of time managing transplant patients in previous calendar year** |
| --- | --- | --- | --- | --- | --- |
| **Program Director:** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Transplant Physician(s):** |  |  |  |  |  |
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| **Transplant Coordinator(s)** |  |  |  |  |  |
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| **Social Service:** |  |  |  |  |  |
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| **Financial Coordinator:** |  |  |  |  |  |
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| **Data Coordinator(s):** |  |  |  |  |  |
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| **Others:** |  |  |  |  |  |
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**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.

**D-2. Pediatric Transplant Team Composition**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Board Certification / Specialty** | **Years of experience actively managing transplant patients**  **Allo Auto** | | **Became a Member of this Team**  **Month / Year** | **% of time managing transplant patients in previous calendar year** |
| **Program Director:** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Transplant Physician(s):** |  |  |  |  |  |
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| **Transplant Coordinator(s):** |  |  |  |  |  |
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| **Social Service**: |  |  |  |  |  |
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|  |  |  |  |  |  |
| **Child Life**: |  |  |  |  |  |
|  |  |  |  |  |  |
| **Financial Coordinator:** |  |  |  |  |  |
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|  |  |  |  |  |  |
| **Data Coordinator**: |  |  |  |  |  |
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|  |  |  |  |  |  |
| **Other:** (as appropriate:psychologists, physical therapists, dieticians, etc) |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**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 E: Quality**

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

**Part F: Summary Information**

**F-1. Describe the Program’s unique qualities**.

**F-2. Provide any additional information that you feel is important regarding your program**.

I 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 Date

Name Signature

Title Program Medical Director Date