# 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** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

 **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 2019total | # 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:** |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **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**: |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **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