# 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:**

Chief Executive Officer:

**Program Administrator Telephone: \_\_\_**

|  |  |  |
| --- | --- | --- |
| 2. Is your institution currently licensed by the state’s regulatory agencies? If no, explain:    On what date does your State License expire: | Yes | No |

|  |  |  |
| --- | --- | --- |
| 3. Are there conditions on the current federal, state, or local licenses, permits, or certifications? | Yes | No |

If yes, explain:

|  |  |  |
| --- | --- | --- |
| 4. Is your institution affiliated with or the parent corporation of other hospitals/institutions? | Yes | No |

If yes, what is the name(s) of the affiliated institutions and the nature of the relationship?

**5. Are any pre- or post-transplant services**

**(clinic visit, evaluation, major diagnostic testing,** Yes  No

**etc.) being provided at the affiliated institutions listed in**

**question 4?**

If yes, please list which affiliate and which type of service.

**6. Is your institution currently accredited by any of the following organizations without exception, condition or contingency?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Accreditation Organization**  **(FACT accreditation is addressed in question A-1)** | **YES** | **NO** | **If conditions or contingencies, please note below** |
| **The Joint Commission** |  |  |  |
| **National Integrated Accreditation of Healthcare Organizations (DNV-GL NIAHO)** |  |  |  |
| **Healthcare Facilities Accreditation Program (HFAP)** |  |  |  |
| **Center for Improvement in Healthcare Quality (CIHQ)** |  |  |  |

## 7. Does your institution’s Medical Staff Bylaws contain a comprehensive process for credentialing and re-credentialing of physicians participating in the transplant program (Program), including primary verification of:

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Licensure |  |  |
| Previous Appointments |  |  |
| DEA Certificates |  |  |
| Previous State Medicare / Medicaid Sanctions |  |  |
| The National Practitioner Data Bank |  |  |

If no for any of the above, please attach a copy of the Bylaws related to physician credentialing and re-credentialing.

## 11. 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

## 8. Name and address of immunology laboratory affiliated with transplant program:

## 9. Does your institution have the following facilities and 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?** | |
| Anesthesiology |  | |  | |
| Pathology |  | |  | |
| Blood banking |  | |  | |
| Renal dialysis |  | |  | |
| Operating rooms |  | |  | |
| Emergency clinical care |  | |  | |

|  |  |  |
| --- | --- | --- |
| 10. Are housing accommodations available for patient(s)/companion(s) during the pre- and post-therapy periods? | Yes | No |
|  |  |  |

If yes, list and provide information:

## 11. What kind of ongoing training is provided for the transplant staff?

## 12. Key contacts

|  | Administrator or person **completing form** | Contract Manager |
| --- | --- | --- |
| BMT Program |  |  |

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 completed survey does not automatically result in continued participation.

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Signature(s) |  |
| Title |  | Date |  |

Bottom of Form

# Part A: General Information

**Transplant Center Name:**

**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 notwarrant, 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 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 Autologous Pediatric 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 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)**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Disease | Number of patients receiving tandem transplants | | | |
| **2019** | **2020** | **2021** | **2022** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Autologous Transplant followed by Allogeneic Transplant**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Disease | Number of patients receiving tandem transplants | | | |
| **2019** | **2020** | **2021** | **2022** |
|  |  |  |  |  |
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|  |  |  |  |  |
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**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** | **2019** | **2020** | **2021** | **2022** |
| --- | --- | --- | --- | --- |
| **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** | **2019** | **2020** | **2021** | **2022** |
| --- | --- | --- | --- | --- |
| **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** | | | |
| **2019** | **2020** | **2021** | **2022** | **2019** | **2020** | **2021** | **2022** |
| Number of patients |  |  |  |  |  |  |  |  |

# Part B: Outcomes Data

Report outcomes data using the RFI-associated excel spreadsheets. Please review the definitions tab and the Frequently Asked Questions (FAQ) tab prior to completion of the outcome data tables.

**Part C: Protocols**

**C-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, institutional standard of care or in a REMS program per a commercial source)?

Yes  No

If treatments 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.** **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

**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.**

**(continues on next page)**

**Part D: Program Teams**

**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** |
| --- | --- | --- | --- | --- |
| **Program Director:** |  |  |  |  |
|  |  |  |  |  |
| **Program Administrator:** |  |  |  |  |
|  |  |  |  |  |
| **Transplant Physician(s):** |  |  |  |  |
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| **Transplant Clinical Coordinator(s)** |  |  |  |  |
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| **Social Service:** |  |  |  |  |
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|  |  |  |  |  |
| **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.

**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:** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Program Administrator:** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Transplant Physician(s):** |  |  |  |  |  |
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| **Transplant Clinical Coordinator(s):** |  |  |  |  |  |
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|  |  |  |  |  |  |
| **Social Service**: |  |  |  |  |  |
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|  |  |  |  |  |  |
| **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 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 the 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