

Starting a New Program

What components does a program need to start successfully?

Starting a new Transplant Program

Essential components

Staff

Protocols and Procedures

Access to advice

General guidance

Minimum Requirements

- What is the minimum configuration for a center to produce quality outcomes?

Essential components

- Testing for infections – cultures, CMV assay, fungal testing
- supply of necessary medications – anti-infectives, immunosuppressives
- Laboratory testing to monitor drug levels
- Transfusions—reliable and safe
- social support for patient and family – adapt to budget & literacy.

Basic Competence and Needs

Experience in support and management of AML, SAA
neutropenia, mucositis, infections, GI upset
pulmonary complications, transfusions

Local or regional need

sufficient patients with AML; DLBCL, other NHL
SAA, thalassemia
Myeloma, other

Essential components

- Imaging; which radiology testing is available
- Cell processing: Freezing/thawing; RBC, plasma removal; ID and quality measures
- ICU: close monitoring, cardiac and pulmonary support

- Of the essential components, which represent challenges beyond a program that already is capable of supporting patients through AML induction or prolonged SAA?

Minimum Essentials

- What resources or roles must be available at the center to ensure program vitality?

Staffing needs

MDs

more than one (for vacation, travel to meetings)

training and direct experience at a BMT center

Nurses

training and experience with neutropenia, transfusions; many medications. N per patient

Pharmacists (or MD) to help drug dosing, drug interactions, availability and cost

Consultants (lung, GI, infectious, pathology)

Protocols & Procedures

Patient Eligibility

disease , organ function, comorbidity

Conditioning—defined and pre-planned,
not patient specific.

Supportive care

Infection prevention, screening & therapy;
transfusions,
nutrition—safe, sufficient, when parenteral
GVHD prevention, diagnosis and therapy

Supportive Care

- How long does the patient require support close to the transplant center?
- How should we ensure adequate follow-up in the patient's local area?
 - What about patients who are remote?
- How can the center develop local/regional networks to support referrals and post-HCT care?

Access to Advice

Partner with experienced center;
regional and international

Ongoing communication for protocol review,
consultation

Periodic visits to other centers

Email, skype, phone don't do it alone

General Guidance

Start slow Good risk patients;
need to build on success & build reputation

If patient demand justifies (sufficient NHL, myeloma)
Begin with autologous HCT
Build procedures, protocols, staff confidence

Move to allogeneic HCT slowly Good risk patients
Suitable performance status and age
Sibling donor HCT first
Then only allele-matched unrelated donors
Selected testing of haplo or UCB new approaches