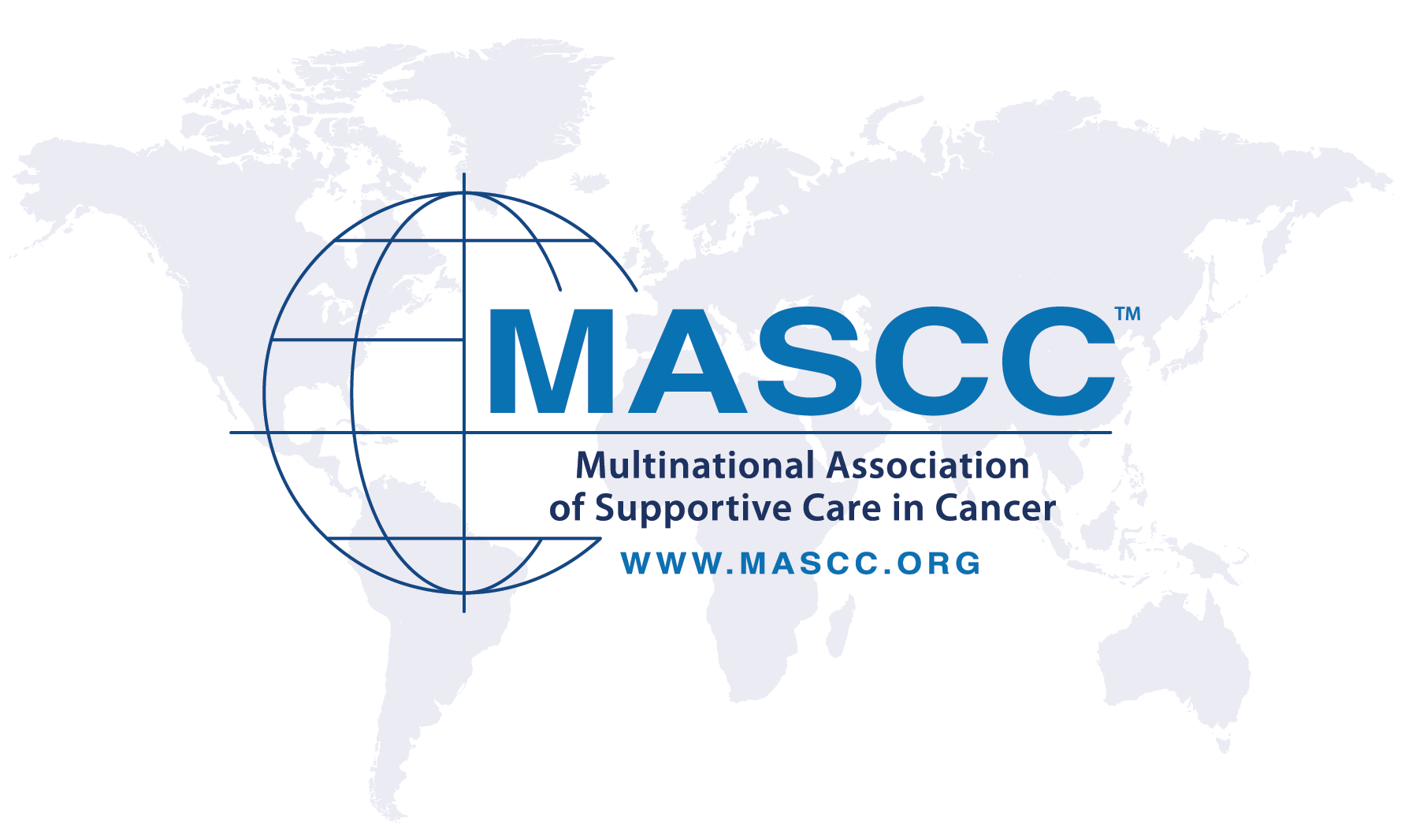
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**Designated Centers of Excellence  
in Supportive Care in Cancer**

Certification Program

*Supportive Care Makes Excellent Cancer Care Possible*

****

**To Be Completed by Applicant**

**General**

|  |  |  |
| --- | --- | --- |
| First Name/Surname of Applicant: | | |
| Title: | Specialized in: | |
| E-mail: | | |
| Phone: | | Fax: |

|  |
| --- |
| Are you directly involved in cancer supportive care? If yes, please specify. |
|  |

|  |  |
| --- | --- |
| Institute: | |
| Mailing address: | |
| Department: | |
| Unit: | |
| Head of the Unit: | Head of the Department: |
| E-mail: | E-mail: |
| Phone: | Phone: |

|  |
| --- |
| Head of the Institute: |
| E-mail: |
| Phone: |

**Membership**

|  |
| --- |
| Are you a MASCC member? If yes, please specify your member ID, found on your member login page. |
| Member ID #: |

**Guidelines**

|  |
| --- |
| What guidelines do you follow in your daily oncology clinical practice? (*Please check all that apply*.)  MASCC guidelines  ASCO guidelines  ESMO guidelines  Other(s) – Please specify: |

**Center Details**

**To what type of institute does this application relate?** *(Please check all that apply.)*

|  |
| --- |
| General Hospital |
| University Hospital |
| Comprehensive Cancer Center |
| Private Clinic |
| Tertiary Center |
| Primary Care |
| Community |
| Other – Please specify: |

**Types of cancer treated at your center** *(Please check all that apply.)*

|  |
| --- |
| Only patients with solid tumors |
| Only patients with hematological malignancies |
| Both |
| Limited types – Please list: |

**Patient age groups** *(Check all that apply.)*

|  |
| --- |
| Pediatric |
| Adolescent and young adult |
| Adult |
| Geriatric |

**Services available at your center** *(Please check all that apply.)*

|  |  |  |
| --- | --- | --- |
| Medical Oncology | | |
| Inpatients | Yes | No |
| Day care | Yes | No |
| Outpatients | Yes | No |

|  |  |  |
| --- | --- | --- |
| Radiation Oncology | | |
| Inpatients | Yes | No |
| Day care | Yes | No |
| Outpatients | Yes | No |

|  |  |  |
| --- | --- | --- |
| Hematology | | |
| Inpatients | Yes | No |
| Day care | Yes | No |
| Outpatients | Yes | No |

|  |  |  |
| --- | --- | --- |
| Supportive Care | | |
| Inpatients | Yes | No |
| Day care | Yes | No |
| Outpatients | Yes | No |

|  |  |  |
| --- | --- | --- |
| Palliative Care | | |
| Hospice | Yes | No |
| Day care | Yes | No |
| Outpatients | Yes | No |

|  |
| --- |
| Does the center provide emergency care for treatment-related toxicities? |
| Yes  No |

**Clinical Activities**

**(Eligibility Criteria Checklist – 1/3)**

In addition to checking all applicable responses below, please attach additional explanations

relating to items 1 through 7.

**1. Supportive care features at your center** *(Please check all that apply.)*

|  |
| --- |
| Which of the following supportive care therapies are provided to patients receiving cancer treatment at your center, and in what settings are they provided? Please attach detailed information about the settings for each supportive care therapy — for example, a European dedicated supportive care unit? A Wisconsin-based dedicated acute care unit? |
| Blood product transfusions (blood, platelets, plasma)  Infusion of immunoglobulins, human albumin, human plasmatic protein, antibiotics, antifungals and   antivirals, iron, electrolytes, analgesics, diuretics, steroids, octreotide, H2-antagonist, glutathione,   antiemetics, or antihistamines |
| Infusion of bisphosphonates/denosumab  Hydration following high-dose chemotherapy |
| Hydration for acute and chronic renal failure  Intravenous hydration, possibly in association with electrolyte supply, and/or multivitamin, protein,   lipid supply, in patients with compromised ability to eat and drink properly, or with toxicity due to   radiotherapy or chemotherapy (i.e., diarrhea, nausea, vomiting, and oropharyngeal high-grade   mucositis) |

|  |
| --- |
| How are outpatients with treatment-related toxicities managed? |
| Unplanned visits:  No  Yes  Who takes care of them?  Unplanned hospitalization:  No  Yes  Who takes care of them?  Followed as outpatients in a day-care service:  No  Yes  Who takes care of them? |

**2. General features at your center** *(Please check all that apply.)*

|  |
| --- |
| Who provides toxicity management and pharmacological support? |
| Treating oncologists  Treating radiotherapists  Dedicated supportive care staff (including allied health) inside the oncology unit  Dedicated supportive care staff (including allied health) inside the radiotherapy unit  Dedicated supportive care staff outside the oncology/radiotherapy unit |
| Emergency department |
| Referred elsewhere – Please specify: |

|  |
| --- |
| Who manages late toxicities during survivorship? |
| Treating oncologists  Treating radiotherapists |
| Dedicated supportive care staff |
| Referred elsewhere – Please specify: |

|  |
| --- |
| Who provides psychological and social support? |
| Specialist clinical psychologists  Social workers  None  Other – Please specify: |

|  |
| --- |
| Who provides spiritual support? |
| Chaplain  No one  Other – Please specify: |

**3. Dedicated multidisciplinary or multi-professional teams (MDTs)** *(Please check all that apply.)*

|  |
| --- |
| Does your center have dedicated MDTs to provide supportive care to cancer patients? |
| No |
| Yes – Please describe your MDTs for supportive care.  What types of expertise are provided by your MDTs? Please describe. |

**4. Logistics** *(Please check all that apply.)*

|  |
| --- |
| In what settings is supportive care provided? |
| In dedicated structures |
| Outside dedicated structures  Please describe. |

|  |
| --- |
| How many hours per day is care provided? |
| Less than 6 hours/day  More than 6 hours, but less than or equal to, 12 hours/day  24 hours/day  Other – Please specify: |

|  |
| --- |
| How many days per week is care provided? |
| 5 out of 7 days  7 out of 7 days  Other – Please specify: |

|  |
| --- |
| Does this include or exclude holidays? |
| Includes |
| Excludes |

|  |
| --- |
| Is care available for unplanned patient visits (as outpatients or day service)? |
| Available |
| Not available |

|  |
| --- |
| Does the service provide dedicated contacts with patients? |
| No dedicated contacts |
| Dedicated phone number – Please specify the activity time: |
| Dedicated mobile number – Please specify the activity time: |
| Dedicated fax line |
| Dedicated e-mail or other electronic devices, such as apps, social networks, etc. |

**5. Staff** *(Please check all that apply.)*

|  |
| --- |
| Please specify the type and number of people who provide supportive care. |
| No one |
| Doctors – number: |
| Nurses – number: |
| Administrators – number: |
| Volunteers – number:  Social workers – number: |

**6. Clinical practice** *(Please check all that apply.)*

|  |
| --- |
| Does the service provide toxicities management for patients receiving cancer treatment *other than immunotherapies*? |
| No, referred to others |
| Grade 1-2 |
| Grade 3-4 |
| Only outpatients |
| Outpatients and inpatients (when needed) |

|  |
| --- |
| Does the service provide toxicities management for patients receiving immunotherapies? |
| No, referred to others |
| Grade 1-2 |
| Grade 3-4 |
| Only outpatients |
| Outpatients and inpatients (when needed) |

|  |
| --- |
| Does the service manage cancer-related symptoms during cancer treatment? |
| No, referred to others |
| Yes |
| Only outpatients |
| Outpatients and inpatients (when needed) |

|  |
| --- |
| Does your center manage common comorbidities in cancer patients? |
| No, referred to others |
| Yes |
| Only outpatients |

|  |
| --- |
| Does the service routinely use validated symptom assessment tools (outside of clinical trials)? |
| No |
| Yes – Please list: |

|  |
| --- |
| Does the service routinely use validated quality-of-life (QoL) assessment tools? |
| No |
| Yes – Please list: |

|  |
| --- |
| Does the service include activity monitoring through electronic records? |
| No |
| Yes |

|  |
| --- |
| Does the service provide psychological specialist support? |
| No |
| Yes |

|  |
| --- |
| Does the service provide rehabilitation services? |
| No |
| Physiatric  Phoniatric  Swallowing experts  Lymphedema experts  Other – Please specify: |

|  |
| --- |
| Does the service provide other non-pharmacological support? |
| No |
| Yes – Please list: |

**7. Palliative care features at your center**

|  |
| --- |
| Please describe the types and level of integration between supportive care and palliative care staff. |
|  |
|  |

|  |
| --- |
| How is end-of-life care and symptom management provided? |
| Integrated outpatient paths |
| Hospice |

|  |
| --- |
| Does your palliative care outpatient service accept referrals of patients with prognoses substantially greater than three months? |
| No |
| Yes |

|  |
| --- |
| How are palliative care experts involved in patient care? |
| Directly within the MDT |
| Called on if needed  The patient or oncologist can request palliative care services. |

|  |
| --- |
| Are medical oncology trainees provided with clinical experience on a palliative care service? |
| No |
| Yes |

**Research and Educational Features of Supportive Care Service**

**(Eligibility Criteria Checklist – 2/3)**

**Research**

|  |
| --- |
| What types of research are center staff involved in? |
| Oncology (general, specific) |
| Supportive care in cancer patients |
| Palliative care in cancer patients |

|  |
| --- |
| Research types |
| Basic |
| Translational |
| Clinical |
| Other – Please specify: |

|  |
| --- |
| Publications in peer-reviewed journals |
| List the 3 papers with highest impact published in the past 2 years (oncology, general). |
| 1. |
| 2. |
| 3. |
| Total number of oncology publications in the past 2 years: |
| List the 3 papers with highest impact published in the last 2 years (supportive care). |
| 1. |
| 2. |
| 3. |
| Total Number of supportive care publications in in the past 2 years: |

|  |
| --- |
| What are the professions of the center’s researchers? (*Check all that apply.*) |
| Doctors |
| Nurses |
| Allied health |

**Educational**

|  |
| --- |
| In what disciplines do center staff teach students? (*Check all that apply.*) |
| No teaching activities |
| Medicine |
| Nursing |
| Allied health |

|  |
| --- |
| What levels and numbers of students receive training at the center? |
| Undergraduate – number: |
| Postgraduate – number: |
| Postdoctoral – number: |

|  |
| --- |
| If you have oncology trainees, do annual lectures include supportive care topics? |
| No |
| Yes |

|  |
| --- |
| How many center staff have given conference presentations in the past 2 years? |
| Oncology/Hematology – Number at national conferences: |
| Oncology/Hematology – Number at international conferences: |
| Supportive Care – Number at national conferences: |
| Supportive Care – Number at international conferences |

**Adherence to International Guidelines**

**(Eligibility Criteria Checklist – 3/3)**

**Please answer the following questions, indicating the reference guidelines or similar.**

|  |  |
| --- | --- |
| Please indicate the reference guidelines for the following topics. | |
| **CINV** | References  No References  Principle guideline:  Others: |
| **Thromboembolic prophylaxis** | References  No References  Principle guideline:  Others: |
| **Bone metastases** | References  No References  Principle guideline:  Others: |
| **Febrile Neutropenia** | References  No References  Principle guideline:  Others: |
| **Pain** | References  No References  Principle guideline:  Others: |
| **Oral mucositis** | References  No References  Principle guideline:  Others: |
| **Immuno-related toxicities** | References  No References  Principle guideline:  Others: |
| **Fatigue** | References  No References  Principle guideline:  Others: |

*Thank you for your participation.*

For eligibility, the application must be signed by the following people.

|  |  |
| --- | --- |
| ***Applicant*** | *Insert digital signature below* |
| Name: |  |
| ***Director of the Unit*** | *Insert digital signature below* |
| Name: |  |
| ***Director of the Department*** | *Insert digital signature below* |
| Name: |  |
| ***Director of the Institute*** | *Insert digital signature below* |
| Name: |  |

|  |
| --- |
| Date: |

Please email this completed application to the MASCC office.

Ruxandra Nedu, MASCC Associate Director

[rnedu@mascc.org](mailto:rnedu@mascc.org)