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August 2016 Newsletter

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Perspectives

By Paul Martin, MD

My first awareness of hematopoietic cell transplantation came from reading the two-part summary of the field published by E. Donnall Thomas, MD, and colleagues in the *New England Journal of Medicine* in 1975 when I was an intern. My interest was piqued by the multifaceted biology of this treatment and its dramatic power to treat diseases that could be cured in no other way. In due course, I learned that this treatment can have many long-lasting adverse effects. While many are cured without major complications, others who survive through the first few months do not live happily ever after. In the unforgettable words of one patient, "It is great that you are saving lives, but don't leave them half-broken in a heap at the end."



The challenges of overcoming early regimen-related toxicity, infections, and acute GVHD attracted many investigators with a surgical fix-it temperament—cowboys and cowgirls bent on conquering a new frontier. Over the years, however, the dawning awareness of late effects has attracted a small cadre of investigators with

a temperament more characteristic of rheumatologists and psychologists—patient, adept at managing chronic problems that are not amenable to simple fixes, empathetic with the emotional and social burdens of chronic illness, and able to derive satisfaction from slow, steady progress.

The number of investigators interested in survivorship has grown as the numbers of HCT survivors have increased over time, with a notable increase during the past decade encouraged by successes of the 2005 and 2014 NIH Consensus Development Projects on Criteria for Clinical Trials in Chronic Graft-versus-Host Disease. This success motivated the NIH to sponsor a consensus conference on late effects. The objectives are to identify problems and barriers that affect the health of transplant survivors, identify research priorities, and develop an organizational framework for solving problems. The goals are to improve the health of survivors, advance science, and improve guidelines for the care of transplant survivors. In Fall 2015, a steering committee and six working groups were formed with membership representing domestic and international academic institutions; representatives from the NIH, FDA, NMDP/Be The Match, CIBMTR, HRSA, and insurance payers; support from ASBMT and EBMT; and the participation of survivors to broaden the dialogue.

Each group was charged with addressing a specific focus: subsequent neoplasms, psychosocial and quality of life outcomes, immune dysregulation and pathobiology, cardiovascular and metabolic impairment, health care delivery, and research methodology and study design. The groups met by teleconference to develop initial outlines for each report. An initial face-to-face discussion was held during the February 2016 BMT Tandem Meetings, and a second meeting was held June 21 and 22 to discuss draft manuscripts from each working group with assistance from outside expert reviewers. Although final reports will be rolled out in print one at a time during the coming months, they will all be published online in *Biology of Blood and Marrow Transplantation* in September as a way to highlight the extensive cross-talk between the six working groups.

For many years, investigators working in the field of late effects might have felt like janitors cleaning up after the party. No longer—it is truly gratifying to see that survivorship work is more attuned to the voices of survivors and is now gaining its rightful place in the academic agenda. It has been projected that by 2030, we will have as many as 500,000 transplant survivors in the US, far exceeding the 25,000–30,000 new transplants anticipated in that year. Everyone working in the field should at least scan through the working group reports from the Consensus Conference. For older and young investigators alike, opportunities are huge. The CIBMTR and Late Effects and Quality of Life Working Committee are prepared and eager to work with temperamentally suited investigators who, in desiring to save lives, also want to find ways to avoid leaving patients half-broken in a heap at the end.

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[Late Effects and Quality of Life Working Committee](#)

Committee Leadership

Co-Chairs:

- [Bipin Savani, MD](#), Vanderbilt University Medical Center
- [Minoo Battiwalla, MD, MS](#), National Heart Lung and Blood Institute – NIH
- [Mary Flowers, MD](#), Fred Hutchinson Cancer Research Center, University of Washington

Scientific Director:

- [Bronwen Shaw, MBChB, MRCP, PhD](#)

Statistical Director:

- [Ruta Brazauskas, PhD](#)

Statistician:

- [Heather Millard, MPH](#)



Back row (left to right): Paul Martin, Bronwen Shaw, Mino Battiwalla, Bipin Savani.
Front row: Mary Flowers

The Late Effects and Quality of Life Working Committee (LEWC) conducts clinical research on long-term survival after HCT, including clinical and psychosocial effects of transplantation. We take advantage of the large clinical database of the CIBMTR to study these effects, many of which are relatively rare in individual centers.

The committee meets yearly in person at the BMT Tandem Meetings, and the Co-Chairs with CIBMTR support staff meet monthly by teleconference to ensure the timely completion of projects as well as to reassess priority areas and promote and develop the scientific agenda.

Previously, our committee identified target areas of post-transplant late effects that deserve specific attention, including fertility and liver toxicity. These interests have led to several publications, which help to inform those working in the field of incidence and risk factors and also to recommend practice.

In keeping with such efforts, the LEWC sent the first survey to the international membership of our committee in 2013 to identify key areas in which recent or comprehensive clinical guidelines were lacking. Close to 100 members responded. Based on the priorities identified, the first topic area - second malignancy screening - was addressed by an active working group and resulted in the [first LEWC review publication](#). A second topic - metabolic syndrome - was undertaken in 2015 by another active working group and resulted in the [second LEWC review publication](#). A third priority topic identified by members of the LEWC in 2016 is now underway.

Another area of intense interest to the committee is quality of life and patient reported outcomes following transplant. Efforts are actively underway in the committee to harmonize and generalize the collection and analysis of such data.

The LEWC has been actively involved in the recent NIH Blood and Marrow Transplant Late Effects initiative led by six working groups in the areas of:

1. New malignancy
2. Quality of life and psychosocial outcomes
3. Immune dysregulation and pathobiology
4. Cardiovascular and metabolic impairment
5. Health care delivery
6. Research methodology and study design

Six manuscripts summarizing the consensus from each working group will be published soon in the *Biology of Blood and Marrow Transplantation*. A full list of the LEWC's studies, including recent publications, is provided on the [LEWC Studies webpage](#).

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[Immunobiology Working Committee](#)

Committee Leadership

Co-Chairs:

- [Katharine Hsu, MD, PhD](#), Memorial Sloan Kettering Cancer Center
- [Katharina Fleischhauer, MD](#), Essen University Hospital, Germany
- [Michael Verneris, MD](#), University of Minnesota Medical Center, Fairview

Scientific Directors:

- [Stephen Spellman, MBS](#)
- [Stephanie J. Lee, MD, MPH](#)

Statistical Director:

- [Tao Wang, PhD](#)

Statistician:

- [Mike Haagenson, MS](#)

The Immunobiology Working Committee (IBWC) is the largest committee of the CIBMTR by study volume and addresses scientific questions about the association between genetic factors and successful transplantation outcomes. The IBWC welcomes studies that assess genes and gene products of the major histocompatibility complex, natural killer cell repertoire, cytokine / proinflammatory cytokine and immune-response determinants, minor histocompatibility loci, and other genetic factors. The committee's studies also include comparisons of clinical outcomes from different donor types, such as mismatched related versus unrelated donors, and exploration of novel biostatistical and analytic approaches to investigate the impact of various HLA mismatches.

The NMDP/Be The Match Research Sample Repository provides a unique resource for investigators conducting retrospective analyses of immune-response determinants and transplant outcomes. Currently, samples are available from more than 34,000 unrelated donor / cord blood-recipient pairs and 3,300 related donor pairs for whom complete clinical data have been collected and validated. Last year, the Repository distributed more than 8,700 aliquots to investigators. Current inventory may be viewed and requests for samples may be submitted using the instructions on the [Sample Types and Inventory Summary webpage](#).

For studies that examine the clinical role of the immune system in transplantation and do not require complete high-resolution HLA typing data and / or samples, the CIBMTR can provide clinical data on more than 43,500 HLA-identical sibling, 7,400 other-related, and 36,000 unrelated donor transplants. The IBWC currently lists 42 studies in progress, some in collaboration with other research organizations, such as the International Histocompatibility Working Group, EBMT, and Eurocord. Publications from the IBWC may be accessed on the [IBWC Studies webpage](#).

The success of the committee depends on vibrant scientific interactions, new ideas and testable hypotheses, and participation by individuals with different perspectives and scientific backgrounds; therefore, the IBWC encourages investigators to submit new and bold proposals. See the [How to Propose a Study webpage](#) for more information. Working Committee meetings convene annually at the BMT Tandem Meetings although other venues for interaction are also available. All investigators with an interest in immunology, immunobiology, and human genetics should feel welcome to become actively involved with this committee. You may contact one of the members of the committee leadership to learn more. We look forward to chatting with you and seeing you at our meetings!

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[CIBMTR Trivia](#)

The CIBMTR currently has _____ Working Committee studies in progress.

- A. 153
- B. 165
- C. 176
- D. 181

[Enter your answer online](#). If you answer correctly, you will be entered into a drawing to win a CIBMTR prize.

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[2017 BMT Tandem Meetings](#)

By Tia Houseman



The BMT Tandem Meetings - the combined annual meetings of the CIBMTR and

ASBMT - are North America's largest international gathering of blood and marrow transplant clinicians and investigators, laboratory technicians, advanced practice professionals, transplant nurses, pharmacists, administrators, and clinical research associates since 1999.

Leading authorities from around the world will present the latest developments in blood and marrow transplantation February 22-26, 2017, during the BMT Tandem Meetings at the Gaylord Palms in Orlando, Florida. Along with state-of-the-art educational offerings, industry-supported satellite sessions and product theaters will broaden the spectrum of presentations. In addition to an outstanding scientific program, the 2017 meetings offer peripheral sessions for BMT pharmacists, center administrators, coordinators, investigators, medical directors, clinical research professionals / data managers, transplant nurses, and advanced practitioners.

The online registration, abstract, and housing site opens mid August. The early registration and abstract deadline is October 3. After registering on the [BMT Tandem Home Site](#), take advantage of special conference guest room rates offered at the Gaylord Palms and several hotels near the Gaylord Palms Convention Center. Don't forget to reserve your ticket to the Saturday evening Tandem Reception to end a memorable week with colleagues and friends!

Questions regarding support opportunities at the 2017 BMT Tandem Meetings may be directed to [Sherry Fisher](#), Director of Advancement for the CIBMTR. For general information, please email bmttandem@mcw.edu.

We look forward to seeing you in Orlando!

Meeting Topics and Special Sessions Include:

- Acute GVHD
- Aging: Treating the Older Patient
- CAR T cells and TCR Gene Therapy (Non-ALL)
- Challenges to BMT in Older Patients: Myeloma, Lymphoma / CLL
- Chronic GVHD
- The Future of BMT 'Immunotherapy of Cancer'
- Long Term Survivorship after HCT: Roadmap for Research and Care
- Primer on New Multiscale Biology / Immunology for Transplanters
- WBMT Joint International Session: Do Stem Cell Transplants Need to be so Expensive?

Plus:

- Mortimer M. Bortin Lecture
- E. Donnell Thomas Lecture
- Oral Abstracts and Poster Sessions
- Late Breaking Abstracts
- CIBMTR Working Committee Meetings
- Meet-the-Professor Luncheon Sessions

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[Meet the Data Operations Clinical Research Assistants](#)

Currently there are two Clinical Research Assistants based in Milwaukee, Claudia Abel and Mona Patel, who help support a variety of projects. Combined, they have more than 30 years of service to the organization!



Claudia Abel



Mona Patel

Claudia and Mona assist with data checks and data queries to transplant centers as assigned by the Data Quality Team. They also assist the CIBMTR IT team with annotation of database variables on CIBMTR data collection forms that are ultimately used by the statisticians. Claudia and Mona enter and update legacy data in the CIBMTR legacy database using SQL developer as needed.

The majority of their time is spent on auditing scanned IBMTR / CIBMTR legacy data forms for readability and accuracy within the FormsNetSM application. If a scanned form does not meet audit specifications, the form is pulled for correction and rescanning. Once the form passes the audit, the paper copy is destroyed. The goal is to ultimately become paperless.

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[BMT CTN: Getting Ready for Renewal!](#)

By Amy Foley, MA

The BMT CTN, with its 20 core and approximately 100 affiliate centers, has enrolled more than 9,000 patients since 2003. This remarkable and successful collaboration is well-described in a [recent review article](#) by Dr. Mary Horowitz on behalf of the BMT CTN Steering Committee.

The Network was established in 2001 and is in its third grant cycle funded by the NHLBI and NCI. In April, the NHLBI shared welcome news that the BMT CTN grant would be re-renewed via their notice of intent to publish a funding opportunity [announcement](#).

Although the funding period is not yet known, the Data and Coordinating Center is grateful that the NHLBI and NCI recognize the BMT CTN is a productive, efficient, and resourceful Network and that the mission to conduct large, multi-institutional clinical trials to improve the outcomes of HCT for patients will continue for years to come.

Clinical Trials: Open Enrollment

The BMT CTN encourages widespread transplant community participation in clinical trials. If your center is interested in participating, visit the [BMT CTN website](#). There are eight trials open to accrual, three released to centers, and seven in development. The following BMT CTN trials were recently released to centers:

- BMT CTN 1401 - Phase II trial of autologous HCT followed by lenalidomide maintenance for multiple myeloma **with or without vaccination with dendritic cell / myeloma fusions**
- BMT CTN 1501 - Randomized, Phase II, open label study evaluating sirolimus and prednisone in **patients with refined Minnesota standard risk, Ann Arbor 1/2 confirmed acute graft-versus-host disease**
- BMT CTN 1503 - Study to compare bone marrow transplantation to standard care in **adolescents and young adults with severe sickle cell disease**

Publications

There are 62 BMT CTN published articles, including 18 primary analyses. The following primary results manuscripts were recently published.

- Laport GG et al. **Reduced-intensity conditioning with fludarabine, cyclophosphamide, and high-dose rituximab for allogeneic hematopoietic cell transplantation for follicular lymphoma: A Phase Two multicenter trial from the Blood and Marrow Transplant Clinical Trials Network.** *Biology of Blood and Marrow Transplantation.* 2016 Apr 23. [Epub ahead of print] [PubMed Link](#)
- Alvarnas JC et al. **Autologous hematopoietic cell transplantation for HIV-related lymphoma: Results of the (BMT CTN) 0803/(AMC) 071 trial.** *Blood.* 2016 Jun 13. [Epub ahead of print] [PubMed Link](#)

About the BMT CTN

The CIBMTR shares administration of the BMT CTN Data and Coordinating Center with NMDP/Be The Match and The Emmes Corporation. Together, these three organizations support all BMT CTN activities. The BMT CTN Steering Committee is currently under the leadership of Chair Steve Devine, MD (Ohio State University Medical University); Chair-Elect Rick Jones, MD (Johns Hopkins University); and Past-Chair Fred Appelbaum, MD (Fred Hutchinson Cancer Research Center).

To get up-to-date information about BMT CTN studies, meetings and news:



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Follow us on Twitter: [@BMTCTN](https://twitter.com/BMTCTN)

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Cellular Therapy Data Collection

By Tiffany Hunt, MS, CCRP, and Emille Love, CSPO

The world of cellular therapies is expanding. The science of infusions changes rapidly, requiring continuous review of CIBMTR forms. To better capture new data available on cellular therapies, and in conjunction with the Form Revision process, the CIBMTR expanded its cellular therapy data collection forms. Over the past year, a team of experts worked to develop new cellular therapy forms, which will be available in the Summer Release. These forms include:

Cellular Therapy Forms	Number	Reporting Schedule
Pre-Cellular Therapy Essential Data (Pre-CTED)	4000	Pre-infusion form, required once per course of cellular therapy
Cellular Therapy Infusion	4006	Required for each infusion
Post-Cellular Therapy Essential Data (Post-CTED)	4100	<p>Non-Genetically Modified: 100 days, 6 months, 1-6 years, and then every other year.</p> <p>Genetically Modified*: Required at 100 days, 6 months, 1-16 years, and then every other year.</p>

*Genetically modified products reported to the CIBMTR will have a modified forms due schedule. Per FDA requirements, follow-up on genetically modified products is required for 15 years.

The new pre-CTED will function like the pre-TED in collecting pre-infusion data for cellular therapies. The F4006 will replace the currently required F2006 and collect all cellular therapy infusion data; it will be required for each infusion given per course of cellular therapy. The F4100 will collect post-infusion data, similar to the F2100. There will be different reporting schedules for infusions with non-genetically modified products versus those with genetically modified products to help meet reporting requirements established by the FDA.

When initially released, these forms will be used to collect data on cellular therapies not related to transplant, such as non-donor cellular infusions (DCI) / co-infusion cell therapies. In the future, reporting of DCI's and co-infusions will be transitioned to the cellular therapy form(s), and additional forms will be revised and developed to expand cellular therapy data collection. Examples include infection forms, disease specific inserts, and others.

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Health Services Research Program Updates

By Linda Burns, MD; Ellen Denzen, MS; Beth Murphy, EdD, RN; and Stephanie Farnia, MPH

Patient-Centered Outcomes Research

Our research portfolio includes two patient focused projects, both funded by PCORI. The first, Individualized Care Plans for HCT Survivors, is conducted through the RCI BMT and has reached its targeted accrual (N=495). This randomized, prospective multi-center study compares transplant centers' standard survivorship care plan for adult survivors with an individualized care plan.

Our second project, Engaging Patients in Developing a Patient-Centered HCT Research Agenda, is progressing at a rapid pace following the first of three planned symposia held during the 2016 BMT Tandem Meetings in February. Based on patient, caregiver, and other key stakeholder input, six working groups were established. Each working group includes representation by key stakeholders, including patients and caregivers. The six working groups are:

- Patient, Caregiver, and Family Education and Support
- Physical Health and Fatigue

- Emotional, Cognitive, and Social Health and Relationships
- Sexual Health and Relationships
- Models of Care Delivery / Survivorship and Late Effects
- Financial Burden

Tasked with identifying patient-centered questions that lend themselves to comparative effectiveness clinical studies, the working groups will present the results of their deliberations for feedback at the second symposium. Tentative plans are to hold the second symposium in the evening on Friday, December 2, prior to the start of the annual ASH meeting in San Diego.

We also developed two webinars that will be held in October and November. The first, Transplant Outcomes that Matter Most to Patients, is scheduled for October 18 and will target patients / caregivers and other stakeholders to engage them in the project. The second, Patient Reported Outcomes Research in Hematopoietic Cell Transplantation, is scheduled for November 16 and will target investigators who are interested in patient-centered outcomes research. We will highlight the research of Heather Jim, PhD; Bill Wood, MD; and Bronwen Shaw, MBChB, PhD. Mark your calendars, spread the word to patients / caregivers / families and colleagues, and plan to join us for the webinars and December symposium.

Impact of BMT CTN 0201 on Clinical Practice

In June, in collaboration with Nandita Khera, MD, we launched a survey of clinicians who advise patients on stem cell sources for allogeneic transplant based on the BMT CTN 0201 prospective, randomized trial that compared unrelated donor peripheral blood and bone marrow as stem cell sources. While overall survival was similar, peripheral blood stem cells were associated with more chronic GVHD, whereas bone marrow stem cells were associated with more graft failure. Since publication of results in October 2012, there has been no impact on the proportion of peripheral blood versus bone marrow stem cell transplants performed. With survey data, we hope to better understand the drivers and barriers to translation of clinical study results into clinical practice.

Palliative Care

Delivery of effective palliative care to patients with hematologic diseases and those undergoing transplant is an unmet need. The Health Services Research Program continues to work closely with the ASBMT Palliative Care Task Force to conduct a survey of clinicians regarding perceptions and availability / utilization of palliative care options for their patients. Be sure to watch your inbox in the coming month for the survey – your input is invaluable in this critical area.

Health Care Costs and Utilization

Costs and utilization of allogeneic HCT compared with chemotherapy alone as initial therapy for older patients with AML is a major focus of our research portfolio. We recently published a “lessons learned” manuscript for those working with administrative claims data, and the analysis of costs and utilization is nearing completion. A second project merged the Centers for Medicare and Medicaid Services database with the CIBMTR Research Database to permit a similar analysis that includes outcomes and a cost-effectiveness component.

Outcomes of transplant for AML are better earlier than later in the disease course; unfortunately, many patients undergo transplant in second remission and beyond. To identify barriers to early referrals and strategies for intervention, we conducted a survey of practicing community hematologists / oncologists (NCCN / Pfizer funded). We are now developing three AML educational webinars to address identified knowledge gaps that impact timing of referral, including cytogenetic / molecular markers for prognostication (September 29), management of AML in first clinical remission (October 20), and therapeutic options for older patients (November 17). Help us advertise the webinars to your center’s referring physicians and clinics.

Other Studies in Our Research Portfolio

- Education Needs Assessment with Adults Who Received a Hematopoietic Cell Transplant (HCT) at Age 65 or Older (in partnership with the City of Hope, Dana Farber Cancer Institute, and the University of Minnesota)
- Easy-to-Read Informed Consent Forms for HCT Multicenter Trials (NHLBI ancillary grant to BMT CTN; BMT CTN 1205)

Recent Peer-Reviewed Publications

- Preussler JM et al. **Administrative claims data for economic analyses in hematopoietic cell transplantation: Challenges and opportunities.** *Biology of Blood Marrow Transplantation: The Official Journal of the American Society for Blood and Marrow Transplantation.* 2016 May 14. [Epub ahead of print] [PubMed Link](#)

- Denzen EM et al. **Financial impact of allogeneic hematopoietic cell transplantation on patients and families over 2 years: Results from a multicenter pilot study.** Bone Marrow Transplant. 2016 Apr 18. [Epub ahead of print] [PubMed Link](#)

Contact [Ellen Denzen, MS](#), Senior Manager of Health Services Research with questions.

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[SCTOD Expands Communication and Hosts Center Outcomes Forum](#)

By Carol Doleys

The SCTOD is part of the US HRSA-funded C.W. Bill Young Cell Transplantation Program that collects data on all allogeneic HCTs performed in the US and on transplants performed elsewhere using cellular products that originated in the US. Several recent activities of the SCTOD are highlighted below.

Expanded Communication

The CIBMTR recently sent a survey to transplant center Medical Directors, asking them to identify Center Administrators and IT personnel at their center. This information will allow the CIBMTR to directly communicate with these individuals to convey important information they may not otherwise see and to connect them to CIBMTR tools more appropriately.

In April 2016, the CIBMTR launched two new applications, enhanced Data Back to Centers (eDBtC) and Center Performance Analytics (CPA), which allow centers to view and analyze their own data. Also available is the Survival Outcomes Calculator, which utilizes the multivariate analysis performed for the most recent center-specific survival report as its source. The purpose of the calculator is to calculate one-year survival after allogeneic transplant to help understand the individual risk of patients that are being considered for transplantation and to make clinical decisions. Given the complex nature of this information, it is currently only available to physicians.

Center Outcomes Forum

Outcomes reporting in allogeneic HCT is necessary to provide information requested by patients, insurers, and government agencies and to comply with current laws. In order to maintain a transparent process to generate fair, scientifically valid center-specific survival reports for related and unrelated HCTs performed in the US, the CIBMTR hosts a Center Outcomes Forum every other year. The purpose of this meeting is to review the methods, processes, and results for the center-specific survival report, which includes related and unrelated HCT, and to consider revisions to the the methods and processes. Review of data elements collected by the CIBMTR to support the risk-adjustment performed in the center-specific survival analysis is another important topic. Forum participants include patient advocates, representatives of HCT centers, experts in center outcomes reporting not involved in HCT, members of the ASBMT Quality Outcomes Committee, statisticians, government project officers, and representatives of the CIBMTR and NMDP/Be The Match. The next invitation-only Center Outcomes Forum will be held October 19 and 20 in conjunction with the NMDP/Be The Match's Implementing Quality and Value in HCT meeting. A summary of the meeting will be distributed to US Medical Directors and posted on the [Center-Specific Outcomes Analysis webpage](#) where past agendas and recommendations are currently posted.

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[Six New Patient Summaries of CIBMTR Research](#)

By Jessica Gillis-Smith, MPH

Six patient summaries of CIBMTR publications were posted on the [CIBMTR Patient Resources webpage](#) this year:

- [How to decide whether a child can safely donate blood-forming cells to a family member](#)
 - Experts make recommendations to help doctors and parents protect children who might donate blood-forming cells to a sick family member.
- [A survey that asks patients about their physical health before transplant may predict how they'll do after transplant](#)
 - How patients feel physically before and after transplant affects transplant outcomes.
- [Transplant may help older patients with acute myeloid leukemia](#)

- Reduced-intensity transplant is a good treatment option for some older patients with AML.
- [Younger unrelated donors are better for transplant patients](#)
 - The best unrelated donors are aged 18-32 years old and closely HLA-matched to the patient.
- [Half-matched \(haploidentical\) transplant for patients with lymphoma](#)
 - Patients who had a haploidentical or unrelated donor transplant had about the same 3-year survival.
 - Patients who had a haploidentical transplant had less chronic GVHD.
- [Experts develop transplant guidelines](#)
 - These recommendations are important guides for doctors and patients as they talk about whether BMT is a treatment option.

Summaries are created through a collaborative process involving CIBMTR Consumer Advocacy Committee members; CIBMTR and NMDP/Be The Match Medical Writers, Communications Specialists, and Patient Education Specialists; and CIBMTR Scientific Directors. Developing these summaries is one of the main initiatives of the Consumer Advocacy Committee.

The [Consumer Advocacy Committee](#) was created in 2005 as a subcommittee of the Advisory Committee to communicate CIBMTR research results and data to the non-medical community and to provide patient and donor perspectives during the development of the CIBMTR research agenda. Many members have personal experience as a donor, recipient, or family member.

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[CIBMTR Advisory Committee](#)

The Advisory Committee, made up of members from across the globe, maintains careful oversight of the CIBMTR research agenda. Visit the [Advisory Committee webpage](#) to view the list of committee members. We sincerely thank all of our committee members for their time and efforts, particularly Jim Omel, MD, who completed his term June 30. We also welcome Jeff Haertling who joins us as of July 1.

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[Our Supporters](#)

The CIBMTR is supported by Public Health Service Grant/Cooperative Agreement 5U24-CA076518 from the National Cancer Institute (NCI), the National Heart, Lung and Blood Institute (NHLBI) and the National Institute of Allergy and Infectious Diseases (NIAID); a Grant/Cooperative Agreement 5U10HL069294 from NHLBI and NCI; a contract HSH250201200016C with Health Resources and Services Administration (HRSA/DHHS); two Grants N00014-13-1-0039 and N00014-14-1-0028 from the Office of Naval Research; and grants from our [corporate and private contributors](#).

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[Abbreviations](#)

Need an acronym defined? Review our [list of common abbreviations](#).

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