Supplementary Table S1: Early Hospital Discharge Survey

Question	Response Choices
Characteristics of AML patients and AML/Transplant treatment patterns (N*)	
How many patients (newly diagnosed and relapsed) with AML does your institution treat per year? (29)	<25
	25-50
	51-100
	101-200
	>200
Of these, about how many are treated with intensive induction or re-induction chemotherapy (e.g. 7+3, HiDAC, FLAG/FLAG-Ida, CLAG-M, or regimens of similar/higher intensity with or without additional drugs) (29)	<25%
	25-50%
	51-75%
	76-100%
Does your center perform allogeneic transplant for adults with AML? (30)	Yes
	No
How many weeks are patients typically hospitalized for myeloablative conditioning and immediate post-transplant care? (29)	<2 weeks
	2-3 weeks
	3-4 weeks
	>4 weeks
How many weeks are patients typically hospitalized for reduced intensity/non-myeloablative conditioning and immediate post-transplant care? (28)	<2 weeks
	2-3 weeks
	3-4 weeks
	>4 weeks
Resources of the cancer center (N)	
When is the infusion center in the outpatient oncology clinic open (check all that apply) (30)	Weekday - daytime hours (approx. 7AM-5PM)
	Weekday - evening hours (approx. 5PM-10PM)
	Weekday - nighttime hours (approx. 10PM-7AM)
	Weekend day – similar availability as weekdays
	Weekend day – reduced availability relative to weekdays
	Holiday days – similar availability as weekend days
	Holiday days – reduced availability relative to weekend days
	No infusion capacity in the outpatient clinic (e.g., no capacity to give blood transfusion or intravenous supportive care medications (IV fluids or IV antibiotics) in outpatient clinic)
How long does it typically take to get blood products (platelet or packed red blood cell transfusions) for a patient in your outpatient clinic who does not have specific transfusion restrictions? (30)	≤4 hours
	4-12 hours
	12-24 hours
	1-3 days
	>3 days

How long does it typically take between ordering and administering IV antimicrobials in the outpatient clinic (e.g. for patient presenting with concern for infection or neutropenic fever)? (30)	<1 hour
	1-2 hours
	>2 hours
	IV antimicrobials cannot be administered in the outpatient clinic
If a patient with AML has an urgent/unscheduled complaint, is same-day evaluation in the outpatient clinic typically possible? If so, by whom? (30)	Not possible – referral to hospital emergency department (ED) needed
	Possible – evaluation by physician
	Possible – evaluation by advanced practice provider ([APP], either nurse practitioner [NP] or physician assistant [PA])
	Possible – evaluation by Registered Nurse (RN)
	Possible – evaluation by other type of provider
If a patient with AML and presumed neutropenia contacts the clinic reporting fever during weekday clinic hours, how will evaluation occur? (30)	Initial evaluation in outpatient clinic, with subsequent hospital admission if deemed necessary for treatment
	Referral to hospital ED for evaluation/treatment
	Direct admission to inpatient (hematology/oncology) ward for evaluation/treatment
If a patient with AML and presumed neutropenia contacts the clinic/covering provider reporting fever outside of regular clinic hours (nighttime, weekend), how will evaluation occur? (29)	Initial evaluation in outpatient clinic, with subsequent hospital admission if deemed necessary for treatment
	Referral to hospital ED for evaluation/treatment
	Direct admission to inpatient (hematology/oncology) ward for evaluation/treatment
If an adult with AML is evaluated in the clinic and needs hospital admission for neutropenic fever with stable hemodynamics, what percent of the time is there typically a bed available for direct admission on a suitable inpatient ward? (30)	No clinic-inpatient ward admissions – patients always sent to ED first
	<25% of the time
	26-50% of the time
	51-75% of the time
	>75% of the time
Practice patterns following intensive (re)induction chemotherapy (N)	
How does your center provide supportive care following completion of intensive (re)induction chemotherapy for adults with AML? (30)	We typically keep patients hospitalized until blood count recovery
	We attempt to discharge patients after completion of chemotherapy before blood count recovery when medically stable and logistically feasible

If you keep AML patients hospitalized until blood count recovery following completion of intensive (re)induction chemotherapy, what are the predominant reasons? (check all that apply) (23)	High risk of fever, infection, and toxicities from chemotherapy requiring inpatient monitoring
	Inability to provide transfusions in the outpatient setting to meet transfusion needs
	Inability to provide other supportive care needs in outpatient clinic
	Patients typically do not live close enough to hospital/clinic and thus outpatient care is not practical
	Patients typically do not have an appropriate caregiver to help them in the outpatient setting
	Patients typically have trouble accessing transportation to clinic
	Other (please specify)
If attempting to discharge patients early after completion of chemotherapy, where are patients typically discharged to? (check all that apply) (10)	Dedicated housing associated with your hospital/clinic
	Their own homes
	Hotel/temporary lodging in the area
	Other
If attempting to discharge patients early after completion of chemotherapy, when are patients typically discharged? (10)	Right after completion of chemotherapy
	After a Day 14 marrow if no further chemotherapy is indicated
	At count recovery (please indicate at what levels for ANC and platelets below)
	After Day 28 marrow
	Other
If attempting to discharge patients early after completion of chemotherapy, how is appropriateness for this care strategy determined? (check all that apply) (10)	Formal checklist with medical criteria (eg, good performance status, no fever)
	Formal checklist with logistical criteria (eg, caregiver, distance to clinic)
	Informal criteria
	Age cutoff
	Other
What is included in your center's formal checklist for early hospital discharge following induction chemotherapy? (check all that apply) (5)	Performance status
	Age
	Type of chemotherapy regimen
	Organ function criteria
	Fever/infection status
	Blood product frequency need
	Availability of a caregiver
	Ability to live close to clinic (please indicate required distance below)
	Other

Has your center's supportive care strategy changed for adults receiving intensive induction/reinduction chemotherapy changed since the beginning of the COVID-19 pandemic? (30)	Yes, we discharge patients early more frequently now
	Yes, we discharge patients early less frequently now
	No
When initiating azacitidine / decitabine+venetoclax in adults with AML, are patients hospitalized to ramp up venetoclax? (30)	Yes
	No
	Sometimes, depends on clinical and/or logistical characteristics
How does your center treat/care for adults receiving CPX-351? (30)	CPX-351 is given inpatient and patient remains inpatient until cytopenias resolve
	CPX-351 is given in the outpatient clinic followed by hospital admission for monitoring/care during period of cytopenias
	CPX-351 is given in the outpatient clinic, and patient remain outpatient unless they develop a fever or complication that requires admission
	Other
	Not applicable – we don't use CPX-351
Practice patterns following post-remission therapy (N)	
How does your center deliver chemotherapy/care for adults with AML in the post-remission setting? (30)	Deliver chemotherapy inpatient, discharge after completion of chemotherapy if possible (medically and logistically)
	Deliver chemotherapy inpatient, provide inpatient supportive care until blood count recovery (please indicate at what level for ANC and platelets below)
	Deliver chemotherapy outpatient, admit patients following chemotherapy until cytopenias resolve
	Deliver chemotherapy outpatient and continue outpatient supportive care unless toxicities arise that require hospital admission
If patients are hospitalized after (re-) induction chemotherapy but discharged after post-remission chemotherapy, what factors underlie this difference in practice patterns? (check all that apply) (30)	Higher risk of infection/critical illness after (re-) induction than post-remission therapy
	Higher transfusion burden after (re-)induction than post-remission therapy
	Higher/more-frequent supportive care needs after (re)induction than post-remission therapy (e.g. lab monitoring, nursing and provider needs)
	Patients just generally sicker/worse functional status after (re-)induction than post-remission therapy
	Not applicable, we typically keep patients hospitalized after (re-)induction and post-remission therapy
	Not applicable, we attempt to discharge patients early after chemotherapy in both settings
	Other

Barriers to EHD implementation (N)	
Would you be interested in participating in (or learning more about) a clinical trial piloting early hospital discharge following intensive chemotherapy in adults with newly diagnosed AML? (30)	Yes
	No (please explain below)
What potential barriers to a clinical trial piloting EHD do you see at your institution (check all that apply) (24)	Transfusion barrier: patients' transfusion needs are too high to support in the outpatient setting
	Toxicity barrier: Toxicity/infection rate is too high following induction chemotherapy, and there is limited bed availability when re-hospitalization becomes necessary
	Supportive care barrier: patients require more visits with RNs, APPs, and/or MDs following (re-) induction than we have the capacity for
	We do not have capacity to evaluate patients urgently in the outpatient clinic
	Housing barrier: patients typically live far from our center and there is no affordable housing for patients to stay sufficiently close to our center
	Transportation barrier: it is too challenging for patients to come to clinic multiple times per week for monitoring/supportive care due to geography or weather
	Other

*Number of institutions that answered each question
Abbreviations: AML, acute myeloid leukemia; EHD, early hospital discharge

