*This form is a supplement to the Educational Activity Planning Worksheet. The information requested here is for the purpose of educational grant requests.*

The completed form must be submitted **a minimum of 6 months prior** to the activity.

**Important:** The entire Educational Grant Request process **MUST** be conducted by the Accredited Provider, ACAAI. ACAAI will be unable to accredit your activity if this procedure is not strictly adhered to for all educational grants. All Letters of Agreement (LOA) for Commercial Support are between the Accredited Provider and the Commercial Supporter and must be reviewed, approved and signed by ACAAI Staff ***prior***to the activity, or they will not be valid. Commercial support **MUST** be acknowledged in the program materials, but by name only, no logos.

[ ]  **YES** [ ]  **NO We will have this activity supported by educational grants.**

[ ]  **We acknowledge that only ACAAI, the accredited provider, is authorized to submit Educational Grant Requests for**

 **this activity.** *(Otherwise, ACAAI will not accredit this activity.)*

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| --- | --- | --- | --- | --- | --- |
| **Signature** |  | **Printed Name** |  | **Date** |  |

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| **Activity Information** |
|  |
| **Title** |  |
| **Date(s)** |  | **Location** *(if applicable)* |  |
| **Joint Provider Name** |  |

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| **Main Contact** |
|  |
| **Name** |  | **Phone** |  |
| **Title** |  | **Email** |  |
|  |  |  |  |
| **ACAAI Staff** |
|  |
| **Name** |  | **Phone** |  |
| **Title** |  | **Email** |  |
| **Name** |  | **Phone** |  |
| **Title** |  | **Email** |  |

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| **Target Audience** | **Expected Attendance** | **Geographic reach** |
| [ ]  MD/DO  |  | [ ]  National[ ]  Regional[ ]  State[ ]  Local |
| [ ]  PharmD |  |
| [ ]  PhD |  |
| [ ]  Physician Assistant  |  |
| ☐ Nurse Practitioner  |  |
| ☐ RNs  |  |
| ☐ Medical Technologists  |  |
| ☐ Other Medical Professionals |  |

**Session or Content Outline**

***Example:*** Moderator: *<insert moderator name>*

11:00 - 11:05 AM Welcome and Introductions

 *<insert speaker name>*

11:05 – 11:30 AM Do the LEAP Results Extend to Other Foods?

*<insert speaker name>*

11:30 - 11:55 AM Infants at Risk for Peanut Allergy

*<insert speaker name>*

Alternate: *<insert speaker name>*

11:55 AM - 12:20 PM What Does the Future Hold? Clinical Guidelines and Research in Food Allergy

*<insert speaker name>*

12:20 - 12:30 PM Questions and Discussion

**12:30 pm Adjourn**

*You may also attach the agenda as a separate sheet.*

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**Section 1: Competencies**

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| **Accreditation Council for Graduate Medical Education (ACGME) Competencies\*\* — *Criterion 6*** | **Institute of Medicine (IOM) Competencies** | **Interprofessional Education Collaborative Competencies** |
| [ ]  Patient Care[ ]  Medical Knowledge[ ]  Practice-Based Learning & Improvement[ ]  Interpersonal & Communication Skills[ ]  Professionalism[ ]  System-Based Practice | [ ]  Provide patient-centered care[ ]  Work in interdisciplinary teams[ ]  Employ evidence-based practice[ ]  Apply Quality Improvement[ ]  Utilize Informatics | [ ]  Values/Ethics for Interprofessional  Practice[ ]  Roles/Responsibilities[ ]  Interprofessional Communication[ ]  Teams and Teamwork |

***\*\*Required***

**Section 2: Overall Practice Gap**

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| **Overall Professional Practice Gap — *Criteria 2, 3****see attachment “1b-Tips & Verbs for Learning Objectives”****This practice gap should be all encompassing for your activity as a whole.*** |
| *Knowledge = information obtained**Competence = ability to apply knowledge, skills, and judgement in practice* | *Performance = what one actually does in practice**Patient Outcomes = measurable results of treatment* |
|  |  |
| **Current practice***(What is)* | **Ideal Practice***(What should be)* | **Existing Gap***(Difference between* *current and ideal)* | **Type of Practice Gap** |
| 1. |  |  |  | [ ]  Knowledge[ ]  Competence[ ]  Performance[ ]  Patient Outcomes |

**Section 3: Practice Gaps by Therapeutic Area**

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| **Professional Practice Gaps by Therapeutic Area — *Criteria 2, 3******For multiple therapeutic areas, attach additional sheets that cover each part of Section 3.*** |
| **Therapeutic Areas** *(Examples)* |
| ∘ HAE∘ Allergic Rhinitis∘Allergic Conjunctivitis∘Allergy Immunotherapy∘Allergy Respiratory | ∘Anaphylaxis∘Asthma∘Bronchial-Thermoplasty∘ COPD∘Exercise-Induced Bronchospasm | ∘Ocular Allergy∘Primary Immunodeficiency Disease∘Rhinosinusitis∘Other *(please specify)* |
|  |  |  |
| **Current practice***(What is)* | **Ideal Practice***(What should be)* | **Existing Gap***(Difference between* *current and ideal)* | **Type of Practice Gap** |
| ***Example:*** *Allergists are not recommending the early introduction of peanuts into the diet of infants to prevent the development of peanut allergies because there is not strong evidence to support this claim.* | *Allergists will have a better understanding of the current research in peanut allergies, and will be better equipped to identify and manage infants deemed at risk for developing peanut allergy, guiding the successful incorporation of peanut into the diet of these children, and make recommendations about the timing of introduction of other potential high risk allergens into the child’s diet.* | *Current infant weaning guidelines do not suggest that solid food introduction be delayed, but such guidance is passive and does not actively recommend deliberate early introduction of any particular food. With the recent advent of the LEAP study findings, the Interim Consensus Guidelines, and the forthcoming NIAID Addendum to the food allergy guidelines, there will be a new consensus that strongly recommends that peanut become one of the first solid foods weaned into the diet of infants to prevent the development of peanut allergy. At present there is insufficient evidence to support the deliberate early introduction of other foods besides peanut for the purposes of allergy prevention. The strategies to best implement early peanut introduction, a radical departure in prior weaning policy, as well as the long term projected outcomes of this policy change, are unknown. Thus, providers will face challenge in the identification and management of infants deemed at risk for developing peanut allergy, guiding the successful incorporation of peanut into the diet of these children, and making recommendations about the timing of introduction of other potential high risk allergens into the child’s diet.* | [ ]  Knowledge[x]  Competence[x]  Performance[ ]  Patient Outcomes |
| **Therapeutic Area** | *Allergy and Immunology / Clinical Immunology and Autoimmune and Biologicals* |
| **Name of Commercial Company** | *Company X* |
| **Grant Request for** (Monetary or In-Kind) | *$25,000* |
|  |  |
| **Current practice***(What is)* | **Ideal Practice***(What should be)* | **Existing Gap***(Difference between* *current and ideal)* | **Type of Practice Gap** |
|  |  |  | [ ]  Knowledge[ ]  Competence[ ]  Performance[ ]  Patient Outcomes |
| **Therapeutic Area** |  |
| **Name of Commercial Company** |  |
| **Grant Request for** (Monetary or In-Kind) |  |

**Sources used to identify gaps**

***Example***

[x]  Formal or informal request by target audience or faculty (educational needs/topics of interest)

-Evaluation results attached: ***Annual ACAAI Scientific Meeting evaluation results*** [x]  Discussion of needs/gaps in committee meetings

-Meeting minutes for ***Foods*** Committee attached

[x]  Formal survey of target audience

-Survey results attached: ***Feedback from 2015 LEAP Plenary Session*** [x]  New diseases states, technology, methods of diagnosis/treatment

-References attached[x]  Legislative, regulatory or practice guidelines changes affecting patient care

-References attached[ ]  Other *(please specify)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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other

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| **Sources used to identify gap** |

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| [ ]  Formal or informal request by target audience or faculty (educational needs/topics of interest) -Evaluation results attached: ***<insert name of evaluation>*** [ ]  Discussion of needs/gaps in committee meetings -Meeting minutes for ***<insert name of committee>*** Committee attached[ ]  Formal survey of target audience-Survey results attached: ***<insert name of survey>***[ ]  New diseases states, technology, methods of diagnosis/treatment -References attached[ ]  Legislative, regulatory or practice guidelines changes affecting patient care -References attached[ ]  Other *(please specify)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Descriptive Summary of Sources**

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| ***Example***1. *The LEAP study represents a single-center study, not performed in the US, but that experts are attempting apply to a US population. Like any clinical trial it has limitations though it was a good study. However, there were multiple short and long-term outcomes not addressed in the study, most specifically if the findings can be replicated with similar effect sizes in reducing the risk of peanut allergy. NIAID, at the 2015 AAAAI meeting, clearly verbalized that no replication study to LEAP would be funded in the US. However, the population studied in the trial was deliberately narrow and potentially not representative of the patient seen at the community level. Thus, there is limited data upon which to base decision-making regarding a new concept in feeding infants peanut early to prevent peanut allergy, and no data to extrapolate to the timing of introduction of other foods for possible prevention.*
2. *An editorial by Gruchalla and Sampson accompanying the LEAP publication in Feb 2015 in the NEJM called for providers to immediately implement the LEAP study screening protocol as a national guideline. This is a narrow approach that has multiple potential problems in terms of provider access, reliability and predictability of pre-exposure skin testing, stakeholder input, cost-effectiveness of the proposed screening algorithm, and necessity of screening prior to introduction. This was a highly controversial proposal that has debatable feasibility in the US healthcare system. If the screening protocol were adapted, it would introduce 800,000 children per year that would potential seek or need evaluation for early peanut introduction (including oral food challenge), with only ~5000 allergists in the US available to provide such service. Thus there is a significant gap in the knowledge translation of what an optimal policy may be, and a significant void in how to best implement and finance significant policy changes such as early peanut introduction*
3. *A group of 10 international medical organizations representing Allergy, Pediatrics, and Dermatology jointly developed an interim consensus statement to help advise providers on how to best apply the LEAP study finding to their practice, and how to best help patients at risk for peanut allergy. This guideline evaluated the LEAP trial and the editorial, and was in general agreement with the approach outlined by the Gruchalla/Sampson editorial though it provided some additional flexibility to the approach given the input was from multiple different areas of the world and reflected differences in culture and prevalence of peanut allergy. However, the document did not address application of early peanut introduction beyond the risk categorization of the LEAP study, or address strategies for implementation, health care service utilization, cost-effectiveness, or stakeholder preferences regarding this policy. Thus there is a significant gap in the knowledge translation of what an optimal policy may be, and a significant void in how to best implement and finance significant policy changes such as early peanut introduction which is only minimally informed through the interim consensus document.*
4. *The NIAID has formed an expert panel to evaluate the current evidence supporting the benefits vs. risks of early peanut introduction. This panel has undertaken a GRADE analysis of the available literature regarding early peanut introduction to create an addendum to the 2010 food allergy guidelines. This addendum has advanced the recommendations regarding early peanut introduction beyond the Interim Consensus document in terms of setting firmer criteria for who constitutes high risk infants in terms of eczema and egg allergy definition compared to the LEAP study, a higher skin testing cut-off, firmer criteria for children who are low risk and could have home peanut introduction, inclusion of sIgE as a means to screen children to help evaluate if they can have home introduction vs. needing allergy evaluation, and expansion of the eligible population to low risk and moderate risk children.*

*Similar to the Interim Consensus, this document does not address long term outcomes, dissemination and implementation of the recommendation, cost-effectiveness of screening and in office challenge, or stakeholder preferences regarding this policy. Thus, GRADE rated addendum, there are still considerable practice gaps in terms of how the allergy provider will synthesize this new information, apply it to their practice, communicate with referring physicians in the community regarding who should seek further evaluation in a specialist office prior to introducing peanut into the diet, and determine who can have introduction at home as opposed to would be better served with introduction in the office. Moreover, there are gaps in long term outcomes of the change in the feeding policy, how to best accommodate early peanut introduction when another family member has an existing peanut allergy, and how effective this policy change will be in terms of altering the long term incidence and prevalence of peanut allergy.*1. *Lastly, the LEAP study dealt only with the early introduction of peanut, and did not investigate other foods and possible prevention. There are ongoing trials regarding early egg introduction, which should be completed and published shortly, and may help inform if early egg introduction can help reduce the risk of egg allergy development, and a recently published study that explored early vs. delayed multiple allergen introduction in otherwise exclusively breastfed children who were not at high risk for food allergy development. At present, there are inconclusive data supporting the optimal timing of egg introduction to prevent the development of egg allergy. As well, the study regarding the timing of multiple foods struggled to achieve any significant differences between groups secondary to compliance issues, and thus could also not inform policy regarding the relationship between the timing of solid food introduction and the prevention of food allergy. Thus, there are significant practice gaps in understanding if the timing of other food introduction (besides peanut) is associated with a decrease risk in developing food allergy, what guidance providers should be offering concerned parents, what children may be at risk for the development of food allergy, and how to best inform infant weaning policy.*
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| **Descriptive Summary of Sources**  |

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**Educational Need**

*What does the participant need to learn in order to close the gap stated above?*

***Example***

*Because of the multiple practice gaps, it is important for the practicing allergist to understand the role in identifying infants at highest theoretical risk for the development of peanut allergy to help facilitate the preventative benefits of early peanut introduction in this group, as well as understand the evidence regarding the general timing of solid food introduction and the risk of food allergy development. In particular, the provider needs to know:*

*--What criteria would make an infant at high risk for the development of peanut and other food allergies*

*--Interpret the NIAID guidelines pertaining to infant weaning, safe facilitation of early peanut introduction, and the prevention of peanut allergy*

*--Interpret the current evidence regarding the early introduction of other solid foods and the risk of developing food allergy*

*--Effective means of communicating the evidence of these risk factors and best-practice strategies to key stakeholders including affected families and referring physicians*

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| **Educational Need***What does the participant need to learn in order to close the gap stated above?* |

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**Learning Objectives**

*See “1c\_Joint Providers\_Tips & Verbs for Learning Objectives” document*

***Example***

*Upon completion of this session, participants should be able to:*

* *Identify which children are at highest risk of developing peanut allergy and of receiving the most benefit from early peanut introduction as a food allergy preventative strategy*
* *Recommend means for facilitating safe introduction of peanut*
* *Recommend strategies regarding the timing of introduction of other potential food allergens in the infant diet*

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| **Learning Objectives***See “Verbs for Learning Objectives” document* |

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**Desired Results**

*How will the information that is presented impact the clinical practice and/or behavior of the learner?*

*(competence, performance, or patient outcomes)*

***Example***

*The allergists will learn:*

* *How to identify children at highest risk for the development of peanut allergy who would most benefit from early peanut introduction*
* *How to manage early peanut introduction in children at high risk for the development of peanut allergy*
* *Current evidence regarding potential for early introduction as a preventative strategy for other foods*

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| **Anticipated Changes in Practice***What observable changes do you anticipate physicians making after participating in this activity?* *(competence, performance, or patient outcomes)* |

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| **Identified Barriers — *Criteria 18, 19***What potential barriers do you anticipate participants may have in incorporating new knowledge, competency and/or performance objectives into practice? ***(check all that apply)*** |
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| [ ]  Lack of time to assess or counsel patients[ ]  Lack of administrative support/resources[ ]  Lack of time to research this topic[ ]  Lack of consensus on professional  guidelines | [ ]  Patient compliance issues[ ]  Insurance/reimbursement issues[ ]  Organizational/Institutional issues[ ]  Cost[ ]  Treatment to adverse events | [ ]  Other *(please specify)*  |
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| ***Please provide the planned discussion that will occur to help overcome the barriers stated above.*** |
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**Section 4: Moore’s Level of Outcomes**

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| **Moore’s Levels of Outcomes — *Criteria 11***Which level(s) of educational evaluation will best determine whether your educational activity has closed the identified gap(s)? ***(check all that apply)*** |
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| **Outcome Levels** | **Description** | **Sources of Data** | **Yes, this level will be met** |
| ***Level 1******Participation*** | Number of learners who participate in the educational activity | ∘Attendance records | [ ]  **YES** |
| ***Level 2******Satisfaction*** | Degree to which participants’ expectations were met regarding the setting and delivery of the educational activity | ∘Activity evaluations completed byparticipants after an educational activity | [ ]  **YES** |
| ***Level 3A******Learning: Declarative Knowledge****(Knows)* | The degree to which participants state the educational activity met the learning objectives | Objective | Pre and posttests ofknowledge | [ ]  **YES** |
| ***Level 3B******Learning: Procedural Knowledge****(Knows how)* | The degree to which participants are able to convey how to accomplish the learning objectives | Subjective | Attendee self-reports personal knowledge gained *(on evaluation form)* | [ ]  **YES** |
| ***Level 4******Competence****(Shows how)* | The degree to which participants show in an educational setting how they are achieving the learning objectives | Objective | Observation in educationalsetting *(e.g., checklists, online peer assessment)* | [ ]  **YES** |
| Subjective | Self-reported competence,intention to change *(on evaluation form)* |
| ***Level 5******Performance****(Does)* | The degree to which participants are able to perform the learning objectives | Objective | Observed performance inclinical setting, patient charts,administrative databases | [ ]  **YES** |
| Subjective | Self-report of performance |
| ***Level 6******Patient Health*** | The degree to which the health status of patients improves due to changes in practice behavior of participants | Objective | Health status measuresrecorded in patient charts oradministrative databases | [ ]  **YES** |
| Subjective | Patient self-report of health status |
| ***Level 7******Community Health*** | The degree to which the health status of a community of patients changes due to changes in the practice behavior ofparticipants | Objective | Epidemiological data and Reports | [ ]  **YES** |
| Subjective | Community self-report |