

## **Frequently Asked Questions: Allergy and Immunology** **Review Committee for Allergy and Immunology** **ACGME**

### **Program Director**

#### **Are co-program directors permitted?** *[Program Requirement II.A.1]*

A program must have one program director who assumes responsibility for the program, including communicating with the ACGME, as specified in the Program Requirements. A program has the option to appoint co- or associate program directors; the ACGME, however, only recognizes a single designated individual as program director.

#### **Does the RRC grant waivers for American Board of Allergy and Immunology (ABAI) certification of the program director if the program director can demonstrate “equivalent qualifications?”** *[Program Requirement II.A.3]*

In unusual circumstances, the RRC will consider an exception to the requirement for ABAI certification. Exceptions are made on a case-by-case basis; in these cases the Committee considers a candidate’s educational and professional experiences, as well as academic productivity.

### **Faculty**

#### **What is considered an 'adequate' level of scholarly activity for establishing and maintaining an environment of inquiry and scholarship?** *[Program Requirement II.B.5]*

The RRC is primarily concerned with the environment for residents and the encouragement and mentoring of scholarly activities. This would be reflected in scholarly activities documented in the program information form (PIF) and would include papers authored by the residents, grants submitted by residents, research projects, and abstracts presented by residents. Although the ideal is to have the program director serve as a mentor in all phases of a resident’s education including the research experience, he or she is not required to demonstrate productivity. Some members of the faculty, however, should be active in research,

### **Resident Appointments**

#### **Is RRC permission required for increasing the resident complement?** *[Program Requirement III.B]*

Program directors are not required to seek prior approval to increase the number of residents currently enrolled in the program. They are, however, required to use the *'Request a Complement Change'* function of the ACGME’s Accreditation Data System (ADS) to notify the RRC of the change. After the DIO has approved the 'request', the information is posted in ADS and the ACGME staff is alerted automatically. RRC staff will process the change in complement and update the program’s history with the new information. If a resident is delayed in completing the program by more than one month, the program must notify the RRC of this change.



## Residents' Scholarly Activities

**What is meant by “25% of the program must be devoted to other educational activities”?**  
*[Program Requirement Int.B.6.c, IV.B.4]*

The other educational activities include **any** experiences determined by the program director to be useful or important for competency in allergy and immunology. That decision should be based on the unique characteristics of the program, or the individual needs of residents. Examples include additional research time; additional clinic time; attending medical meetings; manuscript preparation; the preparation and presentation of teaching conferences, case presentations, and meeting abstracts; electives in other clinical disciplines; teaching medical students and residents; or attending a didactic course. Additional examples are listed in **V.D.3** of the Program Requirements. The program director would ideally utilize this time to address needs, concerns, or interests of an individual resident, not for service needs or resident personal leave for vacation or other nonacademic purposes. A rationale should be available to the site visitor and/or presented in the program information form (PIF) to justify these activities. Ultimately, the resident should achieve **AT LEAST** 50% clinical time and **AT LEAST** 25% research time.

## Educational Program

**How does the RRC assess that residents have at least 20% of direct patient care activity in cross training?** *[Program Requirement IV.A.5.a).(2).(b)]*

The RRC reviews the distribution of time reported on the block diagram and the program director's narrative in the PIF, the percentage/number of pediatric and adult patients logged as primary diagnoses by the residents in the Case Log System, and residents' responses to the annual ACGME Resident Survey. Citations result if significant issues are noted.

**How should the program director respond to a situation in which a required learning experience, such as insect hypersensitivity, is infrequent and cannot be adequately documented in the case logs?** *[Program Requirement IV.A.5.a).(16).(k)]*

Log data should reflect the actual clinical experience of each resident; if a diagnosis such as insect hypersensitivity is in the differential diagnosis, the log entry may include 'insect hypersensitivity.' Additionally, the program director may modify the educational curriculum to include teaching conference(s) about the topic, or virtual case experiences, or by designating and documenting residents' participation in relevant didactic activities at specialty society meetings.

## Duty Hours

**Which licensed independent practitioners are acceptable to provide supervision to residents?** *[Program Requirement VI.D.1]*

Clinical psychologists, clinical social workers, nurse practitioners, physician assistants, and registered dietitians, for example, may supervise residents' clinical activities when the program director determines that their special expertise will promote education and provide a level of supervision equivalent to that provided by an attending physician. During these

situations, there must also be direct or indirect, as required, supervision by a physician faculty member.

**What is the optimal clinical workload for an allergy and immunology resident?**

*[Program Requirement VI.E.]*

A resident's clinical workload should provide sufficient opportunities to meet all of the program requirements for patient care experiences. Using Case Log data as a reference standard, residents should see an adequate number of patients to reach required diagnoses for at least the tenth percentile of patients. Programs should ensure that patients are evenly distributed across the time dedicated for clinical activity during the residency. Residents' logs should be monitored during all formal performance evaluation sessions.

**Which other health care professionals should be a part of the residents' interprofessional team?** *[Program Requirement VI.F.]*

Advanced practice providers, audiologists, billing and administrative staff members, nurses, nutritional consultants, pharmacists, physician assistants, respiratory therapists, social workers, and speech and language pathologists may be included as a part of interprofessional teams.

Residents must demonstrate the ability to work and to communicate with health care professionals to provide effective, patient-focused care.

**Is a first year allergy and immunology resident considered to be a PGY-1 or intermediate level resident?** *[Program Requirement: VI.G.5.b)]*

Program directors should monitor resident duty hour requirements in a manner consistent with the year of post-graduate education each resident has achieved. The majority of allergy and immunology residents enter specialty education at the PGY-4 or PGY-5 level. From a duty hour perspective, first year allergy and immunology residents should be able to function as advanced residents consistent with program requirement VI.G.5.c. However, some may come to residency with a specialized education schedule, and may only be at the PGY-2 or PGY-3 level. These residents should be monitored as "intermediate" residents for one year. Regardless of level of education, all residents must have immediate access by telecommunication devices (pager, cell phone) with a faculty physician while on duty.

**Other**

**Why are sleep disorders and sweat tests listed in the Case Log System?**

These categories were listed in the System when it was first developed, but are no longer monitored by the Residency Review Committee (RRC). It is not necessary for residents to log them, nor will a program be cited for failing to report data in these areas. Because data concerning these categories remain in the System, they are still displayed in summary reports.

While both sleep disorders (diagnosis) and sweat tests (procedure) still appear as selections in the drop-down menu, it is not possible for allergy and immunology residents to enter data for either category; program directors should advise residents to ignore them. When the

ACGME Case Log System is next revised, inactive categories will no longer appear as options.

### **Which procedures must be logged by all fellows?**

Required procedures are: allergen immunotherapy, drug desensitization and challenge, performance and interpretation of immediate hypersensitivity skin testing, IVIG treatment and administration, performance and interpretation of pulmonary function tests, performance and interpretation of physical urticaria testing, and food challenge testing.

### **How should procedures be logged when more than one resident is involved, and when serial treatments are administered?**

An individual resident's log should reflect the activities of that resident. When more than one resident participates in a given procedure, each should log it, providing the criteria outlined below have been met. When serial (e.g., weekly or monthly) treatments are administered to a given patient, the participating resident(s) should log each encounter.

#### **(a) Prescribing and monitoring allergen immunotherapy**

1. The resident is involved in the discussion as to the need for immunotherapy **AND** in the formulation of the allergen vaccine contents (writing the prescription).

**OR**

2. The resident assists physically in the mixing of an allergen vaccine. This would be recorded as one event per patient, even if more than one vial is prepared or multiple dilutions of each vaccine are produced.

**OR**

3. The resident evaluates the indications for, and is involved in the discussion related to, a dose change in allergen vaccine due to pregnancy, local reaction, systemic reaction, change in lung function, interruption of administration schedule, change in other medication (e.g., initiation of beta blocker eye drops), or other relevant event.

**OR**

4. The resident evaluates and assists in the treatment of a local or systemic reaction to specific allergen immunotherapy. This would include treatment of the acute reaction and/or adjustment of the dose or schedule if necessary.

**OR**

5. The resident administers allergen vaccine to an individual patient. This would include drawing the correct dose into a syringe, preparing the skin, administering the dose, and documenting its administration and any adverse events. Allergen immunotherapy should be logged as a single procedure per patient per visit, even if more than one specific allergen extract/vaccine is administered.

#### **(b) Drug desensitization and challenge**

1. The resident assesses a patient with history of an adverse drug reaction and develops a desensitization or challenge procedure based upon review of the medical literature, available protocols, and/or discussions with the attending physician. The resident then orders the specific dosing of the drug, and monitors and documents the results of the desensitization and challenge. The resident participates in the discussion of risks and benefits with the patient and/or obtains informed consent before the procedure and counsels the patient after administration. To fulfill this criterion the resident is not required to remain at the bedside throughout the process provided he/she is available to assist should a problem arise. (Individual programs may have policies requiring the resident to administer the doses or to directly and continuously monitor the patient throughout a procedure. This is not required for the case log).

(c) Performance and interpretation of immediate hypersensitivity skin testing

1. The resident evaluates the patient, is involved in the discussion of the indications and allergen selection for immediate hypersensitivity skin testing, and interprets the results with the attending physician and the patient.

**OR**

2. The resident performs percutaneous and/or intradermal skin testing of the patient. Each patient is logged as a single event, not each skin test.

(d) Ig treatment and administration [this applies to use of intravenous (IV) or subcutaneous (SC) immune globulin for replacement therapy or immunomodulation]

1. The resident evaluates a patient, participates in discussing the need for Ig therapy, **AND** calculates the dose or is involved in writing the order.

**OR**

2. The resident administers or monitors Ig therapy to a patient. This may include starting the IV or SC infusion and adjusting the rate. It may also include being present during infusion and actively participating in the monitoring of vital signs and response to any changes.

**OR**

3. The resident interacts with staff involved in the Ig administration (e.g., assessing a report of an adverse event and recommending treatment). The resident would not have to be present during the actual adverse event.

**OR**

4. The resident is involved in the decision to change the dosage or route of administration of an Ig product.

(e) Performance and interpretation of pulmonary function tests (PFT)

1. The resident assesses the patient and requests the PFT after discussing with the attending physician. The resident and the attending physician interpret the PFT and develop a treatment plan.

**OR**

2. The resident participates in the performance of a PFT of an individual patient such as spirometry or measurement of lung volumes and diffusion capacity. The resident is not required to perform the test directly but must be present during the process. Residents are not required to log Peak Expiratory Flow rate monitoring.

(f) Performance and interpretation of physical urticaria testing

1. The resident evaluates a patient and discusses the need for physical urticaria testing. The resident **participates** in the testing and discusses the result with the patient and attending physician (e.g., testing for dermatographia, or urticaria/angioedema induced by pressure, temperature change (hot/cold), or exposure to UV light). Each test should be logged as a separate procedure.

(g) Food challenge testing

1. The resident evaluates the patient and discusses the need for food challenge testing. The resident is directly involved in ordering the challenge according to an existing protocol, or in developing a medical literature-based protocol. The resident interprets the results and discusses them with the attending physician and the patient. Each logged event is an individual patient on a specific day or with a specific antigen. An individual patient would be logged more than once for repeat testing with different antigens. Placebo challenges, however, would not be logged as separate events. Each dose of antigen is NOT logged as a distinct event. The resident would not have to be present during the actual challenge, but should be immediately available to respond to problems or questions.

**OR**

2. The resident directly performs a food challenge, either blinded or open, and observes the patient for adverse events. If multiple doses of a specific food or a double-blind challenge is performed involving a single patient, the case should be logged as a single event. If the same patient undergoes challenge with other foods, those challenges should be logged as additional events.

**What procedures are fellows 'encouraged' to log?**

The procedures that fellows are encouraged to log include: provocative testing for hyperreactive airways, nasal cytology, contact dermatitis patch testing, rhinolaryngoscopy, and the performance and interpretation of delayed hypersensitivity (anergy) skin testing. **The RRC will not issue citations for 'encouraged' procedures.** If a program director wishes to utilize log data to assess proficiency in these procedures, the following criteria are suggested:

- (a) Provocative testing for hyperreactive airways (methacholine inhalation, allergen challenge, exercise challenge, mannitol challenge, or cold air challenge)
  1. The resident evaluates a patient and discusses the need for provocative testing for hyperreactive airways. The resident orders the test with the

attending physician or participates in the design of the protocol and interprets the results with the attending physician and discusses them with the patient.

**OR**

2. The resident is physically present during provocative testing, evaluates the patient, and/or interacts with the staff assisting in the challenge. Each type of challenge or each unique patient is a separately logged event but NOT each dose or each step of an individual challenge.

(b) Nasal cytology

1. The resident evaluates a patient and participates in the discussion of the indications for nasal cytology. The resident orders the test and interprets the results with the attending physician and discusses them with the patient.

**OR**

2. The resident evaluates a patient and obtains a nasal mucous or mucosal sample, prepares and stains the preparation, and performs the microscopic examination. The results are interpreted with the attending physician and discussed with the patient.

**OR**

3. The resident reviews existing nasal cytology preparations with staff and/or faculty. Each preparation should be logged as a single event.

(c) Patch testing

1. The resident interprets results of patch testing on an individual patient and discusses their relevance as well as appropriate avoidance measures with the patient.

**OR**

2. The resident evaluates a patient and participates in discussion with the attending physician of the need for patch testing, and selection of the specific antigens.

**OR**

3. The resident performs the actual patch test by applying and subsequently removing one or more patches, evaluating the response, and discussing the results with a staff or faculty member and the patient. Each patient should be logged as a single event, NOT each test antigen.

(d) Rhinolaryngoscopy

1. The resident is involved in direct performance of rhinolaryngoscopy (i.e., holds and manipulates the scope, interprets the findings, and discusses the results with the attending physician and patient). Each patient is logged as a single event on a specific day but an individual patient may be logged more than once if rhinoscopy is repeated during later visits. Ideally the resident should assist with obtaining consent, with administering preparatory medications and with cleaning the scope after the procedure.

(e) Performance and interpretation of delayed hypersensitivity (anergy) skin testing

1. The resident evaluates a patient and is involved in discussion of the indications for testing. The resident orders the specific antigen tests, interprets the results, and discusses them with the attending physician and patient.

**OR**

2. The resident directly applies the skin test(s) and interprets the response. The results are discussed with the staff and/or attending physician. Each patient should be logged as a single event, not each skin test.

**How does the RRC assess performance of a program's residents on the ABAI certifying examination?**

The pass rate is defined as 75% for first-time test takers when averaged over the previous five years. Programs that do not have a five-year record will be assessed on a case-by-case basis.

**What circumstances would lead the RRC to request a progress report, and how are progress reports evaluated?**

A progress report is requested when the RRC agrees that a program should provide additional information about areas(s) of noncompliance identified at the time of an RRC review of the program. Progress reports should only be submitted when requested. The request for a report, as well as a submission deadline, is stated in the Letter of Notification sent to a program following the RRC meeting during which the program was reviewed. Unsolicited reports will be administratively acknowledged with no further action, and will not be scheduled for review by the RRC.

When a progress report is received following a request by the RRC, it is added to the program agenda for review by the Committee at the following meeting. The report should provide an update on how the program is addressing the identified area(s) of non-compliance. Prior to the meeting, the submitted progress report is assigned to a Committee member who assesses the response and prepares a written report summarizing the response for discussion by the full RRC. It is important to note that the RRC does not remove a citation from a program's history when a progress report is reviewed. While a notification letter generated after RRC review of the report may state that the area(s) of noncompliance has (have) been satisfactorily addressed, the citation remains part of the program's history to be revisited by the site visitor at the time of the next survey. The RRC will then reexamine the issue as a previous citation.

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