ACGME INTERNATIONAL

Case Log Information for Radiology Programs

Background

The ACGME-I Case Log System is a data depository to support programs in complying with the Advanced Specialty Requirements and to enable program directors to monitor each resident's clinical experience by capturing and categorizing resident cases.

The Surgical/Hospital-based Review Committee-International examines cases completed by graduating residents to determine a program's compliance with clinical experience requirements, judge if educational resources are sufficient for the program's accredited complement of residents, and evaluate the breadth and depth of resident experiences. The Committee understands that documenting experience in any of the listed procedures does not signify achievement of competence in any procedure, nor do the cases required for logging represent the totality of clinical competence needed in any given specialty. Most importantly, completing a certain number of procedures does not replace or negate the requirement that, upon a resident's completion of the program, the program director must verify the resident demonstrates sufficient competence to enter practice without direct supervision.

Case Logs in radiology use aggregated case entry. Programs have a responsibility to enter aggregate numbers of cases accurately and in a timely manner. It is important that cases are logged throughout the duration of a resident's time in the program, even after minimum requirements have been met. Programs will also have an option for residents to log interventional cases. Interventional cases are logged individually by the residents. Although logging of these cases is not required and interventional cases will not be considered by the Review Committee-International, this information may be useful when evaluating or counselling residents or as part of a program's curriculum development.

Program directors have the responsibility to regularly review and analyze each resident's completed cases. It is recommended that program directors review the Activity Report at least quarterly to ensure residents are gaining adequate experience for their level in the program.

The Accreditation Data System (ADS) Case Log tab includes general references on entering and retrieving information. Each specialty's page on the ACGME-I website contains additional Case Log references, including a Resident Quick Guide with definitions and case entry requirements particular to the specialty and a Faculty and Staff Quick Guide to assist program directors and faculty members choose and evaluate Case Log reports. Residents and program personnel responsible for entering aggregated cases are encouraged to review these resources prior to their first case entries and to continue to refer to them as needed. Program directors can use information from the reports in ADS to review resident progress toward meeting clinical experience requirements, to set and evaluate curriculum, and to inform clinical faculty members about residents' clinical experience needs.

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FREQUENTLY ASKED QUESTIONS

1. **If the institution uses an electronic system to track cases, duty hours, resident evaluations, etc., can the Case Log data from this system be uploaded into ADS?** No. At present there is no mechanism to electronically transfer cases from another system into ADS. The program director has ultimate responsibility to ensure that all data reported in ADS is accurate and complete and should encourage residents to enter their case data daily in the Case Log System in ADS.

2. **Will residents have access to their Case Logs after graduation?**
   Yes. Residents can access their Case Log reports after completion of the program to use for hospital credentialing, apply for fellowships, etc. Residents are not able to add cases after completing the program, but can access reports such as, 'Archived Experience by Year' and 'Archived Minimums', to provide a record of their residency experience.

3. **How can a resident use information from their Case Logs?**
   During the residency, Case Logs are useful to help residents determine the breadth and depth of their procedural experience. Case Logs can be used to inform revision of rotations to allow for more experience in a procedure or prevent too much experience with one type of patient or procedure at the expense of broader educational goals. After residency, Case Logs provide a record of experiences when applying for fellowships or for hospital credentialing.

4. **How can a program director use information from resident Case Logs?**
   Program directors can apply filters for several of the reports available on the Case Log tab in ADS to determine how individual rotations, participating sites, or supervising faculty members are contributing to the residents' experiences. Program directors can also review when and how residents are recording their cases. For example, if a program requires residents to enter cases each week, the Resident Activity Report can be run weekly, and it can be quickly identified if a resident has not logged any cases.

5. **How does the Review Committee use Case Log data?**
   The Review Committee-International will review case reports for residents who have graduated from the program to determine the type of clinical experiences graduating residents have completed. The Committee will also review the data to determine if residents are completing large numbers of certain procedures while not obtaining experience in all specialty areas. These analyses will allow the Committee to determine the breadth and depth of experiences provided by a program and to help judge the residents' service obligations. Citations will result if the Committee judges that residents are performing certain procedures as excessive service over education, and if resident reporting is inconsistent or lacking.

   Additionally, the Review Committee-International will periodically review Case Logs of graduating residents to determine if minimum requirements should be revised or if minimums should be established for additional clinical experiences.

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6. **What are the minimum case numbers for radiology procedures?**
The following table summarizes the minimum number requirements for graduating residents in radiology. These procedures will be entered by the program as aggregated data for each resident. Aggregated data for each resident must be entered at least semiannually. Review of Case Logs should be part of each resident's semiannual review.

Procedures	Required minimum number
Chest X-ray	1,900
Computerized Tomography Angiography (CTA), Magnetic Resonance Angiography (MRA)	100
Mammography	300
Computerized Tomography (CT) abdomen/pelvis	600
Ultrasound abdomen/pelvis	350
Image guided biopsy/drainage	25
Magnetic Resonance Imaging (MRI) lower extremity, joints	20
MRI brain	110
Positron Emission Tomography (PET)	30
MRI body	20
MRI spine	60

Programs also have the option for residents to individually log the following procedures. There are no case minimums for these procedures and the Review Committee-International does not review or consider these cases as part of the annual review of the program:

- Aortic Stent Grafting
- Arterial Percutaneous Transluminal Angioplasty (PTA) or stent
- Dialysis Access Intervention
- Embolization
- New Outpatient Clinic Evaluation
- Primary GI intervention such as Percutaneous Transhepatic Biliary Drainage (PTBD), Cholecystostomy or Gastrostomy
- Primary Nephrostomy
- Thrombolysis or Thrombectomy, Arterial or Venous
- Transvenous Intrahepatic Portosystemic Shunt (TIPS) or TIPS Revision
- Tumor Ablation
- Venous Port
- Venous Intervention (Stent, PTA, or Filter)
- Other optional procedures

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