ACGME-I Case Logs
QUICK GUIDE for Faculty and Staff in Neurological Surgery

Consider the following when reviewing resident Case Log reports or when counselling residents on their Case Log entry:

1. The following are definitions for the resident role options:

   Surgeon: Resident has substantial responsibility for the case and performs more than 50 percent of the surgical procedure under appropriate faculty supervision.

   Assistant: Resident assists during the procedure with another surgeon who is an attending or more senior resident and who is responsible for the case. The Assistant performs less than 50 percent of the surgical procedure.

   Teaching Assistant: A senior resident who instructs another resident who is taking credit for the case as Surgeon. The Teaching Assistant performs less than 50 percent of the surgical procedure.

2. Only the resident roles of Surgeon and Teaching Assistant are counted toward minimum case requirements.

   Resident roles can be used by the program director and faculty members to review how the resident is taking progressive responsibility throughout the educational program. The Surgical/Hospital-based Review Committee expects that Case Log data will demonstrate increasing participation and progressive responsibility as the resident progresses through the program.

3. **Credit options:** If multiple procedures are performed during a single operation, one of those procedures must be designated as Primary. Residents may enter more than one procedure per case, but can enter only one for Primary credit. Only Primary credit procedures are counted toward minimum requirements.

   Primary: The procedure or treatment that is the main reason for providing care to the patient on the date indicated

   Secondary: All other subordinate procedures or treatments performed on the date indicated

   If more than one resident participated in a case, each resident may claim the same procedure for credit, as long as the claimed roles are not the same.

4. **Critical Care:** Residents are required to log 60 critical care procedures. Residents can pair one or more minor procedures with a major procedure for a particular patient care episode.

For example, if a resident intubates a patient, places a central line, and participates in a lumbar fusion, he or she may log a primary procedure for airway management as one case, a primary procedure for central line placement as a separate case, and a primary procedure for the lumbar fusion as a third case. Other elements of the spine surgery must still be included as secondary codes within the lumbar fusion case.

5. **Airway Management:** The requirement for 10 procedures in this case category can be met by multiple procedures, including intubation, tracheostomy, thoracentesis, tube thoracostomy, and bronchoscopy. Though direct laryngoscopy is only a component of intubation and may not be performed fiber-optically, coding intubation in this manner will ensure appropriate credit.

6. The following are the definitions for patient type options:

   Adult: 18 years of age or older

   Pediatric: younger than 18 years old

A pediatric patient who is 18 years or older at the time of a follow-up procedure must be logged as an adult patient. A pediatric patient who is 18 years or older at the time of follow up must be logged as an adult patient.

Available Reports

Experience by Role	This report lists all procedures, including those that do not count toward the required minimum numbers, the number of each performed by the selected resident in each of the three roles, as well as the total number for each procedure. This report is very similar to an expanded version of the Minimums Report. It is formatted the same way, but omits the required minimum number for each defined case category, while including procedures that do not have a minimum number required.
Experience by Year	This report provides a summary of the total number of procedures performed by a resident, by year in which they were performed. It provides a quick way to see which procedures are most common for each PG year. Like the Code Summary Report, the Resident Experience Report by Year will provide useful information for monitoring surgical activity in the program, and could be used to determine if changes to curriculum rotation schedules, etc., are needed
Activity Report	This report allows program directors to note the number of cases or procedures logged by residents and the date and time that cases or updates are entered. This report is a quick way to keep track of how frequently residents are entering their cases. For example, if the program has a requirement that residents must enter cases weekly, running this report on a weekly basis is an easy way to identify residents who are not meeting the residency's requirements.

Case Brief Report	This is a brief report that lists the procedure date, case identifying number, CPT code, institution, resident role, attending faculty member and description for each case for the selected resident.
Case Detail Report	All information for each case entered is displayed in this report, making it useful for getting an in-depth view of an individual resident's experience during a defined period. For example, this report can be generated for each resident for the preceding three-month period and used as part of the quarterly evaluation meeting with the program director or designated faculty mentor.
Code Summary Report	This report provides the number of times a unique CPT code is entered into the Case Log System by a resident. Filtering by specific CPT code, attending faculty member, institution, and/or setting can provide information on clinical activity that is useful to make targeted changes in rotation schedules, curriculum, faculty assignments, etc. This report can also be especially helpful in monitoring the procedures that do not count toward minimums. Choosing non-tracked codes on the area dropdown will show the procedures that have been entered and will not count toward minimum requirements. Review of this report can help programs identify whether residents are using the correct codes.
Tracked Codes Report	This report provides a summary and description of all of the cases defined by the specialty that can be entered into the ACGME-I case log system. This report is organized by CPT codes; however, even if CPT codes are not used in your system, the report is useful to get a comprehensive listing of all procedures that are available to be tracked.
Neurological Surgery Defined Category and Minimums Report	This report will track resident progress toward achieving minimum numbers. A separate report should be generated for each resident using the default settings (credit should be primary). Note that the cases reported in the Assistant role do not count for credit; subtract this number.

For technical support or questions regarding the Accreditation Data System (ADS) and the Case Log System, e-mail ADS@acgme.org.