



**RESIDENT CASE LOG SYSTEM
PEDIATRICS**

DATA ENTRY MANUAL

July 2004

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INTRODUCTION

The Resident Case Log System is an Internet-based data collection system utilizing CPT/ICD9 codes.

The system was designed to permit residents to enter Cases on a regular basis at their convenience. However, some programs may prefer to have residents report their Case Entries to one individual who will enter all Cases for all residents. Data may be entered from any PC connected to the internet.

The site is secured by an encryption certificate obtained through the Verisign Corporation.

GETTING STARTED

The RRC office provides each program director with a "User ID" and "Password" to access the system. The program enters program specific information such as residents, Supervisor physicians, locations, and users.

Access to the system is available through most commonly used Internet browsers and providers, such as Microsoft Internet Explorer 4.01, Netscape 4.0, AOL, and Prodigy. No special download is required.

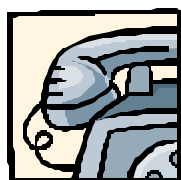


TECHNICAL NOTE: "Cookies" are small pieces of information stored on a web browser that improve computer performance. In order for the Resident Case Log System to work properly, your computer must be set up so that Cookies are *NOT* disabled. Contact your local technical support staff if your computer's default settings need to be changed.

When running reports the system will ask you to download the "Crystal Report Viewer." This is a Seagate Crystal Report application, which allows you to search and print reports. Please answer yes to the download.

CONTACT US

As you use this application, please do not hesitate to contact the ACGME Help Desk (312/755-7464) when you have questions or suggestions. Additionally, you can contact us via e-mail at oplog@acgme.org



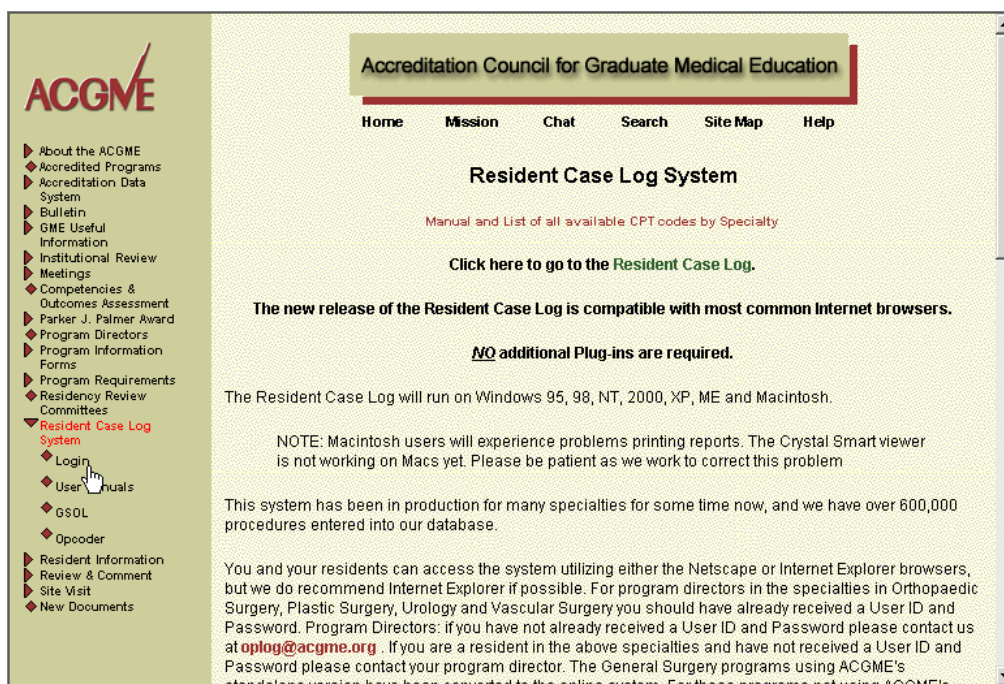
312.755-7464



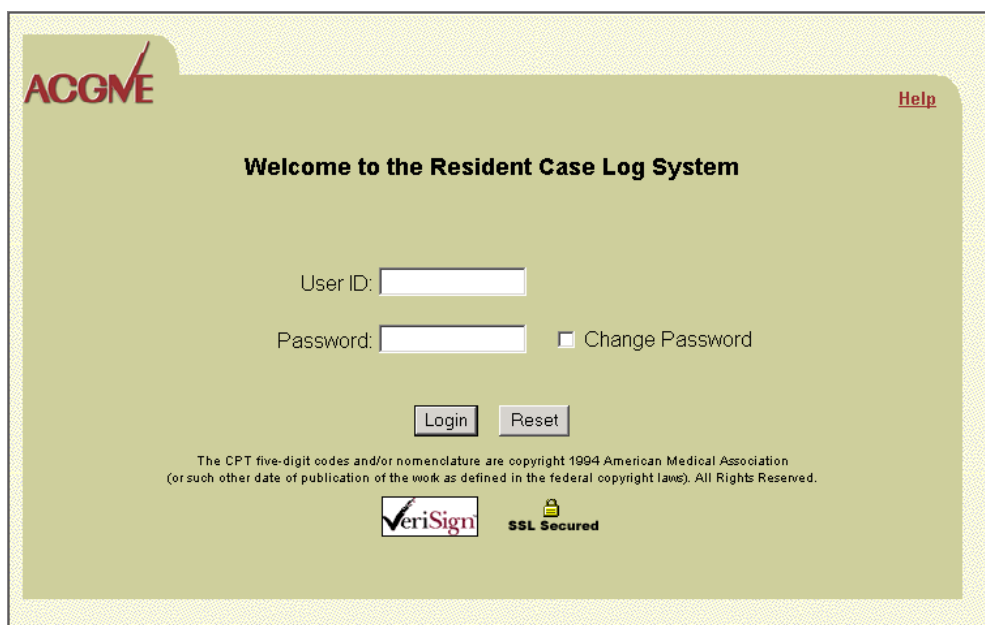
oplog@acgme.org

LOGGING ON

Using your Internet browser, go to the ACGME homepage at www.acgme.org. Select “Resident Case Log System”.



The screenshot shows the ACGME homepage. The header includes the ACGME logo and navigation links: Home, Mission, Chat, Search, Site Map, and Help. The main content area is titled "Resident Case Log System" and includes a link to a manual and list of CPT codes by specialty. A prominent link says "Click here to go to the Resident Case Log." Below this, it states that the new release is compatible with most common internet browsers and that no additional plug-ins are required. It lists supported operating systems: Windows 95, 98, NT, 2000, XP, ME, and Macintosh. A note mentions that Macintosh users may experience printing issues. The page also states that the system has been in production for many specialties and contains over 600,000 procedures. A detailed paragraph explains that users can access the system via Netscape or Internet Explorer, but recommends Internet Explorer. It provides instructions for program directors and residents regarding User ID and Password requirements, including contact information for oplog@acgme.org. The left sidebar contains a navigation menu with "Resident Case Log System" expanded, showing "Login" as the selected option.

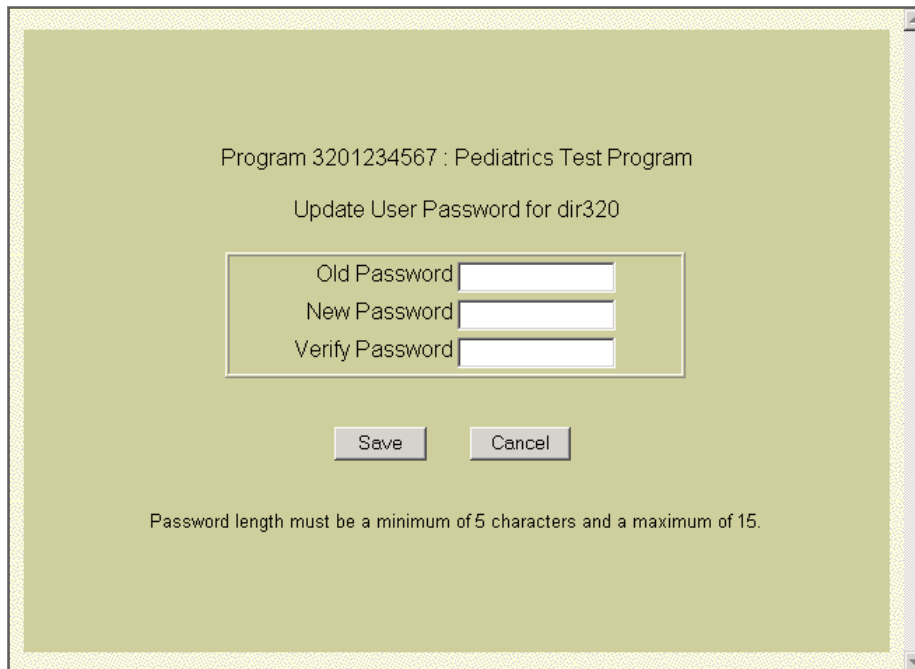


The screenshot shows the login page for the Resident Case Log System. It features the ACGME logo and a "Help" link in the top right. The main heading is "Welcome to the Resident Case Log System". Below this, there are input fields for "User ID:" and "Password:". A checkbox labeled "Change Password" is located to the right of the password field. There are "Login" and "Reset" buttons below the input fields. At the bottom, there is a copyright notice: "The CPT five-digit codes and/or nomenclature are copyright 1994 American Medical Association (or such other date of publication of the work as defined in the federal copyright laws). All Rights Reserved." Below the notice are logos for VeriSign and SSL Secured.

Enter the User ID and Password (provided by your program’s system coordinator) and click on the “Login” button. *If you want to change your password, click on the “Change Password” box **before** you log in.*

CHANGING YOUR PASSWORD

Enter your User ID and Password, click on the “Change password” check box, and press the “Login” button. A new window will open to request your password and confirm the new one. **If you forget your password, your program director or residency coordinator is the only person who can assign you a new one.** Enter the required data and press the save button. If you decide you don’t want to change the password press the Cancel button. You will still be logged on to the system.



Program 3201234567 : Pediatrics Test Program

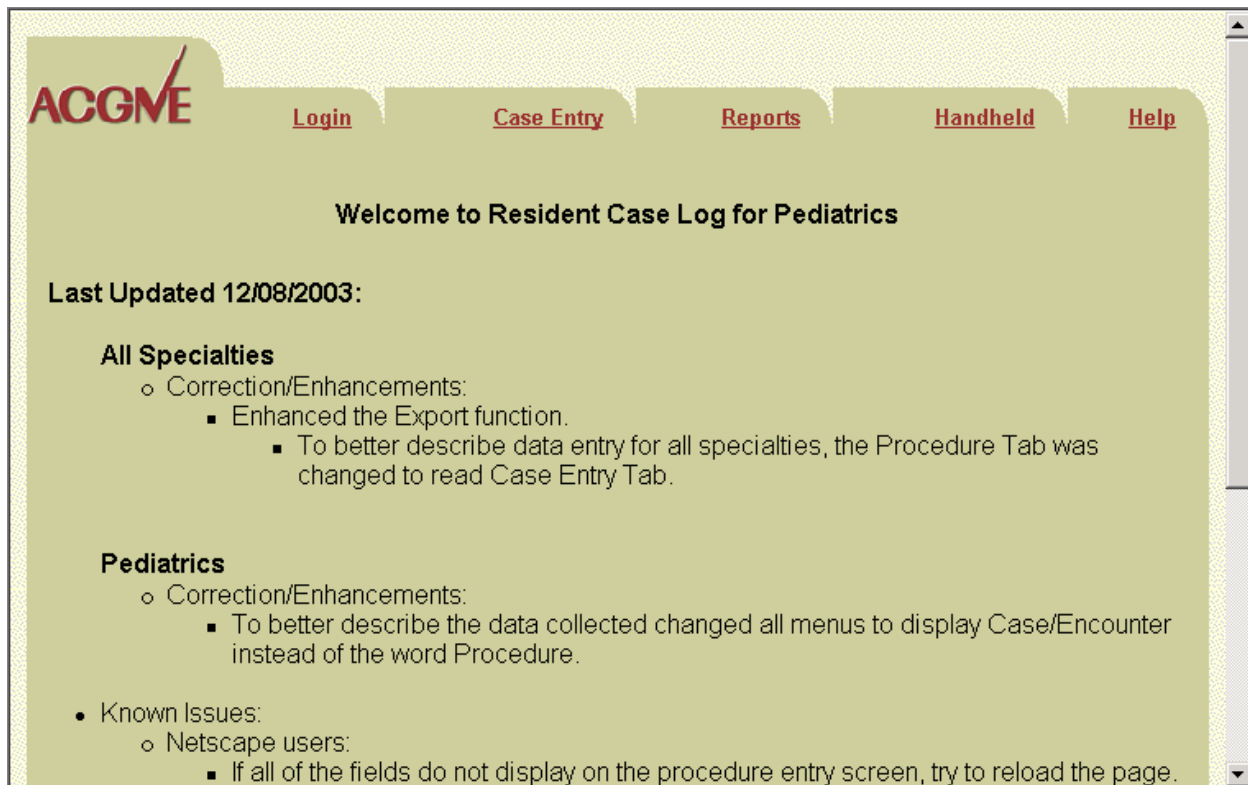
Update User Password for dir320

Old Password	<input type="text"/>
New Password	<input type="text"/>
Verify Password	<input type="text"/>

Password length must be a minimum of 5 characters and a maximum of 15.

WELCOME PAGE

The Welcome Page will be the starting point of any login. It will confirm that you are logged on and keep you abreast of changes or issues. It will also provide you with the necessary tabs to perform your entry.



LIST OF OPTIONS

The Welcome Page has a group of tabs listed across the top of the Page.

1. **Login** will place you on the Login page and permit you to log onto the system. (At this point, however, you are already logged on.)
2. **Case Entry** will allow you to add, edit, delete, and view Case Entries.
3. **Reports** allows you to view and print:
 - a. Resident Experience Summary Report lists total Case Entries by area and type, which can be filtered by date range, Supervisor, and location, etc;
 - b. Resident Full Detail report is an itemized, chronological list of all your entries, which also can be filtered by date range, Supervisor, and location, etc.; or
 - c. Resident Activity report lists the total number of cases, total number of codes entered and last date cases/encounters were entered; or
 - d. Available CPT/ICD9 Codes which can be displayed either by CPT/ICD9 or by Area and Type. (These could be handy, timesaving reference guides, were you to print them out).
4. **Handheld** will allow you to download the handheld application once your program has activated this feature.
5. **Help** will provide you with an index of topics and information about the system.

CASE ENTRIES

Click on the “Case Entry” tab and the Case Entry Menu will display. To add new Cases, click on “Add.” To change, delete or view Case Entries, click on “Search/Update.” To change an incorrect resident Case Entry year, click on “Update Case/Encounter Year”. To download all Case Entries click on “Download Case/Encounters”.



The screenshot shows the ACGME website interface. At the top left is the ACGME logo. To its right are five navigation tabs: [Login](#), [Case Entry](#), [Reports](#), [Handheld](#), and [Help](#). The [Case Entry](#) tab is selected. Below the tabs, the page title is "Case/Encounter Menu". Underneath, there is a bulleted list of options:

- Case/Encounters
 - [Add](#)
 - [Search/Update](#)
 - [Update Case/Encounter Year](#)
 - [Download Case/Encounters](#)

At the bottom of the page, there is a footer that reads: "Please report any problems or suggestions to the OPLog@acgme.org."

ADDING A NEW CASE ENTRY

The list of procedures tracked in the System has been further refined and narrowed. Residents will only be asked to enter those procedures for which the RRC needs to capture national level data. As a result, the procedures have been grouped and listed in three categories. The first group contains procedures that need to be tracked throughout training (endotracheal intubation, umbilical artery catheter, umbilical vein catheter, lumbar puncture, and conscious sedation for procedure or exam). The second group contains procedures tracked until competence is achieved (arterial puncture, placement of intravenous line, venipuncture, suturing of laceration, splinting of simple dislocation, and bladder catheterization). The last group is the listing of additional procedures. These are procedures that the RRC is not currently requiring be entered, but are listed and available for tracking.

After you click on the **Add** link, the Case Entry page will display:

The screenshot shows the ACGME Case/Encounter Entry form. At the top, there is a navigation bar with tabs for Login, Case Entry (selected), Reports, Handheld, and Help. The main form area is titled "Case/Encounter Entry" and contains the following fields and controls:

- Resident: Pedsres. Test (dropdown)
- Resident Year: 2 (text input)
- Supervisor: < Please select a value > (dropdown)
- Competence Lvl: < Please select a value > (dropdown)
- Location: < Please select a value > (dropdown)
- Patient Age: < Please select a value > (dropdown)
- Gender: Male Female
- Date: 6/15/2004 (text input)
- Case Id: (text input)
- Code: (text input) with Select and Search buttons
- Panel:
- Comments: (text area)
- Buttons: Save, Help, Clear, Cancel
- Selected Codes: (text input) with a message: "No Code Descriptions have been currently selected for display." and a Remove Code button
- Full Code Desc: (text input)
- Area: (dropdown)
- Type: (dropdown)

Additionally, the System has been changed so that programs/residents can indicate the name of the specific individual who supervised the resident during the procedure/encounter. The previous list of supervisors (attending, other, other supervising resident, PL-2, PL-3, or subspecialty resident) will remain, but programs will have the option of adding the specific names of the various potential supervisors. While the System requires a supervisor to be indicated, it is the program's choice as to whether they want their residents to use the generic options or enter the individual.

Also, an additional field has been added to the System so the resident can indicate the appropriate competence level for the procedure entered. The options are: N/A, practice independently, and practice with supervision. The N/A option is available because the System has been deliberately designed to allow residents the capability to enter patient encounters other than just procedures (i.e. diagnoses) and the competence level would not necessarily apply in these instances.

Required Fields

Resident:	Select the resident name from the pull down menu.
Resident Year:	Enter the resident's year of residency at the time the case was done. The year will default to the year entered on the resident add/update screen.
Location:	Select the Location where the case was performed using the pull down menu.
Supervisor:	Select the Supervisor using the pull down menu.
Patient Age:	Select the Patient Age from the pull down menu.
Gender:	Select either male or female
Date:	Enter Date including "/" or "-" to separate month/day/year. Format mm/dd/ccyy.
Case ID:	Case ID is a 20-character field that is required. It can be used to search for specific cases or tracking patients. It is also used to avoid making duplicate entries.
Code:	If you know the CPT/ICD9 code: Enter the CPT/ICD9 code and click on the "Select" button. If you don't know the CPT/ICD9 code: Click on the "Search" button.

The panel checkbox is used to indicate whether the patient is part of your panel.

The Comments field is an optional field, which will display in the Resident Full Detail Report.

Selecting a CPT/ICD9 code

If you know the appropriate CPT/ICD9 code(s), type the value, and click on the "Select" button. In the pictured example, CPT code 32002 and ICD code 789.60 were entered. If the CPT/ICD9 code is valid it will automatically be placed in the "Selected Codes" list.

The screenshot displays the ACGME Case/Encounter Entry form. The top navigation bar includes 'Login', 'Case Entry', 'Reports', 'Handheld', and 'Help'. The 'Case/Encounter Entry' section contains the following fields:

- Resident: Pedsres. Test
- Resident Year: 2
- Supervisor: Independent Supervisor
- Competence Lvl: Practice Independently
- Location: Test Location Number 1
- Patient Age: months 12-18
- Date: 6/15/2004
- Case Id: 12345-6
- Gender: Male (selected), Female
- Code: (empty)
- Panel:

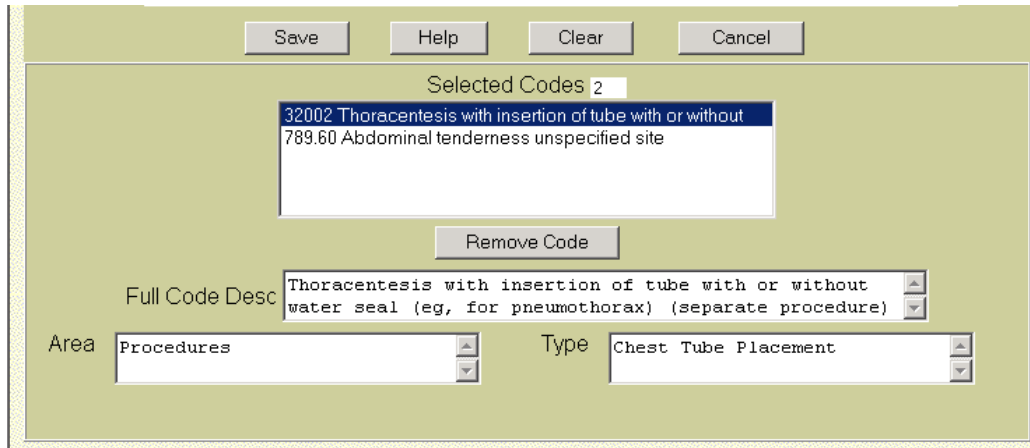
Buttons for 'Select', 'Search', 'Save', 'Help', 'Clear', and 'Cancel' are present. Below the main form is a 'Selected Codes' section with a list box containing:

- 32002 Thoracentesis with insertion of tube with or without
- 789.60 Abdominal tenderness unspecified site

A 'Remove Code' button is located below the list box. The 'Full Code Desc' field shows 'Abdominal tenderness unspecified site'. At the bottom, the 'Area' is set to 'Diagnoses' and the 'Type' is 'Symptoms, Signs, and Ill-Defined Conditions'.

Selected Codes Entry Field

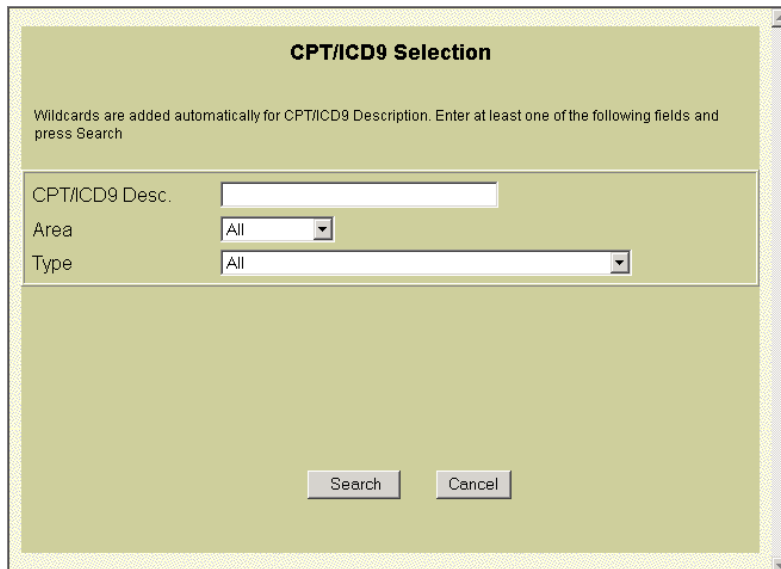
The “Selected Codes” field allows you to browse CPT/ICD9s added to this entry. Use the mouse to point and click on a CPT/ICD9 code, and the selection is highlighted and expanded in the text fields below. To remove the highlighted Case Entry, click on the “Remove Code” button. To remove all of them click on the “Clear” button.



The screenshot shows a software interface for managing selected codes. At the top, there are four buttons: "Save", "Help", "Clear", and "Cancel". Below these is a section titled "Selected Codes 2" which contains a list of two codes: "32002 Thoracentesis with insertion of tube with or without" and "789.60 Abdominal tenderness unspecified site". The first code is highlighted in blue. Below the list is a "Remove Code" button. Underneath, there are three fields: "Full Code Desc" with the text "Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure)", "Area" with the value "Procedures", and "Type" with the value "Chest Tube Placement".

Searching for a CPT/ICD9 Code

To search for a CPT/ICD9, click on the “Search” button next to the CPT/ICD9 code field. The “CPT/ICD9 Selection” window will display:



The screenshot shows a window titled "CPT/ICD9 Selection". It contains a message: "Wildcards are added automatically for CPT/ICD9 Description. Enter at least one of the following fields and press Search". Below this message are three input fields: "CPT/ICD9 Desc." (a text box), "Area" (a dropdown menu with "All" selected), and "Type" (a dropdown menu with "All" selected). At the bottom of the window are two buttons: "Search" and "Cancel".

CPT Selection allows the user to look for Codes in multiple ways. A user can search for a specific phrase, word or partial word in the description, or select an area or type to view all code descriptions available. Below is an example of entering a word or phrase that exists in the description.

Searching for a CPT/ICD9 Code (cont.)

CPT/ICD9 Selection

Wildcards are added automatically for CPT/ICD9 Description. Enter at least one of the following fields and press Search

CPT/ICD9 Desc.

Area

Type

When “congenital” is entered and the “Search” button is clicked, the results are displayed for all of the code descriptions containing the word “congenital”:

CPT/ICD9 Selection

*-indicates CPT/ICD9 is found in multiple area/types

CPT/ICD9	
744.21 Absence of ear lobe congenital	select
756.13 Absence of vertebra congenital	select
759.1 Anomalies of adrenal gland congenital	select
759.2 Anomalies of other endocrine glands congenital	select
746.0 Anomalies of pulmonary valve, congenital	select
759.0 Anomalies of spleen congenital	select
746.01 Atresia of pulmonary valve congenital	select
751.61 Biliary atresia congenital	select*
45100 Biopsy of anorectal wall, anal approach (eg, congenital megacolon)	select
754 Certain congenital musculoskeletal deformities	select
743.53 Chorioretinal degeneration congenital	select
755.58 Cleft hand congenital	select
44322 Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)	select
93531 Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	select
93533 Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	select
93532 Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	select

Click on the “select” link and the CPT/ICD9 code is returned to the Case Entry screen and entered in the “Selected Codes” box.

To save the entry, click on the Save button. To assist with the entry the Location, resident year, and date have remained pre-filled from the previous entry. Change these fields as needed. When finished entering all of your case data, to exit to the Case Entry Menu, click on the Cancel button.

SEARCH/UPDATE A CASE ENTRY

Enter your search criteria. A list of cases matching the specified criteria will be displayed. You can adjust the number of cases displayed per page by typing in the number (enter 9999 to view all the cases within one page). Press the OK button.

Search Case/Encounters

Program Id 3201234567

Location All

Supervisor All

Resident All

Date Range / / to / /

Competence Lvl All

Patient Age All

Case/Encntr Resident Year All

Resident Year All

CPT/ICD9 Code

Area Description All

Type Description All

records per page 12

OK CANCEL

Editing, Deleting, or Viewing a Case Entry

Locate the Case Entry that you want to edit, delete, or view the details of, and click on the appropriate link. Either the “Case Entry Edit,” “Case Entry View”, or “Case Entry Delete” screen will display.

Search Case/Encounters

Program Id 3201234567

Location All

Supervisor All

Resident Pedsres. Test

Date Range / / to / /

Competence Lvl All

Patient Age All

Case/Encntr Resident Year All

Resident Year All

CPT/ICD9 Code

Area Description All

Type Description All

records per page 12

OK CANCEL

Case Entry Edit/Update Screen

To **edit**, make the necessary changes on the screen. To add a new CPT/ICD9 code, type the new desired code in the CPT/ICD9 code box and press the “Select” button. Select only one code for credit. To choose a different CPT/ICD9 code for credit, click on the CPT/ICD9 code with the asterisk next to it and unclick the credit box. When you click on the “Update” button, all changes will be saved and you will be returned to the result list.

Case/Encounter Update

Resident: Pedsres, Test
Supervisor: Pediatric, Attending
Location: Test Location Number 1
Resident Year: 2
Competence Lvl: N/A
Patient Age: months 1 - 3
Gender: Male Female
Date: 03-30-2004
Case Ids:
Code: Select Search
Comments:
Update Help Cancel

Selected Codes 2

- 380.4 Impacted cerumen
- 36600 Arterial puncture, withdrawal of blood for diagnosis

Remove Code

Full Code Desc: Impacted cerumen
Area: Diagnoses Type: Diseases of the Ear

Case Entry View Screen

When you **view** the details regarding a Case Entry, you will not be able to make changes. To return to the result list, click on the “Cancel” button.

Case/Encounter View

Resident: Pedsres, Test
Supervisor: Pediatric, Attending
Location: Test Location Number 1
Resident Year: 2
Competence Lvl: N/A
Patient Age: months 1 - 3
Gender: Male Female
Date: 03-30-2004
Case Ids:
Code: Select Search
Comments:
Help Cancel

Selected Codes 2

- 380.4 Impacted cerumen
- 36600 Arterial puncture, withdrawal of blood for diagnosis

Remove Code

Full Code Desc: Impacted cerumen
Area: Diagnoses Type: Diseases of the Ear

Case/Encounter Delete Screen

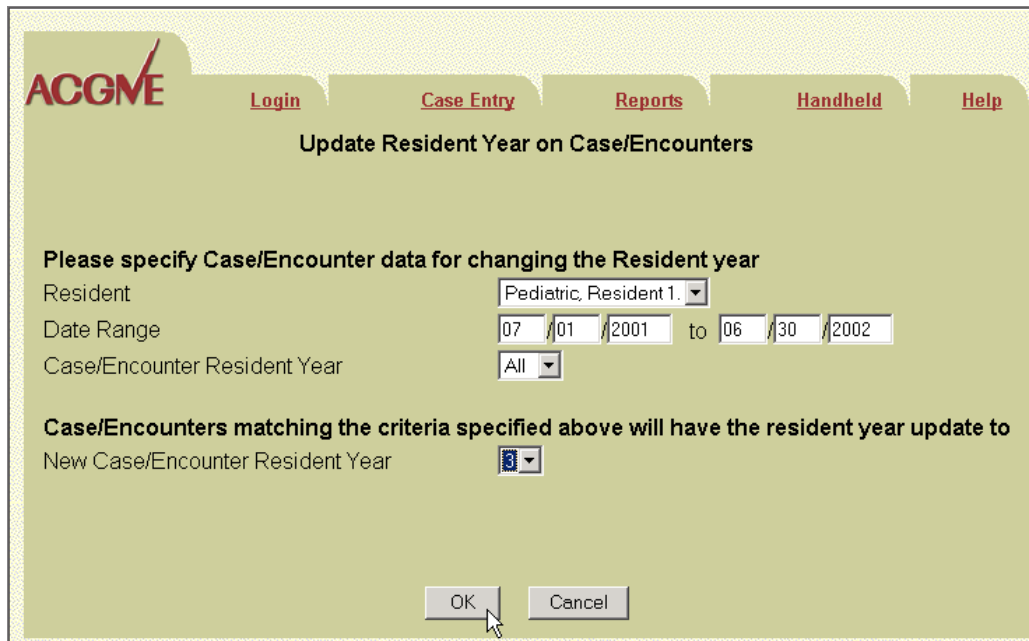
To **delete** a Case/Encounter, click on the “Delete” button. Click on the “Cancel” button to return to the result list.

The screenshot shows a web-based interface titled "Case/Encounter Delete". The form contains the following fields and controls:

- Resident:** Pedsres, Test (dropdown)
- Resident Year:** 2 (text input)
- Supervisor:** Pediatric, Attending (dropdown)
- Competence Lvl:** N/A (dropdown)
- Location:** Test Location Number 1 (dropdown)
- Patient Age:** months 1 - 3 (dropdown)
- Gender:** Male (selected), Female (radio button)
- Date:** 03-30-2004 (text input)
- Case Id's:** (text input)
- Code:** (text input) with "Select" and "Search" buttons.
- Comments:** (text area)
- Buttons:** "Delete", "Help", "Cancel".
- Selected Codes:** A list box titled "Selected Codes 2" containing:
 - 380.4 Impacted cerumen
 - 36600 Arterial puncture, withdrawal of blood for diagnosis
- Remove Code:** (button)
- Full Code Desc:** Impacted cerumen (text input)
- Area:** Diagnoses (dropdown)
- Type:** Diseases of the Ear (dropdown)

UPDATE CASE/ENCOUNTER YEAR

The update Case/Encounter year enables a program to quickly change the resident year in program for a large number of entries. The resident year may be incorrect from converting the data from the old system or if the data originated in another system and was uploaded into the internet system. This feature also allows you to change a resident's year in program for past entries if the resident year was not updated in the program setup section.



The screenshot shows a web application interface for updating resident years. At the top left is the ACGME logo. Navigation tabs include 'Login', 'Case Entry', 'Reports', 'Handheld', and 'Help'. The main heading is 'Update Resident Year on Case/Encounters'. Below this, a section titled 'Please specify Case/Encounter data for changing the Resident year' contains three rows of input fields: 'Resident' with a dropdown menu showing 'Pediatric, Resident 1.', 'Date Range' with two date pickers set to '07 / 01 / 2001' and '06 / 30 / 2002', and 'Case/Encounter Resident Year' with a dropdown menu set to 'All'. A second section, 'Case/Encounters matching the criteria specified above will have the resident year update to', includes a 'New Case/Encounter Resident Year' dropdown menu set to '3'. At the bottom are 'OK' and 'Cancel' buttons.

To update the resident year, first select the resident whose data needs to be updated. Then, specify the appropriate date range. In this example, the entire academic year (07/01/2001 through 06/30/2002) was selected. Next, choose which year is currently entered for the incorrect entries and needs to be changed (selecting all will cause every entry for that resident to be updated to the new value). Finally, choose the correct year to update the entries with. After you click "OK," you will receive a message indicating how many Case/Encounters were updated.



DOWNLOADING CASE/ENCOUNTERS

The Download Case/Encounters section is used to generate an electronic text file of cases/encounters entered for your program. This is a 2-step process; first the file needs to be selected for exporting and then the file will need to be downloaded.



The screenshot shows the ACGME web interface. At the top left is the ACGME logo. To its right are navigation tabs: Login, Case Entry, Reports, Handheld, and Help. The main heading is "Case/Encounter Export List". Below this heading, there are two buttons: "Request new export file" and "Cancel". A mouse cursor is pointing at the "Request new export file" button.

To generate the file for exporting, click on the "Request new export file" button. You can export the data for a particular date range. **If you leave the fields blank, a listing of all case/encounters will be generated.**



The screenshot shows the ACGME web interface for "Selection Criteria for Export File". At the top left is the ACGME logo. To its right are navigation tabs: Login, Case Entry, Reports, Handheld, and Help. The main heading is "Selection Criteria for Export File". Below this heading, there are several input fields: "Program Id" with the value "3201234567", "Resident" with a dropdown menu showing "Pediatric, Resident 1.", "Date Range" with two date input fields separated by "to", and "Procedure Type" with a dropdown menu showing "Case/Encounter". At the bottom, there are two buttons: "OK" and "CANCEL". A mouse cursor is pointing at the "OK" button.

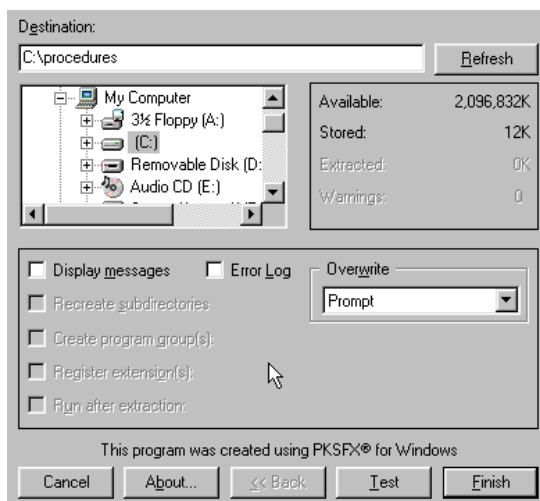
DOWNLOADING CASE/ENCOUNTERS (CONT.)



In the example above, a file of case/encounters performed by Pediatric Resident1 will be generated. The export requests are processed four times daily at 2:00 a.m., 8:00 a.m., 12:30 p.m., and 5:00 p.m. Central time. Once the file has been exported you will need to download it to your computer. Click on the "Cancel Request" link under Status prior the download time.

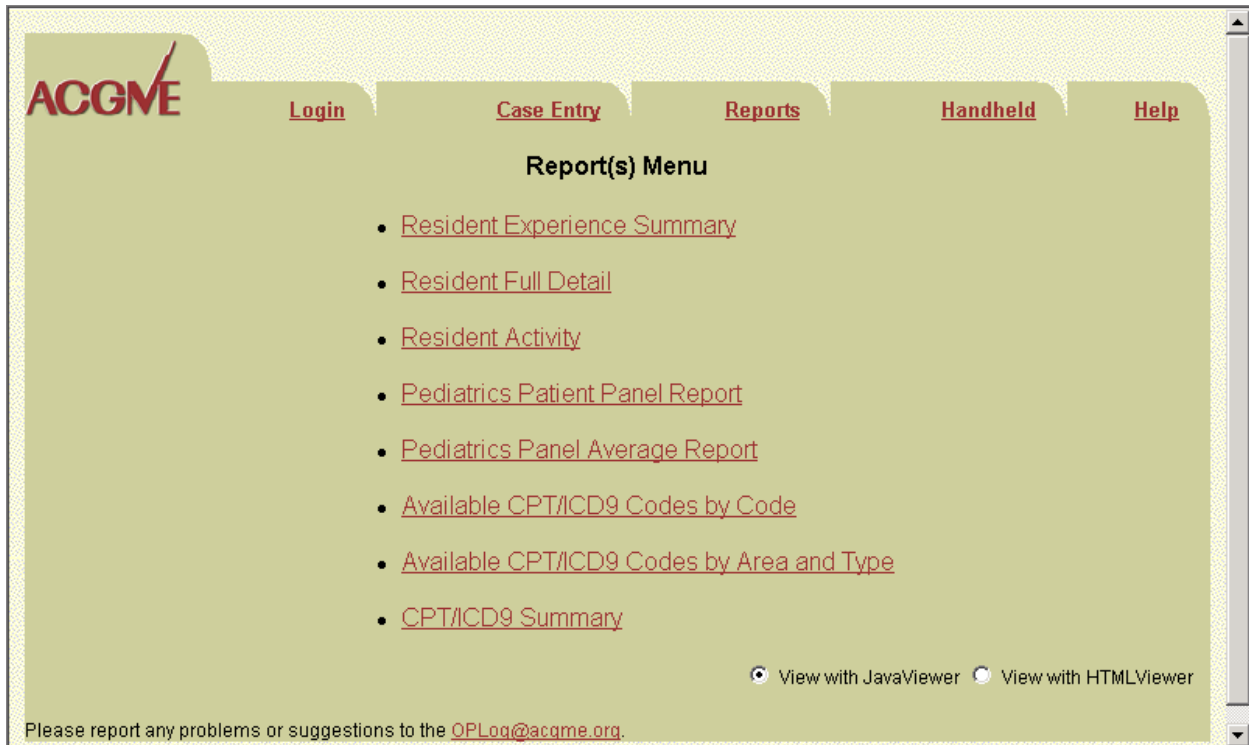
After the times specified above, Cancel Request will be replaced by a filename. To download the file to your computer, click on the file name. A message box will open allowing you to select "open this file under current location" or "save this file to disk". Select "Save this File to disk," and specify where you want to save the file on your computer.

The downloaded file is a self-extracting zip file named 'Case Entries'. Simply double-click on it and a window will pop up. Specify in which directory you want to put the data (it defaults to c:\Case Entries), and click finish. This will extract the file (the first ten characters of the name will be the program id). The resulting text file is tab-delimited with field names on the first row. It can be imported into Excel, Access, FoxPro, etc.



REPORTS

The Resident Experience Summary report is submitted to the Residency Review Committee. The Resident Full Detail report is a detail listing of cases entered which is similar to the Case Search Results list. The Resident Activity report lists the last case date entered by a resident

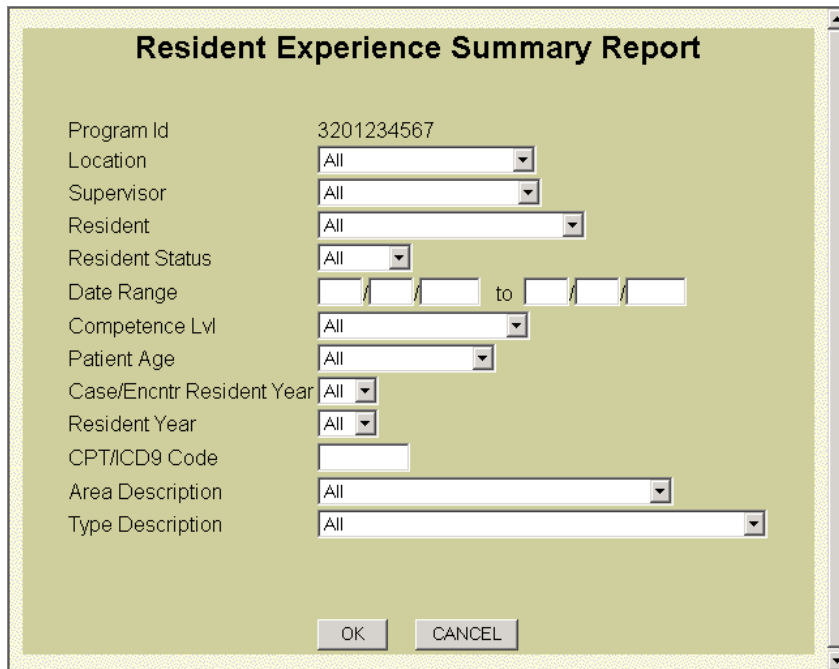


The screenshot shows the ACGME website's Reports menu. At the top left is the ACGME logo. To its right are navigation tabs for Login, Case Entry, Reports (which is highlighted), Handheld, and Help. Below the Reports tab is the "Report(s) Menu" section, which contains a list of report links: Resident Experience Summary, Resident Full Detail, Resident Activity, Pediatrics Patient Panel Report, Pediatrics Panel Average Report, Available CPT/ICD9 Codes by Code, Available CPT/ICD9 Codes by Area and Type, and CPT/ICD9 Summary. At the bottom right of the menu are two radio buttons: "View with JavaViewer" (selected) and "View with HTMLViewer". At the bottom left of the menu is a footer text: "Please report any problems or suggestions to the OPLog@acgme.org."

There are two ways to view reports: Java Viewer and HTML Viewer. These options are listed at the bottom of the report tab. When using the Java Viewer in Netscape you may see unpredictable results, If the Java Viewer is not working right for you, try the HTML Viewer. However, the HTML viewer will only print the current page you are viewing.

REPORTS (cont.)

Select the report you want by clicking on the appropriate link. The selection criteria page displays.



Resident Experience Summary Report

Program Id 3201234567

Location All

Supervisor All

Resident All

Resident Status All

Date Range []/[]/[] to []/[]/[]

Competence Lvl All

Patient Age All

Case/Encntr Resident Year All

Resident Year All

CPT/ICD9 Code []

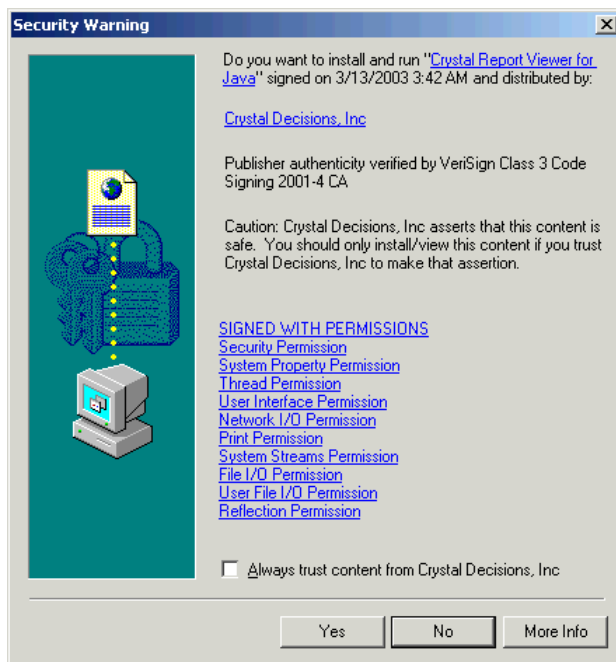
Area Description All

Type Description All

OK CANCEL

Use the selection box to filter data presented on reports and click the OK button to generate the report.

A new window will open displaying the report. The first time you run a report, the ACGME sends a Java applet called Crystal Report Viewer for Java. You will see a security warning asking if you want to install and run the viewer. Click the Yes button see the report (if you press the No button you will see the report but will not be able to print it in its proper format).



The report will display in a new window that will provide you with special functions described below.

RESIDENT EXPERIENCE SUMMARY REPORT

powered by crystal

Preview

Diagnoses
Procedures
Miscellaneous

Resident Experience Summary Report

Program ID: 3201234567 Program Name: Pediatrics Test Program
For All Supervisors at All Locations
For Resident 1. Pediatric
For All Resident Years For All Supervisory Levels For All Patient Ages
For All CPTs For All Areas For All Types
As Of 12/11/2003

	Year 1	Year 2	Year 3
Diagnoses			
Infectious and Parasitic Diseases	0	0	0
Neoplasms	0	0	0
Endocrine, Nutritional and Metabolic Diseases, and	0	0	0
Diseases of the Blood and Blood-Forming Organs	0	0	0
Mental Cognitive Disorders	0	0	0
Diseases of the Nervous System	0	0	0
Diseases of the Eye	0	0	1

RESIDENT FULL DETAIL REPORT

powered by crystal

Preview

Pediatric, Resident 1.

Pediatric Resident Record Report

Program ID: 3201234567 Program Name: Pediatrics Test Program
For All Supervisors at All Locations
For Resident 1. Pediatric
For All Resident Years For All Supervisory Levels For All Patient Ages
For All CPTs in All Areas and All Types including All Techniques
As Of 12/11/2003

Resident Name: Pediatric, Resident 1. **Current Year:** 1

Procedure Date: 4/4/2003	Resident Year: 1	Supervisory Level:	Panel Pa
		Patient Age: months 1 - 3	Case ID:
Area	Type		
Diagnoses	Certain Conditions Originating in the Perinatal Pe		
Procedures	Other (procedures)		
Procedure Date: 4/4/2003	Resident Year: 1	Supervisory Level:	Panel Pa
		Patient Age: months 1 - 3	Case ID:
Area	Type		

RESIDENT ACTIVITY REPORT

powered by **crystal**

Preview

Active

Resident Activity Report

Program ID: 3201234567 Program Name: Pediatrics Test Program
For All Supervisors at All Locations
For Resident 1, Pediatric In All Years
For Procedures In All Years All Supervisory Levels All Patient Ages
For All CPTs in All Areas and All Types
As Of 12/11/2003

Resident Name	Current Year	Cases	Codes	Last Procedure Date
Pediatric, Resident 1.	1 Active	23	25	12/9/2003

AVAILABLE CPT/ICD9 CODES REPORTS

You can view and print all available CPT/ICD9 Codes, sorted either numerically or by area and type, from the "Reports Menu" screen. Printing them may save you time in the long run, as searching through a printed document often takes less time than searching a computer's database.

Available CPT/ICD9 Codes by CPT/ICD9 Report

powered by crystal

Preview

AVAILABLE CPT CODES For Pediatrics

CPT Code	CPT Description
002	Typhoid and paratyphoid fevers
003.0	Salmonella gastroenteritis
003.8	Other specified salmonella infections
004.9	Shigellosis unspecified
005.9	Food poisoning unspecified
006.0	Acute amebic dysentery without abscess
007.1	Giardiasis
008.00	Intestinal infection due to e. coli unspecified
008.01	Intestinal infection due to enteropathogenic e. coli
008.02	Intestinal infection due to enterotoxigenic e. coli
008.04	Intestinal infection due to enterohemorrhagic e. coli
008.43	Intestinal infection due to campylobacter

cptcodes;1.CPTDesc (String)

Available CPT/ICD9 Codes by Area and Type Report

powered by crystal

Preview

Diagnoses
 Procedures

AVAILABLE CPTCODES BY AREA AND TYPE For Pediatrics

DIAGNOSES

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PE

CPT Code	Technique	CPT Description
041.02		Streptococcus infection in conditions classified elsewhere and of u streptococcus group b
090.2		Early congenital syphilis unspecified
098.40		Gonococcal conjunctivitis (neonatorum)
244.8		Other specified acquired hypothyroidism
273.8		Other disorders of plasma protein metabolism
277.01		Cystic fibrosis with meconium ileus
289.7		Methemoglobinemia
333.1		Essential and other specified forms of tremor
519.4		Disorders of diaphragm

cptcodes;1.SpecialtyName (String)

HANDHELD



The Handheld application will run on any handheld device using Palm OS 3.5 or higher. It is available for a nominal fee charged to the programs. The fee is based on the number of residents in program. If you have any questions, please contact the ACGME Help desk at (312) 755-7464 or Email at HelpDesk@acgme.org.

- Internet Access.
- Handheld device running Palm OS 3.5 or higher.
- 2 meg of Free memory.
- Desktop PC running Windows 95/98/2000/NT.
- Port 8028 opened on firewall.
- User password to the Web application must be greater than or equal to 5 characters.
- Scout Client 4.1 (Provided by ACGME on first Sync).

If your program has registered to use the software for the handheld devices, you will see this screen. Have your residents follow the Setup Instructions in order to download the software to their handheld device.

CASE LOG PROCEDURES/ENCOUNTERS EXPORT

There is an export function available within the Resident Case Log System. At any time, a program or resident can request a tab-delimited ASCII file containing all of the data entered into the System. The request can be for a particular timeframe or for all data entered up to that point. Also, the program can get the data for an individual resident or all residents in the program. You can use this file for whatever you need, including running customized reports or loading into another database.

<u>Field Name</u>	<u>Field Type (max)</u>	<u>Field Description</u>
ProcedureID	Integer	Unique case ID.
ProgramID	Text (10)	10-digit ACGME program number.
ProcedureDate	Text (10)	The date of the procedure, in the form MM/DD/YYYY.
ResidentYear	Integer	Resident's year in program when the procedure was performed.
OncologyPatient	Integer	Flag for whether it was an oncology patient. 1 = yes, 0 = no or specialty does not use this field.
MicroSurgery	Integer	Flag for whether it was microsurgery. 1 = yes, 0 = no or specialty does not use this field.
Trauma	Integer	Flag for whether it was trauma patient. 1 = yes, 0 = no or specialty does not use this field.
PatientBirthYr	Text (4)	The 4 digit year of birth, blank if specialty does not use field.
Gender	Text (1)	M or F, otherwise blank if not used by specialty.
CaselD	Text (25)	Case ID entered, blank if specialty do not use.
CPTCode	Text (254)	The CPT or ICD9 Code.
Credit	Integer	Flag to indicate code for credit. Code for credit = 1, 0 = non-credit. Value will be 1 for specialties that do not use credit indicator.
AreaRRCIndexID	Integer	4 digit RRC index ID for the area if used by specialty, otherwise it is blank.
AreaDescription	Text (50)	Full description of the area in which the code counts.
TypeRRCIndexID	Integer (10)	4 digit RRC index ID for the type if used by specialty, otherwise it is blank.
TypeDescription	Text (50)	Full description of the type in which the code counts.
AttendingID	Integer	ID indicating the attending physician.
AttendingLName	Text (55)	Last name of the attending physician.
AttendingMInitial	Text (1)	Middle initial of the attending physician.
AttendingFName	Text (55)	First name of the attending physician.
ResidentID	Integer	ID indicating the resident.
ResidentSS	Text (9)	Resident social security number without dashes.
ResidentLName	Text (55)	Last name of resident.
ResidentMInitial	Text (1)	Middle initial of the resident.
ResidentFName	Text (55)	First name of the resident.
InstitutionID	Integer	ID for the institution.
InstituteName	Text (100)	Name of the institution.
InstituteCity	Text (55)	City where institution located.
InstituteSt	Text (2)	State of institution.
CPTDesc	Text (50)	First 50 characters of CPT or ICD9 description.
ResidentsRole	Text (25)	Resident's role for procedure.
PatientType	Text (25)	Patient type entered, blank if not used by specialty.
RotationName	Text (45)	Rotation, blank if not used by specialty.
DefinedCtgy1	Text (30)	First defined category in which CPT code counts, otherwise blank if specialty does not use this field.
DefinedCtgy2	Text (30)	Second defined category in which CPT code counts, otherwise blank if specialty does not use this field.
CommentText	Text(1280)	Any comments entered.