Case Log Instructions for Osteopathic Neuromusculoskeletal Medicine

This instructional guide was created to specifically assist residents in correctly logging patient encounters and procedures in the ACGME’s Resident Case Log System for osteopathic neuromusculoskeletal medicine. For general information and instructions, a user guide is available within the Case Log System, under the Reference Materials menu.

Each osteopathic neuromusculoskeletal medicine patient encounter that occurs during active training in an ACGME-accredited osteopathic neuromusculoskeletal medicine program must be entered in the Case Log System. The Review Committee uses the information in the system to determine whether residents’ experiences meet expectations as outlined in the Program Requirements. Residents and program directors should also use the Case Log System to monitor resident progress in the required osteopathic neuromusculoskeletal medicine patient encounters and procedures throughout the educational program.

Residents should only log osteopathic neuromusculoskeletal medicine patient encounters supervised by neuromusculoskeletal medicine specialists. Residents performing injection procedures can log those procedures even if they are supervised by a physician who is not a neuromusculoskeletal medicine specialist. Additional information regarding the supervision of injection procedures is included in the FAQs for Osteopathic Neuromusculoskeletal Medicine.
CASE LOG SYSTEM ACCESS

Programs and residents access the Case Log System through the Accreditation Data System (ADS). Programs must grant residents access before they can log patient encounters. Residents only have access to the system while actively training in an ACGME-accredited program.

Access the system at www.acgme.org/connect. Once logged in, click on the “Case Log System” link.

On the case entry screen, enter the necessary patient encounter information.
ENTERING PATIENT ENCOUNTERS – BASIC INFORMATION

All logged patient encounters should include the following basic information: Case ID; the resident’s year in the program; the supervising attending physician; the date patient was seen; setting (inpatient/outpatient); the patient’s age; and patient type if applicable (continuity clinic panel patient, OB, pediatric, surgical).

Resident
The system will autofill the resident’s name. If the name in this field is incorrect, log out of the system and log back in with the correct credentials.

Case ID
The Case ID should be a unique patient identifier, but must not be patient identifiable information such as a patient name or Social Security Number.

Resident Year
The system will autofill the resident’s current year in the program. If the patient encounter occurred in a prior year of the program, select the correct year from the drop-down menu.

Note: residents who enter the program at the ONMM2 level will only log patient encounters at “resident year 2” in the Case Log System.

Attending
Select the name of the attending physician who supervised the osteopathic neuromusculoskeletal medicine patient encounter from the drop-down menu. If this encounter included an injection procedure and was supervised by a physician who is not a neuromusculoskeletal medicine specialist, select “Attending, Not NMM Board Certified”
from the drop-down menu. Contact the program to add physician faculty members if they are board certified in neuromusculoskeletal medicine and do not appear in the drop-down menu.

**Date Patient Seen**
The system will autofill to the date of entry (not the date of the patient encounter), and will need to be changed if the patient encounter occurred previously.

**Setting**
Select the setting, inpatient or outpatient, in which the patient was seen.

**Patient Age**
Select the age range (>= 18 yrs and <=65; <= 18 yrs; or >65) for the patient at the time of the encounter being logged.

**Patient Type**
Check all applicable patient types for the patient encounter. Skip this step if none apply.

**Comments**
Enter any additional basic patient information for the encounter. This field is optional and comments will only be visible in the “Full Detail Report.”

### ENTRY OF PATIENT ENCOUNTERS – SEGMENTAL AND SOMATIC DYSFUNCTION

To enter segmental and somatic dysfunction, click on the “Area and Type” tab.
Select “Segmental and Somatic Dysfunction” from the drop-down menu under “Type” and click “Go.”

Click “Add” next to each relevant region for the patient encounter.
A confirmation message will appear on the screen.

```
  Code added to this Case.
```

To verify what has been logged for the encounter, click “Selected Codes.”

```
  Code added to this Case.
```

```
<table>
<thead>
<tr>
<th>Area</th>
<th>Type</th>
<th>Keyword</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head region</td>
<td>ONMM Procedures</td>
<td>Segmental and Somatic Dysfunction</td>
</tr>
<tr>
<td>Cervical region</td>
<td>ONMM Procedures</td>
<td>Segmental and Somatic Dysfunction</td>
</tr>
</tbody>
</table>
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If an item needs to be removed, click the red “X.”

**ENTERING PATIENT ENCOUNTERS – TREATMENT TECHNIQUE**

Select “Treatment Technique” from the drop-down menu under “Type” and click “Go.”
Click “Add” next to each relevant technique for the patient encounter.

As above, a confirmation message will appear on the screen.

To verify what has been logged for the encounter, click “Selected Codes,” and to remove a selection, click the red “X” that appears.

ENTERING PATIENT ENCOUNTERS – PROCEDURES

If an additional procedure is performed it should be entered as one patient encounter with the “Segmental and Somatic Dysfunction and Treatment Technique.” The Review Committee will only track injection procedures as outlined in Osteopathic Neuromusculoskeletal Medicine Case Log Announcement (available on the Documents and Resources page of the ONMM section of the ACGME website). For instructions on how to log procedures other than those being tracked by the Review Committee, refer to the “Resident User Guide” in ADS.
To log tracked procedures, select “Injection Procedures” from the drop-down menu under “Type” menu and click “Go.”

Click “Add” next to each procedure relevant to the patient encounter.

A confirmation message indicating “Code “20###” added to this case” will appear.

As above, to verify what has been logged for the encounter, click “Selected Codes,” and to remove a selected item, click the red “X” that appears.
SUBMISSION OF PATIENT ENCOUNTER AND PROCEDURES

Prior to saving the patient encounter, thoroughly review the information entered. Each logged patient encounter should include a segmental and somatic dysfunction and a treatment technique. If a procedure other than a treatment technique is performed, it must be entered at the same time. It should not be entered separately. The patient encounter and procedures are only logged and saved once the “Submit” button is clicked.

The Basic Patient Encounter Information should also be reviewed. Once all information has been reviewed, click “Submit” to log and save the patient encounter and procedure(s).
CASE LOG SYSTEM – DOWNLOADING LOGGED CASES

Download cases logged in the system by clicking “Download Cases” from the “Quick Links” menu.

Enter the Start and End Dates for the cases you want to download and click “Search.”
A message will appear identifying how many cases were found in the system for the date range selected. Click “Save to Excel” to download the case data to a spreadsheet.

CASE LOG SYSTEM – REPORTS

A number of reports are available in the “Reports Menu,” accessible under “Quick Links.”
Additional parameters can be set to customize available reports.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Summary Report</td>
<td>Patient Summary Report based on Case Type &amp; Setting</td>
</tr>
<tr>
<td>Experience Report by Year</td>
<td>ACGME categorized summary report by the year on the case.</td>
</tr>
<tr>
<td>Activity Report</td>
<td>Latest case activity for residents. Lists number of cases/procedures, most recent case date &amp; last time an update was made</td>
</tr>
<tr>
<td>Case Brief Report</td>
<td>Generates case level data by case date, including case ID, institution, role, attending initials, code &amp; code description, if applicable</td>
</tr>
<tr>
<td>Full Detail Report</td>
<td>Provides case level detail for individual resident, including institution, comments, attending/supervisor, rotation, and role, if applicable. A detailed list of procedures completed per each case is also displayed</td>
</tr>
<tr>
<td>Code Summary Report</td>
<td>Counts of procedures by CPT code</td>
</tr>
</tbody>
</table>

Direct questions about Case Log requirements to Executive Director Tiffany Moss, MBA: tmoss@acgme.org. Direct questions specific to the system itself to ADS@acgme.org.