How Accurate is Self-Reported Data?: Radiologic Procedure Logs at a Large Academic Medical Center

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## Background

- In 2007, ACGME issued guidelines requiring radiology programs/residents to maintain Radiology Procedure Logs
- Traditionally, our residents have maintained self-recorded logs
- Self-recorded logs require continuous reporting by residents

Background

 Is a user-independent data logging system a feasible replacement for traditional self-recorded procedure logs?

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# Methods

- IRB approval was obtained
- Self-reported resident procedure logs from the graduating class of 2012 (N=13 residents) were examined
- Raw data from radiology reports including time stamp and author of report are periodically retrieved from electronic medical record systems and standardized

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#### Methods

 Self-reported logs were then compared to procedure data obtained from the electronic medical record across 3 hospital systems

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## Methods

- Procedures were categorized by departmental division and technical difficulty (basic or advanced)
- Basic Procedure examples:
  - GI fluoroscopy, Central venous access, US guided breast biopsy, Fluoro-guided lumbar puncture
- Advanced Procedure examples:
  - CT-guided and MRI-guided procedures







### Conclusions

- Automated logging standardizes the process across residents and facilitates administrative analysis, providing a wealth of data to the Radiology Milestones Review Committee
- Automated logging removes a significant burden of administrative paperwork for residents
- Automated procedure logging can be part of a larger comprehensive case log system



### Limitations and Challenges

- Automated logging capabilities may not be available at all institutions
- Our residents rotate among different hospital systems, with varying HIS, RIS, and PACS systems
- Capturing data requires technical expertise and standardization to account for differences in computer systems