Top 10 Essential ACGME Revisions

A Comprehensive Side-by-Side Comparison of Baseline Standards, 2025 Proposed Changes, and 2026 Accepted Guidelines with Resident Impacts.

Changes effective July 2028

1. Conference Time & Didactics

CURRENT REQUIREMENT

Required a minimum of **4 to 5 hours per week** of planned didactics, but tracked locally without rigid nationwide minimum individual resident annual hourly thresholds.

2025 PROPOSED DRAFT

Proposed an average of **5 hours per week (240 hours annually)** with an individual resident minimum of **170 annual hours**.

2026 FINAL ACCEPTED

Finalized at an average of **5 hours per week (230 synchronous hours annually)** with an individual resident minimum of **160 annual hours**.

IMPACT ON RESIDENTS

Guarantees protected learning blocks while establishing a standard, clear minimum (160 hours).

2. Remote Site Rotations

CURRENT REQUIREMENT

Geographically distant sites were defined broadly **(>60 miles or >30 min travel)**, requiring an educational rationale, but lacked formal advance notification.

2025 PROPOSED DRAFT

Sites **> 60 miles away** require explicit Review Committee approval before residents can start the rotation.

2026 FINAL ACCEPTED

Maintained the strict **60-mile prior approval rule**, adding mandates for **timely advance notification** to protect resident planning.

IMPACT ON RESIDENTS

While this protects residents from sudden travel distance expectations, details regarding consequences of travel length-of time and considerations for on-site housing/length of time away from home have not been addressed.

3. Procedure Logging & Simulation Caps

CURRENT REQUIREMENT

Required tracking of major resuscitations and key procedures, but lacked explicit restrictive phrasing regarding single-credit on co-managed codes. Blanket rule that a maximum of 30% of each procedure type, excluding extremely rare procedures, could be simulation-based.

2025 PROPOSED DRAFT

No specific text alterations regarding split resuscitations or performance counting.

2026 FINAL ACCEPTED

Explicitly mandates that only one resident can be credited with leading a resuscitation or performing an individual procedure. Specifies the number of procedures allowable in simulation environments for each procedure type. Rarely performed procedures may continue to be completed entirely in a simulated environment (ex: cricothyrotomies, pericardiocenteses).

IMPACT ON RESIDENTS

Requires logging compliance. If two residents co-manage an unstable patient, only the single designated team leader receives log credit. Required ultrasounds and orthopedic reductions are not allowable in simulation environments.

3 (contd). Updated Procedure Numbers

CURRENT REQUIREMENT (ESTABLISHED 2017)

- **Blanket Sim Cap:** Max 30% across standard procedures

Procedure	Minimum
Adult Medical Resuscitation	45
Adult Trauma Resuscitation	35
Cardiac Pacing	6
Central Venous Access	20
Chest Tubes	10
Cricothyrotomy	3
Dislocation Reduction	10
ED Bedside Ultrasound	150
Intubations	35
Lumbar Puncture	15
Pediatric Medical Resuscitation	15
Pediatric Trauma Resuscitation	10
Pericardiocentesis	3
Procedural Sedation	15
Vaginal Delivery	10

UPDATED MINIMUM TOTALS

- Specified sim caps

Procedure	Minimum	Max Sim Based
Adult Medical Resuscitation – Supervised Team Leader	**45**	**10**
Adult Trauma Resuscitation – Supervised Team Leader	**35**	**10**
Arterial Lines	**10**	**3**
Arthrocentesis	**10**	**5**
Cardiac Pacing	**6**	**6**
Endotracheal Intubation		
• Neonatal	**3**	**3**
• Pediatric	**10**	**7**
• Adult	**50**	**15**
Lumbar Puncture	**10**	**5**
Orthopaedic Reduction		
• Dislocation	**10**	**0**
• Fracture	**10**	**0**
Paracentesis	**10**	**5**

Procedure	Minimum	Max Sim Based
Pediatric Resuscitation		
• Neonatal Assessment at Delivery	**7**	**2**
• Neonatal Resuscitation (0–28 days)	**4**	**4**
• Pediatric Resuscitation (Medical)	**15**	**10**
• Pediatric Resuscitation (Trauma)	**10**	**5**
Pericardiocentesis	**3**	**3**
Procedural Sedation (adult)	**15**	**5**
Procedural Sedation (pediatric)	**15**	**5**
Regional Anesthesia	**10**	**5**
Surgical Airway *Cricothyrotomy)*	**3**	**3**
Thoracostomy *(to include both chest tube and pigtail catheters)*	**10**	**3**
Ultrasound *(Diagnostic and Procedural)*	**300**	**0**
Vaginal Delivery	**10**	**3**
Vascular Access		
• Pediatric Vascular Access	**5**	**2**
• Central Venous Access	**20**	**10**
• Intra-Osseous Access	**5**	**3**

4. Pediatric Procedures

CURRENT REQUIREMENT

Tracked broadly across generic pediatric numbers without separating neonatal specific age blocks or explicit clinical team leadership checkboxes.

2025 PROPOSED DRAFT

Categorized broadly as pediatric medical assessment and generic pediatric resuscitations.

2026 FINAL ACCEPTED

Adds specific index categories for **neonates (0-28 days)**, infants/children under 12, and explicitly tracks the role of supervised team leader.

IMPACT ON RESIDENTS

Refines specific tracking of resuscitations and procedures by age group including neonates (0-28d) and infants/children under 12 years of age.

5. Patient Volume per Training

2,500

MINIMUM TOTAL VISITS

CURRENT REQUIREMENT

Evaluated program patient exposure purely on an annual departmental census baseline (e.g., minimum 30,000 visits at the primary clinical site).

2025 PROPOSED DRAFT

Required an aggregate volume of **3,000 patient visits annually** per approved resident position in the program.

2026 FINAL ACCEPTED

Reconfigured to a flat metric of **2,500 patient visits over the course of the entire residency** per approved position.

IMPACT ON RESIDENTS

Single patient encounters not logged by residents; this volume requirement is managed at the rotation site approval level.

6. Critical Care Patient Volume

135

RESIDENCY ICU CASES

CURRENT REQUIREMENT

Monitored critical care exposure loosely via general intensive care unit block months and general department acuity metrics.

2025 PROPOSED DRAFT

Required an aggregate volume of **120 critical care patients annually** per approved resident position.

2026 FINAL ACCEPTED

Reconfigured to at least **135 critical care patients over the entire residency** per approved slot, precisely counting specific ICU tracking criteria.

IMPACT ON RESIDENTS

Provides a high-volume, highly specified resuscitation experience. Ensures clear definitions on exactly which high-acuity patient stays fulfill critical care targets.

7. Dedicated Ultrasound Block

CURRENT REQUIREMENT

Bedside ultrasound was treated as an integrated longitudinal procedural capability tool, but lacked an explicit, dedicated block timeline mandate.

2025 PROPOSED DRAFT

Identified ultrasound as a generic procedural skill without a dedicated timeline block requirement.

2026 FINAL ACCEPTED

Mandates a **formal 4-week dedicated POCUS experience**, with at least 2 weeks strictly occurring in the first year of residency.

IMPACT ON RESIDENTS

Guarantees immersive, early training as an intern to master foundational diagnostic scans and advanced procedures like regional nerve blocks and ultrasound-guided IVs.

8. Urgent Care & Low Acuity Rotations

CURRENT REQUIREMENT

Expected exposure to low-acuity patient environments (such as urgent care or fast-track settings) but did not explicitly prohibit counting hours from low-resource sites.

2025 PROPOSED DRAFT

Kept standard longitudinal low-acuity tracking targets active without restriction.

2026 FINAL ACCEPTED

Requires at least **8 weeks of low-acuity/urgent care experience**, explicitly stating that time spent in a low-resource ED cannot count toward this total **(low resource ≠ low acuity)**.

IMPACT ON RESIDENTS

Guarantees dedicated training in efficient, high-throughput fast-track models.

9. ED Trained Attendings

CURRENT REQUIREMENT

Required supervising attending physicians to possess current board certification (ABEM/AOBEM), but lacked explicit exclusionary restrictions concerning historical pathways.

2025 PROPOSED DRAFT

Faculty members supervising emergency departments must be emergency medicine physicians.

2026 FINAL ACCEPTED

Explicitly specifies that department supervisors must be emergency medicine physicians **who fully completed an emergency medicine residency**.

IMPACT ON RESIDENTS

Ensures that 100% of core training hours are spent under the direct clinical supervision and mentorship of dedicated, residency-trained emergency physicians.

10. Days Off on EM blocks

CURRENT REQUIREMENT

Upheld the standard common rule where the 1-day-in-7 free from clinical responsibilities was calculated as a flexible mathematical average over a rolling 4-week window.

2025 PROPOSED DRAFT

Maintained the baseline standard that a minimum of one day free in seven could be mathematically averaged over a 4-week window.

2026 FINAL ACCEPTED

Strictly bans 4-week averaging for consecutive days. Residents cannot work more than 6 consecutive days; a **24-hour break** is required per 7 days.

IMPACT ON RESIDENTS

Provides at least one day off over 7 days while working in the ED. Entirely eliminates multi-week stretches without an absolute 24-hour block off. This does not pertain to off-service rotations, which must average one day off a week but over a 4-week block.