ACGME

2025 ACGME ANNUAL EDUCATIONAL CONFERENCE
MEANING in MEDICINE
FEBRUARY 20-22
NASHVILLE

SES013: Emergency Medicine Update

Linda Regan, MD MEd – Review Committee Chair

Tiffany Murano, MD – Review Committee Vice Chair

Felicia Davis, MHA – Review Committee Executive Director

Conflict of Interest Disclosure

Speaker(s): *Linda Regan, MD*
Tiffany Murano, MD
Felicia Davis, MHA

Disclosure

None of the speakers for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Topics for Today…

- ✓ The Review Committee
- ✓ Next Accreditation System Observations
- ✓ Accreditation Data System (ADS)
- ✓ Review Committee Discussions
- ✓ Proposed Program Requirements

The Review Committee

Committee Responsibilities

- Operate under delegated authority from the ACGME BOD
- Evaluate program compliance with the published program requirements - “Peer Review”
- Maintain communication with programs and specialty associations
- Revise and update the program requirements as scheduled per ACGME policies

Emergency Medicine Review Committee

- 4 nominating organizations – ABEM, AMA, AOA, ACEP
- 13 voting members (includes one resident and one public member)
- 6-year terms – except resident (2 years)
- Composed of Program Directors, Chairs, Faculty
- Ex-officios from ABEM, ACEP, AOA (non-voting)

Review Committee Composition

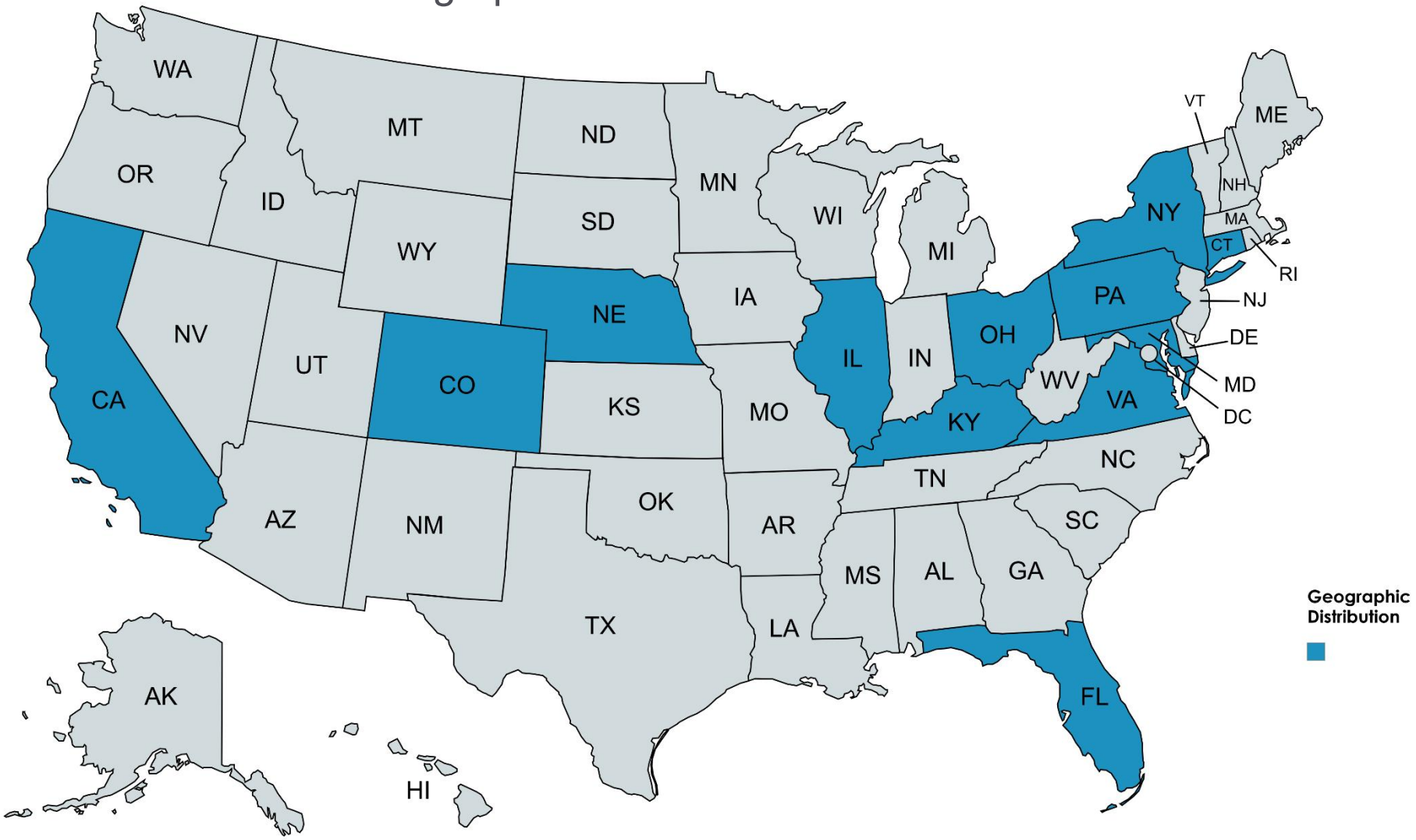
3 members nominated by ABEM
3 members nominated by ACEP
3 members nominated by AMA
2 members nominated by AOA
1 public member – open call for nominations
1 resident member – open call for nominations

*All members selected by the Review Committee from nominated candidates

Emergency Medicine Review Committee 2024-2025

Linda Regan, MD (Chair) Johns Hopkins University	*Paul Ishimine, MD* University of California (San Diego)	*Kimberly Richardson, MA* (Public Member) University of Illinois Cancer Center
Tiffany Murano, MD (Vice Chair) NY Presbyterian Hospital - Columbia	*Eric Lavonas, MD* Denver Health/University of Colorado	*Michael Wadman, MD* University of Nebraska Medical Center
David Caro, MD University of Florida Jacksonville	*Joel Moll, MD* Virginia Commonwealth University	*Jill Stafanucci-Uberti, DO* University of Louisville
Brian Clemency, DO University at Buffalo	*Deborah Pierce, DO, MS* Albert Einstein Medical Center	
Leah Colucci, MD (Resident Member) Yale New Haven Hospital	*Melissa Platt, MD* University of Louisville	

Geographic Distribution of RC Members



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Member Responsibilities

- Act in the best interest of the ACGME
- Recognize and adhere to conflicts of interest
- Exercise fiduciary responsibility
- Maintain Confidentiality

EM Accreditation

Emergency Medicine 2024-2025
(as of February 2025)

Specialty	Number of Programs	Approved Positions	Filled Positions
Emergency Medicine	291	10,646	9812
Emergency Medical Services	87	177	106
Medical Toxicology	32	122	107
Pediatric Emergency Medicine	29	170	147
Sports Medicine (Under EM)	8	18	16
Undersea and Hyperbaric Medicine	8	19	13

EM Accreditation Status 2024-2025

Accreditation Status	Number of Pgms
Initial Accreditation	10
Initial Accreditation w/Warning	3
Continued Accreditation w/o Outcomes	1
Continued Accreditation	268
Continued Accreditation w/Warning	5
Probation	0
Withdrawn	3

New Programs 2024 – 2025

EM	BayCare Health System (St. Joseph's Hospital) *Shayne M. Gue, MD*	Florida
EM	Insight Hospital and Medical Center *Anita Goyal, MD*	Illinois
EMS	Florida State University *Marshall Frank, DO*	Florida
EMS	Florida Atlantic University Charles E. Schmidt COM *Scott Alter, MD*	Florida
EMS	Henry Ford Health/Henry Ford Hospital *Matthew T. Ball MD*	Michigan
EMS	Charleston Area Medical Center/CAMC Institute *Collin Smith, DO*	West Virginia
Sports	Mass General Brigham/Mass General Hospital Program *Gianmichel Corrado, MD*	Massachusetts

Top 3 Citations

1. Program Director Responsibilities
2. Resident Evaluations
3. Learning and Working Environment

ACGME Updates

Site Visits
Continued Accreditation Status

- As of 2024, ACGME began conducting site visits annually for approximately 1-2% of programs with a status of Continued Accreditation that have not had a site visit in 10 or more years.
- These site visits are determined through a sampling process and support the ACGME's responsibility to the public.
- All selected programs for 2025 were notified in November-December 2024 of the site visit target dates (February - June 2025)
- As a reminder, the 10-year Accreditation site visit has been discontinued
- The program Self-Study requirement has been paused, but will be reconfigured and will no longer be linked to a site visit

Direct questions to accreditation@acgme.org

Site Visit FAQs may be found on the ACGME website

under the category Programs and Institutions/Site Visit

NEW! Reformatted Program Requirements

- As part of the Digital Transformation, ACGME requirements will be reformatted
- Announced Feb 10th ACGME eComm
- The reformatting includes a new numbering construct, eliminating the roman numeral outline structure
- Crosswalk documents that map the old reference numbers to the new ones for each set of requirements will be provided
- This reformatting will affect all requirement documents, specialty application forms, FAQ documents, and other related resources.
- Reformatted versions of the requirements are currently posted and will go into effect July 1, 2025

SPECIAL ANNOUNCEMENT

NEW! Announcing ACGME Requirements Reformatting

As part of the Digital Transformation, all ACGME Requirements documents (Common Program Requirements, Institutional Requirements, specialty/subspecialty-specific Program Requirements, and Recognition Requirements) are being reformatted. The reformatted documents will be rolled out in phases between now and July 1, 2025. After that date, the ACGME will no longer use the roman numeral outline structure historically in place. This is a first step that will ultimately facilitate additional benefits and features not previously available to the GME community.

The reformatting includes a new numbering construct, eliminating the roman numeral outline structure and adopting the familiar structure of the ***ACGME Manual of Policies and Procedures***. It also consolidates standards, reducing the number of sub-levels within a requirement.

Except for documents already undergoing revision, **the content of the Requirements is not changing**, just the formatting and numbering structure. The ACGME is providing crosswalk documents that map the old reference numbers to the new ones for each set of Requirements, and updating Frequently Asked Questions (FAQs), applications, and other related documents and resources.

TIMELINE:

- **Today! February 10, 2025**: Reformatted Common Program Requirements (Residency and Fellowship versions); Institutional Requirements; most specialty-/subspecialty-specific Program Requirements; and associated crosswalk documents posted on acgme.org
- **March 2025**: Reformatted Common Program Requirements (One-Year Fellowship and Post-Doctoral Educational Program versions); remaining specialty-/subspecialty-specific Program Requirements; Recognition Require-

Reformatted Requirement *Example*

Current Format

IV.B.1.a).(1)	Residents must demonstrate competence in:
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)
IV.B.1.a).(1).(c)	cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core)
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)
IV.B.1.a).(1).(f)	respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

Reformatted Version 7/1/2025

Residents must demonstrate competence in:

4.3.a.	compassion, integrity, and respect for others; (Core)
4.3.b.	responsiveness to patient needs that supersedes self-interest; (Core)
4.3.c.	cultural humility; (Core)
4.3.d.	respect for patient privacy and autonomy; (Core)
4.3.e.	accountability to patients, society, and the profession; (Core)
4.3.f.	respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)
4.3.g.	ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)

Emergency Medicine

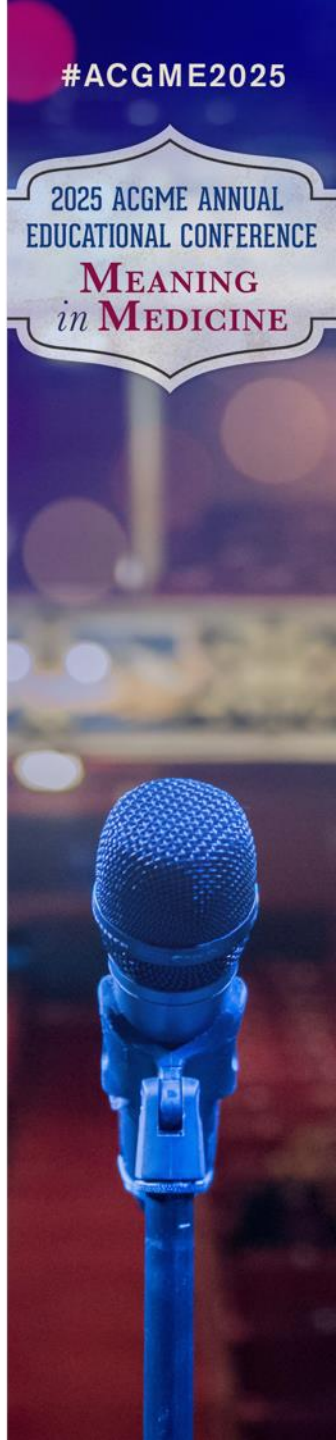
- Program Requirements Effective 7/1/2023
- FAQs
- Reformatted Program Requirements Effective 7/1/2025
- Current and Reformatted Crosswalk
- Specialty-Specific Application

Addiction Medicine

- Program Requirements Effective 7/1/2023
- FAQs
- Program Requirements Effective 7/1/2025
- Program Requirements (TCC) Effective 7/1/2025
- Specialty-Specific Application

ACGME

Proposed EM Requirement Revisions



Important Tips to Read the Proposed Requirements

- The document will be in “track changes” format
- Removed language is ~~lined out~~.
- Added language is underlined.
- Lined out language may be moved to another section and not actually removed.
- There is a new ACGME numbering system
- **Specialty Specific Background and Intent boxes are not a requirement, they clarify a requirement.**

Entire draft document with all program requirement revisions, the impact statement, and key index procedures currently posted on

ACGME's Review and Comment page until

May 1st

Did you see the webinar?

Did you see the Webinar?

- National webinar conducted February 11th, over 400 viewed live
- Revealed the proposed revisions to the Emergency Medicine Program Requirements
- Provided background and rationale for most impactful changes
- Session was recorded and is available on "*Learn at ACGME*" for those unable to attend

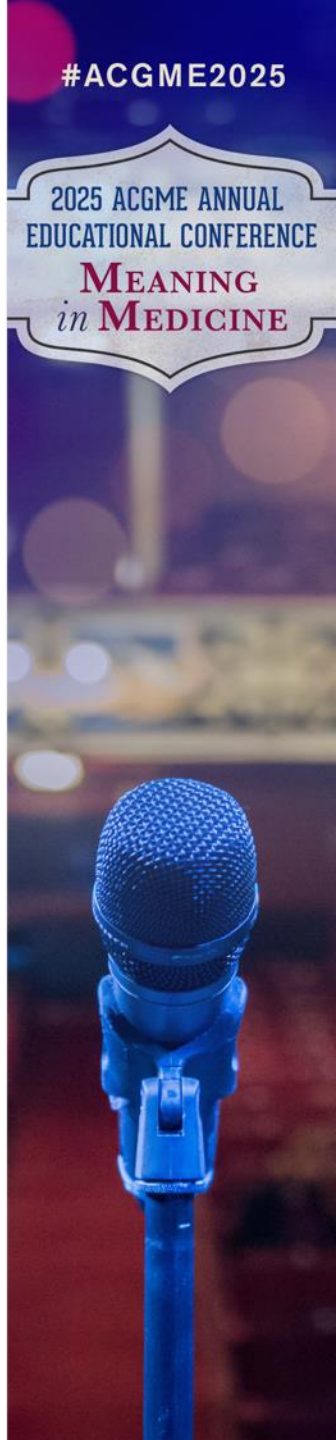
Link to the webinar

Scan me!

Two key takeaways

These requirements are PROPOSED

The earliest implementation, no sooner than **2027**



PR Revision Process

Strategic Planning Consulting Firm

- Professionally facilitated 4-day strategic planning meeting
- Reviewed available evidence: best practices, procedural competency, resident work hours, EM scope
- Conducted stakeholder interviews with ED directors, EM leaders, new graduates in community and academic setting

Stakeholder Summit Attendees Organization (number of attendees)

Writing Group (8)

RC Past Chair

Recent graduate (2)

RSA (2)

EMRA (2)

AAEM (2)

SAEM/AACEM (2)

CORD (4)

ACEP (2)

ACOEP (2)

ABEM (2)

AOBEM (2)

Stakeholder Insights
New graduates often:

- Provide inefficient patient care (low number of patients per hour)
- Don’t understanding of administrative components needed for leading teams in an Emergency Department (ED)
- Less competent with common procedures seen in lower acuity settings (eg, suturing, incision and drainage, fracture reduction)
- Need more training in pediatric emergency care

Stakeholder Insights

Required training/competency needed:

- Addiction Medicine
- Administration
- Emergency Medical Services
- Obstetrics and Gynecology
- Toxicology
- Point of Care Ultrasound
- Primary decision making for multidisciplinary teams
- Telemedicine
- Transfer and Transitions of care
- Observation Medicine

EM Writing Group Major Milestones

- Themes and insights document
- New definition of an Emergency Medicine Physician

- Developed Competencies
- Created Curriculum Elements
- Proposed Program Requirements

The Big Picture

- **Forward-looking process** that is required by ACGME to ensure **future graduates are prepared** for what specialty of EM will face **over the next 20 years**

- **We built a NEW curriculum: Every current program** will have to modify its curricula

- No way to make **significant change** without impacting emotions, including anger, fear of the unknown and loss of comfort zone

What it is NOT?

- **Not a judgement** on current programs, current or prior graduates
- Not an attempt to manipulate the workforce
- Not trying to close small programs or CMGs
- Not a bribe to get cheap labor
- Not an opportunity to revise Common Program Requirements (i.e.- core faculty support)

Proposed Program Requirements for Emergency Medicine

Requirements written in the time frame of weeks

CURRENT PROGRAM REQUIREMENT	PROPOSED PROGRAM REQUIREMENT

Proposed Program Requirements for Emergency Medicine

Didactics

Didactics

IV.C.3.c) There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core)	4.11.a.4. There must be at least **240 synchronous hours of planned didactic experiences** annually, exclusive of morning report of change of shift teaching (Core)

Didactics

IV.C.3.c).(5) Residents must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core)	4.11.a.10. Programs must establish a **minimum** requirement for conference attendance that **meets or exceeds 170 annual hours per resident.** (Core)

Individualized Interactive Instruction (III)

Background & Intent

Individualized interactive instruction (III or I3) will **not** be counted towards the program minimum of 240 hours

III can count towards an individual resident in meeting their attendance requirement of 170 hours annually

Proposed Program Requirements for Emergency Medicine

Procedural Requirements

Procedure logging

NEW

4.5.e
Resident procedural experiences must be tracked in the ACGME Case Log System and must meet minimums as defined by the Review Committee. (Core)

Big Picture Changes: Procedures

- Resuscitation requires performance as a team leader to count
- Resuscitation, venous access, and intubation all have requirements by age with children now < 12 y/o
- The minimum number for simulation in certain procedures is 0
- Ultrasound not being tracked by absolute number but required under formal Structured Experience with flexibility to programs in format and assessment

Key Index Procedures

Procedure	Minimum Total	Maximum Simulated
Adult Medical Resuscitation	45	0
Adult Trauma Resuscitation	35	0
Arterial Lines	10	0
Arthrocentesis	10	5

Faculty Experience

NEW

2.7.a.
There should be **faculty members available** to the program from within the department or institution with background and focused experience in **patient safety, quality improvement, scholarship, ultrasound and medical education (including simulation)**, who are actively engaged in the development, implementation and assessment of their specific areas of curricular content. (Detail)

Proposed Program Requirements for Emergency Medicine

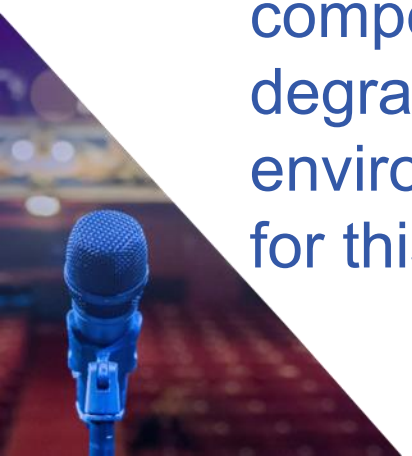
Curricular Building Blocks

Structured Experiences

- A rotation or **another identifiable experience** (e.g. didactic series, simulation training, focused educational materials such as readings/ modules)
- Allows programs to decide how skill acquisition, maintenance of competency, and prevention of skill degradation best fit their environment and available resources for this required experience

Rotations

- Discrete, identifiable periods **depicted on** the block diagram
- Can be described in weeks/calendar months, or longitudinal experiences that, when summed, equal the required rotation time



"Structured Experiences (SE)"

- A rotation or **another identifiable experience** (e.g. didactic series, simulation training, focused educational materials such as readings/ modules)
- Allows programs to decide how skill acquisition, maintenance of competency, and prevention of skill degradation best fit their environment and available resources for this required experience

Required Domains

- Acute Psych Emergencies
- Airway Management
- Non-Lab Diagnostics
- Observation Medicine
- Ophthalmology
- Perform Sensitive Exams
- Primary Decision Making in Multidisciplinary Teams
- Telemedicine
- Transfers and Transitions of Care

NO MINIMUM TIME REQUIREMENT

Ultrasound

- We believe this elevates ultrasound, not lowers it in importance
  - Requiring faculty with experience/background
- A single global target for all "ultrasound"
- Multiple other organizations have guidelines on structure, required numbers, competency, assessment
- We want programs to decide what best works for them

"Rotations"

- Discrete, identifiable periods **depicted on** the block diagram
- Can be described in weeks/calendar months, or longitudinal experiences that, when summed, equal the required rotation time

Critical Care

IV.C.4.a)
four months of dedicated critical care experiences, including critical care of infants and children; (Core)
IV.C.4.a).(1) At least two months of these experiences must be at the PGY-2 level or above. (Core)

4.11.b.3
Critical Care
At least **sixteen weeks of dedicated critical care** rotations, of which at least eight weeks must occur at the PGY-2 level or above, including: (Core)

Critical Care

IV.C.4.a) four months of dedicated critical care experiences, including critical care of infants and children; (Core)	4.11.b.3.a At least **eight weeks** must be in an **adult intensive care unit** outside of the emergency department. (Core)

Critical Care (Pediatrics)

IV.C.4.a) four months of dedicated critical care experiences, including critical care of infants and children; (Core)	4.11.b.3.b At least **four weeks must be in an ICU dedicated to the care of neonates, infants, and children** including training in airway management, resuscitation, and stabilization; and of these four weeks, **at least two weeks must be in a Pediatric Intensive Care Unit (PICU).** (Core)

Critical Care

4.11.b.3.a.
The remaining four weeks can take place in an intensive care unit of the **program's choice**. (Detail)

Background and Intent
... some of these experiences may occur outside of ICUs, such as in designated ED-based ICUs, neonatal/deliver room rapid response teams or on critical care transport teams

Pediatrics

IV.C.4.b)
five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings; (Core)

4.11.b.4.
At least **24 weeks**, or the equivalent, dedicated to the care of **neonates, infants, and children**. The time should be/is calculated by summing identified rotations and equivalent months. (Core)

Pediatrics

IV.C.4.b).(1) At least 50 percent of the five months should be in an emergency setting. (Core)	4.11.b.4.a. At least **twelve weeks**, or the equivalent, must occur in an **emergency department.** (Core)

Flexible Pediatrics Time

- 8 weeks of required time dedicated to pediatrics
- Can do more PEM, Peds ICU, Neonatal ICU
- Can add other peds rotations (i.e. Peds anesthesia, outpatient pediatrics clinic)

Additional Required Rotations

2-weeks each

- Obstetrics
- Administration/Quality Assurance
- Toxicology/Addiction Medicine
- EMS

Emergency Medicine

IV.C.4.d)
at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core)

4.11.b.1
Emergency Medicine
The curriculum must include **at least 124 weeks** of each resident's clinical experience must take place **in the emergency department under the supervision of emergency medicine faculty** members. (Core)

Emergency Medicine

I.B.4.a) The program should be based at the primary clinical site. (Core)	4.11.b.2.c **At least 62 weeks** of the resident's **emergency medicine** clinical experience should occur at the **primary clinical site** (Detail)

Emergency Medicine

- A **low resource** emergency department has limited diagnostic, therapeutic and interventional capabilities, consultants, specialty services and may often transfer patients for higher levels of care
- A **high resource** emergency department has readily available tertiary resources, diagnostic, therapeutic and interventional capabilities, consultants, and rarely transfers patients for higher levels of care

Emergency Medicine

NEW

4.11.b.2.c

At least four weeks of this clinical experience must be at a **low-resourced** emergency department and four weeks at a **high-resourced** emergency department. (Core)

Emergency Medicine

NEW

4.11.b.2.f

Residents should have **no less than eight weeks of experience in a practice setting designated for low acuity patients**, such as an Emergency Department Fast Track or Urgent Care Center. Time spent in a low-resourced ED does not count toward this experience. (Detail)

Emergency Medicine

NEW

2.10.a.
When faculty members who possess **certification other than ABEM or AOBEM** supervise residents assigned to a low-resourced emergency department or low acuity emergency medicine rotation, **this time does not count toward the required 124 weeks of core emergency medicine** experience which must occur under the supervision of board-certified EM physicians. (Core)

How was 48 Months Derived?

- Considered new “future EM physician”
- Considered stakeholder feedback, evidence-based literature, competencies, procedures, patient encounter targets, community needs

- **Writing Group built a curriculum de novo, element-by-element, before summing the elements**

- Did not decide to change 3-year programs to 4-year program
- Format had to be in 12-month increments

Minimum Time in the ED

Defining terms
Month: 30 or 31-day period
Block: 4-week period

One month = 4.3 weeks

Now: 3 or 4-year format; 60% in ED

- 3-year format: 22 months (36*0.6=21.6); 24 blocks (39*0.6=23.4)
- 4-year format: 29 months (48*0.6=28.8); 31 blocks (52*0.6=31.2)

Proposed:

22 months/24 blocks PLUS INCREASE from additional low acuity (2), low (1) and high resource (1) , PEM (1)

Additional Required Time

- 8 weeks from EMS, OB, Admin, Tox
- Possibly 4 more weeks of ICU

- 22 + 5 + 12 = 38 Months

- NO VACATION, ELECTIVE, TIME FOR STRUCTURED EXPERIENCES THAT PROGRAMS WOULD WANT TO BE IN ROTATION FORMAT

Experiential Curriculum Cross-Check

- EM Writing Group built the curriculum element-by-element to derive new proposed requirements
- Program Directors built a curriculum element-by-element and derived a similar curriculum with high concordance

Conclusion: the ACGME Major Program Revision process reflected the EM community's view on a changing experiential curriculum

EM PD Survey

In the sections that follow, you will be asked to **estimate the total required time** you believe is necessary to complete various rotations. **Please make these estimates without considering current ACGME Program Requirements for Emergency Medicine, your current curriculum, or your current program resources.**

These estimates should be based on **what you believe is necessary in order for an emergency medicine resident to acquire the knowledge, skills, and behaviors to enter autonomous practice.**

EM PD Survey

Please consider your time estimates carefully and note that **you will only be able to move forward in the survey (i.e., you will not be able to return to previous pages once you've selected the ***Next page*** button).**

The survey is divided into **four sections**:

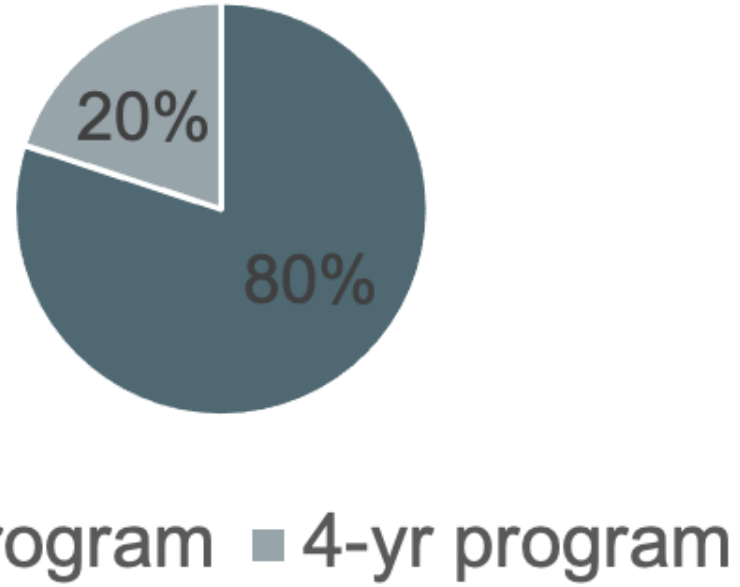
I. Non-Emergency Department-Specific Intensive Care Unit or Critical Care Unit Rotations
II. Additional Experiences Outside of Emergency Department Rotations
III. Pediatric Experiences Outside of Emergency Department
IV. Emergency Medicine

Survey sent to 289 EM PDs

Response Rate:

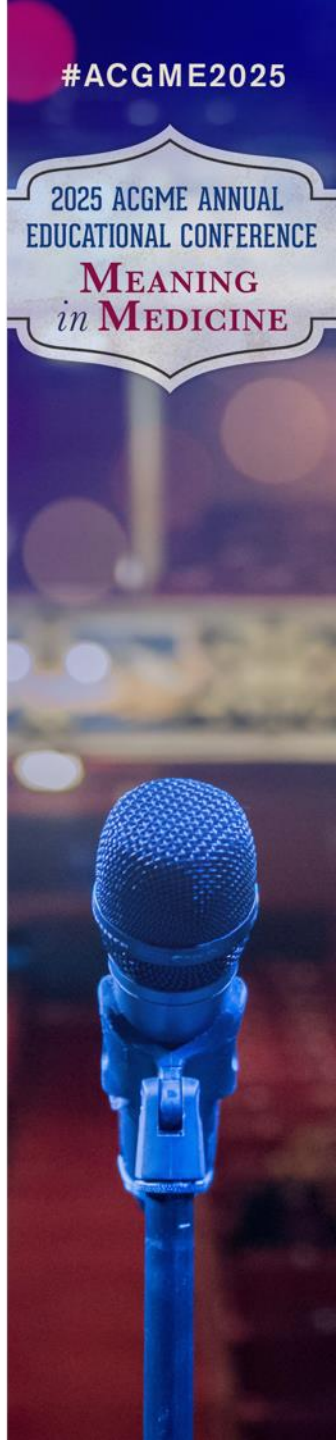
60%

173/289 PDs



Experience	Proposed Curriculum	PD Survey (mean), n=168
Emergency Medicine[1]	Total EM = 31.00 Low-resource ED = 1.00 High-resource ED = 1.00 Low-acuity EM = 2.00 Pediatric EM = 3.00	Total EM = 28.49 General EM = 22.62 Low-acuity EM = 1.27 Pediatric EM = 4.60
Administration[1]	0.50	0.35
Anesthesia[2]	0.00	0.64
Critical Care (including PICU)[1]	4.00 (+1.00)[3]	5.30
Electives	0.00	1.65
EMS (including Disaster Medicine)[1]	0.50	0.60
Obstetrics[1]	0.50	0.73
Orthopedics	0.00	0.43
Other Pediatrics[1]	2.00	0.37
POCUS[2]	0.00	0.93
Quality/Process Improvement[2]	0.00	0.43
Toxicology (including addiction)[1]	0.50	0.53
Trauma (including ACS)	0.00	1.04
Other Suggested Experiences Research/Scholarship Pain Management Palliative Care Critical Care Transport Telemetry Geriatric EM Psychiatry Internal Medicine Neurology	0.00	1.90
Vacation (4 weeks for each of 4 years)	4.00	4.00
Total time in 4-week increments	**43.00 (+1.00)[3]**	**47.39**

e-Publication in the ACGME News and Views section of the Journal of Graduate Medical Education



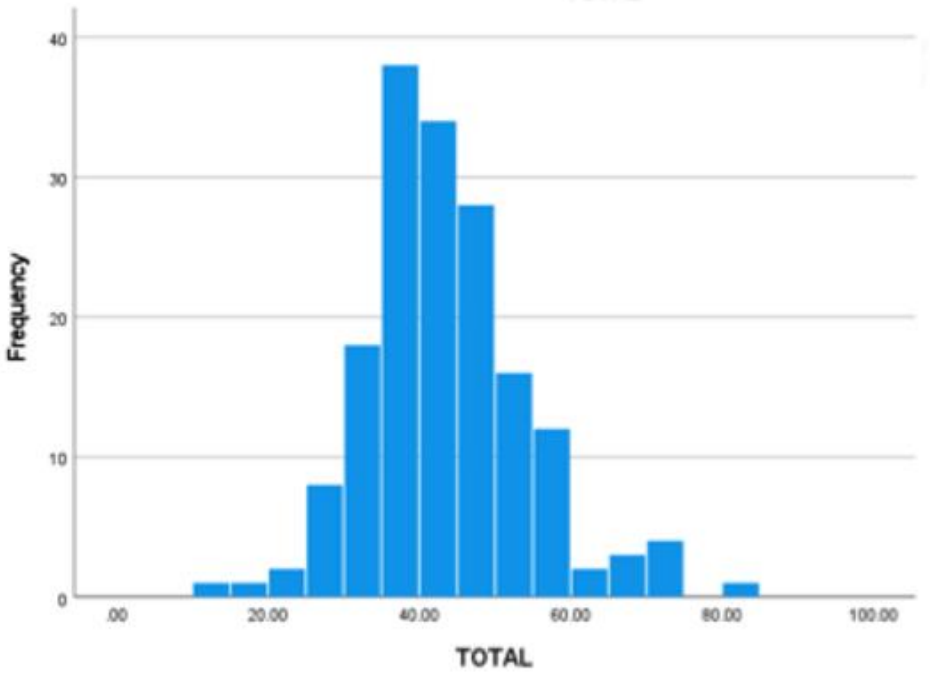
Accreditation Council for Graduate Medical Education

EM Program Director Survey

KEY FINDINGS – TOTAL REQUIRED TIME (FULL SAMPLE)

- Estimated total required time for all EM program components:

	Mean	*SD*	Median	Range	
				Min	*Max*
Total Required Time (Months):	**43.35**	**10.75**	**42.10**	**11.60**	**83.00**
Total Required Time (Years):	**3.61**	**0.90**	**3.51**	**0.97**	**6.92**



*Note: 5 outliers (>3 standard deviations from the mean) were excluded from the analysis; total *N* analyzed = 168 PDs

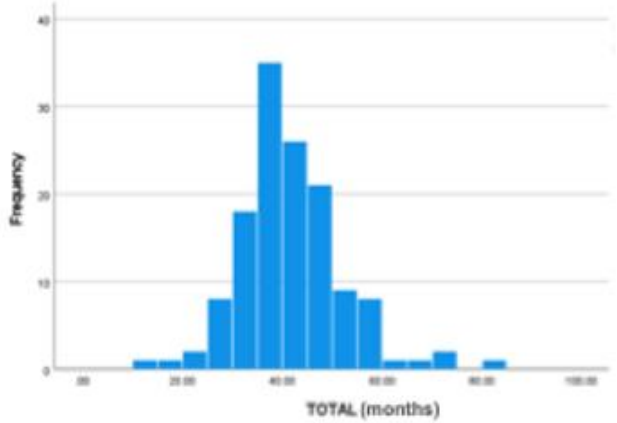
- Estimates do not include vacation time
  - Add 3-4 months to these totals (i.e., 46.35-47.35 months)

Accreditation Council for Graduate Medical Education

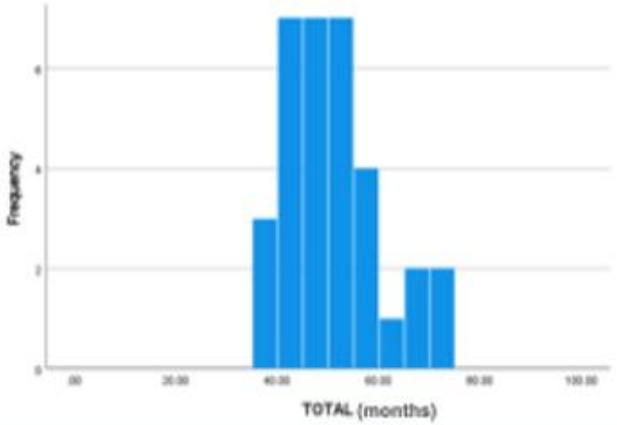
EM Program Director Survey

KEY FINDINGS – TOTAL REQUIRED TIME (BY PD PROGRAM LENGTH)

- Estimated total required time for all EM program components:
  - 3-yr program PDs (*n* = 134):
    M = 41.58 months (3.49 years)



  - 4-yr program PDs (*n* = 33):
    M = 50.65 months (4.22 years)



- Estimates do not include vacation time
  - Add 3-4 months to these totals

Length of Training

Introduction. C. Residency programs in emergency medicine are configured in 36-month and 48- month formats and must include a minimum of 36 months of clinical education. (Core)	**4.1** The educational program in Emergency Medicine **must be 48 months** in duration. (Core)

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Proposed Program Requirements for Emergency Medicine

Resource Requirements

Program Resources

- Total ED and ED Critical Care volumes
  - Current requirements were absolute and focused on primary clinical site
  - Proposed requirements are scalar and aggregate ED volumes and focused on adequate patient volume for number of trainees

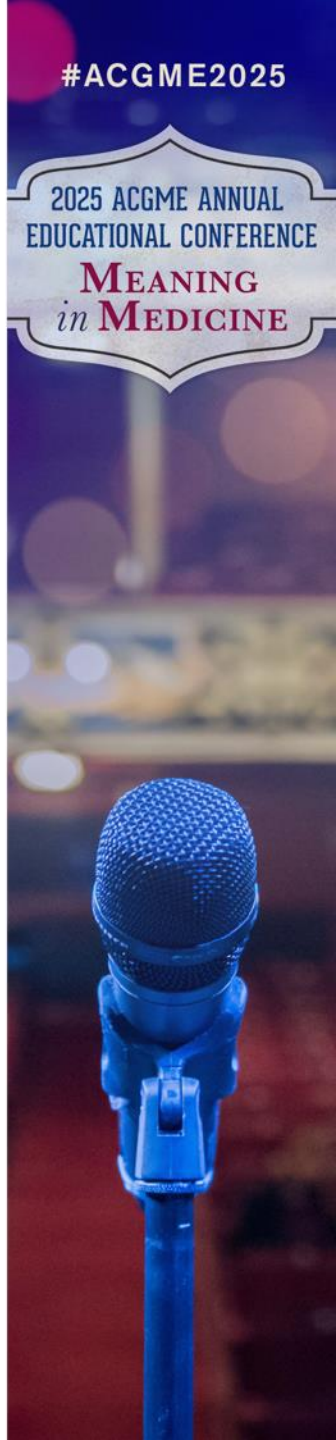
Ideal Target for Total ED Patient Encounters?

How many patients per hour on average?

1.5 patients/hour (pph)?

1.25 patients/hour (pph)?

1.0 patients/hour (pph)?



Current EM Minimums

- 36 month program
- 30,000 volume/year with 60% EM = 18,000
- Minimum 18 residents
- 1000 patients/resident/year

- 3000 patients per resident over the course of the program

Minimum Patient Encounters

Initial considerations: 1.5 pph x 93.6 weeks would equal 5616 patient encounters/resident over the course of training

[93.6 weeks x 40hrs/wk = 3744 (1.5 pph) = 5616]

Initial considerations: 1.5 pph x 124 weeks would equal 7440 patient encounters/resident over the course of training

[124 weeks x 40hrs/wk = 4960 (1.5 pph) = 7440]

Based on best available data stating *on average:*

Residents see 1 new patient per hour (pph)

Residents work 40 hours/week

What are they seeing now?

- 36 months: Work a minimum of 93.6 weeks in EM
  - ➢ 3744 patients over the course of 3-year training

- 48 months: Work a minimum of 124 weeks in EM
  - ➢ 4960 patients over the course of 4-year training

If used 1.1pph → 5456

Settled on **5000** as a minimum goal for patient encounters

Final Survey Question: How Many Total ED encounters?

WG calculated ideal target: **5000** patients/resident

Estimated from PD survey:

- Overall mean 4676, median 4500
- 3-year PDs: mean 4350, median 4250
- 4-year PDs: mean 6031, median 5500

There is no "minimum patient encounters per resident" requirement at this time for graduation

Total ED Volumes

I.D.1.g)
The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)

1.8.h.
The **aggregate annual volume** of patients in the emergency department (ED) at the **primary and participating ED sites** must total **at least 3,000 annual patient visits per approved resident position** in the program, determined via a calculation defined by the Review Committee. (Core)

What is the calculation?

- Calculate for each ED site individually ([Annual ED volume ÷ 52 weeks] x number of weeks in the ED)
- Add total for each site (e.g. Site 1 + Site 2) and ÷ by approved complement
- Must be >/= to 3000 patients per resident
- Ensures that there are enough ED encounters per resident to achieve target encounters* by program's end

Total Critical Care Volumes

I.D.1.g) .(1)
The primary clinical site should have a significant number of critically ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)

1.8.j.
The **aggregate annual volume of critical care patients** at the primary and participating emergency department clinical sites must total **at least 120 critical care patients per approved resident position** in the program, determined via a calculation defined by the Review Committee. (Core)

What is the calculation?

([Total annual CC volume (all sites) / 52 weeks] /yr x number of weeks in the ED) ÷ approved complement

Must be >/= 120 patients per resident

Programs not meeting this target MUST add an additional ICU rotation

Implementation: Key Take Aways

- If approved, effective date no sooner than July 2027
- 36-month program residents, **including those matched in July 2025 and July 2026** can complete 36 months if the program remains configured in the 36- month format
- Proposed goal: Residents starting in **July 2027** would enter a 48-month program
- The RC will work with programs during this transition

What does this mean for students?

Heard concerns about student interest in EM

Other fields being considered:

- Anesthesiology (4)
- Surgery (5)
- Orthopedics (5)
- Psychiatry (4)
- PM&R (4)
- Medicine (3)

- Only remaining 3-year specialties would be IM, FM, Peds

What does this mean for students?

More time in training can allow for shorter shifts, less shifts while maintaining patient encounters

Impact on emotional wellbeing?

Impact on ABEM scores?

What does this mean for students?

What is true about the lack of declining interest in EM over the past 4 years?

Lots of theories, but one to consider one is that students follow OUR lead

Collaboration

- Provide support during transition for programs, including with regards to complement size, funding (come to the late-breaking session at CORD!), & structure
- Discuss best practices for curricula, SEs, procedure training
- Better align training with board certification needs

Impact

- Reviewed % of programs that have required rotations across various experiences
- Looked at each program's ADS data
- Assessed which programs would likely meet ED volume and CC volume resource proposed requirements

Logistics

All programs will have to make changes to either format, curricula, or both

Submit new block diagram

Submit patient population statistics on annual overall volume and critical care volume

We need to hear from you!

- Provide us comments in the Comment Period
- Tell us what you support and what we can improve on

- Join us at CORD

- We will listen at each of these meetings, but formal feedback comes through the Public Comment mechanism

You need to hear from us!

- We will continue to present at EM meetings and meet with stakeholder groups
- The EM community will help support this transition

The Big Picture

- **Forward-looking process** that is required by ACGME to ensure **future graduates are prepared** for what specialty of EM will face **over the next 20 years**

- **We built a NEW curriculum: Every current program** will have to modify its curricula

- No way to make **significant change** without impacting emotions, including anger, fear of the unknown and loss of comfort zone

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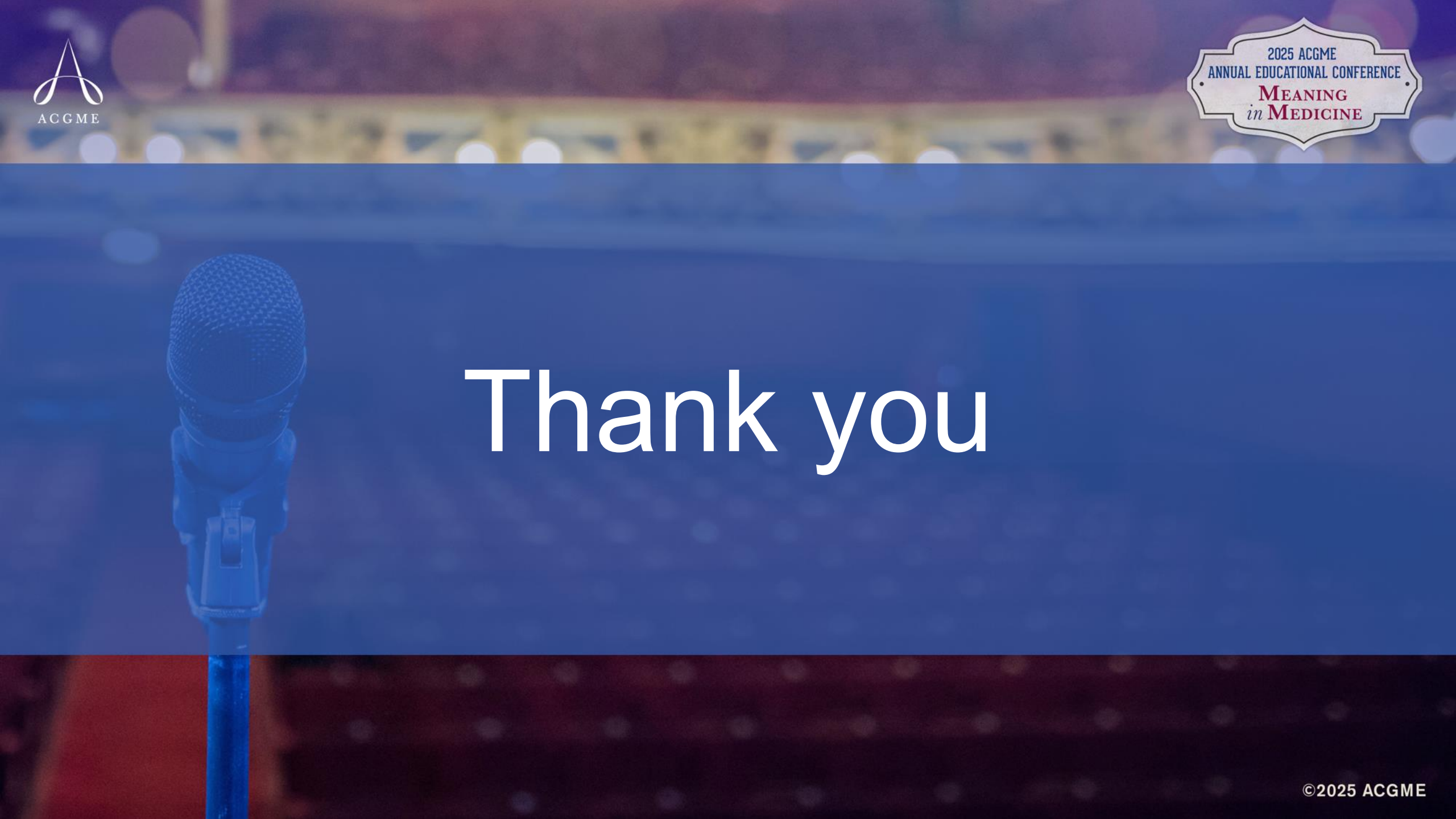
MEANING in MEDICINE

Questions?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