

Predictions and Prescriptions for Institutions Sponsoring Graduate Medical Education

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As children learn to play soccer, they are taught not to chase the ball, running to where it is *now*, but rather to head where the ball is going *next*. Similarly, entrepreneurs embrace the sports metaphor (usually invoking a hockey puck) in trying to anticipate what the public will need and want, and leaders across many domains try mightily to prepare for an always-uncertain future. In this vein, the Accreditation Council for Graduate Medical Education (ACGME) has undertaken a laudable effort to optimize the impact of accreditation on meeting future health care needs. The report from the Sponsoring Institution 2025 (SI2025) initiative, included as a supplement to this issue of the *Journal of Graduate Medical Education*,¹ considers key trends expected to influence the health care landscape in 2025 and offers recommendations for how the ACGME can positively impact their outcome.

Graduate Medical Education Sponsors' Role Over Time

The ACGME's current effort to focus on institutional sponsors of graduate medical education (GME) reflects progressively greater assignment of responsibility and accountability to health care organizations for their individual training programs. In the ACGME's early years, sponsoring institutions (SIs) were expected to fulfill "general requirements" by providing necessary resources (including faculty) and establishing appropriate policies. However, in practice SIs needed to do little more than produce a written "statement of commitment to GME," which was often developed in haste just before a site visit. At many institutions, senior leadership had little engagement with—or even awareness of—GME.

In recent years, the ACGME has raised the bar for SIs with specific requirements outlining responsibilities of the Graduate Medical Education Committee and the designated institutional official. In 2012, the ACGME launched the Clinical Learning Environment Review (CLER) program, based on a conviction that the training environment affects training outcomes.

The CLER program is designed to improve the safety and quality of care delivered to patients, as well as improve resident well-being. Though not an accreditation activity, CLER has broadened and reinforced institutional accountability for GME by strengthening the connection between hospital leaders, clinical and patient safety champions, GME programs, and institutional GME leadership.

Sponsoring institutions, like most health care organizations, have changed significantly amid the rapid evolution of our health care delivery system. In addition to the transformation that individual institutions have undergone, the universe of SIs has diversified and now includes a mix of large multi-institutional health care systems, small teaching health centers, and hospitals that are initiating GME programs in order to address regional physician workforce needs. In addition, the integration of osteopathic institutions into the Single Accreditation System makes the SI2025 initiative a timely and important pursuit.

The SI2025 Process and Findings

For a strategic planning process launched in 2016, 2025 seems like a short horizon, especially given the time needed to develop recommendations and the even longer duration required to plan and effect change. Will we again be left chasing the ball (or puck)? Perhaps, but amid rapid change in the health care delivery system, planning for the next generation may seem completely speculative. An 8-year window allows for greater confidence in visioning what will be needed.

The SI2025 Task Force compiled a series of crowd-sourced predictions about the US health care delivery system in 2025 in order to illuminate needed changes in GME, and to inform a process through which the ACGME can interface with SIs to ensure progress. Input was sought from different types of SIs across the United States and from individuals in varied roles within and outside of health care. This was not a systematic sampling of opinions, and the analysis did not utilize formal qualitative methods; it appears that

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a large volume of input was obtained and thoughtfully evaluated.

The Task Force found that broad input pointed toward 3 major forces underlying the current evolution of health care delivery: *democratization*, *commoditization*, and *corporatization*. The visioning process pointed to a continuation of current familiar trends, rather than major shifts or reversals. For example, mergers of delivery organizations into large integrated systems and emphasis of interdisciplinary team-based care with nonphysician health professionals playing greater roles are anticipated. Likewise, the prescription for changes needed in GME is not novel: it focuses on strengthening a number of curricular elements, which echoes prior consensus recommendations such as the 2011 Macy Foundation GME Conference report.²

Interestingly, the high prevalence of physician burnout was not included among key trends affecting the health care system, though the literature does not seem to indicate this will be solved in the short term. In addition, education-oriented trends were not highlighted. For example, will greater alignment of education theory and practice and expanded utilization of educational technology be used to enhance the efficiency and effectiveness of GME? Perhaps these issues did not emerge because stakeholder questions were focused on health care delivery (rather than education) and because focus group output seemed to emphasize needs more than opportunity.

Predictions and Prescriptions for Sponsoring Institutions in 2025

Looking ahead, the task force anticipates SIs taking on 2 key responsibilities in the coming decade: “enhanced inter- and multidisciplinary education programming and experiences” and “increasing accountability for the value of GME.”¹ Each of these is both valuable and critical.

Multidisciplinary educational programming (across specialties and professions) has many advantages, including:

- improved teaching by leveraging the best educators across a broader pool of learners;
- greater efficiency and lower cost in developing and delivering curricula;
- enriched discussions by incorporating multiple learner perspectives; and
- socialization to support team-based care.

Having offered centrally organized educational programming across traditional silos for 2 decades, we can attest to the advantages of this approach.

System-wide programming at Partners HealthCare includes a core curriculum retreat for interns, a chief residents’ course, a clinical fellow retreat, a core curriculum in quality and safety, and trainee enrichment opportunities focused on thematic areas like global health, health policy, value-based health care, and clinical teaching. Likewise, workshops for GME program directors, administrators, and faculty across specialties and hospitals provide an effective vehicle for skills development and sharing best practices. Cultivating joint programming across SIs nationally, stimulated and perhaps coordinated by the ACGME, is an ambitious but worthwhile goal.

Increased accountability for the value of GME will also rely on—and might well benefit—SIs. Calls for greater accountability in GME have gotten broader attention within and outside the profession, especially in the context of threatened cuts in federal funding. Stakeholders are seeking to clarify what GME should be accountable for, and to whom.^{3,4} At the same time national efforts to codify the outcomes of GME and the metrics for tracking those outcomes are underway.⁵ We anticipate that these efforts will lead toward a system of GME tracking in which all SIs are responsible for collecting and sharing common metrics (and will have access to benchmarking data), thereby yielding important information for guiding national policy as well as institutional decisions.

The SI2025 Task Force recommends that ACGME shepherd the needed evolution of SIs by:

- utilizing the accreditation process, with updated institutional requirements;
- developing a performance-based recognition program for SIs;
- promoting educational programming aimed at developing skills related to systems-based practice, leadership, and innovation; and
- developing a mechanism to monitor the environment to ensure alignment of expectations for SIs.

These recommendations represent an initial scaffold on which more detailed proposals can be built. The plan represents a sound and practical approach to cultivating a partnership with SIs by utilizing—rather than reinventing—an established accreditation mechanism. The recommendations wisely avoid layering a litany of unfunded mandates on institutions that face increasing resource constraints. We applaud the approach of using a recognition program as a “carrot,” rather than accreditation as a “stick.” Finally, we look forward to new, shared resources for innovative educational programming created both by the ACGME and by individual SIs, each

contributing according to their different areas of interest and expertise.

The ACGME has been responsible for pivotal reforms in GME—most notably the articulation of core physician competencies and the requirement that programs develop curricula, learning activities, and assessment tools to ensure these competencies are achieved. This organization is also responsible for progress on controversial issues like duty hours and is now tackling the challenge of maintaining wellness in trainees. The ACGME's role in optimizing GME will be even more critical in the future and will rely on effective collaboration with sponsoring institutions, functioning together as a *system* of GME.

References

1. Duval JF, Opas LM, Nasca TJ, et al. Envisioning the sponsoring institution of the future: report of the SI2025 Task Force. *J Grad Med Educ*. 2017;9(6 suppl 1):11–57.
2. Weinstein D; Josiah Macy Jr Foundation. Ensuring an effective physician workforce for the United States: recommendations for graduate medical education to meet the needs of the public. [http://macyfoundation.org/docs/macy_pubs/JMF_GME_Conference2_Monograph\(2\).pdf](http://macyfoundation.org/docs/macy_pubs/JMF_GME_Conference2_Monograph(2).pdf). Accessed September 29, 2017.
3. Weinstein DF. The elusive goal of accountability in GME. *Acad Med*. 2015;90(9):1188–1190.
4. Baron RB. Can we achieve public accountability for graduate medical education outcomes? *Acad Med*. 2013;88(9):1199–1201.
5. The National Academies of Sciences, Engineering, and Medicine. Graduate medical education outcomes and metrics—workshop. <http://www.nationalacademies.org/hmd/Activities/Workforce/GMEoutcomesandmetrics/2017-OCT-10.aspx>. Accessed September 29, 2017.



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