The History of Sponsoring Institutions, 1982–2017

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Before exploring the projected future of Sponsoring Institutions (SIs), it is important to understand their origins and development. Graduate medical education (GME) has relied on diverse learning communities to educate residents for unsupervised practice. As 1 such learning community, the SI has contributed to the education of residents and fellows by ensuring the provision of support systems, resources, and administrative structures. Through their oversight of GME, SIs have fostered clinical learning and working environments in which residents and fellows achieve educational milestones that indicate their ability to provide high-quality, safe patient care upon completion of their programs and throughout their professional lives. What follows is a brief history of institutional accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the process by which we have come to recognize the SI as that community necessary to form physicians.

Essentials

In 1982, the newly formed ACGME published its "Essentials of Accredited Residencies in Graduate Medical Education," which included a set of "General Requirements" that established standards and responsibilities for GME programs. Part I of these General Requirements began with the declaration that "[p]rograms in graduate medical education are sponsored by institutions engaged in providing medical care and health services. The principal institutions for graduate medical education are hospitals."[2] In Section 1, "Responsibility of Institutions," the ACGME outlined standards that remain at the core of the essential relationships and processes expected of every institution that seeks to educate residents: commitment to sponsorship agreed upon by both faculty and administration; distribution of resources for educational purposes; establishment of institutional policies by which program directors exercised various responsibilities for their respective programs; periodic analyses of each program's effectiveness in meeting its goals and objectives; provision of facilities and resources to support education; and maintenance of hospital accreditation.[3] It is important to note that, at the time, these standards were not new to GME; they were based on well-established groundwork laid by the ACGME's predecessors in program accreditation, namely, the American College of Surgeons, the American Board of Internal Medicine, the American Medical Association's Council on Medical Education, and the Liaison Committee on Graduate Medical Education. Each of these organizations had previously acknowledged the hospital's role as GME sponsor and had included some variation of these expectations in their respective requirements.

To fulfill its accreditation mission, the ACGME delegated authority to specialty-specific Review Committees (RCs) that evaluated individual residency programs for compliance with both the General Requirements and specialty-specific program requirements. Although the ACGME's General Requirements acknowledged SIs and the role they played in GME, attention to how these institutions fulfilled their responsibilities was initially provided in the context of individual residency program review conducted by RCs. While these specialty-specific RCs made accreditation decisions independently of each other, each Committee's activity was reviewed periodically by the ACGME through its Monitoring Committee. As a result, in these earliest years of ACGME's development as an accrediting body, there was no process by which the institutions were reviewed separately from specialty programs, nor was there consideration of how a single institution demonstrated compliance with its responsibilities as specified in the General Requirements for all the programs it sponsored.

General Requirements

Gradually, the ACGME and its RCs began to observe that noncompliance with program requirements often had, at least, some correspondence to areas of institutional responsibility identified in the General Requirements. In 1992, as a result of this increasing awareness, the ACGME approved a separate section of the General Requirements identified specifically as Institutional Requirements, along with a process for institutional review that was initially administered

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[2] Green Book. "Essentials of Accredited Residencies." Chicago, IL: American Medical Association; 1982–1983:9.

[3] Green Book. "General Requirements." Chicago, IL: American Medical Association; 1982–1983:9–10.

through the ACGME's Monitoring Committee. These Institutional Requirements elaborated on the standards that had been outlined in the original General Requirements. This initial institutional review process included a separate institutional site visit. On the basis of the site visit report and information provided in an Institutional Review Document, an institutional review administrator determined whether the SI had adequately documented and implemented policies in compliance with the General Requirements. The administrator then prepared a list of the institutions judged to be in compliance with the General Requirements. The Monitoring Committee reviewed documentation only from a representative sample of these institutions. Only 2 decision options were available. Institutions that received a *favorable* decision were given 5 years until their next review; institutions receiving an *unfavorable* decision were assigned a time frame for their next review, not to exceed 3 years. Three consecutive *unfavorable* decisions for an institution resulted in a loss of its ability to sponsor residency and fellowship programs.

During this period, the growth of medicine was characterized in part by new specialties and subspecialties approved for certification by various specialty boards and for accreditation by the ACGME. The result was an increased workload for the RCs, due to the number of applications by academic medical centers and community teaching hospitals for new specialty and subspecialty programs. While members of RCs were expert evaluators of programs in their specialty, lengthier review agendas, coupled with the added need to understand complex issues from an institutional perspective, underscored the growing need for a separate RC to review institutions. It also became clear to the ACGME that a cadre of individuals familiar with GME from an institutional perspective, and with knowledge of the General Requirements, should provide an expert review for institutional compliance.

In response to these internal and external factors in the health care delivery environment, in GME itself, and within its own internal structure, the ACGME officially constituted the Institutional Review Committee (IRC) in 1995. The IRC was structured in the same manner as the specialty-specific RCs, except with regard to appointment of its members. In contrast to the RCs, the IRC had no formal specialty board or academic medical society of individuals with leadership responsibility for GME at the institutional level from which to draw its membership. As a result, the appointing organization for the IRC became the ACGME itself, with the original members drawn from GME leadership across the country.

The only options available to the newly formed IRC with regard to the review of SIs remained the previously used statuses of *favorable* and *unfavorable*. The outcomes of these reviews were not, strictly speaking, accreditation decisions, although common usage in the field often referred to them as such. Loss of the ability to sponsor accredited programs remained as the action after 3 *unfavorable* decisions were given to an institution. Although such a decision was never made by the IRC, it nonetheless highlighted the growing importance of institutional review. While the seeds of accreditation were sown, the time for official institutional accreditation would wait for nearly a decade.

As health care delivery and funding became more complex through the 1990s, the Institutional Requirements became more detailed. Experience with the institutional review led the ACGME and the IRC to identify with greater specificity the various elements and relationships necessary for maintaining an effective SI in this environment. Managing GME relationships across the institution was an effort that assumed progressively more responsibility and importance. For example, in 1993, the standard calling for each SI to have a Graduate Medical Education Committee (GMEC) was added to the Institutional Requirements; in 1997, the appointment at each SI of a Designated Institutional Official (DIO) as chief administrator for GME was approved. The DIO and GMEC were charged with oversight of the SI's GME efforts. The DIO became the "designated" leader with whom the ACGME could communicate information that affected all programs in the SI, starting with the basic responsibility of receiving the ACGME's annual invoice for accreditation services. Eventually, the DIO became the individual in the SI who was recognized as having the authority to act on behalf of the entire ACGME-accredited enterprise. The DIO had responsibility for accreditation matters, and also assumed many locally defined duties commonly associated with management and supervisory oversight in a complex organization. The Institutional Requirements began to codify the relationships needed at the institutional level for support of the educational environment, and the formal structures that comprised the GME local learning community took shape.

Accreditation

In the mid- to late 1990s, the ACGME underwent its first intensive strategic planning process. A central component of the resulting plan, which eventually became known as the Outcome Project, was initiated in 1999 with a grant from the Robert Wood Johnson Foundation. The central focus of this effort was the identification of 6 general competencies as organizing principles for specialty and subspecialty curricula.

ACGME-accredited programs were expected to identify educational outcomes for residents and to evaluate their achievement based on the general competencies that were eventually codified into all specialty and subspecialty program requirements. During this period, the educational leadership role of the SI's DIO and GMEC became even more apparent to the ACGME, the IRC, and SIs themselves. The need for central oversight of program curricula and resident evaluation processes emerged as a critical institutional responsibility for maintaining overall educational effectiveness within each program and across the institution.

After 10 years' experience observing the maturation of the institutional review process and monitoring the work of the IRC, the ACGME Board of Directors delegated full accreditation authority to the IRC in 2005. The IRC acted with this authority to accredit all SIs having 2 or more accredited programs. With this change, the IRC maintained the same structure as all RCs, with the exception of its member selection process, which remained open to nominations of individuals from the entire GME community.

In 2007, the IRC completed a major revision of the Institutional Requirements in an effort to remove extraneous language and to reflect the increasing recognition of the SI's central role in overseeing GME. As further indication of the growing importance of institutional review, this revision did not occur in a vacuum. DIOs and GMECs had begun to report that areas of programs' noncompliance cited by RCs occasionally overlapped with citations at the institutional level given by the IRC. One reason for such overlap (and sometimes even dissonance or contradiction) occurred because the Institutional and Common Program Requirements had developed independently. Therefore, an ad hoc committee that included representatives from the specialty RCs and the IRC was created to reconcile these 2 sets of requirements. The result was that a major revision of the ACGME Common Program Requirements also occurred in 2007 and included a thorough reconciliation with the Institutional Requirements. This reconciliation initiative revealed how institutional accreditation gradually had come of age within the ACGME accreditation structure and at the grassroots level. Specialty-specific RCs accepted the IRC's expertise in institutional matters and were no longer compelled to cite expectations outlined in the Institutional Requirements.

Consistent with the recognition of the importance of institutional review, the IRC chair eventually became a full voting member of the ACGME Council of Review Committee Chairs, thus assuring an opportunity for ongoing dialogue between the specialty RCs and the IRC. The relationship of program and institutional accreditation was forged; it mirrored the expectation of collaboration among specialty and subspecialty programs at the level of the SI, facilitated by the DIO and GMEC.

Today, institutional accreditation is an integral component of the ACGME's ongoing strategic initiatives. With approval of its Next Accreditation System in 2011, the ACGME Board of Directors codified the responsibility of SIs for educational outcomes: "The ACGME accredits GME programs and SIs based on the demonstration of continuous oversight of processes and outcomes of education, and substantial compliance with accreditation standards, through the review of annually acquired information."[4] Effective institutional oversight of a single program or 100 programs is the expectation for institutional outcomes under scrutiny by the IRC as it monitors institutions on an annual basis. Recognizing this central role of the SI in monitoring outcomes, the IRC completed an extensive revision of the Institutional Requirements in 2013. This time, the revision focused on a major reordering and simplification of the language so that additional focus would be placed on demonstrable outcomes at the institutional level, even as the processes evident in the original standards remained.

Yet another development in institutional accreditation occurred in 2014 when the ACGME, the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) announced their agreement to form a single GME accreditation system in the United States. This decision allows graduates of allopathic and osteopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and to demonstrate achievement of common milestones and competencies. The move toward a single accreditation system means that many AOA-approved institutions and other entities that oversee AOA-approved programs have applied or will apply for ACGME accreditation as SIs. This landmark agreement has resulted in an expanded assortment of governing structures for SIs in which residents and fellows are educated. In addition to commonly encountered institutional models overseen by academic medical centers, community teaching hospitals, medical schools, and single-program institutions, newly ACGME-accredited SIs include osteopathic postdoctoral training institutions (OPTIs), which

[4] ACGME Policies and Procedures. Section 17.10. Effective June 10, 2017.

are educational entities that provide academic oversight and ensure GME resources for hospitals, colleges of osteopathic medicine, clinics, and teaching health sites, sometimes over large geographic areas.

Beyond

In 2012, the ACGME Board of Directors approved the ACGME's Clinical Learning Environment Review (CLER) program, which "provides the profession and the public a broad view of SIs' initiatives to enhance the safety of the learning environment and to determine how residents are engaged in patient safety and quality improvement activities."[5] Although not an accreditation activity, the CLER program emphasizes the institutional relationships necessary to improve health care and population health.

Sponsoring Institutions now define themselves in various ways, often departing from the model of the singular hospital originally identified in the earliest standards for accreditation. What has remained consistent throughout the development of the institution's role in GME, however, is that it is the organizing force that affects GME at all levels, and that creates space for relationships that ensure the quality of resident education.

Sponsoring Institutions are currently in a state of accelerated evolution in response to major changes underway in the health care system and beyond. The next stage in the maturation of SIs will necessarily benefit from reflecting on where these changes will lead. It will require the collaboration of the entire GME community to understand how SIs can meet the needs of patients by creating physicians who are prepared to practice in 2025. As in the past, it is through these relationships that future SIs will realize our future vision for GME.

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[5] ACGME Policies and Procedures. Section 16.10. Effective June 10, 2017.