

**Barriers and Solutions to the Single  
Accreditation System: A Survey Study  
of AOA Family Medicine Residency  
Program Directors**

## Authors

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## Introduction

In 2014, the American Osteopathic Association (AOA) and the Accreditation Council for Graduate Medical Education (ACGME) announced that they would be transitioning from two separate graduate medical education (GME) accreditation systems to a unified Single Accreditation System (SAS).<sup>1</sup> Under this system, all U.S. residencies and fellowships that were previously accredited by the AOA alone must enter into the ACGME accreditation process as a new program and receive accreditation by June 30, 2020.

This survey was designed to assess the attitudes, confidence, and progress of family medicine residencies accredited by the AOA alone (hereafter referred to as “AOA-only” programs) during this transition. In total, there are 263 AOA-accredited family medicine residencies.<sup>2</sup> Ninety-eight (37.3%) of them were already “dually accredited” (i.e., accredited by both the ACGME and AOA) prior to the SAS transition and will therefore retain their ACGME accreditation. At the time the SAS was announced, 165 (62.7%) of the AOA-accredited family medicine residencies accredited by the AOA alone and needed to transition to ACGME accreditation. These 165 residencies account for 623 residency slots per year.

Because AOA family medicine residency programs are more likely to be located in community-based and rural settings than ACGME-only programs, there is concern about the effects of the SAS on the primary care workforce in those areas.<sup>3</sup> Physicians tend to practice within 60 miles of where they were trained, and efforts to alleviate workforce shortages in rural America have highlighted the importance of maintaining and expanding rural GME opportunities. The Council on Graduate Medical Education (COGME) has called for a more decentralized approach to GME to provide more workforce development in ambulatory and community-based settings.<sup>4</sup> As 15.6% (n=41) of AOA-only family medicine residencies are located in rural areas (as defined by a Rural-Urban Continuum Code [RUCC] of  $\geq 4$ ), compared with 6.9% (n=28) of ACGME-only programs, losing the AOA-only programs would work in opposition to COGME’s recommendation.<sup>2,3</sup>

For the purposes of this study, we defined four possible stages for an AOA-only residency during the transition from AOA to ACGME accreditation.

1. “Planning to apply” – These programs stated in the study that they intend to apply for ACGME accreditation and are actively engaged in preparing, but have not yet submitted the application for pre-accreditation.
2. “Pre-accreditation” – This group includes programs that have submitted pre-accreditation paperwork (i.e., “pre-accreditation”), as well as programs that have been reviewed by the ACGME Review Committee (RC) and are still working toward accreditation (i.e., “continued pre-accreditation”).
3. “Accredited” – These programs have received accreditation from the ACGME. For the purposes of this paper, “accredited” programs include those that have received initial or continued ACGME accreditation during the SAS transition. This group does not include the dually accredited programs that were already accredited prior to the SAS transition.

4. “Not applying” – These programs stated that they do not plan to pursue ACGME accreditation; presumably, they will close.

The survey was developed to assess any perceived or actual barriers hindering programs that are progressing through the accreditation process and to identify possible areas of policy intervention to facilitate this transition.

## **Methods**

### **Study participants and data collection**

Using an email list of the American College of Osteopathic Family Physicians (ACOFP), we sent a link to an electronic survey to the program directors of the 165 AOA-only family medicine residencies. Reminder emails were sent two weeks after the initial email and in each of the two weeks before the survey was closed. No fellowships were included in this study. Data were collected from July 3, 2017, to August 4, 2017.

### **Survey instrument**

Respondents were first asked about their stage of ACGME accreditation. For programs in pre-accreditation and those planning to apply, a 4-point Likert scale was used to assess their confidence that they will receive accreditation. We used 4-point Likert scales to assess the extent to which specific regulations or issues were barriers to receiving ACGME accreditation, as well as to identify which administrative or policy interventions would be most helpful in achieving ACGME accreditation. Surveyed barriers and policy interventions are listed in Appendices A and B.

Programs were then given open-ended comment space to discuss the following: 1) any additional barriers to accreditation that were not listed in the Likert scales; 2) how they have tried/were able to overcome any of these barriers; and 3) suggestions for how professional organizations could better support osteopathic family medicine through this transition.

### **Data management and analysis**

Respondents who answered  $\leq 1$  question were excluded from analysis. Quantitative responses were analyzed as aggregate data and by program size. Due to the small number of respondents, we were unable to calculate statistical significance.

We used descriptive content analysis to describe themes in the free text responses. Two authors analyzed responses for primary themes independently, then compared results to develop five content categories. All analysis was performed after the data collection period had concluded. Through discussion with coinvestigators, the authors further refined the categories.

### **Ethical review**

This study was reviewed and approved by the American Academy of Family Physicians (AAFP) Internal Review Board. Informed consent was obtained on the first page of the survey. No incentives for survey participation were given.

## Results

### Key quantitative findings

The survey was sent to the program directors of the 165 AOA-only family medicine residencies, but not to dually accredited residencies. There were 81 total responses. Of those who initiated the survey, nine were excluded for answering  $\leq 1$  question. This resulted in 72 analyzed responses and a total response rate of 43.6%. Table 1 summarizes our response data.

Table 1: Survey Response Rate for AOA-only Family Medicine Residency Program Directors

	Responses
Surveys sent	165
Surveys initiated	81
Excluded	9
Total respondents	72
Response rate	43.6%

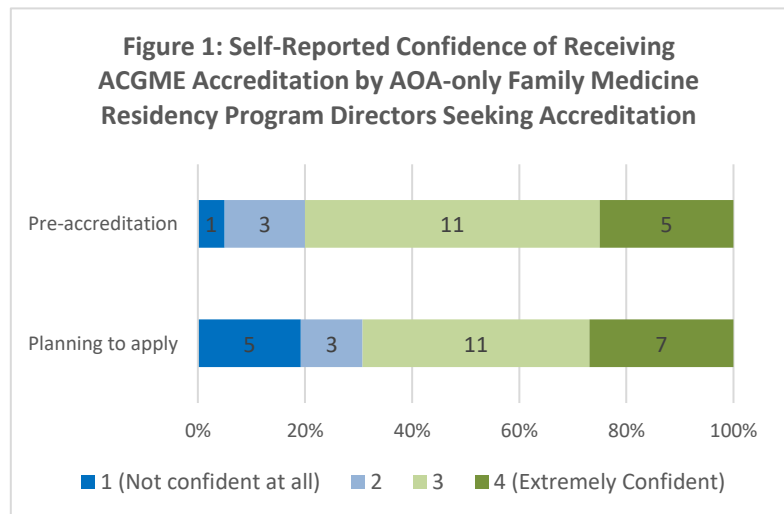
Table 2 summarizes the response rates by accreditation status. Twenty (27.4%) respondents had already received ACGME accreditation. Twenty (27.4%) were in pre-accreditation, 26 (35.6%) had not yet applied but were planning to do so, and six (8.2%) were not planning to apply for ACGME accreditation.

Table 2: Survey Response Rates by ACGME Accreditation Status for AOA-only Family Medicine Residency Program Directors

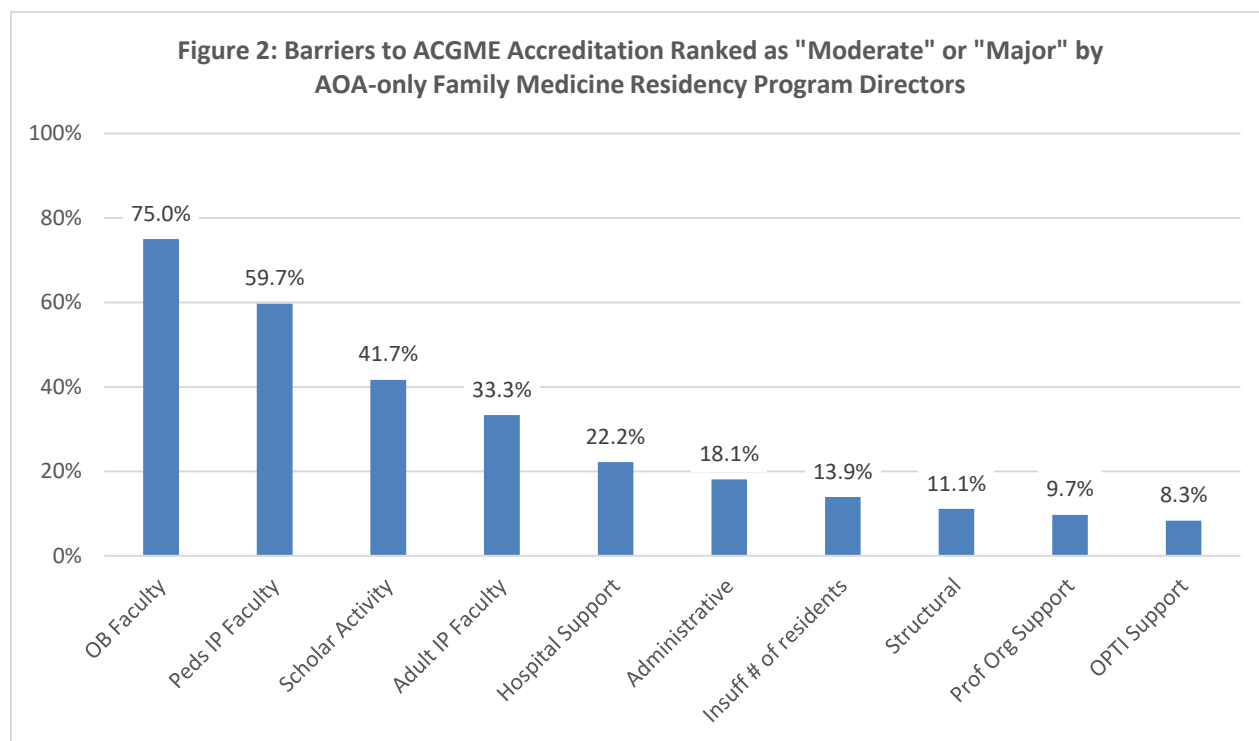
	Accredited	Pre-accreditation	Planning to Apply	Not Applying
Respondents	20	20	26	6
Percent of total	27.4%	27.4%	35.6%	8.2%

The respondents in pre-accreditation and those planning to apply were asked to use a 1-4 scale to rank their confidence that they will receive accreditation; 1 was labeled “Not confident at all” and 4 was labeled “Extremely confident.” The results are shown in Figure 1. Of those who had not yet applied, 69.2% ranked themselves a 3 or 4 in confidence, while 80.0% of those in pre-accreditation ranked themselves a 3 or 4 in confidence (Figure 1).

Averaging all responses, the top barriers to ACGME accreditation (in order from highest to lowest ranked) were obstetric (OB) faculty requirements, pediatric inpatient faculty requirements, scholarly activity



requirements, adult inpatient faculty requirements, and lack of support from medical institutions (Figure 2). Other ranked barriers (in order from highest to lowest ranked) were administrative requirements (e.g., requiring a program coordinator dedicated only to the family medicine residency), insufficient funding to increase the number of residents in the program, structural requirements (e.g., requiring an independent family medicine training center or physical medical library), lack of support from professional organizations, and lack of support from their Osteopathic Postdoctoral Training Institution (OPTI).

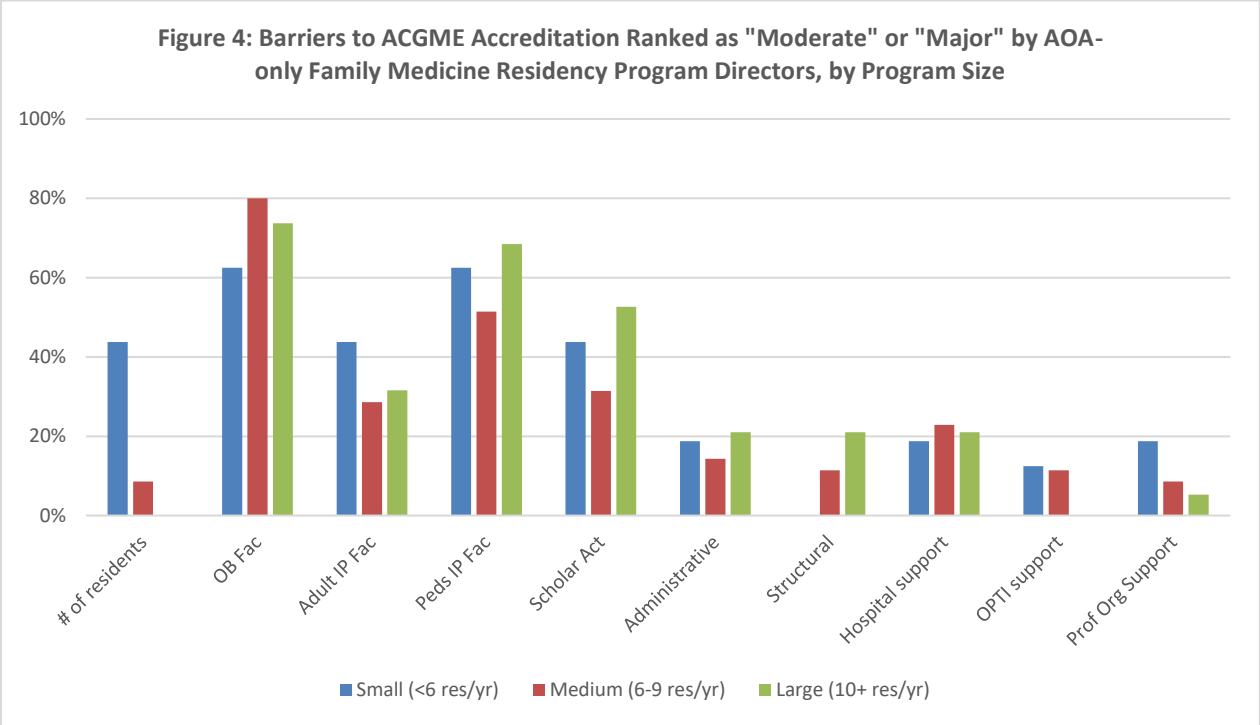
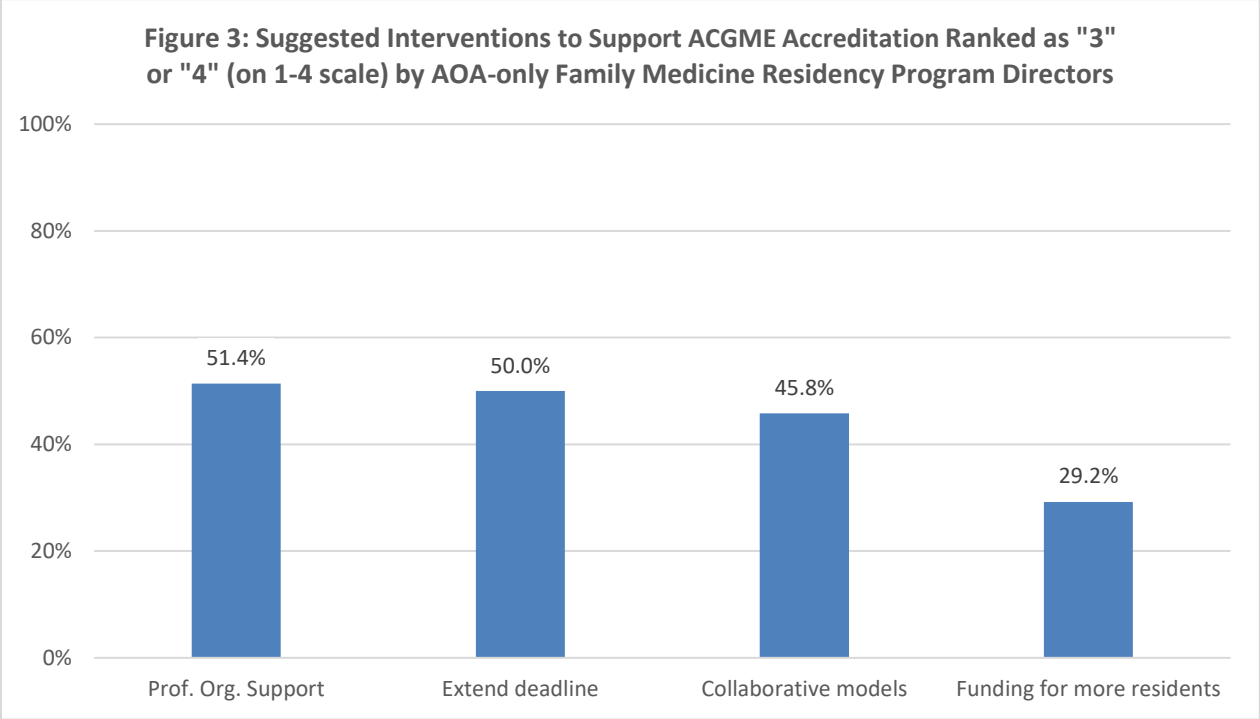


IP = inpatient; OB = obstetric; OPTI = Osteopathic Postdoctoral Training Institution.

The trend was similar when analysis was restricted to only those programs that were actively seeking accreditation (i.e., those in pre-accreditation or planning to apply). When those groups were isolated, 36 (78.3%) ranked OB faculty requirements as a major or moderate barrier. The same groups ranked requirements for pediatric inpatient faculty (69.6%) and scholarly activity (54.3%) among their greatest barriers to accreditation.

Although programs that were not applying for ACGME accreditation still ranked requirements for OB faculty and pediatric inpatient faculty higher as barriers, they ranked insufficient funding for residents and lack of support from medical institutions higher as barriers than any other group.

Figure 3 summarizes the interventions that were ranked as a 3 or 4 in terms of helpfulness. The top-rated interventions were “Increased support from your professional organizations and OPTI” and “Extending the deadline for accreditation past 2020,” followed by “Collaborative arrangements” and “Funding to increase the number of residents.”



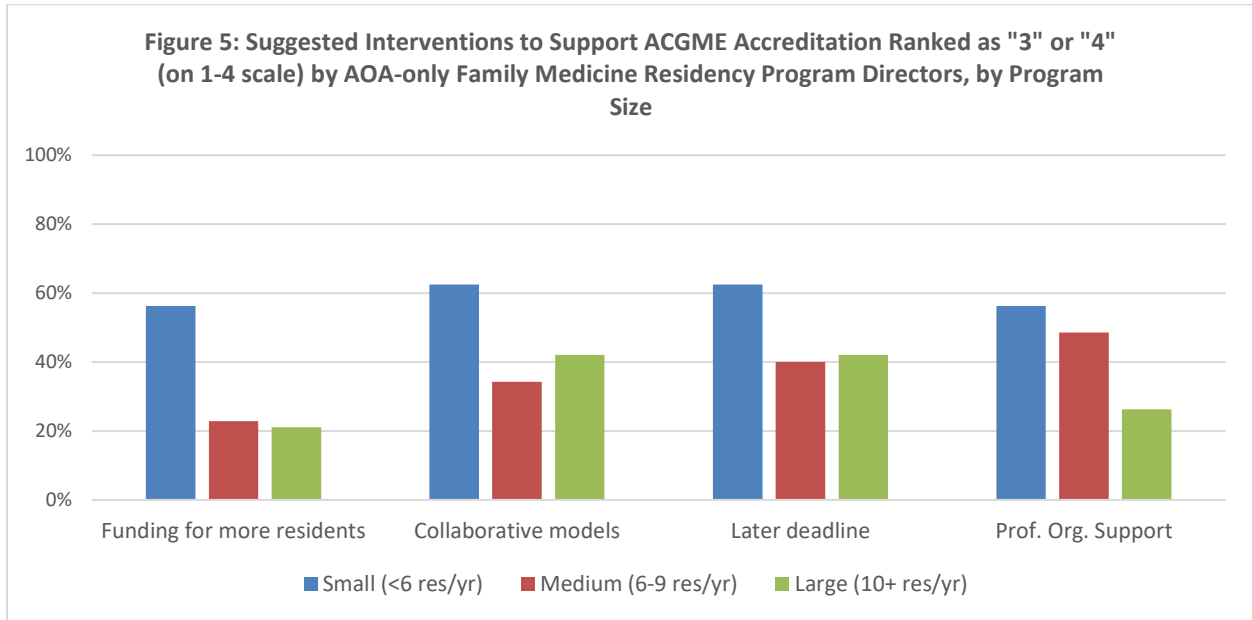
IP = inpatient; OB = obstetric; OPTI = Osteopathic Postdoctoral Training Institution.

We analyzed responses about barriers to ACGME accreditation by program size to assess trends (Figure 4). Programs with five residents per year or fewer prior to the SAS transition were considered small programs (n=16). Medium programs had six to nine residents per year (n=35), and large programs had



10 or more residents per year (n=19). Two respondents did not indicate how many residents were in their programs. No clear trends emerged.

We analyzed responses about helpful interventions from the same groups (Figure 5). Small programs saw all proposed interventions as more helpful than medium or large programs did, but no other clear trends emerged.



Although the survey asked each program to indicate its county and state, 11 (15.2%) respondents did not answer these questions. Therefore, we did not analyze region or rurality.

More detailed response data are included in Appendices C-J.

**Key qualitative findings**

The following themes were pulled from analysis of the qualitative responses:

1. Positive reforms – “We are excited for the future.”

Respondents acknowledged the positive aspects of the SAS transition. One enthusiastic respondent stated, “This has been a lot of preparation and building some infrastructure to our program, but in the end I believe it has forced our program to critically look at and improve some of the areas of weakness. We will now have the manpower in terms of core faculty to take the program to the next level.”

Programs have overcome and are overcoming barriers to accreditation through the following general approaches:

- Collaborating with other programs – Many of the successfully accredited programs cited collaborative models as a key to their success. These programs typically had the support

of an engaged larger organization, such as a hospital system or state/regional education consortium, that took an active role in orchestrating a successful transition.

- Embracing curricular innovation – Programs cited new curricular changes to expand pediatric inpatient services, improve continuity during hospital admissions, and expand scholarly activity curricula for their faculty and residents.
- Seeking consultants – Several respondents had reached out to accreditation consultants. In general, programs found greater success with consultants who traditionally worked with ACGME family medicine residencies.
- Building and developing new physical and personnel infrastructure – Directors noted growth of their programs through creation of new family medicine centers for centralized resident training. In addition, there were almost universal attempts to hire new administrative workers and faculty, although these attempts were often unsuccessful.

Respondents expressed significant interest in forming informational cooperatives in which transitioning AOA residencies could share knowledge and experience. Successfully accredited programs offered to help those still going through the process.

2. Challenges with obstetric and pediatric requirements – “Family medicine faculty members delivering OB and the continuity OB care that [the] ACGME requires [are] antiquated and impossible for most of the small programs to achieve.”

The majority of programs expressed frustration with the ACGME requirements around obstetric and pediatric inpatient training.

- The comments noted pervasive struggles with family medicine faculty recruitment, particularly for obstetric faculty and pediatric inpatient faculty.
- Several programs commented that they have partnered with obstetric and pediatric departments to provide residents with the required number and types of patient training experiences, but they have been unable to recruit family medicine faculty for this purpose.
- Programs expressed concern that these requirements were inconsistent with the modern practice of family medicine and did not account for regional and cultural variations in full-scope practice.

3. Lack of organizational support – “I felt like I was writing an application in a language that was not my mother tongue using a dictionary that was for a third language.”

The majority of respondents expressed frustration with professional organizations for a perceived lack of support. This is consistent with the quantitative analysis, which showed that “Increased support from your professional organizations and OPTI” was the most requested policy intervention.

Respondents' requests reflected two main themes:

- Need for more guidance and direct intervention for programs navigating the ACGME accreditation process
    - Respondents sought more guidance from professional organizations on how to navigate this process.
    - Consultants from allopathic or private GME consulting groups were highly praised for their contributions, while consultants from osteopathic organizations seemed less helpful.
  - Need for increased advocacy for regulatory reform and more collaborative and equitable merging of the two accreditation systems
    - Respondents often did not feel that their professional institutions had advocated for them enough during this transition, citing the lack of regulatory accommodation or compromise in ACGME regulations. As one frustrated respondent stated, “This isn't a merger. It is a takeover.”
    - Respondents specifically asked for advocacy to address obstetric and pediatric requirements.
    - The perceived lack of support contributed to a general sense of resignation among respondents. Many felt that they were working diligently to navigate this transition successfully, but could not do so without increased advocacy efforts. When asked what she was doing to overcome barriers, one respondent lamented, “Praying. I've spent over 600 hours in curriculum research and development. Who knows if they will accept our creative continuity OB plan, but it is the best we can do.”
4. Administrative and financial burden – “Essentially you have to build an ACGME program while still working in an AOA program—building a jet while flying a Cessna full of Cessna employees.”

Respondents overwhelmingly commented on the intense regulatory and financial burden of this transition.

- Increased burden without increased quality
  - Very few programs perceived a benefit in quality with the increased regulation of ACGME accreditation. One program that had already received ACGME accreditation stated, “We were successful, but it does not promote quality. Overwhelmingly unrealistic demands for a small program.”
  - Another respondent lamented that the “regulations were in places arbitrary and without an evidentiary basis. The requirements that did not align with previous AOA requirements were typically added burden without significant foreseeable value.”
  - The majority of programs that are closing cited the increased financial burden as their reason for not applying for ACGME accreditation. One mentioned their “hospital administration decided to close family medicine and pursue a

psychiatry residency [due to] the expense of sending residents to another inpatient facility for OB, inpatient peds, and peds ER.”

- Maintenance of dual accreditation
  - Several programs that had received ACGME accreditation cited the struggle and duplication of effort of maintaining dual accreditation with the ACGME and their prior AOA accreditation.

#### 5. Osteopathic identity and rural medicine – “Our tradition of teaching differs from theirs.”

Although there were no survey questions directly addressing ACGME Osteopathic Recognition (recognition denoting that a program has training in Osteopathic Principles and Practice), respondents often linked osteopathic identity and culture with the need to teach in underserved, rural areas.<sup>5</sup> There was concern about the loss of training elements intrinsic to osteopathic culture and the implications of that loss for rural and community health infrastructure and workforce.

- Loss of osteopathic culture and tradition
  - There was a consistent concern for loss of osteopathic identity through the SAS. Programs expressed that they felt they had been producing quality family physicians for years, but the current SAS “views osteopathic programs as a joke, unworthy of attention.”
  - Osteopathic programs have traditionally relied more on community preceptors than the allopathic teaching model, and community teaching is a priority within osteopathic culture. One respondent lamented that “true, traditional osteopathic training is going away in this system.”
  - The requirement that existing AOA-only programs in good standing must enter the SAS as “new” programs was seen as unrealistic and insulting.
  - A few respondents also noted that the Osteopathic Recognition process, while appreciated, added to administrative burden.
- Concern for small, rural, and community-based programs
  - Respondents often felt that the ACGME requirements were inconsistent with the needs and resources of smaller or more geographically isolated programs. Several commented that their hospitals had intentionally chosen to develop AOA residencies instead of ACGME programs, recognizing that the osteopathic regulatory profile better fit the needs and capabilities of their health care infrastructure.
  - This concern also contributed to a sense of being unheard and dismissed by the ACGME and professional organizations. One accredited respondent stated, “It is clear that ACGME only desires large institutional programs and sees community family programs as unnecessary. Despite the fact that 20% of the population lives in rural America and only 9% of physicians reside in [these] communities.

These smaller programs have been trying to fill that void but the financial barrier and antiquated policies are making it impossible.”

## **Limitations**

Although the survey was sent to all AOA-only family medicine residencies, there are only 165 such residencies and there were an even smaller number of respondents. These small numbers make calculations for statistical significance impossible.

Because we were unable to link responses to identifiable program data, we were limited in our analysis of how program characteristics such as state, rurality, or time since opening affected responses.

There is the possibility of bias in the qualitative analysis, although we took steps to minimize bias by having multiple coinvestigators review qualitative data.

When discussing barriers to accreditation, it is difficult to separate perceived barriers from actual barriers. For example, a program that lists OB faculty requirements as a barrier may have been reviewed by the RC and received a citation for their obstetric curriculum. Alternatively, the program could be expressing concern that it may not be able to recruit obstetric faculty or develop its OB patient population sufficiently. Both actual and perceived barriers are important, but they could require different policy interventions to provide assistance.

## Recommendations

1. AOA-only family medicine residency programs in good standing should be allowed to enter the Single Accreditation System as accredited programs.

This would allow more of a good faith start to the SAS by recognizing the work and standing of existing AOA-only programs. Like any other ACGME program, these programs would still have to meet requirements to maintain accreditation, but they would do so as if they were established ACGME programs.

2. The ACGME Family Medicine RC should adopt an accreditation system that allows for a more ambulatory- and community-based approach to family medicine training, congruent with COGME recommendations.<sup>4</sup>

The family medicine workforce in the United States has progressively shifted to an ambulatory-dominated model. For example, only 7% of U.S. family physicians currently practice obstetrics, continuing a downward trend from 12% in 2012 and 17% in 2003.<sup>6,7,8</sup>

An accreditation system that allows for a more ambulatory, community-based approach to family medicine training could be accomplished through a multitude of formats. A tiered approach to ACGME family medicine maternity training was introduced in 2014, but it retained the requirement of having family medicine OB faculty. Recommendations for a more liberal tiered system have been discussed before<sup>9</sup>, and other countries have successfully addressed their varying national workforce needs by allowing different tracks in their family medicine training. Australia, for example, allows primary care physicians to choose between a general ambulatory track focused on the skills needed to be a predominantly outpatient physician and a rural track that emphasizes full-scope training.<sup>10</sup>

While collaborations between existing residencies appear to be assisting many programs, many existing ACGME programs already struggle to maintain their OB and pediatric inpatient faculty, and there are likely limits on the extent to which these models can overcome this barrier. Given that survey respondents indicated that the OB and pediatric inpatient faculty requirements were the primary barriers to accreditation, changes to the ACGME's faculty requirements in these areas will likely make it easier for a large number of AOA-only residencies to achieve accreditation.

3. Enhanced professional resources should be made available to AOA-only programs in which local organizational infrastructure is absent or less engaged.

Many programs that have received or are close to receiving accreditation cite larger organizational support as a key factor in their success. Larger professional organizations must

step in to support residencies in which local organizational infrastructure is absent or less engaged and coordinate accreditation efforts.

While osteopathic organizations have already developed resources to support the SAS transition, respondents indicated that more direct leadership is helpful. Key ideas from respondents include the following:

- A database of AOA programs that have successfully received ACGME accreditation and are willing to mentor other programs through the process should be developed.
- The AOA should incentivize family medicine graduates who have needed full-scope skills (e.g., OB, pediatric inpatient) to seek faculty positions in osteopathic residencies.

Osteopathic and allopathic family medicine professional organizations need to share resources and unite in their support of these programs. The websites of allopathic organizations such as the Society of Teachers of Family Medicine (STFM) and the Association of Family Medicine Residency Directors (AFMRD) offer extensive resources to assist with new program development and accreditation. Given the relatively short timeline for accreditation, these resources could be endorsed by osteopathic institutions and marketed to osteopathic programs, rather than diverting time and resources to redevelop and rebrand the same information for an osteopathic audience.

4. AOA programs that have received ACGME accreditation could choose to forgo their AOA accreditation.

Although this would eliminate a program's ability to participate in the AOA Match, it would prevent duplication of administrative effort, and free time and resources to be devoted to maintaining ACGME accreditation. In addition, programs could then focus more on maintaining or applying for Osteopathic Recognition status with the ACGME and strengthen osteopathic culture within the new SAS paradigm.<sup>5</sup>



## Conclusions

Overall, program directors of family medicine residencies accredited through the AOA alone are engaged in the Single Accreditation System transition and are confident that they will be successful in receiving ACGME accreditation. The greatest barriers to ACGME accreditation are requirements for obstetric faculty, pediatric inpatient faculty, and scholarly activity. This is unsurprising because osteopathic training models have traditionally emphasized ambulatory, community-based education over full-scope training.

AOA program directors feel they need more support from their professional institutions and do not feel they have adequate resources to effectively navigate this transition. There is concern that the current ACGME regulations do not reflect the modern U.S. primary care workforce's needs and are prohibitive for rural and community-based programs.

Interventions that would enhance the success of this transition and provide more overall support for decentralized primary care GME include the following:

1. Allowing AOA programs to enter the SAS as accredited programs, and then adhere to the maintenance of accreditation requirements as any other ACGME program would
2. Adopting an accreditation model that permits family medicine residents to receive OB and pediatric training from OB-GYN and pediatric faculty, rather than requiring all programs to have family medicine faculty in one or both of these fields
3. Providing enhanced resources and advocacy from professional organizations to assist with navigating this transition and ensure osteopathic culture is preserved
4. AOA residencies that have received ACGME accreditation could consider releasing their AOA accreditation to minimize duplication of administrative effort.

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## Appendices

### Appendix A: Barriers listed in survey Likert scales included:

- Insufficient funding to accept the minimum required four residents per year
- Obstetric faculty requirement
- Adult inpatient requirement
- Pediatric inpatient requirement
- Insufficient scholarly activity
- Administrative staff requirements (i.e., the need for a discrete residency coordinator, etc.)
- Structural requirements (i.e., lack of a physical medical library, continuity clinic or office space requirements, etc.)
- Lack of support from your medical institution
- Lack of support from your Osteopathic Postdoctoral Training Institution (OPTI)
- Lack of support from professional organizations

### Appendix B: Policy interventions listed in survey Likert scales included:

- Funding to increase the number of residents per year
- Developing collaborative arrangements with other residency programs (i.e., consortia, rural training tracks, etc.)
- Extending the deadline for accreditation passed 2020
- Additional support (tool kits, coordination, consultative services, etc.) from professional organizations or OPTI

### Programs that do not plan to apply

**Appendix C:** Responses for AOA-only family medicine residencies that do not plan to apply for ACGME accreditation to the question “Please indicate to what extent each of the following was a barrier to ACGME accreditation.” (n=6)

<i>Barrier</i>	<b>Not a barrier [% , (n)]</b>	<b>Minor barrier [% , (n)]</b>	<b>Moderate barrier [% , (n)]</b>	<b>Major barrier [% , (n)]</b>
<i>Insufficient funding to have 4 residents per year</i>	50.0% (3)	0.0% (0)	16.7% (1)	33.3% (2)
<i>OB faculty requirements</i>	16.7% (1)	0.0% (0)	0.0% (0)	83.3% (5)
<i>Adult inpt faculty requirements</i>	66.7% (4)	0.0% (0)	33.3% (2)	0.0% (0)
<i>Peds inpt faculty requirements</i>	0.0% (0)	16.7% (1)	33.3% (2)	50.0% (3)
<i>Insufficient scholarly activity</i>	83.3% (5)	16.7% (1)	0.0% (0)	0.0% (0)

<i>Administrative staff requirements (i.e., the need for a discrete Residency Coordinator, etc.)</i>	16.7% (1)	66.7% (4)	16.7% (1)	0.0% (0)
<i>Structural requirements (i.e., lack of a physical medical library, continuity clinic or office space requirements, etc.)</i>	83.3% (5)	0.0% (0)	16.7% (1)	0.0% (0)
<i>Lack of support from your medical institution</i>	16.7% (1)	16.7% (1)	16.7% (1)	50.0% (3)
<i>Lack of support from your Osteopathic Postdoctoral Training Institution (OPTI)</i>	83.3% (5)	16.7% (1)	0.0% (0)	0.0% (0)
<i>Lack of support from professional organizations</i>	66.7% (4)	16.7% (1)	0.0% (0)	0.0% (0)

**Appendix D:** Responses for AOA-only family medicine residencies that do not plan to apply for ACGME accreditation to the question “To what extent would the following resources or interventions help your program achieve ACGME accreditation?” (n=5)

<i>Intervention</i>	Not helpful				Extremely helpful
	1	2	3	4	
<i>Funding to increase the number of residents per year</i>	40.0% (2)	20.0% (1)	20.0% (1)	20.0% (1)	
<i>Developing collaborative arrangements with other residency programs (i.e., consortia, rural training tracks, etc.)</i>	20.0% (1)	0.0% (0)	80.0% (4)	0.0% (0)	
<i>Extending the deadline for accreditation pas 2020</i>	80.0% (4)	0.0% (0)	20.0% (1)	0.0% (0)	
<i>Additional support (tool kits, coordination, consultative services, etc.) from your professional organizations or OPTI</i>	60.0% (3)	40.0% (2)	0.0% (0)	0.0% (0)	

**Programs that are planning to apply**

**Appendix E:** Responses for AOA-only family medicine residencies that are planning to apply for ACGME accreditation to the question “Please indicate to what extent each of the following was a barrier to ACGME accreditation.” (n=26)

<i>Barrier</i>	Not a barrier [%, (n)]	Minor barrier [%, (n)]	Moderate barrier [%, (n)]	Major barrier [%, (n)]
<i>Insufficient funding to have 4 residents per year</i>	73.1% (19)	11.5% (3)	3.8% (1)	11.5% (3)
<i>OB faculty requirements</i>	11.5% (3)	7.7% (2)	19.2% (5)	61.1% (16)

<i>Adult inpt faculty requirements</i>	50.0% (13)	19.2% (5)	19.2% (5)	11.5% (3)
<i>Peds inpt faculty requirements</i>	19.2% (5)	11.5% (3)	23.1% (6)	46.2% (12)
<i>Insufficient scholarly activity</i>	23.1% (6)	23.1% (6)	34.6% (9)	19.2% (5)
<i>Administrative staff requirements (i.e., the need for a discrete Residency Coordinator, etc.)</i>	46.2% (12)	15.4% (4)	15.4% (4)	19.2% (5)
<i>Structural requirements (i.e., lack of a physical medical library, continuity clinic or office space requirements, etc.)</i>	65.4% (17)	23.1% (6)	7.7% (2)	3.8% (1)
<i>Lack of support from your medical institution</i>	53.8% (14)	15.4% (4)	11.5% (3)	19.2% (5)
<i>Lack of support from your Osteopathic Postdoctoral Training Institution (OPTI)</i>	61.5% (16)	23.1% (6)	11.5% (3)	3.8% (1)
<i>Lack of support from professional organizations</i>	73.1% (19)	11.5% (3)	7.7% (2)	7.7% (2)

**Appendix F:** Responses for AOA-only family medicine residencies that are planning to apply for ACGME accreditation to the question “To what extent would the following resources or interventions help your program achieve ACGME accreditation?” (n=26)

<i>Intervention</i>	<b>Not helpful</b>				<b>Extremely helpful</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	
<i>Funding to increase the number of residents per year</i>	50.0% (13)	7.7% (2)	3.8% (1)	38.5% (10)	
<i>Developing collaborative arrangements with other residency programs (i.e., consortia, rural training tracks, etc.)</i>	19.2% (5)	23.1% (6)	15.4% (4)	42.3% (11)	
<i>Extending the deadline for accreditation pas2020</i>	7.7% (2)	3.8% (1)	19.2% (5)	69.2% (18)	
<i>Additional support (tool kits, coordination, consultative services, etc.) from your professional organizations or OPTI</i>	19.2% (5)	15.4% (4)	38.5% (10)	26.9% (7)	

### **Programs that are in pre-accreditation**

**Appendix G:** Responses for AOA-only family medicine residencies that are in pre-accreditation to the question “Please indicate to what extent each of the following was a barrier to ACGME accreditation.” (n=20)

<b>Barrier</b>	<b>Not a barrier [% , (n)]</b>	<b>Minor barrier [% , (n)]</b>	<b>Moderate barrier [% , (n)]</b>	<b>Major barrier [% , (n)]</b>
<i>Insufficient funding to have 4 residents per year</i>	75.0% (15)	20.0% (4)	0.0% (0)	5.0% (1)
<i>OB faculty requirements</i>	10.0% (2)	15.0% (3)	5.0% (1)	70.0% (16)
<i>Adult inpt faculty requirements</i>	35.0% (7)	10.0% (2)	35.0% (7)	20.0% (4)
<i>Peds inpt faculty requirements</i>	20.0% (4)	10.0% (2)	20.0% (4)	50.0% (3)
<i>Insufficient scholarly activity</i>	10.0% (2)	40.0% (8)	45.0% (9)	10.0% (2)
<i>Administrative staff requirements (i.e., the need for a discrete Residency Coordinator, etc.)</i>	75.0% (15)	20.0% (4)	5.0% (1)	0.0% (0)
<i>Structural requirements (i.e., lack of a physical medical library, continuity clinic or office space requirements, etc.)</i>	70.0% (14)	25.0% (5)	5.0% (1)	0.0% (0)
<i>Lack of support from your medical institution</i>	50.0% (3)	35.0% (7)	15.0% (3)	0.0% (0)
<i>Lack of support from your Osteopathic Postdoctoral Training Institution (OPTI)</i>	70.0% (14)	30.0% (6)	0.0% (0)	0.0% (0)
<i>Lack of support from professional organizations</i>	80.0% (16)	15.0% (3)	0.0% (0)	5.0% (1)

**Appendix H:** Responses for AOA-only family medicine residencies that are in pre-accreditation to the question “To what extent would the following resources or interventions help your program achieve ACGME accreditation?” (n=20)

<b>Intervention</b>	<b>Not helpful</b>			<b>Extremely helpful</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<i>Funding to increase the number of residents per year</i>	55.0% (11)	35.0% (7)	5.0% (1)	5.0% (1)
<i>Developing collaborative arrangements with other residency programs (i.e., consortia, rural training tracks, etc.)</i>	25.0% (5)	35.0% (7)	25.0% (5)	15.0% (3)
<i>Extending the deadline for accreditation past 2020</i>	30.0% (6)	30.0% (6)	5.0% (1)	35.0% (7)
<i>Additional support (tool kits, coordination, consultative services, etc.) from your professional organizations or OPTI</i>	15.0% (3)	30.0% (6)	35.0% (7)	20.0% (4)

**Programs with ACGME accreditation**

**Appendix I:** Responses for AOA-only family medicine residencies that have received ACGME accreditation to the question “Please indicate to what extent each of the following was a barrier to ACGME accreditation.” (n=20)

<b>Barrier</b>	<b>Not a barrier [% , (n)]</b>	<b>Minor barrier [% , (n)]</b>	<b>Moderate barrier [% , (n)]</b>	<b>Major barrier [% , (n)]</b>
<i>Insufficient funding to have 4 residents per year</i>	85.0% (17)	5.0% (1)	0.0% (0)	10.0% (2)
<i>OB faculty requirements</i>	20.0% (4)	15.0% (3)	35.0% (7)	30.0% (6)
<i>Adult inpt faculty requirements</i>	60.0% (12)	25.0% (5)	15.0% (3)	0.0% (0)
<i>Peds inpt faculty requirements</i>	35.0% (7)	35.0% (7)	15.0% (3)	15.0% (3)
<i>Insufficient scholarly activity</i>	30.0% (6)	40.0% (8)	25.0% (5)	5.0% (1)
<i>Administrative staff requirements (i.e., the need for a discrete Residency Coordinator, etc.)</i>	85.0% (17)	5.0% (1)	0.0% (0)	10.0% (2)
<i>Structural requirements (i.e., lack of a physical medical library, continuity clinic or office space requirements, etc.)</i>	65.0% (13)	20.0% (4)	10.0% (2)	5.0% (1)
<i>Lack of support from your medical institution</i>	90.0% (18)	5.0% (1)	5.0% (1)	0.0% (0)
<i>Lack of support from your Osteopathic Postdoctoral Training Institution (OPTI)</i>	80.0% (16)	10.0% (2)	10.0% (2)	0.0% (0)
<i>Lack of support from professional organizations</i>	70.0% (14)	20.0% (4)	0.0% (0)	10.0% (2)

**Appendix J:** Responses for AOA-only family medicine residencies that have received ACGME accreditation to the question “To what extent would the following resources or interventions help your program achieve ACGME accreditation?” (n=19)

<b>Intervention</b>	<b>Not helpful</b>			<b>Extremely helpful</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<i>Funding to increase the number of residents per year</i>	57.9% (11)	5.3% (1)	0.0% (0)	31.6% (6)
<i>Developing collaborative arrangements with other residency programs (i.e., consortia, rural training tracks, etc.)</i>	21.1% (4)	42.1% (8)	10.5% (2)	21.1% (4)
<i>Extending the deadline for accreditation past 2020</i>	68.4% (13)	5.3% (1)	15.8% (3)	5.3% (1)
<i>Additional support (tool kits, coordination, consultative services,</i>	15.8% (3)	31.6% (6)	31.6% (6)	15.8% (3)

*etc.) from your professional organizations or OPTI*

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