practice locations as underserved (Health Professions Shortage Area, Medically Underserved Area, Medically Underserved Population, or Federally Qualified Health Center/Community Health Center) and/or rural (Centers for Medicare and Medicaid Services [CMS] Rural Health Clinic Program eligibility, Federal Office of Rural Health Policy grant eligibility or Rural-Urban Commuting Code > 4). We identified graduates who met the mission of the CHS program from which they had graduated by their specialty and practice type. We then compared outcomes across the different data sources to assess discrepancies and if so, patterns of discrepancy between sources.

Outcomes: We found that using the NPPES alone, that the information was out of date for 36% of the graduates, based on the expected year of residency completion. We found repeated discrepancies in reported graduate practice location comparing across all sources, making measuring graduate outcomes difficult. No data source had complete information for each graduate, with 1.1% of graduates missing from NPPES, 18.6% of graduates missing from the state medical board data, 22% missing from Google, and 43.5% from the AMA Masterfile.

Of those included in the secondary data available, 60.3%–63.7% of CHS graduates practice a primary care specialty (internal medicine, family medicine, and pediatrics) depending on data source. 1.1%, 44.6%, 36.2%, and 14.7% of specialties were unknown in the NPPES, AMA Masterfile, state medical board, and Google sources, respectively. Family medicine was the most popular specialty, particularly among rural program graduates, the longest running program. Of those with training status data, program graduate training status ranged from 53.0% to 77.7% dependent on data source. Practice in an underserved location ranged from 56.5% to 62.3% of graduates dependent on data source. Practice location was missing for 1.1%, 71.8%, 26.0%, and 35.6% of graduates in the NPPES, AMA Masterfile, state medical board, and Google data sources, respectively.

Discussion: Since 2011, UCDSOM’s CHS pathways have produced physicians who practice in California’s underserved rural, urban, and Central Valley communities. The growing needs of the California health workforce require further investment in the development, funding, and expansion of similar programs. However, tracking graduate specialty and practice outcomes is challenging due to discrepancies among secondary data sources.

As we develop new programs to address physician shortages, we need a robust system to follow graduates and accurately measure program success. Our findings suggest that schools may need to develop graduate tracking processes and systems as a first step rather than use secondary data. Our next steps include contacting program graduates directly by phone and email to obtain practice and specialty information and assessment of secondary sources.

Significance: Many programs use secondary data sources to track and report on their graduate outcomes, but our study finds discrepancies across these data sources. Current estimates of physician supply in underserved areas nationally may be inaccurate given potential lack of reliability in secondary data sources.

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Leadership Education to Advance Diversity–African, Black and Caribbean (LEAD-ABC): A Mission-Based Model Approach to Addressing Racial Diversity and Inclusive Excellence in Medicine

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Purpose: The COVID-19 pandemic highlighted the socioeconomic and health disparities that continue to impact our underserved communities. One way that academic medicine can contribute to improving health equity is to address racial diversity within medicine. A case in point is the staggering fact that only 5% of physicians in the United States are Black, while Black people represent more than 13% of the U.S. population.1

In October 2020, the Association of American Medical Colleges (AAMC) released a framework for Addressing and Eliminating Racism at the AAMC, in Academic Medicine, and Beyond2 that outlined 4 pillars of work to guide their efforts to address the damaging effects of cultural racism impacting our nation. The third pillar centers on our work as part of the academic medicine community, including a need to identify promising systems-based solutions that achieve equitable enrollment and support for learners to thrive.

Approach/Methods: The University of California, Irvine School of Medicine (UCISOM) has been committed to systems-based solutions for over 15 years through its mission-based program model that focuses on areas of health care for which a specific need has been identified. The first of such programs was the UCISOM Program in Medical Education for the Latino Community (PRIME-LC) to address the needs of underserved Latino communities. PRIME-LC has demonstrated a consistent track record of graduating physician leaders who serve Latino communities in California and beyond. Following the success of this model, Leadership Education to Advance Diversity–African, Black and Caribbean (LEAD-ABC) was established in 2019 as a mission-based program aimed at
producing future physician leaders who are committed to addressing the health needs of African, Black, and Caribbean communities.

LEAD-ABC is a longitudinal, 4-year program that begins from the first day of medical school with an emphasis on community engagement, advocacy, research, and mentorship. Curricular aspects include courses and experiential learning activities designed to expand students’ knowledge, abilities, and confidence in addressing the needs of ABC patients and populations. The curriculum is structured around 3 core domains: A—Awareness, B—Belonging, C—Clinical Skills and Competency. Students also complete a scholarly project before graduation.

Results/Outcomes: The initial success of LEAD-ABC is evident in the numbers. While there were no Black medical students who graduated in the UCISOM Class of 2020, the incoming class that matriculated in August 2020 included 12% Black students. This percentage is more than 2 times that of Black physicians in the United States (5%) and 6 times the local population of Black residents (2%).

Discussion: LEAD-ABC demonstrates that a systems-based solution, beginning with a holistic admissions process and culminating in a culturally sensitive curriculum designed to foster professional development and belonging, can be an effective approach to addressing the dire need for Black physicians in the United States. While local demographics are often cited as a challenge to recruitment of Black students, LEAD-ABC provides a framework that schools may use to overcome this perceived barrier.

Significance: LEAD-ABC is the first medical school program in the nation designed to specifically develop physician leaders who will serve the unique health needs of ABC communities. The LEAD-ABC mission-based model offers academic institutions a programmatic framework for improving racial diversity and creating inclusive environments for their student body. Next steps include: continued interdisciplinary community engagement, implementation of pathway programs, creation of a consortium to further support students, dissemination of the LEAD-ABC framework to other medical schools, expansion into graduate medical education, and development of an interprofessional program model.

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