Key Performance Indicators for RWJF Grant Aims at Howard University College of Medicine

This section presents evidence-based Key Performance Indicators (KPIs) for each of the five RWJF grant aims. Each aim is addressed with both quantitative and qualitative metrics that are relevant and feasible to track. We include process measures (to monitor implementation of activities) and outcome measures (to gauge the impact), along with benchmarks and best practices from similar institutions and national bodies (AAMC, NIH, HRSA, etc.). Clear definitions and guidance are provided for how each KPI links to grant reporting and strategic success.

Aim 1: Institutionalizing DEI Through Structural Reform

Aim 1 Definition: Integrate justice, equity, diversity, and inclusion (JEDI) principles into the College of Medicine's structures, policies, and everyday operations. Success involves making DEI a sustained, accountable part of the institution's "DNA," rather than isolated programs. Key KPIs include measures of structural changes, policy adoption, and cultural climate improvements:

- **Completion of DEI Self-Assessment & Action Plan (Process):** *Definition:* Whether the College conducts a comprehensive DEI climate self-study and produces a formal improvement plan. *Application:* This one-time but foundational metric tracks if the institution has identified gaps and strategies. It aligns with evidence that institutional self-assessment drives sustained DEI progress. Grant reports can note completion of the self-study and the number of action items identified, demonstrating a data-driven roadmap for reform.
- **DEI Training Participation Rate (Process):** *Definition:* Percentage of faculty, staff, and students completing mandatory DEI trainings (e.g. cultural humility, implicit bias workshops). *Application:* A high participation rate (target ~100% of community members) indicates broad engagement in DEI capacity-building. This is feasible to track via attendance records or online module completion. For example, Howard's plan includes mandatory cultural humility training for all constituents. Grant reporting can highlight this as a structural commitment, and improved participation over time shows institutionalization of DEI learning.
- **Diversity of Leadership & Committees (Outcome):** *Definition:* Proportion of leadership positions (deans, department chairs, key committees) held by individuals from URM groups, compared to their availability in the talent pool. *Application:* This metric assesses structural inclusion at decision-making levels. For instance, track the percentage of department chairs who are Black, Latinx, or other underrepresented groups and aim to mirror or exceed national benchmarks. Similar HBCU medical schools emphasize diverse leadership; measuring this helps ensure that DEI is not just policy but reflected in governance. This can be benchmarked against AAMC data (e.g., AAMC faculty roster

reports) or peer institutions' records. Increasing leadership diversity over the grant period signals progress in dismantling structural barriers.

- **Integration of DEI in Policies & Strategic Plan (Process):** *Definition:* The extent to which official policies and the College's strategic plan include DEI objectives and accountability. *Application:* This can be measured by counting new or revised institutional policies that embed DEI (for example, **hiring and promotion guidelines that reward mentorship and diversity efforts**). One specific indicator is the inclusion of mentorship or DEI service in faculty promotion criteria, which Howard plans to implement (mentorship participation "counted toward promotion"). Tracking such policy changes (and their enforcement) provides evidence of structural reform. In grant reports, the College can document policy reforms (e.g. "X policies updated to support JEDI goals") as a tangible outcome of Aim 1.

- **DEI Dashboard Implementation (Process/Outcome):** *Definition:* Establishment of a "robust dashboard" that regularly tracks key diversity and inclusion metrics across the College. *Application:* This involves selecting a set of core indicators (e.g., demographic composition, climate survey scores, training rates, retention rates) and reporting them institution-wide. The KPI is twofold: (1) **Process:** that the dashboard is developed and operational; (2) **Outcome:** improvements in the tracked metrics over time. For example, the dashboard might show yearly trends in student/faculty URM percentages, or the number of DEI initiatives in each department. A functioning dashboard itself institutionalizes accountability. Grant reporting can include snapshots from this dashboard to demonstrate transparency and progress on DEI goals.

- **Climate of Inclusion Index (Outcome – Qualitative):** *Definition:* An index or score derived from climate survey responses about belonging, respect, and equity. This could include items like "I feel valued and included at this institution" and "There are clear avenues to address discrimination," aggregated into a score. *Application:* Conduct baseline and follow-up climate surveys among students, faculty, and staff. Improvement in the inclusion index over the grant period would indicate cultural change resulting from structural reforms. For example, **sense of belonging and safety** are critical metrics – the College might target an X% increase in positive responses to belongingness questions. Such qualitative metrics are feasible via tools like the AAMC Diversity Engagement Survey or custom surveys. Positive movement links directly to Aim 1's goal, demonstrating that structural changes (training, policies, leadership diversity) are translating into a more inclusive daily experience. This is a key outcome for strategic success, as a welcoming climate supports retention of students and faculty.

- **Community and Stakeholder Engagement in DEI (Process):** *Definition:* Number of departments or units actively engaged in DEI committees, task forces, or community partnerships as part of the structural reform. *Application:* This can be measured by counting departmental DEI committees established, or tracking participation in the college-wide JEDI Task Force. Aim 1 emphasizes embedding JEDI across operations, so having every department designate a DEI liaison or committee with regular meetings could be a KPI. Additionally, tracking *community-engaged efforts* (e.g., partnerships with local organizations for health equity) reflects structural commitment beyond campus. The **Departmental EDI Metrics framework** suggests tracking community-engaged research or outreach participation as a sign of an inclusive mission. In reports, Howard

can show that 100% of departments have DEI plans or that X community partnerships were formed to advance health equity, illustrating institutionalization of DEI at all levels.

Benchmark & Best Practice Notes: AAMC accreditation standards (LCME Element 3.3) require institutions to demonstrate ongoing diversity efforts and outcomes – e.g., schools must report on recruitment and retention of diverse students/faculty. Meeting or exceeding these national expectations can serve as benchmarks (such as having a **diversity strategic plan with annual outcome tracking**, which Howard is implementing). Similar institutions like Meharry and Morehouse have Offices of Diversity & Inclusion that publish annual metrics (composition, climate survey results, etc.), indicating that Howard's KPIs should be in line with peer best practices. For instance, Morehouse School of Medicine attributes its success in diversifying the workforce to **holistic admissions and robust student support**, monitored through outcomes like board scores and graduation rates – those structural supports are analogous to Howard's efforts in Aim 1 and 4. Howard's DEI dashboard and climate survey results can also be compared to national benchmarks (e.g., AAMC's Diversity Engagement Survey provides a comparison against a national cohort on themes of inclusion). Ultimately, Aim 1 KPIs tie directly to grant success by evidencing that RWJF funding enabled lasting structural changes (policies, systems, culture) that will sustain DEI progress beyond the grant period.

Aim 2: Making Health Professions Tangible to Minority Youth

Aim 2 Definition: Expand pipeline programs and early exposure initiatives to inspire and prepare K-12 minority youth for health and science careers. The goal is to **spark interest and confidence** in health professions among underrepresented youth by providing tangible experiences (e.g., "mini-medical school" programs, hands-on STEM workshops). Effective KPIs for Aim 2 focus on outreach breadth, youth engagement, and the pipeline's success in guiding students toward health career paths:

- **Outreach Reach – Number of Students and Schools Engaged (Quantitative Process):** *Definition:* The count of minority youth reached through pipeline activities and the number of partner schools or programs involved. *Application:* This is a fundamental metric indicating scale. Howard aims to expand to **10 Title I schools in DC's Wards 5, 7, 8**, so KPIs include: "# of schools partnered (target = 10)" and "# of K-12 students participating per year." Baseline values (e.g., last year HUCM engaged X schools and Y students) can be compared to annual figures to show growth. For example, prior HUCM STEM outreach impacted over *1,000 students* over a decade; with RWJF support, they might target doubling annual participants. This KPI is easily tracked via attendance rosters and partnership agreements. It demonstrates to RWJF the expanded pipeline penetration in the community.
- **Participant Demographics and Inclusion (Process/Outcome):** *Definition:* Demographic profile of students in the programs – specifically the percentage who are underrepresented minorities, from low-income backgrounds, or first-generation potential college students. *Application:* Ensuring the program reaches the intended population is critical. A KPI could be "% of participants

who are URM or from disadvantaged backgrounds (e.g., Pell-eligible families)." National pathway programs provide benchmarks: for instance, the federal HCOP program in 2018-19 supported 1,300 trainees, **99% of whom were from underrepresented minority groups and 64% from economically or educationally disadvantaged backgrounds**. Howard can set similar targets (e.g., ≥90% URM participants). This data is collected via applications or surveys. High inclusion rates will show the grant is effectively targeting equity. (This also aligns with RWJF's focus on a *Culture of Health*, ensuring opportunities reach underserved youth.)

- **Program Intensity & Exposure Activities (Process):** *Definition:* The number and quality of experiential learning sessions provided – e.g., hands-on workshops, mentorship sessions, hospital visits – that make health professions "tangible." *Application:* KPIs can include "# of workshops or experiential events conducted per semester" and "average hours of exposure per student." For example, the **Mini-Med School program** might be delivered monthly; if 8 sessions were offered last year, the target could be 12 sessions/year with RWJF funding. Howard's description highlights activities like anatomy labs, first-aid training, and even take-home stethoscopes for students. Tracking these activities ensures the program's promised components are delivered. Additionally, *qualitative assessments* of content can be captured (e.g., student feedback that sessions were engaging and increased understanding of health careers). This metric links to strategic success by confirming that the program isn't just reaching students in name, but providing substantive, regular engagements that build interest.

- **Youth Interest and Self-Efficacy in Health Careers (Outcome – Qualitative/Quantitative):** *Definition:* Changes in participants' interest in health professions and confidence in pursuing these careers, measured via pre- and post-program surveys. *Application:* This KPI gets at the program's impact on mindset. Surveys might ask students to rate their interest in a health career or their agreement with statements like "I can become a doctor, nurse, or scientist" before vs. after the program. A successful outcome could be, for example, a **20% increase** in the share of participants who say they are "very interested" in a health career after completing the program. Qualitatively, student testimonials or focus groups can indicate increased awareness of career options (e.g., "I didn't know what a pharmacist does, now I want to be one"). Such metrics are common in pipeline program evaluations – improved self-efficacy is a known precursor to students actually pursuing those careers. Grant-wise, demonstrating a measurable shift in attitudes among hundreds of minority youth provides a compelling narrative of impact beyond the raw participation numbers.

- **Mentorship Pairings and Engagement (Process/Outcome):** *Definition:* Number of mentorship relationships formed between HUCM students/faculty and the youth, and the consistency of those interactions. *Application:* Howard's mini-med program pairs each elementary student with a medical student mentor. KPIs could be "mentor-to-mentee ratio" (target 1:1 or 1:2) and "# of mentorship hours or meetings per participant." Additionally, monitor *mentor retention* (do the same mentors stay engaged throughout the year) and *mentee feedback* on mentoring. This is qualitative but crucial: it's often the personal mentorship that makes professions tangible. Similar institutions leverage alumni or student volunteers in pipeline mentoring; for example, Morehouse School of Medicine's pipeline programs engage medical students as role models, which they find critical in sustaining interest. If Howard can report that, say, 30 medical/dental

students volunteered as mentors and met monthly with youth, this indicates robust institutional support and contributes to Aim 2 success. As an outcome, one might track if mentored youth show greater persistence in the program or heightened interest compared to those without mentors (if applicable).

- **Continuation to Next-Step Opportunities (Outcome):** *Definition:* The rate at which pipeline participants progress to further steps in the health/STEM pipeline – for example, high schoolers enrolling in college STEM programs, or middle schoolers choosing science-focused high schools. *Application:* While long-term, this is the ultimate outcome Aim 2 feeds into. A feasible approach is to track participants in their senior year of high school and see how many apply to college in a science or pre-health major. Another proxy: track enrollment of pipeline alumni in Howard's own college programs or other known pathway programs (like Aim 3's HUIPP or national programs). **Similar institutions' outcomes provide context** – e.g., Morehouse's "Reach One Each One" high school program reports ~61% of its 90+ alumni went on to enroll in pre-med college programs. That ~60% figure is a benchmark of pipeline success. Howard can aim to achieve a comparable or higher college matriculation rate among its pipeline alumni. Although full realization might occur after the grant period, even interim data (such as seniors' college intentions or scholarship offers) can be collected and reported. Achieving strong continuation rates demonstrates that the "tangible" experiences are translating into concrete career pursuits, directly supporting the grant's purpose of diversifying health professions.
- **Youth Academic Outcomes & Performance (Outcome):** *Definition:* Improvement in participants' academic indicators related to STEM, such as science grades or standardized test scores, after involvement in the program. *Application:* While the primary goal is inspiration, a secondary goal is enhancing academic preparedness. If feasible, partner schools can share data on participants – for instance, did students' science GPA or biology exam scores improve year-over-year? Even qualitative academic outcomes count: increased enrollment in advanced science classes or STEM clubs after attending HUCM workshops. National reports note that comprehensive pipeline programs (with academic enrichment, tutoring, etc.) can positively affect academic outcomes. If Howard's program includes any academic content (e.g. basic science concepts in workshops), measuring knowledge gain through quizzes or project evaluations could be a KPI. For grant reporting, any evidence that pipeline activities helped students perform better or feel more prepared academically (perhaps leading to honors or science fair participation) will reinforce the program's effectiveness and long-term impact on the pipeline.

Benchmark & Best Practice Notes: Pipeline programs often look at both **short-term engagement metrics** and **long-term tracking**. Best practices from the AAMC and AMA pathway literature suggest combining these approaches. For example, the **AMA's 2021 report on pathway programs** highlights that effective programs integrate multiple interventions (academic support, mentoring, financial support) and recommends tracking participants over time to evaluate increased diversity in medical education. Howard's KPIs reflect these recommendations. In terms of national benchmarks: programs like the **Summer Health Professions Education Program (SHPEP)** for college students (RWJF-funded) have documented outcomes (~64% of alumni matriculate into health professions schools), and high

school programs like the one at Morehouse show >60% entering pre-med, as noted. Achieving similar outcomes would put Howard's pipeline at the forefront of national efforts. Process-wise, reaching 10 schools and sustaining yearly engagement is ambitious but comparable to other HBCU medical schools' community programs (for instance, Charles Drew University runs multiple high school academies in Los Angeles). Furthermore, aligning content with best practices – e.g. culturally relevant health topics, hands-on activities, near-peer mentors – will be reflected in improved interest and knowledge KPIs. Each KPI ultimately ties back to the grant's success by showing that RWJF's investment is cultivating a new generation of diverse health professionals, starting from an early age, and that this cultivation is measurable and on track to yield future health profession matriculants.

Aim 3: Preparing URM College Students for Health Professions

Aim 3 Definition: Strengthen and prepare underrepresented minority (URM) undergraduates for successful admission to health professional schools (medicine, dentistry, nursing, etc.). Howard's plan includes launching the **Howard University Interprofessional Pathways Program (HUIPP)** – a comprehensive summer enrichment program for college juniors and seniors – to fill the gap as RWJF's national SHPEP funding sunsets. KPIs for Aim 3 focus on academic enrichment outcomes, professional school application success, and readiness of participants, drawing on metrics used by similar pipeline programs:

- **Program Enrollment and Completion (Process):** *Definition:* Number of URM college students enrolled in and completing HUIPP each year, by discipline (medicine, dentistry, nursing, pharmacy tracks). *Application:* The target is 24 students per year (8 pre-med, 6 pre-dent, 5 pre-nursing, 5 pre-pharmacy). A KPI is achieving full enrollment (24/24 slots filled) with minimal dropouts (completion rate ~100% each summer). Tracking application numbers can also be useful (e.g., if 100+ students apply for 24 slots, indicating demand and reach). This metric is straightforward and demonstrates the program's capacity: consistent full cohorts show feasibility and attractiveness. It also ensures the program is helping the intended number of students annually as promised to RWJF. In reports, Howard can note how many students were trained each cycle, broken down by field, as a fundamental output of Aim 3.

- **Participant Academic Performance Improvement (Outcome):** *Definition:* Gains in participants' academic indicators relevant to health professional school admission – for example, improvement in GPA in science courses, or performance on standardized tests (MCAT, DAT, etc.) after the program. *Application:* HUIPP includes basic sciences and communication curriculum, so pre- and post-tests can be administered. One KPI could be the **average increase in a diagnostic MCAT/DAT score** after the program (e.g., participants' practice MCAT scores improve by 3 points on average). Another could be percentage of students who report improved mastery of core science concepts (via pre/post self-assessment). **Evidence from Morehouse School of Medicine's interventions** shows that providing academic support can significantly "shift the curve" of standardized exam performance for URM students. In line with that, Howard can aim for measurable academic gains in its cohort. These improvements are strong indicators to

include in grant reports, as they demonstrate the program's direct effect on participants' preparedness.

- **Health Professional School Application and Acceptance Rates (Outcome):** *Definition:* The proportion of HUIPP participants who apply to at least one health professions school, and the proportion who are accepted (matriculate). *Application:* This is arguably the **ultimate KPI** for Aim 3. For each cohort, track how many students go on to apply to medical/dental/nursing/pharmacy schools within 1-2 years. Among those, measure how many gained admission. Benchmarks: the outgoing SHPEP program (nationally) historically saw about **64%–65% of its alumni matriculate** into health professional programs. Another study noted that intensive pathway programs can increase URM matriculation in med school by ~25% compared to peers. Howard can set a target (for example) that at least 70% of HUIPP alumni apply to a health professions school, and at least 50% matriculate within two years – ambitious but attainable given national data. This KPI requires follow-up data collection (surveys or alumni tracking), but it is crucial for demonstrating impact. When reporting to RWJF, being able to say "X out of Y scholars (Z%) from the 2025 cohort are now in medical or graduate health programs" powerfully links the program to long-term outcomes in diversifying the workforce.

- **Skill Competency and Confidence Gains (Outcome – Qualitative):** *Definition:* Improvements in participants' competencies and confidence in areas critical for professional school success – such as research skills, clinical exposure, teamwork, and cultural humility. *Application:* HUIPP's design includes career development (with a visit to NIH), wellness seminars, interprofessional simulation experiences, and cultural awareness training. To measure impact, Howard can use evaluations or reflection surveys asking students to rate their confidence in various domains before vs. after (e.g., "Understanding of interprofessional teamwork" or "Confidence interacting with patients"). Another KPI: the number of participants who complete a capstone project or action plan (since HUIPP includes developing a career action plan). For example, if 100% of students create a plan and 90% achieve milestones on it (like taking the MCAT by a certain date), that indicates success. Qualitatively, participants might report feeling more motivated and informed about the application process – capturing this in testimonials or focus group summaries adds depth to the quantitative outcomes. These measures align with best practices that **comprehensive programs improve not just academic scores but also professional confidence and networks**. They help demonstrate to RWJF that HUIPP is producing well-rounded, prepared candidates, not just test-takers.

- **Mentorship and Networking Outcomes (Process/Outcome):** *Definition:* The extent of mentoring, shadowing, or networking opportunities provided – and subsequent benefits like mentoring relationships maintained or research internships secured. *Application:* KPI examples: "# of faculty or peer mentors assigned per student" (process) and "% of students who report having an ongoing mentor in the health field after the program" (outcome). If, say, each HUIPP participant is paired with a Howard faculty mentor or a medical student, track how often they meet (at least biweekly during the program). Outcome-wise, see if those mentorships continue informally after the program – a sign of lasting impact. Similarly, track how many HUIPP students secure research opportunities or internships as a result of program connections (for instance, a student meets a

researcher during the NIH visit and later joins their lab). Such networking outcomes can be captured in follow-up surveys or LinkedIn tracking. Other institutions often emphasize mentorship as a key success factor; formal mentoring has been shown to increase students' engagement and likelihood of pursuing advanced training. In grant terms, a rich mentorship component is a qualitative success indicator – Howard can report stories of HUIPP scholars being accepted into labs or receiving recommendation letters from mentors, illustrating how the program's process measures (mentorship provided) convert to tangible stepping stones for participants.

- **Diversity of Disciplines and Interprofessional Exposure (Process):** *Definition:* Inclusion of multiple health professions in the program and the level of interdisciplinary learning achieved. *Application:* Since HUIPP is explicitly interprofessional, a KPI can be ensuring representation from four disciplines (medicine, dentistry, nursing, pharmacy) in both the student cohort and the curriculum. For example, confirm each cohort has the intended mix (8 pre-med, etc.), and that all students get exposure to all fields (e.g., *100% of participants shadow at least two different health profession simulations*). Measurement can include attendance in all interprofessional simulation sessions, and feedback on whether participants understand roles of the various professions (perhaps via a quiz or reflection prompt). Achieving true interprofessional education is a best practice that aligns with RWJF's **"Culture of Health"** initiative requiring cross-disciplinary collaboration. By tracking this, Howard ensures Aim 3 doesn't become siloed within medicine alone but broadens opportunities. In reports, highlighting that HUIPP produced candidates not only for med school but also for dental, nursing, etc., with all learning together, underscores a holistic approach to diversifying the *health* workforce (beyond physicians alone).

Benchmark & Best Practice Notes: Aim 3 leverages lessons from decades of pipeline programs (like **HRSA's HCOP, Centers of Excellence, and RWJF's own SHPEP**). Best practices from those programs have shown that providing a combination of academic enrichment, mentoring, exposure, and financial support yields the best outcomes. For instance, data published on pipeline effectiveness indicate that participants in enriched pathway programs apply and matriculate to medical school at significantly higher rates than non-participants. Howard's KPI targets (e.g., >50% matriculation rate) are set in light of these findings. Similar HBCU institutions: **Meharry Medical College** and **Morehouse School of Medicine** have historically hosted summer enrichment programs (like the former MEDPREP or post-baccalaureate programs) and track their success by how many students get admitted to health professional schools. Morehouse's PREP program, for example, might report the number of its alumni who enter MSM or other med schools each year as a key outcome. Additionally, **AAMC and NIH benchmarks**: The AAMC's Faculty Toll data and NIH training grant reports often look at matriculation or progression rates as primary outcomes for training programs. Howard can also compare HUIPP outcomes to the national med school acceptance rates for URM applicants (for context, in recent years around 8–9% of med school entrants have been Black and similar for Latinx; a successful pipeline would boost the absolute numbers beyond what random chance would yield). By presenting both process accomplishments (X students trained, Y hours of curriculum delivered) and outcome successes (Z% gained admission, test score improvements, etc.), Aim 3's KPIs will convincingly link the RWJF-funded activities to the strategic goal of expanding the pool of competitive URM applicants entering health professions schools.

Aim 4: Supporting Medical Students via Retention and Scholarship

Aim 4 Definition: Enhance support for enrolled medical students, especially those from disadvantaged backgrounds or underrepresented groups, to **improve retention and academic success** through to graduation. This includes reducing financial and social barriers (food or housing insecurity, lack of research funds) and providing scholarships, wellness resources, and academic support to prevent attrition. Key KPIs for Aim 4 revolve around student persistence, well-being, and achievement:

- **Medical Student Attrition Rate (Outcome):** *Definition:* The percentage of medical students who withdraw or are dismissed from the program before completion, tracked annually or by cohort. *Application:* A low attrition (high retention) rate is a primary success indicator. Nationally, medical schools have very high graduation rates – around **96% graduate within 6 years, implying ~3–4% attrition overall**. URM students historically have faced slightly higher attrition at some institutions, often due to financial or social stressors. Howard can use its baseline attrition (if, say, X% of a class doesn't graduate on time) and set a goal to reduce that by a certain amount (e.g., cut attrition in half, or ensure it stays at or below the national ~3%). Yearly monitoring by class year is feasible via the registrar. Importantly, Aim 4 initiatives (food pantry, emergency funds, etc.) target non-academic reasons for leaving; a successful outcome is that **no student leaves due to financial hardship.** In reports, Howard can highlight narratives like "In the grant period, *0* students were lost due to inability to afford living expenses," supported by the quantitative attrition data. Maintaining a >95% graduation rate, especially among at-risk groups, will be a concrete marker of strategic success.
- **Utilization of Financial Assistance Programs (Process):** *Definition:* The number of students who access and benefit from the new support programs – e.g., those using the food pantry, receiving emergency housing grants, or obtaining research travel/publishing funds. *Application:* Each sub-initiative can have a metric: "# of pantry visits or unique students served per semester," "# of emergency grants disbursed and $ amount," "# of students receiving Research Equity travel/publishing grants (and total $ awarded)." High utilization suggests that the programs are well-publicized and meeting needs. For example, if 50 students used the pantry in year 1 and the need seems higher, Howard might aim for increased usage as destigmatization grows. Conversely, over time, a decrease might indicate improved baseline food security. It's also useful to track **unmet requests** (if any students in crisis could not be helped due to lack of funds, which ideally stays at zero). These process metrics feed into outcome metrics – e.g., a student who gets a $5,000 emergency grant stays enrolled rather than taking leave. For RWJF reporting, detailing these numbers (how many students directly benefited and stories of how it kept them in school) will illustrate the immediate impact of funding on retention.
- **Student Financial Hardship Indicators (Outcome – Quantitative/Qualitative):** *Definition:* The prevalence of financial insecurity among students, measured by surveys or counseling data – for instance, percentage of students who report food insecurity, housing instability, or high stress about finances. *Application:* Howard could add questions to an internal survey or use an

existing instrument to gauge food insecurity (e.g., USDA two-item food insecurity screening) among medical students annually. A KPI could be **"% of students screening positive for food insecurity," aiming to decrease this percentage year-over-year.** Given that research cited by Howard notes food insecurity is a significant predictor of attrition, a drop in this indicator would be a direct positive outcome of Aim 4a (stocking a food pantry). Similarly, track the number of students seeking financial counseling or reporting monetary concerns. A qualitative angle: testimonies like "I was considering leaving due to finances, but the emergency fund helped me stay" – these indicate reduced hardship. National benchmarks here are less formal, but any reduction moves toward the ideal of **zero students unable to meet basic needs**. This KPI connects to strategic success by showing the College provides a safety net, which likely correlates with improved mental health and focus among students (and thus better academic performance).

- **Academic Performance and Progress Metrics (Outcome):** *Definition:* Student performance indicators such as USMLE Step exam pass rates and scores, course remediation rates, and on-time progression/graduation rates, with an eye on any gaps between groups. *Application:* Retention is not just about not dropping out, but also about thriving academically. Key metrics: **Step 1 and Step 2 CK pass rates** – Aim 4 support (tutoring, reduced stress via financial aid) should help maintain high pass rates. Howard can target 100% first-time Step 1 pass rate (if not already at that) or an increase in average score. Morehouse School of Medicine provides a benchmark: through strong mentoring and monitoring, their students' **Step 1 scores exceeded what was predicted by their MCATs**. Howard could similarly track an index of "actual vs. expected performance" to demonstrate added value from support systems. Another metric: **remediation or deceleration frequency** (how many students need to repeat a course or take a leave for academic reasons). A drop in those numbers post-intervention would show improved academic resilience. These metrics are readily available in academic records and are often reported to accrediting bodies. For RWJF, improved exam outcomes underscore that scholarship support and retention efforts are not only keeping students in school but enabling them to succeed at key milestones (a strong predictor of eventual graduation and residency placement).

- **Scholarship Funds Awarded & Debt Reduction (Process/Outcome):** *Definition:* The amount of scholarship or grant funding provided to students and its effect on student indebtedness. *Application:* Howard can track "$ of new scholarships or grants distributed as a result of RWJF funding" and the number of students receiving support (e.g., how many got partial or full scholarships they wouldn't have otherwise). Outcome-wise, monitor average debt at graduation for the class – if Aim 4's scholarship components are substantial, they might reduce the average debt burden or at least slow its growth. For instance, if baseline average debt for HUCM graduates is $200k, perhaps the target is to keep it below that while national averages climb, or to increase the percentage of students graduating with lower debt. Also, track whether **financial stress perception** (from surveys like the AAMC Graduation Questionnaire, which asks about education debt and financial counseling satisfaction) improves. An example benchmark: AAMC reports about 73% of med students graduate with debt, with median debt ~$200k; Howard could aim to lower the proportion with debt or provide enough aid that more students feel financially supported. In grant terms, every dollar allocated to a student is an immediate

output – totaling these and perhaps noting any **notable scholarships (like named RWJF Scholars)** can be powerful. Moreover, if financial relief correlates with other outcomes (e.g., those who got help had 0% attrition), that's worth highlighting.

- **Student Wellness and Engagement (Outcome – Qualitative):** *Definition:* Measures of student well-being, engagement, and satisfaction with the support environment, often via surveys such as the AAMC Graduation Questionnaire (GQ) or internal wellness surveys. *Application:* Relevant KPIs include: "% of students rating the adequacy of student support services as 'excellent' on the GQ," "scores on burnout or mental health inventories," or "participation rates in wellness programming." Howard could institute a brief wellness survey each term; for example, track the average self-reported stress level and aim for a decrease after implementing wellness activities (mindfulness retreats, etc.). Another specific GQ item is "Would you choose to attend this medical school again?" – an increase in affirmative responses can indicate an improved overall student experience. Additionally, **reports of mistreatment or discrimination** can be monitored (since such experiences can drive attrition). A decrease in mistreatment incidents or an increase in students feeling the administration effectively addresses their concerns would show a healthier climate. While qualitative, these are evidence-based: a Yale study found that students who experience less mistreatment are less likely to leave medical school. For RWJF, combining these qualitative indicators with the hard numbers provides a holistic picture. For instance, "Student satisfaction with financial aid and wellbeing resources rose by X%, according to surveys, alongside a decline in attrition" directly links Aim 4 initiatives to strategic success in producing more graduating physicians.

- **Residency Match Success (Outcome):** *Definition:* The percentage of graduating students who successfully match to a residency program, especially on the first attempt, and potentially the quality of matches (e.g., into chosen specialties). *Application:* Although many factors influence Match outcomes, retention and support certainly enable students to reach this milestone. A near-term KPI is maintaining a high Match rate (e.g., ≥95% match on Match Day). If Howard sees improvement (say from 92% to 98% over the grant period), that's a strong outcome. This can be benchmarked nationally (U.S. seniors' match rate ~93-94% in recent years). Howard might also highlight URM student match rates specifically, ensuring there's no disparity. Additionally, if Aim 4 includes academic and career advising support, they might track how many students obtained their top-choice specialty or entered primary care in underserved areas (aligning with health equity goals). While the grant's timeframe might be short for significantly altering Match outcomes, reporting a stable or rising trend – "All students, including those from at-risk backgrounds, are successfully graduating and moving into residency" – is critical since it completes the education pipeline. This KPI essentially encapsulates the success of retention, academic, and wellness efforts through the culmination of medical school.

Benchmark & Best Practice Notes: Supporting URM and disadvantaged medical students is an area with known best practices in the literature. For example, the **AAMC urges schools to monitor student wellness and attrition closely**, and schools like UCLA (through its Track in Medical Education for URM students) or UCSF have implemented food security programs for students, tracking usage and impacts. Howard's approach (food pantry, emergency aid, research funding) is innovative and aligns with holistic support trends. Best practice metrics often come

from the AAMC **Graduation Questionnaire (GQ)** – many schools use GQ data as KPIs (e.g., *"our goal is to improve our student satisfaction with wellness support by 10% next year"*). Another benchmark: Morehouse School of Medicine's student support strategies (e.g., intensive Step 1 prep and faculty mentoring) have resulted in above-predicted exam scores and a very high graduation rate. Howard can similarly claim success if Aim 4 yields no Step exam failures and on-time graduation for virtually all students. Nationally, the importance of these efforts is underscored by research linking unmet student needs to attrition; by addressing those, Howard is expected to meet or exceed national retention averages. Each Aim 4 KPI ties to grant reporting by showing how RWJF funds directly mitigated risks (hunger, burnout, lack of funds to present research) that often disproportionately hinder URM students. The result is not only retention (which is fundamental) but also empowering these students to excel and enter the next phase of their careers confidently – thereby advancing the broader goal of a diverse and well-supported physician workforce.

Aim 5: Retaining Faculty Through Holistic Support

Aim 5 Definition: Improve the retention of faculty (with an emphasis on faculty from underrepresented or marginalized groups) by providing comprehensive support – including bias training for leadership, funding for scholarly growth, wellness and community-building, and leadership development opportunities. Essentially, this aim recognizes that sustaining a diverse learning environment requires keeping talented faculty engaged and thriving. KPIs for Aim 5 focus on faculty turnover rates, professional development engagement, and measures of faculty satisfaction and success:

- **Faculty Retention/Turnover Rate (Outcome):** *Definition:* The percentage of faculty who remain at the College each year (or conversely, the percentage who leave, excluding planned retirements), overall and by key subgroups (URM vs non-URM faculty). *Application:* This is a critical bottom-line metric. For example, if historically the College had an annual faculty turnover of 10%, perhaps with URM faculty turnover higher, the goal would be to reduce that (e.g., to 5% or less annual attrition). Tracking can be done via HR records each year. A relevant benchmark: A recent national cohort study found that median retention for Black faculty in U.S. medical schools was ~7.8 years compared to ~9.9 years for White faculty, highlighting a retention gap. Howard can use such data to set goals (e.g., "eliminate the retention gap" so that URM faculty at Howard stay as long as others, or increase overall median faculty tenure to 10+ years). During the grant, a practical KPI could be **the 3-year retention rate** of faculty hired in a given period, aiming to improve it by a certain percentage. Improvement in retention demonstrates holistic support is working. In reports, if Howard can say "faculty attrition dropped by 20% after implementing holistic supports," it directly validates Aim 5 (notably, the proposal cites data that investments in faculty development can reduce attrition by ~20%).
- **Engagement in Faculty Development Programs (Process):** *Definition:* Participation rates in the new support offerings – e.g., number of department chairs and Promotions Committee members trained in bias mitigation, number of faculty receiving mini-grants for research, attendance at wellness events, and enrollment in leadership development workshops. *Application:* Each subcomponent yields a KPI: (a) **Leadership Training**

Coverage: e.g., *100% of Chairs/APT committee members* complete implicit bias and respectful review training (tracked via training rosters). (b) **Mini-Grants Awarded:** e.g., *X faculty received interdisciplinary research mini-grants (up to $15k each) and utilized them* – track how many grants given and total funds used (target might be ~5–10 grants/year). (c) **Wellness Program Participation:** e.g., *# of faculty attending each mindfulness retreat or peer support circle* – aiming to increase turnout over time as culture supports wellness. (d) **Leadership Development Uptake:** e.g., *20 faculty selected for leadership development per year* (as planned) and completion rate of those programs. High engagement in these opportunities is a proxy for faculty trust and interest in growth (low engagement could signal issues in communication or culture). For grant purposes, these process metrics show the breadth of support delivered: "During the grant, all 15 department chairs were trained in equitable evaluation, 18 faculty received research grants, and 50 faculty participated in at least one wellness or leadership activity," for example. This demonstrates RWJF resources directly translated into faculty support actions.

- **Faculty Promotion and Advancement Rates (Outcome):** *Definition:* The rate at which faculty (especially URM faculty) advance in rank or achieve tenure, and the time it takes, compared before vs. after interventions. *Application:* If one goal of holistic support is to retain faculty, another is to help them succeed and feel valued (which in academia often means promotion). Metrics: "Promotion rate of assistant professors within 6–8 years" and "proportion of URM faculty promoted vs eligible." Historically, URM faculty have faced slower promotions in many places. A success KPI would be eliminating disparities – e.g., if 80% of non-URM faculty hired 7 years ago got promoted and only 60% of URM did, the aim is to raise URM promotion to 80% as well. Tracking through academic affairs data, Howard can compare cohorts before and after implementing bias training for promotions committees. An increase in overall promotion rates or a shortening of time to advancement suggests the environment is more supportive and equitable. The **AAMC has identified clarity in promotion and effective mentoring as key to faculty retention and advancement**. By training committees and providing mentorship (Aim 1b, 5), Howard expects to see more faculty moving up the ranks. This can be reported to RWJF as evidence that the grant not only kept faculty on board but helped them progress into leadership roles – a clear marker of institutional success in faculty development.

- **Mentorship and Collaborative Engagement (Process/Outcome):** *Definition:* The extent of mentorship and peer networking among faculty, measured by participation in formal mentoring programs or peer circles and resultant outcomes like increased collaboration or grants. *Application:* Howard's plan includes **peer mentorship circles and a 3-tiered mentorship model** connecting faculty with students and with each other across departments. KPIs: "# of active mentorship pairs or circles established" and "frequency of meetings." One could also survey faculty: "% of faculty who report having a mentor or being a mentor." Nationally, the presence of a mentor is a known factor in faculty satisfaction – yet surveys show only ~30% of faculty have formal mentors. Howard could aim to boost that to, say, 60% with the new program. Outcome-wise, effective mentoring and networking might reflect in **increased scholarly output or grant submissions** among participants, or simply higher retention (which could be separately measured). There is evidence that formal mentoring programs significantly improve metrics of faculty career development and intent to stay. Thus, another KPI

might be "Difference in 2-year retention between mentored vs non-mentored faculty" – expecting higher retention in the mentored group, which would validate the approach. These metrics show RWJF that a supportive community is forming: for example, "25 junior faculty were paired with senior mentors, meeting monthly, leading to 5 joint research proposals – and our surveys show mentored faculty are more likely to foresee a long-term career at Howard." This ties mentorship activities directly to strategic outcomes of productivity and retention.

- **Faculty Satisfaction and Well-Being Index (Outcome – Qualitative):** *Definition:* Faculty perceptions of the workplace climate, support, and their own well-being, typically measured through surveys (e.g., the AAMC StandPoint Faculty Engagement Survey or custom instruments). *Application:* A composite index can be created from items like "Satisfaction with support for research/professional development," "Work-life balance satisfaction," "Sense of belonging in the College," and "Likelihood to recommend this institution as a place to work." Howard might participate in the AAMC StandPoint survey (formerly Faculty Forward) which provides benchmarks on these dimensions; for example, one could track improvements in the percent of faculty who agree that *"the institution supports my career development"* and *"I intend to remain at this institution for the next 5 years."* According to AAMC data, **faculty who feel supported in growth and receive regular feedback report higher engagement and lower intent to leave**. Howard's interventions (like leadership training and feedback through mentorship) target those aspects. A feasible KPI is "Faculty engagement score" or "Intent to stay rate" from such a survey, aiming to increase it relative to baseline or to meet/exceed national averages. Additionally, specific feedback on the new programs can be gathered (e.g., "% of faculty who rate the research mini-grants or wellness retreats as 'very useful'"). In grant reports, showing a positive shift in faculty morale and engagement – perhaps through a few key survey stats or quotes – will illustrate that the holistic support approach is succeeding in making faculty feel valued and thus more likely to stay.

- **Scholarly Productivity and Funding Outcomes (Outcome):** *Definition:* Measures of faculty scholarly output (publications, presentations) and success in obtaining external grants, particularly as influenced by the support programs. *Application:* The mini-grants for pilot research are meant to re-energize faculty scholarship, which can be tracked by outcomes like: "# of publications or conference abstracts produced by mini-grant recipients" and "# of larger grant proposals submitted (or won) that stemmed from pilot funding." For example, if 10 faculty get mini-grants, a KPI might be that by year's end, 8 of them have submitted an NIH or foundation grant, or produced at least one manuscript. Similarly, those in leadership development might take on new roles; one could track "# of faculty promoted to leadership positions (committee chair, etc.) after completing development training." While these are more achievement-focused than direct retention, they strongly correlate with retention because **faculty who achieve their professional goals are more likely to stay**. Moreover, these outcomes feed the institution's mission (advancing research and innovation), so they have strategic value. In reporting to RWJF, Howard can highlight stories such as "Dr. X received a $15k pilot grant through this program, which led to preliminary data and subsequently a $200k NIH award – a success that keeps Dr. X on a solid career path at Howard." Such outcomes show that RWJF's

investment had a multiplier effect on faculty success and by extension, institutional prestige and stability.

Benchmark & Best Practice Notes: Faculty retention and development are well-studied in academic medicine. The **AAMC StandPoint survey** provides national benchmarks on faculty engagement – for example, one could compare Howard's faculty satisfaction to the national median (if Howard was below in certain areas, the aim is to meet or exceed the median after interventions). Research (e.g., a study in *JAMA Network Open*) confirms that underrepresented faculty leave academic medicine sooner than majority faculty, often citing lack of support or undue service burdens ("minority tax"). Best practices to counter this include formal mentoring, leadership training, bias-free promotion practices, and attention to work-life balance – all elements present in Howard's plan. Morehouse and Meharry have smaller faculties but have historically emphasized supportive environments; for instance, Morehouse's faculty mentoring ethos is credited with their high student success, and Meharry's Health Equity research focus likely involves mentoring junior faculty into research careers. Howard's use of mini-grants is akin to an internal "grant leap" program; some institutions measure their success by the external funding those seed grants attract – a useful benchmark being, say, a 3:1 return on investment in 2 years. Another benchmark: institutions often aim for **faculty turnover below a certain threshold** (e.g., <8%/year); academic health centers strive to retain talent in a competitive market. If Howard can demonstrate a downward trend in departures, it will stand out. Each of Aim 5's KPIs strengthens the case that RWJF's funding helped create an environment where diverse faculty not only stay, but **flourish** – evidenced by longer tenures, higher satisfaction, and continued scholarly and leadership contributions. This is vital for sustaining the pipeline of diverse learners (faculty serve as mentors and role models), thus linking back to the overall mission of diversifying the health professions at all levels.

Conclusion: The above KPIs – spanning quantitative counts (e.g., number of students or faculty impacted, rates and percentages) and qualitative indicators (e.g., survey-based climate and satisfaction measures) – provide a comprehensive framework for evaluating each of the five grant aims. They incorporate best practices from similar institutions and national bodies: for instance, using AAMC-derived metrics for diversity and climate, pipeline outcome measures inspired by programs like SHPEP, and retention indicators reflecting known challenges in medical education. By tracking both **process measures** (implementation of activities and outputs) and **outcome measures** (the resulting changes and benefits), Howard University College of Medicine can effectively monitor progress, make data-informed adjustments, and demonstrate to RWJF and other stakeholders how each aim contributes to the overarching goal of a more equitable, inclusive, and excellent academic medicine environment. Each KPI is not just a number but a story of change – together they will document the grant's role in institutional transformation and its impact on individuals from the classroom to the faculty ranks, ultimately advancing health equity through diversification of the workforce.

Sources: Connected references supporting the KPIs and context are included inline above, for example from AAMC data snapshots, published pipeline program evaluations, and the grant's

proposal text, among others. These provide the evidence base and benchmarks that inform the chosen metrics.