New Jersey System of Public Research Universities
System Planning Project

Final Report on Principles to Guide Future System-wide Hospital and Health Services

**** Final Draft ****

A White Paper Issued by the
System-wide Hospital Affairs Issues Working Group
of the
Review, Planning, and Implementation Steering Committee

Approved by the
System-wide Hospital Affairs Issues Working Group
October 16, 2003

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EXECUTIVE SUMMARY

In 2002, New Jersey Governor James E. McGreevey created the Commission on Health Science, Education and Training, which recommended the creation of a single New Jersey public research university. Subsequently, a Steering Committee created several subcommittees and working groups to address specific issues related to its planning effort. This White Paper is the report of one of those working groups: the System-wide Hospital Affairs Issues Working Group.

This Working Group was charged by the Steering Committee to develop recommendations for the new system of public research universities concerning four areas. The Working Group conducted its work from late July to mid-October, 2003. In particular, the Working Group focused on developing principles that could be used to guide subsequent planning and implementation actions. The four areas and related principles are summarized as follows:

Charge #1. Academic Affiliation Principles

"Outline System-wide academic affiliation principles to guide relationships and expectations between the medical schools of the three restructured universities and their major affiliated teaching hospitals." As explained in the body of the report, this charge applies to the medical schools' main or major academic affiliations, that is, those that are identified in current UMDNJ policy as the "principal" or "university" affiliations of UMDNJ, as well as "major clinical affiliates" that have a substantial role in teaching with UMDNJ.

Charge #1 Principles

Principle 1.1 Affiliate for academic excellence and fair value: Continuing the current general practice, the medical school of each new regional university should maintain and develop major academic and clinical affiliations with those hospitals that enable the medical school to provide an outstanding educational experience, and receive fair value in sharing the costs of medical education and research. Typically, affiliations may demonstrate several of the following elements:

1.1.1. The medical school will form an affiliation where needed to meet its requirements for an outstanding educational opportunity for its students and faculty.

1.1.2. The medical school will form an affiliation where it can assure that there is a fair exchange of value in sharing the costs of education and training between the school and its affiliate.

1.1.3. The medical school will form an affiliation where its hospital affiliate has a strong reputation for quality and commitment to academic medicine.

Principle 1.2 Observe regions of influence: Continuing the current practice, each medical school of each new regional university should concentrate its major teaching hospital affiliations within a defined geographic region of influence of the surrounding 7 New Jersey counties. The new regional universities should be encouraged to cooperate in continuing these regions of influence for the medical schools. The medical schools of the new regional universities also should be encouraged to cooperate in the event that by sharing a specialized service or program beyond their designated region they significantly can improve their care, expertise or efficiencies.

Principle 1.3 Continue current affiliations: The current affiliations between each regional medical school and its main teaching hospitals should be encouraged to continue wherever such relationships meet the needs of the region's medical school and its teaching hospital affiliate. The formation of the new system of public research universities need not alter the substance of the specific contractual terms between the region's medical school and its main teaching hospitals. The specific contractual terms for each affiliation between a region's medical school and its main teaching hospitals remains the responsibility of that medical school.

Charge #2. **Charity Care**

"Develop a recommended statement to the Newark community on behalf of the new system that articulates University Hospital's commitment to continue its important role of community service and charity care for the greater Newark community."

Charge #2 Principles

Principle 2.1 Continue the commitment: University Hospital should and will continue its commitment to the people of Newark and the surrounding communities, consistent with the spirit of the 1968 Newark Agreements.

Principle 2.2 Support fairness in State charity funding: The State of New Jersey should continue its commitment to support charity care and care for the indigent with adequate funding and a distribution formula that is fair to hospitals in light of their charity and indigent burden.

Principle 2.3 Recognize the burden of charity care for physicians. The State of New Jersey should consider exploring and evaluating options that recognize the financial role of individual faculty physicians of the regional medical schools in providing charity care and care for the indigent, and that reduce the financial burden borne by these faculty.

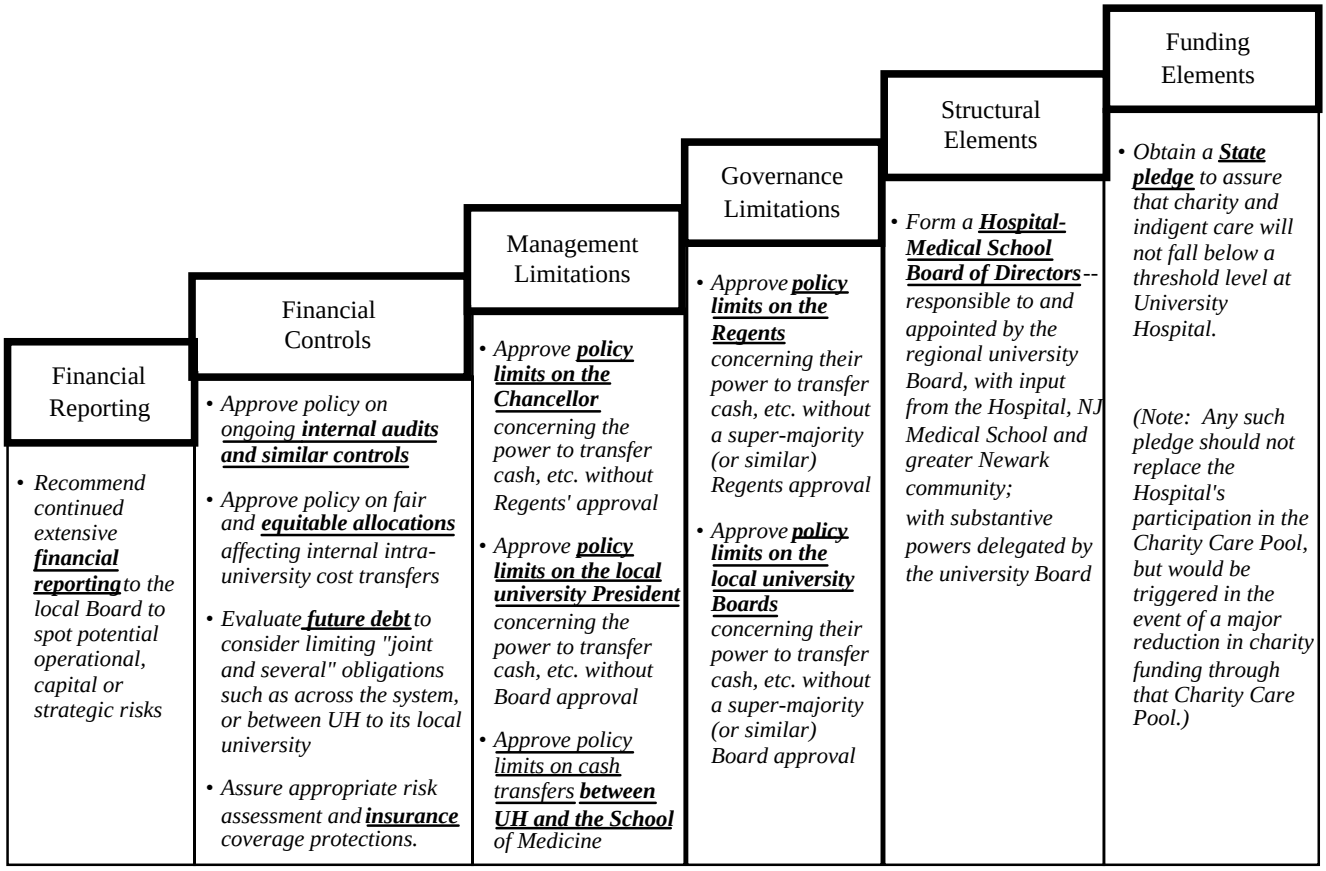
Statement: Consistent with the spirit of the 1968 Newark Agreements, University Hospital will continue its commitment to the people of Newark and the surrounding communities to provide outstanding quality patient care, teaching and research, and to make available educational and employment opportunities. Within New Jersey's new system of public research universities, University Hospital will remain an integral part of the new university in Newark, and thereby remain a State entity. As such, University Hospital also will remain an important channel for the vital funds from the State of New Jersey that support charity and indigent care, and that are essential in enabling University Hospital to maintain its level of charity services. University Hospital is a citizen of the greater Newark community, and is proud of its role and responsibility in contributing to a healthy and strong community.

Charge #3. "**Firewall**"

"Recommend principles for a framework intended to provide protection, to the degree possible, for the system of public research universities, and especially the University of the North, from potential liabilities that might arise from the operations of University Hospital (Newark)."

Charge #3 Principles

Principle 3.1 Apply reciprocal "building block" policies: Achieve financial protection through a series of reciprocal "building block" policies. The new system of research universities should implement a series of policies at several levels to provide financial protection to limit the potential for material and foreseeable financial risks arising in one part of the university from jeopardizing another portion. This principle recognizes that several "building blocks" are needed. These policies are illustrated by the examples in the accompanying chart. These examples should be further reviewed and developed in subsequent stages of implementing the new system of research universities.



Principle 3.2 Promote effective operations: Achieve financial protection while promoting effective operations. The financial firewall protections should promote the effective working relationships among units of the university – especially between the University Hospital and the New Jersey Medical School, operating together under the direction of the Dean of the New Jersey Medical School. In so doing, such firewall protections also protect the academic and safety net mission of the Hospital and New Jersey Medical School.

Principle 3.3 Retain UH within the new north university: University Hospital and the new system of public research universities should achieve the needed financial protections while retaining University Hospital as a State entity within the new north university. University Hospital is a major asset and resource for the Newark region and for the State, and as such, the Hospital should continue to be operated as an entity in service to all the people of the State -- as a State entity. By contrast, University Hospital should neither become a separate corporation, nor an agency or entity of another lower level of civil government in New Jersey.

Charge #4. University Behavioral Health Care

"Recommend a framework to address how University Behavioral Health Care (UBHC) might best operate and serve the people of New Jersey within the new system."

Charge #4 Principles

Principle 4.1 Apply criteria for an excellent academic and clinical enterprise: Select the future organizational framework for UBHC based on criteria for an excellent academic and clinical enterprise in behavioral health. These criteria include the following seven:

4.1.1. Academic commitment: Maintain and expand UBHC's academic commitment and "connectivity" between UBHC and the new system of research universities -- continuing existing UBHC support for teaching and research, expanding it, and developing UBHC linkages to other schools and programs in the university system.

4.1.2. Centralized infrastructure: Capitalize on UBHC's current centralized infrastructure for patient intake and case management, electronic medical records, patient care practices and policies, managed care contracting, marketing, and similar centralized management infrastructure elements.

4.1.3. Patient care quality: Enhance and protect the quality in clinical behavioral health care for New Jerseyans.

4.1.4. State funding for charity and indigent care: Promote the continuation of New Jersey State funding allocations to address needs for charity and indigent behavioral health care.

4.1.5. Recruitment: Maintain and strengthen effective recruitment of faculty and staff for UBHC and the related academic programs.

4.1.6. Financial protections: Provide the ability to have thorough protections of a financial "firewall" to minimize the potential for financial risks arising in UBHC from affecting the system of research universities, or vice versa. For example, the relationship for UBHC with the new system of public research universities should include financial protections through a series of "building block" policies described in the report section on Firewall protections, as adapted to UBHC.

4.1.7. Training: Continue UBHC's role in promoting ongoing training for mental health professionals, especially for those in New Jersey.

Principle 4.2 Respect diverse community interests: Select a reporting relationship for UBHC that respects and balances the interests of various geographic and academic communities served by UBHC. Such interests include assuring access to excellent behavioral health services, allowing input and influence for the clinical and academic direction of UBHC services, and improving coordination among a region's providers of behavioral health care.

Principle 4.3 Develop UBHC's strategic direction: Supplement any decisions about UBHC's organizational framework with thorough strategic planning for UBHC -- in a process that addresses future external trends in behavioral health care and research; opportunities to strengthen UBHC's clinical delivery, service quality and academic program; and approaches to strengthen the financial position of the UBHC clinical and academic enterprise.

With this White Paper the Working Group has completed its charge. Its Chair and members acknowledge the support of the Steering Committee, and also express appreciation to the many people, both members and non-members of the Working Group, who made a generous contribution of their time and talent to make this report possible.

New Jersey System of Public Research Universities
System Planning Project

A Report on Principles to Guide Future System-wide Hospital and Health Services

I. INTRODUCTION

In 2002, New Jersey Governor James E. McGreevey created the Commission on Health Science, Education and Training (the Commission). The Commission recommended the creation of a single New Jersey public research university system that builds on the collective strengths the New Jersey Institute of Technology (NJIT), Rutgers, the State University of New Jersey, and the University of Medicine and Dentistry of New Jersey (UMDNJ). Subsequently, the Governor issued Executive Order 42 establishing a Review, Planning and Implementation Steering Committee (the Steering Committee) to undertake the planning effort for this new public research university system. In 2003 the Steering Committee created several subcommittees and working groups to address specific issues related to its planning effort.

This White Paper is the report of one of those working groups — the System-wide Hospital Affairs Issues Working Group (the Working Group). This Working Group was charged by the Steering Committee to develop recommendations for the new system of public research universities concerning four areas:

1. **Academic Affiliation Principles** – Outline System-wide academic affiliation principles to guide relationships and expectations between the medical schools of the three restructured universities and their major affiliated teaching hospitals.

2. **Charity Care** – Develop a recommended statement to the Newark community on behalf of the new system that articulates University Hospital's commitment to continue its important role of community service and charity care for the greater Newark community.

3. "**Firewall**" – Recommend principles for a framework intended to provide protection, to the degree possible, for the system of public research universities, and especially the University of the North, from potential liabilities that might arise from the operations of University Hospital (Newark).

4. **University Behavioral Health Care** – Recommend a framework to address how University Behavioral Health Care (UBHC) might best operate and serve the people of New Jersey within the new system.

As stated in the charge, this Working Group focused on developing principles that could be used to guide subsequent planning and implementation actions. In keeping with its charge, the effort of this Working Group was particularly qualitative, which was somewhat in contrast to some other working groups whose charge required extensive quantitative analyses. The Working Group conducted its work from late July to mid-October, 2003. Its members and staff conducted interviews, examined selected reports and analyses, contacted other academic medical centers, and met several times as a full Working Group to review and develop possible principles. It also tasked two subcommittees; one addressed the matter of financial protections through "firewall" principles, and the other considered principles to guide how University Behavioral Health Care (UBHC) might be organized and operate within the new system of research universities, together with advantages and disadvantages of various options for doing so.

The members of the Working Group were:

Chair: Russell T. Joffe, MD	Dean	UMDNJ- NJ Medical School

Peter Amenta, MD	Chief of Staff	Robert Wood Johnson University Hospital
Christopher J. Barone, DO	Vice President - Chief Medical Officer	Kennedy Health System
Carolyn E. Bekes, MD	Executive Vice President, Medical Affairs	The Cooper Health System
William Black, MD	Senior Vice President - Medical Affairs	Hackensack University Medical Center
Joel Cantor, ScD	Director, Center for State Health Policy	Institute for Health Care Policy and Aging Research, Rutgers
R Michael Gallagher, DO	Dean	UMDNJ-School of Osteopathic Medicine
Mahmud Hassan, PhD	Professor, Department of Finance and Economics	Rutgers
Adam Henick	Vice President, Ambulatory Care	UMDNJ-University Hospital
William C. Hunter, PhD	Chair, Biomedical Engineering	NJIT
Karen Kavanagh	Executive Vice President for Administrative Affairs	Rutgers
James Lawler	CFO	UMDNJ- University Hospital
Mary Mathis-Ford	Chairperson	Board of Concerned Citizens

Harold L. Paz, MD	Dean	Robert Wood Johnson Medical School
Suresh Raina, MD	Chief Medical Officer	UMDNJ- University Hospital
David Roe	Associate Dean and CFO/Office of the Dean	UMDNJ-NJ Medical School
Gary Rosenberg, MD	Medical Director, Child and Adolescent Services	University Behavioral Health Care
Alan Weinkrantz	CFO	University Behavioral Health Care

The remainder of this report explains the perspectives and principles for each area considered by this Working Group.

II. CHARGE #1. PRINCIPLES FOR ACADEMIC AFFILIATIONS

In this section of the White Paper the Working Group addresses its first charge as outlined by the Steering Committee: **Academic Affiliation Principles** – "Outline System-wide academic affiliation principles to guide relationships and expectations between the medical schools of the three restructured universities and their major affiliated teaching hospitals." For this charge, the Working Group developed three principles (listed below as 1.1, 1.2, and 1.3). It is useful to note that UMDNJ policy outlines four levels of hospital affiliations, termed "principal", "university", "major clinical affiliates", and "clinical affiliates". The levels of "principal" and "university" affiliate entail substantial academic alignment, as shown by the policy requirements for these levels, such as that the affiliated hospital must have significant representation on its governing board from UMDNJ, and that its chiefs of service generally must be UMDNJ departmental chairs or approved by a UMDNJ Dean. Major clinical affiliates may also have an important role in teaching. For this charge and this report, the terms "main" or "major" teaching affiliate refers to the "principal" or "university" affiliations of UMDNJ, as well as "major clinical affiliates" that have a substantial role in teaching with UMDNJ.

PERSPECTIVE AND PRINCIPLE #1.1

Affiliations between medical schools and teaching hospitals are vital to meeting the mission of the medical school, to providing clinical care, together with teaching and research opportunities. As such, the specific terms of any affiliation agreement may share broad principles in common with many other affiliation agreements. Affiliations also reflect the specific needs and interests of the parties. In this way, the contractual terms of an affiliation are very specific to the individual parties.

To recognize these factors, members of the Working Group sought to develop a principle that struck an appropriate balance to recognize broad principles that could apply on a State-wide basis across all the medical schools of the new systems of research universities, while not becoming intrusive into the specific relationships that are the responsibility of each medical school.

This balance is stated in Principle 1.1. This principle states core reasons in forming and maintaining successful affiliations. As such, it is a principle that has system-wide applicability to the medical schools of the new system of public research universities.

Principle 1.1 Affiliate for academic excellence and fair value: Continuing the current general practice, the medical school of each new regional university should maintain and develop major academic and clinical affiliations with those hospitals that enable the medical school to provide an outstanding educational experience, and receive fair value in sharing the costs of medical education and research. Typically, affiliations may demonstrate several of the following elements:

1.1.1. The medical school will form an affiliation where needed to meet its requirements for an outstanding educational opportunity for its students and faculty.

1.1.2. The medical school will form an affiliation where it can assure that there is a fair exchange of value in sharing the costs of education and training between the school and its affiliate.

1.1.3. The medical school will form an affiliation where its hospital affiliate has a strong reputation for quality and commitment to academic medicine.

PERSPECTIVE AND PRINCIPLE #1.2

As a second perspective, members of the Working Group recognized that a past practice had served the medical schools well in forming their teaching hospital affiliations – namely, that the schools had formed their major teaching affiliations with hospitals located within the geographic region near and surrounding the medical school. Specifically, each medical school has had a region of influence for such affiliations of 7 surrounding counties. Continuing this practice also appears consistent with the direction and developing structure of the new system of public research universities.

Notwithstanding such regions of influence, from time to time specific circumstances have arisen in which affiliations have been formed beyond the 7-county regions. Such circumstance do not relate to forming the major teaching hospital affiliation. Rather, they arise when the affiliate institution can offer uniquely specialized capabilities or services for the medical school, and typically these involve a program or service available from that affiliate. For such specialized services, the same affiliate could even have relationships with several of the New Jersey medical schools. Such relationships can be very beneficial to the schools and their academic mission, and the new research universities and their medical schools should not use regions of influence to pose a barrier to such worthwhile affiliations.

This concept for regions of influence is stated in Principle 1.2.

Principle 1.2 Observe regions of influence: Continuing the current practice, each medical school of each new regional university should concentrate its major teaching hospital affiliations within a defined geographic region of influence of the surrounding 7 New Jersey counties. The new regional universities should be encouraged to cooperate in continuing these regions of influence for the medical schools. The medical schools of the new regional universities also should be encouraged to cooperate in the event that by sharing a specialized service or program beyond their designated region they significantly can improve their care, expertise or efficiencies.

PERSPECTIVE AND PRINCIPLE #1.3

As the third academic affiliation perspective, members of the Working Group recognized that current affiliations are the responsibility of the individual medical schools. The current affiliations of UMDNJ have been guided and defined by UMDNJ policy, in "Criteria and Procedures for Designation of a Hospital or Other Health Care Facility …" Those organizations currently designated as "principal hospitals of a UMDNJ academic health center" are for New Jersey Medical School – UMDNJ-University Hospital; and for Robert Wood Johnson Medical School – The Cooper Health System, and Robert Wood Johnson University Hospital. The level of affiliation termed "university hospital of UMDNJ" includes the following: for New Jersey Medical School – Hackensack University Medical Center; for Robert Wood Johnson Medical School – Meridian Hospitals Corporation/Jersey Shore University Medical Center, St. Peter's University Hospital, and the University Medical Center at Princeton; and for the School of Osteopathic Medicine – Kennedy Memorial Hospitals-University Medical Center. The remaining level of affiliation relevant to this charge is "major clinical affiliate of UMDNJ" and includes: for New Jersey Medical School – Department of Veterans Affairs, New Jersey Health Care System-East Orange, and Kessler Institute of Rehabilitation; for Robert Wood Johnson Medical School – Raritan Bay Health Services Corporation/Raritan Bay Medical Center, and Somerset Medical Center; and for the School of Osteopathic Medicine – Our Lady of Lourdes Medical Center.

Further, members of the Working Group believed that forming the new system of research universities should not disrupt those relationships that are beneficial. Accordingly, appropriate current affiliations should remain in place, and any changes to

such remain the responsibility of the individual medical schools. This perspective is articulated in Principle 1.3, which again has system-wide applicability.

Principle 1.3 Continue current affiliations: The current affiliations between each regional medical school and its main teaching hospitals should be encouraged to continue wherever such relationships meet the needs of the region's medical school and its teaching hospital affiliate. The formation of the new system of public research universities need not alter the substance of the specific contractual terms between the region's medical school and its main teaching hospitals. The specific contractual terms for each affiliation between a region's medical school and its main teaching hospitals remains the responsibility of that medical school.

III. CHARGE #2. PRINCIPLES FOR CHARITY CARE

In this section of the White Paper the Working Group addresses its second charge as outlined by the Steering Committee: **Charity Care** – "Develop a recommended statement to the Newark community on behalf of the new system that articulates University Hospital's commitment to continue its important role of community service and charity care for the greater Newark community."

This charge was specifically focused on University Hospital and the community it serves. For this charge, the Working Group developed three principles (listed below as 2.1, 2.2, and 2.3) and the statement of commitment.

PERSPECTIVE AND PRINCIPLE #2.1

In 1968 agreements were reached between the City and people of Newark and the New Jersey College of Medicine and Dentistry, the predecessor institution of UMDNJ (the University). These agreements, variously known as the Newark Accord or the Newark Agreements, represent a significant commitment between the University (and by extension, University Hospital and the State of New Jersey) and the community of Newark and the surrounding communities. In summary, in exchange for Newark granting to the University the Newark City Hospital and property for what would become University Hospital, the University expressed several commitments to area residents, including to provide access to health care, access to employment, and access to education and training. By the early 1970's, the University sponsored the formation of a community group, known as The Board of Concerned Citizens, as an organization to work cooperatively with the University and area residents and health employees to promote responsiveness to the Agreements and to the health needs of the community.

The members of the Working Group recognize and appreciate the importance of, and depth of emotion related to, the Newark Agreements and the ongoing commitments of UMDNJ to those Agreements. They further do not believe that the restructuring efforts to form a new system of public research universities should affect, nor need have any impact on, those Agreements.

In light of these commitments, the Working Group endorsed the following principle:

Principle 2.1 Continue the commitment: University Hospital should and will continue its commitment to the people of Newark and the surrounding communities, consistent with the spirit of the 1968 Newark Agreements.

PERSPECTIVE AND PRINCIPLE #2.2

Notwithstanding this commitment, the members of the Working Group recognize that factors beyond the control of University Hospital could impact its capability to continue its services at levels comparable to those at present. In particular, an oft-cited risk to continuing University Hospital's level of services is the prospect of substantially reduced State funding for charity care.

The State of New Jersey provides funding for charity care through the Charity Pool and a distribution formula that allocates the pool-funds to hospitals in New Jersey. For many hospitals across the State, this funding is essential to supporting their mission. This is especially true for University Hospital. It provides approximately 70% of the charity care in Newark[1], and charity care and hospital relief subsidies have accounted for approximately 20% of net patient service revenue for University Hospital in recent years[2]. In its report, The New Jersey Commission on Health Science, Education, and Training noted that such funding for University Hospital could conceivably decline in the event of State fiscal difficulties, or an increase in documented charity from other hospitals participating in the Charity Pool [3].

In addition to the impact on University Hospital, members of the Working Group expressed concern that a reduction in Charity Pool funding would be detrimental to other hospitals, particularly academic health centers, such as those now aligned with UMDNJ. These centers often provide more sophisticated and expensive services that attract patients from a wide geography, regardless of the patient's ability to pay; this can place a particular burden on academic centers and their faculty.

With these factors in mind, the Working Group endorsed the following principle.

Principle 2.2 Support fairness in State charity funding: The State of New Jersey should continue its commitment to support charity care and care for the indigent with adequate funding and a distribution formula that is fair to hospitals in light of their charity and indigent burden.

[1] See The New Jersey Commission on Health Science, Education, and Training; page 98.
[2] See The New Jersey Commission on Health Science, Education, and Training; page 96.
[3] See The New Jersey Commission on Health Science, Education, and Training; pages 96 and 97.

PERSPECTIVE AND PRINCIPLE #2.3

While recognizing that the Working Group charge was focused on University Hospital, the members also acknowledged that the burden of charity and indigent care also falls on clinical physicians of the faculty -- there is no Charity Pool for physicians. Retaining superior faculty is essential to maintaining services of the academic health centers, including their charity care and other community services. To help prevent an erosion of services from academic health centers, the Working Group members believed it will become important to explore options to address the charity and indigent care concerns of physician faculty. As such, they felt it was appropriate to express the following principle:

Principle 2.3 Recognize the burden of charity care for physicians. The State of New Jersey should consider exploring and evaluating options that recognize the financial role of individual faculty physicians of the regional medical schools in providing charity care and care for the indigent, and that reduce the financial burden borne by these faculty.

Finally, this charge specifically called for the Working Group to propose a statement of commitment concerning University Hospital. The following is that statement specific to University Hospital. It should be noted, and should be clear from the preceding three principles, that the Working Group also believes the issues of charity and indigent care are important to all the medical schools of UMDNJ, to their faculty, to their affiliated major teaching hospitals, and to the communities they serve.

Statement: Consistent with the spirit of the 1968 Newark Agreements, University Hospital will continue its commitment to the people of Newark and the surrounding communities to provide outstanding quality patient care, teaching and research, and to make available educational and employment opportunities. Within New Jersey's new system of public research universities, University Hospital will remain an integral part of the new university in Newark, and thereby remain a State entity. As such, University Hospital also will remain an important channel for the vital funds from the State of New Jersey that support charity and indigent care, and that are essential in enabling University Hospital to maintain its level of charity services. University Hospital is a citizen of the greater Newark community, and is proud of its role and responsibility in contributing to a healthy and strong community.

IV. CHARGE #3. PRINCIPLES FOR FINANCIAL "FIREWALL" PROTECTIONS

The third charge to the Working Group concerned potential financial risks, as follows: "**Firewall**" – "Recommend principles for a framework intended to provide protection, to the degree possible, for the system of public research universities, and especially the University of the North, from potential liabilities that might arise from the operations of University Hospital (Newark)."

As with the previous charge, this charge was specifically focused on University Hospital, especially in its relationship to the new north campus university.

The Working Group endorsed the recommendations of its Subcommittee for this charge. Those recommendations provide three principles (listed at the close of this section as 3.1, 3.2, and 3.3) which include a framework of policy "building blocks". To develop these, the Subcommittee prepared a report, which is reproduced in this White Paper section.

CHARGE, ISSUES AND CONSTRAINTS -- DEVELOP & RECOMMEND PRINCIPLES

The charge of the Firewall Subcommittee was to recommend principles for a framework intended to provide protection to the degree possible for the system of public research universities, and especially for the University of the North-Campus, from potential liabilities that might arise from the operations of University Hospital (Newark). This was the charge assigned to the System-wide Hospital Affairs Issues Working Group by the overall Steering Committee. The Subcommittee also recognized the reciprocity in its charge, that is, to provide protection for University Hospital from potential liabilities arising elsewhere in the new system of universities.

The following issues needed to be addressed in the principles proposed by the Subcommittee.

- Protection "both ways": Protection needs to apply for the Universities from University Hospital (UH), and for UH from the Universities.

- Protection for financial risks: This firewall is for *financial* exposure (not for information security, etc.)

- Protection for the material and foreseeable: Clearly there may be risks that could be highly improbable, immaterial or not even foreseeable, and this firewall is not intended for such. This firewall should protect for known risks experienced elsewhere, or for risks seen at UH in the past, or for risks which could reasonably be foreseen as part of a future scenario for UH or the new system of universities.

- Protection for different types of financial risk: There are several types of financial risk -- including State or institutional budgetary shortfalls, failure to comply with bond covenants, major malpractice awards, catastrophic loss … A firewall can include various "building blocks" to address these different types of risk with different types of protection. In concept, a few "blocks" may offer some level of protection, and *more* blocks may afford *more* protection.

- Protection without separation: *First*, the need for financial protections cannot hinder effective working relationships between the University Hospital and the Medical School, and the university. In particular, the University Hospital and the School of Medicine need to operate in a close, synergistic manner under the direction of the

Dean. As such, a "firewall" cannot cause a separation between these components of the university. *Second*, University Hospital is a major clinical and financial resource of the Newark community and of the State, and as such, University Hospital should remain a State entity.

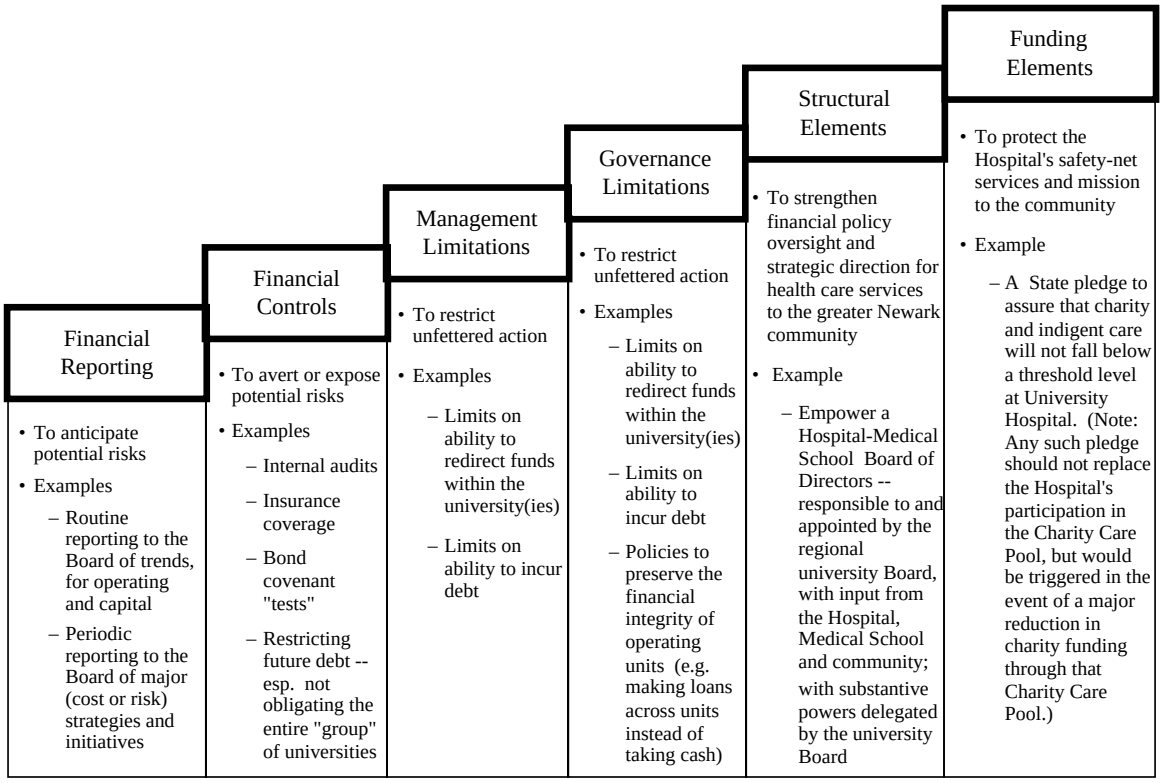
- As yet undetermined structure of the new system of research universities: The overall system-of-universities structure may not be decided until after this Subcommittee completes its work, so its principles must be flexible to accommodate uncertainty about the overall structure of the system.

- Consistent with the powers of the Chancellor: Powers for the Chancellor have been defined on a preliminary basis. This Subcommittee may suggest refinements to these powers not inconsistent with this preliminary statement of powers.

- No separate incorporation for UH: The option of separate incorporation has been considered as one possible component of firewall protection by other academic medical centers elsewhere in the country. For reasons discussed later in this document, for this Subcommittee this option has not been deemed appropriate to consider for University Hospital.

A "FRAMEWORK" TO CONSIDER IN FORMING FIREWALL PRINCIPLES

The following illustration suggests examples of elements for a comprehensive firewall framework with six major "building blocks". It includes a set of firewall "building blocks" that address differing types of protection spanning various levels of an organization.



WORK STEPS, AND FINDINGS

The Subcommittee performed the following work steps:

- Interviewed representatives within the new system of research universities
  - Firewall subcommittee members
  - Representatives of the Commission Steering Committee
  - Selected others at UMDNJ familiar with UH and University financial matters
- Reviewed literature
  - Contacted AAMC and University Hospital Consortium for firewall information
  - Conducted Internet literature search
- Interviewed representatives of selected academic medical schools
- Performed high-level review of University Hospital and UMDNJ financial patterns and policies to assess the materiality for potential risks

FINDINGS RELATED TO THE NEW SYSTEM OF NEW JERSEY RESEARCH UNIVERSITIES

Legal structure of the new system of New Jersey research universities

- As noted, based on interviews with representatives of the Commission staff and Steering Committee, the legal structure for the new system of research universities is not yet determined -- such as whether the universities will be arms of the State government, or separate corporations, or other. Moreover, related to the legal structure for University Hospital, these representatives and the Chair of the Working Group believe that discussion of any separate corporate entity for UH is not appropriate for the Subcommittee or the Working Group. In part, this reflects both the perspectives articulated in the Governor's Commission Report of 2002, and the often-daunting technical and logistical complexities and costs associated with separating a university hospital from its institution.
- *Implication for the Subcommittee*: Firewall principles recommended cannot be dependant on legal structural changes requiring a separate corporate entity for University Hospital, and no such separate structure will be recommended for University Hospital. Accordingly, the financial protections in a firewall will be based on policies -- of the State, of the new system of research universities, and of the regional/local universities. (However, these policies need not be codified as State statutes.)

Powers of the Regents and Chancellor

- Based on current draft materials and interviews with representatives of the Commission staff and Steering Committee, as currently outlined the powers of the

Chancellor and Regents, could be broad. Although current draft documents advocate "largely autonomous public research universities", and indicate the Chancellor's Office would be strategic "rather than operational", the phrasing could allow a range of interpretations in which either the Regents or Chancellor could have authority to transfer cash among universities.

- *Implication for the Subcommittee*: Firewall principles recommended could suggest types of limitations on powers of the Regents and Chancellor that could limit the autonomy of a Chancellor or Regents in transferring cash from part of the new system, or obligating part of the system, to meet the financial needs elsewhere in the system -- i.e., breaching a firewall. For example, there could be system-wide limits:

  - Limits on the absolute dollar amounts of any such transfers, possibly including a total restriction, without the express approval of the affected university executives, such as a President, or the President of University Hospital.
  - Requirements for a super-majority approval by the Regents for cash transfer amounts in excess of a dollar-limit.

University Hospital's reporting relationship

- Based on current draft materials and interviews with representatives of the Commission staff and Steering Committee, as currently outlined the powers of the individual university Boards and Presidents also could be broad, with full responsibility for financial affairs at their respective university. In that context, it appears a local university President could have the authority to transfer cash in or out of the university's units to meet needs elsewhere within that local university -- again breaching a firewall.

- Also, the reporting relationship for University Hospital will be similar to its present one -- with the Hospital and its President reporting to the Dean of the Medical School, as specified in the Commission's Report. This view has been stressed in the Governor's Commission Report, and is widely viewed in interviews as essential to the continuity of academic and safety net mission and the effective operation of University Hospital and the Medical School.

- *Implications for the Subcommittee*

  First, firewall operating policies could suggest types of limitations on powers of the local Boards and Presidents -- particularly for the Newark campus -- that could limit the likelihood of transferring cash from part of the university to another part without specified approvals. Similar to the previous system-wide examples, there could be local university limits:

  - Limits on the absolute dollar amounts of any such transfers, possibly including a total restriction, without the express approval of the affected university executives, such as the Dean within a School, or the President of University Hospital.

- Requirements for the local Board to secure a super-majority approval for cash transfer amounts in excess of a dollar-limit.

Second, firewall policies could require (continued) financial policies and controls over UH and the local university to assure routine internal audits, and similar controls.

Third, in order to reduce the potential for *surprise* financial developments, firewall policies could require (continued) financial reporting by UH to the local university President and Board.

Fourth, to strengthen *financial policy* oversight and *strategic direction* for health care services to the greater Newark community, the regional university could empower a Hospital-Medical School Board reporting to the university Board. Such a board would have the expertise and focus to guide an academic medical center under the Dean's leadership, to give attention to the strategic direction of UH, to build this asset of the State and to reduce the potential for financial risks.

Fifth, the reporting relationship for University Hospital will continue -- reporting to the Dean of the Medical School, and the reporting relationship of Medical School Faculty need not and would not be altered by firewall financial protections.

FINDINGS RELATED TO THE FIREWALL AT UNIVERSITY HOSPITAL WITHIN UMDNJ

Potential UH-related firewall considerations

- Operating risks and potential benefits include the following:
  - In the 1990s University Hospital incurred operating losses in some years. More recently University Hospital has strengthened its financial position. Future risks or losses could arise from potential changes in payer mix and/or reimbursement rates, or in reduced State support.
    - » For example, it is widely acknowledged that one of the most material potential financial risks that conceivably might arise for University Hospital would be the significant reduction of State funding for charity care.
    - » Such might occur in the event of an adverse change in the State Charity Care Pool funding formula, or in the event of a drastic State-wide cut in available funds for charity support.

    Such financial risks -- or surpluses -- could amount to several millions of dollars. (Quantifying such risks depends on extensive financial modeling and assumptions and is beyond the assigned scope of the Subcommittee.)

- As just noted, the new local university may also face operating financial risks. At present these have not been identified; conceivably losses could arise from expensive new programs, tuition shortfalls, reduction in State support, and the like. Such risks also could amount to several millions of dollars.

- *Implications for the Subcommittee*: First, essential to minimizing such operating risks are routine reporting of forecasted financial trends, and rapid implementation of preventive measures. Depending on specific circumstances, UH either may be a source of risk to the remaining university, or a substantial asset to the university, as well as to the communities it serves. Second, since some risks could arise from State actions outside the control of the university or Hospital, financial protections should include a pledge from the State to provide a threshold level of charity care through University Hospital to the greater Newark community. For example, such funding could be triggered in the event the State substantially were to reduce other charity care funding to the Hospital from the Charity Care Pool.

- Insurance-related risks of University Hospital and UMDNJ

  - Regarding malpractice, liability and other insurable catastrophic loss, UH and UMDNJ maintain insurance and follow practices that limit their exposure, such as to malpractice claims. For example, reportedly for medical malpractice, University Hospital is self-insured and has coverage through a State of New Jersey trust fund, and the State bears final responsibility to cover claims if in excess of the trust fund amounts. Or as another example, UMDNJ conducts periodical analyses of potential claims.

  - *Implication for the Subcommittee*: Essential to minimizing such insurance-related risks are regular insurance risk assessments and updating of coverage levels.

- Bond-related matters

  - The inability of an entity to comply with its debt covenants can jeopardize outstanding debt, or increase the cost of debt. Given that University Hospital will remain a part of the university, then the Hospital cannot be entirely separated from the financial obligation for the university as a whole. Accordingly, losses by either the Hospital or by other academic units of the university conceivably could impair compliance with the debt covenants. On the other hand, surpluses in one portion of the university can benefit other portions of the university. Also, the debt capacity of University Hospital can benefit the rest of the university, and vice versa. In this regard, it is worth noting that currently the Hospital has no outstanding long-term debt.

  - *Implication for the Subcommittee*: Essential to minimizing such debt covenant risks are maintaining financial performance required by debt covenants. Also, even though reducing exposure from losses incurred by one part of the university

to debt covenants may be unlikely, it may be useful in the future to explore possibilities to reduce such exposure.

Past examples of redirecting funds within or affecting UMDNJ

- Within UMDNJ there reportedly has been some concern of redirecting funds from one part of the university to meet needs elsewhere in the university. In addition, there is recent history in which the State of New Jersey has re-allocated funds from the State malpractice insurance trust fund to meet other State budget needs.

- *Implication for the Subcommittee*: Principles could include limitations on the ability to transfer cash unilaterally, as suggested earlier, such as limits on the authority of the President for the new local university, and of the Chancellor of the system.

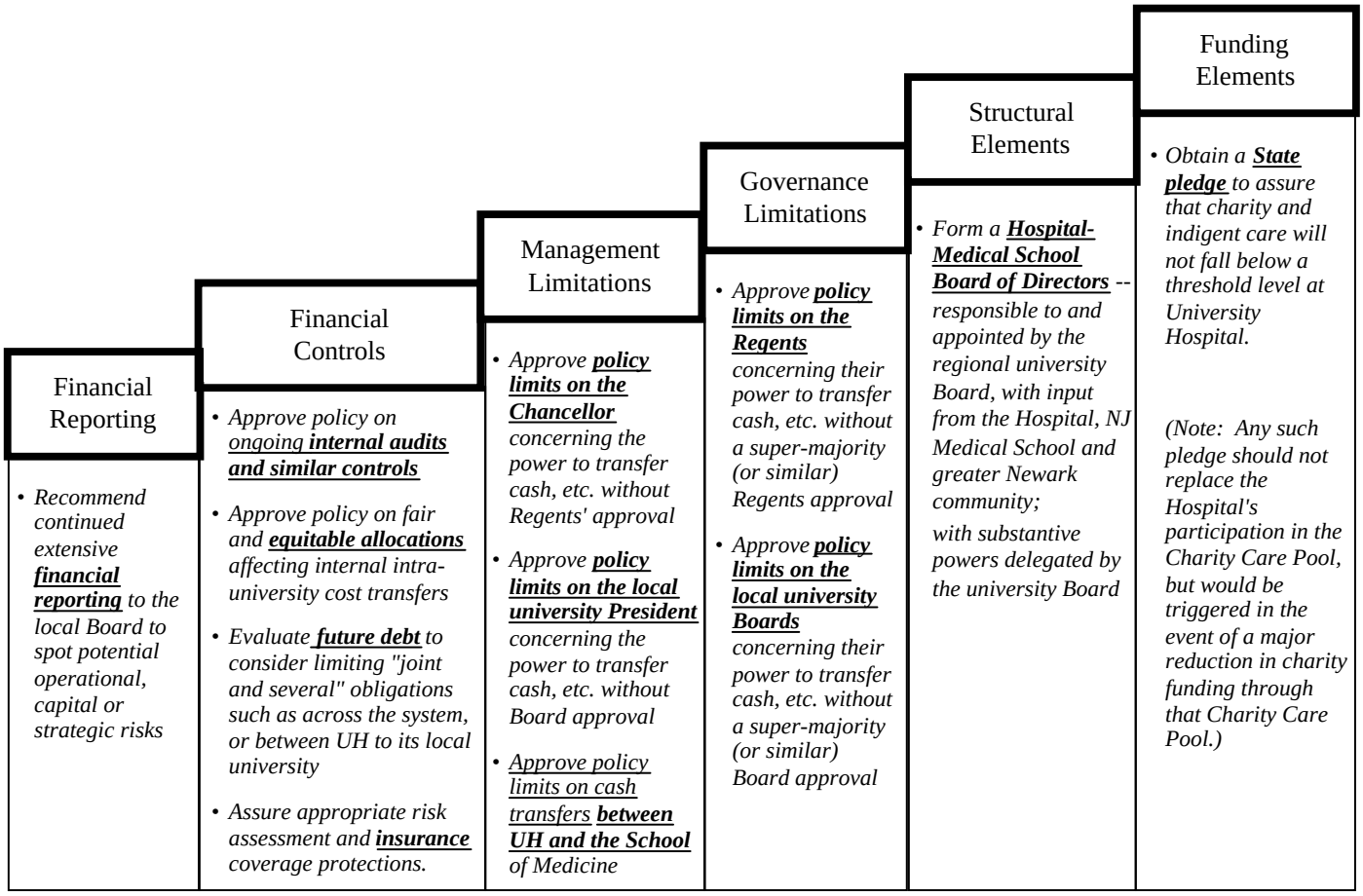
Summary -- The experience at UMDNJ supports implementing a series of policies for firewall controls and limitations

- Firewall principles should include *operating policies* and procedures for routine reporting of forecasted financial trends, and measures to assure rapid implementation of preventive actions, *insurance-related measures* for regular insurance risk assessments and updating of coverage levels with thorough backing for catastrophic loss (such as from reinsurance or the State), and *debt covenant measures* to maintain compliance with debt covenants.

- In addition, as noted earlier, the *powers of the new local university President (and Board)* should include limitations on their ability to transfer cash either to or from University Hospital, or to incur debt obligations that involve the Hospital's assets or revenue streams.

- Finally, firewall principles should acknowledge the important academic and safety net mission of University Hospital to its community, and that while there may be a potential for financial risk from University Hospital to other parts of the university, so also there is the potential for UH to be a significant asset and strength to the university.

The following diagram is a summary of policy implications affecting firewall options, suggesting possible policies to be developed in a later stage of implementation planning for the new system of research universities.



FINDINGS RELATED TO THE FIREWALL EXAMPLES AT OTHER ACADEMIC MEDICAL CENTERS

The firewall experience of other academic medical centers was considered by the Subcommittee. Interviewees from other academic medical centers and data available suggested that a number of other academic centers have considered the issue of separating their respective hospitals from their universities, such as into a separate non-profit corporation; in some cases the university has restructured its hospital in this manner, while in other cases the university has chosen not to restructure the hospital. Generally speaking, many such deliberations arose due to concerns about major financial losses or unsupportable debt obligations.

Interviewees and reviewed literature stated that financial firewall protection might be enhanced through such a separate corporation approach, since the separate corporate entity provided for legally-enforceable arms-length transactions and controls to minimize firewall breaches. Nonetheless, the findings also indicate that:

- First, the "corporate veil" may be "pierced" -- that is, separate corporate structure in

itself is not a perfect protection; the barrier of the separate corporation can be breached in some situations.

- Second, in spite of the potential firewall benefits of a separate corporate structure, some academic medical centers have remained a single legal entity due to the costs or risks of such action. In part such decisions reflected:
  - The desire for a *unified mission and direction*, which can be compromised when a portion of the university is separately incorporated.
  - The *restrictions of existing debt* (that obligated the assets of both the hospital and the reminder of the university) made separation impractical if not impossible.
  - The "*mechanical" complexity of incorporation*, potentially re-writing hundreds of contracts and leases pertaining to managed care, to property, to equipment, to physician/Faculty appointments, and so on.
- Third, changing circumstances can call for reassessing alternatives. As the internal or external factors that led some academic centers to consider restructuring changed over time, some centers found they needed to reassess their alternatives on restructuring in light of those changes.

Implication for the Subcommittee: Separate incorporation entails possible benefits and significant costs. In the absence of separately incorporating the hospital -- an option *not* available for University Hospital, the interviewees noted that thorough financial reporting and forecasting, and trust in the university leadership were important elements for financial protection.

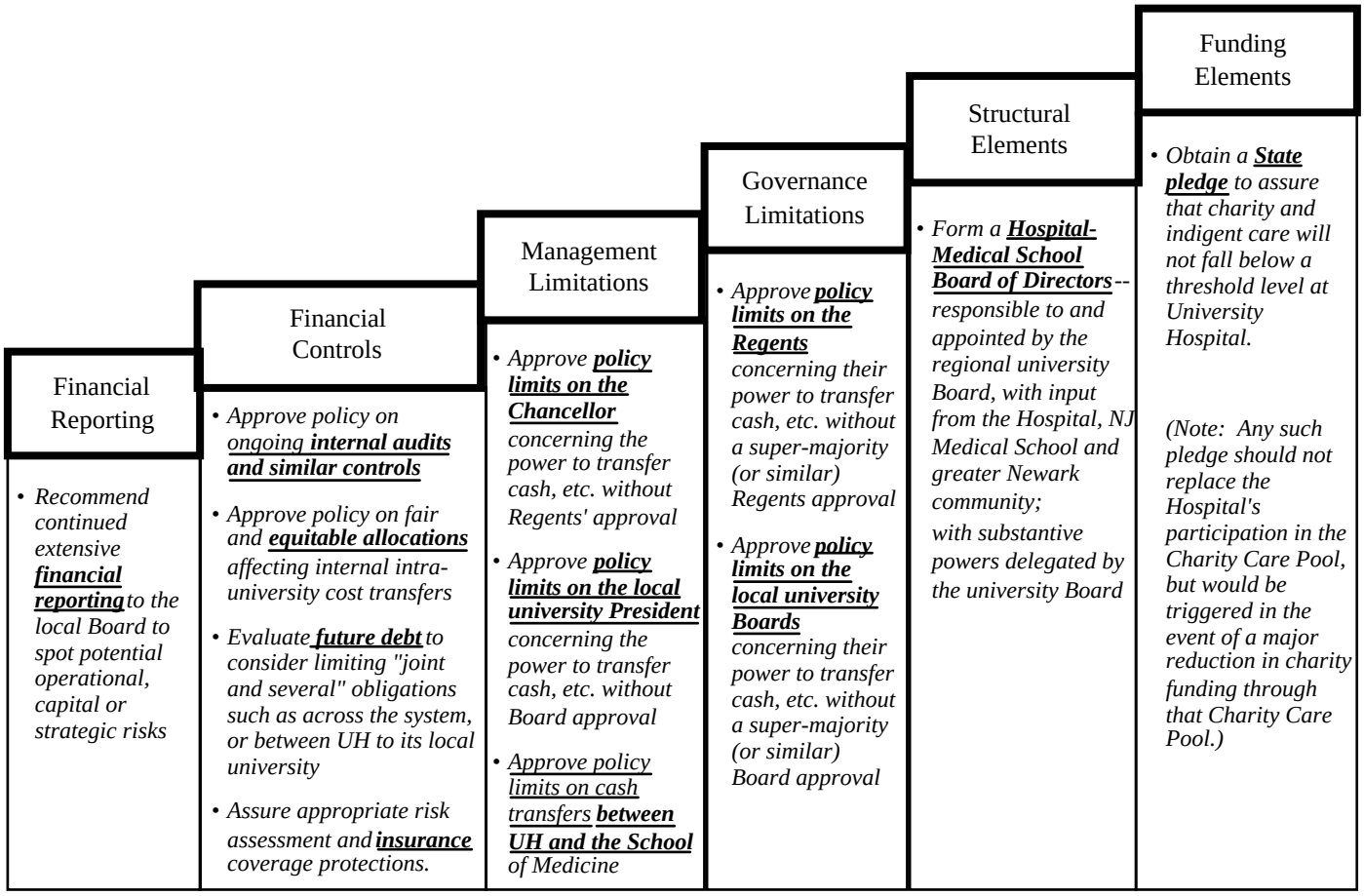
RECOMMENDED "FIREWALL" PRINCIPLES

The following points summarize the principles recommended by the Subcommittee.

Principle 3.1 Protection through a series of reciprocal "building block" policies: The overarching principle is that the new system of research universities should implement a series of policies at several levels to provide financial firewall protection -- that is, to limit the potential for material and foreseeable financial risks arising in one part of the university from jeopardizing another portion. This principle recognizes the following:

- First, no single policy on its own is likely to form a substantial firewall barrier; several "building blocks" are needed.
- Second, no firewall is impenetrable; nonetheless, reasonable and thorough policies can reduce risk.

These "building block" policies are illustrated by the examples in the accompanying chart. They should be further reviewed and developed in subsequent stages of implementing the new system of research universities.



Principle 3.2 Protection while promoting effective operations: The financial firewall protections should promote the effective working relationships between the University Hospital and the New Jersey Medical School, together under the direction of the Dean of the New Jersey Medical School. In so doing, they also protect the academic and safety net mission of the Hospital and New Jersey Medical School.

Principle 3.3 Protection while retaining University Hospital within the new north university as a State entity: University Hospital and the new system of research universities should achieve the needed financial protections while retaining University Hospital within the new north university. University Hospital is a major asset and resource for the Newark region and for the State, and as such, the Hospital should continue to be operated as an entity in service to all the people of the State -- as a State entity. By contrast, University Hospital should neither become a separate corporation, nor an agency or entity of another lower level of civil government in New Jersey.

"Firewall" Subcommittee Members

Russell T. Joffe, MD Ex officio	Dean	UMDNJ-NJ Medical School
Chair: David Roe	Associate Dean and CFO/Office of the Dean	UMDNJ-NJ Medical School

Karen Kavanagh	Executive Vice President for Administrative Affairs	Rutgers
Vivian Sanks-King, Esq.	VP, Legal Management	UMDNJ
James Lawler	CFO	UMDNJ-University Hospital
Mary Mathis-Ford	Chairperson	Board of Concerned Citizens
Sidney E. Mitchell, FACHE	President & CEO	UMDNJ-University Hospital

V. CHARGE #4. PRINCIPLES FOR A FUTURE FRAMEWORK FOR ORGANIZING AND OPERATING UNIVERSITY BEHAVIORAL HEALTH CARE

In this section, the Working Group addresses its last charge: **University Behavioral Health Care** – "Recommend a framework to address how University Behavioral Health Care (UBHC) might best operate and serve the people of New Jersey within the new system."

As part of the extensive process to plan for a new statewide system of research universities in New Jersey, the potential future relationship of UBHC to this new system was considered by the UBHC Subcommittee of the System-wide Hospital Affairs Issues Working Group. The UBHC Subcommittee (listed later in this section) was appointed by the Chair of the System-wide Hospital Affairs Issues Working Group. The Subcommittee included members knowledgeable in the management and operations of UBHC, in the academic services of UBHC, in the related academic departments of the New Jersey Medical School (NJMS), the Robert Wood Johnson Medical School (RWJMS), and the School of Osteopathic Medicine (SOM), as well as others familiar with planning and public policy (in this case, from Rutgers University). Members of the Subcommittee collected and summarized data on UBHC in mid-August, and the Subcommittee met in August and September, 2003.

The Working Group endorsed the recommendations of its Subcommittee for this charge. As in the prior section, the report of the Subcommittee was reproduced for this section of the White Paper. The Subcommittee's recommendations provide three principles (listed in this section as 4.1, 4.2, and 4.3). The Subcommittee also compared various organizational reporting relationships for UBHC, which appear in diagrams within this

section. The advantages and disadvantages of each were summarized by the Subcommittee (and due to their detailed nature were not included in this White Paper).

While many options were considered, the Subcommittee also faced several issues that were difficult to reconcile, and that made selecting a preferred option impossible at this time. Accordingly, it should be noted that the Subcommittee and Working Group did not select a preferred option for how UBHC might "best operate and serve the people of New Jersey."

PERSPECTIVE AND OPTIONS

University Behavioral Health Care (UBHC) is the behavioral health care enterprise of the University of Medicine and Dentistry of New Jersey (UMDNJ), providing clinical services as well as teaching and research in settings across New Jersey. To help the work of the Subcommittee, UBHC provided information to profile its history and services. A summary of that profile follows.

UBHC's history began in 1967 with the authorization under NJ Public Law 30:4-177.19a to establish a demonstration community mental health center in Piscataway. In 1969 another center was authorized in Newark under the direction of the College of Medicine and Dentistry of New Jersey. Both centers provided five core services – inpatient, outpatient, partial hospitalization, emergency services, and consultation and education. Both were funded almost entirely by state and federal grants. In 1986 the two centers were merged under the direction of UMDNJ.

As UBHC has developed, it has expanded its range of services. These now include training and research initiatives, such as the Behavioral Research and Training Institute and a major venture with Eli Lilly for National Psychoeducational Training, funding for faculty and residents and internships in the departments of psychiatry at New Jersey Medical School and the Robert Wood Johnson Medical School, school-based mental health programs, addictions programs, geriatric programs, employee assistance programs, and a police program – the Cop2Cop hotline. Staff of UBHC and faculty of UMDNJ collaborate on numerous academic research initiatives and publications. UBHC also has developed an extensive centralized infrastructure to support its services and programs. This infrastructure includes information systems for financial reporting, and an electronic medical record for patient management; standardized protocols for patient intake, case management and follow-up; and marketing for statewide managed care contracts.

Currently, UBHC treats about 25,000 individuals a year; in FY2003 UBHC recorded over 14,000 inpatient days, over 2,500 emergency visits, and about 250,000 outpatient visits, partial hospitalizations and residential days. In FY2003 UBHC reported revenue over $77 million, which included over $18 million of State appropriations. Approximately 30% of the revenues are attributable to UBHC's Newark region, and 70% are attributable to UBHC's Piscataway region. (Note: At present UBHC does not separately report data for its limited amount of services in southern New Jersey, and includes the negligible revenues earned in southern New Jersey with the Piscataway region data.) In the Newark

region, and in recognition of the Newark Agreements, UBHC has provided a broad range of community-based activities in addition to its direct patient treatment. These services include programs on sexual abuse prevention, various types of training for area professionals, community-based psychotherapy assistance for children, services for HIV/AIDS patients, an emotional learning curriculum for Newark schools, and programs on violence prevention and victim therapy.

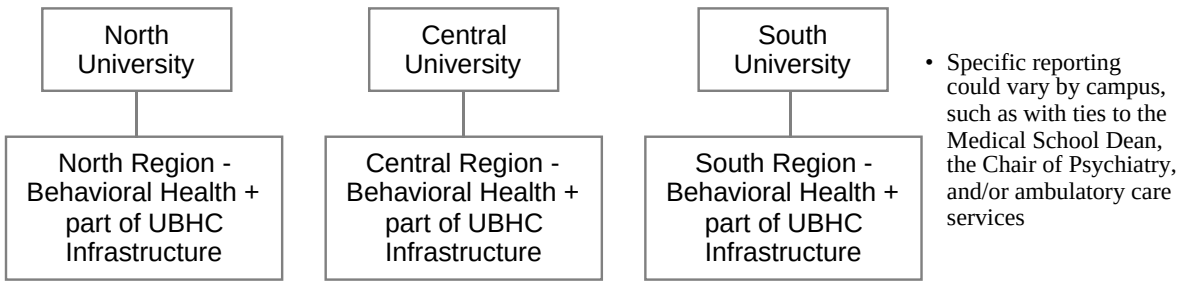
Relative to UBHC's reporting structure, currently UBHC reports within UMDNJ to the Academic Vice President; IBHC also is aligned with – but does not report to -- the UMDNJ departments of psychiatry. UBHC believes that this distinctive reporting structure has enabled it to operate with an entrepreneurial style and clinical focus, and thereby to provide services beyond the locality of any one medical school, to develop statewide managed care contracts, and to build its infrastructure of information systems and procedures. It should be noted that the Subcommittee advocated that UBHC further strengthen its academic collaboration with the psychiatry departments and medical leadership of the medical schools.

Summary of Options

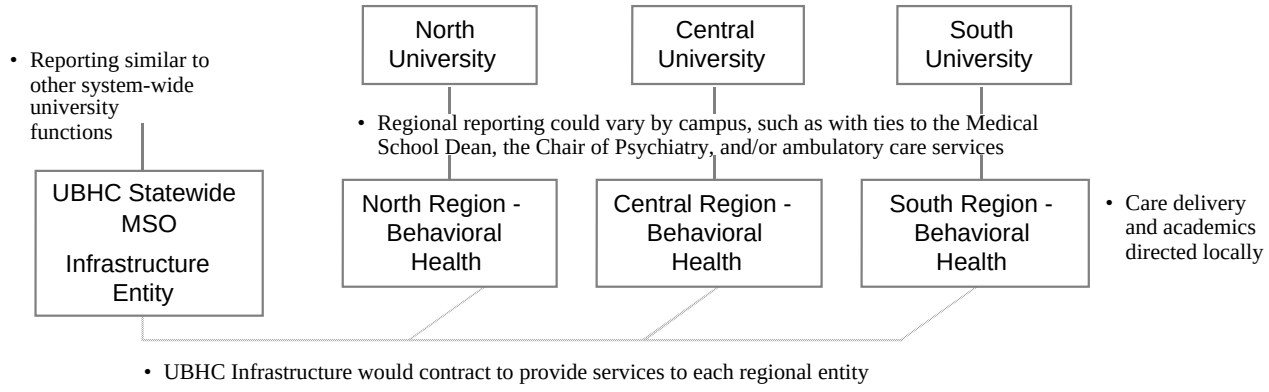
Based on discussions, a "Grid" was prepared that summarized possible reporting-structure Options for UBHC, in light of seven criteria that a desirable Option should meet. (These criteria are listed later, in Principle 4.1.) Subsequently, the Subcommittee refined the Grid, and considered whether consensus on an Option could be reached.

Regarding the "Grid" of UBHC Options and related advantages and disadvantages of each. The "Grid" of UBHC Options was revised to include variations of previously-listed Options, and to add a new Option. The "numbering" of Options reflects the evolution of Options from earlier-numbered Options.

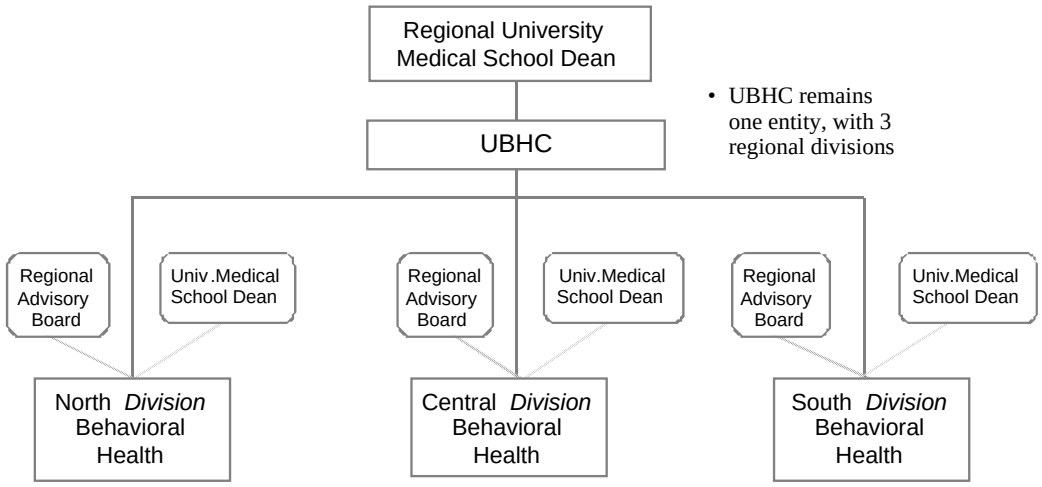
1a. **"Divide into 3"** -- Divide UBHC into 3 regional entities, aligning each unit with the respective academic unit of the regional university. (Note: Initially in this Option, UBHC probably would be divided into 2 entities, reflecting the current distribution of its services. Over time, a third division could be developed for southern New Jersey.)



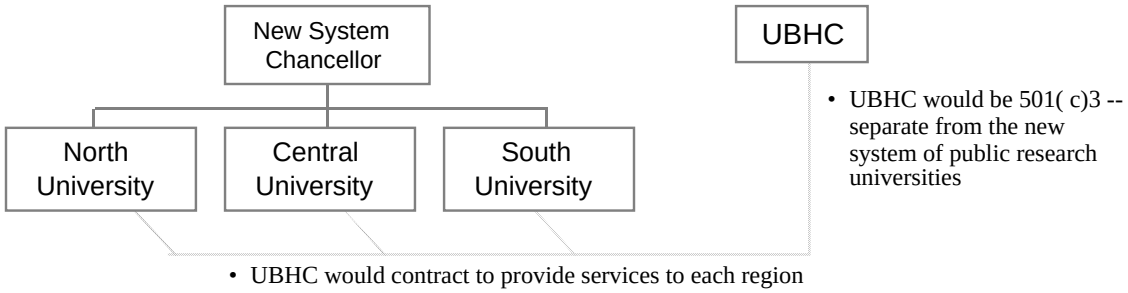
1b. "Divided Regional Clinical and Academic Direction + Statewide MSO Infrastructure" -- Divide UBHC, with regional entities at each campus directing their own clinical and academic programs for behavioral health, and retaining the infrastructure services of UBHC as a single statewide "management services" organization (MSO) to serve those regional entities. This could be illustrated in simplified form as follows:



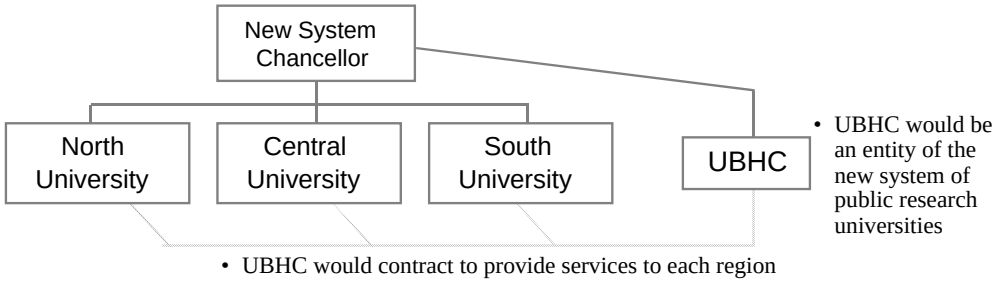
1c. "Unified UBHC with Regional Clinical and Academic Divisions and Statewide Infrastructure" -- This Option "evolved" in discussion from Option 1b; in the end, it is similar to Option 6 (Report to Regional Medical School Dean). It seeks to retain the "wholeness" of UBHC, while allowing regional divisions to direct local clinical and academic programs, in coordination with the regional Medical School Dean and with input from an Advisory Board. The overall UBHC reporting relationship, including UBHC's infrastructure functions, would be to the Medical School Dean of a regional university.



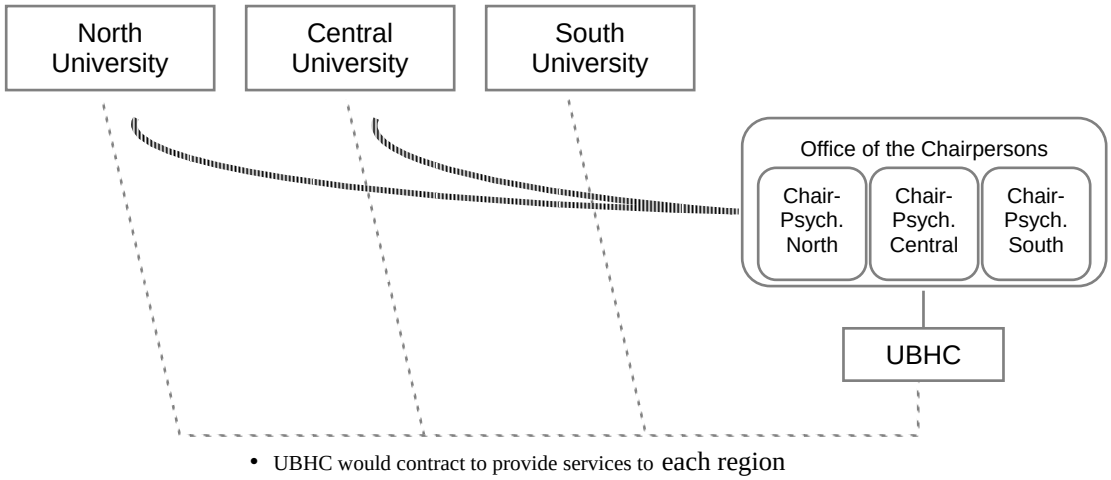
2. **"Spin off"** -- Spin-off all UBHC as <u>one entity</u> into a separate <u>non-profit corporation</u> [501(c)3], which contracts with each new regional university.



3. **"Report to Chancellor"** -- Re-align all UBHC as <u>one entity</u> in one "division" of the new system of universities, <u>reporting to the Chancellor's Office</u>, with contracts from UBHC to each new regional university.

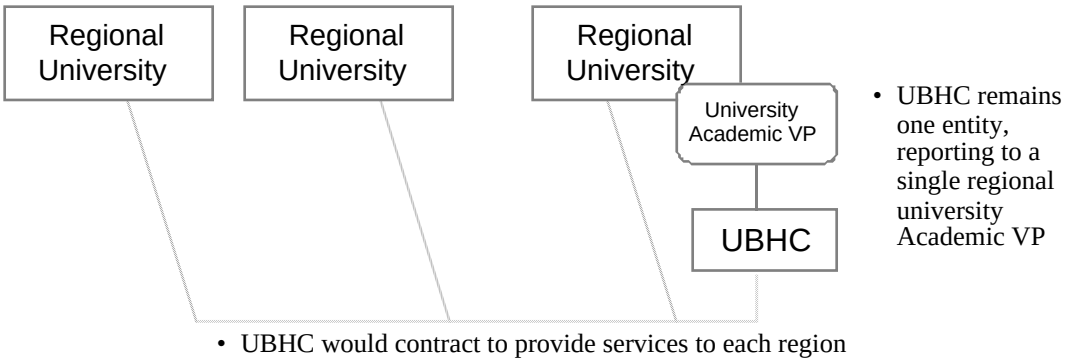


4. **"Report to 3 Chairs"** -- Re-align all UBHC as <u>one entity</u> in one "division" of the new system of universities (see Option 3), with the UBHC President reporting to the 3 Chairs of Psychiatry in each new regional university. (Note: Elements of Option 1c. also might overlap with aspects of this Option as well.)



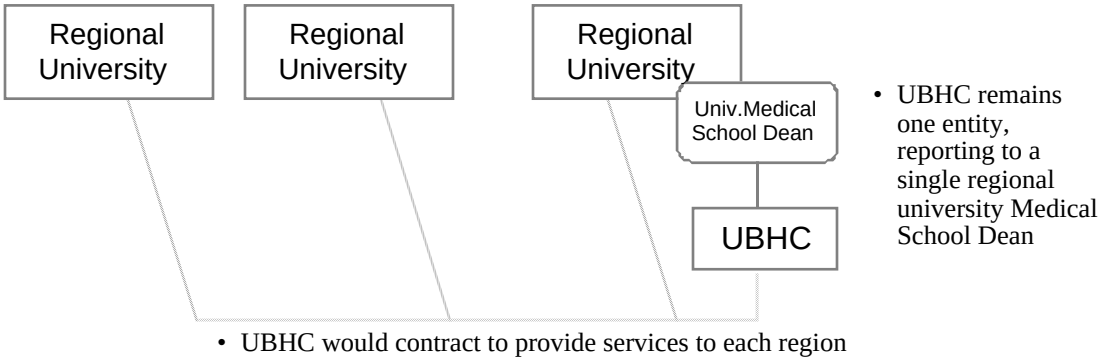
5. **"Report to Regional University Academic Vice President"** -- Re-align all UBHC as <u>one entity</u> administratively as part of one regional university, <u>reporting to that university's Academic VP</u> (as now), with contracts from UBHC to the other 2 regional universities.

    a. **Report to the ***North*** Regional University Academic Vice President**
    b. **Report to the ***Central*** Regional University Academic Vice President**
    c. **Report to the ***South*** Regional University Academic Vice President**



6. **"Report to Regional Medical School Dean"** -- Re-align all UBHC as <u>one entity</u> administratively as part of one regional university, <u>reporting to that university's Medical School Dean</u>, with contracts from UBHC to the other 2 regional universities.

    d. **Report to the ***North*** Regional Medical School Dean**
    e. **Report to the ***Central*** Regional l Medical School Dean**
    f. **Report to the ***South*** Regional l Medical School Dean**



The following principle summarizes the interest of the Subcommittee to apply criteria for guiding the selection of Options:

Principle 4.1 Apply criteria for an excellent academic and clinical enterprise: Select the future organizational framework for UBHC based on criteria for an excellent academic and clinical enterprise in behavioral health. These criteria include:

- Maintain and Expand UBHC's Academic Commitment: Maintain and expand the academic "connectivity" and commitment between UBHC and the new system of research universities -- continuing existing UBHC support for teaching and research, expanding it, and developing UBHC linkages to other schools and programs in the new system.
- Capitalize on UBHC's Current Centralized Infrastructure: Maintain and support unified UBHC infrastructure for patient intake and case management, electronic medical records, patient care practices and policies, managed care contracting, marketing, and similar centralized management infrastructure elements.
- Enhance Patient Care Quality: Promote and protect quality in clinical behavioral health care for New Jerseyans.
- Promote State Funding for Charity and Indigent Care: Support the continuation of New Jersey State funding allocations to address needs for charity care and indigent care in behavioral health.
- Maintain Recruitment: Promote effective recruitment of faculty and staff.
- Provide Financial Firewall Protections: Provide the ability to have thorough protections of a financial "firewall" to minimize the potential for financial risks arising in UBHC from affecting the system of research universities, or vice versa. (Note: Though the Subcommittee did not discuss this criterion at length, it is expected that the financial protections suggested by the "Firewall" Subcommittee in general could apply or be adapted to UBHC. For example, the relationship for UBHC with the new system of public research universities should include financial protections through a series of "building block" policies described in the report section on Firewall protections, as adapted to UBHC.)
- Continue Role in Training: Promote ongoing training for mental health professionals, especially for those in New Jersey.

Regarding Areas for Possible Consensus.

During the discussions, several issues were noted. In general, most members favored retaining the "wholeness" of UBHC. However, no Option had unanimous Subcommittee support, due to factors that were deemed by some members to be disadvantages; accordingly, the Subcommittee did not reach a consensus on a specific reporting relationship Option for UBHC.

In summary, Option 1a. appears likely to be disruptive to patient care and cause costly duplication of the divided infrastructure. Option 1b. would still divide UBHC, which some members believe could lead to unmanageable difficulties in certain functions, such as quality assurance. Option 1c., plus Options 5 and 6, were viewed as likely to provoke a negative response from whichever local community or campus that did not have the UBHC alignment, and accordingly were viewed by some members as unrealistic or untenable for political reasons. Option 2 would remove UBHC from the university, and risk losing its support and participation in academic matters. Option 3 - "Report to Chancellor" – appears to run counter to proposals for the new system that the Chancellor's Office not become engaged in operational matters. And the remaining Option - Option 4, with UBHC reporting to all 3 Chairs of Psychiatry – uses a reporting structure that is deemed by some to be too cumbersome for efficient management of a multi-million dollar enterprise.

Finally, while consensus was not reached on a specific Option, several Subcommittee members acknowledge the following related to the Subcommittee's charge:

Principle 4.2 Respect diverse community interests: Select a reporting relationship for UBHC that respects and balances the interests of various geographic and academic communities served by UBHC. Such interests include assuring access to excellent behavioral health services, allowing input and influence for the clinical and academic direction of UBHC services, and improving coordination among a region's providers of behavioral health care.

Principle 4.3 Develop UBHC's strategic direction: Supplement any decisions about UBHC's organizational framework with thorough strategic planning for UBHC -- in a process that addresses future external trends in behavioral health care and research; opportunities to strengthen UBHC's clinical delivery, service quality and academic program; and approaches to strengthen the financial position of the UBHC clinical and academic enterprise.

UBHC Subcommittee Members

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Chair: Adam Henick	Vice President, Ambulatory Care	UMDNJ-University Hospital

Peter Amenta, MD	Chief of Staff	Robert Wood Johnson University Hospital
Javier Escobar, MD	Chair, Department of Psychiatry	Robert Wood Johnson Medical School
Charles H. Kellner, MD	Chair, Department of Psychiatry	UMDNJ-NJ Medical School

Christopher Kosseff	President and CEO	University Behavioral Health Care
Harold L. Paz, MD	Dean	Robert Wood Johnson Medical School
David Rissmiller, D.O.	Chair, Department of Psychiatry	UMDNJ-School of Osteopathic Medicine
Gary Rosenberg, MD	Medical Director, Child and Adolescent Services	University Behavioral Health Care
Alan Weinkrantz	CFO	University Behavioral Health Care
Nancy Wolff, PhD	Associate Professor, Center for Mental Health Services & Criminal Justice Research	EJ Bloustein School of Planning and Public Policy, Rutgers

VI. CONCLUSIONS AND NEXT STEPS

With this White Paper the Working Group has completed its charge. It has developed principles in each of its assigned areas to guide the further development of the new system of public research universities.

The Working Group clearly recognizes that since its charge focused on developing principles, further work by others in a future phase of planning will be needed to implement the recommended principles. For each charge area, steps could include:

- Developing the principles into specific policy statements for approval at the respective new universities; and

- Convening key campus and community leaders to discuss and refine the implications of those policies.

In addition, several principles could require extensive implementation support. For example, developing the "building block" policies for the financial "firewall" principles could require dedicated attention from leaders at University Hospital and the medical school. For the issue of charity and indigent care, evaluating options to recognize the role of physician/faculty in charity care could be a substantial statewide process engaging various faculty, State officials, and others. And for UBHC, the principle that suggests reviewing and developing new strategic directions could involve a substantial exercise for leaders of that organization.

In completing its task, the Chair and members of this Working Group acknowledge the support of the Steering Committee, and express appreciation to the many people, both members and non-members of the Working Group, who made a generous contribution of their time and talent to make this report possible.