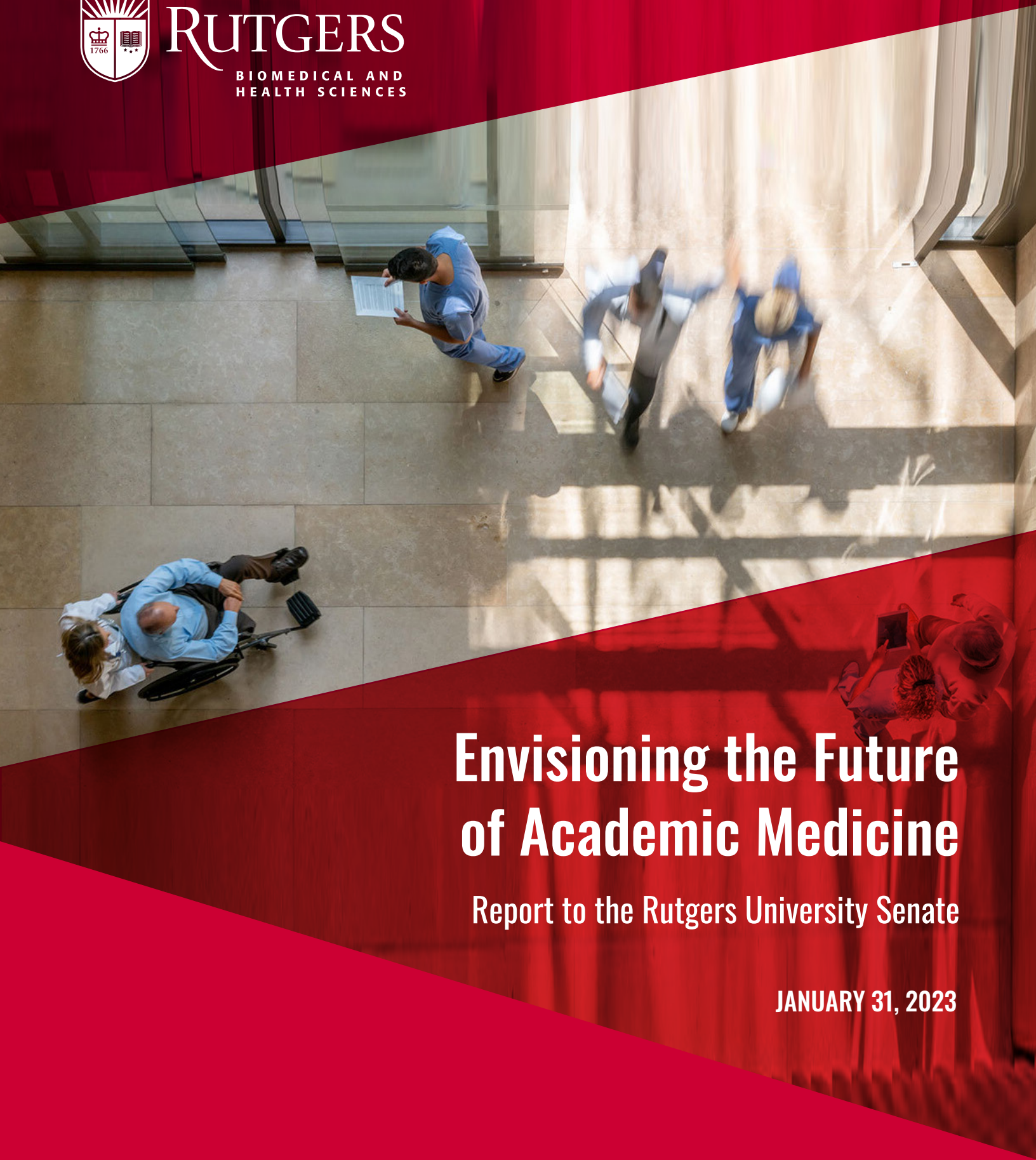
RUTGERS
BIOMEDICAL AND HEALTH SCIENCES



Envisioning the Future of Academic Medicine

Report to the Rutgers University Senate

JANUARY 31, 2023

RUTGERS
BIOMEDICAL AND
HEALTH SCIENCES

Office of the Chancellor
Rutgers Biomedical and Health Sciences
Rutgers, The State University of New Jersey
65 Bergen Street, Suite 1535
Newark, NJ 07107

chancellor@rbhs.rutgers.edu
rbhs.rutgers.edu

p. 973-972-4400
f. 973-972-4429

Brian L. Strom, MD, MPH
Chancellor
Executive Vice President for Health Affairs

To: Adrienne Simonds, Chair, University Senate

From: Brian Strom, MD, MPH, Chancellor, Rutgers Biomedical and Health Sciences

Date: January 31, 2023

Subject: Envisioning the Future of Academic Medicine at Rutgers University

Since the inception of Rutgers Biomedical and Health Sciences (RBHS) in 2013, we have focused on collaborations and cooperation between and among our schools and institutes to build an academic health community focused on excellence and accomplishment in research, scholarship, education, patient care, and community engagement. As we near our ten-year anniversary as the health care and biomedical research unit of Rutgers University, we would like to embark on our second decade with a renewed commitment to achieving excellence in all of our mission areas. With the prompt from the RBHS strategic planning process, the University Senate's series of questions, and a request from University senior leadership and governance bodies to come to some resolution, we would like to continue the dialogue on the optimal structure for Rutgers' medical schools with the University Senate initiated in 2020.

We provide the University Senate with the collective work product of numerous faculty, staff, students, community members, and administrators of the New Jersey Medical School (NJMS) and the Robert Wood Johnson Medical School (RWJMS) responding to the series of questions posed by your members concerning the potential integration of Rutgers' two medical schools.

By way of background, NJMS and RWJMS were originally designed by Dr. Stan Bergen to compete with each other. That model, to foster rapid regional growth and development, was apt for its time. We have succeeded in many areas under this model. Our students are consummately prepared for residency and achieve placements in top programs across the nation. Our research portfolio has been expanding rapidly, and in some areas such as infection and inflammation, microbiome, and cancer, we can claim national leadership status. Clinical programs like the liver transplant unit, trauma centers, etc. are highly regarded for providing world-class care equal or superior to regional competitors. For some world-class initiatives we have built institutes to cut across our schools successfully, e.g., cancer, clinical research, infection/immunology, and neuroscience.

However, we must recognize that the delivery of health care continues to change and become more complex, and institutions that train the next generation of health care workers must not only be attuned to these changes but be nimble enough to adapt to more changes yet to come. These dynamics, coupled with an ever-increasing health care worker shortage, represent the foremost reason why RBHS should evaluate the current educational structure of the medical schools to ensure it is positioning its students to meet the demands in this decade and beyond. In addition, New Jersey continues to export its newly trained physicians to other markets. Further, many of the patients in our state travel elsewhere for certain types of care. By re-evaluating our education structure, we can perhaps identify opportunities that will allow us to better retain our top talent to work on behalf of all the citizens of New Jersey.

The inquiry into the optimal structure of medical education at Rutgers began in January 2019 with the appointment of the Committee on the Future of Academic Medicine, containing faculty from both Rutgers medical schools. It continued with the January 2020 report of the Committee on the Future of Academic Medicine, specifically the examination of the "optimal level of integration and cooperation" between NJMS and RWJMS. In response to this report, the University Senate developed a set of questions spanning a variety of topics and issues related to the potential integration of NJMS and RWJMS, which it subsequently forwarded to me. That process halted with the Covid-19 pandemic, when all in healthcare were mobilized to support this public health emergency.

In October 2022, the leadership of RBHS, including Robert Johnson, MD, (Dean of NJMS), Amy Murtha, MD, (Dean of RWJMS), and me, revived this discussion. The initial set of 350 Senate questions were reduced, in collaboration with the Senate leadership, to 42, as some of the original questions were duplicates, overlapped with other questions, and in some cases were related to topics timely only for 2020. The 42 questions were then organized into four groupings, three to be addressed by committees of faculty, staff, students, health system colleagues, and community representatives. The fourth set of questions on administration and research was to be answered by RBHS leadership. RBHS engaged ECG Management Consultants and Janis Orlowski, MD, to provide logistical and analytical support, meeting facilitation, and content expertise for the committees, and a web site was developed to ensure the university community was transparently apprised of the process, the progress, and engaged in the process.

During the past three months, committees related to admissions, culture, and curriculum met to address the questions on this topic from the University Senate (please refer to appendix A for their charge, list of questions, and committee members), while additional input was provided from internal and external community members through a town hall-style "Conversation with Our Communities" and an online survey. The answers provided, unedited, are attached. One of the most prevalent comments from faculty, staff, students, community partners, and other stakeholders, however, was a

desire to understand RBHS's rationale for considering a potential merger of the medical schools, especially since any merger will inevitably entail work and disruption.

It is worth noting that what is being envisioned is a "merger light," where there would be a single accreditation but in most other ways the schools would function separately, at least for now, as two equal campuses of one school.

The remainder of this memo summarizes the reasoning for and potential benefits from an integrated medical school model, as identified by RBHS leadership. We look forward to working with the University Senate as it begins its deliberative process.

Impact on Educational Mission – closer collaboration on the educational mission offers a broader scope and scale of teaching talent, learning content, and clinical experiences that will benefit educators and learners.

- ***Attracting and keeping talent*** – An enhanced reputation and national prominence (see below) will help to attract and retain the best students and trainees.
- ***Broader and more consistent educational experiences*** – The best medical schools give their students experiences in a university hospital, private hospital, and safety net hospital. With a merger, medical students will have access to a wider array of clinical clerkships/electives and types of patient experiences, without the current administrative barriers to crossing over the two schools. Graduate Medical Education (GME) will also be integrated to form larger, stronger, and more uniform programs that are able to offer broader clinical experiences to trainees.
- ***More convenient learning opportunities*** – Many students have adapted to lectures via live or recorded video, a process which began long before the pandemic. A broader array of lectures (and lecture topics) will be available from faculty at both campuses, but discussion sections may remain regionally defined.
- ***Enhancement of MD/PhD programs*** – Over time, the individual programs could be combined, taking advantage of the scientific strengths of both schools, higher prestige, and access to more faculty and funding, and thereby becoming more nationally visible and more competitive for grants.
- ***Developing and sharing best practices*** – There will be an enhanced opportunity for innovation in education across both campuses, comparing approaches, and subsequently sharing and implementing innovations from one campus to the other.

Impact on Research Mission – leveraging our tremendous capacity as an integrated medical school will more accurately reflect our growing impact on clinical, translational, and basic

biomedical research placing Rutgers at the forefront of the innovation economy attracting more federal and industry funding.

- ***Elevation in rankings*** – The impact of an integrated medical school on research rankings is substantial, whether looking at the ranking of individual departments or the medical school overall, and across all types of funding (e.g., federal and state funding among others), and this impacts other ranking systems (e.g., USNWR). For example, our federal fiscal year (FFY) 2021 NIH funding institutional rankings[1] among 143 US medical schools are:
  - RWJMS at #62 with $68 million.
  - NJMS at #74 with $51 million.
  - Combined RWJMS/NJMS at #47 with $119 million.

  The potential impact on our research rankings across the medical schools of the Big 10 is noted in a later section on reputational considerations.
- ***The sum is greater than the parts*** – Combining complementary strengths, expertise, and resources from both schools will make the integrated medical school more competitive for external research and training grants. Similarly, a larger Rutgers-oriented patient base will make us more competitive for clinical trials.
- ***Attracting and keeping talent*** – An enhanced reputation and national prominence will help to attract and retain the best research faculty and trainees.

Impact on Clinical Mission – A single medical school has the potential to expand our portfolio of tertiary and quaternary services and launch new services to a wider patient base this platform will help us save lives, maintain health, improve outcomes and patient satisfaction, reduce health care inequities and disparities, and create competitive fellowship programs.

- ***Strength and stability in the market*** – Current populations in each city are relatively small, especially when compared with New York or Philadelphia, making it impractical to offer as wide an array of specialized services. Additionally, our current service lines are too fragile, with the departure of one faculty member often hampering the ability to continue to offer a clinical service at the involved school. An integrated medical school provides the opportunity for greater breadth, depth, and coordination of services. This will increase our ability to offer the most specialized care, establish regional and national clinical destination programs, and better compete for market share locally and regionally.
- ***Improved service to our communities*** – Increasing our ability to offer the most specialized clinical services will better serve our communities, as patients will not need to travel to New York or Philadelphia to receive them. This minimizes, if not eliminates, barriers related to inconvenience, and expense (e.g., out-of-network care is much more expensive to the patient and the state). It

[1] FFY 2022 rankings will be available in March 2023.

also helps to address health inequities, as the most needy in our communities cannot afford to make such trips and pay for such care.

- ***Access to clinical trials*** – A larger Rutgers-oriented patient base, combined with a burgeoning research ranking and reputation, will make us more competitive for clinical trials and gain access for our patients to more cutting-edge treatments, therapeutics, and procedures.
- ***Attracting and keeping talent*** – An enhanced reputation and national prominence (see below) will help to attract and retain the best clinical faculty and trainees.

Reputational Considerations – an integrated medical school strongly identified with Rutgers University has the potential to broaden the recognition of the excellent medical education programs and growing research portfolios than each school has individually.

- ***Connection to Rutgers brand*** – Potential faculty and students and the public may not necessarily associate NJMS and RWJMS with Rutgers. An integrated medical school provides the opportunity to tie more closely to and benefit from the stronger, nationally recognized Rutgers brand.
- ***Alignment with more common medical school organizational models*** – Excluding large university systems (e.g., University of California and University of Texas), we know of only four universities in the country that have more than one autonomous medical school (i.e., Rutgers, University of South Carolina, New York University, and University of Arizona), and at least one of those (University of Arizona) is reconsidering its organizational model.
- ***Advancement within the Big 10*** – Each of our schools now is small, relative to other schools. In part for this reason, of the 14 Big 10 medical schools (Rutgers' individual schools are counted separately), Rutgers now ranks only #12 (RWJMS) and #13 (NJMS), above only Michigan State University's medical school. A combined medical school would rise to #9 in the Big 10 and be more closely comparable to the University of Iowa and Ohio State University.
- ***Improvement in other rankings*** – Published rankings are driven substantially by research, and while NJMS and RWJMS are already artificially combined in Blue Ridge's NIH rankings, US News and World Report (USNWR) evaluates schools separately based on their individual accreditations (which also divides and weakens the rankings of clinical and basic science departments). It is recognized that many institutions (e.g., Columbia, Harvard, Mt. Sinai, University of Pennsylvania, and Stanford) have decided to discontinue their participation in the USNWR medical school rankings, given concerns about how those rankings are determined. Our expectation is that the rankings will continue, as the public desires them, and we hope that USNWR will revise its formulae to address some of the objections (as it has done for its law school rankings). At the least, they may be based more on publicly available metrics, which would make NIH funding even more important.
- ***More philanthropic support*** – Enhanced national prominence is more likely to garner philanthropic gifts to support scholarships, selective research efforts, and endowed professorships.

Efficiency and Effectiveness of Administrative Infrastructure – processes and systems that inhibit faculty productivity and employee satisfaction can be streamlined.

- ***Increased simplicity*** – Structures and processes will be simpler and more straightforward, after an anticipated transition period. Examples include:
  - Faculty appointment processes will not need to be repeated for someone to teach at the other campus.
  - Best practices from one campus can be identified and applied in the other.
  - There will be a single accreditation process.
  - RBHS will not need to start new centers/institutes simply to foster inter-medical school programs.
- ***Limiting duplication*** – Combining the medical schools will identify and remove redundancies in many administrative structures, mobilizing personnel and other resources to enhance the school's primary missions.

* * * * * *

The outcomes of the committees' work and other activities related to this initiative during the past three months are another step in a multi-step journey, which entails additional evaluation, analysis, and planning, as well as the continued involvement of and input from faculty, staff, students, affiliated partners, and community members. I would like to acknowledge the contributions made by each of the members of the three committees and thank them for their time and effort. Their responses are thorough and thoughtful and have greatly enhanced the quality of the work product we provide to the Senate. As always, I welcome your questions and feedback on this document.

Appendix A

Chancellor's Charge to Committees

As you begin your work to answer questions from the University Senate about the future of academic medicine, I would like to provide you with the following guidelines and historical context.

Historical Context of Medical Schools

New Jersey Medical School and Robert Wood Johnson Medical School were originally set up by Dr. Stan Bergen to compete with each other. That model, to foster rapid regional growth and development, was apt for its time. We have succeeded in so many areas under this model: Our students are consummately prepared for residency and achieve placements in top programs across the nation. Our research portfolio has been expanding rapidly and in some areas we can claim national leadership status like infection and inflammation, microbiome, and cancer. Clinical programs like the liver transplant unit, trauma centers, etc. are highly regarded for providing world-class care equal or superior to regional competitors. For other world-class initiatives we have built institutes to cut across our schools successfully, e.g., cancer, infection/immunology, and neuroscience.

Changes in Academic Medicine Today

Is our current model sustainable in today's health care climate? Today, the health care payer and provider markets are consolidating rapidly and across much wider swaths of geography than were contemplated at the inception of medical education in New Jersey. Our competition is not from within, but from other New Jersey hospital systems, newer local medical schools, and aggressive and expansive academic health centers based in New York, Philadelphia, and in some instances even farther afield. Patients are leaving NJ to get the most advanced care, as too often it is not available in NJ. This out-of-network care is much more expensive, and especially hurts patients who cannot afford to go elsewhere for such care.

Telemedicine is erasing local licensing restrictions; previously unimaginably large data sets move instantaneously across the world; dissections can be virtual; lectures are asynchronous and can be (and are) played by the students at double speed; and diagnostics, monitoring, and follow ups are no longer exclusively dependent upon the physical presence of patients at clinical sites. Medical care is shifting from inpatient sites to outpatient sites, with important implications as well to the future of medical education.

We also are in the fortunate situation with substantial investment newly available for major capital construction, in both cities, and for broad-based faculty recruitment. Given this, our immediate task is

to develop responses to the questions posed by the University Senate in the areas designated for each committee.

Committees' Charges

The three committees will focus on:

- Admissions: Would the admissions processes in the schools need to change at all, recognizing that medical school admission processes of course naturally evolve over time?
- Curriculum: Would the curriculum in the schools need to change at all, recognizing that medical school curricula of course naturally evolve over time?
- Culture and Identity

I ask you to contemplate a hypothetical administrative structure where New Jersey Medical School and Robert Wood Johnson Medical School can attain the maximum level of cooperation and coordination, i.e., if they were placed under one LCME accreditation, while still maintaining their unique campus identity and culture.

Let me set a few parameters on how I envision this:

- I do not envision a future for the medical schools where one is ever subordinate to the other.
- I do not envision a scenario that results in the loss of jobs (union or otherwise) among the faculty or staff, at either school; rather I see growth and investment in clinical care, research, and educational opportunities.
- I do not envision a scenario where either school will be expanding its student body, since the inpatient clinical capacity could not sustain that.
- I do see that each campus will benefit from the hands-on presence of a local dean working collaboratively with a colleague similarly situated 26 miles away.
- I do see a scenario where we can offer new tertiary and quaternary services at Robert Wood Johnson University Hospital in New Brunswick and University Hospital in Newark to meet more of our patients' needs within the State of New Jersey.

My hope is that our medical students will be able to take advantage of the best educational opportunities that each school can offer and pursue their interests and ambitions seamlessly across schools without undue impediments. How can we achieve this and maintain our high admissions standards across the two schools, and enroll classes that reflect our state's diversity? How can we provide a thorough and comprehensive curriculum to meet the needs of our future physicians and their patients? How can we retain the unique and valuable contributions and culture that distinguish and enhance the faculty, staff, student, and patient experience at each school, which is and will continue to be reflective of their principal teaching hospital?

If you can, contemplate these questions with the hypothetical construct that NJMS and RWJMS will in some way integrate their operations and activities more closely than we do today.

Next Steps

Dean Johnson, Dean Murtha, and I will also be developing responses to those questions that are administrative in nature, and we will be working with the RBHS Office of Research to answer those questions particular to research. In addition, we will be setting up a web-based survey instrument to collect comments from across the medical schools and across the state.

ECG will collect and distribute all the responses and we will share this document with you, our medical schools, the community, and the University Senate for their review. We plan some forums in each city to obtain input from our host communities and local leaders. Following the Senate review a formal proposal will be drafted for President Holloway and the Boards to review.

We all seek a medical education program that best delivers on the promises made to our communities, the people of New Jersey, our professions, and our patients. I welcome your thoughts, perspectives, experience, and knowledge as we contemplate a structure that will optimally deliver on our missions.

Admissions Committee Membership and Assigned Questions

Name	Title	Institution
H. Liesel Copeland, PhD (cochair)	Assistant Dean of Admissions	RWJMS
George F. Heinrich, MD (cochair)	Associate Dean of Admissions	NJMS
Gloria A. Bachmann, MD	Associate Dean of Women's Health	RWJMS
Natalia L. Kellam	Student	RWJMS
Payal V. Shah	Student	NJMS
Carol A. Terregino, MD	Senior Associate Dean of Education and Academic Affairs	RWJMS
Joshua M. Kaplan, MD	Associate Professor of Medicine	NJMS
Sonia C. Laumbach, MD	Assistant Dean of Student Affairs	RWJMS
Maria L. Soto-Greene, MD	Executive Vice Dean	NJMS
Danitza M. Velazquez, MD	Assistant Professor, Pediatrics	NJMS

#1 – How would an integrated medical school handle student applications, admissions, tuition, and fees?

#2 – Will student enrollment increase?

#3 – What are the metrics for success in a proposed integration?

Culture Committee Membership and Assigned Questions

Name	Title	Institution
Charletta A. Ayers, MD, MPH (cochair)	Associate Professor, Obstetrics, Gynecology and Reproductive Sciences	RWJMS
Melissa B, Rogers, PhD (cochair)	Associate Professor, Microbiology, Biochemistry and Molecular Genetics	NJMS
Shareif Abdelwahab	Student	RWJMS
Bill Arnold	President and Chief Executive Officer (CEO)	RWJ University Hospital
Detlev Boison, PhD	Professor, Neurosurgery	RWJMS
Alison L. Clarke	Program Coordinator	RWJMS
Dr. C. Roy Epps	President and CEO	Civic League of Greater New Brunswick
Carmen L. Guzman-McLaughlin, MPH	Senior Director, Administration	NJMS
George Hampton	Retired Vice President	The University of Medicine and Dentistry of New Jersey
Michael Kelly, MD	Associate Dean, Graduate Education	RWJMS
Neil Kothari, MD	Associate Dean, Graduate Medical Education	NJMS
M. Chiara Manzini, PhD	Associate Professor, Child Health Institute of New Jersey	RWJMS
Mary Maples, JD	Interim President and CEO	University Hospital
Ana M. Natale-Pereira, MD, MPH	Associate Professor, Department of Medicine	NJMS
J. Patrick O'Connor, PhD	Associate Professor, Orthopedics	NJMS
Jon L. Oliver	Assistant Dean of Information Technology	Rutgers School of Communication and Information
Timothy Pistell	Student	NJMS
Nikolaos Pyrsopoulos, MD, PhD	Professor and Chief, Gastroenterology and Hepatology	NJMS
Arnold Rabson, MD, PhD	Director, Child Health Institute of New Jersey	RWJMS
Frank Sonnenberg, MD	Chief Informatics Officer	RWJMS
Ian Whitehead, PhD	Professor, Microbiology, Biochemistry, and Molecular Genetics	NJMS

#1 – How will the medical schools' integration ensure that the campuses are coequal?

#2 – Will school departments be integrated under single chairs, or will each campus retain a local chair?

#3 – What will the impact of an integrated medical school be on our relationships with our primary hospital affiliates, University Hospital, and the RWJ Barnabas Health (RWJBH) system?

#4 – How will each campus retain its unique identity and strengths?

#5 – How will faculty governance be implemented?

#6 – What are the metrics for success in a proposed integration?

Curriculum Committee Membership and Assigned Questions

Name	Title	Institution
Maria L. Soto-Greene, MD (cochair)	Executive Vice Dean	NJMS
Carol A. Terregino, MD (cochair)	Senior Associate Dean of Education and Academic Affairs	RWJMS
Rashi Aggarwal, MD	Vice Chair, Residency Training Director	NJMS
Alla Fayngersh, MD	Assistant Professor, Department of Medicine	NJMS
Meigra (Maggie) Myers Chin, MD	Associate Professor, Emergency Medicine	RWJMS
Amir George	Student	NJMS
Brooke K. Phillips	Student	RWJMS
Archana Pradhan, MD	Associate Dean for Clinical Education	RWJMS
Monica Roth, PhD	Professor, Pharmacology	RWJMS
Michael E. Shapiro, MD	Professor, Surgery	NJMS
Ranita Sharma, MD	Executive Vice Chair, Residency Program Director	RWJMS
Christin Traba, MD	Associate Dean for Education	NJMS

#1 – What is the vision for a transformational undergraduate medical education curriculum/program?

#2 – How would integration of the two medical schools align, reconcile, or reimagine the curriculum?

#3 – How will an integrated medical school address clinical placements, pre-clerkship rotations, and clerkships?

#4 – Will students be able to enroll in core classes and/or electives across campuses?

#5 – Will there be a greater emphasis on distance or remote learning?

#6 – Will students be expected to travel between campuses?

#7 – How would an integrated medical school impact the current MD/PhD program?

#8 – What are the metrics for success in a proposed integration?

TABLE OF CONTENTS

Introduction and Process Overview

Introduction and Process Overview

Rutgers, The State University of New Jersey, is a leading public research university and a member of the Association of American Universities. Rutgers comprises three main regional locations and the state's largest academic health center, Rutgers Biomedical and Health Sciences (RBHS), with over 1,500 faculty members and 6,700 students across eight schools. Two of the institutions included within RBHS are New Jersey Medical School (NJMS), located in Newark, and Robert Wood Johnson Medical School (RWJMS), located in New Brunswick. NJMS and RWJMS are allopathic schools of medicine that are separately accredited by the Liaison Committee on Medical Education (LCME). A university-based health sciences center with two separate and distinct schools of medicine is a unique model in the current medical education landscape, with only one other truly comparable example.[1] Furthermore, excluding large university systems (e.g., University of California and University of Texas), there are only two other universities[2] that have more than one autonomous medical school.

In January of 2019, the RBHS Chancellor, Brian Strom, MD, MPH, convened a special Committee on the Future of Academic Medicine (FAM) at Rutgers, charging it to "fully assess the pros and cons of a wide range of options for medical education at Rutgers from maintaining the status quo, to fostering greater strategic collaborations, to a full restructuring and integration."[3] After a 12-month evaluation and planning process, the FAM Committee issued its final report to the chancellor in January of 2020. In response to the report, the University Senate developed a set of questions spanning a variety of topics and issues related to the potential integration of NJMS and RWJMS, which it subsequently forwarded to Dr. Strom. However, the onset of the COVID pandemic in March of 2020 halted any further substantive discussions regarding the findings and recommendations of the FAM Committee. Then, in January 2022, as part of a very broad-based reboot of the RBHS strategic plan, the topic was raised again, but the Senate's questions had never been answered.

In the fall of 2022, Dr. Strom, along with Robert Johnson, MD, FAACP (Dean of NJMS) and Amy Murtha, MD (Dean of RWJMS), decided to revive the examination of the "optimal level of integration and cooperation" between the two medical schools, identifying as an immediate next step the development of responses to the questions from the University Senate, with targeted submission to this body in January or very early February 2023. Given this aggressive timeline, RBHS leadership undertook the following:

- Collaborated with University Senate leadership to streamline the list of questions and categorize them into the following five topic areas (many others were duplicative or no longer relevant):
  - Administration/Leadership
  - Admissions

[1] The University of Arizona (UA) Health Sciences includes two LCME-accredited colleges of medicine (UACOM-Tucson and UACOM-Phoenix), and its two-COM model is being re-evaluated.

[2] University of South Carolina (separately accredited medical schools in Columbia and Greenville) and New York University (separately accredited medical schools in New York City and Long Island).

[3] Source: Chancellor Strom's email announcement to RBHS community on the committee's formation, December 20, 2018.

  - Culture and identity
  - Curriculum
  - Research
- Convened three committees in November 2022 (one each for admissions, culture and identity, and curriculum), including many representatives from the Senate and other faculty governance organizations, and charged them with developing responses to the related questions from the University Senate.
  - Refer to exhibit I for a listing of committee membership.
  - Refer to exhibit II for Dr. Strom's charge to the committees.
- Engaged ECG Management Consultants and Janis Orlowski, MD, an expert in LCME accreditation,to provide logistical and analytical support, meeting facilitation, and content expertise for the committees.
- Developed a website (Envisioning the Future of Academic Medicine | RBHS (rutgers.edu)) to provide background, updates, and other key information on this initiative so it would be completely transparent to the Rutgers community and the public, as well as serving as an online survey portal for anonymous feedback.
- Organized a virtual "Conversation with Our Communities" event in December 2022 for RBHS faculty, staff, students, and other stakeholders to gather additional comments and perspectives. (Notes from the breakout rooms related to their specific topics were provided to each of the committees.)
- Requested various individuals within the RBHS leadership structure for feedback on the remaining administration/leadership and research questions to develop attendant responses.

The remainder of this document provides unedited syntheses of the committees' discussions regarding and responses to the assigned questions as well as RBHS leadership's responses to questions that were not assigned to one of the committees.

Admissions Committee Feedback

Admissions Committee Feedback

Background

To provide context for its discussions, the admissions committee reviewed various background data and analyses for both medical schools, including:

- Applicant, matriculant, enrollment, and graduate profiles and trends (refer to appendix A)
- Faculty hiring and turnover (refer to appendix B)
- Summary of combined program offerings and major clinical affiliates (refer to appendix C)
- Comparisons of admissions processes, tuition, and fees (refer to appendix D)
- Residency match trends (refer to appendix E)
- Case studies for select medical schools with admissions processes for multiple campuses (appendix F)
- Sections from LCME Data Collection Instrument (DCI) related to student selection

In addition to the above information, the committee also considered feedback on admissions-related topics provided through the online survey and the Conversation with Our Communities event.

Potential Framework and Milestones

Fundamental to the committee's discussions and development of responses were the following tenets:

- In its recommendations and responses, the committee must prioritize New Jersey Medical School (NJMS) and Robert Wood Johnson Medical School's (RWJMS's) commitment to excellence and selecting candidates who align with the schools' mission and values.
- Potential impacts to LCME accreditation must be accounted for in any admissions process changes.
- Measures of success must consider both schools' cultures and track records of diversity and service to local communities.
- In contemplating a more integrated model, both schools should consider external economic factors and minimize competition between campuses.
- The committee needs to closely examine key differences in admissions processes and approaches where there may not be any overlap.

To complement its responses to the assigned questions and emphasize the points above, the committee developed a potential framework and timeline of admissions-related activities for achieving single LCME accreditation, which is provided as exhibit III.

Responses to Assigned Questions

#1 – How would an integrated medical school handle student applications, admissions, tuition, and fees?

Development of a unified admissions process under a single accreditation model will require detailed planning over a multiyear period, as well as close coordination and alignment with decisions and outcomes from the curriculum committee. Please note the proposed framework and timeline (assuming an entering class of 2028 under a single accreditation) presented separately. As part of the detailed planning process, the following key topics must be appropriately evaluated and addressed:

- Development of a single application process for individuals applying to more than one campus
- Determination of when an applicant must indicate which campus(es) they are interested in applying to while ensuring that campus preference is identified by the applicant.
- All unique considerations for dual degree, pathway, and other special programs
- Design of an executive committee and maintenance of the campus-specific admissions sub-committees in a structure that meets the LCME standards
- Determination of application fee(s)
- Consistency and appropriateness of tuition levels and student fees for a single medical school with two campuses
- Approach for reviewing the alternate list between the two campuses
- Process for updating policies and procedures to ensure consistency and agility
- Approach for students wishing to switch campuses/tracks following matriculation

#2 – Will student enrollment increase?

No. We do not expect an increase in medical school enrollment for either campus stemming from a more integrated model, primarily due to limitations in clinical training slots at our affiliated teaching hospitals. Our existing partners are already at capacity with our current enrollment, and opportunities for developing new clinical affiliations are minimal.

In fact, the proposed integration provides the leadership teams an opportunity to evaluate the current class sizes to ensure they align with available clinical volumes, faculty capacity, and other resources required to provide a high-quality educational experience.

#3 – What are the metrics for success in a proposed integration?

- **Application metrics**
  - Number of applicants from communities underrepresented in medicine
  - Number of students that applied to both campuses
  - Number of out-of-state applicants
  - Number and amount of scholarship opportunities and funding
- **Matriculation metrics**
  - Yield of matriculated to accepted
  - Class composition (including key demographic metrics)
- **Survey data to measure admission process experience**

- Metric from admissions office student survey
- MSQ survey

- **Other**
  - Graduation rates
  - Match rates
  - Graduate questionnaire scores
  - Metric to be identified that will evaluate the integration process
  - Metric to be identified that will evaluate admission of students who align with schools' missions and values
  - Student feedback (via survey or QR code at yearly check point or other established meetings)
  - Feedback from potential students who were accepted but chose not to matriculate

Other Key Considerations

As the committee discussed and developed responses for the assigned questions, it also identified the following additional concerns and considerations related to an integrated medical school model.

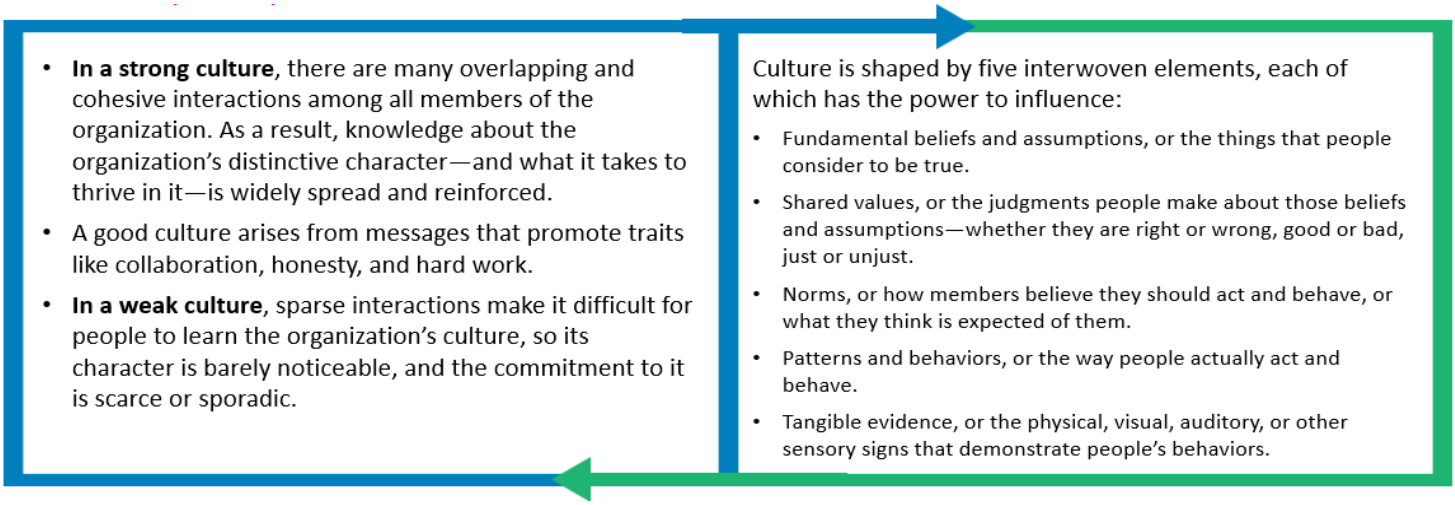
- A merged school may lead to fewer overall residency spots in a given GME program for students from Rutgers, especially for the more competitive residencies (as compared to the two schools separately).
- There is an overall university commitment to not increasing tuition and fees, and there is strong sentiment that higher tuition should not be considered for the integrated medical school.
- The merger will have an impact on alumni engagement and philanthropy, with the potential extent to be examined further. Communication with alumni regarding the integration and its implications on financial and other contributions, the institutional name on their degrees, etc., will be of high importance.
- The impact of a single accreditation on scholarships (especially those that are campus specific) will need to be evaluated.
- The total number of applications (and revenues from application fees) may decrease based on the number of students who historically would have separately applied to both RWJMS and NJMS.
- Some scholarships are campus specific; this will likely be difficult to change even with the integration, and its impact should be explored further.
- Student feedback should be solicited regarding school choice to preserve desirable elements for applicants.
- There is a desire to understand the "why" and the potential benefits of the merger.
- There is a high level of concern around resource challenges and the additional strain a merger will place on the admissions process/teams.

Culture and Identity Committee Feedback

Culture and Identify Committee Feedback

Background

The committee first proceeded by defining culture as follows:



Source: https://www.gse.harvard.edu/news/uk/18/07/what-makes-good-school-culture.

The committee also requested and reviewed various background data and analyses for both medical schools, including:

- Applicant, matriculant, enrollment, and graduate profiles and trends (refer to appendix A)
- Faculty hiring and turnover (refer to appendix B)
- Summary of combined program offerings and major clinical affiliates (refer to appendix C)
- Overview of strategic plans, including mission, vision, and values (appendix G)
- Key financial resources (see tables 3-5 in next section)
- Previously completed marketing and branding analyses (appendix H)
- Overview of key buildings (appendix I)
- Faculty governance structures (appendix J)
- Relevant LCME accreditation standards (appendix K)
- Summary results from key surveys (appendix L)
    - Mentoring program survey
    - Translational research barriers survey
    - AAMC Standpoint survey (RWJMS only)
    - AAMC Graduation Questionnaire

Relevant stakeholder feedback provided through the online survey and the Conversation with Our Communities event was also evaluated and considered.

Responses to Assigned Questions[1]

Given the limited time and availability of information requested from university and school entities, the committee prioritized the discussion and analysis of question #1; however, this section includes all committee thoughts and conclusions on questions #2 -5 as well.

#1 – How will the medical schools' integration ensure that the campuses are coequal?

Full realization of the benefits of a merger (e.g., increased research collaboration, community outreach, and enhancement of clinical capabilities) requires a coequal and equitable status between the campuses, based on open communication, transparency, and collaborative planning.

We note that the definition of coequality differs from equitability. LCME accreditation prizes coequality. In contrast, the schools' overall function and community support are strengthened by equitable status.

Administration must clearly define the benefits of a merger for the following reasons. A massive amount of effort will be required on the part of administration, faculty, staff, and students. Uncertainty regarding the school's identity may impact recruitment and retention of faculty, staff, medical students, and residents, and accreditation. Likewise, other stakeholders such as community partners and alumni, may be negatively impacted. Furthermore, the significant political and legislative concerns must be addressed regarding Newark and University Hospital. The merger of the Camden and Newark Law Schools offers a cautionary tale.

Coequality between the campuses will need to be evaluated and defined within the context of what is being merged and the distinct goals and objectives of each campus. For example, LCME accreditation will require a high degree of parity in resources devoted to admissions, curriculum development/management, faculty teaching commitments, and student experiences and evaluation. As stated by the AAMC consultant "In a single accredited school, LCME values unity in school vision, in core competencies and curricula, and in bylaws regarding faculty promotion. Curricula should be developed jointly and monitored by the faculty. Admission decisions should rest solely in the hands of a unified admissions committee. Faculty should reach understanding and consensus regarding necessary changes and their roles in implementing such changes."

The campuses have unique attributes related to research, patient care, and community service that should be maintained and will involve equitable resource commitments (see Table 6). The process by which funding is allocated to the campuses must be transparent and equitable. Numeric differences should be based on objective measures that clearly justify funding levels. While it would be a mistake to categorically state that the dollars must be equal, the equitability and needs for large differences should be explained clearly to avoid the appearance of biases (see Table 5). Any disparities in existing

[1] Some final edits were added by the co-chairs based on meeting notes and follow-up emails that are intended to reflect the committee's thoughts and discussion but, due to time restraints, were not redistributed to the committee for their review.

resources and capital investments need to be evaluated and addressed (e.g., renovation of existing buildings versus new construction) to ensure there are no persistent inequities in meeting the schools' goals for their clinical, research, educational, and service missions. Transparency regarding which funds are discretionary and how they are distributed is essential.

Core aspects of an integrated model with coequal campuses that require detailed examination and planning include:

- Faculty and student governance must include equitable representation from both campuses: centralized or executive-level administrative positions required for clinical/research/educational/service missions, committees, governance structures, faculty organizations, and student organizations.
- Current student and staff participation in school governance should be enhanced with the specific goals of empowering their contributions to the schools' missions.
- Equitable and aligned student affairs and advising resources to ensure consistency in availability, guidance, and disciplinary measures. LCME criteria and ongoing internal review is paramount.
- Alignment of student to faculty ratios (currently 1.5 at NJMS, 1.0 at RWJMS). This includes a reevaluation of both the total number and tracks of faculty positions at each school, which currently stands at **487** faculty at NJMS and **714** faculty at RWJMS. See Tables 1 and 2.

TABLE 1: Student/Faculty Ratio

	July 2018	July 2019	July 2020	July 2021	July 2022
NJMS student/faculty ratio	1.52	1.53	1.45	1.55	1.54
RWJMS student/faculty ratio	1.13	1.03	1.01	1.01	1.05
Significantly different per T test:			*p = 4.60768E-05*		

Source: Document titled "NJMS RWJMS Faculty by track Student Faculty ratio.xlsx" provided by RBHS Faculty Affairs on December 5, 2022.

TABLE 2. Head Count of Faculty 0.5 FTEs or Greater by School and Track, 2017–2022

School/Track	July 2017	July 2018	July 2019	July 2020	July 2021	July 2022
New Jersey Medical School	**466**	**506**	**512**	**529**	**490**	**487**
Clinical Educator	112	118	116	114	111	121
Clinical Scholar	9	6	8	9	8	7
Professional Practice	142	182	194	202	190	186
RBHS Instructor	16	15	11	20	19	9

School/Track	July 2017	July 2018	July 2019	July 2020	July 2021	July 2022
Research	51	51	46	48	41	39
Teaching	7	7	7	7	7	8
Tenure	106	106	106	104	89	89
Tenure Track	23	21	24	25	25	28
Robert Wood Johnson Medical School	**669**	**680**	**716**	**745**	**742**	**714**
Clinical Educator	169	165	162	167	171	153
Clinical Scholar	62	60	59	56	55	59
Professional Practice	141	197	249	277	264	251
RBHS Instructor	99	65	47	47	46	38
RBHS Lecturer			1	2	2	
Research	19	25	29	31	29	33
Teaching	24	23	23	24	23	23
Tenure	117	113	116	109	116	116
Tenure Track	38	32	30	32	36	41

Source: Document titled "NJMS RWJMS Faculty by track Student Faculty ratio.xlsx" provided by RBHS Faculty Affairs on December 5, 2022.

- Alignment of research investment, e.g., infrastructure (new buildings and renovations), core facility support, and faculty support. The capacity and condition of all research facilities should be of adequate quality to support both current and future funded projects. See Tables 3, 4, and 5.
- Accurate assignment of credit for effort on large, multi-PI, collaborative projects to each school, department, and unit. Currently Tableau and RAPSS don't accurately report multi-PI contributions. The Contact principal investigator's unit receives most if not all credit.

TABLE 3: NIH Grants/Faculty

School/Track	July 2018	July 2019	July 2020	July 2021	July 2022
NJMS NIH grants	$50,174,414	$46,943,222	$61,027,098	$60,426,802	$60,594,935
RWJMS (includes CINJ) NIH grants	$31,827,369	$45,082,009	$56,396,263	$63,023,800	$69,391,105
NJMS NIH grants/faculty	$99,160	$91,686	$115,363	$123,320	$124,425
RWJMS NIH grants/faculty	$46,805	$62,964	$75,700	$84,938	$97,186

Sources: NIH Reporter and document titled "NJMS RWJMS Faculty by track Student Faculty ratio.xlsx" provided by RBHS Faculty Affairs on December 5, 2022 (for faculty counts in denominator).

TABLE 4: RWJBH Support[1]

	2021	2022	2023 Projection
Newark RWJBH support	$1,383,324	$2,165,274	$3,417,821
NB/Piscataway RWJBH support	$73,097,040	$50,826,640	$49,149,121
Newark RWJBH support/faculty	$2,823	$4,446	$7,018
NB/Piscataway RWJBH support/faculty	$98,514	$71,186	$68,836

[1] The above figures appear to be largely research mission focused and clinical service contribution is unclear.

Source: Document entitled "RBHS_Mission_Support_Budget_FY_2023_21A_21B_22B_23B" provided by AAUP-BHSNJ December 16, 2022; Document titled "NJMS RWJMS Faculty by track Student Faculty ratio.xlsx" provided by RBHS Faculty Affairs on December 5, 2022. NJMS administration indicated that under the clinical services agreement (CSA), UH pays NJMS for physician services. The CSA also includes incentive payments and payments for additional clinical services, a lease agreement in the DOC, and contract payments for lab services. NJMS received approximately $65M for the CSA payment in FY 2022 from UH.

TABLE 5: Appropriations by School

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023B
NJMS						
State Appropriations[1]	$38,601,969	$37,860,402	$36,589,522	$30,491,581	$31,092,350	$30,057,414
State Appropriations for Clinical Subsidy[2]	-	-	-	-	-	-
Net State Appropriations[1]	**$38,601,969**	**$37,860,402**	**$36,589,522**	**$30,491,581**	**$31,092,350**	**$30,057,414**
RWJMS						
State Appropriations[1]	$32,323,615	$29,449,110	$30,980,907	$10,423,808	$10,395,064	$11,279,386
State Appropriations for Clinical Subsidy[2]	-	-	-	$17,500,000	$17,500,000	$17,500,000
Net State Appropriations[1]	**$32,323,615**	**$29,449,110**	**$30,980,907**	**$27,923,808**	**$27,895,064**	**$28,779,386**

[1] Allocations of state appropriations occur before the investment in the MAPS Program.
[2] Redirected to be used as mission support.

Source: Document titled "Medical School Appropriations FY17-23.xlsx" provided by RBHS Faculty Affairs on December 6, 2022.

- Equitable allocation of residency positions over all clinical sites
- Allocation of clinical/research/educational staff to provide sufficient administrative and IT support.
- Salary equity for similar performance, expertise, and qualifications.

#2 – Will school departments be integrated under single chairs, or will each campus retain a local chair?

The committee members have diverse opinions on this topic; however, the need for transparency and clear communication between chairs and faculty was universally noted. Some advocate for a single-chair model (with a vice chair dedicated to each campus) as the more effective approach for achieving true integration (i.e., single point of accountability and strategic guidance, overcoming any artificial geographic limitations). Others view a model with separate departments with separate chairs reporting to a single dean as a more effective means for managing campus-specific nuances and playing an active role in the development of junior faculty members. The two chairs should have a regular and open channel of communication (e.g., regular joint meetings of chairs and vice chairs of the two departments) to ensure that joint opportunities are identified and exploited.

There is little to no interest in maintaining the current mixed model of department leadership given experiences to date, which have been variable and far from universally successfully.

#3 – What will the impact of an integrated medical school be on our relationships with our primary hospital affiliates, University Hospital (UH), and the RWJ Barnabas Health (RWJBH) system?

In terms of faculty and student access with our clinical partners, no significant changes are envisioned from an integrated model. In fact, it may allow students from each campus to complete elective rotations in specialty areas at the other campus that were previously not available. However, benefits may be tempered by capacity limitations at a given affiliate and lengthy travel times. Also, a more integrated model may provide the opportunity to develop a common vision for the future of healthcare, research, and education that is shared across the medical school, UH, and RWJBH, such as:

- Increased scale that improves the impact of population health initiatives and other collaborative strategies.
- Increased data sharing between the affiliate systems that improves competitiveness in acquiring extramural funding and negotiating with payers/vendors
- Identification of gaps in specialty areas, community services, and educational programs that lead to shared and coordinated strategies for addressing areas of need and enhancing existing programs.

An area of complexity that will require more detailed evaluation, discussion, and decision-making is the current legislation that defines UH as the principal teaching hospital for NJMS. How an integrated model impacts compliance with that requirement must be determined, and a framework for

managing through other predictable issues, such as conflicting clinical programs and hospital representation in university and school governance structures, must be developed. Other areas of concern resulting from an integrated model include:

- Potential impact on the essential rejuvenation of UH.
- Willingness to use funding from RWJBH to invest in faculty and infrastructure at NJMS/UH.
- Availability of services and training programs at UH that benefit the NJMS mission and Newark community

#4 – How will each campus retain its unique identity and strengths?

The culture of each campus will be changed by the merger; therefore, the key objective is to determine which unique elements must be preserved and how to do so (See Table 6). Each campus has a unique history, traditions, and connections with and commitments to their communities and partners. These must be identified and honored and not diluted. However, development of an integrated model also may serve as the disruptive opportunity for abandoning stale, ossified, and nonproductive ways of doing things and reimagining aspects of the campus cultures to develop new strengths, serve more people, and advance medicine in the state (i.e., establishing a common bar of excellence while maintaining the unique attributes and identities of the campuses). Extensive evaluation and planning will be required to ensure that appropriate financial and human resources (HR), governance structures, infrastructure, staffing, and policies are in place and sustainable.

The committee recommends that UH and Rutgers leaders not ignore history. They should revisit and study the Newark Agreements, as well as invite and encourage necessary and credible input from strategic community stakeholders. Indeed, they must recognize the value of comprehensive strategic civic engagement at all unit levels throughout the Rutgers' institutions.

Ensuring that any merger plans put the health of New Jersey communities first, particularly the communities in which the medical schools reside, is of utmost importance. For example, it might be hoped that a merger of the schools could address horrific issues, such as the unacceptable disparities in maternal mortality in the state. The question is how best to get there. Is a (yet another) potentially highly disruptive merger, with potential loss of key faculty and staff and without a major infusion of new resources, the best way to get there? Even in the context of two medical schools, or of a minimal merger involving only LCME-associated components, a potential approach is to immediately create a joint initiative/task force across both schools and health care systems to identify areas in which working together can make a difference to the health of our communities. For example, can we mobilize a group across all entities to address the issue of maternal mortality? We don't have to merge the schools right now for that purpose, but we can build trust and working relationships and maybe have a few successes of joint ventures that can help serve as the basis for a merger (or a more comprehensive merger, if only the curricula/LCME are merged now). This is quite consistent with many of the earlier recommendations of the FAM report.

The pathway for each campus to retain its unique identity and strengths is to initially have a very limited "merger," focusing solely on issues related to LCME accreditation and fulfilling criteria related to admissions, curriculum, and educational experience of the students. Other aspects of integration should proceed more gradually from the "bottom up," employing strategies indicated in the Future of Academic Medicine report that would increase collaborations in research, clinical care, and community involvement. This will require increased investment in structures and additional funding to facilitate and incentivize these interactions.

TABLE 6: Specific Committee Feedback on Medical School Culture

Topic/Mission	NJMS	RWJMS
Unique attributes of each school		
Education	"Community engagement and volunteerism embedded" in educational experiences, e.g., NJMS is one of only 43 of 119 AAMC reviewed schools with a Community Engaged Service Learning (CESL) course. This is a required (not elective) course overseen by the Office of Primary Care and Community Initiatives. "Faculty take pride in guiding students to above average scores on standardized exams, despite frequent disadvantages" "Collaborations with RWJMS North"	"Distinction programs in various academic areas" Interwoven relationship with the "full service" Rutgers University (RU) campus, including shared graduate programs/students, seminar series, and buildings; connections with undergraduate students; and collaborations with other schools and institutes "Multidisciplinary continuing medical education"
Research	"Faculty are highly productive" despite challenges (Table 3) "NIH grants in unique services (e.g., Center for Emerging Pathogens, Public Health Research Institute)"	Affiliations with "nationally recognized clinical and research institutions (e.g., CINJ)" Robust "research collaborations", including a cohesive research structure and links with BHI Established "mentorship" relationships
Clinical	UH designation as a level 1 trauma center with NJMS faculty comprising the medical staff who are providing the highest level of care through primary and specialty services has a significant impact on care in the community beyond Newark. Diverse patient population and communities served "Connections to state programs (e.g., liver transplant program)"	Broad network of "affiliate hospitals" "RWJ is more efficient, so more patients can be seen…Consequently, practicing at RWJ hospitals generates more RVUs relative to NJMS"

Topic/Mission	NJMS	RWJMS
	Strong "infectious disease and HIV care programs" "World class in ENT and orthopedics"	
Community	"Identity rooted in services provided, educational opportunities, and community commitments" see *Broken Promises to the People of Newark: A Historical Review of the Newark Uprising, the Newark Agreements, and Rutgers New Jersey Medical School's Commitments to Newark* Franklin *et al.* Int J Environ Res Public Health. 2021 Feb; 18(4): 2117. Commitment to the "city of Newark and its underserved population", e.g., NJMS Student Family Health Care Clinic (https://njms.rutgers.edu/community/SFHCC/), the first medical student run clinic of its kind in the US, was established after the 1967 riots to meet the needs of the medically underserved and offers free, quality health care to the Newark community. Rich "culture and history" NJMS "Office of Primary Care and Community Initiatives in FY 21-22 reached over 6000 community members, with 30 CESL projects" "The Newark Agreements, the Board of Concerned Citizens (BCC) and the community programs that followed were given birth by the riots because impoverished and disenfranchised citizens demanded recognition and respect from powerful government/public institutional leaders. The institutional leaders recognized the need to respectfully engage the community as a credible and necessary partner. *That commitment waned over the last few years*."	Strong "community and global outreach" programs and community connections with socioeconomically and ethnically diverse populations RWJMS culture is "enmeshed in the identity and culture" of its community "Health equity advocacy"

Topic/Mission	NJMS	RWJMS
Most important attribute of school culture		
Education/ Research	Faculty "care deeply about their research and educational and service activities" "Protect … our work against major outside influences"	"Collaboration and collegiality across the medical schools" and other educational institutes on the RU New Brunswick/ Piscataway campus with some connections easier than others "Dedication to education "Collaboration to foster innovation"
Clinical		"Serving the community through clinical excellence"
Community	Strong connection and "history of service to the city of Newark" "Tradition and serving the community"	"Relationships with local health centers and collaboration with local public education centers and political and community agencies" "Rich history and strong connections to the local communities in and around New Brunswick"
What needs to change		
Education/ Research	Increased "collaboration" and "a more collegial environment" "Better collaboration" RBHS leadership ignoring "previous committee work that leads to thoughtful reports" Faculty incentives aligned with stated priorities. Improved infrastructure that "elevates the campus" and its capabilities Absence of support for CESL student led efforts	Transition from a "curriculum that is heavy on multiple-choice testing" to "one that emphasizes the development of clinical skills, critical thinking, and decision-making" "Increased mentoring and advising that are tailored for each student's preferred choice of specialty" "Greater integration with RU and the other professional schools of RBHS" Improved "communication" and "better collaboration" A "raised bar of excellence that replaces cultural relics from 20+ years ago" and reflect the "new vision behind the school merger" Absence of support for CESL student led efforts
Clinical	Reduce administration's "focus on revenue generating efforts"	

Topic/Mission	NJMS	RWJMS
	Recognition that different sites have different staffing and capacity that impact revenue generation "At NJMS, 1/3 of patients are no-shows. Staffing limitations decrease efficiency. Consequently, generating RVUs is more difficult than in the RWJ system."	
Community	Increased appreciation and respect of faculty by NJMS and RBHS leadership The New Jersey Medical and Health Sciences Education and Restructuring Act (bills: S2063 and A3102) created two advisory boards to take on some of the responsibilities of the Board of Concerned Citizens: the University Hospital Community Oversight Board and the Rutgers-Newark Campus Advisory Board. Top leadership should work with and empower these boards to recreate the respectful and stable relationship developed by the first two UMDNJ presidents, Drs. Bergen and Cook. "Increased pride" in the NJMS campus, "beginning with facility improvements" Definition of "community" expanded beyond Newark Increased facility maintenance and resources dedicated to "campus beautification" Reduce need for RBHS food bank	Improved faculty engagement and participation in forums such as faculty meetings Increased appreciation of faculty by RBHS leadership and additional engagement of faculty in decision-making to overcome increased apathy about the future direction of the school Boost in faculty trust of RBHS leadership Definition of community expanded beyond New Brunswick "Top-down leadership"

#5 – How will faculty governance be implemented?

While campus-specific governance bodies should be preserved, a more integrated model will require enhancement of structures that span the two campuses, e.g., a "super-council" composed of members of each campus-specific council, which would have regular, open, virtual meetings to identify areas of common concerns, meet LCME accreditation requirements, and bring a unified faculty voice to the table. Initiating this process as soon as possible utilizing existing faculty structures would allow a clear articulation of faculty concerns and ideas as the merger process proceeds.

Faculty by-laws will need to be reviewed, revised, and harmonized to account for the integrated model. The roles and responsibilities of the RBHS Faculty Council will need to be strengthened, and an RBHS faculty-wide organization will need to be created. Additional joint governing bodies/committees may be identified and implemented as integration efforts continue. The University Senate also will need to be consulted throughout this process and will play a critical role in the oversight and guidance of an integrated medical school.

#6 – What are the metrics for success in a proposed integration?

- **Academic performance metrics**
  - Improved medical school ranking (caveat: recent discussions and withdrawals of prestigious institutions from US News & World Report medical school rankings highlight the flaws of this metric)
  - Faculty to student ratios
  - Increased publications
  - Development of new modalities for medical student training
  - Improved residency-matching statistics
  - LCME accreditation status
  - Increased number of applicants (e.g., medical school, residency, fellowships, graduate school)
  - Increased support for Community Engaged Service Learning (CESL) efforts by students in the community
  - Diversity of faculty, staff, medical students, and residents
  - Increased quality of applicants (e.g., medical school, residency, fellowships, graduate school)
  - Reduced student debt
- **Community metrics**
  - Increased positive health outcomes for the patient population. Community Health Needs Assessment (CHNA) can support future planning for UH and RWJBH
  - Increased support for Community Engaged Service Learning (CESL) efforts in the community
  - Rutgers/Medical School Community Board that would integrate with the communities that are served by the medical school to centralize the priority of community and the individuals that are served based on the Newark Agreement.
  - Expanding community to include overall health of the State of New Jersey, which the medical schools serve, i.e., Health equity, COVID, Childhood Obesity, Cancer screenings, Maternal Heath
  - Meeting community outreach and engagement goals as described in efforts such as:
    - RWJMS Community outreach - Healthier New Brunswick (https://rwjms.rutgers.edu/community_health/other/healthier-new-brunswick/overview)
    - Alliance Shared Measurement Project (https://rwjms.rutgers.edu/community_health/other/healthier-new-brunswick/alliance-shared-measurement-project)
    - Newark Community outreach - 2022 Community Health Needs Assessment (https://www.uhnj.org/chna/)

- **Engagement and satisfaction metrics**
  - Improved faculty and staff engagement, satisfaction, and wellness survey scores
  - Increased faculty, resident, and staff recruitment and retention
  - Increased student satisfaction (e.g., survey scores on pre-clerkship education and clerkship experiences)
  - Alumni satisfaction
- **Financial metrics**
  - Increased administrative efficiency
  - Administrative cost savings (e.g., reduced administrative expense per employee FTE and/or per student)
- **Hospital integration metrics**
  - Population health outcomes
  - Residency training program success
  - Reduced administrative burden of hospital/education/research interactions
- **Research metrics**
  - Improved facilities (e.g., average age, condition, and capacity of the buildings and facilities)
  - Increased grant funding
  - Increased research collaboration between departments and schools
  - Increased core use and capabilities
  - Improved research administration functions, e.g., IRB efficiency
  - Sufficient reporting mechanisms to accurately apportion credit for multi-PI, collaborative projects between schools, departments, and units.

Other Key Considerations

As the committee discussed and developed responses for the assigned questions, it also identified the following key concerns and considerations related to an integrated medical school model to forward to RBHS leadership.

- Clearly defining and communicating the rationale for and potential benefits from a merged medical school model.
- Rutgers' legal counsel must review regulatory and legislative implications of the potential merger as soon as possible and prior to any further commitment of faculty and staff time toward planning and implementation.
- Determine the budget for and implementation costs of the proposed medical school merger, including any incremental administrative requirements.
- Consider lessons the University has learned from other mergers (e.g., nursing schools [Newark and New Brunswick] and law schools [Newark and Camden]). A member of the committee interviewed a senior faculty member and administrator at the Law School. (A synopsis is provided as appendix M.) After 7 years, the Law School merger has met few of its stated goals and has overloaded

administrators, faculty, and staff. Faculty, staff, and alumni are unhappy and frustrated. This Law School faculty member strongly recommended:

  - Do the most limited merger possible to achieve specific functional goal(s) while preserving the sovereignty and integrity of both schools.
  - Limit the merger to specifically operations that will function better as merged.

- Identify additional resource requirements and acknowledge the capacity challenges faced by the current faculty.
- Additional efforts will be required of faculty and staff to provide detailed planning and implementation for a merged medical school.
- The merger has the potential to seriously exacerbate existing faculty retention and recruitment challenges. The recent faculty survey on the merger of departments and medical schools has confirmed that a high percentage of the faculty at both schools have significant concerns about possible major negative impacts to their work life. These concerns need to be recognized and acknowledged for their potential impact, and proactive strategies developed at the highest levels of Rutgers to mitigate them. This will be essential to ensure retention of the outstanding faculty who have dedicated their careers to the success of both schools.
- The merger may impact existing faculty recruitment and retention challenges.
- The merger process should be introduced to and understood by the faculty well before an LCME visit.
- There is a request to understand if there are factors (e.g., financial need, state/political considerations) that make a merger inevitable. If such a fact were made known, then faculty and staff would be more open to the process.
- Recognize the potential impact of another major institutional change on faculty and staff morale and retention.

Curriculum Committee Feedback

Curriculum Committee Feedback

Background

To provide context for its discussions, the curriculum committee reviewed various background data and analyses for both medical schools, including:

- Applicant, matriculant, enrollment, and graduate profiles and trends (refer to appendix A)
- Faculty hiring and turnover (refer to appendix B)
- Summary of combined program offerings and major clinical affiliates (refer to appendix C)
- Overviews of medical student curricula and learning objectives (refer to appendix N)
- Relevant LCME accreditation standards (refer to appendix O)

In addition to the above information, the committee also considered feedback on curriculum-related topics provided through the online survey and the Conversation with Our Communities event.

Potential Framework and Milestones

Fundamental to the committee's discussions and development of responses were the following tenets:

- Both medical schools will need to focus on their LCME accreditations for the foreseeable future, i.e., we need a stable platform before any form of integrated model is developed and implemented.
- A fundamental consideration under an integrated medical school model will be a decision to 1) maintain separate curriculum "tracks" at each campus or 2) design a single curriculum.
- A preemptive LCME site visit may help shape a more successful implementation process of an integrated model.

To complement its responses to the assigned questions and emphasize the points above, the committee developed a potential framework and timeline of curriculum-related activities for achieving single LCME accreditation, which is provided as exhibit IV. This framework and timeline are intended to ensure that there is appropriate time, bandwidth, and focus on:

- Securing a full accreditation status for both NJMS and RWJMS (i.e., both schools need a "clean bill of health" before a more integrated model is implemented).
- Upholding the primacy of education within the institution and quality outcomes for its students and graduates.
- Promoting inclusivity, collaboration, and community building in the development of the model and a more extended and detailed planning process.

Furthermore, the proposed framework and timeline align with a similar document developed by the admissions committee (refer to exhibit III).

Responses to Assigned Questions

#1 – What is the vision for a transformational undergraduate medical education curriculum/program?

Transformational medical education employs a curriculum that promotes higher-order, integrative, and reflective learning behaviors through problem-solving, collaborative learning, independent learning, and investigation. There is a focus on refining critical thinking, diagnostic accuracy, and clinical learning and opportunities for practice in simulated and real clinical spaces. This will promote the opportunity for personalized learning and precision education for competency- and timed-based medical education strategies. To accomplish this transformation, teaching faculty must be prioritized, supported, and valued, with their contributions to UME in the classroom and in clinical settings recognized in their compensation models.

#2 – How would integration of the two medical schools align, reconcile, or reimagine the curriculum?

Three parallel processes by which integration could occur are needed.

- Continue attention to separate accreditation. It is critical that priority be given to the ongoing accreditation of NJMS, which involves a limited site visit in February 2023. Additionally, RWJMS is in the middle of curricular reform, and its upcoming accreditation activities will include evaluating the outcomes of this new curriculum, which should be implemented and evaluated prior to the proposed joint accreditation.
- Align and reconcile between NJMS and RWJMS. These activities should commence following the June 2023 accreditation decision for NJMS. The schools' faculty and leadership and standing committee leadership will determine the appropriate oversight structure, reconciliation of school governance and standing committee composition, and policies related to the medical education program.
- Reimagine what a single school would look like and develop a joint committee structure and vision for transformation. The faculty own the curriculum. The process of reimagining will be the result of thoughtful contemplation of the possibilities of a combined medical school.

A key decision will be determining whether each campus will have its own curriculum track or whether a single curriculum will be designed. If the latter is preferred, the two curricula will need to be closely examined and reconciled to develop a unified model. Emphasis will need to be placed on ensuring learning objectives are clearly articulated and understood by students and faculty.

#3 – How will an integrated medical school address clinical placements, pre-clerkship rotations, and clerkships?

Given the scarcity of clinical placement spots, geography is given the priority as pre-clerkships, rotations, and clerkships are assigned. Though geography will be respected as much as possible, both NJMS and RWJMS will prioritize what is best for the learner and the development of individualized educational experiences.

#4 – Will students be able to enroll in core classes and/or electives across campuses?

There will be opportunities for students to enroll in classes across campuses. Core classes will be offered on a student's assigned campus, and the elective calendars will be aligned to allow for cross-

campus electives. Detailed planning will also need to consider greater consistency in the lengths of required clerkships to support a student's ability to participate in cross-campus electives.

#5 – Will there be a greater emphasis on distance or remote learning?

No. Multiple learning modalities will continue to be employed; however, the focus will be on in-person learning. Furthermore, the curriculum must emphasize and prioritize active learning for our students, including movement from large-group to small-group formats.

#6 – Will students be expected to travel between campuses?

There may be some cross-campus travel. While requiring students to travel from one campus to another for required courses and clerkships may cause recruitment challenges, travel for certain specialties may increase opportunities for students focused on those specialties. As described in our response to question four, there may be opportunities for optional cross-campus travel for elective offerings. The university should consider options to support students who may want to travel from one campus to another (e.g., shuttle system, housing, and other identified resources).

#7 – How would an integrated medical school impact the current MD/PhD program?

To understand the full impact of the MD/PhD program between RWJMS and Princeton University, exploration would need to occur between the two schools. NJMS could consider integration into the program in the longer term; however, in the near term as the integrated model is further evaluated and defined, priority must be placed on preserving the current relationship with Princeton University. Any assessment and planning process for a combined RWJMS/NJMS program also must identify and address existing inequities, especially in compensation levels for MD/PhD students.

#8 – What are the metrics for success in a proposed integration?

- **Medical Education Program Evaluation (the key metrics for each campus should remain the same or improve)**
  - Match rate and analysis of the number of Rutgers students matching to top-tier programs
  - USMLE scores
  - Shelf exam scores
  - Medical education graduation questionnaire scores
  - Student evaluation of educational experience (courses and clerkships)
  - LCME accreditation status
  - Program Director surveys on graduates' performance
- **Satisfaction and Attraction Metrics**
  - Faculty, student, and staff satisfaction and wellness survey scores
  - Faculty and staff retention rates
  - Faculty recruitment relative to workforce plan
  - Faculty promotion rates
- **Matriculation Metrics**
  - Yield (i.e., the ratio of matriculated to accepted)
  - Diversity of class composition

    - Increase in out-of-state matriculants (non-New Jersey/New York, no personal linkages to the region) indicating an improved national brand
- **Financial Metrics**
    - Growth in research grants
    - Increased philanthropy for scholarships

Other Key Considerations

Finally, as the committee discussed and developed responses for the assigned questions, it also identified the following additional concerns and considerations related to an integrated medical school model.

- Identifying additional resources that may be required and acknowledgement of current capacity challenges faced by current faculty, especially relative to a transition period when multiple curricula are running simultaneously.
- Determining the budget for and implementation costs of the proposed medical school merger, including any incremental administrative requirements.
- Gaining approval from faculty for any changes to bylaws that may be necessary under a single accreditation model.
- Understanding the potential impact on revenue if applications and/or enrollment decrease.
- Recognizing the potential impact of another major institutional change on faculty/staff morale and retention.
- If multiple curricula are maintained after the merger, determining a process for campus/curriculum selection and assignment (i.e., the admissions committee must consider this, as well).
- Achieving comparability of educational facilities across the two campuses.
- Investing additional resources to address existing (and future) faculty capacity constraints, given the level of engagement and time commitment in planning and implementing an integrated medical school.
- Addressing stakeholder and community concerns regarding the rationale for the merger.
- Capitalizing on the opportunity for innovation and for identifying and sharing best practices across campuses as a potential outcome/benefit of the merger.

Responses to Other Questions

Responses to Other Questions

Research-Related Questions

#1 – How will the integration improve administrative and research infrastructure on the two campuses?

Our intention is to create an infrastructure that will increase efficiency and allow for potential redirection of resources to enhance services provided by the RBHS Office of Research to make us more competitive with peer institutions.

Importantly, there is no intent to lay off staff. The goal is to train (and retrain) individuals to adapt to research needs and to provide an infrastructure that minimizes the administrative burden on investigators while bolstering cores, space, pre- and post-award support, grant bridging support, and recognition of researchers, among other services.

#2 – What is the appropriate role and reporting relationship between medical school departments and RBHS research-based institutes vis-à-vis the integrated medical school?

Currently, there are no reporting relationships between medical school departments and centers/institutes, and this would not change with an integrated medical school. An important reason for developing institutes and centers is to have nationally renowned units that focus on a specific research theme (e.g., neuroscience, cancer) in a multi-disciplinary, interschool, and sometimes interchancellor-led unit fashion. The RBHS academic professoriate appointments will remain with the schools (medical and non-medical). However, if the medical school were already integrated, there might be less need for new institutes/centers.

#3 – How will access to research cores be addressed?

There is no foreseen issue regarding access or costs across the campuses in an integrated model. For core services where distance makes their utilization impractical (or infeasible), satellite core facilities will be established to provide access for faculty and their trainees. There will be one cost for users regardless of location.

#4 – Will integration enhance faculty competition for research funding or inhibit it as limited submission NIH grant applications with only be one school applying versus two?

In most cases, this is already not an issue due to the DUNS/UEI consolidation from eight numbers under the RBHS umbrella to one number, similar to the other chancellor-led units. The integration is projected by all measures to enhance faculty competition for research funding – competing from one stronger institution and not competing against each other. The number of limited submission grants is very small and, regardless, having two schools from the same university apply to the same grant creates internal competition (rather than collaboration) and may even lead to external reviewers questioning why two schools in the same chancellor-led unit are competing against each other for a limited submission mechanism. Independent of grants, integration, by definition, is predicted to enhance research collaboration.

#5 – What is the impact on federal grants and any limitations on aid for a larger school?

The integration should have a strong positive impact on the success in competing for and securing federal (and non-federal) grants due to the combined resources (which may include larger potential institutional cost-share), being in a position to put forth stronger applications, and (at least perceived) enhanced feasibility to achieve the proposed research project aims given the improved reputation index (since research dollars and research infrastructure becomes attributed to one larger and stronger entity).

Administration/Leadership Questions

#1 – How will an integrated medical school impact faculty recruitment?

It is not anticipated that an integrated medical school will adversely impact faculty recruitment. It is recognized that communication with candidates regarding any changes will be important, particularly as an integrated structure is being planned and implemented. However, a single school with combined resources and expanded research opportunities (and more highly ranked) may provide a more attractive option for potential recruits.

#2 – What will be the name of the new school? The individual campuses?

Developing a name for the integrated medical school will be considered carefully and involve input from numerous stakeholders, including (but not limited to) faculty, staff, students, community members, and alumni. Each campus's rich history and culture will be considered when establishing any new nomenclature. Tentatively, we are considering "Rutgers Medical School" or "Rutgers School of Medicine", while the campuses would be "NJMS Campus" and "RWJMS Campus," but this is certainly open to further evaluation and discussion.

#3 – What will diplomas say?

Diplomas will be updated as appropriate to reflect any changes to the name of the school **and** the campus from which a student graduates.

#4 – Will the integration result in higher medical school rankings?

The impact of an integrated medical school on research rankings is substantial, whether looking at the ranking of individual departments or the medical school overall, and across all types of funding (e.g., federal and state funding among others), and this impacts other ranking systems (e.g., USNWR). For example, our federal fiscal year (FFY) 2021 NIH funding institutional rankings[4] among 143 US medical schools are:

- RWJMS at #62 with $68 million.
- NJMS at #74 with $51 million.
- Combined RWJMS/NJMS at #47 with $119 million.

Among the 14 Big 10 medical schools (counting Rutgers' individual schools separately), Rutgers now ranks only #12 (RWJMS) and #13 (NJMS), above only Michigan State University's medical school. A

[4] FFY 2022 rankings will be available in March 2023.

combined medical school would rise to #9 in the Big 10 and be more closely comparable to the University of Iowa and Ohio State University.

Other published rankings are driven substantially by research funding. While NJMS and RWJMS are already artificially combined in Blue Ridge's NIH rankings, US News and World Report evaluates schools separately based on their individual accreditations (which also divides and weakens the rankings of our clinical and basic science departments).[5]

Under an integrated model, there may be some resources or other elements of each school that may operate more efficiently/effectively when combined into a single entity leading to an outcome that further improves rankings (e.g., acquisition of grants that may not have been awarded to the schools separately).

#5 – What is the anticipated cost of integrating the medical schools?

A key objective in developing an integrated model will be to avoid any unnecessary duplication of administrative infrastructure already being provided by the medical schools, RBHS, or university. As such, we do not expect the costs of the proposed integration to be significant. The only elements of integration with direct costs known to date are the hiring of consultants (ECG and Dr. Janis Orlowski) to facilitate and coordinate the development of this report. Potential future costs may include additional external assistance in certain planning and implementation activities, LCME and other accreditation-related expenses, the possible implementation of transportation options between campuses, and the expense of rebranding once the schools are merged.

#6 – What is the process to review and approve an integration of the medical schools?

Following submission of this report to the University Senate and responding to any follow-up questions or requests, it will also be shared with the University President and Board for their determination of next steps. An integrated medical school would also require a formal consultation, review, and approval by LCME.

#7 – Who will be consulted? Students? Faculty? Alumni? Government Officials? Senate? Boards? LCME? Local communities? Hospital affiliates? Donors?

To ensure that internal and external stakeholder voices are heard, there will need to be significant emphasis placed on community engagement through a multi-faceted approach. In the development of this report alone, there has been a website providing details about the process, where it stands, and collecting data via an online survey, other forums for sharing feedback (e.g., Conversation with our Communities event), engagement of government officials, and consultations with alumni. Additionally, each of the three committees included faculty, staff, and students from both NJMS and RWJMS, many representatives from the Senate and other faculty governance organizations, as well as representatives from the community and clinical affiliates.

[5] It is recognized that many institutions (e.g., Columbia, Harvard, Mt. Sinai, University of Pennsylvania, and Stanford) have decided to discontinue their participation in the USNWR medical school rankings, given concerns about how those rankings are determined. Our expectation is that the rankings will continue, as the public desires them, and we hope that USNWR will revise its formulae to address some of the objections (as it has done for its law school rankings). At the least, the rankings may be based more on publicly available metrics, which would make NIH funding even more important.

#8 – Will each school/campus budget be held harmless and receive comparable funding once integrated as in prior years?

Yes. There are no anticipated budget changes for each campus post-integration. Each campus would maintain its own budget and accountability for its own operational and financial performance.

#9 – What are the budget, revenue, revenue cycle, and funds flow models for an integrated medical school?

Because we do not expect the budgets of NJMS and RWJMS to merge, these processes/models (i.e., budget, revenue, revenue cycle, and funds flow) would also not be expected to change and would remain locally managed at each campus.

#10 – How will administrative systems be integrated, like IT? Grants management?

Most of the administrative systems within RBHS and its component schools are university-based systems and not specific to either medical school campus. Therefore, the systems are already integrated across Rutgers and not expected to change.

#11 – What is the proposed administrative structure of an integrated medical school?

The administrative structure of an integrated medical school would require some centralized leadership (e.g., co-deans) and committees (e.g., curriculum) to provide collective oversight and meet accreditation requirements. Local leadership and administrative infrastructure would be kept in place, with campus deans and other infrastructure dedicated to NJMS and RWJMS to support campus-specific goals, relationships, processes, and initiatives. Goals and job descriptions for any new roles would be developed with engagement and input from both NJMS and RWJMS leadership.

#12 – Will there be more or less faculty and staff in an integrated medical school?

It is anticipated that integrating the two medical schools will present opportunities for growth through new offerings and growth in research and other existing service offerings. It is expected that this growth will be attractive to potential faculty and staff and result in increased recruitment.

#13 – How will the integration improve administrative infrastructure on the two campuses?

Many university and RBHS administrative services are already centralized, and it is not expected that the integration will lead to significant changes in university and RBHS administrative infrastructure. As described previously, the administrative structure of an integrated medical school would require some centralized leadership and committees to provide collective oversight and meet accreditation requirements. It is anticipated that these centralized leadership structures over time will also provide a means for disseminating best practices between campuses and identifying potential shared service opportunities that improve access for both campuses to administrative expertise and resources.

#14 – How will the clinical practices be organized in an integrated medical school?

It is not anticipated that the organizational models of the clinical practices will change as a result of an integrated medical school structure.

#15 – Will clinical services be provided locally, regionally, or both?

Clinical services will continue to be provided locally and regionally as currently structured, with integration offering opportunities for greater levels of coordination and planning between the two schools.

#16 – What is the role of the dean?

As previously described, it is anticipated that each campus will have a local campus dean to serve as academic and administrative leader and support campus-specific goals, programs, and initiatives. This campus-specific leadership model may evolve as the needs of the medical school and campuses change over time. As planning for the integration progresses, the exact title that is used for these leadership roles may change, although defined responsibilities will not.

#17 – What is a proposed timeline to accomplish a medical school integration?

The development of this report is one step in the journey for developing an integrated medical school, and a timeline has not been finalized. There are several planning processes and approvals that will need to occur (e.g., review and accreditation by LCME) and may require 4 to 5 years to accomplish. More immediate next steps include review of and response to this report by the University Senate, followed by sharing the report and feedback from the University Senate with the University President and Board of Governors for their consideration.

#18 – How will transportation and parking between the two campuses be addressed?

With the increased use of Zoom and other virtual teaching options, transportation between campuses has not been a recent issue. With the renovation and expansion of the New Brunswick train station, train travel between the cities will become even easier as well. If faculty, staff, and students will be traveling more frequently between campuses due to opportunities arising from the integrated structure, however, RBHS leadership can consider options to support related transportation requirements (e.g., a shuttle bus between the two campuses).

#19 – Will faculty be expected to travel between campuses?

There is no intent to have faculty necessarily travel between campuses due to the integration or to change how faculty members move between the campuses today. It is expected, however, that there will be newly hired sub-specialized clinical faculty, who will split their clinical time between the two campuses.

#20 – How will faculty promotions and tenure decisions be implemented?

Decisions on faculty promotion and tenure will continue to follow the overarching RBHS and Rutgers process, as negotiated with the union. In contrast to the law schools, both schools are under the same chancellor. In contrast to the nursing school, faculty in both schools are members of the same union.

RUTGERS Biomedical and Health Sciences

Report to the Rutgers University Senate – Exhibits and Appendices

Rutgers Biomedical and Health Sciences

January 31, 2023

Exhibits

Exhibit I - Admissions Committee Members

Name	Title	Institution
H. Liesel Copeland, PhD (cochair)	Assistant Dean of Admissions	RWJMS
George F. Heinrich, MD (cochair)	Associate Dean of Admissions	NJMS
Gloria A. Bachmann, MD	Associate Dean of Women's Health	RWJMS
Natalia L. Kellam	Student	RWJMS
Payal V. Shah	Student	NJMS
Carol A. Terregino, MD	Senior Associate Dean of Education and Academic Affairs	RWJMS
Joshua M. Kaplan, MD	Associate Professor of Medicine	NJMS
Sonia C. Laumbach, MD	Assistant Dean of Student Affairs	RWJMS
Maria L. Soto-Greene, MD	Executive Vice Dean	NJMS
Danitza M. Velazquez, MD	Assistant Professor, Pediatrics	NJMS

Exhibit I – Culture and Identity Committee Members

Name	Title	Institution
Charletta A. Ayers, MD, MPH (cochair)	Associate Professor, Obstetrics, Gynecology and Reproductive Sciences	RWJMS
Melissa B. Rogers, PhD (cochair)	Associate Professor, Microbiology, Biochemistry and Molecular Genetics	NJMS
Shareif Abdelwahab	Student	RWJMS
Bill Arnold	President and Chief Executive Officer (CEO)	Robert Wood Johnson University Hospital
Detlev Boison, PhD	Professor, Neurosurgery	RWJMS
Alison L. Clarke	Program Coordinator	RWJMS
Dr. C. Roy Epps	President and CEO	Civic League of Greater New Brunswick
Carmen L. Guzman-McLaughlin, MPH	Senior Director, Administration	NJMS
George Hampton	Retired VP	The University of Medicine and Dentistry of New Jersey
Michael Kelly, MD	Associate Dean, Graduate Education	RWJMS
Neil Kothari, MD	Associate Dean, Graduate Medical Education	NJMS
M. Chiara Manzini, PhD	Associate Professor, Child Health Institute of New Jersey	RWJMS
Mary Maples, JD	Interim President and CEO	University Hospital
Ana M. Natale-Pereira, MD, MPH	Associate Professor, Department of Medicine	NJMS
J. Patrick O'Connor, PhD	Associate Professor, Orthopedics	NJMS
Jon L. Oliver	Assistant Dean of Information Technology	Rutgers School of Communication and Information
Timothy Pistell	Student	NJMS
Nikolaos Pyrsopoulos, MD, PhD	Professor and Chief, Gastroenterology and Hepatology	NJMS
Arnold Rabson, MD, PhD	Director, Child Health Institute of New Jersey	RWJMS
Frank Sonnenberg, MD	Chief Informatics Officer	RWJMS
Ian Whitehead, PhD	Professor, Microbiology, Biochemistry, and Molecular Genetics	NJMS

Exhibit I – Curriculum Committee Members

Name	Title	Institution
Maria Soto-Greene, MD (cochair)	Executive Vice Dean	NJMS
Carol A. Terregino, MD (cochair)	Senior Associate Dean of Education and Academic Affairs	RWJMS
Rashi Aggarwal, MD	Vice Chair, Residency Training Director	NJMS
Alla Fayngersh, MD	Assistant Professor, Department of Medicine	NJMS
Meigra (Maggie) Myers Chin, MD	Associate Professor, Emergency Medicine	RWJMS
Amir George	Student	NJMS
Brooke K. Phillips	Student	RWJMS
Archana Pradhan, MD	Associate Dean for Clinical Education	RWJMS
Monica Roth, PhD	Professor, Pharmacology	RWJMS
Michael E. Shapiro, MD	Professor, Surgery	NJMS
Ranita Sharma, MD	Executive Vice Chair, Residency Program Director	RWJMS
Christin Traba, MD	Associate Dean for Education	NJMS

Exhibit II – Chancellor's Charge to the Committees

As you begin your work to answer questions from the University Senate about the future of academic medicine, I would like to provide you with the following guidelines and historical context.

Historical Context of Medical Schools

New Jersey Medical School and Robert Wood Johnson Medical School were originally set up by Dr. Stan Bergen to compete with each other. That model, to foster rapid regional growth and development, was apt for its time. We have succeeded in so many areas under this model: Our students are consummately prepared for residency and achieve placements in top programs across the nation. Our research portfolio has been expanding rapidly and in some areas we can claim national leadership status like infection and inflammation, microbiome, and cancer. Clinical programs like the liver transplant unit, trauma centers, etc. are highly regarded for providing world-class care equal or superior to regional competitors. For other world-class initiatives we have built institutes to cut across our schools successfully, e.g., cancer, infection/immunology, and neuroscience.

Changes in Academic Medicine Today

Is our current model sustainable in today's health care climate? Today, the health care payer and provider markets are consolidating rapidly and across much wider swaths of geography than were contemplated at the inception of medical education in New Jersey. Our competition is not from within, but from other New Jersey hospital systems, newer local medical schools, and aggressive and expansive academic health centers based in New York, Philadelphia, and in some instances even farther afield. Patients are leaving NJ to get the most advanced care, as too often it is not available in NJ. This out-of-network care is much more expensive, and especially hurts patients who cannot afford to go elsewhere for such care.

Telemedicine is erasing local licensing restrictions; previously unimaginably large data sets move instantaneously across the world; dissections can be virtual; lectures are asynchronous and can be (and are) played by the students at double speed; and diagnostics, monitoring, and follow ups are no longer exclusively dependent upon the physical presence of patients at clinical sites. Medical care is shifting from inpatient sites to outpatient sites, with important implications as well to the future of medical education.

We also are in the fortunate situation with substantial investment newly available for major capital construction, in both cities, and for broad-based faculty recruitment. Given this, our immediate task is to develop responses to the questions posed by the University Senate in the areas designated for each committee.

Exhibit II – Chancellor's Charge to the Committees (continued)

Committees' Charges

The three committees will focus on:

- Admissions: Would the admissions processes in the schools need to change at all, recognizing that medical school admission processes of course naturally evolve over time?
- Curriculum: Would the curriculum in the schools need to change at all, recognizing that medical school curricula of course naturally evolve over time?
- Culture and Identity

I ask you to contemplate a hypothetical administrative structure where New Jersey Medical School and Robert Wood Johnson Medical School can attain the maximum level of cooperation and coordination, i.e., if they were placed under one LCME accreditation, while still maintaining their unique campus identity and culture.

Let me set a few parameters on how I envision this:

- I do not envision a future for the medical schools where one is ever subordinate to the other.
- I do not envision a scenario that results in the loss of jobs (union or otherwise) among the faculty or staff, at either school; rather I see growth and investment in clinical care, research, and educational opportunities.
- I do not envision a scenario where either school will be expanding its student body, since the inpatient clinical capacity could not sustain that.
- I do see that each campus will benefit from the hands-on presence of a local dean working collaboratively with a colleague similarly situated 26 miles away.
- I do see a scenario where we can offer new tertiary and quaternary services at Robert Wood Johnson University Hospital in New Brunswick and University Hospital in Newark to meet more of our patients' needs within the State of New Jersey.

Exhibit II – Chancellor's Charge to the Committees (continued)

My hope is that our medical students will be able to take advantage of the best educational opportunities that each school can offer and pursue their interests and ambitions seamlessly across schools without undue impediments. How can we achieve this and maintain our high admissions standards across the two schools, and enroll classes that reflect our state's diversity? How can we provide a thorough and comprehensive curriculum to meet the needs of our future physicians and their patients? How can we retain the unique and valuable contributions and culture that distinguish and enhance the faculty, staff, student, and patient experience at each school, which is and will continue to be reflective of their principal teaching hospital?

If you can, contemplate these questions with the hypothetical construct that NJMS and RWJMS will in some way integrate their operations and activities more closely than we do today.

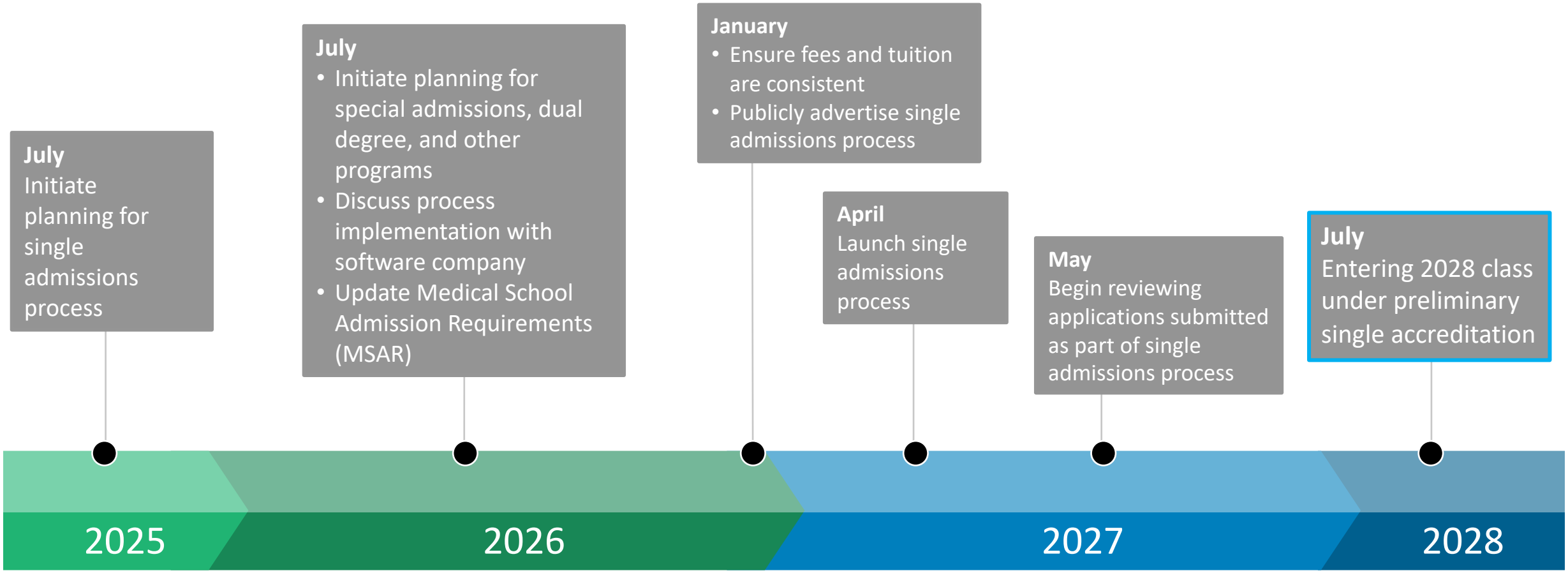
Next Steps

Dean Johnson, Dean Murtha, and I will also be developing responses to those questions that are administrative in nature, and we will be working with the RBHS Office of Research to answer those questions particular to research. In addition, we will be setting up a web-based survey instrument to collect comments from across the medical schools and across the state.

ECG will collect and distribute all the responses and we will share this document with you, our medical schools, the community, and the University Senate for their review. We plan some forums in each city to obtain input from our host communities and local leaders. Following the Senate review a formal proposal will be drafted for President Holloway and the Boards to review.

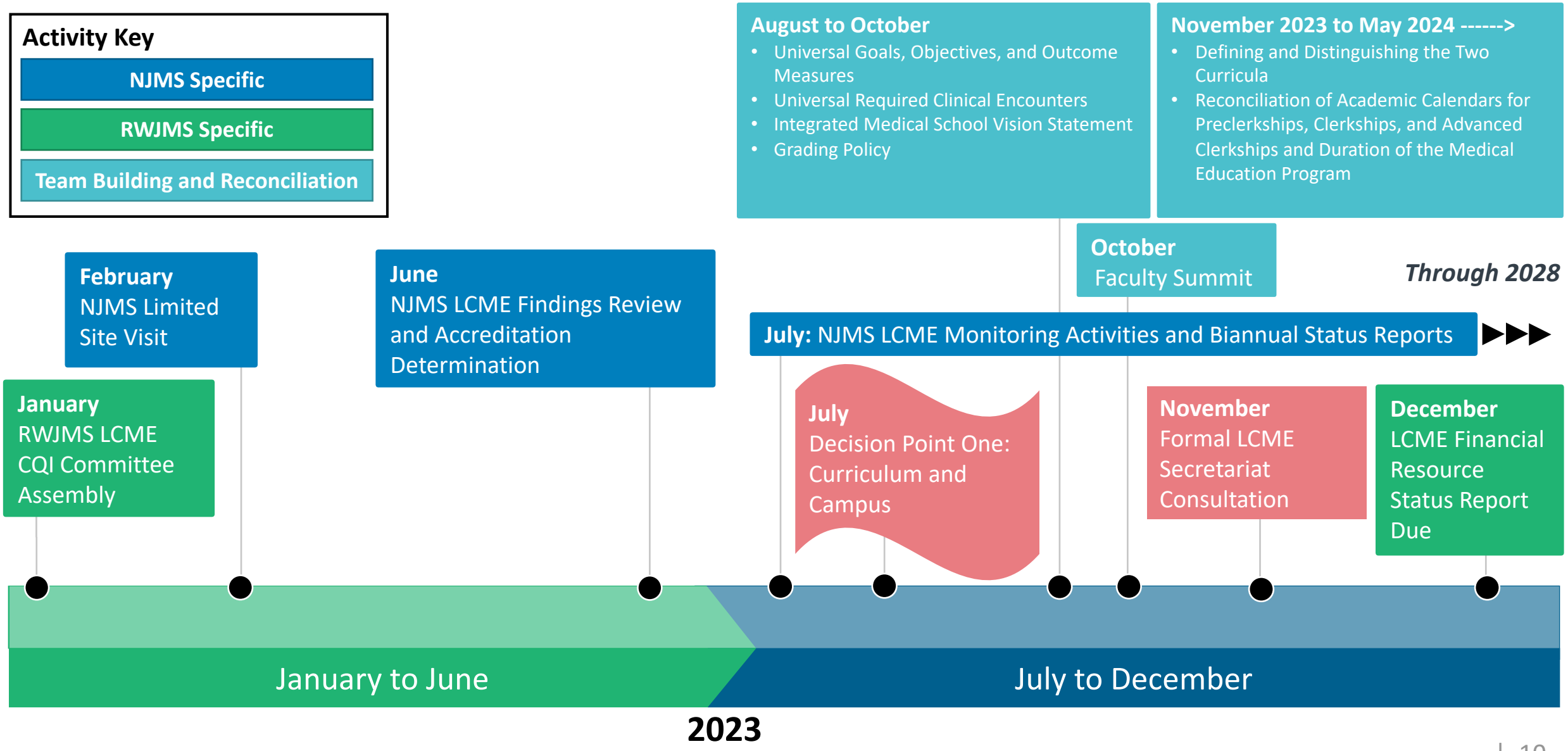
We all seek a medical education program that best delivers on the promises made to our communities, the people of New Jersey, our professions, and our patients. I welcome your thoughts, perspectives, experience, and knowledge as we contemplate a structure that will optimally deliver on our missions.

Exhibit III – Potential Framework and Timeline with Key Milestones for Admissions Process under Single LCME Accreditation

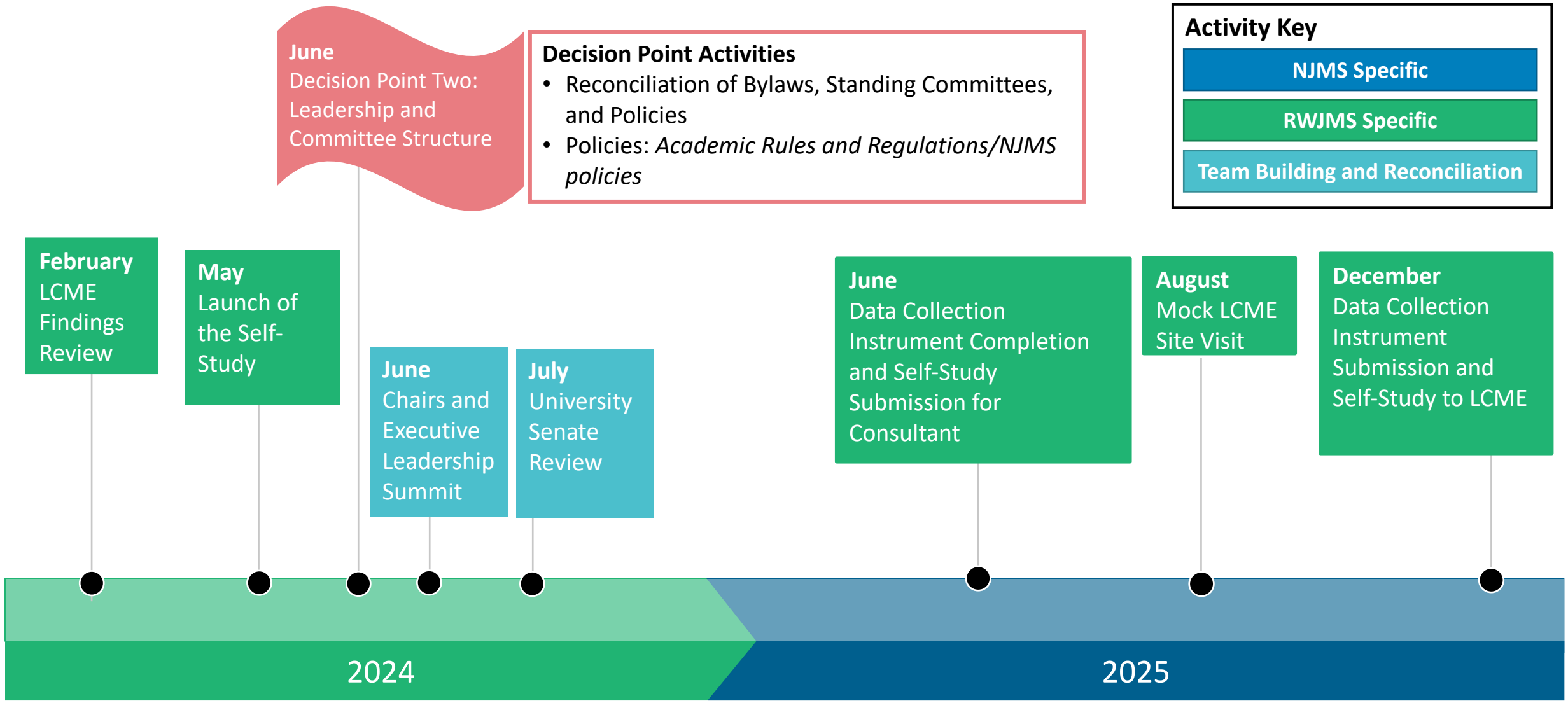


Entering classes of 2025, 2026, and 2027 graduating in 2029, 2030, and 2031 continue under separate RWJMS and NJMS accreditations.

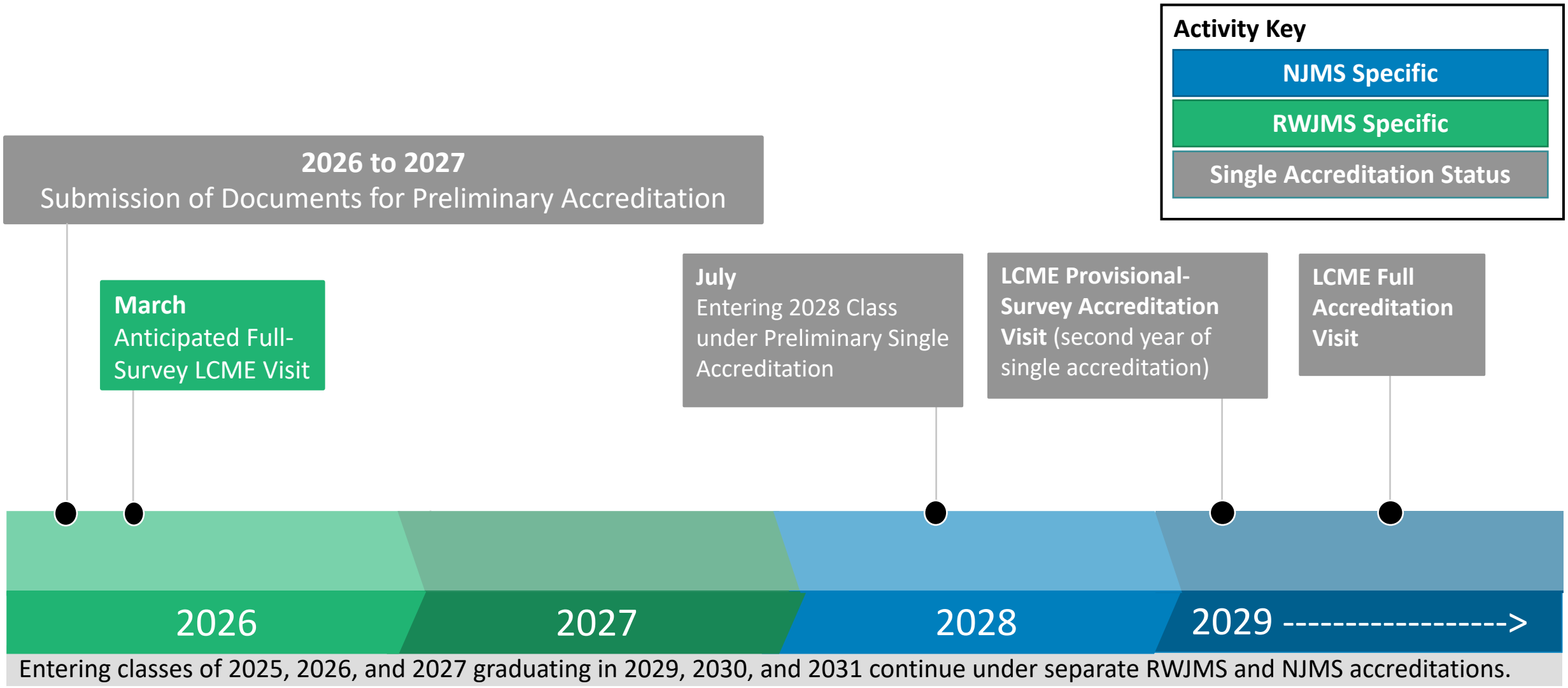
Potential Framework and Timeline with Key Decision Points



Potential Framework and Timeline with Key Decision Points *(continued)*



Potential Framework and Timeline with Key Decision Points *(continued)*



Appendix A
Applicant, Matriculant, Enrollment, and Graduate Profiles and Trends

Data Comparison across Schools: Applicants and Matriculants

Metric	NJMS	RWJMS
Total Applicants (class of 2022–2023)	5,904	5,524
Total Matriculants (class of 2022–2023)	176	165
Total MD/PhD Applicants (class of 2022–2023)	155	218
Total MD/PhD Matriculants (class of 2022-2023)	2	4
Applicant Gender Profile (class of 2025)	42% men/58% women	41% men/59% women
Out-of-State Applicants (class of 2025)	74%	72%
Matriculant Gender Profile (class of 2025)	44% men/56% women	40% men/61% women
Out-of-State Matriculants (class of 2025)	22%	22%
Matriculants Underrepresented in Medicine (class of 2025)	26%	28%

Note: "Underrepresented in medicine" means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population. Refer to Underrepresented in Medicine Definition | AAMC.

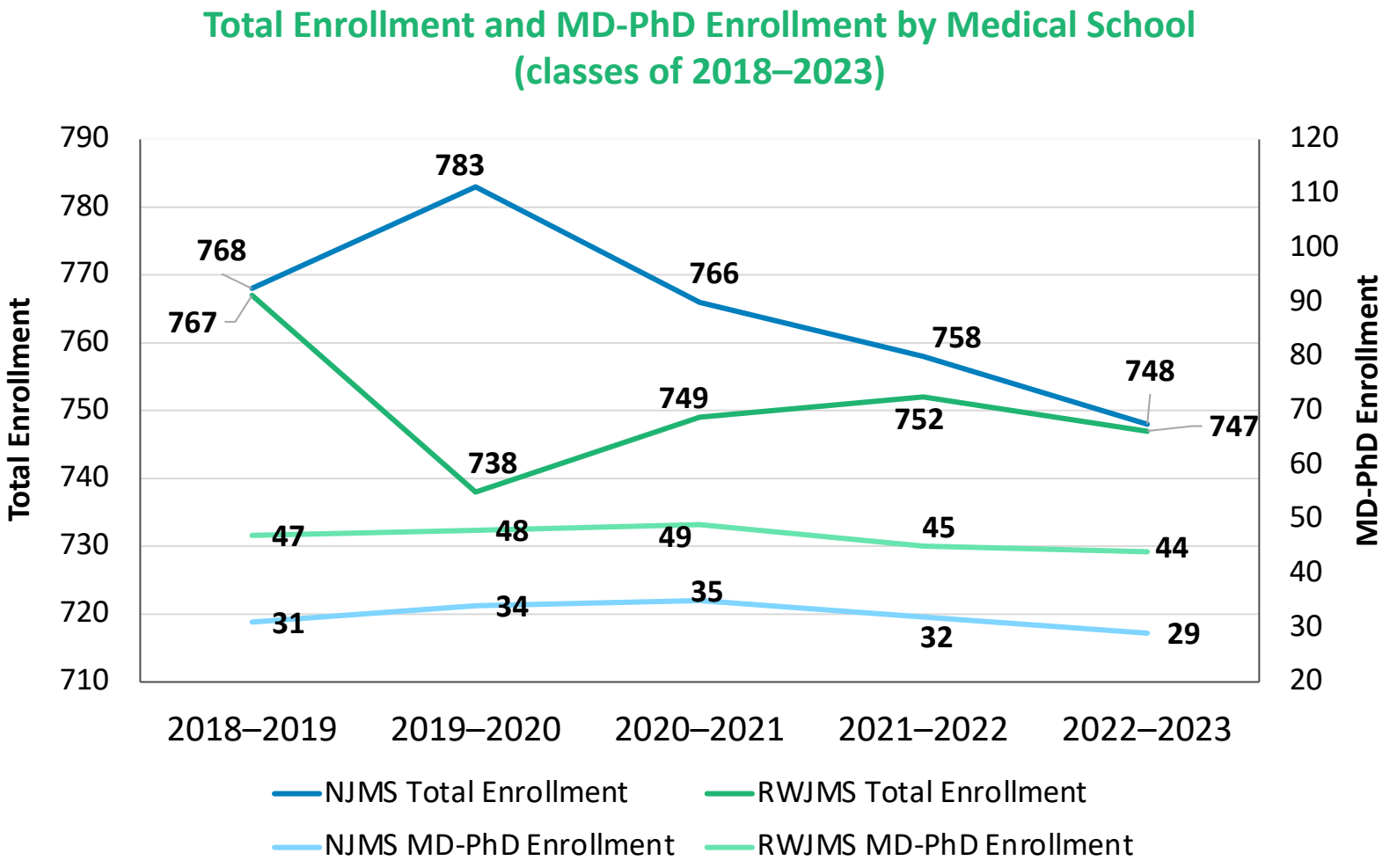
Sources: AAMC FACTS Data Table A-1 U.S. MD-Granting Medical School Applications and Matriculants by School, State of Legal Residence, and Gender, 2022–2023
AAMC FACTS Data Table B-8 U.S. MD-Granting Medical School MD-PhD Applications and Matriculants by School, State of Legal Residence, and Gender, 2022–2023.
AAMC FACTS Data B-2.2: Total Graduates by U.S. MD-Granting Medical School and Gender, 2017–2018 through 2021–2022.
NJMS Matriculants URIM statistic provided by curriculum committee co-chair.
Rutgers New Jersey Medical School Admissions Guide (available AdmissionsInformation.pdf (rutgers.edu)).

Demographics for NJMS and RWJMS Enrollees (2022–2023)

	NJMS	RWJMS
Enrollment	748	747
Percentage Breakdown by Race/Ethnicity	**NJMS**	**RWJMS**
Asian	41.3%	36.4%
Black or African American	10.7%	10.2%
Hispanic, Latino, or of Spanish Origin	9.5%	7.4%
White	24.5%	32.3%
Multiple Race/Ethnicity	8.4%	8.8%
Other	3.9%	3.2%
Unknown Race/Ethnicity	1.6%	1.1%

Note: Less than 1% of each school's total enrollment identifies as a non–US citizen or non–permanent resident.
Source: AAMC FACTS Data Table B-5.1 Total Enrollment by U.S. MD-Granting Medical School and Race/Ethnicity (Alone), 2022–2023.

Enrollment Trends



Key Takeaways

- The enrollment period immediately prior to COVID-19 (2019–2020) shows the greatest annual variance in total enrollment for both schools:
  - NJMS = 2% increase
  - RWJMS = 4.8% decrease
- Both NJMS and RWJMS show a slight (2.5%) decrease in total enrollment since AY 2018–2019.
- MD-PhD enrollment has remained stable over the last five academic years at both medical schools.

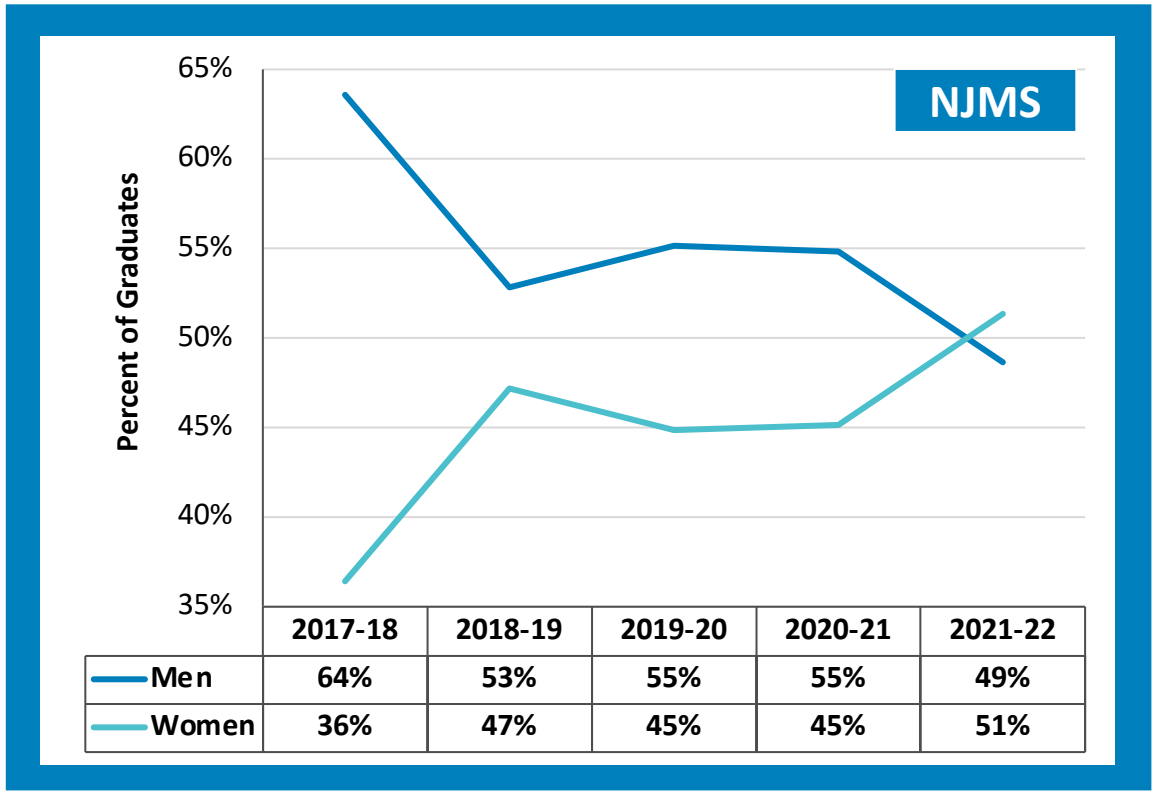
Source: AAMC FACTS Data B-1.2 Total Enrollment by U.S. Medical School and Sex, 2018–2019 through 2022–2023.

Demographics for NJMS and RWJMS Graduates (2021–2022)

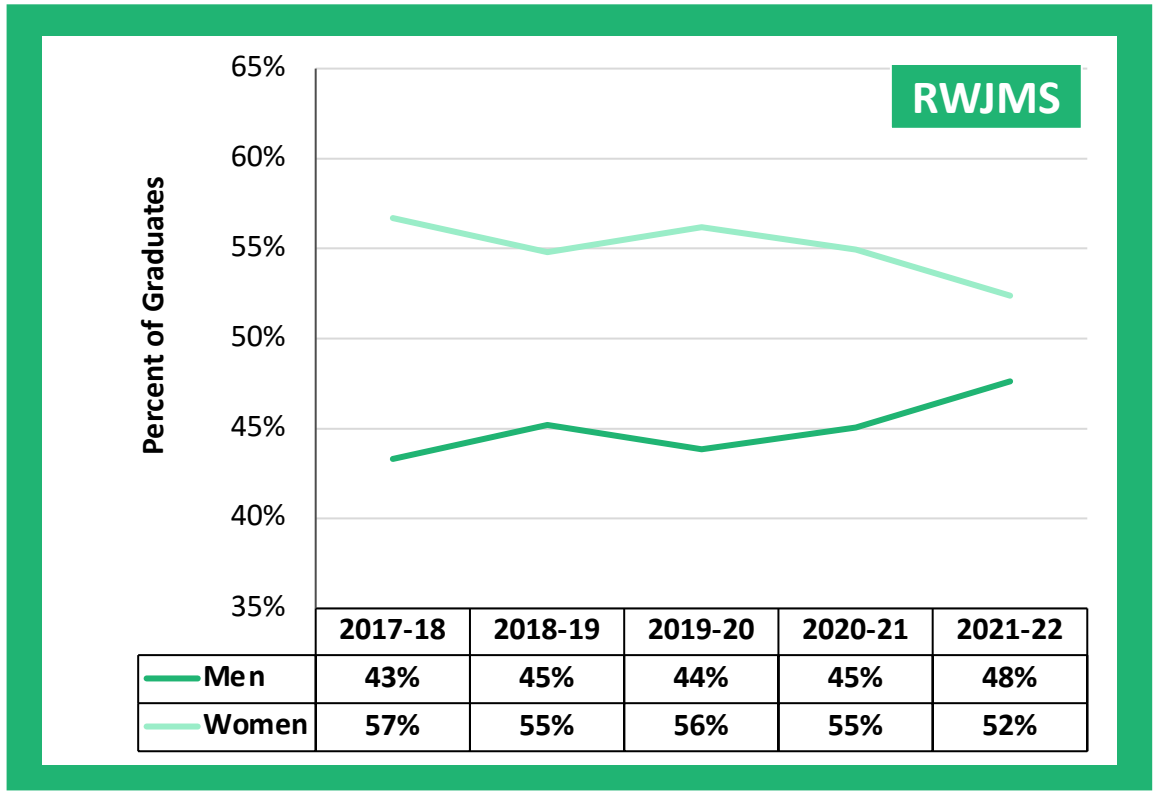
	NJMS	RWJMS
Graduates	185	168
Race/Ethnicity	**NJMS**	**RWJMS**
Asian	38.4%	33.3%
Black or African American	8.6%	13.1%
Hispanic, Latino, or of Spanish Origin	8.6%	5.4%
White	31.4%	35.7%
Multiple Race/Ethnicity	7.6%	6.0%
Other	5.4%	3.6%
Unknown Race/Ethnicity	0%	1.8%
Non–US Citizen and Non–Permanent Resident	0%	1.2%

Source: AAMC FACTS Data Table B-6.1 Total Graduates by U.S. MD-Granting Medical School and Race/Ethnicity (Alone), 2021–2022.

Medical School Graduates by Gender



	2017-18	2018-19	2019-20	2020-21	2021-22
Men	64%	53%	55%	55%	49%
Women	36%	47%	45%	45%	51%



	2017-18	2018-19	2019-20	2020-21	2021-22
Men	43%	45%	44%	45%	48%
Women	57%	55%	56%	55%	52%

Source: AAMC FACTS Data B-2.2: Total Graduates by U.S. MD-Granting Medical School and Gender, 2017–2018 through 2021–2022.

Appendix B
Faculty Hiring and Turnover

Data Comparison across Schools: Faculty and Department Chairs

Metric	NJMS	RWJMS
Three-Year Average Faculty New Hires per Year (AY 2017–2018 through AY 2020–2021, N and percentage of total)		
Men	28.5 (54%)	48.3 (53%)
Women	23.8 (46%)	43.0 (47%)
Three-Year Average Faculty Departures per Year (AY 2017–2018 through AY 2020–2021, N and percentage of total)		
Men	42.5 (62%)	32.0 (57%)
Women	26.3 (38%)	24.0 (43%)
Department Chair Demographics		
Basic Sciences: Men	2	0
Basic Sciences: Women	1	3
Clinical Sciences: Men	14	13
Clinical Sciences: Women	2	1

Sources: AAMC Data Table A: Average Full-Time Faculty New Hires and Departures by Medical School and Gender, Academic Years 2017–2018 through 2020–2021.
AAMC Data Table D: Department Chairs by Medical School, Department Type, and Gender, 2021 (reflects both interim and permanent positions).

Data Comparison across Schools: Faculty New Hires and Departures

		AY 2015–2016 through AY 2018–2019	AY 2016–2017 through AY 2019–2020	AY 2017–2018 through AY 2020–2021	Percentage Change
NJMS	Three-Year Average Faculty New Hires per Year	51.3	54.5	52.3	1.9%
	Three-Year Average Faculty Departures per Year	55.8	74.6	68.8	23.3%
RWJMS	Three-Year Average Faculty New Hires per Year	89.0	91.3	91.3	2.6%
	Three-Year Average Faculty Departures per Year	67.8	63.0	56.0	-17.4%

Sources: AAMC Data Table A: Average Full-Time Faculty New Hires and Departures by Medical School and Gender, Academic Years 2017–2018 through 2020–2021.
AAMC Data Table A: Average Full-Time Faculty New Hires and Departures by Medical School and Gender, Academic Years 2016–2017 through 2019–2020.
AAMC Data Table A: Average Full-Time Faculty New Hires and Departures by Medical School and Gender, Academic Years 2015–2016 through 2018–2019.

Appendix C
Summary of Combined Program Offerings and Clinical Affiliations

Combined Program Offerings

NJMS

MD/MBA: Collaboration between NJMS and Rutgers Business School

- Provides students with healthcare management background

MD/MPH: Five-year program in partnership with Rutgers School of Public Health

MD/PhD: Seven-year interdisciplinary experience with emphasis on full-time research in years three through five to fulfill PhD

MD with Thesis Program: Geared toward students with career ambitions in academic medicine

- Additional year of learning is dedicated to independent research in area of choice

Source: Rutgers New Jersey Medical School.

RWJMS

MD/MPH: Five-year program in partnership with Rutgers School of Public Health

MD/PhD: Joint program with Princeton and Rutgers Business School–New Brunswick

MD/MBAL: Collaboration with Rutgers Business School–New Brunswick

MD/JD: Collaboration with Rutgers Law

MD/MSCTS: MS degree awarded by Rutgers Graduate School of Biomedical Sciences

PharmD/MDL: Partnership with the Ernest Mario School of Pharmacy

- PharmD students are directly admitted to RWJMS without MCAT requirement.

Source: Dual Degree Programs.

Major Clinical Affiliates by School

NJMS

- **Principal Hospital: UMDNJ–University Hospital**
- Hackensack University Medical Center
- Cooperman Barnabas Medical Center
- Newark Beth Israel Medical Center
- St. Joseph's Regional Medical Center
- St. Joseph's University Medical Center
- East Orange VA Medical Center

Source: Rutgers New Jersey Medical School

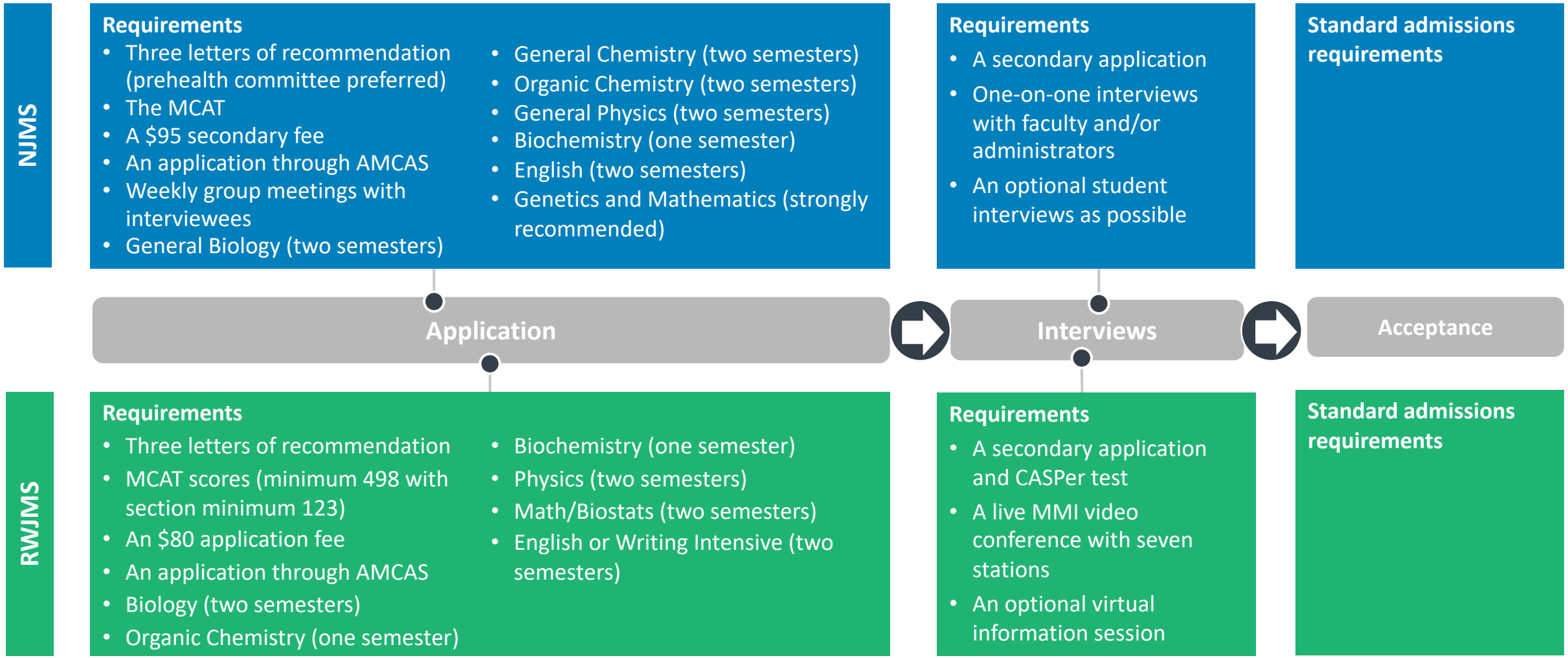
RWJMS

- **Principal Hospital: Robert Wood Johnson University Hospital–New Brunswick**
- Monmouth Medical Center
- Robert Wood Johnson University Hospital Somerset
- University Medical Center of Princeton at Plainsboro
- Saint Peter's University Hospital
- JFK University Medical Center
- Raritan Bay Medical Center

Source: Affiliated Hospitals and feedback from committee cochair

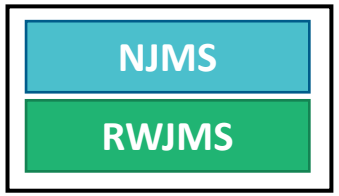
Appendix D
Comparisons of Admissions Process, Tuition, and Fees

Admissions Processes



Sources: NJMS Source: The New Jersey Medical School Office Of Admissions (rutgers.edu).
RWJMS Source: Applying to RWJMS (rutgers.edu) and information provided by the committee cochair.

Admissions Processes



	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.
AMCAS Application Available									
Secondary Application Available									
Early Decision Interviews Begin	5/3	Starts 6/28		8/1					
Early Decision Acceptances Begin			7/8		Begins 9/1				
Early Decision AMCAS Application Deadline									
Regular Decision Interviews Begin				All month					
Early Decision Supporting Materials Due				8/1					
AMCAS Application Deadline, Regular and Joint Decision Programs									
MCAT Scores									
Secondary Application Deadline								12/1	
Letters of Recommendation Deadline						10/31		12/15	1/5

Sources: NJMS Source: Applying to NJMS (rutgers.edu).
RWJMS Source: Applying to RWJMS (rutgers.edu) and Rutgers RWJMS–Education (rutgers.edu) and feedback from committee cochair.

Tuition Comparisons (academic year [AY] 2022–2023)

State	School of Medicine (SOM)	Ownership Type	Tuition	
			Resident	Nonresident
New Jersey	NJMS	Public	$44,435	$68,564
	RWJMS	Public	$44,435	$68,564
	Cooper Medical School of Rowan University (CMSRW)	Public	$42,505	$67,452
New York	Jacobs SOM and Biomedical Sciences (University of Buffalo)	Public	$43,670	$65,160
	SUNY Upstate Medical University–Norton College of Medicine (COM)	Public	$43,670	$65,160
	SUNY Downstate Health Sciences University COM	Public	$43,670	$65,160
Connecticut	University of Connecticut SOM	Public	$43,156	$74,367
Maryland	University of Maryland SOM	Public	$38,573	$68,249
Virginia	Eastern Virginia Medical School	Public	$34,442	$57,510
	University of Virginia SOM	Public	$46,044	$57,792
	Virginia Commonwealth University SOM	Public	$34,427	$57,710
Ohio	Northeast Ohio Medical University	Public	$41,687	$83,374
	Ohio State University COM	Public	$30,124	$55,044
	University of Toledo COM	Public	$33,966	$65,971
	University of Cincinnati COM	Public	$32,318	$51,176
	Wright State University Boonshoft SOM	Public	$37,837	$57,979
	Median Tuition (excluding Rutgers)		$40,130	$65,160
	Average Tuition (excluding Rutgers)		$39,006	$63,772

Source: AAMC Tuition and Student Fees Report for first-year students, AY 2022–2023 (AAMC tuition and student fees questionnaire).

Student Fees Comparisons (AY 2022–2023)

State	SOM	Ownership Type	Student Fees	
			Resident	Nonresident
New Jersey	NJMS	Public	$3,070	$3,070
	RWJMS	Public	$2,202	$2,202
	Cooper Medical School of Rowan University (CMSRW)	Public	$2,290	$2,290
New York	Jacobs SOM and Biomedical Sciences (University of Buffalo)	Public	$3,258	$3,258
	SUNY Upstate Medical University–Norton COM	Public	$1,543	$1,543
	SUNY Downstate Health Sciences University COM	Public	$733	$733
Connecticut	University of Connecticut SOM	Public	$2,660	$2,660
Maryland	University of Maryland SOM	Public	$2,925	$2,925
Virginia	Eastern Virginia Medical School	Public	$3,843	$5,672
	University of Virginia SOM	Public	$4,990	$4,534
	Virginia Commonwealth University SOM	Public	$3,843	$4,534
Ohio	Northeast Ohio Medical University	Public	$5,213	$5,213
	Ohio State University COM	Public	$957	$957
	University of Toledo COM	Public	$2,938	$2,938
	University of Cincinnati COM	Public	$2,064	$2,064
	Wright State University Boonshoft SOM	Public	$2,415	$2,415
		Median Fees (excluding Rutgers)	***$2,793***	***$2,793***
		Average Fees (excluding Rutgers)	***$2,834***	***$2,932***

Source: AAMC Tuition and Student Fees Report for first-year students, AY 2022–2023 (AAMC tuition and student fees questionnaire).

Appendix E
Residency Match Trends

Comparison of Match Data across Schools

	NJMS and RWJMS Student Matching by Program									
	2018		2019		2020		2021		2022	
	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS
Montefiore Medical Center–Albert Einstein COM										
Anesthesiology			2	1			1	2		
Emergency Medicine							1	1		
Internal Medicine					2	1			6	1
Neurology			1	1						
Pediatrics	2	1	2	1					4	1
NewYork-Presbyterian (NYP) Columbia University Irving Medical Center										
Anesthesiology									4	1
Family Medicine										
Internal Medicine			1	1						
Pediatrics							1	1		
Psychiatry									1	1
Icahn SOM at Mount Sinai										
Anesthesiology			1	1					1	1
Internal Medicine	1	1	2	4	4	2	4	1	2	2
Neurology					1	2				
OB/GYN							1	1		
Pediatrics	1	1							2	1
Radiation - Diagnostic					1	1				

Source: Committee cochairs.
Note: Rutgers programs with overlap are excluded here.

Comparison of Match Data across Schools *(continued)*

	NJMS and RWJMS Student Matching by Program									
	2018		2019		2020		2021		2022	
	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS
NYP/Weill Cornell Medical Center										
Anesthesiology			1	1						
Internal Medicine	2	2	2	2	2	1	1	1		
NYU Grossman SOM										
Anesthesiology					1	1				
Emergency Medicine							1	1		
Orthopedic Surgery					1	1				
Pediatrics					1	2				
Icahn SOM at Mount Sinai Morningside-West										
Anesthesiology							1	1	1	1
Morristown Medical Center										
Emergency Medicine					1	2				
Icahn SOM St. Luke's-Roosevelt										
Emergency Medicine			1	1						
Maimonide Medical Center										
Emergency Medicine			1	1			1	1		
University of Chicago Medical Center										
Emergency Medicine					1	1				

Source: Committee cochairs.
Note: Rutgers programs with overlap are excluded here.

Comparison of Match Data across Schools *(continued)*

	NJMS and RWJMS Student Matching by Program									
	2018		2019		2020		2021		2022	
	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS
NYP Brooklyn Methodist Hospital										
Emergency Medicine							1	1		
Thomas Jefferson University										
Family Medicine			1	1						
Internal Medicine			1	5			2	1	2	2
Radiation–Diagnostic					2	2				
Hunterdon Medical Center										
Family Medicine			1	1					1	2
Ocean University Medical Center										
Family Medicine					1	1				
Boston University Medical Campus										
Internal Medicine			1	2						
CMSRU/Cooper University Hospital										
Internal Medicine									2	1
Emory University SOM										
Internal Medicine					1	1				
Hospital of the University of Pennsylvania										
Internal Medicine	1	2							1	2
Stanford University Programs										
Internal Medicine			1	1						

Source: Committee cochairs.
Note: Rutgers programs with overlap are excluded here.

Comparison of Match Data across Schools *(continued)*

	NJMS and RWJMS Student Matching by Program									
	2018		2019		2020		2021		2022	
	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS
Temple University Hospital										
Internal Medicine	3	1	1	1			2	1		
OB/GYN							1	1		
Tufts Medical Center										
Internal Medicine	1	1			1	1				
University of Maryland Medical Center										
Internal Medicine			2	1					1	1
University of Southern California										
Internal Medicine	1	1								
University of Washington Affiliated Hospitals										
Internal Medicine									1	1
Westchester Medical Center										
Internal Medicine							2	1		
Orthopedic Surgery							1	1		
St Luke's University Hospital–Bethlehem Campus										
OB/GYN									1	1
Jackson Memorial Hospital										
Orthopedic Surgery	1	1								

Source: Committee cochairs.
Note: Rutgers programs with overlap are excluded here.

Comparison of Match Data across Schools *(continued)*

	NJMS and RWJMS Student Matching by Program									
	2018		2019		2020		2021		2022	
	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS	NJMS	RWJMS
St. Christopher's Hospital for Children										
Pediatrics	1	1								
UT Southwestern Medical Center										
Pediatrics									1	1
Zucker SOM at Hofstra/Northwell–Cohen Children's Medical Center										
Pediatrics	1	1	2	2	1	1	1	2		
Burke Rehabilitation Hospital										
Phys. Med/Rehab							1	1		
Icahn SOM at Mount Sinai Beth Israel										
Psychiatry							1	1	2	1
Rhode Island Hospital–Brown University										
Urology					1	1				

Source: Committee cochairs.
Note: Rutgers programs with overlap are excluded here.

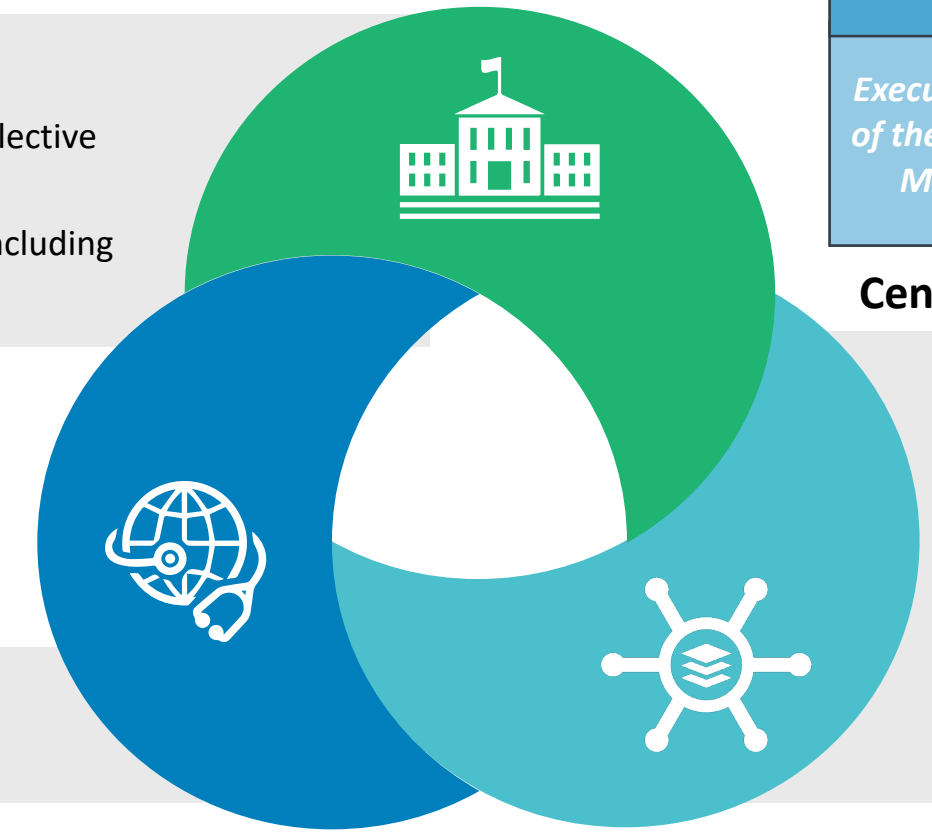
Appendix F
Case Studies

Multicampus SOM Case Study: Medical College of Wisconsin

"Three Campuses, One Community of Learning"		
Executive Dean of the School of Medicine	*Shared admissions process for applicants*	*Discovery curriculum utilized across all campuses*

Milwaukee Campus

- Flagship campus
- Four-year curriculum program (more elective courses, rotations, and internships)
- Widest variety of education options, including several dual degree programs



Central Wisconsin (Wausau) Campus

- Accelerated three-year curriculum training PCPs and psychiatrists
- Regional campus dean appointed
- No research labs; not suited to train in complex specialties
- Focused on training community providers and emphasizing the need for physician retention in northern Wisconsin post-graduation

Green Bay Campus

- Accelerated three-year curriculum
- Regional campus dean appointed

Campus preferences are designated on the secondary application. If admission is offered, it is for a specific campus and is not transferrable.

Source: Campuses | Medical School | Medical College of Wisconsin (mcw.edu).

Multicampus SOM Case Study: University of Minnesota (UMN)

Twin Cities Flagship Campus: MD-PhD dual degree offered, biomedical research experience, and 100+ faculty available for thesis mentorship	**Duluth Campus Mission:** "Be a leader in educating physicians dedicated to family medicine, to serve the needs of rural Minnesota and Native American communities."

A renewed systems-based, three-phase curriculum is to be introduced in fall 2023 across both campuses. The three phases are Foundations, Clinical Immersion, and Specialty-Specific Transitions. The Foundations phase will be identical for all UMN Medical School students with the goal of unifying the curriculum between both campuses.

Application and Admissions Process

1. Submit AMCAS Application

Prospective students submit primary AMCAS application prior to proposing a desired campus.

2. Select Campus Preference

- Instructions to submit campus preference will automate prior to UMN supplemental application.
- Applicants can apply to either campus for a $100 nonrefundable fee.

☐ **Twin Cities campus**
☐ **Duluth campus**
☑ **Either campus**

3. Campus Placement

- Placement for applicants who select "either" is based on capacity and possible preferred ranking (if requested).
- All MD-PhD selected applicants are placed at the Twin Cities campus.

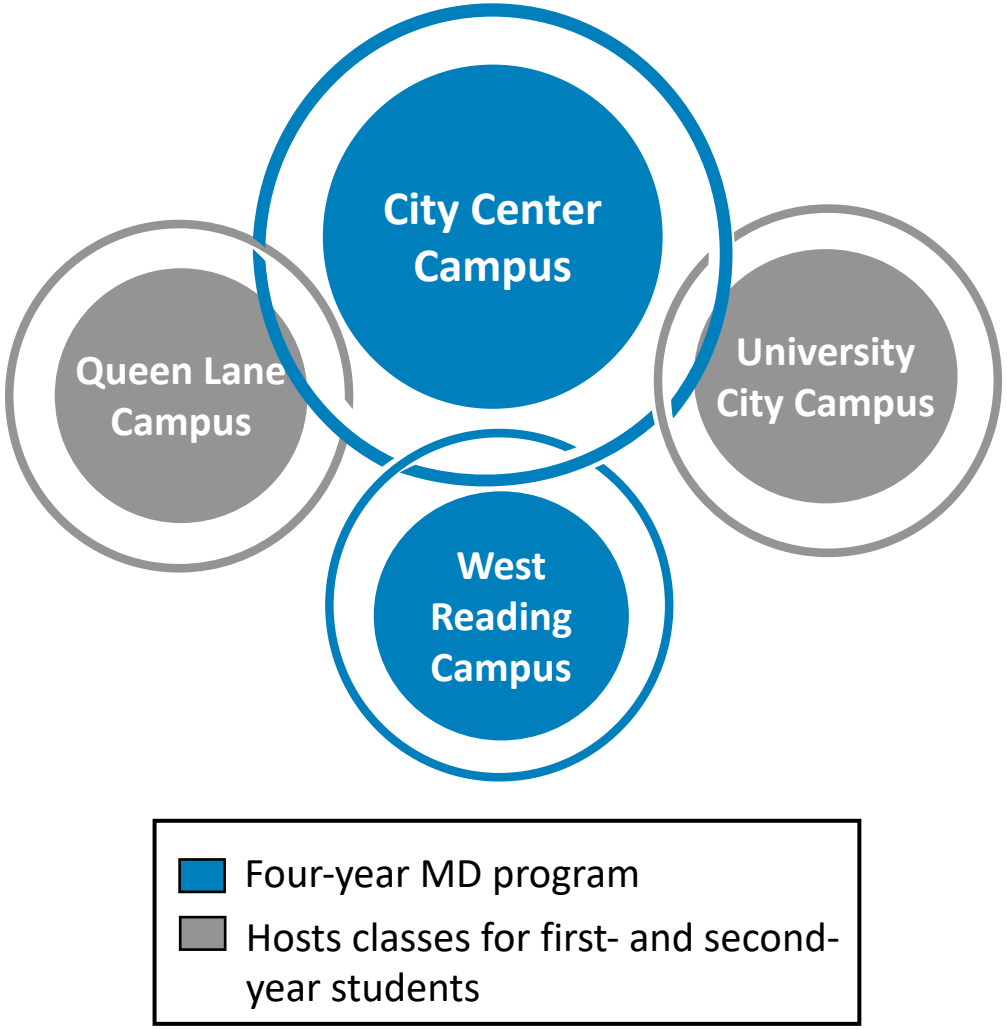
Source: Admissions | Medical School - University of Minnesota (umn.edu).

Multicampus SOM Case Study: Drexel University

All Drexel campuses utilize a uniform admissions process.

1. Accepted students are admitted to Drexel College of Medicine without consideration of campus preference
2. Campus preference is requested after final acceptance to the MD program
3. Deposit required prior to campus assignment
4. Campus assignments are shared via the applicant portal after March 30 or on a rolling basis for applicants accepted after March 30
5. Students accepted after June 15 receive a campus assignment with their acceptance letter
6. Campus reassignment requests can be submitted for consideration until June 10. Reassignments are not guaranteed.

Source: MD Program Admissions - Drexel University College of Medicine



Appendix G
Overview of Strategic Plans

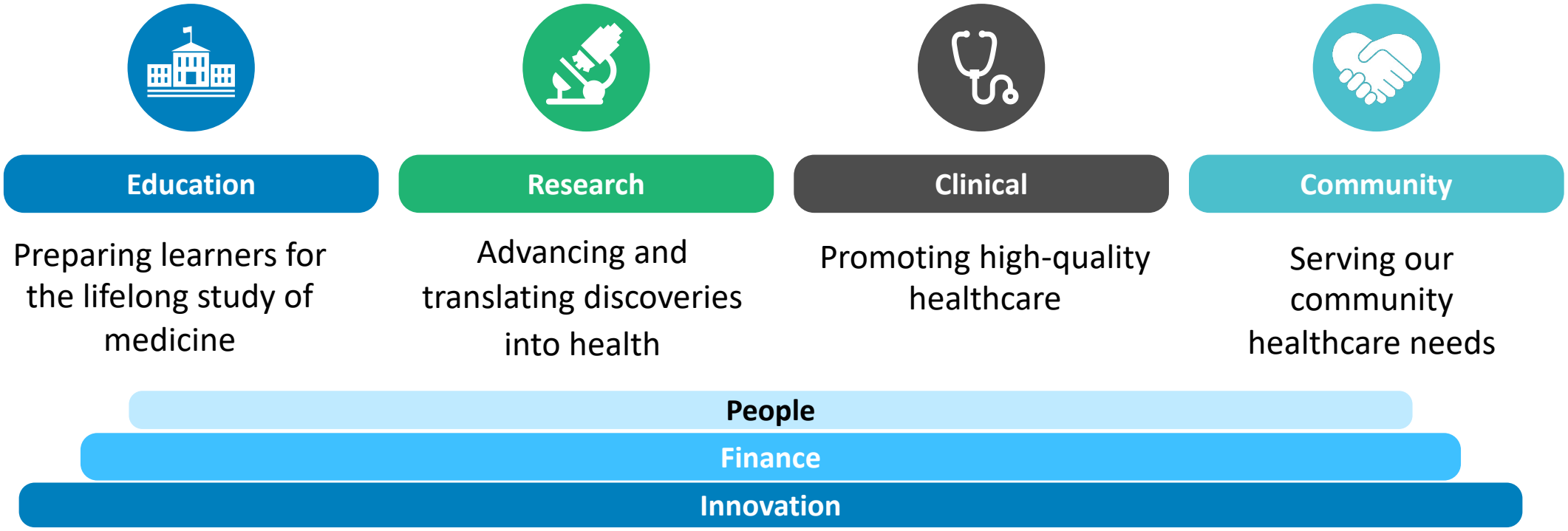
Mission, Vision, and Values

	NJMS	RWJMS
Mission	To prepare humanistic leaders in global healthcare and pioneering science by building upon our strengths of diversity, educational innovation, immersive clinical training, and transformative research	Robert Wood Johnson Medical School is dedicated to transforming healthcare for New Jersey and the nation through innovation and excellence in education, research, patient- and family-centered care, and addressing the health of our diverse community.
Vision	NJMS aspires to optimize health and social well-being by: • Providing cutting-edge tertiary and quaternary medical care of distinction and serving all patients. • Enhancing our position as the top biomedical research institution in the state of New Jersey. • Creating a culture of intellectual curiosity and lifelong learning in a welcoming and inclusive environment. • Advancing the health, education, and care of all people whom we serve, including underserved and vulnerable populations, by preparing an educated and diverse workforce.	Robert Wood Johnson Medical School will become the academic engine driving a new healthcare paradigm in New Jersey—the state's first and largest academic high-value healthcare system.
Values	In pursuit of our mission and vision, we value: • Integrity and professionalism. • Diversity and inclusion. • Humanism and equity. • Leadership and collaboration. • Innovation and intellectual rigor. • Wellness and balance.	**R:** Respect, dignity, and humanism for the diverse population we serve **W:** Wellness and resilience **J:** Joining learners hand-in-hand with care delivery **M:** Making patients first with safe, compassionate, high-quality care **S:** Science to advance human health

RWJMS Strategic Plan

"[RWJMS] will become the academic engine driving a new healthcare paradigm in New Jersey and the state's first and largest academic, patient-centered, high-value healthcare system."

The core of RWJMS's strategic plan is composed of four pillars and supported by three cornerstones. Each pillar includes three to five strategic aims to serve as the focus for strengthening each cornerstone of the school's success.



Source: *RWJMS Strategic Plan 2016–2021*.

RWJMS Strategic Aims Associated with Each Pillar

Education

- Pursue novel approaches to teaching and experiential learning.
- Integrate tenets of Triple Aim curriculum into the educational mission, and fully integrate learners in clinical care.
- Enhance the academic learning environment.

Research

- Increase federal, state, foundation, philanthropic, and institutional investment in research with a focus on our environment and innovation.
- Increase academic stature through programmatic development, team science, and scholarly activity.
- Advance basic, clinical, and translational research through improved infrastructure and research resources, as evidenced by an increase in our research activity and investment in support for grants and contracts

Clinical

- Increase patient satisfaction.
- Improve quality.
- Increase practice efficiency.

Community

- Expand access to culturally effective healthcare.
- Support the community health/global health education of health professionals and the community, both nationally and internationally.
- Expand programming to improve the overall health of communities.
- Expand RWJMS community and global health capacity to engage in population health initiatives around patient-centered outcomes, practice-based dissemination, and implementation and translational research.
- Expand the reach of global health activities.

Source: *RWJMS Strategic Plan 2016–2021*.

NJMS Strategic Priorities

Education

Goal: To be a nationally recognized medical education program that prepares diverse students and trainees to be:

1. Competent and collaborative practitioners of medicine
2. Participants in lifelong learning
3. Users of evidence-based medicine as a guide to clinical practice
4. Prepared educational leaders with an understanding of the health of underserved and vulnerable populations

Research

Goal: To build on our prominence in biomedical research to promote progress and innovation in basic and translational science through core research services and infrastructure

Clinical

Goal: To improve access and provide high-quality, cost-effective, high-value medical care to members of the local community and to partner with RWJBH, University Hospital, and others to expand services and promote health equity, diversity, and inclusion and wellness

Community

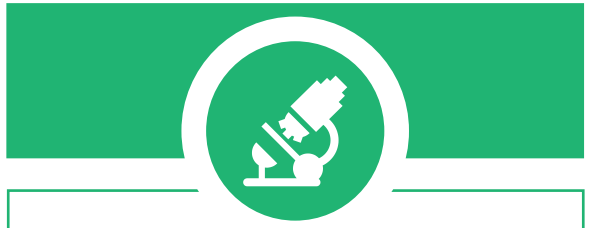
Goal: To provide education and service to Newark, the surrounding communities, and globally with a focus on diverse populations, including vulnerable and marginalized people, through an integrated approach to education, career awareness, development, recruitment and retention of primary care providers, and interdisciplinary efforts and programs to increase workforce diversity

Source: *Rutgers New Jersey Medical School Strategic Plan 2019–2024*.

NJMS Strategic Initiatives to Support the Strategic Priorities

Education

1. Pursue novel approaches to teaching and experiential learning.
2. Promote methods to attract, develop, and advance diverse and inclusive trainees and faculty in order to maintain an optimal learning environment.



Research

1. Improve CORE research services and infrastructure for basic, clinical, and translational research.
2. Optimize regulatory processes for research work.
3. Optimize research and sponsored programs and grants administration services to increase revenue from collaborative clinical, basic science, and translational research.

Clinical

1. Continually improve the quality of services provided by our clinical programs.
2. Improve patient satisfaction.
3. Optimize patient access to medical services.

Community

1. Cultivate community service and engagement.
2. Improve the health of the community through primary care initiatives and workforce diversity.
3. Increase philanthropic funding and branding of our programs.

Source: *Rutgers New Jersey Medical School Strategic Plan 2019–2024*.

Appendix H
Marketing and Branding Analyses

Marketing and Branding Analyses

Simpson Scarborough

***Rutgers–New Brunswick & Rutgers Health Brand & Marketing Research*, January 2020**

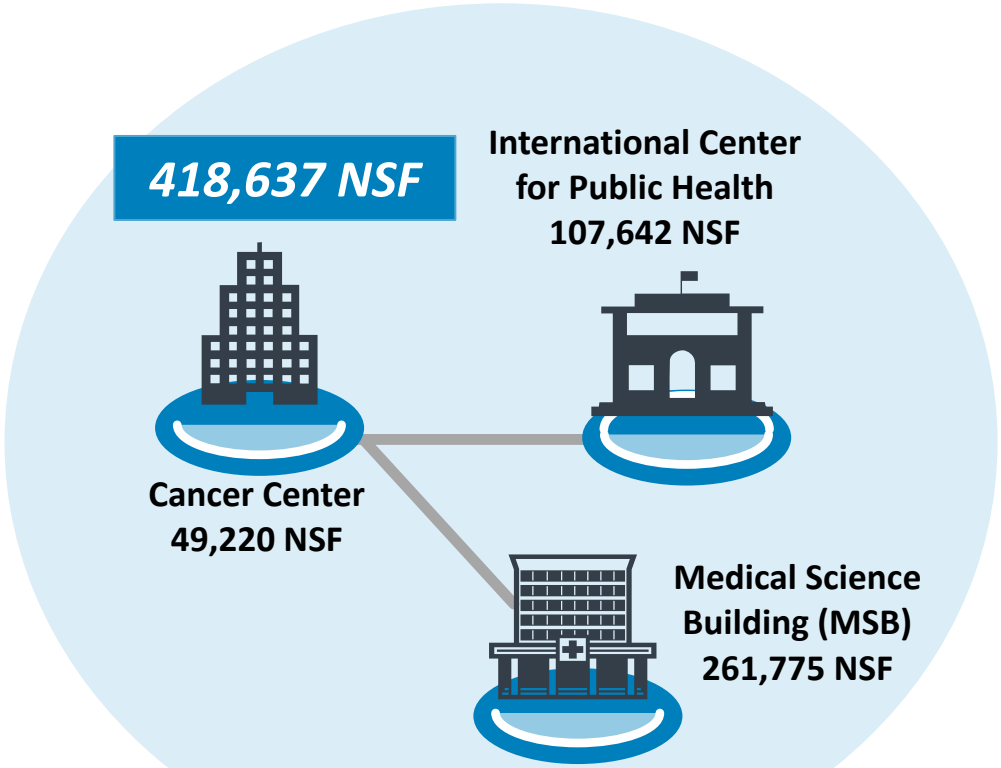
"Familiarity with academic health systems (73%) and with Rutgers Health (65%) is strong, but only one in three general public respondents have used this type of facility or know someone who has used this type of facility."

"While one in four general public respondents consider the 'conducts extensive research, including clinical trials, to develop new ways to prevent, detect, and treat illness,' statement a strength of Rutgers Health, nearly one in three don't know."

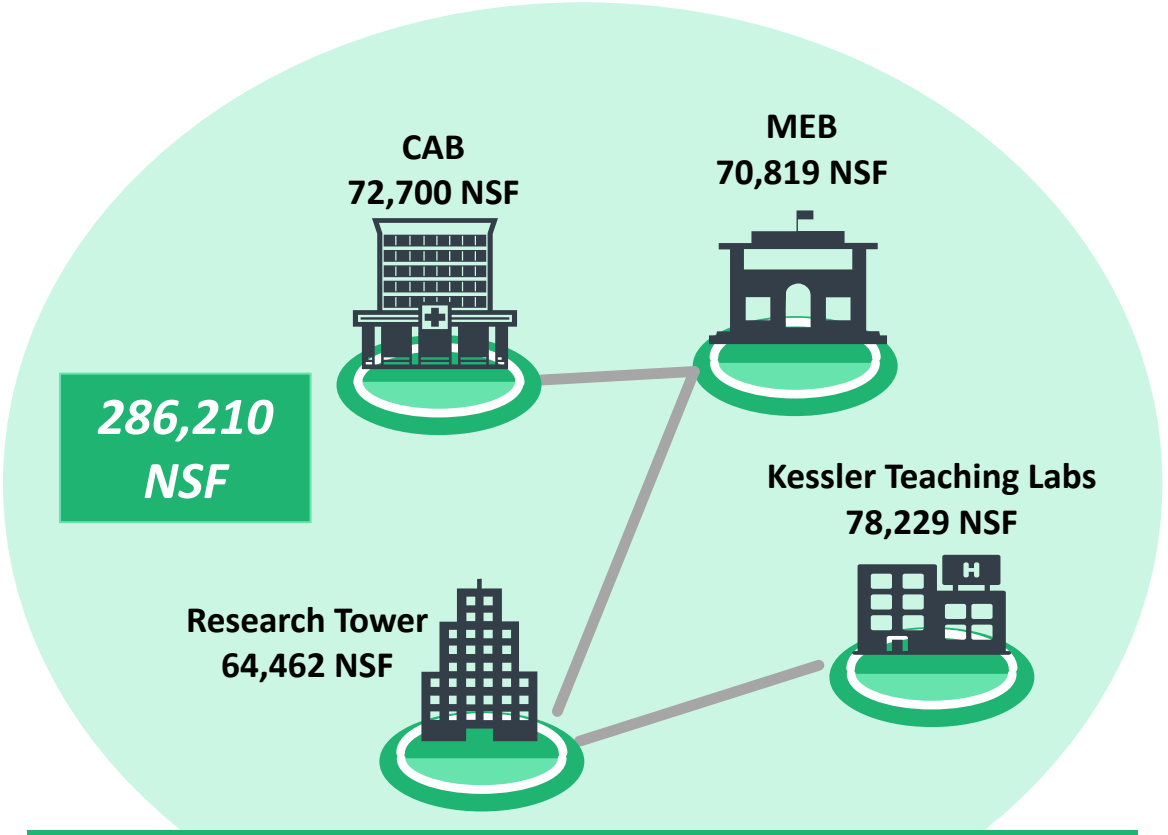
Respondents ages 20 to 39 are more likely to say Rutgers Health "provides all levels of care to patients" and "uses cutting-edge technologies, resources, and therapies."

Appendix I
Overview of Key Buildings

Overview of Key Buildings



NJMS Buildings	Net Square Footage
MSB	261,775
International Center for Public Health	107,642
Cancer Center	49,220
Total	**418,637**

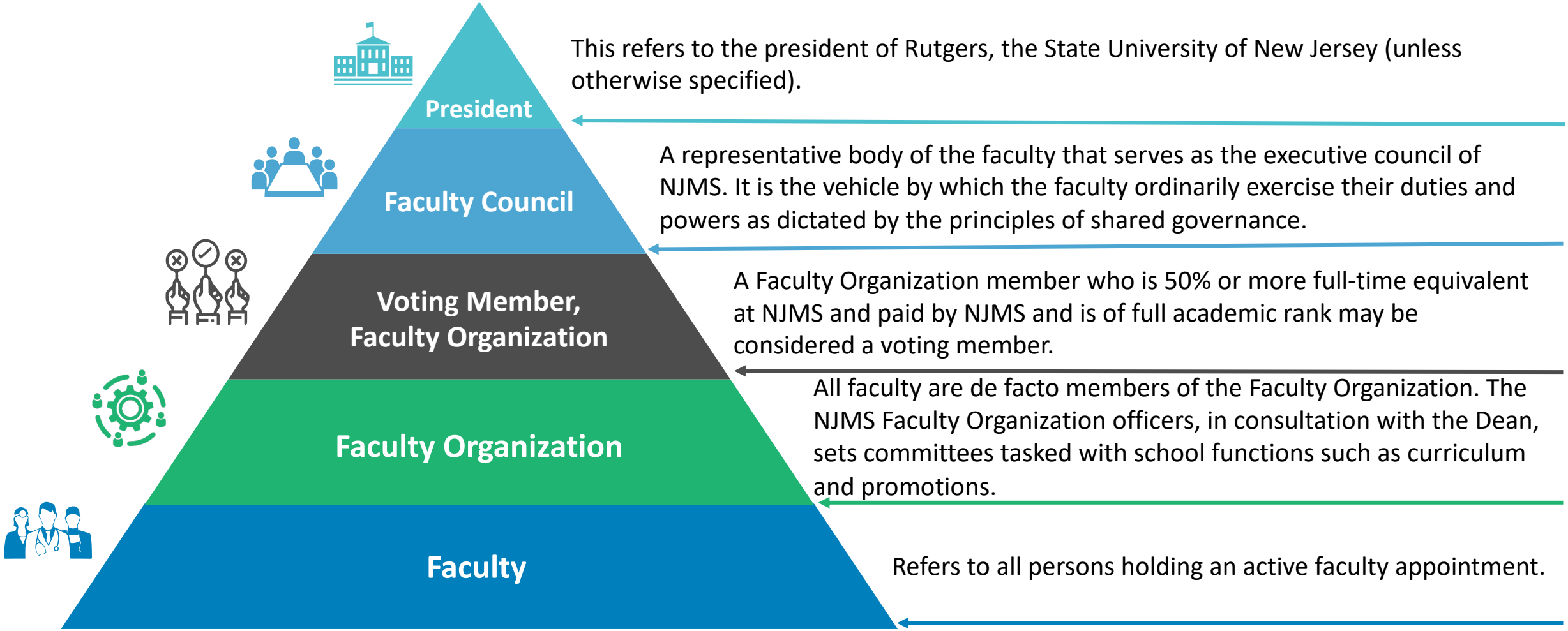


RWJMS Buildings	Net Square Footage
Clinical Academic Building (CAB)	72,700
Medical Education Building (MEB)	70,819
Kessler Teaching Labs	78,229
Research Tower	64,462
Total	**286,210**

Notes: Figures may not be exact due to rounding. Includes buildings on each campus greater than ~50,000 square feet.
Source: Client-provided data.

Appendix J
Faculty Governance Structures

NJMS Faculty Governance



Source: NJMS Bylaws (provided by client).

RWJMS Faculty Governance

Executive Committee

The major leadership committee of the school that advises the dean and makes recommendations and votes on matters affecting the business, operations, and policies of the medical school

- Academic Standing Committee
- Admissions Committee
- School-Wide Advisory on Appointments and Promotions
- Curriculum Committee
- Committee of Review
- Continuing Medical Education Committee
- Research Committee
- Nominations and Electives Committee
- Graduate Medical Education Committee
- Professionalism Committee

Source: RWJMS Bylaws (provided by client).

Appendix K
Relevant LCME Accreditation Standards – Culture and Identity Committee

Notable LCME Accreditation Requirements

Strategic Planning and Continuous Quality Improvement

A medical school engages in ongoing strategic planning and continuous quality-improvement processes that establish its short- and long-term programmatic goals, result in the achievement of measurable outcomes that are used to improve educational program quality, and ensure effective monitoring of the medical education program's compliance with accreditation standards.

Functional Integration of the Faculty

At a medical school with one or more regional campuses, the faculty at the departmental and medical school levels at each campus are functionally integrated by appropriate administrative mechanisms (e.g., regular meetings and/or communication, periodic visits, participation in shared governance, data sharing).

Learning Environments and Professionalism

A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

Source: LCME accreditation standards, 2023–2024.

Appendix L
Summary Results from Key Surveys

Mentoring Program Survey

NJMS

Response N = 93 (2016), 24 (2022)

- Mentorship rate has increased from 11% in 2016 to 59% in 2022
- Satisfaction with mentoring arrangements and availability of mentors have decreased
- Faculty want protected time to do research, more experienced mentors, grant-writing skill development, and research infrastructure
- 100% of NJMS respondents said they are familiar with appointments and promotion guidelines, up from 69% in 2016
- Job satisfaction has decreased overall, from 77% moderately, slightly, or extremely satisfied in 2016 to 54% in 2022
- Clinical Scholar and Clinical Educator tracks are less satisfied overall than other tracks

RWJMS

Response N = 100 (2016), 66 (2022)

- Mentorship rate has increased from 23% in 2016 to 47% in 2022
- There is a need for more experienced mentors and opportunity for mid-level and senior faculty to mentor junior colleagues
- Mentors want more recognition, credit, incentive, and dedicated FTE time
- Job satisfaction has decreased overall, from 75% moderately, slightly, or extremely satisfied in 2016 to 45% in 2022
- Clinical Scholar and Clinical Educator tracks are less satisfied overall than other tracks

Source: Mentoring Program Survey for RBHS Faculty, 2022 – NJMS Report; Mentoring Program Survey for RBHS Faculty, 2022 – RWJMS Report

RBHS Translational Research Barriers Survey: Key Findings

1. Obtaining timely IRB approval of the protocol and study materials was ranked as a moderate to major barrier by 65% of respondents.

2. Recruiting adequately trained research staff was ranked as a moderate to major barrier by 77% of respondents.

3. Lack of institutional infrastructure to assist with required reports and administrative tasks was ranked as a moderate to major barrier by 77% of respondents.

Source: NJ ACTS Barriers in Translational Research Survey Collated Data

AAMC Standpoint Survey: RWJMS

Summary Score	Appointment Status		Department Type		Rank		Gender		Race/Ethnicity		Administrative Title	
	Full-Time	Part-Time	Basic Science	Clinical	Senior	Junior	Male	Female	Majority	Minority	Admin Title	Non-Admin Title
My Job	69.0%	69.6%	86.6%	66.9%	67.8%	69.7%	68.4%	69.8%	69.4%	71.5%	71.1%	68.3%
Focus on Medical School Mission	57.8%	66.1%	65.4%	57.4%	52.0%	64.0%	55.7%	61.4%	58.0%	63.1%	57.9%	59.2%
Workplace Culture	48.8%	54.9%	50.6%	48.9%	41.8%	55.8%	48.3%	50.0%	49.1%	52.6%	47.2%	51.0%
Department Governance	59.0%	66.9%	81.4%	56.6%	57.3%	61.4%	60.7%	57.8%	59.8%	53.5%	59.1%	59.5%
Medical School Governance	31.2%	35.3%	25.7%	32.2%	25.1%	38.9%	30.6%	32.5%	30.8%	39.9%	32.6%	31.2%
Relationship with Supervisor	71.4%	84.4%	89.6%	69.8%	69.2%	74.3%	69.2%	75.8%	72.5%	71.2%	72.7%	72.0%
Growth Opportunities	53.9%	53.7%	52.3%	54.0%	52.3%	54.3%	54.3%	53.3%	53.5%	60.7%	57.7%	51.8%
Promotion and Tenure Requirements	43.1%	53.3%	46.6%	43.3%	43.6%	43.9%	42.0%	45.6%	42.9%	51.5%	43.7%	44.0%
Promotion Equality	60.4%	48.5%	67.7%	58.8%	58.6%	61.0%	64.2%	54.2%	60.2%	59.7%	61.3%	58.7%
Collegiality and Collaboration	68.7%	72.7%	74.1%	68.2%	66.6%	71.1%	68.6%	69.3%	69.2%	69.1%	71.3%	67.5%
Compensation and Benefits	57.7%	59.3%	57.4%	57.8%	56.7%	58.1%	54.0%	62.7%	56.3%	74.5%	58.9%	57.2%
Faculty Recruitment and Retention	39.9%	48.8%	34.8%	41.1%	34.1%	47.1%	37.7%	43.8%	39.7%	52.3%	43.1%	39.1%
Faculty Diversity and Inclusion	62.9%	69.8%	43.4%	65.8%	57.7%	69.1%	65.0%	61.0%	63.1%	65.9%	64.5%	62.8%
Clinical Practice	48.9%	58.5%	N<5	49.4%	43.5%	54.6%	49.3%	49.6%	47.8%	65.6%	49.4%	49.4%

Source: 2019 AAMC StandPoint Survey: Faculty Executive Summary Report, Rutgers, Robert Wood Johnson Medical School

Table includes summary scores for the overall top two response options (e.g., strongly agree or agree)

AAMC Graduation Questionnaire: NJMS

Strengths

- Science relevance and integration were 50th-75th percentile
- Pediatrics clerkship experiences were primarily rated 50th-75th or 75th-90th percentile
- "The diversity within my medical school class enhanced my training and skills to work with individuals from different backgrounds" was 90th percentile
- Office of the Dean for Educational Programs/Curricular Affairs rated >90th percentile for awareness of and responsiveness to student problems

Areas of Opportunity

- Basic sciences:
  - Gross anatomy was 10th-25th percentile
  - Many other sciences were 25th-50th percentile
- Family Medicine and Surgery clerkship experiences mostly rated 10th-25th percentile
- Psychiatry clerkship experiences mostly rated 25th-50th percentile
- Elective participation rated 25th-50th percentile for many options
- Most faculty professionalism categories ranked 25th-50th percentile
- Student satisfaction with library resources ranked <10th percentile

Source: 2022 AAMC Graduation Questionnaire Summary of Major Findings, NJMS Report

AAMC Graduation Questionnaire: RWJMS

Strengths

- Basic science education was >90th percentile
- Basic sciences as preparation for clinical clerkships and electives was primarily 75th-90th+ percentile
- Quality of educational experiences in clinical clerkships
  - Most rotations were 75th-90th+ percentile
- Effective resident teaching
  - Most rotations were 75th-90th+ percentile
- "The diversity within my medical school class enhanced my training and skills to work with individuals from different backgrounds" was >90th percentile
- Student-faculty interaction was >90th percentile
- Most learning environment questions were 75th-90th+ percentile

Areas of Opportunity

- Psychiatry quality of educational experiences was 50th percentile
- OB/Gyn, pediatrics, psychiatry, and surgery observed history and physical were between <10th and 10th-25th percentile
- Facilities and other student services satisfaction scores were below the national average
  - Computer resource center/IT resources was 80% compared to 86% nationally
  - Student relaxation space 61% was compared to 65% nationally
- Some behavior occurred more frequently than the national average:
  - Never subjected to unwanted sexual advances was 95% vs 96% nationally (25th percentile)
  - Never received lower evaluations based solely on race or ethnicity was 94% vs 96% (25th-50th percentile)
  - Those who did not report incidents due to a fear of reprisal was 43% compared to 33% nationally

Source: 2022 AAMC Graduation Questionnaire Summary of Major Findings, RWJMS Report

Appendix M
Interview Synopsis

Synopsis of Interview between Committee Member and Senior Faculty Member/Administrator at Rutgers Law School

- "The Law School merger is 7 years in and is still very controversial. It has met almost none of its stated goals and has preoccupied administrators, faculty and staff over the whole time. There is a sense that if it could be done over, a majority of the faculty would want to unwind it."
- Recommendation based on their experience is to do the most limited merger possible to achieve specific functional goal(s), preserving the sovereignty and integrity of both schools. Limit the merger just to the operations that will function better as merged.
- Specific issues/outcomes of the law school merger include:
    - Trying to operate the two schools as a single unit has proven to be extraordinary time consuming and "conflict intensive."
    - The projected benefits were illusory. The merger was billed to help improve ratings and the quality of students and administrative efficiency, but, in reality, it has done none of these. Administrators are more overloaded, and there is an inefficient reporting structure. The co-dean structure is problematic as deans have different needs for their schools and have to check with each other in order to move things forward. The administrations at each school need independence to move the school forward.
    - Products of the merger have been "resentment, competition and inefficiencies."
        - Everyone failed to anticipate how damaging the resentment would be.
        - Some of the competition for resources has been brutal, generating resentment on both campuses.
    - Faculty governance has suffered significantly. It is very hard for faculty to have a voice when hundreds of faculty from these disparate campuses are all trying to work through a single meeting.
    - Staff are frustrated having to travel back and forth 80 miles between the two campuses.
    - Alumni are very unhappy.

Synopsis of Interview between Committee Member and Senior Faculty Member/Administrator at Rutgers Law School (continued)

Other comments:

- Recommendation to speak with John Farmer, a former Dean who became General Counsel for the university, to share his view of what happened.
- The fact that two chancellors were involved has little bearing on these problems with the merger. There are issues about the budgets and competition, but the major issues are not because of the schools spanning two chancellors.
- Accreditation has not been an issue. The accreditation visits have been quite straightforward and a chance to highlight problems to administration. The accreditation process seems to be unlike the medical schools for which the LCME's demands for equality at both campuses may be a significant constraint imposed by an external pressure that we can only guess at.

How to do it if we move forward with medical school integration:

- Careful analysis of what are the functions that should be shared and will be advantageous to share, for which economics of scale are convincing and all will see.
- Need to have an eye on how to attract and retain talent, both faculty and administration. Law schools have lost a lot of staff who were overwhelmed.
- Do the most minimal merger and focus on the most obvious functions that leads to greater efficiency. Preserve as much sovereignty, faculty governance, and discretion.
- After I (committee member) described issues with hospitals, the response was: "The questions won't be resolved later! The chasm will only grow. Questions that are not addressed will become an obsession and will annoy everyone and there will be attrition, as people think 'this is not what I signed up for'."

Synopsis of Interview between Committee Member and Senior Faculty Member/Administrator at Rutgers Law School (continued)

Overall recommendations:

- Try to achieve the maximum gain of goals with minimum integration, and a presumption of sovereignty.
- Only those functions that justify integration should be integrated, which will avoid some conflicts.
- Change as few fundamental aspects as possible. You can always add more later.
- Think creatively about fail-safe mechanisms in the event problems can and do arise. Put these in place ahead of time. How will conflicts between the schools be managed? Don't try to do it on the fly after the conflicts arise. Build in crisis avoidance mechanisms ahead of time, e.g., requiring a super majority for some changes, or having an empowered Task Force already in place.
- "To do less is to do more and have fail safe mechanisms."

Appendix N
Overview of Medical Student Curricula and Learning Objectives

NJMS and RWJMS Year One Curriculum

NJMS	Phase I: Core Biomedical Curriculum					
	Foundations of Body Systems (19 weeks)	Musculoskeletal and Integumentary (6 weeks)	Cardiovascular (6 weeks)	Pulmonary (5 weeks)	Renal (3 weeks)	Year One EPA OSCE
	Patient-Centered Medicine Thread and Longitudinal Health Equity and Social Justice Course					
	Service Learning, Humanism, Culturally Competent Quality Care, Interprofessional Education, Healthcare Systems and Prevention Threads					

RWJMS	M1 Block	Physicianship/ Physician Development and Practice (PDP) (4 weeks)	Foundations in Medical Sciences (16 weeks)	Intersession (1 week)	Foundations in Medical Sciences (4 weeks)	Integrated Systems and Disease 1 (3 weeks)	Intersession (1 week)	Integrated Systems and Disease 1 (5 weeks)	Intersession (2 weeks)	Integrated Systems and Disease 1 (5 weeks)
	Course	Physicianship	• Cells to Structure • Principles of Pharmacology, Disease, and Defense	PDP	Mechanisms of Disease and Defense	Metabolism and the Cardiovascular System	PDP	Metabolism and the Cardiovascular System	PDP	Pulmonary and Renal Systems

Source: Curricula provided by committee cochairs.

NJMS and RWJMS Year Two Curriculum

NJMS	Phase I: Core Biomedical Curriculum					
	Digestive (5 weeks)	Genitourinary/Endocrinology (8 weeks)	Neuro/Psych/Biostats (14 weeks)	Year Two EPA OSCE	USMLE Study Time	Transition to Clerkships
	Patient-Centered Medicine Thread and Longitudinal Health Equity and Social Justice Course					
	Service Learning, Humanism, Culturally Competent Quality Care, Interprofessional Education, and Healthcare Systems and Prevention Threads					

Transition block at the end of the year is continuous.

Clerkships start at the end of the second year.

First Clerkship

RWJMS	M2 Block	Integrated Systems and Disease 2 (5 weeks)	Intersession (2 weeks)	Integrated Systems and Disease 2 (5 weeks)	Intersession (2 weeks)	Clinical Neurology and Behavioral Science (10 weeks)	Intersession (2 weeks)	End of Preclerkship Curriculum Preparation for USMLE Step 1 (6 weeks)	Clerkship Transition (1 week)	Women and Children (W&C) (13 weeks)
	Course	Endocrinology and Reproduction	PDP	GI	PDP	• Head & Neck • Clinical Neuro • Behavioral Science	PDP			• OB/GYN • Pediatrics • W&C Intercession

Source: Curricula provided by committee cochairs.

NJMS and RWJMS Year Three Curriculum

NJMS	Phase II: Core Clinical Clerkships and Clinical Electives						
	Ambulatory Primary Care (5 weeks)	Medicine (10 weeks)	Pediatrics (6 weeks)	Surgery (8 weeks)	OB/GYN (6 weeks)	Neurology (4 weeks)	Psychiatry (4 weeks)
	Six weeks of electives; two integrative weeks with year three EPA OSCEs (midyear and end of year)						
	Service Learning, Humanism, Culturally Competent Quality Care, Interprofessional Education, and Healthcare Systems and Prevention Threads						

Electives are spread out between other blocks.

RWJMS	M3 Block	Family and Behavioral Health (FBH) Intersession and Integrated Systems and Disease 2 (12 weeks)	Hospital Med. (12 weeks)	Rapid Diagnosis, Challenging Differentials, and Critical Learning (12 weeks)	Career Exploration Personalization (4 weeks)	Transition to Advanced Clinical Experiences (4 weeks)	Critical Care Selective (4 weeks)	Subinternship (4 weeks)
	Clerkship/ Selectives/ Electives	• Family Medicine • Psychiatry • FBH Intersession	• Surgery • Medicine	• Emergency Medicine • Neurology	Electives	Step Two CK	Adult or Pediatric	Inpatient Disciplines

Source: Curricula provided by committee cochairs.

NJMS and RWJMS Year Four Curriculum

NJMS	Phase III: Acting Internships and Clinical Immersion Electives				
	Emergency Medicine (4 weeks)	Acting Internship (20 weeks)	Physical Medicine and Rehabilitation (2 weeks)	Electives (20 weeks)	Transition to Residency
	Year Four Graduation OSCE				
	Service Learning, Humanism, Culturally Competent Quality Care, Interprofessional Education, and Healthcare Systems and Prevention Threads				

NJMS has mandatory clerkships in the fourth year.

RWJMS	M4 Block	Career Exploration, Enrichment, and Personalization (40 weeks)	Transition to Residency (4 weeks)
	Selectives/ Electives/ Boot Camp	Electives	Specialty-Specific Boot Camps

Source: Curricula provided by committee cochairs.

Three-Year Curricula Options

RWJMS's three-year PACCE program places students in affiliated Family Medicine residency programs or the Pediatrics program, while NJMS's MD PC students are offered conditional acceptance into an affiliated Internal Medicine, Med/Peds, or Pediatrics residency following completion of their three-year curriculum.

<table>
<tr><td rowspan="6">NJMS</td><td colspan="7">Phase I: Core Biomedical Curriculum</td></tr>
<tr><td rowspan="3">Year One
Clinical Immersion and Population Health
(52 weeks)</td><td>Foundations of Body Systems</td><td>Musculoskeletal and Integumentary</td><td>Cardiovascular</td><td>Pulmonary</td><td>Renal</td><td>Year One EPA OSCE</td></tr>
<tr><td colspan="6">Longitudinal Preceptorship</td></tr>
<tr><td colspan="6">Patient-Centered Medicine Thread and Longitudinal Health Equity and Social Justice Course</td></tr>
<tr><td colspan="7">Service Learning, Humanism, Culturally Competent Quality Care, Interprofessional Education, and Healthcare Systems and Prevention Threads</td></tr>
<tr><td rowspan="3">Year Two
Ambulatory Primary Care/Clinical Elective/Population Health
(44 weeks)</td><td>Digestive</td><td>Genitourinary/ Endocrinology</td><td>Neuro/Psych/ Biostats</td><td rowspan="2">Year Two EPA OSCE</td><td rowspan="2">USMLE Study Time</td><td rowspan="2">Transition to Clerkships</td></tr>
<tr><td colspan="3">Longitudinal Preceptorship</td></tr>
<tr><td colspan="6">Patient-Centered Medicine Thread and Longitudinal Health Equity and Social Justice Course</td></tr>
<tr><td colspan="7">Service Learning, Humanism, Culturally Competent Quality Care, Interprofessional Education, and Healthcare Systems and Prevention Threads</td></tr>
</table>

Source: Curricula provided by committee cochairs.

Three-Year Curricula *(continued)*

NJMS	Phases II and III: Core Clinical Clerkships, Acting Internships, and Clinical Electives (55 weeks)								
	Emergency Medicine	Pediatrics	Surgery	OB/GYN	Neurology	Psychiatry	Physical Medicine and Rehabilitation	Acting Internship	Emergency Medicine
	Longitudinal Preceptorship								
	Two weeks of elective; year three EPA OSCEs and graduation OSCE								
	Service Learning, Humanism, Culturally Competent Quality Care, Interprofessional Education, and Healthcare Systems and Prevention Threads								

RWJMS	Introduction to Clinical Experience (1 week)	Internal Medicine Clerkship (6 weeks)	Surgery Clerkship (6 weeks)	PACCE Orientation (1 week)	Neurology Clerkship (3 weeks)	PACCE Clinical Experience (7 weeks)	OB/GYN Clerkship (4 weeks)	Elective (2 weeks)	Pediatrics Clerkship (3 weeks)	Psychiatry Clerkship (3 weeks)	PACCE Clinical Experience (12 weeks)	Transition to Fourth Year (1 week)

Sources: NJMS: Curricula provided by committee cochair; RWJMS: FAM Report

Appendix O
LCME Accreditation Requirements Related to Curriculum

Notable LCME Accreditation Requirements

Program and Learning Objectives

The faculty of a medical school define medical education program objectives in outcome-based terms that enable the assessment of medical students' progress in developing the competencies the profession and the public expect of a physician. The medical school makes these objectives known to all medical students and faculty. In addition, the medical school ensures the objectives for each required learning experience (e.g., course, clerkship) are made known to all medical students and those faculty, residents, and others with teaching and assessment responsibilities in those required experiences.

Elective Opportunities

The faculty of a medical school ensure the curriculum includes elective opportunities that supplement required learning experiences and permit medical students to gain exposure to and expand their understanding of medical specialties and to pursue their individual academic interests.

Academic Environments

The faculty of a medical school ensure that medical students have opportunities to learn in academic environments that permit interaction with students enrolled in other health professions, in graduate and professional degree programs, and in clinical environments where there are opportunities for interaction with physicians in graduate medical education and continuing medical education programs.

Source: LCME accreditation standards, 2023–2024.

Notable LCME Accreditation Requirements *(continued)*

Curricular Management

A medical school has an institutional body (i.e., a faculty committee) that oversees the medical education program as a whole and has responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum.

Use of Medical Educational Program Objectives

The faculty of a medical school, through the faculty committee responsible for the medical curriculum, ensure the medical curriculum uses formally adopted medical education program objectives to guide the selection of curriculum content and to review and revise the curriculum. The faculty leadership responsible for each required course and clerkship link the learning objectives of that course or clerkship to the medical education program objectives.

Curricular Design, Review, and Revision/Content Monitoring

The faculty of a medical school, through the faculty committee responsible for the medical curriculum, are responsible for the detailed development, design, and implementation of all components of the medical education program, including the program objectives, the learning objectives for each required curricular segment, instructional and assessment methods appropriate for the achievement of those objectives, content and content sequencing, ongoing review and updating of content, and evaluation of course, clerkship, and teacher quality. These medical education program objectives, learning objectives, content, and instructional and assessment methods are subject to ongoing monitoring, review, and revision by the responsible committee.

Source: LCME accreditation standards, 2023–2024.

Notable LCME Accreditation Requirements *(continued)*

Evaluation of Educational Program Outcomes

A medical school collects and uses a variety of outcome data, including national norms of accomplishment, to demonstrate the extent to which medical students are achieving medical education program objectives and to enhance the quality of the medical education program as a whole. This data is collected during program enrollment and after program completion.

Comparability of Education/Assessment

A medical school ensures the medical curriculum includes comparable educational experiences and equivalent methods of assessment across all locations within a given course and clerkship to ensure that all medical students achieve the same medical education program objectives.

Source: LCME accreditation standards, 2023–2024.

RUTGERS

BIOMEDICAL AND
HEALTH SCIENCES