

January 16, 2009

WMU School of Medicine Planning Committee
Robert G. Miller, Assoc. V.P., Chair
Western Michigan University
Kalamazoo, MI

Dear Bob and Members of the Committee:

We are pleased to submit the attached *An Academic Health Center in Kalamazoo, A Picture of the Future - 2014*. As you will see, it has been drafted as a document written five years in the future that looks back on the history of the early days of the WMU School of Medicine. We hope that it will serve as a useful start of a discussion for the January 26, 2009 Committee meeting.

At the meeting we would hope that the discussion would focus on the two questions that we have been asked to address:

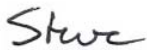
1. Do WMU, Borgess, and Bronson have the capability to start a School of Medicine?
 - We believe that the answer to that question is yes. There is present within the region the resources necessary for establishing and maintaining an excellent medical school. Further, we believe that a medical school could be an important contributor to the future success of Kalamazoo and of the region. The reasons for this belief make a lengthy list but include: enhanced quality of patient care; the well-documented role of medical schools as economic drivers for a community; the potential for important synergies between a School of Medicine and its university for factors ranging from student recruitment to research; and the opportunity for collaboration with the local drug, medical devices and other industries.
2. What would it take to get there?
 - The *Picture of the Future – 2014* document outlines key steps that will need to be taken, and a plan for moving forward. This work, coupled with the activities that Jack Luderer has begun, should serve as a strong basis for proceeding.

We will also discuss next steps. We anticipate that these will include:

- Submission of the report to the parent Boards of the University and of the Hospitals, along with your recommendations. They will then be asked to decide whether or not to proceed further with planning and implementation. If they respond positively they will thank the Planning Committee for its efforts and appoint a new Steering Committee and various other Committees and Sub-committees to proceed with the detailed work required for planning Curriculum, Facilities, Finance, and Governance, etc. that are required by the Liaison Committee on Medical Education (LCME) for medical school accreditation. We would expect that current Planning Committee members would be asked to continue to add their expertise to the efforts of one or more of these new groups.
- Develop a business plan for the proposed School of Medicine, and
- Formally seek accreditation by the LCME.

Again, we hope that the attached *Picture of the Future - 2014* will be the basis for a stimulating and useful discussion. We look forward to seeing you soon.

Sincerely yours,



Stephen Larned, M.D.



Ethel Weinberg, M.D.

An Academic Health Center in Kalamazoo

A Picture of the Future – 2014

Larned & Weinberg

December 2008

TABLE OF CONTENTS

PROLOGUE: 4

BACKGROUND: 4

CRITICAL QUESTIONS: 5

 Vision 5

 Mission 5

 Class size 6

 Curriculum 6

 Governance 7

 Management 7

 Location 8

 Funding 8

 Kalamazoo Center for Medical Studies (KCMS) 9

 Faculty/Medical Staff 9

2009 – 2014 FIRST STEPS 10

CASE FOR SUPPORT 10

 Need for Physicians 10

 Advantages to Western Michigan University 10

 The Economic and Civic Case 10

 Quality of care 11

 Inter-relationship between patient care, education, and research 11

 Market strategy/Physician recruitment 11

 Research 12

MOVING FORWARD 12

 Steering Committee 12

 Planning Committee 12

 Dean’s Search Committee 12

 Curriculum Subcommittee 13

 Clinical Faculty/Medical Staff Subcommittee 13

 Facilities Subcommittee 13

Graduate Medical Education (GME)..... 13

Community Engagement..... 13

FIVE YEARS LATER 14

 Liaison Committee on Medical Education (LCME) 14

 Undergraduate Medical Education (UME) 14

 Graduate Medical Education (GME)..... 14

 Faculty..... 14

 Research..... 14

 Clinical programs in our hospitals 15

 Administration and management..... 15

SUMMARY 16

Appendix 1..... 17

Appendix 2..... 19

PROLOGUE: We write this document in 2014. It is intended to describe how our medical school was conceived, the major issues we faced, and how we addressed them.

BACKGROUND: Shortly after his arrival in 2007 as the President of Western Michigan University (WMU), John M. Dunn began to raise the possibility of developing a new medical school in Kalamazoo. Following discussions with Paul Spaude, President & CEO of Borgess Medical Center and Frank Sardone, President & CEO of the Bronson Healthcare Group, WMU, Borgess, and Bronson agreed to collaborate on exploring the potential of such a project. Together we engaged DJW Associates to initiate our appraisal.

DJW Associates' February 6, 2008, Observation Report included the following: "WMU has the administrative and academic foundation necessary for the development of a new program in allopathic medicine leading to a Doctor of Medicine degree" and "by affiliating with the strong clinical education, service and research programs of KCMS, Borgess Health and Bronson Healthcare Group, the University has the potential to create an excellent system of medical education."

In order to continue with a more detailed assessment and to begin a strategic planning process, we engaged Larned & Weinberg, Academic Health Consultants, in the Spring of 2008 to provide consultative assistance. It was agreed that the scope of that work was "intended to prepare you and the other key constituents to make an informed decision concerning whether or not to proceed with developing a formal application for accreditation to the Liaison Committee on Medical Education. Your decision will be based upon a clear understanding of the shared vision of the new medical school, of the resources needed to accomplish the vision and of the commitments made to proceed with the required detailed implementation plan and application."

In addition to a general assessment of the support in the community for a new medical school, consideration was given to the following:

- Vision
- Faculty
- Curriculum
- Facilities
- Respective roles and responsibilities of WMU , hospitals, and others
- Management options
- Budgetary issues and funding options
- Process for Proceeding

In the summer of 2008 Larned and Weinberg interviewed a broad spectrum of potential stakeholders in a new medical school. That list, included as Appendix 1, included leadership of the three organizations, community leaders including the Mayors of Kalamazoo and Portage, faculty from

WMU, medical staff leaders, and others. They also met with a Feasibility Committee whose membership is included as Appendix 2.

This work was broadly reported in September, 2008 through a slide presentation entitled, “*Establish a Medical School at Western Michigan University? Preliminary Assessment and Next Steps.*”

CRITICAL QUESTIONS: As we write this paper in 2014 we look back on a series of critical questions and decisions that have shaped our progress to date.

Vision: A major breakthrough in our thinking occurred when we realized that we were thinking of much more than establishing a medical school to educate medical students. We were contemplating establishing an academic health center¹ comprising local hospitals, a closely affiliated medical school, and a faculty all of whom would collaborate to achieve excellence. We drafted the following preliminary vision statement:

Draft Vision: The Western Michigan University, Borgess Medical Center and Bronson Methodist Hospital are together committed to building and supporting an Academic Health Center recognized for providing the highest quality in patient care, medical education and research.

We then addressed the following key questions and came to some preliminary decisions as indicated in italics.

Mission: What will be the respective missions of the Medical School and of the Academic Health Center? Should the Medical School limit its focus to undergraduate medical education or should it also include graduate medical education, research, and clinical care?

Although some medical schools see their mission as being relatively distinct from that of their affiliated teaching hospitals, we decided that given that the physician faculty responsible for undergraduate medical education, primarily members of the medical staffs of our partner hospitals, would also be involved in Graduate Medical Education (GME), research, and clinical

¹ A number of authors have observed that there is no generally accepted definition of an Academic Health Center (AHC). The authors of the Institute of Medicine’s *Academic Health Centers* (Kohn, LT, editor, *Academic Health Centers, Leading Change in the 21st Century*, Institute of Medicine, National Academy of Sciences, 2004. p. 15 and 20) comment on the functional and organizational variability of AHCs and note that they do not see an AHC “as a single institution, but as a constellation of functions and organizations committed to improving the health of patients and populations through the integration of their roles in research, education, and patient care to produce the knowledge and evidence base that becomes the foundation for both treating illness and improving health.” We believe that this definition describes the collaborative arrangement that is envisioned by many in Kalamazoo with whom we spoke.

care, that the mission of our enterprise should include undergraduate medical education, graduate medical education, research, and clinical care, and should extend across all three partner institutions, the WMU School of Medicine, Borgess Medical Center, and Bronson Healthcare Group.

Accordingly, we drafted missions for the School of Medicine and the Academic Health Center that reflected this broad vision.

Class size – How large should the class be? Should there be a preference for Michigan residents? We felt that the limiting factor would likely be the availability of clinical teaching sites. We knew that a larger class would allow overhead to be spread over a larger number of students and would increase tuition dollars. Further, we felt that building classroom and student laboratory facilities that were too small for future growth could be a serious mistake. For purposes of planning we envisioned a class size of 80, which would be a stretch unless the majority of the potential teaching resources were available for Undergraduate Medical Education (UME), i.e. most hospital patients were used for teaching and most members of the medical staff participated, both of which represented a significant change from the KCMS model that had involved only 25-30 students per class and had involved a minority of both hospitalized patients and physicians. We assumed that preference for medical school admission might be given to residents of Michigan and others who were likely to practice in the area, but that tuition would be the same for all students.

We assigned a planning committee responsibility for determining class size and related issues in light of available teaching sites as well as financial and other considerations. For planning purposes we agreed on a class size of 80 students.

Curriculum – Should there be any special curricular emphasis?

We noted that accreditation requirements dictated a core body of knowledge and skills for all medical students. We were aware, though that various schools had sometimes elected to emphasize particular areas, e. g., research, rural medicine, primary care, opportunities for master's level studies in public health, epidemiology, law, etc. It seemed clear to us that the WMU medical school should build upon Borgess's and Bronson's strengths and recognized excellence in health care delivery.

We agreed to develop a program that emphasized optimal delivery of care including traditional biomedical science; an understanding and appreciation of psychological, social, and environmental influences on health; as well as new curricular content, such as managing clinical processes, continuous quality improvement, team approach to providing service, and enhancing care delivery through new approaches, including personalized medicine. We believed that this would result in students who were well-equipped to care for individual patients and who would understand how to care for groups of patients, based upon an appreciation of systems of care.

Governance – The governance model, of course, will be critical. How should the institution be organized so that accreditation requirements would be met and that all three parents could have appropriate involvement in all aspects of the enterprise while assuring efficiency in governance and a focus on doing what is best for the medical school, without eliminating the prerogatives of any of the parents?

We assigned the Planning Committee² responsibility to recommend a governing structure for a private school that would be related to but distinct from WMU and that would include representation from the three parent organizations, the medical staff and the community.

Management - What structure would ensure that the Dean had the authority and resources to achieve success for the medical school, as required by the LCME, while giving the hospitals the authority that they require? How would the faculty, particularly the academic chairs function within the hospitals? How could they have the authority and resources to achieve success for undergraduate and graduate medical education and contribute to the success of the hospitals? Should there be a faculty practice plan, how should it be structured?

We recognized that in traditional medical schools the academic chairs of the clinical departments also routinely served as the chairs of hospital departments and were responsible to the Dean for academic programs and to the hospital for clinical programs. The Dean and the hospital CEO negotiate, ideally collaborate, in setting priorities that meet both the needs of the medical school and the hospital. The faculty practice plan is often a free-standing entity with its own ability to set priorities, although is sometimes housed in the medical school or the hospital.

We felt that our 2008 hospital medical staff governance model with elected clinical chairs had not been designed to take advantage of a vibrant academic community and could hamper the recruitment of academic medical school chairs who might believe that to be successful they must have responsibility and authority within the clinical systems in which they practice and teach. We believed, however, that an abrupt change in the governance model could be disruptive and opted instead for evolutionary change.

We asked the Planning Committee to recommend a system that would maintain the governance responsibility of our medical staffs, but would allow the Dean to lead the faculty and the Clinical Chairs in building and supporting both academic and hospital programs. This might be done by developing a system within the medical school and hospitals that involved full-time academic chairs who would work in collaboration with the elected hospital-based clinical chairs, with appropriate division of responsibility. This might be begun in the core departments, with residency program directors

² The proposed Planning Committee is described on page 12 below.

reporting to the Chair and the Chairs reporting jointly to the Vice President for Medical Affairs (VPMA) for clinical issues and to the Dean for academic matters. We recommended a “Clinical Council,” that might include the Chairs, the Dean, and hospital leaders, and serve as a senior advisory group on resource allocation and similar issues within the hospitals.

Location – Where should the medical school be located?

We agreed that clinical faculty uniformly favor location of a medical school and of their offices and research laboratories within easy walking distance of their hospital. It is similarly efficient for medical students who are assigned to short clinical experiences in the first two years to be able to walk to a hospital.

Parity between the major hospitals, however, was clearly an issue and efforts would need to be made to keep an even playing field while attempting to do what was best for the medical school.

We agreed to develop a Borgess campus, a Bronson campus and a WMU campus and to house selected departments and facilities within each of the campuses, as appropriate.

Funding – How was the school to be funded? What would be the role of tuition, philanthropy, clinical practice etc?

Our preliminary budget used conservative assumptions and contained a number of variables. While it resulted in a break-even budget by assuming some revenue from philanthropy and clinical practice, and does not rely on income from the state, the results could vary widely.

The base assumptions in the budget model included 80 student cohorts, 60 new FTEs, with approximately 60% of the costs covered by tuition and the balance covered by clinical fees and philanthropy. The projected tuition charges would place WMU in the mid range of private medical schools. This does not address the concerns noted in the following paragraph.

Not included in the basic budget is an allowance for funding to assure a diverse student body. Another concern expressed by the committee is the ability to drive some of our graduates into underserved population areas. Both the inclusion of a diverse student base and the ability to drive graduates to underserved populations could be accomplished by issuing forgivable loans. The ability to move this direction would expand the expense side of the budget and would likely need to be funded by endowment gifts.

Kalamazoo Center for Medical Studies (KCMS) – What would be the role of KCMS, KCMS faculty, staff, and related clinical facilities? Would there be an on-going commitment to MSU students? If not, when would they be phased out?

KCMS had served a useful purpose as a home for medical education and for some patient care activities. It was widely perceived, however, as being relatively distinct from the hospitals and that medical education and the KCMS faculty were not well-integrated into the fabric of the hospitals. Research activities were minimal. Although MSU was a major component of KCMS, there would not likely be sufficient clinical opportunities to accommodate MSU medical students once the new school had junior and senior classes

We agreed that when it was clear that the new school would receive LCME accreditation, MSU should be given three years notice of the intent to stop accepting undergraduate medical students. We provided that notice, KCMS was subsequently dissolved, and we integrated KCMS academic, clinical, and support staff in the WMU Academic Health Center.

Faculty/Medical Staff – How will our faculty be comprised? What will be the relationship of basic science faculty in the School of Medicine and the rest of the WMU faculty? What will be the academic roles of volunteer, paid volunteer, part-time, and full-time physicians?

The active involvement and support of the Kalamazoo physician community was seen as essential to the success of the medical school. We anticipated that some would be very supportive and seek to join the faculty on a paid or voluntary basis, whereas others might be concerned that the employed faculty physicians would compete with them and cause them to lose patients. Further, the need to make decisions concerning adding full-time faculty in particular areas had the potential of causing discord between the hospitals and the medical school.

It was agreed that most academic medical centers expect that all medical staff members will support medical education by allowing their patients to be seen by students and residents, by teaching, by supporting research activities, etc. We concluded that having substantial numbers of medical staff who did not offer such support would result in the loss of potential educational resources that would be needed for the programs that were envisioned.

We determined that the core basic science faculty would have appointments in the School of Medicine and could also have adjunct appointments in other departments or schools within WMU. We also recognized that there would be a wide range of opportunities for secondary appointments within the School of Medicine for other WMU faculty. Further, we agreed that to the extent feasible, we would build our medical school clinical faculty by beginning with the academic and clinical leaders who were already based in Kalamazoo. We planned to jointly recruit new faculty with existing medical groups, whenever practical, but, when necessary, to recruit unilaterally.

A decision was also made to grandfather current volunteer medical staff, but to consider making application for faculty appointments a requirement for future members of the medical staff, assuming adequate credentials and willingness to teach, with or without payment, as appropriate.

2009 – 2014 FIRST STEPS

CASE FOR SUPPORT: Our first step was to assure that all of our major constituencies were in agreement with our vision. We recognized that we had moved from a discussion of the planning of a medical school to the discussion of the development of an academic health center where medical education, high quality clinical care and research were tightly integrated in support of excellence in medical care for current and future patients. Our plan was taken for discussion to broad array of constituents and modifications made, as appropriate.

In early 2009, our respective Boards, with the support of the Medical staffs of the two hospitals, committed to attempting to establish the WMU School of Medicine as a part of a new Academic Health Center in Kalamazoo. This decision was based upon the case study, which was a part of our assessment process and presented to the Planning Committee and an array of key groups from the parent organizations.. Specifically we were influenced by the following factors as summarized below:

Need for Physicians: The Association of American Medical Colleges studies indicated a need for a thirty percent increase in the number of graduating medical students and a need to increase the diversity among medical students. The need to increase the numbers of physicians in Michigan was particularly pressing because of the aging physician population.

Advantages to Western Michigan University: The addition of a medical school to WMU was seen as a logical next step in its development as a research university. A medical school, building upon the strength of current health-related assets, would increase the scope and revenue for research, enhance recruitment of excellent undergraduate students, improve philanthropy and university prestige, and offer a broad array of opportunities for further synergy with existing programs, e.g., engineering might add biomedical engineering, business might add health administration and health care economics, electrical and computer engineering might add health informatics, and a Center for Applied Research on Health Disparities might draw on the expertise of medical, social, and biological scientists from throughout the university as well as from the School of Public Affairs and Administration.

The Economic and Civic Case: A medical school is seen as an opportunity to catalyze additional economic development in southwest Michigan through further growth of the health care and biomedical industry. The business and economic impact of medical schools on local economies has been recently documented by the AAMC and Tripp Umbach, a research,

strategy, and impact consulting firm.³ Michigan ranks 8th nationally in total direct and indirect economic impact from medical schools and teaching hospitals, which is estimated to exceed \$18.7B.⁴

The enhanced services and resources brought to the region by the academic health center will enhance the quality of life in Kalamazoo and throughout Southwest Michigan, especially to medically underserved communities and to patients who otherwise might be inclined to leave the area to seek the care they need – or go without potentially life-saving and life-enhancing care.

Quality of care: We were impressed by studies (e.g. Kupersmith⁵) that demonstrated better quality of care outcomes in teaching hospital than in non-teaching hospitals. We believed that continuing the transition to an academic health center with a wider spectrum of specialty services and greater attention to research in care outcomes would continue to enhance the quality of care in our hospitals.

Inter-relationship between patient care, education, and research: We recognized education, research and patient care were interdependent and that we could not do one well without the others.

Market strategy/Physician recruitment: We believed that enhancing the spectrum of care and assuring patients that excellent care was available locally was an important strategy. Further, developing strong academic programs whose graduates were interested in staying within the system would help us to recruit the physicians necessary to make this goal a reality.

We also believed that it was necessary to develop “cutting-edge” clinical programs. This, in turn, would be dependent on our ability to recruit physicians, particularly for leadership of clinical programs that might compete effectively with university centers. These same physicians would enhance our attractiveness to the best medical students, help us retain the strongest of those students in our residencies, and recruit the finest of them to our medical staff and referral network.

We were confident that if our Academic Health Center could achieve this vision that our hospitals would also increase their overall volume, the percentage of regional high-end clinical business, our market share and reach, and our overall financial success..

³ The Economic Impact of AAMC-Member Medical Schools and Teaching Hospitals, 2005. Tripp Umbach AAMC 2007.

⁴ Ibid.

⁵ Kupersmith, J. Quality of Care in Teaching Hospitals: A Literature Review. Academic Medicine. 2005; 80: 458-466

Research: We believed that our patients would benefit from early access new to therapies, intellectual stimulation, and the other advantages that come from being a part of an academic health center, with its integrated clinical care, research, and teaching.

MOVING FORWARD:

We realized that there was a great deal of work to be done and that, although recruitment of a Founding Dean was essential, we could begin much of the work immediately. We also realized that recruitment of the Founding Dean would be facilitated by evidence that we had been able to come to agreement on certain key issues such as how the three parent organizations would relate to each other, the management structure for the new School, and the roles of the Dean and academic chairs. We also knew that promise of significant philanthropic support of the new School would be enormously important in helping us to move forward.

With the desire to build upon the excitement and momentum that had been generated by the announcement about the new medical school we took the following steps:

Steering Committee: We appointed a high level steering committee comprising the Presidents of the three parent organizations and committed to meeting biweekly for as long as necessary. Equally important, we agreed that we would do our utmost to make decisions based upon what was best for the new Academic Health Center and not for our individual organizations. We did this believing that ultimately the success of the Medical School and the AHC would contribute to the success of all. A major role of the Steering Committee was to plan and coordinate the crucial approach to philanthropy.

Planning Committee: We appointed a Planning Committee consisting of the Chairs of each of the Subcommittees. We charged this Planning Committee with coordinating all aspects of the planning process with the understanding that we wanted to accomplish as much as possible prior to the arrival of the Founding Dean without committing the Dean to decisions that could not be revoked. We agreed to attempt to use a timeline that would have us achieve LCME accreditation and admit our first class as soon as we were ready, perhaps as early as the fall of 2012.

Dean's Search Committee: We established a Search Committee for the Founding Dean. We believed that the candidate must have impeccable academic credentials and be a visionary with a very practical approach to how to proceed with the enormous task ahead. We were very aware of the particular challenges within Kalamazoo of needing to balance the interests of the hospitals and of working with a medical community that would be asked to make significant changes. With the help of a search firm, it took six months to recruit an excellent candidate and then another three months before the new Dean was on campus in Kalamazoo. We were glad that we had made the decision to move ahead vigorously with our planning during the search process.

Curriculum Subcommittee: We appointed a curriculum subcommittee and charged it with making a preliminary recommendation on the overview of our medical education program. We wished to offer a strong general program that would prepare students to enter residency programs of their choice but also one that would build upon the strength and emerging research interests of our hospitals in patient outcomes. We believed that understanding how to give care not just to individual patients but to a population of patients and how to work effectively with other health care workers would be essential for future physicians.

We asked that the subcommittee begin by preparing a discussion paper on trends in medical education. This helped us to become knowledgeable about such themes as problem-based learning, use of simulation laboratories, and early introduction of patients, both real and virtual. We arranged for several members of our group to visit a number of medical schools with differing approaches to undergraduate medical education. This work was also important as we began to think about facility requirements for our medical education building.

Clinical Faculty/Medical Staff Subcommittee: We convened a clinical faculty/medical staff sub-committee to help us think through the various issues involved in building a clinical faculty in a setting with numerous existing physician practices, some large, some small; some based at Borgess, some based at Bronson, some within KCMS, and some free-standing; some of which collaborate and some of which compete. We knew that the medical school would wish to engage a number of Kalamazoo-based physicians as well as to recruit additional new physicians for academic programs. The committee suggested approaches to filling academic positions, including our academic chairs, by working through existing medical groups, when feasible, but recruiting directly to the medical school when that was the best option.

Facilities Subcommittee: We appointed a facilities subcommittee to begin to develop an understanding of the requirements for a new medical school building. We asked that they prepare a report on trends in medical school buildings to help us understand what kinds of spaces were most needed, the role of laboratories and how they might be designed for flexible use, the need for simulation laboratories, etc. We asked that they plan on flexibility to allow for future growth of faculty and, possibly, of the student body. We suggested that they visit some of the new medical school buildings around the country and hoped that their report would form the basis of our plan for the building program.

Graduate Medical Education (GME): We completed a comprehensive review of each residency program and looked for opportunities for improvement. We determined to use our Medicare funded slots in a way best suited to meet the long term needs of the system. In addition, we began a systematic review of the experience of our students and residents and made improvements in order to be an even stronger site for residency education.

Community Engagement: We planned an extensive community engagement campaign in the form of meetings with area citizens and discussions with public officials, and leaders of community and faith-based organizations. We discussed both the capabilities of the new

academic health center as well as its commitment to be responsive to the needs and interests of all sectors of the community.

FIVE YEARS LATER: In 2014 we are a work in progress. We count amongst our successes the following:

Liaison Committee on Medical Education (LCME): We achieved preliminary approval from the LCME and welcomed our first class shortly thereafter. We look forward to graduating that first class soon and to achieving full accreditation at that time.

Undergraduate Medical Education (UME): We have recruited several excellent classes of medical students from diverse backgrounds with regard to race, ethnicity, gender, life experiences, undergraduate majors, and geographic origins. These students have been drawn Kalamazoo by the excitement of a new medical school whose faculty and fellow students are energetic and infused with a strong sense of purpose and ethic of service. They also are attracted by the innovative curriculum, interesting research opportunities, state of the art information technology and equipment for live and virtual patient simulations.

Graduate Medical Education (GME): Our already strong GME programs have benefitted from the new faculty, facilities and research opportunities. We are now attracting larger numbers of applicants and anticipate being able to keep many of our best graduates in the area to practice. We have added several new residency and fellowship programs that enhance our ability to attract faculty and offer excellent care in an ever broadening spectrum of specialties and subspecialties.

Faculty: We have recruited a small but growing number of basic science faculty. Initially their efforts were focused on developing a strong curriculum, but research is beginning to become a priority. As planned, we selected both established and junior investigators with the expectation that as our research grants increased we would be able to continue recruiting a faculty with a broader range of interests and capabilities.

Our clinical faculty is evolving as well. We have recruited strong academic chairs who are able to lead our academic efforts as well as making significant contributions to our clinical enterprise. We now have a mix of full-time academic faculty and volunteers, many of whom are paid for teaching. Over time some community physicians have followed a national trend and have chosen to become employed by the hospital. For many this has allowed a focus on the medical side of being a physician and has relieved them of concerns about the business aspects.

Research: We agreed that our initial research focus would be in the area of health outcomes and patient safety but also understood that we needed to have research opportunities that would attract physician faculty with other interests, opportunities that would build on potential synergy with WMU faculty, including both basic and social scientists, engineers, and others,

and the potential for relationships with the large number of pharmaceutical and other companies in the greater Kalamazoo area.

We have been successful with our plan to build upon the strengths of our hospitals by setting health outcomes and patient safety as research priorities. We have received national recognition and substantial funding for these programs that have led to enhanced prestige and credibility for our health center. We have made concerted efforts to build upon opportunities for collaboration with WMU faculty and with local pharmaceutical firms. These efforts are beginning to see success and we find that more we achieve, the easier it is to make another productive connection.

Clinical programs in our hospitals: Our hospitals' clinical programs have expanded in scope and are widely recognized as being of the best quality. We have found that the opportunity to become a faculty member in our new medical school is an important part of attracting physicians who are able to offer the most sophisticated of medical services. This enhanced capability, coupled with our traditional reputation as institutions known for our caring atmosphere, has substantially increased our market share as we have become the destination for care in our region.

Administration and management: Our administrative and management systems are maturing and we feel that we are learning how to successfully collaborate in ways that can make our three involved institutions more than the sum of their parts. The medical school has identified or recruited full-time academic chairs in Internal Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry, and Family Medicine, the majority of whom also serve in leadership roles at Borgess or Bronson, or both. Our residency program directors report to the academic chairs, as well as to the Associate Dean for GME, who serves as Designated Institutional Official (DIO) for our ACGME-accredited residencies and fellowships. As planned, we have largely built our medical school clinical faculty around Kalamazoo's existing academic and clinical leaders, recruiting new talent only when necessary and largely through existing medical groups. This has resulted in a relatively small medical school-based faculty and related practice plan, but Borgess and Bronson have continued to work with us on helping to balance our budget, including both revenue sources and expenses.

The medical school and the hospitals jointly review annual strategies and priorities, and seek to identify potentially beneficial collaborative opportunities. Last year we agreed to found a new collaborative clinical and research enterprise that will involve physicians, researchers, and other health professionals in providing comprehensive and highly specialized care to patients across the boundaries of traditional specialties, developing a mature research infrastructure, and promoting collaborative research.

SUMMARY

The collaboration between our three organizations and our faculty/physicians has resulted in an excellent Academic Health Center. Our School of Medicine is well on its way to recognition as an outstanding institution, known for its unique approach to educating students for care of individuals as well its focus on quality of care and aggregate outcomes for particular groups of patients. The presence of the School of Medicine has allowed Borgess and Bronson Hospitals to develop cutting-edge programs in a wide array of clinical areas and to retain many graduates who have chosen to practice in our vibrant medical community.

Kalamazoo, building upon its reputation as a caring, entrepreneurial, knowledge-based community, is becoming the destination for care for an increasingly large portion of Michigan and surrounding areas. Our concentration on clinical outcomes research has resulted in a national recognition in selected areas that confers credibility on the entire enterprise.

Western Michigan University has benefited by enhanced research opportunities, its ability to attract an increasingly strong student body, and an a large array of synergistic programs. The medical school has become a catalyst for economic development, as evidenced by growing research funding and collaborations with our burgeoning life sciences industry.

In short, we are seen as an outstanding example of an Academic Health Center that has been built upon the strengths of a community and in turn contributes greatly to the community.

Stakeholders who met with Drs. Larned and Weinberg

Terry Baxter, MD, Chief Medical Officer, Borgess Hospital

Elizabeth Burns, MD, CEO, KCMS

James Carter, M.D., Bronson, former head of KCMS

Dean's Council Meeting

Robert Doud, Ed.D., Vice President of Public Affairs and Development, Bronson

Bronson Drs. Meeting

Borgess Drs. Meeting

John M. Dunn, Ed.D., President, WMU

Patrick Dyson, Executive Vice President, Borgess

Alex Enyedi, Ph.D., Assoc. Dean Arts and Sciences

Wes Freeland, Advisor to the President/CEO, Kalamazoo Community Foundation

Dave Gardiner, Vice President Community Investment, Kalamazoo Community Foundation

Patrick Garrett, President Battle Creek Health Systems

Timothy Greene, Ph.D., Provost, WMU

William Hamman, M.D., Scientific Researcher, College of Aviation, WMU

Bobby Hopewell, Mayor, Kalamazoo

Thomas Kent, Ph.D., Dean, College of Arts and Sciences

Ron Kitchens, Chief Executive Office, Southwest Michigan First

Scott Larson, M.D., Sr. VP Medical Affairs and Chief Medical Officer, Bronson

Jim Leja, Rh.D., Interim Dir., Social Work

Dan Litynski, Ph.D., Dean, College of Engineering & Applied Sciences

Mark Loehrke, MD, Internal Medicine Program, Director, KCMS

Appendix 1, Continued

Bob Miller, Assoc. VP, Community Outreach, WMU

Ken Miller, Chair, WMU Board of Trustees, Principal Partner of Millennium Restaurant Group

Jeffrey, Mitchell, M.D., VP Medical Affairs, Battle Creek Health Systems

Cindee Quake-Rapp, Ph.D., Chair, OT Dept.

Lowell Rinker, VP Business and Finance, WMU

Steward Sandstrom, President and CEO, Kalamazoo Regional Chamber of Commerce

Frank Sardone, President & CEO, Bronson Healthcare Group

Paul Spaude, President & CEO of Borgess Health and Borgess Medical Center

Sue Stapleton, Ph.D., Assoc. Dean Arts and Sciences

Peter Strazdas, Mayor, Portage, MI

Carol Sundberg, Ph.D., Dir., Unified Clinics

Ken Taft, Executive Vice President and COO, Bronson

Earlie Washington, Ph.D., Dean, Health and Human Services, WMU

Thomas Zavitz, Chief Operating Officer, MSU/KCMS

Linda Zoeller, Ph.D., School of Nursing

Feasibility Committee

Bob Miller, Associate Vice President, Community Outreach, WMU, Chair

Nicholas Andreadis, M.D., Interim Associate Dean, Lee Honors College, WMU

Terry Baxter, M.D., Chief Medical Officer, Borgess

Elizabeth Burns, M.D., CEO, KCMS

David Dakin, Director, Campus Facility Development, WMU

Bob Doud, Ed.D., Vice President of Public Affairs and Development, Bronson

Patrick Dyson, Executive Vice President, Borgess

Timothy Greene, Ph.D., Provost, WMU

William Hamman, M.D., Ph.D., Scientific Researcher, College of Aviation, WMU

Bassam Harik, Ph.D., Vice Provost for Budget and Personnel, WMU

Scott Larson, M.D., Sr. Vice President for Medical Affairs and Chief Medical Officer, Bronson

Mark Loehrke, M.D., Internal Medicine Program Director, KCMS

Jack Luderer, M.D., Executive Director, Biosciences Research and Commercialization Center, WMU

Timothy Ready, Ph.D., Director, Lewis Walker Institute, WMU

Lowell Rinker, Vice President of Business and Finance, WMU

Ken Taft, Executive Vice President and COO, Bronson

Earlie Washington, Ph.D., Dean, Health and Human Services, WMU

Thomas Zavitz, COO, KCMS