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ONE TEAM ONE HEALTH
COLLEGE OF MEDICINE TASKFORCE REPORT
NOVEMBER 26, 2025

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Report from the One College Task Force

The One College Task Force was charged with evaluating a proposal that would unite the DO and MD programs under a single medical school and report on the barriers to this proposal. The hypothesis was that unifying the two programs into a single college is feasible, and the task force was asked to identify reasons that it should not be done.

The task force considered the perceived drivers of the proposed unification and explored the potential benefits and tradeoffs of a one-college model and a two-college model.

Throughout this report, the term "**one-college model**" will refer to a model in which MSU maintains two distinct pathways for physician education (MD and DO) within a single college or school, taking the place of the current College of Human Medicine and College of Osteopathic Medicine. The term "**two-college model**" will refer to a model in which MSU maintains two distinct schools with the acknowledgement that the future state will include opportunities and expectations for synergy.

The report presents the task force findings in four **statements**; each is a proposition or hypothesis which tests or frames a component of a one-college model. Descriptions of present state within the current programs and from the broader medical education community are provided for context. Findings of opportunity and trade-offs, surfaced by the task force, are included, accompanied by a **recommendation** based on deliberations of the task force members.

A **summary** provides the task force conclusions, categorized as perceived benefits and perceived trade-offs. The report also includes a proposed model to advance the stated goals of the One Team, One Health initiative and leverage unique opportunities within the MSU+Henry Ford Health partnership. This proposal envisions a novel institute for physician education located at the Henry Ford Hospital Detroit campus, where select MD and DO students would train together in a specialized curricular track. This model preserves the historic community-based medical education model that is central to the MSU land-grant mission, while also launching a first-in-the nation innovative interprofessional pathway through the HF+MSU partnership.

Statement 1:

A one-college model is a viable option from the standpoint of accreditation.

The DO degree program is accredited by the Commission on Osteopathic College Accreditation (COCA). The MD degree program is accredited by the Liaison Committee on Medical Education (LCME) (**Appendix Item 1**). Both bodies are themselves accredited through the US Department of Education. Both sets of standards address the required elements of the respective degree programs, including administration, faculty and staff, facilities, curriculum, research, and student services.

From the perspective of the accrediting bodies, as well as common practice, MD and DO programs are housed within their own medical college or school; in fact, the standards are written such that the program is the equivalent of the school or college. This is evident in the standards themselves: the LCME standards are titled "Functions and Structure of a Medical School" and the COCA standards are titled "Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards". While there are limited examples of other universities with both MD and DO programs, in each case – including here at MSU – these programs are housed within separate colleges or schools. Additionally, it should be noted that all US DO degree programs are housed within a school or college specifically identified as an "osteopathic" institution. In contrast, nationally a college or school of medicine is presumed to offer an MD degree.

To evaluate whether a single college or school could administer two medical degree programs (DO and MD) according to the respective requirements, the COCA and LCME standards were reviewed by both the One College Task Force and the Accreditation Task Force. Representatives from COCA and LCME were consulted and provided with specific questions and scenarios projecting how the elements might be met in a one-college model based on preliminary and theoretical descriptions. Initial indications from each accrediting body were that the proposed one-college model may be theoretically possible but may also pose risks of closer scrutiny in the coming years, which will significantly increase administrative and financial burden for the university.

Additional input from LCME in response to shared draft documents indicated several significant concerns; notably, with respect to the following:

- Leadership of the MD program and concern that a single dean over both MD and DO programs would create a conflict of interest.
- Academic governance and concern that a college-level curriculum committee would permit direct oversight of the MD program by voting members who were not part of the program.
- Concerns about affiliation agreements and student clinical placements, with a concern that shared affiliation agreements may impede primacy of programming and could impact comparability across campus sites.
- Equity among students, with the concern that unless all student services were equivalently resourced across both the MD and DO programs it would create cultural challenges for the other program. This was stated with recognition that the LCME would have oversight and jurisdiction only over resources impacting MD students. The

concern that housing both programs in the same college but providing different levels of resources for each program is something the university should consider and address if plans proceed for a one-college model. The expense of providing the highest level of student services that is required by either accreditor for all students in a single college may be insurmountable.

- Questions about the relationship between the MD program leadership and that of the clinical affiliates, which is stipulated by the LCME and was not clear during the consultative visit.

- As per the July 2025 LCME Rules of Procedure, any anticipated change in governance that affects the medical education program requires prior notification to the LCME, through completion of the Change in Ownership or Governance Notification Form. After reviewing the notification form, the LCME will determine if changes in its determinations of the program's performance in the relevant accreditation elements and of compliance with the relevant standards are warranted. This notification and review could result in changes to CHM's accreditation status or term.

It is important to note that the medical education program leading to the MD degree at the Michigan State University College of Human Medicine received written notification on November 13, 2025 in response to their recent two-year accreditation review. The indeterminate term was ended and full accreditation was continued for the medical school through AY 2030-31. Although there was significant improvement in almost all elements and standards under review, eight elements still require monitoring and four remain unsatisfactory, with the next LCME report due August 16, 2027. A timeline or decision regarding college restructuring or resource reallocation must take this into account or MSU would risk increasing the vulnerability of the MD program's accreditation.

Similarly, input from COCA included the following responses:

- The COCA regards a "DO program" and the college or school in which it is housed to be the same entity; there is no entity between the college and the university.
- The head or lead administrator of the DO program/college must be the Dean for that program; alternative titles such as associate or vice dean were not supported. A Dean of a COM typically reports to a provost, not another Dean or Executive Dean of another college.
- The Dean of a DO program/college must have a full-time appointment as Dean of the DO program/college and must be an osteopathic physician
- The Dean of a DO program/college must have budgetary authority over the DO program/college.
- The DO program must be responsible for developing policies and procedures for appointing clinical faculty and credentialling and/or approving its faculty members.
- The College of Osteopathic Medicine must have a defined research plan and budget that includes research advancing osteopathic medicine and opportunities for osteopathic medical students
- The College of Osteopathic Medicine must have a curriculum committee with responsibility for the DO educational program.
- The College of Osteopathic Medicine must include a primary care department with a Chair who must be an osteopathic physician with AOA or ABMS board certification in a primary care discipline. A model where all primary care clinical chairs could possess

either an MD or DO degree, but neither be required for any department, would not meet COCA standards. The College must also have a osteopathic manipulative medicine department with an appropriately credentialed osteopathic physician as chair.

Recommendation: A loss of either accreditation through the process of advancing a one-college model would be catastrophic to both our students and the reputation of MSU. In advancing any model, we must continue working with the accreditors to ensure that LCME and COCA accreditation will be achievable, and that any reorganization provides initial and ongoing strategies to align with both sets of standards. Initial feedback from the LCME and COCA included a substantial level of concern about the proposed model, including structural questions related to governance and budgets as well as cultural questions related to equity of student experiences. LCME also described increased scrutiny that would accompany a decision to proceed with a one-college model. While some of these comments should not be regarded as insurmountable, and some of their queries were on points other than strict adherence to the standards, they do represent a challenge and a substantial risk to both programs that should be considered when a decision is made. The concern about accreditation risks is a major driver regarding lack of consensus for a one-college model at MSU. Further information regarding accreditation risk will certainly be included in the report from the Accreditation Task Force.

Discussions with both the LCME and the COCA made clear that neither body would commit to endorsing a proposed model in advance. It will be incumbent upon each program to demonstrate compliance with its respective standards. Therefore, the task force is unable to ensure that the proposed one-college model meets accreditation requirements. This risk could be mitigated by maintaining the two-college model while implementing internal structural changes. Should these changes be shown to be operational and should further benefits of a one-college model be identified, MSU could then pursue a one-college model with greater assurance of successfully maintaining accreditation for both programs.

Statement 2:

A one-college model can be synergistic and can address internal functional issues.

Establishing two separate medical colleges at MSU in the 1960s led to unique structural and functional features that can be traced to program mission, professional identity, academic programs, clinical and research initiatives, and strategic priorities. While the colleges share several departments, over time, systems have evolved that fall into the following categories:

- Those that serve one program only, including distinct departments such as several new departments at Henry Ford
- Those that are duplicated and independent in each program including, distinct research and faculty affairs offices
- Those that serve both programs including several shared departments

The task force considers that MD and DO medicine represent two distinct medical professions, which both bring value to patients, and the training of each brings value to MSU. These professions evolved with different philosophies, unique educational and clinical practices, and independent licensure and certification pathways, although MD and DO graduates now train in residency programs under a single accreditation system. While the history of DO and MD medicine evolved along separate and sometimes contentious paths, these distinctive professions today share significant goals in terms of holistic and patient-centered models, foundational competencies, and graduate medical education oversight.

Guided by the vision of One Team, One Health, and dedicated to the missions of each program and the university, following the Michigan State model of shared departments and low institutional barriers to collaboration is advisable. In this spirit, opportunities to align or combine systems should be considered whenever possible to meet one or more of the following objectives.

- Envisioning a stronger future for healthcare education and biomedical research at MSU
- Expanding access and opportunities for students
- Amplifying community impact, including One Health
- Improving efficiency, cost-effectiveness, and synergy across the medical school mission

Examples of internal variation that may impede efficiency include:

- Departmental structure: duplication of some clinical departments in COM and CHM; conflicts with HF+MSU organization (e.g., in faculty appointments and department development)
- Academics and faculty teaching load: varying or redundant curricula, pedagogies, and teaching assignments place additional demand on faculty
- Third-party technologies and applications: CHM and COM work with different products and vendors for curriculum management, clerkship scheduling, etc.
- Variability in academic, financial and administrative policies and procedures
- Variation in budget allocations including how funding allocation models differ between the two colleges and even within a college- e.g.,. CHM's model for funding researchers

in Grand Rapids- and Flint-based departments is different from East Lansing-based joint departments.
- Absence of administrative mandates or incentives for cross-college cooperation

Recommendation: The task force is in strong agreement that there is an opportunity for redefining healthcare education overall at MSU. A decision to restructure into a one-college model will not solve problems or create opportunities on its own. Significant work and financial investment will be required to design new systems across the academic, clinical, and research enterprises to proceed with thoughtful intention. That said, the task force also concluded similar objectives could still be achieved within the existing two-college model, provided that each program's administration receives appropriate direction. This would require reconfiguring structures and processes to hardwire partnerships and accountability for outcomes. The task force did not reach consensus that a one-college model would be preferable or necessary to achieve the above stated objectives. .

Statement 3:

A one-college model may streamline delivery of physician education.

The task force notes the history of medical education systems in the post-Flexner era, with largely separate, parallel paths for DO and MD undergraduate medical education (UME) and graduate medical education (GME). The GME of DOs and MDs is becoming more integrated through consolidation of accreditation for GME programs in a single system under ACGME, and in the recent document jointly developed by AAMC, AACOM, and ACGME, describing the foundational competencies for UME.

Within MSU, the task force notes the history of the formation of CHM and COM, with MD and DO students sharing some courses at MSU, and the present state in which CHM and COM take a significantly different approach to instruction and assessment. The faculty of each college are charged with the design, delivery, and oversight of each college's physician degree program, and housing both programs in a single college would not necessarily result in a mandate or even a recommendation to blend the programs in full or in part.

The task force notes opportunities for greater synergy in terms of curriculum development and delivery that would benefit students and faculty in both programs. Examples include:

- Creating or curating a library of basic and clinical science shared resources
- Intentional effort to develop and incorporate AI tools for medical education and assessment
- Developing common curricula for selected or emerging topics
- Sharing best practices in simulation, clinical skills assessment, and interprofessional education
- Standardizing policies and procedures

A model for one-college oversight of the two medical degree programs might be that of the University Committee on Curriculum (UCC), where subcommittees would be charged with the work of approving and monitoring courses and requirements for each degree program and would report up through a combined College Curriculum Committee (CCC) with oversight responsibility. Of note, LCME raised concerns about this model, noting that only faculty associated with the MD program should make academic governance decisions regarding the MD program, and COCA stated that there must be a curriculum committee with responsibility for the College of Osteopathic Medicine's education program, thus indicating that this model might not be viable without a clear program-specific (MD and DO) responsibility demarcation. An alternative strategy in a two-college model might include a liaison work group of faculty and administrative representatives from both programs that is charged with facilitating coordination of curricular elements for greater collaboration and efficiency.

Importantly, if an integration is pursued, then the task force operated under the assumption that all students in an integrated college structure would have equal access to student services and support, including tutoring services, wellness programming, research opportunities, career services, and others. In this scenario, all students in a combined college would need programming sufficient to clearly meet the most rigorous accreditation standards of either professional accreditation board. Significant work and resources will be required to recruit research faculty mentors, educators, and support staff essential to achieve the goal of robustly providing enhanced services for DO and MD students.

Recommendation: The MD and DO programs must maintain an accredited, faculty-approved curriculum that leads to the respective degree and is compliant with professional standards. The task force did not reach consensus on whether a one-college model is preferable or necessary to synergize physician education and other medical school missions at MSU. The task force concludes that while it is possible for two distinct degree programs within a single college to maintain their individual models and resources, integrating two distinct degree programs may affect the student experience by creating disparities in access and shaping a divided culture within the merged college. Moving forward, structural and operational changes should be initiated to make better use of shared resources, whether under the one-college or two-college model. In either model, the goals should be for MSU programs to be competitive within their missions of healthcare education, research, and clinical service, and to avoid counterproductive competition between the two programs.

The task force presented an alternative model of “Michigan State University Medicine” as an entity that either houses or supports both DO and MD training programs, and it is possible that this could be accomplished by maintaining two distinct colleges. Under this structure, the Michigan State University Medicine entity would either house all shared resources that would not jeopardize COCA or LCME accreditation, using a structure not dissimilar from the relationship between the Graduate School and MSU’s campus-wide doctoral programs, or would provide oversight of the deans of the distinct medical colleges with a mandate for increased programmatic cooperation. Thus, resources that benefit the greater healthcare education system could be provided to each program, with shared benefits to both while maintaining individual identities and accreditation.

Statement 4:

A one-college model may better position MSU within a community-distributed UME system.

Both the MD and DO programs rely on a community-distributed model for delivery of the clinical portion of the curriculum. Each program has a core curriculum of required clerkship rotations, elective rotations in various clinical specialties, and other experiences. Each rotation is a college and UCC-approved course, with a unique course number, course description, instructor of record, learning objectives, and assessment methodology. The Department of Psychiatry has modeled the psychiatry clerkship similarly for MD and DO students; nearly all core rotations and most electives are managed as separate courses by the colleges and their respective departments.

The COCA and LCME standards inform the organization and requirements of the clerkship experiences for the DO and MD programs, respectively. The core rotations may include a standardized subject-matter examination offered by the respective national licensure board, e.g., COMAT examinations offered to DO students by the National Board of Osteopathic Medical Examiners and the USMLE shelf examinations offered to MD students by the National Board of Medical Examiners.

With respect to the architecture of the clerkship phase, CHM uses a regional campus model where students are assigned to a geographical location with MSU faculty and administrators, which serves as a hub for their clinical education. Students are assigned to various hospitals and clinics throughout the region that, with the MSU faculty, form the regional campus. Each regional campus may offer a general clerkship experience or be a location at which students in a specific track or pathway are assigned. In this model, the regional campuses and community assistant deans work together under an associate dean to ensure comparability of student services, didactics, and clinical experiences. COM uses a base-hospital model, where students complete most or all core required rotations and also participate in a common longitudinal didactic curriculum developed by the college. Administration of the clerkships includes centrally located associate/assistant deans within the college. In both programs, affiliation agreements are used to facilitate clinical placements. Each program currently uses a different third-party software solution to support clerkship management.

Relationships with community partners are essential to both programs. Availability of clinical rotations is constrained by several factors, including the number of in-state medical schools, the needs of other health professions trainees including nurses and physician assistants, competition from medical schools that pay a higher per-rotation amount, etc. This ecosystem is fragile and relies on carefully cultivated relationships with academic leaders in each program and the communities in which the regional campus or base hospital is located. Accreditation standards may be a challenge to developing a combined affiliation agreement for MD and DO programs; for example, the LCME secretariat clearly articulated that in affiliation agreements with community partners, the MD program must have primacy over access to appropriate resources for education, appointment and assignment of faculty members, and education/assessment of MD students.

To the extent that DO and MD students may complete clinical rotations with the same clinical partners, efforts should be made to coordinate internally to ensure MSU programs remain a preferred source of student rotators. This need has been articulated by Henry Ford Health System in particular, through the expressed outcome of having MSU programs “speak with one

voice" was reiterated in discussions with McLaren. This statement from major partners should be more carefully explored to determine the solutions that will best address the perceived issues. This could also be said of any shared community partner, recognizing that the concerns and solutions may be different at each location. If speaking with one voice means having a clearer shared mission, or processes that could be streamlined, the benefit to that partner seems clear. That said, given the nuances and delicate nature of these relationships, the task force favored maintaining responsibility for managing medical student rotations within each academic program.

There may be additional reasons to suggest that a one-college model may be more effective than a two-college model in fostering a community-distributed approach. For example, over the past several years, CHM and COM have worked together with Munson Medical Center to coordinate clinical placements and student services, a model that could potentially be replicated in other regions of the state. Notably, CHM has demonstrated significant success in Grand Rapids and Flint over the past 10 to 15 years, through sustained strategic investments and by working closely with the clinical partners such as Corewell Health, McLaren, and Hurley Medical Center. These successes remind us that, while a unified vision and voice are critical, a single college is not essential for success. Preserving and expanding this unified vision must be a major goal if the two colleges are consolidated. However, it is critical to recognize that the trust and partnerships that CHM built in these communities, or that COM has built through longstanding relationships with its base hospitals, could be undermined if the transition to a one-college model lacks respect, transparency, and inclusivity. To ensure success, the process must prioritize maintaining these relationships through open communication and collaborative decision-making.

Recommendation: The DO and MD programs should work together to maximize student interprofessional opportunities and create efficiencies wherever practical. Examples for further evaluation include:

- Coordination or consolidation of core rotations
- Creation of electives open to both CHM and COM students
- Consideration of approaches at our clerkship sites that meet their needs and also make MSU the preferred partner over other in-state or international medical schools
- Leveraging the regional campus locations and base hospitals to support all health professions students and to expand community impact
- Deploying a common third-party system for clerkship management, creating efficiencies with MSU IT and integrations and negotiating for enterprise-level cost reductions

The task force recommends that clerkship management and administration remain a function of each respective program, while noting that opportunities to streamline or coordinate can be explored to create more positive experiences and ease of use for shared community sites. The task force notes that these recommendations are applicable to either a one-college or two-college model and does not find that a one-college model is the only or the preferred way to administer a community-distributed model. The task force further cautions that any changes ensure that each program can continue to demonstrate adequacy of clerkship rotations and compliance with all other applicable accreditation standards.

Summary

On the question “can MSU reorganize physician education from the current model of two colleges into a single college or school of medicine?”, the task force seeks input from the Accreditation Task Force. However, as noted by LCME, the Accreditation Task Force as such does not include members with expertise in LCME and COCA and therefore must rely on members of this task force for expertise. It should be noted that it is unlikely that either LCME or COCA will respond with a definitive prohibition, since their methods are generally consultative until they assess accreditation status. It should also be noted that the goal of accreditation is to meet the standards of the accrediting body, and our Task Force has not ruled out that these could be met with either model. The Task Force is categorical in concluding that accreditation of both programs is essential and of the highest priority for MSU Medicine.

Absent an absolute barrier from either accrediting body, the question becomes “should MSU reorganize physician education from the current model of two colleges into a single college or school of medicine?” On that question, and in the spirit of providing thoughtful feedback to President Guskiewicz and the One Health Council, the task force offers the following conclusions:

One-College Feasibility: Neither accrediting body has explicitly stated that a one-college model cannot be done, although both have expressed several substantive concerns, and LCME has indicated that such a change would be closely scrutinized. This is not as a hard stop, but a serious caution with potential financial, institutional, and reputational risk. As no institution has attempted to provide MD and DO education under one college or school, there is no precedent or recommended path to guide us, and it **would be** our job to demonstrate the value of doing so and **our ability** to meet the accreditation standards. Our ability to convince the university community and the broader academic community for why this is important to do is critical for the success of this effort, so the general rationale needs to be clearly delineated. This is especially important as there is no consensus within the taskforce that the rationale for combining the two colleges is strong or well-rationalized. Our success could change the paradigm for physician education in the process. We only note that this path is uncharted and a decision to proceed should carefully weigh the desired outcomes, tradeoffs and risks, and alternatives.

Perceived benefits:

The benefits envisioned include:

- Enhancing interprofessional collaborations between MD and DO students that mirrors the real-world environments of residency programs and subsequent clinical practices
- Achieving greater collaboration and efficiency
- Enabling MSU to advance unified, consistent messaging around our priorities, strategies, and mission with our community partners, perhaps strengthening our leverage as well
- Creating a more sustainable future for physician education at MSU that includes both DO and MD degrees
- Acknowledging the shared physician competencies that are common to MDs and DOs while also maintaining the contributions and recognition of each profession
- Advancing a “One Team, One Health” vision by integrating the following major operations functions:
    - Research faculty support
    - Leadership recruitment

- Research training
- Medical student research opportunities
- Research strategic planning and development
- Partnerships with internal and external entities
- Any additional operations whose unification does not affect accreditation

While these unifying themes are inspiring and worthy goals, the task force is split on whether a one-college model is the only way – or the optimal way – to achieve them. Accordingly, the ability of the task force to articulate the perceived benefits of the one-college model is, by definition, limited to speculation about positive outcomes with no predictive data analytics to support such speculation.

Perceived tradeoffs/risks:

The charge of the task force was to identify a reason(s) not to proceed with a consolidated college. Notwithstanding yet unsettled issues of accreditation, we have not identified a definitive reason since such a merger of an MD and DO college has never been attempted. However, with its operational knowledge, the task force identified challenges and perceived tradeoffs/risks associated with changing from the two-college model to a one-college model. These are offered in the spirit of due diligence and include:

- Loss of brands/identities: CHM and COM have established a brand identity within MSU and across the country. Whether there is a positive or negative impact of changing the names or the brands is not clear, but the task force identified the following specific areas of concern or potential risk:
  - *Admissions:* We risk having a negative impact on application decisions and recruitment of students who apply to COM and CHM because they are attracted to unique aspects of each school and the different professional identities formed in them.
  - *Student Residency Applications:* How residency programs might respond to graduates from a single medical school with both DO and MD training programs is unclear. At minimum, there is a concern that the name of the medical school implies the degree. With all DO students in the United States currently graduating from a college or school of osteopathic medicine, it is not clear whether there may be greater difficulty for residency programs to discern if the student is in the allopathic or osteopathic program.
  - *Alumni Relations:* Alumni have connections and allegiance to their college identities and may react negatively to a name change.
  - *Partner Relations:* MSUCHM enjoys a well-established 15-year relationship with the Grand Rapids community, which has an economic and political stake in a strong MSU partnership. MSUCHM's partnership with the CS Mott Foundation and Flint community is decades long and critically important for significant scholarship and donor relationships. COM has developed similar strong relationships in Southeast Michigan through the COM campus sites in Detroit and Macomb county. Based on conversations with the community stakeholders, the Task Force acknowledges that these and other key relationships may be at risk if not managed proactively during the One College process to ensure the continued confidence and trust of our partners and to build from these successful alliances.
  - *Community Relations:* The Grand Rapids community has the expectation that the headquarters for the College of Human Medicine is in Grand Rapids. The

communities in Detroit and Macomb county have similar expectations for the COM leadership structures at those campus locations. The greater Lansing community has valued the longstanding presence of both COM and CHM. These community perspectives need to be managed if a consolidated college is developed.

- Costs associated with reorganization: Creating a new, consolidated medical school/college will be complex and costly. It will require developing new organizational structures, as well as updating countless documents, bylaws, websites, courses in the university catalog, signs, contracts, affiliation agreements, etc. that are currently in use in each program. Thoughtful consideration of the costs to the university in terms of time, personnel, reduced capacity to pursue other opportunities, and physical resources is required. The task force emphasizes transparency in sharing analyses that demonstrate long-range financial and strategic benefit to justify and garner support for this investment. As noted above, there is a non-negligible possibility that to meet the accreditation standards of both COCA and LCME for a consolidated college, MSU must be prepared to spend considerable resources. Even if this is not required by either accrediting body, it is counterintuitive to a "One Team, One Health" model to accept having variable levels of resources for two students in the same college by virtue of the degree program in which they are enrolled. These additional resources must not come at the expense of resources currently allocated to one college or that could threaten accreditation. Information provided to the task force by the Business Plan Development Office describes the drivers of different operational activities and the current structure of these operations in CHM, COM, and OHS (*see* **Appendix Item 3**).

- Reappointment, Promotion, and Tenure (RPT): Developing a single entity including both CHM and COM will necessitate a single RPT process for Michigan State University Medicine faculty, which, in turn, will require common standards for promotion across our multiple missions. Currently, there are some different expectations built into the two colleges' RPT guidelines (e.g., expectations for fixed-term track promotions of non-Health Programs, non-clinician faculty). Recruiting and retaining top faculty in a consolidated medical school will remain a priority and the processes around doing so in such a college will need to be thoughtfully considered. A point that came up often is that when hiring medical school leadership, due to the far greater numbers of MD academic physicians than DO academic physicians, there will be a larger number of qualified MD candidates for leadership positions in a consolidated medical school. Unless there are structural elements ensuring inclusion of DOs in leadership positions in an integrated medical college, there is a valid concern of evolving towards a medical school with largely MD leadership that happens to have a DO curriculum in addition to an MD curriculum.

- College Leadership: The leader of a combined college requires an understanding of all aspects of the mission as well as a comprehensive understanding of accreditation requirements for both educational programs. A college leader must also be mindful of the distinctive value of both training pathways and be committed to mitigating concerns about bias towards either pathway. MSU Medicine must avoid inadvertently negotiating opportunities with health system or community partners that are not feasible, which could cause distrust and undermine the strength of a single college.

- Faculty Engagement and Support: If a one-college model is adopted, the transition from COM/CHM to Michigan State University Medicine will require close consultation with

faculty to seek insights about addressing the tradeoffs and challenges. Faculty in leadership positions will need to be supported to maintain stability during this period of transition. This is particularly so for those currently serving as department chairs or in high-level administrative roles in COM or CHM that might be combined in the new Michigan State University Medicine college.

- National Ranking: Some national rankings, such as Blue Ridge, score extramurally funded research normalized to the entire faculty cohort. Much of the extramural research in COM is in its associated basic science or joint clinical departments, with less extramural research in the COM-only clinical departments. Therefore, the overall research productivity of the combined faculty in Michigan State University Medicine might look diluted on merging the two schools. This is not a concern for all rankings: the AAU normalizes research productivity to the number of tenure-track and non-tenure-track faculty (identified through AAMC) as the denominator. Thus, adding the research productivity from COM clinical departments would be advantageous for AAU rankings since faculty in these departments would not be included in the denominator. Blue Ridge also ranks schools of osteopathic medicine and currently COM ranks #1 for NIH funding among osteopathic medical schools. It is not clear how rankings will be attributed for COM if all faculty are under Michigan State University Medicine.

Alternative to a Consolidated One-College Model

While the task force was not specifically charged with presenting alternatives, we have not taken on this work only to remain entrenched in the *status quo*. The work of the task force illuminated how the two medical colleges were established and evolved to where they are today. The charge to examine these structures was itself groundbreaking, in that the colleges previously had no process, let alone a mandate, to understand and work with each other for the greater benefit of MSU. The obvious question of “Why not?”, while relevant and instructive, may be less important to the One Team model than the question of “What now?”.

Two-college chimeric model: Achieving a better understanding by each program of the other evolved as a result of task force meetings and has fostered a desire to engage in greater cooperation. This positive side-effect of the process is encouraging. Still, it does not create the systemic, sustainable change initially envisioned by the administration, nor does it ensure an administrative structure to sustain such cooperation in the future. Weighing the intended outcomes, the perceived benefits, and the potential trade-offs, the task force suggests an alternative strategy could be considered. This approach would maintain both colleges and their respective physician degree programs with definitive structural modifications, including (but not limited to):

- Changes to the organizational model of health professions education with governance that will hold both programs accountable, in a fashion envisioned for the one-college model
- Collaborative curriculum development to integrate One Health into each program and to reduce redundancies and inefficiencies
- Evaluation of the benefits for reorganizing selected units (e.g., research, faculty affairs, administration, advancement) under a “Michigan State University Medicine” model to break down silos and increase impact.
    - CHM, COM and CON currently share pre- and post-award support through the Health College Research Services. Expanding the collaboration to include functions important to enhance research productivity could enhance synergies

envisioned as part of the One Team, One Health initiative, while respecting the current hybrid model that allows each college to determine their own priorities.
    - Faculty affairs leaders in CHM, COM, CON and CVM began meeting summer 2025 to discuss how to share resources to support HP faculty in their promotion efforts. While this group is in the initial data gathering stages, the intention is to create shared services and programs.
    - Administration is a broad set of functions, some that are consistent between CHM and COM due to university requirements, while others differ to respond to mission/accreditation requirements or cultural differences. The colleges have made different investment decisions over the years to respond to their unique challenges and a discussion on collaborative opportunities has the potential to elevate services for both while recognizing the different circumstances of each college.
    - Advancement staff are all connected through the university advancement office but are located in colleges. Future discussions could explore how best to structure these services within the two colleges to maximize impact for the university, building upon the current structure and optimizing current investments.
- Amplification of community-based medical education, including leveraging regional campus locations and base hospital relationships to support more interprofessional education and community service
- Collaboration between academic units outside of the MD and DO programs such as continuing medical education and graduate medical education could enhance services and offerings. For example, the CHM and COM CME offices already share a software and use the same forms allowing further conversations about priorities and investments to guide partnership discussions. Graduate medical education is another example. COM has invested in developing a statewide structure of support for residency programs. CHM's GME office is relatively small, largely focusing on the sponsored programs and partnering with COM would represent opportunities to better support key clinical partners' programs.

Ultimately, the One College Task Force concludes that structural change is appropriate and needed to optimize physician education and enhance biomedical research opportunities at MSU. A watershed structural change could be achieved in a two-college model and may be achievable in a one-college model if endorsed by both accrediting bodies. Realigning MD and DO education into a one-college model is unprecedented; it presents both opportunities for MSU to break new ground in healthcare education and risks in terms of accreditation challenges, as well as financial and people costs, and trade-offs. Realigning DO and MD education in a two-college model with coordinated missions and resources under One Team, One Health would also be unprecedented; yet it presents similar (but less overt) opportunities for MSU to innovate while mitigating the risks associated with a transition to a one-college model. Proposed working organizational structures for the two models are included as **Appendix Item 2**.

MSU Medicine Institute

Our discussions included a model for meeting the expectations of key health systems with interests in advancing research, excellence, and innovation through their partnership with MSU Medicine, while maintaining our community-based medical education goals and vision throughout the state. The task force envisioned MSU Medicine Institutes serving as development targets, and laboratories for accredited medical education innovation, that trained both DO and MD physicians with an interest in academic medicine.

MSU Medicine Institutes would establish specialized medical education campus locations or institutes on select campuses as sites for preclinical and clerkship education of both MD and DO students. In the proposed model, students admitted to the DO or MD program at MSU who meet specialized criteria could apply for acceptance into MSU Medicine Institutes. They would either complete all four years there or would complete the first year of medical school at one of the core MD/DO campuses and then complete clinical education through the MSU Medicine Institute track (**Appendix Item 4**).

A distinct advantage of the MSU Medicine Institutes model is that their development could begin immediately; with careful management the model would not impact accreditation of either college; innovation hubs could include additional MSU colleges including engineering, business, etc.; the university could invest in innovation rather than organizational redesign; and the model could significantly advance the reputation and scale of partnership of Michigan State University.

Appendix Material

Appendix Item 1: DO (COCA) and MD (LCME) Accreditation Bodies

Accreditation of UME is fundamental as it ensures that UME meets rigorous national standards and provides the value that makes the degrees (DO and MD) meaningful. Graduates of non-accredited medical programs are not eligible for residency training or subsequent licensure and therefore cannot practice as physicians. While the Accreditation Task Force is specifically addressing accreditation-related issues, it is important for this Task Force to have an understanding of the accreditation landscape, as it affects program structure, student eligibility, and institutional resources. This appendix provides a concise overview of the two primary accrediting bodies for UME in the US.

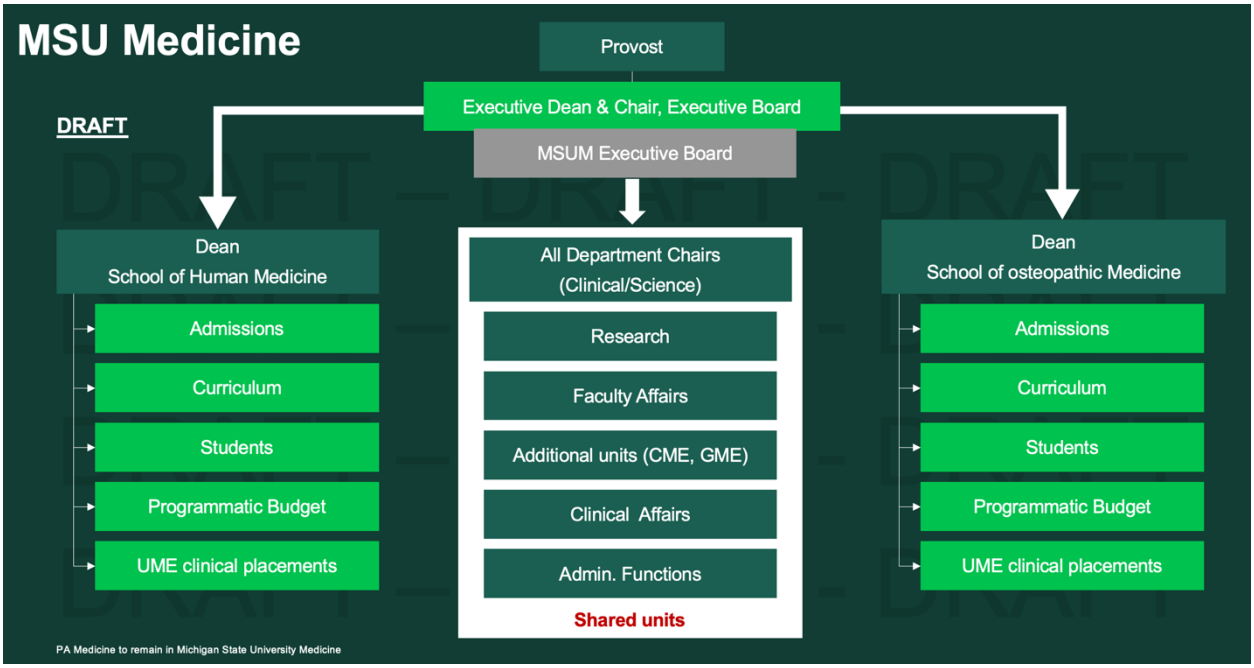
Commission on Osteopathic College Accreditation (COCA):
https://osteopathic.org/accreditation/

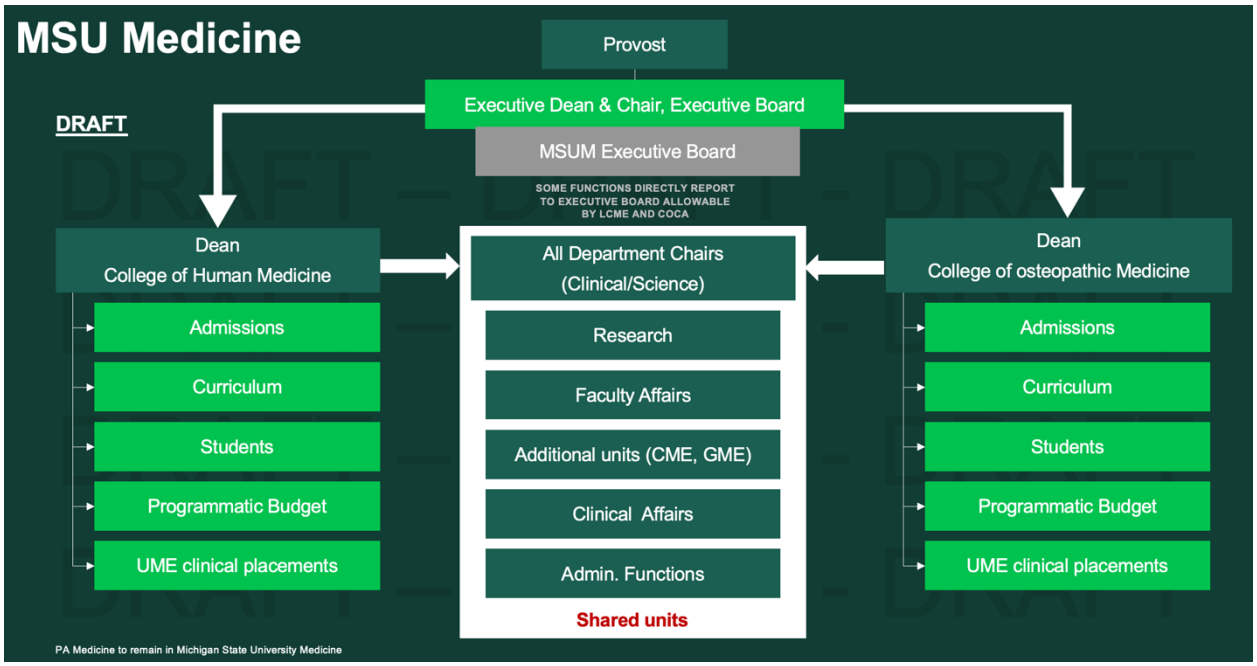
- COCA is the accrediting body for Doctor of Osteopathic Medicine (DO) programs in the US.
- COCA accredits osteopathic medical schools leading to the DO degree that meet standards set forth in the *Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards* documentation (2023 COCA Standards; Revised April 16, 2025).
  https://osteopathic.org/index.php?aam-media=/wp-content/uploads/COCA-2023-COM-Continuing-Accreditation-Standards.pdf
  Additional documents can be found here: https://osteopathic.org/accreditation/standards/
- COCA accreditation is required for DO graduates to be eligible for residency training and licensure as a physician.

Liaison Committee on Medical Education (LCME):
https://lcme.org/

- LCME is the accrediting body for Doctor of Medicine (MD) programs in the US.
- LCME accredits medical schools leading to the MD degree that meet standards set forth in the *Functions and Structure of a Medical School Standards for Accreditation of Medical Education Programs Leading to the MD Degree* documentation (Published May 2025; Standards and Elements Effective July 1, 2026)
  https://lcme.org/wp-content/uploads/2025/05/2026-27-Functions-and-Structure_2025-05-21.docx
  Additional documents can be found here: https://lcme.org/publications/
- LCME accreditation is required for MD graduates to be eligible for residency training and licensure as a physician.

Appendix Item 2. Draft Proposed Organizational Structures for MSU Medicine





Appendix Item 3. Business Plan Development Administrative Functions Assessment

Administrative functions

The overarching definition of an administrative function is any activity other than the direct conduct of instruction, patient care, and research. There is of course a grey area between support functions that are closely related to the delivery of those services.

Beyond that, we distinguish between functions that are primarily internal or more general business functions, those that focus on supporting faculty, and those that are student-focused.

In considering the optimal level of resources and structure for these functions, there are factors specific to each area that need to be addressed first. In addition, there are often activity drivers that need to be taken into consideration.

This document contains the following information for each of these administrative functions:

- General definition for each function, based in part on generic descriptions of these functions and tailored for the specifics at MSU.
- Description of how the resources devoted to that task are organized today. This can be reviewed in tandem with the table provided earlier that aligns departments in the 3 units (COM, CHM and Health Sciences) with these functions.
- Description of the factors related to a potential reorganization that could drive decisions on resources and structure in these areas.
- Primary activity drivers.

Our recommendation would be that, as the structure and goals for a future organization of medical education, research, and clinical service take shape, those developing the detailed models should first look at the areas we've identified as "primarily internal" in any pursuit of efficiencies. The health colleges have already found ways to share resources in functions like Research Administration and IT, so this would be a logical continuation of those efforts.

Primarily internal

Function: Advancement

Develops and executes fundraising programs to support student scholarships, education programs and research endeavors. Cultivates relationships with alumni, donors, and community partners to secure philanthropic support for scholarships, facilities, research, and programs. Manages major gift and annual giving campaigns as well as stewardship activities to ensure sustainable funding for the unit's mission and growth. Builds donor base by partnering closely with alumni relations to foster long-term philanthropic support, annual giving to build broad support and affinity, communications to message and engage with constituents, and performs stewardship, campaign planning, and donor strategy. Collaborates with central advancement on shared services around gift processing, planned giving, corporate giving, foundation relations.

Organization and departments: Each college and OHS has Advancement functions. Many fundraising positions are jointly funded with central Advancement.

Factors for resources and structure: The programmatic structure of the college and the degree to which parts of the program appeal to different donor bases that need to be approached differently.

Activity Drivers: Number of alumni, community campuses, and departments, ambition of research and other programs, annual and campaign fundraising goals.

Function: Business and Finance

Oversees fiscal planning, budget management, contract management, data analytics, and financial operations. Manages resource allocation, monitors revenue & expenditures, and ensures compliance with institutional and regulatory financial requirements. Partners w/ other college units/departments to support all missions of the college (Research, Education, Clinical, Outreach, etc.). Works with central university units on the annual all funds budgeting process, faculty and support staff raise processes, quarterly financial projections, annual Fall Planning process, and monthly program allocation commitments, etc. Manages Medicaid Enhanced Reimbursement program.

Organization and departments: central Business and Finance offices in colleges and OHS, with additional staff in CHM Academic Affairs. Some Business and Finance-related functions are a natural part of many administrative positions across the units.

Factors for resources and structure: strategic roles follow the structure of the organization. Certain portions of the function are driven by volumes that would only change if there were significant programs and initiatives added or shed.

Activity Drivers: number of accounts and programs, number of faculty and staff, size of departments and budgets, number and size of complex relationships/partnerships/agreements, number of unique funding agreements/commitments, and volume of research, clinical activity, and revenue streams.

Function: Clinical Affairs

Coordinates clinical activity of faculty, including relationships with partner healthcare facilities and organizations. Negotiates compensation for MSU from clinical activity. Partners with department chairs, the practice plan (HCI), hospital affiliates, and Henry Ford Clinical Affairs to optimize clinical operations, reduce losses, and identify growth opportunities. Acting as both gatekeeper and catalyst, aligns resources, contracts, and partnerships to ensure clinical activity sustains clinical salaries. Works closely with the business function to implement financial discipline, improve margin performance, and advance strategic priorities.

Location and departments: primarily in OHS and CHM

Factors for resources and structure: Variety of clinical relationships, integration of relationships for both DO and MD providers. Volume and scope of clinical activity, the number and complexity of partner agreements, and the financial performance of divisions. Strategic decisions about service line expansion, closure of non-viable programs, and alignment with partner health systems have direct impact on required

staffing, analytical capacity, and administrative support. The degree of integration with MSU Health Care and other health partners also shapes optimal organizational design.

Activity Drivers: number of active clinical divisions, programs, and partnerships, volume of partner negotiations and contract management, clinical margin performance relative to budget targets, Scale and complexity of collaborations with MSU Health Care, Henry Ford Health, and hospital affiliates, frequency and depth of financial performance reviews and strategic planning cycles

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Function: Communications

Plans, develops, and implements communication and marketing strategic plans and initiatives to promote the schools' mission, achievements, and programs. Responsible for the development of the college's image and reputation as leaders in medical education, research, and community impact. Enhances brand awareness through integrated marketing strategy and implementation, internal and external communications, brand management, research publicity, crisis communication, state and national media relations, social media, advertising, media production and web management. Manages internal and external messaging, digital marketing materials and campaigns, creation and management of websites and intranet sites, college storytelling, social media, photography, videography, and public relations efforts to enhance institutional visibility and reputation. Supports/provides leadership communications. Creates content for various audiences, including prospective students, faculty, alumni, and community stakeholders. Supports other units in their internal and external communications.

Organization and departments: Each college and OHS have functions devoted to this. There are some people with related functions in other departments

Factors for resources and structure: variety of programs and audiences, degree of shared policies and platforms

Activity Drivers: Number of community-based campuses, external stakeholders, department/academic units, and students/faculty/staff to be supported. The volume of events, outreach efforts and grant-funded research.

Function: Community and External Relations

Develops, manages and provides leadership for strategic partnerships with hospitals, community leaders, elected officials and industry partners to advance medical education, research and clinical initiatives. Responsibilities include developing, managing, and leading a comprehensive strategy that advances the college's reputation, partnerships, advocacy and outreach efforts. By aligning communications, public relations, events, government relations and community engagement activities, the team ensures that college values and priorities are clearly represented and reinforced in each location it serves. Efforts focus on fostering community trust and engagement through ongoing collaboration and by facilitating local events, programs, and relationships that support the college's mission.

Location and departments: clearest dedicated staffing in CHM

Factors for resources and structure: changes in scope of community locations and partnerships

Activity Drivers: The number and diversity of community-based campuses and hospital partners. The complexity of stakeholder relationships across urban and rural areas. The volume of events, outreach efforts, and communication needs. The importance of building trust and long-term collaboration with community partners for medical education and public health impact. The ever evolving political and governmental landscape for health and medical education at the local, state, and federal levels.

Function: Access, Opportunity, and Excellence

Promotes access, opportunity, and excellence through recruitment, retention, and support programs for students, faculty, and staff. Develops initiatives that foster cultural competency and address disparities in medical education and practice. Creates programming that celebrates diversity while ensuring equitable opportunities for success across all members of the community.

Location and departments:

Factors for resources and structure:

Activity Drivers: number of faculty, staff and students served

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Function: Executive Leadership

Provides strategic direction and administrative oversight for all missions of the college – education, research, and clinical. Coordinates with university leadership and consults with constituent departments and stakeholders to develop strategic plans, establish priorities, policies, and long-term planning initiatives. Ensures effective governance and decision-making processes. Responsible for deployment and utilization of resources. Establishes and maintains relationships with health systems, community partners, and governmental entities to support educational, research, economic, and clinical workforce goals for the state.

Organization and departments: the senior level executives in the colleges and OHS who generally have responsibility for multiple functions as defined here.

Factors for resources and structure: to some extent follows from decision on fundamental structure, but a larger organization might require additional Deputy or Associate/Assistant positions to support the senior-most executives in an area. A transition period will require support and engagement of leaders trusted by students, faculty, and staff. Additional leadership roles may be needed in response to new initiatives.

Activity Drivers: org structure, number and complexity of initiatives

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Function: Facilities/Operations

Manages physical infrastructure, space planning, operational logistics, and security for college-owned and leased facilities. Oversees maintenance, security, and utilization of classrooms,

laboratories, and clinical training spaces. Manages building and renovation projects both on campus and for college-owned and leased space. Coordinates facility needs across multiple locations to ensure optimal learning, administrative, and research environments that meet safety standards and university requirements. Collaborates with the academic affairs to ensure accreditation standards are met.

Organization and departments: for CHM Grand Rapids, most are in the Operations unit. Other CHM locations and COM rely more on external contracts or agreements with partner hospitals. Locations on campus in East Lansing served by IPF.

Factors for resources and structure: if changes in organization structure result in any changes in the amount or allocation of space, otherwise changes in organization structure would not result in changes to resources required

Activity Drivers: number, age and complexity of geographic locations and buildings, square feet, ownership vs leased space, office/classroom/wet lab/dry lab breakdown

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Function: Human Resources

Provides oversight and leadership for the college and its units for recruitment and retention of faculty, staff and student employees; employee relations negotiations with central HR and unions; and, professional development of support staff and faculty. Manages initial and reappointment process for community-based faculty. Ensures college-wide compliance with employment regulations as well as university and college policies and procedures. Facilitates conflict resolution college-wide between employees and between employees and their supervisors or leadership. Leads the college's raise process, offer letters, initial compensation package development, and conducts comprehensive annual assessments of faculty compensation to ensure competitive compensation packages. Provides HR support to the dean's office for all functions. Collaborates with the academic affairs to ensure accreditation standards are met.

Organization and departments: Each college and OHS has offices dedicated to this function. HR functions are delivered through a combination of dedicated HR staff and administrative personnel across multiple campuses and departments.

Factors for resources and structure: to some extent follows fundamental org structure, but like Business and Finance some aspects are volume driven and would not change unless there were changes in those transaction levels. Significant changes to an organizational structure will create additional work for HR.

Activity Drivers: Number of faculty and staff supported; size of the unit; complexity of the unit (clinical practice adds complexity to hiring/retention/compensation, research adds complexity managing position funding, etc.); and whether the unit is in a growth, stable or contraction phase.

Function: Information Technology

Provides technical infrastructure, software systems, research and educational equipment, and digital learning platforms essential for transformative research, modern medical education and efficient administration. Ensures cybersecurity, data privacy, and reliable technical support for faculty, staff, and students in their educational, research and administrative activities. Advises college leadership on long-term planning to meet technology needs and implement innovative solutions. Support operations and security teams to maintain specialty systems essential in college-owned and leased space. Collaborate with academic affairs to ensure compliance with accreditation requirements.

Organization and departments: IT needs are handled through a combination of federated IT structure in which staff report to central IT and in the case of CHM, directly-funded, dedicated staff located in Grand Rapids, East Lansing and Flint and COM has directly-funded, dedicated staff located at its Detroit and Macomb campuses.

Factors for resources and structure: already heavily coordinated, may not change from here based on organizational model.

Activity Drivers: number of users, number of geographic locations, age of technology/planned refreshes due, number and complexity of technology systems supported, number of devices, and office/classroom/wet lab/dry lab breakdown.

Function: Research Administration

Develop and implement a research strategic plan. Manage research operations: finances, startups, internal grant programs, compliance management, space assignments etc. Oversight of Research development (including grant writing development and leadership development) and Research Analytics (data informed decision making for research investments and research development). Mange Research Administration (pre- and post-award). Oversight of Research training (postdocs and grad students) and Medical student research. Facilitate access and opportunities for medical student research. Support research faculty and research leader recruitment (and retention) to all campuses. Key college-level contact for all issues related to grant funding agencies including state and federal agencies and for working with university officials on all compliance issues, research misconduct issues. Work with existing research partnerships and building new ones. Partner with government and external relations for advocacy

Organization and departments: Health Colleges Research Services unit provides pre-award grant support for faculty appointed in COM, CHM, CON, and HFHS. There are currently distinct research offices for each college: the CHM Office of Research and the COM Research, Innovation, and Scholarly Engagement (RISE) unit. MSU provides robust college-independent research support facilities, e.g., the Clinical Translation Science Institute, Institute for Cyber Enabled Research, Center for Statistical Training and Consulting, and the Research Technology Support Facility.

Factors for resources and structure: differences in types of research supported, which could result in different mixes of funders. Community campus structure and external relations to communities such as Grand Rapids, Flint, Southeast Michigan, Traverse City etc. A variety of

funding sources and mechanisms are utilized by faculty in both colleges and often have unique compliance and regulatory elements.

Activity Drivers: Number and dollar volume of grants, number of geographic locations, faculty well-being, number, type and level of funding of the various grant mechanisms and funding sources available to the investigators, number of researchers supported, intramural and extramural collaborations, industry partnerships, entrepeneurship, community and hospital relationships.

Faculty-focused

Function: Faculty Affairs

Oversight of the reappointment, promotion, tenure, and continuing status review processes across different faculty and academic staff appointment systems, including college-based and community-based clinical educators. Support faculty recruitment, appointment, retention, and performance reviews, including evaluations of department chairs and the dean's direct reports. Manage the annual conflict of interest reporting and compliance process for both paid and unpaid faculty appointments. Coordinate faculty development initiatives, including mentoring programs, webinars, workshops and courses, conferences and leadership development opportunities.

Organization and departments: CHM has an established unit for this purpose, COM has a Director of Faculty Development housed under the Graduate Medical Education department but would like to grow this office.

Factors for resources and structure: Changes in the number and complexity of appointment systems, programmatic structure, institutional goals for faculty success, and scope of faculty development initiatives.

Activity Drivers: number of faculty

Function: Medical Education

Oversees the design, implementation, and continuous improvement of medical curriculum across all phases of training, including Continuing Medical Education. Manages preclinical and clinical education programs, instructional design, simulation experiences, and clinical partnerships. Coordinates community-based programs across multiple locations while ensuring compliance with accreditation standards and maintaining clinical affiliations that support comprehensive medical education. Coordinate and administer cross-college programs such as labs, small group sessions, and service learning for 1st and 2nd year CHM students, advanced skills and knowledge courses for 3rd and 4th year students, and certificate programs. Manages relationships with clinical sites, oversees clinical placements including clerkships and rotations, and ensures that clinical training opportunities meet quality and accreditation standards.

Administer student assessments. Track degree progress and provide guidance and intervention when needed.

Organization and departments: Both colleges have central Medical Education functions and staff dedicated to this function in sites around the state, including community campuses in CHM and Detroit and Macomb centers in COM. Individual academic departments also fulfill this function for the parts of the education process for which they are responsible. Support for simulations is located in the two colleges, but all of the staff together support both colleges. Graduate Medical Education is advanced through the GME Alliance.

Factors for resources and structure: Differences between programmatic design, budgets, and accreditation standards for DO and MD training. Convergence or separation of clinical training locations, convergence or divergence of platforms.

Activity Drivers: number of students, variety of programs, accreditation needs

Student-facing

Function: Admissions

Manages the application review and selection process for incoming students; provides statewide outreach to undergraduate premedical groups; engages in recruitment programming to ensure a robust pool of qualified applicants for programs; manages the Early Assurance programs and early admission processes with college and university partners; maintains communication with prospective students throughout the admissions cycle; and works with MSU admissions to ensure seamless enrollment.

Organization and departments: each college maintains an Admissions office

Factors for resources and structure: fundamental academic structure, degree to which programs recruit from similar populations of prospective students, fluidity of students across programs. Also geographical reach of recruitment efforts.

Activity Drivers: size of class, number of applicants, details of admissions process

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Function: Advising and Career Services

Provides academic guidance to students throughout their educational journey. Offers personalized support for course selection, career planning, and professional development opportunities. Coordinates with Student Affairs to address both academic challenges and personal wellness, ensuring students have the resources needed to succeed. Facilitates career exploration, residency preparation, and professional development for students. Provides guidance on career development, specialty selection, residency applications, and interview preparation through workshops, career and residency fairs, formal curricula, and individual counseling. Maintains relationships with residency programs and healthcare employers to

create networking and placement opportunities for graduates. Train faculty and alumni to serve as advisors.

Organization and departments: dedicated department in COM, split between at least two offices in CHM.

Factors for resources and structure: convergence or divergence of academic requirements, career opportunities, and core employers

Activity Drivers: number of students

Function: Financial Aid

Administers financial assistance programs, including scholarships, loans, and work-study opportunities for students. Provides financial literacy education and counseling to help students manage educational debt and make informed financial decisions. Coordinates with academic affairs to ensure financial barriers don't impede student success and graduation.

Organization and departments: Primarily performed by central university staff, CHM has a liaison position for this function.

Factors for resources and structure: organizational changes would have minimal impact

Activity Drivers: number of students

Function: Student Records

Maintains the integrity, security, and accessibility of academic records, manages transcript services, and ensures compliance with privacy regulations for medical students. Maintains course schedule and manages the academic calendar. Enters section information and processes enrollment actions. Resolves enrollment issues. Maintains and audits student records. Collaborates with other units to develop and implement academic policies, processes, and systems that optimize the student experience and support the needs of the college. Coordinates to track academic progress, handle grade reporting, and facilitate transfers or leave requests. Serve as a key resource to interpret and enforce academic policies, registration procedures, and student records, and adhere to curriculum and school compliances. Provides documentation for residency applications, licensing requirements, and other professional credentialing needs. Produces student IDs. Provides reporting and query services.

Organization and departments: dedicated unit in COM, staff within CHM Student Affairs and Services

Factors for resources and structure: fundamental program organization structure

Activity Drivers: number of students and number and variety of programs, number and complexity of systems

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Function: Student Services

Provides comprehensive support services addressing the diverse needs of medical students, including mental health resources, leadership development, and quality-of-life services. Responsible for all health compliance, health care access, health and wellness curriculum, regular wellness events and services; provision of personal counseling; referral to mental health and psychiatric services. Coordinates housing, dining, transportation, and other essential services to ensure students have the support needed for success throughout medical school. Manage outreach programs. Coordinates compliance with health insurance and liaises with HR for student health insurance, manages policies and procedures related to compliance, such as immunizations, drug screening, and background screening.

Organization and departments: category covers a number of offices including Student Affairs at both colleges, Student Engagement and Leadership in COM, CHM Academic Affairs, and COM's Wellness and Counseling function. Individual academic departments also typically provide services that fall under this category.

Factors for resources and structure: fundamental program organization structure

Activity Drivers: number of students served, complexity and changes in student needs, number and complexity of programs, political climate, world events, and federal mandates.

Appendix Item 4 Table identifying functions across CHM, COM, and OHS

Function	Department	CHM	COM	OHS
Admissions				
	Admissions	x	x	
	Macomb University Center		x	
Advancement				
	Advancement			x
	Development	x	x	
Advising and Career Services				
	Academic Affairs	x		
	Academic and Career Advising	X	x	
	Student Affairs and Services	x		
Business and Finance				
	Academic Affairs	x		
	Budget/Finance	x		
	Finance			x
	Finance & Budget		x	
Clinical Affairs				
	Clinical Affairs			x
	Dean's Office	x		
Communications				
	Communications		x	
	Communications & Marketing			x
	Marketing & Communications	x		
Community Relations				
	Government/Community Relations	x		
Diversity				
	Dean’s Office	x		
Executive Leadership				
	Academic Affairs	x		
	Dean's Office	x	x	
	OHS			x
Facilities/Operations				
	Operations	x		
	Space Planning			x
Faculty Affairs				
	Faculty Affairs and Development	x		
Financial Aid				
	Academic Affairs	x		
	Student Affairs and Services	x		

General				
	Academic Affairs	x		
	Detroit Medical Center		x	
	Macomb University Center		x	
Human Resources				
	Human Resources	x	x	x
Information Technology				
	Detroit Medical Center		x	
	Information Technologies			x
	Macomb University Center		x	
Medical Education				
	Academic Affairs	x		
	Academic Programs-Clerkship		x	
	Academic Programs-Preclinical		x	
	Assessment	x		
	Clinical Experiences	x		
	Community Academic Programs	x		
	Community Academic Programs--Detroit	x		
	Community Academic Programs--Flint	x		
	Community Academic Programs--Grand Rapids	x		
	Community Academic Programs--Lansing	x		
	Community Academic Programs--Midland	x		
	Community Academic Programs—Southeast Community Academic Programs—Traverse City	X X		
	Community Academic Programs--Upper Peninsula	x		
	Detroit Medical Center		x	
	Family Medicine GME Network Graduate Medical Education Alliance	X	x	
	Instructional Design	X	x	
	JIT & C3	x		
	Macomb University Center		x	
	PEAK		x	

	Simulation	x		
	Undergraduate Medical Education	x		
	Learning and Assessment Center		x	
Research Administration				
	Office of Research	x		
	Research Office		x	
Student Records				
	Enrollment Services and Student Records		x	
	Student Affairs and Services	x		
Student Services				
	Academic Affairs	x		
	Enrollment Services and Student Records		x	
	Student Affairs		x	
	Student Affairs and Services	x		
	Student Engagement & Leadership		x	
	Wellness and Counseling	X	x	

Appendix Item 5. Proposed MSU Medicine Institute Model (using Henry Ford Health System Example)

MSU Medicine@Henry Ford

Students apply with supplemental applications to MSUM@HF when applying to medical school

Students are admitted to MD or DO program, and then interview separately for MSU@HF spot

- HFHS interviews and selects students for MSUM@HF from this pool
- All DO/PhD and MD/PhD candidates are eligible to choose MSUM@HF as primary site
- All OMFS students are placed in MSUM@HF

Only MSU@HF students are placed at HF main

MSUM@HF admits 30-40 students per year – mix of DO and MD candidates

MSUM@HF students spend all four years at HFHS (or more for PhD candidates)

- Infrastructure exists for 3rd and 4th year
- Will need to build campus infrastructure for 1st and 2nd year

MSUM@HF could be incubator and pilot site for educational innovation

MSUM@HF assistant dean reports to both DO and MD Deans

Request accreditation as a parallel program, so comparability within campus system is no longer a concern

PhD dual degree students could be funded by HFHS and MSTP program; philanthropy could fund all tuition for others admitted