



**Finding the Right Prescription
for Higher Education's Ills:**

Can Health Care Provide Answers?

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Foreword: Facing the Diagnosis

The symptoms being experienced by higher education are well known: rising costs, declining public confidence and support, new competitors, and questions about quality and value. Do prescriptions exist to address these symptoms, or are they precursors to something more serious for higher education? The health-care metaphor, while telling, is also apt. Health care as an industry has faced challenges similar to those of higher education and has undergone significant change in search of healing itself.

In the fall of 2011, with generous support from the Lumina Foundation, the National Association of College and University Business Officers (NACUBO) conducted a series of workshops grounded in lessons from the health-care industry. The audience was college and university senior leaders, who today face a confluence of difficult choices and strategic opportunities for their institutions. The goal: Engage leaders in exploring how to initiate necessary change at the campus level and industrywide. The conversations offered a unique opportunity to examine health care as an industry change model for higher education. Thanks to the expertise of panelists representing a broad array of health-care change efforts, participants were able to draw parallels between the two sectors with regard to common external pressures and cultural characteristics. A key question shaping the workshop discussions was how higher education might adapt lessons learned from change efforts launched within the health-care sector. A summary of those deliberations are contained within this report.

In addition to dissecting what lessons the health-care sector offers regarding change at the macro level, the workshops allowed participants to delve into pressing ground-level challenges on their campuses with the help of change experts and authors Chip and

Dan Heath (*Switch*) and Yoram (Jerry) Wind (*The Power of Impossible Thinking*). For a recap of the change-management models discussed, see the [full Web version](#) of this report in the leadership archive under the Business and Policy Areas tab at www.nacubo.org.

In the midst of the tumultuous social, political, and economic climate that currently exists, something no one in higher education questions is that to remain viable as an industry going forward, leaders must respond to the core challenges our institutions face. Whether those challenges are short term or long term, everyday or existential, the time has most certainly come for leaders to collectively face our industry's diagnosis head-on. Armed with greater understanding about external obstacles and unexplored opportunities, we can then develop a clear plan of action for bolstering the health and strength of our American higher education institutions, which continue to provide a critical lifeline of education, training, and a brighter future for so many within our nation's borders and beyond.

John Walda, NACUBO president and CEO
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Higher Education and Health Care: Parallel Trajectories

Higher education is facing a series of very tough questions: Is higher education's business model broken? How can costs that are fast outpacing family median income be reined in? How can higher education demonstrate that students are getting the education they expect and deserve? Is higher education competing in ways that lower cost, increase access, and improve quality?

How well colleges and universities are addressing these questions is debatable. While there is some worthwhile work being done, necessary changes have not happened rapidly enough or broadly enough. Finding sufficient answers is difficult, yet essential. In short, there is much work ahead.

Where can higher education leaders turn for fresh ideas for approaching the kind of business model changes required? What other organizations may have faced similar challenges that can provide lessons from past successes and past failures? Health care offers one industry model. While health care and higher education historically have existed in their own realms (with a bit of overlap in academic health centers), their traditional pathways and recent trajectories share much in common:

- Their fundamental purpose is service to others—in the form of education and research or provision of health care.
- They are dominated by large cadres of highly educated staff (physicians and faculty) who operate with great expertise and autonomy and expect to have a strong say in the business and operations of their organizations.

- Both sectors have complex bottom lines that extend beyond financial return on investment into areas (learning and health) difficult to quantify on a balance sheet.
- Their business models—which make it difficult to trace cross-subsidization and which strongly rely on third-party payers and auxiliary activities outside their core missions—are opaque if not seemingly downright dysfunctional to outsiders.
- They are concurrently market-driven industries that are strongly public-policy orientated. Both respond to market forces and need to compete broadly to secure revenue and manage costs, yet the ways they operate are circumscribed by public policy that often shapes what they do, who they serve, how they operate, and the environment in which they compete.
- Finally, both sectors are composed of value-driven organizations. While the bottom line is important, values are what really drive these organizations and provide a common calling for the work each undertakes.

Both higher education and health care are also buffered by similar types of environmental challenges that push each to change—increasingly in significant and uncomfortable ways. It is the common future shaped by parallel challenges that is most intriguing. Health care seems to be 10 to 20 years ahead of higher education in its transformation, driven by changing public policy, new societal expectations, a disrupted business model, and increasing competition from similar and dissimilar providers. How has health care responded? How has it fared? What insights can higher education gain from a focused look at an industry with which it shares much in common?

COMMON CHALLENGES AND CONCERNS

Higher education and health care are shaped by a number of similar dynamic forces that likely will continue to influence both industries for years to come. Workshop panelists highlighted a number of those key challenges.

The economics of funding and costs. College and university leaders hear plenty these days about how the higher education business model is broken, notes Peter Eckel, vice president for governance and leadership programs at the Association of Governing Boards of

Universities and Colleges, who moderated two of the three meetings. Higher education costs are far outpacing even growing costs of health care in American society. At the same time, state disinvestment in public higher education is producing nonsustainable growth in tuition and fees. Further evidence of a dramatic shift in higher education third-party providers is the huge influx of federal dollars even as states have withdrawn their support, notes Eckel. Unknown at this point is what

“The policy conversations for higher education have much to do with the decline in the share of Americans with any kind of postsecondary degree at a time when the nation needs more educated citizens,” says Peter Eckel.

kind of funding relationship will continue between the federal government and the higher education industry and what type of accountability will emerge for such a sizable investment.

Add to those pressures the fact that the public is undeniably unhappy with industry costs. That reality is true for health care as well as for higher education, notes James Bentley, an independent health policy analyst and former administrator of both the American Hospital Association and the Association of American Medical Colleges. In higher education, the debate continues about whether expanding student loans allows colleges and universities to raise tuition. And increased demand in health care has led consumers to

become inattentive to how much they are using services they may not need. “Both industries are at a point where rising costs are seen as not only unacceptable, but unaffordable,” suggests Bentley.

Changing policy environments. Because of the nature of the relationship of both higher education and health care with government, their performance remains under close scrutiny. The policy conversations for higher education focus on the need for a much larger educated workforce. U.S. high school students are not only slipping in international test score rankings for reading, math, and science, but Americans are falling behind in postsecondary degree completion. Likewise, the sophisticated level of health care available in the United States and the enormous expenditure to provide that care are not translating into best-world outcomes. For higher education and health care alike, a rebalancing of national and social priorities and revised cost and revenue models are likely required to bend the curves in a different direction.

Technology impacts. Advances in technology have transformed both industries and will likely continue to do so, extending their service reach and capability. Higher education has witnessed an increase year after year in the number of students taking online courses. The expanding role of online education has challenged colleges and universities to keep pace with new competitors whose physical location is irrelevant. It has also introduced new faculty-student and classroom dynamics. In addition to new requirements for faculty to generate more online and blended content, the embrace by students of new technologies and social networking is changing the meaning of campus community and student-faculty relationships.

Technology is likewise reshaping the patient-doctor relationship. Smart phones, as one example, are revolutionizing communication among health-care providers and patients, says Joanne Conroy, chief

health care officer for the Association of American Medical Colleges. “They have expanded our access to data and may well be the way patients in the future carry their own health records from physician to physician. Phones can marshal a team of providers within minutes in the event of an emergency. We can use phones to do virtual visits with patients, monitor ICU patients from a remote location, and provide 24/7 consultations across the globe.” In the future, patients may also be visiting the doctor’s office a lot less, notes Conroy.

Changing consumer demographics. For higher education, the rapid growth in nontraditional and older students as well as more minority and lower-income students has required new services and service models to accommodate demands for alternative scheduling and content delivery and to address needs for more remedial education. For health care, in addition to an influx of young and minority populations into the national health-care system, the industry has seen and will continue to see enormous growth in the aging of its patients. On the positive side, this has led to some specialized services for seniors not available before. Yet, these services have largely been built across old models of acute care (i.e., open heart surgery) versus adapting to an increased need for ongoing treatment of cancer survivors and individuals with chronic conditions such as diabetes and heart disease, for which a markedly different kind of care is needed, says Bentley.

Societal needs and expectations. When considering the mushrooming debt load of American college students—coupled with the current inability of many new graduates to land jobs—it’s not surprising that there is growing skepticism about the benefit of investing in a college degree. That potentially dangerous shift in perception about the value of higher education isn’t occurring among recent graduates only. Parents are also beginning to wonder if college is a worthwhile investment, suggests Bentley. The expectation from so-

ciety and from government that colleges and universities must graduate more students of higher quality, and do so more efficiently and cost effectively, is similar to expectations for health care to improve health and quality care outcomes while simultaneously bending the cost curve downward. For example, the new health reform law expands the number of Americans with health insurance and access to care, seeks to improve quality by providing financial penalties for excessive readmissions and errors in medical care, includes incentive payments for improved coordination of care, and reduces the expected expenditures for health by both creating more cost-competitive insurance markets and restraining payment for government-sponsored patients receiving health services.

Competition. For higher education, in addition to the push for the most impressive facilities, competition for donors, grant funding, and new programming is viewed as having significant impact on an institution’s ability to attract students and faculty. With the rise of online learning, nongeographic institutions and for-profit educators have introduced a new level of competition for students unimaginable even 20 years ago. While many foreign students continue to seek entrance to U.S. institutions, the emergence of quality higher education institutions in their own home countries and around the globe is increasing competition for attracting the best and brightest international students. Similarly, in health care, hospitals and systems routinely compete for physicians and patients. From a services perspective, competition has grown between institutional health-care providers and independent or group physicians and with freestanding imaging centers and specialty clinics, notes Bentley. Furthermore, new providers such as MinuteClinic and its brethren offer alternatives to primary-care physicians and full-scale medical practices.

A real challenge for health care and higher education with regard to competition pressures is that both are high-level ser-

vice industries, says Ellen Chaffee, senior fellow at the Association of Governing Boards of Universities and Colleges, and the former president of two universities and two national professional associations. “In their defense, both higher education and health care face limits on the extent to which each can increase productivity, versus a manufacturing enterprise that makes products,” says Chaffee. “On many fronts, it can be difficult for either to get truly efficient. Both industries require an array of high-level expertise that isn’t interchangeable and can’t easily be substituted.”

Emphasis on outcomes. Calls for greater accountability permeate both industries, and for both sectors, there is increased demand for data with regard to quality and performance. At the same time, questions remain about what makes most sense to measure and report. For health care, “We are now seeing a dramatic shift to measuring how each physician’s practice conforms to standards that improve the health of populations. Although you may be personally satisfied with your ability to diagnose the ‘medical mystery,’ you are going to be rewarded for adhering to evidence-based standards for diabetes prevention and blood-sugar management or control of high blood pressure,” says Conroy. “There is a culture shift where physicians are being held accountable for their patients’ health after they walk out the door. It’s no longer out of sight, out of mind.”

Higher education is facing similar challenges. Student learning is opaque and the “just trust us” attitudes of the past regarding student learning are no longer satisfactory given the increase in the cost of a college degree and society’s interest in return on investment. Yet, no broad agreement exists regarding what constitutes an educated learner, and few mechanisms exist to capture or track any such data across institutions. The inability of not-for-profit higher

education as a sector to come to consensus about what to measure in terms of outputs not only undermines our ability to make the case for the value that we bring to the table, but also makes it more likely that external stakeholders may seek to impose what they consider appropriate outcomes, cautions John Walda, president and chief executive officer of the National Association of College and University Business Officers. He points to the Department of Education’s focus on gainful employment as one example. “We need to ensure not only that we focus on good outcomes, but also that we are focusing on the *right* outcomes.”

COMMON COMPLEXITIES

In addition to being high-level service industries, the higher education and health-care sectors share a number of traits that further complicate their ability to easily change in large-scale ways.

Autonomous workforce. Faculty and physicians share a strong expectation for autonomy and tend to identify more strongly with their field than with their particular employer. This autonomy is important, as highly educated experts—both in the waiting room as well as in the classroom and lab—have deep understandings of their respective fields and the capacity to respond and deliver as needed. However, the growth of and demand for specialists within both sectors has helped reinforce traditional silos and divisions.

Entitlement mentality. Deeply embedded in the collective mind-set of many hospital and higher education leaders is a sense that their institutions are doing important work for the

“One of our key problems as a sector is communicating with members of Congress, the Education Department, and other decision makers about the real value of what we do and explaining what we produce in exchange for educational assistance to students,” says John Walda.

larger society for which others should pay, says Bentley. Despite industry assumptions and scholarly literature touting the importance of what each sector provides, a value gap arises from this sense of entitlement that plagues both industries, argues Bentley. “While no one may be arguing that higher education and health care should operate like publicly traded companies, neither sector can afford to assume that there is no limit to what consumers are willing to pay for what each provides.” For higher education, this entitlement mentality can extend to assumptions about such things as federal student financial aid funding, says Walda.

Fractured revenue models. While both sectors do important socially relevant work, neither should be off the hook for continually seeking more efficient and more cost-effective ways to deliver quality services and expertise, says Chaffee. At the same time, both sectors have had a hard time explaining cost/price differences to the public, she adds. For instance, it’s difficult to convey that changes in price reflect what it costs a consumer to go to school or receive medical care. All of this will require some big thinking about new service and revenue models, and not down the road, but right now, asserts Chaffee.

More in Common Than Different

As much as higher education and health care share external pressures and cultural characteristics, the two sectors are dissimilar in key ways. As one workshop participant noted, the medical world can pretty quickly determine if someone has a disease or doesn’t. Assessing student success takes many years and multiple generations of students. Differences aside, are there lessons—or at least words of caution—for higher education to extract from the transitions that have taken place within the health-care industry over the past 20 years? That is the subject of the next chapter.

Health-Care’s Prescriptions: Lessons for Higher Education?

Based upon the external pressures in common for higher education and health care, as well as the similar characteristics both industries share, what lessons might higher education leaders adopt and adapt from the change efforts within the health-care sector? Workshop panelists identified a handful of key lessons that may benefit higher education.

Recognize the Need to Address a Flawed System

When a system focuses on the wrong outcomes, you get a system that rewards the wrong actions. In health care, the fee-for-service system still largely in existence provides a compensation structure based on volume. The more patients you see and the more tests you administer, the more you make. Quality of care, or even outcomes tied to individual wellness, are not factors. That is slowly changing, according to James Bentley, an independent health policy analyst and former administrator of both the American Hospital Association and the Association of American Medical Colleges. “Previously, volume drove value and revenue. We are now trying to think differently about value as coming from better coordination of care and for providing evidence-based practice.” With this new focus, the value of care is what will create volume and drive revenue, explains Bentley. And, under this approach, some sectors of health care as we know it may not survive. For instance, with an emphasis on coordinating care efficiently, and caring for patients in the least expensive setting appropriate for their needs, the nation is likely to see the number of hospital beds decline and a reduction in the number of free-standing ambulatory surgery and imaging centers, notes Bentley. “Duplication and fragmentation are expensive and will be difficult to sustain in a value-driven, orga-

nized system. At the same time, high technology home-care services, hospice care for terminally ill patients, and patient-ordered laboratory tests or test kits are likely to increase.” Bottom line, says Bentley, “If we are going to get costs down and reward value, then we must lose some parts or consolidate or do work differently.”

Also important to recognize is that operating within a broken system constrains leaders, says Mitch Creem, chief executive officer for the Keck Hospital of USC and the USC Norris Cancer Hospital. “Well-intentioned leaders have had to make decisions about

“What leaders of both health care and higher education must not lose sight of is that despite the drive to produce greater results for less, we are mission-based service organizations. And that means that the way people experience our hospitals and universities is as important as the specific products or services they receive,” says Mitch Creem.

institutional survival based on a flawed system of priorities. We have the difficult and often conflicting job of balancing the population’s needs for prevention and wellness programs with the need to care for the sick, for which we get paid.” True change will come only when the health-care system is changed to pay for keeping people well in the first place, notes Creem.

Similarly, flawed systems of reward exist within higher education,

where leaders likewise face tough choices with regard to mission and institutional viability. For instance, in the face of pressures to increase completion rates, do you decide not to accept students in need of significant remedial training because you know it will drive up costs to prepare them to succeed and graduate? Do you develop partnerships with K-12 schools to help prepare students before they come to your institution? Do you beef up your training programs and measure your own progress based on the aptitudes of students when they arrive compared with when they leave your institution?

Focus on Needs, Cost, and Undervalued Services

Disruptive innovation often comes from a keen focus on customer needs. Joanne Conroy, chief health care officer for the Association of American Medical Colleges, points to medical MinuteClinics as representative of a model that emerged to meet a real need for fast care, at a set price, for an established set of services such as kids’ physicals for sports and for flu shots—market needs that were typically undervalued, notes Conroy. Sometimes, however, innovation comes in the form of what you don’t offer. “How much of what we recommend is necessary? Where are some opportunities for greater efficiencies by eliminating tests that patients don’t need? Or by offering lower-cost options? We’ve already seen how higher co-pays can drive patient behavior to choose generics over name-brand pharmaceuticals,” notes Conroy. In health care, as in higher education, service models are in continuous need of innovation. “We are seeing more experimentation in the use of extenders—care providers who have a limited scope of practice but who increase patient access and provide care more efficiently. They call someone with a greater level of expertise for patient circumstances that are more complicated than they are trained to handle,” explains Conroy.

Higher education is seeing its own disruption, albeit on a small but growing scale. Providers that seek to make education available any time and any place via technology are part of this landscape. Nontraditional owners of content, such as the *Washington Post* and the textbook firm Pearson Publishing are moving into instruction and content delivery. The Western Governors University and University of Maryland University College—with their focus on degree completion and adults with some college education—are further examples of meeting customers where

they are. Furthermore, as technology becomes more sophisticated and as new generations of young users grow up with new notions of community, how might the physical nature of more traditional, residential campuses be challenged?

Engage Your Customers

It is natural for an organization to consider itself an expert, but more often than not, if you ask patients or students how something worked for them, it quickly becomes evident that your expert knowledge doesn't always get you where you need to go, says Christine Malcolm, academic medical center practice co-leader for Navigant Consulting, Inc., and a former senior executive at Kaiser Permanente. She points to Kaiser Permanente's Garfield Health Care Innovation Center as a prime example of engaging customers to help bring theory down to reality. At the center, patients are central to helping with facility design and process redesign, notes Malcolm. "Engaging the patient in the process of care, and designing facilities and services around them and their families produces a happier patient, actively engaged in their recovery," explains Malcolm. "For instance, we know that patients do better at home, and at Kaiser Permanente, we were committed to making home the hub of patient care."

It may not be as easy for higher education to listen to its key customers—students—for dramatic advances. While people often know when they feel healthy (or don't feel ill), when do students feel well educated? Nevertheless, students, their families, and employers do have much to share that can improve higher education's quality as well as its productivity. Streamlining credit-transfer systems and clarifying articulation agreements represent one step. Problem-based learning that puts the student in the center of interdisciplinary instruction may more deeply engage students in the types of intellectual content in which they are most comfortable. As

one president once said, "The world has problems, and universities have departments." A familiar, real-world, problem-based approach may prove beneficial.

Look at the Hard Facts

In health care, change is often driven by scary facts—for instance, when someone who should not have died during a procedure does die, says Conroy. "We examine the case for evidence of human or system errors. As a culture, we say this is unacceptable and needs to be fixed. We have physicians and nurses in agreement that we can't accept those mistakes as unavoidable consequences of care. All this results in teams working across traditional silos to figure it out. So, real change occurs when you have a burning platform, principled leadership, real data, and a culture that refuses to dismiss the uncomfortable truth," suggests Conroy. Bentley concurs. "From an institutional standpoint, it may be that you are the third hospital in a two-hospital town. When you have a threat that is clear and understandable to all, you are more likely to get movement."

Although higher education is an enterprise about data and learning, it too infrequently uses its own data—particularly those that may make it uncomfortable—to alter its habits and practices. What can be learned by analyzing student success in key gateway courses by race and ethnicity, gender, age, veteran status, preparation level, or whatever set of characteristics might be strategically relevant for the campus? How might institutions use data mining to understand patterns of student success and risk? Higher education has successfully used fine-grained data concerning enrollments and institutional aid. To what extent and in what ways might similar strategies and efforts be tied to student retention and success? The question then is, how do you *use* the

data to focus campus attention, agree on the problem, and work collectively toward solutions? Who makes sense of the data, how, and with what messages can either put people on the defensive or attract them to the cause. This work is the “principled leadership” mentioned above.

Understand Changing Cultures and Their Disconnects

The operating model of academic medical centers and their physician practices has changed significantly since the 1990s, when centers in the United States developed an intense focus on generating clinical revenue and increasing market share by increasing the number of services delivered, notes Conroy. “With the new fee-for-service system that ensured you generated revenue for every

“We must determine how we can train physicians to be agents of change as they grapple with new expectations about compensation based on a different set of measurements and rewards,” says Joanne Conroy.

service rendered, focus shifted from being mission-driven to the profitability of the organization,” says Conroy. “The pendulum is now returning to focus on our public service mission and being accountable for a population’s health, but this shift is proving a challenge for those trained in a fee-for-service environment,” notes Conroy. “How does the revenue model change for that? This is one of the biggest culture shifts we will face.”

Indeed, changing established internal cultural norms and expectations can prove as difficult if not more difficult than responding to external pressures. To this point, health-care institutions have been much more likely than their higher education counterparts to merge or form multihospital systems, for instance, as a measure to reduce both cost and competition, says Bentley. One case in point is Indiana University Health (IU Health). IU Health began as Clarian Health Partners

in 1997 through the consolidation of Methodist Hospital of Indiana, Indiana University Hospital, and Riley Hospital for Children. Today, IU Health includes five hospitals in the Indianapolis central region as well as hospitals in key geographic regions across the state. Steven Wantz, senior vice president for administration and chief of staff at IU Health, witnessed firsthand the higher levels of burnout and turnover among staff due to a major shift in focus on cost containment within the health-care industry during the 1980s while he was at Methodist Hospital. “Part of what we had to do in response was to help staff rediscover their purpose in the midst of trying to facilitate change. We still had to pay attention to cost and revenue, but also remind everyone of our mission,” says Wantz.

Amplifying a commonality of purpose was equally important during the blending of organization cultures, says Stephen Bogdewic, executive associate dean for faculty affairs and professional development and the George W. Copeland Professor and associate chair of Family Medicine at Indiana University School of Medicine. “One real concern of the IU Health merger for those within the academic environment was fear of deemphasizing the academic mission. Our perceived differences appeared huge at the beginning. However, by focusing on the essential missions of each entity we discovered those perceived differences were not great at all. Finding ways to continually connect to the shared purpose of the enterprise—conveying and reminding others of why we are here—is especially critical to do within a complex system,” notes Bogdewic. (For more about the change-management story of IU Health, see the “Stories on Health-Care Change” appendix in the [full Web version](#) of this report.)

Higher education is also facing a shifting set of cultures. What was once a pretty consistent, if not staid, academic culture is changing in many dimensions, in different ways, and on varying

timetables. The shift to undergraduate student learning and its outcomes focus from a teaching-centric culture is one example. The cultural changes driven by the rise of adjunct and contingent faculty in sizable numbers within particular departments is another. Technology is driving more cultural change, and changing student demographics are increasing the diversity of many campuses. The work of leaders is to understand all the dynamics of these changes, recognize where the new cultures that are emerging create problems or inconsistencies, and figure out how best to harness these changes to advance the institution.

Does the Cure Fit the Ills?

This report and the meetings upon which it was predicated is based on the idea that higher education and health care have much in common, and that because health care is a decade or two ahead of higher education in facing head-on some of its challenges, college and university leaders presumably have much to learn from their health-care leader counterparts. The points above make a strong case for paying attention to health care, but also for proceeding carefully, as health care itself has not clearly found the cure to all of its problems. The helpful aspects may not be the medicine health care prescribes for higher education as much as the questions it helps to raise related to our own diagnosis and which symptoms demand the greatest attention. Following the doctor's orders may be only part of the regimen higher education will need to adhere to in the future. Ultimately the industry must create its own path forward.

The Work Ahead

The challenges and insights from health care provide an important lens through which to focus the efforts of higher education leaders. Over the course of three meetings, more than 100 presidents, chief business officers, chief academic officers, and other campus leaders discussed and debated the most relevant work ahead. During discussions about the comparisons between health care and higher education, workshop participants reflected on the future of higher education. Where are we as a sector headed? What are our most difficult challenges? And to what extent is higher education up the proverbial creek? These conversations yielded a set of pressing questions related to business and revenue models, communicating value, student learning, student preparedness, accountability, ability to change, and the shape of the enterprise. (For the list of questions, see the [full Web version](#) of this report.)

While the workshops offered an opportunity to look to the health-care sector for possible lessons, participants found that for all the innovation, streamlining, and cultural shifts that sector has weathered, health care still faces as many unanswered questions as does higher education. Panelists provided invaluable perspective, but they could not impart enough prescriptive wisdom to send us on our way feeling remarkably better. There are no super-medications to address higher education's ills. Rather, the hard work that remains will require the forthright will to continue to ask and answer difficult questions and the resolve to create a new set of strategies that will lead higher education where it needs to go one difficult and possibly painful step at a time. Done right, and tackled together, higher education's leaders can generate the energy and momentum to place the industry on a healthier path.

Connecting Values and Mission

While higher education has a lot it can learn from health care, one particular lesson stood out as a potential harbinger for higher education. When we lose focus on what really matters—why people commit to their institutions and the purposes they serve, and the special contributions that health care (and by extension, higher education) offer the human endeavor—we risk everything, regardless of revenue, efficiency measures, benchmarks, quality indicators, and strategic priorities. Mitch Creem, chief executive officer for Keck Hospital of USC and USC Norris Cancer Hospital, recounted the evolution of large-scale change (if not turmoil) within health care and how the challenges of the day created a narrow sense of focus that ultimately impeded the industry's change efforts.

“Twenty years ago in health care, it was all about the numbers, ratios, and bottom line. We talked about burning platforms, and about having courage. The state-of-the-art in health care was driving up expense at a time when more people were expecting greater service, and reimbursements were going down. We had to learn to become more efficient.

Downsizing—one common approach—often meant pushing managers to execute your will. Urgency translated into quick fixes, draconian solutions, and short-term results. But rapid cutting often undermines the very ability to deliver your mission, and shooting for another 5 percent improvement in productivity each year would not sustain us over time. Under this model, management seemed unengaged, and staff came to feel unsupported and disconnected.

A primary reason this numbers-only-focused turnaround solution was unsustainable was because the methods and messages of management were inconsistent with the mis-

sion of the doctors and nurses—to heal and nurture those suffering and in pain. Ultimately health care is a business of the heart. Doctors and nurses spend their lives healing and comforting those in pain and suffering from disease. They have a mindful connection to body and soul. How could they believe in slash-and-burn artists only interested in improving profits? In order to move our organizations forward with breakthrough results, management would have to learn to connect deeply and to lead from the heart. As an industry, we needed something more transformative. We needed to return to our values with long-term planning and a set of goals that we could all agree on and commit to.

Today in our health-care organizations, we talk about our values every day—at meetings, management training, and employee orientation. Yet, talking about those values and living those values are two different things. Truly transformative change—especially in the midst of economic, social, or cultural turmoil—requires a central focus on the values that drive our mission. Focusing on revenue generation and bottom-line efficiency is important to balance our budgets, but it won't inspire our people to carry out the important, and often difficult, work we must do in service to others.”

Keeping the Right Focus

The language of numbers, ratios, and bottom lines, and about calls for courage and bold action, is all too prevalent in today's college and university cabinets and boardrooms. In fact, those terms often dominate the conversations, with justifiable understanding given the pressures on most campuses. That said, higher education must come to understand the potential implications of our driven focus

on these aspects. While health care is fundamentally a business of the heart and soul, higher education is fundamentally a business of the mind and soul. Without keeping that ideal in the forefront we may make progress on the metrics, ratios, and numbers, but in the end these achievements will mean little if we don't stay focused on higher education's fundamental principles and purposes. By thinking we are making expedient progress, we may put at risk what is most essential.

Like health care, higher education is a mission-driven enterprise; it is about improving lives, building communities, and creating a more informed and just world. These notions are what attract people to commit to higher education. In times of change, if not turbulence, leaders must work hard to keep the right focus, and balance demands with purpose. For it is fundamentally a focus on the purpose that will give higher education and its leaders the energy, passion, and commitment to do what it does and what it needs to do: prepare a nation, if not a world, for a different and better future. The importance of that focus is the key lesson from health care. And one that higher education can ill-afford to ignore.

APPENDIX: Workshop Participants

NACUBO wishes to thank the more than 100 workshop attendees representing more than 60 higher education institutions from across the country who took time to participate.

HIGHER EDUCATION INSTITUTION ATTENDEES

Bethel College: Clair W. Knapp, vice president and CFO; and Lisa Malkewicz, director, human resources.

California State University, Northridge: Harry Hellenbrand, provost and vice chancellor, academic affairs.

Carl Sandburg College: Lisa Blake, CFO/treasurer; and Lori L. Sundburg, president.

Centenary College: Rob Miller, associate dean of academic affairs and director of institutional research.

College of Mount Saint Joseph: Anthony Aretz, president.

College of Saint Mary: Sarah M. Kottich, vice president, financial services and CFO; and Maryanne Stevens, president.

Colorado State University: Allison Dineen, director; and Anne Hudgens, executive director.

CUNY Queens College: Sue Henderson, vice president for institutional advancement; and James L. Muyskens, president.

Danville Area Community College: Jill A. Cranmore, director of human resources.

Delaware County Community College: Mary Jo Boyer, vice provost and vice president.

Diablo Valley College: Andrea Gonzalez, human resource manager; and Reed Rawlinson, human resource senior analyst.

Eastern Illinois University: Blair Lord, vice president, academic affairs; and William V. Weber, vice president, business affairs.

Eastern Mennonite University: Daryl Bert, vice president of finance.

Eastern University: Diana S. Bacci, vice president for university administration; Polly W. Berol, associate provost for finance and administration; David R. Black, president; Bettie Ann Brigham, vice president of student development; Pernell Jones, vice president for finance and operations; and Tom Ridington, senior vice president and chief marketing officer.

Edgewood College: Michael Harold Guns, vice president for business and finance.

Eureka College: Marc P. Pasteris, CFO.

Franklin University: Marvin Briskey, CFO; and Pam Shay, vice president of accreditation and institutional effectiveness.

Fresno Pacific University: Diane Catlin, vice president for finance and business affairs.

Gainesville State College: Al Panu, vice president for academic affairs.

Harcum College: Barry G. Cohen, vice president, finance and operations.

Harper College: Maria Coons, senior executive to the president; and Roger Spayer, chief human resources officer.

Indiana State University: John Beacon, vice president for enrollment management and communications; and Carmen Taylor Tillery, vice president of student affairs.

Indiana University System: Krista Hoffmann-Longtin, director of programs and evaluation, school of medicine office of faculty affairs and professional development.

Ithaca College: Thomas Rochon, president.

Ivy Tech Community College of Indiana-Indianapolis: Susan Farren, executive director of employee benefits, office of the president.

Johnson College: Katie Leonard, vice president of institutional advancement; and Ann L. Pipinski, president.

Lake Forest Graduate School of Management: John N. Popoli, president.

Lakeshore Technical College: Deryl Davis-Fulmer, vice president of instruction and academic officer; and Barb Dodge, dean of health and human services.

Lamar Institute of Technology: Betty J. Reynard, vice president for academic affairs.

Lehigh University: Margaret F. Plympton, vice president, finance and administration.

Manchester College: Dale Carpenter, director, human resources; and Jack A. Gochenaur, vice president, financial affairs and treasurer.

Massachusetts School of Professional Psychology: Nicholas Covino, president.

Mesa State College: Tim Foster, president.

Naropa University: Cheryl Barbour, vice president, student affairs and enrollment management; and Todd Kilburn, chief administrative officer.

North Central State College: Jim Hull, dean of health.

Northeast State Technical Community College: Steven Cory Cole, executive finance assistant to the president.

Northeast Texas Community College: Brad Johnson, president.

Northern Arizona University: M.J. McMahon, executive vice president.

Notre Dame College: Mary Breckenridge, provost and vice president for academic affairs; John C. Phillips, vice president, finance and administration; and Andrew Roth, president.

Oglethorpe University: Michael Horan, vice president for business and finance.

Providence Christian College: Dawn Dirksen, director, operations; and J. Derek Halvorson, president.

Ramapo College of New Jersey: Beth Barnett, provost.

Rochester Institute of Technology: Cynthia (Cindee) S. Gray, managing director, RIT and Rochester General Health System Alliance.

Rockford College: Barrett Bell, vice president for enrollment management; Robert L. Head, president; Stephanie Quinn, executive vice president and dean; and Bernard Sundstedt, vice president for institutional advancement.

Saginaw Valley State University: James Muladore, executive vice president, administration and business affairs; and Jack VanHoorelbeke, director, human resources.

Saint Augustine's College: Hengameh G. Allen, dean and executive director.

Salem State University: Kristin G. Esterberg, provost and vice president, academic affairs; and Andrew Soll, vice president, finance and facilities.

Shepherd University: Richard L. Staisloff, acting vice president for administration and finance.

South Georgia College: Virginia Carson, president.

Southern California University of Health Sciences: Todd Knudsen, vice president of academic affairs.

Southern Oregon University: Craig Morris, vice president, finance and administration.

St. Cloud Technical College: Carolyn Olson, dean, nursing program; Margaret Shroyer, vice president of academic and student affairs; and Janet Steinkamp, dean of health and human services.

State Fair Community College: Marsha Drennon, president.

SUNY College at Geneseo: Carol S. Long, president.

SUNY Empire State College: Bridget Nettleton, dean, nursing program.

Texas Tech University: Michael Wilson, vice provost, financial planning.

The University of Akron Main Campus: Brian E. Davis, associate vice president for treasury and financial planning; and Nathan J. Mortimer, associate vice president, institutional operations.

The University of Scranton: Harold W. Baillie, provost and vice president for academic affairs.

Thomas More College: Bradley A. Bielski, vice president for academic affairs; and Sister Margaret A. Stallmeyer, president.

Thomas University: Gary Bonvillian, president.

University of Minnesota-Twin Cities: Michelle Wills, CFO.

University of North Texas Health Science Center at Fort Worth: Michael B. Mueller, vice president for finance and CFO.

University of Pittsburgh at Bradford: Richard T. Esch, vice president for business affairs.

Western Nevada College: Connie Capurro, vice president, academic and student affairs; Mark Ghan, vice president, human resources and legal counsel; Carol A. Lucey, president; and Daniel J. Neverett, vice president, finance and administrative services.

Western Washington University: Catherine Riordan, provost and vice president for academic affairs.

NON-INSTITUTION ATTENDEES

John Case, president, FJ Case Consulting

David Coleman, senior associate, strategic facility planner, Christner, Inc.

Kara Freeman, vice president, administration, and chief information officer, American Council on Education

Charles Hatcher, consultant, Lumina Foundation for Education

APPENDIX: Panelist and Facilitator Biographies

A special thanks to the distinguished health-care industry leaders who served as workshop panelists.

HEALTH-CARE INDUSTRY PANELISTS

James D. Bentley is a semi-retired health policy analyst who currently works with hospitals and state hospital associations on the implications of national health reform for their operations. He previously served on staff at the American Hospital Association and the Association of American Medical Colleges.

Stephen P. Bogdewic is executive associate dean for faculty affairs and professional development and the George W. Copeland Professor and associate chair of Family Medicine at Indiana University School of Medicine.

Ellen Chaffee is a senior fellow at the Association of Governing Boards of Universities and Colleges (AGB). From 2009 to 2011, she directed a Lumina Foundation project for AGB that helped presidents and governing boards work together to meet key goals by improving academic, strategic, and financial performance. Previously Chaffee served as president of two universities and two national professional associations.

Joanne M. Conroy, M.D., is chief health care officer of the Association of American Medical Colleges. In this role, Conroy focuses on the interface between the health-care delivery system and academic medicine.

Mitch Creem serves as chief executive officer for Keck Hospital of USC and USC Norris Cancer Hospital. He has nearly 30 years of management experience covering all aspects of the health-care industry, including hospital, research, and faculty group practice management.

Christine Malcolm is the academic medical center practice co-leader, West Coast health-care leader, and managing director for Navigant Consulting Inc. Previously Malcolm served as a member of the senior executive team at Kaiser Permanente, Rush University Medical Center, and the University of Chicago Medical Center.

Steven L. Wantz is senior vice president for administration and chief of staff at Indiana University Health.

WORKSHOP FACILITATORS

Peter D. Eckel serves as vice president for governance and leadership programs at the Association of Governing Boards of Universities and Colleges. Eckel has written and spoken extensively on academic leadership, institutional change, and campus governance.

Susan Jurow retired as senior vice president for professional development from the National Association of College and University Business Officers in June 2010. She then served as the subject matter consultant for leadership for NACUBO until January 2012, during which time she completed work on three major grants funded by the Lumina Foundation, including this project.

John Walda is president and chief executive officer of NACUBO.

AUTHORS

Peter D. Eckel (*see biography above*).

Karla Hignite is a freelance writer and an editorial consultant to NACUBO.



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