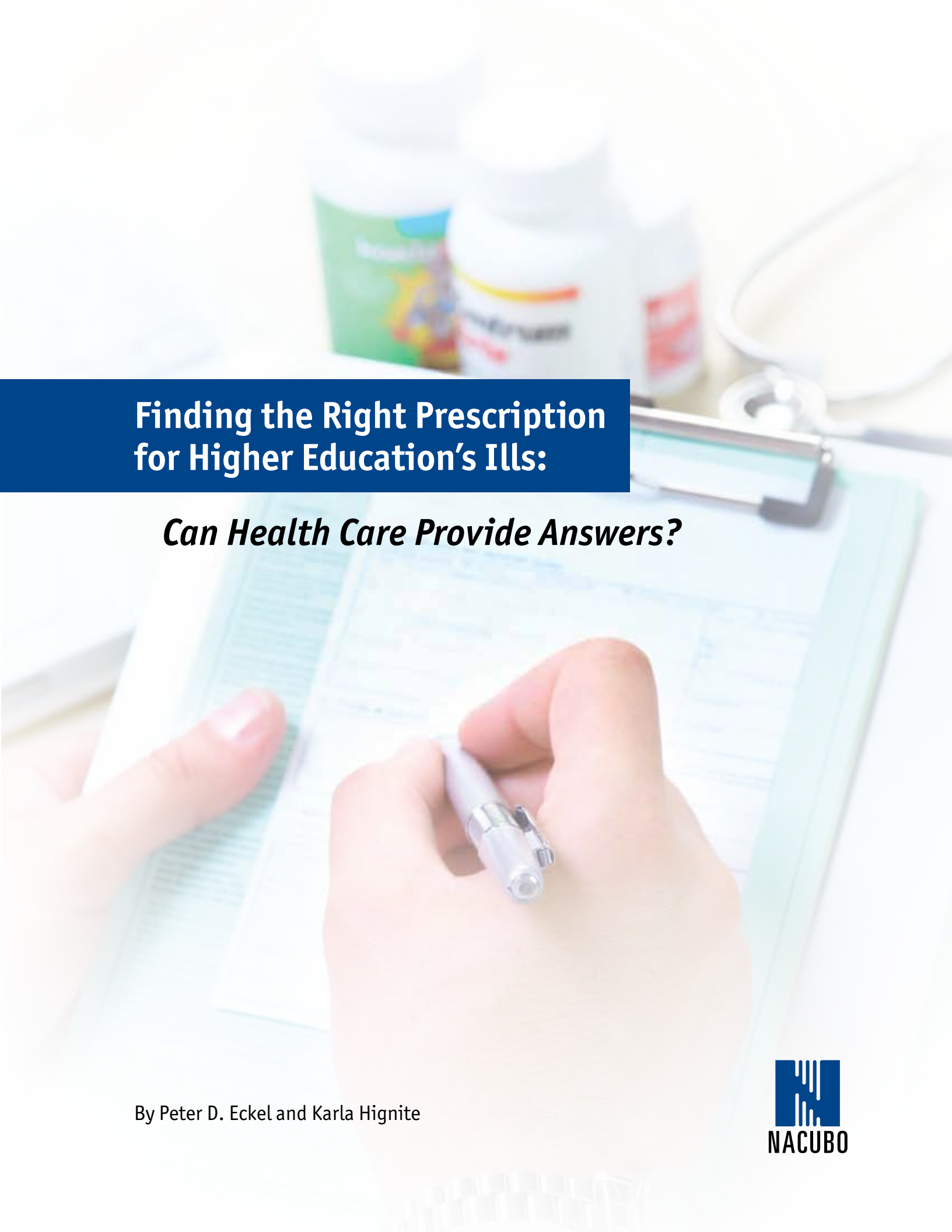

Finding the Right Prescription for Higher Education's Ills:

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 and focused on leading change. The audience was college and university senior leaders, who today face a confluence of difficult choices and strategic opportunities for their institutions in the coming years. The goal: Engage leaders in exploring how to initiate necessary change at the campus level and industrywide.

The workshop 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 during the past three decades, participants were able to draw parallels between the two sectors with regard to common external pressures and cultural characteristics. For instance, each industry faces challenges regarding cost, quality, and access, and both struggle to address changing societal expectations for their services within an increasingly competitive environment. 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.

There is no doubt that today's leadership challenges within higher education are deep and wide. Identifying where to dig in can itself feel overwhelming. Yet, no large-scale change is possible without plenty of practice with the smaller stuff. Change experts themselves don't speak in terms of overnight success, but rather, of the incremental experimentation that paves the way for bigger change. 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. How to increase student enrollment and retention, reallocate precious resources, introduce blended-learning models, and a host of other operational and academic dilemmas are of great importance to sustaining an institution's long-term financial health and ensuring vibrant learning communities. Change experts and authors Chip and Dan Heath (*Switch*) and Yoram (Jerry) Wind (*The Power of Impossible Thinking*) facilitated discussions and exercises for workshop participants to provide new ways of assessing the change that is needed and options for breaking big change into doable pieces. (For a recap of the change-management models discussed and sample exercises, see the "Change-Management Exercises" appendix.)

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 institu-

tions 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. "Yet, we don't always unpack this to determine what that means in the context of our current funding methods, pricing strategies, efficiency and productivity measures, and student learning outcomes." What most leaders do agree on is that it's time to tackle the hard questions associated with cost, revenue, cross-subsidy, and value, says Eckel. How can higher education reframe the conversation about what we do, how we do it, and how to pay for it? While these and other crucial questions will continue to press higher education leaders, time is short. The business model is wrapped up in what we spend, what we charge, what we do, and how we compete. The confluence of so many defining issues suggests the need for concerted action on many moving parts simultaneously.

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. According to research from the American Council on Education's Center for Policy Analysis, from 1991 to 2011, federal government support of student aid mushroomed from $35 billion to $160 billion. During that same time frame, federally supported research rose from $10 billion to $28 billion, and federal tax support increased from $1 billion to $23 billion. Not surprising, that swell in federal funding has been followed by increased government interest in oversight. Unknown at this point is what 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. "Society firmly believes that what each industry provides is too expensive and cost unconscious, and economists believe the government subsidies from which both industries benefit have only driven up price and demand," adds Bentley. 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.

What *will* ultimately drive big changes in the higher education business model? In the case of health care, legislation is currently reshaping models of care, argues Bentley. Regardless of the fate of the new health reform law (the Patient Protection and Affordable Care Act), three key aspects will have lasting impact:

1. Financial penalties for poor quality or performance (e.g, re-admittance) and rewards for good quality measures and performance.
2. A continued push for coordination across silos and the need to find efficiencies across the system so that care is made seamless.
3. Formal funded initiatives to identify, adopt, and communicate best practices.

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. Furthermore, today's younger generation is not that much more likely to have a degree than are older generations, particularly when compared to their international peers. Only about 40 percent of Americans are tertiary degree holders—a percentage that will not produce the projected numbers needed to remain competitive as a nation in the future.

International rankings within the health-care industry regarding costs and outcomes likewise cast the United States with a less-than-stellar standing and capture the attention of policy makers. World Health Organization statistics for 2006 indicate the United States ranked No. 1 in per capita health-care spending, yet placed 39th for infant mortality and 36th for overall life expectancy. Rankings aside, the sophisticated level of 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.

"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.

Technology Impacts and Costs

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. "While currently it may be difficult for many patients to make that leap in how they access care, a new more virtual world of medicine should make life simpler for many and will seem perfectly natural for today's younger generations."

In health care, the desire for the latest technology wherever possible has most certainly led to greater cost, but new technologies have also expanded access to services and are dramatically changing how care is delivered, notes Conroy. The same rings true in higher education. The latest technology can be pricey, and also seems to improve function by extending or deepening impact. The result may be better care or instruction, though not necessarily lower costs for existing functions.

Changing Consumer Demographics

During the past two decades in particular, both higher education and health care have witnessed significant shifts in their customer bases. 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.

"Today, with so many worried about recession impacts and the inability even for college-educated students to get jobs, this could signal a huge shift in public perception about the value of education at a time when we need to become more competitive and skilled as a nation," says James 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. While some of the perception downgrade is driven by factors beyond the industry's control, leaders must do more to communicate the long-term value of education, he adds.

The expectation from society 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

Both higher education and health care exist in a multicompetitive marketplace. 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. And some four-year institutions in particular are feeling the pinch from an increasing number of students opting to spend their first two years in community college in hopes of curbing the amount of debt they will eventually owe, adds Bentley.

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 free-standing imaging centers and specialty clinics, notes Bentley. Furthermore, new providers such as Minute-

Clinic and its brethren offer alternatives to primary-care physicians and full-scale medical practices.

Because both industries suffer from perceptions that what they provide is too costly, competition has added pressure to streamline work and reduce administrative and operational costs in particular. Over the years both sectors have engaged in work redesign and continuously sought new ways to consolidate and leverage resources, leading institutions to engage in group purchasing and outsourcing of a host of services. However, the policy environment frequently curtails certain efforts to cut costs, as regulation—even when needed in many instances—creates expenses or limits cuts.

A real challenge for health care and higher education with regard to competition pressures is that both are high-level service 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." The famous analogy is a string quartet. It can't be made more efficient with only three players or by simply playing the music faster.

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, while loads of data are available, no nationally coordinated effort has been able to agree on exactly what measures provide a full picture of performance. "When we talk about using measurement to improve patient outcomes, we are trying to apply rigorous analysis to an amorphous situation. We end up monitoring our processes, because that is what is really measurable," explains Conroy. She notes that most physicians came up through an apprentice system in which their practice patterns mirrored how they were taught. But this doesn't necessarily ensure high quality care throughout a physician's career. "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. Health policy and public health leaders believe that addressing these kinds of measures focused on population health-related outcomes is the way to improve our health-care system and the health of our nation. "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. This will require us to work in teams, rely on home-health providers as important extenders, and reach out to families to make them our partners in care—a different set of expectations for physicians."

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. Meanwhile, boards of trustees struggle with their role in holding institutions accountable for student learning outcomes. According to a recent Association of Governing Boards of Universities and Colleges report, nearly 62 percent of respondents report that the board spends insufficient time on student learning outcomes, and nearly 22 percent note that student learning—the core function of any college or university—is not an appropriate role for the board. (See "How Boards

Oversee Educational Quality: A Report on a Survey on Boards and the Assessment of Student Learning," Association of Governing Boards, 2010.)

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."

"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.

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. Perhaps the most common characteristic both industries share—one with wide-ranging implications—is a key workforce segment that is relatively autonomous. 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. An administrator, even a high-ranking one, in either a hospital or university would be jeopardizing the quality of the institution if he or she were dispensing care or teaching in areas outside their expertise. We want an anesthetist to deliver anesthesia and a physicist to teach physics.

The growth of and demand for specialists within both sectors has helped reinforce traditional silos and divisions. The implications are better-focused care and specialization, but also more narrow approaches to decision making and resource allocation. It remains difficult to see the whole when one is divided and subdivided into discrete and focused units.

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 larger society for which others should pay, says Bentley. "The prevailing argument is that if it costs us X to provide quality education and health care, then society should be happy to pay for it. What leaders must recognize is that society at large has a different set of expectations about quality education and health care and what both are worth." 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. "The reason the price of health care is so high is because it costs so much to deliver health care *the way we currently do it*. The reason tuition is so high is because it costs so much to provide higher education *the way we currently do it*. Bottom line, we have to reduce our costs, and that means we have to figure out how to do things differently."

All of this will require some big thinking about new service and revenue models, and not down the road, but right now, asserts Chaffee. For starters, these models must focus on new processes for learning, not simply on increasing enrollment; managing the education of each learner; effective teaching strategies and evidence-based practice; and reorganizing resources. "The 19th century brought land grant institutions. In the 20th century came the GI Bill. Some would say we are now in midst of similar shift in the structure and funding of higher education. Given the context of our current challenges, I believe that if we aren't thinking about and talking about innovation along a full spectrum of issues—including our revenue models—that many institutions will not prevail," says Chaffee. "Institutions have to figure out how to raise more, spend less, and better allocate resources. And we have to do all those squared. Now."

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, organized 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 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?

"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.

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. The emergence of these clinics made some nervous, particularly those in primary care, since these clinics were providing the low-hanging-fruit services that many primary-care physicians provided, adds Conroy.

Technology has obviously ushered in new tools that are not only making care more sophisticated and more efficient, but are also allowing individual consumers to answer some of the questions they want to know before they go to a doctor's office, says Conroy. It complicates, if not shifts, the knowledge centers of medicine. 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. While 90 percent of patients may say they prefer to see a physician, if you also ask about their preference if they had to wait three weeks to do so, 70 percent of those 90 percent would opt for seeing an extender, notes 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."

How might this translate for education? What kind of environment do students want, asks Malcolm. "Will your physical campus continue to be the hub for education? Can students afford to stay in your dorms in the future? Can they afford to be full-time students?" In the same way that clinicians may think they know what patients need, many faculty may think they know what students want, says Malcolm. Turn that assumption on its head and consider what big ideas can come from your students, their parents, and the future employers of your students, suggests Malcolm. "This approach can reshape how and where you provide service and instruction to students in a way that can help you compete effectively," adds Malcolm.

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." And it may be that very threat of survival that helps drive innovation, suggests Bentley. "Innovations often come from those second-best places in town. Because they have a clear goal in mind, they may be more flexible on making necessary changes to attain that goal."

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? It is one thing to have the reports, another thing to get them off the shelf and use them constructively. Progress based on data can be difficult, as data can be threatening. While numbers are definite, their meaning is open to interpretation. 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 service rendered, focus shifted from being mission-driven to the profitability of the organization. While we valued money brought to the institution through research, we didn't always equally value the role of education in preparing physicians for the future," 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."

"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.

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.)

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, it must create its own path forward. The chapter that follows helps chart that course through focusing on the difficult decisions and outlining the important work ahead.

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? The list that follows highlights the most pressing questions identified by senior campus leaders.

Business and revenue models:

- What are the key principles upon which our business model is predicated? Are they essential to our mission, or as in health care, can we develop a different system that prioritizes the right outcomes and still be financially viable?
- While we have tended to set our expenses by what money is available, how can we begin to rethink those models and get faculty and staff to begin thinking differently as well?
- What would it take for higher education to fundamentally reinvent how we do business?
- How can higher education as an industry address the fact that we have a growing number of students coming to our institutions who are not able to pay? What is the work of individual institutions in this sectorwide problem?
- What are the real effects of tuition discounting efforts? Who is best served? How? What might be a different way to talk about price?
- With the enormous and growing level of student indebtedness, how can we as an industry fundamentally address the cost structures to ensure that education remains within reach?

Communicating value:

- What work can leaders do to help create a society that views our nation's higher education system as an asset that our country can't afford to weaken? How do we best engage policy makers and public opinion leaders?
- How can we as higher education leaders talk about the value proposition in a more understandable way to students and parents?
- How can we do a better job of communicating return on investment—what students actually get for what they pay? Given the soaring costs, can we look ourselves in the mirror regarding return on investment?

Student learning:

- Where have we really put students and student learning first? What current habits and silos exist that deter real progress?
- Are we designing our programs to the best use of time (and money) for our students? How can we agree on what students should really know and do?
- How must our approaches to curriculum design and student advising change?
- What new kinds of teaching partnerships and collaborations do we need to envision? With whom should we be partnering? How will our content delivery models need to change, and are we preparing faculty quickly enough for those changes?
- Are we prepared to take recommendations by students, alumni, and employers to heart with regard to how students want to learn and participate in higher education?

Student preparedness:

- How can we be more involved in preparing students for college?
- With so many students coming to our institutions who are academically unprepared, how can we do a better job of engaging students in what it means to attend college and to study?
- How can we help instill a sense of personal responsibility so that students understand their need to participate in their own learning?

Accountability:

- How do we get better at documenting what students learn and how they grow? What outcomes and measures should we communicate to our external stakeholders?
- How could the accreditation process evolve to help our institutions become more innovative and to focus on the right outcomes, while at the same time be more externally accountable? Are those two objectives at all reconcilable? If so, how?
- Regarding assessment, how do we account for institutional differences as well as student differences given institutional diversity from open-access colleges to the most elite universities?
- What are the best outcomes for higher education to measure? What are we currently measuring that is *not* helpful? If the outcomes approach for hospitals should have the goal of making a person well, what should higher education hold as its ultimate goal?

Ability to change:

- How can we get our institutions to focus on the right things given our fiscal constraints? How might we eliminate or do less well what isn't fundamental to our mission?
- How can our institutions adopt a campuswide innovation-seeking culture instead of a risk-avoiding culture? How can we get pockets of innovation to be more widespread and have a larger impact?

The shape of the enterprise:

- What will higher education look like going forward?
- Will many of our institutions face the need to radically specialize and to find a niche in order to thrive and not just survive?
- Will there still be a role for traditional residential institutions?
- How should we rethink campus infrastructure within the context of fewer traditional students?
- What will be the nature of higher education partnerships and collaborations in the future?
- To what extent will we see mergers occur within our industry?

These are difficult questions and ones, like in health care, that do not have easy answers. 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.

Conclusion: Keeping the Right Focus

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 mission 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."

A Business of the Mind and Soul

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: Stories on Health-Care Change

Workshop panelists representing the health-care industry shared their experiences of leading institution change. Here are three stories.

INDIANA UNIVERSITY HEALTH: Blending Cultures

Indiana University 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. Two individuals involved in this transition from the start were Steven Wantz, senior vice president for administration and chief of staff at IU Health, and 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.

Steven Wantz:

In thinking about how to engage institutions within a larger system in a cohesive change effort, I suggest that there are at least three key elements for success:

1. Give voice to the system.
2. Create skills and structure for dialogue.
3. Underscore the importance of vision and measurement.

I joined Methodist Hospital of Indiana in 1982. Soon after, the industry's reimbursement method shifted to a focus on cost containment. In the early years, this spurred consolidation and greater focus on financial performance in addition to the care of patients. This change in focus was a factor in burnout and higher turnover rates, so part of what we had to do in response was to help staff rediscover their purpose in the midst of trying to facilitate needed change. Then along came total quality management and other continuous improvement approaches. While not all change is an improvement, these various methods did help to give rise to a common language of quality and cost measures that helped us focus on improving our processes.

Next, the 1990s brought a decade of mergers and acquisitions, largely in attempts to spread overhead costs. In Indianapolis, this resulted in five large health systems. Clarian formed in the midst of 1997 with the merger of Methodist Hospital with IU Medical Center. This was a very mission-centric merger. Methodist was a large teaching and research hospital as was IU Medical Center, so our underlying values were quite similar if not always obvious. One question we had was how we would sustain these great institutions. We did some things early on that served us well:

- For starters, we quickly scrambled the eggs—creating one board, one medical staff, and a consolidated infrastructure. We rapidly integrated our back offices, and we removed legacy structures so that we couldn't go back. This served the organization and the community because it ensured that we couldn't easily come undone.
- In keeping our aim in mind, we created a committee on values to ensure we would stay true to our mission and to discern how to operationalize our values.
- We also created a board committee on education and research to maintain focus on the academic mission of our new organization.

This full-scale integration of leadership structures may well have been our secret sauce, because we began acting like we were integrated before we probably were. Keeping mission and values first all the time has likewise served us well. While vision

is important, it's not enough. You have to follow through with tools and techniques to fill any gaps. Today, we are preparing for our next big change. Accountable care will now require us to set goals about population health management. Addressing principles about "system-ness" and how we use resources and apply practices will become the next chapter in our change process.

Stephen Bogdewic:

I have been in medical education more than 30 years and am now in charge of faculty development. In thinking about our change process from a school standpoint, one real concern of a merger for those within the academic environment was fear of the academic mission being deemphasized. Two key factors helped ease that fear: a compelling shared vision that provided a sense of purpose, and practical and routine strategies and tactics for connecting to that purpose—conveying and reminding others of why we are here. This is especially critical to do within a complex system. In the larger enterprise of IU Health and IU School of Medicine, one thing we emphasize is that we must continually pay attention to those delivering the services. If those on the front lines feel a connection to purpose, our customers will embrace the change as well—and they have.

Something else we talked about quite a bit throughout the merger centered on the culture we were trying to create. In our meetings we talked about money but always in the context of mission. Perhaps one reason we are at the point we are nationally with our health-care system is that we aren't focusing enough on our ultimate goal. If we are about health then a singular focus on treatment will be insufficient. Focusing on the ultimate goal of health causes us to look beyond treatment, which is the cultural shift that seems necessary to create a sustainable health-care system.

Within an academic institution it can be difficult to create a sense of urgency for large-scale change—the proverbial burning platform. As a family therapist, I readily see the connections between families and complex enterprises. Both are complex systems. A useful strategy for both is that of incremental and continuous improvement. A helpful resource for accomplishing this is *The Improvement Guide*, which calls for the consistent use of three questions: 1) what are we trying to accomplish, 2) how will we know a change is an improvement, and 3) what changes do we predict will result in improvement? This is essentially what systems therapists do. Focus on what you can readily change today, and that will lead to further change tomorrow.

KECK HOSPITAL OF USC: Connecting Mission to Transition

Mitch Creem *serves as chief executive officer for Keck Hospital of USC and USC Norris Cancer Hospital, an enterprise consisting of 471 patient beds and medical services staffed by 2,800 personnel. Creem came to USC in 2008 as vice provost to provide leadership and guidance as the university negotiated to acquire two private hospitals owned by Tenet Healthcare Corp., a for-profit hospital company. He became CEO in April 2009.*

At USC, we have recently experienced two levels of transformation: 1) outside industry pressures causing us to do things differently, and 2) internal reorganization resulting from a hospital acquisition. At the time of the hospitals acquisition, five distinct organizational cultures existed: Tenet Healthcare Corporation, the Norris Cancer Hospital/USC, the Doheny Eye Institute, the LAC + USC Medical Center, and the private practices of the USC faculty physicians. Each of these groups took pride in their work, but historically they had not been called to work together toward common goals.

When we acquired the hospitals in April 2009, demand for services had been steadily dropping, the employee turnover rate was close to 30 percent, and employee morale was low. At this same time, expectations for the success of our new venture ran high among our university's senior administrators and trustees. After all, we had made a significant investment on this acquisition during the worst eco-

nomic conditions since the Great Depression. I knew that our success depended on our ability to work together. We needed a transformational agenda and a common vision. The biggest challenge in trying to blend our various cultures was getting buy-in from all of our constituent cultures and collaboration to achieve a larger shared mission.

I remember reading Patrick Lencioni's *The Four Obsessions of an Extraordinary Executive.* In particular, the obsession regarding values had a significant impact on me. This wasn't merely calling for a whiteboard exercise to come up with the five values of your company to put into your mission statement. It was about embodying those values and living them, out loud, every day. While I understood this intellectually, I didn't know exactly how to put it into practice. It seemed too subtle. It wasn't until I read *The Three Laws of Performance* by Steve Zaffron and Dave Logan that I began to understand that these values can live in language—a language to be created, shared with, and owned by all employees.

To that end, we spent eight months with our employees and physicians developing a new vision of our collective future, learning how to work together and communicate with each other using a language of commitment and collaboration. A team of 65 faculty and staff developed a new mission statement highlighting these values and a strategic plan that provided a three-year road map to 2014. To date, more than 1,000 employees and physicians have signed this statement. We've seen tremendous growth in our medical enterprise since our acquisition and integration in 2009. Revenues have grown from $400 million to $600 million; volume has grown by 30 percent; and we have recruited 50 new clinical faculty from around the country and hired nearly 1,000 new staff. Staff turnover is down to 4 percent, and morale is high. Patient satisfaction scores have steadily increased. While all of our success cannot be attributed only to this management approach, I know it is having a powerful effect throughout our newly named Keck Medical Center of USC.

For any organizational change effort, it is important to recognize that the fundamental shift that needs to take place is to move from an environment of solo practitioners to a highly functioning, collaborative team. One of the fascinating things about any change initiative is that you quickly learn who wants to be involved. Like oil and water, you begin to see a clear separation. The good news is that you don't have to get everyone on board or every leadership position involved. What you do need is to achieve that tipping point of engagement that will allow your change to take hold and go viral.

KAISER PERMANENTE: Rebuilding Buy-In

Christine Malcolm *is the academic medical center practice co-leader for Navigant Consulting, Inc. She previously served as a senior executive at three well-known health-care organizations: Kaiser Permanente, Rush University Medical Center, and the University of Chicago Medical Center. While at Kaiser Permanente, Malcolm led a massive facility redesign effort, overseeing a team of 2,900 staff engaged in delivering a $24 billion capital program and managing one of the largest privately held real estate portfolios in U.S. health care—more than 60 million square feet and more than 1,000 buildings.*

Part of my charge when I came to Kaiser Permanente was to totally replace, rebuild, or build 27 hospital campuses. The push to do this came from two primary drivers. First, the passage of seismic legislation in California turned a number of our facilities obsolete overnight. And second, many of Kaiser's facilities were either in need of repair or in the wrong locations. All of the investment needed to occur in a way that created the best outcome for the least cost. I found that working through capital reallocation was one of the most political things you can be involved in—with everyone positioning to influence who gets what. We also had a charge to incorporate green standards and high-efficiency measures into our facilities construction, while keeping the cost of our program lower than our competitors.

We developed a simple strategy: engaging the entire team in creating the future of our dreams.

Knowing I faced an uphill battle with regard to employee engagement, I laid down my pitch: "I need everyone to get out of the stands and start helping. I am going to spend six months talking with you. I will not promise to implement everything you tell me, but I will listen. And at the end of this, we will all know what we should stand for, and will be committed to accomplishing it together."

What we ultimately came up with was an overarching goal still in place today that captured the imagination and energy of everyone involved. We said: "We as group of individuals are committed to building the smartest buildings and the best facilities in health care—true healing environments." That unifying goal provided the energy and gratification we all needed to maintain buy-in during the painful process of working through all the capital reallocation and redesign. Once you are able to turn off the cynicism and let people reconnect with why came into the field in the first place, they can accomplish what you and they may have never thought was possible.

APPENDIX: Change-Management Exercises

The hardest part of any change initiative may be getting started. If the change that is required seems overwhelming, few are likely to engage willingly or energetically. That spells quick doom for any change effort.

In addition to discussing what lessons the health-care sector offers higher education regarding change at the macro level, the workshops allowed participants to delve into pressing ground-level challenges on their campuses. To facilitate those discussions, change experts and authors Chip and Dan Heath and Yoram (Jerry) Wind employed their models to help campus leaders consider how to approach change—big or small—in doable chunks. In their book *Switch: How to Change Things When Change is Hard,* the Heath brothers offer a formula for providing direction and motivation and doing what you can to shape the environment in favor of the change you seek. In *The Power of Impossible Thinking: Transform the Business of Your Life and the Life of Your Business,* Wind details the need to first challenge one's own mental models. What follows is a synopsis of the change strategies shared by these facilitators with workshop participants, paired with examples of institution change initiatives applying these principles that emerged from workshop discussions.

MODEL 1

APPEAL TO PLANNERS AND DOERS

Conventional wisdom about change is that it's hard, you can't teach an old dog new tricks, and most people resist change at all costs. But that conventional wisdom isn't always true, notes Chip Heath. Consider how receptive to change most of us are when it comes to our technology habits. And, there is concrete evidence that people don't always dread or resist change. Some changes many of us willingly accept, such as marriage and having kids. So the trick is to think about the change that is easy or that we eagerly take on and see if there are tips or tricks about that kind of change that we can apply to change that is harder to make—including the kind of changes required for many organizations, and the changes in behavior leaders may need to invoke from colleagues or employees, explains Heath. That kind of change is definitely not easy.

What allows change to succeed—or most often causes it to fail—is the split we have in our brains, notes Dan Heath. Each of us comes wired with a rational, deliberative system skilled at analysis and formulating a plan. The flip side is our emotional or unconscious system that is instinctive and impulsive—what we do on autopilot. Sometimes the planner and the doer sides of our brain work in sync, but more often they fight each other. When that happens, it's never a fair fight because the emotional side will win, says Heath. Consider this in the context of a diet in which we want two different things: that healthy, slender body, and the delivery pizza.

To illustrate their change model, the Heaths employ an analogy used by University of Virginia psychologist Jonathan Haidt in his book *The Happiness Hypothesis,* in which a Rider (rational, planner side) sits atop an Elephant (emotional, doer side). While the Rider may think he is in charge (after all, he has the reins and presumably can pick where to go), if there is a conflict, the Elephant has a 6-ton weight advantage over the direction the two will go, explains Chip Heath.

This is not to say that the Elephant is the villain. Most often, the Elephant—able to latch on to the excitement and energy of an idea—is behind successful business start-ups and Nobel prizes. Similarly, say the Heaths, the Rider is not always the good guy,

since the Rider can be somewhat of a wheel spinner, using nine statistics in a presentation when two would do the job. In fact, when it comes to organizational change, the Rider too often presents the business case—complete with charts and spreadsheets—and thereby connects only with other riders, who are most likely to agree with a rational argument. Where the Rider too often fails is in not tapping into the emotion of the Elephant, suggests Dan Heath. Change happens when we manage to align these two sides of our brains.

During their workshop presentations, the Heaths outlined the three-part framework for change that they detail in *Switch.* Based on this underlying assumption about how we all are wired, they argue that for successful change, leaders must not only provide direction to the Rider, but also motivate the Elephant. The third step: Leaders must do all they can to shape the path and create an environment conducive to change.

All three steps are preceded by first clarifying the change needed: Who needs to change (audience)? And what needs to change (goal)?

What follows is a brief overview of the three-step change model the Heaths shared with workshop participants.

STEP ONE: Direct the Rider

The Rider loves to argue and debate. Because the analytical can suffer from their own analysis paralysis, propose a destination that provides clear guidance, including details about how to circumvent any obstacles. Bear in mind that what looks like resistance to change is often cluelessness. Give people a sense of what change looks like. Two responsibilities for leaders:

1. **Script the critical moves.** Identify a series of logical steps. Make the change you are asking of people as transparent as an actor reading a script. Eliminate the mystery of the behavior you expect. At the same time, don't try to script every move. Look for the high value or high bang-for-the-buck moves.
2. **Find the bright spots.** The Rider also loves problems and often spends too much time assessing what is wrong or trying to identify the root cause of failure. At the beginning of a change initiative, it's easy to obsess about what must be fixed, but this can quickly become unproductive. Instead, scan the environment to find out what is working—the bright spots—and seek to do more of that. This doesn't mean that current circumstances are perfect, but they are likely better than anything else. Take what is working and see how you can scale it to enhance success elsewhere.

Consider this: Instead of seeing your role as one of dealing with emergencies and putting out proverbial fires, what if you instead spent that time working with your best people, or your best faculty, or those using money the wisest, and determine what they are doing that works.

Questions: *What are the one or two critical moves that would create the most rapid progress toward our goal? How can we obsess about success with the same intensity that we've all used to obsess about failure?*

STEP TWO: Motivate the Elephant

For many change initiatives, the Elephant is the bottleneck. The Elephant is all about short-term satisfaction versus achieving a long-term goal. Implementing budget cuts today in order to have a better tomorrow may appeal to the Rider, but it won't move the Elephant. Important to bear in mind is that no change journey will go anywhere or will last without the energy and passion of Elephant. Three strategies can help boost motivation:

1. **Find the feeling.** Lasting change is rarely triggered by information alone. Consider the warnings on cigarette packs that smoking can be deadly. These messages provide information that is true, but they don't actually deter most people from continuing to smoke. Similarly

many organizations might understand conceptually that their long-term survival is in danger, but that knowledge alone may not inspire dramatic action, because people also understand that painful changes may be required to deal with that reality. A sense of urgency can help. Only when the economy began to collapse at the end of the previous decade did many businesses and consumers take notice, realizing that if they didn't change their practices, they might go out of business. While panic and fear are powerful feelings, they don't have to be the motivating factors you seek to tap. Hope, passion, and creativity are equally effective for encouraging change. So can tapping into someone's competitive drive.

2 **Shrink the change.** Most people are more easily motivated if they see quick results. Shrink the change by breaking it into a series of manageable steps to ease what may seem daunting when looking at the big picture. For instance, for an organization that is experiencing declining revenues, rather than asking units to cut 5 percent or 10 percent across the board, ask them to review one or two line items at a time for cuts that could easily be made. Shrinking the change allows people to get moving in the right direction and can instill a sense of satisfaction, providing the energy to tackle each successive step.

3 **Grow your people.** At the same time that you shrink the change required, you can help others feel ready to tackle change. Give them a head start by reminding them of what they've already conquered so they can sense the momentum.

Questions: *What can you share with colleagues and faculty to give them a visceral sense of why change is needed? How can you make the desired behavior or the change that is needed the path of least resistance? What previous accomplishments can you identify as a way to inspire others to do more?*

Step Three: Shape the Path

For change to take hold, it must seem within reach. If a clear pathway does not exist, leaders must take action to cultivate a culture conducive to change. Three techniques may prove especially useful:

1 **Rally the herd.** For behavior to be contagious, it must be visible. One of the most profound tools in a leader's toolbox is an ability to shine a spotlight on what others are doing, thereby creating conditions for a particular behavior to spread. Sometimes you can appeal to the norm, since most people look for cues about what others are doing that is deemed admirable behavior. However, a problem in many change situations is that the crowd may be heading in the wrong, same old direction. In those situations, creating a "free space" places those who are doing the right thing (the "enlightened minority") in a majority situation where they can meet to share ideas and build confidence to move forward. Letting people spend more time among others who support change allows a herd mentality to grow and to gain steam.

2 **Build habits.** Change is easier when the desired course of action becomes habit. While the self-control each of us has is limited and can easily be exhausted, our habitual behavior requires no real energy. The magic of a habit is that action essentially takes place while on autopilot. As leader, you can help others create habits to facilitate change. When first trying to build a new habit, consider making it voluntary or starting with a group of individuals who are motivated, again providing them with the free space to develop a new process or procedure. You can also piggyback new habits on old habits to increase the likelihood that new habits will stick.

3 **Tweak the environment.** Adjusting the environment is arguably the simplest tool for any leader seeking change, and it is the holy grail of path shaping. We too often are quick to characterize people, assuming they are lazy or adverse to change. Yet,

sometimes there may be an obstacle blocking the path that keeps well-intentioned people from tackling change. Even a small tweak can make it easier for people to respond. Tweaks to the environment can not only make desired behavior easier, but can also make undesirable behavior more difficult.

Questions: *How can you publicize positive norms or create a free space to encourage the minority who are doing things right to do more? What established procedure or routine can you use as a foundation for building a new habit? What obvious obstacles are blocking the pathway to change within your institution? Would reorganizing working groups remove obstacles to cross-collaboration? Would instituting impromptu meetings that you conduct standing up make idea-sharing more efficient? What simple tweaks might be made to student learning models to improve outcomes or to technology integration to help consolidate resources?*

Additional Tips

The most difficult aspects of this change process are likely framing the problem and scripting the critical moves, notes Dan Heath. Something for leaders to consider as they formulate a plan using these techniques is whether their challenge is a direction issue (people don't know what is expected) or a motivation issue (there is too much junk in the way). This will help leaders identify which techniques may work. And beware of the fundamental attribution error—blaming people rather than focusing on the situation, adds Chip Heath. You don't always have to change people to change their behavior. Tweaking the environment often solves a situation problem.

If the enormity and the nature of some challenges are such that you can't change the circumstances on your own, or in a time frame that is acceptable, the question becomes what can you do today to alter the outcome in your favor, suggests Chip Heath. What is taking place right now that you *can* change? And how can you scale that change to have an impact even if you can't completely resolve the situation? Being a leader doesn't mean you have to come up with all the great ideas. What you need to do is to determine what is possible. Find the bright spots and set up circumstances for success that you can tweak, scale, and repeat.

GROUP WORK

Workshop participants were asked to consider specific challenges their institutions face, clarifying the change needed (audience and goal), and then identifying the relevant *Switch* principles they could apply to initiate their change efforts. What follows is an overview of some of the challenges discussed.

CHANGE GOAL: Increase conversion rate of prospects to enrolled students by 10 percent by the following academic year.

Background: This institution had a secret shopper who called as a parent inquiring about enrollment. The institution's phone system failed to field the call in a timely manner, and the eventual conversation did not go well. The secret shopper eventually wrote a letter to the institution's president detailing why she would not be sending her student to the institution.

Script the critical moves: Institute a process-improvement committee to study the problem and develop recommendations to streamline our current process. Determine what improvements are needed to our current phone system so that we don't miss any calls.

Find the bright spots: Identify departments that are responding to phone calls the same day they are received. (As it turns out, our finance department had already established a culture of answering every call within 24 hours.)

Find the feeling: Identify what motivates people to provide good service. Is it job security? Would it help to institute a competitive bonus system for staff as an incentive? Or perhaps appeal to their competitive nature by comparing our conversion rates to those of our peer institutions? Should we share the secret shopper's letter with staff to help them understand the impact of lost calls and to put a face on students

and parents who don't receive good service?

Shrink the change: Have the process-improvement team report back with first impressions regarding our biggest gaps in service. Map how phone calls are routed—and should be routed—to ensure a live person is always available to answer calls or respond as soon as possible. Develop and distribute incremental targets to motivate employees with a series of smaller goals.

Grow your people: Develop role-playing scenarios and/or training exercises to ensure that all staff are reading from the same "script" while still allowing for employees to personalize their service.

Rally the herd: Bring together the departments that are providing the best service and ask them to pool their ideas and practices to compile and share with other departments.

Build habits: Develop a short "cheat sheet" of fundamentals for fielding calls and responding to caller inquiries to distribute to all service representatives to post by their phones for quick reference.

Tweak the environment: Address all technical deficiencies with our phone system.

CHANGE GOAL: Improve the efficiency of our student learning assessment process.

Background: Currently this is a faculty-centered process for which we lack consistent data to determine whether students are actually learning what they need to know. Some departments are doing a good job of providing data in a timely manner, while others continue to employ archaic processes. If we can centralize our method of data collection, we believe we can improve our outcomes.

Find the bright spots: In certain departments that are doing a good job, we found that staff members are actually doing more of the work. Not only is this building the confidence of faculty members that staff know what they are doing, but it has also become a source of motivation for staff. They cite an opportunity to do more analysis and higher-level work that they haven't been able to in the past. This bright spot points to a potential "herd" identity opportunity to develop best practices to share with staff in other departments.

Find the feeling: Convince departments that are using outdated processes that they can save time with a centralized method. Appeal to faculty and staff regarding the importance of timely and consistent data collection to help the institution better monitor and improve student learning outcomes.

Grow your people: Perhaps we could showcase the successes and accomplishments (i.e., better results) of certain departments by having those involved in the data collection efforts conduct presentations for other department groups, explaining what they've done via a peer training exchange.

CHANGE GOAL: Increase faculty member participation in student recruitment.

Background: Our data shows that personal interaction with faculty enhances student experience and positively impacts how students feel about the institution. Our challenge is to convince faculty of the importance of their involvement in student recruitment. We anticipate that some faculty members will likely view this as a request for them to engage in public relations on behalf of the institution—on top of their already busy workloads of teaching, research, and publishing.

Find the bright spots: We could begin by identifying current and former students to talk about the impact of their interactions with faculty and create video clips telling how students were motivated by these conversations so that we could then share these messages with faculty.

Shrink the change: So that faculty don't feel overburdened by this request, we could quantify the number of events we need faculty to attend and/or the number of phone calls we need them to make during the course of a semester.

Script the critical moves: To make the task less daunting, we could develop a handful of general scripted talking points they could use that would still allow them to personalize their comments and talk about their area of expertise and the classes they teach.

CHANGE GOAL: Increase recruitment of African American students from our region.

Background: We have had success in the past recruiting from areas of our community that are mostly Hispanic. We now would like to increase enrollment from the African American population in our region.

Find the bright spots: We believe one reason for our success in recruiting more Hispanic students is that we hired a Hispanic counselor. We also launched and continue to run a Latina math and science camp for rising 10th grade girls during the summer. Participants stay on campus and are introduced to our services and facilities at a point in their education when many may begin thinking about a college education.

Script the critical moves: We have talked about taking similar measures to appeal to young adults in our African American communities. However, historically our retention rates are much lower for this population. One thought we have is to conduct focus groups with our current African American students on campus to find out what they think is helping them succeed or keeping them from excelling at our institution.

Find the feeling: Many institutions that can get students in the door have difficulty making the case for why they should stay. It can be easy for many students to feel they are in the wrong place. One general theory behind recruitment is that it is ineffective to recruit students one at a time. For some populations, it might work best to recruit students as a group to begin to build those peer connections from the start. That theory reinforces why we have had success recruiting students who have attended our summer camp program.

CHANGE GOAL: Enhance distance education offerings for students in our region.

Background: We are located in a rural area and provide services to students within an 18-square-mile radius. Because our students are widely distributed, the only way some of our students can take courses and complete a degree is to attend online. We want to communicate the importance of this to our faculty so that more are compelled to develop online programming that meets national standards for quality.

Find the bright spots: We currently have some academic faculty who are offering online courses whom we plan to use as mentors to encourage and assist their colleagues with online content development and instruction.

Find the feeling: We believe our first step is to get faculty motivated and to have them internalize the fact that some of our students don't have other options for furthering their education without online instruction. While most faculty understand that our students are spread out, not all have made the visceral connection to the potential lifeline they represent for some students to earn a degree. One tactic we could employ is to create a big map on which we attach photos of our online-only students to provide a visual for faculty to sense how these students would be left out if we did not offer distance programming. Something that would require a bit more time and resources would be to visit some of our students and videotape them in news-anchor fashion to provide context about why they are grateful for having access to online programming. These personal stories might help more faculty empathize with remotely located students and underscore the importance of enhancing our online curriculum.

MODEL 2

CHANGE YOUR VIEW

When seeking change, how you frame an issue can go a long way toward challenging established assumptions, asserts Yoram (Jerry) Wind. For instance, swapping the term *inner city* with *emerging domestic market* can shift one's perception from an image of crime to that of opportunity. What if we referred to *integrative medicine* instead of *alternative medicine*? In the world of financial accounting, are people considered an *asset* or an *expense*? Is inventory an *asset* or a *liability*? The simple act of renaming something can alter our response to it.

Yet, to change mind-sets, behaviors, and institution culture requires far greater effort than applying a different phrase to the challenges we face. In

today's more volatile, more uncertain, and more complex economic, social, and global environments, what leaders need are new mental models to lead their organizations forward. In fact, Wind asserts that the primary obstacle to real transformation is not a lack of resources, or technology challenges, or demographic shifts, or regulatory constraints, or any other external pressure. The biggest blockade to change is ineffective mental models. Trying to operate within a new cultural context or economic environment by applying the same assumptions and approaches will not produce the kind of dramatic change sought or required. Continuously challenging and adapting established mental models is a must, argues Wind.

Higher education leaders don't lack new ideas, but they too often tend to extend their new ideas along traditional ideologies, suggests Wind. For instance, is the traditional approach to teaching students in a face-to-face physical classroom over the course of a semester really the best way for students to learn? All traditional assumptions about teaching and learning should be challenged, and faculty and administrators must be willing to experiment with a range of new approaches, argues Wind.

While having campuswide conversations is important to stimulate ideas, such conversations must be preceded by education about the larger external and internal environments and analysis of current approaches and behaviors and why these exist. Understanding current mental models and articulating their value will help leaders identify what aspects are worth retaining even as they seek to change those models.

What tactics can leaders use to challenge their own mental models and institutional assumptions? Here are some of the tools Wind offered workshop participants.

Ask Your Stakeholders

Reinvent your relationships. Among the characteristics shared by companies successful both before and after the recent economic crisis is a concerted effort to reinvent the customer relationship, says Wind. Today's higher education environment requires seeing students not only as consumers but also as partners who can help you identify where you need to go—including how to design, price, produce, market, and distribute your products and services.

Wind recounts the time when he led reinvention of the Wharton MBA curriculum and brought in employers to ask what they were looking for in students. With the exception of those looking for specialized investment skills such as banking, no other employers seemed bothered about what degree a student had, notes Wind. What they wanted above all else were enlightened individuals who could understand the problem. Had he not engaged the school's customers (employers), the reinvention effort may have missed sight of a primary goal.

Something else to bear in mind about customers: While leaders tend to view challenges in logical terms, from a consumer standpoint, these same issues and concerns are often emotional. What is the story or narrative of your institution? Why should students come? Institutions must build an effective platform to engage students in an ongoing manner.

Open Your Mind

Adopt an open innovation mind-set. This mind-set allows institutions to think more creatively about how to address key challenges. Although no problem today can be solved by a single discipline, most higher education institutions still provide largely siloed education, notes Wind. These silos are reinforced by the way most colleges and universities are organized and how they distribute information. What must change organizationally to tap interdisciplinary perspectives to solve your institution problems? Learning to apply an open innovation approach to all your key domains and activities will dramatically change your business model.

Invite the radicals into your arena. Recognize there may be those with contrarian ideas who could do the most to help solve your institution's core challenges. In most industries, true innovators come from outside, not internally, notes Wind. In this regard,

higher education is extremely susceptible to "insider" mentality compared to most other industries, in part because institution cultures are deeply ingrained with how things have been done in the past. Today, the more disruptive innovation and radical thinking we can inject into the decision-making process, the greater the benefit for an organization, argues Wind.

Expand Your Horizons

Travel. Literally and figuratively, get out and scan the environment for ideas and practices occurring elsewhere that you aren't doing but could implement. Wind notes that Starbucks CEO Howard Schultz, following his travels to Europe, considered how to replicate the outdoor café in the United States to make coffee an experience for Americans instead of a commodity.

Zoom in and out. Make it standard practice to look at each challenge from different vantage points to uncover different parts of the reality and of the solution.

Challenge Conventional Wisdom

Scrutinize established assumptions. The danger with most scenario-planning efforts is that they allow individuals and institutions to deny or reject scenarios inconsistent with their current, comfortable mental models, argues Wind. In many organizations, there is great reluctance if not actual fear in challenging conventional wisdom, so leaders must grant permission to challenge the status quo in a way that avoids politics and personality.

A key tenant of the quality movement of the 1980s was doing the right thing right, but too many organizations have forgotten the first part, argues Wind. We need to first make sure we are doing the *right* thing—then ask if we are doing it right. Wind suggests that if you look at how organizations operate, most could reduce costs 20 percent, but that requires challenging conventional understanding about resources—not only about having enough resources, but how to allocate them in the right way.

Rethink benchmarks. The least amount of new information an organization can obtain is by benchmarking itself against its peers, and yet that is what the majority of colleges and universities do, notes Wind. Much more can be learned from institutions, organizations, and industries unlike your own.

Seek Relevance and Stretch

Develop analogies. Wind cites an example of how a group charged with improving hospital emergency-room practices developed the analogy of a pit crew in a race. This new way of imagining their work led to creation of prepackaged tools for operations to ensure that doctors and nurses had all the necessary tools on hand—similar to the predetermined roles of each crew member equipped with all the components needed to repair cars under critical time constraints.

Insert stretch. While analogies provide fresh insights, there are times when whole new approaches are in order. Stretch objectives should eventually be achievable, though not by using current methods, notes Wind. The whole idea of a stretch objective is to force you to rethink what you are currently doing. Once again, consider if faculty and administrators would forget about teaching and instead focus on learning. The end goal may be the same, but the approach might be fundamentally different and could require developing a whole new skill set.

Create the Future

Design from scratch. Within every organization is a collection of Band-Aids used to fix common problems. But what if we were unconstrained by, for instance, the traditional design of a classroom, posits Wind. An idealized future begins with a blank sheet of paper.

Write your own story. Another tool for engaging in unencumbered problem solving is to select a favorite magazine, any number of years in future, and write the story of what you want to be in 5 years or in 10 years, says Wind. What are your future underlying models and how do these compare to current mental models?

Try and Try Again

Experiment or die. According to Wind, adaptive (continuous) experimentation is the one tool every organization and leader must adopt to move forward. Experimentation ultimately yields better and more effective decisions, provides learning through data about what works and doesn't work, engages more people, increases confidence and buy-in, decreases resistance, increases visibility, faces complexity head-on, challenges current mental models, encourages innovation, and changes institution culture by providing a philosophy that says it is OK to fail because we know we learn most from our failures, asserts Wind. Adaptive experimentation is required precisely because we live in a world where there is no silver bullet. While leaders can select among a full range of approaches they wish to employ in their change efforts, experimentation is non-negotiable if you want to do change right, argues Wind. In that respect, every change effort should identify experiments to deploy to test success.

GROUP WORK

Wind challenged workshop participants to consider specific concerns their institutions face, asking groups to: 1) identify current views and approaches; 2) develop new mental models to address the challenge; 3) consider which tools to employ to strengthen the new mental model; and 4) devise an experiment to test the new model. What follows is an overview of some of the challenges discussed.

CHALLENGE: Address new reality of reduced state and federal funding.

Current mental model: Assume that the good days will return, so we will wait it out.

New model: Higher education maintains a largely traditional payment system. How can we consider more innovative ways to sell our product? Look for other sources of funding, including partnerships with industry, additional services we might provide (e.g., executive education), and different tuition pricing structures we could implement.

Tools: Challenge conventional wisdom about resource needs and service models. Invite disciplinary perspectives from across the institution to identify solutions and propose new funding sources and models.

Experiment: Regarding tuition payment models, consider setting up a test to offer a cohort of student applicants free tuition in exchange for 1 percent of their earned income for life.

CHALLENGE: Better serve society's unemployed and underemployed.

Current mental model: Remain focused on serving traditional-age college students.

New model: At a time of high long-term unemployment and underemployment for so many Americans, and within the context of employers that indicate the lack of a highly skilled workforce, identify and address the training needs of this newest segment of the nontraditional student.

Tools: Engage customers (employers) to identify skill shortfalls and content needs for technical proficiency. Engage customers (students) to identify needs for flexibility in completing coursework and training.

Experiment: Develop partnerships with employers and workforce development agencies to identify specific disciplines to cross-train the unemployed into more job-secure areas. Establish pilot programs to develop curriculum in partnership with local and regional employers.

CHALLENGE: Improve faculty understanding of resource allocation.

Current mental model: Top-down budgeting approach identifies revenues and allowable expenses. When faculty are asked about resource plans for the year, most assume a siloed structure and complain that they don't have enough.

New model: Solicit faculty input and collaboration surrounding budget priorities.

Tools: Employ scenario planning to think about resource allocation in creative new ways. Develop stretch objectives by building budgeting education

into strategic planning efforts. Compare budgeting approaches to those employed by other institutions.

Experiment: Provide financial data to faculty and ask them to conduct budget presentations for other faculty, engaging them to anticipate questions from their colleagues and how to make sense of what others need to know about institution resources and how best to allocate them to match institution priorities.

CHALLENGE: Transition to blended-learning models.

Current mental model: Negotiate with faculty to increase online content development and delivery. This model assumes that face-to-face interaction in small classes offers the best teaching approach.

New model: Traditional face-to-face instruction is becoming obsolete. While we need to cherish our strong faculty culture, we also must better understand the needs and demands of today's students and challenge the notion of the teacher as the sole expert about content development and delivery.

Tools: Travel to review blended and online learning models at other institutions. Bring in the radicals (e.g., corporate educators and for-profit providers) to find out how their models are structured and what works. Ask students how they best learn and prefer to receive information, and enlist their help in convincing faculty of their preference for new learning formats.

Experiment: Set up control groups to test the effectiveness of different delivery methods. Reward faculty who agree to offer the same class with the same learning objectives in different formats: classroom only, online only, and a blend of classroom and online. Compare student learning results at the end of the term.

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, provost.
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 Bonvilliian, 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 and to the change-management experts who facilitated discussions on leading change.

HEALTH-CARE INDUSTRY PANELISTS

James D. Bentley is a semi-retired health policy analyst who currently works with a number of hospitals and state hospital associations on the implications of national health reform for their operations. In October 2009, Bentley concluded 18 years at the American Hospital Association (AHA) where he was responsible for strategic policy planning, including AHA committees on long-range policy, health professions, and workforce initiatives. He was also involved in disaster preparedness and response, and exploring new hospital-medical staff relationships. Before joining the AHA, Bentley spent 15 years with the Association of American Medical Colleges (AAMC). Initially responsible for legislative and regulatory activities affecting teaching hospitals, he concluded his AAMC career as vice president of clinical services, with responsibility for the association's program of services for teaching hospitals and faculty practice plans. Bentley also spent five years in the U.S. Navy Medical Service and taught in the health administration program at George Washington University. He is currently a member of the national board of directors for Trinity Health of Novi, Michigan—a multi-hospital Catholic health system with facilities from Maryland to California. Bentley is also a member of Trinity's sponsoring organization, Catholic Health Ministries. Previously, he served as a member of the board of trustees of Holy Cross Health in Silver Spring, Maryland, and as a member of several of its board committees. Bentley earned his B.A. in Health Facilities Management from Michigan State University, and his Ph.D. in Medical Care Organization from the University of Michigan.

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. He also holds appointments in medicine, pediatrics, and public and environmental affairs. Bogdewic is past president of the Indiana University School of Medicine faculty, and is also one of the hosts of *Sound Medicine,* a weekly public radio program sponsored by the Indiana University School of Medicine and WFYI Public Radio. Bogdewic is a nationally recognized lecturer, consultant, and educator. He is also a licensed therapist and maintains an active clinical practice. His scholarly interests include professional development, leadership development, clinical teaching skills, and the quality improvement of health care. He is past president of the Society of Teachers of Family Medicine and recipient of the society's highest teaching award, the Excellence in Education Award. In 2008 Bogdewic was elected to honorary membership into the Alpha Omega Alpha Honor Medical Society. Bogdewic received his Ph.D. in adult education and organizational development from the University of North Carolina and his M.A. in marriage, family, and child counseling from Santa Clara University.

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 in an environment of scarce resources.

Chaffee's career spans institutional, system, policy, and national professional leadership in both public and private higher education, as well as extensive research and publication. Past president of two universities and two national professional associations, she has led executive, academic affairs, student affairs, research, and equal opportunity functions. Chaffee has served on and consulted with numerous governing boards as well as national organizations in higher education research, health care, allied health, and foundations. Previous positions include president of Valley City State University, president of Mayville State University, academic vice-chancellor for the North Dakota University System, and director of organizational studies at the National Center for Higher Education Management Systems. Chaffee was president of the Association for Institutional Research and the Association for the Study of Higher Education, as well as the public member of the American Council on Pharmaceutical Education, the accrediting board for pharmacy. Trustee of a major health-care system for eight years, Chaffee chaired the board and guided its 50/50 merger that resulted in a $2 billion health-care system. She has published five books and dozens of articles in refereed journals, as well as 750 weekly columns in community newspapers. Chaffee earned her master's and doctorate in higher education administration and policy analysis at Stanford University.

Joanne M. Conroy, M.D., is chief health care officer of the Association of American Medical Colleges (AAMC). In this role, Conroy focuses on the interface between the health-care delivery system and academic medicine, paying particular attention to how health care in academic settings can address quality-of-care and patient-centered care issues. Conroy represents the interests of approximately 400 major teaching hospitals and health systems, including 64 Veterans Affairs medical centers, through the AAMC Council of Teaching Hospitals and Health Systems in addition to overseeing the group on faculty practice, group on resident affairs, chief medical officers group, and the compliance officers forum. Conroy started her career in Charleston, South Carolina, as chair of anesthesia and preoperative medicine of the University Hospital and senior associate dean of the college of medicine at Medical University of South Carolina. From 2001 to 2008, Conroy served as executive vice president of Atlantic Health System and chief operating officer and president of Morristown Memorial Hospital in Morristown, New Jersey. In those roles, Conroy gained an understanding of health system operations, hospital-physician relationships, and collaborative partnerships among the various elements of academic health systems. She earned her B.A. degree in chemistry from Dartmouth College and was awarded her M.D. degree from the Medical University of South Carolina.

Mitch Creem serves as chief executive officer for Keck Hospital of USC and USC Norris Cancer Hospital, an enterprise consisting of 471 patient beds and medical services staffed by personnel numbering 2,800. He came to USC in June 2008 as vice provost to provide leadership and guidance as the university negotiated to acquire the hospitals from Tenet Healthcare Corporation. He became CEO in April 2009. Before coming to USC, Creem served as the associate vice chancellor and chief financial officer for the UCLA Medical Sciences, a group of institutions that includes the Geffen School of Medicine at UCLA, UCLA Faculty Practice, and the UCLA Hospital System. In addition to these duties, Creem served briefly as interim chief information officer for UCLA Medical Sciences, where his primary focus was on developing the information technology strategy and transition plan for the new hospital buildings. Creem arrived at USC with 25 years of management experience, covering all aspects of the health-care industry, including hospital, research, and faculty group practice management. Before joining UCLA, Creem was chief financial officer for the Beth Israel Deaconess Medical Center, a Harvard teaching hospital, and the Tufts Medical Center, a Tufts University teaching hospital. For both, Creem implemented turnaround plans leading each from significant operating losses to profitability within two years. Creem has also held several key administrative and financial positions at Massachusetts General Hospital in Boston, where he helped launch

two for-profit subsidiaries in international telemedicine services and hardware/software sales. He also worked for several years in a senior management position at the Healthcare Practice Group of PricewaterhouseCoopers, where he was responsible for numerous consulting engagements, financial statement audits, and financial feasibility studies. In the hospital and health-care sector, he has considerable experience with business valuation and pricing strategies; organizational, financial, and governance structures; strategies for clinical and operational consolidation; bankruptcies and reorganizations; and health-care start-ups. He has served on numerous boards of community hospitals and hospital and physician joint ventures. Creem holds a master's degree in health administration from Duke University and a B.S. in accounting and business administration from Boston University.

Christine Malcolm is the academic medical center practice co-leader, West Coast health-care leader, and managing director for Navigant Consulting Inc. Malcolm is a nationally recognized strategic health-care executive with experience in leading transformational change in several of the leading health-care systems and academic medical centers in the United States. She has proven expertise in areas of health-care leadership most important today—including organizing for innovation, mergers and acquisitions, strategy and growth, response to health reform, physician integration and alignment, performance improvement, and clinical program development. Previously Malcolm served as a member of the senior executive team at three well-known health-care organizations: Kaiser Permanente, Rush University Medical Center, and the University of Chicago Medical Center. She has served as a consulting leader at Navigant, CSC Healthcare, the University Health System Consortium, and PricewaterhouseCoopers. In each of her senior executive positions, Malcolm was engaged in leading transformational change. In both university settings, she led growth and strategic development across the enterprise, including science and academic planning. She also was a member of the Rush University faculty. A majority of Malcolm's consulting experience has been in the academic setting, and continues to be so at Navigant, where her clients include the University of California at San Francisco, eight academic children's hospitals, and the Association of American Medical Colleges. While at the University Health System Consortium, she led several national strategic studies on the impact of managed care on the academic health center and physician workforce; mergers, acquisitions and de-mergers; physician models fostering success in academic health centers; and organization, governance, and leadership success factors for academic health centers. An active speaker, Malcolm has presented research and facilitated planning retreats in more than 50 academic health centers as well as to the Institute of Medicine of the National Academy of Sciences and numerous other national academic, scientific, specialty society, and health-care meetings. Malcolm received her MBA in health-care administration and her baccalaureate degree in public affairs from the University of Chicago.

Steven L. Wantz is senior vice president for administration and chief of staff at Indiana University Health (IU Health), Indiana's most comprehensive academic medical center and one of the busiest health systems in the United States, comprised of five hospitals in the Indianapolis central region as well as hospitals in key geographic regions across the state. Wantz began his health-care career at Methodist Hospital in 1982. Since that time in his various roles with Methodist and IU Health, he has provided leadership in human resources, organization design and development, strategic planning, quality improvement, regulatory compliance, physician relations, operations improvement, and board development. Wantz serves on a number of not-for-profit community and faith-based boards. He earned both his master's degree in industrial relations/management and bachelor's in sociology/clinical psychology from Purdue University.

CHANGE-MANAGEMENT EXPERTS

Chip Heath is a professor at Stanford Graduate School of Business, teaching courses on business

strategy and organizations. He is coauthor, along with his brother, Dan, of two books, including their most recent book, *Switch: How to Change Things When Change is Hard,* and *Stick: Why Some Ideas Survive and Others Die.* Chip Heath has taught courses on organizational behavior, negotiation, strategy, international strategy, and social entrepreneurship. Prior to joining Stanford, he taught at the University of Chicago Graduate School of Business and the Fuqua School of Business at Duke University. His research has appeared in academic journals in psychology, economics, and management. Popular accounts of his research have appeared in *Scientific American,* the *Financial Times, The Washington Post, Business Week, Psychology Today,* and *Vanity Fair,* and he has appeared on NPR and National Geographic television programs. Chip Heath received his B.S. in industrial engineering from Texas A&M University and his Ph.D. in psychology from Stanford University.

Dan Heath is a senior fellow at Duke University's CASE center, which supports entrepreneurs fighting for social good. He is a columnist for *Fast Company* magazine, and he has taught and consulted with organizations such as Microsoft, Philips, Vanguard, Macy's, USAID, and the American Heart Association. Previously, Dan Heath worked as a researcher and case writer for Harvard Business School, coauthoring 10 case studies on entrepreneurial ventures, and later served as a consultant to the policy programs of the Aspen Institute. In 1997, he co-founded a publishing company called Thinkwell, which continues to produce a radically reinvented line of college textbooks. He currently serves on the board of trustees of Rare, a conservation organization. Dan Heath has an MBA from Harvard Business School, and a B.A. from the Plan II Honors Program from the University of Texas at Austin.

Yoram (Jerry) Wind is Lauder Professor and professor of marketing at the Wharton School of the University of Pennsylvania, director of the SEI Center for Advanced Studies in Management, and academic director of The Wharton Fellows Program. Wind joined The Wharton School faculty in 1967. During his tenure, he has piloted development of the Wharton globalization strategy, and led the reinvention of the Wharton MBA curriculum and the creation of the Wharton Executive MBA Program. He was founding director of the Joseph H. Lauder Institute and the Wharton International Forum. Wind has served in editorial positions for many top marketing journals and has published more than 250 papers and articles and more than 20 books. He has consulted with more than 100 companies, and provided expert testimony in intellectual property and antitrust cases. He is a member of the advisory boards for various entrepreneurial ventures, board member of Fox Chase Cancer Center, trustee of the Philadelphia Museum of Art, and co-chair of its Digital Age Committee. Wind was recently selected as one of the 10 Legends of Marketing, with eight volumes of his writing to be anthologized by Sage. Wind received his M.A. and B.S. degrees from The Hebrew University in Jerusalem and his Ph.D. from Stanford University.

WORKSHOP FACILITATORS

Peter D. Eckel serves as vice president for governance and leadership programs at the Association of Governing Boards of Universities and Colleges (AGB). He is responsible for AGB Consulting as well as the National Conference on Trusteeship, the Institute for Board Chairs and Presidents, and the Presidents Academy on Trusteeship. Eckel has written and spoken extensively on academic leadership, institutional change, and campus governance. He has written and edited six books—most recently *Changing Course: Making the Hard Decisions to Eliminate Academic Programs* and *Privatizing the Public University: Perspectives from Across the Academy*—and 22 nationally disseminated papers as well as numerous articles and book chapters. He was the lead author of *The CAO Census*, the first national study of chief academic officers. His papers have appeared in *Trusteeship, Change Magazine, The Journal of Higher Education, The Review of Higher Education*, and *Higher Education Policy,* among others. Additionally, Eckel serves as associate adjunct professor in the University of Pennsylvania's Graduate School of Education, teaching in its executive doctorate pro-

gram. Prior to joining AGB, Eckel worked at the American Council on Education (ACE) where he created and ran the ACE Institute for New Chief Academic Officers, the Advancing to the Presidency Workshop, and the ACE Presidential Roundtable Series. Eckel earned his doctorate from the University of Maryland, College Park, in education policy, planning, and administration, and his bachelor's degree in journalism from Michigan State University. He has been a fellow at the Salzburg Seminar in Austria and at the Centre for Higher Education Transformation in South Africa.

Susan Jurow retired as senior vice president for professional development from the National Association of College and University Business Officers (NACUBO) 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. The projects included: 1) bringing together senior administrators from higher education with change agents from health care to determine what lessons can be learned from health-care's change trajectory over the past 20 years; 2) creating a series of case studies that capture the essence of contemporary concerns and horizon issues for business officers in higher education; and 3) developing a cadre of institutions committed to using the Baldrige methodology in the form of NACUBO's *Excellence in Higher Education* and associated tools to assess, plan, improve, and provide organizational leadership. During her tenure at NACUBO, Jurow was responsible for the design and delivery of products and services including the annual conference, workshops, distance learning, and publications. Before coming to NACUBO, she served as the executive director of the College and University Personnel Association (CUPA) from 1996 to 1999. Prior to joining CUPA, she was the assistant executive director for administration and the director of the Office of Management Services for the Association of Research Libraries. She served in public service positions in a number of academic and research libraries including Stanford University and the University of Houston. Jurow earned her master's degree in library science from Rutgers University and a bachelor of arts in French from Stanford University.

John Walda is the president and chief executive officer of the National Association of College and University Business Officers (NACUBO), Washington, D.C. His career has also been in both public policy and law. Walda was president of the Indiana University Board of Trustees for eight years; chairman of the Association of Governing Boards of Universities and Colleges; chairman of the Board of Clarian Health Partners in Indianapolis, which owns and operates the Indiana University hospitals; and chairman of the Indiana Lottery Commission. Before coming to NACUBO, Walda was a partner in the Litigation Group of Bose McKinney & Evans, representing clients in Indianapolis and Washington, D.C., and senior vice president, federal relations, for BoseTreacy Associates LLC. He was elected a fellow in the American College of Trial Lawyers. Walda has been the chairman of the Washington Higher Education Secretariat (2009-2011) and a director of the American Council on Education (2008-2011). He is a trustee for Carroll College, a trustee for Stetson University, a director of the Indiana University Foundation, and a director of the Yellowstone Park Foundation. Walda received his B.A. degree and J.D. from Indiana University.

AUTHORS

Peter D. Eckel serves as vice president for governance and leadership programs at the Association of Governing Boards of Universities and Colleges. *See extended biography above.*

Karla Hignite is a freelance writer and editor and an editorial consultant to the National Association of College and University Business Officer (NACUBO). She has written extensively on higher education business issues as a contributing editor for *Business Officer* magazine and serves as editor of NACUBO's *HR Horizons*, an electronic quarterly newsletter. She previously served on the staff of the American Society of Association Executives as a senior editor.

APPENDIX: Resources for Further Reading

The following resources were provided to participants as background or mentioned during the course of workshop discussions.

The Four Obsessions of an Extraordinary Executive: A Leadership Fable, by Patrick Lencioni (Jossey-Bass, 2000).

"From Mental Models to Transformation: Overcoming Inhibitors to Change," by Jerry Wind and Colin Crook, *Rotman Magazine,* April 2009.

The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, by Gerald J. Langley, Ronald Moen, Kevin M. Nolan, Thomas W. Nolan, Clifford L. Norman, and Lloyd P. Provost (Jossey-Bass, 2009).

The Innovator's Prescription: A Disruptive Solution for Health Care, by Clayton M. Christensen, Jerome H. Grossman, M.D., and Jason Hwang, M.D. (McGraw-Hill, 2008).

The Power of Impossible Thinking: Transform the Business of Your Life and the Life of Your Business, by Yoram (Jerry) Wind and Colin Crook (Pearson Prentice Hall, 2006).

"Redefining Competition Constructively: The Challenges of Privatisation, Competition and Market-based State Policy in the United States," by Peter D. Eckel, *Higher Education Management and Policy,* Vol. 19, No. 1, 2007.

"Redefining Competition in Health Care," by Michael E. Porter and Elizabeth Olmsted Teisberg, *Harvard Business Review,* June 2004.

Switch: How to Change Things When Change is Hard, by Chip Heath and Dan Heath (Broadway Books, 2010).

The Three Laws of Performance: Rewriting the Future of Your Organization and Your Life, by Steve Zaffron and Dave Logan (Jossey-Bass, 2011).

"Viewpoint: Parallel Crises in Health Care, Higher Education," by Patrick Callan and Andrew L. Yarrow, Public Agenda, January 11, 2009 (www. publicagenda. org). Reprinted from *The Baltimore Sun,* January 11, 2009.

"Why Innovation in Health Care is So Hard," by Regina E. Herzlinger, *Harvard Business Review,* May 2006.

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