While higher education and health care share some important characteristics and problems, many hospitals and clinics have achieved more thorough reforms than have colleges and universities.

Governance of many hospitals and clinics has become more strategic, with board discussions focusing less exclusively on budget and finance and more on aligning resources to achieve well-defined goals, including improvements in quality.

Universities could benefit from revisiting the “continuous quality improvement” approach, which sectors of health care now use to pursue evidence-based, systematic improvements.

Evidence-based medicine has become a requirement for hospital accreditation, using metrics from the government and other outside groups. Higher-education performance metrics on student learning tend to come from institutions themselves.

FINANCIAL PROBLEMS PLAGUE BOTH HIGHER education and health care, two sectors that struggle to meet public expectations for quality services at affordable rates. A growing number of people cannot afford higher education, and many universities are cutting personnel, canceling capital projects, eliminating programs, and even turning students away. Health care has parallel problems.
Contagious ideas from health care
Access to care is a national issue, with resource shortages stressing both consumers and providers of health care.

Both higher education and health care also have a complex bottom line, heavy reliance on relatively autonomous professionals, and clients who share personal responsibility for achieving successful outcomes. Each sector is pursuing an array of initiatives to deal with significant public concerns, and both continue to seek effective ways to deal with their highly complex systems and difficult environments.

As someone who has both headed universities and served on the board of a health system with many clinics and hospitals, I firmly believe that higher education can find valuable ideas in health care—ideas that validate what some universities are already doing, and ideas that are less familiar but may have potential for universities.

To illustrate, in 2001 the Institute of Medicine at the National Academies reported that 98,000 people were dying annually due to preventable medical errors; it identified the culprit as the delivery process for complex care, not recklessness or incompetence. The horrifying statistic prompted significant responses. The Institute for Healthcare Improvement (IHI), a large non-profit organization based in Massachusetts, launched a highly successful “100,000 Lives Campaign,” which systematically identified and worked to eliminate the root causes of preventable errors through such countermeasures as differentiated packaging for similar medical products. IHI followed up with a similarly effective “Protecting 5 Million Lives from Harm Campaign.” This safety-focused approach identified so many research-based ways to improve care that the IHI has published an online map to help providers find what they can best use.

In higher education, a similar campaign is emerging to create the 15 million more college graduates that America’s economic growth requires. Lumina Foundation for Education and others are leading a major national thrust to improve access, focusing on “making opportunity affordable.” Many past calls to reform higher education have fizzled out before making a major, systemic difference. This one may work, and it has some of the same features as the IHI campaigns, including a clear, focused agenda; a number of key partners; and access to significant resources.

In addition to these changes in health-care delivery, governance of health care has also changed. According to Jim Bentley of the American Hospital Association, “Trusteeship is no longer just honorific in health care, and board contributions extend far beyond the financial. There is much more accountability and much more work on a broader scope of issues, without getting into operations. They’ve gone from a nice annual dinner to deep strategic engagement.”

I know from my own experience that health-system board members began asking different kinds of questions than in the past. They began asking how many deaths might have been prevented in their own hospital’s operations and what more could be done to avoid them. Often their fresh perspectives have helped executives identify additional ways to improve health care.

By no means does health care get everything right, but often what happens to health care institutions happens to higher education a few years later. Maybe we can get ahead of the curve. And in fact, a growing number of college and university boards are stepping up their strategic focus.

It’s About Quality

Although few would dispute the claim that the quality of American higher education is the best in the world, that claim actually is hard to prove. Clearly, we have some of the best universities in terms of brilliant, international prize-winning faculty members and breakthrough scientific research. But when it comes to student learning, we just don’t have much collective data to substantiate the claim. Importantly, some assessments have gained traction in higher education, such as the National Survey of Student Engagement and the Collegiate Learning Assessment. However, such assessments are voluntary, and it’s up to institutions to decide whether to release their results publicly.

Health care has taken a leadership position in defining quality, measuring it, giving data to consumers, and systematically supporting the behaviors that produce quality. Perhaps that is because the consequences of mistakes in health care are so serious. Yet some of our mistakes in higher education also have serious consequences for the individuals affected, including wasted time, wasted money, and high debt that can haunt college dropouts for decades.

Evidence-Based Medicine

In the last decade, evidence-based medicine has become a requirement for hospital accreditation and therefore an institutional matter, resulting in less variation in the treatment of individuals with the same condition. Many steps in the hospital’s patient-care process now have mandatory checklists and protocols. On-site hospital accreditation reviews now focus primarily on “tracers”—randomly selected patients’ experiences from start to finish, which are subjected to thorough analysis to see whether providers both used and documented best practices. Would higher education benefit from evidence-based teaching, advising, or management?

If higher education were to act as health providers increasingly do, we might have:

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- Detailed analyses of individual students’ learning experiences from matriculation to graduation;
- Much more funded research on effective teaching practices;
- A national clearinghouse on quality metrics in higher education;
- A national consortium of faculty associations to define and promote best practices in teaching and learning;
- More systematic, widespread, and comparable publicly reported data on educational quality, both by institution and individuals’ experiences; and
- Measurable goals for improvement and reports on educational quality at every board of trustees meeting.

We know a good deal now about learning styles and effective teaching strategies, but “evidence-based teaching” is not currently a widespread concept in higher education. In fact, many university faculty members still have little or no formal education in how to teach, especially compared to pre-collegiate teachers. To their credit, many universities have excellent programs to help faculty members improve their teaching, but these are typically voluntary and may depend on resources that are increasingly difficult to find.

**Metrics**

In contrast to higher education, quality measures derived from research evidence on patient care are everywhere in health care. The federal government, professional associations, and accreditors are deeply involved in measuring patient outcomes and making the results available to all. Consumers can compare providers’ quality indicators on Web sites such as www.hospitalcompare.gov, www.qualitymeasures.ahrq.gov, www.healthgrades.com, and www.qualitycheck.org. (In fact, there are so many indicators that providers cannot possibly track and improve their progress on all of them at once.)

While health-care metrics tend to come from diverse outside organizations, higher-education performance metrics on student learning tend to come from institutions themselves. They often are home-grown, each attempting to respond to its own mission, priorities, and academic or campus political mandates. This makes it very difficult for consumers to gain a strong sense of what is most important or how well institutions are doing over time or how they can be compared with one another overall. Some metrics for student-learning outcomes, such as the National Survey of Student Engagement, are gaining greater attention, and systems being organized by public and private colleges and universities are emerging at the national level with the goal of helping students and families compare institutions on dimensions of educational quality. These are, however, still in their formative stages in terms of providing information on core learning outcomes.

**Systematic Quality Improvement**

Some sectors of health care now demand continuous quality improvement and pursue it systematically. Known by terms such as Lean, Six Sigma, or the Toyota Production System in health care, this kind of evidence-based, systematic quality improvement has characterized manufacturing organizations for many years. The basic premises are simple, but adopting this approach requires a major transformation for most organizations.

Quality improvement in higher education is much less systematic, for the most part. True, quality assurance is the fundamental premise of regional accrediting associations in higher education, but their definitions, indicators, and expectations of quality vary from one organization to the next. Many universities have adopted specific research-based improvement strategies, especially for student retention. Both higher education and health care adopt well-respected programs, but health care is far more likely also to pursue the more fine-grained, analytical, local-process improve-

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**It’s About Capacity**

Public concern about excessive cost is high for both health care and higher education. While the debate usually emphasizes the cost to patients and students, the underlying crisis is how much it costs each enterprise to operate its current business model. The fact that growing numbers of people can afford neither health care nor higher education is a symptom of the runaway costs of providing them. The price of health care is high because it costs a lot to do health care the way we do. The same is true in higher education.
Questions Trustees Might Ask About Improving Quality

- Do our faculty members know and practice effective teaching strategies?
- Do we have an effective retention program?
- What do their employers think of our recent graduates?
- What are the best indicators of quality for our university, and how are we doing on those?
- Given our mission, what, if anything, is as important as or more important than student-learning outcomes?
- What quality data do we make public?
- What initiatives or programs do we have to systematically improve the quality of student learning? Are they working? How do we know?
- Do we participate in any national quality studies? What are we learning from that? What are we doing about our results?
- Where are we doing well in adding value for students? Where could we improve?
- Could we graduate more of our students without increasing the cost?
- What processes add significant value for student learning? What are we doing that does not add significant value to student learning?

Both health care and higher education in the United States cost more than twice the comparable figures in other developed countries, whether measured by resources per unit of service or share of gross domestic product. Moreover, both sectors’ costs are rising faster than the economy. About three dozen other nations have better health-care outcomes than we do, and at least 10 other nations have higher rates of college completion and relatively more college-educated adults.

To help institutions increase their capacity while containing costs, higher-education boards are going to have to be more engaged with institutional strategy and focused on results. Not long ago, health systems might have had strategic plans, and their trustees might have been involved in shaping them. It is different now for many health-care boards. The emphasis is on aligning all their available resources to achieve well-defined goals through thoroughly vetted and deeply understood strategies.

Involving trustees at this level allows them to contribute expert advice in new ways, drawing on their diverse backgrounds and broad experience. It also requires good communication and mutual respect to ensure that the board and the chief executive officer do not cross into each other’s roles.

One way to increase capacity is to decrease cost by discontinuing anything that does not add value to the expected results. In health care, that includes cutting unnecessary tests. In higher education, it could mean changing academic requirements that are based more on departmental self-interest than student learning. It could also mean making some very difficult discussions about the appropriate level of support for functions that are not part of the core mission.

University leaders dealing with scarce resources often believe they need to cut academic programs based on high cost or questionable mission relevance. By contrast, cutting services in this way is not on the agenda of many financially stressed health-care systems. The ability to identify more subtle but equally effective cost savings is one of the major benefits of systematic quality improvement.

For example, some health systems assign nurses to work closely with individual patients who have chronic diseases to fine-tune their treatment and promote their compliance with medical advice. This may seem like added expense, but it often lowers costs due to early intervention and increased compliance. MeritCare Health System partnered with Blue Cross Blue Shield of North Dakota in a pilot project to explore this approach with diabetes patients. In one year, the program saved over $330,000.

Academic advising at its best can also customize the student experience. In its most powerful manifestation, the student’s curricular pathway would lead directly to the student’s desired outcome, with no filler courses and no need to retake a similar course after transfer because of some institutional requirement. When the student encountered academic problems, he would have supplementary learning opportunities that best fit his specific content needs and learning style, to get him back on track in the shortest time. Another student would have expert advice on the best co-curricular or internship options to maximize her post-graduate employment opportunities. Such an approach gives “student-centered learning” new meaning.

One very powerful tool that is taking hold in health care to focus board and executive discussions is the “balanced scorecard,” containing key indicators of...
organizational health to identify progress and areas needing extra attention. Such indicators may include total expense per patient discharged, 12-month personnel turnover, or composite indexes representing several indicators, such as a safety index. The scorecard becomes the centerpiece of board meetings, a powerful tool to generate significant board-level discussions, and an effective aid to smooth executive transitions.

Similarly, some colleges and universities are using dashboards or scorecards to help them focus on results. Balanced scorecards, based on the work of Robert Kaplan and David Norton and elaborated by others, have indicators in areas that are essential to organizational success, track performance over time on desired strategic results as well as basic organizational health, and use benchmarks based on both self-selected targets and best-practice performance elsewhere.

The National Association of College and University Business Officers has helped its members learn about and use balanced scorecards for several years. However, it appears that most of our balanced scorecards relate to departments or divisions within a university. The academic area tends not to be included, and few if any uses are university-wide. As with systematic quality improvement, higher education’s adoption of the balanced scorecard has been limited in both scope and number of institutions adopting it.

**It’s About Leadership**

Presidents have never needed appropriate, proactive trustee leadership alongside them more than they do today. Stressful conditions bring out strong opinions on all sides and make presidents especially vulnerable to criticism, no matter what they do. Rather than having presidents succumb to the temptation to keep a low profile and avoid major change, trustees who are committed to fulfilling their fiduciary duties owe presidents who demonstrate strong and effective leadership their own best thinking and support. Universities and presidents need trustees to embrace that responsibility without stepping into a managerial role.

Fiduciary and strategic roles have taken over the agenda of the health-system board on which I serve. We used to spend hours on financial statements, budgets, and medical privileges. Now we are focused on the mission and vision, quality improvement, balanced scorecard trends, and major strategic moves. All of our trustees and executives are focused on aligning the system’s strategies, people, and financial resources with its mission of delivering on the promise of integrated health care.

To adopt a similar focus, a university board’s agenda might begin with a review of progress on the latest version of a balanced scorecard, perhaps generating questions about when the new program to improve student retention might be expected to impact the numbers, whether cost per student by discipline is a useful metric for strategic decisions, or whether we are spending more than our peers on marketing.

The academic-affairs committee could report on a study of typical student pathways through the curriculum to identify streamlining opportunities, a faculty project to reduce time spent on routine functions and support faculty efforts to reach more students more effectively, or potential strategies to bring evidence-based teaching into all classes.

The student-affairs committee might report on a comprehensive study of roadblocks to student success at the university and how the results will translate into the next revision of the strategic plan. The financial-affairs committee might have exciting news about cost savings attributable to quality-improvement projects and progress made in defining and measuring capacity throughout the university. The budget discussion could focus on how resource allocation drives achievement of the strategic plan.

Among the most consistent conclusions in studies of organizational response to stress are these: the best solutions build on the institution’s strengths; there are no magic bullets; and success requires multiple initiatives that are mutually reinforcing and synergistic. In the end, the best strategies for your college or university are the ones that arise from the best thinking on campus and in the board room, thinking that is focused on a serious re-commitment to improving quality and capacity.

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