

student health SPECTRUM

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Performance Measurement In Student Health Centers: What Information is Reliable?

by Stephen C. Caulfield

At this year's ACHA meeting in Philadelphia, Gary Frederickson of California Polytechnic University, Pomona; Dana Mills of Marquette University, Milwaukee; and Evelyn Wiener of the University of Pennsylvania, Philadelphia, presented the ten new recommended ACHA benchmarks for Student Health. (See page 6.) These benchmarks are designed to be simple, but meaningful, comparisons of demand, use, resources consumed (both capital and human), resources available for mental health and health education, compliance with immunization requirements, and member satisfaction.

Data definitions accompanied each recommended benchmark, although the consensus among both the presenters and the participants was that these data definitions allowed considerable latitude of interpretation. Since most of the benchmarks are rates per thousand or ratios, this latitude in data definition could cause significant variation in a number of the denominators used, resulting in variation within the calculated benchmark where little or no variations may actually exist. The presenters noted this concern. Furthermore, the presenters noted that observed differences in reported benchmarks might well be attributed to differences in the scope of practice, the mission of the Student Health Service, and/or the availability of the alternative clinical resources proximate to the campus.

Why all the attention to benchmarks, and to the quality and reliability of the data which produces them? There are many reasons, but principal among them is the increasing competition for limited financial resources on most campuses. This competition for resources causes both those within Student Health Services (SHS) and those with oversight responsibility, to ask the question "How are we doing compared to our peers?" Furthermore, three equally important questions are posed: "Are our peers providing the necessary and appropriate services?"; "Are they doing it efficiently?"; and, "How did they get their results?" We've all had the experience of observing some extraordinary accomplishment only to quickly ask, "How did they do it?"

The question of measurement is, of course, not limited only to Student Health, but is a central issue with regard to all health care. Last year's July/August Issue of *Health Affairs* was devoted to "Measuring Plan Performance Quality in an Information Age" and the news was not encouraging. The lead article by David Eddy, M.D., stated, "The net effect of all these data quality problems is that today's measures tend to be blunt, expensive, incomplete, and distorting." A fairly sweeping indictment, particularly considering Dr. Eddy served on the Committee on Performance Measurement which developed the Health Plan Employer Data and Information Set (HEDIS®). Two issues later, in the same journal, J.D. Kleinke wrote "The Health

(continued on page 4)

Excerpt from the *Association of American
Medical Colleges Reporter*, June 1999

“Medical Schools Training for Reality of Managed Care”

by Cari Coleman

According to preliminary data from the AAMC's 1999 Medical School Graduate questionnaire, 60 percent of students think not enough time is devoted to managed care in the educational setting. “Managed care and academic medicine are two very different cultures,” observes M. Brownell Anderson, Associate V.P. for Educational Programs at the AAMC. “A major challenge we face is bridging these two cultures. There is certainly more activity under way in medical education to begin building those bridges than in the past, but I think that's going to take some time.”

Two “Cultures” Team Up

Aetna U.S. Healthcare, one of the nation's largest managed care companies, took a bold step in reorganizing the interests of medical schools and teaching hospitals by creating the Academic Medicine and Managed Care Forum, two-and-a-half years ago. “What's positive about Aetna,” says Anderson, who serves on the forum's Medical Education working group, “is that they're trying to meet academic medicine partway, instead of dictating the terms and conditions of the dialogue. And through medical schools' participation with them, they are learning about the culture and needs of the medical school.”

“Managed care companies were seen as bottom-line driven and profit-motivated, while academic medical centers were seen operating with little regard to cost. We didn't think either assumption was fair,” says Dennis Oakes, Executive Director of the forum.

The forum brings together 40 academic institutions and 36 representatives from business, professional societies, associations, and health organizations. One high-priority activity is conducting the research needed to demonstrate the effectiveness of managed care principles. “Our goal,” says Oakes, “is to put findings into practice, and to work with organizations that have similar ideas.”

Aetna and their corporate partners awarded \$6.8 million to participating academic centers last year, examples include a \$299,994 grant to Johns Hopkins University School of Medicine to evaluate indicators of quality in primary care, and a \$359,943 grant to Yale University School of Medicine to research recovery following coronary bypass grafting surgery in women.

New York Medical College has partnered with Aetna to introduce its students to primary care in a managed care outpatient setting, and to give faculty an education in managed care. “An Aetna health care provider agrees to teach one of our first-, second-, or third-year students in primary care or

family medicine,” explains Martha Grayson, M.D., Senior Associate Dean for Primary Care.

Aetna also sponsors workshops for faculty to enhance communications skills between doctor and patient, and in their teaching. “in regard to communication skills, we've found that what makes you a better doctor also makes you a better teacher,” Dr. Grayson says.

Doctors on Aetna's staff who serve as preceptors in this program are reimbursed at 0.5 percent capitation, as are those who take part in the communication skills training. Through this contribution, says Dr. Grayson, Aetna helps to defray educational costs. “This makes the agreement unique, and it sends a strong message that a managed care company is willing to do that.”

Special Thanks to Todd Bentsen, Managing Editor of the AAMC Reporter for allowing Student Health Spectrum to reprint the above excerpts.

Aetna U.S. Healthcare is Chickering's principle underwriting partner providing Chickering's clients with access to Aetna U.S. Healthcare's nationwide network of participating physicians, hospitals, and pharmacies.

Benchmarks for College Health

by Evelyn Wiener, M.D.
and Gary Fredericksen, M.Ed.

A benchmark can be a point of reference from which measurements are made, or it can serve as a standard by which others are measured. The importance of benchmarks for college health is reiterated in ACHA's newly revised Guidelines for a College Health Program, which sanctions college health programs to measure the impact of services on the health of the community and to demonstrate that services are delivered efficiently and effectively.

The Benchmarking Work Group has been working to identify an appropriate set of benchmarks for the college health field. The intent is to create a process of benchmarking that measures the practice of college health and identifies the best practices of health services throughout the country. The Work Group recommends that data collection for benchmarking and for the ACHA Datashare project be integrated, as many of the same data elements are present in both projects. Other recommendations are that it be simple to participate in the benchmarking process, that participation be inexpensive or free, and that, whenever possible, the benchmarks incorporate ACHA's Guidelines for College Health Programs.

Although benchmarks for college health should be mindful of the work of other educational and clinical associations, the selection and interpretation of these measures should reflect the status of college health services as both clinical practices and as service providers within their educational institutions. While it is important that college health benchmarks be consistent with quality indicators used by clinical accrediting organizations such as Accreditation Association for Ambulatory HealthCare (AAHC) and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO),

college health centers frequently assume administrative, educational and public health responsibilities outside the scope of traditional medical practices. In a similar vein, administrative organizations, such as the National Association of College and University Business Officers (NACUBO) and the National Association of Student Personnel Administrators (NASPA), may have a different focus and perspective on issues of cost, efficiency and productivity. They may not interpret utilization benchmarks in the same way as individuals in Student Health Services and they may not fully consider the clinical or medical interests of college health.

THE BENCHMARKING SURVEY

The Work Group has identified a number of measures to serve as the initial benchmarks; these measures and the reason for their selection are listed below. It is important to recognize that a variety of factors may influence the performance of any campus on these benchmarks. These include student demographics, characteristics of the campus, and institutional policies. The scope of service will have a major impact on the benchmarking profile of a health service. The presence of health promotion or mental health programs, in particular, will influence the performance of any program.

The Work Group recognizes that the initial set of benchmarks is imperfect and incomplete. The measures are written broadly and will not capture the full scope of practice for most health services. A survey that more completely reflects the diversity of practice amongst college health services should be provided in the full Datashare survey. That said, this initial benchmarking survey should provide valuable data to the field of college health and to the individ-

ual participants alike. The results of the survey will direct the revisions and refinements to the benchmarks.

ACHA's first benchmarking survey is now in its final stage of editing and revision. The target date for mailing is October 1, 1999 with a return date of November 25, 1999. Results will be available in the Spring of 2000. Health services that choose to participate will have the option of receiving individualized reports in which the results of the individual institution are compared to the aggregated results of "cohort" schools. The Work Group will also present a report at the Annual Meeting in Toronto.

The Work Group hopes to identify other benchmark measures, especially those that reflect clinical and/or academic outcome, issues of diversity and the health of the campus community. All ACHA Task Forces and Work Groups will be encouraged to develop benchmarks that can be used to assess their areas. Another objective for the Work Group in the coming year is to develop a standard patient satisfaction survey. The intent is that this survey incorporate four or five measures that would be asked by all participating institutions; schools could include additional items particular to their campus or services as they see fit.

Finally, the Work Group and ACHA will be exploring collaborative relationships with accrediting agencies and with related professional associations. These relationships can encompass the development of standard benchmarking measures, the actual process of data collection, analysis and reporting, and the use of benchmarking results for accreditation itself.

(See page 6 for List of Benchmarks.)

(continued from page 1)

Information Technology (HIT) products are complex; they require testing; and many of them will fail."

So where is the Student Health field in this difficult environment where benchmarking is desired; where evidence-based medicine is the vogue; where performances and productivity measures are sought; while the scientific literature is saying 'not so quickly!' because of data quality and availability? Indeed, a recent issue of the *Journal of American Medicine* (JAMA) suggested that individual physician's practices do not contain statistically significant sample sizes for meaningful comparisons of many types of similar clinical events.

At Chickering, we believe that despite the limitations of existing data, Student Health Services can develop approaches to use the available data and information to improve the performances of student health programs at the Student Health Services level, at the broader level of the student health insurance program, and perhaps, most importantly, to also create a healthier environment and learning experience on each campus.

These improvements can include: the more efficient use of resources, improved quality of care, improved patient satisfaction, more effective compliance with treatment, more cost-effective use of prescription drugs, improved health education, reduction in risk behaviors, and a stronger "value" image within the university community.

To achieve these results, Student Health Services must start with the data they know with reasonable certainty. First of all are the demographics. The populations at risk can be known in considerable detail. For example, students can be identified by factors such as age, gender, marital status, health status and health risk, zip code of home address, and usually some form of academic program identifier. Further, virtually all the campuses have information concerning residence life, academic loads, athletic programs and financial aid. Spence Turner, M.D., and his colleagues at the University of Kentucky have gone further. Building on the survey work of the Center for Disease Control and the ACHA, they have identified and quantified six specific areas of health risk behaviors and are currently designing Primary and Secondary Prevention Programs for each.¹ While Dr. Turner's work is specific to the

University of Kentucky, Mary Hoban, at ACHA, is directing the National College Health Assessment, which adds significant richness to our understanding of the population at risk.

In addition to demographics, we know a great deal about the resources committed to campus-based student health services. These can be quantified by measurements of space, equipment, personnel and contracted services, as well as those resources funded by the university and/or sponsored research.

Beyond the denominator of the population at risk and the resources committed, a great deal can be known about the numerator of the visible demand for student health services. What is missing, of course, is the non-participating student who may have very real, but non-visible needs. Unfortunately, the old line from the country and western ballad, "when the phone don't ring, I know it's you" does not apply to college health. We do not know what we do not know, although estimating technologies do exist. Thus, we can measure both resources and demand with an acceptable level of confidence.

But can we measure the health delivery process? While we can measure visits, admissions, prescriptions, laboratory tests, and other clinical encounters, we know less about what goes on in the actual encounter. Problems of upcoding, miscoding, inter-rater reliability, patient understanding and compliance, and other complexities, make 'transactional' measurements more difficult to compute. These uncertainties are compounded in insurance data, which are derived from claims data, and lack the detail and peer review of the medical record. These data problems are confounded by huge variation in practice patterns. For example, a few years ago, *The Journal of The American Board of Family Practice* reported that eighty-two family practitioners in the state of Washington suggested 137 different strategies for treating lower urinary tract infections in women.

Still, in college health we know substantially more about resource need and effective use than the medical group practices and the HMOs in the community do, because of the knowledge of the student populations and the considerable control the SHS has over the delivery system.

To begin organizing the existing information about student health, Chickering asked a number of leaders in Student Health what they thought were desirable measurements. (See *Spectrum*, Winter 1999, Vol.1, Number 2 on www.chickering.com for complete measurement topics.)

More recently, in a workshop we conducted for the New England College Health Association (NECHA), we asked the twenty-two participants what data they used to run their centers. Using a travel metaphor, most SHS programs felt they had sufficient data points to select their destination, to choose the most effective route, to develop the appropriate vehicle, to help them operate it efficiently, and, finally, to help count the milestones along the way. And while there was a considerable consensus about what they knew, there was also notable variability in how these data were translated into programs.

In an attempt to think about these management tools in an orderly way, we subsequently developed a simple matrix to cross correlate the availability and reliability of data with its importance to the management of Student Health Programs. We assumed that "importance" had to embrace both care and treatment, as well as health education, primary prevention and improved academic performance.

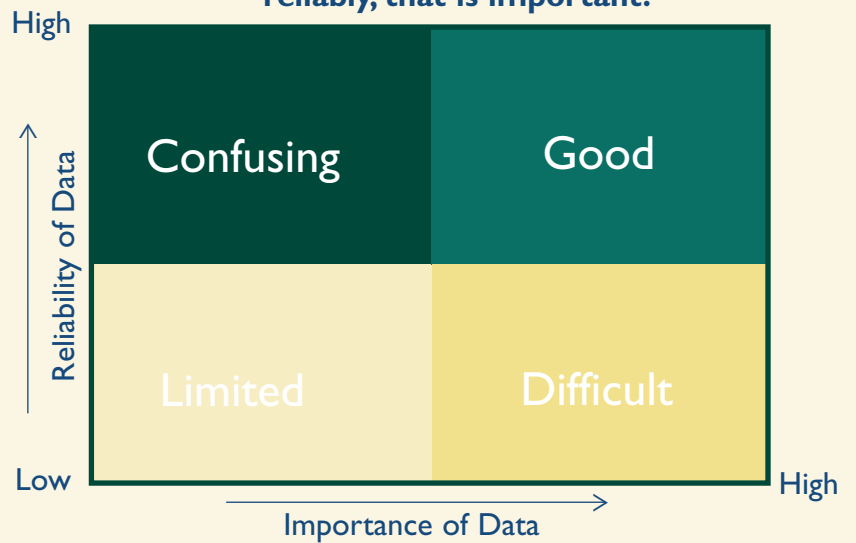
The resulting four quadrants were labeled as follows:

(Clockwise from the bottom left on Figure 1.)

- The data that have low availability and reliability, but also are of limited importance, we labeled "**limited**".
- The data that are available, reliable, but not critically important, we labeled "**confusing**". This quadrant is reminiscent of the old story of the person who looked for his keys where the light was best, although he knew he dropped them elsewhere. This is the quadrant where false or artificial measures of productivity are formed, such as visits per day per full time equivalent, where throughput is confused with productive intervention. High throughput with high revisit rates, low patient compliance, high prescription drug costs, and low patient satisfaction is hardly an efficient use of resources.

¹The six are: Alcohol, Smoking, Exercise, Nutrition, Violence, and Eating Disorders.

Figure 1-Measurement: What do we know reliably, that is important?



· The data that are both strong and important, we labeled "good". These are the data that make the management task relatively easy, because all parties can agree on both the quality of the information and what it means for the program. Resources consumed for the entire population is a good example, as is patient satisfaction

· Finally, the data that are the most important measurements of quality, effectiveness, and performance, appear also to be difficult to capture with reliability and consistency. This final quadrant we labeled "difficult". Measures like outcomes, where few good metrics exist, reside here.

We then used a "Delphic" approach (see Figure 2.) to place the various management tools into this matrix, by consulting with a number of SHS directors and thought leaders. The consensus is shown below. (The rounded shapes suggest softer data; the rectangles symbolize reasonably hard data.) (Note: This chart is specific to student health. For other populations, such as risk management, continuity of care, and detection of a symptomatic disease are all of greater importance.)

The conventional wisdom is that college-age students present both low-levels and relatively consistent patterns of morbidity. If this is true, observed differences in demand, utilization, and cost may be attributed to other variables such as access, plan design, practice patterns, and patient demand differences in family of origin. From a data management and interpretation basis, uniform underlying morbidity has a very significant advantage in that it avoids the need for "groupers" which are data management tools that attempt to assess patient morbidity in the same way.

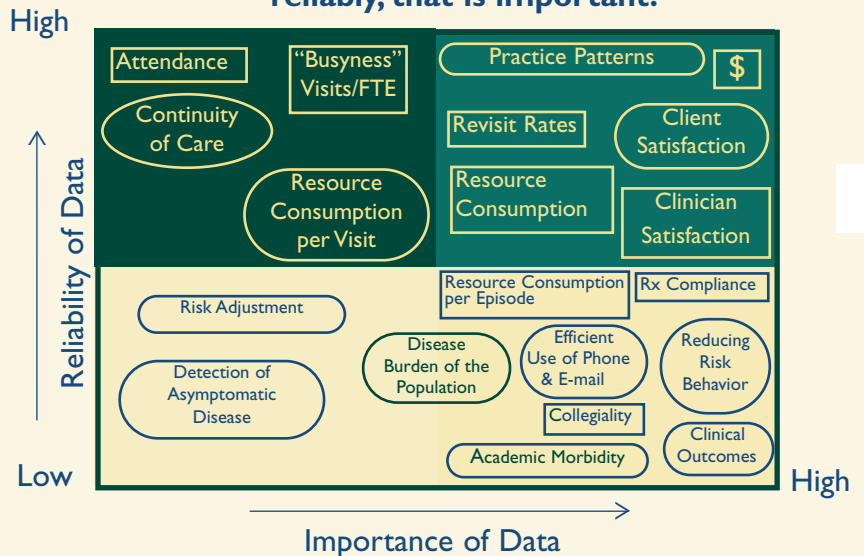
In summary, Student Health's ability to capture meaningful data and apply it to improving programs appears to be somewhat more advanced than the larger health care delivery system in several important ways:

· the richness of data on the population to be served,

- the fact that much primary care is delivered through "captive" student health services where resources utilized can be quantified and where practice pattern variations can be minimized (although the access to clinical care in the community surrounding the campus may confound this variable),
- the consistent patterns of observed morbidity in the student population, and
- a strong consensus among student health center professionals as to what is programatically important to achieve the proper balance among primary, secondary, and tertiary prevention.

Still, much of the important work on the application of data remains in what we have labeled as the "difficult" quadrant of our matrix. The challenge is to engage the clinician in discerning best practices from limited or weak data, while simultaneously improving the quality of data by consistent definition, correlation, reporting, and analysis. Here Chickering applauds the work of the ACHA "Benchmark Task Force" as an important and central contribution to this effort. ■

Figure 2-Measurement: What do we know reliably, that is important?



College Health Benchmarks Listed

(Continued from page 3.)

THE BENCHMARKS

1) The number of eligible student users of student health services as a percentage of total eligible students.

The intent of this benchmark is to provide a view of the share of the student health market that the Student Health Service holds.

This benchmark attempts to measure the efficiency of the providers of the Student Health Service.

2) The number of patient visits by eligible students per total eligible student
This benchmark measures the utilization of the Student Health Service by the student population of the campus.

3) The number of patient visits by A) eligible students, B) all other visits and C) total visits per FTE provider..

4) The cost per patient visit (total).

This benchmark looks at the cost of providing health services for eligible students and others on a per-visit basis.

5) The number of patient visits (total) per gross square foot of facility space.

The purpose of this measure is to define the adequacy or the physical facility utilized by the Student Health Service.

6) The FTE health education staff per eligible enrolled student.

One of the ACHA recommended standards for college health is for "strong health education and campus outreach components." This benchmark was created to assess the staffing associated with reaching this objective.

7) The FTE mental health professional in student health services per eligible enrolled student

University counseling and mental health programs are combined with Student Health Services on a significant number of campuses. This benchmark was created to measure the presence of this service in Student Health Services and to assess the staffing associated with reaching this objective.

8) The number of Pap smears per A) enrolled eligible female student and B) eligible female patient of student health services.

One of the recommended standards for women's health is for annual Pap smears. This benchmark looks at the success of the Student Health Service in providing this service.

9) The number of eligible students in compliance with A) ACHA and/or B) institutional immunization requirements for measles, hepatitis B and PPD tests per total eligible enrolled student.

This benchmark looks at preventative health and public health initiatives and is the first to reflect ACHA recommended standards. This benchmark is included to measure compliance with both the ACHA recommended immunization standards and to create a format for campuses to assess their compliance with their own institutional requirements.

This article originally appeared in different form as the Report of the Benchmarking Work Group to the ACHA Executive Board in December 1998. Gary Fredericksen, M.Ed., Director of Student Health Services at California State Polytechnic University, Pomona, was chief author of the report.

Evelyn Wiener, M.D., is Associate Director of Student Health Services at the University of Pennsylvania.

In the SPOTLIGHT

Student Health Insurance Eligibility and Enrollment: Best Practices for Hard Waiver and Mandatory Plans

by Joanne Gladstone

Summer at The Chickering Group is no day at the beach—client school brochures are written, edited, and produced against tight deadlines. Enrollment begins early summer and runs through September. The Enrollment and Eligibility Department's main objective is for the enrollment process to be completed with ID cards issued by the date the plan year begins, usually in mid-August.

In the past, enrollment data were submitted as registration periods came to a close and the designated office on campus could be sure the list was accurate, usually sometime late in October or early in November. For the most part, this late submission pattern was based on hard waiver schools wanting to ensure that those students who wished to waive the insurance coverage would not be charged. Although administratively effective, this motivation did not serve the initial intent of the student insurance plan, which, as noted above, is to secure coverage for those who need it. This methodology no longer meets the needs of today's student.

In an effort to return to the initial intent and convey the highest levels of customer service to those students and dependents who want the insurance plan, several excellent strategies have been implemented at Chickering. Some of these best practices across our client schools include:

- 1. Use of an Enrollment/Waiver card.** This allows students to indicate their coverage choice as early as possible, not leaving those who wish to enroll in the plan to be enrolled by default.
- 2. Firm waiver deadlines set clear guidelines and expectations for institutions and their students.**

- 3. Incremental and early submission of positive enrollment based on point 1.** Institutions now routinely submit a list of those students actively electing insurance coverage as early as mid-July. These students can now be enrolled on the plan, issued ID cards, and obtain pharmacy benefits as soon as the plan incepts.

- 4. Multiple electronic file submissions.** Most eligibility is now submitted using Internet FTP protocol or via email between 5 & 10 times during the plan year. Each file is a complete replacement, thereby enabling a reconciled state with each update.

- 5. Premium billing between the carrier and institution has been de-coupled.** In the past, it was common practice for payment checks to be sent to a carrier or administrator along with the initial enrollment roster, usually delaying submission of that roster. With a pre-negotiated payment and reconciliation schedule, there is no need to delay roster submission for payments. Consequently, claims are paid earlier leaving students and their families happy.

These five initiatives, in conjunction with others, have served to increase student satisfaction with insurance programs while reducing the stress level placed on both the institution and the administrator of the plan. As with all things, the time invested in planning up front has greatly improved the final outcome. As all institutions have unique needs and capabilities, you should work closely with your claims administrator to develop a plan that will best serve all involved.

On-Campus Hazing Survey Results

by Dr. Michael E. Hyde
Vice President of University Relations, Alfred University

Over 325,000 athletes at more than 1,000 National Collegiate Athletic Association schools participated in intercollegiate sports during 1998-99. Of these athletes:

More than a quarter of a million (250,000+) experienced some form of hazing to join a college athletic team.

One in five was subjected to clearly unacceptable and potentially illegal hazing. They were forced victims of kidnappings, beatings or being tied up and abandoned. They were also forced to commit crimes - destroy property, making prank calls or harassing others.

Half were required to participate in drinking contests or alcohol-related hazing.

Two in five consumed alcohol on recruitment visits even before enrolling.

Two-thirds were subjected to humiliating hazing.

Only one in five participated exclusively in positive initiations.

Athletes most at risk for any kind of hazing for college sports were men; non-Greek members; and either swimmers, divers, soccer players, or lacrosse players. The campuses where hazing was most likely to occur were primarily in eastern or southern states with no anti-hazing laws. The campuses were rural; residential; and had Greek systems.

Women were more apt to be involved in alcohol-related hazing than in other forms of hazing.

Football players were most at risk for dangerous and potentially illegal hazing.

Non-Greeks were most at risk being hazed for athletics, even though a Greek system on campus is a significant predictor of hazing.

Eastern and western campuses had the most alcohol-related hazing.

Southern and midwestern campuses had the largest amounts of dangerous and potentially illegal hazing.

Athletes, coaches, athletic directors and college administrators agreed on strategies to prevent hazing:

Send a clear anti-hazing message in policy, education, and enforcement.

Expect responsibility, integrity, and civility on the part of athletes, team captains, coaches, and administrators.

Offer team-building initiation rites facilitated by trained coaches or other adults.

Editor's Note: Dr. Michael Hyde and his colleagues surveyed college athletes at more than 220 colleges and universities. We are pleased to publish this executive summary contemporaneous with this study's release. For further information please contact Sue Goetschius, Director of Communications, Alfred University at goetschius@king.alfred.edu. The hazing study information can be found online at http://www.alfred.edu/new/html/hazing_study.html.

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If you would like to see a topic covered or would like to be a contributing writer, please contact Communications Specialist, Christine Murray, by telephone at (617) 225-2525 or by fax at (617) 225-2140.

Where to See Chickering Next...

We will be participating in the University Risk Management and Insurance Association conference in Albuquerque, New Mexico

September 26-29, 1999

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