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student health SPECTRUM

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1 Quality in Student Health

2 The Journey of Service Excellence

4 Budgeting for Innovation in Student Health Services

Quality in Student Health: Do We Need a New Quality Initiative

by
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(***Author's Note:*** *This article is intended to raise and advance discussions among college health professionals as to whether there are common and consistent quality improvement opportunities in college health. We know from peer review that some of the suggestions that follow are not universally supported. The need for more data and discussion is freely acknowledged.)*

A number of aspects of a quality student health program were reviewed in the last issue of Spectrum (Winter 2001) in the summary of Chickering's Leadership Forum on the topic.

Quality in health care in the U.S. has recently become a top tier concern with the 1999 Institute of Medicine Report on medical errors and the formation at about the same time of a large and prestigious group of private and public purchasers (The Leapfrog Group) to "trigger a giant leap forward in quality, customer service, and affordability of healthcare of all types." (Aetna is a member of Leapfrog.)

In this issue, we will review quality in student health programs from several perspectives, that of the different participants- patients, clinicians, parents and the University; the different responsibilities of student health- direct care, public health and support of the academic missions and, finally, from the different approaches to measuring quality.

Our own perspective here is that of a primary care student health service, which may or may not be fully integrated with counseling services for behavioral health.

The conclusions we will reach are these:

The student/patient will define quality most frequently in terms of convenience and service expectations- e.g. "What I want, when I want it."

The student health clinician will define quality in terms of both process and outcome- e.g. "I was able to determine what was going on, intervene appropriately, have the patient comply, resulting in an efficient use of resources and a favorable outcome."

Parents and Presidents will define quality as "no complaints" and no missed school because of illness.

Direct care will get far more attention for quality measurement and improvement than will the public health mission, because of patient demand, clinician training, and the patient care orientation of the SHS.

Employer-sponsored plan measurements such as Hedis and NCQA have little applicability to student health. The Leapfrog Group's emphasis on safety and preventable deaths will also have little relevance to student health. But, unfortunately, no uniform measures of quality for student health programs have achieved the level of acceptance these other measures have.

If these conclusions are correct, managing a student health service for quality will require bridging the gaps in expectations between the patient and clinician, elevating the importance of public health interventions and developing alternative measures to Hedis and NCQA for student health programs. All of this should be done with an understanding that a principle quality challenge in student health is to identify and treat serious conditions in a population that is generally perceived to be well and to reduce risks and improve the health status for the whole population. Two related quality problems are that many of these more serious issues are in the domain of behavioral health, and conditions with insidious onsets and chronicity are among the more difficult to deal with. Said another way, college health is quite good at identifying and treating acute serious conditions as well as self-limiting minor illnesses and injuries.

(Continued on page 6.)

In the
SPOTLIGHT

The Journey of Service Excellence

By Douglas Plaisted
Call Center Manager

What is Your expectation of Strong Customer Service? Often what the customer expects for service may not always coincide with a company's service objectives. Why does this occur? One explanation is that a customer's expectations can be very subjective and personal while a company often takes a more objective and "vanilla" approach toward servicing their customers. This lack of targeting customers' expectations can be attributed to a company's effort to manage staffing projections, budgets and call volumes, therefore, some Customer Service Centers minimize what the customers' expectations are in order to meet their own administrative requirements. This is not our approach at The Chickering Group. We take the time, effort and expense to determine what our customers expect and have developed and implemented a plan for Continuous Improvement to meet these expectations.

How do we determine the expectations of our customers?

· A quality telephone audit program that monitors at least 2% of all of our calls. This program allows us to collect service data in the areas of accuracy, product knowledge and service success.

· We compile information from customer feedback letters that have given us praise for a job well done as well as offering a critique on how to improve.

· We solicit feedback from our Customer Service Representatives, who are the first line of contact with our customers. They always inform us as to which policies are having a less than positive effect on our customers and are a great source for recommendations.

· Our most recent feedback tool was our investment in an on-line satisfaction survey where we contact individuals who we service and compile data as to what their experience with us has been.

What have we learned from this data? It should come as no surprise that we have learned that our customers do not want gimmicks or unreasonable promises. What they do have are four basic expectations:

1. To be treated with respect.
2. To be given accurate information.
3. To have their issues resolved in a timely manner.
4. To be educated on the uniqueness of Student Health Insurance.

Our constituency can be segregated into two basic groups. The first is the 18-19 year old student who is brand new to health insurance, while the second group consists of medical providers and students who are returning to school, both of whom have an understanding of group health insurance.

The first group has never been responsible for their own insurance so we spend a great deal of time explaining basic concepts such as deductibles, referrals and the difference between in-network and out of network benefits. The second group is a bit more challenging. Medical providers and students who have had insurance previously may understand the requirements of Group Health but they mistakenly try to overlay this knowledge onto our Student Health Insurance Plans. Our Customer Service Representatives spend a significant amount of time in educating this group as to the differences between group and student health insurance and the nuances of the student programs.

Our service plan to address our customers' expectations can best be described as our "Four T's of Service":

- **Technology**, ensuring the Service Team has the most current technology available to them. We have purchased equipment and software, as well as developing our own applications in-house.

  Two examples are the purchase of a new Lucent phone system three years ago and the in-house development of the STAR (STudent Accuracy Response) system. This system houses all of our benefits for the last four years with all of our schools loaded into a point and click database available at the representative's desk.

- **Training**, continuously in areas of product knowledge and service skills. This commitment was evidenced by the hiring of a Corporate Trainer who works in assessing areas of need from internal audit results to changes in the dynamic insurance industry, and then incorporating this feedback into training for the team.

- **Team**, maintaining a cohesive team, free of excessive turnover. We have aggressively hired quality candidates and worked to retain strong members of our current team. Our excellent retention record has been accomplished through instituting team meetings, offering competitive salaries, providing developmental opportunities, and creating attainable career paths.

- **Two-way dialogue**, empowering any member in the department to provide critical feedback to management. We recognize that the Service Representatives are on the "front lines" as the face of the company. Through their interaction with the customers, they are the first to identify a policy that may not be fully addressing our customers' needs as well as any other trends that are occurring. This information is then communicated to the management team where a decision is made on how to disseminate it to the rest of the company

Where do we go from here? Much of what we have experienced over the last three years has been a growing process. We are now truly servicing our customers.

The focus is to continue working towards our service objectives and work to reduce "unnecessary calls", which are those that are either repeat calls or inquiries that could have been answered through other reference materials our customers have available to them.

The ultimate benefit from this continuous improvement is the satisfaction of our customers. Some of the benefits of this program are an improved average speed of answer and our improved ability to resolve problems at the initial call, which has been instrumental in the reduction of our call volume. The running joke might be that through our continuous ability to reduce calls we will be reducing ourselves out of a job; but isn't that the best measurement of our service and product? If the Customer Service department were viewed like the "Maytag repairman" that never had to be used, what would that say about the quality of our insurance product and services? **Efficient, Reliable and Easy** to use. ■

Budgeting for Innovation in Student Health Services-a University of Vermont Case Study

by
Estelle Maartmann-Moe
Director of Health and Wellbeing Center
University of Vermont

In most service organizations and particularly student health services, budgets are built from the ground up-money for persons (salaries and benefits), for places (facilities), and for things (supplies, equipment, travel). Pragmatically, this makes sense since student health is a labor-intensive business and we should commit resources for our people first, and then the things they need to work efficiently.

At the University of Vermont, we have created an exciting adjustment to our "people" budget, a small amount each year for Center for Health & Wellbeing Innovation Grants. What is particularly unique about our approach to budgeting is that these grants are not in an "if there is anything left over" category, it has its own budget line just like salaries and benefits.

"Why do we do this?", "How much is involved?", "How does this work?", and "What are the results?" are four commonly asked questions. Let me address each.

We do this for four main reasons, although there are many other benefits. First, we want and need our staff to feel empowered to think creatively about what our mission is and how we can best achieve our goals. By offering real budget dollars for testing innovative ideas, thinking and questioning become an essential part of people's jobs, just as much as doing their day-to-day tasks.

Second, in a professional organization we want to encourage independent and creative thinking about how the place runs, not rely solely on management for direction. Our innovation grants are an important component in team building and sharing of responsibilities and ideas. It has boosted staff morale, too.

Third, by elevating creativity and innovation, we become more closely aligned with our colleagues in academic departments and in the health sciences. This improves the image of the SHS and results in better customer satisfaction. (If faculty view the SHS as an intellectual backwater, that message gets transmitted to our patients and potential patients, sometimes, not too subtly).

Finally, we get some great ideas, test them, and adopt a few on a permanent basis, and resulting in getting incrementally better at what we do.

Remarkably, this is not an expensive budget item. Last year it represented less than 1% of our total budget. We awarded seven grants. There are of course indirect costs. People use "company time" to develop their ideas and grant proposals, but given their work loads, they frequently use some of their own time. Our budget for those grants is only for incremental costs and we do not account for existing operational costs that may be exploited in testing new ideas.

How does it work? We make a huge effort to keep it simple. Any member of our staff may apply. The grant requester completes a simple two page form including a brief description of the project, how they will measure the results, what resources (both existing and new) will be required, and if it has been tried in another setting or at another time.

We like to encourage grant applications over the summer and make awards at the beginning of the academic year. The awards committee is composed of myself and four Assistant Directors.

What are the results? We've been doing this for two years. We had some real winners, and some "I can't tell you yet". Some of the winners? Developing an Alcohol and Drug screening tool specifically for college-age clients, Expressive Therapy (sand play therapy), Inventory Control - Barcode scanning system, Sports Psychology, Neuromuscular Programming, Development of a UVM Mindfulness Center, and Peer Ed Theatre Troupe enhancements.

Our Sports Psychology Grant is a great example of positive outcomes. We hired a sports psychologist a few hours a month to train our counselors and athletic trainers and also to work with coaches and teams. The number of athletes seeking performance enhancement counseling increased markedly! Counselors now incorporate the information and techniques with athletes as well as other students. Other benefits have been the enhanced communication, understanding and appreciation of each others' areas of expertise (counselors, athletic trainers, coaches) and a sense of collaboration.

Our Health Promotion Theatre Troupe had many requests for performances, yet had difficulty maintaining a cast. This grant was to see if paying a small stipend would enhance the recruitment and retention of student actors. This proved true, so next year Health Promotion will need to figure out how to incorporate the cost into their regular budget.

The screening tool for Alcohol and Drug Services has been developed. It will need to be tested next year to see if we are able to shorten the time students need to spend with a CADC in evaluation.

Two of the beauties of building this kind of creative culture are that people don't stop thinking after the grants are made; and second, the creative process frequently gets applied to the current "hot" topic.

Are there risks to inviting innovation? Yes. Your mother told you to be careful what you ask for because you might get it. That applies here. If, in the main, you like the status quo, don't ask folks to shake things up. You also have to be careful that the process does not become a reason or an excuse for one of your staff to not pull their load of the day-to-day work. You can't play favorites with either people or ideas. And you must be rigorous about some reasonable approach to evaluation.

If you are fair, open, and objective, making innovation a part of your normal budget will strengthen you, your staff and your services to students.

Last year we funded an innovation grant to work with athletes and the use of alcohol. It turned out to be the perfect pilot study for a large Federal Grant we applied for this year. When we talk to faculty and other staff, on campus about our "grants", their eyes frequently light up and questions start to flow. They want to recreate the idea in their department. And we receive the reputation of a creative and competent department.

(Continued from front page)

Central to any discussion on student health and quality is an understanding of the unique health and wellness needs of college age young adults and the increasingly stressful environment of higher education today. Most importantly, is that late adolescence and early adulthood are the age of the onset for many serious psychiatric disorders with both affective and cognitive symptoms. Substance abuse disorders also manifest at this time, as functioning and performance becomes visibly impaired. Adults between the ages of 18 and 24 years have relatively high prevalence rates for the use of virtually every substance, including alcohol.[1] Further, the normative life crises of separation, relationships and career choice occur during the college and graduate education years. Inherent in this mix of morbidity is the complicating and obscuring effect of residential life and changing academic interests.

"Is a student's inability to finish a paper due to poor study habits, an inappropriate choice of major, changing academic interests, or obsessive-compulsive disorder?"

-Harvard University Provost's Committee on Student Mental Health Services

If adult medicine is plagued by medical errors, which according to the Institute of Medicine study, Lucian Leape's work and others, is the case, then some have argued that quality in student health may be limited by the difficulty in identifying and treating students with behavioral problems. But some recent claims data suggest college health is identifying, treating and referring students with emotional problems in very large numbers.

According to an analysis of the last two years of claims data for care rendered in the community, the most frequently presenting diagnostic classifications for students are neurotic depression, gynecological exams, pregnancy, orthopedic and dermatological conditions.

A similar analysis of prescription claims by major class reinforces this story, with the most frequently prescribed class of drugs being the SSRI's (anti-depressants known as serotonin-specific re-uptake inhibitors) (11.3%), followed closely by acne products (8.5%) and antihistamines- non-sedating (7.7%).

What we cannot infer from these claims data is the degree to which student health services are identifying and referring students to care in the community, or whether these are pre-existing conditions where care is simply continuing, or whether self-referral is operative. In other words, how many of these students are known to the SHS, and what should be the response of the SHS? Further, without additional chart level research, we do not know the specialty or experience of the caregiver.

Despite these gaps in our knowledge, a credible working hypothesis is that a challenge to quality in student health is to effectively reach, diagnose and treat behavioral health needs in the context of the SHS and residence life, and community resources. The key question that follows is: do our staff, training programs, data and management systems support that goal? Beyond these questions in behavioral health, are there other aspects of college health that challenge our pursuit of quality?

If we review the several reasons the Leapfrog Group cited for their formation for patient safety, we don't see a clear parallel to student health, but three, at least, are worth some careful thought:

"Poor performance management," meaning identifiable quality indices are not a key part of the management of the program. Are they in student health?

"Poor clinical information systems" While college health has made great strides in information technology in the last few years, are there opportunities for more collaborative efforts, joint purchasing, and coordinated reporting that could be pursued more aggressively?

"Silent calamity," by which the Leapfrog Group references the mortality and morbidity caused by medical care, citing the 1999 Institute of Medicine study of 44,000-98,000 preventable deaths each year from medical errors during hospitalization (7,000 of which are attributable to medication errors). Ambulatory statistics are not known.

We doubt college health has a silent calamity and know these are not directly applicable to college health, however, they do raise the question: If we in college health were to form our own Quality group, what would be our reasons for being? Quite simply, are there significant quality problems in student health? If so, what are they? Should we address them before someone else addresses them for us?

Several large universities have recently studied their psychological, developmental and emotional counseling services. One university looked at every suicide over the past twenty years and noted that fully half of those deaths had no prior contact with the student health service or counseling. Suicide is the third leading cause of death for Americans 15 to 24.[2] One in 12 U.S. college students makes a suicide plan and 7 out of 100,000 students kill themselves.[3] The incidence for men is four to eight times that of women.[4] For the more than 14 million U.S. college students, this is 1,000 deaths. For each month of the nine month school year, 111 deaths. Some of these are preventable.

Behind these suicide rates is an observation that the incidence of depression on campuses is increasing. The Provost's committee at Harvard observed there was an "increased fragility of students and apparent higher incidence of depression and serious mental illness than previously believed." As noted, this is supported by recent claims data where neurotic depression is by far the most frequent diagnosis.

The clinical challenge to diagnose and treat these students is compounded by many students' strong motivation to deny their condition and a culture of alcohol abuse in which drinking to excess is the treatment of choice for management of stress and anxiety. This is particularly true among men. Patterns of substance abuse differ by gender, culture and ethnicity, making more difficult the assessment and prevention opportunities.

1. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, American Psychiatric Association, 2000, pg.205.
2. Report of the Provost's Committee on Student Mental Health Services 1999, Harvard University, pg. 2. (www.provost.harvard.edu)
3. Campus Mental Health Issues: Best Practices: A Guide for Colleges, Meg Muckenhoupt, ScM, Education Development Center, Newton, MA, 2000 pg.1.
4. McCall P.L., Adolescent and Elderly White Male Suicide Trends: Evidence of Changing Wellbeing. J. Gorontol, 1991; 46(1): 543-551.

The exploding use of club drugs in many urban campus communities needs careful examination. Preliminary indications suggest, however, these are not the drugs of choice for stress management, whereas alcohol is.

When the claims data are sorted by gender, the findings generally follow prevalence patterns for adults, but suggest college health has been much more effective at diagnosing and treating depression, anxiety and other behavioral issues in women than in men.

The issues of early case finding for students at risk for behavioral health and strategies for bridging the gaps between the "silos" of student health, residence life, judicial affairs and academic departments were reviewed in Spectrum a year ago. (Fall 1999, Vol. 3, Number 2) While the ongoing need to reach these students continues, particularly among men, one questions whether this constitutes a "silent calamity" comparable to medical errors in the rest of health care.

Are there other quality problems in student health? When the authors informally polled several leaders in the field, four concerns were expressed:

The need for productivity to solve the high service demand/constrained resource dilemma often crowds out opportunities to pick up on subtle clues from patients on emotional and behavioral issues.

Although peer review is characterized as "the most robust form of quality assurance," in practice, effective peer review may be uneven in college health. "Incident reviews" are somewhat more common, but case conferencing, chart review and regular clinical supervision are less frequent in part, because of time demands for direct patient care, and because it may be personally threatening (see Dr. Davidson's article, Spectrum Spring 2000, Vol.4, Number 1). One person commented, "We assume quality, hope it's happening, but we do little systematically to ensure it." But others report a high level of meaningful peer review.

Third, if quality is defined as reaching the non-user, the under-user, "we just don't have the resources or the strategies." And, "if it has a more public health flavor of doing something about the toxicity of this environment, we're nowhere close." Toxicity? Academic stress, the Greek System, athletic hazing, Homecoming, Parents' Weekends are some of the contributors to stress, alcohol abuse, and violence.

Fourth, a quality challenge in student health may be our prescribing patterns and whether student health clinicians are educating their patients on the appropriate use of prescription drugs. With regard to prescribing patterns, the data should be more readily available than for other measures, but linking those data and tying them back to the prescribing physician is not the norm in college health. (Perhaps, like Leapfrog, an emphasis on computer prescribing would be an appropriate quality goal for student health.) Nationwide, and across age groups, there is broad consensus that antibiotics are prescribed much too frequently. The CDC has issued guidelines, provided pamphlets and posters. To what degree are these being used in student health? For sore throats, a common student complaint, one recent study across all age groups found that 42% of the time, antibiotics were prescribed without a throat culture. The prescribing of psychotropic drugs, particularly the SSRI class of anti-depressants, by non-psychiatrists is another area for review.

A preliminary answer then, to what are student health quality questions might be as follows:

Is the integration of behavioral health and counseling with primary care adequate and do we fail to reach students in need of care and provide support for emotional and behavioral difficulties, particularly in men?

Do we fail to establish a culture of quality through peer review?

Do we fail to reduce known risks in the environment?

Do we fail to examine practice patterns, particularly prescribing practices?

If these four represent the quality opportunity in student health, are there reasonable programs and strategies that will make a difference, be feasible within existing resource constraints, be measurable and sustainable?

Let us suggest a few.

To improve behavioral health case finding and integration of treatment, assign a small group within your SHS to bring forth recommendations based on a review of the literature including, but not limited to:

1. Beating the College Blues, authored by Paul A. Grayson, Ph.D. and Philip W. Meilman, Ph.D., Facts on File, Inc., New York, New York.

2. Campus Mental Health Issues: Best Practices: A Guide for Colleges, authored by Meg Muckenhoupt, ScM, Education Development Counter, Newton, MA, 2000.

3. "The Integration of Behavioral Health and Ambulatory Care," The Healthcare Advisory Board, April 1998, Catalog # 001-203-686.

4. "Report of the Provost's Committee on Student Mental Health Services 1999", Harvard University (www.provost.harvard.edu)

5. The 15-Minute Hour- Psychotherapy for the Primary Care Physician authored by Joseph Lieberman, MD and Marian Stuart, Ph.D., Greenwood Publishing Group.

To establish a culture of quality, we suggest measuring convenience and access and reporting these data against achievable, but stretch goals. This will begin to align the SHS along that quality axis that is most critical to students.

(Continued on back page)

(Continued from page 7)

It is further suggested SHS programs identify two or three metrics which will align your program with the clinician's definitions or quality. One might be some measure of patient compliance. Beyond data, it may be desirable to re-examine your programs for case conferencing and clinical supervision.

Certainly, "incident" reviews should be part of every program, although the definition of incident may vary. Some programs review all requests for medical leaves, others admissions and/or emergency department visits for primary care sensitive diagnoses. Some programs use "special interest diagnoses," which can vary over time, to trigger case reviews.

Journal clubs and small research projects also may promote an environment of quality through inquiry.

Prescribing patterns and other practice pattern variations e.g. revisit rates by major diagnostic category, should be the easiest quality activity around which to gather data. It is critical that any data reported be meaningful (small numbers are highly suspect) and are presented without value judgments. It is common in group practices for subtle patterns of internal referral to evolve over time, which could well explain both practice and prescribing pattern variations. Revisit rates may be appropriately high or low depending on other considerations.

As we have noted above, after examining 200,000 prescription claims for colleges and universities for calendar year 2000, Claritin is the most frequently prescribed individual drug and the most expensive in terms of total paid claims. SSRI's are the leading class of drugs, representing over 11% of all prescription claims. Our question: What do these data mean in terms of quality within your SHS?

Perhaps the thorniest issue for SHS programs is how to mount an effective public health initiative within the context of limited resources. Our recommendations are to target two or three population risk factors, look for leverage through other campus and external resources. (See Estelle Maartman-Moe's article in this issue.)

A plan for measuring results should be part of each strategy. Fortunately, the ACHA Journal and the annual meeting presentations offer many suggestions and provide peer support from other campuses.

Identifying "public health," population-based programs that stand a reasonable chance of success in relatively short time frame is desirable because it allows you to build momentum in a part of your program that is often secondary to direct patient care. Social norms programs for campus drinking, although somewhat controversial, meet these criteria.

When some of the best minds in American business and government came together to start the Leapfrog Group in 1998, they established five criteria for "leaps." They are:

"What's the difference?" The leap will produce a big, measurable movement.
"Value is self-evident." The leap can be appreciated by consumers- it makes good sense.
"Feasible now"- the implementation steps are doable.
"Easily ascertainable"- if you are doing it, people can see it is in place.
"Focus"- by concentrating efforts, leaps can be remembered.

College health is decidedly different from the rest of health care. The problems of hospital-based care, medication errors, lack of intensivists and volume sensitive procedures (e.g. coronary artery bypass graft, coronary angioplasty, and carotid endarterectomy) have little relevance to student health. Nonetheless, student health, in our judgment has some real quality opportunities. The Leapfrog criteria have a universal appeal for developing quality programs.

Would it be appropriate, throughout the student health field to create a quality initiative, endorsed by ACHA and totally consistent with accreditation, that would serve to focus on a few areas of opportunity, mobilize resources and create a multiple-campus program? We think it would be. ■

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Where to See Chickering Next?

Ohio College Health Association, Aurora, Ohio; June 11-12, 2001

Leadership Forum 2001 (Look for details in the mail early September)