

student health **SPECTRUM**

Leadership Forum 2002

Benchmarking College Health: The 1999-2000 Benchmarking DataShare II Survey

by Evelyn Wiener, MD
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(Editor's note: In our summer 1999 Issue Drs. Evelyn Wiener and Gary Fredericksen reported on the development of the ACHA's first benchmarking survey. In this article, Dr. Wiener, reports on the continuing work of the Benchmarking Task Force, of which she is chair. Some of this material was presented by Dr. Wiener at this year's ACHA meeting in Washington.)

The charge to the American College Health Association's Advisory Committee on Benchmarking is to identify measures useful in comparing college health services to each other, and to collect and analyze data that relate to those measures. Participation in the American College Health Association's Benchmarking/DataShare program should enable college health services to obtain data that measure the impact of services on the community and that demonstrate that services are delivered efficiently and effectively. Participants may use the benchmarking surveys as a reference for reports and/or recommendations to their school's administration; the results may also be used for informal comparisons with other schools, tracking performance compared to peers and tracking trends over time.

The pilot survey, 1998-99 Benchmarking DataShare I Survey (BDSI), was the first attempt at creating an instrument that would achieve these objectives. The nine benchmarks in BDSI were carefully developed to permit resource and performance measurements to be adjusted to match the diversity among participating schools.

One goal was to determine if there were common patterns of performance among similar schools, especially for penetration (percentage of students accessing care), utilization (number of visits per student), and available resources. The general health literature suggests that there should be positive correlation among these three measures, that schools with more resources would report higher utilization and greater penetration. (However, the literature on health policy, resource utilization and outcomes, also suggests that beyond some basic threshold, more resources, more utilization and greater penetration do not necessarily translate into measurable, improved outcomes.)

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As with many pilot studies, this pilot study was found to have shortcomings. BDSI demonstrated the challenges in measuring the performance of diverse health services. While there were certain features common to most, if not all, schools, there were also significant differences in the scope of on-site services, provider mix, student populations, revenue streams and other important factors. BDSI limited participants' ability to describe the specific attributes and practice patterns of their clinics, including the scope of on-site services, provider mix, student population and various revenue streams.

The 1999-2000 Benchmarking DataShare II Survey (BDSII) was the next step in the effort to create an instrument that would provide a macroscopic view of college health services' performance yet still allow each institution to report the particular characteristics of its operations. The questionnaire repeated many of the benchmarks developed for BDSI, but added an increased level of detail for most measures, with separate and collective data for undergraduate and graduate populations as well as for different provider types.

Continued from cover page.

The intent was that this format would allow a participating institution to assess more directly those aspects of its data derived from its particular set of attributes, while still permitting overall comparisons for aspects of practice common to all centers. Given the results of BDSI, we anticipated central tendencies among similar schools in resources, utilization and penetration.

A total of 102 college and university health services (all ACHA institutional members) submitted data to the survey. Participants ranged in size from campuses of 700 students to those with populations greater than 50,000. As with the first Benchmarking DataShare, there was a great diversity of practice among different student health centers, reflecting the fact that each center responds to the needs and the structure of its individual institution. The final report of the 1999-2000 Benchmarking DataShare II Survey is available through the American College Health Association.

Briefly, BDSII found similar correlations between certain institutional attributes and performance as reported in the first survey. The attributes most often found

to correlate with performance were institutional type, student enrollment, percentage of on-campus residents and provision of ancillary services. There was clear correspondence between these institutional attributes and hours of operation and provision of ancillary services. These elements then impacted staffing levels, which in turn affected student to staff ratio and the proportion of student visits.

Additional analysis will be needed to determine the impact of other elements, such as the scope of clinic services, the hours of operation, and staffing patterns. Other factors may also affect the performance of a given center, including the relative percentages of women and men in the student population, the convenience of location, charges for services and the types of appointment systems.

Attributes such as the percentage of students with inadequate health insurance, the availability of appropriate and economical primary care/urgent care services in the local area and the adequacy of local referral are likely to impact utilization and productivity. The effectiveness of promotional materials and reputation, along with consumer satisfaction, health

education efforts, and campus culture could also have effect on measures of penetration, utilization and, ultimately, productivity. Some of these factors might be benchmarked in future surveys. Most important is the need to identify relevant outcome measures and to determine if there are specific attributes and/or practices that correlate with improved outcomes. Benchmarking/DataShare remains a work in progress. Its purpose is to define and measure the systems common to all college health services; at the same time, its intent is to capture the specific practices and structures unique to individual institutions. For benchmarking to be of value to participants, studies should identify those functions, both clinical and administrative, that are most relevant and significant to college health services. The basic questions about benchmarking are what measures should be counted, why should a given measure be counted and how should a given measure be counted? Continued feedback from schools is essential in revising the survey to provide information that is significant and useful to participants.

The Benchmarking/DataShare III survey is in development. Stay tuned... ■

**Benchmarking/DataShare asks:
Are there central tendencies in
penetration and utilization among
similar schools? From Chickering
Claims data, we observe...**

**Outpatient Mental Health Utilization -
Comparison of Four Peer Schools**

Peer School	# of Claimant per 1000 Students	# of Visits per Claimant
Peer School 1	67.18	15.23
Peer School 2	72.36	17.72
Peer School 3	62.14	16.00
Peer School 4	76.73	13.10

Notes:

- 1.) Comparison is based on student only utilization of outpatient mental health benefits, exclusive of services provided at the student health center.
- 2.) A "peer school" is defined as:
 - a.) a large nationally recognized institution of higher learning,
 - b.) situated in an urban setting,
 - c.) with comparable counseling and psychological services provided at the student health center and
 - d.) an insured student health population which is heavily dominated by graduate/professional students.
- 3.) Peer School 3 has a low reimbursement level, which may lead to an understatement in reported claims.

The Value of a Complaint

by Eleanor W. Davidson, MD
Case Western Reserve University

Editor's note: Dr. Davidson presented the substance of this paper at ACHA in Washington to much favorable comment. We are grateful to her for preparing it for publication in Spectrum.

"Give me a fruitful error anytime, full of seeds, bursting with its own corrections. You can keep your sterile truth for yourself." -Pareto

I. A Management Perspective:

After 15 years' experience as the director of a health service, I was still unsure about the best way to answer complaint letters. Should I share them with the staff or simply cull the patterns from them and let the staff know about these? I decided to do some research to answer my questions.

I began with a review of the business literature concerning customer feedback and discovered the book, A Complaint is a Gift, by Janelle Barlow and Claus Moller (1996). This was an excellent foundation for developing a complaint policy for our health service. We built our approach on five critical points made by Barlow and Moller:

1. For every one person who makes a complaint about service, 26 others are equally as unhappy, but have not made their complaint known to you.

2. The goal of an excellent complaint management system is not (surprisingly) to arrive at zero complaints, or even to arrive at fewer complaints; the goal is actually to receive more complaints because, as the authors point out, complaining customers are at least still talking to you. "Complaining customers are giving us the chance to find out what their problems are so we can help them."

3. Everyone in your organization must understand and 'buy into' your complaint philosophy so that no one is silencing complaints before they reach you (and also so your boss knows your philosophy!)

4. Recognize the special circumstances presented by 'dependency relationships;' how do you complain to the person who may be responsible for getting you well? (How do you complain to the University who is in charge of whether or not you will graduate and what kind of recommendation you will receive?)

5. Responses to a complaint should include:

- a. Thanking the person for the complaint
- b. Explaining why you appreciate their taking the time to complain
- c. Apologizing for the mistake
- d. Promising to do something about the situation immediately

II. The Complaint Data (From The Health Service at Case Western Reserve University):

In the fourteen years, from 1988-2002, there were 34 written complaints, or a bit more than two per year.

Students (22/34) wrote the majority, with almost the same number of male students writing complaints as female students. Nine parents wrote letters, and mothers wrote eight of these nine.

Twenty-four complaints cited concerns about money or access/eligibility. The access issues have been well addressed by initiatives such as those of the Institute for Healthcare Improvement (www.ihi.org).

[Editor's note: Dr. Donald Berwick, director of the Institute for Healthcare Improvement has developed and advocated an "open access" model for primary care.

Many student health centers have adopted this approach. See *Spectrum*, Winter 2001, for a discussion of the "open access" model.]

Five complaints alleged 'misdiagnosis' or 'incorrect' medical treatment.

Twenty-three complaint letters contained themes of:

- 'not being taken seriously'
- 'rude' treatment
- alleged humiliation or being shamed.

Sixteen letters wrote of more than one negative experience or interaction with the student health service.

III. Perplexing Themes

Some of the letters had bothered me significantly. Their language was intense, their complaints equally so. I was unsure where all the complaints about rudeness and humiliation came from. I was also quite confused by students who chose to address their complaints to my boss (the VP for Student Affairs) or my 'big boss' (the President of the University). A student who wrote the President about an alleged misdiagnosis of a potentially embarrassing sexually transmitted disease particularly confused me. Why would he risk this embarrassment?

In the spring of 2000, I heard Medical Grand Rounds given on the topic of "Shame & Humiliation in the Medical Encounter," by Aaron Lazare MD, a psychiatrist, who is the Chancellor of the University of Massachusetts Academic Medical Center at Worcester.

Subsequently, an article in *The Boston Globe* (August 18, 2002), by Anne Barnard, "A rude doctor could be hazardous to your health..." helped me put more of the puzzle together. Perhaps this example will be useful in comprehending the complaint letters:

Barnard recounted this experience: A 'mild-mannered professor' complained to her surgeon when (for the second time in a row) he was more than 2 hours late for an appointment. The surgeon, when asked by the patient for an apology, responded by snapping her xrays off the viewbox, commenting that he was 'not accustomed to being scolded by his patients,' and threatening to terminate the visit.

Dr. David Blumenthal, a researcher at Massachusetts General Hospital's Institute for Health Policy, was asked about this and said: "if physicians were disciplined for being disrespectful, inconsiderate, and not on time, the medical offices of our nation would be empty."

What was going on here?

Dr. Lazare: "Patients commonly perceive illnesses or diseases as defects, inadequacies, or shortcomings," and thus a visit to the doctor "requires physical and psychological exposure for the patient." Such exposure, coupled with the perception of the illness as a defect or personal inadequacy, often causes the patient to feel ashamed or humiliated (for having such a body that is failing them).

A patient can feel vulnerable merely going to the doctor or healthcare practitioner. When the doctor is late, the patient feels ignored.

She believes his lateness is a comment on the lack of importance of her symptoms.

Dr. Lazare: "It is important for physicians to see patients with minimal delay. Long waits for physicians after the designated appointment time...devalue the importance of patients' time and worries. A simple apology for significant lateness... acknowledges that the delay...is the doctor's problem...."

Instead, the surgeon said he was 'not accustomed to being scolded by his patients.' Odd language, isn't it? Makes one think about a child being scolded by a parent, more than the situation at hand.

Could that be a clue? Did the surgeon feel humiliated by the patient's pointing out his failure to be on time and her request for an apology? Dr. Lazare: "One of the most difficult, but important tasks for physicians in the clinical encounter is the recognition and management of their own shame and humiliation. A clue to this situation is the physician's anger at the patient, his/her inadvertent humiliation of the patient, or his/her wish not to see the patient again."

So what happened? The surgeon (for reasons we don't know) was unfortunately late for not one but two appointments. The patient took offense and requested an apology. The surgeon took offense and threatened to leave. Barnard, *The Boston Globe* reporter, continued the cycle, by publicly humiliating the surgeon (giving him a dose of his own medicine, so to speak). And a downward spiral of shame and counterhumiliation ensued.

How do these spirals begin and how do we end them?

Some physicians (and other health-care professionals) are easily shamed, especially when their job performance has been called inadequate. Their work is not a job; it constitutes their identity. As Lazare points out, this shame-prone state of some physicians "can have adaptive functions: the doctor works long hours with diligence and dedication to maintain the highest standards of practice."

Physicians and other healthcare providers need tools to identify and change dysfunctional patterns. Instead of taking offense at the patient's request for an apology, the surgeon could (under ideal conditions) step back, realize that his lateness had inadvertently humiliated his patient, and apologize for the action. The visit, then, could have proceeded very differently.

IV. Responding to Complaints

Clearly, each health service will respond differently because of circumstances unique to their own setting. Let me suggest, however, some common themes:

- The whole organization must 'buy into' the complaint philosophy and understand how feedback from students helps the organization carry out its mission/vision/goals (certainly formalized routes of gaining consumer feedback such as student health advisory boards can be effective);
- Probably the most difficult task in using complaints to improve both individual and organizational performance is differentiating between the complaints that were 'about us' v. 'not about us'.

By the latter, I mean that often complex process where frustration and anger appropriately linked to

one set of people or circumstances ends up "displaced" onto another (e.g. the SHS). Sometimes, clues to this happening are clear-cut, such as language that is too strong for the situation at hand. The ability to discern 'appropriate' anger from displaced anger can be compromised by a natural defensiveness on the part of the listener. (All anger is taken personally, for example.) Essentially one should follow the usual procedure in medicine: listen with some clinical detachment, control your own affective response, and look for patterns to emerge.

- You might want to look at ways you inadvertently expose your patients to their own shame. I began to wonder if our well meaning initial patient questionnaires, medical history et al (filled out before we even begin to see the patient) were overly intrusive. They expose the student (lay the patient bare, so to speak) before we have begun the therapeutic relationship. Women's Clinic histories that ask about number of sexual partners, gender of the partners, etc would fall into such a category. I have come to believe it is best for me to approach the student with a simple welcome and query, "how can I be of help?"

- Understand the cycles of shame and counterhumiliation and learn how to recognize them. I realized that one way a student shows me exactly how humiliated he/she has been at my health service is to go humiliate me to my boss (hence the complaints to the President or the humiliation handed out in the student newspaper).

- Attend to the simply courtesies such as being on time.

If you are unavoidably late, apologize for your lateness. (Dr. Lazare

offers other suggestions in his excellent paper previously noted).

- Realize the difficulty in obtaining feedback within dependency relationships. Consider a Wish Box in the waiting room ("what do you wish we might do differently?"), rather than a Complaint Box.

- If you are the person who receives all the complaints, find someone to help you deal with this burden. Your mental health is your strongest tool in understanding what these are about and helping you avoid job burnout.

In summary, complaints are rare (for us only slightly more than two per year), but of high value in that they represent a larger group of unhappy constituents and they afford the organization real opportunities to improve.

Our key insights have been these: Complaints blame people, but the root causes are usually organizational. Such organizational causes include access issues, staffing problems, or pervasive attitudes which made up the "culture" of our services and about which we had little insight before the complaint.

Complaints must not be used as either a club or a lever to change a behavior, but rather as a light to examine practices and process. If we use complaints to blame individuals, we will inevitably move down the path of shame and counterhumiliation-the least useful path, in my opinion.

My own preference is to teach our staff how to avoid these pitfalls and how to respond to confusing situations-give them tools and techniques to do better, as I am convinced is their desire. ■



INTERNATIONAL EDUCATIONAL EXCHANGE: *Planning for Students Health Care Needs*

by Linda Ragosta, Ed.D.

For many years, health care for international students and travel medicine programs for domestic students going abroad was a "footnote" on the Student Health Service Director's job description. Today, substantial increases in numbers of students arriving and departing, increases in the health and safety risks of many countries of origin and destination, the resurgence of tuberculosis, and the widespread use of marginal, low limit health insurance, have substantially increased the responsibilities and burdens of student health services.

Increases in the numbers of students engaged in international exchange programs in the United States and around the globe are presenting new challenges for universities in preparing U.S. students for study abroad and international students studying in the U.S. Based on recent literature and the experiences of many on university campuses, three trends seem to emerge. First, the numbers of U.S. students studying abroad continues to increase, 11% in 1999-2000 and 61% in the five previous years.¹ Second, the number of international students studying in the United States is also higher than ever before according to the Institute of International Education. More than 547,000 international students enrolled in higher education institutions in the U.S. in the 2000-2001 academic year, up 6.4% from the previous year and approximately 19% in the past five years.² Third, is the dramatic increase in the less developed countries of origin for students coming to the U.S. and less traditional destination countries for American students studying abroad. Latin America, Africa, and Asia, have seen the greatest increases, with notable increases also from countries of the former Soviet Union and Eastern Europe.

This last trend poses new challenges and an increased burden of responsibility for universities in providing students with access to health care in less developed areas of the world, as well as providing care for growing numbers of international students arriving from those regions.

In the immediate wake of the events of September 11, 2001, predictions were made that students would hesitate to engage in study abroad programs. Just the opposite has proven true. Increases in study abroad activity in the year following the attacks has been documented by an October 2001 survey conducted by the Institute for International Education and a follow-up survey in August 2002.³ The numbers of students going to Western European countries has remained strong with growth occurring as more students travel to more exotic locations. These often are countries with higher public health risks, reduced health care resources, and higher personal safety risks. For example, physicians at Ohio State University have noted that health professions students traveling abroad need to know how to obtain post-exposure prophylaxis in the event of blood-borne pathogen exposure. Leading the list of countries with public health and safety issues include: China, Brazil, the Czech Republic, India, Kenya, and Vietnam. Responding to both student interest and an increasing demand for globalizing education, institutions are establishing and expanding study abroad programs, many in less traditional locations. Students will often initiate self-designed study abroad programs or enroll through another university if the home institution does not offer a program in a desired location. These are often in a country considered "less traditional."

Further, students often travel across multiple borders while they are abroad. These situations limit the control of the home institution in the care a student can access while abroad.

Dr. Ted Grace, Director of Student Health Services at Ohio State University, told us, "Many students move from country to country while abroad. This puts a unique burden on our travel medicine staff because we must take into consideration that entry requirements from the U.S. are often different than for entry from other countries. We have to be sure the student has accurate documentation to meet all the entry requirements anticipated in their travel program."

In planning for how an institution provides for the health needs of study abroad students, health services must often initiate contact with other offices on campus. At New York University, Dr. Ernesto Ferran, Director of University Health Services, reached out to the University Global Affairs Office to offer assistance and expertise in researching and communicating with local providers at international program sites. "They jumped at the chance for our help. Our Travel Medicine Department was excited about collaborating in the effort to research the capabilities of the off-site campuses and their local providers so that we might then establish a coordinated network of support for our students going abroad. We also send our staff to conduct health education programs for our students at our international campus sites." NYU has one of the largest study abroad programs in the nation.

The Ohio State University Student Health Services has also established a close working relationship with their

Office of International Education, and together with the OIE they have reviewed not only health risks, but also personal safety risks. Again, from Dr. Grace, "we subscribe to travel software that gives us not only current health risks, but also information on the risks of assault, kidnapping, and other threats to personal safety. In travel medicine we try to review all of the risks with the student."

Similarly, international students are coming to U.S. universities from more remote regions of the world. This brings a higher risk profile for vaccine-preventable and/or primary care preventable diseases such as tuberculosis. Further, international students often arrive with less than adequate health records and documentation of immunizations. International students with poorly documented health records entering the U.S. for the first time are often reluctant to have the required immunizations if they believe they may have received them in their home country. In Massachusetts, the Tuberculosis Control Office of the Department of Public Health is developing a pilot program focused on controlling the incidence and spread of tuberculosis. In doing so, they have developed a list of countries determined to have high rates of tuberculosis. Currently, a questionnaire is being pilot tested, following which a recommended screening protocol will be developed for incoming international students. Screening may be advisable for students determined to be in a higher risk group based on the country of origin, or if they have traveled or lived for more than one month in any of the designated countries. The data collected from this pilot program will be used to further develop screening recommendations.

Many other universities have had to develop "targeted" screening programs to be cost effective and to be consistent with public health guidelines. While not a regulatory agency, the CDC can provide important advice on screening programs for international students.

This change in the level of activity and geographic range of the international exchange of students has significantly increased the responsibility of both the institution and the student health service. Travel medicine is becoming more complex. To meet the increased demand and increased complexities, educators that work with study abroad programs are engaging in more active outreach and collaboration among the various university divisions and departments that serve international and U.S. exchange students. At Iowa State University, the Office of Risk Management initiated a comprehensive risk audit of all study abroad programs in 1997. The institution-wide project took nearly five years. The audit reviewed every dimension of each program and their locations. It resulted in development of established protocols for emergency situations, handbooks for students and faculty supervisors, and expansion of the scope of student orientation programs. Now, a campus-wide committee conducts periodic reviews of study abroad programs using the checklists developed in the initial audit process. They then update policies, protocols and materials for all programs. Rebecca Adair, Director of Risk Management at Iowa State University, said, "It took intense collaboration among many departments to conduct a very thorough audit, and nearly five years to implement recommendations. We are at a point where we are not just trying to catch up, we are in a position to stay current with managing the inherent risks involved. We have done it through collaboration." Still, most of the activities associated with study abroad programs are within academic affairs and not student affairs where student health typically reports.

In preparing this article, we spoke with several student health services directors, risk managers, and others involved in International Education. Virtually all noted the lack of structural linkages for these programs and stressed the importance of personal outreach to coordinate activities.

When collaboration is working, policy decisions regarding sponsored travel will be informed and timely. Students must know how to access health care in particular countries, including economic access through insurance or other guaranteed forms of payment. According to the National Association of Foreign Student Advisors (NAFSA), adequate insurance coverage for American students going abroad is necessary to ensure that students do not face financial hardship or substandard care in the event of an accident or illness. Educators, students, and families planning for study abroad will find that most institutions require a student to have coverage through the institution-sponsored plan or their own, perhaps under a parent's plan. Even then, students, their families, and their advisors must thoroughly review the student's coverage while outside of the United States. Dr. Grace noted, "You have got to understand that many foreign hospitals will not admit or treat patients without cash or a credit card. Institutions of higher education have had to pull out their university credit cards on occasion to get a student cared for. Now, our Office of International Education requires all students traveling abroad to purchase daily travel medical coverage for however long they will be overseas."

For international students studying in the United States, navigating the American health care system is often one of the first lessons they must learn about living and studying in the United States. Health Services staff and university educators who work with international students devote considerable time during international student orientation programs to acquainting students with the system of health care in the U.S. and about the role of health insurance.

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International Students also bring varying cultural perceptions of health care and when and how to utilize it. Understanding these various cultural viewpoints is another critical factor in facilitating international students' use of health care that is available to them when they need it. Interesting to note, Ohio State University reported international students more frequently seek dental coverage through the student health service than domestic students.

Some aspects of ensuring the ability to access health care are clear. In the United States, federal regulations governing J Exchange Visitors require that the J-1 students and all J-2 dependents carry insurance that meet State Department guidelines (22CFR 514.14). Similar requirements are not currently in place for F1 students and F2 dependents, however they are expected when updates are next made. The difference in criteria between F1 and J1 immigration status is primarily the source of funding under which the student enters the U.S. J1 status is available to students who are supported substantially by funding other than personal or family funds. Other sources may include the U.S. government, the student's home government, an international organization, or the university. Immigration status for students is determined at the time of entry into the U.S. by the INS. In Massachusetts, state law requires that all college students enrolled full-time or carrying a credit load of at least 75% of full-time, must carry health insurance that meets minimum standards as defined by the Qualifying Student Health Insurance Plan (QSHIP) law 114.6 CMR 3.04 (3).

This includes F1 international students. New Jersey also requires full-time college students to carry health insurance coverage. It, however, requires only that such coverage include basic hospital benefits. It does not specify minimum benefit levels as does the Massachusetts law.

The J regulations focus on several key elements of insurance coverage as a starting point for what is considered adequate coverage. It must be noted that the requirements were developed by the U.S. State Department in 1993, and were structured as minimums, even then. Most international educators agree that these requirements represent the most minimal levels needed. Key requirements for J exchange students include:

- Medical benefits of at least \$50,000 per accident or illness;
- A minimum of \$7,500 for repatriation of remains;
- A minimum of \$10,000 for expenses associated with medical evacuation to his or her home country;
- A deductible not to exceed \$500 per accident or illness.
- A reasonable waiting period for coverage of pre-existing conditions, as determined by current industry standards;
- Underwritten by an insurance corporation having an A.M. Best rating of "A-" or above, an Insurance Solvency International, Ltd. (ISI) rating of "A-i" or above, a Standard & Poor's Claims-paying Ability rating of "A-" or above, a Weiss Research, Inc. rating of B+ or above, or such other rating as the Agency may from time to time specify. [58 FR 15196, Mar. 19, 1993, as amended at 59 FR 34761, July 7, 1994]

As limited as this coverage is, many students have even less, and are not detected because of lack of resources to check on various policies. As one SHS Director from another state told us, "I think students buy a policy from a vending machine in the airport before they leave. It's called insurance, but it's terrible coverage. I wish we had a mechanism to deal with it, but we don't. Instead we have to explain to ill or injured students

why they have to pay so much out of their pockets."

By contrast, the Student Health Insurance Advisory Committee at the University of Pennsylvania has established four minimum criteria for all students, including international students. Health insurance must have:

- No pre-existing condition limits
- At least a \$500,000 lifetime maximum benefit
- At least 70% coverage for inpatient care (including behavioral health) rendered in the Philadelphia area
- At least 70% coverage for out patient care (including behavioral health) rendered in the Philadelphia area.

Although all students are required to stipulate to each of the four criteria, because international students may be less familiar with health insurance matters, a special mailing is sent to them at the beginning of the academic year. The University of Massachusetts, Dartmouth, implemented a new policy this fall requiring that all F1 international students enroll in the university sponsored student health insurance plan. According to Barbara Agee, Director of Health Services, "This has already made a very positive difference for a number of students that needed care outside of our services."

Based on the collective experiences of international educators regarding international students and insurance coverage NAFSA makes several recommendations.

- The J regulations set types of coverage and minimum levels, and suggest a responsibility for institutions to evaluate diligently an insurance product it may offer to participants on its J program.

· In addition to levels and types of coverage, the institution should consider an insurance company's claims service record, as well as licensure to sell a particular insurance product in the state where the institution is located.

· Other areas of coverage that are in high demand among student populations include prescription drugs, outpatient physician and clinic services, routine physical examinations, routine diagnostic procedures, psychiatric treatment and psychological counseling, and vision and dental coverage.

· Most schools offer insurance programs that cover catastrophic accident and illness, repatriation and medical evacuation, most inpatient expenses (following a deductible and co-payment schedule) until an out-of-pocket maximum is reached, some selected outpatient procedures, and pre-existing conditions.⁴

Other resources in determining an appropriate and credible health insurance and benefits program for students engaging in international exchange experiences are the Standards for Student Health Insurance/Benefits Programs established in 1993 by the American College Health Association. NAFSA also established a Position Statement on Health Insurance for International Students in 1986. This position statement emphasizes the need for institutions to provide for dissemination of information to enable international students to make informed decisions regarding their health and accessing

healthcare while in the U.S. It also recommends that institutions offer an institution-sponsored plan that has incorporated appropriate minimum standards for coverage and benefits as well as education on accessing health resources and health care on and off-campus. Although these documents are general in scope, updates reflecting current trends and recommendations would be useful.

It is evident that students are far more mobile and this trend is likely to continue. As educators develop institutional policies for participation in international educational exchange programs, such policies must include travel medicine services through student health services, and requirements for health insurance coverage. Educators, including health services, student affairs, and international

exchange advisors, must work together to determine the needs of their students and how best to provide for them. ■

End Notes:

1. Open Doors 2001, Institute for International Education, November 2001
2. Open Doors 2001, IIE, November 2001.
3. Institute for International Education, 2002.
4. Optimizing Health Care in International Educational Exchange, NAFSA, 2002

Sources Consulted:
ACHA Guidelines, Health Insurance for International Students and Scholars and their Dependents, May 1993
NAFSA, Position Statement on Health Insurance for International Students, 1986
Massachusetts Department of Public Health

INFORMATION RESOURCES

- **CDC Health Information for International Travel 2001-2002, DHHS, Atlanta, GA:** <http://www.cdc.gov/travel/index.htm>
- **World Health Organization (WHO) International Travel and Health site:** www.who.int.ith
- **U.S. Department of State, Overseas Citizens Emergency Center:** 202-647-5222 or www.travel.state.gov
- **U.S. Central Intelligence Agency:** www.odci.gov/cia/publications/pubs.html (Select "World Factbook")
- **International Society of Travel Medicine:** www.istm.org
- **Association of International Educators:** www.nafsa.org
- **Institute of International Educators:** www.iienetwork.org

The above resources were part of a presentation by Elaine C. Jong, MD, Travel & Transportation Medicine, University of Washington, Seattle, WA at the February 2002 Student Health Services Associated Academic Medical Center (SHSAAMC) Conference.

BRIEFLY NOTED...



Briefly Noted summarizes industry-related articles from leading publications for our *Spectrum* readers.

Job-Based Health Benefits in 2002: Some Important Trends: Premium growth accelerates, employees bear greater costs, and coverage declines.

By John Gabel, Larry Levitt, Erin Holve, Jeremy Pickreign, Heidi Whitmore, Kelley Dhont, Samantha Hawkins, and Diane Rowland

Published by Project Hope. Health Affairs; September/October, Vol. 21, Number 5, pg. 143, 2002. www.healthaffairs.org

Abstract: Based on a national survey of 2,014 randomly selected public and private firms with three or more workers, this paper reports changes in employer-based health insurance from spring 2001 to spring 2002. The cost of health insurance rose 12.7 percent, the highest rate of growth since 1990. Employee contributions (monthly) for health insurance rose in 2002, from \$30 to \$38 for single coverage and from \$150 to \$174 for family coverage. Deductibles and copayments rose also, and employers adopted formularies and three tier cost-sharing formulas to control prescription drug expenses. PPO and HMO enrollment rose, while the percentage of small employers offering health benefits fell. Because increasing claims expenses rather than the underwriting cycle are the major driver of rising premiums, double-digit growth appears likely to continue.

Student health insurance is closely linked to employer-sponsored parental or spousal plans in several important ways. As employees pay more for coverage, as this study reports, alternative coverage through college-sponsored programs may become an attractive option. Further, as benefits are reduced, again as reported in this study, the likelihood that students may have significant gaps in coverage increases. A more serious concern is the potential for students to be uninsured, with this study noting that "80 % of the uninsured reside in families in which a household member works full- or part -time."

All of this suggests that colleges and universities need to be particularly concerned about the adequacy of parental insurance and should consider moving from voluntary or "soft waiver" check-off programs to qualified, "hard-waiver" programs which specify both minimum coverage requirements and broad geographic access to benefits.

With regard to the linkage between employer-sponsored insurance trend and trend in student health, the differences and similarities have been noted in Paul Cronin's *Spectrum* article in the Winter 2002 issue. Three findings in the Dr. Gabel et al's article have direct relevance to student health trend:

- Trend is primarily driven by an increase in underlying claims expenses.

"Thus, surging underlying medical claims expenses, rather than catch-up pricing is now largely driving today's double-digit increases in the cost of health insurance."

- Prescription drug costs continue to be a significant cost driver, and employers are placing "employees at greater financial risk if they purchase brand name drugs when generics are available."

"Consequently, employees now pay an average co-payment of \$26 for brand-name drugs with generic substitutes."

- The outlook for the future is for continuing increases in underlying medical costs with both prices and utilization rising.

"The implication is that the nation may be facing many years of double-digit premium increases.

This is the fourth year of the annual Henry J. Kaiser Family Foundation/ Health Research and Educational Trust Survey of Employer -Sponsored Health Benefits. Its findings of average trend of 13 percent for 2002 correlate with the eighth year of The Buck National Health Care Trend Survey of HMO's BC/BS Plans, health insurers and other plan administrators. ■

BRIEFLY NOTED...

National Trends in Use of Medications in Office-Based Practice, 1985-1999

Drugs were discussed 59 percent more often in office visits in 1999 than in 1985, rising to a rate of 146 prescriptions per 100 visits. By Catharine W. Burt

Published by Project Hope; *Health Affairs*; July/August, Vol. 21, Number 4, Pg. 206, 2002. www.healthaffairs.org

Abstract: Increases in physician office visits involving the use or prescribing of a drug were observed between 1985 and 1999 using data from the National Ambulatory Medical Care Survey. The prescription rate increased from 109 to 146 prescriptions per 100 visits. Growth in drug mention rates for specific therapeutic classes varied by patients' age. The rate of multiple prescriptions per visit rose 39 percent. Similar-size increases were observed after differences in patients' age, number of comorbidities, source of payment, and physician specialty were controlled for.

This study, which reports the data sorted in a variety of ways, including by patient's age and by therapeutic class, may be a useful discussion article for a student health service's physician staff regarding prescribing patterns.

Supporting the anecdotal reports from many student health services that significant changes in use of prescription drugs are observed in entering freshmen, Dr. Burt's article notes the largest significant percentage increase across all ages and all therapeutic classes was for children under age 15 for central nervous system drugs (327% increase). Noteworthy, as well, was a 130% increase for central nervous system drugs for the 15 to 24 year cohort.

These data are consistent with Chickering's claims data previously reported in *Spectrum* and at American College Health Association (ACHA) on the significant use of SSRI's among students.

These findings were corroborated by a study by Medco, the pharmacy benefit manager of Merck & Co, released on September 19, 2002. In that study, Medco found that prescription drug spending in 2001 increased by 28% for persons under 19 years old. This was the largest increase for all age cohorts reported. Medco's data suggests that 2.3 million more children and teenagers now take prescription drugs than did so eight years ago. Both the possibility that children are overmedicated, and that new effective therapies for diseases such as asthma contribute to these findings are discussed. ■

"In 1996 Dartmouth Medical School introduced its new skills curriculum. Students are introduced to Dartmouth's innovative approach by watching 'It's a Dog's Life,' a movie about a man and his dog who are injured while jogging. The dog's experience with its vet turns out to be better than the man's with his physician."

From Managed Care,
September, 2002

The Heinz Family Philanthropies Partners with The Chickering Group

The Heinz Family Philanthropies, in partnership with Chickering, is distributing thousands of "Facts About" cards on the health of today's college students. The pocket-sized laminated card provides a summary of timely and accurate facts about specific health issues affecting the nation's 14.5 million college and university students. Although young people are among the healthiest in the United States, students often gamble with their lives and futures risking the negative consequences associated with the use of drugs, alcohol, and tobacco, poor nutrition, disordered eating, and misconceptions about sexual health.

Through this partnership, The Heinz Family Philanthropies and The Chickering Group developed the "Facts About" card on student health. Frederick H. Chicos, President of The Chickering Group, said the partnership with the Heinz Family Philanthropies is a way to help leaders better understand the complexity of student health issues on our nation's campuses. "It's not enough to help protect students and their families from the financial costs of injury or illness. These cards are one more way for us to promote awareness of the importance of keeping students healthy and in school."

Facts About: **Health of College Students** 2002

- ▶ There are approximately 14.5 million college students in the U.S. attending 4,182 colleges and universities.
- ▶ Approximately 30% of college students do not have health insurance.
- ▶ 500,000 college students between the ages of 18 and 24 are injured under the influence of alcohol annually.
- ▶ Annually, more than 70,000 college students between the ages of 18 and 24 are victims of alcohol-related sexual assault or date rape.
- ▶ Between 20 and 25 percent of college students are infected with a sexually transmitted disease.
- ▶ More than half of college women have experienced symptoms of an eating disorder.

- ▶ More than a quarter of college students mistakenly believe oral contraceptives provide protection from sexually transmitted diseases.
- ▶ The use of marijuana among college students increased 22% between 1993 and 1999.
- ▶ Less than 20 percent of college students are immunized against Hepatitis B.
- ▶ Massachusetts and New Jersey require college students to have health insurance.
- ▶ College students without health insurance are less likely to complete their education than those who are insured. Lack of insurance often necessitates leaving school to pay medical bills.
- ▶ More than one-third of college students smoke cigarettes.

A Project of the **Heinz Family Philanthropies**: Teresa Heinz, Chairman; Jeffrey Lewis, Executive Director (jlewis@heinz.org) and **The Chickering Group**, Frederick H. Chicos, President (health@chickering.com).

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If you would like to see a topic covered or would like to be a contributing writer, please contact Marketing Communications Manager, Christine Murray, by telephone at (617) 582-5000 or by fax at (617) 582-5001.

Where to see Chickering Next?

Chickering Leadership Forum:
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November 14-15 San Francisco, CA

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Illinois

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Center for Higher Education
Think Tank Program
Worcester, MA

November 7-9 NECHA, (New England)
Farmington, CT

November 10-12 MACHA, (Mid-America)
Maryland

November 20-23 PCCHA, (Pacific Coast)
Long Beach, CA

December 4-7 Council of Graduate Students
Washington, DC