

student health SPECTRUM

Winter 2003

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Chickering's Sixth Leadership Forum: Core Competencies for the Student Health Services Director

by Stephen Caulfield
Chairman

Summary: In late October and mid-November, two groups of leaders in student health met in Washington D.C. and in San Francisco to discuss the core competencies required to direct a successful student health service.

In all, thirty leaders from twenty-six colleges and universities located in seventeen states participated. Public and private institutions were represented, including several leaders with multiple student health centers under their control.

Core competencies were identified which could be described by a matrix of knowledge, skills, and personal characteristics; and management, health care, and higher education. Within that matrix, five broad categories of competencies were identified.

The ability to identify and communicate a shared vision.

The ability to plan for future needs and to obtain the requisite resources.

The ability to recruit, develop, and retain highly qualified staff.

The ability to integrate data, decisions, and delegation to empower staff at all levels.

The ability to develop broader institutional relationships to ensure the SHS adequately supports the missions of the University.

Four current management challenges were chosen to test the application of these core competencies.

A significant mandated reduction in university funds.

A popular, but low productivity clinician.

A significant increase in demand for behavioral health services.

A changing environment for students, the university, health care, and the economy.

While many participants felt they had acquired many of the requisite competencies through on-the-job experience, there was strong consensus that more organized training opportunities would add greater rigor in content and the value of shared experiences in the training process.

The day long meetings were divided into three sessions.

Session I: Participants suggested several core competencies critical to their leadership role.

Session II: Participants discussed ways in which these skills might be acquired.

Session III: Discussion focused on the application of competencies to several specific and current challenges to leadership.

As in past years, the topic was suggested by a student health center director.

This year, Evelyn Wiener from the University of Pennsylvania, suggested the topic which participants found to be timely. Almost universally, all are being challenged to provide more services with fewer resources, ask that many felt they were ill prepared to handle.^{1,2}

Many challenged the implicit assumption that becoming competent correlated with successful leadership.

"You are not going to get there just with competencies. Leadership should be competent, but it must also go beyond. One of my mentors, Cy Briefer at Michigan taught me that an effective SHS director must be 'connected' both within the SHS and most critically within the University."

***-Ted Grace, MD
The Ohio State University***

Many, agreeing with Ted, spoke about the importance of the "political capital" of relationships within the University.

"Spending time with people tends to create strong and positive relationships. I make it a practice to have lunch at the faculty club, so that I can build those relationships among colleagues outside the SHS."

***-Ira Friedman, MD
Stanford University***

In the SPOTLIGHT

Interactive Alcohol Intervention: MyStudentBody.comSM, An Online High-risk Drinking Prevention Program

by
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Abstract: The National Institute on Alcohol Abuse and Alcoholism (NIAAA)'s recent report entitled, "A Call to Action: Changing the Culture of Drinking at U.S. Colleges," highlighted methods that are most effective with college students. Recently completed controlled efficacy and satisfaction field trials, on an intervention with 260 students reported significant decreases in binge drinking episodes, coupled with very high to extremely high satisfaction rates.

Inflexxion, Inc., a behavioral health care technology company, has recently introduced the first in a series of personalized, interactive, web-based interventions for college students. These sites implement all of the "Tier I" strategies deemed effective by the NIAAA report and were developed with support from NIAAA. MyStudentBody.comSM - Alcohol (MSB-Alcohol) is a high-risk drinking prevention program to help educate students about alcohol and decrease the negative consequences associated with high-risk drinking. [The NIAAA report exposed the devastating consequences of alcohol abuse on campus: 1,400 alcohol-related deaths, 500,000 injuries, 70,000 sexual assaults, and 2.1 million incidences of impaired driving each year.]

After completing a risk assessment profile, users receive immediate, tailored motivational feedback. Statistical research and advice is presented in language that appeals directly to college students. As they use the site any time, day or night, each user builds a confidential, personal and password-protected profile to track their own alcohol consumption. Weekly consumption can be compared to national averages based on age, gender, race, year in school, and Greek/athletic participation. Students may also learn from peers, access experts, and read the latest alcohol-related news.

The reported Alcohol controlled efficacy and satisfaction field trials were conducted with 260 students at five Boston-area colleges and universities¹. between January and August 2002. All students met the criteria for binge drinking² and were randomly assigned (50% to each) to either four visits to the site (MyStudentBody.comSM - Alcohol, including the *Rate Myself* motivational intervention) or four visits to an alcohol information website³. The students ranged from ages 18-24 and represented an equal number of males and females, of which 25% were minorities.

Initial results derived from the baseline, one month and three month follow-up of students in the study group included:

Significantly larger decreases in binge drinking episodes per typical week compared to baseline (2.1 to .9 for MyStudentBody.comSM - Alcohol vs. 2.5 to 1.3 for controls, $p=0.03$), with an especially strong effect exhibited by female binge drinkers.

Females reported a significantly greater decrease in average drinks per drinking day (4.6 to 3.1 vs. 5.3 to 4.2 for the control group, $p=0.02$).

Minority students experienced significantly fewer negative consequences of drinking at three-month follow-up compared to minority control students (score of 40.7 to 29.7 vs. 45.7 to 34.7, $p=0.04$).

Results of a satisfaction survey with field trial students indicate that:

a significant difference in the overall satisfaction with the MSB-Alcohol site as compared to the control: 77% of the study group reported very high (5) to extremely high (7) satisfaction with the site versus 65% in the control ($p = .019$);

a significantly greater percent of students rated the MSB-Alcohol website very (5) to extremely (7) successful in addressing health issues pertaining to college students (84%), as compared to 64% in the control group ($p = .001$);

(45%) of the study group reported that they would be likely to refer the site to a friend, versus 28% in the control group ($p = .017$).

Given that all students in the study were binge drinkers and may be less inclined to view alcohol information favorably, these differences are viewed to be very meaningful. This study also supports NIAAA recommendations for using brief motivational interventions, which were found to be superior to information-only approaches.

Recruitment for a larger beta trial conducted in the Fall of 2002 was accomplished through a posting on a listserv that caters to college administrators, faculty, and staff. Twenty-six schools were selected to provide broad geographical representation, as well as a balance of smaller and larger colleges and universities. They received free access to the MSB site for the Fall 2002 semester. Results from this beta trial are now being collected, but are promising, with at least a third of the participants electing to purchase access through the 2003-2004 year. Preliminary reports indicate some campus-wide initiatives, as well as targeted strategies tied to various campus organizations, including judicial affairs.

All MyStudentBody.comSM websites are funded by the National Institutes of Health (NIH). For more information, visit www.mystudentbody.com or www.inflexxion.com. ●

End Notes:

1. Tufts University, Boston University, Middlesex Community College - Lowell, Middlesex Community College - Bedford and U-Mass Dartmouth
2. For women, defined as four or more drinks on a single occasion in the past week; for men, defined as five or more drinks on a single occasion in the past week
3. Text-based web intervention created from government information materials and brochures available in the public domain, e.g. from the NIAAA

Continued from cover page.

"Maybe the key differentiation between competencies and leadership is the leader must have the vision and must pursue it with a clear moral compass."

-Ron Elson, MD

University of California, Berkley

While there was consensus that leadership skills and core competencies for student health service directors were not synonymous, there was agreement that there was much overlap, and both could be acquired and improved with training, mentoring, and experience.

Although an organizational construct for synthesizing the discussions did not emerge immediately, it may be useful at this point to present a model that evolved over the two meetings.

That model began to develop when Lance Hopkins, SHS director at Northeastern University, suggested dividing competencies by subject area, offering three large groupings:

- Management
- Healthcare
- Higher Education

Later, Tom Mackey, Director at the University of Texas at Houston, suggested another three part structure:

- Knowledge
- Skills
- Personal Attributes

By combining these two organizational suggestions, a three by three matrix can be constructed.

Understanding that many personal attributes apply broadly, the matrix still provides a useful structure against which critical tasks can be analyzed for essential competencies.

For example, virtually every participant agreed the personnel tasks—recruiting, hiring, evaluating, training, redeploying, mentoring, and even terminating were absolutely essential to the job of directing a student health service.³

If you follow those tasks through the matrix, knowledge of the management literature on personnel issues in a professional service organization will provide a good starting point.

"When I started running a student health service years ago, I knew I lacked an understanding of how to manage people. I was able to take a several day workshop on 'human factors' management, which exposed me to Myers-Briggs, how to communicate to different personality types, and how to motivate people. It was all extremely useful, and I still use it today."

-Bill Christmas, MD, Duke University

"Our leadership team has developed a new approach to our interview process. We now use interview teams, and rely on both 'head' checks and 'gut,' checks, in our hiring process."

-Jim Nelson, Iowa State University

"Our Human Resource Department has helped us with a discipline they refer to as 'vector analysis,' which requires that we be very clear about what we are recruiting for before we begin the process."

**-Laurie Reitman, MD
Washington University**

But, as you move from management knowledge to health care knowledge, a new set of criteria emerge.

"Medicine requires a different kind of team. When the bell rings and an ill or injured patient needs care, the team has to function optimally, both as individuals and as a unit."

**-Nell Davidson, MD
Case Western Reserve University**

"The recruitment of good clinical people is my biggest challenge. They can have a great curriculum vitae and good references from colleagues, but how do we judge whether they are good with our patient population?"

**-Lance Hopkins, Health Center
Director, Northeastern University**

"Our clinicians must not only diagnose and treat—they must also have the ability to educate the student on their role as an adult patient. We are really training the next generation of health care consumers. Are our clinicians skilled at that task?"

-Sue Courts, RN, MSN

University of Northern Iowa

And if you were to move the personnel management knowledge question to the next cell on the matrix, higher education, you get still another level of information.

"...In institutions (of higher education), and in areas like college health, it is not always easy or even possible to bat 100% or even 60% in picking the right people. That is a hard lesson, and a frustrating one. It is also particularly difficult to correct in an institutional setting with overwhelming HR regulations and protections. I have found far more protections for employees than for supervisors and management."

-Larry Neinstein, MD

**University of Southern California
(by email)**

So, one can see how the matrix imposes a structure which asks, in this example, for hiring, what do we need to know from general management, from student health, and from higher education. Each provided a different, but important and valid window on the question.

Without overdrawing the point, one can move from knowledge, to skills, to personal attributes, and learn skills like interviewing, negotiating, and listening. Under personal attributes, participants spoke of passion, determination, humility, and humor.

So as to not lose some of the more spontaneous and interactive sense of the discussion, consider these descriptions of core competencies for the student health service director, which we have grouped, somewhat arbitrarily, into five categories:

I. Identification and Communication of a Shared Vision.

Throughout the two meetings, participants said in many different ways that the SHS director had to be the lead advocate for student health, the chief "interpreter" of complex medical and public health concepts, and the person who continually keeps the staff focused on the SHS's core mission.

Some, like Larry Payton who directs the program at American University said it very succinctly, "Find your message and defend it."

Some other comments on the role of "chief advocate":

"Enjoy the responsibility of being the only person talking about your unique mission in all those interstitial spaces that exist in universities. It is in those places, between and among departments and programs, where student health can be promoted as a non-competitive, value-added program."

-Margo Amgott
Columbia University

"You are the interpreter. You have to explain the mysteries of medicine, and deal with the accompanying fears about disease and ill health among your colleagues on the faculty, and in the administration."

-Ira Friedman, MD
Stanford University

"If students are important to the University, and they are, then student health is important. That has been my message for twenty years."

-Isabel Goldenberg, MD
George Washington University

"I work in health care, but I work within a business called higher education. I never forget the core business is higher education, not health care. Ours is a supporting role."

-Wayne Ericson, Ph.D.
Illinois State University

"The vision in student health has to have a clear moral compass. How else can we manage in a time of increasing needs and decreasing funding? How else can we resolve conflict? How else can we balance different notions of quality?"

-Ron Elson, MD
University of California, Berkeley

II. Anticipating the future and developing strategies to fulfill the mission in a changing environment.

Many participants identified the ability to anticipate change and to plan for it as critical to their job. This was seen as particularly important with changing student demographics, changes in morbidity, changes in community-based health care and, most importantly, changes in financing models for both student health services, and employer-sponsored plans.

"The number one job of the student health service director is the survival of the SHS. There are many skills and tasks required to ensure survival. Among them several stand out. You must be open to change, and to do that you must understand that all change has both an administrative component and a very high emotional component. You must also have both the skill and discipline to manage 'up' the organization, as well as managing 'down' to those people who report to you. You must always maintain a sense of humor, and you must be able 'to carry the tune,' keeping all reminded of what the job really is."

-Richard Carlson, MD
The New School University

"We need to anticipate where the financing for health care of students will be coming from. My view is it will be less and less from university funds, and also less from parental insurance, as employers push more costs back to employees. I also think our ability to refer care to the community will become more limited. So how do we bring more care into the University sphere, with fewer resources?"

I wish we could get a leadership group that would identify the future scenarios we are likely to face and suggest ways in which we could continue to support the health of students."

-Janet Corson-Rikert, MD
Cornell University

(The University of California system has recently released two reports:

"Undergraduate Health Insurance Implementation Workgroup—Recommendations and Guidelines" and "Campus Health and Counseling Services Workgroup Report." They may be obtained through Steve Lustig, Assistant Vice Chancellor, University of California, Berkeley, who was Chair of the two workgroups.)

"We must not only try to anticipate and understand the future, we have to understand that we can shape the future. 100% of our students will become patients and users of the health care system. Teaching them health habits, self-care, personal responsibility, and treatment compliance is a core part of our job."

-Estelle Maartman Moe, RN-C, NP
University of Vermont

"As Janet (Corson-Rikert) said, student health is a microcosm of our national problems, whether these problems are the uninsured, violence, a fragmented health care financing system, or maldistribution of health care resources. So that imposes on us a responsibility to understand the national health care picture, everything from mental health parity to HIPAA. But we also must understand how Student Health Services are different, providing a great deal of episodic care for self-limiting diseases. We are really part of the mission of the University—to help students achieve something close to their potential."

-Ron Elson, MD
University of California, Berkeley

Chickering Prepares for the HIPAA Privacy Rule: Frequently Asked Questions for Student Health Centers

By
Peter Carpentier, Esq., Corporate Counsel

From the outset Chickering has viewed HIPAA compliance as integral to its fundamental promise to protect the privacy and security of health care information. In December 2002, we completed an extensive HIPAA Privacy and Security assessment process with the help of a consulting firm to ensure full compliance with the implementation date of April 14, 2003 as required by the Final Privacy Rule, (which is the first in a series of HIPAA implementation dates, the next being October 16 for Transaction and Code Sets.) Chickering's employees have undergone professional privacy awareness training using a curriculum custom designed by our consultant. On-going training and system development activities will address the technically detailed and logistically complex nature of information privacy and data exchange among our integrated roles as the health insurance broker, the provider of all (school) client services, customer services (individual insureds), and claims administration. As with all other aspects of our business, our HIPAA compliance is designed to provide a single ("one-stop") solution to the many complex issues involving student health insurance vendor compliance with HIPAA Administrative Simplification rules. Chickering acknowledges interpretations of this ruling are complex and university or college-specific. One of the most common inquiries by schools has been the applicability of HIPAA to its student health center operations ("SHC"). Let us look at that through five questions.

Question #1: Does HIPAA apply to my student health center?

The HIPAA Privacy Rule (the "Privacy Rule") is applicable to (i) providers who transmit any health information in an electronic form in connection with transactions governed by HIPAA, (ii) clearing houses, and (iii) health plans.¹ Under the Privacy Rule, providers are persons or entities which provide medical or health services.² Health information includes a very broad spectrum of personal health data which the Privacy Rule defines as protected health information ("PHI").³ Given this overview of the Privacy Rule, it would seem that most student health centers are providers within the scope of the Privacy Rule and subject to its provisions, unless the SHC is otherwise excepted under the Privacy Rule.

Question #2: What are the exceptions?

A student health center would be exempt from the Rule only if it did not engage in electronic transactions governed by HIPAA; or, despite engaging in a covered electronic transaction such as e-referral, determines that it is FERPA⁴ exempt.

Question #3: My SHC is not FERPA exempt—what now?

If a student health center is not FERPA exempt and transmits electronic e-referral information to Chickering, it is required to comply with the Privacy Rule unless, as indicated above, it eliminates governed electronic transactions altogether.

While this may be a short term option for some student health centers, it is probably not a practical long-term solution, as it is clear that medical records and medical information are moving more and more towards electronic media.

Student health centers eliminating electronic transactions would be required to revert to the mailing or facsimile transmission of referral information, resulting in slower response times, potential problems with accuracy, and increased administrative costs. As a consequence, it would seem that with some rare exceptions, student health centers should consider that compliance with the HIPAA Privacy Rule is necessary to stay current with health information technology.

Question #4: What electronic transactions are Student Health customers likely to utilize?

Chickering has identified several electronic transactions governed by HIPAA which student health centers generally utilize. Subject to the exceptions above stated, each of these transactions, if undertaken by the student health center, would require compliance with the HIPAA Privacy Rule, as each is an electronic transaction governed by HIPAA. The most utilized transactions are:

The transmittal of protected health information through utilization of Chickering's web based referral system (E-Referral);

The viewing of eligibility information through Chickering's web based eligibility system (E-Stat);

The viewing of health claims data ("PHI"), as a customer service function for insured students, through utilization of Chickering's web based E-Stat system;

Question #5: Should my SHC change the way it accesses claims data?

If your SHC uses E-Stat to access claims data to provide a customer service function for students, you may want to consider transferring of this function to the plan sponsor (The University). Under 45 CFR §164.504(f) of the Privacy Rule, a plan sponsor⁵ can view PHI for a specific and limited purpose without complying with HIPAA. To accomplish this, the plan sponsor must amend its plan documents and provide a certification of this plan amendment to the health plan insurer. The certification must comply with the specific requirements of this provision. Accordingly, when a plan sponsor amends its plan documents and provides the necessary certification, a student health center which only views claims data can avoid compliance with HIPAA by requiring that any electronic viewing of claims data for the purpose of providing a customer service function for students be undertaken by the plan sponsor, and not the student health center which is considered the provider. Arguably, this could continue to occur from the student health center situs, but only the plan sponsor could provide this service. (Meaning this function is registered to designated university employees.)

However, should a student health center desire to provide this customer service function, not only would a plan amendment and certification be required, but the student health center would also be required to execute a business associate agreement with Chickering.

A business associate agreement would be necessary as the PHI viewed by the student health center would go beyond the scope of the health center's Treatment, Payment or Health care operations ("TPO")⁶ as defined under the Privacy Rule.

Question #6: This takes care of claims data, but what about E-Referral?

While the above provides an answer to the access of E-Stat information by SHCs by allocating its functionality to the Plan Sponsor, it does not remedy the matter of the transmitting of electronic e-referral information.

Yet, as indicated earlier, if a student health center is a covered entity, or has determined that it is FERPA exempt, the transmittal of referral information to Chickering is within the scope of those activities usual to providers. For a FERPA student health center the transmission of such information is arguably not the transmittal of PHI, but the transmittal of exempt FERPA information. The mere fact that it is electronically transmitted should not alter its characterization, and it should retain its exempt character. This position is buttressed by the fact that FERPA specifically provides that a referral request by a student for outside medical services is a permitted FERPA activity.⁷

A Graphical Summation:

The chart below puts in graphical form the conclusions of this article which, due to the continuing evolution of the Privacy Rule and its interpretation and application, cannot be considered conclusive. Nonetheless, while subject to change, Chickering considers these conclusions operative guidelines for the formulation of its own HIPAA policies. ■

Access to PHI	Agreements/Documents Required	
Function	Plan Sponsor	Student Health Center
Eligibility/Enrollment Data	none	none
Referrals Submission	N/A	none*
Customer Service Function	Requires a plan amendment & certification to health insurer	Covered Entity SHC requires a business associate agreement FERPA SHC loses FERPA protection and becomes a covered entity requiring a business associate agreement.
*Where the SHC is either a covered entity or FERPA exempt.		

Note: The information provided in this article is not intended to provide legal advice and represents the opinions of its author. Individuals should rely upon competent legal advice from counsel for determinative opinions regarding the complex subject of the applicability of HIPAA to student health center operations.

End Notes:
 1. 45 CFR 160.102(a) *Applicability*
 2. 45 CFR 160.103; Definitions: *Health care provider*
 3. 45 CFR 164.501; Definitions: *Protected health information*
 4. 'FERPA' is the acronym for The Family Education Rights and Privacy Act of 1974
 5. 45 CFR 164.501; Definitions: *Plan sponsor*
 6. 45 CFR 164.502: *Uses and disclosures of protected health information: general rules and 45 CFR 164.506 Uses and disclosures to carry out treatment, payment, or health care operations*
 7. 20 USC 1232g(a)(4)(B)(iv) *Family educational and privacy rights*

Continued from page 5.

"Several years ago, we asked ourselves what we would need to survive and fulfill our mission to the students and university. No surprise, the answers were adequate financing, and adequate space and facilities. The challenge was how to get there. We chose a mandatory insurance program (everyone in the university-sponsored plan) as our preferred strategy for adequate, stable financing, although we still get 50% (down from 80%) of our support from the University. How this works is that a portion of the insurance premium becomes a capitation payment into a separate account against which we draw revenue based on the services we provide.

For facilities, we knew we not only needed some donor support, but we had to get onto the universities capital/facilities plan. As I understand it, being selected as a priority on the capital/facilities plan is very hard to achieve almost everywhere in higher education.

To accomplish both, we established a campus-wide task force chaired by a Vice Chancellor, which solicited and received presentations from a number of universities and other 'experts' in student health. (See [Student Health Spectrum](#); Winter 2001, "Washington University Goes Mandatory" by Laurie Reitman, MD, MBA)

Our view was quite simple—we wanted to manage the agenda for the SHS. The alternative is that you are reacting to someone else's priorities and timing, and you lose much of the control of the process."

*-Laurie Reitman, MD, MBA
Washington University*

III. People: Recruiting, Hiring, Motivating, Evaluating, Mentoring, Disengaging.

If one were forced to distill the Leadership Forum to two topics, they would be people and money.

Much of the discussion on people focused on the selection process.

Prior to the meeting, Larry Neinstein at University of Southern California e-mailed us "...but most important are staff that are flexible (very key), dedicated and passionate (an important quality) about what they are doing. It is those individuals who will make or break the success."

Virtually all of the participants agreed. And most participants agreed that getting the right people to start was far more important than any training and education, which might be offered subsequently.

Some of the other comments from this very rich part of the discussion: *"Most people tend to recreate their family dynamics in the work place, so it is critical to know who you are recruiting. It is also true that if you take care of adolescents, you must revisit your own adolescence. This can create significant problems for some people. All of these complex psychological dynamics have to be considered in the hiring process."*

*-Nell Davidson, MD
Case Western Reserve University*

"If I could attend a 'fantasy' workshop on recruiting for Student Health Services it would be one that would help me detect narcissism and negativity. I suppose, because our service tries to function as a fully integrated team, if we have someone prone to narcissism, they become negative when they realize this isn't 'all about me,' but is really about a team serving students."

*-Ira Friedman, MD
Stanford University*

"The staffing or recruitment objectives of a health center (or any university unit for that matter) may not always be completely synchronized with the stated recruitment objectives of the university. For example, the Nebraska legislature enacted university recruitment requirements with the expectation that the uni-

versity increase employment of members of under-represented population groups. The somewhat rhetorical question is 'What takes priority- the staffing needs of a unit or the recruitment goals of the university?' One objective of our health center's resurrected staff development committee is to develop a dual diversity program which focuses both on delivery of patient care and the creation of a diverse, culturally sensitive, employment culture."

*-Jim Yankech, Associate Director of the University Health Center,
University of Nebraska-Lincoln*

While all agreed that recruiting was critical, there were also many comments on staff development, supervision, and evaluation. Wayne Ericson from Illinois State University reminded us that retention of a highly qualified staff also meant that some who are less qualified or otherwise diminish the team's functioning had to be helped to leave. Many reported incidences of counseling people to leave. Peer pressure can also be part of this process, but care must be taken to avoid scapegoating or blaming individuals for organizational problems.

"I try to live by two assumptions: First, there are no bad people, just bad processes. Second, the people who do the work must know best about how to get the work done. Of course, I've proven myself wrong on both counts, but I make many fewer mistakes if I start with these assumptions."

*-Richard Piech, MD
Rutgers University*

"In this kind of work, we really need diversity. I speak not only of gender, racial, ethnic, socio-economic, and sexual preference diversity, but also of Myers-Briggs personality type diversity. Managing this kind of diversity can be very challenging, but it also can be a learned skill. I think this should be a required core competency for all SHS directors."

*-John Andrews, MD
University of Cincinnati*

"One of the great challenges in managing a SHS staff is sorting out the differences between intentions and impact. There are very few who are malevolent. Unfortunately, there are many more who have a negative impact on the team, or the patient, or both. Creating regular feedback mechanisms can make dealing with negative impact less threatening."

-Bernette Melby, Director of Health Services, University of Massachusetts, Amherst

"Two ways to improve people's performances in the Student Health Center is to control the chaos and to run the place with maximum flexibility. Obviously, we can not control surges in demand that occur from time to time, but what we try to convey to staff is 'we'll deal with it, you continue to do your work'."

-Paulette Smith, MS, R.T. University of Maryland

There was much discussion of matching tasks to an individual's skills and credentials. For example, it may not be optimal for a physician to handle labor negotiations with the Nurses Association, whereas it may be critical to have a physician explain the outbreak and management of a Norwalk-like virus to the university or to the media. Many people said a core competency for a SHS director was to continuously match people to jobs.

It was suggested that managing an ongoing health service business can be improved by the use of time-limited projects. Projects permit staff to develop both knowledge and leadership skills. Projects have the advantages of clear and limited goals, measurable progress points, and often, the opportunity to get to know different people in the organization.

Several people spoke of the need for "expressed affection", "recognition", and "celebration" for positive reinforcement in the organization.

It was also suggested that the principle that "fair does not mean equal" should be expressly stated as part of the organizational structure.

But above all, the importance of constant and inclusive communication was stressed as a key management trait.

"Engage the people," said Janet Corson-Rikert of Cornell, a theme many echoed.

"We have two, day-long retreats a year for every member of our staff. We give our view of the 'state of the union,' review the progress we have made on the promises we made to each other the last time. And then we make new promises, all in the service of moving in the direction we have all agreed to. Everyone is included and almost everyone participates."

-Laurie Reitman, MD, MBA Washington University

But some people just don't work out. One of the 'cases' presented for discussion involved a physician who was extremely popular with patients (took time with them, wrote prescriptions freely, and asked no unwanted questions) and with the student body. But he was unpopular with colleagues because of low productivity and was of concern to the director for a variety of quality and productivity issues. Interestingly, many participants reported similar situations, although no one reported any successful remedy. Most reported "counseling out," while a few reported "working around" by managing the cases referred to the physician.

IV. Integrating Data, Decisions, and Delegation.

"A key skill in our organization is deciding what can be delegated and then supporting those autonomous decisions.

Those delegated decisions that were well made and achieved the desired result get public praise. Those that worked out less well will get some private coaching. Staff won't develop unless they are

empowered to make decisions."

-Allison Montgomery University of Virginia

"The 'Hopkins rule' is get the decision made at the lowest valid level."

-Lance Hopkins, SHS Director Northeastern University

"On those few, difficult, conflicted situations, I have to make the decisions and take the risks, but only after getting all the advice from staff and colleagues I can. That is where I rely on the 'moral compass' of our mission, and my personal integrity. These tough decisions don't occur often, but when they do, they provide a real opportunity to reaffirm our mission."

-Laurie Reitman, MD Washington University

"Being a democratic leader does not mean everything is subject to a vote. It does mean working on building a consensus, it does mean accountability and responsibility go together, and it does mean I have to make the hard decisions."

-Jane Halpern, MD Towson State University

"Delegation is one of the most important parts of my job. To have an effective delegation strategy, your staff has to have good judgment, clear authority to make decisions, and both the data and resources necessary to support those decisions. None of that is easy, but maybe most challenging is the 'common sense' issue. Some people have it, and just make good decisions. The trick is to find them, and let them do it."

-Ted Grace, MD The Ohio State University

"My job is to focus on the big picture, and to engage the organization, which is comprised of people from a wide range of backgrounds, in working together. A challenge is to link fairly discrete programs—medical, counseling, and health promotion.

Continued from page 9.

A useful device is to pull people from each area to work on projects, which cut across all three—such as smoking, and eating disorders."

*-Janet Corson-Rikert, MD
Cornell University*

Several other comments may be useful in empowering staff. First, most decisions can be reviewed and modified without significant costs programmatically, fiscally or personally. (A significant exception is hiring or long-term vendor contracts, but even those often have probationary clauses.) Second, Isabel Goldenberg, Director at George Washington University, had an excellent suggestion to get beyond a group's ambivalence about a course of action. She says, "How about we try it and see how it works." Implicit (or explicit if you want) is a review at a future date. A third suggestion was to build on suggestions and /or programs already in place, either within the SHS or from another setting. Taking a previous concept and making it incrementally better or more tailored to the specific situation reduces risk, while still empowering staff. "Decisions with training wheels" one participant called it.

The measurement of success here is both outcome-based and process-based, the latter being the degree to which staff feel empowered.

V. Networking and Diplomacy or "Finding the coin of the realm."

Among the core competencies for student health service directors, most participants agreed that supporting the broader missions of the University through participation on committees and task groups was essential. Most estimated a quarter to a third of their time went to these kinds of activities, with some spending as much as 40%.

"In a university the 'coin of the realm' can take many forms; teaching time, appointments and promotions, space,

but it all boils down to two things: money and reputation. A subset of reputation is 'appearance,' which, unfortunately, often gets a huge premium. So the student health center not only must do a good job, it must also appear to be doing a good job. (Several participants suggested training in marketing and public relations would be useful.) What are the implications for core competencies? For one, it's understanding how funds flow within the University, where the money comes in, where it stops, where it accumulates interest, and where it gets spent. Dollars accumulated by or for the student health center may wind up earning interest for another program. That may be exactly the right thing, but you need to know how it works, if you are going to direct the program."

*-Ira Friedman, MD
Stanford University*

"There is no question we all live in the larger context of the University. Over the years, I have learned to be diplomatically aggressive, to be both persistent and opportunistic, but above all to have a low external 'ego'. I have also learned you have to work at these 'external' university relations. We try each year to create an agenda of genuine involvement for some of our senior people. With regard to 'appearances' and public relations, we recently applied for a 'new initiatives' award from the President's Office. We were selected as one of four programs for this cash award. Even if we had not won, putting ourselves forward would have enhanced our visibility and recognition."

*-Lance Hopkins
Northeastern University*

"I have made it a practice within the university to not only identify myself as the director of the SHS, but also as a professor in the School of Nursing. The SHS may be seen as a 'supporting' function, but teaching and training are the university's core business."

*-Peggy Veaser, EdD, APRN, BC,
University of Tennessee-Memphis*

Peggy's comment raised the question among the clinically trained directors about how much time, if any, was spent seeing patients.

Many reported they no longer saw any patients, although some spent as much as half their time in direct patient care. The controlling variables combined personal interest and "passion" about patient care and legitimate time management issues. Most agreed, if one were to carry an active clinical practice, it should be at least, equivalent to a day a week to maintain one's clinical acumen.

Many commented that the importance of full participation in the life of the university required several levels of SHS personnel be involved.

"I spend a significant amount of my time on 'connectedness' with the university, but I also work hard to see that my direct reports do likewise. But whatever you do with colleagues in the university, try to understand their agenda and their needs. The faculty and staff here are very concerned about mental health issues. Health care is much further down the list. If I don't respond to their needs first, they will not be open to mine."

*-Ted Grace, MD,
The Ohio State University*

"The most frequent way in which we are involved with the university is often around a specific patient. Typically, through some troubling behaviors the student has residence life, judicial affairs, or an academic dean involved. Parents are also part of the equation. Our role often follows the clinical model of carefully eliciting a history, simplifying and comforting, and helping get consensus on an action plan."

*-Carlo Ciotoli, MD
New York University*

Two cautionary tales about involvement in the larger university community; First, agree to do what is within your capabilities and capacity.

"Because of the role we played in the 9/11 disaster in New York, and in the period following with heightened concerns about bioterrorism, the University began to look upon the SHS as the public health officer for the campus. There is no way we were staffed or equipped to take on that responsibility. It is an art form to develop political capital, while you are saying 'no,' but hopefully we did that by interpreting for the University what was really needed."

*-Margo Amgott
Columbia University*

(Author's note: For an excellent discussion on the role a university and the SHS can play in a public health event requiring a broad immunization program, see Jim Turner's response on the listserv. (<http://www.jcrinc.com/subscribers/perspectives.asp>)

And second, be careful about assuming a superior attitude:

"Some days, I think the job is 90% group therapy, and 10% academic politics, some days I say maybe that is an artificial distinction. The important thing to watch out for is that medical people can be arrogant— 'You can't cut our budget.' If I've learned one thing in student health, it is to pick your fights very carefully."

*Maggi Bridwell, MD
University of Maryland*

Application of Core Competencies to Specific SHS Situations.

Participants selected four current challenges to use as case examples for core competencies:

Case One: A mandated ten percent reduction in university support accompanied by a hiring freeze and an early retirement window for long-term employees.

Case Two: A physician who is popular with students, but has low productivity and questionable prescribing practices.

Although a recent hire, this individual is past his/her probationary period.

Case Three: As SHS director, you decide you need to construct credible alternative future scenarios for the student health center against the likely changes to the student body, the university and health care delivery and financing in general.

Case Four: Faced with a significant increase in demand for behavioral health services, including medication checks, brief and longer term psychotherapy, and crisis intervention, it is necessary to develop policies, procedures and financing to coordinate care among the SHS, CAPS, and providers in the community.

While space does not permit reviewing each of these discussions in depth, it is fair to say that no new competencies were identified and each of the five identified groups of competencies were validated.

Throughout the discussion of these four "cases" was the subtext of "how do you lead, when you may not have the authority over programs which are critical to student health."

Leadership derives its authority from three possible sources. The first is statutory authority, which is the authority associated with the position. Statutory authority is often measured by budgets, space, personnel, reporting lines, and the mission of whatever the individual is running.

Second, is the authority gained from knowledge and experience; in the current vernacular, the "been there, done that" authority.

The third kind of authority is personal, a mix of listening skills, synthesizing ability, translating, and, as Ted Grace says, having common sense.

In each of these cases, personal authority was seen as the most critical, followed by

experience and knowledge. Simply being director of the SHS may not get you very far in dealing with CAPs, clinicians in the community, and the various interested parties on the campus. In Lance Hopkins' phrase, it requires "aggressive diplomacy." But participants also stressed academic institutions are influenced by collaborative decision making and reliance on data.

Core Competencies: How Best Acquired

Participants suggested four types of resources which might help those in the field improve their knowledge and skills and acquire some leadership training.

- Existing courses, seminars and workshops (many outside of student health).
- Development of new workshops and training programs within ACHA.
- As alternative to ACHA's developing specific programs, ACHA could encourage modules to be developed within member schools and would approve and catalogue these offerings.
- The development of a leadership-mentoring program, perhaps tied into the ACHA Fellows program.

While many agreed some people seemed to be naturally effective leaders, all felt both knowledge and skills could be acquired more efficiently through training programs than through on-the-job training.

The author is grateful to all who participated for their insight and for their review of this summary. ■

End Notes:

1. The Institute of Medicine's recent report "Closing the Quality Chasm" suggests six tasks for health care leaders.
2. The Accreditation Council for Graduate Medical Education (ACGME) endorsed six core competencies for residency programs. (February 1999)
3. The noted management consultant, Peter Drucker, has suggested the core task of all organizations is the development of people.

Chickering Hosts Go Ask Alice! LIVE Workshop

On December 4, 2002, The Chickering Group hosted "Go Ask Alice! Live," an interactive workshop on Internet health education lead by Jordan Friedman, Director of Columbia University's Go Ask Alice! website.

Approximately twenty individuals from New England colleges and universities gathered at Boston University's School of Management to discuss the creation and maintenance of college health information web sites and how one administers their own site at their particular school. Among the attendees were health educators, doctors, nurses, and deans.

If you are interested in attending a Chickering seminar, please send your name and general topics of interest to Christine Murray, Marketing Communications Manager, The Chickering Group (cmurray@chickering.com).

Chickering Sponsors NASPA-ACPA E-Learning Series

The Chickering Group is proud to provide sponsorship support for the first NASPA - ACPA Student Affairs E-Learning Series. The series was launched last fall as a joint venture between ACPA and NASPA to provide quality professional development opportunities for student affairs professionals, faculty and graduate students. These three-week online seminars are designed and facilitated by nationally renowned leaders within their content area. Each seminar will feature presentation materials, a listing of additional resources, as well as online discussions. For a listing of courses offered throughout the spring go to www.naspa.org or www.acpa.nche.edu.

Setting the Standards for Campus and Community Alcohol Prevention Efforts

The Chickering Group, joined with The Higher Education Center for Alcohol and Other Drug Prevention, Boston College, National Institute on Alcohol Abuse and Alcoholism (NIAAA), and NASPA New England in presenting a workshop on the report and recommendations issued by the NIAAA Task Force on College Drinking. The program, attended by over 165 Senior Student Affairs Administrators, Health Services Directors and Health Educators from more than 55 New England Colleges served as a discussion forum on the report, "A Call to Action: Changing the Culture of Drinking at U.S. Colleges." The NIAAA, an arm of the National Institutes of Health, convened the Task Force comprised of distinguished educators, alcohol researchers, and students.

Dr. Robert Carothers, President of the University of Rhode Island and a member of the Task Force, provided the keynote address focusing on what Presidents and other campus officials can do to ensure the effectiveness of their efforts. Other prominent researchers in the alcohol abuse prevention field provided practical strategies for change and stressed the need for more rigorous research and evaluation of interventions currently in use. Leaders of college AOD prevention initiatives from each New England State presented on local campus and community coalition efforts to combat college drinking. Presenters included Dr. William DeJong, Boston University School of Public Health and Director of the Higher Education Center for Alcohol and Other Drug Prevention, Dr. Ralph Hingson, Boston University School of Public Health, Fred Donodeo, NIAAA, Dr. Jason Kilmer, University of Washington, and Dr. Linda Langford, Tufts University School of Medicine and the Higher Education Center.

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Where to See Chickering Next?

March 13-15 Southern College Health Association, Charlotte, NC

May 25-30 NAFSA, Salt Lake City, Utah

May 27-31 American College Health Association Miami, FL

Correction:

In the Spring 2002 edition of Spectrum, please note we misspelled Zweig, White and Associates (ZweigWhite), of Natick, MA. www.zweigwhite.com
Our apologies.